Connect

Tallaght University Hospital | Ospidéal Ollscoile Thamhlachta

An Academic Partner of Trinity College Dublin

Quarterly Newsletter for GPs | Summer 2022 - Issue 26

Dear Colleagues

August 26th will forever be in the calendar as a significant date in the history of our Hospital. It was with great pleasure that we hosted the Minister for Health Stephen Donnelly TD as he officially opened our new 1,750m2 Intensive Care Wing. The opening is the culmination of years of lobbying, planning and building what is now the most modern Intensive Care Unit in the country.

I am particularly proud that it is yet another major infrastructure project that the Hospital has delivered in partnership with our contractors on time and on budget. The opening is a further element of our strategy implemented that improves access for our most vulnerable patients and prepares the Hospital for the increasing demands of serving a rapidly growing population.

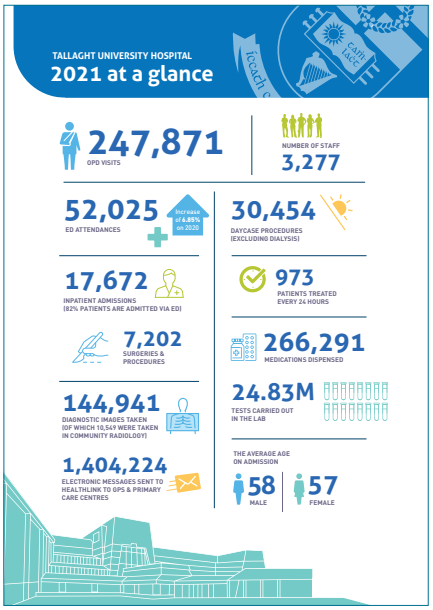
Patients requiring ICU care will now receive it in this appropriate and superior location, ensuring the alternative areas previously used for ICU patients can be used for their proper purpose i.e. post anaesthetic care unit which facilitates complex postoperative patients. The existing 9 ICU beds are also being refurbished.

Our annual staff Hero Awards took place on September 8th. I would like to thank everyone that took the time to nominate their colleagues and congratulate all of the 2022 Heroes. This is a very important day for the Hospital to acknowledge it's staff.

Finally, the 2021 Annual Report was published recently, the challenges of the pandemic and conti cyber-attack did not stop some impressive developments going ahead last year. I would like to acknowledge the resilience and dedication the TUH team have demonstrated once again, delivering the very best of care and service to our patients, community and indeed one another.

Best wishes

Lucy Nugent
Chief Executive
Tallaght University Hospital



'Our Voices' TUH Community Choir: Sing for your Health

The health benefits of singing in a choir are well-documented and evidence based, such as the opportunity for social connection, improved respiratory health and promoting positive mental health, to name a few.

This September, the Arts & Health Department at TUH are starting an exciting new initiative, 'Our Voices'. For 10 weeks the TUH Community Choir for out-patients, their families, friends and carers will meet in Rua Red Theatre, Tallaght from 11am-12:15pm. The choir ethos is to promote well-being and a positive experience of the Hospital for all. It's aim is to bring the community of TUH together in a clinically supported, social and creative context to work towards a shared goal. The purpose is not to produce a polished 'musical sound' but to provide a fun, uplifting experience for all members.

Directed by Clara Monahan, TUH Music Therapist, the music will be a mixture of popular classics and music from the movies/musicals. This project is kindly funded by The Meath Foundation Quality Improvement and Innovation Fund.

Details

Dates: 10 weeks 19th September – 28th November 2022

Rehearsals: Mondays 11am – 12:15pm

Where: RUA RED, South Dublin Arts Centre (Tallaght)

Final Concert: Evening of 29th November 2022

Cost: Free of Charge, we just ask that Choir members commit to attending every week for the ten weeks

If you have a patient / carer that is a patient of TUH that you think would benefit from taking part in the programme then please let them know about the initiative. For more information email artsandhealth@tuh.ie

Assisted Decision Making Act 2015

The Assisted Decision Making (Capacity) Act 2015 was signed into law on the 30th December 2015. This Act applies to everyone and is relevant to all health and social care services. The Act is about supporting decision-making and maximising a person's capacity to make decisions. The Act is due to commence this year.

Key reforms under the Act:

- Capacity is assessed in a time-specific and issue-specific way
- The ward of court system for adults will be abolished and all existing wards will be reviewed and will exit wardship within three years
- The Act provides a new three tiered support framework to support a person's decision-making about property, affairs and personal welfare.
- Establishes new ways for everyone to plan ahead, in case we lose our ability to make certain decisions in the future
- Establishes new guiding principles that emphasise privacy, autonomy and respect for a person's will and preferences.

Guiding Principles under the Act:

- Presume capacity
- Support decision making
- Right to make unwise decisions
- Intervene only where necessary
- An intervention is least restrictive and respects the person's rights
- An intervention gives effect to the person's will and preference
- Consider the views of others
- Consider the likelihood of recovery and urgency or the matter
- Obtaining, using and storing relevant information

The commencement of the Act will impact on how medical professionals can obtain consent and help patients in making decisions about their medical treatment and the care they receive. All clinical and patient facing staff will need to have a knowledge of the guiding principles of the legislation and how to implement this into their everyday practice. Resources are available at: www.assisteddecisionmaking.ie and www.decisionsupportservice.ie

Memory Clinic Secures Long Term Funding

In 2020 Professor Seán Kennelly ran a pilot dementia clinic for people with Down syndrome. The clinic ran with the guidance of Professor Mary McCarron of Trinity College Dublin and a recognised global expert in dementia in people with intellectual disabilities and AVISTA* who had the nursing expertise.

The trial clinic has now received permanent funding from the HSE National Dementia Office. The National Intellectual Disability Memory Service (NIMDS) is the only one of its type in Ireland and is one of only a handful of such clinics available internationally.

Research conducted by Trinity College Dublin found that by 65 years of age, 80% of people with Down syndrome will develop dementia, with the average patient reporting early onset of the illness at the age of 51. This compares to a rate of dementia in the general population of between 4% and 8% in people aged 65 and older.

Despite this high risk, many people struggle to get a diagnosis and caregivers are often overwhelmed. The earlier that dementia is detected, the sooner supports may optimise quality of life for the person living with dementia meaning we must look proactively at prevention and have a greater focus on lifelong brain health. Diagnosis is complex, and for people with intellectual disability there is inequity of access to timely diagnosis. The NIDMS responds by fusing the expertise at the specialist regional memory service in our hospital, the extensive knowledge on dementia in people with intellectual disability at the Trinity Centre for Ageing & Intellectual Disability and the expertise of a well-established dementia specific service and memory clinic for people with ID at AVISTA.

GP Referrals via Health-Link to Prof. Seán Kennelly or by post to Professor Seán Kennelly, NIDMS Clinic, C/O ARHC Dep't., Tallaght University Hospital, D24 NROA. All referrals must be registered in the first instance in the TUH OPD Dep't.

For more information and appointment coordination for the regional specialist memory service queries are to Mary Kelly, Clerical Admin for the Regional Specialist memory Service - email mary.kelly17@tuh.ie, 01 414 2498. Referrals to the national intellectual disability service are to Emma Donnelly Emma.Donnelly@tuh.ie, 01 414 4994.

**formerly known as the Daughters of Charity*

Professor Mary McCarron, Director of the Trinity Centre for Aging & Intellectual Disability and Professor Seán Kennelly, Clinical Director of the NIDMS and Director of the TUH Institute for Memory & Cognition

New Clinical Pathway for Headaches Confirmed

A new clinically approved headache pathway has been confirmed following a successful Sláintecare funded pilot project. The new service for patients with headache and migraine was piloted across three Neurology centres in TUH, Galway University Hospital and St James's Hospital in 2020 & 2021 with funding from the Department of Health's Sláintecare Integration Fund.

Professor Orla Hardiman, National Clinical Lead in Neurology said: "800,000 people in Ireland have a neurological issue, and there are 21,000 people on a waiting list for a neurological appointment in Ireland. Between 25% and 30% of people on those waiting lists were referred because of headache or migraine. Headache was the seventh most common reason for attendance at Emergency Departments, and the second most common reason for attendance at Medical Assessment Units."

The teams delivering the new service include neurologists, Clinical Nurse Specialists (CNS), Psychologists and targeted administrative support. The Migraine Association of Ireland has partnered with the project to streamline services available to patients, especially psychology support groups in the community to facilitate self-care and long-term management of headache, thus reducing the need for ongoing engagement with hospital-based services.

Professor Hardiman adds: "New patient pathways have been key to improving the patient experience, and for a timelier, more appropriate service for patients.

Members of the TUH Headache Clinic team are from right to left Sharon Moran, Clinical Nurse Specialist with specialism in headache; Dr. Petya Bogdanova Mihaylova, Consultant Neurologist and Dr. Claire Hannon, GP with specialist interest in Headache

If the Irish College of General Practitioners headache management guidelines are not working, GPs can refer patients to a multidisciplinary specialist headache team.

The team then works out a care plan with the patient and can refer for additional supports provided by the Migraine Association of Ireland where appropriate. Pharmacies have also been an important partner in the patient pathway, as they are often the first point of contact for people suffering from headache and migraine, and can provide invaluable advice to help with medication compliance".

The project has had a life-changing impact for patients who have accessed the service. Claire, who has suffered with migraine for seven years and attends the clinic in TUH said:

"I got a job in the last six months. It's amazing, I never thought I would be able to work again, I can understand my migraines thanks to the service I've attended in Tallaght, and the Psychology Groups. It's been really helpful in getting a job, my boss can understand my migraines, because I can understand and explain them."

Email is: opcentralrefferals;@tuh.ie

Dr Consultant is Neurologist
Dr Bogdanova Headache Clinic

Clinical Nurse Specialist in Headache Disorders: Sharon Moran 01 4144437.
Email: sharon.moran@tuh.ie

Administration support Tracey
01 4142860 Headache Clinic secretary

General Neurology referral phone no
01 4142090

Headache Pathway - Assessment and Referral Guidance

Key points

- Migraine, TTH (Tension-type headache) and MOH (Medication overuse headache) are most common headache disorders and in most cases not difficult to manage
  - initial primary care management recommended
- Good management of most headache disorders requires monitoring over time
- History is all-important, there is no useful diagnostic test for primary headache disorders and MOH
- Headache diaries (over few weeks) are essential to clarify pattern and frequency of headaches, associated symptoms, triggers, medication use/overuse
- Special investigations, including neuroimaging, are not indicated unless the history/ examination suggest secondary headache
- Sinuses, refractive error, arterial hypertension and cervicogenic problems are not usually causes of headaches
- Opioids (including codeine and dihydrocodeine) not to be prescribed in migraine

Assessment of patients with headache

Full history, including:

- age of headache onset (if →50 years consider Temporal arteritis)
- special attention to any new headache or significant change in existing headache
- duration of headache:
  - Chronic migraine (longstanding and continuous; previously intermittent) vs New Daily Persistent Headache (usually recent and continuous) vs Trigeminal or occipital neuralgia (paroxysmal)
- frequency (if very frequent must suspect medication overuse)
- any specific warning features (see "Red flags")
- medications (if MOH suspected – stop analgesics and caffeine; COCP in migraine)

Examination (mandatory if secondary headache suspected), including:

- Visual acuity; visual fields to confrontation and fundi
- Blood pressure

Patients with acute worst ever headache should be referred to ED

Abbreviations

TTH - tension-type headache
MOH - medication-overuse headache
TN – trigeminal neuralgia
SUNCT - severe unilateral neuralgiform headache with conjunctival injection + tears
SUNA - severe unilateral neuralgiform headache with autonomic features
NDPH - New daily persistent headache
Qol - Quality of life
COCP – combined oral contraceptive pill
PIFP - Persistent idiopathic facial pain

When to refer to a Specialist

(Consider referring to ED depending on presentation and OPD waiting time)

Diagnostic uncertainty, including unclassifiable, atypical headache

Diagnosis of **any of the following:**

- Chronic migraine (patients who have failed at least one preventative agent)
- Cluster headache
- SUNCT/SUNA
- Persistent idiopathic facial pain
- Hemicrania continua/chronic paroxismal hemicranias
- Trigeminal neuralgia

Suspicion of a serious secondary headache (Red flags):

- Progressive headache, worsening over weeks or longer
- Headache triggered by coughing, exercise or sexual activity
- Headache associated with any of the following:
  - postural change (indicative of high or low intracranial pressure)
  - papilloedema
  - focal neurological deficit or seizures
  - rapid progression of unexplained cognitive/ personality/ behavioral change
  - unexplained fever
  - weight loss or poor general condition

New headache:

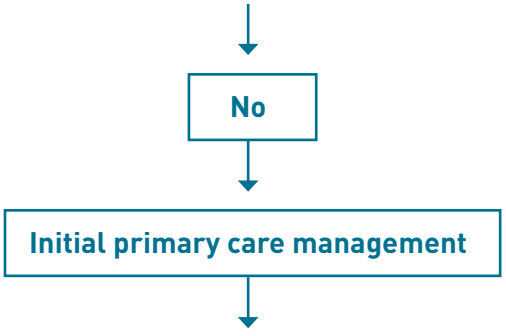
- Presenting as thunderclap (intense headache with "explosive"/abrupt onset)
- In a patient ≥ 50 years, check ESR/CRP and refer
- New daily persistent headache (and no prior history of headache)
- In a patient with risk factors for immunodeficiency or cancer
- In a patient with family history of glaucoma

Headache with atypical aura, especially

- prolonged (lasting> 1 hour) or including significant prolonged motor weakness
- new aura without headache in the absence of a prior history of migraine

Headache not responding satisfactory to management in primary care

Comorbid disorders requiring specialist management



Migraine

Recurrent moderate/severe pain
typically but not always:

- unilateral and/or pulsating
- lasting 4-72 hours untreated
- associated with
  - nausea / vomiting
  - photo- ± phonophobia
  - aggravated by routine physical activity, and disabling
- freedom from these symptoms between attacks

Usually episodic
Can be chronic (15% of cases):

- headache ≥15 d/month, of which ≥8 d migrainous
- often complicated by:
  - depression and/or anxiety
  - low back and/or neck pain
  - medication overuse

Migraine with aura

≈ 1/3 of patients with migraine
Aura 5-60 minutes prior to / with headache
Typical

- visual (>90% of auras): blurring is not diagnostic; and/or
- unilateral sensory

Less common

- brainstem (vertigo, tinnitus, diplopia, ataxia);
- speech and/or language

Rare

- motor weakness

Full recovery after attacks

Acute attack (Restrict simple analgesia to max 6 d/month)

Prefer soluble analgesic, early in the attack, at an adequate dose

- Simple analgesia (high dose aspirin, paracetamol, NSAID) ± antiemetic, or if ineffective
- Triptans (oral, nasal spray, sc injection) or
- Simple analgesia + triptan ± prokinetic antiemetic
- Avoid COCP if any aura / severe migraine
- No triptan DURING aura

Prophylactic therapy (Restrict simple analgesia to max 6 d/month)

Start any drug at a low dose and increase if no major SE; trial for ≥ 8-12 weeks; tapered withdraw after ≥ 6 months of good control

- Propranolol LA 80-160 mg od
- Amitriptyline 10-100 mg at night / Nortriptyline 10-100 mg
- Topiramate 25mg od 2/52, titrate gradually to 50mg bd
- Candesartan 8-16mg od
- Sodium valproate 600-1500 mg/d (! not in women of child-bearing potential and pregnancy; Annual acknowledgment)
- Flunarizine 5-10 mg od

Medication overuse

- Daily or near-daily (≥15 d/month)
- Aggravation of a prior headache (usually migraine or TTH)
- Often worst early in the morning
- Great impact on QoL
- Causally associated with regular use, over >3 months, of:
  - Opioids/ Triptans > 10 d/month
  - Non-opioids > 15 d/month
- Usual acute migraine therapy ineffective
- Headache tends to worsen after analgesia withdraw, but in most cases improves within 2 months

Early intervention essential
Long-term prognosis usually very good

Withdrawal:

- Abruptly
- Tapering over a period of 2-4 weeks
- Replacing overused drug(s) with Naproxen 500 mg bd for max 3-4 weeks

Headache prophylaxis against antecedent headache may be introduced if intermittent primary headache features persist or emerge

Tension-Type Headache

Typically mild/moderate pain without associated symptoms
Not worse with activity
Can occur in combination with migraine

- Infrequent episodic TTH ≤ once/month
- Frequent episodic TTH
  - attack-like episodes on 1–14 d/month,
  - lasting hours to few days;
  - usually generalised (bilateral)
  - pressure or tightness, often spreading to the neck
- Chronic TTH
  - occurs on ≥15 days/month
  - may be daily and unremitting
  - may be associated with mild nausea

If infrequent, ≤ 2 days/week can be successfully treated with simple analgesia.
If frequency > 2 d/week –increased risk for medication use, consider prophylactic therapy:

- 1st line:

Amitriptyline 10-100 mg nocte
or
Nortriptyline (same dose) less SE / less efficacy

- 2nd line:

Mirtazepine 15-30 mg od

- 3rd line:

Venlafaxine 75-150 mg od

Cluster headache

- Affects M:F (3:1 ratio)
- Bouts last 6-12 weeks
- Typically 1-2 x year
- Rarely chronic throughout year
- Very severe pain, often at night
- Strictly unilateral
- Lasts 15–180 min (commonly 30–60)
- Marked agitation
- Triggered by alcohol
- Accompanied by highly characteristic & strictly ipsilateral autonomic symptoms:
  - red and watering eye;
  - rhinorrhea / blocked nostril

+/- ptosis

Prompt referral at first presentation for specialist review + MRI!

Avoid oral triptans and analgesics

Acutely

- Nasal or sc triptan
- 100% Oxygen at ≥ 12L/min until response, or for ≥ 15 min

Specialist care

- Transition therapies
  - Prednisolone
  - Occipital nerve block
- Maintenance prophylaxis
  - Verapamil (ECG)
  - Lithium carbonate (levels)
  - Topiramate (?efficacy)

Other

Should be recognised in primary care, but may require specialist management

Trigeminal neuralgia
Triggered unilateral sudden excruciating facial pain
Brief, often serial

↓

Carbamazepine; Oxcarbazepine; Lamotrigine; Gabapentin

SUNCT / SUNA
Similar to TN (but frontal)
Autonomic ocular symptoms

↓

Lamotrigine

Ice pick / stabbing
Sudden brief head pains
Various locations
and

Chr Paroxysmal Hemicrania
Unilateral periorbital
Autonomic (red eye, lacrimation, nasal congestion, ptosis)
15-30 minutes; multiple/ day
and

Hemicrania continua
Unilateral "side-locked" constant headache > 3 /12
+/- autonomic features
Restlessness

↓

Indomethacin +PPI

PIFP
Dull, daily persistent > 3/12
Poorly localized facial and / or oral pain
Often psychiatric comorbidity

↓

Amitriptyline, Gabapentin, Pregabalin