Chronic pain: opiates

The role of opiates in the management of cancer pain and acute pain is well established. From this evidence base, use and benefit has been extrapolated to other forms of chronic pain.

But is this valid, or are we doing more harm than good?

Headlines:

We should rarely be using opiates in chronic/persistent pain because:

- There is an absence of evidence supporting the benefits of long-term opiates in non-cancer pain.
- There is extensive evidence of harms, including opioid dependence syndrome, motor accidents and overdose.
- There is a greater body of evidence to support non-opiate analgesia, antidepressants, neuropathic painkillers and non-pharmacological interventions, e.g. CBT, exercise therapy.

How big is the problem?

Where the Americans lead, we often follow (NEJM 2016;374:1501).

An editorial by the authors of the new CDC guideline reminds us that, in the USA, it is estimated that:

- 11% of the population has a chronic pain diagnosis.
- 4% are on long-term opiates.
- Rates of dependence in those on long-term opiates may be as high as 26%.
- 1 in 500 patients starting opiates die of opiate-related causes within 2y of first prescription.
- Co-prescription of benzodiazepines is common, and increases the risk of overdose and admission (BMJ 2017;356:j760).

The situation in the UK is clearer since the publication of the Public Health Research Consortium’s report on prescribing patterns of dependence-forming drugs. This was summarised in the BMJ and makes for sober reading (BMJ 2017;358:j4249).

The report used the CPRD (what used to be the GP Research Database) to look at prescribing of opiates, benzodiazepines, Z-drugs and gabapentinoids in a random sample of 50 000 patients. It excluded patients with diagnoses of cancer or epilepsy. It found:

- Prescribing of opiates and Z-drugs doubled between 2000 and 2012.
- The absolute proportion of patients on any dependence-forming drug in 2015 was 9%.
  - 5% patients were on opiates.
  - 2% patients were on Z-drugs.
  - 2% patients were on gabapentinoids.
  - 2% were on benzodiazepines.
- Benzodiazepine prescribing has fallen slightly, as would be expected since they have been on our radar as harmful drugs for a little longer.

The report recommended that the most effective way to cut long-term prescribing of dependence-forming medications was access to dedicated withdrawal services and the commissioning of a 24-hour helpline(?!), together with provision of alternatives for primary care to access when patients first attend with distress.

These services are absent in many areas of the country, and many of us are tackling these issues slowly in our own practices. We hope this article helps.

Why should we change our practice?

Opiates are minimally effective in non-cancer pain

A review of opioid painkillers in the management of lower back pain details many of the issues for primary care clinicians. It casts doubt on the very legitimacy of using opioids in these patients (BMJ 2015;350:g6380).

In short, it says, we have overestimated the benefits of opiates and seriously underestimated their risks.

The evidence of benefit is thin. Most research has been done on low back pain.

- There are no RCTs that look at the role of opioids in low back pain that last beyond 4 months.
- Small, imperfect cohort studies have shown that at best opioids reduce chronic low back pain by about 30% when compared with placebo.
- Studies comparing opioids with NSAIDs show that more patients achieve a 30% or more pain reduction with an NSAID.
- There is an absence of evidence of positive impact on function.
- Some guidelines suggest that opioids are better than NSAIDs in the elderly due to the GI, renal and cardiac risks associated...
with the latter, yet a cohort study found that there were higher mortality rates in elderly patients taking opioids for their arthritis than in those taking NSAIDs.

**Opiates cause significant harms in non-cancer pain**

<table>
<thead>
<tr>
<th>Category of harm</th>
<th>Example</th>
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</table>
| Simple adverse effects (NNH=4)            | - Constipation.  
- Nausea.  
- Sedation.  
- Depression.  
- Sexual dysfunction (men on opioids are more likely to use drugs for sexual dysfunction: 19% vs. 7%).  
- Increased risk of falls and fractures. |
| Tolerance and dependence                  | - Hyperalgesia (an increase in sensitivity to pain). It tends to occur at withdrawal of analgesia, but can occur during treatment. Repeated courses of opioids may ratchet up hyperalgesia.  
- Opioid dependence disorder. This is a new term for dependence and addiction, and is covered in more detail below.  
- Doses of opioids tend to rise over time. |
| Functional impact                         | - Those taking opioids are twice as likely to remain off work.  
- Opioid prescribing within 15d after an acute injury was associated with a higher risk of disability, even after adjusting for the degree of injury.  
- A Danish study found those on long-term opioids had worse pain and quality of life than those not taking opioids. |
| Hormonal effects (hypogonadism)           | Opioids can act on receptors in the hypothalamus, which can result in decreased production of LH/FSH and disruption of normal pulsatility (BMJ 2010;341:c4462).  
- More common in men and those on high doses of opioid medication (particularly intrathecal).  
- Reversible on stopping the opioid; recovery may take 1m.  
- Ask about erectile dysfunction, loss of muscle mass, oligomenorrhoea or amenorrhoea, flushing and sweats, loss of libido, depression and anxiety. (Of course, these can also be features of chronic pain syndromes!)  
- If these features are present, consider testing LH, FSH, testosterone and oestriol.  
- The article suggests that if hypogonadism is demonstrated, we should consider referral for treatment with hormone replacement therapy and bone density monitoring.  
- However, surely a better strategy is to get them off the opiates! |
| Mortality                                 | - Deaths from opioid prescribing now outstrip deaths from cocaine and heroin combined in the USA.  
- Mortality risk rises with dose.  
- One cohort study of patients having lumbar spinal fusions found opioid-related overdoses were the commonest cause of death in the 3y after surgery. |

**Impact of an opiate prescription**

Like with antibiotics, individual practitioners vary in how often they prescribe opiates and how they talk to patients about these drugs. There are few studies in primary care. A recent US emergency department retrospective analysis looked at the impact of receiving an opiate prescription on more than 350 000 opiate-naïve patients (NEJM 2017;376:663). It found that:

- Physician prescribing rates varied widely. There were low-intensity prescribers prescribing in <7% of consultations, and high-intensity prescribers prescribing in more than 24% of consultations.
- Subsequent long-term opiate use was 30% more likely in those who received a prescription from a high-intensity prescriber.
- This equates to a NNH=48 – for every 48 patients prescribed an opiate in an emergency department setting, 1 will become a
Do you know how your personal prescribing rates compare with your colleagues? Can you impact upon this?

**What can we do about this?**

We have used two sources to provide practical hints and tips about opiate prescribing for non-cancer indications in this article:

- CDC guidelines for prescribing opiates in chronic pain from the USA (JAMA 2016;315:1624).
- The UK resource 'Opioid Aware' developed by the Royal College of Anaesthetists (there is a link in the Other Resources section).

Please note, this **does not** apply to prescribing for cancer pain, palliative care or in the last days of life.

**Deciding whether to start opioids**

The key message is **DON'T START OPIOIDS.** We should broaden our approach to chronic pain – the drugs don’t work!

The CDC guideline recommends:

- Non-pharmacological and non-opiate options are preferred choices for chronic pain. They have a better evidence base. Use these first.
- If considering adding an opiate, decide whether benefits for pain and function outweigh the harms, and always combine with non-pharmacological and non-opiate measures.
- Before starting opiates, establish treatment goals with the patient – what will success look like? Continue treatment only if there is clinically meaningful benefit.
- Explicitly discuss how therapy will be discontinued if goals are not achieved.
- Explicitly discuss the known harms and expected benefits, and continue to reassess this on an ongoing basis.

**But if you still decide to try an opiate...**

The 'Opioid Aware' resource explicitly discusses how to do a trial of opiates. It also reminds us that short-term success does not predict long-term efficacy.

<table>
<thead>
<tr>
<th>Starting the trial</th>
<th>• Agree assessable outcomes with the patient that relate to pain and function, e.g.: ability to attend work, do exercise, pain intensity, sleep pattern.</th>
</tr>
</thead>
</table>
| **Duration**       | • If pain is constant, 1–2w is sufficient.  
|                    | • If pain is intermittent, the trial should be long enough to allow for 2–3 episodes of pain. |
| **Choice of opioid** | • Prescribe a short (1–2w) supply of immediate-release morphine liquid or tablets.  
|                    | • Advise patient to explore a range of doses within a fixed limit, e.g. 5–10mg of oral morphine (modified for age, weight, renal and liver function, etc.).  
|                    | • Note that if a single dose of 20mg immediate-release morphine does not offer pain reduction, opiates are not likely to be beneficial in the longer term. |
| **Assessing success** | • The patient should keep a diary focusing on the agreed outcomes and side-effects, and recording exact timings of doses.  
|                    | • If there is no improvement (or <30% improvement), then long-term opioid therapy is not likely to be effective.  
|                    | • If there is an improvement in pain but at a cost of side-effects that impact on function, we need to assess the balance of harms and benefits, consider different dosing regimens and manage side-effects such as constipation. |
| **Documentation**  | • Clearly document all of the above. |
Managing the risks of opiate prescribing

High-risk groups

The CDC guideline recognises that there are a number of groups for whom opiates present particular risks of harm, overdose and dependence.

- Review history for risk factors for misuse and excess harms, e.g. previous overdose, history of substance misuse, previous high doses of opiates, history of mental health problems.
- Review previous prescribing history for evidence of controlled substance use in the past.
- Avoid prescribing opiates and benzodiazepines together wherever possible.
- Consider urine drug testing before and annually during treatment:
  - To assess whether non-prescribed opiates or recreational drugs are being consumed, highlighting a high-risk individual.
  - If it is suspected that prescriptions are being obtained for sale rather than consumption, to assess whether it is safe to stop prescribing without provoking withdrawal.
- Diagnose, label and treat opiate misuse disorder.

It makes specific recommendations about the following groups:

<table>
<thead>
<tr>
<th>Avoid opiate use wherever possible in:</th>
<th>Be aware of increased risk of toxicity/overdose in:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Sleep-disordered breathing, e.g. obstructive sleep apnoea.</td>
<td></td>
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<tr>
<td>- Pregnant patients:</td>
<td></td>
</tr>
<tr>
<td>- For pregnant women on long-term opiates that cannot be reduced and stopped, facilities should be available at delivery to manage any opiate withdrawal in the baby, i.e. hospital delivery.</td>
<td></td>
</tr>
<tr>
<td>- Patients with renal or hepatic failure – needs close monitoring.</td>
<td></td>
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<tr>
<td>- Patients aged 65y or more.</td>
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</tr>
<tr>
<td>- Patients on concomitant benzodiazepines.</td>
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<tr>
<td>- History of past or current drug and alcohol misuse.</td>
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<tr>
<td>- Those recently released from prison, who may rapidly escalate their doses without realising their previous tolerance level has dropped.</td>
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<tr>
<td>- Those with a history of mental health conditions, particularly if treatment is not optimised at the time of opiate treatment.</td>
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</tr>
</tbody>
</table>

For these groups, the guideline recommends considering whether there should be a co-prescription of naloxone. This is more common practice in the USA where it can be prescribed as a nasal spray or IM injection.

High-risk doses

We are aiming to avoid all opiate prescribing, but, for many of us, there are already a substantial portion of patients on opiates. When considering patients on existing long-term prescriptions, and how to tackle this, it might be useful to stratify them into risk groups:

The CDC guidelines highlighted prescribing cut-offs of **50 MMEs** and **90 MMEs** because there is a marked step-up in the rates of harms and accidental overdose at these levels.

Note, when considering this, all opiates should be taken into account if a patient takes more than one or takes long- and short-acting.

**What levels of opiate prescribing are equivalent to 50 and 90 MMEs?**

This table is taken and adapted from the CDC guideline. It is included so you can identify your high-risk patients, and also as a
reminder that sometimes, especially for patients on patches and oxycodone, doses can reach high-risk levels quicker than we realise.

It is important to remember that these conversion factors are only estimates, and individuals vary in how they metabolise these medications – we should therefore err on the side of caution.

*For those who find this muddling to calculate daily equivalent of morphine:
  - Take current daily dose of opiate, e.g. 240mg codeine.
  - Multiply by conversion factor, e.g. 240 x 0.15.
  - This gives you the daily equivalent of morphine, e.g. 36mg.

The ‘Opioid Aware’ guideline also gives us equivalent doses for transdermal patches:

<table>
<thead>
<tr>
<th>Patch</th>
<th>Morphine milligram equivalent (MME)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Buprenorphine patches</strong></td>
<td></td>
</tr>
<tr>
<td>(changed every 7 days)</td>
<td></td>
</tr>
<tr>
<td>Buprenorphine 5 mcg/hr</td>
<td>12</td>
</tr>
<tr>
<td>(changed every 7d)</td>
<td></td>
</tr>
<tr>
<td>Buprenorphine 10 mcg/hr</td>
<td>24</td>
</tr>
<tr>
<td>(changed every 7d)</td>
<td></td>
</tr>
<tr>
<td>Buprenorphine 20 mcg/hr</td>
<td>48</td>
</tr>
<tr>
<td>(changed every 7d)</td>
<td></td>
</tr>
<tr>
<td><strong>Buprenorphine patches</strong></td>
<td></td>
</tr>
<tr>
<td>(changed every 4 days)</td>
<td></td>
</tr>
<tr>
<td>Buprenorphine 35 mcg/hr</td>
<td>84</td>
</tr>
<tr>
<td>(changed every 4d)</td>
<td></td>
</tr>
<tr>
<td>Buprenorphine 52 mcg/hr</td>
<td>126</td>
</tr>
<tr>
<td>(changed every 4d)</td>
<td></td>
</tr>
<tr>
<td>Buprenorphine 70 mcg/hr</td>
<td>168</td>
</tr>
<tr>
<td>(changed every 4d)</td>
<td></td>
</tr>
<tr>
<td><strong>Fentanyl patches</strong></td>
<td></td>
</tr>
<tr>
<td>(changed every 3 days)</td>
<td></td>
</tr>
<tr>
<td>Fentanyl 12 mcg/hr</td>
<td>45</td>
</tr>
<tr>
<td>Fentanyl 25 mcg/hr</td>
<td>90</td>
</tr>
<tr>
<td>Fentanyl 50 mcg/hr</td>
<td>180</td>
</tr>
<tr>
<td>Fentanyl 75 mcg/hr</td>
<td>270</td>
</tr>
<tr>
<td>Fentanyl 100 mcg/hr</td>
<td>360</td>
</tr>
<tr>
<td>Fentanyl 300 mcg/hr</td>
<td>1120</td>
</tr>
</tbody>
</table>

**What about patients already on long-term opioids?**

If your practice has historically high levels of opioid prescribing, you may want to tackle the highest risk groups and doses first. It may also be possible to identify those patients most motivated to change their situation by writing to all patients with a repeat prescription for opiates, explaining the harms prior to their next medication review.

The authors detail the following:
  - Keep the dose of opioids as low as possible (dose equivalences above 50–100mg morphine are unlikely to see further benefit in pain relief).
  - Identify and treat opioid misuse disorder as just that (see below). Do not stop medication suddenly, but engage with your patient and consider using addiction services as a resource.
  - Attempt to reduce opioid prescribing using a gradual reduction programme, adding in other therapy to aid the withdrawal.

For those who would find more specific information helpful, we have summarised useful pointers from the Opioids Aware resource, developed by the UK Royal College of Anaesthetists (see Other Resources below for a link to the whole toolkit).
Dependence refers to the development of:
- Tolerance: the need for increased amounts to achieve the desired effect.
- Withdrawal effects: symptom development with attempts to reduce or stop the drug.
- There are intolerable side-effects.
- There is good evidence that the medication is being diverted/sold to others.

Dependence has been demonstrated at 1m of treatment in patients taking oxycodone. Over half of all patients taking opioids for 3m will still be taking them at 1y. Studies vary on the level of dependency due to different diagnostic criteria, but range between 5 and 30%. Urine testing of patients taking opioids tends to discover a ‘surprise’ in 1 in 5 cases (either no drug found (!), or higher levels than prescribed).

Here are the guidelines written by the Royal College of Anaesthetists regarding the identification and management of patients with opioid dependence. For most of us in primary care, our role will be identification and referral to specialist addictions services. Some GPwSI or practices working under Locally Enhanced Service provision of addiction services may take on more of the role themselves.
Opioids and driving

There are two issues:

Legal

New drug-driving legislation came into force in England and Wales in 2015. The new offence refers to driving with specified amounts of controlled drugs in the body – morphine and methadone are included, but not other prescription opioids. The set levels are generally above the prescribed therapeutic ranges, and there is a statutory ‘medical defence’ if people are found with levels in their bloodstream in accordance with documented prescribed quantities (or quantities recommended by the patient information leaflet).

Safety

In addition to this legislation, it remains the responsibility of all drivers to consider whether their driving may be impaired on every occasion they drive.

Information you can share with patients:

- Drivers testing positive for morphine are 8–32 times more likely to have an accident than those with a negative test result.
- Doses of >200mg/day can result in impairment similar to that seen with driving above the alcohol limit.
- Impairment may occur at much lower doses if there are concomitant prescriptions of sedatives or consumption of alcohol.

Consider prescription opioid dependence in the following situations (these won’t come as a surprise):

- Current or past psychiatric illness or significant emotional trauma.
- History of other substance/prescription drug/alcohol misuse.
- Reports of losing prescriptions/early replacement requested/taking higher doses than prescribed.
- Family express concerns about opioid use.
- Refusal/failure to attend medication reviews or accept referral to addiction services.
- Dr-shopping or location-shopping (OOH/A&E/111) for opioid prescriptions.
- Deteriorating function, e.g. work, social interaction.
- Refusing specialist referral to tackle the underlying issue.

Assessment and referral

- Avoid judgement and confrontation.
- Work together to create a formulation of the whole ‘pain’ and suffering situation, including all bio-psychosocial factors (you are going to need more than 10 minutes or a few appointments).
- Document all dependence-forming drug use and routes of administrations (so benzos, Z-drugs and gabapentinoids).
- Depending on complexity and our individual experience level:
  - In most cases, we will refer these patients to addiction services.
  - Some practices may be well set up to manage this in house.
- One doctor should take over prescribing of all dependence-forming drugs, and develop a treatment and reduction plan.
- This may involve maintenance on current dose of opiates, or opiate substitution treatment and detoxification.

Maintenance treatment

This involves maintaining the current dose of opiates – switch to a long-acting oral opiate, e.g. methadone or buprenorphine.

- Great care must be taken in dose conversion, and it should only be undertaken with support from a clinician experienced in the use of these drugs (so, for most of us, this will require referral or discussion).
- Supervised dosing should be considered, but patients will not be converted to their full dose immediately in case they have been non-compliant (i.e. diverting some of their prescribed dose to others).
- Discuss referral for group support to work towards motivation for detoxification, e.g. Narcotics Anonymous.
- Regular testing for prescribed opiates and elicited substances should occur regularly.

Detoxification treatment

- Ideally, this should take place through outpatient addiction support services.
- Opiates will be converted to a single long-acting oral opiate, e.g. methadone or buprenorphine, and gradually reduced in a plan made with the patient.
- Patients should be warned of the risk of overdose if they relapse and leap up to a higher dose.
- If detoxification is successful, specialists may consider prescribing naltrexone.

Naloxone prescribing

Dependent patients who are at risk of overdose may be prescribed naloxone, and training in how to use this should be offered to their family and carers.

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Discussion in relation to drugs and driving should be clearly documented in the notes and a copy given to patients (see Other Resources below for a printable leaflet).
**Pregabalin and gabapentin: abuse and misuse**

Having considered opiates, what about pregabalin and gabapentin? The issue of the abuse and misuse of the 'pentins' is often raised by delegates on our courses, and is something that concerns Red Whale team. It is now being taken seriously by the Advisory Council on the Misuse of Drugs (ACMD) which has written to the UK Government requesting that these drugs are classed as controlled. An article in the DTB covered this issue (DTB 2017;55(3):26).

It reminds us that:

- UK prescribing of pregabalin and gabapentin has increased by 350% and 150% respectively over the past 5y.
- UK survey data indicates that abuse, often alongside opiates, is common in the prison population.
- Pregabalin is felt to have greater abuse potential, as, in some users, it produces a significant high or elevated mood.
- Use of both pregabalin and gabapentin has been implicated in abuse-related deaths.

The ACMD feels that pregabalin and gabapentin present a similar risk of addiction and harm to tramadol, and should therefore be controlled drugs.

**So, what are the other options?**

The authors of the BMJ review on the management of low back pain without opiates suggest a number of approaches which are likely transferable to a range of chronic pain situations (BMJ 2015;350:g6380).

- **Self-care** should be the foundation of effective back care. Remaining physically active and doing things that are enjoyed is more important than relying on medication.
- **Empathetic, supportive clinicians** are more successful in managing chronic low back pain.
- **Progress** should be monitored by **activity level** rather than pain level.
- **When treatment is considered:**
  - **Use a stepped approach.** Remember, non-drug options can be effective (heat, movement, massage, relaxation, distraction); also NSAIDs, tricyclics and topical analgesia.
  - Ensure patient aware of the **adverse risks** in using opioids.
  - **Evaluate the risk** of dependence in patients by being cautious in those with a history of substance misuse, alcoholism or mood disorder (but the authors point out that you should not imagine you can eliminate all risk in this way).
  - **Consider only using opioids intermittently in short courses.**
  - Avoid starting long-term treatment (avoid adding it to repeats?) without setting goals for the treatment, and stopping treatment if the goal is not reached.
Chronic pain: opiates

- Consider and use all alternatives first.
- Prescribe the lowest effective dose of oral short-acting opiates.
- Think very carefully before prescribing more than 50mg morphine or the equivalent per day.
- Do not prescribe more than the equivalent of 90mg morphine per day.
- Reassess regularly based on pre-agreed treatment goals for pain and function.
- Be aware of high-risk groups and discuss tapering, especially if no impact on pain and function.
- Refer opioid addiction.
- Discuss, document and print driving advice for all patients.

Consider auditing all repeat prescriptions of opiates. You could use ‘Open Prescribing’ to compare your practice and CCG with other local practices: [https://openprescribing.net](https://openprescribing.net)

Identify and flag notes of patients taking more than 50mg morphine/d or equivalent. Review and assess the appropriateness of the dose, and whether a strategy for reduction and a naloxone prescription is needed.

Discuss the CDC guidelines and ‘Opioid Aware’ at your PHCT meeting – re-audit prescription levels 3m later to see if there has been a change in practice.

Could you write to all your patients on repeat opiates and offer them information about harms and an opportunity to taper and reduce?

Useful clinical calculator for opiate doses, including the 25% recommended reduction: [http://clincalc.com/opioids/](http://clincalc.com/opioids/)

This is a great video to show or share with patients when talking about chronic pain: [www.youtube.com/watch?v=qy5vKbdudGk](https://www.youtube.com/watch?v=qy5vKbdudGk)

And a clip to watch about why to stop opiates: [https://www.youtube.com/watch?v=MI1myFQPsCE](https://www.youtube.com/watch?v=MI1myFQPsCE)

The professional and patient resources of the Opioid Aware package can be found here: [https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware](https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware)

A handy printable leaflet on opioids and driving can be found here: [http://tinyurl.com/Opioids-and-driving](http://tinyurl.com/Opioids-and-driving)
All our courses are:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Relevant</td>
<td>Developed and presented by practising GPs and immediately relevant to clinical practice.</td>
</tr>
<tr>
<td>Challenging</td>
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</tr>
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<td>Humorous and entertaining – without compromising the content!</td>
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Our courses are designed for:
- GPs, trainers and appraisers preparing for appraisal and revalidation or wanting to keep up to date across the whole field of general practice.
- GP ST1, 2 & 3, looking for the perfect launch pad into general practice and help with AKT and CSA revision.
- GPs who want to be brought up to speed following maternity leave or a career break.
- General Practice Nurses, especially those seeing patients with chronic diseases.

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- A printed copy of the relevant handbook including the results of the most important research in primary care over the last 5 years and covering the subjects more extensively than possible in the course.
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- Buffet lunch and refreshments throughout the day!

What’s not included?

Our courses contain NO theorists, NO gurus, NO sponsors, NO reps on the day! Just real-life GPs who will be back at the coal face as soon as the course has finished.

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The MSK and Chronic Pain Update Course – New

MSK problems are the most common reason for seeing a GP and represent 30% of repeat GP visits. We want to help build your confidence. On the course we will tackle:

- The evidence-base for common MSK conditions including osteoarthritis, spondyloarthritis, polymyalgia, fibromyalgia and much more.
- Diagnosis: why waddling like a duck might help; and what to do when there is no diagnosis!
- Why chronic pain is ‘in the brain’ – and more importantly, what we and our patients can do about it.

We will provide you with a new narrative and a tool box of strategies you can take back to the surgery and start using the next day.

London Thur 17 May 2018
Manchester Wed 6 Jun 2018
Leeds Thur 11 Oct 2018
Birmingham Fri 12 Oct 2018
London Thur 18 Oct 2018
Brighton SEE BACK PAGE Wed 21 Nov 2018
Lead. Manage. Thrive! – The management skills course for GPs

If you've been waiting for a job as a leader to develop your leadership and management skills then you're missing out! Leadership starts with identifying and taking control over what is in your hands right now! Lead. Manage. Thrive! will give you the confidence to skilfully negotiate, deal with difficult conversations, influence colleagues and bosses, delegate and be proactive about managing your workload. The course is for anyone who wants to step up, find a better way of working and gain a toolkit of strategies to become a successful and resilient practitioner!

London Fri 18 May 2018
Manchester Thur 7 Jun 2018
London Fri 5 Oct 2018
Nottingham Wed 17 Oct 2018

The BRAND NEW Working at Scale Course!

If you're worried about the sustainability of your practice yet feel uncertain about working on a larger scale, then we are here to help! The Working at Scale Course is perfect for all GPs, Practice Managers and primary care practitioners who want to learn more about taking the next steps to working at scale, be it in a federation, through a merger or one of the other host of different models. We'll give you the confidence to weigh up your options and make the best choices for your practice – and we'll show you how to implement the changes successfully! This brand new course will help ease your transition and prepare you for the changes ahead!

London Fri 22 Jun 2018

Manchester Thur 15 Nov 2018
London Fri 23 Nov 2018

The Cancer Update Course

Within the next 15 years the need for cancer care will double and you will look after as many cancer survivors as diabetics. Shared care follow up will become the norm, and secondary care will pass responsibility to us. A key 2015 Lancet Oncology commission paper warned that: “GPs are inadequately trained and resourced to manage the growing demand for cancer care in high income countries”. Education for GPs was one of their five key recommendations – we can help you get ahead of the curve! Established GPs and GP STs can use this course to bridge the gap in traditional GP cancer education which has focussed heavily on referral and end of life care missing out the whole journey in between. This course is able to look in much more detail at the big picture behind the disease perhaps most feared by our patients and, let’s face it, that 1 in 2 of us will be diagnosed with over our lifetime.

London Wed 23 May 2018
Manchester Thur 7 Jun 2018
London Sat 6 Oct 2018

Our Consultation Skills Courses

These small group courses have a different feel and flavour to our topic based Updates and are packed with interactive activities designed to review and refine your consultation skills! But don't worry – we won't ask you to role-play in front of the group! Perfect for GPs, GP STs and Practice Nurses. For more information, please visit www.gp-update.co.uk/courses

The Telephone Consultation Course

London Thur 17 May 2018
Birmingham Fri 8 Jun 2018
Leeds Fri 15 Jun 2018
London Thur 28 Jun 2018

The Effective Consultation Course

London FULLY BOOKED Fri 18 May 2018
Manchester Thur 15 Nov 2018
Leeds Fri 16 Nov 2018
London Fri 23 Nov 2018

The Medically Unexplained Symptoms Course

Manchester Thur 7 Jun 2018
London Thur 18 Oct 2018
I would like to come on the following course(s) (please write legibly!):

☐ The GP Update Course ............................................................... (location) ............................................................... (date) ...............................................................

☐ The MSK and Chronic Pain Update Course ............................................................... (location) ............................................................... (date) ...............................................................

☐ The Working at Scale Course ............................................................... (location) ............................................................... (date) ...............................................................

☐ Lead. Manage. Thrive! Course ............................................................... (location) ............................................................... (date) ...............................................................

☐ The Cancer Update Course ............................................................... (location) ............................................................... (date) ...............................................................

☐ The Women’s Health Update Course ............................................................... (location) ............................................................... (date) ...............................................................

☐ The Telephone Consultation Course ............................................................... (location) ............................................................... (date) ...............................................................

☐ The Effective Consultation Course ............................................................... (location) ............................................................... (date) ...............................................................

☐ The Medically Unexplained Symptoms Course ............................................................... (location) ............................................................... (date) ...............................................................

I can’t attend a course, but would like to order your Handbook or DVD:

☐ GP Update Handbook and 12 months’ access to GPCPD £150

☐ Lead. Manage. Thrive! Handbook (no GPCPD) £70

☐ GP Update Handbook, DVD and 12 months’ access to GPCPD £225* (pre-order for delivery late May 2018)

☐ Women’s Health Update Handbook (no GPCPD) £70

☐ Cancer Update Handbook (no GPCPD) £70

☐ MSK and Chronic Pain Handbook (no GPCPD) £70

Price as stated in the flyer for each course. If applicable, please provide your discount code here.

Please send this form with your cheque payable to GP Update Limited to: Red Whale, University of Reading, Reading Enterprise Centre, Earley Gate Entrance, Whiteknights Road, Reading, Berkshire RG6 6BU

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