ABRIDGED PRESCRIBING INFORMATION ViATIM® Suspension and solution for injection in a prefilled dual chamber syringe. Hepatitis A (inactivated, adsorbed) and Typhoid polysaccharide vaccine. Refer to Summary of Product Characteristics for full product information before prescribing. Additional information is available upon request. Presentation: Suspension and solution for Injection in a prefilled dual chamber syringe. Available as a 1 millilitre single dose in a prefilled, dual-chamber syringe, containing 25 micrograms of Salmonella typhi (Ty2 strain) purified Vi capsule polysaccharide and 160 antigen units of inactivated hepatitis A virus. Indications: For simultaneous active immunisation against typhoid fever and hepatitis A virus in subjects from 16 years of age. Dosage and administration: A single 1 millilitre dose should be administered by slow intramuscular injection in the deltoid region. The two vaccine components should only be mixed immediately prior to injection. To provide long term protection against infection caused by the hepatitis A virus, a booster injection of inactivated hepatitis A vaccine should be given 6 to 36 months later. ViATIM® may 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 or to any of the excipients of ViATIM®. Known hypersensitivity to neomycin (present in trace amounts as a residual of the manufacturing process). Vaccination should be delayed in subjects with an acute severe febrile illness. Warnings and precautions: As with all vaccines, appropriate facilities and medicines should be readily available in case of anaphylaxis or hypersensitivity following injection. Immunogenicity of the vaccine may be impaired in immunosuppressed patients. The effect of ViATIM® on individuals in the incubation period of hepatitis A is not known. Concomitant administration with other inactivated vaccines at different injection sites is unlikely to interfere with the immune response. ViATIM® can be administered concurrently at a different site with yellow fever vaccine. Pregnancy and lactation: Data on a limited number of exposed pregnancies indicate no adverse effects of ViATIM® on pregnancy or on the health of the foetus/new born child. However, caution should be exercised when prescribing to pregnant women. As there are no data on the excretion of ViATIM® in human breast milk, caution should be exercised when prescribing to breast-feeding women. Undesirable effects: Common side effects include: injection site disorders (pain, induration, oedema, erythema), asthenia, headache, malaise, myalgia, nausea, diarrhoea, fever, and arthralgia. Very rarely, serious side effects have been reported and include anaphylactoid reactions, serum sickness and aggravation of asthma. For a complete list of undesirable effects please refer to the Summary of Product Characteristics. Package quantities: Single dose prefilled syringes in single packs. Marketing authorisation holder: Sanofi Pasteur MSD Limited, Block A, Second Floor, Cookstown Court, Old Belgard Road, Tallaght, Dublin 24. Marketing authorisation number: PA 544/37/1 Legal category: POM ® Registered Trademark Date of last review: January 2007

ViATIM® protects for up to 36 months against both hepatitis A and typhoid fever.1

Travel advice only goes so far...
Avoiding contaminated food and water is good advice. But it’s not always realistic.
une 20th and 21st, 2008 will see the IPNA jointly hosting the inaugural All-Ireland Community Nursing Conference in Croke Park with the Institute of Community Health Nursing (ICHN) and the Community Practitioners and Health Visitors Association (CPHVA) in Northern Ireland. This conference comes at an opportune time when community and primary care are currently undergoing major transformation of services with the development of primary care teams and the shift in emphasis in patient care from the acute hospital setting to the community. An impressive line up of presenters will provide delegates with a wide range of stimulating and thought provoking topics over the two days.

Day one of the conference will see Mary Harney TD and Minister for Health and Children delivering the opening address. The focus of this day will be on health policy, practice development and primary care team development from both the Irish and UK perspectives. The afternoon session will commence with a debate chaired by Dr John Bowman on how community nurses can deliver the best model of care. An evening workshop/seminar session on obesity and on women’s health will conclude day one.

Day two will provide delegates with a more clinical dimension. A number of concurrent sessions will be held on traveller health, child health, child protection, district nursing services, community intervention teams, advanced nurse practitioner roles in the community, diabetes, anti-coagulation, COPD, continence promotion and wound care. The day will conclude with presentations on alternative models of working, which will include the advent of independent advanced nurse practitioner roles in the community.

Community nursing in Ireland is currently undergoing similar changes in its healthcare system that the UK underwent a number of years ago. This is a unique opportunity for nurses working in all community settings to come together, network, share experiences and learn from each other from within Ireland and in the UK. For the IPNA, this has been a great opportunity to work with two other professional development organisations that have the same energy, drive and commitment to the development and improvement of nursing in the community to the betterment of patient care and service provision.

Ruth Taylor
# Contents

## Issue 3 Volume 1 | May/June 2008

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EDITORIAL</strong></td>
<td></td>
</tr>
<tr>
<td><strong>NEWS</strong></td>
<td></td>
</tr>
<tr>
<td>National news, NEC news and diary dates</td>
<td></td>
</tr>
<tr>
<td><strong>REGIONAL NEWS</strong></td>
<td></td>
</tr>
<tr>
<td>Round up of branch news</td>
<td></td>
</tr>
<tr>
<td><strong>CLINICAL REVIEWS</strong></td>
<td></td>
</tr>
<tr>
<td>- Osteoporosis</td>
<td></td>
</tr>
<tr>
<td>Professor Moira O’Brien</td>
<td></td>
</tr>
<tr>
<td>- Chronic kidney disease</td>
<td></td>
</tr>
<tr>
<td>Susan McKenna, Clinical Nurse Specialist</td>
<td></td>
</tr>
<tr>
<td>- Coronary heart disease</td>
<td></td>
</tr>
<tr>
<td>Lisa Browne, APN in Chest Pain</td>
<td></td>
</tr>
<tr>
<td><strong>NIGP INTERVIEW</strong></td>
<td></td>
</tr>
<tr>
<td>Practice nurse Margaret Scott on her recent success</td>
<td></td>
</tr>
<tr>
<td><strong>MEETING REPORT</strong></td>
<td></td>
</tr>
<tr>
<td>Psychological impact of teenage cancer</td>
<td></td>
</tr>
<tr>
<td><strong>ABSTRACTS</strong></td>
<td></td>
</tr>
<tr>
<td>Men’s health and psychiatry</td>
<td></td>
</tr>
<tr>
<td><strong>PRODUCT NEWS</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CROSSWORD</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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When they need a helping hand with faltering growth, give them the best product.

For babies with faltering growth, only INFATRINI® offers

- the highest energy per ml – 1 kcal/ml
- best % energy from protein – 10.4%
- optimal protein – 2.6 g/100 ml
- the lowest osmolality – 345 mOsm/kg H₂O

NEW: prebiotics - to support infant’s immune system

INFATRINI® is clinically effective in promoting catch-up growth.¹²

Regular use of SERETIDE prevents asthma symptoms, giving patients the opportunity to experience life to the full.¹-³

SERETIDE™ (salmeterol xinafoate and fluticasone propionate). Abridged prescribing information (see SPC for full prescribing information).

Precautions: Seretide Diskus – Each dose provides 50 mcg salmeterol xinafoate and 100 mcg, 250 mcg or 500 mcg respectively of fluticasone propionate. Therapeutic Indications: Seretide is indicated in the regular treatment of asthma where use of a combination (long-acting beta-2-agonist and inhaled corticosteroid) is appropriate. Seretide Diskus is indicated for the symptomatic treatment of patients with severe COPD (FEV₁ < 50 % predicted normal) and a history of repeated exacerbations, who have significant symptoms despite regular bronchodilator therapy. Dosage and administration: Adults and adolescents 12 years and over: Asthma: Seretide Diskus – one puff b.d. of Seretide 100 or Seretide 250 or Seretide 500 (each containing 50 mcg of salmeterol xinafoate and 100, 250 or 500 mcg respectively of fluticasone propionate). Seretide Evohaler – two puffs b.d. of Seretide 50 or Seretide 125 or Seretide 250 (each containing 25 mcg of salmeterol xinafoate and 50 mcg, 125 mcg or 250 mcg respectively of fluticasone propionate). A short term trial of Seretide may be considered as initial maintenance therapy in adults or adolescents with moderate persistent asthma for whom rapid control of asthma is essential. The recommended initial dose is one puff of Seretide 100 mcg Diskus or two puffs of Seretide 50 mcg Evohaler. Once control of asthma is attained treatment should be reviewed and consideration given as to whether patients should be stepped down to an inhaled corticosteroid alone. Regular review of patients as treatment is stepped down is important. In general inhaled corticosteroids remain the first line treatment for most patients. Seretide is not intended for the initial management of mild asthma. Lowest strength Seretide (50 Evohaler or 100 Diskus) is not appropriate in adults and children with severe asthma; it is recommended to establish the appropriate dosage of inhaled corticosteroid before any fixed combination can be used in patients with severe asthma. Children 4-11 years: Seretide 100 Diskus (50 mcg salmeterol and 100 mcg fluticasone propionate) – one puff b.d. of Seretide 100 (50 mcg salmeterol and 100 mcg fluticasone propionate). 50 mcg inhaled fluticasone propionate is appropriate in children with severe asthma. Seretide 500 Diskus (50 mcg salmeterol and 500 mcg fluticasone propionate) – one puff b.d. Contra-indications: Hypersensitivity. Warnings and Precautions: Seretide should not be used to treat acute asthma symptoms for which a fast- and short-acting bronchodilator is required. Patients should not be initiated on Seretide during an exacerbation. Serious asthma-related adverse events and exacerbations may occur during treatment with Seretide. Patients should be asked to continue treatment but to seek medical advice if asthma symptoms remain uncontrolled or worsen. Treatment with Seretide should not be stopped abruptly in patients with asthma due to risk of exacerbation. Therapy should be down-titrated under physician supervision. For patients with COPD cessation of therapy may also be associated with symptomatic decompensation and should be supervised by a physician. As with all inhaled medication containing corticosteroids, Seretide should be administered with caution in patients with pulmonary tuberculosis, severe cardiovascular disorders, including heart rhythm abnormalities, diabetes mellitus, uncorrected hypokalaemia, thyrotoxicosis or patients predisposed to low levels of serum potassium. Paradoxical bronchospasm Substitute alternative therapy. Systemic effects may occur with any inhaled corticosteroid, particularly at high doses prescribed for long periods, but are less likely than with oral steroids. (See SPC for further details on use of spacer devices). Prolonged treatment of patients with high doses of inhaled corticosteroids may result in adrenal suppression and acute adrenal crisis. It is important, therefore, for asthma patients that the dose of inhaled steroid is titrated to the lowest dose at which effective control is maintained. Monitor height of children on prolonged inhaled steroid therapy. Transfer from oral steroids. Special care needed. Monitor adrenal function. Do not stop abruptly. Consider appropriate steroid therapy in stressful situations. Drug Interactions: Avoid beta-blockers. Care with co-administering known strong CYP3A4 inhibitors (eg ketocanazole, ritonavir). Pregnancy and Lactation: Experience limited. Balance risks against benefits. Side effects: Hounsfield/aphonia, throat irritation, headache, candidiasis of mouth and throat and palpitations. See Flixotide™ and Serevent™ PA’s for other possible side effects. PA Holder: GlaxoSmithKline (Ireland) Limited Stonemasons Way, Rathfarnham, Dublin 14, Ireland Trading as Allen & Hanburys. PA Numbers: Seretide Diskus PA 1077/46/1-3 Seretide Evohaler PA 1077/46/4 Drug classification: SIA. Package quantities: Seretide Diskus is available in 60 dose Diskus. Seretide Evohaler is available in 120 inhalations Inhaler. Seretide, Flixotide, Serevent, Evohaler and Diskus are registered trademarks of the GlaxoSmithKline group of companies. ©2007 GlaxoSmithKline group of companies. All rights reserved. Date of Preparation of API January 2007. References: 1. Barnes ED et al Am J Resp Crit Care Med 2004; 170: 856-864. 2. Woodcock AA et al Prim Care Respir J 2007 in press. 3. Bateam ED et al Eur Respir J 2007; 29: 56-63. Further information available from: Allen & Hanburys Ltd., Stonemasons Way, Rathfarnham, Dublin.
NATIONAL NEWS   RITA LAWLOR

News from the PDC for practice nurses

The roll-out of the stand alone modules which have been developed in conjunction with DCU have proved a very popular educational option for practice nurses. CNE/NMPDU HSE South (SE) facilitated a very successful Diabetes Module through DCU recently. Similarly, the Cardiovascular Disease Module was delivered in Dublin. Well done to everyone who participated.

The third in a series of stand alone modules on long term conditions that have been developed for nurses in primary care will address ‘The Nursing Management of Persons with Respiratory Conditions’. This will commence in September (South East) and in October in Dublin/North East. Like the previous modules it is accredited at Level 8 of the National Qualifications Framework of Ireland (NQAI).

Update in midwifery skills for practice nurses

The need for this programme was originally highlighted by practice nurses through the national training needs assessment, which was conducted by the professional development co-ordinator for practice nurses. Many practice nurses are also registered midwives but may not have updated their midwifery skills in years. Therefore a two-day update programme has been developed in conjunction with the Centre for Midwifery Education, to equip practice nurses who are also registered midwives with the theoretical knowledge required to provide evidence based practice.

Four programmes will be held in July and August in the Coombe Women’s Hospital, Dublin and two programmes in September in the South East.

Childhood primary immunisation schedule

A series of information sessions for practice nurses, PHNs and community RGNs are being conducted nationally. They will address the forthcoming changes as recommended by the National Immunisation Advisory Committee (NIAC). A document entitled ‘A Practical Guide to Immunisations’ is also available from www.immunisations.ie

Injection technique workshops

Injection technique workshops are being held in May in Dublin, Waterford and New Ross. If you require further details on any the programmes outlined above, please contact your local PDC. As all funded programmes places are limited, booking is essential.

NEC NEWS   LISA NOLAN

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IPNA WEBSITE: www.ncnm.ie/ipna
The Tell Her Cervical Cancer Awareness Roadshow has just been launched on behalf of tellher.ie, a sanofi pasteur MSD initiative, and the All Ireland Cancer Foundation to encourage Irish women to learn more about cervical cancer - a disease that kills 73 women in Ireland each year. The Tell Her Roadshow unveiled by Rachel Kavanagh of Fair City fame, will run from May 17th – June 15th, 2008 to raise awareness of cervical cancer and ways to prevent it among women of all ages. Nurses will be available at information stands in major shopping centres in Dublin, Galway, Cork, Kerry, Athlone, Kildare and Limerick to answer questions and provide information on cervical cancer, human papillomavirus (HPV) and other diseases it causes.

In Ireland, an average of 209 women will be newly diagnosed with the disease this year, which is one of the highest rates of cervical cancer in Europe. Virtually all cervical cancer is caused by human papillomavirus (HPV), a virus that approximately 80 per cent of sexually active woman become infected with at some point in their lifetime. Fortunately, most infections clear naturally through the body’s own immune defences.

The Cervical Cancer Awareness Week will visit the following shopping centres:
- Saturday May 17th: Blanchardstown Shopping Centre, Dublin
- Sunday May 18th: Ilac Shopping Centre, Dublin
- Saturday May 24th: Liffey Valley Shopping Centre, Dublin
- Saturday May 31st: Mahon Point Shopping Centre, Cork
- Sunday June 1st: Arthur’s Quay Shopping Centre, Limerick
- Saturday June 7th: Eyre Square Shopping Centre, Galway
- Sunday June 8th: Athlone Town Centre, Athlone
- Saturday June 14th: White Water Shopping Centre, Kildare
- Sunday June 15th: Manor West Shopping Centre, Kerry

The Tell Her Cervical Cancer Roadshow is an initiative of sanofi pasteur MSD. Please visit www.tellher.ie for more information on cervical cancer and ways to prevent it.

World Asthma Day

Pictured at the launch for World Asthma Day, on the May 6th is Brent Pope, childhood asthma sufferer, who explains the ins and outs of asthma awareness to a model. World Asthma Day and the Asthma Society of Ireland highlighted the impact that the environment can have on asthma. For more information check www.asthmasociety.ie
Prescribing information:

Malarone 250mg/100mg Tablets Trade name: Malarone 250mg/100mg Film-coated Tablets.

Quantity of active ingredient(s) per unit dose. Each tablet contains 250mg of Atovaquone and 100mg of Proguanil hydrochloride.

Indications
Malarone is a fixed dose combination of atovaquone and proguanil hydrochloride which is indicated for the prophylaxis (in adults) of Plasmodium falciparum malaria and for the treatment (in adults and children) of acute, uncomplicated Plasmodium falciparum malaria (see SPC for full details).

Posology and Administration
Prophylaxis:
- One Malarone tablet daily. Prophylaxis should commence 24 or 48 hours prior to entering a malaria-endemic area, continue during the period of the stay, which should not exceed 28 days, and also continue for 7 days after leaving the area. In residents (semi-immune subjects) of endemic areas, the safety and effectiveness of Malarone has been established in studies of up to 12 weeks. Malarone tablets are not recommended for malaria prophylaxis in persons under 40kg bodyweight.

Treatment (Adults):
- Four Malarone tablets as a single dose for three consecutive days.

Treatment (Children):
- 11-20kg bodyweight - one tablet daily for three consecutive days;
- 21-30kg bodyweight - two tablets as a single dose for three consecutive days;
- 31-40kg bodyweight - three tablets as a single dose for three consecutive days;
- >40kg bodyweight - dose as for adults. The daily dose should be taken with food or a milky drink at the same time each day.

Contraindications:
Known hypersensitivity to atovaquone or proguanil hydrochloride or any component of the formulation. Prophylaxis of P. falciparum malaria in patients with severe renal impairment (creatinine clearance <30mL/min). Precautions and warnings: Persons taking Malarone for prophylaxis or treatment of malaria should take a repeat dose if they vomit within 1 hour of dosing (see SPC for full details).

Side effects (undesirable effects):
Adverse events are generally mild and of limited duration but include: anaemia, neutropenia, anorexia, hyponatraemia, abdominal pain, nausea, vomiting, diarrhoea, gastric intolerance, oral ulceration, stomatitis, elevated liver enzyme levels, cough, headache, insomnia, dizziness, fever, hair loss and allergic reactions, including: rash, urticaria, angioedema and isolated reports of anaphylaxis (See SPC for full details).

Legal category: POM Product Licence Number: PA 1077/111/1 Marketing Authorisation Holder: GlaxoSmithKline (Ireland) Limited, Stonemasons way, Rathfarnham Dublin 16 Further information is available from: GlaxoSmithKline (Ireland) Limited, Stonemasons way, Rathfarnham Dublin 16 Tel: 01 495 5000 Fax: 01 495 5225 Date of preparation: December 2005

References

04/08/Malarone1449
Croí, the West of Ireland Cardiology Foundation, supported by Pfizer Healthcare Ireland, recently hosted its second annual nurse symposium ‘Cardiovascular Disease: Promoting Excellence in Practice’ in the Radisson SAS Hotel Galway. The conference, which was attended by over 170 practices nurses from throughout Ireland, discussed the most up-to-date research on aspects of cardiovascular disease relevant to everyday clinical practice and provided a forum for discussion on current issues in cardiovascular disease management.

The conference was opened by holistic therapist Karen Ward (former RTE Health Squad presenter), who presented an overview of holistic therapies in heart disease. This was followed by a presentation from Dr Marcia Bell, consultant endocrinologist, University Hospital, Galway on ‘Diabetes in Pregnancy’, where she outlined implications for the future. Paula Mee, food and nutrition consultant, gave a dietician’s perspective on ‘Managing Obesity in Primary Care’, while Dr Rory O’Hanlon, CMR fellow, Royal Brompton Hospital London, presented on new modalities to identify cardiovascular patients ‘at risk’. The morning session closed with a presentation on ‘Smoking Cessation’, by Dr JJ Gilmartin, consultant respiratory physician, Merlin Park Hospital, Galway.

The conference concluded with an open forum where a panel of experts addressed issues such as anti-coagulation therapy, blood pressure management, screening in heart disease, ICD pacemakers and managing chest pain and cardiac emergencies.

Margaret Scott, Elphin Medical Centre practice nurse, was highly commended recently at the first Crystal Clear MSD Health Literacy Awards in Ireland for her efforts in communicating with patients in a clear and accessible way. Margaret was announced joint finalist by Minister Mary Harney in the category ‘Literacy innovation in a primary care setting’ for her ‘appointment card’. Each project was designed to address the issue of health literacy, which is a person’s ability to understand basic health information and subsequently make informed decisions. The nationwide campaign was developed by MSD Ireland (Human Health) Ltd in partnership with the National Adult Literacy Agency (NALA).

The card was developed for people with limited English, hearing and literacy difficulties. “The IPNA is delighted to support and participate in the first ever Health Literacy Awards in Ireland,” said Ruth Taylor, national chairperson, Irish Practice Nurses Association (IPNA) and member of the Crystal Clear Awards judging panel. “We see the Crystal Clear Awards as a vehicle for improving the quality of service for Irish patients. These awards recognise best practice in the area of health literacy and we celebrate those within the healthcare arena who are making impressive strides in this area and those who will be inspired to embark on a similar journey.”

Further details on the Crystal Clear MSD Health Literacy Awards can be found on www.crystalclearawards.ie

NIGP’s Karina Corbett interviews Margaret Scott in this issue on page 32.
A day when life got easier

MabThera in combination with methotrexate is licensed for patients who have had an inadequate response or intolerance to other DMARDs including one or more TNF inhibitor therapies.

B SELECTIVE • B EFFECTIVE

1851 Arthur Leared from Co. Wexford invents the modern binaural stethoscope.1

2006

In severe active rheumatoid arthritis, selective b cell therapy heralds a new treatment era.

MabThera in combination with methotrexate is licensed for patients who have had an inadequate response or intolerance to other DMARDs including one or more TNF inhibitor therapies.
CLARE

ANNA AKAMNONU

Our April meeting was a lively affair and was very well supported. Ina Crowley, professional development co-ordinator for practice nurses in the Mid West, informed us of forthcoming study days in Limerick, Ennis and Nenagh on immunisation and the proposed new immunisation schedule. Information on dates for these study days will be posted on our new email address and can be accessed by all our members. This email facility is also proving very useful in getting access to all the latest news from Lisa Nolan of IPNA.

Other news - many congratulations to Eleanor McCarthy, one of our members, who delivered a lovely baby girl in February. We are all delighted for her and wish her all the best.

Meanwhile, Carmel Kilkeen, one of our practice nurses, did her best in assisting an unexpected roadside delivery in Clare. Together with a local GP, she ensured a safe delivery for a mother on the main Kilkee to Kilrush road. The pregnant mum was en route to Regional Maternity Hospital in Limerick but … it’s a long, long way from Clare to there! In fact it was the fourth emergency birth in West Clare during the last two months.

Another one of our members, Mary O’Brien, announced her retirement. She will be leaving her practice nursing post in Corofin, Co Clare in the near future. Mary has been a dedicated practice nurse and a committed branch member, during her long-standing professional career. Her dignity and gentle caring has been an inspiration to all of us. We wish her a happy, healthy and enjoyable retirement.

The night was sponsored by Schering Plough and Ann Martina Mulligan secured a very wonderful speaker - Dr Gerard O’Flaherty, physician and lecturer in Medicine at NUI Galway. He educated and entertained us with an in-depth and fascinating presentation on the management of type 2 diabetes. His approach to this expanding topic was practical and so refreshing.

Hopefully, our May meeting will be equally as exciting and, as it will be our last meeting before the summer break, all members are very welcome and we look forward to a great turn-out.

For the upcoming IPNA Annual Conference in October 2008, we hope to organise a mini bus service to Cavan. Anybody interested in attending and availing of this bus service should contact our Clare branch secretary as soon as possible.

CORK

AINE O’DRISCOLL

There are only a few meetings left before the summer holidays and the Cork branch committee would like to thank its members for their continued support at the monthly meetings.

Our March meeting was sponsored by Rose Howard of Milupa and presented by nutritionist Margaret Byrne. The topic was ‘fussy eaters’, a frequent problem we encounter with parents of toddlers. It can be very stressful for parents to deal with. We got some useful tips from our speaker and we can pass these on to parents, helping them to manage the problem of fussy eating.

Our April meeting was sponsored by Ann McCarthy of United Drug and Ann spoke about the national cold chain and the role of United Drug. Ordering of cold chain vaccines is something we as practice nurses do everyday and Ann reminded us that all the team at United Drug are there to ensure a safe, efficient and friendly service.

Summer is nearly upon us and the Cork branch is getting very active for the summer outing. We are planning on climbing the Galtee Mountains in Co Cork and we are all looking forward to an exciting day out. We will be accompanied by an experienced guide to ensure our safety and all in all we should be walking for about two/three hours. For the less adventurous, a trip to the Mitchelstown Caves is planned on the same day and we will all meet up in the Firgrove Hotel after for a bit of ‘craic agus ceoil’! This day is planned for Saturday, June 14th and the day will be sponsored by Pfizer. It is a good opportunity for new members to join in and get to know everyone.

DONEGAL

ELSIE STEWART

The Ramada Hotel in Letterkenny was the venue for our March meeting, which was kindly sponsored by Michelle Heneghan from Nutricia. Our guest speaker was Orla Loftus-Moran, who presented a very informative overview on contraception, and who returned again for our April meeting with an excellent presentation on various aspects of infertility. We are indeed indebted to Orla for travelling all the way from Mayo both evenings to be with us - thank you Orla. Thanks also to Elena Fitzgerald and Nicola Callaghan from MSD who generously sponsored our April meeting, once again held in the Ramada Hotel.

An excellent two-day Sexual Health Awareness course recently held in St Conal’s Education Centre, Letterkenny, was attended by many of our members. Thanks to Ann McGill PDC for facilitating the event.

During the next few months at various locations throughout the county, all practice nurses are urged to attend vaccinations
updates, with particular regard to the new vaccine schedule. Please contact Imelda Bonner, County Clinic, Letterkenny, to confirm venue of choice.

Congratulations to Ursula Molloy on her recent appointment as secretary of the practice nurse’s section of the INO. My sincere apologies to our former chairperson, Bella Stew-

DUBLIN

CIARA BUTLER

Hello to all the Dublin branch members! To recap on our last couple of meetings, our March meeting was kindly sponsored by Cow & Gate and the subject talk was on domestic violence. I know all those who attended the meeting found it extremely informative.

At the meeting Mary Sullivan was elected as the new treasurer, so good luck with the new role Mary, and thanks once again to Ann Kernan who did a fantastic job as treasurer for the last year.

Our April meeting was sponsored by Astra Zeneca and the subject talk was on eating disorders. Marie Devine from Body-whys gave a hugely informative talk on the subject, which those who attended found would be very relevant in their current role as practice nurses.

Our next branch meeting will take place on Wednesday, May 28th in the usual venue of Mercer’s Hotel, after which there is a summer break and meetings will recommence on October 29th.

Dates for your diary: an early reminder that this year’s IPNA national conference will take place in the Slieve Russell Hotel in Co Cavan on October 16th and 17th and is hosted by the Wicklow Branch.

GALWAY

MAUREEN DELANEY

Thursday, March 13th brought the Galway practice nurses to the Courtyard Merriot Hotel for a very informative meeting. Angela Moore, SRN, clinical nurse specialist, UHG, gave a talk on Haemochromatosis to a very attentive audience. Our thanks to Roger Towey and Lisa Gillen of sanofi aventis for their sponsorship on the night.

Our thanks to Croi and Pfizer Healthcare Ireland for a very enjoyable conference. The second Annual Nurse Symposium topic was ‘Cardiovascular Disease - Promoting Excellence in Practice’ held in the Radisson Hotel on March 28th and 29th. The conference was attended by over 170 practice nurses from all over Ireland. Karen Ward, holistic therapist from RTE’s Health Squad opened the conference with an overview of holistic therapies in heart disease. Saturday’s topics included ‘Diabetes in Pregnancy’, ‘Managing Obesity in Primary Care’ and ‘Smoking Cessation’, all of which were relevant to the practice nurses who attended. ‘We look forward to next year and to meeting you all again.

We would like to offer our sympathy to Catherine Kirrane, vice chairperson, on the recent bereavement of her sister Marie Melody, RIP. We cancelled our May meeting as a mark of respect. It has been rescheduled for June, with the date yet to be arranged. Novartis will be our sponsor as Mary O’Sullivan, heart failure nurse, UCHG, will give us an ECG workshop. We are gathering at the Radisson on May 15th, where polycystic ovary disease will be presented by Dr Durkan, consultant endocrinologist, Portiuncula Hospital, Ballinasloe. As the weather is getting better and the evenings longer, I hope you all are making the most of it and getting out for a nice walk and keeping healthy. Looking forward to seeing you all on the 15th.

KERRY

CATHERINE DOYLE

Our March meeting was sponsored by Jennie Fitzgibbon of sanofi aventis and the speaker was Dr Balall from Kerry General Hospital. The topic was ‘Cardiovascular Risk Factors in Diabetes’ and the talk was very interesting and very much relevant to practice nursing. Jennie also provided us with a lovely buffet afterwards.

Our April meeting, the second part of our diabetes talk, was sponsored by Colette Holland of sanofi aventis. Helen Crowley, the diabetologist, Portiuncula Hospital, gave us a very interesting talk about managing cardiometabolic risk. Helen is very experienced in this area and as always we gained more knowledge in the area of diabetes.

Our new committee for September 2008 was finally decided. As outgoing chairperson I would like to welcome Mary Brick as our new chairperson, Marie Rolls will be secretary with Phil Dunne supporting. Mary Cullen is our new treasurer. Ann Edwards is INO representative, Amina Parkes is NEC representative and Paula Morris is our communications officer. I would like to thank Margaret Condon for organising a very interesting range of talks over the last couple of years and I welcome Sheila Ryle as our new education co-ordinator.

We in Kerry would like to wish you all a long hot summer and look forward to meeting you all in Cavan in October.
KILKENNY

IMELDA CURRAN

Belated good wishes to the magazine from the Kilkenny branch. We finally get around to sending in our news. Firstly, I would like to congratulate you all on the magazine. Great to have it back in circulation.

On behalf of the Kilkenny branch I would like to extend our deepest sympathy to Una Stapleton on the recent death of her mother.

We have had two good educational meetings lately – Asthma and use of devices – always good to have a revisit of techniques! Our last talk was by a local GP on managing hypertension and this again was very informative. I would like to encourage all members to attend as many meetings as possible – it’s a great way to keep up to date!

LIMERICK/NORTH TIPPERARY

ANITA FITZGERALD

The Limerick/North Tipperary branch meeting for March took place in the Absolute Hotel, Limerick on March 13th, 2008. Thanks to Elaine Ryan of sanofi aventis for sponsoring the meeting.

Dr Ray O’Connor gave us an excellent talk on interpretation of blood results, and this was followed by Dr Graham Fry from the TMB on April 17th, who gave an excellent update on travel vaccines. Many thanks to sanofi for sponsoring our meeting.

As we are all aware the National Childhood Immunisation schedule will change later this year. In order to facilitate this change Ina Crowley, professional development coordinator for practice nurses, NMPDU has organised a programme for the HSE West. The one-day courses will run in May and anyone requiring a place should contact Michelle.frawley@hse.ie before May 6th.

On completion of the programme participants will be provided with A Practical Guide to Immunisation certificate of attendance with An Bord Atranais Category 1 approval.

LOUTH/MEATH BRANCH

GENEVIEVE O’DONOHOE

Coming to the close of spring and awaiting in hopeful anticipation of a glorious Summer. May is upon us and we have a number of meetings behind us, which have been very well attended and thanks to all.

Primarily, I would like to thank the out-going chairperson, Sheila McKeown and our secretary Carmel Finnegan for their contribution to the Louth/Meath branch for the last two years – a job well done. A new chairperson and secretary Genny O’Donohoe and Joan Kehoe Ward were elected who both work in practice in Skerries, working for Dr Seamus Mulholland. Alison Geraghty continues in the role of secretary, Ida Fitzpatrick takes over from Joan Pentony as the national representative. Belatedly, we would like to extend our heartiest congratulations to Joan Pentony on her Excellence in Practice Nursing 2008 award, a great achievement, setting a very high standard for us all in the Louth/Meath branch!

We have had meetings sponsored by Allen and Hanbury where Dr John Faul gave an update on adult asthma. GSK sponsored our next meeting on the cervical cancer vaccine, highlighting the future role of the vaccine. We had a very interesting speaker from the Drogheda refuge centre, who spoke on domestic abuse. This topic was well received and gave us an insight into the scale of abuse, how to recognise the warning signs and the support that is available for the victims. Berlipharm kindly sponsored this night. ‘Clinical Developments in Infertility’ was our next topic of choice, Allen and Hanbury provided the speaker Kay O’Dwyer, who is a practice nurse based in Kells Co Meath. A comprehensive insight on this topic was given outlining the NaPro Technology that is currently available.

Our most recent meeting, sponsored by Bayer Shering Pharma, addressed the treatment of Sexually Transmitted Infections. The speaker was Sheila Dooley St James’s Hospital.

Ideas for future topics were discussed including, menopause, travel immunisations, and training for nurses on the new vaccine schedule. We are currently trying to identify suitable speakers/sponsors in these areas for forthcoming meetings.

Ruth Taylor, our practice nurse co-ordinator for the region has given the education update at the meetings. The prospects for 2008 has been published in book and DVD format and is now available. A very successful introductory course has been run for new practice nurses and it is hoped to secure funding to repeat this course in the future. A new tailor-made course for existing PNs is planned for April/May to run for five days to ensure best nursing practice and update knowledge. It is planned to hold a family planning study day, spirometry study day and an immunisation information workshop.

Finally, I would like to thank all our branch members for their input, contribution and mainly their strong attendance at the meetings. It is a great support to each other to have a forum to discuss individual issues and keep ourselves updated in areas pertinent to practice.
The first vaccine that can prevent cervical cancer
and other diseases caused by
4 human papillomavirus
types 6, 11, 16 and 18

Benefits before cervical cancer
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Before cervical cancer occurs, GARDASIL.

• can prevent pre-cancerous cervical lesions (CIN 2/3)
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• can prevent genital warts
• can prevent pre-cancerous vulval lesions (VIN 2/3)

Caused by human papillomavirus types 6, 11, 16 or 18

To help protect young women, children and adolescents

ABRIDGED PRESCRIBING INFORMATION
GARDASIL® (Human Papillomavirus Vaccine [Types 6, 11, 16, 18] [Recombinant, adsorbed]). Refer to Summary of Product Characteristics for full product information before prescribing. Additional information is available on request.

Presentation: Gardasil is supplied as a single dose pre-filled syringe containing 0.5 ml of suspension. Each dose of the quadrivalent vaccine contains highly purified virus-like particles (VLPs) of the major capsid L1 protein of Human Papillomavirus (HPV).

These are type 6 (20 μg), type 11 (40 μg), type 16 (40 μg) and type 18 (20 μg).

Indications: Prevention of high-grade cervical dysplasia (CIN 2/3), cervical carcinoma, high-grade vulvar dysplastic lesions (VIN 2/3) and external genital warts (condyloma acuminata) causally related to HPV types 6, 11, 16 and 18. Gardasil is indicated for 16 – 26 year old females and 9 – 15 year old children and adolescents.

Dosage and administration: The primary vaccination series consists of 3 separate 0.5ml 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. Administration at the same time as Hepatitis B vaccine has been shown to not interfere with the immune system. 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: 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 because bleeding may occur following an intramuscular administration in these individuals. 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. Vaccination is not a substitute for routine cervical screening. There are no data on the use of Gardasil in subjects with impaired immune responsiveness. As with any vaccine, vaccination with Gardasil may not result in protection in all vaccine recipients.

Undesirable effects: Very common side effects include: pyrexia and at the injection site, erythema, pain and swelling. Common side effects include bleeding and pruritus at the injection site. Very rarely, bronchospasm has been reported. 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 syringes with a needle guard and two needles.

Marketing authorisation holder: Sanofi Pasteur MSD SNC, 8 rue Jonas Salk, F-69007, Lyon, France

Marketing authorisation number: EU/1/06/357/003 - 017

Legal category: POM ® Registered trademark

Date of last review: July 2007

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 0344 1628 785291
WATERFORD

DEIRDRE MCCANN

Hello once again from the sunny South East. Since January the Waterford branch has held two practice meetings. The first one in January was very well attended. It was a good start to the New Year - a New Year’s resolution to attend meetings or was it the interest in the speaker of the night that drew a crowd? Hats off to our speaker of the evening, Geraldine Tabbs, transformation development officer, HSE, to attend and face the wrath of the Waterford practice nurses. 

As mentioned in my previous regional report the Waterford practice nurses have been excluded from any discussions regarding the Primary Care Teams soon to be up and running in Waterford. Geraldine gave a comprehensive HSE account of Primary Care Teams covering geographical location, including naming core team members. Included in the team, in fact second on the list, were practice nurses. We were also described as CORE stakeholders in the whole programme. The investment in the health service has really paid off. The HSE now can read minds. To date no discussion has occurred between the Waterford practice nurses and the HSE regarding Primary Care Teams, until this meeting, although most of the issues appeared to have been decided at this stage. As a group, however, we remain true to our patients providing health promotion and education, screening, immunisations, acute minor illness, minor illness management, management of chronic conditions, women’s health, men’s health, antenatal and postnatal care, research and clinical audit - the list could go on. The HSE may consider our relevance in time.

The second meeting took place on the first week in March. The speaker for the night was Andy Hargreaves, drugs education officer for Waterford. To explain how the night went, here is a quote from one of our practice nurses: “I could listen all night.” Andy had the hard task of trying to give an overview of drugs in an hour or thereabouts when he would usually do daylong workshops on the topic. Information poured out and questions were sensibly and factually answered.

Good news in regards to the roll-out of the new vaccination programme for children. We have been informed that a half a day study will be available to practice nurses to educate themselves with regard to the new programme. – a must for any nurse involved.

Our thanks were conveyed to both practice nurses who attended the INO and National Executive Meetings on our behalf. Also many thanks to the generosity of the sponsors of the evenings, namely Abbott and Pfizer.

Next Waterford meeting will take place on May 14th, 2008 and we hope to see a good crowd there.

WICKLOW

MARY FINNEGAN

Our first meeting this year was held on January 21st with an excellent talk on infertility given by Joan Hamilton RGN nurse counsellor in the HARI unit, Rotunda. This was a very interesting session, outlining each step of the journey a couple take while attending the HARI. Joan also spoke of her role as nurse counsellor in the unit. The talk certainly gave us all more understanding of what infertility, its investigations and treatment involves.

The next meeting was held in March. This was sponsored by GSK, and Claire Byrne, asthma nurse gave us an excellent talk on asthma and the latest studies relating to it. By the time you are reading this we will have held our last meeting before the summer on April 28th. The topic that night was ‘An Update on Dermatology’, presented by Dr Ernan Gallagher, a local GP, with a special interest in dermatology. The meeting was sponsored by Leo Pharma. It was excellent and very informative. Our meetings will resume in September, and we look forward to welcoming both new and ‘old’ members. Perhaps you may not have attended any meetings recently, but we would love to encourage you back into the ‘fold’! Perhaps you might consider rejoining us at branch meetings from September?

Currently at branch level, we are very busy arranging the annual conference in the Slieve Russell Hotel in Cavan on October 17th and 18th for a fun filled, exciting weekend, with excellent clinical content.

As we are starting a lot earlier on the Friday, we hope those of you who can join us early, will have time to relax, chat, eat, (sleep!), have a spa treatment, attend the workshops and view the exhibitions during the afternoon, before we open the conference officially at 6pm.

Our sincere thanks to Grainne Lynch for all her time, patience, and organisational skills. She has managed to allay all fears, and calm the occasional panics!! Everything is on schedule, so hopefully we may all be able to relax a little during the summer, before we head into a very busy September!

Again, a plea to all our branch members for as much help as possible for the conference weekend...all volunteers welcome!

Finally, congratulations to Deborah Murtagh on the safe delivery of her beautiful baby son Niall (a little brother for Ailbhe) on Saturday, April 26th. Best wishes from all in the branch.

ROSCOMMON

MARGARET SCOTT

The final meeting before summer was held in Roscommon on March 15th. There was a large attendance and it was kindly sponsored by sanofi pasteur, with Declan Brehony at the helm. A report was given from the IPNA section of the INO meeting in Dublin. The PNO will open to other nurses, eg those who work in weekend call centres. Declan Brehony spoke on Gardasil for the prevention and treatment of HPV in girls/women. The company advises three injections to give immunity, aged 12 upwards. Dr Dom Colbert, Galway, gave an excellent presentation on travel vaccines and the diseases prevalent all over the world. The meeting closed with a lovely meal and the branch will resume again in September.
Abridged Prescribing Information

Trade name: Avamys 75 mcg monohydrate spray nasal suspension

Quantity of active ingredient per unit dose: Each spray actuation delivers 25.0 mcg of fluticasone furoate. Therapeutic indications: Adults, adolescents (12 years and over) and children (6 – 11 years)

Treatment of the symptoms of allergic rhinitis.

Dosage and method of administration: By the intranasal route only. Regular usage is recommended. Onset of action has been observed as early as 8 hours after initial administration. However, it may take several days of treatment to achieve maximum benefit. The duration of treatment should be restricted to the period that corresponds to allergenic exposure. For patients with severe persistent symptoms, treatment should be continued throughout the year.

Adults,

The recommended starting dose is one spray in each nostril once daily (total daily dose, 110 mcg). Once control of symptoms is achieved, dose reduction to one spray in each nostril once daily may be effective for maintenance. Patients not responding to one spray in each nostril once daily may use two sprays in each nostril once daily (total daily dose, 220 mcg). Once adequate control is achieved, dose reduction to one spray in each nostril may be effective for maintenance. Children 11 and 10 years of age: The recommended starting dose is one spray in each nostril once daily (total daily dose, 55 mcg). Once control of symptoms is achieved, dose reduction to one spray in each nostril once daily may be effective for maintenance. Children under 6 years of age: Safety and efficacy in this group has not been well established (see SPC for further information).

Hypersensitivity to any of the ingredients.

Therapeutic indications: Adults, adolescents (12 years and over) and children (6 – 11 years)

Treatment of the symptoms of allergic rhinitis. Hypersensitivity to any of the ingredients. Special warnings and precautions: Systemic effects may occur, particularly at high doses prescribed for prolonged periods. Treatment with high than recommended doses may result in clinically significant adrenal suppression. The total systemic burden of corticosteroids should be considered whenever other forms of corticosteroid treatment are prescribed concurrently. Growth retardation has been reported in children receiving prolonged treatment. The height and weight of children receiving prolonged treatment should be monitored. If growth is slowed, therapy should be reviewed. Endocrine function is impaired; care must be taken when transferring patients from systemic steroid treatment to fluticasone furoate. Caution is advised when treating patients with severe liver disease. Concomitant administration with rifampin is not recommended. Avamys contains benzalkonium chloride which may cause irritation of the nasal mucosa.

Drug Interactions: Concurrent administration with rifampin is not recommended. Caution is recommended when co-administering fluticasone furoate with potent CYP3A4 inhibitors. Pregnancy and lactation: Fluticasone furoate should be used only if the benefits to the mother outweigh the potential risks to the foetus or child. Side effects: Respiratory, nasal and mediastinal disorders: Epistaxis (very common), Nasal abrasion (common), PA number: EU/1/2001/0006 Name and address of PA holder: Glaxo Group Ltd, Greenford, Middlesex, UB6 0NN, United Kingdom Legal category: POM For further information please contact: GlaxoSmithKline (Ireland) Ltd, Shannonpark, Rathfarnham, Dublin 15. AP number: I02008Avamys1246.

References:


It’s available as a simple, once daily dose through a novel, easy to use device.

Avamys is a new intranasal steroid providing relief from both nasal and ocular symptoms of seasonal allergic rhinitis.

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osteoporosis is the commonest bone disease worldwide. It is a silent disease. The first sign is usually a low trauma fracture, or loss of height. Osteoporosis does not cause pain, unless the person has had a fracture, which in many cases could have been prevented. Osteoporosis is a major public health hazard, with high morbidity, mortality and social costs, because of the high risk of fractures. Osteoporosis is a systemic skeletal disease characterised by low bone mass, micro architectural deterioration of bone tissue and compromised bone strength, with a consequent increase in bone fragility and susceptibility to fracture, particularly of the wrist, hip and spine, which consist of trabecular or spongy bone, but any bone can be affected. The majority of people who fracture have osteopenia. The risk of a subsequent fracture is much higher in postmenopausal women who have already had a fracture. It is the result of the negative balance between bone formation and bone resorption, ie more bone is lost than formed. Bones require normal levels of sex hormones, adequate caloric intake, particularly protein, calcium and vitamin D and regular weight bearing exercise. The rate of bone turnover is determined by hormonal and local factors.

Age profile
Osteoporosis can occur at any age in both males and females and may be due to a variety of different causes. It is not just an old lady’s disease. In a large number of cases it is preventable and treatable. One low trauma fracture increases the risk of a second in the near future, if not diagnosed and treated.

One in three postmenopausal women and one in five men will develop a fracture during their lifetime. Twenty per cent of people who fracture their hip will die from complications in the first year. Fifty per cent will have difficulty in looking after themselves and at least 25% will require long-term care and lose their independence.

The incidence of vertebral fractures begins to increase in late middle age, mirroring the age related decrease in bone mass. In contrast, the incidence of hip fractures increases exponentially after age 70, so that 90% of hip fractures occur after this age. One particularly high-risk group for hip fractures is nursing home residents. The rate of hip fracture among residents of nursing homes is between three and 11 times that of age-matched community-dwellers.

Children and adolescents
Although osteoporosis is most likely to affect people who are older, the disease process begins years – if not decades – earlier. Bone mass is primarily laid down during childhood and adolescence. The child or adolescent who does not develop healthy bones is at risk of becoming an adult with osteoporosis. Bone age has to be determined by using Greulich-Pyle Atlas on an x-ray of the bones of the left hand and special paediatric software.

Diagnosis of osteoporosis
Osteoporosis is diagnosed by having your hip and lumbar spine scanned by a Dual Energy X-ray Absorptiometry or DXA machine. It is the gold standard for diagnosing osteoporosis. It is painless, no injections, you do not have to take clothes off and takes five to ten minutes. There must be no metal in the area to be scanned and...
the patient must not be pregnant or have had a barium meal or enema recently. When assessing the effect of treatment you must monitor on the same DXA machine.

The WHO (1994) states that osteoporosis is present when the bone mineral density or bone mineral content is over 2.5 standard deviations below the young adult mean (-2.5 T Score) when measured by DXA or the patient has an osteoporotic fracture.

The risk of developing a fragility fracture (breaking a bone as a result of a minor fall) depends on the amount and strength of bone and the rate at which bone is lost and the type of fall. The most common cause of osteoporosis is deficiency of oestrogen in females and testosterone in males. Prevention starts when children are young and continues throughout life.

The WHO approach to fracture risk assessment is based on the following risk factors:
- Age
- Previous fracture
- Family history of hip fracture
- Glucocorticoid use
- Current smoking
- Alcohol use > 2 units/day
- Rheumatoid arthritis

Many medical conditions, or their medication, can increase the risk of osteoporotic fractures. Multiple factors contribute to low bone mass and osteoporotic fractures.

Factors that predispose to osteoporosis: and osteoporotic fractures:

* Genetic - a family history of osteoporosis is an important risk factor, particularly if it includes a history of hip fracture.
* Age; older more at risk.
* Previous fracture after minor trauma.
* Loss of height or upper or low back pain.
* Low bone mineral density by DXA.
* Endocrine disorders such hypogonadism for any reason, eg surgical removal of either ovaries or testes or Turner’s syndrome, Klinefelter’s syndrome.
* Late menarche, ie over 16 years, prolonged amenorrhea or history of very irregular menstruation, frequent loss of periods for more than three months (not pregnant).
* Premature menopause (before 45 years)/ophorhectomy or early menopause, either natural or due to radiation or chemotherapy are also at increased risk.
* Eating disorders (anorexia nervosa or bulimia).
* Athletic Triad (amenorrhea, eating disorder and osteoporosis or osteopenia).
* In men: low levels of the male hormone, testosterone, characterised by loss of libido, loss of erection, depression or fatigue at any age.
* Hyperadrenocorticism, endogenous or exogenous, Cushing’s syndrome.
* Hyperthyroidism.
* Hyperparathyroidism (primary or secondary to low vitamin D).
* Acromegaly.
* Hypopituitarism.
* Hyperprolactinaemia.
* Insulin dependent diabetes.
* Haemochromatosis.
* Inactivity or prolonged immobility (bed bound or wheelchair) for more than six weeks or long term.
* Excessive exercise particularly with inadequate caloric intake.
* Excessive psychological stress.
* Asian or Caucasian.
* Cancer.
* Gastrointestinal disorders including malabsorption problems eg gluten sensitivity, lactose intolerance, Crohn’s Disease, irritable bowel, ulcerative colitis.
* Gastrectomy or small bowel resection.
* Chronic obstructive jaundice.
* Primary biliary cirrhosis.
* Severe malnutrition.
* Collagen disorders and other medical conditions
  - Osteogenesis imperfecta.
  - Ehlers-Danlos syndrome.
  - Marfan’s Syndrome.
  - Homocystinuria.
  - Polymyalgia.
  - Sarcoiosis.
  - Rheumatoid arthritis.
  - Chronic obstructive lung disease.
  - Hypercalcuria.
  - Organ transplant.
* Neurological including dementia, stroke etc.
* Multiple sclerosis, spinal cord lesions etc.
* Bone marrow disorders
  - Multiple myeloma.
  - Systemic mastocytosis.
  - Lymphoma.
  - Disseminated carcinomatosis.

The factors that put children at risk of problems with bone health are similar to those in adults but include osteogenesis imperfecta, metabolic disorders, a history of chronic glucocorticoid use (to treat diseases such as asthma, undernourishment due to an eating disorder (eg anorexia) or a malabsorption syndrome (eg coeliac disease, cystic fibrosis, arthritis and some forms of cancer) inadequate intake or absorption of calcium and vitamin D.

* Female gender – lower peak bone mass, increased bone loss at menopause, and greater longevity all put women at greater risk than men. Women have less bone thickness than men and the levels of oestrogen drop at the menopause, particularly in thin women. This is when the main loss occurs; it is lost at a faster rate in some women, particularly if they have other risk factors, such as a family history or if they have diarrhoea due to gluten sensitivity.
* Advancing age – older people are more likely to have low vitamin D levels, take less exercise and have other medical conditions or may be on medication that will increase bone loss.
• Race – Caucasian and Asian people are more likely to get osteoporosis than people of Hispanic or African heritage because the latter usually have genetically thicker bones.

• Heredity – a family history of osteoporosis or particularly a hip fracture increases your risk of osteoporosis.

• Premature menopause (under 45 years of age, ovari/ ovaries or hysterectomy) – oestrogen helps keep bones strong. The younger a woman experiences menopause, the more rapidly she loses the benefits of oestrogen.

• Body type – if you are thin-boned, of low weight, and petite or tall, you are at greater risk of osteoporosis and fractures than people who weigh more and have thicker bones.

• Lack of exercise – weight bearing exercise increases your bone mass and strength, inactivity or prolonged bed rest can result in weaker bones. Excessive exercise, associated with a low caloric intake, can cause women to have irregular or miss their periods (not due to pregnancy) or men to lose libido; these are also risk factors for the disease.

• Diet – a diet that has inadequate calories, excessive fibre or a low intake of vitamin D and calcium, increases your risk of osteoporosis. These contribute to bone density and strength, so a decreased intake or inadequate absorption will result in weaker bones. Vitamin D also plays an important role in calcium absorption, muscle and nerve function and the prevention of falls. Excessive caffeine or soft drinks also affects bone loss.

• Smoking (either currently or in the past) - the nicotine and cadmium found in cigarettes can have a direct toxic effect on bone cells. In addition, smoking robs your body of oestrogen and lowers the amount of calcium adsorbed from the intestine. Smoking is also associated with an earlier onset of menopause and a higher risk of fracture.

• Excessive alcohol is toxic to bone building cells and can cause damage to the liver and pancreas, thereby affecting the body’s ability to absorb calcium and make vitamin D. Chronic heavy drinking also lowers levels of oestrogen and testosterone and may increase the likelihood of fracture.

Drug Induced

* Long-term use of corticosteroids (eg cortisone, prednisolone, dexamethasone). Corticosteroids are the most common cause of secondary osteoporosis (caused due to another condition or drug use). Bone loss occurs in the first six months of treatment. Corticosteroids 7.5 mg a day or more than three months in a year, may occur at lower doses in some people, particularly if there are other risk factors.

* Thyroxine, if serum levels are high.

* Post transplant osteoporosis.

* Anticonvulsant therapy, anti-epileptic medications – when taken over a long time they can interfere with calcium absorption and the production of vitamin D.

* Chronic heparin or Warfarin therapy.

* Long term lithium therapy.

* GnRH analogue.

* LHRH analogue; testosterone suppression.

* Prolactin raising drugs, antipsychotic medication, eg some SSRIs.

* Chemotherapy.

* Radiation.

* Aromatase inhibitors.

* Diuretics (Burinex, Lasix). Besides preventing fluid build up by causing the kidneys to excrete water and sodium, they also cause the kidneys to excrete more calcium.

* Chemotherapy and radiation.

* Aromatase inhibitors.

* Proton pump inhibitors.

Tranquilizers and sedatives may increase risk of falls. Osteoporosis of pregnancy may occur during the third trimester of pregnancy or postpartum during lactation.

Summary

It is never too late to treat osteoporosis, one in five men, one in three women (one in two women 65+) and children are affected by this preventable and treatable disease, however early detection is essential. If your patients have any of the risk factors described above they need to get a DXA scan.

A list of DXA scan clinics around the country can be found on the IOS website or by calling the IOS office. Treatment of osteoporosis should have a multidisciplinary approach. It is never too late to treat. But you must treat the cause.

Every patient should be given lifestyle advice. It is important to determine and treat the cause as well as the osteoporosis. Treatments should be individualised, based on the patient’s medical and surgical history and should include the menstrual, dietary and history of exercise, as too little, or too much exercise can increase bone loss. The result of a DXA helps to indicate the risk of osteoporotic fractures.

References


Professor Moira O’Brien, FRCPI, FFSEM, FFSEM, UK, Charter Medical, Smithfield, Dublin 7
**ABRIDGED PRESCRIBING INFORMATION** (For full prescribing information refer to the Summary of Product Characteristics [SmPC])

**Bonviva® (ibandronic acid) 150mg film-coated tablets**

**Indication:** Treatment of osteoporosis in postmenopausal women at increased risk of fracture. A reduction in the risk of vertebral fractures has been demonstrated, efficacy on femoral neck fractures has not been established.

**Dosage and Administration:** No experience in children. Not recommended where creatinine clearance <30 ml/min. Patients should receive supplemental calcium and/or Vitamin D – see SmPC. 150 mg once a month swallowed whole (the tablet should not be sucked or chewed) with plain water only (180-240 ml) whilst sitting or standing in an upright position. Take after overnight (≥6 hours) fast and one hour before the first food, drink (except water) or any other oral medicinal products or supplements (including calcium). Patients must not lie down for 1 hour after administration. Refer to SmPC for missed doses.

**Contraindications:** Hypocalcaemia, hypersensitivity to any ingredient.

**Warnings and Precautions:** Treat hypocalcaemia and other disturbances of bone and mineral metabolism before starting Bonviva. Ensure adequate intake of calcium and vitamin D. Osteonecrosis of the jaw reported. A dental examination with appropriate preventive dentistry should be considered prior to treatment in patients with concomitant risk factors. Avoid invasive dental procedures if possible during treatment. Refer to SmPC for full details. Not recommended if creatinine clearance <<30 ml/min. Potential for dysphagia, esophagitis and oesophageal or gastric ulcers. Follow dosing instructions especially if history of prolonged oesophageal transit time. Monitor for signs or symptoms of possible oesophageal reactions — instruct patients to discontinue therapy and seek medical attention if symptoms of oesophageal irritation develop. Caution with NSAIDs. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take the tablet presentation.

**Drug Interactions:** Observe fasting requirements for food, drink and oral medicinal products/supplements.

**Pregnancy and Lactation:** Do not use.

**Side Effects and Adverse Reactions:**

- **Common adverse drug reactions (>1/100, ≤1/10):** Dyspepsia, nausea, abdominal pain, diarrhoea, headache, influenza-like illness, fatigue, arthralgia, muscle cramp, rash, dizziness, vomiting, gastritis, oesophagitis.
- **Uncommon adverse drug reactions (1/100 - 1/1000):** Dysphagia, vomiting, gastritis, oesophagitis including oesophageal ulcerations or strictures, dizziness, back pain. Rare adverse drug reactions (1/10000): angioedema, urticaria.

**Legal Category:** Limited to sale and supply on prescription only.

**Presentation and Marketing Authorisation Numbers:** 1 tablet blister pack EU/1/03/265/003. Further information is available from Roche Products Ireland Limited, 3004 Lake Drive, Citywest, Naas Road, Dublin 24. Telephone: (01) 4690700. Fax: (01) 4690791. Bonviva is a registered trade mark.

**Date of Preparation:** September 2007.

**References:**

1. **BONVIVA 150mg Summary of Product Characteristics, available from www.medicines.ie**
Introduction

The number of people with chronic kidney disease (CKD) continues to grow worldwide. Ireland is also experiencing this exponential increase in the incidence of CKD with an estimated 280,000 people having some degree of renal impairment and of those 140,000 to 180,000 will have significant renal disease (Irish Nephrology Society, 2007). The cause of this increasing prevalence is multifaceted but the rising incidence of type 2 diabetes, increasing longevity and advances in medical interventions have all contributed to this growth.

CKD is a grave, life limiting chronic disease and is a major risk factor for cardiovascular mortality. Recent research has established that those patients with reduced kidney function and proteinuria are ten times more likely to die from a cardiac event prior to reaching end stage kidney disease (ESRD) (Dirks, 2005).

CKD usually develops slowly with few signs or symptoms in the early stages and if, as often happens, by the time the patient develops symptoms or his physician become aware of renal impairment the damage is advanced and irreversible.

Renal impairment requires life long monitoring and may eventually lead to ESRD and the requirement for renal replacement therapy (RRT) to maintain life.

According to the Irish Nephrology Society (2007) the number of patients reaching ESRD is rising rapidly. Predictions are that these numbers will continue to grow at a rate of 18 per cent per annum with a predicted doubling of the numbers of individuals requiring dialysis in the next four to five years. Currently approximately 3,000 patients are receiving dialysis. This increase is placing increasing demands on renal services including dialysis and transplantation and palliative care provision.

However patients requiring dialysis or kidney transplantation are simply the tip of the iceberg and healthcare providers have begun to focus on those unrecognised patients with renal impairment in our communities. Worldwide strategies to screen and monitor the level of CKD in...
the general population are being introduced to tackle this major public health issue and to provide interventions to halt or reduce the decline of kidney function. Enhancing the provision of and restructuring the organising of care of patients with renal disease is now becoming a priority.

Functions of the kidney
The kidneys are two bean shaped organs positioned in the posterior abdominal wall in the retroperitoneal space in front of, and on both sides of, the vertebral column between the twelfth thoracic and third lumbar vertebrae (Figure 1). The nephron is the structural and functional unit of the kidney and each kidney contains about one million nephrons. The functions of the kidney include regulation of body fluid volume and osmolality and electrolyte balance within narrow limits (ANNA, 2001). The functions of the kidney are summarised in Table 1.

Causes of CKD
There are many potential causes of CKD leading to gradual functional decline and the development of ESRD. However underlying disease is a major contributing factor with diabetes and high blood pressure now responsible for up to two-thirds of cases of CKD (Table 2).

Definition
CKD is defined as either kidney damage or a glomerular filtration rate (GFR) of less than 60 mls/min for three months or more. This is invariably a progressive process that results in loss of kidney function which, if not treated, will lead to the need for dialysis. The symptoms of CKD are very often sub clinical but progress relentlessly and by the time they become symptomatic the course of the disease is irreversible. It is now becoming clear that cardiovascular disease and renal disease are inextricably linked and factors that worsen one inevitably worsen the other. Even mild CKD is a major risk factor for death from cardiovascular disease and is said to have the equivalent prognosis to lung cancer. Indeed such is the burden of CKD, patients are more likely to die prematurely than to progress to renal failure requiring dialysis.

Measuring kidney function or creatinine clearance
Renal function can be measured in several ways but many are too expensive or inconvenient for routine use. The level of kidney function is measured via the ability of the kidneys to clear creatinine in mls per minute called creatinine clearance or GFR and this measurement is generally accepted as the best overall measure of kidney function.

Biochemistry serum creatinine alone (a product of muscle breakdown) has been commonly used to approximate renal impairment but serum creatinine alone is a poor predictor of kidney function as it is influenced by extraneous factors such as age, sex, weight, muscle mass and ethnicity. For this reason, it is no longer considered a reliable index of renal function.

While measurement of creatinine clearance or GFR was historically measured by a 24 hour urine collection this method of measuring clearance was notoriously unreliable and a shift away from 24 hour collections is occurring. Estimated creatinine clearance or estimated GFR (eGFR) are a better reflection of renal function. This is difficult to measure but can be estimated using the Crockcroft-Gault or modification of diet in renal disease formula (MDRD) (Table 3). The MDRD is now universally used to estimate

**TABLE 1. KIDNEY FUNCTIONS**

<table>
<thead>
<tr>
<th>Excretion</th>
<th>Removal of metabolic wastes from the body fluids eg urea and creatinine</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Regulate body fluid volume: concentration and dilution of urine</td>
</tr>
<tr>
<td></td>
<td>Regulate acid base balance of body fluids in conjunction with body buffer systems and the respiratory system: excretion of hydrogen ions and conservation of bicarbonate ions</td>
</tr>
<tr>
<td></td>
<td>Regulation of electrolyte balance of body fluids eg potassium</td>
</tr>
<tr>
<td></td>
<td>Removal of drugs and toxins.</td>
</tr>
<tr>
<td>Secretion</td>
<td>Regulation of blood pressure by controlling vascular volume and by secreting renin: renin – angiotensin mechanism</td>
</tr>
<tr>
<td></td>
<td>Regulate bone marrow production of red blood cells: erythropoietin</td>
</tr>
<tr>
<td></td>
<td>Regulation of calcium metabolism and convert vitamin D to its active form</td>
</tr>
<tr>
<td></td>
<td>Synthesise hormones, such as prostaglandins</td>
</tr>
</tbody>
</table>

Redmond and McClelland (2006)
creatinine clearance/eGFR as it is quite accurate, easy to calculate from a table and does not require either urine collection or height and weight assessment. The MDRD is recommended as the primary method for measuring renal function in the guidelines of the Irish Nephrology Society and the American and British Renal Associations (McGregor, 2006).

Once the creatinine clearance is measured the level of kidney function is then staged. Chronic renal disease is classified into five ‘stages’ on the basis of renal impairment based on the American Kidney Foundation’s Kidney Disease Outcomes Quality Initiative (K/DOQI) classification (Table 4) and has been accepted internationally.

**Treatment options**
Renal replacement therapy usually consists of artificial methods to replace renal functioning such as haemodialysis, peritoneal dialysis or transplantation and, more recently, conservative management. Thus RRT is considered a palliative life supporting therapy. However, the ever-increasing aging population has contributed to the need for conservative management as patients may be unsuitable for dialysis or they themselves may feel the burden of commencing dialysis may be unacceptable for quality of life issues (Brick et al, 2005).

**CKD management in the primary care setting**
Due to the sheer numbers of patients with CKD all patients cannot be referred to a specialist nephrologist and a shift has been made, in the majority of western health care jurisdictions, to identify patients at risk of renal impairment in the primary care setting and to intervene earlier in the course of CKD.

Early detection is important to prevent further injury and progressive loss of renal function and to ensure early referral to a nephrologist if required. Late referral of patients with CKD is associated with a greater burden and severity of co-morbid disease and increased risk of poorer patient outcomes and death.

Primary care providers, GPs and practice nurses have an important role in the evaluation and monitoring of at-risk patients. In Britain there has been a concerted effort to ensure that early identification and more effective management of patients with CKD into primary care and a move away for managing patients in specialist centres. Detection of CKD is a priority and screening is required to detect CKD long before patients feel unwell.

The British National Service Framework for Renal Services (2005) highlights the importance of primary care in the early identification and management of CKD to minimise its consequences and delay its progression. This framework introduced the addition of eGFR results on all routine biochemistry testing as an effective and simple method of screening GFR rates, thus enabling the early identification of renal disease in primary care. As of April 2006, all laboratoires report eGFR routinely in the UK.

In Northern Ireland shared care with GPs and the provision of clear guidelines for treatment and referral is outlined via the British Renal Association Guidelines for CKD: evaluation, classification and stratification. Screening of patients with CKD is also encouraged under the General Medical Services contracts Quality and Outcomes Framework (QOF) with the GP practice receiving monetary reward for each of the following: maintaining a registrar of all patients found to have CKD stages 3 to 5, achieving a blood pressure target of 140/85 mm/Hg, and the prescribing of angiotension converting enzymes inhibitors and/or angiotension receptor blockers.

In Ireland a National Renal Service Review (NRSR) was conducted in 2007. This review was commissioned by the Department of Health and Children following the publication of the National Health Strategy ‘Quality and Fairness – A Health

**TABLE 3. FORMULAE USED TO MEASURE CREATININE CLEARANCE/GFR**

<table>
<thead>
<tr>
<th>Creatinine Clearance</th>
<th>Formula</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gault</td>
<td>Creatinine clearance = X (140-age X weight (Kg))</td>
</tr>
<tr>
<td>Crockcroft</td>
<td>Creatinine clearance = X (140-age X weight (Kg))</td>
</tr>
<tr>
<td>MDRD</td>
<td>GFR = 170 x (plasma creat) - .999 x (age) – 0.176 x (0.762 for females) X 1.180 (if pt. is black) x (serum urea) – 0.170 x (albumin) + 0.318</td>
</tr>
</tbody>
</table>

**TABLE 4. THE US NATIONAL KIDNEY FOUNDATION’S KIDNEY DISEASE OUTCOMES Quality Initiative (K/DOQI) classification**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
<th>GFR (ml/min/1.73m²)</th>
<th>Focus of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Kidney damage with normal or increase GFR</td>
<td>&gt;90</td>
<td>Diagnosis and disease specific therapies</td>
</tr>
<tr>
<td>2</td>
<td>Kidney damage with mildly impaired GFR</td>
<td>60 - 89</td>
<td>Slowing of progression and reduction of cardiovascular risk</td>
</tr>
<tr>
<td>3</td>
<td>Moderately impaired GFR</td>
<td>30 - 59</td>
<td>Addressing complications of CKD</td>
</tr>
<tr>
<td>4</td>
<td>Severely impaired GFR</td>
<td>15 - 29</td>
<td>Preparation for dialysis</td>
</tr>
<tr>
<td>5</td>
<td>Established renal failure</td>
<td>&lt;15 or on dialysis</td>
<td>Dialysis, transplantation or conservative care</td>
</tr>
</tbody>
</table>
Indication: Chronic Kidney Disease (CKD) associated anaemia. No data in other indications.

Dosage and Administration:
Initiate treatment under supervision of experienced physician. Administer either subcutaneously (sc) or intravenously (iv). Monitor haemoglobin (Hb) every two weeks until stabilised and periodically thereafter.

Erythropoiesis Stimulating Agent (ESA)- naïve patients; 0.6µg/kg once a fortnight until Hb >11g/dL by single injection. Increase dose by approximately 25% if Hb rise < 1g/dL/month. Further increases of 25% can be made at monthly intervals until Hb target is reached. Once Hb target of above 11g/dL is reached, it is possible to switch to monthly dosing at double the fortnightly dose. Converting from current ESA: start MIRCERA as a single injection once monthly at next scheduled dose. Current weekly darbepoetin alfa < 40µg or epoetin < 8000IU start monthly MIRCERA 120µg; current weekly darbepoetin alfa 40 – 80µg or epoetin 8000 – 16000IU start monthly MIRCERA 200µg; current weekly darbepoetin alfa >80µg or epoetin >16000IU start monthly MIRCERA 360µg. If dose adjustment is required to maintain Hb >11g/dL, increase monthly dose by 25%. For ESA naïve patients and patients converting from current ESA: If Hb > 12g/dL/month or Hb rising towards 12g/dL, decrease dose by 25%. If Hb continues to rise interrupt therapy until Hb levels decrease and restart at a dose 25% lower than the previously administered dose. Dose adjustments should not be made more frequently than once a month. Not recommended for patients under 18 years. Due to limited treatment experience, regular Hb monitoring and strict adherence to dose adjustment guidance is recommended for patients on peritoneal dialysis. Treatment with MIRCERA can be interrupted at any time. If one dose of MIRCERA is missed, administer the missed dose as soon as possible and restart MIRCERA at the prescribed dosing frequency. No data in patients with severe liver disease—exercise caution.

Contraindications:
Hypersensitivity to methoxy polyethylene glycol-epoetin beta or any of the excipients. Uncontrolled hypertension.

Warnings and Precautions:
Monitor iron status prior to and during treatment. Supplementary iron therapy recommended in patients if serum ferritin < 100 µg/L or transferrin saturation below 20%. Failure to respond to treatment should be investigated: correct iron, folic acid or vitamin B12 deficiencies (refer to SmPC for full details). Discontinue therapy if PRCA diagnosed and do not switch to another ESA. Patients suspected or confirmed to have antibodies to erythropoietin should not be switched to MIRCERA. Blood pressure should be controlled before, at initiation of and during treatment with MIRCERA. If high blood pressure is difficult to control, dose must be reduced or withheld. Caution in patients with haemoglobinopathies, seizures, bleeding, recent bleeding requiring transfusion, with platelets > 500 x 10^9/L. Epoetins are growth factors and there is a concern that they could stimulate the growth of any type of malignancy. Misuse of MIRCERA in healthy people may lead to an excessive increase in Hb and associated life threatening cardiovascular complications. MIRCERA contains less than 1 mmol sodium per dose. Drug Interactions: No interaction studies have been performed. Pregnancy and lactation: No data in humans. Caution when prescribing to pregnant women. Assess the risk benefit with lactating mothers.

Side Effects and Adverse Reactions:
Common (>1/100 - <1/10): hypertension, Uncommon (>1/1000 - <1/100): headache and vascular access thrombosis, Rare (>1/10,000 - <1/1000): hypertensive encephalopathy, rash (maculo-papular), hot flush and hypersensitivity. During treatment a slight decrease in platelet counts remaining within the normal range was observed in clinical trials. Refer to SmPC for full details. Legal Category: Limted to sale and supply on prescription only. Presentation and Marketing Authorisation Numbers: Pre-filled syringe: 50, 75, 100, 150, 200 and 250 µg solution in 0.3 mL (Pack size of 1) EU/1/07/400/008, 009, 010, 011, 012, 013. Marketing Authorisation Holder: Roche Registration Ltd., 6 Falcon Way, Shire Park, Welwyn Garden City, AL7 1TW, UK. Further information is available from Roche Products (Ireland) Limited, 1000 Lake Drive, Cheadle, Manchester Road, Dublin 24. Telephone: 011 4606166. Fax: 011 4608799. MIRCERA is a registered trade mark. Date of Preparation: August 2007.


* The end user may remove MIRCERA from refrigeration for storage at room temperature (not above 25 degrees) for one single period of 1 month, once removed, MIRCERA must be used within this period.
The NRSR recognised the need to consider the treatment of CKD and ESRD as a whole entity and to develop people-centred policies to ensure a holistic approach in dealing with this chronic illness. By producing recommendations for service provision and a framework for the implementation of its recommendations, the NRSR hopes to ensure a more joined-up approach to managing the CKD epidemic and generating a greater focus on the root causes of CKD, with earlier interventions and prevention at a primary care level. The NRSR has yet to be published by the Department of Health and Children.

The Irish Nephrology Society also calls for all laboratories in Ireland to commence reporting eGFR with routine biochemistry to assist with the early treatment of the complications of CKD, thus preserving existing kidney function. The initiation of such a systematic approach to screening for CKD would perhaps create an initial flood of referrals, but would in the long run provide a more timely and ultimately cost-effective care for all patients with, as yet undiagnosed, CKD. AGgressive treatment of hypertension with ACE inhibitors to a target BP 130/70 has been proven to delay and sometimes prevent patients from progressing to the next stage of renal impairment.

Current research has proven the benefit of early intervention in the primary care setting. While the main aim of primary prevention is to address the causal risk factors of CKD and to continue to develop strategies to identify and ‘stage’ a patient’s level of renal impairment and measure their risk factors for progression to ESRD.

• Aggressive treatment of hypertension with ACE inhibitors to a target BP 130/70 has been proven to delay and sometimes prevent patients from progressing to the next stage of renal impairment.
• Tight diabetic control and management of blood sugars with a target HbA1c of 7.0% can significantly improve prognosis of patients with diabetic nephropathy.
• The use of angiotensin converting enzymes (ACE) and angiotensin receptor blockers (ARBs) have been shown to reduce proteinuria and reduce the rate of progression of kidney disease and while producing a nephro protective effect on kidney function.
• Smoking damages kidneys in the same way as it damages the cardiovascular system. A practice nurse can have a significant influence on a patient who may be thinking of quitting or needs the support and motivation to do so.

Conclusion
There is no doubt that there is a planned restructuring of the organisation of care provision to patients with CKD. Enhancing the early identification and more effective management of patients with CKD in primary care and moving away from managing renal patients only in specialist centres. The key elements of which are outlined above (Table 5). However, this approach will require significant support for GPs and practice nurses in terms of education, development of referral pathways, access to support and advice and an accompanying strategy to reinforce this planned transition. As in other jurisdictions (Table 6) this shift has to be supported through the publication of the National Renal Strategy, monetary input into the provision of renal trained nurses to bridge the gap between primary and secondary care along with the engagement of the primary care team with the ultimate aim of improving the quality of the care provided and the outcomes for patients with CKD.

References on request
Susan McKenna
Renal Clinical Nurse Specialist
Cavan General Hospital
All the slides are accredited where taken from articles and these articles are referenced. Other tables are taken from clinical practice guidelines

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**TABLE 5. STRATEGIES TO MANAGE CKD IN THE PRIMARY CARE SETTING**

| Use of eGFR to measure renal function |
| All biochemistry for serum creatinine to include eGFR |
| Dip stick Urinalysis for proteinuria |
| Laboratory Urinalysis for albumin creatinine ratio |
| Maintain registrar of ‘At Risk’ patients |
| Use of INS ‘CKD information pack’ to guide management and referral strategies |
| Enhancing the role of the primary care providers through education and support |
| Patient self-management and education |
| Smoking cessation |

Modified from: Management of Chronic Kidney Disease in the Primary Care Setting Craven (2005)
Coronary heart disease

LISA BROWNE, APN IN CHEST PAIN

Coronary Heart Disease (CHD) is the single most common cause of death in Europe, accounting for 1.92 million deaths each year. For many years, Irish males had one of the highest rates of premature mortality from CHD within the EU. This trend has, however, changed and in recent years we have seen very significant improvements in our mortality rates. Recent figures published by the European Heart Network (2008) illustrated a drop in CHD mortality in Irish males to just below the European average. This reduction can be attributed to numerous causes, including better primary prevention and improved diagnostic and treatment strategies. Despite these improvements, we as a society cannot risk complacency; our increased incidence of obesity, diabetes and physical inactivity all threaten to reverse this downward trend. In addition the demographic profile of the Irish population has changed with an ever-increasing aging population. These factors are likely to bear significantly on the future burden of CHD in this country.

Pathophysiology

The pathophysiology of atherosclerosis in coronary arteries is such that it develops insidiously over many years and it is often at an advanced or critical stage when symptoms occur. Several factors have been shown to accelerate the pathogenesis of atherosclerotic disease. These risk factors include smoking, hypertension, hypercholesterolaemia, diabetes, and a family history of premature onset CHD (males<55, females< 65). This multifactorial disease is characterised by endothelial dysfunction, focal proliferation of smooth-muscle cells, and the accumulation of lipid rich plaques within the intima of large and medium sized coronary arteries. These atherosclerotic plaques become insulated by a fibrous cap, and while these lesions can remain clinically insignificant for many years, they too may progress, predisposing to significant luminal narrowing. Atheromatous plaques that cause obstruction of less than 70 per cent of the diameter of the vessel rarely cause anginal symptoms, however as the plaques grow, significant reduction in the oxygen supply to the myocardium occurs, and this gives rise to ischaemic symptoms. In stable angina, symptoms are typically reproduced by physical exertion (myocardial oxygen demand increases) and subside or are relieved by rest (myocardial oxygen demand and supply meet equilibrium).

The occurrence of plaque disruption by fissuring or rupture of the fibrous cap signifies an unstable episode. For many patients this is the first clinical sign of any underlying disease and may occur at the site of mild to moderate obstruction. Plaque rupture is largely an unpredictable event, thought to be related to inflammatory changes within the artery and the size and composition of the fibrous cap. When this occurs blood may enter the atheromatous plaque predisposing to thrombus formation, further narrowing or completely occluding coronary blood flow. The clinical consequence of this process is termed as an acute coronary syndrome (ACS).

ACS is an umbrella term for three clinical conditions, namely unstable angina (USA), non-ST elevation myocardial infarction (NSTEMI) and ST elevation myocardial infarction (STEMI). These conditions are cardiac emergencies and require in-hospital assessment and management. The
treatment options available for patients with ACS are very effective and generally the sooner treatment is initiated the better the outcome. This is particularly true for patients with STEMI, where there is total occlusion of the infarcted artery. The time difference between occlusion and restoration of coronary blood flow is a critical factor in determining mortality and morbidity, with the greatest benefit seen when coronary patency is restored within the first few hours. Unfortunately the majority of people who die from CHD do so suddenly and out of hospital, so the aforementioned treatment options are therefore inapplicable.

To redress this issue, emphasis must be placed on strategies to prevent the acceleration of obstructive coronary disease and to maximise pre-hospital care for those who succumb to symptoms of acute myocardial ischaemia.

Prevention
The single most important means by which we as a society can tackle the problem of premature mortality from CHD is through primary prevention. Primary prevention refers to the identification of individuals who have never had a clinical cardiovascular event and who currently display no overt symptoms. It refers additionally to the implementation of therapeutic intervention, which limits the acceleration of atherosclerotic disease in persons at high risk due to familial, physiological or lifestyle factors.

There is a strong link between the pathogenesis of coronary disease and lifestyles and modifiable physiological factors. Priorities in primary prevention should focus on identifying individuals at the highest risk of developing atherosclerotic disease. This includes persons with multiple risk factors including smoking, hypertension, hypercholesterolaemia, diabetes, family history, obesity and inactivity. Furthermore the risk of atherosclerotic disease increases exponentially with age. Middle-aged and older individuals would therefore benefit from routine screening.

In order to estimate a person’s total cardiovascular risk, knowledge of their blood pressure and cholesterol levels are necessary. Screening blood pressure and cholesterol should therefore be an integral part of any primary prevention strategy. Those with marked elevation in a single risk factor (cholesterol > 8 mmol/l, LDL > 6 mmol/l or blood pressure >180/110 mmHg) are at particularly high risk and generally require pharmacological treatment. In general total cholesterol should be below 5 mmol/l and LDL cholesterol below 3 mmol/l. For patients with other concurrent risk factors (e.g. diabetes) treatment targets are lower. The risk of cardiovascular disease increases as blood pressure rises. Target blood pressure values of <140/90 mmHg are therefore advocated with lower values in persons with diabetes (<130/80 mmHg).

Diabetes is a particularly potent risk factor. Approximately 75 per cent of diabetic patients will die from cardiovascular disease and 30 per cent of insulin dependent patients develop coronary heart disease before the age of 50. For these high-risk individuals, good glycaemic control, weight reduction, cholesterol control, optimum blood pressure management and smoking cessation are imperative.

The deleterious effects of smoking on cardiovascular health are now well recognised. While clear health benefits exist for non-smokers, there is also a significant decline in cardiac risk after smoking cessation. All smokers should therefore be advised and encouraged to stop smoking all forms of tobacco permanently.

Primary prevention strategies should also focus on screening first-degree relatives of person who develop premature coronary disease. These individuals may have an inherited predisposition or may have familial hypercholesterolaemia or other inherited dyslipidaemias. These inherited traits can be effectively treated thereby significantly lowering the indi-
The forecast is good for patients with High Blood Pressure
individuals overall cardiovascular risk.

**Reducing pre-hospital mortality**

Sudden death is a common terminal event in persons with obstructive coronary disease. It is estimated that 50 per cent of patients who succumb to acute myocardial infarction will die within the first two hours of their symptoms. 1 The recognition of acute cardiac symptoms in the community and the initiation of appropriate intervention are therefore critical in reducing this mortality.

Cardiac arrest is the cardinal symptom of acute myocardial ischaemia. Many patients with serious cardiac chest pain wait too long before seeking professional medical care. This is an important factor in the high out of hospital mortality rate. Symptoms are often misinterpreted by patients as being benign. Public education programmes are required to assist patients in identifying their own heart attack risk, to recognise the symptoms and to advise them on the most appropriate reaction. This knowledge is necessary to facilitate appropriate and expeditious response.

Cardiac chest pain can often be differentiated from non-cardiac pain by simple assessment or questioning techniques. Chest pain exacerbated by inspiration or coughing is more likely to be respiratory in origin, whereas chest pain reproduced by movement and associated with chest wall tenderness is more likely to have a musculoskeletal aetiology.

It should also be noted that the severity of the symptom does not correlate well to the severity of the underlying cause. Many people have a pre-existing expectation of what a heart attack should feel like. They often expect severe and dramatic ‘crushing chest pain’. This is, however, a contrast to the clinical reality. Chest discomfort is a subjective experience and patient’s symptoms may therefore vary from mild to more severe discomfort. Furthermore a significant minority of patients with ACS will present with symptoms other than chest pain other than chest pain. This is particularly evident in women, the elderly and diabetic patients who may experience jaw pain, left arm discomfort, acute dyspnoea, syncope or epigastric fullness as their main ischaemic symptom. It is recommended that persons who develop acute symptoms, which may be cardiac in origin, be referred for prompt assessment. This precaution will help minimise the adverse effects of failing to identify patients with active myocardial ischaemia. Assessments should be carried out in the nearest emergency department or at the increasing number of chest pain evaluation units within our health service.

The majority of people who die suddenly from a cardiac cause have significant coronary disease. For some of these individuals the first manifestation of this disease is sudden cardiac arrest. Myocardial cells become irritable when they are deprived of their blood supply and are prone to electrical instability, ventricular fibrillation and sudden cardiac arrest. Making the general public aware of what should be done in the case of a cardiac arrest is an important factor in reducing out of hospital mortality, particularly in light of the fact that the majority cardiac arrests occur in the home. 2 A person having a cardiac arrest is most likely to survive if their collapse is witnessed by a bystander who can perform CPR and if defibrillation can be delivered promptly. Public education programmes should therefore focus on recognising the signs of cardiac arrest, activating the emergency medical services and initiating cardiopulmonary resuscitation as a bridge to defibrillation.

**Management**

The management of patients with established coronary disease is now well standardised. Aspirin, beta-blockers, ACE inhibitors and statins are the main pharmacological agents used in secondary prevention and the importance of compliance with these agents cannot be underestimated. A daily dose of the antiplatelet (aspirin) can reduce reinfarction rates by up to 25 per cent. 3 Beta-blockers are very effective in relieving symptoms of myocardial ischaemia; this is achieved by lowering the heart rate and blood pressure response to exercise.

Angiotensin converting enzyme inhibitors (ACE inhibitors) have traditionally been used in the treatment of patients post myocardial infarction with clinical signs of heart failure or evidence of left ventricular systolic dysfunction. Through their ability to interfere with ventricular remodelling, these agents have demonstrated reduced cardiovascular mortality, recurrent MI and cardiac arrest in this high-risk subgroup of patients.

In recent years ace inhibitors have been shown to be of benefit in reducing cardiac events and the progression of atherosclerosis in patients without left ventricular systolic dysfunction. 4 There is now a wealth of evidence to support the use of cholesterol-lowering therapy in persons with coronary disease. In addition to lowering total cholesterol levels, statins or HMGCoA reductase inhibitors also appear to improve endothelial dysfunction and stabilise platelet function.

**Conclusion**

The in-hospital management of patients with established coronary disease has improved significantly in the past decade. This is reflected in improved survival after myocardial infarction and a steady decline in overall mortality. Despite this trend, CHD remains a very significant problem in terms of mortality and morbidity. The key to addressing this problem is primary prevention and better pre-hospital care. Aggressive screening and treatment of cardiovascular risk factors is now recognised as fundamental to preventing the acceleration of atherosclerotic disease.

In addition, for individuals who develop acute ischaemic symptoms in the community, early access to diagnostic and treatment strategies may be life saving.

**References**


Lisa Browne is APN in Chest Pain, Mater Misericordiae Hospital, Dublin.
CRESTOR®
(rosuvastatin)
THE MOST EFFECTIVE STATIN FOR LOWERING LDL-C 1-8

Lowers LDL-C  I Raises HDL-C  I Reduces Triglycerides

Abbreviated Prescribing Information CRESTOR® Refer to the full Summary of Product Characteristics before prescribing. Presentation: Film-coated tablets containing 5mg, 10mg, 20mg, or 40mg of rosuvastatin. Indications: In patients unresponsive to diet and other non-pharmacological measures, CRESTOR® is indicated for primary hypercholesterolaemia (including heterozygous familial hypercholesterolaemia), homozygous familial hypercholesterolaemia, or mixed dyslipidaemia. Dosage: The recommended start dose is 5 or 10 mg daily (including those being switched from other statins). The choice of start dose should take into account the individual patient’s cholesterol level and future cardiovascular risk as well as the potential risk for adverse reactions. A dose adjustment to the next dose level can be made if the previous dose is well tolerated but there is no adequate lowering of LDL-C. Despite this, the maximum recommended dose is 40 mg daily. CRESTOR should be taken with breakfast, and the tablets should be swallowed whole with water. The recommended start dose is 5 mg for patients who do not achieve their treatment goal on 20 mg, and in whom routine follow-up will be performed. Specialised treatment is recommended when the 40 mg dose is initiated. May be given at any time of the day with or without food. Elderly: A start dose of 5 mg is recommended in patients ≥70 years. No further dose adjustment is necessary in relation to age. Drug interactions: Drug interactions may lead to an increase in rosuvastatin levels when administered with certain other drugs, combination of CRESTOR with gemfibrozil is not recommended. CRESTOR is contraindicated in pregnancy and lactation. Contra-indications: Hypersensitivity to any of the ingredients, active liver disease or unexplained persistent elevations in serum transaminases and any serum transaminase > 3 x upper limit of normal; severe renal impairment; myopathy; concomitant ciclosporin; pregnancy and lactation; women of child-bearing potential not using contraception. In patients with concomitant fibrates, and in patients with predisposing factors for myopathy /rhabdomyolysis (refer to Contraindications). The most common adverse reactions are headache, dizziness, constipation, nausea, abdominal pain, myalgia, and asthenia. Uncommon: pruritus, rash and urticaria. Rare: myopathy, rhabdomyolysis, pancreatitis. Very rare: jaundice, hepatitis, haematuria, angiodema, increased hepatic transaminases, episodes of angina pectoris, syncope, acute liver failure secondary to cholestasis. Renal, haematological, occasionally associated with impairment of renal function has been reported with all doses and in particular doses ≥20mg. Liver effects: CRESTOR should be used with caution in patients with a history of liver disease and/or alcoholism. Liver function tests should be carried out, prior to, and 3 months following the initiation of treatment. If serum transaminases are > 3 x upper limit of normal, CRESTOR should be discontinued or the dose reduced if the level of serum transaminases is greater than 3-times the upper limit of normal. The reporting rate of serious hepatic events is higher at the 40 mg dose. The concomitant use of rosuvastatin in HFP patients receiving protease inhibitors is not recommended. Pregnancy and lactation: CRESTOR® is contraindicated in pregnancy and lactation. Drug interactions: CRESTOR® is neither an inhibitor nor inducer of cytochrome P450 isoenzymes. CRESTOR® may potentiate the anticoagulant effect of Vitamin K antagonists (e.g. warfarin). Decrease in CRESTOR levels seen when co-administered with erythromycin or antacids containing aluminium and magnesium hydroxide. Increase in oral contraceptive level and hormone replacement therapy level is seen when co-administered with CRESTOR®. Concomitant use of CRESTOR® and gemfibrozil resulted in a 2-fold increase in rosuvastatin Cmax. Concomitant use of CRESTOR® and ezetimibe resulted in no change in AUC or Cmax for either drug; however a pharmacodynamic interaction in terms of adverse events cannot be ruled out. Proteinuria: Proteinuria which in most cases decreases or disappears spontaneously on continued therapy – a causal relationship to Crestor has not been established. An assessment of renal function should be considered during routine follow-up of patients treated with CRESTOR®. Hatawara has been observed very rarely. Muscle effects: Patients with signs and symptoms of myopathy should be asked to report their symptoms immediately and should have their creatine kinase (CK) levels monitored. CRESTOR should be discontinued if CK levels are markedly elevated or, if muscle symptoms are severe and cause daily impairments. Concomitant use of rosuvastatin in HIV patients receiving protease inhibitors is not recommended. A dose adjustment to the next dose level can be made if the previous dose is well tolerated but there is no adequate lowering of LDL-C. Despite this, the maximum recommended dose is 40 mg daily. CRESTOR should be discontinued if CK levels are markedly elevated or, if muscle symptoms are severe and cause daily impairments. Concomitant use of rosuvastatin in HIV patients receiving protease inhibitors is not recommended. A dose adjustment to the next dose level can be made if the previous dose is well tolerated but there is no adequate lowering of LDL-C. Despite this, the maximum recommended dose is 40 mg daily. CRESTOR should be discontinued if CK levels are markedly elevated or, if muscle symptoms are severe and cause daily impairments.
interview

Practice nurse Margaret Scott was recently made joint finalist in the category ‘Literacy innovation in a primary care setting’ for her ‘appointment card’ at the first Crystal Clear MSD Health Literacy Awards in Ireland. Commended for her efforts in communicating with patients in a clear and accessible way, each project was designed to address the issue of health literacy, which is a person’s ability to understand basic health information and subsequently make informed decisions. The nationwide campaign was developed by MSD Ireland (Human Health) Ltd in partnership with the National Adult Literacy Agency (NALA).

Results of a recent nationwide survey found that one in five Irish people are not fully confident that they understand all of the information they receive from their healthcare professional, and a further 60 per cent of the population don’t fully understand the word ‘prognosis’, a common term used by healthcare professionals in consultation with patients.

Background
Margaret has been working as a practice nurse in Elphin Medical Centre in Co Roscommon for the past 17 years. The centre is made up of two doctors – one male and one female – along with counsellors, a speech therapist, an occupational therapist and a dentist. It’s a big, busy practice that runs a leg ulcer clinic as well.

“I work four days every week,” she told Nursing in General Practice. “I trained in Temple Street in Dublin and worked in James Connolly Memorial Hospital in Blanchardstown in the 1970s. I also worked in Sligo General Hospital for a while.”

Margaret then took a career break for a while,

Patient communication made easy

Practice Nurse, Margaret Scott, winner in the Health Literacy Awards talks to Karina Corbett about her award.
before taking up her current position – one that she got into by accident and which she now loves.

“You’re dealing very much with people,” she explained, “it’s hands-on with the people. And I like working in the locality, I know everyone and it’s a very pleasant place to work.”

Challenges of a rural practice
So what does she think is different about practice nursing?

“I suppose it’s very much relative to each practice,” she said. “Some might specialise in a certain area, such as asthma. Some might have a lot of children. We are in a rural community so we have a lot of older people here. We would have transport problems as we don’t have a regular bus service and we’d have a lot of elderly people living on their own. But we have a good day care centre in the area for older people once a week. Being in a rural farming community too, a lot of the injuries coming in would be from farm machinery.”

Literacy awards
Margaret’s decision to enter the awards came about literally when the post arrived.

“I got an entry form in the post – a circular went out to each practice so I decided to send away the appointment card.”

She got the idea for the card because in her practice there are a number of people who are illiterate. They also have a deaf patient, a lot elderly patients and an increasing number of foreign nationals in the community with limited English. Her invention includes a bold image of a clock, calendar and a plate of food. The nurse highlights in bold red marker for patients the time and date of their next appointment and whether or not of food. The nurse highlights in bold red marker for patients the invention includes a bold image of a clock, calendar and a plate of food. The nurse highlights in bold red marker for patients the

“I just wanted something that would be basic and easy to understand, and easy to see too for the older people”

The judging panel for the Crystal Clear MSD Health Literacy Awards was represented by individuals from NALA, the Health Service Executive (HSE), the Health Information and Quality Authority (HIQA), Irish College of General Practitioners (ICGP), the Irish Practice Nurses Association, UCD School of Business, University College Cork, the Adelaide Hospital Society and the African Women’s Network. And while Margaret was naturally ‘delighted’ with her success, it’s now back to taking care of the patients at the busy medical centre in Co Roscommon.

book review

A Peaceful Mind By Bernie Kirwan

Bernie Kirwan [Sherwin] is a 48 yr old woman living in Gorey Co Wexford. In June 2000 she was diagnosed with breast cancer and following a mastectomy and chemotherapy she remains healthy and well. A nurse who trained in Waterford Regional Hospital she has nothing only praise for the staff there who looked after her so well at that time.

Her story of hope and inspiration is told in her book A Peaceful Mind that was recently very successfully launched in Gorey. It is available online from originalwriting.ie and kennybooksgalway. Alternatively if you bring details along [i.e. title, author and website address of publisher, isbn1906018383] to any good book shop they should order it in. At present it is available from Byrne’s Book Shop Gorey, Waterford and Wexford Book Centre, Just Books Mullingar, Cathedral Books Sackville Place Dublin [beside Clerys].

The best thing about reading A Peaceful Mind is that it’s just like having a conversation with the author. Bernie Kirwan’s honesty and humour effortlessly engage the reader in her harrowing journey through breast cancer, from diagnosis to treatment to recovery.

At no time does Bernie avoid sharing the pain and hardship of her experience, yet her determination to explore every possible way of becoming well in the most holistic sense makes this an inspiring and uplifting read. Bernie’s journey back to health is one of reclaiming and celebrating the importance of self honesty and the willingness to experience and appreciate beauty in all things, from the changing of the seasons to the value of human relationships.

This book is gentle, compassionate and above all practical. It is a powerful and essential read for anybody facing a cancer diagnosis and invaluable for anyone close to them. Bernie still attends Dr Paula Calvert for her six monthly checks, indeed Dr Calvert has kindly written the foreword for the book. She currently works at the Hope Cancer Support Centre in Enniscorthy, Co Wexford which provides therapies such as massage reflexology counselling etc for cancer patients and their families.
Although the primary concern upon a cancer diagnosis in an adolescent is to provide adequate and appropriate treatment with subsequent vigilance for extended periods, it is also important to recognise that diagnosis and treatment for childhood and adolescent cancer can have both life-challenging and life-affirming aspects. Some survivors suffer from long-lasting psychological restrictions due to their cancer experience, holding back in new and challenging situations and participating less actively in life. However, most survivors of childhood cancer will move forward with their lives and reach a point where they are able to view their cancer experience as a stimulus to growth and maturity – the life-affirming aspect.

“For a very small percentage of cancer survivors, where the cancer was diagnosed in childhood or adolescence, these ‘negatives’ can last a very long time, returning with intensity at various difficult times in life,” said Professor Spinetta. “But for most survivors, these ‘negatives’ gradually disappear. Follow-up studies of survivors ten and 20 years after treatment find them as fully functioning, resilient, autonomous adults, focusing on the life-enhancing aspect of having had cancer as a child or adolescent.”

He referred to studies suggesting that for the great majority of survivors of childhood and adolescent cancer, there is a deep and abiding sense of having learned lessons of resilience and thriving from the cancer experience. The critical element of this ‘growth’ and resilience perspective is the healthy balance between acknowledging the pain of cancer and its treatment and using the pain as a step back towards growth and maturity.

“Our task as parents and healthcare professionals is to enhance this view of healthy psychological resilience among our adolescents during the course of their treatment for cancer and afterwards,” continued Professor Spinetta. “We need to help them learn coping skills and strategies as they go through their cancer treatment. But along the way let us also give them the freedom to be normal teenagers.”

Adolescent ‘tasks’

Professor Spinetta identified eight developmental ‘tasks’ of adolescence that must be accomplished by all teenagers,

**The psychological impact of cancer on teenagers**

Professor John Spinetta of San Diego State University, a leading expert on the psychological impact of a cancer diagnosis on teenagers, spoke recently at an Irish Cancer Society (ICS) conference.
Regardless of cancer status:

1. Self-image: accepting one’s physique and using the body effectively.
2. Friendship: achieving new and more mature relationships with age mates of both sexes.
3. Sexual identity: achieving a masculine or feminine role.
4. Independence: achieving emotional independence from parents and other adults.
5. Career/finances: preparing for an economic career.
7. Responsibility: desiring and achieving socially responsible behaviour.
8. Ideology/values: acquiring a set of values and an ethical system as a guide to behaviour.

Life affirming attitudes

The great majority of survivors of childhood cancer view themselves as functioning with greater psychological maturity, greater compassion and empathy, new values and priorities, new strengths and recognition of vulnerability and a deeper appreciation for life. The critical element of this life-affirming aspect of childhood cancer diagnosis is a healthy balance between acknowledging the pain and using the pain as a step toward growth and maturity. The task of parents and healthcare professionals is to enhance this view of healthy psychological resilience among adolescents during the course of their treatment for cancer and afterwards.

Professor Spinetta finished his presentation by insisting that having cancer as a child should not be allowed to become an excuse to aim less high in life and that children with cancer cannot be ‘frozen’ in place for two years while they go through the treatment, and then expect them to catch up on their psychological development.

Infertility

One of the main long-term effects of cancer treatment is infertility. In males, chemotherapy and radiotherapy can reduce or damage spermatogenesis in the testicles, meaning that fewer sperm are made even after cancer treatment has finished. In females, treatment can reduce the number of eggs in the ovary, effectively making the menopause occur too soon. Additionally, if the womb has been exposed to radiation, its ability to support a pregnancy can be affected.

Dr Allan Pacey, senior lecturer at the Academic Unit of Reproductive and Developmental Medicine, University of Sheffield, who also spoke during the ICS conference said: “Although the ability to preserve fertility of boys who have gone through puberty by means of sperm banking is well established, corresponding strategies for girls to bank their eggs are still considered to be experimental. The only viable fertility preservation option for women is to create and store embryos with in-vitro fertilisation (IVF) prior to cancer treatment if there is time to do so. However, as this option also requires the woman to have a partner to provide the sperm, this often prevents young women and teenagers from taking advantage of this option.”

Human Assisted Reproduction Ireland (HARI), based at the Rotunda Hospital in Dublin, offers sperm banking for cancer patients, but this is only offered to males from aged 16 years and upwards. HARI also offers egg banking to female cancer patients from age 18 years of age. Semen can be banked for up to ten years. Eggs can also be banked for up to ten years. Both of these storage periods can be extended. HARI however recommends that eggs are used by the time the woman is 40 years of age.

CanTeen

Data from the National Cancer Registry shows that there were 78 new cases of cancer in females aged ten to 19 years in 2005 and 62 new cases in males in 2005. The ICS has developed CanTeen, a support group for young people who have cancer or have had cancer, and are between the ages of 12 and 25. CanTeen aims to provide support to young people who have been diagnosed with cancer by providing information about their cancer, by encouraging activity and communication and by promoting enjoyment and fun. The group is keen to involve not just the young people with a cancer diagnosis, but also brothers, sisters and friends. CanTeen aims to:

* Help teenagers come to terms with their diagnosis of cancer.
* Discuss the feelings and anxieties that may be experienced by teenagers who are told they have to have surgery or receive chemotherapy/radiotherapy.
* Organise social and recreational activities to prevent isolation and promote a positive attitude towards illness.
FOCUS ON: MEN’S HEALTH

Erectile dysfunction and men’s health: developing a comorbidity risk calculator

Shabsigh R, Shah M, Sand M, Division of Urology, Maimonides Medical Center, Brooklyn, New York, NY

The association between erectile dysfunction (ED) and cardiovascular risk factors is well established and ED can be considered an early marker for cardiovascular disease. The researchers wanted to generate a calculator to predict the risk of diabetes, hypertension, hyperlipidemia or angina in men with ED, based on an analysis of data from the Men’s Attitudes to Life Events and Sexuality (MALES) 2004 study.

Main outcome measure: a logistic regression model using the variables overall health, ED severity, having/not having a sexual partner and waist size. The MALES was a multinational, population-based study conducted in 2001, in which the prevalence of ED and co-morbid medical conditions was assessed in 27,839 men aged 20-75 years. In 2004, the cohort of men with ED (N = 1843) were recontacted and 919 (50 per cent) agreed to participate in the MALES 2004 longitudinal study. Multistep analysis of data from 808 patients was performed, with 289 variables evaluated.

Only those variables significantly correlated with outcome and those making clinical sense were retained. A logistic regression model was applied to 90 per cent of the sample; results were validated in the remaining 10 per cent with sensitivity and specificity testing.

Of the 2004 cohort, 20.7 per cent had been diagnosed with diabetes, 44.3 per cent with hypertension, 42.5 per cent with hyperlipidemia, and 25.7 per cent with angina. The following modifiable factors affected the risk of comorbidities, and were therefore included in the risk calculator: health status, waist size, ED severity, and having or not having a sexual partner. Using these variables in the model resulted in a sensitivity of 86.2 per cent and specificity of 54.5 per cent. The primary limitation of the calculator is that it is not a prediction calculator. The authors concluded that ED is a key factor in calculating the probability of major risks to men’s health, such as diabetes, hypertension, hyperlipidemia, and angina.

Engaging with sleep: male definitions, understandings and attitudes

Meadows R, Arber S, Venn S, Hislop J, Centre for Research on Ageing and Gender (CRAG), Department of Sociology, University of Surrey, UK

Recent literature has highlighted the sociological significance of sleep and has suggested that sleep offers a ‘window’ onto the gendered nature of our lives. Yet within this body of work men’s sleep has been largely ignored. This paper seeks to rectify this omission and situates itself at the intersection between literature on the sociological aspects of sleep and social-constructionist-orientated writings on men’s health. It draws upon qualitative data from 40 men to investigate male understandings of, and attitudes towards, sleep. At first glance, it could be suggested that men have little regard for sleep, and are prone to taking risks with their dormancy. Viewed in this way sleep becomes an instrument used in the negotiation of status and power and intrinsically bound up with the demonstration of masculinities. Yet, men’s relationship with sleep is more complex than this. Amongst other things, the men within the present study were embroiled in a function/non-function dichotomy. Sleep was seen as needed for the praxis of ‘father’, ‘worker’, ‘husband’ and ‘mate’ but was also considered as something which should not get in the way of performing their roles.

Duration of erectile dysfunction and its relationship to treatment seeking and satisfaction with treatment using PDE5 inhibitors

Matic H, McCabe, MP, School of Psychology, Deakin University, Melbourne, Victoria, Australia

This cross-sectional study was designed to evaluate whether the duration of erectile dysfunction (ED) influenced treatment seeking and satisfaction with treatment using PDE5 inhibitors.

Participants were 409 men with ED who were primarily recruited over the internet via men’s health web sites. Participants completed a questionnaire to assess the duration and perceived severity of ED, information and help-seeking behaviors for ED, and treatment usage and satisfaction with PDE5 inhibitor medication.

The results demonstrated that men with ED of longer duration were more likely to have discussed their ED with their partner and doctor and to have sought information and treatment for their ED problem. No differences were found in reported satisfaction with ED medication usage or expected future medication use across the varying levels of ED duration, once variance attributable to age was accounted for.

These results suggest that men are more likely to accept that they have ED and seek treatment for their ED with increasing duration of the condition, although these men are not more satisfied with PDE5 inhibitors as a treatment option.
### FOCUS ON: PSYCHIATRY

**Anxiety, depression, and quality of life in primary care patients**

Anxiety and depressive disorders have a significant and negative impact on quality of life. However, less is known about the effects of anxiety and depressive symptoms on quality of life. The study examined the impact of anxiety and depressive symptoms on emotional and physical functioning, the effects of anxiety symptoms on functioning independent of depressive symptoms, and the effects of depressive symptoms on functioning independent of anxiety symptoms. Participants included 919 patients, recruited from two university-affiliated primary care clinics between May 2004 and September 2006, who completed self-report measures of anxiety symptoms, depressive symptoms, and quality of life.

The results showed that almost 40 per cent of the sample reported anxiety symptoms and 30 per cent reported depressive symptoms. In both unadjusted and adjusted models, anxiety and depressive symptoms were significantly associated with all domains of quality of life. When anxiety and depressive symptoms were added simultaneously, both remained significant. As the severity of anxiety or depressive symptoms increased, quality of life decreased. Furthermore, patients with moderate to severe anxiety or depressive symptoms had greater impairments in most quality of life domains than patients with acute myocardial infarction, congestive heart failure, or diabetes.

The authors therefore recommend the detection and treatment of anxiety and depressive symptoms in the primary care setting.

### Depression in females linked to sense of smell

Scientists from Tel Aviv University recently linked depression to a biological mechanism that affects the sense of smell. Scientific research that supports this theory was published this year in the journal *Arthritis and Rheumatism*.

“Our scientific findings suggest that women who are depressed are also losing their sense of smell, and may overcompensate by using more perfume,” said Professor Yehuda Shoenfeld, at Tel Aviv University. “We also believe that depression has biological roots and may be an immune system response to certain physiological cues.”

Women who are depressed are also more likely to lose weight. With a reduced sense of smell, they are less likely to have a healthy appetite, according to Professor Schoenfeld.

### Etanercept drug reverses early symptoms of Alzheimer’s in ten minutes

Researchers in the US have presented startling data, which demonstrated that treatment with the anti-inflammatory etanercept reversed some of the early symptoms of Alzheimer’s disease in a patient in a matter of minutes. The researchers, who published their study in *Journal of Neuroinflammation*, say the memory of an 81-year-old man improved dramatically after the drug etanercept, currently used to treat arthritis, was injected into his spine.

Some studies have suggested that too much of a body chemical called tumour necrosis factor-alpha may be at least partly to blame for the advance of the condition.

Etanercept, which is licensed for use as a rheumatoid arthritis drug, works to block this body chemical. The study highlights the importance of certain soluble proteins, called cytokines, in Alzheimer’s disease and the cytokine, tumor necrosis factor-alpha (TNF), is a critical component of the brain’s immune system. In normal circumstances TNF finely regulates the transmission of neural impulses in the brain and the researchers hypothesised that elevated levels of TNF in Alzheimer’s disease interfere with this regulation.

The theory was that an injection of etanercept would reduce the elevated levels of TNF. The scientists had noticed in previous research that injecting the drug into the neck spine seemed to deliver almost immediate effects. The decided to test the medication on just one patient, a former doctor who had the early stages of the disease. Before the injection they measured his performance on cognitive tests, and found he performed poorly and was unable to remember the name of the doctor treating him, the date, or the state in which he lived. Neither could he perform simple mental arithmetic, or name more than two animals.

To the astonishment of his family ten minutes after a dose of etanercept, he was noticeably calmer, more attentive, and less frustrated; he also knew he lived in California, knew the day of the week, and the month, could name five animals, and performed better at the arithmetic test.

The US Alzheimer’s Research Trust said the study is promising and innovative but is in the early stages and further work is needed with a larger number of patients before it can be concluded that etanercept could work as a treatment for Alzheimer’s.
The IPNA and Nursing in General Practice are delighted to present the second annual IPNA Clinical Award. This year the award is focused on diabetes and the winner will receive an educational bursary of €1,000.

RULES
• Entrants must be working as a practice nurse in the Republic of Ireland.
• Entrants must answer all questions.
• Entrants must submit their entry on or before the closing date.
• Joint entries will not be accepted.
• The judges' decision is final and no correspondence will be entered into.

HOW TO ENTER
Below is a case study accompanied by a set of questions that must be answered. Please post, or e-mail your completed answers, along with your name and full contact details to:

Maura Henderson: e-mail: maura@greencrosspublishing.ie
Post: Maura Henderson, GreenCross Publishing, Lr Ground Floor, 5 Harrington Street, Dublin 8.

Closing date for receipt of entries is extended until 30th June 2008.

The winner will be notified by telephone and will also be announced in a later issue of Nursing in General Practice.

CASE STUDY
Michael Murphy is 50 years old and lives with his wife Mary and their two children, Paul aged 14 and Anne aged 12. He enjoys good health and is not on any medication. He works in a company that makes computer hardware, which requires him to sit most of the time at work. Michael describes himself as a social drinker, taking six pints on three nights per week. He weighs 102kg and he is 1.7m tall. He has not been to his family doctor for at least ten years. Recently, he had his blood sugar checked during a Health Awareness day at work. His glucometer blood sugar reading was 12.2mmol/l and he has been advised to see his GP. Michael attends his GP and is given an appointment to see the practice nurse (PN) for an Oral Glucose Tolerance Test (GTT). The PN gives Michael a return appointment for three days later to discuss the results. The GTT Results are as follows: Fasting Blood Sugar = 7.2, Blood Sugar two hours post 75g glucose load = 12.

QUESTIONS
1. What are the criteria for a diagnosis of diabetes?
2. What type of diabetes is Michael likely to have? Give reasons for your answer.
3. Describe key elements of the initial assessment? Please include what other investigations, if any, should be included.
4. Michael needs the knowledge, skills and motivation to manage his diabetes care. Outline key points to be included in patient education.
5. What are the complications of diabetes that Michael could be at risk of?
6. What is the aim of diabetes care?
7. What care should Michael expect? Briefly mention the role of each person involved in the diabetes care team.
8. What should be included in an annual review of diabetes?
9. Give the targets for blood pressure, lipid profile, HbA1c.
11. In your opinion what are the barriers to delivering diabetes care in general practice?
12. Outline a protocol for diabetes care in your practice. Present an ideal situation, rather than currently available resources, incorporating all elements which you believe should be included to give the highest evidence based standard of care.
Disorders can be associated with depressive disorders and may result in loss of efficacy. Pregnant patients should notify their physician if they are planning to become pregnant. Use is contraindicated during lactation. Effects on ability to drive and use machines: Patients should be instructed not to increase their dose of Acomplia. Patients who have had a cardiovascular event less than 6 months ago were excluded in the studies.

Adverse Reactions: Common (≥ 1%, < 10%) – gastroenterological symptoms, anxiety, irritability, nervousness, sleep disorders, insomnia, parasomnias, memory loss, dizziness, tremor, palpitations, muscle spasm, depressive disorders, mood alterations with depressive disorder and may result in loss of efficacy. Depression and Libidinal: Use in pregnancy is not recommended. Patients should notify their physician if they do not respond to treatment with rimonabant. Use is contraindicated during lactation. Effects on ability to drive and use machines: Patients should be instructed to increase their dose of Acomplia. Patients who have had a cardiovascular event less than 6 months ago were excluded in the studies.

Adverse Reactions: Common (≥ 1%, < 10%) – gastroenterological symptoms, anxiety, irritability, nervousness, sleep disorders, insomnia, parasomnias, memory loss, dizziness, tremor, palpitations, muscle spasm, depressive disorders, mood alterations with depressive disorder and may result in loss of efficacy. Depression and Libidinal: Use in pregnancy is not recommended. Patients should notify their physician if they do not respond to treatment with rimonabant. Use is contraindicated during lactation. Effects on ability to drive and use machines: Patients should be instructed to increase their dose of Acomplia. Patients who have had a cardiovascular event less than 6 months ago were excluded in the studies.
“Be Active with Arthritis” is the new exercise programme tailor-made by Arthritis Ireland for people with arthritis. This is the first of its kind, enabling people with arthritis to maintain and improve their mobility and overall well-being by using the step-by-step DVD or book in the comfort of their home.

The programme has been designed in consultation with physiotherapists who specialise in the area of arthritis and those who have followed it have reported that they experience less pain and stiffness, improved flexibility and mobility, increased muscle strength and a better level of aerobic fitness and overall well-being.

Arthritis Ireland recruited the support of four people with arthritis to demonstrate the exercises in the DVD and book and is fronted by senior physiotherapist Emer McAuliffe.

Arthritis Ireland is dedicated to improving the quality of life of the one in six people who have arthritis, from toddlers right through to grandparents. They do this by providing practical support, information and advice and are delighted to now add this easy to follow exercise DVD to their support tools. They do note that the exercises in the programme are based on best practice, but warn that people should discuss their exercise plan with their GP or physiotherapist to rule out any reason why they may not participate.

The book costs €9.99, the DVD €12.99 or buy both for €20 and are available from Arthritis Ireland by calling on 01 6618188 or by visiting their online shop on www.arthritisireland.ie.

All proceeds go to Arthritis Ireland to help make a difference to the lives of the 714,000 people with arthritis.

The project was supported by Roche Products (Ireland) Limited.

L-Theanine calms and focuses the mind

L-Theanine is a well-researched, safe and effective amino acid. A perfect, natural aid for alleviating stress and anxiety, it gently calms and focuses the mind, and makes life that little bit easier at times.

“L-Theanine has been used successfully to promote relaxation, reduce stress and anxiety, and improve mood,” said medical nutritionist Naomi Beinart. “Nearly everyone could benefit from taking this product at some point, to help cope with life’s ups and downs, as anxiety and depression can be debilitating conditions that effect performance and general well being amongst many other things. This product will work within 40 minutes of being in the body and can be taken only when needed, or everyday if required.”

L-Theanine appears to cross the blood brain barrier and has been shown to influence brain wave activity, possibly via an influence on neurotransmitters such as dopamine and serotonin, suggesting potential applications in stress, anxiety and depression. It can be used ‘as and when required’ for short-term anxiety symptoms, or daily to support health needs. Solgar L-Theanine is sold nationwide through health food stores and selected pharmacies. For further L-Theanine technical information, please speak to Solgar Technical Support on tel: +44 1442 890 355.

Biogen Idec and Elan present new TYSABRI data at the 60th annual meeting of the American Academy of Neurology

Biogen Idec and Elan Corporation, have announced new data on the global use, safety and overall patient exposure of TYSABRI (natalizumab). As of March 2008, approximately 26,000 patients were on commercial and clinical therapy worldwide with no cases of progressive multifocal leukoencephalopathy (PML) reported since re-launch in the US and launch internationally in July 2006. Growth in global use plus increasing confidence in the favourable benefit-risk profile of TYSABRI indicate the companies are making great progress toward the goal of 100,000 patients on therapy by year-end 2010.

“These data suggest that neurologists and patients are increasingly choosing TYSABRI for the treatment of their disease,” said Michael Panzara, MD, MPH, vice president and chief medical officer, Neurology Strategic Business Unit, Biogen Idec. “The significant clinical benefits are established and TYSABRI continues to offer the potential for compelling efficacy and hope for those patients living with MS.”

“Positive outcomes for patients continue to support TYSABRI’s strength as a valuable treatment for multiple sclerosis patients in more than 30 countries around the world,” said Gordon Francis, MD, senior vice president, Global Clinical Development, Elan. “We are also excited that patients with Crohn’s Disease are now enrolling in the TOUCH program and beginning to receive TYSABRI treatment in the US.”
At a late breaking presentation made on April 29th during the annual meeting of the European Atherosclerosis Society held in Istanbul, the investigators of ADAGIO-LIPIDS presented the key findings of a one year trial aiming at further studying the effects of rimonabant on several features of HDL and on a comprehensive set of cardiometabolic markers. Furthermore, an imaging substudy using computed tomography was conducted to test, for the first time, the hypothesis that rimonabant could induce a loss of visceral fat and liver fat.

“We know that the most prevalent form of the metabolic syndrome is associated with abdominal obesity, particularly with an excess of visceral fat as well as with accumulation of fat at undesired sites such as the liver, the heart, the muscle and the pancreas, a phenomenon referred to as ectopic fat deposition,” said Dr Jean-Pierre Després from the Hôpital Laval Research Center, Université Laval, Québec, Canada, who is the principal investigator of ADAGIO LIPIDS. “Although we had evidence from the phase III studies conducted with rimonabant that antagonism of the endocannabinoid system could induce a reduction in waist circumference (a crude marker of abdominal fat) and improve several features of the metabolic syndrome, no study had ever quantified the effect of this drug on visceral adiposity and liver fat.”

“Results of ADAGIO-LIPIDS are pretty much ‘textbook’ regarding what we knew from endocannabinoid physiology and their effect on lipid metabolism,” continued Dr Després. “All markers of cardiometabolic risk improved in the right direction with rimonabant therapy, including a significant reduction of -3.3 mmHg for systolic and of -2.4 mmHg for diastolic blood pressure (p<0.0001). The next important question was, how does rimonabant work?”

“Results of the CT imaging study are pretty straightforward. We found that rimonabant therapy for one year induced a preferential mobilization of visceral adipose tissue compared to placebo (reduction of 10.1% vs placebo, p<0.0005), which was greater than the loss of subcutaneous fat (decrease of 5.1% vs placebo, p<0.005)” stated Dr Robert Ross, the co-principal investigator of ADAGIO-LIPIDS. “Another relevant finding is that we report for the first time that rimonabant induced a significant mobilization of liver fat (decrease in the fatty liver index, p<0.005) which was associated with a significant improvement in ALT levels (p<0.001), a commonly used marker of liver function also associated with the features of the metabolic syndrome.”

As CB1 receptors are located in organs other than the brain, such as the adipose tissue and the liver, results of ADAGIO-LIPIDS are consistent with the hypothesis that antagonism of these peripheral CB1 receptors could slow lipogenesis in both adipose tissue and the liver, leading to loss of both visceral and liver fat.

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**Predictive genetic test for bowel cancer treatment introduced in the UK**

Amgen Limited UK and Lab21 have announced their partnership to introduce a new genetic therapy test for advanced bowel cancer treatment in the UK. Under the terms of the agreement, leading diagnostics company Lab21 will provide a screening test to indicate which patients are likely to benefit from Amgen’s new drug for advanced bowel cancer Vectibix (panitumumab). It is the first time that the European Commission has licensed a bowel cancer product with the stipulation that a predictive test should be carried out. The Lab21 test was developed by DxS Ltd, a developer of biomarker assays and companion diagnostics for targeted cancer therapies.

Introduced to the UK earlier this year, Vectibix is currently licensed for patients with metastatic bowel cancer for whom standard chemotherapy has failed in patients with a specific gene mutation. In a biomarker analysis of the pivotal clinical trial, the drug doubled median progression-free survival in patients with non-mutated (wild type) KRAS (Kirsten Rat Sarcoma 2 viral oncogene homologue) compared with patients receiving best supportive care alone.

Amgen scientists had discovered that only those patients with the non-mutated (wild type) KRAS would respond to Vectibix. Patients with metastatic bowel cancer will be tested for the presence of the wild type KRAS gene before they are prescribed the drug.

According to Dr Charles Brigden, medical director of Amgen Limited UK, the company is proud that for the first time it will be able to treat advanced bowel cancer patients with a targeted agent based on a predictive biomarker.

“This is a big step forward towards individualised care in bowel cancer. We now know that Vectibix will only be effective in those patients whose cancers are positive for non-mutated (wild type) KRAS. Conversely, it also means that we can exclude those patients in whom the agent will not be beneficial.”
Study shows that high-dose, high-frequency interferon produces no additional benefit on efficacy compared to once weekly AVONEX (interferon beta-1a) in patients with relapsing-remitting multiple sclerosis (RRMS)

Results of a phase IV, open label, head-to-head study of intramuscular AVONEX and high-dose, high-frequency subcutaneous Rebif (interferon beta-1a) provide clinical evidence that the two drugs show similar efficacy over 18 to 30 months of continued therapy in patients with RRMS. These data are published in the April 2008 issue of the Journal Current Medical Research and Opinion.

The Prospective and Retrospective Long-Term Observation- al Study of AVONEX and Rebif (PROOF), involved 217 patients, 136 completed the study, with 69 completing a median of 25.9 months of AVONEX 30mcg once weekly and 67 completing a median of 22.2 months of Rebif 44mcg three times weekly.

After controlling for baseline disability level, Expanded Disability Status Scale (EDSS) scores showed no statistically significant differences between the two treatment groups during the prospective portion of the study, with sustained disability progression similar for both: 25.8 per cent for AVONEX vs. 26.7 per cent for Rebif 44.

Relapse rates, MRI endpoints of brain parenchymal fraction, T1 lesion volume, T2 lesion volume, number of new/enlarging T2 lesions and gadolinium enhancing (Gd+) lesion volume and count were also comparable between both groups. In addition, 19 per cent of patients taking Rebif 44 tested positive for neutralising antibodies (NAbs) at end of treatment compared with zero per cent taking AVONEX.

“Given that this data shows similar efficacy between AVONEX and Rebif 44, physicians and patients with relapsing-remitting MS may want to consider factors that influence ease of use and adherence to treatment such as convenience of administration, injection tolerability and immunogenicity when selecting therapy,” said Dr Murray.

“These results are in accordance with a growing body of evidence from other trials that consistently prove that interferons demonstrate efficacy. This efficacy seems to be similar regardless of dose or frequency,” said Pete Smith, MD, Biogen Idec, UK and Ireland. “AVONEX is the only once-a-week therapy that reduces disability progression whilst offering a low incidence of injection site reactions.”

New powerful antihypertensive MicardisPlus 80/25 (80mg telmisartan/25mg hydrochlorothiazide) approved by EU Commission

Boehringer Ingelheim has announced that the EC has granted marketing authorisation for the new powerful strength of their fixed dose combination antihypertensive drug MicardisPlus 80/25 in all 27 EU member states. It will be launched in Germany and Denmark in the coming weeks, followed soon by Ireland, the UK and the rest of EU.

MicardisPlus 80/25 is licensed for the treatment of essential hypertension in patients whose blood pressure is not adequately controlled on MicardisPlus 80/12.5 (80mg telmisartan/12.5mg hydrochlorothiazide) or patients who have been previously stabilised on telmisartan and hydrochlorothiazide separately at the same dosages.

The new strength will be marketed by Boehringer Ingelheim in all 27 countries of the EU under the brand name MicardisPlus 80/25.

NEW PREPARATION H* RANGE LAUNCHED

Preparation H Cooling Gel is a modern new product which is non-greasy and easy to apply. Formulated as a clear gel with Witch Hazel and other moisturising ingredients, Preparation H Cooling Gel provides cooling relief from sore skin associated with piles.

Designed to be used in place of regular toilet tissue, Preparation H Soothing Wipes are hypoallergenic, fully biodegradable and flushable. They should be used in combination with existing treatments to soothe and cleanse the affected area after each bowel movement. Impregnated with Witch Hazel and Aloe Vera, Preparation H Cooling Wipes help to relieve external itching and dry, sore skin.

Importantly, the products in the Preparation H range are suitable for use by pregnant and breastfeeding women.

Available only from pharmacies, Preparation H Cooling Gel is available in tubes of 25g and 50g and the Soothing Wipes come in a 30s handy pack with a moisture lock lid.

* Trade Mark
Patients treated with Merck’s investigational extended-release niacin/laropiprant reported significantly less flushing than patients treated with prolonged-release nicotinic acid in Phase III study

Data presented at the recent Scientific Session of the American College of Cardiology (ACC) in Chicago highlighted that patients with dyslipidemia treated with extended release niacin/laropiprant reported significantly less flushing and significantly fewer discontinuations due to flushing than patients treated with PR niacin. Niacin is a proven lipid-modifying agent; however, a major barrier to its use is the side effect of flushing.

Niacin/laropiprant is an investigational lipid-modifying agent in development by Merck & Co Inc. that combines Merck-developed extended release (ER) niacin with the agent laropiprant, a novel flushing pathway inhibitor. Niacin-induced flushing is caused primarily by a prostaglandin, PGD2, a chemical that acts through the DP1 flushing pathway to cause vasodilation in the skin and flushing symptoms. Laropiprant selectively blocks the binding of PGD2 to its receptor, DP1, thereby reducing flushing associated with niacin. One tablet contains 1g of Merck-developed ER niacin and 20 mg of laropiprant.

“Niacin lowers LDL cholesterol and triglycerides, is a highly effective therapy for raising HDL cholesterol and is proven to reduce the risk of cardiovascular events in patients with heart disease,” said Dr Colm Galligan, medical director, MSD Ireland (Human Health) Ltd. “Yet, the severity, frequency and duration of the flushing side effect of niacin limits patients from staying on therapy and reaching the maximum recommended dose of 2g. This study shows that the improved tolerability profile of niacin/laropiprant may prevent more patients from discontinuing therapy due to flushing.”

NICE releases appraisal consultation document on treatment of pulmonary arterial hypertension in adults

The National Institute for Clinical Excellence (NICE) has published on its website the preliminary recommendations of its Appraisal Committee on the use of epoprostenol, iloprost, bosentan, sitaxentan and sildenafil for the treatment of pulmonary hypertension in adults.

In UK clinical practice, patients with PPH normally begin with symptomatic treatment alone. As the disease progresses, the patient will require disease-specific oral therapies and will eventually need a prostanooid in order to control the advancement of the disease and maintain quality of life. Prostanoids can be inhaled or given by intravenous infusion. The appraisal consultation document from NICE proposes that patients are to be denied access to prostanooid therapy and that other therapeutic choices are limited to one first line oral therapy (sildenafil) and two alternative oral therapies (bosentan and sitaxentan), for patients in whom sildenafil is contraindicated or poorly tolerated.

Ventavis(R) (inhaled iloprost) has a vital role in bridging the gap between oral therapy alone and the need for continuous IV prostanooids (eg epoprostenol). It is not intended as a replacement for oral therapies. Ventavis(R) offers advantages over IV therapy in respect to convenience and tolerability and avoids both tachyphylaxis (large increases in dose, therefore cost, over time) and the risks associated with the IV route of administration.

Novel drug tocilizumab significantly improves the debilitating symptoms of RA in patients who have an inadequate response to standard therapy

People with rheumatoid arthritis (RA) treated with tocilizumab experienced a rapid and significant reduction in the signs and symptoms of their disease, according to a study published in a recent issue of The Lancet.

Tocilizumab is the first humanised interleukin-6 (IL-6) receptor-inhibiting monoclonal antibody.

Results from the OPTION trial – a major Phase III international study – demonstrated that people with RA not only achieved greater improvement of symptoms but also a higher quality-of-life with tocilizumab, an innovative interleukin-6 (IL-6) receptor inhibitor, compared with methotrexate, a commonly used RA treatment.

“Results of this pivotal study convincingly demonstrate that tocilizumab can effectively and rapidly diminish the painful and debilitating effects of rheumatoid arthritis,” said Josef Smolen, MD, lead investigator of the OPTION trial and Professor of Medicine at the Department of Internal Medicine at the Medical University of Vienna, Austria. “These trial findings are significant because we know that many rheumatoid arthritis patients continue to experience symptoms of joint pain and stiffness, physical disability and fatigue despite treatment with existing therapies.”

Tocilizumab is the first humanised interleukin-6 (IL-6) receptor-inhibiting monoclonal antibody and it represents a novel mechanism of action to treat RA. Research has shown that reducing the activity of IL-6, one of several key cytokines involved in the inflammatory process, reduces inflammation of the joints and relieves certain systemic effects of RA.
ACROSS
6 It's enough to turn litmus blue! (6)
7 Cores, we hear, but that's rough (6)
8 Would they pass for health resorts? (4)
9 I ban clan for eating its own species (8)
10 Breaking par during Open can be gas! (7)
12 Swimmer at the extremities of 12 down (4)
13 Laid about for the House! (4)
15 A live TV mix-up in Israel (3,4)
17 Grace gets ill irrationally due to being hypersensitive to 11 down (8)
20 Reign, we hear, of the horse, perhaps (4)
21 Young doctor may become unnaturally tinner (6)
22 Shellfish worthy of a festival in Galway (6)

DOWN
1 It's a mistake to reverse pupils! (4-2)
2 Loots bar drunkenly for a seat (3,5)
3 Record (4)
4 Tax incentive includes public transport (4)
5 Mr Wilde's awards? (6)
7 Would a botched lance go on to coagulate? (7)
11 Toxin extracted from genatin? (7)
12 Could having a high temperature even be found in 12 across? (8)
14 I align poorly, feeling poorly (6)
16 Envied, funnily, having blood vessels (6)
18 It's not odd that it is smooth (4)
19 What a rooster might do – or another bird is! (4)

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