DIABETES MELLITUS — DIAGNOSIS AND MANAGEMENT
Rita Forde

BONE HEALTH — ROLE OF THE PRACTICE NURSE
Mary Daly

ASTHMA — SYMPTOMS, DIAGNOSIS AND CLASSIFICATION
Ruth Taylor

POSTNATAL DEPRESSION AND PRIMARY CARE NURSING
Una Forde

PROFILE OF A CARDIOLOGY MANAGEMENT SYSTEM
Catherine Dyer

NEW DERMATOLOGY SERIES: ROSACEA
A body of evidence

Cubitan is the only wound care sip feed. Enriched with added free arginine, it stimulates tissue repair and improves immune function.

Cubitan's specialised formulation has been shown to reduce wound area by 29% in just 3 weeks, faster and more effectively than standard high protein feeds.2

Prescribe Cubitan and see the evidence yourself.

Managing chronic illness in the community

Despite all the negativity in recent times, developments in general practice, primary care and public health have demonstrated that the role of the practice nurse is here to stay.

The introduction of the national cervical screening programme and the expansion of the primary childhood immunisation programme will not survive without the involvement of practice nurses. These programmes along with the influenza and pneumococcal immunisation campaigns are essential for public health nationally and internationally. Management of chronic illness in the community has been highlighted by the HSE as the way forward to reducing unnecessary hospital admissions. There appears to be a push to move some nursing specialists currently based in the hospital setting into the community in an attempt to address the management of chronic illness. This expertise in the community is to be welcomed. However, this should not be at the expense of acute hospital services.

For years, practice nurses have undertaken education programmes in various chronic illnesses and there is huge dearth of knowledge and expertise in the community which is not being used to its maximum potential. Despite, there being significant challenges and barriers around the involvement of practice nurses in community based services, there must be a change in thinking and the development of a culture of creativity to develop services for chronic illness within the community. Certainly, the ethos of primary care teams should enhance such development. However, the rate of development of such teams appears to be very varied across the country. The HSE must recognise the range and depth of skills that practice nurses have and optimise them to their full potential. Many of us will say that we are already overworked, with full appointment lists but there may be ways of working more efficiently and effectively in managing chronic illness. For example, running a community based pulmonary rehabilitation programme will empower and educate patients in self-management of their COPD, thus reducing exacerbation rates and the need to regular reviews.

Currently, there is no incentive to general practice to develop respiratory services despite respiratory illness being one of the leading causes of attendance and admission to hospital. If the HSE wants to manage the annual bed crisis in our hospitals, then it will to have seriously consider the development of general practice and primary care.

Ruth Taylor
Consulting Editor.
GARDASIL®
CAN PREVENT

✓ Cervical cancer*,
✓ High-grade cervical intra-epithelial neoplasia,
✓ High-grade vulvar and vaginal intra-epithelial neoplasia,
✓ and genital warts,

causally related to HPV 6, 11, 16, 18.¹

More than 30 million doses distributed worldwide²

GARDASIL® the quadrivalent HPV cervical cancer* vaccine for protection against a wide range of genital diseases causally related to HPV 6, 11, 16, & 18

* Related to HPV 16, 18

TODAY WE CAN DO MORE

GARDASIL®
Human Papillomavirus Vaccine
Types 6, 11, 16, 18
Recombinant, adsorbed

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

Presentation:
Gardasil is supplied as a single dose prefilled syringe containing 0.5 millilitre of suspension. Each dose of the quadrivalent vaccine contains highly purified virus-like particles (VLPs) of the major capsid L1 protein of Human Papillomavirus (HPV). These are type 6 (20 μg), type 11 (40 μg), type 16 (40 μg) and type 18 (20 μg).

Indications:
Prevention of premalignant genital lesions (cervical, vulvar and vaginal), cervical cancer and external genital warts (condyloma acuminata) causally related to HPV types 6, 11, 16 and 18. Gardasil is indicated for 16 – 26 year old females and 9 – 15 year old children and adolescents.

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

Contraindications:
Hypersensitivity to any component of the vaccine. Hypersensitivity after previous administration of Gardasil. Acute severe febrile illness. Warnings and precautions: As with all vaccines, appropriate medical treatment should be available in case of rare anaphylactic reactions. The vaccine should be given with caution to individuals with thrombocytopenia or any coagulation disorder because bleeding may occur following an intramuscular administration in these individuals. There is insufficient data to recommend use of Gardasil during pregnancy therefore the vaccination should be postponed until after completion of the pregnancy. The vaccine can be given to breastfeeding women. Gardasil will only protect against diseases that are caused by HPV types 6, 11, 16 and 18 and to some limited extent against diseases caused by certain related HPV types. Vaccination is not a substitute for routine cervical screening. There are no data on the use of Gardasil in subjects with impaired immune responsiveness. As with any vaccine, vaccination with Gardasil may not result in protection in all vaccine recipients. There are no safety, immunogenicity or efficacy data to support interchangeability of Gardasil with other HPV vaccines. Undesirable effects: Very common side effects include: pyrexia and at the injection site, erythema, pain and swelling. Common side effects include bruising and pruritus at the injection site. Very rarely, bronchospasm has been reported. Guillain-Barré Syndrome and hypersensitivity reactions including anaphylactic/anaphylactoid reactions have also been reported. For a complete list of undesirable effects please refer to the Summary of Product Characteristics. Package quantities: Single pack containing one 0.5 millilitre dose prefilled syringe with two separate needles. Marketing authorisation holder: Sanofi Pasteur MSD SNC, 8 rue Jonas Salk, F-69007, Lyon, France. Marketing authorisation number: EU/1/06/357/007 (prefilled syringe with two separate needles). Legal category: POM® Registered trademark Date of last review: September 2008.

Contents

<table>
<thead>
<tr>
<th>Issue 1 Volume 2</th>
<th>January/February 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4 NATIONAL NEWS AND NEC NEWS</td>
</tr>
<tr>
<td></td>
<td>7 NEWS</td>
</tr>
<tr>
<td></td>
<td>14 REGIONAL NEWS</td>
</tr>
<tr>
<td></td>
<td>News from the branches</td>
</tr>
<tr>
<td></td>
<td>CLINICAL REVIEWS</td>
</tr>
<tr>
<td></td>
<td>21 Diabetes mellitus — diagnosis and management</td>
</tr>
<tr>
<td></td>
<td>Rita Forde</td>
</tr>
<tr>
<td></td>
<td>32 Asthma — symptoms, diagnosis and classification</td>
</tr>
<tr>
<td></td>
<td>Ruth Taylor</td>
</tr>
<tr>
<td></td>
<td>40 The role of practice nurses in bone health</td>
</tr>
<tr>
<td></td>
<td>Mary Daly</td>
</tr>
<tr>
<td></td>
<td>45 Early detection and treatment of postnatal depression in primary care nursing</td>
</tr>
<tr>
<td></td>
<td>Una Forde</td>
</tr>
<tr>
<td></td>
<td>28 IT</td>
</tr>
<tr>
<td></td>
<td>Profile of a Cardiology Management System (HSE – South East)</td>
</tr>
<tr>
<td></td>
<td>Catherine Dyer</td>
</tr>
<tr>
<td></td>
<td>37 NEW SERIES — DERMATOLOGY</td>
</tr>
<tr>
<td></td>
<td>Rosacea ‘the curse of the Celts’</td>
</tr>
<tr>
<td></td>
<td>49 PRODUCT NEWS</td>
</tr>
<tr>
<td></td>
<td>52 CROSSWORD</td>
</tr>
</tbody>
</table>

EDITOR
Maura Henderson

CONSULTING EDITORS
Darina Lane and Ruth Taylor

SUB EDITOR
Tim Ilsley

DESIGNER
Barbara Vasic

PUBLISHERS
Graham Cooke
Maura Henderson

CONTRIBUTORS
Ciara Butler, Imelda Curran, June D’Arcy, Maureen Delaney, Catherine Doyle, Mary Finnegan, Anita Fitzgerald, Liam Glynn, Patricia Jenkins, Mary Kelly  Rita Lawlor, Margaret Mary Lynch, Orla Loftus-Moran, Deirdre McCann, Lisa Nolan, Emer O’Byrne, Aine O’Driscoll, Grainne Parker, Elsie Stewart, Ruth Taylor.

GreenCross Publishing is a recently established publishing house which is jointly owned by Graham Cooke and Maura Henderson. Between them Graham and Maura have over 25 years experience working in healthcare publishing. Their stated aim is to publish titles which are incisive, vibrant and pertinent to their readership.

Graham can be contacted at graham@greencrosspublishing.ie
Maura at maura@greencrosspublishing.ie

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.
Exciting educational initiatives

Happy new year to all readers. 2008 saw some exciting educational initiatives for practice nursing. The first Update in Midwifery for Practice Nurses was held in conjunction with the Coombe Centre for Midwifery Education. This long awaited and much needed two-day programme was very well evaluated by the practice nurses who attended the course. They found it very informative in updating their clinical knowledge in ante, peri and post natal care.

During October and November 2008 the new Senior Practice Nursing Course was held in Dublin. This was the first programme of its kind to be delivered nationally. Several practice nurses who attended the original Introduction to Practice Nursing Course also attended the Senior Course. Now that they are working in general practice a few years they found that there was a need to extend their knowledge and clinical skills to provide a more expanded nursing service. One of the features of the course was to provide training to practice nurses in undertaking an audit using a specific template. On completion of the programme each participant presented an audit of an aspect of their clinical practice using the audit tool.

The Cardiovascular Health Management for Nurses, the Respiratory Disease Modules were also delivered. These programmes are open to hospital and community nurses in order to share knowledge between each discipline. These two level 8 programmes were funded for practice nurses and continues with the theme of chronic disease management education for practice nurses. Accreditation is from DCU.

Clinical changes in 2008 include the new schedule for Primary Childhood Immunisations and the implementation PCV catch up programme. The Cervical Screening Programme for women between the ages of 25 – 65 also commenced in September 2008. These changes are largely implemented and sustained by the practice nurse.

Introduction to Practice Nursing Course

And so what will 2009 bring. The Introduction to Practice Nursing Course, Dublin will commence in February 2009

Many nurses go into general practice nursing having acquired a wealth of experience gained mainly in secondary care settings. However they frequently are unaware of the scope of the role and level of knowledge expected of them in a general practice setting. For some the transition from being a member of a large multidisciplinary team to being the only nurse in the practice can be daunting. The only time they may have visited a surgery is as a patient themselves or with a member of their family. Currently there is no mandatory education for practice nursing in Ireland. Nonetheless, in the words of the girl guides – “be prepared”.

The Introduction to Practice Nursing Course, is for new, or relatively new, nurses who are working in general practice. It is a practical programme developed to give practice nurses the confidence and competence to provide holistic care to the practice population on a range of topics that are pertinent to practice nursing. The programme includes tuition on the following topics from a Primary Care perspective

• Mental Health
• Men’s health
• Women’s Health
• Child Development
• Long Term Illness
• Nutrition
• Wound Management
• Practice Management
• Treatment Room
• Diabetes
• Childhood Immunisations

Postgraduate Diplomas NUI Galway

Congratulations and well done to the practitioners from across the country who successfully completed either the Postgraduate Diploma in Nursing (Practice Nursing) or Postgraduate Diploma in Primary Care at National University of Ireland, Galway 2007/2008. These included Irene Clancy (PN Ennistymon, Co. Clare), Carmel Finnerty (PN Galway City), Fiona Hoare (PN Longford), Trish Kiernan (PN Crossmolina, Co Mayo), Therese Nolan (CNS Glenamaddy, Co Galway) Emer O’Halloran (PN Corofin, Co. Clare) and Orla Reynolds (PN Limerick City).

Successful students on the Postgraduate Diploma in Primary Care (Clinical) were Claire Duffy (CNS Ballina, Co Mayo) and Siobhan Sidaway (PN Ballinasloe, Co Galway). These practitioners are leading the way in community nursing.

The table below is a reminder on what is on offer. These programmes are offered via ‘blended learning’ — this, online option allows students study online in their own home at a time which suits them. Also, as several of the modules are shared between Department of General Practice and School of Nursing, there are opportunities for inter professional learning. Students can also choose to undertake stand alone modules, rather than full programmes if they prefer. This approach aims to facilitate practitioners who have busy lives, and who don’t wish to commit to a full programme.

If you are interested in finding out more about either the stand alone options or postgraduate diplomas, contact your professional development coordinator and/or log on to http://www.nuigalway.ie/cns/

<table>
<thead>
<tr>
<th>Programme (NQF— Level 9)</th>
<th>Developed for-</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post Graduate Diploma in Nursing (Practice Nursing/Community Nursing)</td>
<td>Practice Nurse, Community Nurse, Nurse working in a prison setting.</td>
<td>1 year/or 2 year option now available</td>
</tr>
<tr>
<td>Post Graduate Diploma in Primary Care (Health Sciences)</td>
<td>A practitioner from multidisciplinary team (must be from community setting)</td>
<td>1 year</td>
</tr>
<tr>
<td>Post Graduate Diploma in Primary Care (Clinical)</td>
<td>General Practitioner, Practice Nurse, Community Nurses.</td>
<td>1 year</td>
</tr>
</tbody>
</table>
Stand Alone Module: Nursing Individuals with Diabetes

This five day module is open to nurses in a variety of clinical areas e.g. practice nurses, nurses in the community, acute care, care of the elderly, mental health nurses, and intellectual disability nurses who are working with people who have diabetes. Participants will gain an understanding of the healthcare needs of this cohort and critically review the models of healthcare management of patients with diabetes. The module is accredited with Dublin City University (Level 8, National Framework of Qualifications).

The course will be held in the Academic Centre, Connolly Hospital, Blanchardstown, Dublin 15

CervicalCheck Updates

In December CervicalCheck ran two update sessions in the North West (Donegal and Sligo). An invitation to attend the session was sent to all registered smeartakers directly from CervicalCheck. Similar days are being delivered nationally. The update was delivered by Ms Bernadette Queally, Regional Smear coordinator and our local clinical trainers Louise Mckee (Donegal) and Monica Cullin (Sligo). The sessions included information on CervicalCheck including,

- How the Programme works
- Completing the Cervical Cytology Form
- Troubleshooting
- Launching of the ‘Guide for Smeartakers’
- Questions & Answers session.

Both days were positively evaluated. The newly launched, Guide for Smeartakers, is an excellent document to support registered smeartakers and provides information on all aspects of the programme. The national screening programme, launched in September is in development and under regular review. Important points from the sessions included

- The primary care professional should promote the screening programme and patient registration with programme
- Ensure the all fields of the smear request form are fully completed prior to sending to Quest
- Ensure that an agreed process is in place in the practice to inform women of their smear results.
- The recall recommendations noted on the smear results should be checked with the woman's clinical history and findings at the time of the smear, reinforcing the need for the reporting of smears in the practice to be undertaken by a registered smeartaker.

If you have any concerns or queries regarding the programme please contact CervicalCheck directly 1800 45 45 55 For information on smeartaker training courses contact the: SmearTaker Training Unit by emailing: STU@cervicalcheck.ie or on 061 461234/146.

Good News!

It is nice to start the year with good news so:

Congratulations to Sylvia Wynne, Practice Nurse, Naas who has been accredited as a Clinical Nurse Specialist - General Practice in Kildare.

If you require further details on any of the above programmes, do not hesitate to contact your local Professional Development Co-ordinator for Practice Nurses.

New Publications in 2008

Domestic violence – a Guide for General Practice

This evidence based guideline which provides GPs and PNs with an understanding of the problem and assistance in identifying domestic violence has been collaboratively developed with members of the Irish College of General Practitioners (ICGP), HSE, Women’s Aid and the Rape Crisis Network.

The full evidence based guide focuses on three key issues for the management of domestic violence by health professionals which are described as the 3Rs:

Recognise: know the signs, indications and sequence of abuse
Respond: know how to deal with the issue of abuse
Refer: make a good, appropriate referral.

National Training Workshops on how to identify and address issues of domestic violence in a general practice setting will be held for general practitioners and practice nurses during 2009 (details to follow).

DIARY DATES

Diabetes Management – an Introductory Course for Nurses

This course is being held on Monday 20th and Tuesday 21st April 2009 at the Diabetes Centre in the Mater Misericordiae University Hospital, Dublin 7. For further information and to reserve a place on this course please phone 01 8034613 or email diabetesdaycentre@mater.ie

2009 notices and news

New email addresses

New email addresses have been set up as follows:

- Lisa Nolan, Administrator: admin@irishpracticenurses.ie
- Grainne Lynch, Conference Coordinator: conference@irishpracticenurses.ie
- Tracey Rooney, Membership Secretary: membership@irishpracticenurses.ie

Niall Mellon – thank you

Helen Jordan, Kildare/Carlow Branch and past-National Treasurer, would like to extend her sincere thanks to all her colleagues and friends in the IPNA who contributed so generously to the fundraising for her forthcoming trip to the Niall Mellon project in Africa.

Next NEC Meeting

Wednesday 4th February 2009, Castleknock Hotel, Dublin 15 at 11.15am. Agenda will be emailed to all NEC representatives before the meeting.
Tel: 042-9692403 or e-mail: admin@irishpracticenurses.ie
ABRIDGED PRESCRIBING INFORMATION VIATIM® Suspension and solution for injection in a prefilled dual chamber syringe. Hepatitis A (inactivated, adsorbed) and Typhoid polysaccharide vaccine. Refer to Summary of Product Characteristics for full product information before prescribing. Additional information is available upon request. Presentation: Suspension and solution for injection in a prefilled dual chamber syringe. Available as a 1 millilitre single dose in a prefilled, dual-chamber syringe, containing 25 micrograms of Salmonella typhi (Ty2 strain) purified Vi capsular polysaccharide and 160 antigen units of inactivated hepatitis A virus. Indications: For simultaneous active immunisation against typhoid fever and hepatitis A virus infection in subjects from 16 years of age. Dosage and administration: A single 1 millilitre dose should be administered by slow intramuscular injection in the deltoid region. The two vaccine components should only be mixed immediately prior to injection. To provide long term protection against infection caused by the hepatitis A virus, a booster injection of inactivated hepatitis A vaccine should be given 6 to 36 months later. VIATIM® may be used as a booster vaccine in subjects who have received an inactivated hepatitis A vaccine 6 to 36 months earlier, and who require protection against typhoid fever. Contraindications: Known hypersensitivity to the active substances or to any of the excipients of VIATIM®. Known hypersensitivity to neomycin (present in trace amounts as a residual of the manufacturing process). Vaccination should be delayed in subjects with an acute severe febrile illness. Warnings and precautions: As with all vaccines, appropriate facilities and medicines should be readily available in case of anaphylaxis or hypersensitivity following injection. Immunogenicity of the vaccine may be impaired in immunosuppressed patients. The effect of VIATIM® on individuals in the incubation period of hepatitis A is not known. Concomitant administration with other inactivated vaccines at different injection sites is unlikely to interfere with the immune response. VIATIM® can be administered concurrently at a different site with yellow fever vaccine. Pregnancy and lactation: Data on a limited number of exposed pregnancies indicate no adverse effects of VIATIM® on pregnancy or on the health of the foetus/new born child. However, caution should be exercised when prescribing to pregnant women. As there are no data on the excretion of VIATIM® in human breast milk, caution should be exercised when prescribing to breast-feeding women. Undesirable effects: Common side effects include: injection site disorders (pain, induration, oedema, erythema), asthenia, headache, malaise, myalgia, nausea, diarrhoea, fever, and arthralgia. Very rarely, serious side effects have been reported and include anaphylactoid reactions, serum sickness and aggravation of asthma. For a complete list of undesirable effects please refer to the Summary of Product Characteristics. Package quantities: Single dose prefilled syringes in single packs. Marketing authorisation holder: Sanofi Pasteur MSD Limited, Block A, Second Floor, Cookstown Court, Old Belgard Road, Tallaght, Dublin 24. Marketing authorisation number: PA 544/37/1 Legal category: POM ® Registered Trademark Date of last review: January 2007

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

Avoiding contaminated food and water is good advice. But it’s not always realistic.

Travel advice only goes so far...

ViATIM®  protects for up to 36 months against both hepatitis A and typhoid fever.1
Croí Hosts 3rd National Practice Nurse Conference on Cardiovascular Disease

West of Ireland heart charity Croí, supported by Pfizer Healthcare Ireland, have just announced details of their 3rd Annual National Practice Nurse Conference which will take place in Galway on Friday 27th and Saturday 28th February 2009, titled Cardiovascular Disease: Primary Care – The Way Forward.

The opening session of the conference will be addressed by experts across a wide variety of topics pertinent to heart disease and primary care, such as the Medical Advisory Board of the Asthma Society of Ireland, A Tobacco Free Society, with Dr Fenton Howell (Director of Public Health, HSE & Board Member, ASH Ireland); Managing Type 2 Diabetes in Primary Care; with Dr Ray O’Connor, GP and Cardiovascular Disease Prevention with Dr Susan Connolly, Consultant Cardiologist, Imperial College London.

A significant feature of this year’s programme will be case study presentations on erectile dysfunction, pre and post cardiac surgical care, care post ICD insertion and diabetes.

The second session of the conference programme will address practical primary care issues such as; managing heart failure in the community; smoking cessation and prescribing effective physical activity.

As complimentary overnight accommodation is provided, places are limited and will be offered on a first come, first served basis. Accordingly, early booking is advisable.

For further information and bookings, contact Alma O’Connell on 091-769866 or email: alma@croi.ie.

Revised Gina guidelines launched by the asthma society of Ireland and the ICGP

New guidelines are adapted for Irish healthcare professionals

The Asthma Society of Ireland together with the Quality in Practice Committee of the ICGP has adapted the Global Initiative for Asthma (GINA) guidelines specifically for Irish healthcare professionals. Entitled ‘Asthma in Control in General Practice’, the guidelines are intended to encourage best practice asthma management for the 470,000 people in Ireland living with asthma. The guidelines have been endorsed by the ICGP who worked with the Asthma Society of Ireland in developing the document to encourage best practice primary care management of asthma symptoms in order to ensure the best possible outcome for patients.

The revised guidelines for Ireland provide in-depth information on the management of asthma including information on clinical diagnosis, doctor/patient partnership, identifying and reducing exposure to risk factors, assessment, treatment and monitoring of asthma and managing asthma exacerbations. The guidelines also feature a sample written asthma plan for patients which, as part of a guided self-management approach, can improve asthma control; this includes information on when and how to increase treatment and when to call the doctor/clinic.

In Finland where evidence based guidelines were successfully implemented, the burden of asthma has decreased considerably. The number of hospital admissions fell by 54% and mortality decreased by 90%. The cost of asthma care also fell significantly with the cost per patient decreasing by 36%. The Finnish experience demonstrates that it is possible to reduce the morbidity and mortality of asthma and its impact on individuals as well as on society.

“I am delighted that the ICGP has agreed to support the implementation of the evidence-based International GINA Asthma Management and Treatment Guidelines. The Asthma Society of Ireland has worked closely with the Quality in Practice Committee of the ICGP in the preparation of this document and it is our hope that this will improve the care of the 470,000 people with asthma in Ireland,” said Dr Jean Holohan, CEO Asthma Society of Ireland.

Dr Margaret O’Riordan, National Director for Specialist Training in General Practice commented, “Ireland has one of the highest rates of asthma in Europe and the fourth highest in the world. This alarming statistic highlights the importance of greater focus on asthma management and control. We believe that the new guidelines are a step in the right direction to help reduce asthma morbidity and mortality in Ireland.”

In 2006, a GINA report stated that it was reasonable to expect that for most patients with asthma, control of the disease can, and should be achieved and maintained. To meet that challenge the updated GINA guidelines not only incorporate updated scientific information but recommend an approach to asthma management based on asthma control, rather than severity of the disease.

The revised guidelines are available through The Asthma Society of Ireland. For more information log on to www.asthmasicotie.ie or call 1850 44 54 64.
HSE to evaluate nurse prescribing initiative

Gary Finnegan

The HSE is set to appoint external consultants to conduct an independent evaluation of its Nurse and Midwife Prescribing Initiative, Nursing in General Practice has learned.

The Executive is currently in the process of finalizing negotiations on the contract which was awarded following a tender process. However, a spokesperson declined to identify the contractors as talks were at a sensitive stage. A final report is expected later this year and will examine barriers to implementation, the educational selection process, and value-for-money, in addition to other criteria.

“The evaluation process is now complete and a preferred tenderer has been selected. The HSE are currently concluding contractual issues with the preferred tenderer and hope to be in a position to award a contract shortly, after which a contract award notice will be published.”

The primary legislation supporting the Nurse and Midwife Prescribing Initiative was laid down by Health Minister Mary Harney in the Irish Medicines Board Act 2006, with regulations signed into law in May 2007 allowing for implementation of the plan. Last January 2008), the first four nurse and midwife prescribers were registered by An Bord Altranais.

There are now 39 nurses and midwives entitled to prescribe, and another five applications are currently with An Bord Altranais. A further 89 candidates are preparing for registration, according to the HSE. To date, a total of 225 candidates across 58 clinical disciplines have commenced or completed a training programme in nurse prescribing.

It is expected that the numbers of nurses qualified to prescribe will continue to grow, with general practice highlighted as an area where nurses’ role can be expanded. Diabetes care, oncology, and paediatrics are among the specialties where nurses are now qualified to prescribe certain medicines under strictly controlled conditions. Prescribing as part of multidisciplinary teams in the nursing home setting and emergency departments is also expanding quickly.

In November, the HSE published a Guiding Framework for the Introduction of Nurse and Midwife Prescribing in Ireland which is seen as the roadmap for developing the role of nurse prescribers. The document is available at www.hse.ie.

The document says the independent evaluation will provide the framework to underpin the further expansion of the initiative across the HSE over the next five years. “The evaluation will take place over a six month period with the final report anticipated for mid-2009.”

More than 450,000 Irish men have never had a general health check

More than 450,000 Irish men have never attended a GP for a general health check.

Of those who have never attended a GP, nearly 250,000 said they didn’t need to go as they believe they are healthy and an estimated 120,000 will only go to their doctor when ill and would not attend for routine checks of blood pressure or cholesterol. These are results from recent research conducted by TNS mrbi on behalf of the international pharmaceutical company Lilly, who researches and develops treatments for erectile dysfunction. With current life expectancies of 80 years for women and 75 years for men, today men are called upon to be more health conscious in 2009 at the launch of new men’s health research.

Despite the fact that ED is so common, fewer than one in four men go to their doctor about a sexual health problem and up to 40% of men’s visits to their doctor are prompted by the woman in their lives. Mary O’Connor, psycho-Sexual Therapist, Albany Clinic, says, My advice to anybody suffering with ED is to seek help as soon as possible, in the first instance from your GP, in order to avoid it eventually seriously impacting on your general relationship.

ED is a common condition with over 50% of men aged 40+ likely to experience the condition at some stage in their lives.9 Talking about ED can be embarrassing for some patients and according to the research an estimated 200,000 Irish men would still be uncomfortable discussing a condition like ED with their GP, although the condition has become increasingly destigmatised in recent years.

There are several effective treatments for ED which include tablets, vacuum pumps, hormone treatment, injectable treatment, surgery & counselling. Tablets are the most popular and vary in how long their effect lasts, some working for up to 4 hours and others for up to 36 hours depending on the type of medicine. Even if you didn’t have a good experience of treatment for ED in the past, it is worth discussing other options with your GP who will be able to provide more information on the most suitable treatment for you. For more information see www.manmatters.ie

Launch of the Solution for Wellness website www.solutionsforwellness.org

Tony Daly (Loughrea, Galway Mental Health Services), Karen Loughrey and Edel Woods (2nd and 3rd from left respectively), both from Owendoher Day Hospital, Dublin 8. Azaliya Musina, Lilly, Noreen Foye from Swinford Day Hospital, Dermot McNamara, Lilly; Marie Quinn, Lilly; John Saunders, Schizophrenia Ireland.
Think calories. Think Calogen.

Calogen provides more energy than any other supplement.

Research indicates that Calogen increases energy intake by 31%, with no change in appetite and no adverse effects.1

Recommend Calogen 3 x 30ml per day for your patients.


For samples or further information, call Nutricia on Freephone 1800 923 404

Nutricia, Block 1 Deansgrange Business Park, Deansgrange, Co. Dublin.
Tel: +353 1 289 0283  |  Fax: +353 1 289 0255  |  Email: info@ncc.nutricia.ie
The HSE recently joined with the Department of Health and Children and nursing unions in launching a major framework document on enhanced roles for nurses and midwives. Nurses and midwives are pioneering what is one of the most important changes in Irish healthcare. Today there are 43 nurses and midwives prescribing medicines in different parts of the country — and this number is steadily increasing.

New legislation and regulations giving nurses and midwives the power to write prescriptions represents one of the most fundamental changes in healthcare practices aimed at improving the service to patients throughout the country. Nurse prescribers are improving services to patients and reducing health service delays. Working in the community and in our major hospitals these nurses are already registering very positive feedback from patients.

The driving force behind this innovative change is the Resource and Implementation Group on Nurse and Midwife Prescribing. At their final meeting the Group’s chairperson Dr Siobhan O’Halloran paid tribute to the contribution and commitment of all members of the group over the past two years. “It is, in no small part, due to the skill and expertise of the group members that the national implementation of nurse and midwife medicinal product prescribing has been so successful,” Dr O’Halloran said.

Dr O’Halloran was speaking at the publication of a special report entitled Guiding Framework for the Implementation of Nurse and Midwife Prescribing in Ireland in Dublin at the National Maternity Hospital, Holles Street.

In October 2005 the Minister for Health and Children, Mary Harney TD, prioritised the introduction of nurse and midwife prescribing. The Minister recognised the complexity of the task ahead and readily acknowledged the ground-breaking work that had already been done by a number of different parties when establishing the resource and implementation group. The first nurse and midwife prescribers registered with An Bord Altranais in January 2008. The Registered Nurse Prescribers (RNP) currently practising are from a variety of clinical settings. Registered nurse prescribers have written 1,674 prescriptions for 1,499 patients and 2,423 individual medicinal products since January 25th, 2008.

Seventy-nine health service providers across the Health Service Executives’ National Hospital Office and Primary, Community and Continuing Care are currently introducing nurse and midwife medicinal product prescribing.

A total of 225 nurses and midwives are undergoing or have completed the education programme with broad representation from 58 different clinical areas.

Fellowship degree awarded to Moira Noone

Congratulations to Moira Noone, FFNM, RCSI, MSc, BSc, H.Dip, Nursing, FPC, RGN, who received her fellowship degree on the 15th December 2008 from the Royal College of Surgeons. Moira works as a clinical nurse specialist in general practice with her husband, Dr Patrick Noone in Ballyhaunis, Co Mayo. Photo shows Moira receiving her degree from Professor Seamus Cowman, RCSI.

International urgent medical care seminar in DCU

Jenny Clarke, Ciara Lanigan, Sinead Harte at the first international urgent medical care seminar.
LEAD THE WAY IN 
BP CONTROL

1st Direct Renin Inhibitor

Powerful and sustained efficacy

For new patients and as add-on

ALREADY PRESCRIBED TO OVER 300,000 PATIENTS WORLDWIDE†

† IMS Disease Analyzer - Verispan 2008

Please refer to Summary of Product Characteristics (SmPC) before prescribing.

Presentation: Rasilez film-coated tablets containing 150mg and 300mg of aliskiren (as hemifumarate).

Indications: Treatment of essential hypertension.

Dosage: 150mg to 300mg once daily with a light meal (do not take with grapefruit juice), alone or in combination with other anti-hypertensive agents. No adjustment of initial dose required in elderly (>65 years), renal and liver impairment. Not recommended < 18 years of age.

Contraindications:

- Hypersensitivity to the active substance or excipients.
- Second and third trimesters of pregnancy
- Concomitant use with ciclosporin and other potent P-gp inhibitors (quinidine, verapamil).

Warnings/Precautions:

- Increased risk of hyperkalaemia in patients receiving other RAS agents, and/or those with reduced kidney function and/or diabetes mellitus
- Caution in patients using moderate P-gp inhibitors concomitantly
- Caution in patients with severe heart failure (NYHA class III/IV)
- Close medical supervision in patients with marked volume- and/or salt-depletion due to risk of hypotension
- Caution in patients with severe renal dysfunction, renal artery stenosis, a history of dialysis, nephrotic syndrome, or renovascular hypertension
- Not recommended during pregnancy or when planning to become pregnant, to be discontinued if pregnancy occurs.
- Not recommended in breastfeeding women.
- In event of severe and persistent diarrhoea, Rasilez should be stopped.

Interactions:

- Monitoring when used concomitantly with furosemide
- Interaction with ketoconazole, other moderate P-gp inhibitors and potent P-gp inhibitors
- Concomitant treatment with drugs that may increase serum potassium levels
- Possible interaction with digoxin, cholesterol, St. John’s wort, rifampicin, other P-gp inducers and grapefruit juice
- Meals with high fat content substantially reduce absorption.

Adverse reactions:

- Common: diarrhoea
- Uncommon: Rash
- Rare: Angioedema
- Laboratory values: decrease in haemoglobin and haematocrit, increase in serum potassium.

Legal Category: POM

Pack sizes: 14 and 28 film-coated tablets

Marketing Authorisation Holder: Novartis Europharm Limited, Wimblehurst Road, Horsham, West Sussex, RH12 5AB, United Kingdom.

Marketing Authorisation Numbers: EU/1/07/405/2-3, 12-13

Full prescribing information is available on request from Novartis Ireland Ltd, Beech Hill Office Campus, Coolock, Dublin 4. Tel: 01 2611205. Date of Revision of API Text: September 9th 2008.

Date of Preparation: to be completed by marketing.
Promed support Coisceim Eile

Following the publication of an article in a local newspaper, staff at Promed Dental and Medical supplies in Killorglin decided to help support the charitable group Coisceim Eile, in their efforts to raise enough money for the purchase of a LOKOMAT machine for the Munster region.

The Lokomat machine is a specialist piece of equipment that allows people with disability to exercise their own muscles. This machine can be of great benefit to stroke victims, people with disabilities, MS, cerebral palsy and spina bifida. There is currently only one such machine in Ireland and it is located in Dublin.

The group Coisceim Eile (Another Step) was founded by Joan Ryan from Clonoulty, Co Tipperary, after an accident in which her daughter was injured. She, along with parents in a similar situation from across Munster, formed the group in order to fundraise for the machine, which will be put in the First Step rehabilitation clinic in Patrickswell in Limerick.

Staff at Promed held a fancy dress day on October 31st to raise funds, they also sold tickets for a dinner dance in Cahirciveen on the 14th November, and the GM, Colin Denman, was pleased to meet with Committee member Maura Moriarty on the 26th of November to present her with a cheque for €1,500 toward this worthy cause.

Donations to the Coisceim Eile fund can be made at Bank of Ireland in Cashel, account number 90406898 and Joan Ryan can be contacted on 0504 42375.

MSD Cardiovascular Prevention Strategy Nurses Meeting

Ms Anna Meagher (MSD), Clinical Nurse Specialists Ms Mary O’Sullivan and Ms Anne Staunton.

Livinghealth Clinic — “Ireland’s most Advanced Primary Care Service”

Minister Michael Martin officially opened the new Livinghealth Clinic in Mitchelstown, Co Cork recently. Livinghealth Clinic is a GP led initiative, offering an independent, complete advanced primary care service to the local community as well as providing specialist and ancillary services to the surrounding regions of Cork, Limerick, Tipperary and Waterford.

The new clinic is based on extensive international experience, site visits, research and an in-depth understanding of the community’s health needs and the greater region’s health care needs and ever changing healthcare technology.

A €10million investment has resulted in a 30,000 sq ft state-of-the-art facility, providing a professional, high-quality integrated approach to healthcare on one site.

Livinghealth Clinic was founded and developed by six local GPs: Dr Tom O’Callaghan, Dr Brian Carr, Dr Jack Griffin, Dr Elma Gaffney, Dr Delcan Herlihy and Dr Frank O’Connor.

Having opened its doors last November, the clinic currently employs 40 people including 20 new jobs. This will increase to 80 full and part-time positions once all hospital consultants and ancillary health care service providers are in place. The Livinghealth Clinic has been a very welcome development in the Mitchelstown area and has met with a wave of good will and support locally, with over 2,500 people attending the community launch in November.

Livinghealth Clinic, Mitchelstown, Co Cork
Tel: (025) 52000
www.livinghealth.ie
Learn about probiotics to continue your professional development

Yakult, the probiotic fermented milk drink, arrived in Ireland in 2004. Although still relatively new to Ireland the product was developed over 70 years ago in Japan and is today consumed in 31 countries around the world.

Each bottle of Yakult contains *Lactobacillus casei* Shirōta – a unique and safe probiotic strain that helps maintain a healthy balance of intestinal flora – thus supporting a healthy digestive system and in turn the body’s natural defences.

Probiotic research papers are now being published at an incredible rate, describing human trials and other studies conducted with a range of microbial strains and for a wide variety of health benefits. Learning about probiotics could be hugely advantageous for your continued professional development.

**THE IMPORTANCE OF CONTINUING PROFESSIONAL DEVELOPMENT**

Continuing professional development (CPD) is relevant to all healthcare professionals as it helps maintain, improve and broaden knowledge and skills in order to offer patients high quality care. CPD is your commitment to being professional, keeping up to date and continuously seeking to improve.

**HOW CAN YAKULT HELP WITH CPD?**

The science team at Yakult consists of nutritionists, dietitians and a microbiologist, all of whom are probiotic experts. A member of the team can visit you and your colleagues at your workplace to give an educational presentation that objectively reviews the scientific evidence for probiotics. Seminars can be tailored depending on your specific areas of interest: e.g. digestive health, immune benefit and infection control.

As part of the educational seminars we are able to offer self reflection forms and certificates of attendance, both of which are useful for demonstrating CPD.

Please contact the science department at Yakult Ireland for more information.

**YAKULT IN YOUR HOSPITAL**

Are you interested in conducting your own investigations into the potential benefits of probiotics for patients? We can offer a limited free supply of Yakult to hospitals who receive our educational presentation. During this, we can provide an overview of Yakult research and advise how you could use your free samples.

Please contact the science department at Yakult Ireland for more information.

---

**FREE SCIENTIFIC RESOURCES**

Yakult has produced a number of booklets and resources to educate healthcare professionals about probiotics and their potential benefits. These include:

**THE POTENTIAL OF PROBIOTICS IN PRIMARY CARE BOOKLET**

This resource is primarily aimed at nurses and GPs, however, it is a valuable tool for anyone interested in probiotics. The booklet reviews the latest research for probiotics in general, giving an overview of healthcare areas in which they have shown potential.

**PROBIOTIC BULLETIN NEWSLETTER**

Yakult’s science department also produces a quarterly newsletter which is emailed to healthcare professionals throughout the UK and Ireland. It contains the latest news on probiotics, including a research round up, interviews with key healthcare professionals and scientists, as well as information on the latest conferences attended or sponsored by Yakult, and much more.

To sign up to receive a copy of the Probiotic Bulletin or to request any of our literature please email science@yakult.ie

**DEDICATED WEBSITE FOR HEALTHCARE PROFESSIONALS**

Yakult has developed a website which contains information solely for use by healthcare professionals. The site provides you with access to evidence-based information and resources to update your professional knowledge and carry out informed practice.

Visit www.yakult.ie/hcp for more information.

---

**CONTACT US**

Yakult is committed to supporting you continue your professional development.

For further information and to discuss how we can help please contact:

Science Department,
Yakult Ireland, Berkeley House,
21 Cookstown Industrial Estate,
Tallaght, Dublin 24.
Telephone: 01 4599580
Email: science@yakult.ie
CARLOW/KILDARE

KATE ATTRIDE

The November meeting of the Carlow/Kildare Branch took place in the Clonard Court Hotel Athy on Wed 19th November. The meeting was kindly sponsored by Nutricia and was attended by representatives, Brid Downey and Noeleen Byrne. Edel Duffy, Practice Dietitian gave a very informative talk on “Consequences of undernutrition”. Many members from our branch attended the IPNA Annual Educational Conference/AGM in Cavan recently. Well done to the Wicklow branch for organising such a successful conference. We would like to wish Helen Jordan all the best on her trip to South Africa with the Niall Melon project.

Our December meeting took place on the 9th December in the Bay Tree in Athy, this was our AGM together with our Christmas night out. Wishing everyone a happy and healthy 2009

CLARE

ANNA AKAMNONU

Hope everyone had a good Christmas and we wish all our colleagues around the country best wishes for 2009. The Clare branch had their last meeting of the year on 18th November 2008. It was well attended and a talk given by Dr Beatrice Neaufeldt on family planning was very well received by all present. Her presentation was novel, interactive and refreshing and encompassed a completely holistic approach. It was truly impressive and we look forward to inviting her again to talk on another topic at a future date. Our Christmas night out on 13th December was a very enjoyable evening. We met in Morrisey’s Pub/Restaurant, Doonbeg and had a wonderful meal with great food and great chat. The weather was bitterly cold but the atmosphere was festive and warm. We later crossed the road to the local pub, Comerford’s where we sang and danced the night away. Our January meeting took place on 20th, the third Tuesday of the month in the Old Ground Hotel, Ennis. We look forward to a large attendance and any new members are very welcome.

CORK

TRISH O’CONNOR

On behalf of the Cork Branch Committee I want to wish you all the very best of health and happiness for 2009. The Cork Branch had a busy but entertaining end to 2008. Our Branch AGM was held in November in the Kingsley Hotel kindly sponsored by Pfizer. The meeting was very well attended and a new Cork Branch Committee was duly elected. The committee would like to take this opportunity to thank all of their predecessors for their hard work and commitment throughout the past year.

After the business of the night was taken care of, guest speaker, Catherine McGonigle, Pain Nurse Specialist, CUH gave a very interesting series of case presentations on the topic of neuropathic pain.

In keeping with the festive season the December meeting combined our monthly meeting with our annual Christmas social night. This meeting was held in the Rochestown Park Hotel and was very kindly sponsored by Chrissie Shanahan and Angie O’Sullivan of Allen & Hanburys. The educational part of the evening consisted of three very interesting and informative presentations on the topics of Asthma, the National Breast Screening Programme and the National Cervical Screening Programme. Information packs for nurses from the Migraine Association of Ireland were also distributed.

This concluded the business side of things and we then all enjoyed good food and company for the rest of the evening. On the night, spot prizes were raffled off raising over €400 for the Cork Simon Community. The success on the night was a testimony to all the well laid preparations that go into organising a night such as this and we would like to take this opportunity to thank all those involved.

We are looking forward to 2009 where we are hoping our meetings will continue to be as enjoyable and educational experience for both existing and new members in our new venue the Rochestown Park Hotel.

There is a busy schedule of meetings in planning for Spring 2009.
GALWAY

MAUREEN DELANEY

We reconvened after the summer break in Almuretto Resturant on the 18th September, with thanks to Ruth Lynch of MSD and Dohme. Our speaker Samer Arnous, cardiac registrar in University College Hospital, spoke to us on a very relevant topic “24 hour BP monitoring and its’ interpretation. We welcomed members old and new back after the summer holidays.

October 4th brought the Galway practice nurses to the Courtyard by Marriott Hotel, where Karina Lyons, Convatec, demonstrated dressing selection and wound care. Following which, we held our branch meeting where I have remained on as Chairperson and Catherine Kirrane remained as Vice-Chairperson. Doreen Eaton has taken on the position as Treasurer from Evelyn Brown and Marea Burke accepted the position of Secretary from Sally Whelan. I would like to thank Evelyn and Sally for a job well done and look forward to seeing them at future meetings.

Michael McGreal, GSK, gave us an informative and thought provoking evening in The Twelve in Bearn. Mary Durkan, RGN and barrister discussed Practice Nurses and the Law.

The upcoming Croí conference is scheduled for February 27th and 28th in the Radisson Hotel in Galway. Irene Gibson, Croí Community Cardiac Care Co-ordinator has promised us an educational and enjoyable weekend and we are looking forward to seeing everybody there.

We would like to offer our congratulations to Eileen Fahy and Marie Smyth on the birth of their healthy babies and wish them all the best.

Kathy McSharry has asked me to remind anyone interested in doing the stand alone modules in NUIG, that funding is available. Please feel free to contact Kathy if you have any queries about same.

The Galway IPNA would like to extend our congratulations to Moira Noone, who on behalf of the Galway branch, won the poster award at this year’s AGM. Well done to Wicklow branch on a job well done.

Our December meeting was scheduled for the 12th of December in Cloonacauneen Castle.

Looking forward to the coming year, we hope that you can attend our monthly meetings which continue to take place on the third Thursday of each month. Our meetings are educational and informative and they give us an opportunity to discuss many topics with our colleagues and to develop our friendships. I would like to take this opportunity to wish all our members, old and new, good health and happiness for 2009.

KERRY

MARY BRICK

On behalf of the Kerry Branch of IPNA I would like to wish all our colleagues and friends a wunderfully happy and healthy New Year.

Cathy O’Sullivan of ASTRA ZENECA organised an excellent lecture from Dr Walsh, Cork on Haemachromatosis at our November meeting.

It was great to have Marie Courtney in attendance at our December meeting. We had a very interesting information evening on infant massage and its benefits given by Ann O’Donnell. We had a fabulous dinner chat and fun at the Station House, Blennerville, Tralee. This was hosted by Angie O’Sullivan and Kate Spillane of Glaxo Smith Kline.

KILKENNY

PATRICIAN MCQUILLAN

Congratulations to Margaret Cuddihy on her recent retirement from practice nursing. Mags has been a stalwart of the IPNA from the days we travelled together to Clonmel in the early 1990s for our meetings, to setting up our own branch in Kilkenny.

We had our AGM in early December when Patricia McQuillan was elected as chair with Kathleen Phelan as secretary, Mary Fogarty is staying on as treasurer for another year.

We had three meetings before Christmas with the first being at the end of October. Pfizer sponsored Emer Gartland, the PHN for Continence in the Carlow, Kilkenny area who gave an informative talk on the over active bladder. In November we met again for a short talk by Niamh from Arganon who gave an update on the Novaring – this was followed by our AGM, before we adjourned to the dining room for an early Christmas dinner.

Before Christmas, Cow & Gate sponsored the evening with Gráinne Parker delivering a talk on Infection Prevention and Control in General Practice. Gráinne is the Communicable Disease Prevention and Control Nurse based in the Public Health Department in the HSE in the south east and she also covered common communicable diseases and their management.

The attendance has improved at the local meetings and this is a very good sign. Practice nurses work autonomously and often in isolated positions with no nursing colleagues or nursing management. The IPNA meetings are an important forum for support and networking.

At our January meeting we will welcome Denise Blanchfield, ANP/Diabetes in Carlow/Kilkenny and Mary Stokes, Podiatrist.

Further details of the meetings in the Kilkenny area can be obtained from the Chair on 087 2281548.
**LIMERICK/NORTH TIPPERARY**

ANITA FITZGERALD

The Limerick/North Tipperary Branch of the IPNA took place on 20th November in the Castletroy Park Hotel Limerick. This was our AGM. The meeting was sponsored by Shire Pharmaceuticals and Dr Colm Hackett, Newmarket-on-Fergus spoke on the topic of dementia. Our thanks to Theresa Kiernan for sponsoring the meeting.

We would like to extend our congratulations to Patricia Collins our branch treasurer on the birth of her baby daughter Hannah.

We also extend condolences to Barbara English on the death of her sister Mary Reale, may she rest in peace.

Our 4th December meeting took place in the Marriott Hotel Limerick. A big thank you to Pauline Prendegast and Martin Murphy GSK for a most enjoyable night. Our January meeting took place in the Maldron Hotel Limerick on 22nd January 2009.

Hoping everyone has a very Happy New Year and looking forward to seeing you all in 2009.

---

**LOUTH/MEATH**

SINÉAD MCGRATH

Apologies we are an issue behind with our news, I did not realise it was my position as new chairperson to submit our news — four faults straight off! At this point, I must welcome Carol O’Flynn Kilcoyne and Siobhan Matthews as they take up the posts of Secretary and Treasurer respectively. Ida Fitzpatrick continues as NEC rep.

May I take this opportunity to thank Genny O’Donoghue, outgoing Chairperson; Joan Kehoe Ward, outgoing Secretary and Alison Geraghty outgoing Treasurer. Many thanks for doing a fantastic job.

Our first meeting as a new committee was held on Thursday 6th November in George’s Patisserie in Slane, which was kindly sponsored by Sinéad O’Callaghan from Roche and Therese O’Regan from GSK. Kate McCabe gave an excellent talk on psychosexual therapy. We had an impressive turnout of 33 members! Carol and I are still unsure whether it was the hot topic or if the new venue attracted the crowd.

Otherwise all the other midwives present signed a petition requesting a midwifery update for our area as recommended by An Bord Altranais. Ruth Taylor is to instruct me as to where to forward the petition. Other news is that there is a diabetes course based in JCMH, Blanchardstown which is available next year to practice nurses in our area. Please contact Ruth for the details.

Congratulations to Sheila McKeown who delivered baby Catherine the day before our last meeting. As I was stalking her with regards to a laptop she was delivering a new life to the world.

Speaking of midwifery, last Wednesday 26th November, I attended Our Lady of Lourdes Hospital, Drogheda for the recent Birth Matters Meeting, where the committee is desperately trying to improve Maternity Services in the North East. We need more consumers on board, please contact myself at: sineadmcgrath5@hotmail.com for further details.

Lastly, may I say how delighted we were at the recent turnout. At our meeting on December 4th Orla Duffy, dietitian discussed, Diabetes – Nutrition Intervention Updates.

Remember united we stand, divided we fall, together we build a mighty wall.

Happy New Year.

---

**ROSCOMMON EAST GALWAY**

MARGARET SCOTT

Our November branch meeting was held in the Abbey Hotel, Roscommon and was very well attended. Some new nurses were welcomed back after their breaks. Introductions were given all round and the branch wished them well in their new posts.

Members were asked to ensure membership was paid up for the coming year and our treasurer Niamh did quite well on the right!

The meeting was kindly sponsored by Deirdre Gordon of Yakult Ireland Ltd who gave us an amazing presentation on research done regarding the benefits of probiotics. She explained that not only do probiotics contribute to a balanced diet but that there is growing evidence that probiotics provide health benefits in a clinical setting. The meeting concluded with questions and answers followed by some lovely food.

Our next meeting is expected to cover the topic ‘wound management’ and ideas as to what topics we would like discussed are welcomed by our secretary Mary. We wish everyone a happy New Year.
help your patients quit\textsuperscript{1-4}

Quitting smoking is an uphill struggle\textsuperscript{5-7} but choosing CHAMPIX\textsuperscript{\textregistered} can make all the difference for your patients.

CHAMPIX offers:

- reduced craving and withdrawal symptoms\textsuperscript{1-3}
- significantly greater quit success vs. NRT patch, bupropion or placebo at 12 weeks\textsuperscript{8}
- over 8.9 million patients’ experience worldwide\textsuperscript{9}

A 12 week CHAMPIX course, together with your support and advice, can help your patients overcome their smoking addiction.\textsuperscript{1-4}

PRESCRIBING INFORMATION CHAMPIX

Please refer to the SmPC before prescribing Champix 0.5 mg and 1 mg. Presentation: White, capsaicin-shaped, bicavus tablets debossed with “Pfizer” on one side and “CH 0.5” on the other side and light blue, capsular-shaped, bicavus tablets debossed with “Pfizer” on one side and “CH 1.0” on the other side. Indications: Champix is indicated for smoking cessation in adults. Dosage: The recommended dose is 1 mg varenicline twice daily following a 1-week titration as follows: Days 1–3: 0.5 mg once daily, Days 4–7: 0.5 mg twice daily and Day 8 – End of treatment: 1 mg twice daily. The patient should set a date to stop smoking. Cessation should start 1–2 weeks before this date. Patients who cannot tolerate adverse effects may have the dose lowered temporarily or permanently to 0.5 mg twice daily. Patients should be treated with Champix for 12 weeks. For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment at 1 mg twice daily may be considered. Following the end of treatment, dose tapering may be considered in patients with a high risk of relapse. Patients with renal impairment: AMI to moderate renal impairment: No dosage adjustment is necessary. Patients with moderate renal impairment who experience intolerable adverse events Cessing may be reduced to 1 mg once daily. Severe renal impairment: 1 mg once daily is recommended. Dosage should begin at 0.5 mg once daily for the first 3 days then increased to 1 mg once daily. Patients with end-stage renal disease: Treatment is not recommended. Patients with hepatic impairment and elderly patients: No dosage adjustment is necessary. Paediatric patients: Not recommended in patients below the age of 16 years. Contraindications: Hypersensitivity to the active substance or to any of the excipients. Warnings and precautions: Effect of smoking cessation: Stopping smoking may alter the pharmacokinetics or pharmacodynamics of some medicinal products, for which dosage adjustment may be necessary (examples include theophylline, warfarin and insulin). Depression, suicidal ideation and behavior and suicide attempts have been reported in patients attempting to quit smoking with Champix in the post-marketing experience. Not all patients had stopped smoking at the time of onset of symptoms and not all patients had known pre-existing psychiatric illness. Champix should be discontinued immediately if agitation, depressed mood or changes in behavior that are of concern for the doctor, the patient, family or caregivers are observed, or if the patient develops suicidal ideation or suicidal behavior. Depressed mood, rarely including suicidal ideation and suicide attempt, may be a symptom of nicotine withdrawal. In addition, smoking cessation, with or without pharmacotherapy, has been associated with the exacerbation of underlying psychiatric illness (eg, depression). The safety and efficacy of Champix in patients with serious psychiatric illness has not been established. There is no clinical experience with Champix in patients with epilepsy. At the end of treatment, discontinuation of Champix was associated with an increase in immobility, urge to smoke, depression, and/or insomnia in up to 3% of patients, therefore dose tapering may be considered. Pregnancy and lactation: Champix should not be used during pregnancy. It is unknown whether varenicline is excreted in human breast milk. Pregnancy and lactation: Varenicline has been shown to be dialyzed in patients with end-stage renal disease. Treatment of varenicline, an α4β2 nicotinic receptor partial agonist for smoking cessation, J Med Chem 2005; 48:3474-3477. Jorenby DE et al. Efficacy of varenicline, an α4β2 nicotinic acetylcholine receptor partial agonist, vs placebo or sustained-release bupropion for smoking cessation: A randomized controlled trial. JAMA 2006; 296:56-63. D. Gonzales D et al Varenicline, an α4β2 nicotinic acetylcholine receptor partial agonist, vs sustained-release bupropion and placebo for smoking cessation: A randomized controlled trial. JAMA 2006; 296:47-55. A. Nides M et al Varenicline versus bupropion OR placebo for smoking cessation: a pooled analysis. Am J Health Behav 2009; 33:664-675. S. Burn J M. Why people smoke. BMJ 2004; 328:277-279. B. West P, Shiffman S. Fast Facts. Smoking cessation. Indispensable guides to clinical practice. 2004, Oxford Health Press. T. Davis JA, Harris RA. NRT: Pharamcology and concomidity with alcohol abuse and mental illness. Nature Neuroscience 2005; 8:1465-1475. A. Aubin H-J et al. Varenicline versus transdermal nicotine patch for smoking cessation. Results from a randomised, open-label trial. Thorax 2009, 64:717-724. B. NSIS Meds data July 2006-June 2008.
SOUTH TIPPERARY

CATHERINE DELAHUNTY

Since last writing, the IPNA Conference has taken place. The South Tipp delegates wish to thank everyone at the conference for their hospitality; it was a very positive and enjoyable conference. The workshops deserve a special mention; it was felt that they were particularly appropriate for practice nurses.

Our November meeting was kindly sponsored by Liz O’Reilly of Pfizer and facilitated by Margaret Killian. This was a well attended meeting and our practice nurses were required to actively participate in what proved to be a very practical update in CPR and AED use. Margaret gave a whirlwind update on the new guidelines for CPR. This was a very worthwhile night and Margaret was an excellent facilitator.

Our AGM followed the CPR update — we wish all our officers for 2008-2009 the best of luck and we hope the recent interest in and growth of our branch continues. Many thanks to Rita and Kathy and all who assisted them for their fantastic work in the last year. We wish everybody a happy and healthy Christmas and we hope to see your all back with renewed energy in the New Year.

WATERFORD

DEIRDRE MCCANN

Happy New year to all readers. A cold spell seems to have crossed the whole country, both economically and meteorologically, so here’s wishing you an warmer 2009.

The Waterford Branch held two meetings since our last update. One in October and one in November, with a meeting imminent on Wednesday the 14th of January.

Our thanks to the sponsors of the October meeting, namely Niamh Carroll from Organon. The speakers for the evening, Joan Houlihan and Sheila Croke came from the Irish Family Planning Association, which has a premises in Waterford City. They provide sexual and reproductive health information, crisis pregnancy counselling, clinical services, education and training. The two speakers from the voluntary organisation held the attention of the floor for the evening.

The second meeting in November was kindly sponsored by Astra Zeneca. The speaker was Catherine Dwyer, Nurse Specialist working in Interventional Cardiology. The most up to date clinical information was divulged.

Our up and coming meeting is on Wednesday the 14th January. Our sponsor for the evening is Martha Cox, Medical Representative with Cow and Gate. We are delighted to have Dr Ann-Marie Tully, Senior Community Dietitian, HSE South and are looking forward to hearing about the latest changes in the area of Infant Nutrition. Hope to see big numbers attending. Until the next update, slán,

WICKLOW

MARY FINNEGAN

Happy New Year to all in Wicklow branch and hope you all had a happy, healthy Christmas and New Year, and were not struck down by this respiratory ‘epidemic’. It has been a very difficult and extremely busy month for us all in GP surgeries, with so many sick, often for weeks on end. Even the freezing weather did not kill off the bugs! Hopefully, the arrival of Spring will see an end to it all.

We held our branch AGM on Monday 1st Dec. Our guest speaker that night was Niamh Marrinian, from Body Whys, who gave a very interesting presentation on their work in this group, and answered questions from the floor after her talk. The meeting was very kindly sponsored by Roche, who were represented by Sheila Hogan.

Our meeting continued with a report and feedback on the national AGM, held in October. All those who were there agreed that it had been a great success. We would like to thank all those branches who emailed, wrote, sent cards, etc, to us following the weekend. It was lovely to have such positive feedback, and thank you all too, for your very kind comments in your branch section of this journal, last issue. We were also delighted to receive thanks and compliments from our guest speakers who all assure us they had an excellent weekend!

It was then time to elect our new Branch committee for the next two years. Thank you to all those who were willing to take on a job, and the election went through very smoothly. To make things a little easier, as we all have such busy lives, we decided to share the jobs of Secretary, INO Rep and NEC Rep, by electing two people to each job. We wish them all, all the best in their new jobs.

A big thank you once again to all the outgoing committee, (listed in the last report), we hope they enjoy their well earned ‘retirement’.

Our next meeting is a talk on cryotherapy, taking place on 26th January. Further meetings are planned for March 9th, April 20th, and May 25th.

We look forward to seeing you all at your Branch meetings, over the next few months, and would be delighted to welcome new members to the Branch, at any time.

Finally, we would like to extend our deepest sympathy to Liz Given, our outgoing INO Rep, on the very sudden, and untimely death, of her dear mother, at New Year. Our thoughts and prayers are with Liz and her family at this difficult heartbreaking time.
Promed Skills Workshops 2009

Promed, in association with Charles Bloe Training Ltd UK are providing a series of workshops in early 2009 on Venepuncture and 12-lead ECG placement Skills. Your speaker and coach will be Charles Bloe, BSc (Edin) RN NDN ITU cert.

Due to the hands-on nature of the workshops, places are limited, so please book your place early to avoid disappointment. For full details on these workshops and also for information about our online training courses, log on to the Promed website http://www.promed.ie/medicalfocus.html

12 LEAD ECG WORKSHOPS

DATES & LOCATIONS

MORNING SESSIONS

Dublin / Leinster

The Carlton Hotel, Old Airport Road, Cloghran, Dublin Airport
Thursday 5th February 2009 9.00a.m-12.30p.m.
The Stillorgan Park Hotel, Stillorgan Road, Dublin 18
Friday 6th February 2009 9.00a.m-12.30p.m.
The Sheraton Hotel, Glesson Street, Athlone, Co.Westmeath
Wednesday 20th May 2009 9.00a.m-12.30p.m.

Munster

Athenaeum House Hotel, Christendom, Waterford
Thursday 5th March 2009 9.00a.m-12.30p.m.
The Kingsley Hotel, Victoria Cross, Cork City
Friday 6th March 2009 9.00a.m-12.30p.m.
The Radisson SAS Hotel, Ennis Road, Limerick
Thursday 2nd April 2009 9.00a.m-12.30p.m.

Connaught

The G-Hotel, Wellpark, Galway City
Friday 3rd April 2009 9.00a.m-12.30p.m.
The Glasshouse, Swanpoint, Sligo
Tuesday 19th May 2009 9.00a.m-12.30p.m.

VENEPUNCTURE WORKSHOPS

DATES & LOCATIONS

AFTERNOON SESSIONS

Dublin / Leinster

The Carlton Hotel, Old Airport Road, Cloghran, Dublin Airport
Thursday 5th February 2009 1.30p.m-5.00p.m.
The Stillorgan Park Hotel, Stillorgan Road, Dublin 18
Friday 6th February 2009 1.30p.m-5.00p.m.
The Sheraton Hotel, Gleston Street, Athlone, Co.Westmeath
Wednesday 20th May 2009 1.30p.m-5.00p.m.

Munster

Athenaeum House Hotel, Christendom, Waterford
Thursday 5th March 2009 1.30p.m-5.00p.m.
The Kingsley Hotel, Victoria Cross, Cork City
Friday 6th March 2009 1.30p.m-5.00p.m.
The Radisson SAS Hotel, Ennis Road, Limerick
Thursday 2nd April 2009 1.30p.m-5.00p.m.

Connaught

The G-Hotel, Wellpark, Galway City
Friday 3rd April 2009 1.30p.m-5.00p.m.
The Glasshouse, Swanpoint, Sligo
Tuesday 19th May 2009 1.30p.m-5.00p.m.

The cost for attendance per workshop is €30.00 (which must be sent in with a completed registration form) and this will be refunded in Promed vouchers to attendees on the day.
discover

Time to discover the new univadis.
Finding medical information on the Internet is now easier!

univadis® is an internet portal which offers Irish Healthcare Professionals independent, up-to-date medical information and innovative learning tools.

univadis® is free to all Irish Healthcare Professionals and is offered as a service by Merck Sharp & Dohme Ireland (Human Health) Limited.

univadis.ie

> Register Online
Simply go to www.univadis.ie,
click ‘Register Now’ and follow the simple steps for free access
(You must have your An Bord Altranais PIN)

eCME
Independent, peer reviewed online medical education from BMJ Learning. Free access to up to 350 BMJ Learning courses, with a wide range of modules, covering 20 therapy areas - now available FREE to Irish Healthcare Professionals at univadis.ie

Medical News
Exclusive to univadis - peer reviewed news delivered to your inbox. Independent, credible, and personalised to your medical specialty.

BraunwaldPLUS
Choose from over 4000 free images to include in your PowerPoint™ presentations.

3D Anatomy
The world’s most detailed 3D model of human anatomy – graphic details, MRI, video and more.

First View
Exclusive to univadis – articles and commentary from over 100 key journals. Stay on top of the latest developments.

Search
Search leading medical resources (e.g. PubMed, BMJ Learning and Google™ simultaneously)

TRIP Database
Medical search engine with emphasis on evidence based medicine (EBM). Allowing users to easily and rapidly identify the highest quality evidence from a wide range of sources (including Cochrane and Bandolier).
Diabetes mellitus is a condition in which there is a chronically elevated blood glucose level. It is caused by either an absolute or relative lack of insulin (insulin not being produced by the beta cells in the pancreas or insufficient insulin production and or insufficient insulin action to meet the demands of the body). This chronic multi system disease results in an alteration in the metabolism of carbohydrates, fats and protein.  

Diagnosis

It is essential that the criteria be followed when making a diagnosis of diabetes mellitus. Such a diagnosis has significant implications, not only from a medical aspect, but also from a social perspective.

The onset of type 2 diabetes is subtle, and often diagnosis is only made when the person presents with a complication of the condition. While clinical suspicion may lead to the monitoring of capillary blood glucose levels for diagnosis of diabetes, venous blood glucose sampling is mandatory.

There are several ways to diagnose diabetes mellitus:

- In people with clinical symptoms of diabetes by random plasma glucose of equal or greater than 11.1mmols/L.
- In those with a fasting plasma glucose equal or greater than 7.0mmols/L on two occasions.
- In those with plasma glucose level equal or greater than 11.1mmols/L two hours after a 75gm load of glucose.  

During the natural history of all forms of diabetes, the condition progresses through a stage of altered glucose metabolism. While these conditions do not meet the criteria for diabetes, the levels are too high to be considered normal. Impaired glucose tolerance (IGT) by definition is present when the plasma blood glucose is greater or equal to 7.8mmols/L but less than 11.1mmols/L. Impaired fasting glucose (IFG) is based on a fasting plasma glucose concentration greater or equal to 5.6mmols/L but less than 7.0mmols/L.  

A diagnosis of IGT or IFG is often referred to as ‘pre-diabetes’. People with these conditions are at a high risk of developing diabetes and those with IGT have the potential for the cardiovascular risk factors associated with diabetes.

Glycaemic control

Glycaemic control, or diabetes control, represents the extent to which metabolism in the person with diabetes differs from that in the person without diabetes.

Glycaemic control tends to focus on blood glucose concentrations; both short and long term. Short term measurements are generally assessed by the person with diabetes with the use of home blood glucose monitoring while the long term are hospital laboratory values. The most frequently used for this purpose is the glycosylated haemoglobin (HbA1c) level. This long-term measurement gives an average of the glucose concentration over the previous 6-8 weeks and is expressed as a percentage.

The HbA1c measurement is used when exploring the relationship of the development or progression of the complications of diabetes and the management strategies used to treat the condition. The landmark studies, which guide diabetes management, used this value as an indicator...
for diabetes control and the development of complications associated with diabetes mellitus. Generally people with type 1 diabetes are encouraged to aim for a HbA1c level of less than 7%. For those with type 2 the level should be less than 6.5%.

**Patient education**

Education about self-management of this chronic condition is the foundation of diabetes care. The aim of diabetes education is to assist people living with this condition and their families to understand the disease and its treatment, to co-operate with healthcare providers, to live healthily and to maintain or improve their quality of life. In order to facilitate this, the healthcare providers must take into account how the person will adapt to their illness, what their beliefs are about the illness while incorporating their subjective and objective needs.

Health education involves more than just providing information. The goal of diabetes education is to help those with diabetes to live well. This can ultimately be achieved by assisting those with the condition to integrate their diabetes care into their lifestyles and if necessary to adapt their lifestyle to incorporate healthy living and adherence to treatment recommendations. Knowledge is central to any decision making process, therefore patient education is imperative if people with diabetes are to become active participants in the management of their diabetes.

**Complications**

The ultimate aim of diabetes care is to prevent or delay the onset or progression of the complications of the condition. The complications of diabetes can be broadly described as either acute or chronic. The acute complications are hypoglycaemia, or hyperglycaemia-diabetic ketoacidosis (DKA) and hyperosmolar non-ketotic acidosis (HONK).

**Hypoglycaemia**

For people requiring insulin and sulphonylureas, hypoglycaemia is a significant limitation in the management of their diabetes. Hypoglycaemia is the most common acute complication of diabetes, with its onset usually being rapid and the symptoms ranging from very mild to severe enough to cause brain damage or death.

It is recommended to test and record the blood glucose level when hypoglycaemia is suspected. A blood glucose reading of less than 4.0mmols/l is considered a hypoglycaemia event and should be treated accordingly. While there is no grading system for hypoglycaemia it is generally categorised as mild, moderate or severe.

Mild hypoglycaemia is one that is easily treated by the individual by the intake of some refined carbohydrate. Moderate hypoglycaemia is when the intervention of someone else is necessary to give the carbohydrate food or drink, as the person with diabetes may display some cognitive impairment. A severe hypoglycaemia means that the individual has altered consciousness or may be unconscious and requires assistance with treating the episode.

The onset of type 2 diabetes is subtle and often diagnosis is made when the person presents with a complication of the condition.

**Hyperglycaemia**

Diabetic ketoacidosis (DKA)

DKA is associated with people with type 1 diabetes. It is defined as the triad of hyperglycaemia, acidosis and ketosis. The primary cause of this is insulin deficiency.

Hyperosmolar non-ketotic acidosis (HONK)

This metabolic disturbance is associated with type 2 diabetes. It is characterised by an increase in serum osmolality, extreme hyperglycaemia and dehydration and the absence of ketones. It is caused by inadequate insulin levels.

The aims of treatment for these hyperglycaemic states are to initially correct:
For patients monitoring blood glucose who need the extra reassurance that checking blood ketones provides.

- Fast 3-second blood glucose testing, with tiny sample size (0.3µL)
- Large backlit display
- Large memory with averaging
- Allows early detection of rising blood ketone levels

To find out more and reserve your demonstration meter call 1800 776633

www.abbottdiabetescare.ie
The management of these conditions will require admission to hospital, therefore they should be advised to attend their local emergency department.10

**Chronic complications**

Chronic complications can be described as either microvascular or macrovascular. These are associated with hyperglycaemia and the long-term damage, dysfunction and failure of various organs particularly the eyes, kidneys, nerves, heart and blood vessels that can result. The development and progression of these chronic complications of diabetes are associated with the level of glycaemic control and the duration of diabetes.

**Microvascular**

The main sequelae of microvascular disease are diabetic retinopathy, diabetic nephropathy and peripheral neuropathy as the retina, renal glomerulus and peripheral nervous system are primarily affected. The major influential factors for the development of these complications are the duration of diabetes and glycaemic control in conjunction with the blood pressure control. There is such a close relationship between the complications that in the presence of nephropathy, retinopathy should be suspected.

**Macrovascular**

Macrovascular disease is an extensive and progressive condition that is both aggravated by the presence of diabetes and is a complication of it. It encompasses coronary heart disease, peripheral vascular disease and cerebrovascular disease and is the leading cause of mortality and serious morbidity in people with diabetes. In an attempt to address this condition it is necessary to focus on the cardiovascular risk factors namely hypertension, dyslipidaemia, central obesity, and cigarette smoking.

**Treatment of diabetes**

The treatment of diabetes reflects the condition itself and can often lead to intricate management regimens. These include not only oral anti-diabetic agents or insulin but also there is often a need for anti-hypertensive agents, lipid lowering agents and aspirin therapy in an attempt to meet with the internationally recommended targets.6,11

The majority of people with type 2 diabetes are unable to achieve or sustain near normal blood sugar levels without oral antidiabetic agents.11 More frequently people with type 2 diabetes require insulin in an effort to maintain optimal long-term glycaemic control.12 Insulin therapy can be used for people with type 2 diabetes either as a monotherapy or in conjunction with the various classes of oral antidiabetic medications. Traditionally when considering oral antidiabetic medications the classes of agents were, insulin sensitisers and alpha-glucosidase inhibitors.

Two additional therapies have been licensed for use for people with type 2 diabetes in the last number of years. The therapeutic action of these new agents is based on the enhancement of gastrointestinal hormone action. These treatments are associated with slowing of gastric emptying, stimulation of insulin and inhibition of glucagon secretion, improved control of postprandial hyperglycaemia and control of body weight.13 These new agents are the incretin mimetics (Exenatide) administered by subcutaneous injection and dipeptidyl peptidase IV (DPP-IV) inhibitors (Sitagliptin) an oral agent.

With so many available treatment options the management of type 2 diabetes can on occasions be as complex as the condition itself.”
References


FRAMEWORK FOR REFLECTION ON LEARNING
ARTICLE: Diabetes mellitus – diagnosis and management
REFERENCE: Author: Rita Forde, ANP, Nursing in General Practice, Issue 1 Volume 2 2009

What have I learned from this article?

To what extent were the intended learning outcomes met?

What do I know now, that I did not before this?

What can I do now, that I could not do before this?

What can I apply immediately to my practice or client/patient care?

Do I have any further questions that were not answered here?

Is there anything that I did not understand, need to explore, or read about further to clarify my understanding?

What else do I need to do/know, to extend my professional development in this particular area?

What other needs have I identified in relation to my professional development in general?

How might I achieve the above needs?
(convert these to short/medium/long-term goals and draw up an action plan)

Action Plan to achieve further educational needs:

Target date:

Date:
Janumet 50mg/100mg and Janumet 50mg/200mg film-coated tablets (50 mg of sitagliptin as phospho-nitrobenzoyl sitagliptin hydrochloride and 100 mg or 200 mg of metformin hydrochloride). 

ABRIDGED PRODUCT INFORMATION
Refer to Summary of Product Characteristics before prescribing.

Presentation: Janumet 50mg/100mg film-coated tablets. Capsule-shaped, pink film-coated tablet with “515” debossed on one side containing 50 mg of sitagliptin as phospho-nitrobenzoyl sitagliptin hydrochloride and 100 mg of metformin hydrochloride. Janumet 50mg/200mg film-coated tablets. Capsule-shaped, red film-coated tablet with “377” debossed on one side containing 50 mg of sitagliptin as phospho-nitrobenzoyl hydrochloride and 200 mg of metformin hydrochloride. USES: For patients with type 2 diabetes mellitus: Janumet is indicated as an adjunct to diet and exercise to improve glycemic control in patients inadequately controlled on their maximal tolerated dose of metformin alone or those already being treated with the combination of sitagliptin and metformin. Janumet is also indicated in combination with a sulphonylurea (i.e., triple combination therapy) as an adjunct to diet and exercise in patients inadequately controlled on their maximal tolerated dose of metformin and a sulphonylurea. DOSEAGE AND ADMINISTRATION The dose of antihyperglycaemic therapy with Janumet should be individualised on the basis of the patient’s current regimen, effectiveness, and tolerability while not exceeding the maximum recommended daily dose of 100 mg sitagliptin. For patients not adequately controlled on metformin alone, the usual starting dose of Janumet should provide sitagliptin dosed as 50 mg twice daily (100 mg total daily dose) plus the dose of metformin already being taken. For patients switching from co-administration of sitagliptin and metformin, Janumet should be initiated at the dose of sitagliptin and metformin already being taken. For patients inadequately controlled on dual combination therapy with the maximal tolerated dose of metformin and a sulphonylurea, the dose of Janumet should provide sitagliptin dosed as 50 mg twice daily (100 mg total daily dose) and a dose of metformin similar to the dose already being taken. When Janumet is used in combination with a sulphonylurea, a lower dose of the sulphonylurea may be required to reduce the risk of hypoglycaemia. All patients should continue their diet with an adequate distribution of carbohydrate intake during the day. Overweight patients should continue their energy-restricted diet. Janumet should be given twice daily with meals to reduce the gastrointestinal undesirable effects associated with metformin. Use in renal insufficiency: Janumet should not be used in patients with moderate or severe renal impairment (creatinine clearance < 60 ml/min). Use in hepatic insufficiency: Janumet should not be used in patients with hepatic impairment. In elderly, Janumet should be used with caution as age increases. Monitoring of renal function is necessary to aid in prevention of metformin-associated lactic acidosis. Limited safety data on sitagliptin is available in patients > 75 years of age and care should be exercised.

Use in children: Co-administration of OAT3 inhibitors has not been evaluated clinically. The intravascular administration of iodinated contrast agents in radiological studies may lead to renal failure, resulting in metformin accumulation and a risk of lactic acidosis. There-is therefore, close monitoring of plasma sitagliptin levels is necessary. If either form occurs, Janumet should be stopped immediately and other appropriate corrective measures instituted. Drug interactions: Co-administration of multiple doses of sitagliptin (50 mg twice daily) and metformin (1,000 mg twice daily) did not meaningfully alter the pharmacokinetics of either sitagliptin or metformin in patients with severe renal insufficiency or ESRD. The effects of potent CYP3A4 inhibitors in the setting of severe renal insufficiency or ESRD. For this reason, it is possible that potent inhibitors co-administered. The intravascular administration of iodinated contrast agents in radiological studies may lead to renal failure, resulting in metformin accumulation and a risk of lactic acidosis. Therefore, close monitoring of plasma sitagliptin levels is necessary. If either form occurs, Janumet should be stopped immediately and other appropriate corrective measures instituted. Drug interactions: Co-administration of multiple doses of sitagliptin (50 mg twice daily) and metformin (1,000 mg twice daily) did not meaningfully alter the pharmacokinetics of either sitagliptin or metformin in patients with type 2 diabetes. There is increased risk of lactic acidosis in acute alcohol intoxication (particularly in the cases of fasting, malnutrition or hepatic insufficiency) due to the metformin active substance of Janumet. Consumption of alcohol and medicinal products containing alcohol should be avoided. Cationic agents that are eliminated by renal tubular secretion (e.g., cimetidine) may interact with metformin by competing for common renal tubular transport systems. Therefore, close monitoring of plasma sitagliptin levels is necessary. If either form occurs, Janumet should be stopped immediately and other appropriate corrective measures instituted. Drug interactions: Co-administration of multiple doses of sitagliptin (50 mg twice daily) and metformin (1,000 mg twice daily) did not meaningfully alter the pharmacokinetics of either sitagliptin or metformin in patients with type 2 diabetes. There is increased risk of lactic acidosis in acute alcohol intoxication (particularly in the cases of fasting, malnutrition or hepatic insufficiency) due to the metformin active substance of Janumet. Consumption of alcohol and medicinal products containing alcohol should be avoided. Cationic agents that are eliminated by renal tubular secretion (e.g., cimetidine) may interact with metformin by competing for common renal tubular transport systems.

Introducing New JANUMET® for powerful glucose reductions
For patients not at goal on metformin alone

In clinical studies of patients with type 2 diabetes,

Powerful and sustained HbA1c reductions over year1,2

Weight loss and less hypoglycemia vs an SU* + metformin (with sitagliptin 100 mg + metformin)3

3-D Control: comprehensive mechanism of action targets 3 key defects of type 2 diabetes1

Janumet 50mg/100mg and Janumet 50mg/200mg film-coated tablets (50 mg of sitagliptin as phospho-nitrobenzoyl sitagliptin hydrochloride, 100 mg or 200 mg of metformin hydrochloride).

REFERENCES
Merck Sharp & Dohme Limited 2008. All rights reserved.


2. New-09-09-JMT-2008-IRL-2072-J
considered to be clinically meaningful. The renal clearance of sitagliptin was not meaningfully altered. Therefore, meaningful interactions would not be expected with other p-glycoprotein inhibitors. In vitro studies indicated that the primary enzyme responsible for the limited metabolism of sitagliptin is CYP3A4, with contribution from CYP2C9. In patients with normal renal function, metabolism, including CYP3A4 plays only a small role in the clearance of sitagliptin. Metabolism may play a more significant role in the elimination of sitagliptin in the setting of severe renal insufficiency or ESFR. For this reason, it is possible that potent CYP3A4 inhibitors (e.g., ketoconazole, itraconazole, ritonavir, clarithromycin) could alter the pharmacokinetics of sitagliptin in patients with severe renal insufficiency or ESFR. The effects of potent CYP3A4 inhibitors in the setting of renal insufficiency has not been assessed in a clinical study. In vitro transport studies showed that sitagliptin is a substrate for a P-glycoprotein and OAT1 (OAT mediated transport of sitagliptin was inhibited in vitro by probenecid, although the risk of clinically meaningful interactions is considered to be low. Concomi-
tant administration of OAT3 inhibitors has not been evaluated in vivo. Effects of sitagliptin on other medicinal products. In vitro data suggest that sitagliptin does not inhibit or induce CYP450 isoenzymes. In clinical stud-
ies, sitagliptin did not meaningfully alter the pharmacokinetics of metformin, glyburide, simvastatin, rosigita-
zeone, warfarin, or oral contraceptives, providing in vivo evidence of a low propensity for causing interactions with substrates of CYP3A4, CYP2C9, CYP2D6, and organic anion transporter (OAT1). Sitagliptin had a small effect on plasma diazepam concentrations, and may be a mild inhibitor of p-glycoprotein in vivo. Diazepam: Sita-
ligptin had a small effect on plasma diazepam concentrations. Following administration of 0.35 mg diazepam con-
comitantly with 100 mg of sitagliptin daily for 10 days, the plasma AUC of diazepam was increased on average by 11 %, and the plasma Cmax on average by 18 %, but no dose adjustment of diazepam is recommended. However, patients at risk of diazepam toxicity should be monitored for this when sitagliptin and diazepam are administered concomitantly. Use in pregnancy and lactation: Janumet should not be used during pregnancy or breast-
feeding. Effects on ability to drive and use machines: No studies on the effects on the ability to drive and use machines have been performed. However, when driving or operating machines, it should be taken into ac-
count that dizziness and somnolence have been reported. Patients should be alerted to the risk of hypogly-
ccaemia when Janumet is used in combination with other sulphonylurea agents. SIDE EFFECTS: There have been no therapeutic clinical trials conducted with Janumet tablets however bioequivalence of Janumet with co-administered sitagliptin and metformin has been demonstrated. Sitagliptin and Metformin Adverse reac-
tions considered as drug related reported in excess (> 1.2 %, and difference > 1 patients of placebo and in patients receiving sitagliptin in combination with metformin in double-blind studies are listed below. Frequen-
cies are defined as 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 (≥ 1/100,000, ≥ 10/100,000). Sitagliptin with Metformin: In a placebo-controlled 24-week study of sitagliptin 100 mg once daily added to ongoing metformin, the incidence of adverse reactions con-
sidered as drug related in patients treated with sitagliptin added to ongoing metformin compared to treat-
ment with placebo added to ongoing metformin was 8.3 % and 10.1 %, respectively. Investigations Uncom-
mon: blood glucose decreased. Nervous system disorders: Uncommon: somnolence. Gastrointestinal disorders: Common: nausea, uncommon: upper abdominal pain, diarrhoea. In 1 year study of sitagliptin 100 mg once daily added to ongoing metformin, the incidence of adverse reactions considered as drug related in patients treated with sitagliptin added to ongoing metformin compared to placebo added to ongoing metformin was 14.5 % and 33.3 %, respectively. In pooled studies of up to 1 year in duration comparing sita-
ligptin added to ongoing metformin to a sulphonylurea agent added to ongoing metformin, adverse reactions considered as drug related reported in patients treated with sitagliptin 100 mg in excess ≥ 1.2 % and difference > 1 patient of that in patients receiving the sulphonylurea agent are as follows: Metabolism and nutrition disorders uncommon: anorexia. Investigations uncommon: weight decreased. Sitagliptin with Metformin and a dipeptidyl peptidase-4 inhibitor: in a 24-week, placebo-controlled study of sitagliptin 100 mg once daily added to ongoing combination treatment with glimepiride and metformin, the overall incidence of adverse reactions considered as drug related in patients treated with the addition of sitagliptin to the ongoing treatment with glimepiride and metformin was 18.1 % compared to treatment with the addition of placebo to the ongoing treatment with glimepiride and metformin which was 7.1 %. Gastrointestinal disorders: Common: constipation. Metabolism and nutrition disorders: Very common: hypoglycaemia. In a 24-week study of initial combination therapy with sitagliptin and metformin administered twice daily (sitagliptin/metformin 50 mg/500 mg or 100 mg/1000 mg), the overall incidence of adverse reactions considered as drug-related in patients treated with the combination of sitagliptin and metformin compared to patients treated with placebo was 14.0 % and 9.3 %, respectively. The overall incidence of adverse reactions considered as drug related in patients treated with the combination of sitagliptin and metformin was comparable to metformin alone (14.0 %) each and greater than sitagliptin alone (8.7 %), with the differences relative to sitagliptin alone primarily due to gastrointestinal adverse reactions. No clinically meaningful information on the individual active substances of the fixed dose combination. Sitagliptin in addition, in monotherapy studies of up to 24 weeks in duration of sitagliptin 50 mg once daily alone compared to placebo, adverse reactions considered as drug-related reported in patients treated with sitagliptin in excess ≥ 0.2 % and difference > 1 patient of that in patients receiving placebo are headache, hypoglycaemia, constipation, and dizziness. In addition to the drug related adverse reactions described above, adverse events (reported regardless of causal relationship to medicinal product) occurring in at least 1 % and more commonly in patients treated with sitagliptin included upper respiratory tract infection and nasopharyngitis. Additional adverse events that occurred more frequently in patients treated with sitagliptin not reaching the 0.5 % level, but occurring with an incidence of ≥ 0.5 % higher with sitagliptin than that in the control group included osteoarthritis and pain in extremity. Across clinical studies, a small increase in white blood cell (WBC) count was observed to occur in at least 1 % of patients. This obser-
vation was seen in most, but not all studies. This change in laboratory parameters is not considered to be clinically relevant. No clinically meaningful changes in vital signs or in ECG (including in QTc interval) were observed with sitagliptin treatment. Post-marketing data: Sitagliptin during post-marketing experience of Janumet or sitagliptin, one of the active substances of Janumet, the following additional adverse reactions have been reported (frequency not known): hypersensitivity reactions including anaphylaxis, angioedema, rash, urticaria, and exfoliative skin conditions including Stevens-Johnson syndrome. Metformin: Nervous system disorders: Common: metabolic. Gastrointestinal disorders: Very common: gastrointestinal symp-
toms. Skin and subcutaneous disorders: Very rare: urticaria, erythema, pruritus. Metabolism and nutrition disorders: Very rare: lactic acidosis, vitamin B12 deficiency, neuropathy disorders: Very rare: liver function disorders, hepatitis. PACKAGE QUANTITIES: Janumet 50mg/850mg and 50mg/1000mg film-coated tablets, 56 tablets. PVC/Alu blister packs. Pharmaceutical workers: SCIENCE MEDICINES FROM MSD. 06.09 JMT-2009-IRL-2355-J. Marketing Au-
The escalating demand for cardiology services in Ireland over the past ten years, together with the availability of later generation diagnostic modalities during the same period has resulted in a fragmented cardiology service model which is incapable of meeting the needs of today’s clinicians and healthcare management.

The inherent impediments to the efficient management of that traditional cardiology service have long since been acknowledged including the primary lack of automation and co-ordination between the many facets of that service, which resulted in reduced efficiency, traceability and the lack of any coherent monitoring/management mechanism. In an effort to address these deficiencies, a complete review of cardiology services in the south-east was undertaken in 2000.

Objective
The objective was to review the existing fragmented system and then design, develop and implement an alternative computerised system that would interface with, and optimally manage all aspects of cardiac procedures, including the associated patient data and cardiology images.

This new system would include a central comprehensive repository of all data associated with cardiac patients and to that end, the system would need to directly interface with all relevant medical diagnostic equipment (clinical images and data) and other hospital systems, (patient demographics, etc). Optimum efficiency, security, standardisation and expandability had to be inherent features of the system.

System design
Extensive input from all stakeholders was sought during the design of the system. This capitalised on vital expertise including: clinicians, technicians, IT, hospital management, external software providers, etc.

Both current and future needs of the system were identified to ensure the design of the system could facilitate later development and expansion without necessitating later core changes to the system. Functionality, automation, expandability, upgradeability, security and ease of use were the primary considerations at this design stage.

Implementation
Based on our agreed system specification, a suitable external software package provider was identified. This was a result of an assessment of all known systems currently available. Emphasis was placed on the particular system that would necessitate minimum manipulation and customisation to realise our agreed objective. Cost-effectiveness and the guarantee of future technical support from a system provider were also part of that selection criteria.

Following that exercise, the TOMCAT (Note*) was chosen as the backbone of our system. Significant customising of that TOMCAT system was then undertaken including extensive interaction/work with the TOMCAT provider. This also included putting in place hardware/software interfaces throughout the design stage, emphasis was towards an automated collection of data/images and a consolidated sharing of all cardiology patient data across the full south eastern geographic area, thus ensuring local standardisation, whilst preserving the later potential of this system ultimately constituting a national standard.

The new cardiology system would also need to import data directly from clinical equipment and other existing hospital systems including hospital laboratory and patient administration systems. After several iterations, the core functionality of the system was identified and standardised templates, data tables were agreed which then formed the system specification.
with all cardiology diagnostic equipment and existing (patient administration system) from which results, images and patient data would need to be extracted to feed the new cardiology patient data management system. A prototype system was then developed and initially installed in Waterford Regional Hospital. User training was carried out by TOMCAT to allow the prototype system to be evaluated and thus facilitate constructive feedback. After several iterations, the performance of the system was deemed satisfactory to warrant full implementation at that hospital. Further and more comprehensive user-training was then provided to ensure the smooth changeover from our previous manual systems to the fully computerised cardiology image and data management system. On-going communication was maintained with all vested clinicians, technicians and hospital managers at all other hospital sites in the south-east throughout this time and the importance of that communication can not be over emphasised.

Following the initial implementation, the system at Waterford Regional Hospital was then incrementally expanded to cater for additional medical equipment modalities at that hospital. After this had proved satisfactory, a structured roll-out of the system was then undertaken to all other acute hospitals in the south eastern area. This involved significant co-ordination between the various hospital sites and the provision of further comprehensive user-training and support.

A review of the current performance of the system in Waterford Regional Hospital, Wexford General Hospital, St. Luke’s Hospital Kilkenny and South Tipperary General Hospital would testify to a very high level of satisfaction from consultants, technicians and hospital management.

Note*: The TOMCAT system was provided, installed and supported by TOMCAT Clinical Systems Belfast Ltd and the performance of both this product and the associated supplier to date has proven most satisfactory.

“The system provides instant access to complete patient cardiac history from anywhere in the region.”
On-going support and development

Whilst fully acknowledging the importance of the design and implementation stages of this system, it was nonetheless acknowledged from the outset of this project that the subsequent accrued benefits from this or any such system are a direct function of the user-training and the on-going support provided. To that end, significant resources and time were invested to cater for:

- On-going system development and software upgrades
- Development of new diagnostic modalities and features
- On-going user training and support
- Extending and configuring further management/clinical audit reports
- Liaising with other third parties who have an interest in cardiology patient data (CVD, national data sets, etc)
- Image transfer and laboratory results (work in progress)
- Further expansion of the system at a national level to realise a fully standardised system across the country, sharing common data/image databases. (The benefits of such a system from a healthcare management and patient care perspective cannot be over-emphasised.)

Benefits to the organisation

The result of this project is a fully integrated and standardised cardiology management system which combines all aspects of cardiac patient care into a single efficient and user-friendly system capable of optimally monitoring and managing all aspects of that cardiology service.

The core benefits include:
Consolidates all current and historical cardiology patient data (measurements, images, patient demographics etc) into one efficient single data repository.
- Ensures optimum operational efficiency and use of resources.
- Ensures optimum data security and traceability.
- Standardisation of patient data/images and up to date and remote online access to all such data for all clinicians.
- Workflow management.
- Patient appointments scheduling.
- Patient referral path management.
- Links to modules including continuing care applications etc.
- Activity and statistical/clinical reports.
- Provides an invaluable management tool to affect the optimum monitoring and management of the cardiology service, including comprehensive report generator facilities.
- Readily upgradeable and expandable to other hospitals.
- System design will readily allow expansion of the system to other cardiology services outside the immediate south east geographic area.

Key points for future development of any similar system

Establish a small core working project group with key players that are responsible for the overall realisation of the project objectives.

- Fully capitalise on the range of expertise currently available from clinicians, IT, healthcare management, external system providers, equipment manufacturers etc.
- Select the optimally suitable external software provider.
- Ensure full and open bidirectional communication with all stakeholders throughout all stages of the project. This in turn serves significant benefits in the later change-process from the old to the new system.
- Include inherent future expansion and upgradeability in the agreed system specifications.
- Include a nominated technical IT resource
- Establish an on-going programme of continuous improvement to the system to ensure the system continues to realise its anticipated objectives in a changing healthcare environment.

Report Manager

- Every database field can be reported on
- Reports are designed using Query Wizard
- Filters used to create variations on a theme
- Reports based on board-wide data
- Enables Standard & ad-hoc reporting
- Management Aid

Query Wizard

Waiting List Analysis

Procedure by consultant
Interactions: mild-to-moderate hepatic impairment, renal impairment, diabetes mellitus, hypertension, type 2 diabetes; angiotensin II receptor antagonists, NSAIDs, heparin, immunosuppressors, trimethoprim/sulfamethoxazole; lithium; NSAIDs, thiazide or loop diuretics, other antihypertensive agents, baclofen, hydralazine, diuretics, lithium, extended trauma.

Side effects: common (incidence >1%): headache, dizziness, back pain, chest pain, abdominal pain, insomnia, depression, chest congestion, cough, hyperhidrosis, diarrhoea, rhinitis, upper respiratory tract infections, influenza, rash.

Contra-indications: hypersensitivity to any of the ingredients, pregnancy and lactation, primary aldosteronism, obstructive hypertrophic cardiomyopathy or subacute bacterial endocarditis, severe hepatic impairment, severe renal impairment, liver failure, haemodialysis, recommended starting dose is 20mg in these patients.

Dose: adults: once daily of 40/12.5 mg or 80/25 mg or 80/12.5 mg respectively.

Asthma — symptoms, diagnosis and classification

RUTH TAYLOR, ADVANCED NURSE PRACTITIONER (PRIMARY CARE)

This article aims to explore the symptoms, diagnosis and classification of asthma based on the 2006 Global Strategy for Asthma Management and Prevention (GINA, 2006).

**Symptoms**
There are four symptoms which may prompt the diagnosis of asthma – wheezing, cough, shortness of breath and chest tightness. The occurrence of symptoms after exposure to an allergen, seasonal variability of symptoms and a positive family history of asthma are helpful aids when considering the diagnosis of asthma. There are a number of variances in asthma such as cough variant asthma and exercise induced asthma. These will be discussed in further detail later in this article.

**Diagnosis**
- The diagnosis of asthma is underpinned by:
  - good history taking
  - physical examination
  - tests for diagnosis

**History taking**
Figure 1 describes useful questions which should be considered when establishing the diagnosis of asthma. Family history, current medications, and the pattern of symptoms in relation to trigger factors should all be considered.

**Figure 1 : Questions to consider in the diagnosis of asthma**
- Has the patient had an attack or recurrent attack of wheezing?
- Does the patient have a troublesome cough at night?
- Does the patient wheeze or cough after exercise?
- Does the patient experience wheezing, chest tightness or cough after exposure to airborne allergens or pollutants?
- Do the patient’s colds “go to the chest” or take more than 10 days to clear up?
- Are symptoms improved by appropriate asthma treatment?

Cough variant asthma where patients have cough as their principal, if not only, symptom is particularly common in children and is more problematic at night with normal evaluations during the day. Assessment of variability in lung function or of airway hyperresponsiveness is required for these patients.

Exercise induced bronchoconstriction is an important cause for many people with asthma and for some it is the only cause. In this incidence, bronchoconstriction occurs 5 – 10 minutes after exercise (rarely during exercise) resulting in asthma symptoms which resolve spontaneously within 30 – 45 minutes. Exercise induced asthma may occur in any climate but is more common when the patient inhales dry, cold air. A rapid improvement of symptoms after inhaled beta 2 agonist or...
prevention by pre-treatment of an inhaled beta 2 agonist pre-exercise supports a diagnosis of asthma. Some children with asthma present only with exercise-induced symptoms. If in doubt about the diagnosis, an 8 minute running protocol may be performed to establish the diagnosis of asthma.

**Physical examination**
Physical examination of the respiratory system may be normal due to the variability of asthma symptoms. Wheezing may be heard on auscultation of the lungs which confirms the presence of airflow limitation. However, even in the presence of airflow limitation, wheezing may be absent or only present when the patient exhales forcibly. In severe asthma, wheezing may be absent owing to severely reduced airflow and ventilation. Other symptoms will be present such as cyanosis, drowsiness, difficulty speaking, tachycardia, hyperinflated chest, use of accessory muscles and intercostals recession.

**Tests for diagnosis**
Tests used in the diagnosis of asthma include measurement of lung function, measurement of airway responsiveness, non-invasive markers of airway inflammation and measurement of allergic status.

**Lung function**
Measurement of lung function is a useful tool to enhance the diagnosis of asthma. Frequently, the diagnosis of asthma is based on characteristic symptoms but measuring lung function can provide the clinician and the patient with more information such as reversibility and variability. Lung function can be measured in patients over the age of 5 and the two methods which are widely used are spirometry and peak expiratory flow rate (PEFR) measurement. In spirometry the measurement of forced expiratory volume in 1 second (FEV1) and of forced vital capacity (FVC) are the tools which are of most beneficial.

Reversibility and variability occur when changes in symptoms are accompanied by airflow limitation that occur spontaneously or in response to treatment. Reversibility is a rapid improvement in FEV1 or PEFR within minutes of inhaling a rapid acting bronchodilator (e.g. salbutamol or terbutaline). Variability refers to the improvement or the deterioration of symptoms and lung function over a period of time. Variability may occur over one day (diurnal variation) or it may be seasonal or monthly.

**Airway responsiveness**
Measurement of airway responsiveness reflects the sensitivity of the airways to factors which can cause asthma. It is useful to carry out this assessment in patients who have symptoms consistent with asthma but have normal lung function measurements. Measurements of airway responsiveness to metacholine, histamine, mannitol or exercise challenge may assist in the diagnosis of asthma. However, these tests are sensitive for a diagnosis of asthma but have limited specificity. This means that a positive test does not always mean that the patient has asthma as patients with allergic rhinitis, cystic fibrosis, bronchiectasis and COPD may also demonstrate airway hyper-responsiveness.

**Non-invasive markers of airway inflammation**
Non-invasive markers of airway inflammation may be evaluated by examining spontaneously produced or hypertonic saline-induced sputum for eosinophilic or neutrophilic inflammation. In addition, levels of inhaled nitric oxide and carbon monoxide have been suggested as non-invasive markers of airway inflammation. Levels of nitric oxide are elevated in people with asthma who are not taking inhaled glucocorticosteroids compared to people who do not have asthma.

**Allergic status**
Measurement of allergic status assists in identifying the risk factors that cause asthma symptoms in individuals. There is a strong association between asthma and allergic rhinitis. The presence of allergies, allergic diseases and allergic rhinitis increases the probability of a diagnosis of asthma in patients with respiratory symptoms. Skin tests with allergens represent the primary diagnostic tool in determining allergic status. The main limitations of methods used to assess allergic status is that a positive test does not necessarily mean that the disease is allergic in nature as some people have specific IgE antibodies without any symptoms.

**Differential diagnosis**
The differential diagnosis in patients with suspected asthma differs among different age groups — infants, children, young adults and the elderly. These are illustrated in Figure 2.

![Figure 2: Differential diagnosis for asthma](image)

<table>
<thead>
<tr>
<th>Age group</th>
<th>Differential diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants and children under the age of 5</td>
<td>Prematurity, parental smoking, acute viral respiratory infections, chronic rhino-sinusitis, gastroesophageal reflux, cystic fibrosis, bronchopulmonary dysplasia, TB, congenital malformation, foreign body aspiration, primary biliary dyskinesia, immune deficiency, congenital heart disease</td>
</tr>
<tr>
<td>Older children and adults</td>
<td>Hyperventilation syndrome and panic attacks, inhaled foreign bodies, vocal cord dysfunction, obstructive lung disease, non-obstructive forms of lung disease, non-respiratory causes of symptoms such as left ventricular failure</td>
</tr>
<tr>
<td>Elderly</td>
<td>Left ventricular failure, COPD</td>
</tr>
</tbody>
</table>

**Classification**
Many attempts have been made to classify asthma in terms of etiology and asthma severity. In relation to etiology, the usefulness of this classification is debatable as in some patients no environmental cause can be found. However, it is important to environmental trigger factors so that the patient can be educated in avoiding such trigger factors.

Previously, asthma severity was classified based on level of symptoms, airflow limitation and lung function variability into four categories — intermittent, mild persistent, moderate persistent or severe persistent. Whilst this classification is useful for patients prior to commencing treatment, its value for patients who are on treatment is debatable. As a result, GINA (2006) now recommend that the classification of asthma is determined by level of control and that assessment of asthma control should be carried out periodically. Figure 3 illustrates this classification.
Asthma is a complex condition which is highly prevalent in our society. It requires accurate and timely diagnosis to ensure patients receive optimal management and educational programmes to assist them in the management of their condition. This article has addressed the symptoms, clinical diagnosis, differential diagnosis and classification of asthma. Some of these topics will be explored and developed further in future articles.

Figure 3: Classification of asthma based on level of control

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Controlled (All of the following)</th>
<th>Partly controlled (Any measure present in any week)</th>
<th>Uncontrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daytime symptoms</td>
<td>None (twice or less/week)</td>
<td>More than twice/week</td>
<td>Three or more features of partly controlled asthma present in any week</td>
</tr>
<tr>
<td>Limitation of activities</td>
<td>None</td>
<td>Any</td>
<td></td>
</tr>
<tr>
<td>Nocturnal symptoms/awakening</td>
<td>None</td>
<td>Any</td>
<td></td>
</tr>
<tr>
<td>Need for reliever/rescue treatment</td>
<td>None (twice or less/week)</td>
<td>More than twice/week</td>
<td></td>
</tr>
<tr>
<td>Lung function (PEF or FEV**)</td>
<td>Normal</td>
<td>&lt;80% predicted or personal best (if known)</td>
<td></td>
</tr>
<tr>
<td>Exacerbations</td>
<td>None</td>
<td>One or more per year *</td>
<td>One in any week***</td>
</tr>
</tbody>
</table>

* Any exacerbation should prompt review of maintenance treatment to ensure that it is adequate
** Lung function is not a reliable test for children 5 years and younger
*** By definition, an exacerbation in any week makes that an uncontrolled asthma week

Conclusion
Asthma is a complex condition which is highly prevalent in our society. It requires accurate and timely diagnosis to ensure patients receive optimal management and educational programmes to assist them in the management of their condition. This article has addressed the symptoms, clinical diagnosis, differential diagnosis and classification of asthma. Some of these topics will be explored and developed further in future articles.

Further information is available on www.ginasthma.org

References
Global Initiative for Asthma, 2006, Global Strategy for Asthma Management and Prevention, GINA.

Ruth Taylor, Advanced Nurse Practitioner (Primary Care)
Symbicort Maintenance And Reliever Therapy

Simplifying Asthma Management

Corticosteroid and long acting beta₂ agonist.

Uses: Asthma: Each inhalation containing metered doses equivalent to 200mcg budesonide Turbohaler and 6mcg formoterol Turbohaler.

Turbohaler: Each inhalation containing metered doses equivalent to 100mcg budesonide Turbohaler and 6mcg formoterol Turbohaler.

Inhalation Powder (budesonide/formoterol) Presentations: Prescribing) Symbicort® 100/6 Turbohaler® , Inhalation Powder Symbicort® 200/6 Turbohaler® ,

PRESCRIBING INFORMATION (Refer to Full Summary of Product Characteristics before administration).

Dosage and Administration: Asthma (Symbicort maintenance therapy – regular maintenance treatment with a separate rescue medication): 1-2 inhalations twice daily. Not intended for the initial management of asthma. Dose should be individualised. If an individual patient requires dosages outside recommended regimen, appropriate doses of beta₂-agonist and/or corticosteroid should be prescribed. When symptoms are controlled, titrate to the lowest effective dose, which could include a once daily dosage.

Children under 6: Not recommended. Asthma (Symbicort maintenance and reliever therapy – regular maintenance treatment and as needed in response to symptoms): should especially be considered for children with inadequate asthma control and in frequent need of reliever medication (i) patients with asthma exacerbations in the past requiring medical intervention (Adults (including elderly)): Asthma) (including elderly) Asthma twice daily or 1-2 inhalations twice daily. Some patients may require a maximum of 4 inhalations twice daily. Adolescents (12-17 years): 1-2 inhalations twice daily. Children 6 years and older (Symbicort 100/6 only): 2 inhalations twice daily. Not intended for the initial management of asthma. Dose should be individualised. For all children 6 years and above, metered dose inhalers should be used. Appropriate doses of inhalers should be prescribed. When symptoms are controlled, titrate to the lowest effective dose, which could include a once daily dosage. Children under 6 years: Not recommended. Asthma (Symbicort maintenance and reliever therapy – regular maintenance treatment and as needed in response to symptoms): should especially be considered for children with inadequate asthma control and in frequent need of reliever medication (i) patients with asthma exacerbations in the past requiring medical intervention

Contraindications: Hypersensitivity (allergy) to budesonide, formoterol or lactose (which contains small amounts of milk protein).

Warnings and Precautions: If treatment is ineffective, or there is a worsening of the underlying condition, therapy should be reassessed. Treatment should not be stopped abruptly. Sudden and progressive deterioration in control requires urgent medical assessment. Patients should have their appropriate rescue medication available at all times, i.e. either Symbicort as a separate reliever; inhaled for prophylactic use (e.g. before exercise) a separate reliever should be used. Therapy should not be initiated during exacerbation. Serious asthma-related adverse events and exacerbations may occur and patients should continue treatment but seek medical advice if asthma symptoms remain uncontrolled or worsen after initiation with Symbicort. As with any inhaled corticosteroid, systemic effects may occur, particularly at high doses prescribed for long periods. These may include adrenal suppression, growth retardation in children and adolescents, decrease in bone mineral density, cataracts and glaucoma. Patients on high doses for prolonged periods that have co-existing risk factors for osteoporosis. Cautions when transferring patients who have required high dose emergency corticosteroid therapy in the past or prolonged treatment with high doses of inhaled corticosteroid or oral corticosteroids or in a situation likely to produce stress (e.g. physical exercise). Concomitant treatment with inhaled corticosteroid and long-acting inhaled beta₂-agonists in patients with severe asthma, may increase the risk of osteoporosis. Concomitant use of theophylline, triamcinolone acetonide, budesonide, formoterol, budesonide/formoterol, inhaled corticosteroids and beta₂-agonists may result in an increase in blood levels of insulin, free fatty acids, glycerol and ketone bodies.

Packaging: Each Symbicort Turbohaler contains 120 inhalations. Marketing Authorisation Number (s): PA 970/28/1-2

Side-effects: Common: Palpitations, tremor, headache, mild irritation in the throat, coughing, hoarseness. Uncommon: Pancytopenia, signs and symptoms of systemic glucocorticoid effects e.g. adipose tissue redistribution, decrease in bone mineral density, cataracts and glaucoma, hyperglycaemia, taste disturbances, depression, behavioural disturbances (mainly in children), variations in blood pressure. As with all other inhaled therapy, paradoxical bronchospasm may occur in very rare cases. Adverse suppression: growth retardation in children and adolescents, decrease in bone mineral density, cataracts and glaucoma may occur as systemic effects of high doses of inhaled corticosteroids over prolonged periods of time. Treatment with beta₂-agonists may result in a rise in blood levels of insulin, free fatty acids, glycerol and ketone bodies.

Package Information: Each Symbicort Turbohaler contains 120 inhalations. Legal Category: Prescription Only Medicine (POM) Marketing Authorisation Number(s): PA 970/28/1-2 Marketing authorisation Holder: AstraZeneca UK Limited, 600 Capability Green, Luton, LU1 3LU, UK. Further information available on request from: AstraZeneca Pharmaceuticals Limited, 150 College Park House, 20 Nassau Street, Dublin 2. Telephone: (01) 607 7000 Fax: (01) 676 6500. Abridged Prescribing Information prepared: 08/08

*Symbicort and Turbohaler are Trade Marks of the AstraZeneca group of companies. Date of Preparation: October 2008. URN: 058588
ROSALIAC XL
Anti-redness fortifying moisturiser

Neutralises redness and fortifies skin. Every day.

Triple protection to fortify skin and fight against redness

→ Vitamin CG: Strengthens blood vessels and diminishes their reactivity
→ Vitamin B3: Protects skin against irritating & climatic factors
→ Mexoryl XL: Protects skin against UV rays. SPF 15. PPD 10

Complexion instantly evened

→ Optical correctors instantly evens skin tone

Paraben-free

Efficacy medically measured over a two month period

Before After

-37% diffused redness*
-17% blood vessel dilation*
-44% redness breakouts*

*Efficiency test carried out on 64 subjects

LA ROCHE-POSAY. COMMITTED TO DERMATOLOGY.
www.laroche-posay.ie
Rosacea: ‘the curse of the Celts’

What is rosacea?
Rosacea is a common skin disorder, occurring anywhere on the face. It predominantly affects middle-aged and fair-skinned people. Sometimes referred to as the ‘curse of the Celts’ it affects mostly people of northern European decent and is one of the most common skin conditions seen by dermatologists in Ireland.

Presentation
It begins as erythema (flushing and redness) on the central face and across the cheeks, nose, or forehead but can also less commonly affect the neck and chest. As rosacea progresses, other symptoms can develop such as semi-permanent erythema, (redness) telangiectasia (dilation of superficial blood vessels on the face), red domed papules (small bumps) and pustules, burning and stinging sensations, and in some advanced cases, a red enlarged nose (rhinophyma).

Rosacea can also present with lymphoedema of the cheeks, nose, forehead and chin. Eye involvement with blepharitis and conjunctivitis are common complications.

Differential diagnosis
In some cases the disorder can be confused with, and co-exist with acne vulgaris and/or seborrhoeic dermatitis. While rosacea affects both sexes, it is almost three times more common in women, and has a peak age of onset between 30 and 60 years of age. Although rosacea is more commonly seen in women the symptoms tend to be more severe in men.

The characteristic features of redness and flushing may have a number of trigger factors including heat, alcohol, sunlight, hot beverages, stress, menstruation, certain medications and foods.

Unfortunately for many who suffer from the condition they can also suffer from an erroneous public perception that it is related to excessive alcohol consumption. In one study, nearly a quarter of sufferers had been asked if they have a drinking problem.

As alcohol is a frequent trigger of flushing it is quite likely that those with the disease drink less than the general population.

Causes
The cause of rosacea is not fully understood. Rosacea does seem to run in some families, but it is still not clear whether heredity plays a big part in this.

There are a variety of trigger factors which may make rosacea worse, including alcohol, exercise, high and low temperatures, hot drinks, spicy foods and stress. Rosacea can be worsened by natural sunlight, particularly the UVA part of the spectrum so it is always advised that patients with this condition use the highest UVA/UVB protection on their skin daily.

Symptoms
The rash and the flushing associated with rosacea are cosmetic issues and can lead to embarrassment, lowered self-esteem and self-confidence, anxiety and even depression. Furthermore, the
skin of the face is often sensitive, and can burn or sting. Some people with rosacea have symptoms affecting their eyes (which include red, itchy, sore eyes and eyelids, a gritty feeling and sensitivity to light). Some patients with rosacea may develop more serious eye problems, such as painful inflammation involving the clear front part of the eye (rosacea keratitis), which can interfere with vision.

Appearance
Rosacea starts with a tendency to blush and flush easily. After a while, the central areas of the face become a permanent deeper shade of red, with small dilated and broken blood vessels, studded with small red bumps and pus-filled spots, which appear sporadically.

Occasionally, there may be some swelling of the face (lymphoedema), especially around the eyes. Very occasionally, an overgrowth of the oil-secreting glands may cause the nose to become enlarged, and red (rhinophyma). Rhinophyma is more commonly seen in men.

Treatment
The inflammation that accompanies rosacea can be treated with prescription medication. Topical creams applied to the skin or taken by mouth will decrease the inflammation but these will not help the redness or flushing that may be associated with rosacea.

The inflammatory element of mild to moderate rosacea may be controlled with just a topical preparation. Metronidazole gel (Metrogel/Rosex) twice daily is commonly prescribed.

Preparations including metronidazole and azelaic acid take time, at least 8 weeks, for their effect to become evident so it is important to advise your patients of this.

Antibiotics are also prescribed to treat the inflammatory element of moderate or severe rosacea. The most commonly used antibiotics belong to the tetracycline group and include tetracycline, oxytetracycline, doxycycline, lymecycline and minocycline. Erythromycin is another commonly used antibiotic. Some of these prescribed antibiotics may also have a side effect of photosensitivity so it is important to advise daily photoprotection not only to prevent an overt skin reaction but as a matter of course when somebody presents with this condition as daily UV exposure is a major trigger in rosacea.

Key advice
Daily skin care is of paramount importance for the patient with rosacea. His or her skin will be extremely sensitive and must be protected from the sun everyday by using the highest UVA/UVB photo protection. UVA which is received year round and penetrates cloud and glass is a key aggravating factor in this condition. La Roche-Posay’s Anthelios 50+ is recommended by dermatologists for patients with photo aggravated skin conditions such as rosacea.

Using daily skin care that has been specially formulated for patients with rosacea will enhance first line pharmaceutical treatment as well as relieving symptoms of flushing. La Roche-Posay has a specific skin care range called Rosaliac which is specially formulated for skin prone to redness and flushing. Active ingredients Vitamin C strengthens the lining of fragile blood vessels decreasing flushing. Vitamin B3 reduces inflammation and caffeine has anti oedematous action on the skin. These products are available over the counter in pharmacies.

It is also important to remind the patient to keep a note of lifestyle factors that can make their skin flare up. By keeping notes of these trigger factors the patient will be able to adopt lifestyle changes that will help reduce incidences or flare ups.

Camouflage makeup can be life changing for patients with rosacea. Dermablend by Vichy is an excellent camouflage makeup range that can be used by women and men to achieve the most effective, long-lasting camouflage cover for all facial imperfections. Dermablend covers skin flaws maintaining perfect coverage with no mask-like effect or caking. By providing a natural looking finish which holds all day, the patient can feel more comfortable with their appearance and less distressed with their skin condition. Dermablend has an SPF 30 which is also beneficial in blocking the UV trigger of this condition.

Practical and sympathetic advice together with clinically proven solutions are key to improving the quality of life of patients with rosacea.

La Roche-Posay and Vichy are pharmacy only brands.

References
www.laroche-posay.ie
www.dermblend.ie
www.vichy.ie
osteoporosis is characterised by a progressive decrease in bone density, causing bones to become more fragile, brittle and weakened, and fracture easily. Osteoporosis causes 15 million bone fractures worldwide annually. (Royal College of Physicians, 2005) Osteoporosis leads to musculoskeletal pain and loss of posture. It occurs most frequently in women after menopause, although it also occurs in men. Caucasian and Asian women have a higher risk for developing osteoporosis than Africans, but one’s race does not exclude the possibility of developing this disease. Osteoporosis is not painful at an early stage and is often undiagnosed until a fracture occurs and is a major public health concern. (National Osteoporosis Society 2005). It is the cause of most fractures in older people and is an important contributor to mortality, physical ability, and medical expense. We know genetic predisposition, aging, and oestrogen deficiency are the most common contributors, severe bone loss may also be caused by a wide variety of medical problems including rheumatoid arthritis and drugs such as corticosteroids. Early diagnosis of bone loss can reduce or eliminate the risk of fractures. (Bainbridge, Sowers and Crutchfield 2002).

In the last decade we have seen a growing interest in osteoporosis and major advancement in new therapies to slow and even stop the progression of this disease. Nurses are in a position to play a pivotal role in the prevention and detection of osteoporosis, as well as in the management and monitoring of this disease. Practice nurses can take a very important lead role in identifying the at risk group of patients within their practice. Osteoporosis has to assume its prominent place along with other chronic illnesses, such as rheumatoid arthritis, cardiovascular disease, diabetes and others.

Various nursing roles are well placed to help with the prevention of this disease through education of groups of individuals regarding bone health (Allanach 2000). Within community settings and schools, nurses can play a key role in the education of children, youth and parents regarding healthy lifestyle to promote bone health for the future. Such healthcare advice would prove a very effective contribution to osteoporosis prevention. Emphasis on physical activity and calcium intake is very important especially as teenagers become sedentary and diets tend to exclude sufficient amounts of calcium to achieve bone health. As nurses we can play an integral role in facilitating the detection of osteoporosis, through our involvement in the assessment of patients at various points of contact within our healthcare
Simple observations during standard patient assessments can facilitate early detection, for example a history of loss of height or a fragility fracture from minimal trauma and other risk factors for the development of osteoporosis (Blalock et al. 2000, Peterson et al. 2000).

Risk factor awareness
Many factors increase the risk of developing osteoporosis and fracture.
- Older age (starting mid-30s but accelerating after 50 years of age)
- Small bone structure
- Family history of osteoporosis or osteoporosis related fracture
- Sex hormone deficiency, particularly oestrogen deficiency, both in women and men
- Anorexia nervosa
- Cigarette smoking
- Alcohol abuse
- Low dietary intake of calcium and vitamin D
- Sedentary lifestyle or immobility
- Medications: steroid therapy, excess thyroid hormone replacement
- Certain endocrine disorders such as hyperthyroidism, hyperparathyroidism, rheumatoid arthritis, etc.

Osteoporosis prevention and treatment
To maintain bone health an adequate calcium intake must be maintained (1,000 mg per day for women before the menopause and 1,500mg for women who are post menopausal) Adequate vitamin D is very important for calcium absorption and to maintain muscle strength (400iu per day until 60m years, 600-800iu per day after 60 years). Daily regular exercise is very important especially weight bearing exercise; such as brisk walking or skipping.

A number of medications are used for the prevention and treatment of osteoporosis:

“Nurses are instrumental in providing psychosocial support for patients with osteoporosis.”

Bisphosphonates
Alendronate, risedronate and ibandronate have been approved for the prevention and treatment of osteoporosis in postmenopausal women. Both alendronate and risedronate are approved for the prevention and treatment of glucocorticoid-induced osteoporosis in men and women. These medications slow down bone loss and have been shown to decrease the risk of fracture. Alendronate and risedronate can be taken once a week, while ibandronate can be taken once a month. These medications must be taken on an empty stomach with water. Because they can have the potential for irritating the oesophagus, it is recommended for patients to remain upright for at least an hour after taking these medications. There are also two other IV forms of bisphosphonate available for osteoporosis management.

There have been recent reports of osteonecrosis of the jaw resulting from high dose IV bisphosphonate used primarily in the management of patients with underlying cancers.

Hormone replacement therapy
Oestrogen therapy alone or in combination with progestin has been shown to decrease the risk of osteoporosis and fractures in women. However, the combination of oestrogen and progestin has been shown to increase the risk for breast cancer, stroke and emboli.
Calcichew-D3 Forte is indicated for the treatment and prevention of calcium and vitamin D deficiency.6
Selective oestrogen receptor modulators (SERMs)
These medications mimic oestrogen’s good effect on bone without the serious side effects such as breast cancer. Raloxifene (Evista) decreases spinal fractures in women.

Parathyroid hormone therapy
Teriparatide (Forsteo) and Preotact (Preos) is a form of parathyroid hormone that helps to stimulate osteoblasts and is licensed for the treatment of severe or refractory osteoporosis in men and postmenopausal women. This treatment involves daily subcutaneous injections for 18 months.

Strontium ranelate
Protelos is classified as a dual acting bone agent and is licensed for the treatment of postmenopausal osteoporosis. It also has proven efficacy for the reduction of hip and vertebral fracture risk. It has to be used with caution in women who have a history of deep vein thrombosis or pulmonary embolism.

Nursing role
Following a diagnosis of osteoporosis, nurses can play a significant role in supporting patients in the treatment, education, counselling and management of this condition. Although most patients with osteoporosis can be treated by their general practitioner, there are specialist consultants who treat the more severe cases of osteoporosis. Nurses are instrumental in providing psychosocial support for patients with osteoporosis. For many patients this is a chronic condition that they are faced with, and can lead to anxiety regarding the diagnosis, treatment and diagnosis. Nursing assessment and support assists patients in maintaining their commitment and compliance to lifestyle modifications and treatment over the course of their lives. Nurses can also play a role in enabling patients to cope with this chronic condition through the development of coping strategies and pain management as required.

Today there is heightened interest in this disease and its treatment. New and improved technologies make detection more accurate and new medications make the management of this disease more feasible.

In conclusion osteoporosis should not be considered simply a disease of the elderly and a normal part of aging, as now there are treatments that can reduce the risk of fracture. Reducing fractures will increase the likelihood that older individuals can maintain their independence, mobility and thus their quality of life.

“Daily regular exercise is very important especially weight bearing exercise; such as brisk walking or skipping.”

References


Paralink

Comforts & Soothes all those little pains

For teething pains, high temperature (Pyrexia), aches and pains, colds and flu. Paralink can be taken alone or mixed with a little milk or fruit juice. Also available in suppository form - a very effective alternative where vomiting is occurring. Only available in pharmacies.

Relieves Pain, Reduces Temperature

Paralink SUPPOSITORIES
180mg PARACETAMOL
Relieves Pain, Reduces Temperature
10 SUPPOSITORIES

Paralink ORAL SOLUTION 120mg

Relieves Pain
Reduces Temperature
Colour Free
Suitable from 3 months

Rice Steele Manufacturing Ltd.,
Cookstown Industrial Estate, Tallaght, Dublin 24.
Site also contains information about illnesses and the proper use of OTC medicines available for their treatment.

Edited by Dr Martin Henman, the new site not only acts as a reference guide for pharmacists and other healthcare professionals, it also aims to encourage the public in the correct approach to self-medication.

www.yourmedicines.ie will be supported by an online advertising campaign along with promotion in mainstream media.
Early detection and treatment of postnatal depression in primary care nursing

Postnatal depression has a relatively high incidence in Ireland. It is estimated that with 60,000 births annually more than 6,000 women will need help for this condition. The aim of this article is to highlight the necessity for early detection, intervention and treatment of the illness to prevent detrimental effects on the mother, partner, infant and other family members.

Postnatal depression is experienced at a time when contact with health professionals is at its peak, and also when exceptional physical and emotional demands are being made on the mother, therefore it is important early signs are recognised and treated promptly. Early identification and treatment of postnatal depression is pivotal in reducing the risk of the mother developing severe depression (Harris 1996).

Evidence also suggests that postnatal depression is linked with disturbances in the mother-infant relationship, and can have an effect on the infant’s development with implications for the emotional, social, intellectual and behavioural development of the child in the longer term (Hay et al. 2001).

Challenges
For most mothers giving birth is one of the definitive moments of their lives, some women will describe the experience in terms of excitement, euphoria and a sense of fulfilment. Newly delivered mothers who show no signs of postnatal depression have to face a number of challenges, some of which are described by Gelder et al., (2000).

• Sleep deprivation and physical exhaustion
• Breast-feeding: whilst this is beneficial and worthwhile it can be very demanding and time consuming for the mother and there may be difficulties initially in getting it established. Other problematic areas for mothers when breast-feeding include cracked and sore nipples, engorgement or mastitis.
• Social isolation: being confined to the house, loss of contact with work colleagues or being unable to pursue leisure activities.
• A new mother may have problems with weight gain following the birth of her baby and may have difficulty in regaining her pre-pregnancy figure and feel a sense of loss of attractiveness.
• Physical problems associated with childbirth are episiotomies, vaginal or anal tears, which may cause urinary or faecal incontinence; these are not commonly discussed and can be very traumatic.

This combination of social, biological and psychological experiences can have a daunting effect on a new mother and it is not surprising that a variety of psychiatric disorders can occur at this time.

Causes of postnatal depression
There may be many causes of postnatal depression some of which are the shock of becoming a mother and having to learn new skills associated with this. The occurrence of stressful life events in general and unemployment in particular, have all consistently been found to be major factors in the causation of postnatal depression.

Some of the indicators for the likelihood of a woman getting postnatal depression are:

• If the woman has suffered from depression (especially postnatal depression) before.
• Poor support: for example the presence of marital conflict,
and the absence of personal support from spouse, family, and friends. Kumar and Robson (1984) suggest that a poor relationship or separation from one’s own mother can be a causative factor in developing postnatal depression.

- Have a premature, sick or disabled baby.
- Experienced several stressors in a short period of time such as a bereavement, loss of employment, housing or financial problems.
- Hormonal levels, some women may be more sensitive to these changes than others.

There are many reasons why women don’t seek help, some of these are the high expectations placed on new mothers through either myths or the media. Holden (1996) suggests that some mothers will not seek help because of the guilt of admitting that they are not coping and the fear of a getting a psychiatric diagnosis. Other problems include lack of knowledge of the illness and not knowing where to get help.

Types of postpartum disorders
There are three main post partum psychiatric disorders:

- **Postpartum baby blues.** Clarke (2000) suggests that the baby blues affect 70% of women in the first week after giving birth.
- **Postpartum depression.** Davies et al. (2003) describe this as a common disorder specific to the postnatal period. It can present as mild, moderate or severe.
- **Postpartum psychosis.** This condition is quite rare and affects 1 or 2 per 1000 new mothers (Paradice 1995). Puerperal psychosis is quite different to postnatal depression; this is an acute, severe psychiatric illness, which usually occurs between 2 and 14 days after delivery, it is classified as a psychiatric emergency. The mother often presents initially as perplexed or erratic with a poor sleep pattern but psychotic symptoms soon emerge such as florid psychosis with hallucinations and delusions causing confusion and hyperactivity. This condition requires urgent treatment and can necessitate admission to hospital.

Signs and symptoms of postnatal depression
The mother often becomes increasingly angry, weepy, tired, anxious, panicky and generally overwhelmed. She may become socially isolated not willing to leave the house or afraid to be alone. Her moods are likely to be erratic and unpredictable and other indicators may be:

- Despondency, no hope for the future, feeling inadequate and unable to cope
- Guilty about not loving the baby enough
- Unusual irritability, which can make guilt worse, hostility or indifference to a normally loved husband or partner
- Sleep problems — difficulty in getting to sleep or early morning waking, even when the baby is not crying
- Obsessive fears about the health of the baby, partner or another loved one
- Difficulty in concentrating
- A strong sense of anxiety about things, which would not normally worry her
- Loss of appetite
- Loss of interest in sex
- Suicidal ideation or suicide attempts.

Failure to identify PD
There are many reasons why postnatal depression can go unnoticed; some of these reasons are discussed by Holden (1996);

- Short appointments, it is very common for a mother coming from a crowded waiting room to think that the nurse or doctor is under pressure and does not have time to talk to them about their problems
- Fixed agenda mothers may feel that they should not deviate from the fixed reason for the visit i.e. vaccination of baby.
- Physical orientation of care
- Baby-centred contacts, the visit may revolve around the baby but these contacts can be a good indicator of the mother’s well-being and if she is coping. It is always prudent to explore the possibility of postnatal depression with mother if she is presenting with minor worries about her baby more often than is normal.
- Acceptance of normality of ‘baby blues’ very often a mother will confuse postnatal depression with ‘baby blues’ and her illness may go undetected for some time.

**Detection**
The depressed mother is often in a state of helplessness, isolation and confusion combined with the inability to cope and guilt about her feelings and inadequacies. She may just be waiting for a sympathetic person to recognise that she is having problems and to encourage her to vent her feelings.

Postnatal depression occurs at a critical time in the mother-infant relationship and it is recommended that a screening tool such as the Edinburgh Postnatal Depression Scale (EPDS) be used on each new mother during the ante-natal and postnatal periods. The greatest difficulty mothers may have is admitting their feelings and difficulties and it is in this instance that the Edinburgh Postnatal Depression Scale (EPDS) Cox et al. (1987) is a very useful instrument. It is validated and reliable and widely used both nationally and internationally. This scale is ideal for the measurement of social/emotional wellbeing in pregnancy and helps to open up the subject on any worries the mother may be experiencing and to identify those women who need support, Cox et al. (1987). The EPDS is easy to complete and”

“The practice nurse in the ideal position to carry out the EPDS: as most mothers will have attended the surgery for antenatal and postnatal checkups, a rapport is easy to establish.”

only takes a few minutes. The advantages of the routine use of the EPDS means that it increases detection of postnatal depression by health professionals and raises awareness among mothers, fathers and families in general. It also gives women permission to speak and professionals indicators to listen (Holden 1996).

Wisner and Wheeler (1994) suggest that pregnant women have frequent contact, both antenatal and postnatal, and this should enable health professionals to detect risk factors and develop prevention programmes. This places the practice nurse in the ideal position to carry out the EPDS, and as most mothers will have attended the surgery for antenatal and postnatal checkups a rapport is easy to establish.
Ireland’s No.1 prescribed anti-depressant.  

Active response for effective treatment of depression.  

- Major Depressive Episodes  
- Generalised Anxiety Disorder  
- Social Anxiety Disorder  
- Panic Disorder  
- Obsessive Compulsive Disorder  

Abbreviated Prescribing Information: Please refer to the Summary of Product Characteristics before prescribing. Presentations: Lexapro® Tablets 5 mg, 10 mg, 15 mg and 20 mg containing escitalopram as the inactive ingredients. Treatment of major depressive episodes, panic disorder with or without agoraphobia, Generalised Anxiety Disorder, Obsessive Compulsive Disorder, Obsessive Compulsive Disorder. Dosage: Treating depression: Adults: Initial dosage is 10 mg once daily. The dose may be increased to a maximum of 20 mg daily. The dose may subsequently be decreased to 5 mg or increased to a maximum of 20 mg/day. Elderly (>65 yrs): An initial dose of 5 mg/day should be used, which can be increased to 10 mg after assessment. Precautions: Treatment of panic disorder with or without agoraphobia: In patients with severely reduced renal function (CLcr<30 ml/min). Dosage adjustment is not necessary in patients with mild or moderate renal impairment. Caution is advised in patients with controlled epilepsy. Stop treatment immediately if patient develops seizures. Use at a low starting dose for panic disorders. Avoid abrupt discontinuation. Gradual discontinuation by dose tapering is advised. As with all SSRIs it is advisable to closely monitor patients for suicide and self-harm risk in the first few weeks of treatment and until significant remission occurs. Caution is advised in patients with coronary heart disease. The use of 5HT3/5HT2A antagonists has been associated with the development of arrhythmias increasing the risk in these patients may be detrimental. Drug Interactions: MAO inhibitors (see Contraindications/ Precautions), avoid concomitant use with irreversible selective MAO-I inhibition (e.g. selegiline). Caution in use with lithium, tricyclics, monoamine oxidase inhibitors or with products capable of lowering the seizure threshold. Avoid concomitant use with St. John’s Wort in known poor metabolisers, with respect to CYP2C19, an initial 5 mg/day dose should be used, which is to be increased to 10 mg after assessment. Caution is advised with co-administration of drugs metabolized by enzymes CYPIA1 and CYPID6.
in practice

“Antidepressant medication is indicated for those women who fail to respond to any psychological intervention or who have a severe depressive illness.”

Clarke (2000) suggests that professionals should use a structured approach to using the EPDS and that a proactive role should be adopted in antenatal and postnatal care. It is recommended that the EPDS be carried out approximately 6 weeks post delivery. The EPDS should be carried out in conjunction with a structured interview and practice nurses ought to use their clinical judgement to assess each individual situation taking social and cultural circumstances into account. Davies et al, (2003) recommend that once a score of 12 or higher has been identified the woman should be given an opportunity to talk about her feelings, and also suggest that there is the possibility of extra work for the professional if “listening” visits are required but stress that practitioners who identify cases through the use of the EPDS but do not feel competent to provide counselling should refer to other agencies. Clarke (2000) recommends that should anyone express an intention to self-harm the GP should be notified and appropriate action should be taken.

There are other assessment tools available such as the Beck Depression Inventory, a 21 item self-rating scale which is more generalised to depression but the scores are also an indicator of the levels of distress the individual may be experiencing.

Management/treatment of postnatal depression

The treatment of postnatal depression can be multifaceted taking the form of social psychological and pharmacological interventions. The use of brief psychotherapy in postnatal depression has a lot of benefits for the mother in adjusting to this major change in her life. Hoffbrand et al, (2001) suggest that social factors are particularly prevalent in the aetiology and prognosis of postnatal depression and treatment is often mainly by social supports and psychological interventions. Hendrick (2003) suggests that once postnatal depression has been identified many, if not all, patients can be treated in primary care. Antidepressant medication is indicated for those women who fail to respond to any psychological intervention or who have a severe depressive illness. Many women are reluctant to take medications because of their lack of knowledge of them and fear of any possible side effects. This information should be given to the mother with the guidance on the drugs and the benefits of completing the treatment to prevent a relapse of their illness.

It is suggested that antidepressants should be taken for at least 4-6 months after recovery and only stopped in conjunction with a doctor’s advice.

Taking antidepressants whilst breast-feeding is usually a decision for each individual mother in conjunction with her treating doctor. Most of the data developed by drug companies carry warnings that antidepressants should not be given to women who are breastfeeding. Because all antidepressants are secreted in breast milk the mother may be advised to stop breast-feeding whilst taking medication. Hoffbrand et al, (2001) suggest that the lack of systematic data on the safety of taking antidepressants whilst breast feeding leads physicians to advise patients not to breastfeed when taking antidepressants.

Conclusion

To recap, evidence would suggest that the routine use of a screening tool such as the Edinburgh Postnatal Depression Scale is effective in recognising postnatal problems. The practice nurse is in the ideal position for the early identification of postnatal depression because she has first hand contact with the mother and will have developed a relationship with her throughout the pregnancy. By routine use of the scale it could become common practice to screen every mother thus promoting the psychological well being of postnatal mothers and raising awareness and preventing serious mental health issues.

References


VIMPATe— new epilepsy treatment for partial-onset seizures

UCB (Pharma) Ireland have announced that the European Commission (EC) has approved VIMPAT (lacosamide) as adjunctive therapy in the treatment of partial-onset seizures with or without secondary generalisation in patients with epilepsy aged 16 years and older and it is now available for prescription in Ireland. VIMPAT is the first new antiepileptic drug (AED) for partial-onset seizures in three years and offers a new treatment option for European patients living with uncontrolled partial-onset epilepsy.

Professor Elinor Ben-Menachem, Clinical Trial Investigator, Department of Clinical Neuroscience, Goteborg University, Sweden said, “VIMPAT offers new hope for improved seizure control in adult patients with partial onset seizures. The novel mode of action of VIMPAT makes it different from all other antiepileptic drugs currently available. VIMPAT should be considered a valuable treatment option for adult patients with partial-onset seizures who need additional seizure control.”

A novel mode of action
Preclinical studies indicate that VIMPAT has a novel mode of action. While the precise mechanism by which VIMPAT exerts its antiepileptic effect in humans remains to be fully elucidated, in preclinical studies VIMPAT has been shown to modulate sodium channel activity differently compared with other sodium channel blocking AEDs.

Improved seizure control when added to a wide range of antiepileptic drugs
In clinical trials VIMPAT improved seizure control when added to a wide range of first and second generation antiepileptic drugs. Pooled analysis shows that treatment with VIMPAT200 mg/day and 400 mg/day reduced seizures by half in 34% and 40% of patients with partial-onset seizures, respectively, compared with 23% in the placebo group. VIMPAT was generally well tolerated with the most common adverse events (≥10% and greater than placebo) reported in these trials including dizziness, headache, nausea and diplopia.

Multiple formulations for ease of use
VIMPAT has been approved as oral tablet (50mg, 100mg, 150mg, 200mg), oral syrup (15mg/ml) and solution for infusion (10mg/ml), to allow for additional dosage formulation options. VIMPAT solution for infusion is an alternative for patients when oral administration is temporarily not feasible.

For more information please contact Ms Gillian Bermingham, Product Manager Vimpat (gillian.bermingham@ucb-group.com) or Emma Lynch, onMedical Scientific Advisor (emma.lynch@ucb-group.com) 01 4637395.

New generation cleaning and disinfecting wipe

Vernacare has launched a powerful new cleaning and disinfecting wipe that is kind to the hands, yet eradicates the major five major groups of pathogens, including C. diff, MRSA and E. coli.

Tuffie 5 has passed EU cosmetic legislation as safe to use on skin without gloves, yet is clinically proven to destroy spores such as C. diff; bacteria, including E. coli and MRSA; mycobacteria like Mycobacterium terrae; yeasts and fungi including Candida, together with viruses such as Hepatitis C and HIV/Aids.

The new wipes provide a highly effective pre-impregnated wet wipe, capable of disinfecting all hard surfaces and equipment.

Tuffie 5 eradicates pathogens on initial impact, but industry tests show that its disinfecting properties continue to work after cleaning has taken place.

The wipes are fragrance, chlorine and alcohol free, and are available initially in easy access tub dispensers containing 225 wipes. Small soft packs and wall mounted dispensers will also be introduced.

Results show the product is significantly safer and more effective than existing alcohol based products and independent tests back up these claims. All pathogens tested have been reduced by Log 4 or greater against BSEN standards, meaning 99.99% of bacteria, including C. diff, have been destroyed.

Tuffie 5 has passed EN 1276, EN 14384, EN 1650, EN 13704, EN 13727, EN1275 and EN 12054 standards. It also complies with EU 76/768/EEC cosmetics legislation as safe to use on hands. It conforms to British Standards (BS12054) as an effective hand sanitiser.

Available exclusively in Ireland through MMS Medical, Tony Kelleher, MMS Director commented; “We are delighted to bring to the market, a single powerful wipe that fits all uses. Tuffie 5 is proven by stringent scientific tests to destroy the five major groups of pathogens – offering a product that infection control teams can rely upon to reduce infection risks.”

Free trial samples and further information are available through MMS Medical by contacting Adam Lingard, Tel.021 461 8000 or e-mail: adamlingard@mmsmedical.ie
Targeted therapies can make a huge difference in the treatment of lung cancer

In the presence of some of Ireland’s leading oncologists and lung cancer specialists in Dublin’s Royal College of Physicians, Professor Thomas J Lynch, Chief of Haematology-Oncology and Professor of Medicine at the Massachusetts General Hospital (MGH) Cancer Center and Harvard Medical School in the US, recently provided an insightful lecture entitled ‘Progress in Targeted Therapies of Non Small Cell Lung Cancer (NSCLC),’ examining current targeted NSCLC treatments and the future of lung cancer care. The meeting was hosted by Roche Products (Ireland) Ltd.

With the focus of the meeting on targeted therapies, Tarceva (erlotinib) and Avastin (bevacizumab) were discussed in great detail. Avastin, a vascular endothelial growth factor (VEGF) inhibitor, is the first cancer drug in over ten years to be shown to extend one year survival in patients with nonsquamous NSCLC. Prof Lynch outlined the ECOG 45992 study, describing it as “probably the best trial for first line therapy in the US.” ECOG 4599 was one of the studies that formed part of the dossier submitted to the European Committee for Medicinal Products for Human Use (CHMP) that subsequently resulted in the positive opinion for the use of Avastin in the treatment of metastatic NSCLC.

Supporting the idea that epidermal growth factor receptor 1 (EGFR) tyrosine kinase increased copy number makes a difference, Professor Lynch presented details of the BR21 study, which showed a survival benefit with the use of the tyrosine kinase inhibitor (TKI) Tarceva (erlotinib).

The BR213 study found that the treatment of NSCLC patients with Tarceva resulted in a statistically significant improvement in the primary endpoint of overall survival versus placebo. Patients treated with Tarceva (median survival=6.7 months) survived 30 per cent longer than placebo-treated patients (median survival=4.7 months). One-year survival rates were increased 48 per cent by treatment with Tarceva. Tarceva is an oral treatment that is indicated in Ireland for the treatment of patients with locally advanced or metastatic NSCLC after the failure of at least one chemotherapy regimen.

Professor Lynch concluded the lecture by saying: “Since I began this talk 80 people have died of lung cancer worldwide. I believe that we need to commit ourselves to discovery if we are going to improve outcomes for patients. We need fundamental research findings that uncover the secrets of why lung cancer is so malignant and why it is so difficult to treat. I would say to the scientists to never underestimate the enthusiasm that clinicians have for bringing new drugs to patients. If we can really put together a coordinated effort, we may be able to make some real progress with this disease.”

Betnovate-N Cream 30g — discontinued

GlaxoSmithKline wishes to announce that Betnovate-N (Betamethasone Valerate 0.1% w/w. Neomycin Sulphate 0.5% w/w, Cream 30g) will be discontinued on 27th February 2009. This does not affect other products in the Betnovate range. Alternative products are licensed in Ireland for the treatment of corticosteroid sensitive dermatoses complicated by infections due to micro-organisms sensitive to the anti-infectives.

Please call 01-4955000 for further information if required. GlaxoSmithKline apologises for any inconvenience caused.

New product protects children from colds and flu

The cold bug is biting its way back into homes and schools across Ireland, forcing thousands of people to stay home over the coming winter months. And with the costs of healthcare increasing, the added hassle of having to stay home can cause strain on families.

Luckily, a new remedy is now on the Irish market and set to banish the winter blues for many parents. Hypomer, a new, family-friendly seawater nasal spray, is a simple low-tech way to wash out viruses, bacteria, and all other foreign bodies which land inside the nose and sinus passages and contribute to colds, nasal congestion, sinus infections, and other respiratory ills.

With its high mineral and trace marine content, and a unique infant safety nozzle, Hypomer is a natural daily nasal cleanser, which can be used by all people of all ages, from baby right through to adult.

Dr Turlough Bolger, Consultant in Paediatrics, Mount Carmel Hospital, believes nasal sprays such as Hypomer can help lighten this load. “In my experience this is very beneficial in clearing the nasal passages of dried mucus which is common at this time of year. It can lead to improved feeding, as infants are able to breathe easily and results in less respiratory distress. It also has the added effect of removing the need for unnecessary medication and trips to your GP.”

An added stress is the disruption to work. Mums and dads are forced to take leave from the office to look after their sick children, and the fact that most young children catch 8-10 colds on average before they have even turned two years old, doesn’t help.

Determined to conquer the snuffly noses of her three children, Dublin Mum Thomasena O’Nuallain talked about her experiences with Hypomer. “As a part-time lecturer, I find my hectic schedule far too demanding to take extra time off work when my children are sick. All three of my children get chronic colds at this time of year, and when my third child came along, I decided the least I could do was to find a solution to ease the family’s discomfort from constant colds. “From my personal experience and from trying many nasal sprays, I have found Hypomer effectively cleanses and relieves the nasal passages of my whole family.”

Children spend enough time learning all their daily healthy habits and mountain of life skills; feeding themselves, brushing their teeth, and washing their hands, for starters. Few can be messier than blowing their noses and the frustration of congestion can in fact inhibit them from learning as fast as they should — which is why Hypomer can help make home life easier for families in the winter months.

Hypomer is now available in pharmacies nationwide in a 100ml bottle for RSP €9.95 and is a better value alternative compared to other similar products on the market.
Circadin

Lundbeck Ireland Ltd. is delighted to announce the introduction of CIRCADIN®, Ireland’s first and only melatonin agent licenced for primary insomnia, to the Irish market on 1st February 2009. Circadin is indicated as monotherapy for the short- term treatment of primary insomnia characterised by poor quality of sleep in patients who are aged 55 or over. Circadin is not reimbursed – the cost to patient is approximately €24.00

For further information contact:
Lundbeck Ireland Ltd., 7 Riverwalk, Citywest Business Park, Citywest, Dublin 24. Tel: 01 - 4689800

Mirap Orodispersible launched

Rowex Ltd have announced the launch of Mirap Orodispersible Tablets 15mg, 30mg and 45mg (Mirtazapine).

Mirap Orodispersible 15mg, 30mg and 45mg are indicated for major depressive episodes.

Mirap (Mirtazapine) pricing details are as follows:
- Mirap 15mg Orodispersible Tablets - €13.64
- Mirap 30mg Orodispersible Tablets - €27.24
- Mirap 45mg Orodispersible Tablets - €40.86

This presentation is fully reimbursable under the GMS.

The brand leader is 25% per cent more expensive than MIRAP Orodispersible Tablets 15mg, 30mg and 45mg.

For further information contact Rowex Ltd, Bantry, Co. Cork. Freephone 1800 304 400, email rowex@rowa-pharma.ie

Bayer Schering Pharma’s new low-dose oral contraceptive YAZ has been approved and is now available in Ireland. YAZ is the first oral contraceptive on the Irish market containing the unique progestin drospirenone combined with a low dose of ethinyl estradiol in a new dosing regimen of 24 days of active hormone tablets and four days of placebo.

YAZ is an innovative 24+4 dosing regimen that provides women with three additional days of antimineralocorticoid and antiandrogenic activity. This extended delivery system also results in a reduction of hormonal fluctuations which often occur with conventional 21+7 OCs. Clinical studies demonstrate that a shortened hormone free interval of 3-4 days provides many benefits and reduces the frequency of side effects that commonly occur with traditional 21+7 regimens. YAZ effectively improves the emotional and physical symptoms associated with the menstrual cycle (headaches, breast tenderness, bloating) and improves skin condition.

Welcoming the launch of YAZ, Dr. Tina Peers, Specialist in Contraception and Reproductive Healthcare said, “Ongoing research and development in the area of women’s health is resulting in the introduction of innovative and unique products like YAZ. A first in class, YAZ’s unique 24+4 dosing system will be particularly important for women who typically experience hormone fluctuations and withdrawal symptoms more commonly seen with the conventional 21+7 OC. This new dosing regimen provides three additional days of antimineralocorticoid and antiandrogenic activity which is shown to improve the emotional and physical symptoms associated with the menstrual cycle and also moderate acne. I think YAZ will be a very attractive option for Irish women.”

YAZ is a safe and well tolerated oral contraceptive offering women excellent cycle control comparable to other low dose combined OCs. YAZ, with its 24-day regimen and the mode of action of its progestin drospirenone, offers more benefits to women which have resulted in high levels of patient satisfaction.

Dr. Mary Short, Specialist in Women’s Health, Dublin stated, “Research has shown that one in five young women forget to take their pill at least twice a month. With over 220,000 unplanned pregnancies worldwide everyday, the importance of taking the pill at the right time must not be understated. The new everyday regime may help in this regard as there is no break from the pill: you take one everyday. With the pills that are currently available, women often forget to restart their pill at the correct time after the 7-day break.”

For Further information on YAZ, please contact Lucy McGillion on 01 2999313
SPONSORED BY

Wyeth
Consumer Healthcare

Congratulations to the winner of last month’s crossword, Marie Rolls, Clounaloul Medical Centre, Oakpark, Tralee, Co. Kerry.

Please send your answers to the Editor, Nursing in General Practice, GreenCross Publishing, Lower Ground Floor, 5 Harrington Street, Dublin 8. Closing date for entries: 23rd March 2009.

Winner will receive €50.

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

ACROSS
1. Neck vein could have a few balls in the air, we hear. (7)
4. Send a new South American range. (5)
7. Dip is in stew – how tasteless! (7)
8. Inspector soon reveals human trunk. (5)
10. My robe developed for a foetus. (6)
12. Method of birth control requiring a beat? (6)
15. Is snide, perhaps, for guts? (7)
17. Ms Malone. (5)
19. Eric, the deviant with sacrilegious views. (7)
20. No hollow matter. (5)
21. A salt, we hear, for battery. (7)

DOWN
1. Low dive for knee, elbow etc. (5)
2. Spy role treated a tropical disease. (7)
3. Arm bone half the width of a circle? (6)
4. Farewell to a dew, we hear. (5)
5. Local vernacular confuses idle cat. (7)
6. Ray bans emu controversially. (7)
10. Ed riots in disturbance for newspaper bosses. (7)
11. A shy dwarf! (7)
13. The funny bone? (7)
14. Is maths a formula for a breathing problem? (6)
16. Do get Des back, now that he’s taken his medicine. (5)
18. Sailing boat could make Cathy nauseous. (5)

Name: ____________________________
Address: ___________________________
Email: ____________________________

ANSWERS TO LAST MONTH’S CROSSWORD

ACROSS
1. Neck vein could have a few balls in the air, we hear. (7)
4. Send a new South American range. (5)
7. Dip is in stew – how tasteless! (7)
8. Inspector soon reveals human trunk. (5)
10. My robe developed for a foetus. (6)
12. Method of birth control requiring a beat? (6)
15. Is snide, perhaps, for guts? (7)
17. Ms Malone. (5)
19. Eric, the deviant with sacrilegious views. (7)
20. No hollow matter. (5)
21. A salt, we hear, for battery. (7)

DOWN
1. Low dive for knee, elbow etc. (5)
2. Spy role treated a tropical disease. (7)
3. Arm bone half the width of a circle? (6)
4. Farewell to a dew, we hear. (5)
5. Local vernacular confuses idle cat. (7)
6. Ray bans emu controversially. (7)
10. Ed riots in disturbance for newspaper bosses. (7)
11. A shy dwarf! (7)
13. The funny bone? (7)
14. Is maths a formula for a breathing problem? (6)
16. Do get Des back, now that he’s taken his medicine. (5)
18. Sailing boat could make Cathy nauseous. (5)
How do you quickly diagnose and relieve Cow’s Milk Allergy (CMA) when the symptoms can be so diverse?

<table>
<thead>
<tr>
<th>GASTROINTESTINAL</th>
<th>Reflux • Diarrhoea • Vomiting • Constipation • GORD</th>
</tr>
</thead>
<tbody>
<tr>
<td>DERMATOLOGICAL</td>
<td>Eczema • Rash • Urticaria</td>
</tr>
<tr>
<td>RESPIRATORY</td>
<td>Excessive Crying/Irritability • Wheezing • Distress</td>
</tr>
</tbody>
</table>

Choose Neocate!

Neocate is the best way to diagnose, relieve and manage Cow’s Milk Allergy

Relieves symptoms in 3-14 days1-4

- Hypoallergenic amino-acid based formula
- Proven to promote catch-up growth5
- Suitable from 0-12 months
- Manufactured in a milk protein-free environment

References on request.

Trust Neocate: Trust 25 years of experience

For more information on Neocate, freephone our Careline on 1800 34 11 11
Nutricia, Block 1, Deansgrange Business Park, Deansgrange, Co Dublin.

www.neocate.ie | www.actagainstallergy.ie