Breast cancer: managing the consequences of treatment

Nearly 80% of women diagnosed and treated for breast cancer will survive for 10 years or more. In primary care, they form a large proportion of our patients who live with cancer as a long-term condition. As part of the 2020 Cancer Plan, the majority of breast cancer patients will be discharged early for shared care follow-up in primary care. The exact model and funding of this is in development.

Macmillan offers lots of helpful information for clinicians and patients; links to this are shown below. They have also worked in partnership with EMIS, SystmOne and Vision to incorporate the National Cancer Care review template into all major primary care IT systems. It is a useful guide to remind us of pertinent issues.

It is important that we are aware of the long-term consequences of treatment. We have pulled together a number of resources to highlight the common concerns and issues that breast cancer survivors may experience. A recent BJGP review considered this (BJGP 2017;67:140) and highlighted the following key areas:

- Menopausal symptoms.
- Bone health.
- Cardiovascular disease and cardiotoxicity of treatment.
- Psychological problems.
- Persistent pain.
- Lymphoedema.
- Fertility concerns.

Let’s look at each of these in turn.

Managing menopausal symptoms after breast cancer

The detail for this is taken from a combination of two NICE guidelines (NICE on Menopause NG23 2015; NICE on Early and Advanced Breast Cancer CG80 2009):

NICE suggests that women should be offered a referral to a ‘healthcare professional with expertise in menopause’. In reality, the stage at which we do this will depend on the severity of a woman’s symptoms, our own confidence and the availability of menopause clinics in secondary care. Here is some guidance.

**HRT**

- Stop HRT in women diagnosed with breast cancer.
- Do NOT routinely offer HRT to women with menopausal symptoms after breast cancer.
- In exceptional cases, HRT may be used, but this would be a specialist decision shared between the woman’s oncologist, a menopause specialist and the woman.
- Tibolone is not a safe alternative – the LIBERATE trial showed an increased rate of breast cancer recurrence with tibolone compared with placebo (Drug Safety Update, February 2009;2(7)).

**Alternatives**

<table>
<thead>
<tr>
<th>Options for all women with a history of breast cancer</th>
<th>Options for women who ARE NOT taking tamoxifen</th>
<th>Things NICE recommends we should not use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifestyle measures (exercise, relaxation) Avoiding triggers, e.g. caffeine, alcohol, spicy food Cooling pillows CBT Venlafaxine Clonidine (transdermal 0.1 mg/d seems better than oral (BMJ 2007;334:736)) Gabapentin</td>
<td>Paroxetine Fluoxetine</td>
<td>HRT Soy Red clover Black cohosh Vitamin D Magnetic devices Tibolone</td>
</tr>
</tbody>
</table>
What about vaginal oestrogens?

Many women who have had breast cancer will get vaginal atrophy and experience sexual discomfort. Lubricants, e.g. Replens, may be adequate to manage this. The question of whether to prescribe vaginal oestrogens remains a little controversial. Active breast cancer is an absolute contraindication, but, after treatment, it is more of a grey area.

Systemic absorption of topical oestrogen is MUCH lower than oral oestrogen, and a year of typical use equates to about 1 tablet of oral HRT (Climacteric 2015;18(2):121).

NICE guidance on menopause (2015;NG23) states:
- Local oestrogens may be considered for women with a history of breast cancer with symptoms of urogenital atrophy.
- However, even the very small amount of oestradiol absorbed systemically may decrease the effect of aromatase inhibitors.

For women taking tamoxifen or aromatase inhibitors, we would probably seek advice from oncology before initiating.

Bone Health

The BJGP review reminds us that adjuvant therapies for breast cancer, particularly aromatase inhibitors, present a significant risk for osteoporosis (BJGP 2017;67:140).

It recommends that all women taking aromatase inhibitors should:
- Have a calcium-rich diet (use a calcium calculator to assess if intake is sufficient).
- Take 1000–2000 IU vitamin D daily.
- Undertake regular weight-bearing exercise.

A baseline DEXA should be undertaken, ideally before starting treatment. For those with a T-score <-2, repeat every 1–2y. Bisphosphonates should be started if:
- Patient becomes osteoporotic: T-score <-2.5.
- >10% bone density loss annually.
- 4–5% loss annually in those osteopenic at baseline.

It is also possible that bisphosphonates may offer a survival benefit for women with breast cancer and reduce the risk of bone metastases – this is discussed in more detail in the article Breast cancer management (Lancet 2015;386:1353).

Cardiovascular health

Cardio-oncology is a growing field (this is bringing new meaning to super specialisation!). The risk of nearly all types of cardiac disease is significantly higher in those who are undergoing, and those who have completed, cancer treatment. There are some specific issues for breast cancer survivors. The new targeted cancer therapies increase these risks further. This was the subject of an interesting review (NEJM 2016;375:1457).

Why is cardiac disease more common in cancer survivors?

Cancer and cardiovascular disease share common risk factors, e.g. smoking, obesity, sedentary lifestyle, diabetes.

In many cases, this means that having cancer increases an individual’s risk of cardiovascular disease, even before taking into account the impact of treatments, which can be significant.

How do cancer treatments increase the risk?

This table, adapted from the clinical review, summarises the basics of how cancer treatments can increase the risk.
<table>
<thead>
<tr>
<th>Treatment</th>
<th>Examples</th>
<th>Potential impact on cardiovascular system</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation</td>
<td>Any vascular bed exposed to radiotherapy is susceptible to premature atherosclerosis.</td>
<td>Accelerated atherosclerosis, ischemia, pericarditis, myocarditis, valvular disease, arrhythmia.</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Anthracyclines e.g. doxorubicin</td>
<td>Cardiomyopathy, myocarditis, pericarditis, arrhythmia.</td>
</tr>
<tr>
<td></td>
<td>Platinums e.g. cisplatin</td>
<td>Hypertension, ischemia</td>
</tr>
<tr>
<td></td>
<td>Antimetabolites e.g. capecitabine</td>
<td>Myocardial ischemia, arrhythmia</td>
</tr>
<tr>
<td></td>
<td>Alkylating agents</td>
<td>Congestive heart failure</td>
</tr>
<tr>
<td></td>
<td>Anti-microtuble agents e.g. paclitaxel</td>
<td>Arrhythmias</td>
</tr>
<tr>
<td>Targeted cancer therapies</td>
<td>HER2 inhibitors (breast cancer)</td>
<td>Congestive heart failure, impaired left ventricular ejection fraction.</td>
</tr>
<tr>
<td></td>
<td>VEGF pathway inhibitors e.g. Avastin (used in breast, bowel, ovarian and kidney cancers)</td>
<td>Hypertension, venous and arterial thromboembolism, proteinuria, cardiomyopathy</td>
</tr>
<tr>
<td></td>
<td>Multitarget tyrosine kinase inhibitors ‘-nibs’</td>
<td>AF, pulmonary hypertension, coronary, cerebral and peripheral vascular events</td>
</tr>
</tbody>
</table>

**Ischaemic heart disease in cancer survivors**

The increased risk of ischaemic heart disease has been most studied in breast cancer survivors who have received chest wall radiotherapy.

A well-designed, population-based case–control study looked at the rate of major coronary events (myocardial infarction, coronary revascularisation or death from ischaemic heart disease) in 1000 women who underwent radiotherapy for breast cancer, compared with matched controls (NEJM 2013;368:987). The vast majority of women in the study were aged >40, so it is difficult to extrapolate the results to younger women.

It found:

- Rates of major coronary event increased linearly with mean radiation dose to the heart.
- The magnitude of risk increase was 7.4% per Gy radiation exposure to the heart.
- The increased risk started within 5y of radiotherapy, and continued for at least 20y after radiotherapy.
- The increased risk by radiation dose exposure was proportionately the same, regardless of a woman’s baseline cardiovascular risk, **but** absolute risk was higher for women with higher baseline risk.
- Women with left-sided breast cancer generally have a higher heart radiation exposure than women with right-sided breast cancer.

In addition, a clinical review on late cardiac effects of cancer treatment reminds us that hypertension is a long-term consequence of many anticancer chemotherapy treatments, affecting up to 50% of patients (J Clin Onc 2012;30:3657). It also reminds us that any vascular bed in a radiotherapy field is susceptible to premature atherosclerosis (e.g. carotid disease in neck radiotherapy and peripheral vascular disease in pelvic radiotherapy).

**What does this mean in practice?**

- **This is interesting and helpful to oncologists in deciding risks vs. benefits of radiotherapy for patients with a raised cardiovascular risk.**
- **We should be aware of chest radiotherapy as an independent risk factor for ischaemic heart disease, and that any vascular bed exposed to radiation is at risk of premature atherosclerosis.**
- **Cardiovascular risk should be assessed and managed from the time of diagnosis through to survivorship for cancer patients.**

**Heart failure/valvular heart disease in cancer survivors**

This clinical review reminds us that (J Clin Onc 2012;30:3657):

- Valvular degeneration is a common late consequence of mediastinal irradiation.
- Several classes of chemotherapy agents have heart failure as an important side-effect:
  - Anthracyclines, e.g. drug names ending -rubicin.
  - HER2-receptor antagonists, e.g. Herceptin.
  - Antiangiogenic-based treatments, e.g. Avastin, Sutent, Thalidomide.
- Hypertension during chemotherapy should be managed to help reduce the risk of heart failure. Preferred drugs are ACEI, ARB and BB because of their prognostic benefits in heart failure.
• If a patient develops heart failure after chemotherapy, the drug treatment is the same as for any other cause of heart failure (i.e. ACEI + BB +/- diuretics first line).

**What can we do in practice?**

After a very complex scientific discussion about all the different cancer treatments and their impact, the review in the NEJM makes some beautifully simple (and humbling) suggestions of what can be done to ameliorate these risks. It calls this the ‘ABCDE approach’, and nearly all of it is easily achievable in primary care. And, what is more, most of these interventions have the potential to reduce the risk of cancer recurrence (NEJM 2016;375:1457).

| A | Awareness  
Assessment (so QRISK, referral if symptomatic)  
Aspirin |
<table>
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</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Blood pressure control</td>
</tr>
</tbody>
</table>
| C | Cholesterol  
Cigarette smoking |
| D | Diet  
Diabetes management  
(Dose of chemotherapy) |
| E | Exercise  
Echoes if appropriate |

Cancer-related fatigue

This is defined as a distressing, persistent, subjective sense of physical, emotional and cognitive tiredness that is related to cancer or cancer treatment (J Clin Onc 2012;30:3687).

• The prevalence is between 60 and 90%.
• It is most common in patients undergoing chemotherapy.
• Symptoms can persist for months to years after completing treatment!

The cause is not known. The review suggests it may relate to dysregulation of inflammation and hypothalamic–pituitary–adrenal function. I suspect most GPs would recognise the psychosocial aspects of illness as being extremely important here!

How can we help?

**Treat underlying conditions** (*this seems common sense, though there is no evidence that doing this improves the fatigue!*):

- Anaemia.
- Hypothyroidism.
- Depression.
- Pain.
- Insomnia.

**Don’t use pharmacological treatment** purely to treat fatigue.

Trials have demonstrated that modafinil, methylphenidate, dexamphetamine, paroxetine and donepezil offer no statistically significant improvement in cancer-related fatigue (*I can’t think of many cases where UK primary care would have prescribed these!*).

**Recommend non-pharmacological interventions:**

- Physical activity has been demonstrated to be beneficial in reducing cancer-related fatigue (see article on *Lifestyle advice for cancer survivors*).
- A small RCT showed that yoga offered significant improvements in cancer fatigue in breast cancer survivors compared with an education intervention.
- Psychological interventions such as coping strategy training, CBT and supportive therapy have shown small benefits (could you recommend a local support group?).
The review does not mention this, but I suspect we can help by just being there as GPs! We can help the patient contextualise what has happened to them, understand why they feel as they do, and make an action plan to regain their health.

Mental health

Psychological wellbeing is significantly affected by a cancer diagnosis and subsequent treatment. There are a range of problems that can affect women with breast cancer during and after treatment. We should also remember that family and carers can be affected.

Insomnia

This is common both during and after treatment, with a prevalence of 30–50% (J Clin Onc 2012;30:3687).

Pharmacological treatment

There are relatively few trials looking at the role of medication in cancer-related insomnia. Tolerance, daytime somnolence and side-effects are at least as common in cancer patients, and use of sleeping medication has been associated with lower quality-of-life indices.

- If you prescribe sleeping tablets (either benzodiazepines or the z-drugs), do so at the lowest dose and for the shortest duration possible.
- Combine with sleep hygiene and psychosocial interventions.
- There is no evidence that melatonin or valerian are effective in this population.

Psychological interventions

- CBT for insomnia has been shown to be effective – this includes a mixture of sleep hygiene training, relaxation therapies, stimulus control and sleep restriction therapy.
- This should be offered (where possible!) as first-line therapy.
- Physical exercise and yoga have also been shown to be beneficial.

Depression

The prevalence of major depression in the general UK population is estimated to be about 2%. It is higher in cancer patients and survivors.

A well-designed, large Scottish study aimed to determine the prevalence of depression in cancer patients and how effectively it is treated (Lancet Psychiatry 2014;1:343).

- This study showed that in women with breast cancer, the prevalence of depression was 9.3% (CI 8.7–10.0).
- Those receiving curative treatment were at the same risk as those receiving palliative treatment.
- Young age, female sex and social deprivation were independent risk factors.
- Nearly three-quarters were not receiving potentially effective treatment (i.e. they were not seeing a mental health professional or receiving an antidepressant at a therapeutic dose).

A follow-up study by the same authors compared usual care (by GPs) with a more intensive intervention which included 10 sessions over 4m with a specialist cancer nurse; this nurse provided support and information about problem solving, keeping active, depression and titration of antidepressants, with the support of a psychiatrist if indicated or preferred.

Perhaps unsurprisingly, the intervention was more effective than usual care:

- 62% of the intervention group had a significant treatment response at 24w compared with just 17% of the usual care group (OR=8.5; CI 5.5–13.4).
- The intervention group had more health professional contacts, and was more likely to receive an effective dose of antidepressant.
- Very few in the usual care group received counselling or formal psychological assessment.
- The intervention was estimated to cost an additional £613 per patient.

What does this mean in practice?

Unsurprisingly, depressed patients with cancer benefit from more intensive support, regular contact and appropriate adjustment of antidepressants than usual care provides. It is not possible to say from these studies which component is ‘the magic bullet’, but common sense suggests it is likely to be a combination of factors.
The accompanying editorial suggests that while access to psychological treatment, medication and counselling is available from primary care, in this context it was not consistently applied as part of usual care.

For me, this is a call to action that we can make a difference to depression symptoms in patients with all prognostic types of cancer. Unless we have access to similar schemes, we should be more proactive at screening for depression, and offering both psychological and drug-based treatment as part of our cancer care.

Depression and anxiety in longer-term cancer survivors

A systematic review and meta-analysis considered whether mood disorders are more common in long-term cancer survivors (>2y from diagnosis) than in their spouses and healthy controls (Lancet Oncology 2013;14:721). This is pooled data from patients across a range of cancer types, and is therefore a different group from the studies presented above.

• There was no difference in the incidence of depression between cancer survivors and healthy controls (RR=1.11; CI 0.96–1.27).
• Cancer survivors were more likely to experience anxiety than healthy controls (18% vs. 14%; RR=1.27; CI 1.08–1.50).
• The prevalence of anxiety and depression did not differ significantly between cancer survivors and their spouses.
• At an average of 7y after diagnosis, 40% of spouses had significant anxiety symptoms.

Anxiety rather than depression seems to be an ongoing issue in cancer survivors and their spouses, yet we often screen only for depression.

We should look for, and offer support with, anxiety management in cancer survivors and their spouses.

Lymphoedema

20% of women who have had treatment for breast cancer will develop lymphoedema; this can occur at any time, but usually within the first 2 years after treatment.

A BMJ ‘Uncertainties’ review considered this subject and the available evidence for interventions that may (or may not!) be helpful (BMJ 2017; 357:j2330).

What is lymphoedema?

Lymphoedema is fluid accumulation in a limb due to damage to the lymphatic drainage system. It is a common complication of breast cancer treatment. Its incidence is reducing because of the increased practice of sentinel node biopsy rather than automatic block dissection of axillary lymph nodes. Only women with disease-positive lymph nodes now undergo axillary dissection.

Lymphoedema cannot be completely cured but it can be managed. There is, however, a paucity of evidence as to what works best.

Risk factors

Any treatment for breast cancer increases the risk of lymphoedema, but specific factors are:

• Increased number of metastatic lymph nodes.
• Axillary node dissection.
• Overweight/obesity.
• Lack of regular physical exercise.
• Infection in the upper limb on the affected side at any time after breast cancer treatment.

Prevention

Women are routinely given this advice following treatment:

• Avoid skin puncture or injections in the upper limb on the affected side (there is an absence of evidence to warrant this recommendation, but, practically, if we can avoid it, we should).
• Maintain a healthy weight.
• Wear compression garments for exercise or travel.
• Recognise the signs of infection.Cellulitis and seek early treatment.
• Watch out for signs of early lymphoedema – heaviness, tension or swelling in the limb – and seek help.

While all common sense, there is an absence of evidence as to whether these strategies are truly effective.
Management options

The article recommends that women with symptoms should be referred to a lymphoedema centre where the following treatments should be offered:

<table>
<thead>
<tr>
<th>Treatment option</th>
<th>How it works</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compression therapy</td>
<td>Multilayer bandaging/pneumatic compression for 2–4 weeks followed by maintenance compression hosiery. Theoretically enhances lymph flow and promotes muscle pump function.</td>
</tr>
<tr>
<td>Exercise</td>
<td>Specific exercises to enhance lymph flow (see links below). General exercises such as yoga and walking may also be helpful. Resistance training has now been shown to be safe.</td>
</tr>
<tr>
<td>Manual lymph drainage</td>
<td>Gentle manual massage therapy (usually performed by a trained physio or lymphoedema practitioner) enhances lymph flow and prevents/treats oedema.</td>
</tr>
<tr>
<td>Decongestive lymphatic therapy (a combination of the above 3 interventions)</td>
<td>Combination of all these interventions.</td>
</tr>
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</table>

There have been 3 Cochrane reviews looking at the evidence for prevention and intervention, but it has not been possible to draw any firm conclusions because of small, poor-quality studies. There are a number of studies ongoing, but it is not clear yet when they will report.

Persistent pain

Persistent pain after surgical treatment for breast cancer is a common problem, affecting 25–60% of women beyond 3m after surgery. The long-term effects have not previously been assessed.

This Danish cohort study aimed to establish the long-term prevalence and risk factors for persistent pain around the site of surgery after treatment for breast cancer (BMJ 2013;346:f1865).

It identified nearly 3000 eligible women on Denmark’s cancer registry who underwent surgery for breast cancer between 2005 and 2006. It sent out questionnaires about pain and sensory disturbance in 2008 and 2012. The response rate was excellent at 89%!

It found that:

- Prevalence of pain varied from 22 to 53% depending on the type of treatment.
- Pain was more common in women who had undergone lymph node dissection rather than sentinel node biopsy. It was also more common in women aged ≤49y at diagnosis.
- Radiotherapy was not shown to be a risk factor in this study, though it has been in other studies.
- Pain could occur and regress at any time after treatment, but overall was less common at 6y follow-up than at 2y follow-up (37% vs. 45%).
- Some women who had not experienced pain at 2y were experiencing pain at 6y.

There is not a strong evidence base for the best management strategies for this type of persistent pain, and we will have to deploy all the skills we use in other persistent pain states.
<table>
<thead>
<tr>
<th>Take home messages</th>
<th>Breast cancer treatment: side-effects</th>
</tr>
</thead>
</table>
| **Menopausal symptoms after breast cancer treatment** | • HRT and tibolone are absolutely contraindicated.  
• The use of vaginal oestrogens is controversial – systemic absorption is minimal, but even a small amount of oestrogen can impact on the effectiveness of aromatase inhibitors. The decision whether to prescribe these should be discussed with the patient and their oncologist.  
• Recommend lifestyle interventions: exercise, limiting caffeine and alcohol, healthy BMI.  
• Clonidine, venlafaxine and gabapentin may offer some benefits.  
• Group CBT has been shown to help women cope and improve their quality of life. |
| **Bone health** | • Aromatase inhibitors have a significant impact on bone health. |
| **Persistent pain after breast cancer treatment** | • Ask about persistent pain at medication reviews/opportunistic review of women who have had surgical treatment for breast cancer – it's really common and it fluctuates with time! |
| **Lymphoedema** | • Occurs in 20% of breast cancer patients. Improved surgical techniques and selective axillary node dissection will make the biggest impact.  
• Offer patients simple prevention advice, and encourage them to keep active and maintain a healthy weight (this improves their breast cancer prognosis as well).  
• Refer symptomatic women to lymphoedema services for treatment. |

| Further information | Could you create a template to act as a prompt to consider these issues when seeing breast cancer survivors?  
Do you know if you have access to local lymphoedema services?  
If not, see useful resources below.  
If you want to look at a quality improvement project around improving the care of patients who have had cancer treatment, the RCGP and Macmillan have produced a toolkit:  

| Other resources | **For professionals:**  
For a quick guide to all the cardiotoxic treatments:  
https://tinyurl.com/Macmillan-Heart-health  
**For patients:**  
Macmillan has lots of helpful information leaflets for women in this situation. They could be printed off in cancer care reviews to support your message. Links are shown below:  
Menopause symptoms  
https://tinyurl.com/Macmillan-Menopause-symptoms  
Bone Health  
https://tinyurl.com/Macmillan-Bone-Health  
Tiredness and fatigue  
https://tinyurl.com/Macmillan-Tiredness-tips  
Worry and anxiety  
https://tinyurl.com/Macmillan-Fear-and-Anxiety  
Sleep problems  
https://tinyurl.com/Macmillan-Sleep-disturbance  
Pain and discomfort  
https://tinyurl.com/Macmillan-Pain-and-discomfort  
Lymphoedema  
https://tinyurl.com/Macmillan-Lymphoedema  
Cancer Research UK Lymphoedema information and exercise suggestions:  
http://preview.tinyurl.com/GPU-Lymphoedema-information  
Lymphoedema support group and DVDs of exercises:  
http://www.lymphoedema.org/index.php/shop/lsm-products#dvd |
Did you know that Macmillan provide a wealth of useful information for primary care professionals? Take a look through their quarterly e-newsletter, Primary Care Update and check out the range of useful resources on their Support page!

Support for Primary Care: [www.macmillan.org.uk/gp](http://www.macmillan.org.uk/gp)

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<th>Location</th>
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<tbody>
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#### The Women’s Health Update Course – ALL NEW CONTENT!

Our Women’s Health Update has ALL NEW CONTENT for 2018! This completely refreshed one day update will arm you with the skills to manage this area of general practice with confidence! Expect the latest on perimenopausal contraception, low libido, fertility, post-coital bleeding and the ‘abnormal’ cervix as well as benign breast disease and lots more! We promise it’ll be interactive, entertaining and relevant for ALL GPs and GP STs!

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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.

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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

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 skillfully 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 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 FULLY BOOKED Thur 17 May 2018
Birmingham Fri 8 Jun 2018
Leeds Fri 15 Jun 2018
London Thu 28 Jun 2018

The Effective Consultation Course

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

The Medically Unexplained Symptoms Course

Manchester FULLY BOOKED Thur 7 Jun 2018
London Thur 18 Oct 2018
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 attend three courses in 2018. Use discount code 3BUNDLE2018 when booking via www.gp-update.co.uk. Even if you’ve already booked one or two courses this year, simply call us with your existing booking details on 03330 093 090 and upgrade.*
(Charged at the same rate as standard landline numbers that start with 01 or 02.

* All courses to be taken by the same delegate in the 2018 calendar year. Only one promotion code to be used per booking.

To book go to www.gp-update.co.uk or call us on 03330 093 090 or use the form below.

I would like to come on the following course(s) (please write legibly):

- The GP Update Course
- The MSK and Chronic Pain Update Course
- The Working at Scale Course
- Lead. Manage. Thrive! Course
- The Cancer Update Course
- The Women’s Health Update Course
- The Telephone Consultation Course
- The Effective Consultation Course
- The Medically Unexplained Symptoms Course

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 (no GPCPD) £70
- Cancer Update Handbook (no GPCPD) £70
- MSK and Chronic Pain Handbook (no GPCPD) £70

* (pre-order for delivery late May 2018)

Name........................................................................................................ Address
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Email.........................................................................................................................

(We will send your booking confirmation and receipt to you via email. We would also like to send you our FREE clinical updates and information about our other courses. Please tick here if you are happy to receive our emails: ☐ Rest assured we will never share your information with anyone else. To see our privacy policy please go to www.gp-update.co.uk/privacy).

Mobile Number (We can’t complete your course booking without this, but it will only be used if we need to contact you urgently about the course.)

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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