

# 63rd St Andrew's Day Festival Symposium: Updates on Acute Medicine

Unanswered Slido Questions

Thursday 23 November 2023

Session 1

## **SIR JAMES CAMERON LECTURE: The burden of treatment - Professor Frances Mair**

*Q: What do you think about the current trend of building new large hospital centres very far away from community? I always wonder how my patients can get to the hospital especially when they live in a remote part*

A: I think a balance has to be struck between having expertise (through seeing enough cases to be safe) versus the needs of the local community. Travelling far distances to hospital will generally increase the burden of treatment for patients, which is often unhelpful. But obviously for certain procedures, doctors need to deal with a minimum number of cases per year to be well qualified, so there are circumstances where centralisation of services are the safest option for low volume but high risk interventions.

*Q: If Drug X works in a carefully selected study population, but has little impact in elderly or multi-morbid patients should these studies not be refused for publishing without "real world" outcomes?*

A: Well I don't think they should be blocked from publishing but the strengths and limitations of the studies need to be made explicit. Nowadays an increasing number of studies include older people with multimorbidity but as always....those most likely to volunteer for research are often the fitter people within these categories. The following papers might be of interest to you:

Hanlon, P., Hannigan, L., Rodriguez-Perez, J. *et al.* Representation of people with comorbidity and multimorbidity in clinical trials of novel drug therapies: an individual-level participant data analysis. *BMC Med* **17**, 201 (2019). <https://doi.org/10.1186/s12916-019-1427-1>. This paper essentially shows that while multimorbidity is less common in trials than in community populations it is nevertheless, common in trials. This suggests that standard, industry-funded clinical trials are an underused resource for investigating treatment effects in people with comorbidity and multimorbidity.

Also this paper:

Observed and expected serious adverse event rates in randomised clinical trials for hypertension: an observational study comparing trials that do and do not focus on older people. Hanlon, Peter *et al.* *The Lancet Healthy Longevity*, Volume 2, Issue 7, e398 - e406

The bottom line is that: "Clinicians should be cautious when applying trial recommendations to older people, even when trials focus on older participants or include those with multimorbidity."

*Q: I would love to be able to use back door admissions. management don't like it- impacts on bed flow at front door. Most of my patients are multimorbid (Dol renal physician), I'm not always the best person to manage everything and other specialities work in silos. How do we fix this?*

A: I think this is a MAJOR issue.....and clearly patients and health professionals often prefer "back door" admissions as they improve the patient experience and there is growing evidence that not doing this is associated with poorer outcomes. There is mounting evidence, that for example, frail older people have worse outcomes when we keep in the A+E for prolonged periods. I really think

this is something we collectively as health professionals should be working with patient representative organisations to lobby for change. Essentially, our current approach is about centralising systems to make life easier for hospital systems but deprioritising the needs of patients. The reference below is one that highlights the risks of our current approaches, especially when the NHS is overwhelmed and people are experiencing long waiting times in A+E. Roussel M, Teissandier D, Yordanov Y, et al. Overnight Stay in the Emergency Department and Mortality in Older Patients. *JAMA Intern Med.* 2023;183(12):1378–1385. doi:10.1001/jamainternmed.2023.5961

*Q: How can we talk about digital health opportunities when we are also stating that finance and poverty affect outcomes? - many of my patients simply can afford regular Internet access.*

A: Ah yes, this is true....my own view is that investment in upstream determinants of health (lifting people out of poverty) would be the most important thing to do.....however, digital health opportunities could potentially help everyone (my worry however, is that there is insufficient emphasis on investing in technologies that will reduce rather than widen health inequalities). For example, it used to be in my health board that I could not see blood test results if undertaken in hospital whereas now I can.....(because of a digital portal that primary care can access) ....this means that many of my poorer patients can avoid unnecessary repeat blood tests because I can see hospital ordered blood results.....so this helps rich and poorer patients alike.....for our complex patients in socioeconomically deprived communities ...having AI that can bring together info from primary/secondary/social care to inform decision making at a glance.....could prove beneficial.....so I think it depends on the technology. But you are correct that providing an APP in English to a non English speaking patient is useless.....and remote telecare monitoring via WIFI no use if you do not have it.....

*Q: What was the rationale and justification for getting rid of a practice for the homeless population and what has been put in place to fill in the gap?*

A: Well I am not privy to the real reasons...but it seems to have followed Glasgow City HSCP budget cuts of nearly £22m but the partnership claims the closure has nothing to do with these cuts. All I know is that the Hunter Street Practice was closed in March 2023 as part of an incorporation to the Complex Needs Service with one week's notice. There has been much anger at the decision and some info is provided in this BBC news link: <https://www.bbc.co.uk/news/uk-scotland-glasgow-west-65393243> and also here: <https://www.pulsetoday.co.uk/views/guest-opinion/gps-criticise-the-closure-of-a-specialist-homeless-practice-in-glasgow/>

Certainly the Deep End Group of Scottish GPs have been up in arms about it.....the new Complex Needs Service is a secondary care service that patients cannot access directly.....they need to be referred in.....so a real barrier for homeless people...the homeless people previously served by the practice have had to find local GPs to look after them (because of the short notice...some had seen a GP one week and told to return 2 wks later for follow up only to find the practice closed!).....and local A+Es have been dismayed as they have no certain primary care link to refer people who need further help post an A+E visit.....it is really quite a mess.... Again, a decision that does not seem to take account of the potential increased burden of treatment for patients I'm afraid.....

*Q: Would having dedicated sessions of CGAs help reduce the treatment burden? Can this be facilitated by ACPs/ PAs?*

A: Sorry cannot answer this as uncertain what CGAs are?

## Session 2 – How I manage...

### Malabsorption - Dr Ben Shandro

*Q: >3kg weight loss is mentioned as significant- over what period of time?*

A: I use >3kg and 6 months. The definition of unintentional weight loss is not as well defined as people might presume, but most research literature uses either 5% or 10% total body weight, and usually use 3, 6 or 12 months. The >3kg figure over 6 months is a conservative 'rule of thumb' (it would be 5% weight loss in someone weighting 60kg). The lesser the degree of weight loss, and the longer the duration of weight loss, both generally indicate benign entities.

*Q: How long does secondary lactose intolerance take to resolve? How long should they follow a dairy free diet - unpleasant for many!*

A: It depends on the cause! Once you have addressed the underlying cause of the enteropathy, the villi begin regenerating within days. In the context of infectious gastroenteritis, I usually suggest 1-2 weeks dairy free then re-introduce. Patients with coeliac usually need 2-3 months for villous healing to advance (and ~2 years to fully heal). The key thing is that dairy free diet is to help symptoms only, and does not confer any other benefit, so if they want to try introducing immediately, that is also fine - they can self-titrate.

*Q: In the case study was there any relevance to the initial eosinophilia?*

A: Not that we have found. As it resolved spontaneously, we have not pursued bone marrow etc, but through drug history, allergy screen and parasite screen all negative. It remains normal today.

*Q: Do you have any advice for patients with pancreatic malignancy or chronic pancreatitis who are not responding to high doses of pancreatic enzymes?*

A: With untreated pancreatic malignancy, even adequate Creon cannot cancel out the cancer cachexia. In operated patients, and those with chronic pancreatitis, usually non-response can be addressed though. Increasing the Creon dose, adding adjunctive PPI, and thorough dietetic review (with regards to storage of Creon, how they are taking it (best spread out throughout each meal, not just all at the start), ensuring adequate dietary intake etc). If all else fails, it is worth excluding other diagnoses such as SIBO. There is a reasonable summary of approach to non-response in a review paper I co-wrote with a dietitian - PMID 30397535.

*Q: Symptoms of SIBO and IBS overlap a lot. In structurally normal small bowel, how common is SIBO, and how do you investigate?*

A: This is actually a very complex question! There is a huge variety of prevalences of SIBO reported in IBS in the literature (from 4-80% in IBS, and from 1-50% in 'healthy' controls). This probably reflects difficulties with the syndromic classification of IBS and with the tests for SIBO. The glucose breath test is fairly insensitive and non-specific, but is the most widely used test now, and we use it at my centre. Few centres do jejunal aspirates any more (which was v specific but probably quite insensitive). For now, my practice is to only test for SIBO in patients with IBS-D (not C) where there is some suggestion of malabsorption (e.g. low B12, high folate etc), or where there is demonstrable abdominal distension (without constipation). I suspect as our microbiome understanding progresses, this area will really expand.

## Session 4 – Interactive case studies: Clinical cases that provide valuable lessons for the generalist

## **Respiratory medicine - Dr Tom Mackay**

Q: *It seems his human rights have been temporarily removed (deemed to have no capacity) based on the assumption of drug use / past use; this seems a weak presumption for such a significant decision. Is there an element of discrimination here? Or a risk of looking for a reason for a lack of capacity?*

A: There was absolutely no evidence of discrimination. The reason that 2 Consultant Psychiatrists were involved in this case was to ensure that the decisions that we made were in the best interests of the patient who had a life threatening condition

Q: *Vaping and bullous lung disease? Worse with cannabis oils?*

A: Vaping using cannabis oils may well produce significant risk in terms of developing emphysema similar to the risks with smoking cannabis

Q: *Were the drug and alcohol liaison team involved?*

A: The drug and alcohol liaison team was involved during the patient's stay in hospital but he refused any follow up appointments

Q: *Is it possible to go straight to VATS?*

A: We thought that a VATS procedure was the last resort but it did prove necessary to perform that operation in the end

**Friday 24 November 2023**

## **Session 2 – What does the future hold?**

### **Dementia positive practice and non-pharmacological interventions - Professor Debbie Tolson**

Q: *As a junior doctor on nights, we are often asked to prescribe antipsychotics too late- when the window of opportunity for 'good dementia nursing care' seems to have all but closed. Can we do anything to stop these middle of the night crises in the absence of more staff?*

A: Distressed behaviours, including sleep disturbance, are usually manifestations of an underlying unmet need in the person with dementia, most guidance recommends non-pharmacological interventions in the first instance—at any time day or night. As you will know, thorough clinical examination is required to determine whether or not it would be appropriate and safe to prescribe antipsychotics.

This will not be easy if the person is in a heightened state of distress. There are techniques that can and should be used by staff including yourself to calm a person and if you are unsure you might find it useful to speak with your local Alzheimer Scotland Dementia Consultant and or local Dementia Champions. There are colleagues who will be able to support additional dementia training and if you are being called out repeatedly with similar requests for different patients it would be sensible to alert senior nursing staff and seek their input.

Feeling that it is 'too late' suggests that you are referring to situations of severe distress so you need to be clear if this how the staff or you feel or is it really how the patient feels. If you are not sure take time to be clear about what is happening and why it might be happening now and what is the appropriate clinical response. What are the behavioural and psychological features that you are treating, what are the psychotic features, is there a physical cause such as pain or a fear trigger that

can be addressed- are you seeing hyperactive delirium? The staff who are calling you at night may not be confident in positive dementia practice, alternatively those staff who have the knowledge and skills may not feel able to provide the required level of care to keep the person because of unsafe staffing levels. Whether it is a lack of confidence or staffing levels this needs to be raised with senior nurses on the unit and the Alzheimer Scotland Dementia Consultant could be helpfully involved . In Scotland, the Health and Care Staffing Act has shines a spotlight on safe staffing levels, including supply of nurses who are enabled to keep their practice up to date through CPD [Health and Care \(Staffing\) \(Scotland\) Act 2019: overview - gov.scot \(www.gov.scot\)](#) .

In forming your view as what to do when called out during the night – always make sure your decision is based on what is best for the patient and appropriate given the underlying illness. It can be tempting to prescribe what night staff are requesting you to do, but staff shortage is not an excuse for a poor clinical decision- although it may be a quick solution in the moment. Always be clear as to why you are prescribing any drug and think about the consequences including benefits and risks for the person and be clear about the alternatives.

If sleep disturbance is the main issue, while the person is in an acute hospital this may be temporary and associated with the ward environment and the primary reason for admission. Sleep hygiene approaches can be woven into the 24 hour care plan and could involve reducing daytime napping, increasing activities during the day, agreeing realistic expectations for sleep duration and having an agreed intervention plan setting out what to do during the night. Family members can also inform you about what is happening at home and if this is a new occurrence of something that has been happening for a while. Family may also be able to advise what they think could calm or reassure the person at night.

Antipsychotics should not be used for person with Lewy Body Dementia without specialist clinical advice. It can be useful to have a plan discussed in advanced with a senior clinician of what to do for individual patients should they become distressed at night during their time in hospital and to be clear about the risks and benefits for that individual and others. Unfortunately, there may not be a simple solution- and you will have to use your clinical judgement in the situation.

*Q: No 2 dementia patients are the same and have very different needs. They also tend to change in time, time of the day and/ or with acute illness. What severity of illness are these interventions and strategies aimed at?*

A: Many non-pharmacological interventions are not designed for acute illness escalations. But there are techniques which are calming and can be used including hand massage, music therapies and other activities which are familiar to the person. *Getting to Know Me* documentation is helpful as this sets out the person's interests, preferences and the activities they currently enjoy and when they use these different interventions/activities during the day or night.

*Q: Complementary therapies can't be looked at as RCTs - I believe a recent cochrane review found very limited evidence for effectiveness. Where healthcare resource is stretched should there be better evidence to support use?*

A: I share your frustration and desire to make it possible for us to provide evidence informed care within our services and hospitals.

In theory all interventions can be protocolised and investigated using intervention research designs including trial designs. There will only be more evidence for dementia caring interventions, including

complementary therapies, if research teams propose such studies and convince the funders they are worthwhile funding! When systematic reviews show a lack of evidence that does not mean that an intervention is not useful it simply means there is a research gap. Sometimes the apparent lack of evidence can be linked to our choices of measures of effectiveness and core outcomes within studies which need to be appropriate to the intervention under scrutiny. As you will appreciate designing caring intervention studies is particularly challenging when the recipient of care is not able to directly or reliably self-report.

Research into complementary therapies and other caring interventions is justified as it is about evidence for practice for a complex progressive illness experience. The arguments for evidence informed dementia care are different from issues of healthcare resource so it can be helpful to make a distinction. There is as you will recognise lots that could be done to deepen our evidence base for dementia care interventions and different research designs that could and do contribute to the evidence base for practice, but do not necessarily get captured by systematic reviews focused on intervention efficacy.

*Q: Do you believe there is a national problem with providing adequate domiciliary/ nursing home care to patients due to a lack of staff or unsuitable profile from the perspective of caregivers?*

A: There is a legacy of underfunding and low status afforded to nursing home practice. I believe that dementia is a complex and progressive illness experience, and that we need new models for long term care including housing with alternative dementia specific care models. Family carers make a significant contribution to care in the community and we must invest in family carer practical skills dementia education- and value family members as care partners.

### **Session 3 – Diabetic dilemmas**

#### **Hyperosmolar hyperglycaemic state - Dr Jane Dymott**

*Q: As a rotating doctor in training I find it very difficult as the guidelines in each hospital are all different, these can be very difficult to navigate especially on a busy shift with an unwell patient - is there any plan to nationalise the guideline to reduce the risk of errors?*

A: At present there are no national guidelines, principles will be the same and JBDS-IP guidance summary good option if there are no local guidelines.

*Q: Is the rate of fluid replacement in DKA/ HHS slower if that patient has established HFREF? Would be reduced as well in HFpEF?*

A: Fluid replacement in both DKA and HHS needs to be adjusted based on clinical judgement, would adjust depending on clinical assessment and the key is to monitor regularly and adjust management in response to this monitoring and clinical assessment.

*Q: Do you see more DKA with extremely high glucose e.g >50 now that there are very long lasting insulins?*

A: This is not a relationship I have particularly seen. In my experience people presenting with very high glucose in DKA tend to be people who have relative insulin deficiency and then a combination of provoking illness and hyperglycaemia tips them in to DKA, ie they probably started more like an HHS picture but then as condition progresses become ketotic and acidotic.

*Q: To calculate the osmolality, do we need to correct the Na in equation as sodium may be falsely low due to hyperosmolality?*

A: No you do not correct sodium for calculating osmo, glucose is in the equation. I would calculate corrected sodium if there are concerns about an increasing sodium, and this can provide reassurance that this is due to a falling glucose rather than inappropriate fluids.

*Q: Would a patient with CKD5 still develop the hyperglycemic diuresis therefore the hypovolemic state?*

A: So it will depend on how much urine the person still produces, for example people on dialysis will not become dehydrated with hyperglycaemia due to lack of osmotic diuresis, will vary depending on residual renal function.

*Q: Which one has higher mortality HHS or DKA? Need aggressive fluid in HHS than DKA?*

A: HHS has a much higher mortality than DKA. Overall people with HHS will have greater water deficits compared to DKA, but need more cautious fluid replacement due to slower onset and higher risk of other conditions. For DKA with SGLT2i I use standard DKA management, reviewing fluids depending on other conditions.

*Q: For patients already admitted HHS can be manifestation of end of life. It's difficult to know when not to treat and I feel sometimes we treat people unnecessarily who may be dying. Any insight into this?*

A: Hopefully covered at the end of the talk, I personally feel this is where professionalism comes in, taking a person centred holistic approach and speaking to seniors or other colleagues if uncertain.

*Q: When the patient meets criteria for HHS we can follow the guidance. But what about management for those with DM2 with high glucose who don't quite meet the criteria? There is a reluctance to use insulin if the criteria aren't fulfilled.*

A: This is a whole talk in itself! Depending on the situation, might be able to adjust usual medications, give fluids (would only use insulin in HHS if glucose not initially falling) treat the underlying cause....might need to be invited back to do another talk to fully cover!

*Q: If HHS presents with Na=168, what should be the fluid of choice?*

A: I would still start with 0.9% saline as this is hypotonic compared to person, and we don't want to lower sodium too quickly

*Q: Is cognitive impairment or abnormal thirst/water access prerequisite to fully develop HHS? Please can you expand on why 0.9% saline is the fluid of choice? Given mounting evidence for acidosis and balance crystalloids better for the critically ill?*

A: More commonly see HHS in people who are less likely to increase water intake, but can occur in people who should be able to increase fluid intake but cannot keep up with losses due to osmotic diuresis. Regarding fluids, there is no evidence in this situation for other fluids, main principle would be to ensure not dropping sodium too quickly, so not using fluids that are too hypotonic compared to patient, and ensuring have options for potassium replacement. Debate about fluids tends to come around- when I was a trainee colloids were the "best thing". Just need to know what fluid you are giving, what is in it. I stick with 0.9% saline for HHS and DKA as life is already too complicated!

*Q: How to modify HHS management (fluid replacement) in patients with advanced CKD?*

A: This would depend on clinical assessment, will need to monitor closely and adjust fluid rate depending on clinical findings/observation.

#### **Session 4 – What I ought to know about...**

##### **Novel cancer drugs – Dr Peter Gallagher**

*Q: Do you believe all patients receiving oncological treatment should be cared for in an oncology ward when inpatient? In my AMU we are often faced with push back from Oncology colleagues regarding taking over patients admitted via our unit. Should these patients be admitted directly to Oncology?*

A: Please see answer to 6<sup>th</sup> question

*Q: Can immunotherapy trigger smouldering diseases like vasculitis or IBD?*

A: Absolutely, vasculitis is a recognised potential complication of immune-checkpoint inhibition but is thankfully rare. With regards to a longer-term inflammatory bowel syndrome, thankfully any cases of enterocolitis we have seen have resolved/remained quiescent following sufficient treatment (including infliximab +/- vedolizumab if had not fully responded to steroids). In cases where an enterocolitis has been difficult to manage, we will often permanently discontinue the immune-checkpoint inhibitor which may also limit further risk of a longer-term IBD picture.

*Q: Is there a case for pre-emptive steroid therapy given how commonly the complications occur?*

A: No- we would not prophylactically treat with corticosteroids, as being on steroids at the time of treatment initiation may limit the efficacy of immune-checkpoint inhibition (potentially through an effect on immune-priming). Retrospective analyses from several centres and disease types has demonstrated a potentially negative impact of early steroid initiation. I would usually not commence immunotherapy until patients are on the lowest amount of steroid required (ideally should not be on any, or be  $\leq 10$ mg prednisolone daily/equivalent dose). Although early steroid initiation may be associated with impaired treatment efficacy, we should not be deterred from commencing steroids in those who require it for management of a toxicity as use for this purpose does not appear to impair outcomes (and if anything, commencing steroids for toxicity management may be associated with improved outcomes, likely as the occurrence of that toxicity may indicate an immune response).

*Q: How do you approach patients with pre-existing inflammatory conditions - ie Rheumatoid arthritis - when commencing checkpoint inhibitors?*

A: This is a very interesting question, and one for which data on individual conditions is limited but under exploration. The primary concern is the higher risk of a flare of the underlying autoimmune/inflammatory condition. In these cases consideration needs to be given to: the nature of the underlying condition, patients history of this (ie. how is it currently controlled, how has it been managed in the past/ has it been difficult to manage before etc.), and whether or not there are any non-immunotherapy related treatment options for their cancer. For patients who have significant inflammatory conditions (eg significant RA) who require immune-checkpoint inhibitors for their cancer, then ensuring they are on lowest immunosuppression required with lowest steroid dose is important- we will consult their treating team (eg. Rheumatology) to guide this. Furthermore, some more selective immune-suppressants may control the underlying inflammatory condition while not having as significant impact on immunotherapy outcome and a mutli-disciplinary approach of a



switch to one of these may be appropriate (please see Haanen J et al. Annals of Oncology. 2020; 31: 724).

*Q: It feels that there is sometimes limited input from oncology and other specialties are left dealing with these toxicities with limited assistance. Is there a shortage of oncologists able to both deliver these new therapies and be responsible for the side effects?*

A: Please see answer to 6th question

*Q: Given the spectrum of illness these treatments cause, should they not be looked after by an oncologist? We have no on site oncology and never see them come and review patients.*

A: Differences will exist in the capacity of individual oncology units to provide inpatient care for patients receiving oncology treatments. Within our own region, some patients will receive oncology treatment/SACT as an outpatient in peripheral units/satellite hubs, and as the treating oncologist we are only at these units for a limited time with no inpatient capacity/admission rights into these units. Our patients often prefer admission to their local hospital as it is closer to family, and we do not have capacity at our regional cancer unit to admit all oncology patients who require inpatient care. Therefore, there are many cases where cancer patients are admitted under acute medicine/other medical specialties. However, if oncology specific management which cannot be provided in the peripheral units is required, we are happy to accept for admission. As a specialty, it is recognised that as we treat more patients, particularly with newer more complex drugs, that not only do we need to expand our services to prescribe/deliver these treatments but we also need to expand our services to manage the complications from treatment. Therefore, we have expanded our acute oncology services with a team now available within each health trust, consisting of oncology nurse specialists/specialty doctors and lead by an oncology consultant. They can often provide oncology specific advice, and can be a useful contact for other medical specialties, but I also find them a useful contact for myself and will liaise with them if I require information on patients admitted elsewhere. I appreciate acute oncology services are not available everywhere; in cases where a patient is admitted unwell or with a particular toxicity of cancer treatment I think that most oncologists would like to be contacted (although I cannot speak for every oncologist) to ensure oncology related issues are managed appropriately. Ultimately we all want the best outcome for the patient at involved, and very often in oncology, a multi-disciplinary approach is required.

### **Palliative care – best practice – Dr Katharine Thompson**

*Q: What do you think about the generalists using SPICT or GSF PIG as guidance for EoL and referral to palliative care?*

A: I answered this on the day (will be in recorded session)\*

*Q: I'm a rehab physician. Many of the clinical indicators of dying you describe are pretty common in chronic neurological conditions, and apply to a greater or lesser extent in most of my patients. Any thoughts on identifying end of life in patients with long-term neurological conditions?*

A: I agree and this is certainly challenging: the SPICT (Supportive and Palliative Care Indicators Tool) <https://www.spict.org.uk/the-spict/> provides helpful guidance to support identification of patient deterioration in various situations including neurological conditions. Factors to consider would include more rapid physical/cognitive functional decline, deterioration in speech or swallow, recurrent aspiration pneumonia and weight loss.

## Managing chronic pain - Dr John Muthiah

*Q: How do we combat the current drive for GPs to de-prescribe addictive analgesics, for patients whom truly require these for analgesia? (Recently had a debate with a practice that refused to prescribe certain classes of analgesics)*

A: There is evidence for benefit of opioids in the short to medium term in the management of pain but the challenge is to follow the process of 1. Selecting appropriate patients 2. Discussing the pros and cons of analgesics and also the goals of treatment

3. Plan for regular review of these patients

4. Plan to wean analgesics if the goals are not being met or the pain has improved or the patients have significant side-effects or there is evidence of inappropriate drug use or diversion.

I can understand why GPs struggle with this due to current pressures and with no good evidence to support long-term use of opioids I can see their point of view.

*Q: Patients with chronic primary pain tend to have a similar personality type (often quite dependent, apathetic and sensitive). Do you think that this is a personality type that may predispose to developing chronic pain or do the personality traits develop as a result of chronic pain?*

A: If you look at the Acceptance and Commitment Therapy the patients need to possess psychological flexibility to gain any benefit from treatment. The patients who are entrenched in the behaviours that you describe may be psychologically inflexible and may not benefit from self management approaches. It is possible that childhood experiences and social and cultural influences may predispose patients to become entrenched in these behaviours. It is also possible that these behaviours prevent them from rehabilitation rather than being the direct cause for chronic pain or being the consequence of chronic pain. I am not sure whether it answers your question.

*Q: How do you deal with patients who do not engage with services / accept the 'faulty thermostat' type explanations and continue to demand resolution of symptoms with escalating drug doses?*

A: Engagement is key to the success of any self management approaches. Patient education at multiple levels of the patient pathway is likely to be beneficial with the reinforcement of the message that Chronic Pain is a long-term condition without a cure. I usually follow the ethos of "first do no harm" as there is clear evidence of long-term harm from doses above 120 mg of morphine and/or the goals of treatment are not being met and risks of continuing opioids outweighs the benefit. If the patient disagrees then I may offer to get a second opinion from a colleague.

*Q: Have you had any success with wellbeing Apps CBT input for managing chronic pain?*

A: I have not used the wellbeing apps resource in my patients but I have used the silvercloud online CBT programme for some of my patients with benefit. I presume it is similar to what you are talking about.

*Q: In many European countries the physical therapies like US/laser therapy/ electrotherapy/ hydrotherapy are used to alleviate MSK pain but in UK is not enough based medical evidence to approve the use; if pain is more about self-management could placebo have a role in management of pain*

A: Placebo response seems to play some role in reinforcement of the benefit patients derive from chronic pain treatments but I think we probably already use it. But in a resource limited health care system it will be difficult to convince commissioners of services to allow treatments, which are beneficial exclusively due to placebo effect, to be offered. I agree chronic pain patients continue to access a lot of such treatments. Similarly it may be important to mitigate nocebo response to maximise treatment benefits.

Q: *What are your thoughts on use of once a week Buprenorphine patches in patients with injuries like pelvic, humerus or vertebral fractures instead of BD or QDS analgesics to enable discharge home...*

A: I do not think there is evidence for this but there may be a small group of patients who may benefit from this approach. We still need to have a plan to wean these patients of opioids (in this case buprenorphine patch) once the condition resolves ....I know it is easier said than done.