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European General Practice Research Network

Riga-Latvia

11th -14th May, 2017

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SCIENTIFIC and SOCIAL PROGRAMME

THEME: "Reducing the Risk of Chronic Diseases in General Practice/Family Medicine"

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

<u>CONFERENCE VENUE</u>

Riga Stradins University
Dzirciema Street 16
Riga LV1007 - Latvia
Website - http://www.rsu.lv/eng/

COLOPHON

European General Practice Research Network - EGPRN

EGPRN ABSTRACTBOOK

11-14 May 2017

ISBN: **978-3-8440-5328-9**

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

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"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 Riga.

"Reducing the Risk of Chronic Diseases in General practice / Family medicine".

Dear doctors, researchers, and colleagues,

The main cause of death in Latvia just like a whole Europe are chronic diseases.

In Latvia cardiovascular diseases and diabetes alongside with chronic obstructive pulmonary disease and cancer are among the four main chronic diseases (NCD) altogether responsible for 82% of NCD deaths. CVD and diabetes are responsible for 50.2% of NCDs deaths.

Premature death is a major consideration when evaluating the impact of NCDs on a given population and is used as an indicator in the global monitoring framework. Approximately 42% of all NCD deaths occurred before the age of 70 years in 2012. Cardiovascular diseases (37%) and diabetes (4%) were responsible for 41% of NCD deaths under the age of 70 years followed by cancers (27%), other causes (23%) and chronic respiratory diseases (8%). Probability of dying from the four main NCDs between the ages of 30 and 70 years in Latvia in 2000 and 2012 (25,3% and 24.1%) still exceeds the global average (23% and 19%) being the highest rate among European Union countries and the third highest rate among high-income countries after Trinidad and Tobago and Russian Federation. According to WHO data (2012) age-standardized mortality rate (per 100 000 population) from cardiovascular diseases is still the highest in Latvia (males – 512.4; females – 266.5; both sexes – 361.1) compared with, for example, Estonia (387.4; 199.5; 272.1), Lithuania (448.2; 241.6; 322.5), Sweden (162.8; 105.7; 132.0), Finland (197.3; 104.1; 145.9), despite the slight decrease since 2000.

Abstracts:

●**Screening programm**

In Latvia cancer screening programme for breast cancer, cervix cancer and colorectal cancer has been started in 2009. However, the percentage of completed examinations is low for all three cancer types with not exceeding 35 % for breast cancer, 28 % for cervix cancer and 25 % for colorectal cancer.

Number of new registered cancer cases has increased both in absolute numbers (from 8834 cases in 2000 to 11123 cases in 2015) and per 100,000 inhabitants (from 373 in 2000 to 562 in 2015). There is a slight improvement regarding the stage of CA at diagnosis. In 2000 only 17% of CA were found at stage 1, while in 26 % the diagnosis was at the late stage 4. In 2015 the percentage of diagnosis at stage 1 and 4 were 28 % and 20 respectively. However, first year letality in general has decreased only by 7%, from 39 in 2000 to 32 in 2015.

●**Prevention of non-communicable diseases**

●**Life style behavioural changes**

It is still very low level of awareness about the importance of a healthy lifestyle among Latvian population.

Physical activity is an important part of a healthy lifestyle. Latvian adult population have insufficient physical activity. Only 17.2% of men and 12.9% of women outside work hours engage in exercise sufficiently strenuous to cause mild breathlessness or sweating at least 30 minutes and at least 4-6 times a week. Physical activity decreases by age.

The proportion of respondents reporting going to and from work on foot or by bicycle, which takes more than 30 minutes daily, is 19.5% for males and 23.8% for females. Sedentary behaviour among Latvian adult population is prevalent. A total of 49.1% of men and 49.6% of women spend their free time reading or watching TV. 40.7% of the adults (age 18 – 64 years) consider their physical condition as average. The percentage of women who rate their physical condition as rather poor or very poor is,respectively, 11.4% and 1.6% but that of men – 6.2% and 0.6%.Taking into account the insufficiency of general physical activity in the population,the attitude of health professionals is surprising. A very low percentage of respondents have reported that health professionals have suggested to them to increase their physical activity. This reflects the low value given to physical activity by health personnel in the maintenance of health of their patients.

●**Personel resources**

Burnout syndrome widespread not only in Latvian among health professionals, but throughout Europe.

Number of Family doctors and general practitioners in Latvia per 10 000 inhabitants is lowest among the Baltic states (6,8), as well as nurses. despite the heavy workload with 20-60 patient visits per day , family doctors' and nursing personnel outpatient visits per person are also lowest in the Baltic States. Precise data on purposes of visits are not available, because statistics allow to register only one purpose per visit.

Dr.Gunta Ticmane,
EGPRN National Representive Latvia

E G P R N   11th-14th MAY, 2017

PROGRAMME OF THE EUROPEAN GENERAL PRACTICE RESEARCH NETWORK IN RIGA-LATVIA

THURSDAY 11th MAY, 2017

Location: **Riga Stradins University**
                       Dzirciema Street 16 - Riga LV1007 - Latvia

09.00 - 17.00 :   **COGITA 2017 -meeting**
                       in: Hall of Senat, K building, 2 floor, auditory K-212

09.30 - 12.30 :   **Business meeting**
                       Welcome and Coffee for Executive Board EGPRN.
                       EGPRN Executive Board Meeting (only for members of the Executive Board of EGPRN).
                       in: C building, 1 st floor auditory 1C

10.00 - 12.30 :   2 parallel EGPRN Pre-Conference Morning Workshops;
                       €35 (non-members €65) p.p.:
                       1.   Pre-conference Workshop *"Writing for Publication – Meet the Editors for Tips and Tricks!"*.
                       Chairs: Hans Thulesius (Sweden) and Jelle Stoffers (The Netherlands)
                       in: Aulas rehearsal hall; 16, K building, 1st floor

                       2.   Pre-conference Workshop *"How to Start Building GP Research in a low capacity country. A Manual/Cookbook"*.
                       Chairs: Lieve Peremans and Hilde Bastiaens (Belgium)
                       in: K building, 2nd floor, Auditory K-204, (30)

13.00 - 14.00 :   **Lunch for participants of pre-conf.ws. (price not included in fee conference workshops)!**
                       in: Cafetaria, 1st floor

14.00 - 16.30 :   2 parallel EGPRN Pre-Conference Afternoon Workshops;
€35 (non-members €65) p.p.:

3.   Pre-conference Workshop *"Everyday Practice and Evidence Based Medicine".*
Chair: Vytautas Kasiulevicius (Lithuania)
in: auditory 202, B building, 2nd floor.

4.   Pre-conference Workshop *"How to Make a Good Abstract"*
Chairs: Ruth Kalda and Anneli Rätsep (Estonia)
in: C building, 1 st floor auditory 1A

14.00 – 18.00 :   **EGPRN Study Group**
EGPRN Collaborative Study 'FPDM' and 'TATA'
chair: Jean Yves Le Reste
in: B building, 2 nd floor auditory 203
((10 persons including data projection devices and coffee/tea/water and cakes))

14.00 – 16.45 :   **Business meeting**
Council Meeting with the National Representatives (only for EGPRN-Council).
in: Aulas rehearsal hall

16.45 – 17.30:   **Business meeting**
Committee Meetings and Working Groups
in:
  - auditory1A – C building,
  - auditory 202, B building, 2 nd floor,
  - Aulas rehearsal hall; K building, 1st floor

18.00 - 19.00:   **EGPRN Study Group**
EGPRN Collaborative Study 'PROCOPD'
chair: Ana Clavería
in: B building, 2 nd floor auditory 203
((including data projection devices))

18.00 - 19.00:   **EGPRN Study Group**
'PIPE'
chair: Péter Torzsa
in: K-204 (K building, 2nd floor, for 30 persons)

19.30 - :   **WELCOME RECEPTION**
                   Welcome Reception and Opening Cocktail for all participants of this
                   meeting who are present in RIGA-Latvia at this time.

Location: Riga Stradins University
Room: "Canteen"
Dzirciema 16, 1 st floor
Riga-Latvia

EGPRN participants will be especially welcomed to Riga by:

→ **Dr. Liga Kozlovska**, General practitioner, Riga Stradins University; President of Rural Family Doctors association of Latvia.

→ **Professor Tatjana Koķe,** Vice-Rector for Education, Riga Stradins University

FRIDAY 12th MAY, 2017:

Location: **Riga Stradins University**
                   Dzirciema Street 16
                   Riga LV1007 - Latvia

08.00 - 08.30 :   Registration at EGPRN Registration Desk.

08.30 - 11.00 :   **Plenary Session incl. K E Y N O T E**
                   in: Auditory No 1 - C Block, 1 st floor
                   Chair: Mehmet Ungan / Gunta Ticmane

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. Ruth Kalda*; (Department of Family
                   Medicine, University of Tartu-Estonia).
                   Theme: *"Reducing the risk of chronic diseases in General Practice / Family
                   medicine".*

09.30 – 11.00 :   **3 Theme Papers (plenary)**
                   in: Auditory No 1 - C Block, 1 st floor
                   Chair: Davorina Petek

1. *id23* **Sophie Lalande (France)**
   Frequency of family physician visits and extent of family difficulties are decompensation
   factors for multimorbid outpatients.

2. *id42* **Sven Streit (Switzerland)**
   Variation in physicians' decisions on antihypertensive treatment in oldest-old and frail
   individuals across 29 countries.

3. *id87* **Michael Harris (United Kingdom)**
   How do health system factors affect primary care practitioners' referral decisions in patients
   that could have cancer? Results from the Örenäs Research Group study.

11.00 – 11.30:   **Coffee break**
                    in: Cafetaria, 1st floor

11.00 – 11.30:   **BLUE DOT Coffee break**
                    in: Cafetaria, 1st floor-B section

11.30 - 13.00 :   **Parallel session A – 3 Theme Papers**
           in: Auditory No 1 - C Block, 1 st floor
           Chair: Lieve Peremans

4. *id85* **Michele Odorico (France)**
Search for decompensation risk factors within the egprn multimorbidity's definition themes.
Cohort study followed up at 12 months in nursing home (nh).

5. *id83* **Delphine Le Goff (France)**
Search for decompensation risk factors within the EGPRN Multimorbidity's Definition
themes. Cohort pilot study, follow up at 12 months in primary care outpatients.

6. *id107* **Marilena Anastasaki (Greece)**
Preventing chronic respiratory diseases by implementing awareness-raising interventions to
reduce smoking and household air pollution in rural Crete, Greece.

11.30 - 13.00 :   **Parallel session B – 3 Freestanding Papers**
           in: RSU Hippocrates lecture theatre, C Block, 1 st floor
           Chair: Peter Torzsa

7. *id36* **Mihai Iacob (Romania)**
Ultrasonographical diagnosis of subclinical atherosclerosis and assessment of vulnerability at
atheromatous plaques with the Strain Elastography in primary care.

8. *id27* **Remus Georgescu (Romania)**
Results of the European Survey regarding the Point of Care Ultrasonography applications in
the GPs practice, and an experimental Emergency Ultrasound Screening related to their
applicability in primary care.

9. *id9* **Sharon Kleitman (Israel)**
Stress management workshop - in office skills with MST tools.

13.00 - 14.00 :   **Lunch**
           in: Cafetaria, 1st floor

13.00 - 14.00 :   **The Educational Committee Lunch workshop – "Big Data"** 60 minutes
           with *Dr. Miguel Angel Muñoz Pérez,* (Responsable de la Unitat de Suport a la Recerca
           Àmbit d'Atenció Primària Barcelona Ciutat Institut Català de la Salut. IDIAP-Jordi Gol. Barcelona-
           Spain),
           Workshop leader Miguel Angel Muñoz Pérez: The computerisation of the primary care patient
           records of the Catalan Health Institute was completed in 2005 and was developed the SIDIA
           database. SIDIAP was designed to provide a valid and reliable database of selected
           information from clinical records of patients registered in primary care centres for use in
           biomedical research. SIDIAP contains anonymized data of patients for more than five million
           people registered in 287 primary healthcare practices throughout Catalonia.

SIDIAP includes data collected by health professionals during routine visits in primary care, including anthropometric measurements, diagnoses (International Classification of Diseases 10th revision [ICD-10]), laboratory tests, treatments, hospital referrals, demographic and lifestyle information.. The high quality of these data has been previously documented, and SIDIAP has been successfully applied to epidemiological studies.

There is no charge for this workshop. Participants can eat their lunch during the workshop. Please bring your lunchbox.

in: Aulas rehearsal hall; K building, 1st floor

13.00 - 14.00 :　　**EGPRN Study Group**
"Googling in the waiting room"
(chair: Joseph Azuri)
in: RSU Hippocrates lecture theatre, C Block, 1st floor

14.00 - 16.00 :　　**Parallel session C – 4 Theme Papers**
in: Auditory No 1 - C Block, 1 st floor
Chair: Sven Streit

10. *id122* **Yochai Schonmann (United Kingdom)**
Statins for (almost) everyone? Validation of the 2016 US Preventive Services Taskforce (USPSTF) Recommendations for primary cardiovascular prevention.

11. *id37* **Liina Pilv (Estonia)**
Assessment and Comparison of Obstacles in Everyday Life of Patients with Type 2 Diabetes in Six European Countries.

12. *id15* **Shlomo Vinker (Israel)**
The obesity paradox among type 2 diabetes patients: Does being overweight necessarily confer a worse prognosis?

14.00 - 16.00 :　　**Parallel session D – 4 Freestanding Papers**
in: RSU Hippocrates lecture theatre, C Block, 1 st floor
Chair: Ana Luisa Neves

13. *id35* **Hava Tabenkin (Israel)**
Assessing Preceptor Performance in Family Medicine Using the One-Minute Preceptor Model.

14. *id18* **Ljiljana Majnaric (Croatia)**
A research method to use data from electronic health records not specifically prepared for research.

15. *id38* **Johannes Hauswaldt (Germany)**
De-identifying GP routine data for secondary health services research.

16. *id10* **Stefan Bösner (Germany)**
Medical decision making strategies in general practice vs. the emergency department - a comparative analysis.

16.00 - 16.20:   **Coffee break**
in: Cafetaria, 1st floor

16.20 -16.50 :   **Parallel session E - 1 Theme Paper**
in: Auditory No 1 - C Block, 1 st floor
Chair: Claire Collins

17. *id51* **Korbinian Saggau (Germany)**
Clinical governance as professional self-reflection- How can we know how good we are?

16.20 -17.20 :   **Parallel session F – 2 Freestanding Papers**
in: RSU Hippocrates lecture theatre, C Block, 1 st floor
Chair: Miguel Munoz

18. *id55* **David Spitaels (Belgium)**
Exploring knee osteoarthritis management in primary care: what about arthroscopy? A case-notes review.

19. *id108* **Tugrul Biyiklioglu, Pavlo Kolesnyk, Enkeleint-Aggelos Mechil (EGPRN Fellows-project)**
What are the challenges that family practitioners face in the management of chronic diseases? A European research protocol from the EGPRN Fellows .

17.20 – 17.30 :   **Closing of the day by *Prof. Ruth Kalda*,** keynote speaker, who will summarize on today's theme papers; EPILOGUE.
in: Auditory No 1 - C Block, 1 st floor

17.30 - 17.35 :   **Closure of the day by chair of session.**

17.45 - 18.45:   <u>**EGPRN Collaborative Study Group**</u>
"CoCo study"
(chair: Robert Hoffman)
in: RSU Hippocrates lecture theatre; C Block, 1 st floor

POSTER PRESENTATION WITHIN THE WORKSHOP
id102 **Anika Thielmann, Ferdinando Petrazzuoli, Clara Guede, Juliette Chambe, Heidrun Lingner, Lea Charton, Robert D. Hoffman, Krzysztof**

Buczkowski, Slawomir Czachowski, Tamer Edirne, Kathryn Hoffmann, Tuomas Koskela – on behalf of CoCo Study Group
European Study on Self-care for Common Colds: Comparison of tea use in 12 European nations (COCO study)

European Study on Self-care for Common Colds: Comparison of Tea Use in 12 European Nations (COCO study)

for the European General Practice Research Network Working Group on Self-Care*

Background

■ Self-care for common colds is frequent, yet little is known about the use of tea for this purpose.

Research question: Which participants and regional characteristics are associated with tea use for self-care?

Methods

Study design: Cross-sectional study at 27 sites in 12 European countries.
Sampling: 120 consecutive patients (age 18+) were asked to fill a questionnaire which offered 105 self-care practices and free-text options.

Analysis:

▪ Classification of sites based on European Union's "Regions Nomenclature of Statistical Territorial Units" (NUTS) level 3: a) predominantly urban, b) intermediate or c) predominantly rural
▪ Bivariate analyses were used to identify associations between drinking more teas than 50% of the participants and sioco-demographic characteristics.

Results

Response: 2,724 patients
Participants' characteristics:
Women (62.5%), mean age: 46.7 years.
Regional characteristics:
Urban (50%), intermediate (41%) and rural areas (9%)
Use of tea:
At least two teas (48%) (mean: 1.9 ± 1.88), one tea (25%), no tea (27%)
Use of tea types:
Herbal (63%), fruit (30%), and black/green tea (11%)
Frequently used teas:
Lemon with honey (18%), chamomile (18%), peppermint/mint (17%), mixed herbal teas (17%), sage (16%)

	Less tea than 50% of the participants: <2 teas	More tea than 50% of the participants: ≥2 teas	p-value
Female	55.4%	69.9%	p<0.001
Age (in years)	47.8	45.6	p=0.001
No use of self-grown plants	93.6%	79.7%	p<0.001
Region **Urban** **Intermediate** **Rural**	48.8% 58.5% 35.1%	51.2% 41.5% 64.9%	p<0.001
≥1 chronic condition	40.3%	39.5%	p=0.669
Education (cutoffs: country-specific medians)	42.2%	44.4%	p=0.258

Table 1: Bivariate analyses for using more types of tea than 50% the participants

Definitely not!

Is grandma the only one?

	Urban (n=1357) % (n)	Intermediate (n=1128) % (n)	Rural (n=239) % (n)
Fruit tea	33.9 (460)	24.5 (276)	33.9 (81)
Herbal tea	67.5 (916)	53.5 (604)	84.1 (201)
Black/Green tea	10.3 (140)	11.9 (134)	10.5 (25)

Table 2: Types of tea by region

Conclusion

More than 70% of European patients are using tea when having a common cold. In accordance to the general tendency, female gender and younger age are associated with higher tea use.

* B Weltermann, A Thielmann, F Petrazzuoli, C Guede, J Chambe, H Lingner, R Hoffman, K Buczkowski, S Czachowski, T Edirne, K Hoffmann, T Koskela, V Mevsim, S Tekiner, A Zielinski, M Petek-Ster, E Pirrotta, A Uludağ, H Yikilkan, S Kreitmayer Peštiæ, L Charton and B Gerasimovska Kitanovska

18.00 - 19.30 :   <u>Study Group</u>
Örenäs Research Group
"Early Diagnosis of Cancer in Primary Care Study"
(chair: Michael Harris)
in: Aulas rehearsal hall; K Block, 1st floor

<u>**Social Programme :**</u>
18.10 – 19.40 :   Practice Visits to 4 various local Health Centres in Riga.
We will leave from the conference venue to different practices.
Registration for practice visit will be in the registration area.

SATURDAY 13th MAY, 20176:

Location: **Riga Stradins University**
Dzirciema Street 16
Riga LV1007 – Latvia

08.30 – 09.10 :   **Plenary Session incl. K E Y N O T E**
in: Auditory No 3 - C building, 1 st floor
Chair: Shlomo Vinker

08.30 - 09.10 :   **National Keynote Speaker: *Dr. Vija Silina*; (Dept. of Family Medicine, Stradins University, Riga** - Latvia).
Theme: "State of the Art of Family Medicine/General Practice in Latvia".

09.10 - 10.40 :   **Parallel session G - 3 Theme Papers**
in: Auditory No 3 - C Block, 1 st floor
chair: Hans Thulesius

20. *id43* **Leonard Mada (Romania)**
Hypertensive Crisis: Analysis of 16384 Cases Documented in GP practices across Romania.

21. *id11* **Michal Shani (Israel)**
Heart failure clinic within a primary care clinic in Beit Shemesh.

22. *id74* **Baumann-Coblentz Laurence (France)**
Identification of the obstacles to achievements of pro re nata medication (PRN) in palliative home cares by Doctors of the palliative care networks.

09.10 - 10.40 :   **Parallel session H - 3 Papers – EGPRN Special Methodology Session**
in: Aulas rehearsal hall; K Block, 1st floor
Chair: Jean Karl Soler

23. *id65* **Michael Van der Elst (Belgium)**
How can contextual factors be operationalized in a RCT for people with chronic problems?

24. *id100* **Pavlina Nikolova (Bulgaria)**
Monofilament testing for detection of lost sensation of feet in diabetic neuropathy and its correlation to foot ulcerations

25. *id119* **Elina Millere (Latvia)**
Patient enablement in GP practice in Latvia

10.40 - 11.10 :   **Coffee break**
             in: Cafetaria, 1st floor

11.10 -13.10 :   **Parallel session I – 4 Freestanding Papers**
             in: Auditory No 3 - C Block, 1 st floor
             Chair: Ayse Caylan

26. *id16* **Marie Barais (France)**
    How acceptable is the Gut Feelings Questionnaire in daily GP practice: a feasibility study in four European countries.

27. *id 25* **Erik Stolper (Netherlands)**
    Gut feelings of patients: do they influence their general practitioner' diagnostic reasoning?

28. *id118* **Peter Torsza (Hungaria)**
    Hungarian family physicians' and residents' knowledge of and attitude towards OSAS (obstructive sleep apnoea syndrome).. Do they screen sleep apnoea during the general medical checkup for the driving licence?

29. *id34* **Katharina Schmalstieg (Germany)**
    Common practice: out-of-pocket prescriptions for benzodiazepine and Z-drugs. But why?

11.10 - 13.10:   **Parallel session J - 9 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: Audotory No 3, C Block, 1 st floor
             face to face in: Senat Hall, K Block , 2 floor, auditory K-212
             Chair: Ferdinando Petrazzuoli

30. *id32* **Maxime Pautrat (France)**
    PAPRICA study (Problematic use and Addiction in Primary Care) - Evaluation of poly-dependency screening test in primary care setting - a systematic review.

31. *id97* **Bernardino Oliva (Spain)**
    Prevalence, diagnostic value and factors related with gut feelings of GPs in the diagnosis of severe disease and cancer: protocol of study.

32. *id44* **Alexandra Verzhbitsky (Israel)**
    The effect of the breast cancer on control of diabetes.

33. *id50* **Segolene de Rouffignac (Belgium)**
    Measuring the patient activation in HIV-infected patients: A tool to predict health outcomes and optimize care. A study protocol.

34. *id48* **Naomi Aerts (Belgium)**
Integration of nurses in general practice: a qualitative, exploratory study from the perspective of patients with chronic disease

35. id106 **Patrice Nabbe (France)**
Establish a Questionnaire to evaluate multidisciplinary primary care from the patient's point of view.

36. *id86* **Eva Hummers (Germany)**
Home-Based Screening for Early Detection of Atrial Fibrillation in Primary Care – the SCREEN-AF Trial.

37. *id58* **Kristine Sitca (Latvia)**
Senior dancing – socializing tool against vascular dementia.

38. *id67* **Vanja Lazic (Croatia)**
Measuring innovation: Real-world approach to falls prevention in elderly.

13.10 – 14.10 :   **Lunch**
   in: Cafetaria, 1st floor

14.10 – 14.30 :   **Chairperson's Report by EGPRN Chair: Prof. Mehmet Ungan.**
   Report of EGPRN Executive Board and Council meeting.
   in: Auditory No 3 - C Block, 1 st floor

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:** *"Cancer & Cancer Prevention"*
   in: RSU main building's Hall, 1 st floor
   Chair: Peter Torsza

39. *id120* **Pemra C.Unalan (Turkey)**
Validity and Reliability of the Turkish Quality of Life Questionnaire for Advanced Cancer Home Care Patients (Turk- QLQ-C15-PAL)

40. *id72* **Ludmila Terjajeva (Latvia)**
Impact of intervention on the number of cervical cancer screens - a randomized controlled pilot study.

41. id110 **Kathrin Schloessler (Germany)**
What attitudes do medical students have towards cancer-screening?

42. *id49* **Jekaterina Ivanova (Latvia)**
Patients' compliance to fecal occult blood test in Latvia.

43. *id112* **Marta Cuní Munné (Spain)**
Prescription-Indication study of Fentanyl transdermal patches at Primary healthcare.

14.30 – 15.45 : **Parallel group 2: Posters:** *"Metabolic Diseases"*
  in: RSU main building's Hall, 1 st floor
  Chair: Eva Hummers

44. *id111* **Maija Puce (Latvia)**
Iron deficiency and anemia in prophylactic examinations of 1 year old children.

45. *id105* **Joan Llobera (Spain)**
Hybrid evaluation trial of a complex multi-risk intervention to promote healthy behaviours in people between 45 to 75 years attending Primary Health Care. EIRA3 study (Phase III).

46. *id45* **Robert D. Hoffman (Israel)**
Elucidating metabolic effects of smoking cessation.

47. *id99* **Tevfik Tanju Yilmazer (Turkey)**
Perception of illness at patients with hyperlipidemia.

48. *id52* **Ilze Skuja (Latvia)**
Modifiable risk factors of non-communicable diseases in Latvia and Sweden.

14.30 – 15.45 : **Parallel group 3: Posters:** *"Cardiovascular Risk & Diseases"*
  in: RSU main building's Hall, 1 st floor
  Chair: Tuomas Koskela

49. *id121* **Hilde Bastiaens (Belgium)**
Improving cardiovascular disease (CVD) prevention and care in Europe and Sub-Saharan Africa: an implementation project (SPICES).

50. *id93* **Aiga Markevica (Latvia)**
Does appropriate antihypertensive treatment alone affect the cardiovascular disease risk?

51. *id47* **Miguel-Angel Munoz (Spain)**
Determinants of heart failure decompensation in patients attended in primary care.

14.30 – 15.45 : **Parallel group 4: Posters:** *"Health Care Services"*
  in: RSU main building's Hall, 1 st floor
  Chair: Radost Asenova

52. *id113* **Ann Verhoeven (Belgium)**
Organization of locum GPs in Europe.

53. *id40* **Isabel Roig Grau (Spain)**
Evidence after five years of antitobaco law.

54. *id125* **Ausra Saxvik (Sweden)**
Acculturation effects in PLUS - program for learning and development in Swedish health care.

55. *id114* **Marija Petek Šter (Slovenia)**
Factors influencing speciality choice in final year medical students - are students with intended career choice in family medicine are different to other students?

14.30 – 15.45 :   **Parallel group 5: Posters:** *"Miscellaneous"*
in: RSU main building's Hall, 1 st floor
Chair: Erik Stolper

56. *id13* **Sabine Bayen (France)**
Beliefs and knowledge about sexual transmitted diseases in women who have sex with other women.

57. *id17* **Clarisse Dibao-Dina (France)**
Masked hypertension prevalence in diabetic II patients in primary care.

58. *Id91* **Ana Claveria (Spain)**
Quality of life and multimorbidity in PEOEPPC/COPD.

15.45 – 16.15 :   **Coffee break**
in: Cafetaria, 1st floor

16.15 – 17.15 :   **Parallel session K - 2 Theme Papers**
in: Auditory No 3 - C Block, 1 st floor
Chair: Thomas Frese

59. *id73* **Jean Yves Le Reste (France)**
Which GPs training methods will increase colorectal cancer screening? A systematic review.

60. *id30* **Claire Collins (Ireland)**
Promoting the physical health of people with severe mental illness.

16.15 – 17.15 :   **Parallel session L – EGPRN Webbased Research Course; kickoff.**
   in: Aulas rehearsal hall; K Block, 1st floor
   Chairs: Shlomo Vinker and Ferdinando Petrazzuoli

EGPRN is happy to announce the start of the Web-based Course on Research in Primary Health Care. The aim of this course is to provide family physicians with the knowledge, skills and attitudes necessary for undertaking research. The course contains about 20 web-based off-line modules of teaching and practical face to face workshop as a final step of each course. Participation in the web-based modules will be free of charge for EGPRN members.

Aim of the workshop:
1) To present the International Web-based Course on Research in Primary Health Care and its topics;
2) To identify strategies to promote the course and adjust it to the needs of residents and young family physicians;
Methods: Three presentations by the course leaders (about) 30 minutes in total followed by group-based work and interactive discussions.

The meeting continues with a Plenary Session till 18.05 hrs.
   in: Auditory No 3 - C Block, 1 st floor
   Chair: Mehmet Ungan

17.15 – 17.35 :   **Closing of the day by *Dr. Vija Silina,* 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 Riga-Latvia.**

17.45 – 18.00 :   **Introduction on the next EGPRN-meeting in Dublin-Ireland, by *Dr. Claire Collins*, EGPRN National Representative of Ireland - host organizing committee Dublin.**

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.**
   Address: Peldu street 19, Basement, Old town,
                      Riga-Latvia.
   Web: **http://www.folkklubs.lv/en/about-us**

SUNDAY 16th OCTOBER, 2016:

Location: **Riga Stradins University**
Dzirciema Street 16
Riga LV1007 – Latvia

09.30 – 12.00:   **2nd Meeting of the EGPRN Ex+cecutive Board**
in: room Nr. 1c

FRIDAY 12th MAY, 2017:
Location: **Riga Stradins University**
Dzirciema Street 16
Riga LV1007 - Latvia

08.45 - 09.30: **International Keynote Speaker:** *Prof. Ruth Kalda*
Department of Family Medicine, University of Tartu - Estonia
Theme: *"Reducing the risk of chronic diseases in General Practice / Family medicine".*

Although chronic diseases are the most common and costly health problems, they are also the most preventable. Prevention can be seen as health promotion activities that encourage healthy living and limit the initial onset of chronic diseases but it also includes early detection activities, such as screening at-risk populations, as well as strategies for appropriate management of existing diseases and related complications. As general practitioners/family physicians, we spend the majority of our time caring for patients with chronic diseases, but studies show that we achieve the standard of care for chronic diseases and preventive care less than 50 percent.

Is our health care system designed to prevent chronic illnesses? Can the traditional physician-patient interaction which is organized to respond to patient acute illness, be the same effective in managing chronic diseases?

Studies of chronic disease prevention and management based on the Chronic Care Model (CCM) show promising results in reducing the health care costs, improving performance and health outcomes. CCM enhances the role of multidisciplinary primary health care. Although chronically ill clients value a single source of care for their multiple needs, the complexity of the same needs means that no single professional can provide the expert care. An interdisciplinary mix of primary care professionals, working in organized team, has been shown to improve care for the chronically ill, and provide effective prevention. Cochrane Collaboration review confirmed that multicomponent practice changes in four categories led to the greatest improvements in health outcomes: increasing providers' expertise and skill, educating and supporting patients, making care delivery more team-based and planned, and making better use of registry-based information systems. Although full implementation of the chronic care model is highly demanding because needs involvement the entire healthcare system and the community, many of the features can be implemented also in smaller practices.

Prof. Ruth Kalda
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SATURDAY 13th MAY, 20176:
Location: **Riga Stradins University**
Dzirciema Street 16
Riga LV1007 – Latvia

08.30 - 09.10 : **National Keynote Speaker:** *Dr. Vija Silina*
Dept. of Family Medicine, Stradins University, Riga **-** Latvia
Theme: "State of the Art of Family Medicine/General Practice in Latvia".

Latvia is a country by the Baltic Sea hosting 1,969,000 inhabitants. It is called "green" country due to its forests and abundance of wildlife. About half of inhabitants above 15 years of age (45% women and 55% men) are sure that they are at very good or good health. Inhabitants are in general appreciating family medicine as 62% are fully and 28% are partly satisfied with their family physician. Representative studies on health behaviour of Latvian population show that there is still a big effort needed by both family physicians and patients to implement favourable lifestyle changes. For example, half of working age people (54,6%) are overweight or obese and traditions of riding bicycles are still to be enhanced, as 77% report not riding bicycle at all. Latvians are still to be encouraged to accept preventive measures as coverage of cancer screening programmes is below 40% and human papilloma virus vaccination rates in 12 year olds females do not exceed 45%. As both healthy life expectancy at birth (67,1 years) and the public spending on health as share of GDP per capita (below 4%) are one of the lowest in European region, effective primary health care (PHC) teams are essential in Latvia.

In clinical family medicine Latvia has implemented an impressive change since 1993. It has switched from the Soviet polyclinic-based healthcare system with different narrow specialists dealing with individual health problems of a patient towards a Western system based on comprehensive patient-oriented approach of a family physician. Since then the number of family physicians in the country has grown from 0 to 1450. Opinion of family physicians is now taken into account as an effort of two powerful associations: Association of Latvian Family Physicians and Association of Latvian Rural Family Physicians. A total of 1329 physicians have public agreements with National Health Service (6.7 PHC physicians per 10,000 inhabitants) and on average 1530 patients are registered per physician. Most family physicians have their private practices supported by one or two nurses or physician's assistants. Primary health care paediatricians and internists form a minor part of PHC. E-medicine is at the doorsteps and is currently piloted. After trying different financing systems and models, Latvia has now stopped at mixed capitation model. Quality criteria are set, but seem to be non-motivating. In this setup the main challenge is to fit competencies of the family physician so well incorporated in the WONCA tree into the legislative and financial framework of Latvia.

As 54% of primary health care physicians are older than 55, education of young family physicians is crucial. Education system of a family physician in Latvia is similar to Lithuania and Estonia with 6 undergraduate years and 3 post-graduate years. Two universities (Riga Stradins University and University of Latvia) are training both undergraduate and post-graduate physicians. Family medicine is incorporated in the last year program for undergraduates and

there is a big intention to introduce basics of family medicine earlier. The prestige and number of medicine students is growing every year in Riga Stradins University, e.g., during academic year 2016/2017 a total of 315 students (including 116 foreign students) undertook a basic course in family medicine. Most students are satisfied with the course and a new perspective of problem-solving. On average 40 post-graduates are trained in family medicine each year since 2014 with most training in family medicine during the last year.

Research in family medicine has been slower, compared to other Baltic countries. Establishment of the Department of Family medicine in Riga Stradins University in 2010 was a serious sign of changing attitudes towards family medicine. Now the Department comprises 10 lecturers with only one assistant professor in family medicine. The main challenge is involvement of clinically active, competent physicians into academic and research environment. Capacity building in writing project proposals and publications is still essential. Post-graduates (residents) form a serious potential for further research activities. Latvia is ready to continue its way towards academic family medicine, and hosting EGPRN Riga Conference is another big step towards reaching this target.

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PRESENTATION 1:   **Friday 12th May, 2017**   **THEME PAPER**
                                         09.30–10.00 h.   **Finished Study**

Frequency of family physician visits and extent of family difficulties are decompensation factors for multimorbid outpatients

Sophie Lalande, Jeremy Derriennic, Michele Odorico, Delphine le Goff, Pauline Grall, Patrice Nabbe, Bernard Le Floch, Marie Barais, Pierre Barraine, Lingner Heidrun, Jean Yves Le Reste
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Id 23

Background: The European General Practitioners Research Network (EGPRN) designed and validated a comprehensive definition of multimorbidity using a systematic literature review and qualitative research throughout Europe. This definition was tested as a model to assess decompensation in multimorbid outpatients.

Research question: To assess which criteria in the EGPRN concept of multimorbidity could detect decompensating outpatients in a primary care cohort at a 6-month follow-up.

Method: Family Physicians (FPs) included a random sample of multimorbid patients encountered in their office from July to December 2014. Inclusion criteria were those of the EGPRN definition of Multimorbidity. Exclusion criteria were patients under legal protection and those unable to complete the 2-years follow-up. Decompensation was defined as the occurrence of death or hospitalization for more than seven days. Statistical analysis was undertaken with uni- and multivariate analysis at a 6-months follow-up using a combination of approaches including both automatic classification and expert decision making. A Multiple Correspondence Analysis confirmed results consistency. A logistic regression was finally performed in order to identify and quantify risk factors for decompensation.

Results: 19 FPs participated in the study. 96 patients were analyzed. 3 different clusters were identified. MCA showed the central function of psychosocial factors and peaceful versus conflictual relationships with relatives in all clusters. Age, frequency of family physician visits and extent of family difficulties were the factors which predicted decompensation.

Conclusions: action should be taken to prevent decompensation in older patients who have frequent family physician encounters and who experience family difficulties.

Points for discussion:

Variation in physicians' decisions on antihypertensive treatment in oldest-old and frail individuals across 29 countries

Sven Streit, Verschoor Marjolein, Nicolas Rodondi Bonfim Daiana, Burman Robert A, Canan Tuz, Collins Claire, Gerasimovska Kitanovska Biljana, Gintere Sandra, Gómez Bravo Raquel, Hoffmann Kath
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Id 42
Background: In oldest-old (>80 years), few trials showed efficacy of treating hypertension including mostly healthier individuals. The resulting lack of knowledge has led to inconsistent guidelines, mainly based on systolic blood pressure (SBP) and cardiovascular disease (CVD) but neglecting frailty as an important characteristic of many oldest-old patients.
Research question: To investigate clinical variation among general practitioners (GPs) across 29 countries in their decision to start antihypertensive treatment in oldest-old and to identify the role of frailty in that decision.
Method: Using a survey, we asked GPs if they would start antihypertensive treatment in cases of oldest-old varying in SBP, CVD, and frailty. We invited GPs in Europe, Brazil, Israel, and New Zealand and compared percentages of cases that would be treated per countries. A logistic mixed-effects model was used to derive odds ratio (OR) for frailty with 95% confidence intervals (CI), adjusted for SBP, CVD, and GP characteristics (sex, location and prevalence of oldest-old per GP office, experience, and guideline adherence when treating hypertension in oldest-old). The mixed-effects model was used to account for multiple assessments per GP.
Results: The 29 countries yielded 2,543 participating GPs: 52% female, 51% based in cities, 38% with >20 years of experience. Across countries, considerable variation to start antihypertensive treatment was found ranging from 34 to 88%. In 24/29 (83%) countries, frailty was still associated with GP's decision not to treat hypertension when adjusted for SBP and CVD (overall OR 0.53, 95% CI 0.48-0.59; ORs per country ranged from 0.11-1.78).
Conclusions: In the participating countries, the decisions to start antihypertensive medication in oldest-old showed considerable variation. The frail oldest-old had an almost 50% lower probability of receiving antihypertensive treatment. Future hypertension trials should include frail patients in order to establish whether frailty is an important factor to consider when treating hypertension in oldest-old.

Points for discussion:
1. What other hypotheses could be generated to explain the considerable variation of treatment decision to start antihypertensive therapy in oldest-old.
2. How could we improve response rates for such studies that was done with the support of many EGPRN.

PRESENTATION 3:   **Friday 12ᵗʰ May, 2017**   **THEME PAPER**
                              10.30–11.00 h.   **Almost Finished Study**

How do health system factors affect primary care practitioners' referral decisions in patients that could have cancer? Results from the Örenäs Research Group study

Michael Harris, Michael Harris, Department for Health, University of Bath, UK, on behalf of the Örenäs study group
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Id 87
Background: There is wide variation in national cancer survival rates. This is linked to national variations in how Primary Care Practitioners (PCPs) act when faced with patients that could have cancer. This, in turn, is likely to be affected by their health systems are organised.The Örenäs Research Group (ÖRG) is a collaborative group of researchers from 21 European countries that investigates how health system factors influence cancer survival rates.
Research question: How do health system factors affect primary care practitioners' referral decisions in patients that could have cancer, and how do these relate to national cancer survival rates?
Method: ÖRG members identified 45 system factors that may affect PCP decision-making in patients who may have cancer. Pilots indicated that 20 of those factors vary significantly across European countries.The study uses a questionnaire with closed-ended questions: -four clinical vignettes (patients with possible breast, lung, ovarian and colorectal cancer), each with a question asking for the PCPs' most likely immediate investigation/referral decisions; -a list of the 20 system factors, with Likert scales for respondents to indicate how much each factor affected those referral decisions.The questionnaire was translated and adapted into each local language, with validation by back-translation.
Results: A total of 2,086 PCPs in 20 European countries took part in the ÖRG study, with questionnaires in 20 languages. A median of 72 PCPs per country participated, with a median response rate of 21%.Factor analysis of the data has identified that the 20 system items can be put into five main groups. Analyses of how these relate to PCP decision-making and national cancer survival will be presented at the conference.
Conclusions: The results will help identify which system factors need to be addressed, to allow optimisation of the primary care management of patients who may have cancer.

Points for discussion:
1. How do delegates' own research and clinical experiences fit in with the reported findings?
2. How could health care organisations use this knowledge to support the timely diagnosis of cancer in their countries?
3. What is the potential for further comparat

PRESENTATION 4:   **Friday 12ᵗʰ May, 2017**   **THEME PAPER**
                              16.20–16.50 h.   **Finished Study**

Search for decompensation risk factors within the egprn multimorbidity's definition themes. cohort study followed up at 12 months in nursing home (NH).

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Id 85
Background: In General Practice (GP), elderly people are numerous and a part of them are residing in Nursing Home (NH). Multimorbidity concerns the majority of Nursing Homes residents. Multimorbidity was recently defined by the European General Practice Research Network (EGPRN).Multimorbide patients require considerable attention from their General Practitioners (GPs) because of their frailty and decompensation risk.. Research question: to discover decompensation risk factors within the multimorbidity definition criteria.
Methods: analytical, epidemiological and prospective cohort study with Lanmeur's NH residents meeting the definition of multimorbidity. Decompensation was defined by a hospitalization more than seven days or death. At 12 months of follow up, patients' status were collected and each patient was assigned in the group "decompensate" ("D") or "nothing to report" ("NTR"). Statistical analysis was univariate and multivariate using Cox regression method.
Results: 64 patients were included from July to December 2014. At 12 months, 23 were in the "D" group (14 were dead and 9 have been hospitalized) and 41 in the "NTR" group. The multivariate analysis found two variables with a presumption of statistical significance: pain as a risk factor (HR, 2.33; 90% IC, 0.98-5.57; p-value, 0.056) and coping strategies of the entourage as a protective factor (HR, 0.41; 90% IC, 0.15-1.13; p-value, 0.085).
Conclusions: This study showed that elderly people in NH decompensate more when they suffer from pain or when their entourage did not use coping strategies. The cohort was small and the population study unrepresentative of the French NH population which limits its generalization. Further studies on a larger scale are necessary in order to confirm or not the risk factors highlighted in this study.

Points for discussion:

Search for decompensation risk factors within the egprn multimorbidity's definition themes. Cohort pilot study, follow up at 12 months in primary care outpatients.

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Id 83

Background: In 2013, the European General Practice Research Network (EGPRN) has defined multimorbidity. Multimorbidity is a patient's condition defined as having a chronic disease associated with at least another disease (acute or chronic) or a biopsychosocial factor (associated or not) or a somatic risk factor. This concept is taking into account all the patient's biopsychosocial conditions. A tool based on this concept could be developed to identify patients at risk of decompensation in general practice.
Research question: What are decompensation risk factors at twelve months according to the themes of multimorbidity's definition in a cohort of primary care outpatients?
Method: General practitioners (GPs) included patients consulting in general practice, corresponding to the multimorbidity's definition of the EGPRN. After 12 months of follow-up, patients who were hospitalized at least 7 days consecutively or died were allocated in the group "decompensation". Others were allocated in the group "nothing to report". A multivariate statistical analysis using Cox's model was conducted to find significant link between multimorbidity's themes and decompensation.
Results: Nineteen GPs included 96 patients. At 12 months, 23 patients were allocated to the "decompensation" group and 70 to the "nothing to report" group. 3 patients were lost to follow up. Age, number of visits to the family physician, family problems, number of treatment and complications of acute disease were significantly associated with decompensation.
Conclusions: Five variables from three different themes of Multimorbidity's definition seemed to be associated with risk of decompensation for primary care outpatients. These data will be confirmed by an European study, conducted on a larger scale.

Points for discussion:
What did we consider as family problem? After 12 months of follow up, more variables are associated to decompensation. We need more powerful studies to confirm those results.

PRESENTATION 6:   **Friday 12th May, 2017**   **THEME PAPER**
                        12.00–12.30 h.   **Ongoing study no results yet**

Preventing chronic respiratory diseases by implementing awareness-raising interventions to reduce smoking and household air pollution in rural Crete, Greece

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Id 107
Background: Exposure to tobacco smoke and household air pollution (HAP) are risk factors for chronic respiratory diseases (CRDs). Greece has one of the highest smoking rates in Europe, while wood burning for heating has increased during the economic recession.
Research question: Can awareness-raising interventions be effective in motivating behavioral change regarding tobacco and HAP exposure in rural areas of Crete, Greece?
Method: This study is part of the European Horizon 2020 project 'FRESH AIR'. A "teach-the-teacher" module will be implemented to raise awareness among healthcare professionals and community members, identified in six rural settings in Heraklion county, Crete. General Practitioners will be trained to use educational materials, adjusted to the local context, to teach other healthcare professionals who will teach community members on the harmful effects of smoking and HAP. Obtained knowledge will be assessed through questionnaires (already tested in practice), administered before and after each training. Theoretical input from the Theory of Planned Behavior and Motivational Interviewing will be utilized. An awareness-raising media campaign is also under discussion. Its effectiveness would be measured by surveying a sample of community members before and after four months upon its release.
Anticipated impact: This study will provide novel data on levels of awareness for CRDs' risk factors in Greek primary care and community settings. In the long term, it is anticipated that raised awareness will contribute to the reduction of the burden of CRDs in Crete. Training and educational materials will remain available to healthcare professionals and facilities, enhancing their capacity and skills. Policy makers will be provided with evidence on the effectiveness of such awareness-raising approaches for future use.
Conclusions: Implementing awareness-raising interventions is expected to be an effective strategy for promoting behavioral change towards modifiable risk factors for CRDs, especially in low-resource settings, such as rural areas of Crete.

Points for discussion:
1. How could general practitioners' involvement enhance the implementation of such awareness raising activities?
2. How could lessons learnt from this study inform training programs and daily practices of general practitioners?
3. How can results

PRESENTATION 7:   **Friday 12th May, 2017**   **FREESTANDING PAPER**
                       11.30–12.00 h.   **Finished Study**

Ultrasonographical diagnosis of subclinical atherosclerosis and assessment of vulnerability at atheromatous plaques with the Strain Elastography in primary care.

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Id 36
Background: Atherosclerosis is a chronic inflammatory disease of the arterial wall induced from endothelial injury followed finally by the complications of plaque and its obstruction. It is the leading cause of morbidity and mortality from heart attacks and strokes in Romania.
Research question: How can we detect and assess the vulnerability of atherosclerosis plaque?
Method: We did a randomized clinical trial, controlled, on 500 Caucasian patients, aged 40-80years, sex ratio1:1. Inclusion criteria were asymptomatic patients with high-risk lipid profile (LDL>160mg%) with or without statins and antiplatelet therapy in the past two years. Exclusion criteria were target organ damage. We formed two groups: first under treatment with statins and antiplatelet agents and second as control group with untreated patients. All patients were examined with Doppler ultrasound and SE in three regions: carotid, abdominal aorta, and femoral arteries. We monitored following: IMT, velocity, RI, PI, stenosis. We have established some criteria of elastography, for classification of atherosclerotic plaque in "stable-uniform elasticity" or "unstable-mosaic stiffness", and designed an ultrasound score to diagnose the vulnerable plaque.
Results: Increase of carotid IMT between 0.9-1.5 mm had meant: mild and moderate atherosclerosis in 42% of patients in the first and 33% in the control group. IMT over 1.5 mm had meant severe atherosclerosis in 58% of the first and 67% in the second group. Cut off value of the aorta and femoral IMT>0.5 cm. Sensitivity:96.2%, specificity:88%, 95%CI:79.97%to93.64%, prevalence:83%. The relative risk was:0.86 with 95%CI:0.75to1, Odds Ratio:0.68, p<0.05.Conclusions:Ultrasound measurement of IMT in three regions, when assessing subclinical atherosclerosis and assessment of the atheroma plaque stiffness, was important for primary prevention of cardiovascular events.

Points for discussion:
1. How can we diagnose subclinical atherosclerosis?
2. Is it possible to identify and treat of the vulnerable plaque?
3. What tools are handy of the family physician in assessing plaque?

Results of the European Survey regarding the Point of Care Ultrasonography applications in the GPs practice, and an experimental Emergency Ultrasound Screening related to their applicability in primary care.

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Id 27
The Point of Care Ultrasonography performed by the clinician, both in the medical office or at home, is an important tool to guide and improve the case management for the early diagnosis and treatment. It represents an extension and complement, to the clinical examination of the physician, to achieve an accurate positive and differential diagnosis.
Research question: Is required to use the Emergency Ultrasound?
Method: Indications of PoC-US diagnoses are the detection of stones, fluid accumulation, enlarged organs, digestive tube paresis, aneurysms and obstruction of vessels, enlarged heart, cardiac diseases, thyroid and breast pathology, pleural effusions. All these had presented a typical ultrasound pattern, and simple diagnostic criteria can be used. In connection with the clinical picture, the diagnosis could be very accurate and enough start the treatment. We did a brainstorming and conducted an online survey, about what we can apply in primary care. We designed a questionnaire with PoC-US applications which we distributed to family physicians. Then we made an experimental PoC-US Screening of3400 patients with acute and emergency pathology, who were examined first time by the family physician confirmed after by the specialist. Each patient followed our ultrasound protocol and was archived in a computerized database. We made an initial descriptive statistics of the emergency pathology and finally were analyzed all data obtained at this screening.
Results: We had a total of 400 respondents to this survey. We made a comparative analysis of their answers. We want to find out which PoC-US applications are of great interest to family physicians from Europe. Accuracy: 94,54%, Sensitivity: 96,43%, Specificity: 91,16%, p<0,001.
In conclusion, because of a significant number of advantages, ultrasonography should be a diagnosis tool besides to the stethoscope at family physicians. Early diagnosis can help to save many patients in primary care, based on notions of good clinical practice.

Points for discussion:
1. What kind of the PoC-US applications may be required in family medicine?
2. Can be considered the PoC-US as a complement to clinical examination?
3. What investigations can guide better the case management for GP's to the bedridden and emergency pa

Stress management workshop - in office skills with MST tools

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Id 9
Background: MST- is a practical set of tools that harness the power of mind using the 5 senses enabling than to become "quiet" and by this to build up the power of concentration. This set of tools enable the mind eliciting the relaxation response, the common pathway of all mind-body technologies (1), as a counter reaction to the stress response, what is known as to fight or flight response in men or the tend and befriend response in females. The relaxation response counters the harmful effects of the stress response, referred to as allostatic loading. (2)
Aim: The aim of the workshop is to show practical tools for stress reduction and pressure management.
Methods: the course will start with physical exercises than after several breathing technique will be taught and practiced. In the last part of the workshop few relaxation methods will be explained and the basic techniques for meditation.
Results: By constant practicing MST set of tools and the experiencing the relaxation response the mind and the body can counter and resist the stress response. Stress through its mediators, can lead to acute or chronic pathological, physical and mental conditions in individuals with a vulnerable genetic, constitutional and/or epigenetic background (2), thus making the relaxation response a good practical tool to counter these effects by causing a decrease in metabolism, heart rate, blood pressure, respiratory rate, oxygen consumption, management of chronic pain and insomnia (2,3,4). Evidence is accumulating regarding the ability of mind body techniques to treat anxiety and depression, Alzheimer disease, fighting cancer, autoimmunity conditions, and influencing the immune system with respect to infectious diseases. (5)A decrease in negative feelings, and increase in positive emotions is being felt by people who practice regularly, and anxiety and depression events can be treated.

Points for discussion:

Statins for (almost) everyone? Validation of the 2016 US Preventive Services Taskforce (USPSTF) Recommendations for primary cardiovascular prevention

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Id 122

Background: Primary prevention treatment with statins is advised for high risk patients, but there is no consensus on how to ascertain risk. The American College of Cardiology and American Heart Association (ACC/AHA) issued recommendations based on the "Pooled Cohort Equations" calculator, but were shown to overestimate risk in US cohorts. In 2016, the US Preventive Services Task Force USPSTF proposed a modification, narrowing the patient selection. These recommendations were not validated to-date.

Research question: How well do the USPSTF recommendations preform in a contemporary non-US cohort?

Methods: A retrospective cohort using electronic health records. All patients eligible for primary cardiovascular prevention in 2005 in the Tel Aviv district of Clalit Health Services in Israel were identified. 10,889 primary prevention patients were followed for 10 years (98,258 person-years). Predicted risk was compared to observed events.

Results: Average age was 60.3 years (s.d. 9.4), and 69.1% were women. Outcome events were recorded in 1,351 patients (12.4%). Both guidelines indicated low risk in 3,594 (32%) patients, and were in agreement for statin eligibility in 2,483 patients (22.8%). Implementation of the USPSTF recommendations would result in a 26% reduction in newly eligible patients for statin treatment. The predicted to observed ratio was 1.0 and 0.98 among USPSTF and AHA/ACC statin eligible patients, respectively. Discrimination of both models was poor [Harrel's C=0.63 (0.62-0.65) vs 0.64 (0.63-0.66), p=0.26 for the USPSTF and the AHA-ACC recommendations respectively]. The USPSTF recommendations were less sensitive for detection of outcome events than the AHA/ACC recommendations (61% vs. 75% respectively), but were more specific (68% vs 55%). Net Reclassification Improvement was of -0.01.

Conclusions: Applying the USPSTF recommendations seems a reasonable approach to reduce statin over-treatment. Clinicians and policy makers should be aware of the implications of different models in real-life settings.

PRESENTATION 11: **Friday 12th May, 2017** **THEME PAPER**
14.30–15.00 h. **Ongoing study with preliminary results**

Assessment and Comparison of Obstacles in Everyday Life of Patients with Type 2 Diabetes in Six European Countries.

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Id 37
Background: The EGPRN initiated a qualitative research EUROBSTACLE to create a broadly conceptualized diabetes- related quality of life (DR-QoL) instrument. The DOQ-30 was developed. It showed an excellent internal reliability, and external and construct- validity.
Research question:The purpose of the study is to analyse and compare the results of the DOQ-30 by included samples from Belgium, France, Estonia, Serbia, Slovenia, and Turkey.
Method: The study design was similar in all countries. A cross-sectional study with the DOQ was carried out in Belgium, France, Estonia, Serbia, Slovenia, Turkey. The analysis included data from all 853 participants. The DOQ-30 comprises 30 items, in 9 scales. We computed the arithmetic mean for all the scales and transformed a score from 2 to 100. A score of < 50 suggests the suboptimal quality of life.Measures of central tendency, PostHoc tests, and ANOVA, for all the samples of the six countries, were computed.
Results: The mean age of the participants 64 years- higher was in Estonia and lower in Turkey, and the mean duration of T2DM was 7.3 years- lower in Belgium. At least, arithmetic mean for every scale differed (p< 0,05) by 1-2 countries. Fewer obstacles for T2DM patients encountered in Turkey and more in Belgium. Predictive characteristics were most often age, duration of T2DM and HbA1c.
Conclusions: The patients with T2DM of the six countries show contemporary similar obstacle pattern and the questionnaire is ready to be implemented in everyday use by GP-s

Points for discussion:
MethodologyImplementation into praxis

The obesity paradox among type 2 diabetes patients: Does being overweight necessarily confer a worse prognosis?

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Id 15

Background: Over-weight and obese type 2 Diabetes Mellitus (T2DM) patients are encouraged to lose weight, yet the association between body-weight and morbidity, and mortality had not been established yet. Recently an invert association between Body Mass Index (BMI) and morbidity and mortality had been described, a phenomenon named "the obesity paradox".

Research question: To examine whether an obesity paradox exists in the context of morbidity and mortality of T2DM patients. Method: A retrospective cohort study included 45 years or older T2DM patients insured in "Clalit Medical Services", excluding patients with previously diagnosed cardiovascular diseases, CKD4-5, and cancer. The final cohort included 102,063 patients. Follow-up was 7 years or until the patient's death. Outcomes measured were: incidence of ischemic heart disease, CKD4-5, and all-cause mortality. Multivariable logistic regression was used in analysis of kidney failure incidence. Cox proportional hazard regression was used in analysis of ischemic heart disease and all-cause mortality incidence.

Results: Compared to normal weight diabetes patients, hazard-ratios of incidence of ischemic heart disease were 1.161, 1.232, 1.281, 1.246 for BMI 25.00-29.99, BMI 30.00-34.99, BMI 35.00-39.99 and BMI 40 and above, respectively. All results were statistically significant. Compared to normal weight diabetes patients, incidence of CKD4-5 was significantly higher only in the BMI category of 40 and above; HR 1.402, p=0.001. 7.8% of patients died during follow-up. Compared to normal weight diabetes patients, hazard ratio of all-cause mortality were 0.795, 0.811, 0.931, 1.403 for BMI 25.00-29.99, BMI 30.00-34.99, BMI 35.00-39.99 and BMI 40 and above, respectively. All results were statistically significant.

Conclusions: A direct association was found between BMI and ischemic heart disease incidence. Over-weight and obese T2DM patients were found at lower risk of mortality compared to their normal weight counterparts. The results of the study support the existence of an obesity paradox among T2DM patients in Israel.

Points for discussion:
1. How could we explain the obesity - diabetes paradox?
2. Would it make a change in our recommendations to T2DM patients?

Assessing Preceptor Performance in Family Medicine Using the One-Minute Preceptor Model

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Id 35
Background: The One-Minute Preceptor is a robust model for clinical teaching that includes a series of discrete "microskills: getting a commitment, probing for supportive evidence, teaching general rules, and giving feedback.
Objectives: We developed a rating tool based on this model and used it to study preceptor behavior when supervising family medicine residents.
Methods: An experienced clinical teacher observed multiple resident-preceptor encounters daily for 2 weeks and scored each microskill on a scale of 1-5. A summary mean score for each preceptor was assigned on each microskill based on the encounters observed. In addition, observations were recorded regarding resident reactions during precepting.
Results: Eighty-five encounters with 14 different preceptors were observed. Highest scores were for getting a commitment and teaching general rules. Preceptors gave positive feedback more often than corrective feedback. In shorter and simpler cases, preceptors did not execute all the microskills. Residents appeared satisfied with the guidance they received. Curiously, many residents stood throughout their presentations, while faculty often appeared pressed for time.
Conclusions: The One-Minute Preceptor model provides a framework for describing precepting encounters through direct observation. Based on observations at this site, faculty may benefit from additional support in giving feedback, particularly corrective or negative feedback. Although residents and faculty appear to feel time-constrained, compared to other settings they have the relative luxury of dedicated precepting time and might be able to take better advantage of it.

Points for discussion:
The use of One minute preceptor model to evaluate students, residents and teachers can be used as teaching tool to evaluate treatment of chronic diseases

PRESENTATION 14: **Friday 12th May, 2017**   **FREESTANDING PAPER**
                              14.30–15.00 h.   **Finished Study**

A research method to use data from electronic health records not specifically prepared for research

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Id 18
Background: Only in several EU countries, data from General Practice (GP) electronic Health Records (eHRs)have been aggregated in a longitudinal way, to allow large-scale research. A range of research questions, which can be performed in this way, isratherlimited.
Research question: Can we still useeHRs for researchin countries where GP eHRsare not specifically prepared for researchand for which research questions?
Method: A study case was Metabolic Syndrome (MS) inhypertensive women in age of menopause, 50-55 years.There were 200 women in thesample, diagnosed with hypertension. Those among them who also matched criteria for MSwere identified according to the IDFdefinition. Only structured data were used from GPeHRs, complemented with patients interview. Machine Learning (ML) methodswere applied, including: the Welch`s two sample t-test and Pearson's chi-squared test, foranalysis of differences, and the Youden method, for estimation ofcut-off values. Some interesting results were also presented graphically.
Results: Women with MS, compared to those with hypertension alone, showed multiple metabolic derangements and had more co-morbid disorders. In hypertensive women in menopause, MS can be highly expected if they are overweight (BMI >25) and their waist circumference exceeds 89 cm. Cut-off values forfasting blood glucose and triglycerides fitted well to the conventional definition (5.7 and 1.7 mmol/L, respectively), while the cut-off value for HDL-cholesterol was setted up much higher (1.9 mmol/L in our study vs 1.3 in the IDF definition). Some other parameters and their cut-off values, including total and LDL-cholesterol (6.0 and 3.1 mmol/l, respectively), lymphocytes % in DWBC and haematocrit (25 and 41%, respectively), were identified as new biomarkers.
Conclusions: Although based on a cross sectional design and a small sample, this method provided many new details on MS in hypertensive women in age of menopause.

Points for discussion:
1. Research topics which can be performed from data used from eHRs
2. Can we perform research from eHRs not prepared for research?
3. Collaboration between GPs and informaticians

De-identifying GP routine data for secondary health services research

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Id 38

Background: European parliamentâ€™s recent legislation allows for scientific health data analysis while adhering to fundamental privacy protection laws.

Research question: Real world primary care data, after being prepared for research, are examined for potential violation of effective de-identification.

Method: Electronic routine data, 2010 to 2012, from a medium-sized group practice were extracted via a mandatory software interface. Direct identifiers, e.g. patient's name or insurance number, were removed. We examined resulting raw data for quasi-identifiers, such as patient's gender, birth date, ZIP code and others. Typically, effective anonymity is assumed if frequency of unique data values meets $k = 5$, better $k = 30$. Frequency analyses of single variables and their combinations were performed and repeated for modified variables.

Results: 3,811, with 2,114 female (55.5%), of 12,600 registered patients had at least one practice contact during the three-year observation period. Date of birth fell short of a critical $k = 5$, but patient's age in years and age decade were sufficient for $k = 30$, except for age under 10 and above 90 years. Distribution of patient's ZIP code, even when truncated, was highly skewed. 1,382 ICD10 code entities were found, with n â‰¥ 5 in 543 (39%) and n â‰¥ 30 in 194 codes (14%), respectively. Of 744 ICD codes, truncated to leading three positions, 414 (56%) and 186 (25%), respectively, could be considered sufficiently anonymous.

Conclusions: Patient's gender or age if over 10 or less than 90 years, both indispensable in health services research, are not critical as quasi-identifiers in a general practice population. Patient's ZIP code or locality information should be discarded. Especially diagnoses for rare diseases may cause an anonymity breach in secondary routine data utilization. Effective anonymity is a dynamic construct depending on the specific research question, required variables and factual data distribution.

Points for discussion:
1. Do you suggest any other variable to be critical when de-identifying GP routine data?
2. Do you know of any secondary routine data analysis in your country and of accompanying obstacles for privacy protection?
3. Which additional provisions ma

Medical decision making strategies in general practice vs. the emergency department - a comparative analysis

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Id 10

Background: Quality and underlying cognitive mechanisms of medical decision-making have been subject of many studies, most of them conducted in a rather artificial environment. Few studies have actually investigated different diagnostic or judgement approaches of physicians' cognition in their natural working environment.

Research question: What medical decision making strategies do general practitioners use in comparison to physicians working in the emergency department.

Method: 12 German general practitioners (GPs) were videotaped during their consultations. 134 consultations contained diagnostic episodes and were analyzed. GPs reflected after each patient during a partly standardized interview on their diagnostic reasoning. 16 emergency physicians based at two tertiary care hospitals in the United States of America were observed during 171 consultations and their reflections recorded. Unit of observation was the physician-patient interaction. Transcripts of interviews and observational notes were coded and analyzed qualitatively by two independent raters.

Results: Emergency physicians more often considered severe conditions, and showed much more willingness to order further diagnostic tests, even if pre-test probability was conceived to be low. Patients in the emergency department were hardly able to influence the decision making process, nor did they make diagnostic suggestions as much as they would in the setting of the general practitioner's office. Patients in the emergency department would not receive assurance as often as in general practice. Emergency physicians apparently considered themselves rather as 'distributionists' than diagnosticians. Opposed to GPs they also presented a more directive style of interviewing, with large accumulations of routine questions and rarely used open questions or active listening.

Conclusions: There are differences between the two specialties, in terms of self-perception (role in their respective environment), relationship to patients, style of interrogation and gathering information, as well as use of given cognitive and material resources. Both groups are adapted to the specific features of their working environment.

Points for discussion:
1. Could physicians in the emergency room learn from strategies used in primary care?
2. Could GPs benefit from the checklist routine of the emergency department?
3. How suitable is a qualitative approach in diagnostic research?

Clinical governance as professional self-reflection. How can we know how good we are?

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Id 51
Background: Although electronic health records (EHR) are widespread, most German GPs do not use their data for quality of care purposes. EHR in their current form are inadequately equipped for auditing quality of care on a daily basis. Standardized diagnostic and therapeutic decision making runs the risk of being overlooked in busy clinics when dealing with different patients and clinical needs.

Research question: How can we describe and measure the quality of our COPD care? Can checklists help provide better care and collect data simultaneously? Regarding benchmarking, how successful can such a tool be in reminding GPs of relevant treatment decisions?

Method: The study aimed to develop the necessary tools for data collection, followed by a before-after study to test these and estimate the benchmark of care for COPD. Patients diagnosed with COPD were identified via the EHR of the University Health Centre. We created a template for data collection with the freeware Epi-Info 7.2 and embedded a corresponding checklist within the EHR. The data was analyzed with respect to personal information, quality of diagnosis and therapy. Patients were then invited to checklist-guided interviews (intervention). The main goal was ensuring the correct diagnosis, correct grade and guideline-directed treatment of COPD. During the consultations, template and checklist served as an outline and data capture tool simultaneously. Quality of care before and after the follow-up visits were compared.

Results: Before the intervention, the quality of documentation and quality of care provided were inadequate. For example, a patient´s smoking status was not documented in 45/103 cases and 58/103 patients were COPD classified incorrectly. The intervention is currently ongoing and post-intervention results will be reported at the conference.

Conclusions: Checklists can ensure, patients receive the individual care they need and provide family doctors with a tool to monitor the quality of care they deliver.

Points for discussion:
1. Advantages and disadvantages of checklists in patient care.
2. How can standardization and benchmarking be fostered?
3. How well is data capture and analysis implemented in the EHRs of other countries?

Exploring knee osteoarthritis management in primary care: what about arthroscopy? A case-notes review

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Id 55
Background: Arthroscopy is a common surgical intervention for patients with knee osteoarthritis (KOA), but it is unclear when a general practitioner should refer a patient for arthroscopy.
Aim: To evaluate KOA management in primary care with a focus on arthroscopic interventions and the indications for arthroscopy. In addition, possible determinants for arthroscopic interventions at patient level are explored.
Design and setting: Retrospective case-notes review in six Belgian general practices, affiliated with the University of Leuven.
Method: Eligible patients with knee osteoarthritis were identified in the Electronic Health Records between 2005 and 2015. In these records, patients with KOA were identified using six inclusion criteria. Data on diagnostic procedures and management were collected with a focus on arthroscopic interventions. Available orthopedics' correspondence on arthroscopic interventions was analyzed for stated indications. In addition, possible determinants for arthroscopic interventions at patient level were explored using a regression model.
Results: In total, 576 patients with KOA were identified of whom 11.1% received physical therapy and 31.8% were prescribed the recommended drug acetaminophen. In total, 112 patients received an arthroscopic intervention after being diagnosed with KOA. Meniscal pathology and knee osteoarthritis were the two most mentioned indications in the orthopedics referral notes. Previous knee trauma and received physical therapy were identified as determinants to receive arthroscopy.
Conclusion: Conservative treatment options are not optimized yet, based on the low referral for physiotherapy and underuse of acetaminophen for the pain. Arthroscopy is performed in a quarter of the study population. Previous knee trauma and received physical therapy are determinants with higher risk for an arthroscopic intervention.

Points for discussion:
1. The role of GPs in the management of knee OA? Osteoarthritis should not be considered a normal aging phenomenon. Non-surgical interventions can make a difference.
2. If arthroscopic interventions are overused, how can the GP play a role in it?

What are the challenges that family practitioners face in the management of chronic diseases? A European research protocol from the EGPRN Fellows

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Id 108
Background: There is considerable variation in the way that chronic diseases are managed across Europe, in terms of the degree to which family practitioners (FPs) are involved, the degree of uptake by patients, the levels of interest and input from health policy makers and other stakeholders, the content of chronic disease management (CDM) programmes, and the quality of care in these programmes.
Research question: What are the challenges that family practitioners face in the management of chronic diseases?
Method: Possible approaches to this qualitative study include surveys of FPs, one-to-one interviews, and focus group interviews. The EGPRN's three Fellows are working together to study the background to this research question, choose and develop the methodology, and prepare a protocol for the subsequent study in their three European countries. They will also evaluate the newly developed EGPRN Fellowship model.
Results: The Fellows will present their study protocol, and their evaluation of the EGPRN Fellowship.
Conclusions: An understanding of how FPs think their role in CDM could be improved, and the barriers that they face in this, is key to addressing the policy issues necessary to provide high-quality and affordable health care for people suffering from chronic disease. This study will result in recommendations for improving the management of chronic diseases by FPs in three different countries, and these may also be relevant in other European settings.

Points for discussion:
1. What methods are best suited to multi-country, multi-language qualitative research?
2. How much impact can the results of such studies have on health policy?
3. How effective is the EGPRN Fellowship model?

PRESENTATION 20:   **Saturday 13th May, 2017**   **THEME PAPER**
                         09.10–09.40 h.   **Ongoing study with preliminary results**

Hypertensive Crisis: Analysis of 16384 Cases Documented in GP practices across Romania.

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Id 43

Background: Hypertensive crisis is a severe increase in blood pressure that can lead acutely to target organ damage, including stroke.

Research question: To evaluate the importance and the clincal presentation of cases with hypertensive crisis presenting to GP practices across Romania.

Method: We identified 14469 unique patients with hypertensive crisis documented by Romanian GPs using the icMED medical informatics system. This system enables doctors to explicitly code a hypertensive crisis/emergency. Coding was possible since 02-2013 and 16364 episodes of hypertensive emergency were coded until 09-2014 (352 episodes were documented retrospectively prior to the start date). Cases coded only as hypertension, with additional information in the medical record suggesting hypertensive crisis, were not included in this study.

Results: Most patients were older (mean age at first episode: 64.6 years, SD = 13.57) and females (61%). Clinical symptoms were recorded for 8953 cases (55%). The most common presenting symptoms were headache (3299, 20%); vertigo (2701, 17%); thoracic pain/angina (580, 4%), palpitations (352, 2%), dispnoea (306, 2%). The BP was recorded for 2827 episodes (17%). Systolic BP was >=180 in 2087 cases (74%), while diastolic BP was >=120 in 444 cases (16%). Furosemid was administered in 273 episodes, captopril in 149 and nifedipine in 11 cases: acute medication was not documented in the remaining cases.

Conclusions: Hypertensive crisis is an important condition in the GP practice, although it lacks a specific ICD10 code. However, GPs have accepted to use an internal code for this condition, even though complete medical information was not available for all cases. Improving documentation remains an open issue. Further analysis will focus on all 57543 cases recorded until the end of 2016.

Points for discussion:

Heart failure clinic within a primary care clinic in Beit Shemesh

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Id 11
Background: Various interventions were conducted in order to find models for improving the treatment and reducing the costs in heart failure patients. Heart failure centers showed increased treatment adherence, improvement of functional status of patients and hospitalizations reduction.
Research question: Objective: To evaluate the heart failure clinic in Beit Shemesh as regard to clinical outcome and heath service utilization of its patients.
Method: Retrospective cohort study. Data was retrieved from Clalit Health Service records for all heart failure patients in Beit Shemesh area for 2013-2014. Patients who were treated in the heart failure clinic were compared to heart failure patients who were not treated by the clinic.
Results: Basic patients' characteristics were similar in both groups. Patients who were treated at the heart failure clinic visited their family physician more often than patients who didnt visit the clinic (62.4 visits vs. 38.5 $p<0.0001$) visited the ER more often (0.75 visits vs. 0.41 $p=0.003$) and were hospitalized more (2.47 times vs. 1.41 $p=0.0002$) during the study period compare to patients who didn't visited the clinic. Both groups demonstrated a downward trend in ICU admissions. A significant reduction in mortality rate was observed in the group of patients treated in the heart failure clinic 6.1% deaths in the study period compare to 36.3% in the control group $p<0.0001$. Adjustment for various confounders didn't change the result.
Conclusions: Treatment in the heart failure clinic in addition to standard care of heart failure patients was associated with higher health service utilization, and much lower mortality rate.

Points for discussion:
How can we collaborate with the hospital for better patient outcome.

Identification of the obstacles to achievements of pro re nata medication (PRN) in palliative home cares by Doctors of the palliative care networks

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Id 74

Background: The main target of the palliative care networks is the palliative cares AT HOME in the best possible conditions by anticipating the occurrence of painful symptoms and implementing pro re nata medications (PRN). PRN are supposed to allievate disconfort and suffuring. In France 37%, only, of the palliative cared patients benefit from PRN while home cared.

Research question: Identification of the obstacles to achievements of pro re nata medication (PRN) in palliative home cares by Doctors of the palliative care networks.

Method: Qualitative analysis. Semi-directed face to face interviews of 13 medecins working in palliative care networks. Analysis according grounded theory method. Rational sample method has been used. Number of interviews setted by data saturation method. Medecins have been invited, with listed open questions, to share their experiences and feelings about PRN implementations.

Results: Highligted obstacles to implementation of PRN are the following : Personal temporality of the patient versus illness itself and his ability to hear about aggravation. Difficulties to medecins to the palliative announcement, their overload and lack of experience and trainning in palliative cares, desir and skills of family physician to manage urgency, ability of the relatives to medicine administration in case of emmergency and inability of the family physician to set up and prescribe PRN's.

Conclusions: There are many obstacles to pro re nata medication (PRN) implementation : Human obstacles linked to patient or home palliative care actors. As well as logistic , deontologic or legal obstacles. For some of them, solutions seem to be obvious and easy to implement, for some others, deep interogation and group works with all home palliative cares actors and health authorities are necessary.

Points for discussion:

How can contextual factors be operationalized in a RCT for people with chronic problems?

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Id 65
Background: Research suggest that contextual factors might be an important factor for the effectiveness of an intervention. Therefore the coordination and context of care must be taken into consideration when evaluating the effectiveness of an intervention.
Research question: How can contextual factors be operationalized in a RCT for people with chronic problems?
Method: This is an explorative research: literature was investigated, experts were contacted and public data were explored in three municipalities under scope, that will participate in a trial which aims to detect and support frail, community dwelling elder persons.
Results: Contextual factors were defined in three clusters: socio-demographic/socio-economic parameters, supply of local services and care coordination. For socio-demographic/socio-economic parameters two public datasets were available (IMA and local statistics). A first selection of relevant data was made by two researchers and a list of indicators was made. A group of experts evaluated this list (preliminary data will be presented). The supply of local services was inventoried, a public dataset was used (the social map). Afterwards a list of relevant services was made and controlled by the dispatchers. A third cluster contains the level of coordination. These data will be collected by a questionnaire, filled in by the dispatchers. This questionnaire is based on a theoretical framework of care coordination. The data will be validated through a focus interview with the dispatchers. In the last step a group of experts will be asked to identify the indicators that are likely to have an impact on the effectiveness of the intervention.
Conclusions: Even though the contextual factors might have an influence the outcome of an intervention, no standard procedure exists to operationalize the context of an intervention. Public databases can be used to describe socio-demographic/socio-economic factors and the supply of local services.

Points for discussion:
We would like to discuss with the audience the method/approach of the operationalization of contextual factors in a RCT.

Monofilament testing for detection of lost sensation of feet in diabetic neuropathy and its correlation to foot ulcerations

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Id 100
Background: Diabetic neuropathy is among most frequent and severe diabetic complications that can lead to foot ulcerations and amputations. Lost feet sensation is a risk factor for diabetic foot, although patients could not have any complains.
Research question: Is the lost sensation in diabetic feet, detected by 10g monofilament, a common condition in diabetic patients and is it related to presence of foot ulcerations and / or amputations.
Method: Michigan Neuropathy Screening Instrument with its two parts was used for each diabetic patient, included in the study. Questionnaires were translated into Bulgarian language and spread in a pilot doctors and patients groups. The patient part was filled by diabetic patient and summarizes its anamnesis and clinical complains. Doctor`s part was completed by doctors. It included sensory testing (touch sensation via10g monofilament and vibration perception via Rydel Seiffer tuning fork), ankle reflex testing, foot-appearance and presence of foot ulcerations.
Results: Results, represented here, are preliminary, part of ongoing PhD study on long term care for diabetic patients in general practice. 485 doctors (GPs, endocrinologists and neurologists) and 8638 diabetic patients were enrolled. Two parts of questionnaire were performed for each patient. Most of all questionnaires are fully completed and suitable for statistics. The study was made from September to Decemper 2016. Doctors and patients were from all regions of Bulgaria. Average 10 to15 minutes were needed for fulfillment of doctor`s part of questionnaire and 5 to 7 minutes for patient`s part.
Conclusions: Michigan Neuropathy Screening Instrument is easy to use and perform in everyday general practice. It is fast, cheap and reliable for detection of diabetic neuropathy in both specialized healthcare and primary care setting and could be suitable for monitoring too. It can be used as a predictive tool for future development of diabetic foot ulcerations as well

Points for discussion:
1. Do GPs screen diabetic patients for diabetic complications and how often?
2. Have you some experience with monofilament testing in general practice?
3. Are GPs motivated to perform this screening?

PRESENTATION 25: Saturday 13th May, 2017   SPECIAL METHODOLOGY SESSION
                         10.00–10.30 h.   Ongoing study with preliminary results

Patient enablement in GP practice in Latvia

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Id 119
Background: Primary health care (PHC) system plays a crucial role in disease prevention and helps patients understand and manage their disease. Lately there has been increasing interest in the patient's perspective and holism which belongs to the core values of general practice and patient enablement. Enablement is defined as an intervention by which the health care provider recognizes, promotes and enhances a patient's ability to manage their own health.
Research question: Patient enablement in GP practices in Latvia and is there associations between enablement and patient, consultation related parameters?
Method: Quantitative research method was used by implementing questionnaire - The Patient Enablement Instrument with additional questions about person's health, reasons for visiting the doctor and consultation feedback. Questionnaire showed high internal consistency (Cronbach's alpha 0.91). Distribution of questionnaires in GP practices of Latvia was organized according to the recommendations - at least 50 questionnaires per GP practice. Together 1116 questionnaires were collected.
Results: Participants were 18 - 95 years old (mean - 48,4). 68,4 % were females and 31,6 % males. Mean length of a GP consultation was 15, 9 minutes (min.: 1 min/ max.: 75 min). The average enablement score (PEI) was - 5,5. It was found that 41,6% of patients, who visited GP, suffer from a chronical physical health problem and their PEI is - 6,1. The longest consultation length (17,5 and 17,0 minutes) have patients with sexual health and family planning problems, PEI for these groups was 5,0 and 6,3.
Conclusions: In comparison to UK (PEI - 3,1) and Poland (PEI - 3,6) studies, GP consultations in Latvia have a higher PEI - 5,5, however PEI score found in Croatia was 6,6. The different PEI scores between the countries could be explained by probable cultural differences. These are only preliminary results, there is a need for further research in this area.

Points for discussion:

How acceptable is the Gut Feelings Questionnaire in daily GP practice: a feasibility study in four European countries

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Id 16

Background: The Gut Feelings Questionnaire (GFQ) is a ten items questionnaire based on consensus statements defining the sense of alarm and the sense of reassurance. The purpose of the GFQ is to determine the presence or absence of gut feelings in diagnostic reasoning of general practitioners (GPs). All seven items concerning gut feelings were validated, the other three concern the diagnostic work-up. The Dutch GFQ has been translated into English, French, Polish and German applying a linguistic validation procedure. The practicability of the GFQ has never been tested in real practice setting by GPs during office hours.
Research question: The aim was to test the GFQ in real practice setting and if any changes were needed to retest the adapted version.
Method: In the first phase, we performed a think aloud study with 48 Dutch GPs, GP-trainees and clerks filling in GFQs after reading six case vignettes, and a thematic content analysis of the verbatim. We then performed a feasibility study using a mixed methods approach with 42 French and Dutch GPs filling in the GFQ after each of eight consultations of patients with new complaints, and being interviewed about the use of the GFQ afterwards. In the second phase, after a linguistic validation procedure, we repeated the feasibility study using the adapted GFQ, with 40 French, Belgian, German and Dutch GPs.
Results: The first phase led to a small modification concerning the order of items, and to some adaptations of items' wording. A consensual version of the GFQ was defined while not altering the validated seven items.
Conclusions: The GPs participating in the second phase of the study concluded that the adapted GFQ was easy to use in daily practice. The final results comparing the data from four countries will be presented at the conference.

Points for discussion:
1. Do you have any specific experiences regarding a feasibility study? With adapting a questionnaire in General Practice?
2. The GFQ is validated and feasible now. Do you see any possibilities to use the questionnaire in your own research?

Gut feelings of patients: do they influence their general practitioner's diagnostic reasoning?

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Id 25
Background: General Practitioners (GPs) recognize two kinds of gut feelings (GF) in their diagnostic reasoning: a sense of alarm and a sense of reassurance. GF arise from the interaction between a GP's knowledge and experience, and information about the patient, and can be measured by a validated questionnaire. But what about the GF of patients? Research suggests that patients' GF also matter in predicting serious health problems and in diagnostic reasoning of their physicians. The feeling of parents that there is something wrong with their child appeared to be a strong predictor of a serious disease. However, an instrument assessing patients'GF is lacking. Therefore, we aim to compose and validate a GF questionnaire for patients. We made a first step by exploring the experience of GPs and practice-nurses with their patients' GF.
Research question: What phrases and expressions do patients use in their communication when they experience a GF? What is the significance of patients' GF for GPs and practice-nurses? What kind of action do they take after acknowledging a patient' GF?
Method: We interviewed GPs (N=12), practice-nurses (N=16) and practice-secretaries (N=5) in single and in group practices in the Netherlands and Belgium. A thematic content analysis of the verbatim text was performed.
Results: We found that the participants recognized patients' GF. We collected many different wordings and expressions used by patients to express their GF. We found some indications that a patient's GF influences a GP's decision-making process. Participants took their patients' GF often seriously, particularly when expressed by a parent or care provider about their child.
Conclusions: Because of their knowledge and experience, the GF concept of GPs seems to be richer than the patients' GF concept but not fundamentally different. Now we can carry on with interviewing individual patients about their GF.

Points for discussion:
1. In our results, we found slight indications for differences between the Netherlands and Belgium. Do GPs from other countries have information about their patients' GF and how do they deal with it?
2. In the end of our study, we hope to compose a

Hungarian family physicians' and residents' knowledge of and attitude towards OSAS (obstructive sleep apnoea syndrome).. Do they screen sleep apnoea during the general medical checkup for the driving licence?

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Id 118
Background: Obstructive sleep apnoea syndrome (OSAS) without treatment can cause serious cardiovascular, cardiorespiratory, neurological and other complications. Family physicians have an important role in recognizing the disease.
Research question: The aim of the study is to assess the knowledge and attitude of family physicians related to sleep apnoea. Whether OSAS screening is realized during the general medical checkup for drivers.
Method: In the cross-sectional study we used a validated OSAKA questionnaire in mandatory continuous medical education courses, supplemented with four additional questions.
Results: 116 family physicians and 103 family medicine residents filled out the questionnaire. Hungarian family physicians, especially male doctors lack the adequate knowledge of sleep apnoea. The average score of female physicians was significantly higher than that of males (13.4 ± 1.8 vs. 11.7 ± 2.6, p = 0.005). The more sprecializations the doctor has, the higher the score (p = 0.05). Residents' average score was 12.1 ± 2.4 points, which is higher than that of family doctors (p = 0.012). Female residents also had higher average points than male residents (12.6 ± 2.0 vs. 11.3 ± 2.7; p = 0.008). We found correlation between gender and medical knowledge, but there was no correlation between age, number of specialities, body mass index and the theoretical knowledge of the doctors. In terms of attitude female GPs had higher average scores than male GPs (3.5 ± 0.6 vs. 2.9 ± 0.6, p <0.001). Despite the modification of the 13/1992 regulation only 39% of the practices carried out regularly the required OSAS screening as part of the medical examination for a driving licence.
Conclusions: Despite the high prevalence and clinical importance of OSAS, GPs often do not recognize sleep apnoea and they have difficulty in treating their patients for this problem.

Points for discussion:
1. What kind of questionnaire we should use to screen OSAS?
2. Which patient we should screen for OSAS?
3. How can we improve the OSAS screening rate?

Common practice: out-of-pocket prescriptions for benzodiazepine and Z-drugs. But why?

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Id 34

Background: Medication addiction has become a chronic problem and therefore benzodiazepines and Z-drugs should only be used short term. It is estimated that in Germany 50% of these drugs are written as out-of-pocket prescriptions mainly by General Practitioners (GPs). This enables patients to buy the medication but no claim is forwarded to the insurance. Therefore, patients carry the entire costs and it is almost impossible to include the dispensed amount in any kind of statistic. It is unclear why GPs choose this method since all indicated medications could be written as regular prescriptions and should be covered by the insurance. And without an indication no prescription should be issued.

Research question: Why do PCPs choose out-of-pocket prescriptions for benzodiazepine and Z-drugs? What aspects influence the decision?

Method: In this qualitative study semi-structured interviews were conducted with 7 female and 8 male GPs so far. The interviews were audiotaped, transcribed and analyzed with Grounded Theory. In addition the discussion of a quality circle about the topic was taped and analyzed.

Results: The preliminary results show that some GPs understand out-of-pocket prescriptions as a tool to minimize the patientÂ´s drug intake by creating a barrier through the financial burden. It also assigns the responsibility for the consumption and possible addiction to the patient addressing the doctor´s ambivalence between helping and fulfilling the patient´s wish/needs and avoiding the drug and responsibility. Other physicians were unclear about the current guidelines and therefore opted to give out an out-of-pocket-prescription - mainly because they feared the insurance companies would penalize them.

Conclusions: Current guidelines need to be simplified and readily available. Future studies should focus on the patients´ view of out-of-pocket prescriptions since financial costs may not increase the value of the medication but actually lessen it by putting hypnotics in one class with over-the-counter medications.

Points for discussion:
1. The overuse and resulting addiction of Benzodiazepines and Z-drugs is an international problem. How do physicians outside the German health care system handle the problem?
2. What adds more value to the medication: financial costs or a doctor´s

PRESENTATION 30: Saturday 13th May, 2017   **ONE SLIDE/FIVE MINUTES**
                11.10–11.20 h.   **Research in progress, without Results**

PAPRICA study (Problematic use and Addiction in Primary Care) - Evaluation of poly-dependency screening test in primary care setting - a systematic review

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Id 32
Background: Addictive behavior with or without drugs is still a major health concern. This phenomena growing over the years. An efficient screening in primary care settings is encouraged but the lack of a screening approach that fits easily into clinical workflows has restricted its broad implementation. A valid and feasible tool to improve a wide screening in busy primary health care need to be developed.
Research question: Examine poly-dependency screening tests in primary care setting.
Method: A systematic review of the literature was performed through the following sources from inception to the 31th of December 2016 : Pubmed, PsycINFO and The Cochrane Library. We follow three items: screening, dependence and primary care. Selection criteria were: studies that examined the diagnostic accuracy of test to identify two or more dependence in primary care settings, or that examined their feasibility. We restricted the results to "Journal Article".
Results: 1409 papers were selected, 42 studies were included. The comparability of the studies was limited by inaccuracies bias in method, heterogeneity of the population and settings. 11 questionnaires were validated in primary care to screen polydependence. The ASSIST was the only validated test to screen drug use and related problems, and developed in many countries. The length of the ASSIST (80 questions) may preclude its use in settings where brevity is critical. Shorter screening questionnaires were validated but they only focus on quantification and thier psychometrics properties were less performant. No screening test for dependence with and without substance was validated in primary care.
Conclusions: Some tests to screen polydependence are available, but their use in primary care is limited. A brief assessment of addictive vulnerability is preferable as many test about different substances use disorders. A transversal tool, adapted to primary car constraints, screening dependence with and without substance is obviously required.

Points for discussion:
1. perspectives = qualitative study to explore practice of screening?
2. Which questionnaires are use in primary care?

Prevalence, diagnostic value and factors related with gut feelings of GPs in the diagnosis of severe disease and cancer: protocol of study

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Id 97
We present a protocol of study. Our aim is to get advices and opinions from the participants.
Objectives: To know prevalence of GF in GP consultations and its relation with patient characteristics (sociodemographic and clinical) and professional (gender, experience, personality and knowledge of the patient). To assess the validity of gut feelings (sense of alarm and sense of reassurance) to predict severe disease and cancer in GP consultations. 3) To estimate the relationship of gut feelings (sense of alarm) with testing and referrals to specialist consultations.
Methods: Prospective observational study of diagnostic validity. Sample size:2951 patients attending consultation. Variables: Patient (sociodemographic data, type of visit, date, time), professional (age, sex, training, environment, years of experience, Rational-Experiential Inventory, knew the patient?), consultation (GFQ, cancer related symptoms). Tracking variables 6 months: incident diagnosis of serious disease and cancer, testing, referrals, number of visits.
Analysis: Objective 1: descriptive analysis of the variables and prevalence of both GFs. OR calculation and logistic regression with the main variables. Replicate multivariate subgroup analysis will be evaluated, possible interactions and application of random effects, considering a multilevel model. Objective 2: sensitivity, specificity, PPV and NPV, accuracy, LR + and LR- of the senses of alarm and reassurance. Objective 3: bivariate analysis of main variables of diagnostic test and referral, exploring relation to the sense of alarm and reassurance. Multivariate logistic regression analysis. (Poster or 5 minute presentation?)

Points for discussion:

PRESENTATION 32:   Saturday 13th May, 2017   ONE SLIDE/FIVE MINUTES
**   11.30–11.40 h.   Research in progress, without Results**

The effect of the breast cancer on control of diabetes

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Id 44
Background: Type 2 diabetes (DM) is a serious health problem that affects more than 7% of adults in developed countries. Comorbidity with DM was reported in 16% of women with breast cancer. Diabetes and its complications can negatively affect the treatment of cancer such as radiation, and thus affect the outcome of treatment. Researchers have suggested explanations to co-occurrence of both diseases by hormonal mechanism, related to activity of insulin to stimulate growth factors or to intervene in sex hormone balance. In contrast with wide research focusing on the reason for the comorbidity of DM and breast cancer, not much was published on the clinical management of patients at that special situation.
Research question: How does diagnosis of breast cancer influence on morbidity of DM?
Methods: A descriptive study following prospectively after patients with DM who were diagnosed as having breast cancer, compared to the period before the disease.
The data will be retrieved from the central data of Clalit Health Services: -Demographics; -DM morbidity: Control of the disease, complications; -Breast cancer: Provided treatments.
The data of control of DM during the year since the diagnosis of breast cancer will be compared to her data from the year before. Other morbidity data: use of health services: visits to the practice, hospitalization.
Meaning.This study is will bring information that would help family physicians and oncologists To plan a comprehensive care for the patients with diabetes and breast cancer.

Points for discussion:
1. Comorbidity.
2. Diabetes morbidity.

Measuring the patient activation in HIV-infected patients: A tool to predict health outcomes and optimize care. A study protocol

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Id 50
Background: Greater involvement of patients in taking care of their health is seen as one of the elements to improve the management of chronic conditions. The face of the HIV has shifted to a chronic affection due to antiretroviral treatment (ART). Thus, according to the Chronic Care Model, activated patients are essentials to achieve optimal health outcomes. Patient activation, defined as the knowledge, the skill and the willingness of people to play a role in managing their health, has been associated with a broad range of health-related outcomes, including better clinical indicators and self-management, fewer hospitalizations, and lower health care costs. We aim to use the patient activation measure (PAM) as a tool to optimize the management of HIV-infected patients by level of activation.
Research question: Is the PAM level associated to current and future HIV health outcomes? How could we use it to optimize the care, particularly by defining the role of general practioners and patients?
Method: The data set of an HIV care center will be analyzed. First, a cross-sectional study will identify socio-demographic profiles depending on level of PAM and will determine correlations with current health outcomes. Then a two years longitudinal cohort study will analyze the usefulness of PAM in predicting future results. Four types of data will be collected: general data (socio-demographic data, number of chronic diseases, sexual orientation, time of follow-up), PAM data (patient's level of PAM and PAM level assessed by the doctor), data about patient's support and health care utilization (Belgian health interview survey and SSQ6), and clinical outcomes (viral load, CD4 count, side effects, opportunistic infections, preventive screening). Associations between patient characteristics and patient activation will be tested using multivariate analysis. Finally, a Delphi will be organized to collect the opinion of a panel of experts on optimized care.

Points for discussion:

Integration of nurses in general practice: a qualitative, exploratory study from the perspective of patients with chronic disease

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Id 48
Background: Demographic, social and policy evolutions place overwhelming demands on general practitioners. Task shift in primary health care led to interdisciplinary collaboration supported by the integration of nursing skills and competences in general practice. In Belgium, with a tradition of single-handed practices, this current transition requires careful consideration of the patient as key stakeholder.
Research question: The aim of this study was to explore chronically ill patients' perceptions about the shift to an interdisciplinary approach in general practice and to understand to which extent a partnership between a practice nurse and the general practitioner could meet their complex needs.
Method: Using a qualitative, exploratory methodology data were collected through individual, in-depth semi-structured interviews with 13 type 2 diabetes patients in four general practices and one community health center. All participating settings had different practice nurse integration levels. Interview data were analyzed using a descriptive, thematic analysis.
Results: Patients rather need understandable tailored than standardized information and education to get more involved in their health care and being able to take their own decisions. All respondents emphasize the importance of the trust-based relationship with their general practitioner. Developing a professional relationship with the practice nurse can strengthen this central bond and facilitate the affective aspects of care, crucial for chronic patients. The potential benefit of an interdisciplinary care team requires complementary expertise of all caregivers involved. However, because the role of the practice nurse is yet to be defined, their tasks and responsibilities often lack transparency to patients.
Conclusions: Patients with chronic disease have specific expectations, insufficiently fulfilled in our current primary care settings. This study revealed future prospects to offer goal-oriented and patient-centered care with opportunities for differentiation of complex tasks within interprofessional collaboration and accurate integration of clinical and organizational nursing skills and competences in the general practice.

Points for discussion:
1. Used methodology: a.Critical reflection on overall quality of this study and recommendations for future qualitative research.
2. Findings: a.Exchange of experiences related to partnership between practice nurse and general practitioner in different

Establish a Questionnaire to evaluate multidisciplinary primary care from the patient's point of view

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Id 106
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 will be to establish a questionnaire assessing multisisciplinary primary care by patients adapted to the French context.
Method: Identify and analyze within several primary health care structures, the effects of the coordination between professionals on the transformations of the modes of exercise and on the experience of the patients / family caregivers, particularly on the dimensions that constitute the quality of care.Then, construct a scale of assessment of coordinated primary care practice structures based on criteria suggested by patients / family caregivers.Finally, check the stability of the scale by a quantitative study evaluating its internal validity by using a Cronbach alpha. check the effectiveness of the scale against the overall feel of users and professionals through a quantitative correlation study.
Results: in progress.The analysis of these two monographs will allow the construction of a scale of evaluation of the quality of multidisciplinary primary care that will be tested and validated in the second part of the project.
Conclusions: The hypothesis is that the scale achieved is stable and correlated with the overall perceived quality of care.

Points for discussion:
1. How to choose patients to produce monographs?
2. What psychometric properties are important to estimate?
3. How to assess external validity? Correlation with the overall perceived quality of care: is it a good idea?

Home-Based Screening for Early Detection of Atrial Fibrillation in Primary Care - the SCREEN-AF Trial

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Id 86
Background: Stroke is one of the most feared diseases and among the leading causes of death. One promising prevention strategy is the early detection of atrial fibrillation (AF). SCREEN-AF is an ongoing Canadian RCT funded by the Canadian Stroke Prevention Intervention Network (sponsor: Hamilton Health Sciences, Population Health Research Institute) which shall be supplemented by German study centres.
Research question: To investigate if home-based, prolonged monitoring for AF with an ECG patch monitor is superior to standard care.
Method: Overall, 822 patients aged $\geq$75 years with hypertension without known AF shall be included. In Canada, participating general practices did all study related procedures on their own and recruited consulting patients. In Germany, we plan to proceed differently: Mobile study nurses will support 45 practices on site. Eligible patients will be identified in the practice information systems and invited. Respondents will get an appointment for the baseline visit in the practice of his/her GP. The intervention group receives AF screening with a 2-week ambulatory ECG patch monitor at baseline and again at 3 months, as well as a home blood pressure monitor with automatic AF detection capability to be used twice daily for 2 weeks during the monitoring periods. If informed consent for this additional procedure is granted, a blood sample will be collected for biobanking purposes in both groups (DZHK standard). Follow-up will be at 6 months after randomization for the primary endpoint newly diagnosed AF. Secondary endpoints include oral anticoagulant therapy, patient adherence, satisfaction, and tolerability of/with the ECG patch, and incidence of AF, stroke or systemic embolism within 3 years.
Results: Not yet available.
Conclusions: Not yet available.

Points for discussion:
1. Feasibility and relevance of AF screening and biobank sample collection in European GP patients

Senior dancing - socializing tool against vascular dementia

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Id 58
Background: As population gets older, the importance of active and wholesome senior generation raises. Keeping mind and body fit plays the key role in reaching this goal. Dance movement therapy provides both and has proven its effectiveness in slowing down progression of Alcheimer's disease.
Research question: Does dance movement therapy delays development of vascular dementia in aterosclerotic senior patients? What are the main differences in health habits, complaints, social aspects before and after dance movement therapy?
Method: 20 - 30 senior individuals (at age $\geq$ 65) with previously proven atherosclerosis will be examinated using Mini-Mental State Examination, Dementia Quality of Life instrument (DEMQOL) and interviewed about their health, complaints and medication use. Excluding criteria are: severe musculosceletal pathology; already existing dementia; severe neurological condition. Then the dance movement therapy will be started with intensity 2 lessons per week. Every 6-12 months of therapy participants will be evaluated using the same instruments and questions. Outer appearance will be assessed, too.
Results: We expect an improvement or at least constant results in all of performed questions and instruments. Continuous therapy could benefit in biopsychosocial dimensions of health.
Conclusions: Results will explore improvement in self assessment of general health. Senior dancing could prove to be an important part of active ageing program and hopefully will help to fight vascular dementia.

Points for discussion:
1. Should we create a control group of aterosclerotic senior patients who don't participate the dance movement therapy?
2. The progression of dementia is slow, how much time it would take to evaluate the best results?
3. Which pharmacological therapy

Measuring innovation: Real-world approach to falls prevention in elderly (EIP-AHA)

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Id 67
Background: City of Zagreb was recently awarded status of a Reference Site of the European Innovation Partnership on Active and Healthy Ageing (EIP-AHA). EIP-AHA gathers stakeholders from the public and private sector across different policy areas. Together they work on shared interests, activities and projects to find innovative solutions that meet the needs of ageing population. In EU a yearly average of 35848 older adults (>65) were reported to have died from falls (2010-2012.) With over 900 reported fatal falls yearly (>65), Croatia has one of the worst falls incidence rates in the EU.
Research question: To assess the needs and requirements of the ageing population of Zagreb in area of falls prevention. To assess causes and environmental conditions resulting in falls in elderly population in the City of Zagreb and to implement innovative action for prevention. Proposed methodology: Sample: each elderly patient who fall through one year period in the City of Zagreb Reference Site. Data about causes and environmental conditions resulting in falls in elderly will be collected in EMR using innovative service by GP, nurse, field nurse, patient or caregiver. Data analyses wll be used to plan real world intervention (innovative action) with different stakeholders. A framework will be developed for planning, reporting and measuring progress and evaluating the outcomes of innovative action implementation. A protocol and multimodal prevention program will be developed for falls prevention.

Points for discussion:
1. Which data is needed to comprehensively assess the cause of falls – questionnaire.
2. Methods for data analysis to identify potential areas for intervention.
3. Methods to develop protocol for real-world intervention with relevant stakeholders. Potential pit

Validity and Reliability of the Turkish Quality of Life Questionnaire for Advanced Cancer Home Care Patients (Turk- QLQ-C15-PAL)

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Id 120

Background: European Organization for Research and Treatment of Cancer (EORTC) Quality-of-Life Questionnaire Core 15 Palliative Care (QLQ-C15-PAL) is specifically applied to evaluating palliative care patients' quality of life. In this study our aim was to examine the validity and reliability of the Turkish version of QLQ-C15-PAL for the palliative care patients with advanced cancer.

Research question: Is Turk- QLQ-C15-PAL a reliable and valid tool for advanced cancer home care patients?

Method: This methodological study is completed with a population of 147 Medical Oncology outpatient clinic patients of Marmara University Pendik Research and Training Hospital who are referred to Home Care Unit. The test-retest was performed to 16 of the patients in a 10-14 days interval. QLQ-C15-PAL consists of 14 questions about physical functions, emotional function and symptoms with a Likert scale of 4: 'not at all', 'a little', 'quite a bit', 'very much'. The last one is a general quality of life question with a visual scale from 1 (very poor) to 7 (excellent). The questions about the sociodemographic characteristics and daily activities of life were performed face to face by the researcher.

Results: The test-retest total scores were evaluated with Wilcoxon test ($p > 0,05$). Cronbach-$\alpha = 0,88$ demonstrates the internal consistency of the questionnaire. Other than nausea, Pearson coefficient of the symptoms correlated with each other significantly in a range of low ($r = 0,18$) to high degree ($r = 0,67$). Confirmatory factor analysis was computed with Keiser-Meyer Olkin and Barlett test and Turk- QLQ-C15-PAL was found to have 4 subgroups and the internal consistency of these subgroups varied between $r = 0,49$-$0,89$. The quality of life scores were higher with still working and independent patients in daily life activities ($p < 0,05$) than the retired and dependent ones.

Conclusions: The Turkish version of EORTC-QLQ-C15-PAL is a valid and reliable instrument to evaluate the quality of lives of Turkish palliative care cancer patients.

Points for discussion:
1. What are the limitations of the study?
2. Does the interpretation of the results mean that cancer patients need palliative care before the terminal stage?
3. Is this an appropriate study population?

Impact of intervention on the number of cervical cancer screens â€" a randomized controlled pilot study

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Id 72
Background: Despite the relative ease of prevention, cervical cancer remains a global women's health issue responsible for more than 270 000 deaths annually. Mortality rate in Latvia (8.2/100 000) is one of the highest among EU countries. Increasing the uptake of screening is a way of controlling this disease through early diagnosis. Latvian cervical cancer screening coverage rate in 2014 and 2016 were 27.8% and 32.4%, with the lowest rates in Riga region. The minimum quality criterion for cervical cancer screening coverage to be fulfilled by GPs in Latvia is 36%.
Research question: To assess the effectiveness of telephone intervention as a strategy to increase the uptake of Pap smears in the framework of the national cervical cancer screening program.
Method: We conducted a prospective randomized controlled pilot study, which included 160 randomly selected women registered in two GP practices - one in Riga and one outside Riga. Cervical cancer screening non-participants were divided into control and intervention groups. Depending on the group, participants were invited to respond to the questionnaire at the start of the study or after 4 months. The intervention aimed to raise awareness of benefits of cytological screening and encourage women to reduce personal risk of developing cervical cancer. Statistical significance between group differences was assessed by Fisher test.
Results: We found that women randomized in both GP practices in intervention group performed cervical cancer screening more often than women who didn't participate in the telephone survey (30.6% (n=15) vs 7.4% (n=4), p=0.004, in a family practice in Riga and 32.1% (n=17) vs 5.9% (n=3), p=0.001, in a family practice outside Riga).
Conclusions: Telephone intervention improves compliance to cervical cancer screening program, but still within 4 months after intervention doesn't reach the minimum screening coverage rates indicated in Latvian GP quality evaluation criteria.

Points for discussion:
1. Latvian cervical cancer screening rates should increase.
2. Telephone intervention is cost-effective.

What attitudes do medical students have towards cancer-screening?

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Id 110
Background: General Practice is a cornerstone of preventive medicine. However, recent studies found pre-screening discussions to be insufficient. As a starting point for educational interventions, we assessed medical student's attitudes toward screening.
Method: We conducted a mixed-method-study. First, we aimed at exploring medical students attitudes toward cancer screening. Thus, we used a qualitative approach with guided interviews. We started with a deductive coding tree, augmented codings with emerging themes and finally compared them cross-case. To gain representative information, we then conducted a Questionnaire study in different semesters. Besides previous screening experiences, we assessed attitudes towards various screening-tests.
Results: We conducted 14 face to face interviews. Overall, attitudes toward cancer screening were positive. Students differentiated between affective and structural attitudes. While structural attitudes constitute of objective information (mortality), affective attitudes comprise emotions (fear of cancer). Although affective information seem to dominate student's views, this has scarcely been discussed during their courses. Data collection of the Questionnaire will be completed until the conference. Currently we have a response rate of 75% and 200 full data sets. Yet, we see an overall positive attitude toward screening tests. However, comparing early to later semesters, some screening tests are rated more negative. This was the case for controversial tests (PSA, ovarian cancer) as well as for established tests. Only attitudes about skin cancer screening and pap-smear remained equally positive.
Conclusions: We combined a qualitative with a quantitative approach to triangulate information on student's attitudes about screening. As expected, controversial screening-tests were rated more negative in older semesters. However, this was also the case for tests in national screening programs. The findings suggest a lack of knowledge about screening benefits and harms. One educational approach basing on our qualitative study could be to include affective attitudes into education to start from student's point of view.

Points for discussion:

Patients' compliance to fecal occult blood test in Latvia.

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Id 49
Background: The compliance to fecal occult blood test (FOBT) in Latvia is 10.9%. Despite the evidence based benefits, some negative psycho emotional effects of screening methods have been recognized. Therefore patients' acquirement and risks need to be assessed before examinations that are done to improve the health of the population.
Research question: To study the reasons for patients' co-operation or unwillingness to perform the test.
Method: A qualitative research, individual interviews were used to obtain the data. In total 30 respondents were randomly selected. Patients who did agree to complete the test were repeatedly interviewed.Results: During the first interview, 14 persons (47%) agreed to be interviewed, however refused to do the FOBT. Reasons for the rejection were 'lack of time', 'inadequate lifestyle', 'unwillingness to see the doctor without complaints' and 'uselessness' of the test. Out of 30 interviewed patients, 16 (53%) agreed to do the FOBT. After 3 weeks only 4 participants (13% of the studied group) did perform the test and responded that their motivation was interest about their health and confidence to their general practitioner. Those 12 out of 16, who agreed, but did not perform the test informed that the reason for non-compliance were 'lack of time' (n=11) and contraindications (n=1). Out of 30 selected individuals 47% (n=14) were women, 53% (n=16) - men; 77% were employed and 23% were retired; 56% of respondents wished to get FOBT by mail and 44% - at clinic.
Conclusions: The main reason for not performing the FOBT in the studied group was â€œlack of timeâ€? in both individuals willing and unwilling to perform the FOBT. Reasons for co-operation are interest about their health and confidence to their general practitioner. In â€œhealthyâ€? people time factor seems to be prior to understanding the necessity of the cancer screening.

Points for discussion:
Unwillingness to check for medical assistance and faithlessness to the test could be changed offering people qualitative information about the colon cancer and its screening methods.

Prescription-Indication study of Fentanyl transdermal patches at Primary healthcare

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Id 112
Background: 19% of european population suffers chronic non-oncological pain, the majority of whom is attended at Primary healthcare. Aging, chronic diseases and nonsteroidal anti-inflammatory drugs's contraindications limit the analgesic options for these patients. Fentanyl in transdermal patches, an opioid alternative, has increased its consumption by 92.1% since its comercialization in 2002. The controversy that has been generated in the media after the death of the singer Prince may lead to demonization of this opioid. The aim of this project is to study its prescription characteristics (indications, adequation and security) in the real clinical practice conditions of Primary healthcare.
Research question: The main objective of this project is to describe the use of Fentanyl in transdermal patches in patients with non-oncologic pain at Primary healthcare.The secundary objectives are to know the indications of Fentanyl; prescription characteristics; secundary effects; previous or concomitant analgesic treatments; contraindications of the previous analgesia that originate the prescription; and other situations that lead to the prescription of Fentanyl.
Method: Drugs study of Prescription-indication type (multicenter, descriptive, therapeutic audit without intervention and retrospective) that will be carried ou at 53 Primary healthcare Centers in Barcelona. Participants: adults patients attended at Primary healthcare with an active prescription of Fentanyl transdermal patches registered at our electronical clinical record at May 2016. Exlusion criteria: oncological pain related to Fentanyl prescription; patients residing at nursing homes. Systematic random sample of 347 patients. Variables related to Fentanyl's prescription and descriptive statistical analysis of them. Limitation: lack of prescription information registered on the clinical records. Results: study in progress.
Conclusions: study in progress. We cannot stablish any conclusion yet

Points for discussion:
To know the characteristics of the prescription of Fentanyl (main indication, prescribed regimen, side effects, characteristics of pain and its evolution, history of previous analgesia). To evaluate the existence of ladder or analgesic elevator in the pai

Iron deficiency and anemia in prophylactic examinations of 1 year old children

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Id 111
Background: Iron deficiency is the most common cause of anemia especially in higher risk groups: newborns, infants age 6-24 months old. Latvia is listed among the countries where anemia is average: 20-40%, children pre-school age.
Research question: What is the prevalence of anemia and iron deficiency in healthy 1 year old children? What are possible risk factors that could be taken into account in primary health care?
Method: A retrospective study of medical reports, 171 patients were included in a primary care practice in Riga. Children whose haemoglobin levels at age of 1 year were included and differences were compared with child's sex, birth week, antropometric measures, nourishing type and time additional nutrients were introduced. Indicators of iron deficiency and ferritin levels were assessed. Pearson Chi Square test was used to analyse differences. For determination of correlations, Spearman correlation test. Binary Logistic regression model was used to estimate predictive value of time introducing with addition food risk factors regarding anemia developing.
Results: In group 25% (n=45) had anemia and 75% (n=126): normal haemoglobin levels. Serum ferritin, iron reserves were low in 76,7% (n=31)of children with anemia, 21.3% (n=13) with normal haemoglobin level. We found that the later additional food was introduced, after 6th month of life the higher risk to develop anemia (Spearman' correlation coefficient -0.496 (p=0.01) Fisher test: 22.5 (p=0.01) OR=4.68; Binary logistic regression Exp(B) -5.868 (SD= -7.896/-3.772) (p=0.02)). We found a statistically significant between haemoglobin levels and gestation week at birth, infants born premature and those who were born on time(P=0.043). We found no statistically significant difference between sex, nourishing type and antropometric measurements.
Conclusions: There are risk factors which could lead to anemia and iron deficiency like being borne premature and later introduction of additional nourishment after 6 months of age. Serum ferrtine can possibly be used as a marker for primary prevention of iron deficiency.

Points for discussion:
Serum ferritine, anemia, iron deficiency in preschool age

Hybrid evaluation trial of a complex multi-risk intervention to promote healthy behaviours in people between 45 to 75 years attending Primary Health Care. EIRA3 study (Phase III)

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Id 105
Background: Primary health care (PHC) is the ideal setting to implement health promotion (HP) activities. We have been developing the different phases of a complex intervention, as recommended by the Medical Research Council, to develop health-promoting behaviours that improve quality of life and avoid most common chronic diseases. Phase 0: we identified the components of intervention, reviewed the literature in HP and the theoretical framework (15 reviews published). Phase I: we determined the components, their interrelation and the relationship to health outcomes. Qualitative studies were conducted with stakeholders. Phase II: an exploratory trial at 14 Primary Health Centres (PCC) was conducted. Nowadays, we are carrying out the Phase III.
Research question: Is this intervention cost-effective, feasible, appropriate and acceptable?
Objective: Evaluate the cost-effectiveness and the implementation of a complex multi-risk intervention to reduce tobacco consumption, poor adherence to Mediterranean diet and insufficient physical activity in people between 45 to 75 years attending PHC with at least two of this behaviours or risks.
Method: Hybrid cluster randomized controlled trial to evaluate implementation and effectiveness, using mixed methods. 3600 persons will be selected (1800 for each study group) assigned to 26 PCC from 7 Spanish regions. The randomization unit will be the PCC. From the previous results, intervention is based on Transtheoretical Model of Behaviour Change, 5 A's Behaviour Change Model and Motivational Interview. The intervention group will receive individual recommendations on their behaviour, group sessions in the PCC, social prescription and some Information and Communitation Technologies. The control group will receive usual care. The main outcome variable will be positive change in at least one of the three behaviours. Cost-effectiveness and implementation evaluation (adoption, acceptability, appropriateness, feasibility and fidelity) will be done.
Conclusions: A complex multi-risk intervention adapted to each PCC is evaluated to allow a long-term implementation (phase IV).

Points for discussion:

PRESENTATION 46:   **Saturday 13th May, 2017**   **POSTER**
                                    14.30–15.45 h.   **Ongoing study, no results yet**

Elucidating metabolic effects of smoking cessation

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Id 45
Background: Cigarette smoking is universally considered to be a negative health behavior with a wide range of deleterious effects. Therefore, cigarette-smoking cessation is a central theme in our work as GP's in trying to improve our patients' health. One of the known effects of stopping smoking is weight gain, as well as increases in blood glucose and decreases in lipid levels. However, there are additional unknown metabolic effects that cigarette cessation and the medicines used to facilitate cessation may have. Since 2010, Israel has promoted a national program for smoking cessation. In order to elucidate the implications of smoking cessation, we study the metabolic effects resulting from cigarette smoking cessation.
Research question: What are the short term metabolic effects of cigarette smoking cessation?
Method: The study we are performing has two arms. The first is a retrospective file review of 200 patients who had completed a smoking cessation program in the Meuhedet HMO in 2014, to analyze changes in blood glucose and lipid test results. We are examining results from the year preceding the smoking cessation program and from the year after the program and contacting the patients to verify smoking status. The second arm of the study is a prospective study of 100 consecutive patients enrolled in the HMO smoking cessation program. We are collecting data regarding BMI and waist circumference measurement, before, during, and after the smoking cessation program. We will then analyze the metabolic changes of these patients following smoking cessation.
Results: Data being collected.
Conclusions: Working Hypothesis: The metabolic effects resulting from cigarette smoking cessation are common and are not negligible. In addition to the known weight gain, the increase in fasting glucose levels may be long lasting and may increase the risk of developing Diabetes Mellitus.

Points for discussion:
1. Is there an ethical issue with research that may find negative effects associated with a positive lifestyle behavior change?
2. What can, and should GP's and other health professionals do about the negative metabolic effects of cigarette cessation.

Perception of illness at patients with hyperlipidemia

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Id 99
Background: Hyperlipidemia is a major risk factor for cardiovascular diseases and appropriate diagnosis and treatment of hyperlipidemia can reduce risk of cardiovascular disease. Primary and secondary prophylaxis of hyperlipidemia are due for patients where primary prophylaxis implies the medication done before any cardiovascular disease prevails while secondary in the presence of a manifest one.Illness perception is in short a self-regulatory process by which individuals respond to a perceived health threat. Continuous stimuli such as symptoms generate both cognitive and emotional representations of the illness or the health threat where the individual first forms the representation of the illness and next adoption of behaviours to cope with this.
Research question: What is the effect of medication used for primary or secondary prophylaxis of hyperlipidemia on the perception of health and what are the sociodemographic factors affecting it?
Method: This is an ongoing study where the patients had been started to be enrolled on November 2016 and will be closed at the end of January 2017. Brief Illness Perception Questionnaire (BIPQ) has been applied to 130 patients with hyperlipidemia so far who had applied to family medicine and cardiology out-patient clinics where medication is prescribed for both primary and secondary prophylactic purposes. A sociodemographic set of questions are also being given to patients.
Results: Despite the fact that preliminary results are being obtained, the final statistical results will be ready by the end of March 2017 including correlation tests among variables.
Conclusions: We plan to reach the conclusion of finding how prophylaxis affect the patients with hyperlipidemia, what the factors affecting their perception are and thus being able to state the regulatory methods to cope with this situation.

Points for discussion:
1. The concept of illness perception.
2. The factors affecting the illness perception of hyperlipidemic patients.
3. The affect of primary and secondary prophylaxis on patients' perception of the hyperlipidemia.

Modifiable risk factors of non-communicable diseases in Latvia and Sweden

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Id 52
Background: It is estimated that non-communicable diseases (NCD) accounts for 63% of the global mortality and resulted to that 14 million people died within a premature age, younger than 70 years old. The WHO global action plan is focused on a global decline of the contributing factors of NCD. Individual approach to risk reduction could be better to reduce the NCD prevalence and death from NCD.

Research question: The aim is to investigate the prevalence and difference of the individual modifiable NCD risk factors in Latvia and Sweden.

Method: This Pilot study included a collection of questionnaire data about NCD risk factors (smoking habit, physical activity and dietary patterns) from 50 voluntary patients from Sweden and 50- from Latvia. Systolic and diastolic blood pressure (SBP, DBP), pulse, body mass index (BMI) were taken for all patients. Data from the two countries were compared using SPSS program.

Results: Comparing patients' objective indicators between the two countries there were no statistically significant differences in patient age, SBP, DBP, and pulse, but Latvian median BMI was statistically significantly higher than Swedish (27.21 [24.2;29.7] and 24.1 [22.1;27.2]; p=0.002). There is no significant difference in smoking and physical activities between countries (p=0,085 and p=0,063). Analyzing dietary habits, we found that Latvians eat less vegetables and fruits and don't restrict sugar and fat intake (p=0.048; p=0.005, p=0.030). There was no difference between fiber intake and salt restriction (p>0.005).

Conclusions: Our pilot study showed difference between patient habits and dietary patterns in these countries. There are different ways to improve patient health in different countries. Further investigation is indicated to find out the main problems in each country to set more precise goals to reduce NCD risk according to national lifestyle habits.

Points for discussion:
Modifiable risk factors for non-communicable diseases- individual approach?

Improving cardiovascular disease (CVD) prevention and care in Europe and Sub-Saharan
Africa: an implementation project (SPICES)

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Id 121
Background: By the year 2030, non-communicable diseases will account for more than three-quarters of deaths worldwide. In Europe, cardiovascular diseases (CVDs) will be the leading causes of death. In low-income countries, CVDs will be responsible for more deaths than infectious diseases, maternal and perinatal conditions, and nutritional disorders combined. Easily implementable lifestyle behavior tools are needed to prevent this epidemic, and, for instance, to help people know their blood pressure. The SPICES (Scaling-up Packages of Interventions for Cardiovascular disease prevention in selected sites in Europe and Sub-Saharan Africa) project is a Horizon 2020 project financed by the European Commission. Successful cardiovascular prevention will also benefit cancer incidence.

The overall objective is to implement and evaluate a comprehensive cardiovascular disease (CVD) prevention and care program at the community level in five countries (Belgium, France, Uganda, UK, South Africa), to identify and compare barriers and facilitators for implementation across study contexts and to develop a learning community.

Methods: Several innovative strategies with scale-up potential can strengthen health systems to provide care for CVD and other non-communicable diseases (NCDs). These strategies include the HIV response model and the WHO's Innovative Care for Chronic Conditions (ICCC) framework. The SPICES project wants to draw lessons from those models. Also, models and theories from implementation science will be used. The project includes different work-packages focusing on scaling-upevidence based interventions targeting health promotion and prevention, risk profiling, management and care and self-management.

Expected results: The project started on 1 January 2017 and by May an overview of potential scale up interventions and an implementation and evaluation plan can be presented.

Points for discussion:

Does appropriate antihypertensive treatment alone affect the cardiovascular disease risk?

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Id 93
Background: The World Health Organization has a goal of decreasing cardiovascular diseases (CVD) by 25% by 2025. Arterial hypertension is one of the most important CVD risk factor. Current recommendations for prevention of CVD are based on targeting all individual risk factors. However GP patients are often not compliant to reduce all CVD risk factors at once. In Latvia General Practitioners use SCORE risk chart to determine the total 10 year cardiovascular fatal event risk.
Research question: The aim is to compare the total ten-year risk for developing a fatal CVD event using SCORE in patients with diagnosed and treated arterial hypertension.
Method: The study included 100 patients (50 males), between the ages of 40-75 years. Inclusion criteria were that each patient was diagnosed with arterial hypertension and currently receiving antihypertensive therapy. Exclusion criteria consisted of patients who had the diagnosis Diabetes Mellitus. The SCORE was calculated twice with The High risk chart, using blood pressure values before and after the use of antihypertensive therapy, total cholesterol level was determined before the therapy.
Results: The results of the scientific study showed a significant difference in systolic and diastolic blood pressure after the use of appropriate antihypertensive therapy (p<0.05) The total risk SCORE for developing a fatal CVD event was significantly higher before antihypertensive therapy (3 [1;6] before and 2 [1;3] after therapy, p<0,001).
Conclusions: This study showed that the efforts of targeting even one risk factor could reduce the total CVD fatal event risk. Appropriate antihypertensive therapy is very important for everybody in reducing CVD risk. General Practitioners have to try to achieve a target blood pressure, even if patient does not want to participate in the reduction of other CVD risk factors.

Points for discussion:
1. Is SCORE calculation useful in GP practice?

Determinants of heart failure decompensation in patients attended in primary care

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Id 47

Background: Most knowledge about the main causes of heart failure decompensation comes from hospital setting. Evidence coming from primary care is scarce.
Research question: To determine the distribution of determinants which contribute to cardiac decompensation in patients attended in primary care setting.
Method: HEFESTOS is a multinational collaborative cohort study aimed at knowing the main determinants related to a heart failure decompensation, attended in primary care setting, and those related to the prognosis of these patients at short term. In this abstract we are presenting a descriptive analysis of the most common determinants of decompensation.
Results: a total of 344 patients were included. Women represented 55.8% and mean age was 81.9 (8.4) years. Potential causative factors for decompensated heart failure were identified in 82.8 % of cases. More than one factor was identified in 36.9% of patients. Non-compliance with fluid or salt restriction was the most commonly identified factor, present in 32.6% of cases. Respiratory infection was found in 31.1%, and lack of adherence to the drug treatment was found in 24.4% of patients. Other factors related to decompensation were acute episode of a pre-existing atrial fibrillation (11.6 %), taking contraindicated drugs (9.1 %), worsening renal function (5.2%) , anemia (4.7%) , inadequate diuretic therapy (3.2%), coronary disease (3.2%) and others (2,4 %).
Conclusions: The more common factors related to the heart failure decompensation were non-adherence to the prescribed measures and respiratory infections. An adequate management of stable patients would prevent a high number of decompensations.

Points for discussion:
What can General practitioner do to prevent the decompensation of Heart Failure patients?

Organization of locum GPs in Europe

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Id 113
Background: The prevalence of burn-out in general practitioners (GP) ranges between 5 and 12%. One of the recommendations to prevent burn-out is to facilitate the temporary replacement of GPs by locum GPs, which seems to be difficult to organize. The aim of this project is to make an inventory of the organization of locum GPs in European countries.
Research question: How do various countries in Europe organize the replacement of GPs by locum GPs and what lessons can be learned?
Method: A qualitative inquiry in (up to now) 26 countries was done, using a semi structured email questionnaire, sent to key stakeholders covering 20 items regarding 5 different themes: the existence of locum GPs, the organization, the financial structure, quality control and available literature. If there were any uncertainties or additional info was needed, extra information was gathered by email. Using a thematic analysis, we looked for strengths, weaknesses, differences and similarities.
Results: Preliminary analysis shows that there is a lack of existence of replacement pools in Europe. In 20 of the 26 countries locum GPs do exist. In three countries locum GPs organized themselves as a professional group. Locum GPs are paid by the hour, a day-part or a monthly salary and in two countries per patient contact. In 5 countries the locum GPs do not have the same social rights as the other GPs. Nine countries have no monitoring of quality and only 13 countries mention that locum GPs have to fulfill the same criteria as the other GPs.
Conclusions: There is a large variety in the organization of locum GPs in Europe. The final results of this project will enable drafting a first set of recommendations for future innovations regarding the organization of locum GPs in Belgium and possibly other European countries.

Points for discussion:
The formulation of recommendations based upon this qualitative inquiry.The thresholds for the development of recommendations.The relevance of these recommendations for other European countries.

Evidence after five years of antitobaco law

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Id 40
Background: Impact of the anti-smoking law after five years.
Method: Scientific method, observational and cross-sectional direct study.Population analyzed: From 17906 inhabitants (8310 males and 9596 females), 1939 patients between 18 and 60 years old (1073 males and 866 females) are registered as smokers through F17 code in the informatics system of E-CAP. From this sampling, 500 surveys have been analyzed.
Results: The survey contains the following items: -Gender: 210 females (42%) / 290 males (58%). -Age: Mean 39.54, SD 11.19, Min-max 18-62. -Years of smoking: Mean 18.44, SD 10.25, range 1-48. -Number of cigarettes/day: Mean 14.65, SD 8.15, range 0-40. -Implementation of the law at their job: YES: 426 cases (85%) Exterior: 30 (6% of patients who work outdoor, driving…) No: 44 cases (9%). -Effectiveness of the law: YES 319 cases (63.8%). -Do the patients agree with the law? YES 393 (78.6%).-Has he or she quit smoking? No 489 (97.8%), Yes 11 (2.2%). -Has he or she considered stop smoking? No 432 (86.4%). -Had he or she considered stopped smoking before? Yes 334 (66.8%). -Has he or she reduced its consumption? Yes 201 (40.2%). -Which factor has most influence? Health 460 (92%), Cost 20 (4%), Independence 15 (3%), motivation 5 (1%).
Conclusions: Patients are generally in accordance with the law and smoke less since the entry into force of this regulation, but only a few patients have considered stop smoking specifically because of this law and almost nobody has stopped smoking because of the law. Patients consider the implementation of this law is effective and it is mostly well accomplished at their jobs.The main reason to quit smoking is health, and long-range and similar from one to another are cost and independence (freedom).

Points for discussion:

Acculturation effects in PLUS - program for learning and development in Swedish health care

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Id 125
Background: With a shortage of medical doctors, the functioning of the Swedish health care depends increasingly on recruitment of foreign-trained doctors (FTD). In order to facilitate the introduction of FTD into the health care system, the region of Western Sweden (Västra Götaland Region -VGR) established the introduction course PLUS. PLUS was based on principles for adult learning with considerable time for reflection and supervision in a group with experienced colleagues.
Research question: What improvements did participants describe after completing PLUS? How did PLUS "feel" for them? In which way does participants' acculturation process affect the experience of PLUS?
Method: An Applied Cultural Analysis was conducted in autumn 2014, based on three months of qualitative ethnographic fieldwork using methods such as participant observation and semi-structured in-depth interviews. The Applied Cultural Analysis focused on the participants experience of the program.
Results: PLUS was perceived as an important breaking point for participants acculturation in the Swedish healthcare-system. Participants gave multiple meanings to the program - as source of knowledge, network, and answer to workplace-related challenges but raised also questions concerning effectivity of discussions, duration as well as the influence on career opportunities. The pedagogical tool of discussions was perceived as less effective learning tool.
Conclusions: Participants in stable workplace- and family situations were more satisfied with the program, whereas participants who perceived their situation as less stable experienced PLUS as another destabilizing momentum. Adult learning turned out to be the major cultural challenge for participants in PLUS, highlighting the importance of the soft facts in acculturation and workplace introduction. Participants felt more secure in their professional role, more familiar with Swedish Healthcare and better integrated into their health care team. It was concluded that this should lead to improved patient security and better working environment for the physician as well as his/her coworkers.

Points for discussion:
1. How do you experience the situation in your workplace/country - do you work with colleagues trained in other countries?
2. How do you apply measures inspired by WHO Global code of practice on the international recruitment of health personnel? What

Factors influencing speciality choice in final year medical students - are students with intended career choice in family medicine are different to other students?

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Id 114
Background: Students in the final year of their medical study think about their future career - most of them have already had an idea about their future specialty.
Research Question: We would like to know the factors which influence the choice of most frequent specialties and compare the characteristics of those whose intended career choice is family medicine to those who is going to choose other popular specialties.
Methods: A questionnaire was distributed to final year medical students on the begging of rotation from family medicine in academic year 2015/16 at Medical faculty Ljubljana, Slovenia. Basic demographic data, data about their future career choice and factors that might influence on future career choice were obtained. We compared the characteristics of students who is going to choose the most popular specialists (frequency more than 5 %).
Results: In the sample were 205 students; 132 (64.4 %) were female students. 7 (3.4 %) of students did not mentioned any specialties. Most frequently mentioned specialties were: family medicine (10.7 %), gynecology (9.8 %), pediatric (9.3 %), psychiatry (8.3 %), general internal medicine (7.8 %), general surgery (6.3 %) and neurology (5.9 %). Students who are going to choose family medicine mentioned is different to students listed other specialties in smaller tendency for mobility, respect role-model and compatibility with family life and prefer working in ambulance setting. Long term relationship was mentioned also in students with career choice in psychiatry and pediatric and holistic approach in students with interest in internal medicine
Conclusions: Most of the graduates of medical faculty would like to work as physicians. There is some overlapping of factors influencing career choice between students with intended career choice in family medicine and other clinical specialties, mainly with those who would like to choose psychiatry or pediatric.

Points for discussion:

Beliefs and knowledge about sexual transmitted diseases in women who have sex with other women

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Id 13
Background: In France, homosexual women do not feel concerned by prevention and screening of sexual transmitted diseases (STD). But this population is also at risk as heterosexual women and should benefice of the same prevention in primary care. The aim of this study was to identify their beliefs about STD in order to optimize their prevention.
Research question: What do believe and know women who have sex with other women about STD?
Method: A qualitative study by semi-directed face-to face interviews has been conducted to theoretical saturation. Adult women who have occasional or exclusively sex with other women were included. Transgender women were excluded. Verbatims have been analysed with nvivo® software after data's triangulation.
Results: Most of women had heterosexual relations before. Protection means were globally known and used. Specific protection means for use between women were only discovered in lesbian association, but rarely used. They were considered to be restrictive. AIDS was the first cited STD. Other STDs were few or not known at all. Screening was often realized in case of pregnancy, hospitalization or in case of doubt about a former partner. In couple, the risk of STD was not discussed in the beginning of the relation but only when it became serious and stable. Women were questioning their selves about their risk but did not dare to ask their doctor because they felt embarrassed. They deplore a lack of divulgation of prevention messages from their general Practitioner and Gynaecologist as the invisibility of their sexuality in prevention campaigns which talks more often to homosexual men.
Conclusions: Early information at school, more presence of homosexual women in public prevention campaign and more prevention messages delivered by GPs could improve STD prevention.

Points for discussion:
1. At which moment we have to start with information at school?
2. Should we consult systematically our patientes about their sexual orientation?

Masked hypertension prevalence in diabetic II patients in primary care

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Id 17
Background: Masked hypertension (MH) is defined as a clinical condition in which a patient's office blood pressure (BP) level is <140/90 mm Hg but ambulatory or home BP readings are in the hypertensive range. Subjects with MH show a 1.5- to 3-fold higher risk of major cardiovascular (CV) disease than those with normal BP, and their risk is not different from that of patients with sustained hypertension. There is no study on MH prevalence in diabetic patients, who are at high cardiovascular risk.
Research question: What is the prevalence in general practice of MH in type II diabetic patients?
Method: Prevalence study. Patients were included in Centre Region of France between March and August 2013. Inclusion criteria were age>18 years old, type II diabetes and office BP ≤40/90 mmHg. Cardiovascular risk factors, antihypertensive treatments and home BP readings were recorded. Prevalence and risk factors of MH were explored.
Results: 112 patients were included. Patients were 52% male, with a mean age of 66 years old; 82%were overweighed, 70% were already treated with antihypertensive treatments, 20% smokers and 15% with a familial history of myocardial infarction. Mean LDL cholesterol was 1.04g/L and mean HbA1C was 7.3%. With an office BP threshold of 140/90mmHg, MH prevalence was 49.1% and 71.4% with a home BP threshold of 135/85 mmHg and 130/80 mmHg respectively. An elevated body mass index or a familial history of myocardial infarction was a risk factor of having a MH. Conclusion: Larger studies are needed to confirm those prevalence and risk factors of MH.

Points for discussion:
Do we have to systematically measure ambulatory BP in diabetic population?
Which home BP thresholds do we have to take into account?Do we have to introduce or modify antihypertensive treatment for diabetic patients with MH?

Quality of life and multimorbidity in PROEPOC/COPD cohort

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Id91

Background: A European cohort in primary care (PROEPOC/COPD study) was initiated by an EGPRN group in 2015 to compare multidimensional scales. Multimobidity following the definition by FPDM collaborative study was included in the study.

Research question: How much is the impact of multimorbidity (diseases, life style, social aspects) in COPD patient's quality of life.Method: Design: Open and prospective cohort study in primary care. Setting: 36 health centres in 6 European high, medium and low income countries. Subjects: First 250 patients from PROEPC/COPD study, captured in clinical visit by their General Practitioner/Nurse. 477 expected at the end of recruitment. Variables: Sex, age, Charlson index, COMCOLD index (depression, anxiety, cerebrovascular and cardiac disease, peripheral vascular disease), lung function test, cough (no/yes), dyspnoea and quality of life (CAT questionnaire). Analysis: Descriptive statistics. Generalized lineal model with CAT as outcome variable. Confidence interval calculated with bootstrap methods.

Results: Multimorbidity measured by COMCOLD (0.39452, CI: 0.09625672-0.66472420, $p< 0.001$), cough (2.66974, CI: 1.00885610-4.30285796, $p< 0.001$) and dyspnea (4.58804, CI: 3.39345839- 5.75707833, $p< 0.001$) had an adjusted significant positive effect in CAT. Lower age (-0.09774, CI: -0.17771610 to -0.02496427, $p< 0.033$) and postbronchodilation FEV1 (-0.09976, CI: -0.15103137 to -0.03549027, $p< 0.001$) decreased quality of life significantly. Life style and social network didn't have any significant effect in our cohort. Variability explained by the model was 41.72%.Conclusions: Quality of life in COPD is influenced not only by disease specific signs and symptoms. Other comorbidities must be taken in account by GPs.

Points for discussion:

Which GPs training methods will increase colorectal cancer screening? A systematic review.

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Background: Colorectal Cancer (CRC) is the third most common cancer in western countries. Fecal test are used to detect precancerous and asymptomatic preclinical CRC. Fecal test are prescribed in France by general practitioners (GPs), the screening rate is insufficient in most countries to achieve a shift in mortality. Research question: Which training methods for GPs are available and efficient to increase the number of CRC screening test effectively used by patient?
Method: Systematic literature review following the PRISMA guidelines. Pubmed, Scopus, Cochrane, BDSP and grey literature were searched, using searching terms related to CRC screening and training method. Every study interested in training method to GPs and CRC screening were included. Training method and efficiency were collected within the publications or with an additional search for each study.
Results: 1112 records were found. 32 studies were included. Training method were: academic detailing, visit targeting physician's behavior, visit targeting communication training, educational academic seminar and seminar targeting communication training. Three methods increased CRC screening rate, seminar targeting communication (from 10.9 to 12.2%), visit targeting physician's behavior (8.8%) and academic detailing with quality improvement (from 4.9 to 5.66%).

Points for discussion: Academic detailing and educational academic seminar did not increase CRC screening rate. Only training method needs that modified physician's behavior and trained them to enhance patient centered care communication enhance CRC screening.

PRESENTATION 60: **Saturday 13th May, 2017** **THEME PAPER**
16.45–17.15 h. **Ongoing study with preliminary results**

Promoting the physical health of people with severe mental illness

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Background: Mental illness can act as barrier to accessing and obtaining effective medical care, and is associated with increased medical morbidity. People with serious mental illness have higher morbidity and mortality from chronic diseases than the general population, and this results in a significantly reduced life expectancy. The vast majority of the gap in life expectancy is accounted for by physical illness. There is also evidence that people with mental illness are further disadvantaged as they are less likely than the general population to be offered, or to access, regular health screening. There is evidence to suggest that the physical health needs of people with serious mental illness are often "unrecognised, unnoticed or poorly managed".
Research question: What are the barriers and facilitators experienced in accessing and engaging in health services related to the care of the physical health of people with severe mental illness.
Method: The aspect presented here involves qualitative semi-structured interviews with service providers (general practitioners (GPs) and general practice staff, psychiatrists and members of the community mental health teams) and patients.
Results: Preliminary results indicate that the physical health of people with a severe mental illness is not currently addressed regularly by the primary care team or the patient's GP or the mental health team. Factors associated with this includes patient attendance and adherence and time constraints in consultations. A barrier to GPs having a role in this in an integrated model is the present funding approach, which does not adequately 'incentivise' such activities.
Conclusions: Improving physical health for this patient group takes considerable time, needs to be introduced step by step and requires sustained effort. The evidence from this work could form the basis for innovation and change in practice and service delivery for people with a severe mental health illness.

Points for discussion:
1. Integration between primary and secondary care
2. Mechanisms to improve the monitoring of physical health care

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