

# 9 Management of minor illness

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## Evidence-based practice

It is helpful for all members of a primary care team, whether in a general practice, walk-in centre or other setting, to be consistent in the way that we manage minor illness. Where differences are apparent, you should be able to access up-to-date, high-quality research evidence to aid discussion and help you to reach agreement. Critical analysis of published research has become highly complex and very time-consuming; thankfully there are now several agencies such as the Cochrane Collaboration which analyse the evidence on your behalf, and provide easy access to this information on the Internet.

Although these reviews will explore possible flaws in the published papers, there are several factors which inherently bias the whole process of evaluating evidence. They include:

- the rigorous standards and large sample sizes that are now expected in clinical trials lead to very high costs, which make it difficult to attract funding other than from pharmaceutical companies with a high turnover
- funded research is more likely to favour the sponsor's product
- negative results are less likely to be published
- old drugs may appear inadequately researched compared to new ones
- little research is conducted in primary care
- therapies that do not employ the same disease categories as Western medicine are almost impossible to research in this way

With these reservations, we recommend the following sources:

- [www.prodigy.nhs.uk](http://www.prodigy.nhs.uk) (excellent, evidence-based overviews; also has good patient information leaflets)
- [www.library.nhs.uk](http://www.library.nhs.uk) (many useful resources, including the *BNF* and the Cochrane Library)

The recommendations in this book were extensively checked against Prodigy guidance at the time of writing.

## Holistic care

It will be apparent from reading the other chapters of this book that the previous optimism of Western medicine about the eradication of infectious diseases by antibiotics has not been fulfilled. The more that we research these drugs, the more evidence we find that their benefits in most cases of minor illness are marginal; yet little evidence exists to support alternative treatments. Nor is it likely to be provided because, despite the recommendations of the Medical Research Council in 1997, funding for research into minor illness and the relief of self-limiting symptoms remains limited.

The nurse's first priority must be to satisfy herself that there is no evidence of serious disease, and if so to reassure the patient accordingly. This may be all that is necessary; patients do not necessarily want advice on managing their illness, and traditional nursing advice (e.g. rest, copious fluids and regular paracetamol) is not well supported by research.

It is important to be sensitive to the patient's beliefs and expectations, or 'agenda'. They may have attended in order to legitimise their illness to an employer, or at the insistence of a relative. Social factors, such as an impending holiday or examination, will often be of far greater importance to patients than any medical issues, and will inevitably influence their assessment of the relative risks and benefits of any treatment.

In Western medicine the 'placebo effect' is regarded as a nuisance which interferes with the evaluation of the 'real' effects of a treatment in clinical trials. Yet the placebo effect is itself very real, and represents the influence of the patient's belief on the intrinsic healing ability of the body. You can harness this effect very easily, by being positive and emphasising that a good recovery is likely. The placebo effect of any treatment that you suggest will be enhanced by the fact that you have recommended it, particularly if you have established a good relationship with the patient. Try to avoid destroying this effect by being too evidence based, provided that you can be sure that the treatment will do no harm. For example, writing a prescription for simple linctus while explaining 'actually, there's no evidence that this works' is unlikely to benefit the patient. Remember that any therapy that makes the patient feel better is likely to accelerate the healing process.

## References

- Ernst E (2001) Towards a scientific understanding of placebo effects. In: Peters D (ed) *Understanding the Placebo Effect in Complementary Medicine*. Churchill Livingstone, Edinburgh, pp. 17–29.
- Medical Research Council (MRC) (1997) *MRC Topic Review: primary health care*. Medical Research Council, London, pp. 44–5.

## Infections

The traditional Western explanation of the infectious process portrays the human body as a sterile environment that has been invaded by a hostile organism. Our scientists' efforts have been concentrated on finding newer and better chemical weapons to defeat these enemy forces. However, the spread of antibiotic resistance is causing increasing concern. Our ability to develop new antibiotics is limited; only one of the antibiotics in our formulary (clarithromycin) has been introduced within the last 20 years.

We are beginning to see that this warlike model is fundamentally flawed. The human body is more like an ecosystem, supporting a myriad of other organisms far greater in number than the cells in our body. Some of them are essential for our survival, like the intestinal bacteria which manufacture vitamin K. Broad-spectrum antibiotics dramatically alter our internal flora, leading to side-effects such as diarrhoea and vaginal thrush.

Many of the organisms that can cause infections are normal inhabitants of the healthy human body (*commensals*). The process which causes them to become pathogenic is not well understood, but often seems to be initiated by a fall in the vigilance of the immune system rather than a change in the organism itself. The immune system has intricate links with all other systems of the body, and is susceptible to the effects of nutrition and psychosocial stress. It follows from this that the maintenance of a healthy body and mind is important, both in reducing the chances of developing an infection and in speeding recovery. It also seems logical that medicines that interfere with the natural defences of the body (e.g. antipyretics, anti-emetics and antidiarrhoeal drugs) should be used with caution.

Table 9.1 shows some of the bacteria that cause common infections and the antibiotics most frequently used against them.

### Reference

- Guarner F and Malgelada J-R (2003) Gut flora in health and disease. *Lancet* **361**: 512–19.

**Table 9.1** Some of the bacteria that cause common infections, and the antibiotics most frequently used against them

<i>Organism</i>	<i>Commensal of:</i>	<i>Diseases</i>	<i>Antibiotic susceptibility</i>
<i>Streptococcus</i>	Throat	Pharyngitis, otitis media, pneumonia, meningitis, cellulitis, impetigo	Penicillin V, amoxicillin, clarithromycin
<i>Staphylococcus</i>	Nose	Impetigo, boils, abscesses	Flucloxacillin, erythromycin, clarithromycin
<i>Haemophilus influenzae</i>	Upper respiratory tract	Otitis media, epiglottitis, meningitis, chest infections	Amoxicillin (80%), co-amoxiclav, erythromycin, clarithromycin, doxycycline
<i>Escherichia coli</i>	Intestine	UTI, abscesses, gastroenteritis	Trimethoprim, nitrofurantoin, cefalexin

### **Box 9.1** Recurrent infections

Sometimes patients present with a history of several different types of infection over a short period of time.

In such cases, consider:

- psychosocial stress (a potent immunosuppressant)
- increased exposure to infections (e.g. child starting school)
- white cell dysfunction (e.g. leukaemia – FBC)
- diabetes (urinalysis or fasting blood glucose)
- HIV (test with full counselling beforehand)

#### **Reference**

- Kiercolt-Glaser J *et al.* (1991) Spousal caregivers of dementia victims, changes in immunity and health. *Psychosom Med* **53**: 345.

## **Notifiable diseases**

Diseases which must be notified to the Consultant in Communicable Disease Control (CCDC) on the appropriate form include:

- food poisoning
- suspected food poisoning
- measles
- mumps
- rubella
- pertussis

A full list is given on the cover of the book of notification forms. This notification is statutory and does not require the patient's consent. (See [www.hpa.org.uk/confidentiality/default.htm](http://www.hpa.org.uk/confidentiality/default.htm))

Warn the patient that he or she may be contacted by the local Health Protection Unit, and explain that their role is to identify the source of infections and prevent their spread.

If there are any implications for the community, e.g. suspected food poisoning in a chef, or a rare infectious disease, notify the local consultant in communicable disease by telephone or fax.

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### Useful websites

- Information on infectiousness: [www.hpa.org.uk/infections/topics\\_az/schools/schools.pdf](http://www.hpa.org.uk/infections/topics_az/schools/schools.pdf)
- *Information on rashes in pregnancy*: [www.hpa.org.uk/infections/topics\\_az/rubella/rash.pdf](http://www.hpa.org.uk/infections/topics_az/rubella/rash.pdf)
- *Information on immunoglobulin administration*: [www.hpa.org.uk/infections/topics\\_az/immunoglobulin/pdfs/ig\\_handbook120704.pdf](http://www.hpa.org.uk/infections/topics_az/immunoglobulin/pdfs/ig_handbook120704.pdf)

Table 9.2 lists infectiousness and exclusion periods for common diseases, derived from information on [www.hpa.org.uk](http://www.hpa.org.uk).

**Table 9.2** Infectiousness and exclusion periods for common diseases

<i>Disease</i>	<i>Incubation period</i>	<i>Infective period</i>	<i>Exclude from school – case</i>	<i>Action for contacts</i>
Chickenpox (less likely to be infectious if lesions covered)	11–20 days (chickenpox)	From 1 day before until 5 days from onset of rash	5 days after rash appears	Refer babies under 4 weeks, non-immune immunocompromised or pregnant contacts
Conjunctivitis	3–29 days	While discharge present	None	None
Diarrhoea and vomiting	1 hour–14 days (depending on cause)	While diarrhoea lasts	Until 24 h after last diarrhoea or vomiting (48 h for under 5s)	No exclusion unless bacterial cause, when CCDC will decide
Glandular fever	33–49 days	While symptomatic	Until well	None
Hand, foot and mouth disease	3–5 days	Up to 7 days	1 week or until ulcers are healed	None
Head lice	7–10 days	As long as lice or live eggs are present	Until child and family have been treated	None
Impetigo	Unknown	While purulent lesions persist	Until lesions crusted, or 48 h after treatment begun	None
Measles	6–19 days	From 4 days before onset of rash to 4 days after	5 days	Refer non-immune immunocompromised or pregnant contacts
Mumps	15–24 days	From 6 days before symptoms to 4 days after onset	5 days	None

*continued overleaf*

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**Table 9.2** Continued

<i>Disease</i>	<i>Incubation period</i>	<i>Infective period</i>	<i>Exclude from school – case</i>	<i>Action for contacts</i>
Parvovirus (slapped cheek)	13–18 days	Until rash appears	None	Refer pregnant contacts under 30 weeks
Pertussis (whooping cough)	5–21 days	Up to 3 weeks if untreated	5 days after starting antibiotic	None
Rubella	13–21 days	From 13 days before rash until 6 days after	5 days	Refer non-immune pregnant contacts under 20 weeks
Scabies	7–27 days	Until mites and eggs have been destroyed	Until day after treatment	None once treated
Shingles	None	Until five days after onset of rash	None, provided lesions covered	Refer babies under 4 weeks, non-immune immunocompromised or pregnant contacts if exposed to uncovered lesions
Streptococcal throat infection	12 h to 5 days	Up to 48 h after antibiotic	None, unless rash present (exclude for 5 days)	None
Threadworms	2–6 weeks	As long as eggs present on perianal skin	None once treated	None once treated
Tinea	1–2 weeks	While lesions are active	Only if epidemic suspected	None
Verrucae (plantar warts)	1–24 months	As long as wart present	None (cover wart with waterproof dressing for swimming/barefoot sports)	None

Source: Health Protection Agency, Dec 2004.

## Certificates

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### NHS certificates

These are not issued for periods of less than 7 days: in these cases the patient should obtain an SC2 form from his or her employer, or an SC1 from the surgery if self-employed or unemployed.

The usual white certificate (MED3) is issued at the time that the patient sees a doctor. Certificates can be backdated if the patient has previously been seen by a GP, deputising service doctor or hospital doctor (pink form: MED 5). These should not be used for periods longer than one month.

No certificate can be forward-dated, although overlapping is permitted.

Closed certificates (with a return-to-work date) can only be given if the date is within 14 days of the date of issue.

### Reference

- [www.dwp.gov.uk/medical/faq.asp](http://www.dwp.gov.uk/medical/faq.asp) (accessed 10 June 2005).

### Private certificates

These can be issued at the recommended British Medical Association (BMA) rate, which should be reclaimed from the employer.

