SEPTEMBER 2007

Gastroenterology IN PRIMARY CARE

JOURNAL OF THE PRIMARY CARE SOCIETY FOR GASTROENTEROLOGY

USE and ABUSE of Sedation

DR ALAN IRELAND

Despite the fact that much good practice exists in this field, recent audit reports confirm that over-sedation is still a problem in practice (NCEPOD 2004 - 'Scoping our Practice'), as well as deficiencies in monitoring. Very few Trusts offer training in sedation techniques, despite the call from the Academy of Medical Royal Colleges in 2001.

If sedation is chosen, then 'conscious sedation' should be the aim, defined as 'A technique in which the use of a drug produces a state of depression of the CNS enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation. Always be aware that if you lose that verbal contact, you have anaesthetised the patient! Recent studies have shown that such deep sedation occurs regularly, even for a short period, in more than 50% of most endoscopic tests.

There is of course a discrepancy between what the patient wants from his/her sedation experience and what we are currently trying to deliver. Assessment of the patient in advance will obviously inform the sedation decision, and the ASA grading system may be helpful to some people. Throat-spray only for OGD is widely acceptable though less well tolerated in younger, and female, patients. The amnesic effect of Midazolam means that clear, written, post-procedure instructions are vital on discharge, especially after therapy eg. polypectomy, sphincterotomy. Clearly of course, some patients do require general anaesthesia eg. young children, patients with learning difficulties, severely phobic patients, large variceal GI bleeds.

If using Pethidine and Midazolam, never forget the synergism, and the fact that the opiate will augment the benzodiazepine up to 4 times. Always give the opiate first, and titrate up the benzodiazepine.

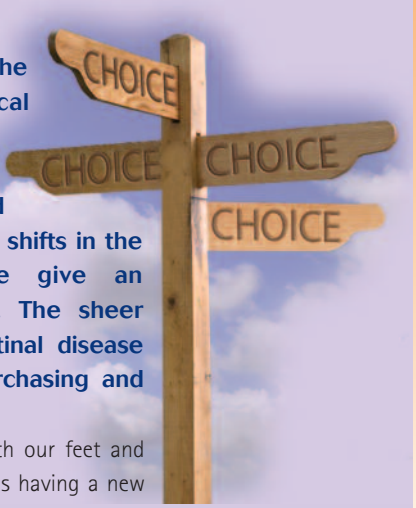
Remember however that an end-point of drooping eyelids is probably too far! Doses above 50mg Pethidine and 4mg Midazolam should rarely now be used. There is a huge literature on the use of Propofol for endoscopic procedure, as it is rapidly effective and controllable. It may also be very helpful in patient controlled sedation. The BSG guidelines are clear however that Propofol should not be used except in the presence of an anaesthetist.

A number of studies of patient-controlled sedation have been very successful, with lower doses and quicker recovery times. There is also some data showing that relaxing music is helpful in reducing the need for sedation/analgesia. There is still debate about the use of Nitrous Oxide for colonoscopy. Controlled data is not particularly supportive though the technique clearly still has its proponents, and therefore a place if found helpful locally.

Finally, there is a real need for ongoing audit in the area of sedation, and I would encourage you all to start auditing figures for sedation doses, the use of reversal agents in your units, and patient comfort scores in conjunction with the nursing staff.

This issue...

EDITORIAL



Gastroenterology has often felt the poor relation to other medical specialities. It was not recognised with a National Service Framework. It is absent from the current Quality and Outcomes Framework. However seismic shifts in the National Health Service landscape give an opportunity to redress this situation. The sheer prevalence and burden of gastrointestinal disease give a substantial presence in the purchasing and provision of services.

The political ground has been shifting beneath our feet and there is no reason to think this will change. Does having a new prime minister mean a new health policy? How will he resolve his alleged "old labour" tendencies with his reputation as a moderniser? Does Mr. Brown bear a personal grudge against general practitioners for the increased costs associated with the new contract? Time will tell the answers to these questions but it is reasonable to expect that the purchaser-provider split and effective internal market will stay.

No market can function without consumer choice – ideally rational and informed choice. Introducing choice into the health market is the introduction of a tool to make a market function and is not a commodity in itself. Many patients will want to continue to be served by their local hospital but the prospect that a few at the margins may be persuaded to look elsewhere introduces a competitive opportunity for provider units.

For gastroenterology a major development will be the inclusion of diagnostics in Choose and Book. Approximately 1% of the population have an endoscopy every year and traditional secondary care providers, Independent Treatment Centres and entrepreneurial GP endoscopists will all compete to offer endoscopy services. In the previous command economy of health, referral to endoscopy was often governed by local referral guidelines. These were commendable where they reflected current evidence and were in the best interest of the patient. A danger in the new multi-provider era is that the providers may actively seek to encourage referral and over, or inappropriate, investigation may not serve our patients well.

In such situations patients need to make rational choices and since they are not in a situation to do this themselves they must rely on the advice of their agents – their general practitioners. It is beholden then that GPs are in a position to give the best advice and the complexity of modern medicine means that they may need a resource to guide and inform their decision. This is clearly a potential role for the Primary Care Society for Gastroenterology; to provide credible and appropriate advice to working general practitioners from our special perspective of being GPs ourselves but with an interest in gastroenterology.

Richard Stevens

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FIFTEEN THIN
COE

Coeliac disease is a life-long autoimmune condition caused by an intolerance to gluten, the protein fraction in the cereals wheat, barley and rye. Coeliac disease is thought to affect 1 in 100 people[1,2], although only 1 in 8 are diagnosed[3]. Most patients present with gut related symptoms including; bloating, diarrhoea, constipation and wind.

1 Symptoms vary in terms of severity, and alongside gastrointestinal symptoms can include tiredness, anaemia, headaches, mouth ulcers, weight loss, skin problems, depression, neurological symptoms, recurrent miscarriages and joint or bone pain.

2 There is a clear procedure for diagnosing coeliac disease. The first stage is to measure coeliac disease specific serology, IgA based tTGA (tissue transglutaminase antibodies) and/or EMA (endomysial antibodies). A small bowel biopsy is then required to confirm diagnosis[4].

3 The antibody blood tests are not 90-95% accurate[5]. As coeliac disease is an autoimmune disease the antibodies will not show in the blood if the patient is following a low gluten or gluten-free diet. At least 2% of people with coeliac disease are IgA negative[5]. If antibody tests results are zero, serum IgA should be measured to detect IgA deficiency. If IgA deficient IgG based tTGA and/or EMA should be measured, followed by a small bowel biopsy if the results are positive[4].

4 If a patient has already removed gluten or is on a low gluten diet prior to the either the blood tests or the biopsy they need to re-introduce it before the tests are carried out. It is recommended that people re-introduce gluten for approximately 6 weeks at a level of 10-15g gluten per day, which is approximately 4 slices of bread[6]. This varies widely amongst people with coeliac disease, so a plan for gluten challenge should be discussed on an individual basis.

5 Symptoms for coeliac disease are similar to Irritable Bowel Syndrome (IBS) and consequently misdiagnosis is common[7]. Although there is now a more structured diagnostic criteria for IBS the draft guidelines for NICE [due to be published in February 2008] state that before a diagnosis of IBS is given, coeliac disease should be excluded[8].

IGS THAT YOU MIGHT NOT KNOW ABOUT
LIAC DISEASE

6 Complete treatment for coeliac disease is the gluten-free diet. This means that wheat, barley, rye and their derivatives must be avoided. Some people may also be sensitive to uncontaminated oats and so need to avoid these too (see point 7).

7 Oats are generally contaminated with other gluten containing grains and so unsuitable for people with coeliac disease. Although 1 in 20 are able to tolerate uncontaminated oats without a problem, some research has suggested that people who are gluten intolerant may react to the avenin in oats[9].

8 In the UK people with coeliac disease are eligible for food on prescription. The foods that are available on prescription are listed in MiMMs, the BNF and the Drug Tariff, as well as in Coeliac UK's food and drink directory. National prescribing guidelines for gluten-free foods have been developed to assist health professionals[10].

9 Coeliac disease is genetically based, and linked to the HLA antigens, DQ2 and DQ8. There is a 1 in 10 chance that a first line blood relative of someone with coeliac disease will also have the condition[11]. There are no agreed recommendations for screening relatives but genetic screening can exclude the possibility of coeliac disease in relatives of people with the condition.

10 Dermatitis Herpetiformis (DH) is a skin manifestation of coeliac disease which affects 1 in 10 000. It commonly occurs on the elbows, forearms, knees and buttocks, although it may occur anywhere on the body. A skin biopsy is used to diagnose DH. Intestinal biopsy nearly always shows flattening of the intestinal villi, in people with DH, although most people with DH have none of the gastrointestinal symptoms which are characteristic of coeliac disease.

11 Other autoimmune conditions occur in association with coeliac disease, these include thyroid disease, rheumatoid arthritis and Type 1 diabetes. Coeliac disease occurs in 3-6% of people with type 1 diabetes[12] and most specialist diabetes centres now screen for coeliac disease in children with Type 1 diabetes. There is no association between type 2 diabetes and coeliac disease.

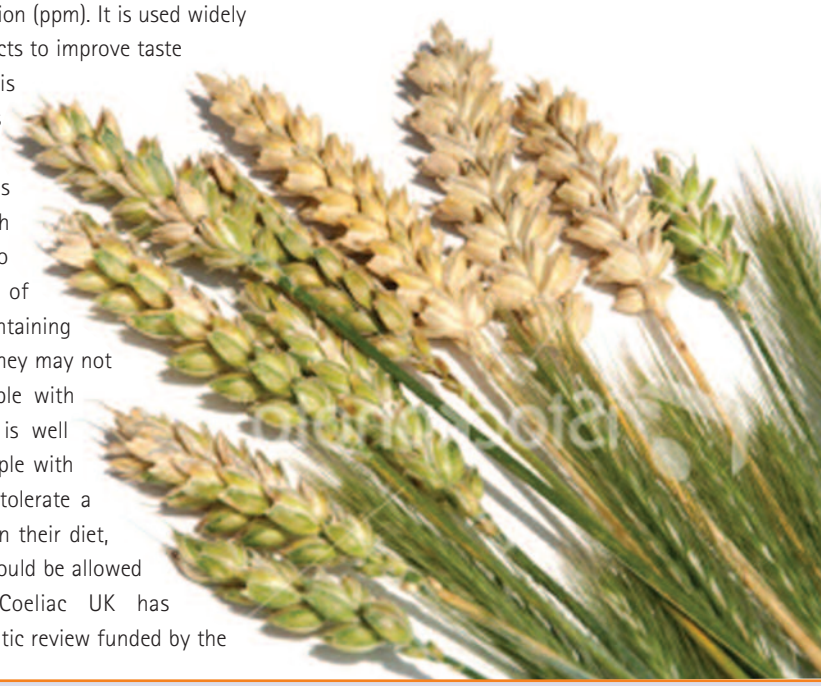
12 Complications of undiagnosed coeliac disease include bowel cancer and osteoporosis. Once established on a gluten-free diet the risk of bowel cancer is reduced to that of the general population. However, the increased risk of osteoporosis in the coeliac population remains due to less effective absorption. For this reason it is recommended that people with coeliac disease have 1500mg of calcium a day, twice that recommended for the general population[13]. It is also recommended that people with coeliac disease are followed up on an annual basis by their gastroenterologist, dietitian or GP and assessed for antibody levels and nutritional deficiencies.

13 Codex wheat starch is wheat starch that has had the gluten removed to a trace level which is within the Codex standard of 200 parts per million (ppm). It is used widely in gluten-free products to improve taste and texture. This Codex standard is not accepted world wide and there has been some research to suggest that due to the additive effect of consuming foods containing 200ppm of gluten, they may not be safe for all people with coeliac disease[14]. It is well established that people with coeliac disease can tolerate a low level of gluten in their diet, but the level that should be allowed is not known[15]. Coeliac UK has completed a systematic review funded by the Food Standards Agency to assess if the current threshold for gluten-free food is appropriate. The report will be published in due course.

14 Currently around 60% of patients with coeliac disease are diagnosed by serological testing in primary care. The ready use of serological testing has resulted in an increase in diagnosis rates, and highlights the important role GP's have to play[16]. Ensuring appropriate education for GP's as well as for specialists in secondary care, will help prevent delayed diagnosis.

15 Coeliac UK is the national charity for people with coeliac disease and dermatitis herpetiformis. Members will receive a Gluten-free Food and Drink Directory containing over 11,000 gluten-free foods, a quarterly magazine 'Crossed Grain' and a welcome pack. Coeliac UK also run a helpline which is open 10am-4pm Monday to Friday, with a later 1100hrs start on Wednesdays. You can contact Coeliac UK via their website at **www.coeliac.org.uk** or by phoning their helpline on **0870 444 8804**.

Emma Merrikin, Dietitian, Coeliac UK



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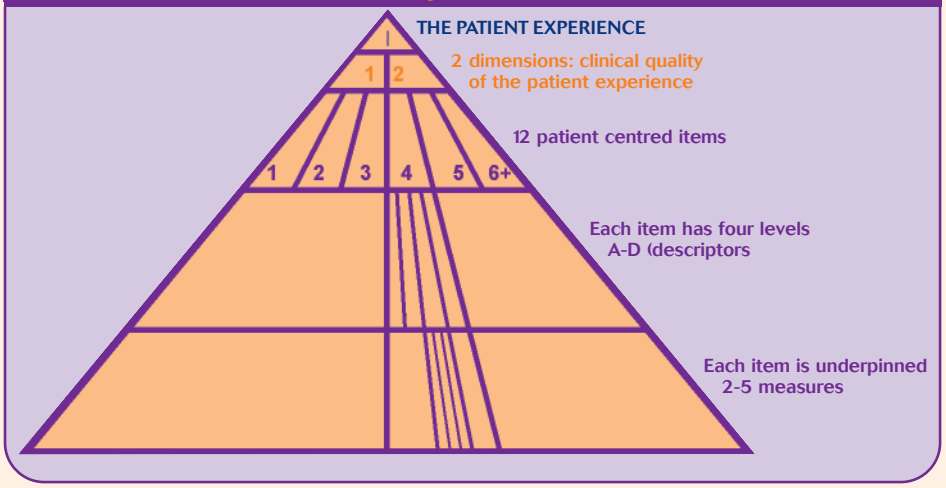
The Global Rating S

Many GPs with a special interest in gastroenterology particularly those who endoscope will be aware of the GRS. However, this may only be a passing acknowledgement of its existence as, unless they are running their own units, they will not have been actively involved in completing the scale. This article introduces the GRS and gives a background to the scale and its implications for GP endoscopy, in particular, GP activity in the community setting.

FIG 1 - ENDOSCOPY GLOBAL RATING SCALE



The GRS was devised by the National Endoscopy Team as a robust method of assessing endoscopy units in terms of criteria determined nationally. This means that all endoscopy units, including community units, will be judged by the same standards. On the one hand, this gives the community unit and an opportunity to compete with secondary care units on a level playing field however it also means that community units may be judged by inappropriate secondary care standards. This poses an important question - is the GRS fit for purpose in the community setting?

The background to the GRS is that in 2004 the National Endoscopy team held a number of meetings with endoscopy staff to answer the question: 'What matters to a patient having an endoscopy?' From their answers the 12 items of the endoscopy scale were created. These were divided into the clinical quality of the endoscopy procedure and the quality of the patient experience (see below).

Clinical quality	Quality of patient experience
● appropriateness	● equality
● information/consent	● timeliness
● safety	● choice
● comfort	● privacy and dignity
● quality	● aftercare
● timely results	● ability to provide feedback

These items formed the measures of the patient experience that were underwritten by 'descriptors' which, in turn, were determined by the normative 'measures' of the quality of the service provided by that unit. Thus creating pyramidal representation of the global rating scale with the patient at the top of the pyramid and measures of the service as its foundation (fig 1).

The global rating scale is completed on-line, where 'measures' are unambiguous statements that require either a 'yes' or 'no' answer. The number of measures that are achieved determines the descriptor level achieved by that particular unit. Where D is the basic level and A is an excellent level. An example of the statements for the consent process in the Clinical Quality of the Patient Centred Item is shown in fig 2.

To achieve a particular descriptor (D to A) then all measures have to be answered in the affirmative for that particular level and in all the levels below it. The unit will then achieve a score for each of the 12 patient centred items that can be compared locally and nationally. The process of assessing the unit is repeated six monthly with the expectation that scores will improve as the unit changes its policies and procedures in line with the standards set by the National Endoscopy Team. The great advantage of this rating scale is that each measure is underpinned by a knowledge management system that units can access to improve their performance.

In considering the GRS from the community point of view there are a number of questions that need to be addressed.

Is this:

- **secondary care dictating to the community?**
- **inappropriate secondary care practice and procedures in the community?**
- **an effective way to change the service provision and improve community endoscopy?**

With regard to the first point, it is true to say that secondary care is dictating to the community but there is very little we can do about this as the National endoscopy team were given the remit by the JAG to produce the scale.

Secondly, it quickly became apparent that a number of measures were not appropriate for community units. For example, a basic measure dictated that endoscopy reports had to be filed in the hospital records before the patient leaves the unit or the unit had to provide a 24/7 on-call bleed rota. Clearly these, and other measure, were not appropriate in the community setting. As a result, representations were made to the National Endoscopy team. Accordingly, the rating scale was amended to account for the particular conditions in a community unit.

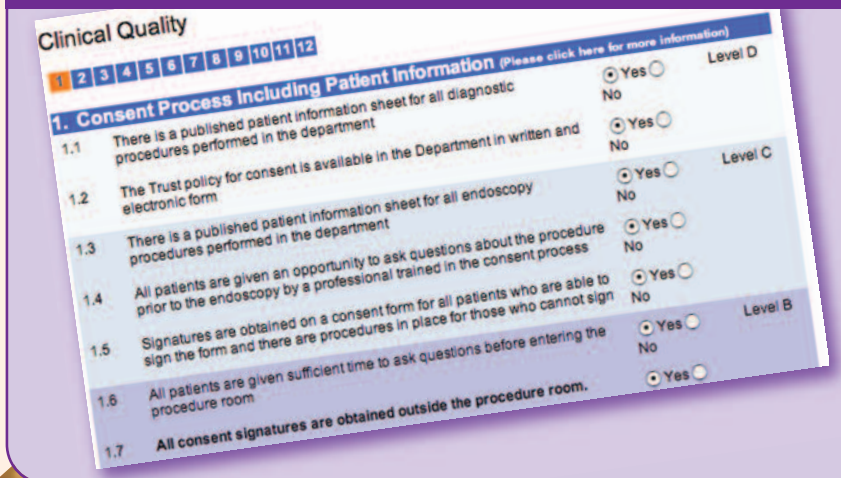
Finally, our own personal experience is that our practice and procedures have changed and improved following the introduction of the GRS.

The GRS is a scale that applies to and improves care in all endoscopy units. It has the effect of standardising care across secondary care and community units. Now community units can complete on a level playing field.

The GRS is an effective framework for assessment with good background documentation and the scale has been adjusted to account for the different practice in the community. By monitoring our performance we

Scale (GRS)

FIG 2 - STATEMENTS FOR THE CONSENT PROCESS



Clinical Quality

1 2 3 4 5 6 7 8 9 10 11 12

1. Consent Process including Patient Information (Please click here for more information)

1.1	There is a published patient information sheet for all diagnostic procedures performed in the department	Yes / No	Level D
1.2	The Trust policy for consent is available in the Department in written and electronic form	Yes / No	
1.3	There is a published patient information sheet for all endoscopy procedures performed in the department	Yes / No	Level C
1.4	All patients are given an opportunity to ask questions about the procedure prior to the endoscopy by a professional trained in the consent process	Yes / No	
1.5	Signatures are obtained on a consent form for all patients who are able to sign the form and there are procedures in place for those who cannot sign	Yes / No	
1.6	All patients are given sufficient time to ask questions before entering the procedure room	Yes / No	Level B
1.7	**All consent signatures are obtained outside the procedure room.**	Yes	

are able to identify financial and service development for our unit.

But looking to the future... The GRS will become the quality standard with a pass or fail outcome. Furthermore, the GRS will generate league tables with consequences on patient choice, funding and financial implications for service development.

In the new NHS we cannot ignore these pressures and the GRS is an inevitable task we have to accept. Optimistically, we can say that the scale is nested in the patient experience; the scale has been modified with deference to the community units; and, initially, it seems that the national standards of endoscopy have improved.

THE FRINGE

Every important meeting has a fringe. There is lots of learning to be had over coffee breaks, afternoon tea and drinks before dinner, pearls of wisdom that can change practice, rolling around and bowling us over with bright ideas.

- Did you know that carbon dioxide insufflation for colonoscopy is much more comfortable for the patient?
- That nasendoscopy is a useful alternative for those difficult non-sedated endoscopies.
- Oral diazepam given an hour and a half before the procedure can make a magic difference to tolerability
- If you scope outside the hospital and scope infection control is a problem, there are now some central sterile supply depots from where scopes can be shot out into the community and returned for cleaning.
- If fresh fish can be delivered on a daily basis from Billingsgate, then so can scopes!
- To run a cost effective endoscopy unit, it is possible to base a business case on prices that well undercut tariff price.
- Unfilled sessions are not economically viable, so it is important that your unit is sited in an area where plenty of people live, has accessibility and has good transport links.

You would never find details like this in any text book but such is the learning from the PCSG meeting at Brighton.

Last word went to our Chairman Dr Richard Stevens, when he quoted a patient being discharged. "You will be able to drive home now, as you had your procedure without sedation ". "That's wonderful" the chap replied, "I have never had a driving lesson in my life!"

Dr Marion Sloan

Lower GI Disorders

INVESTIGATION AND MANAGEMENT

Lower GI symptoms are very common. In a study by Chaplin et al in 2000 596 patients were interviewed at home and 57% had at least one lower GI symptom. Only 31% with new onset of significant symptoms had consulted their GPs.

The spectrum of symptoms are
Alteration of bowel habit
Rectal bleeding
Abdominal pain
Anorectal symptoms
(Anaemia)

Benign and malignant disease share many similar symptoms and strategies need to be developed to decide which of those patients should be referred urgently and what to do with those who do not meet referral criteria.

The most reliable combination of symptoms in predicting colorectal cancer is the combination of rectal bleeding with a change in bowel habit.

COLORECTAL CANCER PRESENTATION

204 Cancers:	
Rectum/Sigmoid	
Rectal bleeding + change bowel habit	84%
Rectal bleeding - perianal symptoms	9%
Other symptoms + rectal mass	2%
Colonic	
Emergency surgery	34%
Anaemia alone	29%
Anaemia + abdominal mass	34%

Ellis et al 1999

As a result patients should be referred under the 2 week suspected cancer rule if they have recent onset of high risk symptoms which would include

- Rectal bleeding + persistent change in bowel habit for >= 6 weeks, with tendency to increased frequency and/or looser stools
- Persistent change in bowel habit of recent onset and at least 6 weeks to looser stools or increased frequency, rectal bleeding persistently without anal symptoms and no obvious evidence of external anal lesion
- Fe def anaemia without obvious cause <10G in men and post menopausal women
- Definite right sided abdominal mass or rectal mass

For patients without high risk symptoms referral should be made for an urgent appointment in a routine clinic and for low risk symptoms - usually anorectal disease arising from haemorrhoids and fissures - the majority can be managed in primary care. Only 5% of haemorrhoids need any form of surgical intervention with improvement in symptoms occurring by prescription of a high fibre diet, high fluid intake and soothing local applications of proprietary creams and suppositories such as anusol. Acutely thrombosed or prolapsed haemorrhoids can be managed at home with rest and application of witch hazel lotion soaked gauze. Those patients not responding to local measures will often settle with rubber band ligation which is a technique that can be offered in the primary care setting with a minimum of capital investment.

Anal fissure can usually be managed by high fibre diets and increased fluid intake. Lignocaine gel is usually sufficient to control pain and chronic fissures will often heal with the application of GTN ointment or diltiazem cream.

Perianal abscesses should not be treated with antibiotics but referred for surgical incision and drainage.

Choice of Investigation

The current methods for investigation of lower gi symptoms are
Rigid sigmoidoscopy + Barium Enema
Flexible sigmoidoscopy + Barium Enema
Colonoscopy

Flexible sigmoidoscopy with DCBE is only marginally less sensitive for diagnosis of polyps and cancer and certainly is a cheaper option for mass screening of symptomatic patients. However colonoscopy allows biopsy of suspicious lesions and prevention of cancer by polypectomy. A rational approach would be to do an outpatient flexible sigmoidoscopy with barium enema on low to medium risk patients and for high risk and screening use colonoscopy

BARIUM ENEMA vs COLONOSCOPY

100 patients with positive FOB
BE + colonoscopy 7 to 14 days later
9 BE inadequate, 2 incomplete colonoscopy
5 cancers identified by both studies

	BE	Colonoscopy
DD	42	18
Polyps <5mm	3	36
Polyps 6-9mm	5	15
Polyps >=10mm	4 (3)	15 (7)

The burden of lower GI symptoms and disease is high. Delay in diagnosis of serious disease could be avoided if primary care undertook the treatment of minor anorectal disease but at the same time had direct rapid access to diagnostics. Such access would be allowed so long as referral guidelines were adhered to.

Roger Leicester

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JOURNAL OF THE PRIMARY CARE SOCIETY FOR GASTROENTEROLOGY

Getting to the Bottom of It:

A FREUDIAN PERSPECTIVE

"I can't stomach them anymore"; "I'm sick to death of it"; "They are a pain in the backside". All colloquial expressions common in everyday English language. Common too in the therapy room, as clients attempt to communicate feelings pertaining to their external and internal worlds. Feelings with origins that may be felt to be unknown to the client, but feelings whose meaning is searched for, and struggled with, within the therapeutic process.

In an attempt to get to the bottom of what might be behind these client verbalisations, - excuse the pun, the British societal fascination with 'toilet humour' lives on - it is perhaps worth considering the Freudian perspective.

Freud in his early writings in the 'Three Essays on the Theory of Sexuality'(1905), saw infant psychological development as a negotiation through 'stages' - oral, anal, phallic and genital. Stages to maturity worked through by individuals, with pathology arising from 'arrest' at one or another of these stages.

Anna Freud writes, "Detaching sexuality from genitals enabled Freud to trace the development of sexual functioning from its manifestation in the adult to its first beginnings in early childhood. What had previously been deemed infantile misdemeanours - thumb sucking, interest in excrement, masturbation... appeared in this new light as the search for sexual pleasure though not connected with the genitals but dependant upon specific bodily zones." (Freud, A.1981 cited in 2005 p.272).

Freud's theory based on erotogenic zones starts with the mouth. This oral or cannibalistic phase is where sexual activity (ie. infancy libido) has not yet been separated from feeding. "The object of both activities is the same; the sexual aim consists of incorporation of the object - the prototype of a process which is later to play such an important psychological part" (Freud 1905 p.117).

The anal stage, centered on the erotogenic zone of the anus involves the principle of, "the instinct for mastery through the agency of the somatic musculature" (Freud 1905 p.117). Freud also recognised the ability of the infant to use expulsion functions in the way they relate to adults. "The content of the bowels have other important meanings for the infant. They are clearly treated as part of the infant's own body and represent his first 'gift': by producing them he can express his active compliance with his environment and by witholding them, his disobedience" (Freud 1905 p.103).

Any parent can identify with the desperate wish for the infant to 'poo in the potty' - the pleasure (for the infant too), pride and relief at this happening and the frustration, confusion and anger when it does not. The infant's creation comes to represent something important and powerful, eliciting strong feelings in the adult others around him, as well as in himself. So too later, in the therapy, the creativity of the adult client manifests itself, symbolically resonating in earlier unconscious infantile experiences.

A client's narrative can be looked at therefore, in terms of what is being pushed down, expelled, held onto, introjected, unassimilated, devoured, surrendered, created etc., in the wider context of the success, or lack of it, in negotiating through these infancy developmental stages and how this has come to inform the client's internal world as it is now.

The therapy itself can also come to represent a container, a symbolic 'lavatory bowl' perhaps, whereby something can be felt to be metaphorically sicked up or excreted into and onto, with all the feelings unconscious or otherwise, derived from infancy, that this may evoke for the client - feelings of pleasure, pain, anxiety, shame, fear. Feelings may be aroused pertaining to where 'this' all came from and anxiety about where 'this' has been expelled to – therapy, after all does not have a convenient flush to clean it all away. Feelings of loss that emerge can be thought about in the context of infancy experiences too - of "narcissistic injury through a bodily loss the daily surrender of his faeces" (Freud 1923 p.310).

So, what of the client who presents in therapy with his "painful haemorrhoid"? Perhaps the internal and external worlds of the client can be thought about in terms of what it is, symbolically, that is felt to be painful or too unmanageable to push out. Or what it is, or whom, that needs to be 'kept in' and not able to be surrendered yet, without fear of the untold 'damage' this 'getting rid of' would cause.

Or the bulimic client, whose therapist in the counter transference feels the hunger pangs, perhaps mirroring the clients hunger for both food and the psychical nourishment of therapy. Yet, paradoxically the client cannot tolerate introjecting and being 'full' of either the food or the therapy. What primitive infancy anxieties pertaining to the oral stage and being 'full' and 'empty' are evoked in her?

Or the client with the ever present "worry tummy", whose infantile verbalisation perhaps mirrors infantile expressions of psychical pain, denoting disruption in the negotiation of the anal stage of infancy development. So the list goes on...

Of course, Freud's seminal theory of psychological development perhaps needs to be contextualised within a wider psychoanalytic framework, as indeed all clinical cases need to be thought about within an holistic framework - an impossibility here, but maybe it can be considered that early events, although not consciously remembered, influence the way we experience and relate to the world generally. It is these influences that are revealed in the transference, particularly in times of heightened emotion (Bateman & Holmes 1995), poignantly, transference that can be keenly aroused for the client when in the GP and the therapy setting.

Food for thought, perhaps.

Ann Mountford

References: •Bateman, A. & Holmes, J. (1995) Introduction to Psychoanalysis London: Routledge •Freud, A. (1981 cited in 2005) The Essentials of Psychoanalysis London: Sage •Freud, S. (1905) Three Essays on the Theory of Sexuality Penguin Freud Library Volume 7 •Freud, S. (1923) The Infantile Genital Organization Penguin Freud Library Volume 7

Event Diary

12 October 2007
Annual Scientific Meeting/AGM,
RCP, London
Contact: pcsg@pcsg.org.uk

Sat 27 - Weds 31 October 2007
UEGW
Paris
Contact: www.uegw.org.uk

8 February 2008
PCSG Regional Meeting
Peterbrough – tbc
Contact: pcsg@pcsg.org.uk

Mon 10 - Thurs 13 March 2008
BSG Annual Scientific Meeting
ICC, Birmingham
Contact: www.bsg.org.uk

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