Academy of PHYSICAL MEDICINE

Transcript

Pharmacology
With Nigel Hulme

APM: This evening's presentation is of course all about pharmaceuticals, pharmacology and I'm joined in the studio by Nigel. Nigel has been a GP for 27 years and a private GP for four years and he's been training GPs for 20 years, but he's established himself under the title of the 'tablets avoiding doctor'. So I suspect that he has quite a lot of philosophy in common with many of our viewers this evening and hopefully you'll have plenty of questions for him and get those questions into me early because I think there's going to be a lot by the end of the show. Whatever you don't know about pharmacology, whatever concerns you have about pharmacology and get them into us because I'm sure Nigel will be ideally placed to answer those questions. But Nigel, fantastic interview on the show. Thank you for joining us. And I'm going to start with that business about you being a private GP because that's a fairly rare animal.

NH: Very rare animal. Um, so as a GP in Stanford for 13 years and then did 13 years in academic practice down the road. About four or five years ago started getting a bit restless and probably challenging the system a little bit and I'm thinking it's time to have a change

Are you still training GPs as well?

Uh No, and so I, uh, took my NHS pension early and decided to free myself up to play outs, go up mountains, do photography and kind of recreate myself. I was at a practice meeting once and the partner said, Oh, you'll get even more cynical about medication. Um, and I and it just came to him. I said, I'm going to be the tablet avoiding doctor. Um, a week later I met Perry Westbrook, another osteopath that some of you may know. And I said, Oh, I've got this idea Perry, of setting up as a private GP within an osteopathic practice. And he goes, yeah, let's do it.

What's your connection with osteopathy…why osteopathic practice?

So Perry arrived in Stanford probably around 94, 95, I think I was a GP a young GP there. And he was kind of the new kid on the block, keen, enthusiastic on..

Is he still keen and enthusiastic?

he's still very keen and enthusiastic as is Anthea, um, and I think his enthusiasm has probably grown, not reduced. So as soon as I went to him and said, I've got this idea and he was keen and we set up a clinic within two or three weeks of that meeting and I set up a website and originally my pathway was going to be, to do with a recreational kind of outdoor people who are going on an expedition, things like that and advice. And it didn't really develop in that way. Directs that most patients were interested in the doctor who wanted to avoid tablets. I think that goes really well with the kind of, the ethos of, of the practice and osteopaths, and physios, and sports and chiropractors And so, uh, it, I didn't. My parents were particularly challenging of the medical profession and didn't really believe medics very often.

They weren't medics themselves?

They weren't medics. And my dad was an engineer and my mom was a dressmaker and they, uh, the GP lived opposite, but whenever they were faulted, they always went to see an osteopath. And they were always very cynical, so when I got to medical school I was kind of a bit … hhmm osteopaths are fine medicine needs to prove itself.

they’re quite enlightened there actually, because generation back people tended to hold the medical professional in great awe didn’t they.

uh, yes. Yeah, I think probably too much.

But getting back to the private GP business, I imagine your nervousness and other people sort of skepticism would be, well actually you can see the GP for nothing in the NHS and just why would I pay to see you as a private GP?

Absolutely. And My colleagues were saying so why are they’re going to pay to see you? Um, I think it's grown really gently at, but certainly the last year has taken off properly kind of exponentially. I feel that the patients I see really value the time to talk. It's much more of an old fashioned kind of relationship

Well you’ve only got 10 minutes

No it’s an hour. So all my patients come see me for an hour, for the first,

imagine seeing a GP for an hour crikey.

And I just say, look, it's absolutely fine to cover all the areas where as you probably have heard, most GPs are struggling and they don't like complicated multiple problem consultations mainly because they haven't got the time. So I am, I thought I'm going to do, I'm going to offer everyone an hour's appointment and if they want me to look at the knee and look at the back and talk about the statins and the blood pressure, I'm very happy to do that. Um, and it just seems to be embraced and is also that kind of time to talk first 20 minutes. We normally just talk and find about them, find about the social history and this kind of seems to take away that kind of rush to kind of get to the nitty gritty of what's going on.

And I've made it clear to our audience and our various courses in the past. And I hope I made it clear to you early on that I’m not in the least bit critical of GPs, but I think what all our concern is that GPs are led to a rather formulaic approach to their patients that you come in and you've got this pain, here's the prescription that you're going to get because that's

what we're told we have to do for this particular NICE recommended condition. Um, is that the case was being overly concerned about what it means now.

I think that's nicely summed up. Um, I think what has happened as I've trained GPs for 20 years, when they come in their bright and bushy tailed and they want to cover all the options or they want to listen to the patient. Sadly, we've honed them into a system where they expected to see a patient within 10 minutes. And within that take history examination, prescription and sum up, um, you can't do that in today's society. Or my feeling is that and the trainees universally used to say to me, why have we got to do it in 10 minutes? So I think there is a pressure.

What's the answer to that question?

I don't think there is an answer at the moment, the way the NHS is run and we're, as you know, we're hemorrhaging GPs more than a thousand GPs left the UK this year. Um, I think the patient complexity is definitely increasing. I think we all recognize that society is aging. Um, it would be lovely to say - right we'll turn all consultations to 20 minutes, but we haven't gotten enough appointments already. Most surgeries are waiting two to three weeks.

Is that ten minutes set by NICE or is it just what practices have come down to realize is the only practicable option?

Well, in 1990 a lot GPs, we're doing five minute consultations. Um, and in the mid-nineties practices were advertising that we do seven and a half minute consultations that was seen as kind of something new. Um, later on it moved probably late nineties. It moved to a lot of practices doing ten. So it's just kind of been imposed on the system. I think most GPs need to see about 15 patients in the morning, 15 in the afternoon, just because the numbers, but they've never cleared the decks when they do that.

But I also say I realize that this broadcast is about pharmacology and um, we will be talking about pharmacology, but one of the things that I wanted to get through here is your understanding of the

pressures that are on the GPs, why GPs do what they do and how maybe we can help with that problem as well as look out for warning signs that are happening because of the pressure that GPs are under, which is where we're going to go with this.

And I totally agree with that. I, I see the kind of complimentary health care as an add on, that's an advantage to the GP. Not something that should be seen as um, um, when all options have failed. I know I particularly liked to share between the complimentary system osteopaths whatever and general practice because we need to win the system of moving patients on. Um, and if we can work in kind of in tandem so that, that you're helping us, we're helping you. I think the system works a lot better and certainly I've seen that I'm working at broad street.

I think greater understanding across the professions is going to help there because there's a lot of cynicism in the GP world about osteopaths and chiropractors, and absolutely, guess there's quite a bit going the other way as well. And perhaps a little less because we think we have a better understanding of conventional medicine that works the other way.

My observation is that the newer trainees in the twenties and thirties are more open to the ideas of, um, of chiros, osteos, physios. I think the, they seem to be more accepting. I think some of the dyed in the wall where GPs are a bit older than me. Maybe a little bit more cynical.

You know, you've got some particular medical interests of your own haven't you which seem slightly on ophthalmology care of the elderly and thyroid and wheeze really. W-H-E-E-Z-E.

When I, when I joined the practice, I've done quite a lot of care of the elderly medicine then called geriatrics, which I really enjoyed. I liked talking to old people like sussing what's out, what's behind this.

It's easier as the years go by isn't it.

Absolutely. So, um, so I started as clinical assistant, so I worked as a GP, but I worked two days a week at

Stanford Hospital doing ward rounds and kind of under the supervision of a consultant. I really enjoyed that and did that for several years, when that finished, mainly just due to time constraints, I decided to do the eye clinic and work in tandem with an ophthalmologist one day a week in the eye clinic. And that gave me into the expertise that I could take back to general practice. Uh, and that,

Just out of curiousity, what did you, what did you take back that you could use in practice from that.

um, well, the first thing we've got one of the consultants retired and gave me slit lamp. So that allowed me to look at the eye in more detail. Um, it allowed me to assess the eyes for cataracts and um, or the other common conditions and particularly with a little bit more confidence. A ophthalmology is taught quite badly in med school and she probably get one or two weeks, but

I think I remember the afternoon they taught it to us in college as well. Yeah. And I never gave us any practice in, in, in clinic.

So I'm far, far from consultant level that knowledge, but I found that it was helpful in day to day general practice and the other partners would send cases that they're struggling with and say, what do you think's going on here?

A much publicized um statistic of year or two ago, wasn't there, that actually most GPs don't really know how to use a stethoscope and they carry it as a badge of office but didn't really know how to use it. And I think this was uh, this was a, this was a medical study. Not … wasn't coming from a, you know, complimentary…

certainly, I'm seeing GPs who don't. There is a bit of an ethos to rely now on the investigation more than the old fashion inspection auscultation and they they're more reliant on a chest x-ray and some of them say, well, you need a chest x-ray to diagnose a chest infection, and now I don't agree with that. I think the old fashioned methods if you concentrate probably is helpful,

but that's clearly from your reaction is that something that you've seen is that GPs are perhaps not as practiced with stethoscopes as they might.

I've definitely. I've definitely. I've definitely seen people who struggle with confidence using the tool

because it's not something you're doing all the time and I'm. I'm hearing the range of results you might probably is.

There is a massive. There's a massive leap from around the time that you. You pass your finals to finish in your hospital jobs and I would hope that most of us have gotten there by the end of then.

But then the reason I mentioned it because you, talking about ophthalmology and I was thinking, well, is it one of those,

oh no, you kind of come out of med school with very, very minimal knowledge on eyes. And by the time you've finished your GP training, you'd probably only a little bit better. So it takes quite a bit longer to hone those skills.

OK. So what about the interest in the underactive thyroid?

Really interesting in that because I'd seen many patients who'd be had borderline fibroids and said, everything's OK and then it had gone undiagnosed for years and they were getting bigger and slower. And uh, well I say has anyone checked your thyroid and I realize it's a common problem as we know. It's very common in ladies above 45 often runs in families and I find, I just found it a fascinating condition to A diagnose cause you can use clinical acumen firstly, and Secondly, it's really, it's a nice condition to treat.

Right and by what method would you diagnose underactive thyroid? Or thyroid problems?

So history first. Yeah, a history is really important. So you need to listen to what's happened to the weights, what's happening to the energy levels, what's happening to the skin, what's happened to the hair, what did they know anything about the pulse, what did

they know… the pulse used to be are they getting palpitations are they lethargic particularly how the bowels and how would they feel it, you know, how do they feel about themselves? Because often if they're under active, lethargic, dry skin, sluggish. And then next thing is to go on to examination. Fabulous signs for underactive thyroid. So first of all, look at the patient, look at the skin, see how they're sitting are they sweaty, clammy and take the pulse. Resting Pulse may be reduced. So often a consultation, most patients would run a pulse of 76 to eighty, but they may have a resting pulse of 46, 50. And um, or the opposite. They may have a racing pulse even though they don't look anxious. Reflexes, absolutely love reflexes. People with thyroid toxicosis, overactive thyroid have very jumpy reflexes, and sometimes it's kind of out of proportion to their anxiety.

You'll, we'll see a patient who come a bit on edge when they first walk into the consultation room, but they're, sometimes they look quite calm, but the reflexes are very jumpy and, uh, uh, overactive and what we call grade three reflexes. All of them, all of them um symmetrical. Um, next thing is to look for a goiter because often, and it's amazing how many people have said, oh, the family have noticed something. And of course you can have a goiter and still have a, an overactive or underactive thyroid. So the goiter isn't always an indication whether it could be over or under and look at their eyes. So people with thyroid disease, often have eye symptoms, so it might be dry eyes, they may just feel that their tired and a classical sign is they get proptosis that their eyes become poppy out and their eyes become dry because they're actually the, the cornea is pushing out from the orbit. Um, and we used to see this, commonly in eye clinic often had been missed or the patient thought they just had dry eyes and it was blamed on something else or age commonly.

It's interesting. We've talked about this for a couple of minutes. You haven't mentioned measuring TSH levels yet, which is

no, I always take the history first. I do the examination next. Um, if you've, if the symptoms fits or more commonly the patient has got a whiff that the thyroid's

faulty it’s absolutely reasonable to do blood tests. And I would say that it's better to err on the side of doing more than less because occasionally you see patients who've got paradoxical symptoms, so they'll be feeling jittery and they'll be feeling anxious. The pulse is probably sometimes normal. Um, but yet they are underactive and vice versa. So you do get paradoxical symptoms, so if in doubt do a TSH.

I asked the question because um, you saw me grabbing my paper here and I did that because I just wanted your interests, but if you were to look at the website, if you, if you google, sorry, if you do a search on our website for smartt s, m, a, r, double t, um you'll find the recording we have of our interview with John Smartt and there is a download there of his paper on underactive thyroid which he’s got a particular interest in. And one of the things he mentioned in the paper is that TSH is very often normal in underactive thyroid. And actually it's, it's all the things you've described which give you the clues first of all, absolutely. But what does the tablet avoiding doctor do for an underactive thyroid?

So I think it just needs treating. So, um, my ethos is always to prove the diagnosis beyond doubt and to prove to you and the patients that treatment is needed. And it's a nice condition because the history often fares, the examination helps you clinch it, maybe on two or three points and then you've got the blood tests to back it or refuse it, that we all know this is based on Tsh, t3 and t4 and 3t4 and I probably get one patient a month or maybe two or three a month who are asking for more sophisticated t3 and T4 tests. Um, and I think my, my tack on that, as long as the TSH is in the middle of the normal range and the examination is normal and the history isn't obviously abnormal, then it's reasonable to do a TSH first and then review the patient.

John in his paper, was arguing that actually the really reliable test was a hair analysis.

I've, I'm not familiar with that. And if I was in doubt I would do a T3-T4 and then review the bloods perhaps in four to six months.

So the number of what we were in here to talk about this evening. What are your concerns about Pharma Pharmaceuticals Pharmacology at the moment in general practice and elsewhere.

Um, so my overall, my angle is always being to see patients and decide do I really need to prescribe to this patient and can I avoid prescribing in this condition? I think going back to the early nineties, patients were very, and we look back to antibiotics. Patients were very keen to have a prescription. I think it's not like that now. I think people are beginning to challenge the system a lot more and my observation as a junior doctor in, on the wards where there are so many patients who were in there because of the medication, um, the, you know, the adverse, the number of patients who are admitted to hospitals for adverse events from medication is massive and it's going up not down.

Why is it going up?

Umm Polypharmacy. So we, the, the profession along with medical advancement means that patients are now expected to be on several drugs. A lot of patients now are already on a lots of drugs because of their conditions. And then they may take other additional medication and that has knock on effects.

When you said they are expected to be on certain drugs and we did touch on this in our discussion before the show, there is an opinion, there's a belief around the GPs are given extra money for making sure that patients are on the convention, the statins and so on. And you and I currently, according to Nice guidelines should be on statins just because we're the ages we are.

so a really important point and if we follow the evidence purely follow evidence, you're correct, man over 50 with any other risk factors should probably be on their, on statins. Um, my belief is that you need to look at the whole picture and you need to ask the patient whether what they feel about it. There's so many patients who are now- So we'll take a diabetic who's moderately overweight, be on aspirin and ace inhibitor, a statin, props two other blood pressure

medications a bit arthritic. They'll take some painkillers they're commonly on five medications. One or two papers recently said that a diabetic over towards the fifties and sixties should be on at least four medications. And I challenge that because of the possibly because of the risk of complications, side effects and I think patients are challenging it.

When you say side effects, if we're talking about statins particularly, how often do you see adverse side effects from statins in clinic?

They used to say that the statin, about one in a thousand patients would get Myalgia or muscle pains or feel unwell on statins. I think the current evidence is five percent of patients put on a statin would get some muscle pain, but problem is it's very hard to sort out have they got muscle pain from aging? Have they got muscle pain from another problem or, or is it the statin? Uh, so, but I think in a, in a week, in a general practice, you will be asked that question maybe two or three times a day about – should I be on a statin doctor? And do you think it's making me ill?

Yeah, we, um, we talked earlier on about Malcolm Kendrick who has, as you know, has a particular opinion about statins and cholesterol and so on. And he's not opposed to statins in certain circumstances, but he does have a fairly strong opinion in most cases about statins, but the, the point he made was that the statistic that you mentioned, five percent of people getting adverse side effects, Myalgia um is distorted because actually they're generally not asked the detailed questions which would reveal the side effects, people will come into the surgery. And asked how are you doing on the statins and the patient then says I'm OK and that's the end of the conversation. Whereas if you were asked, do you have memory loss? Are you suffering from all the other potential side effects actually you might get a fuller picture, sometimes the spouse is better place to notice these things than the patient. Is that a realistic picture doing?

I think that's realistic. Uh, If the GP is seeing a patient with diabetes and hypertension. Who is, who should be on the statin, hm, he, his focus is going to be on the blood pressure. Their HbA1c the wait, he's got 10

minutes. The chance he's going to investigate the statin line once the patient is inverted commas settled on it is a remote, uh, and often the conversations, the first time you see a patient perhaps two months after starting it, seeing how they're feeling and then it felt continued to take it. I think this kind of hands on nicely to your early question is there is an incentive for GPs to keep people on the statins because their targets will improve and if you've got a patient who's a diabetic and not on the statin, it won't look so good on your target data.

And how important is that target data for your practice as a GP?

It is, that's important.

Why?

I'm, there are financial incentives to keep it going to keep on target. The government is looking at those at the moment and I'm trying to take target driven medicine or reduce target driven medicine. Um, some people have postulated that target driven medicine has increased cost, but as not, I'm not extrapolated into total benefit across the board.

Yeah it'd be hard to measure that benefit.

It is, absolutely. Yeah.

It's quite a complicated process to get meaningful patient feedback on this as well as you know, you might not feel any better, but would you be dead if I hadn't given you this drug?

Absolutely. Um, it, it, it's a really difficult, um, analysis and these patients are always have other things like weight, hypertension, prediabetes, and it's hard to un-pick which, which factor to hit first really.

In terms of the polypharmacy that you referred to, um, how does the business that we now have pre-diabetes as well as diabetes and pre hypertension, which one can argue for a big pharma-led drive GPs and medical personnel. Generally into giving drugs earlier than perhaps a necessary. There is such a thing as pre-diabetes?...

Um, there are, I've worked with doctors who he would call a patient in with a pre with, uh, an HbA1C that was suggestive of early pre-diabetes

Early pre-diabetes?

and other people who would file it as normal because it's not a diabetic, my feeling is that the profession needs to be really, really cautious of this. This has appeared in the BMJ. I think we're following the American system, prehypertension, prediabetes, and I think we need to be careful that we're not just swept down the alley with a, with the Americans and start.

They've got a lot more money and a lot more resources to throw it there so they're not doing it perfectly.

Have they got a lot more money than our NHS at the moment I'm not sure. My feeling is, is that there are drugs that we use in diabetes that have also been shown to increase cardiovascular complications. Uh, and I think we sometimes use those maybe a little bit too freely without actually explaining to the patient of the potential side effects of them.. Metformin is a drug that's been put forward as a patient who was, say a patient is moderately overweight, BMI may be kind of 28. Um, the patient's HbA1C has been monitored a few times. They're still not diabetic, but they're heading there. Some doctors will put them on metformin quite early. Metformin has got lots of side effects, particularly gastrointestinal, so nausea, flatulence, bowel changes and lots of patients don't tolerate very well. If you explain to them, and this is my, this is my ethos, if you explain to them that actually exercise and weight loss, will do as much good as the metformin. They'll come alongside with you.

One of the questions I had sort of lined up for you anyway, have you got some great tips for us on how effective ways to encourage lifestyle change. Because when you said people don't want to be on tablets, I think there is a generation that just wants a pill to fix everything and they don't want to go to the gym and they don't want to stop eating whatever food it is.

I think the problem is in the kind of practice we're working in, um, we've got a self-selected population

that these are patients who have booked and pay money for a service outside the NHS and they're kind of already, they're kind of ready to make the changes. So by the time they arrive at my door and they've probably seen Perry or Anthea or someone else in the practice and then maybe a nutritionist, that kind of message is getting through. But my key thing is to get this to get concordance and if you actually explain to someone that the benefits of walking three times a week for 40 minutes is as good as a statin or aspirin and they kind of, they don't think the profession is very good at actually getting that message across. And they go so you're saying that's nearly as good as staticn or as good as my blood pressure tablets, particularly blood pressure tablets and lots of half a stone weight loss, um, has the same effects as the average anti-hypertensive.

OK. And virtually everybody we see over 40, 45 is on hypertensives these days seems to me.

Masses. Yeah, yeah. Yeah. Really. And um, I think the figures for treating hypertension are fairly robust, uh, I believe them and I think we should go along with them. But I think

When you say that the figures for treating, what do you mean?

Yeah, I mean the, the, the studies that came out in the seventies and eighties and Framingham Studies and other big studies suggested that treating hypertension was a cost effective way of keeping people alive and particularly stopping strokes and cardiac events, more strokes than it is for cardiac events. Uh, I think the evidence is robust. I don't think we should challenge that, but I think we should challenge the mechanism by how we treat initially and I think there's been a bit of a knee jerk response that patients. So your blood pressures that we're going to put you on tablet one, um two, three months later. Your blood pressure is still up tablet two um, and it's not uncommon for people to be on four medications for blood pressure

and my experience is very limited by comparison to yours, but I see so many patients who have, they've never found the right balance for their anti-

hypertensives. They're constantly juggling high, low blood pressure and a cocktail of different pills.

Um, I think, I think as a profession, I think we've improved somewhat on that because we're doing more ambulatory monitoring, I think the idea that is not long ago that you did, you kind of have three regions in the GP surgery and if they're all high you ended up on the tablet. I think now with ambulatory monitoring that makes the diagnosis a little bit clearer and you do get patients who've got white coat hypertension, you'll see them in practice who are really anxious and you do well at the beginning of the practice and the 170 over 95 and you do one at the end of it when they've had a calm and kind of that kind of opened up a little bit under 140/85 and it makes a huge difference. So, oh.

What do you regard as high blood pressure in the average middle age adult?

Well the figures will be 140/80 is normal. Uh, I think if the systolic is persistently above 140 and certainly up to 160 and the diastolic is 90, I would be wanting to kind of investigate that and think about therapy. I think the, the problem that the complicated factors as you need to take other factors into account as well, those figures may be tighter in a diabetic or someone who's got renal disease.

I think we also mentioned on a previous broadcast that actually it's not a linear relationship between blood pressure and ill health is it, actually its experiential as you get closer to 160, the curve go sharp upwards.

Yep. Absolutely. So I think our parameters have got tighter and the ability to accept figures that are slightly near the edge of those parameters is probably most GPs are trying to jump on the figures earlier rather than later. I think evidence is there for that, but I think it means that patients are more likely ended up on multiple tablets and medicines. Um, and I think that brings me back to point one, which is get the lifestyle message in first rather than medication.

I've got some questions coming in. I'll do. The first one I've got here is why do you need to be on statins if you're diabetic? You mentioned earlier on,

um, so, um, so it's all to do with cardiovascular risk. Um, our most people believe that diabetics, have got a high cardiovascular risk, full stop. And you may have a normal cholesterol or normal-ish cholesterol. So let's say for sake of argument, 5.6, which the average in Britain, is about 5.6 to 5.7 if you keep the Scots in. Um, and we would argue those patients who've got high risk, um, and a statin would be protective is still cardio protective even though the, the cholesterol is normal, borderline. And you may have talked about this with, um, Dr. Kendrick is that statins have got more than one effects. They may reduce cholesterol, but they're also stabilizing the plaques in the coronary arteries.

One got the impression that the pharmaceutical companies were desperately looking for extra things, they could claim as being benefits of statins,

I think the evidence for that, is probably creeping out a little bit stronger than we expected rather than the other way.

You're sort of went down a bit of an aside earlier on about the best way of reducing the UK's rate of heart disease. And that was Scottish independence. Wasn't there somebody, somebody came up with a message with half our rate of heart disease, apologies about that to any of our Scottish viewers. but a few other questions here. Um, if you've got a patient whose symptoms fit the thyroid picture but a TSH blood test has been normal. Is it worth suggesting more tests?

Uh, yes. So the, um, I started some work with a lab recently where patients can do home testing and the prices are really quite reasonable. Uh, I send the request off the patient then gets the kits and the test is done at home.

What's the test?

um, so TSH, so we'll do a whole profile. So they'll do an advanced thyroid profile or baseline one, a normal one is the TSH and the T3, 3T4. Um, but they will do antibodies as well. I think the, the thing to be wearable is not do test too frequently, but to be, to keep the possibility as a diagnosis still hanging in the air, particularly if the patient's convinced. And yes, I would

do more. I'll do the whole, the whole profile T3-T4, antibodies and TSH.

I've got a very long question here, which I'll ask in a second, um, there are some shorter ones which are easier to handle. Jason has asked the question, pharmaceuticals are big business, is he, right to be slightly skeptical, of evidence based medicine when a lot of research and new drugs is funded and therefore results published by companies that want to sell their own product or is he being a conspiracy theorist? Which is a reasonable suspicion.

I really like that question? I think it's important. I think what you have to do is you need. What I've learned is to, is to challenge that drug company information mainly and then look to other kinds of, um, all the trials like the Cochrane database. So are you familiar with Cochrane database really started in the mid nineties and certainly when the Internet was kind of first taking off, I think their studies and their meta-analyses or give you a better yard stick compared to the drug industry and the way they present their data. I tend to believe more than umm.

Although there is a Cochrane study into the value of meta-analyses, which was particularly brilliant but Cochrane studies are better than most,

So I, you know, when we get plots together of data that suggests that, that um, the confidence intervals across the mid line, then I think we just have to be a little bit more cynical, but when we've got a clustering all on one side of the midline and I'll take that more on board. So I really like Cochrane.

Can patients reduce the number of, um, blood pressure medications? Is there a best combination or was it very individual? I guess that's, can patients do it off their own backs?

So I see that would be a common consultation for me on a Saturday with patients arriving with a often a carrier bag of medications saying that my doctor's got me on all these medications and then I'll have to unpick what medications I think are the most harmful to them.

I like the approach

So I normally go for the most problematic medicine in that patient. And I could give a good example of that. So thiazide diuretic bendroflumethiazide was a really common bog standard medication First line drug for hypertension in the late nineties, we don't use it as often now, but there are patients still on it so they might have been started in the fifties and now in the seventies.

Why would they still be on it then? Just because they've never been reviewed properly.

Well, it would be the blood pressure is controlled and they're ok, so let's stay on it. But those drugs are actually encourage diabetes, so they're diabetogenic. And they also trigger gout. They also make people have low sodium. So if you see a patient who was on an old fashioned drug like this, the blood pressure may not be optimum it may be middle of the range, normal range and you can find the drug that may be the least effective for maybe the most problematic. Particularly if they've had gouts, particularly if they've got a recent blood sugar that's borderline and say, well actually I think we'll go for this drug first and we'll see how you are. But in the mean time.

What do you do take them off it or just substitute?

So depending on safety. So let's say the blood pressure is 142/85, they're not in danger. You can say to them this blood pressure is acceptable for you at the situation I want you to monitor blood pressure. We will take this medication off. I would inform your GP and we'll see you in two or three weeks and see how you are it's amazing how many will turn up with the blood pressure not changed.

How do the GPs respond when you do this. So they get a bit pissed off that the private GP Doctor Hulme is counter demanding what they've decided to be right.

That's a good question. I don't know how many of you have told me, um, uh, and I certainly don't get much feedback about whether this is suspicious of, of me, maybe, but I think it may be the way you word that.

But if you word that and say this patient has got pre-diabetes and has had gout and is still on the thiazide and the patients is keen to discontinue it and your blood pressure is acceptable. You may be on safer ground keeping it to a kind of physiological calm letter.

there have been quite a few drugs in the GP press recently accused of inciting gout, a lot of the anti-hypertensive, so apart from don't know which one it is now, but there's

so any, anything that's a diuretic is more likely to give you gout. The other point that's interesting is that we know that gout is an independent risk factor for developing cardiovascular disease. So you may have a normal blood pressure, you may have a normal cholesterol, you may have a normal lipid profile, but if you've had gout, you're a much higher risk of developing a, cardiac disease

Any idea about the mechanism for that or…

I'm a bit uncertain of that. Uh, I think it will be tied up with the insulin resistance and that kind of connection with insulin resistant hypertension. I'm not certain.

Does that risk go away if you can address the gout through medication or. Actually you're still just as vulnerable?

I think, I think sadly, I think it may be a genetic factor and the drugs that kind of just adding to that problem. So what are the other drugs that, which we do exacerbate the risks of, of gout, ACE inhibitors?

Yep ACE Inhibotors can do Furosemide, which we commonly use for ladies with edema from, um, from maybe cardiac failure. Sadly, we sometimes used to use Furosemide in patients who just had swollen ankles and it's quite a potent drug. It's excreted by the kidney, causes low sodium, often low blood pressure, dehydration and it's not a great drug if you don't need it. Thiazide is a key you wanted to look at, ace inhibitors have been implicated in there, but mainly diuretics.

Somebody actually asked if we could put information on our website about the private fibroid testing process. Which if you can give us the information.

Are you allowed to use advertising is it like the BBC and you can't use?

No we do whatever the hell we like I swear all the time.

So it's called Thriva t-h-r-i-v-a. They've got a really interesting website, very easy to use and the patients can request the test themselves, not expensive.

We'll put the link up on website afterwards ... And somebody has asked which lab do you use for investigations?

Um, well I have been using Stanford hospital, they take the blood and it goes over to Peterborough and processed, but having seen the link to this website's probably two months ago I'm just kind of on the um, the first few patients who come in through having those tests and it seems to be a good system.

The long question, this is um anonymous, so I don't know who it is, but whoever it is, says I'm quoting. I'm 59 in a few months happy birthday. Um, I was surprisingly diagnosed with very high blood pressure. 179/120 six to eight weeks ago. I no diabetes or cholesterol was a little high and liver, a little fatty. I took the amlodipine medication to get the hypertension down. Last check it was down to 128/91. So it's quite a big drop. In the last years I stopped taking the medication and completely changed my diet and getting back to the gym. I've now lost a shack of weight and I'm feeling better and I'm on a crusade to get down even further. I've not had my BP checked again since my last visit to the GP, but refused to go on statins. Were they silly to refuse, supplementary is I'm taking a daily benecol also milk thistle. I also have LSA.

Um so there're bits of information that we need to know on, on the Mr. Anonymous. Um, so, um, alcohol history will be important because with a fatty liver, um, I, it's possible that the alcohol intake may be higher than normal, patients lost weight so that may go in hand in hand with the alcohol, but they may be slim,

thin active, with no alcohol. So the other important things we need to know his renal function. So the GP has done a, maybe an ultrasound or a liver function test, we need to know renal function as well. Systolic blood pressure of 170 at that age.

Down to 128 now.

So it's still a bit unusual. So I, uh, it may all be lifestyle related. So I think it's quite reasonable to reduce the weight, increase the exercise, do the lipids, but I think the important thing. So just check there's nothing else kind of hanging in the, in the background. Are triglycerides elevated, are liver function tests going up not down, and his renal function OK.

Was he silly not to go on statins?

But I don't think it's really, I don't think he needs statins yet, I think we need more information and importantly, if the lifestyle intervention as in fact, I've seen patients who've had cholesterol of seven drop to five by just pure going to the gym, exercising, cycling, and that's kind of more than you expect with a statin.

Its just a rabbit hole we could go down though, isn't it? Because again, you talked about Malcolm Kendrick, Dr. Kendrick, who we've interviewed a couple of times and um, in his, in his books, he talks an awful lot about the fact that the body regulates it's cholesterol very, very effectively and it's not affected by your food and it's merely a symptom of other things going on or a sign of other things going on. If it's elevated, he's not the cause of problems. So maybe we shouldn't go down that route. For now.

I think really important point on that is that if people have got an unusually high cholesterol and particularly if there is no family history, you need to look looking for something else. Yeah, and particularly look for hepatic problems I'd do the liver function test and look at the gamma gt. The amount of men who would say they're drinking 25 units and actually when you add it and got on gamma gt, normally be under 50… A gamma gt is an enzyme that is metabolized. It metabolizes alcohol and it's an indicator of how much someone's drinking,

so it is good for metabolizing alcohol?

Yes it is

Can we get it in supplement form?

but at the enzyme goes up when you drink a lot, a high level maybe kind of over 70, 80, but sometimes you've got an isolated rising gamma gt and they're not drinking. You need to look to see if there's anything else going on. Alcohol is a common one and it may be that Triglycerides as another pointer for that and the other one is secondary. Hypercholesterolemia from thyroid, so someone may not have a family history that may have a good lifestyle, but the kind of the lipids are all over the place and you need to look for hypothyroidism in those as well

Thyroid comes into a lot doesn't it.

It does yeah. So, uh, so I think just being a little bit um not cynical but, but I think you need to dig a bit deeper as to what else is going on,

which I mentioned earlier on John Smartt its his theory works in Australia, but I think it's his theory that um thyroid problems are seriously underdiagnosed.

Definitely

I recommend having a look at his paper and um, we'll see what other information we can dig out of you that we can post on the website as well.

That's fine

if that's alright with you, whoever they are they're staying anonymous. Just that last thing says related to the last question a little to no alcohol and the kidneys are fine. We know they're lying about the alcohol, but apart from that, um,

well I'd, I'd pursue the weight loss in the gym to start off with and see what happens. I think that that drop is unusual. Um, so if someone's dropped from a 170 to, what was it again?

It was a 179 to 128,

so that drop, so the average blood pressure tablet across the range, so whether that be a thiazide or Beta blocker and ace inhibitor or calcium antagonist -drops your blood pressure about six to eight millimeters and that is equivalent to half stone weight loss. That is a statistic that's been accepted for a long time. So to drop on the dose of Amlodipine to that suggest that either the first level was maybe a more elevated than you would imagine. And I think I'm really, I'm a bit of a dinosaur for the old fashioned blood pressure cuffs that if you've got people who are using electronic machines on the blood pressure readings are a bit erratic. You may see this in clinic, you put it on and the first time it's 170 over 92 and the next minute it's 150 over 80 and you don't know which one to take. Then palpate the pulse, just check. They're not in atrial fibrillation and just check that the machine isn't been, um, tricked by abnormal pulse because that does happen.

Well actually there is one blood pressure device which is good at detecting atrial fibrillation, NICE recommended. I can't remember what it is an electronic device, we'll post that as well on the site.

I'm not familiar. I'm um, I just like taking the pulse and I think the old fashioned way you actually listen to the pulse, the stethoscope over the artery, gives you more information as well about the pulse count.

The more you do it and the more confident you're going to get … I certainly wouldn't feel comfortable doing that. What's the best way to get practice with, you know, obviously doing what's right and what's wrong.

Yeah, I mean, I think, I think we should. I think in practice I think it's completely reasonable for Osteo, physio, Chiro to take the pulse count it and just feel the pulse character. I think the more you do that, the more you will pick up what, what feels normal. And if someone's got pulses all over the place and like a, uh, jumping cat and there's something going on,

great diagnosis, there's something going on somewhere. I've never had so many questions so early in the broadcast.

All right, OK.

With weight loss as an approach to manage hypertension, do you consider diet or exercise, cardiovascular fitness to be the more important factor? Which I suppose diet or exercise, presumably in an ideal world both combined but which, if you had a choice. Thank you, Robin for the question.

Oh, that's a tricky one. Um I suspect the evidence is that weight reduction makes more difference than exercise, but my belief is that they go hand in hand. That there is lots of interesting people who've got a raised BMI but are very muscular and that they are still taking lots of exercise. I think exercises, cardio protective as weight reduction is. So I think I'd find it hard… I think I'll keep myself on the fence on that one. I'm not good at dieting, but I'm good at exercising.

You do a lot, don't you?

Yeah, yeah do lots of mountain biking, kayaking, skiing,

cross-country or downhill?

Downhill

Not the uphill ski?

No, no, no. Yeah, perhaps I should. Um, so I think the evidence is there for both. I'm not sure which, where the evidence favors..

Yeah

what do you think?

well, like you, I would rather not cut down on my perfectly manageable alcohol habit, or my eating but I'm, I love going to the gym and I love doing exercise so you know, I will try to lose weight that way but I have to say that on those occasions when I go for a month or so without drinking, which periodically I do just to prove that I'm not dependent on the stuff it makes a big difference, and you feel better for it and treat yourself a drink at the end of the month, but yeah I'm on the fence. But anyway, back to these questions. Um,

yeah.

Apparently we were the same anonymous person that's talking to me about this. Um, it was uh, an old fashioned cuff, an ECG was perfect apparantly. They say we've probably exhausted that line of questioning I think. Monica has got a question for you. Thanks Monica. Um, could you please ask why is it so difficult or even impossible to get T3 tests and virtually impossible to get t3 prescribed here? When in Europe it's very well researched and t3 is prescribed quite regularly, especially for Wilson's temperature syndrome, et cetera. It here the patients are forced to go privately or make frequent trips abroad. Monica I should add is German.

So, um, I, I, I only recently met some patients in this scenario. Who wants to get, um, kind of other medications from abroad. I think there is a, there's a danger at the moment that some of these patients who have got normal thyroid function tests, but they disbelieve that these thyroid functions really represent what's going on. There's also been some interest about the over-marketing of T3 and there is no proven benefit to it and more expensive.

What's your theory on this? Is there evidence to prove that it's, it's been over marketed or it's ineffective?

I still have the old fashioned that normal a thyroxin is fine. Um, there are, there is one or two patients seeking, um, natural thyroid extracts which is not available on the NHS and that is very common in Germany and the Netherlands and you can get that as a private prescription and send it over to the labs over there and it comes measured in grains and the patients then take the is desiccated thyroid extract. I think it's from pigs I think. Uh, and then we monitor the normal TSH.

is there a Halal version and a Kosher version of it

Its a really interesting one that I haven't been asked that one before.

Um, let’s get back to these questions, how often or do you how often should GPs review medications,

especially in the elderly population? I have seen some patients who seem to be on numerous medications that are doing pretty much the same thing. That's polypharmacy again

a superb question. Um, the danger is that most practices are struggling to see the patients who are acutely unwell, uh, and the patients who are, um, uh, kind of ticking along OK they're not making GP appointments. There is a bit of an ethos to just review the medications on the screen and if it looks OK and fairly safe and the patient um has not been in complications are often reviewed, kind of on-screen de novo without seeing the patient. Not a great lover of that, but I'm aware that that has to happen because we just haven't got enough freedom. I think if a patient is on an ace inhibitor and a diuretic or other cardiac drug, I think they should be seen twice a year really. And the whole medication picture reviewed. Nursing homes are often, patients are on more than eight medications in nursing homes and GPs used to visit them frequently, but that's died away because they haven't got manpower. So in answer to the question, I think they should be reviewed twice a year.

There was a lot of publicity recently that they weren't being reduced, reviewed at all, wasn't there and it's just the patient going back to the pharmacy, same old repeat prescription.

Yeah. Sadly, you know, I, I've seen it happen and I know it happens and it's part of the system. Um, and it may be reviewed on the screen, but often it's not the same doctor, it's not someone who's familiar with the case. It's easier to sign it than is to kind of revoke it and question it.

The question again from a presuming the same Jason, um, he says, considering all the diets that there are out there, what's your view on the low carb high fat approach? Probably another man who was reading Dr. Malcolm Kendrick's blog on there.

I'm, I'm completely lost on the Diet front at the moment, probably because I'm not losing weight, but I keep watching the channel 4 programs and the morally programs and the more I watch, the more confused I

get. Um, what I, what I do notice is that patients need to kind of find the one that fits with their, their ethos, their belief, and you need, as I said, early on, concordance is the key. If you've got someone who likes lots of exercise, but likes their treats, then you know, you've got a different menu to offer them. Um, I think the very high, I've seen some patients in the gym who were on very high fat diet and then wanted me to monitor lipids and the lipids went awfully worrying, you know, so cholesterol that started off a six and a half to choletsterols of nine and half, 10.

It's an interesting, an interesting relationship because there is, as I understand it, no mechanism by which fat can turn into cholesterol, but nevertheless there is a relationship.

So, so 80, eighty percent of the cholesterol in your body is self manufactured and that's what we kind of, that's not really publicized it. It's almost as though, well, we, we can, uh, we can attack it by diet. I don't think that's the case, but I think if people have an inbalance of what they're eating and the purely on fat and not on, I think we really forget about the, the, the diets that are really advocated at the moment for Alzheimer's and memory and cognitive changes, which is the kind of Greek diets and multiple colors, peppers, reds, greens, oranges, all those kinds of things. I think we shouldn't forget that one but as to which diet helps you lose weight I'm completely lost.

some cheeky bastard out there. It just said when was the last time I stopped drinking for a month?

Was it January

It was some time ago, I must admit. Although it's highly controversial, do you think that cbd oil cannabis oil I presume that is and extracts made may eventually be used widely in this country as we're seeing in the majority of the states in the USA. And have you seen any positive evidence with this product? As Jason who asked the question, gets more and more questions in practice about medical use of cannabis. And it’s a pressing question in the press at the moment about some young baby who's had a huge beneficial effects

for his epilepsy from cannabis oil. Can't get it prescribed.

Yeah. I think the government is probably in a bit of a cleft stick on this one is whether to license it. Um I think if you, if you've got someone who's got a neuromuscular problem and you give them cannabis oil or whatever, then they relax and they improve. Um, cannabis oil has also been a advocated for certain types of cancer and certainly the remit seems to go out because I'm not sure where we are, we're licensing and certainly it's not something I've ever got involved with or advocated,

which is stupid, isn't it? I mean the nice thing is as far as I understand the police don't prosecute you for cannabis anyway, so we're just going to acquire it from somebody in a Hoodie on a street corner and anyway, that's just my particular opinion about these things um you wanted to talk earlier on about seeing the particular risks in the society for both medications and population at risk areas, so where's the risk area as far as your concerned. Risky drugs?

So I think um the kind of what I see is that there are risky patients who arrive in practice to you as osteopaths, Chiros, whatever. And in general practice and these are the obvious ones. We, they're complicated patients and let's, let's start with an overweight hypertensive, diabetic. It's a common scenario. These patients often have early cardiac disease. It may be asymptomatic and they often get prescribed several medications and then a well meaning person in in musculoskeletal medicine says, oh, you need to go to your GP and get some Brufen, Diclofenac, Naproxen, and what I see commonly is that a patient who's already who's teetering on the brink gets given another medication and that causes a series of catastrophic events and I think we can't underestimate the effects of nonsteroidals. So I think one of the common things that I've seen in the last 10 years, our patients who have been sent from the osteopath to go and get some pain relief or some non-steroidals and they'll often say, oh, you need Diclofenac, or you need some naproxen. They may have taken Ibuprofen already, but I think the complication rate of these drugs is high on particularly

in these risky patients and as we probably all know is that the highest risk is a gastrointestinal hemorrhage. But when you add these drugs into these patients, they've already got renal impairment. One of the things that's not known of about as frequently is that non-steroidals, impair renal function. So if you've already got teetering renal function, you then have a little bleed, the blood sticking in your colon, um the kidneys, come under more stress and the non-steroidals reduced perfusion to the kidney and the patient who was teetering OK either, goes into renal failure or cardiac failure and I think this is something that you see in hospitals fairly commonly, but also in general practice. You sometimes just pull them out of the woods before they arrive into general practice. And I think we've got to be really careful of the, of these kind of complicated pre cardiac patients who teeter on the brink and we give them non-steroidals

and if a patient has been prescribed a nonsteroidal and is now going beyond that, brink into cardiac failure or something. What would you expect us to see in our practice before they actually ring 999 and get taken to?

Um, so, so, so say classically, you saw someone with a nerve root pain two to three weeks before you said, Oh, well you've, you've put up with it for a long time. You're taking many medications and toddle off to the GP. And he may have given them a cellex, gave them a naproxen. the naproxen causes fluid retention, and reduces um renal function. If they're already teetering on the brink, they will then go into cardiac failure. And the commonest symptom is breathlessness on exertion. So if the patient toddles into your clinic and they get on the couch and they lie on there that even just getting into the couch breathless or particularly lying down flat. So orthopnea, breathlessness as on lying flat is a very important indicator of possible cardiac failure, swollen ankles. We see so many patients with swollen ankles. It's hard to kind of workout which are. But if a patient didn't have swollen ankles and now they have, um, and they’re breathless than you should, uh, think, uh, their going into failure.

And I've seen a few patients and it always becomes a bit of surprise me who got not massively serious pitting edema, but enough to see a fingerprint in their ankles

when you poke them. And at that stage, I mean, is that something I really ought to say? Go back to the GP straight away or.

Um, I think, um, I think I'll be guided by the patients, so if they said, oh, these ankles weren't swollen at all last week and now this swell and this week, and I'm really breathless at night, yeah. Then they probably need seen within 48 hours, two or three days. I wouldn't want them to wait more than a week to get an appointment.

They're out of luck then they better come see a private GP.

I think you can. Oh, I'm quite empowering patients to use the right words for receptionists. So you say to you ring, the receptionist say 'I'm very breathless and my ankles are swollen', most receptionist will respond to them. If they don't get an appointment, I think it's reasonable to say, can you put a message on the screen of the on call doctor that I'm breathless and my ankles are swollen and that that is a really good way of getting through the reception hurdle.

That's a key moment from this broadcast. Is that a really useful thing to be able to say to patients and now everybody who wants an appointment with their GP is going to say I'm breathless and I've got swollen ankles? You know, whether they have or not. I have no idea the receptionists were stupid of me. They were trained to recognize the key words because I thought they were Rottweiler's who are designed to keep people away.

well there are good and bad in all these professions, as in mechanics. Um, and I think a lot of receptionists would pick those up as, as, as the kind of thing that I will put on the doctor's screen. And I, I tell my kids this, these are, these are key words that will get you into a GP surgery.

Yes. OK. I've got a couple of questions coming in while you were discussing that and say, well, you know, what, what, what drugs do you then recommend for people with low back pain or for other pain relief? Well, first of all, I would advocate diagnostics first to find out what's going on and uh, I would always start

with paracetamol or wouldn't go straight to a non-steroidal. I have to prove to myself that it's an inflammatory condition, that other things has failed on the, there is, there is a safe reason to give them a non-steroidal. Now that's a small group. So if you take hypertensive out, cardiac out, coronary artery disease out and renal failure out and diabetics out, people over 65 out, you're not left with many, so I go from that side and I'll say to the patients, I think we should persevere with paracetamol and if that fails, add in codeine a small dose, 15 milligrams and see how they tolerate that and review them. There are patients who get handed down, Diclofenac with dihydrocodeine and then if that fails, tramadol and if that fails, amitriptyline I'm going to actually really against that idea because these are really toxic drugs in a group of patients that often doesn't tolerate them very well, so I would always go for a paracetamol and educate the patient how to use that first and then also um prescribe codeine if needed, as an extra. Particularly for nighttime pain.

Yeah. Am I wrong in thinking that donkeys years ago if you wanted pain relief. You took aspirin and paracetamol became the drug that everyone thought this is the new kid on the block and now it's, Ibuprofen and patients will presumably come to the GP saying, Oh, they'll go to the pharmacy and say I want some Ibuprofen, and I'd be,

um, patients are a commonly buy an Ibuprofen over the counter now. And you have to be really cautious of that because it's not uncommon where the patient said, oh, my friend took Volterol and it works really well. Kind of have some of that on the osteopaths said it's really good. And then you find out they're already taking Ibuprofen as well. And sometimes it's easy to co-prescribe. And taking two nonsteroidals together is, is, is a bad habit and this is a much higher risk of GI bleed and shouldn't be done. Um the, it's very cheap. Ibuprofens in Sainsbury’s is about 80 90 pence for a small packet. Um, aspirin is more dangerous than Ibuprofen. So the, the risks, the risk of harm for aspirin is 1.6 higher than the risk of ibuprofen.

Are patients who used to be prescribed you an aspirin a day for as, an anti coagulant is that now being

stopped by GPs. So and said there was a big fuss about aspirin or a year or so. Wasn't there,

yeah, I think that they're not stopping it, but you need to assess the risk in more detail. And I think the difficult ones are the patients who are in the middle of the range of normal so they may, might not have hypertension, but they may be fifty-five and there was a family history of heart disease, but all the other parameters are OK before we might have heard on the side, on the side of caution so that we'll will. It's reasonable to take aspirin, but you know, there is a number needed to harm for aspirin and that people do get harmed even by taking small doses

when you explain the number needed to harm who's,

um, so for. So if we look at statins for instance, the number needed to benefit, number needed to treat. You need to put people are 37 people on a statin that want to get benefit, right, but the number needs to get benefits.

They get benefit?

OK, number needed to treat, however, that will change depending on the risk profile of that patient. So if they're already diabetic and hypertensive, et Cetera, you may do more good. If you've got a patient who, um, let's take non-steroidal drugs number needed to harm the number of patients she needs to treat with that drug for a year, for one of them to be harmed. And that is in a region of about 50 to 55. So if you, if you prescribe some ibuprofens to someone or you advocate as a good drug to take, you about every 50 patients, one will be harmed.

That’s worth knowing

Yeah, that's the great figures on Cochrane database on that as well. So I think that's worth something.

Yeah and we’ll post it and of course there will be something that we certainly haven't considered.

So I of course with my, the way I practice number needed to harm is a really important figure number needed treat is great because that's what the drug

industry show, but number needed to harm is not really out there.

Somebody has asked here about asthma, drugs affecting the risk of risk of gout. And I suppose we could talk about steroids particularly. Um, if. Well you tell me about the risk of steroids and just how serious we should take that. We're talked about nonsteroidals-

Um so steroids are bad news. I think the problem with steroids is it affects every tissue in the body, affects, the brain, the eyes, the cardiac system, the blood vessels, full stop.

as far as asthma is concerned these are the preventers.

So are we talking inhaled steroids? Oral steroids?

Well they just asked about asthma drugs. So I presume they're asking about ventolin and preventers as well.

So inhaled corticosteroids in small doses are still really important drugs for treatment of asthma. All the complication well when the investigation of deaths for asthma or over the last 10 or 20 years have always shown that the majority of deaths are caused by under treatment of asthma by GPS. And that figure stands out. What we have learned is that the doses that we're using inhaled corticosteroids, um, so a Becotide would be the classical one. We used to use doses of 800 micrograms and stay there, but we now know that smaller doses and tapering down the dose to the dope, the lowest dose that controls the patient is the key. My feeling is that I wouldn't want my children on more than 400 micrograms of inhaled corticosteroids .. of Becotide

what does if you have an inhaler is that one squirt or three?

So you have to be careful? So that could be 50 microgram per shot, hundred micrograms a shot or even 200 microgram a shot. So you really need to kind of research that with patients. I think it's something we can look at as, oh, you can do it as osteopaths, physios and Chiros, that if patients are on huge doses of these drugs and we all know there's a … a correlation between build emphysema, um, previous asthma on

high doses of steroids. Um, I think it's worth actually getting hold of the inhaler is seeing how many micrograms and working out how many micrograms and they're taking the daily. So total daily dose should be below 800 and ideally 400 or below. Importantly when they're well, step down.

So I'm just going to have questions my team on this and I wonder if somebody in the team could actually prioritize my questions. I've got too many to handle here and I need the top priority ones at the top of the list please.

So I think it's a really important so that in the use of inhaled corticosteroids in asthma is important and I don't think we should underestimate the importance but I think we should be vigilant at tailing down the dose when the patient's well. And I think we all recognize that patients, if you say to them are you or are you a winter wheezer or summer wheezer they often know. Do you wheeze in the summer with the pollen or do you wheeze when you get a cold – ahh no I'm more… and I try to get them to recognize when that is, step up the dose for when there's the time that they are problematic and tail down.

So is it an asthmatic wheeze that you have a particular interest in?

Well, I'm, I'm really interested in bronchiolitis, which is a winter wheeze in children under two, uh, often starts around boxing day and Christmas Day and it's a seasonal virus that makes children appear asthmatic and they wheeze their very breathless.

Is it misdiagnosed?

Um. Yes. It used to be. I think it can be quite hard to work out as a two year old developing asthma, or is he got a winter virus? Sadly about two to five percent of these children get admitted and they wheeze and we not - Over the last few years it's been difficult to decide how best to treat them. Some of it is a self-limited illness. They get better on their own, but about two to five percent need help with oxygen.

And you say it's difficult to treat?

Well it's a viral illness. It's, it's self-limiting, they get over it. But people have tried steroids. People tried giving them ventolin. People try give in atrovents. And there are various ways of, even immunoglobulins, we know that it's in children who are, who've got small birth weight or premature or as a family history of asthma, they tend to get the disease early. In answer to the question, I quite interested in children who've got chronic cough and haven't been, where the parents were unsure if it's asthma and there's no A to B in the family and everyone's the GP is not sure whether it's asthma or not and sometimes just listening to the story of the investigating a bit more in detail. Maybe see an immunologist can be helpful.

There's a, there's a new asthma drug. Doing the rounds and other which is a combined preventer and reliever.

Yeah. Yeah,

and is that. Is that better than Becotide and Ventolin or is a separate..

Um, the studies have combined inhalers tend to show that A patients like them and B the compliance is fairly good because if you tell a patient this is when you get wheezy and this is to stop you getting wheezy they get mixed up first thing um the combined inhalers suggests they get better symptom control because every time they take a dose of the reliever, we get a dose of the inhaled corticosteroid.

Um, but the, the evidence, I'm not sure if the NHS, but everyone says it costs more and the taking the higher doses of inhaled corticosteroids. Because, whenever they get symptoms they they bump up the inhaled steroid dose

But they're still taking it every day as a preventer as well.

Yeah yeah. So I, so the evidence is that it may cost more, but compliance is good.

um Suzanne asked about Gabapentin and Pregablin

who I love these or don't like them. So um a Gabapentin seen, um, is a really toxic drug and we'll

see more use of Pregablin, which is kind of a brother of Gabapentin. It's a, it was, it was an originally an anti-epileptic drug and it's now been licensed for the use of neurogenic pain in diabetics, but also it gets used willy nilly in patients who've got unexplained pain and have got neuropathic pain and in complicated patients where nothing will work. Um it's the evidence that it works broad stream is not good and about a third of patients who benefit for pain and two thirds see more side effects than benefit. I spend a lot of time counseling patients who've been put on it and already on horrible other drugs like tramadol and codeine and recently I saw someone who's taking codeine, tramadol, opiate patches and Gabapentin, and it's a really toxic combination. I think. I think the side effect profile is worse, is worse than the benefit. right now.

I was going to say that do the side effects outweigh the benefits.

Yeah. So I think that patients often get there because they've seen several specialists, they've been to pain. So there's osteopath, GP, um no diagnosis orthopedic surgeon, no diagnosis, rheumatologists not quite clear a pain clinic. And then they then in comes in the pregablin. um often, these patients are already loaded with those drugs and their very sedative, um, common to cause confusion, dry mouth, blurred vision, agitation and behavioral problems. And sometimes the other thing is that when you see these patients, they can be quite hard to step them down because they've read the data sheet, which quite rightly says do not stop these abruptly because they do get withdrawal reactions in stopping these. Um, I just think there are quite a toxic drug and they're often used in complicated patients who've got other illnesses, concomitant illnesses, and often prone to the side effects.

Um, I don't know who this questioner is, but they say they've always been under the impression that a disc prolapse or herniation without terrible neuropathic pain use anti inflammatories, because they need to reduce the inflammation of the disc. Is that right?

I think, um, do you believe that as an osteopath? Um, I'm struggling a bit. I'm not sure I do subscribe to that either.

So I think you've, you've, um, I think if we just go on physiology, that if you've got a disk herniating and it's pressing on the nerve and the nerve and they've just come back from walking holiday and push themselves, then I think an anti inflammatory would be reasonable. But I would go from the assumption that we need, is the drug safe in that patient and do, I wouldn't go from the side that they definitely need a non-steroidal, if they've had some paracetamol, they have some codeine, they're deteriorating and there is no risk profile that that's of all the other things we've just talked about. I might try it and there's no doubt that a lot of those patients will come back happy, but I. But the key thing is to give them the lowest dose for the shortest amount of time and not put it on repeat. And I normally give 10 days of antiinflammatories and don't put it on repeat.

I remember reading some years ago, or being taught some years ago. But actually when you, when you prescribe anti inflammatories, you've got to take them for a week or so before they're likely to have any effect. That might be a mild analgesic effect at the beginning. But the anti-inflammatory effect takes a long time, much longer time.

Yeah. I mean, uh, it varies dependent on their anti inflammatory. But I think most evidence suggests that the antiinflammatory effect doesn't kick in for seven to 10 days or maybe longer. Um, if you've ever taken brufen or naproxen for a dental abscess, you can almost feel the pain easing off in half an hour, 40 minutes. So the analgesic effect kicks in and Voltarol, which we use, uh, for kidney stones can give rectal. um Voltarol and it kills the pain of kidney stones in minutes. Yeah. So you could argue, you could argue that that is, that's an antiinflammatory, but it's mainly the analgesic effect. That I think we're missing

OK, let me see. Interesting here. This question, what about topical non-steroidal drugs? Do they have side effects? Are they effective?

So Cochrane review does a really good article on this and that their meta analysis and overview is that um they kind of came out on the fence really. But what it did say is that patients find benefit from them and for, for surface type thing. So tenosynovitis at the back of the thumb, a little bit of early tennis elbow in a patient who's in intolerant of oral drugs were at risk. Then it's reasonable to try and that's what I do, they're cheap, they're cheerful and they're less likely to cause a problem, but even though you give them that drug topically, it's absorbed, it still does affect the blood and it does affect the stomach as well. So it isn't totally safe but yeah, it's less irritant than a, than an oral dose. So I believe I do use it for patients who've got superficial tendinopathy.

Right.

And they like it because it gives it something to do in and they'll say, well, this is a nice…

There's always that slight suspicion. It's the rubbing that does the good, oh, here we go. I have a patient who was a receptionist at a GP practice and they've just been having triage training. They're all very nervous about the extra screening responsibility. I'm not sure if this is UK wide or just GP practices in their part of Essex. It wasn't actually a question, but um, and

I think all practices are on to this, that using the GPs to triage questions is, is an important system, but for what they're paid and the responsibility they take, I wouldn't want to do it.

Is it a bit like 999 call handlers? There are key words that you recognize.

Yeah, I mean I'd rather trainee your receptionist to say that if someone rings up and their breathless and they've just haemorrhaged, then um want you to put them through um. I think that's the bottom line. I think sadly sometimes the patients who are really poorly just don't get through the system and they get put on the end of a telephone list the following day. So I think triage is important, but I think, I think our receptionist, the key in the practice, I've worked the triage which goes to the nurse practitioners who are often

paramedics and I think the evidence is that triage are just doing better by, by highly trained people as opposed to people following on a spreadsheet.

Um Louise asks a question. She has a patient with a TSH of 12.3 and also antibodies. How realistic is it for her to change this through diet or stress management or with medication necessary in a case like that?

Um I would say that she does need to start her on thyroxin . Um, I think it's unlikely that she'll get better on their own, but I have seen patients who have gone on diets and massive fitness regimes and are convinced that they've corrected them. One of them was a daughter's friend who had hypothyroidism, change the Diet and got better. Um, so it does happen. The question is, is you don't know whether this is part of the autoimmune process that they started on the.. that not going thyrotoxic. So, um, do I believe that diet can correct an underactive thyroid? I don't really. OK, but there are patients who say they've got better. I wonder whether it was the disease process just burning itself out.

Some of these questions don't really about pharmaceuticals, but sure. Who's asked this one they're not telling they like to stay anonymous some of these people. May I ask about the pediatric population. They ask drugs for reflux, seem to be handed out like candy. Oh yes. I've had babies as young as seven weeks on in ranitidine, omeprazole and domperidone That sounds like something out of the Godfather,, simultaneously. While some babies obviously do have reflux, not many, several meds at once. What would you suggest to parents to stop one, and if so, which one or contact the GP? Well, why not cranial osteopathy or Chiropractic or oh no we can't say that.

So reflux is a, is a trendy disease in adults and children and in babies Uh, we used to call it on fat-happy-refluxes they’re normally chubby. They normally smile, but they vomit. Um, they're often difficult to feed and their problematic in evening, I do not believe you should be treating those children with, with drugs in fact the last adverse event meeting it went to was where a consultant and put someone on a massive

dose of a ranitidine, for presumed reflux and it was an abnormal dose. Then there was a problem.

Um, it must be hellishly difficult to get the dose right for a small child.

It was a baby. Um, I, I, I think we need to challenge it. So I think you're absolutely right. I think we need to look at, um, supporting the parents a lifting, you know, elevating the cop mattress, finding what the parental belief is, looking at the stress, um,

parental beliefs, what do you mean by that?

Um why do you think your child's ill? How'd you think it's going to come to harm? What do you think's going on? What's going on in the family? The reflux in babies are common? Some just don't reflux. Is it an illness? I'm not convinced it is. Sometimes they grow out of it after they turned two.

Do they do themselves any harm?

Um, my uh, yeah, I don't think. I don't think they do. I think they'll grow out of it and I think we've, we're, we've medicalized a very common problem. I wouldn't be keen to put my children on those drugs.

And how much do you think that a diet high in sugar and processed foods is to blame for type two diabetes and other health problems somebody has asked.

Well, I think all you have to do is look at films from the 1960's and 70's and see people who were raised in a more, um, probably a healthy balanced diet with less sugar, a possibility of eating more fat, but less sugar, and I think it is driving diabetes

So rationing is good for us

It's interesting one this week from the health. Um, uh, I think it was the shadow health minister talking about that diabetes is increasing because people are having high calorie snack through the day and those snacks are about equivalent of about 800 calories extra, and probably calorie load that's driving the obesity side. Not, not what we're eating. But we all know it's easy to go into petrol station and pick up.

It’s hard not to

Yeah so it’s those naughty foods are absolutely in front of us and we're not really pushing. So I think, um, yeah, I think carbs are pushing the obesity epidemic is it sugar or carbs and is it lifestyle and it's just too handy. And too easy.

I’ve got two related questions here, again, both anonymous, um, what are your thoughts on patients becoming addicted to painkillers like co codamol and recently this person's had a client struggling to come off after a year and the other question is we’re being told that naproxen destroys stomach and Co-codamol’s addictive. What should our patients with musculoskeletal pain take?

So, um, I think if, so the, they'll take it in two parts. So um inflammatories brufen is probably it's got the best, the best safety profile, but it's still a tricky drug in complicated patients. diclofenac has probably got one of the worst safety profiles of the cardiac risks for cardiac events. Naproxen is probably the safer of those. So if you've got a cardia-cy patient um choose Naproxen… what was the second bit of that one?

Oh one was about addiction,

opiates are addictive. So, um, um patients who've taken opiates for probably more than two or three weeks, I think will have to be tailed off them slowly. Having said that, I've seen many patients who've just decided to bin the lot and go cold Turkey and to which would not come to harm. But I think that's, that's kind of mental power on a medical knowledge and they are addictive and I just tell patients saying very, very gently and actually explain it. So I think the key thing is when you, if you say to patients, this is codeine, it's, here's paracetamol, here’s anti-inflammatories, codeines here, and there’s morphine, um this drug is addictive it will cause side effects, uh, it'll make you sluggish, it'll make you tired, it will make you constipated. The more you take the more of those things, you'll get. And I don’t want you to stay on it long term. If you tell them that in the beginning you've got, it's easy to get them off. Now I know when we get patients with chronic pain that you'll see commonly, um, I think we've got to

ram home the message that these drugs need to be tailed down. And as we saw on the Mali program, on the BBC 2 um earlier last year, they were taking people on chronic pain. One lady was there with an arm pain and the frozen shoulder, et cetera. And they tailed the medication down and actually had no more pain when she was off. Everything. Really.

One patient of my own that springs to mind, who is on two or three tramadol every night without the tramadol claims that he can't sleep and the pain was unbearable and he's been on this now for several years, five, six years probably, um, if not longer. And what would you advise a patient in that situation where you say, we'll try and coming up with it anyway?

Yes, definitely. All patients on tramadol will get side effects if you actually explain to them they'd be brighter off it, there'll be more mentally agile. Um, they will be brighter in…

his argument is that he won't because he can't sleep because the pain is too bad

If they weren't come along with you we're stuck. But if you can educate and bring them along and gain, concordance, then you've got some hope. I think my experience is that with the right, um, education and coaxing and most patients will come along with you. There's always the Dr Defeater and you'll see those as much as, as I do, if they don't want to and they won't listen. And they don't see the risks. You're on a difficult wicket. Yeah.

We interviewed somebody. Um Neil Stanley, who's a, one of the country's experts on sleep, uh, several months ago now, I think. And he was saying that opioids are actually very bad for sleep quality and if you reduce the quality of deep sleep, then actually that in itself causes pain or reduces your resistance to pain. So getting better sleep is an analgesic. So in some ways the opioid is, it may be defeating the object. Is that something that you are familiar of?

I just see that as a similar to patients who are drinking too much alcohol. They get disturbed sleep, they liked the, the alcohol to get them to sleep, but they get

disturbed sleep when they're awake, they're more aware of the pain and we know that tiredness increases or you experienced pain more vividly, and more deeply when you're tired. And I think it's important to treat sleep disorder, but I think we should need to do other things like hypnotherapy, acupuncture, sleep hygiene, rather than giving people medications.. the evidence for s, uh, sleeping tablets causing problems across the board. Is is just getting higher year on year end and I think we're probably going to have a bit of a backlash like we did in the diazepam debate in the eighties. Um, there is a lot of interest about whether they increase the risk of Alzheimer's disease and cognitive decline on a think. I just, I just try not to get in the situation where you've chronically prescribed sleeping tablets.

I'm probably going to get chance for one on one or two more questions before we finish. Um, this one's been sitting on my list for a while and I've got a patient says this person again, anonymous, um, who has been placed on statins and a lot of pain after being diagnosed with cancer on further investigation in the patient's anxiety and development of tremors, early signs of Parkinson's alongside many other symptoms coincide with the period of time these medications were prescribed with the terrible number of side effects to these drugs. Having potentially created a vicious cycle for overall health. As a doctor, what would you prescribe as a lifestyle change that could benefit his future outcome?

Well, the first thing is, um, if he's, if he's, if his cancer’s um nasty, it's life limiting, does he wants to be on the statin? and does he believe that the statin, or she, did they believe that the statin is causing some side effects? So I'd go down that line first and I think if I was wanting to reduce cholesterol because if we say it's not a life-threatening disease, I would go for exercise, a high vegetable diet, lots of colors, lots of Greens, lots of red, avocado exercise four times a week for 40 minutes and meditation

And your a mindfulness aficionado

Yeah. Well I'm interested in mindfulness and I think, um, I think patients really benefit from those ideas. I

think the difficulty with these patients is that it's probably that the GP was trying to do the best at that moment in a 10 minute consultation with cancer lipids, hypertension and really sometimes the talking therapy may maybe just as good.

there is. If I can briefly just mention Malcolm Kendrick again, one of his particular hobby horses. It is that he thinks that stress is a much underdiagnosed causes other real health problems such as high cholesterol and other things like that. Um, and mindfulness must be an excellent way of addressing that.

So, so my, my belief very strongly is that physical health is connected absolutely interlinked with mental health and people start going faulty physically when the mental health is poor.

If I gave you two minutes, which I'm going to to, to give us, what are your key messages that we came here to talk about? what would be your takeaway messages for everyone watching this evening?

My takeaway message, are be very wary of prescribing an antiinflammatory drugs across the board to patients who are in a risk group and those risk groups are cardiac patients, diabetic and vascular patients. So that's number one. And number two is always go from the angle that if you want to, if you wish a GP to take another line of action or prescribe something, be really clear in your own minds that that patient fits into a safe group for your line of action because if you're going to suggest it and the patient and you believe the patient is going to benefit, you need a little bit of evidence that that's safe maneuver. And the third thing,

for example there, where would we get it wrong?

Maybe diclofenac. yeah. I think diclofenac may be now there are some articles that suggest it's not a safe drug for cardiovascular is one of the highest risk of cardio vascular events in people who've been prescribed. Not a GI bleed but vascular events. Um, and the third one is actually allowing your patients to interact with the GP surgery and facilitate that by actually educating a little bit. So we were talking about patients who've got

swollen ankles, some breathlessness you can say. You can give them kind of key sentences to use and say, I would like the following test because of…and I think GPs will struggle to say no if the patient puts it well.

And do you think it's a helpful if they don't say my osteopath or chiropractor says I should have this because or does that depends on the GP.

It depends on the GP

Nigel it's been fantastic. It's been great to have someone of your immense experience in here, a reassuring us that GPs are not just a breed of pill popping a pill Selling.

I think the tide is changing I think

and reassuring too to know that more and more of them are welcoming to those sort of things that we do in our, in our own practices. Thank you very much. I've got a whole load of the questions which I'm going to ask you hopefully we can get it up on the website.

Thanks very much.