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PULBOROUGH PATIENT LINK

PULBOROUGH PATIENT LINK AND YOUR MEDICAL GROUP WORKING TOGETHER TO GIVE YOU THE BEST POSSIBLE CARE

NEWSLETTER NUMBER 29 SPRING '15

This issue includes articles on:

Painkillers

Melanoma

PMG Charity & Update

Pulborough Patient Link

invites you to a Public Meeting in

Pulborough Village Hall on

Monday 23 March

What Every Patient Needs to Know about

Osteoporosis

with

Dr Sanjeev Menon

MA (Cantab), MB BS, FRCP
Consultant Rheumatologist
St. Richard's and Nuffield Health
Chichester Hospitals

Areas of specialist interest include:
inflammatory joint disease, polymyalgia, connective tissue disorders, osteoarthritis, gout and osteoporosis

Talk 7.00 – approx. 8.30pm
Refreshments and Raffle Draw 8pm

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CHAIRMAN'S LETTER – FEBRUARY 2015

I hope you have got through the winter without too many health problems.

The crises that always seem suddenly to hit the NHS have certainly hit us again this year. As usual the A&E units at our local hospitals have been under tremendous pressure, as have all medical staff nationwide. Some of our GPs have been helping out at St Richard's to try to ease the pressure and have enabled 111 to direct less serious patients to PMG on some Saturdays.

The crises, we are told, have not been helped by the UK's ageing population. It is often presented as a phenomenon that has suddenly arisen - and taken everyone by surprise! I'm sorry, but this could have been foreseen 20 or 30 years ago. The problem, of course, is money.

Everyone is agreed that more money should be allocated to the NHS. In the next few months every political party will be promising more money for the health service and the provision of better services. All sorts of things will be pledged with little or no consultation with frontline medical services or, heaven forbid, with patients. Who knows what policies will look like after May 7th? And what promises will be kept?

What does this all mean for the Pulborough Patient Link? Irrespective of politics, our primary duty is to listen to you and work with our excellent local doctors to improve even further all they seek to provide.

The PPL is respected in the wider health community and we must also aim to represent your views in the wider NHS Community. One body that we will be striving to help in the year ahead is the Coastal Commissioning Group (CCG) for our local

area. You will recall that they attracted much adverse publicity on the now-aborted proposal to contract BUPA/CSH to supply MSK services.

The CCG Board is made up of dedicated, experienced medical professionals – indeed Dr Katie Armstrong, their Clinical Chief Officer, does GP work at our local surgery. However, much of the reason for their existence is probably unknown to you. I hope in the next few months we can help them get stronger links with patients and groups like PPL, and give them whatever support they need.

The dates of our Public Meetings for 2015 are:

March 23
July 13
October 12

If you are receiving a printed copy of this Newsletter it is because you are a full Member of PPL. Only you have the right to decide who should represent you on our Committee and on our future direction. This year we are having a full members-only Annual General Meeting in May when you will also be able to hear about, and question, the health services you receive now and after the General Election.

We always welcome your views – on anything! Please email on

david@pulboroughpatientlink.org

or follow us on

Twitter at @pulboropatients

David McGill

Now also available at PMG:

Every Friday afternoon from 6 March between 2-5pm

Walk-in hearing aid repairs: Re-tubing/battery replacement

A GUIDE TO PAINKILLERS - Dr Tim Fooks

Painkillers are probably the most frequently taken and prescribed medicines. As a group they are also known as analgesics, a term which means “without pain”.

The intention of this article is to give some general pointers as to the types of painkiller that are commonly used by doctors or are available over-the-counter in supermarkets and pharmacies. Very good sources of more detailed information about all the medicines referred to, and advice as to which ones are useful to keep at home, are to be found on-line at the following two websites:

http://www.nhs.uk/medicine-guides/pages/default.aspx

http://www.patient.co.uk/health/useful-medicines-to-keep-at-home

Of course, as well as the GPs, your local experts at our health centre are the pharmacists, and it is always a good idea to discuss with them the use of any medicine you are intending to buy over the counter. They will be able to tell you if the medicines will work for your problem and if there are likely to be adverse effects with any other medical conditions you have, or any unhelpful interactions with other treatments you may already be using.
Please note that I am not using this article to discuss all treatments that might be effective in reducing pain - alternative approaches can be also studied on the internet and include: physical therapies, acupuncture, TENS, relaxation techniques and hypnosis.

Types of Painkiller

In general terms there are five main classes of painkiller and this article will concentrate on classes 1-3:

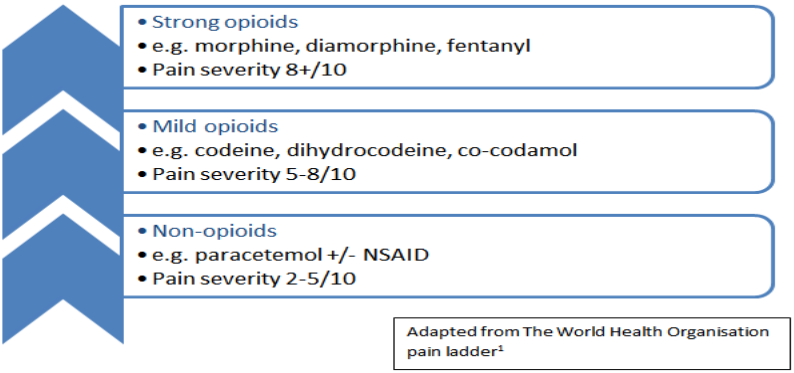
1. Opiates
2. Paracetamol
3. Non-steroidal anti-inflammatories (NSAID)
4. Nerve stabilisers derived from two very different classes of drug:
    a. tri-cyclics (in the past this group was also commonly used as antidepressants)
    b. anti-epileptics
5. Anaesthetics

Painkiller Combinations

Doctors often prescribe combinations of painkillers and codeine with paracetamol preparations (eg co-codamol) are used very commonly. Non-steroidal painkillers are also used in combination with paracetamol and/or opiates, often allowing very good pain control whilst avoiding excessive use (and side effects) of any one drug.

The Pain Ladder

Despite all the developments in pain relief medicines, the way in which these drugs are used does not always relieve pain satisfactorily. To try to improve this situation the WHO developed the concept of a pain ladder to guide clinicians to be more effective in their use of analgesics. In some cases, even this is inadequate and additional techniques are required.



Opiate Analgesics

Opiates drugs are all derivatives of morphine (also known as opium) and they work on pain nerves both in the body and in the brain.

1. **Uses:** to reduce all types of pain although not so effective with nerve pain.
2. **Examples of opiates in order of strength** (with weakest first): codeine, tramadol, dihydrocodeine, oxycodone, morphine (eg oramorph, MST, Zomorph), methadone, diamorphine (aka heroin), buprenorphine, and fentanyl.
3. **Variability in strength:** weight for weight, morphine is approximately ten times as powerful as codeine but only a 1/75 of the strength of fentanyl.
4. **Administration:** by mouth, under the gum, by injection, via a syringe driver, or patch (stuck to skin for 3 days or 7 days).
5. **Adverse effects** are related to both the dose and the relative strength of the medicine. However, some people are extremely intolerant to opiates and are unable to use this group of medicines. Common side-effects include – nausea, vomiting, constipation, drowsiness, mood disturbance, risk of physiological dependence (stopping an opiate suddenly after prolonged use may lead to symptoms of withdrawal known as 'cold turkey'). Tolerance can also occur with prolonged use (where an increasing dose is required to preserve the same effect). A chronic painkiller-induced headache can occur at any stage following long term use of any opiate.
6. **Overdose:** when an excess of an opiate is taken in any form, the features of an overdose, as we had to learn them as medical students, are those of "an under-sexed introvert with pin-point pupils" (as opposed to the effect of an overdose of cocaine which causes "an over-sexed extrovert with wide-dilated pupils"!)

7. **Opiates with other medicines.** Codeine and dihydrocodeine are frequently used in combination with paracetamol to make - co-codamol and co-dydramol respectively. These make effective painkillers of mild to moderate potency. However, these combinations are limited to the maximum dose of paracetamol that can be taken during a 24 hour period (4 g)
8. **Use in Children.** Children can benefit from opiate medication when required but these occasions are almost exclusively in a hospital setting, for example after surgery or an accident.

Paracetamol

What is it? Paracetamol is a painkilling (analgesic) medicine available over-the-counter without a prescription. It is sold by a range of manufacturers, under many different brand names and, in some countries, paracetamol is known as acetaminophen.

How it works. Paracetamol works as a painkiller by affecting chemicals in the body called prostaglandins. Prostaglandins are substances released in response to illness or injury. Paracetamol blocks the production of prostaglandins, making the body less aware of the pain or injury. It reduces temperature by acting on the area of the brain responsible for controlling temperature. Each dose is not long-lasting, remaining effective for only 4-6 hours. It, therefore, needs to be administered every 6 hours to maintain a good effect.

Uses: a) ease mild to moderate pain – for example, headaches, sprains, or toothache. b) **c**ontrol a fever **(high** temperature, also known as pyrexia) – for example, when someone has the flu (influenza). c) moderate to severe pain in hospital setting.

Preparations: Paracetamol is available as tablets, caplets, capsules, soluble tablets, oral suspension (liquid medicine) or suppositories. In hospital it can be administered via an intravenous drip for moderate to severe pain.

Paracetamol with other medicines: In some products, paracetamol is combined with other ingredients. For example, it may be combined with a decongestant (a type of medicine that provides short-term relief for a blocked nose) and sold as a cold and flu remedy. Paracetamol may also be combined with other painkillers in medicines as described above.
Liquid paracetamol comes in 2 strengths: For **under** 6 year olds 120mg/5ml and **over** 6 year old strength 250mg/5ml.
Who can use paracetamol? Paracetamol should be used with caution by those with liver problems, kidney problems or alcohol dependence. It may be used during pregnancy, in babies over 2 months and in breast feeding mothers.
Side effects are rare but can include a rash or swelling.
Dose: In adults the maximum dose to be taken in 24 hours is 4g. This is equivalent to 8 standard strength paracetamol tablets. In children the maximum dose is listed on the bottle of liquid paracetamol. For children under 6 year old, a simple calculation may also be used:

- Total number of 5ml teaspoons of liquid paracetamol suitable for children under 6 year (120mg/5ml) to be administered during 24 hours is given by the calculation ⇨
- For example, an infant weighing 10kg, the max number of 5ml tspn in 24 hours is five.

$$\frac{\text{Child's Weight in kg}}{2}$$

Overdose and Interactions: paracetamol is very toxic to the liver and kidney when very large doses are taken inappropriately. In these circumstances it can become very dangerous and hospital admission for treatment is always required. Paracetamol may interact with some other medicines, including some medicines taken to treat cancer or epilepsy.

Use in children. Babies and children can be given paracetamol to treat fever or pain if they are over two months old. For example, one dose of paracetamol may be given to babies if they have a high temperature following vaccinations. This dose may be repeated once after six hours. However, if a child has a fever but is **not** distressed, the raised temperature should **not** be treated as the body's immune defences have been shown to work better at a slightly higher temperature. **If your baby's or child's high temperature does not get better, or they are still in pain, speak to your GP or call NHS 111.**

Non-Steroidal Anti-inflammatory Painkillers/Drugs (NSAIDs) are medications widely used to treat a range of conditions:
To: relieve pain, reduce inflammation (redness and swelling), bring down a high temperature (fever)
Common acute (short-term) conditions that can be treated with NSAIDs include: headaches, painful periods, toothache, soft tissue injuries such as sprains and strains, infections, such as the common cold or the flu (NSAIDs do not treat the underlying infections, but can help to relieve symptoms, especially fever)
Common chronic (long-term) conditions that can be treated with NSAIDs include: most types of arthritis, including rheumatoid arthritis, other forms of inflammatory arthritis and osteoarthritis, chronic back pain, chronic neck pain

Adverse Effects. NSAIDs can increase the risk of heart attack, stroke, and heart failure. These risks are small and are related to how long they are used for, the dosage and certain types of NSAIDs, and the presence of other risk factors such as old age, smoking, diabetes and pre-existing cardiovascular problems, including hypertension. NSAIDs can also cause gastric inflammation and ulceration, and can also affect the kidney and liver. Patients with asthma are at a small risk of an exacerbation due to NSAIDs. They are not recommended in pregnancy. **NSAIDs are therefore very useful drugs which should be used with caution and, if there is any doubt about the dose**

or duration of use of these medicines, advice should be sought from a doctor or pharmacist. *Read more about side effects of NSAIDs in NHS Choices or Patient UK.*

Preparations. Tablets, capsules, liquid oral suspension, cream/gels, eye drops, injections and suppositories.

Examples: Aspirin is a NSAID but it is not effective enough to recommend as a first-line analgesic and **it should NOT be given to children under 16 years**. The two safest NSAIDs are ibuprofen and naproxen. Other examples are diclofenac, celecoxib, mefenamic acid, etoricoxib, and indometacin. These NSAIDs are usually used under medical supervision of the GP or specialist.

Dosage in adults: The standard dose of Ibuprofen in adults is 400mg three times in 24 hours. In more marked pain, this medicine can be taken up to a maximum dose of 2.4g in 24 hours. The dose of naproxen is 250mg – 500mg twice a day.

Use in Children. By far the most frequently used NSAID in children is ibuprofen. It may be used in children from 2 months of age eg after immunisations at a dose of 50mg. Ibuprofen is a more effective medicine than paracetamol for relief of fever and pain. Each dose last 6-8 hours and so the frequency of administration is 3 x a day (rather than four as for paracetamol). The suspension is supplied at a strength of 100mg/5ml teaspoon. The dosage for each age group is gien on the bottle but the maximum allowed in
24 hours is equivalent to 30mg/kg of child's weight. For example, a child of 10kg may have no more than 300mg in 24 hours = three 5ml doses

Melanoma

Melanoma is a cancer that usually starts in the skin – either in a mole or in normal looking skin. A rising number of people in the UK are being diagnosed each year, currently more than 10,600.

In December 2013 my sister suddenly became very ill with severe headaches, nausea and dizziness. Following CT and MRI scans, she was diagnosed with advanced melanoma. She had 2 brain tumours, as well as 1 tumour on a lung, another on a kidney. A year ago my darling sister was given just 3 weeks to live. What a bombshell as she regularly ran half marathons and seemed the picture of health.

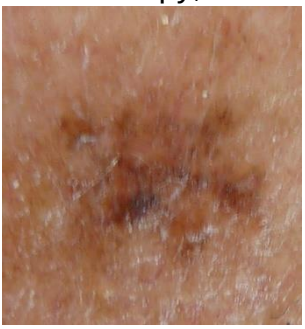
Because of what happened I went with my two other sisters to the Mole Clinic in London. I was shocked to discover I had 2 possible skin cancers, having two moles removed, one of which turned out to be a melanoma.

Last spring I noticed an area on my chest that looked 'different', with a little cluster of unusual pigmentation. I thought I was worrying unnecessarily so I did not contact a doctor then. Thank goodness I had my skin looked at - if I had left it unchecked I could now be in the same situation as my sister.

As children we spent a lot of time outside in the sunshine without any kind of sun protection. In the sixties people did not know about skin cancer, slapping on aftersun lotion and thinking nothing more about it. The Dermatology Dept at Worthing are treating increasing numbers of middle aged people with skin cancers caused by sun damage that occurred many years ago. My skin will now be checked thoroughly every 3 months and if anything is flagged up as suspicious it will be removed - which is very reassuring.

Due to advances in medical science (particularly the new drugs that are now available to melanoma patients) my sister is still with us. She is still very ill, but she is doing all she can to beat this 'melanoma monster'. Her positive mental attitude and healthy, natural (largely raw food) diet no doubt help. Thanks to the NHS, she is taking part in a drugs trial which has given her access to melanoma drugs that are not licenced in the UK yet. It is hoped that the 'wonder drug ', called Pembrolizunab, will offer her a lifeline.

Our family has learnt a great deal about the dangers of melanoma, and it has been shocking to see what my younger sister has had to endure (chemotherapy and radiotherapy, with unpleasant side effects, causing her to lose all her hair). This is all due to a melanoma that was not treated at an early enough stage. I am pleased to say her hair is starting to grow back again and we feel she is in with a chance. I used to think that melanomas would be either raised or crusty. Mine was flat. It's hard to describe what it looked like so to give you more of an idea here is a picture of it.



There are two things I would urge you to do. Firstly, if you notice that you have a mole that is either growing or changing in pigmentation, or if you discover a new skin lesion, that is larger than the size of a pencil head, please have it looked at, either by a GP or at a skin clinic. A good time to check your skin is after a bath or shower. Make sure you have plenty of light and use a full-length mirror and a hand held mirror for areas that are hard to reach, getting your partner, relative or friend to look at your back, neck and parts of your skin that are hard to see. It's also a good idea to keep a photo diary so that you can see if anything is changing.

Secondly, please do not get sunburnt. Sunscreen is readily available which could save your life. Your local pharmacy will help you choose, but you can't go far wrong with a SPF30.
The Royal Marsden has recently said that the incidence of melanoma is doubling every decade and one third of people falling victim to it are aged under 50.

You can Google NHS Choices or Patient UK for more information on melanoma. If you have a suspicious mole please get it looked at. Melanoma can be cured if found at an early stage. Do not be complacent. A simple check could save your life.

Jacqueline – a PMG patient

What is Melanoma? (from Macmillan Cancer Support booklet)

In the UK melanoma is the most common cancer in people aged 15-34. Like most cancers, though, it's more common in older people as our risk of cancer rises with age. People with black or brown skin are much less likely than people with white skin to get melanoma because their skin has more natural protection against it. In women the most common place to develop melanoma is on the legs; in men it's on the chest and back.

Signs and Symptoms

About half of all melanomas start with a change in previously normal-looking skin. This usually looks like a dark area or an abnormal new mole. Other melanomas develop from a mole or freckle that you already have. It can be difficult to tell the difference between a melanoma and a normal mole, but the ABCDE checklist will give you an idea of what to look out for:

Asymmetry – Melanomas are likely to have an irregular border with jagged edges. Ordinary moles are usually symmetrical.

Border – Melanomas are likely to have an irregular border with jagged edges. Ordinary moles usually are well-defined and regular.
Colour – Melanomas tend to be more than one colour. They may have different shades, such as brown mixed with a black, red, pink, white or bluish tint. Normal moles tend to be one shade of brown.
Diameter (width) – Melanomas are usually more than 7mm in diameter. Moles are normally no bigger than the blunt end of a pencil (about 6mm across).
Evolving (changing) - changes in size, shape or colour of a mole.

Causes and Risk Factors
The main risk factor for developing melanoma is exposure to UV radiation, through natural sunlight or artificially from sunbeds or lamps. UV radiation damages the DNA (genetic material) in our skin cells and can cause skin cancers such as a melanoma.
In the UK the number of white people developing melanoma and other skin cancers is steadily rising, the main reason being increased sun exposure as a result of holidaying in the sun. People who experience episodes of sunburn (especially where the skin blisters) are more at risk.

How Melanoma Develops
Melanoma develops from melanocytes that start to grow and divide more quickly than usual. In melanoma, the melanocytes also start to spread into the surrounding surface layers of skin. When they grow out of control, they usually look like a dark spot or mole.
It is important to treat melanomas as early as possible. If a melanoma is not removed, the cells can grow down deeper into the layers of skin. These layers contain tiny blood vessels and lymphatic tubes, which form part of our immune system. If melanoma cells go into the blood vessels or lymphatic tubes, they can travel to other parts of the body. Early-stage melanomas are unlikely to spread into the blood vessels or

lymphatic tubes. However the cancer cells have the ability to spread beyond the original area of the body. If the tumour is left untreated it may spread into surrounding tissue. Sometimes cells break away from the original (primary) cancer. They may spread to other organs in the body through the bloodstream or lymphatic system.

Melanoma in situ

Melanoma in situ is a term used to describe the earliest stage of melanoma where cells are just in the very top layer of skin (epidermis) and haven't started to spread down into the dermis. Because the melanoma is only in this top layer of skin, people with melanoma in situ do not usually have any risk of the melanoma spreading to other parts of the body. Local surgery to remove a melanoma is the most common treatment, and at this early stage, this is usually the only treatment that's needed with the chances of being cured being high.

PMG CHARITY

We have received this information from PMG about a Charity which has been set up in response to patients' wishes to donate money to the Practice, enabling various medical equipment to be purchased for the benefit of all PMG patients.

PULBOROUGH MEDICAL LIMITED – Company No 3867447
Directors: Drs Tim Fooks and David Pullan, Mr. Alan Bolt

CHARITY'S OBJECTS

The relief of sickness and infirmity through the provision of Medical and Diagnostics, screening and treatment for disabled or sick persons within West Sussex.

This registered Charitable fund is administered by Dr Fooks, Dr Pullan and Alan Bolt; who are responsible for discussing and agreeing expenditure of any funds. Any proposed expenditure is referred to a full Partners Meeting for agreement. The main criteria for any expenditure is for the benefit of patients of the Practice, and we therefore try to ensure that any equipment purchased provides maximum benefit to the most number of patients.

All donations from patients are gratefully received, and we will ensure maximum benefit by taking full advantage of Gift Aid and VAT relief on any purchases. If you wish to make a donation, cheques should be made payable to Pulborough Medical Ltd, or please contact Alan Bolt, Managing Partner.

To date we have received over £31,150.00 in donations and have made the following purchases (see explanation overleaf):

PURCHASES:

Hyfrecator	Jun-11	2,524.80
Various dermatological equipment	Jul-11	2,106.67
Doppler machine	Oct-12	2,300.00
Micro spirometer	Nov-12	1,127.85
Anapulse 300 handheld pulse	Dec-12	162.50
Spirometry equipment (spida upgrade to SPCS)	May-13	169.95
Air conditioning – waiting room/ Reception/minor ops suite	Dec-14	9,711.60
Portable SPO2 patient monitoring system	Jan-15	1,100.00
TOTAL		**19,203.37**

Hyefrector – used to destroy tissue (ie mole removal)

Doppler – an ultrasound test reflecting sound waves to see how blood flows through blood vessels

Anapulse – finger pulse oximeter (amount of oxygen in the blood)

Spirometer – used to detect lung conditions

SPO2 – measures the concentration of oxygen in the blood

PMG Update January 2015

Staff – there have been quite a few changes to clinical and administration staff at the Practice since the last newsletter.

First of all, as we're sure you all know, Dr Peter Hard retired at the end of December 2014; he will be a great loss to PMG, but we are delighted that Dr Nikki Tooley (who joined PMG in January 2014) has taken his place as our new GP Partner. To replace Dr Tooley as a salaried GP, we welcome Dr Eloise Scahill who started in post at the beginning of this year. We also

said goodbye to Dr Amelia Bolgar who is taking up a GP Partner post nearer to her home; we are currently advertising for a salaried GP to take over her sessions at the Practice. Dr Carole Campbell has now completed her maternity leave and re-joined the team in February.

Other staff changes involve our nursing, health care assistant and phlebotomy as well as reception teams – Petula Mitchell HCA, has been replaced by Carole Santillo (who used to be our phlebotomist) and Clare Tommans-Porter has joined the team as our new phlebotomist. We have a new practice nurse – Jemma Davenport, who is working 4 days a week. New receptionists who have taken up their posts are Renate Hutchings, Sally Dixon and Anita Walder.

Clinical Services

In the last Newsletter we explained a bit about the new Admission Avoidance Designated Enhanced Service (*helping to keep patients out of hospital);* we now have a register of patients with Care Plans, for whom we hope to reduce the number of avoidable admissions or A&E attendances.

These patients and their care plans will be reviewed on a regular basis, and any admissions/A&E attendances will be assessed to see if there is any further support which could be put in place to prevent this occurring in the future.

We have also been writing to our older patients as part of a 'named, accountable GP for people aged 75 and over' programme instigated by NHS England. As part of a commitment to more personalised care for patients with long-term conditions, all patients aged 75 and over will have a named, accountable GP with overall responsibility for their care.

In October we held our usual flu clinics, ably assisted by members of the PPL Committee. We also gave Shingles

vaccination to those patients falling within the target group identified by NHS England.
We will continue to send out letters to those who have not been in the category for immunisation before, but we are considering alternative methods for notifying those who are already part of our annual flu vaccination programme. We must ensure we are finding the right balance between the cost of sending letters each year to every eligible patient and making sure those who are entitled are reminded of these clinics. We have no separate budget for 'advertising' the flu clinics; as part of an overall programme we regularly review Practice expenditure and we are assessing alternative means of informing patients about these clinics. We will publicise the clinics widely in the Surgery, on our website and through other means, including through the PPL.

All of you will have seen in the news over Christmas and the New Year that our hospitals were at capacity; West Sussex Hospitals were not the only ones involved, and this picture was reflected across the country. Coastal West Sussex Clinical Commissioning Group asked Primary Care providers if they could help alleviate some of these pressures by opening on Saturday morning and we are very pleased that PMG was able to respond to this urgent request.
Of course, this clinic on a Saturday morning was in direct response to a request from Secondary Care and in particular the A&E Departments at St Richards and Worthing Hospitals. All patients were triaged – the usual Out of Hours procedures were followed by patients contacting NHS 111; they were then processed appropriately by the Out of Hours service and those who needed to be seen by a doctor were then booked to see a GP.
Finally, we are pleased to be able to announce the return on 1st April of Travel Clinics (further detail available on the website). If you are planning to visit some of the more unusual parts of the globe it is likely that immunisation of some sort will be advisable or even essential.

The Foreign Office website gives information on requirements for various countries and you can then book for those travelling to receive (sometimes with a charge) the relevant protection.

Taking Part in Clinical Research

Ian Gray of the National Institute for Health Research (NIHR) tells us something of the Institute's work and how PMG is helping.

'Over recent years the Pulborough Practice has been involved with many clinical research studies, sponsored either by universities or pharmaceutical companies.

Recently the Practice has been asking patients newly diagnosed with atrial fibrillation to consider taking part in the GARFIELD-AF study. This is a global study which plans to collect data on over 30,000 patients, with the aim of improving treatment in the longer term.

The Practice is also taking part in the Child Parent Screening Study (CPSS). This study is seeking to take blood samples from 10,000 children in the UK to examine their DNA to determine if they have familial hypercholesterolemia (FH is not caused by an unhealthy lifestyle, but is passed from generation to generation by a 'faulty' or 'altered' gene.).

The local Clinical Research Network (CRN) has a continually evolving portfolio of studies available to patients and practices. For example, studies looking at:

early arthritis, hypertension, modifications to asthma treatment or bowel screening

are currently open to new patients and practices.

Please contact staff at the Practice for more information.'

pulborough patient link

- your voice in local health

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