Symptoms in the Pharmacy
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A Guide to the Management of Common Illness

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FIFTH EDITION
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Preface

This is the fifth edition of our book. Among the important changes since the last edition is the move of more medicines from the prescription-only medicine (POM) category to the pharmacy (P) medicine category. Omeprazole was the first proton pump inhibitor (PPI) to move to the P category in 2004. The move of simvastatin to over-the-counter (OTC) availability is another landmark change. Here, the pharmacist’s skills in questioning and explaining in relation to risk assessment for heart disease are paramount, as are links to other health professionals.

There have also been important changes in the National Health Service (NHS) since the last edition. In many areas NHS-funded community pharmacy Minor Ailment Schemes are now in operation. Under these schemes patients who are exempt from prescription charges can obtain free treatment from the pharmacy. Thus more people will consult the pharmacist for advice who previously consulted their doctor, and this role of the pharmacist may develop into independent prescribing. The existing schemes are well used, particularly for children’s minor illness. We have thus expanded our explanation of common childhood illnesses to enable the pharmacist to manage where appropriate, to reassure and refer when necessary.

The supply of medicines under Patient Group Directions (PGDs) in community pharmacies is another key change. It enables the pharmacist to supply, on the NHS, treatments that would otherwise be POMs. Examples include chloramphenicol eye drops for eye infections and trimethoprim for uncomplicated urinary tract infection. In response we have extended our coverage of eye conditions.

The public will increasingly use their community pharmacy for advice and treatment. We have incorporated new case studies that test the boundaries of pharmacists’ professional judgement and further develop risk assessment skills.

The move towards partnership in medicines use (concordance) has developed further since the last edition. We believe this is just as relevant to OTC as to POMs. Therefore we have revised the introduction to strengthen the partnership approach. We have also introduced a patient perspective to some of our case studies and about specific issues (e.g. chronic conditions) where this can increase pharmacists’
understanding of how things look ‘from the other side of the counter’. We will welcome feedback from you on these changes.

Systematic reviews of published evidence are continuing to contribute to pharmacists’ treatment choices, and their findings have been incorporated and updated into this edition. Evidence on benefits and potential harm from herbal and other complementary medicines continues to emerge; thus we extend our discussion on glucosamine and chondroitin in arthritic conditions, and on St John’s wort in depression.

These changes mean that pharmacists at all stages of their career need practical information to help them in dealing with new areas of patient care and to ensure their knowledge is up to date. We have reviewed all of the practical case studies and added new ones to give a better reflection of current issues in practice.

We have received many positive letters and comments from pharmacists (undergraduate students, pre-registration trainees and practising pharmacists) all over the world following the earlier editions of the book and have tried to act on our readers’ suggestions. We would like to thank all the pharmacists who contributed in this way and hope that the present edition will meet the needs they have helped us to identify.

We would also like to thank Kathryn Coates and her network of mums, who provided advice on childhood conditions and on women’s health, and on the sort of concerns and queries that they hoped their pharmacists would answer.

Thanks also to Charlotte Purcell at Bradford School of Pharmacy.

Alison Blenkinsopp
Paul Paxton
John Blenkinsopp
Every working day, people come to the community pharmacy for advice about minor ailments. For the average community pharmacy a minimum of ten such requests will be received each day; for some the figure is far higher. With increasing pressure on doctors’ workload it is likely that the community pharmacy will be even more widely used as a first port of call for minor illness. Members of the public present to pharmacists and their staff in three ways:

• Requesting advice about symptoms.
• Asking to purchase a named medicine.
• Requiring general health advice (e.g. about dietary supplements).

The pharmacist’s role in responding to symptoms and overseeing the sale of over-the-counter (OTC) medicines is substantial and requires a mix of knowledge and skills in the area of diseases and their treatment. In addition, pharmacists are responsible for ensuring that their staff provide appropriate advice and recommendations.

Research on the appropriateness of advice-giving in community pharmacies has identified a set of criteria that pharmacists can use to consider their own pharmacy’s approach (Bissell, P., Ward, P. R. & Noyce, P. R. Appropriateness in measurement: application to advice-giving in community pharmacies. *Soc Sci Med* 2000; 51: 343–59):

• General communication skills.
• What information is gathered by pharmacy staff?
• How is the information gathered by the pharmacy staff?
• Issues to be considered by pharmacy staff before giving advice.
• Rational content of advice given by pharmacy staff.
• How is the advice given?
• Rational product choice made by pharmacy staff.
• Referral.

Key skills are:

• Differentiation between minor and more serious symptoms.
• Listening skills.
• Questioning skills.
• Treatment choices based on evidence of effectiveness.
• The ability to pass these skills on by acting as a role model for other pharmacy staff.
Working in partnership with patients

In this book we refer to the people seeking advice about symptoms as patients. It is important to recognise that many of these patients will in fact be healthy people. We use the word ‘patient’ because we feel that the terms ‘customer’ and ‘client’ do not capture the nature of consultations about ill-health.

Pharmacists are skilled and knowledgeable about medicines and about the likely causes of illness. In the past the approach has been to see the pharmacist as expert and the patient as beneficiary of the pharmacist’s information and advice. But patients are not blank sheets or empty vessels. They are experts in their own and their children’s health. The patient
– may have experienced the same or a similar condition in the past;
– may have tried different treatments already;
– will have their own ideas about possible causes;
– will have views about different sorts of treatments; and
– may have preferences for certain treatment approaches.

The pharmacist needs to take this into account in the consultation with the patient, and to enable the patient to participate by actively eliciting their views and preferences. Not all patients will want to engage in decision-making about how to manage their symptoms but research shows that many do. Some will want the pharmacist to simply make a decision on their behalf. What the pharmacist needs to do is to find out what the patient wants.

Responding to a request for a named product

Where a request is made to purchase a named medicine, the approach needs to take into account that the person making the request might be an expert or a novice user. We define the expert user as someone who has used the medicine before for the same or a similar condition and is familiar with it. While pharmacists and their staff need to ensure that the requested medicine is appropriate, they also need to bear in mind the previous knowledge and experience of the purchaser.

Research shows that the majority of pharmacy customers do not mind being asked questions about their medicine purchase. An exception to this is those who wish to buy a medicine they have used before and would prefer not to be subjected to the same questions each time they ask for the product. There are two key points here for the pharmacist: firstly, it can be helpful to briefly explain why questions are needed, and secondly, fewer questions are normally needed where customers request a named medicine that they have used before.
A suggested sequence in response to a request for a named product

Ask whether the person has used the medicine before, and if the answer is yes, ask if any further information is needed.

Quickly check on whether other medicines are being taken.

If the person has not used the medicine before, more questions will be needed. One option is to follow the sequence for responding to requests for advice about symptoms (see below). It can be useful to ask how the person came to request this particular medicine; for example, have they seen an advertisement for it? Has it been recommended by a friend or family member?

Pharmacists will use their professional judgement in dealing with regular customers whom they know well and where the individual’s medication history is known. The pharmacy patient medication records (PMRs) are a source of back-up information for regular customers. However, for new customers where such information is not known, more questions are likely to be needed.

Responding to a request for help with symptoms

1 Information-gathering: by developing rapport and by listening and questioning to obtain information about symptoms, e.g. to identify problems that require referral; what treatments (if any) have helped before; what medications are being taken regularly; what the patient's ideas, concerns and expectations are about their problem and possible treatment.

2 Decision-making: is referral for a medical opinion required?

3 Treatment: the selection of possible, appropriate and effective treatments (where needed); offering options to the patient and advising on use of treatment.

4 Outcome: telling the patient what action to take if the symptoms do not improve.

1 Information-gathering

Most information required to make a decision and recommend treatment can be gleaned from just listening to the patient. The process should start with open-type questions and perhaps an explanation of why it is necessary to ask personal questions. Some patients do not yet understand why the pharmacist needs to ask questions before recommending treatment. An example might be:

Patient: Can you give me something for my piles?
Pharmacist: I’m sure I can. To help me give the best advice though, I’d like a bit more information from you, so I need to ask a few questions. Is that OK?
Patient: That’s fine.
Pharmacist: Could you just tell me what sort of trouble you get with your piles?

 Hopefully this will lead to a description of most of the symptoms required for the pharmacist to make an assessment. Other forms of open questions could include: How does that affect you? What sort of problems does it cause you? By carefully listening and possibly reflecting on comments made by the patient, the pharmacist can obtain a more complete picture.

Patient: Well, I get spells of bleeding, and soreness. It’s been going on for years.
Pharmacist: You say years?
Patient: Yes, on and off for 20 years since my last pregnancy. I’ve seen my doctor several times and had them injected, but it keeps coming back. My doctor said I’d have to have an operation but I don’t want one; can you give me some suppositories to stop them bleeding?
Pharmacist: Bleeding…?
Patient: Yes, every time I go to the toilet blood splashes around the bowl. It’s bright red.

This form of listening can be helped by asking questions to clarify points: I’m not sure I quite understand when you say…, or I’m not quite clear what you meant by…. Another useful technique is to summarise the information so far: I’d just like to make sure I’ve got it right. You tell me you’ve had this problem since…

Once this form of information-gathering has occurred there will be some facts still missing. It is now appropriate to move onto some direct questions.

Pharmacist: How are your bowels… has there been any change? (This question is very important to exclude a more serious cause for the symptoms that would require referral.)
Patient: No, they are fine, always regular.
Pharmacist: Can you tell me what sort of treatments you have used in the past, and how effective they were?

Other questions could include: What treatments have you tried so far this time? What sort of treatment were you hoping for today? What other medications are you taking at present? Do you have any allergies?

2 Decision-making
Triaging is the term given to assessing the level of seriousness of a presenting condition and thus the most appropriate action. It has
come to be associated with both prioritisation (e.g. as used in accident and emergency (A&E) departments) and clinical assessment. Community pharmacists have developed procedures for information-gathering when responding to requests for advice that identify when the presenting problem can be managed within the pharmacy and when referral for medical advice is needed. The use of questioning to obtain the sorts of information needed is discussed below. Furthermore, in making this clinical assessment, pharmacists incorporate management of certain conditions and making recommendations about this.

The use of protocols and algorithms in the triaging process is becoming more widespread in the UK, with computerised decision support systems increasingly used. Such systems are currently the basis for the nurse-led national telephone health advice service, NHS Direct, and have been used in other countries, notably the USA. It is possible that in the future computerised decision support may play a greater part in face-to-face consultations, perhaps including community pharmacies.

If the following information were obtained, then a referral would be required:

**Pharmacist:** Could you tell me what sort of trouble you have had with your piles?

**Patient:** Well, I get spells of bleeding, and soreness. It’s been going on for years, although seems worse this time . . .

**Pharmacist:** When you say worse, what does that mean?

**Patient:** Well . . . my bowels have been playing up and I’ve had some diarrhoea . . . I have to go three or four times a day . . . and this has been going on for about 2 months.

For more information on when to refer see ‘D: Danger symptoms’ below.

### 3 Treatment

The pharmacist’s background in pharmacology, therapeutics and pharmaceutics gives a sound base on which to make logical treatment choices based on the individual patient’s need, together with the characteristics of the medicine concerned. In addition to the effectiveness of the active ingredients included in the product, the pharmacist will need to consider potential interactions, cautions, contraindications and adverse reaction profile of each constituent. With the increasing move to evidence-based practice, pharmacists need to think carefully about the effectiveness of the treatments they recommend, combining this with their own and the patient’s experience.
Concordance in the use of OTC medicines is important and the pharmacist will elicit the patient’s preferences and discuss treatment options in this context. Some pharmacists have developed their own OTC formularies with preferred treatments that are recommended by pharmacists and their staff. In some areas these have been discussed with local general practitioners (GPs) and practice nurses to cover the referral of patients from the GP practice to the pharmacy.

PMRs can play an important part in supporting the process of responding to symptoms. Research shows that only one in four pharmacists currently records OTC treatment on the pharmacist’s own PMR system. Yet such recording can complete the profile of medication, and review of concurrent drug therapy can identify potential drug interactions and adverse effects. In addition, such record-keeping can make an important contribution to clinical governance. Improvements in IT systems in pharmacies will make routine record-keeping more feasible. Keeping records for specific groups of patients, e.g. older people, is one approach in the meantime.

**Effectiveness of treatments**

Pharmacists and their staff should, wherever possible, base treatment recommendations on evidence. For more recently introduced medicines and for those that have moved from prescription-only-medicine (POM) to pharmacy (P) medicine, there is usually an adequate evidence base. For some medicines, particularly older ones, there may be little or no evidence. Here, pharmacists need to bear in mind that absence of evidence does not in itself signify absence of effectiveness.

Current evidence of effectiveness is summarised in the relevant *British National Formulary* (BNF) monograph. More detailed reviews of evidence can be found in *Clinical Evidence* (BMJ Publishing Group). Both publications have two editions each year and are available online. The BNF can be found at www.bnf.org.uk. *Clinical Evidence* can be accessed free of charge through the National Electronic Library for Health at www.nelh.nhs.uk. Useful websites for clinical guidelines are PRODIGY, the National Health Service (NHS) decision support system for prescribers at www.prodigy.nhs.uk/guidance; the Scottish Inter-Collegiate Guideline Network (SIGN) at www.sign.ac.uk and the National Institute for Clinical Excellence at www.nice.org.uk. Pharma-
cists can access MEDLINE to search for original references via the links section of the Royal Pharmaceutical Society of Great Britain website at www.rpsgb.org.uk. The website for NHS Direct at www.nhsdirect.nhs.uk includes algorithms and management advice for minor ailments as well as Best Treatments for patients to access information about their condition and treatment options.

Key interactions between OTC treatments and other drugs are included in each section of this book. The BNF provides an alphabetical listing of drugs and interactions, together with an indication of clinical significance. In this book, generic drug names are italicised. For symptoms discussed in this book, the section on ‘Management’ includes brief information about the efficacy, advantages and disadvantages of possible therapeutic options. Also included are useful points of information for patients about the optimum use of OTC treatments, under the heading ‘Practical points’.

4 Outcome
Most of the symptoms dealt with by the community pharmacist will be of a minor and self-limiting nature and should resolve within a few days. However, sometimes this will not be the case and it is the pharmacist’s responsibility to make sure that patients know what to do if they do not get better. Here, a defined timescale should be used, as suggested in the relevant sections of this book, so that when offering treatment the pharmacist can set a time beyond which the patient should seek medical advice if symptoms do not improve. The ‘Treatment timescales’ outlined in this book naturally vary according to the symptom and sometimes according to the patient’s age, but are usually less than 1 week.

Pharmacists are likely to be increasingly involved in the management of long-term chronic or intermittent conditions. Here, monitoring of progress is important and a series of consultations is likely rather than just one.

Mnemonics and the consultation
Pharmacists need to develop a method of information-seeking that works for them. Some pharmacists find that a mnemonic such as the two shown below can be useful, although care needs to be taken not to recite questions in rote fashion without considering their relevance to the individual case. Good listening will glean much of the information required. The mnemonic can be a prompt to ensure all relevant information has been obtained. Developing rapport is essential to obtain good information, and reading out a list of questions can be off-putting and counterproductive.
**W** Who is the patient and what are the symptoms?

**H** How long have the symptoms been present?

**A** Action taken?

**M** Medication being taken?

**W:** The pharmacist must first establish the identity of the patient: the person in the pharmacy might be there on someone else’s behalf. The exact nature of the symptoms should be established: patients often self-diagnose illnesses and the pharmacist must not accept such a self-diagnosis at face value.

**H:** Duration of symptoms can be an important indicator of whether referral to the doctor might be required. In general, the longer the duration, the more likely is the possibility of a serious rather than a minor case. Most minor conditions are self-limiting and should clear up within a few days.

**A:** Any action taken by the patient should be established, including the use of any medication to treat the symptoms. About one in two patients will have tried at least one remedy before seeking the pharmacist’s advice. Treatment may have consisted of OTC medicines bought from the pharmacy or elsewhere, other medicines prescribed by the doctor on this or a previous occasion, or medicines borrowed from a friend or neighbour or found in the medicine cabinet. Homoeopathic or herbal remedies may have been used. The cultural traditions of people from different ethnic backgrounds include the use of various remedies that may not be considered medicines.

If the patient has used one or more apparently appropriate treatments without improvement, referral to the family doctor may be the best course of action.

**M:** The identity of any medicines taken regularly by the patient is important for two reasons: possible interactions and potential adverse reactions. Such medicines will usually be those prescribed by the doctor, but may also include OTC products. The pharmacist needs to know about all the medicines being taken by the patient because of the potential for interaction with any treatment that the pharmacist might recommend.

The community pharmacist has an increasingly important role in detecting adverse drug reactions, and consideration should be given to the possibility that the patient’s symptoms might be an adverse effect caused by medication. For example, whether gastric symptoms such as
indigestion might be due to a non-steroidal anti-inflammatory drug (NSAID) taken on prescription, or a cough might be due to an angiotensin-converting enzyme (ACE) inhibitor being taken by the patient. Where the pharmacist suspects an adverse drug reaction to a prescribed medicine, the pharmacist should discuss with the doctor what actions should be taken (perhaps including a Yellow Card report to the Committee on Safety of Medicines, which can now be made by the pharmacist) and the doctor may wish the patient to be referred so that treatment can be reviewed.

The second mnemonic, ASMETHOD, was developed by Derek Balon, a community pharmacist in London:

A  Age/appearance
S  Self or someone else
M  Medication
E  Extra medicines
T  Time persisting
H  History
O  Other symptoms
D  Danger symptoms

Some of the areas covered by the ASMETHOD list have been discussed already. The others can now be considered.

A: Age and appearance

The appearance of the patient can be a useful indicator of whether a minor or more serious condition is involved. If the patient looks ill, e.g. pale, clammy, flushed or grey, the pharmacist should consider referral to the doctor. As far as children are concerned, appearance is important, but in addition the pharmacist can ask the parent whether the child is generally well. A child who is cheerful and energetic is unlikely to have anything other than a minor problem, whereas one who is quiet and listless, or who is fractious, irritable and feverish, might require referral.

The age of the patient is important because the pharmacist will consider some symptoms as potentially more serious according to age. For example, acute diarrhoea in an otherwise healthy adult could reasonably be treated by the pharmacist. However, such symptoms in a baby could produce dehydration more quickly; elderly patients are also at a higher risk of becoming dehydrated. Oral thrush is common in babies, less common in older children and adults; the pharmacist’s decision about whether to treat or refer could therefore be influenced by age.
Age will play an important part in determining any treatment offered by the pharmacist. Some preparations are not recommended at all for children under 12 years, e.g. loperamide. Hydrocortisone cream and ointment should not be recommended for children under 10; aspirin should not be used in children under 16; corticosteroid nasal sprays and omeprazole should not be recommended for those under 18. Others must be given in a reduced dose or as a paediatric formulation and the pharmacist will thus consider recommendations carefully.

Other OTC preparations have a minimum specified age, e.g. 16 years for emergency hormonal contraception and nicotine replacement therapy (NRT), and 18 for treatments of vaginal thrush. Pharmacists are used to assessing patients’ approximate age and would not routinely ask for proof of age here, unless there was a specific reason to do so.

There are two aspects to the term ‘history’ in relation to responding to symptoms: firstly, the history of the symptom being presented and secondly, previous medical history. For example, does the patient have diabetes, hypertension or asthma? PMRs should be used to record relevant existing conditions.

Questioning about the history of a condition may be useful; how and when the problem began, how it has progressed and so on. If the patient has had the problem before, previous episodes should be asked about to determine the action taken by the patient and its degree of success. In recurrent mouth ulcers, for example, do the current ulcers resemble the previous ones, was the doctor or dentist seen on previous occasions, was any treatment prescribed or OTC medicine purchased and, if so, did it work?

In asking about the history, the timing of particular symptoms can give valuable clues as to possible causes. The attacks of heartburn that occur after going to bed or on stooping or bending down are indeed likely to be due to reflux, whereas those that happen during exertion such as exercise or heavy work may not be.

History-taking is particularly important when assessing skin disease. Pharmacists often think, erroneously, that recognition of the
appearance of skin conditions is the most important factor in responding to such symptoms. In fact, many dermatologists would argue that history-taking is more important because some skin conditions resemble each other in appearance. Furthermore, the appearance may be altered during the course of the condition. For example, the use of a topical corticosteroid inappropriately on infected or infested skin may substantially change the appearance; allergy to ingredients such as local anaesthetics may produce a problem in addition to the original complaint. The pharmacist must know therefore which creams, ointments or lotions have been applied.

O: Other symptoms
Patients generally tend to complain about the symptoms that concern them most. The pharmacist should always ask whether the patient has noticed any other symptoms, or anything different from usual because, for various reasons, patients may not volunteer all the important information. Embarrassment may be one such reason, so that patients experiencing rectal bleeding may only mention that they have piles or are constipated.

The importance or significance of symptoms may not be recognised by patients; for example, those who have constipation as a side-effect from a tricyclic antidepressant will probably not mention their dry mouth because they can see no link or connection between the two problems.

D: Danger symptoms
These are the symptoms or combinations of symptoms that should ring warning bells for pharmacists because immediate referral to the doctor is required. Blood in the sputum, vomit, urine or faeces would be examples of such symptoms, as would unexplained weight loss. Danger symptoms are included and discussed in each section of this book so that their significance can be understood by the pharmacist.

Decision-making: risk assessment
In making decisions the pharmacist assesses the possible risk to the patient of different decision paths. The possible reasons for referral for further advice include:
- ‘danger’ or ‘red flag’ signs or symptoms
- incomplete information (e.g. a ear condition where the ear has not been examined)
- duration or recurrence of symptoms
As a general rule, the following indicate a higher risk of a serious
condition and should make the pharmacist consider referring the
patient to the doctor:
- long duration of symptoms
- recurring or worsening problems
- severe pain
- failed medication (one or more appropriate medicines used already,
  without improvement)
- suspected adverse drug reactions (to prescription or OTC medicine)
- danger symptoms

For relevant sections of this book, the duration of symptoms beyond
which the pharmacist should consider immediate referral is defined
in the section ‘When to refer’. In addition, for relevant sections a
‘Treatment timescale’ is included; this is the length of time for which
the problem might be treated before the patient sees the doctor.

Some community pharmacists now use referral forms as an
additional means of conveying information to the doctor with the
patient. Several primary care organisations have introduced such
forms and the National Pharmaceutical Association also supplies
them.

Discussions with local family doctors can assist the development of
protocols and guidelines for referral, and we recommend that pharma-
cists take the opportunity to develop such guidelines with their med-
ical and nursing colleagues in primary care. Joint discussions of this
sort can lead to effective two-way referral systems and local agree-
ments about preferred treatments.

Privacy in the pharmacy

Roughly half of pharmacy customers feel that there is insufficient
privacy in the shop to discuss personal matters. There is some evidence
of a gap between patients’ and pharmacists’ perceptions of privacy.
Pharmacists observe from their own experience that some patients are
content to discuss even potentially sensitive subjects in the pharmacy.
While this is true for some people, others are put off asking for advice
because of insufficient privacy.

The pharmacist should always bear the question of privacy in
mind and, where possible, seek to create an atmosphere of confidential-
ity if sensitive problems are to be discussed. Using professional
judgement and personal experience, the pharmacist can look for
signs of hesitancy or embarrassment on the patient’s part and can
suggest moving to a quieter part of the pharmacy to continue the
conversation.
The provision of a consultation area, where possible, may encourage embarrassed patients to seek advice more readily. In a recent Consumers’ Association survey of the general public, installation of a consultation area was the third most popular change cited to improve community pharmacy services. The number of pharmacies with a consultation area is increasing and this trend is set to continue. Some primary care organisations in England are experimenting with premises investment schemes for community pharmacies and providing financial support for the installation of consultation areas and the necessary refitting or building.

**Working with family doctors and nurse colleagues in primary care**

Community pharmacists are the key gateway into the formal NHS through their filtering of symptoms, with referral to the family doctor when necessary. This filtering is more correctly termed triaging and will be increasingly important in maximising the skills and input of pharmacists and nurses. The role of nurses in the management of minor ailments is becoming more formalised in medical practices and the NHS Direct telephone triage system. NHS Direct (and NHS 24 in Scotland) now refers patients to community pharmacies.

Some community pharmacists are now working more closely with local GP practices and primary care organisations by participating in NHS minor ailment schemes and advising on prescribing. Nurses are providing care in GP practice-based minor illness clinics, Walk-In Centres and other settings such as Minor Injuries Units and A&E departments.

There is a great deal of scope for joint working in the area of OTC medicines. We suggest that pharmacists might consider the following steps:

- Agreeing guidelines for referral with local family doctors, perhaps including feedback from the GP to the pharmacist on the outcome of the referral. Two-way referrals with Walk-In Centres are also helpful.
- Using PMRs to keep information on OTC recommendations to patients.
- Keeping local family doctors and nurses informed about POM to P changes.
- Using referral forms when recommending that a patient see his or her doctor.
- Agreeing an OTC formulary with local GPs and practice nurses.
- Agreeing with local GPs the response to suspected adverse drug reactions.
Actions like these will help to improve communication, will increase GPs’ and nurses’ confidence in the contribution the pharmacist can make to patient care and will also support the pharmacist’s integration into the primary care team.
Respiratory Problems
Colds and flu

The common cold comprises a mixture of viral upper respiratory tract infections (URTIs). Although colds are self-limiting, many people choose to buy OTC medicines for symptomatic relief. Some of the ingredients of OTC cold remedies may interact with prescribed therapy, occasionally with serious consequences. Therefore, careful attention needs to be given to taking a medication history and selecting an appropriate product.

What you need to know

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<th>What you need to know</th>
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<td>Age (approximate)</td>
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<td>Child, adult</td>
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<td>Duration of symptoms</td>
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<td>Summer cold</td>
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<td>Sneezing/coughing</td>
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<td>Generalised aches/headache</td>
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<td>Earache</td>
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<td>Facial pain/frontal headache</td>
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<td>Flu</td>
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<td>Bronchitis</td>
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<td>Heart disease</td>
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<td>Present medication</td>
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Significance of questions and answers

Age

Establishing who the patient is – child or adult – will influence the pharmacist’s decision about the necessity of referral to the doctor and choice of treatment. Children are more susceptible to URTI than adults.
Duration
Patients may describe a rapid onset of symptoms or a gradual onset over several hours; the former is said to be more commonly true of flu, the latter of the common cold. Such guidelines are general rather than definitive. The symptoms of the common cold usually last for 7–14 days. Some symptoms, such as a cough, may persist after the worst of the cold is over.

Symptoms

*Runny/blocked nose*
Most patients will experience a runny nose (rhinorrhoea). This is initially a clear watery fluid, which is then followed by the production of thicker and more tenacious mucus (this may be purulent). Nasal congestion occurs because of dilatation of blood vessels, leading to swelling of the lining surfaces of the nose. This narrows the nasal passages, which are further blocked by increased mucus production.

*Summer colds*
In summer colds the main symptoms are nasal congestion, sneezing and irritant watery eyes; these are more likely to be due to allergic rhinitis (see p. 49).

*Sneezing/coughing*
Sneezing occurs because the nasal passages are irritated and congested. A cough may be present (see p. 29) either because the pharynx is irritated (producing a dry, tickly cough) or as a result of irritation of the bronchus caused by postnasal drip.

*Aches and pains/headache*
Headaches may be experienced because of inflammation and congestion of the nasal passages and sinuses. A persistent or worsening frontal headache (pain above or below the eyes) may be due to sinusitis (see below and p. 199). People with flu often report muscular and joint aches and this is more likely to occur with flu than with the common cold (see below).

*High temperature*
Those suffering from a cold often complain of feeling hot, but in general a high temperature will not be present. The presence of fever may be an indication that the patient has flu rather than a cold (see below).

*Sore throat*
The throat often feels dry and sore during a cold and may sometimes be the first sign that a cold is imminent (see p. 41).
**Earache**

Earache is a common complication of colds, especially in children. When nasal catarrh is present, the ear can feel blocked. This is due to blockage of the Eustachian tube, which is the tube connecting the middle ear to the back of the nasal cavity. Under normal circumstances the middle ear is an air-containing compartment. However, if the Eustachian tube is blocked, the ear can no longer be cleared by swallowing and may feel uncomfortable and deaf. This situation often resolves spontaneously, but decongestants and inhalations can be helpful (see ‘Management’ below). Sometimes the situation worsens when the middle ear fills up with fluid. This is an ideal site for a secondary infection to settle. When this does occur, the ear becomes acutely painful and can require antibiotics. The infection is called acute otitis media (AOM). AOM is a common infection in young children. In the UK about 30% of children visit their GP with AOM each year and 97% receive antibiotics. The evidence for antibiotic use is conflicting with some trials showing benefit and others no benefit for taking antibiotics. Antibiotics have also been shown to increase the risk of vomiting, diarrhoea and rash, and it is known that in about 80% of children AOM will resolve spontaneously in about 3 days without antibiotics.

In summary, a painful ear can initially be managed by the pharmacist. There is evidence that both paracetamol and ibuprofen are effective treatments for AOM. However, if pain were to persist or be associated with an unwell child (e.g. high fever, very restless or listless, vomiting), then referral to the GP would be advisable.

**Facial pain/frontal headache**

Facial pain or frontal headache may signify sinusitis. Sinuses are air-containing spaces in the bony structures adjacent to the nose (maxillary sinuses) and above the eyes (frontal sinuses). In a cold their lining surfaces become inflamed and swollen, producing catarrh. The secretions drain into the nasal cavity. If the drainage passage becomes blocked, fluid builds up in the sinus and can become secondarily (bacterially) infected. If this happens, persistent pain arises in the sinus areas. The maxillary sinuses are most commonly involved. When the frontal sinuses are infected, the sufferer may complain of a frontal (forehead) headache. The headache is typically worsened by lying down or bending forwards.

**Flu**

Differentiating between colds and flu may be needed to make a decision about whether referral is needed. Patients in ‘at-risk’ groups
might be considered for antiviral treatment. Flu is generally con-
considered to be likely if
• temperature is 38°C or higher (37.5°C in the elderly).
• a minimum of one respiratory symptom (cough, sore throat, nasal
congestion or rhinorrhoea) is present.
• a minimum of one constitutional symptom (headache, malaise, my-
algia, sweats/chills, prostration) is present.

Flu often starts abruptly with sweats and chills, muscular aches and
pains in the limbs, a dry sore throat, cough and high temperature. Someone with flu may be bedbound and unable to go about usual
activities. There is often a period of generalised weakness and malaise
following the worst of the symptoms. A dry cough may persist for
some time.

True influenza is relatively uncommon compared to the large
number of flu-like infections that occur. Influenza is generally more
unpleasant, although both usually settle with no need for referral.

Flu can be complicated by secondary lung infection (pneumonia).
Complications are much more likely to occur in the very young, the
very old and those who have pre-existing heart or lung disease
(chronic bronchitis). Warning that complications are developing
may be given by a severe or productive cough, persisting high fever,
pleuritic-type chest pain (see p. 59) or delirium.

Asthma

Asthmatic attacks can be triggered by respiratory viral infections.
Most asthma sufferers learn to start or increase their usual medication
to prevent such an occurrence. However, if these measures fail, referral
is recommended.

Previous history

People with a history of chronic bronchitis (defined as a chronic cough
and or mucus production for at least 3 months in at least 2 consecutive
years when other causes of chronic cough have been excluded) may be
advised to see their doctor if they have a bad cold or flu-like infection as it
often causes an exacerbation of their bronchitis. In this situation the
doctor is likely to increase the dose of inhaled anticholinergics and beta-2
agonists and prescribe a course of antibiotics. Certain medications are
best avoided in those with heart disease, hypertension and diabetes.

Present medication

The pharmacist must ascertain any medicines being taken by the
patient. It is important to remember that interactions might occur
with some of the constituents of commonly used OTC medicines.