University of BRISTOL

Report

COMP2 GP Teachers' Workshop

Engineers' House, Clifton, Bristol
Tuesday 28th February 2012

Review of COMP2 and Faculty update

How to teach

- **Domestic violence**
- **Diarrhoea**
- **Assessment of mobility in the elderly**

Teaching clinical skills

- **Measuring O_2 saturation**
- **Measuring blood glucose**

The new Academic Mentor Scheme

The new Clinical Skills Log Books

Parallel sessions

- **New Year 4 teachers**
- **Effective feedback giving**
- **Blackboard and online learning resources**

Guest lecturers

Prof. Gene Feder
Rev. Mr. Nigel Rawlinson
Dr. Sue Wensley
Dr. Alex Di Mambro

Report compiled by Barbara Laue, Sian Goodson, Jessica Buchan and Sarah Jahfar

Year 4 (COMP2) GP Teacher Workshop Programme

Tuesday 28th February 2012
Engineers House, Clifton, Bristol

9-9.30	*Coffee & registration*	
9.30 – 9.50	*Introduction & COMP2 update*	*Sian Goodson*
9.50 – 10.20	***Domestic Violence** – overview*	*Gene Feder*
10.20 – 10.45	*Clinical teaching skills (4 groups rotate through sessions) – session 1* • ***Practicalities of teaching your students about Domestic Violence** - Gene Feder (Professor, Primary Care)* • ***Assessing mobility in elderly patients** - Sue Wensley (Consultant Medicine for Older People)* • ***'I've got diarrhoea, doctor'** - Alex Di Mambro (Consultant Gastroenterologist)* • ***Measuring blood glucose and oxygen saturation** – Jessica Bucchan (Teaching Fellow & GP) & Andrew Blythe (Head of Teaching, Primary Care)*	
10.45 – 11.15	*Coffee*	
11.15 – 11.40 *11.40 – 12.05* *12.05 – 12.30*	*Clinical teaching skills (4 groups) – sessions 2, 3 and 4*	
12.30 – 1.30	*Lunch*	
1.30 – 2.00	***Introduction to the new Academic Mentor Scheme & Clinical Skills log books***	*Nigel Rawlinson, Director of Student Affairs*
2.00 – 2.30	*University update and news*	*Andrew Blythe*
2.30 – 3.00	*Small group discussions –using the log books in practice, mentor scheme*	*Facilitators*
3.00 – 3.20	*Tea*	
3.20 – 4.00	*Choice of parallel sessions:* • ***New Teacher session** – Andrew Blythe* • ***Giving effective feedback** – Barbara Laue* • ***Blackboard and online learning resources** - Sian Goodson*	
4.00 – 4.15	*Summary, feedback from students, Q&A.*	*Sian Goodson*

COMP2 GP Teacher Workshop 2012

We were delighted to welcome 50 GPs, 7 fourth year medical students and several extermal speakers to the workshop. As ever, there were lively discussions about all the topics covered and many opportunities to share experiences. The students contributed very well to all the sessions and were an excellent resource. Thank you to everyone for your active participation and help in making the day a success.

Overview of COMP2 this year

GP academy leads

Academy	GP Lead	GP Telephone
Gloucestershire	Dr Anne Hampton anne.hampton@glos.nhs.uk	01453 764696
North Bristol	Dr Barbara Laue Barbara.laue@bristol.ac.uk	0117 3313845
South Bristol	Dr Sarah Jahfar sjahfar@yahoo.com	0117 9557474
Swindon	Dr Lindsay O'Kelly lindsay.okelly@nhs.net	
Bath	Dr Melanie Blackman Melanie.blackman@gp-J83625.nhs.uk	08444 770919
Somerset -Taunton	Dr Charles Macadam Charles.macadam@canningtonhc.nhs.uk	01278 652 335
Somerset -Yeovil	Dr Andrew Tresidder Andrew.tresidder@springmead.nhs.uk	01460 63380

Course Aims

- Describe the role of the GP and the other members of the primary health care team
- Appraise the different systems providing open access health care in the UK
- Conduct a complete consultation on any of the 16 core clinical problems listed in the table of learning outcomes
- Help patients reduce their risk of developing chronic disease
- Describe methods by which the impact of disability on patients can be minimised

Changes to the 16 core clinical topics

Eczema and acne have been removed as these are well covered through dermatology during the same time period. This means that students will not have questions about dermatology as part of the primary care questions in their exams. However they will be tested on these topics through the dermatoogy questions and so will hopelfully contionue to gain primary care experience of these important topics. The two new topics are domestic violence and substance misuse. A full summary of the topics/learning objectives is in the Teacher handbook
http://www.bristol.ac.uk/primaryhealthcare/teachingundergraduate/year/four/

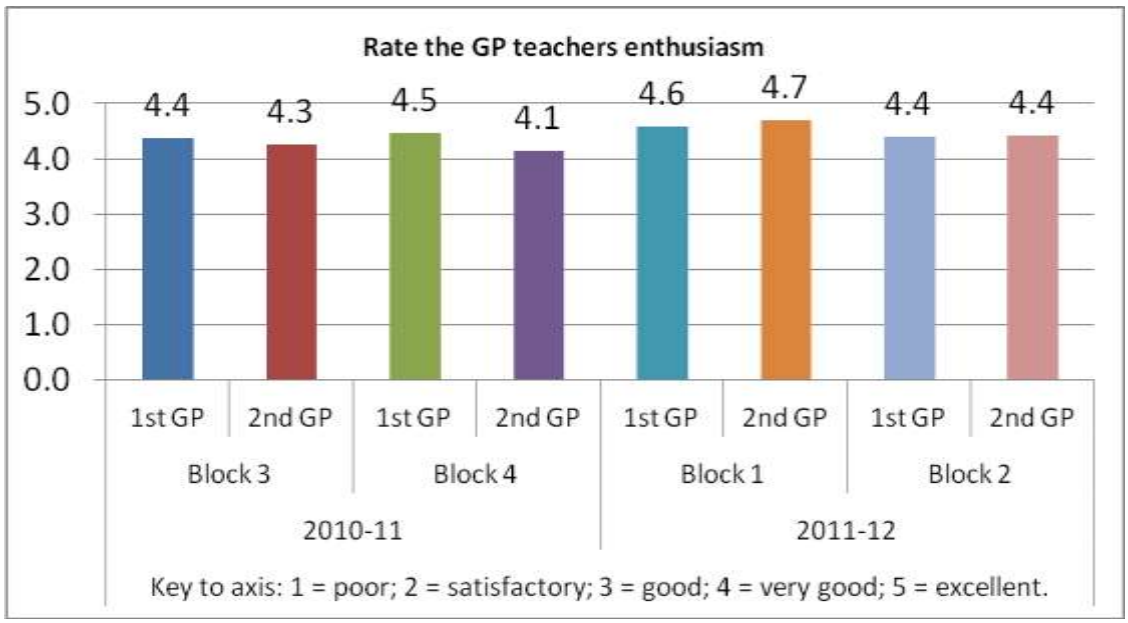
The COMP2 structure is unchanged from last academic year, with most students now completing a four week placement in one practice. Central teaching is on the first two days of week one and the final three days of week nine. Primary Care teaching involves and introduction and Effective Consultation Skills workshop (role playing with actors) in week one. In week nine there are lectures on Access to Healthcare, Domestic Violence, Risk of Cardiovascular Disease, Minor illness and OSCE revision. There is a Disability Workshop where students gain experinmec consulting with people with hearing or visual impairment. However, the majority of the learing occurs during the GP placements, where students build from observing consultations to participating and then conducting complete consultations themselves. They gain most from doing as many consultations as possible themselves.

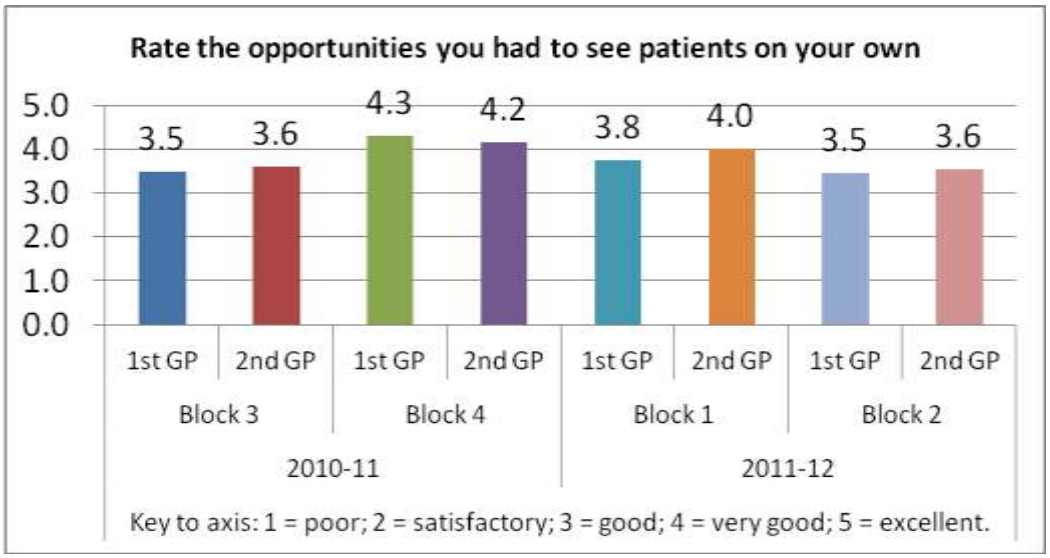
COMP2 Assessments

OSCE – held twice a year in January and June. The standard setting method has changed this year to the borderline regression method, in keeping with most other medical schools and final exams at Bristol. For the OSCE in Januray 2012 three students failed out of 126.
Written exam in June for all students
SSC essays – completed each block.
Professional behaviuour forms are being phased out and replaced by ‘Student Concern Forms’ to be completed as needed.

Student feedback

This is collected personally by GPs, centrally by an online survey in line with current GMC guidance and through exam results. This year we are also introducing some focus groups. Below are slides summarising the central feedback over the past year:


Rate the GP teachers enthusiasm
5.0
4.0
3.0
2.0
1.0
0.0
4.4
4.3
4.5
4.1
4.6
4.7
4.4
4.4
1st GP
2nd GP
1st GP
2nd GP
1st GP
2nd GP
1st GP
2nd GP
Block 3
Block 4
Block 1
Block 2
2010-11
2011-12
Key to axis: 1 = poor; 2 = satisfactory; 3 = good; 4 = very good; 5 = excellent.


Rate the opportunities you had to see patients on your own
5.0
4.0
3.0
2.0
1.0
0.0
3.5
3.6
4.3
4.2
3.8
4.0
3.5
3.6
1st GP
2nd GP
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Block 3
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Block 2
2010-11
2011-12
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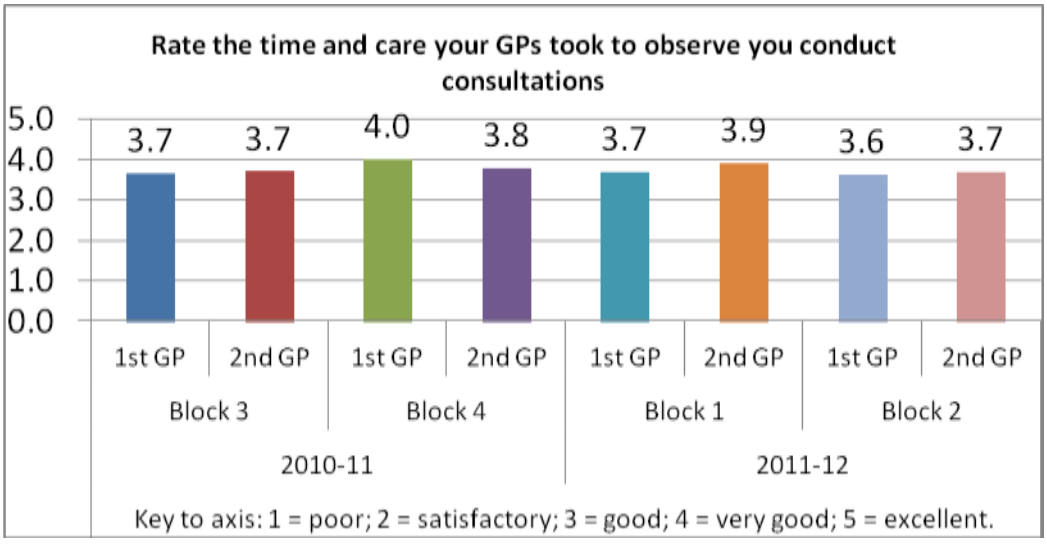
Rate the time and care your GPs took to observe you conduct consultations
5.0
4.0
3.0
2.0
1.0
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3.7
3.7
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3.8
3.7
3.9
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1st GP
2nd GP
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Block 3
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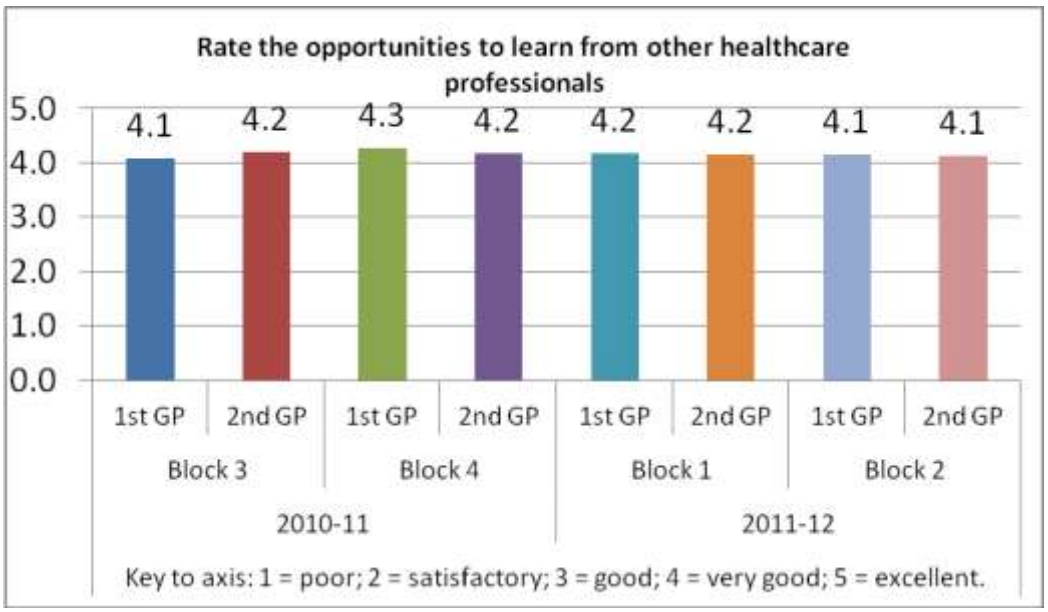
Rate the opportunities to learn from other healthcare professionals
5.0
4.0
3.0
2.0
1.0
0.0
4.1
4.2
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4.2
4.2
4.2
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1st GP
2nd GP
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1st GP
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Block 3
Block 4
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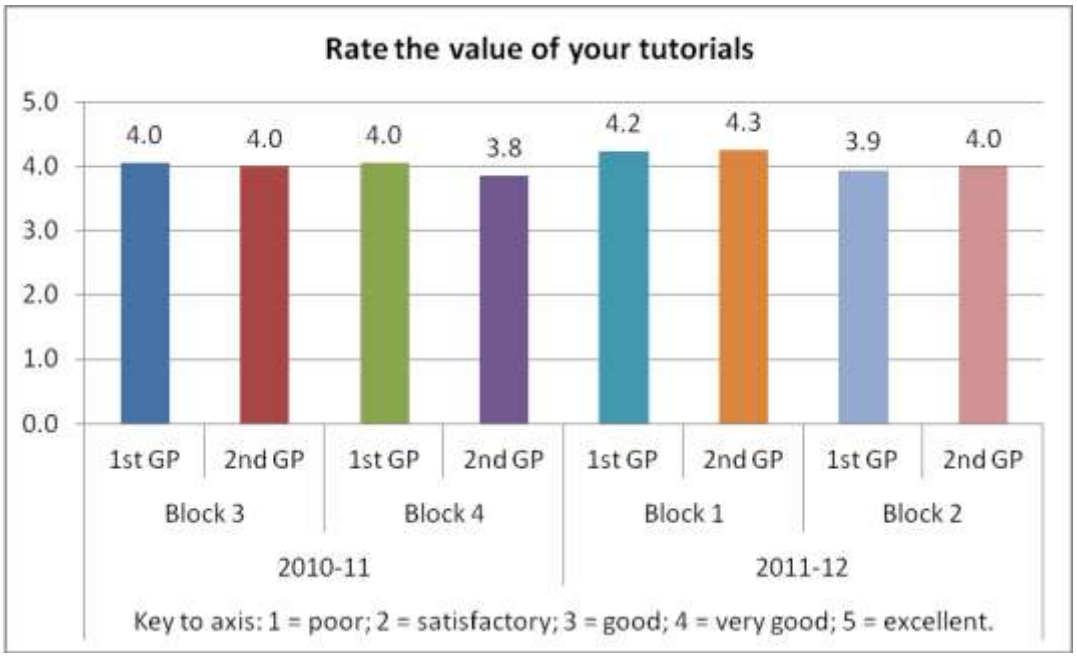
Rate the value of your tutorials
5.0
4.0
3.0
2.0
1.0
0.0
4.0
4.0
4.0
3.8
4.2
4.3
3.9
4.0
1st GP
2nd GP
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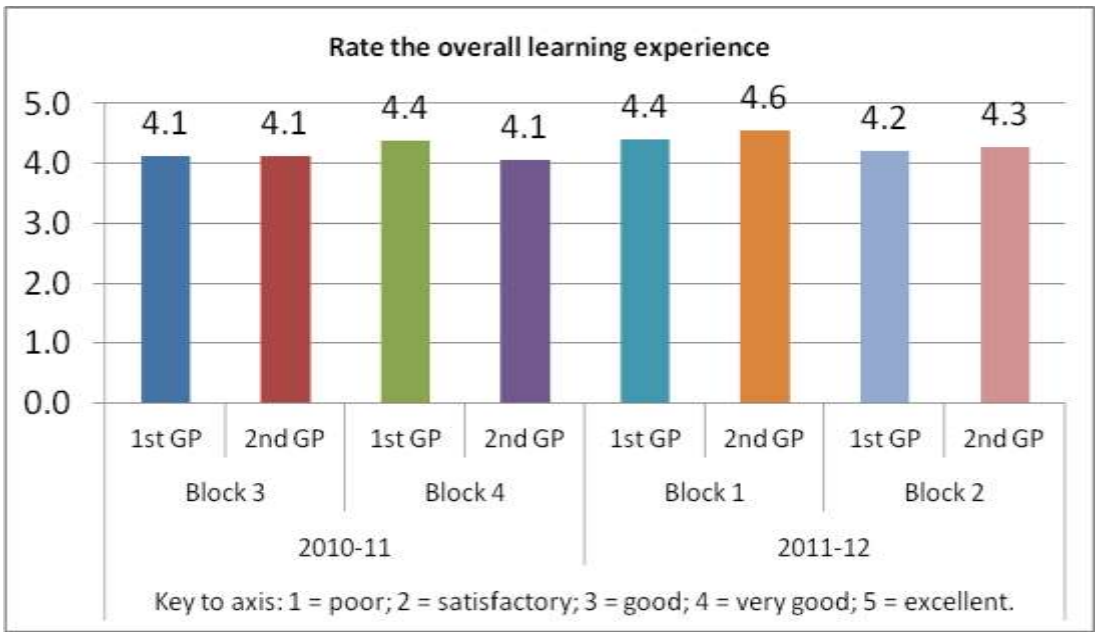


Change for next year

Sian Goodson is moving to Australia. Jessica Buchan will be taking over as Element Lead for Primary care in COMP2, supported by Andrew Blythe.

Academic mentor scheme – Nigel Rawlinson, Director for student affairs (DSA)

For pastoral student problems email
med-dsa@bristol.ac.uk

Aim of the scheme

- For students to have a chance to talk to somebody twice a year who can professionally affirm them
- To nurture the professional and academic development of undergraduate students at Bristol University
- To encourage students to start thinking about their career as they will need to make decisions about their career as F1s – surgical or medical

Overall structure of the support available to students
Should be looked at as a team, a single person can't deal with all issues

- Director of student affairs at Senate Hse, the 'hub'
- General pastoral care from Ros Forge and colleague Emma
- Preclinical lead – Eugene Lloyd
- For graduate students – Nicki Cohen
- Academy Deans
- Tutors who supervise intercalated projects
- Academic tutors

Students have just been given access to an undergraduate eportfolio. This is intended to be formative, not summative

Update from the Faculty – Andrew Blythe

Who is who in the faculty?
- Prof P. Matthieson is the dean of the Faculty of Med and Dentistry
- Dr. David Cahill is the Director of the MBChB programme (1200 students)
- Nicki Cohen is the Deputy director
- Dr N Rawlinson is the Director for student affairs
- Dr. Andrew Blythe is the director for assessment
- 7 Academy Deans

New
- Finals are now held in December (started Dec. 2010)
- ERASMUS scheme has been stopped
- Academic mentor scheme has been launched
- Logbook for practical clinical skills has been launched
- 2012 is the last year when students can qualify with honours
- From 2013 top 10% get distinctions, next 15% get merits
- Students are ranked nationally for their F1 jobs out of about 6000 students

Challenges
- Mentoring students who are scattered over a large area
- Burden of assessment (national prescribing exam and situational judgement tests coming in)
- Transition to paper light teaching
- Supporting transition from Year 2 to Year 3, preclinical to clinical

Academic mentor scheme – small groups

Thoughts, implications of becoming a mentor, how to encourage students to use it
- Although not supposed to be pastoral, there needs to be a social element as well
- Will 20 minutes twice a year be enough?

Clinical skills logbooks –small groups

What do you think of the new logbook?
- The general feeling was that they would be useful "formative" documents, although one colleague had grave concerns over its legal basis, wondered who would actually check it at the end and how it could actually be used to pass or fail a student. The question was asked "who owns the logbook medicolegally?"(Andrew Blythe later explained that it will not be used to fail a student in its current format, but that any fraud would be treated as a fitness to practice issue for that student).
- Both student and doctors present felt it was rather hard on the current 4th years and that we should support them by not letting them get too stressed about it, but signing them off for skills whenever possible.
- The log book was felt to be old-fashioned, when one considers what technology is now available, although we agreed that not all students could be expected to have an iPad or similar just yet!

- We discussed what might happen if a student loses it and fact that it would be unfair to disadvantage a student who loses it, as this will inevitably occur to one or two per year. The student present explained that the onus will be on them to upload completed sections on to their eportfolio and that this will reduce this risk to an extent.
- One concern that was widely expressed was that the logbook might encourage students to be even more "exam and tick box" orientated and detract from the patient/doctor/student relationship, in the same way that QOF interrupts GP/patient consultations. We all agreed that we should resolve not to let this happen in GP placements. If we see that a particular student has become too goal orientated, we need to steer them back to the main aim of the Primary Care placement, to learn about GP.

How do you think you will use it with your students?

- We thought that the log books may help to standardise teaching levels better, as GP teachers will have a resource to help them to teach a skill correctly, in a way that will help a student to pass exams. The student thought that it could be helpful to look up the logbook before a specific teaching session.
- We thought it would be a good guide for GP teachers, as well as for nurses.
- It could be used to share knowledge of student learning needs with colleagues in the practice, such as other partners, pharmacists, etc...
- On arrival – learning needs assessment
- Spread this round practice
- Improve clinical skills of teachers
- Involve GP registrars

Any tip to ensure it is used for max. potential?

- Don't wait till the end of the attachment before looking at it
- Leave the student in control
- Make sure students are aware of the opportunities in primary Care

How do you plan to ensure as many of the skills are signed off as possible?

- Make sure everyone in the practice is aware of it
- Attending chronic disease clinics

Bedside capillary blood glucose monitoring

To successfully learn a new skill, learners need to understand the relevance of learning the skill. We discussed how this might be done, e.g. through setting background reading as preparation for a tutorial. Consider using a pre tutorial quiz or discussion of clinical scenarios including the management of different values.

<u>What do the students need to know?</u>

Situations in which a GP might test capillary blood glucose:

- Diabetics who are unwell and you suspect ketoacidosis/HONK and can't self test
- Diabetics demonstrating neuroglycopenic or autonomic symptoms suggesting hypoglycaemia
- Demonstrating to a diabetic patient or carer how to self-test
- Collapsed patient

The limitations of bedside capillary blood glucose testing:

- Not for diagnosis of diabetes, useful for screening
- Peripheral compromise, e.g. in shock makes finger tip capillary blood more difficult to access and increases error
- If hands not clean risk of inaccurate reading, alcohol wipes may affect reading

- To reduce error some new monitors won't work if test strips out of date, or monitor not calibrated every 6 months.
- The accuracy may not be much better than reading stix on their own but the amount of blood needed for a good reading is different, much less needed when using a glucometer

Normal values and when to act on values outside of the normal range:

- Normal fasting glucose range in adult non diabetic population is 3.4 to 5.5 mmol/L, shortly after eating this may rise to 7.8 mmol/l but the body should then restore levels to 4.4 to 6.1 mmol/l.
- Impaired fasting glycaemia > 6.1 but <7.0 mmol/l so capillary glucose in this range needs fasting assessment of venous plasma glucose.
- Impaired glucose tolerance 2 hours after eating >7.8 but less than 11.1mmol/l again random capillary glucose in this range needs follow up.
- Diabetics should maintain fasting capillary blood glucose between 4 and 7.0 mmol/L, post prandial glucose should be < 8.5 in type 2 Diabetes and <9 in type 1. (levels are different in children and not covered here)
- Children often present with severe symptoms and a one off high reading should prompt immediate referral.
- Hypoglycaemia likely to cause symptoms <3.2mmol/l and neuroglycopenic symptoms e.g. irritability/drowsiness <3.0mmol/l

Capillary blood glucose is often known as "BM" this relates to Boehringer Mannheim one of the early manufacturers of near patient testing glucose monitors.

<u>Preparing to teach this as a clinical skill</u>

Who, What, Where?
Some GP's carry capillary blood glucose monitoring equipment that they use regularly and others utilise the practice nurse for this when in surgery, and take the practice monitor on home visits when necessary. For the latter scenario we discussed that the practice nurse may be best placed to teach this clinical skill in your practice, particularly as part of the student sitting in on a diabetic clinic. The nurse needs to understand how to teach a skill to a student and the criteria for signing off the skill in the CAPS handbook.

Discuss

- Talk the student through the procedure as laid out in the CAPS handbook, include pitfalls. Choose a site:
  - Use non dominant hand
  - Finger tip capillary glucose is nearer venous blood glucose than other sites
  - Be aware of sensitive areas e.g finger tips so use side of finger
  - Avoid the thumb and index finger or recently used site
  - Avoid visible vessels.
  - Assess the appearance of the skin, if thickened skin some lancets allow adjustment of depth and force of lance.

Demonstrate

- Show process to the student
- Check patient details
- Explain procedure and consent patient
- Checking the patient has washed their hands with soap and water
- Wash own hands and wear gloves
- choosing a site (see below)

Familiarise

- Allow the student to become familiar with the equipment and instruction manual including how to use control solution (machines should usually be calibrated every 6 months) and change batteries.

Practice

- Allow the student to run through the whole process or explain to you what they would do step by step. Check and correct the students skill.

Assess

anscutaneous Monitoring of Oxygen Saturation

How it works
Spectrophotometry. Oxyhaemaglobin absorbs different spectrum of light than does carboxyhaemoglobin. Pulse oximeters use infra-red light.

General thoughts
- Consider it one of the tools, still need judgement. Teach them not just to rely on it
- Particularly useful in children. Can be used in a positive way 'Look mum, sats 99%...'

Things we want students to know
- How it works
- How to use it
- How to interpret the information
- What is normal?
- What are the causes of low oxygen saturation?
- What are the causes of error?
- When should you use it?

How to teach these things
- Demonstrate
- Student can test themselves
- They should use it on patients

How to use it
- On finger (which finger?) or ear. Index finger is best
- Use adapter/smaller probe for children
- Need to leave it on for a while – watch the SpO2 rise
- Does it need cleaning?

How to interpret the information
What is normal? **> 92%**
< 92% has high specificity (86%) & high sensitivity (100%)
< 94% has lower specificity (54%)
What are the causes of low oxygen saturation?
PE, chest infection, hypovolaemia
What are the causes of error?
Falsely low SpO2
Arrhythmia, anaemia, haemoglobinopathies, poor perfusion, (nail varnish), carbon monoxide poisoning
Falsely high SpO2
Pigmented skin,

Pitfalls
- Takes 30 seconds to reach full reading, lower to start with
- Red nail varnish skews reading
- Cold peripheries affect reading
- Be prepared for surprises
- Carbon monoxide poisoning – can be normal

When should you use it?
- Breathless, chest pain eg ? PE, asthma, chest infection – when deciding on admission
- Wheezy children (when you don't want to do invasive arterial blood sampling)
- Monitoring patients with COPD (Telehealth Project in Birmingham)

Giving feedback effectively – how to do it small group session

We started off by reflecting on something that we knew we could do really well. How did we know that?

- People tell you - **Feedback**
- It works
- You see good results – Learning objectives achieved
- It gives you pleasure
- Feeling satisfied
- Comes naturally
- Compare yourself to others

It is easier to feed back if

- The feedback is positive
- Students are asking for feedback and criticising themselves – insight
- It is expected – plan for feedback, tell the student when, how often etc
- There is something to measure against – learning objectives
- Time and space are appropriate

It is harder to feed back if

- The student needs to change something
- The student is challenging, lacks insight
- There has not been any change after previous feedback
- The student is not aware of expectations

A short role play highlighted the following **feedback tips**

- Invite student to **self assess**
    - 'How do you think it is going?'
    - 'What do you think went well?'
    - 'What are you trying to achieve?'
- Start with the **positive**
- The student has probably seen other people consult. Ask what was good about their consultations, what have they seen, **role models**?
- Use 'breaking bad news skills'
- Be gently coaxing
- **Plan** - Encourage student to problem solve, find own solutions, alternatives
- **Focus** – be specific 'What did you notice when you moved his shoulders?'

Websites for COMP2 students and GP teachers

1. www.bristol.ac.uk/primaryhealthcare

Go to undergraduate teaching, then teaching by year, choose year 4. Here are useful docs such as the Teacher Handbook, Student Concern Form.

2. www.ole.bris.ac.uk

This is Blackboard where all learning materials, timetables, handbooks are available for the students. Please encourage the students to do the elearning and to look at the Consultation Skills folder where there is elearning about the Calgary Cambridge Guide.
GP teachers have access to this site using the following log on and password

Guest username: med021
Password: primcare

3. http://www.bristol.ac.uk/medical-school/hippocrates

This is the Year 3 Medical School site. Most of it is freely available. Useful Mock OSCE tutorial under the General Practice tab. For this you need to enter the login details as above for Blackboard.

4. www.evidence.nhs.uk

This has replaced CKS guidelines. An excellent site for students to research the clinical problems and look for up to date management plans.

5. www.npc.nhs.uk

The Prescribing site has free elearning available. Good site for students to use.

6. http://www.galenicals.org.uk/yearguides/year4/comp2

This is the students' own society site. They have info about the units here – including what has been in the exams!

7. www.nice.org.uk

The students should know this one.

8. www.outofourheads.net

This site showcases some of the excellent creative work and reflections written by Bristol students.

Domestic violence (DV) - Prof. Gene Feder

Worldwide statistics

Physical abuse	1:3 ♀	1:10♂
Sexual abuse	1:10♀	

Lifetime risk for UK women of partner abuse 1:4 and sexual assault 1:4

Gender asymmetry, vastly greater risk for women fearing for their lives and for being sexually assaulted

Conditions associated with DV

- Chronic pain
- Minor illnesses/infections
- Neuro symptoms – i.e. dizziness
- Chronic GI symptoms, i.e. IBS
- Increased BP and CV risk

Ask about abuse

Non-judgemental support

Nextlink number 0117 9250680

Conditions 4x more likely to be associated with DV

- Depression
- PTSD
- Alcohol abuse
- Suicidality

↑ risk of mental health problems in children, even if they are not direct witnesses

Evidence shows that women feel that doctors are important people to disclose to

What do survivors want?

- Try to ensure continuity between doctors
- Make it possible to disclose
- Don't pressurise for full disclosure
- Ensure that women feel they have control
- Understand the chronicity

Evidence of efficacy of interventions
Particularly in women who have actively sought help and who have left their partner

How to teach DV

It is now part of the COMP2 curriculum

- Debrief after surgery
- Case review
- Role play a DV disclosure consultation
- Give info on size of problem and epidemiology
- It is prevalent
- Not very visible
- **Asking makes it visible**
- Role for student – get them to find out more, to organise poster for waiting room, cards to hand out to patients etc
- Discuss how to record physical injuries – draw body map and scan in
- Read book on family violence by Iona Heath

How likely is it that a student will witness the disclosure of DV? We felt that it was not very likely

Assessing mobility in the elderly patient – Sue Wensley, Consultant in Medicine for Older People

Ability to move is defined by the following factors

- Cognitive
- Psychosocial
- Physical
- Environmental
- Financial

History

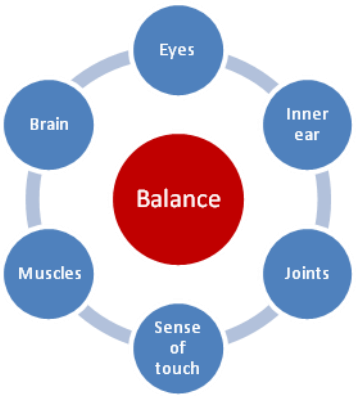
- Falls are the commonest presentation of dementia
- Exercise tolerance – distance a person can walk without stopping
- Stairs, outside, shops

Risk assess whether the patient has a gait and balance disorder

Gait and balance – inspection

- Walking? Upright? Kyphosis? Asymmetry?
- Arm swing symmetrical? Asymmetry could be subtle sign of stroke
- Speed of walking
- Gait step length the same, variable?
- Antalgic gait?
- Excessive sway?
- Shuffling?
- Lifting feet?
- Hesitant?
- Festinant gait?
- Stroke pattern
- Variability, day to day, hour to hour?

Balance is a complex function



Testing balance
Stand on one leg, close eyes and tilt head back

Rhomberg test
Stand with feet together, arms by your side. There should only be gentle swaying. If more exaggerated swaying, the test is positive

Timed get up and go
Testing whether the person is able to rise from a chair unaided (not using hands), walk 3 meters and return to the chair. The timing is from starting to rise to sitting down. Difficulty getting up and slow time is associated with increased risk of falling and death

Watch the test on YouTube at http://www.youtube.com/watch?v=s0ngzvt9JSs

Taking <20 seconds to complete the test suggests fitness for independent living
Taking >30 seconds suggests higher risk of dependence and risk of falls

In one study staff who knew the patient made better predictions than the test. Read more at http://ageing.oxfordjournals.org/content/37/4/442.full

Much ado about poo – Alex Mambro, Consultant gastroenterologist, Weston General

Diarrhoea – What to teach

Definition: 3 or more loose motions per day or more than is normal for that person
Use Bristol stool chart to help patients with their descriptions. Find it at http://www.sthk.nhs.uk/library/documents/stoolchart.pdf

Types of diarrhoea

Secretory	Cholera, continues even if you stop eating
Osmotic	Pancreatic, Coeliac, Vit C OD, laxatives, magnesium
Exudative	E.coli, severe infections, IBD (can have discharge)
Rapid transit	Diabetes, gastropathy, vagotomy, hyperthyroidism
Infammatory	IBD, infective, malignancies, microscopic colitis in patients with diarrhoea predominant IBS

Infective diarrhoea

Viral	Rota, noro, astro, adeno
Bacterial	Campylobacter, Salmonella, Shigella, some strains of E.coli
Chlostrid. diff.	
Parasites	Giardia, Entamoeba histolytica

Campylobacter can cause Reiter's syndrome and Guillain Barré syndrome

If the diarrhoea doesn't stop when the patient stops eating it is a cause for concern as they could quickly dehydrate (Cholera). Look for causes

Post infective IBS

- Can last for 18/12
- Treat with Amitriptyline
- Use probiotic – highest concentration of beneficial bacteria in VSL#3 (available online and chemists). Avoid lactose containing probiotics

C. Diff. – Who gets it?

- Elderly
- IBD x2-3 more likely
- Antibiotic use in last 6 months
- Renal impairment
- Immunocompromised
- If on PPI?

Horizon scanning

- Calprotectin new stool test, highly sensitive for bowel inflammation
- Rifaxamin non-absorbable antibiotic, currently used in patients with hepatic Encephalopathy

Hx!!!

- Weight loss
- Abdo pain
- Blood mixed with stool

Investigate if diarrhoea >2/52

- FBC
- Albumin
- B12, Folate, Ferritin
- CRP
- U+E
- TTG
- TSH
- Faecal elastase to look for pancreatic insufficiency

Treatment options

Known IBD	5ASA – Pentasa 2g bd, good in mild to moderate flare
Infection suspected, but not found	Trial of Metronidazole 400mg tds, kills giardia, colonic spirochaetosis. Don't forget C.diff

Microscopic colitis

- Some medication causes — NSAIDs, PPIs, SSRIs
  - Diarrhoea takes 6/12 to stop after stopping the drug
- 50% self limiting
- Treatment
  - Loperamide (not harmful)
  - Bismuth
  - Budesonide, Prednisolone, Azathioprine

Diarrhoea predominant IBS

- Many symptoms
- Lack of nocturnal diarrhoea
- Amitriptyline 20-50mg nocte
- Diet low or free of fermentable polysaccharides the 'FODMAP' diet

FODMAPs (**F**ermentable **O**ligo-, **D**i-, and **M**ono-saccharides, **A**nd **P**olyols) are short-chain carbohydrates. Read more at http://www.healthhype.com/fodmap-diet-foods-to-avoid-in-ibs-bowel-disorders-with-bloating-and-gas.html

Reflective Template	**COMP2 GP Teacher Workshop**	University of BRISTOL
Date/Venue/Hours	28th February 2012, Engineers' House, Clifton, Bristol	**6 hours**
Description		
Reflection and Feedback		
▪ What have I learned? ▪ What did I enjoy?		
Forward Planning		
Things I want to try in my own teaching Things I would like to find out more about		
Key points to remember		
Name, date, signature		