Pennine GP Learning Group

Minutes of meeting

Date: Tuesday 26th September

Topic: Summary of Guidelines for Prescribing Specialist Infant Formula In Primary Care, Summary of Subclinical B12 deficiency - diagnosis and management and a case based discussion

Members present: Dr Rukhsana Hussain, Dr Ainie Chaudhry, Dr Ann Holmes

1. Dr Hussain updated members regarding the recent Calderdale LMC GP Forward View event.

2. Dr Hussain presented **A summary of guidelines for prescribing specialist infant formula in Primary Care**

This was based on a guideline produced by South West Yorkshire Area Prescribing Committee (SWYAPC). The guideline outlined recommendations of brand prescribing according to cost-effectiveness.

Dr Hussain mentioned that before summarising these guidelines she had not realised that Similec Alimentum was the most cost-effective formula and would prescribe Aptamil Pepti for those with CMPA or suspected CMPA. Having reviewed the guidelines she will now prescribe the more cost-effective option.

We all acknowledged how difficult it is to decide how much milk to prescribe and found the guidelines regarding quantities a useful reference.

The guidelines reminded us that we should not be prescribing Soya Milk to those under 6 months and if it is required over that age parents should buy it as it is available widely and at a similar cost to Cow's Milk. Dr Hussain mentioned that she had, just that day, had the conversation about stopping prescribing Soya Milk to a 3 year old girl who attended for a "medication review". Had she not read the guidelines, she acknowledged she may not have done so as the parents wanted her to continue the milk.

We discussed the management of reflux which is common in babies and usually resolves within 12-15 months. Dr Hussain mentioned how she had never prescribed the thickening formulae mentioned, SMA Staydown and Enfamil AR, but would consider them an option in the future.

We were reminded not to prescribe antacids with thickening formula as the stomach acids are needed for the formula to work and prevent reflux.

The guidelines also outlined when to suspect secondary lactose intolerance and the treatment for the same.

3. Dr Holmes discussed the case of a patient with a low serum B12 reading but no symptoms. She reviewed and summarised the guidance related to subclinical deficiency. We were reminded of the drugs that can cause problems with B12 absorption including Metformin, Colchicine and Ranitidine as well as PPIs. We were also reminded of the problems with the B12 assay and difficulties in interpreting blood tests. We were told that 25 % of patients with neuropsychiatric features related to B12 deficiency would have a normal MCV!

Dr Holmes also mentioned recommendations for low dose b12 in subclinical deficiency as a possible treatment strategy for these patients.

Dr Holmes also mentioned that patients with b12 deficiency but not responding to treatment could have copper deficiency, which can present similarly and that this should be especially considered in those who have had upper GI surgery in the past.

4. Dr Hussain mentioned the case of an acquaintance who had recently been unwell with fatigue and vertigo symptoms and mentioned her medical history to her. She had a history of intermittent episodes of severe decompensation out of proportion to intercurrent illness with problems with muscle weakness, pains and mobility. There was also a history of parental consanguinity and she had siblings with disabilities due to genetic defects. She had been the child that had been born without disabilities but developed these symptoms later in life.

Dr Hussain wondered whether she could have an inborn error of metabolism as her symptoms reminded her of a patient she had seen admitted to a hospital whilst she was working there. That patient had a metabolic defect and was treated with an IV dextrose infusion as per a specific protocol for her and improved.

Dr Hussain shared how she had done some reading and that people with inborn errors of metabolism can present as adults and that we should have a high index of suspicion if the aforementioned factors are present.

We discussed that it would be very easy to label the aforementioned patient as someone with chronic fatigue syndrome or fibromyalgia when in fact they may have an underlying metabolic disease due to a genetic defect! This could only be identified if their clinician thought of it and referred to a suitable specialist.

Action Plan

1. The next meeting will be in October 2017. Topic to be decided.

2. Dr Hussain will upload the presentation and minutes of the meeting to the website and inform members regarding the same.

3. One of the members missed the meeting as she thought it was on a Wednesday as it usually is, so Dr Hussain has decided to try to ensure the meetings are on Wednesdays in future to avoid the same confusion happening again.