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Hearing loss and dementia

Iliffe and Manthorpe's editorial in the August issue¹ is apposite in view of the publication in July of the Lancet Commissions' report *Dementia prevention, intervention, and care*, which expands on several of the themes raised.² In particular, the editorial's focus on the role of general practice in prevention and research is to be welcomed. However they do not mention hearing loss, to which the *Lancet* report devotes considerable space and ascribes a significant potential preventive role. Hearing loss is independently associated with developing dementia in about one-third of cases.

Recent research has suggested that use of hearing aids may reduce or prevent the increased prevalence of dementia seen in adults with hearing loss.^{3,4} This needs confirmation, as current evidence is weak due to the large number of confounding factors. General practice is ideally suited to carry out this research thanks to our large-scale and long-duration databases. In the meanwhile, GPs are likely to see increasing numbers of patients asking for referral for hearing aids, as some in the commercial sector are stating this benefit of hearing aids as fact. Such referral should be expedited; GPs are sometimes accused of minimising hearing loss and delaying referral, but early users of hearing aids are more likely to use aids successfully over a longer timescale as they can be difficult to use. Hearing loss is associated with depression and social isolation;⁵ denial of the disability is common, as is irritability and interference with relationships. By the age of 70 years, 70% of GP patients have hearing loss. If in doubt, or if the patient is reluctant, a simple validated screening test is available over the phone or online.⁶

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Competing interests

Ted Leverton has hearing loss and undertakes training sessions on hearing loss for health professionals. He is a volunteer at Action on Hearing Loss.

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Adrenaline auto-injector prescribing may be putting patients at risk

Adrenaline auto-injector (AAI) prescribing for children in UK primary care has increased dramatically since 2000.¹ As these young patients grow older, an increasing number of adults will require AAls to mitigate their risk of an anaphylactic reaction.

Current National Institute for Health and Care Excellence (NICE) guidance advises that adults and children aged >12 years should receive 500 µg adrenaline intramuscularly at the onset of suspected anaphylaxis, with doses of 300 µg and 150 µg advised for children aged 6–12 years and <6 years respectively.²

A recent audit of AAI prescribing I undertook while working at a West London surgery found 100% adherence to these doses for patients aged <6 years, but adherence fell to 62% in children aged 6–12 years and to just 3% in patients aged >12 years.

The current lack of a 500 µg AAI in the popular 'EpiPen' range may be a factor in the underdosing of adults at risk of anaphylaxis

(96% of AAls prescribed were from this range). Five-hundred microgram AAls are available as part of the local formulary at a similar price to 'EpiPen' products but appear to be seldom prescribed despite this.

Care should also be taken to ensure that the dose of AAI prescribed is increased appropriately as young patients turn 6 and 12 to avoid the potential for undertreatment of life-threatening anaphylactic reactions.

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Bad Medicine: The medical untouchables

As a named petitioner in the Scottish Parliament public petition cited by Des Spence in this article,¹ I would like to thank Dr Spence wholeheartedly for his support on TV and radio, and now in this journal. I would also like to thank the *BJGP* for publication. We too have been 'banging on about this', (the harm caused by prescription drugs) on behalf of patients, for years. We have become acutely aware of how 'untouchable' the topic is for doctors, and aware of their extreme discomfort when patients try to flag up the issues. GPs, especially, seem to have been placed in an extraordinarily difficult situation altogether by a system that has failed to provide them with the guidance and support that they surely deserve. Perhaps, between us all, we can truly recognise what has gone wrong and start to really communicate collaboratively about what needs to happen now.

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Bad Medicine: The medical untouchables

Thank you Dr Des Spence for having the courage and moral fortitude to speak where thousands of others remain deafeningly silent. I am polydrugged, having been prescribed Ativan (1985), sertraline (2005), and tramadol (2012). The consensus is that I should come off these. I agree, BUT who, pray, will help me with withdrawal? On my medication it says with a view of

reduction, that is, on the Ativan and tramadol — although not once has there been any suggestion as to how. I turned to 'Dr Google' and a helpline in Bristol — one of only two in the UK. It has taken 2 painstaking years to withdraw safely from benzodiazepines.

I am a taxpayer and have been for over 40 years. Why, unlike for illegal substances, is there no help, TLC, or rehab facilities for me and thousands like me? A worker, a mother, a friend. I have no respect for the doctors who are either ignorant about this or wilfully silent. Honesty is needed from the profession in order to restore a semblance of trust.

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A new spin on old methods

I recall my GP trainer sharing with me his preferred distraction techniques to ease the examination of young children, particularly those distressed with intercurrent illness. Over the last 25 years I've added my own methods, the latest of which, an accidental discovery, puts a new spin on clinical examination techniques.¹ Recently, a 5-year-old with distressing otalgia picked up the fidget spinner on my desk and was so engrossed he barely noticed me examine him. I must add that the fidget spinner was a gift, but this experience perhaps gives colleagues an excuse to buy one as a justifiable practice expense. Happy spinning!

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