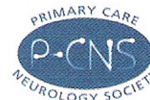
Primary Care Neurology Society Meeting

Birmingham, UK, 17 May, 2007.



The Primary Care Neurology Society (P-CNS; www.p-cns.org.uk) seeks to develop links between primary and secondary care in order to optimise the care and management of patients with neurological disorders. A select audience (GPs and specialist nurses vastly outnumbering neurologists) converged on the Birmingham Hippodrome to hear presentations on a variety of topics of mutual interest and concern, including dementia, stroke and TIA, Parkinson's disease, epilepsy and headache.

A number of talks focused on how much GPs can and/or should do before involving secondary care, particularly in light of NICE or expert guidelines; for example whether or not to give a trial of medication in suspected Parkinson's disease prior to the recommended referral to an 'expert' for diagnosis (Paul Morrish), or diagnosing dementia and using the dreaded 'D' word (Louise Robinson). A study suggesting an average four year delay from first GP-recorded symptoms of dementia to actual diagnosis (Fam Pract 2007;24:108-16) may reflect, at least in part, diagnostic and therapeutic nihilism in this area, although with the latest (2006) NICE guidance on cholinesterase inhibitor use (and non-use) such reticence may not necessarily seem inappropriate. Interestingly, an absolute criterion for referral to the speaker's clinic was GP performance of the MMSE, whereas we have found that less than 20% of referrals to a dedicated Cognitive Function Clinic report this as having been done. There was no firm guidance to GPs on the best screening or assessment tool for dementia, the MMSE being described as "the best of a bad lot". P-CNS would seem ideally placed to investigate this further, and provide advice. On the other hand, it might perhaps be seen as odd that the subject of dementia should be on the conference agenda when NICE/SCIE guidance essentially envisages no role for neurology in the diagnosis and management of this condition, despite its being the archetypal disease of higher brain function.

In a discussion on TIA/stroke (Ganesh Subramanian) it was suggested that any cerebrovascular neurological event lasting longer than one hour, rather than the current twenty-four hours, should be regarded as a stroke rather than TIA, and the ABCD2 risk stratification for TIA was promoted for wider use. Practical advice was on hand for the management of difficult problems, including neuropathic pain (Chris Wells), for which codeine is apparently worse than placebo. Delegates were urged to consider the possibility of a neuropathic component to many chronic pain syndromes, including low back pain, with the therapeutic options that this may open up. The recognition of epilepsy syndromes was covered (Richard Hills) with the aid of illustrative video-EEGs, but some eyebrows were raised when the findings of the recently published SANAD trial (see ACNR 7(2): 39-40) were called into question on methodological grounds. A talk on the diagnosis and management of headache (Andrew Dowson) prompted lively debate. The need to recognise concurrent anxiety, depression, and social phobias which may drive the illness behaviour in chronic headache was emphasised, a point also relevant to neuropathic pain.

The need for a collaborative approach between neurologists and GPs is self-evident and will hopefully engage more practitioners, especially neurologists, in future P-CNS meetings.

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