

EUROPEAN GENERAL PRACTICE



RESEARCH NETWORK

*EGPRN is a network organisation within
WONCA Region Europe - ESGP/FM*

EGPRN Co-ordination Centre: Mrs. Hanny Prick
Netherlands School of Primary CaRe Research (CaRe), Universiteit Maastricht
P.O. Box 616, NL 6200 MD Maastricht, The Netherlands.
Phone: +31 43 388 2319; Fax: +31-43-388 2830; E-mail: hanny.prick@haq.unimaas.nl
Website: www.egprn.org

European General Practice Research Network

Nice – France

19th – 22nd May, 2011

SCIENTIFIC and SOCIAL PROGRAMME

***THEME:* “Relevant Outcome Measures in General Practice
Research into Chronic Diseases”**

**Pre-Conference Workshops
Theme Papers
Freestanding Papers
One slide/Five minutes Presentations
Posters**

Place

**St.Jean d’Angely Campus
24 Avenue des Diables Bleus, 06357 Nice cedex 4 - France
Website: <http://meeting.egprn.org/home>**

This EGPRN Meeting has been made possible thanks to the unconditional support of the following sponsors:



CNGE: French national college of teachers in general practice



Pierre Fabre



Ville de Nice



Novo Nordisk



CAGE: Riviera regional college of teachers in general practice



FACULTY of MEDICINE
General practice teaching department



Sanofi Aventis France Laboratories

The meetings of the European General Practice Research Network (EGPRN) have earned accreditation as official postgraduate medical education activities by the Norwegian, Slovenian, Irish and Dutch College of General Practitioners.

Those participants who need a certificate can contact Mrs. Hanny Prick at the EGPRN-Coordinating Office in Maastricht, The Netherlands.

“Relevant Outcomes Measures in General Practice Research into Chronic Diseases”

Dear colleagues and friends,

On behalf of the host organizing committee, we would like to express how honored and glad we feel to organize the 72nd EGPRN-meeting. We welcome you to Nice, well known for its sun, beaches and “Promenade des Anglais”.

The theme of the meeting “Relevant Outcome Measures in General Practice Research into Chronic Disease” refers to the great importance in the choice of the outcome when working out a study, particularly in primary care and general practice. Chronic diseases are specific stakes for patients’ quality of life, relationship between patients and GPs, and health policy; furthermore with the greater life expectancy.

The right outcome would be patient centered, clinically relevant and realistic. But it is not so easy to perform. It needs to be applicable in a daily practice to improve patient’s health in his/her real life. For many clinical questions in general practice we are still lacking evidence what to do best. But even in fields with strong and clear evidences there is often uncertainty on how to implement results in practice. How to translate figure value in the real life of patient? This question is particularly relevant for patients with chronic disease.

Many of these relevant questions in primary care will be discussed in keynote lectures, oral presentations, posters and workshops. This is truly a challenge for our discipline.

This methodological question on outcomes will be introduced by a basic EGPRN course running for three days from Monday May 16th to Wednesday May 18th, entitled “*From research question to detailed proposal*”.

We are convinced that Nice offers an attractive location, especially in May. The Nice-Côte d’Azur Airport, the second largest in France, offers direct flights from most of European capitals and the city centre is within 15 Minutes from the Airport by bus. Arriving by train or car is also possible. The location of the meeting is close to the historic centre of the City, easy to reach by tramway.

We warmly welcome you in Nice. Besides the congress, you will enjoy some of the cultural or “provençale” gastronomic treasures that the city and its lovely environment offer to you.

We are looking forward to meeting you in Nice,

Yours sincerely,

Caroline Huas, MD, National Representative of EGPRN France

On behalf of the Host Organizing Committee

Denis Pouchain, MD, Department of GP, Paris Ile de France West University

Michèle Lieurade, CNGE, French National College of GP Teachers

Isabelle Aubin-Auger, MD, French National College of GP Teachers, senior lecturer, Department of GP, Paris 7 University

Jean Pierre Jacquet, MD, French National College of GP Teachers, associate professor, Department of GP, Grenoble University

Vincent Renard, MD, French National College of GP Teachers, Department of GP, Paris XII University

Philippe Hofliger, MD associate professor, Department of GP, Nice University

David Darmon, MD, fellowship, Department of GP, Nice University

Henry Chan, MD Department of GP, Nice University Nice

Michel Papa, MD Department of GP, Nice University Nice

Alain Mercier, MD, French National College of GP Teachers, associate professor Department of GP , Rouen university

**MEETING EXECUTIVE BOARD
GENERAL COUNCIL MEETING**

Executive Boardmeeting
Thursday 19th May, 2011

09.30 - 10.00: Welcome and Coffee for Executive Board
10.00 - 12.30: Executive Board members

Location: Conference Venue St.Jean d'Angely Campus – Bâtiment (building) 2
Room: 2B362B36

General Council meeting with the National Representatives
Thursday 19th May, 2011

14.00 - 17.00 : Executive Board members and National Representatives
-Research Strategy Committee
-PR and Communication Committee
-Educational Committee

Location: Conference Venue St.Jean d'Angely Campus - Bâtiment (building) 2
Room: 22B48B48

REGISTRATION

► Thursday 19 May 2011

REGISTRATION FOR PARTICIPANTS OF PRE-CONFERENCE WORKSHOPS ONLY

Location: - St. Jean d'Angely Campus
24 Avenue des Diabes Bleus, 06357 Nice Cedex 4

On arrival, every participant, who has not paid by electronic bank transfer, pays €25,= (or €50,= if a non-member) per person for each pre-conference workshop

► Friday 20 May 2011

REGISTRATION FOR ALL PARTICIPANTS

Time: 08.00 – 08.30 h.

Location: St. Jean d'Angely Campus
(24 Avenue des Diabes Bleus, 06357 Nice Cedex 4)

On arrival, every participant, who has not paid by electronic bank transfer, pays €100,= (or €200,= if a non-member) per person.

FOR ALL EGPRN PARTICIPANTS

Social night on Saturday 21st May 2011

(Gala Dinner, Speeches and Party)

Also the “1st edition of the EGPRN folkloric dance contest”, each country is invited to participate in bringing dance music and costumes.

At: Le LIGURE restaurant

Address: 15, Rue Biscarra 06000 NICE - www.ligure.com/

Entrance Fee: €30,= per person.

Please address to EGPRN Registration Desk.

Unfortunately, we have **NO** facility for electronic payments (credit card, Maestro) on the spot. We only accept **EUROS**.

We do **NOT** prefer payment by cheque, given the extra costs. If you have no other option we will charge € 25 extra.

EGPRN 19th - 22th MAY, 2011

PROGRAMME OF THE EUROPEAN GENERAL PRACTICE RESEARCH NETWORK IN NICE-FRANCE

MONDAY-WEDNESDAY 16th -18th MAY, 2011:

Location : **St. Jean d'Angely Campus – Bâtiment (building) 2**
2 rooms: 2B16 and 2B08.

Whole day : EGPRN Research Course

WEDNESDAY 18th MAY, 2011:

Location : **St. Jean d'Angely Campus**

16.00 – 19.00 : **“WoMan Power”**
in: room 2B08

THURSDAY 19th MAY, 2011:

Location : **St. Jean d'Angely Campus**

09.00 - 12.00 : **“WoMan Power”**
in: room 2B04

09.30 - 12.30 : **Executive Board Meeting**
(only for Executive Board Members)
in: room Building 2 Hall (coffee)
in: room 2B36 (meeting)

10.00 - 12.30 : **Pre-Conference Workshop (participants may have registered
beforehand)**

10.00 - 12.30 : **1 EGPRN Pre-Conference Morning Workshop; €25 (€50) each p.p.:**
**a. *Workshop on “Asking Focused Research Question. Comment formuler
une question de recherché?” (in French language).***
**Chairs: Jean-François Chenot (Göttingen, Germany) / Caroline Huas (Paris,
France).**
in: room 2B16

12.30 - 13.00 : **Lunch (price not included in fee pre-conference workshops)**

Afternoon: 2 EGPRN Pre-Conference Afternoon Workshops €25 (€50) each p.p
Parallel workshops:

13.00 - 16.00 : *b. Workshop on “Randomised Control Trial in Cluster”.*
Chairs: Denis Pouchain (Vincennes, France) / Luc Martinez (Bois d’Arcy, France)
in: room 2B16

13.30 – 16.00 : *c. Workshop on “How to choose an Appropriate Method?”*
Chairs: Frances Griffiths (Coventry, United Kingdom) / Laurent Letrilliart (Lyon, France)
in: room 2B36

14.00 - 17.00 : **EGPRN General Council Meeting.**
Meeting of the Executive Board Members with National Representatives (only for Council Members).
As part of the Council meeting, the EGPRN Committees will take place as well: -Educational Committee, PR & Communication Committee, Research Strategy Committee.
Meeting of EGPRN Working Groups (part of the Council meeting)
- **Research Strategy Committee**
- **Educational Committee**
- **Communication and PR Committee**
in: room 2B48

Social Program: For ALL EGPRN-participants of this meeting who are present in
18.30 – : Nice at this time. (Entrance Free)
Welcome Reception and Opening Cocktail for all participants.
Location: Théâtre de la photographie et de l’image
27 boulevard Dubouchage, Nice
((Tram 1, stop 4 « Jean Médecin))

FRIDAY 20th MAY, 2011:

**Location : St. Jean d'Angely Campus - Bâtiment (building) 2
in room: Amphi 4**

08.00 - 08.30 : Registration at EGPRN Registration Desk.

**08.30 - 09.00 : Welcome.
Opening of the EGPRN-meeting by the Chairperson of the EGPRN,
Prof. Dr. Eva Hummers-Pradier**

**09.00 – 09.10: Dr.Vincent Renard – lecturer in General Practice, President of the
CNGE (French College of Teachers in General Practice.**

**09.10 - 09.40: 1st Keynote Speaker: *Prof. Dominique Huas* – Tours, France.
Theme: “When three was a crowd: the birth and rise of general
practice research in France”.**

**09.40 - 10.10: 2nd Keynote Speaker: *Dr. Frances Griffiths, PhD* – Coventry, United
Kingdom.
Theme: “Primary Care research into chronic disease: qualitative
outcomes”.**

**10.10 – 10.40 : 1 Theme Paper (plenary)
in room: Amphi 4**

- 1. Denis Pouchain (France)**
Effects of a multifaceted intervention on the Cardiovascular risk factors of high risk
hypertensive patients in primary prevention. ESCAPE Trial.

10.40 - 11.10 : Coffee Break

**11.10 – 12.40 : 3 Freestanding Papers (parallel session)
‘Difficult Situations’
in room: Amphi 4**

- 2. Christiane Duchesnes (Belgium)**
Palliative care at home: families’ experiences.
- 3. Anne-Lise Bolot (France)**
Identification of intimate partner violence in general practice: evaluation of two
interventions.

4. **Frédéric Ketterer (Belgium)**
Palliative care at home: the place of the carers who stay with the patient within the multidisciplinary team.

11.10 – 12.40 : 3 Freestanding Papers (parallel session)
‘Miscellaneous’
in room: 2B48

5. **Jean Yves Le Reste (France)**
The FPDM (Family Practice Depression and Multimorbidity) Study: Project for systematic review of literature to find criteria for multimorbidity definition.
6. **Birgitte Schoenmakers (Belgium)**
Referrals to a psychologist: do we speak the same language?
7. **Marie Barais (France)**
Gut feelings consensus in general practice in France: final results.

12.40 - 14.00 : Lunch
in: Restaurant Universitaire St Jean d’Angely

After lunch, the meeting continues with parallel sessions till 15.30 h.

14.00 – 15.30 : 3 Theme Papers (parallel session)
in room: amphi 4

8. **Karen Kjaer Larsen (Denmark)**
Mental health following myocardial infarction: cohort study in general practice.
9. **Andrej Kravos (Slovenia)**
Functional health status of patients with peripheral arterial disease compared with controls: results of one year observation.
10. **Jean-Pascal Fournier (France)**
Do nonsteroidal anti-inflammatory drugs (NSAIDs) modify antihypertensive regimen? A population-based cohort study.

14.00 – 15.30 : 7 One-Slide/Five Minutes Presentations
in room: 2B48

11. **Ferdinando Petrazzuoli (Italy)**
Cooperation between primary and secondary care: the roadmap for thrombolysis in outpatients with acute stroke.
12. **Aline Ramond (France)**
What is the ideal outcome criterion in clinical trials of low back pain?

13. **Giannoula Tsakitzidis (Belgium)**
Outcome of interprofessional collaboration on quality of care for chronic geriatric care in nursing homes.
14. **Liliana Laranjo (Portugal)**
Management of type 2 diabetes mellitus: the use of personal health records.
15. **Benoit Chiron (France)**
Ultrasound in family practice: a systematic literature review.
16. **Selin Bozdog (Turkey)**
Preventing initiation of tobacco use among youth: how can a stage play as an peer educational material be an effective and alternative strategy in the fight against smoking?
17. **Tolga Günvar (Turkey)**
What do primary care physicians know and do regarding the biopsychosocial approach?

15.30 – 16.00 : Coffee/Tea Break
in room: building 2 hall

16.00 – 17.30 : 2 Theme Papers, 1 Freestanding Paper
in room: Amphi 4

18. **Luc Martinez (France)**
Determinants of health-related quality of life (HRQoL) in postmenopausal women enrolled in POSSIBLE EU.
19. **Jean Sébastien Cadwallader (France)**
Patients' and physicians' attitudes towards research in general practice: the RepR study.
20. **Marloes Gerrits (The Netherlands)**
Impact of chronic pain on the course of depressive and anxiety disorders.

17.30 – 17.50 : **Plenary Session in: Amphi 4**
Closing of the day by Prof. Frances Griffiths, PhD, keynote speaker, who will summarize on today's theme papers.

Social Programme :

18.00 – : **Practice Visits to local Health Centres in Nice.**
Meeting point: Hall - colleagues will be waiting for you.

19.00 – 21.00 : Collaborative European general practice study on : “Depression and Loneliness in Late Life”.
Chair: Jean Yves Le Reste (Brest-France)
in: room SON 6 B2

SATURDAY 21st MAY, 2011:

Location : St. Jean d'Angely Campus – Bâtiment (Building) 2
in room: Amphi 4

08.30 – 08.50: 3rd Keynote Speakers: *Prof. Dr. André Knottnerus, PhD, MD* –
Maastricht, The Netherlands.
**Theme: “Outcome measures in primary care research into
chronic illness: principles and challenges”.**

08.50 – 10.20 : 3 Theme Papers (plenary)
in room: Amphi 4

21. **Thomas O’Dowd (Ireland)**
Bullying and chronic illness in 9-year-old children.
22. **Jean Karl Soler (Malta)**
Diagnosis and chronic disease in the Transition Project.
23. **Sophia Eilat-Tsanani (Israel)**
Adherence to guidelines and outcome measures – can we increase GPs’ cooperation?

10.20 - 10.50 : Coffee Break
in room: Hall

10.50 – 12.50 : 4 Freestanding Papers (plenary)
‘Cardiovascular’
in room: Amphi 4

24. **Erika Baum (Germany)**
Differential diagnosis of patients presenting with leg oedema in general practice: a qualitative study of GPs’ approaches.
25. **Anthony Heymann (Israel)**
A qualitative study to examine patient and physician understanding of barriers to the effective treatment of hypertension.
26. **Dominique Durrer (Switzerland)**
What is the patients’ views on nutrition and physical activity prevention in general practice/family medicine: a European study.
27. **Dominique Huas (France)**
Effects of a multifaceted intervention on the cardiovascular risk factors of high risk hypertensive with type 2 diabetes patients in primary prevention.

12.50 - 14.00 : Lunch
In: Restaurant Universitaire St Jean d'Angély

After lunch, the meeting continues with 5 parallel Poster sessions till 15.30 h.

14.00 - 15.30 : Posters
In five parallel sessions (5 groups)
in room: Hall

14.00 - 15.30 : Parallel group 1: Posters “Outcomes of research into chronic disease”
(6)

- 28. Nicolas Chauvel (France)**
Pay-for-performance and outcomes for diabetic patients in France: What pitfalls lie ahead?
- 29. Ioannis E. Sokolakis (Greece)**
Evaluation of local infusion of betamethasone-lidocaine in adult patients with knee osteoarthritis that were under anticoagulation therapy.
- 30. Anthony Chapron (France)**
Asthma and indoors environment: usefulness of global avoidance methods on exposure to fungi at home, and on asthma control.
- 31. Laure Fiquet (France)**
Methodological contribution, a process to elaborate quality of care indicators in chronic diseases.
- 32. Joan Torras-Borrell (Spain)**
Mortality causes in a recently diagnosed type 2 diabetic patient cohort in primary care followed up to 20 years.
- 33. Clarisse Dibao-Dina (France)**
General practitioner's management of the post-myocardial infarction phase during the year after hospital discharge.

14.00 - 15.30 : Parallel group 2: Posters “Mental Health” (5)

- 34. Slawomir Czachowski (Poland)**
Measuring psychological change during and after brief CBT in primary care using a PSYCHLOPS questionnaire ('Psychological Outcome Profiles').
- 35. Maribel Fernández-San-Martin (Spain)**
Effectiveness of a general practice and mental health team collaboration to improve cardiovascular risk factors follow-up in psychotic patients.
- 36. Alain Mercier (France)**
Anti depressant drugs in non psychiatric conditions: GPs opinions, and international guidelines.

37. **Benoît Cambon (France)**
Existential suffering in general practice.
38. **Oliver Saint-Lary (France)**
Ethical issues raised by the introduction of payment for performance in France for chronic disease management.

14.00 - 15.30 : Parallel group 3: Posters “Primary Care Management” (4)

39. **Miguel Muñoz (Spain)**
Analysis of differences between registered and perceived chronic conditions in Spain.
40. **G. Vitas Athanasios (Greece)**
Evaluation of general practitioner’s contribution in primary health care in the prevention of chronic diseases in rural regions of our country.
41. **Marin Beyer (Germany)**
Patient safety should be supported by practice software – A study towards requirement specifications of GP in Germany.
42. **Eva Flynn (Ireland)**
General practitioner’s reported use of clinical guidelines for hypertension and ambulatory blood pressure monitoring in the west of Ireland.

14.00 - 15.30 : Parallel group 4: Posters “Dependance/Adolescents” (5)

43. **Catherine Laporte (France)**
Pilot study of CANABIC randomized clinical trial: CANnabis and Adolescents, effects of a Brief Intervention on their Consumption.
44. **Joseph Azuri (Israel)**
Smoking habits, personal characteristics and attitudes toward smoking among Israeli-Arab adolescents.
45. **Julie Dupouy (France)**
Impact of urinary screening tests on addiction practice: an interventional study.
46. **Svetlana Oulesova (Spain)**
Detection of intimate partner violence for women in primary care.
47. **Jantina Lucia van der Velde (The Netherlands)**
Adolescent-parent disagreement on health-related quality of life in food allergic adolescents; Who makes the difference?

14.00 - 15.30 : Parallel group 5: Posters “Gerontology” (3)

48. **Ana Luisa Neves (Portugal)**

Assessment of activities of daily living (ADL) ability in the elderly – a multicentric survey in Vila Nova de Gaia, Portugal.

49. **Isabelle Aubin-Auger (France)**
How French GPs deliver the FOBT: a qualitative study.
50. **Jean-Pierre Lebeau (France)**
Escape-Quali.

15.30 - 16.00 : Coffee Break
in room: Hall

After Coffee Break, the meeting continues with a Plenary session till 18.15 h.
Plenary Session in room: Amphi 4

- 16.00 - 16.30 : ●● **Chairperson's report by Prof. Eva Hummers-Pradier. Report of Executive Board and Council Meeting.**
- 16.30 - 16.40 : ●● **Introduction on the next EGPRN-meeting in Krakow-Poland by the Polish national representative.**

16.40 – 17.40 : 2 Theme Papers
in room: Amphi 4

51. **Patrice Nabbe (France)**
The FPDM (family practice depression and multimorbidity) Study: project for systematic review of literature to find tolls for depression diagnosis uses in primary care.
52. **Sil Aarts (The Netherlands)**
The effects of (multi)morbidity on mental and physical health: temporary or persistent? A 3 and 6 year follow-up from the Maastricht aging study.

- 17.40 – 18.15 : Plenary Closing Session in room: Amphi 4**
- **Closing of the day by Prof. Dr. André Knottnerus**, keynote speaker, who will summarize on today's theme papers and posters.
 - **Presentation of the EGPRN Poster prize by Dr. Tiny van Merode.**
 - **Closing of the conference by Prof. Eva Hummers-Pradier, EGPRN chairperson.**

Social Program :

- 20.00 - : Social Night – Gala Dinner, speeches and Party**
“1st edition of the EGPRN folkloric dance contest: each country is

invited to participate in bringing dance music and costumes.
The *Palme d'Or* will reward the best choreography”.

In: Restaurant LE LIGURE

Entrance Fee: €30,= per person.

Meetingpoint : Restaurant LE LIGURE

Address: 15, Rue Biscarra 06000 NICE

www.ligure.com

SUNDAY 22nd MAY, 2011:

**Location : Novotel Nice Centre Acropolis
 in: Room CHERET**

09.30 - 11.30 : 2nd Meeting of the EGPRN Executive Board.

FRIDAY 20th MAY, 2010:

Location : St. Jean d'Angely Campus
In room: Amphi 4

09.00 - 09.20: 1st Keynote Speaker: Prof. Dominique Huas – France.

**Theme: “When three was a crowd: the birth and rise of general practice research in France.
Yesterday, today and tomorrow “**

The development of research in general practice (GP) in France is recent. Confirmation of this can be seen by looking at the French participation in the EGPRW (now EGPRN) meetings since the first one in Paris (1979). The first meeting has no record of French GP participation. Between 79 and 91, one French GP participated. In May 1992, one French GP appeared and perpetuated the French attendance under the laughing eyes of the other European country delegations. Six months later, came the first French communication. In 1993 the meeting was organised in Paris with a notable French participation. A consistent flat engagement followed until 2003, with the number of attendees and communications at one or two per meeting. However, the new interest in research in GP in France is evident in the increased attendance and communication culminating in the conference in Nice in 2011. Several reasons explain this exemplary change:

Academic general practice is at last recognized in France. Specialization in GP, and of research in GP is now permitted. The number of people following training in research, at masters and PhD level, is growing. General practitioners wish to be involved as research investigators. The recently new chief residents and the research course in GP are probably the main reasons. The ability to collaborate with non-French and non-GP researchers is now also acceptable. English writing and communication is no longer a handicap. To become a full professor, the young general practitioners must get a MSc or PhD and while there are still few, many are in the process of obtaining these.

There are still two major difficulties to French research becoming internationally recognized: (1) publications, and particularly international ones, are rare - no more than ten/year. However, I anticipated this will increase due to the development of the MSc and PhD programme. (2) lack of funding.

Nevertheless, I am particularly optimistic because the advances are so important, that the remaining difficulties will not drive back the improvements obtained in the past five years.

Prof. Dominique Huas MD
Département de Médecine Générale - Faculté de médecine de Tours, France
E-mail: huasdom@orange.fr

FRIDAY 20th MAY, 2010:

Location : St. Jean d'Angely Campus
In room: Amphi 4

09.20 – 09.40: 2nd Keynote Speakers: *Dr. Frances Griffiths, PhD – United Kingdom*

Theme: “Primary Care Research into chronic disease: qualitative outcomes”.

For chronic disease such as type 2 diabetes and low back pain, clinical trials of complex interventions often show a small mean benefit, if any. Yet these complex interventions build on decades of research and are often based on rigorously developed behavioural theory. The trials are well designed and use tried and tested assessment tools. For me, this situation prompted the question, what are we missing? We therefore returned to listen to patients' experiences of chronic illness.

We recruited and interviewed 15 people with chronic low back pain (6 men, 8 women; age range 35-69 years). Eleven follow up interviews were undertaken at three months and/or six months and 7 follow-up interviews at 12 months after recruitment. We also recruited and interviewed 22 people living with type 2 diabetes (13 men, 9 women; age range 25-80 years). As chronic illness refers to illness over time, for our analysis we focused on change over time. Although empirical studies and theoretical frameworks have addressed change over time in chronic illness, we considered there was a need for further understanding of how people experience the time between major changes, as this is often when complex interventions are offered. We analysed the interviews to understand the dynamic patterns experienced by people with chronic illness during the present phase (at the time of the interview). From our analysis of this emergent present, we developed categories to capture how this phase is experienced: (a) relatively calm at the moment but overshadowed by past experiences; (b) lots of activity but feeling stuck, held in place by internal or external forces; (c) not a lot of change but finding ways of living with pain or diabetes; (d) in a distressed state with no change and no expectation of change. These dynamic categories are in turn linked to processes of adjustment and adaptation to illness.

When listening to patients to discern how to tailor their treatment, clinicians might find it useful to consider these categories of dynamic patterns. Further research is ongoing to explore the use of these categories in the evaluation of complex interventions.

**Frances Griffiths, Professor of Medicine in Society
Warwick Medical School, University of Warwick
Coventry, CV47AL, United Kingdom
e-mail: f.e.griffiths@warwick.ac.uk**

SATURDAY 21th MAY, 2010:

Location : St. Jean d'Angely Campus
In room: Amphi 4

08.30 – 08.50: 3rd Keynote Speaker: *Professor J. André Knottnerus MD, PhD* –
The Netherlands

Theme: “Outcome measures in primary care research into chronic illness: principles and challenges”

First and foremost is the research question when choosing an appropriate instrument for measuring patient outcome in primary care research. A directly related issue is the choice between selecting an already existing instrument from a candidate population of tools on the one hand and developing a new one at the other. Important considerations are: making highly accurate measurements for the study at hand (specificity) versus comparability with other studies (external validity); keeping in pace with scientific progress versus continuity over time; and focus versus comprehensiveness in covering the key characteristics and concepts under study. Also (internal) validity should be addressed (including accuracy, internal consistency, reproducibility, reliability, and responsiveness), which is not an easy task. In addition, efficiency, feasibility, and degree of integration in routine practice should be incorporated into the decision-making, taking expected patient and doctor adherence into account. Performing a pilot study in a context that is comparable with the intended study setting will generally be useful.

**J. André Knottnerus, Professor of General Practice
Maastricht University, Department of General Practice
Maastricht, The Netherlands
e-mail: andre.knottnerus@maastrichtuniversity.nl**

TITLE: EffectS of a multifaceted intervention on the CARdiovascular risk factors of high risk hyPERTensive patients in primary prevention. ESCAPE Trial.

AUTHOR(S): Denis Pouchain, Dominique Huas, Jean-Pierre Lebeau
Patrick Chevallier, Vincent Renard, Pierre-Louis Druais
and the National French College of Teachers in General Practice

ADDRESS: French National College of Teachers in General Practice
6 bis, rue des 2 communes, 94300 Vincennes-France
Phone: + 33625914951
Email: d.pouchain@cngc.fr

Background:

Many observational studies have shown that a majority of hypertensive patients do not reach the blood pressure targets recommended in guidelines.

Research question:

Can a multifaceted intervention on GPs, improve hypertensive patient's healthcare outcomes without affecting their quality of life?

Method:

Pragmatic cluster randomized trial. The intervention was one day of medical education, focusing on the therapeutic targets and strategies for achievement featured in guidelines, an electronic BP measurement device, a short leaflet summarizing the guidelines, 4 prevention-dedicated consultations in 2 years, and a feedback on intervention group (IG) patients' results at baseline and at 1 year follow-up.

Patient's inclusion criteria: hypertensive patients treated for at least 6 months with at least 2 other cardiovascular risk factors in primary prevention.

Primary end point: number of patients achieving all the targets featured in the guidelines. Secondary end points: number of patients achieving each target, variation of the value of the targets, and quality of life.

Results:

A total of 128 GPs were randomized as clusters in the IG, and 131 in the control group (CG). GPs have included 1,823 hypertensive patients, 1,047 of them had type 2 diabetes.

The number of patients reaching all their targets increased by 3.5% in the CG, and 6.6% in the IG ($p < 0.02$). The number of patients reaching their BP targets increased by 3.7% in the CG, and by 13.8% in the IG ($p < 0.01$). Systolic BP decreased by 1.5 mmHg in the CG and by 6.3 mmHg in the IG ($p < 0.001$). Diastolic BP decreased by 1.4 mmHg in the CG and 3.5 mmHg in the IG ($p < 0.05$). Change in quality of life was similar in the 2 groups.

Conclusion:

A multifaceted intervention aimed at GPs improves high risk hypertensive patients' health outcomes without affecting their quality of life.

Points for discussion:

1. Which is the best outcome? Number of patients reaching blood pressure target or level of blood pressure?

**PRESENTATION 2: Friday 20th May, 2011
11.10–11.40 h.**

FREESTANDING PAPER

TITLE: Palliative care at home: families' experiences.

AUTHOR(S): F. Ketterer, Christiane Duchesnes, D. Giet

ADDRESS: Dept. General practice, Medical Faculty of Liège
Rue de l'Hôpital 1 Bât B23, 4000 Liège-Belgium
Phone: + 32.4.366.98.31; Fax: + 32.4.366.42.77
Email: cduchesnes@ulg.ac.be

Background:

Palliative care at home is only possible with the development of a well organized network of health care professionals. The "Fédération wallonne des soins palliatifs" ordered this study to analyze the population's needs and improve the services offered to the patient and his/her family.

Research question:

How did the patient's relatives experience palliative care at home?

Method:

Interviews of 50 deceased patients' relatives having experienced palliative care at home were conducted during summer and fall 2010. Interviews were recorded and fully transcribed. The verbatim was analyzed by two researchers and classified into themes.

Results:

First the participants usually took care of the patient by themselves with occasional input from professionals. Though this was viewed as a rewarding period, it required a lot of organization, energy and time. With the evolution of the disease and sometimes because of exhaustion, they needed more organized professional help. Courses of action to obtain the help were not well known. Organizational problems such as delay before the setting-up, working hours, multiple involved professionals, and financial aspects were mentioned. Relational problems of the family or the patient with the professionals were sometimes pinpointed though positive feelings often appeared regarding this matter. Finally, all the interviewees mentioned the importance of being at home for the patient.

Conclusions:

Ambivalent feelings have been expressed and should be taken into account by professionals devoted to help. The need for better information concerning the services has been mentioned. Improvement in available personnel, working hours and financial help would be greatly appreciated.

Points for discussion:

1. How to best help the relatives without taking their place?
2. How and where should services be advertised to inform the families in time?

**PRESENTATION 3: Friday 20th May, 2011
11.40–12.10 h.**

FREESTANDING PAPER

TITLE: Identification of intimate partner violence in general practice: evaluation of two interventions.

AUTHOR(S): Anne-Lise Bolot, F. Dumel

ADDRESS: Dept. de Médecine Générale, Faculté de Médecine et de Pharmacie de Besançon, Rue Ambroise Paré, 25000 Besancon-France
Phone: + 0642543504
Email: annelisebolot@yahoo.fr

Background:

Intimate partner violence (IPV) is a real problem for public health in France, because of the prevalence and the consequences on the health of the women. The women don't speak enough about the violence they undergo and the general practitioners (GPs) don't often tackle the problem.

Research question:

Evaluate the efficiency of two interventions to identify IPV among women aged 18 years to 80 years, who consult GPs in Franche-Comté.

Methods:

The first intervention consisted of information leaflets about IPV on the desk of GPs (n = 10), the GPs must query women interested in the leaflet and determine by themselves if the woman is a victim. The second intervention consisted of GPs (n = 13) questioning each woman who consulted using the woman abuse screening tool (WAST).

Results:

Six women on 480 (1.25%) were detected as victims in the group using the leaflet against 70 women on 242 (28.93%) in the group administering the WAST ($p < 0.0001$). In the WAST group, 69.2% of the GPs think that the WAST is feasible during a consultation, 76.3% think it is a good screening tool and 46.1% are ready to use it in their daily practice. Over three-quarters of GPs in the WAST group (76.9%) that identification of a woman as a victim of IPV modifies care compared to 30% of the GPs using the leaflet ($p < 0,04$).

Conclusions:

More than one in four women, who consult in general practice from Franche-Comté in France, is a victim of IPV. The use of a screening tool has a positive impact because it allows GPs to adapt their care of the women.

Points for discussion:

1. The positive impact of a screening tool in the detection of IPV: should systematic screening be recommended?
2. Mixed opinions of GPs about screening: what are the ways to change their attitudes?

**PRESENTATION 4: Friday 20th May, 2011
12.10–12.40 h.**

FREESTANDING PAPER

TITLE: Palliative care at home: the place of the carers who stay with the patient within the multidisciplinary team.

AUTHOR(S): Frédéric Ketterer, V. Massart, C. Duchesnes, D. Giet

ADDRESS: Dept. General Practice, Medical Faculty of Liège
Rue de l'Hôpital 1 Bât B23, 4000 Liège-Belgium
Phone: + 32.4.366.98.31; Fax: + 32.4.366.42.77
Email: cduchesnes@ulg.ac.be

Background:

Carers who stay at home with the patient watch over him/her, listen and detect discomfort, report on the daily situation to the other professionals, relieve relatives' anxiety and workload. Their profession as well as their training and competencies are historically heterogeneous and not well defined. This work has been performed to detect their needs and difficulties and to suggest improvements. It is a part of a larger study concerning palliative care.

Research question:

How do professionals involved in palliative care perceive the work of carers who stay at home with the patient?

Method:

Seven focus groups were held during spring 2010. Two were organized with coordinators of multidisciplinary teams, two with specialized nurses and three with carers. The discussions were recorded and fully transcribed. The verbatim text was analyzed by two researchers and classified into themes.

Results:

Various problems related to the need for the presence of a person near the patient were mentioned by the professionals. The lack of knowledge of the existing services delays family's demand. Some difficulties are organizational: heavy financial load for the patient, lack of qualified personnel and use of unqualified carers, temporal organization, heterogeneity of the carers' training and competencies. Others are relational: turnover of the personnel, poor relations with some members of the team because of the lack of well-defined tasks and responsibilities, possible conflicting relations with the family. The stressful work in dealing with disease, pain and death all day long was also widely evoked. Suggestions of improvements were made by the participants.

Conclusions:

The results show the need of a clear description of the carers' tasks and training. Moreover, valorization of this profession should be emphasized through advertising, financial help to the family and better information of the other professionals regarding the carers' competencies.

Points for discussion:

1. Definition of the carer's competencies and training requirements.
2. How to improve the carer's involvement in the multidisciplinary team?

PRESENTATION 5: Friday 20th May, 2011
11.10–11.40 h.

FREESTANDING PAPER
Ongoing study with preliminary results

TITLE: The FPDM (Family Practice Depression and Multimorbidity) Study: Project for systematic review of literature to find criteria for multimorbidity definition.

AUTHOR(S): Jean Yves Le Reste, Patrice Nabbe, Bénédicte Manceau, B. Chiron M.A. Munoz, A. Claveria, C. Fonseca, S. Argyradiou, C. Lygidakis S. Czachowsky, C. Mueller, E. Hummers Pradier, H. van Marwijk P. van Royen

ADDRESS: Dept. Médecine Générale, Université de Bretagne Occidentale
22 av Camille Desmoulins, 29200 Brest-France
Phone: + 33 6 74 35 27 89; Fax: + 33 6 74 35 27 89
Email: lerestej@aliceadsl.fr

Background:

Multimorbidity is a new concept close to co-morbidity with a global vision in addition. This concept is deeply in touch with the GPs core competencies as described by WONCA, and especially with the holistic modelling core competency. It could also help to detect frail patients in primary care before deterioration. However, as often for new concepts, its definition and subsequent operationalisation are still unclear.

Research question:

What are the definition criteria of multimorbidity found in the literature?

Method:

A systematic qualitative review of literature with ten national teams from EGPRN (European general practitioner research network) using the keyword multimorbidity. Searched databases were Pubmed, Embase and Cochrane. For inclusion multimorbidity had to be in the research question, and some criteria or definition at least in the results. Articles were dispatched between the national teams. All articles were double screened for inclusion. Coding was performed in a phenomenological way. First an open coding for multimorbidity criteria was done by two independent researchers in each team, then an axial coding was carried out.

Results:

Preliminary results will be available for May 2011.

Conclusions:

With this systematic review, we will find and group criteria for definition of multimorbidity. Those criteria will be used further in the FPDM study for comparison with the qualitative research's results about definition of multimorbidity by GPs.

Points for discussion:

1. What are the definition criteria of multimorbidity for the audience?
2. What are the useful concepts in multimorbidity for GPs in the audience?

**PRESENTATION 6: Friday 20th May, 2011
11.40–12.10 h.**

FREESTANDING PAPER

TITLE: Referrals to a psychologist: do we speak the same language?

AUTHOR(S): Birgitte Schoenmakers, Marleen Brems, Wouter van Mechelen
Dominique Dewilde, Kristel Vandeput, Sabine van Baelen
Geert van Boxem

ADDRESS: Dept. Public Health, Academic Centre of general Practice
Catholic University Leuven
Kapucijnenvoer 33 block J, box 7001, 3000 Leuven-Belgium
Phone: + 3216325454
Email:birgitte.schoenmakers@med.kuleuven.be

Introduction:

Although in most European countries GP's have a comprehensive experience in collaboration models with psychologist, research on this topic is scarce. In-house referrals to a psychologist are assumed to lower thresholds for both patients and GP's; collaboration with a residing psychologist does not lower referrals to specialized care. With increasing psychosocial consultations, adequate referral to a psychologist is indispensable.

Research question:

Are the motives of the referring GP in accordance with the treatment policy of the residing psychologist?

Study design:

Retrospective, observational cross-sectional design. GP's and residing psychologist were questioned. Outcome measures: referral motives of GP's and treatment policy of psychologist. Analysis: in a correlation model the accordance between referral motives and treatment policy was tested. In a logistic regression model, with repeated measure techniques, the impact of the confounding variables were tested.

Results:

A total sample of 92 patients and 6 GPs was studied. Over 60% of the patients were referred for counseling but only 25% of the cases received same. Overall, the referral motives of the GP were not in accordance with the treatment policy of the psychologist. Second, motives of referral are more closely related to patient characteristics than to pathology.

Discussion:

A close collaboration between general practitioners and psychologists is difficult but indispensable. This study demonstrated that referral motives of GPs usually do not correspond to the treatment policy of the psychologist. This observation is partly explained by a poor understanding by GPs of psychologist treatment strategies. Above, there is a pre-selection of GP referrals and these are more influenced by patient characteristics than by pathology. Not necessarily the neediest patients are referred to the psychologist.

Further research should show what the underlying mechanisms of GP referrals are in order to achieve adequate referral patterns.

Points for discussion:

1. Definition of referral motives.
2. Does accordance between GP and psychologist in treatment policy yield better outcome for patients?

**PRESENTATION 7: Friday 20th May, 2011
12.10–12.40 h.**

FREESTANDING PAPER

TITLE: Gut Feelings consensus in general practice in France: final results.

AUTHOR(S): Marie Barais, Elisabeth Chipeaux, Pierre Barraine

ADDRESS: Dept. Universitaire de Médecine Générale + Département LUSSIUMR 3192
Lab-STICC/CID. Université de Bretagne Occidentale
22 avenue Camille Desmoulins, 29238 Brest-France
Phone: + 33 6 98 18 96 81
Email: marie.barais@gmail.com

Background:

Gut feelings in general practice have been defined as a third track by Flemish GPs working on medical decision making and problem solving. Sense of alarm and sense of reassurance are defined concepts obtained by a Delphi procedure with Dutch and Belgian GPs or ex-GPs involved in academic educational or research programmes. The same procedure was carried out in France among academic GPs only. In order to avoid bias of theorization, it was necessary to study the point of view of non academic GPs.

Research question:

What is the definition of 'Gut Feelings' for non academic French GPs?

Method:

Qualitative research including a Delphi consensus procedure with a heterogeneous sample of 20 French GPs, who were full time physicians and not familiar with academic research. GPs were approached by phone and 20 of 25 contacted accepted to participate. They were then visited by the researcher at their office to receive standardized explanations on the procedure. Initial Dutch statements were then submitted to the participants by mail after double translation. Each comment was discussed with the research group (6 participants) before adjusting the statement.

Results:

Eight consensus criteria were obtained at the third round Delphi. General practitioners have developed their own definition of sense of alarm and reassurance. Sense of alarm means that the GP feels concerned about the health of the patient even if he does not have any objective reasons. It stimulates the GP to reformulate the diagnostic hypotheses, to conduct other forms of intervention (monitoring, paraclinical examinations, experts' opinion). Sense of reassurance means that the GP feels confident enough to continue his management even without definitive diagnosis.

Conclusions:

These criteria are similar to those developed by the Dutch and French academic GPs.

Points for discussion:

1. Research group with trainees.
2. Further research on gut feelings.

PRESENTATION 8: Friday 20th May, 2011

14.00–14.30 h.

THEME PAPER

Ongoing study with preliminary results

TITLE: Mental health following myocardial infarction: cohort study in general practice.

AUTHOR(S): Karen Kjaer Larsen, Mogens Vestergaard, Jens Søndergaard
Bo Christensen

ADDRESS: Dept. General Practice, School of Public Health, Aarhus University
Bartholins Allé 2, 8000 Aarhus C-Denmark
Phone: + 45 2089 9503
Email: kkl@alm.au.dk

Background:

Myocardial infarction (MI) is associated with an increased risk of anxiety, depression and suicide. Screening for depression and provision of psychosocial support is recommended as part of the rehabilitation after MI, but insufficiently provided during hospital based out-patient rehabilitation. With this backdrop, mental health is an important focus area for general practice (GP) in the continuing rehabilitation.

Aim:

To describe how general practitioners handle post-myocardial depression and analyze factors of importance to improve and maintain mental health after MI.

Design and method:

Population-based cohort study of patients with first time MI in 2009 from the Central Denmark Region. Data were obtained from patient questionnaires and nationwide registers 14-16 weeks (baseline) and 12-13 months (follow-up) after MI and from GP questionnaires 12-13 months after MI.

Results:

At baseline 908 (70%) of the 1,288 eligible patients responded. The mean age was 67.1 (SD: 11.7) years and 282 (31 %) were women. At 14-16 weeks after the MI, 156 (25%) men and 106 (38%) women had anxiety or depressive disorder according to the Hospital Anxiety and Depression Scale. At the 72nd EGPRN meeting, we will present follow-up data and factors that improve and maintain mental health after MI.

Points for discussion:

-

PRESENTATION 09: Friday 20th May, 2011
14.30–15.00 h.

THEME PAPER
Ongoing study with preliminary results

TITLE: Functional health status of patients with peripheral arterial disease compared with controls: results of one year observation.

AUTHOR(S): Andrej Kravos

ADDRESS: Dept. of Family Medicine, Medical faculty, University of Ljubljana
Poljanski nasip 58, 1000 Ljubljana-Slovenia
Phone: + 386 41 408890
Email: kravos.andrej@siol.net

Background:

Peripheral arterial disease (PAD) is a common condition in primary care and, if untreated, has a poor prognosis. Patients with PAD have more cardiovascular events and higher mortality, but we don't know if they also have lower functional health status (FHS).

Research question:

What are the differences regarding mortality, morbidity and FHS of patients with peripheral arterial disease compared with controls over a one year period.

Method:

We conducted an observational study to measure FHS of people with peripheral arterial disease compared with controls matched for sex and age, using the COOP/WONCA charts with six different items. Diagnostic criterion of peripheral arterial disease was ankle brachial index lower than 0.9. After one year, we again assessed FHS, mortality and morbidity of both groups and the change of each FHS item was calculated.

Results:

In total, 827 family practice attendees with PAD, and 789 controls participated at the beginning of the study; and 743 patients and 722 controls after a one year period. People with PAD had worse FHS when compared with controls for physical fitness, feelings, daily activities, social activities and overall health ($p < 0.001$). The difference was also significant, after the one year period ($p < 0.001$). Cardiovascular and overall mortality, cardiovascular events and revascularizations were more common in the PAD group. FHS didn't change significantly after one year. Only physical fitness was worse in the PAD group ($p = 0.036$). In the control group, physical fitness ($p < 0.001$) and daily activities ($p = 0.029$) were worse.

Conclusions:

This study found a significantly worse functional health status in the group with peripheral arterial disease compared to the control group. After one year, there was no significant FHS change, with the exception of physical fitness.

Points for discussion:

1. Comments on methodological aspects: assessment of functional health status change during progression of chronic disease.
2. Comments on preliminary results.

**PRESENTATION 10: Friday 20th May, 2011
15.00–15.30 h.**

THEME PAPER

TITLE: Do Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) modify antihypertensive regimen? A population-based cohort study.

AUTHOR(S): Jean-Pascal Fournier, Maryse Lapeyre-Mestre, Agnès Sommet, Stéphane Oustric, Jean-Louis Montastruc

ADDRESS: Dept. Universitaire de Médecine Générale
Faculté de Médecine, Université de Toulouse
133 route de Narbonne, 31062 Toulouse-France
Phone: + 335 62 88 90 48
Email: jeanpascal.fournier@dumg-toulouse.fr

Background:

Nonsteroidal anti-inflammatory drugs (NSAIDs) are known to antagonize effects of antihypertensive drugs. Their association can lead to an increase in blood pressure.

Research question:

What is the influence of NSAID exposure on antihypertensive drug regimen?

Method:

We conducted a cohort study on 6,001 subjects, treated and stabilized with their antihypertensive therapy and without any NSAID prescription between 1 April 2005 and 1 April 2006, using the reimbursement database of the French Health Insurance System. We investigated whether the introduction of NSAIDs during a 4 year-follow-up could induce an intensification of the antihypertensive regimen. Our main outcome was therefore defined as the introduction of a new antihypertensive drug. We used Cox proportional hazard regression analyses with exposure to drugs entered into the model as time-dependent variables for estimating the Hazard Ratios (HR) of antihypertensive therapy intensification.

Results:

HR for antihypertensive therapy intensification were 1.32 [1.04-1.69] for NSAIDs in general (and 1.96 [1.16-3.31] for oxicams in particular). There were significant interactions with Angiotensin Converting Enzyme (ACE) inhibitors or Angiotensin Receptor Blockers (ARBs) but not with other antihypertensive drugs.

Conclusions:

Exposure to NSAIDs is associated with an increased risk of antihypertensive treatment intensification, mainly involving interactions with ACE inhibitors and ARBs.

Points for discussion:

1. Choice of the outcome on administrative databases.

**PRESENTATION 11: Friday 20th May, 2011
14.00–14.10 h.**

**ONE SLIDE/FIVE MINUTES
Study proposal / idea**

TITLE: Cooperation between Primary and Secondary care: the roadmap for thrombolysis in outpatients with acute stroke.

AUTHOR(S): Luca Puccetti¹, Mirene Anna Luciani², Giovanni Orlandi³, Alberto Chiti³
Vincenzo Costigliola⁴, Ferdinando Petrazzuoli
¹) SMIPG; GP-Pisa-Italy;
²) Dept. Family Medicine-Pisa-Italy;
³) Dept. Neuroscience University of Pisa- Italy;
European Medical Association GP-Brussels- Belgium;
⁴) Snamid (Caserta-Italy)

ADDRESS: Dept. Snamid Caserta-Italy
Via Orientale 3, 81010 Ruviano (CE)-Italy
Phone: +390823860032
Email: 0823860032@iol.it

Background:

Intravenous thrombolysis (IT) performed within 3 hours in “selected” patients with ischemic stroke reduces both mortality and disability: “time is brain”. Unfortunately, only a few patients (< 5%) with stroke undergo IT, because of organizational problems, which causes irremediable delay in and out of the hospital setting.

Research Question:

Can an advanced model of cooperation between primary and secondary care be feasible and effective in reducing the delay for prompt IT in patients with ischemic stroke?

Methods:

The setting of our proposed project is the city of Pisa (Italy). The project will start in 2011 and will last for 3 years. The trained family doctors involved in the project will evaluate patients on their list and classify patients at high risk of ischemic stroke according to the Stroke Prevention and Educational Awareness Diffusion (SPREAD) Guidelines. These data and the electronic medical records (EMR) of these selected patients will be made available for the staff of a Stroke Emergency Care Unit which is provided with an ambulance with a Specialized Team on board; the equipment also includes an on-board laboratory for simple blood test and a Cranial Computerized Tomography scanner. The decision to perform IT or not will be taken after the assessment of the EMR and GPs' data and if possible after a telecommunication between the GP and the on-board neurologist, in order to avoid serious adverse side effects (mainly cerebral haemorrhage).

Results:

Effectiveness of the project will be assessed evaluating outcome indicators such as, number of IT performed, number of deaths, major disabilities and adverse side effects with those in a control group.

Conclusions:

The results of the project will be useful for further decision and evaluation on the cost and feasibility to implement this approach on a wider scale.

Points for discussion:

1. Methodology for evaluating effectiveness: control group or comparison with the past.
2. European experience on shared clinical data between primary and secondary care.

PRESENTATION 12: Friday 20th May, 2011
14.10–14.20 h.

ONE SLIDE/FIVE MINUTES
Ongoing study with preliminary results

TITLE: What is the ideal outcome criterion in clinical trials of low back pain?

AUTHOR(S): Aline Ramond, A.S. Gobin, C. Bouton, M. Cambou, J.F. Huez

ADDRESS: Dept. of general practice, Faculty of medicine, University of Angers
1, rue haute de reculée, 49045 Angers Cédex-France
Phone: + 33 2 41 73 59 30; Fax: + 33 2 41 73 58 81
Email: aline.ramond@univ-angers.fr

Background:

Low back pain (LBP) is a major public health problem. We are interested in evaluating the effectiveness of an early intervention focusing on PS issues in patients with subacute LBP in primary care. The definition and the implementation of such an intervention have to be carefully thought out and described. Moreover, some methodological choices are almost as important as the intervention itself, to ensure the ability to demonstrate any significant effect. The choice of the outcome criteria used to assess the effectiveness of the intervention is of particular concern, since LBP is a multidimensional and time-varying pathology.

Research question:

What would be the ideal criterion to assess the outcome in clinical trials of LBP in primary care?

Method:

A review of literature is being conducted at the moment, to systematically examine the clinical trials aimed at improving the evolution of LBP sufferers in primary care by addressing some PS issues. The outcome criteria used in these studies will be listed and systematically considered for their clinical and methodological relevance.

Expected results:

Most of the clinically relevant outcome criteria belong to five main domains: pain assessment, disability assessment, return-to-work criteria, patient's global satisfaction with care or with residual symptoms and quality of life.

Points for discussion:

1. Which dimensions in LBP are the most important to assess?
2. For a given dimension, how should the ideal scale be chosen?
3. Since LBP is a multi-dimensional and time-varying pathology, is it relevant to use composite criteria and/or repeated measures?

**PRESENTATION 13: Friday 20th May, 2011
14.20–14.30 h.**

**ONE SLIDE/FIVE MINUTES
Study proposal/idea**

TITLE: Outcome of interprofessional collaboration on quality of care for chronic geriatric care in nursing homes.

AUTHOR(S): Giannoula Tsakitzidis, P. van Royen, H. Meulemans, S. Truijen

ADDRESS: Dept. of general practice, University of Angers
Universiteitsplein 1, 2610 Wilrijk-Belgium
Phone: + 32 3 265 29 09; Fax: + 32 3 265 25 26
Email: giannoula.tsakitzidis@ua.ac.be

Background:

Interprofessional collaboration can improve healthcare processes and outcomes (Zwarenstein, Goldman et al. 2009). There is a need for further investigation in this field on chronic geriatric patients in nursing homes.

Research question:

What are the effects of 'coordinated' interprofessional collaboration (IPC) on quality of care in chronic geriatric care in nursing homes compared to usual care?

Method:

To describe usual chronic geriatric care in nursing homes we will perform a qualitative study, including non-participant observations, focus groups and interviews with professionals and patients.

In the second phase an intervention cohort study pre-post design will be performed in 4 nursing homes, with 120 participants. The inclusion criteria are: being 65y+, 'independent', language Dutch, at least 1 year living in nursing home, MMSE >18/30.

All related professionals such as: general practitioners, nurses, physiotherapists and occupational therapists related with the nursing homes, will be involved in the intervention of 'coordinated IPC.

Intervention group participants living in nursing homes will receive 'coordinated' interprofessional care as the new model of collaboration. Control group participants are those living in the nursing home who receive only usual care.

Outcomes:

The following prior outcome variables will be described: Intensity of interprofessional Care, HR-QoL, patient independence, uncertainty. Other indicators will be measured as secondary outcome variables: medication management, fall prevention, unanticipated transitions, hospitalization and length of stay, costs.

Points for discussion:

1. What are your suggestions for measuring outcome variables of quality of care for the specific area of chronic geriatric care?
2. Do you have experiences and suggestions?
3. Do you have of similar research in other countries?

**PRESENTATION 14: Friday 20th May, 2011
14.30–14.40 h.**

**ONE SLIDE/FIVE MINUTES
Study proposal/idea**

TITLE: Management of type 2 Diabetes Mellitus: the use of Personal Health Records.

AUTHOR(S): Liliana Laranjo

ADDRESS: Dept. USF Villa Longa, Faculdade de Medicina de Lisboa
Rua ilha dos amores, lote 4.12, bloco E, 1^o dto, 1990-122 Lisboa-Portugal
Phone: + 351 965647542
Email: liliana.laranjo@gmail.com

Background:

Diabetes mellitus (DM) is a challenging health problem worldwide. One of the shortfalls in DM care is the poor metabolic control of many patients, despite the provision of evidence-based care and the availability of effective medical therapy. There is an increasing need for changes in the delivery of DM care, as well as innovative approaches to DM self-management. Several studies suggest an association between the use of patient-oriented health information technology (HIT) interventions in DM and improvements in glycated haemoglobin (HbA1c) levels. Personal health records (PHR), allowing the input and output of health information between the system and the user, facilitate patients' empowerment and have great potential to positively influence DM management.

Research question:

- What is the effect on HbA1c of using a PHR?
- What are the effects of using a PHR on DM knowledge and patients' satisfaction with care?
- How does patients' compliance to a PHR evolve throughout time?

Method:

A PHR is being developed by a major information technology company in Portugal; a partnership with the Portuguese School of Public Health was established in order to evaluate and assist its development.

The diabetes-related module of that PHR will be the platform for this study, which will be conducted as a quasi-experimental 12 months intervention (pretest-post test) and implemented in the Portuguese primary care context. The target population consists of type 2 diabetic patients (n=200), who will be invited to participate by their general practitioners, previously recruited to the study. The data collection tools will be: the PHR, the electronic medical record, a DM knowledge questionnaire (DKN-A) translated and validated to use in Portugal and a patients' satisfaction with care questionnaire.

Conclusions:

This project intends to add useful knowledge to the growing body of evidence relating to the utility and effectiveness of patient-centered HIT in DM management.

Points for discussion:

1. What are the study's limitations?
2. What is the importance of evaluating diabetes-related knowledge?
3. What are the expected results?

**PRESENTATION 15: Friday 20th May, 2011
14.40–14.50 h.**

ONE SLIDE/FIVE MINUTES

TITLE: Ultrasound in family practice: a systematic literature review.

AUTHOR(S): J.Y. Le Reste, J.C. Martin, Benoit Chiron, P. Nabbe, B. Le Floch

ADDRESS: Dept. Médecine générale, Université de Bretagne occidentale
22 av Camille Desmoulins, 29200 Brest-France
Phone: + 00 33 6 74 35 27 89; Fax: + 00 33 6 74 35 27 89
Email: lerestejy@aliceadsl.fr

Background:

Ultrasound is used in primary care in northern Europe, Germany and North America. In France its use in primary care (PC) remains confidential. The French national ultrasound diploma has no general practice module. French GPs wishing to train must achieve the same training as radiologists.

Research question:

What are the ultrasound indications in the literature for PC in order to propose a PC module for the French ultrasound diploma?

Method:

Systematic literature review in Pubmed and Cochrane library databases. Key words were ultrasonography, ultrasound, sonography, family practice, family physician, primary health care and primary care.

Results:

A total of 41 articles were found. All were found in Pubmed and none in the Cochrane Library. On these 41 items only 29 described indications in PC. Those indications were in obstetrics (58%), vascular medicine (14%), emergency medicine (14%), cardiology (7%) and abdominal (7%). Ten of these articles reported a validation test against a gold standard. These validations were positive in abdominal and obstetrics and negative in cardiology.

Conclusion:

Poverty of the literature did not provide an exhaustive list of ultrasound indications in PC. However it did provide a validated list of detectable pathology for obstetrics and abdominal diseases. It gave a list of indications in emergency and vascular medicine without validation. Finally it showed that cardiac ultrasound should be performed by a cardiologist. The validated list of indications will be the basis of the ultrasound degree for French GPs. Further research remains essential to validate other indications.

Points for discussion:

1. Do you know some grey literature in your country which could validate some other indications for Ultrasound in PC?

**PRESENTATION 16: Friday 20th May, 2011
14.50-15.00 h.**

**ONE SLIDE/FIVE MINUTES
Ongoing study, no results yet**

TITLE: Preventing initiation of tobacco use among youth: how can a stage play as an peer educational material be an effective and alternative strategy in the fight against smoking?

AUTHOR(S): Selin Bozdag, Vildan Mevsim

ADDRESS: Dept. School of Medicine , Dokuz Eylul University
Inciralti/Balcova, 35340 Izmir-Turkey
Phone: + 905318101861
Email: selin.bozdag@ogr.deu.edu.tr

Background:

The majority of adult smokers initiated the habit when they were adolescents and are less likely to stop smoking than smokers who started later in life. To fight effectively against smoking, it is important to reach and communicate with the youth. Despite preventative studies, smoking prevalence is increasing among youths. We suggest an alternative method that is more impressive rather than informative.

Research question:

How can a stage play as an peer educational material be an effective and alternative strategy in struggling against smoking?

Method:

The research is being conducted in five phases. The first two phases have been completed. In the first phase, a questionnaire that investigated perspectives of youths about smoking and sought to determine the necessary conditions which prevents them commencing smoking was constructed with a delphi technique using focus group interviews with selected students and in the second phase, this questionnaire was applied to 13-15 aged students in İzmir.

The rest of study is designed based on determined criteria using cross sectional analyses. The third phase consists of writing the play text including highlights by professional people who are funded by the European Union. And then as the fourth phase, we thought that "a stage play that performed peer players" is absolutely effective for reaching youth in schools.

We estimate that intervention will result in an improved level of knowledge and changes in attitudes towards smoking in the targeted youth communities. In the last phase, self-administered questionnaires will be used to assess the effectiveness.

Points for discussion:

1. Is it possible to determine common perspectives of youth about smoking and necessary conditions which prevents them commencing smoking across European countries?
2. Is peer education an effective tool to raise awareness on smoking issues among youths?

**PRESENTATION 17: Friday 20th May, 2011
15.00-15.10 h.**

**ONE SLIDE/FIVE MINUTES
Study proposal/idea**

TITLE: What do primary care physicians know and do regarding the biopsychosocial approach?

AUTHOR(S): M. Gökhan Şen, Tolga Günvar, Dilek Güldal

ADDRESS: Dokuz Eylül University Faculty of Medicine, Dept. of Family Medicine
Inciralti/Balcova, 35340 Izmir-Turkey
Phone: + 905055407126
Email: tolga.gunvar@deu.edu.tr

Background:

According to WONCA, the primary care physician (PCP) deals with health problems in their physical, psychological, social, cultural and existential dimensions. This requires a specific clinical method which must be patient centered and holistic. The backbone of this method consists of many elements such as the hierarchy of systems described by Engel, patient perspective and shared clinical decision making.

Although many primary care physicians know the word "biopsychosocial", it is arguable to what extent the biopsychosocial (BPS) approach is known and practiced during their clinical practice. However it is difficult to measure this. It is especially hard to investigate a large number of physicians at the same time.

Our aim is to explore knowledge of primary care physicians about the biopsychosocial approach and its implementation in their daily practice using a convenient, quick and accurate method.

Research question:

What do primary care physicians know and do regarding the biopsychosocial approach?

Method:

We are planning to:

- record 10 PCP interviews with real or standardized patients
- discuss BPS approach in daily clinical practice with 10 PCPs
- 3 specialist and 10 physicians will watch recordings and discuss which attitude or behavior is consistent with BPS approach
- these items will be converted into a questionnaire
- this questionnaire will be applied to PCPs in Izmir.

Points for discussion:

1. We would like to discuss the methodology of our research proposal.

TITLE: Determinants of health-related quality of life (HRQoL) in postmenopausal women enrolled in POSSIBLE EU.

AUTHOR(S): Luc Martinez, N. Freemantle, C. Cooper, Adolfo Diez-Perez, R. Horne S. Ortolani, J. Pfeilschifter, S. Shepherd, A. Marciniak, M. Gitlin F. Guillemin

ADDRESS: Dept. General Practice, Pierre & Marie Curie University Paris
50 Avenue Jean Jaures, 78390 Bois D'arcy-France
Phone: + 33 (0) 6 61 59 81 81; Fax: + 33 (0) 1 30 23 81 99
Email: luc.martinez@wanadoo.fr

Background:

Understanding health-related quality of life (HRQoL) among patients receiving bone loss medication can help physicians provide good care for their patients.

Research question:

To investigate the relationship between HRQoL and patient characteristics in postmenopausal women receiving bone loss medication, using baseline data from two large clinical trials.

Method:

POSSIBLE EU is a prospective observational study exploring the experience of postmenopausal women receiving bone loss medications in Europe. Overall 3,402 women were enrolled in 3 treatment cohorts: established (treated ≥ 1 year), inception (initiating) or switching treatment. Clinical data and HRQoL (including EQ-5D) were collected at baseline (N = 3,011). A multivariable analysis model was fitted to identify determinants of EQ-5D score. The linear relationship of each variable was assessed using a forward selection process (entry level 0.05). The non-linear relationships of the selected variables with the outcome were assessed using natural logarithmic and cubic spline transformations. Analyses were performed using SAS software, version 9.1 and GNU R.

Results:

For the full analysis set, median age (Q1, Q3) was 69 (61, 76) years; women had a median of 3 ongoing comorbid conditions at baseline. A high proportion of patients had hypertension (44%), ongoing back pain (41%), osteoarthritis (34%), hyperlipidaemia (32%), ongoing upper gastrointestinal issues (18%), prior vertebral fractures (13%), or depression (13%). For the 3,011 patients included in the model, 12 variables were significantly associated with EQ-5D score, explaining 39.4% of the residual variance. Ongoing depression, any prior vertebral fracture and fear of falling were significantly associated with health utility scores. The number of ongoing comorbid conditions and ongoing back pain were associated to a lesser extent with poorer HRQoL.

Conclusions:

In European women who are receiving/initiating bone loss medication, prior vertebral fracture, ongoing depression, fear of falling, ongoing comorbid conditions and back pain are prevalent, and predictive of lower HRQoL.

Points for discussion:

1. Understanding HRQoL profiles can help physicians provide the best overall care for their patients.
2. HRQoL is significantly affected by previous fractures, comorbid conditions and fear of falling.

**PRESENTATION 19: Friday 20th May, 2011
PAPER**

FREESTANDING

16.30-17.00 h.

TITLE: Patients' and physicians' attitudes towards research in general practice: the RepR study.

AUTHOR(S): Jean Sébastien Cadwallader, Jean Pierre Lebeau, Evelyne Lasserre
Anne Catherine Schlegel, Laurent Letrilliart

ADDRESS: Dept. General Practice, University of Lyon 1
40 rue Bonte Pollet appt 111 Bat B, 59000 Lille-France
Phone: + 0033686674376
Email: jscadwallader@yahoo.fr

Background:

Research in general practice (GP) is poorly developed, especially in France, resulting in a restricted amount of scientific data on this discipline, despite its recent recognition by the university authorities. Research question: What are the patients' and professionals' attitudes towards research in general practice?

Method:

Nationwide French study conducted between January and June 2010, based on focus groups of four different types of participants, recruited using strategic sampling (patients, general practitioners, researchers and teachers in GP, researchers and teachers in other fundamental or clinical specialities). A grounded theory approach was used and the analysis of qualitative data was supported by NVivo 8 Software.

Results:

Nine focus groups, totalling 57 participants, were performed in three different regions of France. Most of them described a specificity of GP based on the population managed in primary care. The influence of the pharmaceutical industry, rivalries between university disciplines and the split between researchers and practitioners were the main hazards identified. The vision of the medical researcher as a "laboratory worker", a lack of awareness of the existence of research in GP as well as a lack of time and training, were identified as barriers by the four different categories of participants.

Conclusions:

The legitimacy of research in GP is not disputed but should be strengthened through collaboration and publication. Its roots in day-to-day practice can be considered as a strength given the patient-practitioner relationship, but also a weakness given the lack of availability of the practitioners. What the new governance of health care in France calls for is the establishment of computerized practices, within multidisciplinary health centres and GP research networks. Research in general practice has a relative specificity and is facing cultural and practical obstacles in France. It will surely benefit from the on-going efforts to reorganize the health care system.

Points for discussion:

1. This study includes patients and physicians on this topic, which has never been done in the medical and sociological literature.
2. The hermeneutic analysis was done with Nvivo 8 software to merge data from different coders.
3. The focus groups were carried out.

TITLE: Impact of chronic pain on the course of depressive and anxiety disorders.

AUTHOR(S): Marloes Gerrits, N. Vogelzangs, P. van Oppen, H. van Marwijk
H. van der Horst, B. Penninx

ADDRESS: Dept. General Practice, EMGO+ institute of VU University Medical Center
Esmoreitstraat 8 huis, 1055 CD Amsterdam-The Netherlands
Phone: + 0031(0)207884541; Fax: + 0031(0)207885664
Email: mj.gerrits@vumc.nl

Background:

The combination of a depressive or anxiety disorder with pain is commonly seen in daily general practice. Little is known about the effects of chronic pain on psychopathology over time as previous studies were mainly cross-sectional.

Research question:

What is the impact of chronic pain on the course of depressive and anxiety disorders and are there other factors that might explain these possible associations?

Method:

Data from the Netherlands Study of Depression and Anxiety (NESDA) were used. Overall, 1,209 participants with a depressive or anxiety disorder and with or without chronic pain at baseline were followed for two years. Pain was analyzed by location, number of locations, use of pain medication and severity using the Chronic Pain Grade. Course of depressive and anxiety disorders was assessed by CIDI and Life Chart Interview.

Results:

Of participants 27.1% reported chronic pain highly disabling daily life. Chronic Pain Grade (per grade increase: OR=1.29; 95%CI=1.16-1.45), number of pain locations (per location increase: OR=1.12; 95%CI=1.04-1.20), use of pain medication daily (OR=1.78; 95%CI=1.16-2.73) and joint pain (OR=1.64; 95%CI=1.29-2.10) were associated with a worse course of depressive and anxiety disorders. The strengths of these associations were hardly affected by age, gender, education, number of somatic diseases and age of onset of the mental disorder. However, the associations were largely mediated by severity of the mental disorder, since considering severity reduced associations considerably. Pain of the joints and daily use of pain medication were still associated with worse outcome of depressive and anxiety disorders.

Conclusions:

This study shows that patients who have chronic pain are more prone towards chronic depressive and anxiety disorders, although severity of the depressive and anxiety disorders in part mediates this relationship. More attention to chronic pain seems necessary when diagnosing and treating depressive and anxiety disorders.

Points for discussion:

1. How can general practitioners optimize recognition of chronic pain and chronic diseases in patients with psychopathology?
2. Studies on treatment modalities for the co-occurrence of chronic pain with psychopathology, so far, focus on the effect.

TITLE: Bullying and chronic illness in 9-year-old children.

AUTHOR(S): Thomas O'Dowd, U. Reulbach

ADDRESS: Dept. Public Health & Primary Care, Trinity College Dublin
AMNCH Campus, Tallaght, Dublin 24-Ireland
Phone: + 00 353 1 8961087; Fax: + 12122
Email: todowd@tcd.ie

Background:

Understanding and preventing bullying at an early stage may reduce problems later in life. An association between chronic conditions and being bullied has been found among adolescents.

Research question:

What is the association between bullying in children with chronic illness?

Method:

Based on a sample of 8,570 nine year old children and their families from the National Longitudinal Study of Children in Ireland. The sample was randomly selected from a representative sample of 910 Primary Schools in Ireland.

Results:

Bullying victimization in the past year was reported in 23.5% (95% CI: 22.6-24.4%) by the primary caregiver and in 39.9% (95% CI: 38.9-40.9%) by the study children. The most common forms of bullying were verbal, physical and social (in terms of exclusion). Only a minority reported cyber-bullying, or being bullied by notes or in any other form. Children who were bullied were about four times more likely than children who were not bullied to participate in bullying other children. In a socioeconomic adjusted logistic regression, having an ongoing chronic illness was associated with a 1.5 (based on study child reported figures; 95% CI: 1.17-1.90; p=0.001) – 1.75 (based on primary caregiver reported figures; 95% CI: 1.35-2.26; p<0.001) risk of being bullied in the past year. For boys, an ongoing chronic illness was only significantly associated with being bullied when it was reported by the primary caregiver, not when it was reported by the study child.

Conclusions:

Bullying is significantly associated with an ongoing chronic illness in nine year old children. The awareness of bullying is higher in primary caregivers when an ongoing chronic illness is present. Gender differences in terms of victimization, becoming a perpetrator and choice of methods should be taken into account in the care of children with chronic illness in general practice.

Points for discussion:

1. Bullying in young children with chronic illness is common.
2. Bullied children also bully other children.
3. Needs to be explored in the consultation with the child with a chronic illness and parent.

TITLE: Diagnosis and Chronic disease in the Transition Project.

AUTHOR(S): Jean Karl Soler

ADDRESS: Mediterranean Institute of Primary Care
19, Triq ir-Rand, ATD1300 Attard-Malta
Phone: + 35621421617; Fax: + 35621421625
Email: jksoler@synapse.net.mt

Background:

This study uses the Transition Project data to study the contribution of patients' reasons for encounter to the final diagnoses of common problems in family practice. This work is part of our contribution to the EU funded TRANSFoRm project. Additionally, a measure of the chronicity of a disease is proposed (ratio of incidence to prevalence).

Research question:

What is the relative contribution of patients' symptoms and complaints to the diagnoses of common problems in family practice?

Method:

The Transition Project database, collected from the electronic patient records of family doctor practices in four countries since the 1990's, was used to study the epidemiology of family medicine. The data on patients' reasons for encounter and doctors' interventions and diagnostic labels was captured, studied and analyzed using the International Classification of Primary Care (version 2 electronic; ICPC-2-E) within an episode of care data structure model.

Episodes of care were defined and coded by the family doctors using ICPC. The relationships between patients' reasons for encounter and doctors' diagnostic labels are studied, using standard methodology (likelihood and odds ratios), using Bayesian techniques.

Results:

The relationships between patients' reasons for encounter and doctors' interventions and the diagnosis within episodes of care of common health problems, as coded in the doctors' EPR using ICPC are described. A measure for how "chronic" a health problem is, is proposed.

Conclusions:

The epidemiology of common health problems in family practice in four countries is studied, and specific conclusions are postulated.

Points for discussion:

1. Discussion of the use of the ICPC within EPR to study the content of family practice.
2. Discussion of the methodology and statistical analysis.
3. Discussion on the potential to expand this project within EGPRN.

**PRESENTATION 23: Saturday 21st May, 2011
09.50-10.20 h.**

**THEME PAPER
Ongoing Study, no results yet**

TITLE: Adherence to guidelines and outcome measures – can we increase GPs' cooperation?

AUTHOR(S): Sophia Eilat-Tsanani, A. Reitman, Y. Mualem, A. Shostak

ADDRESS: Dept. Family Medicine, Emek Medical Center
83 Hagalil St., 36570 Give'at Ela-Israel
Phone: + 972-4-6515628; Fax: + 972-4-6068828
Email: eilat_s@netvision.net.il

Background:

Chronic Kidney Disease (CKD) can be identified at early stage when medical care can help to slow its progression and reduce complications.

A project aimed to promote health of CKD patients was planned. As part of the discussion on the project we kept in mind GPs' claim that they feel as forced to activities in the light of outcome measures.

We have decided to use the opportunity of launching a new project as a model to analyze GPs' response to different modes of providing information on outcome measures.

Research question:

Which way of providing information to GPs about outcome measures achieves better results?

Method:

Prospective controlled interventional study.

The study sample was comprised of all GPs in the district.

GPs in the district were divided into 3 groups: Intervention: A: Guidelines and specific information on each CKD patient; B: Guidelines and specific information on each CKD patient together with specific recommendation to every patient.

Control: No information was provided.

Outcome measures: The rate of adherence to guidelines before and after the intervention.

The project: Information: A document presenting translated and edited NICE guidelines for the care of CKD in the community.

A table in which the names of the patients with GFR 30-60 together with three comorbidities (hypertension + diabetes + ischemic heart disease) were detailed for every GP, together with their nephrologic and relevant other disease parameters.

The material was sent by mail to GPs with a letter describing the project.

The study instrument: A computerized system in which outcome measures are documented sorted by GP. The study included 60 GPs and 1800 patients.

Follow up period: 3 months

Results:

The study is ongoing. GPs in both intervention groups responded positively.

Results will be presented at the meeting.

Points for discussion:

1. How do the audiences prefer to receive information on outcome measure of their patients?
2. Do you think that there is association between the means of providing information and?

TITLE: Differential diagnosis of patients presenting with leg oedema in general practice: a qualitative study of GPs' approaches.

AUTHOR(S): Erika Baum, J. Diederich, S. Hartel, S. Bösner

ADDRESS: Dept. General Practice, University of Marburg
Dresdener Str. 34, 35444 Biebertal-Germany
Phone: + 06409 7076; Fax: + 06409 2878
Email: erika.baum@staff.uni-marburg.de

Background:

In patients with leg oedema, general practitioners (GPs) face a broad range of possible underlying conditions. Patient history and physical examination remain the main diagnostic tools. Little is known about GPs' diagnostic approach in patients with leg oedema.

Research question:

How do GPs approach patients presenting with leg oedema?

Method:

In semi-structured interviews, 15 GPs were asked to describe their personal diagnostic approaches in 2-3 of their patients with leg oedema prospectively identified. Interviews were taped, transcribed and analyzed qualitatively by two independent raters.

Results:

Personal intuition, professional experience and knowledge of the patient's previous medical history helped GPs to classify leg oedema into different categories (unilateral, bilateral, cardiac, venous stasis, lymphoedema, lipoedema). GPs used individualized diagnostic work-up procedures; and diagnosis was mainly dependent on findings from the patient's history and physical examination. GPs had developed different strategies to handle uncertainty in the diagnostic process.

Conclusions:

Apart from the classical textbook knowledge, GPs use prior information of individual patients in a specific way. The patient's history and findings from the physical examination allow the GP to group the patient in one or more possible categories of underlying aetiologies. Within these categories, further tests and/or referral to a specialist are utilized to either rule out or rule in disease.

Points for discussion:

1. Which diagnostic strategies are usual in other European countries on this topic?
2. How can we study the effectiveness of different diagnostic approaches?
3. What is the impact of the patient's history on different diagnosis?

TITLE: A qualitative study to examine patient and physician understanding of barriers to the effective treatment of hypertension.

AUTHOR(S): Anthony Heymann, L. Valisky, I. Zuker, G. Chodick, V. Shalev

ADDRESS: Dept. Family Medicine, Tel Aviv University
27 Carmeli St, 52223 Ramat Gan-Israel
Phone: + 972 508800130; Fax: + 972 35143920
Email: heymann_t@mac.org.il

Background:

Hypertension is a common chronic disease. The high prevalence of hypertension together with its deleterious effect on health make it a major public health problem; and as such, it is the subject of intensive medical research, which has led to the development of many treatments. Despite these advances, many patients with hypertension remain poorly controlled. A significant factor is poor adherence to treatment.

Research Question:

We wished to explore beliefs and perceptions regarding hypertension and gain an understanding of barriers to treatment.

Methods:

Ten focus groups were held with hypertensive patients in three age ranges, with and without diabetes; and three groups with primary care physicians.

Results:

Of 86 patient participants, 37 had hypertension and diabetes. Eighteen primary care physicians participated.

The analysis was presented as:

1. Patients' perception of hypertension
2. Patient modes of management.
3. Primary care physicians' perception of hypertension management.

Patients see hypertension as a risk rather than a disease process, therefore making non-adherence to treatment a gamble with a potential positive outcome. Most patients compromised between "ideal" and "palatable" treatment. Many believe they "know their bodies" and are able to control their blood pressure and overestimated the effect of stress. The recurring themes mentioned were avoiding anxiety associated with a disease that may be fatal, avoiding the limitations dictated by recommended treatment, feeling ashamed of being sick and perceiving the diagnosis as a sign of aging. Primary care physicians' reportedly deviated from clinical guidelines, and reported difficulties in overcoming patient barriers to treatment.

Conclusion:

There is a need to change perception of hypertension from a risk factor associated with ageing to a manageable disease process.

Practice implications: Patients must be told that they have an illness called hypertension that causes long-term damage and that reducing stress isn't a substitute for treatment.

Points for discussion:

1. The use of focus groups in chronic illness research.
2. The differences in approach to their illness of patients who have another chronic disease in addition to hypertension.
3. Implementation of research conclusions.

**PRESENTATION 26: Saturday 21st May, 2011
11.50–12.20 h.**

FREESTANDING PAPER

TITLE: What are the patients' views on nutrition and physical activity prevention in General Practice/Family Medicine: a European study.

AUTHOR(S): Dominique Durrer, Carlos Broton, Mateja Bulc, Yves Schutz

ADDRESS: Dept. Medicine, Eurobesitas/Europrev
Quai Perdonnet 14, 1800, Vevey-Switzerland
Phone: + 41 21 923 53 33; Fax: + 41 21 923 53 36
Email: dominique.durrer@bluewin.ch

Background:

On a European level, information on eating habits, physical activity and body weight from the patients' point of view is scant, so a European standardized study was initiated in 2007 by the European Network for Prevention & Health Promotion in Family Medicine and General Practice (EUROPREV).

Research question:

Are there large disparities in patients' judgments on physical activity and nutrition prevention within European countries?

Method:

A total of 7,947 patients from 22 European countries in 200 centers replied to a questionnaire given by their general/family practitioners. The data were sent via website and analyzed by EUROPREV.

Results:

"Eating Habits view": the percentage of replies categorized from "very unhealthy" and "rather unhealthy" to "healthy" and "very healthy" ranged from 2% to 44% and from 5% to 78%, respectively. The "physical activity" item showed that 3% to 47% of the patients declared themselves "very inactive" whereas 0% to 77% declared themselves "very active". On body weight management, half of participants believed that they must lose weight.

Conclusion:

First, huge inter-country variability must be highlighted. Second, almost half of participants declared they should improve their lifestyle in terms of diet, physical activity and body weight. Third, more than half of these planned to change in the near future and more than two thirds were confident of success. Two thirds of participating patients desired to receive advice on lifestyle changes from their general/family physician, not from specialists or others. However, surprisingly, only half of their doctors had ever addressed these topics during a medical consultation.

Points for discussion:

1. Factors for modifying lifestyle.
2. How to motivate patients to change lifestyle.
3. Communication between GPs and patients about lifestyle changes (nutrition & physical activity).

TITLE: Effects of a multifaceted intervention on the cardiovascular risk factors of high risk hypertensive with type 2 diabetes patients in primary prevention.

AUTHOR(S): Dominique Huas, D. Pouchain, J.P. Lebeau
and French College of Teachers in General Practice

ADDRESS: Dept. of general practice, Faculty of Tours France
23 rue des chateliers, 41500 Sèvres-France
Phone: + 00 33 6 60 57 08 37
Email: huasdom@orange.fr

Background:

Observational studies have shown that a majority of hypertensive patients with type 2 diabetes (T2D) do not reach blood pressure and HbA1c targets advocated in guidelines.

Research question:

Can a multifaceted intervention on GPs improve hypertensive T2D patient's healthcare outcomes without affecting their quality of life?

Method:

Pragmatic cluster randomized trial. Intervention: one day of medical education on the therapeutic targets and strategies featured in guidelines, supply of an electronic BP measurement device and of a leaflet summarizing guidelines, 4 prevention-dedicated consultations in 2 years, and a feedback on interventional group (IG) patients' results at baseline and at 1 year follow-up.

Inclusion criteria: hypertensive patients with T2D, treated for at least 6 months, with at least 1 other cardiovascular risk factor in primary prevention.

Primary endpoint: number of patients achieving the 5 targets featured in the guidelines. Secondary endpoints: number of patients achieving each target, variation of the mean values of the 5 measured items, and quality of life (SF8).

Results:

A total of 128 GPs were randomized as clusters in the IG, and 131 in the usual care group (UCG). They have included 1,047 hypertensive patients with T2D.

The number of patients reaching the 5 targets increased by 1% in the UCG, and 3.3% in the IG (OR=2.36; 95%CI=0.68-8.18). Number of patients reaching BP targets increased by 2.2% (ns) in the UCG and by 9.3% in the IG (OR=1.94; 95%CI=1.19-3.17, P=0.008). Systolic BP decreased by 1.6 mmHg in the UCG (P=0.09) and 6.3 mmHg in the IG (P<0.0001 between groups). HbA1c levels and quality of life did not vary differently in both groups.

Conclusion:

A multifaceted intervention aimed at GPs did not significantly increase the number of hypertensive patients with T2D reaching the 5 targets recommended in the guidelines. However, it did significantly increase the number of patients reaching the BP target values.

Points for discussion:

1. Is such a trial in progress elsewhere?
2. How should we maintain this cohort?
3. Which results deserve an implementation through the guidelines?

TITLE: Pay-for-performance and outcomes for diabetic patients in France:
What pitfalls lie ahead?

AUTHOR(S): Nicolas Chauvel, M. Le Vaillant, N. Pelletier-Fleury

ADDRESS: Dept. Family practice, Rennes 1 university
2 Avenue professeur Léon Bernard, 35043 Rennes Cedex-France
Phone: + 33(2) 23 23 49 93 Fax: + 33(6)20 32 36 50
Email: nicolaschauvel35@gmail.com

Objective:

Prior to the implementation of a primary care pay-for-performance program (P4P) in France, we investigated the impact of physician characteristics on the variability of a P4P indicator for diabetes care, i.e. the percentage of patients undergoing 3 or 4 HbA1c tests during one year.

Research design and methods:

We studied a French public health care system database in Brittany to select a cohort of diabetic patients who had been attended to by their doctors for one year (2008). In all, 2,545 general practitioners attending to 41,453 diabetic patients were included. A three-level hierarchical logistic model was used to analyze the data.

Results:

Thirty-six percent of patients underwent 3 or 4 HbA1c tests during the year (the target objective was 65%). Younger patients of low socioeconomic status, who were not hospitalized in an endocrinology unit during the course of the year, were significantly less likely to be prescribed the recommended HbA1c test. There was a large variability between GPs even after adjusting for patient characteristics. Doctors who were female, young, working in a group practice, participating in quality groups, or who had a lower patient load prescribed the 3 or 4 recommended tests more often.

Conclusions:

To improve the quality of care of diabetic patients, financial incentives are not the only considerations to take into account. Other initiatives (adherence to quality-control groups, and health practitioner group promotion) are likely to produce favorable incentive effects.

Points for discussion:

-

TITLE: Evaluation of local infusion of betamethasone-lidocaine in adult patients with Knee Osteoarthritis that were under anticoagulation therapy.

AUTHOR(S): Athanasios G. Vitas, Ioannis E. Sokolakis
Anestis P. Vlachogiannis, Theofilos L. Panagiotidis
Nikolaos A. Papagrigoriou, Panagiotis Ch. Panagiotidis

ADDRESS: Dept. Community Clinic of Doxato
Primary Health Care Center of Kato Nevrokopi
Sotiros 3, 66100, Drama-Greece
Phone: + 30 6974 212 472; Fax: + 30 25210 45985
Email: athanasiosgvitas@eemmo.gr

Background:

Although intra-articular hyaluronic acid and corticosteroids are well established as a treatment for paroxysms of knee osteoarthritis (PKOA), a major concern occurs when the patient is under anticoagulation therapy.

Research question:

The aim of this prospective control study is to evaluate the local infusion of a mixture of betamethasone, lidocaine and water for injection (IMblw) as a treatment for PKOA in adult patients, receiving acenocoumarol as anticoagulation therapy, in a primary health care environment.

Methods:

A random sample of 69 patients (41 (59%) male – 28 (41%) female), with a mean age of 68 ± 8.9 years, were included in the study. The sample was randomly divided into two groups. The first group (active treatment group, ATG), consisting of 35 (51%) patients, was infused with IMblw, whereas the second group (placebo treatment group, PTG), consisting of 34 (49%) patients, was infused with water for injection. We used a needle of 26G 0.45x0.13mm at the point of maximum intensity of pain (IP). The IP was recorded at arrival and one hour after the infusion, using integer numbers of a 0-10 numeric rating scale of pain for patient self-assessment. All patients had $INR < 2.4$ and the mean PT was 21.2 ± 1.7 . They were also matched based on age, sex, radiological findings, and underlying diseases.

Results:

In ATG the mean IP at the arrival was 8.3 ± 1.7 , whereas one hour after the infusion was recorded in the same patients at 4.1 ± 0.9 ($p < 0.002$). In PTG the mean IP at arrival was 8.2 ± 1.8 and one hour after the infusion was measured at 7.8 ± 1.8 ($p = ns$). No ecchymosis, bleeding or other local or systematic complications were noted.

Conclusions:

The local infusion of IMblw was accompanied by major improvement of the clinical symptoms of PKOA and in the same time the highest safety was ensured.

Points for discussion:

-

TITLE: Asthma and indoors environment: usefulness of global avoidance methods on exposure to fungi at home, and on asthma control.

AUTHOR(S): Anthony Chapron, Matthieu Bouvrias

ADDRESS: Dept. de Médecine Générale, University of Rennes 1
13 Lot le Clos de la Garette, 22490 Plouër sur Rance-France
Phone: + 06 81 11 40 93
Email: anthony.chapron@gmail.com

Background:

Several international recommendations have recognized the worthiness of global allergen avoidance measures in non pharmacological asthma treatment. Nevertheless, clinical benefits have only been demonstrated by experimental clinical studies which would be difficult to implement as common practices.

Research question:

Clinical efficiency of a global avoidance method as common practice implemented by an indoors environment medical counselor (IEMC).

Method:

Prospective study on 27 asthmatic patients, aged 12 and over, which were visited by an IEMC. Asthma control was assessed at inception and then 6 to 12 months later. A follow-up inspection was performed within 30 months of the initial visit, in order to assess the impact of intervention on indoors environment; and especially on exposure to fungi at home.

Results:

A significant clinical improvement was observed regarding patients' asthma control ($p < 0.001$) and emergency hospitalizations due to asthma attack ($p = 0.001$). Furthermore, a decrease in exposure to fungi is likely; even if not demonstrated, considering the significant decrease in indirect signs of dampness ($p = 0.05$) and in size of damp patches ($p = 0.05$). Finally, several fungi-facilitating factors were identified, in accordance with the literature.

Conclusions:

These results confirm the usefulness of global avoidance methods.

Points for discussion:

1. Would it be interesting to further this study with a larger-scale study using a bigger sample, including a control group in order to confirm causalities?
2. Develop a pharmaco-economic approach?

**PRESENTATION 31: Saturday 21st May, 2011
14.00–15.30 h.**

**POSTER
Ongoing study with preliminary results**

TITLE: Methodological contribution, a process to elaborate quality of care indicators in chronic diseases.

AUTHOR(S): M.D. Beaulieu, B. Côté, Laure Fiquet

ADDRESS: Dept. Médecine Générale Rennes, Rennes 1 University
93 B Bd Voltaire, 35000 Rennes-France
Phone: + 0689493728
Email: laure.fiquet@univ-rennes1.fr

Abstract:

Chronic diseases are a major cause of chronic morbidity and mortality. In Quebec, AETMIS (Agence d'évaluation des technologies et modes d'intervention en santé) leads a project to develop quality of care indicators. The goal is to help healthcare professionals to provide better care in some chronic diseases.

Although many organizations are developing quality indicators, there is no consensus on what constitutes a gold standard methodology. All methods aim to provide a balance between evidence-based and consensual processes. Some organizations involve an interdisciplinary panel of experts. Few involve patients. We will present the process proposed by AETMIS applied to chronic obstructive pulmonary disease (COPD).

Research question:

This project aims to develop quality indicators and decision-support tools for healthcare professionals and suggest appropriate processes. First, we focus on developing a process to elaborate these indicators. Then, a panel of healthcare professionals has to determine indicators' feasibility, acceptability and efficiency.

Method:

First, we identified the relevant evidence on COPD management and indicators already developed. We analyzed the main clinical practice guidelines. We assessed their quality using the AGREE2 instrument. We extracted recommendations and their level of evidence. Indicators which have been developed by other researchers and elaboration methods were identified and mapped to the corresponding evidence. These first inputs (recommendations, indicators and issues raised) were reviewed by a group of experts (family physician, respiratory specialists, nurse, pharmacist and respiratory therapists).

In future months, those indicators will be submitted to a panel of primary care providers. Patients will also be involved in the process.

Results:

We will present the set of indicators that resulted from this process.

Conclusions:

It will be interesting to compare these indicators on COPD produced by this method with those produced from other approaches.

Points for discussion:

-

**PRESENTATION 32: Saturday 21st May, 2011
14.00–15.30 h.**

**POSTER
Ongoing study with preliminary results**

TITLE: Mortality causes in a recently diagnosed type 2 diabetic patient cohort in primary care followed up to 20 years.

AUTHOR(S): Joan Torras-Borrell, Núria Soldevila-Bacardit
Anibal José Cardenas-havez, Marco Colombini
Paula Carbonell-Soler, Robinson M. Nwachuknu
Clara Canela-Pujol, Manel Mata-Cases
Sandra González-Sánchez, Noemí Olona-Tabuena

ADDRESS: Dept. CAP La Mina, Institut Català de la Salut
C/ Mar, s/n, 08930 Sant Adrià del Besòs-Spain
Phone: + 34933811593; Fax: + 34933812141
Email: joan.torras.borrell@gmail.com

Research question:

Causes of mortality in type 2 Diabetes Mellitus (T2DM) patients diagnosed between 1991 and 2000 and followed up until December 2010.

Method:

A retrospective, longitudinal study performed based on the records of a cohort of all T2DM patients diagnosed in an urban primary care centre from 1991 to 2000 and followed up until December 2010. All patients without a previous glycaemic test in the 3 years before diagnosis were excluded in order to be sure that they were at the beginning of the disease. Patients who became diabetes-free during the follow-up were also excluded. Death causes were obtained from the electronic clinical records and validated in the mortality register of Spanish's Statistics National Institute.

Results:

There were 598 new cases of T2DM registered during the study period, of which only 469 of them accomplished the inclusion criteria (mean age [SD]: 59.7 [11.4] years; 51.3% women). During this period 131 patients died (27.9%): 65 men (30.1%) and 66 women (26.1%) (p=ns). 34 cases (26% of the deceased) died from macrovascular causes (18.5 % in men and 33.3% in women); 39 (29.7%) from cancer (41.5% in men and 18.2% in women), 41 (31.3%) from other causes (32.3% in men and 30.3% in women), and 17 cases (9.9%) by unknown causes (7.7% in men and 18.2% in women, p<0.01). The most frequent specific cardiovascular causes were: coronary heart disease 9.1% (9.2% in men and 9.1% in women, ns) and stroke 9.9% (6.2% in men and 13.6% in women, ns). Among neoplastic causes, the most frequent were lung (only men: 12.3%) and colorectal (6.2% in men and 3% in women, ns).

Conclusions:

Overall 27,9% died during follow up, however only about one quarter of them died due to macrovascular cause. Men died more frequently from cancer and women from macrovascular disease.

Points for discussion:

-

**PRESENTATION 33: Saturday 21st May, 2011
14.00–15.30 h.**

**POSTER
Ongoing study, no results yet**

TITLE: General practitioner's management of the post-myocardial infarction phase during the year after hospital discharge.

AUTHOR(S): Abdallah Karim, Lehr-drylewicz Anne-Marie, Clarisse Dibao-dina

ADDRESS: Dept. DUMG Tours
75 rue de la Scellerie, 37000 Tours-France
Phone: + 0033 2 47 51 50 22
Email: clarissedd@gmail.com

Background:

Updated in 2009, the recommendations for the management of the post-myocardial infarction (MI) phase were use of aldosterone antagonists and statins at discharge, in addition to continuation of all acute therapies such as aspirin, clopidogrel and beta-blockers at the appropriate dose. Biological controls have to be performed at 3 months and strategies to improve lifestyle habits implemented (tobacco withdrawal, physical exercises and diet advices). In France, follow-up can be managed by the general practitioner (GP) and/or the cardiologist.

Research question:

To evaluate the GP's management of patients at 6 months and 1 year after an inpatient treatment for MI.

Method:

Prospective observational monocentric cohort of patients in a post-MI phase followed by their GP and /or their cardiologist. Inclusion criteria were adult patients who presented an acute coronary syndrome and a ST-segment elevation and/or increased troponin I and had a coronary angiography in the CHU of Tours from January to June 2009. Data collection (especially treatment (type, doses), LDL-cholesterol and HbA1C levels, and tobacco withdrawal) at inclusion, 3 or 6 months and at 1 year of the study. The role of the GP (change of treatment, dose adaptation, and therapeutic education) was also investigated.

Results:

Among the 185 selected patients, 118 have been included in the analysis (2 patients lost-to-follow-up, 40 followed at the hospital, 16 who had an angiography for other reason than MI, 5 dead before hospital discharge and 4 with administrative problems). Data collection are still in progress, more than 70% of patients were followed by GPs. Full results will be available for the EGPRN meeting.

Conclusions:

We expect that the recommendations are respected by GPs who follow post-MI patients.

Points for discussion:

1. Who follows the patients in the post-MI phase in your country: the hospital, the cardiologist, or the GP?

TITLE: Measuring psychological change during and after brief CBT in primary care using a PSYCHLOPS questionnaire ('Psychological Outcome Profiles').

AUTHOR(S): Slawomir Czachowski, Mark Ashworth Chris Evans

ADDRESS: Dept. Family Doctor, Nicolas Copernicus University
Grabowa 10, 87-100 Torun-Poland
Phone: + 605427566; Fax: + 48 56 6458757
Email: s.czachowski@to.home.pl

Background:

We have devised and validated a patient generated measure, PSYCHLOPS ('Psychological Outcome Profiles'), which is administered before and after talking therapy. Usually, over half the patients starting therapy fail to complete a post-therapy questionnaire, thus preventing the calculation of a change score. We have overcome this limitation by devising a 'during-therapy' version of PSYCHLOPS, enabling change scores to be calculated throughout the duration of talking therapy. Repeated measures have not previously been reported for patient-generated mental health outcome instruments in primary care. We aimed to validate PSYCHLOPS as a measure of change over time.

Research question:

Is the validation of PSYCHLOPS acceptable?

Method:

Patients were recruited from primary care in Poland where brief CBT is routinely offered by GPs. Responses to PSYCHLOPS pre-, during- and post-therapy were compared. Change scores were calculated using Effect Sizes (change divided by SD of baseline score).

Results: A total of 238 patients completed the pre-therapy questionnaire, 194 (81.5%) completed the during-therapy questionnaire and 135 completed the post-therapy questionnaire (56.7%). Based on the sample completing all three measures, the mean score fell from 15.82 pre-therapy to 11.31 during therapy and to 6.44 post-therapy (score range: 0-20). The mean Effect Sizes for change pre- to during-therapy and during- to post-therapy were 1.41 (95% CIs, 1.23, 1.59) and 1.53 (1.36, 1.69), respectively; overall Effect Size was 2.94 (2.71, 3.17). Although the majority of patients reported new problems arising during therapy (n = 100; 74.1%), their mean change scores were similar to those not reporting new problems: 9.62 vs 8.69; t = -1.09, p = 0.23.

Conclusions:

A large proportion of outcome data is lost when outcome measures depend upon completed end of therapy questionnaires. Using repeated measures, we found that improvement during therapy (over three time points) was broadly linear and that the appearance of new problems during therapy did not hamper overall recovery.

Points for discussion:

1. Importance of talkative therapy (CBT therapy) in primary care setting.

TITLE: Effectiveness of a general practice and mental health team collaboration to improve cardiovascular risk factors follow-up in psychotic patients.

AUTHOR(S): Maribel Fernández-San-Martín, L. Viñas-Cabrera, L.M. Martín-López A. Barroso-Garcia, L. San-Emeterio, J. Morró-Plà, J. Martín-Royo E. Iludain-Ayala, R. Masa-Font, R. Ciurana-Misol, B. Díaz-Múgica

ADDRESS: Dept. Servicio d'Atenció Primària Litoral, Institut Català de la Salut
Lope de Vega 138, 08005 Barcelona-Spain
Phone: + 34 675782689; Fax: + 34 93 2662293
Email: mifsanmartin.bcn.ics@gencat.cat

Background:

The monitoring of cardiovascular risk factors (CVRF) of patients with psychosis is important because of high rates of cardiovascular morbidity and mortality.

Research question:

Evaluate the effectiveness of general practice and mental health team collaborative intervention to improve CVRF follow-up in psychotic patients.

Method:

Study design: multicenter before-after intervention study.

Participants and settings: all the patients assigned to general practice teams between 18-65 years of age with a diagnosis of psychosis in their clinical registers, re-confirmed by their doctors (n = 690).

Seven general practice and two mental health centres in Barcelona have participated.

Variables: sex, age, number of appointments per centre/year, psychiatric treatment, smoking, blood pressure, body mass index (BMI), total cholesterol, HDL cholesterol, triglycerides, glycemia, abdominal circumference (PA), Cardiovascular Risk.

Intervention: Clinical sessions shared (2009-2010), developing a collaborative primary-mental health protocol (2009-2010) and protocol implementation (2010-2011).

Analysis: comparison of CVRF records between 2008 (before intervention) and 2009 (early intervention), using statistical tests for paired data. Calculating the prevalence of CVRF.

Results:

Average age of 42.38 (SD 11.37), 67.1% men. 86.8% attended last year. All CVRF significantly increased in registration in the second year, except for smoking. The highest difference (8.5%) was for BMI register. Prevalence of CVRF in 2009: 19% dyslipemia, 15.9% obesity, 12.3% hypertension, 8.3% diabetes mellitus. The 78.1% of the patients with a smoking habit register were smokers. The prevalences were higher than in 2008.

Conclusions:

Prevalence and CVRF registration increased in 2009. The prevalences were high considering the age of the patients. Preliminary results support the importance of primary and mental health centre collaboration.

Points for discussion:

1. Are cardiovascular risk factor in psychotic patients under controlled by general practice?
2. Are psychotic patients with one or more cardiovascular risk factor under treated?
3. Is adherence to health style habits in these patients more difficult?

TITLE: Anti depressant drugs in non psychiatric conditions: GPs' opinions and international guidelines.

AUTHOR(S): Alain Mercier, I. Auger-Aubin, J.P. Lebeau, I. Pellerin, J.L. Hermil
P. van Royen, L. Peremans

ADDRESS: Dept. General Practice, Faculté de médecine de Rouen
22 Bd Gambetta, 76000 Rouen-France
Phone: + 0612801947
Email: alain.mercier@univ-rouen.fr

Background:

Main indications of antidepressants (ATD) are psychiatric conditions (e.g. depression, anxiety). Those drugs are also effective for certain non psychiatric conditions. In several cross sectional studies, it has been found that 20-30 % of the prescriptions could have been motivated by non psychiatric diseases. The indications for antidepressant drugs in these cases are not always endorsed. These non-psychiatric situations are often seen in primary care (eg. Migraine, fibromyalgia). Such situations have been cited in a previous qualitative study using focus groups. In this study, GPs have assessed 24 precise pathological situations leading to prescription. The use of antidepressant appears to be sometimes inappropriate, according to the guidelines.

Research question:

In non psychiatric conditions, what are indications and evidence levels for antidepressant drugs?

Method:

The databases of the French HAS (High Authority of Health Care), the NICE (UK), and the National Guideline Clearinghouse (USA) have been examined. Guidelines have been systematically screened with the following key words: antidepressant(s), tricyclic(s), serotonin, ISRS. For each condition quoted or associated with the key words, the level of evidence was compared between the databases and with the related use by the GPs. A complementary search has been performed for inconsistent data, on Pubmed and on the Cochrane database.

Results:

A total of 864 guidelines have been examined; only 40 remained after screening. Twenty-one non psychiatric conditions associated with the assessment of ATD were found in the guidelines. For one third, they were related to pain conditions. Two times out of three, GPs were prescribing for these diseases. Several inconsistencies have been found between the sources for several conditions: migraine, neuropathic pain, irritable bowel and urinary track incontinence.

Conclusions:

Even if the use of antidepressant drugs is frequent, clear information is not available, and the results difficult to implement in daily practice.

Points for discussion:

-

**PRESENTATION 37: Saturday 21st May, 2011
14.00–15.30 h.**

POSTER

Ongoing study with preliminary results

TITLE: Existential suffering in general practice.

AUTHOR(S): Benoît Cambon, Gilles Tanguy, Laurent Marty

ADDRESS: Dept. de médecine générale, faculté de médecine
Place H Dunant, 63000 Clermont Ferrand-France
Phone: + 0637949198
Email: benoit-cambon@wanadoo.fr

Background:

GPs frequently hear the existential suffering of patients: bereavement, divorce, chronic illness, disability, financial problems, harassment etc. In today's fragmented, complex and in an incessantly changing world, consultation with a GP is one of the few places where those sufferings can be expressed with a professional, who is known and trusted.

Research question:

What do GPs do when existential suffering is perceived in their patients?

Method:

Qualitative study, consisting of four focus groups with GPs. The sample of GPs included men and women, with varied ages and places of practice. The coding and analysis were carried out independently by a health anthropologist, a GP and a trainer. A joint analysis was performed.

Results:

GPs asked the question of their role when faced with such suffering. "Should we dig or leave it quiet"? They may have difficulty saying to the patients to come back to talk only about their existential difficulties. They did not always feel competent enough to help patients in this area. The patient's suffering could lead to GPs suffering. The GP's solitary exercise did not allow him/her to share any difficulties.

The possible responses of the GPs were multifaceted: listen with empathy, provide elements allowing patients to find solutions, let time fix it, give a drug prescription, referral to a specialist.

The ability to listen to the patient's suffering seemed to increase with length of practice.

Being perceived as a doctor who can talk, to help the patient and to receive his/her thanks seemed to contribute to the fight against GP burn-out.

Conclusions:

GPs hear the existential suffering of their patients and are an aid for them in this area. However, this requires time and appropriate training.

This is a preliminary results of a research project to explore and develop the GP's response when faced with patients' existential suffering.

Points for discussion:

1. Is there another team who is working on this topic?
2. In other countries, is it the role of the GP to listen to patients' existential suffering?

TITLE: Ethical issues raised by the introduction of payment for performance in France for chronic disease management.

AUTHOR(S): Oliver Saint-Lary, I. Plu, M. Naiditch

ADDRESS: Dept. Medecine Generale PIFO, UVSQ
16 bis avenue Simon Vouet, 78560 Le Port Marly-France
Phone: + 01 39 17 12 56
Email: oliviersaintlary@hotmail.com

Background:

In 2009, payment for performance (P4P) was introduced for general practitioners (GP) in France. One of the aims stated by its promoter (CNAM) was the improvement of chronic disease management. However, P4P has already been in effect for several years in other countries and has raised several issues, particularly ethical.

Research question:

What are the ethical issues raised by the introduction of payment performance for French GPs?

Method:

Qualitative research consisting of twofocus groups (FG): one consisting of a GP strategic sample who joined P4P, the other consisting of GPs who didn't join P4P. The separation was designed in order to avoid debate sterilization. Topic guides were based on data from the literature. The FGs were facilitated by a sociologist working in this field. All collective interviews were recorded, and then fully transcribed. An inductive analysis of thematic content with construction of categories based on the analysis was carried out. All the data were triangulated.

Results:

Two principal axes emerged from the content:

1 / Patient relationship

All participants agreed that conflicts of interest will inevitably appear, and the resurgence of doctors' control may occur, which can be to the detriment of the patient's autonomy.

GPs who didn't join P4P believed that this system will bring only a selection of patients, the other group did not.

2 / The relationship to money.

The level of remuneration of the P4P, considered as low by GPs, is thought as offensive by GP non-signatories, whereas it minimized the risk of drifting for the GP signatories.

Conclusions:

Behind laudable public health reasons, particularly concerning support of chronic disease management, for French GP the P4P raises new concerns about the autonomy of the patient and about the occurrence of new conflicts of interest.

Points for discussion:

1. What was the main reason why GPs accepted P4P or not?
2. Was it easy to recruit GPs for this project?

TITLE: Analysis of differences between registered and perceived chronic conditions in Spain

AUTHOR(S): Miguel Muñoz, Eduard Hermosilla, Concepción Violan
Mireia Fábregas, Isabel Mansilla, Luz-María Vilca

ADDRESS: Dept. Primary Health Care Research Unit
Institut Català de la Salut-IDIAP Jordi Gol
Sant Elies 42, 08006 Barcelona-Spain
Phone: + 34618653790; Fax:+ 34932000686
Email: mamunoz.bcn.ics@gencat.cat

Background:

The progressive aging of the population has implied an increase in the prevalence of chronic diseases. It is known that medical registries do not always agree with the perception of the population about their own morbidity.

Research question:

We would like to know if the prevalence of chronic diseases obtained from a Regional Health Survey agrees with those registered in medical records.

Method:

Cross-sectional study comparing the prevalence of 27 perceived chronic health conditions between the Catalan Health Survey and the information coming from medical records of patients attended in the previous three years. Perceived morbidity was coded using the International Classification of Diseases (ICD-10) in order to facilitate the comparison with morbidity registered in clinical records.

Results:

A total of 4,141,286 medical records were analyzed. No differences in socio-demographic characteristics of the population attended and the population interviewed in the Health Survey were found. Women comprised 52.4%; 21.2% were people older than 64 years. No differences in the prevalence of hypertension (19.8 vs 19.7), myocardial infarction (2.0% vs 2.2%), prostatic disorders (8.4% vs 8.4%) or skin conditions (7.2% vs 7.5%) were found between registered and perceived morbidity, respectively. Registered morbidity was higher than the perceived in the case of diabetes, mental disorders and malignant conditions. In the rest of the health problems considered, the perceived morbidity prevalence was higher than the registered one, especially in the case of musculoskeletal disorders (osteoarthritis, neck and back pain), other circulatory conditions (varicose veins, hemorrhoids and unspecific circulatory alterations) and chronic allergies.

Conclusions:

There is a big gap between the self reported information concerning chronic morbidity and those registered in medical records, especially in the case of more unspecific and symptomatic medical conditions. This gap could have repercussions for the treatment and control of patients.

Points for discussion:

1. How can we explain the differences between the registered and perceived morbidity?
2. These differences, are important enough to think that patients are not properly attended?

TITLE: Evaluation of General Practitioner's contribution in Primary Health Care to Prevention of Chronic Diseases in rural regions of our Country.

AUTHOR(S): Athanasios G. Vitas, Ioannis E. Sokolakis, A. Nikolaos Papagrighoriou
Athanasios V. Chalvatzis, Andreas G. Vitas
Panagiotis Ch. Panagiotidis, Anestis P. Vlachogiannis

ADDRESS: Dept. Community Clinic of Doxato
Primary Health Care Center of Kato Nevrokopi
Sotiros 3, 66100 Drama-Greece
Phone: + 30 6974 212 472; Fax: + 30 25210 45985
Email: athanasiosgvitas@eemmo.gr

Background:

The General Practice training program in our Country was introduced in 1986 and the first specialists in the field emerged in 1988. It is only in the past few years that a significant percentage of the Primary Health Care Centers are covered with General Practitioners (GPs).

Research question:

This retrospective study evaluates the contribution of a GP in the promotion of public health during the period 2004-2010 in an area that lacked the presence of a GP in the community clinic before 2004.

Methods:

We collected data from 3,281 patients, who suffered mainly from chronic diseases. We recorded patients' medical history, diagnosis at attendance and/or hospitalization to the emergency department or the clinics of the nearby General Hospital from its database. We calculated morbidity and mortality rates of many diseases at 2004 and at 2010.

Results:

During the last six years, a significant reduction of vascular diseases (-27%; $p < 0.004$), acute ischemic syndromes (-36%; $p < 0.001$), hip fractures (-28.5% $p < 0.004$) and vertebral fractures (-43%; $p < 0.0003$) were noted. Furthermore a significant decrease of hospitalization days in secondary health care institutes, due to respiratory infections (-67.5%; $p < 0.0001$), urinary track infections (-19.4%; $p < 0.042$) and diabetes deregulation (-56%; $p < 0.0002$) were also recorded. A significant reduction in attendance to emergency departments of secondary hospitals was also noted, from patients who suffered from acute and chronic musculoskeletal pain (acute: -31.8%; $p < 0.003$, chronic: -21.9%; $p = 0.0428$). Reduction of overall morbidity (-43.5%; $p < 0.0003$) and mortality (-19.7%; $p = 0.00572$) rates was recorded, with an increase in life expectancy (+2.9%). However, an increase in depression's morbidity (+8.5%) and malignancies (+1.05%) was also noted.

Conclusions:

The presence of a GP seems to contribute significantly to the reduction of morbidity and mortality rates of chronic diseases, hospital attendances and hospitalization days in the population of responsibility.

Points for discussion:

1. The increase in the morbidity related to depression and malignancies.

TITLE: Patient safety should be supported by practice software - A study towards requirement specifications of GP in Germany.

AUTHOR(S): Martin Beyer, Silke Neumann, Bernhard Gibis, Ferdinand M. Gerlach
Antje Erler

ADDRESS: Institute for General Practice, Goethe University
Theodor-Stern-Kai 7, 60590 Frankfurt-Germany
Phone:+ 49-(0)69-6301-83877; Fax:+ 49-(0)69-6301-6428
Email: Beyer@allgemeinmedizin.uni-frankfurt.de

Background:

Computerized Physician Order Entry Systems (CPOE) and Clinical Decision Support Systems (CDS) have been proven to support patient safety in prescribing, but only few studies have explored needs and expectations of general practitioners. In Germany more than a hundred practice software systems are competing, most of which are lacking the basic features of an Electronic Health Record and, thus, cannot provide core functionalities on behalf of patient safety.

Research question:

Based on evidence based proposals of safety features of electronic patient records, which functionalities would be prioritized by panels of German GPs?

Method:

We performed a systematic literature search for safety features of electronic health records which are feasible for family practice. Within three focus groups of GPs and an additional focus group with health care assistants, we discussed some 40 propositions, and the participants were invited to explain their own experience with patient safety issues about medication in their practice. A content analysis of the focus group discussions was performed and further prioritization by researchers and members of the statutory body (the German Association of Sickness Fund Physicians) will be presented.

Results:

Support of patient safety issues by electronic systems was welcomed, and the state of present software was rated as poor or worse. Thirteen of the (40) propositions were appreciated in the fields of patient identification / clinical data, (patient-held) medication record (and reconciliation), decision support in prescribing, meaningful alerts, and the general ergonomic use. A manageable medication record (with decision-supporting and alerting functions) was seen as a core functionality for the GP.

Conclusions:

The inclusion of the users provided important insights in the daily use of electronic systems. Some of the requirements could easily be developed in the software environment while others will require more stringent implementation principles of Electronic Health Records in German software.

Points for discussion:

1. Are the participants from other European countries confident that the GP-practice software in their countries is sufficiently guaranteeing patient safety in prescribing (or allowing 'meaningful use' - as the US expression is)?
2. How can we include?

TITLE: General Practitioner's Reported Use of Clinical Guidelines for Hypertension and Ambulatory Blood Pressure Monitoring in the West of Ireland.

AUTHOR(S): Eva Flynn, Aonghus Flavin

ADDRESS: Dept. General Practice
Western regional training programme, Galway, Ireland
15 cuirt eanna, Longwalk, Galway-Ireland
Phone: + 35 386 397 3345
Email: evaflynn@hotmail.com

Background:

Uncontrolled hypertension is a serious health concern. In Ireland, high blood pressure affects more than 70% of those aged over 70 years. Uncontrolled hypertension poses significant risk to the patient and a burden on the economy. In addition, the burden of hypertension is set to increase as ours is an aging population.

General practice is, however, the cornerstone for management of hypertension. International research has yielded practice-changing clinical guidelines, which recommend the use of Ambulatory Blood Pressure Monitoring (ABPM). A prominent Irish study has shown that ABPM significantly improves blood pressure control in primary care. European work has revealed circadian rhythm abnormalities on ABPM that are related to cardiovascular events and strokes.

Research question:

In Ireland there is currently no evidence quantifying the use of clinical guidelines for hypertension by GPs. This study aims to quantify this. The merits of ABPM are well described. Given this, this study aims to explore the role of ABPM in General Practice.

Method:

This is a cross-sectional quantitative study using a questionnaire format. The population studied was 250 GPs working in the West of Ireland in September 2010.

Results:

This study had a response rate of 68% and found that 88% of GPs use clinical guidelines for hypertension. Overall, 82% report that use of clinic blood pressure monitoring alone is insufficient for the diagnosis and monitoring of hypertension. Lack of remuneration, 72%, cost, 68%, and lack of time, 51%, are the most commonly reported limiting factors for the use of ABPM.

Conclusions:

GPs are using clinical guidelines for hypertension, which advocates the use of ABPM. GPs see ABPM as an indispensable clinical tool. Despite good access to ABPM, this work identifies definite barriers of lack of remuneration, cost and lack of time, which restrict the use of ABPM. A suggestion from this work is to incentivize ABPM, which would result in increased use of ABPM and improved blood pressure control.

References on request.

Points for discussion:

1. Use of ABPM and removing restrictions to use.
2. Cost effectiveness of ABPM, reduces burden of hypertension and its ill effects greatly, reduces amount of antihypertensive meds prescribed.
3. Comparing ABPM use in different countries.

**PRESENTATION 43: Saturday 21st May, 2011
14.00–15.30 h.**

**POSTER
Ongoing study with preliminary results**

TITLE: Pilot study of CANABIC randomized clinical trial: CANNabis and Adolescents, effects of a Brief Intervention on their Consumption.

AUTHOR(S): Catherine Laporte, C. Dubray, B. Pereira, V. Picard-Bernard
H. Vaillant-Roussel, P.M. LLorca, P. Vorilhon

ADDRESS: Dept. de Médecine Générale, Faculté de Médecine de Clermont Ferrand
206 avenue de la liberation, 63000 Clermont Ferrand-France
Phone: + 06 11 37 55 52
Email: catherinelaporte63@gmail.com

Background:

Cannabis (THC) is the first illegal drug used in France. First experiment occurs around 15 years-old, consumption increases up to 25 years-old and then stabilizes or decreases. The general practitioner (GP) is the health professional most consulted by adolescents. However, cannabis consumption isn't investigated during consultations. Brief intervention (BI) is a validated approach to address adult excessive alcohol consumption and thus could be a tool for GPs in respect of teenager cannabis consumption. CANABIC is a randomized clinical trial which aims to validate an adapted BI for 15 to 25 years-old teenagers consuming THC. An ongoing pilot study is being performed to test trial feasibility.

Research question:

Test the feasibility of a clinical trial named CANABIC : CANNabis and Adolescents, effects of a Brief Intervention on their Consumption.

Method:

Pilot study performed by six settled practicing GPs from Auvergne. Those GP attended training on the 17th of September 2010: and a qualitative seminar was held with teenagers and GPs, which permitted the analyses of difficulties communicating about THC. During a four month period, each GP had to include five teenagers: detection of cannabis consumption and BI application. One follow-up consultation was planned three months later.

Results:

As the inclusion period ends on the 17th of January, all consultation results will be brought together before the 17th of April 2011.

Rates of teenager's participation, inclusion and GP follow-up will be analyzed.

The case report Form will be reviewed by GPs in order to be improved.

Conclusions:

This pilot study will allow optimizing CANABIC trial success.

Points for discussion:

1. Difficulties of inclusions.
2. How to ameliorate protocol and case report form depending on results of the pilot study?

TITLE: Smoking habits, personal characteristics and attitudes toward smoking among Israeli-Arab adolescents.

AUTHOR(S): Joseph Azuri, H. Mahajne, S. Vinker

ADDRESS: Dept. Family Medicine, Maccabi Healthcare
17 Emeq Bracha St, 67456 Tel Aviv-Israel
Phone: + 972-50-8800068; Fax: + 972-3-6954841
Email: azuri_yo@mac.org.il

Background:

Smoking usually begins in early adolescence. According to the Israeli Health Minister Report about Smoking, 3.6% of the 8th grade pupils (age 14 years) smoke regularly (4.9% for males and 2.3% for females). Water-pipe (Nargila) smoking became a very common phenomenon among adolescents in Israel with 41% of Jewish adolescents smoking Nargila to some extent and 22% of them smoking Nargila at least every weekend.

Objectives:

Characterization of knowledge, attitudes and smoking habits (cigarettes and Nargila) among 9th grade pupils (age 15 years) among Israeli Arabs.

Methods: Questionnaires were distributed to all 9th grade pupils in two high schools in different areas in Israel, which represent Arab populations of different religiosity. The questionnaire included questions about knowledge, attitudes and habits regarding smoking.

Results:

A total 562 out of 566 questionnaires were completed (99.3% response rate), 49.11% males. The knowledge level of the pupils was not uniform. Overall, 25.4% of male pupils defined themselves as current smokers, compared to 1% of females ($p < 0.0001$). The rate of Nargila smokers was higher than cigarette smokers (34.8% compared to 25.4%) in males. There was a correlation between adolescent cigarette smoking and whether they had family members who smoke either cigarettes or Nargila. The majority of smokers stated they began smoking at the age of 13-14 years. Most pupils smoke with their friends, few of them smoke alone. Lower knowledge was correlated more to cigarette smoking than Nargila smoking. Non-smokers expressed less desire to smoke in the future. There was a strong correlation between thoughts about social acceptance and cigarette and Nargila smoking.

Conclusions:

Cigarette and Nargila smoking are very common among male Arab adolescents in Israel and uncommon among female teenagers. Smoking is a social more than an individual act for adolescents, especially with regard to Nargila smoking. Campaigns against smoking including Nargila in very early ages are important.

Points for discussion:

1. Smoking habits among adolescents.
2. Nargila Vs cigarette smoking among adolescents.
3. Ways of coping with smoking among adolescents.

**PRESENTATION 45: Saturday 21st May, 2011
14.00–15.30 h.**

**POSTER
Ongoing study, no results yet**

TITLE: Impact of urinary screening tests on addiction practice: an intervention study.

AUTHOR(S): Julie Dupouy, S. Bismuth, S. Oustric, M. Lapeyre-Mestre

ADDRESS: Dept. of General Practice, University of Toulouse
Rangueil, 133 route de Narbonne, 31063 Toulouse-France
Phone: + 0683773142
Email: dupouy.julie@gmail.com

Background:

In France 80,000 patients were under buprenorphine treatment in 2003 versus 16,000 under methadone treatment; most of them were managed in family practice. All general practitioners (GPs) can prescribe buprenorphine. Methadone has to be initiated in a specialized centre but can be renewed by any GP. French recommendations are to assess opiate dependence performing urinary tests for initiation and follow-up of opioïd substitution therapy (OST). Recently, urinary on-site screening tests for drugs of abuse (UDT) are available. These tests are not used by French GPs who lack knowledge of them.

Research question:

The impact of performing UDT on opioïd-dependent patients in the context of general practice remains unknown. We present the protocol of an intervention study which investigates how UDT could change GPs' practice for management of OST.

Method:

A sample of French GPs taking care of opioïd-dependent patients will be randomized into two groups: the intervention group and the control group. Intervention will have the availability of UDT in the medical office. The control group will be free to perform screening tests or not as they usually do. All GPs will be invited to include up to ten consecutive patients during their first visit for prescription of OST (initiation or renewal) and to follow them for six months. The main outcome will be maintenance rate at six months. Secondary outcomes will be acceptability to patients and physicians (self administered questionnaires), number of UDT performed and GPs' opinion about the modification of their practice by UDT.

Results:

Our hypothesis is that UDT will help GPs assess opiate dependence and so optimize OST prescription, as well as reinforce dialogue.

Conclusions:

UDT could be a tool for GPs in charge of opioïd-dependent patients and could be spread to all GPs, thus facilitating care access for these patients.

Points for discussion:

1. Experiences about UDT in other European countries.
2. Assessing patients' management in terms of dialogue and education.

**PRESENTATION 46: Saturday 21st May, 2011
14.00–15.30 h.**

**POSTER
Ongoing study with preliminary results**

TITLE: Detection of intimate partner violence for women in primary care.

AUTHOR(S): Svetlana Ulesova, Susana Hernáiz, Fernando Lago, Ignacio Porrit
María Tato, José Luis Salgado

ADDRESS: Health Center of Sárdoma
Baixada a Laxe 76, 36204 Vigo-Spain
Phone: + 34986416324
Email: flagod@meditex.es

Background:

Gender-based violence is a public health problem in Spain, because of its high prevalence (15-20%) and major physical (including death) and mental health consequences.

Research question:

What is the prevalence of domestic violence, physical and nonphysical, in the Val Miñor health area? Psychometric analysis to validate a shorter questionnaire.

Method:

Data collection and application of the survey Index of Spouse Abuse, previously validated for Spain, which includes a subscale of physical and other non physical criteria, in a sample of 360 women in a primary care health population of 36,931; chosen by consecutive sampling.

Results:

Preliminary results are presented for the 222 initial surveys. Average age of 41.4 years (range 16-78), 1.75 children (± 1.09), 97.3% Spanish nationality, 68.5% work outside the home, 96.9% are married or cohabiting, 5.4% have no education, 33.5% are university students, 52.7% have household incomes exceeding €1200. The percentage of physical abuse is 3.3% and 7.3% non-physical, with both occurring in 2.3%. There are no differences between the group of battered and not battered with regard to social variables, except for marital status (married or cohabiting less battered). The psychometric analysis is not yet completed.

Conclusions:

The percentage of abuse is less than reported in Spanish literature. The influence of marital status will be confirmed when the study is completed.

Points for discussion:

1. Which is the social profile of battered woman?
2. What factor best explains the mistreatment?

TITLE: Adolescent-parent disagreement on health-related quality of life in food allergic adolescents; Who makes the difference?

AUTHOR(S): Jantina Lucia van der Velde, B.M.J. Flokstra-de Blok, A. Hamp R.C. Knibb, E.J. Duiverman, A.E.J. Dubois

ADDRESS: Dept. pediatric allergy and pulmonology, university medical centre Groningen Hanzplein 1, 9700 VB Groningen-Netherlands
Phone: + 316 15263299; Fax: + 0031 50 3614235
Email: j.l.van.der.velde@bkk.umcg.nl

Background:

Food allergic adolescents are at highest risk for food allergy fatalities, which may be partly due to compromised self-management behaviour. Such behaviour may be negatively influenced by conflictual situations caused by child-parent disagreement on the adolescent's Health-Related Quality of Life (HRQL). Child-parent disagreement on the adolescent's HRQL has never extensively been studied in food allergic adolescents.

Research question:

- 1) Do food allergic adolescents and their parents (dis)agree on the adolescent's HRQL?
- 2) Which factors influence adolescent-parent (dis)agreement?

Method:

Dutch adolescents (13-17 years) with at least one physician diagnosed (General Practitioner/ Allergist) food allergy and their parents were included in this cross-sectional study. Questionnaire packages containing a Teenager Form (-TF) and Parent Form (-PFA) of the Food Allergy Quality of Life Questionnaire (FAQLQ), Food Allergy Independent Measure (FAIM) and Brief-Illness Perception Questionnaire (Brief-IPQ) were completed at home. ICCs, t-tests and Bland-Altman plots were used to investigate adolescent-parent agreement on the adolescent's HRQL. Factors (participant characteristics, illness expectations and perceptions) influencing agreement were studied using linear regression analysis.

Results:

Seventy adolescent-parent pairs were included. There was a moderate correlation (ICC=0.61, 95% CI=0.44-0.77, $p<0.001$,) and no significant difference (3.78 versus 3.56, $p=0.136$) between adolescent- and parent-proxy-reports on the adolescent's HRQL. However, Bland-Altman plots showed relevant differences (exceeding minimal important difference) for 64% of all adolescent-parent pairs. Regression analysis showed that an older age of adolescents, poorer adolescent-reported illness comprehension (Brief-IPQ-TF, coherence) and higher adolescent-reported perceived disease severity (FAIM-TF) were associated with adolescent-parent disagreement.

Conclusions:

Agreement between food allergic adolescents and their parents on the adolescent's HRQL was moderate. Disagreement was mainly associated with adolescent's rather than parent's perceptions and characteristics. Illness comprehension may be an important target for intervention aimed at improving adolescent-parent agreement. The outcome measures, FAQLQ-TF and -PFA, should be used together to highlight areas of adolescent-parent disagreement.

Points for discussion:

1. The outcome measures, FAQLQ-TF and -PFA, should be used together to highlight areas of adolescent-parent disagreement on the adolescent's HRQL.
2. Adolescent-parent disagreement on the adolescent's HRQL was mainly associated with adolescent's rate of severity.

**PRESENTATION 48: Saturday 21st May, 2011
14.00–15.30 h.**

**POSTER
Ongoing study with preliminary results**

TITLE: Assessment of activities of daily living (ADL) ability in the elderly – a multicentre survey in Vila Nova de Gaia, Portugal.

AUTHOR(S): Ana Luisa Neves, Diana Martins, José Luis Fernandes
Patricia Marques, Ricardo Silva

ADDRESS: Dept. Primary Care Unit Camélias, Faculty of Medicine, University of Porto
Rua do Carregal, 699, 4410-279 Canelas VNG-Portugal
Phone: + 00351919143894
Email: ana.luisa.neves@gmail.com

Background:

The growing aging population raises the concerns regarding the functional ability of elderly, in particular their ability to perform activities of daily living (ADLs), which is a recognized marker of quality of life. In Portugal, the data for this parameter are scarce, and there are no studies using validated questionnaires.

Research question:

To determine the prevalence of different degrees of dependency of elderly portuguese in basic ADLs performance and to analyze related socio-demographic factors.

Method:

An observational, cross-sectional survey was performed. Six hundred and fifty individuals aged over 65 years were randomly selected from four primary care centers in the north of Portugal, and a questionnaire assessing socio-demographic variables and the Barthel index was applied, between May and August 2010. Descriptive and inferential statistics were performed with SPSS18®, and a significance level of 0.05 was adopted.

Results:

We had a response rate of 90%. Our sample included 584 individuals - 60.1% male, mean age 76 years. The prevalence of dependence was 37.8%. The degree of dependence increased with age ($p<0.05$). Women seem to have a higher average level of dependence ($p<0.001$), however this association loses some of its magnitude after adjustment for age. More educated elderly are less dependent ($p<0.001$), and statistically significant relationships were also found between the level of dependence and marital status ($p=0.011$) and the number of elements of the family ($p<0.001$).

Conclusions:

In this survey, the prevalence of dependence in ADL performance was higher than stated in the National Observatory of Health report, which used a non-validated scale. The association between the level of dependence and age and sex have been previously described in other European populations. Our study provides a validated assessment and characterization of the ability in this population, which may be a first step in signaling medical and social interventions.

Points for discussion:

1. Knowing that a timely recognition of older people at higher risk of dependence is essential to devise strategies in order to multidisciplinary promote their autonomy and quality of life - after the assessment of the problem, what can we offer to our patients?

**PRESENTATION 49: Saturday 21st May, 2011
14.00–15.30 h.**

**POSTER
Ongoing study with preliminary results**

TITLE: How French GPs deliver the FOBT: a qualitative study.

AUTHOR(S): Isabelle Aubin-Auger, A. Mercier, J.P. Lebeau, M. Bismuth
L. Peremans, P. Van Royen

ADDRESS: Dept. Paris7, Denis Diderot University
40 rue Carnot, 95230 Soisy sous Montmorency-France
Phone: + 33 134 051 818; Fax: + 33 134 051 819
Email: isabelle.aubinauger@sfr.fr

Background:

Colorectal cancer has the third highest frequency rate in France with 38,250 cases every year, and is also the second cause of mortality by cancer. A guaiac fecal occult blood test (gFOBT) is used for screening. Mass screening was gradually extended to the whole country from 2002 to 2008. Patients from 50 to 74 receive an invitation every two years, urging them to ask their GP for the test. During this consultation, GPs first identify high risk patients and exclude them from mass screening. For others, GPs deliver the gFOBT and explain how to perform it. They are also supposed to explain the meanings and consequences of the results. The low rate of participation allows us to ask questions about the real content of this consultation and its consequences on patients' test participation.

Research question:

What is the core content of the consultation when French GPs deliver the FOBT?

Method:

Fifteen GPs were asked to audio-record their next four consultations while delivering the FOBT. A purposeful sampling of the GPs was carried out to reach as much diversity as possible about age, sex, place of practice and experience of the mass screening. The analysis was done by two researchers with Nvivo 8 and explored content, conversation and communication between the GP and his patient. The categorization was done with a predefined framework.

Results:

Only nine GPs took part in the study. The content analysis identified that GPs had stereotyped consultations. Explanations were mostly about technical aspects of the test. Only a few GPs had a patient centered approach asking patients about their knowledge and their understanding.

Conclusions:

The analysis of the screening consultation could deliver relevant information to improve and build a trial, using this information, and assessing its influence on GPs' performance.

Points for discussion:

-

**PRESENTATION 50: Saturday 21st May, 2011
14.00–15.30 h.**

**POSTER
Ongoing study with preliminary results**

TITLE: Escape-Quali.

AUTHOR(S): Jean-Pierre Lebeau, A. Mercier, I. Aubin-Auger, J.S. Cadwallader
B. Schnebert, D. Pouchain

ADDRESS: Dept. General Practice, University of Tours
10 Boulevard Tonnelles, 37000 Tours-France
Phone: + 0033607390999; Fax: + 0033254779787
Email: lebeaujeanpierre@yahoo.fr

Background:

Therapeutic inertia is a major cause of uncontrolled hypertension. In France, 85% of the hypertensive patients who are treated but not controlled, leave their doctor's office with the same treatment. There seems to be multiple reasons underlying this behavior, which are still not well understood. The personality of the general practitioner (GP) may be pre-eminent.

Research question:

Are there specific GPs' profiles in therapeutic inertia?

Method:

Ancillary qualitative study nested in a cluster randomized controlled trial. Mixed-method analysis with concurrent nested design. The data consisted in a closed database of 2 643 written answers to the open question: *"If the targets were not reached (BP, HbA1c, LDL-c values, and low-dose aspirin for diabetic patients) for this patient, and you didn't make any change in the treatment, could you tell us why?"* Simple semantic coding was first performed, and semantic units were counted. Thematic coding was then performed. Finally, matrix coding, combining semantic themes and GPs was achieved, in order to come up with GPs' profiles.

Results:

Through descriptive quantitative analysis of the frequencies of occurrence of semantic unit, weightings are attributed to the reasons put forward for therapeutic inertia. Through thematic coding, a number of GPs profile in answering the specific question are being identified. The analysis is still in progress. Complete results will be available in May 2011.

Conclusions:

Whatever the results of the analysis, the data remains purely declarative, and consists mainly in very short and pragmatic explanations. Starting from this first step, further qualitative data gathering and analysis, from focus groups and interviews, will allow more a thorough understanding of the inner process of therapeutic inertia.

Points for discussion:

1. Are there any mixed-method designs other than concurrent nested that could be useful?
2. Should the forthcoming focus group recruitment be based on the results of the profiles of this study?
3. Is there another study of the same kind currently in progress?

**PRESENTATION 51: Saturday 21st May, 2011
16.40-17.10 h.**

**THEME PAPER
Ongoing study with preliminary results**

TITLE: The FPDM (family practice depression and Multimorbidity) Study:
Project for systematic review of literature to find tools for depression
diagnosis used in primary care.

AUTHOR(S): Patrice Nabbe, J.Y. Le Reste, B. Chiron, A. Le Prielec, M.A. Munoz
A. Claveria, C. Fonseca, S. Argyriadou, H. Argyriadou
S. Czachowsky, C. Mueller, E. Hummer Pradier, H. Van Marwijk
P. Van Royen

ADDRESS: Dept. Universitaire de Médecine Générale
Faculté de Médecine et des Sciences de la Santé
22 avenue Camille Desmoulins CS 93837, 29238 BREST cedex 3-FRANCE
Phone: + 0607631490
Email:nabbe.patrice@gmail.com

Background:

Many tools for depression screening, severity assessment and diagnosis in primary care have been produced over the years. However, their intrinsic validity, predictive validity, feasibility and reproducibility are not well known and disseminated, specifically not in everyday GP practice samples.

Research question:

What are the validity, reproducibility and feasibility of screening and diagnostic tools for depression developed for use in primary care?

Method:

Systematic review of literature with ten national teams from EGPRN. Key words are: depression definition, depression criteria, depression diagnosis, depressive disorders, depressive syndromes and tools or scales, questionnaires and primary care, family practice, general practice. Searched databases are Pubmed, Embase and Cochrane. All hits were screened based on the abstract with inclusion and exclusion criteria by the French team. Those abstracts were dispatched between the national teams. All articles were critically assessed by two reviewers using the same criteria for identification of specific tools for screening and/or diagnosis of depression. For each tool we assessed its properties as mentioned in the articles versus a reference standard: sensitivity, specificity, negative and positive predictive value, area under the curve, Youden index, likelihood ratio's. We also evaluated feasibility, reproducibility, and actual use in practice.

Results: preliminary results will be available for May 2011.

Conclusions:

With this systematic review, we will find tools used for depression screening and diagnosis and we will be able to identify their validity, reproducibility and feasibility.

Points for discussion:

1. What tools do you use to screen depression?
2. What tools do you use to diagnose depression?

TITLE: The effects of (multi)morbidity on mental and physical health: Temporary or persistent? A 3 and 6 year follow-up from the Maastricht aging study.

AUTHOR(S): Sil Aarts, M. van den Akker, H. Bosma, F.E.S. Tan, F.R.J. Verhey
J.F.M. Metsemakers, M.P.J. van Boxtel

ADDRESS: Dept. General Practice, Caphri
Debyeplein 1, 6200 MD Maastricht-The Netherlands
Phone: + 0031433882323
Email: sil.aarts@maastrichtuniversity.nl

Background

Multimorbidity, the occurrence of two or more chronic diseases within one person, is well known for its profound negative effects on mental and physical health. However, it remains unclear if these effects are temporal or permanent.

Objective

The primary aim of this study was to clarify the relationship between morbidity and multimorbidity on one side and self-reported mental and physical health on the other. By evaluating the effects of (multi)morbidity on mental/physical health at two follow-up time points, it was possible to monitor the stability of the consequence of (multi)morbidity.

Methods

Data were collected as part of the Maastricht Aging Study (MAAS), a prospective study into the determinants of cognitive aging. Eligible MAAS participants (N=1641), 24–81 years old, were recruited from the Registration Network Family Practices (RNH), a patient database for research in primary care which enabled the apriori use of medical records. The overall disease count (i.e. the number of chronic medical conditions based on 96 included chronic diseases) of all MAAS participants was assessed by looking at the medical records at baseline, at three and six year follow-up; the Short Form Health Survey (SF-36) was also completed at these three time points. A multilevel statistical analysis was used, which respects the hierarchical structure of the study data.

Results and discussion

The analysis is going. Precisely 30% of the participants suffered from morbidity and more than 29% suffered from multimorbidity. More results will be available at time of the congress meeting.

