Are your patients at risk?

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

**See Immunisation Guidelines for Ireland www.immunisation.ie

AN OVERVIEW OF ASTHMA
Frances Guiney

THE BENEFITS OF NASAL DOUCHING
Dr Paul Carson

MULTIMORBIDITY – THE PRACTICE NURSE PERSPECTIVE
Jane Campion
Dr Mary Byrne

WOMEN AND EPILEPSY
Sinead Murphy

COMBATING OBESITY IN CHILDREN
Marie Flood

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

Marketing authorisation holder: Sanofi Pasteur MSD Limited, Block A, Second Floor, Cookstown Court, Old Belvedere Road, Tallaght, Dublin 24.
Marketing authorisation number: PA 544/21/3
Legal category: POM

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

* All infants are offered immunisation against pneumococcal disease as part of the National Immunisation Programme.
** See Immunisation Guidelines for Ireland www.immunisation.ie
Pneumococcal Disease

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

**PNEUMOVAX® II**

Pneumococcal Polysaccharide Vaccine

**Indications:**
For active immunisation against disease caused by the pneumococcal serotypes included in the vaccine. The vaccine is recommended for individuals 2 years of age or older in whom there is an increased risk of morbidity and mortality from pneumococcal disease. It is not known whether the vaccine can cause foetal harm or affect reproduction capacity when administered to a pregnant woman; the vaccine can be given to pregnant women only if clearly needed (potential benefit outweighs potential risk). It is not known whether this vaccine is excreted in human milk; caution should be exercised when the vaccine is administered to a nursing mother. Vaccination should be delayed until 1 month post-partum. Vaccination should not be given to a patient within 5 years of a previous dose of pneumococcal vaccine.

**Contraindications:** Hypersensitivity to any component of the vaccine. Warnings and precautions: As with any vaccine, adequate medical treatment, including epinephrine (adrenaline), and supervision should always be available in case of an acute anaphylactic reaction. It is not known whether the vaccine can cause foetal harm or affect reproduction capacity when administered to a pregnant woman; the vaccine can be given to pregnant women only if clearly needed (potential benefit outweighs potential risk). It is not known whether this vaccine is excreted in human milk; caution should be exercised when the vaccine is administered to a nursing mother. Vaccination should be delayed until 1 month post-partum. Vaccination should not be given to a patient within 5 years of a previous dose of pneumococcal vaccine.

**Package quantities:** Single pack containing one 0.5 millilitre single dose vial. Marketing authorisation holder: Sanofi Pasteur MSD Limited, Block A, Second Floor, Cockstown Court, Old Belvedere Road, Tallaght, Dublin 24. Marketing authorisation number: PA 544/21/3 Legal category: POM Date of last review: June 2010

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

* All infants are offered immunisation against pneumococcal disease as part of the National Immunisation Programme.
** See Immunisation Guidelines for Ireland www.immunisation.ie
Reasons to be cheerful

We are living in a world of change. There only constant in this world is change. By the time this journal is published we will have a new president and a swingeing budget not far behind.

It is said that the HSE has been living “precariously” – financially speaking - for some time now. Health Minister James Reilly, recently stated that we must enhance and expand our capacity in the primary healthcare arena aiming to deliver universal PHC. Mr Reilly explains further that we need to remove cost as a barrier to access for patients.” This is critical if we are to deliver a proactive, joined-up approach to the management of our nation’s health.”...“If we are to develop the health services it is vital that we do so in a unified manner, where there is a common understanding of our goals and how they can be achieved in difficult circumstances.”

Yet a war of words between the IMO and the HSE is threatening to blow up into a dispute following a threat to withhold General Practitioner payments!

According to Dr Richard Barker, health systems around the world are “heading for a major meltdown in the next 20 years unless we get our strategy right now.” Barker believes that healthcare is “one of people’s most cherished needs and indeed rights, so it’s political dynamite. But it is also full of vested interests that fight change”. It seems that policy seriously dictates before people.

There is talk about moving the national vaccination programme into community pharmacies. If this happens the future of vaccination schedules and preventive measures is not an optimistic one.

Up to now practice nurses nationally have increased the uptake of vaccinations and continue to push forward completing vaccination schedules by 95% in many practices. To move the service into community pharmacies would amount to no specific responsibility for ensuring that the patient is vaccinated. What chaos would occur?

To date some pharmacists have taken further education and updates to provide and administer the flu vaccination this year; some of them are still waiting for a delivery of the vaccinations due to lack of finalised policy and payment agreements. Dare I mention the disastrous lack of administration and organisation last year with the introduction of the H1N1 vaccination programme?

Rather than lament the past let’s recognise that we have amazing technologies which predict, detect and treat many diseases. We have wonderful imaging tools, new cell therapies, smart implantable devices, and mobile health technologies and screening services the list is endless.

We also have …the Practice Nurse. We can contribute to saving the day but only as a member of a team working together. Let’s not forget that we are the existing link between: healthcare prevention, chronic disease management, patient empowerment, waste reduction. With all these skills we are as a group tackling disease earlier. On the note of waste management about two thirds of hospital admissions result from poorly managed chronic disease, for which we can all aim to improve as a group. We do need to empower patients to take charge of their own health to the best they can. It seems that the challenge is to co-ordinate the implementation of complex change across the country.

In essence, James Reilly has said that “the HSE has committed to having clear lines of accountability at individual, service, regional and national levels, with accountability to employers, professional bodies, service users and the public”. (IHCA 2011, AGM)

What can you do to make a change…to make a difference…to make it better? Only you know that.

‘Triumph and disaster’ are both imposters as Rudyard Kipling said in his poem, If.

Darina Lane
Long-acting, specific antimuscarinic agent, available as hard capsules of powder for inhalation, containing tiotropium bromide monohydrate equivalent to 18 micrograms tiotropium. **Indication** Tiotropium is indicated as a maintenance bronchodilator treatment to relieve symptoms of patients with chronic obstructive pulmonary disease (COPD). **Dose** Adults only age 18 years or over: Inhalation of the contents of one capsule once daily from the HandiHaler® device. **Contra-indications** Hypersensitivity to tiotropium bromide, atropine or its derivatives, or to the excipient lactose monohydrate which contains milk protein. **Precautions** Not for the initial treatment of acute episodes of bronchospasm, i.e. rescue therapy. Immediate hypersensitivity reactions may occur after administration of tiotropium bromide inhalation powder. Caution in patients with narrow-angle glaucoma, prostatic hyperplasia or bladder-neck obstruction. Inhaled medicines may cause inhalation-induced bronchospasm. In patients with moderate to severe renal impairment tiotropium bromide should be used only if the expected benefit outweighs the potential risk. Patients should be advised that this may result in precipitation or worsening of narrow-angle glaucoma, eye pain or discomfort, temporary blurring of vision, visual halos or coloured images in association with red eyes from conjunctival congestion and corneal oedema. Should any combination of these eye symptoms develop, patients should stop using tiotropium bromide and consult a specialist immediately. Tiotropium bromide should not be used more frequently than once a day. Spiriva capsules contain 5.5 mg lactose monohydrate. **Interactions** Although no formal drug interaction studies have been performed tiotropium bromide inhalation powder has been used concomitantly with other drugs without clinical evidence of drug interactions. These include sympathomimetic bronchodilators, methylxanthines, oral and inhaled steroids, commonly used in the treatment of COPD. The co-administration of tiotropium bromide with other anticholinergic-containing drugs has not been studied and is therefore not recommended. **Pregnancy and Lactation** No clinical data on exposed pregnancies are available. The potential risk for humans is unknown. Spiriva should therefore only be used during pregnancy when clearly indicated. It is unknown whether tiotropium bromide is excreted in human breast milk. Use of Spiriva is not recommended during breast feeding. A decision on whether to continue or discontinue breast feeding or therapy with tiotropium bromide should be made taking into account the benefit of breast feeding to the child and the benefit of tiotropium bromide therapy to the woman. **Side-effects** Common (≥1/100, <1/10): Dry mouth. Uncommon (≥1/1,000, <1/100): Dizziness, headache, taste disorders, vision blurred, cough, pharyngitis, dysphonia, rash, nausea, stomatitis, dysuria, urinary retention, gastrooesophageal reflux disease, atrial fibrillation, constipation. See SPC for other undesirable effects. Events of unknown frequency not attributed to tiotropium in clinical trials but considered to be adverse drug reactions: dehydration, dental caries, angioneurotic oedema, skin infection, skin ulcer, dry skin, joint swelling. An increase in anticholinergic effects may occur with increasing age. **Pack sizes** HandiHaler device and 30 capsules (3 blister strips); HandiHaler device plus 10 capsules (1 blister strip); 30 capsules (3 blister strips). **Marketing authorisation number** PA 7752/1. **Legal category** POM. **Marketing Authorisation holder** Boehringer Ingelheim International GmbH, D-55216 Ingelheim am Rhein, Germany. For full prescribing information please see Summary of Product Characteristics. Updated July 2009.

**Prescribing Information (Ireland)**

**SPIRIVA® (tiotropium)**

Prescribe SPIRIVA® (tiotropium) and reduce the number of exacerbations in your COPD patients this winter

**Reference:**

Tiotropium is indicated as a maintenance bronchodilator treatment in adults with chronic obstructive pulmonary disease (COPD).

Prescribing Information (Ireland)

Contra-indications

Hypersensitivity to tiotropium bromide, atropine or its derivatives, or to the excipient lactose monohydrate which contains milk protein.

Interactions

Although no formal drug interactions have been studied, the potential for interactions with other drugs should be considered, particularly when taking into account the benefit of bronchodilator therapy to the woman. Tiotropium has been shown to potentiate the anticholinergic effects of other anticholinergic-containing drugs. Tiotropium has been co-administered with beta2-sympathomimetic bronchodilators, methylxanthines, oral inhaled steroids, and other long-acting muscarinic antagonists in clinical trials but considered to be adverse drug reactions: dehydration, dental caries, angioneurotic oedema, nasal and ocular dryness, abnormal liver function tests, increased serum creatinine, increased serum uric acid, skin infections, skin ulcers, application site reactions, transient fever, joint pain.

Pack sizes

HandiHaler device plus 10 capsules (1 blister strip); 30 capsules (3 blister strips). HandiHaler device plus 30 capsules (3 blister strips).

Pregnancy and Lactation

Spiriva should be used with caution in pregnancy if clearly indicated. It is not recommended to use Spiriva during pregnancy, unless the potential risk for the child is considered to outweigh the potential risk of breast feeding.

The contents of Nursing in General Practice are protected by copyright. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form by any means – electronic, mechanical or photocopy recording or otherwise – whole or in part, in any form whatsoever for advertising or promotional purposes without the prior written permission of the editor or publishers.

Disclaimer

The views expressed in Nursing in General Practice are not necessarily those of the publishers, editor or editorial advisory board. While the publishers, editor and editorial advisory board have taken every care with regard to accuracy of editorial and advertisement contributions, they cannot be held responsible for any errors or omissions contained.
Protecting today.
Growing tomorrow.

Pfizer Vaccines –
helping to protect children right from the start.
IPNA CONFERENCE AGM 2011

New NEC Officers were elected as follows:

**National Chairperson** Róisín Doogue

**National Vice-Chairperson** Siobhán Jordan

**National Honorary Treasurer** Bríd Buckley

**National PRO** Judy Hayes

The NEC would like to thank the outgoing NEC Officers (Orla Loftus-Moran, Mary O’Connor and Lynn Cartwright) most sincerely for all their time and efforts in fulfilling their roles over the past number of years.

Motions ratified at the AGM: NEC Motion and Cavan/Monaghan Motion. The ratified NEC Motion will be sent as soon as possible to the Charities Section of the Revenue Commissioners for approval.

The NEC would like to congratulate all who won Educational Awards at the Conference.

**IPNA Educational Bursary**

Winner: Ruth Morrow

---

**IPNA Clinical Award**

Winner: Margaret Geoghegan

Runner-up: Chinemye Onuoha

**IPNA Valerie Mangan IPNA Loyalty Award**

Winner: Maureen Delaney

1st Runner-up: Catherine Enright

2nd Runner-up: Monica Dowling

3rd Runner-up: Siobhan Moore

ProMed won the Best Exhibit Award which was offered by the South Tipperary Branch (hosts) and judged by the conference delegates.

**NEC MEETINGS 2012**

**Ashling Hotel, Parkgate Street, Dublin 8**

- Wednesday 1st February 2012.
- Wednesday 2nd May 2012.
- Wednesday 5th September 2012.

**IPNA WEBSITE**

The IPNA website, www.irishpracticenurses.ie is updated constantly, so please log-in regularly to get the latest news on study days etc.

Lisa Nolan Tel: 042-9692403 e-mail: admin@irishpracticenurses.ie

---

**First PhD programmes in nursing at WIT**

Waterford Institute of Technology (WIT) announced recently that its Department of Nursing has been granted the power to deliver doctoral research programmes in nursing by the Higher Education and Training Awards Council (HETAC). WIT is the first Institute of Technology to offer a Level 10 research programme in nursing. The doctoral programme will focus on making a direct impact on the nursing aspect of patient care in clinical and community settings.

Dr Donal Ormonde, Chairman of WIT’s Governing Body, and WIT PhD students: Jennifer Cunningham, Annette Murphy and Lorraine Murphy

---

**Part time practice nurse required**

Part time practice nurse required for General Practice in city centre, Dublin 2.

- 9-12 hours a week initially, morning clinics.
- Duties include immunization, smear taking, phlebotomy. Midwifery an advantage.
- Fully computerised (GP Dynamic).

*Please apply with CV to email: reception@harcourtheath.ie*
New resource directory for people with ADHD

Minister Frances Fitzgerald launched the HADD (Hyperactivity Attention Deficit Disorder) family support group’s new guide to ADHD services for people living with ADHD in Ireland recently. The guide, entitled ‘The A to Zee of ADHD’, clearly outlines the diagnosis and treatment pathway for people living with ADHD in Ireland. The guide has been created by HADD to help people with ADHD to navigate the healthcare system to receive the best care available in Ireland. ADHD affects between 3% – 7% of school age children which equates to between 25,000 – 60,000 children.

However, a new report contributed to by HADD also revealed that there are major gaps in the services available to people living with the condition. The report entitled ‘ADHD Europe Survey 2011’ includes a review of the diagnosis and treatment of ADHD in Europe. The report highlighted discrepancies across Europe in terms of the diagnosis, treatment and provision of services for people living with ADHD. This is despite projected increases of people seeking help across Europe. In addition, the need for professional training, guidance for teachers and inclusion of children with ADHD in main stream education remains unfulfilled. In Ireland, the ratio of psychologist to student is 5,000 to 1, compared with the European average of 3,000 to 1. In terms of diagnosis, in Ireland there is only one psychiatrist per 168 children living with ADHD and the waiting time for a public consultation can be over a year in many cases.

‘The A to Zee of ADHD’ covers a wide range of information including assessment, treatment options and support services available. This is the first time that all of this information has been made available in one succinct directory that is available to the general public.

To receive a copy of ‘The A to Zee of ADHD’, contact HADD Family Support Group on 01 874 8349 or download a copy at www.hadd.ie

Psoriasis awareness campaign and website

Irish actress Jenny Kavanagh revealed details of her 15 year experience with psoriasis at the launch of an educational campaign aimed at dispelling the myths associated with the skin condition.

Healthcare professionals can register with www.dermatologyinfocus.ie to receive convenient day-to-day access to dermatology news and trends within this specialty area. To register for Dermatology in Focus, simply log on to website and enter the promotional code ‘dermainfocus’ to get instant access to this new resource.

The Dermatology in Focus website also offers users the opportunity to sign up for the quarterly newsletter publication, Dermatology in Focus which features contributions from Irish healthcare professionals.

New UK study finds increased role for practice nurses in treating depression

Structured contact with practice nurses can help people with chronic and recurrent depression in their recovery, a study by the Royal College of Nursing and Mind has shown.

The findings of a three-year ProCEED intervention study released today show that enhanced nurse-led care can have significant mutual benefits for nurses and patients.

RCN Chief Executive and General Secretary, Dr Peter Carter, says that general practice nurses play a huge role in managing the care of patients with long term physical conditions but says their potential for improving the quality of life for patients with depression has never been realised across the board.

“Depression is a co-existing factor in many long term conditions and this new approach will see a more holistic approach to treatment for the benefit for patients and clients,” he says.

A new training pack on depression aimed at practice nurses has also recently been released.

“We are delighted to support this new initiative and hope that nurses will be encouraged to use this excellent training pack to enhance their skills, knowledge and confidence in the management of depression,” adds Dr Carter.

Read more about Mind at www.mind.org.uk

Assessing and managing pain meeting

Mary Herron, Portumna Retirement Village, Aine O’Toole, Portumna Retirement Village, Maggie Budzowska, Coral Haven Nursing Home and Colette Holland, Grünenthal at the Assessing and Managing Pain, A Nursing Perspective Meeting sponsored by Grünenthal Pharma Ltd.
Congratulations to South Tipperary branch for hosting this years AGM in Tullamore, Co Offaly. A very informative and enjoyable weekend was had by all.

The Cavan/Monaghan branch had their AGM in The White Horse Hotel in September. Fiona Boyle is stepping down as secretary with Claire Burke kindly taking over. Margaret McLean remains as chairperson, Margaret Geoghegan remains as Treasurer, Maura Costello will continue to organise meetings, Winnie McCabe will continue as INO rep and Patricia Jenkins as PRO. We wish to thank Fiona for her excellent contribution as branch secretary over the last three years and wish her well in the future.

A committee was formed to help organise next year’s AGM as it will be hosted by the Cavan/Monaghan branch. Some ideas and themes were put forward - looking forward to it already.

Winnie informed us that the next INO practice nurse section meeting is on 5th November when a GP from ICGP, Dr Deirdre Lundy, will talk to us on contraception.

A calendar was drawn up for next year’s meetings. The next branch meeting is in The Errigal House Hotel, Cooteshill on 30th November, 2011. Please encourage new practice nurses to come along and join the IPNA. Branch meetings not only help us network but keep us abreast of continual changes in clinical practice.

The Cork Branch would like to take this opportunity to congratulate the South Tipperary Branch for a most enjoyable Conference - the speakers were excellent and it was a great opportunity to meet up with colleagues.

Our October meeting was held at Rochestown Park Hotel, kindly sponsored by Cathy O’Sullivan from Astra Zeneca. Guest speaker was Fiona Barton, CNS cardiovascular disease. Fiona gave a very practical and informative talk on atrial fibrillation which was thoroughly enjoyed by all.

Our November meeting, which coincided with our AGM, was on Wednesday 9th at Rochestown Park Hotel at 7.30pm. This is kindly sponsored by Mikie Doyle, Jannsen Pharmaceutical. Guest speaker is Liz Murphy, speaking on infectious diseases.

Also of note for November, the NCCP is hosting a cancer education evening on Wednesday 23rd in the MDT Room, Cardiac Renal Centre, CUH from 7.30 to 9.30 pm. They hope to raise awareness of referral guidelines, update on bowel and diabetic retinopathy screening planned for 2012, strategies to increase awareness of screening, use of cancer referral guidelines, cancers being treated in regional cancer centres and electronic guidelines.

The December meeting will be on 7th December and coincides with our Christmas Night. Sponsorship is kindly provided by Paula Duggan, Pfizer. Guest Speaker is Marie Courtney, PDC, who will talk to us about the Clinical Care Programmes notably the ones dealing with asthma, diabetes, heart failure and COPD, and the role of the practice nurse within these programmes.

We would like to take this opportunity to thank our sponsors for their support in 2011 and our guest speakers. We would also like to thank our members for their continued support throughout the year and hope this continues for the forthcoming year.

Our first meeting back after our summer break was on the 13th September and it was our AGM. The meeting was sponsored by Bayer Healthcare. Our guest speaker was Dr D Lundy who gave an update on contraception. At our AGM the same committee members were re-elected – Brid Buckley as Chairperson, Siobhan Moore as Treasurer and myself as secretary. Brid gave a review of the last year and Siobhan a review of our ‘finances’. Educational Bursaries were given to two of our members and new members were also welcomed.

Wednesday 19th October saw our next meeting, which was sponsored by GSK, presenting a talk on travel and vaccines. At this meeting, members were presented with certificates of attendance for the meetings they had attended in the past ‘branch year’.

Thanks to the Tipperary branch for hosting this year’s IPNA conference – I believe that we as a branch are hosting it in 2013!! Congratulations to Brid for being elected as Treasurer for the NEC, to Siobhan Moore for receiving one of the runners up awards in the Valerie Mangan Award. Also to Chineye Onuoha for winning the educational award.

Hi to all from the Kerry branch. Our September meeting was held in the Carlton Hotel, Tralee. It was sponsored by Maire Curtain GSK and the speaker was Claire Cullinane. Claire’s topic for the night was: How cows milk protein allergy may present in infancy. The meeting was well attended and very interesting.

Our October meeting was again held in the Carlton Hotel and was not sponsored. We had two guest speakers on the night from CUH. Lynn Swinburne, Health Promotion Officer, from the National Cancer Screening Service, gave us an update on BreastCheck and cervical screening and also a further update on bowel and diabetic retinopathy programmes planned for 2012. This was followed by our second speaker, Antoinette Cotter, Nurse Cancer Co-ordinator, from the Regional Cancer Centre, who gave us an overview of the centre and also an update on the NCCP Guidelines. Both these talks were very informative and again our meeting was well attended.

I would just like to take this opportunity to congratulate the South Tipperary Branch on their fantastic conference held in Tullamore. A good time was had by all and their speakers were both educational and interesting. Our next meeting is scheduled for Wednesday 16th November.
KILKENNY

UNA STAPLETON

Our first meeting of the autumn was held in late September where John Leahy, Substance Abuse Officer HSE spoke on addiction. This talk was sponsored by Lisa Dunworth from McNeil Healthcare. It was very informative evening.

Our next meeting scheduled for Nov 30th in Lyrath House, Kilkenny, is sponsored by Aptamil and the topic is food allergies in children and anaphylaxis. This meeting is our AGM so would like to see all members present, when members will give consideration to NEC officer change.

On behalf of the Kilkenny Branch I would like to send congratulations to the South Tipp Branch for hosting a very enjoyable and informative conference in Tullamore. Well done to all.

WICKLOW

MARY FINNEGAN

Hello to all in Wicklow Branch! Hope you all survived the atrocious weather and flooding. We remember especially the three families who have been so tragically bereaved during the recent floods. Our thoughts and prayers are with all who have suffered in any way.

Our Branch meetings resumed on Monday 26th September after the (non existent summer!!) break.

Once again this year we will be holding all meetings in the Ramada Woodland Court Hotel in Bray. All members have agreed that it is a very convenient central location for the county.

Meetings are on Mondays at 8pm, and usually finish up about 10pm.

The meeting on 26th September was very kindly sponsored by Claire Byrne from Pfizer, and both Claire and her colleague Annette Barnved attended the meeting.

Our guest speaker was Collette Blake, Urodynamics Nurse Specialist, Wexford General Hospital, who gave us a very interesting and worthwhile talk on over active bladder, urodynamics, and an overview of her role, and type of patient referrals.

The National AGM and Conference was held in Tullamore on 14th and 15th October, and 5 members from Wicklow Branch attended the weekend.

The central location of the Tullamore Court Hotel was perfect, and there was a lot of positive feedback re location. The Conference was excellent, and we would like to congratulate the South Tipperary Branch who were our hosts for the weekend. At just €90 for the full conference it was excellent value for money.

All ran very smoothly, the three workshops were excellent, if a little rushed. (Could certainly be extended by at least 15 minutes in future, as all the nurses really enjoyed the clinical workshops).

There were three excellent speakers on the Saturday morning, covering mental health in primary care, STIs, and nurse prescribing in general practice.

The weekend worked very well in its shortened version, and omitting live entertainment at the dinner was a great idea, as it gave all a chance to catch up, meet old friends, network, without the interruption of loud music. The impromptu entertainment provided by delegates was wonderful, and what a wealth of talent hidden among our colleagues!

There were 43 pharmaceutical/medical companies exhibiting, which was incredible, and all put on excellent displays with, of course, many samples for the nurses, and excellent raffles too! Without their support, this conference would not be possible, and they all deserve a special thank you for always supporting the nurses.

In all, a very enjoyable, worthwhile weekend and well done to all involved.

I am delighted to report that Wicklow’s very small branch has swelled from just 12 members three years ago to its present day count of 47! If you are one of these new members, and have not yet attended one of our branch educational meetings, you are very welcome, and we look forward to meeting you in the near future. We are a very informal group and it is always good to meet new people, share your experiences, get advice, support, and generally network.

The following is a list of meeting dates from now until end of May: Monday 21st Nov 2011 - this will be the Branch AGM, but will also have an educational topic (TBC). Monday 16th Jan 2012; Monday 27th February 2012; Monday 16th April 2012; Monday 28th May 2012.

Look forward to meeting with you all over the next few months!

WEXFORD

JUNE D’ARCY

Hi to all. We had our first meeting of the season in September, kindly sponsored by Eoin Banville from Novartis Ireland. The topic was an introduction and overview of the FISH! Philosophy, and how it can be applied not only to our work situations, but also to everyday living: an interesting concept, and one which had us in reflective mood...well, me anyway! Hopefully, you are intrigued now, and will enquire regarding same.

Congratulations in abundance to the South Tipperary Branch on a most enjoyable annual conference. It was well organised, educational and informative, good fun, very pleasant surroundings and a fantastic opportunity to meet old friends and make new ones...nurturing on all fronts! The girls present from Wexford did not come home empty handed either – four prizes from raffles and two for Catherine and Monica for the Valerie Mangan Loyalty Award, which is special to us here in Wexford, particularly on this occasion as both Catherine and Monica knew Valerie. Well done to all involved.

Our next meeting is on November 9th and will include our AGM.
An overview of asthma

Proper diagnosis, patient education, allergen avoidance, and medication compliance are all vital parts of asthma management.

FRANCES GUINEY, ASTHMA NURSE, THE ASTHMA SOCIETY

Asthma is a common chronic inflammatory disease of the airways characterized by variable and recurring symptoms, reversible airflow obstruction, and bronchospasm. Symptoms include wheezing, coughing, chest tightness, and shortness of breath.

Over the past 25 to 30 years the prevalence of asthma and allergies has increased considerably worldwide. In most cases the condition has its onset in early childhood with 80% to 90% of all cases initially being diagnosed before the age of six years. This was not always the case. For example in the early 1970s the prevalence of asthma and allergies were roughly half of what they are today.

In Ireland, asthma is the most common chronic disease and affects people of all ages, from all socio-economic groups and all geographic regions. Asthma is the most common chronic disease in childhood and the most common respiratory disease in Ireland. The morbidity of the disease varies greatly in patients and can be very mild, with no impact on their daily lives, to a severely debilitating disease with frequent hospitalisation and a huge impact on the patient’s quality of life. Asthma can be under-diagnosed and under controlled, creating a substantial burden to individuals.

CAUSES

The cause of asthma is likely to be attributable to genetic factors. However, there is a substantial amount of evidence which suggests that genetic factors alone cannot account for the increase in prevalence, as they take several generations to manifest.

There is clearly an equatorial disparity between north and south, with western industrialised countries which are furthest away from the equator – New Zealand, Australia and the UK having the highest prevalence worldwide. In the USA the asthma epidemic appears to be worse among the urban poor, particularly among African-Americans and Puerto Ricans and there is also a clear urban/rural gradient among poorer, developing nations.

It is important to note that, not only has asthma and Th2 diseases such as allergic rhinitis, eczema and food allergy increased but so too have a number of Th1 conditions such as type 1 diabetes and Crohn’s disease.

One theory behind the increase in asthma is the hygiene hypothesis, which states that a decrease in childhood infections leads to a “missing immune deviation”; however this does not explain the rise in Th1 conditions or why children who are most at risk of developing asthma are also susceptible to upper respiratory infections.
Not only has asthma and Th2 diseases such as allergic rhinitis, eczema and food allergy increased but so too have a number of Th1 conditions such as type 1 diabetes and Crohn’s disease.

Diet and lifestyle have contributed to the increase in asthma. There are numerous recent papers linking diet to respiratory disease, in both adults, children and during pregnancy. In particular, there are links made between the role of vitamins, choice of food and respiratory health. In addition, the affect of indoor environment, tobacco smoke and obesity on the rise of asthma prevalence deserve further study and consideration.

SYMPTOMS
Asthma is a chronic inflammatory disorder of the airways in which many cells and cellular elements play a role. The chronic inflammation is associated with airway hyper-responsiveness that leads to recurrent episodes of wheezing, breathlessness, chest tightness, and coughing, particularly at night or in the early morning. These episodes are usually associated with widespread, but variable airflow obstruction within the lung that is often reversible, either spontaneously or with treatment.

DIAGNOSIS
A diagnosis of asthma is based on the recognition of a significant pattern of symptoms. Asthma symptoms may be intermittent and non specific and a correct diagnosis is essential for proper management of the condition. This is particularly true among children where misdiagnosis often identifies various forms of bronchitis or croup. Misdiagnosis in the elderly often takes the form of a diagnosis of COPD or a cardiac condition which in turn leads to mismanagement and inappropriate treatment. The key is to take a careful clinical history and in many cases this will allow a reasonably certain diagnosis of asthma or an alternative diagnosis to be made.

Useful questions to consider when making a diagnosis:
- Are the symptoms worsened by seasonal increases in specific aeroallergens e.g. pollen, birch and ragweed pollens.
- Is there a cough-variant element present? This is particularly common in children.
- Other diagnoses to be considered are cough induced as a result of ACE inhibitors, gastro-oesophageal reflux (GORD), postnasal drip, reflux, chronic sinusitis, vocal cord dysfunction.

The physical examination may show a normal respiratory system because of the variability of asthma symptoms. Wheezing on auscultation is usually found; however, in severe asthma exacerbations wheezing may be absent. Clinical signs maybe present if patients are examined during symptomatic periods. It is important, even in relatively clear-cut cases, to obtain objective support for the diagnosis.

There are several tests for diagnosis and monitoring asthma:
- Measurement of spirometry and peak expiratory flow provides an assessment of severity of airflow limitation, its reversibility and its variability, and provides confirmation of the diagnosis of asthma.
- Spirometry is recommended as the ideal method to establish a diagnosis of asthma.
- Reversibility (improvements in FEV1 within minutes after inhalation of rapid-acting bronchodilator or sustained improvement over days/weeks after introduction of effective controller treatment such as inhaled glucocorticosteroids). The degree of reversibility in FEV1 which indicates a diagnosis of asthma is accepted as >12% (or >200ml) from pre-bronchodilator value.
- Variability (improvement or deterioration occurring over time, day to day, month to month or seasonally). Obtaining a history of variability is an essential component of the diagnosis of asthma.
- Measurement of PEF is not interchangeable with FEV1. PEF should be measured first thing in the morning, before treatment is taken when values are at their lowest and last thing at night when values are usually higher.
- A 60 L/min (or >20% of pre-bronchodilator PEF) improvement after inhalation of a bronchodilator or a diurnal variation in PEF >20% suggests a diagnosis of asthma. Other tests of airflow obstruction, airway responsiveness and airway inflammation which may also support the diagnosis of asthma are:
  - Measurement of airway responsiveness to methacholine, histamine, mannitol, or exercise challenge may help establish a diagnosis of asthma for patients with symptoms consistent with asthma, but with normal spirometry. These are generally performed in a pulmonary function laboratory.
  - Measurement of allergic status (IgE, RAST, skin allergy tests) can help to identify risk factors that cause asthma symptoms in individual patients. The presence of allergies, eczema, and allergic rhinitis in particular, increase the probability of a diagnosis of asthma. Skin tests with allergens represent the primary diagnostic tool in determining allergic status. They are simple and rapid to perform, have a low cost and high sensitivity. When performed incorrectly skin tests can lead to false positive or false negative results. Measurement of specific IgE in serum does not surpass the reliability of results from skin tests and is more expensive. Measurement of total IgE in serum has no diagnostic value as a diagnostic test for atopy.
  - Confirmation of asthma hinges on demonstration of airflow obstruction varying over short periods of time. It is also important to point out that the diagnosis in patients with possible asthma differs among age groups and produces a diagnostic challenge.

MANAGEMENT
There is no cure for asthma but through appropriate management patients can achieve a level of control that allows for a good quality of life. There is much more to good asthma management than writing a prescription. Proper diagnosis, patient education, allergen avoidance, medication prescribed...
Onbrez® Breezhaler®

- Superior Bronchodilation versus tiotropium
- 5 minute rapid onset of action

A first line once daily maintenance treatment for COPD

---

**Onbrez® Breezhaler®**

**Presentation:** Onbrez Breezhaler 300mcg and 600mcg inhalation powder unit dose capsules containing indacaterol maleate, and separate Onbrez Breezhaler inhaler. **Indications:** For maintenance bronchodilator treatment of airflow obstruction in adult patients with chronic obstructive pulmonary disease (COPD). **Dosage and administration:** Recommended dose is the inhalation of the content of one 150mcg capsule once a day, administered at the same time of the day, each day, using the Onbrez Breezhaler inhaler. **Contraindications:** Onbrez Breezhaler should not be used in asthma. **Warnings/Precautions:** 1. Onbrez Breezhaler should be discontinued immediately and alternative therapy substituted. **Deterioration of disease:** Indacaterol should be used with caution in patients with cardiovascular disorders (coronary artery disease, acute myocardial infarction, cardiac arrhythmias, hypertension), in patients with convulsive disorders or thyrotoxicosis, and in patients who are unusually responsive to beta2-adrenergic agonists. **Cardiovascular effects:** Indacaterol may produce a clinically significant cardiovascular effect in some patients as measured by increases in heart rate, blood pressure, and/or symptoms, ECG changes. In case such effects occur, treatment may need to be discontinued. **Hypokalaemia:** Indacaterol may produce significant hypokalaemia in some patients, which has the potential to produce cardiovascular effects. Patients with severe COPD, hypokalaemia may be potentiated by diuretics and concomitant treatments which may increase the susceptibility to cardiac arrhythmias. **Hypoglycaemia:** Indacaterol may produce clinically significant increases in plasma glucose. **Interactions:** Indacaterol should not be given together with beta-adrenergic blockers (including eye drops) as these may weaken or antagonise the effect of beta2-adrenergic agonists. Where required, cardioselective beta-adrenergic blockers should be preferred, although they should be administered with caution. **Adverse reactions:** The most common adverse reactions with Onbrez Breezhaler are: nausea, upper respiratory tract infection, influenza, diabetes mellitus and hyperglycaemia, headache, ischaemic heart disease, cough, pharyngolaryngeal pain, rhinitis, depression, cough, rhinorrhea, dyspepsia, food intolerance, insomnia, infections of the respiratory system, allergic rhinitis, influenza, nasopharyngitis, upper respiratory tract infection, pharyngitis, rhinitis, dyspepsia, food intolerance, and infections of the respiratory system. **Product information:** Available at Novartis Ireland Ltd. Beech Hill Office Campus, Cloneague, Dublin 4. Tel: 01 2601255 or www.medicines.ie Date of Creation of API: 2009-03-02. Date of Preparation: 2011-03-11. **References:** 1. Onbrez Breezhaler SmPC. Available at www.medicines.ie 2. Donohue JF et al. Once daily Bronchodilators for Chronic Obstructive Lung Disease: Indacaterol versus Tiotropium. Am J Crit Care Med. Vol 182. Pp 155-162, 2010. 3. Balint et al. Onset of action of indacaterol in patients with COPD: Comparison with salbutamol and salmeterol-fluticasone. International Journal of COPD. 2010:5 311-318. *I NHANCE Study comparator was open label tiotropium.
For most classes of controller medications, improvement begins within days of initiating treatment, but the full benefit may only be evident after 3 to 4 months.

according to findings from objective tests, medication compliance and inhaler technique are all vital parts of asthma management. Equal or greater attention should be paid to the fact that asthma has a significant impact on individuals, their families and society. Partnership between the healthcare professional and patient is also important in achieving good control, as management plans can be tailored to the individual patient.

The goals of long-term asthma management are to:

- achieve and maintain control of symptoms
- maintain normal activity levels, including exercise
- maintain pulmonary function (FEV1/PEF) as close to normal as possible
- prevent asthma exacerbations
- avoid adverse effects from asthma medications
- prevent asthma mortality.

Asthma can be effectively controlled in most patients by intervening to suppress and reverse inflammation as well as treating bronchoconstriction and related symptoms. A short term reliever therapy of an inhaled short acting β2 agonist should be prescribed for all patients with a diagnosis of asthma. Inhaled corticosteroids are the recommended controller medication for adults and children to achieve good asthma management. It is important that before initiating a new drug therapy or increasing existing medication, inhaler technique, medication compliance and avoidance or exposure to new triggers should be re-checked.

An inhaled long acting β2 agonist is the first choice as an add-on therapy to inhaled steroids in adults and children aged between 5 and 12 years. It should be considered before going above a dose of 400mcg BDP or equivalent per day. The first choice of add-on therapy to inhaled steroids in children under 5 years old is a leukotriene modifiers.

It is imperative to say that once asthma control is achieved ongoing monitoring is essential to maintain control and to establish the lowest step and dose of treatment necessary, which maximises the safety of treatment. Asthma is a variable disease, and treatment has to be altered in response to loss of control as indicated by worsening symptoms or the development of an exacerbation. Asthma control should be monitored by the healthcare professional and also by the patient at regular intervals, depending on the clinical severity and the patient’s involvement.

For most classes of controller medications, improvement begins within days of initiating treatment, but the full benefit may only be evident after 3 to 4 months. The reduced need for medication once control is achieved is not fully understood, but may reflect the reversal of some of the consequences of long-term inflammation. At other times treatment may need to be increased either in response to loss of control or an acute exacerbation (defined as a more acute and severe loss of control that requires urgent treatment).

Some further points of extreme importance in managing asthma:

- The need for repeated doses of rapid on-set, short acting or long acting B2 – agonist bronchodilators over more than one or two days signals the need for review and possible increase of controller therapy.
- Temporarily doubling the dose of ICS has not been shown to be effective, and is no longer recommended. A four-fold or greater increase has been demonstrated to be equivalent to a short course of oral glucocorticosteroids in adult patients with acute deterioration. The higher dose should be maintained for 7 to 14 days, more research is needed in both adults and children to standardise this approach.
- A combination of ICS and rapid and long-acting B2-agonist (e.g. formoterol) in a single inhaler, both as a controller and reliever, is effective in maintaining a high level of asthma control and reduces exacerbations requiring systemic steroids and hospitalisation.

In conclusion, as a result of evidence-based guidelines, our understanding of what causes asthma, what is occurring in the airways and how best to treat the condition has advanced considerably.

For more information on asthma, its causes and treatments contact the Asthma Society of Ireland by calling 01 817 8886, emailing office@asthmasociety.ie or by visiting our website at www.asthmasociety.ie.

References

1. 2010 Global Strategy for Asthma Management and Prevention
2. 2008 British Guideline on the Management of Asthma
4. 2006 Ito K, Chung KF, Adcock IM, Update on Glucocorticoid Action and Resistance, Journal of Allergy Clinical Immunology 2006 117 (3) 522-43
6. Devereux G, Seaton A, Diet as a Risk Factor for Atopy and Asthma. Journal of Allergy Clinical Immunology 2005, 115 (6) 1109-17
Women and epilepsy

A diagnosis of epilepsy is difficult for anyone but even more so for women of childbearing age.

**SINEAD MURPHY, COMMUNITY EPILEPSY SPECIALIST NURSE**

Epilepsy is the most common serious neurological disorder in young people affecting an estimated 50 million people worldwide. A recent Irish prevalence study estimated that up to 37,000 people over the age of 5 years in Ireland have the disorder, which gives a point prevalence of about 0.8% in line with other industrialized nations.

It is defined as the tendency to have recurrent seizures. Recurrent is generally defined as two or more episodes. As many as 1 in 20 people will have a single isolated seizure at some point in their lives whereas 1 in 1:15 will subsequently be diagnosed with epilepsy. It is estimated that there are as many as 10,000 women of childbearing potential in Ireland with epilepsy.

Epilepsy is individual and affects each person differently; to date there is no single cure for all those people affected. Medication is the first line of treatment, in some cases surgery and a vagus nerve stimulator are employed.

**SYMPTOMS**

A seizure is a brief burst of excessive electrical activity within the brain that causes a range of symptoms which may be described as seizures. How the seizures are described depends on where they happen in the brain and how and whether they spread. There are two broad categories of seizures identified; these are referred to as generalised and partial.

**DIAGNOSIS**

The diagnosis of epilepsy is primarily made on an accurate eyewitness account, however in addition some investigations conducted by both the general practitioner (GP) and neurologist will include lying and standing blood pressure, electrocardiogram (ECG), an electroencephalogram (EEG) and magnetic resonance imaging (MRI) may be conducted in an effort to seek further clarification. Prior to diagnosis a specialist may also request a home video of the person’s events.

The diagnosis of epilepsy can have a devastating effect on an individual and their family; alongside this impact it has certain implications and particular lifestyle repercussions depending on the person’s age and sex. In particular, women with epilepsy (WWE) and their partners, as appropriate, must be given accurate information and counselling about contraception, conception, pregnancy, caring for children, breastfeeding and menopause. If we are now to adopt a multidisciplinary team approach to caring for this cohort of women as suggested by the NICE and SIGN guidelines then we as health professionals owe it to these women to keep ourselves fully informed.
In 2001 the Irish Epilepsy and Pregnancy Register was commenced for pregnant women with epilepsy in Ireland. A major objective of the register is to obtain and publish information on the frequency of major malformations such as heart defects, spina bifida and cleft palate among infants whose mothers take one or more anti-epileptic drugs to prevent seizures. Women with epilepsy who become pregnant, whether or not they are taking anti-epileptic drugs for their epilepsy are eligible to register their pregnancy. They are required to register before outcomes are known.

Since 2007 the Irish register has formally joined up with the United Kingdom Epilepsy and Pregnancy Register (which was established in 1996 for pregnant women with epilepsy in the UK). The ongoing running of each register remains unchanged, however, anonymised information from both registers will be joined regularly. It is estimated that there are approximately 672 women registered in the Republic of Ireland - all on a voluntary basis.

As part of my role and interest in this condition I attend the epilepsy clinic at the Rotunda Hospital, Dublin together with Dr Mary Holohan. On average we meet between 100-150 pregnant women with epilepsy in a year. Although it is our aim to meet with these women prior to pregnancy to counsel them on the effects of epilepsy in pregnancy and on the unborn child, it is often too late at our initial meeting.

EDUCATION
Issues that need to be addressed with these women include:

- folic acid,
- contraception
- pre conception counselling
- pregnancy
- labour and delivery
- post natal advice
- ongoing monitoring of their condition and identifying the correct health professional to do this.

Ideally all involved with caring for WWE should begin to educate these women about their epilepsy at the initial contact and reinforce the information at all the various life stages: information should be tailored to that specific life stage.

All women from menarche are advised to take folic acid before they become pregnant and during the first three months of pregnancy in order to reduce the risk of spina bifida. This is usually a dose of 400 micrograms. In women taking anti-epileptic drugs (AEDs) they are advised to take a five milligrams dose of folic acid once a day; this is as a result of some studies where the levels of folic acid were lower in some women taking AEDs.

COUNSELLING
Preconception counselling should be available to all women with epilepsy who are considering pregnancy and again this information should be reinforced regularly at patient consultations. The main aim of preconception counselling is to ensure that women embark upon pregnancy with a minimum of risk factors, fully aware of any risks and benefits of treatment, and able to make informed decisions about the pregnancy.

It is hoped by empowering these women with all the relevant information it will promote a safe and healthy pregnancy.

Now may also be the ideal opportunity to discuss the risks of AEDs in pregnancy, and the risk of non compliance, as often these women abruptly stop their medication without seeking medical advice - this we know to be extremely dangerous.

In one study of Irish midwifery students 31 out of 44 of the midwifery students stated that the woman should not stop taking her medication; 7 stated she should; and 6 stated that they did not know. Some of the midwifery students stated that the woman may need the dose of her medication reviewed but neglected to say whether the medication needed to be increased or decreased depending on the woman’s wellbeing and seizure control.

RISKS TO BABY
We know from pregnancies around the world recorded on the various registers that there are increased risks for these children. These risks can be further subdivided in to major malformations, minor malformations and neurodevelopment problems. This risk is individual and depends on several factors including the amount and type of medication, amount and type of seizures, folic acid supplementation and general lifestyle factors. Hence the importance of encouraging these women to register with the epilepsy and pregnancy register and to seek preconceptual advice.
CONTRACEPTION
Contraception is often a difficult subject to tackle either because of the influence of hormonal methods on the AED or because of the AEDs influence on the hormonal methods. When exactly to address this and by who can also cause concern; if there is confusion the woman should be referred to her specialist for advice. Mothers with epilepsy need to be given the time to discuss their various options with regard to the ideal method of contraception bearing in mind their specific AED treatment and lifestyle. In general the Depo provera, IUD and Mirena intra uterine system provide the most effective method of contraception as they are not affected by AEDs (some AEDs metabolise the oral contraceptive pill much quicker).

When planning a pregnancy most women want to know if pregnancy will affect her epilepsy. Many women with epilepsy do not experience an increase in seizures while pregnant. Of those women who do have an increase in seizures (between 8% and 46% in various studies) the increase can often be attributed to factors such as poor compliance with prescribed AEDs (sometimes compounded by vomiting), inappropriate reduction of AED therapy, a pregnancy-related fall in plasma drug concentrations (phenytoin, carbamazepine, phenobarbitone, and lamotrigine), and sleep deprivation. There is a debate as to whether AED concentrations should be routinely measured during pregnancy however, in the woman where seizures are not controlled it is advised to get an AED level where possible at around week 12 in pregnancy in order to have a baseline level in case of increased seizure activity later on in pregnancy. All women should be treated as routinely as possible - with priority care given where necessary.

It is not unreasonable to ask the women to consider writing a birth plan and asking all the members of the multidisciplinary team to contribute on their area of expertise, all seizure types should be clearly documented along with regular medication and the management of seizures during pregnancy, labour and during the peurperium, should be clearly documented. The use of pethidine, over breathing, sleep deprivation, pain, and emotional stress increase the risk of seizures during labour, and it is appropriate to consider epidural anaesthesia early on. The patient’s regular AED should be continued throughout this time. Remember most WWE have event free labours and the majority have normal deliveries.

Whichever method they choose women with epilepsy should be encouraged to feed their baby. That said, while breastfeeding is encouraged, some caution may be exercised depending on the medication and type of seizures; a commonsense approach should be employed and support network in place to support these women when caring for their newborn. Again in the same study of midwifery students, 30 of them agreed that a woman with epilepsy on anti seizure medication could breastfeed while 13 disagreed and 1 did not know.

Some simple tips should include advising the woman to report any increase in seizures or any adverse side effects from the medication. Her medication is often increased in the later stages of pregnancy to accommodate a lower plasma concentration. Other advice should include information on avoiding bathing the baby unaccompanied; safety at home to include carrying the baby - where possible in a car seat; the use of a playpen if she feels in any way unwell; feeding the baby on the floor surrounded by cushions.

As WWE approach the later stages in their lives they should be encouraged to seek advice on the menopause and bone health. Unfortunately the menopause in WWE in under researched, however, we do now know that certain AED medication can influence bone health therefore these women should be referred as appropriate for bone density testing.

If you require any additional information on any of the above please contact sinead@epilepsy.ie alternatively you can contact the Epilepsy and Pregnancy Register by phoning 1800 320 820.

Some of the midwifery students stated that the woman may need the dose of her medication reviewed but neglected to say whether the medication needed to be increased or decreased depending on the woman’s wellbeing and seizure control.

References
5. Morell M. Folic Acid and Epilepsy. Epilepsy Current 2002 March;2(2):31-34
7. Murphy S. Investigating the knowledge of midwifery students caring for women with epilepsy in pregnancy prior to and post a teaching session with the community epilepsy nurse specialist and assessing the effectiveness of the teaching package provided. [Unpublished Thesis] Dublin: Birmingham University; 2008
Combating obesity in children

The rate at which Irish children are becoming obese demands an urgent response to address the inevitable devastating health problems.

MARIE FLOOD, DIETITIAN, ORSMOND CLINIC, DUBLIN

Childhood obesity is one of the most serious public health challenges of the 21st century. The problem is global and is steadily affecting many low- and middle-income countries, particularly in urban settings. The prevalence has increased at an alarming rate. Globally, in 2010 the number of overweight children under the age of five is estimated to be over 42 million.1

Childhood obesity is on the rise with an alarming 300,000 Irish children either obese or overweight.2 This number is expected to grow by 10,000 every year.2 Results from the 19th annual meeting of the European Childhood Obesity Group, the largest childhood obesity conference ever to take place in Ireland revealed that Ireland has one of the highest rates of childhood obesity in the world, with one in 10 children aged between five and 12 in Ireland being classed as obese.3 The rate at which Irish children are becoming obese demands an urgent response to address the devastating health problems.

Body mass index, a formula that expresses the relationship of weight-to-height, is used to screen for risk of obesity. Children with a BMI at or above the 95th percentile on the UK 90 centile chart are recognised as obese or overweight, while children with a BMI between the 85th and 95th percentile are at risk.4

Mental health

Childhood obesity is not merely an aesthetic issue; it has major implications on long-term physical and mental health risks.2 Excess weight significantly increases children’s risk factors for a range of health problems both in childhood and adult life, including diabetes, heart disease, asthma, hypertension, sleep apnoea, osteoarthritis, bone and joint disorders, cancer, dyslipidemia, liver and gallbladder disease, menstrual abnormalities among others.2,5,6 On an emotional level, “obese children can suffer self-blame, negative body image and depression related to societal stigmatisation of obesity”.6 “Obese children can experience rejection by their peers and as a result suffer low self-esteem impairing academic and social functioning”.6

Obesity in childhood has a tendency to persist into adulthood.6 Children who are obese between six months and five years of age have a 25% chance of becoming obese adults. If they are obese when they are over six this increases to 50% and obese adolescents are 80% more likely to become obese adults.7 Obesity accounts for 5% of heart attacks and stroke, 10% of osteoarthritis, 20% of hypertension, 30% of cancers and 80% of type 2 diabetes.7 Based on these shocking statistics, childhood obesity is not an issue which should be taken lightly.
Ireland has one of the highest rates of childhood obesity in the world, with one in 10 children aged between five and 12 in Ireland being classed as obese.

It is estimated that from 1990 to 2005, overweight and obesity in children has increased 2-4 fold.8

Reasons for epidemic
Research has identified genetic, environmental, and societal factors that place children at risk for obesity.5

One major issue surrounding the rise in childhood obesity appears to be parental denial. According to recent studies, a large number of Irish mothers whose children were overweight or obese did not consider their child’s weight to be an issue. Of the parents who did recognise that their child was overweight or obese, it was found that they did not tackle the issue as they considered it too difficult.2 In other words parents of overweight children are either oblivious to the problem or lacking sufficient information, support and guidance on how to improve the situation.2

Another way in which parents are contributing to the childhood obesity epidemic is parental obesity.6 Various studies have indicated that if one parent is obese, a child is three times more likely to become obese than a child who has parents of normal weight.6 If both parents are obese the risk increases 10-fold. “The correlation between parent and child obesity is attributed to environmental and societal factors to which all members of the family are exposed.”6

Processed foods
With regards nutrition, Ireland has seen a dramatic change in eating habits including what is eaten, where it is eaten, frequency and quantity of food eaten.2 Our hectic lifestyles no longer encourage the preparation and consumption of homemade, nutritious food. Instead we are living in an environment that promotes the consumption of processed foods high in fat and sugar that are laden with calories. This convenience food culture means we are becoming more reliant on quick and convenient foods that fit into our ever hectic lifestyles.2

At the same time opportunities for physical activity are decreasing as we become more reliant on cars for transport as opposed to cycling or walking leading to an overall reduction in physical activity.3 Coupled with this, children are exposed to sedentary behaviours such as video games, computers and hours watching TV as means of recreation. The result is a generation of children who are over-consuming calories while simultaneously leading a more sedentary lifestyle turning to visual media for the stimulation that earlier generations derived from physical activities such as football and other outdoor activities.2

This combination of super-sized food portions and highly processed convenient foods has transformed western societies into “obesigenic environments”.6

How do we combat obesity
To date, obesity treatment programmes have achieved only moderate success and the increasing prevalence of the condition has facilitated a shift toward preventive interventions,6 therefore the focus should be on prevention and early intervention of childhood obesity.

Acknowledging a weight problem and understanding its health consequences are essential first steps in tackling obesity.9 Encouraging healthy eating and activity at home are the next steps. This will require educating parents on good nutrition suitable for the entire family so that they can put it into action. The focus should be on educating parents on what a balanced diet consists of. Making the focus about healthier eating habits instead of just about weight loss makes it easier for the family as a whole to make the necessary changes.7 Often diets that are high in sugar, salt and fatty foods are low in essential vitamins and minerals and the intake of these types of foods displaces good nutritious foods.7

The National Children’s Food Survey highlighted that Irish kids are getting the balance wrong. Many Irish children aged between 5 and 12 years have inadequate intakes of calcium, iron, folate and vitamins A and D. On the other hand, an estimated 25.5% of their calorie intake is supplied by biscuits, cakes, confectionary, sugars, fats and desserts everyday.7 Such deficiencies as these can be easily rectified by improved dietary choices at home.

Parents need to consider:
- The types of foods that they have available at home
- The structure of mealtimes
- Their own dietary and lifestyle habits – are they good role models?
- How can they best encourage their child to make positive changes to their eating habits without allowing food to become a contentious issue
- Attitude towards food – are certain foods used as rewards, do children have access to high fat/high sugar snacks?

Focusing on incorporating healthier food into the diet in order to achieve a more balance diet can be a better angle to combat childhood obesity rather than trying to eliminate all ‘junk’ food from the diet.2 Often just getting a better nutritional balance can result in a natural tendency to eat less high fat foods. Focusing on balanced nutrition without focusing too much on counting calories can be an effective weight loss solution for families.7

Offering simple guidelines like those listed below can help families start making positive changes without feeling they have to change their entire lifestyles:

1. Base your child’s diet on the healthy eating guidelines.
2. Include fruit or vegetables at each meal – include a variety of colours and types. Often children are hesitant to try different fruit or vegetables. It is important not to give up at the first hurdle and continue to encourage them to try a variety. Some child friendly vegetables include grated carrot, lettuce and peppers.
3. Limit snacking – snacks should consist of fruit, yoghurt, chopped vegetables, etc.
4. Limit confectionary in diet such as biscuits, cakes and buns
5. Include wholegrains – cut out white breads and refined cereals and start choosing high fibre options for the whole family. This will increase fibre in the diet and promote the intake of slow release energy foods at mealtimes.
6. Water – encourage water as a drink, recommended 6-8 cups per day. We often mistake thirst for hunger and not drinking enough fluid in the day can effect concentration too. Using sugar free squash can be a good way of encouraging children to drink more water. Encourage 1 glass of juice per day, water and 1-2 glasses of low fat milk.7

17
Clinical Review

We often mistake thirst for hunger and not drinking enough fluid in the day can effect concentration too.

Role of the Practice Nurse

Nurses play a key role in the prevention of childhood obesity. At an early level nurses can identify children at risk of becoming overweight or obese. Lifestyle advice and preventive measures can be suggested in a bid to reduce the prevalence of childhood obesity and related health complications.6

As educators and health promoters, nurses have a responsibility to educate families about childhood obesity.9 Parents and children need to be taught about proper nutrition and the need for physical activity as well as the potentially harmful effects of sedentary activities.9 Offering parents some general guidelines on good nutrition and benefits of exercise can provide support and inspiration to parents to put a plan in action. “Children’s eating habits are not only impacted by the food choices available to them, but also by children’s tendencies to emulate their parents eating habits. To nurses this means educating parents regarding nutritional needs for themselves and their children.”9

Education opportunities exist in a variety of settings. Children’s healthcare appointments, community organisations, health fairs and childcare centres all provide for educational opportunities.

By taking preventive steps to educate families of the importance of good nutrition, a regular eating pattern, an active, healthy lifestyle, and reduction in sedentary behaviours, childhood obesity can be curbed.9

Tackling childhood obesity is vital for the future health of our country and the rest of the world. The Foresight report concludes “that unless sustained efforts are made to treat childhood obesity, the number of children who are either overweight or obese could rise as high as 50% by 2050.”11 As professionals we all have a role to play in the fight against childhood obesity. We must continue to play our role in maintaining the principles of healthy eating and exercise for our children if success is to be achieved.

References

6. The BC. Take action!: a nurse practitioner practice guide for prevention of childhood obesity. Available at http://www.nursing.arizona.edu/Library/The_BC.pdf

Websites

http://www.irishealwww.com/article.html?id=16132
http://debates.oireachtas.ie/dail/2011/06/07/00229.asp
http://www.medpages.ie/articles/january-2010/childhood-obesity
New Ensure Plus –
It’s the taste we love!

Ensure Plus -
The preferred supplement¹

SUSTAIN study*

Visit us at
www.abbottnutrition.ie

* Study to improve Understanding of Sensory factors and Taste And their Impact on compliance with Nutritional drinks.

References available on request.

Abbott Laboratories Ltd., 4051 Kingswood Drive, Citywest Business Campus, Dublin 24
Tel: (01) 4691500. Fax: (01) 4691501. Email: abbott_nutrition_irl@abbott.com

Date of Preparation: January 2011     ANI/SIP/2011/002
This paper is a report of a study of practice nurse perspectives on caring for elderly patients with multimorbidity, with a view to informing practical methods of managing this group.

**INTRODUCTION**

The accompanying article on Multimorbidity in Primary Care which appeared in the last issue, showed it is clear that appropriate care for patients with multimorbidity is complex and must go further than the parallel application of guidelines for managing single chronic conditions. Furthermore, we know that practice nurses are ideally placed to improve outcomes for these patients, but no information is available about their perspectives on how best to manage multimorbidity effectively. This study aimed to explore PN perspectives of caring for elderly (aged >65 years) patients with multimorbidity, with a view to informing practical methods of managing this group.

**METHODOLOGY**

This was a mixed methods study, primarily qualitative (semi-structured interviews) with a quantitative component (postal questionnaire). The qualitative research methodology followed the broad precepts of grounded theory.

**Sampling, recruitment and data collection**

The sampling frame was all 74 PNs in the IPNA Dublin and Wicklow branches (55 and 19 members respectively). The study was piloted in the Wexford branch.

A preliminary postal questionnaire sought information about the characteristics of respondents and the practices where they worked, particularly in relation to chronic disease management. Non-respondents were followed up by post after two weeks. The response rate was 68.9% (51/74). Two respondents were excluded as they no longer worked as PNs. Of the remainder, 59.2% (29/49) were willing to be interviewed.

Eleven face-to-face, semi-structured interviews took place; the sample size was determined by data saturation. Purposeful sampling was used to achieve maximum variation of interviewee characteristics. The number was not intended to be large enough to deduce statistically significant results, but to allow an in-depth understanding of current practices and perceptions, service provision and potential areas for improving the care of patients with multimorbidity, from a PN perspective.

Ethical approval was granted by the ICGP Research Ethics Committee. Confidentiality and anonymity were maintained by storing anonymised data securely and separately from unique identifier codes.

**Data analysis**

Quantitative data were analysed using SPSS (Statistical Package for the Social Sciences). Statistically significant group differences were explored using Mann-Whitney U (ordinal data) and Pearson’s Chi-Square (nominal data). QSR Nvivo was used to assist in managing the qualitative data which generated substantive codes that were clustered into categories. Propositions about the relationships among and between the categories created a conceptual framework, which guided further data collection. Additional data thought likely to answer generated hypotheses were collected until all categories were “saturated”.

**Rigour**

A number of strategies were employed to ensure accuracy, rigour and validity during the process of data analysis and interpretation. These included saturation, audit trail, peer debriefing and reflexivity.

**RESULTS**

The characteristics of participating PNs and their practices are summarised in Table 1.

Table 2 shows that most respondents (87.5%) reported some involvement with chronic disease management. Involvement was not statistically significantly associated with practice computerisation (p=0.50), GP training practice (p=0.69), full-time/part-time PN (p=1.0), number of GPs (p=0.48) or PNs (p=0.62) in the practice, or PN years of experience (p=0.60).

Interestingly, there was an inverse relationship between the area of chronic disease management PNs were involved with and their area of educational attainment: they were more likely to be involved in CVD but more likely to be educated in respiratory, and vice versa. This may be a reflection of the longer availability in Ireland of educational courses for respiratory diseases than other chronic diseases; the lack of formal programmes of care or financial incentives for respiratory disease management; or the interests of the employing GPs.

**PERCEIVED BARRIERS AND FACILITATORS**

Time constraints were seen as the most common barrier to chronic disease management, and hence multimorbidity management, by all but one interviewee. Indeed some felt “the workload is overwhelming…..”. Time was seen as more
of a barrier than skills for patient care: “We don’t have the hours….but we’ve been trained”. Time-related factors hindering multimorbidity management included implementing guidelines, providing new services, following up defaulters, holding practice meetings, and reflecting on practice.

The only ways PNs thought it feasible to bring in any new services (e.g. case management for multimorbidity) were by dropping some of the existing services, or bringing in another nurse. Some practices brought in pharmaceutical company sponsored specialist nurses for clinics, which was also considered cost-effective. Moreover, if patients with multimorbidity were reviewed in-depth on a regular basis this would reduce their visit frequency.

**Information technology (IT):** most practices were fully computerised, two partly, and one not at all. IT systems were primarily used for patient records, laboratory results and prescriptions. Some PNs expressed an interest in further training, because they weren’t using the software to its best capabilities. Using the software for registers or auditing was often perceived to be inaccurate because coding was inconsistent for a number of reasons:

- Time-consuming to identify and enter correct codes
- Codes not entered on all patient’s records either because they were missed, or only some practice staff were coding
- Generally, coding done opportunistically as diagnosis made
- The only way for two participants to search for specific patients was through their prescription databases. This was complex, and again not accurate, as not all private prescriptions were computerised. Two practices were using a paper trail in addition to IT, because the IT system in the practice was either relatively new or unreliable.

**Financial considerations:** four PNs saw ‘cost’ for private patients as a barrier to managing chronic disease and multimorbidity. “GMS patients…..are not out of pocket so they don’t mind”. PNs were conscious that “with our current economic climate you don’t want to be too pushy in forcing people to come back, you can only encourage them”. Chronic disease management is time consuming and therefore costly, so some practices referred patients on to hospital clinics if there was no financial reward for structured management of diseases like diabetes. However, this wasn’t always the case; some GPs with special interests were instrumental in setting up programmes such as structured diabetes care.

---

Table 1: Profile of participants and their practices (italics indicate most common response in that category)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n/total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban* practice</td>
<td>47/49</td>
<td>95.9%</td>
</tr>
<tr>
<td>Member of primary care team</td>
<td>15/45</td>
<td>33.3%</td>
</tr>
<tr>
<td>Computerised</td>
<td>43/49</td>
<td>87.8%</td>
</tr>
<tr>
<td>Administrative support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 admin. staff</td>
<td>25/49</td>
<td>51%</td>
</tr>
<tr>
<td>2 admin. staff</td>
<td>12/49</td>
<td>24.5%</td>
</tr>
<tr>
<td>1 admin. staff</td>
<td>12/49</td>
<td>24.5%</td>
</tr>
<tr>
<td>GP training practice</td>
<td>26/46</td>
<td>56.5%</td>
</tr>
<tr>
<td>Number of GPs in the practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single GP</td>
<td>7/48</td>
<td>14.6%</td>
</tr>
<tr>
<td>2 GPs</td>
<td>11/48</td>
<td>22.9%</td>
</tr>
<tr>
<td>3+ GPs</td>
<td>30/49</td>
<td>62.5%</td>
</tr>
<tr>
<td>Full time PNs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>34/49</td>
<td>69.4%</td>
</tr>
<tr>
<td>1</td>
<td>14/49</td>
<td>28.6%</td>
</tr>
<tr>
<td>2</td>
<td>1/49</td>
<td>2%</td>
</tr>
<tr>
<td>Part time PNs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>9/50</td>
<td>18%</td>
</tr>
<tr>
<td>1</td>
<td>23/50</td>
<td>46%</td>
</tr>
<tr>
<td>2</td>
<td>15/50</td>
<td>30%</td>
</tr>
<tr>
<td>3</td>
<td>1/50</td>
<td>2%</td>
</tr>
<tr>
<td>4</td>
<td>2/50</td>
<td>4%</td>
</tr>
<tr>
<td>Hours worked/week by PNs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;10</td>
<td>2/49</td>
<td>4.1%</td>
</tr>
<tr>
<td>11-20</td>
<td>22/49</td>
<td>44.9%</td>
</tr>
<tr>
<td>21-30</td>
<td>13/49</td>
<td>26.5%</td>
</tr>
<tr>
<td>31-40</td>
<td>12/49</td>
<td>24.5%</td>
</tr>
<tr>
<td>Years of PN experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;2</td>
<td>5/49</td>
<td>10.2%</td>
</tr>
<tr>
<td>2-5</td>
<td>14/49</td>
<td>28.6%</td>
</tr>
<tr>
<td>6-10</td>
<td>21/49</td>
<td>42.9%</td>
</tr>
<tr>
<td>11-15</td>
<td>5/49</td>
<td>10.2%</td>
</tr>
<tr>
<td>16-20</td>
<td>2/49</td>
<td>4.1%</td>
</tr>
<tr>
<td>&gt;20</td>
<td>2/49</td>
<td>4.1%</td>
</tr>
<tr>
<td>Decade of General Nurse Registration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1970-79</td>
<td>19/47</td>
<td>40.4%</td>
</tr>
<tr>
<td>1980-89</td>
<td>18/47</td>
<td>38.3%</td>
</tr>
<tr>
<td>1990-99</td>
<td>8/47</td>
<td>17%</td>
</tr>
<tr>
<td>2000+</td>
<td>2/47</td>
<td>4.3%</td>
</tr>
<tr>
<td>Professional qualifications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RN only (prerequisite for PN)</td>
<td>12/49</td>
<td>24.5%</td>
</tr>
<tr>
<td>Higher Diploma in Practice Nursing</td>
<td>4/49</td>
<td>10.8%</td>
</tr>
<tr>
<td>Clinical Nurse Specialist (incl.</td>
<td>9/49</td>
<td>18.4%</td>
</tr>
<tr>
<td>Advanced Practice)</td>
<td>32/49</td>
<td>65.3%</td>
</tr>
</tbody>
</table>
| * Urban was defined as a town or city with a population >1,500. ** Where the valid total is 30, this is because one of the 49 respondents worked part time in two practices which had different characteristics.

Table 2: Participants’ involvement and education in chronic disease management

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n/total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involved in CDM</td>
<td>42/48</td>
<td>87.5%</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>33/48</td>
<td>68.8%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>28/48</td>
<td>58.3%</td>
</tr>
<tr>
<td>Respiratory</td>
<td>20/48</td>
<td>41.7%</td>
</tr>
<tr>
<td>All three areas</td>
<td>14/48</td>
<td>33.3%</td>
</tr>
<tr>
<td>Education* in CDM</td>
<td>34/49</td>
<td>69.4%</td>
</tr>
<tr>
<td>Respiratory</td>
<td>23/49</td>
<td>46.9%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>14/49</td>
<td>28.6%</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>12/49</td>
<td>24.5%</td>
</tr>
</tbody>
</table>

*Education was defined as any educational modules or courses.
Planning of new initiatives: when planning any new initiatives PNs felt there was a need to have everyone on board and importantly that those “working at the coal front...have a voice to the initial idea”. There was a perception that everything is being decanted into primary care. Resources need to be properly in place before this can happen, e.g. time; IT systems; training; experience and knowledge base; financial incentives for GPs; physical infrastructure; having local support services in situ, and familiarity with them; protocols and referral pathways in place; good team structure and communication, with protected time to meet and reflect.

Practice Nurse education: PNs need to be able to work autonomously and identify chronic diseases; “...because you are autonomous, you have to take responsibility and be happy with what you are doing”. “I’ve done the courses....it stimulates your interest. You just feel more confident”. Courses need to be applicable to nurses’ roles to be of value, otherwise skills are lost. “I’ve definitely lost my knowledge and skills from doing that course [respiratory]....there’s not enough coming here for me to up-skill in that area”. Education empowers the nurse, in turn, to educate and enable patients: “They could self-manage at home if they had the knowledge and were competent with that through education by us”.

Patient education: patients who had the capability to be responsible for their own care were empowered through education in self-management skills. Four participants didn’t use self-management plans (SMPs) due to unfamiliarity or time constraints but “if we could make them more responsible perhaps that workload would diminish”. Four PNs used verbal SMPs: “We wouldn’t have, as such, a management plan on paper...we would go on telling and giving them the advice”. Three PNs used written SMPs, one form of which was a patient-held health record card. However, one commented “they all think it’s fantastic...two years later...they haven’t seen it since the last day they were here”. In addition to a more structured format, opportunistic patient education occurred simultaneously with other tasks.

Some patients manage chronic diseases well, but when a new health problem is added in they can’t cope. CVD was the one area where a number of PNs related their role (unprompted) to the treatment of co-morbidities, referring to combining care of diabetes and CVD together. On the other hand, PNs commented that co-morbidities raised challenges for giving lifestyle advice and setting targets, and ensuring compliance with medications was more difficult with multimorbid patients due to polypharmacy.

Communication: communication was felt to be a key factor influencing management of chronic diseases and multimorbidity, facilitating consistency in patient care: “We don’t want conflicting...advice, we want the advice to be as uniform as possible”. This extended to communication within practices, within primary care, and between primary and secondary care.

Five practices held regular team meetings, ranging from twice weekly to once monthly. Nurses in practices where there were no meetings felt it affected team collaboration.

Familiarity and communication between PNs and Public Health Nurses (PHNs) was considered important. PHNs rarely have access to IT “so it’s mainly just old fashioned snail mail and telephones”. The introduction of Primary Care Teams (where established) “has improved communication with PHNs massively...any barrier there ever was between practice and community is gone” according to one PN.

Communication between primary and secondary care tended to be poor. “I still find we do things, the hospital do things and nobody knows what the other half is doing...that’s a huge problem...there’s no fluidity, it’s very disjointed”. One PN described having regular links and meetings, and had protocols collaboratively written “for example, with endocrinologists...we can email and say what do you think of this...and we’ll get an email back saying yeah I think it’s a good idea or whatever”. With others, communication was predominately by phone and varied widely. “Consultant X is brilliant...he will happily take a phone call from PNs....but he’s the sole person, his [junior doctors], nurses won’t”. Conversely, another PN reported “we can speak to the CNS or the nurse practitioner in both respiratory and diabetic care...they are very accessible, and very accommodating”. Three consultants accepted PN referrals from one PN. Receiving reports from diabetic clinics was inconsistent, from none at all, to sometimes to, unusually, “always”.

PERSPECTIVES ON MANAGING MULTIMORBIDITY

In this study, none of the participants provided formal targeted care for multimorbidity. Some PNs, when asked to focus on multimorbidity, found it difficult to conceptualise patient problems beyond individual diseases. Multimorbidity management was considered to be embedded in general practice and a natural part of patient care, but not necessarily thought about in a structured way:

“I never really heard the word co-morbidity until you said it to me. So I don’t think about it, it’s just we have a lot of patients with different problems, so I suppose they are there, and they are being managed”.

“It’s very difficult...you are making me think about stuff I’ve never thought about. And yet, I’ve worked in the practice for years...I believe many of our older patient shave co-morbidities, they seem to be happy and they appear to be well looked after. But I can’t say why”.

One PN felt that regular patient-centred (rather than disease-centred) reviews of patients focusing on multimorbidity may need longer consultations but in the long run could reduce consultation frequency. Ten of the eleven PNs (when prompted) felt they could see a role for Clinical Practice Guidelines (CPG) in multimorbidity management. However, some issues were raised: they would need to be “implemented correctly”. Indeed, another PN who didn’t use them routinely because of time constraints said “if they get too over-waffly I think that people just don’t use them”. Furthermore, while CPGs facilitate consistent care they “change so often” that time is a barrier to keeping everyone on board and up-to-date. The point was also made that it’s difficult to generalise protocols and guidelines to incorporate the complexity of co-morbid conditions, because the combination of illnesses were so particular to each patient.

Only one PN was aware of the case management model for multimorbidity. However, the concept was generally welcomed. Four PNs felt that the case management concept was already being done but not labelled, or in a structured format, and was certainly not acknowledged. It’s “happening, but it may not have a title...it would be much better if it was recognised as the specialism it is...community nurses are doing it...just self-supporting”.

One PN reflected on an experience of having a diabetic nurse specialist coming into the practice: “What we found, and what she found...she did the care but she didn’t know the patients. The reality was, there was no integration at all. When I took it over, I had to start at the very beginning because I knew so much more about the patient, families and everything...the chronic disease model is general practice and I think it should be situated there for the patients, rather than parachuting a specialist nurse into the
Some PNs, when asked to focus on multimorbidity, found it difficult to conceptualise patient problems beyond individual diseases.

was circumpect, reflecting perhaps concerns in the literature about their limited utility for patients with multimorbidity who may be attending a variety of specialists. Kahn1 and van Weel2 both recommend that disease-specific guidelines should be replaced by a holistic approach, centred around individual patient needs, to overcome this issue and facilitate management.

LIMITATIONS, STRENGTHS AND FUTURE RESEARCH
This was a mixed-methods study which employed various techniques to ensure the accuracy, rigour and validity of data collection and analysis. The grounded theory approach was appropriate given the lack of existing research in the area. There was a good response rate to both the questionnaires (68.9%) and interviews (59.2%). Nevertheless, the study doesn’t claim to be representative of all PNs. The sample was from an almost entirely urban area and this may have influenced participants’ perspectives, as access to secondary care support was geographically near.

Whilst PNs are key stakeholders in multimorbidity management, this study explores the perspective of only one profession. For practical reasons (constraints on time and funding) it wasn’t possible to seek the perspectives of GPs and patients to gain a broader understanding. There is potential for further research here. Research is also needed to provide a greater understanding of multimorbidity in an Irish context, including establishing prevalence, exploring the burden of multimorbidity, and testing the use of a multimorbidity index such as the Cumulative Illness Rating Scale (CIRS), an instrument measuring the clinical burden of several medical problems in the same patient.1 Key to all this is the nurturing of a research culture in Irish general practice, which is necessary for evidence on which to base best practice.4

CONCLUSION
Starfield1 states that “primary care is the only level of service in a position to understand and deal with multimorbidity”. Practice nursing is a dynamic discipline, and needs to be flexible enough to meet continually changing demands for quality healthcare. Expanding the role of PNs is crucial to the provision and development of patient care.4 With the increasing focus on chronic disease management comes the opportunity for advancing nursing practice, and indeed for nursing as a profession to lead the way in establishing an innovative, primary care based health service for patients with multimorbidity.

References
What is the Advantage of NeilMed® SINUS RINSE™?
Some amount of mucous production from the nasal and sinus lining is normal. Allergies and infections will cause excessive mucous production. This creates drip. When you perform a nasal rinse, you wash away excess mucous and allergy causing irritants such as pollen, dust particles, pollutants and bacteria, thus reducing inflammation of the mucous membrane. Normal mucosa will fight infections and allergies better, and symptoms may be reduced.

Drug Free • Preservative Free

Natural Relief from Cold • Sinus Symptoms • Allergies • Hay Fever

Year Round Relief

Natural Relief from Allergies, Hay Fever & Sinus Symptoms

Natural Relief from Allergies, Hay Fever & Sinus Symptoms

Natural Relief from Cold, Flu and Sinus Symptoms

Implements Quality of Life

Daily Nasal Hygiene

Sold Separately

120 Premixed Refill Sachets

IPU 5099627691383

Natural Relief for snoring and sleep apnoea. Helps to cleanse nasal and sinus cavities, thus improving air flow and breathing.

NATURAL RELIEF FOR:

• Nasal Symptoms from Cold, Flu & Allergies
• Nasal Allergies & Congestion
• Sinus Pressure & Nasal Stuffyness
• Post Nasal Drip
• Allergies from Occupational and House Dust, Fumes, Animal Dander, Grass, Pollen, Smoke, etc.
• CPAP Users with Sleep Apnoea
• Cystic Fibrosis and Immotile Ciliary Syndrome
• Asthma
• Snoring and Sleep Apnoea

Free Professional Sample Request

Please complete information below.

Name: ______________________________________________________
Facility Name: ______________________________________________
Address: ___________________________________________________
City: ___________________ State/Province: _______ Postal Code: ______
Tel: ___________________ Email: ________________________________
Medical Specialty: ____________________________________________

Use Appropriate Fax Number For Your Area

USA Fax: +1(707) 324-6030
Canada Fax: +1(416) 981-7339
Australia Fax: +61 (0)3 8677 9989
United Kingdom Fax: +44 (0)207 900 6414
Ireland Fax: +35 3 1 686 5077
Singapore Fax: +65 (0)6 491 5930
New Zealand Fax: +64 (0)9 353 1430
Malaysia Fax: +60 3 2178 4890

or scan and email to: questions@neilmed.com
or write to: NeilMed Pharmaceuticals Inc., 601 Aviation Blvd, Santa Rosa, CA 95403 USA

www.neilmed.com
Bowing your nose to relieve stuffiness may be second nature, but some ENT specialists argue it reverses the flow of mucus into the sinuses. It also slows the natural drainage of the sinuses.

To test the concept, infectious disease investigators at the University of Virginia in the US conducted CT scans and other measurements as subjects coughed, sneezed and blew their noses. In some cases, the subjects had an opaque dye dripped into their rear nasal cavities.

Coughing and sneezing generated little if any pressure in the nasal cavities. But nose blowing generated enormous pressure – “equivalent to a person’s blood pressure reading,” one researcher said – and propelled mucus into the sinuses every time. It was unclear whether this was harmful, but the theory is that during sickness it could force viruses or bacteria into the sinuses, and possibly cause further infection.

According to ENT experts at the New York University Langone Medical Centre, the correct method is to blow one nostril at a time and to take decongestants. This prevents a build up of excess pressure.

Conclusion: blowing your nose can create a build up of excess pressure in sinus cavities.

While some amount of mucus production from the nasal and sinus lining is normal, allergies and sinus infections can cause excessive mucus production. (see images 1 and 2: nasal cavities showing significant mucus collection). This excess mucus causes nasal and sinus symptoms such as a runny and stuffy nose or post-nasal drip. The key to symptom relief is to physically wash away this excess mucus and allergens, such as grass and tree pollen, dust particles, pollutants and bacteria from the nasal passages. Rinsing reduces inflammation of the nasal membrane, allowing patients breathe more normally (see images 4 and 5, same nasal cavity post rinsing).

Sinus irrigation (nasal douching, nasal lavage)
1. Gets rid of any allergy provoking material in your nose.
2. Gets rid of any pockets of infection that might be forming.
3. Clears the nose and makes it easier to breath.
5. Feels refreshing.

All that is involved is squirting a solution of slightly salty water up your nose, letting it drip out, blowing your nose gently, then repeating. The mechanical action of flushing out thickened mucus cleanses the nasal passages, making it easier for the tiny hair-like cilia that line the nose to push the remaining mucus out.

In Asian cultures nasal lavage has a long tradition. There it is considered a very effective therapy with almost no side effects and low cost. The easiest way is to sniff the fluid from the palm of the hand. Nasal showers and Neti Pots are marketed in healthfood stores and this type of mechanical rinsing is claimed to free the nose of any congested secretions and mucus which create a breeding ground for bacteria. In the US hydro pulse systems are popular. These units produce a gentle, pulsating stream to cleanse and moisturize the sinuses, remove foreign matter, crusts, and other undesirable materials.

Certainly there is strong support for nasal lavage amongst specialists in ENT and allergy. “Many patients who have sinus disease, allergies, or chronic infections are improved by lavaging their nose out once or twice a day,” says a top USA based ENT specialist. “And for those who have had surgery to open up narrowed sinuses, regular cleansing is a must. The main improvement they experience is the ability to wash out the cavity.”
Aggressive rhino-sinusitis pre rinse (l)

Aggressive rhino-sinusitis pre rinse (r)

Aggressive rhino-sinusitis post rinse (l)

Aggressive rhino-sinusitis post rinse (r)

Infective rhino-sinusitis pre rinse (l)

Infective rhino-sinusitis pre rinse (r)

Infective rhino-sinusitis post rinse (l)

Infective rhino-sinusitis post rinse (r)

Promed is pleased to announce we have partnered with the Irish Heart Foundation.

Promed has pledged that for every ECG machine purchased from our company, we will make a donation to the Irish Heart Foundation, so not only are you investing in high-quality equipment with excellent after-sales support, you are also supporting a worthy cause.

Established in 1966, the Irish Heart Foundation is the national charity fighting stroke and heart disease. It is funded up to 90 per cent by public and corporate donations. The mission of the Irish Heart Foundation is to lead in improving the cardiovascular health of people living in Ireland, by working to reduce preventable disability and death from heart, stroke and blood vessel disease.

Promed is Ireland’s leading supplier of medical equipment and consumables, with Service Engineers available nationwide. Established in 1985, we have a strong focus on education and patient support, running workshops and training seminars.

Our aim is to help our GP customers to offer additional patient services to their patients, enabling them to grow their practices.

For more information about the Cardiac Screening packages Promed can offer, such as Resting ECG, ABPM, and Holter Monitoring, please call us on freephone 1800 619 619 or log onto the Promed website www.promed.ie

To make a donation to the Irish Heart Foundation through their website, please log on to www.irishheart.ie
Increasingly [sinus irrigation] is being recommended as a daily routine for anyone troubled with sinusitis

“Even if antibacterial medications are added to the lavage solution, most of the benefit is from the mechanical rinsing of the nasal cavity,” says yet another specialist at the Massachusetts Nose, Eye and Ear Infirmary. “Among other things, the gunk you rinse out in mucus includes natural chemicals called cytokines, which promote inflammation. If you remove the mucus, you can actually reduce the inflammation. But people need to do it with salty water to wash out mucus.” (See images 4 and 5, pre and post lavage in acute bacterial sinusitis).

One study of more than 200 patients published in 2000 in the journal Laryngoscope found that after three to six weeks of nasal irrigation, patients reported statistically fewer nasal symptoms. A 1997 study of 21 volunteers in the same journal found that lavage improved the speed with which nasal cilia were able to move mucus along. A 1998 study in children published in the Journal of Allergy and Clinical Immunology showed that lavage is ‘tolerable, inexpensive, and effective’.

Current medical literature indicates that large volume saline nasal irrigation, delivered with low positive pressure, provides superior symptom relief to patients with sinus disease and nasal allergies. For an effective nasal rinse, you need to use a large volume (100-200 mls) of saline solution in each of the nasal passages, delivered with adequate positive pressure to displace the mucus, pollen and allergens from the nasal passages. The OTC product Neil-Med Sinurinse offers this in a cheap and easy to use formula.

The images accompanying this article show how mucus/discharge can significantly obstruct the nasal cavity. So when prescribing any intra-nasal spray first ask the patient to wash their nose so that the medication can hit a ‘clean’ target mucosa.

Sinus irrigation is the mainstay of treatment for patients who’ve had sinus surgery. Increasingly it’s being recommended as a daily routine for anyone troubled with sinusitis. In the US it’s considered almost as important as brushing your teeth and combing your hair before going out for the day. Consider it like dental floss, except for the nose and sinuses.

Promed is pleased to announce we have partnered with the Irish Heart Foundation

Promed has pledged that for every ECG machine purchased from our company, we will make a donation to the Irish Heart Foundation, so not only are you investing in high-quality equipment with excellent aftersales support, you are also supporting a worthy cause.

Established in 1966, the Irish Heart Foundation is the national charity fighting stroke and heart disease. It is funded up to 90 per cent by public and corporate donations. The mission of the Irish Heart Foundation is to lead in improving the cardiovascular health of people living in Ireland, by working to reduce preventable disability and death from heart, stroke and blood vessel disease.

Promed is Ireland’s leading supplier of medical equipment and consumables, with Service Engineers available nationwide. Established in 1985, we have a strong focus on education and patient support, running workshops and training seminars. Our aim is to help our GP customers to offer additional patient services to their patients, enabling them to grow their practices.

For more information about the Cardiac Screening packages Promed can offer, such as Resting ECG, ABPM, and Holter Monitoring, please call us on freephone 1800 619 619 or log onto the Promed website www.promed.ie

To make a donation to the Irish Heart Foundation through their website, please log on to www.irishheart.ie
Winter Infections and the Elderly

Winter can be challenging, particularly for the elderly who experience more frequent and severe community-acquired respiratory and gastrointestinal infections.¹

The effect of Actimel® on common infectious diseases (CIDs both gastrointestinal and respiratory) has been investigated firstly in an exploratory pilot study followed by a large confirmatory study involving free-living elderly people.

3 Guillemard E. et al. Consumption of a fermented dairy product containing the probiotic Lactobacillus casei DN-114 001 reduces the duration of respiratory infections in the elderly in a randomised controlled trial; Br J Nutr. 2010;103, 58–68.

These results add to the body of evidence to support the effect of Actimel® in helping to strengthen the natural defences of the elderly which has an important impact on the overall health of the elderly population.

For more information visit www.probioticsinpractice.ie

¹ Danone Actimel is a probiotic food containing the exclusive probiotic culture Lactobacillus casei DN 114 001. Danone Actimel helps strengthen the natural defences when consumed daily as part of a healthy diet & lifestyle.
³ Guillemard E. et al. Consumption of a fermented dairy product containing the probiotic Lactobacillus casei DN-114 001 reduces the duration of respiratory infections in the elderly in a randomised controlled trial; Br J Nutr. 2010;103, 58–68.
Psychosexual treatment of PE required for both psychological and biological factors


A recent study has shown that psychosexual treatment may help the patient with premature ejaculation (PE) and his partner to address their sexual problems and improve their overall relationship. A number of milestones in the treatment of PE have occurred over the past five decades, including the development of various behavioral and cognitive techniques as well as pharmacotherapies that modify neurophysiological processes involved in ejaculation. Nevertheless, the notion that sexual responses such as PE are influenced by physiological, psychobehavioral, cultural, and relationship factors is as valid now as it was 50 years ago, and therefore, interventions should consider all such domains in the development of effective treatment strategies.

The aim of this study was to provide an overview of which patients with PE are suitable to receive psychosexual treatment and the psychological approaches for managing this disorder. Designed around a literature review the end point was finding psychosexual treatments that integrate behavioral, psychological, and relationship functioning.

PE is typically a couple’s problem and, therefore, psychotherapy is best when the partner is involved. Before embarking on psychotherapy, the clinician should obtain a medical history pertaining to sexual-, psychological-, and relationship-related factors, so that the treatment strategy can be tailored to the needs of the individual. General strategies underpinning integrative, ‘process-oriented’ elements of psychotherapy most relevant to PE are developing the therapist–patient relationship; expressing empathy, genuineness, and positive regard; motivational interviewing, i.e., developing motivation to change; developing discrepancy; working through resistance; identifying PE-related affect, cognitions, and behaviors (including interaction with partners); and supporting self-efficacy. The four main domains that encompass psychotherapy techniques specific to the treatment of PE are behavioral, cognitive, affective and relational. Sustained positive outcomes in PE may be obtained using a combination treatment strategy that addresses all elements of PE, including psychological and biological factors.

The authors concluded that psychosexual treatments may help the patient with PE and his partner to address their sexual problems and improve their overall relationship. The effects of psychosexual therapy may be augmented by combining this intervention with pharmacotherapy.

The link between erectile and cardiovascular health: the canary in the coal mine


Better understanding of the complex factors influencing erectile health provides more immediate motivation for men to improve their lifestyle habits and cardiovascular health. Lifestyle and nutrition have been increasingly recognised as central factors influencing vascular nitric oxide (NO) production and erectile function. This review underscores the importance of NO as the principal mediator influencing cardiovascular health and erectile function. Erectile dysfunction (ED) is associated with smoking, excessive alcohol intake, physical inactivity, abdominal obesity, diabetes, hypertension, and decreased antioxidant defenses, all of which reduce NO production. Better lifestyle choices; physical exercise; improved nutrition and weight control; adequate intake of or supplementation with omega-3 fatty acids, antioxidants, calcium, and folic acid; and replacement of any testosterone deficiency will all improve vascular and erectile function and the response to phosphodiesterase-5 inhibitors, which also increase vascular NO production. More frequent penile-specific exercise improves local endothelial NO production. Excessive intake of vitamin E, calcium, L-arginine, or L-citrulline may impart significant cardiovascular risks. Interventions discussed also lower blood pressure or prevent hypertension. Certain angiotensin II receptor blockers improve erectile function and reduce oxidative stress. In men aged <60 years and in men with diabetes or hypertension, erectile dysfunction can be a critical warning sign for existing or impending cardiovascular disease and risk for death. The antiarrhythmic effect of omega-3 fatty acids may be particularly crucial for these men at greatest risk for sudden death. In conclusion, by better understanding the complex factors influencing erectile and overall vascular health, physicians can help their patients prevent vascular disease and improve erectile function, which provides more immediate motivation for men to improve their lifestyle habits and cardiovascular health.
Cialis offers your patients

- Proven efficacy from 30 minutes up to 36 hours with sexual stimulation
- Greater sexual self-confidence and spontaneity than sildenafil

CIALIS* (Tadalafil) REPUBLIC OF IRELAND ABBREVIATED PRESCRIBING INFORMATION

Cialis offers your patients

Pharmaceutical. If prescribed, a careful individual benefit/risk evaluation should be undertaken by the prescribing physician. Once a day dosing has not been evaluated in patients with hepatic impairment. There is limited data about the administration of doses higher than 10mg of tadalafil to patients with hepatic impairment. There is limited clinical data on the safety of Cialis in patients with severe hepatic impairment; if prescribed, a careful individual benefit/risk evaluation should be undertaken by the prescribing physician. Once a day dosing has not been evaluated in patients with hepatic impairment; therefore, if prescribed, a careful individual benefit/risk evaluation should be undertaken by the prescribing physician. Cialis dosing adjustment not required. Impaired renal or hepatic function: In patients with severe renal impairment the recommended dose is 10mg. Once a day dosing of Cialis is not recommended in patients with severe renal impairment. In men with hepatic impairment the recommended dose is 10mg. There are no available data about the administration of doses higher than 10mg of tadalafil to patients with hepatic impairment. There is limited clinical data on the safety of Cialis in patients with severe hepatic impairment; if prescribed, a careful individual benefit/risk evaluation should be undertaken by the prescribing physician. Once a day dosing has not been evaluated in patients with hepatic impairment; therefore, if prescribed, a careful individual benefit/risk evaluation should be undertaken by the prescribing physician. Cialis dosing adjustment not required. Use in children and adolescents: Cialis should not be used in individuals under 18 years of age. Use in elderly patients: Greater sexual self-confidence and spontaneity than sildenafil. Use in patients with impaired renal or hepatic function and the ability to have successful sexual intercourse up to 36 hours following dosing. Contra-indications: Known hypersensitivity to any component. Patients using any form of organic nitrates. In men with cardiac disease for whom sexual activity is advisable. Physicians should consider the potential cardiac risk of sexual activity in patients with pre-existing cardiovascular disease. Patients with myocardial infarction within the last 60 days, patients with unstable angina or angina occurring during sexual intercourse, patients with New York Heart Association class 2 or greater heart failure in the last 6 months, patients with uncontrolled hypertension, hyperlipidaemia (≥400mg/dl), or uncontrolled hypertension, with a stroke within the last 6 months. Cialis is contra-indicated in patients who have lost vision in one eye because of non-arteritic anterior ischaemic optic neuropathy (NAION), regardless of whether this episode was in connection or not with previous PDE5 inhibitor exposure. Warnings and Special Precautions: Prior to any treatment for erectile dysfunction, physicians should consider the cardiovascular status of their patients, since there is a degree of cardiac risk associated with sexual activity. Tadalafil has vasodilator properties, resulting in mild and transient decreases in blood pressure. It augments the hypotensive effect of nitrates. Tadalafil (20mg and 10mg) in patients receiving concurrent antihypertensive medicines, tadalafil may induce a blood pressure decrease. When initiating daily treatment with tadalafil, appropriate clinical considerations should be given in a possible dose adjustment of the antihypertensive therapy. Serious cardiovascular events were reported after post-marketing use of tadalafil. In pooled analysis of post-marketing events, there was a small increased risk of serious cardiovascular events (myocardial infarction, non-Q wave myocardial infarction, unstable angina, and fatal coronary artery disease) and the dose-related increase in myocardial infarction cases (each in both having a small increase in the rate of such events in the treatment groups compared with placebo) as increased tadalafil exposure (AUC) has been observed if the drugs are combined. The safety and efficacy of tadalafil and other PDE5 inhibitors or other treatments for erectile dysfunction have not been studied. Physicians should be informed not to take Cialis with such combinations. Pregnancy and Lactation: Not indicated for use by women. There are limited data from the use of tadalafil in pregnant women. Animal studies do not indicate direct or indirect harmful effects with respect to pregnancy, embryonal/fetal development, parturition, or postnatal development. Adverse effects are mainly gastrointestinal and include nausea and anorexia. Cialis should not be used during breast-feeding. Driving, etc: No studies on the effect on the ability to drive and use machines have been performed. Although the frequency of reports of dizziness in placebo and tadalafil arms in clinical trials was similar; patients should be aware of how they react to Cialis before driving or operating machinery. Undesirable effects: Very common (≥1/10), common (≥1/100 to <1/10), uncommon (≥1/1000 to <1/100), rare (≥1/10,000 to <1/1000), very rare (<1/10,000). Cialis should not be used in patients with aortic stenosis, atrial fibrillation, bundle branch block, conduction defects, hypotension (more commonly reported when tadalafil is given to patients who are already taking antihypertensive agents), myalgia. Contraindications: Hypersensitivity reactions, blurred vision, sensations described as eye pain, tachycardia, palpitations, chest pain, dyspnoea, syncope, hypertension, abdominal pain, gastro-oesophageal reflux, rash, hypotension (sleeping, chest pain), Panic. Strokes* (including haemorrhagic event), myopathy, transient ischaemic attack*, migraine*, visual field defect, swelling of lips, conjunctival hyperaemia, myoclonic jerks, ictus, Stevens-Johnson syndrome*, exfoliative dermatitis*, prolonged erection*, facial oedema*, asthenia, transient anaemia, SADIEV, retinal occlusion, sudden hearing loss*, unsteadiness, angina pectoris*, ventricular arrhythmia*, epistaxis, sudden cardiac death**. Most of the patients in whom these events have been reported had pre-existing cardiovascular risk factors. Sudden decrease or loss of hearing has been reported in a small number of post-marketing and clinical trial cases with the use of all PDE5 inhibitors, including Cialis. Fast-tracking surveillance reported adverse reactions not observed in placebo-controlled clinical trials. Adverse reactions reported with Cialis were transitory and generally mild or moderate. Adverse reaction data are limited in patients >75 years. A slightly higher incidence of ECG abnormalities, particularly atrial fibrillation, has been reported in patients treated with tadalafil once a day as compared with placebo. Most of these ECG abnormalities were not associated with adverse reactions. For full details of these and other side-effects, please see the Summary of Product Characteristics, which is available at http://www.medicines.org.uk/EMC. Legal Category: POM. Marketing Authorisation Numbers and Holder: EU/1/02/237/001 EU/1/02/237/002 EU/1/02/237/003 EU/1/02/237/004 EU/1/02/237/005 EU/1/02/237/006 EU/1/02/237/007 EU/1/02/237/008. Eli Lilly Nederland B.V., 65 Adelaide Road, Dublin 2, Republic of Ireland. Telephone: Dublin (01) 661 4377. E-mail: ukmedinfo@lilly.com. *CIALIS (Tadalafil) is a trademark of Eli Lilly and Company. Date of Preparation: September 2010. Date of Revision: March 2011. References: 1. Cialis Summary of Product Characteristics. 2. Dean, J. et al. Psychosocial outcomes and drug attributes affecting treatment choice in men receiving sildenafil citrate and tadalafil for the treatment of erectile dysfunction: Results of a multicentre, randomised, open label, crossover study. J Sex Med 2006; 3:655-661. ECL/02/017/2
New therapeutic targets for the treatment of erectile dysfunction

Decaluwé K, Pauwels B, Verpoest S et al.
22 September 2011.

Recent research has found an increase in new targets to treat erectile dysfunction. Despite the high efficacy and safety rates of the currently available treatments for erectile dysfunction, basic research reveals numerous new targets that are explored for therapeutic use.

The aim of the study was to overview potential new targets and to review available animal and human studies focusing on the potential of these targets for effective therapy for treating erectile dysfunction. A comprehensive literature search was conducted using the PubMed and Medline database, and citations were selected based on relevance. Data are presented based on the analysis of the selected scientific information and published clinical trials.

Fundamental research has, in the past decade, increased the understanding in both the physiological and the pathophysiological pathways that play a role in erectile function. As this information increases each day, new targets to treat erectile dysfunction are frequently presented. Currently a number of new therapeutic targets have been published. Some of them target the nitric oxide/cyclic guanosine monophosphate relaxation pathway as the phosphodiesterase type 5 inhibitors do, others primarily target pathways involved in contraction. Also, targets within the central nervous system currently receive much attention. Some of these targets have already been used in clinical trials to test their efficacy and safety, with either disappointing or promising results.

The study concluded that this review overviews potential therapeutic targets and summarises animal as well as human studies evaluating their perspectives for the treatment of erectile dysfunction.

Prostate cancer treatment may raise colon cancer risk

Gillessen S, et al.

Androgen-deprivation therapy (ADT) may also be linked to an increased risk of colon cancer, according to a recent observational study.

The use of ADT to treat prostate cancer is often reserved for recurrent disease or cases in which other treatments are contraindicated. It can also be used as an adjuvant to radiation therapy. It’s estimated that hundreds of thousands of men use ADT, which reduces the levels of the male hormones that spur the growth of prostate cancer cells. As a result, the study’s authors urge caution in prescribing the treatment, at least for early stage prostate cancer, because other studies haven’t shown a clear benefit in doing so.

Gillessen and colleagues culled data from the Surveillance, Epidemiology, and End Results–Medicare database to identify 107,859 men 67 years old or older who were diagnosed with prostate cancer between 1993 and 2002. Of those men, 55,901 (51.8%) underwent androgen deprivation, either medically or surgically. Most (89%) received gonadotropin releasing hormone (GnRH) agonists; around 10% underwent orchietomy.

After adjusting for variables that could have an impact on the risk of colon cancer, including a diagnosis of diabetes or obesity, the authors found a 30% to 40% relative increase in the rate of colon cancer among men who had received ADT, compared with those who didn’t.

The absolute risk of colon cancer over five years, however, was much lower: 1.8% in men who didn’t receive ADT, 2.2% in men who took GnRH agonists, and 3.2% in men who had an orchietomy. The authors also found a dose–response effect related to the duration of ADT, with the risk of colon cancer increasing with continued therapy.
BYDUREON®

BYDUREON® (exenatide)

REPUBLIC OF IRELAND ABBREVIATED PRESCRIBING INFORMATION

BYDUREON® (EXENATIDE)

BYDUREON® (exenatide)

BYDUREON® is a registered trade mark and BYDUREON By Your Side is a trade mark of amylin Pharmaceuticals, Inc.

BYDUREON is indicated for treatment of type 2 diabetes mellitus in combination with metformin, sulphonylurea, thiazolidinedione, or combinations of metformin and sulphonylurea or metformin and thiazolidinedione, in adults who have not achieved adequate glycaemic control on maximally tolerated doses of these oral therapies.

BYDUREON is a registered trade mark and BYDUREON By Your Side is a trade mark of amylin Pharmaceuticals, Inc.

BYDUREON is indicated for treatment of type 2 diabetes mellitus in combination with metformin, sulphonylurea, thiazolidinedione, or combinations of metformin and sulphonylurea or metformin and thiazolidinedione, in adults who have not achieved adequate glycaemic control on maximally tolerated doses of these oral therapies.

BYDUREON is a registered trade mark and BYDUREON By Your Side is a trade mark of amylin Pharmaceuticals, Inc.

BYDUREON is indicated for treatment of type 2 diabetes mellitus in combination with metformin, sulphonylurea, thiazolidinedione, or combinations of metformin and sulphonylurea or metformin and thiazolidinedione, in adults who have not achieved adequate glycaemic control on maximally tolerated doses of these oral therapies.

BYDUREON is a registered trade mark and BYDUREON By Your Side is a trade mark of amylin Pharmaceuticals, Inc.

BYDUREON is indicated for treatment of type 2 diabetes mellitus in combination with metformin, sulphonylurea, thiazolidinedione, or combinations of metformin and sulphonylurea or metformin and thiazolidinedione, in adults who have not achieved adequate glycaemic control on maximally tolerated doses of these oral therapies.

BYDUREON is a registered trade mark and BYDUREON By Your Side is a trade mark of amylin Pharmaceuticals, Inc.

BYDUREON is indicated for treatment of type 2 diabetes mellitus in combination with metformin, sulphonylurea, thiazolidinedione, or combinations of metformin and sulphonylurea or metformin and thiazolidinedione, in adults who have not achieved adequate glycaemic control on maximally tolerated doses of these oral therapies.

BYDUREON is a registered trade mark and BYDUREON By Your Side is a trade mark of amylin Pharmaceuticals, Inc.

BYDUREON is indicated for treatment of type 2 diabetes mellitus in combination with metformin, sulphonylurea, thiazolidinedione, or combinations of metformin and sulphonylurea or metformin and thiazolidinedione, in adults who have not achieved adequate glycaemic control on maximally tolerated doses of these oral therapies.

BYDUREON is a registered trade mark and BYDUREON By Your Side is a trade mark of amylin Pharmaceuticals, Inc.
Peer-led diabetes education programs in high-risk Mexican Americans improve glycemic control compared with standard approaches


Research has shown that a low-cost approach to culturally sensitive self-management education for high-risk diabetic populations is effective. The aim of the study was to evaluate the effect of a culturally sensitive diabetes self-management education programme that uses a low-cost, peer-educator format (Project Dulce) on glucose control and metabolic parameters in low-income Mexican Americans with type 2 diabetes.

A total of 207 Mexican-American patients recruited from federally funded community health centres in San Diego County with HbA1c >8% were randomly assigned to the Project Dulce peer intervention or continuation of standard diabetes care. The primary outcome of interest was HbA1c.

The majority of subjects were born in Mexico, were female, were middle-aged, had less than an eighth-grade education, and had high baseline HbA1c levels. Significant time-by-group interaction effects for HbA1c (P = 0.02) and diastolic blood pressure (P = 0.04) indicated that the Project Dulce group exhibited greater improvement (i.e., decreases) across time. Within-group analyses showed that the intervention group exhibited significant improvements from baseline to month 4 in absolute levels of HbA1c (−1.7%, P = 0.001) and diastolic blood pressure (−1.4 mmHg, P = 0.04) and from baseline to month 10 in absolute levels of HbA1c (−1.5%, P = 0.01), total cholesterol (−7.2 mg/dL, P = 0.04), HDL cholesterol (+1.6 mg/dL, P = 0.01), and LDL cholesterol (−8.1 mg/dL, P = 0.02). No significant changes were noted in the control group.

This randomised trial, using the Project Dulce model of culturally sensitive, peer-led education, demonstrates improvement in glucose and metabolic control and suggests that this low-cost approach to self-management education for high-risk diabetic populations is effective.

Patient education on retinopathy


Recent research has shown that education made a difference to the way in which the patients experienced retinopathy. This research described the results of an intervention study considering patient education on retinopathy, aiming to increase knowledge of retinopathy, self-care and self-efficacy.

Fifty patients were randomised to either an education programme or standard follow up in the clinical setting. The patients were followed for two years. Parameters were measured at baseline, and after one and two years. Twelve patients were interviewed after one year using semi-structured focus group interviews. The analyses were grounded in the framework of Steinar Kvale’s ‘sense of coherence’.

Several themes emerged. The main themes in both groups were fear, knowledge and acceptance, but there was a difference in the way in which these themes were described. The intervention group could describe how they used the knowledge in their everyday life. In contrast, the control group indicated knowledge about retinopathy but appeared not to use this knowledge in everyday life. Furthermore, the intervention group regarded prevention of retinopathy as a responsibility shared between themselves and the health professionals in relation to self-care skills, whereas the control group appeared not to take responsibility. The only theme described identically in both groups was ‘anxiety’ at the time of diagnosis. The quantitative data did not show any significant effect of the patient education.

The authors concluded that education made a difference to the way in which the patients experienced retinopathy. The intervention group showed ‘sense of coherence’ by expressing comprehensibility, manageability, and meaningfulness.
For patients not adequately controlled on metformin alone, powerful glucose reductions to help get patients to goal

Glucose reductions at 24 weeks

JANUMET 50/1000 mg twice daily

-3.9 mmol/L (n=149; mean baseline 16.8 mmol/L; P=0.001)

Insulin 50/1000 mg twice daily

-6.5 mmol/L (n=132; mean baseline 15.9 mmol/L; P<0.001)

JANUMET: Powerful efficacy to help get patients to goal

- As an adjunct to diet and exercise, in combination with a glitazone or sufonylurea
- In combination with insulin

Additional HbA1c results at 24 weeks

- 1.3% placebo-adjusted HbA1c reduction with metformin 1000 mg twice daily (n=177; mean baseline 8.7%; P<0.001)
- 1.6% placebo-adjusted HbA1c reduction with JANUMET™ (sitagliptin/metformin, MSD) 50/500 mg twice daily (n=183; mean baseline 8.8%; P<0.001)
- 1.0% placebo-adjusted HbA1c reduction with metformin 500 mg twice daily (n=178; mean baseline 8.9%; P<0.001)
- 0.8% placebo-adjusted HbA1c reduction with sitagliptin 100 mg once daily (n=178; mean baseline 8.9%; P<0.001)

JANUMET: Powerful efficacy to help get patients to goal

- As an adjunct to diet and exercise, in combination with a glitazone or sufonylurea
- In combination with insulin

For patients not adequately controlled on metformin alone, powerful glucose reductions to help get patients to goal

Glucose reductions at 24 weeks

JANUMET 50/1000 mg twice daily

-3.9 mmol/L (n=149; mean baseline 16.8 mmol/L; P=0.001)

Insulin 50/1000 mg twice daily

-6.5 mmol/L (n=132; mean baseline 15.9 mmol/L; P<0.001)

JANUMET: Powerful efficacy to help get patients to goal

- As an adjunct to diet and exercise, in combination with a glitazone or sufonylurea
- In combination with insulin

Additional HbA1c results at 24 weeks

- 1.3% placebo-adjusted HbA1c reduction with metformin 1000 mg twice daily (n=177; mean baseline 8.7%; P<0.001)
- 1.6% placebo-adjusted HbA1c reduction with JANUMET™ (sitagliptin/metformin, MSD) 50/500 mg twice daily (n=183; mean baseline 8.8%; P<0.001)
- 1.0% placebo-adjusted HbA1c reduction with metformin 500 mg twice daily (n=178; mean baseline 8.9%; P<0.001)
- 0.8% placebo-adjusted HbA1c reduction with sitagliptin 100 mg once daily (n=178; mean baseline 8.9%; P<0.001)

JANUMET: Powerful efficacy to help get patients to goal

- As an adjunct to diet and exercise, in combination with a glitazone or sufonylurea
- In combination with insulin

For patients not adequately controlled on metformin alone, powerful glucose reductions to help get patients to goal

Glucose reductions at 24 weeks

JANUMET 50/1000 mg twice daily

-3.9 mmol/L (n=149; mean baseline 16.8 mmol/L; P=0.001)

Insulin 50/1000 mg twice daily

-6.5 mmol/L (n=132; mean baseline 15.9 mmol/L; P<0.001)

JANUMET: Powerful efficacy to help get patients to goal

- As an adjunct to diet and exercise, in combination with a glitazone or sufonylurea
- In combination with insulin

Additional HbA1c results at 24 weeks

- 1.3% placebo-adjusted HbA1c reduction with metformin 1000 mg twice daily (n=177; mean baseline 8.7%; P<0.001)
- 1.6% placebo-adjusted HbA1c reduction with JANUMET™ (sitagliptin/metformin, MSD) 50/500 mg twice daily (n=183; mean baseline 8.8%; P<0.001)
- 1.0% placebo-adjusted HbA1c reduction with metformin 500 mg twice daily (n=178; mean baseline 8.9%; P<0.001)
- 0.8% placebo-adjusted HbA1c reduction with sitagliptin 100 mg once daily (n=178; mean baseline 8.9%; P<0.001)

JANUMET: Powerful efficacy to help get patients to goal

- As an adjunct to diet and exercise, in combination with a glitazone or sufonylurea
- In combination with insulin

For patients not adequately controlled on metformin alone, powerful glucose reductions to help get patients to goal

Glucose reductions at 24 weeks

JANUMET 50/1000 mg twice daily

-3.9 mmol/L (n=149; mean baseline 16.8 mmol/L; P=0.001)

Insulin 50/1000 mg twice daily

-6.5 mmol/L (n=132; mean baseline 15.9 mmol/L; P<0.001)

JANUMET: Powerful efficacy to help get patients to goal

- As an adjunct to diet and exercise, in combination with a glitazone or sufonylurea
- In combination with insulin

Additional HbA1c results at 24 weeks

- 1.3% placebo-adjusted HbA1c reduction with metformin 1000 mg twice daily (n=177; mean baseline 8.7%; P<0.001)
- 1.6% placebo-adjusted HbA1c reduction with JANUMET™ (sitagliptin/metformin, MSD) 50/500 mg twice daily (n=183; mean baseline 8.8%; P<0.001)
- 1.0% placebo-adjusted HbA1c reduction with metformin 500 mg twice daily (n=178; mean baseline 8.9%; P<0.001)
- 0.8% placebo-adjusted HbA1c reduction with sitagliptin 100 mg once daily (n=178; mean baseline 8.9%; P<0.001)

JANUMET: Powerful efficacy to help get patients to goal

- As an adjunct to diet and exercise, in combination with a glitazone or sufonylurea
- In combination with insulin

For patients not adequately controlled on metformin alone, powerful glucose reductions to help get patients to goal

Glucose reductions at 24 weeks

JANUMET 50/1000 mg twice daily

-3.9 mmol/L (n=149; mean baseline 16.8 mmol/L; P=0.001)

Insulin 50/1000 mg twice daily

-6.5 mmol/L (n=132; mean baseline 15.9 mmol/L; P<0.001)

JANUMET: Powerful efficacy to help get patients to goal

- As an adjunct to diet and exercise, in combination with a glitazone or sufonylurea
- In combination with insulin

Additional HbA1c results at 24 weeks

- 1.3% placebo-adjusted HbA1c reduction with metformin 1000 mg twice daily (n=177; mean baseline 8.7%; P<0.001)
- 1.6% placebo-adjusted HbA1c reduction with JANUMET™ (sitagliptin/metformin, MSD) 50/500 mg twice daily (n=183; mean baseline 8.8%; P<0.001)
- 1.0% placebo-adjusted HbA1c reduction with metformin 500 mg twice daily (n=178; mean baseline 8.9%; P<0.001)
- 0.8% placebo-adjusted HbA1c reduction with sitagliptin 100 mg once daily (n=178; mean baseline 8.9%; P<0.001)
Self-care of school-age children with diabetes: an integrative review

Kelo M, Martikainen M, Eriksson E et al. 

A recent study has shown that nurses must adopt an empowering manner of education and recognise and assess a child’s readiness to learn diabetes care and bear responsibility for it.

This study was a report of an integrative review of findings from empirical studies on self-care in school-age children with type 1 diabetes. The purpose was to generate insight into opportunities to develop empowering patient education.

Managing diabetes is demanding and requires parental involvement in care. Good self-care forms the basis for diabetes management and self-care patterns are established at school age, but how and to what extent school-age children increase their self-care capabilities is unclear.

A search for studies from 1998 to 2010 focusing on self-care in school-age children with diabetes was conducted through electronic databases. Using integrative methods, quantitative and qualitative papers surveyed were analysed separately, but the themes that arose were combined at the end of the analysis.

Self-care is formed in a learning process involving the objectives of normality, being able to cope and independence. The content of self-care is a combination of knowledge and skills. Children have the technical skill, but they need their parents to participate in the care and share responsibility for it. The factors related to self-care comprised the characteristics of the child; the nature of the illness and care; and support from the parents, school environment, peers and healthcare team.

A balance between diabetes care requirements and a child’s maturity should be found. Nurses must adopt an empowering manner of education and recognise and assess a child’s readiness to learn diabetes care and bear responsibility for it. Nurses must also help parents and other adults to gradually shift the responsibility to the children.

Evaluation of a pharmacist independent prescriber in a diabetes clinic

Journal of Diabetes Nursing 2011; 15(6)

A study has shown that an experienced pharmacist independent prescriber (PIP) can have a positive impact on patient outcomes in a type 2 diabetes clinic to help in the attainment of national targets.

A previous study showed that pharmacists can safely and reliably make pharmacotherapy recommendations to aid adherence to diabetes treatment guidelines. The aim of the study was to establish if there is difference between the ability of a PIP or a medical prescriber to attain recommended metabolic targets in people with type 2 diabetes. Retrospective data on the metabolic targets and weight for 50 people who had been seen by the PIP in a type 2 diabetes clinic and 50 who had seen a doctor within a two-year period were assessed. Results from the study showed that for all study participants, the mean reduction in cholesterol levels from baseline to follow-up visit was greater for the PIP group compared with the medical prescriber group (P=0.038). For those with a blood pressure (BP) >130/80 mmHg at baseline, the mean reduction in diastolic BP was greater for the PIP group (n=20) compared with doctor group (n=26); the mean between-group difference was –7.8 mmHg (P=0.003). The authors concluded that an experienced PIP can have a positive impact on patient outcomes in a type 2 diabetes clinic to help in the attainment of national targets.
82% of patients with UUI experience leakage once a week or more

Data presented at ICS demonstrates maintained quality of life improvements in elderly patients with OAB at 24 weeks with Toviaz.

Findings from a new pan-European survey, announced at the recent International Continence Society (ICS) annual meeting, show that 82% of surveyed patients with overactive bladder (OAB) who have urgency urinary continence (UUI) experience leakage once a week or more. These patients report that they find leakage to be the most bothersome symptom of their OAB (1). Data presented at ICS also show that improvements in quality of life (QoL) for elderly patients were maintained at 24 weeks of treatment with Toviaz (fesoterodine).

The European survey findings show that 53% of patients with OAB who have UUI report a significant impact on quality of life compared with 42% of OAB patients without UUI. The survey also highlighted that OAB symptoms have a greater negative impact on daily life for UUI patients than for OAB patients without UUI, including the impact on enjoying activities outside the home (51% vs. 34%) and on their self-esteem (40% vs. 22%). The survey, carried out across six countries with more than 1,000 patients taking part, was sponsored by Pfizer.

Commenting on the study, Dr Eddie O’Donnell, Consultant in Obstetrics and Gynaecology at Waterford Regional Hospital said “While the research did not specifically include Irish patients, we know that OAB has a great impact on all patients’ quality of life, even more so for those patients who have UUI. There are treatments available that can improve patient quality of life and the new data shows evidence that fesoterodine can deliver this.”

Potential of respiratory portfolio to help COPD patients maintain active lives

Novartis has presented new Phase III data at the European Respiratory Society (ERS) congress demonstrating the potential for its portfolio of once-daily inhaled therapies to help patients with chronic obstructive pulmonary disease (COPD) to maintain more active and productive lives.

The GLOW1 and GLOW3 studies show that investigational NVA237 (glycopyrronium bromide) significantly increased patients’ lung function compared to placebo with a fast onset of action at first dose, as well as improving exercise endurance. NVA237 is a new drug in the long-acting anti-muscarinic (LAMA) class which has recently been submitted for approval in the European Union under the brand-name Seebri Breezhaler.

“These results illustrate the potential benefits of NVA237 for COPD patients and are especially encouraging as we move ahead with plans to develop a fixed-dose combination with Onbrez Breezhaler, our once-daily therapy in the LABA class,” said David Epstein, Division Head of Novartis Pharmaceuticals. “This investigational combination of two bronchodilators with complementary modes of action is designed to give COPD patients access to the two leading classes of therapy in a single inhaler for the first time.”

The studies, presented at the ERS congress in Amsterdam, underscore the company’s commitment to developing innovative medicines to treat this life-threatening disease. Although COPD is often thought of as a disease of the elderly, 50% of patients are estimated to be below the age of 65, and are likely to be at the peak of their earning power and family responsibilities.

New reminder solution for insulin pens launching at FEND to ease daily stress of diabetes management

A new product in the management of insulin-dependent diabetes, launched recently, offers patients significant relief through an incorporated timer that tells them how long it’s been since their last insulin injection. Called Timesulin, this innovative ‘smart cap’ marks the first major step forward from the insulin pens that have been a feature of diabetes management since their release twenty years ago. Timesulin will make its debut today at the 16th annual FEND (Foundation of European Nurses in Diabetes) in Lisbon.

Timesulin greatly reduces the chances of missed or accidental double dose - a major concern for health care practitioners and patients alike. That’s why the product has already generated excitement among established names in the diabetes field in Europe, including Dr Ake Sjöholm, Chief of the Diabetes Research Unit at Sweden’s Karolinska Institutet in Stockholm. “Due to the habitual nature of insulin administration patients often forget whether or not they had injected their insulin dose,” Dr Sjöholm noted. “We regard this as a major challenge in managing diabetes and welcome the timely arrival of an innovative solution like Timesulin.”

The solution originated from the creators’ own familiarity with the problem. Timesulin is the brainchild of three entrepreneurs who identified the need to provide a daily solution to people living with diabetes that was simple, easy to use and would improve life balance. “The idea was born out of my own frustration as a Type 1 diabetic of over 25 years,” said Timesulin co-founder John Sjölund. “I manage my insulin injections with insulin pens and know all too well that a missed shot leads to raised blood sugar levels and causes drowsiness and body aches. At the same time, an accidental double dose has the opposite effect: blood sugar levels plummet, bringing on sweats and it can even cause a severe long & short term health complications. But mostly, it causes daily anxiety. I hate that. People with diabetes need a simpler way of knowing if they took their insulin, and when.”

“This is a very common problem: most insulin-dependent patients have at some point missed a dose or taken a double dose, specifically because they weren’t sure when they took their last shot,” said John Grumitt, Vice Chair of the Diabete KS Board of Trustees. “A simple solution, like the one Timesulin offers, should ease the daily anxiety for many people living with diabetes.”

Timesulin carries the CE mark, works with all major insulin pens, requires no change in habit and works straight out of the package without any programming required. Retailing at around £25 for a pack of two replacement caps, Timesulin will be available to customers throughout the EU, including in the UK, from mid-November 2011. For additional information or to purchase Timesulin caps, please visit www.timesulin.com
Congratulations to the winner of last month’s crossword, Ruth McInerney, Knockanean, Ennis, Co Clare.

Please send your answers to the Editor, Nursing in General Practice, GreenCross Publishing, 7 Adelaide Court, Adelaide Road, Dublin 2. Closing date for entries: 2nd January 2012. Winner will receive €50.

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

Caltrate is a trademark. PA 172/38/1.

Full prescribing information available from Wyeth Consumer Healthcare, Plaza 254, Ballycoolin, Dublin 15 or from www.medicines.ie
or diluting can change its time/action profile and mixing can cause precipitation. Years, Lantus should only be used in this age group under careful medical supervision. Close metabolic monitoring is... that increase susceptibility to hypo- or hyperglycaemia. Lantus must not be mixed with other insulins or diluted. Mixing of...care should be exercised, and intensified blood monitoring is advisable, for patients in whom hypoglycaemic episodes...adjustments may be required. Warning signs of hypoglycaemia may be changed, less pronounced or absent in certain risk groups, including patients in whom: glycaemic control is markedly improved; hypoglycaemia develops gradually; an...Lantus may delay recovery from hypoglycaemia. Adherence of the patient to the dosage and dietary regimen, correct...hypo/hyperglycaemic episodes, all relevant factors must be reviewed before dose adjustment is considered. Insulin...effects include weight gain and oedema if pioglitazone is used with Lantus. Discontinue pioglitazone if symptoms of cardiac deterioration occur. Fibrates, fluoxetine, MAO inhibitors, pentoxifylline, propoxyphene, salicylates and sulfonamide antibiotics. Substances...diazoxide, diuretics, glucagon, isoniazid, oestrogens and progestogens, phenothiazine derivatives, somatropin, sympa...Information about adverse event reporting can be found at...Marketing Authorisation Holder:
sanofi-aventis Deutschland GmbH, D-65926 Frankfurt am Main, Germany.

Effective, right from the start.