103rd EGPRN MEETING

22-25 October 2026

Santiago de Compostela - Spain

EGPRN

EUROPEAN GENERAL PRACTICE RESEARCH NETWORK

THEME

Cancer Care Continuum Along the Lifespan

- Programme Book -

www.egprn.org

COLOPHON

Programme Book of the 103rd European General Practice Research Network Meeting
Santiago de Compostela, Spain, 22-25 October 2026

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Foreword

Cancer care continuum along life span

Cancer remains a healthcare priority in Europe, driving the need to strengthen integrated systems in which Primary Care longitudinal care plays a prominent role. Available evidence shows that family physicians are essential throughout all stages of cancer care.

In health promotion, prevention, and early diagnosis, Primary Care contributes through the promotion of healthy lifestyles, management of risk factors, vaccination, participation in screening programmes, and early detection of symptoms. During active treatment, family physicians support the management of comorbidities, adverse effects, and emotional care, providing continuity of care with a biopsychosocial approach.

Following treatment, their role is crucial in the follow-up of cancer survivors, management of long-term sequelae, cardiovascular prevention, palliative care, and coordination with community resources. In addition, shared-care models between oncology and Primary Care improve patient and/or family satisfaction, and evidence shows comparable clinical outcomes.

However, significant barriers still persist across Europe, including poor coordination between levels of care, digital limitations, lack of clinical time, and the need for specific oncology training. Overcoming these challenges represents a strategic opportunity to improve the quality, sustainability, and efficiency of healthcare systems, as well as a necessity to add life to the years of people living with cancer, their families, and friends.

This meeting aims to showcase and highlight the essential role of Primary Care in cancer prevention, early detection, follow-up, and patient-centered care. It seeks to provide a platform for sharing experiences, research, and innovative practices that strengthen the integration of cancer care within the Primary Care setting.

Participants are warmly invited to contribute to the scientific programme by submitting abstracts and communications related to this topic, fostering knowledge exchange and collaborative discussion in this important field.

Host Organising Committee

- Dra. Ana Clavería
- Dra. Ché Fernández
- Dra. Ana Castaño
- Dra. Francisco Gude
- Dra. Noemí López
- Sarai R. Alvarado
- Dra. M Victoria Delgado
- Gabriel Iglesias
- Dra. Cristina Armenteros
- Dra. Carolina Suárez

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<tr><th colspan="4">THURSDAY, 22 OCTOBER 2026</th></tr>
<tr><th>Time</th><th>Cimabue</th><th>Carlos V</th><th>Columnas (2nd Fllor)</th></tr>
<tr><td>9:00</td><td rowspan="2">Workshop 3
AI Tools in Research (Spanish)
Systematic Reviews using Covidence, Claude, Consensus and Elicit - 09:00 - 11:00</td><td rowspan="4"></td><td></td></tr>
<tr><td>9:30</td><td rowspan="3">Executive Board Meeting
09:30 - 13:00</td></tr>
<tr><td>11:00</td><td rowspan="2">Workshop 1: JASP - A fresh way to do statistics (English)
11:00 - 13:00</td></tr>
<tr><td>12:00</td></tr>
<tr><td>13:00</td><td rowspan="2">Workshop 2: Survey design: Design, quality assessment and data management
13:00 - 15:00</td><td rowspan="4">Council Meeting
14:00 - 17:00</td><td rowspan="4"></td></tr>
<tr><td>14:00</td></tr>
<tr><td>15:00</td><td rowspan="2">Workshop 4
AI Tools in Research (English): Practical applications of AI tools
15:00 - 17:00</td></tr>
<tr><td>16:00</td></tr>
<tr><td>17:00
18:00</td><td>Research Strategy Committee
17:00 - 18:00</td><td>Educational Committee
17:00 - 18:00</td><td>PR & Communication Committee
17:00 -18:00</td></tr>
<tr><td>19:30
20:30</td><td colspan="3">Welcome Reception and Opening Cocktail
Venue: Hotel Monumento San Francisco, Patio de Cristal (Ground Floor)
Address: Campillo de, Costa de San Francisco, 3, 15705 Santiago de Compostela</td></tr>
</table>

FRIDAY, 23 OCTOBER 2026			
08:00-08:30	Registration - Ground Floor		
08:30-08:45	**Carlos V** Opening of the Meeting by EGPRN Chairperson Prof. Dr. Lieve Peremans		
08:45-09:00	Welcome by Local Host Prof. Dr. Ana Claveria		
09:00-09:40	International Keynote Lecture Prof. Dr. Patrick Redmond		
09:40-11:10	Plenary Session - Theme Papers		
11:10-11:40	Blue Dot Coffee Break - Patio de Cristal		Coffee Break - Patio de Cristal
11:40-13:10	**Carlos V** Parallel Session A - Theme Papers: When Diagnosis Takes Longer: Lessons from Örenäs Research Group	**Cimabue** Parallel Session B - Freestanding Papers: Persistent Symptoms and Quality of Life	**Columnas** (2nd Floor) Parallel Session C - Freestanding Papers: Engagement and Participation in Care
13:10-14:10	Lunch - Patio de Cristal		
14:10-15:40	**Carlos V** Parallel Session D - Theme Papers: Psychosocial Needs, Rehabilitation and Supportive Care	**Cimabue** Parallel Session E: Freestanding Papers: Vaccines and Infection Prevention	**Columnas** (2nd Floor) Parallel Session F: Freestanding Papers:Patient Experience and Psychosocial Support
15:40-16:00	Coffee Break - Patio de Cristal		
16:00-17:30	**Carlos V** Parallel Session G: One Slide Five Minute Presentations	**Cimabue** Parallel Session H: Freestanding Papers - At the Bedside: Tools for Better Assessment	
17:30-17:40	Summary of the day by the International Keynote Speaker Prof. Dr. Patrick Redmond		
17:40-20:00	Primary Care Networks, A Path For The Future		
18:00	**Practice Visits in Santiago de Compostela**		
	Registration is required. The groups will leave from the conference venue.		

SATURDAY, 24 OCTOBER 2026			
08:30-09:10	**Carlos V** National Keynote Lecture Assoc. Prof. Maria Sala Serra	**Cimabue**	**Columnas** (2nd Floor)
09:10-10:40	Parallel Session I - Theme Papers: Cancer Care in Everyday Practice	Parallel Session J - Freestanding Papers: The Digital Consultation	Parallel Session K: Freestanding Papers: Making Evidence Work in Primary Care
10:40-11:00	Coffee Break - Patio de Cristal		
11:00-12:30	**Poster Sessions - Patio de Cristal**		
	Poster Session 1: Cancer Screening and Risk Assessment	Poster Session 2: Living With Cancer: Communication, Support and Treatment	Poster Session 3: Prevention Beyond the Consulting Room
	Poster Session 4: Maintaining Function, Supporting Recovery	Poster Session 5: Mental Health in a Connected World	Poster Session 6: Prevention, Cardiovascular Risk and Safer Prescribing
	Poster Session 7: Medical Education	Poster Session 8: Primary Care Delivery and Health System Performance	
12:30-13:30	Lunch - Patio de Cristal		
12:50-13:30	Elevator Pitch - Cimabue		
13:30-15:30	**Carlos V** Parallel Session L - Freestanding Papers: Interesting Methodology Session	**Cimabue** Parallel Session M: Web Based Research Course Presentations	**Columnas** (2nd Floor) Parallel Session N - Freestanding Papers: Care for Older People and Patients With Multimorbidity
15:30-15:50	Coffee Break - Patio de Cristal		
15:50-17:20	**Carlos V** Parallel Session O - One Slide Five Minutes Presentations	**Cimabue** Parallel Session P - Freestanding Papers: Across Borders: How Primary Care Works	
17:20-17:30	Summary of the day by the National Keynote Speaker Assoc. Prof. Maria Sala Serra		
17:30-17:50	Chairperson's Report by EGPRN Chair, Prof. Dr. Lieve Peremans		
17:50-18:00	Presentation of the Poster-Prize for the Best Poster Presented		
18:00-18:10	Introduction to the Next EGPRN Meeting		
18:10	Closing		
20:30-00:00	**Social Night with Dinner, Dance and Music! - Online registration required.** Venue: Hotel Monumento San Francisco, Room Monumental Address: Campillo de, Costa de San Francisco, 3, 15705 Santiago de Compostela		

Programme

Thursday, 22 October 2026

09:00 - 11:00	**Workshop 3: AI Tools in Research (I, Spanish edition): Systematic Reviews using Covidence, Claude, Consensus and Elicit** Location: Cimabue Registration is required. Click here to learn more. • Dr. Víctor Quesada Varela • Dr. María Victoria Delgado-Martín
09:30 - 13:00	**EGPRN Executive Board Meeting** Location: Columnas (2nd Floor) Only for Members of the Executive Board
11:00 - 13:00	**Workshop 1E: JASP - A fresh way to do statistics (English)** Location: Cimabue Registration is required. Click here to learn more. • Dr. Gabriel Iglesias-Caride
13:00 - 15:00	**Workshop 2: Survey design: Design, quality assessment and data management (English)** Location: Cimabue Registration is required. Click here to learn more. • Dr Daniel Dias
14:00 - 17:00	**EGPRN Council Meeting** Location: Carlos V Only for EGPRN Executive Board and EGPRN Council members.
15:00 - 17:00	**Workshop 4: AI Tools in Research (I, English edition): Practical applications of AI tools.** Location: Cimabue Registration is required. Click here to learn more. • Dr. Noemí López Rey
17:00 - 18:00	**Educational Committee Meeting** Location: Carlos V
17:00 - 18:00	**PR & Communication Committee Meeting** Location: Columnas (2nd Floor)

17:00 - 18:00	**Research Strategy Committee Meeting** Location: Cimabue
19:30 - 20:30	**Welcome Reception and Opening Cocktail** Location: Patio de Cristal

Friday, 23 October 2026

08:00 - 08:30 **Registration**

08:30 - 08:45 **Opening of the Meeting by EGPRN Chairperson**
Location: Carlos V
- Prof. Lieve Peremans (Speaker)

08:45 - 09:00 **Welcome by Local Host**
Location: Carlos V
- Prof. Ana Clavería (Speaker)

09:00 - 09:40 **International Keynote Lecture**
Location: Carlos V
- Prof. Lieve Peremans (Chair)
- Earlier cancer detection in general practice: tests, trade-offs and the whole pathway - Assoc. Prof. Patrick Redmond

09:40 - 11:10 **Plenary Session - Theme Papers**
Location: Carlos V
- Prof. Lieve Peremans (Chair)
- Colorectal cancer screening in Europe and the role of General Practitioners: a 32-country Örenäs Research Group comparative survey. - Michael Harris
- Depression in Long Breast Cancer Survivors: trayectories and characteristics - Ileana Gefaell
- HPV vaccination perception among parents and children in Türkiye: a Qualitative EGPRN Mentorship project - Hüsna Sarıca Çevik

11:10 - 11:40 **Blue Dot Coffee Break**
Location: Patio de Cristal

For the first time attendees.

11:10 - 11:40 **Coffee Break**
Location: Patio de Cristal

For the regular attendees.

11:40 - 13:10 **Parallel Session A - Theme Papers: When Diagnosis Takes Longer: Lessons from Örenäs Research Group**
Location: Carlos V
- Prof. Ayse Caylan (Chair)
- Learning lessons from their experiences: what would GPs do differently after a delayed cancer diagnosis? Results from an Örenäs Research Group qualitative study. - Tuomas Koskela
- Perspectives of European patients and clinicians on the causes of delayed cancer diagnosis: an Örenäs Research Group scoping review - Raquel Gomez Bravo
- What do European patients and healthcare professionals think are the main causes of delayed cancer diagnosis? Results from an Örenäs Research Group qualitative study. - Magda Gavana

11:40 - 13:10 **Parallel Session B - Freestanding Papers: Persistent Symptoms and Quality of Life**
Location: Cimabue

- Prof. Pemra C. Unalan (Chair)
- Determinants of health-related quality of life in fibromyalgia and chronic fatigue syndrome/myalgic encephalomyelitis: a cross-sectional comparative study in Spanish primary care - Rosa Magallon Botaya
- Longitudinal Changes in Symptom Severity in Post-COVID Syndrome: a Systematic Review and Meta-Analysis - Kousha Sarpari
- What drives cognitive complaints in Long COVID? Depressive symptoms, not objective performance or inflammation: a primary-care cohort study - Fátima Méndez López

11:40 - 13:10 **Parallel Session C - Freestanding Papers: Engagement and Participation in Care**
Location: Columnas (2nd Floor)

- Prof. Hilde Bastiaens (Chair)
- Developing a Consensus-Based Framework to Evaluate Social Prescribing Schemes in Primary Care: The EVALRA Project - Carmen Belén Benedé Azagra
- EVALGUÍA: An Evidence-Based Tool to Strengthen Community Engagement in Health Promotion Projects - Alba Gallego-Royo
- Family doctors' perceptions of barriers and facilitators to treatment adherence among patients with diabetes: quantitative findings - Shlomo Vinker

13:10 - 14:10 **Lunch**
Location: Patio de Cristal

14:10 - 15:40 **Parallel Session D - Theme Papers: Psychosocial Needs, Rehabilitation and Supportive Care**
Location: Carlos V

- Prof. Ana Clavería (Chair)
- Assessment of rehabilitation needs and corresponding needs of primary care contacts in cancer survivors – A cross-sectional survey study - Susanna Calling
- Evaluation of the functionality and loneliness levels to the needs and experiences of the population over 80 years of age who are registered to the homecare list of a primary care outpatient clinic - Pemra C. Unalan
- Implementation gap in mental health care across the cancer care continuum: a retrospective clinical audit in primary care in Kazakhstan - Lazzat Zhamaliyeva

14:10 - 15:40 **Parallel Session E - Freestanding Papers: Vaccines and Infection Prevention**
Location: Cimabue

- Prof. Giulio Rigon (Chair)
- Family physicians perspectives on Q fever awareness and prevention - Daniel Cifo
- Real-World Effectiveness of Recombinant Zoster Vaccine in Adults Aged 50 Years or Older: A Population-Based Cohort Study - Yochai Schonmann
- Real-world safety assessment of Mpox Vaccine in Catalonia: Retrospective Cohort Study of AESIs and Breakthrough Infections - Felipe Villalobos

14:10 - 15:40 **Parallel Session F: Freestanding Papers: Patient Experience and Psychosocial Support**
Location: Columnas (2nd Floor)

- Prof. Philippe-Richard Domeyer (Chair)
- Best Practices in Gender-Based Violence Prevention and Care in the Spanish National Health System (2012–2019): A Descriptive Review - Sandra León-Herrera
- Loneliness and emotional support helpline use in Spain: primary care implications from a 20-year observational study - Alejandra Aguilar-Latorre
- The Role of General Practice in Maternity Journeys: Women's Perspectives on GP prenatal and postnatal care in Ireland - Ivana Keenan

15:40 - 16:00 **Coffee Break**
Location: Patio de Cristal

16:00 - 17:30 **Parallel Session G: One Slide Five Minute Presentations**
Location: Carlos V

- Prof. Mehmet Ungan (Chair)
- Dr. Ferdinando Petrazzuoli (Chair)
- Prof. Shlomo Vinker (Chair)
- Adapting the SDM-Q9 for Colorectal Cancer Screening: A Delphi Consensus Study with EGPRN Experts - Paul Aujoulat
- Characterization of patients admitted to an Oncological Palliative Care Unit: Role of timing and multidisciplinary involvement - Jesus Martin Treviño Theriot
- International Patterns of Cancer-Related Primary Care Visits: Evidence from INTRePID - Karen Tu
- Overcoming Barriers to Breast Cancer Screening Participation Among Women: The Effectiveness of a Three-Stage Primary Care Intervention - Bengi Tör
- Restoring Human Connection in Chronic Care: Evaluating the Implementation of AI-Assisted Clinical Scribes in General Practice - Gökçe İşcan
- Transforming Smoking Cessation Consultations into Comprehensive Cancer Prevention Opportunities in Primary Care - Didem Kafadar

16:00 - 17:30 **Parallel Session H - Freestanding Papers: At the Bedside: Tools for Better Assessment**
Location: Cimabue

- Dr. Marija Glavinić (Chair)
- ABI Variability as a Potential Predictor of Cardiovascular Complications in Patients with Diabetes Mellitus - Stanislava Mikulová
- Cardiac Auscultation and Echocardiographic Screening for Valvular Heart Disease in Asymptomatic Elderly Primary Care Patients: A Cross-Sectional Study - Ülkü Sur Ünal
- Physician Perspectives on Point-of-Care Ultrasound (POCUS) in Primary Care: A Cross-Sectional Study in Israel - Ilan Yehoshua

17:30 - 17:40 **Summary of the day**
Location: Carlos V

- Assoc. Prof. Patrick Redmond (Speaker)

17:40 - 20:00 **Plenary Session: Primary Care Networks, A Path For The Future**
Location: Carlos V

Are you involved in a Practice-Based Research Network (PBRN) or another primary care research network? Join us for an interactive Network Session bringing together networks from across Europe.

This session will provide an opportunity to share experiences, connect with colleagues, explore collaboration opportunities, and develop ideas for future joint research. Together, we aim to strengthen links between national networks and build a more connected European primary care research community.

Come and share your network, your experience, and your ideas for future collaboration!

- Prof. Ana Clavería (Chair)
- Rafael Ramos
- Prof. Thomas Frese
- Christos Lionis
- Ms. Laura O'Connor
- Prof. Tuomas Koskela

18:00 - 20:00	**Practice Visits in Santiago de Compostela** Registration is required. Click here for more information

Saturday, 24 October 2026

08:30 - 09:10 **National Keynote Lecture**
Location: Carlos V
- Prof. Ana Clavería (Chair)
- Multimorbidity and care trajectories among Long-Term Breast Cancer Survivors: Lessons from the SURBCAN Project - Assoc. Prof. Maria Sala Serra (Speaker)

09:10 - 10:40 **Parallel Session I - Theme Papers: Cancer Care in Everyday Practice**
Location: Carlos V
- Prof. Michael Harris (Chair)
- Breaking Bad News in Oncology: Simulation-Based Training for Family Medicine Residents - Daina Malinsa
- Evaluation of Pre-Diagnosis Cancer Screening Status and Related Determinants in Patients Diagnosed with Colorectal, Cervical, or Breast Cancer: A Cross-Sectional Study - Yüksel Duygu Altıparmak
- Supporting Continuity of Cancer Care Through Safe Air Travel: Development of the Cancer Air Travel Assessment Framework (CAT-AF) - Md Al Araf Hussain

09:10 - 10:40 **Parallel Session J - Freestanding Papers: The Digital Consultation**
Location: Cimabue
- Dr. Negar Pourbordbari (Chair)
- Artificial Intelligence in General Practice: A Systematic Review and Meta-Analysis of Diagnostic Performance, Bias, and Implementation Challenges. - Alberto Parada
- BRIDGE-PC: Mapping Digital Health Training in Primary Care Medical Curriculum Worldwide - Ana Luisa Neves
- Reconfiguring the Primary Care Consultation: Aligning Digital Convenience with Clinical Craft - Hans Thulesius

09:10 - 10:40 **Parallel Session K - Freestanding Papers: Making Evidence Work in Primary Care**
Location: Columnas (2nd Floor)
- Prof. Jako Burgers (Chair)
- Association Between Screen Time and Depressive Symptoms in Adolescents: A Systematic Review of Longitudinal Studies - Carolina Pais Neto
- European Consensus Statement on the Management of Disorders of Gut–Brain Interaction in Primary Care - Heather L Rogers
- For which patient groups is continuity of GP care more strongly associated with beneficial outcomes? Preliminary findings from a systematic review of within-study comparisons - David Lerma Irureta

10:40 - 11:00 **Coffee Break**
Location: Patio de Cristal

11:00 - 12:30 **Poster Session 1: Cancer Screening and Risk Assessment**
Location: Patio de Cristal
- Dr. Hüsna Sarıca Çevik (Chair)
- AUTO-HPV CSP: evaluating the impact of vaginal self-sampling for HPV testing on cervical cancer screening uptake in primary care, a multicentre comparative study protocol - Margarida Gil Conde
- CANDOR (CANcer Digital Outreach and Referral): A Participatory Study on Enhancing Cancer Prevention Uptake via Digital Transformation in Primary Care Settings. - Nora Mueller
- Functional Characterization of MLH1 Variants of Uncertain Significance for Improved Genetic Counseling - Miguel Castro Fernandez
- Personality traits influence breast cancer risk factors and participation in screening -

Krisztián Vörös
- Why Do Women Decline HPV-Based Cervical Cancer Screening? A Qualitative Primary Care Study Among Women Aged 30 Years and Older in Türkiye - Ayşen Fenercioğlu

11:00 - 12:30 **Poster Session 2: Living With Cancer: Communication, Support and Treatment**
Location: Patio de Cristal
- Prof. Hilde Bastiaens (Chair)
- Cancer patients' experiences of integrated palliative care visits during ongoing cancer treatments - Eliisa Tenkanen
- Enablers and Barriers to Health Literacy Interventions Across the Cancer Care Continuum - Noemí López Rey
- Health Literacy Interventions Across the Cancer Continuum: an AI-Assisted Systematic Review - Gabriel Iglesias-Caride
- Implementation of Social Prescribing for People with Cancer in Primary Care: Baseline Findings from Aragón and Future Evaluation Using the EVALRA Framework - Rosa Fraile Escriche
- Patients with advanced EGFR+ lung cancer treated with osimertinib: clinical experience in a health área. - Maria Jose Fernandez Dominguez

11:00 - 12:30 **Poster Session 3: Prevention Beyond the Consulting Room**
Location: Patio de Cristal
- Dr. Negar Pourbordbari (Chair)
- A consensus-based framework for evaluating Community Health Strategies in primary care: a national modified Delphi study - Barbara Oliván Blazquez
- Defining social prescribing link worker practice in Europe: An international Delphi consensus study of core functions, training needs, and implementation conditions - Ferdinando Petrazzuoli
- From Community Screening to Confirmed Skin Cancer Diagnosis: Findings and Follow-Up Pathways after a Street Public Dermoscopy Campaign - Sofiia Kucheriavchenko
- How can GPs improve adherence to physical activity programmes amongst sedentary patients, thereby also reducing the risk of obesity and cancer? - Matteo Zecchetto
- Reaching the Public: Information Pathways and Barriers to Participation in a Street-Based Skin Cancer Check - Olha Rusanovska

11:00 - 12:30 **Poster Session 4: Maintaining Function, Supporting Recovery**
Location: Patio de Cristal
- Dr. Heather L Rogers (Chair)
- Ageism in Physicians' Attitudes Toward Older Patients: A Qualitative Study - Ahmet Furkan Akyürek
- Assessment of Neurocognitive Decline in Primary Care - János Zsuffa
- Frailty, Functional Performance and BMI in older people at Risk of Hospitalisation - Maria Samefors
- Life-time prevalence of polymyalgia rheumatica and temporal arteritis in a population-based primary care cohort of rural Swedish women born 1901-1931 - Elias Engström
- Towards Consensus-Based Physical Activity and Rehabilitation Guidance After Organ Transplantation: - Lodewijk Pas
- Twenty-year fracture outcomes and hospital-care cost analysis after a targeted primary care prevention programme in older women in Sweden - Daniel Albertsson

11:00 - 12:30 **Poster Session 5: Mental Health in a Connected World**
Location: Patio de Cristal
- Dr. Frank Mueller (Chair)
- Assessment Of Social Determinants Of Health In Primary Care Settings In Europe - Dúnia Bel Verge
- Problematic Video Game Use and Online Gaming Among Adolescents - María Victoria Delgado-Martín

- Relationship between problematic video game use and involvement in cyberbullying behaviors. - Sarai Rodríguez-Alvarado
- Relationship Between Video Game Use and Psychological Well-Being in Adolescents: A Mediation Analysis of Problematic Video Game Use - Rosalía Del Carmen Pino López
- The Effect of Patient-Centred Follow-up Interviews on Anxiety and Self-Efficacy in Patients with Chronic Wounds - Nurgül Übeyitoğulları
- The impact of resilience and self-care on mental health: rural-urban differences - Álvar Sáez Marina

11:00 - 12:30 **Poster Session 6: Prevention, Cardiovascular Risk and Safer Prescribing**
Location: Patio de Cristal

- Prof. Tuomas Koskela (Chair)
- Agreement between artificial intelligence-driven chatbots and primary care physicians in deprescribing decision-making: preliminary results from a case vignette study - Maria Axelsson
- Cardiovascular Events Following Corticosteroid Injections: A Pilot Cohort Study - Maria Rodriguez Barragan
- Health literacy, activation and locus of control in the maintenance of healthy lifestyle habits and health perception - Carla Estévez Queija
- Structured Pharmacist Consultations Embedded in General Practitioner Practices for Older Statin-Treated Patients: A 12-Month Longitudinal Study - Anna Artner
- Utility of Carotid and Femoral Ultrasound in Primary Care for Dyslipidemic Patients with a Low-to-Moderate Cardiovascular Risk Score - Carolina Suarez

11:00 - 12:30 **Poster Session 7: Medical Education**
Location: Patio de Cristal

- Prof. Juan A Lopez-Rodriguez (Chair)
- A polyvalent tool for breaking bad news developed using the Delphi method - PRIESO protocol - Yaritza Carneiro
- Design and Validation of a Community Health Knowledge Questionnaire - María Isabel Fernández San Martín
- Digital.Pulse: Empowering Medical Students for General Practice 4.0. Qualitative Findings from a Feasibility Study - Arian Karimzadeh
- Needs analysis of learning objectives for a lifestyle medicine curriculum in family medicine residency program: an E-Delphi study - Duygu Ayhan Başer
- Perceived incentives and barriers among Family Medicine tutors for engaging in research in primary care: preliminary results of a qualitative study - Marina Guisado Clavero

11:00 - 12:30 **Poster Session 8: Primary Care Delivery and Health System Performance**
Location: Patio de Cristal

- Prof. Magda Gavana (Chair)
- Assessment of interruptions to Primary Care consultation: EIAP study - Enrique Díaz Del Pino
- Audit Of A Regional Protocol For The Management Of Acute Pharyngotonsillitis In Adults In A Primary Care Health Area - Alicia Castillo Páramo
- Health services use for patients consulting nurse practitioners-lead clinics in primary care. A longitudinal study in Québec, Canada - Arnaud Duhoux
- Preventive Checks in General Practice in Slovakia: Current Status and Future Challenges - Ludmila Kutakova
- Using EMS data for rural health planning: the June 2026 heatwave as a first IRIS use case - Linda Hoffmeister

12:30 - 13:30 **Lunch**
Location: Patio de Cristal

12:50 - 13:30 **Elevator Pitch**
Location: Cimabue

Join us to share your research ideas - or learn about other people's research ideas!
If you have a new research idea, and have not sent an abstract to present it at the EGPRN Santiago de Compostela Meeting, why not present it to us as an 'elevator pitch'? 'Elevator pitches' are usually used to 'sell' a business idea, but here you will have 2 minutes to tell us about your ideas for a new research study.

13:30 - 15:30 **Parallel Session L - Freestanding Papers: Interesting Methodology Session**
Location: Carlos V

- Prof. Paul Van Royen (Chair)
- Governing the Loop: Three Architectures for AI Systems That Co-Produce Clinical and Administrative Reality - Odi Stummer
- How Patients' Words Can Become Biomarkers: Narrative Phenotyping with the Human Phenotype Ontology in Long COVID - Serha Soylu
- Impact of a performance-based prescribing incentive on national drug consumption in a non-gatekeeping health system: an interrupted time series study - Sena Tunç
- Latent Genetic Liability To Internalizing Disorders And Total Medıcation Burden: Evidence From Genomic Sem And Mendelian Randomization - Cemre Durlanık

13:30 - 15:30 **Parallel Session M- Web Based Research Course Presentations**
Location: Cimabue

- Prof. Mehmet Ungan (Chair)
- Prof. Shlomo Vinker (Chair)
- Dr. Ferdinando Petrazzuoli (Chair)
- Awareness and adoption of the WHO ICOPE model among primary care physicians and nurses in Portugal: a proposal for a national cross-sectional survey - Ana Viegas
- From Home-Health Narratives to Longitudinal Clinical Signals: A Validation Proposal Relevant to Cancer and Complex Care - Metehan Guzelkaya
- How can we improve the experience of Breaking Bad News? A Systematic review. - Alice Laurandeau

13:30 - 15:30 **Parallel Session N - Freestanding Papers: Care for Older People and Patients With Multimorbidity**
Location: Columnas (2nd Floor)

- Dr. Gökçe İşcan (Chair)
- Patient activation and associated psychosocial factors in middle-aged adults with multimorbidity in primary care: a cross-sectional analysis of the e-mpoderaT cohort - Angela Revilla
- Prevention of Urinary Tract Infections in Institutionalized Older Adults: An Intervention Project - Helena Costa
- Primary care-adapted Comprehensive Geriatric Assessment: costs and effects of the prospective matched-controlled SAFE trial - Moa Lundgren

15:30 - 15:50 **Coffee Break**
Location: Patio de Cristal

15:50 - 17:20 **Parallel Session O - One Slide Five Minutes Presentations**
Location: Carlos V

- Dr. Ferdinando Petrazzuoli (Chair)
- Prof. Shlomo Vinker (Chair)
- Prof. Mehmet Ungan (Chair)
- Can a web-based digital prevention advisor "CheckMe" improve opportunistic screening

performance (including cancer screening)? A pilot randomized controlled trial in primary care - I-Hsin Yang
- Digital Health Anxiety and Its Influence on the GP–Patient Relationship: A Primary Care Perspective (Single-Center Study) - Mariam Abisonashvili
- Patient–Family Physician Relationships During Active Cancer Treatment: A Linked-Pair Qualitative Study - Egem Eren
- Primary care assessment of cognitive complaints after cancer treatment: a proposal for a European EGPRN multicentre survey - Kübra Efe
- The Role of Socratic Questioning in Encouraging Participation in Cancer Screening in Primary Care: A Pilot Pragmatic Cluster Randomised Controlled Trial - Sıdıka Ece Yokuş
- Understanding Clinical Heterogeneity in Metabolic Syndrome Through Multidimensional Phenotyping in Primary Care - Helder Manuel Pereira-Sousa

15:50 - 17:20 **Parallel Session P - Freestanding Papers: Across Borders: How Primary Care Works**
Location: Cimabue
- Prof. Radost Asenova (Chair)
- Familiarity with tools for detecting potentially inappropriate prescribing in older people among primary care physicians in Europe: a collaborative study - Naldy Parodi López
- Integration assessment of Digital Risk Prediction Strategies for Psychosis Prevention in Primary Care: The ePreventPsych Study - Maria Miñana Castellanos
- What's in a name? Mapping the professional identity of family doctors across 44 European countries - Sara Ares Blanco

17:20 - 17:30 **Summary of the day**
Location: Carlos V
- Assoc. Prof. Maria Sala Serra

17:30 - 17:50 **Chairperson’s Report by EGPRN Chair**
Location: Carlos V
- Prof. Lieve Peremans (Speaker)

17:50 - 18:00 **Presentation of the Poster Prize for the best poster presented**
Location: Carlos V
- Prof. Radost Asenova

18:00 - 18:10 **Introduction to the next EGPRN meeting**
Location: Carlos V
- Prof. Philippe-Richard Domeyer

18:10 - 18:15 **Closing**
Location: Carlos V

20:30 - 00:00 **Social Night with Dinner, Dance and Music!**
Location: Monumental

Online registration required.
Venue: Hotel Monumento San Francisco
Address: Campillo de, Costa de San Francisco, 3, 15705 Santiago de Compostela, A Coruña, Spain

International Keynote Lecture

Earlier cancer detection in general practice: tests, trade-offs and the whole pathway

Prof. Patrick Redmond

Earlier cancer detection is not a single test but a chain of decisions: who is considered at risk, when investigation begins, which test is used, how uncertain findings are managed, and whether patients can complete the pathway. Using three clinical scenarios, this keynote will examine how primary care responds to a changing symptom trajectory, how a health system should offer and deliver proven lung cancer screening, and what should happen when a new risk signal - from a risk score, biomarker or multi-cancer blood test - enters care. It will ask what evidence is needed before a new test or pathway should change practice, and how patient preferences, multimorbidity, workload and inequalities alter the balance of benefit and harm. Examples from PRiCAN and European collaborations will lead to a practical research agenda for comparing diagnostic pathways across health systems.

About the speaker

Patrick Redmond is a GP and Associate Professor in General Practice at RCSI University of Medicine and Health Sciences, Dublin, where he leads PRiCAN (Primary Care Research into Cancer). His research focuses on earlier cancer detection, screening and diagnostic pathways in primary care, using pragmatic trials, routinely collected health data, health economics and patient-preference methods. He coordinates TRACES, a Marie Skłodowska-Curie Staff Exchanges programme examining pre-diagnostic cancer signals across health systems, and leads or co-leads national and European studies in lung, colorectal and pancreatic cancer. He has held clinical academic roles in Ireland, Australia and the UK, including at the University of Cambridge, King’s College London and the University of Western Australia. He is a former Editor-in-Chief of BJGP Open.

National Keynote Lecture

Multimorbidity and care trajectories among Long-Term Breast Cancer Survivors: Lessons from the SURBCAN Project

Maria Sala, MD, MPH, PhD

Advances in breast cancer diagnosis and treatment have led to a growing population of long-term breast cancer survivors. In Spain, where breast cancer is the most common cancer among women, increasing survival rates have shifted the focus from acute cancer care to the long-term management of survivorship, including the challenges posed by comorbidity and multimorbidity. Understanding how these women use healthcare services and how their care needs evolve over time is essential for developing effective, patient-centered follow-up models. This keynote will present the main findings of the SURBCAN (SUrvival Breast CANcer) project, a multicenter study conducted within the RICAPPS network using real-world data from five Spanish regions. The project included 6,512 women who had survived breast cancer for at least five years and 12,816 age-matched women without a history of breast cancer. By combining epidemiological methods, analyses of electronic health records, multimorbidity clustering techniques, healthcare utilization studies, and innovative data-mining approaches to characterize care trajectories, SURBCAN provides a comprehensive picture of survivorship care in Spain. Results show that long-term breast cancer survivors make greater use of both primary and specialist healthcare services than women without breast cancer, although service utilization gradually decreases with increasing time since diagnosis. Adherence to follow-up recommendations also declines over time and appears potentially suboptimal among both younger and older survivors. Importantly, the study identified five distinct multimorbidity patterns, each associated with different healthcare needs and service-use profiles. More than 80% of survivors presented multimorbidity, highlighting its central role in survivorship care. A particularly novel contribution of SURBCAN is the application of data-mining techniques to visualize and characterize healthcare trajectories. These analyses reveal substantial heterogeneity in the pathways followed by survivors and demonstrate how multimorbidity influences both patterns of care and long-term outcomes. Interestingly, women with multimorbidity showed higher adherence to follow-up recommendations, suggesting that more frequent contact with healthcare services may facilitate surveillance and continuity of care. The findings underline the need to move beyond disease-centered follow-up models and towards integrated approaches that consider multimorbidity, patient complexity, and coordinated care between primary and specialist services. By providing robust real-world evidence on healthcare utilization, adherence, and survivorship trajectories, SURBCAN offers valuable insights to inform future clinical guidelines, healthcare planning, and the organization of survivorship care for the growing population of long-term breast cancer survivors.

About the speaker

Maria Sala, MD, MPH, PhD is a specialist in Preventive Medicine and Public Health and serves as Head of the Epidemiology and Evaluation Department and Director of Quality at Hospital del Mar, Barcelona. She also coordinates the Epidemiology and Evaluation Research Group at the Hospital del Mar Research Institute (HMRI). She holds Master's degrees in Biomedical Research Methodology and Healthcare Management from the Universitat Autònoma de Barcelona (UAB). She is Associate Professor at the Universitat Pompeu Fabra (UPF) and has extensive experience in teaching, research supervision, and mentoring of healthcare professionals. Her research focuses on cancer epidemiology, health services evaluation, and survivorship care, particularly in breast cancer screening and long-term breast cancer outcomes. She is a member of the Spanish research network RICAPPS (Research Network on Chronicity, Primary Care and Health Promotion). Her work has contributed significantly to advancing evidence-based survivorship care and the integration of epidemiological research into healthcare quality improvement.

Pre-conference Workshop 1

JASP - A fresh way to do statistics

Thursday, 22 October, 11:00 - 13:00

- Iglesias Gabrie
  Psychologist
  I-Saúde Research Group Senior Researcher, IISGS Vigo, Spain. RICAPPS Network

The workshop focuses on the use of JASP software, demonstrating the effectiveness of this tool as a robust, intuitive and open-access statistical resource that facilitates the understanding and application of data analysis among students and professionals

Pre-conference Workshop 2

Survey design: Design, quality assessment and data management.

Thursday, 22 October, 13:00 - 15:00

- Daniel Martinho Dias
  Family Physician
  RISE-Health, Department of Community Medicine, Information and Decision Sciences, University of Porto
  Local Health Unit São João, Porto, Portugal Emergency Department

The design of questionnaires will be reviewed, including methods of survey, questionnaire appearance, recruitment and response rate and checklist for reporting (CHERRIES, CROSS Statements). REDCap will be used for data collection and management.

Pre-conference Workshop 3

AI Tools in Research (I, Spanish edition): Systematic Reviews using Covidence, Claude, Consensus and Elicit

Thursday, 22 October, 09:00 - 11:00

- **María Victoria Delgado-Martín**
  Paediatrician
  I-Saúde Research Group PhD student, IISGS Vigo, Spain
  RICAPPS Network
- **Víctor Quesada Varela**
  Family Physician
  Medical Director of Chronic Care, Vigo Health Área, Spain

Practical applications of AI tools such as Covidence, Claude, Consensus, and Elicit to streamline and enhance the conduct of systematic reviews in medical research.

Pre-conference Workshop 4

AI Tools in Research (I, English edition): Practical applications of AI tools.

Thursday, 22 October, 15:00 - 17:00

- Noemí López Rey
  Family Phiysician
  Vilalba Health Center, Lugo. SERGAS, Spain
  I-Saúde Research Group. AGAMFEC/SEMFyC Research Group. RICAPPS

We will begin with a straightforward introduction to the key concepts — Machine Learning, Deep Learning, and Large Language Models (LLMs) — and their limitations: biases, hallucinations, and the importance of not relying on unvalidated models for clinical decision-making. From there, we will learn how to design effective prompts, explore the most useful general-purpose and healthcare-specific AI tools, and see how to apply them in everyday practice: diagnostic support, literature search, teaching, task automation, and much more. The workshop closes with real practice: participants will create their own prompts and experiment with simple automation tools. Because the best way to stop being afraid of AI is to actually use it.

Theme Paper / Finished study

Colorectal cancer screening in Europe and the role of General Practitioners: a 32-country Örenäs Research Group comparative survey.

Smyrnakis Emmanouil, Dimitra Iosifina Papageorgiou, Robert Hoffman, Krzysztof Buczkowski, Zlata Ozvacic Adzic, Jeļena Danilenko, Michael Harris

University of Bath, UK, BA3 4SJ Radstock, United Kingdom. E-mail: michaelharris681@btinternet.com

Keywords: Colorectal cancer screening, General practice, Primary health care; Early diagnosis; European region

Background:
Colorectal cancer (CRC) ranks second in cancer deaths worldwide. Screening allows diagnosis at an earlier stage and improves survival. While there are European recommendations on the age-range and frequency of CRC screening, participation in screening programmes varies substantially, possibly due to differences in how they are organised and implemented.

Research questions:
To describe the CRC screening programmes in European countries and investigate how primary healthcare professionals are involved in this process.

Method:
A cross-sectional survey in 32 countries. Key informants with relevant expertise answered online questions about the characteristics of their screening programmes and general practitioners' (GPs) roles in this.
Responses were refined through an iterative consensus process using meetings between national leaders and the core researcher group. We analysed data to identify patterns in GP engagement.

Results:
We found substantial variation in programme organisation, GP involvement, financial incentives and screening uptake. While most countries used population-based programmes, though with varying levels of GP involvement, some had opportunistic models. Countries using a population-based approach had a higher median uptake (49.2%) than those with an opportunistic approach (19.1%). GP involvement within a population-based approach was not associated with higher uptake rates.
There was a moderate positive correlation between CRC screening uptakes and 5-year CRC survival rates (Pearson's r=0.57, 95% CI 0.23–0.79, P=0.003).
Seven countries gave their GPs target-based incentives for screening, and six had fee-for-service incentives.

Conclusions:
There are important differences in how CRC screening is organised in European countries. A population-based approach was linked with a considerably higher screening uptake. GP involvement varied considerably across surveyed countries.
Our findings suggest that countries using an opportunistic model should, where feasible, consider moving to a structured, population-based one.
Research to find the optimal balance between centralised programme management and primary care engagement is essential to ensuring equitable, timely access to CRC screening across healthcare settings.

Points for discussion:
How can we investigate the optimal balance between centralised programme management and primary care involvement?

Is there a need to develop targeted strategies to ensure equitable access for diverse ethnic and socioeconomic groups?

How can AI be used to improve screening uptake and monitoring?

Presentation on 23/10/2026 09:40 in "Plenary Session - Theme Papers" by Michael Harris.

Theme Paper / Almost finished study

Depression in Long Breast Cancer Survivors: trayectories and characteristics

Ileana Gefaell, Javier Rubio Serrano, Teresa Sanz-Cuesta, Daniel Cifo, María Méndez-Hernando, Cristina Muntañola-Valero, Isabel Del-Cura-González, Claudia Iglesias-Carabias, Maria Sala Serra

Primary Care Research Unit, Madrid, Spain, 28004 Madrid, Spain. E-mail: ileanagefaell@gmail.com

Keywords: Breast Neoplasms, Long Term Cancer Survivors, Depression

Background:
Treatment advances in Breast cancer (BC) have raised 5-year disease-free survival to 85%, living as Long-term Breast Cancer Survivors (LBCS) requiring follow-up in primary care (PC). Depression is linked to BC diagnosis, but little is known about its course in LBCS.

Research questions:
What is the incidence of depression in LBCS at 5, 10, and 15 years after tumour diagnosis?
How do women who remain depression-free throughout follow-up differ from those who develop incident depression?

Method:
Design: retrospective cohort sub-analysis, within the SURBCAN study, including women LBCS aged ≥18 from Spain (n=6,292). LBCS were recruited in two phases: those with incident BC in 2000–2006 and in 2007–2012, followed until 2021. Cases were identified through cancer registries and linked to PC records.
Variables: age at BC and depression diagnosis, sociodemographic, deprivation index, BC stage and treatment, and comorbidities.
Analysis: Descriptive trajectories using a Sankey diagram. Depression incidence was calculated at each follow-up point (number of new depression cases/participants without depression at risk). Bivariate analysis of LBCS with incident depression vs those who remained depression-free.

Results:
Mean age at cancer diagnosis was 57.5(SD:12.5), depression onset at 60.1(SD:13.3) years and 57.22%(n=2,291) had higher deprivation index.
Before BC diagnosis the prevalence of depression was 9.9%(95%CI:9.3%-10.8%). Depression incidence was 11.7%(95%CI:10.8%-12.6%) 5 years after BC diagnosis free of disease (LBCS), falling to 6.4%(95%CI:5.7%-7.2%) at 10 years and, 3.9%(95%CI:3.3%-4.5%) by the end of follow-up.
Women with incident depression had a lower deprivation index (48.5% vs.42.7%; p=0.009), less advanced BC (stage III/IV:7.6%vs.11.4%;p=0.005), and more chronic diseases (6.3(SD:3.0) vs. 5.4(SD:3.0); p<0.001) than those without depression. Depressed LBCS had a higher mortality (18.4% vs 14.1%; p:0.002) No differences emerged in BC treatment.

Conclusions:
Depression incidence declines over long-term follow-up after breast cancer. Depression among LBCS is associated with less advanced disease, higher socioeconomic status, and greater comorbidity burden.

Points for discussion:
How can we explain that LBCS with depression had a lower deprivation index and less advanced disease?

Is real world data (RWD) appropriate to assess mental health diseases in LBCS?

How would you model the trajectories? Would you use Latent Transition analysis or subsequent analysis?

Presentation on 23/10/2026 09:40 in "Plenary Session - Theme Papers" by Ileana Gefaell.

Theme Paper / Published

HPV vaccination perception among parents and children in Türkiye: a Qualitative EGPRN Mentorship project

Hüsna Sarıca Çevik, Elif Ozeller, Lieve Peremans

Ankara University Faculty of Medicine, 06230 Ankara, Türkiye. E-mail: saricahusna@gmail.com

Keywords: Health communication, Human papillomavirus vaccines, Qualitative research

Background:
HPV vaccination is fundamental to primary cancer prevention throughout the lifespan. In Türkiye, the vaccine is available but not included in the national immunisation programme. Consequently, uptake relies on out-of-pocket payment and individual counselling. Examining how parents and vaccine-eligible children perceive HPV vaccination may help family physicians provide more effective HPV prevention counselling.

Research questions:
How do parents and children of primary vaccination age perceive HPV vaccination, and how do they view the role of family physicians in supporting vaccination decisions?

Method:
We conducted a qualitative individual-interview study in paediatrics outpatient clinics in Ankara between 1 February-1 March 2025. 15 parents and 15 children aged 9-13 were recruited by convenience sampling. Face-to-face semi-structured interviews explored knowledge, perceived need, trust, gendered meanings, affordability, and preferred vaccination pathways. Audio-recorded interviews were anonymised, transcribed and analysed inductively using Braun and Clarke's six-phase thematic analysis, supported by MAXQDA.

Results:
Parents' interviews revealed five themes: perceptions of the HPV vaccine, cost and access inequities, post-COVID vaccine hesitancy, gendered perceptions of HPV vaccination, and role and trust in family medicine. Children's interviews revealed four themes: perceptions of infection and prevention, knowledge and perceptions of HPV and vaccination, views on HPV vaccine cost, and preferences for family physician- and school-based vaccination. Across both groups, low awareness alone was insufficient to explain decision-making. Affordability, programme absence, misinformation, institutional trust after COVID-19, and female-focused framing shaped hesitancy. Family health centres were perceived as trusted, accessible and safe, while school-based vaccination was valued by some children for convenience and peer support. Children engaged actively with prevention, fairness, and health equity.

Conclusions:
HPV vaccination counselling in family medicine should move beyond knowledge correction toward age-appropriate, gender-neutral, equity-oriented communication and recall systems. Although conducted in a single urban academic setting, this study highlights missed opportunities for family-physician-led counselling and suggests practical directions for strengthening primary-care-based cancer prevention.

Points for discussion:
Which contextual factors should be considered when interpreting these findings in other European primary care settings with low HPV vaccination uptake?

Presentation on 23/10/2026 09:40 in "Plenary Session - Theme Papers" by Hüsna Sarıca Çevik.

Theme Paper / Published

Learning lessons from their experiences: what would GPs do differently after a delayed cancer diagnosis? Results from an Örenäs Research Group qualitative study.

Tuomas Koskela, Marcello Mangione, Mercè Marzo-Castillejo, Davorina Petek, Vija Silina, Michael Harris

University of Bath, UK, BA3 4SJ Radstock, United Kingdom. E-mail: michaelharris681@btinternet.com

Keywords: Cancer; Diagnostic Errors; Europe; Primary Care Physicians; Primary Health Care; Qualitative Research

Background:
Diagnosis of cancer is challenging in primary care. A prolonged diagnostic interval may be due to doctor, patient or system factors, or may be due to the characteristics of the cancer itself.

Research questions:
What would Primary Care Physicians (PCPs) do differently after they have failed to think of, or act on, a cancer diagnosis?

Method:
A qualitative, online survey with narratives from 159 PCPs in 23 European countries. We aimed for 5-10 responses from each participating country.
We asked PCPs to write a short description of a time when they were slow to think of a cancer diagnosis, or where they had thought of cancer but were slow to do something about it. We then asked: 'If you saw this patient with cancer presenting in the same way today, what would you do differently?'
Survey questions were in English for all participants, but PCPs could answer the question either in their own languages or in English. We translated answers into English before analysis.
We used thematic analysis to analyse the data.

Results:
The main themes were:
- Thinking broadly: always keeping the possibility of cancer as a differential diagnostic possibility.
- Improvement in communication: attentive listening to the patients' symptoms; the importance of negotiation, trust and agreement with the patient; and the need to be assertive with patients, if needed, when suspecting cancer.
- Use of other available resources: guidelines and electronic reminders.
- Improving clinical management: the need for time to evaluate the medical history, and to monitor and follow their patients up when needed.

Conclusions:
To achieve more timely cancer diagnosis, PCPs need to provide a long-term, holistic and active approach with effective communication, and to ensure shared decision-making, follow-up and continuing re-assessment of their patients' clinical conditions.

Points for discussion:
What educational interventions, based on these themes, would reduce the risk of prolonged cancer diagnostic interval?

How can we assess which interventions would improve safety-netting and follow-up?

Should future research explore patients' perspectives on the same diagnostic encounters?

Presentation on 23/10/2026 11:40 in "Parallel Session A - Theme Papers: When Diagnosis Takes Longer: Lessons from Örenäs Research Group" by Tuomas Koskela.

Theme Paper / Almost finished study

Perspectives of European patients and clinicians on the causes of delayed cancer diagnosis: an Örenäs Research Group scoping review

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Keywords: Delayed cancer diagnosis · Diagnostic delay · Cancer detection · Patient perspectives · Primary care · Secondary care · Healthcare professionals' perceptions · Scoping review · PRISMA-ScR · Referral pathways · Diagnostic pathway · Multidisciplinary care · Early detection · Europe · Örenäs Research Group

Background:
Timely cancer diagnosis is essential for improving outcomes, yet delays remain common across Europe. Existing evidence suggests that patients, primary care clinicians, and secondary care clinicians may hold differing views on the causes of diagnostic delay, but these perspectives have not been systematically compared. A clearer understanding of these viewpoints is needed to inform patient-centred, multidisciplinary strategies for earlier cancer detection.

Research questions:
How do the views of European patients, primary and secondary healthcare professionals on the main causes of delayed cancer diagnosis compare and contrast across healthcare settings?

Method:
This scoping review follows the Joanna Briggs Institute methodology and PRISMA-ScR guidelines. Using the PCC framework (Population, Concept, and Context), we will search five major databases (PubMed, Scopus, Web of Science, Cochrane, Embase) and grey literature sources for studies published between 2016 and 2026. Eligible studies will report perceptions of delayed cancer diagnosis among patients, primary care professionals, or secondary care professionals. Two reviewers will independently screen titles/abstracts and full texts, extract data using a standardised form, and synthesise findings thematically. Outcomes include perceived causes of delay, diagnostic pathway stages implicated, and areas of agreement or divergence between stakeholder groups.

Results:
Early mapping indicates that patients frequently attribute delays to symptom misinterpretation, access barriers, and difficulties navigating healthcare systems. Primary care professionals more often highlight referral processes, diagnostic access, and coordination challenges. Secondary care professionals tend to emphasise hospital organisational factors, waiting times, and resource constraints. Variability across European countries appears linked to differences in system organisation and diagnostic pathways.

Conclusions:
Preliminary findings suggest meaningful differences - and some areas of alignment - in how stakeholder groups perceive the causes of delayed cancer diagnosis. The final review will provide a comprehensive map of these perspectives, supporting the development of patient-centred, multidisciplinary approaches to earlier cancer detection. Results will be presented at the EGPRN Conference

Points for discussion:
Given that patients, primary care clinicians, and secondary care clinicians attribute delay to different stages of the pathway (symptom interpretation, referral, and hospital organisation, respectively), where should a multidisciplinary intervention be targeted first for the greatest impact on time-to-diagnosis?

How much of the observed cross-country variability reflects genuine differences in health system organisation versus differences in how "delay" has been defined and measured across the included studies?

What would a truly patient-centred model of diagnostic pathway redesign look like in practice, and how can primary and secondary care be better aligned around the patient's own experience of delay rather than each sector's institutional perspective?

Presentation on 23/10/2026 11:40 in "Parallel Session A - Theme Papers: When Diagnosis Takes Longer: Lessons from Örenäs Research Group" by Raquel Gomez Bravo.

Theme Paper / Almost finished study

What do European patients and healthcare professionals think are the main causes of delayed cancer diagnosis? Results from an Örenäs Research Group qualitative study.

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Keywords: Europe; Primary health care; Early detection of cancer; Qualitative research; Delivery of health care; Patient perspectives; Clinician perspectives

Background:
Timely diagnosis of cancer is a key part of health policy throughout Europe. There is a gap in the evidence on patients' and clinicians' views on the reasons for delayed diagnosis.

Research questions:
What, from their experience, do European patients, primary and secondary healthcare professionals think are the main causes of delayed cancer diagnosis?

Method:
In this anonymous online qualitative survey, 450 patients, their loved ones and caregivers, 334 primary and 211 secondary care clinicians from 15 Europe countries answered demographic questions and a single open-ended question asking 'What, from your own experience, do you think are the main causes of delayed cancer diagnosis?' National Leads translated the questionnaire into their local languages, with validation by back-translation. Responses were translated into English in a standardised way for each country.
We examined the data using thematic analysis, with National Leads independently coding their countries' text following a validation process. We then organised the data into themes and sub-themes in multiple online meetings.

Results:
Participants gave wide-ranging explanations for their personal experiences of diagnostic delays:
• Ineffective screening and lack of a preventative medicine culture.
• Patient-related factors: fear and denial, neglecting health needs, mistrust, language barriers.
• Clinical and diagnostic challenges: nonspecific or minimal symptoms, misdiagnosis.
• Systemic and structural barriers: long waits for tests and specialists, health policy issues (high clinician workload, poor organisation, lack of continuity of care), and patient accessibility problems (financial and geographical).

Conclusions:
Our findings suggest that policies focused solely on clinician performance are unlikely to substantially reduce diagnostic delays. Policymakers should recognise that organisational factors, including healthcare capacity, referral systems, diagnostic infrastructure and equitable access to care, play a major role in timely cancer diagnosis. Efforts to improve early diagnosis should therefore adopt a whole-system approach.

Points for discussion:
What interventions would increase informed uptake, while minimising harms such as overdiagnosis?

How can we examine whether these perceived causes relate to objectively measured diagnostic intervals and cancer outcomes?

How can we evaluate interventions targeting patient awareness and help-seeking behaviour?

Presentation on 23/10/2026 11:40 in "Parallel Session A - Theme Papers: When Diagnosis Takes Longer: Lessons from Örenäs Research Group" by Magda Gavana.

Freestanding Paper / Finished study

Determinants of health-related quality of life in fibromyalgia and chronic fatigue syndrome/myalgic encephalomyelitis: a cross-sectional comparative study in Spanish primary care

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Keywords: fibromyalgia; chronic fatigue syndrome; myalgic encephalomyelitis; quality of life; primary care; mental health

Background:
Fibromyalgia (FM) and chronic fatigue syndrome/myalgic encephalomyelitis (CFS/ME) are managed largely in primary care and cause severe reductions in health-related quality of life (HRQoL). Which dimension — pain, fatigue, sleep, mental health, or function — carries the most weight remains uncertain, and clinical heterogeneity is rarely characterized in primary care populations.

Research questions:
Among primary-care patients with FM and/or CFS/ME, which clinical domains are independently associated with HRQoL, and can clinically distinct profiles be identified within the patient group?

Method:
Cross-sectional comparative study within the ARALONGCOV primary-care cohort (Aragón, Spain). We included 121 patients with a clinical diagnosis of FM, CFS/ME, or both, and 142 controls without chronic-pain symptomatology. Measures: HRQoL (SF-12 total and physical/mental component summaries), sleep (PSQI), fatigue (FSS), depressive symptoms (PHQ-9), anxiety and depression (HADS), pain catastrophizing (PCS), functional status (PCFS-derived index), and physical performance. Groups were compared using nonparametric tests; determinants of SF-12 were modeled using multivariable linear regression. Clinical profiles within the patient group were explored using k-means clustering.

Results:
Patients with FM/CFS-ME had markedly lower SF-12 total scores (median 20.4, range 0–82.5) than controls (87.5, 6.7–98.3), and worse scores across every domain assessed. In the multivariable model (adjusted R^2=0.586), HRQoL was independently associated with anxiety (HADS-A: B=−1.26; 95%CI −1.92 to −0.60), depressive symptoms (PHQ-9: B=−0.88; 95%CI −1.40 to −0.37), and fatigue (FSS: B=−0.47). Pain catastrophizing and physical performance contributed little after accounting for them. Cluster analysis identified a reproducible high-burden profile within the patient group.

Conclusions:
In primary care, HRQoL in FM/CFS-ME is tied above all to anxiety, depressive symptoms, and fatigue, rather than to pain measures alone. This supports routine multidimensional assessment, including mental health. The cross-sectional design precludes causal inference,e and the profiles require external replication.

Points for discussion:
Should mental-health screening (HADS/PHQ-9) be routine in the primary-care follow-up of FM/CFS-ME, rather than pain-focused assessment alone

Is the high-burden cluster clinically actionable in general practice, or does it need external replication first?

In a cross-sectional design, how do we disentangle whether anxiety and depression drive HRQoL loss or result from it?

Presentation on 23/10/2026 11:40 in "Parallel Session B - Freestanding Papers: Persistent Symptoms and Quality of Life" by Rosa Magallon Botaya.

Freestanding Paper / Finished study

Longitudinal Changes in Symptom Severity in Post-COVID Syndrome: a Systematic Review and Meta-Analysis

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Keywords: Post-COVID syndrome; symptom severity; longitudinal studies; meta-analysis; primary care

Background:
Post-COVID syndrome (PCS) can cause fatigue, dyspnoea, depression, and sleep problems for months. Patients and general practitioners need realistic information about recovery. However, previous reviews have mainly summarized symptom prevalence at single time points, which cannot show whether symptoms become less severe over time.

Research questions:
How does the severity of fatigue, dyspnoea, depression, and sleep problems change over short-, medium-, and longer-term follow-up in adults with PCS?

Method:
We conducted a PROSPERO-registered systematic review and random-effects meta-analysis of longitudinal studies. Six databases were searched from inception to 2 January 2026. Eligible studies assessed adults at least four weeks after infection and reported symptom severity at the first assessment and at least one follow-up. Two reviewers independently extracted data and assessed risk of bias. Follow-up was grouped into ≤13, 14–26, and ≥27 weeks. Changes were pooled as standardized mean differences (SMDs); negative values indicate improvement.

Results:
The review included 94 studies with 20,850 participants; 27 reported fatigue severity, 15 dyspnoea, 23 depression, and 11 sleep problems. The clearest improvements occurred at follow-up of up to 13 weeks for fatigue (SMD −0.68, 95% CI −0.95 to −0.41), dyspnoea (−0.71, −1.11 to −0.31), and depression (−0.38, −0.50 to −0.25). Depression also improved at 14–26 weeks (−0.32, −0.53 to −0.11). Fatigue estimates remained similar at later follow-up but were less precise. Dyspnoea estimates after 13 weeks were highly uncertain, and no clear change in sleep-problem severity was identified. Wide prediction intervals indicated substantial differences between studies.

Conclusions:
Fatigue, dyspnoea, and depression severity improved most clearly within 13 weeks after the index assessment, whereas longer-term symptom trajectories remained uncertain. For primary care, these findings support repeated symptom assessment and individualized follow-up, particularly for patients with persistent fatigue, as recovery may be incomplete and vary substantially between individuals.

Points for discussion:
How should general practitioners explain expected recovery when average improvement coexists with wide variation between patients?

How long should symptom-based follow-up continue when symptoms persist?

Which brief symptom measures are most practical (for repeated use) in primary care?

Presentation on 23/10/2026 11:40 in "Parallel Session B - Freestanding Papers: Persistent Symptoms and Quality of Life" by Kousha Sarpari.

Freestanding Paper / Almost finished study

What drives cognitive complaints in Long COVID? Depressive symptoms, not objective performance or inflammation: a primary-care cohort study

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Keywords: Long COVID; cognitive complaints; brain fog; depression; neurocognitive testing; primary care

Background:
Cognitive complaints (“brain fog”) affect 20–40% of patients with Long COVID and are among the most disabling sequelae presenting in general practice. Whether they reflect objective neurocognitive impairment, psychological distress or persistent inflammation remains contested, leaving GPs without clear guidance on what the complaint actually tracks.

Research questions:
Within patients with Long COVID, which clinical dimension — psychological symptom burden, fatigue, sleep, pain catastrophising, objective neurocognitive performance, or a previously reported inflammatory panel — predicts the severity of the self-reported cognitive complaint?

Method:
Cross-sectional analysis of the baseline wave (2022) of the ARALONGCOV primary-care cohort (Aragón, Spain): 85 patients meeting WHO criteria for Long COVID and 85 age- and sex-matched recovered controls, assessed 12–24 months after acute infection. Outcome: cognitive complaint intensity (ordinal self-report, 0–6). Predictors: PHQ-9, FSS, PSQI, pain catastrophising and SF-12; three objective neurocognitive tests (SDMT, Rey copy, Rey memory) plus a computerised global score (subgroup, n=83); and a five-marker inflammatory/autoimmune panel previously reported in this cohort. Primary analysis: pre-specified multivariable proportional-odds ordinal regression.

Results:
Within the Long COVID group (n=79 in the full multivariable model), complaint severity was associated with depressive symptoms (PHQ-9: OR per point 1.13; 95%CI 1.04–1.23) and, unexpectedly, with better visuoconstructive performance (Rey copy: OR 0.80; 95%CI 0.68–0.94). SDMT, Rey memory, the computerised global score and the inflammatory panel showed no association with complaint severity. No univariate correlation survived correction for multiple testing.

Conclusions:
In primary care, the severity of the cognitive complaint in Long COVID is captured mainly by depressive-symptom burden, not by objective performance or by inflammation. This supports assessing mood when patients report brain fog. The association is partly inflated by item overlap between PHQ-9 and the complaint itself.

Points for discussion:
If the complaint tracks mood rather than measured performance, what should the GP do first when a patient reports brain fog

Does formal neurocognitive testing add value in primary care for these patients, or does it mainly reassure?

How do we act on the mood signal without dismissing the complaint as “just depression”?

Presentation on 23/10/2026 11:40 in "Parallel Session B - Freestanding Papers: Persistent Symptoms and Quality of Life" by Fátima Méndez López.

Freestanding Paper / Published

Developing a Consensus-Based Framework to Evaluate Social Prescribing Schemes in Primary Care: The EVALRA Project

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Keywords: Social prescribing, Primary Health Care ,Evaluation framework

Background:
Social prescribing is implemented in primary care to address social determinants of health and improve health and well-being. However, the lack of standardised evaluation frameworks limits the assessment, comparison and continuous improvement of these programmes across different healthcare systems and diverse community settings worldwide. Developing evidence-based recommendations and consensus indicators is essential to support implementation and ensure evaluation across healthcare settings.

Research questions:
Can a consensus-based framework be developed to evaluate the implementation and outcomes of social prescribing schemes in primary care?

Method:
The EVALRA project used a mixed-methods approach within the Spanish public healthcare system. Evidence from a literature review was combined with qualitative research involving patients, primary care professionals, health asset providers and decision-makers. Findings informed a two-round Delphi study with national experts to achieve consensus on evaluation recommendations and indicators. The final framework was organised according to Donabedian's quality model, including structure, process and outcome domains.

Results:
The project developed a consensus-based evaluation framework for social prescribing in primary care. The framework comprises 11 structure indicators, 14 process indicators and 10 outcome indicators, together with seven evidence-based recommendations addressing implementation areas. The recommendations emphasise adapting the framework to local contexts, strengthening coordination between healthcare and community organisations, improving interoperability of information systems, and supporting continuous quality improvement and decision-making. The framework provides practical tools to monitor implementation and evaluate the quality and impact of social prescribing in primary care practice.

Conclusions:
EVALRA provides an evidence-informed framework to evaluate social prescribing schemes from multiple stakeholder perspectives. The proposed recommendations and indicators support implementation, quality improvement and accountability, facilitating the integration of social prescribing into routine primary care while generating comparable evidence for research and policy, supporting future international collaboration opportunities. The EVALRA project is available at https://evalra.com/, and the final guideline, including the recommendations and consensus-based evaluation indicators, is freely available at https://evalra.com/publicaciones/.

Points for discussion:
How can standardised evaluation frameworks improve the implementation and sustainability of social prescribing in primary care?

Which outcomes should be prioritised when evaluating social prescribing: patient-reported outcomes, implementation outcomes, or health system outcomes?

How can consensus-based indicators facilitate international comparison and knowledge transfer across different health systems?

Presentation on 23/10/2026 11:40 in "Parallel Session C - Freestanding Papers: Engagement and Participation in Care" by Carmen Belén Benedé Azagra.

Freestanding Paper / Published

EVALGUÍA: An Evidence-Based Tool to Strengthen Community Engagement in Health Promotion Projects

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Keywords: Health promotion, Primary Health Care Implementation science, Community engagement

Background:
Community participation is a key strategy for improving population health and reducing health inequalities. Within the AdaptA GPS project, the NICE NG44 guideline on community engagement was adapted to the Spanish context, highlighting the need for an evidence-based tool to support the implementation and evaluation of community participation in health promotion projects. Despite its recognised importance, few validated tools guide professionals in routine practice.

Research questions:
Can an evidence-based tool be developed to assess and strengthen community participation in health promotion projects while supporting the implementation of the adapted NICE NG44 guideline?

Method:
EVALGUÍA was developed in three phases. First, an evaluation tool was designed through a literature review and validated using an adapted Delphi process with experts in community and health promotion. Second, it was implemented in 13 health promotion projects using a mixed-methods before–after study, with three community programmes as controls, to identify changes, facilitators and barriers. Finally, the tool was refined based on user feedback and pilot-tested in two health promotion workshops to assess feasibility and usability.

Results:
The literature review confirmed limited evidence on implementing public health guidelines. The Delphi process produced the first consensus version of the tool. Its application identified improvements in project organisation, community engagement and evaluation practices. User feedback led to a simplified final version with two sections: one assessing participation across project stages and another exploring organisational aspects, communication, inclusion and support. Pilot testing demonstrated high acceptability and feasibility.

Conclusions:
EVALGUÍA is an evidence-based, practical tool to assess and strengthen community participation in health promotion projects. It promotes collective reflection, supports continuous quality improvement through feasible action plans, and has the potential to improve the effectiveness and sustainability of health promotion interventions while reducing health inequalities. The final version is freely available at evaluagps.com, facilitating its adoption by professionals, researchers and organisations involved in health promotion.

Points for discussion:
Experiences and challenges in implementing community participation assessment tools in primary care and health promotion projects

How can practical tools such as EVALGUÍA support the transfer of evidence into everyday practice and improve community participation?

Future opportunities for international collaboration to validate and adapt EVALGUÍA in different countries and cultural contexts.

Presentation on 23/10/2026 11:40 in "Parallel Session C - Freestanding Papers: Engagement and Participation in Care" by Alba Gallego-Royo.

Freestanding Paper / Finished study

Family doctors' perceptions of barriers and facilitators to treatment adherence among patients with diabetes: quantitative findings

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Keywords: diabetes mellitus, adherence, bariers and facilitators

Background:
Poor adherence to long-term diabetes treatment remains a major challenge in primary care. Less is known about how family doctors perceive patient-, physician-, and system-related barriers and facilitators for adherence within routine community practice.

Research questions:
How do family doctors rate barriers, facilitators, and their own role in improving treatment adherence among patients with diabetes, and which physician or practice characteristics are associated with these perceptions?

Method:
A quantitative cross-sectional survey among all family doctors in one Israeli health maintenance organization. The questionnaire was developed from a preceding qualitative phase and covered physician and clinic characteristics, perceived barriers, and facilitators for adherence. It was distributed to 576 physicians. Responses were measured on five-point Likert scales. Analyses included descriptive statistics, comparisons between domains, reliability testing, bivariate analyses, and multivariable linear regression.

Results:
Overall, 127 questionnaires were returned (response rate 22.0%). Physicians rated patient- and system-related barriers significantly higher than physician-related barriers ($P<0.001$). Key barriers included difficulty maintaining a healthy lifestyle, patients' competing life challenges, limited visit time, ineffective communication, limited shared decision-making, and insufficient teamwork. Physician-related facilitators were rated highly, including shared decision-making, encouragement of a healthy lifestyle, treatment management, and culturally adapted communication. Most physicians (84%) perceived adherence as a shared responsibility between physician and patient. In multivariable models, clinics' districts were associated with perceived patient barriers ($P=0.024$), while specialty status and employment type were associated with perceived system barriers ($P=0.001$). Non-specialist family doctors rated patient and physician facilitators lower than specialists, whereas physicians treating ultra-Orthodox Jewish patients rated physician facilitators higher.

Conclusions:
Family doctors perceive diabetes adherence as a multidimensional challenge shaped by patients, physicians, the health system, and their interaction. Interventions should combine physician communication training, shared decision-making, nurse availability, multidisciplinary teamwork, electronic follow-up tools, and culturally adapted patient support.

Points for discussion:
How can physician-focused adherence interventions be integrated into short primary care consultations?

How can adherence support be adapted to culturally diverse patient populations in European primary care?

Presentation on 23/10/2026 11:40 in "Parallel Session C - Freestanding Papers: Engagement and Participation in Care" by Shlomo Vinker.

Theme Paper / Finished study

Assessment of rehabilitation needs and corresponding needs of primary care contacts in cancer survivors – A cross-sectional survey study

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Keywords: Cancer survivors, rehabilitation needs, health care contacts, primary care

Background:
The number of cancer survivors is increasing rapidly. Primary care is expected to play an important role in cancer rehabilitation, yet previous studies have reported limited use of systematic needs assessments and insufficient cancer-specific competence in primary care.

Research questions:
This study aimed to assess rehabilitation needs among short-term and long-term cancer survivors and their corresponding need for contact with primary care and /or specialized cancer care.

Method:
A cross-sectional digital survey using the Assessment of Rehabilitation Needs Checklist (ARNC) was conducted among survivors of breast, prostate, lung, and colorectal cancer 1–2 years or 5–6 years after diagnosis in southern Sweden (n=2,131). Rehabilitation needs and associated need for healthcare contacts (primary care and/or specialized cancer care) were summarized descriptively for each ARNC item. Differences between short-term and long-term survivors, including preferred contact pathways (primary care versus specialized cancer care), were analyzed using Pearson's chi-square test.

Results:
Short-term (1–2 years post-diagnosis) cancer survivors reported significantly more rehabilitation needs than long-term (5–6 years post-diagnosis) survivors (mean 5.7 vs. 4.2 needs). Across both groups, the most prevalent rehabilitation needs related to sexuality and fatigue. Only 15% of reported rehabilitation needs were associated with a need for healthcare contact. Among rehabilitation needs for which survivors sought contact with primary care, pain, fatigue, and tingling were most common. Long-term survivors were significantly more likely than short-term survivors to seek contact with primary care.

Conclusions:
Many long-term cancer survivors reported substantial rehabilitation needs, highlighting the importance of systematic needs assessment throughout the cancer survivorship trajectory. The greater use of primary care among long-term survivors suggests an increasingly important role for primary care in addressing cancer rehabilitation needs. Improved collaboration between primary and specialized cancer care could strengthen survivorship care. These findings may inform future interventions and support the inclusion of primary care in cancer rehabilitation pathways and survivorship care.

Points for discussion:
How can collaboration between primary care and specialized cancer care be strengthened to support integrated, person-centred survivorship care?

How can rehabilitation needs among long-term cancer survivors be systematically identified and addressed?

What competencies and resources are required in primary care to meet the growing rehabilitation needs of cancer survivors?

Presentation on 23/10/2026 14:10 in "Parallel Session D - Theme Papers: Psychosocial Needs, Rehabilitation and Supportive Care" by Susanna Calling.

Theme Paper / Finished study

Evaluation of the functionality and loneliness levels to the needs and experiences of the population over 80 years of age who are registered to the homecare list of a primary care outpatient clinic

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Keywords: over 80 years of age, functionality, loneliness, community based, home care

Background:
Physical and social changes that occur through aging affect the quality of life of elderly individuals who live in their homes and lead to limitations in their daily activities. Home visits are an important practice to meet the health needs of older people, improve quality of life and reduce demand on the health system.

Research questions:
What is the need of individuals aged 80 years and over for home visits, the rates of utilization of these services and the implementation status of the services?

Method:
The study was conducted with a cross-sectional design on a sample of individuals aged 80 and over residing in a district of Istanbul. Demographic information, health status, home visit experiences, and dependency levels of the participants were collected by survey method. Katz Activities of Daily Living (ADL) Scale and Loneliness Scale for the Elderly (LSE) were used for data collection.

Results:
In the study, 40.3% of the participants requested home visits. Of the fulfilled requests, 82.9% were provided by home healthcare services, 13% by family physicians, and 3.3% by municipal services. Individuals who needed home visits were mostly women, widowed, living with a family caregiver, and with low income levels. Individuals with lower ADL scores had a higher need for home visits. When the loneliness levels were analyzed, 43.5% of the participants stated that they did not feel lonely, while 24.5% stated that they felt intense loneliness. It was observed that the rate of dependent individuals requesting home visits and utilizing from this service was higher than other groups.

Conclusions:
The need for home visits among individuals aged 80 and above is directly associated with dependency levels and sociodemographic factors. Primary care physicians can identify and prioritize the groups with the greatest needs and can inform the public to increase the access of the elderly people.

Points for discussion:
Which points should be discussed in this study?

Do you suggest any more statistical analysis?

Presentation on 23/10/2026 14:10 in "Parallel Session D - Theme Papers: Psychosocial Needs, Rehabilitation and Supportive Care" by Pemra C. Unalan.

Theme Paper / Almost finished study

Implementation gap in mental health care across the cancer care continuum: a retrospective clinical audit in primary care in Kazakhstan

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Keywords: primary care; cancer care continuum; mental health assessment; psychosocial care

Background:
Psychological distress, depression and anxiety are common among people living with cancer and adversely affect quality of life, treatment adherence and clinical outcomes. Although international oncology guidelines recommend routine psychosocial assessment throughout the cancer care continuum, little is known about the implementation of these recommendations in primary care in Kazakhstan.

Research questions:
To what extent are mental health assessment and psychosocial care integrated into routine primary care follow-up of patients with cancer in Kazakhstan, and reflected in national oncology clinical guidelines?

Method:
A retrospective clinical audit included 147 outpatient medical records of adults with cancer followed in primary care between July 2025 and July 2026. Audit indicators, developed from international guidelines (including NCCN Distress Management and ESMO Clinical Practice Guidelines), included documentation of psycho-emotional assessment, depression, anxiety, suicide risk, referrals to mental health professionals and psychologist consultation records. National oncology guidelines for six common cancers were reviewed for psychosocial care recommendations.

Results:
Despite a median of 52 primary care visits (IQR 24–76), no documented mental health assessment, psycho-emotional evaluation, depression, anxiety or suicide risk assessment was identified in the reviewed physician records. Patients had a median age of 65 years (IQR 56–72), median disease duration of 3 years (IQR 1–4). No referrals to psychiatrists were documented. Eighty-seven patients (59.2%) had no psychologist records; the remainder had one to three psychologist notes. Twelve records contained recommendations to consult a psychologist without documented assessment, referral rationale or follow-up. Only two national oncology guidelines contained limited references to psychological care, and none recommended routine screening for psychological distress, depression or anxiety.

Conclusions:
This clinical audit identified a substantial implementation gap in integrating mental health into routine oncology follow-up in Kazakhstan. The findings support the integration of routine psychosocial assessment and structured mental health care pathways into oncology services and primary care.

Points for discussion:
How can routine mental health assessment be effectively integrated into primary care follow-up for patients with cancer?

What are the main barriers to implementing psychosocial care pathways in resource-constrained health systems?

What role can general practitioners play in improving continuity of psychosocial care across the cancer care continuum?

Presentation on 23/10/2026 14:10 in "Parallel Session D - Theme Papers: Psychosocial Needs, Rehabilitation and Supportive Care" by Lazzat Zhamaliyeva.

Freestanding Paper / Finished study

Family physicians perspectives on Q fever awareness and prevention

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Keywords: Q fever; zoonoses; awareness, infectious diseases; one health

Background:
Q fever is a zoonotic disease caused by Coxiella burnetii. Cattle, sheep and goats are the main reservoirs. Family physicians (FP) may encounter Q fever in rural areas, particularly among people working, living or spending time near farms, but awareness may remain limited, even in endemic settings

Research questions:
What is the level of knowledge of European FPs regarding Q fever and its prevention?

Method:
A descriptive cross-sectional Computer-Assisted Telephone Interviewing (CATI) survey was conducted in 2024 among FPs from eight European countries (France, Germany, Poland, Belgium, the Netherlands, the United Kingdom, Spain and Italy). An ad hoc 12-item questionnaire assessed awareness, clinical experience, risk perception, knowledge, and prevention. Sociodemographic and practice characteristics, including rural experience and patient exposure, were collected. Data were analysed descriptively, with cross-country comparisons using chi-square tests ($p < 0.05$).

Results:
A total of 360 FPs participated. Mean age was 46–47 years, with 13–15 years of rural practice. Overall, 42% of FPs reported caring for patients working on farms and 54% for patients living near farms. Experience with Q fever patients varied substantially, from 74% in Spain to 16% in Poland ($p < 0.05$). Overall, 44% considered Q fever underdiagnosed (59% in the Netherlands vs 23% in Poland; $p < 0.05$) and 29% reported insufficient information. Flu-like illness was the best-recognised presentation (88%, 94% in France, 77% in Italy, $p < 0.05$). Farmers were commonly identified as at-risk (58%), whereas farm neighbours (14%) and visitors (2%) were less often recognised. Awareness of vaccination in animal reservoirs and animal-management prevention measures was of 15%, with no cross-country statistically significant differences.

Conclusions:
Q fever remains as a relatively unknown condition for FPs, including in settings where exposure may be expected. Targeted training could improve recognition of at-risk groups and awareness of preventive measures.

Points for discussion:
What type of training would be adequate to address the topic?

Do you believe this kind of study design is appropriate to explore FP awareness?

Could it be improved with other perspectives?

Presentation on 23/10/2026 14:10 in "Parallel Session E - Freestanding Papers: Vaccines and Infection Prevention" by Daniel Cifo.

Freestanding Paper / Almost finished study

Real-World Effectiveness of Recombinant Zoster Vaccine in Adults Aged 50 Years or Older: A Population-Based Cohort Study

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Keywords: Recombinant zoster vaccine; Herpes zoster; Vaccine effectiveness; Real-world evidence

Background:
The recombinant zoster vaccine (RZV; Shingrix) demonstrated high efficacy in clinical trials. However, real-world effectiveness estimates have generally been lower, and evidence from populations outside the United States remains limited.

Research questions:
To estimate the real-world effectiveness of RZV in preventing herpes zoster among adults aged ≥50 years in a large population-based healthcare cohort.

Method:
We conducted a retrospective cohort study of adults aged ≥50 years with at least one year of continuous healthcare membership and eligibility for follow-up between August 2023 and May 2026. For vaccinated participants, time zero was the date of first RZV receipt. Unvaccinated participants were assigned a random pseudo-index date based on the distribution of time from cohort entry to vaccination among vaccinated participants. Baseline demographic, socioeconomic, clinical, and healthcare-utilization characteristics were incorporated into a multivariable propensity-score model, and stabilized inverse-probability-of-treatment weights were applied. The primary outcome was herpes zoster identified by a diagnostic code accompanied by antiviral treatment within seven days. Weighted Cox regression estimated hazard ratios (HRs); Vaccine effectiveness was calculated as 100% minus the hazard ratio expressed as a percentage.

Results:
The analysis included 1,307,836 participants, of whom 168,355 (12.9%) received at least one RZV dose during follow-up; 142,590 (84.7% of vaccine recipients) completed the two-dose series. Mean age was 66 years (±11), and median follow-up was 17.5 months. Overall, 14,490 herpes zoster episodes occurred during follow-up. After weighting, measured baseline characteristics were well balanced, and RZV receipt was associated with a lower hazard of herpes zoster (weighted HR, 0.54; 95% CI, 0.39–0.74), corresponding to vaccine effectiveness of 46% (95% CI, 26%–61%).

Conclusions:
In this large population-based cohort, RZV receipt was associated with a substantial reduction in herpes zoster incidence among adults aged ≥50 years. These findings provide important real-world evidence to support continued implementation of RZV in routine clinical practice.

Presentation on 23/10/2026 14:10 in "Parallel Session E - Freestanding Papers: Vaccines and Infection Prevention" by Yochai Schonmann.

Freestanding Paper / Almost finished study

Real-world safety assessment of Mpox Vaccine in Catalonia: Retrospective Cohort Study of AESIs and Breakthrough Infections

Felipe Villalobos, Aaron Switzer-Rodriguez, Víctor Roigé Peña, Irma Convertino, Martín Solórzano, Marc Far

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Keywords: Mpox; Mpox vaccine; Vaccine safety; Primary care

Background:
In Catalonia, the MVA-BN (IMVANEX) vaccine is recommended for mpox prevention among high-risk populations, including men who have sex with men, sex workers, and close contacts of confirmed or suspected cases. Real-world safety data on adverse events of special interest (AESIs) remain limited in European settings, despite ongoing mpox outbreaks and post-authorization pharmacovigilance requirements. This study aims to generate region-specific evidence on IMVANEX safety using routinely collected primary care and hospital data.

Research questions:
What is the occurrence of five prespecified AESIs (myocarditis, pericarditis, thrombocytopenia, anaphylaxis, and generalized convulsive seizure) following IMVANEX vaccination in adults over 18 years in Catalonia, and what is the frequency of post-vaccination mpox infections during follow-up?

Method:
We conducted a retrospective cohort study using routinely collected primary care and linked hospital electronic health records from the SIDIAP database in Catalonia. The cohort included 8,039 adults who received at least one IMVANEX dose between 13 June 2022 and 31 December 2024. AESIs were identified using Safety Platform for Emergency vACcines (SPEAC) case definitions within prespecified 0–28-day post-dose risk windows, and post-vaccination mpox infections were described over a maximum follow-up of 30 months.

Results:
AESIs were rare: fewer than five pericarditis cases were identified within the 0–28-day post-dose risk window, and no myocarditis, thrombocytopenia, anaphylaxis, or generalized convulsive seizures were detected. During follow-up, 16 post-vaccination mpox infections were recorded (0.20%; 199 per 100,000 vaccinees), with no unexpected clustering of AESIs or breakthrough infections within risk windows.

Conclusions:
This retrospective cohort provides preliminary descriptive real-world evidence on the IMVANEX safety profile in Catalonia, suggesting no unexpected AESI patterns within predefined risk windows. The observational design and rarity of events mean that larger multicentre surveillance studies are needed before drawing definitive safety conclusions, but these results can support transparency and trust in the Catalan mpox vaccination programme among higher-risk populations.

Points for discussion:
How can multicentre or cross-country collaborations strengthen pharmacovigilance for mpox vaccines, given the rarity of AESIs?

What are the main strengths and limitations of using primary care and linked hospital EHRs (such as SIDIAP) for vaccine safety monitoring in real time?

How should policymakers and practitioners communicate these reassuring but preliminary findings to high-risk populations while emphasizing the need for continued safety surveillance and cautious interpretation?

Presentation on 23/10/2026 14:10 in "Parallel Session E - Freestanding Papers: Vaccines and Infection Prevention" by Felipe Villalobos.

Freestanding Paper / Finished study

Best Practices in Gender-Based Violence Prevention and Care in the Spanish National Health System (2012–2019): A Descriptive Review

Raquel Gomez Bravo, Sandra León-Herrera, Lydia Salvador-Sánchez, Sara Ares Blanco, Susana Sanchez Ramón, Rosa López Rodríguez, María Del Carmen Fernandez-Alonso

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Keywords: Gender-based violence; Best Practices; Spain; Primary Health Care; Public Health Policy; Women's Health; Intersectoral coordination; National Health System

Background:
Since Organic Law 1/2004, Spain has progressively strengthened its health system's response to gender-based violence (GBV). Under the National Health System's (NHS) Cohesion and Quality framework, the Ministry of Health, supported by the Women's Health Observatory, established a national mechanism to identify, evaluate, and disseminate Best Practices (BBPPs) addressing GBV.

Research questions:
What is the scope, distribution, and thematic focus of officially recognized BBPPs addressing GBV prevention, detection, and management within the Spanish NHS between 2012 and 2019?

Method:
We conducted a descriptive review of 41 BBPPs accredited across five national calls (2012, 2013, 2015, 2017, 2019), using data from the Ministry of Health repository. Practices were classified by care level, intervention type, intersectoral coordination, and scope.

Results:
BBPPs were implemented across all 17 autonomous communities, most frequently in Primary Health Care or community settings (46%), followed by hospital/emergency care (29%). Key components included intersectoral coordination, professional training, information systems, community empowerment, and clinical protocols. Overall, 37% focused on prevention, 34% on detection and care, and 29% on capacity building.

Conclusions:
Spain's BBPP framework reflects strong institutional commitment to GBV and consolidates Primary Health Care as a cornerstone for early detection and coordinated response. However, evaluation remains largely descriptive, standardized outcome indicators are lacking, and GBV was excluded from national BBPP calls between 2020 and 2024, only partially reintroduced in 2025–2026. Recognized internationally by GREVIO, The Lancet, and WHO, this model offers a replicable framework for embedding gender-sensitive violence prevention within primary care systems elsewhere. Sustained investment in evaluation, data integration, and training is essential for equitable, sustainable GBV responses nationwide.

Points for discussion:
How can standardized, survivor-centred outcome indicators be built into national BBPP evaluation, moving beyond process-level assessment?

What explains GBV's discontinuation as a specific NHS thematic priority since 2019, and what does this mean for gender mainstreaming in health policy?

How can intersectional perspectives be better embedded in future best-practice models?

Presentation on 23/10/2026 14:10 in "Parallel Session F: Freestanding Papers: Patient Experience and Psychosocial Support" by Sandra León-Herrera.

Freestanding Paper / Published

Loneliness and emotional support helpline use in Spain: primary care implications from a 20-year observational study

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Keywords: Loneliness; emotional support helpline; help-seeking; psychological distress; primary care

Background:
Emotional support helplines provide low-threshold assistance for psychological distress and may complement primary care by detecting unmet psychosocial needs and facilitating referral. However, long-term evidence on reasons for helpline contact in Spain is scarce, particularly regarding loneliness, an increasingly important determinant of health across the life course.

Research questions:
How did psychological motives for contacting a Spanish emotional support helpline vary over 2004–2023, and how were loneliness and other selected motives associated with callers' sex and age?

Method:
We conducted a retrospective observational study of 2,194,175 anonymised contact records from a Spanish emotional support helpline between 2004 and 2023. Annual proportions described temporal patterns in seven selected primary presenting motives. Multinomial logistic regression examined associations between sex, age group, calendar year and selected motive, using loneliness/communication difficulties as the reference outcome. Adjusted odds ratios, 95% confidence intervals and model-based predicted probabilities were estimated. Analyses used available cases and interpreted contact episodes rather than unique individuals.

Results:
Contacts increased markedly, peaking in 2021–2023. Women accounted for 67.1% of contacts. Loneliness/communication difficulties was the most frequent selected primary motive (10.1%), followed by depressed mood (7.2%) and anxiety-related problems (7.0%). Age contributed most to model fit. Within the seven-motive model, the adjusted predicted probability of loneliness increased from 15.75% among contacts aged ≤18 years to 77.44% among those aged ≥76 years. Men had higher relative odds of suicidal ideation (aOR 1.468, 95% CI 1.430–1.506) and suicidal crisis (aOR 1.391, 95% CI 1.329–1.455) than women. Suicidality-related motives increased in recent years and were concentrated in younger groups.

Conclusions:
These findings show robust age-, sex- and time-related patterns across a large 20-year registry, but describe contact episodes and counsellor-recorded motives rather than population prevalence. Closer helpline–primary care links may support identification of loneliness, referral and age-sensitive suicide prevention.

Points for discussion:
How can primary care and emotional support helplines collaborate to identify and support people experiencing loneliness?

How can helpline records be used responsibly to monitor population mental health needs?

How can helplines and primary care improve suicide prevention, particularly among young people and men?

Presentation on 23/10/2026 14:10 in "Parallel Session F: Freestanding Papers: Patient Experience and Psychosocial Support" by Alejandra Aguilar-Latorre.

Freestanding Paper / Almost finished study

The Role of General Practice in Maternity Journeys: Women's Perspectives on GP prenatal and postnatal care in Ireland

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Background:
High-quality maternity care is essential to ensuring safety and positive health outcomes for mothers and their babies. In Ireland, general practitioners (GPs) play an important role in supporting women throughout pregnancy, highlighting the need of exploring women's perspectives on the care GPs provide.

Research questions:
What are women's experiences of maternity care provided by their GP?

Method:
The study is a mixed-methods secondary analysis of qualitative and quantitative data from the 2025 National Maternity Experience Survey (NMES) in Ireland, which collected feedback from 3,354 women on maternity care services. Two cohorts from the NMES dataset were investigated: full cohort of 3,354 participants and their experiences with GP care, and a subgroup of 328 women who provided open-text feedback specifically mentioning their GP. The full cohort was analysed using descriptive statistics in SPSS; open-text data were analysed thematically.

Results:
Among 3,354 survey respondents, 76.6% reported that their GP was the first healthcare professional they contacted during pregnancy. GPs provided antenatal and postnatal care to 85.1% and 70.5% of women, respectively. Most participants (69.3%) felt their GP spent sufficient time addressing physical health and recovery at the 6-week postnatal visit, and 89.5% reported receiving information in an understandable manner. Additional breastfeeding support was reported by 7.7%, while 32.2% identified their GP as providing perinatal mental health supports. Open-text feedback revealed positive reflections (n=147), highlighting GP support as person-centred and attentive. Perceived gaps (n=188) in postnatal care were identified. At times, it was felt to be rushed, with a lack of focus on maternal mental health. A need for improved communication between GPs and hospitals was also emphasised.

Conclusions:
Findings highlight GPs as trusted providers of maternity care in Ireland. Appropriate resourcing is essential to ensure that maternity care is integrated across primary and secondary care and allows for comprehensive assessment in both the antenatal and postnatal periods.

Presentation on 23/10/2026 14:10 in "Parallel Session F: Freestanding Papers: Patient Experience and Psychosocial Support" by Ivana Keenan.

One-Slide/Five Minutes Presentation / Study Proposal / Idea

Adapting the SDM-Q9 for Colorectal Cancer Screening: A Delphi Consensus Study with EGPRN Experts

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Keywords: Colorectal Cancer, shared-decision, patient-centered approach

Background:
Colorectal cancer (CRC) screening uptake in Europe remains suboptimal (~30-40%), partly due to insufficient patient engagement. Shared Decision-Making (SDM) improves adherence and satisfaction, but no validated tool exists to measure SDM specifically for CRC screening. The SDM-Q9, a 9-item questionnaire, is widely used for general SDM but lacks CRC-specific adaptation.

Research questions:
Can we adapt and validate the SDM-Q9 to accurately measure SDM in CRC screening across Europe?

Method:
A 3-round Delphi consensus study will be conducted with 20-30 EGPRN experts (GPs, researchers, patient representatives) from 5+ European countries. In Round 1, experts will rate the relevance and clarity of an adapted SDM-Q9 version for CRC screening (e.g., rephrasing questions to reflect binary choices: do the test, defer, or decline). Rounds 2-3 will refine the tool based on feedback until ≥80% consensus is achieved. The final version will be tested with 20 patients for comprehension and pilot-tested in clinical settings

Results:
A consensus-based, CRC-specific SDM-Q9 version, validated for reliability (Cronbach's α >0.7) and content validity. Preliminary data may show cultural differences in SDM perceptions (e.g., paternalistic vs. collaborative models). This tool will enable standardized SDM assessment in CRC screening programs.

Conclusions:
This project will provide the first validated tool to measure SDM in CRC screening, addressing a critical gap in patient-centered care. By leveraging the EGPRN network, we aim to improve screening uptake through better understanding and implementation of SDM. Future steps include psychometric validation in a larger cohort and integration into screening programs.

Presentation on 23/10/2026 16:00 in "Parallel Session G: One Slide Five Minute Presentations" by Paul Aujoulat.

One-Slide/Five Minutes Presentation / Study Proposal / Idea

Characterization of patients admitted to an Oncological Palliative Care Unit: Role of timing and multidisciplinary involvement

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Keywords: Palliative care needs. Palliative identification. Multidisciplinary involment

Background:
The WHO supports continuity of Palliative Care (PC) through multidisciplinary teams, engaging patients and caregivers. However, European and Canadian experiences highlight barriers like poor interprofessional communication and fragmented clinical records, causing late initiation of palliative care. The Basque Country Healthcare System has an integrated electronic medical record (EMR) and its 2023-2027 PC Strategy emphasizes primary care as the foundation for PC shared decision-making, using screening tools like NECPAL CCOMS-ICO and IDC-Pal. According to local data, 54% of cases are identified in their last month of life.

Research questions:
The overarching aim is to characterize the PC needs and medical history of patients admitted to the oncological PC Unit at a Basque Country local hospital and examine the roles of the multidisciplinary professionals involved.

Method:
Study design: A observational, descriptive study
Sample: Patients admitted to the Oncological PC Unit at Santa Marina Hospital in 2027
Methods: At the time of admission, specific variables will be collected through an EMR review. Socio-demographic characteristics and clinical variables such as cancer type, stage, cancer history and treatment modalities (including dates of diagnoses and of administration), and comorbidities. In addition, the date and specialist type adding the palliative care needs flag, the NECPAL CCOMS-ICO score, the IPC-Pal score, PPS scores and PC resources utilized will be captured. PC Unit re-admission dates will be logged, as will dates and type of medical visits in the year prior to admission.

Results:
Descriptive statistics will be performed, timings calculated, and patient trajectories analyzed and summarized. Characteristics of those identified early vs. late will be compared, with the cut-off determined by the data collected.

Conclusions:
An analysis of the current state-of-practice towards oncological PC should form an evidence-base for recommendations to improve adherence to the healthcare system strategy and increase patient benefits from existing PC resources.

Points for discussion:
The NECPAL CCOMS-ICO score is currently how palliative care needs will be defined. How might this palliative care needs identification be better defined?

What data analytic strategies might be applicable to summarize these trajectories?

How involved is primary care in palliative care in your country?

Presentation on 23/10/2026 16:00 in "Parallel Session G: One Slide Five Minute Presentations" by Jesus Martin Treviño Theriot.

One-Slide/Five Minutes Presentation / Study Proposal / Idea

International Patterns of Cancer-Related Primary Care Visits: Evidence from INTRePID

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Keywords: cancer, primary care, international comparison

Background:
Primary care plays an important role in the cancer care continuum through prevention, screening, diagnosis, management and follow-up. The variation in primary care activity for cancer-related care internationally needs to be better understood. This study will provide insights into knowledge on the role of primary care in cancer care delivery across different healthcare settings.

Research questions:
What proportion of primary care activity is related to cancer care across INTRePID countries, and how does the rate of cancer-related primary care visits vary across international settings?

Method:
This proposed study will use routinely collected primary care data from the International Consortium of Primary Care Big Data Researchers-INTRePID. INTRePID countries span the globe, including Ghana, Togo, Uganda in Africa, Australia, China, Hong Kong, Indonesia, Japan, Singapore, South Korea in Asia Pacific, Belgium, Israel, Norway, Spain, Sweden, the United Kingdom in Europe, Argentina, Brazil, Chile, Mexico, Peru in Latin America and Canada and the USA in North America. Cancer-related primary care encounters will be identified using harmonized primary care data. The primary outcome will be the rate of cancer-related primary care visits across INTRePID countries. Secondary analyses will describe the distribution of cancer-related encounters and cancer type by age group, sex, rurality, socioeconomic indicators, and visit modality.

Results:
Expected findings will describe primary care activity for cancer-related care across INTRePID countries. Findings will identify differences in cancer-related encounter patterns across populations and healthcare settings. Analyses will describe the frequency and distribution of cancer-related primary care visits in relation to overall primary care activity and examine how visit patterns differ across INTRePID countries.

Conclusions:
This study will provide an international comparison of cancer-related primary care activity. Findings may support a better understanding of primary care's role in cancer care delivery around the world.

Points for discussion:
How do countries differ in there delivery of cancer care in primary care?

Is it feasible to measure cancer care delivery in primary care with big data?

How accurate is harmonized aggregated big data in measuring primary care delivery of cancer care?

Presentation on 23/10/2026 16:00 in "Parallel Session G: One Slide Five Minute Presentations" by Karen Tu.

One-Slide/Five Minutes Presentation / Study Proposal / Idea

Overcoming Barriers to Breast Cancer Screening Participation Among Women: The Effectiveness of a Three-Stage Primary Care Intervention

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Keywords: Breast cancer Screening, Primary Care, Intervention

Background:
Early detection through cancer screening is paramount for women's health. While primary care awareness campaigns successfully reach large populations, individual barriers often hinder actual screening uptake.Navigating the current health system requires multiple days of repetitive hospital visits, which creates a major "time constraint," particularly for working women.Furthermore, evidence shows that lower educational levels correlate with a tendency to avoid health-related information (information avoidance) due to fear.Transportation and logistical challenges further lower participation rates.This study aims to evaluate the effectiveness of a three-stage, appointment-driven primary care model designed to systematically eliminate the mentioned barriers.

Research questions:
Are the primary reasons for non-participation are "information avoidance" (exacerbated by lower education levels), time constraints for repeated hospital visits due to work obligations, or logistical/transportation constraints.?
Following the implementation of our detailed information delivery, appointment optimization, and transportation model, can actual screening participation increase?

Method:
This interventional study will be conducted in a primary care setting over a 6-month follow-up.To eliminate the individual barriers, a three-stage structured intervention model will be implemented. In the first stage; questions regarding attendance to scrrenings will be asked.Women in the target population will be invited to provide comprehensive information about screening, specifically targeting and mitigating the unawareness.In the second stage; integrated, personalized appointment slots will be scheduled to condense a multi-day hospital process into a single day, optimizing time management for working women.
In the third stage; with the help of the local authorities, round-trip transportation to and from the hospital will be fully provided within the program, eliminating financial and logistical accessibility barriers. Actual screening participation rates before and after the intervention will be compared.

Results:
TBA

Conclusions:
Raising awareness to improve cancer screening along with interventions targeting multifaceted barriers especially among working women and those with lower educational backgrounds may be highly effective framework to reduce unparticipation and optimize screening outcomes.

Points for discussion:
What other strategies can be utilized increase participation?

Presentation on 23/10/2026 16:00 in "Parallel Session G: One Slide Five Minute Presentations" by Bengi Tör.

One-Slide/Five Minutes Presentation / Study Proposal / Idea

Restoring Human Connection in Chronic Care: Evaluating the Implementation of AI-Assisted Clinical Scribes in General Practice

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Background:
Primary care physicians are becoming increasingly overwhelmed by the rigid Electronic Health Record (EHR) documentation process. This administrative burden directly diminishes meaningful patient–physician interaction, thereby eroding compassionate care. The practical application of AI, specifically AI-assisted ambient scribes, has the potential to automate clinical documentation and free up physicians to give their undivided attention to patients.

Research questions:
Does implementing an AI-assisted ambient scribe system for chronic disease consultations improve patients' perception of physician compassion compared to traditional manual EHR documentation?

Method:
A pilot crossover observational study will be conducted in various primary care settings. GPs will conduct consultations under two conditions: manual EHR documentation and utilising an AI-driven ambient voice-to-text scribe. The primary outcome is patient-perceived compassion, which will be quantified using the Schwartz Center Compassionate Care Scale.

Results:
This abstract outlines a study protocol.

Conclusions:
If AI documentation tools can demonstrably enhance patient-perceived compassion while reducing physician cognitive overload, integrating such technologies could be a game-changing strategy for improving the humanistic quality of chronic care.

Points for discussion:
Based on practical applications of AI in your region, would the presence of an ambient listening device alter patients' willingness to disclose sensitive information?

What specific data management protocols are required to balance AI scribe tools with stringent European GDPR standards?

Presentation on 23/10/2026 16:00 in "Parallel Session G: One Slide Five Minute Presentations" by Gökçe İşcan.

One-Slide/Five Minutes Presentation / Study Proposal / Idea

Transforming Smoking Cessation Consultations into Comprehensive Cancer Prevention Opportunities in Primary Care

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Keywords: Smoking Cessation; Early Detection of Cancer; Primary Health Care

Background:
Smoking causes roughly 15% of new cancer cases worldwide — in Europe, the number climbs to one in five. Most cessation research has kept its focus narrow, centred on lung cancer screening; multi-cancer prevention within these same consultations has barely been studied. A patient seeking help to quit is, in many respects, already signalling a broader readiness to engage with their health. That makes the cessation visit an underused opportunity for evidence-based cancer prevention in primary care.

Research questions:
Does turning smoking cessation consultations into structured cancer prevention opportunities raise participation in recommended screening — and can primary care actually deliver this?

Method:
This will be a prospective implementation study, run in a primary care smoking cessation clinic, recruiting adult smokers consecutively. Alongside standard cessation management, each participant undergoes a cancer prevention assessment: risk factors, family history, screening eligibility for breast, cervical, colorectal and lung cancer where relevant, lifestyle risks, and tailored counselling, with referral for those eligible. Follow-up runs six months. Completion of recommended screening is the primary outcome. Abstinence, referral adherence, patient acceptance, and feasibility in routine practice are the secondary ones.

Results:
The working assumption is that reframing cessation visits this way will raise screening uptake and sharpen patients' awareness of cancer prevention, while also showing this can be done in ordinary primary care settings. Just how much difference it makes will depend on the risk profile of whoever's attending the clinic and how much screening was already happening locally.

Conclusions:
Cessation consultations remain an underused route into cancer prevention. Should this work, it points to family physicians taking on a larger role across the cancer care continuum — pairing tobacco control with cancer prevention in the same visit, in a way that could scale beyond a single clinic.

Points for discussion:
1. Can smoking cessation consultations become a standard entry point for comprehensive cancer prevention in primary care?

2. Which implementation barriers may limit integration of cancer prevention into routine consultations?

3. How can this model be adapted to different primary care systems across Europe?

Presentation on 23/10/2026 16:00 in "Parallel Session G: One Slide Five Minute Presentations" by Didem Kafadar.

Freestanding Paper / Almost finished study

ABI Variability as a Potential Predictor of Cardiovascular Complications in Patients with Diabetes Mellitus

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Keywords: coronary heart disease, stroke, diabetes mellitus, variability of ankle-brachial index

Background:
Diabetes mellitus (DM) has an alarming prevalence and its cardiovascular complications reduce life expectancy and quality of life worlwide. Early identification of patients at increased cardiovascular risk is therefore essential. In Slovakia the ankle-brachial index ABI is routinely used to the diagnose periferal arterial disease (PAD) among periodic preventive health examination (each 2 years). Evidence on the association between ABI and cardiovascular disease is limited, and the role of ABI variability has been largely unexplored.

Research questions:
Does the variability in ABI predict the risk of cardiovascular complications in diabetics?

Method:
This retrospective study evaluated the clinical utility of ABI variability (ΔABI) as a potential predictor of stroke, coronary heart disease (CHD), and MI in patients with DM. Patients were followed for three years using data obtained from the national eHealth system and paper medical records. ABI was measured by the oscillometric method. ΔABI was defined as the difference between the most recent ABI measurement and the previous measurement performed during a preventive health examination. Non-parametric statistical tests were used because the data were not normally distributed.

Results:
The study included 256 patients (138 men and 118 women), most of whom had type 2 DM. Stroke was present in 24.2% of patients, MI in 16.4%, CHD in 46.1%, and PAD in 29.7%. DM duration was significantly associated with CHD ($p < 0.001$), stroke, and MI (both $p < 0.05$). ΔABI showed significant positive correlations with stroke and CHD (both $p < 0.001$), as well as with DM duration ($p < 0.001$) and pulse wave velocity ($p < 0.05$).

Conclusions:
ABI variability may represent a simple and readily available marker for identifying patients with DM at increased risk of cardiovascular complications, particularly stroke and CHD. As ABI is routinely measured during preventive health examinations, its clinical utility could be extended to cardiovascular risk stratification using ΔABI.

Presentation on 23/10/2026 16:00 in "Parallel Session H - Freestanding Papers: At the Bedside: Tools for Better Assessment" by Stanislava Mikulová.

Freestanding Paper / Finished study

Cardiac Auscultation and Echocardiographic Screening for Valvular Heart Disease in Asymptomatic Elderly Primary Care Patients: A Cross-Sectional Study

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Background:
Valvular heart diseases (VHD) frequently present asymptomatically in elderly populations (aged 65 years or older), posing a significant public health challenge. While transthoracic echocardiography (TTE) is the diagnostic gold standard, the clinical value and diagnostic utility of routine primary care cardiac auscultation (CA) screening remain debated.

Research questions:
1. What is the diagnostic utility (sensitivity, specificity, negative predictive value) of cardiac auscultation compared to direct TTE in this population?
2. What is the prevalence of VHD detected by TTE among asymptomatic primary care patients aged 65 years or older without known heart disease?

Method:
This cross-sectional randomized study included 79 asymptomatic individuals aged 65 years or older without prior VHD, registered at Marmara University Tuzla Education Family Health Center. Symptoms were excluded using AHA's "Heart Valve Disease Symptom Tracker". Participants were randomized: Group 1 (n=39) underwent CA prior to TTE, while Group 2 (n=40) received direct TTE. Primary outcomes were VHD prevalence, lesion types, and CA diagnostic accuracy parameters ($p < 0.05$).

Results:
TTE identified valvular pathology in 79.7% (n=63) of participants, predominantly mild mitral regurgitation (84%), tricuspid regurgitation (84%), and aortic regurgitation (50%). Direct TTE without prior auscultation resulted in unexamined physical findings in 90% (n=36) of patients (p=0.027). Murmur presence demonstrated 11.11% sensitivity and 87.50% specificity. Notably, the negative predictive value (NPV) of murmur absence in excluding significant valvular disease was 96.43%.

Conclusions:
VHD prevalence is high among asymptomatic elderly primary care attendees. Although murmur sensitivity is low, high NPV indicates that normal auscultation reliably rules out significant pathology. Despite single-center sample size constraints (N=79), routine physical examination remains essential in primary care to evaluate clinical findings before advanced imaging.

Points for discussion:
Given the low sensitivity (11.11%) but high NPV (96.43%) of cardiac murmurs, what is the exact practical role of auscultation in primary care decision-making for elderly patients?

With 79.7% of asymptomatic elderly showing predominantly mild VHD on TTE, how can family physicians avoid over-investigation while ensuring timely referrals for progressive disease?

Should point-of-care ultrasound (POCUS) or targeted auscultation protocols be integrated into routine primary care health checks for populations over 65?

Presentation on 23/10/2026 16:00 in "Parallel Session H - Freestanding Papers: At the Bedside: Tools for Better Assessment" by Ülkü Sur Ünal.

Freestanding Paper / Finished study

Physician Perspectives on Point-of-Care Ultrasound (POCUS) in Primary Care: A Cross-Sectional Study in Israel

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Keywords: Point of Care Ultra Sound; POCUS; physiaincs' perspectives; primary care.

Background:
Point-of-care ultrasound (POCUS) offers significant potential to enhance diagnostic certainty and therapeutic decision-making in primary care settings. Despite widespread conceptual endorsement and the introduction of training programs, real-world adoption remains limited.

Research questions:
This study aimed to evaluate attitudes, clinical practice patterns, and barriers to integration among Primary Care Physicians (PCPs) who received formal POCUS training within a large Israeli healthcare organization.

Method:
A cross-sectional study was conducted among PCPs in one Healthcare Maintenance Organization in Israel who had previously completed POCUS training. Data were collected via an electronic questionnaire assessing specific modules used, device types, satisfaction levels, and perceived barriers. Respondents were categorized as active, former, or never users, and statistical analyses were performed to identify correlations among device type, usage, and satisfaction.

Results:
Of 341 eligible PCPs, 126 completed the survey (37% response rate). The majority (88%) were active users. The most frequently utilized applications were lung (93%), abdominal (79%), and musculoskeletal (55%) assessments, with a specific focus on lung parenchyma and urinary pathologies. Active users reported high levels of diagnostic confidence (84%) and believed POCUS improved treatment (77%). The primary barriers cited were a lack of time (60%), a lack of experience (50%), a lack of confidence (39%), and insufficient compensation (32%).

Conclusions:
Trained PCPs perceive POCUS as a valuable tool that enhances diagnosis and treatment. However, barriers regarding time constraints, confidence, and experience persist despite formal training. Successful integration of POCUS in primary care requires addressing these workflow-specific challenges and selecting devices that align with the unique needs of ambulatory practice.

Points for discussion:
Integration of POCUS to primary care

POCUS - barriers and enahncers for usages

Presentation on 23/10/2026 16:00 in "Parallel Session H - Freestanding Papers: At the Bedside: Tools for Better Assessment" by Ilan Yehoshua.

Theme Paper / Finished study

Breaking Bad News in Oncology: Simulation-Based Training for Family Medicine Residents

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Keywords: Breaking bad news, SPIKES protocol, oncology care

Background:
Family physicians play a central role in cancer care, often being among the first healthcare professionals to discuss suspected cancer, abnormal screening results, diagnostic uncertainty, and poor prognostic information with patients. Delivering bad news is a complex communication skill that is rarely practiced in a safe educational environment. Simulation-based education may provide an effective method for preparing residents for these challenging conversations.

Research questions:
Evaluation of the impact of simulation-based training on family medicine residents' self-reported preparedness for delivering bad news in oncology-related clinical situations.

Method:
As part of a one-week simulation-based educational programme, first-year family medicine residents participated in communication-focused simulation scenarios involving difficult patient conversations. Residents completed anonymous self-assessment questionnaires before and after the programme using a six-point Likert scale evaluating confidence in various clinical competencies, including delivering bad news to patients. Open-ended questions explored participants' learning experiences and perceptions of simulation training.

Results:
Nineteen residents completed both pre- and post-training evaluations. Mean self-assessed competence in delivering bad news increased from 3.05/6 before the programme to 5.53/6 after training. The median score increased from 3 to 6. Prior to the intervention, only 21.1% of residents rated their competence highly (scores 5–6), compared with 84.2% following training. Qualitative analysis identified three main themes: emotional realism of simulation scenarios, perceived educational value of experiential learning, and the importance of psychological safety during communication training. Participants frequently described the simulations as realistic and emotionally engaging while reporting increased confidence in handling difficult conversations with patients.

Conclusions:
Simulation-based communication training was associated with substantial improvements in family medicine residents' self-reported preparedness to deliver bad news. Participants valued the opportunity to practice emotionally challenging conversations in a safe learning environment. Simulation may be an effective educational strategy for preparing future family physicians for oncology-related communication throughout the cancer care continuum.

Points for discussion:
Communication skills require deliberate practice, not only theoretical teaching

Simulation provides a safe environment for emotionally challenging conversations

Psychological safety should be considered when designing communication training

Presentation on 24/10/2026 09:10 in "Parallel Session I - Theme Papers: Cancer Care in Everyday Practice" by Daina Malinsa.

Theme Paper / Finished study

Evaluation of Pre-Diagnosis Cancer Screening Status and Related Determinants in Patients Diagnosed with Colorectal, Cervical, or Breast Cancer: A Cross-Sectional Study

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Background:
Early detection in primary care is vital to maintain the cancer care continuum and lower mortality. While screening protocols exist, public adherence remains sub-optimal. Evaluating pre-diagnosis habits helps clarify barriers to early presentation. This study evaluates pre-diagnosis screening participation, prior information status, and primary care-related factors in a sample of cancer patients.

Research questions:
1. What are the pre-diagnosis screening status, prior information status, and diagnostic pathways among breast, cervical, or colorectal cancer patients?
2. How do primary care recommendations and sociodemographic factors correlate with screening adherence and disease stage?

Method:
This single-center cross-sectional study was conducted between December 2025 and April 2026 at Marmara University Hospital Oncology Outpatient Clinic. Sixty adult patients with breast, cervical, or colorectal cancer were consecutively enrolled. Structured face-to-face questionnaires assessed sociodemographic factors, primary care utilization, and screening history. Primary outcomes were pre-diagnosis screening participation and stage at diagnosis. Bivariate quantitative analyses were performed using IBM SPSS v32.0 employing Chi-square and Fisher's exact tests ($p < 0.05$).

Results:
Mean age was 59.7 years (75.0% female; 63.3% secondary education or lower). Diagnoses were breast (51.7%), colorectal (38.3%), and cervical cancer (10.0%). Diagnoses were predominantly symptom-driven (60.0%), whereas 31.7% were detected via routine screening. Prior to diagnosis, 56.2% lacked information regarding screenings. Family physicians were the primary recommendation source (36.7%). Explicit physician recommendations were significantly associated with breast ($p=0.001$) and colorectal cancer screening ($p=0.001$). Furthermore, prior knowledge of mammography significantly correlated with breast cancer screening participation ($p=0.05$).

Conclusions:
Explicit primary care recommendations significantly drive screening participation and early detection. Although limited by a small single-center sample (N=60) restricting generalizability, findings emphasize the actionable need to strengthen proactive Family Health Center referral mechanisms along the lifespan.

Points for discussion:
Since 60% of patients were diagnosed only after becoming symptomatic, what low-cost, feasible outreach methods can Family Health Centers use to engage unscreened, asymptomatic adults?

Given challenges such as dense breast tissue and varying individual risks, to what extent are standard age-based (>40 years) mammography protocols adequate for effective early detection in primary care?

Presentation on 24/10/2026 09:10 in "Parallel Session I - Theme Papers: Cancer Care in Everyday Practice" by Yüksel Duygu Altıparmak.

Theme Paper / Almost finished study

Supporting Continuity of Cancer Care Through Safe Air Travel: Development of the Cancer Air Travel Assessment Framework (CAT-AF)

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Keywords: Cancer; Commercial air travel; Fitness to fly; Scoping review; Clinical decision support; Continuity of care

Background:
Advances in cancer prevention, diagnosis, and treatment have transformed many malignancies into chronic diseases, resulting in a growing population of patients who remain socially, professionally, and geographically mobile. Commercial air travel has consequently become an integral component of the cancer journey, supporting access to specialist care, clinical trials, rehabilitation, survivorship services, family, employment, and international travel. However, the physiological effects of flight, combined with cancer- and treatment-related complications, create unique challenges when determining fitness to fly. Existing recommendations are dispersed across oncology, aviation medicine, respiratory medicine, travel medicine, and airline guidance, with no integrated evidence-informed framework to support consistent clinical decision-making.

Research questions:
Can evidence from multiple disciplines be synthesized into a structured clinical decision-support framework for pre-travel assessment of adults with cancer, and what are the key domains required for safe commercial air travel?

Method:
A PRISMA-ScR-compliant scoping review is being conducted. Systematic searches were performed in PubMed, with additional searches planned in Scopus and Google Scholar. International clinical guidelines, consensus statements, aviation medicine resources, and airline medical guidance are also reviewed. Eligible studies undergo title/abstract screening, full-text assessment, and thematic synthesis to identify assessment domains, recommendations, and evidence gaps.

Results:
Systematic searches identified over 800 records. Following title and abstract screening, over 600 records were excluded. Forty-three studies met the inclusion criteria, while more than 30 full-text articles remain under eligibility assessment. Preliminary thematic synthesis identified four assessment domains: cancer characteristics, clinical stability, travel-related risks, and airline operational requirements. These domains underpin the Cancer Air Travel Assessment Framework (CAT-AF).

Conclusions:
CAT-AF aims to provide an evidence-informed clinical decision-support framework for structured fitness-to-fly assessment in adults with cancer. By integrating multidisciplinary recommendations into a practical assessment pathway, the framework has the potential to improve consistency in pre-travel assessment, facilitate continuity of cancer care, and support communication between clinicians and airline medical services.

Points for discussion:
Should CAT-AF undergo Delphi consensus before prospective validation?

Which assessment domains require stronger primary evidence?

How can CAT-AF be implemented in primary care and oncology settings?

Presentation on 24/10/2026 09:10 in "Parallel Session I - Theme Papers: Cancer Care in Everyday Practice" by Md Al Araf Hussain.

Freestanding Paper / Almost finished study

Artificial Intelligence in General Practice: A Systematic Review and Meta-Analysis of Diagnostic Performance, Bias, and Implementation Challenges.

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Keywords: Artificial Intelligence, General Practice, Primary Care, Clinical Decision Support, Algorithmic Bias, Diagnostic Accuracy, EU AI Act

Background:
AI adoption is accelerating in general practice (GP), with generative and machine-learning tools increasingly used for diagnosis, documentation and triage. Evidence on real-world performance, safety and equity remains fragmented, and algorithmic bias is insufficiently characterised. A rigorous synthesis is needed to inform responsible implementation in primary care.

Research questions:
What is the diagnostic performance, efficiency impact, and algorithmic bias profile of AI systems used in general practice, and what barriers and facilitators shape their adoption, compared with standard clinical practice?

Method:
Systematic review with meta-analysis following PRISMA 2020. Six databases (MEDLINE/PubMed, Scopus, Web of Science, Cochrane Central, JMIR, AI Watch) were searched (2020-2025). Of 13,320 records identified, 83 studies met eligibility criteria after duplicate removal, title/abstract and full-text screening by two independent reviewers; 45 studies with comparable diagnostic-accuracy outcomes were pooled using random-effects meta-analysis. Risk of bias was assessed with PROBAST, adapted for AI studies. Barriers/facilitators to adoption and algorithmic bias were analysed narratively, including subgroup comparisons by population ethnicity.

Results:
Pooled diagnostic accuracy across AI models was 52.1% (95% CI 47.0-57.1%), reflecting substantial heterogeneity across models and clinical tasks; advanced generative models (GPT-4) reached up to 97% accuracy on selected top-diagnosis tasks in controlled settings. Ambient documentation AI reduced documentation time by 28.8%, a plausible lever against burnout. PROBAST assessment found high risk of bias in 76% of studies, concentrated in participant/data and analysis domains. Performance for population subgroups defined by ethnicity was reduced by 12-18% compared with majority groups. Reported barriers to adoption centred on training gaps, workflow integration and trust; funding and infrastructure were key facilitators.

Conclusions:
AI shows promising but highly heterogeneous diagnostic performance and measurable efficiency gains, alongside substantial bias risks. Responsible GP implementation requires structured training, bias mitigation, and regulatory-compliant, equity-focused pilot deployment.

Points for discussion:
How can heterogeneity across AI models and clinical tasks be reduced to allow meaningful benchmarking in general practice?

What practical strategies can mitigate the 12-18% accuracy gap observed for minority populations before wider deployment in primary care?

How should national/regional data and AI infrastructure (e.g. Belgian Health Data Agency, AI4Belgium) be leveraged to support equitable pilot studies in GP?

Presentation on 24/10/2026 09:10 in "Parallel Session J - Freestanding Papers: The Digital Consultation" by Alberto Parada.

Freestanding Paper / Almost finished study

BRIDGE-PC: Mapping Digital Health Training in Primary Care Medical Curriculum Worldwide

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Background:
Digital health technologies are increasingly integrated into primary care; however, their safe and effective implementation relies on clinicians' competence and confidence. Although existing evidence indicates considerable variation across countries and training stages, the global distribution, content, and structure of formal digital health education for future primary care physicians remain unclear. Mapping the current provision is therefore necessary to identify training gaps and support more coherent curriculum development.

Research questions:
How is digital health training incorporated across undergraduate, postgraduate and residency programmes worldwide, and where are the main gaps in formal training provision?

Method:
The BRIDGE-PC project is a multinational cross-sectional survey coordinated through a network of primary care national leads. These leads provided information on undergraduate, postgraduate, and residency programmes at their affiliated institutions and mapped additional institutions within their country. Collected data encompassed the presence of formal digital health content, the mandatory or optional nature of training, duration, curriculum recency, and assessment and evaluation methods. Multiple-choice and free-text responses were analysed using descriptive methods.

Results:
Fifty-seven countries from all seven WONCA regions participated. Among 52 countries with classified undergraduate data, 32 reported at least one digital health module, 15 reported none, and five had unknown or missing data. Residency-level training was less common: eight countries reported at least one module, 25 reported none, and 19 had unknown or missing data. Postgraduate provision was also heterogeneous, ranging from no identified programmes to three programmes per country. Module titles, included topics, delivery approaches and assessment methods varied considerably across settings. Data collection has ended, and further analysis is ongoing.

Conclusions:
Formal digital health education remains uneven across countries and training stages, with particularly limited residency-level provision. These findings provide an international baseline for identifying priority gaps, comparing approaches across health systems, and informing the future development of primary-care-specific digital health curricula, competency frameworks, and evaluation strategies.

Points for discussion:
How is digital health incorporated into the training curriculum in high-income countries vs low- and middle-income countries?

To what extent does the presence of formal digital health content in a curriculum reflect actual competence and preparedness for digital primary care practice?

What are some digital health topics which are prioritised/commonly featured in the existing curriculum?

Presentation on 24/10/2026 09:10 in "Parallel Session J - Freestanding Papers: The Digital Consultation" by Ana Luisa Neves.

Freestanding Paper / Finished study

Reconfiguring the Primary Care Consultation: Aligning Digital Convenience with Clinical Craft

Hans Thulesius, Sofia Olofsson, Jens Wilkens, Eva Arvidsson, Mattias Röösst, Veronica Milos Nymberg, Björn Ekman

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Keywords: Telehealth, General practice, Grounded theory, Video consultation, Artificial intelligence

Background:
Telehealth and AI are transforming primary care, yet uptake of video consultations remains lower than anticipated despite high patient satisfaction and political support. Existing research has mainly described facilitators and barriers to implementation, but less is known about the underlying process by which digital technologies reshape consultations and professional practice.

Research questions:
How do telehealth and AI reconfigure the primary care consultation, and how do general practitioners integrate digital convenience with the core values of general practice?

Method:
Classic Grounded Theory methodology was applied using constant comparison and theoretical memoing. Data were theoretically sampled from multiple sources including interviews with 24 telehealth stakeholders, qualitative interviews with Swedish GPs about video consultations, scientific literature, policy documents, professional texts, newspaper articles and informal professional discussions. Emerging concepts guided continued theoretical sampling until conceptual saturation.

Results:
The emerging theory suggests that GPs continually resolve their main concern about telehealth by Aligning Digital Convenience with clinical craft. This involves balancing accessibility with holistic care, redistributing rather than reducing clinical information, adapting changing professional roles and power symmetry, and embedding AI as a supportive rather than substitutive tool. Video consultations reduce geographical distance while simultaneously changing the forms of proximity, contextual understanding and embodied knowledge available during consultations.

Conclusions:
Telehealth is a reconfiguration of the consultation rather than a new consultation modality. The emerging theory explains how clinicians preserve the core values of general practice by aligning digital convenience with professional judgement, relational continuity and embodied knowledge within blended models of care.

Points for discussion:
How can telehealth and AI be integrated into primary care without disrupting the core values of general practice?

How does digital care reshape professional roles, power symmetry and contextual understanding between patients and clinicians?

How might the emerging theory of Aligning Digital Convenience explain variation in telehealth adoption across different primary care settings?

Presentation on 24/10/2026 09:10 in "Parallel Session J - Freestanding Papers: The Digital Consultation" by Hans Thulesius.

Freestanding Paper / Finished study

Association Between Screen Time and Depressive Symptoms in Adolescents: A Systematic Review of Longitudinal Studies

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Keywords: Screen Time; Depression; Adolescent; Systematic Review

Background:
Adolescence is a critical period for mental health, with depression representing one of the leading causes of morbidity. Exposure to screen-based technologies has increased rapidly, raising concerns about its potential impact during adolescence. Increased screen time has been associated with heightened depressive symptoms in adolescents, though the strength and nature of this relationship remain elusive.

Research questions:
Synthesize longitudinal evidence on the association between screen time and subsequent onset or worsening of depressive symptoms in adolescents.

Method:
Following the PRISMA statement, PubMed, PsycINFO, Scopus and Web of Science were systematically searched for longitudinal studies published up to February 2025. Eligible studies included individuals aged 10–19 years, assessed screen time exposure through any device or activity and reported on depressive symptoms outcomes. Study quality was assessed using the Newcastle–Ottawa Scale. Two authors independently assessed study eligibility and quality. The study protocol was registered in PROSPERO.

Results:
A total of unique 31 longitudinal studies were included. A small positive association was observed between total screen time and subsequent depressive symptoms though the direction and strength of the relationship varied across devices and activities. Internet and smartphone use were consistently associated with increased risk, whereas video game, television and video showed predominantly no association. Evidence for social media and computer use, and screen-based communication was inconsistent. Sex appeared to moderate the association, with female adolescents showing greater vulnerability. Substantial heterogeneity was observed, reflecting differences in screen time definitions, exposure and outcome assessment and analytic strategies.

Conclusions:
Screen time was prospectively associated with increased depressive symptoms in adolescents. However, this effect is small and dependent on screen engagement patterns and individual characteristics. These findings support recommendations to limit prolonged recreational screen use among adolescents. Future research should adopt standardized definitions and objective measures for screen time, while considering screen content and inherent motivations.

Points for discussion:
This systematic review found a small positive association between screen time and depressive symptoms in adolescents.

The impact of screen time on depressive symptoms varied according to device and activity, with internet and smartphone use associated with increased risk, whereas video game, television and video exhibited predominantly no association.

The findings support recommendations to limit prolonged recreational screen time and highlight the need to promote healthier digital habits among adolescents.

Presentation on 24/10/2026 09:10 in "Parallel Session K - Freestanding Papers: Making Evidence Work in Primary Care" by Carolina Pais Neto.

Freestanding Paper / Finished study

European Consensus Statement on the Management of Disorders of Gut–Brain Interaction in Primary Care

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Background:
Disorders of gut–brain interaction (DGBI), including irritable bowel syndrome (IBS) and functional dyspepsia (FD), are highly prevalent conditions that affect quality of life and healthcare utilization; however, their management in primary care (PC) settings remains variable.

Research questions:
This aim of this study was to develop a European consensus on practical, evidence-based guidance for management of DGBI disorders tailored to primary care settings with a primary focus on IBS and FD.

Method:
A multidisciplinary expert panel led by a representative of the European Society For Primary Care Gastroenterology. Population, Intervention, Comparison, Outcome (PICO) questions were developed, followed by a targeted literature review. Publications were screened by two public health researchers with discrepancies resolved through consensus. 17 statements addressing symptom identification, diagnostic capacity in primary care, therapeutic options, and longitudinal management were drafted and assessed using the GRADE framework. A modified Delphi methodology with two rounds was used to obtain expert consensus on the drafted statements. Consensus agreement was defined as at least 80% of participants rating a statement 4 or 5, consensus disagreement as at least 80% rating it 1 or 2, and no consensus when neither threshold was met. All Delphi rounds were conducted anonymously using a web-based questionnaire (Google Forms), ensuring independence and confidentiality of individual responses.

Results:
High levels of agreement were achieved for statements addressing symptom identification, diagnostic capacity, and overall management of irritable bowel syndrome and functional dyspepsia in primary care. The statements validated the Rome IV criteria for symptom-based diagnosis, primary care as the setting for positive diagnosis of IBS, and the usefulness of pharmacotherapy and non-drug treatments. Consensus was not achieved concerning diagnostic tools and biomarkers.

Conclusions:
The current European consensus provides practical, evidence-based guidelines for the management of DGBI in the primary care setting, focusing on IBS and FD.

Points for discussion:
Practical implications: To what extent do you find the consensus statements feasible to implement in your daily practice?

Methdology: What are the strengths and limitations of the Delphi process?

Omission: Based on your expertise, what is missing from the consensus recommendations based on your expertise?

Presentation on 24/10/2026 09:10 in "Parallel Session K - Freestanding Papers: Making Evidence Work in Primary Care" by Heather L Rogers.

Freestanding Paper / Almost finished study

For which patient groups is continuity of GP care more strongly associated with beneficial outcomes? Preliminary findings from a systematic review of within-study comparisons

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Keywords: continuity of patient care, primary care, multimorbidity, systematic review

Background:
Relational continuity is consistently associated with better outcomes. Under workforce pressure, health systems are shifting from universal to targeted continuity: England's 2025 GP contract requires practices to identify patients benefiting most. Yet whether subgroup benefits are genuinely stronger, or instances of a general effect, is untested.

Research questions:
Within general practice populations, for which patient groups is relational continuity of GP care more strongly associated with beneficial outcomes, in direct comparison with other patient groups within the same study?

Method:
Systematic review. MEDLINE, Embase, Scopus, CINAHL, Web of Science, Cochrane were searched from 2010 without language restriction. Eligible studies were primary-care based, quantified relational continuity (UPC, Bice-Boxerman, SECON, Herfindahl, relationship duration), and reported the continuity-outcome association separately for two or more patient groups; single pooled populations were excluded. Records were screened in duplicate. Data are extracted by one reviewer and checked by a second; risk of bias, ROBINS-I; certainty, GRADE. Meta-analysis is planned only where measures, outcomes and subgroup definitions are sufficiently similar; otherwise narrative synthesis.

Results:
These are preliminary results of an ongoing review; extraction continues. Twenty included studies, all observational, have been extracted to date (>6.9 million patients; Europe, North America, Australia). Associations were consistently stronger in older patients (ambulatory care sensitive admissions: −8.4% versus −3.4% per 0.2 UPC increase, ages 76–82 versus 62–68; end-of-life admissions IRR 0.39, 95%CI 0.23–0.65 in people over 95 with dementia), in complex/multimorbid patients and frequent attenders. Socioeconomic findings were inconsistent. Risk of bias was serious in 11 and moderate in 9 (confounding by indication). No study extracted so far compared cancer patients with other groups.

Conclusions:
Preliminary evidence suggests continuity is most strongly associated with benefit in older, complex and frequently attending patients. Evidence is observational, at moderate-to-serious risk of bias; targeting continuity may be defensible, withdrawing it elsewhere is not.

Points for discussion:
Is the within-study subgroup comparison a defensible way to identify who benefits most from continuity, given that between-study comparisons confound subgroup with design, setting and population?

Confounding by indication runs opposite to the observed effect (sicker patients see more doctors, so have lower continuity). Does this attenuate or inflate the subgroup differences we report?

No study extracted so far has compared continuity effects in cancer patients versus other groups — a gap directly relevant to this meeting's theme. What design would fill it?

Presentation on 24/10/2026 09:10 in "Parallel Session K - Freestanding Papers: Making Evidence Work in Primary Care" by David Lerma Irureta.

Poster / Study Proposal / Idea

AUTO-HPV CSP: evaluating the impact of vaginal self-sampling for HPV testing on cervical cancer screening uptake in primary care, a multicentre comparative study protocol

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Keywords: HPV, cancer screening, patient-centered

Background:
Cervical cancer remains an important challenge despite organised screening programmes.
In Portugal, organised population-based cervical cancer screening with HPV testing has been progressively implemented in primary care since 2010 and is currently a national program. However, participation remains heterogeneous across regions, and access still depends on women's engagement and professionals' availability to collect samples.
Vaginal self-sampling for HPV testing has emerged as a valid alternative to clinician-collected sampling, particularly among under-screened populations. Although evidence supports its diagnostic performance, less is known about its pragmatic integration into routine primary care screening pathways.

Research questions:
Can offering vaginal self-sampling for HPV testing within routine Portuguese primary care improve cervical cancer screening uptake?

Method:
Auto-HPV is a prospective, multicentre, pragmatic pilot comparative study across three Portuguese primary care units. One centre will implement vaginal self-sampling as an alternative screening strategy, one will implement an active invitation model with clinician-collected sampling, and one will maintain standard care.
Women eligible for cervical cancer screening will be invited to participate. The primary outcome is screening uptake. Secondary outcomes include sample validity, high-risk HPV positivity rates, time from sample collection to laboratory result, completion of follow-up after positive results, and participant-reported acceptability, including comfort, privacy, ease of use and willingness to repeat.
Quantitative data will be analysed descriptively and comparatively using appropriate statistical tests.

Results:
This study is expected to generate preliminary evidence on the feasibility, acceptability and effectiveness of integrating self-sampling into routine pathways in Portuguese primary care. It is anticipated that self-sampling may increase screening uptake, particularly by reducing logistical and emotional barriers, while maintaining adequate sample validity and continuity of follow-up after positive results.

Conclusions:
AUTO-HPV CSP will provide real-world evidence on the implementation of self-sampling in organised primary care screening programmes. Its findings may inform future strategies to improve accessibility, participation and equity in cervical cancer prevention.

Points for discussion:
How can self-sampling be safely integrated into organised cervical cancer screening pathways in primary care?

Can self-sampling reduce inequalities in participation among under-screened populations, or will it mainly benefit women who already engage with healthcare services?

What organizational changes are needed to ensure follow-up, quality assurance and sustainability when introducing self-sampling into routine practice?

Presentation on 24/10/2026 11:00 in "Poster Session 1: Cancer Screening and Risk Assessment" by Margarida Gil Conde.

Poster / Study Proposal / Idea

CANDOR (CANcer Digital Outreach and Referral): A Participatory Study on Enhancing Cancer Prevention Uptake via Digital Transformation in Primary Care Settings.

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Keywords: Cancer Prevention, Digital Health, Preventive Services

Background:
Primary care is crucial for cancer prevention but faces systemic challenges, including severe time constraints and administrative burdens, leading to persistently low uptake of preventive services.

Research questions:
Can the integration of a comprehensive, equity-driven digital cancer prevention system (CANDOR) into primary care workflows effectively improve patient matching to statutory health insurance (SHI)-covered preventive services while demonstrating high clinical utility, algorithmic fairness, and implementation success?

Method:
This research program uses a participatory design and a twelve-month stepped-wedge implementation pilot across eight primary care practices involving 160 patients. The CANDOR intervention adapts an existing evidence-based digital tool into an electronic health record-connected dashboard for provider-facing risk stratification and a patient-facing app for localized resource referral. The methodology features two synergistic streams: developing a machine learning (ML)-supported risk stratification tool that incorporates socioeconomic factors, and assessing behavioral and organizational implementation dimensions. Generalized Estimating Equations (GEE) will estimate intervention effects across control and intervention periods. Furthermore, predefined fairness audits, subgroup-specific performance analyses, and bias mitigation strategies will be applied during model development to ensure algorithmic equity.

Results:
The anticipated primary outcomes for the ML risk-stratification framework include robust calibration, discrimination, clinical utility, and fairness. Concurrently, implementation outcomes will provide comprehensive data on the system's reach, adoption, acceptability, usability, workflow integration, and associated costs, specifically evaluating its effectiveness in systematically connecting patients to targeted cancer prevention resources.

Conclusions:
The CANDOR system aims to dismantle navigational barriers and increase prevention uptake by automating the identification of, and referral to, localized preventive services. We seek to optimize clinical workflows, reduce administrative burdens, and establish an evidence base to support new national standards for digitally supported cancer prevention in primary care.

Points for discussion:
What are persisting organizational and behavioral barriers to cancer prevention in primary care and what are some practice-based strategies to address these?

How can digital practice system inadvertently create disparities in care, and how can this be prevented?

What is the role of primary care in cancer prevention and how can it best be supported?

Presentation on 24/10/2026 11:00 in "Poster Session 1: Cancer Screening and Risk Assessment" by Nora Mueller.

Poster / Finished study

Functional Characterization of MLH1 Variants of Uncertain Significance for Improved Genetic Counseling

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Keywords: Genetic Counseling, Lynch syndrome , methylation tolerance assays

Background:
Germline variants affecting genes involved in DNA repair can confer a hereditary predisposition to cancer. Among these conditions, Lynch syndrome is one of the most common and is caused by pathogenic variants in genes involved in DNA mismatch repair (MMR) pathway, mainly MLH1 and MSH2. The increasing use of genetic testing has led to the identification of numerous variants of uncertain significance (VUS), whose clinical interpretation remains challenging in the absence of functional evidence.

Research questions:
The aim of this study is the characterization of MLH1 VUS identified at the Genetic Counselling Unit (GCU) of Salamanca in order to improve Genetic Counseling.

Method:
MLH1 variants were selected based on their classification as variants of uncertain significance (VUS) in at least one of two publicly available databases, ClinVar or VarSome. Selected variants were introduced by site-directed mutagenesis, and stable cell lines expressing wild-type or variant MLH1 were generated by lentiviral transduction of the MLH1-deficient cell line HCT116. MMR function was evaluated in the resulting cell lines using methylation tolerance assays.

Results:
The MLH1 variants c.107 T>G, c.170 A>G, c.206 G>A, c.595 G>A and c.1048 C>T exhibited protein expression and functional behaviour compatible with preserved MMR activity, whereas the MLH1 c.1360G>C variant showed loss of protein expression and alterations suggestive of impaired MMR function. Therefore, patients and families carrying this mutation would have an increased lifetime risk of developing colorectal cancer (and other types of malignancies).

Conclusions:
The use of methylation tolerance assays is a rapid strategy for variant reclassification and improved Genetic Counselling. The characterization of MLH1 variants translates genetic data into actionable clinical insights, allowing for personalized risk prediction and improved targeted prevention programs for high-risk individuals.

Points for discussion:
The Importance of Enhanced, Targeted Screening Programs for Individuals at High Risk for Lynch Syndrome

Methylation tolerance assays is a rapid strategy for variant reclassification and improved Genetic Counselling

The Importance of Personalized Risk Assessment and Improved, Targeted Prevention Programs for Individuals at High Risk for Lynch Syndrome

Presentation on 24/10/2026 11:00 in "Poster Session 1: Cancer Screening and Risk Assessment" by Miguel Castro Fernandez.

Poster / Almost finished study

Personality traits influence breast cancer risk factors and participation in screening

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Keywords: personality traits, breast cancer, risk factor, screening, mammography

Background:
Breast cancer is the leading cause of cancer related morbidity and mortality among women. Beside health system related factors, personality traits can also influence the occurrence of modifiable risk factors and willingness to participate in screening programs. Affective temperaments are stable patterns in how people experience and express emotions, influencing mood, energy, behavior and response to stress.

Research questions:
Our aim was to assess how temperaments (hyperthym, cyclothym, depressed, anxious and irritable) affect the risk factors and attitude about screening.

Method:
In two teaching practices, women aged 40-65 years were contacted in email and asked to fill out a self-administered questionnaire about lifestyle, risk factors, and motivational and hampering factors to mammography. Affective temperaments were assessed with Temperament Evaluation of Memphis, Pisa, Paris and San Diego (TEMPS-A) questionnaire.

Results:
Among the 85 participants mean number risk factors was 2.38±1.27 (1.97±1.07 modifiable). A significant proportion of patients remembered attending to mammography (73.1%), but actual attendance rate was only 52.3% ($p<0.001$).
Hyperthymic score associated with higher attendance rate ($p=0.008$), more physical activity (0.016), and more accurate recall of attendance ($p=0.049$).
Cyclothymic score associated with lower attendance rate ($p=0.009$). It also correlated with lower motivation ($p=0.003$), and with experiencing more obstacles to screening (0.029). Higher rate of smoking among them had marginal significance ($p=0.053$).
Depressive temperament score also associated with lower motivation ($p=0.021$) and higher perception of some obstacles, but not with lower attendance rate.

Conclusions:
Mammography screening uptake, risk factors, and perceived obstacles and motivation are influenced by personality traits. Assessing affective temperaments could help family doctors to provide tailored care for their patients. Women with cyclothymic and depressive temperaments may benefit from additional help in coping with risk factors and achieving high mammography screening rates to decrease morbidity.

Points for discussion:
Primary prevention - effective ways of reducing the number of risk factors

Secondary prevention - increasing screening uptake

How feasible it is to evaluate personality traits?

Poster / Study Proposal / Idea

Why Do Women Decline HPV-Based Cervical Cancer Screening? A Qualitative Primary Care Study Among Women Aged 30 Years and Older in Türkiye

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Keywords: Cervical cancer screening, Human papillomavirus (HPV), Cancer prevention

Background:
Cervical cancer is one of the few cancers that can be effectively prevented through HPV vaccination and organized screening programmes. The WHO has identified achieving high screening coverage as a key component of the global strategy for cervical cancer elimination. Although Türkiye has implemented a nationwide HPV-based cervical cancer screening programme for women aged 30–65 years, participation remains suboptimal. Previous quantitative studies have identified barriers such as insufficient knowledge, embarrassment, fear, cultural beliefs and limited access to healthcare; however, these factors are complex and context-dependent, requiring qualitative exploration to better understand women's experiences and decision-making processes.

Research questions:
What individual, sociocultural, interpersonal and healthcare-related factors influence non-participation in HPV-based cervical cancer screening among women aged 30 years and older in Türkiye?

Method:
A qualitative study using semi-structured individual interviews and focus group discussions will be conducted in primary care settings. Women aged 30–65 years who have declined screening will be recruited through purposive maximum-variation sampling. Individual interviews will explore personal experiences, including embarrassment, fear of diagnosis, previous healthcare experiences and privacy concerns, while focus groups will examine shared cultural beliefs, social norms, family influence and perceptions of primary healthcare services. Data collection will continue until sufficient information power and thematic saturation are achieved. Interviews will be audio-recorded, transcribed verbatim and analysed using reflexive thematic analysis following Braun and Clarke's approach. The study will be reported in accordance with the COREQ checklist.

Results:
This study will generate an in-depth understanding of barriers to HPV-based cervical cancer screening in Türkiye and provide evidence to support culturally appropriate, patient-centred interventions within family medicine. The findings are expected to inform communication strategies, shared decision-making and screening policies across the cervical cancer care continuum.

Conclusions:
By exploring women's lived experiences and perceptions, this study is expected to generate qualitative evidence that cannot be captured through quantitative surveys alone.

Points for discussion:
What individual, sociocultural, and healthcare-related factors influence women's decisions to decline HPV-based cervical cancer screening in Türkiye?

How do women perceive HPV testing, cervical cancer risk, and their interactions with family physicians when making decisions about screening?

Which patient-centred and culturally appropriate primary care interventions could improve the acceptability and uptake of HPV-based cervical cancer screening among women aged 30 years and older?

Presentation on 24/10/2026 11:00 in "Poster Session 1: Cancer Screening and Risk Assessment" by Ayşen Fenercioğlu.

Poster / Ongoing study with preliminary results

Cancer patients' experiences of integrated palliative care visits during ongoing cancer treatments

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Keywords: Integrated Palliative Care, Incurable Cancer, Patients' Perceptions, Advance Care Planning

Background:
Integrating palliative care into standard oncologic care is recommended and has been shown to be beneficial when taking care of patients with incurable cancer. Despite the benefits, the most optimal time and patient selection criteria are still under debate. The referral criteria for integrated palliative visits often emphasize the professionals' assessment of the patients' situation. We have limited knowledge about patients´ perceptions and experiences of palliative care integration, and none in Finnish cancer care.

Research questions:
How do patients with incurable cancer perceive palliative care integration? Which needs do the patients identify? What are patients´ perceptions of the timing of palliative intervention and advance care planning (ACP) in relation to their oncologic trajectory?

Method:
Patients who were referred to integrated palliative outpatient visits in the palliative unit in Tampere University Hospital were recruited to participate in semi-structured interviews after the visit. The interviews were recorded, transcribed, and analyzed using inductive, qualitative thematic analysis.

Results:
Altogether, ten patients with incurable cancer, 6 women and 4 men, aged 45-89, participated in the study. The preliminary findings of the analysis show that the referral to palliative care is associated with a stigma related to death. Most of the participants did not identify specific palliative care needs. However, the visit was perceived positively, and the content of the visit was perceived as appropriate and sufficient. Discussions about ACP were acceptable to all participants and were not experienced as distressing or inappropriate. Participants wished they had received more information about palliative care earlier in their disease trajectory.

Conclusions:
Overall, the findings suggest that integrated palliative care is acceptable and beneficial from the patients' perspective. Most patients expressed a preference for earlier information about palliative care from their treating oncologist. These findings create new hypotheses that should be investigated with quantitative methods.

Presentation on 24/10/2026 11:00 in "Poster Session 2: Living With Cancer: Communication, Support and Treatment" by Eliisa Tenkanen.

Poster / Finished study

Enablers and Barriers to Health Literacy Interventions Across the Cancer Care Continuum

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Keywords: Systematic review; Health Literacy; cancer treatment and care; Primary Care; Artificial Intelligence.

Background:
Health Literacy is a key element on cancer health promotion, prevention, screening, treatment adherence, palliative care, survivors and psychosocial outcomes. Yet, its enablers and barriers across cancer interventions to promote it have not been systematically mapped, considering people with cancer, professionals and settings.

Research questions:
Have any enablers and barriers to Health Literacy been systematically reported across randomised/quasi-randomised trials to enhance Health Literacy across the cancer continuum? Do these factors cluster into recurrent patterns, and present any interactions of interest?

Method:
Thematic synthesis of 92 studies analysing interventions to improve Health Literacy across the cancer continuum included in the iNTERVENE WP2 systematic review (EU4H 2024 PJ 02, Grant Agreement 101219203). Enabler and barrier statements were first analysed separately, and then co-occurrences were presented.

Results:
More than one out of four studies referenced digital platforms (33.7%), content personalisation and tailoring of content (32.6%) and cultural/linguistic adaptation (26.1%) were the most cited enablers. On the other hand, anxiety/psychological distress (16.3%), low Health Literacy/education (14.1%) and the digital divide/technology barriers (14.1%) were the most prevalent barriers. Similarly, a "digital paradox" emerged, indicating that 25.8% of the studies reported digital platforms were reported as enablers while indicating the digital divide as a barrier at some degree. Knowledge gains frequently failed to translate into sustained behaviour change, and barriers tended to group into mutually reinforcing "vulnerability constellations" (such as low literacy, low income, older age or mistrust in healthcare professionals). Trust in healthcare professionals and multicomponent, culturally tailored, navigator-supported interventions were consistently associated with greater benefit.

Conclusions:
Health Literacy interventions would benefit from a multimodal approach, taking into consideration elements such as preference-sensitive delivery, structural barrier resolution, and anxiety-sensitive design, rather than reliance on single-component knowledge transfer or digital delivery alone. What's more, given the clustering of Health Literacy barriers in "vulnerability constellations", an intersectional perspective is highly needed.

Points for discussion:
Could AI be used to elaborate digital Health Literacy tools tailored to the specific needs and requirements of different segments of populations, especially vulnerable ones, such as the elderly or lower-educated populations?

Do Health Literacy enablers and barriers found in the scientific literature match the ones that professionals find in their practice?

How can emotional distress be systematically addressed within Health Literacy interventions without over-medicalising routine cancer communication?

Presentation on 24/10/2026 11:00 in "Poster Session 2: Living With Cancer: Communication, Support and Treatment" by Noemí López Rey.

Poster / Finished study

Health Literacy Interventions Across the Cancer Continuum: an AI-Assisted Systematic Review

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Keywords: Systematic review; Health Literacy; cancer treatment and care; Primary Care; Artificial Intelligence.

Background:
Health Literacy is the capacity to obtain, process, understand, and act upon health-related information to make informed decisions to maintain and improve health. It occupies a central place in Primary Care, yet Health Literacy interventions across the cancer continuum are evaluated using heterogeneous designs, populations and outcome measures, limiting evidence synthesis. The iNTERVENE project (EU4Health, GA101219203) undertook a systematic review to consolidate this evidence, following the Health Literacy Pathway Model.

Research questions:
What interventions to improve Health Literacy across the cancer continuum do exist? How is Health Literacy measured? Which populations and settings have been targeted? What is the overall quality of the studies?

Method:
We examined seven bibliographic databases (2016–2025) and manual reference searching. Two reviewers screened titles/abstracts, and data extraction and risk of bias assessment were performed through a hybrid pipeline using AI and systematic human validation of every extracted field.

Results:
We recovered 994 papers -670 after deduplication-, selected 214, and analysed 92, predominantly from the United States, targeting people with cancer in active diagnosis/treatment, concentrated in the detection/screening and treatment stages, addressing mainly colorectal, breast and prostate cancer.
Interventions were mostly educational/training-based, and Health Literacy was measured both through direct instruments and proxy outcomes, with an overlap. Papers employed mostly purpose-built, study-specific questionnaires, and targeted knowledge more frequently.
Knowledge and self-efficacy improved most consistently, while effects on screening behaviour were mixed.
Most of studies presented high risk of bias, due to limitations in the blinding of participants/personnel, a domain structurally difficult to satisfy in non-pharmacological interventions.

Conclusions:
There is a plethora of studies focusing on Health Literacy across cancer continuum, although in a very inconsistent manner methodologically: there is a geographical divide, an under-representation of survivorship, palliative care and caregiver populations, an under-use of validated Health Literacy instruments, and published papers tend to exhibit a high risk of bias.

Points for discussion:
Can hybrid AI–human workflows become a solid alternative to conduct systematic reviews optimizing time and resources?

Should the use of standardized Health Literacy instruments be prioritised over study-specific scales in future trial design, at the cost of losing specificity?

How can the knowledge gathered regarding Health Literacy measurement and assessment be translated into daily practice?

Presentation on 24/10/2026 11:00 in "Poster Session 2: Living With Cancer: Communication, Support and Treatment" by Gabriel Iglesias-Caride.

Poster / Ongoing study with preliminary results

Implementation of Social Prescribing for People with Cancer in Primary Care: Baseline Findings from Aragón and Future Evaluation Using the EVALRA Framework

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Keywords: Social prescribing, Primary care, Cancer

Background:
Social prescribing is increasingly implemented in primary care to improve health and well-being by connecting people with community resources. In Aragón (Spain), health asset recommendation has been integrated into primary care. People with cancer may benefit. Although evidence suggests that social prescribing improves quality of life and emotional well-being in cancer care, implementation evidence remains limited. This study presents the first descriptive analysis of social prescribing for people with cancer in Aragón and provides the baseline for future evaluation using the EVALRA framework.

Research questions:
How has social prescribing for people with cancer been implemented in primary care in Aragón, and what are its characteristics and outcomes?

Method:
A cross-sectional descriptive study was conducted across 124 primary care teams in Aragón, Spain. All patients with an oncological diagnosis recorded in the electronic health record who received one or more health asset recommendations between September 2018 and January 2026 were included. Descriptive analyses were performed using frequencies, percentages and means. Variables included sex, age, ICPC diagnosis, targeted skill, recommended asset, attendance, satisfaction and perceived improvement.

Results:
A total of 129 health asset recommendations were issued to 94 patients with different oncological conditions. Overall, 104 recommendations were made for women and 25 for men. The mean age was 61.7 years. Most recommendations aimed to strengthen emotional skills, while cancer-related patient associations were the most frequently recommended assets. Follow-up was available for 21 patients: one did not attend, one attended occasionally and ten attended regularly. Satisfaction was assessed in 17 patients (mean 4.4/5), and perceived improvement in 15 patients (mean 4.1/5).

Conclusions:
Social prescribing appears to be a feasible and valuable intervention for people with cancer in primary care. These findings provide baseline evidence and will support a comprehensive evaluation of implementation and outcomes using the EVALRA framework, contributing to evidence for integrating social prescribing into oncology care.

Points for discussion:
How can social prescribing be systematically integrated into routine cancer care pathways in primary care?

What strategies are needed to improve follow-up and outcome evaluation of social prescribing interventions for people with cancer?

How can the EVALRA framework support the standardised evaluation and comparison of social prescribing programmes across different healthcare settings?

Presentation on 24/10/2026 11:00 in "Poster Session 2: Living With Cancer: Communication, Support and Treatment" by Rosa Fraile Escriche.

Poster / Finished study

Patients with advanced EGFR+ lung cancer treated with osimertinib: clinical experience in a health área.

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Keywords: lung cancer, osimetinib, clinical experience

Background:
Lung cancer is one of the most frequently diagnosed neoplasms and the leading cause of cancer death worldwide. EGFR mutations define a key subgroup in non-small cell lung cancer. Osimertinib is a third-generation epidermal growth factor receptor (EGFR) tyrosine-kinase inhibitor that has become the standard of care due to its efficacy and its ability to cross the blood-brain barrier

Research questions:
To analyze the clinical experience, effectiveness, and safety of osimertinib in real-world practice as a first-line treatment in the Ourense health area

Method:
Observational, multicenter, retrospective study of real-world clinical practice conducted between January 2016 and 2024. The study included 30 adult patients with EGFR+ advanced NSCLC treated with osimertinib from the time of diagnosis.

Results:
60% (95% CI: 49.8; 79.1) of patients were women and 40% (95% CI: 20.8; 59.1) were men, with a median age of 65 years. 66.6% (95% CI %: 48.1; 85.2) had never smoked.
97% (95% CI: 82.7; 99.9) of the lung tumours were adenocarcinomas, of which 70% (95% CI: 51.9; 88) were stage IVB at diagnosis. The most frequent mutations were DEL 19 (63.3 % ((95% CI: 44.4; 82.2)) and L858R (26.7 % 95% CI: 9.1; 44.1)).
The partial response rate was 73.3% (95% CI: 55.8; 90.8). The median overall survival was 35.64 months. The 25-month survival probability was 57% (DE:10,5).
The main adverse effect observed was skin rash (56,7 % (95% CI: 37.2; 76.1)).

Conclusions:
The results confirm the effectiveness of osimertinib, with an overall survival exceeding 35 months. The safety profile is manageable, unlike the systemic effects seen with other drugs in the same class. These data support its use as a first-line treatment in real-world practice for this patient profile.

Points for discussion:
The Importance of Treating Metastatic Lung Cancer

The importance of osimertinib

Survival with osimertinib

Presentation on 24/10/2026 11:00 in "Poster Session 2: Living With Cancer: Communication, Support and Treatment" by Maria Jose Fernandez Dominguez.

Poster / Finished study

A consensus-based framework for evaluating Community Health Strategies in primary care: a national modified Delphi study

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Keywords: Community Health Services, Health Strategies, Community Health Status Indicatos, Delphi Technique

Background:
Community-oriented primary care is increasingly recognised as a key approach to improving population health and reducing health inequalities. Although Community Health Strategies are being implemented in many settings, their evaluation remains inconsistent due to the lack of a shared indicator framework. A standardized evaluation tool could support quality improvement, benchmarking and evidence-informed decision-making within primary care.

Research questions:
Which indicators are considered essential by a multidisciplinary national expert panel for evaluating Community Health Strategies in primary care, and can they provide a common framework for regional evaluation?

Method:
We conducted a mixed-methods study using a modified Delphi consensus process between April 2024 and February 2025. Candidate indicators were identified by the research team and refined by the Community Health Working Group of the Spanish Ministry of Health. Thirty-six experts from across Spain, including primary care professionals, public health specialists, representatives of professional organisations, scientific societies, patient organisations and regional health authorities, participated in two Delphi rounds using a five-point Likert scale. Indicators meeting predefined consensus criteria were accepted or excluded, while those without clear consensus underwent structured group discussion before final approval. Descriptive analyses assessed agreement and convergence between rounds.

Results:
Sixty-one candidate indicators entered the consensus process. After Delphi rounds and structured deliberation, a final framework of 32 indicators was agreed and organised into five strategic domains: planning, organisational measures, levels of community involvement, resources and tools, and budget. It provides a standardized basis for monitoring the implementation and maturity of Community Health Strategies and enables comparable evaluation across regions.

Conclusions:
This study provides the first nationally agreed framework for evaluating Community Health Strategies in Spain. The framework offers a practical tool for strengthening community-oriented primary care, facilitating benchmarking and informing policy and service development in Spain and potentially in other health systems.

Points for discussion:
How are Community Health Strategies currently evaluated in your country or region?

What are the main barriers and facilitators to implementing a common evaluation framework in primary care?

How can evaluation results best support quality improvement and decision-making in community-oriented primary care?

Presentation on 24/10/2026 11:00 in "Poster Session 3: Prevention Beyond the Consulting Room" by Barbara Oliván Blazquez.

Poster / Finished study

Defining social prescribing link worker practice in Europe: An international Delphi consensus study of core functions, training needs, and implementation conditions

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Keywords: social prescribing, link worker,

Background:
Social prescribing can help primary care address social determinants of health by linking people with community resources. Across Europe, however, the social prescribing link worker (SPLW) role, competencies and implementation arrangements remain heterogeneous. This project received an EGPRN grant.

Research questions:
What consensus-based recommendations can guide SPLW roles, training and implementation in European primary care?

Method:
We conducted a three-round online Delphi study (April–December 2025) with a multidisciplinary European panel. Round 1 used open-ended questions to identify relevant domains and generate statements. In Round 2, participants rated 52 statements on a five-point Likert scale. Statements not reaching the pre-specified ≥80% agreement threshold were re-rated in Round 3 after structured feedback and wording refinement. Descriptive analyses summarised response distributions and agreement.

Results:
Round 1 was completed by 75/85 invited panellists (88%); 57/75 (76%) completed Round 2 and all 57 completed Round 3. The panel represented 15 European countries/UK nations and included physicians, researchers, social workers and link workers. Nineteen of 52 Round-2 statements reached consensus. After Round 3, 13 of 19 re-rated statements were approved and two rejected. Consensus supported a person-centred SPLW role encompassing exploration of “what matters”, navigation, advocacy, follow-up and documentation. Participants endorsed mandatory communication and community-resource-navigation training, regular supervision and continuing professional development. They also supported context-sensitive funding, co-funded multi-sector employment, multiple access routes including self-referral and secondary-care referral, and digital tools as complements, not replacements, for relational support.

Conclusions:
This European Delphi study provides actionable, consensus-based recommendations for safe, person-centred SPLW practice and context-adaptable implementation. The findings can inform primary-care role descriptions, training, service design and comparative implementation research. Remaining uncertainty about professional background, formal certification and some referral routes supports locally tailored models rather than a single European template.

Points for discussion:
1. How can European primary-care systems implement a core SPLW role while preserving local adaptability?

2. What minimum training and supervision standards are feasible across countries?

3. How should future research assess equity, sustainability and outcomes of social prescribing pathways?

Presentation on 24/10/2026 11:00 in "Poster Session 3: Prevention Beyond the Consulting Room" by Ferdinando Petrazzuoli.

Poster / Finished study

From Community Screening to Confirmed Skin Cancer Diagnosis: Findings and Follow-Up Pathways after a Street Public Dermoscopy Campaign

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Keywords: community-based public screening; skin cancer early diagnostics; dermoscopy.

Background:
Skin cancer incidence is increasing worldwide, and community-based screening may increase it's early detection. We evaluated clinical findings and patients' pathways after a public skin cancer early detection campaign.

Research questions:
To assess the incidence of skin malignancy in community-based skin-check campaign. To evaluate participants' adherence to follow recommendations provided by specialists.

Method:
A cross-sectional study was conducted during a one-day community-based skin-check campaign. A total of 552 pedestrians underwent dermatological examination with dermoscopy at 5 open-air temporaty examination tents. The campaign was delivered by 6 dermatologists and interns, 8 family physicians, and interns. After finding the suspicious malignant lesions, recommendations were provided specialists. An anonymous questionnaire assessed participants' acceptance to follow recommendations.

Results:
Of 552 individuals examined basal cell carcinoma was detected in 12 participants, squamous cell carcinoma in 9, Bowen's disease in 5, and actinic keratosis in 6. Recommendations included routine observation, planned dermatological follow-up, sun protection, and referral for further assessment or lesion removal. Most respondents who reported their intended adherence stated that they would follow the recommendations, while some of them remained unsure.

Conclusions:
Community-based public open-air skin-chek campaign identified clinically significant malignant and precancerous skin lesions and enabled to provide recommendations. These findings support the diagnostic value of public campaigns initiatives and their potential role to achieve adherence to follow the specialists' recommendations.

Points for discussion:
Can street-based dermoscopy campaigns improve early detection of non-melanoma skin cancer among people who do not routinely attend dermatological examinations?

What follow-up pathway is needed to ensure that participants with suspicious lesions complete diagnostic confirmation and treatment?

Presentation on 24/10/2026 11:00 in "Poster Session 3: Prevention Beyond the Consulting Room" by Sofiia Kucheriavchenko.

Poster / Finished study

How can GPs improve adherence to physical activity programmes amongst sedentary patients, thereby also reducing the risk of obesity and cancer?

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Keywords: Physical Activity, Cancer Prevention; Obesity Prevention, Primary Care

Background:
A lack of physical activity is one of the most significant modifiable risk factors for chronic non-communicable diseases and cancer. Although national and international guidelines (WCRF, MOVING Framework) identify the general practitioner as the cornerstone of prevention, a simple, brief verbal counselling session is often ineffective.

Research questions:
In order to bridge the gap between intention and action in patients with a sedentary lifestyle, based on the principles of ‘nudging’, this pilot study evaluates the effectiveness of an intervention in the form of a ‘tangible prescription’ such as a general practitioner-issued personalized sports voucher, on behavior change and perceptions among previously sedentary patients.

Method:
A prospective study using a mixed-methods approach was conducted on a sample of 18 inactive patients aged 18 to 75 who had comorbidities or were at risk for cancer, recruited from a primary care practice. The intervention consisted of a motivational interview followed by the presentation of a Health Voucher (a one-month trial gym membership at a reduced rate), presented in a paper package similar to that of a pharmaceutical product, in order to enhance its relevance and perceived medical value.

Results:
The 55.5% of patients (n = 10) redeemed the voucher. At the end of the trial period, 70% of those who had started exercising (n = 7) took out an annual membership, thereby consolidating their exercise habit; this represents 38.8% of the initial total sample. The qualitative analysis revealed that the physical packaging acted as a powerful visual reminder, whilst the doctor’s role as an ‘active role model’ improved adherence to the programme. Significant barriers emerged, linked to the social burden on carers and the need for structured financial support from the state.

Conclusions:
The specific prescription of physical activity within general practice has proved to be an effective tool for translating preventive advice into concrete behaviour.

Points for discussion:
A multidisciplinary support to patient is needed, involving specialists professionals who could assist GPs in managing these programs, ensuring that patients receive also the necessary guidance to maintain their good habits.

The Identification of Socio-Economic Barriers (social and financial burden on caregivers) suggests the necessity to integrate these behavioral "nudging" strategies into national health policies as a standard part of preventive care, reducing socio-economic barriers to sports and physical activity by a structural financial aid.

Presentation on 24/10/2026 11:00 in "Poster Session 3: Prevention Beyond the Consulting Room" by Matteo Zecchetto.

Poster / Finished study

Reaching the Public: Information Pathways and Barriers to Participation in a Street-Based Skin Cancer Check

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Keywords: street-based campaign, skin cancer early detection, information channels, participation

Background:
Previous studies have demonstrated that community skin cancer campaigns supported by multiple communication channels (television, newspapers, radio, and printed materials) substantially increase public awareness and stimulate dermatology referrals. However, limited evidence exists regarding which information channels are being used to spread information such as community campaign

Research questions:
To identify effective information pathways and perceived barriers to participation in a street-based skin cancer check, in order to inform strategies for reaching a wider population.

Method:
A qualitative survey was conducted during a one-day public, community-based skin cancer early-detection event. A multidisciplinary team examined 550 pedestrians in a public square using dermatoscopy. Of these, 197 participants completed an anonymous validated survey containing open-ended questions about information sources, expectations, motivations, perceived barriers to participation, and recommendations for encouraging others to attend. Responses were independently reviewed and coded by two researchers and analysed thematically until data saturation was reached.

Results:
Digital media and opportunistic exposure in public spaces were the main information sources. Lack of time, fear, and limited awareness were the predominant barriers. Participants primarily expected professional reassurance and guidance, and emphasized that greater public awareness, multichannel communication, and easily accessible community-based screening events would enhance future participation.

Conclusions:
This study identified key information pathways and perceived barriers to participation in a street-based skin cancer check, providing a basis for strategies to reach a wider population

Points for discussion:
Which communication channels are most effective for reaching people who are less likely to attend preventive skin cancer checks?

How can family medicine and community organisations reduce practical and informational barriers to participation in street-based skin cancer checks?

Presentation on 24/10/2026 11:00 in "Poster Session 3: Prevention Beyond the Consulting Room" by Olha Rusanovska.

Poster / Finished study

Ageism in Physicians' Attitudes Toward Older Patients: A Qualitative Study

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Keywords: Ageism, Physician attitudes, Stigma

Background:
Healthcare for older patients requires speciphic approaches due to challenges like multimorbidity and communication barriers. However, clinical ageism may manifest by attributing symptoms solely to aging and consequently overlooking them, or by displaying prejudicial attitudes.

Research questions:
How do physicians' communicate with older patients, their experiences in healthcare delivery, and their attitudes within the context of ageism?

Method:
Through maximum variation sampling, in-depth interviews were conducted with 14 physicians of various specialties and seniorities at Marmara University Prof. Dr. Asaf Ataseven Hospital. Utilizing a semi-structured interview guide based on ageism literature, the open-ended interviews were audio-recorded with informed consent and anonymously transcribed. Data were then evaluated using thematic analysis.

Results:
Physicians' attitudes and experiences regarding older patients were grouped into five main themes:1-Prejudices related to aging: Some physicians perceived older adults as individuals who exaggerate symptoms and have high expectations. Consequently, symptoms were sometimes overlooked and attributed solely to old age 2-Age-specific communication strategies: Physicians tended to use a gentle, friendly tone and devote more time to older patients, though mutual communication difficulties negatively affected interactions 3-Challenges in healthcare delivery: Clinical processes were complicated by multimorbidity, increased time requirements, and mal-treatment adherence issues 4-Need for an authoritarian approach: Physicians demonstrated a tendency to assume a more authoritarian and directing role during interactions 5-Presence of cognitive problems: The cognitive difficulties of older patients significantly impacted the overall clinical process.

Conclusions:
Physicians' attitudes toward older patients are influenced by their own prejudices regarding aging, alongside external factors like time constraints, communication barriers, and infrastructural conditions. The reflection of ageism in clinical practice may lead to the neglect of patients' symptoms or the adoption of authoritarian approaches. Enhancing physicians' awareness of ageism and implementing structural improvements are essential for providing high-quality healthcare to older adults.

Points for discussion:
Through these results can we suggest a tool to improve the approach for Physicians to igive healthcare for the elderly?

What are the limitations and the weak Points of the Study that can be improved?

Presentation on 24/10/2026 11:00 in "Poster Session 4: Maintaining Function, Supporting Recovery" by Ahmet Furkan Akyürek.

Poster / Ongoing study with preliminary results

Assessment of Neurocognitive Decline in Primary Care

János Zsuffa, Krisztián Vörös, Csenge Hargittay, Anna Krolopp, Zoltán Lakó-Futó, Ágnes Szélvári, Bernadett Márkus, Flóra Lendvai, Bálint Kabella, Lilla Németh, Péter Torzsa

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Keywords: Neurocognitive Disorders; Mild Cognitive Impairment; Primary Health Care; Screening; Digital Technology

Background:
Neurocognitive disorders pose a significant public health burden but often remain undetected at an early stage. Since several risk factors are modifiable, primary care plays a crucial role in prevention, screening, and management.

Research questions:
This study investigated the prevalence of cognitive decline and its associated demographic, lifestyle, health, and digital factors among patients aged 65 and older in a general practitioner practice in Budapest.

Method:
This cross-sectional study included 214 adult patients. Cognitive performance was measured using the education-adjusted Montreal Cognitive Assessment. Mood symptoms were assessed via the Hospital Anxiety and Depression Scale, while sociodemographic, lifestyle, health, and digital habits were recorded using a self-administered questionnaire. Data were analyzed using Spearman’s rank correlation.

Results:
The participants' mean age was 75.8±7.2 years; 66.8% were women, and 59.8% held a college degree. The mean Montreal Cognitive Assessment score was 26.6±2.5. Suspected cognitive impairment was identified in 29.9% of participants using the standard <26 cutoff, andin 9.4% using a stricter <24 cutoff. Montreal Cognitive Assessment scores correlated negatively with age, but showed significant positive associations with mobility, self-care, quality of life, better mood, good general health, subjective cognitive assessment, and daily digital device use ($p<0.05$). Education and chronic disease count showed no significant associations.

Conclusions:
The Montreal Cognitive Assessment is an effective primary care screening tool. Our results emphasize the importance of comprehensive, lifestyle-oriented prevention. The link between digital device use and cognition could inspire computer-based screening, monitoring and training programs in primary care.

Points for discussion:
Early-stage neurocognitive decline is highly prevalent in general practice and requires structured screening to be detected.

The significant links between cognitive performance and functional, lifestyle, and digital factors highlight the necessity of a multifactorial approach.

The link between digital device use and cognition could inspire computer-based screening, monitoring and training programs in primary care.

Presentation on 24/10/2026 11:00 in "Poster Session 4: Maintaining Function, Supporting Recovery" by János Zsuffa.

Poster / Finished study

Frailty, Functional Performance and BMI in older people at Risk of Hospitalisation

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Keywords: Primary health care, Aging, Frailty, Functional status, Body Mass Index

Background:
Frailty is characterised by impaired physiological reserves and increased vulnerability to several adverse health outcomes. From a clinical perspective, it is essential to accurately identify individuals with frailty with the highest possible precision as this enables targeted interventions for those who are most likely to benefit from health-promoting measures.

Research questions:
This study aimed to explore the relationship between age, BMI, performance on functional tests and frailty assessed with Clinical Frailty Scale (CFS) in older people at risk of hospitalisation in Swedish primary care.

Method:
This study is based on baseline data from the prospective matched-controlled clinical multi-centre trial: Secure And Focused primary care for older pEople (SAFE) with community-dwelling individuals 75 years and above, with the approximately 15 % highest risk of hospitalisation in Swedish primary care. A comprehensive geriatric assessment including an estimation of the level of frailty with CFS and three functional tests: Timed Up and Go (TUG), 30 second Chair Stand Test and test of hand-grip strength was performed.

Results:
A total of 999 individuals (445 women and 554 men) with mean age 84 years participated. We found an increasing degree of frailty assessed with CFS with increasing age, and in people both with underweight and with obesity. One third of the participants were unable to complete one or more of the functional tests. TUG was the functional test that demonstrated the strongest correlation with CFS, and the best discriminatory ability in identifying frailty with AUC 0.75 (95% confidence interval 0.71 – 0.79) in the ROC analyses.

Conclusions:
This study enhances the understanding of functional performance and BMI in relation to frailty, emphasising the use of TUG in identifying frailty. These findings may inform targeted interventions to improve physical capacity and counteract malnutrition in older people at risk of hospitalisation in primary care.

Points for discussion:
How can we identify individuals with frailty with good precision in primary care?

Is it practical and feasible to incorporate functional performance testing into routine primary care visits?

Presentation on 24/10/2026 11:00 in "Poster Session 4: Maintaining Function, Supporting Recovery" by Maria Samefors.

Poster / Ongoing study with preliminary results

Life-time prevalence of polymyalgia rheumatica and temporal arteritis in a population-based primary care cohort of rural Swedish women born 1901-1931

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Keywords: Polymyalgia rheumatica; temporal arteritis; giant cell arteritis; lifetime occurrence; population-based cohort; primary care; fragility fractures; glucocorticoids; rural health; Sweden

Background:
Nordic populations have the world´s highest incidence and prevalence of polymyalgia rheumatica and temporal arteritis (aka giant cell arteritis). This probably explains why these disorders are primarily treated by Swedish primary care physicians. Diagnosed by high sedimentation rate and/or CRP together with proximal muscular pain in shoulders and hips and often morning stiffness followed by fast successful prednisolone treatment (=ex juvantibus).

Research questions:
What is the life time prevalence for polymyalgia rheumatica and temporal arteritis in rural Swedish older women? What characterizes women with these diagnoses?

Method:
This cohort study is nested within a fall and fracture preventive study of 842 women born 1901–1931 - 83% of the eligible female population — in two rural Swedish municipalities in 2002, followed until death or censoring in June 2026 - observation time 29,000 person-years >50 years of age.
Scanned paper records before 2002 and electronic primary- and secondary-care records thereafter were reviewed to date for 707 women. Polymyalgia rheumatica and temporal arteritis diagnoses, onset age and year, glucocorticoid treatment, survival, cause of death and fragility fractures were registered and descriptive statistics and regression models were applied.

Results:
Of 707 women 84 had polymyalgia rheumatica and 16 temporal arteritis, corresponding to a combined lifetime prevalence of 14% (100/707). Median onset age was 79 years (range 47–96), onset years ranged from 1968-2022. Prednisolone was prescribed from diagnosis until death for 40 of 100 women. No statistically significant differences were observed between women with or without polymyalgia rheumatica/temporal arteritis regarding: Lifespan (92 vs 91 years, p=0.2), Neoplastic disease as cause of death (9% vs 12%, p=0.3), and Fragility-fracture occurrence since baseline (63% vs 57%, p=0.6).

Conclusions:
In this population-based cohort, polymyalgia rheumatica/temporal arteritis life time prevalence was 14%. No clear differences in longevity, cancer related mortality or fragility fractures were observed between women with or without polymyalgia rheumatica/temporal arteritis.

Points for discussion:
Would review of the remaining cohort records materially improve the precision and representativeness of the lifetime-occurrence estimate?

What might the high Nordic occurrence suggest about genetic susceptibility, shared environment and diagnostic practice?

How do polymyalgia rheumatica and temporal arteritis diagnosis, glucocorticoid tapering, specialist access, osteoporosis prophylaxis and long-term follow-up differ across EGPRN countries?

Presentation on 24/10/2026 11:00 in "Poster Session 4: Maintaining Function, Supporting Recovery" by Elias Engström.

Poster / Study Proposal / Idea

Towards Consensus-Based Physical Activity and Rehabilitation Guidance After Organ Transplantation:

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Keywords: Transplantation, rehabilitation, physical activity, barriers, taskdefinition, mixed method research

Background:
Solid organ transplantation is an established treatment for selected patients with end-stage organ failure and some malignancies. Transplantations are increasingly lifesaving for cancerous and non-cancerous diseases. Physical activity and healthy lifestyle behaviours are increasingly recognised as important contributors to recovery and long-term health after solid organ and stem cell transplantation. Despite these benefits, many transplant recipients encounter medical, psychological, social and organisational barriers that limit participation in physical activity. In addition, primary care professionals and community-based sports coaches often lack transplant-specific knowledge and confidence to support recipients effectively. Existing recommendations are fragmented and may not adequately address the needs of patients, healthcare providers and coaches across different transplant populations.

Research questions:
1. What information and support do transplant recipients need to engage in and maintain physical activity after transplantation?
2. What knowledge, competencies and resources do primary care professionals and sports coaches require to support transplant recipients?
3. Which information gaps and priority topics should guide the development of physical activity and rehabilitation guidance after organ transplantation?

Method:
This study is part of a broader multidisciplinary transplantation rehabilitation programme. A mixed-methods approach will be used to identify barriers, facilitators and information needs related to physical activity after transplantation.
A scoping review will synthesise existing evidence on post-transplant physical activity, rehabilitation and community support.
Focus groups and interviews will be conducted with transplant recipients, primary care professionals, sports coaches and transplant centre staff. Recruitment will include both active and less active transplant recipients. Data collection will be initiated during the Belgian Transplant Games (2026–2027) and the World Transplant Games (2027).

Results:
Findings will inform a three-round online Delphi process to establish stakeholder consensus
on priorities and recommendations for future guidance

Conclusions:
The international primary care community should consider multidisciplinary lifestyle rehabilitation for transplantation clients, stimulating physical activity and in collaboration with coaches and transplantation centres.

Points for discussion:
1. What information should be prioritised when assessing the needs of primary care professionals caring for transplant recipients?

2. What could be the main barriers preventing primary care professionals from supporting physically active transplant recipients?

3. Which responsibilities related to physical activity promotion, monitoring and follow-up should be undertaken in primary care, and which should remain within transplant centres?

Presentation on 24/10/2026 11:00 in "Poster Session 4: Maintaining Function, Supporting Recovery" by Lodewijk Pas.

Poster / Almost finished study

Twenty-year fracture outcomes and hospital-care cost analysis after a targeted primary care prevention programme in older women in Sweden

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Keywords: Primary care; fracture prevention; fragility fracture; fall-prevention; physical exercise; older women; cost analysis; healthy ageing

Background:
Fragility fractures often cause disability, mortality, and healthcare costs in older adults. Although primary care–based prevention may help preserve mobility, reduce fracture risk and healthcare use, long-term evidence remains limited.

Research questions:
Can a targeted primary care prevention programme reduce long-term fragility fractures and hospital-care costs among older women?

Method:
In this controlled population-based cohort study with 83% participation, 1,233 women aged 70–100 years (mean 79) were followed from 2002 to 2021. The intervention group (n=434) received a fall-prevention brochure: women at high hip-fracture risk with 2-4 clinical risk factors (n=103) were additionally offered nurse home visits (n=65) and physiotherapist-led groups (n=20), focusing on physical exercise and fall prevention. High-risk women with low heel bone mineral density also received osteoporosis medication (n=37). Controls comprised 799 age-matched women from two comparable municipalities. Fragility fractures, identified from radiology reports, were analysed using Poisson regression. Intervention costs – staff time, travel, osteoporosis medication, and all materials – were compared with hospital-care costs for fractures prevented. All costs were expressed in 2026 EUR.

Results:
Over 20 years, 856 fragility fractures were recorded: 261 among intervention women and 595 among controls. The intervention group had a lower fracture rate (incidence rate ratio 0.79, 95% CI 0.67–0.92), with an estimated 68 fractures prevented. Total programme costs in primary care were estimated at EUR 126,500. With a mean hospital-care cost of EUR 5,600 per fragility fracture, avoided hospital-care costs were estimated at EUR 330,400 (excluding nine prevented vertebral fractures not receiving hospital-care), resulting in net savings of EUR 203,900. Quality-of-life gains were not included in the analysis.

Conclusions:
A risk-tailored, multicomponent primary care programme, in a population-based cohort, was associated with reduction in fractures and substantial hospital-care cost savings over 20 years. Despite its non-randomised design, the findings support further evaluation of integrated fall prevention, exercise, and osteoporosis management in primary care.

Points for discussion:
1. What do we lose when prevention focuses primarily on medication, without improving and sustaining muscle strength, balance and confidence in movement?

2. How can we practically identify high fracture risk and combine the intervention methods – exercise, fall prevention, and osteoporosis management – in primary care?

3. How can this long-term fracture + cost gain study be used for policy decision-makers, by transferring healthcare investments from acute hospital care to primary care?

Presentation on 24/10/2026 11:00 in "Poster Session 4: Maintaining Function, Supporting Recovery" by Daniel Albertsson.

Poster / Almost finished study

Assessment Of Social Determinants Of Health In Primary Care Settings In Europe

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Keywords: Social Determinants of Health; Primary Health Care; Electronic Health Records

Background:
Social Determinants of Health (SDoH) significantly impact health outcomes, yet their assessment in Primary Care (PC) remains non-systematic.

Research questions:
How are SDoH assessed by PC professionals in Europe during clinical practice?
Do SDoH assessment practices and EHR registration differ across countries?
What are the potential barriers that hinder the assessment of SDoH?

Method:
A multilingual cross-sectional survey was conducted (September 2025–June 2026) among PC physicians and nurses. The survey was used 5-point Likert scales to measure SDoH assessment, documentation, and barriers. Independent variables included sociodemographic and professional data. Data were analyzed using descriptive and inferential statistics.

Results:
Preliminary results from 386 professionals (258 physicians, 128 nurses) in Spain (n=237), France (n=77), and Turkey (n=72) are presented as means [95% CI]. Respondents show a high level of agreement on the high impact of SDoH on health (4.70 [4.63–4.77]). Globally, professionals report frequent socioeconomic-focused patient interviews (3.69 [3.59–3.79]) and multidisciplinary coordination (3.66 [3.55–3.77]), whereas standardized screening (2.21 [2.10–2.32]) and coded documentation (2.08 [1.96–2.20]) are infrequent. Spain shows higher means for registration, coding, and coordination (all $p < 0.001$), while France scores higher in the socioeconomic determinant-focused interview ($p < 0.001$). 80.3% of participants lack knowledge of specific assessment tools, and coded documentation capabilities differ significantly by country ($p < 0.001$). Primary barriers include lack of time (4.15 [4.06–4.24]), insufficient training (4.11 [4.03–4.19]), and limited resources (3.98 [3.89–4.07]). Spain scores highest for lack of time ($p < 0.001$), while Turkey reports the highest patient-related barriers($p = 0.002$) and lack of multidisciplinary collaboration ($p < 0.001$). Lack of resources is consistent across all countries ($p = 0.648$).

Conclusions:
- Professionals acknowledge the significant impact of SDoH on health, yet persistent gaps remain between patient inquiry and systematic EHR documentation.
- Differences between countries are observed regarding clinical practice, documentation of social determinants, and the identification of barriers.

Points for discussion:
Discrepancy Between Awareness and Systematic Practice

Future strategies to address barriers.

Presentation on 24/10/2026 11:00 in "Poster Session 5: Mental Health in a Connected World" by Dúnia Bel Verge.

Poster / Finished study

Problematic Video Game Use and Online Gaming Among Adolescents

María Rey-Grandal, Vicente Romo-Pérez, Gabriel Iglesias-Caride, María Victoria Delgado-Martín, Sarai Rodríguez-Alvarado, Juan López-Barreiro, Ana Clavería, Lucía González Puga, Ismael Calvo-Alonso, Laura Iglesias-Gómez, Luis Lago-López, María Del Carmen Rodríguez-Estévez, Verónica Rodríguez-García

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Keywords: Adolescents, Video games, Gambling, Mental health, Prevalence

Background:
Video game addiction among adolescents is a growing public health problem with associated psychosocial consequences.

Research questions:
What is the prevalence of problematic use and potential addiction to video games and online gaming among high school students, and what is the association between this phenomenon and psychosocial risk factors, as well as its impact on mental health?

Method:
A descriptive, cross-sectional study based on anonymous questionnaires processed using the REDCap platform. Between July 2025 and May 2026. The target population consisted of students at public high schools in the Vigo health district. The study included a final sample of 278 cases (mean age 16.27 years; 57.2% female), exceeding the minimum of 217 required for a 95% CI (margin of error ±5%). The GASA and BAGS scales were used as primary measures to assess the prevalence of pathological gambling and betting. Secondary variables were also analyzed using the PHQ-9, LUCAD-R3, and SSSC instruments.

Results:
The prevalence of problematic/pathological video game use was 4.7%. Men had higher scores for pathological/problematic gaming (8.4% vs. 2.5%; 95% CI: 0.107–0.372). No significant differences were found based on area of residence. Problematic video game use was confirmed as a direct predictor of lower perceived social support (95% CI: 0.759 – 0.828), while locus of control proved to be a strong predictor of depressive symptoms (95% CI: 0.803 – 0.862). In addition, 11.2% require clinical evaluation for loss of control in gambling.

Conclusions:
Behavioral addictions affect perceived social support. Gender is a critical determinant of the risk profile, unlike the residential environment, which does not show a significant influence. A gender-specific clinical approach is recommended, along with strengthening the locus of control as a protective factor against depression and implementing gambling screenings in primary care. These results suggest that emotional support should be prioritised for women and impulse control for men.

Points for discussion:
The differences compared with other studies are due to the instrument used (GASA), the age of the sample or cultural differences

Preventive strategies should be gender-sensitive

Strengthening self-efficacy and perceived control could act as a protective factor.

Presentation on 24/10/2026 11:00 in "Poster Session 5: Mental Health in a Connected World" by María Victoria Delgado-Martín.

Poster / Ongoing study with preliminary results

Relationship between problematic video game use and involvement in cyberbullying behaviors.

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Keywords: technology addiction, adolescent, cyberbullying, video games

Background:
Cyberbullying and problematic video game use are relevant concerns during adolescence. Previous research has linked gaming-related variables with cyberbullying involvement, although the role of gaming time, compared with problematic patterns of video game use, requires further clarification.

Research questions:
Is problematic video game use associated with greater involvement in cyberbullying among adolescents? Does this association differ between cybervictimization and cyberaggression? Does weekly gaming time mediate the relationship between problematic video game use and cyberbullying involvement?

Method:
A community-based, observational, cross-sectional study was conducted within the AQUÉJUGAMOS project. The sample included 410 first-year compulsory secondary education students from schools in Pontevedra, Galicia, Spain. Problematic video game use was assessed using the Game Addiction Scale for Adolescents (GASA). Cyberbullying involvement was measured with the European Cyberbullying Intervention Project Questionnaire (ECIPQ), differentiating between victimization and aggression. Sociodemographic variables, including age and sex, and weekly hours spent playing video games were also collected. Descriptive analyses, linear regression models, and mediation analyses were performed.

Results:
Mean weekly video game use was 6.75 hours (95% CI: 5.83–7.70), with a median of 4 hours. Overall, 7.6% of participants met criteria for problematic video game use. Most adolescents reported no involvement in cyberbullying (91%); 5% were classified as victims and 0.2% as aggressors. Problematic video game use was positively and significantly associated with cybervictimization ($p < 0.01$; adjusted $R^2 = 0.040$) and cyberaggression ($p < 0.01$; adjusted $R^2 = 0.023$). Mediation analysis showed that problematic video game use was significantly associated with both cyberbullying involvement and weekly gaming time. However, weekly gaming time was not directly associated with cyberbullying involvement.

Conclusions:
Problematic video game use was associated with greater involvement in cyberbullying, both in terms of victimization and aggression. These findings suggest that problematic gaming patterns may be more relevant than gaming duration alone.

Points for discussion:
Should preventive strategies focus more on problematic gaming patterns than on gaming duration alone?

Could early identification of problematic video game use help reduce adolescents' involvement in cyberbullying?

What contextual or psychosocial factors might explain the association between problematic video game use and cyberbullying?

Presentation on 24/10/2026 11:00 in "Poster Session 5: Mental Health in a Connected World" by Sarai Rodríguez-Alvarado.

Poster / Finished study

Relationship Between Video Game Use and Psychological Well-Being in Adolescents: A Mediation Analysis of Problematic Video Game Use

Sara Seguín Otero, Anxo Costa Posada, Rosalía Del Carmen Pino López, Zaira Santa Gómez, Senen Prieto Martínez, Laura Centeno García

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Keywords: Video Games, Mental Health, Adolescent, Psychology, Surveys and Questionnaires.

Background:
Video games constitute the central leisure activity of adolescents globally.
The WHO and DSM-5 recognize Gaming Disorder as an issue, based on criteria that consider hours of use but also the impact on daily functioning.

Research questions:
Is there a relationship between the hours of use of video games and psychological well-being in adolescents?

Does GASA act as a mediating variable in this relationship?

Method:
Participants: 397 students in their first year of secondary education.
Instruments: Self-administered questionnaires to assess gaming time, Gaming Addiction Scale for Adolescents (GASA) and Ryff Scale for Psychological Well-Being.

Statistical analysis: Mediation analysis and linear regression were performed using JASP.

Results:
Prevalence of problematic gaming was 7.3% (95% CI: 4.7%–9.9%), with a higher prevalence among males (9.76%; 95% CI: 5.6%–13.9%) than females (4.69%; 95% CI: 1.7%–7.6%). Males spent significantly more hours gaming per week than females (mean: 3.3 vs. 2.1 hours; mean difference = 1.2; 95% CI: 0.2–2.2; $p < 0.01$), as well as on weekends (mean: 4.5 vs. 2.6 hours; mean difference = 1.9; 95% CI: 1.1–2.7; $p < 0.01$).

Gaming time alone did not directly predict psychological well-being ($p > 0.05$). However, mediation analysis demonstrated a significant indirect effect of weekend gaming time on psychological well-being, mediated by problematic gaming as measured by the GASA ($p < 0.001$). Likewise, problematic gaming was inversely associated with psychological well-being measured by the Ryff Scale ($\beta = -0.286$; 95% CI: −0.384 to −0.188; $p < 0.001$).

Conclusions:
Adolescents' psychological well-being appears to depend less on the amount of time spent playing video games than on the nature of their gaming behavior.
Weekend gaming time predicted problematic gaming, which in turn was associated with poorer perceived psychological well-being. These findings highlight the importance of identifying and preventing problematic gaming behaviors as part of community health strategies aimed at promoting adolescent mental well-being.

Presentation on 24/10/2026 11:00 in "Poster Session 5: Mental Health in a Connected World" by Rosalía Del Carmen Pino López.

Poster / Finished study

The Effect of Patient-Centred Follow-up Interviews on Anxiety and Self-Efficacy in Patients with Chronic Wounds

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Keywords: Anxiety; BATHE; chronic wound; patient-centred care; self-efficacy

Background:
Chronic wounds require long-term care, regular follow-up, and active patient participation. Pain, limited mobility, odour, exudate, and fear of complications may increase psychosocial burden and anxiety. Brief, structured, patient-centred interviews may help identify psychosocial concerns and strengthen patients' confidence in managing their condition.

Research questions:
Do brief, structured follow-up interviews modelled on the BATHE approach reduce anxiety and improve self-efficacy in patients with chronic wounds compared with standard wound care alone?

Method:
This non-randomised controlled intervention study was conducted between July and December 2025. A total of 64 participants were enrolled, and 40 completed the study, including 20 in the intervention group and 20 in the control group. The intervention group received standard wound care plus brief, structured BATHE-based interviews at weeks 0, 2, 4, 6, and 8. The control group received standard wound care only. Anxiety and self-efficacy were assessed at baseline and week 8. Non-parametric statistical tests were used, and $p<0.05$ was considered statistically significant.

Results:
In the intervention group, anxiety scores decreased from 47.2±7.6 to 39.8±7.5 ($p<0.001$), while no significant change was observed in the control group. Self-efficacy increased from 5.7±1.7 to 7.6±1.2 in the intervention group ($p<0.001$), whereas the change in the control group was not significant. Between-group comparisons demonstrated a greater reduction in anxiety and a greater improvement in self-efficacy in the intervention group.

Conclusions:
BATHE-based interviews to standard chronic wound care was associated with reduced anxiety and improved self-efficacy. This brief, low-cost, patient-centred approach may support continuity of care and active patient participation in long-term chronic wound management.

Points for discussion:
Do you offer any more analysis?

What is the strenth and limitations of This Study?

Presentation on 24/10/2026 11:00 in "Poster Session 5: Mental Health in a Connected World" by Nurgül Übeyitoğulları.

Poster / Finished study

The impact of resilience and self-care on mental health: rural-urban differences

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Keywords: Mental health, resilience, self-care, rural, urban.

Background:
Resilience and self-care are two of the factors that have the greatest influence on mental health issues. In this study, we will examine their impact primarily on depressive and anxiety disorders, whilst also analysing whether there is a significant difference between rural and urban settings.

Research questions:
To analyze the role of resilience and self-care in anxiety and depression.

To determine whether there are differences between rural and urban settings.

Method:
A descriptive cross-sectional study was conducted on a randomsample of 350 people aged 35 to 74. Sociodemographic, clinical, and lifestyle variables werecollected. Resilience was measured using the Connor-Davidson scale, and arousal using the PAM-13. Anxiety was assessed using the GAD-7 and depression using the PHQ-9.

Results:
53.4% (95% CI: 48–58.8) of the sample were women, with a median age of 54 years (IQR: 18). 16.9% (95% CI: 12.8–21) had mood disorders (anxiety, depression), 14.4% (95% CI: 10.5; 18.2) had moderate-to-severe anxiety, which was more common in women, and 13.6% (95% CI: 9.8; 17.3) exhibit moderate-to-severe depressive symptoms. Higher self-efficacy was associated with less severe depressive symptoms and lower anxiety levels, with both relationships being highly significant ($p < 0.001$). Higher scores on the resilience scale were associated with lower severity of depressive and anxiety symptoms ($p<0.001$.We did find statistical significance on the anxiety scale between urban and rural areas, with medians of 4 (IQR:6) and 2 (IQR:7), respectively, and on the SF-12 mental health scale, with medians of 55.06 (IQR:9.81) and 57.03 (IQR:8.55) for urban and rural areas, respectively.

Conclusions:
Resilience and self-care act as protective factors against depression and anxiety, reducing both their prevalence and the severity of their symptoms. The differences between rural and urban settings are largely inconsistent, with alcohol consumption and self-care playing a more significant role in rural areas.

Points for discussion:
The importance of resilience in mental health

The importance of self-care in mental health and

Are there differences in how we take care of our mental health depending on our environment?

Presentation on 24/10/2026 11:00 in "Poster Session 5: Mental Health in a Connected World" by Álvar Sáez Marina.

Poster / Ongoing study with preliminary results

Agreement between artificial intelligence-driven chatbots and primary care physicians in deprescribing decision-making: preliminary results from a case vignette study

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Keywords: Artificial intelligence, chatbot, deprescribing, potentially inappropriate medication, primary healh care

Background:
The performance of artificial intelligence (AI)-driven chatbots, such as ChatGPT and Gemini, has been explored in several areas of healthcare, but the extent to which their responses align with primary care physicians' deprescribing decision-making (i.e., medication discontinuation or dose reductions) has not previously been investigated.

Research questions:
To what extent do AI-driven chatbots agree with primary care physicians in deprescribing decision-making in multimorbid older patients in primary care?

Method:
Forty case vignettes of older patients (≥65 years, ≥5 medications) attending a primary health care centre were constructed by two general practitioners (GPs). Two other GPs then assessed the cases, independently followed by consensus discussions. Their assessments included whether potentially inappropriate medications (PIMs) were present and whether deprescribing was warranted. One author then prompted all cases in ChatGPT 5.4. and Gemini Plus. The agreement between the AI-driven chatbots and the GPs' consensus decision was assessed.

Results:
Among the 40 case vignettes (53% women; age: 65–92 years; total number of medications: 281, range: 5–14), the two GPs in consensus identified ≥1 PIM, and ≥1 medication for deprescribing in 38 cases. ChatGPT and Gemini identified ≥1 PIM in 37 cases and ≥1 medication for deprescribing in 38 cases. For identifying ≥1 PIM, percent agreement between ChatGPT and the GPs' consensus was 97%. The corresponding values for identifying ≥1 medication for deprescribing was 100%. For Gemini, percent agreement was 97% for identifying ≥1 PIM, and 100% for identifying ≥1 medication for deprescribing. Medications frequently similarly identified for deprescribing by both chatbots and the GPs' consensus were omeprazol (n=6), furosemide (n=4), and acetylsalicylic acid (n=4).

Conclusions:
AI-driven chatbots show substantial agreement with GPs' consensus decisions in identifying cases with PIMs and medications for deprescribing. Further analyses are required to evaluate the extent of agreement at the medication level, as well as the rationale underlying these decisions.

Points for discussion:
To what extent do primary care physicians use AI-driven chatbots for pharmacotherapeutic decision-making including the identification of inappropriate medications and deprescribing recommendations?

Would access to AI-driven chatbots that do not transmit patient data externally facilitate the integration of AI into clinical pharmacotherapy and deprescribing practices?

Presentation on 24/10/2026 11:00 in "Poster Session 6: Prevention, Cardiovascular Risk and Safer Prescribing" by Maria Axelsson.

Poster / Ongoing study no results yet

Cardiovascular Events Following Corticosteroid Injections: A Pilot Cohort Study

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Keywords: Injections, Intra-Articular; Primary Health Care; Cardiovascular Diseases

Background:
Corticosteroid injections are widely used in Primary Care (PC) for the management of musculoskeletal conditions, including osteoarthritis, tendinopathies, and local inflammatory disorders. Although they are generally considered safe and effective for pain relief and functional improvement, emerging evidence suggests that locally administered corticosteroids may produce transient systemic effects. Observational studies have reported a possible increase in the risk of major adverse cardiovascular events (MACE), including acute coronary syndrome, ischaemic stroke, and heart failure, during the days following injection. Given the high frequency of this procedure in PC and the cardiovascular vulnerability of many patients, further research is needed.

Research questions:
Are corticosteroid injections associated with an increased short-term risk of MACE among patients attending PC? Does the risk vary within 7, 30, and 90 days following injection? Which patient characteristics are associated with a higher risk? Is there a cumulative association between the number of corticosteroid injections received and the risk of MACE?

Method:
Retrospective pilot cohort study between 2005-2025 with a 3-months follow-up. Exposed cohort: patients attending a PC centre aged ≥15 years who received at least one corticosteroid injection. Control cohort: age- and sex-matched of patients without corticosteroid injections during the previous year. The primary outcome will be fatal or non-fatal MACE. Other variables: Sociodemographic characteristics, cardiovascular risk factors, comorbidities, and concomitant medications. Baseline characteristics and event incidence will be described, and incidence rate ratios will be estimated using Poisson regression models.

Results:
Data collection and analysis are currently underway.

Conclusions:
This pilot study addresses the safety of corticosteroid injections in PC, a frequently performed intervention in family medicine. Its results will provide real-world evidence on the cardiovascular safety that may change prescribing decisions, risk assessment, and patient counselling in PC. The findings may support evidence-based clinical decision-making and help optimise the safe use of this common therapeutic procedure.

Points for discussion:
Should patients at high cardiovascular risk be routinely assessed before receiving corticosteroid injections in primary care?

As it is a pilot study, what would be the most appropriate methodological approach to evaluate the short-term cardiovascular safety of corticosteroid injections using real-world primary care data?

Presentation on 24/10/2026 11:00 in "Poster Session 6: Prevention, Cardiovascular Risk and Safer Prescribing" by Maria Rodriguez Barragan.

Poster / Finished study

Health literacy, activation and locus of control in the maintenance of healthy lifestyle habits and health perception

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Keywords: healthy habits, health literacy, health engagement, locus of control, self-perception

Background:
Health literacy—which emphasizes the knowledge needed to understand and make decisions related to one's own health—; empowerment, understood as the capacity and ability to maintain one's own health; and locus of control, which refers to the perception of internal or external control over health outcomes, are key determinants in the adoption and maintenance of healthy habits. Analyzing these variables together allows for a better understanding of how people manage their well-being, perceive their health, and approach self-care.

Research questions:
To analyze the relationship between health literacy, engagement, and locus of control with the maintenance of healthy behaviors and self-perceived health status in the adult population.

Method:
A descriptive cross-sectional study was conducted on a random sample of 300 individuals aged 35 to 74 from the Galician community. Data on health literacy, activation, locus of control, self-perceived health, lifestyle habits, and sociodemographic variables were collected and analyzed. Descriptive and bivariate analyses were performed.

Results:
The sample consisted of a slight majority of women and was similar in age across genders, with a predominance of urban residents, married individuals, and those with a high school education. Lifestyle habits show low to moderate alcohol consumption, a high proportion of nonsmokers, mostly moderate adherence to the Mediterranean diet, and high levels of physical activity. Sleep quality is suboptimal in 40% of participants. Sufficient health literacy and high activation predominate, with generally favorable quality of life and health perception scores and a predominance of internal locus of control.

Conclusions:
The sample demonstrates good health literacy and health engagement, generally favorable habits, and a predominantly internal locus of control, which are associated with a better perception of health, quality of life, and greater involvement in self-care.

Points for discussion:
The Importance of Health Literacy and Patient Empowerment in Maintaining Healthy Lifestyles

The Importance of Locus of Control in Maintaining Healthy Lifestyles

The Importance of Health Literacy, Patient Empowerment, and Locus of Control in Perceptions of Health

Presentation on 24/10/2026 11:00 in "Poster Session 6: Prevention, Cardiovascular Risk and Safer Prescribing" by Carla Estévez Queija.

Poster / Finished study

Structured Pharmacist Consultations Embedded in General Practitioner Practices for Older Statin-Treated Patients: A 12-Month Longitudinal Study

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Keywords: Statins; Medication adherence ;Pharmaceutical care; Primary care; Older adults; Drug-related problems

Background:
Older adults receiving long-term statin therapy often have multimorbidity, polypharmacy, and concomitant supplement use, which may increase the risk of statin therapy-related drug-related problems (DRPs). Integrating pharmacists into general practitioner (GP) practices may support the systematic identification of these issues, patient counselling, and GP-pharmacist communication at the point of care.

Research questions:
Is a structured pharmacist consultation model embedded in GP practices feasible, and can it support the identification and follow-up of statin-related adherence issues, drug-related problems, side effects, and lipid outcomes in older adults receiving long-term statin therapy?

Method:
In this randomized controlled trial, patients aged ≥65 years on statin therapy for ≥1 year received usual GP care or usual care plus structured pharmacist consultations at baseline and Months 3, 6, 9, and 12. Consultations included medication review, statin-specific adherence and side-effect assessment, review of prescription/dispensing records, DRP identification, GP communication when indicated, and lipid parameter recording when available.

Results:
Forty-eight participants completed the baseline pharmacist consultation, and 42 (87.5%) were retained at Month 12. Concomitant medication or supplement use was reported by 93.8% at baseline. Coded statin therapy-related DRPs decreased from 14.6% at baseline to 2.2% at Month 3, 2.3% at Month 6, and 0% at Months 9 and 12; overall, 9 participants (18.8%) had at least one DRP flagged. Patient-reported statin refill and prescribed use remained high, while deviations from prescribed use decreased from 19.1% to approximately 5% by Months 9-12, and statin-related side-effect reports fell from 10.6% to 0% from Month 6 onward. Available lipid data showed substantial inter-individual variability and should be interpreted cautiously.

Conclusions:
Structured pharmacist consultations embedded in GP practices were feasible and supported high retention, sustained patient-reported statin adherence, and systematic identification of statin-related DRPs. The model's main value may lie in point-of-care medication review, early DRP recognition, patient counselling, and coordinated GP-pharmacist care in primary care.

Presentation on 24/10/2026 11:00 in "Poster Session 6: Prevention, Cardiovascular Risk and Safer Prescribing" by Anna Artner.

Poster / Finished study

Utility of Carotid and Femoral Ultrasound in Primary Care for Dyslipidemic Patients with a Low-to-Moderate Cardiovascular Risk Score

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Keywords: cardiovascular risk, ultrasound

Background:
Cardiovascular risk assessment in primary care relies on prediction models such as SCORE-2. However, these models may underestimate risk in patients with dyslipidaemia. Vascular ultrasound is a non-invasive test that accurately reflects the extent of atherosclerosis in the vascular and coronary systems, particularly in patients at low or moderate risk. However, its role in routine primary care remains unclear.

Research questions:
Is carotid and femoral ultrasound an effective method of improving the classification of cardiovascular risk in patients with dyslipidaemia who are categorised as low or moderate risk according to the SCORE-2 model? What is its association with other cardiovascular risk factors?

Method:
This multicentre, cross-sectional, observational study was conducted at two urban primary care centres in Vigo, Spain. Of the 1,030 patients with dyslipidaemia, those aged 41–74 years with low or moderate cardiovascular risk according to SCORE-2 were selected. All participants underwent bilateral vascular ultrasound scanning of the carotid and femoral arteries to detect atherosclerotic plaques. Demographic, anthropometric, and biochemical variables were compared according to the presence or absence of plaques using the appropriate statistical tests.

Results:
A total of 205 patients were included in the study (76% women). Atherosclerotic plaques were detected in 36.1% of participants (95% CI: 29.8–42.9), with a similar prevalence in both groups but an absolute number almost double among women. Plaques were found with a comparable frequency in the carotid and femoral arteries, while 11.2% of patients had plaques in both vascular territories (95% CI: 7.6–16.3). Women had a significantly higher mean age than men (56.4 versus 43.3 years).

Conclusions:
More than a third of patients with dyslipidaemia and a low or moderate SCORE2 risk seen in primary care had subclinical atherosclerosis detected by vascular ultrasound, suggesting that this technique could contribute to better care.

Points for discussion:
Which primary care patients with low or moderate SCORE2 risk are most likely to benefit from carotid and femoral vascular ultrasound for cardiovascular risk assessment?

Should vascular ultrasound be incorporated into routine cardiovascular risk assessment in primary care, and if so, under which clinical or organisational conditions would it be feasible and cost-effective?

What type of prospective evidence is needed to demonstrate that ultrasound-guided cardiovascular risk reclassification translates into improved clinical outcomes and more appropriate preventive treatment?

Presentation on 24/10/2026 11:00 in "Poster Session 6: Prevention, Cardiovascular Risk and Safer Prescribing" by Carolina Suarez.

Poster / Finished study

A polyvalent tool for breaking bad news developed using the Delphi method - PRIESO protocol

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Keywords: PRIESO, Breaking bad news, medical training, medical education

Background:
Breaking bad news is a delicate moment that is essential to master in the doctor-patient relationship. Several protocols exist. Many studies have tried to adapt them to specific contexts (oncology, pediatrics, palliative care, etc.). This work gathered experts from different specialties and practice settings to develop a polyvalent tool.

Research questions:
Can an expert consensus using a Delphi methodology establish a generic, multidisciplinary protocol for breaking bad news applicable across healthcare professions, medical specialties, and clinical settings?

Method:
The main objective was to develop an expert consensus on the content of an announcement protocol that could be used by all healthcare professionals.
To achieve this, we used a three-round DELPHI method. Fifty-two participants from all specialties, working in hospitals and in city medical offices, evaluated and commented on 37 items based on a narrative review of the literature.

Results:
After quantitative and qualitative analysis of the results obtained, 41 items were validated. These items are divided into 6 parts : "Preparing for the interview", "Building a therapeutic relationship: assessing the patient's perception and seeking consent", "Delivering information and communicating well", "Managing patient reactions - encouraging and validating emotions", "Presenting the strategy and summarizing the interview" and "Organizing follow-up and care coordination".

Conclusions:
This work has led to the development of a polyvalent protocol for breaking bad news. It is divided into 6 parts, summarized by the acronym PRIESO : Preparing the interview, building a therapeutic relationship, delivering information, encouraging emotions, presenting the strategy and organizing follow-up. It can be used by all caregivers as an interview guide, and is a useful resource for simulation training in breaking bad news.

Points for discussion:
The PRIESO protocol provides the first multidisciplinary, generic framework for breaking bad news that is applicable across healthcare professions, specialties, and clinical settings.

The Delphi methodology enabled the integration of expert perspectives from diverse practice environments, supporting the protocol's relevance and acceptability.

The next step is to evaluate the implementation and effectiveness of the PRIESO protocol in real-world clinical practice and medical education, particularly regarding its impact on communication skills, patient experience, and healthcare professionals' confidence.

Presentation on 24/10/2026 11:00 in "Poster Session 7: Medical Education" by Yaritza Carneiro.

Poster / Ongoing study with preliminary results

Design and Validation of a Community Health Knowledge Questionnaire

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Keywords: Community Health Services, Health Knowledge, Attitudes, Practice, validation studies

Background:
Community care is a competency area included in both Family and Community Medicine and Nursing specialty programs. One way to assess the knowledge acquired in this area is through a knowledge questionnaire

Research questions:
To design a community health knowledge questionnaire for Family and Community Medicine and Nursing residents and to evaluate its validity

Method:
A first version of the questionnaire, consisting of 30 questions with 4 response options, was designed based on different bibliographic sources. It was sent to 19 experts to evaluate the relevance, validity, and level of understanding of each question. The final version was administered to two groups of residents at the Family and Community Care Teaching Unit in Barcelona: residents who had just begun their training (R1) and residents who had completed their training (R2 in Nursing and R4 in Medicine). The scores obtained for each question are quantified to describe ceiling and floor effects, and for each section, means and confidence intervals are calculated. Differences between resident groups and professional profiles were compared using bivariate statistical techniques.

Results:
A total of 10 experts and 111 residents participated.

The final questionnaire, after incorporating the experts' opinions, consisted of 20 questions and 5 sections: general aspects, social determinants of health, health assets, design of a community project, and project evaluation. The average score obtained by the residents was 6.4 out of 10 (maximum), with lower scores in the design (5.9) and project evaluation (4.8) sections. Three questions were answered correctly by 90% or more of the participants.

First-year residents (R1) had lower scores than veteran residents in project design and evaluation, as well as in the total score, with the differences being statistically significant ($p<0.05$).

Conclusions:
The community health knowledge questionnaire is valid in terms of its content and its ability to discriminate between residents of different years of training.

Points for discussion:
Is the area of community health important in the training of residents in other countries?

Is it useful to have a knowledge assessment tool?

How could community health skills be assessed?

Presentation on 24/10/2026 11:00 in "Poster Session 7: Medical Education" by María Isabel Fernández San Martín.

Poster / Finished study

Digital.Pulse: Empowering Medical Students for General Practice 4.0. Qualitative Findings from a Feasibility Study

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Keywords: digital competencies, medical education, general practice, curriculum development, feasibility study, qualitative research, mixed-methods study, digital health

Background:
Digital technologies are integral to general practice and support healthcare delivery and practice organisation. Physicians need to carefully assess the opportunities, limitations, and risks of digital applications in order to ensure patient-cantered care. Digital competencies remain insufficiently integrated into undergraduate medical curricula. Digital.Pulse, funded by Stiftung Innovation in der Hochschullehre (Germany), is developing a structured elective for final-year medical students completing their general practice rotation to strengthen digital competencies.

Research questions:
This qualitative study examined the perceived relevance, feasibility, and practical applicability of Digital.Pulse from the perspectives of final-year medical students and GP trainees and identified areas for curriculum development.

Method:
In a prospective mixed-methods feasibility study, Digital.Pulse was evaluated through semi-structured individual interviews with four course graduates and two GP trainees. The interviews focused on relevance, feasibility, and practical applicability. Data were analysed using Mayring's structuring qualitative content analysis, based on deductively derived and inductively refined categories.

Results:
The findings indicate that digital competencies are highly relevant to final-year medical students and teaching practices. Participants valued the course organisation, involvement of external experts, and interactive, practice-oriented teaching formats. Areas for improvement included scheduling and integration into routine practice. Most students considered online formats more feasible given the time constraints of their clinical placements. Students and trainees emphasised transferring course topics directly into clinical practice.

Conclusions:
The findings suggest that digital competencies are perceived as a relevant educational topic during the final-year general practice rotation. Practical applicability, curricular alignment, and organisational feasibility appear key to the acceptance and value of the elective. The findings provide specific directions for refining Digital.Pulse before the effectiveness phase. Strengthening digital competencies is important and feasible within an elective during the final-year general practice rotation. Teaching practices may also benefit from their students' participation in Digital.Pulse.

Points for discussion:
How should digital competencies be integrated into undergraduate general practice curricula?

Which teaching formats best support the transfer of digital competencies into clinical practice?

How can elective courses be organised to meet the needs of students and teaching practices?

Presentation on 24/10/2026 11:00 in "Poster Session 7: Medical Education" by Arian Karimzadeh.

Poster / Published

Needs analysis of learning objectives for a lifestyle medicine curriculum in family medicine residency program: an E-Delphi study

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Keywords: Lifestyle Medicine, Family Medicine, Core Competencies, E-Delphi, Curriculum Development

Background:
Lifestyle Medicine (LM) plays a critical role in the prevention, treatment, and even reversal of chronic diseases through evidence-based lifestyle interventions. Despite its importance, LM is not yet systematically embedded into family medicine residency training. Current approaches often focus narrowly on behavior change and lack an integrated curriculum framework. This study aimed to identify and reach expert consensus on the core learning objectives necessary for incorporating LM into family medicine specialty education in Turkey.

Research questions:
1. What are the core learning objectives for integrating Lifestyle Medicine into family medicine residency training, and what level of expert consensus can be achieved through the E-Delphi method?
2. Does implementing consensus-based Lifestyle Medicine learning objectives in residency programs improve graduates' clinical competencies and patient outcomes in practice?

Method:
A two-round electronic modified Delphi (E-Delphi) method was employed to gather consensus from a multidisciplinary expert panel. Fifteen participants—including family medicine academicians, practicing physicians, residents, and professionals in medical education, nutrition, and sports medicine—evaluated 114 learning objectives developed by a steering committee through literature review. A 5-point Likert scale was used for scoring. Consensus was defined as ≥80% agreement, a median score ≥4, and an interquartile range (IQR) ≤1.

Results:
In the first round, consensus was achieved for 107 objectives. In the second round, 96 learning objectives reached final consensus, covering eight core domains: introduction to LM, nutrition, physical activity, sleep health, stress management, substance use, sexual health, social relationships, and environmental exposures. The highest agreement was observed in nutrition and physical activity; objectives related to stress regulation, sleep assessment, and environmental policy received lower consensus, indicating areas needing further curricular clarification

Conclusions:
The findings provide a foundational framework for curriculum development and may guide international efforts to integrate LM into postgraduate medical education.

Points for discussion:
The gap between knowledge-based and behavioral objectives in LM education

The boundary problem: what belongs in primary care vs. specialized care?

Generalizability of a Turkish expert consensus to other health systems

Presentation on 24/10/2026 11:00 in "Poster Session 7: Medical Education" by Duygu Ayhan Başer.

Poster / Ongoing study with preliminary results

Perceived incentives and barriers among Family Medicine tutors for engaging in research in primary care: preliminary results of a qualitative study

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Keywords: Internship and Residency; Family Practice; Primary Health Care; Qualitative Research

Background:
Research in Primary Care faces well-known structural and cultural barriers. Residency tutors in Family Medicine (FM) are key figures in training future generations. Research is central to the specialty's training programme and to its advancement. However, little evidence exists on how tutors themselves perceive incentives and barriers to research.

Research questions:
What incentives/motivations and barriers do FM residency tutors perceive for integrating research into their clinical and teaching practice?

Method:
Qualitative phenomenological study. Two focus groups were conducted with residency tutors (n=12) from seven Family Medicine teaching units in Madrid (Spain), through purposive theoretical sampling seeking heterogeneity in age, gender, and research experience. Sessions were audio-recorded, transcribed, and analysed using reflexive inductive thematic analysis: codebook development following joint team readings, coding of transcripts by the principal investigator with review by two additional researchers, and thematic reporting. Triangulation was carried out in three stages: these focus groups (phase 1), a survey of the same population (phase 2), and a member-checking session with participating tutors to validate the interpretation (phase 3).

Results:
Tutors identified curiosity, satisfaction from improving clinical practice, recognition from feeling part of a research team, and, to a lesser extent, professional or academic advancement as the main incentives. Barriers included lack of protected time —research was consistently carried out outside working hours—, limited methodological training, absence of substitute staff, and limited institutional support. Research was perceived as formally expected of tutors without translating into genuine recognition. Mandatory research projects required of residents were experienced as an administrative formality, except when the tutor was actively involved from the outset.

Conclusions:
Tutors show intrinsic motivation to engage in research but lack the structural conditions —protected time, training, and institutional recognition— needed to translate this motivation into sustained research activity.

Points for discussion:
1. How can genuine institutional recognition (protected time, not just a formal expectation) be designed for tutors who conduct research?

2. What role should tutors —beyond residents— play in building a stable research culture in primary care?

3. To what extent are these barriers specific to the Spanish primary care system, or are they transferable to other European primary care contexts?

Presentation on 24/10/2026 11:00 in "Poster Session 7: Medical Education" by Marina Guisado Clavero.

Poster / Finished study

Assessment of interruptions to Primary Care consultation: EIAP study

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Keywords: Interruption; Primary Health Care; Communication skills

Background:
Interruptions during clinical consultations in Primary Care are frequent and inherent to teamwork. Some studies show the frequency of interruptions, the characteristics and/or organizational proposals to reduce them. But there is limited evidence regarding how they are managed by professionals and perceived by patients.

Research questions:
How do healthcare professionals respond to interruptions during clinical practice?
What is the level of patient discomfort?
What communicative needs appear during the interruptions that could lead to formative strategies?

Method:
Quasi-experimental study without control group at a Primary Healthcare Centre. 15 professionals (9 family doctors, 6 nurses) underwent standardized one-minute unexpected interruptions by trained researchers (residents and nursing assistants). Assessment from three perspectives: 1) observation of the interrupter, 2) patients' survey after the consultation, 3) professionals' self-assessment. Variables: communicative quality, perceived stress, level of resolution, ability to continue with the consultation, and emotional perception of patients and professionals.

Results:
59 standardized interruptions (30 clinical, 29 administrative). According to direct observation: 94.9% of professionals showed high assertiveness, 88.1% maintained optimal communication with the interrupter. In 72.9% of the interruptions the patient was ignored during the interaction and in 93.2% no apologies were given. 63.2% of professionals felt comfortable, 21.1% indifferent, and 15.8% uncomfortable. 80.7% picked up the thread of the interview without difficulty and 7% lost it. 94.9% of patients were aware of the interruption and 86.4% felt indifferent, comfortable, or very uncomfortable. Patients with more than 10 years of relationship with the professional showed significantly less discomfort (p=0.036).

Conclusions:
Interruptions generate little discomfort in professionals and patients. Most of the professionals show assertiveness and can resume the interview without losing the thread. The study identifies areas of poor communication, especially in apologizing to the patient. Longitudinality of professional-patient relationships has a protective effect on patients' perception.

Points for discussion:
Are interruptions a problema in medical consultations?

Can a pattern of "good communication" be established during interruptions?

What role do interruptions play in the culture of the Primary Care team?

Presentation on 24/10/2026 11:00 in "Poster Session 8: Primary Care Delivery and Health System Performance" by Enrique Díaz Del Pino.

Poster / Finished study

Audit Of A Regional Protocol For The Management Of Acute Pharyngotonsillitis In Adults In A Primary Care Health Area

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Keywords: pharyngotonsillitis, adult, Primary Health Care, clinical audit

Background:
Currently, training policies, protocols, and incentives are being implemented to minimize the misuse of antibiotics due to the emergence of resistant bacteria. It is important to determine whether these measures are effective in clinical practice, particularly in adults, in primary care, where the percentage of prescribed antibiotics is higher, and to extend these measures to other health regions.

Research questions:
Is the Galician Health Service protocol followed in the diagnosis and treatment of acute pharyngotonsillitis (APT) in adults? What factors influence its adherence?

Method:
Cross-sectional observational study by electronic health record auditing of 500,000 adults, randomized selection. Inclusion criteria: diagnosed with APT, within a one-year period, at health centers and primary care urgent care facilities. Exclusion criteria: incomplete information or those outside the study area.
Variables described using absolute frequencies and percentages, employing the chi-square test (bivariate analysis) and Wilson's method (95% confidence intervals).
Adherence was analyzed as follows: compliance with the diagnostic-therapeutic algorithm; appropriateness of the antibiotic, dosage, and duration; and overall compliance.

Results:
Primary care resident physicians reviewed 378 medical records of patients with APT episodes. Initial management was appropriate in 21.2% (17.3%–25.6%). Among the 271 patients with evaluable treatment, it was correct in 44.6% (38.8%–50.6%). Overall protocol adherence reached 19.3% (15.6%–23.6%). Although 80.2% of patients did not meet the Centor clinical criteria for testing, 49.2% of these patients underwent rapid diagnostic testing nonetheless.
There were no significant differences in appropriateness according to sex, age, or season.
A statistically significant difference in appropriateness was detected according to the point of care ($p = 0.002$): urgent care (59.3%) vs. health centers (38.4%).

Conclusions:
Overall adherence to the protocol is low. Variability among healthcare facilities necessitates enhanced training and standardized criteria. These results allow for the identification of areas for improvement, and involving residents will enhance their training in antibiotic therapy.

Points for discussion:
Does the low compliance reflect a problem with adherence to the protocol or limitations of the protocol itself?

Is it better for antibiotic treatment protocols to be applicable to other countries or to be adapted to local resistance patterns?

What explains the better fit of urgent care facilities compared to health centers?

Presentation on 24/10/2026 11:00 in "Poster Session 8: Primary Care Delivery and Health System Performance" by Alicia Castillo Páramo.

Poster / Ongoing study with preliminary results

Health services use for patients consulting nurse practitioners-lead clinics in primary care. A longitudinal study in Québec, Canada

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Keywords: Primary care nurse practitioner, ER use

Background:
Nurse practitioners (NPs) are a growing workforce with significant potential to improve access to primary care services across the life course and across diseases and conditions. However, in interprofessional primary care settings, some nurses experience practice limitations, reducing their contribution to the response to primary care population needs. In 2022, the province of Quebec, Canada, opened its first “NP-clinics” to improve access to primary care and reduce pressure on emergency departments. The services offered by these clinics is predominantly provided by NPs with a holistic approach. The services are designed to ensure access to the right services, at the right time in the right place and include telehealth. They must also go beyond the provision of acute care and focus on integrated care and care continuity between care settings.

Research questions:
The objective of this study is to examine the effects of 8 participating NP-clinics on the patients’ use of primary care and emergency department services.

Method:
We collected medical-administrative data from all the patients (n=44 304) who consulted at least one time in one of the participating NP-clinics over a 3-year period (2 years before and 1 year after the first consultation). A control cohort was matched on gender, age group, comorbidity index, level of rurality and level of deprivation. Negative binomial models were used to compare pre-post periods and cohorts.

Results:
The results of the analysis of effects using 3 indicators of access to primary care services will be presented for both cohorts. Non-urgent visits to ER decreased after the first consultation to a NP-clinic.

Conclusions:
Our results allow us to evaluate the effects of NP-clinics on the improvement of access to primary care services for the patients, and to compare the results with the patients using general primary care services.

Points for discussion:
What is the contribution of NP-Clinics to primary care services?

How can NPs be integrated to a primary care system?

How can we reduce the use of ER for non-urgent consultations?

Presentation on 24/10/2026 11:00 in "Poster Session 8: Primary Care Delivery and Health System Performance" by Arnaud Duhoux.

Poster / Ongoing study with preliminary results

Preventive Checks in General Practice in Slovakia: Current Status and Future Challenges

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Keywords: preventive checks, preventable conditions, general practice

Background:
In Slovakia, adults are eligible for preventive health checks with general practitioners (GPs) every two years. These examinations are intended to support early detection of common chronic and preventable conditions and form part of a broader system of preventive care that also includes dental and, where appropriate, gynaecological, urological, and gastroenterological examinations. Approximately 1 million preventive GP checks are performed annually in Slovakia, and more than 40% of adults attend at least once within a two-year interval. International evidence shows that preventive checks are widely accepted and commonly delivered in primary care, although formal requirements vary across health systems and the strongest evidence supports targeted, guideline-based prevention rather than indiscriminate routine testing.

Research questions:
To assess the current status and temporal trends of preventive checks in general practice in Slovakia from 2016 to 2024.

Method:
A retrospective quantitative study was conducted using data from the National Health Information Centre. The study population included individuals aged 19 years and older who attended a preventive check in general practice. Descriptive statistical methods were used to analyse participation trends.

Results:
Participation in biennial preventive checks in Slovak general practice increased modestly from 35.5% in 2016 to 44.0% in 2024. In 2024, the highest participation was observed in the 18-24-year age group (24.8%), whereas the lowest participation was recorded among adults aged 25-44 years (20.7%). This pattern is consistent with broader evidence that preventive programme uptake is often uneven and influenced by social, behavioural, and organisational factors.

Conclusions:
General practitioners in Slovakia play a central role in the delivery of biennial preventive checks, including patient invitation, identification of health risks, and follow-up of abnormal findings to support continuity of care. Future policy should focus on sustaining participation above current levels, improving reach in underrepresented groups, and strengthening targeted, evidence-based prevention while preserving efficient use of general practice capacity.

Points for discussion:
Should Slovak preventive checks remain broadly offered to all adults every two years, or should they become more targeted and risk-stratified?

How do evidence-based periodic health exams compare with routine GP screenings?

Presentation on 24/10/2026 11:00 in "Poster Session 8: Primary Care Delivery and Health System Performance" by Ludmila Kutakova.

Poster / Ongoing study with preliminary results

Using EMS data for rural health planning: the June 2026 heatwave as a first IRIS use case

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Background:
Rural regions face ageing populations and thinning primary care coverage, while local health authorities struggle in public health planning. Emergency medical services (EMS) document every emergency in a standardised format, yet these data are used for billing and rarely for population health planning. Whether they can inform local planning is untested.

Research questions:
Can EMS data be used for public health planning at district level? What do such data reveal about health service demand during an extreme event, taking the record-breaking June 2026 heat wave as a first use case?

Method:
The IRIS project builds an interoperable, anonymised data infrastructure between the EMS and the public health department of the rural district of Helmstedt, Lower Saxony (89,771 residents). Using this infrastructure, we analyze EMS missions constantly for various questions. To assess the impact of the heat wave (24–28 June) daily mission counts were modelled with quasi-Poisson regression adjusted for weekday, reporting incidence rate ratios (IRR) with 95% confidence intervals, complemented by negative binomial, time-trend-adjusted, leave-one-day-out and single-day lag models.

Results:
Of 2,684 missions in a 67 days period, 267 occurred during the five heat-wave days (mean 53.4/day) versus 39.0/day otherwise. The heat wave was associated with a 36% higher mission rate (IRR 1.36; 95% CI 1.16–1.59), robust across all sensitivity analyses (IRR 1.31–1.42), and demand remained elevated three days afterwards (IRR 1.22; 95% CI 1.02–1.46). Data were available within days, whereas mortality statistics take months.

Conclusions:
EMS data can be made usable for rural health planning and detect health impacts far earlier than established surveillance, offering primary care and public health a timely planning and response instrument.

Points for discussion:
1. Which other primary care routine data can feed into a municipal infrastructure like this, and what obstacles would you expect in your country?

2. How can practices, public health departments, and EMS be linked so that findings translates into prevention?

3. Every mission is geolocated, so we can map clusters. Beyond heat, we are working on infection outbreaks, alcohol- and drug-related emergencies, and psychiatric crises. What other use cases do you see?

Presentation on 24/10/2026 11:00 in "Poster Session 8: Primary Care Delivery and Health System Performance" by Linda Hoffmeister.

Freestanding Paper / Finished study

Governing the Loop: Three Architectures for AI Systems That Co-Produce Clinical and Administrative Reality

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Keywords: artificial intelligence governance; clinical documentation; healthcare ontology; self-evolving agents; reification feedback loop

Background:
AI systems trained on Minimal Medical Data Sets (MMDS) risk internalising administrative patterns as clinical reality. MMDS entries are not recorded but constructed through continuous negotiation between clinical observation and billing requirement. Self-evolving agents that modify their own architectures turn this data-quality problem into a governance crisis.

Research questions:
What do AI systems actually learn from coded health data, and how should the clinical-versus-administrative weighting of self-evolving clinical AI be made explicit and governed?

Method:
We characterise a reification feedback loop linking documentation requirements, coded data, and AI outputs. We define three governance architectures, Clinical-first (0.8), Equilibrium (0.5/0.5), and Business-first (0.8), and illustrate their behaviour computationally on synthetic electronic health records over five feedback cycles.

Results:
The three architectures produced measurably different drift trajectories. Business-first amplified coding distortion 17 times, Equilibrium 21 times, and Clinical-first only 2 times. Equilibrium, despite the lowest single-cycle distortion, showed the highest cumulative amplification, indicating that balanced weights alone are insufficient without architectural safeguards. Self-evolving agents removed the corrective mechanisms present at earlier stages.

Conclusions:
The clinician's question "symptom or billing rule?" is now also an AI architecture decision with population-level consequences. Making the clinical-versus-administrative weighting explicit is a prerequisite for governing self-evolving AI in clinical documentation.

Points for discussion:
How can requisite clinical variety be preserved when administrative reward signals are immediate while clinical outcomes are delayed?

Should regulators require explicit, auditable reward-weighting disclosure for self-evolving clinical AI?

What real-world validation would move this from synthetic illustration to deployable governance?

Presentation on 24/10/2026 13:30 in "Parallel Session L - Freestanding Papers: Interesting Methodology Session" by Odi Stummer.

Freestanding Paper / Almost finished study

How Patients' Words Can Become Biomarkers: Narrative Phenotyping with the Human Phenotype Ontology in Long COVID

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Keywords: Long COVID; Primary care; Narrative medicine; Human Phenotype Ontology; Phenotyping; Artificial intelligence.

Background:
Long COVID remains a clinical diagnosis despite the absence of validated biological biomarkers. In primary care, diagnosis is largely based on patients' narratives collected during repeated consultations. Although these narratives determine inclusion in research cohorts, they are rarely incorporated into subsequent biological research. Recent advances in natural language processing and biomedical ontologies provide an opportunity to transform patients' descriptions into structured, computable phenotypic data.

Research questions:
Can narrative phenotyping using the Human Phenotype Ontology (HPO) transform patients' words into reproducible phenotypic biomarkers that complement biological investigations in Long COVID?

Method:
Since 2021, a prospective primary care cohort of more than 450 patients with clinically recognised Long COVID has been followed using recorded narrative consultations. Patient narratives were transcribed, automatically annotated using artificial intelligence, mapped to HPO concepts, and systematically reviewed by physicians to ensure semantic accuracy. The resulting corpus preserves both patients' original expressions and standardised phenotypic terminology.

Results:
Despite considerable linguistic diversity, recurrent clinical narratives converged towards reproducible HPO phenotypes, including post-exertional malaise, cognitive dysfunction, sensory hypersensitivity, autonomic dysfunction and altered interoception. Ontology-based annotation enabled longitudinal follow-up, comparison between patients and interoperability with electronic health records. It also created a structured clinical phenotype suitable for integration with imaging, transcriptomic and immunological datasets, allowing patient narratives to remain part of the research process rather than being discarded after cohort recruitment.

Conclusions:
Narrative phenotyping provides a bridge between the clinical reasoning of general practitioners and precision medicine. By transforming patients' words into computable phenotypic biomarkers, primary care narratives become reusable scientific data that can complement biological biomarkers and support translational research in Long COVID.

Points for discussion:
Should patient narratives be considered a source of phenotypic biomarkers in primary care research?

How can ontologies such as HPO strengthen the contribution of general practice to precision medicine?

Can narrative phenotyping improve interoperability between primary care, hospital research and artificial intelligence?

Presentation on 24/10/2026 13:30 in "Parallel Session L - Freestanding Papers: Interesting Methodology Session" by Serha Soylu.

Freestanding Paper / Finished study

Impact of a performance-based prescribing incentive on national drug consumption in a non-gatekeeping health system: an interrupted time series study

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Keywords: Interrupted time series analysis; Drug utilization; Proton pump inhibitors; Prescribing; Health policy; Primary care

Background:
Proton pump inhibitors (PPIs), NSAIDs and antibiotics are among the most frequently prescribed medicines and are widely overused. Financial incentives are used to steer prescribing, but their real-world effect on national consumption is rarely quantified particularly in non-gatekeeping systems, where patients access specialists directly and family physicians are only one source of prescriptions. In November 2024 Turkey introduced a performance-based payment regulation targeting PPI prescribing by family physicians.

Research questions:
Did regulation change national consumption of the incentive-targeted class (PPIs) and of other anti-inflammatory and antibiotic classes?

Method:
National interrupted time series study using monthly IQVIA pharmaceutical sales (2015–2025; 132 months), converted to WHO defined daily doses per 1000 inhabitants/day (DID). Although the incentive targeted family physicians, evaluation used country-wide sales covering all prescribers. All groups were analysed separately, with thyroid hormones as a non-equivalent control and COVID-19 case counts as a covariate; the outpatient (retail) channel was primary. The main analysis was segmented regression with SARIMA errors (immediate level change at November 2024); robustness was assessed with heteroskedasticity-consistent errors, Bayesian structural time series, placebo-in-time testing and fully Bayesian estimation. A secondary analysis examined substitution towards H2-antagonists (famotidine).

Results:
By SARIMAX, PPI consumption fell abruptly (−31.4 DID; 95% CI −46.2 to −16.5). NSAID use declined (−14.0 DID; 95% CI −22.0 to −5.9); antibiotic consumption showed no significant change (−5.1 DID; 95% CI −13.4 to 3.1). All robustness methods supported these findings, and placebo testing confirmed they were date-specific. In the secondary analysis, famotidine rose significantly (+2.5 DID; 95% CI 1.7 to 3.3) but replaced only ≈10% of the lost PPI volume; the thyroid control was unchanged.

Conclusions:
In a non-gatekeeping system, a prescribing incentive targeting family physicians produced a substantial reduction in national PPI and NSAID consumption, with only partial substitution and no effect on antibiotics.

Points for discussion:
What role should family physicians play in designing prescribing incentives that affect their own practice?

Does a rapid, large fall in PPI prescribing risk leaving high-risk patients (e.g., on NSAIDs or anticoagulants) without needed gastroprotection?

How transferable are performance-based prescribing policies across countries with different reimbursement structures and prescribing cultures?

Presentation on 24/10/2026 13:30 in "Parallel Session L - Freestanding Papers: Interesting Methodology Session" by Sena Tunç.

Freestanding Paper / Finished study

Latent Genetic Liability To Internalizing Disorders And Total Medıcation Burden: Evidence From Genomic Sem And Mendelian Randomization

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Keywords: Mendelian randomization; internalizing psychopathology; polypharmacy; genomic structural equation modelling; genetic liability; medication burden; primary care

Background:
Polypharmacy and multimorbidity are among the defining challenges of contemporary primary care, where most long-term prescribing and deprescribing decisions are made. Internalizing conditions, depression, anxiety, PTSD, and the related trait neuroticism are among the commonest presentations in general practice and are observationally linked to greater medication use, but confounding and reverse causation leave the relationship's causal status unresolved.

Research questions:
Does the shared genetic liability to internalizing psychopathology causally increase a person's total medication burden?

Method:
Using genomic structural equation modelling, we built a common internalizing factor from European-ancestry GWAS of anxiety, depression, PTSD, and neuroticism, and ran a genome-wide association study of the latent factor. We then performed two-sample Mendelian randomization with the number of medications taken (UK Biobank; N = 462,933) as outcome, using inverse-variance-weighted (IVW) regression alongside weighted-median, MR-Egger, mode-based, and MR-PRESSO estimators, Steiger filtering, and correction for sample overlap.

Results:
The four indicators loaded strongly on a well-fitting common factor (loadings 0.77–0.94; CFI 0.976), yielding 346 independent instruments (mean F = 49). Higher internalizing liability causally increased medications taken (IVW β = 0.285 SD per SD increase in liability; $P = 1.5\times10^{-38}$), concordant across weighted-median (0.288) and mode-based estimators, strengthened after outlier removal (MR-PRESSO 0.312), directionally supported by Steiger, and robust to sample-overlap correction. Each indicator was individually causal; multivariable models were uninformative because the indicators' high genetic correlation (up to 0.93) leaves too little independent signal, supporting the common-factor approach.

Conclusions:
Genetic liability to internalizing psychopathology causally raises overall medication burden, plausibly through greater physical morbidity, amplified somatic-symptom reporting, and higher health-care use. This positions the internalizing conditions routinely managed in primary care as a modifiable upstream driver of polypharmacy, strengthening the rationale for collaborative mental-health care and for trials adopting medication burden as an outcome.

Points for discussion:
Which pathway dominates: greater physical morbidity, amplified somatic-symptom reporting, or increased help-seeking? Genetics cannot adjudicate this; primary care clinicians see the distinction daily. How might we separate them in routine practice data?

Medication review and deprescribing tools are drug-centred (STOPP/START, anticholinergic burden). Should recognising and treating internalizing psychopathology become an explicit upstream step in structured medication review or is that asking general practice to absorb yet another task without resource?

Presentation on 24/10/2026 13:30 in "Parallel Session L - Freestanding Papers: Interesting Methodology Session" by Cemre Durlanık.

Web Based Research Course Presentation / Study Proposal / Idea

Awareness and adoption of the WHO ICOPE model among primary care physicians and nurses in Portugal: a proposal for a national cross-sectional survey

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Keywords: Integrated care for older people, Intrinsic capacity, Primary health care, Health knowledge

Background:
Portugal is among the most aged countries in Europe and has no medical specialty in Geriatrics, which places much of the care of older people within primary care. The WHO ICOPE model proposes organising this care around intrinsic capacity and assigns a central role to the family medicine team. Although national implementation initiatives are underway, to our knowledge there are no national data on how familiar primary care professionals are with ICOPE or to what extent they use it.

Research questions:
What proportion of family doctors and nurses in Portuguese primary care are aware of the ICOPE model and use it in practice? Which professional characteristics, knowledge, attitudes, and contextual factors are associated with its adoption?

Method:
National cross-sectional study using a structured, anonymous, self-administered online questionnaire, reported according to STROBE. Target population: family medicine specialists and trainees and nurses working in NHS primary care units (14,034 eligible professionals). Convenience and snowball sampling through scientific societies, professional bodies, and primary care structures, over 8 weeks. Representativeness will be assessed against national workforce data, with post-stratification weighting considered to address selection bias. The questionnaire follows the knowledge, attitudes and practices framework, covering awareness, knowledge, attitudes, adoption, barriers, facilitators, and training needs. Primary outcome: adoption, defined as having applied the ICOPE Step 1 screening tool to at least one older person in the previous 12 months. The target of 650 complete responses ensures precision after finite population correction and allows detection of a 10 percentage point difference in adoption between doctors and nurses (80% power). Analysis: descriptive statistics with Wilson 95% confidence intervals and multivariable logistic regression.

Results:
Not applicable.

Conclusions:
This study aims to provide the first national baseline of ICOPE awareness and adoption and to identify modifiable determinants to inform the national implementation strategy and targeted training.

Points for discussion:
How can we reduce self-selection bias in an online survey of this kind, so that we reach professionals who are not already interested in the care of older people?

Is our primary outcome, applying ICOPE Step 1 screening to at least one older person in the previous 12 months, a meaningful threshold for "adoption", or should we require sustained use?

Would colleagues from other countries be interested in replicating this survey to allow European comparisons of ICOPE awareness and adoption in primary care?

Presentation on 24/10/2026 13:30 in "Parallel Session M- Web Based Research Course Presentations" by Ana Viegas.

Web Based Research Course Presentation / Study Proposal / Idea

From Home-Health Narratives to Longitudinal Clinical Signals: A Validation Proposal Relevant to Cancer and Complex Care

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Keywords: Home health care; Primary care; Clinical information extraction; Rule-based natural language processing; Longitudinal clinical data

Background:
Continuity of cancer and other complex care extends into the home, where primary care and home-health teams monitor symptoms, nutrition, function, pressure injuries, infections, respiratory problems, devices, treatment burden, acute deterioration, and transitions to emergency or palliative care. These changes are recorded in free-text narratives but remain difficult to reuse longitudinally. A transparent and independently validated signal representation is needed.

Research questions:
Can a locked, deterministic rule-based framework accurately identify predefined clinical signals and their contextual states from routine Turkish home-health narratives, compared with a physician-adjudicated reference standard and simpler lexical baselines?

Method:
This retrospective methodological development and independent validation study will use pseudonymised routine home-health encounter narratives from a Turkish training and research hospital, without patient contact. An evidence-informed candidate universe will undergo eligibility screening and independent three-physician scoring. A provisional signal set will be assessed in a development cohort through blinded dual-physician annotation and third-physician adjudication; empirical observability and annotatability will then inform the final balanced ten-signal portfolio. Rule refinement will be permitted only in the development cohort. After rule lock, an independent cohort will compare exact lexical lookup, morphology-aware context-naïve patterns, and the full context-aware framework. Primary outcomes will be per-signal sensitivity and positive predictive value with 95% confidence intervals; secondary outcomes will include specificity, F1-score, contextual-flag performance, and inter-rater agreement using Gwet's AC2.

Results:
No clinical validation results are yet available. An existing prototype and synthetic regression tests demonstrate engineering feasibility, but do not establish clinical validity or independent generalisability.

Conclusions:
This study will determine whether a transparent rule-based signal layer can support reproducible longitudinal research and care-quality evaluation in home-based primary care, with potential relevance to cancer-care continuity, complex home care, family medicine, and reusable routine-care data.

Points for discussion:
Which clinical signals would be most important to capture from home-health notes for continuity of cancer and complex care?

How should we balance signals that are common and easy to identify with signals that are clinically important but more difficult to extract?

Would validation in two home-health service units be sufficient for an initial study, or should a second institution also be included?

Presentation on 24/10/2026 13:30 in "Parallel Session M- Web Based Research Course Presentations" by Metehan Guzelkaya.

Web Based Research Course Presentation / Finished study

How can we improve the experience of Breaking Bad News? A Systematic review.

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Keywords: breaking bad news, bad news, anxiety, stress, depression, satisfaction, preferences, hope, recall, quality of life

Background:
Breaking bad news is a frequent experience requiring communication skills. Existing protocols (SPIKES, ACBCDE...) provide guidance for physicians, but few studies have focused on patient preferences.

Research questions:
How can we improve the delivery of bad news according to patients?

Method:
To answer this question, formulated using the PICO method, a systematic literature review was carried out to extract elements relating to anxiety, depression, satisfaction, patient preferences, hope, memory and quality of life from ten databases and grey literature. In line with PRISMA recommendations, articles were screened by two readers, in double-blind conditions, and disagreements were resolved by a third reader.

Results:
Twenty-two studies included, including two literature reviews.
Involvement of a nurse reduced anxiety and depression. Use of the word “cancer” reduced depressive symptoms. Families of intensive care patients were more satisfied when doctors supported their end-of-life decisions. Parents of sick children were more satisfied when they were given time, clear, consistent and accessible information, and the opportunity to ask questions later.
Patients expressed preferences for a summary of the situation, a point of understanding, a choice of third-party presence, verification of the desired level of information and emotional support. Women valued content and wanted more emotional support. Men prefer to be consulted about the presence of a third party. Young adult cancer patients need more psychological and social support. Older patients are less likely to remember long, rich consultations.

Conclusions:
This literature review identifies ways of improving the experience of breaking bad news according to patients' preferences. Better integrating them into existing protocols would improve the experience of breaking bad news.

Points for discussion:
Despite general preferences, specificities of age, gender, context and culture need to be anticipated, while respecting each person's individuality.

Training seems necessary to learn how to adapt to the individuality of each person.

Presentation on 24/10/2026 13:30 in "Parallel Session M- Web Based Research Course Presentations" by Alice Laurandeau.

Freestanding Paper / Finished study

Patient activation and associated psychosocial factors in middle-aged adults with multimorbidity in primary care: a cross-sectional analysis of the e-mpoderaT cohort

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Keywords: Anxiety, Depression, Multimorbidity, Patient Activation, Patient Empowerment, Primary Health Care, Quality of life, Treatment Burden.

Background:
Multimorbidity is frequently associated with psychological distress, treatment burden, and reduced quality of life, which may affect patients' ability to engage in self-management. Patient activation reflects individuals' knowledge, skills, and confidence in managing their health and has emerged as a relevant construct in chronic care. However, factors associated with patient activation in adults with multimorbidity remain insufficiently understood.

Research questions:
To describe patient activation levels in middle-aged adults with multimorbidity in primary care and to identify sociodemographic, clinical and psychosocial factors associated with patient activation.

Method:
This cross-sectional study used baseline data from participants enrolled in the multicentre e-mpoderaT project conducted in primary care centres in Madrid and the Canary Islands, Spain. Adults aged 30–60 years with at least two chronic conditions and access to digital technology were included. Baseline measures included sociodemographic and clinical variables, patient activation (PAM-13), depressive symptoms (PHQ-9), anxiety (HADS-A), treatment burden (MTBQ), and health-related quality of life (EQ-5D-5L). Descriptive statistics, correlation analyses, principal component analysis, and exploratory analyses were performed.

Results:
A total of 67% of participants reported moderate-to-high levels of activation (PAM levels 3–4). Most participants had minimal depressive symptoms, while one-third reported clinically significant anxiety. Treatment burden varied across participants, and overall health-related quality of life was moderate according to EQ-5D-5L and EQ-VAS. Depressive symptoms, anxiety symptoms and treatment burden were moderately positively correlated with each other, and inversely correlated with health-related quality of life. In contrast, patient activation showed weaker correlations with these variables, suggesting that activation may represent a partially distinct dimension of patient experience in multimorbidity.

Conclusions:
Adults with multimorbidity in primary care showed moderate-to-high levels of patient activation despite substantial psychological distress and treatment burden. These findings highlight the multidimensional complexity of multimorbidity and suggest that patient activation should be considered together with psychosocial and treatment-related factors when designing patient-centred interventions in primary care.

Points for discussion:
Being activated or engaged in self-management does not necessarily imply better psychological well-being or lower perceived treatment burden.

The coexistence of moderate-to-high activation with relevant psychological burden also highlights the importance of multidimensional assessment in patients with multimorbidity.

Presentation on 24/10/2026 13:30 in "Parallel Session N - Freestanding Papers: Care for Older People and Patients With Multimorbidity" by Angela Revilla.

Freestanding Paper / Finished study

Prevention of Urinary Tract Infections in Institutionalized Older Adults: An Intervention Project

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Keywords: Urinary tract infections; Older adults; Residential care; Prevention; Intervention.

Background:
Urinary tract infections (UTIs) are among the most common healthcare-associated infections in institutionalized older adults and are associated with increased morbidity, antibiotic use, avoidable hospital admissions and reduced quality of life. Educational interventions targeting healthcare professionals may strengthen infection prevention practices and reduce the burden of UTIs in residential care facilities.

Research questions:
Among institutionalized older adults living in a residential care facility, does a structured educational intervention for healthcare professionals reduce the incidence of urinary tract infections compared with the pre-intervention period?

Method:
A longitudinal intervention study was conducted in a Portuguese residential care facility for older adults. Fifty-five residents were included. UTI incidence was compared over two three-month periods: before (November 2025–January 2026) and after (February–April 2026) a structured educational intervention delivered to all healthcare professionals. The intervention combined theoretical and practical training on standard infection prevention precautions, including hand hygiene, urinary device care and intimate hygiene. UTI episodes were identified through electronic medical records (SClínico® and Electronic Medical Prescription®). The primary outcome was the change in UTI incidence following the intervention.

Results:
UTI incidence decreased from 61.8% before the intervention to 20.0% afterwards, representing a relative reduction of 67.6% and exceeding the predefined target of a 50% reduction. The findings suggest that the educational intervention was associated with a substantial decrease in documented UTI episodes during the three-month follow-up period.

Conclusions:
This intervention project demonstrated that a structured educational programme for healthcare professionals was associated with a marked reduction in UTI incidence among institutionalized older adults. Although limited by its single-centre, uncontrolled design, the intervention was simple, low-cost and feasible to implement, suggesting potential for replication in other residential care facilities. Further multicentre studies with longer follow-up are needed to confirm effectiveness and assess long-term sustainability.

Points for discussion:
Role of educational interventions in preventing urinary tract infections in residential care facilities.

Implementation and replicability of low-cost intervention projects in long-term care.

Evaluation of intervention projects in primary care: strengths and methodological challenges

Presentation on 24/10/2026 13:30 in "Parallel Session N - Freestanding Papers: Care for Older People and Patients With Multimorbidity" by Helena Costa.

Freestanding Paper / Finished study

Primary care-adapted Comprehensive Geriatric Assessment: costs and effects of the prospective matched-controlled SAFE trial

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Keywords: Integrated care, Comprehensive Geriatric Assessment, Primary care, Older adults

Background:
Older people with frailty and multimorbidity often have complex needs spanning medical, functional, and social domains, calling for integrated, person-centred care.

Research questions:
This study examined whether a proactive primary care model based on comprehensive geriatric assessment (CGA), incorporating long-term care coordination and increased patient participation, reduces inpatient care among community-dwelling older people.

Method:
SAFE (Secure And Focused primary care for older pEople) is a prospective multicentre clinical trial. The trial includes 24 intervention primary care centres, 28 matched control centres, and 3 488 community-dwelling, 75 years or older, participants, identified as being at high risk of inpatient care using a statistical risk prediction model. At intervention centres, participants were invited to undergo a primary care-adapted CGA by a dedicated nurse, resulting in a person-centred care agreement or advance care planning. When needed, participants were assessed by physicians or rehabilitation staff. The primary outcome was inpatient days over two years. Secondary outcomes included health-related quality of life (HRQoL), mortality, costs, and use of healthcare and social services, based on questionnaires and registry data.

Results:
No statistically significant difference was found in mean inpatient days (9.2 vs 8.2, p=0.12). There were also no significant differences in inpatient episodes, outpatient visits, primary care visits, emergency room visits, health-related quality of life, mortality, or nursing home admission. Adjusted inpatient costs were higher in the intervention group (€1 478, p=0.05), while other costs did not differ significantly.

Conclusions:
This primary care-adapted CGA intervention did not reduce inpatient days in Swedish primary care. The findings suggest that patient selection based on electronic risk prediction requires refinement, preferably in combination with clinical frailty assessment, to more accurately identify individuals most likely to benefit from CGA-based integrated care interventions. Further studies are needed to refine patient selection, evaluate implementation in municipal home care, and assess potential effects over longer follow-up periods.

Points for discussion:
What are your experiences with CGA, and specifically CGA in a primary care setting?

What are your thoughts on statistical prediction models to identify patients at risk?

Is it possible that the intervention would have had an effect if the follow-up period had been longer or if it had been targeted to a more frail population, such as municipal home care patients?

Presentation on 24/10/2026 13:30 in "Parallel Session N - Freestanding Papers: Care for Older People and Patients With Multimorbidity" by Moa Lundgren.

One-Slide/Five Minutes Presentation / Study Proposal / Idea

Can a web-based digital prevention advisor “CheckMe” improve opportunistic screening performance (including cancer screening)? A pilot randomized controlled trial in primary care

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Keywords: Population-based screening, state prevention programs, CheckMe, personalised prevention adviser

Background:
Population-based screening programmes for cancer and other chronic conditions remain limited or inconsistently implemented in several Eastern European countries, including Ukraine. Consequently, preventive care often relies on opportunistic screening during primary care consultations. Family physicians may face difficulties identifying and communicating individualized evidence-based preventive recommendations within limited consultation time. Optional methods of patients motivation for opportunistic screening have to be suggested.

Research questions:
Can a web-based digital prevention advisor (CheckMe) improve uptake of evidence-based opportunistic screening (including cancer screening) recommendations compared with standard physician counselling?

Method:
We propose a pilot pragmatic randomized controlled trial. Adults attending routine state-supported cardiovascular and diabetes screening visits will be invited to participate. Participants will be randomly allocated to either an intervention group receiving personalized evidence-based preventive recommendations generated by "CheckMe", including cancer screening, vaccination, and other age- and risk-specific interventions, or a control group receiving standard verbal recommendations from their family physician. The primary outcome will be the proportion of recommended investigations completed within one month after consultation. Secondary outcomes will include uptake of cancer screening recommendations, number of preventive interventions initiated, patient satisfaction, physician usability, and identification of previously undetected health conditions. Data will be analysed on an intention-to-treat basis.

Results:
Aim of the study is to evaluate the effectiveness of "CheckMe" in increasing uptake of preventive and cancer screening interventions among adults attending primary care consultations. We hypothesize that patients receiving personalized digital recommendations through "CheckMe" will demonstrate higher uptake of recommended screening and preventive interventions than patients receiving standard verbal advice.

Conclusions:
If effective, "CheckMe" could provide a scalable, low-cost strategy to strengthen opportunistic screening and cancer prevention in primary care settings where organized population-based screening programmes are absent or limited. The findings will inform the design of larger multicentre studies within primary care research networks.

Points for discussion:
Digital prevention tools may help overcome barriers to opportunistic screening by providing personalized, evidence-based recommendations during routine primary care consultations.

The study will explore whether digital decision support can improve implementation of cancer screening and preventive care in health systems without (or with limited) organized population-based screening programmes.

Findings may inform scalable approaches for strengthening prevention delivery in primary care and support future multicentre research within the EGPRN network.

Presentation on 24/10/2026 15:50 in "Parallel Session O - One Slide Five Minutes Presentations" by I-Hsin Yang.

One-Slide/Five Minutes Presentation / Study Proposal / Idea

Digital Health Anxiety and Its Influence on the GP–Patient Relationship: A Primary Care Perspective (Single-Center Study)

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Keywords: Health information seeking behavior (HISB), Artificial Intelligence , Internet , Digital Health , Patient empowerment

Background:
Digital health has transformed patient access to health information, yet it can also increase anxiety, reassurance-seeking, and consultation burden when patients encounter low-quality online content. There is limited primary care research specifically examining how digital health anxiety influences the GP-patient relationship in routine clinical practice.

Research questions:
Research questions:
1)What is the level of digital health anxiety among adult patients attending primary care?
2)Is digital health anxiety associated with poorer GP-patient relationship quality?
3)Does eHealth literacy moderate this relationship?
4)How does digital health anxiety influence patients' perception of trust and communication?
5)What factors are associated with better GP-patient relationship quality despite high digital health anxiety?

Method:
A cross-sectional analytical study is conducted at the Raymann Clinic in Tbilisi, Georgia. Consecutive sampling is used to recruit adult patients over 2-3 months. Digital health anxiety is measured using the Cyberchondria Severity Scale (CSS-12), and GP-patient relationship quality is assessed via the Patient-Doctor Relationship Questionnaire (PDRQ-9). eHealth literacy is measured using the eHEALS scale. Data will be analyzed using multivariable regression to evaluate associations between digital health anxiety and relationship quality, adjusting for age, sex, education, chronic disease, and consultation frequency.

Results:
As this is an ongoing pilot study, formal results are not yet available. Data collection is currently underway, with the study expected to conclude in September 2026. The research aims to recruit a sample of 150-200 patients to generate hypotheses and inform larger, potentially multicountry studies.

Conclusions:
Preliminary expectations are that the findings will clarify the impact of digital health anxiety on the GP-patient relationship. The study aims to provide evidence-based insights for developing practical communication strategies, patient education, and digital health literacy interventions tailored for family medicine.

Points for discussion:
Balancing Autonomy and Anxiety: How to preserve the benefits of patient autonomy enabled by digital health tools while mitigating the risks of increased health anxiety and consultation tension.

The Role of the GP: Addressing the challenges GPs face when interpreting conflicting online information and managing patients’ persistent reassurance-seeking behaviors.

Integration into Practice: Exploring the potential for incorporating digital health literacy support into primary care curricula, consultation models, and routine clinical communication strategies.

Presentation on 24/10/2026 15:50 in "Parallel Session O - One Slide Five Minutes Presentations" by Mariam Abisonashvili.

One-Slide/Five Minutes Presentation / Study Proposal / Idea

Patient–Family Physician Relationships During Active Cancer Treatment: A Linked-Pair Qualitative Study

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Keywords: family medicine, cancer, continuity of care, qualitative research, physician-patient relations

Background:
Family physicians play an important role throughout the cancer care continuum; however, their involvement during active cancer treatment remains poorly understood. Little is known about how patients and family physicians perceive, experience, and negotiate their relationship during active treatment. Previous studies have reported conflicting patterns of family physician contact following a cancer diagnosis, mostly in healthcare systems where family physicians serve as gatekeepers. In our country, where patients have direct access to both oncology and primary care through a nationwide electronic health record system without a gatekeeping model, this relationship may be shaped by unique contextual factors. This study aims to explore the shared beliefs, expectations, and role perceptions that shape patient–family physician contact during active cancer treatment.

Research questions:
How do patients and family physicians perceive and experience their relationship during active cancer treatment, and what factors influence its continuation, transformation, or discontinuation?

Method:
A qualitative linked-pair study design will be employed. Adult outpatients receiving active systemic anticancer treatment at a university hospital medical oncology unit will be purposively sampled. Separate semi-structured interviews will be conducted with each member of the dyad to explore experiences of contact during treatment; reasons for consulting or not consulting the family physician; perceptions of roles and responsibilities, competence, and communication with oncology services; management of cancer-related and chronic conditions; expectations; and biopsychosocial needs. Interviews will be audio-recorded, transcribed verbatim, and analysed using reflexive thematic analysis.

Results:
The study is expected to generate an in-depth understanding of how patient–family physician relationships are experienced and negotiated during active cancer treatment from both perspectives.

Conclusions:
By examining the perspectives of both patients and family physicians simultaneously, this study is expected to provide insights into the relational processes that shape continuity of care during active cancer treatment and to inform family medicine education, integrated cancer care, and future shared-care models.

Points for discussion:
How can candour be preserved when each participant knows their counterpart is also being interviewed?

What methodological approaches best support the interpretation of convergence and divergence within patient–family physician dyads?

How can dyadic qualitative findings be translated into interventions that strengthen the role of family physicians during active cancer treatment?

Presentation on 24/10/2026 15:50 in "Parallel Session O - One Slide Five Minutes Presentations" by Egem Eren.

One-Slide/Five Minutes Presentation / Study Proposal / Idea

Primary care assessment of cognitive complaints after cancer treatment: a proposal for a European EGPRN multicentre survey

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Keywords: primary care; cancer survivorship; cognitive complaints; family medicine; survey

Background:
Improved cancer survival has increased the number of adults presenting in primary care with cognitive complaints after cancer treatment. These symptoms are clinically important because they may affect daily functioning and may coexist with potentially reversible contributors such as anaemia, sleep disturbance, anxiety or depression, pain, medication effects, and nutritional deficiencies. Nevertheless, little is known about how general practitioners/family physicians across Europe currently assess and manage these patients in routine practice.

Research questions:
How do general practitioners/family physicians in Europe assess and manage adults presenting with cognitive complaints after cancer treatment?

Method:
We propose a multicentre, cross-sectional, web-based survey within the EGPRN network. A draft questionnaire will examine consultation frequency, symptom assessment, consideration of reversible factors, use of brief cognitive assessment tools, laboratory work-up, medication review, red-flag symptoms, and referral patterns. After pilot testing in a limited number of countries, the questionnaire will be refined and distributed more widely across participating EGPRN countries. Data will be analysed using descriptive statistics and, where appropriate, exploratory between-country comparisons.

Results:
The study protocol, draft questionnaire, and planned international collaboration model will be presented.

Conclusions:
This study aims to map current primary care practice regarding cognitive complaints after cancer treatment and to provide a basis for a shared assessment framework and future development of clinical algorithms in primary care.

Points for discussion:
What information should every participating country collect for this study?

Which brief cognitive assessment tools are practical for routine use in primary care?

When should patients with cognitive complaints after cancer treatment be referred for specialist assessment?

Presentation on 24/10/2026 15:50 in "Parallel Session O - One Slide Five Minutes Presentations" by Kübra Efe.

One-Slide/Five Minutes Presentation / Study Proposal / Idea

The Role of Socratic Questioning in Encouraging Participation in Cancer Screening in Primary Care: A Pilot Pragmatic Cluster Randomised Controlled Trial

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Keywords: Cancer screening; Socratic questioning; cluster randomised trial

Background:
Cancer screening participation in family medicine remains below target levels. Family physicians can address patients' fears and hesitancy, but brief, autonomy-preserving communication methods for screening refusal are lacking. Socratic questioning, a structured, non-directive approach, may help patients re-evaluate their concerns. This study will assess whether Socratic questioning is a suitable technique for increasing cancer screening participation in primary care.

Research questions:
Is the brief, single-session Socratic questioning intervention feasible in routine primary care practice?
Could it have a preliminary effect on increasing participation in cancer screening compared with standard care (informational brochure alone)?

Method:
This pilot pragmatic cluster-randomised controlled trial will be conducted in 12 family health units in Turkey, randomised 1:1 to intervention or control. Approximately 180 adults who refused or delayed breast, cervical, or colorectal cancer screening will be recruited over three months and followed for three months. Physicians in the intervention arm will deliver a 10-minute Socratic questioning session plus a brochure; controls will receive the brochure and routine care. Physicians will complete a thematically-analysed questionnaire on acceptability. Feasibility and exploratory outcomes will be summarised descriptively, with the intracluster correlation coefficient estimated.

Results:
As this is a research protocol rather than a completed study, no results are yet available. The pilot is expected to yield feasibility estimates (recruitment, intervention delivery, physician acceptability, retention, and data completeness), the intracluster correlation coefficient, cluster size variability, and a preliminary estimate of the intervention's effect on cancer screening completion, reported with 95% confidence intervals where applicable.

Conclusions:
This proposed design aims to clarify whether the intervention is ready for evaluation in a definitive trial and will directly inform its design, including sample size calculation.

Points for discussion:
Which feasibility outcomes should be prioritised before progressing to a definitive cluster-randomised trial?

How should intervention fidelity be assessed in this pilot and in a future definitive trial, without compromising the pragmatic nature of the intervention?

Could informed decision-making be incorporated as an outcome in this study, and if so, how might this be feasibly measured?

Presentation on 24/10/2026 15:50 in "Parallel Session O - One Slide Five Minutes Presentations" by Sıdıka Ece Yokuş.

One-Slide/Five Minutes Presentation / Study Proposal / Idea

Understanding Clinical Heterogeneity in Metabolic Syndrome Through Multidimensional Phenotyping in Primary Care

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Keywords: Metabolic Syndrome; Primary Care; Phenotyping; Translational Research; Precision Medicine.

Background:
Adults meeting the diagnostic criteria for metabolic syndrome frequently exhibit markedly different body composition, functional capacity, metabolic profiles, disease trajectories and responses to treatment despite sharing the same diagnosis. Current classifications identify metabolic syndrome but insufficiently explain its clinical heterogeneity. Emerging evidence suggests that inter-organ crosstalk involving adipose tissue, skeletal muscle and liver may contribute to these differences, yet these biological mechanisms remain largely disconnected from routine assessment in primary care.

Research questions:
Can multidimensional clinical phenotyping integrated with translational biomarkers identify clinically meaningful phenotypes of adults with metabolic syndrome beyond conventional diagnostic criteria?

Can this approach improve our understanding of why adults sharing the same diagnosis experience different clinical trajectories?

Method:
We propose the PHENO Framework, a hypothesis-generating multidimensional phenotyping strategy developed from longitudinal clinical observation in primary care, informed by literature review and multidisciplinary collaboration within an ongoing doctoral research programme in endocrinology. The framework integrates metabolic health, body composition, functional capacity and social determinants of health and is designed to incorporate circulating biomarkers reflecting inter-organ crosstalk, including adipokines, myokines, hepatokines, inflammatory mediators and markers of fibrosis.

Results:
The PHENO Framework was developed as a conceptual multidimensional phenotyping model to investigate the biological heterogeneity of metabolic syndrome. It provides a structured platform for integrating clinical, functional and translational information, generating the hypothesis that differences in inter-organ crosstalk may underlie clinically meaningful phenotypes associated with distinct disease trajectories, sarcopenia, MASLD and therapeutic response, and provides the conceptual basis for future observational and translational validation studies.

Conclusions:
The PHENO Framework proposes a translational research strategy linking person-centred primary care with the biological mechanisms underlying metabolic syndrome. Future validation studies will determine whether integrating multidimensional phenotyping with biomarkers of inter-organ crosstalk enables biologically informed patient stratification and supports personalised prevention and treatment.

Points for discussion:
Should metabolic syndrome be characterised beyond conventional diagnostic criteria using multidimensional phenotyping?

Which circulating biomarkers best reflect clinically relevant inter-organ crosstalk in adults with metabolic syndrome?

How can primary care contribute to validating biologically informed phenotypes and translating them into personalised prevention and treatment?

Presentation on 24/10/2026 15:50 in "Parallel Session O - One Slide Five Minutes Presentations" by Helder Manuel Pereira-Sousa.

Freestanding Paper / Almost finished study

Familiarity with tools for detecting potentially inappropriate prescribing in older people among primary care physicians in Europe: a collaborative study

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Keywords: older people, potentially inappropriate medications, potential prescribing omissions, primary health care, screeening tools

Background:
Older people in primary care often have multiple morbidities and are treated with multiple medications, posing significant prescribing challenges. Screening tools to detect potentially inappropriate prescribing (PIP) have been developed to support physicians' daily practice.

Research questions:
To what extent are primary care physicians across Europe familiar with screening tools that identify PIP in older people, and which barriers to their use do they identify?

Method:
Physicians working in primary care in European countries were invited by national collaborators to complete an anonymous online survey on their familiarity with tools to detect PIP in older people between September 2025 and February 2026. Data were analysed descriptively.

Results:
Responses from 462 physicians in 27 countries were analysed (1–46 per country). In total, 329 (71%) respondents were at least somewhat familiar with at least one screening tool for PIP in older people. The most common ways of becoming aware of PIP in older people were clinical judgement (n=400, 87%) and clinical practice guidelines (n=328, 71%). Barriers to using tools for detecting PIP were primarily lack of integration into the electronic medical record system (n=300, 65%) and lack of time (n=268, 58%).

Conclusions:
In this study, most primary care physicians in Europe were aware of screening tools for detecting PIP in older people. However, one third remain unaware of these tools and a substantial proportion do not have such tools integrated into electronic medical record systems. Further efforts to increase awareness and accessibility to screening tools may be helpful.

Points for discussion:
Which screening tools for detecting potentially inappropriate prescribing are primary care physicians across Europe familiar with?

Do primary care physicians across Europe consider these tools useful?

Presentation on 24/10/2026 15:50 in "Parallel Session P - Freestanding Papers: Across Borders: How Primary Care Works" by Naldy Parodi López.

Freestanding Paper / Almost finished study

Integration assessment of Digital Risk Prediction Strategies for Psychosis Prevention in Primary Care: The ePreventPsych Study

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Keywords: Primary Health Care; Psychotic Disorders; Decision Support Systems, Clinical; Risk Assessment

Background:
Early identification of individuals at risk of severe mental illness (SMI) is a key challenge in Primary Care (PC), where timely detection and referral may improve clinical outcomes. Digital decision-support tools based on risk prediction models have the potential to support clinicians in identifying people at increased risk of severe mental illness. However, their successful implementation requires understanding the perspectives of healthcare professionals, people with lived experience, and other stakeholders, as well as addressing ethical, social, and legal considerations.

Research questions:
What are the specific implementation barriers, facilitators, and algorithmic performance requirements for integrating digital predictive models for SMI risk into routine family medicine consultation and mental health departments in Spain? What do patients think about it? How should risk information be communicated to patients?

Method:
Mixed-methods study, with a qualitative emphasis (part of the ePreventPsych project). Data collection will include: (1) an online survey of healthcare professionals (n≥50); (2) semi-structured interviews with people with lived experience (patients, caregivers, etc.) (n=10–15) and healthcare professionals (n=10–15); and (3) a consensus workshop involving researchers, clinicians, people with lived experience, and ethics experts (n=8–10). Participants will be purposively sampled from PC, hospital, and community settings. This workshop will aim to get consensus on how risk should be communicated to patients. Survey data will be analyzed using descriptive statistics and content analysis for open-ended responses. Qualitative data will undergo framework and thematic analysis, with analytical triangulation to enhance rigour.

Results:
As this is an ongoing study, final data are not yet available.

Conclusions:
The findings will inform the development and implementation of digital decision-support systems for early psychosis detection. By integrating clinical evidence, ethical principles, and lived experience, the study aims to promote person-centred, proactive mental healthcare and strengthen collaboration between primary care and specialised mental health services.

Points for discussion:
Shared decision-making in mental health prediction: What is the best strategy to communicate algorithmic risk to patients and caregivers in a way that supports shared decision-making without causing alarm or stigma?

Preventing "alert fatigue" in Primary Care: How can we integrate digital predictive models into Electronic Health Records (EHR) without worsening the digital burden and alert fatigue currently experienced by family physicians?

Presentation on 24/10/2026 15:50 in "Parallel Session P - Freestanding Papers: Across Borders: How Primary Care Works" by Maria Miñana Castellanos.

Freestanding Paper / Almost finished study

What's in a name? Mapping the professional identity of family doctors across 44 European countries

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Keywords: Family Practice, General Practice, Medicine

Background:
Family doctors are referred to as Family Doctors, General Doctors, General Practitioners, or other terms across Europe, both in their official professional title and by their patients. This variation may contribute to inconsistencies in the visibility of the discipline among patients, policymakers, and other stakeholders

Research questions:
How are family doctors called and qualify in Europe? Is family medicine recognized as a specialty in these countries?

Method:
A cross-sectional descriptive study was conducted using a structured questionnaire distributed through the WONCA Europe and WHO Europe networks in 2025-2026. National key informants provided one consensus response per country on official qualification titles, commonly used professional titles and specialty recognition. Responses were independently reviewed by two researchers and analysed descriptively. Overall, 140 key informants from 44 countries contributed.

Results:
Official qualification titles varied across 44 countries: 19 (43.2%) used titles based on Family Medicine/Family Doctor, 11 (25.0%) on General Practice/General Practitioner, nine (20.5%) combined both concepts, and five (11.4%) used country-specific professional titles or certification names. Overall, 28 countries (63.6%) included the term Family and 20 (45.5%) the term General in the official qualification title. The term used by patients also varied: 20 countries (45.5%) predominantly used Family Doctor/Physician, 14 (31.8%) General Practitioner, three (6.8%) both terms, and seven (15.9%) country-specific designations. FM/GP specialist training was mandatory for practicing in 34 of 43 countries (79.1%). FM/GP was formally recognised as a medical specialty in 37 of 42 responding countries (90.2%).

Conclusions:
There were variations in both official qualification titles and patient´s description across Europe. Greater consistency in professional nomenclature could strengthen the visibility of the discipline and support European advocacy for Family Medicine/General Practice.

Points for discussion:
1. Which term should be adopted as the standard designation for family doctors across Europe?

2. Should Europe move towards harmonising the terminology used to describe the discipline?

3. If so, would adopting a combined term such as Family Doctor/General Practitioner (FD/GP) for international communication and advocacy be an appropriate option?

Presentation on 24/10/2026 15:50 in "Parallel Session P - Freestanding Papers: Across Borders: How Primary Care Works" by Sara Ares Blanco.

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