EUROPEAN GENERAL PRACTICE
EGPRN
RESEARCH NETWORK

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

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European General Practice Research Network

Kraków – Poland

13th – 16th October, 2011

SCIENTIFIC and SOCIAL PROGRAMME

THEME: "Infectious Diseases in Primary Care; managing the interface between the person and the community"

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

Place

City Council
Urząd Miasta Krakowa
Plac Wszystkich Świętych 3-4
31-004 Kraków - Poland
Tram stop: Plac Wszystkich Świętych

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

The College of Family Physicians in Poland

Pfizer

National Programme on Antibiotic Protection

Honorary Partonage of Mr Jacek Majchrowski - The Mayor of the City of Krakow

Honorary Partonage of Mr Marek Sowa - The Marshal of Malopolska Region

The meetings of the European General Practice Research Network (EGPRN) have earned accreditation as official postgraduate medical education activities by the Norwegian, Slovenian, Irish and Dutch College of General Practitioners.
Those participants who need a certificate can contact Mrs. Hanny Prick at the EGPRN-Coordinating Office in Maastricht, The Netherlands.

"**Infectious Diseases in Primary Care; managing the interface between the person and the community".**

Dear doctors, researchers, and colleagues,

On behalf of the host organizing committee, I would like to welcome all the faculty and participants of 73rd EGPRN-meeting. We are proud that this meeting takes place in Cracow - one of the most renown historical, cultural, and spiritual cities of Poland.
The theme of our conference is: "Infectious Diseases in Primary Care; managing the interface between the person and the community". We will have an opportunity to learn about common pathogens and medications, used to treat various types of infections. We need to understand the rationale behind antimicrobial therapy, the mechanism of action of different classes of antibiotics as well as multiple problems, associated with their use, ranging from adverse effects to drug resistance. The main goal is to limit the spread of these diseases in our communities, and to improve patients' outcomes. During this conference, we would like to focus our attention on another challenging topic: **"Endangerment of the patient's safety". Unfortunately, the patient's safety is often jeopardized by diagnostic or therapeutic delays, errors related to pharmacotherapy (such as inappropriate dosages, or interactions between medications), inaccurate medical records, and also, by malfunctioning of organizational structure of the health care system. Therefore, family physicians need to acquire special skills, related to risk management. Good medical knowledge and documentation are very important methods of reducing the risk of both medical errors and malpractice claims. In addition, clear communication with patients, their families, nursing staff and consulting physicians, represents a key strategy, which facilitates understanding of the clinical and emotional situation, and helps in proper decision making, leading to minimizing errors.**

We encourage all of you to active participation in this educational event, and to direct involvement in various workshops and presentations, during which you may ask questions and gain valuable "practice pearls". Also, we would like to provide for you a lot of opportunities for networking and exchanging experiences with your pears and instructors. One of our objectives is to address several issues, related to both research and a daily family practice. Activities of this conference, such as formal lectures, workshops, presentations, and poster sessions will serve as vehicles of current knowledge. In addition, there will be plenty of time for informal sharing of the experiences relevant to individualized patient care, practice management, and research design. Together with our experts, you will discuss some strategies of how to deal with challenges and dangers of modern civilization, and how to successfully cooperate within multidisciplinary teams. We hope that you will find Cracow as a friendly city that has a very unique atmosphere for both scientific study and historical site-seeing. We expect that you travel arrangements and hotel accommodations will be comfortable. There are many direct flights from European capitals to Cracow, and there is a convenient train and bus transportation from the BALICE Airport to the center of Cracow. Your hotels should be within walking distance from the conference location. In addition, many nice restaurants, café-shops, recreation, business and shopping centers will be available for you. We believe that you will find some time to enjoy and contemplate places, where Copernicus developed his brilliant and revolutionary ideas, and that this "special climate" will also inspire your future research projects and practice. We are looking forward to seeing you in Cracow, and wishing you the most interesting, fruitful and happy time in our unforgettable city!

Best Regards,

Prof. Witold Lukas, MD, PhD,
National Representative of EGPRN in Poland
On behalf of the Host Organizing Committee

MEETING EXECUTIVE BOARD
GENERAL COUNCIL MEETING

Executive Boardmeeting
Thursday 13th October, 2011

09.30 - 10.00: Welcome and Coffee for Executive Board
10.00 - 12.30: Executive Board members
Location: City Council
in: room C (Wyspiański Room)

General Council meeting with the National Representatives
Thursday 13th October, 2011

14.00 - 16.30 : Executive Board members and National Representatives

16.30 - 17.30 : Meeting of the Special Committees and Working Groups:
-Research Strategy Committee
-PR and Communication Committee
-Educational Commitee

Location: City Council
in: room C (Wyspiański Room)

REGISTRATION

► Thursday 13 October 2011

REGISTRATION FOR PARTICIPANTS OF PRE-CONFERENCE WORKSHOPS ONLY

Location: **City Council**
Urząd Miasta Krakowa
Plac Wszystkich Świętych 3-4; 31-004 Kraków
Tram stop: Plac Wszystkich Świętych

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

► Friday 14 October 2011

REGISTRATION FOR ALL PARTICIPANTS
Time: **08.00 – 08.30 h.**

Location: **City Council Conference Room**

On arrival, every participant, who has not paid by electronic bank transfer, pays € 150,= (or € 300,= if a non-member) per person.

FOR ALL EGPRN PARTICIPANTS

Social night on Saturday 15th October 2010
Dinner, speeches and party
At WESELNA' Restaurant, Market Square 44
(*first floor – entrance through the 'Staropolska Karczma' Restaurant at the ground floor*)
Entrance Fee: € 40,= per person.
Please address to EGPRN Registration Desk.

Unfortunately, we have **NO** facility for electronic payments (credit card, Maestro) on the spot. We only accept **EUROS**.
We do **NOT** prefer pay cheques, given the extra costs. If you have no other option we will charge € 25 extra.

Map of the Krakow City Centre

1 MARKET SQUARE

2 CONFERENCE VENUE - City Council, Plac Wszystkich Świętych 3-4

3 DEPARTMENT OF FAMILY MEDICINE Jagiellonian Uniwersity, ul. Bocheńska 4

E G P R N 13th – 16th OCTOBER, 2011

PROGRAMME OF THE EUROPEAN GENERAL PRACTICE RESEARCH NETWORK IN KRAKÓW - POLAND

WEDNESDAY 12th OCTOBER, 2011:

Location : **Dept. of Family Medicine**
Jagiellonian University Medical College
Bocheńska 4 St., Krakow

14.00 – 18.00 : **"Cogita"**
in: room A

16.00 – 19.00 : **"WoManPower"**
in: room B

THURSDAY 13th OCTOBER, 2011:

Location : **Dept. of Family Medicine**
Jagiellonian University Medical College
Bocheńska 4 St., Krakow

09.00 - 12.00 : **"WoManPower"**
in: room B

09.00 – 13.00 : **"Cogita"**
in: room A

Location : **City Council Conference Room**

09.30 - 12.30 : **Executive Board Meeting**
(only for Executive Board Members)
in: room C (Wyspiański Room)

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

10.00 - 12.30 : **2 EGPRN Pre-Conference Morning Workshop**; €25 (€50) each p.p.
Parallel workshops:

a. Workshop on "Focussing Research Questions".
Chairs: Christophe Berkhout (Lille, France), Slawomir Chlabicz (Bialystok, Poland).
in: room D (Lea Room) – coffeebreak 11.00-11.15 hrs. in corridor

b. Workshop on "Infectious Diseases".
Chairs (from TRACE & GRIN): S. Coenen (Antwerp, Belgium), Maciek Godycki-Ćwirko (Lodz, Poland), Theo Verheij (Utrecht, The Netherlands), W.Hryniewicz, (Poland).
in: room E (Kupiecka Room) – coffeebreak 11.00-11.15 hrs. in corridor

12.30 - 13.00 : Lunch (price <u>not</u> included in fee pre-conference workshops)

Afternoon: 1 EGPRN Pre-Conference Afternoon Workshops €25 (€50) each p.p

13.30 – 16.30 : ***c. Workshop on "Dealing with Medical Errors".***
Chairs: Maciej Godycki-Ćwirko (Poland), Martin Beyer (Frankfurt am Main, Germany)
. **in: room D (Lea Room) – coffeebreak 15.30 hrs. in corridor**

14.00 - 16.30 : <u>EGPRN General Council Meeting</u>.
Meeting of the Executive Board Members with National Representatives (<u>only</u> for Council Members).
. **in: room C (Wyspiański Room) – coffeebreak 15.30 hrs. in corridor**

As part of the Council meeting, the EGPRN Committees will take place as well : -Educational Committee, PR & Communication Committee, Research Strategy Committee.

16.30 - 17.30 : Meeting of EGPRN Working Groups (part of the Council meeting)
- **Research Strategy Committee**
- **Educational Committee**
- **Communication and PR Committee**

in: room C (Wyspiański Room)

Social Program: **For ALL EGPRN-participants of this meeting who are present in Kraków at this time. (Entrance Free)**
18.30 – 20.30 : Welcome Reception and Opening Cocktail for all participants.
Location: City Hall
Urząd Miasta Krakowa
Plac Wszystkich Świętych 3-4
31-004 Kraków - Poland
Tram stop: Plac Wszystkich Świętych

FRIDAY 14th OCTOBER, 2011:

Location : City Council
in: room C (Wyspiański Room)

08.00 - 08.30 : Registration at EGPRN Registration Desk.

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

09.00 - 09.45: 1st Keynote Speaker: *Prof. Adam Windak, PhD* – Poland.
Theme: "The Main Directions of Family Medicine in Poland, including future prospective".

09.45 - 10.30: 2nd Keynote Speaker: *Prof. Samuel Coenen, MD, PhD* – Antwerp, Belgium.
Theme: "Infectious Diseases in Primary Care; managing the interface between the person and the community".

10.30 - 11.00 : Coffee Break

11.00 – 12.30 : 3 Theme Papers (plenary) – "Urinary Tract"
in: room C (Wyspiański Room)

1. **Akke Vellinga (Ireland)**
Antimicrobial management and appropriateness of treatment of urinary tract infection in general practice in Ireland.

2. **Stefan Heytens (Belgium)**
Cystitis: Symptomatology in women with suspected uncomplicated urinary tract infection.

3. **Casper den Heijer (The Netherlands)**
Male urinary tract infections in Dutch general practices.

12.30 - 13.30 : Lunch
in: room E (Kupiecka Room)

13.30 – 15.00 : 3 Theme Papers (plenary) – "Respiratory Tract"
in: room C (Wyspiański Room)

4. **Barbara Michiels (Belgium)**
Clinical prediction rules to distinguish influenza from influenza-like illnesses in primary care.

5. **Jorund Straand (Norway)**
Do GPs' consultation rates influence their prescribing patterns of antibiotics for acute respiratory tract infections?

6. **Samuel Coenen (Belgium)**
Impact of amoxicillin therapy on oropharyngeal streptococci of patients with community-acquired lower respiratory tract infections.

15.00 – 15.30 : Coffee/Tea Break
in: room E (Kupiecka Room)

After coffee Break, the meeting continues with parallel sessions till 17.30 h.

15.30 – 17.30 : A. Parallel session - 4 Freestanding Papers – "Mental"
in: room C (Wyspiański Room)

7. **Jean Yves Le Reste (France)**
The FPDM (Family Practice Depression and Multimorbidity) Study: Systematic review of literature to find criteria for multimorbidity definition.

8. **Caroline Huas (France)**
Impact of body mass index and body weight perception on adolescent's depression: study of an interaction.

9. **Jozien Meijaard (Belgium)**
Are you a good partner when your patient with an unintended pregnancy speaks to you?

10. **Roger Ruiz Moral (Spain)**
Family doctors' opinions about patient involvement in decision-making. A study with video-vignettes.

15.30 – 17.30 : B. Parallel session - 4 Freestanding Papers – "Miscellaneous"
in: room D (Lea Room)

11. **Mark Vanmeerbeek (Belgium)**
Predisposing, enabling and reinforcing factors to preventive healthcare in general practice. A qualitative study based on interviews.

12. **Johannes Hauswaldt (Germany)**
Harmonizing electronic data from a German GP based research network.

13. **Paul van Royen (Belgium)**
TRANSFoRm: Translational research and patient safety in Europe.

14. **Hilde Bastiaens (Belgium)**
TRANSFoRm: Defining functional requirements for the learning healthcare system.

17.30 – 18.00 : Plenary Session
in: room C (Wyspiański Room)

Closing of the day by *Prof. Samuel Coenen, PhD,* keynote speaker, who will summarize on today's theme papers.

Location : **Dept. of Family Medicine**
Jagiellonian University Medical College
Bocheńska 4 St., Krakow
in: room A

18.00 – 20.00 : Collaborative Study "FPDM" (Family Practice Depression and Multimorbidity).

Social Programme :

18.00 – : Practice Visits to local Health Centres of Kraków and environment.

Meeting point: **Foyer City Council Hall - colleagues will be waiting for you.**

SATURDAY 15th OCTOBER, 2011:

Location : City Council
in: room C (Wyspiański Room)

08.30 – 09.15: 3rd Keynote Speaker: *Prof. Waleria Hryniewicz, MD, PhD* – Poland
Theme: "The Risks related to Streptococcus Pneumoniae Infection, including preventive options, early diagnosis and treatment".

09.15 – 10.15 : 2 Theme Papers (plenary) – "AB Prescribing"
in: room C (Wyspiański Room)

15. Philippe Ryckebosch (Belgium)
Disease-specific antibiotic prescribing quality indicator assessment in a Flemish out-of-hours service centre.

16. Evelien van Bijnen (The Netherlands)
The appropriateness of prescribing antibiotics in primary health care in Europe: the APRES study.

10.15 – 10.45 : Coffee/Tea Break
in: room E (Kupiecka Room)

10.45 – 12.45 : C. Parallel session - 4 Freestanding/Theme Papers– "Various"
in: room C (Wyspiański Room)

17. Emma Ladewig (Ireland)
The association between breastfeeding initiation and respiratory infections in infants.

18. Knut-Arne Wensaas (Norway)
Irritable bowel syndrome and chronic fatigue three years after acute giardiasis.

19. Camilla Antonneau (Belgium)
Hepatitis C virus infection in men having sex with men: awareness of general practitioners in Flanders, Belgium.

20. Karola Mergenthal (Germany)
Roles of health care assistants with a foreign background in Germany.

10.45 – 12.45 : D. Parallel session - 3 Freestanding Papers– "Cardiovascular"
in: room D (Lea Room)

21. Eszter Kovács (Hungary)
The effectiveness of care in high cardiovascular risk patients in the Hungarian primary care.

22. Norbert Donner-Banzhoff (Germany)
Ruling out coronary artery disease in primary care: the Marburg Heart Score.

23. Petra Erkens (The Netherlands)
Safe exclusion of pulmonary embolism using the Wells rule and D-dimer testing in primary care: a diagnostic validation study.

12.45 - 13.45 : Lunch

13.45 - 14.10 : Chairperson's report by Prof. Eva Hummers-Pradier. Report of Executive Board and Council Meeting.

The meeting continues with 6 parallel Poster sessions till 15.25 h.

14.10- 15.25 : Posters
In six parallel sessions (6 groups)
in: Foyer City Hall

14.10- 15.25 : Parallel group 1: Posters *"Theme I: Managing Infections"* (5)

24. Mehmet Ungan (Turkey)
Prevalence of active tuberculosis infection among immigrant and refugees.

25. Beata Mazinska (Poland)
Pediatricians' attitudes and knowledge regarding antibiotics based on a questionnaire survey conducted within the National Programme for Antibiotic Protection.

26. Luiz Miguel Santiago (Portugal)
Trend of antibiotics prescription in the general practice/family medicine in the centre of Portugal: how informatics can help ascertain its reality.

27. Pavlo Kolesnyk (Ukraine)
Study of Helicobacter pylory-associated gastro duodenal disorders management and anemia among household members and opportunity of their treatment in family sources of helicobacteriosis in Transcarpathian region of Ukraine.

28. Fergus O'Kelly (Ireland)
The natural history of a community based cohort of injecting drug users (1985-2010).

14.10- 15.25 : Parallel group 2: Posters *"Theme II: Respiratory Infections"* (5)

29. Kristian Anton Simonsen (Norway)
Influenza-like illness in general practice in Norway: clinical course and attitudes towards vaccination and preventive measures during the 2009 pandemic.

30. Claire Collins (Ireland)

Monitoring influenza vaccine effectiveness using the general practitioners' sentinel surveillance system in Ireland.

31. Jose R. Loayssa (Spain)
Attendance to family medicine consultation for acute tract respiratory infections, fever and flu during the summer of the A(H1N1) flu pandemic outbreak in a Spanish region.

32. Amélie Calvez (France)
Bronco pulmonary infections: following guideline is far enough for French nursing homes.

33. Dervla Kelly (Ireland)
Chest infection in infants and its association with family structure.

14.10- 15.25 : Parallel group 3: Posters *"Miscellaneous"* (5)

34. Jean-Pierre Lebeau (France)
Therapeutic inertia in hypertension: a systematic review.

35. Marija Petek Ster (Slovenia)
Chronic kidney disease in patients with arterial hypertension.

36. Katell Mignotte (France)
Placebo prescription: really deliberately?

37. François Dumel (France)
Oral anticoagulation treatment management: point of view of elderly (over 75 years old) patients.

38. Udo Reulbach (Ireland)
Does crèche care impact negatively on infants' health?

14.10- 15.25 : Parallel group 4: Posters *"Free II: GP's and Students"* (5)

39. Peter Torzsa (Hungary)
Burnout among Hungarian general practitioners and residents.

40. Tolga Gunvar (Turkey)
Primary care physicians: How much are they determined regarding lifestyle changes?

41. Bernard Le Floch (France)
Which positive factors determine the attractiveness of general practice and retention in clinical practice? A qualitative research.

42. Ewelina Gowin (Poland)
Polish medical students' career choices.

43. Pemra C. Ünalan (Turkey)
Evaluating the nutritional habits of the Turkish medical school.

14.10- 15.25 : Parallel group 5: Posters *"Free III: Research"* (5)

44. Patrice Nabbe (France)
The FPDM (family practice depression and multimorbidity) Study: Project for systematic literature review to find tools for depression diagnosis used in primary care.

45. Slawomir Czachowski (Poland)
Evaluating the coross-cultural validity of a somatisation questionnaire: Differential Item Functioning (DIF) analyses of the Polish version of the 4DSQ questionnaire.

46. Stephanie Heinemann (Germany)
Barriers to computer-based data collection in general practice research: results from practice staff intervies.

47. Miguel Muňoz (Spain)
An approach to the study of multimorbidity in primary health care.

48. Ferdinando Petrazzuoli (Italy)
Coherence between reason for encounter and final diagnosis in infectious diseases in the primary care setting.

14.10- 15.25 : Parallel group 6: Posters *"Free IV: Pain & Cough"* (4)

49. Aline Ramond-Roquin (France)
Patients with chronic low back pain: factors which influence care seeking.

50. Athanasios Vitas (Greece)
Evaluation of local infusions of betamethasone – Lidocaine in myofascial trigger points in difficult cases of adult patients with chronic mulculoskeletal pain.

51. Aleksander Stephanovič (Slovenia)
Efficacy of treatment of herpes zoster and prevention of post-herpetic neuralgia with Trans Cutaneous Neural Stimulation (TENS).

52. Gergana Foreva (Bulgaria)
Communication with palliative patients: general practitioners' view.

15.25 - 15.55 : Coffee Break
in: room E (Kupiecka Room)

The meeting continues with 2 parallel One Slide/Five Minutes' sessions till 16.25 h.

15.55 – 16.25 : E. Parallel session – 3 One-Slide/Five Minutes Presentations
in: room C (Wyspiański Room)

53. Siri Jensen (Norway)
Why do we have a low antibiotic consumption and a low level of antimicrobial resistance in Norway?

54. Christophe Berkhout (France)
Self-sampling: a solution to improve attendance to cervical cancer screening?

55. Luybima Despotova-Toleva (Bulgaria)
Travel medicine and infectious diseases: the responsibilities of the general practitioner.

15.55 – 16.25 : F. Parallel session – 3 One-Slide/Five Minutes Presentations in: room D (Lea Room)

56. Athina Tatsioni (Greece)
Clinical prediction rules in primary care: a research proposal.

57. Melida Hasanagic (Bosnia and Herzegovina)
Influence of infective diseases in family medicine practice in Mostar region, BH.

58. László Kolozsvári (Hungary)
Administrative and reporting tasks of general practitioners (GP) in Europe.

The meeting continues with a Plenary session till 17.45 h.
Plenary Session in: room C (Wyspiański Room)

16.30 - 17.00 : **Closing of the day by *Prof. Waleria Hryniewicz,*** keynote speaker, who will summarize on today's theme papers and posters.

17.00 – 17.15 : **Presentation of the EGPRN Poster prize by *Dr. Tiny van Merode*.**

17.15 – 17.30 : **Introduction on the next EGPRN-meeting in Ljubljana-Slovenia by the Slovenian national representative.**

17.30 – 17.45 : **Closing of the conference by *Prof. Eva Hummers-Pradier*, EGPRN chairperson.**

Social Program :

19.30 - : **Social Night – Gala Dinner, speeches and Party in a Restaurant in the Old City Centre.**
WESELNA' Restaurant, Market Square 44
(*first floor – entrance through the 'Staropolska Karczma' Restaurant at the ground floor*)
Entrance Fee: € 40,= per person.

SUNDAY 16th OCTOBER, 2011:

Location : City Council
in: room C (Wyspiański Room)

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

FRIDAY 14th OCTOBER, 2011:

Location : City Council Conference Room

09.00 - 09.45: 1st Keynote Speaker: *Prof. Adam Windak, PhD* – Poland.

Theme: "The main directions of family medicine in Poland, including future prospective"

Poland is a Central European country with over 38 million of inhabitants. 13,5% of population is over 65. Life expectancy on birth is 79,96 for females and 71,26 for male. Total healthcare expenditures are equal to 6,4% of GDP.

97,7% of inhabitants are obligatory insured by National Health Fund – the exclusive public health insurance company. In the year 2009, 13,25% of its budget was reserved for the primary care services. The health insurance fully covers primary care services, which are provided free of charge, without any patient co-payment. Primary care is reimbursed mainly on per capita basis and only small part of them are paid as a fee-for-service, mainly in case of preventive programmes. This last activities are often financed separately by local governments from their own resources. Primary care physicians can work both as a salaried personnel or as independent contractors. Over 60% of all PC physicians and over 80% of vocationally trained family physicians run their practices as independent contractors. PHC physicians are allowed to have their own lists of patients. The average patient list size is 1539. However in rural are this figure can be far bigger, while in big cities smaller. In the theory PHC physicians act as a gate keepers. However referrals are not needed to psychiatrists, oncologists, dermatologists or ophthalmologists. PC practices should be open from 8 a.m. to 6 p.m. during all working days.

Family medicine was recognized as a speciality in 1994 and since that time over 10 thousands of physicians completed vocational training in this field. By law only physicians vocationally trained in family/general medicine are allowed to work as primary care doctors within the public system. All other physicians, already working in PC settings, are allowed to continue their work up to 2017 and till that date they should complete specialization in family medicine.

All insured patients have an unlimited access to his/her own PC physician. Patients have rights to choose a family doctor or alternatively an internist or a paediatrician. At the end of 2010, 8129 family physicians worked as PHC doctors (33%). In the same time there were 9899 internists (41%) and 6252 paediatricians (26%) working within the public system. Family medicine is considered as a deficit speciality, what results in special governmental financial incentives to increase number of trainees in this field. This policy increased number physicians choosing family medicine as their future professional career. However still more training places are available for future internists than for family doctors. Family medicine is also taught to medical students at all universities with minimum number of 100 teaching hours. Vocational training lasts 4 years and more than a half of this time is spent in family practice.

The main professional organization of PHC doctors is the College of Family Physicians in Poland established in 1992. The College undertakes initiatives aimed at practice and system organization improvements, quality assurance, education and research. Since 1996 the College is a full member of WONCA. Other important organization active in PHC is Federation of Unions of Employers in Health Care, which defends financial and material interests of family doctors, mainly those acting as independent contractors. There are two major medical journals for family physicians. The educational one "Lekarz Rodzinny" (Family Physician) is published 11 times per year with 15000

copies per issue, while the scientific one “Problemy Medycyny Rodzinnej” (Topics in Family Medicine) is published quarterly.

Currently the main problems for family medicine in Poland are due to low number of new trainees, which may result in future workforce shortage, unclear vision of future PHC development and inadequate financing and increasing bureaucracy imposed mainly by National Health Fund. The main challenge is further academic development of the discipline, resulting in more attractive career options for medical graduates as well as stable vision of the role of family medicine within the whole health care system

Prof. Adam Windak MD, PhD,
mmwindak@cyf-kr.edu.pl

FRIDAY 14th OCTOBER, 2011:

Location : City Council Conference Room

09.45 - 10.30: 2nd Keynote Speaker: *Prof. Samuel Coenen, MD, PhD* – Antwerp, Belgium.

Theme: "Infectious Diseases in Primary Care; managing the interface between the person and the community".

Infectious diseases still are among the commonest new diagnoses in primary care. The most common infectious diseases in primary care are respiratory infections. The most frequent reasons for encounter is acute cough. Managing respiratory infections, primary care physicians have to make antibiotic prescribing decisions in a context of diagnostic uncertainty, patient preferences and the global problem of antimicrobial resistance.

A causal link between antimicrobial resistance and antibiotic prescribing in primary care can be illustrated both at the ecological and the individual patient level. The most recent ESAC (European Surveillance of Antimicrobial Consumption; www.esac.ua.ac.be) data confirm persistent variation in outpatient antibiotic use in Europe. Mixed-effects models allow statistical assessment of the trend over time over the last decade of both total use and seasonal variation.

Data from GRACE (Genomics to combat Resistance against Antibiotics in Community-acquired LRTI in Europe; www.grace-lrti.org) observational studies show that variation in clinical presentation does not explain the considerable variation in antibiotic prescribing between 14 primary care networks in Europe for adults presenting with acute cough. Less than half of those who were prescribed antibiotics received a first choice antibiotic (i.e. tetracycline or amoxicillin). No (relevant) differences in recovery were found between those treated with any antibiotic, a particular antibiotic class or no antibiotic. Patients with discoloured sputum were prescribed antibiotics more often, but sputum colour, alone
or together with feeling generally unwell, was not associated with recovery or benefit from antibiotic treatment either. Patient expectations regarding antibiotic prescribing might have changed, but still determine the antibiotic prescribing decision as do the prescribers' perceptions of patient expectations.

While establishing the aetiology, diagnosis and prognosis in adult patients with acute cough remains a challenge in primary care, preliminary results from a first randomised double-blind placebo-controlled trial in GRACE, including more patients than all trial in the current Cochrane Review, seem to corroborate the results from the observational GRACE studies. Another randomised controlled trial within GRACE assessed the effect on antibiotic prescribing of either an online training on the use of a C-reactive protein point-of-care test supplemented with the provision of such a device or an online communication skills training supplemented with the provision of an interactive patient booklet endorsed by the European Antibiotic Awareness Day (GRACE INTRO). Preliminary trial results suggest positive effects of both interventions and great opportunity for large-scale support of primary care physicians to manage the interface between the person and the community when dealing with respiratory infections in primary care, particularly the antibiotic prescribing decision.

Prof. Samuel Coenen MD, PhD,
Centre for General Practice and Laboratory of Medical Microbiology, Vaccine & Infectious Disease Institute (VAXINFECTIO), University of Antwerp, Belgium.

SATURDAY 15th OCTOBER, 2011:

Location : City Council Conference Room

08.30 – 09.15: 3rd Keynote Speaker: *Prof. Waleria Hryniewicz, MD, PhD* – Poland

Theme: "The Risks related to Streptococcus Pneumoniae Infection, including preventive options, early diagnosis and treatment".

The risks related to Streptococcus pneumoniae infection, including preventive options, early diagnosis and treatment

Waleria Hryniewicz, Department of Epidemiology and Clinical Microbiology, National Medicines Institute, Warsaw, Poland

Streptococcus pneumoniae (Pneumococcus) a Gram positive diplococcus is divided into 93 capsular serotypes all able to produce disease in humans but only some of them are responsible for the majority of infections. Pneumococcus is a leading cause of human infections, often very severe, acquired mostly in the community and causing a variety of both invasive and noninvasive disease. The former usually present as bacteremia, meningitis and bacteremic pneumonia; and the latter as upper and lower respiratory tract infections. S. pneumoniae is not only associated with very high morbidity but also in certain conditions with extremely high mortality. This is due to the variety of virulence factors and acquisition of multiple antibiotic resistance genes. According to WHO over 1mln children die every year of pneumococcal infections. The risk of developing pneumococcal infection is higher in patients at extremes of age (< 2 years old and > 65). Others at risk include patients with chronic pulmonary, cardiac and kidney diseases, diabetics, immunocompromised such as HIV/AIDS, asplenics, patients with sickle cell anemia, alcoholics and patients abusing nicotine. Viral infections often precede acquisition of pneumococcal infection by facilitating their spread from nasopharynx and thus development of a secondary disease. In infants and younger children very high nasopharyngeal colonisation has been observed which is particularly frequent in children attending day care centers. Administration of antibiotics to those children promotes emergence and spread of resistant strains. Diagnosis of S. pneumoniae infection is mostly based on clinical picture and epidemiological data. However, several attempts have been made to develop reliable and rapid microbiological diagnostics for POC. Some progress has been made with the introduction of rapid urine test to diagnose pneumococcal pneumonia, especially applicable in the adults. Several commercial and in house molecular methods have become available to diagnose of invasive disease. During last decade a dynamic spread of resistant strains has been observed. Nonsusceptibility to penicillin exceeds in certain regions 50% and very often is associated with resistance to macrolides/lincosamides , tetracyclines and cotrimoxazole. In some countries growing resistance to parenteral IIIrd generation cephalosporines among invasive organisms became a real therapeutic challenge. In the light of the above immunoprophylaxis plays a significant role. There are 2 vaccines available, first containing 23 capsular polysaccharides ,mostly used in elderly, second comprising protein-conjugated capsular antigens for children below 5 years of age. Two formulations are at the market :10-valent (Synflorix) and 13-valent (Prevenar13).

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PRESENTATION 1: Friday 14th October, 2011 **THEME PAPER**
11.00–11.30 h.

TITLE: Antimicrobial management and appropriateness of treatment of urinary tract infection in general practice in Ireland.

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Urinary tract infections (UTIs) are the second most common bacterial infections in general practice and a frequent indication for antimicrobial prescribing. Increasing concern about the association between the use of antimicrobials and acquired antimicrobial resistance has highlighted the need for rational pharmacotherapy of common infections.

How are UTIs managed in general practice and is there room for improvement?

Management of urinary tract infections in general practice was studied prospectively over 8 weeks. Patients presenting with suspected UTI submitted a urine sample and were enrolled with an opt-out methodology. Data were recorded from GP charts. Appropriateness of the prescribed and three different treatment scenarios (if all patients who received an antimicrobial were treated with nitrofurantoin/trimethoprim/ciprofloxacin only) was assessed by comparing treatment with the laboratory report of the urine sample.

A total of 22 practices participated in the study and 866 patients were included of whom 21% had bacteriuria, 9% pyuria and 70% no laboratory evidence of UTI. An antimicrobial agent was prescribed to 56% (481) of the patients (33% with an isolate, 11% pyuria only, 56% without laboratory evidence of UTI). When taking all patients into account, 14% patients had an isolate identified and were prescribed an antimicrobial to which the isolate was susceptible. The agents most commonly prescribed were co-amoxyclav (33%), trimethoprim (26%) and fluoroquinolones (17%).
Prescribing differed considerably between practices. Treatment as prescribed by the GP was interpreted as appropriate for 55% of the patients. Treatment as prescribed by the GP was equally as effective as treatment with nitrofurantoin only or ciprofloxacin only but at a much lower prescribing cost for nitrofurantoin. Empirical treatment of all patients with trimethoprim only was less effective due to the higher resistance levels.

There appears to be considerable scope to reduce the frequency and quality of antimicrobial prescribing for patients with suspected UTI.

Points for discussion:
How can we improve (antimicrobial) prescribing in general practice

PRESENTATION 2: Friday 14th October, 2011 **THEME PAPER**
11.30-12.00 h.

TITLE: Cystitis: Symptomatology in Women with Suspected Uncomplicated Urinary Tract Infection.

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Background:
Although cystitis in women is very common in general practice, its evolution in symptoms has not been clearly studied. Qualitative research has pointed to other than the classic symptomatology.

Research question:
What is the clinical course of various symptoms, their duration, and the factors that may influence the duration in patients consulting their general practitioner GP) with complaints suggestive of an uncomplicated Urinary Tract Infection (UTI).

Method:
This was a prospective observational study of the symptomatology at presentation and the evolution of the symptoms in treated women with suspected uncomplicated UTI. Women consulting their general practitioner (GP) for dysuria, urgency, or frequency produced a urine sample (for bacteriologic processing) and kept a diary until the end of the symptoms. Exclusion criteria included complaints > 1 week, fever, vaginal discharge, and known pathology.

Results:
Of the 300 asked to participate, 148 (49%) returned the diary. Although none of the patients developed acute pyelonephritis, a substantial number of the women had such complaints as feeling feverish (33% in culture-positive group, 38% in culture-negative group), back pains (44% vs. 56%), and feeling weak and tired (71% vs. 65%). Differences between the culture-positive and culture-negative groups were not statistically significant except for the duration of symptoms, which was shorter in the culture-positive group (4 vs. 6 days). More severe symptoms at inclusion were correlated with a longer duration of these symptoms.

Conclusions:
The spectrum of complaints in women with suspected uncomplicated UTI is broad and comprises a number of symptoms usually associated with an upper UTI. The occurrence of these symptoms should not automatically prompt GPs to prescribe broad-spectrum antibiotics. Moreover, the duration of symptoms exceeding the recommended duration of antibiotic therapy does not indicate therapy failure and, thus, the need for changing antibiotic therapy.

Points for discussion:
1) No correlation has been found between the extent of bacteriuria at inclusion and the severity of the symptoms. Moreover there is an ongoing discussion about the most appropriate cut off value to define a urine sample as a postive culture.

PRESENTATION 3: Friday 14th October, 2011 **THEME PAPER**
12.00–12.30 h.

TITLE: Male urinary tract infections in Dutch general practices.

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Background:
With acknowledged differences between female and male UTIs, it is equally important to regularly evaluate the Escherichia coli antimicrobial susceptibility and therapeutic policy for UTIs in men to control antimicrobial resistance.

Objectives:
We determined antibiotic prescription rates for male UTIs in Dutch general practices, and the antibiotic susceptibility (including extended-spectrum beta-lactamases (ESBL)) of uropathogenic E. coli. Results were compared with data from a similar 2004 study.

Methods:
From January 2009 to December 2010, 42 GPs collected urinary samples from male patients (≥12 years) with symptoms indicative of UTI and recorded prescribed antimicrobial treatment. Uropathogens were identified and antibiotic susceptibility of E. coli was determined. A p-value ≤0.05 was considered statistically significant in comparing the current and 2004 study.

Results:
A total of 545 urinary samples were collected, of which 351 (64%) were positive (≥103 cfu/mL). E. coli was most commonly isolated (50%). High susceptibility rates were observed to fluoroquinolones and co-amoxiclav (95% and 89% respectively), whereas amoxicillin (67%), trimethoprim (77%) and co-trimoxazole (77%) showed lower rates. One ESBL (0.6%) was found. There were no differences with the susceptibility data from 2004 (all p>0.05).
Antibiotic prescription data were available from 524 patients, of which 324 (62%) were empirically treated. Fluoroquinolones (28%) and co-amoxiclav (27%) showed highest prescription rates followed by nitrofurantoin (22%) and co-trimoxazole (15%). Co-amoxiclav prescription rates increased (11% vs 27%, p<0.05) and co-trimoxazole rates decreased (24% vs 15%, p<0.05) over time.

Conclusions:
For male UTIs no significant differences were observed in E. coli susceptibility over a 5-year period. ESBL prevalence was low. Differences in prescription rates over time were in accordance with observed susceptibility rates. Regular surveillances remain necessary to update clinical guidelines and control antimicrobial resistance.

Points for discussion:
Is nitrofurantoin appropriate as an antibiotic for male UTIs?
In male UTIs, that there was no difference in E. coli susceptibility rates over a 5-year period.

PRESENTATION 4: Friday 14th October, 2011 **THEME PAPER**
13.30–14.00 h.

TITLE: Clinical prediction rules to distinguish influenza from influenza-like illnesses in primary care.

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Background:
During an influenza epidemic prompt diagnosis of influenza is important. This diagnosis however is essentially based on the interpretation of symptoms and signs by general practitioners (GPs).

Research question:
To formulate prediction rules for the diagnosis of influenza with the best diagnostic performance, combining symptoms, signs and context among patients with influenza-like illness.

Method:
During five consecutive winter periods (2002-2007), 138 sentinel GPs sampled (naso-oropharyngeal swabs) 4597 patients with an influenza-like illness (ILI) and registered their symptoms and signs, general characteristics and contextual information. The samples were analyzed by a DirectigenFlu-A&B and RT-PCR tests, and 4584 records were useful for further analysis. Starting from the most relevant variables in a Generalized Estimating Equations (GEE) model, we calculated the area under the Receiver Operating Characteristic curve (ROC-AUC), sensitivity, specificity and likelihood ratios for positive (LR+) and negative test results (LR-) of single and combined signs, symptoms and context taking into account pre-test and post-test odds.

Results:
In total 52.6%(2409/4584) of the samples were positive for influenza virus: 64%(2066/3212) during and 25%(343/1372) pre/post an influenza epidemic. During and pre/post an influenza epidemic the LR+ of 'previous flu-like contacts', 'coughing', 'expectoration on the first day of illness' and 'body temperature above 37.8°C' is 3.35(95%CI:2.67-4.03) and 1.34(95%CI:0.97-1.72), respectively. During and pre/post an influenza epidemic the LR- of 'coughing' and 'a body temperature above 37.8°C' is 0.34(95%CI:0.27-0.41) and 0.07(95%CI:0.05-0.08), respectively.

Conclusions:
Ruling out influenza using clinical and contextual information is easier than ruling it in. Outside an influenza epidemic the absence of cough and fever (>37,8°C) makes influenza 14 times less likely in ILI patients. During an epidemic the presence of 'previous flu-like contacts', cough, 'expectoration on the first day of illness' and fever (>37,8°C) increases the likelihood for influenza threefold. The additional diagnostic value of rapid point of care tests still has to be established.

PRESENTATION 5: Friday 14th October, 2011 **THEME PAPER**
14.00–14.30 h.

TITLE: Do GPs' consultation rates influence their prescribing patterns of antibiotics for acute respiratory tract infections?

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Background:
The present study is part of the Prescription Peer Academic Detailing (Rx-PAD) study, an educational intervention study in GPs' Continuous Medical Education (CME) aiming at improving the quality of GPs' antibiotic prescription patterns for acute respiratory tract infections (ARTIs).

Research question:
To examine general practitioners' (GPs') prescribing patterns of antibiotics for ARTIs as compared with national guidelines. We also wanted to explore possible predictors of antibiotic prescription patterns.

Method:
Observational study based on prescription data from 440 Norwegian GPs in December 2004 through November 2005. Outcome measures were: Type and frequency of antibiotic prescriptions for various ARTI diagnoses with patients' and GPs' characteristics as explanatory variables.

Results:
In the study period, the 440 GPs treated a total of 142, 900 ARTI episodes. In 33.5% (95% CI: 31.9% to 35.1%) of these episodes an antibiotic was issued, of which penicillin V (pcV) accounted for 41.2% (95% CI: 37.4% to 44.9%). GPs with a high number of total annual encounters had higher antibiotic prescription rates for ARTIs and used more non-pcV compared to GPs with fewer annual patient encounters. GPs in the highest quintile with respect to total annual encounters rates had 1.6 times the odds of prescribing antibiotics compared to GPs in the lowest quintile. Correspondingly, the odds of choosing a non-pcV antibiotic were 2.8 times higher in the top quintile of GPs' compared to the bottom quintile with respect to antibiotic prescription rates.

Conclusions:
ARTIs are frequently treated with antibiotics, and often with more broad-spectrum agents than pcV which is the recommended first line antibiotic in the Norwegian guidelines. GPs with a high practice activity are in general more liberal with respect to prescription of antibiotics for ARTIs, and the higher the antibiotic prescription rates, the larger the share of non-pcV agents.

PRESENTATION 6: Friday 14th October, 2011 **THEME PAPER**
14.30–15.00 h.

TITLE: Impact of amoxicillin therapy on oropharyngeal streptococci of patients with community-acquired lower respiratory tract infections.

AUTHOR(S): Surbhi Malhotra-Kumar, Liesbet Van Heirstraeten, Samuel Coenen, Christine Lammens, Greet Ieven, Chris Butler, Theo Verheij, Paul Little, Herman Goossens on behalf of the GRACE Study Group

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Background:
We previously showed that macrolide use is the single most important driver of macrolide resistance in oropharyngeal streptococci of healthy volunteers (Lancet 2007;369:482-90). This randomized, double-blind, placebo-controlled study (RCT) investigated the effect of amoxicillin therapy on non-susceptibility in oropharyngeal streptococci of adult patients presenting to primary care with community-acquired lower respiratory tract infection (LRTI) in GRACE (Genomics to combat Resistance against Antibiotics in community-acquired LRTI in Europe; www.grace-lrti.org)

Method:
Patients received amoxicillin (1 gram, TID; n=37) or placebo (n=38) for 1 week. Oropharyngeal swabs collected at baseline (d0), at day 8 (d8) and 28 (d28) were spiral plated on streptococci selective medium with and without amoxicillin (0.5 µg/ml) or penicillin (0.25 µg/ml). Proportions of amoxicillin - and penicillin - non-susceptible streptococci were determined by colony counts and analyzed using linear mixed models.

Results:
Mean proportions of amoxicillin - and penicillin - non-susceptible streptococci did not differ significantly at d0 (-6.6%, 95% CI -16.5 – 3.2, and -0.6%, 95% CI -5.3 – 4.2, respectively), were significantly higher in the amoxicillin group compared to the placebo group on d8 (mean differences 41.5%, 95% CI 31.6 − 51.3, and 44.2%, 95% CI 32.0 − 56.3, respectively), and not differ significantly at d28 (1.3%, 95% CI -8.6 – 11.2, and -3.4%, 95% CI -8.2 – 18.5, respectively).

Conclusions:
Temporal persistence of resistance selection is much shorter with amoxicillin (<1 month) compared to macrolides (> 6 months for azithromycin and clarithromycin), which has important therapeutic and public health implications. Strategies promoting appropriate antibiotic use and targeting prescribers, e.g. guidelines, should take these findings into account to support the choice of recommended antibiotics in those conditions where antibiotic treatment is justified.

Points for discussion:
1. Will knowledge about the shorter temporal persistence of resistance selection of amoxicillin compared to for example macrolides make prescribers use the recommended antibiotic for most respiratory infections more often when antibiotic treatment is just

PRESENTATION 7: Friday 14th October, 2011 FREESTANDING PAPER
15.30–16.00 h.

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

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Background:
Due to ageing, multimorbidity is a new, poorly defined, but highly practically relevant phenomenon in primary care. Good management of multimorbid patients is deeply in touch with the GP's core competencies, and especially with the holistic modelling core competency. A valid definition could also help to detect frail patients in primary care before decompensating.

Research question:
What are the definitions and criteria found in the literature for multimorbidity?
Method: Systematic qualitative review of literature with nine national teams from EGPRN (European general practitioner research network). The only keyword was multimorbidity. Searched databases were Pubmed, Embase and Cochrane. For inclusion, criteria for multimorbidity should be described in the article. Articles were dispatched between the national teams according to their own language, and doubly screened. Two independent researchers did data extraction first in an open way, then a thematic analysis was done.

Results:
A total of 416 abstracts were extracted and, 66 articles included. Excluded articles were editorials and not scientific articles for (5), multimorbidity was only a 'leitmotiv' for (7) papers, and scientific quality of the article was considered too poor for (2), leaving 52 papers. Data extraction will be done by all teams for the meeting. The French team extraction of data is yet available and theydid retrieved 501 different criterias with at least 60 different definitions.

Conclusion:
Multimorbidity is an enormous concept with a broad range of definitions. Those definitions are changing from study to study,. aAs most definitions have been createdmade for research purposes, GPs should perhaps develop and validate their own definitions to allow better and more specific practical use.

Points for discussion:
As comorbidity and morbidity as often use as synonyms of multimorbidity should we include those terms in our keywords for database searches?

PRESENTATION 8: Friday 14th October, 2011 FREESTANDING PAPER
16.00–16.30 h.

TITLE: Impact of Body mass index and Body Weight perception on adolescent's' depression: study of an interaction.

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Background:
Adolescents with extra norm body mass index (BMI) and/or incorrect body weight perception (BWP - "how do you see your weight at present?") are at higher risk of depression, eating disorders, and suicide. An interaction between BMI and BWP is highly suspected. But in literature sample sizes were often insufficient, and adolescent's' depression has always been measured with adolescent's non-specific instruments.

Research question:
Is there an interaction between BMI and BWP on adolescent's' depression?

Method:
In 2008, a national representative survey, ESCAPAD, interviewed 39, 542 adolescents of 17 years old with a self-administered anonymous questionnaire. Following WHO thresholds, adolescents were classified as underweight (BMI ≤ 17 kg/m2), normal weight (BMI between 17-24), overweight (24-29), or obese (BMI > 29). Five items were proposed to characterize BWP (much too thin/fat, a little too thin/fat and almost the right weight). Depression was measured with an adolescent's validated instrument, the Adolescent Depression Rating Scale. The interaction between BPW, BMI and depression scores was studied using variance analysis, adjusted on parent's' work status and family structure.

Results:
Overall 84.1 % of adolescents reported a normal BMI. For BWP, 57.4 % of adolescents perceived themselves as almost the right weight, but 17.2 % boys perceived themselves as a little too thin, whereas 39.0 % girls considered themselves a little too fat and 5.0 % much too fat. Whatever their BMI and gender, adolescents who felt almost the right weight had the lower depression scores. The higher depression scores concerned were found in girls with normal BMI but a BWP of having much too fat.

Conclusions:
BWP was more discriminating than BMI for adolescents' depression scores: adolescents not feeling at the right weight were more depressed. During medical consultation, asking for BWP when weighting adolescent could help to better identify those at higher risk of depression, especially for girls with a normal BMI.

Points for discussion:
- Do you ask patients for their BWP? How do you handle the answer?
- Are you aware of BWP measurement in Primary Care in your country?

PRESENTATION 9: Friday 14th October, 2011 **FREESTANDING PAPER**
16.30–17.00 h. **Ongoing study with preliminary results**

TITLE: Are you a good partner when your patient with an unintended pregnancy speaks to you?

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Background:
In many European countries induced abortion is legal. The GP's role in reproductive health care differs in each country. Previous studies showed mainly research on the experience of women with counseling and procedures in the centers but not on the role of the GP. The counseling of contraceptives and women requiring an induced abortion is suboptimal.

Research question:
What are abortion clients' Which opinions and experiences do abortion clients have about thewith general practitioners with respect to in counseling for contraceptives and unintended pregnancy/induced abortion?

Method:
This research was done from a phenomenological perspective. Abortion clients were recruited in two abortion centers in Flanders. Semi-structured interviews (n= 16) were performed with Dutch speaking Belgian or foreign women, aged from 16 to 29 years old. The interviews were tape recorded and typed afterwards. These transcripts were coded in Nvivo8 by 3 researchers creating a codebook. New codes were added during the whole process of analyzing. Saturation for the patient's view on the doctor's role was reached.

Results:
A cClose relationship with the GP can be threatening whento discussing an unintended pregnancy because of the risk of breaching one's duty of professional confidentiality. Some women prefer to visit their gynecologist, because they think he has more competence and they trust him more. Nearly all patients who visited the GP appreciated the open non-judging attitude and the good referral procedure. Women mainly chose the GP for contraception prescriptions and thought they were well informed. Some GPs didn't know that nullipara might have an IUD. None of the women was referred to her GP after the abortion, although they preferred the GP to talk to the GP about their contraceptive choice.

Conclusion:
A close relationship with the GP can stimulate women to talk about unintended pregnancy but it can also be an obstacle. GPs need to improve their knowledge on contraceptive health.

Points for discussion:
1. Would recruitment of patients in GP general practice give other results? Can we decide that saturation was reached?
2. Role of GP in other European countries?

PRESENTATION 10: Friday 14th October, 2011 17.00–17.30 h. **FREESTANDING PAPER**

TITLE: Family Doctors opinions about patient involvement in decision-making. A study with video-vignettes

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Background:
Patient's involvement in decision making (PIDM) is increasingly advocated and widely accepted. Nevertheless, there is still no agreement among professionals and patients about what this concept means and how doctors can apply it in practice.

Research question:
Do family doctors identify PIDM? Do the doctors consider PIDM as appropriate for the Primary Care setting and for the type of consultation explored?

Method:
In this study 120 fFamily dDoctors attending continuing educational workshops were invited to watch four video-vignettes of simulated consultations portraying four different doctor's styles regarding PIDM: (A) Doctor-Centered; (B) Shared Decision Making 1; (C) Shared Decision Making 2; (D) Patient-Centered (Selected passages will be shown). With a 10 points Analogical-Visual-Scale, doctors assessed the PIDM as well as their opinion about the appropriateness of the doctor behaviour. Analysis: A descriptive and X Square.

Results:
The table shows the scores of the 4 interviews for the degree of participation and the appropriateness of doctor behaviour. There were a significant number of doctors that considered appropriate consultations with low patient participation (A 4.49; p: 0.034; B 29.8; p <0.001) and the opposite occurred in patient the centered scenario (D 20.14; p<0.001).

Type of Interview	A	B	C	D
Pat Participation	1.50/ 1.25-1.75	5.54/ 5.17-5.91	7.18/ 6.88-7.48	8.20/ 7.84-8.56
Doc Adequacy	3.81/ 3.46-4.15	6.5/ 6.2-6.85	7.58/ 7.25-7.9	7.44/ 6.96-7.91

Mean/IC 95%

Conclusions:
In primary care setting and dealing with an acute self limited and low risk problem, doctors recognized different levels and ways of PIDM. They see the patient involvement that generates a “pure” patient-centered consultation as higher than the involvement made by a formal Shared Decision Making consultation. Nevertheless some of them considered the directive approaches more realistic in practice.

Points for discussion:
Is theto involvement of patients in decision making the same as to be patient-centered?
Is to be patient-centered the same as to share decision making?
To IPDM as the Shared Decision Making models propose (C Charles et al. Soc Sci Med 1997; 44:681-92) is a

PRESENTATION 11: Friday 14th October, 2011 FREESTANDING PAPER
15.30–16.00 h. Ongoing study with preliminary results

TITLE: Predisposing, enabling and reinforcing factors to preventive healthcare in general practice. A qualitative study based on interviews

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Background:
In Belgium, success in implementing preventive care remains below expectations in various areas, often with a socioeconomic gradient, with poorer coverage for the disadvantaged. A greater involvement of GPs in preventive healthcare would be needed, but their means and desire to be implementers of public health policy is unknown.

Research question:
What do GPs say about several preventive healthcare related determinants identified through a literature review?

Method:
We conducted ten semi-directed structured interviews with French-speaking GPs (purposive sampling). A literature review was carried out in order to choose the themes to be investigated:

- Definition of and place of preventive care within the practice;
- Organization of preventive care;
- Application of recommendations regarding preventive care in GP practice, influence of the doctor's faith in the preventive procedure;
- Place of GPs in the country's preventive care system;
- Ways of implementing preventive care assessment.

The content was analyzed in a thematic way with reference to the Walsh & McPhee systems model of clinical preventive care.

Results:
Predisposing factors: limitations were cited: taboo subjects, GP's' specific skills and interests. Equity was not a major concern. Reinforcing factors: media influence certain preventive actions. Self assessment was rare. Preventive activities within a structured organization and contact with peers were valuable supports. Internal enabling factors: clinical and relational skills were sometimes lacking. The information sources were sometimes of poor quality. The lack of organizational skills hinders collective management or systematization. External enabling factors: preventive processes are often introduced in an opportunistic way, or at the patient's' requests. Data circulation between the various providers is poor. Direct GPs' involvement was better accepted than public health campaigns.

Conclusions:
GPs are currently involved in preventive healthcare mainly in an opportunistic way at an individual level. Proactive behavior towards patients and organizational skills for collective management are underdeveloped.

Points for discussion:
1. Paradigm shifts
Beyond organizational change and improvement of skills, it seems that the attitude of doctors needs to evolve. I would like to discuss the relevance of two paradigm shifts that were identified in this study. The first paradigm

PRESENTATION 12: Friday 14th October, 2011 **FREESTANDING PAPER**
16.00–16.30 h. **Ongoing study with preliminary results**

TITLE: Harmonizing electronic data from a German GP based research network.

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Background:
Practice based research networks (PBRN) and using GPs' electronic routine data for secondary analysis have been feasible and successful in health services research.
In Germany, to utilize GPs' data is hampered by

- a vast number of existing practice information systems (PIS)
- missing uniform requirements for internal data representation
- insufficient software interfaces for external data communication
- lacking consensus on essential PIS data for primary care research.

Research question:
To identify benefits of PBRN for participating practices and researchers.
To promote consensus by presenting actual definition and requirements of a scientific use file (SUF).

Methods:
Focus group discussion of teaching and affiliated general practitioners, its video- and audio-recording being analyzed using mind mapping technique for data interpretation.
Literature research.
Case study of ongoing research and technical implementation.

Results:
General practitioners in the focus group discussion had no fundamental objection against utilization of their PIS data for research purposes. They emphasized the importance of their own early involvement in research question generation, effective both-way communication, a clear and comprehensive description of their prospective workload within such a network, and requested minimal disturbances of daily practice.
Using Unified Modelling Language (UML), an extensive overview of data elements from PIS with their internal hierarchy and relationship was created and considered to be sufficient for most research questions. Central orientation was the single encounter between patient and his GP. Patient's, physician's and practice specific data were identified.

Conclusions:
In the ongoing process of building a practice based research network for utilization of GPs' electronic routine data, major steps weare reached with identifying crucial prerequisites and demands on side of the GPs generating primary data, with technically defining automatized, repeated, standardized, reliable and secure data communication, and with selecting relevant elements and their interdependence for a scientific use file in primary care research.

Points for discussion:
Missing prerequisites or demands from the GP's point of view?
Missing elements for a scientific use file (SUF)?
Recommendation for effective data communication?

PRESENTATION 13: Friday 14th October, 2011 **FREESTANDING PAPER**
16.30-17.00 h. **Research in progress, without results**

TITLE: Translational research and patient safety in Europe (TRANSFoRm).

AUTHOR(S): Bastiaens H, Leysen P, Argeus L, Taweel A, Delaney BC, Van Royen P on behalf of the TRANSFoRm Consortium.

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Background:
TRANSFoRm (www.transformproject.eu) is a 5-year, 18 partner integrated project partly funded by the European Commission that aims to develop the infrastructure for the learning healthcare system in Europe.

Research question:
To develop the rich capture of clinical data in electronic health records (eHR)
To enable the interoperability of eHR data to enable large-scale studies/clinical trials
To develop software tools and services to enable integration and reuse of clinical research data.

Method:
The first year of the project has defined two clinical research 'use cases' which will underpin the development of the software and its evaluation. An analysis of requirements of these use cases, linking to the relevant EU legal and ethical frameworks has informed the development of a confidentiality and privacy framework. This framework is reflected in plans to manage provenance (audit and tracking), security (access control) and the plans for development of the system architecture.

Results:
Clinical use cases were developed with an emphasis on the challenges and requirements that they raise for the project. These are, a phenotype-genotype study of risks of complications and response to oral medication in Type 2 diabetes mellitus, a case-control study of the risk of developing adenocarcinoma of the oesophagus relating to gastro-oesophageal Reflux Disease (GERD)symptoms and Proton Pump Inhibitor (PPI) use, and an RCT of on-demand versus continuous PPI use in GERD with patient-related outcomes. A confidentiality framework allowing researchers to use completely anonymised data and linked- 'pseudo-anonymised' data as appropriate for the project and the local legal reguirements was developed.In close collaboration with EGPRN, the capacity and readiness of existing national/regional health care databases for linkage to the project, their interactivity with high quality eHR-systems across Europe was finalised.

Conclusion
TRANSFoRm is an important project aiming to support patient safety and clinical research in primary care

Points for discussion:
How will this project help to integrate different databases from different health care systems, across countries?

PRESENTATION 14: Friday 14th October, 2011 FREESTANDING PAPER
17.00-17.30 h.

TITLE: TRANSFoRm: Defining functional requirements for the learning healthcare system.

AUTHOR(S): Bastiaens Hilde, Leysen P., Wens J., Argeus L., Delaney B.C, Van Royen P. on behalf of the TRANSFoRm Consortium.

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Background:
TRANSFoRm (www.transformproject.eu) is a 5-year, 18 partner integrated project part-funded by the European Commission that aims to develop the infrastructure for the learning healthcare system in Europe. During the first year of the project, we have developed two research 'use cases', one on diabetes mellitus (DM) and one on gastro-esophageal reflux disease (GERD) and conducted a detailed requirements analysis.

Research question:
The purpose of the two use cases is to serve as a vision for the development of models and systems.
Method:
The well-defined use case was worked out in three steps: 1) development of a clinical study outline based on literature and expert meetings, 2) translation of parameters for clinical studies into data elements and 3) translation of key requirements for the clinical studies into key functionalities of the TRANSFoRm system and into a model.

Results:
Parameters related to selection of patients and extraction of variables were translated into data elements (e.g. diagnosis of type 2 DM…) and operational selection criteria (e.g. coded diagnosis, therapeutic and laboratory data). The following main functional requirements were derived from the use cases:
- Authorisation model: general or explicit depending on data type (DM, GERD)
- Consent model : general or explicit depending on data type (DM, GERD)
- Maintenance of phenotypic linked data: allowing linked data to be updated for cohorts (DM GERD)
- Selection of SNPs: allowing selection of subjects within identifiable data (DM)
- Recruitment agent: real time recruitment from eHR (GERD)
- Recruitment service: manages subject contact and consent on behalf of sites (GERD)
- Semantically enriched eCRF tool: links eHR and research data in real time (GERD)
- Subject portal: for questionnaire completion via web or mobile device (GERD)

Points for discussion:
- Are these use cases and the requirements analysis relevant for future clinical research in primary care?

PRESENTATION 15: Saturday 15th October, 2011 **THEME PAPER**
09.15-09.45 h.

TITLE: Disease-specific antibiotic prescribing quality indicator assessment in a Flemish out-of-hours service centre.

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Background:
Antibiotic use is increasingly recognised as the main driver for antimicrobial resistance, and the largest volumes of antibiotic prescriptions for systemic use are prescribed in primary care. If we want to improve antibiotic use, we have to be able to measure its quality. Recently, the European Surveillance of Antimicrobial Consumption (ESAC; www.esac.ua.ac.be) project published a set of disease-specific antibiotic prescribing quality indicators (APQI) to assess the quality of antibiotic prescribing in primary care (BMJ Qual Saf 2011; online).

Research question:
What is the quality of antibiotic prescribing in the general practitioners' (GPs) out-of-hours service centre in Deurne-Borgerhout, Belgium (HDB) when applying these APQI?

Method:
Data linking International Classification of Primary Care (ICPC) labelled diagnoses with ATC labelled antibiotic prescriptions were extracted from the electronic medical record, HWP Mailer, which is mandatory used by every GP working in HDB. The values of each of the 21 APQI (3 indicators for each of 7 indications (ICPC codes H71, R74, R75, R76, R78, R81 and U71)) were calculated and compared with the proposed ranges of acceptable use (target)

Results:
Only for U71 (cystitis/other urinary infection) the percentage of patients prescribed an antibiotic (indicator a) reached the target. Within the subgroup of patients prescribed an antibiotic the percentage of those prescribed the recommended antibiotic (indicator b) and those prescribed a quinolone (indicator c), reached the target in none and four (H71 (acute otitis media/myringitis); R74 (acute upper respiratory infection); R75 (acute/chronic sinusitis); R76 (acute tonsillitis)) of the indications, respectively. For R78 (acute bronchitis/bronchiolitis) and R81 (pneumonia) none of the three indicators reached the target.

Conclusions:
Assessment of the ESAC APQI revealed suboptimal quality of antibiotic prescribing in a Flemish out-of-hours service centre (HDB). In particular, the use of recommended antibiotics offers a huge opportunity for quality improvement.

Points for discussion:
1. Are data to perform a similar assessment in daily general practice routinely available in your country?
2. Would you feed this information back to the prescribers?
3. What else would you do to deal with suboptimal quality of antibiotic prescribing in

PRESENTATION 16: Saturday 15th October, 2011 **THEME PAPER**
09.45–10.15 h. **Ongoing study with preliminary results**

TITLE: The appropriateness of prescribing antibiotics in primary health care in Europe: the APRES study.

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Background:
Resistance to antibiotics is increasing and this forms an important public health threat. In Europe, over 90% of all antibiotics are prescribed in primary care but research on resistance has primarily focused on hospital settings. The APRES study assesses antibiotic resistance patterns in the community and antibiotic prescription patterns in primary care, and is being carried out in nine European countries. This results in evidence-based antibiotic treatment guidelines in primary health care in Europe, to facilitate GPs in prescribing antibiotics, taking resistance patterns into account.

Research question:
To what extent is the prescribing behaviour of primary care physicians in Europe congruent with the national or regional community antibiotic resistance patterns?

Method:
1) Resistance patterns: Resistance data wasis collected from November 2010 to June 2011 by taking nose swabs of patients (N=4,000 per country) visiting a primary care practice for a non-infectious disease. Two bacteria wereill be isolated (Staphylococcus aureus and Streptococcus.pneumoniae) and tested for resistance to a range of antibiotics in one central laboratory. 2) Prescription patterns: Data on antibiotic prescriptions for the past 5 years will be extracted from the practice data systems of the participating GPs (N=20 per country).

Results:
Data collection for resistance patterns has been completed;, 31,367 swabs have been collected (see Table). Prevalence patterns of S aureus and S pneumoniae vary across Europe, resistance testing is ongoing. Prescription data is expected at the end of 2011. To make recommendations, a first investigation of relevant guidelines has been done. This indicated variation throughout Europe, regarding quality and content of the guidelines.

Conclusions:
Data collection and analysis is ongoing, a further update will be presented at the conference. APRES aims to present an integrated analysis (resistance patterns, prescriptions patterns) of antibiotic use in primary care across Europe, resulting in evidence based recommendations for antibiotic treatment guidelines.

Points for discussion:
Table 1: APRES data collection – status update.
APRES: overview of the number of swabs taken and the S. aureus and S. pneumoniae rates of all countries.
Country-Reporting date-Collected swabs -S. aureus rate % -S. pneumoniae rate %.

PRESENTATION 17: Saturday 15th October, 2011 **THEME PAPER**
10.45-11.15 h.

TITLE: The association between breastfeeding initiation and respiratory infections in infants.

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Background:
Respiratory illness is one of the leading causes of morbidity and mortality in children under five years old. Breastfeeding has been well established as the optimal form of nutrition for infants, with breastfed infants less prone to a variety of illnesses. The association between breastfeeding and respiratory infection however is not clear and remains controversial.

Research question:
Does any amount of breastfeeding provide a protective effect against respiratory infection in Irish infants?

Method:
This study presents findings from the first wave of data collection from the national Growing Up in Ireland cohort study. The sample of 11,134 nine month old infants was randomly selected from the national Child Benefit Register. Data collection consisted of questionnaires completed with the primary caregiver addressing the breastfeeding and respiratory infection history of the infant. Pearson's Chi-Square test and logistic regression analysis were used to investigate the association between breastfeeding and respiratory infection.

Results: Infants who had been breastfed were significantly less likely to have been taken to a health professional for asthma or wheezing (7.1%; [95% confidence interval CI: 6.5 – 7.7%] vs. 11.2% [10.4 – 12.1%]), or because of a chest infection (28.9% [27.8 – 30.1%] vs. 36.2% [34.9 – 37.6%]) than those never breastfed. This association remained significant for children who had never been breastfed in logistic regression models which were adjusted for social inequalities and maternal risk factors. The odds ratio (OR) for being diagnosed with a respiratory illness was 1.36 [1.08 – 1.70], for being seen due to asthma or wheezing it was 1.23 [1.06 – 1.42] and for chest infection 1.15 [CI: 1.05 – 1.27].

Conclusions:
These findings indicate that breastfeeding is an important protective factor against respiratory infection in Irish infants. This finding can assist practitioners in family medicine in providing education and support to parents.

Points for discussion:
Respiratory infections in infancy and the predominant wheeze phenotype seen in this population.
The established benefits of breastfeeding for infants, particularly focusing on protection against infectious diseases.
Increasing breastfeeding rates throug

PRESENTATION 18: Saturday 15th October, 2011 **THEME PAPER**
11.15-11.45 h.

TITLE: Irritable bowel syndrome and chronic fatigue three years after acute giardiasis.

AUTHOR(S): Knut-Arne Wensaas, Nina Langeland, Kurt Hanevik, Kristine Mørch, Trygve Hausken, Geir Egil Eide, Guri Rortveit

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Background:
Giardia lamblia is a common cause of acute and chronic gastroenteritis. It is endemic in many tropical and sub-tropical areas, whereas in Europe and North-America Giardia is a frequently identified pathogen in waterborne outbreaks of disease. There is limited knowledge about the long term complications after giardiasis.

Research question:
What is the prevalence and relative risk of irritable bowel syndrome (IBS) and chronic fatigue three years after acute giardiasis?

Method:
Historic cohort study after a large community outbreak of giardiasis in Bergen, Norway, in the autumn of 2004. We mailed a questionnaire to all 1252 patients who had verified giardiasis by detection of cysts in stool samples, and to 3598 uninfected controls matched by age and gender. The main outcomes were IBS according to Rome III criteria and chronic fatigue.

Results:
A total of 817 patients exposed to Giardia lamblia infection and 1128 matched controls participated in the study. The prevalence of IBS in the exposed group was 46.1% , compared to 14.0% in the control group, and the adjusted relative risk was 3.4 (95% CI 2.9–3.8). Chronic fatigue was reported by 46.1% of the exposed and 12.0% of the controls, the adjusted relative risk was 4.0 (95% CI 3.5–4.5). IBS and chronic fatigue were associated and the relative risk for the exposed group of having the combination of the two outcomes was 6.8 (95% CI 5.3–8.5). The relative risk was also increased for having just one of the two syndromes only, 1.8 for IBS (95% CI 1.4–2.3) and 2.2 for chronic fatigue (95% CI 1.7–2.8).

Conclusions:
Infection with Giardia lamblia in a non-endemic area was associated with a high prevalence of IBS and chronic fatigue three years after acute illness, and the risk was significantly higher than in the control group.

Points for discussion:
1. How can an acute duodenal infection, like giardiasis, cause chronic problems including large bowel symptoms and systemic manifestations?
2. How will the choice of setting and sample population influence possible research questions and results in res

PRESENTATION 19: Saturday 15th October, 2011 **THEME PAPER**
11.45-12.15 h. **Ongoing study with preliminary results**

TITLE: Hepatitis C Virus infection in men having sex with men: awareness of general practitioners in Flanders, Belgium.

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Background:
During the last ten years an increasing incidence of acute hepatitis C virus (HCV) infection has been observed amongst human immunodeficiency virus (HIV)-infected men having sex with men (MSM). Recent studies found that this increase is due to sexual transmission, suggesting the presence of an international MSM specific transmission network. Rough sexual techniques, ulcerative sexually transmitted infections (STIs), recreational drugs, and inconsistent condom use were found to be significant risk factors for HCV transmission in HIV-positive MSM. Full understanding of the exact sexual practices leading to transmission is lacking.

Research question:
What is the awareness of Flemish general practitioners (GPs) about the risk factors for sexual transmission of HCV among MSM?

Method:
An online survey, including seven multiple choice questions to define the GP profile, and a short case describing an MSM patient was sent by email to all GPs involved with vocational training at the four universities of Flanders.
Statistical analysis was performed with SPSS 18.0.

Results:
A total of 187 (response rate 36 %) GPs anonymously completed the questionnaire. Of these, 54.,8% wereas working in urban areas, 71.,7% in group practices, 66% had over 15 years of experience. Overall 26.,2% never or seldom performed STI consults and. 44.,9% saw between 2 - 5 and 5 STI patients per month. The majority, 64%, considered they had enough skills concerning STIs. Working in a group practice and/or in the city significantly correlated with increased contact with STI and MSM. The number of STI consults and MSM patients per month significantly influenced the attitude of screening for acute HCV infection.

Conclusions:
Workplace and –context are important factors that influencinge awareness of Flemish GPs concerning HCV among MSM.
A new call has been issued to the same group of GPs to increase the response rate. Complete results will be presented at the EGPRN congress.

Points for discussion:
High number (26.,2%) of GPs reporting no or rare STI consults: what to think about that?
HCV awareness in other European countries.

PRESENTATION 20: Saturday 15th October, 2011 FREESTANDING PAPER
12.15-12.45 h.

TITLE: Roles of health care assistants with a foreign background in Germany.

AUTHOR(S): Karola Mergenthal, Martin Beyer, Corina Guethlin.

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Background:
We know that 16.0 million people with a migration background live in Germany. There is only a small number of foreign doctors practicing in primary care, the number of foreign health care assistants (HCA), however, is fairly high. We could not find any studies in Germany regarding , how professionals with a foreign background specifically contribute specific potentials to the activities and care of GP teams.

Research question:
What are the roles of health care assistants with a foreign background? Are they using their cultural competencies in face to the patient consultations?

Method:
A convenience sample of six HCA from six6 general practices in Hessen/Germany was interviewed. The interviews were carried out by using semi-standardized interviews. After transcription, the interviews were analyzed using content analysis according to Mayring by a team of psychologist, medical student and the first author (being a trained HCA and researcher in public health).

Results:
Towards (immigrant) patients, HCAs with a migration background (Turkish/Serbian/Morrocan/Italian) often take over the role of a translator, a cultural mediator, and, by times, a confidant. This is not confined to members of the same nationality but foreigners in general. Initially some reserves on the part of the (domestic) team as well as of the (domestic) patients were reported. That changed very quickly into acceptance and consideration. In sum they emphasize their full integration into the practice team.

Conclusions:
Health care assistants in Germany with migration backgrounds consider themselves as fully integrated into the practice team and being accepted by the (domestic) patients. Particularly in practices with a high proportion of immigrant patients, they provide additional services (interpreter, confidaent person) and help the practice team to meet the needs of these patients. Acknowledging a reality of up to 30-40% immigrant patients in inner-city practices in Germany, it is recommended that the intercultural competencies of HCA should be fostered and recognized.

Points for discussion:
What's the position of immigrant members of primary health care teams in other European countries? How can intercultural competencies of immigrant members of the team be fostered in order to improve access (and adequate understanding) for immigrant patients?

PRESENTATION 21: Saturday 15th October, 2011 FREESTANDING PAPER
10.45-11.15 h.

TITLE: The effectiveness of care in high cardiovascular risk patients in the Hungarian primary care.

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Background:
Cardiovascular diseases (CVD) have the highest mortality rate in Europe.
Guidelines divide high cardiovascular risk patients into three groups: 1/patients with, 2/without cardiovascular symptoms, and 3/very high risk patients associated with diabetes, smoking or metabolic syndrome.

Research questions:
How the target levels of guidelines meets the laboratory values of patients with hypertension, dyslipidemia and diabetes. How GPs consider treatment recommendations?

Method:
A Rrepresentative sample of Hungarian GPs were involved in this cross sectional study. Patients treated for diabetes, hypertension and dyslipidemia were randomly selected by the participating 20 GPs.
Electronic data sheets were filled completed with all parameters needed for estimating cardiovascular risk and treatment. The average of previous measurements in the past year was considered and evaluated how the target values were reached.

Results:
Data of 679 patients were evaluated; 60% of the study population wereas above 60years, 36% had high risk without cardiovascular symptom and 48% had very high risk.
Statins were administered byto 80% of the dyslipidemic patients.
ToBy hypertensive patients: 85% ACE inhibitors or AT receptor blockers, 70% beta blockers, 50% calcium channel blockers and 50% diuretics were prescribed.
, Toby diabetics: 70% biguanids, 50% sulfanylurea, 30% insulin and 10% gliptins were prescribed.
Only 14% of patients reached the target cholesterol, and 40% the target blood pressure levels.
Only 26% of diabetic patients had a HbA1c target level below 6.5%, and 57% of them below 7%, 15% had a fasting blood glucose level below 6mmol/L.
In hypertensive patients whose blood pressure were above the target value, not recommended drug combinations were found in a significantly higher ratio.
Conclusions:
Comparing the published data from other European countries, the effectiveness of care of patients with hypertension and dyslipidemia is fairly good, while target values in diabetic HbA1c patients is poorly reached. Further improvement is desirable regarding patient's' compliance and the activity of GPs.

Points for discussion:
1. How to improve patient's compliance?
2. How to improve doctors's adherence to guidelines?
3. Please share with us your positive experiences and tools for the more effective treatment.

PRESENTATION 22: Saturday 15th October, 2011 FREESTANDING PAPER
11.15-11.45 h.

TITLE: Ruling out Coronary Artery Disease in Primary Care: the Marburg Heart Score.

AUTHOR(S): Norbert Donner-Banzhoff, MHSc, Stefan Bösner, Paul Vaucher, Lilli Herzig, Monika Heinzel-Gutenbrunner, Erika Baum, Jörg Haasenritter

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Background:
Chest pain is a symptom frequently presented to GPs. Although coronary artery disease (CAD) is the cause in only 10% to 15% of cases, it has to be ruled out with sufficient certainty. We developed a simple clinical decision rule with five5 items. Here we wish to present the results of the second external validation in general practice patients.

Research question:
Is the Marburg Heart Score (MHS) valid for ruling out CAD in patients presenting with chest pain in primary care? How does its accuracy compare with GPs' clinical judgment?

Method:
Cross-sectional diagnostic study with delayed-type reference standard; 56 German GPs recruited 844 men and women aged ≥ 35 years presenting with chest pain between July 2009 and February 2010. Baseline data included the items of the MHS and the GPs' clinical judgment. Data on subsequent course of chest pain, investigations, hospitalisations and medication were collected over six6 months and were reviewed by an independent expert panel. CAD was the reference condition. Measures of diagnostic accuracy included area under the ROC curve (AUC), sensitivity, specificity, likelihood ratios, and predictive values.

Results:
The area under the curve was 0.84 (0.80-0.88). For a cut-off of 3, the MHS showed a sensitivity of 89.1% (95% CI: 81.1 to 94.0%), a specificity of 63.5% (95% CI: 60.0 to 66.9%), a positive predictive value of 23.3% (95% CI: 19.2 to 28.0%), and a negative predictive value of 97.9% (95% CI: 96.2 to 98.9%). The GPs whose clinical judgment was aided by the score showed a higher sensitivity (90.0 versus 82.9%) and specificity (66.8 versus 61.8) than their colleagues' unaided clinical judgment.

Conclusions:
Considering the MHS's robustness, the easy application, and its potential for increasing the diagnostic accuracy of the GPs' clinical judgment we recommend its use in clinical practice.

Points for discussion:
Which research designs are appropriate for deriving and validating diagnostic tests in low prevalence settings?
Are clinical predictions rules worthwhile? What determines their usefulness for experienced GPs?

PRESENTATION 23: Saturday 15th October, 2011 FREESTANDING PAPER
11.45-12.15 h.

TITLE: Safe exclusion of Pulmonary Embolism using the Wells rule and D-dimer testing in Primary Care: a diagnostic validation study.

AUTHOR(S): Petra Erkens, G.J. Geersing, W.A.M. Lucassen, H.E.J.H. Stoffers H.R. Buller, A.W. Hoes, R. Oudega, M.H. Prins, H. Ten Cate H.C.P.M. Weert, K.G.M. Moons

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Background:
Pulmonary Embolism (PE) is the most frequently missed diagnosis in medicine. General Practitioners (GPs), who are commonly the first to encounter outpatients with suspected pulmonary embolism, need an accurate diagnostic tool that enables them to discriminate between patients in whom PE can be excluded and patients with a high probability of PE, who need referral for further diagnostic work-up.

Research question:
Does the Wells rule for PE combined with D-dimer testing safely exclude PE in primary care?

Method:
Between November 2007 and December 2010 approximately 500 GPs in three regions of the Netherlands included 604 patients with suspected PE in this multicenter diagnostic validation study. GPs scored the seven7 variables of the Wells score and performed the point-of-care D-dimer test (Clearview Simplify). Next, patients were referred to secondary care and diagnosed according local protocols, including quantitative D-dimer testing. PE was confirmed or refuted based on a composite reference, including three3 months of follow-up.

Results:
Mean age of the 604 study patients was 48 years and 71% were females. Using a threshold at ≤ 4 or <2, 427 and 240 patients were categorized as low risk by the Wells score, respectively. The point-of-care D-dimer test missed four4 (1.5%) and two2 (1.2%) cases of PE in these low-risk groups, respectively. Using a quantitative D-dimer test, only one1 case of PE was missed at a threshold ≤ 4 (0.4%) as well as at a threshold of < 2 (0.6%).

Conclusions:
Excluding PE using a Wells score ≤ 4 combined with a negative qualitative or quantitative D-dimer test is safe in primary care, with the highest safety for a quantitative D-dimer test.

Points for discussion:
How to use the Wells score for PE? One of the variables of the Wells score is the subjective criterion 'PE more likely than an alternative diagnosis'. What is the diagnostic value of this subjective criterion in primary care? How to score this crit

PRESENTATION 24: Saturday 15th October, 2011 **POSTER**
14.10-15.25 h.

TITLE: Prevalence of active Tuberculosis Infection Among Immigrant and Refugees.

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Background:
Without rapid scale-up of Tuberculosis (TB) prevention and diagnosis, some 10 million people will die of this curable disease by 2015. Addressing TB is also critical for meeting other development goals on poverty, HIV, women & children's health. Without investment on the diagnostic research, discovering the most powerful anti-TB drugs will not achieve the goal of eliminating the disease as a public health problem by 2050.

Research question:
What is the prevalence of clinically suspected TB cases among a refugee/immigrant population and what is the rate of active TB?

Method:
The specific immigrant data set of our practice (n=4160) for the year 2010 was analysed. Base screening for an adult included a physician-administered signs and symptoms questionnaire, physical examination and cChest X-rRay. Those younger than 15 years and older than two2 years are screened by TB Sskin test and, for those who were test positive, a two sided chest x-ray was ordered. Any cChest X-ray finding (evaluated by radiology specialist) or physical examination finding indicating a TB sign were asked for three3 sputum samples both for smears and cultures. A positive smear and/or culture result was the only diagnostic criteria for an active TB infection. Prevalence of active TB for the whole screening population in the 12 months was the outcome.

Results:
All of the applicants were tested for TB and the prevalence of findings indicative for TB infection was 2.5%. The Active TB diagnosis rate among the suspected cases wasere 1.92%. The prevalence of active TB was found to be 48/100, 000 for the year 2010.

Conclusions:
TB should not be underestimated. Published TB prevalence rates are 10-47/100,000 for the region. As nearly 2 million people die yearly, this pandemic airborne transmittable disease is worth to getdeserves a priority as a pan-European research target for European FP/GPs.

Points for discussion:
1. Is the designed TB screening method enough for the diagnosis of TB cases, are we missing some of the TB cases?
2. How can we check the appropriateness off the TB smear & TB culture procedure?

PRESENTATION 25: Saturday 15th October, 2011 **POSTER**
14.10-15.25 h. **Ongoing study with preliminary results**

TITLE: Pediatricians' attitudes and knowledge regarding antibiotics based on a questionnaire survey conducted within the National Programme for Antibiotic Protection.

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Background:
Antibiotic resistance (AMR) is currently one of the major threats to public health. Enhanced education of health care professionals on rational antibiotic use is a part of the strategy aiming at containment of this phenomenon. Paediatricians are one of the main antibiotics prescribers and one of the most important sources of information for patients.

Research question:
Is pediatricians' knowledge sufficient concerning the public threat of antimicrobial resistance and the actions needed to stop its spread?

Method:
A special questionnaire was prepared, consisting of 22 closed multiple-choice or multiple-response questions together with free response questions. The questionnaire survey was carried out in a single phase among the participants of the 8th edition of the Congress "Postgraduate Academy of Pediatrics", held in Warsaw, 11-12.03.2011. The congress was nationwide, with 1,500 physicians participating, of which 324 responded to the survey questions.

Results:
Ninety percent of respondents believe that AMR is a very serious problem. Among factors considered when prescribing antibiotics, health factors and therapeutic recommendations were indicated, also current epidemiological data and increasing AMR. Only 22% uses rapid Streptest for the diagnosis of pharyngitis. Nearly 40% indicated that purulent nasal discharge, high temperature, earache, chest pain, shortness of breath and increased respiratory rate require microbiological diagnostics. Nearly 60% prescribe antibiotics in acute bronchitis (1 year .of age) and 33% in acute otitis in children in 2nd year. of life, with first symptoms. Over 90% are aware of new national recommendations for the management of respiratory tract infections. All declared a need to learn more about general rules of the prudent antibiotic use, AMR and modern microbiological diagnosis.

Conclusions:
There is still not enough knowledge on rationale antibiotic therapy. Broaden and updated knowledge on the use of antibiotics and AMR are needed.

Points for discussion:
How to improve antibiotic prescriptions in paediatricians' practices.

PRESENTATION 26: Saturday 15th October, 2011 POSTER
14.10-15.25 h.

TITLE: Trend of antibiotics prescription in the General Practice Family Medicine in the centre of Portugal: how informatics can help ascertain its reality.

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Background:
Antibiotic prescription in the General Practice/Family Medicine setting is, for Portugal, of excessive volume, mainly for quinolones and cephalosporins. Informatic assisted antbiotic prescription allows the knowledge of the profile prescription and of the trend of its utilization.

Research question:
To study, bettween 2006 and 2010, the trend of the Daily Dedined Dose (DDD) prescription of the total of antibiotics, of quinolones and of cephalosporins, using he utilization index: DDD/1000inh/day.

Method:
Observational, retrospective, descriptive study using a statistical package to study the informatic generated files of prescription in a Centre of Portugal Health Unit, of 11 doctors and 5 trainnees. Population inscripted in the medium term of each consecutive year. Medicines studied by the third level of the Portuguese pharmacotherapeutical classification in DDD for volume.

Results:
We studied the antibiotic prescrition in a population of n=17385 in 2006 and of n=18402 in 2010. (Δ 2006-2010: 5,9).The utilization trend in DDD/1000 inhab/ day, bettween 2006 and 2010 for total antibiotics varied from 5,05 in 2006 to 5,10 in 2010 (Δ 2006-2010: 0,01), for Quinolones from 0,68 in 2006 to 0,44 (Δ 2006-2010: -0,36) and for Cephalosporines from 0,73 in 2006 to 0,56 in 2010 (Δ 2006-2010: -0,23). The ratio of total DDD of Cephalosporines and Quinolones in relation to the total of DDD of antibiotics came from 27,91% in 2006 to 19,57% in 2010 (Δ 2006-2010: -0,30).

Conclusions:
We find no other data to compare ours. Allthough there is a growth in population from 2006 to 2010 and a concomitant increase of the utilization of total antibiotics, the trend in utilization of Quinolones and Cephalosporins shows a rate of reduction due to the information in the computer display or to the better knowledge about antibiotics prescription in primary care. Future works should address this field of study.

Points for discussion:
Use of utilization indexes in general practice/family medicine
Use of antibiotics in the general practice/family medicine comparing different settings or realities
Use of multicentric studies to assess quality and to increase it.

PRESENTATION 27: Saturday 15th October, 2011 **POSTER**
14.10–15.25 h.

TITLE: Study of Helicobacter pylory-associated gastro duodenal disorders management and anemia among household members and opportunity of their treatment in family sources of helicobacteriosis in Transcarpathian region of Ukraine.

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Background:
Intrafamilial clustering and transmission is implicated as one of thea major routes for acquisition of H.pylori infection. There is an urgent need for the development a strategy for theof management and treatment of the patients in family sources of helicobacteriosis for reducing the ongoing the pathological process caused by chronic infection not only in gastroduodenal zone (that which is wellgood evaluated) but also in csertain non-gastric diseases such as Fe-insufficient anemia.

Research question:
The occurrence of Hp-associated digestive disorders among relatives of the patients with gastroduodenal diseases hasve been observed in correlation with prolongation of their co-living; proving the high risk of digestive and also non-gastric disorders, which were associated with Hp in the household members of the index patients, stimulates developing the algorithm of all-family eradication treatment.

Method:
Invasive and non-invasive tests for H.pylori detachment were held carried out among 248 household members of different age in 57 family sources of helicobacteriosis where patients with duodenal or gastric ulcer and gastritis lived.

Results:
The occurrence of digestive disorders in household members of the index patients families was observed by clinical and instrumental investigation ($p<0,05$). The household members and the index patients got treatment by the schedule list that caused high eradication effect and low level of reinfection observed by invasive tests during 1 year and was mostly always accompanied by changes in Ig G titres.

Conclusions:
A Hhigh level of Helicobacter pylori-associated digestive disorders and anemia has been observed among household family members who lived with the patents with duodenal ulcer or gastritis.
All-family eradication efficiency has been provend for reducing reinfection of H.pylori.
All-family eradication may help to avoid reinfection, intrafamilial clustering and transmission of H.pyloriy infection among household members; eradication of H.pylori infection can reduce the risk of digestive disorders and csertain non-gastric diseases in family sources of helicobacteriosis.

Points for discussion:
What is the prevalence of H.pylori among the household members?
What is the frequency of H.pylori infection among children?
Is all-family eradication treatment necessary?

PRESENTATION 28: Saturday 15th October, 2011 **POSTER**
14.10–15.25 h.

TITLE: The natural history of a community based cohort of injecting drug users (1985-2010).

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Research question:
To establish the natural history of a community based cohort of drug users, 82 injecting drug users (heroin) were recruited over the summer months of 1985 and followed up at regular intervals over the next 25 years.

Methods:
A non-intervention descriptive study of a cohort of injecting drug users first established in one small community area of Dublin in 1985. This was done prior to HIV testing being available in Ireland. Setting: One district electoral area of the South Inner City of Dublin – the main researcher has been in continuous general medical practice in this area since 1978. Interviews took place in the target groups' homes, clinics, community offices and in prisons.

Results:
There were 52 (63.4%) deaths in the cohort between 1985 and 2010;. 38 of the 52 that who died during this period were HIV sero-positive'. 25 of these deaths were HIV related deaths, 7 due to opiate overdose, 7 due to accident or violence and 13 were due to medical 'non-HIV'. Of the 52 that who died over the 25-year period, 85% were male, 50% were single, median age of death was 35.9 years and 53% were unemployed. The majority of deaths, 29(56%), occurred in the first 10-year period (1985-1995) of this study, of which 14 were HIV-related. In tThe following 15 years (1995-2010) show that 23 deaths occurred, of which 11 were HIV-related.

Conclusions:
The reducing numbers of HIV-related deaths over the 25-year period may be connected to, but not exclusively due to, the introduction of highly active antiretroviral therapy (HAART) in the Republic during 1996 and 1997.

Points for discussion:
The effect of infectious diseases on injecting drug users.
The natural history of injecting drug users.
The influence of triple therapy on long term outlooks.

PRESENTATION 29: Saturday 15th October, 2011 POSTER
14.10–15.25 h.

TITLE: Influenza-like illness in general practice in Norway: Clinical course and attitudes towards vaccination and preventive measures during the 2009 pandemic.

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Background:
In 2009, a new influenza A (H1N1) virus spread rapidly throughout the globe. The clinical course of H1N1 influenza appeared to be mild in most cases, but individual cases of severe complications and deaths were observed in healthy young individuals, pregnant women and obese people.

Research question:
To document clinical characteristics of ILI, reported use of health preventive measures and attitudes towards vaccination among patients with ILI in general practice during the pandemic in 2009.

Method:
This is a cross-sectional survey in general practice. Patients who were identified as having ILI during the peak of the influenza pandemic activity in Norway, were eligible for inclusion in the study. A questionnaire was sent 2-4 weeks after the patient's visit to GP with ILI diagnosis during October to December 2009, from GP practices in a county in Norway. A sample of responders older than 18 years also had a blood test to check for serological response to the pandemic H1N1-virus.

Results:
Questionnaires were sent to 1324 patients, and 357 (27%) were returned. Fever (91% vs. 49%, pP<0.01), cough (85% vs. 73%, pP=0.016) and GI-symptoms (58% vs. 38%, pP<0.01) were more frequent in the age group <18 years compared to older patients. Serological H1N1 responses were analysed in 72 patients; 34 cases (47%) were positive (HAI titres >40). There were no statistically significant differences in symptoms between seropositive and seronegative patients. Women reported better adherence than men to personal protective measures, such as hand washing and cough etiquette, than men. Women were also more concerned about possible adverse effects of the pandemic influenza vaccination than men.

Conclusions:
Discrimination between influenza and other viral upper respiratory tract infections is difficult in daily clinical practice, even during an influenza pandemic. A gender difference was found in reported precautions to prevent influenza.

Points for discussion:
Low response rate. How does it aeffects external validation?
Gender difference in precautions to prevent influenza (hand-washing, cough prevention).

PRESENTATION 30: Saturday 15th October, 2011 POSTER
14.10–15.25 h.

TITLE: Monitoring influenza vaccine effectiveness using the general practitioners' sentinel surveillance system in Ireland.

AUTHOR(S): Claire Collins, Anne-Sophie Barret, Joan O'Donnell, Aidan O'Hora, Suzie Coughlan, Michael Joyce, Joanne Moran, Darina O'Flanagan

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Background:
As influenza viruses constantly evolve, influenza vaccines are reformulated every year. Clinical trials can provide data on vaccine efficacy but cannot be conducted yearly and are usually limited to healthy adults. Therefore observational studies are needed to monitor influenza vaccine effectiveness (IVE) every year at population level.

Research question:
What was the 2010/2011 influenza vaccine effectiveness (IVE) in Ireland to prevent medically-attended laboratory confirmed influenza?

Method:
We conducted a case-control study between October 2010 and May 2011 using the Irish College of General Practitioners (ICGP) influenza sentinel surveillance system. This study was part of a multicentre study conducted within I-MOVE (Influenza Monitoring Vaccine Effectiveness in Europe). Participating sentinel general practitioners (GPs) collected swabs from patients presenting with influenza-like illness (ILI) along with their vaccination history and possible confounders. Cases were ILI patients with laboratory-confirmed influenza. Controls were ILI patients testing negative for influenza. Vaccination was defined as having received the 2010/2011 vaccine more than 14 days before symptom onset. The IVE was computed as 1 – Odds Ratio.

Results:
All sixty sentinel GP practices were invited to participate in the study. Twenty-two agreed to participate and 17 (28%) recruited at least one ILI patient. Eighty-five controls and 106 (55.5%) influenza cases were included in the analysis. Seven controls and one influenza B case were vaccinated. The crude IVE was 89.4% [95% CI: 13.8%; 99.8%] against all influenza subtypes; 100% [-8%; 100%] against influenza A(H1N1)2009; and 77% [-90.0%; 99.5%] against influenza B.

Conclusions:
Our results suggest that the 2010/2011 influenza vaccines had a protective effect. However, the sample size was insufficient to obtain precise IVE estimates. The Irish influenza sentinel surveillance network could be used to monitor the IVE in subsequent years but sample size should be increased to gain precision and perform multivariable and stratified analyses.

Points for discussion:
How can we encourage GPs to participate and facilitate the integration of research studies into daily GP practice?
Could the sentinel GP system be used to estimate vaccine effectiveness for other diseases (e.g. chickenpox, pertussis, etc.)?

PRESENTATION 31: Saturday 15th October, 2011 POSTER
14.10–15.25 h.

TITLE: Attendance to family medicine consultation for Acute Tract Respiratory Infections, Fever and Flu during the summer of the A(H1N1) Flu Pandemic outbreak in a Spanish Region.

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Background:
In the late spring and summer of 2009 a flu epidemic wave took place. Due to the fact that it was caused by a new strain of virus, initially some symptoms of alarm were described and this could have had an influence oin the attendance of the population to medical consultations.

Research question:
Did the emergence of H1N1 flu pandemic impacted oin the attendance of patients who were had a diagnosis of fFever or aAcute tTract rRespiratory infection?

Method:
The consultations with the diagnosis of fFever (ICPC A03), uUpper rRespiratory infection (ICPC R74), bBronchitis (ICPC R78) and fFlu (ICPC R80) from the 21st of June to 21st of September of 2009 were identified in the electronic medical record database (that which covers 95% of the population) of the family health centres in a Spanish Region . A comparison by sex and age with the same period of the years 2006-2007-2008 was carried out.

Results:
In the summer of 2009, were registered 5/1000 inhabitants cases of flu were registered. The flu outbreak coincided with an increase of 44% in theDiagnosis of fFever (rate 5.,3/1000 inhabitants (ICI 95% 5.,2-5.,5), 6% of uUpper rRespiratory iInfection (4.,17/1.000 (ICI 95% 13.,8-14.,49 (p>0.,001)) and 8% of bBronchitis (8%) 6.,9 (IIC 95% 6.,7-7.,1 p 0.,003) in relationcompared with the means of previous years. These diagnoses accounted for an increase of 3., 2 consultations by 1000 inhabitants. There was no difference by sex distribution did not show differences.

Conclusions:
An increase inof consultations for fFever and non serious aAcute rRespiratory infections accompanied the H1N1 flu outbreak. This could be caused by population alarm or flu subclinical cases.

Points for discussion:
Was the increase in attendance registered related to the alarm caused by the new flu?
What are the implications for the management of this kind of crisis by hHealth authorities?

PRESENTATION 32: Saturday 15th October, 2011 POSTER
14.10–15.25 h.

TITLE: Broncho pulmonary infections: following guidelines is far enough for french French nursing homes.

AUTHOR(S): Amélie Calvez, J.Y Le Reste, N. Le Lez, B. Chiron, B. Le Floch P. Nabbe, S. Cadier

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Background:
Broncho pulmonary nosocomial infections in elderly care are common and rough. They are the first cause of infectious related death in cause the for elderly care. In France most of the nursing homes are managed by local practicing GPs. Few studies have tried to evaluate treatment, morbidity and mortality of those infections.

Research question:
Wwhat idare the incidence, death rate and antibiotherapy of nosocomial broncho-pulmonary infection in a nursing home? What risk factors could be identified? Could a technical support change those results?

Method:
A cross sectional retrospective survey on a representative population of French nursing home's patients. Patient inclusion was based on CIM 10 diagnostic data recorded in computerized reords in the medical database by their GPs. Collection of medical, nursing and prescription data was carried outdone for each patient. Analysis was performed with a chi square or a fisher test according to population size. A systematic review on pubmed was realized completed to find Ffrench elderly care broncho pulmonary infections data (incidence, mortality rate, antibiotherapy).

Results:
A total of 98 included patients were included. Incidence was 3.2/1000 patient days. Death rate was 13.26 %. Empiric antibiotherapy followed the Ffrench national guidelines in the first and second intention. The significant risk factors were false passage (p=0.012), age (p=0,0004) and alcoholism (p=0.009). The systematic review did only found only data for hospital care with technical support. Incidence is in the higher means of the founded studies found. Death rate is in the lower means of the founded studies found.

Conclusions:
It is impossible to change neither age nor previous alcoholism in nursing homes. Therefore prevention should focus on false passage. The empiric treatment did followed the recommendations and the mortality rate was similar to in the lower rates part compared tofound in other studies. Following guidelines is enough to heal bronchopulmonary infections in French nursing homes without using any technical support, moving the patient, and added traumatism.

Points for discussion:
Does the high means of incidence in that study could come of from over declaration of infections by their local GPs ?

PRESENTATION 33: Saturday 15th October, 2011 POSTER
14.10–15.25 h.

TITLE: Chest infection in infants and its association with family structure.

AUTHOR(S): Dervla Kelly, Tom O'Dowd and Udo Reulbach

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Background:
Family size and structure is associated with childhood morbidity and mortality. A socioeconomic gradient has been described for infant and child respiratory health. Research is sparse in disentangling underlying factors of health inequalities in family structures and socioeconomic groups.

Research question:
To investigate the association between family structure and the prevalence of chest infections in infants.

Method:
The study population of the national longitudinal cohort study 'Growing Up in Ireland' was randomly selected from the Child Benefit Register in the Republic of Ireland. Data collection of the first wave of the infant cohort (11,134 nine-month-olds) consisted of interviewer administered questionnaires with parents in their home. Pearson's Chi Square tests and logistic regression models were used. Analysis was based on statistically reweighted data to ensure it was representative of all nine-month-olds in Ireland.

Results:
Male nine-month-olds were significantly more often taken to a health practitioner due to chest infection than female infants since their birth (34.7% [95% CI: 33.5 – 36.0%] versus 29.4% [95% CI: 28.2 – 30.6%]). The household type was significantly associated with chest infectious – related visits to a health practitioner (one parent, one child (< 18 years): 34.9% [31.7 – 38.3%]; two and more children: 42.5% [39.2 – 45.8%]; two parents, one child: 25.6% [24.3 – 27.0%]; two children: 34.3% [33.1 – 35.5%]). In a multivariate logistic regression (adjusted for socioeconomic factors related to the primary caregiver and the household), infants in a lone parenthood had an odds ratio (OR) of 1.34 [1.15-1.55] of having a chest infection when compared to infants with both parents living in a household. An OR of 1.19 [1.14-1.25] for chest infectious health utilisation was associated with each additional sibling.

Conclusions:
Being a male infant with siblings in a lone parent household is associated with the highest prevalence of chest infections.

Points for discussion:
What supports do lone parents need to enhance the health resilience of their children?
The health of mothers in lone parenthood is often impaired when compared to mothers with a partner. Would maternal health promotion benefit their children and how co

PRESENTATION 34: Saturday 15th October, 2011 **POSTER**
14.10–15.25 h. **Ongoing study with preliminary results**

TITLE: Therapeutic inertia in hypertension: a systematic review.

AUTHOR(S): Lebeau Jean-Pierre, Cadwallader JS, Aubin-Auger I, Mercier A, Pasquet T, Hendrickx K, Vermeire E.

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Background:
Although experts agree that therapeutic inertia is a major cause of uncontrolled hypertension, there is no consensus on its definition yet. A clear definition of therapeutic inertia in the drug treatment of hypertension is required before exploring its causes and developing intervention to try and overcome it. Searching the literature is the first step for setting up this definition and its limits.

Research question:
What are the components of the definition of therapeutic inertia in the drug treatment of hypertension?

Method:
Systematic review of the literature.
MedLine, EMbase, PsycInfo, and the Cochrane library databases were systematically searched for alla available literature until Aapril 30, 2011. Google Scholar and Web of Science were also searched. Hand searching included personal databases and snowballing from selected articles.
PubMed search for Medline was : ("guideline adherence"[MeSH Terms] OR "clinical inertia"[All Fields] OR "therapeutic inertia"[All Fields] OR ("practice guidelines as topic"[MeSH Terms] AND ("clinical audit"[MeSH Terms] OR "clinical competence"[MeSH Terms] OR "attitude of health personnel"[MeSH Terms] OR "delivery of health care"[MeSH Terms] OR "physician's practice patterns"[MeSH Terms] OR "nurse's practice patterns"[MeSH Terms]))) AND ("hypertension"[MeSH Terms] OR "antihypertensive agents"[MeSH Terms])
From this initial query, search queries were adapted for each specific database language.
Potentially relevant abstracts will then be assessed by two independent researchers. A third researcher will review all the results and arbitrates any disagreements.

Results:
Systematic search of databases returned 3, 510 potentially relevant articles. Selected abstracts are currently being assessed. The analysis is still in progress. Complete results will be available in September 2011.

Conclusions:
This systematic review allowed the identification of the various components of therapeutic inertia in hypertension. An expert consensus with a Delphi method is the next step, and will allow the statement of a clear and usable definition.

Points for discussion:
Starting from the literature search results, is Delphi the appropriate method for going further?

PRESENTATION 35: Saturday 15th October, 2011 **POSTER**
14.10–15.25 h.

TITLE: Chronic kidney disease in patients with arterial hypertension.

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Background:
Arterial hypertension is one of the most common causes of chronic kidney disease (CKD). On the other hand the presence of CKD points to greater risk of development of other cardio-vascular complications.

Research question:
The purpose of the research was to identify the proportion and characteristics of patients with arterial hypertension who have CKD.

Method:
In a retrospective pilot study we included all the patients with essential arterial hypertension in one general practitioner's office. We collected data from patient's medical record. We collected data about duration of hypertension, comorbidities, treatment of hypertension and blood pressure control. CKD was defined as the most recent recorded glomerular filtration rate calculated with MDRD equation less than 60 ml/min/1.73 m2 and/or presence of proteins in at least two urine samples in the three months period.

Results:
234 patients were included,102 male (43.6%) and 132 female (56.4%). They were from 29 to 98 years old (mean 63, SD 12.3 years). The average duration of hypertension was 10.3 years (SD 10.3 years). 88 (37.6%) of patients had diabetes, 184 (78.6%) dyslipidemia and 98 (41.9%) patients had already presented cardio-vascular disease. The most common manifestation of cardiovascular disease was ischemic heart disease in 54 (23,1%) patients. Estimated level of glomerular filtration less than 60 ml/min/1,73 m2 had 65 patients (28.3%). Taking into account both criteria of CKD 75 (32.6%) of patients had CKD.
CKD was more common in older patients (t=7,926, p>0,001), patients with lower diastolic blood pressure (t=-3,515, p=0,001), patients with diabetes (HI2=4,616, P 0,032), ischemic heart disease HI2 =4,385, p= 0,036) and chronic heart failure (HI2 =11,408, p= 0,001).

Conclusions:
Chronic kidney disease is common among patients with arterial hypertension. Older age, diabetes and the presence of cardiovascular disease are the most important risk factors for CKD.

Points for discussion:
-Inclusion criteria?
-Ideas for future research on this topic?

PRESENTATION 36: Saturday 15th October, 2011 **POSTER**
14.10–15.25 h.

TITLE: Placebo prescription: really deliberately?

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Background:
A placebo is a substance without any specific activity for the condition being treated. Family physicians give it deliberately according to surveys, such as antibiotics, iron, vitamins. Ethical issues in patient-physician relationship have been debated. Placebo is deceptive, it threatens patients' autonomy, but is less expensive, and not dangerous. Some Ethicists have suggested conditions for an appropriate use. The triggering factors of this placebo prescription by French family physicians have not yet been elicited. These reasons may raise contextual ethical issues

Research question:
What are the ethical issues raised by studying the triggering factors of placebo prescription ?

Method:
This is a qualitative explorative study. Semi structured interviews were performed until saturation. Participants were 18 French urban general practitioners, purposive sample. Evaluative assertion analysis, expression analysis were manually performed by two researchers. Cognitivo-discursive analysis was performed, using Tropes software, developed by Molette P and Landré A., based on Ghiglione R research work.

Results:
General Practitioners do not feel comfortable about prescribing placebo. Patients strongly ask for a pill as a treatment although it may not be the best treatment. Time and money are raised issues. Convincing or educating is too long when the remuneration method is fee-for-service payment. Active treatment or polypharmacy could induce complications or addiction. The clinical decision is not always evidence-based. There is a lack of trust in different information sources. There is no evidence-based treatment for the condition of the patient. Evidence based medicine is perceived as not always relevant to primary care.

Conclusions:
Family physicians consider placebo prescription as a result of ethical tensions, such as money, time, and the difficulty of making a therapeutic decision. Other remuneration methods are currently studied, in ENMR for example. Communication on evidence-base therapeutics should be developed to help the family physician. Non-pharmacological treatment should be promoted in the population.

Points for discussion:
- Fee-for-service payment is the main remuneration method for family practitionners in France. Do they have same issues with others remuneration methods?
- Considering pharmacological treatment as the only way to recover health is a French patients' habi

PRESENTATION 37: Saturday 15th October, 2011 **POSTER**
14.10–15.25 h.

TITLE: Oral anticoagulation treatment management : point of view of elderly (over 75 years old) patients.

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Background:
Oral anti-coagulation for elderly patients is a recurrent problem in primary care, with an increased risk of hemorrhagic accidents (18, 000 hospitalizations in 2007).

Research question:
To document know the point of view of the elderly patients concerning the management of their oral anti-coagulation and to understand their difficulties.

Method:
Descriptive study of 50 patients over 75 years old, treated with long-term anti-coagulation and followed by their general physicians in the region North-Eastern region of France, using a questionnaire based on the model of the study Barcelona 1999.

Results:
When the following monitoring is carefully framed explained the treatment is well accepted by the elderly patients. Only 10% of them complain about the consequences of the treatment on their every-day life, they are often alone and disabled and receive poly-pharmacy.
Patients with higher school level describe more fears about secondary effects and complications. Some patients describe fear, misunderstanding and feel uncomfortable facing the unstable level of INR.
50% seek for help every day in the preparation of the pill-box, 52% modified their feeding habits and 40% deprive themselves of vegetables. For 25%, following monitoring and therapeutic education are unsuitable. Only 10% decreased their physical and leisure activities (activities already reduced by other factors related to aging).
The majority, 80%, have a positive perception of their treatment with a sensation of protection related to the close medical monitoring following.

Conclusions:
Management of difficulties regarding the treatment in this population is related to the characteristics of the elderly population: loneliness, poly-pharmacy and disabilities.

PRESENTATION 38: Saturday 15th October, 2011 **POSTER**
14.10–15.25 h.

TITLE: Does crèche care impact negatively on infants' health?.

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Background:
The number of infants in centre-based care has been growing steadily in recent years as more women are working outside the home. Some of the prevalence increase of infectious diseases may be related to the type of child care.

Research question:
Is the type of child care associated with the rate of infectious diseases in infants?

Method:
This study presents findings from the first wave of data collection from the Growing Up in Ireland longitudinal cohort study. The sample of 11,134 nine month old infants was randomly selected from the national Child Benefit Register. Data collection consisted of questionnaires completed with the primary caregiver addressing the main type of childcare (in-home-parental, in-home-minder, out-of-home minder, crèche / centre-based) and the history of snuffles or common cold, chest infection, asthma / wheezing and ear infection). Pearson's Chi Square tests and crude and adjusted logistic regression analyses were used to investigate the association between breastfeeding and respiratory infection. Analysis was based on statistically reweighted data to ensure it was representative of all nine-month-olds in Ireland.

Results:
Residents reported significantly lower cynicism/depersonalization (t (df): 2.8 (476); $p< 0.01$) and personal accomplishment (t (df): 2.0 (485); $p< 0.05$) compared to GPs. No gender differences were identified in the level of burnout. Significantly more GPs reported a high ($\chi 2$ (df)=5.9 (1); $p< 0.05$) or intermediate ($\chi 2$ (df)=4.6 (1); $p< 0.05$) degree of depersonalization. Emotional exhaustion, depersonalization, and low personal accomplishment were reported by around 30%, 60%, and 100% of the physicians, respectively. Being a resident emerged as the strongest negative predictor of depersonalization (β=-0.09, 95% CI -0.22 – -0.002).

Conclusions:
The prevalence of burnout is high among GPs and almost all GPs report a low degree of personal accomplishment. Residency emerged as a significant protective correlate of depersonalization. These findings provide further data for cross-cultural burnout research.

PRESENTATION 39: Saturday 15th October, 2011 **POSTER**
14.10–15.25 h.

TITLE: Burnout among Hungarian general practitioners and residents.

AUTHOR(S): Peter Torzsa, Szilvia Ádám, Ajándék Előry, Zsuzsa Győrff
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Background:
General practitioners (GPs) play a central role in patient care and are exposed to high levels of work strain and consequent burnout due to the large number of stressful patient-doctor relationships. Despite the high likelihood of burnout among GPs, limited information is available about this topic.

Research question:
What is the prevalence of burnout among GPs and residents in Hungary?
Which factors are associated with high levels of burnout?

Method:
Epidemiological, exploratory/descriptive, cross-sectional study with self-administered questionnaires among 453 GPs and 43 residents. To assess burnout, the Malachi Burnout Inventory was used (MBI-GS). To evaluate the level of burnout, mean (SD) scores on the emotional exhaustion, cynicism/depersonalization, and personal accomplishment dimensions of the MBI were determined among male and female physicians and among GPs and residents. Differences in the level or degree of burnout (high, intermediate and low) in all three burnout dimensions between male and female physicians and between residents and GPs were examined by independent samples t-test and $\chi 2$-tests. Socio-demographic antecedents to burnout were assessed by linear regression analyses.

Results:
Residents reported significantly lower cynicism/depersonalization (t (df): 2.8 (476); $p < .01$) and personal accomplishment (t (df): 2.0 (485); $p < .05$) compared to GPs. No gender differences were identified in the level of burnout. Significantly more GPs reported high ($\chi 2$ (df)=5.9 (1); $p < .05$) or intermediate ($\chi 2$ (df)=4.6 (1); $p < .05$) degree of depersonalization. Emotional exhaustion, depersonalization, and low personal accomplishment were reported by around 30%, 60%, and 100% of the physicians, respectively. Being a resident emerged as the strongest negative predictor of depersonalization (β=-0.09, 95% CI -0.22 – -0.002).
Conclusions:The prevalence of burnout is high among GPs and almost all GPs report low degree of personal accomplishment. Residency emerged as a significant protective correlate of depersonalization. These findings provide further data for cross-cultural burnout research.

PRESENTATION 40: Saturday 15th October, 2011 **POSTER**
14.10–15.25 h.

TITLE: Care Physicians: How Much Are They Determined Regarding Lifestyle Changes?

AUTHOR(S): Tolga Günvar, Emel Kuruoglo, Aynur Toksun, Armağan Erden Dilek Güldal

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Background:
The importance of healthy lifestyle changes (HLSC) are highlighted increasingly since the second half of the 1980's. Our aim is to explore attitudes, behaviours and thoughts of primary care physicians regarding HLSC in which they have a critical implementation role in its implementation.

Research question:
What do primary care physicians do and think about lifestyle changes?

Method:
A questionnaire consisting of 14 questions related with attitudes, behaviours and thoughts regarding HLSC, was applied to 291 primary care physicians practicing in family health centers in Izmir.

Results:
Overall, 60.5% of participants felt that they are responsible for HLSC more than any other physicians. The majority, 87.5% of physicians, stated that they especially emphasized HLSC in cases of a chronic condition such as HT or DM. Almost three quarters (73.5%) of physicians who choose to use medication instead of HLSC also thought that their patients prefer to use drugs instead of HLSC (p=0.000). Physicians who believe that their patients comply with their recommendations were more likely to state that they provide accurate information on each visit. On the other hand, physicians who believe that they provide accurate information on each visit were not likely to think that their patients comply with their recommendations.

Conclusions:
Although primary care physicians believe that HLSC are important, this believe does not reflect to in their practice. Reasons of for this gap between belief and practice should be investigated.

Points for discussion:
What are the reasons forof gaps between the beliefs and attitudes of primary care physicans about lifestyle changes?
How should these gaps be measured?

PRESENTATION 41: Saturday 15th October, 2011 **POSTER**
14.10–15.25 h. **Ongoing study with preliminary results**

TITLE: Which positive factors determine the attractiveness of General Practice and retention in Clinical Practice? A qualitative research.

AUTHOR(S): Bernard Le Floch, Jean-Yves Le Reste, Claire Lietard, Claire Collins Villanueva Tiago, Robert Hoffman, Hulya Yikilkan, Linger Heidrun Lieve Peremans.

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Background:
GPs are leaving clinical practice and GP's the general practice workforce is declining. Research to date has paid focussed on the negative factors explaining this tendency. Strategies to improve capacity have not been successful until now. Why are we not looking for positive factors to develop policies for GP retention and attractiveness?

Research question:
What positive factors can be found to improve the attractiveness and retention of GPs in their practice?

Method:
The French WoManpower team has done carried out a qualitative research study from a participant's and phenomenological perspective. GPs were selected by a purposive and theoretical sampling strategy until saturation of data. Focus groups were audio and video recorded and transcribed Verbatim. Two researchers analysed separately analysed the transcripts with open and axial coding and pooled them secondary thereafter with the whole team.

Results:
Five focus groups including involving a total of 38 GPs were performed. Saturation was obtained after three focus groups. GPs satisfaction was explained by classic themes like professional (diversity of job content, teaching, patient-doctor relationship…) and non-professional factors (personal life, life setting...). New and unexpected themes did emerged (intellectual stimulation, relationship with the social and professional community, liberal aspects that enhance the freedom of professional setting and work organization). The balance of all these factors and the coping strategies are important in the decision to stay in the profession.

Conclusions:
Freedom, conviviality and intellectual stimulation are topics to enhance GPs retention. More analysis in detail and further research in other European countries are necessary to confirm these hypotheses. However these themes are difficult to translate into policies.

Points for discussion:
We want to do a European collaborative study and develop the same theme with other teams. studies on the same theme.

PRESENTATION 42: Saturday 15th October, 2011 **POSTER**
14.10–15.25 h. **Research in Progress, without results**

TITLE: Polish Medical Students Career Choices.

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Background:
Currently many developed countries experience shortage of primary care doctors. Based on the literature it is known, that students' opinions about future career choices are an important predictor of future choice. That is why the career choices of medical students are of increasing concern to governments who strive to provide the right balance of medical professionals to meet the needs of the community. Overseas only a few medical students are willing to specialize in family medicine. Family mMedicine is a quite a new medical discipline in Poland. In our country a model of family doctor providing care over whole families is not well established yet and still there is still a big need for more specialists in family medicine.

Research question:
What are the future career choices of first, third and sixth year Polish medical students?
What are the changes in students' career aspirations during their education?

Method:
As part of a multi-centre, multi-year questionnaire study, we have been surveying student career aspirations at six Polish medical universities. In each academic year (2010/2011 to 2016/2017) we are going to ask first, third and sixth year medical students. Participants answer several closed questions. The questionnaire consists of two parts: the first collects sociodemographic data, the second has seven closed questions about future career choices. Participants usually complete and hande in the anonymous surveys in class. The survey instrument was developed by the authors and pilot-tested on 10 undergraduate students for clarity.

Results:
The results of the study will give an insight into students' opinions about future career choices, following a student during their education will show changes occurring in their preferences.

Points for discussion:
What is the place of family medicine in students' career choices?
Who goes for family medicine?
Are there any changes in students' career choices during their education?

PRESENTATION 43: Saturday 15th October, 2011 **POSTER**
14.10–15.25 h.

TITLE: Evaluating the Nutritional Habits of the Turkish Medical School.

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Background:
Because of the intense daily education programs, medical school students complain about the irregular meal hours, limited time for feeding, carelessly done created student canteen menus and preferring fast-food. All these conditions may cause a unhealthy nutritional state for medical students because of cholesterol, saturated fat and carbonhydrate rich diets.

Research question:
What is the nutritional state and habits of the 4th year medical students?

Method:
This is a cross-sectional descriptive study. The data was gathered by a self completed survey during a pPublic hHealth course and a food frequencyt questionnaire for the last 24 hours. Results are compared to the Turkey Specific Nutrition Guide data and USDA (United States Department of Agriculture) Dietary Reference Intake by SPSS 17.0 and BeBis 6.1 programs. The participation rate was 80%.

Results:
Overall, 71% were male, 18% consumed vitamin pills for the last year, 6% were on a diet, 68% accept hiswere within normal weight between normal limits, but 19% obese, 42% were skipping at least one meal in a day, 50% were consuming junky food and candies were mostly preferred. In the 24-hour food questionnaire daily intake was 1530.9±537.9 kilocal. but the distribution of the macronutritional elements were unbalanced.

Conclusion:
Turkish medical students' diet was low in calories, fibreer, E, C, B, Ca, K and Zn but high in carbonhydrate, Na and P.

Points for discussion:
1-What are the additional points for further discussion?
2-What kind of intervention can be planned depending based on the results?

PRESENTATION 44: Saturday 15th October, 2011 **POSTER**
14.10–15.25 h. **Research in Progress, without results**

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

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Background:
Many tools for depression screening and diagnosis in primary care have been produced. However, their validity, reproducibility and feasibility are not well known and not specifically assessed in everyday GP practice samples.

Aim (research question):
to To identify, the validity, reproducibility and feasibility and actual use of screening and diagnostic tools for depression in primary care
Tto assess the screening and diagnostic properties of these tools (sensitivity, specificity, negative and positive predictive value, area under the curve, Youden index, likelihood ratio's)
Tto classify those tools.

Method:
Systematic literature review. Key words were: depression definition, depression criteria, depression diagnosis, depressive disorders, depressive syndromes, tools, scales, questionnaires, primary care, family practice, general practice. Searched databases: Pubmed, Embase, Cochrane. Those abstracts were dispatched between the nine EGPRN national teams. All selected articles were critically assessed by two reviewers. Based on the validated tools, the team has to build a composite variable aimed to rank the tools.

Results:
Total number of abstracts: 615. total number of articles: 64. A composite variable used to classify. The ranked list of tools used in depression in primary care.

Discussion:
tThe composite variable is the result of the combination of values about validity, feasibility, reproducibility and data considered as important;, each data or value is weighted. The aim is to obtain a single numeric value by tool reflecting thea global efficiency of the tool in primary care.

Conclusions:
Wwith this systematic review, we will find tools used for depression screening and diagnosis and we will be able to identify their validity, reproducibility and feasibility, but we need to discuss the composite variable to obtain a larger consensus about it.

Points for discussion:
Tto discuss the composite variable aimed to at ranking the tools used in screening and diagnosis depression in primary care.

PRESENTATION 45: Saturday 15th October, 2011 **POSTER**
14.10–15.25 h.

TITLE: Evaluating the cross-cultural validity of a somatization questionnaire: Differential Item Functioning (DIF) analyses of the Polish version of the 4DSQ questionnaire.

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Background:
The Four-Dimensional Symptom Questionnaire (4DSQ), which measures distress, depression, anxiety and somatization, has been translated and validated in Poland.

Research question:
Does the Polish 4DSQ measure the same constructs in the same way as does the Dutch 4DSQ?

Method:
4DSQ data were collected from primary care patients and students. The Polish data were compared with the 4DSQ data of a matched sample of Dutch students and primary care attendees. The sample comprised 254 Polish and 262 Dutch subjects of which 66% were female. The mean age was 34.0 and 33.2 years respectively. Two methods of differential item functioning (DIF) analysis, Zumbo's ordinal logistic regression and generalized Mantel-Haenszel, were used to detect items with DIF, and linear regression analysis was used to estimate the scale level impact of DIF.

Results:
Four of the 16 items of the distress scale demonstrated DIF, however, these differences turned out not to influence results on scale level. Only one of the 12 items of the anxiety scale exhibited DIF causing Polish subjects with moderate anxiety to score ca 0.78 points less than their Dutch counterparts. Similarly, only one of the 16 items of the somatization scale were identified with DIF. However, on the scale level there was no significant effect of DIF on the somatization score. The depression items were free of DIF.

Conclusions:
The results of the DIF analyses suggest that the Polish 4DSQ measures the same constructs as the Dutch 4DSQ. Dutch cut-off points can validly be transposed to Polish settings, except for the cut-off point for moderate anxiety, which should be 7 rather than 8. These conclusions are further confirmed by validity studies which showed that the construct validity characteristics of the Polish 4DSQ are similar to those of the Dutch version.

Points for discussion:
Cross – cultural studies across European Union could be a valuable project to establish epidemiology for the four most prevalent mental health dimensions (anxiety, depression, somatization and distress) in primary care.

PRESENTATION 46: Saturday 15th October, 2011 **POSTER**
14.10–15.25 h.

TITLE: Barriers to computer-based data collection in general practice research: Results from practice staff interviews.

AUTHOR(S): Stephanie Heinemann, Carmen Ilgner, Wolfgang Himmel

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Background:
For the practice staff in general practices, it is often difficult to combine routine activities (i.e. diagnosis and treatment of acute and chronic illnesses) with research activities. A computer-based data collection tool automatically identified eligible patients and assisted the practice staff in surveying a target of 200 patients in every practice. The success of this strategy varied widely in the participating practices (range 9 – 312 surveyed patients).

Research question:
What factors did practice staff members consider important for the implementation of computer-based data collection in their local practice?

Methods:
Semi-structured telephone interviews were conducted with all 47 practice staff members who participated in the study. The interviews were analyzed according to Mayring's content analysis method to find relevant categories. The participating practices were divided into "good recruiters" (≥ 50% target achievement) and "poor recruiters" (≤ 15% target achievement) to see whether the practice staff's feedback differed according to the degree of target achievement.

Results:
Five categories turned out to be relevant for the practice staff when recruiting and surveying patients: people resources, material resources, time, patient factors and the integration of data collection into daily practice. Practice staff from good and poor recruiting practices did not assess the role of material resources (e.g. as a separate room for surveys), survey time or patient factors differently. Good recruiters mentioned the smooth integration of data collection into their workflow as a part of their normal duties (i.e. taking blood pressure) whereas poor recruiters often felt disturbed by data collection. A lack of colleagues was more often reported by poor than good recruiters.

Conclusions:
A lack of personal resources and the ability to combine research activities with routine activities should receive more attention in the future to fully exploit the potential of computer-based data collection in general practice research.

Points for discussion:
1. Can intelligent recruitment tools that aim for an optimal integration into the practice organization be flexible enough to address unforeseen problems during the research process?
2. How can we better make use of the practice staff's experiences in

PRESENTATION 47: Saturday 15th October, 2011 **POSTER**
14.10–15.25 h. **Ongoing study with preliminary results**

TITLE: An approach to the study of Multimorbidity in primary health care.

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Background:
Multimorbidity is an important issue in primary health care.

Research question:
To determine the most frequent associations between chronic diseases in patients presenting with multimorbidity.

Method:
Cross-sectional study based on information from primary care electronic medical records of people aged 15 years old or more older who attended in Primary Health Care in Catalonia (Spain). We reviewed the health problems included in three3 sources of information: the Quality and Outcomes Framework (UK), the "Estandard de Qualitat Assistencial" (Catalonia) and the Health Survey of Catalonia . To be considered in the analysis of multimorbidity, the health problems have to be included in at least two of the three sources. We also added musculoskeletal pathologies in the final list.

Results:
We analyzed 1,597,258 electronic medical records. The mean age was 46.6 years (SD 18.8); and women were 52.4% were women; and 49.9% had. People having two or more health problems were 49.9%. Among people having multimorbidity, the most frequent couple combination of problems were hypertension and osteoarthritis (12.2%). In men, the most frequent was diabetes and hypertension (11.1%), and in women, hypertension and osteoarthritis (14.4%). Regarding the age, both in the group of 15-44 and in the group aged 45-64 years, the most frequent association was depression and other mental disorders (13.2% and 12.5%, in each group, respectively). Hypertension and osteoarthritis was the most frequent, both in the group ofthose aged 65-74 years (22.7%) and in those aged 75 years or older (31.8%).

Conclusions:
The most common combination of health problems in people with multimorbidity is hypertension and osteoarthritis. Nevertheless, the distribution varied depending on age and sex.

Points for discussion:
Is the distribution of multimorbidity the same across European Countries?

PRESENTATION 48: Saturday 15th October, 2011 **POSTER**
14.10–15.25 h.

TITLE: Coherence between Reason for Encounter and Final Diagnosis in Infectious Diseases in the Primary Care setting.

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Background:
In the International Classification for Primary Care (ICPC), the Reason for Encounter (RFE), which reflects mainly the patient' s perspective, is an essential part of the episode of care.
Research question: What are the most common RFEs for infectious diseases in our setting and how often are these coherent with the final diagnosis?

Method:
The data set derives from the Electronic Medical Records (EMRs) of two practices in the Emilia Romagna Region which both use the ICPC classification. The cohort of patients includes =2899 patients. The period evaluated was June 2010 - May 2011. Coherence between RFE and final diagnosis was based on the GP's retrospective self judgement.

Results:
Over this period 533 episodes of care out of a total of 5780 (9.22%) were related to infectious diseases. Patients with infectious disease were totalled 454 (181 males, 263 females) with a mean age of 52.3 years. The most common RFEs were: R05 cough; R21 tThroat symptom/complaint; A03 fFever; U01 dDysuria/painful urination, R75 sSinusitis acute/chronic. The most common diagnosis were R77 lLaryngitis/tracheitis acute; R74 uUpper respiratory infection acute; R78 aAcute bronchitis/bronchiolitis; U71 cCystitis/urinary infection other. Overall 21 RFEs accounted for 74.8% of all the episodes, while 21 diagnosis accounted for 90.8% of these episodes. Coherence between RFE and final diagnosis was found in 88.3% of episodes . A total of 50 out of /533 (9.,3%) of the RFEs were requests for (antibiotic) prescription.

Conclusions:
Our results showed a high level of coherence between RFE and final diagnosis in infectious diseases in our setting; therefore the RFE can be “per se” one of the most important elements to establish the final diagnosis for infectious diseases in the PC setting, usually characterized by a low level of sophisticated instrumental diagnostic procedures. Unfortunately, in spite of hundreds of educational campaigns against antibiotic abuse, patients' attitude to push GPs' for an antibiotic prescription is still quite high.

Points for discussion:
1. Do you have the same findings in your country?
2. Is the patient's request for an antibiotic prescription popular in your country?

PRESENTATION 49: Saturday 15th October, 2011 **POSTER**
14.10–15.25 h. **Ongoing study with preliminary results**

TITLE: Patients with chronic low back pain : factors which influence care seeking.

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Background:
Chronic low back pain (LBP) is a major public health problem. Patients with LBP seek care from numerous different health care providers. Interactions between these patients and their caregivers, and between the caregivers, may influence the evolution of this condition. Deeper understanding of patients' behaviours in seeking care for LBP is required before proposing new management strategies, which could be focused on better care coordination.

Research question:
Which factors do influence care seeking in patients with chronic LBP?

Method:
A qualitative study was conducted in 2011. Patients were recruited before attending a program of functional rehabilitation for chronic LBP in a university centere. Individual semi-structured interviews were conducted among a purposive sample, based on factors supposed to be influent on care seeking: age, gender, socio-occupational category, history of spinal surgery, occupational compensation, and current sick leave. They were invited to talk about their LBP history, and to describe their relations with each of the different caregivers they had met, wanted to meet, or expected to meet, with special interest in what/who had contributed to their first meetings, what they expected from it and what had influenced their following relationship of care. These interviews were audio-recorded, then fully transcribed. Thematic analysis of the verbatim record was conducted with the software NVIVO8.
All patients signed a written informed consent and this study was approved by our ethical committee.

Results:
This study is still ongoing. To date, eleven patients have been interviewed. Analysis has begun and highlighted a wide range of different factors influencing the behaviour in care seeking: related to patients' expectations, beliefs and representations, to patients' financial and occupational conditions, to the patients' relatives, to previous relations with caregivers, to the health care system, etc.
Other interviews will probably be needed to achieve saturation of the data.

Points for discussion:
1. The recruitment of patients attending a program of functional rehabilitation for chronic LBP in a university centere has excluded patients with more favorable evolution of LBP, and patients seeking care in less academic settings.

PRESENTATION 50: Saturday 15th October, 2011 **POSTER**
14.10–15.25 h. **Ongoing study with preliminary results**

TITLE: Evaluation of Local Infusions of Betamethasone - Lidocaine in Myofascial Trigger Points in Difficult Cases of Adult Patients with Chronic Musculoskeletal Pain.

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Background:
The treatment of myofascial trigger points (MTrP) seems to be controversial in medical studies varying from massage to botulinum toxin injections.

Research question:
This prospective clinical trial aims to evaluate the effect of local infusions of a mixture, consisting of betamethasone, lidocaine and water for injection (IMbxw), in MTrPs for the treatment of difficult cases of chronic musculoskeletal pain.

Method:
We took a random population sample of 74 patients (43 male (58%), 31 women (42%)), who suffered from chronic musculoskeletal pain due to MTrPs in various locations and didn't get adequate relief from pain with the usual conservative treatments or had specific contraindications in taking them. The intensity of pain (IP) was recorded 30 minutes before and after the infusion, using integer numbers of a 0-10 numeric rating scale of pain for patient self-assessment. A programmed follow-up was performed 30 days later. SPSS software was used fFor the statistical analysis of the collected data SPSS software was used.

Results:
Our sample population had a mean age of 54±+3 years old and at the time of arrival the mean duration of the pain was 63.2±+19.4 days. The mean IP half an hour before the infusion was 8.13±+1.24, whereas thirty minutes after the infusion was recorded at 3.9±+1.17 –($p<0.0002$). During the follow-up, the mean IP was recorded at 2.3±+0.81 (– $p<0.0001$). The mean time passed from the infusion until the maximum relief from pain was 5.21±+2.23 minutes. The analgesic effect of IMbxw was faster in younger patients with recent onset of the pain than in older patients with chronic pain (1.3±+0.4 than 35.6±+1.1 minutes). No side-effects or complications were reported.

Conclusions:
The performance of local infusions (IMbxw), in MTrPs for the treatment of difficult cases of chronic musculoskeletal pain was accompanied by significant clinical improvement and reduction of IP.

PRESENTATION 51: Saturday 15th October, 2011 **POSTER**
14.10–15.25 h. **Ongoing study with preliminary results**

TITLE: Efficacy of treatment of Herpes Zoster and prevention of post-herpetic neuralgia with Trans Cutaneous Neural Stimulation (TENS).

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Background:
Post-herpetic neuralgia is the most common complication of Herpes Zoster. Its treatment is difficult and results are not good. Antiviral therapy can reduce its incidence. The results of some rare retrospective studies have shown that treatment of Herpes Zoster with TENS is at least as effective as with antiviral drugs, and that the prevention of post-herpetic neuralgia is even better.

Research question:
We would like to show that TENS is more effective in prevention of post-herpetic neuralgia as antiviral drugs.

Method:
In prospective, case control study we are comparinge the effectiveness of treatment of Herpes Zoster and prevention of post-herpetic neuralgia with antiviral drugs and TENS. We're enrolling 300 adult immunocompetent patients of both sexes which are divided into two groups. The Ffirst group is not receiving antiviral therapy; first subgroup (1/2 of first group) is receiving TENS, second subgroup (1/2 of first group) is receiving only analgesic treatment, if needed. The sSecond group is receiving antiviral therapy; first subgroup (1/2 of second group) is receiving only antiviral drug, second subgroup (1/2 of second group) is receiving antiviral drug and TENS. We're following the duration of pain preceding the rash, the number of papules and vesicles, the duration and the intensity of pain (assessed on VAS), the period until the resolution of rash and possible side effects. Patients are checked two times weekly until the resolution of rash, and three and six months after the rash. The changes on skin and presence of neuralgic pain are assessed.

Results:
We expect to show that TENS is an efficient, affordable and safe treatment of Herpes Zoster and prevention of post-herpetic neuralgia. At the moment we have enrolled around 100 patients. Results regarding relief of acute pain are very good. For the assessment of the prevention of post-herpetic neuralgia a longer period of follow up will be needed.

Points for discussion:
Design of study – why we don't have only two groups (TENS and NO TENS)? Is it possible to make this study double blind? Does it have any influence on results?

PRESENTATION 52: Saturday 15th October, 2011 **POSTER**
14.10–15.25 h.

TITLE: Communication with palliative patients: general practitioners' view.

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Background:
Official health policy did not stimulate the development of palliative care in Bulgaria. With the exception of a few hospices, departments for terminal cancer patients and nongovernment organization initiatives, the concept was not integrated into the health care system. Nevertheless, general practitioners (GPs) could care for palliative patients.
Research question: The aim of the study was to investigate GPs' view on communication with patients with life-threatening diseases.

Method:
A sSpecially designed questionnaire was filled in by 329 GPs. Data were processed with SPSS.17. Characteristics of the investigated group: 62.,3%±2.,67% women; half of the physicians had over twenty years length of service; 14%±1.,91% of them worked in rural areas; 46.,8%±2,75% had over 1500 patients in their lists.

Results:
GPs assessed that they had ten patients on average yearly who needed palliative care. Only 1/3 accepted bad news deliverying as their own task; according to 60.,6%±2.,69% the specialist could inform the patient and 10.,9%±1.,71% insisted on a psychologist to dodoing it. The opinion about the necessity to discuss a disease related to feelings was spread into four categories -– 6.,1%±1.,31% "always", 42.,2%±2.,72% "often", 39.,4%±2.,69% "sometimes' and 12.,1%±1.,79% 'never". Regarding to the conversation about death, GPs chose and ranged - psychologists (38.,1%±2.,67%), specialists (33.,4%±2.,60%), GPs (19%±2.,16%), relatives (19%±2.,16%) and clergymen (14.3%±1.,93%). Overall, 24.,2%±2.,36% had never talked about death with their palliative patients. Only 42.,4%±2.,72% had passed communication skill training. Differences were found according to sex and length of service.

Conclusions:
The results correlated with the current lack of formal palliative care services. GPs provided much of the medical care required by patients who died in the community. The questionnaire survey presented highlighted GPs' discomfort about their communication with palliative patients.

PRESENTATION 53: Saturday 15th October, 2011 ONE SLIDE/FIVE MINUTES
15.55–16.05 h. Research in Progress, without results

TITLE: Why do we have a low antibiotic consumption and a low level of antimicrobial resistance in Norway?

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Background:
Norway has, together with countries such as Netherlands and Sweden, had some one of the lowest consumption rates of antibiotics in Europe and very little development of antimicrobial resistance. Resistance is closely linked to a high consumption of antibiotics, especially broad spectred, something which can explain the low development of resistance in Norway. But how did this come about? Has Norway been extremely foresighted? Are Norwegian GPs particularly cautious when prescribing antibiotics? Are Norwegians more sceptical towards the use of antibiotics, and if so, is this a cultural phenomenon? These are some of the questions forming the backdrop for a witness seminar on the history of AMR in Norway held in Oslo in 2008.

Research question:
Why do we have a low antibiotic consumption and a low level of antimicrobial resistance in Norway?

Method:
A witness seminar is a relatively new method used in contemporary history to establish new sources and material to an already existing material linked to important events in the near past. People connected to a specific event are invited to share their memories and experiences and discuss these in the company of others.

Conclusion:
The impression is that there has been a small, but powerful group of people who were the driving force behind the work on AMR in Norway. These have been able to create their own discipline within a subject matter which evolved through single episodes and grew into a comprehensive problem. It has been a practical approach to the problems and much of the knowledge came as a result of this. The milieu has been small and lucid and easy to intervene when necessary. The history also bears traces of coincidences and luck. But whatever the reason, luck or acquired competence, Norway is still in relatively good shape when it comes to resistance.

PRESENTATION 54: Saturday 15th October, 2011 ONE SLIDE/FIVE MINUTES
16.05–16.15 h. Research in Progress, without results

TITLE: Self-sampling: a solution to improve attendance to cervical cancer screening?

AUTHOR(S): Christophe Berkhout, Charlotte Squimbre, Eugénie Fromont, Marie Blanckaert, Pamela Nesslany

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Background:
Cervical cancer is a disease caused by a persistent infection with human papillomavirus (HPV). Though no survey has demonstrated that screening for cervical cancer reduces mortality, the risk of invasive cervical cancer drops by 3 to - 10 times with the Pap-test. Screening for cervical cancer is mainly not organized in France: it is opportunistic and has to be carried out every three3 years to fulfill national guidelines. About 40% of women are screened more often by their GP or gynaecologist, but about the same rate of women is screened less than every five5 years or not at all. Reasons for under-screening are roughly known and are related to women and GPs. Screening in women aged over 30 can be carried out by hybrid capture II high risk HPV-test, followed by triage with cytology or biomarkers. Samples can then be self-collected with a lavage device.

Aim:
What is the rate of women attending GP waiting rooms that is under-screened for cervical cancer? Could self-sampling be an answer to increase attendance to cervical cancer screening? In what conditions?

Method:
Survey by self-completed questionnaires in GP waiting rooms and face to face in- depth interviews with the under-screened women and their GPs. Randomization unit: GPs. Self-sampling with a lavage device is to be shown at the end of the interview and reactions of the interviewee are to be collected. Verbatim accounts are to be coded using as categories the variables defined by Fishbein's integrative model (IM) predicting intensions. The IM attempts to identify a limited set of variables that can account for a considerable proportion of the variance in any given behaviour.

Expected results:
For which women, and which GPs, is self-sampling with a lavage device an attractive alternative to screen for cervical cancer, with the potential to increase the attendance rate.

Points for discussion:
Do you have an experience of self sampling for cervical cancer screening in your country?
Is the background organised or opportunistic screening?

PRESENTATION 55: Saturday 15th October, 2011 ONE SLIDE/FIVE MINUTES
16.15-16.25 h.

TITLE: Travel medicine and Infectious diseases: the responsibilities of the general practitioner

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Background:
Nowadays millions of people are travelling around the globe, crossing borders and continents in hours - unprecedented phenomenon in the all known human history. General practitioners have the difficult task to prepare their patients for travel and to consult and observe them after their return, protecting them and the society from different and sometimes severe and especially dangerous infections.

Research question:
Do GPs realize their responsibilities and are they prepared for the challenge of that enormous human global movement, focusing on infectious diseases?
Method: We created a structured questionnaire, which allows us to assess GPs' competence in the infectious diseases aspect of travel medicine and the understanding of their responsibilities not only for their patients, but for the health and wellbeing of the society. The questionnaire will be is presented to the GPs in Bulgarian and English languages.

Results:
General practitioners from different European and non-European countries, including Bulgaria are involved. We are organizing the study, targeting on a reasonable geographical balance between the countries and having in mind the most important and most at-risk groups of travellers for every country. We intend to compare the results and propose suggestions for improving GPs' education and training accordingly to the current needs and changes in the global world.

Conclusions:
The topic becomes more and more important. GPs have to be aware and ready to cope with many not well known, rare and/or especially dangerous infections coming from all over the world.

Points for discussion:
1. Suggestions about the scope of the study.
2. Discussion on the target group training.
3. Could the study be developed as a 7th FP project, forming a research consortium?

PRESENTATION 56: Saturday 15th October, 2011 **ONE SLIDE/FIVE MINUTES**
15.55-16.05 h. **Study proposal / idea**

TITLE: Clinical prediction rules in primary care: a research proposal.

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Background:
Clinical prediction rules attempt to increase the accuracy of clinician's' diagnostic and prognostic assessments. However, the robustness of clinical prediction rules that have been developed for primary care has not been systematically assessed.

Research question:
What is the hierarchy of evidence for clinical prediction rules in primary care?

Method:
PubMed and ISI Web of Science searches to identify studies related to derivation, validation, and impact of clinical decision rules in primary care. The evidence for each rule will be assigned one of four hierarchy levels (from highest I to lowest IV).

Conclusions:
This study is expected to identify prediction rules with a high level of evidence that may be suggested for use in clinical practice guidelines.

Points for discussion:
1. Why we need clinical prediction rules in primary care.
2. How we can evaluate them.
3. What the implications of the project would be for primary care.

PRESENTATION 57: Saturday 15th October, 2011 ONE SLIDE/FIVE MINUTES
16.05-16.15 h. Ongoing study with preliminary results

TITLE: Influence of infective diseases in family medicine practice in Mostar region, BH.

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Background:
Some regions in Bosnia and Herzegovina do not have enough doctors. When the patients needs time to be observed that becomes problem because too many patients are waiting for medical service

Research question:
Is there any influence of number of patience with infective diseases on everyday work in Mostar region, BH.

Method:
Populational study done using simple questionairer form about registered patients in family medicine Clinics in the Mostar region.The survey was completed by 6 teams of 10 in Mostar region during December 2010, January, March and June 2011.

Results:
Preliminary results for January 2011 for one team said that among 760 patients. 147 of them had infective diseases. Our patients were mostly women who suffered from respiratory diseases while men had severe pneumonia, cystitis and prostatitis. The mostly prescribed drugs for females were amoxicillin with clavulonic acid while for men ciprofloxacin and klaritromicin.

Conclusions:
-

Points for discussion:
- kinds of infective diseases during the winter time and time for patients
- kind of antibiotics for pneumonia

PRESENTATION 58: Saturday 15th October, 2011 ONE SLIDE/FIVE MINUTES
16.15-16.25 h. Study proposal / idea

TITLE: Administrative and reporting tasks of general practitioners (GP) in Europe.

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Background:
The GPs increasing administrative workload of GPs is challenging in all European countries. Due to the increasing administrative tasks, GPs can spend less time with patient consultations.

Research question:
How do general practitioners feel about their administrative workload?
What would be the ideal percentage of administration in primary care?
Which system is the most time consuming or cost effective?
How could we decrease the time of administration and increase the time spentding with the patients?
Are there similarities and differences in the European countries?

Method:
Pilot study: During a previous EGPRN meeting in Nice a pre – study questionnaire was filled out by GPs from 18 European countries, investigating the national systems and the connection between the finance and administrative tasks of the GPs.
Further steps in the proposed study:
-Systematic literature review in the relevant topic including the grey literature in the participant countries.
-Overview of the different systems in Europe.
-Survey of the GPs' subjective feeling about administration (by filling out a questionnaire about administrative tasks and workload – 20 GPs/ country).

Results:
Beside differences between countries, similarities were found. There are only a few available articles in English; most relevant data could be published in the native languages. The GPs who filled out the pre-study questionnaire were interested in the topic.
Expected output: Requirements of correct professional administrations should be determined and modifications may be added depending on the gate-keeper function, the insurance and reimbursement systems of the respective countries.

Conclusions:
There is a need for further research, information from official national bodies and authorities.
We would like to invite more GPs from all European countries.

Points for discussion:
1. To discuss the methodology of our study.
2. Is there any further relevant literature on this topic in your country?
3. Recruiting participants.