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Lisinopril: the only once-daily ACE-inhibitor
indicated for hypertension, congestive heart failure
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of experience

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• Lisinopril is on over 75% of hospital
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PRESCRIBING INFORMATION
Consult Data Sheet before prescribing.

ZESTRIL
USE: All grades of essential hypertension and renovascular hypertension.
Congestive heart failure (adjunctive therapy). Acute myocardial infarction in
haemodynamically stable patients (in addition to standard coronary care).
PRESENTATION: Tablets containing 2.5mg, 5mg, 10mg or 20mg lisinopril.

DOSE AND ADMINISTRATION: Hypertension Adults (incl. elderly): initially 2.5mg daily, a 2.5mg dose without a therapeutic response; adjust dose according to response. Maintenance usually 10-20mg once daily. Maximum is 40mg daily.

Diabetic-treated patients - if possible stop diuretic 2-3 days before starting ‘Zestril’. Resume diuretic later if desired.

Congestive heart failure Adults: initially 2.5mg daily under close medical supervision (hospital initiation for severe or unstable heart failure and other patients at higher risk), increasing to 5-20mg once daily according to response. Monitor blood pressure and renal function.

Acute myocardial infarction Treatment may be started within 24 hours of symptoms. First dose is 5mg, followed by 5mg after 4 hours, 10mg after 8 hours and then 10mg once daily. Dosing should continue for six weeks. Lower dosage in patients with low systolic blood pressure (120mmHg or less) - see Data Sheet.

Renal impairment - may require lower maintenance dose. ‘Zestril’ is dialysable.

Children - not recommended.

CONTRA-INDICATIONS: Pregnancy. Hypersensitivity to Zestril. Patients with history of angioedema or previous ACE-inhibitor therapy. Patients with acute aortic stenosis, coarctation or outflow tract obstruction.

PRECAUTIONS: Assessment of renal function is recommended. Symptomatic hypotension may occur, particularly in volume depleted patients and congestive heart failure. Caution in patients with ischaemic heart or cerebrovascular disease; renal insufficiency; renovascular hypertension. Patients with a history of angioedema may be at increased risk of angioedema with an ACE inhibitor. Acute myocardial infarction patients with evidence of renal dysfunction or at risk of serious haemodynamic deterioration - see Data Sheet. Cough has been reported with ACE inhibitors. Renal impairment (vasodilators resistant) may occur in some patients. Hypertension may occur during surgery or anaesthesia. Caution in nursing mothers. No paediatric experience. Afro-Caribbean patients may show reduced therapeutic response. Symptomatic hypotension can be minimised by discontinuing diuretic prior to ‘Zestril’. Interaction with indomethacin and lithium. Potassium supplements, potassium sparing diuretics and potassium containing salt substitutes not recommended. Avoid concomitant use with high-flux dialysis membranes.

SIDE EFFECTS: Hypotension, dizziness, headache, diarrhoea, cough, nausea, fatigue. Loss frequency, rash, asthma. Rare: angioedema, eczema and other angioedema-like reactions, myocardial infarction or cerebrovascular accidents.可行性 to excessive hypotension in high-risk patients, palpitations, tachycardia, abdominal pain, dry mouth, pancreatitis, hepatitis, jaundice, mood alterations, mental confusion, paraesthesia, bronchospasm, diplopia, urticaria, diaphoresis, pruritus, urinaemia, oliguria/anuria, renal dysfunction, acute renal failure, impotence, haemolytic anaemia. A symptom complex which may include fever, tachycardia, rash, arthralgia/myalgia, positive ANA, decreased ESR, eosinophilia, leukocytosis, rash, photosensitivity or other dermatological manifestations may occur. Increases (usually reversible) in blood urea, serum creatinine, liver enzymes and serum bilirubin. Decreases in haemoglobin and haematocrit, Hyperkalaemia and hypokalaemia.

Anaphylactoid reactions during desensitisation treatment. Leucopenia and thrombocytopenia have occurred (causal relationship not established).

LEGAL CATEGORY: POM

PRODUCT Licence NUMBERS AND BASIC NHS COSTS: Zestril 2.5mg (126/190/008) 28 tablets £1.64; 5mg (126/190/005) 28 tablets. £3.58; 10mg (126/190/007) 28 tablets. £11.65; 20mg (126/190/007) 28 tablets. £11.38.

‘Zestril’ is a trademark, the property of ZENeca Limited.

Further information is available from: ZENeca Pharmaceuticals, King’s Court, Water Lane, Winslow, Buckinghamshire HP14 4AZ.

95-106H Issued Sept ‘95

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Information Management Group
CANCER SERVICES: FROM CALMAN TO THE MILLENIUM
9 ~ 10 May 1996, Birmingham International Convention Centre

- What progress has been made towards the implementation of the April 1995 Calman Report on Cancer Services?
- What are the barriers to implementation?
- How far are we from ensuring that all cancer patients receive a uniformly high standard of care?
- Cancer research within the NHS - can the cost be met?
- How may we build upon the policy framework of the Calman Report in the future?

These questions will be addressed at this two-day conference on the state of cancer services in Britain, initiated by the NHS Executive, West Midlands, and of nationwide significance. There will be ample time for discussion of these issues between presentations.


Thursday 9 May

3.30 Welcome address
Barnes Cumberlege, Parliamentary Under Secretary of State for Health

CHALLENGES PRESENTED BY THE CALMAN REPORT

9.40 Chair’s introduction
Professor Peter Selby, Leeds

9.50 Regional, and local, variations in cancer survival
Professor Rod Griffiths, Director of Public Health, NHS Executive, West Midlands

10.10 Implementing the Report over the last 12 months:
1. Report from the West Midlands
Professor Brian Edwards, until recently, Regional Director, NHS Executive, West Midlands

10.30 2. Report from the North West
Dr Brian Cottier, Chief Executive, Clatterbridge Hospital, Wirral

11.35 New initiatives in the USA
Dr Bernard Saliek, Chief Executive, Salick Healthcare

12.10 Health economics and rationing issues
Professor Charles Normand, London School of Tropical Medicine and Hygiene

12.35 Is the Calman Report the best framework? How do we measure its success?
Professor David Hunter, Leeds

1.00 Lunch

CANCER RESEARCH IN THE NHS - CAN THE COST BE MET?

2.15 Chair’s introduction
Professor Karol Sikora, Hammersmith Hospital, London

2.20 The value of randomised clinical trials
Professor James Cassidy, Aberdeen

2.45 Cancer research in the NHS: a priority for funding
Professor John Smyth, Edinburgh

3.15 The pharmaceutical industry/NHS interface
Dr John Patterson, Zeneca Pharmaceuticals

4.15 ‘Translational’ research
Sir Walter Bodmer, Director, General, ICRF

4.35 Innovative cancer treatments
Professor David Kerr, Birmingham

5.00 Innovative approaches in cancer surgery
Mr John Fielding, Birmingham

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Friday 10 May

CANCER SERVICES NOW - ARE THESE WHAT THE PATIENT WANTS?

9.00 Chair’s introduction
Rebecca Miles, Regional Cancer Services Adviser, NHS Executive, West Midlands

9.10 How do we empower patients to make choices?
John Spiers, The Patients’ Association

9.25 Psychiatric morbidity
Dr Penelope Hopwood, Manchester

9.40 Psychosocial impact in the community: palliative care
Dr Irene Haggison, London School of Tropical Medicine and Hygiene

10.00 The media: help or hindrance?
Jane Stephenson, Series editor, “The Pulse”, Channel 4

10.15 What do quality of life measures show?
Dr Anne Cull, Edinburgh

11.25 What patients want
Sue Bell, National Cancer Alliance, co-presenting with a cancer patient

11.40 Integrated clinical records and patient access
Dr Mark Drury, GP, Oxfordshire

11.55 Involving patients’ preferences more in clinical trials
Dr Jane Maher, Mount Vernon

12.10 New ways of informing and involving patients
Robert Cann, Director, Help for Health Trust

12.50 Lunch

CANCER SERVICES: WHICH WAY FORWARD?

2.00 Chair’s introduction
Professors Rod Griffiths and Brian Edwards

2.05 The national perspective for cancer services
Sir Kenneth Calman, Chief Medical Officer

2.25 The Health Authorities’ view
Speaker TBA

2.45 The cancer registries in the future
Professor Ciaran Woodman, Manchester

3.00 Which way forward? A GP’s perspective
Professor Richard Hobbs, Birmingham

4.05 Providers of cancer services
Timothy Matthews, Chief Executive, Guy’s and St Thomas’ Hospital, London

4.25 Nursing cancer patients
Dr Jessica Corner, Royal Marsden Hospital, London

4.45 Cancer guidance for purchasers – the work of the cancer subgroup of the Clinical Outcomes Group
Professor Bob Haward, Leeds

5.00 A vision for the future of cancer services
Professor Karol Sikora, Hammersmith Hospital, London

5.30 Summary and close

* PGEA accreditation applied for

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The Royal Over-Seas League provides the ideal club for internationally minded men and women. It has a long history of welcoming writers, diplomats, business people and travellers from around the world to its London and Edinburgh clubhouses and providing international support networks through branches, reciprocal club arrangements and honorary representatives.

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Royal Over-Seas League
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Better Writing Workshops are led by Susan Kerr, BA, author, freelance health writer and qualified adult teacher, and by Dr Richard Maxwell, MA FRCGP, a published practising GP with an interest in communication skills.

Application closing date for the next 1996 workshop:
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Further information, dates and venues from: Dr Richard Maxwell, Lodgeside Surgery, 22 Lodgeside Avenue, Kingswood, Bristol BS15 1NH.
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Next Entry October 1996.

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BEST PRACTICE FOR GP FUNDHOLDERS

The NHS Executive has just published this guidance document, which is intended to help GP Fundholding practices make sure that they are in full control of their information and systems. The guidance document was prepared by the Leeds FHSA Internal Audit department; the department is actually based at St James's and Seacroft University Hospitals Trust and provides internal audit services to the FHSA on an agency basis.

The guidance provides detailed procedural guidelines for fundholding practices to assist them in imposing an effective control, monitoring and reporting environment. It summarises some mandatory procedures, but much of it is advice on best practice which is offered to GP Fundholders as a tool to help them to manage their affairs. The guidance is split into several chapters, each of which provides detailed guidance on a discrete area of Fundholding.

The guidance is based on the authors' extensive experience of auditing GP Fundholders, and on comments made by internal and external auditors around the country. Several GP Fundholders in the Leeds FHSA area also made a valuable input into the guidance.

In summary, this best practice guide is designed to provide practice, effective and useable advice to GP fundholding practices, and has been developed wholly within the NHS by people with a detailed understanding of, if not a direct day to day involvement in, fundholding.

Copies are available free of charge from: Department of Health Mailings, c/o TwoTen Communications, PO Box 410, WETHERBY, West Yorkshire, LS23 7LN. Fax 01937 845381.
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Dosage and administration: Initial dosage should be one 0.2mg tablet twice daily. This dose may be increased by increments of 0.2 – 0.4mg per day up to a maximum of 2.4mg (12 tablets) per day, according to the patient’s response. In cases where no opiate use occurs during detoxification a duration of treatment of 7-10 days is recommended. In some cases a longer treatment period may be warranted. At the end of treatment dosage should be reduced gradually over a period of at least 2-4 days (see under Precautions).
Contra-indications, warnings, etc.: Contra-indications: Lofexidine is contra-indicated in cases of sensitivity to other Imidazoline derivatives. Interactions: Lofexidine may enhance the CNS depressive effects of alcohol, barbiturates and other sedatives, although concurrent medication to aid sleeping has frequently been used in withdrawal studies. Concomitant use of tricyclic antidepressants may reduce the efficacy of lofexidine. Pregnancy: The safety of lofexidine in pregnant women has not been established and it should only be administered during pregnancy if the benefit outweighs the potential risk to mother and foetus. It is not known whether lofexidine is excreted in human milk and caution should be exercised when it is administered to nursing mothers.
Precautions: Lofexidine may have a mild sedative effect. If affected, patients should be advised not to drive or operate machinery. Lofexidine does not normally produce any clinically significant effects on blood pressure, but since lofexidine possesses mild hypotensive properties it should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure. Lofexidine should not be discontinued abruptly, but withdrawn gradually over 2-4 days, or longer, to minimise any risk of blood pressure elevation and associated signs and symptoms. It should also be used with caution in patients with marked bradycardia (55 beats per minute); pulse rate should be assessed frequently. Patients with a history of depression should be carefully observed during long term therapy with lofexidine.
Side-effects: The side-effects of lofexidine are primarily related to its central alpha-adrenergic effects and comprise drowsiness and related symptoms and dryness of mucus membranes especially mouth, throat and nose. Hypotension and bradycardia may occur. Treatment of Overdosage: Overdosage may cause hypotension, bradycardia, sedation and coma. Gastric lavage should be carried out where appropriate. In most cases all that is required are general supportive measures.
Pharmaceutical Precautions: Protect from heat, moisture and light.
Legal category: POM.
Package Quantities: 60 tablets.
Further Information: Nil.
Basic NHS Cost: 60 tablets £77.95.
Product Licence Number: 4483/0036.
Date of Last Revision: January 1996
Don’t forget the convenience of FELDENE MELT

Feldene MELT

MELTS IN THE MOUTH FOR POWER IN THE JOINTS

PRESCRIBING INFORMATION FOR FELDENE MELT® (PIROXICAM): UK. Indications: Adults: Rheumatoid arthritis, osteoarthritis, ankylosing spondylitis, acute gout and acute musculoskeletal disorders. Elderly: As with other NSAIDs, elderly patients should be closely supervised. Children: FELDENE MELT is not recommended in children. For treatment of juvenile chronic arthritis (Still’s disease) please see oral data sheet. Dosage: Rheumatoid arthritis, osteoarthritis and ankylosing spondylitis - normal starting and maintenance dosage 20mg once daily. Long-term use of 30mg daily or more carries an increased risk of gastro-intestinal side-effects. Acute gout - 40mg daily in single or divided doses for up to 7 days. Acute musculoskeletal disorders - 40mg daily, in single or divided doses, for the first 2 days, 20mg daily for the remainder of the 7 to 14 days’ treatment. Contra-indications: Active peptic ulceration or history of recurrent ulceration. Hypersensitivity to FELDENE, aspirin or other NSAIDs. Warnings: Pregnancy, lactation.

Precautions: Significant renal, hepatic or cardiac insufficiency. Patients with phenylketonuria - each FELDENE MELT tablet contains 0.14mg phenylalanine. Drug Interactions: Monitor patients on concurrent anticoagulants, lithium or diuretic therapy. Concurrent use of aspirin or other NSAIDs is not advised. Side-Effects: Gastro-intestinal symptoms: if peptic ulceration or gastro-intestinal bleeding occurs withdraw FELDENE. Oedema, mainly ankle. Skin rashes. CNS effects, including headaches and dizziness. Rare cases of renal and hepatic abnormalities have been reported. Haematological reactions including thrombocytopenia and anaemia and hypersensitivity reactions such as bronchospasm and angioedema have been reported very rarely. Legal Category: POM. Package Quantities and Basic NHS Cost: FELDENE MELT tablets 20mg, pack of 28, £9.83 (PL 0057/0052). Further information on request Pfizer Limited, Sandwich, Kent.

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