

Guidelines in practice

Colour Key:

- NICE or Department of Health guideline
- SIGN guideline
- Independent professional body guideline
- Working party guideline
- Other articles

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The majority of patients with headache can be managed in primary care



The SIGN guideline on the diagnosis and management of headache in adults is a comprehensive resource for GPs, says Dr David PB Watson

Headache accounts for 4.4% of all consultations in primary care;¹ this means that every GP in the UK is likely to see a patient with headache at least once a week. Diagnosis involves taking a good history; examination and tests have very little extra to offer.²

In general, GPs are good at taking histories so the diagnosis and management of headache would seem to be well suited to a primary care setting. However, this does not appear to be happening, a recent study has shown that in 70% of cases, adult patients with new-onset headache presenting to their GP were not given a diagnostic label.³ General practitioners find the diagnosis and management of headache difficult and they worry about missing rare, serious causes such as brain tumours;⁴ however, for every 1000 patients seen in primary care with isolated headache as the only symptom, only one patient will have a primary brain tumour.⁵

The SIGN guideline on *Diagnosis and management of headache in adults* has been developed against this background to inform healthcare professionals about the different headache types and to provide practical guidance on their management.²

Headache subtypes

Headache can be classified as either primary or secondary:

- ▶ the primary headaches are not related to any underlying pathology, and include migraine, tension-type headache (TTH), and cluster headache
- ▶ the secondary headache disorders are caused by an underlying pathological condition, and include any head pain of infectious, neoplastic, vascular, or drug-induced origin.⁶

Chronic headache is defined as headache that occurs on >15 days per month for >3 months.²

There are over 200 types of headache as listed by the International Classification of Headache Disorders (ICHD-II);⁷ however, the SIGN guideline focuses on the more common primary headache disorders, and on secondary headache caused by medication overuse, as this can make the management of primary headache difficult.² While the entire guideline is relevant to primary care, this article summarises three key areas for primary care practitioners:

- ▶ the exclusion of secondary headache
- ▶ migraine
- ▶ medication-overuse headache (MOH).

An increased awareness of these areas on the part of the GP, and their implementation, will have the greatest impact on improving patient care and promoting best practice. Although TTH is the commonest type of primary headache, patients rarely present to their GPs with it as it is not disabling. Cluster headache and the other trigeminal autonomic cephalalgias are not discussed in this article because these are rare headaches;² on an average practice list, for every patient with cluster headache there are 100 patients with migraine.²

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Cardiovascular risk should be reduced in patients with CKD



Dr Alan Begg reviews the guidelines on chronic kidney disease from NICE and SIGN, and highlights key clinical points for management in primary care

In June 2008, the Scottish Intercollegiate Guidelines Network (SIGN) published its guideline on *Diagnosis and management of chronic kidney disease*.¹ This was followed in September 2008 by publication of the National Institute for Health and Clinical Excellence (NICE) guideline on *Early identification and management of chronic kidney disease in adults in primary and secondary care*.² There are noticeable differences between the guidelines that could potentially result in variation in clinical care.

The SIGN guideline was developed according to its standard procedure, with recommendations graded according to the level and weight of evidence. The National Collaborating Centre for Chronic Conditions worked with a group of healthcare professionals, as well as patients, carers, and technical staff, who reviewed the evidence and drafted their recommendations, to produce the NICE guideline.

This paper compares the two guidelines on chronic kidney disease (CKD) and highlights the key clinical points for primary care. Articles on the individual guidelines were included in the October 2008 (SIGN) and February 2009 (NICE) issues of *Guidelines in Practice*.

Classification of CKD

The NICE and SIGN guidelines agree that an estimate of glomerular filtration rate (eGFR) using a prediction equation should be used to stratify CKD into different stages. They have both adopted the recommendation of the UK Consensus Conference on the subdivision of Stage 3 into 3A and 3B to reflect the different levels of risk.¹⁻³ The suffix p is used to indicate proteinuria

but the two guidelines use different threshold values, which will lead to a variation in staging:

- ▶ NICE—albumin:creatinine ratio (ACR) ≥ 30 mg/mmol or protein:creatinine ratio (PCR) ≥ 50 mg/mmol
- ▶ SIGN— >1 g/day equivalent to PCR >100 mg/mmol.

The SIGN guideline recommends adding the suffix T to indicate a patient with a functioning renal transplant and that those individuals on dialysis should be classified as Stage 5D.¹

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Quantifying proteinuria

The NICE guideline advises measurement of ACR as the best means of detecting proteinuria, in preference to PCR, because the former has greater sensitivity.² An ACR of ≥ 30 mg/mmol can be considered clinically significant proteinuria. If ACR is ≥ 30 mg/mmol but <70 mg/mmol, levels should be confirmed by an early morning sample. In patients who also have diabetes, the ACR should be measured to determine if microalbuminuria is present (>2.5 mg/mmol in men and >3.5 mg/mmol in women).²

NICE advises on best practice for patients with breast cancer

Guidance from NICE on best practice for the diagnosis and treatment of early and locally advanced, and advanced breast cancer has been published. The two clinical guidelines produced for NICE by the National Collaborating Centre for Cancer will help healthcare professionals to care for patients with breast cancer in a consistent and logical manner.

Key recommendations on the care of early and locally advanced breast cancer include:

- ▶ minimal surgery should be performed, rather than lymph-node clearance, to stage the axilla for patients with early invasive breast cancer with no evidence of lymph-node involvement
- ▶ immediate breast reconstruction should be

discussed with all patients who have been advised to have a mastectomy.

Recommendations from the guideline on managing advanced breast cancer include:

- ▶ the majority of patients with oestrogen receptor-positive advanced breast cancer should be offered endocrine therapy as first-line treatment

- ▶ if a patient is receiving trastuzumab for advanced breast cancer, and the disease has progressed outside the central nervous system, trastuzumab should be discontinued; however, if disease progression occurs only within the central nervous system, trastuzumab should be continued.

www.nice.org.uk

NICE updates guidance on treatment of influenza

Technology Appraisal (TA) 168 on treating influenza with oseltamivir, amantadine, and zanamivir has been published by NICE.

Oseltamivir and zanamivir are recommended within their marketing authorisations for treating adults and children with influenza if **all** of the following criteria apply:

- ▶ influenza virus A and B is circulating as indicated by national surveillance schemes
- ▶ the patient is in an 'at-risk' group (see below)
- ▶ the patient presents with an influenza-like illness and is able to commence treatment within 48 hours (or within 36 hours for zanamivir treatment in children).

'At-risk' patients are defined as those who have one or more of the following:

- ▶ chronic respiratory disease (including asthma and chronic obstructive pulmonary disease)

- ▶ chronic heart disease
- ▶ chronic renal disease
- ▶ chronic liver disease
- ▶ chronic neurological conditions
- ▶ diabetes mellitus.

Patients who are aged 65 years or over and people who may be immunosuppressed are also defined as 'at risk'.

The decision to choose between oseltamivir and zanamivir should be made in discussion with the healthcare professional, the patient, and the carer. Patient preferences regarding drug delivery, possible adverse effects, and contraindications should also be considered.

Treatment of influenza with amantadine is not recommended in TA168.

The appraisal does not cover the circumstances of a pandemic, or widespread epidemic of a new influenza strain to which there is little or no community resistance.

www.nice.org.uk

News in brief

NICE has produced guidance on the provision of needle and syringe programmes (NSPs). These programmes provide injecting drug users with sterile injecting equipment and advice on safer practice and methods of disposal. NSPs can play an important part in reducing the transmission of blood-borne viruses, such as hepatitis C and HIV.
www.nice.org.uk

SIGN has published a booklet for patients and carers on cancer pain. The booklet covers the different types of pain that a patient with cancer may experience, and the methods used to assess pain. The drug treatments available in Scotland and their side-effects are discussed, along with non-pharmacological therapy.
www.sign.ac.uk

The British Association for Parenteral & Enteral Nutrition has highlighted the lack of recognition received by malnutrition in their latest report. The findings from the report show that the majority of people with malnutrition are in the community rather than care homes and hospitals. The report makes 25 recommendations to tackle malnutrition.
www.bapen.org.uk

Professor Sir Michael Rawlins has been reappointed as NICE Chair for a further 2 years. Commenting on this decision, he said: *'The Institute is entering an extremely exciting phase in its nearly 10-year history and I am very grateful for the opportunity to be able to play a part in its continuing development.'*
www.nice.org.uk