Nursing
IN GENERAL PRACTICE
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Issue 6 Volume 6 November/December 2013

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Up to 80% of sexually active women become infected with an HPV type in their lifetime

Why gamble?

Most women under 45 years of age can gain some protection from Gardasil® against HPV types 6, 11, 16 & 18 regardless of past or current infection

to any component of the vaccine. Warnings and precautions: As with any vaccine, adequate medical treatment, including epinephrine (adrenaline), and supervision should always be available in case of an acute anaphylactic reaction. It is not known whether the vaccine can cause foetal harm or affect reproduction capacity when administered to a pregnant woman; the vaccine can be given to pregnant women only if clearly needed (potential benefit outweighs potential risk). It is not known whether this vaccine is excreted in human milk; caution should be exercised when the vaccine is administered to a nursing mother. Vaccination should be delayed in the presence of significant febrile illness or other active infection, except where delay involves greater risk. The vaccine should never be injected intravascularly. The vaccine should not be injected intradermally as injection by that route is associated with increased local reactions. If the vaccine is administered to patients who are immunosuppressed due to either an underlying condition or medical treatment (e.g. immunosuppressive therapy), the expected serum antibody response may not be obtained after a first or second dose, so such patients may not be as well protected against pneumococcal disease as immunocompetent individuals. Required prophylactic pneumococcal antibiotic therapy should not be stopped after vaccination. The vaccine may not be effective in preventing infection resulting from basilar skull fracture or from external communication with cerebrospinal fluid. As with any vaccine, vaccination with Pneumovax II may not result in complete protection in all recipients. Pneumovax II and Zostavax should not be given concurrently because concomitant use in a clinical trial resulted in reduced immunogenicity of Zostavax. Undesirable effects: Very common side effects: Fever and injection site reactions such as pain, soreness, erythema, warmth, swelling and induration. Other reported side effects that may potentially be serious include thrombocytopenia in patients with stabilised idiopathic thrombocytopenic purpura, haemolytic anaemia in patients who have had other haematologic disorders, leukocytosis, anaphylactoid reactions, serum sickness, angio-neurotic oedema, Guillain-Barré Syndrome, radiculoneuropathy, febrile convulsions and injection site cellulitis. For a complete list of undesirable effects please refer to the Summary of Product Characteristics. Package quantities and basic NHS cost: Single pack containing one 0.5 millilitre single dose vial, basic NHS cost £8.32 (single). Marketing authorisation holder: Sanofi Pasteur MSD Limited, Mallards Reach, Bridge Avenue, Maidenhead, Berkshire SL6 1QP. Marketing authorisation number: PL 06745/0103 Legal category: POM Date of last review: August 2013

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Pneumococcal Disease

Vaccinate your at-risk patients and those 65 years and over against serious pneumococcal disease.

**PNEUMOVAX® II solution for injection in a vial** Pneumococcal Polysaccharide Vaccine Refer to Summary of Product Characteristics for full product information. Presentation: Pneumovax II is supplied as a single dose vial containing 0.5 millilitre of solution. Each dose contains 25 micrograms of each polysaccharide type derived from capsules of the 23 most prevalent pneumococci, dissolved in isotonic saline solution containing 0.25% phenol. Indications: For active immunisation against disease caused by the pneumococcal serotypes included in the vaccine. The vaccine is recommended for individuals 2 years of age or older in whom there is an increased risk of morbidity and mortality from pneumococcal disease. The specific risk categories of persons to be immunised are to be determined on the basis of official recommendations. The vaccine is not effective for the prevention of acute otitis media, sinusitis and other common upper respiratory tract infections. Doseage and administration: One single dose of 0.5 millilitre is administered by intramuscular or subcutaneous injection. Special dosing: It is recommended that pneumococcal vaccine is given at least two weeks before elective splenectomy or the initiation of chemotherapy or other immunosuppressive treatment. Vaccination during chemotherapy or radiation therapy should be avoided, and the vaccine should not be administered any sooner than three months after completion of such therapy. Persons with asymptomatic or symptomatic HIV infection should be vaccinated as soon as possible after diagnosis is confirmed. Revaccination: Healthy adults and children should not be revaccinated routinely. Revaccination at intervals of less than three years is not recommended because of an increased risk of adverse reactions. Revaccination may be considered for adults at increased risk of serious pneumococcal infection who were given pneumococcal vaccine more than five years earlier or for those known to have rapid decline in pneumococcal antibody levels. Revaccination after 3 years may be considered for selected populations (e.g. asplenics) who are known to be at high risk of fatal pneumococcal infections and for children 10 years old or younger at high risk of pneumococcal infection (Contraindications: Hypersensitivity to any component of the vaccine. Warnings and precautions: As with any vaccine, adequate medical treatment, including epinephrine (adrenaline), and supervision should always be available in case of an acute anaphylactic reaction. It is not known whether the vaccine can cause foetal

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**Are your patients at risk?**

age 65+
chronic lung, liver, heart or renal disease
diabetes
weakened immune system
smoker
other at-risk groups*

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Information about adverse event reporting can be found at www.imb.ie

Adverse events and inadvertent vaccination during pregnancy should also be reported to Sanofi Pasteur MSD by calling 00 44 1628 785291.

* See Immunisation Guidelines for Ireland www.immunication.ie
The end of the year is nigh, and what a year it has been. Amongst all the politics and austerity we are told that we can look forward to exiting the bailout by mid-December according to Michael Noonan. However, the challenges and opportunities for healthcare will continue to arise into the New Year.

Due to the constraints on purse strings evidenced based practice has never been so important in order to justify spending on better healthcare in the community.

Take BreastCheck for example: the footfall towards the total turn out has risen to 70% of the target group screened. Despite this the desirability of screening 50-65 year olds, irrespective of risk factors, has come into question.

Dr Toqir Mukahtar, a researcher Oxford University explains that through her research review that “there is no discernible impact on mammography screening”.

She also states that “there is as much of a reduction in mortality for those unscreened as those screened in mammography screening”.

On the other hand, Dr Ann O’Doherty, clinical director of BreastCheck argues that “until there is a more structured strategy at for example, molecular level, we need to continue the programme.”

Dr O’Doherty cites the Marmot report as part of her evidence describing it as one of “the most intensely examined and audited pieces of research available”. Dr O’Doherty insists on the importance of screening at population level as it reduces mortality in women by 20%.

Until otherwise stated it is imperative that we as practice nurses provide the most up to date information to all our female patients encouraging them to present for screening until the debate concludes.

Breast self-examination also plays its part in cancer reduction allowing the patient to take part in her role to maintain early detection of any breast abnormalities guided by the practice nurse or general practitioner. We also have a duty of care to remind women that mammography is not 100% sensitive of specific. The process is indeed a balance and a choice that Irish women have to make.

We cannot leave 2013 without mentioning midwifery healthcare. Although all practice nurses are not dual qualified when it comes to midwifery care we do come into constant contact with pregnant women. Primarily it is about recognising our remit of professional accountability and responsibility. If we do not hold a midwifery qualification should we be triaging a pregnant woman? Should we be checking blood pressure and testing urine to ease the pressure of our GP colleagues or should we allow holistic care to take over allowing less room for assumptions and errors in care.

The HIQA report into the death of Savita Halappanavar found: “a failure to provide the most basic patient care…and many missed opportunities which if acted upon, might have changed the outcome for her.” HIQA, 2013

In essence the whole scenario demonstrates how important it is to focus on safety, quality and standards of services provided by healthcare professionals. It is also about sharing information and reporting abnormalities to the relevant professionals and following through to the end. Responsibility cannot be diluted.

HIQA called upon the National Maternity Services strategy to ensure women receive “safe, high quality, and reliable care. No matter what the topic of care this engages practice nurses to participate in the best patient care available founded on evidence based care, improving all the time. An on-going process for all of us.

As practice nurses lets continue to contribute towards better health care for the nation in 2014.

Darina Lane
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HEART UK – the UK’s cholesterol charity, has just launched its Ultimate Cholesterol Lowering Plan© (UCLP©) on-line course – AVAILABLE NOW to all health professionals.

The UCLP© course is a must for health professionals searching for a credible, practical and realistic step-by-step approach to helping all patients lower their cholesterol.

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- Step 3 - The four cholesterol-busting foods

Refresh your heart health and cholesterol know-how:
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Take it at your own pace    Pause and resume the course at your convenience    No time constraints

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Supported by an education grant from Alpro UK Ltd
Nurses and midwives most ethical

Nurses and midwives are considered the most ethical when compared to other professions, and are ranked 'high' or 'very high' for honesty and ethics by 79% of the general public, it has been revealed.

The finding, part of a new study by Amárach Research, comes as the Nursing and Midwifery Board of Ireland (NMBI), the regulator, published its new draft ‘Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives’ as part of the inaugural Nurses Week 2013.

“This new Amárach Research shows nursing and midwifery to be viewed by the general public as ethical, trustworthy and extremely compassionate professions,” according to Dr Maura Pidgeon, Chief Executive Officer of the NMBI.

“The draft Code we have published is the next step in formalising these attributes by creating a framework of standards for the regulation, monitoring and enforcement of professional conduct. The intention is to guide nurses and midwives in their day-to-day practice and to help them to understand their responsibilities in caring for service users in a safe, ethical and effective way. The Code supports ethical and clinical decision-making, on-going reflection and professional self-development and informs the general public about the professional care they can expect from nurses and midwives. I call now for interested stakeholders to give their views on this draft Code as part of our consultation process,” said Dr Pidgeon.

The draft Code’s five key principles include respect for the dignity of the person, professional responsibility and accountability, trust and confidentiality, quality of practice as well as collaboration with others. Each principle underpins the ethical values and related standards of conduct and practice. Together these guide the various relationships between nurses, midwives, service users and colleagues. The NMBI’s consultation process is intended to get the views of the professions, the public and other stakeholders on the new draft Code, building on an earlier communications process involving focus groups, surveys and interviews. Stakeholder information sessions are being held in parallel with the call for written submissions on the draft code. The consultation period runs until Friday, 10 January, 2014. The draft Code and consultation feedback forms for submission can be viewed on www.nmbi.ie. Submissions can be emailed to reviewofcode@nmbi.ie or sent in hard-copy by post to: Code Consultation, Nursing and Midwifery Board of Ireland, 18-20 Carysfort, Avenue, Blackrock, Co Dublin.

Chief Nursing Officer appointed

The Minister for Health Dr James Reilly welcomed the appointment of Dr Siobhan O’Halloran as Chief Nursing Officer in the Department of Health recently. The position of Chief Nursing Officer has now been established at the level of Assistant Secretary in the Department, ensuring that the role of nursing and midwifery is represented at the highest level in terms of policy making for the health service. Commenting on Dr O’Halloran’s appointment Minister Reilly said “nurses and midwives form the bedrock of our health services. As we move to bring about radical change to improve our health services across the board, nurses and midwives are a vital group in achieving those reforms. It is imperative that their voice is heard at the highest level in the department and the appointment of the Chief Nursing Officer at Assistant Secretary level will achieve that aim.” Dr Siobhan O’Halloran was appointed to the post of Chief Nursing Officer following an open recruitment process conducted by the Public Appointments Service (PAS).

Anxiety and Depression – GP open day

Una Butler Ballycotton, Paul Gilligan CEO St. Patrick’s Mental Health Services, Professor Jim Lucey Medical Director St. Patrick’s Mental Health Services and Margo Hurley Cork City Pictured at a GP and public information event on Anxiety and Depression at The River Lee Hotel, Cork, Hosted by mental health recovery service Dean Clinic with Kathleen Lynch TD, Minister of State at the Department of Health and Department of Justice, Equality & Defence with responsibility for Disability, Older People, Equality & Mental Health. Hosted by community-based mental health recovery service Dean Clinic Cork, based at City Gate, Mahon
Perfect Christmas present for nurses and doctors!

For two decades, Dr Maurice Guéret has been examining the tonsils of the nation and prescribing his witty and original dose of good humour with lashings of healthy common sense. Dr Guéret is a direct descendant of the Cunningham family who used to operate a Wool and Drapery business in Newry town centre.

His popular Rude Health column in the Sunday Independent is a weekend feast for more than half a million readers and this collection features many of his very best columns alongside new pieces not published before. What The Doctor Saw includes a chapter about the life and work of his late grandfather, Dr Billy Coyne, who was Governor and Chief Psychiatrist at Dundrum Asylum in Dublin. That’s him on the cover of the book, aboard Neddy, the donkey from the Asylum’s Farm.

What The Doctor Saw has one hundred and forty pieces on topics that include Patient Bloopers, Execution by Hanging, Rude Consultants, The Last Castrato, Honest Crisps, The Absurdity of Jogging, Men in Gardens, Papal Health, Irish Transsexuals, Tasers, Quacks, Cryogenics, Sigmund Freud’s Birthday, Dead

Ireland has one of the highest rates of nursing applications

Ireland continues to see an interest in nursing and midwifery well above the European average, it was revealed recently at the Annual Conference of the Nursing and Midwifery Board of Ireland (NMBI).

Dr Maura Pidgeon, Chief Executive Officer of the NMBI, said that CAO figures show the overall ratio of applicants to nursing places in Ireland is six to one, indicating a strong interest across Ireland amongst people keen to enter a dynamic and evolving part of Irish healthcare.

“Not only does demand outstrip nursing and midwifery vacancies in this country, Ireland shows a level of interest in these professions that is significantly higher than most other countries in Europe. In particular, the total number of mature applicants has been rising consistently since 2008.”

“The Amárach Research study also shows the strong desire on the part of the general public to expand the role of nurses and midwives to improve the Irish healthcare system. The nurse and midwife is central to quality care provision, and nurses and midwives are becoming leaders across Irish healthcare. Their roles are evolving as they build new skills and expertise and this is very much reflected in the ongoing demand for careers in these areas.”

“Our job as statutory regulator at the NMBI is to protect the public in its dealings with nurses and midwives but also to protect the integrity of the practice of nursing and midwifery through the promotion of the highest standards of professional education, training, practice and professional conduct. Possessing attributes such as compassion, care and a sense of ethics are crucial in nursing and midwifery. In fact one of the things we are doing today is actually launching a new self-assessment tool to help people work out themselves if they have the right suitability for nursing and midwifery,” added Dr Pidgeon.

Entitled ‘Back to the future: Preserving the fundamentals of nursing and midwifery and adapting to new futures in healthcare’, the NMBI conference explored the centrality of the patient within the care experience provided by nurses and midwives.

Healthy travel campaign

What did you catch this summer? Infectious disease expert Dr Jack Lambert and travel writer Fionn Davenport are warning globetrotters not to be complacent about their health by launching the Healthy Travel awareness campaign on behalf of Sanofi Pasteur MSD.

A the launch of the campaign were Lisa Mc Laughlin, Senior Manager, Marketing, Sanofi Pasteur MSD, Ian Pitcher, Business Development and Key Accounts Executive, Sanofi Pasteur MSD, Travel Expert, Fionn Davenport, Dr Jack Lambert, Consultant in Infectious Diseases, Mater and Rotunda Hospitals and University College Dublin, and model Libby Sheehy.
CAVAN/MONAGHAN BRANCH

MARGARET GEOGHEGAN

11 members from Cavan/Monaghan branch attended the 2013 Conference and AGM in Athlone. We all thoroughly enjoyed it. Both the programme and exhibitions were excellent. A big thank you to the Dublin North branch for a job well done.

DONEGAL

BRIDGET BREEN

Our autumn season kicked off on September 25th at the Ramada Hotel in Letterkenny. Chris Kenny kindly sponsored the evening. Fiona Boyle, Smoking Cessation Officer gave an overview of her work in the area, and the many ways she can help people to give up smoking. Clinics are held at a few district hospitals throughout the county. Fiona also gives telephone advise and, as you can imagine, is kept very busy.

This was followed by a very interesting talk by Dr McManus from the Education Centre, on healthy lifestyle and ways of getting people motivated to take more exercise and responsibility for their own health. Both speakers were well received, with 18 nurses in attendance.

October saw nine of us heading to Athlone for the AGM. It was a great weekend and compliments to the Dublin Branch for putting it all together in such a professional manner. The only missing person on the night was Sam Maguire!!!

We came home happy as our colleague, Christine Doherty from Clonmany, received the Clinical Award. We are all so proud of her and her achievement in getting the prize. We now look forward to reading her article in this magazine (See page 17).

Another colleague, Patricia Gallagher from the Bayview Practice in Ballyshannon was our Donegal Representative for the Practice Nurse of the Year. She represented us well, but just didn’t come first. Many thanks to Patricia for the time and effort she put into her application. I hope she and Joe enjoyed their well deserved holiday afterwards. Congratulations to the winner and hope she continues to do well in general practice.

Our next meetings are November 14th and December 5th. Topics to be decided. Louise will be sending out the texts regarding same.

Happy Christmas to you all.

KILDARE

MARGARET CLANCY

Our first autumnal meeting was held 17th September. It was sponsored by Aoife Smith-Johnson from SMA. Carrie Powles from the National Cervical Screening Programme gave us a national update. This was well attended by the practice nurses.

The IPNA annual conference and AGM hosted by the Dublin north branch was entitled Old Issues-New Ideas. This excellent conference was very informative and educational. It was an ideal opportunity for new and established practice nurses to network. Well done North Dublin branch!

Our last branch meeting was held on 22nd October, and sponsored by Pamela Large from Boehringer Ingelheim. Michelle Dunne, respiratory scientist, gave a short introduction to Spirometry. She showed us how to use a spirometer in general practice. It gave us a hands on opportunity to practise its use.

Our next meeting will be Tuesday 19th November, in Maudlins Hotel Naas at 19:45, which will be our branch AGM for 2013. All members welcome.
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- In patients with high risk of venous thromboembolism, e.g. general surgery, recommended dose of Clexane® is 20mg (2,000IU) once daily subcutaneously.
- In patients following cardiac surgery or arterial revascularisation. Patients undergoing surgery, initial dose approximately 2 hours preoperatively.
- In patients with low to moderate risk of thromboembolism, e.g. general surgery, recommended dose of Clexane® is 20mg (2,000IU) once daily subcutaneously.
- In patients with moderate risk of thromboembolism, e.g. gynaecological surgery, recommended dose of Clexane® is 10mg (1,000IU) once daily subcutaneously.
- In patients with clinical or subclinical hypercoagulable conditions, e.g. history of thromboembolic episodes, and conditions or patients with increased bleeding potential (such as those with peptic ulcers, recent ischemic stroke, uncontrolled severe hypertension, diabetes mellitus type I or II, renal failure, elderly or extremes of weight). Please consult SPC for full details of the recognised side effects of Clexane® and Clexane® Forte.

Prophylaxis:

- In patients undergoing surgery, initial dose approximately 12 hours preoperatively.
- In patients following cardiac surgery or arterial revascularisation. Patients undergoing surgery, initial dose approximately 2 hours preoperatively.
- In patients with low to moderate risk of thromboembolism, e.g. general surgery, recommended dose of Clexane® is 20mg (2,000IU) once daily subcutaneously.
- In patients with moderate risk of thromboembolism, e.g. gynaecological surgery, recommended dose of Clexane® is 10mg (1,000IU) once daily subcutaneously.
- In patients with clinical or subclinical hypercoagulable conditions, e.g. history of thromboembolic episodes, and conditions or patients with increased bleeding potential (such as those with peptic ulcers, recent ischemic stroke, uncontrolled severe hypertension, diabetes mellitus type I or II, renal failure, elderly or extremes of weight). Please consult SPC for full details of the recognised side effects of Clexane® and Clexane® Forte.

During haemodialysis:

- 1mg/kg (100IU/kg) Clexane® introduced into arterial line of the circuit at beginning of dialysis. This dose is usually sufficient for a 4 hour session. If fibrin rings are found, e.g. after a longer session, a further 0.5 to 1mg/kg (50 to 100IU/kg) may be given. In patients with high risk of haemorrhage reduce dosage by 50%.

Removal of closure devices:

- Sheath can be removed 6 hours after the last IV/SC enoxaparin sodium injection. If treatment is to be continued, the next scheduled dose should be given no sooner than 6 to 8 hours after sheath removal. The site of the procedure should be observed for signs of bleeding or haematoma formation.

Prophylaxis:

- In patients undergoing surgery, initial dose approximately 12 hours preoperatively.
- In patients following cardiac surgery or arterial revascularisation. Patients undergoing surgery, initial dose approximately 2 hours preoperatively.
- In patients with low to moderate risk of thromboembolism, e.g. general surgery, recommended dose of Clexane® is 20mg (2,000IU) once daily subcutaneously.
- In patients with moderate risk of thromboembolism, e.g. gynaecological surgery, recommended dose of Clexane® is 10mg (1,000IU) once daily subcutaneously.
- In patients with clinical or subclinical hypercoagulable conditions, e.g. history of thromboembolic episodes, and conditions or patients with increased bleeding potential (such as those with peptic ulcers, recent ischemic stroke, uncontrolled severe hypertension, diabetes mellitus type I or II, renal failure, elderly or extremes of weight). Please consult SPC for full details of the recognised side effects of Clexane® and Clexane® Forte.

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KILKENNY

LEONIE FINNEGAN

Welcome back to all from the Kilkenny branch as we blitz through another season of flu vaccines!

Congrats to all the members of the Dublin Branch and the Committee members on a very successful, relevant and enjoyable Conference. Very well done to you all. Our meeting held on the 23rd of October was both our AGM and educational meeting. A full update from our NEC was delivered to the branch by Mary Fogarty. A new definition of a Practice Nurse is currently sought. Patricia McQuillan has drafted one, which was discussed at our meeting and will be brought to the next NEC meeting. We thank Roisin Doogue for all her hard work and dedication as chairperson nationally and welcome and support Siobhan Jordon into that role. We look forward to the new IPNA site e-learning hub and GreenCross Publishing's, educational online support also, during the coming year.

Following election of officers at this AGM Helen Fogarty is welcomed as chairperson and Catriona Lynch as secretary (with joint-secretary support of Sandra Blanchfield). Treasurers and NEC positions remain unchanged for this coming year. The incoming officers are offered much support from branch members and many thanks for taking these positions. Leonie Finnegan stepped down as Chairperson and Una Stapleton as Secretary and both were thanked for their work and commitment over the last 4 years. Appreciation is also due to Patricia McQuillan for her role in communication and support which is ongoing.

Also on this evening, sponsors Novartis, with Eoin Banville facilitated our educational topic of COPD to be capably delivered Dr Breda Cushen, SPR, who is based in St Luke’s Hospital Kilkenny. Breda gave us an excellent, very relevant and informative update on COPD.

Finally, on behalf of all members I would like to extend our heartfelt condolences to Helen Fogarty on the untimely passing of her brother Martin this summer.

We are grateful to and wish to thank all our members for their on-going support, for education and networking, in our branch throughout the year and we wish each of you and all of us, a healthy, calm and happy run up to the fast approaching Christmas season!

NORTH DUBLIN

ANNE MARIE ELLWOOD, ORLA DONELLY

Our September meeting concluded our arrangements for the Conference. We hope that all those who attended enjoyed both the educational and social component of the conference. We enjoyed hosting it and all the hard work was rewarded by the large attendance. To all those who helped in any small way, we wish to say a very big thank you. Our very best wishes to the Kerry branch for next year, if we can be of any help please do not hesitate to ask.

Finally, we would like to wish our colleague Lynn Cartwright the very best wishes as she returns to the UK. She will be missed by all.

SOUTH DUBLIN

KAREN CANNING

Firstly on behalf of our branch, I would like to congratulate two of our members, Anne O’Connor on the safe arrival of her daughter Niamh and Margaret Lynch on the safe arrival of her son Neil.

There was no October branch meeting due to the annual IPNA national conference. But we are looking forward to our November educational meeting. The guest speaker is Rita Lawlor, PDC who will discuss professional development for Practice Nurses.

I would like to sincerely thank Anne O’Connor, the IPNA South Dublin branch and all involved in my nomination for Practice Nurse of the Year Award.

We were very pleased that 8 members of our IPNA South Dublin branch were able to attend and support this years annual IPNA conference.

It was very clear from the moment one walked through the doors of the Radisson Blu Hotel, Athlone the extent of planning our colleagues from the IPNA North Dublin branch had gone to in organising our national conference.

It was obvious who was part of the organising branch by their royal blue sashes and the attention to detail throughout the conference was superb.

The Dublin colours were everywhere so we were left in no doubt as to which branch was the organising one.

The little touches were such a nice idea (county flags and a framed verse of a relevant county song on all the tables).

The lists of speakers and presentations were excellent.

Unlike past years, this years keynote speaker gave a light-hearted and amusing talk. This was a very good idea and I hope it becomes a tradition for future conferences. Another change to previous years was that there were no workshops, so no need for us to leave the main conference room.

To win Practice Nurse of the Year Award was the icing on the cake for me. I am totally overwhelmed. I would like to thank Anthony Carroll, SMA, for securing the educational bursary.

The hotel’s facilities were excellent – bedroom, conference facilities, dinner, wine, breakfast and lunch.

Well done to the IPNA North Dublin branch on hosting such a fabulous conference.

WICKLOW

MARY FINNEGAN

We resumed our branch meetings after the summer break, on Monday 23rd September. We had an excellent topic that night:
Acute and Chronic Pain Management, and our guest speaker was Dr Hugh Gallagher Consultant in Anaesthetic Medicine in SCH & SVUH. This was such an interesting topic, and an excellent talk giving rise to many questions from the floor at the end. The meeting was kindly sponsored by Peter Daly from Mundipharma.

We had no October meeting as the National IPNA Conference was held on 10th and 11th October. Five of our branch members attended the weekend, which was hosted by North Dublin Branch. This was an excellent weekend of speakers, and congratulations to all in the hosting branch for a very smoothly run weekend. The central location of Athlone was excellent too, allowing members to easily access the Conference from all over Ireland. The only tiny ‘complaint’ is that we missed the interactive clinical workshops of the previous Conferences, and would definitely like to see these included in future conference weekends. But, overall, it was a very enjoyable weekend, and a great opportunity to meet up with old friends and network with other branches.

We were also very proud to have one of our Wicklow members, Mary Sullivan, elected as National Treasurer on the NEC.

Our next meeting will be held on Monday 18th November in Bray. This will also be the Branch AGM. Yes, it’s that time of year again, where we hope to elect some new officers to the branch committee!

Our educational topic on the 18th will be the annual Smeartakers update, which will be provided by Carrie Powell from Cervical Check. We are delighted that Carrie can provide this update for us at branch level, at one of our scheduled meetings, as it is so difficult for our members to find free days to attend further meetings, outside of their working hours.

St Vincent’s Private Hospital started a series of bi annual educational meetings for practice nurses, in our area, last year, and these have run successfully in March and November for the past 2 years. The next meeting is scheduled for Wednesday 27th November in SVPH from 6.30 – 9.30, and the topic will be Eating Disorders, which will be given by Dr Donal O’Shea from SCH & SVH. There will also be speakers from St John of God Hospital who will speak on Mental Health. These are always excellent meetings and we are very grateful to Mary Connolly, Director of Nursing in SVPH, for arranging and facilitating these meetings for our members.

We will have no branch meeting in December, and meetings will resume on Monday 13th January.

Can I close by wishing all our members a very happy, healthy, peaceful, worry free Christmas, and look forward to meeting you all at branch meetings over the coming few months.

**NEC NEWS**

**IPNA CONFERENCE 2013**

The NEC would like to congratulate the North Dublin branch on hosting a very successful conference and to thank them for all their hard work on this.

Speakers’ presentations will be posted on the IPNA website as soon as possible.

**IPNA AWARDS 2013**

Congratulations to all who won Awards at the recent IPNA Conference! The winners were as follows:

- Practice Nurse of the Year 2013 – Karen Canning (South Dublin Branch)
- IPNA Clinical Award 2013 (ESC CVD Prevention Guidelines 2012) – Christine Doherty (Donegal Branch)
- Valerie Mangan IPNA Loyalty Award 2013 – Pauline McLoughlin (Sligo/Leitrim Branch):

- Well done also to the other nominees for the Practice Nurse of the Year Award who were as follows:
  - Maura Costello – Cavan/Monaghan Branch nominee
  - Patricia Gallagher – Donegal Branch nominee
  - Brid Buckley – North Dublin Branch nominee
  - Siobhan Jordan – South Tipperary Branch nominee

**eLEARNING FOR MEMBERS**

The new IPNA eLearning platform was launched at the IPNA Conference. It is still being developed and all members will be contacted with details of how to access it as soon as these are available.

**IPNA AGM 2013**

**Motions**

Both motions that were proposed were ratified at AGM and have been sent to the Revenue Commissioners’ Charities Section for approval.

**Election of NEC Officers**

The following members were elected as NEC Officers:

- Siobhan Jordan (South Tipperary Branch) – National Chairperson
- Cora Goold (Cork Branch) – National Vice-Chairperson
- Mary Sullivan (Wicklow Branch) – National Honorary Treasurer
- Ruth Morrow (Cavan/Monaghan Branch) – National PRO

The NEC would like to thank the outgoing NEC Officers (Róisín Doogue and Brid Buckley) most sincerely for all their work on behalf of the IPNA over the past year.

**DATE FOR DIARY**

The 2014 IPNA Annual Educational Conference / AGM will be held on Friday 17th and Saturday 18th October 2014 in the Limerick Strand Hotel, hosted by the IPNA Kerry Branch.

**NEC MEETINGS 2014**

- Wednesday 5th February 2014, Ashling Hotel, D.8, 11am-3pm
- Wednesday 7th May 2014, Ashling Hotel, D.8, 11am-3pm
- Wednesday 3rd September 2014, Ashling Hotel, D.8, 11am-3pm
- Friday 17th October 2014, Limerick Strand Hotel, time tbc

**IPNA WEBSITE**

The IPNA website, www.irishpracticenurses.ie is updated constantly, so please log in regularly to get the latest news on study days, education, new comments in the Discussion boards and more. You will also find IPNA Policies, Articles of Association and Minutes of all NEC meetings to date in the Members Area.

**IPNA ON TWITTER**

If you have a Twitter account you can follow the handle @ PracticeNurses to receive IPNA news, reminders & useful information that is retweeted from other groups – directly to your timeline.

Lisa Nolan, IPNA Administrator Tel: 042 9692403 email: admin@irishpracticenurses.ie
Introduction
Symptoms of gastro-oesophageal reflux disease (GORD) are frequently observed in children with developmental disability. Gastro-oesophageal reflux (GOR) refers to the passage of gastric contents into the oesophagus, with or without regurgitation and vomiting, and is considered a normal physiological process. Conversely, GORD, refers to the troublesome symptoms and/or complications that develop secondary to persistent GOR. Children with developmental disability are at increased risk of developing GORD and generally experience a greater number of complications associated with the disease than their otherwise healthy counterparts. Thickening feeds represents one means by which symptoms of the disease may be managed in children, however, there is limited evidence to support this line of treatment in those with cerebral palsy, epilepsy, autism spectrum disorder and other forms of developmental disability. The potential side-effects associated with long-term use of feed thickeners should not be overlooked and the financial implications of their use in enteral feeds requires consideration. A lack of published recommendations and national guidelines for managing this patient group has led to variance in practice between dietitians who treat such children in Ireland.

GORD in developmental disability
Episodes of GOR are usually caused by transient relaxations of the lower oesophageal sphincter (TLOS), which normally allow excess gas to escape from the stomach. In those with developmental disability, the development of GORD is likely to be due to altered gastric motility, altered oesophageal motility, or an increase in the number of TLOS, all of which may occur secondary to central nervous system and enteric nervous system dysfunction. Up to 75% of this patient group experience symptoms of the disease. Moreover, the type of GORD commonly observed in these children is severe and chronic in nature, and increases these patients’ risk of developing associated complications, which may include; erosive oesophagitis, Barrett’s oesophagus and adenocarcinoma. In children with neurological impairment, recurrent vomiting is the objective hallmark of GORD, although haematemeses, anaemia, rumination and regurgitation have also been observed in increased frequency in this patient group. Other signs and symptoms that may be indicative of GORD are outlined in Table 1.
Management

Management of GORD generally involves aspects of positional, nutritional, and dietary modification, with use of pharmacological agents as required.7 Thickening feeds represents one dietary modification by which symptoms of GORD may be managed. Commercial thickening agents include carob bean gum, maltodextrin, modified maize or rice starch, sodium carboxymethyl cellulose, pectin and cellulose. In children with GOR who are otherwise healthy, it appears that feeds that are thickened with these agents reduce the frequency of overt regurgitation; however, they have not consistently been shown to reduce the actual number of oesophageal reflux episodes, as measured by oesophageal pH monitoring.5,10–13 Nonetheless, their use may provide a welcome improvement in symptoms for parents and carers of these children.7

Only one small trial has investigated the effectiveness of thickened feeds for managing GORD in children with developmental disability. Miyazawa et al.14 investigated the effects of a pectin-thickened enteral feed on symptoms of GORD and oesophageal parameters in 18 children with cerebral palsy. Results revealed a reduction in the number of vomiting and coughing episodes and improvements in some, but not all, oesophageal pH parameters.

A medical position statement commissioned by the European Society of Paediatric Gastroenterology, Hepatology, and Nutrition (ESPGHAN) suggested that the lack of observed effect of some thickened formulas may be due to slower clearance of thickened acid refluxate from the oesophagus when ingested orally.15 Hence, in the study carried out by Miyazawa et al.,14 had the thickener been administered orally, it is possible that the results for oesophageal parameters and symptoms of GORD may have differed.

Lack of clinical guidance

There is no algorithm or clinical guideline available on the use of thickened feeds for managing GORD in children with developmental disability. The National Institute for Health and Clinical Excellence (NICE) have recently proposed the development of guidelines for managing GORD in children and young people.16 These guidelines aim to give special consideration to children with neurodevelopmental disorders; however, they are not due to be published until October 2014.

The lack of clinical guidance in this area has been highlighted by a recent survey of dietitians practising in Ireland who have experience managing GORD in children with disability. The main finding from the survey was that significantly more dietitians working in tertiary (n=11) and general hospitals (n=11) than in the community (n=3) reported recommending thickened feeds to manage symptoms of GORD in these children (p<0.01, p<0.001 respectively). In addition to this, 20 dietitians reported observing thickened feeds being used in conjunction with enteral feeds in practice, and three reported observing these agents being used in post-pyloric feeds.

NICE guidelines for the prevention and control of healthcare associated infections in the community state that reconstituted feeds should be administered over a maximum period of four hours.17 Additionally, they state that administration sets and feed containers should be discarded after each feeding session when this approach to feeding is being undertaken. Despite this, only 7 out of 17 question respondents were of the opinion that giving sets should be changed every 4 hours when used with thickened enteral feeds. Of these dietitians, only three believed that the NICE guidelines are being implemented in practice where feed thickeners are being recommended. These findings further highlight the need for published guidelines in the area to promote consistent standards of care and to optimise treatment of GORD in this patient group.

Thickening agents in enteral feeds

Results of the aforementioned survey that surround the use of thickened enteral feeds are also of concern. Children with developmental disability are at risk of undernutrition.18 Additionally, poor nutritional status is a risk factor for many infectious diseases.19 Therefore, children with developmental disability who are at increased risk of acquiring infections may be at further risk if proper aseptic technique is not being adopted when enterally fed. This may be further exacerbated if thickening agents are added to jejunal feeds, in which case, the stomach’s acid defences are being bypassed.

Conversely, if the NICE best practice guidelines for preventing infection in the community are to be implemented, the economic consequences of using thickening agents in enteral feeds becomes a major issue. Thickening agents themselves are relatively affordable, ranging from €3 to €8 (as per General Medical Scheme GMS prices; November 2013).

Table 1. Symptoms and signs that may be associated with gastro-oesophageal reflux*

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent regurgitation with/without vomiting</td>
<td>Oesophagitis</td>
</tr>
<tr>
<td>Weight loss or poor weight gain</td>
<td>Oesophageal stricture</td>
</tr>
<tr>
<td>Irritability in infants</td>
<td>Barrett’s oesophagus</td>
</tr>
<tr>
<td>Heartburn or chest pain</td>
<td>Recurrent pneumonia</td>
</tr>
<tr>
<td>Dysphagia</td>
<td>Laryngeal/pharyngeal inflammation</td>
</tr>
<tr>
<td>Odynophagia</td>
<td>Apnoea spells</td>
</tr>
<tr>
<td>Wheezing</td>
<td>Dental erosion</td>
</tr>
<tr>
<td>Stridor</td>
<td>Feeding refusal</td>
</tr>
<tr>
<td>Cough</td>
<td>Dystonic neck posturing (Sandifer syndrome)</td>
</tr>
<tr>
<td>Hoarseness</td>
<td>Apparent life-threatening events</td>
</tr>
</tbody>
</table>

*Modified from Vandenplas et al., 2009

In those with developmental disability, the development of GORD is likely to be due to altered gastric motility, altered oesophageal motility, or an increase in the number of TLOSR.
2012). However, if thickening agents are being administered with decanted enteral feed, best practice guidelines would necessitate changing giving sets and feed reservoirs every four hours, which vastly increases the cost of feeding. Case scenarios 1 and 2 outline the estimated cost difference of administering unthickened versus thickened enteral feed.

**Case scenario 1:** administration of enteral feed (ready-to-use)

**Example:** 5 year old patient with cerebral palsy: estimated energy requirements: ~700kcal

**Total feeding time:** 14 hours @50ml/hr (standard 1kcal/ml fibre-enriched enteral feed)

**Total feeding volume:** 700ml enteral feed

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost per Item (€)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fibre-enriched enteral feed (200ml)</td>
<td>2.80</td>
</tr>
<tr>
<td>Fibre-enriched enteral feed (500ml)</td>
<td>7.00</td>
</tr>
<tr>
<td>Giving set</td>
<td>8.30</td>
</tr>
<tr>
<td>Daily total</td>
<td>18.10</td>
</tr>
<tr>
<td>Weekly total</td>
<td>134.20</td>
</tr>
</tbody>
</table>

*Price of feeds based on GMS prices (November 2012). Cost of giving set estimated from €250 for 30 giving sets. Weekly total includes cost of one syringe (~€7.50).

**Case scenario 2:** addition of thickening agent to enteral feeding

**Total feeding volume:** 700ml decanted feed + 24g standard feed thickener per day (4 scoops per 200ml)

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost per Item (€)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fibre-enriched enteral feed (200ml)</td>
<td>2.80</td>
</tr>
<tr>
<td>Giving set</td>
<td>8.30</td>
</tr>
<tr>
<td>Feed reservoir</td>
<td>2.20</td>
</tr>
<tr>
<td>Feed thickener (6.8g)</td>
<td>0.15</td>
</tr>
<tr>
<td>Total per 4 hour feed</td>
<td>13.45</td>
</tr>
<tr>
<td>Daily total</td>
<td>53.80</td>
</tr>
<tr>
<td>Weekly total</td>
<td>384.10</td>
</tr>
</tbody>
</table>

*Price of enteral feeds and thickening agent based on GMS prices (November 2012). Estimate from feed thickener (135g box): €3.00. Cost of giving set estimated from €250 for 30 giving sets. Cost of feed reservoir estimated from €66 for 30 feed reservoirs. Total includes cost of one syringe (~€7.50).

Administering ready-to-use formula permits safe feed delivery over 24 hours without need to change giving sets and removes the need to use a feed reservoir. Therefore, in the previous case scenarios, using a thickening agent would increase the daily cost of enteral feeding by around €36 per day and €250 per week.

It is important to consider the financial burden that using these agents in enteral feeds places on families of children as well as the financial burden they are likely to place on the State. Anti-reflux medication ranges from €4 to €15.20 thus provision of appropriate medical agents appears to be a more appropriate strategy than recommending thickened enteral feeds to manage these children’s symptoms.

**Thickened feeds: potential side-effects**

The long-term effects of consuming thickened feeds have not been investigated and the potential allergenicity of commercial thickening agents warrants further research. Side-effects reported with short-term use include diarrhoea, increased coughing episodes and an increase in gastric emptying time. In vitro studies suggest that the bioavailability and intestinal absorption of carbohydrates, fat, calcium, iron, zinc and copper may be reduced by feeds thickened with non-digestible carbohydrate. An increased risk of developing complications associated with GORD by using thickeners should also be considered. For instance, if thickened feeds only reduce symptoms of GORD but do not reduce actual oesophageal reflux (as indicated by the majority of studies), their long-term use in children has the potential to mask persistent GOR that could otherwise be treated with anti-reflux medication. In such a scenario, prolonged use of thickened feeds could further increase these children’s risk for developing serious complications associated with GORD.

**Medical therapy for the management of GORD**

The North American Society of Paediatric Gastroenterology, Hepatology, and Nutrition (NASPGHAN) and ESPGHAN recommends that anti-secretory therapy should be optimised in children with GORD and neurological impairment (including those with developmental delay). Whilst the risk of side-effects also accompanies the use of anti-secretory medication, there are nutritional and clinical consequences of uncontrolled symptoms of GORD. At present, there is a greater evidence base to support the use of proton pump inhibitors in children with underlying disability and GORD than that which favours thickened feeds for managing these children. Additionally, where enteral feeding is indicated, medication represents a cheaper, more practical means by which symptoms can be managed.

**Conclusion**

Further research is warranted to determine the effectiveness of thickened feeds in managing children with GORD and underlying disability. Until then, the potential side-effects associated with using thickened feeds should not be overlooked, nor should the serious financial burdens they place on families of these children when used in enteral feeds. Future guidelines that reflect the relevant literature are required in order to promote consistent standards of care and ultimately optimise the quality of treatment for GORD in children with a disability.
**Abridged Prescribing Information**

**ViATIM®** Suspension and solution for suspension for injection in a pre-filled syringe. Hepatitis A (inactivated, adsorbed) and Typhoid polysaccharide vaccine.

Refer to Summary of Product Characteristics for full product information before prescribing.

**Indications:**

- ViATIM is indicated for the immunisation against typhoid fever and hepatitis A virus infection in subjects from 16 years of age.
- ViATIM can be used as a booster vaccine in subjects who have received an inactivated hepatitis A vaccine 6 to 36 months earlier, and who require protection against typhoid fever.

**Contraindications:**

- Known hypersensitivity to the active substances, any of the excipients of VIATIM (including formaldehyde) or to neomycin (present in trace amounts as a residual of the manufacturing process).

**Warnings and Precautions:**

- Vaccination during pregnancy should also be reported.
- Data on a limited number of exposed pregnancies indicate no adverse effects of VIATIM on pregnancy or on the health of the fetus/new born child. However, caution should be exercised when prescribing to pregnant women.
- Do not inject intravascularly. Also avoid administration into buttocks.
- No data on the safety of ViATIM in children and adolescents below 16 years are available. For a complete list of undesirable effects please refer to the Summary of Product Characteristics.

**Package quantities:** Single dose pre-filled syringes in single packs.

**Marketing authorisation holder:** Sanofi Pasteur MSD Limited, Block A, Second Floor, Cookstown Court, Old Belard Road, Tallaght, Dublin 24

**Date of last review:** October 2013

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**Let them know before they go!**

Avoiding contaminated food and water is good advice, but they don’t always remember it.

---

**ViATIM® protects for up to 36 months against both hepatitis A and typhoid fever.**

1. Sanofi Pasteur MSD. ViATIM, summary of product characteristics, October 2012.
References


20. Primary Care Reimbursement Services (Health Service Executive) [Internet] [cited 2013 May 5]; Available from: http://www.sspcrs.ie/druglist/search.jsp


Nicorette Invisi Patch Prescribing Information

**Name of medicinal product:** Nicorette Invisi Patch 15mg Transdermal Patch, Nicorette Invisi Patch 15mg Transdermal Patch, Combinations: Nicorette Invisi Patch 10mg - Nicorette Invisi Patch 10mg, Nicorette Invisi Patch 10mg - Nicorette Invisi Patch 20mg, Nicorette Invisi Patch 20mg - Nicorette Invisi Patch 20mg, Nicorette Invisi Patch 20mg.

**Indication:** Nicorette Invisi Patch is indicated for smoking cessation in adults. The Invisi Patch is not recommended for smoking cessation in adolescents or as a cessation aid for pregnant women.

**Usage:** The Invisi Patch should be applied to the upper mid-sternum, just below the collarbone, once daily for a period of 6 weeks.

**Duration:** The Invisi Patch is indicated for use in individuals who are ready to quit smoking and have attempted to quit more than once or who have used other nicotine replacement therapies with limited success.

**Contraindications:** The Invisi Patch is contraindicated in patients with a history of serious cardiovascular disease, known bronchial asthma, or other serious lung disease, or who are allergic to any component of the Invisi Patch.

**Adverse Reactions:** The Invisi Patch is generally well tolerated. Common side effects include skin irritation and allergic reactions.

**Precautions:** The Invisi Patch should not be used by children, pregnant women, or individuals with a history of cardiovascular disease.

**References:**

1. McNeil Healthcare Limited. For every cigarette, there's a nicotine.


She’s offered protection from HPV types 6, 11, 16 and 18 through the national HPV vaccination programme in second level

What about them?

Gardasil® – paves the way for cervical cancer and other HPV genital disease prevention

• Most women under 45 years can gain some benefit from Gardasil® regardless of past or current infection

• Gardasil is effective in preventing genital warts causally related to HPV 6, 11, 16 and 18 in males

• Gardasil is indicated from 9-45 years of age in women and 9-26 years of age in men

Gardasil® is a vaccine for use from the age of 9 years for the prevention of premalignant genital lesions (cervical, vulvar and vaginal) and cervical cancer causally related to certain oncogenic Human Papillomavirus (HPV) types and genital warts (condyloma acuminata) causally related to specific HPV types. The indication is based on the demonstration of efficacy of Gardasil in females 16 to 45 years of age and in males 16 to 26 years of age and on the demonstration of immunogenicity of Gardasil in 9- to 15-year old children and adolescents.

Dosage and administration: The primary vaccination series consists of 3 separate 0.5 millilitre doses administered according to the following schedule: 0, 2, 6 months. If an alternate schedule is necessary the second dose should be administered at least one month after the first and the third dose at least three months after the second. All three doses should be given within a 1 year period. The need for a booster dose has not been established. The vaccine should be administered by intramuscular injection.

Contraindications: Hypersensitivity to any component of the vaccine. Hypersensitivity after previous administration of Gardasil. Acute severe febrile illness.

Warnings and precautions: The decision to vaccinate an individual should take into account the risk for previous HPV exposure and potential benefit from vaccination. As with all vaccines, appropriate medical treatment should always be available in case of rare anaphylactic reactions. The vaccine should be given with caution to individuals with thrombocytopaenia or any coagulation disorder because bleeding may occur following an intramuscular administration in these individuals. Syncope, sometimes associated with falling, can occur before or after vaccination with Gardasil as a psychogenic response to the needle injection. Vaccinees should be observed for approximately 15 minutes after vaccination; procedures should be in place to avoid injury from faints. There is insufficient data to recommend use of Gardasil during pregnancy therefore the vaccination should be postponed until after completion of the pregnancy. The vaccine can be given to breastfeeding women. Gardasil will only protect against diseases that are caused by HPV types 6, 11, 16 and 18 and to some limited extent against diseases caused by certain related HPV types. Vaccination is not a substitute for routine cervical screening.

Individuals with impaired immune responsiveness, due to either the use of potent immunosuppressive therapy, a genetic defect, or other causes, may not respond to the vaccine. As with any vaccine, vaccination with Gardasil may not result in protection in all vaccine recipients. There are no safety, immunogenicity or efficacy data to support interchangeability of Gardasil with other HPV vaccines. Undesirable effects: Very common side effects include: headache and at the injection site, erythema, pain and swelling.

Common side effects include: bruising and pruritus at the injection site, pyrexia, nausea, and pain in the extremity. Common side effects include: bruising and pruritus at the injection site, pyrexia, nausea, and pain in the extremity. Rarely urticaria and very rarely bronchospasm has been reported. Idiopathic thrombocytopenic purpura, Guillain-Barré syndrome and hypersensitivity reactions including anaphylactic/anaphylactoid reactions have also been reported. For a complete list of undesirable effects please refer to the Summary of Product Characteristics.
CASE STUDY
Acute coronary syndrome
Michael is a 46 year old man who has recently been discharged from hospital with a diagnosis of acute coronary syndrome.
He presented to the hospital initially complaining of 2 hour history of severe chest pain. Initially he thought it was indigestion and took some antacid. As there was no relief from the pain and it suddenly became worse and he also felt clammy and nauseated, his colleague brought him straight to A and E.
Previous history: Indigestion and some shortness of breath on exertion in recent months
Medications: Nil
Allergies: Nil known
Smoking status: 20/day for 25 years approx.
Alcohol history: Drinks in excess of 35 units/week as beer/wine.
Family History: Father died suddenly 15 years previously of a heart attack. Mother is a diabetic.

Michael was admitted for investigations and treatment. His admission ECG showed ST elevation in inferior leads. His troponin levels were elevated. He was taken to the coronary angiogram lab and had a coronary angiogram performed. His right coronary artery (RCA) was 90% blocked with minor disease in the other coronary arteries. A drug eluting stent was inserted into the RCA. Michael spent 2 days in the coronary care unit before transfer to a ward and then discharged home.

The results of his tests were as follows:
ECG: STEMI (Inferior leads) which resolved with q wave formation.
ECHO: Area of dyskinesia in the right ventricular wall. Ejection Fraction 55%
Angiogram: 90% narrowing RCA and minor disease in the other arteries.
CXR: Normal
Troponin: 0.56
Renal profile: Normal
Liver Profile: Normal
FBC: Hb 14.2
Fasting Lipids: Total Chol 6.2, Trigs 3.6, LDL 3.2, HDL 0.77 mmol/L
Glucose: 6.3 mmol/L

His discharge medications are:
Ramipril 1.25mg OD to increase to 2.5mgs after one week
Bisoprolol 1.25mg OD to increase to 2.5mgs after one week
Aspirin 75mg OD
Prasugrel 10mgs OD
Atorvastatin 80mgs OD

QUESTIONS:
1. What are the particular risk factors that caused Michael’s heart disease?
2. Name two other risk factors that lead to the development of heart disease?
3. Outline the non-pharmaceutical measures that you would discuss with Michael in order to control his condition in line with ESC 2012 guidelines.
4. What steps outlined in the ESC 2012 guidelines would help you motivate Michael to quit smoking if he had not yet done so?
5. What concerns do you have about Michael’s alcohol intake and what advice would you offer him?
6. Explain briefly the need for his new regime of medications and reasons for compliance.
7. What medications are proven to reduce cholesterol?
8. Explain briefly why such a high dose of a statin has been prescribed?
9. What blood tests would you repeat following commencement of this (statin) medication and why?
10. According to the new ESC 2012 guidelines what is the target for LDL cholesterol?
11. What is a normal blood sugar level and what follow up tests are required for Michael?
12. Today Michael’s BP was initially high. What is the target BP for patients with CVD according to the ESC 2012 guidelines? What follow up would Michael need to monitor his BP if it remained high?
Q1.

Worldwide, cardiovascular disease (CVD) remains a significant cause of premature death.1 Health promotion in the primary and secondary prevention of CVD focuses on the modification of globally recognised risk factors. The WHO calculates that 80-90% of CVD deaths can be attributed to 1 or more major risk factors.15

Modifiable risk factors are:

- Smoking – Michael smokes 20 daily for 25 years
- Hypercholesterolaemia – Michael’s total cholesterol is elevated at 6.2mmol/l, with raised triglycerides and LDL and low levels of cardioprotective HDL.
- Hypertension – Michael has grade 1 hypertension
- Obesity – Michael has a BMI of 28kg/m² with possible abdominal adiposity (central obesity).
- Alcohol consumption – Michael drinks >35 units per week
- Impaired fasting glucose/type 2 diabetes – Michael’s fasting plasma glucose is 6.3mmol/l.

Non-modifiable risk factors include age, gender and family history (Michael’s father had a fatal myocardial infarction).

Q2.

Two other risk factors that could lead to the development of heart disease are.1

Diet and exercise
1) Sub-optimal intakes of fruit, vegetables, fish and fibre.
   Excess salt, saturated and trans-fats in the diet.
2) A sedentary lifestyle or irregular and inconsistent exercise.
Psychosocial risk factors
1) Low socio-economic status
2) Work and family stressors
3) Depression and anxiety
4) Social isolation
5) Hostility
6) Type ‘D’ personality.

Q3.

1. All patients should unequivocally be encouraged and supported to quit smoking.1,12,15
2. Fruit, Vegetables, Fibre and Fish have cardioprotective benefits.
   4-6 portions of fruit and vegetables and 30-45grams of fibre daily are recommended.
   Fish consumption of 1-2 servings per week have been shown to reduce CHD mortality by an impressive 36%.1,33
3. A diet low in saturated and trans-fats.14,15
   High fat diets contribute to obesity levels and cardiovascular and metabolic ill-health.
   Trans-fats offer no nutritional benefit, yet are commonplace in vegetable oils, fast foods and baking.
4. Reduce salt intake to <5grams daily.
   Processed foods, bacon and ham have a high salt content. Michael should be advised that 1g of salt is equivalent to 0.4g of sodium as this misunderstanding could lead to excess salt intake. Advise Michael to avoid salt alternatives due to raised potassium content. Although potassium is beneficial for blood pressure control, excess intake could be arrhythmogenic.16 Suitable substitutes are herbs and spices.
5. Limit alcohol to 2 glasses a day (for males).1 Caution

Michael: re: substituting alcohol with soft drinks due to the association with obesity and diabetes development.

6. Increase regular exercise – to optimise cardiovascular fitness, reduce weight, control BP, reduce risk of type 2 diabetes, improve HDL cholesterol and reduce LDL levels. Encourage participation in moderate intensity exercise for 30 minutes daily or a minimum of 2.5 hours weekly. Low intensity exercise eg. walking may be advised initially if Michael has been sedentary.1,3,7

7. Manage weight – aim for a BMI of 18.5-24.9kg/m².1 Obesity is becoming a worldwide crisis. Michael’s BMI of 28 qualifies him as obese. A waist circumference measurement of >94cm for males indicates central obesity, which has implications for type 2 diabetes development.1,12 Diet and exercise advice to manage weight will also benefit BP control, glucose and lipid levels.

8. Offer Michael tips to manage stressors in his work-life balance.1 Diet, exercise, peer support, adequate sleep and reduced alcohol dependence are important areas to consider.

Q4.

Smoking is prothrombotic and contributes significantly to premature death rates. Amounts of tobacco and duration of use are important factors contributing to irreversible plaque formation.1,2

ESC guidelines (2012) indicate that smoking cessation is the most important singular factor in secondary prevention, with significant reductions in mortality evident even after 6 months cessation.

Unfortunately, many patients often revert to smoking once the acute phase of their MI has passe.2

Nurses must actively discourage smoking. Brief motivational interventions using the 5 As strategy should be used at each patient contact opportunity.11,14,15

<table>
<thead>
<tr>
<th>5 As</th>
<th>Patient contact</th>
<th>Health promotion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask</td>
<td>If the patient is a smoker, ask about amount and duration. If non-smoker, advise to avoid passive smoking</td>
<td></td>
</tr>
<tr>
<td>Advise</td>
<td>Reiterate harmful effects of smoking, encourage total abstinence, reduction in cigarettes does not offer comparative benefits</td>
<td></td>
</tr>
<tr>
<td>Assess</td>
<td>Readiness to quit. Is the patient at the pre-contemplative or contemplative stage? Explore advantages and disadvantages of quitting</td>
<td></td>
</tr>
<tr>
<td>Assist</td>
<td>Set date for quitting. Provide supportive, individualised care and counselling. Re: managing withdrawal symptoms, NRT and patches and access to smoking cessation groups.</td>
<td></td>
</tr>
<tr>
<td>Arrange</td>
<td>Follow-up visit to praise/encourage /offer support if patient is lapsing. Acknowledge success. Reflect on difficult areas.</td>
<td></td>
</tr>
</tbody>
</table>
NEW in COPD
ADD BREATH BACK
TO PATIENTS' MORNINGS
WITH ONE-DAILY
SEEBRI® BREATHER® 44 MG

NOVARTIS

[Image of a medical device and two individuals]
Q5.
Alcohol has atherosclerotic effects, contributing to hypertension, CVA and cardiomyopathy. Alcohol excess can promote obesity and malnutrition and is associated with depression and cancer.

Michael over-indulges in alcohol (>35 units/week). The potential for chronic ill-health exists, given his current lifestyle choices. Alcohol use should be discussed at primary care level and brief motivational interventions employed. Health promotion should focus on education and self-monitoring.

Instruct Michael regarding the daily alcohol limits (2 drinks/day for men) and the long-term health implications of excess consumption. It may be pertinent to encourage Michael to acknowledge triggers for his drinking habits. NICE (2010) advise the FRAMES formula:
- FEEDBACK on the problem
- RESPONSIBILITY for change
- ADVICE when required
- MENU of choices to enable change
- EMPATHY
- SELF-EFFICACY

Q6.
ACEi (Ramipril) are used extensively in primary and secondary CVD prevention. ACEi reduces post-MI mortality and has anti-hypertensive properties.

Longterm ACEi therapy is recommended in patients with large wall motion abnormalities. Michael has an area of dyskinesis in his right ventricular wall, although left ventricular systolic function is preserved, given his ejection fraction of 55%. ACEi preserves renal function in diabetic patients and reduces incidence of microalbuminuria and proteinuria. This may be relevant for Michael given his impaired fasting glucose level and brief motivational interventions employed. Health promotion should focus on education and self-monitoring.

Bisoprolol has anti-arrhythmic and anti-hypertensive properties. This is advantageous for Michael given his diagnosis of inferior MI in the setting of possible hypertension (152/96mmHg).

Bisoprolol displays anti-anginal qualities by reducing cardiac workload and cardiac O2 consumption. Administration in a once-daily dose will also facilitate compliance where polypharmacy is an issue.

Aspirin and Prasugrel – Dual anti-platelet therapy is advised post MI.

Aspirin has shown positive results in secondary prevention and is recommended lifelong. It maintains the patency of the affected artery and reduces the extent of a re-infarction. A maintenance dose of 75mgs has similar benefits to higher doses without the risk of GI bleeding.

Prasugrel at 10mgs is recommended in the acute phase post-MI and where the patient has had angioplasty. Michael was stented to his RCA. Treatment is advised for 12 months.

Poor compliance to longterm drug treatments is a very legitimate concern in secondary prevention. Nurses need to be vigilant in exploring reasons for non-adherence and to continue to educate, support and empower patients to accept their diagnosis.

Q7.
Raised plasma cholesterol, LDL and triglycerides levels and low cardioprotective HDL levels are recognised risk factors in CHD. Reducing LDL cholesterol by 1mmol can reduce CHD risk by 21%.

Statins are first-line therapy for dyslipidaemia. ESC (2012) guidelines suggest that statins arrest atherosclerotic progression. Early studies have proven the efficacy of statins – the Scandinavian Simvastatin Survival Study 1994 documented notable reductions in total and LDL cholesterol with reductions in morbidity and mortality.

Where statin intolerance develops, other drugs may be used – fibrates, Niacin or Ezetrol. Certain high-risk patients may require a combination of these therapies.

Q8.
Guidelines advocate intensive and immediate treatment (80mgs Atorvastatin) in the post-MI period. Statins inhibit cholesterol synthesis, thereby lowering levels of atherogenic LDLs. An optimal target LDL of <1.8mmol/l is suggested as this has been attributed to a lower risk of recurrence of cardiovascular events.

The use of the maximum tolerated dose of a statin must be balanced against the potential risk of adverse effects eg. Myositis or liver dysfunction.

Q9.

<table>
<thead>
<tr>
<th>TEST</th>
<th>RATIONALE</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lipids</td>
<td>4-6 weeks after initiation of statin, a reduction in total and LDL cholesterol should be evident.</td>
<td>Query compliance. Atorvastatin can be taken in the morning. Reiterate lifestyle advice. If target LDL achieved, consider reducing statin dose</td>
</tr>
<tr>
<td>Liver tests</td>
<td>To monitor for hepatic impairment.</td>
<td>If elevated, discontinue/change statin. Monitor for drug interactions e.g. avoid grapefruit, certain antibiotics (Clarithromycin)</td>
</tr>
<tr>
<td>CK (Creatine Kinase)</td>
<td>If patient reports new myalgia. To monitor for development of myopathy. Avoid progression to rhabdomyolysis.</td>
<td>If elevated, discontinue drug. Check for drug interactions.</td>
</tr>
<tr>
<td>Thyroid function</td>
<td>TFTs if not already completed to rule out secondary dyslipidaemia.</td>
<td>If TFTs indicate hypothyroidism, commence Eltroxin.</td>
</tr>
</tbody>
</table>

Q10.
Asymptomatic individuals with elevated total and LDL cholesterol are risk assessed for the probability of developing CVD over a 10 year period. Lifestyle (diet and exercise)
INNOVATIVE AWARD-WINNING
OSTEOARTHRITIS TREATMENT!

Relieves pain and restores joint mobility¹-³

Natural lubrication for arthritic joints⁴,⁵

Pain relief as effective as celecoxib¹

Avoids heart and stomach risks¹-³
common to most OA drug treatments⁶,⁷

FLEXISEQ™ with Sequessome Technology®

References:
2. Rother M, Conaghan PG. A multicentre, randomised, double-blind, placebo-controlled phase III trial comparing the efficacy and safety of epicutaneously applied ketoprofen in Transfersome® gel (IDEA 033) with drug-free Transfersome® gel (TDT 064) for pain associated with osteoarthritis of the knee. Manuscript submitted.

A Medical Device. Manufactured according to ISO 13485.
Conforms to EU Medical Device Directive 93/42 EEC.
modification is strongly advised to achieve a target TC of <5mmol/l.
Moderate risk individuals should aim for LDL cholesterol of <3mmol/l.
Control is tightened for patients with high risks to <2.5mmol/L. This may be achieved by intensive lifestyle advice +/- statin addition.
Very high risk patients (previous cardiac event, with multi-morbidities or risk factors), should strive for a LDL of <1.8 mmol/l or at least a 50% reduction in baseline LDL.

Q11.

In Ireland, diabetes has increased by 13% since 1980s and is predicted to rise by 37% from 2005-2015. Hyperglycaemia increases risks of cardiovascular and microvascular (retinopathy, nephropathy and neuropathy) complications.

In asymptomatic patients, a diagnosis is confirmed by 2 abnormal results, either fasting plasma glucose or HbA1c. Oral glucose tolerance testing (OGTT) is recommended, where fasting levels exceed 5.6mmol/l or HbA1c is 5.7-6.4%. Target HbA1c is <7.0%

The following table classifies Michael's potential results.

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>RESULT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impaired fasting glucose</td>
<td>Fasting glucose of 5.6 – 6.9 mmol/l on 2 separate occasions.</td>
</tr>
<tr>
<td>Impaired glucose tolerance</td>
<td>Post OGTT – 2 hour glucose 7.8 – 11.0 mmol/l.</td>
</tr>
<tr>
<td>Type 2 diabetes</td>
<td>Post OGTT – 2 hour glucose of &gt;11.1 mmol/l.</td>
</tr>
</tbody>
</table>

Michael needs assessment for detection of symptoms associated with type 2 diabetes. He is at risk of metabolic syndrome and insulin resistance. Having risk factors of type 2 diabetes. He is at risk of metabolic syndrome and insulin resistance.

Q12.

Michael has Grade 1 hypertension with BP of 152/96mmHg, however, this may simply be white coat hypertension. Guidelines suggest a target BP for patients with CVD of 130-139/80-85mmHg. Lower targets have not consistently been supported in research, except for patients with CVAs. Persistently elevated BP needs to be confirmed by means of either.
1. Ambulatory BP monitoring – targets of 125-130/80mmHg.
2. Home BP monitoring – target of 130-135/85mmHg.

If hypertension is confirmed, Michael needs advice regarding lifestyle modification, namely, smoking cessation, weight management, alcohol moderation, regular exercise, low-salt, low-fat diet with improved intake of fruit and vegetables.

Potassium in fruit and vegetables will help to reduce BP however, given that Michael is on ACEi also, it may be prudent to monitor serum electrolytes, to reduce risk of hyperkalaemia.

Michael's anti-hypertensive medications, Ramipril and Bisoprolol can be titrated to maximum tolerated doses. Combination therapy is more beneficial for BP control than simply maximising the dose of one drug.

Conduct an ECG to rule out evidence of left ventricular hypertrophy (LVH) which is an independent CV risk. Assess renal damage by checking urine to measure creatinine and glomerular filtration rate (GFR) and to detect microalbuminuria or proteinuria.

Ensure Michael's compliance with therapy by clarifying any issues that may arise and offer support and counselling, as required, in the post-MI period.

References:
Managing postmenopausal vaginal atrophy

Vaginal atrophy is a common and distressing symptom of the menopause, yet it is rarely discussed openly and only a minority of women seek medical help. The delicate lining of the vagina depends on oestrogen to stay thick and moist. After the menopause oestrogen levels drop dramatically from an average of 120 pg/mL to around 18 pg/mL. As oestrogen levels drop the skin and support tissues around the vagina become thinner and less elastic. Vaginal and cervical secretions also decrease, leading to reduced lubrication. This results in symptoms of vaginal dryness, soreness and itching. There may also be pain or bleeding during sexual intercourse. In addition, the pH of the vaginal secretions changes, from less than 4.5 in the premenopausal woman to over 6 in postmenopausal women. This affects the balance of microorganisms in the secretions and increases the risk of infection and inflammation.

Symptoms of vaginal atrophy
• vaginal dryness
• vaginal irritation
• vaginal soreness
• itching in and around the vagina
• pain or bleeding during sexual intercourse
• painful urination.

The average age of the menopause is 50 years. With life expectancy for women in Ireland now at 81.6 years, this means that an Irish woman experiences more than one third of her life after the menopause.

Many women may not be aware of a link between declining oestrogen levels and vaginal discomfort. In addition, many women are too embarrassed to discuss the problem, particularly with a male doctor. The International Menopause Society says that the impetus is upon the health professional to raise the topic of vaginal health. They suggest saying: “Some women notice that they experience vaginal dryness during this time of life. I wonder if you are having any discomfort with intercourse?”

Dr Hugh O’Connor, consultant obstetrician at Coombe Women & Infants University Hospital in Dublin said: “Post menopausal women can suffer from vaginal dryness, irritation, urinary tract infection and painful intercourse. As time goes on vaginal prolapse is more common, as is stress incontinence.”
Many women dismiss the symptoms of vaginal atrophy as an inevitable consequence of getting older. However, women do not have to put up with the discomfort and reduced quality of life as there are effective treatments available. A popular first line option is the use of a vaginal lubricant or moisturiser which can help if sex is uncomfortable. However, this is only a temporary measure and does not provide a long term solution.

Another option is systemic hormone replacement therapy (HRT) which relieves vaginal atrophy in about 75% of women. However, a quarter of women using systemic HRT still experience the symptoms of urogenital atrophy and may need to be prescribed a combination of local and systemic therapy.  

The International Menopause Society also recommends that clinicians should prescribe the lowest effective dose of oestrogen. From 1 October 2013 there will be an ultra low dose vaginal oestrogen tablet available in Ireland for the first time. Vagifem® 10 mcg (estradiol hemihydrate) contains 17β estradiol - the same oestrogen that the body makes. Vagifem® was previously available as a 25 mcg dose but from 31 December 2013 this will be discontinued. Vagifem® 25 mcg was withdrawn from the UK two years ago.

Dr O’Connor said: “The vaginal symptoms of menopause can be very distressing and often women are too embarrassed to discuss them with friends or health professionals.”

He added: “It is a silent crisis for many women. The health professional needs to ask direct questions.”

Dr Hugh O’Connor, Coombe Women and Infants University Hospital, Dublin

Vagifem® 10 mcg is inserted using a preloaded disposable applicator which ensures precise dosing every time. The initial dose is one tablet inserted intravaginally once daily for two weeks followed by a maintenance dose of one tablet twice a week. Small amounts of oestrogen are released locally into the vaginal tissues. Women may continue to use Vagifem® 10 mcg for as long as symptoms persist. 

Vagifem® 10 mcg has undergone rigorous approval procedures in North America and the EU where clinical research has shown that the low dose is effective in treating symptoms of vaginal atrophy. A multi-centre double blind study found that Vagifem® 10 mcg was effective in significantly reducing urogenital symptoms such as vaginal dryness, soreness and itching as well as pain or bleeding associated with sexual intercourse over 12 weeks of treatment. The study also found that Vagifem® induces maturation of vaginal epithelial cells. Treatment increases the percentage of superficial cells, which usually lessen in postmenopausal women and reduces the number of parabasal cells, which are typically more prominent after the menopause. Vagifem® 10 mcg also changes the vaginal pH towards the more acidic ranges typical of non-menopausal women.
The British Menopause Society Council Consensus Statement states that low dose oestrogen preparations do not require added progestogen because systemic absorption of oestrogen is low without systemic effects and hormone levels remain within the postmenopausal range. However, because there is still some systemic absorption of oestrogen it potentially may be associated with the same risks as other forms of HRT and so carries the same warnings. Patients should be told to report any unusual vaginal bleeding straight away as it could be a warning sign of cancer of the uterus.

### Healthcare professionals should routinely talk to postmenopausal women about their urogenital health

### Treatment should be started early before irrevocable atrophic changes have occurred

### Treatment needs to be continued to maintain the benefits

### Local oestrogen preparations are effective and patient preference will usually determine the treatment used

### Additional progestogen is not indicated when low dose local oestrogen is used.

---

**Abbreviated Prescribing Information**

**Vagifem® 10 micrograms vaginal tablets**

**Estradiol hemihydrate**

**Presentation**

Vaginal tablet containing estradiol hemihydrate equivalent to estradiol 10 micrograms. Each tablet is insert in a disposable applicator.

**Indication**

Treatment of vaginal atrophy due to oestrogen deficiency in postmenopausal women.

**Posology and Administration**

Administered intravaginally by use of an applicator. The applicator is inserted into the vagina until resistance is met (8-10 cm) and the tablet released by pressing the plunger. The applicator is then withdrawn and disposed of. Initial dose of 1 tablet daily for two weeks followed by maintenance dose of one tablet twice a week.

**Contra-indications**

Known, past or suspected breast cancer; known or suspected oestrogen-dependent malignant tumours; undiagnosed genital bleeding; venous thromboembolism (deep vein thrombosis (DVT) and pulmonary embolism); known thrombophilic disorders; acute or recent arterial or cerebrovascular disease; severe liver disease; recent history of liver disease as long as liver function tests have failed to return to normal; hypertension; hypercholesterolaemia; allergy to any component of the product; pregnancy or breast feeding; known or suspected bilateral tubal factor; known or suspected breast cancer.

**Precautions**

HRT should only be initiated for symptoms that adversely affect quality of life. Take personal and family medical history before initiation or reinstitution of therapy. Periodic checks are recommended. Physical examination and investigations including appropriate imaging tools should be carried out based on clinical needs of individual. Patients should be closely supervised if the following conditions are present, have previously occurred or have been aggravated during pregnancy or taking Hormone Replacement Therapy (HRT): leukaemia or endometriosis; risk factors for thromboembolic disorders; risk factors for oestrogen-dependent tumours; hypertension; liver disorders; diabetes mellitus with or without vascular involvement; cholelithiasis; migraines, possible conversion to or development of a history of endometrial hyperplasia; epilepsy; asthma and ototoxicosis. These conditions may recur or be aggravated during oestrogen treatment however due to very low absorption of estradiol during treatment with Vagifem® the recurrence or aggravation of the conditions is less likely than with systemic oestrogen treatment. Discontinue if contraindication discovered or if the following occurs: paradoxical or deterioration in lower function, significant increase in blood pressure, new onset of migraine-type headache; pregnancy. Women with an intact uterus with abnormal internal or unknown endometrial disease, who are previously treated with unopposed oestrogens should be examined to exclude hyperstimulation/malignancy of endometrium before treatment initiation. A minor degree of systemic absorption may occur especially during the first two weeks of treatment with Vagifem®, an evaluation showed average plasma E2 concentrations remained within normal postmenopausal range. For repeated use treatment should have reviewed at least annually taking into account symptoms of endometrial hyperplasia/carcinoma. In women with an intact uterus, progesterogen treatment is not necessary. Characteristics: Section 4.4 in relation to endometrial hyperplasia and carcinoma. Vagifem® may be used in women with or without an intact uterus. Physical/cytopathological examination should be done if treatment is extended beyond one year. Bleeding or spotting appearing at any time on therapy should be investigated. Caution is advised in using this product in women who have undergone hysterectomy because of endometriosis as unopposed oestrogen may lead to premalignant or malignant transformation in the residual foc of endometriosis. Evidence suggests an increased risk of breast cancer in women taking combined oestrogen-progestogen and possibly oestrogen-only HRT that is dependent on the duration of taking HRT. HRT increases the density of mammographic images which may adversely affect the radiological detection of breast cancer. Long term (at least 5-10 years) use of oestrogens only HRT products has been associated with a slightly increased risk of ovarian cancer. HRT is associated with a 1.3-3 fold risk of developing venous thromboembolism (VTE) especially in the first year of use. Risk factors for VTE include use of oestrogens, older age, major surgery, prolonged immobilisation, obesity, pregnancy/postpartum period, systemic lupus erythematosus and personal/family history related to VTE/thromboembolic defects. Consider temporarily stopping HRT four to six weeks prior to surgery and prolonged immobilisation. Women should be totally mobilised. Carefully consider benefit-risk of use of HRT in women on anticoagulant treatment. Discontinue HRT if VTE develops during treatment. Patients should contact the doctor immediately if they become aware of a potential thromboembolic symptom. A relationship between breast cancer risk, ovarian cancer risk and VTE with low dose local vaginal oestrogen use is uncertain. No evidence of protection from HRT against myocardial infarction. Data shows no increased risk of coronary artery disease in hysterectomised women using oestrogen-only therapy. Combined oestrogen-progestogen and oestrogen-only therapy is associated with up to a 1.5 fold risk increased risk of ischaemic stroke. The overall risk of stroke in women who use HRT increases with age. A relationship between breast cancer risk, ovarian cancer risk, ischaemic stroke and VTE with low dose local vaginal oestrogen is uncertain. Oestrogens may cause fluid retention, monitor patients with cardiac or renal dysfunction. Women with pre-existing hyperlipidaemia should be followed closely during oestrogen replacement or HRT due to the link with pancreatitis in rare cases of high levels of plasma triglycerides. Symptoms may include severe headache including thyroid, cortical and sex-hormone-binding globulin leading to increased circulating corticosteroids and sex steroid. The effect of estradiol on plasma binding proteins is likely to be less with local vaginal oestrogen compared to systemic administration. HRT does not improve cognitive function. There is some evidence to demonstrate that there is an increased risk of probable dementia in women who start using continuous combined or oestrogen-only HRT after the age of 65.

**References:**

2. Sturdee DW and Faruq IA on behalf of the International Menopause Society Writing Group Climacteric. 2010 DOI: 10.3109/13697137.2010.522875
8. Vagifem® 10 μg Summary of Product Characteristics
A little goes a long way

- Lowest effective dose* available²,³
- Significant long-term improvement in vaginal health¹
- Precise dose,³ locally administered,³ locally effective¹

Abbreviated Prescribing Information
Vagifem® 10 micrograms Vaginal Tablets. Refer to the Summary of Product Characteristics before prescribing. Qualitative and quantitative composition: Each tablet contains estradiol hemihydrate equivalent to 10 micrograms of estradiol. Therapeutic indication: Treatment of vaginal atrophy due to oestrogen deficiency in postmenopausal women. Contraindications: Known, past or suspected breast cancer, known, past or suspected oestrogen dependent malignant tumours (e.g. endometrial cancer), undiagnosed genital bleeding, untreated endometrial hyperplasia, previous or current venous thromboembolism (deep venous thrombosis, pulmonary embolism), known thrombophilic disorders (e.g. protein C, protein S, or antithrombin deficiency), active or recent arterial thromboembolic disease (e.g. angina, myocardial infarction), acute liver disease, or a history of liver disease as long as liver function tests have failed to return to normal, known hypersensitivity to the active substances or to any of the excipients, porphyria. Special warnings: The dose of 17β-estradiol is very low and the treatment is local; however, minimal absorption may be seen, especially during the first two weeks of treatment. Pregnancy and lactation: Vagifem® 10 micrograms is not indicated during pregnancy and lactation. Dosage and administration: Vagifem® 10 micrograms is administered into the vagina, using the applicator. Initial dose: One vaginal tablet a day for two weeks. Maintenance dose: One vaginal tablet twice a week. Treatment may be started on any convenient day. Side effects: The most commonly reported adverse events are headache, abdominal pain, vaginal haemorrhage, vaginal discharge or vaginal discomfort. Legal category: Only available on prescription. For further information please contact Novo Nordisk FemCare AG, Thurgauerstrasse 36/38, CH-8050 Zurich, Switzerland or the local Novo Nordisk subsidiary. Vagifem® is a registered trademark of Novo Nordisk FemCare AG.

Date of preparation: September 2012.

Reference:

* of local 17β-estradiol

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ID 4536, November 2012

Vagifem® 10µg – ultra low dose for vaginal atrophy¹

Effective.¹ Convenient.⁴ Clean.⁵
The role of the practice nurse in managing psoriasis in primary care

**DR DAVID BUCKLEY, MRCGP, DP DERMATOLOGY, MD, SOLAS DERMATOLOGY & LASER CLINIC, THE ASHE STREET CLINIC, TRALEE, CO KERRY**

Psoriasis is a chronic, common skin condition affecting about 3% of the Irish population. It can occur at any age and both sexes are affected equally. Approximately 50% of patients will have a first-degree relative with psoriasis, which shows that there is a strong hereditary component. There are certain well-known triggering factors, including hormones, infection, drugs, alcohol and stress. It is probably more common that the psoriasis causes stress rather than vice versa.

The practice nurse has an important role in managing this chronic disease as patients need explanations, reassurance and education on how to manage the disease.

It has been more recently recognised that psoriasis can be linked to increased incidence of cardiovascular disease, with strokes and peripheral vascular disease being more common in patients with psoriasis. Psoriasis patients also have a higher incidence of hypertension, hyperlipidemia, central obesity, liver disease and type II diabetes. Adult patients with psoriasis should be screened for these conditions and strongly encouraged not to smoke and to keep alcohol consumption to a minimum.

**Psoriatic arthritis**

Psoriatic arthritis can occur in up to 5% of patients with psoriasis, although some patients with quiet severe psoriatic arthritis might only have mild skin manifestations of the disease. Conversely patients with severe psoriasis may have no psoriatic arthritis.

Psoriasis is a T-cell mediated disease in which the epidermis renews itself up to six times faster than normal in the affected areas, resulting in thickening and red scaling of the skin. Psoriasis may appear in traumatised skin such as a cut or burn – this is known as the Koebner phenomenon.

Nail changes are found in up to 60% of patients with psoriasis, which can often help in clinching the diagnosis in unusual cases. Pitting and onycholysis (lifting of the nail from the nail bed) are the most common nail changes. Sometimes nails can be thickened, discoloured or may fall off as a result of psoriasis. It can be difficult and sometimes almost impossible to differentiate between nail psoriasis and fungal nail infection. Sending nail clipping for fungal stain and culture may be the only way to make the diagnosis. Some patients can have psoriasis infecting the nails with little or no skin involvement. Apart from systemic therapies, there is no effective treatment for nail psoriasis.

There are various clinical types of psoriasis, the most common being chronic plaque psoriasis, small plaque psoriasis, guttate psoriasis and flexural psoriasis.

**Guttate psoriasis**

Guttate usually presents in young adults and may be precipitated by a streptococcal sore throat. Small plaques of psoriasis can be distributed all over the body but mainly along the trunk and upper arms. Gutta is the Latin word for teardrop, and this type of psoriasis looks like a shower of red scaly teardrops that have fallen down on the body. The rash can develop quite quickly over a couple of days but usually clears spontaneously after 6 or 12 weeks.

Treatment is usually with emollients or a 10% tar and 10% urea cream, which can be applied all over the affected areas twice a day. More severe protracted cases usually respond well to Dovobet or phototherapy.

Psoriatic arthritis can occur in up to 5% of patients with psoriasis, although some patients with quiet severe psoriatic arthritis might only have mild skin manifestations of the disease.
**Chronic plaque psoriasis**

Chronic plaque usually causes large red scaly plaques on the elbows and knees. Plaques are also commonly found on the lower back and the scalp. However, any part of the body can be affected including the face. Small plaque psoriasis causes a similar rash but as the name implies the plaques are smaller usually measuring only 2 – 4 cm in diameter. Many patients have learned to live with plaque psoriasis, particularly when it is localised to the elbows and knees and they can manage with simple emollients and clothing that will cover up the affected area. Younger patients and women might find it harder to live with this type of psoriasis and often require treatment (see Table 1).

Calcipotriol (Dovonex) is a vitamin D analogue and is often used as a first line treatment for more troublesome plaque psoriasis. However because of its slow onset of action, Calcipotriol is often combined with a potent topical steroid such as betamethasone (Dovobet) resulting in a much more rapid response, which encourages the patient to continue the treatment. It can take up to 6 or 12 weeks to clear psoriasis. Because the Dovobet contains a potent steroid it cannot be used on the face or flexures and is not licensed for children and teenagers under the age of 18. It is also best not to use it long term because of the risks of skin atrophy and systemic absorption. Most patients find that by using Dovobet once daily to the affected areas on the body for one month, it will give approximately 50% improvement in the appearance of the rash. Patients should then be weaned off Dovobet in the second month by using it only on Saturdays and Sundays and using Dovonex once daily on the other five days of the week. In the third month, Dovobet should be stopped completely and the patient should use Dovonex on its own seven days a week until the psoriasis clears. The ointment preparation is considered more potent but also more messy than the jel formulation. The maximum weekly dose of Dovonex is 100g/week in adults and it should not be used on more than 30% of the body surface area.

In children, Dovonex can be used in the mornings and Eumovate ointment applied at night to the rash on the body for the first month. The child should then be weaned off the Eumovate over the next month or two.

Although expensive, Dovonex is safe when used correctly, is convenient, clean and non-smelly for the patient, and can help clear psoriasis in 60% – 70% of patients with chronic stable plaque psoriasis and small plaque psoriasis. However, it does not work for all patients.

Dithranol has been on the market for almost two hundred years, and is known to have an anti-inflammatory and anti-proliferative effect for home use. Dithranol is best used as Dithrocrem, which comes in various strengths, from 0.1% up to 2%. This can be safely applied to plaques of psoriasis on the body and scalp once daily for 30 minutes, and then washed off. Patients are usually instructed to increase the strength of the Dithrocrem once weekly until they reach the high strength after five weeks (2%). Patients have to be careful to apply Dithranol only to the affected areas, as it will cause burning of uninvolved skin, particularly when the patient goes up to stronger strengths. Dithranol also causes temporary brown staining of the skin, and therefore is unsuitable for the face. The staining usually fades after a week or two once Dithranol is stopped. As Dithranol contains no steroid, it is safe (even weekly) in children. It can clear psoriasis in approximately 80% of patients, when used correctly, and it can result in long remission times. However, because it causes staining and takes longer for the patient to apply, it is usually reserved for second-line treatment.

Coal tar preparations can also be effective in psoriasis although they can be messy to use and smelly. Coal tar 10% is often combined with urea 10% and this ointment can be applied rubbing downwards twice a day to help clear psoriasis. Coal tar is often used in combination with other treatments, such as Calcipotriol (Dovonex, Dovobet) or dithranol. Tar is often used in combination with salicylic acid to descale the scalp (e.g. Cocois). Patients with more severe, extensive or resistant psoriasis or psoriatic arthritis should be referred on...
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Psoriasis on the face or flexures usually presents with more erythema and itch and less scale.

for hospital treatments, such as phototherapy or systemic therapies such as methotrexate, fumaric acid esters, or the new biological therapies such as Humira.

Face and flexures
Psoriasis on the face or flexures usually presents with more erythema and itch and less scale. Calcipotriol, potent steroids and Dithranol cannot be used on these areas but because the skin is thinner and less scaly often 1% hydrocortisone can help. An anti-yeast agent is often combined with 1% hydrocortisone for the face and flexures, which can give a more long-lasting clearance (e.g. Daktacort, Canesten HC). For more severe psoriasis affecting the face or flexures, tacrolimus (Protopic) can often be effective. Although not licensed for psoriasis, it is safe to use on these areas, usually twice a day for three weeks and once or twice a week thereafter until the psoriasis clears. Patients should be warned that it can cause a transient erythema, a slight burning of the skin in the first week which usually settles in the second and subsequent weeks. The weaker strength (0.03%) should be used in children from the age of 2 to 12 years of age, and the stronger strength (0.1%) should be used in adults.

The scalp
Scalp psoriasis can often cause itch and heavy flaking. Dark coloured clothes should be avoided as these make the scales shed more obvious. Although the hair can camouflage the psoriasis, it can also make the application of treatments more difficult. Thick plaques can be dislodged by using a tar and salicylic acid combination (e.g. Cocois) for the first week or two before using more targeted treatments such as calcipotriol combined with a potent topical steroid (Dovobet gel) or Dithranol. Dovobet Gel, which is a combination of calcipotriol and betamethasone, should only be used overnight and washed out in the morning. After a week or two it can usually be reduced to 2 or 3 times a week. Scalp psoriasis often co-exists with seborrhoeic dermatitis, so an anti-fungal shampoo such as ketoconazole (Nizoral) or Ciclopiroxolamine (Stieprox shampoo) should be used once or twice a week on a regular basis.

Summary
While psoriasis is rarely life threatening, it can cause a lot of distress, particularly in younger patients with more extensive disease. Fortunately the vast majority of patients with psoriasis can be managed in primary care and the practice nurse has an important role in managing this chronic disease.

References on request.
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Appropriate doses of the β2-agonist and inhaled corticosteroid (ICS) in separate inhalers, or the ICS alone, should be prescribed if a patient requires doses outside the recommended dose regimens. Patients should be assured of the efficacy and safety of the combination product. Treatment should be reviewed and stepped down to the lowest effective dose, or an ICS alone. It is extremely important to regularly assess patients with asthma and once asthma is controlled, treatment should be reviewed and stepped down to the lowest effective dose, or an ICS alone. It is extremely important to regularly review patients as their treatment is stepped down. ICS alone are first-line treatment for most patients. Flutiform® is not intended for initial treatment of mild asthma. For patients with severe asthma the ICS therapy should be established before prescribing a fixed-dose combination product. Patients on flutiform must not use the additional LABA. An inhaled SABA should be taken for immediate relief of asthma symptoms arising between doses. The Flutiform Plus® spacer device is recommended in patients who find it difficult to use inhalers; re-titration should always follow the introduction of a spacer device. Patients should be advised to contact their pharmacist if the dose of the ICS is getting near zero. Caution indications: Hyperresponsivity to any of the active substances or excipients. Precautions and warnings: Flutiform should not be used for the first treatment of asthma, to treat acute asthma symptoms or for prophylaxis of exercise-induced asthma. It should not be initiated during an exacerbation, during significantly worsening or acutely deteriorating asthma, and should not be stopped abruptly. Patients should be advised that flutiform maintenance treatment as prescribed, even when asymptomatic. If a patient experiences serious asthma-related adverse events or exacerbations, they should continue treatment but also seek medical advice. Patients should be reviewed as soon as possible if there is any indication of deteriorating asthma control. In the case of sudden and progressive deterioration, which is potentially life-threatening, urgent medical assessment should be carried out. Use with caution in patients with pulmonary tuberculosis, quasi-tuberculous; fungal, viral or other infections of the airways: thymic; phaeohyphomycosis, diabetes mellitus (consider additional blood sugar controls); uncontrolled hypothyroidism; predisposition to low levels of serum potassium; impaired adrenal function (monitor HPA axis function regularly); Hypertrophic obstructive cardiomyopathy; idiopathic subvalvular aortic stenosis; severe hypertension; aneurysm or other severe cardiovascular disorders. There is risk of potentially serious hypokalaemia with high doses of β₂-agonists or concurrent treatment with β₂ agonists, and drugs that can induce or potentiate a hypokalaemic effect. Particular caution is recommended in unstable or acute severe asthma and other conditions when the likelihood for hypokalaemia adverse effects is increased. Monitoring of serum potassium levels is recommended during these circumstances. Flutiform may induce prolongation of the QT interval. Caution should be observed when treating patients with existing prolongation of the QT interval. Flutiform should be discontinued immediately if there is evidence of paroxysmal bradycardia. Symptomatic effects with an ICS may occur, particularly at high doses for prolonged periods or when combined with potent CYP3A4 inhibitors, but are less likely than with oral corticosteroids. Use of a spacer device may also cause an increased systemic exposure. Increased exposure can be expected in patients with severe hepatic impairment. Prolonged treatment with high doses of corticosteroids may result in adrenal suppression and acute adrenal crisis, particularly in adolescents and children or potentially as a result of trauma, surgery, infection or rapid dose reduction. Patients should be advised that flutiform contains a small amount of salbutamol, however this negligible amount does not pose a risk to patients. Flutiform is not recommended in children under 12 years of age. Concomitant use of ß-adrenergic drugs can have a potentially additive effect. Extreme caution should be taken when using flutiform with drugs known to prolong the QT interval, such as tricyclic antidepressants or MAOIs (and for two weeks following their discontinuation), as well as antiarrhythmics (including phenothiazines), quinidine, diclofenac, procainamide and antiarrhythmics. Concomitant use of an MAO or a similar agent, such as haloperidol or procarbazine, may precipitate hypertensive reactions. β-blockers and formoterol may inhibit the effect of each other. β-blockers may produce severe bronchospasm in asthmatic patients, and they should not normally be treated with β-blockers including those that are used as eye drops to treat glaucoma. Under certain circumstances, e.g. asphyxiation after myocardial infarction, cardiovascular β-blockers could be considered with caution.

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Date of preparation: January 2013

Reference:
1. Flutiform Study of Product Characteristics

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Neurological and psychiatric: drowsiness; headache; nervousness; anxiety; insomnia; depression; panic attacks; agitation; tremor; myoclonus; dystonia; convulsions; psychoses; paresthesias; parkinsonism; cerebellar ataxia; clonus; tics; paraesthesia; psychoses; mania; delirium; irritability; emotional lability; hostility; hallucinations; increased blood pressure; angioedema; pancytopenia; aplastic anaemia; aplasia.

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The NEW asthma maintenance treatment

Modern aerosol device with a patient-facing dose counter
Insulin initiation in the community

HELENA FARRELL RGN, MSC DIABETES, BLACKROCK HALL PRIMARY CARE CENTRE, CORK, DIRECTOR OF HELENA FARRELL CONSULTANCY

Type 2 diabetes is a progressive condition, where beta cell function declines and fails, therefore requiring almost all individuals to be commenced on insulin therapy. There appears to be a very real clinical inertia within community care in relation to the initiation of insulin and GLP-1 hormones in the community. This appears to be dependent on a number of variables, most notably cost, efficacy and side-effects. Also access to specialist supports such as access to a diabetes specialist nurse and consultant care has to be considered. This is not just unique to Ireland, it is a worldwide phenomenon. As with most insulin initiation and GLP-1 hormone initiation in the community, it is primarily for individuals with type 2 diabetes, so this article will focus on that population.

Clinical inertia
Clinical Inertia is a widely recognized problem in diabetes management within primary care, directly linked to poor glycaemic control and elevated HbA1c levels (Ziemer et al, 2005). Lack of familiarity, education, training and overestimation of the care needed are all reasons cited by primary care physicians for not intensifying current treatment regimes or initiating insulin therapy (Philips et al, 2001). While non-adherence was cited as another contributory factor, this has been shown in many studies not to be as big an issue as clinical inertia (Reach, 2008, Giugliano et al, 2011). There is a general consensus amongst many primary care physicians that insulin therapy should only be commenced when absolutely necessary (Peyrot et al, 2005), despite the fact that there is evidence to
suggest that by achieving good glycaemic control early in the course of diabetes, that long term vascular outcomes improve and potentially prolong beta-cell function (Niswender et al, 2002).

Role of general practice
Traditionally insulin initiation in type 2 diabetes has usually been commenced within a specialist setting and/or in secondary care. Due to type 2 diabetes reaching epidemic proportions, which is putting huge strain on an already over stretched secondary care service, there is a growing need for physicians within primary care to take on the management of what may have traditionally been viewed as more complex patients with type 2 diabetes.

Targets for HbA1c levels are not being met despite more drug regimes being made available. Type 2 diabetes is a progressive condition and this was shown through the UK Prospective Diabetes Study, which saw that those with type 2 diabetes had only 50% of normal insulin secretion at diagnosis and after six years had only less than 25% (UKPDS, 1998). Therefore the only way to achieve good glycaemic control in many of these patients is through the initiation of insulin.

Patient education
There is no doubt that intensifying regimes and/or initiating insulin within the type 2 diabetes population requires a certain amount of support, confidence and knowledge, not just for the healthcare professional, but also the patient. The education that is involved is time consuming and intensive, which may be a barrier for both the healthcare professional and the individual concerned. A number of factors must be considered before commencing someone on insulin therapy or a GLP-1 hormone. Patient safety is an obvious primary concern with environmental and social factors also being taken into consideration. Do they live alone? Have they home support for e.g. home help, public health nurse etc. What is their health literacy like? What is their ability to understand and adhere to an insulin therapy regime?

One of the major barriers to insulin initiation is the individual’s own resistance or reluctance to commence insulin therapy. Many patients view commencing insulin therapy as a failure and subsequently there is a huge element of self-blame (Hunt et al, 1997). In one study, up to three quarters of participants viewed the initiation of insulin therapy as a ‘severe crisis’ in their condition (Ratzman, 1991). This may result in an individual go through the Five Stages of Grieving (Kubler-Ross, 2005). These are five emotional states of denial, depression, anger, bargaining and acceptance which an individual goes through not just when grieving for a loved one, but it is now well recognized that they also occur when grieving for a loss or their health or what they perceive as a worsening of their condition (Brown, 1985). Unless the healthcare professional acknowledges and understands these five stages and supports the individual, concerned this may lead to significant mental health issues such as depression, which may affect their adherence to an insulin regime (Kilbourne, 2005). There is a significant relationship between diabetes and depression, which may present another barrier to commencing insulin therapy (Robinson et al, 2008).

Side effects of insulin
The side effects of insulin can also be a barrier to both patients and healthcare professionals commencing any regime. Hypoglycaemia, weight gain and complications are very real concerns and should be discussed with any individual when commencing insulin therapy to allay any fears that could present a challenge to adhering to a regime. Other barriers to insulin initiation are concerns over restrictions to daily life that they suspect may arise when they are on insulin therapy, as well as an increase in the frequency of capillary blood glucose testing (Okazaki et al, 1999).

Needle phobia is another issue when commencing insulin therapy and its severity and prevalence can be underestimated amongst the healthcare profession. Up to 14% of people with diabetes can display some injection related anxiety, with up to 45% avoiding insulin injections (Zambanini et al, 1999). Needle phobia can be related to an underlying general anxiety disorder (GAD) which may need to be considered and addressed prior to commencing insulin therapy (Popkin et al, 1988). Education about proper injection technique is also paramount to prevent issues such as lipohypertrophy which can affect insulin absorption and therefore adversely affect glycaemic control (Young et al, 1984). Lipohypertrophy arises when a lump occurs under the skin due to an accumulation of fat from multiple insulin injections at that particular site (Rapini et al, 2007). Not changing needles and injecting at the same site repeatedly can contribute to the development of lipohypertrophy. The use of educational aids to assist an individual practising injection technique prior to the commencement of insulin therapy will ensure best practice, help allay any fears and allow for an open, honest discussion in relation to their overall diabetes management.

There is a real onus on healthcare providers to ensure that a patient fully understands the reasons why insulin therapy is being considered and the benefits to an individual’s health. Many people who have type 2 diabetes do not consider insulin therapy to be part of their management, only associating it with type 1 diabetes, and when the issue is raised with them, it can come as a huge shock. There is an opportunity when reviewing medication regimes or when educating an individual with type 2 diabetes on glycaemic control, to discuss their thoughts and perceptions, (known as health beliefs) in relation to insulin therapy, which effectively is facilitating and ‘sowing a seed’ towards self-efficacy and empowerment.

Conclusion
Insulin is a safe and effective way of achieving good glycaemic control in individuals with diabetes; unfortunately it is not initiated enough, used often enough or aggressively enough. The use of education when initiating insulin therapy within the community is essential in helping to increase self-efficacy in an individual with type 2 diabetes and also in coping with the
complexities of the regime. Insulin therapy should be viewed as a normal and routine part of diabetes management, rather than being used as a threat for when a patient does not adhere with certain aspects of their care. Education helps to break down barriers and dispel many of the myths that are associated with insulin therapy.

References

In one study, up to three quarters of participants viewed the initiation of insulin therapy as a ‘severe crisis’ in their condition.

About the author
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The indication is based on the demonstration of efficacy of Gardasil in females 16 to 45 years of age and in males 16 to 26 years of age and on the demonstration of immunogenicity of Gardasil in 9- to 15-year-old children and adolescents. Dosage and administration: The primary vaccination series consists of 3 separate 0.5 millilitre doses administered according to the following schedule: 0, 2, 6 months. If an alternate schedule is necessary the second dose should be administered at least one month after the first and the third dose at least three months after the second. All three doses should be given within a 1 year period. The need for a booster dose has not been established. The vaccine should be administered by intramuscular injection. Contraindications: Hypersensitivity to any component of the vaccine. Hypersensitivity to L1 capsid protein from certain animal species has also been described. 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However, the safety of the vaccine in pregnancy should be considered on an individual basis. The vaccine should be given during the first trimester of pregnancy. Gardasil® should be given with caution to individuals with thrombocytopenic purpura, Guillain-Barré Syndrome and hypersensitivity reactions including, anaphylactic/anaphylactoid reactions. There are no data to suggest that Gardasil® should be given to a breastfeeding woman. There is no evidence that the vaccine will cause harm to the newborn. Use of Gardasil during pregnancy therefore the vaccination should be postponed until after completion of the pregnancy. The vaccine can be given to breastfeeding women. Gardasil will only protect against diseases that are caused by HPV types 6, 11, 16 and 18 and to some limited extent against diseases caused by certain related HPV types. Vaccination is not a substitute for routine cervical screening. Individuals with impaired immune responsiveness, due to either the use of potent immunosuppressive therapy, a genetic defect, or other causes, may not respond to the vaccine. As with any vaccine, vaccination with Gardasil may not result in protection in all vaccine recipients. There are no safety, immunogenicity or efficacy data to support interchangeability of Gardasil with other HPV vaccines. Undesirable effects: Common side effects include bruising and pruritus at the injection site, pyrexia, nausea, and pain in the extremity. Rarely urticaria and very rarely bronchospasm has been reported. Idiopathic thrombocytopenic purpura, Guillain-Barré Syndrome and hypersensitivity reactions including, anaphylactic/anaphylactoid reactions have also been reported. For a complete list of undesirable effects please refer to the Summary of Product Characteristics. Package quantities: Single pack containing one 0.5 millilitre dose pre-filled syringe with two separate needles. Marketing authorisation holder: Sanofi Pasteur MSD SNC, 8 rue Jonas Salk, F-69007 Lyon, France. Marketing authorisation number: EU/1/06/357/007 (pre-filled syringe with two separate needles). Legal category: POM. ®Registered trademark. Date of last review: Nov 2012. References: 1. Health Protection Surveillance Centre. http://www.hpcs.ihcpc.ie/pics/A-Z/Hepatitis/HPV/Factsheet/ Accessed August 2013. 2. Gardasil® Summary of Product Characteristics. 3. Kjaer SK et al. A pooled analysis of continued prophylactic efficacy of a quadrivalent human papillomavirus (types 6/11/16/18) vaccine against high-grade cervical and external genital lesions. Cancer Prev Res 2009;2(10):868-878. 4. The Future II Study Group. Prophylactic efficacy of a quadrivalent human papillomavirus (HPV) vaccine in women with virological evidence of HPV infection. J Infect Dis 2007; 196(10): 1438-4615. 5. Joura EA et al. Effect of the human papillomavirus (HPV) quadrivalent vaccine in a subgroup of women with cervical and vulvar disease: retrospective pooled analysis of trial data. BMJ 2012;344:e1401.

Information about adverse event reporting can be found at www.imb.ie. Adverse events and inadvertent vaccination during pregnancy should also be reported to Sanofi Pasteur MSD by calling 00 44 1628 785291.

Further information available upon request.
It’s probably safe to say that anyone who is not using social media by now is either afraid of it or doesn’t have the time for it.

While time is certainly an issue for many, a significant number of people remain intensely distrustful of social media. Worries about invasion of privacy, concern about personal security (particularly in relation to children) and fear of cyber-bullying are all valid reasons to steer clear.

Nurses face a whole host of additional risks if they are active on social media sites: professionalism, ensuring appropriate nurse/patient relationships, legal/moral/ethical issues, being seen to give medical advice and maintaining patient confidentiality are all issues that should be considered.

We are used to maintaining patient confidentiality in the ‘real’ world. It was drummed into us during our training and for the most part is, thankfully, normal practice in healthcare settings. Talking about patients in lifts, corridors or the car park instinctively feels wrong so our default habit is to avoid it at all costs. Customs and practices related to patient privacy in healthcare settings are pretty much set in stone now.

However, the pace of our migration to the online world has been supersonic, so customs and practices related to patient privacy in healthcare settings are pretty much set in stone now.

There have been some spectacular online breaches of confidentiality from healthcare providers all over the world. Some are so blatantly negligent they are difficult to credit. Others may have been unintentional but they are breaches of privacy nonetheless.

For example:
- Violations by healthcare professionals around the world have included, a physician asking a patient for a date, another who labelled a patient lazy and ignorant for attending hospital repeatedly for treatment of uncontrolled blood sugars, a medical student who filmed a chest drain being inserted into a patient whose face was clearly visible, the sharing of a picture of a patient’s medical record on a healthcare employee’s Facebook account, a nurse assistant who took and shared a picture of a quadriplegic patient after he had had a bowel movement, discussions with colleagues on Facebook about specific patients and the sharing of a photo of a stab victim who later died.

If you wouldn’t say it using a loudspeaker at the GPO, don’t post it online.
4) Be careful if taking team photos of you and your colleagues.

3) Most of the teenagers and adults sitting in your waiting room right now have a smartphone and children are likely to have Nintendos that have inbuilt cameras. Are they taking pictures of other patients? How would your practice deal with this if another patient complained?

2) Don’t rely on privacy settings to keep your online activity contained to a specific audience. In fact, from 11th November Google will show users’ names and photos (along with any ratings and comments they may have made on particular products in the past) in internet adverts; i.e. endorsing marketers’ products – unless they specifically opt out. Facebook is also currently changing its policies so that all users will be discoverable via their Graph Search – unless they specifically opt out. Always assume that anything you post online is visible to everyone, both now and in the future.

1) Texting and mailing counts as ‘online activity’. Technology

Are [patients in your waiting room] taking pictures of other patients? How would your practice deal with this if another patient complained?

5) Changing details (like a name or age) doesn’t guarantee confidentiality.

Resources:
There are a number of useful resources for nurses using social media. Here are some of the best ones.


The ICGP has numerous factsheets and guidelines on the use of social media, all relevant to both GPs and Practice Nurses. http://www.icgp.ie/go/in_the_practice/it_faqs

The Nursing and Midwifery Council (UK) has guidelines on applying their Code to social networking sites. http://www.nmc-uk.org/Nurses-and-midwives/Advice-by-topic/A/Advice/Social-networking-sites/

The American Nurses Association has an extensive Social Networking Principles Toolkit at http://www.nursingworld.org/socialnetworkingtoolkit.aspx


Nurse Together has a five minute YouTube clip entitled Social Media Guidelines for Nurses via www.nursetogether.com

We Nurses has a very useful set of links to guidelines for nurses using social media, via www.wenurses.co.uk

References and sources:
www.FierceHealthcare.com
www.medicalprotection.org

A breath of fresh air
COPDexchange.ie aims to encourage education and awareness of a condition which remains undiagnosed in many cases

JAMES FOGARTY

COPD will be the third biggest killer in Ireland by 2020, a meeting of GPs and practice nurses heard recently. Dr Bob Rutherford, Consultant Respiratory Physician at Galway University Hospital, made the comments at the launch of a new learning resource COPDexchange.ie.

The independent educational resource, launched by Boehringer Ingelheim, is aimed exclusively at Irish healthcare professionals (HCPs) caring for patients with COPD. HCPs can register for free on www.COPDexchange.ie for access to a suite of peer-reviewed materials designed to aid in the accurate diagnosis and effective management of one of Ireland’s leading causes of mortality. The website’s two educational modules are recognised for one CPD point each, which are awarded to HCPs on successful completion. The Irish Nursing Board also recognises www.COPDexchange.ie for category one approval.

All content on COPDexchange.ie is developed in line with the latest Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines, and a panel of respiratory experts hold editorial control to ensure that information provided is educational and independent.

Once registered, users have access to a suite of tools for HCPs including a smoking pack-years calculator, a downloadable Fletcher and Peto Chart and a COPD Assessment Test questionnaire.

The initiative follows the success of COPDexchange.co.uk, which provides similar resources for HCPs in the UK. Since going live in 2009, it has attracted more than 8,000 HCPs to register for continually updated educational content.

Diagnosis
“We have a major problem here, but there are plenty of opportunities to deal with it,” Dr Rutherford explained.

COPD is a debilitating disease in almost every sense, which impacts on every aspect of the patient’s life. The number of known patients runs into the hundreds of thousands, however, most disturbingly, half of patients are diagnosed with COPD only when they have developed severe or very severe symptoms.

After the age of 30, about 25ml to 30ml of lung capacity per year is lost naturally through ageing, but patients susceptible to COPD lose, on average, 60ml. However, while some can lose a lot less, others unfortunately lose up to 100ml per year.

“It is the third most common cause of acute admissions to hospitals. It is a massive problem. The average length of stay for a hospital admission is six days, the average stay for a COPD patient is nine days,” Dr Rutherford told the audience.

“Many have lost half of their lung function by the time they are diagnosed and about 50 to 75 per cent are not diagnosed at all.”

Clearly this is not an acceptable situation for patients or healthcare professionals. The risk factors of the disease are well known: smoking, occupational and chemical fumes, and indoor air pollutants. While the majority of patients develop the disease due to a tobacco habit, a minority develop COPD through exposure to occupational and chemical fumes, and indoor air pollutants.

Cessation
Dr Derek Forde, ICGP Clinical Lead in COPD, also told the meeting that while some patients will doubt whether they can quit after a lifetime of smoking, the importance of smoking cessation cannot be overestimated.

“It is never too late to stop,” he said. Dr Forde added that he uses the Fletcher Peto Curve as a tool to motivate patients to try smoking cessation.

“When you show smokers where they are heading, compared to where they will be if they stop smoking at 30 or 50, it is an eye-opener. A spirometer is useful in showing them their lung age. If a patient is 50 years of age and a smoker and you say ‘OK your lung age is 85’, they wake up and engage with you,” Dr Forde explains. “The basic fact is if you are not stopping smoking and you are susceptible to COPD, you are in big trouble.”

Dr Rutherford also emphasised the importance of smoking cessation.

“This is a very insidious condition and it is not until there is a 50 per cent reduction in capacity that all patients become symptomatic. Once you get to 30 per cent or 25 per cent you are at risk of dying. It is never too late to stop smoking. If you stop smoking at the age of 50, you will continue to lose lung function, but just at the normal rate. Even at the age of 70 it is still worth stopping; it is never too late to stop smoking.”

COPDexchange.ie provides free peer-reviewed resources, expert guidelines, and CPD accredited learning content, which both Dr Forde and Dr Rutherford helped to create.

However, they both agree that the continued lack of a national screening programme is a stumbling block for treatment.

“If there was not the current impasse between the Department of Health and the ICGP clinical programmes, a COPD screening programme would be the next phase,” said Dr Forde. “If we were screening, spirometry would be the most important test. It is objective if it is done properly, it is...
affordable and it is safe.” The average spirometer only costs about €2,500.

Dr Rutherford suggested that the next logical step after screening is the establishment of specialised units, similar to the cancer centres of excellence, which would provide all facets of COPD treatment under one roof.

“If you are going to screen for something, you have got to be able to do something about it,” he explained. “If we had a national screening programme, I think it would lead to better uniformity of treatment – everyone being tested on the same inhalers, being interpreted in the same way and perhaps being put on the same medications.”

One of the biggest concerns for doctors treating COPD patients is exacerbations, and Dr Rutherford adds that patients who experience a lot of exacerbations are on a steep downward curve.

“Each infection is another hit to the airway,” Dr Rutherford said. “Unfortunately, the worse your lung function, the more exacerbations you get, and each exacerbation is disastrous for that patient. For a start, there is an 8 to 9 per cent mortality rate for that particular admission, and 20 to 25 per cent are dead within one year. So it is significantly worse than a heart attack.”

Management
The strategies used in the management of COPD have changed in recent years, a move that Dr Forde welcomes.

“Up to recently, the main respiratory disease in primary care was asthma,” he explained. “Unfortunately many COPD patients followed an asthma-type management plan. This is not correct, as evidence has shown that steroids increase instances of respiratory infection and pneumonia. More and more evidence suggests stopping the use of steroids early in the treatment of COPD, which is totally different to your asthmatics.”

Dr Rutherford echoed this, saying that inhaled steroids should never be given on their own to COPD patients due to the high risk of pneumonia. However, Dr Rutherford went on to to describe the annual flu vaccine as a “critical intervention; protecting not only against flu, but also significantly reducing the rates of pneumonia. He added that elective pulmonary rehab, while not reducing exacerbations, might reduce length of hospital stay and may even reduce mortality. For patients who experience very frequent exacerbations, Dr Rutherford also recommends the use of azithromycin.

“In the 1980s and 1990s, Japanese patients developed a condition called panbronchiolitis and the mortality of this condition was 80 per cent. Somebody put them onto azithromycin and it changed the landscape for this condition,” he added. “The mortality fell to five to 10 per cent.”

He also said that the most positive study ever on reducing exacerbations centred on azithromycin and he uses it regularly. However, if the patient still exacerbates on azithromycin, Dr Rutherford said he would discontinue the drug and place the patient on the PDE-4 inhibitor roflumilast.

Dr Forde also pointed to the use of the updated GOLD guidelines issued this year. These guidelines help in the management of patients who are at varying levels of symptom severity, but may have the same spirometry reading. The guidelines also help identify patients earlier, heading off complications and exacerbations in the future.

Dr Forde also recommended the use of the CAT test and the modified Medical Research Council (MRC) dyspnoea scale as well as use of exercise.

“For me it is all about moving and exercise, even if you are house bound,” he said.

He added that given that there can be a number of co-morbidities with the more severe patients, drug compliance can be a problem.

“What makes COPD complicated is the overlap in symptoms,” he said. “In my practice with patients over 60, it is very rare that they will have only one disease. One condition is usually accompanied with others like diabetes, renal failure or heart failure.”

Practice Nurse, Ms Ruth Murrow, also discussed some of the other practicalities of running a COPD clinic.

“COPD has been historically perceived as difficult to manage with a poor prognosis as it is not as glamorous as asthma,” she added.

However, she said that COPD management in clinical practice is important and more emphasis should be placed on proper management to reduce exacerbations, hospitalisations, emergency department (ED) attendances and emergency GP visits.

Among the things a clinic can help with, she suggested, are an annual physical examination with a spirometry test, inhaler technique and, of course, smoking cessation.

Clinical Nurse Specialist at GUH, Ms Marie Byrnes also discussed the COPD outreach programmes available around the country. In those, active treatment is provided by healthcare professionals in the patient’s own home for an acute exacerbation of COPD (AECOPD), an event which would require hospital care otherwise.

Inhaled steroids should never be given on their own to COPD patients due to the high risk of pneumonia.

Her colleague, Ms Niamh Duignan, Senior Physiotherapist at Merlin Park, also discussed the importance of physiotherapy for COPD patients. She explained that, according to the UK’s standards authority, NICE, COPD patients with an MRC dyspnoea scale score of three to five benefit from pulmonary rehabilitation.

Ms Maria McNeill, Chief Respiratory Scientist, at the Midland Regional Hospital, Mullingar, also told the meeting that there would be great benefits from improving links between the hospital and primary care. She cited a study she was involved in where respiratory scientists performed spirometry in general practices. As well as being very popular with patients and GPs, the study also had the effect of reducing waiting lists and times.

While once the future looked bleak for COPD sufferers, the establishment of COPDexchange.ie and the mooted establishment of a screening programme means that this disease may finally get the attention it deserves.

“As we get more and more involved in chronic disease management,” said Dr Forde, “my view is that you are just not at the races unless you and your practice nurses are working as a team”.
Burden of illness and quality of life in patients being treated for seasonal allergic rhinitis: a cohort survey

Small M, Piercy J, Demoly P, Marsden H.

Allergic rhinitis is an inflammatory disease which is characterised by burdensome nasal and/or ocular symptoms. This study aimed to assess the impact of symptoms (number of symptom-free days (SFD) and quality of life (QoL)) in patients with seasonal allergic rhinitis (SAR) being treated with fluticasone furoate (FF), mometasone furoate (MF) or fluticasone propionate (FP).

In a cross-sectional, non-interventional, cohort analysis, primary care physicians and allergy specialists in France, Germany, and Spain were recruited via telephone interviews. Each physician prospectively recruited 4 SAR patients – 2 receiving FF, 1 receiving MF and 1 receiving FP – during June 2009. Patients answered questions on symptoms and completed questionnaires on QoL (mini-rhinoconjunctivitis Quality of Life Questionnaire, RQLQ) and burden of illness (Pittsburgh Sleep Quality Index). ClinicalTrials.gov identifier: NCT01199757.

A total of 540 patients were recruited during June 2009. 88 patients were subsequently found to be ineligible and excluded from the analyses. In the 4 weeks prior to assessment, patients reported a mean of 14.58 (+/-8.42) SFD. Patients receiving FF had more SFD (mean 15.45 +/-8.29) than patients receiving MF (adjusted mean difference – 1.22, 95% Confidence Interval (CI) [-3.16 to 0.72], p=0.434) or FP (adjusted mean difference – 1.95, 95% CI [-3.87 to – 0.03], p=0.092), although statistical significance was not achieved. The mean RQLQ score was 1.54 (+/-1.06). Patients receiving FF had a better quality of life in the previous week (mini-RQLQ score: mean 1.42, +/-1.04) than patients receiving MF (adjusted mean difference 0.28, 95% CI [0.03 to 0.52], p=0.052) or FP (adjusted mean difference 0.18, 95% CI [-0.05 to 0.41], p=0.244) Again, none of these results achieved statistical significance.

At the height of the allergy season, patients with SAR suffer symptoms approximately 50% of the time, and report an impact on their QoL. No significant differences were observed between FF, FP and MF related to SFD or QoL.

Investigation of poly (ADP-Ribose) polymerase-1 genetic variants as a possible risk for allergic rhinitis

Ozaydin A, Akbas F, Aksoy F et al

Department of Medical Biology, Cerrahpasa Faculty of Medicine, Istanbul University, Istanbul, Turkey.

Recent studies point toward the involvement of poly (ADP-ribose) polymerase-1 (PARP-1) in the pathogenesis of allergic airway inflammation, such as asthma and allergic rhinitis (AR). It has been suggested that inhibition of PARP-1 provides significant protection against systemic or tissue inflammation in animal models. The objective of this study was to investigate whether single-nucleotide polymorphisms of PARP-1 gene are associated with genetic susceptibility to AR. We studied the effect of promoter variations and Val762Ala polymorphism of the PARP-1 gene on the risk for developing AR in a case-control association study with 110 RA patients and 130 control subjects in a Turkish population. The polymorphisms of 410 C/T, – 1672G/A, and Val762Ala in the PARP-1 gene were analyzed using the polymerase chain reaction-restriction fragment length polymorphism method. Haplotype analysis of these groups was also performed. The results were statistically analyzed by calculating the odds ratio (OR) and their 95% confidence intervals using χ2 tests. The heterozygote genotype of the promoter polymorphism (-1672) was significantly found to be associated with susceptibility to AR (OR:0.56) among the tested single-nucleotide polymorphisms. Haplotypes of PARP-1 – 410, – 1672, and 762 were not associated with an increased risk for AR. These results raise the possibility that the promoter (-1672) polymorphism of the PARP-1 gene may be a risk factor for AR.
Because congestion can impact your patients with allergic rhinitis any time of year...

Nasal spray containing mometasone furoate (mometasone furoate) [Phenylethyl alcohol-free formulation] ADDED PRODUCT INFORMATION Refer to Summary of Product Characteristics before prescribing PRESENTATION: Nasal spray suspension containing mometasone furoate (as monohydrate) 50 micrograms per actuation. INDICATIONS: Adults and children aged 18 and over: Treatment of nasal polyps. Adults and children over the age of 12 years: For the treatment of the symptoms of seasonal allergic rhinitis or perennial allergic rhinitis. Children aged 6 to 17 years of age: for the treatment of the symptoms of seasonal allergic rhinitis in children over the age of 6 years. DISEASE AND ADMINISTRATION: Nasal Polyposis: Adults and children aged 18 and over: The usual recommended starting dose for polyposis is two actuations (100 micrograms) in each nostril once daily (total dose 200 micrograms). In children 6 to 17 years of age, polyposis is usually controlled, the dose may be increased to daily dose of two sprays in each nostril (total daily dose 400 micrograms). The dose should be reduced following control of symptoms. If no improvement in symptoms is seen after 5 to 14 days of twice daily administration, alternative therapies should be considered. Efficacy and safety studies of Nasonex Nasal Spray for the treatment of nasal polyposis were four months in duration. Seasonal or Perennial Allergic Rhinitis: Adults and children over the age of 12 years: The usual recommended starting dose for rhinitis is one spray (50 micrograms/spray) in each nostril once daily (total dose 100 micrograms). The dose may be increased to a daily dose of two sprays in each nostril (total dose 200 micrograms). Once symptoms are controlled, dose reduction to one spray in each nostril (total dose 100 micrograms) may be effective for maintenance. If symptoms are inadequately controlled, the dose may be increased to a maximum daily dose of four sprays in each nostril (total dose 400 micrograms). Dose reduction is recommended following control of symptoms. Children aged 6 to 17 years of age: the usual recommended starting dose for rhinitis is two actuations (100 micrograms) in each nostril once daily (total dose 200 micrograms). Clinically significant onset of action occurs within 24 hours. PRECAUTIONS AND WARNINGS: Treatment with higher than recommended doses may result in clinically significant adrenal suppression. If higher than recommended doses are being used, then additional systemic corticosteroid cover should be considered during control of symptoms is maintained. In addition, consideration should be given to referring patients to a paediatric endocrinologist to monitor growth. Treatment with nasal corticosteroids should be considered in children only if the nasal symptoms are severe. Consideration should be given to monitoring the height of children receiving prolonged treatment with nasal corticosteroids is regularly monitored. If growth is reduced, the dose of nasal corticosteroids should be reviewed with the aim of reducing the dose of nasal corticosteroid, if possible, to the lowest dose at which effective control of symptoms is maintained. In addition, consideration should be given to referring patients to a paediatric endocrinologist to monitor growth. Treatment with nasal corticosteroids should be considered in children only if the nasal symptoms are severe.

A clinical interaction study was conducted with loratadine. No interactions were observed. PREGNANCY AND LACTATION: Nasonex should only be used in pregnant women, nursing mothers or women of child-bearing age if the potential benefit justifies the potential risk to the mother, foetus or infant. SIDE EFFECTS: Adverse effects commonly reported in clinical trials in adult and adolescent patients include headache, epistaxis, pharyngitis, nasal burning, nasal irritation and nasolabial oedema. Other less common and rarely reported side effects are listed in the SPC. PACKAGE QUALITY: 18g per bottle, supplied with a metered-dose manual spray pump actuator which delivers 50 micrograms per actuation. Logo Category: Prescription Only Medicine. Marketing Authorisation Number: PA 1286/38/1. Marketing Authorisation Holder: Merck Sharp & Dohme Ireland Limited, Red Oak North, South County Business Park, Leopardstown, Dublin 18, Ireland. Date of Revision of Text: March 2013 Further information is available on request from: MSD, Red Oak North, South County Business Park, Leopardstown, Dublin 18. All rights reserved. Date of preparation: April 2013.

**Pocket hydration launched in Ireland**

O.R.S®, a soluble tablet form of the standard oral rehydration salts formula, is now available across Ireland. O.R.S is available in new great tasting blackcurrant, lemon and strawberry flavours. O.R.S is one of the fastest growing OTC brands in the UK. The success comes from the brand expanding a traditional medical market for the O.R.S formula by introducing a convenient, great tasting soluble tablet which delivers the right balance of electrolytes, glucose and minerals formulated to quickly restore optimum hydration in a highly portable solution. This is driving new markets in the UK and Ireland in travel, sports, wellbeing and health and beauty.

Sports people involved in intensive training and plenty of sweating, from rugby to Gaelic football and running to gym classes, will appreciate the easy to prepare soluble tablets in handy 12 and 24 tablet tube packs.

Available to order in Ireland from Pharmed with the Recommended Retail Price for the 24 pack are €8.99 and €5.99 for the 12 pack.

For more information on O.R.S® including details on why the formula is so effective at maintaining an optimum fluid balance go to: www.ors.uk.com.

**Flexiseq creates big buzz in Irish market**

The buzz surrounding Flexiseq has certainly made the Irish pharmacy community sit up and take notice – it is the biggest selling OTC product Ireland has seen in years, with 15,000 tubes being sold per week, the company said.

With Arthritis CEO John Church publically welcoming the “innovative” new pain-relieving gel when it launched here in June, the company said it is no wonder pharmacists have described Flexiseq as the big hit of the summer.

The drug-free “wonder gel” is being heralded as a godsend by an increasing number of Ireland’s 450,000-plus osteoarthritis sufferers – particularly those at risk from the common gastrointestinal and cardiovascular side effects associated with NSAIDs, such as celecoxib and diclofenac.

Eamonn Brady, owner of Whelehan’s Pharmacy in Mullingar, said: “What I like about it is that it’s not a drug but it works.

“To have a drug-free way of relieving joint pains from osteoarthritis is great because we have many patients who are on a lot of medication and can’t use conventional painkillers, but because it’s drug free they can use Flexiseq.

“It’s rare that you get something like that – when I recommend it to somebody I can feel confident that it should give them relief.”

The innovative, award-winning OA treatment from Pro Bono Bio relieves pain and restores joint mobility without posing any risk to the patient’s heart and stomach thanks to Sequessome Technology.

It’s on sale in most pharmacists in Ireland, retailing at around €22 a tube or €58 for a three-pack – though keeping it in stock has been the big challenge for many shops around the country, the company said.

**Pfizer launches Pfizer Paracetamol and Pfizer ParaExtra in Ireland**

Pfizer Consumer Healthcare is delighted to announce the introduction of a new range of analgesics to the Irish market. Leveraging the strength of Pfizer, two new products are set to appear on retail shelves over the coming weeks with the launch of Pfizer Paracetamol and Pfizer ParaExtra.

Developed following extensive consumer research, Pfizer Paracetamol replaces the company’s existing Paracetamol 500mg product with an exciting new packaging design. Adding to the quality appearance and feel of the product, the packaging is being upgraded to metpol board for a sleeker and more sophisticated look. A pharmacy only 24-pack is available as well as a 12-count pack.

Choice in the analgesics category will be broadened for consumers with the introduction of Pfizer ParaExtra, a paracetamol and caffeine based capsule which provides rapid relief from pain.

Consumer research revealed that two-thirds of respondents expressed a liking for the new Pfizer Paracetamol packaging. Significantly, a massive 80 per cent said that they would be likely to buy the product with over half of these being positively influenced by the Pfizer branding.

As well as looking well, the range will be attractively priced ensuring that in today’s value-led environment, consumer demand will be strong for the new range.

Commenting on the launch, a spokesperson for Pfizer Consumer Healthcare said that this launch was a global first for the company in the branding of OTC medicines. “We are delighted to be introducing this product under the Pfizer brand – a brand which is well recognised and respected in Ireland and synonymous with cutting-edge medicines,” he added.

Pfizer Consumer Healthcare reminds pharmacists that full product details are available from their local Pfizer Consumer representative and on www.medicines.ie.

**New 56 blister pack for Clonmel Healthcare Folic Acid 5mg Tablets**

Clonmel Healthcare would like to advise that Folic Acid 5mg Tablets are now available in blister packs of 56. These replace the previous packs of 250.

The formulation has also changed. The tablet is now around, yellow to orange yellow, speckled biplane tablet.

A GMS code for this new pack size has been available from November 1, 2013.

Full prescribing information for Folic Acid is available on request or go to www.clonmel-health.ie. This product is subject to medical prescription.

If you require any further information, please contact Clonmel Healthcare on 01 620 4000.
Actavis launch Ultraceck pregnancy test

Actavis Ireland is pleased to announce the launch of Ultraceck Pregnancy Test to the Irish market. The launch of Ultraceck not only adds to the extensive Actavis portfolio, but further strengthens the company’s over the counter offering, it said. Ultraceck is available in a single and double pack to all pharmacies in Ireland.

Tony Hynds, MD of Actavis Ireland said: “Actavis is delighted to introduce Ultraceck to the Irish market. With over 75,000 pregnancy test kits sold in pharmacy in the last 12 months, this launch represents an innovative addition to our growing OTC range and builds on our reputation of bringing choice and value to our customers.”

For further information on the Actavis OTC portfolio contact Actavis Ireland on 1890 33 32 31 or email on contact@actavis.ie.

Champix (varenicline) increases smoking cessation in subjects with depression – study

Results from a study recently published in The Annals of Internal Medicine reveals that patients with a past or present diagnosis of major depressive disorder treated with Champix were significantly more likely to quit smoking and maintain abstinence at the end of the treatment period than patients in the placebo group.

The study, "Effects of Varenicline on Smoking Cessation in Adults with Stable Treated Current or Past Major Depression", was a double-blind, placebo-controlled, randomised clinical trial designed to assess the efficacy and safety of Champix for smoking cessation in patients with a history of major depressive disorder (MDD) in the past two years or under current stable treatment. A total of 525 male and female motivated to quit smokers, aged 18-75 years, were treated for 12 weeks and followed for an additional 40 weeks. Patients had a current or past diagnosis of MDD without psychotic features and were either on stable antidepressant treatment or had a successfully treated episode of MDD in the past two years.

The study met both the primary and secondary efficacy endpoints. Patients treated with Champix for 12 weeks showed significantly higher abstinence rates compared to patients treated with placebo. Efficacy results in this study are consistent with other varenicline trials.

Commenting on the study, Dr Declan O’Callaghan, Medical Director Pfizer Healthcare Ireland said: “This study offers important information which contributes to a further understanding of the clinical profile of Champix. The results suggest that Champix may be a suitable smoking cessation treatment for smokers with stable currently treated or past major depression.”

Pfizer announces further Lipitor price reduction

Pfizer has announced a further price reduction to Lipitor (atorvastatin). Lipitor is now at the reference price across the dose range and most patients currently taking Lipitor can continue to do so at no increased cost. Lipitor is now priced at 15% of the original price making Ireland’s price among the lowest in the EU, and in fact the lowest on some strengths.

“Pfizer has decided to reduce the price of Lipitor to the reference price to ensure that we can fairly compete against other interchangeable atorvastatins,” said Mr John Molony, Director and Head of Established Products Business Unit, Pfizer Healthcare Ireland. “The price of Lipitor has been steadily reducing since patent expiry in 2012. This is good news for patients who pay for their medicines themselves and it is good news for the state who pay for medicines supplied to patients under the GMS and community drug schemes.”

New legislation came into effect earlier this year which allows pharmacists to substitute medicines that have been designated interchangeable by the Irish Medicines Board. Atorvastatin was deemed interchangeable in August 2013. In addition, the Department of Health and HSE have introduced a reference price; the amount the state will refund a pharmacist for a group of medicines that are interchangeable. If a patient’s medicine is at or below the reference price, they can continue to stay on their existing medicine at no increased cost. The reference price for atorvastatin has been set and comes into effect on November 1st 2013.

Mr Paul Reid, Managing Director, Pfizer Healthcare Ireland said “Pfizer supports competitive pharmaceutical markets and this legislation does not stipulate whether patients should receive a substitute medicine of any particular type, be it a brand or a generic, it stipulates that patients must be offered the medicine of lowest cost to the state or the patient and this applies to all patients.”

New treatment option for ADHD in children and adolescents as Shire launches Tyvense

Shire Pharmaceuticals Ireland Ltd has announced that its single-daily dose long-acting prodrug stimulant, Tyvense (lisdexamfetamine dimesylate), has been authorised by Irish Medicines Board for the treatment of ADHD in children aged six years and over when response to previous methylphenidate treatment is considered clinically inadequate.

Tyvense is the first stimulant prodrug to be launched in Europe for the treatment of ADHD. It provides a long duration of effect to help patients achieve control of their ADHD symptoms, said Shire. The prodrug is ingested in an inactive form and subsequently activated within the body, meaning that the active part of Tyvense is gradually released over time.

European guidelines recommend the use of ADHD medications that reduce the need for children to take medication through the course of the school day.

The most commonly prescribed medications for ADHD are stimulants. In Europe, the most frequently prescribed stimulant is methylphenidate. However, not all patients show a clinically adequate response to this treatment.
Ground-breaking innovation brings strip-free testing to people with diabetes

The latest technology in blood glucose monitoring, approved by the HSE, has been designed specifically for people with diabetes on insulin.

Roche’s latest innovation in blood glucose monitoring, the new Accu-Chek Mobile system, brings the latest technology for people with diabetes to Ireland. The new system features innovative strip-free testing which has the significant advantage of requiring no handling or disposal of strips, making testing easier and more convenient.

With its all-in-one design and simple ‘4 step’ testing process, patients can monitor their blood glucose whenever and wherever they are. The increased convenience and ease of use for blood glucose monitoring has been shown to improve patient adherence.

Effective blood glucose monitoring remains a challenge for many people with diabetes in Ireland. Poor blood glucose management increases the likelihood of long-term health complications such as cardiovascular disease, nephropathy and retinopathy.

The Health Service Executive (HSE) prioritises improvements in diabetes management in Ireland to bring about better patient outcomes. Despite a period of austerity, the HSE is allowing innovations with clear patient benefits such as the Accu-Chek Mobile blood glucose monitoring system to be listed on the General Medical Services Scheme (GMS). This provides substantial cost-savings for the HSE and a great opportunity for people with diabetes in Ireland to benefit from state-of-the-art technology.

Jackie McGrath, diabetes specialist nurse, Naas General Hospital commented on the new system:

‘I have had positive feedback from my patients who are using the new Accu-Chek Mobile system. A big advantage is the fact that there are no lancets or dirty strips to dispose of which makes it a good choice for people who are on the go.’

The Accu-Chek Mobile system features strip-free technology in the form of 50 tests on a continuous tape held on a cassette, meaning users no longer have to handle or dispose of single test strips. The system also provides six lancets in a drum with an integrated finger pricker, making the handling of single lancets obsolete. The new and advanced system also includes a PC-ready reports function. These reports offer a comprehensive overview of trends for both patients and caregivers to help them easily visualise and interpret blood glucose profiles. The new model also cuts handling steps by more than two thirds. Studies show the Accu-Chek Mobile system keeps readings accurate: 99.5% of the testing results were within strict accuracy limits.

The innovation of the new Accu-Chek Mobile system has been shown to reduce handling steps and therefore reduces the risk of infection. Studies show that a significant reduction in handling steps can lead to an increased likelihood of adherence.

The accuracy of the new Accu-Chek Mobile system has been shown to be more accurate than other systems on the market, reducing the risk of incorrect readings and the potential for error.

For more information on the Accu-Chek Mobile system please visit www.accu-chek.ie
Freephone Accu-Chek Careline: 1 800 709 600.
Congratulations to the winner of last month’s crossword, Colette Gibbons, c/o Dr P. Henaghan’s Surgery, Chapel Street, Louisburgh, Co Mayo.

Please send your answers to the Editor, Nursing in General Practice, GreenCross Publishing, 7 Leeson Street, Dublin 4.

Closing date for entries: 31 December 2013.

Winner will receive €50.

Please note: the winners’ cheques will be sent out within 45 days.

ACROSS
6 Untangle moss so I can enable the passage of fluid through a porous membrane (7)
7 Children’s respiratory problem in micro upsurge (5)
9 and 12 Down. She was barely recognisable on a horse! (4,6)
10 Pause can upset pot (8)
11 Hog enthusiastic about gnu? (4-2)
13 Dublin Area Rapid Transport, in short (4)
15 Burden placed upon ourselves? (4)
16 She ... ... a fever, and no-one could save her! (4,2)
18 Heavy ref diagnosed as having pollen allergy (3,5)
21 The 13 across runs through its capital (4)
22 Skin disease prevalent where bees live? (5)
23 The saw-bones patient? (7)

DOWN
1 Attempt a written composition! (5)
2 Just go by befuddled mugs (4,4)
3 Assists immune deficiency illness? (4)
4 Family, apple or Christmas (4)
5 Oh! Pears sound foreign for domestics (2,5)
8 Our ref riotously leads to public outburst (6)
12 See 9 across.
13 It requires guts to cause MOD undue difficulty (8)
14 Can a D.T.I. cure an upset tummy? (7)
17 Colour for putting on? Of course it is! (5)
19 24, 36 and 48 inches, for example! (4)
20 Access for an awkward pram? (4)

ANSWERS TO LAST ISSUE’S CROSSWORD
ACROSS: 6 Lanolin, 7 Limbo, 9 Echo, 10 Sculptor, 11 Tattoo, 13 Meet, 15 Bray, 16 Refuse, 18 Engaging, 21 Each, 22 Mummy, 23 Tonsils.
DOWN: 1 Match, 2 Coronary, 3 Miss, 4 Lisp, 5 Abdomen, 8 Cut off, 12 Tumip, 13 Masseuse, 14 Cranium, 17 Scalp, 19 Army, 20 Gaol.
Herceptin SC

Proven comparable efficacy and safety to IV. Herceptin

Simple, ready to use formulation, frees up clinic resources

ABRIDGED PRESCRIBING INFORMATION (Early & Metastatic Breast Cancer)

For the Full SmPC visit www.medicines.org.uk/SmPC

Survey of Summary of Product Characteristics [SmPC] HERCEPTIN® (trastuzumab)

Herceptin SC

HERCEPTIN (trastuzumab) 600mg/5ml solution for injection validated assay.

HER2 overexpression or HER2 gene amplification as determined by an accurate and validated HER2 testing mandatory prior to initiation. The administration of anastrozole did not appear to influence the pharmacokinetics during and for 7 months after last treatment. Cases of fatal renal growth and/or teratogenicity were demonstrated when combined with Herceptin. The PK of cisplatin was not affected by concurrent use of cisplatin plus Herceptin. However, higher mean AUC and individual and mean Herceptin trough serum concentrations varied within and across studies however no clear effect of the concomitant administration of other antineoplastic agents

During treatment and every 6 months following discontinuation of treatment for at least 1 year or until disease progression; whichever occurs first. Recommended dose is 600mg/5ml irrespective of the patient's body weight. No loading dose is required. Administration and should be administered via a SC injection only. Check product information for details. Neoadjuvant-adjuvant treatment is not recommended for Herceptin SC formulation from the pivotal trial in eBC was overall similar to the known safety profile of the IV formulation. Adverse events reported more frequently for the SC formulation. Serious adverse events which included post-operative wound infections, ARRs, hypertension. The following adverse reactions have been reported with Herceptin IV monotherapy or in combination with chemotherapy in trials and in the post-marketing setting:

All the benefits of Herceptin, now in a faster format