CONTACT

KEEPING YOU UP TO DATE THROUGH THE PATIENTS PARTICIPATION GROUP

PRACTICE NEWS

Issue 75

PRACTICE NEWS

Welcome to the latest edition of Contact.

Practice Staff
A warm welcome to our recently arrived registrars, Dr Hema Venkatakrishnan, Dr Kumar Loganathan, Dr Ben Wilson and Dr Eleanor Rowlands, and a big thank you to Drs Wake, Hussain and Houlihan during their rotation here.

Sadly, two of our nurses, Annie Drake and Helen Burkimsher, have left for pastures new and one of our Reception team, Trudy Earl, has also left after relocating to the coast.

However, we are pleased to welcome Tracey Martin to our Nursing team and Maryanne Mills who has joined in Reception. We hope to announce the appointment of a new nurse very shortly.

Electronic Prescribing Service (EPS)
We have recently gone live on EPS. You can now nominate a specific pharmacy to receive your prescription electronically, once your GP has approved your request (subject to a few restrictions). We recommend the service as it reduces paper usage, is more efficient for your doctor, gets to your pharmacy quicker, and saves visiting the surgery to collect the prescription.

The next stage is for us to approve your repeat prescription for more than one month, which will enable your nominated pharmacy to issue your repeat medication without having to request authorisation from us each time. We will start using this approach during September on a few patients and expand on over the coming months.

If you think EPS would be beneficial to you, please ask either Reception or your Pharmacy for more details.

Flu Vaccinations
The Flu vaccination season is almost back upon us, and our plans for this year are:

Appointments available from 24th September for 5 weeks – **bookable from** 1st September, as follows:

Tuesday	Mornings
Wednesday	Afternoons
Thursday	Mornings
Saturday	Mornings (07:45 to 10:45)

REMEMBER IT TAKES 6 WEEKS TO BECOME EFFECTIVE – SO BOOK EARLY

The criteria for eligibility is little changed from last year, so if you suffer from:

Chronic Heart Disease (CHD)	Chronic Renal Disease
Chronic Respiratory Disease (or asthma with regular inhalers)	Chronic Liver Disease
Chronic Neurological Disease	Immunosuppression
Diabetes Mellitus	

If you fall into one of the four categories below:

Are aged over 65	Receive carer's allowance
Reside in a long stay residential care home or other facility	Care for an elderly or disabled person whose welfare may be at risk if you fall ill

Or, if you are Pregnant - Then make an appointment to have your jab as soon as possible.

Please note on Saturday 13th October nearly all our GPs will be present to administer flu vaccinations. Appointments will be required, but there will be plenty of availability.

Emailing invitations to attend for review

Those of you with a chronic disease will be aware that we write to you each year inviting you to attend your annual review. We have recently changed the system to enable us to email that invitation to you, where we hold an email address. The obvious benefits are the speed of communication and the reduction in postage costs to the surgery. We hope you will benefit from this change, so please confirm your email address with our Nursing team on your next visit.

Virtual Patient Participation Group

You can still register for the above by visiting our website, following the link and providing your email address. You will then receive a copy of the monthly minutes and other ad-hoc reports throughout the year.

Finally…..

It is with regret that I advise I am leaving the surgery in early October. I have enjoyed my time here and thank all the Doctors, Nurses, Reception and Administration staff for their support as we have strived over the past three years to deliver a first class service. I would also like to thank the PPG for the support and direction they have given me during my time here.

The Partners are currently recruiting a replacement and are planning to be able to make an announcement in mid-September.

Paul Butterworth
PRACTICE MANAGER

Dermatitis

The term ***dermatitis*** is a generic term that embodies several skin conditions, such as seborrhoeic dermatitis, eczema, irritant contact dermatitis, allergic contact dermatitis. It is important to understand the differences.

Seborrhoeic dermatitis – common harmless scaling rash affecting anywhere where the skin is oily (can look like dandruff). It is common in the eyebrows, edges of the eyelids, inside and behind the ears, in the creases around the nose and sometimes in the hairline. It can also involve the armpits and groins. It may be itchy and the appearance and discomfort can vary from day to day.

It is caused by an inflammatory reaction to a yeast that is a normal skin inhabitant called Malassezia.

Treatment is generally regular use of topical antifungal agents and intermittent use of topical steroids. For more persistent or severe episodes, the antifungal agent may need to be taken in tablet form.

In the UK, we understand the term dermatitis to mean either, irritant contact dermatitis or allergic contact dermatitis – so we will look at these two forms.

Eczema is a very broad subject in its own right and will not be covered in this article but if eczema is of interest to you then please visit the National Eczema Society website for clear accurate evidenced based information on the many forms of eczema and its management at – http://www.eczema.org/factsheets.html.

Irritant Contact dermatitis
This occurs when the skin is exposed to chemicals, or physical agents that irritate the surface of the skin causing it to become damaged (red and sore), the damage occurs faster than the skin can repair itself.
The severity varies on a number of factors:

- The amount and strength of the irritant
- Length and frequency of exposure
- Whether the skin involved is thick, thin, oily, dry, very fair, previously damaged or if pre-existing eczema is present
- Environmental elements such as high or low temperature/humidity

What are irritants?
Everyday things – water, detergents (soaps/hand washes etc.), solvents (nail polish remover, acetone, carbolic acid), acids (being or having properties of an acid), alkalis (saliva), adhesives, metalworking fluids - (straight oils, soluble oils,

semi-synthetic and synthetic oils), friction (triggered by repeated rubbing). Several of these may act together to injure the skin.

What happens to cause the skin to become sore?
The natural oils and water in our skin which help to act as a skin barrier are removed by the irritant from the outer layer of the skin – this in turn removes the protection that is provided by these natural oils and water, allowing the irritants to absorb into the skin and penetrate more deeply, causing further damage and inflammation.

People with eczema are more prone to developing irritant contact dermatitis. About 80% of occupational hand dermatitis is due to irritants often affecting cleaners, hairdressers, food handlers, healthcare workers and workers in industry.

It is usually confined to the site of contact initially, but if prolonged or severe, may spread to previously unaffected areas – but less likely than with *Allergic Contact Dermatitis*.

Signs and symptoms:
Accidental exposure to a strong irritant may cause an immediate reaction such as pain, swelling and blistering whereas contact with mild irritants may over a period of time cause dryness which triggers itching, scratching and cracking of the skin resulting in weeping, crusts and scales.

Tests:
No reliable, specific tests can predict the effect of a particular irritant, and Irritant Dermatitis is usually the result of the cumulative effect of multiple irritants.

Treatment:
Emollient (medical term for moisturiser) creams/ointments
Topical steroids to calm the inflammation
Antibiotics, if the skin is broken and infection is suspected
If you suspect a particular irritant – avoid where possible or use protective clothing.

Allergic contact dermatitis:
This is a different type of dermatitis from *irritant contact dermatitis*. It is caused by an allergic reaction to 'material' in contact with the skin. Allergy is a reaction to a substance known as an allergen which is harmless to those who are not allergic to it. Only small quantities of an allergen are required to trigger a reaction.
Allergic contact dermatitis, also referred to as a delayed-type IV allergic response (Gell P.G.H., Coombs R.R.A., 1963) as opposed to a Type I, which can trigger anaphylaxis (causing swelling of the lips, tongue and throat – a very severe allergic reaction from for example penicillin, nuts, bee stings, latex etc., can trigger a type I response).

In allergic contact dermatitis, the first contact does not result in allergy – often the individual has been in contact with the 'material' on the skin (rather than an internal source or food) for many years without an adverse reaction, hence the term *'delayed-type IV allergic reaction'*.

It is generally confined to the site of contact with the allergen but like irritant dermatitis, severe cases may extend outside the contact area or become generalised if untreated. In allergic contact dermatitis the allergen may be transferred from one site to another by the fingers (nail varnish, perfume) and transferred to say the eyelids, lips, genitals etc.

We touch our faces 16 times per hour, or once every 3 minutes - so it is easy to see how the reaction may affect different sites.

There are many sources of allergens in our daily lives such as: -
Plants (Giant Hogweed, Japanese Lacquer Tree, Poison Ivy and Sumach, all cause severe skin/eye irritancy). Some types of Lily, Chrysanthemum, Daphne, Fig, Iris and Hedera are also common allergens. UV light, nickel, preservatives, fragrances, rubber (latex), dyes (hair colourants and henna), adhesives, topical medications, such as antibiotics, are other allergen groups to consider.

Signs and symptoms:
Redness, swelling, blistering, or dry and bumpy skin. Eczema like in its appearance

Tests:
Sometimes it is easy to recognise the allergen – so no tests are necessary. The rash usually (but not always) completely clears up if the allergen is no longer contacts with the skin, but will recur with the slightest contact with it in the future.

Open testing – i.e. applying the suspected allergen repeatedly to a sensitive site – several times a day, for several days, to a less visible area to avoid any further distress.

Patch testing - depending on frequency and severity. Your local dermatology department will do this (referral necessary). The dermatologist will then decide if prick testing or RAST blood tests are necessary, depending on the trigger allergen.

Treatment:

- Recognise how you are in contact with the allergen and avoid where possible
- Patch tests may be advised by your doctor
- Identify where the allergen is found
- Examine your environment – "cross reactions' can occur with contact to similar chemicals with different names
- Use of emollient (moisturiser) cream/ointment
- Topical steroids to reduce inflammation
- Topical or oral antibiotics for secondary infection
- Oral steroids – usually a short course for severe cases
- Photochemotherapy (light treatment with a drug)
- Immunosuppressive drugs – Azathioprine, ciclosporin, topical Tacrolimus or pimecrolimus creams.

I hope you have found this information useful. Please contact your Practice Nurse, or GP, if you have any further queries.

Declaration: I am employed by Galderma UK and have written this article in my capacity as Dermatology Nurse Specialist within my clinical role at Ipswich Hospital NHS Trust.

Anna Bianconi-Moore

PATIENT SURVEY

You may have noticed that members of the PPG now administer the monthly Patient Survey, formerly carried out by the Doctors. This has freed up more of their time to deal with patients.

This survey invites you to comment on how you are treated by all members of staff, whether they are Doctors, Nurses, Receptionists or any other. The frequency of a monthly survey then allows a small tweak here and there where improvements may be made. If are not registered with the Practice and only come in for a blood test, or use its facilities, (e.g. Yellow Fever Clinic), you may also like to comment on how you found the service you received.

So far, the Practice has had very favourable feedback and 91% of people would definitely recommend the Practice to anyone thinking of changing Doctors. A number of small items have been identified, and these have been attended to immediately, while others are being closely monitored. The survey is completely anonymous and other than sex and age no personal details are requested, but remember you are free to make as much comment as you like and even request a telephone call back if you have a particular problem with any aspect of the service that the Practice provides. Remember that all Practices can opt out of providing any service for whatever reason they deem fit.

Fortunately this Practice does not take any of these options lightly and provides more services that some others.

The PPG is a forum for you, the Patient, to have your say and we currently have vacancies on the Committee for a Fundraiser, Secretary and General Member. All that is required is attendance at nine meetings out of twelve on the first Monday of the month from 2 – 3 p.m.

This item is written with the support of the Practice, and is strictly impartial.

Brian Johnson
Vice Chairman PPG

Contact is a service of, and is published by
King Edward Road Surgery Patients Participation Group
King Edward Road
Northampton NN1 5LY