Top Tips

in

Two Minutes

for Primary Care Professionals

-2012 Series -

Top Tips
in
Two Minutes

Over the last four years we have been asking our speakers to imagine the following situation:

"You are about to give a talk to a group of interested GPs. You were going to speak for 1 hour at an important international conference, but as bad luck would have it, you and a group of GPs have got stuck in a lift and your talk has been cancelled.

You will be rescued, but not for TWO MINUTES.

Knowing what an interesting speaker you are and how passionately you feel about this area of your work, your colleagues plead with you to pass on some essential pearls of wisdom. What are your top tips in two minutes??!!"

In this booklet, we have gathered together their 'Top Tips*'

We hope you find them of use.

*Addenbrooke's PGMC provides these top tips as an educational aid to clinical practice based on published evidence. The ultimate judgement regarding a particular clinical problem lies with the clinician directly involved and in light of the information presented by the patient and the options available. These guides are not meant to be prescriptive.

All of these top tips together with the latest updates can be found at:
www.addenbrookes-pgmc.org.uk

NIPPA's
New Ideas in Paediatric Practice at Addenbrooke's

Addenbrooke's pgm Centre
Postgraduate Medical Education

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NIPPA's
New Ideas in Paediatric Practice at Addenbrooke's

The **NIPPAs** group of General Practitioners, was set up to develop the role of lead GPs in practices, and to enhance paediatric management skills within primary care, with the possibility of becoming local practice leads.

The Group ran successfully between 2005 and 2009, when it was decided that the time had come to "rest" the Group.

We would like to thank the Local specialists, who have facilitated bimonthly sessions.

Developing 'Top Tips' information sheets was also very much a key activity of this Group, and our NIPPAs devised 'Top Tips' are identified by the emblem featured at the foot of the page.

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Dental

Top Tips in Two Minutes. Dental Problems in General Practice

Why:

Dental problems should be seen by a dentist, if the GP is consulted - consider treatment options + signposting to appropriate care.
Access to emergency dental treatment is: (in order of priority)

1. Their own General Dental Practitioner (GDP) they are under no obligation to see if patient is not currently being treated
2. If no GDP, NHS Cambs PALs will offer advice on locating a convenient NHS dentist.
3. Dental Access Centres at Cambridge, Huntingdon, Wisbech and Peterborough will see patients with no GDP.
4. Cambridgeshire Emergency Dental Service operates weekdays 6pm to 9 am and weekends 6pm Friday to 9am Monday.

How:

Dental triage – what to look for:

1. Pain history
   When did it start? Trauma? – Nocturnal waking. Type of pain? Intensity? Triggers? What makes it worse / soothes it? Tender when percussed (with spatula)?
   Response to analgesia? Previous dental treatment
2. Visual observation, degree of pain
3. Medical history
4. Examination

Extra oral – swelling, lymphadenopathy trauma
Intra oral – swelling, cavities, avulsed teeth, broken displaced teeth

What next and when:

Common causes of oral / dental pain include:

PAIN	Think about	Possible Actions + refer to dentist
Intense / severe/ very sensitive to hot/cold/or sweet / spontaneous pain or pain on hot that is soothed by cold. Patient visibly distressed + difficult to locate tooth.	**Irreversible Pulpitis**	Analgesia. Only treatment to relieve pain is for the dentist to denervate the tooth. Ice could help Antibiotics won't help.
Constant "throbbing". Severe, unprovoked, can progress to make the patient systemically unwell.	**Peri- apical Abscesses.** Infection caused by decay in tooth, killing nerve and blood supply. Tooth may be slightly extruded	Drainage if possible. Burst swelling. Analgesia. Hot salt water mouthwash (HSMW) 1. Amoxicillin 250mg tds 5/7 2. Metronidazole 200mg tds 3/7 3. Erythromycin / azithromycin (Refer soon)
Sensitive to hot /cold /sweet	**Caries / Pulpitis**	Temporary filling material can be bought. Chewing gum poss. to cover hole. Antibiotics won't help.
Dental Trauma - fall /blow	Includes crown fractures, root fractures, loose teeth, extruded, displaced, intruded and avulsed (knocked out) teeth. (Early intervention – more likely to be successful)	Keep/find tooth. If **permanent tooth avulsed**, store in milk or under lip in mouth. (Refer urgent) Broken front teeth. - break in enamel, enamel/dentine.(refer soon). If blood supply to tooth visible (refer urgent)
Trismus: limited opening of jaw, pain on biting, swelling,	**A, Pericorinitis (wisdom teeth) problems** Usually in ages 17-25 Wisdom teeth erupting and overlying gum flap swells becoming infected **B. peri- apical abscess** **C. Dislocated jaw**. Condyles out of socket **D. Fractured jaw**, condyles or midline usually	Refer (soon) 1. Metranidazole200mg tds 3/7 2. amoxicillin 250mg tds 5/7and Chlorhexidine or HSMW (C. Support head firmly, push jaw down on lower teeth, jaw springs back) Pain relief
Lump on gum; tooth not tender to tapping	**Periodontal (Gum Abscess)**	1. Amoxicillin 250mg tds 5/7 2. Metronidazole 200mg tds 3/7 (Refer soon)
Pain on biting or on releasing bite.	**Cracked Tooth** Can ulcerate tongue	Refer (soon). Avoid biting, soft diet. pt can file down sharp edges / cover with temporary filler/ chewing gum. Antibiotics won't help
Painful extraction socket.	**Alveolar Osteitis / 'Dry Socket'** esp. smokers / oral contraceptive users	Pain after normal extractions lasts up to a week. 4th day is often worst. 7 days much better. Chlorhexidine or HSMW. Antibiotics won't help
Mouth ulcers	**Simple. Various causes – infections / systemic. Herbal medicines, Piercings**	Benzyamine Hydrochloride Oral Spray. Review 10/7 and refer if not healed 14/7
Shedding of 'baby' teeth	Ages. 5 yrs to 14yrs Pain with biting. Swelling at eruption site; 20 teeth have to be shed!	Reassurance.
Halitosis, poorly localised pain, possibly pyrexia and red swollen bleeding gums with ulcerated interdental papillae covered by a greyish white necrotic area	**Acute Necrotising Gingivitis** Usually affects young (14 – 35 year old or immuno-compromised) Smoking intensifies condition	Stop Smoking. Refer (soon) /can prescribe Metronidazole or amoxicillin / Chlorhexidine or HSMW.

Antibiotics dosages are for adults

When to refer

Refer to secondary care if:

- Trauma not confined to teeth
- Severe haemorrhage
- Airway problems
- Septicaemia
- Spreading cellulitis
- Avulsed (knocked out) adult tooth if no Dental Access Centre open

Where else:

Access dental care: patients can call NHS Cambs PALs on **0800 279 2535**.
Cambridge Dental Access Centre: **01223 – 723 093**
Huntingdon Dental Access Centre: **01480 – 363 760**
Wisbech Dental Access Centre: **01945 – 465 919**
Peterborough Dental Access Centre: **01733 – 295 854**
Cambridgeshire Emergency Dental Service (after 6pm and at weekends): **01223 – 471 798**

Professional advice: dental surgeon at Brookfields Dental Clinic on **01223 – 723 093.**

Ref: DH FGDP + RCS guidelines on antimicrobial prescribing 2011

Web links: www.dentaltraumaguide.org

Who are you: Maria Ross-Russell: Clinical Director / Business Manager CCS NHS Trust Dental Service maria.ross-russell@ccs.nhs.uk
Dr Tony Holland: General Dental Practitioner Cambridge 16 Burleigh Street CB1 1DG

Review date: March 2012

Review date: **March** 2014

ENT

Top Tips in Two Minutes: Otitis Externa

Why:	Otitis externa (OE) is a diffuse inflammation of the external ear canal and external layer of the tympanic membrane. It is often caused by water and instrumentation of the ear canal with cotton buds, which leads to infection and pain.
How:	The inflamed skin in the external auditory meatus becomes infected with pathogenic bacteria, usually staphylococcus and pseudomonas. Digital contamination may also introduce coliforms. (Note: a rare form of OE, malignant otitis externa is a severe infection caused by pseudomonas *sp.* this is characterized by severe pain, bone erosion and cranial n palsies. It is common in diabetics and immunocompromised and requires IV treatment.) The inflammation results in itching and pain, particularly on moving the tragus e.g. when inserting the auroscope (this moves the infected hair follicles in the external auditory meatus). The physical signs may be relatively minor as even a small degree of swelling has nowhere to expand as the ear canal is surrounded by bone. There may be a watery discharge (serous) but not mucoid (which would arise from the middle ear). The infection can then spread to the surrounding pinna causing a secondary perichondritis and cellulitis.
What next and when:	Most infections will respond to topical antifungal/ antibiotic/steroid mixtures, e.g. *locorten-vioform (oily and good in flaky skin), Sofradex or Otosporin (stronger steroid and good where discharge predominates).* Where there is a suspicion of tympanic perforation ciprofloxacin eye drops *0.3% or ofloxacin 0.3%* eye drops are a good alternative and have good antipseudomonal activity. The pinna can be treated with topical trimovate in the conchal bowl at night. Swabs are useful if the condition does not respond to the above. **Refer**? In non-responders, in whom suction under microscope is usually required to remove debris in the ear canal. Where swabs indicate Candida or aspergillus (occurs in long term antibiotic use) When the canal is completely occluded. Severe swelling of the pinna Elderly or immunocompromised (see malignant otitis externa, above). **Prevention?** Keep ears dry; especially avoid soapy water, which lowers the surface tension. Recurrent infections with staphylococcus can be prevented with antiseptic cream containing chlorhexidine (e.g. Savlon). Recurrent infections with pseudomonas can be prevented by white wine vinegar diluted 50:50 with cooled boiled water (acetic acid 8%) as eardrops.
Where else:	
References:	BMJ 327 : 1201 doi: 10.1136/bmj.327.7425.1201
Web links:	http://www.thelancet.com/journals/laninf/article/PIIS1473-3099(03)00858-2/fulltext#cor1
Who are you:	Dr Andrew Watson GPwSI, Cambridgeshire Mr. Roger Gray, Consultant ENT surgeon. Addenbrooke's Hospital
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Septal Haematoma

Why:	The nose is the most frequently injured facial structure. Trauma, even relatively mild to the anterior nasal septum can result in haematoma formation. Although a rare condition, it is much more common in children and if not treated promptly, can result in abscess formation, perforation and saddle deformity. It is more important to look for, and drain a septal haematoma than to worry about a nasal fracture.
How:	The anterior portion of the nasal septum consists of a thin cartilage plate to which muco-perichondrium is loosely adherent, especially in children. Buckling of the perichondrium during trauma tears the submucosal blood vessels, which bleed resulting in a haematoma collecting between the perichondrium and septal cartilage.
What next and when:	Infection of the haematoma and subsequent abscess formation can occur within 3 days. Diagnosis is by direct inspection of the septum (an auroscope is good for this). This will show a blue/ reddish fluctuant convex swelling on both sides of the septum The swelling is not usually tender and can be palpated with a gloved little finger demonstrating fluctuance. If there appears to be a deviated septum within the nose on both sides following trauma then the diagnosis is a septal haematoma.
Where else:	The patient should be admitted for urgent drainage, failure to do this may result in avascular necrosis of the septal cartilage with subsequent development of a saddle nose and possible extension of infection to the cavernous sinus.
References:	(web references below)
Web links:	http://www.doctors.net.uk/Forum/viewPost.aspx?LastViewed=1&forum_id=237&post_id=4481760 http://emedicine.medscape.com/article/149280-overview
Who are you:	Dr Andrew Watson GPwSI, Cambridgeshire Mr. Roger Gray, Consultant ENT surgeon, Addenbrooke's Hospital
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Otitis Media with Effusion (Glue Ear)

Why:	Glue ear (OME) is the commonest cause of hearing loss in children. Almost all children will develop an episode during childhood. One third will resolve spontaneously within 3 months. However, hearing loss lasting for longer than 6 months results in a delay in speech and language development.
How:	An effusion of the middle ear is generally sterile and has no symptoms of infection. It is distinguished from acute otitis media (AOM) where there is inflammation, pain and temperature and often resulting in tympanic membrane perforation. OME is usually self-limiting with a peak incidence between 2 and 5 years. It is often found at routine hearing appointments and can sometimes present as speech and language delay. As a rule of thumb: a child should have 50 words by age 2 years. Some children may also have nasal obstruction, snoring and purulent rhinorrhoea, suggestive of enlarged and infected adenoids. Otoscopy will indicate dull tympanic membranes on both sides with prominent vessels on the handle of the malleus. In children over 4 years a conductive hearing loss can be demonstrated by tuning fork tests and an audiogram.
What next and when:	A period of "watchful waiting" in cooperation with community paediatrics is recommended for 3 months. Referral for detailed hearing tests should be made if there is no resolution after this. **Routine** referral is appropriate for those under 4 years. An "**urgent**" appointment should be made if there is a suggestion of a sensorineural loss, significant speech delay, Down's syndrome or parental concern. An **urgent** referral should also be made for an adult with a unilateral glue ear to exclude nasopharyngeal carcinoma.
Where else:	Grommets are inserted as a day case. These have a benefit for about one year and also result in improvement in behaviour and speech and language, for up to two years after insertion. Adenoidectomy is only performed if there are adenoidal symptoms (see above) or the need for a second set of grommets. Hearing aids Not helpful: steroids, antibiotics (unless AOM) decongestants, and antihistamines auto inflation devices.
References:	(web references below)
Web links:	**Web ref:** Diagnosis and management of childhood otitis media 2003 SIGN **www.sign.ac.uk/guidelines/fulltext/66/references.html**
Who are you:	Dr Andrew Watson GPwSI, Cambridgeshire Mr. Roger Gray, Consultant ENT surgeon, Addenbrooke's Hospital
Review date:	March 2014
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Ethics & Law

Top tips in Two Minutes: Mental Capacity Act, Information Sharing and Access to Records

Why:	**Mental Capacity Act 2005**: Prior to 1st April 2007 , if an adult was deemed to lack capacity this was generally assumed to be a permanent state, - care decisions, including those about information use and sharing were made on the basis of 'best interests', often with clinical staff dominating the decision. This is no longer the case. **Information sharing**: Right to confidentiality is not absolute It is usual to seek consent when sharing information Sharing information is vital to good health care **Access to records**: Individuals have the right to have a copy of what is held about them- care organisations must adhere to this right as well as balancing their own additional statutory rights and duties
How:	All health and social care organisations that hold information about people have statutory responsibility to comply with: • Data Protection Act 1998 – including notification (registration – Information Commissioner) • Freedom of Information Act 2000 (business information) And adhere to: • DOH Codes of Practice – Caldicott, Information Governance Mental Capacity Act 2005 gives the first statutory guidance in the UK on decision making for those over 16 who lack capacity
What next and when:	Patients/staff should be aware of what information is used for: • Leaflets and posters – who to contact • Rights to limit information use – who can have information about them • No automatic right to information about others, e.g. husband, wife, 'next of kin' Staff should be aware that the Mental Capacity Act 2005 creates a '*decision specific'* view of capacity, i.e. a person may be able to decide what to wear or eat, but not take a serious financial decision such as take out a mortgage. Act has: • Five key principles – enabling individuals to make decisions • Four point functional test of capacity • Compels care organisations to assist in decision making • Creates criminal offence of abuse • Allows individuals to nominate others to represent them should they lack capacity to make a particular decision – Lasting Power of Attorney • Codifies advance directives/livings wills
Web links:	http://www.ico.gov.uk/ Information Commissioners office – Data Protection and Freedom of Information http://www.justice.gov.uk/ Ministry of Justice – Mental Capacity Act, see also http://www.guardianship.gov.uk/ Public Guardianship Office (Lasting Powers of Attorney – replaces Enduring power of attorney) http://www.dh.gov.uk/en/Home Department of Health, homepage https://www.igt.connectingforhealth.nhs.uk Information Governance Toolkit, Connecting for Health team
Who are you:	Mary Mitchell – Head of Risk Support, Anglia Support Partnership
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INFECTIONS

Top Tips in Two Minutes: Genital Herpes

Why:	• It is thought that at least 7% of adults in the UK have genital herpes • Most have not had their disease diagnosed • Most transmissions take place when people are unaware of their herpes • Neonatal herpes is often fatal, but is preventable and, fortunately, rare
How:	• Ask re: evolution of symptoms – classical is vesicles then ulcers then scabs • Recurrence, 50% of recurrences are preceded by up to 48 hours of prodromal symptoms e.g. tingling, discomfort • Sexual history including received oral sex? (most new cases in women, and many in men, are acquired this way i.e. Herpes simplex virus type-1 – HSV-1) • Approximately 50% of first episodes are non-primary (i.e. patient had pre-existing antibodies to HSV-1) and are therefore mild (like a recurrence). • Remember that candida can sometimes cause superficial, often linear, ulceration. • Herpes ulcers often (but not always) have a ring of surrounding erythema.
What Next and When:	• Take swab for herpes PCR or refer immediately to GU Medicine • Consider test for syphilis (whose ulcers are not always single and painless) • Then start treatment e.g. Aciclovir 200mg 5 x / day x 5 days • PCR is more sensitive than the old culture tests, but a negative test does not disprove the diagnosis • Follow up at 10 days with results • Screen for other STIs (especially if HSV-2) – can be at GU Medicine (Genito Urinary) • (Herpes Simplex Virus) (Sexually Transmitted Infection) Counselling (can be at GU Medicine) to cover: - – Possible Prognosis (and what treatment is possible) 50% chance of HSV-1 recurring, as opposed to 90% with HSV-2. HSV-1 often recurs c.1x/year; HSV-2 tends to recur more often. Continuous suppression (with Aciclovir 400mg bd) is offered if 6 or more attacks per year. – Most recurrences are mild and do not require treatment – Avoiding transmission (no sex from start of prodromal symptoms, if any, until one week after skin is back to normal) – Asymptomatic shedding, worse in first 3 months, is proportional to frequency of symptomatic recurrences. It occurs especially in the week before and the week after an attack. • Partners should be informed (and have STI screen if HSV-2) • At least 1/3 of cases of apparently newly acquired herpes were acquired over 3 months ago. Leaflets are useful (lots of information to remember) Available from http://www.patient.co.uk/showdoc/23068744/
Where else:	Contact local GU Clinic: Addenbrookes 01223 217 774 or Cambridge sexual health hub The Laurels, 20 Newmarket Road, Cambridge CB5 8DT Telephone: 08456 50 51 52 The Herpes Viruses Association: http://www.herpes.org.uk/ FPA information: http://www.fpa.org.uk/helpandadvice/sexuallytransmittedinfectionsstis/genitalherpes
References:	Jungmann E. Genital Herpes. Clin Evid 2005; 14 : 1937-49
Web links:	British Association for Sexual Health and HIV: http://www.bashh.org/documents/115/115.pdf
Who are you:	Dr Chris Carne, Consultant in Genitourinary Medicine, Addenbrooke's Hospital, Cambridge
Review date:	March 2012
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Top Tips in Two Minutes: HIV Infection

Why:

An estimated 91,500 people were living with HIV in the UK at the end of 2010, of whom nearly a quarter (24%) was unaware of their infection.
The prognosis is good provided that HIV is not diagnosed too late
Spread to others is less likely if the patient is aware of their HIV

How:

Major Risk Factors

- Homosexual/bisexual man
- From high risk areas of the world e.g. sub-Saharan Africa
- Heterosexual sex with someone from high risk group
- History of injecting drug use
- e.g. you might ask "are you concerned that you may have put yourself at high risk of HIV?"

Common Symptoms and Signs of Primary HIV Infection (Seroconversion Illness)

- Fever
- Malaise
- Arthralgia
- Maculopapular Rash

Standard HIV tests may be negative at this stage. Discuss with Lab if high level of suspicion.
Otherwise repeat HIV antibody test 3 months after last risk.

"Tell-Tale" Signs – HIV Infection (Prior to Profound Immunosuppression)

- Persistent generalised lymphadenopathy (especially axillary and posterior cervical regions)
- Troublesome seborrhoeic dermatitis and other severe or hard-to-treat rashes
- Recurrent respiratory infections
- Shingles

"Tell-Tale" Signs – Late HIV Infection

- Oral Candida
- Oral Hairy Leukoplakia (furring on lateral borders of tongue)
- All patients with tuberculosis should have an HIV test
- Unexplained weight loss/diarrhoea
- Wide range of infections of RS, GIS, NS (Respiratory System) (Gastro Intestinal System) (Neurological System)
- Tumours include Kaposi's (esp. skin), lymphoma, Ca cervix

What Next and When:

Can test in general practice or can refer to GU Clinic
Patients at risk of HIV are often at higher risk of other STIs e.g. Chlamydia, hepatitis B etc.
Pre-test discussion (necessary when patient has risk factor or is anxious)

- Exploration and explanation of degree of risk
- Meaning of test (HIV vs. AIDS)
- Window period of 3 months (although the latest tests are very nearly 100% accurate at one month)
- Meaning of positive results
- Action if positive result – support, follow up, informing partner(s)
- Good prognosis (very successful drugs when become immunosuppressed)
- Life insurance only an issue if diagnosed HIV positive
- Patient may wish to go away to consider whether to take test

Perform HIV antibody test (result has to be confirmed by multiple confirmatory tests on first sample).
When result is given to patient, this is subject to performing a second blood test for HIV at this time, to ensure no mix-up of samples has taken place.
If positive, refer to GU (Genito Urinary) Clinic for early appointment and follow up.
Anti-retro-virals have high risk of drug interactions, which may cause any regimen to fail. Discuss starting treatment when CD4 count drops to c.350 i.e. 2008 guideline (normal is 500 or higher).

Where else:

Contact local GU Clinic

References:

Adler MW. ABC of AIDS (5th Edition) Pub: BMJ Books

Web links:

http://hivinsite.ucsf.edu/InSite.jsp?page=KB (online text book)
www.bhiva.org (detailed guidelines)
www.hiv-druginteractions.org (for HIV drug interaction charts)

Who are you: Dr Chris Carne, Consultant in Genitourinary Medicine, Addenbrooke's Hospital, Cambridge

Review date: March 2012
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MEDICINE

Top Tips in Two Minutes: Chronic Kidney Disease

Why:

Chronic Kidney Disease: Been around forever, but important because of eGFR (estimated Glomerular Filtration Rate) and the QOF (Quality Outcome Framework)

How:

Example: A laboratory result comes back on one of your patients, an 80 yr old woman, showing that creatinine is 125 micromol/l, which doesn't seem too bad, but eGFR is calculated as 38 ml/min, CKD stage 3B.

Proceed as follows:

1) Remember that CKD stage 3 affects 3-4% of the population and 30% of people over 75 years, most of whom do not need referral to renal services.
2) Do not tell the woman and her family that she has Chronic Kidney Disease: say that her kidney function is slightly reduced, as it is in one third of older patients.
3) Check if creatinine has been measured before: if so, is it stable? If not, repeat within two weeks.
4) History – previous kidney problems: UTI, haematuria, stones, protein in urine (pregnancies, medicals), episodes of swelling; family; cardiovascular risk factors (esp hypertension, diabetes).
5) Examination – is the bladder palpable (especially elderly men)? If it is - organise urgent ultrasound of urinary tract and discuss with urological services.
6) Examination - check blood pressure.

What next and when:

CKD stage defined by eGFR

Stage	eGFR (ml/min)	Comment	Proteinuria
1	>90	Must have other evidence of kidney disease	Suffix P can be applied to any stage of CKD if ACR >65mg/mmol
2	60-89	Must have other evidence of kidney disease	
3A	45-59	Defined by eGFR alone	
3B	30-44		
4	15-29		
5	<15		

CKD stages 1 and 2

1) Few patients with CKD 1 or 2 require referral to renal services.
2) Urine – stick test for blood and protein; quantitate proteinuria by albumin creatinine ratio (ACR). Refer to renal services if no blood and ACR >65mg/mmol, or blood and ACR >30mg/mmol.
3) Annual monitoring in primary care – check creatinine, potassium, cholesterol, ACR.
4) BP control - '140/90 max, or 130/80 in patients with urinary ACR >70mg/mmol (approx equivalent to 2+ or greater on dipstick test) is the ideal' … but common sense must prevail.

CKD stage 3

1) Few patients with CKD3 require referral to renal services.
2) Urine – as for CKD stages 1 and 2.
3) Other blood tests: haemoglobin, cholesterol.
4) Action – stop poisons (NSAIDs).
5) BP control – as above.
6) Monitoring in primary care every 6-12 months - check creatinine and (2) and (3) and refer to renal services if eGFR declining by >5 ml/min/year or reaches CKD stage 4.
7) May need iron and/or epo for anaemia, but unlikely to do so – discuss with renal services.
8) Immunization – influenza and pneumococcal.
9) Patients with CKD stages 1-3B do NOT need routine measurement of calcium, phosphate, PTH and vitamin D levels.

CKD stages 4 and 5

As for stage 3, except (in contrast to Stage 3) please refer to or discuss with renal services, except in patients in whom:

1) All appropriate investigations have been performed and there is an agreed and understood care pathway.
2) Severe renal impairment is part of another terminal illness.
3) Further investigation and management is clearly inappropriate.

Standard clinical management (for those for whom it is appropriate) will include monitoring and treatment as for CKD stage 3, with:

1) Check of eGFR every 3 months.
2) Measurement of calcium, phosphate, PTH and vitamin D levels - treatment with phosphate binders and/or vitamin D analogues is likely to be required.

Web links/ References:

The short CKD eGuide http://www.renal.org/eGFR/eguide.html
The Edinburgh Renal Unit GP guide http://renux.dmed.ed.ac.uk/EdREN/Unitbits/GPinfo.html
Patient UK Chronic Kidney Disease – a summary
http://www.patient.co.uk/search.asp?searchterm=chronic+kidney+disease&searchcoll=All&site=All
Patient leaflet on CKD from RCGP http://www.renal.org/eGFR/resources/PatientCKDinfJan2007.pdf
NICE guidance on CKD (Sept 2008) - http://www.nice.org.uk/Guidance/CG73

Who are you:

Dr John Firth, Consultant Nephrologist, Addenbrooke's Hospital, Cambridge

Review date: March 2012

Review due: March 2014

Top Tips in Two Minutes: Haemochromatosis

Why:	• Hereditary haemochromatosis (HH) now easily screened for as most are homozygous for the C282Y mutation in the HFE gene • 1 in 200 of Caucasian populations are homozygous (1 in 10 carriers) • There is variable expression ranging from asymptomatic (often just a raised transferrin saturation only) to those with 'bronze diabetes'; many will have subtle symptoms and modest elevation of ferritin • Expression depends on age, iron losses (blood donation or menstruation lessen burden), alcohol use
How: (what to look for)	• Symptoms usually non-specific including fatigue, arthralgia, loss of libido, abdominal pain • Typical signs: hepatomegaly, diabetes, pigmentation, arthropathy (hips, knees and particularly 2nd and 3rd metacarpophalangeal joints) • Check iron indices in anyone with raised ALT and in those with combination of above symptoms / signs (Alanine Transaminases)
What next and when:	<u>Suspected haemochromatosis:</u> • If raised ferritin and transferrin saturation, send an EDTA sample for HFE genotyping to Molecular Genetics • If unsure re genetic counselling or age < 40 refer to Medical Genetics for testing (box 134, Addenbrooke's Hospital) • Genotypes compatible with HH: C282Y/C282Y (homozygous) or C282Y/H63D (compound heterozygote – less common and milder) • If homozygous then family screening as below • HH with ferritin > 1000 or raised ALT, or non-HH iron overload: refer to Hepatology as may need liver biopsy • HH with ferritin < 1000 and normal ALT: no biopsy as minimal risk of liver fibrosis but venesect if ferritin > 400 (refer Hepatology or local venesection service if available, aiming for ferritin of 50) • NB non-HH genotype + mildly raised ferritin / ALT = likely fatty liver <u>Family screening (C282Y homozygous index cases only):</u> • Refer to Medical Genetics if: 1) index case genetics unknown 2) uncertain re counselling 3) index not homozygous but family request • Siblings should have HFE / iron indices sent • Children tested only when adult but can screen partner/spouse to see if carrier (children only at risk if spouse is carrier = 10% chance) • Parents if symptoms suggestive of HH (homozygosity risk low if not) • HH genotype + ferritin <200: reassure and monitor 2-5 yearly (less frequent if female, compound heterozygote, no sign of iron loading) • HH genotype + ferritin 200-400: reassure and suggest blood donation via NBS up to 4 x year max to prevent further iron overload (monitor annually) • HH genotype + ferritin >400 see above ('Suspected haemochromatosis' points 5 and 6)
References:	Griffiths WJ. Review article: the genetic basis of haemochromatosis. *Aliment Pharmacol Ther* 2007; 26:331-342
Web links:	www.haemochromatosis.org.uk (British haemochromatosis society)
Who are you:	Dr Bill Griffiths, Consultant Hepatologist, Box 210, Addenbrooke's Hospital
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Diagnosis of Lung Cancer

Why:	Main cause of cancer death in the UK 38,000 new cases per annum in UK - accounting for 34,000 deaths Although incidence in men is falling, far more cases are being seen in women. Male: Female ratio has changed from 6:1 to 3:2 **Changes in practice** Diagnosis and staging techniques have improved (PET-CT, endobronchial and endoscopic ultrasound) More patients are being offered treatment with curative intent (surgery; radical radiotherapy, radical chemo/radiotherapy) and this will lead to improved survival rates. More patients are being offered molecular targeted agents such as epidermal growth factor receptor (EGF-R) inhibitors (Iressa/Gefitinib or Tarceva/Erlotinib). Increasing use of endobronchial tumour debulking palliative techniques. Many patients in Anglia will be offered opportunity to participate in research studies/trials
How:	There are no *specific* symptoms or signs for lung cancer. **Most common symptoms** Cough for more than 3 weeks Worsening or change in nature of long standing cough Unexplained persistent breathless Haemoptysis Persistent chest infections Unexplained persistent tiredness or lethargy Unexplained persistent weight loss Stridor Hoarse voice Persistent chest or shoulder pain **Have low threshold for CXR in any patient with symptoms who has a smoking history** *The earlier the diagnosis, the better the chance of cure* Symptom cytology is of little use. Note: 10% of cases in never smokers and becoming more common in women. Most cases now are in ex-smokers
What next and when:	If you have **any** suspicion that patient might have lung cancer use the rapid 2/52 referral system for suspected cancer. Very helpful if you tell patient that you are referring them because of an abnormal CXR/symptom etc. and that among other things you have to consider lung cancer
Where else:	Referrals should be made to local respiratory medicine team who will refer onwards to Papworth with minimal delay where the regional thoracic oncology diagnostics service is based. At present Papworth Thoracic Oncology does not take direct GP referrals. However, we are very happy to be contacted at Papworth for advice: robert.rintoul@nhs.net; 01480 364342
References:	National Institute for Health and Clinical Evidence – Lung Cancer Guidelines – updated 2011 CR-UK lung cancer help pages Roy Castle Lung Cancer Foundation
Web links:	National guidance: http://www.nice.org.uk/Guidance/cg121 Information for patients and carers: http://www.cancerhelp.org.uk/help/default.asp?page=2787 http://www.roycastle.org/
Who are you:	Robert Rintoul, Consultant Chest Physician (w/ special interest in lung cancer and mesothelioma)
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Spirometry

Why:	Spirometry is a relatively simple but effective tool for diagnosing whether patients have a lung function abnormality. These can simply be categorised as obstructive, restrictive or mixed. Spirometry can also be used to aid in the diagnosis of relatively rare complications such as extra-thoracic obstruction (i.e. in the case of a goitre which is pressing on the trachea) or vocal chord dysfunction. Both of these abnormalities can be detected from the flow-volume loop which will show reduced inspiratory and expiratory flow for a fixed extra-thoracic obstruction or reduced inspiratory flow only for vocal chord dysfunction. Spirometry can also be used to assess respiratory muscle weakness if performed in the standing/sitting and laying positions. A fall in vital capacity from the standing/sitting position to the laying position of 30% or more is suggestive of severe diaphragmatic weakness.
How:	FEV_1 – Forced expiratory volume in one second FVC – Forced vital capacity SVC – Slow vital capacity Ensure that a minimum of 3 manoeuvres are performed. Values of FEV_1, FVC and PEF should be within 5% of each other when ensuring reproducibility of the measurements. Take ALL values from the manoeuvre with the best FEV_1 and PEF, DO NOT CHERRY PICK from different manoeuvres. **General rule of thumb:** If FEV_1, FVC & SVC reduced likely to be restrictive abnormality FEV_1/SVC will be normal or increased depending on severity If FEV_1 reduced, FVC & SVC normal likely to be obstructive abnormality FEV_1/SVC will be reduced In line with NICE/GOLD COPD guidelines percentage of predicted is used to monitor normality Consider values between 80-120% predicted as normal 60-79% mild abnormality 40-59% moderate abnormality <40% severe abnormality However, please note concerns in using percentage of predicted www.spirxpert.com
What next and when:	If results suggestive of an obstructive abnormality, give short-acting β_2-agonist wait 20 minutes and repeat spirometry. If FEV_1 improves by >15% suggestive of reversible airways, i.e. asthma. If respiratory muscle weakness suspected, performance of maximal inspiratory/expiratory pressures required to confirm. If any of the above detected it may be necessary to refer to a chest consultant in order for more complex tests of lung function to be performed.
Where else:	GPs can refer direct to Chest Physician at Addenbrooke's who will organise lung function assessment. Lung function team happy to discuss any respiratory physiology related questions, 01223 217065. karl.sylvester@addenbrookes.nhs.uk
References:	1. *Diagnostic Spirometry in Primary Care* Primary Care Respiratory Journal 2009; **18**(3): 130-147 2. *Standardisation of Spirometry* Eur Respir J 2005; **26**: 319–338 3. *Interpretative strategies for lung function tests* Eur Respir J 2005; **26**: 948–968
Web links:	The Association for Respiratory Technology and Physiology is the sole professional organisation in the UK for practitioners working in clinical respiratory physiology and technology. Patient information including instructional videos available at www.artp.org.uk European respiratory society - www.ersnet.org
Who are you:	Dr Karl Sylvester, Chief Clinical Respiratory Physiologist/NIHR Post-Doctoral Research Fellow/Vice-Chair ARTP
Review date:	March 2012
Due review:	March 2014

Top Tips in Two Minutes: Bowel Cancer Screening

Why:	Bowel cancer is the third commonest cancer in the UK and the second commonest cause of cancer related death. There are 35,000 new cases each year. Survival after diagnosis with bowel cancer is dependent on stage with 5 year survival varying from 85% for Dukes' A cancers to <5% for Dukes' D. In general cancers undergo a prolonged pre-malignant adenomatous stage and a long asymptomatic phase. As a result only 10% are currently Dukes' A. The NHS Bowel cancer screening programme (BCSP) was introduced in 2006 to improve outcomes. Bowel cancer related mortality can be reduced by 16% by faecal occult blood test (FOBt) based screening. 2 in 1000 will test positive on FOBt. Of these, 10% will have bowel cancer and 40% will have adenomatous polyps. One-off flexible sigmoidoscopy at 55 is due to be rolled out in addition over the next 3 years. This has been shown to reduce the incidence of bowel cancer by 33% and bowel cancer related mortality by 43% in those screened.
How:	The BCSP is designed for asymptomatic patients aged between 60 and 74 and is not meant for high risk patients (strong family history, previous cancer or polyps, IBD). If patients are symptomatic or high risk, they should be referred through the standard symptomatic service as FOBt has an unacceptable false negative rate in these groups.
What next and when:	60 to 74 year olds will receive an invitation for screening automatically during each 2 year cycle assuming they are registered with a GP. Those 74 or older can request a one-off round of screening. Participants return FOBt and if positive receive an appointment with a screening practitioner prior to colonoscopy.
Where else:	http://www.cancerscreening.nhs.uk/bowel/ 0800 707 6060 for over 74 opt in
Web links:	http://www.cancerscreening.nhs.uk/bowel/
Who are you:	Dr Ewen Cameron, Clinical lead for Endoscopy and Cambridge Bowel cancer screening centre
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Diabetic Feet

Why:	Patients with diabetes related foot disease have some of the longest in-patient stays; associated co-morbidities place these individuals at high risk of premature death. Many of the lesions, hospital admissions and amputations are avoidable with good self care, early effective management and early referral when needed. **Late referral results in early amputation.** If a lesion isn't getting better, ask for help.
How:	• Many problems present without pain as a result of peripheral neuropathy. The fact that a lesion is painless is a worrying sign and should NOT be taken as reassurance that the problem is not serious. • If problems are treated early enough, amputation can often be avoided, function can be maintained and length of stay decreased. • All Patients should have regular, annual foot checks. Do more frequently if neuropathy, peripheral vascular disease or foot deformation present. Monofilament testing helps identify an "at-risk foot"- any sensory loss is abnormal- but is only a part of the foot assessment. • If a lesion is found, ask yourself – "Why **this lesion** in **that position** on **that foot**?" Lesions do not appear by magic and a simple history, seeing how the patient weight bears on their foot when standing plus looking at the footwear they were (or were not!) wearing when the lesion developed can be hugely informative • Always, always look at the other foot. The same risk factors (neuropathy, peripheral vascular disease, callus, poor nail care, footwear) are invariably present and often there are second lesions that the patient didn't even know they had.
What next and when:	If a lesion is found-address 5 key areas: • **Infection**-swab open lesions before commencing antibiotics- who says every bug is sensitive to flucloxacillin? • **Vascular**-are there pulses? Do not be falsely reassured by your Doppler machine. The inability to detect pulses with your fingertips is an abnormal finding and should be respected as such. • **Mechanical**-how do you reduce weight-bearing? Are the patient's shoes the problem? • **Metabolic**-treat hyperglycaemia aggressively • **Social**-can the patient undertake their daily activities if they are reducing pressure onto the lesion Remember, there is no dressing in the world that will sort out deep infection, vascular insufficiency or severe abnormal pressure loading. **If you don't know how to tackle these issues, ask someone who does.** Advise all patients • Good footwear is essential- have your shoes *fitted* • Check and moisturise feet daily (get someone else to do it if you can't) Refer to community podiatrist if: • At risk feet and a podiatric condition • Ulceration with foot pulses and no clinical evidence of infection Refer to the specialist foot clinic if: • Ulceration and no foot pulses • Ulceration and infection/ cellulitis • Suspected Charcot's (hot swollen, red foot) • Necrosis/gangrene Have a much lower threshold for immediate referral for anyone with lots of previous foot pathology (previous amputation, reconstruction). Left unchecked, they can and will deteriorate very rapidly Remember a foot lesion may be the presenting feature of previously undiagnosed diabetes. Even when the index lesion has healed, always think • What can I do to stop it happening again? o Some of these patients need orthotics or even surgery
Where else:	If there is no improvement in 1 week and/or the lesion has not healed at 4 weeks, contact the specialist foot service for advice. Phone - 01223 216706 Fax – 01223 586988
References:	1. Edmonds M, Foster A. Diabetic Foot ulcers BMJ 2006;332:407-410 2. Cheer K, Shearman C, Jude EB. Managing complications of the diabetic foot. BMJ. 2009;339:b4905
Web links:	http://www.diabetes-healthnet.ac.uk/HandBook/ScreeningOfFoot.aspx A link to a comprehensive website detailing many of the important points of screening and treatment
Who are you:	Dr Tony Coll, **Consultant Lead**; Dr Latika Sibal, **Community Diabetologist**; Dr David Simmons, **Lead Diabetes Specialist**; Cathy Eaton, Lucy Bishop, **Diabetes Specialist Podiatrists**; Candice Taylor, **Podiatry**; Karen Rogers, **Health Care Assistant**; Barbara Williams, **Secretary** The Diabetes Foot Team, Institute of Metabolic Science, Addenbrooke's Hospital
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Renal Stones

Why:	Aetiology • Incidence 120-140 per 100,000, Prevalence 2-3% • Risk for a white male is 1 in 8 by age 70 yr • Affects men 2-3 times more commonly than women (except for infected stones) Causes: Hypercalciuria, Hyperuricosuria, Hyperoxaluria - (1^{o} (AR) Glycerate Dehydrogenase def^{y}, 2^{o} increased bowel abs (IBD etc) (Inflammatory Bowel Disease), urinary oxalate – 80% metabolic, 20% dietary), Cystinuria, Hypocitraturia (idiopathic, IBD, distal renal tubular acidosis), Recurrent UTI
How:	Presentation: • Renal stones: vague flank pain or asymptomatic • Ureteric stones: severe colicky pain, loin to groin radiation of pain in testicle/labia, strangury • Sometimes with haematuria, irritative voiding symptoms, sepsis Assessment: • Soft abdomen with loin tenderness • Exclude other intraperitoneal causes (AAA, appendicitis, diverticular disease etc) • Exclude musculoskeletal pain • Micro-haematuria in 95%
What next and when:	Investigations: • FBC, U and E, BFTs, Urate, Bicarbonate • Urine for culture, urine for cysteine • Imaging: • CT/KUB is investigation of choice (Highly sensitive, quick, no contrast required, may show other intra-abdominal causes of pain) Management: • NSAIDs preferable to Opioids (Holdgate A, Pollock T.BMJ 2004) • Alpha-blockers – expedite passage of stones with fewer pain episodes (Yilmaz et al 2005) • Ureteric stones - overall 85% pass spontaneously (<4mm - 90% pass spont, 4-5mm - 50% pass spont, >5mm – 10% pass spont) When to admit • Uncontrolled pain • Single kidney/renal impairment • Signs of sepsis • Oliguria/anuria
Where else:	Guidelines, information and referral protocol available on Website www.camurology.org.uk Contact Urology Clinical fellow / SpR /Consultant on call via switch to discuss Email: Nimish.shah@addenbrookes.nhs.uk
References:	Holgate A, Pollock T, Systematic review of the relative efficacy of NSAID and opiods in the treatment of acute renal colic.BMJ 2004: 328: 1401-1404 http://www.bmj.com/cgi/content/abstract/328/7453/1401 Yilmaz E et al Comparison and efficacy of 3 different alpha 1 adrenergic blockers for distal renal stones. Journal of urology 2005; 173: 2010-2012
Web links:	Cambridge Urology website www.camurology.org.uk
Who are you:	Nimish Shah Consultant Urologist, Addenbrooke's Hospital, Cambridge
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Persistent Oral Ulcers, Oral Lesion & Oral Cancer

Why:	• Oral lesions are very common but persistent lesions may be malignant • Any oral ulcer/lesion persisting for more than three weeks with no known cause should be referred • Oral cancer is becoming more common affecting some 4,000 people a year in England. Oral cancer affects all ages and even those with no risk factors which are smoking and alcohol • Early treatment gives the best results
How:	History of a persistent oral lesion: • White or red patch • Ulcer • Swelling • Loosening of teeth • Bleeding • Thickening of mucosa • Pain • Problem with swallowing Medical history including social history for smoking and/or drinking Examination of oral lesion in good light with gloves Examination of neck nodes
What next and when:	• To consider fast-track referral • Consider starting anti-fungal treatment, antibiotics and an antiseptic mouthwash as appropriate • Reassure patient indicating that investigation and biopsy may be needed • Reassure patient these problems can be treated
Where else:	Use fast track referral to Dept. of oral & Maxillofacial Surgery, Box 47, Addenbrooke's Hospital Fax: 01223 216708 Tel: 01223 216635 Consultants: David Adlam, Malcolm Cameron & Mark Thompson
References:	Scully C, Porter S. ABC of Oral Health. BMJ 2000: 321; 97-100 Oral cancer (cancer research UK information) http://info.cancerresearchuk.org/cancerstats/types/oral/symptoms/ Mouth cancer foundation: www.MouthCancerFoundation.org
Who are you:	Mr David Adlam, Consultant Oral & Maxillofacial Surgeon, Addenbrooke's Hospital, Cambridge
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Irritable Bowel Syndrome

Why:	**Irritable bowel syndrome (IBS) affects 20% of the population. The diagnosis should be considered in patients with at least a six month history of:** • Abdominal pain or discomfort • Bloating • Change in bowel habit
How:	**Consider diagnosing IBS if abdo-pain or discomfort is:** • Relieved by defaecation or • Associated with altered bowel frequency or stool form **and at least two of the following:** • Altered stool passage (straining, urgency, incomplete evacuation) • Abdominal bloating, distension, tension or hardness • Symptoms made worse by eating • Passage mucous Lethargy, nausea, backache and bladder symptoms may be used to support diagnosis. **"Red Flag" indicators (refer to secondary care if present):** • Unintentional and unexplained weight loss • Rectal bleeding • Any family history of bowel or ovarian cancer • In people aged over 60, a change in bowel habit lasting more than 6-weeks with looser and/or more frequent stools. • Anaemia • Abdominal masses • Rectal masses • Inflammatory markers for inflammatory bowel disease If symptoms suggest ovarian cancer, undertake appropriate examination and referral Investigations to exclude other diagnoses. Investigate/refer as appropriate if abnormal: • Full blood count (FBC) • Erythrocyte sedimentation rate (ESR) • C-reactive protein (CRP) • Anti-body testing for Coeliac Disease (Tissue Transglutaminase - TTG)
What next and when:	**Provide information about self-help covering lifestyle, physical activity, diet and symptom targeted medication. Arrange follow up to assess response and re-assess "red flags".** **First line pharmacological treatment** Choose single or combination medication based on predominant symptom(s). • antispasmodic agents • laxatives for constipation (not lactulose) • loperamide for diarrhoea • Advise people to adjust doses according to response, shown by stool consistency. Aim for soft, well formed stool (Bristol Stool Form Type 4 http://www.nice.org.uk/nicemedia/live/11927/39937/39937.ppt) **Second line pharmacological treatment** Consider tricyclic antidepressants(TCAs) • Start at a low dose (5-10 mgs equivalent of amitriptyline) taken at night and review regularly. • The dose may be increased (but should not exceed 30 mgs) • Consider selective serotonin reuptake inhibiters (SSRIs) only if TCAs are ineffective or contraindicated. Take into account the possible side effects of TCAs and SSRIs if prescribing for the first time. **Referral for psychological interventions:** People whose symptoms do not respond to pharmacological treatments after 12-months and who develop a continuing symptom profile (refractory IBS) consider referring for: • cognitive behavioural therapy (CBT) • hypnotherapy • psychological therapy
Weblinks:	NICE guidance: http://www.nice.org.uk/nicemedia/pdf/cg61ibsqrg.pdf British Dietetic Association info sheet: http://www.bda.uk.com/publications/IBSdietary_resource.pdf
Who are you:	Sister Lynette Byatt (specialist sister) and Dr Ewen Cameron (Consultant), Department of Gastroenterology, Addenbrooke's Hospital
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Respiratory

Why:	Facts:- 3.7 million people suffer with COPD and 2.8million unaware of it. 89% of people in UK never heard of COPD and 85% among those are smokers and high risk for COPD. 5th leading cause of death in UK and will be 3rd by 2020! £500million/yr spend on COPD patients Rationale: COPD to diagnose early and correctly can significantly improve patients quality and national health economy. Mild COPD-£149/yr/pt, Moderate-£307/yrpt, Severe-£1307/yr/pt
How:	Salient Features:- Age>35yr, chronic cough, frequent bronchitis, SMOKER or EX, sob. wheeze with no clinical feature of asthma, frequent sputum production.
What next and when:	Baseline Investigations:- FBC, Infection markers, CXR Specific Investigations:- Spirometery/lung functions. Stages:- FEV1/FVC <0.70 diagnostic FEV1>80% mild COPD(stage 1) FEV1=50-79% Moderate(stage 2) FEV1=30-49% Severe(Stage 3) FEV1<30% Very Severe(Stage 4) Rx:- Short acting(Salbutamol; Ipratropium) Longacting(Salmetrole); LAMA- Tiotropium Combined: LABA+ICS=Symbicort; Seretide Miscellaneous: aminophyllines, prednisolone, abx, carbocisteine etc etc
Where else:	Landmark/National Framework Project: a) Spirometry training b) GP Education c) Improved communication b/w primary and 2ndary care d) Planned and details discharge summary e) Identification of frequent admitters f) COPD education to patients and Health workers g) Single point of access and Rapid Access clinic
References:	NICE BLF(British lung foundation) Invisible Lives (study published 2007)
Web links:	NICE, BLF, World COPD awareness day
Who are you:	Dr Muhammad NB Khan, GP Partner, Bridge Street Medical Centre
Review date:	March 2012
Review due:	March 2014

MEN'S HEALTH

Top Tips in Two minutes: Erectile Dysfunction (ED)

Why:	ED is increasingly becoming a common presentation to GPs. Prevalence of complete ED: 5% in 40yr-olds, 10% in 60s, 15% in 70s and 30-40%in 80s. • Can have a severe effect on psychological and social well-being, and can negatively impact on personal relationships • May be a marker for hypertension, diabetes or depression Causes: Vascular (33%), DM (25%) (Diabetes Mellitus), Nerve disorder (8%), Pelvic surgery (7%), Drugs (6%), Psychogenic (10-15%) Most can be managed in primary care. Can initiate treatment after correction of reversible risk factors due to the availability of oral agents e.g. Viagra (Sildenafil), Levitra (Vardenafil), Cialis (Tadalafil) and Uprima (Apomorphine))
How:	• History: differentiate physical (gradual onset, loss of nocturnal/morning erections) from psychogenic (sudden onset, maintains nocturnal erections, often associated relationship problems), smoking, drugs including recreational, alcohol • Physical Exam: external genitalia - phimosis, balanitis, penile ulceration, a short penile frenulum & penile induration due to Peyronie's disease. Any painful, penile condition may inhibit erection simply by virtue of the pain it induces. Also assess general body habitus for evidence of normal, male hirsutism
What next and when:	Investigations: • Urine dip for DM (+/- blood glucose), • Hormone tests including testosterone, FSH/LH (pituitary hypogonadism), Prolactin (prolactin adenoma), TSH (hypothyroidism), • LFTs (liver disease) • Blood lipids, • (+/- PSA if LUTs or abnormal DRE) (Lower Urinary Tract Symptoms) (Digital Rectal Symptoms) • Specific tests e.g. cavernography etc rarely necessary for specific conditions (e.g. venous leak) Management: • Investigate and exclude treatable causes (including drugs) • Treat risk factors (if possible) • Address life-style issues • Consider psychosexual counselling, couple therapy or psychiatric referral if predominantly psychogenic ED although physical treatment may be used in selected patients • First-line treatment for organic erectile dysfunction is a PDE-5 inhibitor, initiated in general practice; this is effective in 65-75% of patients regardless of the cause of the erectile dysfunction • Other treatments are only indicated if PDE-5 inhibitors are ineffective, associated with severe side-effects or contraindicated (because of concomitant use of nitrates, either for angina or recreationally), alternative oral treatment Apomorphine Consider urological referral if above failed or contraindicated for other options including: *Self-administered penile prostaglandin injections (Caverject®),Intra-urethral administration of prostaglandin (MUSE®), Vacuum erection assistance devices,* *Insertion of penile prostheses, Re-vascularisation of the penis using by-pass surgery or angioplasty*
Where else:	Flow chart on investigation and management, Guidelines, information and referral protocol available on Website www.camurology.org.uk Referrals to Urology Department, Addenbrooke's Hospital or Hinchingbrooke Hospitals.
References:	Drug & Therapeutics Bulletin (2004) 42, 49-52
Web links:	www.camurology.org.uk
Who are you:	Nimish Shah, Consultant Urologist, Addenbrooke's and Hinchingbrooke
Review date:	February 2012
Review due:	February 2014

Top Tips in Two Minutes: Prostate Cancer

Why:	Prostate cancer is the commonest solid tumour in men. It accounts for 30,000 new cases every year and around 10,000 deaths. In its early stages it produces no symptoms. Be aware of the following symptoms: - LUTS (Lower Urinary Tract Symptoms) - Persistent bone pain particularly in thighs and back - Haematuria - Onset of renal failure caused either by chronic retention or because of ureteric obstruction Differential diagnosis - BPH - Non-malignant causes of back pain Retention caused by BPH and renal failure of other causes
How:	There is considerable controversy over the implementation of a national screening programme for prostate cancer. However, recent screening studies have shown clearly that early detection of prostate cancer saves lives. If a man comes to see you wanting early detection then the current policy of the Dept of Health supported by the British Associate of Urological Surgeons is that he should be given a PSA test after discussion about the pros and cons. Information to give to the man will include that a high PSA would imply that a Transrectal ultrasound scan and biopsy would be required to make a diagnosis. There is no "normal level of PSA". Current guidelines from the US suggest that a young man with a positive family history aged 40 a PSA of 1 would carry an increased risk of prostate cancer. For men aged between 50 and 69 a PSA of around 3 would be regarded as the cut point for referral. In men aged over 69 higher levels of PSA might be used to trigger urological referral. Some prostate cancers present with a low PSA so a digital rectal examination is still useful. *Top learning point* A PSA of 1 or less in a man aged 60 is associated with a near negligible risk of future clinical problems from prostate cancer. A PSA of 0.5 or less in a man aged less than 50 is associated with a very low risk of clinical problems from prostate cancer.
What next and when:	High PSA should be an indication for onward referral to the Urology Dept. It is very reasonable to wait 4 to 6 weeks and repeat the PSA before sending the patient in. Increasingly men who have been treated for prostate cancer will be managed in the community. The key thing here is to ensure that the man himself is aware of the level of PSA that should trigger referral back to the hospital. For instance following radical prostatectomy the PSA should be undetectable (supersensitive PSA of 0.02 or less). A supersensitive PSA is required for following men with prostate cancer because if the PSA goes up to 0.1 or 0.2 then early radiotherapy can provide long term cure for local recurrence. PSA levels following radiotherapy are not as low as after surgery and local guidance will be given for the individual patient as to what should trigger rereferral back. Increasingly active surveillance/active monitoring programmes are used for men with low risk prostate cancer (low risk being defined as low volume Gleason Grade 6 cancer, clinical T1 (normal prostate) or T2a (small nodule) and a PSA of less than 10. Individual guidance would be given for referral but a 50% increase in the PSA would imply the need for urological opinion. More advanced men might be followed up in primary care following hormonal treatment and again individual guidance would be given to trigger referral but an increase in PSA or symptoms mentioned in bullet point 1 would suffice.
Where else:	Information can be obtained from the Dept of Urology website http://www.camurology.org.uk/, Cancer Research UK www.cancerresearchuk.org or Cancer Backup (Macmillan and Cancerbackup merged in 2008.) www.macmillan.org.uk There is increasing recognition that treatments for prostate cancer associated with the deterioration of well being and sexual problems and there is great potential for development of joint programmes involving primary care and secondary care.
References:	Hugosson, J. *et al*. Mortality results from the Göteborg randomised population-based prostate-cancer screening trial. *Lancet Oncol.* doi: 10.1016/S1470-2045(10)70146-7
Who are you:	Professor of Surgical Oncology and Group Leader at the Cambridge Research Institute I am a Consultant Urologist with an interest in urological cancers and run a research group studying biomarker development and clinical trials for prostate cancer.
Review date:	February 2012
Review due:	February 2014

Top Tips in Two Minutes: Community Urology Partnership

Why:	• Improvement of patients' journey
	• More clinically appropriate service
	• Development of consistent clinical & operational pathways
	• Collaboration of all services
	• Allocation of medical need to respective clinical resource
	  • Formalised and assured utilisation of skills in the community
	  • Targeted utilisation of specialist skills

How:	**LUTS:** • Development of consistent clinical & operational pathways (NICE) • All behavioural/drug treatment provided in primary care and appropriately • Education strategy with online clinical management tool and Feedback system • Collaboration with the continence service **PSA FU (LES):** • PSA follow-up carried out, where appropriate, in community settings (Closer-to-home) • Structured discharge process with precise advice by urologists • Patient held record booklets • Oversight and education provided by specialists **Continence:** • Pathway to redirect patients to community continence service • Primary care pathway to allow appropriate treatment • Education and information strategy • Collaboration of individual practitioners and specialists within a network
What next and when:	LUTS: available online within the next 2 weeks PSA (FU): discharge will commence within 2 weeks Continence: already launched
Where else:	GPConnect, CamUrology, CATCH and CCS websites Continence: direct access to continence Advisors (phone number/email available via CCS) PSA FU: for questions regarding patients formally discharged to primary care only (!) use Adds-tr.psaCambridgeshire@nhs.net
References:	NICE International Continence Society National Continence Audit
Web links:	GPConnect CamUrology CATCH CCS
Who are you:	Mark Brookes, GP Christof Kastner, Urologist Co-chairs Urology Partnership Cambridge
Review date:	March 2012
Review due:	March 2014

MENTAL HEALTH

Top Tips in Two Minutes: Dementia

Why:	Condition is under diagnosed in General Practice populations • Group of disorders including Alzheimer's Disease, Vascular dementia, Lewy body dementia and several focal disorders e.g. Fronto-temporal dementia. • Prevalence rates rise exponentially with age, doubling approximately every 5 years after 65. 5% of over 65s in total • Dramatic increase in number of cases worldwide in line with ageing population- developed countries increases from 12 to 20 million between 2000 and 2050 • Major challenge to medical/social/ psychiatric services • Approximately 25% of acute hospital beds occupied by people with dementia • QOF target. Dem 1 and 2 • Commonest psychiatric disorder of late life
How:	Presentation of patient with apparent cognitive impairment, remember reversible organic causes of cognitive impairment, including delirium. • Commonest B12/folate deficiency, hypothyroidism, UTIs, chest infection, iatrogenic (medicines with anti-cholinergic properties) • May be superimposed delirium on pre-existing cognitive impairment • Collateral history vital- determine characteristics of onset/progression of disorder/ specific impairments • Main features of dementia include impairments in memory, thinking, orientation, language, judgement and additionally deteriorations in emotional and social functioning • NB depression in older adults can present with subjective complaints about memory (depressive pseudodementia). Do: • Blood tests -FBC, UsE, LFT, glucose, TFT, B12, Folate, ESR, cholesterol (and ECG if considering Acetylcholinesterase inhibitor therapy (AcheIs) • Urinalysis/ syphilis/ HIV screening if specifically indicated • Cognitive screening measure (best known MMSE –copyright issues, or GP-COG http://www.gpcog.com.au/info.php, AMTS
What next and when:	• Refer to local old age psychiatry services for formal diagnosis /initiation of AcheIs/ stabilisation of treatment where appropriate. Shared care protocol usual practice • Referral (or re-referral) also for specialist intervention to manage complex social, behavioural, or psychological symptoms, carer stress. • Social care-refer locality team • Neurology referral if acute onset/rapid decline/ neurological signs or symptoms/ fits/blackouts/young onset (under 65)
Where else: Professional Advice and Help	• Alzheimer's Society-advice/support for patients /carers- pub lunches/support groups • AGE UK • Help with benefits advice /lasting power of attorney at direct gov websites
Web links:	• www.alzheimers.org.uk • www.ageuk.org.uk • www.direct.gov.uk • www.carersuk.org
Who are you:	Dr Susan F Welsh, Clinical Director OPMH at CPFT
Review date:	March 2012
Review due:	March 2014

SUBSTANCE MISUSE & THE VULNERABLE ADULT

Top Tips in Two Minutes: Healthcare of the Homeless

Why:	Health of homeless patients characterised by high morbidity and mortality and low access to services. A person is homeless if • They have no accommodation in the UK or elsewhere which is available to them and to which they have a legal right of occupation. • They have accommodation, but they cannot secure entry to it • Their accommodation is a moveable structure that has no place it can be placed • They have accommodation, but it would not be *reasonable* for them to occupy it I.e. homeless is not only roofless: ask patients where they are living, even if you think you know their address.
How:	Rough sleepers: numbers are relatively small, but many not known about and there is a rapid turnover: • Life expectancy 42 years; suicide 35x more likely; 4x more likely to die of unnatural causes • Access = 50% alcohol problem, 70% SM (substance misusing); 30-50% mental health problems (often major and untreated -schizophrenia/ bipolar, often compounded by personality disorder +/- offending) • Do not easily access services- GPs reluctant to register NFA, rough sleepers do not prioritise health Young people: (England 20,000 <25 live in supported accommodation) • 1/3rd have been in care: family breakdown, child abuse and neglect, DV (domestic violence) • High incidence of mental health problems, drug problems, teenage pregnancy, asylum seeking refugee status, offending. • Health has low priority- poor sexual + other health, low self esteem, do not access services Families: (UK, 100,000 households per year accepted as homeless) • Child immunisation rates low, miss out patient appointments (itinerant, health has low priority) • Children and mothers poor physical and mental health • Co-morbidities especially related to DV, anxiety/depression/PTSD in the adult victim; neglect, • physical harm, emotional abuse and interrupted education in children
What next and when:	Opportunities for prevention: • Prevention of homelessness in primary care- recognition and intervention in vulnerable/high risk groups; child abuse/neglect/domestic violence/in care or been in care; SM (better to recognise and intervene/refer early before behaviour entrenched); mental health problems (especially untreated/under treated/not recognised- beware of patients who disengage from treatment), family breakdown, bereavement. Very expensive once someone is homeless (£120,000 per individual taken off the street). Timely support from Citizens Advice etc with housing or other benefits may prevent loss of accommodation. Harm minimisation: • Offer full registration wherever possible (use surgery address for NFA). Engage the patient (listen to their view of priorities and needs), inter-professional work with other services (e.g. Addaction, mental health services) and other agencies (e.g. housing, social services, voluntary agencies) Need to address a range of physical and mental health problems as well as those related to social exclusion- do as much as possible in one visit, patient may move on. Work can be very high challenge – do not be afraid of asking for advice.
Where else:	**Inclusion (drugs and alcohol);** 723020 (can self refer). Huntingdon Inclusion 01480 413800 St Neots 01480 406823 **Street Outreach Team**; 366292 (can self refer) **Jimmy's Night Shelter;** 576085 bed, food, washing + laundry facilities (self referral) **Cambridge Access Surgery;** 358961 Specialist primary care for those homeless or at risk of homelessness (self referral) **Overstream house (Wintercomfort);** 518140 day centre- food, washing + laundry facilities, counselling and activities (self referral) **City Council Housing Aid**; help with homeless applications 457934 (can self refer, but GP letter can be crucial) Safeguarding vulnerable adults issues: call **0345 045 5202** emergency duty team out of hours **01733 234724 http://www.cambridgeshire.gov.uk**
Web links:	Citizens Advice Bureau http://www.cambridgecab.org.uk/ Cambridgeshire Drug and Alcohol Treatment Team (DATT) http://www.cambsdaat.org/ for contacts/local services
Who are you:	Dr Ruth Bastable, GP, Cambridge Access Surgery
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Care of injecting drug users (IDU) in General Practice

Why:	Caring for patients who are IDU can be challenging - often have significant physical and psychiatric co-morbidities, present late in their illness, have high rates of A&E attendances, loss to follow up, housing and social issues and possible criminal involvement with periods of time in prison. May not engage with primary care. All-cause mortality and morbidity is greatly increased, and risks of suicide are substantially higher than the rest of the population (injecting heroin user 22 x more likely to die than non user). **The aim should be to offer the same health care as for any other patient plus:** • Reducing health problems, social problems and crime both related and unrelated to drug misuse • Reducing harmful/risky behaviours and transmission of blood borne viruses • Attaining controlled, non dependent, non problematic drug use • Attaining abstinence from drugs **Domains of treatment:** • Managing drug and alcohol misuse • Managing physical and psychological health • Improving social functioning • Deterring criminal involvement Assessment of risks to dependent children
How:	**Identification: Most injecting use will be heroin and/or crack (also amphetamines and anabolic steroids).** Patient may present declaring drug use, but it is more likely you will have to ask! – anyone with psychiatric symptoms, recurrent sickness absence, known alcohol problems, if you suspect drug use. Patients may be reluctant or embarrassed to disclose. IDU often have polysubstance misuse so may be using variety of prescribed and street drugs taken IV, IM or orally. Misuse of prescribed (or internet-purchased medical) drugs is increasingly significant. **Establish the patient agenda** and as far as possible address this. Patient agenda may be very different from what you think it should be; building trust can take time; assiduously avoid "head to head" argumentation, as this is more likely to result in disengagement than "convincement". Ask about any acute problems associated with IDU e.g. abscess, venous leg ulcer, DVTs. Lifestyle and priorities will mean late presentation of drug-related and non drug-related problems are common; drug use will mask symptoms. **Establish patient's ideas, concerns and expectations** regarding management of substance misuse. Are they ready to change behaviour? Ask about current drug use (type, frequency, route of administration, method of funding habit (crime, prostitution), other addictions/harmful behaviours (e.g. alcohol, smoking). Take past medical, surgical and psychiatric history & establish current social circumstance –housing, children. **Are there child protection issues?** **For all, give harm minimisation advice:** Never share anything (needles, syringes, filters, spoons), minimise injecting risk (use peripheral sites site, don't use groin or neck, never use on your own, smoke it instead of injecting). Offer contraception/sexual health advice. Offer BBV screening and hepatitis A/B and tetanus immunisation (unless already immunised). If known Hep C positive, vital to minimise alcohol intake (progression to cirrhosis more likely and faster). Check baseline bloods: FBC – for Hb and MCV, U&E, LFT, gammaGT. **Examination**: Check weight, BP. Injection sites, check legs for DVT. If you have time, respiratory (e.g. crack lung), cardiac (e.g. murmurs, endocarditis) and abdominal exam (hepatic disease, peptic ulcer disease, pancreatitis due to alcohol use).
What next and when:	**Refer**: Encourage the patient to access specialist care for drug problem (refer or encourage self-referral to drug treatment services) – psychosocial interventions, available through drug treatment services, are vital to holistic care and relapse prevention, treatment is so much 'more than methadone'. **Take your time, comply with guidelines on treatment:** It is rarely necessary to prescribe anything straight away, take time to make an assessment. Do not give codeine/dihydrocodeine (not authorised as OST-Opiate Substitute Treatment). Rarely necessary to give benzodiazepines at all, these are freely available to buy on the internet and on the street, withdrawal fits will only occur with massive intake. **Shared Care:** If you offer it, this is the best chance for the patient for holistic care. Only offer authorised OST (methadone, buprenorphine or buprenorphine/naloxone) if you are trained to do so and as part of shared care arrangement. **Keep in touch whatever:** Encourage patient to return to you even if shared care/OST is not done by you. Patients are often ill and in need of general practice care.
Where else:	Refer to Inclusion drug services http://inclusionuk.org 01223 72302 Mill House Cambridge If under 18, refer to Cambridgeshire Child and Adolescent Substance Use Services (CASUS) http://www.casus.cpft.nhs.uk - has videos and information for young people and carers, and a link to its online treatment manual: http://ambit-casus.tiddlyspace.com
Web links:	Drug misuse and dependence. UK guidelines on clinical management DH 2007 http://www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf Clinical Guidelines: http://www.smmgp.org.uk/html/clinical.php#Access RCGP substance misuse and associated health for courses (SMAH), conferences, loads of guidance e learning (no charge) http://www.rcgp.org.uk/substance_misuse/drug_misuse_certificate/guidelines.aspx Video: Role of the GP in the recovery process YouTube channel - http://youtu.be/ucjWEI2ETTE SMMGP - free to join, excellent resource http://www.smmgp.org.uk
Who are you:	Dr Shobhana Nagraj, Academic Clinical Fellow in General Practice, Cambridge VTS Dr Ruth Bastable, GP, Cambridge Access Surgery
Review date:	March 2012 (V7)
Review due:	March 2014

Top Tips in Two Minutes: Diagnosis Assessment and Management of Harmful Drinking and Alcohol Dependence in Primary Care

Why:	Dependence: Affects 4% of 16-65 year olds in England (6% men, 2% women). Characterised by withdrawal symptoms, cravings, tolerance, and loss of control in the context of continuing harm. Associated health problems +++ • Physical: Liver: alcohol cirrhosis, hepatitis, cancer: GIT: oral cancers, oesophageal cancer, varices, pancreatitis (acute /chronic), portal hypertension/varices: CV disease: atrial fibrillation, hypertension, CVA, alcoholic cardiomyopathy/heart failure, lipid disorder: Neurological disease: acute intoxication with loss of consciousness, seizures, peripheral neuropathy, Wernike-Korsakoff syndrome, sub dural cerebellar degeneration, alcohol amblyopia. • Psychiatric: Alcohol dependence syndrome: Suicidal ideation: Depression : Anxiety • Miscellaneous: Accidents, violent crime, antisocial behaviour, risk to children, domestic violence loss of libido, foetal alcohol syndrome
How:	Identify using AUDIT Calculate units per day/week = Alcohol Volume Content (AVC) x volume /1000 e.g. 1 litre 5% = 5 units Assess severity clinically e.g. severity of withdrawal symptoms, rapidity of onset, and/or use tools such as Severity of Alcohol Use Disorder Questionnaire (SADQ) Offer support at all stages – refer for psychosocial support
What next and when:	Assess: • Take history of drinking (how much, pattern, how long) number of units. Other substances being use/drugs taken. Support available, motivation of patient, stability of accommodations, other medical problems such as history of seizures, physical/psychiatric problems, and learning disability. Update re other health problems (e.g. CVD, COPD, smoking, contraception) • Do general physical examination of patient • Start Thiamine 100mg tds (sudden high need for this at start of detox) and vitamin B strong 2 daily, consider multivitamins, think about diet, may need to see dietician. • Perform investigations: FCB, LFT,GGT, U and E, clotting (if severe dependency or other evidence of liver damage), up to date on BBV. Other investigations as indicated. • Optimise patient's state of health- vomiting/gastritis do h pylori testing and rx PPI • Assess for suitability re community detox: >15 units a day, motivated and ready (as above), got the support, psychological interventions. • Usually in patient detox if high intake (NICE states >30 units per day) severe dependence (SADQ >30) epilepsy or history DTs, marked psychiatric or physical problems, learning disability, malnutrition. Community detox: Preparation is essential, don't do unplanned detoxes • Advise patient to SLOWLY reduce intake as much as possible prior to detox • Patient needs to have adequate support (key worker, CPN) • Advise patient of procedure, NO alcohol once starts detox, daily attendance / home visit and daily pick up of chlordiazepoxide, detox lasts 8-10 days (approx), any drinking and it stops • Start detoxes at the start of the week; this is a **planned** procedure, don't offer unplanned and unscheduled detoxes. If the patient is very ill/vomiting/withdrawing/at risk of seizures then consider inpatient. • Patient to attend for first appointment having consumed MINIMAL alcohol or no alcohol that day. • Daily (or more to start) monitoring (withdrawal, psychosocial, BP, pulse) • Follow up support and plan essential to minimise relapse. Aftercare: • Continuing need for support +++, 'lapses' common. Usually problems sleeping, anxious, if continues >4w consider Rx. Give Thiamine 100mg tds plus Vit B strong bd for 3 months (indefinite if Korsakoff/Wernike's). Consider acamprosate/naltrexone and or antabuse
Where else:	Addaction: 01223 723020 psychosocial support and supported detoxes, follow up support which is needed ++++++ and meaningful occupation (groups, day centre etc)
References:	NICE: Alcohol dependence and harmful alcohol use (Feb 2011) http://guidance.nice.org.uk/CG115 NICE: Alcohol-use disorders: physical complications http://guidance.nice.org.uk/CG100 (June 2010) Diagnosis, assessment, and management of harmful drinking and alcohol dependence: summary of NICE guidance Pilling S et al. BMJ 2011; 34 DH Alcohol e learning module http://www.alcohollearningcentre.org.uk/eLearning/IBA Can be combined with face to face 1 day course to obtain Certificate in the Management of Alcohol Problems in Primary Carehttp://www.smmgp.org.uk/html/rcgp.php#Alcohol
Web links:	SADQ http://www.prisonmentalhealth.org/downloads/professional_resources/09-5_sadq_alcohol_assessment.pdf Alcohol Use Identification Test (AUDIT condensed and full 10 question version)http://www.patient.co.uk/doctor/Alcohol-Use-Disorders-Identification-Test-(AUDIT).htm Alcohol units calculator http://www.drinkaware.co.uk/tips-and-tools/drink-diary
Who are you:	Dr Ruth Bastable and Dr Sarah Rann
Review date:	March 2012
Review due:	March 2014

Questions	Score					Scoring column
	0	1	2	3	4	
1 How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2 How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3 How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4 How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5 How often during the last year have you failed to do what was normally expected from you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6 How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7 How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8 How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9 Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the same year	
10 Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the same year	
					Total score	

Interpretation of AUDIT scores

- A total score of more than 8 indicates hazardous drinking[6]
- A total score of 16 to 19 indicates harmful drinking or mild or moderate dependence; the current NICE guideline recommends people with a score of more than 15 should be considered for comprehensive assessment[4]
- A total score of 20 or more indicates severe dependence; the current NICE guideline recommends that people with a score of 20 or more should be considered for assessment for assisted alcohol withdrawal[4]

Fixed dose chlordiazepoxide doses for assisted alcohol withdrawal:

Give Thiamine 100mg tds and vitamin B strong 2 daily while drinking, during detox and for 3 months after detox.

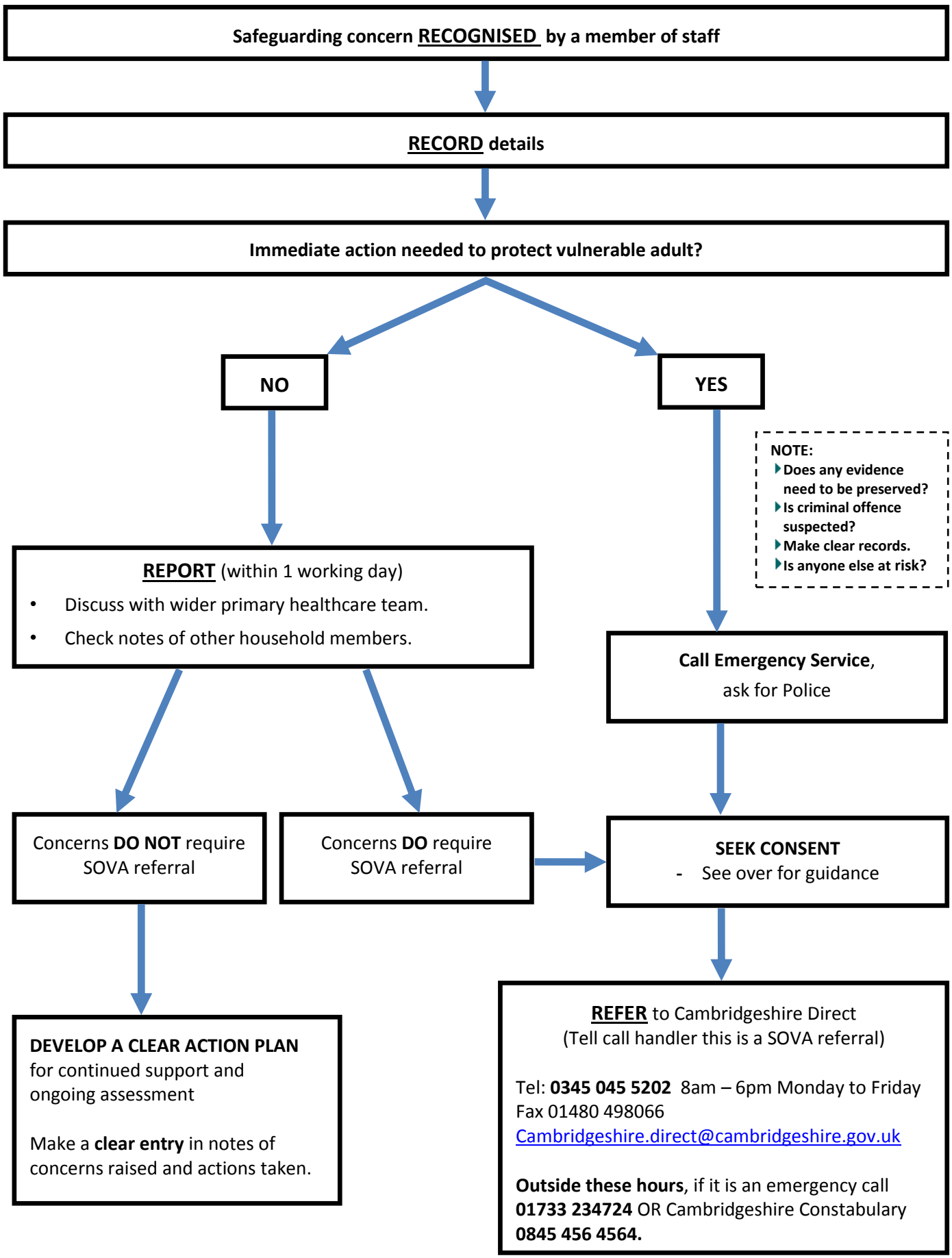
Doses 30mg qds or more should only be given if severe symptoms of withdrawal are anticipated and require careful monitoring. Doses >40mg qds not advised for community detoxes.

Units	**15-25**		**30-49**	
	Dose range		**Dose range**	
Day 1	15mg qds	25mg qds	30mg qds	40mg qds
Day 2	10-mg qds	20mg qds	25mg qds	35mg qds
Day 3	5mg tds	15mg qds	20mg qds	30mg qds
Day 4	5mg bd	10mg qds	15mg qds	25mg qds
Day 5	5mg nocte	10mg tds	10mg qds	20mg qds
Day 6		5mg tds	10mg tds	15mg qds
Day 7		5mg bd	5mg tds	10mg qds
Day 8		5mg nocte	5mg bd	10mg tds
Day 9			5mg nocte	5mg tds
Day 10				5mg bd
Day 11				5mg nocte

Top Tips in Two Minutes: Safeguarding of Vulnerable Adults (SOVA) – Good Practice Guide

What is SOVA?	• Abuse of vulnerable adults is common, hidden (by both the victim and the alleged perpetrator). The most likely perpetrator is a care-giver or someone else close to the victim. • Everyone working in general practice has an important role to play in protecting vulnerable adults. This includes ***recognising, recording, reporting*** *and* ***referring*** concerns about abuse. • Concerns may be recognised by anyone working with or knowing the vulnerable adult. This includes all health professions, care staff (care home or community), members of the public, friends and family or by the adult themselves. • It is vital to listen and to take concerns seriously. **Vulnerable adult**: A vulnerable adult may be anyone over the age of 18, who has a physical or sensory impairment, learning disability or a mental health problem and who may be unable to protect themselves from harm or abuse. Many frail or confused older people are especially vulnerable. Risk increases if socially isolated, history of family violence, communication problems, drugs or alcohol involved, relationships under stress, poor staffing levels and poor staff training. Most occurrences are in own home or care facility but can be in hospital or any other setting. **Abuse** – may be single or repeated. It may be: physical: sexual: psychological: financial or material: neglect or acts of omission: discriminatory (race, ageism etc): institutional: domestic abuse and violence: significant harm.
Why do we need to do this?	Help the Aged estimate that 5-10% of elderly people are being abused at any one time. Most incidences of abuse are not reported – there were 717 in Cambridgeshire in 2008. The numbers increase year on year, this is mostly due to increased recognition and referral but is still only the tip of the iceberg. Most recognised is physical abuse (1/3rd of all reported) most commonly female (2/3rds). 60% of reported are elderly or have learning disability; 80% of perpetrators are close relative, service user, paid carer or staff member.
How do we need to respond?	***Recognise*:** Know what to look for; get trained to recognise the signs and symptoms and listen to concerns of those working with vulnerable adults. Train everyone in the practice (including reception and admin staff) using e-learning module. Seek help and discuss early in the course of your concerns. ***Record*:** Record concerns clearly in the patient notes, check other household member notes. ***Report*:** Know where to get help and who to talk to – develop an in-house protocol, nominate a Safeguarding Adults practice lead, preferably someone with additional knowledge and training. ***Refer*:** Know where to refer and what to do to get more help; keep a note of contact details of Cambridgeshire Direct. ***Remember****;* this is a common problem, but is hidden by both the victim (fear of reprisals) and the perpetrator (and the most likely perpetrator is someone caring for the patient).
What next and when:	**Training:** E learning module is suitable for anyone working in Health Care www.kwango.com/cambssalogin using the following logins. Username: cambssafead Password: cambssa1 **Confidentiality**: Consent to refer should be sought. If a vulnerable adult with capacity does not give consent, it may be necessary to disclose if • The vulnerable adult is being subjected to abuse on a continuous basis • They are under undue influence to not give consent • They are subjected to a type of abuse that constitutes a crime • Other vulnerable adults/children are being placed at risk Record any decision to override consent The Mental Capacity Act 2005 provides statutory framework to empower and protect people who lack capacity and are not able to make their own decisions.
Where else?	**Summary Practice guidelines and Procedure** (information on referral, next steps and monitoring forms) www.cambridgeshire.gov.uk/social/adultprot/Adult+Safeguarding+Policy+Guidance+and+Procedures.htm http://www.peterborough.nhs.uk/default.asp?id=121 All professionals have an important role in early recognition of risk factors and signs and symptoms of abuse, liaising with broader primary healthcare team. If you work with, or care for, someone aged 16 or over who is unable to make particular decisions for themselves, you must comply with the **Mental Capacity Act 2005** principles: http://www.legislation.gov.uk/ukpga/2005/9/contents • A person must be assumed to have capacity unless it is established that they lack capacity. • A person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success. • A person should not be treated as unable to make a decision merely because he/she makes an unwise decision. • An act done, or decision made, under this Act for or on behalf of a person who lacks capacity, must be done, or made, in his/her best interests. • Before the act is done, or the decision is made, regard must be had as to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.
Who?	Dr Sarah Rann and Dr Ruth Bastable, GPs
Review date:	March 2012
Review due:	March 2014

TOP TIP: Safeguarding of Vulnerable Adults (SOVA)



Seek advice at any stage from Practice SOVA Lead or Vulnerable Adults Team at Cambridgeshire Direct

SURGERY

Top Tips in Two Minutes: Dressings and Wound Care

Why:	Wound care products provide PROTECTION and help create the right ENVIRONMENT for healing. Wound management requires an HOLISTIC ASSESSMENT: • Need to understand wound healing physiology and the phases of wound healing • Need to understand the BARRIERS to wound healing • Need to understand the properties of dressings to promote healing
How: .	***ASSESS WOUND, PATIENT and STAGE OF HEALING*** • Wound factors: TISSUE (slough, granulating, clean); INFECTION (may need to swab, antibiotics); MOISTURE (amount of exudate); EDGES (getting smaller or larger, raised or irregular) • Patient factors: SYSTEMIC ILLNESS (diabetes, obesity, immuno-compromised); CONCORDANCE; ALLERGIES; INDIVIDUAL PATIENT NEEDS • Other factors: stage of healing, condition of surrounding skin **WASH HANDS**. Wear gloves. Dispose of dirty dressings appropriately. Use sterile dressing and procedure. Clean with sterile normal saline if necessary. Remember cleaning can remove any new cell growth so soak off old dressings carefully
What next and when:	**SELECT APPROPRIATE DRESSING.** Use local formulary Type of dressing: consider application/removal; comfort; pain relief; frequency of change; evidence base and cost. **Optimum dressing** maintains high humidity between wound and dressing, removes excess exudates, provides thermal insulation and is impermeable to bacteria • **MINOR SUPERFICIAL, DRY, ABRASIONS** with little or no exudates Low adherent dressings: Non-adherent dressings and gauze. Thin hydrocolloids (Tulles still used but beware as granulation tissue can grow through weave) • **EXUDING WOUNDS** (dressing needs to absorb wound exudates; heavy exudates can lead to maceration of surrounding healthy skin/use barrier stick eg. Cavilon) Foam dressings: (thermal insulation/optimum temperature for wound healing; maintain moist environment; non-adherent) Suitable for all exuding wounds Alginate dressings: (derived from seaweed; fibrous and highly absorbent; haemostatic/Kaltostat; need secondary dressing to secure) Suitable moderate to heavy exudates Hydrocolloid dressings: (occlusive and forms a gel on contact with exudates) DO NOT USE ON CLINICALLY INFECTED WOUNDS. Suitable for light to moderate exudates • **SLOUGHY WOUNDS** (need to be de-sloughed) Hydrogels: (used to clean sloughy or necrotic wounds by re-hydrating dead tissue and debriding; need secondary dressing) Also suitable for low exudates and granulating wounds Honey ointment • **CLEAN, GRANULATING WOUNDS** need moist environment for optimum healing. Any of the following may be suitable Foam dressings; Alginate dressings; Hydrocolloid dressings; Low adherent dressings; Honey dressings • **MINOR BURNS and SCALDS** need non-adherent dressings that could absorb exudates if necessary and maintain a moist environment for healing. Selection may depend on burn site, pain and exudates level. Low adherent dressings; Foam dressings; Hydrocolloid dressings; Honey dressings • **OTHER DRESSINGS** Secondary dressings to secure primary dressings. Include adhesive film dressings (permeable to water and oxygen; impermeable to bacteria) and bandages (will avoid skin tears) Antibacterial dressings: Medically prepared honey dressings (osmotic, anti inflammatory action); silver/carbon dressings (normally used for 2 weeks only) Avoid iodine dressings in iodine sensitive patients, those with thyroid problems and pregnant women **WHAT and WHEN TO REFER** • Serious burns. All burns need very careful assessment. • Suspicion of malignancy • Involvement of deeper structures • Serious local or systemic infection • Lower leg wounds which fail to heal may need Doppler assessment
Where else:	Your local Primary Care trust http://www.cambridgeshire.nhs.uk/ Community Wound care Formulary; Infection Control Manual; Tissue Viability Team
References:	Myles, J. Wound dressing types and dressing selection *Practice Nurse* 2006 Vol 32 No 9 p53-62 Palfreyman, S Tissue Viability British Journal of Nursing 2008 Vol 17, Iss 6 Supplement, 27 Mar 2008
Web links:	http://www.worldwidewounds.com (Independent online journal with peer-reviewed articles) http://www.dressings.org/dressings-datacards-by-alpha.html (Wound Management Practice Resource Centre) http://www.journalofwoundcare.com/
Who are you:	Lavinia Barker (Practice Nurse Tutor PGMC, Addenbrooke's Hospital) Anne Holman (Wound Care Practice Nurse)
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Local Anaesthesia

Why:	Minor surgery in General Practice usually requires local anaesthesia (LA). Important to get dose and type of anaesthetic right Need to be aware of side effects
How:	Two commonly used agents will cover most requirements: **Lignocaine, (Xylocaine)** • Fast onset of action (2-3 mins) • Lasts for 1-2 hours. • Maximum safe dose is 200mgs (3mgs / kg body wt. i.e.20 mls of a 1% solution or 40mls of a 0.5% solution. • If adrenaline is added to this then a larger amount can be administered locally since absorption is slower secondary to local vasospasm. • Up to 500 mgs (7 mgs / kg body wt.) can be used with adrenaline. **Bupivicaine (Chirocaine)** • Slower onset of action of 10-15 minutes. • Duration of action is longer at 4-6 hours. • Maximum safe dose is 140mgs (2 mgs / kg body wt.). This equates to 28mls of a standard 0.5% solution or 56mls of the 0.25% solution. • Up to 280mgs can be used with adrenaline **Techniques for LA.** • Local S/C infiltration along the intended incision line or around the lesion to be excised will suffice for most minor surgery. • In nervous patients the use of EMLA can be helpful. • Systemic sedation with midazolam can also be utilised, but again care is required to avoid toxicity and respiratory depression. • For digits a ring block at the base works well. Use a stronger solution (2% lignocaine) to penetrate the digital nerve more effectively. Total volume 10 mls, five on each side to the dorsal and palmar (plantar) neurovascular bundles.
What next and when:	**LA with Adrenaline** • *Local anaesthetics with adrenaline should be used only for specific indications and with great care.* • Addition of adrenaline to the local anaesthetic can be of benefit in vascular areas where the vasospasm reduces skin edge bleeding. The scalp is one such area. • Vasospastic effect is slower than the anaesthetic effect. LA containing adrenaline therefore needs to be administered early in order to gain the benefit of the vasospasm. • Potentially allows a larger volume of local anaesthetic to be used, although for most minor surgery this should not be a problem. The risks of toxicity increase as larger volumes of local are used, and adrenaline itself has the potential for toxic and other side effects. • Important to avoid intravascular injection when using LA with adrenaline. • Should never be used in areas with limited vascular collateral supply such as end organs e.g. the digits, nose, ear and penis. **LA Toxicity** • To avoid toxicity comply with the recommended doses. • Always aspirate before injecting to avoid intravascular injection • If large volume required, use a low dose (0.5%) spreading the volume out sequentially in order to reduce any peaks in absorption. • Always have some IV access Neuro toxicity: Patients experience numbness of the tongue and mouth, light-headedness, visual disturbance, unconsciousness, convulsions, coma and lastly apnoea. Cardiotoxicity: Starts with hypotension then bradycardia. Cardiac standstill and resistant VF may also develop. Bupivocaine is relatively more cardio toxic than lignocaine. In general with lignocaine the neurological symptoms appear first.
Web links:	Update in anaesthesia http://www.nda.ox.ac.uk/wfsa/html/u04/u04_014.htm Surgical tutor http://www.surgical-tutor.org.uk/default-home.htm?core/preop1/loc_anaesthesia.htm~right
Who are you:	Mr Kevin Varty, Consultant Vascular Surgeon
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Abdominal Aortic Aneurysms – Screening and Stenting

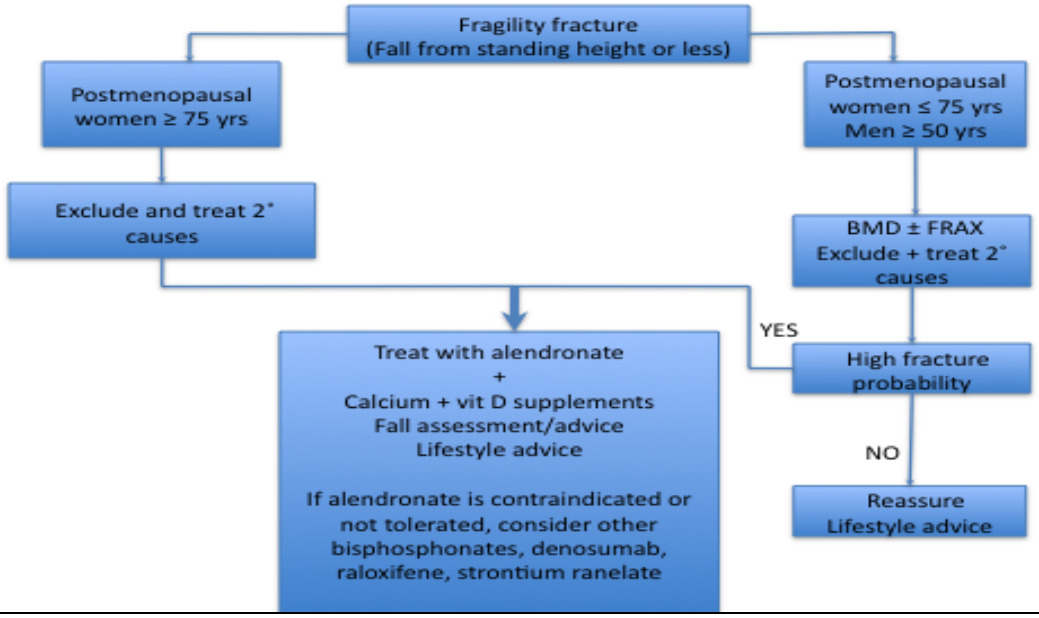
Why:	AAA Screening is starting in the Cambridgeshire area in 2012 so you need to know about it. Up to 75% of AAA's will now be treated with a stent graft, so this is something you should become familiar with.
How:	Ultrasound screening of men in their 65th year by a mobile team in surgeries, local hospitals, and drop in centres is due to commence in 2012. A list of proposed patients for screening will be sent to GPs 6 weeks in advance of the screening clinic. Unfit / unsuitable patients can therefore be removed at this stage. Letters and information will be sent to patients from the co-ordinating centre. A reminder will also be sent. Patients will be given their scan result; the GP will get a written report. Small AAA's will get annual reviews, large AAA's (>5.5cms) need referral. Normal scans will be discharged. Stenting AAA's is becoming common. Early mortality is 1/3rd of open surgery, hospital stay is halved. Later on, scans and re-interventions are more common. Cost is higher. There remains some debate therefore about the overall role of AAA stenting, but for selected cases it has definite advantages.
What next and when:	Screening and stenting do not change the thresholds for intervention. AAA's between 3- 4.5 cms can have annual surveillance. AAA's between 4.5 – 5.5 cms in men need 6 month surveillance. AAA's > 5.5 cms in men need referral for intervention if fit enough. AAA's > 5.0 cms in women need referral. It is rare for AAA's to rapidly expand (>1cm /yr) without symptoms and need more urgent assessment. Symptoms, tenderness, need urgent assessment via the on-call emergency service.
Where else:	Cambridge Vascular Unit: 01223 216992 / 217246 Specialist Nurse: 01223 596382 Patient information can be found at http://www.circulationfoundation.org.uk/vascular_disease/abdominal_aortic_aneurysm
References:	Screening MASS study. Lancet 2002 ; 360 ; 1531 EVAR vs Open repair. NEJM 2008 ; 358 ; 464
Web links:	www.vascularsociety.org.uk NICE: http://www.nice.org.uk/guidance/index.jsp?action=byID&r=true&o=11030#null
Who are you:	Mr Kevin Varty, Consultant Vascular Surgeon, Addenbrooke's Hospital, Cambridge
Review date:	March 2012
Review due:	March 2014

MSK

Top Tips in Two Minutes: Sorting out Shoulder Pain

Why:	A correct diagnosis will enable you to initiate appropriate treatment and to advise the patient on the likely prognosis. Although there are many causes of shoulder pain, identifying key clinical features will help distinguish between patients with two of the commonest causes of shoulder pain: rotator cuff tendinopathy and adhesive capsulitis (frozen shoulder).
How: .	**History** *Where do you feel the pain?* • Pain from the shoulder is usually felt in the muscles of the upper arm. *What makes it worse?* • Pain worse on shoulder movement, especially reaching out, up or behind, points to the shoulder as the origin of the pain. Do not forget that pain can be referred to the shoulder form the neck, chest or abdomen. **Examination** *Compare active and passive range of movement* • Active abduction and active internal rotation are commonly reduced and painful in both adhesive capsulitis and rotator cuff tendinopathy. • Passive movements are reduced in adhesive capsulitis but usually near normal in rotator cuff tendinopathy. • In adhesive capsulitis active and passive range are nearly equal. • The finding of **reduced external rotation** is very helpful in identifying adhesive capsulitis. External rotation is well preserved in all shoulder problems except adhesive capsulitis and glenohumeral arthritis (which is much less common). • Test external rotation by rotating the patient's hand outwards with the elbow flexed at 90º and kept tucked in close to the waist. • In adhesive capsulitis external rotation is significantly reduced compared with the normal side.
What Next and When:	*Having identified adhesive capsulitis you should* • Carry out a proper history and examination, with testing for diabetes and possibly a chest X-ray. Although most cases of adhesive capsulitis are idiopathic, there may be underlying pathology such as diabetes, or carcinoma of the lung. • Explain to the patient the typical natural history of the condition, which usually lasts about 18 months, but in the end resolves completely: 3-6/12 "freezing" - painful and very stiff 6/12 "frozen" - immobile but much less painful 6/12 "thawing" - gradual recovery of range • Interventions are not very helpful in the early stages. Steroid injections may give short term relief but do not alter the overall course. In the early stages physiotherapy is geared towards pain relief and very gentle exercises to maintain a little mobility. Overdoing the exercises will result in pain but will not help the movement. Physiotherapy exercises are more important in the third stage when muscle strength and joint mobility can be restored. • Prescribe adequate analgesia. In the early stages adhesive capsulitis pain can be severe and may require opiate analgesics and night sedation. • About 20% of patients will later develop adhesive capsulitis in the other shoulder. *Having identified rotator cuff tendinopathy* • Analgesics/ short-term non-steroidal anti-inflammatory drugs may help • Subacromial steroid injections may help • Physiotherapy – strengthening the rotator cuff reduces pain and improves function. • Surgical referral may be appropriate in refractory cases, especially if there is subacromial impingement.
Web links/ References:	BMJ Clinical Evidence http://clinicalevidence.bmj.com/ceweb/conditions/msd/msd.jsp Shoulder pain interventions from the Cochrane Library http://www.jr2.ox.ac.uk/bandolier/booth/Arthritis/shoulder.html
Who are you:	Dr. B. Silverman and Dr. J. R. Jenner, Consultant Rheumatologists, Addenbrooke's Hospital
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Fragility Fracture / Osteoporosis Risks

Why:	**People who have had an osteoporotic fragility fracture should be prioritized for assessment and offered treatment to prevent further fractures. Lifestyle, nutrition and exercise (including exercise referral) should also be considered.** *Addenbrooke's Fracture Liaison Service assesses >1000 fracture clinic patients yearly. The nurse writes to GPs with treatment advice for those aged > 75 or requests a dual energy X-ray absorptiometry (DXA) scan. DXA reports contain treatment & follow-up advice.* • NICE recommend, on the basis of cost-effectiveness analyses, that postmenopausal women with a fragility fracture be offered treatment if a DXA scan confirms osteoporosis (T-score ≤–2.5) or they are at least 75 years of age (NICE 161) • National Osteoporosis Guidelines Group (NOGG) recommend a case-finding strategy be used where people are identified because of a fragility fracture or by the presence of clinical risk factors • Experts recommend generating a person's absolute 10 year fragility fracture risk estimates using the WHO online FRAX tool (*see below*). This will work even without a DXA result (it uses age, height, weight and 7 simple *yes/no* clinical risk factors) and tells you if a DXA scan could help. The NOGG 'treat' recommendation is made when the person's 10 year risk is on or above a set age-matched value (=the absolute risk of someone that age with one fragility fracture sustaining another fracture within 10 years).
How:	Consider osteoporosis if patient has: • A history of **fragility fracture** (low trauma or fall from standing height or less) • Clinical evidence of a new or unrecognized osteoporotic fragility fracture (**including vertebral fracture on x-ray)**. • **Kyphosis** (curvature of the spine), **loss of height** (more than 2 inches), or **unexplained back pain**. For all these also consider **separate lateral X-rays of thoracic and lumbar spine** to detect vertebral fractures. • **Clinical risk factors for osteoporosis and fragility fractures**, such as: • Parental history of hip fracture, excessive alcohol consumption (≥ 3 units/d), low body mass index (≤19 kg/m^2), current smoking, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease, continuous systemic glucocorticoid use ≥ 3 months, prolonged immobility, untreated hypogonadism, or other cause of secondary osteoporosis. 
What next and when:	WHO fracture risk assessment tool (FRAX) http://www.shef.ac.uk/FRAX/tool.jsp Reassess fracture risk with DXA after 5 years oral bisphosphonates (3 years IV zoledronate/ibandronate or denosumab) Women ≥75 yrs there is an *option* to do DXA (e.g. if unclear if it was a low trauma fracture). Can give therapy to those ≥75 yrs with hip or vertebral fracture without BMD, but one initial DXA assessment can be useful (baseline for assessing response at 5 years, if further vertebral fracture despite therapy)
Where else:	http://www.nos.org.uk/page.aspx?pid=1024 **Patient information leaflets: free pdfs on almost all osteoporosis and bone health topics**
References:	**NICE January 2011**: http://guidance.nice.org.uk/TA161
Web links:	**NOGG 2012** www.shef.ac.uk/NOGG/
Who are you:	Ken Poole: University Lecturer and Honorary Consultant CUHFNHT Juliet Compston: Professor of Bone Medicine and Honorary Consultant CUHP
Review date:	March 2012
Review due:	March 2014

OPHTHALMOLOGY

Top Tips in Two Minutes: Posterior Vitreous Detachment (PVD)

Why:	Very common. A study looking at prevalence found PVD in 2/3 people over 60. It is important to pick up patients who have had, or are at risk of complications like retinal tears. They need urgent referral to prevent or repair retinal detachment before it reaches the macula.
How:	Key symptoms: • **Floaters** – best seen against a light background, they will move with eye motion. They may be any shape or size, often described as a 'fly, spider or ring' but usually come on suddenly. • **Flash of light** – usually an arc of dim white/yellow light in the temporal field, exacerbated by eye motion and seen best in low light. Often but not always present, this is a very reliable symptom of PVD. Multiple flashes of a different description imply a different pathology. PVD usually occurs between 45-65yrs, is uncommon in <30's if emmetropic, and shows increasing prevalence with age. **Combined onset of flashes and floaters indicates PVD in 90-100% of cases.** Symptoms indicating complication: • A shower of tiny black or red floaters suggests vitreous haemorrhage or pigment cells (Tear) • Description of cobwebs or swirls of red blobs (haemorrhage) • Subjective reduction of acuity, even if no reduction on Snellen (Haemorrhage/Tear) • Curtain effect – A non-fluctuating black or grey shadow, like a crescent, with a clear edge moving from the periphery (retinal detachment.) Factors indicating a high risk PVD: • Age – symptomatic PVD in a relatively young patient • Myopia • History of previous retinal tear in the fellow eye • Previous penetrating trauma • Family history of retinal tears or detachment • Early onset cataracts (whether operated on or not) On examination, the eye may appear essentially normal. Assess: • Acuity, visual fields, pupil reflexes, RAPD, red reflex + fundoscopy **N.B. previous eye surgery is not usually a risk factor, unless it was complicated cataract surgery. However, please remember that PVD can still occur in patients who have undergone intraocular surgery involving vitrectomy.** Screen for and exclude other conditions which may present with the onset of flashes or floaters: • Floaters – normal variation, high myopia, uveitis • Flashes – migraine
What next and when:	Investigations – primarily a clinical diagnosis Process for referral to Ophthalmology: - Symptoms + **any risk factors/signs of complication** needs urgent telephone referral - Symptoms with no risk factors doesn't need a referral unless you or the patient are particularly worried, in which case it can be non-urgent. Watch for symptoms of complication. Patient advice: If there is a retinal tear or detachment then the patient will require urgent surgery. Even if a tear is not present or noted immediately, they can progress over the next few months. Warn the patient to be vigilant for new symptoms and have a low threshold for referral for the next 2-3 months. - The patient can carry on with normal lifestyle.
Where else:	If unsure then please call your local Ophthalmology clinic for advice. Addenbrooke's on 01223-216105, Monday to Friday 9-5, out of hours and week-end call switch and page on-call ophthalmology registrar. Vitreoretinal online service for leaflets and contact advice – www.vitreoretinalservice.org
References:	Posterior Vitreous Detachment: Current Concepts and Management – A.Ang, A.V. Poulson, D.R. Snead, M.P. Snead Comprehensive Ophthalmology Update – July-August 2005 Volume 6, Number 4 Clinicopathological changes at the vitreoretinal junction: posterior vitreous detachment – M.P. Snead et al. Eye (2008), 1-6 Understanding the vitreous: Anatomy, ageing and transformation– J. Lombardo PDF on www.optometry.co.uk
Who are you:	Greg Moore, Final year medical student, Cambridge University Medical School With many thanks to Mr. M. P. Snead (Cons. Ophthalmologist Addenbrooke's Hospital) Reviewer: Dr Gregory Ho-Yen
Review date:	March 2012
Review due:	March 2014

Which Referral?

Low Risk

unlikely to be a tear

- Referral not essential, unless you or patient are worried
- Non-urgent referral
- Watch for complications
- Low referral threshold

High Risk

- Symptomatic PVD at younger age
- Shower of dots/cobwebs/shadow
- Myopia
- Retinal tear in fellow eye
- Previous penetrating injury
- Family history of tear or RD
- Early onset cataracts

Urgent telephone referral

PAEDIATRICS

Top Tips in Two Minutes: Children Behaving Badly

Why:	**Early identification and intervention in high risk groups can significantly reduce the severity and persistence of these behaviours.** Tantrums and aggressive behaviours in young children are very common and will usually remit spontaneously but in a significant proportion of children (approx. 5%) can herald the onset of serious disruptive behavioural disorder. About 30% of these will also have ADHD for which we have effective medical as well as behavioural treatments.
How: .	**Child Factors** Frequency of behaviours Severity of aggression Pervasive or only at home Social skills Delayed language Attentional skills **Parent Factors** Parental mental illness (esp. mum) Parental antisocial behaviour (esp. dad) Social isolation Large families (poor supervision) Parental educational level Domestic violence Substance misuse Overly physical punishment

What next and when:	Corroborative information from health visitor/nursery school
	• If mild/mod give advice on parenting and monitor (usually family nurse)
	• If mod/severe:
	  • If behaviour confined to home environment focus on family/parent interventions e.g. referral to adult mental health/voluntary groups for mental health treatment or parenting groups. Consider referral to social services (OCYPS) for parenting support
	  • If behaviour pervasive all the above still apply but also consider neurodevelopmental disorders (e.g. ADHD, language disorder, dyspraxia, autism spectrum). Refer to community paediatrics
	  • If behaviour severe and involves risk to child/others and generic service interventions have not been helpful then refer to child and adolescent mental health team

References:	• Toddler Taming A Parent's Guide to the First Four Years. Green C. Vermillion, London • 123 Magic: Effective Discipline for Children 2-12. Phelan T. Child Management Inc, Illinois • Hughes, Claire & Ensor, Rosie (2006) Behavioural problems in 2-year-olds: links with individual differences in theory of mind, executive function and harsh parenting. *Journal of Child Psychology and Psychiatry* **47** (5), 488-497 • Egger, Helen Link & Angold, Adrian (2006) Common emotional and behavioural disorders in preschool children: presentation, nosology, and epidemiology. *Journal of Child Psychology and Psychiatry* **47** (3-4), 313-337.
Useful Links	http://www.parentlineplus.org.uk/ information for parents on sources of help www.cafamily.org.uk advice for parents of children with developmental disorders and challenging behaviour http://www.rcpsych.ac.uk useful section of leaflets for parents, children and adolescents about mental health problems including restless and challenging preschoolers
Who are you:	Joanne Holmes, Consultant in Child Psychiatry
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Cough in Children

Why:	Cough can be very significant and is a common presentation to GPs. **Most can be managed in primary care but some important things mustn't get missed.** • Foreign body • Upper airway obstruction • Aspiration • Chronic suppurative lung disease A number of conditions are common and need to be considered. • Viral infections, esp. croup / pertussis – even if have been immunised • Laryngomalacia • GO reflux (Gastro Oesophageal Reflux) • Idiopathic Cough due to asthma (as sole symptom) or cough due to post nasal drip are uncommon.
How:	Duration - <1/12 = acute, >3/12 = chronic **Clues in the history:** Age at onset • <1/12 congenital – e.g. TOF/cleft larynx (Tracheo Oesophageal Fistula) • 1-3/12 Laryngomalacia, Chlamydia, Suppurative lung disease. • *exact* date of onset known – think of foreign body Patient well/unwell Wet / dry - wet (productive) – Suppurative / pneumonia Character - • Spasmodic – pertussis (+/- vomiting) • Barking – croup/ TOF • Odd – psychogenic Timing – • With/straight after feeds – aspiration/ GORD, (Gastro Oesophageal Reflux Disease) • Night time – GORD, asthma. • Morning – Suppurative lung disease • Never at night- psychogenic Associated noises – • Stridor – (e.g. on exercise or crying) upper airway obstruction or laryngomalacia • Wheeze – asthma FB (Foreign Body) FH/SH/PMH– smoking / atopy / eczema
What next and when:	**Investigations** • Peak flow / lung function (can help if asthma suspected- need a diary) • CXR – probably useful in chronic cough to exclude significant disease. Need to ask for expiratory film if FB is suspected. • Immunology investigations where failure to thrive or chronic diarrhoea • Significant fever assoc with episodic productive moist cough needs referral for review and investigation. **Referral**: • ?Foreign body • Significant upper airway obstruction • Suppurative lung disease (frequent productive cough + fever) • ?TOF/Cleft larynx • Preschooler on regular oral steroids • Pneumonia non resolving • Children who are on level 3 Rx for asthma – when cough is major symptom • Interval symptoms when no URTI etc
Where else:	Urgent cases should be sent to the A&E department. Advice can be sought via the respiratory secretary: Tracey Nunn (216020)
References:	Mini symposium on cough in children. *Paediatric Respiratory Reviews* 2006; Vol 7: p 1 -34 Guidelines for Evaluating Chronic Cough in Pediatrics *Chest.* 2006;129:260S-283S **Evaluation and Outcome of Young Children With Chronic Cough. *C**hest.* 2006;129:1132 – 1141 Management of Chronic Non-Specific Cough in Childhood *Arch Dis Child Educ Pract Ed* 2007; 92: ep33-39 Brodlie M, Graham C, McKean M. Childhood cough. BMJ 2012;344:e1177
Who are you:	Dr Rob Ross Russell, Consultant Paediatrician
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Pneumonia in Children

Why:	Many cases can be community managed without investigation; however it is important to pick out those children who should have secondary care management. Although lower respiratory tract (LRI) infections are commonly diagnosed, genuine bacterial pneumonia (i.e. excluding bronchiolitis) is fairly uncommon in children.
How:	Current treatment of pneumonia in children tends to be haphazard, and good guidelines exist that make management relatively simple. The separation of bacterial from viral pneumonia can be difficult. Guidelines point to two helpful clinical guides that can differentiate between them: • In the preschool child, if wheeze is present, primary bacterial pneumonia is unlikely. • Bacterial pneumonia tends to be associated with fever > 38.5, and tachypnoea/dyspnoea (RR > 50 in the under 3, with recession). (Respiratory Rate) Cough is common, and usually 'wet' or productive. Focal signs in the chest may or may not be present. Transmitted noises can often be confused for lung noise, and documented pneumonias may have no signs at all. Subtle signs of distress such as nasal flaring can be helpful.
What next and when:	**No investigations** and **no chest X ray** are needed in a child with appropriate clinical picture seen in the community. **Oxygen saturation should be measured**. If ≤92% the child should be referred to hospital Other criteria for referral include: • Significant tachypnoea/dyspnoea (RR > 70/min in infants or 50/min in older children) • Significant grunting/distress • Difficulty feeding/dehydration • Families unable to care adequately Antibiotic choice is simple: Amoxicillin for the pre school child and a macrolide (Clarithromycin or Erythromycin) for the older child. Physiotherapy has no benefit. **Patients whose fever and symptoms do not resolve within 7 days should be referred in view of the possibility of empyema**.
Where else:	Referral for cases causing concern should be through the on call registrar at Addenbrooke's. **All patients should be seen 3-4 weeks** after the antibiotics to ensure that symptoms have settled completely. Persistent symptoms at this stage warrant referral to the respiratory team for a review and probable x-ray.
References:	Community acquired pneumonia in children: a clinical update *Archives of Disease in Childhood Education and Practice Edition* 2004;**89**:ep29-ep34 Community Acquired pneumonia. *Arch Dis Child 2001;* **85:** 445-6
Web links:	The BTS guidelines for the management of community acquired pneumonia in children. (British Thoracic Society, 2011) http://www.brit-thoracic.org.uk/guidelines/pneumonia-guidelines.aspx http://cid.oxfordjournals.org/content/early/2011/08/30/cid.cir531.full
Author:	Dr Rob Ross Russell, Consultant Paediatrician, Addenbrooke's Hospital, Cambridge
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Engaging With Young People: the 'In Betweeners'

Why:	• Adolescents are neither children nor adults - consultation styles need to be adapted to their specific needs. • General practice consultations with young people are shorter than those with other patients and yet teenagers have health concerns & needs that can often go unrecognised (e.g. around 25% detection rates for depressive disorders in one study) • Both young people and GPs themselves frequently report dissatisfaction with the consultation process. • Core issues for young people are access, acceptance, and clarity about consent and confidentiality. • After that they do know, when we do know, and when we don't, they want professionalism just like an adult, expertise and help. • Young people want to be 'taken seriously' but they also want good adult advice and guidance, this is the core paradox the *'In Betweeners'* • Making changes to meet the needs of young people can improve consultation skills with all patients. • Population characteristics with particular difficulty accessing primary care: disabled, in poverty, ethnic subgroups, being looked after and sexual orientation • YP with mental health needs more often start consultations with complaints of a physical nature: they can fear or be embarrassed to discus MH needs • The adolescent brain development means there is more impulsivity yet feelings can be very mature, so things can shift very quickly
How:	**'Youth Infusion': empowerment, participation, engagement** Before and after the consultation: (see Your Welcome Criteria Dept of Health 2005) • Think about how to maximise accessibility to the practice for young people e.g. How can they make appointments? When are the appointments? Can they get to you on their own? • Promote an understanding of consent and confidentiality – practice confidentiality policy to specifically encompass under 16 year olds; train all staff; publicise in age appropriate practice leaflets and posters. • Develop a YP welcoming environment – non-judgemental reception staff, some literature specifically aimed at YP etc. • Option of choice of gender of staff who YP will see • Involve young people with feedback e.g. with focus groups or surveys, comments etc. In the consultation: • 'Start young' – talk to young people directly so that they become used to being active in the consultation, and can feel empowered • Aim to see YP alone for part of the consultation, even if they come with parents – develop strategies for getting them out. • As far as possible, keep parents/carers in the picture without breaking confidentiality • Provide assurance about consent and confidentiality (and also its limits) • Be *seen* to be interested in the young person and their problems. • Be aware of hidden agendas – but equally there is not *always* a hidden agenda! • Use simple language, don't assume knowledge, but don't patronise. • Consider common unmet health needs and concerns that YP may not feel able to raise – sexual health, pubertal changes, drug use, depression/mental health, abuse issues. • Facilitate return visits – develop a relationship, and deal with practical issues to make re-attendance easier. • Be aware of transitions and discontinuities in care
References:	Difficult Consultations with Adolescents. Chris Donovan & Heather Suckling, 2004. Radcliffe Medical Press Adolescents and Sex – the handbook for professionals working with young people. Sarah Bekaert, 2005. Radcliffe Publishing. Adolescence and health: Wiley Series I understanding adolescents (2007). Editors: John Coleman, Leo B. Hendry & Marion Kleop
Web links:	www.teenagehealthfreak.org www.youthinfusion.com
Who are you:	Dr Raphael Kelvin Consultant and Associate Lecturer in Child & Adolescent Psychiatry, Cambridge, Cambridge & Peterborough Foundation Trust & Cambridge University
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Eczema Herpeticum

Why:	Eczema Herpeticum (also known as Kaposi varicelliform eruption) is the development of widespread cutaneous HSV (Herpes simplex virus) infection in a patient with eczema. In children it is commonly a primary HSV infection (majority HSV-1). It is important to recognise eczema herpeticum so that appropriate treatment can be given promptly and potentially serious sequelae avoided. If diagnosed early treatment can be given successfully in primary care.
How:	Eczema Herpeticum arises on the background of atopic eczema (although it does not have to be severe) and occurs in children and adults. **History** The onset is usually fairly rapid over a few days Sudden deterioration of the eczema Child is usually 'grizzly' There may a history of contact with HSV (cold sore) **Clinical** Lesions start as vesicles but due to itch these may be replaced by crusted lesions or punched-out erosions. Pustules may also be present. Lesions may be discrete or confluent and any site can be affected but limbs typically involved Pyrexia in up to 75%. Associated clinical symptoms include: intense itching, malaise, vomiting, and lymphadenopathy. Secondary bacterial infection usually present.
What next and when:	If possible, swab skin from affected site for viral and bacterial culture. Stop topical steroids and wet wraps/bandages. If child is not systemically unwell and lesions are localised, treat with oral aciclovir (do not wait for swab results). Treat any secondary bacterial infection with oral flucloxacillin. If unwell or extensive lesions, urgent referral to hospital for IV acyclovir. Contact on call dermatologist/paediatrician. **Complications** Can become fulminant if not treated Eye involvement - seek urgent ophthalmological opinion if lesions near the eye Recurrences common (20%) in first few months
Where else:	Contact on call Dermatology SpR or Consultant http://www.dermnetnz.org/viral/herpes-simplex.html http://emedicine.medscape.com/article/1132622-overview
References:	Goodyear HM. Harper's Textbook of Paediatric Dermatology 3rd Edn 2011.Eds Irvine, Hoeger, Yan
Who are you:	Dr Nigel Burrows, Consultant Dermatologist
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Autism

Why:	Autism Spectrum Conditions are becoming increasingly prevalent – affecting approximately 1% of the population. Diagnosis is often delayed, especially for milder cases like Asperger's Syndrome. Early diagnosis can lead to improved outcome for child.
How:	Look out for behavioural symptoms/obtain history from parent: **Social** Show no interest in other children playing, aggressive towards siblings, Sits alone crying and not seek comfort from parent, Unresponsive when parent leaves or returns from being out, Shows no interest in interactive games, Resistant to being cuddled **Communication** Unaware of environment, Avoids eye contact, Leads parent by hand to objects s/he wants **Repetitive/Stereotyped Behaviours** Hand flapping, Attention to moving objects – e.g. fan, washing machine, Spinning, Lining up toys e.g. cars, Shows no interest in toys, but may develop attachment to specific object e.g. stone, Focuses on one aspect of toy e.g. spinning wheels on toy car, flicking doll's eyes repeatedly, Rocking, Switching lights on and off, Pica, Flicking fingers in front of eyes, Faecal smearing **Motor Behaviours** Fine motor deficits, Poor coordination, Toe walking, Depth perception deficit, Exceptional balance, Clumsy, Dribbling **Sensory Issues** Difficulty with haircuts, Unable to tolerate seatbelts, Difficult to bathe, Finds common household smells obnoxious, Difficulty tolerating music, Spinning objects close to face, May appear deaf, Difficulty wearing outdoor clothing in winter, Resists having clothes changed, Rips out labels from clothes, Insists on wearing winter clothing during summer **Self Injurious Behaviours** Head-banging, Biting self, Scratching at skin, Hair-pulling **Safety Issues** No sense of danger, No fear of heights **Gastro Intestinal Disturbances** Diarrhoea, Undigested food in stools, Severe self-limiting diet and/or food sensitivity, Constipation **Other** Sleep disturbances, Seizures, Altered pain responses
What next and when:	Use brief screening tool – e.g. CAST (Childhood Asperger Syndrome Test). Children aged 4 – 11 - if score >15 and child is showing some of above behaviours/symptoms – definite referral to local Child Development Centre (CDC) for multidisciplinary assessment. Tell family that child is displaying some autistic symptoms that need to be thoroughly assessed.
Where else:	Parents can contact 01223 216 662 for information regarding the CDC assessment and waiting list times.
References:	Williams, J., Scott, F., Stott, C., Allison, C., Bolton, P., Baron-Cohen, S., & Brayne, C. (2005). The CAST (Childhood Asperger Syndrome Test): Test accuracy. *Autism, 9*, 45-68. **For more recent research on identifying autism spectrum conditions, see:** Allison, C., Auyeung B., Baron-Cohen, S. (2012). Toward Brief "Red Flags" for Autism Screening: The Short Autism Spectrum Quotient and the Short Quantitative Checklist in 1,000 Cases and 3,000 Controls. *Journal Of The American Academy Of Child & Adolescent Psychiatry*, *51.2*, 202-212.e7.
Web links:	**www.autismresearchcentre.com/** www.nas.org.uk
Who are you:	Carrie Allison, Research Associate, Autism Research Centre
Review date:	Interim review: February 2012
Review due:	July 2012

Top Tips in Two Minutes: Watery and Sticky Eyes in the First Year of Life

Why:	A very common problem which can often be managed in primary care setting: ◦ Commonest cause: congenital naso - lacrimal duct obstruction (CLNDO) ◦ Also common: Conjunctivitis ◦ Uncommon: Corneal pathology e.g. crystals, splits/opaque lines due to congenital glaucoma
How:	RED eye + epiphora + discharge = likely conjunctivitis WHITE eye + epiphora + discharge from birth = likely CNLDO WHITE eye + epiphora (not sticky) + other (photophobia, hazy cornea) = suspect corneal pathology Conjunctivitis: conjunctival swelling and hyperaemia in the inferior fornix is present CNLDO: Use your little finger to massage the lacrimal sac against bone (just medial and inferior to the medial canthus – often get release of discharge through lacrimal punctae Instil Fluorescein & examine the cornea with ophthalmoscope set on +20Dioptres (with white light and blue filter).
What next and when:	Neonatal conjunctivitis requires bacterial, herpetic and chlamydial swabs (prior to fluorescein staining). Start g / chloramphenicol / Fucithalmic. Fax referral to Eye Clinic if severe / no better in a week or if chlamydial scrape positive CLNDO: No point doing conjunctival swab. Topical antibiotics not needed unless secondary conjunctivitis. Advise lacrimal sac massage 5 minutes every feed, then clean the eye with cooled kettle water on cotton wool pad. If the skin is sore, advise parent to apply Vaseline to skin of lower eyelids at bedtime. Refer if no better after 10 months of age. See link to Patient Information Leaflet below. Syringe and probing is usually performed if child is symptomatic at 1 year of age. Corneal Pathology: Refer in to Ophthalmology Clinic urgently
Where else:	Consultant Contact: louise.allen@addenbrookes.nhs.uk Departmental fax for urgent referrals: 01223 217968
References:	Congenital Naso -Lacrimal Duct Obstruction. Shepherd et al. JPOS 1995 32 (4) 270-271
Web Links	http://www.cuh.org.uk/resources/pdf/patient_information_leaflets/PIN0610_children_sticky_watery_eyes.pdf http://www.cuh.org.uk/resources/pdf/consent_forms/CF121_eye_syringeprobe_ducts.pdf
Who are you?	Miss Louise Allen, Consultant Paediatric Ophthalmologist
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Squint

Why:	Common problem affecting 5% children. Early diagnosis can often prevent loss of binocularity / amblyopia / need for surgery. Most squints are primary but some can be secondary to serious pathology Types of squint Primary: Constant / intermittent: Convergent / Divergent Secondary to poor vision in one or both eyes; cataract, retinoblastoma Secondary to neurological causes: cranial nerve palsies, raised ICP (Intracranial Pressure)
How:	**Onset:** Most primary squints start intermittent and become constant over months. Beware the acute onset squint with diplopia in older children – this can be secondary to intra-cranial pathology! **Age at Onset:** Variable squints are common before 6 weeks of life due to maturation of vision. Constant squints after 6 weeks are not common and are unlikely to resolve spontaneously. Most accommodative squints occur at 3-4years when the child becomes interested in near work and natural range of accommodation is declining Beware acute onset of squint >4 year old with diplopia **Type of Squint:** Intermittent vs. Constant. Try to make the child accommodate on areas of a detailed target to identify accommodative squint. Childhood squints are usually concomitant i.e. do not usually vary depending on the position of gaze and eye movements are full. Incomitant squints, where the angle of squint varies depending on the position of gaze should ring alarm bells as they suggest orbital or intra-cranial pathology. **Pre-Natal / Neonatal History:** Early onset squints are common in premature / cerebral palsy children and those with syndromes e.g. Down **FH:** A family history of squint / amblyopia / long sight should increase suspicion **CHECK RED REFLEXES** **CHECK EXTRA-OCULAR MOVEMENTS ARE FULL** **CHECK DISCS in older child with sudden onset of convergent squint**
What next and when:	Definite squint at any age (or ? squint in <6/12 old) refer routinely to the hospital eye service ?Squint in >6/12 old: refer to secondary orthoptic community screening if in Cambs Acute onset squint in older child / limitation of eye movements / abnormal red reflex / swollen discs refer urgently by fax to the hospital eye service
Where else:	Consultant Contact: louise.allen@addenbrookes.nhs.uk Departmental fax for urgent referrals: 01223 217968
References:	ABC Eyes: Squint. Elkington AR BMJ 1988 297(6648):608-11 The Management of Squint. Fielder A. Arch Dis Child. 1989 64(3):413-8
Web Links	http://www.patient.co.uk/showdoc/23068827/ http://www.cuh.org.uk/resources/pdf/consent_forms/CF122_eye_surg_squint.pdf
Who are you?	Miss Louise Allen, Consultant Paediatric Ophthalmologist
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Paediatric Gynaecology

Why:	Important for GPs who will see children with common gynaecological conditions and need to know how to manage them and if / when to refer. Common conditions include vulvovaginitis, labial adhesions, vaginal bleeding. Less common conditions include delayed puberty.
How:	Vulvovaginitis: ask whether intermittent / constant, possibility foreign body insertion, other skin conditions and most importantly likelihood of sexual abuse. "No vagina": likely diagnosis is labial adhesions. Ask if problems passing urine. Rarely due to abnormal anatomy. Vaginal bleeding: assess pubertal status, ask if cyclical, exclude sexual abuse Menstrual dysfunction: Give menstrual calendar and check Haemoglobin +/- coagulation
What next and when:	Vulvovaginitis: Perineal hygiene, Rx infection if present. Refer if fails to settle Labial adhesions: Short course of E2 cream (especially if urinary symptoms) or nothing. Will not recur after puberty Vaginal bleeding: May need referral to paediatric endocrinology / gynaecology Menstrual dysfunction: Often just need education. Consider TEXA or OCP especially if anaemic
Where else:	Paediatric gynaecology (J. MacDougall) or paediatric endocrinology (I Hughes, D Dunger, Carlo Acerini) BritSPAG information leaflets – see below
References:	Paediatric & adolescent gynaecology: a multidisciplinary approach. Balen, Creighton, Davies, MacDougall & Stanhope. CUP. 2004
Web Links	www.britspag.org/
Who are you?	Jane MacDougall MD FRCOG Consultant in Reproductive Medicine & Paediatric & Adolescent Gynaecology Addenbrooke's Hospital, Cambridge
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Swollen Joints in Children

Why:	There is a broad differential diagnosis of swollen joints in childhood including some potentially life threatening ones and some that may cause long term damage. **Differential diagnosis of inflammatory arthropathy;** • Infection • Juvenile idiopathic arthritis (JIA) • Arthritis associated with other disease • Malignancy • Haematological e.g. haemophilia • Genetic disorders • Drug reactions • Trauma **NB non accidental injury** • Orthopaedic e.g. Perthe's • Misc. e.g. Sarcoid, Chronic multifocal osteomyelitis (SAPHO)
How to pick out symptoms of arthritis:	**Acute painful swelling in a joint needs to be referred to the orthopaedic team 'on call' to exclude septic arthritis** **Pain of < 5 days/ weeks is different** **Duration** – may be acute or several months duration. By definition, JIA is characterised by arthritis of 6 weeks duration **Age at onset - May occur at any age** • 75% of children who get arthritis are girls, age 2-6yrs • systemic arthritis, under 5yrs, slightly more common in boys • late childhood oligoarthritis, also more common in boys **Character** - • morning stiffness • Gelling phenomenon – stiffness after rest • Constitutional upset (Wt loss, off food, disturbed sleep) • Specific fever patterns and rashes • Positive family history **Associated diseases** – • Inflammatory bowel disorder • Psoriasis • Connective tissue disorder Enthesis related – spondyloarthropathy / HLA B27
What next and when :	**Investigations** ▪ FBC, ESR, LFT, CRP, ANA - Do not need imaging or x rays **Referral**: ?Abnormal blood tests –refer with tests in pipeline ▪ Symptoms fail to resolve ▪ Severe constitution upset
Where else:	**Clinic Set up;** Rapid Referral Clinic – Dr Heinz (OMIT consultant lead – rapid response.) Rheumatology Clinic – Adult Rheumatologist (Dr Ostor) and Community Paediatrician (Dr Sansome) Bi **monthly** for confirmed arthritis and children on Methotrexate or long term medication. **Consultant contact**: Dr Peter Heinz, Consultant Ambulatory Paediatrician Clinic 6 fax. 01223 586508 Dr Andrew Ostor, Consultant Rheumatologist secretary: 01223 216459 Dr Alison Sansome, Consultant Community Paediatrician Child Development Centre; 01223 216662 **Treatment options** **NSAIDs** Ibuprofen10mg/kg/dose QDS Regularly **Steroids** – short course for acute management **Disease Modifying Drugs** (DMARDs) Methotrexate Etanercept - Tablet/syrup or S/C injection WEEKLY - Monitor monthly; FBC; Platelets<150, WCC<3.5 or severe drop, LFTs; AST>2x normal. Rash / severe ulcers / Dyspnoea/cough / Avoid live vaccine / Miss dose if acutely unwell / Contraception / ETOH
Web links:	www.kidswitharthritis.org
Who are you:	Alison Sansome, Consultant Community Paediatrician
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: UTI in Children

Why:

NICE guideline
Think UTI if unexplained temp >38'C >24hours
Refer and investigate the few who need it rather than all patients

How:

Lower UTI -dysuria,frequency, urine positive (nitrite +/- leucocytes) –no features of upper UTI
Upper UTI -urine positive and -fever > 38^0 C**,** loin pain
Diferential diagnoses: vulvovaginitis, urethritis, irritation (soaps, poos hygiened), threadworm, balanitis

①Risk factors to explore
-known renal tract abnormality
-positive family history
-dysfunctional voiding
-constipation
-poor growth
-age under 3 months

②Recurrence of UTI
-two or more proven urinary tract infections

③Atypical UTI
-seriously ill
-poor urine flow
-abdo mass
-↑ Creatinine
-No response to Rx after 48 hrs
-non e-coli infection

What next and when:

Carefully examine and check BP in all children
Send urine for culture for all children with exception of a first lower UTI
Refer all seriously ill or any children under 3 months of age to hospital
Assess response to treatment after 24 – 48 hours

Test	Responds well to Rx < 48hours			Atypical UTI			Recurrent UTI		
U/S during infection	No	No	No	Yes	Yes	Yes	Yes	No	No
U/S within 6/52	Yes	No	No	No	No	No	No	Yes	Yes
DMSA 4-6 months following infection	No	No	No	Yes	Yes	No	Yes	Yes	Yes
MCUG	No unless U/s abnormal	No	No	Yes	No	No	yes	No	No
	<6 months	6months – 3 years		>3years					

treat: little evidence to favour a particular antimicrobial. Trimethoprim 50 mg/5 ml, 50 mg bd often used,. others cefalexin amoxicillin and co-amoxiclav. (NOT quinolones)
duration:
lower: 3 days -
upper t 7-10 days

Where else:

Treatment and advice following UTI
-No routine urine re-testing following an episode of proven UTI in children.
-No routine prophylactic antibiotics.
-No routine surgical management of reflux with or without UTI
-Encourage to drink an adequate amount.
-Address dysfunctional elimination syndromes and constipation

Indications for referral to a paediatrician
- children with recurrent UTI or abnormalities on imaging

Patient information:

NICE patient information - http://guidance.nice.org.uk/page.aspx?o=448751

Web links:

NICE UTI in children August 2007. Algorithms can be found at
http://guidance.nice.org.uk/index.jsp?action=download&o=36029
BMJ 2007 ;335: 395-7 BP centile charts http://adc.bmj.com/cgi/reprint/92/4/298
Growth charts http://www.cdc.gov/nchs/about/major/nhanes/growthcharts/clinical_charts.htm
http://www.patient.co.uk/doctor/Childhood-Urinary-Tract-Infection-%28UTI%29.htm

Who are you: Dr Sarah Rann GP, Cambridge

Review date: March 2012

Review due: March 2014

Top Tips in Two Minutes: Adolescent Gynaecology

Why:	This is important for GPs who will see adolescents with gynaecological problems. Many of these can be managed effectively in primary care. GPs also need to be able to recognise or be aware of rarer diagnoses so that appropriate referrals can be made. Common presentations include menstrual dysfunction, pelvic pain and dysmenorrhoea, hirsutism, acne & obesity and oligo or amenorrhea. Recently there have been increasing numbers of teenagers requesting labial reduction.
How:	The consultation with the adolescent can be challenging and needs to be managed with care. Make the adolescent central to any consultation and give them time & space. • Menstrual dysfunction: give menstrual calendar and check Haemoglobin +/- coagulation • Pelvic pain / dysmenorrhoea: take careful history. Exclude infection & pregnancy. • Hirsutism & obesity: Look for features which might suggest different aetiology to PCOS • Oligo / amenorrhoea: History, examination & investigations should be focused on establishing cause. Be aware of rare causes especially if amenorrhea is primary. • Concerns over labial appearance/ discomfort. Exclude dermatological conditions. Measure labial width: normal up to 5cms, some asymmetry common and normal • Remember to use consultation to discuss contraception if teenager is sexually active
What next and when:	• Menstrual dysfunction: Often just need education. Consider TEXA or OCP esp. if anaemic • Pelvic pain / dysmenorrhoea: Once imp causes excluded (e.g. pregnancy & infection) manage symptoms with analgesia +/- OCP. Be aware of social issues • Hirsutism & obesity: If due to PCOS first line management is weight loss. • Oligo / amenorrhoea: Treat cause. Remember that patients may be fertile & conceive – give appropriate contraceptive advice • Requests for labial surgery: surgery rarely appropriate. Reassure normal anatomy, If discomfort, advise reduce shaving and use Dermol 500 for washing.
Where else:	Help and advice: • Obtainable from adolescent gynaecology (Jane MacDougall) or adolescent & paediatric endocrinology (I Hughes, D Dunger, Carlo Acerini, Helen Simpson) • BritSPAG has information leaflets
References:	Paediatric & adolescent gynaecology: a multidisciplinary approach. Balen, Creighton, Davies, MacDougall & Stanhope. CUP. 2004
Web links:	• http://www.britspag.org/ • www.gmc-uk.org
Who are you:	Jane MacDougall MD FRCOG Consultant in Reproductive Medicine & Paediatric & Adolescent Gynaecology Addenbrooke's Hospital, Cambridge
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes:
Common Conditions of the Normal Child: 'Flat Head' (Plagiocephaly) in the 8 Month Old

Why:	Up to 50% of implants have some degree of plagiocephaly – greatly increased incidence since 'Back to Sleep' campaign (although this has been hugely successful in reducing 'cot death' incidence). • Parental worry re will head be normal shape? • Professionals worry as there are occasional serious conditions associated with plagiocephaly.
How:	History: • Obstetric/birth history- intrauterine moulding can be related to malpresentation. Children who are floppy tend to have malpresentation. Birth trauma moulding tends to resolve in first few weeks of life • Developmental: e.g. 8 month old should be sitting, rolling, transferring objects, babbling, and putting objects to the mouth and should not show hand preference. • Ask about how much time baby spends on tummy/back. Should have floor time on tummy, should not spend excessive time sitting e.g. in car seat or bouncer, and should not be in baby walker (they cause accidents and are dangerous).
What next and when:	Examination; • General development • Head size- can be difficult to measure largest circumference • Head exam- check for fontanelle. • Look at ears- the ear ipsilateral to flattening moves forward and is associated with cranial bossing on affected side. In plagiocephaly due to sleeping position the head resembles a parallelogram. This is helpful sign as in craniostenosis; the ear is pushed back (not forward). • Eye movements (if have squint, will preferentially look one way and so encourage plagiocephaly) • Neck movements (exclude torticollis) • Hand movement – there should be no preference presence • Shoulder and upper limb for muscular symmetrical • Hips -limited movement in one hip will encourage baby to lie one way • Muscle tone –babies with general floppiness will tend to develop plagiocephaly as they move less. • Hemiplegia- will not tend to show plasticity at 8 months but will show floppiness, and asymmetrical muscle bulk.
Where else:	If all normal, then spend more time on tummy or side if awake and playing –i.e. 'Back to sleep and over again' Head helmets; (popular in USA) to give baby perfectly round head. Problems: plagiocephaly improves with age anyway; helmets have to be worn 23 or more hours a day; treatment should start <7 months age, lasts months. If torticollis refer physiotherapy. Refer if abnormal findings - especially note: developmental delay; suspected craniostenosis; abnormal head circumference or head circumference out of keeping with weight and /or height; abnormal hip position; weakness or hypotonic,
References:	Saeed SA, Wall S A Dhanwal DK Management of positional plagiocephaly. Archives of Disease in Childhood 2008;93:82-84
Web links:	Information sheet for parents on plagiocephaly http://www.nhsdirect.nhs.uk/articles/article.aspx?articleId=1892 Exercises for torticollis (parent information sheet). http://www.orthoseek.com/articles/ifs-left.html
Who are you:	Dr Peter Heinz, Consultant Paediatrician, Addenbrooke's Hospital Anna Maw, SpR Paediatrics, Addenbrooke's Hospital Reviewer: Dr Rob Ross-Russell, Consultant Paediatrician
Review date:	March 2012
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Top Tips in Two Minutes: Common Conditions in the Normal Child: Foot and Toe Problems in Babies and Toddlers

Why:	Parental concern concerning flat feet is common. Flat feet are usually constitutional – often secondary to generalised physiological joint hypermobility. Toe walking is usually normal up to 3 yrs of age but exclude cerebral palsy and idiopathic tightness of the tendoachilles Surgery is only indicated for crossed and curly toes if they cause rubbing and soreness - orthotics are of little if any value Intoeing is usually physiological due to a combination of femoral torsion (ante version),+/- tibial torsion +/-metatarsus varus (forefoot curves inwards). It improves and resolves spontaneously in 99.9% of cases by 11 years of age. Orthotics are of no value.
How:	**Red flags**: Pain, foot rigidity, marked asymmetry and limp
What next and when:	**Always observe the child walking and examine the whole leg** **Flat foot** • Pain is abnormal • Check flexibility of thumbs elbows and knees (hyperextensible?) • Perform 'Jack's test' to exclude a rigid flat foot – arches reform when standing on tiptoe if simply due to joint hypermobility. **Intoeing** • Birth history – cerebral palsy? • Gait pattern – kissing patellae suggest femoral intorsion • Hip internal rotation greater than 60^0 with femoral intorsion • Malleoli horizontal with tibial intorsion • Feet curve inwards with metatarsus adductus (benign and self limiting if flexible) **Toe waking** • Check that ankles dorsiflex beyond plantargrade (tight TA's?) **Crossed and curly toes** • Look for callosities and soreness • Webbed toes need no treatment, but check for other deformities.
Referral:	Refer if red flags. • Stiff / rigid / painful flat feet • Asymmetry • Limp/gait abnormity • Outside typical age range
Web links:	www.cuh.org.uk/addenbrookes For the link to the pages put together on this subject.
Who are you:	Mr David Conlan FRCS Consultant in Paediatric Orthopaedic and Paediatric Spine Surgery
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Common Conditions in the Normal Child: Bow Legs and Knock Knees

Why:	Bow legs- (genu varum) Most children are bow legged from birth until 3 years of age (due to differential growth around the knee) Knock knees (genu valgum) - most children become knock kneed to some degree between 3-5, usually grow out of it by about 7. Knock knees will often follow bow legs; usually grow out of one and into the other!
How:	Check for asymmetry and pain. Any limp is abnormal
What next and when:	Examine gait. Bow legs – 2 inch rule- no more than 2 inches apart at knee Knock knees; more than 2 inches apart at medial malleoli
Where else:	Red flags (suggested list): • Limp. • Outside 2 inches rule. • Outside typical age range. • Unilateral What not to miss- • Blounts disease (medial necrosis of medial tibia, heavy children, asymmetrical) causes severe bow legs, more common in afro Caribbean and Scandinavian groups. • Metabolic bone disease, • Neuromuscular disease.
Web links:	Orthoseek http://www.orthoseek.com/articles/bowlegs-kk.html#valgum
Who are you:	Dr Peter Heinz Consultant Paediatrician Addenbrooke's Hospital Anna Maw SpR Paediatrics Addenbrooke's Hospital Reviewer: Dr Rob Ross-Russell, Consultant Paediatrician
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Top Tips in Two Minutes: Behaviour Problems in School Age Children

Why:	Behaviour problems are common. Causes are multiple and coordination and commissioning of interventions is often poor. Childhood behaviour problems affect children, their siblings, their parents and teachers. They are a risk factor for a range of adult mental health problems
How:	Parents present children for treatment. Consider who has the problem, and what outcome they want. Consider how the child's behaviour affects and is affected by others. Get to know what services are available locally. Behaviour problems; 5-10% of children, many problems are of recent onset, untreated early onset is associated with more adult problems. • Oppositional Defiant Disorder; tempers, aggression and defiance, often situational ie home or school. Consider underlying causes. • Conduct disorder; as above plus lying and stealing, often an adolescent development of ODD. The following are associated with increased risk of behaviour problems. Longstanding: • ADHD; inattention, over activity and impulsivity. ADHD symptoms present at home and at school. 5% of children should have behaviour management and routine school support, 1% should receive medication (NICE). 50%+ also have challenging behaviour. • Asperger's Syndrome; (approx 1%) lack of empathy, few friends, pedantic and adult in demeanour, limited play repertoire, obsessional interests. • Autism (1:5000); as above, but with markedly delayed language • Attachment problems; children seek attention from carers by challenging behaviour, there should be a history of early childhood adversity, abuse or neglect. Recent: • Family or parental ill health; depression, substance misuse, marital conflict • Childhood depression, substance misuse, bullying, very rarely psychosis Don't forget, child abuse can present as challenging behaviour – neglect, physical, sexual abuse or exposure to domestic violence. Self harm and suicidal behaviour can be brought as a "behaviour problem" or can be a manifestation of poor emotional control in conduct disorder.
What next and when:	See the child, alone if possible. Consider the child's mental health. Gather information from other sources, such as school and other parent to help clarify the extent of the problem. Decide what interventions might be useful and what will be acceptable to the parents and child. Treat parental mental health before childhood behaviour ("You need to be as well as possible to cope with your child"). If there are home problems then encourage parents to attend a parenting group for their child's age. If problems at school consider bullying, learning difficulties, ADHD or ASD. Advice in surgery. • Agree simple house rules with the child and your partner. Write them down. • Agree the rewards for good behaviour (most parents also want to have sanctions for bad behaviour, although they don't work as well as rewards) • Keep to the rules. • Keep calm. • Catch your child being good and give specific praise, "well done for ..." or "I'm pleased you did..." • Find time to spend doing nice things with your child. • Spend time with your partner away from the children.
Where else:	There should be a range of parenting groups offered by the Local Authority, voluntary agencies and schools, CAMHS may also be involved. Referral is often to a Local Authority coordinated programme. Depending on where you live, community paediatricians or CAMHS may assess for ADHD and ASD. You should clarify the pathway and what information they would like about the problems. At a minimum you should have identified many of the symptoms and clarified that they have been present since early childhood. Write directly to schools to ask what assessment they have done to explain the child's behaviour and what their intervention plan is. Refer children with suspected psychosis or significant depression, anxiety or self harm to your local CAMHS.
Reference	NICE guidelines for ADHD and Conduct Disorder
Web links:	http://www.rcpsych.ac.uk/mentalhealthinformation/childrenandyoungpeople.aspx A range of leaflets for children and parents.
Who are you:	Paul Millard. Consultant Child Psychiatrist Cambridgeshire and Peterborough Foundation Trust
Review date:	March 2012
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Top Tips in Two Minutes: Constipation in Children

Why:

Constipation is common in childhood affecting up to 30% of the child population
Constipation is:
- Fewer than 3 complete stools per week of type 3 or 4 Bristol stool chart

It causes:
- Hard large stool
- Causes distress, pain and bleeding on passing stool
- Anal fissures

How:
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Idiopathic constipation does **not** occur in the first few weeks of life
- Meconium ileus
- Hirschprungs

It does occur in babies and may be caused by poor fluid intake, change of diet and weaning
Childhood constipation - definitions
Soiling
- Constipation with over flow
- Inappropriate passage of stool
- Faeces tend to be loose and smelly
- 'No control'

Encopresis
- Inappropriate passage of normal stool
- Passed in pants or other place in which it will be found
- Normal bowel sensation
- Often associated with other behavioural problems

What next and when:

Red Flags in history:
- Delayed motor development
- Presence of neurological sign
- Talipes
- Spinal anomaly/signs
- Hairy patch or pigmentation
- Sacral dimple or skin tag

} Refer Neurosurgery

- Abnormality in position, appearance or patency of anus - Refer Paed Surgery
- Failure to thrive
- Abdominal distension
- Vomiting
- Constant leaking of stool and urine

} Refer Gastroenterology

- Safeguarding — Refer Community Paediatrics

Treatment:
1. Disimpaction
- Inform families that disimpaction treatment can initially increase symptoms of soiling and abdominal pain
- Do not use – rectal medications
  – sodium citrate enemas
- Do not use phosphate enemas unless under specialist supervision in hospital
- Review all children undergoing disimpaction within 1 week

Medication:
- Polyethylene glycol 3350 + electrolytes1 using an escalating dose regimen as the first-line treatment.
- Add a stimulant laxative if no success after 2 weeks
- Consider a stimulant laxative with or without an osmotic laxative if not tolerating first line treatment

2 Maintenance
Medication:
- Polyethylene glycol 3350 + electrolytes as the first-line treatment
  - As a guide for children and young people who have had disimpaction, the starting maintenance dose might be half the disimpaction dose
- Add a stimulant laxative if polyethylene glycol 3350 + electrolytes does not work
- Substitute a stimulant laxative if polyethylene glycol 3350 + electrolytes is not tolerated by the child.
- Add another laxative such as lactulose or docusate if stools are hard

Advice on maintenance therapy:
- Continue medication at maintenance dose for several weeks after regular bowel habit is established.
- Children who are toilet training should remain on laxatives until toilet training is well established.
- Do not stop medication abruptly: gradually reduce the dose over a period of months in response to stool consistency and frequency.
- Some children and young people may require laxative therapy for several years. A minority may require ongoing laxative therapy

Where else:

Community Paediatric Health Bowel Clinic:
Child Health Ida Darwin Hospital, Cambridge CB21 5EE

Specialist Services;
Addenbrooke's Hospital, Cambridge, CB2 2QQ

References:

NICE guidelines published May 2010

Web links:

www.nice.org.uk/guidance/CG99
www.**eric**.org.uk

Who are you:

Dr Alison Sansome, Consultant Community Paediatrician, Cambridge
Associate Specialist Paediatric Urology, Addenbrooke's Hospital
Clinical Lead for Continence and Enuresis

Review date: March 2012

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PALLIATIVE CARE

Top Tips in Two minutes: Emergencies in the Last Days of Life

Why:	Anticipating and planning management of possible symptoms / emergencies is essential in maintaining patients at home at the end of life. Frequency of symptoms in the last 48 hours (1) Noisy / moist breathing 56% Urinary dysfunction 53% Restlessness / agitation 42% Pain 51% Dyspnoea 22% Nausea / vomiting 14% Consider also those related to a specific diagnosis e, g fits, risk of haemorrhage.
How:	Use of syringe driver for crises, not just in the last 48 hours The Liverpool Care Pathway for the Dying Patient (2) gives a framework for planning care at this stage and advocates anticipatory prescribing, 'Just in Case Bag/Box'. Although reversible causes for specific symptoms should be considered, most emergencies in the last 48hours are irreversible and the focus is relief of distress.
What next and when:	Treatments to consider for specific symptoms: **Excess bronchial secretions** • Explanation • Repositioning • Medication: Glycopyrronium 200 mcg subcutaneous (s/c) as required 6hrly or 0.6-1.2mg / 24hr via continuous subcutaneous infusion (csci) or Hyoscine butylbromide 20mg s/c as required 6hrly or 40-60mg/24hr via csci) ***Breathlessness*** • General supportive measures including fan • Diamorphine sc bolus or via csci over 24hours (Dose depending on previous opioid use) and/or Midazolam sc bolus or via csci over 24 hours **Pain** • If unable to take regular oral analgesia convert to equivalent dose of sc opioid e,g diamorphine via csci • Have sc diamorphine or alternative available for breakthrough pain. Consider midazolam for anxiety or muscle spasm **Terminal agitation** • Identify and treat any reversible causes e,g drugs, pain, hypoxia, urinary retention • Medication: Midazolam 2.5mg to 5mg up to 2 hourly sc can be given to assess response. Large doses of midazolam may be needed via csci (30 to 160mg/24hr). Levomepromazine 6-12.5 mg stat s/c, up to 4 hourly or 12.5mg to 150mg/24hr via csci may be needed. Titrate individually, seek advice if needed. **Fits** • Increased risk if no longer able to take oral anticonvulsants. Midazolam (30 to 60mg/24hr) via csci should prevent, but may cause sedation. • S/c or buccal midazolam (5 to 10mg) or PR diazepam (10mg) used if fits occur. Can repeat **Haemorrhage** • Consider discussing in advance: Issues of resuscitation / use of sedation • Have dark towels available • Catastrophic bleed causes almost immediate death with no time for treatment – stay with patient. • Severe bleeding lasting minutes to hours is frightening – have sedation available – midazolam IV / buccal 5mg repeated as necessary. At home rectal diazepam 10mg is alternative.
Where else	Arthur Rank Website: http://www.arthurrankhouse.nhs.uk All drugs in the fact sheets have been agreed for use in palliative care by the Cambridgeshire Palliative Care Guidelines Group.
References/ web links:	(1) Lichter I, Hunt G. J Palliat Care 1990; 6(4): 7-15 (2) Liverpool Care Pathway (includes patient information) See also: http://www.mcpcil.org.uk/liverpool-care-pathway/ Gold Standards Framework www.goldstandardsframework.nhs.uk National end of life care programme: http://www.endoflifecareforadults.nhs.uk/
Who are you:	Author: Janet McCabe, Honorary Associate Specialist, Arthur Rank House, Cambridge Reviewer: Anna Spathis, Macmillan Consultant in Palliative Medicine
Review date:	March 2012
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Top Tips in Two Minutes: Palliative Care - Pharmacological Management of Nausea and Vomiting

Why:	Patient factors • Common (20-30% of all patients in last year of life) • Unpleasant consequences (physical, psychological, social) Health care professional factors • Neglected symptom in HCP training (pain higher priority) • Lack of rationale for antiemetic prescription
How:	Key to managing N+V is determination of cause(s) of symptom. • With understanding of pathophysiology of emetic pathways, once cause is known most appropriate antiemetic can be chosen. • For example, the chemoreceptor trigger zone (CTZ) contains D_2 receptors. Haloperidol (a D_2 antagonist) therefore works well for 'chemical' causes of N+V, such as opioids, uraemia etc. Detailed evaluation of symptom helps determine cause. • Clinical picture of N+V from bowel obstruction: little nausea, larger volume vomitus, undigested food or faeculent vomitus. • Clinical picture of 'chemical' N+V: severe nausea, smaller volume vomitus, with little relief of nausea.
What next and when:	Always find and treat reversible causes of N+V. **First line anti-emetics** Metoclopramide (D_2 antagonist, $5HT_4$ agonist) (Gastric stasis, functional bowel obstruction (partial mechanical obstruction without colic, with care only) Cyclizine (H_1 and ACh_M antagonist) (Raised intracranial pressure, Motion-induced N+V) Haloperidol (D_2 antagonist) (Drug-induced N+V,Uraemia, hypercalcaemia) Second line antiemetics Levomepromazine (multiple receptor actions) (Unknown or multiple causes of N+V) Granisetron ($5HT_3$ antagonist) (Post chemotherapy) **Prescribing points** • Prescribe regular and p.r.n antiemetics. • Prescribe parenteral route even for nausea without vomiting, as nausea induces gastric stasis and reduces enteral absorption • Use complimentary combinations (eg cyclizine and haloperidol) • Avoid antagonistic combinations (eg metoclopramide and cyclizine)
Where else:	Community specialist palliative care services eg Arthur Rank House, central referral line: 01223 723130 Hospital specialist palliative care services eg Addenbrookes Hospital, specialist palliative care team: 01223 245151 ext 4404, for patients in hospital or attending outpatients
Web links:	www.palliativedrugs.com
References:	Twycross R, Back R. Nausea and vomiting in advanced cancer. *Eur J Palliat Care* 1998;5(2)39-45 Bentley A, Boyd K. Use of clinical pictures in the management of nausea and vomiting: a prospective audit. *Palliat Med* 2001;15:247-253 Glare P, Pereira G, Kristjanson L, Stockler M, Tattersall M. Systematic review of the efficacy of antiemetics in the treatment of nausea in patients with far-advanced cancer. *Support Care Cancer* 2004;12:432-440
Who are you:	Dr Anna Spathis, Locum Consultant in Palliative Medicine, Addenbrooke's Hospital
Review date:	March 2012
Review due:	March 2014

WOMEN'S HEALTH

Top Tips in Two Minutes: Human Papilloma Virus (HPV) Vaccines

Why:	Cervical cancer kills just under 1000 women every year in the UK. It is the second most common cancer of women worldwide. 5% of all cancers, both men and women, worldwide are due to HPV infection. • Infection with one of 15 high risk HPVs is the main cause. Two types, HPV 16 and HPV 18, cause more than 70% of carcinoma of the cervix. HPV 6 and 11 cause genital warts, the commonest sexually transmitted viral infection in the UK. HPV is associated with vulval, vaginal, anal, penile and oro-pharyngeal cancers. Other cancers may have a relationship with HPV.+ • HPV infection is extremely common in young sexually active women. One UK study showed that it affected 20% of 20-25 yr old women. 93% of women attending one STD clinic had a least one type of HPV antibody. • It has been estimated that 40% of 15 year olds in England have had sexual intercourse. For effective prophylaxis vaccination should occur before the onset of sexual activity.
How:	Two HPV prophylactic vaccines have been developed. These are Cervarix™ a bivalent HPV 16/18 vaccine and Gardasil™ a quadrivalent HPV 16/18/6/11 vaccine 3 doses are needed over a 6 month period. There are vaccines being developed which cover more HPV types. Gardasil will replace Cervarix in the national vaccination programme from September 2012. It is VITAL that women appreciate that they must have cervical smears as part of the cervical cancer screening programme whether they have been immunised or not. This is because the vaccine will protect against the 70+% of cancers caused by HPV16 and 18. UK Joint Committee on Vaccination and Immunisation (JCVI) recommendations • Routine vaccination of girls aged 12-13 years of age (school years 8) started in September 2008. The uptake has been excellent with nearly 95% of 12 year olds receiving all three vaccines in Cambridgeshire PCT. • The catch up programme has now finished. • Consider the value of HPV immunisation for the young person (<27 years) attending clinic as they may benefit from vaccination in your practice.
What next and when:	Take home messages from the randomised controlled trials of HPV vaccines over the last decade: 1) They are effective in preventing HPV infection 2) Protective antibodies are found in >98% of patients 3) Antibody titres are greater than occur in natural infection 4) They are safe with few side effects. >40million doses have been administered worldwide 5) The duration of protection is at least 8 years and there are indications that it is likely to be much longer. Follow up studies are taking place to establish whether a booster dose will be needed The vaccine is effective in the over 25 year olds as well as men. It has been recommended that vaccination should be given through schools
References/ Web links:	www.immunisation.nhs.uk British Association for Sexual Health and HIV (BASHH) www.bashh.org
Who are you:	Dr Clare Henderson, GP, The Spinney Surgery, St Ives, Cambridgeshire Robin Crawford, Consultant Gynaecologist, Addenbrooke's Hospital, Cambridge
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Ovarian cysts/Ovarian Cancer

Why:	Increasing patient awareness ovarian cancer/cysts Cysts often incidental finding on investigation for other symptoms
How:	Family history ?BRCA gene Symptoms-may be none. Pain-acute rather than chronic? Timing-?ovulation Menstrual history/hormone status Medication/Mirena-10% have cysts
What next/when:	Ovarian cancer is RARE Best investigation-Transvaginal ultrasound Ca125 is more specific in screening, also raised in endometriosis, pelvic infection, pneumonia Cysts: <5cm-leave if simple Others ?rescan after 2-3 months, refer if persist Definite referral-2 week wait: Ascites/other masses Bilateral cysts Complex cysts Large cysts >5cm especially if not completely simple
Where else:	If in doubt - letter to gynae-oncology for review of investigations +/- patient Patient info can be found at http://www.patient.co.uk/showdoc/27000680/ + patient support and info at http://www.cancerbackup.org.uk/Cancertype/Ovary
References:	
Web links:	Up to date info on clinical aspects of ovarian cancer can be found at http://info.cancerresearchuk.org/cancerstats/types/ovary/
Who are you:	Mr Robin Crawford, consultant Gynae-oncologist, Addenbrooke's Hospital Dr Christine Gaston, GP, Cornford House, Cambridge
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Diabetes Mellitus in Women of Reproductive Years

Why:	Women with diabetes have higher risk pregnancies compared to the general maternity population. Risks include miscarriage, preeclampsia, premature delivery, caesarean delivery and progression of complications. Infants have • Twice the risk of major congenital malformation • Three times increased risk of dying within the first 4 weeks of life • Five times increased risk of stillbirth • Five times increased risk of being delivered prematurely (prior to 37 weeks) • Five times increased risk of being macrosomic or large for gestational age **These problems are potentially preventable by attending prepregnancy care**
How:	All women with type 1 or type 2 diabetes must be advised to **plan their pregnancies** carefully and in conjunction with their health care teams. **Written information** regarding the risks of pregnancy and how to prevent them must be provided to all women aged 16-45 years. **Contraception compliance** should be documented at every visit. **Potentially teratogenic medications e.g. ACE, statins, glitazones and some oral hypoglycaemic agents** should be used with caution in women aged 16-45 years
What next and when:	Women planning a pregnancy within the next 12 months should be referred for prepregnancy care. This involves • Support to **optimise glycaemic control before conception**. NICE advise a HbA1c <6.1% if safely achievable • **High dose i.e.5mg folic acid supplementation**
Where else:	Your GP, diabetes nurse or diabetes specialist midwife
References:	**1.** CEMACH: Important Information for General Practitioners and the Primary Care Team http://www.cemach.org.uk/ **2.** NICE: guideline 63: Diabetes in Pregnancy: Management of diabetes and its complications from the pre-conception to the postnatal period. (PDF) http://www.nice.org.uk/nicemedia/pdf/CG063Guidance.pdf
Web links:	The following link will take you to patient information leaflets: http://www.diabetes.org.uk/Documents/Shared%20practice/EASIPOD%20%20leaflet%20GENERICfinal%20200708.pdf
Who are you:	Dr Helen Murphy, Honorary Consultant Physician, Addenbrooke's Hospital, Cambridge
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Vulval Disease 2

Why:	Irritation or soreness are the commonest complaints indicating vulval disease, but: - it *may not* be thrush - it *may not* be allergy Presentation is often delayed due to self-treatment or embarrassment. Itch or soreness are most commonly features of vulvovaginal candidiasis or dermatitis, but can be the presenting symptoms of • Lichen sclerosus, lichen planus, vulval cancer, vulval intraepithelial neoplasia • Rare disorders such as pemphigus, Hailey-Hailey disease, Darier's disease
How:	Clues in the history: What is the primary symptom? soreness may follow scratching itch may follow inflammation Is the skin discoloured? Does the skin bleed? Is sleep disturbed? Is intercourse difficult? *Examination with good lighting is vital* Clues in the examination: Is there colour change? whitish – lichen sclerosus; purplish – lichen planus; yellowish – seborrhoeic dermatitis; beefy red – Strep. Are the apices of the flexures involved? e.g. Candida, seborrhoeic dermatitis, Or spared? e.g. contact dermatitis Are there erosions? e.g. pemphigus, Hailey-Hailey disease, lichen sclerosus Is there lichenification? e.g. lichen simplex, atopic dermatitis Is there warty change? e.g. Darier's disease, VIN
What next and when:	Investigations: Low threshold for vaginal and vulval swab If uncertain signs – vulval biopsy Referral for: • Uncertain diagnosis • Poor response to treatment • Patient dissatisfaction • Anatomical change • Consideration of malignancy (to Gynaecological Oncology) Remember: It *could be* thrush or allergy as well as another diagnosis Lichen sclerosus 1. Establish diagnosis; emollient to improve barrier 2. Initial treatment to control symptoms e.g potent /very potent topical steroid 3. Maintenance therapy & treatment for flares e.g. reduce frequency/potency steroid 4. Monitoring for malignancy
Where else:	Patient support groups: Vulval Health Awareness Campaign – www.vhac.org Vulval Pain Society: www.vulvalpainsociety.org Lichen sclerosus: www.lichensclerosus.org
References:	Skin disorders affecting the vulva. *Obst Gynae Reprod Med* 2011; **21**(6): 169-75 Guidelines for the management of lichen sclerosus. *Br J Dermatol* 2010;**163**:672-82.
Web links:	Patient information leaflets: www.bad.org.uk; www.patient.co.uk www.addenbrookes.nhs.uk (vulval biopsy; lichen sclerosus post-diagnosis)
Who are you:	Jane Sterling, Senior Lecturer and Honorary Consultant Dermatologist, Addenbrooke's Hospital
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Emergency Contraception (EC)

<table>
<tr><td>Why:</td><td>1 in 4: conceptions are terminated
1 in 3: women have a TOP/are repeat TOP/pregnancies are unplanned
1 in 2: pregnancies in teenagers and women>40 are terminated

3 methods available for EC: Levonelle/ellaOne/Cu IUD

Levonelle affects ovulation (not after LH surge)
ellaOne affects ovulation (including LH surge)
IUD affects fertilisation and implantation

Levonelle licenced up to 72hrs post UPSI
ellaOne licenced up to 120hrs post UPSI
IUD licenced up to 5/7 after UPSI or up to 5/7 after ovulation</td></tr>
<tr><td>How:</td><td>Assess level of risk of UPSI:
Establish shortest cycle length in last 6/12
Subtract 14 days to give estimated day of ovulation
High risk = day of ovulation plus 3 days either side
Low risk (2 phases) = last 7 days, and day 1 to ovulation minus 8
Moderate risk = remaining days

<table><tr><td>1-5</td><td>5-10</td><td>11-17</td><td>18-21</td><td>22-28</td></tr><tr><td>LOW</td><td>MODERATE</td><td>HIGH</td><td>MODERATE</td><td>LOW</td></tr></table>
For all level of risk offer IUD
For HIGH risk encourage IUD
If IUD declined offer ellaOne for HIGH risk or Moderate risk if UPSI 72-120hrs</td></tr>
<tr><td>What next and when:</td><td>•Levonelle has a limited window of efficacy
•You will rarely do any harm in providing Levonelle except by failing to consider/mention a Cu IUD especially when the risk of conception is high
•There should be clear pathways for referring women to other providers of EC eg FP/ other GP
•If there is a risk of pregnancy there is also a risk of STIs
•Provision to under 16s is legal but be mindful of safeguarding children issues
•Significant barriers to accessing EC exist within clients, services and healthcare professionals especially for young women</td></tr>
<tr><td>Where else:</td><td>Dr Caroline Cooper and Dr Lynne Gilbert provide this service at The Cambridge Contraception & Sexual Health Service, The Laurels, 20 Newmarket Road, Cambridge, telephone: 08456 505152</td></tr>
<tr><td>References:</td><td>Is it worth paying more for emergency hormonal contraception? Thomas, Schmid, Cameron. J Fam Plann Reprod Health Care 2010; 36(4): 197-201
Glasier et al. Lancet 2010; 375: 555-62</td></tr>
<tr><td>Web links:</td><td>www.fsrh.org
http://my.ibpinitiative.org/ICEC/ECAccess</td></tr>
<tr><td>Who are you:</td><td>Dr Pauline Brimblecombe FRCGP FFSRH MSc(Comm Gynae)</td></tr>
<tr><td>Review date:</td><td>March 2012</td></tr>
<tr><td>Review due:</td><td>March 2014</td></tr>
</table>

MISC

Top Tips in Two Minutes: Managing Sickness Absence

Why:	• Sickness absence costs money. • The duration of sickness absence can often be reduced by simple measures. • Active management of sickness absence is a great opportunity for building relationships in the workplace.
Two sorts:	• Recurrent short term sickness absence • Long term sickness absence
How:	• Need an agreed policy. **Short term sickness absence** • Talk through the issues. Is there a pattern? • Involve occupational health if attendance falls below acceptable levels. • Consider whether there might be an underlying reason for the absences. • If there is an underlying reason, ask occupational health whether the disability provisions of the Equality Act (EA) may apply and if so what adaptations might be appropriate. • If EA does apply it is for the manager to decide what adaptations are reasonable to accept. • Manage the case. **Long term sickness absence** • Get in contact, stay in contact and see it through. If necessary visit at home. • Provide non-judgemental and supportive encouragement. • Avoid coercion and guilt trips. • Encourage people to maintain contact with work and drop in to work during sickness absence for short periods in order to see colleagues– not to work. • Resolve any disciplinary issues early to enable the employee to move on through the process. If needed ask for an occupational health assessment Q. Is the employee fit for disciplinary action? • Consider disability provisions of the Equality Act and reasonable adaptations that will enable the employee to return back to work. • Warn of reduction in pay well ahead of time so that employee can make adjustments. • Plan return to work modifications and rehabilitation programme well ahead. • Undertake a back to work interview. **Referral to Occupational Health** • Arrange for an occupational health assessment earlier rather than later. • Ask good “smart” questions that will enable you to manage the absence. • Discuss OH referral openly with the employee and give them a copy of letter.
References:	• Managing sickness absence and return to work. HSE Books • Healthy workplaces handbook, NHS Employers • Managing Sickness Absence - A toolkit for changing work culture and improving business performance. EEF
Web links:	• Health and Safety Executive Books www.hsebooks.com • NHS Employers www.nhsemployers.org • EEF - ‘We transform our members’ ability to work, innovate and respond to climate change www.eef.org.uk
Who are you:	Dr Martin Cosgrove, Consultant Occupational Physician Cherry Hinton Medical Centre, 34 Fishers Lane, Cambridge, CB1 9HR
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Rolling with Revalidation

<table>
<tr><td>Why:</td><td>Revalidation - by GMC will allow you to continue to practice as a doctor. (Licences were sent out in autumn 2009).
GPs appear on the General Practice Register
GMC guidance – what we must do. RCGP guidance – what we should do. There is still uncertainty, - mostly to do with process
Set up an account with GMC Online. You will need one before revalidation begins.
Not in active clinical practice at the time of revalidation: - you will appear on GP register - license will state – ‘not in clinical practice’.
Current guidance:
Introduction of Revalidation- expected late 2012.
Min. evidence expected likely to increase over first 5 years.
Unclear - how many previous years ‘stuff’ should we keep for first revalidation cycle
Plan - 80-90% of doctors through process in first 3 years.
RCGP guidance: Min. number of work sessions to maintain GP skills: 200 ½ days / 5 years –(100 in 2 years prior to revalidation)
Standard Portfolio: (majority of GPs including retainers salaried docs long term locums).
Min. portfolio - 3 out of 5 years (you will need to have exceptional reasons if you haven’t had appraisal every year)
Non Standard Portfolio: (Peripatetic locums, GPs in very small / remote practices, GPs in secure environments, OOH docs, working overseas, main / only work non clinical). Just as rigorous, but GP can use alternative methods to provide information – be prepared to justify it - it must demonstrate same attributes. Sessional GPs will not have to specify every provider for whom they have worked
Supporting information: 4 areas http://www.gmc-uk.org/doctors/revalidation/faq_revalidation_p3.asp
Your appraiser will be interested in what you did with supporting information - not simply that you collected it and maintained it in a portfolio - what do you think the supporting information says about your practice / how you intend to develop / modify your practice as a result of that reflection. E.g. how you respond to a significant event & change to your work as a result, rather than number that occurred.
Revalidation outcomes: GMC categories
○ Positive affirmation – most of us
○ Deferral request - e.g. prolonged absence – need more time to collect/ collate info
○ Non- engagement – risk of removal from list – administrative removal
○ Fitness to practice concerns</td></tr>
<tr><td>How:</td><td>
<table>
<tr><th>Generic heading</th><th>Supporting information</th></tr>
<tr><td>General information
What you do in all aspects of your work – your whole practice description should be updated annually.</td><td>Personal details & description of practice including extended roles – clinical and non clinical
Contextual details
Participation in annual appraisal, PDP & review of PDP
Statement of probity & health: no issues +in position to receive independent impartial healthcare advice, + has appropriate insurance / indemnity cover</td></tr>
<tr><td>Review of your practice
Evaluating the quality of your professional work
Extended clinical roles*</td><td>Demonstrate participation in activities that review & evaluate quality of your work
Significant Event Audits including any serious incidents
Clinical Audit: Topics and examples for audit will be placed on RCGP web site. You do need to demonstrate change!
Quality improvement activity
Extended practice e.g. GPwSI, teaching, training, research, occupational medicals, medico-legal reports cosmetic procedures etc - *how did you qualify for role, how do you keep up to date in this, how can you demonstrate you are fit to practice in this role. Other roles – statement from organisation / last appraisal</td></tr>
<tr><td>Keeping up to date
Maintaining and enhancing the quality of your professional work</td><td>CPD (continuing professional development)- Learning Credits (50 per year)
Relevant to your individual professional work and cover it all, and personal development plan,
Demonstrate reflection and confirmation of good practice or new learning/practice change where appropriate.</td></tr>
<tr><td>Feedback on practice: How others perceive the quality of your professional work</td><td>Colleague survey Review of complaints
Patient survey Compliments</td></tr>
</table>
</td></tr>
<tr><td>What next - when:</td><td>Keep checking, the detail of what will be expected is likely to change.
http://www.rcgp.org.uk/revalidation/revalidation_guide.aspx links to documents, FAQs, videos, portfolio, revalidation guide V6 Sept 2011 etc http://www.rcgp.org.uk/revalidation/revalidation_guide.aspx
http://www.gmc-uk.org/doctors/revalidation.asp facts and timelines. Resources – e.g. MSF and PSQ
The PCT requires a form 4 and PDP as evidence of appraisal discussion.
Practices, organisations must support and facilitate all docs including sessional docs for purpose of appraisal</td></tr>
<tr><td>Where else:</td><td>What about a revalidation concern – it should have been highlighted and addressed before the RO revalidation reviews – i.e. through appraisal and other routes.
MSF / patient feedback: -tools include GMC, Sheffield peer review tool version 2 (GP-SPRAT) colleague feedback evaluation tool (CFET) improving practice questionnaire (IPQ), Edgecumbe 360 version 2 and doctors interpersonal skills questionnaire (DISQ).
Check what the GMC regard as ‘fit’ for revalidation. Wait till we are sure.</td></tr>
<tr><td>Web links:</td><td>GP tutors: http://www.addenbrookes-pgmc.org.uk/
PCT: http://gp.cambridgeshire.nhs.uk/GP-Resources/Healthcare-Governance/gp-revalidation-and-appraisal.htm
RST: http://www.revalidationsupport.nhs.uk/
LMC: http://www.cambslmc.org/CambsLMC/Welcome.html
RCGP revalidation e- portfolio – appraisal toolkit: http://www.rcgp.org.uk/revalidation.aspx
Appraisal toolkits https://gpeportfolio.rcgp.org.uk/Login.aspx?ReturnUrl=%2fPages%2fAppraiser%2fHome.aspx and http://www.clarity.co.uk/products/appraisal/
Forms and : http://learning.bmj.com/learning/info/revalidation_GPs.html
Structured Reflective Templates: http://llrappraisal.co.uk/index.php?p=45
National Association of Sessional GPs (NASGP): http://www.nasgp.org.uk/</td></tr>
<tr><td>Who</td><td>Ruth Bastable: Appraiser, Sarah Rann: Appraiser, Appraisal Lead Cambridgeshire PCT</td></tr>
<tr><td>Review date:</td><td>March 2012</td></tr>
<tr><td>Review due:</td><td>March 2014</td></tr>
</table>

Top Tips in Two Minutes: Disability Provisions of the Equality Act

Purpose	The purpose of the disability provisions of the Equality Act is to ensure that a disabled person is not disadvantaged when compared to a non-disabled person.	
Discrimination Types:	Direct, Failure to make reasonable adjustments, Disability related discrimination, Victimisation, Harassment	
Definitions – **1. Disability**	Has a physical or mental impairment which has a substantial and long term adverse effect on their ability to carry out day to day activities.	
2. Long term	Has lasted or is likely to last 12 m or the rest of the person's life.	
3. Substantial	Effect is one that is not minor or trivial	
4. Impairment **and** **Normal Day to day Activities**	**Impairment** Mobility, manual dexterity, physical coordination, continence, ability to lift, carry or move everyday objects, speech, hearing or eyesight, memory and ability to concentrate, learn or understand, perception of physical danger.	**Examples of normal day to day activities:** Walk 1 mile at normal pace, go up and down stairs, use public transport, travel in car for 2hours, shop, prepare / cook a meal, use a knife and fork, open doors, difficulty with keyboards at normal speed, carry a moderately loaded tray steadily, pour fluids, infrequent unpredictable faecal incontinence, adapting to minor changes in routine, remembering simple recipe, short list of tasks, normal social interaction etc etc
Specifically excluded:	Addiction to alcohol or other substance unless it was originally the result of medically prescribed drugs or medical treatment, tendency to set fire, steal, physical or sexual abuse of other people, exhibitionism, voyeurism, tattoo, piercing, seasonal allergic rhinitis	
Specifically included:	Cancer, MS, AIDS/HIV from point of diagnosis Severe disfigurements, certified/registered blind or partially sighted	
Also include:	Indirect effects e.g. of medication taken to control the condition Carers of people with disabilities	
Reasonable adjustments:	Act requires employers to make reasonable adjustments to allow the person to remain in the workplace. It is for Occupational Health to suggest which adaptations can be considered. It is for the employer to say whether or not something is reasonable.	
Examples:	Make adjustments to premises; acquire or modify equipment; allocate some of the duties to another person; transfer to fill an existing vacancy; alter working hours; allow absence for rehabilitation, assessment or treatment;	provide or arrange training or mentoring; modify instructions, reference manuals, procedures for testing or assessment; provide a reader or interpreter, supervision or other support. assign to a different place of work;
Is it reasonable? **Depends on:**	The extent to which taking the step would prevent the effect in question, The extent to which it is practicable for the employer to take the step, The financial situation, activities, size of, and costs to the employer, The extent that it would disrupt others activities, The availability of other resources to the employer	
Sources of help:	Access to work, Papworth Trust, Ability Net. Disability Employment Advisor (Job Centre Plus)	
References:	Occupational Health Law, Diana Kloss	
Who are you?	Dr Martin Cosgrove, Consultant Occupational Physician Cherry Hinton Medical Centre, 34 Fishers Lane, Cambridge, CB1 9HR	
Review date:	March 2012	
Review due:	March 2014	

Top Tips in Two Minutes: Clinical Supervision for Primary Care Nurses

Why:	It is an essential component in **safeguarding and ensuring quality practice** and should be available for all staff involved in delivering care, treatment and support to patients/clients**.** Clinical Supervision: • Provides an opportunity for practitioners to reflect and learn through experience • Enables practitioners to develop and sustain effective practice within a supportive open and honest relationship. • Is a requirement as part of Care Quality Commission CQC that requires compliance with essential standards of quality and safety in order to provide services Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 gives a clear requirement to have suitable arrangements in place in order to ensure that staff receive "appropriate training, professional development, supervision and appraisal" • Is in line with relevant national guidance from professional regulators and/or professional bodies and is monitored and reviewed. • Enables practitioners to talk through any issues about their role • Provides a support structure and an opportunity to network • Can be used as a tool to promote a person's awareness of the strengths and weaknesses in their practice. It should be used to review practice and make changes when problems are encountered thus preventing professional isolation. • Maintains and continually improves the quality of care delivered
How:	**Sessions should be in working hours**: 1. Identify and book suitable venues and dates, agree frequency and length of meetings 2. **Clarify supervisor's role** (coordinate sessions; establish and maintain ground rules – "safe environment" facilitate process/summary, action planning, documentation). 3. Use a framework within supervision sessions – to ensure meaningful process / safe participation. 4. Ensure GPs are aware of the benefits and need for clinical supervision and its potential for improving practice 5. Agree an action plan with identified participants and keep brief dated and signed records for audit with **due regard for confidentiality**. Exceptional circumstances of professional concern may present in relation to patient safety. These should be managed in accordance with professional guidance. **Areas to cover:** • Clinical issues/role reflection • Support/professional • Educational issues/workload • Management issues **Get the most out of supervision:** Participants - Commit to the process and attend. • Develop a relationship with the clinical supervisor based on mutual respect • Use the supervision to problem-solve and improve clinical practice. • Keep personal records of the session • Be prepared for the session, having identified issues to discuss. • Develop the ability to share issues freely • Be open to and develop skill in feedback and use it to improve future practice. • Inform manager of planned supervision sessions
What next and when:	**Who are your neighbours in Primary Care – why not start the conversation now – plan and arrange group meetings - find out who is willing and able to supervise i.e. any clinically competent and knowledgeable professional who can**: - Be aware of organisational constraints upon the supervisee. - Develop a supportive, professional relationship - Link theory to practice - Offer reassurance, role modelling and provide clear and constructive feedback - Ensure privacy is available for the session. - Help the supervisee explore and clarify feelings and beliefs in order to become a more reflective practitioner. - Share information, experiences and skills appropriately. - Challenge practice and agree actions with the supervisee.
Web links/ resources:	Nurse Tutor PGMC: Vinny Barker Vinny.barker@nhs.net NHS Cambridgeshire Professional Performance Manager: Dinah Ellis Dinah.ellis@nhs.net Supervision Training: CQC http://www.cqc.org.uk/guidanceforprofessionals/primarymedicalservices.cfm
Review date:	March 2012
Review due:	March 2014

Top Tips in Two minutes: CQC

<table>
<tr><td>Why:</td><td colspan="3">The Care Quality Commission (CQC) is the independent regulatory body for healthcare, adult social care and the operation of the Mental Health Act 1983 in England. CQC was established by the Health and Social Care Act 2008.
A provider must show that it is meets the essential standards of quality and safety in all of its regulated activities.
Treatment of disease, disorder of injury' will apply to all practices. Others that may apply are 'Surgical procedures', 'Diagnostic and screening procedures' and 'Family planning services'. Each regulation has an associated Outcome stating expectation for service users and how providers can achieve the outcome</td></tr>
<tr><td>How:</td><td colspan="3">The CQC registration (online) of most primary medical services providers has been delayed, and most providers will now have to register by April 2013. However, NHS GP out of hours providers, other than those that directly provide out of hours services solely to their own registered patients, still have to register by April 2012
Providers do not have to be compliant with all regulations when applying for registration, but will need to submit action plans showing when they will be compliant
Some evidence used for Standards for Better Health can be used:
Begin to develop systems which show how you :
– Deliver positive outcomes for people who use services.
– Capture information about how users experience the services in the 6 key areas</td></tr>
<tr><td rowspan="4">What next and when:</td><td colspan="3">Check out:
16 outcomes relating to quality and safety
12 outcomes relating to set-up requirements, notifications and finance.</td></tr>
<tr><td>Involvement and information
Outcome 1: Respecting and involving people who use services
Outcome 2: Consent to care and treatment
Outcome 3: Fees</td><td>Personalised care, treatment and support
Outcome 4: Care and welfare of people who use services
Outcome 5: Meeting nutritional needs
Outcome 6: Cooperating with other providers</td><td>Safeguarding and safety
Outcome 7: Safeguarding people who use services from abuse
Outcome 8: Cleanliness and infection control
Outcome 9: Management of medicines
Outcome 10: Safety and suitability of premises
Outcome 11: Safety, availability and suitability of equipment</td></tr>
<tr><td>Suitability of staffing
Outcome 12: Requirements relating to workers
Outcome 13: Staffing
Outcome 14: Supporting workers</td><td>Quality and management
Outcome 15: Statement of purpose
Outcome 16: Assessing and monitoring the quality of service provision
Outcome 17: Complaints
Outcome 18: Notification of death of a person who uses services
Outcome 19: Notification of death or unauthorised absence of a person who is detained or liable to be detained under the Mental Health Act 1983
Outcome 20: Notification of other incidents
Outcome 21: Records</td><td>Suitability of management
Outcome 22: Requirements where the service provider is an individual or partnership
Outcome 23: Requirement where the service provider is a body other than a partnership
Outcome 24: Requirements relating to registered managers
Outcome 25: Registered person: training
Outcome 26: Financial position
Outcome 27: Notifications – notice of absence
Outcome 28: Notifications – notice of changes</td></tr>
<tr><td colspan="3">Outcomes in italics are not included in CQC performance reviews
Review the quality and safety standards and consider how you currently achieve / perform / demonstrate this. these
Talk to your cluster –share what you do, start nurse supervision
Talk to your team – address key area e.g. safeguarding</td></tr>
<tr><td>Where else:</td><td colspan="3">GPC toolkit: to help reduce the burden of the application process - straightforward, plain English explanation of CQC registration, information on applying for registration and suggestions on what you could be doing to meet the CQC's Essential Standards of Quality and Safety. This toolkit also highlights the current situation regarding demonstrating compliance.
Download the CQC toolkit

http://www.bma.org.uk/employmentandcontracts/independent_contractors/cqcregistrationtoolkit.jsp#.Tyfc6k9Q3Uk

CQC guidance gives prompts to help providers self-assess, including specific prompts for different service types
NHSC have produced a framework to support practices.
It brings together:
• what people using the service can expect, and what providers should do
• the Judgment Framework questions
• the related indicators from the GP Standards for Better Health framework completed in early 2010
• the evidence already reviewed by practices for this SfBH framework that will also show compliance with the CQC outcome
• additional evidence that might be needed for the CQC outcome
Get the latest information and guidance: www.cqc.org.uk/primarymedicalservices.
Compliance Guidance: interactive online version at www.cqcguidanceaboutcompliance.org.uk
wendy.lefort @nhs.net – lead for NHSC – for NHSC framework</td></tr>
<tr><td>References:</td><td colspan="3">http://www.cqc.org.uk/</td></tr>
<tr><td>Web links:</td><td colspan="3">http://www.cqc.org.uk/guidanceforprofessionals/introductiontoregistration.cfm</td></tr>
<tr><td>Who are you:</td><td colspan="3">Sarah Rann NHSC+P appraisal lead, Ruth Bastable Appraiser</td></tr>
<tr><td>Review date:</td><td colspan="3">March 2012</td></tr>
<tr><td>Review due:</td><td colspan="3">March 2014</td></tr>
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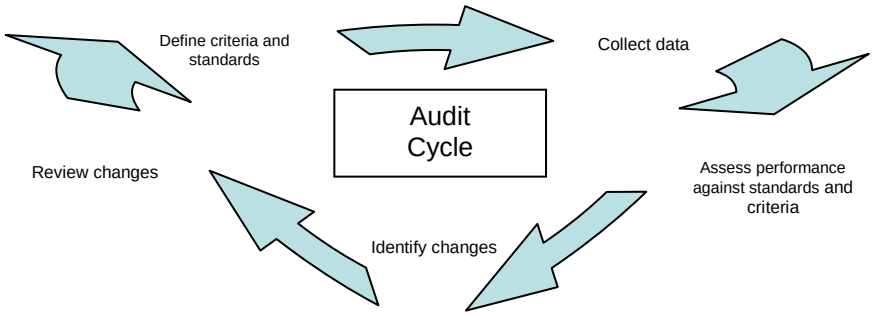
Top Tips in Two Minutes: Audit and Revalidation

Top Tip n° 122



Audit is a quality improvement process that seeks to improve patient care and outcomes thro systematic review of care against explicit standards and the implementation of change (NICE 2002)

Why:	Revalidation is likely to require 1 complete clinical audit cycles in every 5 years – or evidence of a Quality improvement activity. – Not just surveys of current care! Audit should promote learning through shared ideas.
How:	Essential info to put in: 1. title of audit 2. reason for the choice 3. dates of the first data collection and the re-audit 4. The criteria to be audited and the standards set with their justification (ref to guidelines etc) 5. Standards set (what *standard* of care is being set usually expressed as a %) and their justification (reference to guidelines etc.) 6. results of first data collection in comparison with the standards set 7. summary of the discussion and changes agreed, including any changes to agreed standards 8. changes implemented by the GP 9. results of the second data collection in comparison with the standards set (set dates) 10. quality improvement achieved 11. reflections on the Clinical Audit in terms of: • knowledge, skills and performance • safety and quality • communication, partnership and teamwork • maintaining trust GPs working as team may undertake a common audit. If put in Revalidation Portfolio, GP must have contributed properly to choice of topic and standards set, identified own care, or care for which he or she is personally responsible, within first audit and re-audit. GP must state what changes have been instituted and be able to demonstrate effects of those changes. QIP (Quality improvement project) may take place of 2nd Audit Sessional doctors who do not work regularly within practices – NHSC will support you. Contact Wendy Lefort for information. If you are not in this group but would like to participate – not a problem – contact Wendy for more details.Wendy.lefort@nhs.net.
What next and when:	Appraiser's role: agree that audits meet key attributes + required number of audits have been done for revalidation progress. Are topics appropriate choices - given the GP's clinical roles? Does audit reflect the care undertaken by the individual practitioner? Are standards of care set for GP's patients based on recognised evidence and appropriate, or reflecting local or national priorities? Has the GP reflected on the findings of the first data collection and reached appropriate conclusions? Has the GP decided on appropriate changes after the first data collection? Has the GP acted to improve care for his or her patients? Exceptional circumstances: - no second data collection may be acceptable if standards are appropriate and challenging, and initial audit demonstrates exemplary care.
Where else:	http://www.rcgp.org.uk/revalidation/revalidation_guide.aspx links to documents, FAQs, videos, portfolio, revalidation guide http://gp.cambridgeshire.nhs.uk/Default.aspx.ShortcutID-300484.AccessLetter-G.htm - local guidance re appraisal etc
Other stuff:	If you are unsure about what you need to do or how etc ask for help! Try your GP tutor or appraisal team. And don't forget to claim credits for learning activities (inappropriate to claim credits for *process* of data collection, but can claim for process of improvement or maintenance of quality).
Who are you:	Sarah Rann Appraiser, Appraisal lead; Ruth Bastable, Appraiser
Review date:	March 2012
Review due:	March 2014

Top Tips in Two Minutes: Significant Event Audits

Significant event: Any event thought by anyone in the team to be significant in the care of patients or the conduct of the practice

<table>
<tr><td>Why:</td><td colspan="2">Learning: The ultimate aim of Significant Event Audits (SEA) is to learn to reduce the chance of similar events occurring in future.
SEA are key element of good clinical governance and relevant to:
Quality and Outcome Framework (2004): GPs have to undertake a minimum of 12 significant event reviews in the preceding three years
Revalidation: GP's revalidation portfolio is likely to have to include analysis of at least 5 significant events through the revalidation period.
CQC registration. CQC will demand that providers of healthcare have a strong system of clinical governance in place. This includes SEA</td></tr>
<tr><td>How:</td><td>'Stage 1 – Awareness and prioritisation of a significant event
Staff should be confident in their ability to identify and prioritise a significant event when it happens. The practice should be fully committed to the routine and regular audit of significant events.
Stage 2 – Information gathering
Collect and collate as much factual information on the event as possible from personal testimonies, written records and other healthcare documentation. For more complex events, an in-depth analysis, such as root cause analysis, will be required to fully understand causal factors.
Stage 3 – The facilitated team-based meeting
The team should appoint a facilitator who will structure the meeting, maintain basic ground rules and help with the analysis of each event. The team should meet regularly to discuss, investigate and analyse events. These meetings are often the key function in co-ordinating the SEA process and they should be held in a fair, open, honest and on threatening atmosphere. Agree any ground rules before the meeting starts to reinforce the educational spirit of the SEA and ensure opinions are respected and individuals are not 'blamed'. Minutes of the meeting should be taken and action points noted. These should be sent to all staff, including those unable to attend the meeting.
An effective SEA should involve detailed discussion of each event, demonstration of insightful analysis, the identification of learning needs and agreement on any action to be taken.
Stage 4 – Analysis of the significant event
The analysis of a significant event can be guided by answering
four questions:
1. What happened?
2. Why did it happen?
3. What has been learned?
4. What has been changed or actioned?</td><td>The possible outcomes may include:
• no action required;
• a celebration of excellent care;
• identification of a learning need;
• a conventional audit is required;
• immediate action is required;
• a further investigation is needed;
• sharing the learning.
Stage 5 – Agree, implement and monitor change
Any agreed action should be implemented by staff designated to co-ordinate and monitor change in the same way the practice would act on the results of 'traditional' audits.
Progress with the implementation of necessary change should always be monitored by placing it on the agenda for future team or significant event meetings. Where appropriate, the effective implementation and review of change is vital to the SEA process. To test how well the SEA process has gone, practices should ask themselves 'What is the chance of this event happening again?'
Stage 6 – Write it up
It is important to keep a comprehensive, anonymised, written record of every SEA, as external bodies will require evidence that the SEA was undertaken to a satisfactory standard. The SEA report is a written record of how effectively the significant event was analysed.
Stage 7 – Report, share and review
Reporting when things go wrong is essential in general practice. The practice should formally report (either to the National Reporting and Learning Service or via the primary care trust/healthcare organisation) those events where patient safety has, or could have been, compromised. Where a mechanism exists, practices should share knowledge of important significant events with local clinical governance leaders so that others may learn from these.</td></tr>
<tr><td>What else – when to liaise with the PCT:</td><td colspan="2">'Serious incidents' should be reported to the Health Care Governance team at NHS Cambridgeshire for logging and help with investigations e.g.
• Unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
• Serious harm to one or more patients, staff, visitors or members of public or where the outcome either requires life-saving intervention, major surgical/medical intervention, or results in permanent harm shortened life expectancy or prolonged pain or psychological harm
• A scenario that prevents or threatens to prevent practice ability to continue to deliver healthcare services, e.g. actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or IT failure;
• Allegations of abuse;
• Adverse media coverage or public concern about the organisation or the wider NHS.

NHS Cambridgeshire invites practices to share their learning with the Health Care Governance team so that this can be shared with other practices. Current ways of sharing learning are the website, the governance newsletter and the prescribing newsletter.</td></tr>
<tr><td>Web links:</td><td colspan="2">National Patient Safety Agency guidance on how to conduct a Significant Event Analysis 2008:
http://www.nrls.npsa.nhs.uk/resources/?entryid45=61500
NPSA support for developing safety culture in practice 2009 – Seven steps:
http://www.nrls.npsa.nhs.uk/resources/collections/seven-stepsto-patient-safety/?entryid45=61598
RCGP 1995 Occasional paper 70 – Significant Event Auditing
http://www.ncbi.nlm.nih.gov/pmc/issues/172785/
National Patient Safety Agency 2010: National framework for serious incidents in the NHS:
http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/serious-incident-reporting-and-learning-framework-sirl/
NHS Institute – Safer Care:
http://www.institute.nhs.uk/safer_care/safer_care/safer_care_-_home_page_2.html</td></tr>
<tr><td>Who are you:</td><td colspan="2">Peter Scholten, GP, York Street Medical Practice, Cambridge; Associate Medical Director NHS Cambridgeshire, peter.scholten@nhs.net</td></tr>
<tr><td>Review date:</td><td colspan="2">March 2012</td></tr>
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Addenbrooke's Hospital NHS
Cambridge University Hospitals NHS Foundation Trust

Further copies of this booklet can be purchased from:

Mrs Julie Graham
Deputy Manager (Primary Care)

Postgraduate Medical Centre
Clinical School, Box 111
Addenbrooke's Hospital
Hills Road
Cambridge CB2 0SP

Tele: 01223 - 274419 (x.4419)
Fax: 01223 - 217237
Email: jlg37@medschl.cam.ac.uk

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