BHIVA
British HIV Association

BASHH

Dr Laura Waters

Mortimer Market Centre, London

Fourth Joint Conference *of the* **British HIV Association** *with the* **British Association for Sexual Health and HIV**
Edinburgh International Conference Centre • 17–20 April 2018

Advances in general medicine for 2018

Laura Waters
Consultant Physician
CNWL, Mortimer Market Centre, London

Disclosures

- Conference support, speaker/advisory fees from Gilead, ViiV, Janssen & MSD
- Investigator on Gilead & Janssen trials

Content

- Chronic pain & opioids
- Hypertension goals
- Mystery topic

Content

- **Chronic pain & opioids**
- Hypertension goals
- Mystery topic

Apology

- Some focus will be on NICE guidelines therefore Anglocentric

CHRONIC PAIN/OPIOIDS

The WHO analgesic ladder

"Our mistake is to treat chronic pain as if it were acute or end of life pain"

Ballantyne JC. BMJ 2016; 352

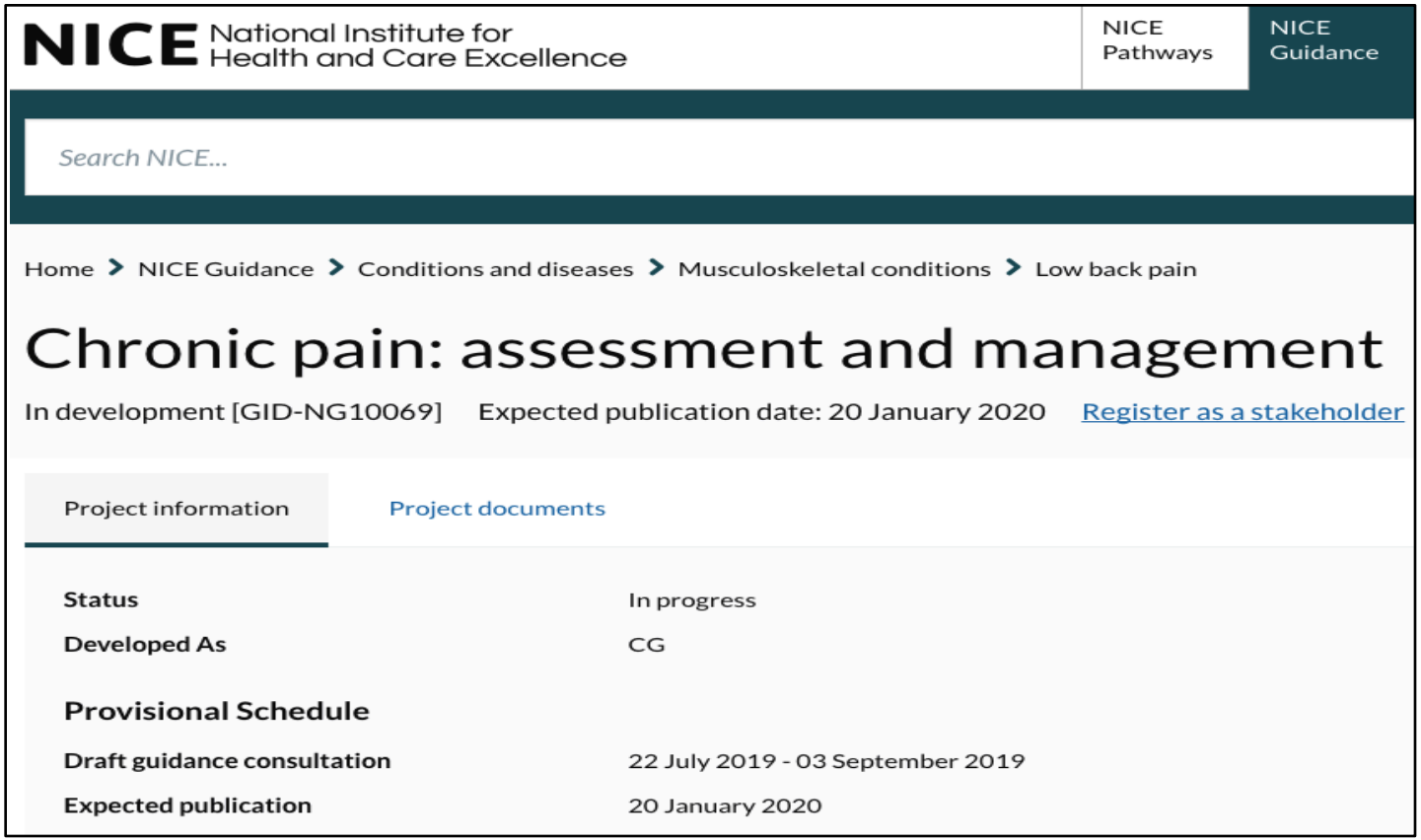
Collated from a surprisingly varied bunch of examples on Google Images 13th April 2018

Background

- Chronic pain common & difficult to manage
  - 48% with chronic pain have depression
- Epidemic of opioid-related harm in USA; in 2015 among US civilian non-institutionalized adults[1]:
  - Almost 40% used prescription opioids & 4.7% misused
- New NICE guidelines are pending….

1. Han B et al. Ann Intern Med. 2017;167(5):293-301.

NICE guidelines



Related NICE guidance

- Endometriosis 2017
- Spondyloarthritis 2017
- Neuropathic pain 2017
- Multimorbidity 2016
- Low back pain & sciatica 2016
- Strong opioids palliative care 2016
- Controlled drugs 2016
- Rheumatoid arthritis 2015
- Headaches 2015
- Workplace health 2015
- Osteoarthritis 2014
- Common mental health problems 2011
- Depression + chronic health 2009
- Depression 2009
- PTSD 2005

Particularly worth a read….

In the mean time….

- NICE Advice
- BMJ Editorial
- BMA briefing report
- Opioids aware

NICE advice….

NICE National Institute for Health and Care Excellence

NICE advice

NICE's advice programmes consists of a range of products that are either based on NICE guidance or involve a critical assessment of relevant evidence. However, these products do not have the status of formal NICE guidance, and do not contain new NICE recommendations.

nice.org.uk/guidance/ktt21

Key points

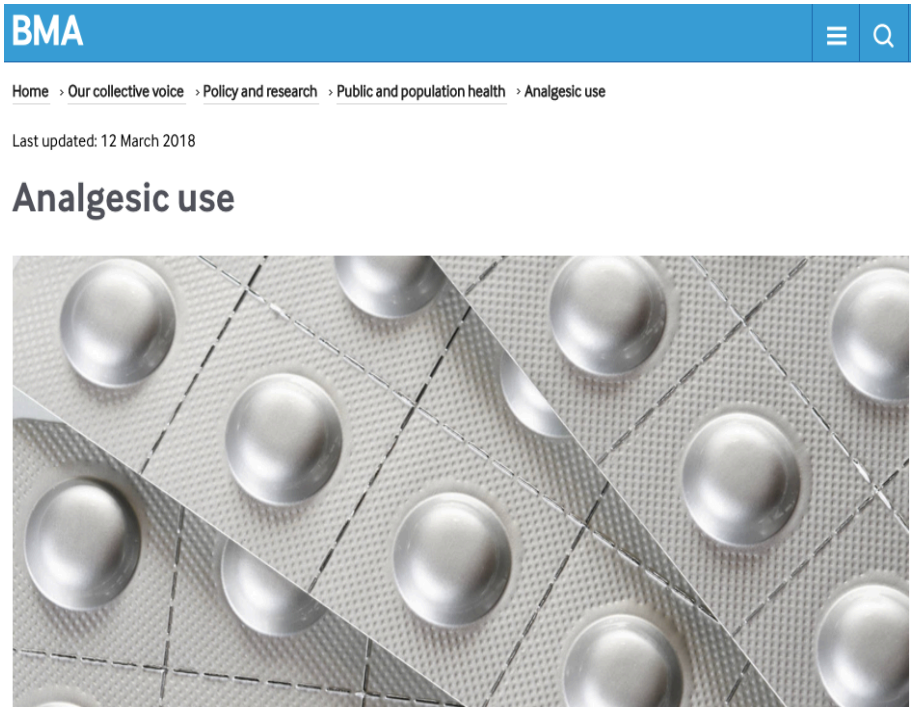
- **Low back pain = main cause of disability worldwide & the NICE low back pain guidelines recommend:**
  - Risk stratification tool: STarT back https://www.keele.ac.uk/sbst/
  - NSAIDs; opioids for acute use only when NSAIDs unsuitable
  - Amitriptyline, duloxetine, gabapentin or pregabalin for sciatica
- **Little evidence to support opioids for long-term pain**

https://www.nice.org.uk/advice/ktt21/chapter/Evidence-context#managing-long-term-chronic-pain accessed 18th April 2018

BMJ Editorial

Set realistic expectations	Recognise limitations of pain medications
Add psychological & physical therapies consider integrative approaches e.g. acupuncture & mind-body therapy	Treat underlying conditions & use multiple medications including muscle relaxants, antidepressants, anticonvulsants, and topical agents as well as conventional analgesics

BMA briefing papers on analgesics



- 2,000 opioid deaths E&W 2015
- Rising opioid use, £330m/yr UK
- Pain = major end of life concern
- BMA conducted 'dialogue events' across UK in 2015: >500 doctors & members of public
- Access patchy, particularly for non-cancer terminal illness

https://www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/analgesics-use accessed 12th April 2018

Highlights

CHRONIC PAIN

- Long-term opioid pain research, including efficacy & safety >6/12
- Primary care investment e.g. longer appointments
- Provider/commissioner collaboration for multi-disciplinary services
- Non-pharmacological options
- Education & training, pain as an undergraduate competency

END OF LIFE CARE

- Promote existing guidance, including to non-specialists
- Age is not be a barrier to opioid use
- Address HCP anxieties about analgesic prescribing
- Better identification/referral of non-cancer terminal illness
- Education & training

https://www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/analgesics-use accessed 12th April 2018

"Opioids aware"

- Web-based, **PHE-funded** & **Faculty of Pain Medicine** hosted (Royal College of Anaesthetists)
- **Developed by HCPs & policy groups:**
  - Several medical royal colleges
  - Royal Pharmaceutical Society, British Pain Society
  - Public Health England, NHS England, NICE
  - Care Quality Commission, NHS Business Services Authority
- www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware

Opioids aware

1. Opioids are very good analgesics for acute pain and for pain at the end of life but there is little evidence that they are helpful for long term pain
2. A small pro… the long-term if the dose … vever it is difficult to…
3. The risk of… equivalent of 120mg/…
4. If a patient… and should be disconti…
5. Chronic pa… g symptoms, particularly if they are on high opioid doses, a very detailed assessment of the many emotional influences on their pain experience is essential.

Who are the guidelines for?

Healthcare professionals working with patients who take opioids

Healthcare professionals working with patients who may be addicted to prescribed opioids

Driving

England & Wales legislation update 2015

- Long illegal to drive ‘impaired’
- In 2015, 8 illicit (zero tolerance) & 8 medicinal drugs (level/impairment dependent) added to legislation

https://www.gov.uk/government/collections/drug-driving accessed 10th April 2018

England & Wales legislation update 2015

‘Medicinal’ drug	Blood threshold
Clonazepam	50 mcg/L
Diazepam	550 mcg/L
Flunitrazepam	300 mcg/L
Lorazepam	100 mcg/L
Methadone	500 mcg/L
Morphine	80 mcg/L
Oxazepam	300 mcg/L
Temazepam	1,000 mcg/L

https://www.gov.uk/government/collections/drug-driving accessed 10th April 2018

Other nations

- **Ireland[1]**
  - Road Traffic Act updated in 2017 to include 'mandatory intoxicant checkpoints' which include testing for opiates & benzodiazepines
  - Illegal to drive while **impaired** under influence of listed drugs (and at all if cannabis, cocaine, heroin)
- **Scotland & Northern Ireland[2]:**
  - Illegal to drive while **impaired** by drugs but there no specific limits or roadside testing (yet)

1. http://www.rsa.ie/en/Utility/News/2017/GARDAI-CAN-NOW-TEST-MOTORISTS-FOR-DRUGS-AT-THE-ROADSIDE/ accessed 10th April 2018
2. https://www.gov.uk/drug-driving-law accessed 10th April 2018

Your responsibility

- It is the responsibility of **prescribers & suppliers** of medicines to give suitable clinical advice to patients regarding the likely risks of their medicines…which might include the advice that the drug may cause sleepiness and so **might impair driving**
- It is a driver's responsibility to decide whether they consider their driving is, or they believe might be, impaired on any given occasion

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/325275/healthcare-profs-drug-driving.pdf

Consent….Bolam no longer enough

"REASONABLE CARE TO ENSURE THAT THE PATIENT IS AWARE OF ANY MATERIAL RISKS INVOLVED IN ANY RECOMMENDED TREATMENT, AND OF ANY REASONABLE ALTERNATIVE OR VARIANT TREATMENTS"

Summary

- Montgomery v Lanarkshire Health Board; UK Supreme Court decision 11 March 2015
- Case of should dystocia in an infant born by NVD to a diabetic woman who was not warned of 9-10% risk
- **Implications:**
  - 'Bolam test' no longer applies to issue of consent
  - The law now requires a doctor to take *"reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments"*
  - Brings law into line with GMC guidance

Sokol DJ. BMJ. 2015 Mar 16;350:h1481.

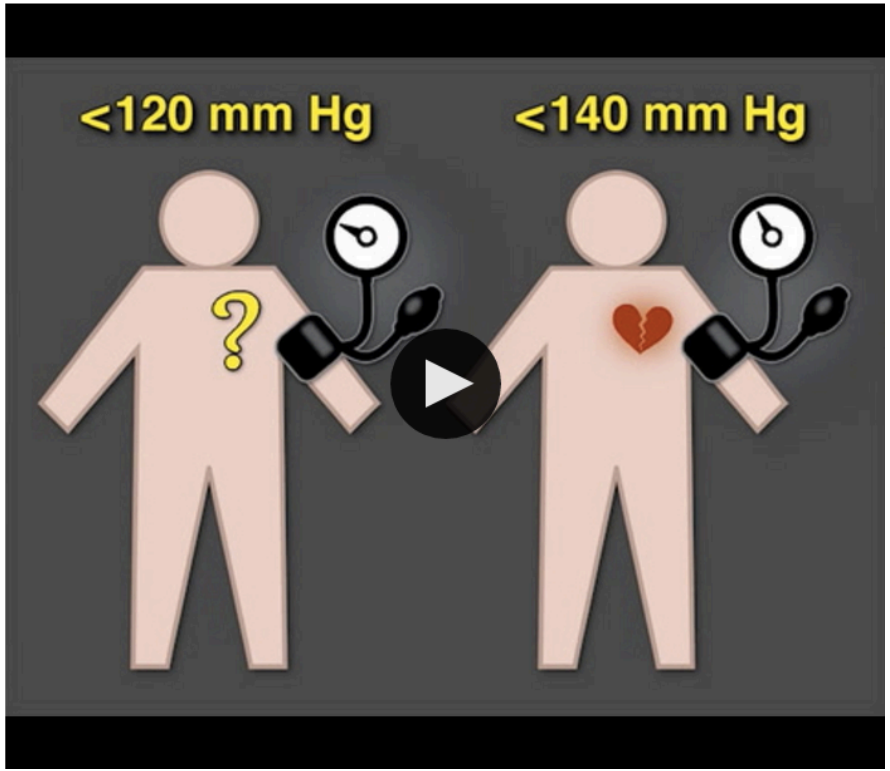
HYPERTENSION GOALS

SPRINT trial

- **Large US hypertension treatment trial in adults at high risk of CVD:**
  - Standard arm: SBP goal <140mmHg
  - Intensive arm SBP goal <120mmHg
- **Terminated early**
  - Fewer CV events & deaths in intensive group
  - BUT more serious adverse events & effect heterogeneous

Wright JT, Jr et al. N Engl J Med. 2015;373:2103–16.

NEJM quick take



http://www.nejm.org/doi/full/10.1056/nejmoa1511939

Change to American Heart Association guidelines 2017

- **Lower target BP:** 130/80, from 140/90, for most
- **Stage 1 hypertension threshold lowered:**
  - Average SBP 130-139 or DBP 80-89 mmHg
  - If estimated atherosclerotic risk <10% = **lifestyle only**
  - If diabetes, renal disease, ≥65 yrs or CV risk >10% = **+ drug treatment**
- **Stage 2 hypertension threshold ≥140/≥90 from ≥160/≥100:**
  - Drug treatment regardless of atherosclerotic risk
- **Most requiring drug treatment should start with 2 agents:**
  - Particularly Black individuals or people with stage 3 hypertension

https://www.medscape.com/viewarticle/889644 accessed 16th April 2018.

Impact of change on US adults

- 46% will be classified as hypertensive (from 32%)
- 53% already on anti-hypertensives have BP >130/80 target
  - **29 million people will need to intensify treatment**
- 14% not on anti-hypertensives have BP 130-139/80-89 and 1 in 3 of these meet treatment indications
  - **4 million will need to start treatment**

Muntner P et al. Circulation. 2018;137:109–118.

A European perspective

Circulation

PERSPECTIVE

Perspective From Sweden on the Global Impact of the 2017 American College of Cardiology/American Heart Association Hypertension Guidelines

A "Sprint" Beyond Evidence in the United States

Brunstrom M et al. Circulation. 2018;137:886–888.

Current NICE hypertension definitions

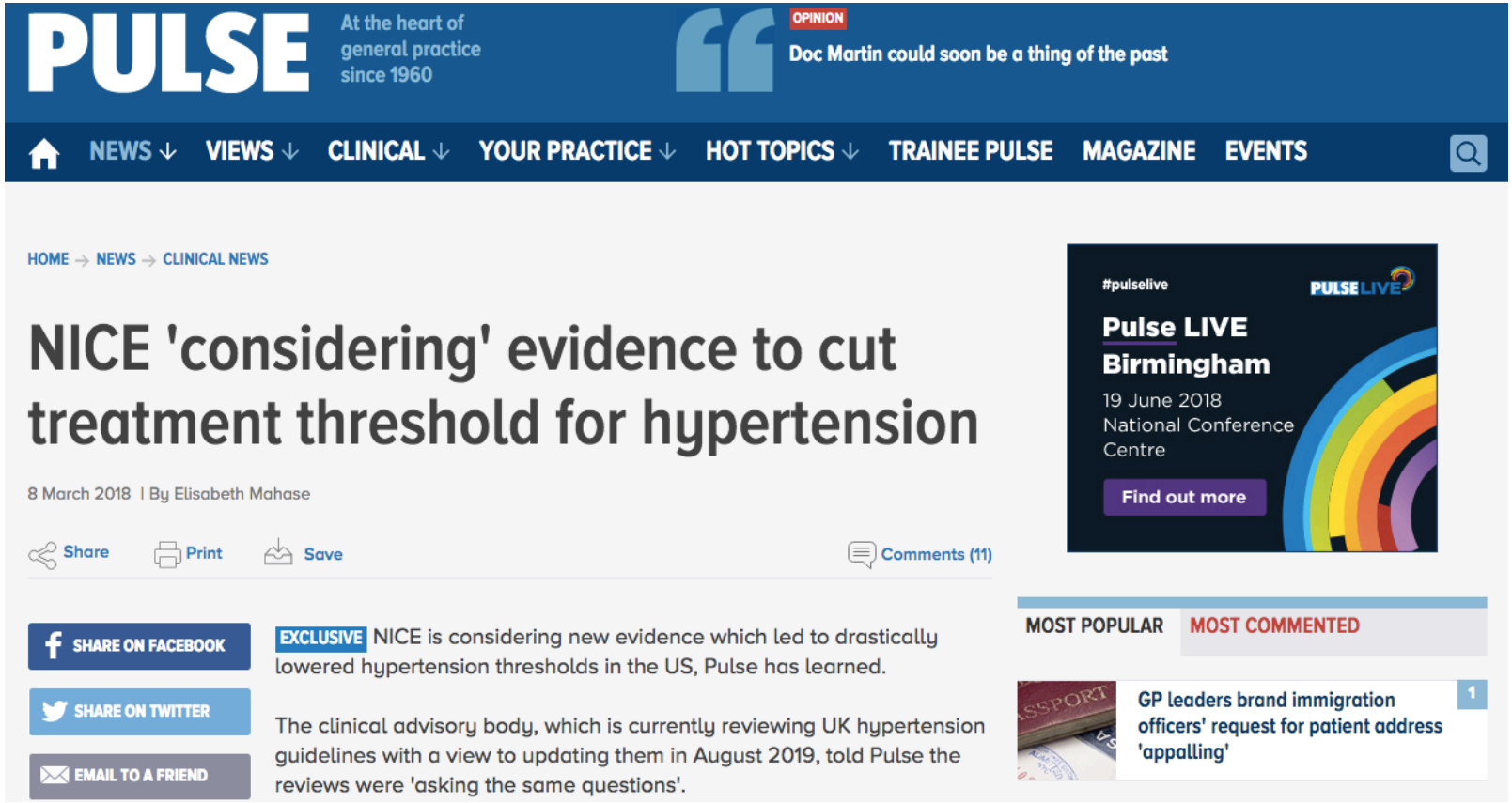
Definitions

In this guideline the following definitions are used.

- **Stage 1 hypertension** Clinic blood pressure is 140/90 mmHg or higher **and** subsequent ambulatory blood pressure monitoring (ABPM) daytime average or home blood pressure monitoring (HBPM) average blood pressure is 135/85 mmHg or higher.
- **Stage 2 hypertension** Clinic blood pressure is 160/100 mmHg or higher **and** subsequent ABPM daytime average or HBPM average blood pressure is 150/95 mmHg or higher.
- **Severe hypertension** Clinic systolic blood pressure is 180 mmHg or higher **or** clinic diastolic blood pressure is 110 mmHg or higher.

https://www.nice.org.uk/guidance/cg127/evidence accessed 12th April 2018

What's next?



PULSE

At the heart of general practice since 1960

OPINION

Doc Martin could soon be a thing of the past

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NICE 'considering' evidence to cut treatment threshold for hypertension

8 March 2018 | By Elisabeth Mahase

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EXCLUSIVE NICE is considering new evidence which led to drastically lowered hypertension thresholds in the US, Pulse has learned.

The clinical advisory body, which is currently reviewing UK hypertension guidelines with a view to updating them in August 2019, told Pulse the reviews were 'asking the same questions'.

#pulselive

PULSE LIVE

Pulse LIVE Birmingham

19 June 2018
National Conference Centre

Find out more

MOST POPULAR MOST COMMENTED

GP leaders brand immigration officers' request for patient address 'appalling' 1

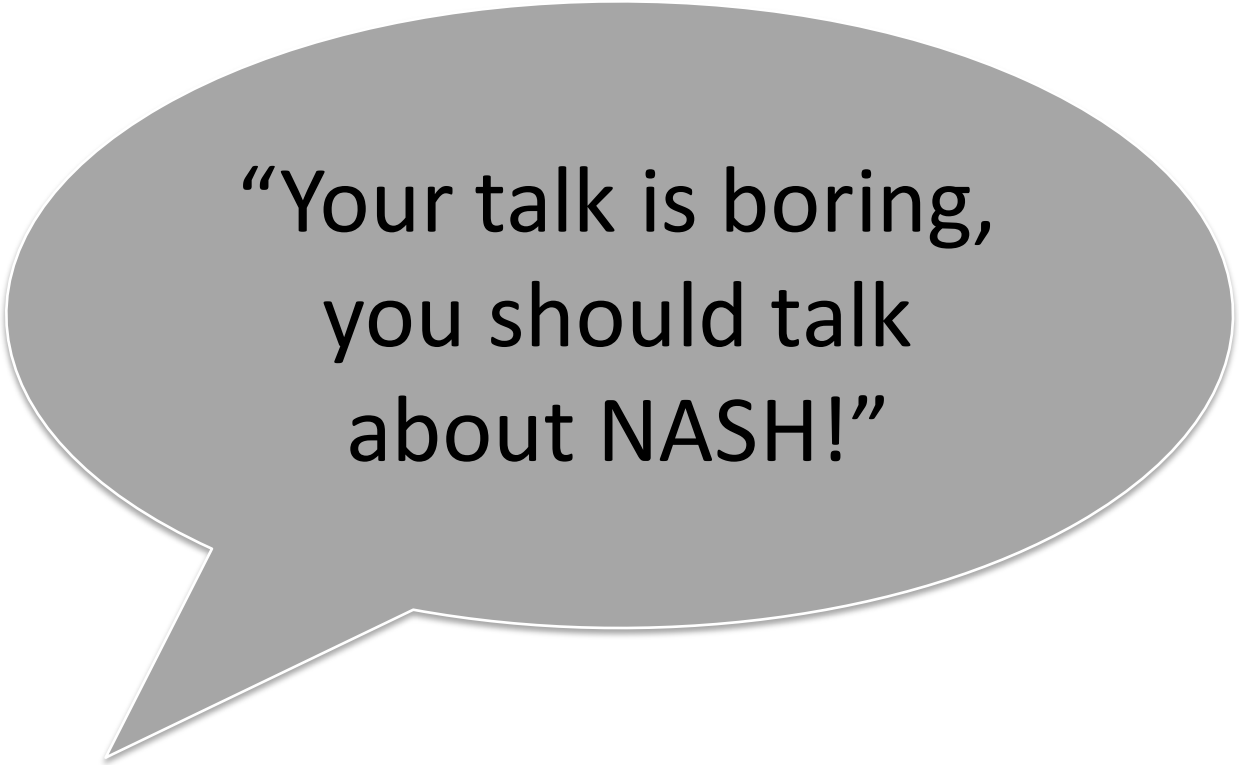
NICE: step 1 drugs

Drug class	Indication	Drug interactions
ACEI & ARB	Adults <55	**ACEIs:** no major interactions with ART **Losartan:** potential weak interaction via CYP2C9 (EFV, EVG, RTV)
CCBs	>55 & Black African or Caribbean origin	**Amlodipine:** predicted 2-fold ↑with boosters & ↓with EFV **Lercanidipine: 15-fold increase with ketoconazole** contra-indicated with boosters, possible ↓with EFV
Thiazide-like diuretics	CCB not suitable	**Chlortalidone:** no predicted DDI with ARVs **Indapimide:** extensive P450 metabolism, possible ↑with boosters and ↓with EFV

https://www.nice.org.uk/guidance/cg127/chapter/1-Guidance#choosing-antihypertensive-drug-treatment-2 accessed 12th April 2018

MYSTERY TOPIC

My mistake….



So I will…..

Can Drinking Coffee Cure NASH or Liver Fibrosis?

COFFEE

Liver benefits

- Coffee protective in several observational studies/meta-analyses for:
  - Cirrhosis progression
  - NAFLD
  - NASH progression
- Other caffeinated drinks **not** protective
- De-caffeinated coffee **is** protective

Umbrella review

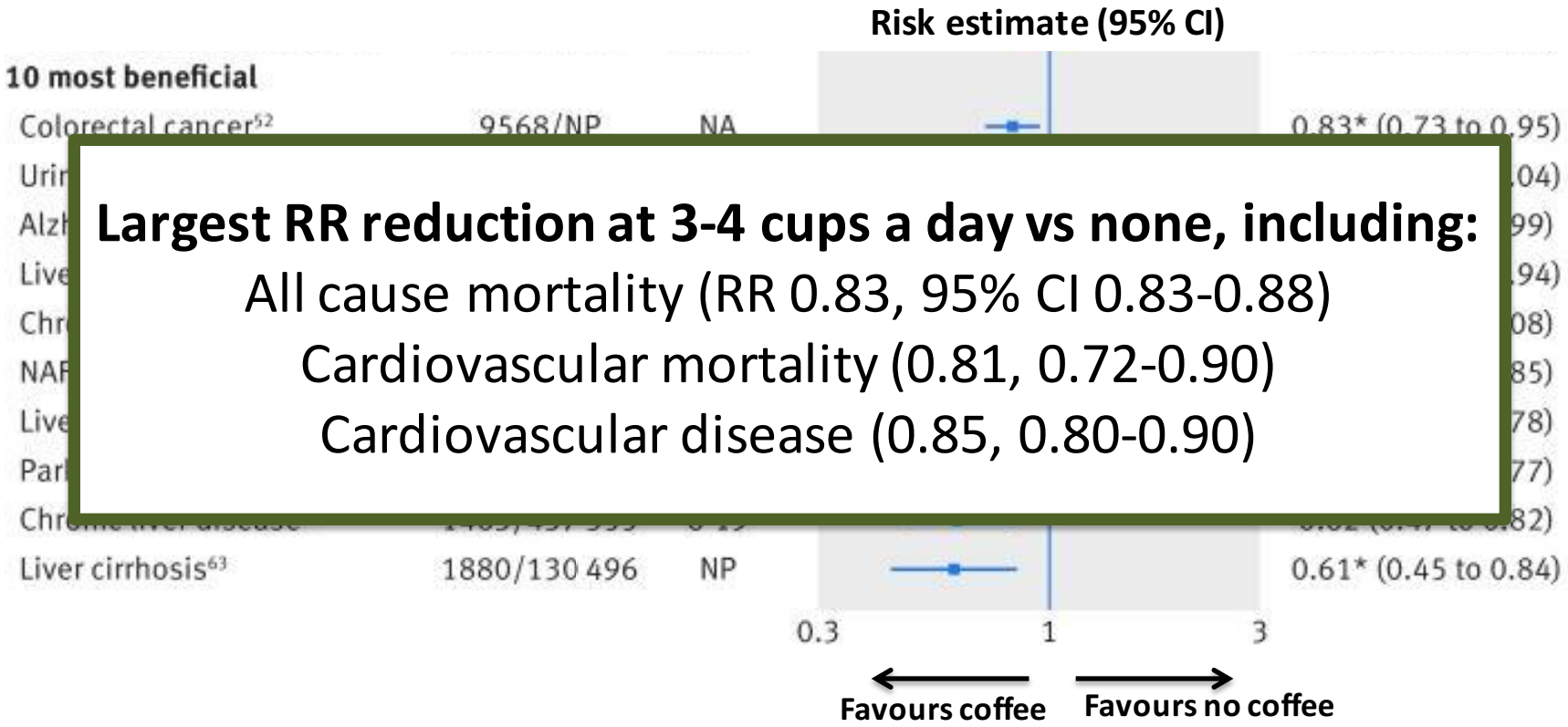
BMJ. 2017; 359: j5024.
Published online 2017 Nov 21. doi: 10.1136/bmj.j5024
PMCID: PMC5696634
PMID: 29167102

Coffee consumption and health: umbrella review of meta-analyses of multiple health outcomes

Robin Poole, specialty registrar in public health,[1] Oliver J Kennedy, graduate medical student,[1] Paul Roderick, professor of public health,[1] Jonathan A Fallowfield, NHS Research Scotland senior clinical fellow,[2] Peter C Hayes, professor of hepatology,[2] and Julie Parkes, associate professor of public health[1]

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5696634/

Results



Largest RR reduction at 3-4 cups a day vs none, including:

All cause mortality (RR 0.83, 95% CI 0.83-0.88)

Cardiovascular mortality (0.81, 0.72-0.90)

Cardiovascular disease (0.85, 0.80-0.90)

The big question!

Thank you!

?

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