Pennine GP Learning Group

Minutes of meeting

Date: Wednesday 19th June 2019

Time: 7.30 – 9.30pm (2 hours)

Topics: Polymyalgia Rheumatica: Diagnosis and Management by Dr Rukhsana Hussain

Suicide Prevention by Dr Louise Ainley

Members present: Louise Ainley, Ibrar Ali, Rukhsana Hussain, Chichi Iroegbu

1. The group welcomed Louise who has recently joined as a new member. We had a general chat regarding the format of the sessions and options for future topics including Familial Hyperlipidaemia and ADHD.

2. Dr Hussain shared with the group regarding the “learning notes” facility on SystemOne under the user tab.

3. Dr Hussain presented a summary of guidelines pertaining to the **Diagnosis and Management of PMR**. She focussed on NICE CKS guidelines which were updated in January 2019 as her main source of information alongside the RCP concise guideline from June 2010.

   We learned that the peak incidence of PMR is among the age 70-80 group and that women are more affected than men. We also learned that PMR is uncommon in Middle Eastern, African, Asian and Hispanic populations and is most common in those with Northern European Ancestry.

   15-20% of people with PMR will develop Giant Cell Arteritis and therefore all patients should be counselled at diagnosis and every review regarding the need for urgent review should they develop the symptoms of this condition.

   40-50% of patients diagnosed with Giant Cell Arteritis will have PMR symptoms.

   Complications of long term steroid treatment are very common and affect up to 50% of patients and hence why guidelines recommend thorough investigation and exclusion of mimicking conditions prior to trialling steroids as steroids could improve symptoms in other conditions too.

   Response to steroids tends to be dramatic in most patients with many symptoms resolving within 72 hours but a significant proportion of patients with the condition (29-45%) may have a lesser response even after 3-4 weeks. It can therefore be a challenging diagnosis to make.

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Higher inflammatory markers at diagnosis are associated with a longer duration of therapy and more relapse.

Although proximal pain and stiffness with a raised acute phase response are an indicator of the diagnosis, the presentation can be varied. Patients with PMR can have significant systemic symptoms such as fever and weight loss and may have distal symptoms also. Some may not have an acute phase response.

Guidelines recommend a 5 step approach to making a diagnosis – Core inclusion criteria, core exclusion criteria, exclude mimicking conditions, assess response to steroids , confirm diagnosis at early follow up.

Muscle strength is not usually impaired in PMR.

A working diagnosis of PMR can be made after assessment of response to prednisolone 15mg daily for 1 week. Patient reported global-improvement of symptoms of 70% or more within a week and normalisation of inflammatory markers after 4 weeks indicates the correct diagnosis.

CKS guidelines advise that all patients with a diagnosis of PMR should be provided with a “blue steroid card” when commencing steroids. The group assumed that the Pharmacists are providing these but decided that we should check that this happens.

Duration of therapy is usually 1- 3 years. Requirement of steroids for greater than 2 years is an indication for referral to a specialist.

Dr Hussain relayed to the group that from her experience she felt that as a group GPs possibly delayed referral to a specialist due to being unaware of the referral criteria. She also made the group aware that adjuvant immunosuppressant therapy can be used if a patient has had 2 relapses. We presumed this did not refer to relapse in symptoms following reducing steroid doses too soon but where patients have been treated for a full course and been symptom free but relapsed after a period.

4. Dr Ainley presented a summary of guidance related to Suicide Prevention following a discussion on the WhatsApp group after a university student committed suicide and the GP was initially criticized for not arranging follow up within a week following the initiation of an SSRI.

   Dr Ali had shared an article with the group and highlighted that NICE guidelines recommend a review of all patients under 30 within a week following initiation of SSRI. The general consensus was that this was unrealistic guidance given the current demands on General Practice and we were not sure if there was any evidence that this would reduce the risk of suicide.

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Dr Ainley informed us of recommendations for "mental health friendly" practices being initiated and the use of "Stay Safe Plans" to be completed in the context of Suicide Prevention. A template was shared and can be found by clicking on the following link: https://papyrus-uk.org/wp-content/uploads/2018/09/Suicide-Safety-Plan-Leaflet.pdf

Doctors were highlighted as a group at high risk of suicide and we discussed how important it was for us as GPs to have support networks available. The group had shared links to these on the WhatsApp forum previously.

Action Plan

1. Dr Hussain will upload the minutes and presentations to the website and share the link with the group.
2. Dr Hussain to look into arranging a caterer for the next meeting
3. Dr Ainley to share the contact details on the WhatsApp group for the nurse running a new Familial Hyperlipidaemia clinic (in Huddersfield). She has said she would be happy to speak to GPs about the clinic and how it works. Dr Hussain explained that due to small numbers attending the learning group face to face sessions it would be best to share on the WhatsApp so that GPs could arrange in-house sessions at their Practices should they wish to do so
4. Dr Hussain deferred the review of the Cardiovascular Pathways in Primary Care presentation by Matt Fay to another date. Possibly the next meeting if there is time.
5. Next meeting is booked for Tuesday 16th July 2019.

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