

## Game Changers

### GAME CHANGERS: ANOTHER REVOLUTION IN HEART ATTACK TREATMENT

Dr Michael J Moore

Major advances in the treatment of coronary artery disease (CAD) over the last three decades have resulted in dramatic improvements in mortality. Despite this, CAD remains a dominant cause of death. The thrombolytic era in Northern Ireland (NI) revolutionised outcomes for ST elevation myocardial infarction (STEMI) in the early 80's. More recently however, Primary Percutaneous Coronary Intervention (PPCI) has replaced thrombolysis in many parts of the world. Randomised controlled trials have demonstrated the significant advantages of PPCI (1).

The National Infarct Angioplasty Project (NIAP) demonstrated the feasibility of PPCI in the UK. The Department of Health (DoH) planned a national rollout of PPCI. The NHS UK have stated that all STEMI's should be treated in designated Heart Attack Centres (HAC's). These HAC's will have 24/7 Cardiac Catheterisation Lab availability with an on call PPCI team. The HSC Board has designated 2 HAC's for NI, The Royal Victoria Hospital (RVH), Belfast Trust and Altnagelvin Area Hospital (AAH), Western Trust. The RVH commenced 24/7 PPCI in 2013, covering mostly east of the River Bann, AAH is due to commence on 15th September 2014 for the West and North West. Outcomes for PPCI are dependent on procedural volume. Two HAC's allows coverage for NI's 1.6 million population while maintaining critical volume for each centre.

Thrombolysis was innovative and life saving but with its imminent departure NI is set for another revolution in Heart Attack treatment.

Keeley EC, Boura JA, Grines CL. Primary angioplasty versus intravenous thrombolytic therapy for acute myocardial infarction: a quantitative review of 23 randomised trials. *Lancet*. 2003; **361(9351)**: 13-20

### EVIDENCE BASE FOR THE ROLE OF SINUS SURGERY IN CHRONIC RHINOSINUSITIS GAINS BETTER DEFINITION.

Dr Brendan Hanna

The landmark paper "Evaluation of the Medical and Surgical Treatment of Chronic Rhinosinusitis: A Prospective, Randomized Controlled trial"<sup>1</sup> demonstrated that 3 months of topical corticosteroids combined with saline nasal rinses and oral macrolide antibiotics produced clinical outcomes equivalent to surgical intervention, in all but those patients with nasal polyposis. The authors' concluded that this medical therapy regimen should be deployed as first line in patients with chronic rhinosinusitis. Many clinicians extrapolated these results, forming the opinion medical therapy to be as good as sinus surgery in chronic rhinosinusitis.

Due to the inherent risks of invasive therapy, surgery is usually reserved for patients who have not had a satisfactory response to medical treatment. In this study randomising patients, at presentation, to either surgery or medical therapy diluted the beneficial effects of surgery by including patients who would have had good outcomes from medical management alone. Here underscores the problem with randomising surgical treatments; patient selection is critical for good surgical outcomes but the process of selection is incompatible with randomisation.

The apparent discrepancy between patient treatment in the randomized trial and in the real clinical world has now been addressed<sup>2</sup>. In this non-randomised study patients with an unsatisfactory response to medical therapy were offered either continued medical therapy or surgery, with a cross-over arm from medical to surgical treatment. There were no statistical differences in disease severity between the cohorts. At one year follow-up surgical patients reported significantly more improvement than medically managed patients.

An evidence base is thus developing for the deployment of sinus surgery as an adjunct to medical therapy where initial medical therapy alone fails.

1. Ragab SM, Lund VJ, Scadding G. Evaluation of the medical and surgical treatment of chronic rhinosinusitis: a prospective, randomised controlled trial. *Laryngoscope*. 2004; **114(5)**: 923-30
2. Smith TL, Kern R, Palmer JN, Schlosser R, Chandra RK, Chiu AG et al. Medical therapy versus surgery for chronic rhinosinusitis: a prospective multi-institutional study with 1-year follow-up. *Int Forum Allergy Rhinol*. 2013; **3(1)**:4-9

### 'WHAT'S THE POINT OF A GP LOCUM?'

Dr Fiona McEvoy

A partner I had worked with for several years asked me this question recently. Having worked as a long term locum in their practice, doing fully booked surgeries, bloods, letters and housecalls, it was clear that the challenges I had (as a locum GP), and volume of work I had done, were not respected or noticed. I was a commodity with no terms and conditions, no boundaries.

At times in the past I had meekly suggested ways in which the workload could be addressed, or ways I could safely net a housecall when I was on my way to another practice, but these attempts were ignored. I was a ghost.

This is what is faced daily by GP locums all over Northern Ireland. I know that because the locums I know are friends and colleagues. Initially when the question was asked I was angry and hurt. On reflection I realised that it was important and needed addressed.

Sessional / non practice based GPs make up 40% of the workforce in the UK.<sup>1</sup> They provide cover for doctors when they are on holidays and when they are sick or need to care for loved ones, but they do not have the team or financial support they need when in the same situation. They are isolated and paid less than partner counterparts who received the same

training as them. They work in multiple locations, sometime miles apart, on different computer systems and with different colleagues daily.<sup>2</sup>

Locum GP's need to start to take professional and personal responsibility for their work, it is a service provided and as such should have set terms and conditions and Professional boundaries.

The work done needs to be respected not demanded, so patient safety can be assured and locums are not left feeling unequal to their partner counterparts.

1. National Association of Sessional GPs. How many locum GPs in the UK? [Internet]. Chichester, UK: NASGP; 2008. Available online from: [http://www.nasgp.org.uk/download/locumnumbers/nasgp\\_how\\_many\\_gp\\_locums\\_in\\_UK.pdf](http://www.nasgp.org.uk/download/locumnumbers/nasgp_how_many_gp_locums_in_UK.pdf). Last accessed August 2014.
2. National Association of Sessional GPs. Locum GPs: The skills we need and how we achieve them [Internet]. Chichester, UK: NASGP; 2010. Available online from: [http://www.nasgp.org.uk/download/locum/skills/locum\\_gps\\_the\\_skills\\_we\\_need\\_and\\_how\\_to\\_achieve\\_them.pdf](http://www.nasgp.org.uk/download/locum/skills/locum_gps_the_skills_we_need_and_how_to_achieve_them.pdf). Last accessed August 2014.