Letters

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Editor's choice

Child health training: why does the College not act?

What I cannot understand is why our College does not derecognise training schemes that don't provide comprehensive general practice training that provides not only child health (for those without prior experience) but also modules in dermatology, ENT, etc.[1] It seems bizarre that we have CSA checking 'consultation technique' but the fundamental clinical experience may be missing. If we want to raise the 'status and recruitment' of our branch of the profession role and make it fit for purpose. Why has the College not acted?

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Proton pump inhibitors may cause elevation in faecal calprotectin levels

NICE has endorsed the use of faecal calprotectin (FCP) testing to enable clinicians to decide which of their patients presenting with diarrhoea may have inflammatory bowel disease or irritable bowel syndrome with diarrhoea (IBS-D). A normal result should reassure the clinician that their patient probably has IBS-D and this should obviate the need for a colonoscopy.

I work in a community-based gastroenterology service and we are now seeing young patients who are referred to us with symptoms highly suggestive of IBS who also have slight or modestly raised levels of faecal calprotectin. Many of these patients are also taking proton pump inhibitors. A paper with very small patient numbers in 2003 demonstrated that omeprazole[1] caused a modest rise in FCP but since then there has been no confirmatory study.

GPs seem to be aware that non-steroidal anti-inflammatory drugs cause a rise in FCP but the link to proton pump inhibitors is less well known.[2] Most of these patients come to colonoscopy and the findings are almost always normal. In these circumstances and, in the absence of alarm, lower gastrointestinal symptoms, it would be quite reasonable to stop the proton pump inhibitor as long as it is clinically safe to do so. One can then repeat the faecal calprotectin 4 weeks later. A persistently raised FCP merits further investigation. Endoscopy services are currently under severe pressure and it makes sense to avoid colonoscopy in young patients who have a very low risk of significant organic disease.

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Good practice in shared care for inflammatory arthritis

Most patients in our practice have for decades had shared care for blood and prescription monitoring when on DMARDs and when attending their GP when unwell. I suspect, like myself, most GPs have wide experience already with methotrexate, sulfasalazine, and occasionally azathioprine as they are also used in patients with inflammatory bowel disease and occasionally severe psoriasis. The article by Lythgoe and Abraham completely misses up-to-date clinical intelligence regarding DMARDs, which for me revolve around GP education in likely issues for patients on monoclonal antibodies.[1] I wish you had written about this as that is where my educational needs lie — can I have an updated clinical intelligence article about monoclonal antibody shared care?

I would like to share a piece of clinical intelligence: I have always asked patients to remember when to take their methotrexate and folic acid by following the medication's initial letter so Methotrexate on a Monday and Folic acid on a Friday. This seems to stick in the patient's mind and works well.

The authors recommend 5–10-yearly reinforcement of pneumococcal vaccination but I cannot find this in chapter 25 of Public Health England's 'Green Book' on pneumococcal vaccination.[2] Guidance needs to be uniform and if NICE wants pneumococcal vaccination re-administered to patients on, for example, methotrexate then this needs to be reflected in changes to the 'Green Book', which is an excellent career-through guide.

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