Depression: antidepressants

In this section I will summarise the results of several trials that have been published in the last 2 years that relate to antidepressants, particularly whether they work or not.

The key issues to address are:

- Antidepressants in pregnancy.
- Maximum doses of citalopram/escitalopram and long QT.
- Tamoxifen and antidepressants.
- Antidepressants: potential interactions.
- What about dosulepin, venlafaxine and mirtazapine?
- Stopping antidepressants.
- Do antidepressants cause suicidal ideation and action?
- Which antidepressants in CHD?
- Antidepressants in the elderly.
- Antidepressants in dementia.
- Are we overusing antidepressants?
- Have IAPT services changed antidepressant prescribing rates?
- What about the new antidepressant agomelatine?

Antidepressants in pregnancy

Antidepressants and congenital heart defects

Some data have suggested an increased risk of congenital heart disease in women who use SSRIs in pregnancy. This massive cohort study (almost 1 million pregnant women, 7% of whom used antidepressants in the first trimester) concluded that there was no increased risk of congenital heart disease, once other risk factors had been adjusted for, although there was a slight increased risk looking at the raw data, RR 1.25 (CI 1.13–1.38) (NEJM 2014;370:2397).

A further cohort study of 2.3 million births in Nordic countries showed a slight increased risk of birth defects in those exposed to SSRIs or venlafaxine in the first trimester of pregnancy, but when compared with a cohort of siblings this slight increased risk disappeared, suggesting the causative agent was not the drugs (BMJ 2015;350:h1798).

- Both these cohort studies offer reassuring news.

However, a large US cohort study looked at women who had given birth to children with and without congenital abnormalities and then looked back at SSRI use at the end of the first trimester (BMJ 2015;350:h3190).

- Sertraline was the antidepressant used by 40% of the women and this was NOT associated with any problems.
- Women who had used paroxetine and fluoxetine at the end of the first trimester had an increased risk of congenital anomalies (for paroxetine these were anencephaly, cardiac anomalies and abdominal wall defects, for fluoxetine these were cardiac defects and craniosynostosis). The absolute risk was still low (for cardiac defects the increased risk went from 10/10 000 to 24/10 000).

Antidepressants and post-partum haemorrhage

SSRIs are known to be associated with an increased bleeding risk. A large US cohort study looked at over 106 000 pregnant women with a mood or anxiety disorder, 12 000 of whom were on antidepressants (an SSRI in 90% of cases) and looked at whether antidepressants increased the risk of a post-partum haemorrhage (PPH) (BMJ 2013;347;f4877).

- All antidepressants increased the risk of PPH.
- In those on SSRIs, the NNH was 80 (for every 80 treated with an SSRI around the time of delivery, 1 will have a PPH that would not have occurred if they were not on an SSRI).
- Importantly, this was a cohort study, so causation cannot be established, particularly because there may be unmeasured confounding factors. However, known confounders were adjusted for, and use of SSRIs earlier in pregnancy, but not around delivery, did not increase the bleeding risk, suggesting it is a true drug effect.
- As the authors point out, the absolute risk increase is small, and further trials are needed to establish causation.
- The bottom line is yes, there may be a small increased risk, and this needs to be balanced against the harms of not treating depression/anxiety on a person by person basis.

Antidepressants and persistent pulmonary hypertension in the newborn

A systematic review and meta-analysis has also suggested that SSRIs may be associated with an increased risk of persistent pulmonary hypertension of the newborn (failure to send sufficient blood to the lungs for oxygenation) (BMJ 2014;348:f6932).

- The risks appear to be SSRI use through the whole of the pregnancy or in late pregnancy.
- Use of SSRIs in early pregnancy was not significant.
However, the risks are relatively small: 286–351 women would need to take SSRIs in late pregnancy to cause 1 additional case.

Once again – we need to balance the risks of use against the potential harms of untreated depression in pregnancy and the neonatal period.

Antidepressants in pregnancy and subsequent autism in the infant

A cohort study in Denmark looked to see if SSRIs given in pregnancy might increase the risk of the infant being diagnosed with autism. The conclusion was that there probably wasn’t a link, but more research was needed (NEJM 2013;369:2406).

Citalopram/escitalopram maximum doses and long QT

The MHRA have issued new guidance about the maximum dose of citalopram (Drug Safety Update 2011;5:5). This is because citalopram is associated with a dose-dependent lengthening of the QT interval. It also applies to escitalopram. Current recommendations on maximum doses:

<table>
<thead>
<tr>
<th>Maximum doses</th>
<th>Adults &lt;65y</th>
<th>&gt;65y</th>
<th>Hepatic impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citalopram</td>
<td>40mg</td>
<td>20mg</td>
<td>20mg</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>20mg</td>
<td>10mg</td>
<td>10mg</td>
</tr>
</tbody>
</table>

In addition:

- Do not use these drugs in those with known long QT.
- Do not use them with other drugs that prolong the QT interval. Which drugs do this? This list produced by our local hospital pharmacy is a good start, although not exhaustive (Oxford Health Medicine Information Bulletin 2011;9:3):
  - Other antidepressants: tricyclics plus trazodone and venlafaxine.
  - Antibiotics:
    - macrolides (erythromycin, clarithromycin, azithromycin)
    - ampicillin
    - co-trimoxazole
    - quinolones (ciprofloxacin, levofloxacin, norfloxacin, moxifloacin).
  - Antiarrhythmics including amiodarone, dronedarone, sotalol and quinidine.
  - Antipsychotics: all antipsychotics, but highest risk with haloperidol and pimozide.
  - Lithium, with greater risk if lithium levels are raised.
  - Methadone, especially doses above 100mg.
  - Antimalarials: mefloquine, chloroquine, artemether/lumefantrine.
  - Quinine: especially at higher doses.
  - Azoles: including fluconazole.
  - Antihistamines: particularly astemizole and mizolastine.

What about the other SSRIs?

A study of almost 40 000 people started on antidepressants for whom ECG data were available looked at which antidepressants might have an impact on QT interval. It concluded that (BMJ 2013;346:f288):

- Citalopram, escitalopram and amitriptyline prolong QT interval, and this is dose-dependent.
- In therapeutic doses, fluoxetine, paroxetine and sertraline do not prolong QT interval. However, in overdose fluoxetine and sertraline may be associated with long QT (Drug Safety Update 2011;5:5).

Tamoxifen and antidepressants

The MHRA have issued a reminder that some antidepressants (and some other drugs) interfere with tamoxifen (Drug Safety Update 2010;4(4):A1).
**Why?** Tamoxifen is a pro-drug and conversion to the active metabolite (endoxifen) is through the cytochrome P450 system (CYP2D6 enzyme). Therefore drugs that inhibit CYP2D6 reduce the availability of the active drug, endoxifen.

**The drugs involved include:** fluoxetine, paroxetine, bupropion, quinidine (an antiarrhythmic) and cinacalcet (used for parathyroid cancers and in hyperparathyroidism in people on dialysis).

**This is not just a theoretical risk!** A population-based cohort study of 24,000 women with breast cancer on tamoxifen and paroxetine showed an increased risk of death from breast cancer and this increased in those who had been on paroxetine for longer (BMJ 2010;340:c693). For those who had been on paroxetine for at least 40% of the time they were on tamoxifen, there would be 1 extra breast cancer death for every 20 women (range 12–46 women) within 5y of stopping tamoxifen. The mortality would increase if the overlap between tamoxifen and paroxetine was greater.

There was no increased risk demonstrated for fluoxetine but this is probably because the sample size of those taking fluoxetine was much smaller (one-third of the cohort on paroxetine). We should not be reassured by this! Fluoxetine, like paroxetine, is also a strong inhibitor of CYP2D6 and if the sample size was larger an increased mortality may well be demonstrated.

**Antidepressants: potential interactions**

Those with chronic physical health problems are often on multiple medications. This table from the NICE guidance summarises the common problems we may face and offers alternative antidepressants for each of these situations.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Recommended antidepressant(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSAIDs</td>
<td>Do not normally offer SSRI. If no suitable alternatives offer gastroprotective medicines (e.g. PPI) with the SSRI. Consider mirtazapine, trazodone, mianserin, reboxetin or moclobemide</td>
</tr>
<tr>
<td>Warfarin or heparin</td>
<td>Do not normally offer SSRI. Consider mirtazapine (INR may slightly increase)</td>
</tr>
<tr>
<td>Aspirin</td>
<td>Use SSRI with caution: if no alternative offer SSRI with PPI cover. Consider mirtazapine, trazodone, mianserin or reboxetine</td>
</tr>
<tr>
<td>Triptans for migraine</td>
<td>Do not offer SSRI. Offer mirtazapine, trazodone, mianserin or reboxetine</td>
</tr>
<tr>
<td>MAOB inhibitors (e.g. selegiline, rasagiline)</td>
<td>Do not normally offer SSRI. Offer mirtazapine, trazodone, mianserin or reboxetine</td>
</tr>
</tbody>
</table>
What about amitriptyline and dosulepin (dothiepin)?

Remember the BNF advises against the use of amitriptyline and dosulepin (dothiepin) in the treatment of depression because of the dangers in overdose.

MHRA advice on venlafaxine

GPs are now able to prescribe venlafaxine once more, but be aware:

- Specialist supervision is required for those who are on doses of 300mg daily or more, or those who are severely depressed, or are in hospital.
- For those using it for anxiety disorders, dose is 75mg daily, and no higher.
- Do not use in uncontrolled hypertension, risk of serious cardiac arrhythmias, recent MI.
- Measure blood pressure at initiation and regularly throughout treatments especially during dose titration – discontinue if sustained hypertension.

And a massive case–control study (almost 7000 cases, with 30 controls for each case) has shown that venlafaxine does not increase the risk of sudden cardiac death or serious arrhythmia (BMJ 2010;340:c249).

What about mirtazapine?

A Cochrane Review (2011, CD006528) concluded that:

- Mirtazapine is likely to have a faster onset of action than SSRIs.
- It may be that mirtazapine is superior to SSRIs by 6–12w.
- Mirtazapine causes adverse events that lead to a similar frequency of dropouts as SSRIs and tricyclic antidepressants, although the adverse event profile of mirtazapine is different: mirtazapine is likely to cause weight gain or increased appetite and somnolence, but is less likely to cause nausea or vomiting and sexual dysfunction than SSRIs so may be a useful 2nd line option if adverse effects of SSRIs are unacceptable.

Stopping or reducing antidepressants – NICE 2009, CG90 & 91

Discontinuation symptoms (such as increased mood swings, restlessness, difficulty sleeping, unsteadiness, sweating, abdominal symptoms and altered sensations) can occur on stopping, missing doses or reducing doses of antidepressants. These symptoms are usually mild and self-limiting over approximately 1w but can be severe especially if the drug is stopped abruptly.

When stopping antidepressants:

- Gradually reduce the dose over 4w (although this is not necessary for fluoxetine due to a long half-life and active metabolites).
- Reduce the dose over even longer periods for drugs with a shorter half-life, e.g. paroxetine, venlafaxine.

If despite this, significant discontinuation symptoms occur and are severe:

- Consider reintroducing the original antidepressant at the dose that was effective and reduce the dose more gradually while monitoring symptoms.
- Or restart another antidepressant with a longer half-life from the same class (so usually fluoxetine for the SSRIs) and reduce slowly once symptoms have settled.

Do antidepressants cause suicidal ideation and action?

| Theophylline, clozapine, methadone or tizamidine | Do not normally offer fluvoxamine  
Offer sertraline or citalopram |
|-----------------------|-----------------------------|
| Flecaïnide or propafenone | Offer sertraline as the preferred antidepressant  
Mirtazapine and moclobemide may also be used |
| Atomoxetine | Do not offer fluoxetine or paroxetine  
Offer a different SSRI |
As you know, concerns have been expressed about antidepressants causing suicidal ideation, especially in young people. This massive meta-analysis (almost 100,000 people) looked at suicidal behaviour (suicide, attempted suicide, preparatory acts) and suicidal ideation in those on antidepressants compared with placebo (BMJ 2009;339:b2880).

- In younger people (<25y) antidepressants increased the risk of suicidal ideation/behaviour, although this was not statistically significant.
- In all other age groups antidepressants reduced the risk of suicidal ideation/behaviour.
- This reinforces the advice from NICE that in those under 18 we should prescribe antidepressants only with specialist advice and supervision.

A cohort study of 240,000 UK patients with a first episode of depression looked at the relationship between suicide attempts and antidepressant classes and as to whether the antidepressant had been recently started or stopped (BMJ 2015;350:h517). Everyone was aged 20–64 years old.

- There was no difference in suicide, attempted suicide or self-harm rates between people on tricyclics and those on SSRIs.
- However, there was an increased risk for those using venlafaxine, trazodone and mirtazapine, but because the numbers of events were small the estimate for increased risk is imprecise (about 3% for venlafaxine vs. 1% for amitriptyline).
- The risk of suicide, attempted suicide or self-harm was greatest in the first 28d of treatment and the first 28d of stopping treatment.

The authors are reassured with the data around SSRIs, but remind us to be alert to the increased risk around the time of starting and stopping antidepressants.

Which antidepressant in CHD?

Data on the use of antidepressants in patients with coronary heart disease (CHD) are limited. However, UK Medicines Information suggested the following (UKMI 2012;55.6):

- **SSRIs are the agents of choice in CHD.** They are generally well tolerated, effective and safe to use in patients with CHD when appropriate precautions are taken.
  - Sertraline is safe post-MI and considered the drug of choice in these patients.
  - However, citalopram is associated with dose-dependent QT interval prolongation and is contraindicated in patients with known QT interval prolongation or congenital long QT syndrome. It is also cautioned in patients at higher risk of developing torsades de pointes.
- **Tricyclic antidepressants should be avoided in patients with CHD and are contraindicated in patients who have had a recent MI.** Tricyclics are viewed as highly cardiotoxic in overdose and may therefore worsen outcomes in CHD patients.
- **Mirtazapine is a suitable alternative in CHD if SSRIs cannot be used, but it should be used with caution.** There is evidence of safety post-MI.

Antidepressants in the elderly

This UK-based cohort study of people aged 65–100y with depression looked at adverse events by class of antidepressant used (SSRI, tricyclic, other). Follow-up was over 5y on average. Obviously, because this was an observational cohort trial there may have been good clinical reasons for selecting one drug over another, which may affect the outcomes, but nevertheless this study reveals some interesting results (BMJ 2011;343:d4551):

- SSRIs were associated with the highest risk of falls and hyponatraemia.
- Other antidepressants (non-SSRI, non-tricyclics) were associated with the highest risk of mortality, self-harm/suicide, stroke/TIA, fracture and epilepsy. However, do note that these drugs are more likely to be used in those with more severe disease because they are not first line treatments.
- For all the outcomes, tricyclics never performed as the ‘worst’ drug (when compared to SSRIs or other antidepressants), but often they were not the ‘best’ either.

Absolute 1y risk for all-cause mortality was:

- 7% whilst on no antidepressants
- 8% whilst on tricyclics
- 11% whilst on SSRIs
- 11% for those on other antidepressants (non-SSRI, non-tricyclics).

Antidepressants in dementia

Depression is common in dementia, with a prevalence estimated to be greater than 20%. The US National Institute for Health Research has run an RCT of just over 300 patients with dementia to see if adding an antidepressant might help. Patients with dementia but without obvious depression were randomised to either placebo, sertraline or mirtazapine at usual clinical doses. At 13 and 39w follow-up sertraline and mirtazapine were no better than placebo. More trials like this are needed to establish what might
Are we overusing antidepressants?

Over recent years there have been a number of studies showing that antidepressant prescribing is increasing. Several reasons for this have been proposed: increased detection, longer courses of treatment, changing demography, etc. This study looked at prescribing data in Scotland from 1995 to 2007 (BJGP 2011;61:556).

Over the period of the study prescribing increased, with the proportion of the population being on an antidepressant increasing from 8% to 13%. The main reason for this was that patients were treated for a longer period, and at a higher dose. The change was not due to changes in demography (age/sex distribution).

Have IAPT services changed antidepressant prescribing rates?

A study looked at antidepressant prescribing since IAPT (Improving Access to Psychological Therapies) services were introduced (BJGP 2013;63:478). It found no change in antidepressant prescribing rates immediately before and in the time after the introduction of the service. They don’t seem to have taken waiting times into account and I wonder if this is a critical determinant of antidepressant use: in areas where waits are long, antidepressants are possibly used until IAPT services are available, whereas if people could be seen immediately, maybe the use of antidepressants would be lower.

What about the antidepressant agomelatine?

Agomelatine is an antidepressant that works on serotonin receptors and melatonin receptors.

The DTB reviewed the evidence for agomelatine and concluded that (DTB 2010;48:93):

- In short-term trials it shows some benefits over placebo; however, there are no published active-comparator trials which look at efficacy in depression.
- It has been shown to have fewer discontinuation symptoms than paroxetine and less sexual dysfunction than venlafaxine, but as the DTB points out, these comparator drugs are particularly likely to cause these unwanted effects, so are not ideal comparators.
- It is more expensive than other agents available (£571/y at standard dose, compared to £20/y for some SSRIs).
- It requires liver function monitoring (at 6, 12 and 24w and then if clinically indicated).
- The DTB concluded ‘we find it hard to see a role for agomelatine in treating patients with depression’.

Antidepressants

- The SSRIs are associated with some increased risks in pregnancy, but these are small and must be balanced on a case by case basis against the benefits of treatment/the harms of not treating.
- Maximum recommended doses of citalopram/escitalopram have now been introduced by the MHRA: make sure you don’t exceed them.
- Tamoxifen’s action is inhibited by some other drugs, particularly fluoxetine and paroxetine. Avoid using these SSRIs in women on tamoxifen.
- In people over 25y, antidepressants protect against suicidal ideation and behaviour, but in those <25y they may increase the risk.
- In CHD the SSRIs, particularly sertraline, are the drugs of choice.
- Review whether any of your patients are on above maximum recommended doses of citalopram for their age or if they have hepatic disease (poorly defined and much harder to search for!). Come up with a plan about how you will contact patients and discuss reducing their dose. This may involve contacting the CMHT if they are under their care.
- Are any of your patients on tamoxifen and either fluoxetine or paroxetine? What will you do about this? Is this a safety audit you should do every year?
- Are patients on venlafaxine having a regular BP check? (Regular isn’t defined but 6m would seem reasonable and with every dose increase.)

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.

GP Update Limited
April 2016
Our comprehensive one-day update courses for GPs, GP STs, and General Practice Nurses.

We do all the legwork to bring you up to speed on the latest issues and guidance.

All our courses are:

Relevant
Developed and presented by practicing GPs and immediately relevant to clinical practice.

Challenging
Stimulating and thought-provoking.

Unbiased
Completely free from any Pharmaceutical company sponsorship.

Fun!
Humorous and entertaining – without compromising the content!

Are they for me?
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.

What’s included?

- 6 CPD credits in a lecture based format, with plenty of time for interaction, humour and video clips, to keep you focused and awake.
- 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.
- 12 months subscription to www.gpcpd.com. With three times the content of the handbook, it allows you to capture CPD credits as you read on the site and use it in consultations! It also comes with focussed learning activities to double your CPD credits…at the end of the year you simply upload everything ready for your appraiser!
- 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.

www.gp-update.co.uk
The GP Update Course – our flagship course!

With the amount of evidence and literature inundating us, it can be hard to know which bits should change our practice, and how. The GP presenters summarise and discuss the results of the most important new evidence and guidance, concentrating on what it means to you and your patients in the consulting room tomorrow.

<table>
<thead>
<tr>
<th>City</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bristol</td>
<td>Wed 11 May</td>
</tr>
<tr>
<td>Exeter</td>
<td>Thur 12 May</td>
</tr>
<tr>
<td>London</td>
<td>Fri 13 May</td>
</tr>
<tr>
<td>London</td>
<td>Sat 14 May</td>
</tr>
<tr>
<td>Newcastle</td>
<td>Wed 18 May</td>
</tr>
<tr>
<td>Sheffield</td>
<td>Thur 19 May</td>
</tr>
<tr>
<td>Manchester</td>
<td>Fri 20 May</td>
</tr>
<tr>
<td>Birmingham</td>
<td>Sat 21 May</td>
</tr>
<tr>
<td>Norwich</td>
<td>Tue 24 May</td>
</tr>
<tr>
<td>Chelmsford</td>
<td>Wed 25 May</td>
</tr>
<tr>
<td>London</td>
<td>Thur 26 May</td>
</tr>
<tr>
<td>Belfast</td>
<td>Wed 8 June</td>
</tr>
<tr>
<td>Oxford</td>
<td>Fri 30 Sep</td>
</tr>
<tr>
<td>Southampton</td>
<td>Sat 1 Oct</td>
</tr>
<tr>
<td>Cardiff</td>
<td>Wed 5 Oct</td>
</tr>
<tr>
<td>Exeter</td>
<td>Thur 6 Oct</td>
</tr>
<tr>
<td>London</td>
<td>Fri 7 Oct</td>
</tr>
<tr>
<td>London</td>
<td>Sat 8 Oct</td>
</tr>
<tr>
<td>Leeds</td>
<td>Wed 12 Oct</td>
</tr>
<tr>
<td>Liverpool</td>
<td>Thur 13 Oct</td>
</tr>
<tr>
<td>Manchester</td>
<td>Fri 14 Oct</td>
</tr>
<tr>
<td>Birmingham</td>
<td>Sat 15 Oct</td>
</tr>
<tr>
<td>Cambridge</td>
<td>Tue 18 Oct</td>
</tr>
<tr>
<td>London</td>
<td>Wed 19 Oct</td>
</tr>
<tr>
<td>Nottingham</td>
<td>Thur 20 Oct</td>
</tr>
<tr>
<td>Inverness</td>
<td>Wed 2 Nov</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>Thur 3 Nov</td>
</tr>
<tr>
<td>Glasgow</td>
<td>Fri 4 Nov</td>
</tr>
</tbody>
</table>

The Women’s Health Update Course

From the pill to pelvic pain, periods and prolapses, this one day women’s health update is a comprehensive guide to understanding and managing common gynaecological problems in general practice. The subjects are covered in a much greater depth than is possible on the GP Update course and includes simple ideas which we as GPs have found helpful in our consultations.

The day is designed for all GPs and GP STs – not just those with a special interest!

<table>
<thead>
<tr>
<th>City</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edinburgh</td>
<td>Thur 23 Jun</td>
</tr>
<tr>
<td>Newcastle</td>
<td>Fri 24 Jun</td>
</tr>
<tr>
<td>Birmingham</td>
<td>Thur 30 Jun</td>
</tr>
<tr>
<td>London</td>
<td>Fri 1 Jul</td>
</tr>
<tr>
<td>Exeter</td>
<td>Thur 3 Nov</td>
</tr>
<tr>
<td>London</td>
<td>Fri 4 Nov</td>
</tr>
<tr>
<td>Leeds</td>
<td>Thur 10 Nov</td>
</tr>
<tr>
<td>Manchester</td>
<td>Fri 11 Nov</td>
</tr>
</tbody>
</table>

The Cancer Update Course

Since 2012, Red Whale | GP Update has joined forces with Macmillan Cancer Support to provide a course that gives all GPs the knowledge and inspiration they need when dealing with cancer. From cancer prevention, screening, diagnosis and treatment to palliative care.

2015 has seen the biggest shake up in cancer in the last 10 years with the publication of the updated NICE guidelines on suspected cancer. If, like many of us in England & Wales, you are still finding your way around them, then this course will definitely help!

<table>
<thead>
<tr>
<th>City</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leeds</td>
<td>Thur 16 June</td>
</tr>
<tr>
<td>Birmingham</td>
<td>Fri 17 June</td>
</tr>
<tr>
<td>Bristol</td>
<td>Thur 23 June</td>
</tr>
<tr>
<td>London</td>
<td>Fri 24 June</td>
</tr>
<tr>
<td>Manchester</td>
<td>Thur 10 Nov</td>
</tr>
<tr>
<td>Birmingham</td>
<td>Fri 11 Nov</td>
</tr>
<tr>
<td>Cambridge</td>
<td>Thur 17 Nov</td>
</tr>
<tr>
<td>London</td>
<td>Fri 18 Nov</td>
</tr>
</tbody>
</table>
Lead. Manage. Thrive! – The NEW management skills course for GPs.

Sometimes it feels like the thriving GP is an endangered species – demands on limited time and resources have never been higher. Our practices run in ever more complex ways and our teams extend beyond the practice walls. Often we get that instinctive feeling that there must be a better way to do things but creating the space to make it happen can be difficult.

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.

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!

The Telephone Consultation Course

With the increased importance of telephone consultations this course aims to deliver practical skills which can be put to use immediately. The telephone is being used more and more by nurses as well as doctors in primary care, for triage, consultation and follow-up; in the daytime as well as out of hours. Our goal is to help you overcome difficulties and leave you with concrete ideas to enhance your own telephone contacts with patients.

The Effective Consultation Course

The Course focuses on behaviours which enhance effective use of time in the consultation. Efficient consultations reduce clinical risk and lower the risk of complaints and lawsuits. The course uses the rich evidence base on which consultation behaviours enhance effectiveness and how to go about learning them. We focus on actions and you will leave with many practical tips to use in your consulting room the following day.

The Medically Unexplained Symptoms Course

A significant proportion of patients who present to us will turn out to have symptoms that are medically inexplicable. We all know that there is no magic solution with these patients and sometimes they leave us feeling defeated and not sure what to do. However, there is evidence which can help address the issue.

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)
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! The management skills 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 (pre-order for shipment mid May 2016) £225
- Women’s Health Update Handbook £70
- Cancer Update Handbook £70

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

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

For downloadable information on becoming a presenter with us please visit: www.gp-update.co.uk/team Or email team@gp-update.co.uk

To book: Online at www.gp-update.co.uk or call us on 0118 9607077 or use the form below

Make waves as a presenter with Red Whale!

Can you prescribe GPs, Nurses and Registrars a lively course of evidence based updates and good humour?

Are you as passionate as we are that pharma sponsorship has no place in medical education?

Do you want to add presenting courses to your GP portfolio?

We are looking for practising GPs to start making big, bold waves in primary care education as Red Whale presenters.

You will be trained in presenting one-day, lecture-based courses to audiences of 50-300 delegates.

GP Update – Red Whale is a market leading educator for GPs, Nurses and Pharmacists. We are looking to expand our team of enthusiastic presenters and continue making our courses relevant, challenging and fun.

To GP Update Limited to:

GP Update, The Science and Technology Centre, Earley Gate, Whiteknights Road, Reading RG6 6BZ

GP Update Limited, registered in England and Wales No. 7135974.
Registered Office: Prospect House, 58 Queens Road, Reading RG1 4RP
Full terms and conditions are available at www.gp-update.co.uk

GPU/05/0616