NURSE AND MIDWIFE PRESCRIBING IN GENERAL PRACTICE
*Ruth Morrow*

**Structured Patient Education for People with Type 2 Diabetes**
*Sally-Ann McLaughlin*

**Epilepsy: Diagnosis and Treatment**
*Sinead Murphy*

**Minimising Pseudohyperkalaemia in Cold Weather**
*Darina Lane*

**Q and A**
*Lisa Nolan*
*IPNA Administrator*
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By the end of January, we will have received our first pay cheque with the December 2010 budget changes. We are now working harder than ever for less money and no doubt there are more cuts down the line. More and more work is being landed on us in primary care. We are being asked to carry out monitoring of patients on chemotherapy, drug therapy such as methotrexate and other disease modifying drugs. Our surgeries are bulging at the seams with seasonal viral illnesses and infections which are prevalent at this time of year. Not to mention, the volume of work including cervical screening, childhood immunisation, influenza immunisations and chronic illness management that we all take in our stride everyday.

My public health nursing colleagues tell me the same is happening in the public health arena with earlier discharges and lack of respite services. This coupled with reduced home care support services and cuts in mileage allowance challenges the public health nurse on a daily basis. Frequently, I ask myself, how much more is going to be pushed into primary care and how much more can be taken on without adequate funding and resources. Do we have to wait until a serious incident occurs before managers realise that it is human life and standards of care that are being affected?

I fully support the idea that the majority of healthcare is best delivered in the community, particularly the areas of health promotion, illness prevention, lifestyle management, and the management of long term conditions. Many practice nurses have up-skilled themselves through ongoing professional development in their own time and at their own expense. I often wonder have we up-skilled and professionally developed ourselves so much to our detriment? In other words, have we invited all this extra work into primary care?

Many patients over the years have said to me that the reason they joined our practice was because there was a practice nursing service as they had already experienced the service in the UK or elsewhere in Ireland.

Despite the constraints we find ourselves working within, we must continue to provide a standard of care to our patients which we would like to receive ourselves. To do this will be challenging and stressful. We must also remember to look after ourselves within all this mayhem and maintain our own optimal health.

I wish you all a happy, healthy and peaceful 2011.

Ruth Morrow
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Twenty high tech nursing jobs over next two years

Unipharm Group, a provider of services to the healthcare and pharmaceutical sectors, has announced the creation of 20 new high-tech nursing jobs over the next two years. In so doing Unipharm has agreed to a long-term partnership with high-tech primary care network Point of Care.

The partnership follows a successful round of investment in Point of Care, and is likely to result in an increase in Point of Care’s distribution network across Ireland.

“This agreement will allow Point of Care to expand our community care services for our patients, as well as creating 20 new high-tech nursing roles over the coming 18-24 months.

“The partnership strengthens our distribution network and pharmacy capabilities across Ireland,” said Jim Joyce, CEO, POC.

POC provides one-to-one nursing care within the local community and delivers patient services through infusion, injection and vaccinations, helping patients to deal with illnesses such as arthritis, Crohn’s disease and MS.

HSE National Dementia Education Programme launched

The HSE National Dementia Education Programme launched in December is a generic education programme designed and developed to identify gaps in dementia specific education and training to nurses and non-nursing staff working across all care services.

The programme is supported by a National Dementia Education Needs Analysis Report and Evaluation pilot programme, the findings of which informed the Dementia Education Programme Manual: An Introduction to Dementia Care which was also launched at the event. The manual will guide the implementation of educational programmes in care settings nationally.

Professor Diarmuid O’Shea, Clinical Care Lead for the Elderly Care Programme and Consultant Geriatrician, St Vincent’s Hospital chaired the launch of the National Generic Education Programme and welcomed the official launch of the three publications.

The education programme was piloted in the HSE West and was externally evaluated for the purposes of the national roll out. The evaluation report details a comprehensive account of the views of the participants and facilitators’ experience of the programme content and delivery. The impact of the programme on staff knowledge and attitudes to dementia along with managers’ views on the impact of the programme, on their organisation/area of work is also captured in the report.

Mary Manning, Project Manager, National Dementia Programme said, “We are delighted to launch the three publications here today. It is very encouraging that the findings from the pilot programme indicate that the participants’ attitudes and knowledge towards dementia were positively influenced by the programme.”

Dr O’ Siobhan O’Halloran, Director of the Office for Nursing & Midwifery Services Directorate warmly welcomed the development of the dementia education programme. She said “The programme content and design of the generic programme reflects the areas identified in the national needs analysis study carried out as part of the project. This is the first time, on a national level, that we have, such comprehensive information gathered and analysed from staff, working across all care groups, on their educational needs in dementia care. I wish it every success in its implementation.”

Dr Siobhan O’Halloran Director of the Office for Nursing & Midwifery Services Directorate; Josephine McDonald – Service User; Minister Mary Harney TD; Professor Diarmuid O’Shea – Clinical Lead for the Elderly Care Programme Consultant Geriatrician, St Vincent’s Hospital and Mary Manning – Project Manager National Dementia Programme.

For more information contact:
Lisa Nolan, IPNA Administrator. Tel: 042-9692403
e-mail: admin@irishpracticenurses.ie
Gestational diabetes mellitus guidelines launched

The national HSE 'Guidelines for the Management of Pre-gestational and Gestational Diabetes Mellitus from Pre-conception to the Postnatal period' were launched recently by Professor Richard Firth in August this year.

The guidelines were brought about through the HSE Diabetes & Pregnancy project which aims to enhance services for women with diabetes in pregnancy and to increase awareness of the possible risks associated with diabetes and pregnancy to both health professionals and women of child-bearing years.

The guidelines are aimed at all health professionals who care for women with diabetes and those at risk of gestational diabetes and they have been endorsed by all the relevant professional groups.

The guidelines are available on the following HSE sites:
- http://hsenet.hse.ie/Library/HSE_Publications/
- http://www.hse.ie/eng/services/Publications/
- http://www.hse.ie/eng/services/Publications/topics/Diabetes/
- http://www.lenus.ie/hse/handle/10147/112890

Over 120,000 women receive BreastCheck mammogram


Free mammograms were provided to 121,160 women aged 50-64 – the highest number of women screened by the programme to date, and almost double the number of women screened in 2007. The overall acceptance of invitation to screening was 75.7 per cent, in excess of the programme target of 70 per cent.

Of the 121,160 women screened, 5,600 were re-called for assessment. Eight hundred and forty-five women were diagnosed with breast cancer, representing 7.0 cancers per 1,000 in 2009.

For subsequent invitations (women who have previously been screened by BreastCheck), there is little difference between the age groups, with a high rate of uptake recorded across all.

Commenting on the publication of the report, Tony O’Brien, Director of the National Cancer Screening Service said: “The expansion of BreastCheck into the south and west of the country has resulted in BreastCheck providing free mammograms to almost twice as many women in comparison to the number of women screened in 2007. Over 121,000 women attended a BreastCheck appointment, representing a 32 per cent increase on 2008 and an 82 per cent increase on 2007. The programme is performing consistently well against the majority of commitments in the BreastCheck Women’s Charter. While the programme faced some challenges in expanding the service nationwide, I am delighted that we are now offering a fully quality assured breast screening service to all eligible women aged 50-64, regardless of their location”.

To date, BreastCheck has provided over 690,600 free mammograms to over 325,700 women and detected over 4,300 breast cancers.

Stress caused by financial worries leading to increased levels of teeth grinding

Dentists believe that the increased levels of bruxism – the medical name for teeth grinding – are due to stress brought on by patients’ financial worries.

Experts believe one in five people will grind their teeth at some time, most commonly at night but dentists here say they are seeing numbers far in excess of that in many surgeries.

The symptoms of bruxism include; headaches, damage to teeth, earaches, and mouth and jaw pain.

Dr Dermot Canavan of the Irish Dental Association says the condition is often linked to anxiety and stress, as well as excessive smoking, alcohol use and the consumption of too much coffee.

‘While we don’t have exact figures I know from my own practise and from talking to other dentists that there has been a substantial increase in the number of patients suffering from this condition. From talking to patients it is clear many are facing severe financial pressures’ Dr Canavan said.

He pointed out that recreational drug use, particularly amphetamines, cocaine and ecstasy, are also believed to lead to increased clenching and grinding activity and this can cause an increase in tooth wear up to eight times greater than that seen in other bruxers.

‘Stress and drug use are a dangerous combination at the best of times but people often do not realise the effect this can have on their dental health not to mind their mental health. If people are suffering from any of the symptoms outlined above then not only should they see their medical doctor but also they should visit their dentist for a check up as soon as possible as bruxism can cause long term damage. There are a variety of treatments available including splints and fitted mouth guards, but damaged teeth may need to be restored’ Dr Canavan concluded.
First nurse group can independently prescribe x-ray

The first group of registered nurses who can independently prescribe medical ionising radiation in Ireland have graduated at a ceremony in Stewarts Hospital, Palmerstown recently.

66 registered nurses in Ireland from 20 hospital sites across the country have completed the nurse education programme for Nurse Prescribing X-Ray. The nurses who have completed the programme represent the various grades of nurses to include staff nurses, clinical nurse managers, clinical nurse specialists and advance nurse practitioners who are in various departments such as emergency departments, orthopaedic, out patients, critical care, medicine and oncology.

Nurse prescribing of medical ionising radiation (x-ray) enables the nurse to prescribe x-rays independently within the agreed list. This practice enables nurses to provide a more responsive, accessible, effective, timely and efficient service that improves and expedites the patient journey within the healthcare service leading to increased levels of patient satisfaction. In addition, it provides an exciting opportunity for registered nurses to expand their roles within the area of practice to meet the needs of the patients in a person-centred manner.

The Nurse Prescribing X-Ray Education Programme was introduced in 2009 following the completion of a HSE national framework (The Guiding Framework for the implementation of a Nurse Prescribing of Medical Ionising Radiation/HSE) by the national advisory committee lead by Dr. Siobhan O’Halloran, Office of the Nursing Services Director. The educational programme was devised by a multi disciplinary team to include nursing profession consultant Radiologists, Radiographers and physicists.

A robust evaluation and auditing of the nurse prescribing of medical ionising radiation will take place at each hospital site. The educational programme has been validated by HETAC and the role out has commenced in two accredited centres based at Connolly Hospital and the Midland Regional Hospital at Tullamore. A new cohort of 33 participants commenced the programme in October this year. It is anticipated that 220 nurses will complete the programme by 2012.

New support for amputees and carers

Amputee Ireland (Amputee Disability Federation Ireland) has launched a brochure of essential information on the services and supports available to the over 4,000 amputees in Ireland. The purpose of the new resource is to provide essential information and support to an amputee on adjusting to the loss of a limb, using a prosthesis and managing pain and other sensations. The resource also provides information on the support available for the families and carers of amputees.

Mr Michael McWilliam, Amputee Ireland commented: ‘Amputee Ireland is a charity representing the interests of over 4,000 amputees in Ireland. An amputee needs specific support structures to help adjust to the loss of a limb. Experiencing an amputation is traumatic. However, an amputee in Ireland is not alone. There are a number of agencies who can help and support an amputee to continue to live their life independently. I am delighted that we can, for the first time, now provide amputees with this essential information in one resource. This booklet aims to support and to empower amputees to help them on the road to recovery and independence.’

The booklet, written in simple language and approved by the National Adult Literacy Association provides specific information on medical costs and the financial supports available, adapting a home or office, dealing with transport and driving, working and individual rights.

The information brochure can be downloaded at www.amputee.ie or is available on request from info@amputee.ie. Amputee Ireland was set up to help amputees achieve independence, participation, social and occupational integration in the life of the community and encourages new members to join. Membership is free and an application can be downloaded at www.amputee.ie. The charity is currently campaigning for the provision of free prostheses to amputees in Ireland.

For more information contact: Amputee Ireland (01) 679 3580. Email: info@amputee.ie
Antibiotic Effects

It is well known that antibiotic intake may have an effect on the gut microflora leading to diarrhoea. Antibiotic Associated Diarrhoea (AAD) may develop in up to 30% of patients treated with antibiotics, and rates have been increasing due to use of broad-spectrum antibiotics1. *Clostridium difficile* Associated Diarrhoea (CDAD) accounts for up to 25% of cases of AAD, most occurring in older patients2,3.

Probiotic Support

According to an independent clinical trial conducted at Hammersmith hospital, London and published in the *British Medical Journal*, drinking Actimel twice a day while on antibiotics in hospital, significantly reduces the incidence of Antibiotic Associated Diarrhoea by 22% and *Clostridium difficile* Associated Diarrhoea by 17%4 in the elderly.

For more information visit [www.probioticsinpractice.ie](http://www.probioticsinpractice.ie)
Conference on ‘true compassion’

The HSE (through St. Patrick’s Hospital in Cashel, Co. Tipperary) and the European Pathways Association joined forces recently to jointly host their second annual Conference at the Cashel Palace Hotel, entitled True Compassion.

The Conference was, in the words of the organisers, "hugely supported" by patient advocates and healthcare professionals. The European Pathways Association is an international not-for-profit organization of clinical care pathway networks, user groups, academic institutions, supporting organisations and individuals who want to develop, implement and evaluate clinical and care pathways.

Mr. Séamus Moore (Local Health Manager for South Tipperary, HSE) said: “This prestigious Conference in Cashel occurred at a very opportune time, as healthcare staff grapple with the current economic crisis. We had a varied, high quality line up of speakers to assist us in developing the theme. The purpose of the conference was to open up avenues which healthcare staff might find useful in maintaining a sense of purpose of their role in healthcare and to further develop the health, wellbeing and safety of the patients, residents and clients in their care. The values outlined help to connect healthcare staff with their own internal personal goals, strengths, motivation and job satisfaction needs, transcending personal status to focus on internal personal motivation to do the best job for something (their patients) which is greater than themselves. Compassion, of course, plays a central role in all of this.”

Ms Mary Prendergast – as Director of Nursing – said the staff and everyone associated with the elderly care facility in Cashel were pleased to have helped organise a second annual Conference, as St. Patrick’s Hospital was founded on connecting care and efficiency. Ms. Prendergast added: “True Compassion is not just an emotion but a firm commitment. We were delighted to read a message to the Conference from the famous actor Brendan Gleeson, who wrote that compassion was the heartbeat of the health service and therefore requires, of the most part, time. Time to comfort, time to reassure, time to understand, time to console, time to analyse, time to diagnose and time to rehabilitate.”

Josie Sheehan, a retired woman from Dublin 8, helps to launch a new publication documenting ageing research in Ireland by the Centre for Ageing Research and Development in Ireland.

New publication gives picture of ageing research in Ireland

The portrayal of older people in advertising; the use of technology to enable older people to live independently; bridging the digital divide through intergenerational learning; and genetic susceptibility to Alzheimer’s disease – these are just some of the topics related to ageing being investigated by researchers in Ireland, as documented in a new publication launched at end of last year by the Centre for Ageing Research and Development in Ireland (CARDI).

The publication, ‘A Picture of Ageing Research’, outlines for the first time ever, major collaborative ageing research projects underway on the island of Ireland. It profiles ageing research work being carried out by the leading academic institutions in Ireland, North and South, and also includes details of projects funded under CARDI’s Research Grants Programme.

Commenting on the publication, Dr Roger O’Sullivan, Director of CARDI, said it would serve as a useful resource for politicians and policymakers, in addition to researchers, older people and others with an interest in ageing.

“The island of Ireland is an ageing society with nearly one million people aged 60 years or older,” he said. By 2041, the number of people aged 85 years or older will rise almost fivefold. Ageing on this scale is unprecedented and will have significant consequences from both a societal and an economic point of view.

“Policy, practice and resource allocation decisions must be made on the best available information, and it is essential that ageing research plays a part in planning for demographic change. In order to adapt, we must better understand the role of older people as citizens, consumers, carers and – increasingly – as workers.

‘A Picture of Ageing Research’ is available to download from: www.cardi.ie Hard copies of the publication may be requested by emailing info@cardi.ie or telephoning 0044-28-90690066.
The only solution for childhood pain and fever
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Sugar & Colour Free
Reduces Temperature

Made in Ireland
Nurses and GPs required for obesity study

Nurses and GPs throughout the island of Ireland are invited to participate in a research project. An all-Ireland project led by researchers in University of Ulster and National University of Ireland, Galway are conducting a survey of health professional attitudes to body weight status. The key project objectives are as follows: 1. To assess the attitudes, current practices/behaviours and knowledge of key health professional groups on an all-island basis; 2. To assess the health professional groups’ ability to identify body weight categories in both adults and children.

The health professional groups that are invited to participate:
1. Public Health Nurses (community; postnatal home/clinic visits and developmental checks);
2. Public Health Nurses (Schools);
3. GPs and Practice Nurses (primary care);
4. Occupational health nurses (workplace).

Nurses and GPs are required to participate in the following studies:
1. Telephone interviews with GPs (10 mins) – to gain an in-depth insight into the views of health professionals in assessing body weight status.
2. Focus group with nurses (max. 1.5 hour) – to gain an in-depth insight into the views of health professionals in assessing body weight status. The focus groups will take place in health clinics/centres, hospitals or universities within the greater Belfast or Galway areas.
3. Survey (mainly on-line but also paper-based; 10-15 mins) – to determine the attitudes, current practices/behaviours and knowledge of health professionals in assessing body weight status.
4. Online study (45 mins) – an on-line programme will be developed to assess health professionals’ ability to identify the body weight category of adults and children.

If you participate in any of the above studies, you will be part of a valuable project, which will contribute to assessing health professionals’ ability to identify body weight categories in both adults and children. Ethical approval has been obtained for this project.

Contact details
If you would like further information or to discuss participating in any of the above studies please do not hesitate to contact the Weight Care Team using the following contact details:
Website: www.science.ulster.ac.uk/weightcareproject
E-mail: weightcareproject@ulster.ac.uk
Tel: +44 (0) 28 9036 6282
Dr. Anne Moorhead (Principal Investigator) & Weight Care Team

STOPP/START – better prescribing for patient safety

A new medication review system has the potential to reduce the prescription of unnecessary, or potentially harmful, drugs to older people in hospital, thereby improving patient safety and substantially reducing prescription costs.

Researchers in UCC have confirmed the validity of a new medication review system, called STOPP (Screening Tool of Older Persons’ potentially inappropriate Prescriptions) and START (Screening Tool to Alert to Right Treatment).

It was created to help doctors and pharmacists avoid potential prescribing errors in older patients and to highlight when practitioners do not prescribe medication that would actually be of benefit to this age group.

The research looked at clinical and prescription details relating to more than 700 older patients in an acute hospital setting and applied the STOPP/START criteria.

“We found that one in every three of these patients received at least one potentially inappropriate drug,” said lead researcher Dr Paul Gallagher.

“A third of this group displayed symptoms attributable to adverse side effects of inappropriately prescribed drugs. We also found that over 40 per cent of patients were not receiving appropriate medication for common conditions including diabetes, stroke and osteoporosis.”

“By comparing the findings with similar cohorts of patients in six other European cities and getting similar results, the UCC group has helped to highlight the issue of inappropriate prescribing internationally as part of the global need to improve the quality and safety of prescribing practices.

STOPP/START recommendations and criteria have now been implemented as an audit tool in several countries, resulting in significant improvements in prescribing quality. Further research is underway to find out if routine application of STOPP/START criteria reduces adverse drug reactions and prescription costs among older people admitted to hospital.

Funded by the Health Research Board (HRB) the information on this research is contained in ‘The Picture of Health’ a snapshot of the positive impacts and outcomes from HRB funded research in 2009.

Asthma poorly controlled in children

Some 97 percent of parents of children treated for asthma believe their child’s symptoms are well controlled or partially controlled, despite the fact that 10 percent of these children still cough or wheeze on a daily basis, 13 percent on a weekly basis and 49 percent on a monthly basis. The results are part of a survey of 271 parents of asthmatic children (under 1-18 years) carried out by MSD Ireland through Irish parenting website, RollerCoaster.ie.

Despite significant advances in managing the condition, results show that asthma continues to be inadequately controlled in over 26 percent of those affected. One in four asthmatic children are found to experience reduced levels of activity, such as lower participation in sport, while the condition results in 27 percent of those affected being absent from school on a monthly basis (or more frequently).

According to the survey, the most common difficulties faced by parents include an inability to control triggers that affect their child’s symptoms (e.g. pollen, dust and air pollution), difficulties in knowing how best to treat the condition and difficulties in administering the medication.

Recent research carried out by MSD shows that over 26 per cent of asthmatic children in Ireland could benefit from better management of their condition. Results show that one in four asthmatic children experience reduced levels of activity, such as lower participation in sport. Pictured on a day out at the park are TJ Hannify (aged 3), Mark Turley (aged 9) and Rebecca Walsh (aged 4) from Dublin.
Roche donate rheumatology equipment

Pictured at St James’s Hospital for the donation of essential medical equipment to the hospital by Roche Products were Ciara O’Loughlin, Rheumatology Nurse Specialist, Dr Gaye Cunnane, Consultant Rheumatologist, D. Barry O’Shea, Consultant Rheumatologist, all with St James’s Hospital, Dublin, and Catherine Moynagh, Roche Representative.

As part of their ongoing commitment to Irish healthcare, Roche Products (Ireland) Limited donated the equipment to the Rheumatology Day Care Centre of St. James’s Hospital, Dublin. The equipment donated consists of a blood pressure monitor and an infusion pump, enabling more patients to gain access to rheumatology treatments.

Free information pack for prostate sufferers and carers

The launch of the free Astellas Pharma Living with Prostate Cancer information pack took place in December. The pack was launched by actor Tom Hopkins (aka Christy in Fair City), John Dowling, prostate cancer survivor, Lillian McGovern, CEO of The Marie Keating Foundation and Ms Aine Brady, Minister for Older People and Health Promotion.

With over 2,500 men diagnosed with prostate cancer in Ireland each year, the initial diagnosis period can be difficult for the patient and their family to take in all the information they need. In answer to this Astellas Pharma produced the free prostate cancer information pack which provides easy to read, understandable, friendly and essential reading for sufferers, family and friends of those affected with prostate cancer.

Entitled Living with Prostate Cancer – The Patient Support Pack it is available free of charge by calling 01 6697684. The patient support pack covers a number of key information areas. The additional aim of the Pack is to heighten awareness of the symptoms in order to encourage potential prostate suffers to seek treatment, increase their knowledge of support services available and also to be used as a patient information tool.

“We welcome this initiative and are pleased to support Astellas in a campaign to provide prostate cancer sufferers with information that is provided to them rather than the patient or his family members having to seek and find. Information at the time of diagnosis is crucial; it can help to keep emotions calm during a difficult period. This booklet will allow a sufferer or their family member to sit down at their own pace and review the road ahead” said Jim Scott, chairman of Men Against Cancer (MAC).

United Drug supporting the Special Olympics

United Drug plc., presented a cheque for €31,000 to Special Olympics Ireland recently. United Drug were Official Medical Supplier to the Games this year. Speaking at the cheque presentation, United Drug Chief Executive Liam Fitzgerald said:

“I am delighted and proud that United Drug, as part of our ongoing corporate responsibility and community engagement programme, was very actively involved and an Official Supplier for the 2010 Special Olympics Ireland Games. In addition to the medical supplies, expertise and monetary contribution, a large number of employees also gave their time to be volunteers for this uniquely worthy cause. This was an exceptional opportunity for us to contribute to the success of the Games and the celebration of Ireland’s talented athletes”.

Staff members of United Drug, including Chief Executive Liam Fitzgerald and partnership co-ordinator Bronagh Boyd presenting the cheque to Joe Feeney Special Olympics athlete and Matt English CEO Special Olympics Ireland.
CAVAN/MONAGHAN

PATRICIA JENKINS

Our November meeting was held in Cavan Crystal Hotel and the topic was COPD. This included current guidelines for diagnosis and an update on current approaches to COPD. Dr James Hayes, consultant respiratory physician at Cavan General Hospital gave the talk which was sponsored by Deirdre O'Doherty from Pfizer. This was followed by our branch meeting and was very well attended.

Our Christmas meeting which was to be held on 8th December was unfortunately cancelled due to poor weather conditions.

The HSE provided update days in January and February on diabetes for those nurses who have previously undertaken the Bradford Diabetic Diploma course.

Our meetings have been very well attended over the past year and I personally look forward to seeing you all again in 2011. On behalf of Cavan and Monaghan members I wish you all a happy and peaceful 2011.

CLARE

AINE LALLY

The Clare branch would like to wish everyone a healthy and happy new year. We held our AGM in November and were delighted to re-elect Anne Akamnonu as Chairperson, Patricia Dolan and Liz Ryan as joint Secretaries and Carmel Killeen as our Treasurer. We would really like to thank Anne and the girls for their great work and support during the last year and look forward to all that the new year brings.

Our November meeting at the Old Ground, Ennis was kindly sponsored by Chris Kenny of Johnson and Johnson. We had a very informative talk on smoking cessation by Mary McMahon of Clare Health Promotion services. We do need to remember to make use of smoking cessation officers in our localities. For our December meeting we danced the night away at our Christmas party in Dromoland Castle. For our next meeting on January 18th we plan to have a CPR refresher for all our nurses.

CORK

ELAINE GOGGIN

On behalf of the Cork Branch Committee I want to wish you all the very best of health and happiness for 2011. Our branch AGM was held in November in the Rochestown Park Hotel kindly sponsored by Rose Howard from Milupa. The speaker was Margaret Byrne, Infant Nutritionist, who gave a very informative presentation on the role of prebiotics in infant feeds. 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 and also many thanks to those who stayed on for another year. Guest speaker, Lorraine O’Hagan, was invited by the Branch and gave a very interesting presentation on how best to encourage and support breastfeeding.

There was such a level of interest in this area, that Lorraine has agreed to do a Saturday morning session in the near future.

Unfortunately due to the extreme weather conditions our December meeting which was also our Christmas night had to be cancelled. We would hope to reschedule this now that the weather has settled down.

There is a busy schedule of meetings are planned for Spring 2011 so we hope to see you all at the next Cork Branch meeting which will take place in the Rochestown Park Hotel on Wednesday the 9th February and will be kindly sponsored by Sara Hyde, McNeil Health. Guest speaker is Joan O’Sullivan, Smoking Cessation, Coordinator, HSE.

KILKENNY

LEONIE FINNEGAN

Unfortunately, our last branch meeting and educational session was postponed due to the severe snow and ice in Kilkenny and its surrounds. However, we would like to take this opportunity to thank all members for attending throughout this year.

We look forward to the coming year for ongoing support, networking opportunities and educational presentations. Looking forward to seeing you all soon in 2011. We always welcome new regional members at any time so please feel free to contact our secretary Úna by email; umstapleton@gmail.com

NORTH DUBLIN BRANCH

LIZ HEALY

Happy New Year to everyone! The North Dublin branch has been up and running since August of last year. It has been given this name as the meetings are being held on the north side of Dublin, mainly in the Hilton Airport Hotel, Northern Cross and the Bewley’s Hotel, Clonsaugh, with easy access from the M1/M50. We welcome all practice nurses from Dublin and at present we have 33 members.

Our meeting in November was sponsored by Pfizer, with our guest speaker giving an excellent presentation on childhood obesity. December’s meeting was an informal affair, sponsored by Novartis, with a talk on COPD.

Topics for 2011 will include: Infertility, Vitamin D, Immunisations, Osteoporosis and Fractures, Menopause, Haemochromatosis.

Best wishes for 2011.
**SOUTH TIPPERARY**

**SIOBHAN JORDAN**

Happy New Year to all IPNA members – here’s hoping 2011 will see our branch grow in strength and numbers. Although we are one of the smaller IPNA branches our meetings are well attended and we are all working hard to bring new members to the group by providing interesting educational sessions which will encourage us all to leave our cosy homes during these colder months.

Our next meeting will be held on 12th January in the Clonmel Park Hotel and is kindly sponsored by Karen O’Sullivan of Smith and Nephew. The presentation will cover wound care, profobe dressings and layered bandaging systems; our AGM will follow. A full list of scheduled meetings, educational sessions and upcoming events in south Tipperary is available on the members’ page of IPNA website.

The national conference and AGM will be held this year in the Tullamore Court Hotel, Co Offaly. After careful consideration the south Tipperary branch is pleased to be the first branch to host the national conference at a centralized location. Although members will not be travelling to the premier county, we can guarantee you all that south Tipp will be very pleased to welcome you in Tullamore. A few busy months ahead of us as we work with Grainne Lynch conference co-ordinator to encourage as many of you as possible to attend this year, … And no, it is not a long way to Tipperary!

**WICKLOW**

**MARY FINNEGAN**

Happy New Year to all! Hope everyone had a wonderful Christmas and New Year, in spite of snow!

We started our branch ‘year’ with a meeting on 20th September. The topic for the night was Women’s Health, HRT, Menopause, Contraception. Our excellent speaker was Dr Deirdre Lundy from the Bray Women’s Health Centre, who has worked in this area for over 20 years – 16 of these with IFPA. Deirdre also lectures for ICGP, IFPA and RCSI on Women’s Health issues. She gave a wonderful presentation, and was more than happy to answer all our questions. The meeting and speaker were very kindly sponsored by Brenda Blewitt from Bayer Healthcare, our Mirena Rep for this area. Brenda opened the meeting with an update on Mirena, and her colleague, Colleen Murray, gave us an introduction to Qlaira, the new OCP. The meeting was very well attended, with 28 of our 49 members present.

We had our second meeting booked for 29th November, but the snow decided otherwise! We had no option but to cancel, and we rescheduled for 13th December. Our topic that night was childhood obesity. Guest speaker was Kizzy Moroney Paediatric Dietitian Temple Street Hospital. Kizzy runs the ‘Weigh to Go’ programme for children. The meeting and speaker were sponsored by Jennifer Dalton Infant Nutrician Advisor SMA

A special thank you to both Kizzy and Jennifer, for making themselves available for 13th after we had November meeting at very short notice! The topic was very interesting, and informative, as we had not been aware of this programme, or how to refer a child to it. Embarrassingly, only five out of our 49 members attended that meeting! Both speaker and sponsor were disappointed at the very poor attendance.

Our Branch AGM was planned for 13th December, but due to poor attendance, we were unable to hold it, and it had to be rescheduled for the new year.

By time you read this, we will have held our January meeting on 17th. This meeting is very kindly sponsored by Jacqueline Jennings from GSK, who will open the meeting with a presentation on Proleia, the new Osteoporosis Rx. Our guest speaker is Dr Anne Manley, from the Osteoporosis Society, who will speak on Treatment and Management of Osteoporosis in Ireland.

Our rescheduled Branch AGM hopefully, will have taken place on 17th January, and a new Committee elected!

The next Branch meeting will be held on Monday 28th February, with two more planned for April and May. Details of all meeting dates were sent to members in August last year, and are also up on the IPNA website, should you forget!

Several of our members had requested a CPR/AED (BLS) course at the September meeting, as their current certification was due to expire. I was delighted to be able to organise this for them, with the help and thanks of the Nurses in the Cardiac Unit in SCH, who have also very kindly offered the course, on a once off basis, at a reduced rate. The course is limited to 12 participants, and will be held on Saturday 29th January in SCH, running for 4 hours.

As mentioned before, we now have 49 members in the Branch, a big change from our previous 18! Again, I would like to welcome all new members to our branch, and look forward to meeting you all at the meetings. Over the past few months as numbers increased, the meetings have become more interactive, with a lot of sharing of information and networking has taken place which is particularly helpful if you are new to practice nursing, or work alone in a small practice.

Feedback from new members has been very positive, and I thank you all for your kind words!

If YOU have not already come to one of our educational meetings, perhaps you might join us this year? We are a very friendly, informal branch, and meetings usually only take two hours!

Wishing you, and all your families peace, friendship, good health and no worries for 2011!

**CORRECTIONS**

**North Dublin**

Apologies for our failure to publish the North Dublin news as written by Liz Healy in the last issue. Sorry for any disappointment caused.

**Clare Branch**

Also in the last issue we inadvertently put ‘Tipperary’ instead of Clare as the heading over the Clare branch news. Apologies for the mix-up.
Nurse and midwife prescribing in general practice

RUTH MORROW, MSC, BNS, RGN, RNP, ADVANCED NURSE PRACTITIONER

In 2009, we decided to introduce nurse and midwife prescribing into the practice. The main reasons for its introduction were:

- To assist in the provision of holistic patient care which is timely, accessible and efficient
- To assist in cost-effective prescribing within the practice
- To ensure patient safety in medication management
- To assist in the professional development of the Advanced Nurse Practitioner (ANP)
- To assist in further development of the ANP role and ANP services within the practices as outlined by the National Council for the Professional Development of Nurses & Midwives (2008).

This article aims to inform you about the introduction of nurse prescribing in the general practice setting and the experiences I had during the process. From the beginning, to signing my first prescription, took 14 months in total. The required education programme is of six months duration with the remainder of the time being spent on accessing the Drugs & Therapeutics (D & T) committee and the development of the Collaborative Practice Agreement (CPA) (An Bord Altranais, 2007a). One of the key components of nurse and midwife prescribing is governance and accountability and this will be discussed further in the article.

Nurse prescribing is guided by legislation, regulation and rules which include:

- Irish Medicines Board (Miscellaneous Provision) Act 2006 (No. 3 of 2006) (Section 10(1)(ii)).

Guiding framework
A number of steps have been suggested by the Office of the Nursing Services Director in the Guiding Framework (2008) for the implementation of nurse prescribing. This document is primarily aimed at HSE sites. However, it can be adapted to meet the needs of general practice. The adapted steps and how we addressed these in our practice are illustrated in Table 1.

An Bord Altranais provide Registered Nurse Prescribers with practice standards which must be adhered in order for the RNP to retain his/her nurse prescribing registration (An Bord Altranais, 2010). The following is a synopsis of the practice standards:

Practice Standard 1: Clinical decision-making process
The RNP documents the treatment plan including the prescribed medication, monitoring/evaluation and follow-up care and ensures continuing care/discharge plan is completed for the patient. RNPs are guided by the Decision-Making Framework (An Bord Altranais, 2007c).

Practice Standard 2: Communication and history taking
Communication and history-taking are essential in safe and effective prescribing to ensure accurate diagnosis, effective treatment, concordance and safety. Medication history is important to reduce the possibility of prescribing errors. This includes the patient’s use of over the counter preparations, herbal remedies, homeopathic remedies, vitamin/dietary supplements, medications which have been prescribed for others, alcohol & illicit drug use (An Bord Altranais, 2010).

Practice Standard 3: Documentation
It is the responsibility of the RNP to record the prescribing consultation. This allows for communication with other health professionals, keeps an accurate record of the consultation and ensures safety of the patient. This also includes the documentation of allergic reactions or adverse drug reactions (An Bord Altranais, 2010).

Practice Standard 4: Prescription writing
These regulations require the prescription to:
- Be legible
- State the name of the person issuing it and include the registration number (PIN) assigned to the nurse by An Bord Altranais
- The prescription (including computer-generated
prescriptions) must be in ink/indelible
  • The prescription must be dated and signed by the registered nurse prescriber with her/his usual signature
  • The full name and address of the patient/service-user must be on the prescription
  • If a patient/service-user is under the age of 12 years, the date of birth is required. (An Bord Altranais, 2010)

Practice Standard 5: Prescribing self, family and significant others
An Bord Altranais (2010) state that “prescribing for self, family and/or significant others is not acceptable professional practice. There should be an established nurse/midwife to patient/service-user relationship when prescribing for another individual. A blurring of professional and personal boundaries of care and accountability results and represents a conflict of interest. Writing and issuing a prescription for personal use or for a family member or significant other must not be undertaken by the registered nurse prescriber, regardless of circumstances. The individual requiring a prescribed medication should be referred to/directed to another appropriate registered prescriber (e.g. family general practitioner) or where health services are provided”.

Practice Standard 6: Repeat prescribing
In general practice, the RNP may be required to issue repeat prescriptions. An Bord Altranais (2010) state that “the registered nurse prescriber should be knowledgeable of the medicines regulations relating to the supply/dispensing of medications in instalments for the duration of individual prescriptions. Repeat prescribing may arise in situations where the original issued prescription was issued by another prescriber and the patient/service-user requests or requires a continued course of medication. This may typically occur in the treatment of chronic health conditions. In instances of repeat prescribing for continued treatment, the registered nurse prescriber should have a valid relationship with the patient/service-user and undertake an appropriate assessment of the need for

<table>
<thead>
<tr>
<th>STEP</th>
<th>HOW THE STEP WAS ADDRESSED WITH IN THE PRACTICE</th>
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<tbody>
<tr>
<td>1</td>
<td>Prepare to lead the development</td>
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<td></td>
<td>Access various documents from An Bord Altranais, colleges, PDC for Practice Nurses.</td>
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<td>2</td>
<td>Initiate local discussions with stakeholders</td>
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<td>In my practice, this was with the GP and the Professional Development Co-ordinator for Practices (PDC). In the absence of a Director of Nursing, the PDC can fulfil this role.</td>
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<td>3</td>
<td>Undertake service needs analysis</td>
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<td>Discussed with key stakeholders the benefits for the introduction of nurse prescribing to enhance patient care and my ANP role.</td>
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<td>4</td>
<td>Establish governance mechanisms</td>
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<td></td>
<td>The governance aspect of nurse &amp; midwife prescribing is overseen by the Drugs &amp; Therapeutics committee in our area. The committee was established for this purpose and includes the PDC for practice nurses, the primary care unit pharmacist, representative from the Primary Care Unit, the Specialist in Public Health Medicine. The committee has access to the clinical risk advisor.</td>
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<tr>
<td>5</td>
<td>Identify mentor</td>
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<td></td>
<td>In our practice, the mentor’s role was undertaken by the GP who attended an information session facilitated by the college to prepare for the role.</td>
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<td>6</td>
<td>Identify a prescribing site co-ordinator</td>
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<td></td>
<td>In the absence of nurse management in general practice, the PDC for practice nurses undertook this role</td>
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<tr>
<td>7</td>
<td>Submit application to college</td>
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<td></td>
<td>When applying for the education programme, the student must agree to have Step 4 in place by the end of the course.</td>
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<td>5 and 6 must be completed and submitted on the application form.</td>
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<tr>
<td>8</td>
<td>Complete six month education programme with clinical supervision</td>
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<td></td>
<td>Whilst completing the education programme, I began the process of developing the Collaborative Practice Agreement (CPA) which requires the nurse to identify the list of drugs he/she will be prescribing from. The CPA must be submitted to the D &amp; T committee for approval before registering with An Bord Altranais. I also developed a Nurse prescribing policy within the practice to support the CPA. The PCCC policy for nurse prescribing (HSE, 2009) can be adapted to general practice.</td>
</tr>
<tr>
<td>9</td>
<td>Registration with An Bord Altranais</td>
</tr>
<tr>
<td></td>
<td>Registration form, CPA with attachments A, B, C and fee submitted to An Bord Altranais.</td>
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<tr>
<td>10</td>
<td>Commencement letter</td>
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<td></td>
<td>I received communication from An Bord Altranais stating that I am on the Nurse prescribing register.</td>
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<tr>
<td>11</td>
<td>Communication</td>
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<td></td>
<td>The practice sent a letter and a copy of the CPA to all local pharmacies informing them of the introduction of nurse prescribing within our practice. The D &amp; T committee also communicate to local pharmacies and hospital consultants.</td>
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<tr>
<td>12</td>
<td>Monitor, audit, evaluation</td>
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<td></td>
<td>I maintain a weekly activity report of nurse prescribing which I submit to the D &amp; T committee on a monthly basis. Audit will be carried out three monthly by two members of the D &amp; T committee during the first year.</td>
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</table>

Table 1: Steps involved in becoming a Registered Nurse Prescriber (RNP)
continued treatment with the prescribed medication. This decision-making should be documented. It should include a discussion with the patient/service-user of perceived effectiveness and adherence to the treatment plan. The registered nurse prescriber should acknowledge her/his scope of practice for prescribing, recognising any limitation of competence/knowledge and refer the patient/service-user to the appropriate practitioner for evaluation concerning the repeat prescription if required”.

**Practice Standard 7: Prescribing of licensed medications**
The Medicinal Products (Licensing and Sale) Regulations, 1998 (S.I. 142 of 1998) provides statutory authority for a medical practitioner to treat a patient under her/his care, using unlicensed medicinal products. It does not extend to authorising a registered nurse prescriber to issue a prescription for an unlicensed medication. This action is at present outside the nurse’s/midwife’s scope of practice for prescriptive authority. A patient/service user need for a prescription for an unlicensed medication should be referred to the appropriate medical practitioner. The CPA should note this restriction in prescribing of medications (An Bord Altranais, 2010).

The RNP may now prescribe off-label i.e. the RNP may prescribe an authorised medication outside the terms of its product authorisation (An Bord Altranais, 2010).

**Practice Standard 8: Prescribing by means of verbal/telephone, email or fax**
Issuing or communicating a prescription by verbally, telephone, email or fax is not considered acceptable prescribing practice for a registered nurse prescriber and should not be conducted under any circumstance. The prescription for a medicinal product must be documented in writing, as required by the medicines regulation and health service provider/employer. Practice standard 1 should be adhered to (An Bord Altranais, 2010).

**Practice Standard 9: Separation of responsibilities in the medication management cycle**
The registered nurse prescriber should separate the activity of prescribing a medication and the subsequent actions of supplying and/or administering the medication. Another individual should undertake the supply/administration component of the medication management cycle, especially in the case of MDA drugs. This is safe practice, providing for the typical safety checks within the medication management cycle (An Bord Altranais, 2010).

The registered nurse prescriber should not undertake to both prescribe and dispense the medication as part of providing episodes of patient/service-user care. There should be clear separation of these activities. There may be circumstances arising when the registered nurse prescriber may be required to supply a medicine without previous dispensing of the medicinal product by a pharmacist. In these situations, the prescriber should be aware of her/his responsibilities with this practice in the overall management of medications (An Bord Altranais, 2010).

**Practice Standard 10: Influence of outside interests**
(relationships with pharmaceutical representation or similar organisations)
The registered nurse prescriber should prescribe in an appropriate, ethical manner, based on the best interests of the patient/service-user only. She or he should not be influenced by factors such as financial support by pharmaceutical and/or health care interests (An Bord Altranais, 2010).

**Practice Standard 11: Continuing professional development and continued competence**
There is an obligation for the registered nurse prescriber to commit to, and engage in, continuing professional development relating to assurance of competency for her/his prescribing practices. This is affirmed in the CPA. Health service providers/employers have a responsibility to provide support and access to continuing professional development and assessment of competence. The CPA signed by the registered nurse prescriber, medical practitioner and the health service provider/employer requires the involved parties to be aware of the professional regulatory and organisational requirements for the registered nurse prescriber’s continued competence for maintaining prescriptive authority (An Bord Altranais, 2010).

**Developing and writing an organisational policy for prescribing**
Currently, the ANP is guided by a practice developed Guideline for Good Practice for Medication Management which is underpinned by An Bord Altranais Guidance for Medication Management (An Bord Altranais, 2007d). This guideline will continue to be in operation alongside the Nurse Prescribing policy to support the ANP with medication management with drugs which are not included in the CPA. With the introduction of nurse prescribing into the general practice setting, an organisational policy has been developed and signed off which is based on the PCCC policy (PCCC Nurse Prescribing Policy, 2009). The main issue which arose during this process was in relation to risk management – an incident report form was developed for reporting of medication errors (PCCC Nurse Prescribing Policy, 2009) and the RNP will report any adverse events using the Irish Medicines Board reporting system. This form addresses the changes in practice which should occur as a result of an error being made so as to avoid a repeat of such an error.

**Collaborative Practice Agreement (CPA)**
The RNP must complete a CPA, submit it to the Drugs & Therapeutic committee for approval and then submit it to An Bord Altranais to be entered on the nurse prescribing register. The CPA contains details about the nurse prescriber, the service and three attachments. The first attachment contains information about the practice and the patients for...asthma, COPD, diabetes, hypertension, CHD, hyperlipidaemia, influenza/pneumococcal vaccine [and]... smoking cessation, weight reduction drugs and antibiotics.
Protecting today. Growing tomorrow.

Pfizer Vaccines – helping to protect children right from the start.

Pfizer Healthcare Ireland, 9 Riverwalk, National Digital Park, Citywest Business Campus, Dublin 24, Ireland.
whom the RNP will be prescribing. In this practice, the RNP may prescribe medicinal products and appliances for people with asthma, COPD, diabetes, hypertension, coronary heart disease, hyperlipidaemia and those who require influenza/pneumococcal vaccine. Also, included are smoking cessation, weight reduction drugs and antibiotics.

The second attachment contains a list of the aforementioned drugs and appliances. To date, there are 70 products on this list. Drugs and appliances may be added or removed from the list as the need arises subject to approval by the D & T committee.

The third attachment is mainly concerned with the procedures in place for governance and audit. The RNP maintains a weekly prescribing activity report which is submitted to the Drugs & Therapeutics committee monthly. During the first year, a member of the Drugs & Therapeutics will audit twenty prescriptions every three months to ensure that An Bord Altranais standards are being adhered to. Patients will also be asked about the service they received in relation to nurse prescribing. These procedures will be reviewed annually.

**Role of the Drugs & Therapeutics Committee**
The role of the D & T committee is to assure appropriate patient drug therapy and outcomes. The purpose of the committee is to ensure that the processes used in prescribing and administration of medicines to patients in our practice is in accordance with best practice and current clinical evidence.

**Medical indemnity**
The Medical Protection Society (MPS) provides the practice (GP and ANP) with medical indemnity. We have informed the MPS to extend our indemnity for Nurse Prescribing and also informed the MPs of the GP’s role in supporting nurse prescribing (PCCC Nurse Prescribing Policy, 2009).

**Conclusion**
This article has sought to address the requirements of a nurse who wishes to become a Registered Nurse Prescriber. It addresses the requirements sought by An Bord Altranais and how our practice addressed these. It should be remembered that education programmes are developing and changing and will become more widely available as they develop and are integrated into Post-graduate Diploma programmes.

**There is an obligation for the registered nurse prescriber to commit to, and engage in, continuing professional development relating to assurance of competency for her/his prescribing practices.**

Introducing nurse prescribing in our practice has been exciting and challenging. I signed my first prescription on 26th August 2010 which gave me a sense of personal and job satisfaction in that I was in an autonomous position to complete the consultation and provide the patient with holistic assessment, diagnosis, education and treatment of their condition.

**Acknowledgments**
A special thank you to Kathy Taaffe, Professional Development Co-ordinator for Practice Nurses in HSE West Sligo/Leitrim for all her support and assistance in introducing nurse prescribing in our practice.

**References**
An Bord Altranais, 2010, Practice Standards for Nurses and Midwives with Prescriptive Authority, An Bord Altranais, Dublin
An Bord Altranais, 2007a, Collaborative Practice Agreement (CPA) for Nurses and Midwives with Prescriptive Authority, An Bord Altranais, Dublin
An Bord Altranais, 2007d, Guidance to Nurses and Midwives on Medication Management, An Bord Altranais, Dublin
Health Services Executive, 2009, National Policy for Nurse and Midwife Medicinal Product Prescribing in Primary, Community and Continuing Care. Health Services Executive, Dublin
Irish Medicines Board (Miscellaneous Provision) Act 2006 (No. 3 of 2006) (Section 10(1)(ii)) Statutory Instrument, Dublin
Office of the Nursing Services Director, 2008, Guiding Framework for the Implementation of Nurse and Midwife Prescribing in Ireland. Health Services Executive, Dublin
Approved from the moderate stage of Alzheimer's Disease onwards

**Dosage: From Start to Maintenance**

### Tablets

**Week 1**
- 5mg once daily
- 5mg once daily
  - ½ tablet

**Week 2**
- 10mg once daily
- 1 tablet

**Week 3**
- 15mg once daily
- 1½ tablets

**Week 4**
- 20mg once daily
- 2 tablets

### Oral Solution

**Before First Use**
- You must prime the pump with 5 downward pumps and discard the liquid.

**Week 1**
- 0.5ml once daily
- 0.5ml per day

**Week 2**
- 1ml once daily
- 1 downward pump per day

**Week 3**
- 1.5ml once daily
- 1½ downward pumps per day

**Week 4**
- 2ml once daily
- 2 downward pumps per day

### Titration is Important

**EB4/1/11**

**References:**
Add Vimpat® for the confidence of additional seizure control

- **Improved seizure control, compared to or regardless of current or prior antiepileptic drug therapy**
- **High long-term retention rate**
- **An innovative mode of action**

Lacosamide is licenced for adjunctive therapy in patients with partial-onset seizures 2-16 years old

*Life with epilepsy can be much more than just a gap between seizures.*

---

**VIMPAT**

**Lacosamide**

**Confidence of additional seizure control**

**ABBREVIATED PRESCRIBING INFORMATION**

*Please consult the Summary of Product Characteristics (SmPC) before prescribing.*

**VIMPAT 50 mg, 100 mg, 150 mg and 200 mg film-coated tablets**

**VIMPAT 15 mg/ml solution for infusion**

**Active Ingredient**: Tablets: Lacosamide 50 mg, 100 mg, 150 mg and 200 mg film-coated tablets. Syrup: Lacosamide 15 mg/ml. Solution for infusion: Lacosamide 10 mg/ml.

**Therapeutic Indications**: VIMPAT is indicated as adjunctive therapy in the treatment of partial-onset seizures with or without secondary generalisation in patients with epilepsy aged 16 years and older.

**Dosage and Administration**: Adults and adolescents from 16 years. Recommended starting dose is 50 mg twice a day which should be increased to an initial therapeutic dose of 100 mg twice a day after 1 week. Maximum daily dose of 400 mg (in two 200 mg doses). For solution for infusion: Infuse over a period of 15 to 60 minutes. Can be administered i.v. without further dilution. Elderly. Do not dose reduction necessary. Age-associated decreased renal clearance with an increase in AUC levels should be considered. Paediatric patients: Not recommended. Patients with renal impairment. No dose adjustment necessary in mild and moderate renal impairment. Dose adjustment is recommended in SPC for patients with severe renal impairment and patients with end-stage renal disease. Dose titration should be performed with caution. Patients with hepatic impairment. No dose adjustment needed in mild to moderate impairment. In accordance with current clinical practice, if VIMPAT has to be discontinued, it is recommended this be done gradually (e.g. taper the daily dose by 200 mg/week).

**Contraindications, Warnings etc**: Contraindications: Hypersensitivity to lacosamide or to any of the excipients. Known second or third-degree atrioventricular block. In addition for tablets, hypersensitivity to peanuts or soy. Precautions: lacosamide has been associated with dizziness. Use with caution in patients with known conduction problems, severe cardiac disease or in elderly. Exempts in the syrup may cause allergic reactions (possibly delayed), should not be taken by those with previous intolerance and may be harmful to patients with phenylketonuric. Monitor patients for signs of suicidal ideation and behaviours. Advise patients and carers to seek medical advice should such signs emerge. Interactions: Prolongations in PR interval with lacosamide have been observed in clinical studies. Use with caution in patients treated with products associated with PR prolongation and those treated with class I antiarrhythmic drugs. Strong enzyme inducers such as rifampicin or St John’s Wort may moderately reduce the systemic exposure of lacosamide. No significant effect on plasma concentrations of carbamazepine and valproic acid. Lacosamide plasma concentrations were not affected by carbamazepine and valproic acid. No clinically relevant interaction with ethinylestradiol and levonorgestrel. No effect on pharmacokinetics of diphenhydramine. Pregnancy and lactation. Should not be used during pregnancy. For precautionary measures, breast feeding should be discontinued during treatment with lacosamide. Dosing etc. Patients are advised not to drive a car or operate other potentially hazardous machinery until they are familiar with the effects of VIMPAT on their ability to perform such activities. Adverse Effects: Very common (≥10%): Dizziness, headache, diplopia, nausea. Common (1% to <10%): Depression, confusional state, balance disorder, abnormal coordination, memory impairment, cognitive disorder, somnolence, tremor, asthenia, hypothermia, dysphoria, disturbance in attention, blurred vision, vertigo, tinnitus, vomiting, constipation, flatulence, dyspepsia, dry mouth, pruritus, rash, muscle spasms, gag disturbance, asthenia, fatigue, irritability, hallucinations. Adverse reactions associated with PR prolongation may occur. Consult SPC in relation to other side effects. Pharmaceutical Precautions: Tablets and Syrup. No special storage precautions. Use syrup within 4 weeks of first opening. Solution for infusion: Do not store above 25°C. Use immediately. Legal Category: POM. Product Licence Numbers: 50 mg: x 1 tab: EU/1/09/470/001; 100 mg: x 1 tab: EU/1/09/470/004; 150 mg: x 1 tab: EU/1/09/470/005; 200 mg: x 1 tab: EU/1/09/470/007; 150 mg: x 1 tab: EU/1/09/470/008; 200 mg: x 1 tab: EU/1/09/470/009; 15 mg/ml: x 200 ml: EU/08/470/015; 15 mg/ml: x 200 ml: EU/08/470/016. Solution for infusion: 10 mg/ml: x 20 ml: EU/08/470/016. Name and Address of PL Holder: UCB Pharma S.A., Allée de la Recherche 60, B-1070 Brussels, Belgium. Further information is available on request from: UCB Pharma Ireland Ltd, Unit D4, Northwall Rd, Mרפא Business Park, Citywest, Dublin 24. Tel: 01 6637395. Fax: 01 6637396. Email: medicalinformation@ucb-group.com


Date of Preparation: October 2010

10WMA73
The word epilepsy comes from the Greek word épilamabanien which means to seize or attack. It is the most common neurological disorder (after migraine) affecting 50 million people worldwide. Irish prevalence figures would suggest there are 36,844 people (over the age of 5) in Ireland affected by the disorder. An estimated 10,000 of whom are women of childbearing potential.

It is a condition associated with a great deal of stigma, which is recognised by the people with the condition. Epilepsy occurs in all social groups. People with epilepsy are often made to feel very different and as a result are very reluctant to reveal their illness. The health service is now beginning to recognise the need for more intervention to educate and support those affected by the condition.

THE ROLE OF THE COMMUNITY EPILEPSY NURSE
This new role was brought about by the partnership of the Health Services Executive, Brainwave – The Irish Epilepsy Association and Beaumont Hospital. The result was the appointment of the first Clinical Nurse Specialist in Community Epilepsy Services in the country and to date there are now three specialist epilepsy nurses working with Brainwave.

I commenced the post of Community Epilepsy Nurse on the 10th June 2002. One of the primary aims of this post was to improve the links between Beaumont Hospital and the primary health care sector, including general practitioners, public health nurses, practice nurses, pharmacists and other allied health professionals as proposed by the National Health Strategy 2002.

The overall aim is to improve patient care and increase awareness of the services provided by Brainwave.

DEFINITION OF EPILEPSY
Epilepsy is a clinical condition characterised by recurrent unprovoked seizures. It is classified by both syndromes and seizures. One seizure does not constitute epilepsy. It is a very common condition affecting approximately one in 115 people. Five per cent of the general population will experience one seizure in their lifetime.

A seizure is a disturbance of the brain cell function in which a brief period of altered awareness or consciousness occurs. The seizure itself is usually short in nature and maybe followed by a period of tiredness or confusion.

TYPES OF SEIZURES
The International League Against Epilepsy designed a classification system in 1981.

They defined seizures as:

Partial seizures
- Simple partial – sometimes also referred to as focal seizures or auras – consciousness is not impaired.
- Complex partial – consciousness is impaired.
- Secondary generalisation.

Generalised seizures
- Absence (formally known as petit mal)
- Tonic clonic (formally known as grand mal)
- Myoclonic (serial jerking movement of limbs, sometimes trunk can be affected)
- Atonic (sudden loss of muscle tone)

Generalised tonic clonic seizures are what were formerly referred to as grand mal seizures. These are the type of events that the general public associates with epilepsy.

CAUSES
For some people there is no known cause and this is called ‘idiopathic’ epilepsy. Sometimes however the reason is found; it could be because of a structural abnormality, brain damage caused by a difficult birth; a head injury; a stroke; or an infection of the brain such as meningitis/encephalitis. Very occasionally the cause is a brain tumour. Epilepsy with a known cause is called ‘symptomatic’ epilepsy.

DIAGNOSIS
The most important part in the diagnosis is the clinical history. This should be accompanied by an eyewitness event such as;
• What was the person doing prior to the event?
• Could they communicate during the event?
• What happened during the event?
• How long did it last?

Where possible the person should be encouraged to bring in a recording of a seizure into their consultant neurologist or epilepsy nurse. After the clinical history is completed some other investigations may be ordered including an electroencephalography (EEG) which is the recording of electrical activity along the scalp produced by the firing of neurons within the brain and magnetic resonance imaging (MRI), or nuclear magnetic resonance imaging (NMRI), which is primarily a noninvasive medical imaging technique used in radiology to visualise detailed internal structures and limited function of the body.

TREATMENTS
Once a definite diagnosis has been made, the individual is usually commenced on an anti-epileptic drug (AED). The exact drug and the dose prescribed depend on the nature of the particular person’s epilepsy, taking into consideration the person’s age, sex, medical history and lifestyle. This medication may need to be changed or altered until a satisfactory one or combination of medication is found. Some patient’s epilepsy may become refractory to medication after a period of time and require further investigations and interventions as a result.

Other treatments to be considered include surgery; this can include the removal of the focal point (only suitable in partial epilepsy). For individuals not suitable for surgery a vagus nerve stimulator may be an option.

The vagus nerve stimulator (VNS) is a device used for the treatment of intractable partial or generalised epilepsy i.e. those people not suitable for epilepsy surgery and for those who fail to respond to two or more AEDs. Mechanistically, the VNS is unlike any other previous treatment for epilepsy. After appropriate evaluation, a patient may undergo surgical implantation of a VNS, usually performed at a specialised epilepsy centre.

EMERGENCY TREATMENT OF SEIZURES
It is well documented that the longer a seizure persists the more difficult it is to bring under control. A new product by the name of Epistatus (buccal midazolam) has been introduced to the Irish market. The aim of this medication is to terminate any seizure lasting longer than 5 minutes, cluster seizures or different than usual seizures, thus endangering the person’s life. Some previous remedies include rectal – diazepam and oral – Ativan. However, as buccal midazolam is administered via the buccal cavity of the mouth or the nose, it is a lot easier to administer and does not impact on a person’s privacy and dignity.

LIFESTYLE IMPLICATIONS
There are many issues that need to be addressed with the individual and their family. Some of the most important issues that should be addressed include, driving, fertility issues, triggers, mood changes, memory problems, education, employment, social issues, disclosure, stigma, and personal safety to include SUDEP (Sudden Unexplained Death in Epilepsy). Informing the individual about adopting these changes into their lifestyle can help them take control of their epilepsy and thus educate them to highlight the particular concerns they are having to their nurse and or doctor.

SUDDEN UNEXPLAINED DEATH IN EPILEPSY
If a person with epilepsy dies suddenly and no obvious cause can be found after a post mortem examination has been carried out, it is called SUDEP.

It is difficult to know exactly how many people with epilepsy die each year, but it is estimated that there is between 60-80 epilepsy deaths in Ireland each year.

The causes of SUDEP are not well understood. Some studies have suggested that the part of the brain that controls breathing may be affected. This could cause the person to stop breathing during a tonic-clonic seizure. For most people, the breathing would start again once the seizure ends, but some are not so lucky. We don’t know yet whether these things happen because the person with epilepsy already has a weakness to their heart or lungs, or whether it is related to the epilepsy itself.

It is well documented that the longer a seizure persists the more difficult it is to bring under control.
The proof is in the pudding:

- The supplement in 7 easy spoonfuls
- High energy and protein
- Easy to swallow and digest
- Convenient and patient-friendly
- 4 great tasting flavours
- Great alternative to nutritional drinks
- Perfect anytime of the day
A seizure is a disturbance of the brain cell function in which a brief period of altered awareness or consciousness occurs.

There is some suggestion that some people may be more at risk than others. These may be people who:
• Have poorly controlled seizures
• Have generalised seizures during their sleep
• Have a learning disability
• Are young adult males
• Are not taking their prescribed antiepileptic medication
• Are having frequent or sudden changes to their antiepileptic medication.

REDUCING THE RISK OF SUDEP
The following will help reduce the risk of SUDEP
• If seizures are not well controlled, the patient should be referred to an epilepsy specialist for their epilepsy and medication to be re-assessed.
• Advise your patient to continually take their prescription medication.
• Advise your patient to never make changes to, or stop, medication without talking to a doctor/nurse first.

BRAINWAVE – THE IRISH EPILEPSY ASSOCIATION
Throughout their existence Brainwave – the Irish Epilepsy Association has worked tirelessly to educate the wider general public and allied healthcare professionals through a variety of settings. Specific information leaflets and publications have been produced for general practitioners, employers and teachers. In 2008 a steering group was established to put together a Nurse’s Information Pack. This group was made up of Brainwave staff and some of the specialist adult and paediatric epilepsy nurses working in Ireland.

This very comprehensive pack includes a variety of information for nurses from all disciplines caring for people with epilepsy to include posters on how the brain works, medication posters for adults and children and the International Classification of Epilepsies and Epileptic Syndromes. It addresses the specific needs of individuals with epilepsy to include those working with special needs, children and women with epilepsy.

HELPING THE PATIENT
In particular the group put together a ‘helping your patient’ section. This is the kind of information gathering that is particularly important to the doctor in the hospital setting. It gives an insight to the type of information that is most beneficial: documenting of seizures in a seizure diary, particularly recording the persons activity prior to, during and post the seizure. It also highlights the importance of an eyewitness account and value of having that person accompany the individual to their hospital appointment.

The pack has included a suggested patient checklist for the consultant appointment and what to bring to that appointment. It also informs nurses about the Long Term Illness Scheme and how all persons with a diagnosis of epilepsy are entitled to their epilepsy medication free of charge.

Finally the helping your patient section gives an insight into the particular lifestyle implications to discuss with your patient such as e driving and safety issues that may affect patients with epilepsy in general.

It is hoped that this pack will be an invaluable reference tool to all the nurses caring for individuals with epilepsy and that patients with epilepsy will benefit greatly from this sharing of information.

If you would like a copy of the Nurse’s Information Pack to download please send an email to info@epilepsy.ie or contact Brainwave’s head office on 01 4557500.

References:
So what’s the best thing about living in Carrickmacross?  
Fresh air, peace and quiet, lovely rolling drumlins.

What’s the downside?  
Can’t get radio, tv, mobile phone or broadband signals – due to aforementioned drumlins.

Who’s your hero?  
Frontline staff in Medicin sans Frontiers – when everyone else is running away from situations - they are running in.

Nursing hero?  
Any of the nursing pioneers throughout history and, (of course!!), Practice Nurses who are so motivated to provide great care that they educate and update themselves in their own time and at their own expense.

Who’s a villain?  
Anyone who knew about any cases of child abuse who didn’t shout and scream about it from the rooftops. What’s wrong with them?

What’s the best thing about practice nursing?  
Getting to know the patients and their families over time – it allows for fantastic continuity and means Practice Nurses really do provide totally holistic care.

Do you miss actual practice nursing?  
Yes, I miss it a lot. The bravery shown by the vast majority of patients is awesome.

And the downside?  
The unfairness of self-funding education and CPD so that the best care can be provided to all patients, and being expected to take on vaccination programmes and care of chronic diseases – but at the same time being conveniently labelled “privately employed” by the Department of Health whenever issues such as study leave or funding for education arise.

What would you change in your job if money, time and red tape were not a factor?  
If I had more time etc, I would like to find a way around all the barriers and get IPNA educational meetings officially accredited and recognised in a meaningful way for Practice Nurses.

What are your hobbies?  
Shopping, cinema and doing fun stuff with my kids. I also get enormous satisfaction from de-cluttering sprees (sad but true!).

Current favorite book?  
“Under the Duvet” by Marian Keyes.

Current favorite film?  
My all-time favourites are “You’ve Got Mail” and “Me, Myself and Irene”.

Clothes shop?  
Pamela Scott or Dorothy Perkins – where normal healthy women are welcome!

What would you like to see in the future for practice nursing?  
Equal educational opportunities and/or more online programmes, and better recognition of the impact Practice Nurses have on patient care.
It’s time to Do more than lower blood glucose

Once-daily Victoza® (liraglutide), in combination with metformin, impacts on multiple factors associated with type 2 diabetes providing, from baseline:1,2

- Reductions in HbA1c: up to 1.30%1,2
- Reductions in weight: up to 2.8kg1,2
- Reductions in systolic blood pressure1,2
- Improvements in beta-cell function1,2

Victoza® NurinGenPrac Jan 2011(1):Layout 1  17/01/2011  15:06  Page 1

Abbreviated Prescribing Information
Victoza® 6 mg/ml solution for injection in pre-filled pen (liраглутид). Please refer to the Summary of Product Characteristics for full information. Victoza® 2 x 3 ml pre-filled pens; Victoza® 3 x 3 ml pre-filled pens. 1 ml of solution contains 6 mg of liраглутид. Indication: Treatment of adults with type 2 diabetes mellitus in combination with metformin or a sulphonylurea, in patients with insufficient glycaemic control despite maximal tolerated dose of metformin or sulphonylurea monotherapy or in combination with metformin and a sulphonylurea, or metformin and a thiazolidinedione in patients with insufficient glycaemic control despite dual therapy. Dosage: Victoza® is administered once daily by subcutaneous injection and can be administered at any time independent of meals; however, it is preferable that Victoza® is injected around the same time of day. Victoza® should not be administered intravenously or intramuscularly. Recommended starting dose is 0.6 mg daily. After at least one week, the dose should be increased to a maintenance dose of 1.2 mg. Based on clinical response, after at least one week the dose can be increased to 1.8 mg to further improve glycaemic control in some patients. Daily doses higher than 1.8 mg are not recommended. When used with existing metformin therapy or in combination with metformin and thiazolidinedione therapy, the current dose of metformin and thiazolidinedione can continue unchanged. When added to existing sulphonylurea therapy or in combination with metformin and sulphonylureas, a reduction in the dose of sulphonylurea may be necessary to reduce the risk of hypoglycaemia. Victoza® can be used in the elderly (≥65 years old) without dose adjustment but therapeutic experience in patients ≥75 years of age is limited. No dose adjustment is required for patients with mild renal impairment (creatinine clearance 60–90 ml/min). Due to lack of Therapeutic experience Victoza® is not to be recommended for use in patients with moderate (creatinine clearance 30–59 ml/min) and severe renal impairment (creatinine clearance below 30 ml/min), patients with end stage renal disease, patients with hepatic impairment and children below 18 years of age. Contraindications: Hypersensitivity to the active substance or any of the excipients. Warnings and Precautions for use: Victoza® should not be used in patients with type 1 diabetes mellitus or for the treatment of diabetic ketoacidosis. Limited experience in patients with congestive heart failure New York Heart Association (NYHA) class III and IV or previous experience in patients with NYHA class III-IV. Due to limited experience Victoza® is not recommended for patients with Inflammatory bowel disease and diabetic gastroparesis. Victoza® is associated with transient gastrointestinal adverse reactions, including nausea, vomiting and diarrhoea. G1P-1 analogues have been associated with pancreatitis; patients should be informed of symptoms of acute pancreatitis: persistent, severe abdominal pain. If pancreatitis is suspected, Victoza® and other suspect medicinal products should be discontinued. Thyroid adverse events, including increased blood calcitriol; goitre and thyroid neoplasm reported in clinical trials particularly in patients with pre-existing thyroid disease. Risk of hypoglycaemia in combination with sulphonylureas; lowered by dose reduction of sulphonylurea. Signs and symptoms of dehydration, including reduced renal function reported with Victoza®. Patients should be advised of potential risk of dehydration in relation to gastrointestinal side effects and take precautions to avoid fluid depletion. No studies on the effects on the ability to drive and use machines performed. Patients should be advised to take precautions to avoid hypoglycaemia while driving and using machines, in particular when Victoza® is used in combination with a sulphonylurea. Substances added to Victoza® may cause degradation, in the absence of compatibility studies Victoza® must not be mixed with other medicinal products. Pregnancy and lactation: Victoza® should not be used during pregnancy or during breast feeding. If a patient wishes to become pregnant, or pregnancy occurs, treatment with Victoza® should be discontinued; use of insulin is recommended instead. Undesirable effects: During clinical trials with Victoza® the most frequently observed adverse reactions which varied according to the combination used (sulphonylurea, metformin or a thiazolidinedione) were; very common: nausea, diarrhoea, hypoglycaemia when used in combination with metformin and a sulphonylurea and headache when used in combination with metformin; Common: hypoglycaemia when used in combination with a thiazolidinedione, vomiting, constipation, abdominal pain, dyspepsia, flatulence, gastroesophageal reflux disease, gastroenteritis viral, toothache, headache, dizziness, nasopharyngitis, bronchitis, anorexia, appetite decreased, fatigue and pruritus. Gastrointestinal adverse reactions are more frequent at start of therapy but are usually transient. Very few hypoglycaemic episodes observed other than with sulphonylureas. Patients ≥70 years or with mild renal impairment (creatinine clearance 60–90 ml/min) may experience more gastrointestinal effects. Consistent with medicinal products containing protein peptides, patients may develop anti-liraglutide antibodies following treatment but this has not been associated with reduced efficacy of Victoza®. Few cases reported of angioedema (0.05%), acute pancreatitis (≤0.2%) and injection site reactions (approx. 2%). Injection site reactions usually mild. No cases reported with liraglutide. Increased blood calcitriol and goitres are the most frequent reported thyroid adverse events – rates per 1000 subjects years of exposure were 6.8, 10.9 and 5.4 of liraglutide treated patients in comparison with 6.4, 10.7 and 2.1 of placebo treated and 2.4, 6.0 and 1.8 of total comparator treated. The Summary of Product Characteristics should be consulted for a full list of side effects. Overdose: In the event of overdose, appropriate supportive treatment should be initiated according to the patient’s clinical signs and symptoms. MA numbers: Victoza® 2 x 3ml pre-filled pens EU/1/09/529/002. Victoza® 3 x 3ml pre-filled pens EU/1/09/529/003. Legal Category: POM. For complete prescribing information please refer to The Summary of Product Characteristics which is available on www.medicines.org.uk or by email from info@novonordisk.ie or from Medical Department, Novo Nordisk Limited, 3 Upper Pembroke Street, Dublin 2, Ireland; www.novonordisk.ie. Date created: Jan 2011.

Further Information is available from:
Novo Nordisk Limited
34 Upper Pembroke Street
Dublin 2, Ireland
Tel: 01 678 5989
Fax: 01 676 3259
Lo Call: 1850 665 665
www.novonordisk.ie

Information about adverse event reporting is available at www.mhra.gov.uk. Adverse events should be reported to the Novo Nordisk Medical Department Tel: 1850 665 665.
There is currently an estimated population of 130,000 people (4.3%) living with diabetes in the Republic of Ireland and this number is expected to rise by 37% over the next five years. Diabetes is a costly condition both for the patient, in terms of quality of life and long term complications and for the health system, in terms of economic burden. The healthcare cost of looking after people with diabetes is very high – accounting for 5-15% of our health expenditure.

Structured Education

Education of adults with diabetes is changing; in response to validated scientific evidence that promotes what is now termed a 'structured' approach to diabetes education. Research shows that structured education programmes, as defined NICE (2003), based on client centred models of care increase and promote self management. People with diabetes are empowered to become actively involved in their treatment by increasing confidence, skills and knowledge.

Self management is a vital component of a high quality diabetes service. People with diabetes see a health professional for approximately three hours a year and rely on themselves for the other 8,757 hours.

The X-PERT programme is one example of a structured patient education programme successfully being rolled out across Ireland by the community nutrition and dietetic services.

What is the X-PERT Programme All About?

This new to Ireland patient-centered, group-based approach to patient education actively encourages participants to discuss and explore their own experiences of living with diabetes. This helps participants to adapt the key messages of diet and lifestyle modification and apply them to their personal circumstances.

After the six week programme, participants are offered refresher sessions within the following six months and an annual update session thereafter. This continuing education and support of lifestyle changes is in line with strong evidence for the value of patient follow up in chronic disease management.

X-PERT Ireland

In 2005 the Community Nutrition and Dietetic Service, HSE South, began liaison with the X-PERT UK to adapt the programme for Ireland. To date (Figures taken from data entered by May 27th 2010), 79 community dietitians from the four HSE regions of Ireland have been trained as X-PERT Ireland Educators. 101 programmes have been delivered across the Republic of Ireland, educating 1189 people with type 2 diabetes. 88.1% of clients have attended four or more of the six sessions. The mean number of session attended is five out of six. The mean participant evaluation score for the programme was 95.8%. Clinical and empowerment data, as displayed in Table 1, shows positive improvements in biochemical and physiological parameters, similar to those seen in Irish and UK trials and in line with audit standards set out for X-PERT.

HSE investment in promoting X-PERT has highlighted the importance of linking with health professionals who are supportive of integrated diabetes care in the wider primary care network. X-PERT has also raised professionals’ awareness, knowledge, confidence, diabetes management skills and partnerships in improving the care and service’s for people with type 2 diabetes.
### Clinical Review

**The X-PERT programme is proven to be cost, time and resource efficient. Clients are extremely happy with the service.** 89% of clients (surveyed in the Dublin North East region) reported that having attended X-PERT, it has inspired them to support others with diabetes in their community. Clients are now actively involved in their own treatment. They are taking responsibility and action for their health and lifestyles and maintaining changes for one year and longer after participating on the programme.

### Comments from Participants After Attending the X-PERT Programme

- “For the first time in my life I feel like I am the one in control of my diabetes.”
- “The programme really helped me and my family take a better look at our lifestyle.”
- “After 23 years with type 2, it’s the first time I’ve really been informed in detail about my condition.”
- “Without this programme I would remain ignorant to my diabetes.”

### Comments from GP Whose Clients Attended the X-PERT Programme

“We undoubtedly feel our patients are more empowered to take proactive steps in managing their disease (with improved knowledge, compliance with drugs, increased awareness about diabetes) and are hopeful this will significantly improve the disease burden for individuals and health providers in the future.”

### Week Content

<table>
<thead>
<tr>
<th>Week</th>
<th>Content</th>
</tr>
</thead>
</table>
| Week 1 | What is diabetes?  
Self monitoring of blood glucose  
Understanding medication  
Diabetes health results – what do they mean? |
| Week 2 | Weight management; energy balance  
Healthy eating and portion control  
Physical activity |
| Week 3 | Carbohydrate awareness  
What are carbohydrates?  
How starches and sugars affect blood glucose levels  
Dispelling myths of the sugar-free diet |
| Week 4 | Reading food labels (supermarket tour).  
A virtual supermarket is created giving clients an opportunity to ask questions, read labels and become more informed about the foods they eat. |
| Week 5 | Possible complications of diabetes – short – and long-term  
Prevention of complications  
Living with diabetes |
| Week 6 | Are you an X-PERT?  
Game designed to recap on main messages of the programme in a fun way while helping to increase skills, knowledge and confidence in making informed decisions regarding diabetes self-management.  
Questions and answers  
Comments and feedback  
Sharing of resources |
| Refreshers and annual sessions | Recap on aspects of 6 week programme as per patient requests  
Further goal setting |

20 minutes at end of each week – goal setting with five step empowerment model.
For patients not at goal on metformin alone

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

Weight loss and less hypoglycemia vs an SU + metformin

(with sitagliptin 100 mg + metformin)

In patients with normal renal function, metabolism, including via CYP1A2, plays only a small role in the clearance of sitagliptin. Metabolism may play a significant role in the elimination of sitagliptin in the setting of renal insufficiency and/or CYP1A2 dysfunction, as is possible that potent CYP1A2 inhibitors (e.g., fluvoxamine, ritonavir, tizanidine, co-administered with a potent CYP1A2 inhibitor, may reduce the clearance of sitagliptin. Therefore, as is possible with potent CYP1A2 inhibitors, patients treated with sitagliptin who are also taking potent CYP1A2 inhibitors should be monitored for signs or symptoms of sitagliptin accumulation. Other clinical studies assessing the impact of concomitant CYP1A2 inhibitors on sitagliptin exposure have not been reported.

In patients with normal renal function, metabolism, including via CYP1A2, plays only a small role in the clearance of sitagliptin. Metabolism may play a significant role in the elimination of sitagliptin in the setting of renal insufficiency and/or CYP1A2 dysfunction, as is possible that potent CYP1A2 inhibitors (e.g., fluvoxamine, ritonavir, tizanidine, co-administered with a potent CYP1A2 inhibitor, may reduce the clearance of sitagliptin. Therefore, as is possible with potent CYP1A2 inhibitors, patients treated with sitagliptin who are also taking potent CYP1A2 inhibitors should be monitored for signs or symptoms of sitagliptin accumulation. Other clinical studies assessing the impact of concomitant CYP1A2 inhibitors on sitagliptin exposure have not been reported.
Clinical review

Table 1. X-PERT Ireland Audit Results 2006-2010
Note: Figures taken from data entered by May 27th 2010

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>6 Months</th>
<th>1 Year</th>
<th>2 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HbA1c %</strong></td>
<td>7.3 (n=1003)</td>
<td>6.8 (n=282)</td>
<td>7.0 (n=164)</td>
<td>7.0 (n=36)</td>
</tr>
<tr>
<td><strong>Weight kg</strong></td>
<td>89.3 (n=1055)</td>
<td>85.2 (n=277)</td>
<td>86.1 (n=148)</td>
<td>85.8 (n=33)</td>
</tr>
<tr>
<td><strong>BMI kg/m2</strong></td>
<td>31.9 (n=1032)</td>
<td>30.8 (n=266)</td>
<td>30.3 (n=148)</td>
<td>30.0 (n=33)</td>
</tr>
<tr>
<td><strong>Total Cholesterol mmol/l</strong></td>
<td>4.3 (n=1068)</td>
<td>4.2 (n=288)</td>
<td>4.0 (n=168)</td>
<td>3.8 (n=38)</td>
</tr>
<tr>
<td><strong>LDL Cholesterol mmol/l</strong></td>
<td>2.4 (n=975)</td>
<td>2.3 (n=255)</td>
<td>2.2 (n=157)</td>
<td>1.9 (n=33)</td>
</tr>
<tr>
<td><strong>HDL Cholesterol mmol/l</strong></td>
<td>1.2 (n=978)</td>
<td>1.2 (n=254)</td>
<td>1.2 (n=159)</td>
<td>1.1 (n=34)</td>
</tr>
<tr>
<td><strong>Triglycerides mmol/l</strong></td>
<td>1.7 (n=859)</td>
<td>1.6 (n=223)</td>
<td>1.5 (n=139)</td>
<td>Not Available</td>
</tr>
<tr>
<td><strong>Systolic Blood Pressure mmHg</strong></td>
<td>135.4 (n=840)</td>
<td>135.7 (n=239)</td>
<td>135.2 (n=144)</td>
<td>133.5 (n=21)</td>
</tr>
<tr>
<td><strong>Diastolic Blood Pressure mmHg</strong></td>
<td>78.1 (n=839)</td>
<td>76.7 (n=239)</td>
<td>76.4 (n=144)</td>
<td>73.9 (n=21)</td>
</tr>
<tr>
<td><strong>Empowerment Score</strong></td>
<td>3.8 Max score = 5</td>
<td>4.4 Max score = 5</td>
<td>4.3 Max score = 5</td>
<td>Not Available</td>
</tr>
</tbody>
</table>

“The programme has helped us meet our patients needs in an effective way by really involving them in organized proactive care plans.”

“The patients now relate to the practice nurse on a more personal basis and we feel the condition of diabetes is much better understood and managed overall.”

The X-PERT programme is being successfully led out across Ireland by the community nutrition and dietetic services. Please contact your local community nutrition and dietetic department for further details.

The healthcare cost of looking after people with diabetes is very high – accounting for 5-15% of our health expenditure.

References
Cialis offers your patients

- Proven efficacy from 30 minutes up to 36 hours with sexual stimulation
- Greater sexual self-confidence and spontaneity than sildenafil
Feeling down once in a while is normal but some people feel a sadness that just won’t go away. Life seems hopeless. Feeling this way, most of the day for two weeks or more is a sign of serious depression.

More than 7% of the population have depression and it is estimated that at any one time, 280,000 people in Ireland have depression. Irish research has shown that it is more common in women, teenagers, the elderly and in single people. It is estimated that one in 10 Irish people will have depression at some point in their lives.

The Link
A number of studies have found a higher prevalence of depressive symptoms in people with diabetes. In controlled studies, the prevalence of depressive symptoms was described to be nearly double in people with diabetes. However, some studies found only small differences between diabetes and non-diabetes subjects. Several studies have demonstrated that depression in people with diabetes is associated with increased co-morbidity and an increased mortality rate.

Collins et al. 2009 carried out a study to identify the prevalence and major determinants of anxiety and depression symptoms in patients with diabetes in Ireland. This was a cross-sectional study of 2049 people with types 1 and 2 diabetes. Anxiety and depression symptoms were assessed with the Hospital Anxiety and Depression Scale (HADS). The overall response rate was 71%. Based on the HADS scale, there was evidence of high levels of anxiety and depression symptoms in patients with diabetes; 32% exceeded the HADS cut-off score of ‘mild to severe’ anxiety and 22.4% exceeded the HADS cut-off score of ‘mild to severe’ depression.

Risk Factors
Diabetes complications, smoking, uncertainty about glycaemic control and being an ex-drinker or a heavy drinker were risk factors for both higher anxiety and depression scores in multivariate analysis. Female gender and poor glycaemic control were risks factors associated only with higher anxiety scores. Higher socio-economic status and older age were protective factors for lower anxiety and depression scores. Type of diabetes, insulin use, marital status and models of care were not significant predictors of anxiety and depression scores. This study indicates that the prevalence of anxiety and depression symptoms in patients with diabetes is considerably higher than in general population samples.

A major depressive episode can be persistent and debilitating. Depression may be under diagnosed and undertreated in 50% of cases, and is often unrecognized by both patients and health professionals. Studies such as the DAWN (Diabetes Attitudes...
Based on the HADS scale, there was evidence of high levels of anxiety and depression symptoms in patients with diabetes.

Wishes and Needs) study have shown that many nurses and physicians do not recognise depression, anxiety and emotional problems in people with diabetes. Health professionals may often be preoccupied with metabolic outcomes whereas people with diabetes have to achieve a balance between keeping well and living a normal life.

Psychological distress or depression can affect a person’s motivation and ability to cope with self management of diabetes, including adhering to prescribed medications, appropriate diet, keeping active and monitoring blood glucose levels.

Fisher et al (2007) suggest that addressing personal and diabetes-related stress by reinforcing coping strategies and problem solving is likely to be more meaningful and effective than treatments specific to depression. Miller (2000) described how people with long term conditions respond to a variety of stressors that may impact on their ability to cope. Miller calls these various domains ‘power resources’. These power resources may be weakened by the experience of having a long term condition and through recognising and understanding what these power resources are, the nurse may be able to provide more useful and specific support. Supporting a person with diabetes during periods of distress and low mood can be achieved by helping the patient to adopt coping skills and by helping them to recognise and manage stressors.

Some of these techniques are borrowed from a cognitive behavioural therapy approach. They do require some skill and practice, but should be within the remit of motivated care providers for people with diabetes. Screening for depression and diabetes-related distress requires sensitive questioning. A lead into asking about mood might begin with questions about how the person with diabetes feels about his/her diabetes. For example, asking questions such as: How are you finding living with diabetes? Do you think that the way you are feeling affects your self-care (such as healthy eating, monitoring and physical activity)? Are there other aspects of your life that are taking priority at the moment? Once this type of dialogue is established, it may then be appropriate to introduce some specific questions that may help to identify any depressive illness. For example: During the past few weeks, have you often been bothered by feeling down, depressed or hopeless? During the past month, have you often been bothered by having little interest or pleasure in doing things? A more comprehensive assessment may need to be implemented at this stage. One useful way to help recognise depression is to use a system called FESTIVAL. This is a list of common symptoms. If five or more of these symptoms are present for more than two weeks, it is likely that a depressive episode is occurring. The symptoms are as follows:

Feeling: depressed, sad, anxious or bored. Energy: tiredness, fatigue, everything seems an effort, slowed movements. Sleep: waking during the night or too early in the morning, oversleeping or trouble getting to sleep. Thinking: slow thinking, poor concentration, forgetful or indecisive. Interest: loss of interest in food, work, sex and life generally. Value: reduced sense of self-worth, low self-esteem or guilt. Aches: headaches, chest or other pains or palpitations without a physical basis. Live: not wanting to live or suicidal thoughts.

The best management depends on a person-centred approach to care, which enables openness and trust between the health professional and the person with diabetes.

Psychological distress can profoundly impact on diabetes self-management. There are no easy answers about why this is true. The stress of being diagnosed with a chronic condition, dealing with the daily management and never having a ‘day off’ from diabetes and feeling restricted in what you can eat and drink, can make a person with diabetes feel alone or set apart from family and friends who don’t have diabetes. If patients face diabetes complications such as nerve damage or are having trouble keeping their blood sugar levels within range, they may be finding it difficult to control their diabetes and this can make them feel frustrated and sad. For people with diabetes, depression can develop as a result of the lifestyle adjustments they have to make to control their diabetes. Managing diabetes can be stressful and time consuming and the dietary restrictions can make life seem less enjoyable. If a person is feeling depressed and has no energy, they may feel less motivated to eat healthy and take regular physical activity.

**TREATMENT**

The outlook for people with diabetes and depression who seek treatment is very promising. The first step in getting help for depression is patients recognising that they may have a problem and discussing their symptoms with their GP or practice nurse. This is not necessarily as easy as it sounds. Depression can be stigmatised negatively and people can feel that they will not be understood and feel alone. Accepting the help of others can be a major hurdle to overcome. As healthcare professionals, we need to be approachable and be responsive to our patients needs.

Attending an Aware Support Group offers the opportunity for those with depression to interact with other people in a similar situation. Aware also has a helpline (1890 303 302) that is a listening service for people affected by depression, either personally or as family and friends. Their website address is: www.aware.ie.

**STUDY DAY – 11th MARCH**

To find out more about diabetes and depression, the Diabetes Federation of Ireland is holding a multidisciplinary study day ‘The Ultimate Diabetes Toolkit to Enhance Cost-effective Management and Reduce Diabetes Related Complications’ in Croke Park March 11th 2011 with guest speaker Richard Holt, Professor in Diabetes & Endocrinology, University of Southampton, talking about Diabetes and Depression – Double the Cost? Contact the Diabetes Federation of Ireland on 01-836 3022 or 1850 909 909 for further details.
References

Multidisciplinary Diabetes Study Day
Friday 11th March 2011
Hogan Mezzanine Suite, Croke Park, Dublin 3
‘The ultimate diabetes toolkit to enhance cost-effective management and reduce diabetes related complications’

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<th>Morning Session: Chair: Dr. Diarmuid Smith</th>
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| 11.30 | Key Note Speaker “Diabetes and Depression – Double the cost? Richard IG Holt, Professor in Diabetes & Endocrinology, Faculty of Medicine University of Southampton |
| 12.45 | Lunch |

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<th>Afternoon session: Upskill your toolkit to enhance everyday management issues Chair: Professor Tomkin</th>
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Valdoxan® 25 mg film-coated tablets

**Indications:** Treatment of major depressive episodes in adults.

**Dosage:**
- Adults: The recommended dose is 25 mg once daily taken orally at bedtime. After two weeks of treatment, if there is no improvement of symptoms, the dose may be increased to 50 mg once daily after at least 4 weeks' treatment as a single daily administration or in two divided doses, with the higher dose being given at bedtime.
- Children and adolescents (<18 years): Not recommended.

**Contraindications:**
- Hypersensitivity to the active substance or any of the excipients.
- History of suicidal ideation prior to commencement of treatment.
- Pregnancy.

**Drug Interactions:**
- Agomelatine is metabolised mainly by cytochrome P450 1A2 (CYP1A2) (90%) and by CYP2C9/19 (10%). Medicinal products that interact with these isoenzymes may decrease or increase the bioavailability of agomelatine. Fluvoxamine, a potent CYP1A2 and moderate CYP2C9 inhibitor, markedly inhibits the metabolism of agomelatine resulting in a 60-fold (range 12-412) increase of agomelatine exposure. Consequently, co-administration of fluvoxamine and Valdoxan (agomelatine) is contraindicated. Combination of agomelatine with oestrogens, caution should be exercised when prescribing agomelatine with other moderate CYP1A2 inhibitors (e.g. propranolol, garefol oxacine, enoxacine) until more experience has been gained.

**Overdosage:**
- There is limited experience with agomelatine overdose. During the clinical development, there were a few reports of agomelatine overdoses, taken alone (up to 450 mg) or in combination up to 1250 mg with other psychotropic medicinal products. Signs and symptoms of overdose were limited and included drowsiness and agitation. No specific antidotes for agomelatine are known. Management of overdose should consist of treatment of clinical symptoms and routine monitoring. Medical follow-up in a specialised environment is recommended.

**Precautions:**
- Patients with a history of suicide-related events or those exhibiting a significant degree of suicidality prior to commencement of treatment are known to be at greater risk of suicidal thoughts or suicide attempts, and should receive careful monitoring during treatment.

**Adverse Events:**
- In clinical trials, over 3,900 depressed patients have received Valdoxan. Adverse reactions were usually mild or moderate and occurred within the first few weeks of treatment. The most common adverse reactions were nausea and dizziness. These adverse reactions were usually transient and did not generally lead to cessation of therapy. Adverse reactions are listed below the following convention: frequency (most common) ≤ 1/100, very rare ≤ 1/10, rare ≤ 1/100 to < 1/10, common ≤ 1/10 to < 1/100, very rare ≤ 1/1000, very very rare ≤ 1/10000.

**Summary of Product Characteristics:**
- Full prescribing information is available from: Servier Laboratories, Block 2, West Pier Business Campus, Old Dunleary Road, Dun Laoghaire, Co Dublin. Tel: (01) 6638110, Fax: (01) 6638120.

**Legal Category:** POM.

**Marketing Authorization Numbers and Holders:** EUL/1/08/499/003 Laboratories Servier, 22 rue Garnier, 92200 Neuilly-sur-Seine, France. Date of Preparation or Last Review: February 2010.

**Date of preparation or last review:** February 2010. Full prescribing information is available from: Servier Laboratories, Block 2, West Pier Business Campus, Old Dunleary Road, Dun Laoghaire, Co Dublin. Tel: (01) 6638110, Fax: (01) 6638120. Date of preparation or last review: February 2010.

**Summary of Product Characteristics for further details.**

**Pharmacological group:** Antidepressants, Melatonergic.

**Pharmacological properties:**
- Agomelatine is a melatonergic agonist (MT1 and MT2 receptors) and 5-HT2C antagonist. Agomelatine resynchronises circadian rhythms in animal models of circadian rhythm disruption. Agomelatine increase noradrenaline and dopamine release specifically in the frontal cortex and has no influence on the extracellular levels of serotonin.

**Therapeutic indications:**
- Treatment of major depressive episodes in adults.

**Pharmacokinetics:**
- The first melatonergic antidepressant.
The Irish weather is known for its rain and wind particularly in the winter. To date the weather has taken us by surprise as it is the coldest snap in decades according to the met office. Ferocious weather has an enormous effect on our health, mood, transport, mobility, down to whether or not most of us get to work or not. Cold weather has a marked effect on determining the quality of a simple blood sample from its journey out of the vein to the laboratory centrifuge.

Minimising abnormal potassium levels (pseudohyperkalaemia) in cold weather and other conditions

30% of blood samples from general practice are reported as abnormal.

With particular focus on potassium samples, pseudohyperkalaemia may arise from poor handling, storing and excessively warm or excessively cold weather. This impacts on clinical time and resources initiating repeat blood tests for the patient.

With the advances in computerisation some of us are lucky to be able to access our patient’s results more quickly via email.

The assessment of renal function, with U and E’s (urea and creatinine, sodium, and potassium) will form a significant percentage of them.

“Severe hyperkalaemia is a life-threatening emergency as it may cause cardiac arrhythmias, leading to cardiac arrest. With these potentially catastrophic sequelae, urgent investigation and treatment of genuine hyperkalaemia is essential. “(Dr Carabine, 2008)

Some of the common causes of hyperkalaemia include renal failure, metabolic acidosis and drugs such as potassium sparing diuretics, angiotensin converting enzyme inhibitors (ACE) and excess potassium therapy.

The practice nurse plays a major role in reducing room for error and avoiding a raised serum potassium that is inaccurate otherwise known as pseudohyperkalaemia.

Pseudohyperkalaemia is described as an artificially raised level of potassium occurring during the collection, storage, or transportation of blood specimens.
Causes include:
• Difficult venepuncture
• A clenched fist whilst the sample is taken
• Cooling of the sample or the sample in excessive heat
• A shaken or squirted sample through a needle into the collection tube.

Contamination with anticoagulant from another sample; therefore, the ‘order of draw’ is important.

Deterioration of the specimen due to the length of storage, hence overnight storage should be avoided.

Blood sample collection needs careful thought throughout the chain of process to get the most accurate result. 30% of blood samples from general practice are reported as abnormal (Johnston and Hawthorne. 1997). The practice nurse needs to be aware that potassium levels are particularly sensitive to temperature.

Temperatures of 25-30°C cause red cell stimulation and consequently results in a fall in serum potassium. (Stuart and Smellie 2007) During the summer season average laboratory results have been reported to fall by up to 0.5mmol. (Trull et al)

Higher temperatures in excess of 30°C or storage for long periods may lead to haemolysis of the sample. Studies have shown that samples stored at 18°C for up to 16 hours maintain accurate potassium levels. (Masters et al. 1996) Each general practice has its own protocol as to how to deal with abnormal potassium results. In essence, a spurious result where there is any doubt, is a source of unnecessary and significant stress for both the doctor and the patient.

How practice nurses can improve standards
Use the recommended green 21 gauge needle and vacutainer for some samples – use of the black narrower needle carries the risk of hyperkalaemia secondary to damage of the red blood vessels.

Try to avoid using a needle and syringe as haemolysis can occur if syringes are used as the blood is squirted through the needle into the collection tube.

Biochemistry samples should always be taken first before collecting other samples. This is to avoid contamination from other sample bottles with additives, which would otherwise artificially raise potassium levels.

Samples should be stored at room temperature.

Avoid long storage times. Perhaps consider a policy of no blood samples in the afternoon therefore avoiding the chance of overnight storage.

Higher temperatures in excess of 30°C or storage for long periods may lead to haemolysis of the sample.

Once the samples leave the practice it is difficult to influence the process further. It is always useful to liaise with laboratory staff as a strict protocol has a win-win result for all. Liaising with the courier who delivers the samples to the hospital may also be very productive.

Summary
In conclusion, it appears that clear advice and education regarding best practice, drawing, storing, and transporting blood samples is paramount in avoiding spuriously raised potassium results. Always ask yourself the following:
• Have I noticed an abnormally raised number of bloods that need to be repeated unnecessarily?
• Have I got a protocol?
• Could I improve my technique, blood storing and transportation of blood samples?
I know I can!

References
Winner of the IPNA Educational Bursary 2010

Multimorbidity – the practice nurse perspective

Jane Campion

Abstract

Background
Practice nurses have a key role in chronic disease management. There are no structured programmes in place specifically targeting patients with multimorbidity in Ireland. When programmes are in place the frequency of GP visits, hospital admissions, and acute episodes are reduced and patient satisfaction is increased.

This study aims to explore practice nurses’ perceptions of caring for patients (>65 years) with multimorbidity, in the Irish Primary Care – General Practice setting, with a view to informing practical methods of managing these patients.

The objectives were to:
1. Identify existing services (if any) the study participants provide, within their own practice, specifically for patients (>65 years of age) with multimorbidity in this setting,
2. Elicit PN perceptions of caring for the patient with multimorbidity,
3. Identify potential methods of caring for this group of patients at a practice level,
4. Inform future research or initiatives for the management of multimorbidity.

Methods
The sampling frame was practice nurses from one region covered by the Irish Practice Nurses Association. This study used mixed methodologies for data collection. Preliminary data collection (quantitative) used postal questionnaires, gathering information on sample characteristics, and facilitating purposeful sampling to achieve maximum variation in qualitative data collection.

Because of the dearth of literature on the practice nurses’ perspective of managing multimorbidity, the main research design was qualitative using broad precepts of grounded theory. Semi-structured interviews allowed an in-depth insight on which to develop recommendations for patient care and service delivery. Sample size was determined by data saturation.

Results
The response rate to the postal questionnaire was 68.9%. Eleven respondents were included in the qualitative analysis. Limited resources such as Information Technology and Time were perceived as barriers to multimorbidity management.

Conclusion
The primary findings of this study are:
• Firstly, a myriad of issues affect multimorbidity management.
• Secondly, PNs felt that many elements of case management were already being done in primary care, but not given a title.
• Thirdly, PN education is vital to enable PNs to empower both themselves and patients by teaching the necessary skills for self-management.
• Fourthly, effective communication is key to quality care.
• Lasty, primary care is already running to full capacity. Caution must be exercised to ensure the appropriate resources including time and IT are in place before new initiatives are implemented.

With such an international and national focus on chronic disease management comes the opportunity for advancing nursing practice and indeed, for nursing, as a profession, to lead the way in establishing a primary care based health service for patients with multimorbidity.
A REVOLUTIONARY TREATMENT FOR WOMEN WITH POSTMENOPAUSAL OSTEOPOROSIS

A NEW FORCE AGAINST FRACTURE

Stopping osteoclasts before they reach the bone.\(^1,2\)

Introducing the first and only licensed RANK Ligand inhibitor that works throughout the skeleton to protect women with postmenopausal osteoporosis from osteoporotic fracture.\(^3\)

A FORCE AGAINST FRACTURE


Prolixa® (denosumab) Brief Prescribing Information

Please refer to the Summary of Product Characteristics before prescribing PROLIA®. Please consult the Summary of Product Characteristics for a full description of undesirable effects. Pharmaceutical Precautions: PROLIA® must not be mixed with other medicinal products. Store at 2°C to 8°C (in a refrigerator). PROLIA® may be exposed to room temperature (up to 25°C) for a maximum single period of up to 30 days in its original container. Once removed from the refrigerator PROLIA® must be used within this 30 day period. Do not freeze. Keep in outer carton to protect from light.


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Remember this is a Swallow Tablet!

Convenient to take swallow tablet

20% more calcium than the market leader¹
Assessment of postmenopausal women and significant risk factors for osteoporosis

Schnatz PF, Marakovits KA, O’Sullivan DM
Obstet Gynecol Surv 2010 Sep; 65 (9): 591-6

The assessment of osteoporosis risk factors can help guide early intervention. The objective of this US study from the Department of Obstetrics, Reading Hospital and Medical Center, was to analyze numerous potential risk factors to see which were associated with postmenopausal osteoporosis.

Women aged 49 or greater presenting for dual-energy x-ray absorptiometry bone scans were recruited from radiology sites in the Hartford, Connecticut area between January 2007 and March 2009, inclusive. Information was collected regarding primary and secondary risk factors for osteoporosis development, as well as family history and history of pregnancy and breastfeeding.

Survey results were subsequently correlated with each woman’s dual-energy x-ray absorptiometry scan results. In a sample of 619 women, history of fracture (odds ratio [OR], 12.49), weight less than 127 pounds (OR, 3.50) and use of anticoagulants (OR, 5.40) increased the chance of developing osteoporosis.

In contrast, multiparity (OR, 0.45) and history of breastfeeding (OR, 0.38) decreased the development of osteoporosis in postmenopausal women.

In women aged 49 to 54, breastfeeding was significantly protective, while low body mass index was most indicative of osteoporosis in women aged 55 to 64. Both previous fracture and low body mass index were associated with osteoporosis in women over the age of 64.

The current results are consistent with other studies suggesting that previous fracture, low body weight and use of anticoagulants increase the risk of osteoporosis. The results also suggest that a history of pregnancy and breastfeeding protects against the development of postmenopausal osteoporosis, especially in women aged 49 to 54.

Women with cardiovascular disease have increased risk of osteoporotic fracture

Chen JS, Hogan C, Lyubomirsky G, Sambrook PN
Calcif Tissue Int 4 November 2010

This Australian study from the Kolling Institute of Medical Research, Sydney Medical School, investigated whether women with cardiovascular disease (CVD) would have an increased risk of fractures as osteoporosis and CVD share many common risk factors.

From February 2006 to January 2007, 17,033 women aged ≥50 years (mean 71.8, range 50-106) were recruited by 1,248 primary care practitioners and interviewed by trained nurses.

For each woman, 10-year probability of a future major osteoporotic fracture was estimated using the World Health Organisation’s Fracture Risk Assessment Tool (FRAX). The study showed that the 10-year probability of a major osteoporotic fracture was higher for the 6,219 CVD women compared to the 10,814 non-CVD women after adjustment for age, BMI, current smoking and alcohol use (adjusted geometric means 14.3 and 13.8%, respectively; p<0.001).

With regard to high risk of fracture (i.e. 10-year probability ≥ 20 per cent), the adjusted odds ratio for CVD was 1.23 (95 per cent CI 1.13-1.35, p<0.001). However, compared to non-CVD women, CVD women were more likely to report a previous fracture, to have a secondary osteoporosis and to use glucocorticoids.

Among the 4,678 women who were classified as having a high fracture risk, the current use rate of bone-related medications (i.e. any one of bisphosphonates, raloxifene, PTH, vitamin D, calcium or hormone therapy) was 50.2 per cent in the CVD group and 56.9 per cent in the non-CVD group.

Women with CVD were at increased risk of fracture partly due to bone-specific risk factors, such as history of previous fracture, use of glucocorticoids and secondary osteoporosis. This risk is not being treated appropriately by primary health physicians.
Implementation of osteoporosis guidelines: a survey of five large fracture liaison services in The Netherlands

J Huntjens KM, van Geel TA, Blonk MC et al
Osteoporos Int
4 November 2010

The implementation of case findings according to guidelines for osteoporosis in fracture patients presenting at a Fracture Liaison Service (FLS) was evaluated. Despite one guideline, all FLSs differed in the performance of patient selection and prevalence of clinical risk factors (CRFs), indicating the need for more concrete and standardised guidelines.

The aim of this study from the Department of Trauma Surgery, Maastricht University Medical Centre, The Netherlands, was to evaluate the implementation of case findings according to guidelines for osteoporosis in fracture patients presenting at FLSs in the Netherlands.

Five FLSs were contacted to participate in this prospective study. Patients older than 50 years with a recent clinical fracture who were able and willing to participate in fracture risk evaluation were included. Performance was evaluated by criteria for patient recruitment, patient characteristics, nurse time, evaluated CRFs, bone mineral density (BMD) and laboratory testing and results of CRFs and BMD were presented.

Differences between FLSs were analysed for performance (by chi-square and Student’s t test) and for prevalence of CRFs (by relative risks [RR]).

All FLSs had a dedicated nurse spending 0.9 to 1.7 hours per patient. During 39 to 58 months follow-up, 7,199 patients were evaluated (15 to 47 patients/centre/month; mean age, 67 years; 77 per cent women).

Major differences were found between FLSs in the performance of patient recruitment, evaluation of CRFs, BMD and laboratory testing, varying between 0 per cent and 100 per cent. The prevalence of CRFs and osteoporosis varied significantly between FLSs (RR between 1.7 and 37.0, depending on the risk factor).

All five participating FLSs with a dedicated fracture nurse differed in the performance of patient selection, CRFs and in the prevalence of CRFs, indicating the need for more concrete and standardised guidelines to organise evaluation of patients at the time of fracture in daily practice.

Low bone mineral density in rotating-shift workers

Quevedo I, Zuniga AM
J Clin Densitom
2010 Oct-Dec; 13 (4): 467-9

Shift workers have been reported to have an increased bone resorption. However, no existing evidence indicates lower bone mineral density (BMD) in this group.

The objective of this Chilean study from the Division of Endocrinology, University of Concepcion, was to test the hypothesis that a rotating-shift work schedule is associated with low BMD and osteoporosis.

The authors evaluated 70 postmenopausal nurses from the Naval Hospital in Concepcion. The participants were categorised according to the type of work schedule: 39 had a rotating shift and 31 were daytime workers.

Medical history, a health examination, a questionnaire on health-related behaviors and biochemical determinations, and BMD examination were obtained for all participants.

When comparing the two groups, the rotating-shift workers had lower BMD in the lumbar spine (L1-L4: 0.957 ± 0.15 versus 1.104 ± 0.13; p<0.05) and lower bone density in both femoral neck bones (right: 0.936 ± 0.17 versus 1.06 ± 0.12; p<0.05 and left: 0.956 ± 0.19 versus 1.05 ± 0.12; p<0.05).

Additionally, the T-scores for 10 (25.6 per cent) of the rotating-shift workers indicated osteoporosis at lumbar spine (T-score<-2.5). No evidence of osteoporosis was found for daytime workers.

When comparing the two groups, the rotating-shift workers had a higher prevalence of osteopenia (T-score=-1.0 to – 2.5) than the daytime workers: 46.2 per cent versus 35.5 per cent, respectively.

The authors found significant evidence that rotating-shift workers have lower BMD in the trabecular and cortical bones, thus suggesting that this type of work may be a risk factor for osteoporosis. Due to the fact that this is the first time that this osteoporosis risk factor has been reported, the association needs to be replicated and confirmed in other settings.
Help Protect Your Post-Menopausal Patients From Osteoporotic Fractures

The Only Osteoporosis Therapy With 5600 IU of Vitamin D That Provides Demonstrated Fracture Prevention at the Hip and Spine, \textsuperscript{1,2,4} in one tablet

Updated NOF \textsuperscript{a} guidelines recommend 800–1000 IU of vitamin D per day for adults ≥50 years \textsuperscript{b}

FOSAVANCE® \textsuperscript{c} is a fixed-dose combination of alendronate and colecalciferol (calciferol) 2800 IU. (See \textsuperscript{d} for complete \textsuperscript{e} warnings, precautions, and \textsuperscript{f} contraindications.)

**Precautions**

- **Intraday calcium and vitamin D:** Patients with rare hereditary problems of fructose intolerance, galactose intolerance, the Lapp lactase deficiency, glucose-galactose malabsorption, or deficiencies of the pyridoxine-dependent enzyme (e.g., hyperparathyroidism, hypophosphatemia), are not recommended.

**Contraindications**

- **Intraocular and/or intracisternal calcium and vitamin D:** Patients with rare hereditary problems of fructose intolerance, galactose intolerance, the Lapp lactase deficiency, glucose-galactose malabsorption, or deficiencies of the pyridoxine-dependent enzyme (e.g., hyperparathyroidism, hypophosphatemia), are not recommended.

- **Intraday calcium and vitamin D:** Patients with rare hereditary problems of fructose intolerance, galactose intolerance, the Lapp lactase deficiency, glucose-galactose malabsorption, or deficiencies of the pyridoxine-dependent enzyme (e.g., hyperparathyroidism, hypophosphatemia), are not recommended.

**Side effects**

- **Skin and subcutaneous tissue disorders:** Includes infections and infestations, including infections and infestations of the skin, subcutaneous tissue, and other sites.

- **Musculoskeletal (bone, muscle or joint) pain:** Includes pain and tenderness of bone, muscles, and joints.

- **Immune system disorder:** Includes infections and infestations of the skin, subcutaneous tissue, and other sites.

- **Eye disorders:** Includes infections and infestations of the skin, subcutaneous tissue, and other sites.

- **Gastrointestinal disorders:** Includes infections and infestations of the skin, subcutaneous tissue, and other sites.

- **General disorders and administrative site conditions:** Includes infections and infestations of the skin, subcutaneous tissue, and other sites.

**References**

1. National Osteoporosis Foundation. \textsuperscript{1} Date of review: November 2009.


3. MSD Australia Pty Ltd. \textsuperscript{c} Date of review: November 2009.


5. MSD Australia Pty Ltd. \textsuperscript{d} Date of review: November 2009.

6. Pelham House, South County Business Park, Leopardstown, Dublin 18, Ireland
A team approach: implementing a model of care for preventing osteoporosis-related fractures

The implementation of a multidisciplinary team-based model of care has led to significant increases in identification of patients with osteoporosis who are at risk of refracture, together with improved treatment uptake and ongoing management. Osteoporosis-related fractures and consequent hospital admissions are largely preventable; however, little attention has been paid to how to achieve this, in particular, through improved models of care. Presentation to emergency departments (ED) with minimal trauma fracture (MTF) provides opportunity for patients at risk to be identified, referred and managed through a systematic process ensuring prompt intervention and continuing follow-up.

This Australian study from the John Hunter Hospital, Newcastle, was aimed to design and implement a care model for people over 50 years of age, presenting to ED with an MTF. A multidisciplinary fracture prevention team to identify and capture at-risk patients for referral and management was established. Clinical data revealed the extent of lost opportunities. An electronic flagging system and data acquisition tool were developed and piloted. A referral pathway to detect, manage and follow-up patients was also established which was coordinated by a fracture prevention nurse.

Increased awareness of osteoporosis as a cause of MTF, better identification of at-risk patients across departments and services and the development of a referral protocol has resulted in 100 per cent capture of at-risk patients presented to ED. As a result, there has been a significant increase in patients attending the fracture prevention clinic (p<0.001) from 11 per cent in 2007 to 29 per cent in 2008 and a significantly reduced time between fracture and when patients were seen in the fracture prevention clinic (p<0.001).

The authors found that a multipronged systematic team approach to identifying and capturing patients with a high risk of refracture and a dedicated nurse coordinator role have created efficiencies in the detection and management of osteoporosis.

Can self-reported height and weight be used to calculate 10-year risk of osteoporotic fracture?

The objectives of this UK study from the Department of Rheumatology, County Durham and Darlington Foundation Trust were: to determine the magnitude of error between self-reported height and weight and measured height and weight; and to measure what affect this has on calculating 10-year probability of osteoporotic fracture using the World Health Organisation’s Fracture Risk Assessment Tool (FRAX).

The data were collected from a nurse-led community osteoporosis clinic and involved 214 post-menopausal women with at least one risk factor for osteoporosis. Collected data included self-reported and measured height and weight, risk factors for osteoporosis, demographic details and 10-year probability of hip fracture or any major osteoporotic fracture as measured by FRAX.

It was found that patients over-reported their height by a mean (95 per cent confidence interval) of 2.8 (2.3-3.2) cm and under-reported their weight by a mean of 2.1 (1.3-2.6) kg. The resulting underestimation of body mass index was 1.8 (1.3-2.0) units.

Using self-reported height and weight resulted in a significant over-estimation of 10-year risk of hip fracture and any major osteoporotic fracture when compared to measured height and weight; median 10-year probability of hip fracture 3.75 per cent versus 3.25 per cent (p<0.001), median 10-year probability of any major osteoporotic fracture 15 per cent versus 14 per cent (p<0.001).

When calculating 10-year risk of fracture using the FRAX online assessment tool, measured height and weight should be used instead of self-reported height and weight.
Calcium and/or vitamin D deficiency in the elderly can lead to loss of muscle tone and an increase in falls and osteoporotic fractures.  

Calcichew-D3 Forte is indicated for the treatment and prevention of calcium and vitamin D deficiency.

**CALCICHEW-D3 FORTE CHEWABLE TABLETS PRESCRIBING INFORMATION**

(Please refer to full Summary of Product Characteristics when prescribing)

**Presentation:** Chewable tablet containing 1250mg calcium carbonate (equivalent to 500mg of elemental calcium) plus 400IU colecalciferol (equivalent to 10 micrograms vitamin D3).

**Uses:** Treatment and prevention of vitamin D/calcium deficiency. Supplementation of vitamin D and calcium as an adjunct to specific therapy for osteoporosis, in pregnancy, in established vitamin D dependent osteomalacia and in other situations requiring therapeutic supplementation of malnutrition.


**Contraindications:** Diseases and/or conditions resulting in hypercalcaemia and/or hypercalciuria, renal stones, hyperparathyroidism, hypervitaminosis D, hypersensitivity to ingredient(s) especially soybean oil and peanut. Precautions: Monitor serum calcium and creatinine levels, particularly in elderly patients on cardiac glycosides or diuretics and in patients with high tendency to calculus formation. Use with caution in patients with impaired renal function. Take into account risk of soft tissue calcification. Avoid in patients with phenylketonuria or sugar intolerance. Prescribe with caution in patients with sarcoidosis. Use with caution in immobilised patients. Additional doses of calcium or vitamin D should only be taken under close medical supervision. Interactions: Tetracyclines (take 2 hours before, or 4 to 6 hours after Calcichew-D3 Forte), bisphosphonates or sodium fluoride (take 3 hours before Calcichew-D3 Forte), thiazide diuretics, corticosteroids, cardiac glycosides, ion exchange resins (cholestyramine), laxatives (paraffin oil). Calcichew-D3 Forte should not be taken within 2 hours of eating foods high in oxalic acid (e.g. spinach and rhubarb) or phytic acid (e.g. whole cereals).

**Side effects:** Hypercalcaemia, hypercalciuria, constipation, flatulence, nausea, abdominal pain, diarrhoea, pruritus, rash, urticaria.

**Use in pregnancy and lactation:** Can be used in case of calcium and vitamin D deficiency. Daily intake in pregnancy should not exceed 1500mg calcium and 600IU colecalciferol (15 micrograms vitamin D3). Avoid overdose as permanent hypercalcaemia affects developing foetus. Calcium and vitamin D3 pass into breast milk so consider this when giving additional vitamin D to the child.

**Pharmacological precautions:** Do not store above 30°C. Keep container tightly closed.

**Legal category:** Pharmacy product. **Product Authorisation No:** 535/1/3. **Product Authorisation holder:** Shire Pharmaceuticals Ltd., Hampshire International Business Park, Chineham, Basingstoke, Hampshire RG24 8EP UK. Distributed in Republic of Ireland by: Cahill May Roberts, P.D. Box 1090, Chapelizod, Dublin 20, Republic of Ireland. Further information is available on request. Date of revision: July 2007. CALCICHEW is a registered trademark of Shire Pharmaceuticals Ltd in the Republic of Ireland.

**Adverse events should be reported to the Pharmacovigilance Unit at the Irish Medicines Board (IMB) (imbpharmacovigilance@imb.ie). Information about adverse event reporting can be found on the IMB website (www.imb.ie). Adverse events may also be reported to Shire Pharmaceuticals Ltd on +44 1256 894000.**

**References:**

**CALCICHOW-D3 FORTE CALCIUM CARBONATE COLECALCIFEROL**

Their strength is our forte

**Now 24% less expensive than our nearest competitor.**

MAT IMS to March 2010

* Nearest competitor defined by market share

July 2007

** scipy reference**

**sciPy Reference**

**Help Protect the Fragile Elderly**

Calcium and/or vitamin D deficiency in the elderly can lead to loss of muscle tone and an increase in falls and osteoporotic fractures.

Calcichew-D³ Forte is indicated for the treatment and prevention of calcium and vitamin D deficiency.

**Their strength is our forte**

**Calcichew Ad 24% 210x297:Layout 1  24/08/2010  15:55  Page 1**
Valdoxan – innovation for the treatment of depression in primary care

The official primary care launch of Valdoxan (agomelatine), the first melatonergic antidepressant for the treatment of adult patients with major depressive disorders (MDD) was announced recently.

After several decades of a single, monoaminergic approach to the treatment of depression, Valdoxan’s unique mechanism of antidepressant action represents a novel and totally innovative pharmacological approach to treating MDD – effectively resynchronising the circadian (sleep) rhythms of depressed patients.

Speaking at the first of a series of primary care meetings held throughout Ireland focussing on innovation in the treatment of depression to mark the launch of Valdoxan, Professor Sidney Kennedy, Professor of Psychiatry, University of Toronto, Canada discussed the products mode of action:

“Valdoxan is the first antidepressant that simultaneously acts as a MT1 and MT2 melatonergic receptors agonist and a 5-HT2C antagonist. As a result, Valdoxan resynchronises circadian rhythms that are profoundly disrupted in depressed patients.”

Discussing the evidence base for Valdoxan, Prof Kennedy detailed both short – and long-term results from a large international clinical development programme of more than 6,000 patients with depression. He said:

“Valdoxan demonstrated superior antidepressant efficacy when compared with placebo, selective serotonin reuptake inhibitors (SSRIs) and serotonin noradrenaline reuptake inhibitors (SNRIs). It has also shown throughout the studies a tolerability and safety comparable to placebo, both in terms of adverse events as well as laboratory parameters or specific tolerability issues, such as sexual function3, body weight, and discontinuation symptoms.”

MiRamel (Pramipexole) 0.088mg and 0.70mg tablets

Clonmel Healthcare has announced the launch of MiRamel (Pramipexole) 0.088mg, 0.18mg & 0.70mg tablets. This product will join our other medicine product listings within the Ethical Prescription Division of Clonmel Healthcare.

MiRamel is indicated for the treatment of the signs and symptoms of idiopathic Parkinson’s disease, alone (without levodopa) or in combination with levodopa, i.e. over the course of the disease through to the late stages. MiRamel is indicated for the symptomatic treatment of moderate to severe idiopathic Restless Legs Syndrome in dosages up to 0.54mg of base (0.75mg of salt).

MiRamel 0.088mg, 0.18mg & 0.70mg tablets are 41% cheaper than the brand leader.

MiRamel 0.088mg, 0.18mg & 0.70mg tablets are 41% cheaper than the GMS from 1st January 2011.

GMS codes for MiRamel tablets are:

MiRamel 0.088mg – 33636
MiRamel 0.18mg – 33637
MiRamel 0.70mg – 33638

Full prescribing information is available on request or go to www.clonmel-health.ie.

Product is subject to prescription. Please contact Clonmel Healthcare on 01-6204000 if you require any additional information on MiRamel (Pramipexole) 0.088mg, 0.18mg & 0.70mg tablets.

Fosavance improves vitamin D levels in postmenopausal women with osteoporosis compared to referred care

MSD Ireland announces that new data from FOCUS D presented at the 2010 Annual Meeting of the American Society for Bone and Mineral Research (ASBMR) demonstrated that the combination tablet alendronate 70 mg/vitamin D3 5600 IU weekly improved the levels of vitamin D among postmenopausal women with osteoporosis and low vitamin D levels defined as 25-hydroxyvitamin D level <20 ng/mL (50 nmol/L), compared to therapies independently prescribed by their personal physicians, which may have included vitamin D supplementation alongside osteoporosis medicine. After 26 weeks of treatment, the proportion of women with low vitamin D levels, defined as 25-hydroxyvitamin D level <20 ng/mL (50 nmol/L), was significantly lower in patients given the combination tablet alendronate 70 mg/vitamin D3 5600 IU, group compared to those in the Referred Care group (7.8% compared to 31.2%, p<0.001).

Data from an extension of the study showed that the same effect on 25-hydroxyvitamin D levels was sustained after 52 weeks of treatment (11.3% compared to 36.9%; p<0.001).

“In postmenopausal women with osteoporosis, vitamin D is critical in helping to protect bones, yet many patients do not receive the necessary amounts as part of their standard care,” said Dr Tara Coughlan, Consultant Geriatrician AMNCH Tallaght.

“Our study found that more than 90 percent of patients with osteoporosis and low vitamin D levels who were treated with the alendronate 70 mg/vitamin D3 5600 IU combination tablet had above the target level of vitamin D compared to 69 percent of those in the Referred Care group.”

Rivaroxaban significantly reduces risk of stroke in patients with atrial fibrillation

Bayer has announced the results from the pivotal, double-blind Phase III, ROCKET AF trial. In the study, rivaroxaban demonstrated superiority to warfarin in reducing the risk of stroke and non-CNS systemic embolism in patients with atrial fibrillation (AF) who take their medication.

Importantly, rates of bleeding were similar to warfarin, and bleeding events most concerning to physicians and patients, including intracranial haemorrhage, critical organ bleed, and bleeding-related death, were significantly lower in the rivaroxaban group. The results were presented as a late-breaker at the American Heart Association Scientific Sessions 2010 in Chicago, USA. Commenting on the significance of the study results Prof David Keane, Consultant Cardiologist, St Vincent’s University Hospital, Dublin said: “AF and stroke devastate the lives of thousands of Irish patients and their families every year. Whilst anticoagulation with warfarin is effective in preventing strokes in patients with AF, it has been the standard of care for more than half a century and its use in clinical practice is associated with many limitations. Disappointingly, aspirin has been found to offer only minimal protection from stroke in patients with atrial fibrillation. “Considering the well-known challenges associated with warfarin it is exciting to be able to offer patients an alternative therapy with comparable safety and without an increase in significant bleeding. “The ROCKET AF study has shown that once-daily rivaroxaban promises patients improved protection from stroke, with good safety and added convenience.”
Iniparib prolongs survival in metastatic triple negative breast cancer

Sanofi-aventis and its fully owned subsidiary, BiPar Sciences, recently announced that final results from a randomized Phase II clinical trial confirmed that treatment with BSI-201 (iniparib) in combination with gemcitabine/carboplatin results in a significant improvement in overall survival and a high rate of clinical response in women with metastatic triple negative breast cancer (mTNBC). Findings from the study were presented at an oral presentation at the 35th European Society for Medical Oncology (ESMO) Congress in Milan, Italy.

Professor John Crown, consultant medical oncologist, St Vincent’s hospital, said: “These promising results suggest the possibility that an effective targeted therapy may soon become available for metastatic triple negative breast cancer. The results of large scale confirmatory trials are very eagerly awaited.”

According to the study results, median overall survival among women who received BSI-201 (iniparib) in combination with the chemotherapy agents gemcitabine and carboplatin was 12.3 months compared with 7.7 months among women who received chemotherapy alone, translating to a 43 percent reduction in the risk of death (HR=0.57). Median progression-free survival in the BSI-201 (iniparib) group was 5.9 months compared to 3.6 months in the chemotherapy group (HR=0.59). In addition, 55.7 percent of patients in the BSI-201 (iniparib) group showed a clinical benefit, defined as a complete or partial response or stable disease of at least six months, compared with 33.9 percent of patients in the chemotherapy group. There was no significant difference in adverse events between the two groups. The most common severe (grade 3 and 4) adverse events included neutropenia, thrombocytopenia, anemia, fatigue, leukopenia and increases in the enzyme ALT. The study included 123 women with mTNBC.

Teva Pharmaceuticals product discontinuation

Teva Pharmaceuticals Ireland has announced its intention to withdraw the following products from the Irish market:

- Aerolin Autohaler CFC-Free 100 micrograms (salbutamol)
  Expected date for depletion of stock for this product is end of January 2011
- Airomir Inhaler 200 dose aerosol (salbutamol) (100 micrograms per metered dose pressurised inhalation suspension)
  Expected date for depletion of stock for this product is end of May 2011

The decision to discontinue both products has been taken for commercial reasons, and is not due to any safety or quality issue, thus allowing pharmacists and patients to continue to dispense or use the stock that they currently have.

The following Teva therapeutic alternatives are available for patients on these products.

- Salamol Easi-Breathe (Salbutamol 100mcg per dose, 200 dose unit)
- Salamol MDI CFC free (Salbutamol 100mcg per dose, 200 dose unit)

Should you require any further information regarding these discontinuations, please contact Teva Pharmaceuticals at (042) 9395892

Lower protein in infant formula supports growth rate similar to breast milk

Newly published findings indicate that infants fed a lower protein infant formula developed by Pfizer Nutrition gained weight at a similar rate to those who were breastfed, according to a study published online today in the European Journal of Clinical Nutrition. Pfizer Nutrition has always recognized that breast milk is the best source of infant nutrition. The study established that infants fed a new; lower-protein infant formula attained the same growth rate and growth pattern as breastfed infants.

The rate of growth of a child is an important indicator of overall health and reflects a child’s nutritional well-being. The WHO recognizes that nutrition during the first years of life is crucial for life-long health and wellness. Globally, twenty-three million children face nutritional challenges, with at least 20 million children under the age of five estimated to be overweight.

“This study showed that when we fed infants with a formula that contained specially-adjusted levels of protein that more closely matched those found in breast milk, these babies grew at a rate similar to breastfed babies,” said a leading study author Rosario Capeding, Asian Hospital and Medical Center, Muntinlupa City, Philippines. “As we learn more about the importance of nutrition during early childhood, we recognize there is a critical need to ensure nutrients are received in the most appropriate proportions to support appropriate growth and development.

One of the ways in which breast milk and standard infant formulas differ is in their protein composition and concentration. Mature human milk contains 10-12 g/L of protein and is rich in essential amino acids. Standard infant formulas typically contain higher levels of protein in order to provide sufficient quantities of essential amino acids. It has been hypothesized that these higher protein concentrations could be one cause of the increased growth velocity seen in some formula-fed infants when compared to growth of infants who are exclusively breastfed. To allow for a reduction in total protein while preserving sufficient content of essential amino acids, the lower protein formula (New formula) used in this study was further enriched with alpha-lactalbumin, a protein that is found in human milk, and supplemented with small amounts of two amino acids, tyrosine and tryptophan.

Clavamel Forte 500mg/125mg film-coated tablets change in pack size

Clonmel Healthcare have announced that the pack size of Clavamel Forte (amoxicillin/clavulanic acid) has changed from 14 to 21 film-coated tablets.

The presentation has also changed from glass bottles to blister packs. The tablets were previously yellowish white to light yellow, oblong tablets debossed with “625” on one side; the new formulation is white to off-white, oval shaped film-coated tablets debossed with “AC” and a score line on one side. The reverse is plain.

If you require any further information, please contact Clonmel Healthcare on 01 6204000.
**Risontel (Risedronic Acid) 35 mg Once a Week Film-coated Tablets**

Clonmel Healthcare has announced the launch of Risontel (Risedronic Acid) 35 mg Once a Week Film-coated tablets. This product will join our other medicine product listings within the Ethical Prescription Division of Clonmel Healthcare.

Risontel is for the treatment of postmenopausal osteoporosis, to reduce the risk of vertebral fractures and hip fractures. It is also used to treat osteoporosis in men at high risk of fractures.

Risontel (Risedronic Acid) 35 mg Once a Week Film-coated Tablets are 28% cheaper than the brand leader. Risontel 35mg Once a Week Film-coated tablets are available on the GMS from 1st January 2011.

The GMS code for Risontel 35mg Once a Week Film-coated Tablets is – 50703:

Full prescribing information is available on request or go to www.clonmel-health.ie.

Product is subject to prescription. Please contact Clonmel Healthcare on 01-6204000 if you require any additional information on Risontel (Risedronic Acid) 35 mg Once a Week Film-coated Tablets.

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**Full dose range of Blopress (candesartan cilexetil) remains available**

Following Astra-Zeneca’s recent announcement confirming the withdrawal of candesartan 2mg, Takeda would like to reassure healthcare professionals that the full dose range of Blopress (candesartan cilexetil), including Blopress 2mg, remains available in Ireland. Blopress is indicated for the treatment of essential hypertension and chronic heart failure in patients with an LVEF < 40%.* Blopress is now the only candesartan treatment available as a 2mg tablet (pack of 7 or 28) and a 32mg tablet (pack of 28).

In addition, Blopress Plus (candesartan cilexetil/hydrochlorothiazide), indicated for the treatment of essential hypertension, is the only fixed dose combination available in the following doses of candesartan/hydrochlorothiazide: 8mg/12.5mg, 32mg/12.5mg and 32mg/25mg (all packs of 28).

Please refer to www.medicines.ie for the Summary of Product Characteristics (SmPC) for both Blopress and Blopress Plus.

* Blopress is indicated for the treatment of chronic heart failure in patients with an LVEF < 40% as an add-on to ACE inhibitors or when ACE inhibitors are not tolerated.

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**Qlaira is first combined oral contraceptive approved to treat heavy menstrual bleeding**

New data show that Qlaira (oestradiol valerate/dienogest) is the first oral contraceptive with proven efficacy in significant, rapid and sustained reductions in menstrual blood loss in women who suffer from heavy menstrual bleeding.

The clinical data were presented at the recent 13th World Congress of Obstetrics, Gynecology and Infertility. Qlaira is the first in a new class of oral contraception to deliver oestradiol combined with the progestogen, dienogest.

It was launched as an oral contraceptive in Ireland in 2009 and, in October 2010, received approval for the additional indication “Treatment of heavy menstrual bleeding in women without organic pathology who desire oral contraception.”

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**Ebixa Oral Solution – name change**

The Alzheimer’s medication Ebixa Oral Drops is to undergo a change of name which will be effective from January 2011. The current name “Ebixa 10mg/g Oral Drops, Solution” is changing at the request of the European Medicines Agency (EMA) to more accurately reflect the actual dosing of the Ebixa oral solution pump device. The new name will, from January 2001, be “Ebixa 5mg/pump, Oral Solution”. From January 2011 the Ebixa oral solution bottles will express the volume of Ebixa solution in mls. The volume will be expressed as 50ml and 100ml and this will replace the current quantity listed on the packs which is expressed in weight i.e 50g and 100g. Existing stocks of the current named product will be exhausted prior to supply of the “Ebixa 5mg/pump, Oral Solution” – 50ml & 100ml bottles.

**Ebixa 10mg Tablets – New Lactose Free tablet – consequential change of tablet colour**

The tablet formulation of Ebixa will also be changed to a lactose free tablet. As a consequence of this the excipients have changed and the colour of the tablet which is ‘yellow’ in colour. It is expected that stock of the yellow tablet will be available from approximately February 2011. Existing stocks of the white tablet will be exhausted prior to the supply of the yellow tablet.

Overall, the above changes to the tablets and oral solution do not affect the dosing of the Ebixa range of medications.
Congratulations to the winner of last month’s crossword, Melanie Carey, 18 Jigginstown Park, Naas, Co Kildare.

Please send your answers to the Editor, Nursing in General Practice, GreenCross Publishing, 7 Adelaide Court, Adelieade Road, Dublin 2. Closing date for entries: 4th March 2011. Winner will receive €50.

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

Across
5 Egg production centre (5)
6 Nicotinic acid found in California, Cinciannati etc. (6)
8 Part of a foot but not of a leg! (4)
9 Severe conjunctivitis contracted from ham actor (8)
10 Aerial on insect’s head? (7)
12 There’s no place like it! (4)
13 Anoble look? (4)
15 Ah! Harpo confused the king of Egypt (7)
17 Bone breakage is far cuter rearranged (8)
20 Mail distribution in Peru (4)
21 Surge forward to energise a battery? (6)
22 Heavenly body with a tail (5)

Down
1 The front of the eyeball can sound cornier (6)
2 The crate misapplied for a drainage tube (8)
3 Sac found in juicy steak (4)
4 Hasty in spots? (4)
6 Falls between U.S.A. and Canada! (7)
7 In Memoriam, in short! (2,3)
11 The god of the sea is a heavenly body! (7)
12 Light for miner or motorist? (8)
14 A planet but not a heavenly body (5)
16 Mr. Dumpty (6)
18 City in a bottleneck? (4)
19 Engrave in a quiet church (4)

Caltrate is a trademark. PA 172/38/1.
Full prescribing information available from Wyeth Consumer Healthcare, Plaza 254, Ballycoolin, Dublin 15 or from www.medicines.ie
TWYNSTA® (telmisartan/amlodipine)
Blue and white double-layer tablets containing telmisartan/amlodipine 40mg/5mg (enlarged A1), 80mg/10mg (enlarged A3) or 160mg/20mg (enlarged A4). Telmisartan is a specific angiotensin II receptor (type AT1) antagonist and amlodipine is a calcium channel blocker. Indications: Treatment of essential hypertension in adult patients whose blood pressure is not controlled on amlodipine monotherapy or as replacement therapy in adult patients receiving both telmisartan and amlodipine components from separate tablets or instead receive tablets of TWYNSTA® containing the same component doses. Once a day for 12 years. The maximum recommended dose is TWYNSTA® 80mg/10mg, one tablet per day. May be taken with or without food. It is recommended to take with some liquid. Special patient populations: Maximum dose of telmisartan in mild to moderate hepatic impairment 40mg. No dose adjustment needed for patients with mild to moderate renal impairment or the elderly. Limited experience available in severe renal impairment or haemodialysis. Not recommended in patients ≥18 years. Contraindications: Hypersensitivity to any of the ingredients of TWYNSTA® or to telmisartan or amlodipine. Secondary and third trimester of pregnancy, in any obstetric disorders, severe hepatic impairment, shock (including cardiogenic shock), severe hypotension, obstruction of the outflow tract of the left ventricle, haemodynamically unstable heart failure after acute MI. Warnings and Precautions: Pregnancy: Hepatic impairment, renal impairment, valvular heart disease, connective tissue disease, diabetes mellitus, collagen disease, infectious mononucleosis, increased liver enzymes, hyperkalaemia, non-cardiac valvular heart disease, hyperkalaemia, diabetes mellitus, collagen disease, infectious mononucleosis. Severe hypeension, obturation of the outflow tract of the left ventricle, haemodynamically unstable heart failure after acute MI

**ONCE DAILY DOSAGE STRENGTHS**

- **T40/A5 mg**
- **T80/A10 mg**
- **T80/A10 mg**

* N.B. Not actual tablet sizes

**Prescribing Information (Ireland)**

TWYNSTA® (telmisartan/amlodipine) is a calcium channel blocker and an angiotensin II receptor antagonist. The combination of these two components provides a potent and effective antihypertensive effect. The combination of telmisartan and amlodipine has been shown to be more effective than either component alone, and the combination is associated with fewer side effects. Telmisartan is a selective blocker of the renin-angiotensin system (RAS), while amlodipine is a calcium channel blocker. The combination of these two components provides a potent and effective antihypertensive effect. The combination of telmisartan and amlodipine has been shown to be more effective than either component alone, and the combination is associated with fewer side effects.

**References:**

**TWY0012**