Letters

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Breastfeeding and systemic agents for psoriasis

In Tso *et al*'s article, it is stated that females on adalimumab should not breastfeed until at least 5 months after the last treatment, according to the manufacturer's information.[1] However, the majority of manufacturers have recently updated their information and now state that adalimumab can be used during breastfeeding.

The NICE guideline PH11 *Maternal and Child Nutrition*[2] recommends that supplementary sources of information should be consulted regarding the prescribing of drugs to breastfeeding mothers, and that the *BNF* should only be used as a 'guide'.

The *BNF* contains little quantitative data on which to make informed decisions. The Summary of Product Characteristics of the vast majority of drugs recommends that they are not used during lactation. This does not imply risk, more that the manufacturers are not required to take responsibility.[3]

I consulted the UK Drugs in Lactation Advisory Service (UKDILAS — https://www.sps.nhs.uk/articles/ukdilas/) and Lactmed (https://toxnet.nlm.nih.gov/pda/lactmed.htm), both specialist sources of information for prescribing in lactation. Lactmed states:

'Limited information indicates that maternal adalimumab injections produce low levels in breastmilk and do not adversely affect the nursing infant. Because adalimumab is a large protein molecule … absorption is unlikely because it is probably destroyed in the infant's gastrointestinal tract. Most experts feel that the drug is probably safe during nursing. However, until more data become available, adalimumab should be used with caution while nursing a newborn or preterm infant.'

Although there is no published information on the use of secukinumab during breastfeeding, as it is a large protein molecule, the amount in milk is likely to be very low. Absorption is unlikely as it is probably destroyed in the infant's gastrointestinal tract. As for adalimumab, until more data become available, secukinumab should be used with caution during breastfeeding, especially while nursing a newborn or preterm infant.

UKDILAS concludes that the benefits of breastfeeding on adalimumab and secukinumab outweigh the risks.

As breastfeeding is of proven benefit to both mother and baby, withholding breastfeeding should not be considered a 'no-harm' option. It is important that breastfeeding mothers are given informed choice with access to balanced information.

Sarah Little,

GP, Dedridge Medical Group, Livingston. Email: sarahealittle@hotmail.com

Sarah Fenner,

West Midlands Medicines Information Service & UK Drugs in Lactation Advisory Service.

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Genetic cancer risk assessment in general practice: systematic review of tools available, clinician attitudes, and patient outcomes

The systematic review by Laforest *et al* is a timely addition to understand the challenges that expanding genetic risk assessment and into primary care pose.[1] This is especially opportune given its online publication in the same week that the Secretary of State Matt Hancock announced the plan for the NHS to offer genomic testing to healthy individuals for a fee.[2]

Direct-to-consumer genetic testing is already available. Companies such as 23andme (https://www.23andme.com/en-gb/dna-health-ancestry/#all-reports-list) will give you a 'genetic health risk' including the cancer risk genes (BRCA1 and 2), Alzheimer's dementia (APOE variant), as well as several other later-onset conditions and carrier status for in excess of 40 recessive conditions. Such testing currently has significant limitations, increasing health anxiety for some and falsely reassuring others.[3] Such tests include substantial disclaimers, advice to discuss findings with healthcare professionals, and having confirmatory testing before taking action on any findings.

The NHS is also 'mainstreaming' genomic technologies for its patients, with the adoption of genetic testing outside of its traditional domain, clinical genetic departments. This change requires increased genomic literacy — discussing risks, interpreting results, and managing uncertainty — across a range of healthcare professionals including GPs.

The review by Laforest *et al* highlights the lack of knowledge and confidence that GPs have in one of these key areas, cancer genetics.[1] They highlight the uncertainties and inconsistencies in how one should approach such patients and the lack of capacity in primary care to take on such a role. With the NHS now endorsing such direct-to-consumer testing, patients will undoubtedly wish and expect to be able to discuss findings with their GPs, who currently are inadequately prepared and resourced to do such a job.

How one should approach such a challenge is unclear. There is certainly a need for greater genomics education for the primary care team. It may also require a restructuring or expansion of the clinical genetics services, even a role for primary care-based genetic services.[4] Greater clarity of appropriate referral pathways and respective responsibilities will also be critical to ensure that appropriate advice is given and resources are used optimally.

This review highlights some of the issues that will need to be overcome to fully