Depression

I find depression one of the most interesting and rewarding aspects of my work. Perhaps that is why we have a standing joke in our practice – if I can get through a whole week without proffering a tissue I have to buy the staff a large bar of chocolate to share for our Friday afternoon tea break. Needless to say, it doesn’t happen very often…!

Diagnosis of depression

Based on the DSM V criteria (which haven’t changed from when they were DSM IV!).

NICE depression guidelines (discussed overleaf) emphasise the need to use DSM V both to aid diagnosis and to grade severity. The criteria are:

- Symptoms must have been present nearly every day for at least 2 weeks.
- At least one of the first 2 criteria and a total of 5 out of the 9 criteria in total:

  - First 2 criteria (you must have at least one of these)
    - Depressed mood
    - Loss of interest or pleasure (anhedonia).

If both criteria above are met, you need a further 3 criteria from the list below.

If only 1 criterion above is met, you need a further 4 criteria from the list below.

- Significant weight loss or gain or change in appetite
- Sleep difficulties (including hypersomnia)
- Psychomotor agitation or retardation
- Fatigue
- Feelings of worthlessness or inappropriate guilt
- Reduced concentration or indecisiveness
- Recurrent thoughts of death or suicidal thoughts.

Grading the severity of depression

Severity is graded by the severity of the symptoms and the functional impairment they cause.

- To have mild depression you must still have 5 or more of the 9 symptoms above, but you will have each relatively mildly, or such that the impact on your functioning is mild.
- Mild depression is not when you have only one or two of the DSM IV criteria.

Is this bipolar?

Several studies, the most recently based in UK primary care, have shown that around 10% of adults taking antidepressants for ‘depression’ actually have features of bipolar disorder (BJGP 2016;66:71). Do you look for features consistent with bipolar?

The Mood Disorder Questionnaire is a simple screening tool that indicates the sorts of questions that would make you suspicious of bipolar: you can either ask them yourself or use it as a questionnaire for people to complete in the waiting room after a consultation (see useful website for link).

And just before we look at the NICE guidelines on depression, I’ll share this paper that significantly changed my practice, even though it is over a decade old!

Screening for eating disorders

The SCOFF questionnaire helps to identify patients with an eating disorder (BMJ 1999;319:1467). I try to use this questionnaire whenever I diagnose depression in women and in young men.

- Have you ever felt so uncomfortably full that you have had to make yourself Sick?
- Do you ever worry you have lost Control over how much you eat?
- Have you recently lost or gained more than One stone in a three-month period?
- Do you believe yourself to be Fat when others say you are too thin?
- Would you say that Food dominates your life?

Score 1 point for every ‘yes’ answer: scores of ≥2 indicate possible eating disorder.

Validation on a GP population showed sensitivity 85%, specificity 90% (BMJ 2002;325:755).
How do you remember the questions? I think of it this way: **SCOFF: Sick Control One Fat Food.** Once I get this far I can usually remember what the precise wording is.

*To me the first question was a revelation – I found it really hard to ask about self-induced vomiting without sounding judgmental, and yet this question puts it so well. It allows patients to admit to self-induced vomiting, but temporarily removes the sense that it is their fault, or that they had any control over the situation.*

**NICE guidelines on depression**

Here I have merged the NICE guideline on depression (2009, CG90) with the NICE guideline on depression in those with a chronic physical health problem (2009, CG91). Both were updated in 2016 but without significant changes.

**Key changes in the new NICE guidance**

- One of the main changes is a **shift towards using the DSM IV criteria for depression** as a diagnostic tool. This is to help identify those with more severe depression.
- For those who do not meet the diagnostic criteria for depression but have distressing or disabling symptoms NICE use the term ‘sub-threshold depressive symptoms’.

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### NICE Depression Guidelines NICE 2009, CG90 & 91

**Diagnosis and assessment**

- **Diagnosis** should be based on DSM IV criteria (overleaf):
  - **For depression:** 5/9 criteria are required, including at least 1 of the first 2 criteria (low mood/anhedonia).
  - **Subthreshold depressive symptoms** are defined as those having <5 of the DSM IV criteria.
    - **Severity** is based on functional impairment, once the diagnostic criteria have been passed (i.e. once you have 5 or more symptoms, one of which must be from the first two criteria).
  - **Mild depression** is 5 or more symptoms (one of which must be from the first two criteria) but with mild functional impairment.
  - **Severe depression** is at least 5 symptoms (one of which must be from the first two criteria), and often most or all will be present with marked functional impairment.
    - **Moderate severity** falls between mild and severe (surely not!)

**Step 1 (NICE use a stepped approach to care: step 1 is about diagnosis, steps 2–4 about management).**

- **Be alert to the possibility of depression**, especially if:
  - a PMH of depression
  - significant illnesses causing disability
  - other mental health problems, e.g. dementia.

**Actively seek out depression in these individuals and others you suspect may have depression using the two screening question test** (if either are positive, seek confirmatory evidence).

  - ‘During the last month have you often been bothered by feeling down, depressed or hopeless?’
  - ‘During the last month have you been bothered by having little interest or pleasure in doing things?’

**For those with a chronic health problem you need to ask 3 further questions**

  - ‘During the last month have you often been bothered by:
    - Feelings of worthlessness?
    - Poor concentration?
    - Thoughts of death?’

**Optimise management of physical health problem. Are drugs used to treat physical health problems contributing to depression?**

  - When symptoms of anxiety and depression are present, you should usually treat depression first (because the anxiety often resolves as the depression is treated).

For all, the usual caveats about ensuring dignity, confidentiality, respecting cultural difference and ensuring capacity/competence are stressed. Families/carers should also be offered support and confidentiality/sharing of information negotiated between the patient and the family/carer.

- **Monitoring risk, including suicidal risk,** is stressed throughout the document. For the sake of tedious repetition I have not included it at each stage.

**Management**

NICE take a stepped approach to care. Step 1 is about diagnosis. Steps 2–4 are about management.

**Step 2. Those with:**

- Mild–moderate depression.
- Persistent subthreshold symptoms.

**Preferred treatment options at step 2 for those without chronic physical health problems:**

- **Offer active monitoring** (discuss concerns, provide information about depression, reassess within 2w; contact the person if they do not attend follow-up appointment).
- **Low-intensity psychological & psychosocial interventions** (e.g. individual self-help based on CBT principles,
computerised CBT, group CBT, group physical activity programme).

Do not routinely use antidepressants (because risk–benefit ratio is poor), unless they:

- Have a past history of moderate–severe depression OR
- They present with subthreshold symptoms that have been present for 2y or more OR
- They have subthreshold symptoms for <2y but they don’t respond to other interventions.

For those with chronic health problems consider the following treatment options at step 2:

- Low-intensity interventions, group based are preferred (e.g. structured group physical activity programme, group based peer support programme, individual self-help based on CBT principles, computerised CBT).
- Use antidepressants if they meet these criteria: past history of depression, subthreshold symptoms for ≥2y, or subthreshold symptoms not responding to other interventions OR if they have mild depression but it is complicating the physical health problems they have.

Step 3. Those with:

- Moderate–severe depression.
- Mild–moderate depression with inadequate response to initial interventions.
- Persistent subthreshold symptoms with poor response to initial interventions.

Choice of treatment should be influenced by:

- Previous illness courses and response to treatment
- Course and treatment of any physical health problems
- Duration of episode
- Likelihood of adherence to therapy
- Patient preference

Preferred treatment options at step 3 for those without chronic physical health problems:

- Medication (usually SSRI).
- High-intensity psychological interventions (e.g. CBT, interpersonal therapy, behavioural couples therapy if relationship contributing to or maintaining depression, or partner can be therapeutic ally).
- Combined treatment (antidepressants and psychological intervention, e.g. CBT).

For those with chronic health problems consider the following treatment options at step 3:

- Medication (usually SSRI). Consider offering CBT and medication if severe depression.
- Psychological interventions (CBT (individual if group CBT unavailable/unsuitable), behavioural couples therapy).
- Collaborative care (only for those with chronic health problems and associated functional impairment): involves close collaboration between physical and mental health services with dedicated case manager).

Interestingly, a fascinating meta-analysis of 2500 individual patients’ data showed that those with even severe depression responded just as well to low intensity treatments (step 2) as those with milder disease (BMJ 2013;346:f540). This raises questions as to whether the stepped model is appropriate. There are caveats to this trial – patient improvement was similar although because they were more severely ill they started at a worse baseline level, they were not all 'cured' and some still had residual symptoms.

Step 4. Those with

- Severe and complex depression.
- Risk to life.
- Severe self-neglect.

Preferred treatment options at step 4 for those without chronic physical health problems:

- The focus here is on maintaining a safe environment and combined, often multifaceted interventions are required, including medication, high-intensity psychological interventions, ECT, crisis service, inpatient care.

For those with chronic health problems, consider the following treatment options at step 4:

- As for those without chronic health problems but with close cooperation between physical & mental health services and in particular pay close regard to potential drug interactions.

Antidepressant prescribing

Using antidepressants

- Do not prescribe or advise the use of St John’s Wort (SJW). NICE are worried about both interactions and lack of consistency of dosing in medications available, although there is evidence that SJW is as effective as traditional antidepressants (systematic review of 5500 patients in 29 trials (Cochrane 2008, CD 000448)).
- Do not routinely use drugs for those with:
  - Persistent subthreshold symptoms.
  - Mild depression.

Because risk–benefit ratio is poor, unless they:

- have a past history of moderate–severe depression OR
- they present with subthreshold symptoms that have been present for 2y or more OR
- they have subthreshold symptoms that don’t respond to other interventions.

Choosing an antidepressant

- Choose an SSRI first line.
  - Remember SSRIs increase the risk of bleeding. Consider a PPI in older people on NSAIDs or aspirin.
SSRs can exacerbate hyponatraemia, especially in the elderly.

- Beware of risk of interactions (especially for those on multiple medications for chronic physical health problems).
  - Fluoxetine, fluvoxamine and paroxetine have a high propensity for interactions.
  - Citalopram & sertraline have fewer interactions so may be better in those on multiple medications.
- Be aware of discontinuation symptoms that make drugs hard to stop.
  - Paroxetine has a higher risk of discontinuation symptoms.
- Consider the risk of toxicity in overdose.
  - Venlafaxine has greater risk of death in overdose than SSRIs.
- Tricyclics (except lofepramine) have increased risks in overdose compared to SSRIs.
- Monitor the elderly more closely for side-effects.

Starting antidepressants

- Explore patient’s concerns about antidepressants.
- Explain:
  - The slow and gradual onset of action.
  - The importance of continuing once remission achieved.
  - The risk and nature of discontinuation symptoms (especially with paroxetine and venlafaxine).
- Review the patient after 2w, and then 2–4 weekly for the first 3m.
  - If <30y or risk of suicide, see more often (e.g. after 1w).
  - If significant side-effects early in treatment:
    - Continue with close monitoring if acceptable to patient.
    - Stop/change antidepressant.
    - Offer short term (2w) benzodiazepine to help anxiety/agitation but not in those with chronic anxiety.
- Expect initial improvement after 2–4w. If no/minimal response after 3–4w increase support and consider:
  - Increasing the dose.
  - Switching to an alternative.
  - If inadequate response after 6–8w consider switching to an alternative antidepressant.

Switching and combining antidepressants

- Remember that a single antidepressant usually gives fewer side-effects than combinations of antidepressants.
- When switching antidepressants:
  - If one SSRI has been ineffective, try an alternative SSRI
  - If that is ineffective, try an alternative class of antidepressants (venlafaxine, tricyclic, MAOI).
  - Do not switch to or start dosulepin (dothiepin) (presumably because of concerns about dangerousness in overdose – the BNF recommends specialist use only).
- Switching can normally be done within 1w if drugs have a short half-life, but be careful if:
  - Switching from fluoxetine/paroxetine to a tricyclic: use lower starting doses of tricyclic.
  - Switching to a newer serotonergic antidepressant (e.g. mirtazapine) or MAOI.
  - For a non-reversible MAOI a 2w washout period is required.
  - Remember fluoxetine has a longer half-life than many of the antidepressants.
- Do not normally combine antidepressants without advice from a consultant psychiatrist.
- Augmentation can be considered with the following if needed, but side-effect burden will be increased:
  - Lithium (U&E & LFTs before treatment and 6-monthly thereafter, consider ECG monitoring if high risk for CV disease)
  - An antipsychotic (e.g. olanzapine, quetiapine, risperidone) (monitor weight, lipids, blood glucose)
  - Another antidepressant (e.g. mianserin or mirtazapine)
  - Do not routinely augment for more than 2w with benzodiazepine
  - Do not routinely augment with buspironine, carbamazepine, lamotrigine, valproate, pindolol or thyroxine.

Stopping antidepressants

- Upon recovery, patients should normally continue antidepressants for at least 6m to greatly reduce risk of relapse.
- If history of recurrent depression or risk of relapse significant consider:
  - Continuing antidepressants at least 2y.
  - Augmenting medication if multiple episodes (but not lithium alone).
  - Psychological interventions (individual CBT, mindfulness-based CBT).
- Usually reduce slowly over 4w (no need to do this with fluoxetine because of longer half-life)
  - More slowly with drugs with short half-life (e.g. paroxetine, venlafaxine).
- Advise patient to seek help if significant discontinuation symptoms
  - Offer additional monitoring/support if mild.
  - If significant, consider reintroducing antidepressant/increasing back to previous dose or swap to a drug with a longer half-life and then reduce.

And just before we look at the frequently asked questions from the NICE guidelines, here is a summary of the SIGN review of non-pharmacological therapies for use in depression. (SIGN cover only the non-pharmacological management of depression. They don’t
SIGN on non-pharmacological management of depression SIGN 2010, 114

The following forms of self-help are recommended for the treatment of depression:
Guided self-help based on principles of CBT.
Computerised CBT.

Psychological therapies recommended for the treatment of depression:
- Behavioural activation.
- Individual CBT.
- Couple focused therapy (when the current relationship appears to be contributing to the depression and the involvement could be therapeutic).
- Interpersonal therapy.
- Problem solving.
- Short-term psychodynamic therapy.

For relapse prevention, in those who have 3 or more episodes of depression:
- Group-based mindfulness-based CBT.

Other therapies:
- Exercise: structured exercise programmes are recommended for the treatment of depression.
- St John’s wort: SIGN do not recommend St John’s wort (hypericum), because of lack of standard doses and common interactions with other drugs, especially the COCP.

FAQs from the NICE depression guidelines

What about alcohol?

Many of you will note that the NICE guidance makes very little reference to alcohol as a contributory factor, a cause, or a maintaining factor in depression. This is in part because NICE guidance, by its very nature, focuses on single conditions. That does not mean alcohol is not a (very) important part of the story in some with depression, both overuse and alcoholism itself. Always ask about alcohol history, and take this into account when considering treatment options, particularly drug options.

What about counselling?

Counselling is only mentioned by NICE as an option for treatment at Step 3, if the patient declines all other interventions.

What is guided self-help?

Guided self-help, sometimes called bibliotherapy, is basically guided reading. In this chapter you will find a list of books recommended in the Welsh ‘Books on prescription’ scheme.

What is mindfulness-based CBT? Does it work?

Mindfulness CBT was developed to help prevent relapse in those with recurrent depression and is based on similar principles to ordinary CBT. Underlying mindfulness is the understanding that negative thoughts are fleeting thoughts that pop into the head, often uninvited, and you have a choice as to whether to engage with them or not. Patients are also taught to develop meditation skills that enhance self-awareness and help them to develop self-compassion. It is usually delivered in a group setting.

Although mindfulness-based CBT has been promoted by NICE for 10 years, what is the evidence?

This BMJ review (BMJ 2012;345:e7194) concludes that:
- There is evidence from a meta-analysis of reduction in rates of relapse compared with usual care or placebo.
- A subsequent RCT of over 400 people with recurrent major depression (at least 3 episodes) randomised people to continue long term antidepressants or to 8 sessions of mindfulness-based CBT followed by 3-monthly refresher sessions. Those in the mindfulness group were encouraged to taper and stop their antidepressants. Over a 2y follow-up there were no differences in relapse rates (about 40% relapsed). Over 70% of those using mindfulness-based CBT stopped their antidepressants (Lancet 2015;386:63).

Computerised CBT

Computerised CBT (CCBT) has been reviewed by NICE (NICE 2006, TA97). They assessed 5 specific packages: 3 for depression, one for panic and phobias and one for OCD. CCBT can be done anywhere with access to the internet (it is also available on CD).

Each session takes an hour and patients do better and are less likely to drop out if they spend 10min or so at the start of each session reviewing progress with a clinician.

- The programme recommended for depression was Beating the Blues.
COPE and Overcoming depression were not recommended.
FearFighter is recommended for panic and phobia.
OC Fighter (previously BTSteps) is NOT recommended for OCD.

A trial looked at using computerised CBT alongside usual GP care (the REEACT trial BMJ 2015;351:h5627). It was a good trial in terms of being pragmatic and applicable to primary care. Over 1200 people were recruited. All scored >9 on a PHQ-9 score and were randomised to receive:

- Usual GP care.
- Usual GP care + Beating the Blues (commercially available).
- Usual GP care plus MoodGYM (which is free to all).

The trial was unblinded for obvious reasons!

The addition of computerised CBT made no difference to depression at any point (assessed at 4, 12 and 24m). Neither CBT package was better than the other. Despite telephone support and follow-up, uptake of computerised CBT was low and drop-out rates were high across all 3 arms: by 4m 75% of people had been lost to follow-up. This means that if continuation rates had been higher, a difference might have been seen between usual care and computerised CBT (although this trial probably reflects what is likely to happen in the real world).

An RCT also looked at whether CBT could be delivered over the internet (live, like video conferencing). Unfortunately, they compared the results to usual GP care, not face-to-face therapy. However, those doing the live computerised CBT did get better (odds ratio 2.39, CI 1.23–4.67) (Lancet 2009;374:628). Now we want to know if it works as well as face-to-face CBT.

CBT or antidepressants?

A meta-analysis has shown that there is no difference between CBT and anti-depressants in major depression in terms of response, achieving remission and discontinuation rates (BMJ 2015;351:h6019). The authors do point out that the trials included in the meta-analysis had some shortcomings, but this is probably the best data we have on this at present. They did not look at long-term relapse rate, although other studies have suggested CBT may offer some longer term protection (BMJ 2015;351:h6315).

Timely access to CBT is often a major factor limiting its use.

Behavioural activation or CBT?

In depression people often stop doing the things they used to and become more withdrawn. This in itself reinforces low mood. In behavioural activation patients are asked to look at the impact activities have on mood and then to schedule activities to help improve mood. They can also look at the cognitive things that inhibit activity, such as rumination. It is easier to train both staff to and patient to do behavioural activation so it is cheaper than CBT.

An RCT randomised 3000 people to CBT or behavioural activation and found that behavioural activation was (Lancet 2016;388:871):

- No less effective than CBT 12 months later (it was a non-inferiority trial, so you can’t say it was better).
- Required less intensive and costly training and could be delivered by more junior people.
- Cost 21% less than standard CBT.

Exercise in depression

When this paper showing that exercise doesn’t help in depression hit the headlines I heard a discussion on the radio about it. It might even have been one of the authors talking. I’m not sure. The interviewer and doctor discussed the fact the study showed exercise didn’t help, and why this might be. The discussion was logical, rational, evidence-based. And then the interview finished with the doctor concluding ‘But this isn’t going to stop me recommending exercise to patients with depression....’

And there it was, opening right before me, the chasm between evidence on populations and a doctor’s hunch that something must be good.

Now hunches can be dangerous – we had a hunch for a long while that aspirin was good in the primary prevention of cardiovascular disease. We just ‘knew’ it must be. We were wrong. But sometimes hunches are good… and individuals may benefit when populations don’t. I’ve read this paper and other evidence. I still encourage my patients to get out and about and to exercise as much as is possible. I don’t know if it works... but I reckon it isn’t likely to harm them, and even if it temporarily lifts their mood, distracts them from the negative thinking, or makes them sleep just a bit better the next night, it just might be worth it.

So what is the evidence?
As the editorial points out, previous trials have suggested exercise may be beneficial but have often been based on small numbers. When only high quality trials are included, the benefit seen becomes marginal (BMJ 2012;344:e3181).

The TREAD(!) trial was an RCT of 360 people with depression, carried out in UK general practice (BMJ 2012;344:e2758). People were randomised to usual care or an intervention to encourage exercise. This consisted of up to three face-to-face sessions and 10 telephone calls over 8m by a trained exercise facilitator providing individually tailored advice to encourage physical activity.

- The intervention group did do significantly more exercise than the control group.
- However, those in the intervention arm had no improvement in their mood compared to the control group at any point over the 12m of the trial.
- There was no difference in antidepressant use between the two groups.

There are some issues with the trial, as the editorial points out (BMJ 2012;344:e3181). Around 25% of the people in the TREAD trial were already doing the recommended amounts of daily exercise (which surprised me), although those randomised to the intervention still increased this. The ‘usual care’ population were offered pretty good care, which may or may not reflect ‘usual’ care.

The editorial suggests that in those with significant depression, suggesting exercise may actually increase a sense of ‘failure’ if they don’t manage it, which may not help, but suggests we could encourage exercise in those who are motivated to do so and likely to achieve.

Collaborative care in depression

A paper in the BMJ compared ‘collaborative care’ with usual GP care (BMJ 2013;347:f4913). ‘Collaborative care’ in this instance was a care manager meeting with the patient for one 30–40min face-to-face session, followed by weekly phone follow-ups of 15–20min over 14w. The care managers were minimally trained at recruitment but received 5 days of training, so this is something that IAPT services should be able to offer. They provided information and support to patients around drugs, symptoms, behavioural activation (understanding the context and impact of depression and what behaviours might help improve mood). The study was a good size (almost 600 patients) and follow-up was for 12m.

- Depression scores were only slightly better in those who had collaborative care at 4 and 12m.
- There was no difference in anxiety levels or physical health between the groups.
- Those receiving collaborative care were more satisfied with their care.

This level of care is reproducible with an IAPT service, but the benefits seen were only modest.

### Depression

- Diagnosis of depression is with the DSM IV criteria. Severity is determined by severity of symptoms and impairment of function. DSM IV criteria must still be met.
- NICE guidelines on depression emphasise the need to use the DSM IV criteria.
- Care offered depends on the severity and duration of symptoms.
- Specific guidance is given for those with depression and physical co-morbidity.
- Ask about suicidal ideation and assess risk at every consultation!
- And don’t forget to ask about alcohol!

#### Review 10 consultations where you diagnose depression (not reviews). Are you using the DSM IV diagnostic criteria? Are you excluding co-morbidity, especially anxiety disorders, alcohol or drug misuse?

Review your use of antidepressants in depression. Are you using them in line with NICE guidance both for starting, dose increases and stopping them? What could you do differently?

#### For professionals:

Screening tool for bipolar disorders:
http://www.dbsalliance.org/pdfs/MDQ.pdf

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We make every effort to ensure the information in these pages is accurate and correct at the date of publication, but it is of necessity of a brief and general nature, and this should not replace your own good clinical judgement, or be regarded as a substitute for taking professional advice in appropriate circumstances. In particular check drug doses, side effects and interactions with the British National Formulary. Save insofar as any such liability cannot be excluded at law, we do not accept any liability for loss of any type caused by reliance on the information in these pages.

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## Lead. Manage. Thrive! – The NEW management skills course for GPs

Many of us have chosen to be salaried or portfolio GPs yet feel impotent or looked over when it comes to contributing to the effective running of our practices. We become frustrated and feel that we have little or no influence over what happens. It’s not your fault, most GPs (experienced and new) have had very little training in management and leadership skills for clinical practice.

Here’s the good news, all of us ‘lead’ whether in an official or unofficial role.

Who is this course for? GPs at every stage in their career who aren’t quite sure how to get unstuck! Also highly relevant to anyone who recognises the need to build their personal resilience and leadership skills to meet the demands of modern primary care, i.e. practice managers, nurses, and administrative and support teams.

As usual Red Whale has done all the legwork to bring you a concise, practical and actionable one-day course and handbook. Not only have we trawled through lots of relevant management, leadership and development literature, but we have also distilled its content through the lens of real GPs, enabling you to apply it to the reality of your practice.

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## The Women’s Health Update Course

From the pill to pelvic pain, periods and prolapses, the one day Women’s Health Update course is a comprehensive guide to understanding and managing common gynaecological problems in general practice. Using a case-based approach will give you the skills to manage your female patients in a real surgery.

We aim to make the day fun, interactive as well as educational. You will leave the course feeling more confident, knowledgeable and with a much stronger pelvic floor!!!

The course is designed for all GPs and GP STs (male and female!) not just those with a special interest, however it does fulfill the CPD criteria for DFSRH/DFFP LoC IUD/SDI.

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ALL OUR 2017 COURSES

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.

Leeds          Thu 22 June
Newcastle      Fri 23 June
London         Thu 29 June
Birmingham     Fri 30 June
Nottingham     Thu 9 Nov
Manchester     Fri 10 Nov
Norwich        Wed 15 Nov
Exeter         Thu 16 Nov
London         Fri 17 Nov

Our Consultation Skills Courses

One day small group courses designed for GPs, GP STs and General Practice Nurses. The courses have a practical focus and lots of engaging exercises allowing delegates to rehearse the most effective consultation behaviours.

But don’t worry, there won’t be any role playing in front of everybody!

For more information on each course, please visit www.gp-update.co.uk/courses

The Effective Consultation Course

Manchester     Wed 10 May      Leeds       Wed 4 Oct
London         Fri 12 May

The Telephone Consultation Course

Leeds          Wed 17 May
Birmingham     Fri 19 May
London         Wed 7 June
Bristol        Fri 9 June
Manchester     Fri 6 Oct
Glasgow        Sat 4 Nov

The Medically Unexplained Symptoms Course

Manchester     Thur 18 May
London         Thur 19 Oct

Prices

GP Update Course:  
GP £195 | GP Registrar £150 | Nurse £150

All other courses: £225 or £210 for members of www.gpcpd.com

(GPCPD members, please log in and then click on the relevant button within the ‘Member information’ box on the right of the home screen to get your discount code)

Join the Red Whale pod

Plan ahead! Save £60 when you book three courses in 2017. Use discount code 3BUNDLE2017 when booking via www.gp-update.co.uk or by phone 0118 960 7077.
I would like to come on the following course(s) (please write legibly!):

- The GP Update Course (location)............................................................... (date)................................
- The Women’s Health Update Course (location)............................................................... (date)................................
- The Cancer Update Course (location)............................................................... (date)................................
- Lead. Manage. Thrive! 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
- GP Update Handbook, DVD and 12 months’ access to GPCPD £225
- Women’s Health Update Handbook £70
- Cancer Update Handbook £70

Name.............................................................................................   Address ...........................................................................................

Email........................................................................................................................................................................................................

(Please write your email address clearly as we’ll use it to send your confirmation letter and receipt.)

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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