

Keeping Well?

The Newsletter of the Nuffield Patient Group

Autumn 2017 Issue 18

Welcome!

There's no denying autumn is upon us. In our family we have now seen off the last of the visitors (phew!) and will soon be lining up for our flu jabs (see page 4).

Our lead story this time is about hearing loss. Almost 20% of the UK population suffer from this, rising to over 30% in those over 60 years old, and about 75% in those over 70 years of age. Our lead story from Maureen Sears takes a positive and personal look at this common problem (see this page).

There's a handy article on page 3 about when it makes sense to buy your medicines over the counter rather than via a prescription, and also featured on that page is the latest news from the practice. We are fortunate to be fully staffed with excellent people.

Turning to page 4, you can learn all about who should have the pneumococcal ('pneumo') vaccine. Never heard of it? Now's your chance to find out!

Finally, Sarah Chapman brings insights into 'frozen shoulder' from Cochrane UK and her own stiff and painful experience.

We love to hear your stories and news so do please get in touch. Contact details on page 6.

Hearing loss and what you can do about it

By Maureen Sears

I am writing a few tips and strategies for coping with hearing loss from my own experience, having lost over 70% of my hearing in a matter of weeks 10 years ago.

At first I could not believe it, I was in a state of confusion and panic, sitting in a meeting and being unable to follow the discussions. My first reaction was to BLUFF and pretend no problem existed. I believe this is a reaction of many people who experience gradual hearing loss as well as the severe and acute kind.

ACCEPTANCE: of the situation and doing something about it is the next course of action.

DO NOT DELAY: I went to the medical centre attached to my work and because of my employment conditions I was seen privately and fitted with what were 'state of the art' aids. These did not suit me – I could not use them effectively. I was probably still in a state of denial and reluctant to learn. I think this is a common experience.

Whether you purchase expensive equipment or are fitted with NHS aids, you have to learn to use them to the best effect for yourself. Many people give up at this point, put their aids in a drawer and continue in their denial of the



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problem. This is not helpful as not hearing and losing the ability to reciprocate leads to social isolation. People can become angry, blaming others for not speaking clearly whilst suffering a growing depression and anxiety. Mild hearing loss almost inevitably worsens with age, making the individual more prone to isolation, loneliness and loss of confidence.

Speaking from experience, a visit to the GP and obtaining a hearing assessment is probably your best course of action. Once an assessment is completed, you can decide on your options. A warning note here, spending a lot of money initially on aids is probably not a good use of funds, although I do know of individuals who are very happy with their purchases, a good choice for them whether accidental or by careful research.

My own experience of hearing loss led to my early retirement despite efforts to cope. I learnt by accident strategies to help me. I learnt that facing the person and watching for visual clues was important. In restaurants or social situations make sure your back is to the light, this means you have a better chance of seeing the talker, it also reduces background noise with a wall or window behind you. I watch people's lips, facial expressions carefully, it is possible soon to lip read well enough to recognize the lip movements used to say, 'hello, how are you' being the most obvious.

I learnt the hard way that bluffing was not useful as it may have caused a laugh with misinterpreted words or missing the whole point of the conversation and although I laughed at myself publicly I felt a growing loss of confidence as I realized the severity of my condition.

As a way of concealing the problem I used a common ploy, to direct the conversation which enabled me to anticipate responses, questions and gave me thinking time. My cover is blown of course when the conversation strays into unfamiliar territory. Perhaps you recognize this strategy as one you have used.

HAVE COURAGE: tell people with whom you are engaged in conversation that you are having difficulty hearing them. Mostly people will respond, speak slowly and emphasize key words without shouting which can be very helpful. When

the topic of conversation changes, this causes difficulties if you are unaware and unfamiliar with the subject matter. When this happens, repeat the words you think you have heard in a questioning manner, this can help clarify the topic and give you confidence to continue to be engaged in the conversation. Ask people to speak one at a time and not to talk over each other, when this happens you have little chance of continuing a meaningful conversation. You have a role as an educator, to teach individuals how to converse with you.



So often people with hearing loss withdraw at this stage with the resulting lowering of self-esteem and confidence.

BE AWARE: look at your current social situation. Assess background noise, identify talkers with beards, moustaches, wearing scarves or those who talk with their hands to their mouths. These situations can be very physically as well as mentally exhausting. Be aware of your own capacity for managing the situation at that particular time.

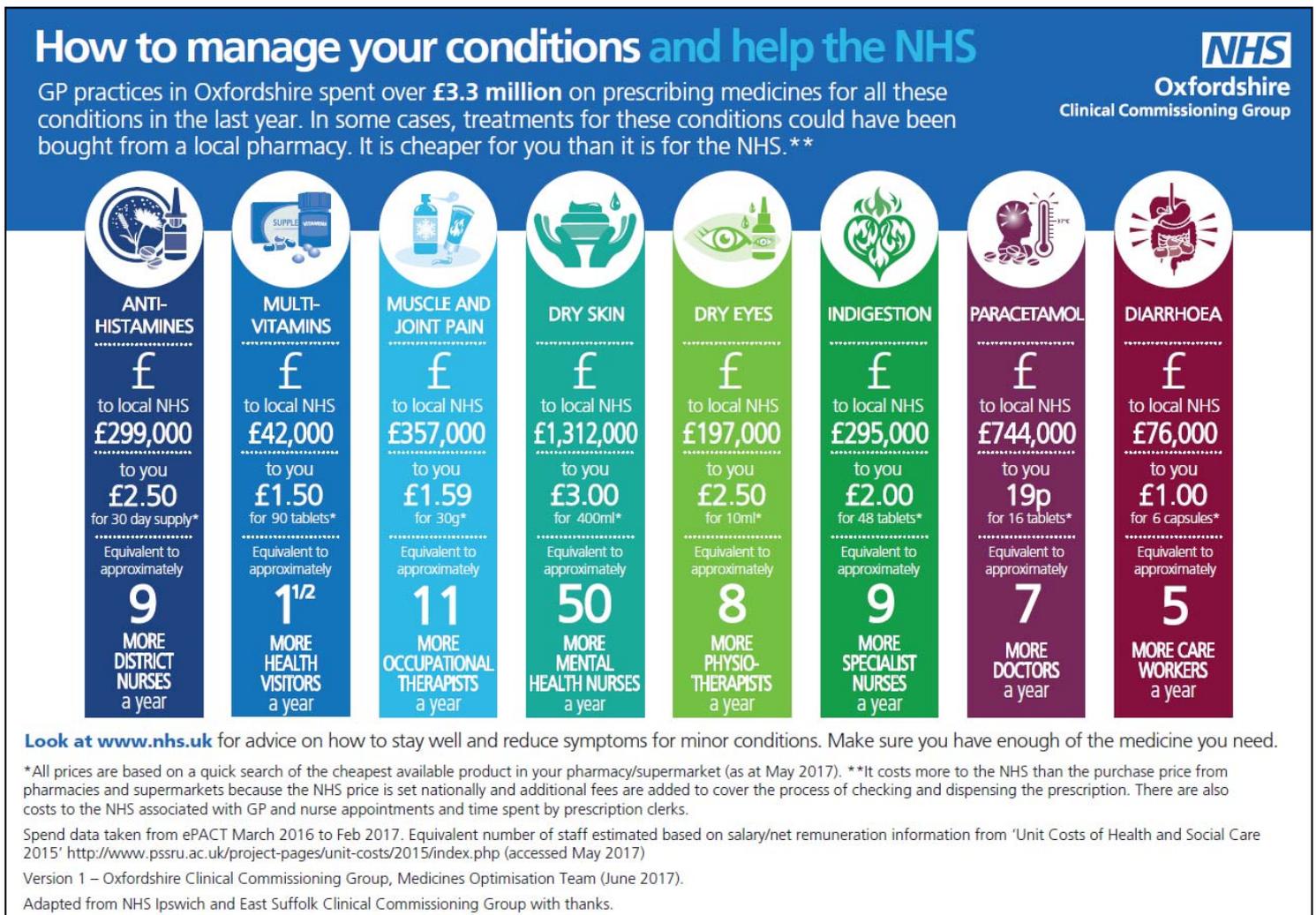
PERSEVERE: learn to use your aid or aids efficiently; no aid can replace normal hearing but as you become used to them you learn to screen out some background noise, depending upon where you are and what you are trying to hear.

BE DEMANDING: you have a right to demand loop systems to be fitted to social venues you may use. Again make yourself familiar with the system and how to adjust your aids. Research aids for the home; enhanced telephones and doorbells is a good place to start. The JR Auditory department on one Thursday morning a month, exhibit home devices that could help you, it is worth a visit, communicate with them first.

VALUE SILENCE: after the rigours of the day, always being alert to visual as well as sound clues, being buffeted by sounds, some pleasant but others, like the high pitched screams of small children in the supermarket, painful to the ears is totally exhausting. I find it restful to remove my aids and allow myself to be cocooned in a quiet cotton wool silence for at least 15 minutes before retiring to bed. Providing you are in a safe

environment it may be worth doing, giving into silence, not having to strain and try any more, just being able to relax into the peace. I find this useful, it may help you.

I hope the advice given above is helpful to you whether you are in the early stages of coping with loss or a seasoned campaigner. I am happy to communicate with readers to hear your stories which in turn can help others.



From the Practice

Dr Anna Morrish will return from Maternity leave at the beginning of September.

Dr Maeve Lawrence will be on Maternity Leave until the end of January 2018 and is being covered by 3 locum GPs; Dr Kirsty Shepherd, Dr Kiren Collison, Dr Linda Jones.

We have a new Registrar. In addition to Dr Tim Robson, who is here until May next year, we have Dr Subaiha Shaikh who will be with us until February.

Have you had your flu jab?

The Flu season is upon us again. If you fall into any of the categories below you are eligible for a flu jab, so please book an appointment at one of our flu clinics, or ask for the jab when you are seeing a GP or a Nurse for another matter:-

- Aged 65 years +

Any patient aged 6 months or above who suffers from any of the following:

- Chronic respiratory disease
- Chronic heart disease
- Chronic kidney disease
- Chronic liver disease
- Chronic neurological disease
- Diabetes

- Immunosuppression
- Pregnant women at any stage of their pregnancy
- People in long stay residential homes
- Carers
- Obese – BMI 40+
- All children aged 2 and 3 years on August 31 2016.

The flu vaccine for children is given as a single dose of nasal spray squirted up each nostril. Not only is it needle-free (a big advantage for children), the nasal spray works even better than the injected flu vaccine).

Due to the success of our Saturday clinics last year, we will be offering two again: 30th September and 14th October from 09.00 – 12.00.

The Pneumococcal Vaccine

The pneumococcal vaccine protects against serious and potentially fatal pneumococcal infections. It's also known as the "pneumo jab" or pneumonia vaccine.

Pneumococcal infections are caused by the bacterium *Streptococcus pneumoniae* and can lead to pneumonia, septicaemia (a kind of blood poisoning) and meningitis. At their worst, they can cause permanent brain damage, or even kill.

Who should have the pneumococcal vaccine?

A pneumococcal infection can affect anyone. However, some people are at higher risk of serious illness and can be given the pneumococcal vaccination on the NHS.

These include:

- babies
- adults aged 65 years or over
- children and adults with certain long-term health conditions, such as a serious heart or kidney condition

Babies and the pneumococcal vaccine

Babies are routinely vaccinated with the type of pneumo jab known as the pneumococcal conjugate vaccine (PCV) as part of their childhood vaccination programme.

They have three injections, which are usually given at:

- 8 weeks old
- 16 weeks old
- One year old

Adults aged 65 years or over and the pneumococcal vaccine

If you are 65 years or over, you will be offered a type of pneumo jab known as the pneumococcal polysaccharide vaccine (PPV). This one-off vaccination is very effective at protecting you against serious forms of pneumococcal infection.



People with long-term health problems and the pneumococcal vaccine

The PPV pneumo jab is available on the NHS for children and adults aged from 2 to 64 years old who are at a higher risk of developing a pneumococcal infection than the general population.

This is generally the same people who are eligible for annual flu vaccination.

Children up to 5 years old may also need the PCV (because the PPV injection doesn't always work in young children).

You're considered to be at a higher risk of a pneumococcal infection if you have:

- had your spleen removed, your spleen does not work properly or if you are at risk of your spleen not working properly in future (for example if you have coeliac disease)
- a long-term respiratory disease, such as chronic obstructive pulmonary disease (COPD)
- heart disease, such as congenital heart disease
- chronic kidney disease
- chronic liver disease, such as liver cirrhosis
- diabetes
- a suppressed immune system caused by a health condition such as HIV
- a suppressed immune system caused by medication such as chemotherapy or steroid tablets
- a cochlear implant (a small hearing device fitted inside your ear)
- had cerebrospinal fluid (the clear fluid that surrounds the brain and spine) leaking from its usual position – this could be due to an accident or surgery.

Adults and children over the age of five who are severely immunocompromised (including anyone with leukaemia; multiple myeloma; genetic disorders affecting the immune system or after

a bone marrow transplant) usually have a single dose of PCV followed by PPV.

Booster doses of pneumococcal vaccine

If you are at increased risk of a pneumococcal infection, you will be given the PPV vaccination just once, and generally this will protect you for life.

However, if your spleen does not work properly or if you have a chronic kidney condition, you may need booster doses of PPV every 5 years. This is because your levels of antibodies against the infection will decrease over time.

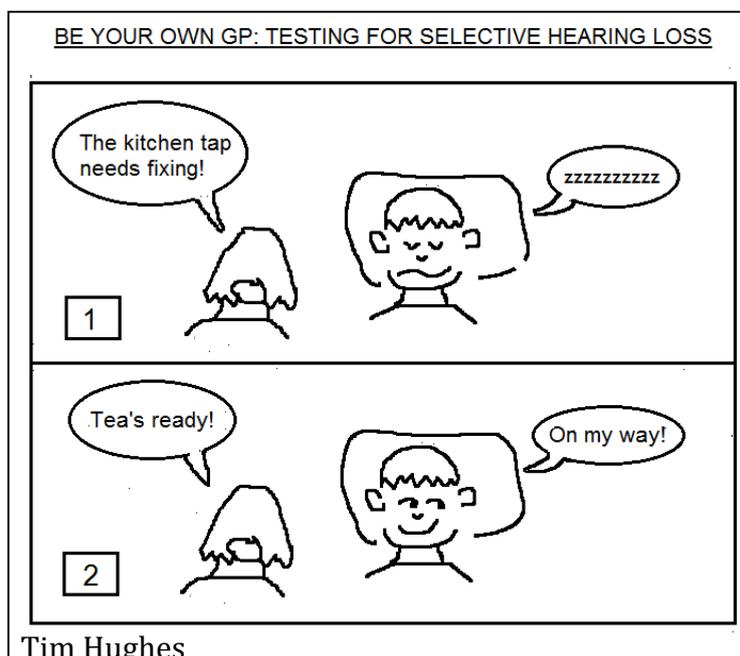
How often is the pneumococcal vaccine given?

Babies receive the pneumococcal vaccine as three separate injections, at 8 weeks, 16 weeks and 1 year old.

People over 65 years only need a single pneumococcal vaccination, which will protect for life. It is not given annually like the flu jab.

People with a long-term health condition may need just a single one-off pneumococcal vaccination or five-yearly vaccination, depending on their underlying health problem.

If you fall into any of the categories above, you will be contacted by the Practice and invited for a jab, or you may be offered it opportunistically when you are seeing a GP or a Nurse. If you know that you are eligible, please feel free to book an appointment even if you have not been invited yet.



Evidence Matters

by Sarah Chapman

I work for Cochrane UK, the UK hub of an international network of people working together to help people make informed decisions about health care. It does this through doing systematic reviews, which bring together the results of clinical trials to answer questions about what helps or harms in health care.

Frozen shoulder: do we know what can help?

Adhesive capsulitis, also known as frozen shoulder, happens when the tissues around the shoulder joint become inflamed and thickened. The reasons are unclear, but as many as 1 in 20 people in the UK will develop frozen shoulder, mostly between the ages of 40 and 60 years, with more women affected than men. It eventually gets better on its own but typically this takes 1–2 years.

I've developed frozen shoulder in recent weeks so I was interested to find out what I might be able to do to speed recovery, as it's painful when I move my arm suddenly, sore to sleep on, and very inconvenient to have limited movement in that arm.

Making decisions about treatment

Three things are important when making decisions about treatment. What the best available evidence says about the safety and effectiveness of a treatment; what your health professional advises, and what your own preferences and priorities are.

The usual treatment options for frozen shoulder are steroid injections, shoulder exercises, and physiotherapy. Sometimes surgery may be considered. I decided to see what evidence there is in the Cochrane Library about any of these options.

What's the evidence?

There is a Cochrane review on manual therapy and exercise for frozen shoulder. Manual therapy

includes any movement of the joints and other structures or manipulation done by a clinician (such as a physiotherapist), while exercise in this context includes any purposeful movement of a joint, muscle contraction or prescribed activity. These components combined in a physical therapy intervention are commonly used to treat frozen shoulder.

The evidence comes from 32 trials with 1836 people. None of the trials compared the treatments with placebo (an inactive, treatment) or with doing nothing. It shows that a combination of manual therapy and exercise, compared with steroid injection, probably results in less improvement at 7 weeks and a similar number of adverse events.

Of the 56 people who had manual therapy and exercise, 26 (46%) reported treatment success, compared with 40 people (77%) of the 52 who had the injection. There were no differences between the groups after 12 months in terms of pain and function. Greater uncertainty remains about other treatment combinations and comparisons.

There is also a Cochrane review on electrotherapy, which leaves us with more questions than answers with no or only limited evidence on the benefits and harms of a range of electrotherapy treatments.

What now?

I've decided to go for physiotherapy, as it feels good to be doing something to try to increase my range of movement, and I might benefit. But we do need better evidence to help people make more informed choices.

You can see the review in full at www.thecochranelibrary.com.

ARTICLE details

Page MJ, Green S, Kramer S, Johnston RV, McBain B, Chau M, Buchbinder R. Manual therapy and exercise for adhesive capsulitis (frozen shoulder). Cochrane Database of Systematic Reviews 2014, Issue 8. Art. No.: CD011275. DOI: 10.1002/14651858.CD011275 and Issue 10. Art. No.: CD011324. DOI: 10.1002/14651858.CD011324.

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