EGPRN Office: Mrs. Hanny Prick
Department of Family Medicine, Maastricht University
P.O. Box 616, NL 6200 MD Maastricht, The Netherlands.
Phone: +31 43 388 2319; E-mail: hanny.prick@maastrichtuniversity.nl
Website: www.egprn.org; Twitter: @HannyPrick

European General Practice Research Network

Leipzig-Germany

12th -16th October, 2016

SCIENTIFIC and SOCIAL PROGRAMME

THEME: "General Practice/Family Medicine in a Changing World"

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

CONFERENCE VENUE

Studienzentrum (study centre), Haus E
located on the Campus of the Medical Faculty
Liebigstraße 27
04103 Leipzig – Germany

EUROPEAN GENERAL PRACTICE
EGPRN
RESEARCH NETWORK

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

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

UNIVERSITÄT LEIPZIG

Medizinische Fakultät
Selbstständige Abteilung für Allgemeinmedizin

DEGAM
Deutsche Gesellschaft für
Allgemeinmedizin und Familienmedizin

GAM
Akademische Allgemein-
und Komplementärmedizin e.V.

"EGPRN and Local Organizing Committee would like to especially thank the local volunteers and sponsors for their contribution to this conference"

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

Those participants who need a certificate can contact Mrs. Hanny Prick during the meeting in Leipzig.

“General Practice/Family Medicine in a Changing World”.

Dear doctors, researchers, and colleagues,

Societies and health care systems in Europe are faced to many changes: Ageing, migration, increasing morbidity, shortness of financial resources. All these changes will influence the future care and research in general practice. It is conclusive that the main topic of the upcoming meeting is thereby of high relevance.
For the upcoming meeting we want to motivate colleagues to contribute actively to the conference. Since we try to attract a broad field of participants, we did not limit the topic to a small spectrum. The contributions should fit into the main topic and especially – but are not limited to – the following mentioned subtopics:
- General practice in a changing world (e.g. shortage of GPs, changing practice management)
- Innovations for future care & research (e.g. Ambient assisted living, European networking)
- Primary care for patients suffering from chronic diseases
- The international development of professional & academic general practice
- The education and support of future general practitioners by innovative solutions

Leipzig is located in eastern Germany, has suffered a lot from Second World War, state regulations of the Nazi Germany and the communist regime. It is located in a region that is still confronted with frequent chronic health problems, a high percentage of elderly persons especially in rural areas and also a shortness of general practitioners in these regions. These problems are a main consequence of an ageing society and migration. Many European countries are facing similar society related problems. We would look forward to presentations from Mediterranean countries that face severe problems of the health care system, such as Greece, from the eastern European countries that are also affected as well as from other countries, particularly GB, the Netherlands, Denmark, Sweden, Finland and Norway. We propose 2 keynote lectures one addressing the changing scene in latter countries with established and stabile care and one from a perspective of a changing system such as in eastern or Mediterranean countries.
In the context of changing societies, patients and physicians, primary care may be strengthened by implementing innovative approaches such as ambient assisted living (AAL) for elderly people and other technical assisting approaches (e.g. regarding mobility). The education and support of future general practitioners by innovative solutions (e.g. innovative methods in medical teaching, the use of smartphone applications for education and daily practice, telemedicine, mobile general practitioner offices) could also be an important part of the meeting.

Local Organizing committee:
- Thomas Frese
- Jarmila Mahlmeister
- Hagen Sandholzer
- Britt Häussler
- Stefan Lippmann
- Tobias Deutsch
- Nicole Schäfer

MEETING EXECUTIVE BOARD

GENERAL COUNCIL MEETING

Executive Boardmeeting
Thursday 13th October, 2016

09.30 – 12.30: Executive Board Meeting
Executive Board members
Coffeebreak at 11.00 hrs.

Location: Studienzentrum (study centre), Haus E
located on the Campus of the Medical Faculty
Liebigstrasse 27
04103 Leipzig - Germany
in: Meeting Room of the Medical Faculty

General Council meeting with the National Representatives
Thursday 13th October, 2016

14.00 - 16.45 : Council Meeting
Executive Board members and National Representatives
Coffeebreak at 15.25

16.45 - 17.30 : Meeting of the Special Committees and Working Groups:
-Research Strategy Committee
-PR and Communication Committee
-Educational Committee

Location: Studienzentrum (study centre), Haus E
located on the Campus of the Medical Faculty
Liebigstrasse 27
04103 Leipzig - Germany
in: Meeting Room of the Medical Faculty

REGISTRATION

► Thursday 13th October 2016

REGISTRATION FOR PARTICIPANTS OF PRE-CONFERENCE WORKSHOPS ONLY

Location: Studienzentrum (study centre), Haus E
Liebigstrasse 27, 04103 Leipzig-Germany.

On arrival, every participant, who has not paid and/or registered online, pays €65,= (or € 35,= if an EGPRN-member) per person for each pre-conference workshop.

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► Friday 14th October 2016

REGISTRATION FOR ALL PARTICIPANTS
Time: 08.00 – 08.30 h.

Location: Studienzentrum (study centre), Haus E
Liebigstrasse 27, 04103 Leipzig-Germany.

On arrival, every participant, who has not yet paid/registered online, will pay €450,= (or €250,= if an EGPRN-member) per person.
+ on site payment +€50 extra administration costs.

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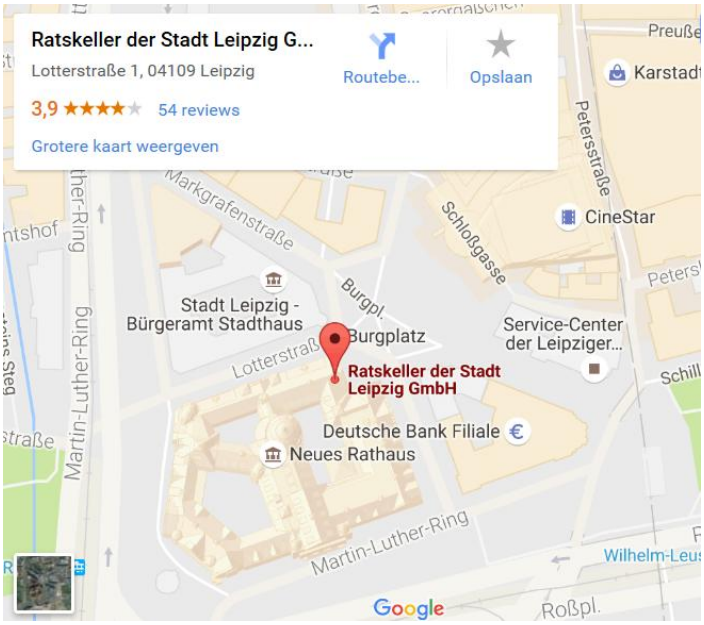
► Saturday 15th October 2016

SOCIAL NIGHT FOR ALL PARTICIPANTS

Social night on Saturday 15th October –– 19.30 hrs.
Dinner, speeches and party.

Location: The **"Ratskeller"-Gewandhaussaal.**
Speeches, Music, Dinner and Dancing in a restaurant in the center of Leipzig.

Address: Lotterstrasse 1, 04109 Leipzig, Germany.



Web: http://www.ratskeller-leipzig.de/ratskeller/raeume/

Entrance Fee: € 40,= 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 CASH EUROS.
We do NOT prefer pay cheques, given the extra costs. If you have no other option we will charge € 25 extra.
On site payment +€50 extra administration costs.

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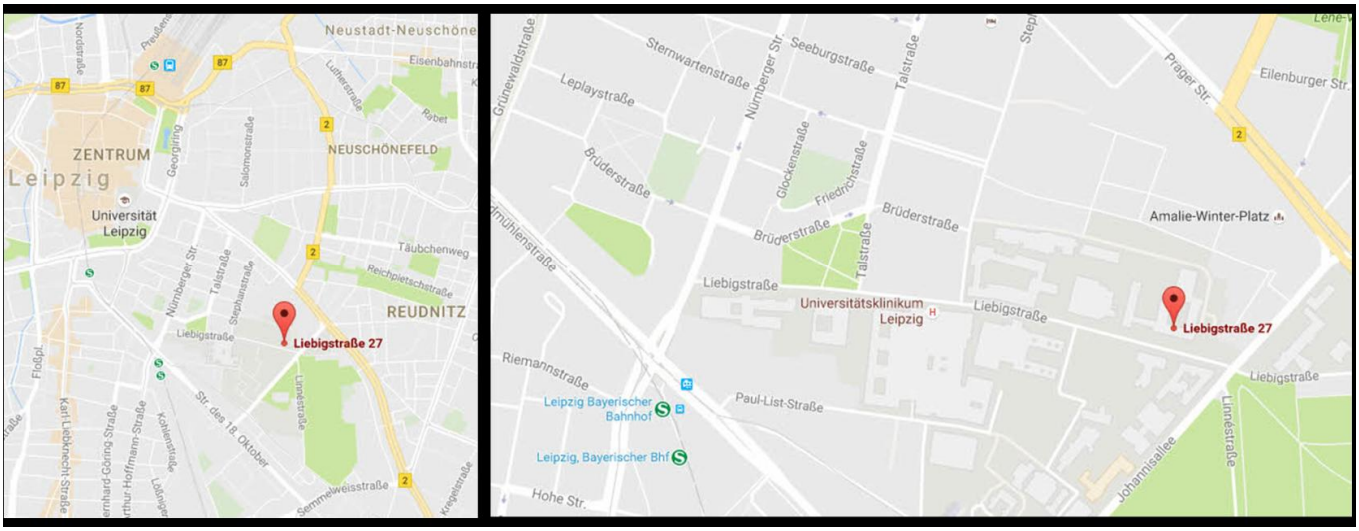
Map to find Conference Venue in Leipzig-Germany



Entrance will be indicated with signs

If people want to come by train closest to the conference venue they should use the train station:
"Leipzig, Bayerischer Bahnhof".

Undermentioned link gives access to the map directly from tablet or smartphone:

https://goo.gl/maps/idfSGSEBc7z

E G P R N 12th-16th OCTOBER, 2016

PROGRAMME OF THE EUROPEAN GENERAL PRACTICE RESEARCH NETWORK IN LEIPZIG-GERMANY

WEDNESDAY 12th OCTOBER, 2016

Location: **Studienzentrum (study centre), Haus E**
located on the Campus of the Medical Faculty
Liebigstraße 27, 04103 Leipzig - Germany

10.00 - 17.00 : **1 EGPRN Pre-Conference Full Day Workshop**

a. **Pre-conference Workshop "Electronic Patient Records".**
Chairs: Jean Karl Soler (Malta), Brendan Delaney (United Kingdom), Thomas Frese (Germany)
in: Meeting Room of the Medical Faculty

13.00 - 14.00 : **Lunch for participants of pre-conf.workshops**
(price NOT included in fee conference workshops)
in: Bistro of the University Hospital (200m from the conference venue)

THURSDAY 13th OCTOBER, 2016

Location: **Studienzentrum (study centre), Haus E**
located on the Campus of the Medical Faculty
Liebigstraße 27, 04103 Leipzig - Germany

09.00 – 17.00 : **EGPRN Collaborative Study Group**
"TATA and FPDM study"
(chair: Jean Yves Le Reste)
in: Seminar Room 5

09.30 - 12.30 : **Business Meeting**
EGPRN Executive Board Meeting
Welcome and Coffee for Executive Board EGPRN, **(only for Executive Board Members)**
in: Meeting Room of the Medical Faculty

10.00 - 12.30 : **2 parallel EGPRN Pre-Conference Morning Workshops**
each €35 (non-members €65) p.p.:

b. **Pre-conference Workshop "Writing for Publication – Meet the Editors for Tips and Tricks!".**

Chairs: Hans Thulesius (Sweden) and Michael Harris (United Kingdom)
in: Seminar Room 1

c. **Pre-conference Workshop "Immigrant Health in Primary Care Research".**
Chairs: Esperanza Diaz (Norway) and Fiona O'Reilly (Ireland)
in: Seminar Room 4

13.00 - 14.00 : **Lunch for participants of pre-conf.workshops**
(price NOT included in fee conference workshops)
in: Bistro of the University Hospital (200m from the conference venue)

14.00 - 16.30 : **2 parallel EGPRN Pre-Conference Afternoon Workshops**;
each €35 (non-members €65) p.p.:
d. **Pre-conference Workshop "BEME Communication Tools".**
Chairs: Prof.Teresa Pawlikowska (Ireland), Dr. Angelique Timmerman (The Netherlands), Prof.Paul van Royen (Belgium).
in: Seminar Room 1

e. **Pre-conference Workshop "Developing, evaluating, and reporting complex interventions - insights into the Medical Research Council's (UK) framework for complex interventions"**
Chairs: Steffen Fleischer & Susanne Saal (Germany)
in: Seminar Room 4

14.00 - 16.45 : **Business Meeting**
EGPRN General Council Meeting.
Meeting of the Executive Board Members with National Representatives (only for Council Members).
in: Meeting Room of the Medical Faculty

-- coffee/tea break will be inside the meeting room --

16.45 - 17.30 : **Business Meeting**
Meeting of the EGPRN Working Groups (last part of the Council meeting)
- Research Strategy Committee – in: Meeting Room of the Medical Faculty
- Communication and PR Committee – in: Meeting Room of the Medical Faculty
- Educational Committee – in: Seminar Room 6

17.00 – 18.00 : **EGPRN Collaborative Study Group**
"HEFESTOS study"
(chair: Miquel Angel Muñoz Perez)
in: Seminar Room 1

18.00 - 19.00: **EGPRN Collaborative Study Group**
"PROCOPD study"
(chair: Ana Clavería)
in: Seminar Room 4

Social Program:
19.30 – :

For ALL EGPRN-participants of this meeting who are present in Leipzig-Germany at this time. (Entrance Free)

Welcome Reception and Opening Cocktail -
for all participants.

- **Welcome by *Dr. Thomas Frese*, national representative EGPRN Germany, on behalf of the team of local organizers and hosts. Moderator.**

- **Welcome by Vice-Dean of the Medical Faculty of the Leipzig University.**

- **Welcome by Prof. Thomas Fabian, Deputy Mayor; Department for Youth, Social Affairs, Health and Schools, City of Leipzig"**

- **Welcome by Prof. Erika Baum, the *President of the DEGAM* (German College of General Practitioners and Family Physicians)**

- **Welcome in the name of the EGPRN by *Prof. Mehmet Ungan*, Chairperson of EGPRN**

Location:
The **Welcome Reception** will be at
the Alte Börse (Old Exchange)
Naschmarkt 2
04109 Leipzig

http://www.stadtgeschichtliches-museum-leipzig.de/site_english/alteboerse/index.php

FRIDAY 14th OCTOBER, 2016:

Location: **Studienzentrum (study centre), Haus E**
located on the Campus of the Medical Faculty
Liebigstraße 27, 04103 Leipzig - Germany

08.00 - 08.30 : **Registration at EGPRN Registration Desk.**

08.30 - 11.00 : **Plenary Session incl. K E Y N O T E**
in: Small Lecture Hall
Chair: ……

08.30 - 08.45 : **W e l c o m e .**
Opening of the EGPRN-meeting by the Chairperson of the EGPRN.

08.45 - 09.30: **International Keynote Speaker: *Prof. Jan De Maeseneer, MD, PhD*;**
(Head of Department of Family Medicine and Primary Health Care, Ghent University, Belgium).
Theme: *"Challenges for General Practice/Primary Care Research in Changing World".*

09.30 – 11.00 : **3 Theme Papers (plenary)**
in: Small Lecture Hall
Chair: …..

1. *id41* **Aniela Angelow (Germany)**
   Effects of lowering treatment threshold for statin therapy in a German population based sample.

2. *id82* **Charles Christian Adarkwah (Germany)**
   Boon or bane? arriba®PSA: A new decision-aid to support the PSA-screening counseling.

3. *id70* **Emma van Bussel (The Netherlands)**
   Dementia incidence trend over 1992-2014: analysis of primary care data in the Netherlands.

11.00 – 11.30: **Coffee break**
in: corridor basement

11.00 – 11.30: **BLUE DOT Coffee break**
in: 1st floor corridor

11.30 - 13.00 : **Parallel session A – 3 Theme Papers**
in: : Small Lecture Hall
Chair: …..

4. *id43* **Gesine Friederike Weckmann (Germany)**
Implications of referral criteria for chronic kidney disease – analysis of a population based sample.

5. *id51* **Jordi Artigas Guix (Spain)**
Does the socioeconomic status influence the diabetes control?

6. *id46* **Stefan Lippmann (Germany)**
Primary care undersupply from the patient perspective.

11.30 - 13.00 : **Parallel session B – 2 Freestanding Papers**
in: Meeting Room
Chair: …..

7. *id27* **Jean-Francois Chenot (Germany)**
Drug safety of patients with rheumatoid disorders treated with methotrexate.

8. *id76* **Hans Thulesius (Sweden)**
Depending decisioning - Danish and Swedish primary care physicians' decision making and diagnostic reasoning in cancer work up -- a grounded theory study.

13.00 -14.00 : **Lunch**
in: Foyer Basement

13.00 -14.00 : **The Educational Committee Lunch workshop – "Grounded theory (GT) – a brief overview"** 60 minutes with *Dr.Hans Thulesius,* (Associate professor of Family Medicine / Department of clinical sciences / Lund University, Malmö / FoU-Kronoberg Växjö / R & D Kronoberg, Växjö-Sweden / On editorial board of Scandinavian Journal of Primary Health Care), Workshop leader: Hans Thulesius. GT is the most cited of all research methods when analysing qualitative data. Yet GT is not a qualitative method describing reality but a general method for conceptualisation of what is going on. The world is however run by description followed by conjecture and conceptualisation runs a distant third, which is why GT is hard to do without proper mentoring. Most people who try GT end up describing which is not bad but it is not GT.
GT aims at naming patterns of behavior that people are engaged in to resolve a main concern. And these pattern names are concepts that explain what is going on in a substantive area.
In EGPRN our main concern is better research and the pattern of how to achieve that sits in the name of our organisation - we are networking. And networking is an example of a concept that fits with GT!

There is no charge for this workshop. Participants can eat their lunch during the workshop. Lunchboxes will be inside Seminar Room 1 for all participants.
in: Seminar Room 1

14.00 - 16.00 : Parallel session C – 4 Theme Papers
in: Small Lecture Hall
Chair: …..

9. *id47* **Aisling O'Shea (Ireland)**
Influenza during pregnancy: prevalence and barriers to uptake?

10. *id78* **Delphine Le Goff (France)**
A systematic review to identify validated tools to assess Therapeutic Alliance (Tool Assessment for Therapeutic Alliance STUDY).

11. *id24* **Mihai Iacob (Romania)**
The Smart Thyroid Ultrasound Software - a computerized diagnostic algorithm for performing thyroid ultrasound screening as an experimental study and a comparative statistical analysis of different type of ultrasound methods (Triplex Doppler or Strain Elas.

12. *id66* **Francesc Orfila (Spain)**
Screening for adverse healthcare outcomes in the elderly in the primary health care office.

14.00 - 16.00 : Parallel session D – 4 Freestanding Papers
in: Meeting Room
Chair: …..

13. *id21* **Frank Müller (Germany)**
Intercultural communication: misunderstanding, frustrations and their impacts on primary care.

14. *id40* **Enkeleint Aggelos Mechili (Greece)**
Enhancing Primary Health Care (PHC) services for refugees and migrants reaching EU countries. The EUR-HUMAN project.

15. *id92* **Peter Torzsa (Hungary)**
Opinions of Hungarian family physicians and residents on vocation and informal payment.

16. *id64* **Katja Krug (Germany)**
How can general practitioners support family caregivers of patients at the end of life in a home-care setting? Executive summary of the PalliPA project.

16.00 - 16.20: Coffee break
in: corridor area 1st floor

16.20 -17.20 : **Parallel session E - 2 Theme Papers**
in: Meeting Room
Chair: …..

17. *id49* **Fiona O'Reilly (Ireland)**
GP Training for areas of deprivation and with marginalized groups: does it make a difference.

18. *id68* **Hina J Shahid (Israel)**
Perspectives on developing Family Medicine Training in the West Bank.

16.20 -17.20 : **Parallel session F – 2 Freestanding Papers**
in: Small Lecture Hall
Chair: …..

19. *id30* **Eva Cedilnik Gorup (Slovenia)**
Use of a STOPP/START-based web application to decrease potentially inappropriate prescribing: randomized controlled study.

20. *id686* **Gerard Bury (Ireland)**
Cardiac arrest in the community - a novel strategy to alert GPs.

16.20 - 17.20: **EGPRN Collaborative Study Group**
"CoCo study"
(chair: Birgitta Weltermann)
in: Seminar Room 6

17.20 - 17.40 : **Closing of the day by *Prof. Jan De Maeseneer,*** keynote speaker, who will summarize on today's theme papers; EPILOGUE.
in: Small Lecture Hall

17.40 - 17.45 : **Closure of the day by chair of session.**

18.10 - 19.40 : **Study Group**
Örenäs Research Group
"Early Diagnosis of Cancer in Primary Care Study"
(chair: Michael Harris)
in: Seminar Room 5

Social Programme :
18.00 – 19.30 : Practice Visits to various local Health Centres in leipzig.
We will leave from the conference venue to different practices.
Registration for practice visit will be in the registration area.

SATURDAY 15th OCTOBER, 2016:

Location: **Studienzentrum (study centre), Haus E**
located on the Campus of the Medical Faculty
Liebigstraße 27, 04103 Leipzig - Germany

08.20 – 09.10 : **Plenary Session incl. K E Y N O T E + W E L C O M E**
in: Big Lecture Hall
Chair: ……

08.20 – 08.30 : ɔ **Welcome by *Prof. Hagen Sandholzer* (Head of department General Practice at University Leipzig-Germany)**

ɔ **Welcome by *Prof. Jürgen H Meixensberger* (Dean of Studies of the Medical Faculty at University Leipzig-Germany)**

08.30 - 09.10 : **2nd Keynote Speaker: *Prof. Joachim Szecsenyi*;** (Dept. of General Practice and Health Services Research-Universitätsklinikum Heidelberg & University of Heidelberg Hospital, Heidelberg - Germany).
Theme: *"State of the Art and Development of Family Medicine/Primary Care in Germany".*

09.10 - 10.40 : **Parallel session G - 3 Papers – EGPRN Collaborative Projects**
in: Small Lecture Hall
chair: ……..

21. *id53* **Biljana Gerasimovska Kitanovska (Macedonia)**
European Study on Self-care for Common Colds: An analysis of self-care and potential medication interactions (COCO study)

22. *id17* **Patrice Nabbe (France)**
FPDM (Family Practice Depression and Multimorbidity): The French version of the Hopkins Symptoms Check List-25 items (HSCL-25), validation in general practice.

23. *id18* **Sophie Lalande (France)**
Quality of Life Scales available for general population. A systematic review.

09.10 - 10.40 : **Parallel session H - 3 Papers – EGPRN Special Methodology Session**
in: Meeting Room
chair: ……..

24. *id90* **Birgitta Weltermann (Germany)**
Prevalence of Burnout among German General Practitioners: Are there differences between physicians working in single and group practices?

25. *id16* **Imre Rurik (Hungary)**
Early and menopausal weight gain, and their relations with diabetes and hypertension An international study on lifelong weight gain and manifestation of metabolic diseases.

26. *id33* **Sophie Haghighi (France)**
Establishing a typology of type 2 diabetes patients in general practice.

10.40 - 11.10 : Coffee break
in: corridor basement

11.10 -13.10 : Parallel session I – 4 Freestanding Papers
in: Small Lecture Hall
Chair: …..

27. *id9* **Christophe Berkhout (France)**
The influence of Papanicolaou tests performed by general practitioners, on the cervical cancer screening participation rate of their female patients.

28. *id79* **Ildikó Gágyor (Germany)**
Reducing antibiotic use for uncomplicated urinary tract infection in general practice by treatment with Uva ursi (REGATTA) – a double-blind, randomized, controlled comparative effectiveness trial.

29. *id77* **Pavlo Kolesnyk (Ukraine)**
Do Multi-children Women Have Higher Risk of Osteopenia and Osteoporosis?

30. *id63* **Lea Charton (France)**
How do French people cure their common cold ? A survey over three population pools.

11.10 - 13.10: Parallel session J - 7 One Slide/Five Minutes Presentations
"ASK the expert session: At the end of the One slide/Five minutes presentation session, presenters will be given the opportunity to have a 10 minute' face to face meeting with an expert in their field of research".
in: Meeting Room
chair: Ferdinando Petrazzuoli

31. *id84* **Claire Collins (Ireland)**
Gonorrhoea Diagnosis and Management in Primary Care in Ireland.

32. *id31* **Florian Wolf (Germany)**
Improving chronic depression care in general practice.

33. *id35* **Baki Derhem (Turkey)**
Physicians' knowledge and behavior about their rights and criminal liabilities according to legislation.

34. *id37* **Tuğrul Bıyıklıoğlu (Turkey)**
Evaluation of the empowerment levels of type 2 diabetes patients seen in an outpatient diabetes clinic of a university hospital.

35. *id39* **Robert D Hoffman and Joseph Azuri (Israel)**
Googling in the Waiting Room.

36. *id44* **Leo Pas (Belgium)**
Dealing with the relationship of mental health problems and violence in primary care.

37. *id74* **Zaida Azeredo (Portugal)**
Elderly frailty: an emergent reality.

13.10 – 14.10 : Lunch
in: Corridor/Foyer Basement

14.10 – 14.30 : Chairperson's Report by Prof. Mehmet Ungan.
Report of EGPRN Executive Board and Council meeting.
in: Small Lecture Hall

The meeting continues with 6 parallel Poster sessions till 15.45 h.

14.30 – 15.45 : Posters
In six parallel sessions (6 groups)

14.30 – 15.45 : Parallel group 1: Posters: *"Practice"*
in: Corridor 1st floor
chair: Florian Wolf

38. *id50* **Maria Isabel Fernández (Spain)**
Relationship between pharmaceutical industry and general practitioner residents of Barcelona.

39. *id93* **Martin Beyer (Germany)**
Learning from Errors in General Practice – the Critical Incident Reporting and Learning System (CIRS) 'www.jeder-fehler-zaehlt.de'(JFZ) is operative for 12 years in Germany.

40. *id38* **Johannes Quart (Germany)**
The willingness to commute among future physicians.

41. *id60* **Alberto Parada (Belgium)**
The doctor, the patient and the new digital medicine.

42. *id15* **Sarah Sausmikat (Germany)**
The WoMan Power Project.

14.30 – 15.45 : Parallel group 2: Posters: *"Chronic Care"*
in: Corridor 1st floor
chair: Djurdica Lazic

43. *id12* **Michele Odorico (France)**
Does the EGPRN multimorbidity definition predict decompensation? A cohort study, follow up at 6 months in nursing home (NH).

44. *id48* **Nils Henning Heiland (Germany)**
POLYCARE (Horizon 2020) - Poly-stakeholders integrated care for chronic patients in acute phases supplied by ICT-solutions (a feasibility-study).

45. *id19* **Ilze Skuja (Latvia)**
Metabolic syndrome criteria in asymptomatic NAFLD patients.

46. *id28* **Christine Kersting (Germany)**
Electronic reminders to facilitate chronic care: A mixed-methods study in primary care.

14.30 – 15.45 : Parallel group 3: Posters: *"Diabetes and Cardiovasc."*
in: Corridor 1st floor
chair: Frank Peters-Klimm

47. *id56* **Nir Tsabar (Israel)**
The design of the LIMIT: Low Indexes of Metabolism email Intervention Trial.

48. *id75* **Clara Guede (Spain)**
Preliminary results: abdominal aorta aneurysm screening by ultrasound in primary care.

49. *id29* **Xavier Mundet (Spain)**
Diabetic retinopathy in catalonia: association with cardiovascular outcomes and chronic kidney disease.

50. *id73* **Marija Petek Ster, Alenka Popovic (Slovenia)**
Importance of appropriate triage in patients with acute myocardial infarction with ST elevation in the ECG.

51. *id61* **Zehra Dagli (Turkey)**
Multi-drug use in hypertensive patients at a family medicine out-patient clinic of a university hospital.

14.30 – 15.45 : Parallel group 4: Posters: *"PSY"*
in: Corridor Basement
chair: Ana Clavería

52. *id23* **Clarisse Dibao-Dina (France)**
Repercussions of the use of the ZARIT scale on the care of patients with Alzheimer's disease and their family caregivers in primary care: a systematic review of the literature.

53. *id20* **Sanda Kreitmayer (Bosnia and Herzegovina)**
Are we really healthy, or just not checked up?

54. *id55* **Sophia Eilat-Tsanani (Israel)**
Adherence to recommendations in discharge notes from Internal Ward by Schizophrenic patients.

55. *id87* **Vanja Lazić (Croatia)**
Social economic characteristics, psychological stress events and regional development-determinants of chronic diseases morbidity of population aged 18-65, 20 years after Croatian War of Independence - a pilot study.

56. *id14* **Jérémy Derriennic (France)**
Questionnaires to evaluate multidisciplinary primary care from the patient's point of view.

14.30 – 15.45 : Parallel group 5: Posters: *"Lifestyle"*
in: Corridor Basement
chair: Radost Asenova

57. *id69* **Joseph Azuri, Sahar Nashef (Israel)**
Primary care physicians' characteristics and attitudes on smoking cessation.

58. *id25* **Mircea Iurciuc (Romania)**
The effects of lifestyle interventions on cardiovascular risk reduction.

59. *id13* **Tine De Burghgraeve (Belgium)**
Occurrence and associated factors of malnutrition in community-dwelling older adults.

60. *id54* **Susana Fontana (Spain)**
Smokers and nonsmokers diabetic patients, are they different?

61. *id67* **Marina Guisado Clavero (Spain)**
Multimorbidity patterns in elderly primary health care patients: K-Means Cluster Analysis.

14.30 – 15.45 : Parallel group 6: Posters: *"Miscellaneous"*
in: Basement
chair: Esperanza Diaz

62. *id10* **Sabine Bayen-Krohn (France)**
Utilization of oral rehydration solution in primary care for in acute gastro enteritis of young children.

63. *id32* **Sarah Sigalat (Israel)**
Volunteering in Serbia: Medical and Psychosocial Relief operation for the Middle-East refugees crossing Europe.

64. *id52* **Jean Yves Le Reste (France)**
Research agenda for French General Practice.

65. *id91* **Anika Thielmann (Germany)**
Chronic stress in general practitioners and practice assistants.

66. *id59* **Anna Nickel (Germany)**
The "real life data" registry BeoNet - Leadoff results of the first use case: COPD.

15.45 – 16.15 : Coffee break
in: corridor basement

The meeting continues with a Plenary Session till 18.05 hrs.
in: Small Lecture Hall

16.15 – 17.15 : 2 Theme Papers (plenary)
in: Small Lecture Hall
Chair: …..

67. *id88* **Lieve Peremans (Belgium)**
Joint Action Health WorkForce – Belgian Pilot Project: Horizon Scanning in General Practice.

68. *id7* **Kathrin Schloessler (Germany)**
A decision Aid to use within pre-screening-counseling about the PSA-test: Practical support or time consuming impeder?

17.15 – 17.35 : **Closing of the day by *Prof. Joachim Szecsenyi,*** keynote speaker, who will summarize on today's theme papers [epilogue].

17.35 – 17.45 : **Presentation of the EGPRN Poster Prize for the best poster presented in Leipzig-Germany.**

17.45 – 18.00 : **Introduction on the next EGPRN-meeting in Riga-Latvia, by *Dr. Gunta Ticmane*, national host organizing committee Riga.**

18.00 – 18.05 : **Closing of the Scientific part of the conference, by the EGPRN Chairperson.**

Social Programme :

19.30 - : **Social Night – Gala Dinner, speeches and party.**

Location: **T**he **"Ratskeller"-Gewandhaussaal.**
Speeches, Music, Dinner and Dancing in a restaurant in the center of Leipzig.

Address: Lotterstrasse 1, 04109 Leipzig, Germany.

Web: **http://www.ratskeller-leipzig.de/ratskeller/raeume/**

Entrance Fee: € 40,= per person.

Please address to EGPRN Registration Desk.

SUNDAY 16th OCTOBER, 2016:

Location : at Louise Kobelt & Thomas Frese
Prager Straße 12a,
04103 Leipzig

09.30 – 12.00: 2nd Meeting of the EGPRN Excecutive Board
in: room

coffee and brunch after the work is done.

FRIDAY 14TH OCTOBER, 2016:

Location: **Studienzentrum (study centre), Haus E**
located on the Campus of the Medical Faculty
Liebigstraße 27, 04103 Leipzig - Germany

08.45 - 09.30: International Keynote Speaker: *Prof. Jan De Maeseneer, MD, PhD*; (Head of Department of Family Medicine and Primary Health Care – Ghent University (Belgium). (part-time) Family Physician, Community Health Center Botermarkt – Ledeberg, Gent (Belgium). Chairman European Forum for Primary Care (www.euprimarycare.org).
Theme: *"Challenges for General Practice/Primary Care Research in Changing World".*

Nowadays health systems are confronted with important challenges: there is de demographical and epidemiological transition: with an important increase of multimorbidity; there are the scientific and technological developments and especially the increasing impact of ICT in care: there are important cultural developments, presenting a new type of "patient": active, informed, critical,...; there is an increasing social health gap, caused by social determinants of health and all global problems are presenting in the waiting room of the provider at the primary care level. These challenges require new types of questions. The components of primary care can be organized around the following cluster: pro-active or pre-care; re-active care; chronic care; community/population oriented care and health system components of primary care. For each of these clusters we can formulate relevant research questions at the nano-, micro-, meso-, and macro-level.
Four dimensions made guide de conceptual basis of our research:

- Equity: e.g. research on access to care, including access to innovative care; financial accessibility; cultural accessibility;...
- Quality: looking at structure-process and outcome, and evaluating the "medical/technical evidence", the "contextual evidence" and the "policy evidence". Importantly, especially in the context of multi-morbidity, our research requires a paradigm-shift from disease-oriented care, towards goal-oriented care in order to assess to what extent our interventions contribute to the achievement of the individual goals of the patient in terms of quantity and quality of life;
- Cost-effectiveness: with a focus not only on "cost-reduction", but on the creation of "added value";
- Sustainability: the "Sustainable Development Goals" invite us to take an intersectoral look at health, involving welfare, work, education,... The study of Community Oriented Primary Care" (COPC), and its contribution to "social cohesion" is one of the strategies to look at "sustainability".

From these research-questions, a magnitude of recess-designs can be developed. Nowadays, in this research we will look at key-concepts that contribute to innovative care: interprofessional

cooperation, the concept of "Social Accountability", the relevance of the care ("does the care really matter for the patient/population?"), the contribution of care to social justice.
These research-projects, continuously developed in interaction with the populations we serve, will help general practice/ primary care to contribute to health systems based on relevance, equity, quality, person- and people centeredness, sustainability and innovation.

Jan De Maeseneer, MD, PhD
Department of Family Medicine and Primary Health Care
Ghent University
Belgium
Email: Jan.DeMaeseneer@UGent.be

SATURDAY 15th OCTOBER, 2016:

Location: **Studienzentrum (study centre), Haus E**
located on the Campus of the Medical Faculty
Liebigstraße 27, 04103 Leipzig - Germany

08.30 - 09.10 : **2nd Keynote Speaker: *Prof. Joachim Szecsenyi*;** (Dept. of General Practice and Health Services Research-Universitätsklinikum Heidelberg & University of Heidelberg Hospital, Heidelberg - Germany).
Theme: *"State of the Art and Development of Family Medicine/Primary Care in Germany".*

This keynote will start with an introduction into the basic principles and key figures of the German healthcare system. Then a brief history of General Practice as an academic discipline will be presented. Nowadays academic departments of General Practice are institutionalized at 30 out of 37 medical faculties. Research output increased dramatically in the last 10 years. Academic departments now play an important role in teaching for medical students and CME for GPs. Networks of research practices are established in some regions. Facing the challenge of an ageing society GPs are going to play a key role in chronic care management. New models of contracting for GPs are implemented into the system as well as new concepts for vocational training to attract more young doctors to become a GP. This presentation will end with an outlook into cultural and technological changes in the society and in healthcare in which General Practice has to find a position and a role.

Prof. Joachim Szecsenyi, MD, MSc ,
Dept. of General Practice and Health Services Research
Universitätsklinikum Heidelberg & University of Heidelberg Hospital
Heidelberg - Germany
e-mail: Joachim.Szecsenyi@med.uni-heidelberg.de

PRESENTATION 1: **Friday 14th October, 2016** **THEME PAPER**
09.30–10.00 h. **Ongoing study with preliminary results**

Effects of lowering treatment threshold for statin therapy in a German population based sample

Aniela Angelow, Gesine Weckmann; Jean-François Chenot
Department of General Practice, Institute for Community Medicine, University Medicine Greifswald, 17475 Greifswald, Germany. E-mail: aniela.angelow@uni-greifswald.de

Id 41

Background: Statin therapy is recommended for primary prevention of cardiovascular disease (CVD) in patients at high CVD risk and all patients with CVD. Recent guidelines lowered the treatment threshold to moderate risk. There are few data on the impact of the implementation of these recommendations on clinical practice in Germany.
Research question: What is the estimated proportion of patients with guideline concordant statin treatment? What is the estimated effect of lowering the statin treatment threshold from high to moderate CVD risk on statin treatment rates?
Method: We analysed data of the population based cohort Study of Health in Pomerania covering a 10-year period. CVD risk factors and statin therapy were defined based on structured interview data, clinical measurements and a medication review. CVD risk was estimated using SCORE-Germany. Subjects with diabetes or prior history of myocardial infarction were classified as high CVD risk (≥5%). Only descriptive analyses were performed.
Results: 1365 subjects aged 40 to 69 years (46% male, mean age 53.1 years, SD 7.6 years) were included. Based on a high CVD risk, 3%, 24% and 58% of subjects aged 40-49, 50-59 and 60-69 years should receive statin treatment. Statin treatment rates in subjects at high CVD risk aged 40-49, 50-59 and 60-69 years were 36%, 25% and 29%. If statin treatment was extended to subjects with moderate CVD risk, 10%, 56% and 93% would be eligible (overall proportion: 49%).
Conclusions: Statin therapy is underused in patients with high CVD risk. However, if treatment is extended to subjects at moderate CVD risk, approximately half of the population aged 40-69 years would be eligible for statin treatment. Given the known overestimation of CVD risk, a more individualized threshold for statin therapy could prevent overmedicalisation.

Points for discussion:
-Can current recommendations on statin therapy be implemented in clinical practice?
-What approach should be used to identify patients who benefit most from statin therapy?
-How are quality indicators based on statin treatment rates aff

PRESENTATION 2: **Friday 14th October, 2016** **THEME PAPER**
10.00–10.30 h. **Ongoing study with preliminary results**

Boon or bane? arriba®PSA: A new decision-aid to support the PSA-screening counseling

Charles Christian Adarkwah, Katrin Kuss, Norbert Donner-Banzhoff, Axel Semjonow, Hans-Werner Hense, Alexandra Simbrich e.a.
Department of General Practice / Family Medicine, University of Marburg, 35043 Marburg, Germany. E-mail: adarkwah@uni-marburg.de

Id 82

Background: The value of PSA-screening for prostate cancer is a matter of current debate. Nevertheless experts agree on the fact that patients need to be informed about risks, benefits and consequences prior to testing. Evidence-based decision-aids (DAs) are able to support the counseling process and increase decision quality. We developed the DA arriba®PSA, which has already been tested in qualitative pre-studies.
Research question: Is counseling with the DA arriba®PSA superior compared to counseling without a DA regarding the decisional conflict and the degree of information?
Method: A cluster-randomized, controlled trial was performed, involving 28 general practitioners who consecutively recruited 169 patients. GPs were randomized to either apply (n=75) or not apply the DA (n=94; “as usual”).Participants filled in questionnaires regarding their current decision, decision quality and -process. Main outcomes are the degree of information and the decisional conflict, measured by the decisional conflict scale (DCS).
Results: arriba®PSA is associated with a higher degree of information. The scores in the DCS are low in both groups and there are no significant differences to be found.
Conclusions: More information might allow for a better decision regarding the decision for or against PSA screening. The DA is applicable in daily practice and might contribute to neutral conseling based on the best available evidence.

Points for discussion:
-transactional decision aids have different advantages compared to e.g. online applications
-DA might raise awareness for a problem that has not been obvious prior to the counseling process

PRESENTATION 3: **Friday 14th October, 2016** **THEME PAPER**
10.30–11.00 h. **Finished study**

Dementia incidence trend over 1992-2014: analysis of primary care data in the Netherlands

Emma F. van Bussel, Edo Richard, Derk L. Arts, Astrid C.J. Nooyens , Preciosa M. Coloma, Margot W. M. de Waal e.a.
General Practice, Academic Medical Center, 0, Amsterdam, the Netherlands. E-mail: e.f.vanbussel@amc.nl

Id 70

Background: Recent reports have suggested declining age-specific incidence rates of dementia in high-income countries. Improved education and cardiovascular health in early age have been suggested to bring about this effect.
Research aim: To estimate the age-specific incidence trend and incidence rates in primary care records from a large population over the last decades in the Netherlands. design and setting: Using primary care records from the general practice registration networks (GPRN) across the country, a dynamic cohort representative of the whole Dutch population was composed. Data regarding dementia incidence were obtained using GP-recorded diagnosis of dementia within the electronic health records. Age-specific dementia incidence rates were calculated; negative binomial regression analysis was used to estimate the time trend.Study population: All persons aged 60 years and over within the population served by general practices participating in a GPRN. Practice registered populations were the denominators.
Results: Nine out of eleven GPRNs provided data on more than 806,051 older people between 1992 and 2014, corresponding to over 4 million person-years and 23,186 incident dementia cases. The annual growth in dementia incidence rate was estimated to be 2.1% (95%CI 0.5 to 3.8%), and incidence rates were 1.08 (95%CI 1.04 to 1.13) times higher for women compared to men. There was no significant overall change since the start of a national dementia program in 2003.
Conclusions: Within the clinical records of a large, representative sample of the Dutch population, we found no evidence for a declining incidence trend of dementia in the Netherlands. This could indicate true stability in incidence rates, or a balance between increased detection and a true reduction.

Points for discussion:
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PRESENTATION 4: **Friday 14th October, 2016** **THEME PAPER**
11.30–12.00 h. **Ongoing study with preliminary results**

Implications of referral criteria for chronic kidney disease - analysis of a population based sample

Gesine Friederike Weckmann, Jean François Chenot, S. Stracke, A. Haase, S. Kiel, J. Spallek e.a.
Department of General Practice and Family Medicine, Institute for Community Medicine, 17475, Greifswald, Germany. E-mail: allgemeinmedizin@uni-greifswald.de

Id 43

Background: Chronic Kidney Disease (CKD) has an age-dependent prevalence of 10% in adults. The majority of CKD patients is only seen in general practice. German Societies for Nephrology and Internal Medicine recommend specialist referral for all subjects with estimated glomerular filtration rate (eGFR) <45 or eGFR 45-59 ml/min/1,73m² with albuminuria, haematuria, hypertension or anaemia.
Research question: What proportion of the general population meets the recommended referral criteria for CKD?
Method: Data of the population based cohort Study of Health in Pomerania (SHIP-2) were analysed to estimate the proportion of subjects who meet the proposed referral criteria.
Results: Data of 2328 subjects from SHIP-2 (53% female; age M= 57 Jahre, SD= 14) were analyzed. 3% of subjects had eGFR<45ml/min/1,73m². 6% had an eGFR between 45-59 ml/min/1,73m². Of those, 8% had albuminuria, 42% haematuria or 67% hypertension and 45% anemia. Referral criteria were met by 0% of subjects aged 30-49 and 1%, 8%, 20% and 41% of those aged 50-59, 60-69, 70-79 and ≥ 80 years (Overall rate 8%). Results of a comparison with actual referral rates based on billing data will be available at the conference.
Conclusions: Adherence to the proposed referral criteria would increase the number of referrals to nephrology manifold, particularly of the elderly. Given a lack of a specific nephrological therapy, the benefit of increasing referrals beyond the capacity of nephrological workforce seems doubtful. Referral criteria for common medical disorders in general practice should be evaluated rigorously.

Points for discussion:
-How can current referral recommendations for CKD patients be implemented in clinical practice?
-Is there a benefit of managing comorbidities (hypertension, diabetes) in specialist care?
-Which alternative criteria could be applied to i

PRESENTATION 5: **Friday 14th October, 2016** **THEME PAPER**
12.00–12.30 h. **Ongoing study with preliminary results**

Does the socioeconomic status influence the diabetes control?

Jordi Artigas Guix, Marta Trenchs, Mercè Lopez Grau, Carme Jané, Laura Arrey, Joyce Ramirez
Primay care, Institut Català de la Salut, 8010, Barcelona, Spain. E-mail: jartigas.bcn.ics@gencat.cat

Id 51

Background: Socioeconomic status is generally inversely associated with the risk of cardiovascular (CV) disease and death as well as the risk of developing type 2 diabetes (T2D).
Research question: Does socioeconomic status influence the clinical characteristics and cardiovascular disease in T2D in the city of Barcelona.
Method: Cross-sectional study, included a total population of 1,047,008 individuals aged >15 = years, attended at primary care centers in Barcelona city. Clinical data were obtained retrospectively from electronic clinical records from january 1 to december 31, 2014. Variables registered were sociodemographic,and clinical data. Descriptive and bivariate analysis were performed looking for differences between the four socioeconomic groups based on the validated MEDEA index: very low (VLSEG)(23%)/low (LSEG)(15%),middle (MSEG)(18%) and high (HSEG)(44%) socioeconomic group.
Results: A total 73.490 T2D were included, mean age 70+/- 12; 46% women. When comparing the socioeconomic groups, patients in the VLSEG group were younger (67 vs 71) and had higher BMI (valors) and HbA1c levels (7,2 vs 7%) The percentage of people with Hb1Ac >8 was higher(20,5 vs14,3%). Furthermore, they were more frequently smokers, had higher systolic blood pressure (134 vs 132 mmHg, and attended more to visits to doctors and nurses during the last year (9,41 vs 8,2 and 10,13vs 7,8, respectively. The HSEG group presented higher percentages of dyslipemia (60,5 vs 54,6%), ischaemic heart disease (13,9 vs 12,7) and depression(17,9% vs 14,9%). All the differences were statistically significant (p<0,005).
Conclusions: Patients in the VLSEG group are younger, more obese and have worse diabetes control although they attend to more visits at primary care than the HSEG group

Points for discussion:
-Which interventions among the T2D VLSEG group will be more effective?
-Define the bundles to improve the care of T2D according to the socioeconomic group.

PRESENTATION 6: **Friday 14th October, 2016** **THEME PAPER**
12.30–13.00 h. **Ongoing study with preliminary results**

Primary care undersupply from the patient perspective

Stefan Lippmann, Theresa Hagen, Tobias Deutsch, Hagen Sandholzer
Department of Primary Care, University of Leipzig, Medical Faculty, 4103, Leipzig, Germany. E-mail: LippmannS@medizin.uni-leipzig.de

Id 46
Background: As a consequence of a persistent GP shortage, especially in rural areas, in some German regions the outpatient care has to be maintained by a decreased number of GPs. Although officially still not "undersupplied" (less than 75 % of the current need according to the federal requirement planning directive), there might be already significant shortcomings from a patient perspective.
Research question: This qualitative study aimed to explore the patient perspective on primary care undersupply and specific associated problems.
Method: We conducted nine focus-group discussions with altogether 48 GP patients living in different areas (rural, small-town, major city). To ensure a wide range of different patients, participants were recruited based on socio-demographic criteria. The discussions were recorded, transcribed and paraphrased following the qualitative content analysis of Mayring and grounded theory methodology.
Results: Patients living in rural and small-town areas with a decreased but officially sufficient GP workforce described shortcomings in four main categories: fundamental problems to get access to primary care (e.g. finding a GP, getting an appointment), insufficient doctor-patient contacts (mainly due to extremely short consultations), problems according to exhausted drug and medical fee budgets, and fears regarding the future maintenance of primary care in the region (e.g. because of GPs in retirement age without a successor). Some patients reported attempts to compensate the problems by using emergency units and services for non-acute medical problems.
Conclusions: Despite officially not undersupplied, patients from regions with a decreased GP workforce describe significant shortcomings. The results imply that, as a complement to the official directive, the patient perspective could be an important marker to assess the sufficiency of the primary care supply in specific regions. The acquired insights might be a starting point for further research in this field, e.g. the development of standardized quantitative assessment instruments.

Points for discussion:
-From the international perspective: Discussion of the potential of the development of patient -oriented quantitative assessment instruments on primary care undersupply.
-Experiences from other European countries regarding this topic.

PRESENTATION 7: **Friday 14th October, 2016** **FREESTANDING PAPER**
11.30–12.00 h. **Almost finished study**

Drug safety of patients with rheumatoid disorders treated with methotrexate

Jean-François Chenot, Aniela Angelow, Armin Mainz, Jochen Walker
General Practice, University Medicine Greifswald, 17475, Greifswald, Germany. E-mail: jchenot@uni-greifswald.de

Id 27

Background: Methotrexate (MTX) is an immunosuppressant for long term treatment of rheumatoid disorders. Potentially live threatening serious adverse events (SAE) are nephrotoxicity, hepatotoxicity and blood dyscrasias. Therefore manufacturers and medical societies recommend periodic monitoring examinations and folic acid supplementation.
Research question: How frequent are serious adverse events of MTX and do patients receive the recommended monitoring examinations and prescriptions for folic acid?
Method: This is a retrospective observational study of anonymised claims data from 7 million subjects covered by statutory health insurance. We identified 40.087 patients who received prescriptions for MTX from 2009 to 2013. 12.451 patients newly started on MTX remained after restriction to adults with rheumatoid disorders (ICD M05-18) without MTX prescription for 12 months prior to the index prescription. They were followed up to 90 days beyond the reach of the last prescription. Mean follow up time was 476 days. During this period we analysed the billing codes for laboratory examinations and coding of SAE.
Results: Acute kidney failure was observed in 3.48, liver failure in 0.68 and aplastic anaemia in 0.93 patients per 1000 person years. The proportion of patients receiving all recommended controls was 46% for CBC, 42% for GGT and ALAT, 43% creatinine and 14% urine dip stick. Discrepancies were mainly observed at the beginning. 73% received prescriptions for folic acid. Most patients (83%) where seen at least once for an annual follow up by the rheumatologist.
Conclusions: The recommended monitoring examinations for patients on MTX and folic acid supplementation are only partly followed. The omission of recommended monitoring examinations might pose a risk for patients and a forensic risk for doctors, although the effectiveness of this measure preventing SAE is unproven.

Points for discussion:
-Who should be responsible for periodic monitoring examinations?
-Should adherence to periodic monitoring examinations become a quality indicator?
-Should recommendations for periodic monitoring examinations be changed or practice of mo

PRESENTATION 8: Friday 14th October, 2016 FREESTANDING PAPER
12.00–12.30 h. Ongoing study with preliminary results

Depending decisioning - Danish and Swedish primary care physicians' decision making and diagnostic reasoning in cancer work up -- a grounded theory study

Hans Thulesius, Ulrika Sandén, Berit Skødeberg Toftegaard, Peter Vedsted
Family Medicine, Lund University, 35250, Växjö, Sweden. E-mail: hansthulesius@gmail.com

Id 76

Background: Diagnostic work up of cancer is complex in primary care where most symptomatic cancers are suspected and eventually detected. Yet, conceptual understanding of what goes on when physicians are engaged in work up of cancer is still weak.
Research question: What happens when primary care physicians (PCP) see patients having symptoms that may indicate cancer?
Method: Grounded theory analysis of written commentaries from Danish and Swedish PCPs responding to an internet survey 2012. The survey's clinical vignettes assessing management of diagnosis of lung, colorectal or ovarian cancer were analyzed. 237 out of 255 (93%) Danish and 165 out of 198 (83%) Swedish PCPs wrote open ended comments in their own words to one or more of the items in the survey. We did classic grounded theory analysis: open coding, theoretical memoing, selective coding, theoretical sorting and writing up.
Results: Cancer diagnosis can be explained by PCPs engaging in a pattern of behaviour we call Depending or Conditioned Decisioning which has a dual meaning referring to: i) contextual conditions -- requirements, steps and routines - in the cancer work-up procedure as well as ii) biomedical conditions -- the decisioning contingent on the type of condition(s) the patient is suffering from. Depending Decisioning is sequential and stratified. It starts with recognising signs and symptoms followed by investigational strategizing adapted, deliberated and reflected upon contingent on contextual and biomedical conditions. Depending Decisioning involves both sequential planning of tests and investigations and execution of tests. The physician elaborates a heuristic plan for future investigations and tests in sequence based on the results of present tests. The plan includes a gauging of both the patient's biomedical condition and consultation contextual conditions.
Conclusions: We present Depending Decisioning as a conceptual understanding of what goes on during PCPs decision making and work up of cancer.

Points for discussion:
-Could this grounded theory be applied to other areas of complex diagnostic work up other than for cancer?

PRESENTATION 9: Friday 14th October, 2016 THEME PAPER
14.00–14.30 h. Ongoing study with preliminary results

Influenza during pregnancy: prevalence and barriers to uptake?

T. Barrett, E. McEntee, A. O'Shea, B. Cleary, R. Drew, Claire Collins, Fiona OReilly, Aisling O'Shea
Partnership for Health Equity, Irish College of General Practice, Dublin, Ireland. Email: fiona.oreilly@ul.ie

Id47

Background: Flu Vaccine is recommended during pregnancy. MMBRACE UK's report found that one in eleven maternal deaths was caused by Influenza. In spite of recommendations the little data that exists on uptake in Ireland suggests uptake is less than optimum. There remains ambiguity about where responsibility for vaccination lies. This study aims to address such ambiguity by informing future policies.
Research question: What is the prevalence of and barriers to uptake of influenza vaccine in pregnancy?
Method: Knowledge, attitudes and practices of women post-delivery are assessed in a maternity hospital in Dublin Ireland. This is complemented by in depth interviews with a small group of women within 6 weeks of birth to allow further exploration of their views and experience. The third component involves an online survey targeted at GPs, Hospital doctors and pharmacists.Results:150 women participated within 48 hours post-delivery. 1181 health providers completed an online survey. 12 women participated in qualitative in-depth interviews. Preliminary findings suggest that uptake of influenza vaccine has increased with 88 (61%) of mothers post-delivery reporting vaccination. Among health care providers, knowledge was variable with 70% providing correct answers on knowledge of risks relating to influenza during pregnancy and 50% correct answers of knowledge relating to the benefits of vaccination. Three quarters (75%) of GPs had been vaccinated themselves compared to 58% of Pharmacists (x2 36.6, $p<0.01$). Qualitative interviews with women highlight the positive potential of health care provider recommendation and that this is not always utilized.
Conclusions: Results indicate an increase in the uptake and acceptability of influenza vaccine during pregnancy. The positive influence by healthcare workers including hospital doctors whose influence is likely to have impact requires further support through clear national policy statement.

Points for discussion:
-Are all health care workers on the same page re vaccination?
-Are practice and recommendations always linked?
-Is vaccination more appropriate for Primary care or hospital based obstetrical care?

PRESENTATION 10: **Friday 14th October, 2016** **THEME PAPER**
14.30–15.00 h. **Finished study**

A systematic review to identify validated tools to assess Therapeutic Alliance (Tool Assessment for Therapeutic Alliance STUDY).

Delphine Le Goff, Michele Odorico, Bernard Le Floch, Jérémy Derriennic, Etienne Melot, Sophie Lalande, e.a.
Département de Médecine Générale, Université Bretagne Occidentale, 29480, Le Relecq Kerhuon, France. E-mail: del-legoff@laposte.net

Id 78

Background: Inside communication skills, Therapeutic Alliance (TA) is a relevant research theme for Family Medicine as it influences treatment's results. TA includes four dimensions: - Emotional relationship - Patient's ability to follow a therapeutic target- Empathic understanding and involvement of the therapist- Agreement on goals and tasks of therapy.
Research question: Which validated tools to assess therapeutic alliance are described in litterature (according to reproducibility, reliability and ergonomics)?
Method: Medline was searched following PRISMA statements with the key words : "therapeutic alliance" AND "scale" OR "index".Inclusion criteria were:- IMRAD format - Scale of TA in title or abstract- Scale could be used in any patient doctor relationship (exclusion of specific scales for pediatrics, oncology…) - Article in English or French- Minimimum one reproducibility criterion.
Results: 181 articles were selected, on which 16 were included identifying 6 rating scales: Working Alliance Inventory (WAI), Helping Alliance Questionnaire (HAQ), California Psychotherapy Alliance Scales (CALPAS), Therapeutic Bond Scale (TBS), Vanderbilt Therapeutic Alliance Scale (VTAS), Kim Alliance Scale (KAS). These scales had only internal validity criteria.
Conclusions: Scales were used exclusively in psychiatry and psychotherapy, except for the KAS. Scales WAI, HAQ and VTAS were more frequently used, probably because of the existence of short forms. The feasibility of these scales was often not mentioned. The majority of articles explored the quality of the therapeutic alliance without assessing scales themselves. Identifying the best-validated and more adapted scale for longitudinal monitoring of TA will be the next task.

Points for discussion:
-Scales ergonomy
-TA definition

PRESENTATION 11: **Friday 14th October, 2016** **THEME PAPER**
15.00–15.30 h. **Finished study**

The Smart Thyroid Ultrasound Software - a computerized diagnostic algorithm for performing thyroid ultrasound screening as an experimental study and a comparative statistical analysis of different type of ultrasound methods (Triplex Doppler or Strain Elas

Mihai Iacob, Madalina Stoican, Ana Remes
Research in family medicine, pediatrics and ultrasonography, advitam medicis medical center, 300150, Timisoara, Romania. E-mail: dr_iacob@yahoo.com

Id 24

Background: In recent decades in Romania we observe a clear increase over ten times of thyroid diseases. Ultrasonography used as a screening method can diagnose both: diffuse thyroid disorders and especially thyroid focal lesions. Our objective was early diagnosis and treatment of the diffuse thyroid diseases and focal thyroid lesions by screening in the high-risk population.
Research question: How can improve early diagnosis and differentiation of the thyroid diseases in primary care?
Method: We report a prospective thyroid ultrasound screening performed on 2149 apparently healthy adults with oncological risk factors+, aged over 20 years, followed for three years. To patients aged 20-40 years, we conducted an ultrasound screening every two years and over 40 years annually. We used the TIRADS classification by Russ modified and Strain Elastography with both the elastography scores by Rago and semiquantitative Strain Ratio(SR), for standardization and to show when fine-needle aspiration biopsy(FNAB) should be performed. We designed an Ultrasound Scoring System(USS) for predicting thyroid malignancy and a diagnostic algorithm software. All patients who entered these studies were stored and counted into our electronic database. Finally, we compared ultrasound scores designed by us, with the histological results.
Results: Prevalence of thyroid pathology was:29,6%(95%CI:26,99to32,31) with screening sensitivity:95,38% and specificity:94,78% and a high accuracy of 94,95%, PPV:88,47%, NPV:97,99%, statistically significant p<0,01. The ROC statistical analysis of our US methods confirmed a higher level of diagnostic accuracy of Strain Elastography, p<0.001,AUC=0,995,95%CI:0,97to1. To the ANOVA analysis- the significant statistical methods used was USS,p<0,001. Our cut-off value of SR for malignancy was2.5
Conclusions: Performing Doppler US Screening together with Strain Elastography, had the best accuracy in analysis of the vascular network in tumors and absence of elasticity in the tumor, for differentiating “benign versus malignant” of the thyroid tumors and for diagnosis of the diffuse thyroid diseases.

Points for discussion:
-What is the role of the family doctor in thyroid pathology?
-How can we identify earlier thyroid tumors?

PRESENTATION 12: **Friday 14th October, 2016** **THEME PAPER**
15.30–16.00 h. **Finished study**

Screening for adverse healthcare outcomes in the elderly in the primary health care office

Francesc Orfila, F. Cegri, C. Casanovas, R. O'Caoimh, W. Molloy
USR Barcelona, IDIAP Jodi Gol, 8025, Barcelona, Spain. E-mail: forfila.bcn.ics@gencat.cat

Id 66

Background: Functional decline and frailty are common in older adults, increasing the risk of adverse outcomes. Predicting risk of adverse outcomes among community elderly is difficult. The Risk Instrument for Screening in the Community (RISC) is a short global subjective assessment of risk created to identify patients' one-year risk of three outcomes: institutionalisation, hospitalisation and death. It has been validated in Irish population.
Research question: To validate the Spanish version of the RISC and assess the predictive ability of the tool in front of the appearance of the outcomes in a one year follow-up.
Method: Prospective cohort study of community dwelling older adults in home care (n=374), in the city of Barcelona. RISC tool, Barthel Index, Short Portable Mental Status Questionnaire (SPMSQ) and Clinical Risk Groups (CRG) were collected. The area under the curve (AUC) and logistic regression models, with odds ratios (OR), comparing discriminatory characteristics of the RISC with other geriatric tests.
Results: N=374 patients. Mean age 84 years (SD 8.9). 69% were female. The one-year incidence of institutionalisation, hospitalisation and death were 9.4%, 29.1% and 23.0% respectively. Patients scored maximum-risk (RISC score 3,4,5) at baseline had a significantly greater rate of institutionalisation (17% and 6.3%,p<0.001), hospitalization (37.6% and 21.4%,p<0.001) and death (36.4% and 15.7%,p<0.001), than those scored minimum-risk (1,2). The RISC had better accuracy for one-year risk of institutionalization, AUC area 0.66 (0.56 - 0.77), hospitalization, AUC area 0.55 (0.48 - 0.62), and Death, AUC area 0.70 (0.63 - 0.76), than Barthel Index, SPMSQ or CRG. The RISC significantly added to the predictive accuracy of the regression model for institutionalisation (OR 1.87 (1.31-2.69)), hospitalization (OR 1.33 (1.03-1.72)), and death (OR 1.86 (1.40-2.47)).
Conclusions: The RISC, a short global subjective assessment, demonstrated satisfactory validity and could be used in primary care as routine screening in the elderly

Points for discussion:
-Frailty definition is unclearUse of variety of tools to detect frailtyNeed of a common tool?

PRESENTATION 13: Friday 14th October, 2016 FREESTANDING PAPER
14.00–14.30 h. Ongoing study with preliminary results

Intercultural Communication: Misunderstanding, Frustrations and their Impacts on Primary Care

Frank Müller, Anne Simmenroth-Nayda
Department of General Practice, University Medical Center Göttingen, 37073, Göttingen, Germany. E-mail: frank.mueller@med.uni-goettingen.de

Id 21

Background: Transnational mobility - like migration, flight or for employment or educational reasons - is commonly increasing in postmodern societies. Diverse linguistic and cultural backgrounds of patients and GPs can serve as a barrier for mutual understanding, especially when no translator is available. This result in inappropriate treatment, poor adhearance and in longer terms patients may avert of the care system. Despite the fact that language barriers are eminent factors influencing medical care, we have weak data concerning protagonists' behaviour in situation of reciprocal non-understanding and how this affects the treatment process.
Research question: How protagonists deal with mutual linguistic and cultural non-understanding? In which fields do problems arise due to misunderstanding?
Method: This is an explorative study with both qualitative and quantitative parts. The study takes place in a health care center for refugees in Friedland, a small town near Göttingen, Germany. Qualitative interviews are conducted with all professional groups (GPs, nurses, social-workers) involved in the medical care of refugees. Repeated consultations are recorded as a surrogate parameter for failed communication.
Results: Preliminary analyses show an increase in consultation-rates: Nearly 30% of patients are consulting their GPs twice or more often within two weeks. Problematic fields of miscommunication are e.g. the application and dosage of medicine, punctuality and appointments and mental or shamefaced issues. Protagonists also mentioned, that gender differences between health-care professionals and patients causes a difficult communication especially for female nurses.
Conclusions: GPs get more and more confronted with cultural and linguistical diverse patients, which they are attending only for a short span of life. Appropriate communication is essential for ensuring health care.

Points for discussion:
-We are planning a follow-up intervention study which aims to show whether a special digital video-based translating software can improve mutual communication in refugees' health care.

PRESENTATION 14: Friday 14th October, 2016 FREESTANDING PAPER
14.30–15.00 h. Ongoing study with preliminary results

Enhancing Primary Health Care (PHC) services for refugees and migrants reaching EU countries. The EUR-HUMAN project

Mechili Enkeleint-Aggelos, Agapi Angelaki, Valeria Chatzea, Dimitra Sifaki-Pistolla, Danica Rotar-Pavlic, Kathryn Hoffman, e.a.
Clinic of Family and Social Medicine, Scool of Medicin, University of Crete, 71410, Heraklion, Greece. E-mail: mechili@uoc.gr

Id 40

Background: Europe is facing a major issue with refugees and migrants. Although several studies have reported on the impact of the refugee crisis on health, an integrated attempt to deliver Primary Health Care (PHC) services based on refugeesÃ¢â‚¬â„¢ health care is lacking. EUR-HUMAN project aims to enhance the capacity, knowledge and expertise of European countries who accept refugees/migrants in addressing their health needs.
Research question: How can General Practitioners (GPs) provide person-centered, continuous, coordinated and comprehensive PHC services to refugees/migrants?
Method: EUR-HUMAN project utilized evidence based methodological and theoretical approaches including Participatory and Learning Action (PLA), Chronic Care Model and "Mental health psychosocial support" model. Data were collected through multiple sources including: PLA focus groups with refugees, literature review jointly with cross-national survey and expert interviews, and a consensus expert meeting that summarized and synthesized the evidence.
Results: According to the PLA method, 98 refugees participated in 43 sessions in seven countries (Greece, Hungary, Italy, Austria, the Netherlands, Slovenia and Croatia). The main health problems mentioned by the participants were related to conflicts and the journey they had to undertake. The results revealed important barriers in accessing PHC services such as time pressure, linguistic and cultural differences, and lack of continuity of care. The systematic literature review revealed obstacles, linked to: health care interventions and measures of evaluation, professional-patient interaction, incentives and resources, local capacity for organizational change, and social, political and legal factors. Ten steps to initial psychosocial aid were identified. The consortium translated all these findings into best practice guidelines, tools and services aiming to enhance capacity building and knowledge of first line health care professionals and GPs.
Conclusions: The project promotes comprehensive, person-centred and integrated health need assessment based on refugees' preferences and the lessons learnt. The feasibility and acceptability of the planned interventions will be assessed in pilot interventions.

Points for discussion:
-The role of GPs and first line health personnel in managing refugees/migrants health problems.Appropriate skills and knowledge for health personnel dealing with refugees/migrants health problems.

PRESENTATION 15: Friday 14th October, 2016 15.00–15.30 h. **FREESTANDING PAPER Finished study**

Opinions of hungarian family physicians and residents on vocation and informal payment

Péter Torzsa, Csenge Hargittay, Ferenc Horváth, Bernadett Márkus, András Mohos, László Kalabay, e.a.
Department of Family Medicine, Semmelweis University, 1125, Budapest, Magyarország. E-mail: ptorzsa@gmail.com

Id 92

Background: The changing of the family medicine can be observed in the New Millenium. The migration, the aging of the healers and informal payment are crucial to the human resource crisis of the health sector.
Research question: What is the physicians' and residents' opinions about the vocation and informal payment?
Method: Exploratory, quantitative study among family physicians (n=363) and family physician residents (n=180). The central questions of our study were the vocation, the income and the informal payment.
Results: The most decisive factors of the carrier choice were responsibility (77%), altruism (66%), honesty (63%) and service (29%). The residents were significantly rejective (19.7% vs. 38.3% $p<0.001$) about informal payment. They would accept smaller amounts of informal payment (14.3% vs. 8.9% $p<0.034$), and would spend it on praxis development (1.4% vs.9.4% $p<0.023$).
Conclusions: The attitudes of family physicians and residents are the same in case of the vocation, but on the issue of informal payment, the two generations have different opinions.

Points for discussion:
-How can we keep the young GP trainees in Hungary?
-What are the most decisive factors of carrier choice in other countries?
-Can the informal payment change the quality of the health service in primary care?

PRESENTATION 16: **Friday 14th October, 2016** **FREESTANDING PAPER**
15.30–16.00 h. **Finished study**

How can general practitioners support family caregivers of patients at the end of life in a home-care setting? Executive summary of the PalliPA project

Katja Krug, Katharina Schurig, René Ballhausen, Regine Bölter, Peter Engeser, Joachim Szecsenyi, Frank Peters-Klimm
Abt. Allgemeinmedizin & Versorgungsforschung, University Hospital Heidelberg, 69120, Heidelberg, Germany. E-mail: katja.krug@med.uni-heidelberg.de

Id 64

Background: Most palliative patients prefer end-of-life home care. Family caregivers (FCGs) play an important but challenging supportive role. General practitioners and their practice team (GPTs) should identify physical and psychosocial burden on FCGs and offer options for burden relief.
Research questions: 1. What do GPTs currently offer to relieve caregiver burden? 2. Which further support can be implemented? 3. How do FCGs experience support from GPTs?
Method: The UK Medical Research Council framework for complex interventions was adopted. In a pilot study, GPTs reflected in qualitative focus groups on the support they currently offer FCGs as well as options for further support possibilities. A participatory action research approach was subsequently implemented evaluating the new options offered. FCGs' experiences of support from GPTs were assessed via semi-structured interviews.
Results: Results from 4 focus groups showed that a wide range of support was already offered by GPTs. Eleven GPTs implemented the following new support strategies: a palliative care register with information about FCGs to identify potentially burdened FCGs and to ease communication within the GPT and an information brochure for FCGs about community support services. In addition, written communication material derived from the guideline "Family Caregivers" of the German College of General Practitioners and Family Physicians (DEGAM) was developed for the GPTs. Implementation was accompanied by regular professional meetings for the participant GPTs, which were considered most helpful for sharing experiences. From the FCGs' perspective appreciated GPT's reliable accessibility, their empathic and encouraging support throughout the care trajectory and their partnership approach to communication.
Conclusions: A high-quality end-of-life care might be enhanced by regular exchanges of GPTs, i.e. in quality circles, and by a local support network. Concerning the FCG's support, GPTs should focus on psychosocial skills.

Points for discussion:
-How can end-of-life care further be implemented in general practice?
-What could be the role of practice staff in end-of-life care?
-How to evaluate effectiveness of complex primary palliative care interventions?

PRESENTATION 17: Friday 14th October, 2016 THEME PAPER
16.20–16.50 h. Ongoing study with preliminary results

GP Training for Areas of Deprivation and with Marginalized groups: Does it mak a difference
Fiona O'Reilly, A. O'Carroll
Partnership for Health Equity, Irish College of General Practice, 0, Dublin, Ireland. E-mail: fiona.oreilly@ul.ie

Id 49
Background: A 2001 UK study found non deprived areas had almost twice the amount of applicants for GP posts as deprived areas which resulted in difficulties filling 68% of urban deprived posts compared to 29% rural posts. It is also known marginalized groups have the worst health indices and have difficult accessing primary care. The North Dublin City GP Training Programme was set up in 2009 to specifically train GP's to work in areas of deprivation and with marginalised groups.
Research question: How is the training Programme meeting its aim to develop GPs with the desire and capacity to work in areas of deprivation and what impact is this having?
Method: A mixed methods descriptive study has been implemented to capture GP trainees reflections and changes to attitudes as they progress through this innovative training programme. Focus group, reflective journals , pre post attitudinal surveys are examined. The structured programmed is reviewed and described. Follow up of graduates is conducted. Video feedback from GP trainees is captured.
Results: Preliminary data demonstrates that GP registrars actively seek to include deprived and marginal group in their practice post graduating. Data demonstrates changes in attitudes. These posts involve GP registrars working one day a week for four months in homeless primary care services; another day in prison and ethnic minority primary care services; and another in Drug Treatment Services. The educational theory for these posts is based on the Contact Hypothesis which proposes that contact breaks down stereotypes. Videos of registrar feedback on these posts will be shown.
Conclusions: This innovative programme has produced results that suggest through training GPs can be better equipped with capacity and desire to work in areas of disadvantage and marginalized groups. Expansion of this model of training is recommended.

Points for discussion:
-Dose structure of Primary Care support GPs to work with deprived and Marginalized?
-What other initiative are being done in Europe to address this issue?

PRESENTATION 18: Friday 14th October, 2016 THEME PAPER
16.50–17.20 h. Ongoing study with preliminary results

Perspectives On Developing Family Medicine Training in the West Bank

Hina J Shahid, Mohammed Rabai, David Jewell
Foundation for the International Development of Family Medicine in Palestine, London, United Kingdom. E-mail: hinajs2012@yahoo.com

Id 68

Background: After two initial attempts at establishing Family Medicine training in the West Bank, the future of the programme has once again been called into question. We aim to analyse barriers to its implementation and how to overcome these.
Research question: What are the key informants' perspectives on the development of the Family Medicine training programme in the West Bank?
Method: 1) Study design: a mixture of semi-structured interviews with key informants and field observations. Three weeks' field work with follow up emails and phone calls with collaborators. Documentary analysis of internal correspondence and reports. 2) Study setting: West Bank cities (Hebron, Ramallah, Nablus) and surrounding towns and villages. 3) Participants: Family Medicine specialists recently qualified; representatives from the Ministry of Health and Palestine Medical Council; faculty members from An-Najah University's Department of Community Health and Family Medicine; and project workers from UK-based NGOs.4) Outcomes: Qualitative analysis using the SCOT framework of strengths, challenges, opportunities and threats to analyse the data.
Results: The Ministry of Health has identified Family Medicine as a national priority for development. Challenges include physical, technical & human resources; academic opportunities; supervision; strategic planning; and complex sociopolitical circumstances. Key stakeholders express optimism that expanding FM is essential to achieve universal health coverage in Palestine and is attainable through a coordinated multi-sectoral effort and supportive international partners.
Conclusions: Family medicine is seen positively in the West Bank with several strengths and opportunities. Stakeholders need to collaborate in order to address the remaining challenges. The study has included a wide range of perspectives and multiple data sources. We hope it will be a useful tool to assess current progress and guide future planning.

Points for discussion:
-How can we address the acute issue of insufficient human resource capacity?
-Are there other barriers and strategies that we need to consider drawing on the audience's experiences of working in other countries?

PRESENTATION 19: **Friday 14th October, 2016** **FREESTANDING PAPER**
16.20–16.50 h. **Almost finished study**

Use of a STOPP/START-based web application to decrease potentially inappropriate prescribing: randomized controlled study

Eva Cedilnik Gorup, Marija Petek Ster
Department for Family medicine, Medical Faculty, University of Ljubljana, 1000, Ljubljana, Slovenia. E-mail: eva.gorup@gmail.com

Id 30

Background: Elderly are exposed to potentially inappropriate prescribing, leading to adverse drug events. STOPP/START are a set of 87 criteria detecting potentially inappropriate medications (PIM) that can be used in medication reviews to decrease inappropriate prescribing. Physicians encounter barriers in performing medication reviews (time constraints, insufficient knowledge, lack to time).
Research question: Does use of computer application detecting STOPP/START criteria in medication review influence presence of PIM in ambulatory elderly patients in primary care setting?Method:A medication review using STOPP/START based software was performed in randomly chosen patients older than 65 years and taking at least one medication regularly who visited primary care offices for whatever reason. If presence of PIM was detected, the software randomly assigned patients to control or intervention group. In the intervention group, physicians received full report on PIM. In the control group and in patients without PIM, physicians received no additional information. After one year, therapy was reviewed again in all patients. Primary endpoint was presence of STOPP/START criteria in intervention and control group. Registered trial number: U1111-1153-1965.
Results: 30 physicians enrolled 624 patients (57.4% female), aged on average 75.2 years. Patients took on average 5.6 medications and 361 (57.9%) of patients had at least one STOPP/START criterion present. In June 2016, one year follow-up has concluded. At the time of writing this Abstract, the final results have not been available yet, but will be presented at the conference.
Conclusions: STOPP/START criteria are highly prevalent in Slovenian population of elderly taking at least one regular medication. The results of the study will show whether performing a medication review using computer software detecting the potentially inappropriate prescribing could decrease this prevalence.

Points for discussion:
-What are the reasons that potentially inappropriate medications are still prescribed although the computer system alert inappropriate prescribing?
-Do the use of STOPP/START criteria reduce the number of prescribed medications?

PRESENTATION 20: Friday 14th October, 2016 FREESTANDING PAPER
16.50–17.20 h. Ongoing study with preliminary results

Cardiac arrest in the community - a novel strategy to alert GPs

T. Barry, M. Egan, M. Headon, Gerard Bury
General Practice, University College Dublin, 0, Dublin, Ireland. E-mail: gerard.bury@ucd.ie

Id 86

Background: Out of hospital cardiac arrest (OHCA) causes around 10% of all deaths in Ireland; survival rates are around 6%. However, where GPs are involved in the care of OHCA cases, survival rates of 18-20% have been consistently reported, usually because of proximity to the incident. Novel technology allows ambulance control centres to automatically text-alert any phone to a nearby OHCA. This project examines its utility in general practice.
Research question: Will GPs in rural Ireland join a voluntary OHCA alert system and what activity/impact does it have?
Method: Since 2006, 505 general practices have been provided with defibrillators and advanced life support training; all continue to report OHCA exposure. Of these, 422 are in rural or mixed locations and were invited in 2015 to join the text alert scheme. Data is collected from the national registry on all cases which GPs were alerted to or responded to and covers key clinical outcomes.
Results: 238/422 (56.4%) GPs expressed interest in the scheme and 102 GPs have joined. Around 50% are available on a seven day, 24 hour basis. Approximately 60% have received at least one text alert for an OHCA in their area and to date around 30% have responded to incidents. Data will be provided on characteristics and outcomes.
Conclusions: Voluntarism is alive and well in general practice. GPs can and will participate in initiatives which they perceive as worthwhile to their communities. Potential exists for extension of this model to other areas and issues.

Points for discussion:
-General practice has a key role in managing OHCA.
-The place of advocacy and voluntarism in general practice.
-Key clinical skills.

PRESENTATION 21: Saturday 15th October, 2016
09.10–09.40 h.
Almost Finished Study

European Study on Self-care for Common Colds: An analysis of self-care and potential medication interactions (COCO study)

Biljana Gerasimovska Kitanovska, Anika Thielmann, Krzysztof Buczkowski, Ferdinando Petrazzuoli, Enzo Pirrotta, Robert D. Hoffman, Aysegul Uludag¸ Kathryn Hoffmann, Slawomir Czachowski, Tamer Edirne, Tuomas Koskela, Heidrun Lingner
University Clinical Centre, Nephrology, 1000 Skopje, Macedonia. E-mail: bgerasimovska@yahoo.com

Id 53

Background: Self-care for common colds is frequent, yet little is known about potential interactions between self-care and medications for chronic conditions in patients across Europe.
Research question: 1. What are potential interactions and frequencies of interactions between reported self-care items for common cold and medications for chronic conditions? 2. Which individuals are at higher risk for potential interactions?
Method: This cross-sectional study was performed at 27 sites in 14 European countries. Participating sites distributed 120 questionnaires to 120 consecutive patients. 105 self-care practices were selected . Potential herb-drug and drug-drug interactions were analyzed for the ten most frequent items in the application mode intestinal absorption, teas and non-tea foodstuffs. Based on the potential number of interactions for each patient's self-care we analyzed which socio-demographic characteristics are associated with a higher risk for interactions.
Results: The final analysis included 2,724 patients, 62.5% were women, the mean age was 46.7 years (±16.8). The total mean item utilization was 11.5(±SD 6.0, range 0-53). 39.9% had at least 1 of 7 chronic conditions. The top 10 items in the application mode intestinal absorption have a potential risk for interaction in 87.3% of respondents, mean number of items used was 2.2(± SD 1.63). Among them, St.John's wort (used by 2,6% patients), ginger tea (13.5%), chamomile (17.5%), and peppermint (17.5%) have reported potential interactions with 14, 5, 4 and 3 drugs, respectively. Three risk profiles were defined, and the group that uses 3 or more items with potential risk has significantly more females (66% vs 51,4%, p<0.001), is younger (44,23 ± 15,73 vs 49.89 ± 17,60 p<0,001) and more educated (13,46 ± 4,12 vs 11,61 ± 4,3 years, p<0,001).
Conclusions: This first cross-national study documented that self-care medications used for common cold have a high potential of interaction with drugs for chronic conditions.

Points for discussion:
-Self-medication
-Medical interaction
-Underreporting of self-medication use

FPDM (Family Practice Depression and Multimorbidity): The French version of the Hopkins Symptoms Check List-25 items (HSCL-25), validation in general practice

Patrice Nabbe, Jean Yves Le Reste, Michele Odorico, F. Gatineau, Bernard Le Floch, Delphine Le Goff, Jérémy Derriennic, E. Melot, S. Lalande, D. Le Graet, E. Guilcher, H. Corvez, T. Montier, Harm Van Marwijk, Paul Van Royen

Université de Bretagne Occidentale Department of General Practice, ERCR SPURBO, 29238 Brest Cedex 3, France. E-mail: patrice.nabbe@univ-brest.fr

Id 17

Background: The Hopkins Symptom Check list-25 (HSCL-25) is a widely used diagnosis and screening self-questionnaire for depression and anxiety. It was validated in Swedish General Practice (GP) in 1993, versus a psychiatric examination using the Present State Examination (PSE-9). Validity coefficients ≥1.75 on a maximum of 4 identify a depression case.
Research question: In France, what are the validity coefficients of the HSCL-25?Method: Randomised multi centered controlled trial with 1100 GP outpatients. Two group of patients were selected, one with a score <1.75 and one with a score ≥1.75. The PSE-9 was applied by a PSE9 trained physician to 1 in 2 patients for the HSCL-25 <1.75 group, to 1 in 16 patients for the HSCL-25 <1.75 group. Analysis was conducted to validate the HSCL-25. The predictive positive and negative values (VPP, VPN), sensitivity (Se) and specificity (Sp) were calculated using Bayes' formula.
Results: 1100 patients were included within 17 GPs practices. All PSE-9 examinations were achieved in 4 weeks time after inclusion. Psychometrics data were: Prevalence 21%, VPP 69.8%, VPN 87%, Se 59.2%, Sp 91.4%, Youden Index: 0.51.
Conclusions: The French HSCL-25 validation allows a new standard for depression diagnostic in French GP and research. This pilot study will be extended throughout Europe with the FPDM team seeking for Horizon 2020 funds.

Points for discussion:
-A HSCL-25 study validation design usable in Europe.Statistically: VPP and VPN: do not use the complete formula, it is to risk a false result (if randomization step is different between 2 groups)

PRESENTATION 23: **Saturday 15th October, 2016**
10.10–10.40 h.

EGPRN COLLABORATIVE PROJECTS
Finished Study

Quality of Life Scales available for general population. A systematic review

Sophie Lalande, Jérémy Deriennic, Etiënne Melot, Delphine Le Goff, Michele Odorico, Benoit Chiron, Patrice Nabbe, Bernard Le Floch, Jean Yves Le Reste.
Department General Practice, University de Bretagne Occidentale, 29200, Brest, France. E-mail: lalande_sophie@yahoo.fr

Id 18

Background: The EGPRN's (European General Practice Research network) research on multimorbidity definition included 11 criteria including quality of life as a possible result of multimorbidity that should be evaluated.
Research question: The main objective of this study was to look for the scales to assess quality of life for general population.
Method: Systematic review of literature according to the Preferred Reporting Items for Systematic reviews and Meta-Analyses was conducted in Pubmed and Cochrane databases. If articles described a quality of life scale, they were included. Articles about specific populations or of poor scientific quality were excluded.
Results: 1617 documents identified, 107 articles included. 11 scales selected. Scales designed by the World Health Organisation : the WHOQOL composed of 6 dimensions, the WHOQOL-BREF trained of 4 dimensions and a global item score. Scales designed by the Medical Outcome Study : SF36 composed of 8 dimensions, the SF36v2 a modification of the previous scale, the SF12 contained the same SF36 dimensions but in 12 items, the SF12v2 corrected version of SF12. The scales designed by the EuroQolGroup, the EQ5D composed of 5 dimensions and the EQ15D with 15 dimensions. The NHP is of 6 dimensions. The QLI composed of 4 dimensions, and the QOLS composed of 8 dimensions.
Conclusions: 11 quality of life scales for the general population found. A study on psychometrics qualities of scales should be realized in order to achieve a consensus on the best validated one.

Points for discussion:

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PRESENTATION 24: **Saturday 15th October, 2016**
09.10–09.40 h.

Finished Study

Prevalence of Burnout among German General Practitioners: Are there differences between physicians working in single and group practices?

Birgitta Weltermann, Mirjam Möller, Anja Viehmann
University Hospital Essen; University Duisburg-Essen, Institute for General Medicine, 45131 Essen, Germany. E-mail: Birgitta.Weltermann@uk-essen.de

Id 90

Background: Stress, depression and burnout are important issues for general practitioners (GP). These symptoms can have serious effects on behavior, treatment of patients and personal satisfaction. Studies from various European countries and Canada showed high burnout prevalences. We studied the prevalence of burnout symptoms among German general practitioners and analyzed if these differ by working conditions.
Research question: What is the prevalence of burnout symptoms among German GPs? Are these results comparable to studies of other European and Canadian GPs? Is there a difference between physicians working in single compared to group practices?
Method: In a cross-sectional-study GPs of 181 general medicine practices from our university network were asked for participation. A questionnaire asked for sociodemographic data and working conditions. Burnout was measured by the German version of the Maslach Burnout Inventory (MBI-D) modified by Glaser et al. We calculated the percentage of physicians scoring high range for the three burnout items (depersonalization, personal accomplishment, emotional exhaustion).
Results: The population consisted of 216 general practitioners (33.3% female). 27.9% (N=60) of the physicians scored in the high range for depersonalization. 20.0% (N=43) showed high values for personal accomplishment and 35.7% (N=75) for emotional exhaustion. 7.4% (N=16) scored high in all three dimensions. Burnout occurrence was higher in group practices compared to GPs working alone in their practice.
Conclusions: The overall prevalence of burnout symptoms was comparable to those in other GP population. To our surprise, working in a group practice was associated with a higher burnout prevalence.

Points for discussion:

PRESENTATION 25: Saturday 15th October, 2016
09.40–10.10 h.
Finished Study

Early and menopausal weight gain, and their relations with diabetes and hypertension An international study on lifelong weight gain and manifestation of metabolic diseases

Imre Rurik, Csaba Móczár, Nicola Buono, Thomas Frese, Pavlo Kolesny, Jarmila Mahlmeister, Ferdinando Petrazzuoli, Enzo Pirrotta, Tímea Ungvári, Iveta Vaverkova, Zoltán Jancsó
University of Debrecen, Occupational and Family Medicine, , 4032 Debrecen, Hungary. E-mail: rurik.imre@sph.unideb.hu

Id 16

Background: Previous research found relations between weight gain and metabolic diseases developed later. These studies covered only short periods, not longer than 4-8 years. We aimed collecting decades long, often life-long anthropometric data for better comparison of this relation.
Methods: A retrospective international study was planned and organized to compare data of self-recorded lifelong weight gain of persons between 60y-70y, to analyze its correlation with developed metabolic diseases, with special attention to women's weight gain around pregnancy, delivery and menopause within primary care settings in Germany, Hungary, Italy, Slovakia and Ukraine.
Results and discussion: There were 815 participants recruited, and 286 men/447 women of them presented completely all the required data. The weight and BMI of the whole study population increased till their seventies, less after their fifties. Changes over decades were higher among patients with hypertension than within "healthy" group. Weight increase in the first decades (20-30y by men, 30-40y by women) was a significant risk factor for the development of diabetes (OR=1.49; p =0.017;95%; CI:1.07-2.08). Significantly higher weight gains were recorded in the last decade before diabetes has been diagnosed. Among patients with diabetes and hypertension, both diagnoses were set up earlier, than by patients with one morbidity. By females, weight increases around delivery and menopause correlated significantly with higher odds for the diagnoses of diabetes and/or hypertension, without significant correlations with the numbers of children.
Conclusions: Primary care physicians during their decade-long contact with their patients are expected to identify the weight gain of the patients still in their early decades and provide intervention, if necessary.

Points for discussion:

PRESENTATION 26: Saturday 15th October, 2016
10.10–10.40 h.

Establishing a typology of type 2 diabetes patients in general practice.

Sophie Haghighi, Alain Mercier, Julien Lebreton, Gilles Hebbrecht, Pascal Clerc, Didier Duhot.
Paris 13 University, Departement of general practice, 93000 Bobigny, France. E-mail: sophie.haghighi@gmail.com

Id 33

Background: More than ever, practice guidelines seem to promote individualization of care for patients with type 2 diabetes. It has been described that one of the major difficulties perceived by GPs when managing chronic illness was the proper categorization of patients. No description of patients living with type 2 diabetes is available.
Research question: The aim of this study was to create a typology of patients with type 2 diabetes.
Method: Factor analysis of French database from the General Medicine Observatory (GMO), from 2009 to 2011. This database was created by a continuous collection of coded consultation information from computerized physicians member of the GMO network. All patients with type 2 diabetes were included, provided that they had met the GP at least once each year for diabetes care. Multiple correspondence analysis was used, followed by a clustering using ascending hierarchical classification. Primary variables (age, sex, cardiovascular risk or diseases, non-cardiovascular diseases) had been chosen beforehand.
Results: 1745 patients were included. 59 % were men, 41 % were women. 6 groups of diabetic patients were identified. Group 1: Diabetes only (31,2%). Group 2: Diabetes and hypertension (N=25,4%). Group 3: Diabetes, obesity, hypertension and hyperlipidemia (N=10,1 %). Group 4: Diabetes, hyperlipidemia and smoking addiction (N=4,8%). Group 5: Diabetes and vascular diseases (N=18,9%). Group 6: Diabetes and multimorbidity (N=9,5%).
Conclusions: By offering a typology for type 2 diabetes patients, we aim to help practitioners when they select the most suitable patient-centered care. In the future, guidelines could recommend care adjusted to a typology of type 2 diabetic patients.

Points for discussion:
-Original question, with a clinical relevance.
-Original method and database of patients followed by ambulatory physicians.
- Guidelines focusing on priorities of each group, to decrease multi-morbidity efficiently.

PRESENTATION 27: **Saturday 15th October, 2016** **FREESTANDING PAPER**
11.10–11.40 h. **Finished Study**

The influence of Papanicolaou tests performed by general practitioners, on the cervical cancer screening participation rate of their female patients

Marine Pelletier, Jonathan Favre, Michaël Rochoy, Thibaut Raginel, Valérie Deken-Delannoy, Alain Duhamel, Christophe Berkhout
University of Lille, Department of general medicine, 59045 Lille Cedex, France. E-mail: christophe.berkhout@univ-lille2.fr

Id 9

Background: Cervical cancer screening reduces the incidence of cervical neoplasms and specific mortality rate. In most cases screening (by means of pap-tests) is performed in France by gynaecologists. The primary objective of this study was to determine whether the cervical cancer screening participation rate is increased when general practitioners (GPs) carry out the screening test themselves. The secondary objective was to seek for other independent characteristics of GPs predicting cervical screening participation rates in women.
Methods: The population of 347 GPs, including their relevant characteristics and their 90,094 eligible for screening female patients over 2 years (2013-2014), was derived from the Health Care Insurance Fund of (French) Flanders database. A telephone survey was carried out among the GPs to know whether they were performing pap-smears.
Results: A total of 343 GPs were included for analysis (98.8% participation rate). The mean cervical cancer screening participation rate in the recommended age group (25-65 years) was 43% (±7). It was significantly higher if GPs declared to perform pap-smears in their practice (44.4%; p= 0.002), if GPs encoded the fulfilment of pap-smears (45.3%; p=0.010) and if the GP's gender was female (45.2%; p=0.010).
Conclusion: This study demonstrated that pap-smears performed by GPs, lead to increased screening participation rates within the recommended age group of women. Unless the study was conducted over 2 years only, the size of this addition is insufficient to reach the expected participation rates and other cervical screening strategies like organised screening and self-sampling for HPV-tests proposed by the GP should be tested.

Points for discussion:
-Some countries in Europe have an organized cervical cancer screening program, and some use an opportunistic screening. In some countries, screening is only based on pap-tests, and in others on pap-tests and (self-collected) HPV-tests. In some countries pa

PRESENTATION 28: Saturday 15th October, 2016 FREESTANDING PAPER
11.40–12.10 h. Ongoing study no results yet

Reducing antibiotic use for uncomplicated urinary tract infection in general practice by treatment with Uva ursi (REGATTA) - a double-blind, randomized, controlled comparative effectiveness trial

Ildikó Gágyor, Jutta Bleidorn, Guido Schmiemann, Karl Wegscheider, Eva Hummers-Pradier
University Medical Center Göttingen, Dept. of General Practice, 37073 Göttingen, Germany. E-mail: Eva.Hummers-Pradier@med.uni-goettingen.de

Id 79

Background: Uncomplicated urinary tract infections (UTI) are common in general practice and are usually treated with antibiotics. This approach results in fast clinical cure, but leads also to increasing bacterial resistance rates. Symptomatic treatment and delayed prescrip-tion have been proven as effective in women with UTI symptoms. For Uva Ursi (UU), a traditionally and commonly used herbal drug for UTI there is no evidence for its effec-tiveness.
Research question: Can treatment with UU in women with UTI reduce the antibiotic use without increasing symptom load, or complications?
Method: This is a randomized-controlled, double-blind, double dummy multicenter comparative effectiveness trial. Women between 18 and 75 years with suspected UTI and at least two of the symptoms dysuria, urgency, frequency or lower abdominal pain will be screened in general practice and enrolled into the trial. Participating patients will receive either immediate antibiotic therapy with fosfomycin-trometamol 1x3g (current German guide-line recommendation) or treatment with UU for fivedays, antibiotic therapy only if needed. We defined two co-primary endpoints: 1) number of all antibiotic prescriptions day 0-28 2) disease burden, defined as a weighted sum of the daily total symptom scores from day 0 to 7. We will recruit 400 women with UTI symptoms. Secondary outcomes include recurrent UTI and complications.
Results: The study will be considered positive if superiority of the conditional antibiotic treatment with respect to the first co-primary endpoint and non-inferiority (<125% symptom burden) with respect to the second co-primary endpoint is demonstrated at a level of 0.025 one-sided.
Conclusions: We expect that initial treatment with UU may allow for a substantial reduction of antibiotics without causing harm, i.e. increased symptoms, recurrences or complications. In this case, UU could be used as an alternative to (immediate or delayed) antibiotics in UTI.

Points for discussion:

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PRESENTATION 29: Saturday 15th October, 2016 FREESTANDING PAPER
12.10–12.40 h. Ongoing study with preliminary results

Do Multi-children Women Have Higher Risk of Osteopenia and Osteoporosis?

Pavlo Kolesnyk, Ivan Kutchak, A. Dolgikh
Uzhgorod National University, Family and Internal Medicine, 88000 Uzhgorod, Ukraine. E-mail: dr.kolesnyk@gmail.com

Id 77
Background: Prevalence of osteoporosis occurs in women of postmenopausal age. Densitometry is devoted to provide screening in this cohort. However osteopenia can be found in fertile multi-children women.
Research question: Can multi-children mothers become a considered cohort for screening of osteoporosis before menopausal age?
Method: 270 record forms of women with more than 3 children including Roma ethnic group from rural western region of Ukraine were processed. 2 groups of women have been selected depending of the number of pregnancies in their history. The average number of pregnancies in women of index group was 4,36±1,62. Women were divided into subgroups - fertile and menopausal. We used questionnaire which evaluated risk factors and women's nutrition. Bone mineral density (BDM) and T-score has been examined using calcaneal quantitative ultrasound densitometer "Sahara Hologic".
Results: Over 46% of examined multi-children women had osteopenia comparing with 35,7% of control group. This difference was not significant among fertile women of examined groups. Frequency of osteopenia and osteoporosis depended on age (rs=-0,42; p>0,05) and was significantly higher among menopausal women. Weak positive correlation was found between BDM (T-score) and number of pregnancies among examined fertile women (rs=0.29, p=0.356) and calcium content in their diet (rs =0.109, p=0.736). Prevalence of osteopenia and osteoporosis did not depend on ethnicity of examined women. Though no significant difference in BMD of fertile women has been observed, frequency of osteopenia and osteoporosis occurred significantly higher among post-menopausal women who have more than 3 pregnancies in their history.
Conclusions: Though number of pregnancies does not correlate with higher level of osteopenia and osteoporosis in fertile age, the cohort of multi-children women can be considered as a risk group of developing osteopenia in early menopausal age.

Points for discussion:
-Can the cohort of multi-children women be considered as a risk group of developing osteopenia?
-At what age do we need to start screening of osteoporosis in women of this cohort?

PRESENTATION 30: **Saturday 15th October, 2016** **FREESTANDING PAPER**
12.40–13.10 h. **Finished Study**

How do French people cure their common cold ? A survey over three population pools

Lea Charton, François Lefebvre, Juliette Chambe, in cooperation with the COCO study group
Medicine, general practitioner, DMG Strasbourg, 67000 Strasbourg, France. E-mail: leacharton@gmail.com

Id 63

The common cold is a frequent motive of consultation for general practitioners. It generates high direct and indirect costs.
Our main goal was to identify the practices of French patients for curing their common cold. The secondary goals were to estimate the incidence of self-medication, to identify iatrogenic risks due to self-medication, and then to find out if there were socio-economic factors likely to influence the choice of the adopted strategy.
This study is an ancillary trial of a transverse study made by the EGPRN (European General Practice Research Network) over 14 European countries.A questionnaire has been distributed to 120 patients consulting in 3 different offices of the Bas-Rhin area (rural, urban, underprivileged sub-urban) for a total of 360 patients.
Among the three offices, the suburban population was more precarious than the other two. Over 325 patients who answered, 3% didn't use any drug treatment, 88% used over-the-counter medication (paracetamol 68%, ibuprofen 24%), 84% changed their diet, 70% worked on their environment and 43% made “grandma’s recipes” (62 % of the suburban). With 50 % of the patients tacking chronic treatments, iatrogenic risks existed.
The main factors influencing the choice of the therapeutic strategy were : place of residence (reflect of the socio-economical status in our study), and family roots. For 25% of the patients, common cold wasn’t a self-limited disease (suburban 38%), and 17% were consulting systematically a doctor for their cold (suburban 22%, urban 7%). Parents were the principal source of information on curing methods for common cold (58 %). Self-medication is dominant, and the range of non-medical strategies is wide. Precarious situations lead to increased consumption of reimbursed medication, but also to more diverse non-medical strategies.

Points for discussion:
-Self-medication in common cold
-Socio-economical factors
-Iatrogenic risks

PRESENTATION 31: **Saturday 15th October, 2016 11.10–11.20 h.** **ONE-SLIDE / FIVE-MINUTES PRESENTATION Finished Study**

Gonorrhoea Diagnosis and Management in Primary Care in Ireland

Marié O'Shea, M. Daly, Claire Collins
Research, Irish College of General Practitioners, 0, Dublin, Ireland. E-mail: marie.oshea@icgp.ie

Id 84

Background: In Ireland, clinicians in primary care play an increasingly important role in gonorrhoea diagnosis and treatment. However, there is limited recent evidence on the extent to which gonorrhoea is successfully diagnosed, treated and managed in general practice in Ireland, and on the appropriateness and quality of care received there.
Research question: What is current practice in relation to the diagnosis and management of gonorrhoea in primary care in Ireland? What are GP's views on how best to achieve optimal management of cases diagnosed?
Method: A mixed method study design involving analysis of existing survey data, a literature review and qualitative interviews with a purposive sample of GPs.
Results: Almost 30% of those GPs who provide testing had completed a Sexually Transmitted Infections Foundation (STIF) course. The main barriers indicated by respondents to providing STI testing in their practice were: no financial incentive (33.6%), lack of time (24%), perceived lack of knowledge and skills (18.5%) and problems accessing testing swabs (12.3%). The majority of qualitative interview participants were aware of AMR gonorrhoea although most did not have any experience with its clinical presentation. Participants identified varied approaches in their practice in relation to testing, and most did not routinely engage in active contact tracing in their practice; instead referred forward or assisted their patients undertaking their own partner notification. All participants clearly expressed that guidelines for the management of gonorrhoea in Ireland would be pertinent and relevant.
Conclusions: The study illustrates that support in Irish general practice in the form of guidelines on testing, including suitable swabs and appropriate testing sites for all patients including MSM patients, diagnosis and the suitable treatment of gonorrhoea cases are necessary. In particular guidelines should address the importance of taking a culture following NAATs positive test and the problem of AMR gonorrhoea.

Points for discussion:

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PRESENTATION 32: **Saturday 15th October, 2016 11.20–11.30 h.** **ONE-SLIDE / FIVE-MINUTES PRESENTATION Study Proposal / Idea**

Improving chronic depression care in general practice

Florian Wolf, Antje Freytag, Sven Schulz, Jochen Gensichen
Jena University Hospital, Friedrich-Schiller-University, Institute of General Practice and Family Medicine, Jena, Germany. E-mail: florian.wolf@med.uni-jena.de

Id 31

Background: Patients with chronic depression (persisting symptoms for ≥2 years) are a clinically relevant group with extensive (co)morbidity, high functional impairment and associated costs in primary care. The General Practitioner (GP) is the main health professional attending to these patients. In a prior survey we demonstrated that GPs present high awareness towards chronic depression reporting safe diagnosis and high-quality care. 92% recommend psychotherapeutic co-treatment to their chronically depressed patients but only 56% perform psychoeducational methods in person. Furthermore 59% of GPs develop adherence enhancement strategies and 50% crisis management plans. The Cognitive Behavioral Analysis System of Psychotherapy (CBASP) is a synthesis model of interpersonal, cognitive and behavioral therapies developed specifically for the treatment of chronic depression. CBASP has been successfully administered to chronically depressed patients within secondary and specialized care. It is unclear if CBASP is feasible and effective when conducted by GPs and their health care assistants in a primary care setting.
Research question: Are German GPs open for implementing case management strategies for chronic depression with low-threshold psychotherapy including procedures derived from CBASP? Which requirements, barriers and opportunities are pointed out by the GPs?
Method: A nationwide cross-sectional survey with a self-constructed and piloted questionnaire is to be conducted. Expecting a response rate of at least 20% to 30%, as obtained in our prior surveys, a systematic sample of 2000 German GPs will be contacted and asked to complete the written questionnaire anonymously. Descriptive analysis of quantitative variables is going to be carried out via SPSS Statistics. In a second step, a focus group based quantitative analysis of German GPs' attitudes and beliefs towards the management of chronic depression is going to be performed using existing quality circles.

Points for discussion:
-Is a sequential mixed method design suitable for developing a treatment manual (case management with low-threshold psychotherapy) for chronic depression in primary care?
-How can risk of bias (selection bias, misclassification bias, social d

PRESENTATION 33: **Saturday 15th October, 2016** **11.30–11.40 h.** **ONE-SLIDE / FIVE-MINUTES PRESENTATION** **Ongoing study with preliminary results**

Physicians' knowledge and behavior about their rights and criminal liabilities according to legislation

Baki Derhem, Mehmet Ungan
Yildizeli Family Health Center, Sivas Public Health Directorate, 58500 Sivas, Turkey. E-mail: dr.baki71@gmail.com

Id 35

Background: Many physicians and policy-makers claim that defensive medicine is responsible for the increasing costs of health care. Besides, increasing malpractice lawsuits are inhibiting physicians to work in a relaxed way and treat their patients objectively.
Research question: What is FM Specialists' and GPs' level of knowledge and behaviours about their rights, criminal liabilities and common rules of law that are regulated by legislation?
Method: Total number of 381 physicians, working at Family Centers located in Ankara, were interviewed face-to-face. We used a 38-item questionnaire that was developed according to current legislation. The questionnaire contains 18 knowledge based questions which 7 questions investigate physician's rights, 7 questions investigate criminal liabilities and 4 questions investigate common rules of law. Then we compared knowledge based questions with sociodemographic factors including if physicians recieved any punishment or taken any education about medico-legal issues.
Results: In comparison of working experience with correct answers, experienced physicians had a lower level of knowledge about medico-legal issues. There was significant difference in correct answers between two groups which were seperated according to whether or not they received a punishment as a result of an inquirement. In our study, the doctors who has taken education about physician's rights and criminal liabilities or not, there was significant difference between them compared in terms of total correct answers in favor of taken education ($p<0,001$).
Conclusions: We determined that family physicians have insufficient knowledge levels about medico-legal issues in Turkey.

Points for discussion:
-Should we perform a multinational study to reveal this problem at Family Medicine?
-What is the most appropriate time and method for providing training about medico-legal issues to FMs/GPs?

PRESENTATION 34: **Saturday 15th October, 2016 11.40–11.50 h.** **ONE-SLIDE / FIVE-MINUTES PRESENTATION Study Proposal / Idea**

Evaluation of the Empowerment Levels of Type 2 Diabetes Patients Seen in an Outpatient Diabetes Clinic of a University Hospital

Tuğrul Bıyıklıoğlu, Mehmet Ungan
Ankara University School of Medicine, Dept. Family Medicine, 6100 Ankara, Turkey. E-mail: mdtugrul@gmail.com

Id 37

Background: Management of chronic diseases is one of the most important challenges that health care systems are facing today. Patient empowerment is considered to be an effective solution for this challenges via promoting self-management and self-care activities. However, literature presents mixed results regarding correlation between empowerment and better clinical outcomes. Especially in Turkey, the concept is not assessed thoroughly.
Research questions: What are the empowerment levels of type 2 diabetes (T2DM) patients seen in the outpatient diabetes clinic of our university hospital? Is there a correlation between empowerment levels and clinical outcomes?
Method: The study is planned as a descriptive study. Study setting is the outpatient diabetes clinic of our university hospital. Inclusion criteria are; T2DM patients between 30-65 years of age and at least 1 year of disease duration. Exclusion criteria are; severe mental disorders, cognitive impairment and dementia and not being able to communicate in Turkish. Two questionnaires will be filled in by the patients under supervision of the researcher. One questionnaire assesses socio-demographic data and diabetes related specifics and the other one assesses empowerment levels of the patients. Weights, heights, waist and hip circumferences of the patients will be measured and BMIs will be calculated. Following clinical parameters will be determined from patients' medical records; HbA1c, blood lipid profile, diabetes complications.
Results: We expect to have an understanding on the empowerment status of T2DM patients seen in our setting, which will guide future studies. We will be able to test the assumption that higher empowerment levels are associated with better clinical outcomes in our setting.
Conclusions: N/A

Points for discussion:
-Assessing patients' perceptions regarding empowerment or self-efficacy is challenging. These perceptions are affected by personality traits of the patients. For example, empowerment and self-efficacy tend to be confused with self-esteem or self-con

PRESENTATION 35: **Saturday 15th October, 2016 11.50–12.00 h.** **ONE-SLIDE / FIVE-MINUTES PRESENTATION Study Proposal / Idea**

Googling in the Waiting Room

Robert D. Hoffman, Iris Reychav, Liliana Laranjo, Ana Luisa Neves, Davorina Petek, Bernardino Oliva-Fanlo, Heidrun Lingner, Parissa Asdagi, Claire Collins, Esperanza Diaz, Sylvester Ebaye, Caroline Huas, Hans Thulesius

Tel Aviv University, Family Medicine, 7629117 Rehovot, Israel. E-mail: hoffman5@netvision.net.il

Id 39

Background: The vast availability of knowledge through the internet has changed the interactions of physicians with patients in various ways. The ability of patients to educate themselves is a source of frustration for many physicians, but can also be harnessed to improve the clinical encounter.

Research question: In this multinational collaborative study, comprising ten countries, we aim to investigate how improving information accessibility impacts the dynamics of the medical encounter. The study will focus on multiple factors, including how availability of information impacts anxiety and satisfaction of patients on the one hand, and aspects of the physician attitude towards use of information resources by the patients on the other hand. We also will examine the usefulness of tablets to help overcome the language barrier while treating foreigners.

Method: Our study will continue the research of Reychav et al. 2016, and utilize an internet connected tablet with pre-set recommended sites on the desktop, to evaluate the effects of tablet use on the patient and physician. Following ethical approval in the participating countries, an on-site research assistant with 3 tables per site will enlist 100 patients over 4 weeks. After consent and demonstration, the patient will do a pretest on the tablet, use the tablet to "Google", go into the doctor's office with the tablet, and after the physician consultation, do a post-test. The Israeli study used a US developed questionnaire to examine Patient Satisfaction, Patient learning, Physician Information giving, and assessed tablet use in the waiting room and during the medical encounter. We will expand this questionnaire according to the areas of interest in our working group.

Results:

Conclusions: The results will shed light over a topic that all physicians face on a daily basis, and hopefully will enable incorporating this new reality to benefit and improve our patient care.

Points for discussion:

-How can we choose universal sites that are comparable?

-Should we do a follow up after "intervention"? (It would be interesting to see if these one time tablets use pre and during visit has any lasting effects. Will the patients continue to prepare

PRESENTATION 36: Saturday 15th October, 2016 ONE-SLIDE / FIVE-MINUTES PRESENTATION
12.00–12.10 h. Ongoing study with preliminary results

Dealing with the relationship of mental health problems and violence in primary care

Leo Pas, Hagit Dascal, Shelly Rothschild, Carmen Fernandez, Raquel Gomez, Nena Kopcavar, Marouan Zoghbi, Kelsey Hegarty
K.U. Leuven, ACGP, 1970 Wezembeek Oppem, Belgium. E-mail: lodewijkpas@gmail.com

Id 44

Background: Mental problems are strongly associated with partner violence, child abuse and elderly abuse.
Research questions: 1.What models are taught on counseling for the relationship between mental health and family violence ? 2.Can psycho-social counselling by GP based on taught models reduce the burden of violence?
Method: A review was performed to understand the relationship between different mental health problems and identify studies on counseling for interrelated mental health problems in general practice.
Results: Although the prevalence of these problems and their mutual relationship is both very high, there are only scarce data available on counseling for the relationship between mental health and family violence. We found one study showing decrease in depression and suicide after training general practitioners to counsel associated with practice support for detection. We found several models taught for detection but non integrating detection and counseling strategies clearly. Using internet facilities on the other hand creates new possibilities for motivational approaches in general practice.
Conclusions: Based on literature on mental health, alcohol use and family violence a draft cognitive behavioral model is proposed to improve detection and counseling in primary care; the aim is to empower the patient to disclose and to define a common view with the caregiver about the background of the mental suffering, substance use and violent behavior.

Points for discussion:
-What is your opinion about and interest in a feasibility study on the detection and counselling by trainees of the developed model?
-Is a cluster randomized trial on practices with and without vocationally trained students a good methodology for further

PRESENTATION 37: Saturday 15th October, 2016 ONE-SLIDE / FIVE-MINUTES PRESENTATION
12.10–12.20 h. Ongoing study with preliminary results

Elderly frailty: an emergent reality

Zaida Azeredo, Ana Paula Barbeito, Margarida Varela, Jan Lepeleire
RECI, IPiaget, Porto, Portugal. E-mail: zaida.reci@gmail.com

Id 74

Background: Resulting from a population ageing and the increase number of very old persons, the PHC Professionals face new situationsin practice, such as, persons with multi-morbidity and co-morbidity, home care demands and elderly frailty. Frailty as a syndrome, has an increase prevalence showing new aspects related to a decreases on biologic and psychological reserves to coop with some events and or stress.
Research question: The elderly are frailt?
Aims: To study elderly frailty in a nursing home. To validate into Portuguese a frailty scale (FRAIL).
Method: We did an exploratory study (first phase) in a nursing home using an opportunistic sample of 23 persons with 65 years or over, of both sexes who want to participate and were able to participate To confirm the validation we again inquired the same persons, one and half month later, using the same scale. From the author we got permission to translate and retranslate the scale. We also respect all ethic aspects.
Results: The age of the participants is between 69 and 96 years old. 57% were female. 60% were widows; 13% were analphabets. In the structure factorial analysis we obtain a KMO=0,771 and a sphericity test of Bartlett P=0,0000 (adequate analysis)In Alpha Cronbach we obtain a consistence of 0,97 (adequate internal consistence to the Portuguese elderly population). All items were important and we didn´t exclude any. Between 1 to 6, most of the participants got 3. Memory tasks and, planning the future were the two items that show a higher frailty.
Conclusions: The Frail scale is a good scale to measure the elderly frailty in General Practice. All items of the scale are important and they have a good internal consistence in a scale between 1 to 6, most of the participants got 3

Points for discussion:
elderly frailt, frailty scale, frail validity in General Practice

PRESENTATION 38: Saturday 15th October, 2016 POSTER
14.30–15.45 h. Ongoing study with preliminary results

Relationship between pharmaceutical industry and general practitioner residents of Barcelona

Judit Pertiñez, Maria Isabel Fernández, Joan Anton Vallès, Francisco Díaz, Jacobo Mendioroz, Angel Cano, Ana Vall-Ilosera
Teaching Unit of Barcelona, Institut Català de la Salut, 8025 Barcelona, Spain. E-mail: mifsanmartin.bcn.ics@gencat.cat

Id 50

Background: Although collaboration between the pharmaceutical industry and health care professionals has important benefits, there is a growing concern about whether these relationships may become a threat to professional education and subsequently, to patient care.
Research question: What is the relationship between pharmaceutical industry and the medical residents of Barcelona?
Methods: During 2015, the teaching unit of Barcelona passed a survey, based on an American study, to their 195 four-year general practitioner residents. Participation was voluntary and data collection anonymous. We were performed a descriptive analysis centered on the interactions between the residents and pharmaceutical industry and the resident's perceptions of the industry. Data was analyzed by gender, age and residence year. Appropriate parametrical and non-parametric statistical test was applied for the analysis.
Results: The response rate was 72.3% (141 residents). The most frequent sources of information used by medical residents were: 90% ask advice of a fellow, 83.9% clinical guidelines, 78.4% vademecum. The interaction with pharmaceutical sales representatives is 'occasionally' for 72.3%. The residents who had received things from the pharmaceutical industry were: 52.5% samples of drugs, 44.0% lunch or a snack in the workplace, 37.1% payment for registration to a congress. 61.7% agreed with the statement: 'Pharmaceutical companies can have access to medical residents' and 44.6% with: 'A physician can accept and use samples/gifts to distribute among his patients'. There were statistical significant differences between year of residence and use of sources of information.
Conclusion: the sources of information used by residents to answer doubts surrounding prescriptions are adequate, but a substantial number of them received things from pharmaceutical representatives. Targeted teaching actions based on this data might improve evidence-based prescribing.

Points for discussion:
-Is the drug prescription of residents influenced by the pharmaceutical industry?
-Are appropriated the information sources consulted by the residents?
-Should the teaching units protect their residents of this influence?

PRESENTATION 39: **Saturday 15th October, 2016** **POSTER**
14.30–15.45 h. **Almost Finished Study**

Learning from Errors in General Practice - the Critical Incident Reporting and Learning System (CIRS) 'www.jeder-fehler-zaehlt.de' (JFZ) is operative for 12 years in Germany

Martin Beyer, Tatjana Blazejewski, Dania Gruber, Beate Mueller
Goeth University, Institute of General Practice, Frankfurt, Germany. E-mail: Beyer@allgemeinmedizin.uni-frankfurt.de

Id 93

Background: Threats to patient safety are frequent in primary care, systematic estimates range from 0.3, to 3 critical incidents per 100 contacts. CIRS are an appropriate means to report and to learn from errors in primary care. The launch of the system 'JFZ' was already presented during the EGPRN meeting in Tartu 2005.
Research question: Analysis of the present repository of reports.
Method: Anonymous error reporting in JFZ is web-based. The reports are introduced into a database, are scientifically classified with respect to error type, severity, contributing factors and other coding, and publicly accessible. Closure of the database and data analysis will be performed in Aug 2016 to provide recent data to the conference, therefore in this abstract results will be mentioned based on our last (German) publication.
Results: 621 reports of very different actions in general practice are available (as of 15.07.16). According to our last analysis 35.6 % of the reports implied no patient harm ('near misses'), whereas 14.6 % mentioned severe, even lethal, harm. The majority, 74.2 % were classified as routine events, only 25.8 % implied specific mistakes based on lacking knowledge or skills. Most critical events occurred in therapy/medication (54.2%), but 16.4% were diagnostic errors. In the presentation we will dedicate them specific attention. The process of critical event analysis will be exemplified in the presentation.
Conclusions: CIRS can present a wealth of experience of critical events in general practice. It is, however, a continuing problem to motivate practice teams to participate in such a system continuously and make efforts to learn - this will be a major discussion point at the meeting. We will present some of our last experiences of implementing a CIRS in practice networks.

Points for discussion:
-How to improve patient safety in General Practice
-Needs and instruments for error reporting in European countries

The willingness to commute among future physicians

Johannes Quart, Thomas Frese, Tobias Deutsch, Hagen Sandholzer
Medizin Universität Leipzig, Selbständig Abteilung fër Allgemeinmedizin, , 4275, Leipzig, Germany. E-mail: jq@arztpraxis-treben.de

Id 38

Background: To prevent a lack of medical supply in rural areas there are efforts to make working there more attractive for young doctors. In consideration of decreasing populations in some areas, temporary solutions like commuting could be a suitable option, too. There is a need for evidence regarding the openness of upcoming doctors towards such work models and the factors influencing their willingness to commute.
Research question: How many young doctors would work in a commuting model and which factors influence them positively to do so?
Method: Multicenter cross-sectional survey (Berlin, Halle, Leipzig) among medical students (8th/10th semester) gathering socio-demographic data, current career preferences, willingness to commute, maximum acceptable time getting to work, and subjective assessments on how several job-related factors would increase the attractiveness of commuting.
Results: The response rate was 92,1% (1108/1203). The participants were on average 25.3±3.2 years old and 64.4 % were female. General practice was the preferred carrier option for 11.8% (126/1067) of the students. The mean acceptable time getting to work was 38.9±13.4 minutes. More than half of the participants could imagine to commute between major city and rural areas. As the strongest factors increasing the attractiveness of commuting, students assessed: higher remuneration, financial compensation of the time getting to work, sharing the work in a small group practice (2 to 3 physicians), the possibility to delegate tasks to specifically trained supply assistants, the provision of a home office for organizational tasks, and a driver service.
Conclusions: Based on a representative sample of 1108 high semester medical students from three German universities of different size, our results indicate that living in a major city and commuting to work in a small-town or rural area is broadly accepted among upcoming physicians and can be made more attractive by changing framework conditions, particularly with regard to remuneration and workload.

Points for discussion:
-Potential differences and incomparabilities with regard to other European countries
-Further research in this area

PRESENTATION 41: Saturday 15th October, 2016 POSTER
14.30–15.45 h. Study Proposal / Idea

The doctor, the patient and the new digital medicine

Alberto Parada
University of Liege, Family medicine, 4983 Basse-Bodeux, Belgique. E-mail: alpadoc@gmail.com

Id 60

Background: In a society undergoing transformation due to the use of digital technologies, the world of health must adapt.It is a metamorphosis of society and our professional activities digitally driven.Digital Medicine 4.0 exchange practices and permanently alters the relationship between neat, helpers and caregivers.The modernization of the health system inevitably go through a widespread use of digital information technologies: telemedicine, information systems for continuous improvement of care, digital imaging, care pathway management, the connected objects, medical databases and smart data are just some examples.
Research question: Do the practicioner tomorrow need a doctor degree in digital? Will the future a dehumanized medicine where the diagnosis is established by "expert systems" reeling millions of patient data? The doctor will be only human auxiliary machines, only able to drive this medicine 4.0? Where the patient has become a connected body, will be analyzed, controlled, continuously by health artificial intelligence? How can the connected devices serve a strengthened relationship between caregivers and patients?
Method: Literature review.
Results: Smart data, management health IT systems, clinical decision support IT systems development of e-health, the other corollary, namely the m-health. Medicine 4.0: benefits and risks.
Conclusions: Physician/patient communication in the “e-health” context.

Points for discussion:
-doctorrs paradigm shift with digital medicine?
-the future of health is your smartphone
-utility of some medical devices

PRESENTATION 42: Saturday 15th October, 2016 POSTER
14.30–15.45 h. Finished Study

The WoMan Power Project: Why become a GP in Germany? Positive aspects of GPs' profession

Sarah Sausmikat, Eva Hummers-Pradier, Susanne Heim, Heidrun Lingner
Zentrum für Öffentliche Gesundheitspflege, Medizinische Hochschule Hannover, 30625 Hannover, Germany. E-mail: sarah_sausmikat@hotmail.com

Id 15

Background: The lack of GPs in medicine is a problem existing not only in Germany, but internationally. Various studies investigate negative aspects of the GPs occupation as well as reasons for a shortage of young doctors choosing general medicine as field of practice. The WoMan Power project aims at collecting positive aspects regarding the job as a GP in order to use them for promoting the profession to young physicians and thus fight the lack of GPs.
Research question: “What do GPs like about their job and what aspects can be used as motivating factors?”
Method: Qualitative explorative design: guided focus groups with GPs were conducted, recorded, summarized using mapping tecnique and analysed on the basis of Mayring. Recruitment was done consecutively using the official registry of practicing GPs in Lower Saxony.
Results: The 3 focus groups consisted of 14 GPs practicing in rural areas and 8 in urban areas. 13 of the participants were male, 9 were female. Aspects being generally applicable to GP’s profession were found as well as some specifically valid in rural areas. All of these should be presented during the congress. Here are some examples for both groups:
general aspects: -individual scheduling of working hours, -good compatibility of family life and job, -satisfying income/remuneration, -greater variety and broader medical spectrum compared to other medical specialities
“rural“ aspects: -well-disposed patients due to balanced social structure, -good relation between local medical colleages, -high quality of life, -advantageous financial conditions for establishment of medical practice.
Conclusions: Results show plenty of positive aspects regarding the occupation as a GP which make this job an attractive one. They should be made accessible to a wide public and can be used well for advertising this profession. Studies show that job satisfaction among practicing GPs is high after all.

Points for discussion:
-Lack of GPs
-Motivating factors

PRESENTATION 43: Saturday 15th October, 2016 POSTER
14.30–15.45 h. Ongoing study with preliminary results

Does the egprn multimorbidity definition predict decompensation? A cohort study, follow up at 6 months in nursing home (NH).

Michele Odorico, A. Le Madec, Jérémy Derriennic, Etiënne Melot, Delphine Le Goff, Sophie Lalande, Pierre Barraine, Patrice Nabbe, Bernard Le Floch, Jean Yves Le Reste
UBO Brest, ERCR SPURBO, 29200 Brest, France. E-mail: m.odoricobrest@gmail.com

Id 12

Background: Multimorbidity is a global concept defined by the European General Practice Research Network (EGPRN) and concerns the majority of residents in Nursing Homes (NH). It is defined by 53 variables.
Research question: which criteria within multimorbidity definition are predictive of decompensation?
Methods: cohort study conducted with a cohort of 64 NH residents meeting the definition of multimorbidity. A questionnaire on multimorbidity criteria was fulfilled for every patient. Six months after inclusion, patients' status was collected and patients were classified in the «decompensation» group (hospitalization for more than 7 days or death) or in the «nothing to report (NTR)» group. Statistical analysis was univariate and multivariate using a logistic regression.
Results: 52 patients were included in the «NTR» group and 12 in the «decompensation» group. Two criteria showed statistically significant difference between the two groups: pain (p=0.003857) and use of psychotropic drugs (p=0.01878). Logistic regression final model let appear pain and lack of chronic disease complexity as decompensation risk factors.
Conclusion: pain seemed to be predictive of decompensation in NH. However, the low number of included patients and the large difference in prevalence of pain compared to French NH limits its generalization. A study on a larger scale should be performed to confirm these results.

Points for discussion:
Specificities about the study population that may be important in interpreting results.

PRESENTATION 44: Saturday 15th October, 2016 POSTER
14.30–15.45 h. Ongoing study, no results yet

POLYCARE (Horizon 2020) - Poly-stakeholders integrated care for chronic patients in acute phases supplied by ICT-solutions (a feasibility- study)

Nils Henning Heiland, D. Mauer, M. Coenen, S. Huhn, Klaus Weckbecker, POLYCARE Consortium (University Hospital Bonn, Bonn, Germany; EVERIS, Madrid, Spain; SALUD (Servicio Aragonés de Salud - Sector Sanitario de Barbastro), Spain; COMARCA de Somontono de Barb
University Hospital Bonn, Institute of General Practice and Family Medicine, 53127 Bonn, Germany. E-mail: nils.heiland@ukb.uni-bonn.de

Id 48

Background: Nowadays, chronic diseases and co-morbidities have to be managed during a long period of time among health and care systems. An EU-Conference stated that 86% of deaths are caused by chronic diseases and -according to an EU consultation- 70% to 80% of healthcare costs are spent on chronic diseases including the costs of frequent hospitalizations of patients with exacerbations. Additionally those hospitalizations lead to a decrease of quality of life and self-management of the patients. Real integrated care implies the involvement of all stakeholders of the individual patients care including the patient himself supported by information- and communication-technologies (ICT). In exacerbations of chronic diseases integrated care might allow home hospitalization defined as patient treatment at home with similar complexity and intensity as in the hospital. Neither systematic “integrated care” nor “home hospitalization” services nor the broader use of ICT solutions have been established in the outpatient care sector in Germany so far.
Research question: Is the care of chronically ill patients with acute exacerbations at home with the support of ICT-solutions feasible for both the different stakeholders and the patients?
Method: After developing the ICT-solutions there will be three pilot sites in France, Spain (100 patients each) and Germany (30 patients) running the proof of concept studies for one year time (start in 2017).The ICT-solutions will include different wearables for monitoring selected vital signs and a collobarative environment providing the opportunity for the stakeholder to communicate and share relevant informations. Furthermore it will include different functions (apps for gamification, education, reminding) to increase the patiens adherence.
Results: The project aims at the description of the usability and the practical implementation of the application of the ICT-solutions for chronically ill pations with acute exacerbations at home in a specific way at each pilot site.

Points for discussion:
-the feasibility of close integration of the different stakeholders
-the care at home similar to hospital treatment
-the application, acceptance and usefulness of the ICT solutions collecting, sharing and analyzing information.

PRESENTATION 45: **Saturday 15th October, 2016** **POSTER**
14.30–15.45 h. **Almost Finished Study**

Metabolic syndrome criteria in asymptomatic NAFLD patients

Ilze Skuja, Elina Skuja, Inga Stukena, Aivars Lejnieks
Riga Stradins University, Family Medicine, Ilze Skuja GP Practice, Riga, Latvia. E-mail: skujailzedr@gmail.com

Id 19

Background: Non-alcoholic fatty liver disease (NAFLD) is the most common liver disease in the western world. Although initially benign and asymptomatic, the disease can progress to non-alcoholic steatohepatitis and subsequently to hepatic fibrosis, cirrhosis of liver and hepatocellular carcinoma. At the present time, there is no specific test which can predict redevelopment.
Research question: How to diagnose and prevent NAFLD?
Method: In 97 patients (30-45 years, asymptomatic) body mass index (BMI), waist circumference (WC), systolic and diastolic blood pressure (SBP and DBP) glucose (Glu), HOMA-IR, TC, HDLC, non-HDLC, LDLC, TG, GGT, AST and ALT were estimated. Chemerin and E-selectin levels were measured by Luminex xMAP technology. All patients underwent a CT examination of the liver with multilayer spiral computer tomograph. The density of the liver and spleen and liver index was determined. Patients were divided into two groups according to liver index (LI) - patients with NAFLD (LI<10) and control group (LI $\geq$10).
Results: There were significant ($p<0.05$) differences in BMI, WC, SBP and DBP and levels of Glu, HOMA-IR, HDLC, non-HDLC, TG, GGT, AST, ALT, chemerin and E-selectin between both patient groups. Significant ($p<0.05$) negative correlations between LI and BMI (r=-0.38) WC (r=-0.59) were found in control group, but negative correlations between LI and BMI (r=-0.35), WC (r=-0.41), SBP (r=-0.38), DBP (r=-0.37) Glu (r=-0.27), HOMA-IR(r=-0.38), ALT (r=-0.58), AST (r=-0.43), GGT (r=-0.48), TG (r=-0.45), E-selectin (r=-0.49) and chemerin (r=-0.37) were found in NAFLD patients group.
Conclusions: Patients with higher WC and/or BMI must underwent tests to check the levels of glucose, insulin resistance, lipids and liver enzymes. In case of abnormal findings it is recommended to screen for NAFLD subsequently starting prevention or treatment. It will be very expediently to monitor BMI, WC, SBP, DBP, insulin resistance and lipid panels to manage better with even asymptomatic NAFLD.

Points for discussion:
Asymptomatic overweight patients in GP practice - to examine for potential diseases or wait untill remarkable symptoms?

PRESENTATION 46: Saturday 15th October, 2016 POSTER
14.30–15.45 h. Ongoing study with preliminary results

Electronic reminders to facilitate chronic care: A mixed-methods study in primary care

Christine Kersting, Birgitta Weltermann
University of Duisburg-Essen, Institute for General Medicine, 45147 Essen, Germany. E-mail: christine.kersting@uk-essen.de

Id 28

Background: Longitudinal, patient-centered chronic care is a challenge for primary care physicians. German practices facilitate this challenge by generating self-designed reminders.
Research question: This study aimed to identify details on reminders used in primary care: (1) the contents of care addressed, (2) the reminders' actual design, (3) their functionalities, and (4) their routine use.
Method: This mixed-methods study combined a cross-sectional survey among 185 primary care practices from a German university network, and structured observations of reminder utilization in six practices. Descriptive statistics were performed for survey data; practice observations were analyzed by grouping the different reminder systems with regard to their designs and functions.
Results: 73 of 185 practices completed the survey (39.5%): 98.6% use reminders in the (electronic) health records (HR/EHR). Frequent care contents addressed are allergies/risks (95.8%), preventive measures/check-up (93.1%), participation in disease management program (87.5%), chronic diseases (75.0%), and vaccinations (68.1%). Practice observations showed different, mainly self-configured reminders with one practice using paper-based reminders. Information was presented (1) continuously in a separate field, (2) scattered through the EHR, and/or (3) in pop-up windows. Design of electronic reminders varied: (1) colored fields with short text, (2) words in colored letters, (3) abbreviations, (4) symbols, (5) EHR-embedded information buttons marked by symbols, e.g., a light-bulb, and (6) pre-structured fields from software add-ons. Five practices develop reminders 'as needed'; one practice applied a comprehensive, EHR-predefined reminder system. Practices had reminders for a mean of 13.3 aspects of care (range: 9-21; standard deviation (SD): 4.3) from 26 aspects outlined in a clinical vignette. Time to retrieve the information for the standardized clinical vignette took from 20 to 35 minutes (mean: 27.5; SD: 6.1).
Conclusions: Most practices use visual reminders for selected aspects of chronic care, yet data-based, sophisticated solutions are required to improve care.

Points for discussion:

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PRESENTATION 47: Saturday 15th October, 2016 POSTER
14.30–15.45 h. Ongoing study with preliminary results

The design of the LIMIT: Low Indexes of Metabolism email Intervention Trial

Nir Tsabar, Yan Press, Johanna Rotman, Bracha Klein, Yonatan Grossman, Maya Vainshtein-Tal, Sophia Eilat-Tsanani
Clalit Health Services North district, 4284200 Bat Hefer, Israel. E-mail: tsabar.nir@gmail.com

Id 56

Background: Too-low body mass index (BMI), HbA1c% or cholesterol levels predict poor survival. Here we present the design and initial results of a randomized controlled clinical trial to evaluate how alerting primary care teams to low metabolic values, would affect the health of patients aged 75 or older.
Research question: Will e-mails to family physicians and nurses about these too-low values improve health and survival of people older than 75 years?
Method: This randomized controlled trial compares usual-care to the addition of an e-mail which alerts to too-low values of a patient and advises on nutritional and medical changes.
Participants: Clalit Health Services patients in Israel's Northern and Southern Districts, aged ≥75 years with any of the following: a. BMI < 23 kg/m2 with BMI drop of ≥2 kg/m2 during previous two years and without dietitian counseling during previous year. b. HbA1c ≤6.5% and received anti-diabetic medicines during previous 2 months. c. Total cholesterol < 160 mg/dL and received cholesterol-lowering medicines during previous 2 months. Excluded from criterion c were patients with either ischemic heart disease, transient ischemic attack or a stroke. The primary outcome is death from any cause, within one year.
Results: Out of 48,623 people over the age of 75 years, 8,584 (17.7%) had low metabolic indices and were randomized to intervention or control groups. E-mails were sent on 11.2015.
Conclusions: Low metabolic reserve is common in people in Israel's peripheral districts aged ≥75 years. LIMIT may show whether alerting primary care staff is beneficial.

Points for discussion:
-The ethics of a large scale informational intervention trial - the 'informed consent' issue.
-Questioning established practices and knowledge regarding cholesterol lowering medicines - is it ethical? Is it practical?

PRESENTATION 48: Saturday 15th October, 2016 POSTER
14.30–15.45 h. Ongoing study with preliminary results

Preliminary results: abdominal aorta aneurysm screening by ultrasound in primary care

Clara Guede, Casandra Bazan, Guillermo Alfaro, Manuel Dominguez, Ana Clavería,
Estructura Organizativa Integrada Vigo, Servicio Gallego de Salud, 36302 Vigo, Spain. E-mail: clara.guede@gmail.com

Id 75

Background: Abdominal Aortic Aneurism (AAA) screening reduces the number of ruptures and therefore specific mortality from this cause in patients with risk factors. The tendency to decrease in incidence questioned its cost effectiveness. Also under discussion which patients select and whether it could be held in AP.
Research question: How much is AAA prevalence in Vigo PC district? Is there an association with cardiovascular risk factors?
Method: Design: Prospective controlled cohort study comprised male patients 65-74 years. Setting: Integrated Management Area Vigo, with 583124 habitants, 23 PC services, and 53 health centers. Participants: 21 family physicians (FP), belonging to 12 PC services of Vigo. Intervention cohort: all men aged 65 to 74, attended by each of FP researchers (1462). Patients who refuse to enter or not to sign informed consent were losses. Exclusion criteria: age, sex, terminal disease, already it is diagnosed or have been operated an AAA. Control cohort: men of the same age belonging to the area of Vigo. Data was extracted anonymously from the administrative databases of the Galician Health Service (SERGAS). Main outcome variable measured: all-cause mortality. As secondary endpoints: cardiovascular mortality, surgery for AAA and discharge from hospital. Independent variables: demographic.Analysis: Prevalence and descriptive analysis of the first 500 recruited patients, logistic regression of risk factors. Groups compared by Inverse probability weighting.
Results: FP: 18. Patients: 1426. Excluded: 78. 475 recruited: 15 diagnosed as AAA. Prevalence estimated: 3.16% (CI 95:1.92-5.14)Age: OR: 1.335 (CI95 1.076-1.675)Smoking: Pack-year: OR: 1.018 (CI95: 1.000-1.037)Albumin-Creatinine index: OR 1.003 (CI95: 1.001-1.005)Social support network: OR 0.119 (CI95: 0.021-0.681).
Conclusions: Difficulties for the implementation of the project will be presented. We would to discuss our preliminary results and their impact in the objectives of the study.

Points for discussion:
-Are these preliminary results expected?
-will be interesting to assess what impact has control of the main risk factors?

PRESENTATION 49: **Saturday 15th October, 2016** **POSTER**
14.30–15.45 h. **Published**

Diabetic retinopathy in catalonia: association with cardiovascular outcomes and chronic kidney disease

Antonio Rodriguez-Poncelas, Sonia Miravet, Joan Barrot, Flora Lopez- Simarro
Universitat Autonoma Barcelona, Medicine, 8032 Barcelona, Barcelona. E-mail: xavier.mundet@uab.cat

Id 29

Background: The presence of diabetic retinopathy (DR) is related to cardiovascular risk factors and consequently a greater incidence of cardiovascular disease. Chronic kidney disease (CKD) and DR reflected similar lesions in the glomerular and retinal vessels.
Research question: To determine cardiovascular outcomes and CKD associated with DR in type 2 diabetes (T2DM)) in Primary Health CareMethod: Cross-sectional population study of T2DM patients (N=329,410) with RP were selected (N=108,723 (33%). DR was classified as Normal, non-Vision Threating Retinopathy (non-VTDR) and Vision Threating retinopathy (VTDR). Cardiovascular Disease (CVD) was defined as Stroke or Coronary Heart Disease (CHD). CKD was defined as estimated glomerular filtration ratio (eGFR) of <60 ml/min/1.73m2 and/or urine albumin to creatinine ratio (UACR) >30 mg/g. Clinical Information was obtained from the SIDIAP database (System for Research and Development in Primary Care).
Results: Of the patients analyzed (55% men), mean age was 66.9 years (SD 11). Mean duration of T2DM was 7.8 years (SD 5.1). Patients with any DR had higher HbA1c mean value (7.8% vs 7.2%) and prevalence of Hypertension (85.2% vs 79.3%), glomerular renal filtration <60 ml/min (MDRD) (26.1% vs 18.9%) and albumin-creatinine ratio > 30 mg/g (27.4% vs 15.5%) than the rest. In the multivariate analysis of CVD the effect of DR was: non-VTDR (OR 1.24 95%CI: 1.15-1.34) and VTDR (OR 1.32 95%CI: 1.09-1.60); CKD was associated with a higher rate of DR (OR 1.5, 95%CI: 1.4-1.7).DR prevalence rose with the increase of UACR levels. This association was significant from UACR values =10 mg/g, and increased considerably with UACR value >300mg/g (OR 2.0, 95% CI: 1.6-2.5). This association was lower in patients with eGFR levels 44-30 mL/min/1.73m2 (OR 1.3, 95% CI: 1.1-1.6).
Conclusions: The presence of RD was related to CVD event and CKD. High UACR and/or low eGFR, appear to be associated with DR in T2DM population.

Points for discussion:
-Diabetic retinopathy should be consider a cardiovascular risk factor ?
-Chronic kidney disease must be consider arisk factor of diabetic retinopathy ?

PRESENTATION 50: **Saturday 15th October, 2016** **POSTER**
14.30–15.45 h. **Finished Study**

Importance of appropriate triage in patients with acute myocardial infarction with ST elevation in the ECG

Marija Petek Šter
University of Ljubljana, Department for family medicine, 1000 Ljubljana, Slovenia. E-mail: marija.petek-ster@mf.uni-lj.si

Id 73

Background: Acute myocardial infarction with ST elevation in the ECG (STEMI) is an emergency condition where rapid recognition of clinical priority and referral to primary coronary intervention (PCI) is crucial for a favorable clinical outcome. Triage in the emergency department is the first step of clinical work-up. Manchester Triage System (MTS) is currently being used in Slovenia as the national triage system.
Research question: Does undertriage in patients with STEMI prolonged time to PCI?
Method: Retrospective analyses of data for 156 patients with STEMI admitted to prehospital emergency department in the time frame between 1. 9. 2012 and 31. 8. 2015 was made. The patients were divided into two groups according to their MTS priority label: the group of appropriately triaged patients (red or orange priority) and the group of undertriaged patients (yellow and green priority). Comparison of system delay was held into consideration and analyzed in both groups.
Results: Among 156 analyzed STEMI patients with the median age of 67.3 years (SD 13.4 years) there were 96 (61.5 %) men. Appropriately triaged (red or orange priority) were 120 patients (76.9%). Appropriately triaged patients received PCI in 59.2 min shorter time frame (86.2 minute vs. 145.4 minute, p <0.001).
Conclusions: Proper triage category of STEMI patients is important, because unappropriated triage category prolongs system delay (time frame for PCI referral). ECG should be incorporated in triage algorithm »chest pain«.

Points for discussion:
- Comparison of patient time delay and system delay in patients with STEMI
- Factors influencing system time delay in patients with STEMI

PRESENTATION 51: Saturday 15th October, 2016 POSTER
14.30–15.45 h. Finished Study

Multi-drug use in hypertensive patients at a family medicine out-patient clinic of a university hospital

Zehra Dagli, Canan Tuz, Filiz AK, Ayse Selda Tekiner, Ayse Gülsen, Ceyhun Peker, Mehmet Ungan
Department of Family Medicine, Ankara University School of Medicine, 6100 Ankara, Turkey. E-mail: zehradagli@yahoo.com

Id 61

Background: In Turkey, the most common diagnosis in prescriptions is primary hypertension (9.29%) and mean number of drugs per one prescription is 2.46. The study was carried out to detect the prevalence of multi-drug use in hypertensive patients and the risks of interaction and adverse reaction with the drugs prescribed for accompanying conditions.
Research questions: What is the prevalence of multi-drug use in hypertensive patients? Do the drugs prescribed for accompanying conditions interact with antihypertensive agents? Do the concurrent drugs affect hypertensive therapy?
Method: The retrospective, cross-sectional, descriptive study included all individuals who attended a family medicine out-patient clinic at a university hospital for their anti-hypertensive medications to be prescribed for the first time in 2014 and 2015. Patients with any cardiovascular, cerebrovascular, endocrinological, metabolic and nephrologic conditions which could interfere with anti-hypertensive therapy were excluded. Only the agents used systemically were taken into account. Continuous and categorical variables were given as mean±standard deviation and percentages, respectively.
Results: Mean age of 150 patients (41.3% male, 58.7% female) was 58.99±13.66 years. Mean number of active anti-hypertensive agents prescribed was 1.74±0.76 (range, 1-5). Of the patients, 42% used only one anti-hypertensive agent, 44.7% used two agents. The most frequent anti-hypertensive drugs prescribed were combinations of angiotensin receptor blockers and diuretics (30.6%), beta blockers (24.0%), and calcium channel blockers (20.0%). Sixty-six percent of the patients were prescribed concurrent drugs. Mean number of agents prescribed for accompanying diseases was 1.45±1.57 (range, 0-8). The most common agents prescribed were non-steroidal anti-inflammatory drugs (25.3%). While 36.7% patients received drugs interacting with anti-hypertensive agents, 23.3% received drugs with adverse effect of hypertension.
Conclusions: Anti-hypertensive drugs prescribed seemed to be accordant with current guidelines. As two thirds of the patients used other drugs along with anti-hypertensive agents, rational drug use should be considered while prescribing routine drugs.

Points for discussion:
-FP/GPs prescribe concurrent drugs to two thirds of the patients. Is it because of accompanying diseases or patients' habit to demand?
-Is educating FP/GPs on rational drug use enough? Can they have a role in patient education by mentioning drug

PRESENTATION 52: **Saturday 15th October, 2016** **POSTER**
14.30–15.45 h. **Finished Study**

Repercussions of the use of the ZARIT scale on the care of patients with Alzheimer's disease and their family caregivers in primary care: a systematic review of the literature.

Julie Grosse, Clarisse Dibao-Dina, J. Robert
DUMG Tours, Faculté de médecine de Tours, 37400 Amboise, France. E-mail: clarisse.dibao-dina@univ-tours.fr

Id 23

Background: The role of family caregivers of patients with Alzheimer's disease has many physical and psychological consequences that can be resume by the caregiver's burden. French guidelines recommend to use the ZARIT scale to evaluate this burden. However, the relevance of the ZARIT in practice is unclear, particularly in terms of consequences on the dyad's care (patient and caregiver).
Research question: What are the repercussions of the use of the ZARIT scale on the care of patients with Alzheimer's disease and their family caregivers in general practice?
Method: Systematic review of the literature on 5 international (Medline, Cochrane, Psycinfo, Francis, Science direct) and 3 french databases.with a MESH search equation (Cognition disorders [MeSH Terms] OR alzheimer disease [MeSH Terms]) AND zarit AND burden AND caregivers [MeSH Terms]). The electronic search was performed in June 2014. Selection criteria were articles on family caregivers, setting in primary care and with a performed ZARIT scale. Articles on ZARIT determinants were excluded. Data were collected with a tested data extraction form and concerned characteristics of studies and population (patients and caregivers), ZARIT scale performances and its consequences.
Results: On 285 eligible articles, twelve were included. All studies were observational and two studies were exclusively in primary care. Patients were 77 years old in average and caregivers 60 years old. An elevated ZARIT score was associated with an increase risk of hospitalization, institutionalization and abuse of the patient with Alzheimer's disease. It was also associated with a risk of psychopathological deterioration for the caregiver. A persistent elevated level of burden was a predictive factor of depression in caregivers. There was no study evaluating an intervention based on the ZARIT scale to improve the dyad's care.
Conclusions: Studies are needed with interventions based on the ZARIT scale to evaluate its relevance in general practice.

Points for discussion:
-Do you use the ZARIT scale in practice?
-Do you think it could be relevant?

PRESENTATION 53: Saturday 15th October, 2016 POSTER
14.30–15.45 h. Ongoing study with preliminary results

Are we really healthy, or just not checked up?

Sanda Kreitmayer, Nurka Pranjic, Azijada Beganlic
Medical Faculty Tuzla, Family Medicine, 75000 Tuzla, Bosnia and Herzegovina. E-mail: kreitmayerdrsanda@yahoo.com

Id 20

Background: 50 young persons were invited (with family history of cardio-vascular diseases and diabetes) for regular check up. We assumed that those persons are healthy. Including factors when selecting the group of patients were positive family history and last visit to family doctor at least two years ago.
Research question: Are young adults really healthy, or just not checked up?
Method: 50 young healthy adults (with family history of cardio-vascular diseases and diabetes), were checked up. We assumed that those persons are healthy. Unfortunately, we were wrong! Including factors when selecting the group of patients were positive family history and last visit to family doctor at least two years ago.
Results: We examined total of 168 patients, 102 women and 66 men, aged 18-35 years, in two months. We performed: laboratory testing checking glucose level, cholesterol and triglycerides; we measured BMI, blood pressure, and checked smoking and drinking status. Out of 168 examined patients, we found that 48 were perfectly healthy, 43 patients were with high blood pressure, 17 with diabetes, 61 with hyperlipidaemia. 102 had BMI higher than normal, 6 were severe obese. 33 patients complained for sight problem, 23 patient were found liver and pancreatic steatosis when performed abdominal ultrasound. Half of examinees complained for at least one episode of backache during last two years. 132 patients reported smoking history or are smokers. 114 patients regularly consume alcohol, 2 of them are alcohol abusers.
Conclusions: Study showed how important is to work on education and early prevention of chronic diseases, especially in those patients with positive family history.We have to educate our patients better in order to get them on regular annual examination. Study showed that 75% of patient whom we assumed healthy, were not. This implicates that we have more patients than we assume and than we treat.

Points for discussion:
-Are young adults really healthy or just not examined?
-Importance of regular check ups in healhy adults without illness symptoms.

Adherence to recommendations in discharge notes from Internal Ward by Schizophrenic patients

Einat Madera, Naama Schwartzb, Alon Reshefa, Itamar Minuhinc, Sophia Eilat-Tsananid,e
Bar Ilan University, Family Medicine, Clalit Health Services, 36570 Give'at Ela, Israel. E-mail: eilat@clalit.org.il; eilatsophia@gmail.com

Id 55

Background: In 2016 Israel health system has launched the Mental Health Reform, in which all mental ambulatory care moved under the responsibility of the community. Continuity of care after discharge from psychiatric departments is well defined in the reform, but not after discharge from general hospitals. Psychiatric morbidity is related to increased and early mortality. Schizophrenic patients (SPs) are characterized with high rate of readmission to general hospitals, and longer in-hospital stay. SPs show low adherence to psychiatric treatments.
Research question: Is there a difference in adherence to recommendations at discharge notes from a general hospital between SPs and patients without psychiatric morbidity (NPPs)?
Method: A retrospective research. We reviewed the discharge notes patients who were discharged from Internal Medicine (IM) ward between 2001-2011. All recommendations were collected (medications, consultations, blood test etc.). Information on adherence with the recommendations was retrieved from the central data in the community, as well as data on visits to family doctors, emergency department and hospitalizations.
Results: The study included 703 (275 SPs and 428 NPPs), out of whom 556 had recommendations at discharge notes. SPs adhered less with the recommendations (45% vs 56%, p=0.005). The low rate of adherence was identified in visits to consultants (34% vs 52%, p=0.012) and not in blood or imaging tests. Rate of visits in emergency room without hospitalization and readmission was higher in SPs (41% vs 31.5%, p=0,009; 34.5% vs 24%, p=0.026). There was no difference in rate of visits to GPs.
Conclusions: SPs tend to adhere less than NPPs with recommendations at discharge from IM department. This may have influence on a higher rate of readmission. Discharge of psychiatric patients from general hospitals should be considered in planning the continuity of care at the community.

Points for discussion:

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PRESENTATION 55: Saturday 15th October, 2016 POSTER
14.30–15.45 h. Ongoing study with preliminary results

Social economic characteristics, psychological stress events and regional development-determinants of chronic diseases morbidity of population aged 18-65, 20 years after Croatian War of Independence - a pilot study

Vanja Lazic, Suncica Petrak Vukovic, Durdica Kasuba Lazic, Antonija Balenovic, Milica Katic
Medical School University of Zagreb, Department of Family Medicine, 10000 Zagreb, Croatia. E-mail: vanjlaz@gmail.com

Id 87

Background: Differences in socioeconomic deprivation, harmful life habits and experience of stress events increase risk of chronic diseases (CD). War leaved long-term social, economic and health effects on Croatian population.
Research question: To examine differences in socioeconomic status, experienced psychological stress events, CD morbidity, harmful habits, and GPs workload in population aged 18-65, in three differently developed regions of Croatia.
Methods: In 2014, pilot study was performed in three GP's offices in different areas of Croatia-defined by "development index of local and regional government"(DI) ranging DI1-low to DI5-high. On GPs lists, 4177 (72.4%) were aged 18-65. GPs recruited 150 patients each by random sampling, 450 in total. Data about age, gender, number and kind of CD, number of GP visits per year, were collected from electronic patient records (EPR). During the GP visit examinees fulfilled structured questionnaire about household, education, income, employment, smoking, alcohol consumption, number and characteristics of psychological stress events experienced in life. Data were analysed by SAS Software, ver.9.4. using the distribution analysis test, the $\chi 2$ test and Kruskal Wallis test.
Results: Significant differences among examinees from three regions were found in education, income, employment status, and the size of psychological stress index ($P<0.0001$). In EMR 869 CDs were recorded (range 1-11), 1.93 CD per patient. Multimorbiditiy was registered as follows (56.7% in DI2, 55.5%, in DI3, 40.0% in DI5). Psychiatric diseases were significantly increased in DI2. Traumatic stress events intensity was strongly associated with frequency of cardiovascular, endocrine and psychiatric diseases ($p<0.0001$). GP visits number was significantly higher in less developed areas.
Conclusion: Significant differences in a broad range of variables that affect the health of individuals and GP workload were observed. Further research should produce more realistic and specific observation of population needs.

Points for discussion:
-How to proceed the further research in order to elucidate the real health needs of the population and their GPs in a different developed areas?

PRESENTATION 56: Saturday 15th October, 2016 POSTER
14.30–15.45 h. Finished Study

Questionnaires to evaluate multidisciplinary primary care from the patient's point of view

Jérémy Derriennic, Chloé Loyez, Etiënne Melot, Michele Odorico, Delphine Le Goff, Sophie Lalande, Marie Barais, Benoit Chiron, Pierre Barraine, Patrice Nabbe, Bernard Le Floch, Jean Yves Le Reste
Université de Bretagne Occidentale, Département Universitaire de Médecine Générale, 29200 Brest, France. E-mail: jeremy_derriennic@hotmail.com

Id 14

Background: Primary care structures involving several professions develop in France. In 2009, 54% of physicians practiced in groups of which a quarter in a multidisciplinary exercise. Since 2007, the policy of supporting multi-professional groups contributes to this development. These organizational innovations raise questions in terms of attractiveness, productivity, quality of care and services for patients. The question of the place of patients in their evaluation arises.
Research question: The objective of this work was to find in the literature validated questionnaires assessing primary care by patients adapted to the French context.
Method: The method used was a systematic literature review. The PRISMA recommendations were followed throughout the process. The questionnaires were then analyzed to keep only those adapted to the evaluation of multi-professional structures with French specificities: it had to assess the patient's admission, the multi-professional cooperation and accessibility.
Results: The literature review found 15 questionnaires. Only the ACES Questionnaire (Ambulatory Care Experiences Survey) corresponded, finally, to the desired criteria. It was developed in the USA in 2002. Its design is based on the definition of primary health care given by the Institute Of Medicine. It includes 39 items divided into 10 subscales.
Conclusions: The ACES questionnaire is a validated tool for use in a process of improving the quality of primary care. It allows patients to be involved in this qualitative approach. It allows teams to have a tool easy to learn and inexpensive in the context of self-assessment. It could allow concrete actions to improve the quality of care (organization, cooperation).

Points for discussion:
-the patient's role in care assessment
-the organization of primary care in Europe: the multi-professional structures in Europe.

PRESENTATION 57: **Saturday 15th October, 2016** **POSTER**
14.30–15.45 h. **Published**

Primary care physicians' characteristics and attitudes on smoking cessation

Joseph Azuri, Sahar Nashef
Family Medicine, Tel Aviv University, 67456, Tel Aviv, Israel. E-mail: azurij@gmail.com

Id 69

Objectives: Primary care physicians are uniquely positioned to initiate and promote smoking cessation. However, their attitude towards smoking cessation is influenced by many factors including their own smoking habits and knowledge.
Research Question: The aim of the study was to assess the impact of smoking habits, knowledge and personal characteristics of primary care physicians on their attitude towards smoking cessation in comparison to a previous study conducted a decade ago.
Methods: 302 primary care physicians filled out a questionnaire, designed specifically to evaluate knowledge, smoking habits and smoking cessation interventions they use.
Results: More never-smoking physicians initiate conversations about smoking cessation recommend smoking cessation groups and set quit date to their smoking patients. They also invest greatest efforts in patients with smoking complications. More current-smoking physicians advise Nicotine Replacement Therapy and joining internet forums and telephone consultation. Keeping good relations with the patients plays an important role in the willingness of physicians to initiate a talk about smoking cessation. A large proportion of physicians stated they would prescribe smoking cessation medications to patient even when contraindicated.
Conclusion: The various approaches of primary care physicians emphasize the importance of physician education according to their smoking habits.

Points for discussion:
-Does the differences between non smoking physicians, current and former smoking physicians imply for a change in physician smoking cessation education approach?
-What should policymakers do with the finding of physicians stating they would prescri

PRESENTATION 58: Saturday 15th October, 2016 POSTER
14.30–15.45 h. Ongoing study, no results yet

The effects of lifestyle interventions on cardiovascular risk reduction

Mircea Iurciuc, Claudia Iftode, Stela Iurciuc, Florina Buleu, Ioana Padure, Ioana Budiu, Daniela Dan, Claudia Stefanescu, Elena Ardeleanu
University of Medicine, Cardiology, 300101 Timisoara, Romania. E-mail: mirceaiurciuc@gmail.com

Id 25

Background: Cardiovascular disease is the leading cause of mortality. Lifestyle changes reduce cardiovascular risk.
Research question: Are there any cost-effective lifestyle interventions to reduce cardiovascular risk further?
Method: This study was conducted on 145 subjects who agreed to make lifestyle changes. To be included, patients of either sex had to have a risk SCORE between 1 and 10, aged 40-80 years, and to be without chronic cardiovascular complications (coronary artery disease, transient ischemic attack or stroke, peripheral artery disease), diabetes mellitus or chronic kidney disease (GFR < 60ml/min/1.73m2). Medication remained unchanged throughout the study period. The subjects undertook a lifestyle modification program for 3 months: they received dietetic recommendations and were stimulated to increase physical activity (monitored using pedometers). Cardiovascular risk was estimated using SCORE Risk Charts taking into account gender, age, use of tobacco, blood pressure (systolic blood pressure - SBP, diastolic blood pressure - DBP), total cholesterol (TC). At the beginning of the study and after three months (at the end) we assessed low density lipoprotein cholesterol (LDL-c), pulse pressure (PP), abdominal circumference (AC), body mass index (BMI) and the number of steps / day.
Results: After the reinforced cardiovascular risk factors treatment, we obtained the following results: SBP decreased by 8.7 mmHg (p=0,0018); DBP decreased by 3.9 mmHg (NS); PP decreased by 4.8 mmHg (p=0,0189); TC decreased by 30.8 mg/dl (p=0,0071); LDL-c decreased by 11.1 mg/dl (p=0,0081); AC decreased by 3.4 cm (p=0,0285) at men, and 3.6 cm (p=0,0275) in women; BMI decreased by 2.7(p=0,0351); SCORE risk decreased by 1.9 and the walking distance increased by1888 steps/day.
Conclusions: Changing lifestyle through more intense physical activity and controlled diet can further reduce cardiovascular risk. This method is at the fingertips of any primary care physician and brings additional benefits for the primary cardiovascular prevention.

Points for discussion:
-Preventing unhealthy lifestyle in patients with cardiovascular risk in the Primary Care.
-The effectiveness of stimulating physical activity (by fighting sedentary lifestyle) in people with cardiovascular risk in the Primary Care.

PRESENTATION 59: **Saturday 15th October, 2016** **POSTER**
14.30–15.45 h. **Finished Study**

Occurrence and associated factors of malnutrition in community-dwelling older adults

Tine De Burghgraeve, Carine van den Broeke, Laura Deckx, Frank Buntinx, Marjan van den Akker
KU Leuven, Public Health and Primary Care, 3000 Leuven, Belgium. E-mail: tine.deburghgraeve@kuleuven.be

Id 13

Background: In older adults, nutritional health is essential for good quality of life and living independently at home. Especially in cancer patients, malnutrition is common and known to complicate treatment.
Research question: This study aims to evaluate the nutritional status and its associated factors in community-dwelling older adults with and without cancer.
Method: This study was imbedded in the Klimop study, an observational cohort study which included older people with and without cancer (≥70 years). Cancer patients included patients with a new diagnosis of breast, lung, prostate, or colorectal cancer. Data collection included measures of nutritional status, quality of life, depression, fatigue, distress and functional status. We used multivariate logistic regression analysis to assess the association between personal characteristics and malnutrition.
Results: Data were available for 657 people; 383 people without cancer and 274 with a cancer diagnosis. Overall, malnutrition was detected in 245 (37.5%) people; in cancer patients this was 66.1%. Multivariate analysis showed that having cancer (OR 13.36, 95% CI: 8.40 - 21.25), being female (OR 2.38, 95% CI: 1.49-3.70), having depression (OR 12.46, 95% CI: 5.54-28.03), distress (OR 2.32, 95% CI: 1.37-3.91) and impaired instrumental activities of daily living (IADL) (OR 2.63, 95% CI: 1.64-4.21) were associated with a higher risk of malnutrition.
Conclusions: The prevalence of malnutrition in community-dwelling older people is high, particularly in patients with cancer. Benchmarking and routine screening of older patients may be helpful strategies to increase awareness of (risk of) malnutrition among professionals.

Points for discussion:

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PRESENTATION 60: Saturday 15th October, 2016 POSTER
14.30–15.45 h. Ongoing study with preliminary results

Smokers and nonsmokers diabetic patients, are they different?

Carlos Martin Cantera, Inka Miñambres, Susana Fontana, Victoria Feijoo, Elisa Puigdomenech, Lorena Soto
Institut Català de la Salut, Primary care, 8010 Barcelona, Spain. E-mail: Carlos.Martin@uab.es

Id 54

Background: Smoking patients with type 2 diabetes (T2D) is related to unfavorable effects. Information concerning the characteristics of smoking patients with T2D is scarce and may help to implement strategies for smoking cessation.
Research question: Do clinical characteristics differ among nonsmokers and smokers T2D patients?
Method: From a database that includes 1047008 individuals aged 15 years or older attended at primary care centers in Barcelona (Spain), we selected and extracted data of T2D patients from January 1 to December 31, 2014 Demographic and clinical characteristics where analyzed. Descriptive and bivariate analysis were undertaken to compare smoking and non-smoking patients.
Results: A total of 73.490 DT2 patients were included, mean age: 70.4±12,3; 53,9% men. The percentage of smokers, former smokers and non-smokers was 15.6%, 10.5% and 73.3%, respectively. When compared to DT2 nonsmokers, smokers were predominantly men (21,8% vs. 8.3% women) and younger (62.1 ± 10.9 vs.72.2 ± 11.8 years). Smokers had higher diastolic blood pressure (76.4 ± 10.2 vs 73.9 ± 9.9), higher LDL cholesterol (106.6 ± 35.0 vs 104.6 ± 36.3) and HbA1c (7.2 ± 1.4 vs 7.02 ± 1.2) and lower levels of HDL cholesterol (45.7 ± 12.8 vs 50.3 ± 19.1). Their diabetes duration was longer (6.8 ± 5.1 vs 8.4 ± 6.1 years)and presented more frequently treatment with insulin (24.9% vs 22.7%) and peripheral arterial disease (10% vs 5.6%). Ex-smokers presented more cardiovascular disease than non-smokers (46,1% vs 38.4%). Finally, smokers had a lower number of annual visits with general practitioners (7.8 ± 6.6 vs 8.9 ± 6.9) and nurses (7.6 ± 9.8 vs 8.9 ± 11.2). More anxiety diagnosis were also registered (12.1% vs 10.2%).
Conclusions: DT2 patients who smoke are mainly men, younger than non-smokers and with worse metabolic control. Anxiety and a lower frequentation of primary care centers are common.

Points for discussion:
-Which interventions among DT2 smokers will be more effective?
-Why do DT2 schedule less face to face visits with health professionals?

PRESENTATION 61: Saturday 15th October, 2016 POSTER
14.30–15.45 h. Ongoing study with preliminary results

Multimorbidity Patterns in Elderly Primary Health Care Patients: K-Means Cluster Analysis

Marina Guisado-Clavero, Tomàs López-Jiménez, Albert Roso-LLorach, Mariona Pons-Vigués, Garcia-Herrera Patricia, Concepción Violán
IDIAP Jordi Gol, IDIAP Jordi Gol, 8007 Barcelona, Spain. E-mail: cviolan@idiapjgol.org

Id 67
Background: The evidence that supports the use of specific statistical methods in the identification of multimorbidity patterns is limited to a few studies with selected samples and reduced number of conditions. Some studies published the pattern of multimorbidity but the heterogeneity of their methodology becomes a challenge to generalize their results.
Research question: Which is the prevalence of chronic diseases in old population from Barcelona during 2009? Which multimorbidity pattern have patients over 65 years in Barcelona during that period?
Method: Design and Setting: Cross-sectional study using electronic health records for 206.146 patients. Participants: Individuals older than 65 years attended within 50 primary health care teams of Barcelona in 2009. Outcome: Multimorbidity (≥ 2 chronic diseases, considering O'Halloran criteria). Other variables: number of diseases per patient, sex, age group (65-79, 80+). Descriptive analysis, categorical variables were expressed as frequencies (percentage) and continuous variables as mean (Standard deviation, SD) or median (interquartile range). The predominant multimorbidity patterns were identified using Multiple Correspondence Analysis and k-means clustering analysis, stratified by age and sex.
Results: 206,146 patients were included in the analysis (mean age, 75.1 years [SD: 6.9], 59.6% women; mean of 5.3 chronic diagnoses [SD: 3.4]) from those 181,565 had multimorbidity. We have found 6 clusters per each group. For men and women, the first cluster included hypertension and lipid disorders for all age groups except man over 80. The second cluster in man contains cardiovascular diseases, metabolic disorders, urinary complications and musculoskeletal diseases. Whereas woman have cardiovascular diseases, metabolic and psychiatric diseases. The last cluster in all groups, included patients with a diagnosis of malignant neoplasm.
Conclusions: Hypertension and lipid disorders were present in almost all patterns of multimorbidity. The K Means method was useful to identify those subgroups of patients with specific patterns.

Points for discussion:
-Is useful to know subgroup of multimorbidity pattern in order to improve the patient's attention
-Which is the better way to identify multimorbidity patterns? Taking diseases as the starting point or the individual person?

PRESENTATION 62: Saturday 15th October, 2016 POSTER
14.30–15.45 h. Finished Study

Utilization of oral rehydration solution in primary care for in acute gastro enteritis of young children

Sabine Bayen- Krohn, Nicolas Devulder, Marc Bayen, Nassir Messaadi
general practice, University Lille 2, 59045 Lille, France. E-mail: kroehnchen@hotmail.fr

Id 10

Background: Acute gastro enteritis of young children is a frequent pathology in primary care which could be serious or letal. Oral rehydratation solution is the indicated treatement and often prescribed. This study concerns parents representations of oral rehydratation solution and also their representations of acute gastro enteritis and its medical and nutritional treatement.
Research question: What are parents representations of oral rehydration solution? What are their hesitations to use it.
Method: Qualitative study by individual semi-structured interviews up to theoretical saturation. Interviewed parents had children younger than 5 years, who received prescription oral rehydratation solution for acute gastro enteritis. Verbatims have been analized by nvivo® software after datas triangulation.
Results: Parents knew symptomes of acute gastro enteritis and its risk of deshydratation but they ignored its evolution. Concerning rehydratation, many errors have been identified as frequent utilization of Coca-Cola® or pure water. Milk products have been stopped frequently. Orale rehydratation solutions were known, usually correctly prepared but not correctly delivered by parents. According to them its taste did not incite children to drink. Parents were further looking for a retarder effect on diturbed transit.
Conclusions: Parents need more global information concerning acute gastro enteritis in order to increase their acceptation of oral rehydratation solution as principal treatement. Concerning nutritional treatement, the medical message has to be unanimous to increase prescription quality of oral rehydratation solution to optimize its utilization.

Points for discussion:
-Would it be interesting to deliver sytematically information prospectus to young parents during first consultation with the new-born?
-Would parents more accede tosolutions when theese were already prepared, parfumed and contained probiotics?

PRESENTATION 63: Saturday 15th October, 2016 POSTER
14.30–15.45 h. Finished Study

Volunteering in Serbia: Medical and Psychosocial Relief operation for the Middle-East refugees crossing Europe

Sarah Sigalat, May Kyttany, Khaled Karkabi
Family Medicine, Rappaport Faculty of Medicine, Technion, Haifa,, Clalit Health Services, Haifa and Western Galilee District, Israel, 32970 Haifa, Israel. E-mail: ssigalat@gmail.com

Id 32

Background: Thousands of refugees from Syria, Iraq and Afghanistan were arriving daily at the transit camp of Presevo, Serbia. They did their journey by boats from Turkey to Greece, then by trains to Macedonian border, walking 6 kms to Presevo, and onwards to Croatia.
Research question: To evaluate medical assistance to refugees from the Middle East during the volunteering period.
Method: NATAN, which is an International Humanitarian Aid, has been sending teams including physicians, nurses, social workers and logisticians, for 2-4 weeks. The clinic, which was an equipped container, operating on a 24/7 basis, was established in Presevo Camp. The work included: registration of the refugees' name, age, gender, country of origin, diagnosis and treatment. Tests performed included: blood pressure, temperature, glucose and urine tests.
Results: For a period of 6 months, began on November 9, 2015 and ended on April 27, 2016, 46 Israeli volunteers, Jews and Arabs, offered their skills and time in a very challenging situation. More than 50% professionals were Arabic speaking and understanding the refugees' culture. 3600 refugees,40% children, received direct primary care by 12 doctors. During my 10 volunteering days, 385 refugees were treated by my colleagues and me. Most complains were: URI, Pneumonia, hypothermia, back and legs pain, headache and insomnia. We treated infected and shooting wounds, frost bites, bandaging, injections, intravenous fluid and antibiotics therapy.
Conclusions: Bio-psycho-social care gave immediate support to people in need. The refugees were relieved to receive health care delivered by professionals speaking their language. It was rewarding to observe Israeli, Jewish and Arab doctors, working side by side in caring of refugees from Arab countries. Medical volunteering is a great challenge and unique experience for family doctors, working together with other organizations. We felt that we were in the middle of a historical nations' movement to Europe.

Points for discussion:
-How family doctors can contribute to disaster medicine?
-How can the volunteering period integrate in our daily health care working?
-Is there any family doctors' organization which is dealing with volunteering in the world?

PRESENTATION 64: Saturday 15th October, 2016 POSTER
14.30–15.45 h. Finished Study

Research agenda for French General Practice

G. Piton, David Darmon, Olivier Saint Lary, Matthieu Schuers, Michele Odorico, Etiënne Melot, Jérémy Derriennic, Sophie Lalande, Delphine Le Goff, Bernard Le Floch, Jean Yves Le Reste
Department of General Practice, Université de Bretagne Occidentale, 29200 Brest, France. E-mail: lereste@univ-brest.fr

Id 52

Background: General practice (GP) is the port of call for French patients. Its recognition as a medical specialty is recent and organizes its research is nowadays mandatory. The European general practitioner research network (EGPRN) published a research agenda for European GP in 2008 using a systematic literature review. This research agenda could be used as the basis of a consensus in France.
Research question: What research agenda could be issued for General Practice In France?
Method: Rand Ucla consensus survey using two Delphi rounds in February and June 2016 with an expert panel meeting in April 2016. Experts had to be French researchers in general practice.
Results: 71 approached experts, 38 included in the first Delphi round, 14 in the panel meeting and 11 in the second Delphi rounds. Reasons for non-participation were other scheduled obligations, illnesses or family difficulties. None of the 71 experts assessed that the research was useless. Finally 23 priority themes were selected for France on the 38 original ones from the EGPRN research agenda. These themes are described according to the WONCA core competencies of GP. Specific complex problem solving skills sets 9 themes, primary care management , patient centeredness, global approach, holistic approach set 3 themes each, community orientation sets 2 themes.
Conclusions: A research agenda issued from the EGPRN is now available for France. Priorities are designed. GP specific complex problem solving skills core competency receives the bigger number of research themes.

Points for discussion:

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PRESENTATION 65: **Saturday 15th October, 2016** **POSTER**
14.30–15.45 h. **Finished Study**

Chronic stress in general practitioners and practice assistants

AnikaThielmann, Anja Viehmann, Birgitta Weltermann
University Hospital Essen, University Duisburg-Essen, Institute for General Medicine, 45131 Essen, Germany. E-mail: Anika.Thielmann@uk-essen.de

Id 91

Background: Although many general practitioners (GPs) as well as practice assistants (PAs) complain about stress, no studies addressed chronic stress in both professional groups simultaneously.
Research question: This study analyzes the distribution of chronic stress in GP practice teams.
Method: This cross-sectional study in 181 general practices measured chronic stress (strain due to stress for ≥3 months) with the validated psychometric 12-item screening-scale TICS-SSCS. Using the sum score (0-46) and the respective medians as cut-offs (PAs > 23, female GPs >23, male GPs >19), each participant was categorized into low or high chronic stress. The proportions of participants with high stress were determined for the total population and separately for both professional groups. The intra-cluster correlation (ICC) was calculated for the TICS-SSC sum score.
Results: Data of 216 GPs (33.6% females) and 549 PAs (99.1% females) of 136 practices were analyzed. The practice assistant/physician ratio was 2.8 (SD 1.3) in single practices (54 of 136; 39.7%) and 2.4 (SD 1.5) in group practices (82 of 136; 60.3%). 32.1% of single practices GPs and 40.4% of the GPs from group practices had high chronic stress. 42.6% of the PAs from single practices and 52.5% from group practices had high chronic stress. In single GP practices with a highly stressed physician, 52.9% of the PAs had high stress. In group practices with ≥1 highly stressed physician, 67.7% of the PAs had high stress. On practice level, 23.4% of the practice members had high stress. We observed an ICC of 0.39 for all PAs and of 0.51 for GPs in group practices.
Conclusions: Chronic stress in GPs and PAs was more prevalent in group than single practices.

Points for discussion:

PRESENTATION 66: Friday 14th October, 2016 POSTER
12.30–13.30 h. Ongoing study with preliminary results

The "real life data" registry BeoNet - Leadoff results of the first use case: COPD

Heidrun Lingner, Anna Nickel, K. Krüger, I. Aumann, M. Wacker, J.M. von der Schulenburg e.a.
Hannover Medical School, Centre for Public Health and Healthcare, 30625, Hannover, Germany.
E-mail: krueger.kathrin@mh-hannover.de

Id 59

Background: Healthcare research needs real-life-data, but they are scarce. The BeoNet-Registry ("Beobachtungspraxen-Netz-Register") compiles the complete information from electronic patient records (eR) of primary care practices (GPs/pneumologists) and links them with patient-reported outcomes. First use case: assessment and analysis of information about patients with chronic obstructive pulmonary disease (COPD).
Research question: Are there any differences in demographics or absences from work between patients with (COPD+) and without COPD (COPD-) or between the target-populations from the different sites or the literature reports? What impediments occur when working with data from eR?
Method: Systems for real time pseudonymous routine data provision from GPs and pneumologists from Hanover, Munich and Heidelberg were set up and tested. eR data, including diagnoses, treatments, procedures and medication were transferred via a standardized secure interface and compiled for analysis. The results of paper based health related quality of life questionnaires were linked to eR information. First descriptive analyses assessed the incidence, age, sex and comorbidities of COPD+ and COPD- and their respective absences from work. Literature searches provided relevant publicly available data.
Results: Currently the weekly updated database (DB) contains 98409 patient-IDs (female: 54%). The BeoNet-incidence of COPD is 4,5% (4455 IDs´). Our results demonstrate that COPD patients in primary care are older (COPD+: 69,12%; COPD-: 52,4%) and more often males (49,56%) compared to patients without COPD (45,7%), are absent from work more frequently and most of them have more comorbidities as COPD-. Half of COPD+ have 3 comorbidities (median) (COPD-: 2); on average 5 additional illnesses (resp 4). More detailed results and the challenges encountered while working with real-life data will be presented at the conference.
Conclusions: The demographics fit well with the literature, supporting the reliability of the registry-data. Further research will analyse the additional information on quality of life of COPD+ and subgroupspecific comorbidities correlations.

Points for discussion:
-Possibilities and invitation to actively participate in the BeoNet-Registry, in data pooling and contrasting analyses.
-Experiences of working with real-life data, especially concerning strategies to ensure data quality.

PRESENTATION 67: **Saturday 15th October, 2016** **THEME PAPER**
16.15–16.45 h. **Finished Study**

Joint Action Health WorkForce - Belgian Pilot Project: Horizon Scanning in General Practice

Lieve Peremans, Jessica Fraeyman, Jean Macq, Maguelone Vignes, Roy Remmen
University of Antwerp, Primary and Interdisciplinary Care, 2610 Antwerpen, Belgium. E-mail: lieve.peremans@uantwerpen.be

Id 88
Background: Current health workforce planning is more than a demographic exercise on replacing retiring GPs but needs to assess the impact from other factors within a changing society. Belgium uses a mathematical model for the calculation of the health workforce planning.
Research question: How can qualitative research methods be used for the development of new parameters for this model.
Method: This study is part of the EU-project 'Joint Action on Health Workforce Planning and Forecasting'. We interviewed a purposive sample of 16 critical cases, from target organisations identified by the Federal Public Service Health. The interview guide was based on an international framework used for Horizon Scanning. For the Delphi we selected two factors: the evolution in GPs demand and future activity rate The Delphi was completed by 27 experts in the second round.
Results: There are concerns about the current role of GPs mostly working in single-handed practices. Those GPs are unable to deliver integrated care needed for people with co-morbid conditions. In the Delphi experts have different opinions on the needs in both parts of the country but overall, the median change for the group above 80 years is expected up to 25%. There is an oversupply of candidate physicians, but all the experts pointed out the imminent retirement GPs. Indeed, 74.16 % of active Belgian GPs were more than 45 years old in 2012. New GPs are predominantly female, with a strong reduction in activity rate. Task delegation and the introduction of new professions as nurse practitioners might give a solution but a change in legal framework is needed.
Conclusions: The qualitative research raises new ideas, but not always easy to translate in a mathematical model. Experts and policymakers must develop a vision on the health care organisation before a more elaborated model can be used.

Points for discussion:
-How is manpower planning performed in other countries?
-What is the value of using a mathematical model in manpower planning?

PRESENTATION 68: Saturday 15th October, 2016 THEME PAPER
16.45–17.15 h. Almost Finished Study

A decision Aid to use within pre-screening-counseling about the PSA-test: Practical support or time consuming impeder?

Kathrin Schloessler, Charles Christian Adarkwah, Alexandra Simbrich, Matthias Borowski, Norbert Donner-Banzhoff, Axel Semjonow, Hans Werner Hense, Peter Maisel, Katrin Kuss
Philipps University Marburg, Family Medicine, 35043 Marburg, Germany. E-mail: schloesk@staff.uni-marburg.de

Id 7

Background:
The value of PSA-screening for prostate cancer is a matter of current debate. Patients have to individually weight benefits and harms. However, this is not a simple task neither for patients nor their consultant physician as some studies found a lack of shared decision-making (SDM) and evidence-based information in pre-screening discussions.
Research question:
Is a transactional Decision Aid (DA) on PSA-Screening a useful and viable innovation to support physicians in pre-screening counseling?
Method:
According to the International Patient Decision Aid Standards we developed a first draft of a DA based on best available evidence. This version was field tested in two qualitative studies with GPs and Urologists, respectively. Both groups counseled men aged 55-69 (n=32). All participants were semi-structured interviewed; interviews were transcribed verbatim and analyzed qualitatively combining deductive categories with emerging themes.
A pilot-study assessed study procedures and implementation. Here GPs were randomized to either apply or not apply the DA ("as usual"). Participating men received questionnaires regarding their current decision; decision quality and –process (SDM). The GPs were interviewed about their experiences in daily practice.
Results:
The qualitative study revealed feedback which led to substantial changes in the DA.-Overall the DA was seen as a helpful tool for pre-screening discussions.-While physicians had concerns about time required, their reported counseling time had a wide range. Interestingly, some physicians changed their own attitude about PSA-screening and learned new information through the use of the DA. In our pilot study aspects of SDM were found in both, intervention and control group. However our analysis remains descriptive due to a small sample size (n=178).
Conclusions:
The use of a DA on PSA-screening during consultation was feasible and might contribute to neutral counseling based on best available evidence.

Points for discussion:
-Are transactional Decision Aids (=used withing pre-screening discussions) *Feasabel? *Neutral?
-What is their contribution to Shared Decision Making?