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European General Practice Research Network

Tel Aviv-Jaffa (Israel)

20th -24th May, 2016

SCIENTIFIC and SOCIAL PROGRAMME

THEME: "Research on Medical Overuse: Overdiagnosis and Overtreatment in Family Medicine and Primary Care"

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

CONFERENCE VENUE

Ruth Daniel Residence
http://english.mishkenot-jaffa.co.il/
47 Jerusalem Boulevard,
68112 Tel Aviv-Jaffa, Israel

EUROPEAN GENERAL PRACTICE
EGPRN
RESEARCH NETWORK

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

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

► Primary Sponsor: Israeli Association of Family Physicians
► Israel Medical Association

Primary Sponsor:
Israeli Association of Family Physicians

Israel Medical Association

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

The meetings of the European General Practice Research Network (EGPRN) have earned accreditation as official postgraduate medical education activities by the Belgian, Norwegian, Slovenian, Irish and Dutch College of General Practitioners.
Those participants who need a certificate can contact Mrs. Hanny Prick during the meeting in Tel Aviv.

“Research on Overdiagnosis and Overtreatment in Family Medicine and Primary Care”.

Dear doctors, researchers, and colleagues,

Overuse of medical care, both over diagnosis and over treatment, is a major issue in all medical organizations around the world[1]. Over diagnosis, occurs when a patient is diagnosed with a disease that will not affect his/her life both in terms of morbidity or mortality, for example the diagnosis of a breast mass that would not have become clinically apparent in the absence of screening. Over treatment means treating such illnesses, which will not affect one's outcome or may even cause harm, such as unnecessary antibiotics use which may result in Clostridium difficile infection. Medical overuse results in preventable harms, including psychological, and loss of valuable medical resources. In recent years, medical overuse has also been related to decreased patient satisfaction. This will be an excellent opportunity for all members to share knowledge and beliefs regarding medical overuse.

- Medical overuse
- Over treatment
- Over diagnosis
- Guidelines
- Choosing wisely

[1] Morgan DJ, Wright SM, Dhruva S, Update on medical overuse, JAMA Intern Med. 2015;175(1):120-124.

We plan to hold the conference in Ruth Daniel Residence (http://english.mishkenot-jaffa.co.il/). It is located in the heart of Jaffa’s Jerusalem Boulevard, adjacent to the old city, the flea market and Jaffa’s colorful port, just a walk away from the picturesque Neveh Tzedek neighborhood and Tel Aviv’s charming beachfront promenade. It is about 15Km from the international Ben-Gurion airport; 60Km from Jerusalem; 160Km from the Dead Sea and 100Km from Nazareth.

There are many lodging options in Tel Aviv with a wide variety of prices, and easy transportation.

Local Organizing committee:

- Joseph Azuri MD MHA
- Shlomo Vinker MD MHA
- Robert Hoffman MD
- Sofia Eilat MD

MEETING EXECUTIVE BOARD

GENERAL COUNCIL MEETING

Executive Boardmeeting
Saturday 21st May, 2016

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

Location: Ruth Daniel Residence
47 Jerusalem Boulevard
68112 Tel Aviv-Jaffa (Israel)
in: Fountain (Hamizraka)

General Council meeting with the National Representatives
Saturday 21st May, 2016

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

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

Location: Ruth Daniel Residence
47 Jerusalem Boulevard
68112 Tel Aviv-Jaffa (Israel)
in: Andromeda

REGISTRATION

► Saturday 21st May 2016

REGISTRATION FOR PARTICIPANTS OF **PRE-CONFERENCE WORKSHOPS ONLY**

Location: Ruth Daniel Residence
47 Jerusalem Boulevard, 68112 Tel Aviv-Jaffa (Israel).

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

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► Sunday 22nd May 2016

REGISTRATION FOR ALL PARTICIPANTS
Time: 08.00 – 08.30 h.

Location: Ruth Daniel Residence
47 Jerusalem Boulevard, 68112 Tel Aviv-Jaffa (Israel)

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

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► Monday 23rd May 2016

SOCIAL NIGHT FOR ALL PARTICIPANTS

Social night on Monday 23rd May 2016 –– 19.30 hrs.
Dinner, speeches and party.

Location: In the **center of Tel Aviv,** not far from **Sarona the renovated Templers neighbourhood.** In the Punchline entertainment http://www.punchline-tlv.co.il/#!punch-line-entertainment-celebrate-your-/c1ue8
Address: 6 harbaa street; Tel Aviv, Israel.
Phone: +972-3-5610785
Web: http://saronatlv.co.il/?lang=en

Entrance Fee: € 40,= per person.

Please address to EGPRN Registration Desk.

Unfortunately, we have NO facility for electronic payments (credit card, Maestro) on the spot. We only accept CASH EUROS.
We do NOT prefer pay cheques, given the extra costs. If you have no other option we will charge € 25 extra.
On site payment +€50 extra administration costs.

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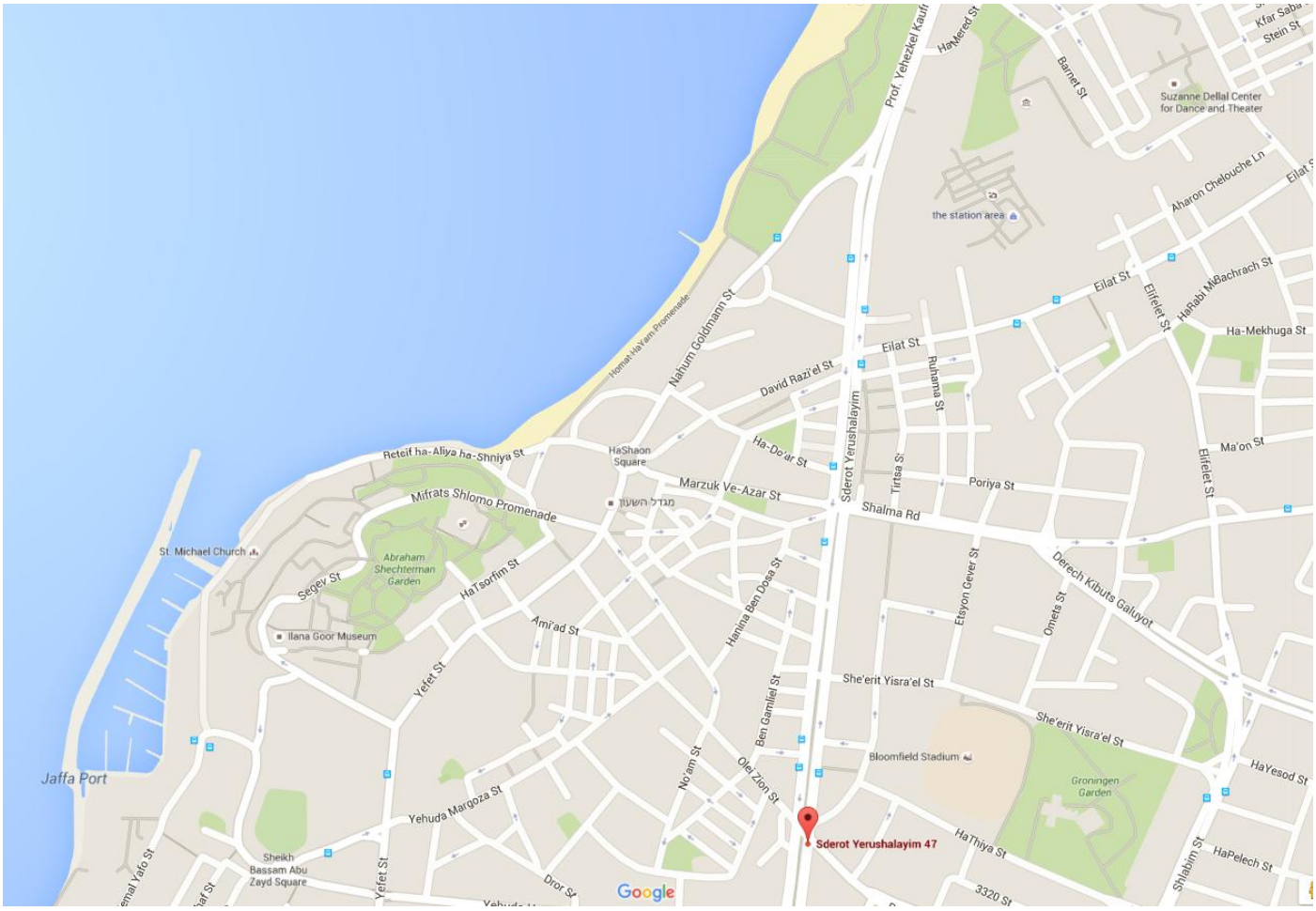
Map of Tel Aviv-Jaffa (Israel)



E G P R N 20th-24 MAY, 2016

PROGRAMME OF THE EUROPEAN GENERAL PRACTICE RESEARCH NETWORK IN TEL AVIV-YAFO; ISRAEL

FRIDAY 20th MAY, 2016:
Location : Ruth Daniel Residence
47 Jerusalem Boulevard, 68112 Tel Aviv-Jaffa (Israel)

12.30 - 15.00 : **1 EGPRN Pre-Conference Morning Workshop**
€65 (€35 for EGPRN members) each per person.
Pre-conference Workshop *"The Pitfalls and Advantages of Big Data Research in General Practice"*
Chair: Prof. Tony Heymann (Israel).
in: Port (Hanamal)

SATURDAY 21st MAY, 2016:
Location : Ruth Daniel Residence
47 Jerusalem Boulevard, 68112 Tel Aviv-Jaffa (Israel)

09.00 - 17.00 : **Collaborative Study Group**
"TATA and FPDM EGPRN Collaborative Study"
(chair J.Y. Le Reste)
in: Port (Hanamal)

09.00 - 17.00 : **Collaborative Study Group**
COGITA 2016 -meeting (pre-registration: cf.stolper@maastrichtuniversity.nl)
in: Lighthouse (Migdalor)

09.30 - 12.30 : **Business Meeting**
EGPRN Executive Board Meeting
Welcome and Coffee for Executive Board EGPRN, **(only for Executive Board Members)**
in: Boardroom Main Diningroom

10.00 - 12.00 : **Collaborative Study Group**
"PROCOPD study"
(chair: Ana Clavería)
in: The Clock (Hashaon)

-- COFFEE/TEA BREAK IN THE CORRIDOR --

10.00 - 12.30: **1 EGPRN Pre-Conference Morning Workshop**
€65 (€35 for EGPRN members) each per person

Pre-conference Workshop *"Qualitative Studies".*
Chair: Prof.Lieve Peremans (Belgium) and Dr. Elsie Nahum MD (Israel)
in: Fountain

12.30 - 13.30 : **Lunch** (price not included in fee conference workshops)

13.30 - 16.00: **1 EGPRN Pre-Conference Afternoon Workshop**
€65 (€35 for EGPRN members) each per person.

Pre-conference Workshop *"The Pitfalls and Advantages of Big Data Research in General Practice"*
Chair: Prof. Tony Heymann (Israel).
in: Fountain

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

-- COFFEE/TEA BREAK IN THE CORRIDOR --

16.45 - 17.45 : **Business Meeting**
Meeting of the EGPRN Working Groups (last part of the Council meeting)
- **Research Strategy Committee – in: Clock**
- **Educational Committee – in: Mandel Auditorium**
- **Communication and PR Committee – in: Mandel Auditorium**

17.30 - 18.30 : **Collaborative Study Group**
"CoCo Study"
(Chair: B.Weltermann)
in: Port (Hanamal)

Social Program: **For ALL EGPRN-participants of this meeting who are present in**
20.45 – : Tel Aviv-Yafo (Israel) at this time. (Entrance Free)

Welcome Reception and Opening Cocktail -
for all participants.

● **Welcome by *Dr. Joseph Azuri*, local host Tel Aviv, national representative EGPRN Israel and Moderator**

● **Welcome by *Dr. Leonid Eidelman*, chairperson of the Israel Medical Association**

● **Welcome by *Prof Shlomo Vinker* the chairman of the local host organization – Israel Association of Family Physicians**

● **Welcome in the name of the EGPRN by *Dr. Jean Karl Soler and Prof. Mehmet Ungan*, present and next Chairpersons of EGPRN**

Location:

The **Welcome reception** will be at the **Venue of the conference on the roof "Cassiopeia"** of the **Ruth Daniel Residence** with beautiful view to Old Jafa.

SUNDAY 22nd MAY, 2016:

Location : Ruth Daniel Residence
47 Jerusalem Boulevard, 68112 Tel Aviv-Jaffa (Israel)

08.30 - 09.00 : Registration at EGPRN Registration Desk.

09.00 - 11.00 : Plenary Session
in: Andromeda
Chair: …….

09.00 - 09.15 : Welcome.
Opening of the EGPRN-meeting by the Chairperson of the EGPRN.

09.15 - 10.00: International Keynote Speaker: *Prof. John Brodersen, MD, GP, PhD*;
(Faculty of Health Sciences, University of Copenhagen-Denmark).
Theme: *"Research into Overtreatment and Overdiagnosis"*

10.00 – 11.00 : 2 Theme Papers (plenary)
in: Andromeda
Chair: …..

1. *id27* **Amnon Lahad (Israel)**
   Population-based screening for breast and ovarian cancer risk due to BRCA1 and BRCA2.

2. *id58* **Ronen Bareket (Israel)**
   Over-screening for Cancer in patients with limited predicted life expectancy. A Cross Sectional Study.

11.00 – 11.30: Coffee break
in: corridor area

11.30 - 13.00 : Parallel session A – 3 Theme Papers
in: Andromeda
Chair: …..

3. *id35* **Colin Bradley (Ireland)**
   Overtreatment of multimorbid patients in primary care: development and feasibility of an intervention to reduce potentially inappropriate prescribing.
4. *id74* **Birgitta Weltermann (Germany)**
   Overuse of coronary procedures in stable coronary disease: A long-term retrospective study of patient careers.

5. *id15* **Jochai Schonmann (Israel)**
Risk Factors and Predictors for Chronic Use and Abuse of Hypnotic Medication. A 10 year retrospective cohort study of 190.000 patients.

11.30 - 13.00 : **Parallel session B – 3 Freestanding Papers - *"Clinical Care"***
in: Lighthouse (Migdalor)
Chair: …..

6. *id75* **Konrad Schmidt (Germany)**
Sepsis aftercare in General Practice.

7. *id46* **Florian Wolf (Germany)**
Chronic depression care in general practice.

8. *id70* **Leonard Mada (Romania)**
Variability of the I-PSS questionnaire in an adult male population from Romania.

13.00 -14.00 : **Lunch**
in: Restaurant

13.00 -14.00 : **The Educational Committee Lunch workshop – "Understanding Health Economics Research"** 60 minutes with *Dr.Michael Harris,* (University of Bath, UK), workshopleader who will present, chair and discuss This lunchtime course will explain the basics of health economics research. Some health economic ideas, for instance value for money, are familiar from our day-to-day lives. Other models are more difficult to follow, so Michael Harris will go through those in more detail.
By the end of the session, you will know about the principles of this type of research, and be able to use that knowledge to understand and critically appraise health economics research papers.*There is no charge for this workshop.*
in: Restaurant

14.00 - 16.00 : **Parallel session C – 4 Theme Papers – "*Medication*"**
in: Andromeda
Chair: …..

9. *id9* **Gari Blumberg (Israel)**
Who chooses laboratory tests? The physician or the computer?

10. *id21* **Sophia Chatelard (France)**
Overmedicalization: a qualitative study to explore GPs point of view.

11. *id40* **Ingrid Keilegavlen Rebnord (Norway)**
Antibiotic prescription and hospital admission after screening with C-reactive protein in out-of-hours services in Norway.

12. *id3* **Johannes Hauswaldt (Germany)**
Increased contact frequencies in general practice for early malignancy detection? - avoiding over-diagnosis.

14.00 - 16.00 : Parallel session D – 4 Freestanding Papers – *"Miscellaneous"*
in: Lighthouse (Migdalor)
Chair: …..

13. *id81* **Pemra C. Ünalan (Turkey)**
Physicians' Attitudes Towards Death/Terminal Illness.

14. *id8* **Erika Baum (Germany)**
Dizziness and vertigo in primary care: results of a systematic review and implications for appropriate diagnostic strategies.

15. *id55* **Agnieszka Sowińska (Poland)**
Struggling with an illness in narratives of patients presenting Medically Unexplained Symptoms (MUS): A study from Poland.

16. *id49* **Michael Harris (United Kingdom)**
The effect of system factors on European GPs decision-making when patients may have cancer: an 18-country Örenäs Research Group survey.

16.00 - 16.30: Coffee break
in: corridor area

16.30 – 17.55: Plenary Session
in: Andromeda
Chair: …..

16.30-17.30 :
17. Paul Wallace, Samar Musmar e.a (Palestine)
WORKSHOP 'International Development of Family Medicine in Palestine (IDFMP)'
IDFMP sponsored workshop on 'The Challenges of Developing and Implementing Effective Family Medicine in the Palestinian Occupied Territories'.

The authors and presenters are from the Foundation for the International Development of Family Medicine in Palestine and include Dr Samar Musmar, former Vice Dean of the Faculty of Medicine at An Najah University and founder of the 4 year family medicine specialisation programme in the West Bank.

17.30 - 17.50 **Closing of the day by *Prof. John Brodersen,*** keynote speaker, who will summarize on today's theme papers.

17.50 - 17.55 : **Closure of the day**

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

Social Programme :

18.00 – 19.30 : Practice Visits to various local Health Centres in Tel Aviv.

We will leave from the conference venue to 6 different practices.
Registration for practice visit will be in the registration area.

MONDAY 23rd MAY, 2016:

Location : Ruth Daniel Residence
47 Jerusalem Boulevard, 68112 Tel Aviv-Jaffa (Israel)

08.30 – 09.10 : Plenary Session
in: Andromeda

08.30 - 09.10 : 2nd Keynote Speaker: *Prof. Arnon Afek*; (Former Director General; currently Associate Director General Ministry of Health of Israel, Director NY State American MD program, Sackler School of Medicine Tel Aviv University).
Theme: *"Israeli health care system-achieving excellence through primary care".*

09.10 -10.40 : Parallel session E - 3 Freestanding Papers - *"EGPRN Collaborative Projects"*
in: Andromeda
chair: ……..

18. *id24* **Jean Yves Le Reste (France)**
A RAND UCLA procedure to select the best reliable tool to assess Therapeutic Alliance within Europe. (Tool Assessment for Therapeutic Alliance STUDY).

19. *id48* **Erik Stolper (The Netherlands)**
EGPRN international work group on gut-feelings in general practice COGITA and its outcome.

20. *id69* **Ana Luisa Neves (Portugal)**
Attitudes of young GPs towards research: perspectives of EGPRN/VDGM Research Workshop participants.

09.10 - 10.40 : Parallel session F – 3 papers 'Special Methodology Workshop'
in: Lighthouse (Migdalor)
chair: ……..

21. *id51* **Pavlina Nikolova (Bulgaria)**
Unawareness of diabetic neuropathy: monofilament testing as screening tool in general practice.

22. *id17* **Mathilde François (France)**
The influence of clinical expertise on drug prescribing for dementia. A longitudinal French study.

23. *id37* **Ioana Padure (Romania)**

Overweight/obesity correlates with increased LDL-cholesterol levels in 20-45 years old patients.

10.40 - 11.10 : **Coffee break**
in: corridor area

11.10 - 12.10 : **Parallel session G - 2 Freestanding Papers – *"Adherence, Treatment, Chronic Illness"***
in: Andromeda
chair: ……..

24. *id26* **Eugene Merzon (Israel)**
Insulin pump therapy - high rate of non-adherence may indicate overuse: a population-based case-cohort study.

25. *id16* **Tamar Berkovich (Israel)**
The influence of using asynchronous e-visit technology in primary care on chronic disease management.

11.10 - 12.00: **Parallel session H - 5 One Slide/Five Minutes Presentations**
"ASK the expert session: At the end of the One slide/Five minutes presentation session, presenters will be given the opportunity to have a 10 minute' face to face meeting with an expert in their field of research".
in: Lighthouse (Migdalor)
chair: Ferdinando Petrazzuoli

26. *id19* **Eric Galam (France)**
How to appreciate the well-being of General Practitioners?

27. *id50* **Claudia Maria Stefanescu (Romania)**
Overtreatment in upper respiratory tract infections - Antibiotics Yes or No ?

28. *id62* **Hailey Russ (Israel)**
Yield of video capsule examination.

29. *id82* **Tevfik Tanju Yilmazer (Turkey)**
Age identity and perception of health in the elderly.

30. *id87* **Nir Tsabar (Israel)**
Effect of email alert about sulfonylurea medicine overtreatment of diabetes.

12.10 – 13.00 : **Plenary Session - SYMPOSIUM**
in: Andromeda

31. *id77* **Caroline Huas (France)**
Actions to bridge the divide in European health research and innovation â€“ proposal to be involved in a European call for funding.

13.00 – 14.00 : **Lunch**
in: Restaurant

14.00 – 14.20 : **Chairperson's Report by Dr. Jean Karl Soler.**
Report of EGPRN Executive Board and Council meeting.
in: Andromeda

The meeting continues with 5 parallel Poster sessions till 15.35 h.

14.20 – 15.35 : **Posters**
In five parallel sessions (5 groups)

14.20 – 15.35 : **Parallel group 1: Posters: *"Overtreatment, Overdiagnosis"***
in: Andromeda
chair: ……..

32. *id56* **Johan Buffels (Belgium)**
Primum non nocere: a qualitative study.

33. *id65* **Gordon Littman (Israel)**
Do diabetic patients aged 65 years or older receive too much medication?

34. *id5* **Laurence Baumann-Coblentz (France)**
How to train caregivers for sick doctors? Preliminary report of a french training program.

35. *id67* **Eva Hummers (Germany)**
It's a bit like in hospital"- general practitioners' experiences and strategies to perform nursing home visits.

36. *id86* **Safadi Michael (Israel)**
The Same Lady in a Different Outfit - Mistakes in Medication Utilization Due to Different Names of the Same Drug.

14.20 – 15.35 : **Parallel group 2: Posters: *"Mental Health"***
in: Andromeda
chair: ……..

37. *id53* **Nicola Buono (Italy)**

Rural and urban differences in Family Doctor's workload during seasonal flu epidemics: management in the Italian family medicine setting.

38. *id78* **Snežana Janković (Serbia)**
Mental illness in the population of Obrenovac before and after floods.

39. *id36* **Nurit Guttman (Israel)**
Evaluation of Responses to Persuasive communication regarding excessive Medical Examinations using an educational video campaign.

40. *id6* **Tiphanie Bouchez (France)**
Disagreements about patient care between Parisian General Practitioners in training and their supervisors. Study of 37 situations.

14.20 – 15.35 : Parallel group 3: Posters: *"Cardiovascular Disease"*
in: Lighthouse (Migdalor)
chair: ……..

41. *id42* **Miguel-Angel Muñoz (Spain)**
HEFESTOS Study: first stages of a European collaborative research project.

42. *id66* **Joan Llobera Canaves (Spain)**
EIRA. A complex multi-risk intervention in primary health care to promote health behaviours in patients aged 45 to 75 years: preliminary results from phase 0, I and II. Design a complex multicentre cluster randomized clinical trial (Phase III).

43. *id68* **Liina Kask-Flight (Estonia)**
Does Current Medication Prescribed To the Young Hypertonic Male Correlate To Their Actual Cardiovascular Risk?

44. *id30* **Patrice Nabbe (France)**
FPDM (Family Practice Depression and Multimorbidity): The French version of the Hopkins Symptoms Check List-25 items (HSCL-25), validation in general practice – Study proposal.

45. *id43* **Shmuel Meir Giveon (Israel)**
Pre-diabetes: true of fiction?

14.20 – 15.35 : Parallel group 4: Posters: *"Miscelaneous"*
in: corridor area
chair: ……..

46. *id63* **Pavlo Kolesnyk (Ukraine)**

Assessing the role of factors affecting the bone density in children and adolescents.

47. *id23* **Robert Hoffman (Israel)**
European Study on Self-care for Common Colds: Gender differences in primary care practice samples from 14 European nations (COCO study).

48. *id25* **Bernard Le Floch (France)**
What tools are usable to assess Quality of life in general population. A systematic literature review.

49. *id28* **Marie Barais (France)**
The linguistic validation of the gut feelings questionnaire into three European languages: an intriguing process.

50. *id31* **Bernardino Oliva-Fanlo (Spain)**
Gut feelings in the diagnostic process of Spanish family physicians: a focus group study.

51. *id57* **Sophia Eilat-Tsanani (Israel)**
Health behavior and utilization of health services in Ultra Orthodox Jews (UOJ) in Safed.

14.20 – 15.35 : Parallel group 5: Posters: *"Cancer, Screening"*
in: corridor area
chair: ……..

52. *id73* **Ioana Budiu (Romania)**
The prevalence of cardiovascular disease (CVD) in obese people in Timis County - Romania.

53. *id39* **Mihai Iacob (Romania)**
The General Ultrasonography as an Experimental Oncological Screening and a comparative statistical analysis of different type of ultrasound methods (Triplex Doppler or Strain Elastography) who can be significant in primary care.

54. *id44* **Marie O'Shea (Ireland)**
Cancer Survivorship - Barriers Encountered by General Practitioners in Ireland.

55. *id84* **Martine Granek-Cativaras (Israel)**
Understanding non-compliance for occult blood test in the Jewish and Arab communities in Israel.

56. *id89* **Yacov Fogelman (Israel)**
Vitamin B12 screening in metformin-treated diabetics in primary care: were elderly patients less likely to be tested?

15.35 – 15.55 : **Coffee break**
in: corridor area

15.55 – 16.55 : **2 Freestanding Papers (plenary) – *"Free Session"***
in: Andromeda
Chair: ……..

57. *id79* **Liliana Laranjo (Australia)**
The influence of social networking sites on health behavior change - meta-analysis.

58. *id34* **Gili Ofer-Bialer (Israel)**
Acute Sinusitis. A common disease with overuse of diagnostic tool and medicine treatment.

The meeting continues with a Plenary Session till 17.55 hrs.
in: Andromeda

16.55 – 17.15 : **Closing of the day by *Prof. Arnon Afek,*** keynote speaker, who will summarize on today's theme papers [epilogue].

17.15 – 17.30 : **Presentation of the EGPRN Poster Prize for the best poster presented in Tel Aviv-Jaffa.**

17.30 – 17.45 : **Introduction on the next EGPRN-meeting in Leipzig-Germany, by *Dr. Thomas Frese*, national host organizing committee Leipzig.**

17.45 – 17.55 : **Closing of the Scientific part of the conference, by the EGPRN Chairperson.**

Social Programme :

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

Location: In the **center of Tel Aviv,** not far from **Sarona the renovated Templers neighbourhood.** In the Punchline entertainment http://www.punchline-tlv.co.il/#!punch-line-entertainment-celebrate-your-/c1ue8

Address: 6 harbaa street; Tel Aviv, Israel.
Phone: +972-3-5610785
Web: http://saronatlv.co.il/?lang=en

Entrance Fee: € 40,= per person.
Please address to EGPRN Registration Desk.

Bus will leave from Conference Venue: 19.30 hrs.

TUESDAY 24th MAY, 2016:

Location : **Maccabi healthcare services headquarters**
27 Hamered st
Tel Aviv-Jaffa (Israel)

09.30 – 12.00: **2nd Meeting of the EGPRN Excecutive Board**
in: Shunit hall, 16th floor

SUNDAY 22nd MAY, 2016:

Location : Ruth Daniel Residence
47 Jerusalem Boulevard, 68112 Tel Aviv-Jaffa (Israel)

09.15 - 10.00: International Keynote Speaker: *Prof. John Brodersen, MD, GP, PhD*;
(Faculty of Health Sciences, University of Copenhagen-Denmark).
Theme: *"Research into Overtreatment and Overdiagnosis"*

"*Life can only be understood backwards*; *but it must be lived forwards*"
- Søren Kierkegaard (Danish philosopher 1813-55)

Overdiagnosis is the diagnosis of deviations, abnormalities, risk factors and/or pathology that never in itself will: cause symptoms (applies only to risk factors and pathology), lead to morbidity or be the cause of death. Treating an overdiagnosed condition (deviation, abnormality, risk factor and/or pathology) will by definition not change the patient's prognosis to the better and can therefore only be harmful(1-3). Treatment of overdiagnosed conditions is one category of overtreatment. Another type of overtreatment is when best available external evidence shows that the treatment has no beneficial effect on diagnosed conditions(4).

At the individual level, neither we as general practitioners (GPs), nor the patient, can be sure when the patient is actually overdiagnosed. Only at the end of the individual patient's life we can for biomedical conditions be certain if our diagnosis was correct or iatrogenic. Within the area of psychosocial conditions we will never get a certain answer. Therefore, the dilemmas and pitfalls in all diagnostic processes in the GPs' daily clinical patient-centred practice - with low prevalence of biomedical diseases and high prevalence of psychosocial illnesses - is so beautifully captured in the abovementioned quote of Kirkegaard. Accordingly, the million (or more accurately multi-billion) dollar question is: how can we conduct research about something that cannot be instantly observed and thereby be able to reduce or prevent overdiagnosis and overtreatment?(3)

If we want to know more about the lived life, the experiences and the thoughts among overdiagnosed individuals we are in most cases raising research questions that have to be explored in qualitative designs: interviews, observational field work, documents, etc. Because we can never be 100% sure that the individual person has been overdiagnosed informants who are most likely to be overdiagnosed, or informants that for a shorter period of time span are overdiagnosed, could be interviewed, e.g. healthy women (over)diagnosed with osteoporosis via screening, men (over)diagnosed with small abdominal aortic aneurisms via screening and screening participants having abnormal screening findings later confirmed to be false positive.

If the research question is about how many people that are overdiagnosed quantitative designs are required. The best available evidence is provided by high quality randomised controlled

trials. Next best available evidence comes from cohort studies and least best available evidence are results generated in modelling studies(5).

A final type of research questions could focus on the consequences of overdiagnosis. Harris and colleagues have suggested a taxonomy describing seven different categories that could be explored: financial strain; hassles/inconveniences; medical costs; opportunity costs; physical harms; psychological harms; and societal costs(6). In addition, we have identified empirical evidence for an additional category: work-related costs(7). All kinds of study designs are needed to explore the empirical evidence in these eight categories of consequences of overdiagnosis.

Reference List

(1) Welch HG, Schwartz L, Woloshin S. Overdiagnosed. Making People Sick in the Pursuit of Health. Boston: Beacon Press; 2011.

(2) Doust J, Glasziou P. Is the problem that everything is a diagnosis? Australian Family Physician 2013 Dec 1;42:856-9.

(3) Brodersen J, Schwartz LM, Woloshin S. Overdiagnosis: how cancer screening can turn indolent pathology into illness. APMIS 2014 Aug;122(8):683-9.

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(5) Carter JL, Coletti RJ, Harris RP. Quantifying and monitoring overdiagnosis in cancer screening: a systematic review of methods. BMJ 2015;350:g7773.

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MONDAY 23rd MAY, 2016:

Location : Ruth Daniel Residence
47 Jerusalem Boulevard, 68112 Tel Aviv-Jaffa (Israel)

08.30 - 09.10 : 2nd Keynote Speaker: *Prof. Arnon Afek*; (General Ministry of Health of Israel, Director NY State American MD program, Sackler School of Medicine Tel Aviv University).
Theme: " *How Israel Achieves Value in Healthcare - Israeli health care system-achieving excellence through primary care".*

The Israeli healthcare system is based on the 1994 National Insurance Act which provides universal coverage to all of its inhabitants. Healthcare is provided by four competing healthcare funds. The health benefit basket is quite extensive and includes novel treatments such as KEYTRUDA for metastatic malignant melanoma. Israel has achieved excellent healthcare indices, including longevity 7th among OECD countries and cardiovascular mortality 4th lowest, and all of that has been achieved with relatively low expenditures: 7.5% of GDP, compared to 17% of USA GDP and 9% OECD average.

These achievements of low spendings and cost effectiveness can be attributed to the organization of the healthcare system, namely, to its structure, financing, regulation and quality. The system is based on community care provided by the health funds, strict regulation by the Ministries of Health and Finance which curbs excessive spending, affordable voluntary health insurance that helps in preventing long waiting times, and quality measurements that are transparent. The OECD report of 2012 stated that Israel has established one of the most enviable healthcare systems among all of the OECD countries.

Israel, as other nations, faces future healthcare challenges, including the aging population, cost of new drugs and technologies, patient-physician relationships, the big data revolution, and the need to invest more extensively in preventive medicine. Israel meets these and other challenges by relying on the innovative nature of its people, the start-up nation.

Together with, and not less important, than the factors mentioned previously are the humanitarian aspects and the caring for our people as well as for other nations facing man-made or natural disasters. Israel's rescue missions have helped thousands of people all over the world, spreading the message and the reality of Israeli healthcare.

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PRESENTATION 1: **Sunday 22nd May, 2016** **THEME PAPER**
10.00–10.30 h.

Population-based screening for breast and ovarian cancer risk due to BRCA1 and BRCA2

Amnon Lahad, Efrat Gabai-Kapara, Bella Kaufman, Eitan Friedman, Shlomo Segev, Paul Renbaum, Rachel Beeri, Moran Gal, Julia Grinshpun-Cohen, Karen Djemal, Jessica B. Mandell, Ming K. Lee, Uziel Beller, Raphael Catane, Mary-Claire King, and Ephrat Levy-Laha
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Id 27

Background: In the Ashkenazi Jewish (AJ) population of Israel, 11% of breast cancer and 40% of ovarian cancer are due to three inherited founder mutations in the cancer predisposition genes BRCA1 and BRCA2. For carriers of these mutations, risk-reducing salpingooophorectomy significantly reduces morbidity and mortality. Population screening for these mutations among AJ women may be justifiable if accurate estimates of cancer risk for mutation carriers can be obtained.
Research question: We undertook to determine risks of breast and ovarian cancer for BRCA1 and BRCA2 mutation carriers ascertained irrespective of personal or family history of cancer.
Method: Families harboring mutations in BRCA1 or BRCA2 were ascertained by identifying mutation carriers among healthy AJ males recruited from health screening centers and outpatient clinics. Female relatives of the carriers were then enrolled and genotyped.
Results: 8,222 male index subjects enrolled in the study. DNA samples from 8,195 subjects (99.7%) were successfully genotyped. 175 carried a mutant allele. Among 431 female relatives, 211 were identified as BRCA1 or BRCA2 mutations carriers. Cumulative risk of developing either breast or ovarian cancer by age 60 and 80, respectively, were 0.60 (± 0.07) and 0.83 (± 0.07) for BRCA1 carriers and 0.33 (± 0.09) and 0.76 (± 0.13) for BRCA2 carriers. Risks were higher in recent vs. earlier birth cohorts (P = 0.006).
Conclusions: High cancer risks in BRCA1 or BRCA2 mutation carriers identified through healthy males provide an evidence base for initiating a general screening program in the AJ population. General screening would identify many carriers who are not evaluated by genetic testing based on family history criteria. Such a program could serve as a model to investigate implementation and outcomes of population screening for genetic predisposition to cancer in other populations.

Points for discussion:
-Among females curriers of the BRCA mutations there is a very high life risk of ovarian and breast cancer.
-Is screening for BRCA mutations will be accepted by the population?
-What will be the psychological and social effect of this screening?

PRESENTATION 2: **Sunday 22nd May, 2016** **THEME PAPER**
10.30–11.00 h. **Ongoing study with preliminary results**

Over-screening for Cancer in patients with limited predicted life expectancy. A Cross Sectional Study

Bareket Ronen, Cohen Arnon, Comaneshter Doron, Schonmann Yochai, Vinker Shlomo
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Id 58

Background: The benefit of screening for colorectal and breast cancer becomes significant only after 10 years of screening. Still, only few Guidelines include limited estimated life expectancy as screening cessation criteria. Schonberg index was validated to estimate 5 and 9 years survival by questionnaire data. Clalit is the largest HMO in Israel with 4.2 million patients. It uses a quality indicators program to make sure eligible patients are being screened.
Research question: Calculate Schonberg score of predicted life expectancy using EHR data, evaluate the rates of cancer screening for patients with limited predicted life expectancy in Israel, and recognize drivers for overdiagnosis in this group.
Method: We used EHR data to estimate life expectancy by Schonberg Index for all adults aged 65 and older. A threshold of Schonberg score 10 was used (50% 9-year survival). We used EHR data to evaluate cancer screening during 2014 - annual FOBT, Colonoscopy in the past 10 years, Mammography in the past two years and PSA in the past year (not recommended in the guidelines).
Results: 355,260 community dwelling participants aged 65-79 included. At ages 65-74 rates of FOBT screening were 36% for high estimated life expectancy and 30% (9,151 screened) for limited life expectancy. Of the 180,547 women rates of Mammography at ages 65-74 were 70% for high estimated life expectancy and 53% (2,121 screened) for limited life expectancy. Of the 164,007 male patients ages 65-79 43% had a PSA test done in the last year, regardless of age group or estimated life expectancy.
Conclusions: We found over-use of screening tests for patients with limited life expectancy. Cancer screening inclusion criteria should include predicted life expectancy criteria in order to lessen the over-screening. Schonberg Index should be validated for use with EHR. Tool to calculate predicated life expectancy should be incorporated in the algorithm in Cancer screening programs and for clinical use.

Points for discussion:
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PRESENTATION 3: **Sunday 22nd May, 2016** **THEME PAPER**
11.30–12.00 h.

Overtreatment of multimorbid patients in primary care: development and feasibility of an intervention to reduce potentially inappropriate prescribing

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Id 35

Background: Although the majority of patients with chronic disease have multimorbidity, medical guidelines are structured around single diseases. This can lead to over-treatment.
Research questionCan we develop and test the feasibility of an intervention to support patient-centred prescribing in the context of multimorbidity in primary care?
Methods: The existing evidence on general practitioners' (GPs') perceptions of the management of multimorbidity was systematically reviewed. A purposive qualitative interview study was conducted with 20 GPs. The Behaviour Change Wheel, a novel method from behavioural science to develop interventions, was used to integrate behavioural theory with the findings of the systematic review and qualitative study to develop our intervention. A feasibility study of the intervention was conducted with 20 GPs from ten primary care centres.
Results: The systematic review revealed difficulties for GPs in four areas: disorganization and fragmentation of health care; inadequacy of guidelines and medical evidence; challenges delivering patient-centred care; and barriers to shared decision-making. The qualitative interviews showed that GPs responded to these difficulties by 'satisficing': accepting care that they deemed satisfactory for a particular patient. In multimorbid patients perceived as stable, GPs preferred to 'maintain the status quo' than actively change medications. These findings informed the development of a structured peer-support intervention which encouraged GP collaborative reviews of patients, called the MultimorbiditY COllaborative Medication Review And DEcision Making (MY COMRADE) intervention. In the feasibility study, GPs reported that the intervention was appropriate for the context of primary care; was widely applicable to their patients with multimorbidity; and that recommendations for optimising medications arose from all collaborative reviews.
Conclusion: This work responds to the call for interventions to improve patient-centred prescribing in multimorbidity. Applying theory to empirical data has led to an intervention that fits well into clinical practice, and has the potential to positively change GPs' behaviour.

Points for discussion:
-How can this intervention be sustained and scaled up without financial incentivisation?
-What outcomes are most appropriate to measure a change in patient-centred care as a result of this intervention?
-Are there barriers/opportunities which may exist in

PRESENTATION 4: **Sunday 22nd May, 2016** **THEME PAPER**
12.00–12.30 h.

Overuse of coronary procedures in stable coronary disease: A long-term retrospective study of patient careers

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Id 74

Background: Studies addressed the appropriateness of recurrent coronary angiographies for stable artery disease (CAD). An overuse with discrepancies between guideline recommendations and clinical practice is documented in Germany and other regions.
Research question: Little is known about individual patients' histories ("patient careers") in interventional cardiology, the associated radiation exposure, and which patient factors predispose to a potential overuse.
Methods: We analyzed all patients with CAD in a general medicine teaching practice who underwent at least one angiography with or without intervention (PTCA/stenting) between 2004 and 2009. All angiographies ever performed in these patients were analyzed: 3 physicians rated the appropriateness according to guidelines. Typical exposure data from the medical literature were used to estimate individual radiation exposures. Factors which predispose to ≥ 1 intervention with low appropriateness rating were calculated in a regression model.
Results: In the cohort of 147 patients, a total of 441 procedures were analyzed: between 1981 and 2009, 3 procedures were performed per patient on average (range 1-19). Appropriateness ratings were 'high/intermediate' in 71%, 'low/no' in 27.6% and data were insufficient for ratings in 1.4%. Procedures with 'low/no' ratings were associated with potentially avoidable exposures of up to 186 mSv for single patients. There was an inverse relationship between the number of procedures per patient and the appropriateness ratings: in individuals with ten or more procedures the average fraction of procedures with a low appropriateness rating rose up to 72 %. The multivariate logistic regression showed that a history of coronary bypass surgery (OR=2.94, p=0.049) and having the first procedure in a tertiary cardiac center (OR=5.13, p=0.01) were significant predictors for one or more procedures with low appropriateness ratings.
Conclusions: Using retrospective data, we exemplify the potential benefit of guideline adherence to decrease overuse and reduce patients' risks.

Points for discussion:
-Geographical variations in the use of coronary interventions across Europe
-Patient and health care systems factors which predispose to recurrent risky procedures
-Role of primary care in the prevention of unnecessary interventional procedures

PRESENTATION 5: **Sunday 22nd May, 2016** **THEME PAPER**
12.30–13.00 h.

Risk Factors and Predictors for Chronic Use and Abuse of Hypnotic Medication. A 10 year retrospective cohort study of 190,000 patients.

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Id 15

Background: Insomnia is highly prevalent. Long term use of hypnotic medications is very common, although not recommended. Newer benzodiazepine receptor agonists (BzRA's, or Z-drugs) are claimed to be safer for long term use and are heavily marketed.
Research questions: To quantify the risk for chronic use and abuse of hypnotics in primary care and to find weather the use BzRA's is associated with different outcomes.
Methods: We used the computerized database of Clalit Health Services(CHS), Israel's largest health care provider. A cohort of 190,044 adult first time users of hypnotic medications between 2000-2005 were identified and followed for 10 years. Patients with major psychiatric morbidity or other medical indications for chronic benzodiazepine use were excluded. Demographic data, type of hypnotic used and redemption of prescriptions were assessed in a multivariate model.
Results: Average age was 63.5 years. 70.0% of first time hypnotic use was with Brotizolam, and 22.5% was with BzRA's. 4.1% used at least one daily defined dose(DDD) a day on the 10th year, while 0.21% used more than two DDD's a day. A composite of concurrent use of more than two hypnotics, constant dose escalation or use of more than 2 DDD's a day was achieved in 1.0% after 10 years.Risk factors for daily use were prior use of antidepressants (RR=1.34,CI=1.12-1.42), opioid use (RR=1.20,CI=1.15-1.26), higher socioeconomic status (RR=1.19,CI=1.13-1.16), and age over 65 (RR=2.34,CI=2.23-2.45). On multivariate analysis, first use of a BzRA was associated with higher risk of daily use on the 10th year compared with benzodiazepines (RR=1.30,CI=1.2-1.5), while initial Brotizolam use was protective (RR=0.79,CI=0.68-0.92).
Conclusions: Risk of chronic use and misuse of hypnotic medications is not negligible, although its scope varies with different definitions applied. Use of BzRA's was not associated with a reduced risk of long term use and misuse after 10 years.

Points for discussion:
-Should reducing hypnotic medication use be a priority for primary care clinicians?
-What should be the first line pharmacologic agent used for treatment of chronic insomnia?
-Is overuse of hypnotic medications driven by marketing of newer Z-drugs?

PRESENTATION 6: **Sunday 22nd May, 2016** **FREESTANDING PAPER**
11.30–12.00 h.

Sepsis aftercare in General Practice

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Id 75
Background: Sepsis survivors often suffer over years from considerable mental and physical complications. This requires substantial aftercare needs following ICU and hospital discharge, mostly provided in General Practice.
Research question: Our study's aim was to evaluate the effectiveness of a primary care-based case management program to reduce sepsis sequelae.
Methods: The Smooth-study is a randomized, multicenter controlled trial [ISRCTN: 61744782]. Recruited sepsis survivors were randomized to usual care or an intervention which comprised: 1) discharge management (structured information between inpatient and outpatient care); 2) training of General Practitioners (GP) and patients on evidence-based care options for sepsis sequelae; and 3) systematic telephone monitoring of symptoms with feedback for the GP by a case manager. Our primary outcome was the health-related quality of life (HrQoL) as assessed with the Short form (36) Health Survey (SF-36) at 6 months after ICU discharge. Secondary outcomes included several mental, functional and process of care outcomes at 6, 12 and 24 months post-ICU.
Results: We recruited 290 patients from 20 ICUs. 220 (75.9%) completed 6 month, 204 (70.3%) 12 month and 185 (63.8%) 24 month follow-up. At baseline, there were no significant differences between randomization groups. At 6 month, we found significant improvements in musculoskeletal function (XSFMA) and Activities of Daily Living (ADL) which tend to sustain at 12 month.
Conclusions: To our knowledge, this is the first large scale, primary care-based interventional trial targeting reduction in post-sepsis sequelae. The intervention improved functional parameters which are of high relevance for daily life. Our findings may be attributable to improved GP awareness and increased patient activation facilitated by case manager monitoring and support.

Points for discussion:
-Relevance of process of care data in General Practice
-Analysis strategies for monitoring data, monthly collected
-Observational research questions

PRESENTATION 7: **Sunday 22nd May, 2016** **FREESTANDING PAPER**
12.00–12.30 h.

Chronic depression care in general practice

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Id 46

Background: Patients with chronic depression are mainly treated in primary care. They represent a clinically relevant group with extensive (co)morbidity, high functional impairment and associated costs. Yet evidence of treatment recommendations for chronically depressed patients with persisting symptoms for ≥ 2 years is limited and little is known about real-life management of these patients.
Research question: The main objective of this study was to examine how GPs manage patients with chronic depression and how patient-related factors influence treatment decisions.
Method: 1000 randomly chosen German GPs were asked to complete a newly designed questionnaire. A cross-sectional study was performed through descriptive analysis.
Results: 220 (22%) GPs participated. 93% stated that they distinguish between treatment of patients with chronic depression and treatment of patients with first onset major depressive episode. 92% would recommend psychotherapeutic co-treatment to their chronically depressed patients. More heterogeneity could be observed when the therapeutic consequences of patient-related factors were inquired. Most GPs favor a restraint on antidepressants (ADs) (52%) in older patients (≥ 75 years) with chronic depression whereas nearly 40% argue for long-term pharmacotherapy. The presence of severe physical comorbidity prompts GPs to either hold back on ADs (65%) or to urgently refer to specialists (40%). Two thirds of GPs see the need for combination therapy in case of a coexisting anxiety disorder. A comorbid substance abuse leads GPs to an urgent referral (84%). Selection-bias and a non-validated questionnaire may limit the results.
Conclusions: Participating GPs present high awareness towards chronic depression. They report safe diagnosis and high-quality care. Patient-related factors as advanced age, severe physical comorbidity and mental comorbidity play a decisive role in their treatment decisions. Our findings may support further research on improved and individualized treatment strategies for chronic depression.

Points for discussion:
-Is it necessary to differentiate between patients with chronic depression and patients with first onset major depressive episode?
-How should comorbidity be approached in patients with chronic depression?
-What is the GP's role in the management

PRESENTATION 8: **Sunday 22nd May, 2016** **FREESTANDING PAPER**
12.30–13.00 h. **Ongoing study with preliminary results**

Variability of the I-PSS questionnaire in an adult male population from Romania

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Id 70

Background: Benign Prostatic Hyperplasia (BPH) is a common cause of Lower Urinary Tract Symptoms (LUTS) in older male patients. The International Prostate Symptom Score (I-PSS) questionnaire is commonly used to measure the severity of LUTS (items 1-7) and the patient's perception about the disease (item 8).
Research question: To evaluate the variability and the impact on medical treatment of the I-PSS questionnaire and of its components in an adult male population in Romania. A secondary objective was to identify any overreferrals to urology specialists.
Method: The study population comprised 1242 patients without prostate cancer who completed the I-PSS questionnaire during a routine visit to one of the 87 GPs participating in this study. BPH was present in 328 patients (26%). Patients with BPH were significantly older (mean age 66.7 vs 61.4 years, $p<0.001$) and had more often hypertension (85% vs 75%, $p=0.0003$) and cystitis (19% vs 7%, $p<0.001$). Diabetes and depression were similar between both groups (15% and 5%).
Results: Only 11% of patients reported severe symptoms (score 20-35 points), while 35% reported moderate or mild (54%) symptoms. The symptoms were more severe in BPH patients (mean 11.8 vs 7.8; $p<0.001$), 63% of patients reporting moderate or severe symptoms vs 39% in the BPH negative group ($p<0.001$). Only 53% of patients with BPH received treatment with a drug belonging to ATC class G04C. The proportion was similar between patients with mild, moderate or severe symptoms (p=NS). Only 34% of patients with BPH had a referral to a urologist in the past 12 month and this proportion was independent of the severity of symptoms.
Conclusions: Most patients with BPH had moderate or severe symptoms as measured by I-PSS, although we did not identify any overreferrals in the previous 12 month. Follow up of the BPH negative population may yield further insight.

Points for discussion:
-optimal research methodology

PRESENTATION 09: Sunday 22nd May, 2016 14.00–14.30 h. **THEME PAPER**

Who chooses laboratory tests? The physician or the computer?

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Id 9

Background: Computerized health records can both help and harm the quality of health care. In the Leumit Health Services HMO physicians have several ways to choose lab tests. Gamma glutamyl transferase (GGT) appears in the "liver tests" and also in the "general chemistry",and also via the search feature. The use of GGT as a screening test for liver function is controversial. Its main utility is in cases where alkaline phosphatase is elevated.
Research question: In April 2014 a decision was made to remove GGT from the main lab screen (so that it could only be sent if searched for specifically) and two months later it was returned, at first completely, and then partially. We hypothesized that the convenience of ticking off GGT on the main screen would lead to larger numbers of physicians ordering the test as compared to having to search specifically for the test.
Method: Leumit has a central laboratory which serves the entire country. We were able to compare the numbers of GGT tests ordered during different periods of time during which the parameters were changed on the main lab screen.
Results: There was a dramatic decrease in orders when GGT could only be ordered by the search function - from 36,000 to 1000 per month. When GGT was added back to one place on the main screen the numbers jumped to 18,000 and back to over 35,000 when GGT returned to both places.
Conclusions: A slight decrease in the convenience of ordering a laboratory test which is not indicated for routine screening led to a dramatic decrease in the number of tests sent. This is a subject which needs to be studied further. Convenience is a positive thing when it saves precious time but if it leads to over-testing we shall not have gained much.

Points for discussion:

-Does saving time take precedence over unnecessary testing?
-Is autonomy (in deciding which tests to order) negated by being given to choose from a limited number of recommended tests in various medical situations? Or are we actually making the jo

PRESENTATION 10: Sunday 22nd May, 2016 THEME PAPER
14.30–15.00 h. Ongoing study with preliminary results

Overmedicalization : a qualitative study to explore GPs' point of view

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Id 21

Background: (Over) medicalization seems a growing phenomenon according to literature. It is partly due to societal reasons, among which the concomitant rise of consumerism, technical and biological breakthroughs, individualism, and a new definition of the concept of "health". General practitioners (GPs) address overmedicalization in a particular way which has been theorized as quaternary prevention. This requires the doctor and patient's ability to manage uncertainty.
Research question: To explore feelings and points of view of GPs about overmedicalization.
Method: In 2015, 3 focus groups were conducted with the same group of 9 French and Swiss general practitioners. Participants were invited to share their own experience and point of view about overmedicalization and were encouraged to give concrete examples from consultations. Grounded theory was used to code and analyze verbatim by 3 researchers. Partial analysis was done after each focus group in order to influence the next one with new hypothesis and to conduct individual interviews with some participants (theoretical saturation).
Results: GPs reported overmedicalization in almost all medical fields (overdiagnosis, overtreatment, non useful surgeries, end of life, pregnancy, social problems, etc.). They felt they needed first to define health and their role and limits as GPs. They thought they suffered OM instead of creating it, as it was mostly due to external factors from their consultation, as a product of our society. As GPs, they were looking for solutions at different levels : health system, practice management and individual level. During consultation, a good doctor-patient relationship seemed to be the key-stone to prevent OM.
Conclusions: GPs were very concerned about OM. They felt they suffered from it in various aspects, but they also were convinced they had a great role to play aside their patients to avoid such a hazard.

Points for discussion:
- These focus groups took place during an anthropological trip to India. We also explored what is the impact of anthropological approach on overmedicalization ?- We can discuss practical solutions given by participants to manage this question during con

PRESENTATION 11: Sunday 22nd May, 2016 15.00–15.30 h. **THEME PAPER**

Antibiotic prescription and hospital admission after screening with C-reactive protein in out-of-hours services in Norway

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Id 40

Background: In Norway 85 % of antibiotics are prescribed in primary care. Despite a decrease in serious infections, the use of antibiotics has been increasing until 2012. C-reactive protein (CRP) as a point-of-care test is frequently used in out-of-hours (OOH) services, aimed to differentiate between bacterial infections and not serious infections to keep the use of antibiotics low. Nevertheless, the use of antibiotics has increased since the test was introduced. Several studies have investigated the diagnostic value of laboratory tests for children with fever, but not in primary care with low prevalence of serious bacterial infections.
Research question: To evaluate the effect of pre-consultation CRP screening on antibiotic prescribing and hospital admission in primary care settings.
Method: Randomized controlled observational study.Inclusion: 401 children < 7 year, presenting fever to OOH-services. Randomizing: Every third child was randomized to a CRP test before the consultation, for the rest CRP taken at request.Data: Examination results and questionnaire to parents.
Results: In the group pretested with CRP the prescription rate was 26 %, compared with 22% in the control group. The admission to hospital was 5% in the group pretested compared with 9% in the control group, not significant results. A CRP test was ordered in 56% of consultations. Antibiotic prescription rate was highest with tonsillitis (68 %) and otitis media/pneumonia (67%). Main predictors for prescription of antibiotics were a high CRP value and earache. A high respiratory rate, low oxygen saturation and parent´s assessment of serious illness were significantly associated with referral to hospital.
Conclusions: CRP is extensively used, especially with high fever. Antibiotic prescription rates in Norway are relatively low compared with other countries, but higher than recommended. CRP screening will not reduce the prescription. Respiratory rate is the most important sign predicting hospital admission.

Points for discussion:
-The importance of CRP in the decision of treatment when the patient is a child with fever or respiratory symptoms
-Factors that can contribute to lower prescription of antibiotics in low-prevalent primary care settings

PRESENTATION 12: Sunday 22nd May, 2016 15.30–16.00 h. **THEME PAPER**

Increased contact frequencies in general practice for early malignancy detection? - avoiding over-diagnosis

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Id 3
Background: Increase in a patient's contacts to doctors usually raises concerns. It may be considered a 'red flag' for a patient's deterioration of health and trigger additional diagnostic activity.
Research question: Does increase of patient-physician contact frequencies indicate new malignancy in a patient's near future and thus call for specific diagnostic efforts?
Method: From 153 German general practices' electronic patient records (EPR), cases with at least one malignancy diagnosis and no-malignancy controls were matched for gender and age. We calculated (1) the number of contacts in the first quarter up to the sixth quarter before a malignancy was diagnosed for the first time, (2) the inter-contact interval (ICI), i.e. the time lag between two consecutive patient-physician contacts measured in days. Differences between cases and controls were investigated in several analyses of variance, with group and time as main factors.Effect size was estimated from multiple correlation R-squared and overall / partial non-linear correlation coefficient eta-squared.
Results: A total of 3,310 cases and 3,310 controls were included. Quarterly frequency for cases in the six quarters before malignancy diagnosis increased from 4.8 contacts (SD 4.3) to 5.5 contacts (SD 4.8). Frequency for controls increased only marginally from 4.3 contacts (SD 3.6) to 4.5 (SD 4.2). The factor 'group' (cases vs. controls) was highly significant in analyses of variance, also 'time' and the interaction 'group * time'. Effect size however was very small.
Conclusions: An increase in contact frequency is a call for GPs to become more attentive towards these patients. It may raise suspicion of an impending serious disease but the increase is not so dramatic and unique that it can be interpreted a reliable sign of impending malignancy diagnosis, without additional support from evidence. To avoid over-diagnosis, watchful waiting ('wait and see') seems to be appropriate.

Points for discussion:
-Secondary use of general practice routine data (EPR) for research in your country
-Which frequentistic, non-parametric or probabilistic methods are appropriate for big data statistical analysis?
- Standard operating procedures after increase in

PRESENTATION 13: Sunday 22nd May, 2016 14.00–14.30 h. **FREESTANDING PAPER**

Physicians' Attitudes Towards Death/Terminal Illness

Pemra C. Unalan, Halil Ibrahim Şimşek, Ege Akcasu, Rabia Hamamci, Ahmet Serdar Durgut
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Id 81

Background: Healthcare workers have communication problems with patients and their families while dealing with terminal illnesses and death.
Research question: How do physicians cope with talking with the patients and families about death/terminal illness?
Method: Deep interviews are made with 25 physicians from different gender, age, experience, specialty and hospitals. A semi-structured form with a series of questions and two case stories were used to get perspectives and attitudes of them towards death and patients with terminal illnesses. All the interviews with a 12,5 minutes mean duration are recorded. All of the transcripts are prepared by the same interviewer and coded by at least 2 different researchers independently. After a discussion a co-decision was reached. All of the researchers and an expert completed the theme analysis.
Results: Emerged themes; 1.Acuteness/chronicity of the serious illness set off the physician's attitude while giving bad news. 2.The physician's emotions are influenced by the patient/families' emotions. 3.The facilitators. 4.Self assessment of the physician after losing a patient. 5.Physician's self-perspective to death/terminal diseases and influencing factors. 6.Physician's approach to a patient with contagious disease. It is explained that the physician's attitude is different towards patient with acute or chronic conditions and it is mainly affected by the emotions and age of the patients and family members. It is determined that the facilitators have a great variety but a specific education need about this topic was a common point. Some of the participants stated that they think to change their specialty and worried for themselves when they are dealing with a contagious disease.
Conclusions: The physicians explain the lack of "how to talk about sensitive topics education" and their anxiety about giving bad news only fades away as they are experienced and imitate the more experienced ones to find their own style.

Points for discussion:
-Is it possible to collect the data of that kind of study by simulated patients?
-Any limitation of the study?

PRESENTATION 14: Sunday 22nd May, 2016 14.30–15.00 h. **FREESTANDING PAPER**

Dizziness and vertigo in primary care: results of a systematic review and implications for appropriate diagnostic strategies

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Id 8

Background: Dizziness and vertigo are common reasons for consulting a general practitioner and there is a broad range of possible underlying aetiologies. There are few evidence based data in regard to prevalence, aetiology and prognosis in primary care. Thus, there is considerable uncertainty about appropriate diagnostic strategies with danger of over- as well as underdiagnosis.

Research question: We aimed to conduct a systematic review of symptom-evaluating studies on prevalence, aetiology or prognosis of dizziness and vertigo in primary care in order to get basic informations for recommending diagnostic pathways.

Method: We systematically searched MEDLINE and EMBASE. Two independent researchers screened titles and abstracts according to predefined criteria. We included all studies evaluating the symptoms 'dizziness' or 'vertigo' as a reason for consultation in primary care. We extracted data about study population and methodology as well as prevalence, aetiology and prognosis. Two raters independently juged study quality and risk of bias. The data were aggregated and presented in a random effects model. We discussed them according to their impact on appropriate diagnostic strategies.

Results: We identified 32 studies (22 on prevalence, 14 on aetiology and 9 on prognosis). Consultation prevalence differed between 1,0 to 15,5%. The most common aetiologies are vestibular/peripheral (5,4-42,1%), benign peripheral positional vertigo (4,3-39,5%), vestibular neuritis (0,6-24,0%), Menière's disease (1,4-2,7%), cardiovascular disease (3,8-56,8%), neurological disease (1,4-11,4%), psychogenic (1,8-21,6%), no clear diagnosis (0,0-80,2%).These findings differ considerably from prevalences in secondary or tertiary care. Studies of good quality showed less variance in the probabilities. They also gave different results according to age groups, with cardiovascular diseases being the most prevalent cause in elderly patients.

Conclusions: There is a broad variety of possible underlying diseases for the symptom dizziness/vertigo. There exist only few methodologically sound studies about the aetiology and prognosis. So there is no good evidence base for diagnostic recommendations.

Points for discussion:

-What recommendations for appropriate diagnostic strategies can be drawn from these results?
-How can we prevent over- and underdiagnosis in this topic?
-How should diagnostic studies on this topic be designed?

PRESENTATION 15: Sunday 22nd May, 2016 15.00–15.30 h. **FREESTANDING PAPER**

Struggling with an illness in narratives of patients presenting Medically Unexplained Symptoms (MUS): A study from Poland.

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Id 55

Background: Patients who suffer from Medically Unexplained Symptoms (MUS) belong to the most difficult group of sick people in primary care. Multiple symptoms have no abnormal proof in organic changes. Patients with MUS account for up to 30% of primary care consultations and up to 50% of secondary care outpatient appointments. For primary care doctors, maintaining a good doctor-patient relationship with these patients and not overlooking a serious organic disease poses a real challenge.
Research question: What is the content and the structure of illness narratives told by MUS patients?
Method: 20 semi-structured interviews were conducted with patients presenting Medically Unexplained Symptoms. The narratives' content and the narratives' structure were explored by referring to a typology of illness narratives proposed by Arthur Frank as well as elements of Conversation Analysis.
Results: There were four major themes: patients' description of the symptoms, patients' explanations, patients' coping and expectations regarding healthcare. MUS patients' stories may display elements of either chaos narratives and be disempowering or restitution narratives. In terms of conversational structure, the patients' descriptions of their condition exhibit characteristics of dispreferential organization.
Conclusions: Exploring MUS patients' narratives may make it easier for GPs to communicate more effectively with these patients, address their psychological needs and concerns and establish diagnosis more quickly. This, in turn, will provide a better quality of care to patients, and may have a significant impact on the economic functioning of primary care.

Points for discussion:
-What is the role of illness narratives in doctor-patient interaction?
-Do narratives of illness experience told by MUS patients reflect the patients' management of symptoms?

PRESENTATION 16: Sunday 22nd May, 2016 FREESTANDING PAPER
15.30–16.00 h. Ongoing study with preliminary results

The effect of system factors on European GPs' decision-making when patients may have cancer: an 18-country Örenäs Research Group survey.

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Id 49

Background: The Örenäs Research Group, a pan-European primary care research collaborative comprising mainly EGPRN members, investigates the factors influencing speed of cancer diagnosis in primary care.There is wide variation in 1-year cancer survival rates across Europe. However, there has been little research to explain how national system factors affect GPs' referral decisions, or how system differences correlate with cancer survival rates.
Research questions: In patients with symptoms that could be due to cancer, what system factors influence GPs' decisions to refer for further investigation? How do these compare across different European countries, and how do they relate to cancer survival rates?
Method: The study design uses a survey with closed-ended questions. Örenäs Research Group members identified 45 system factors that may affect GP decision-making in patients who may have cancer. Pilots indicated that 20 of those factors vary significantly across European countries.The questionnaire has: - four clinical vignettes (patients with possible breast, lung, ovarian and colorectal cancer), each with a question asking for the GPs' most likely immediate investigation/referral actions (if any); - a list of the 20 system factors, with Likert scales for respondents to indicate how much each factor affected those referral decisions.Each participating country is translating the survey into its local language, with validation by back-translation.
Results: Twenty centres in 18 European countries have agreed to translate and validate the survey for this on-going study. Each will recruit at least 50 GPs to complete it. Survey hosting and data analysis are done centrally. Results will be evaluated quantitatively.
Conclusions: Preliminary results will be presented at the EGPRN conference. The results will help identify which system factors act as barriers to the early diagnosis of cancer, and will allow the production of recommendations on measures that countries can take to improve their survival rates.

Points for discussion:
-What are the key messages that we should take from the preliminary results?
-As a result of our findings, what recommendations should we make on how to improve the speed of cancer diagnosis in primary care?
-What should our next research project be?

PRESENTATION 17: Sunday 22nd May, 2016 WORKSHOP

16.30–17.30 h.

WORKSHOP 'Transitioning to family medicine – the challenges of developing and implementing effective family medicine in middle and low income countries with specific reference to the Occupied Palestinian Territories '

an FIDFMP* sponsored workshop at EGPRN, Tel Aviv/Jaffa, May 2016

Prof Paul Wallace[1], Dr Samar Musmar[2], Prof Ann Louise Kinmonth [3], Dr David Jewell[4], Dr Shameq Sayeed [5].
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**FIDFMP – Foundation for International Development of Family Medicine in Palestine*

Workshop aims: To encourage discussion and debate about challenges of achieving the transition to family medicine in low and middle income countries, with specific reference to the additional obstacles posed by military occupation of the Occupied Palestinian Territories in the West Bank.

Workshop structure: 20 minutes' presentations followed by 40 minutes discussion

Background: Family medicine is a crucial aspect of health care, providing horizontally integrated management of acute and chronic conditions, a platform for preventive health care and health promotion, and a managed gateway to specialist investigation and treatment. It has potential to play a major role in fulfilling the global priority of effective, equitable and accessible health care.

Low to middle income countries transitioning to family practice all face significant challenges, but colleagues in the Palestinian Occupied Territories have to deal with serious obstacles due to isolation, resource limitation and the other consequences of military occupation and conflict. As a result, family medicine has remained relatively under-developed, compared with the surrounding regions. Most primary care is currently provided by general doctors and specialists: internists, paediatricians and obstetrician-gynaecologists who have had no access to higher training in family medicine. The service is still largely based on vertical programmes with limited provision for continuity of patient care, problems with unreliable supplies of medication and poor communication with secondary care.

The first and major advance was the pioneering establishment of a four year specialist training programme for family medicine which was launched in 2010 at the University of An-Najah in Nablus. The first cohort of residents graduated from the course in December 2013. To date 16 residents have graduated and gone on to achieve Board Certification in Family Medicine. In

2013 a group of family medicine practitioners and academics from a number of countries joined forces with Palestinian colleagues at An Najah University to establish the Foundation for International Development of Family Medicine in Palestine (FIDFMP). Its aims are as follows:

- To improve morale and self-esteem by providing solidarity, relieving isolation and Inviting Palestinian doctors to show outsiders their successes
- To involve Palestinian doctors in the community of family physicians outside Palestine
- To share approaches and solutions to common problems - in a two-way process
- To improve health outcomes in the long term

These aims have been pursued largely through a cycle of educational programmes held in Nablus for FM residents and graduates (www.idfmp.org).

The University and the Ministry of Health are now at a cross roads in responding to the WHO and UN goals of universal primary care and in complying with WONCA guidance. The faculty in An Najah University is limited in size and lacks the capacity to recruit and train sufficient numbers of family medicine specialists for the future, let alone contribute to the transitional training and accreditation in family medicine of existing non specialist general doctors. The Palestinian Ministry of Health faces major challenges in managing the comprehensive transition to family practice; particularly in resourcing the necessary health service and public health integrative reforms.

Structure of the workshop: Three workshop leads will each make a 10 minute presentation describing:

1: the general challenges facing low and middle income countries transitioning from primary care to family medicine
2: the situation in the West Bank and the current state of primary care and family medicine
3: the An Najah University FM training program and the proposals for the development of a transitional FM training programme for non-specialist GPs.

The presentations will be followed by group discussion focussing on the general challenges posed by transition to family medicine in low and middle income countries with specific reference to the additional obstacles posed by the military occupation of the Occupied Palestinian Territories and how to overcome them.

Recommended reading: *WHO (2008). The World Health Report 2008: Primary Health Care, Now More Than Ever. Tracking universal health coverage: First global monitoring report. Joint WHO/World Bank Group report, June 2015*

PRESENTATION 18: Monday 23rd May, 2016 09.10–09.40 h. **FREESTANDING PAPER**

A RAND UCLA procedure to select the best reliable tool to assess Therapeutic Alliance within Europe. (Tool Assessment for Therapeutic Alliance STUDY).

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Id 24

Background: Inside communication skills, Therapeutic Alliance (TA) is a relevant research theme for Family Medicine. A systematic literature review identified six scales to measure TA in adults. The purpose of the present study was to find the most validated scale (according to reproducibility, reliability and ergonomics) using a RAND/UCLA Appropriateness Method (RAM) in Europe.

Research question: What is the best possible scale to assess therapeutic alliance in general practice?

Method: The six scales were the « Working Alliance Inventory » (WAI) and its short form « Short-Revised » (WAI-SR), the « Helping Alliance Questionnaire », the « California Psychotherapy Alliance Scale », the « Kim Alliance Scale », the « Vanderbilt Therapeutic Alliance Scale », and the « Therapeutic Bond Scale ». A local university expert panel was recruited to rate reproducibility and reliability extracted from additional references. The primary endpoint was reproducibility, and the secondary endpoints reliability and ergonomics.

Results: Fourteen European experts rated reproducibility and reliability during the first Delphi round. Analysis of median quotes by RAM classified appropriateness for each scale in three levels: « appropriate », « uncertain » and « inappropriate ». The WAI, WAI-SR and CALPAS had an appropriate reproducibility. Reliability was uncertain for every scale. Only the WAI-SR gathered an appropriate validity median without disagreement and more than 70% of ratings in the appropriate area. The second Delphi round obtained the expert consensus for the WAI-SR.

Conclusion: A consensus for the WAI-SR was achieved. It was the most appropriate scale, according to its reproducibility and reliability to measure TA in adults. It could turn into an efficient teaching tool to assess TA in medical training, and to raise students' awareness on communication. Further studies are needed to translate the WAI-SR in European language and to validate the translations' qualities in every country.

Points for discussion:

-would you like to participate to the translation and validation studies?

PRESENTATION 19: Monday 23rd May, 2016 09.40–10.10 h. **FREESTANDING PAPER**

EGPRN international work group on gut-feelings in general practice COGITA and its outcome

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Id 48

Background: “Niet pluis”, i.e. that a general practitioner (GP) feels a sense of alarm, was the until then neglected starting point ten years ago for Dutch and Belgian GP researchers, which were immediately joined by German, French, later Polish and other European colleagues. Since 2008 they coordinated and combined efforts as EGPRN international work group COGITA, now invited to report on their results of co-operative work.
Results: E-Mail surveys among EGPRN members, focus group research and structured interviews of GPs revealed that sense of alarm is a rather common phenomenon in general practice in Europe. In a Delphi procedure, educational and research experts of the Netherlands and Flanders found consensus on seven statements of two types of gut feelings, namely sense of alarm and sense of reassurance. These were confirmed by similar results from France. An international research agenda on gut feelings, continuous communication via social media, a well-maintained and up-to-date website (www.gutfeelings.eu) and a framework of annual EGPRN pre-conference meetings allowed for cooperative and step-by-step research of COGITA expert group members yielding numerous publications. Young European researchers were attracted over the years to join the group, and it connected to international researchers in neighboring fields, e.g. Clinical Decision Making. Results found their way into medical education.Recently, a Dutch questionnaire for research on gut feelings in daily practice was translated into English, French, German, and Polish after linguistic validation in a uniform procedure.
Conclusion: Within EGPRN framework, COGITA group members designed and discussed several coherent research projects, which were executed and replicated in regional sub-groups, then again re-combined and integrated into successive research in related fields. Gut feelings in general practice proved to be existent and of substantial importance for professional work, and as a concept added to comprehensive understanding of medical decision making in practice.

Points for discussion:

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PRESENTATION 20: Monday 23rd May, 2016 FREESTANDING PAPER
10.10–10.40 h. Ongoing study with preliminary results

Attitudes of young GPs towards research: perspectives of EGPRN/VDGM Research Workshop participants

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Background: A one-day workshop on Research in Primary Health Care was organised as a joint collaboration between EGPRN and VdGM during the VdGM preconference (Istanbul, October 2015). We aimed to provide young GPs and residents with the knowledge, skills and attitudes necessary to perform clinical research in a primary care setting. This gave an opportunity to assess the attitudes of the participants towards research.
Aims: To assess young GPs' experiences and perspectives regarding a) previous research training, b) publishing activity, and c) the importance of research training.
Method: A questionnaire was emailed to the 30 participants immediately before the research workshop. Google Forms ® was used for questionnaire design and dissemination. Descriptive statistics were used for analysis.
Results: Eighteen of the participants responded (60.0%). Participants had a mean age of 30 years and were from nine European countries (Belgium, Estonia, Finland, France, Germany, Ireland, Italy, Portugal and the United Kingdom); 55.6 % were General Practice / Family Medicine (GP/FM) residents, the remainder were young family doctors. Only 16.7% had received hands-on research training during their undergraduate studies, and only one mentioned having had hands-on research training during their FM/GP residency. However, 22.2% of the participants had authored papers in the field of primary care. All participants considered that research skills are a core family doctor competence, highlighting its relevance for personal development (77.8%), clinical decision-making (77.8%), critical appraisal skills (61.1%) and personal curricular improvement (50.0%).
Conclusions: While course participants believed that GPs/FMs should posess research skills, few had received research training at any stage of their training. There is a need establish whether this is typical across Europe. Identifying the existing levels of research training for GPs/FMs is a crucial step in identifying opportunities for improvement.

Points for discussion:
-Are these findings typical of EGPRN delegates' experiences?
-Where are the gaps and opportunities for improvement?
-How can we best establish the need for research training for GPs/FMs in EGPRN member countries?

PRESENTATION 21: Monday 23rd May, 2016
09.10–09.40 h. SPECIAL METHODOLOGY WORKSHOP
Ongoing study with preliminary results

Unawareness of diabetic neuropathy: monofilament testing as screening tool in general practice

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Id 51

Background: General practitioners have more and more elderly patients with long lasting diabetes. Diabetic neuropathy is among most frequent and severe complications in such patients. Although lot has been made for screening and prevention, diabetic neuropathy is still frequently undiagnosed in primary care.
Research question: Are general practitioners able early to detect and reduce number of undiagnosed diabetic neuropathy and thus - progression to diabetic foot by monofilament testing of diabetic patients feet.
Method: Target groups in our research are general practitioners, endocrinologists and diabetic patients. On the basis of literature search we chose combination of questionnaire and monofilament testing of diabetic patient feet as a tool for detecting diabetic neuropathy. Clinical part is planned for primary setting outpatients. 10g monofilament is chosen and 10 points at each foot are planned to be tested. Education for performing the test is planned for participating doctors.
Results: Questionnaires are designed both for doctors and patients and include several questions sections: passport data; diabetes and its complications; usually used methods for screening and diagnosis of diabetic neuropathy; monofilament testing itself as a screening tool. The three questionnaires, devoted for the three target groups are designed and structured the same way in order to be easily comparable and analyzed statistically. The questionnaires are spread in a pilot doctors and patients groups. Results, represented here, are preliminary and are part of an ongoing PhD study on long term care for diabetic patients in general practice.
Conclusions: Combination of especially designed questionnaires, and monofilament testing is easy to perform and analyze, does not cost much and is sensitive enough. It could be used as reliable screening tool for diabetic neuropathy in primary care and has not been performed in Bulgaria till now. Bulgarian GPs should be trained and encouraged to use the method in every diabetic patient.

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

PRESENTATION 22: Monday 23rd May, 2016
09.40–10.10 h. SPECIAL METHODOLOGY WORKSHOP

The influence of clinical expertise on drug prescribing for dementia. A longitudinal French study.

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Id 17

Background: Clinical expertise and current best evidence are both essential to deliver optimal patient care. In dementia, the effectiveness of pharmacological treatment remains controversial. Recent guidelines in the US and in Europe are going in the same direction, giving clinicians the choice whether to treat or not their patients.
Research question: The aim of the study was to evaluate the influence of clinical expertise on treatments prescribed for patients with dementia and to quantify the impact of the evolution of prescription rates on health care expenditures.
Method: A longitudinal study using data from the French national-health insurance database was performed between 2006 and 2014. The study population included patients over 65 years old, without exclusion criteria. Rates of drugs prescribing were calculated for each year and the policy's impact was tested using adjusted segmented regression analysis. The evolution of prescription rates was simulated, with and without prescribers' behavior change and costs were calculated.
Results: During the 2006 - 2014 period, 119,731 individuals were followed. Among them, 5514 were treated for dementia. The annual rates of drug prescribing increased significantly between 2006 and 2010 (from 2.23% (95%CI: 2.13-2.34%) to 2.73% (95%CI: 2.62-2.84%), $p < 0.0001$) and decreased from 2011 to 2014 (from 2.64% (95%CI: 2.54-2.75%) to 1.92% (95%CI: 1.84-2.01%), $p < 0.01$). The total savings associated with prescribers' behavior change was estimated at almost €110 million.
Conclusions: This study is the first study assessing the clinical expertise through the evolution of doctors' prescriptions. Clinicians seem to doubt about the effectiveness of treatments for dementia with a decrease of prescriptions since 2010. For the coming years, studies should be conducted on patients' values, the third cardinal point of evidence-based medicine.

Points for discussion:
-The decrease of prescriptions began a year before the French recommendation let the decision to treat to the discretion of clinicians
-The impact of clinical expertise could be underestimated because the patient's values are not considered

PRESENTATION 23: Monday 23rd May, 2016
10.10–10.40 h. SPECIAL METHODOLOGY WORKSHOP
Ongoing study with preliminary results

Overweight/obesity correlates with increased LDL-cholesterol levels in 20-45 years old patients

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Id 37

Background: Excessive weight (overweight/obesity), together with dyslipidemia is considered one of the risk factors for developing cardiovascular disease (CVD), hypertension and diabetes. In Romania, obesity is a very common disease, and it occurs frequently in young persons, below the age of 40. These patients usually have a sedentary life style, including the working hours (over 8 hours per day), an unhealthy diet, and most of them are smokers.
Research question: To establish if there is a correlation between overweight/obesity and increased LDL-cholesterol levels in 20-45 years old patients?
Method: We measured every 4th patient aged above 10 years, between October and December 2015, and we determined: height, weight, body mass index (BMI), waist circumference and hip circumference. Other parameters we recorded were: blood pressure (BP) values, personal and family medical history, smoker status, physical activity, diet, medication, and some blood tests like fasting blood glucose, total cholesterol, LDLc, HDLc, triglycerides and uric acid.
Results: Our study group comprised 218 patients, 69 of them having the age between 20 and 45 years. We found that excessive weight, defined by a BMI >25 kg/m2was present in71.1% of the cases, 33.3%of the included patients being obese (BMI >30kg/m2).Mean BMI in our study group was 28.26±6.3kg/m2. Only 28.9% of the patients have a normal weight.
Conclusions: As our data show, excessive weight is a critical fact in young people and it seem to be a positive relationship between overweight/obesity and an increased level of LDLc, meaning a higher cardiovascular risk, even in patients at young ages (20-45 years).It is useful to measure LDLc in overweight/obesity young patients, in order to evaluate their cardiovascular risk and to decide the optimal management plan.

Points for discussion:
-The benefits of therapy in this patients
-If long term statin therapy must be considered

PRESENTATION 24: Monday 23rd May, 2016 11.10–11.40 h. **FREESTANDING PAPER**

Insulin pump therapy - high rate of non-adherence may indicate overuse: a population-based case-cohort study.

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Id 26

Background: In recent years an increasing numbers of diabetic patients in Israel have been placed on Continuous Subcutaneous Insulin Infusion (CSII) pump therapy. This expensive device provides basal level insulin to the body with additional boluses at meal times. Patients, who meet the ministry of health criteria, receive the pump and related equipment free of charge. Despite the increased use of CSII pumps, there is uncertainty about patients' adherence to pumps in real life.
Research question: To evaluate clinical, demographic and socioeconomic factors which are associated with non-adherence to CSII pump therapy among type 1 and type 2 adult diabetics.
Method: We conducted a case-cohort study in an Israeli HMO. All patients above 20 years old, with type 1 or type 2 diabetes, who received CSII pump 2007-2013, were identified (N=707). Patients who didn't purchased supplies for pump maintenance more than 180 days, were defined as non-adhered (N=355). Patients who purchased the supplies were defined as adhered (N=352).
Results: Diabetics adhered to CSII treatment as compared to non-adhered were younger, mean age 48.6 y.o. (95% CI 46.8; 50.3) vs. 52.2(95% CI 50.6; 53.8); predominantly with Type 1 diabetes 72.4% vs. 45.9%; predominantly Jews 79.3% vs. 62.5% and had better glycemic control, mean HgbA1c level 8.6 (95% CI 8.5-8.7) vs. 9.2(95% CI 9.0-9.4). Non-adherence to CSII treatment was positively associated with having diabetes duration longer than 5 years (HR=12.07, 95% CI 8.34-17.47), having poor glycemic control before starting CSII treatment (HR=3.94, 95% CI 2.85-5.45), being non-adherent to nutrition therapy (HR=4.79, 95% CI 3.41-6.74), being smoker (HR=1.65, 95% CI 1.10- 2.48) and being obese (HR=1.41, 95% CI 1.03-1.91).
Conclusions: Only 50% of patients who received CSII pump were adhered to treatment. To prevent over prescription and overuse, we suggest assessing patients' adherence, in a selection of appropriate candidates for pump treatment.

Points for discussion:
Insulin pump, overuse, non-adherence

PRESENTATION 25: Monday 23rd May, 2016 FREESTANDING PAPER
11.40–12.10 h.

The influence of using asynchronous e-visit technology in primary care on chronic disease management

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Id 16

Purpose: Since 2012 patients belonging to MHS have had the opportunity to communicate with their family physicians via asynchronous online e-visit technology. These online visits are rapidly changing the nature of primary medical interface. Our purpose was to examine the influence of these changes on medical outcomes of chronic diseases.
Methods: This is a retrospective study based on the large database of MHS. Study population includes patients registered as having ischemic heart disease and/ or diabetes and/ or hypertension, and statin users. We compared between patients who requested prescriptions via asynchronous e-visits during the end of 2014 and those who did not. We tested adherence to drug treatment, and medical indices in the two groups during entire 2015. Adjustments were made by regression analysis.
Results: Among the 242,218 patients in the study population, 33,629 were using online e-visits to family physicians. The latter group consists of more men than women, has a higher SES level, while age and co-morbidity are similar.
We found significant improved adherence for the purchases of statins, oral anti-diabetic drugs, and anti-hypertensive drugs in the 'virtual visitors' group.
Additionally a slight but significant improvement in medical indices was exhibited among patients using e-visits ($p<0.001$). Average HbA1c was lower in diabetic patients (7.07 vs. 7.23%). Average LDL was lower in ischemic heart patients consuming statins (84.6 vs. 92 mg/dl), and average blood pressure was slightly lower in hypertensive patients (132.9 vs. 134.2 mmHg).
Conclusions: Medical e-visits did not appear to be detrimental and even seem to improve the management and clinical outcomes of chronic diseases.

Points for discussion:

PRESENTATION 26: Monday 23rd May, 2016 ONE SLIDE-FIVE MINUTES
11.10–11.20 h. Study proposal / Idea

How to appreciate the well-being of General Practitioners ?

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Id 19

Background: Overdiagnosis and overtreatment in family medicine and primary care are also generated by physician action. Consequently, they are linked to physician representations and values. From that point of view, quality of care and patient safety are also linked to physician wellbeing. In the same way, oversuse is the mirror image of underuse and bad use. Analysis and management of these problems must take into account the physician action as a part of healthcare system. And this action is correlated to physician involvement and his right place near the patient and in the community. Over-implication or implication in a wrong place can bring physician to burnout, medical error or illness.
Research question: How to appreciate the well-being of General Practitioners ?
Method: In the Family Practice Department of our French University, we conduct medical education and researchs about medical error, burnout and hidden curriculum. We use questionaries, qualitative research and analyse of narrative productions of our General Practitioners in training.
Results: We hope to develop researchs about these topics, and devices to help physicians in their work. Our « one slide-five minutes presentations » wants to invite universities to collaborate with us about these projects.
Conclusions: According to a recent review of literature, « physician wellness is a missing quality indicator » and « it could also be vital to the delivery of high-quality health care ». We believe, it is also a part of the hidden curriculum and can highlight the frontiers between professional and personal parts of the caregiver action.

Points for discussion:
-How to develop researchs about GP wellbeing?
-How to conduct medical education about GP wellbeing?
-How to make devices to help GPs in their daily work?

PRESENTATION 27: Monday 23rd May, 2016 ONE SLIDE-FIVE MINUTES
11.20–11.30 h. Study proposal / Idea

Overtreatment in upper respiratory tract infections â€“ Antibiotics Yes or No ?

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Id 50

Background: Antibiotic resistance is a public health issue all over the world. Primary care physicians, and not only, prescribe in our country a lot of antibiotics for conditions like upper respiratory tract infections (URTI) where there is no clear evidence of benefit. Greater emphasis on educational resources and non antibiotic symptomatic therapies is needed.
Research question: Is antibiotic treatment really necessary in URTI and does it significantly improve the patients' evolution when compared to symptomatic treatment alone?
Method: This is a randomized prospective study comprising 150 patients -all adults- diagnosed with URTI (acute tonsillitis, acute pharyngitis, acute sinusitis, acute nasopharyngitis, influenza, undifferentiated URTI). Patients are divided in two groups and they randomly receive antibiotic and non antibiotic treatment for their condition. The two groups are evaluated for the evolution and duration of their main symptoms - fever, fatigue, sore throat, disphagia, nasal obstruction and discharge, cough. Statistical analysis of the investigated parameters and a comparison between the two groups is performed.
Results: We expect to demonstrate the rate of over treatment with antibiotics in URTI.
Conclusions: Antibiotics continue to be used for URTI's in an inappropriate and excessive manner.

Points for discussion:
-Routinely cultures are of any use in establishing the treatment?
-Do young doctors need educational materials for rationally prescribing of antibiotics?

PRESENTATION 28: Monday 23rd May, 2016 ONE SLIDE-FIVE MINUTES
11.30–11.40 h. Study proposal / Idea

yield of video capsule examination

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Id 62

Background: Video capsule examination is used to detect sources of bleeding ing the GI tract which were not detected by other means, or IBD in the small intestine. It is a costly procedure and therefore requires prior authorization. The principal investigator is responsible for authorizing these tests. The question raises regarding the yield of these tests, i.e: what is the percentage of positive results. With the collaboration of the gastroenterology institute in Meir Medical Center and our family practice residents, we set to verify the yield of these tests.
Research question: What is the yield of video capsule examination.
Method: We will retrieve at random 500 video capsule tests authorized by the principal investigator. The gastroenterologists who participate in the study, in collaboration with the family practice residents, will review the original requests for the tests to verify retroactively whether the authorization complied with the instructions and will retrieve the test results to verify the yield, i.e: what percentage of the tests helped disclosure of any malformation or inflammation in the small intestin
Results: N/A
Conclusions: NA/

Points for discussion:
-what is the yield of video capsule examination

PRESENTATION 29: Monday 23rd May, 2016 ONE SLIDE-FIVE MINUTES
11.40–11.50 h. Study proposal / Idea

Age identity and perception of health in the elderly.

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Id 82

Background: The concept of age identity reveals subjective experience of aging of a person and is supposed to reflect the way one perceives and understands own aging precess. It has important consequences on health components, cognition and satisfaction of life. It is vital to reveal the socioeconomical factors that affect age identity especially in the elderly. The reason for that is factors that form the age identity will also play a big role in management in primary care of health with biopsychosocial aspect.
Research question: What are the socioeconomic factors that shape the age identity of an elderly person which has direct effect on health?
Method: The study which is in planning process will try to focus on socioeconomic factors that shape the age identity and on perceptions of health for a person using a questionaire, A sample of a population that reflects a whole society and that meets the inclusion criteria over 45 years of age will be identified and the study will be carried out in that group. The main focus will be on transitions of life, perception of age and of health in the elderly.
Results: Differences in age identity is thought to be formed by certain factors. These will try to be stated and listed.
Conclusions: The main goal and conclusion trying to be reached is to state the factors that affect the age identity in the elderly and its effect on health components will also be argued.

Points for discussion:
-Age identity, socioeconomic factors, health perception

PRESENTATION 30: Monday 23rd May, 2016 ONE SLIDE-FIVE MINUTES
11.50–12.00 h.

Effect of email alert about sulfonylurea medicine overtreatment of diabetes.

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Id 87

Background: Semi automated emailing to primary physicians about high HbA1c% or cholesterol levels is routine in our organization. However, the same method can be used to address overtreatment. Sulphonylurea (SU) overtreatment may cause hypoglycemia and harm, especially in elderly. Hence, as part of 2014 quality control effort of Clalit North district, 229 patients that are 75+ years old, who took SU and who also had low HbA1c% (6.5% or less) were detected thru the computer system. An alert to their physicians was sent via mail-merge on 23.1.14.
Research question: Would emailing alerts about low HbA1c% affect patient SU intake or mortality ?
Method: SU dispensing and death rates of the 229 patients was collected 4 months after sending the emails. Death rates were compared to previous year control group of 201 patients.
Results: SU dispensing was lower or stopped in 150 (66%) patients and was similar or higher in 79 (34%) patients (Two sided p-value < 0.001). Four patients died (1.8%), while control group had six deaths in four months (3%, Two sided p-value =0.53).
Conclusions: Email to primary physicians may favorably affect overtreatment and patient survival. Further and larger scale research is needed.

Points for discussion:
-Should we study the effect of large scale computer derived alerts on patients health by RCT?
-Is the case of SU different from other chronic medicines?

PRESENTATION 31: Monday 23rd May, 2016 SYMPOSIUM
12.10–13.00 h. Research in progress, without results

Actions to bridge the divide in European health research and innovation â€“ proposal to be involved in a European call for funding

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Id 77

"Actions to bridge the divide in European health research and innovation" is one of a recent call in Horizon 2020 (H2020), asking for projects that can help less performing countries to build capacities and exploit opportunities to eventually increase their participation in EU funded collaborative projects. A project needs partners from both countries with a good research profile and those who are newer in terms of research (also called "widening countries", previously identified by H2020). The proposals should plan concrete measures for tackling structural barriers to health research and innovation, including those related to capacity, skills, policy, regulatory environment, and economic and socio-cultural factors.
The Research Strategy Committee identified this call at an early stage as suitable for EGPRN's aims and work. It has been considered as an optimal opportunity for EGPRN members from both widening and not widening countries to work together in the common goal of improving research in GP/FM throughout Europe. The idea was therefore presented to EGPRN members at our last meeting in October 2015. Our presentation encountered great interest and enthusiasm, and 20 countries have already responded positively. Following this, we organized a brain-storming exercise, summarized results and organized them in provisionally defined work-packages according to the proposal's classification of managing barriers.
Aim: To further discuss and define work-packages and to identify members interested in taking the lead of the different work-packages.
Methods: We will shortly present the state of the application and distribute a summary of the first draft. All EGPRN members from widening and non-widening countries will at this stage be invited to propose the concrete task that they can assume.
Results: pending process, where EGPRN will be the network the project can be build on.

Points for discussion:
-What are participants' experiences in collaborative international research?
-global organization, and workpackages definition

PRESENTATION 32: Monday 23rd May, 2016 14.20–15.35 h. **POSTER**

Primum non nocere: a qualitative study

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Id 56

Background: Advancements in modern medicine, and increasing medical awareness of the general population through the internet and other media have substantially complicated the decision-making process. Even though a physician who acts evidence based has nothing to be afraid of, fear of missing diagnoses, legal repercussions, continuing anxiety from patients, external pressure, or simply a lack of time and energy for exhaustive explanations, can lead to overconsumption of medical resources, possibly with harmful effects towards the patient. But where do we draw the line? In this setting, a fourth type of prevention emerges. Quaternary prevention (QP), or protecting a patient when there is an illness without established disease. We believe that the general practicioner, as a key actor between different specialists and caregivers, plays a crucial part in protecting patients from overmedicalization.
Research question: We investigated what the Flemish general practitioners know about QP, whether they share our vision, too which degree they implement it in their daily practice, and which factors other than guidelines and scientific evidence guide theirdecision-making.
Method: To do so, we set up a qualitative research in which we interviewed twelve general practitioners from different regions. We chose the most relevant topics based on a brief literature study, and set up a questionnaire with 27 questions to guide these conversations, in order to discover as much information as possible to find an answer to these questions.The semi-structured interview were transcribed verbatim, and cluster analysis was performed.
Results: GPs although unfamiliar with the term, are actively envolved in QP and acknowledge their important role in this matter. Guidelines and and sensibilisation campaigns have reached them in different ways. Too often though, external factors make them deviate from evidence-based practicing, so there is still much room for improvement

Points for discussion:
-How can the awareness of GPs of their role in quaternary prevention be improved?

PRESENTATION 33: Monday 23rd May, 2016 POSTER
14.20–15.35 h.

Do diabetic patients aged 65 years or older receive too much medication?

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Id 65

Background: In Israel, the main use of quality indicators for chronic diseases in primary care is to identify patients who are not receiving the appropriate treatment. Since the publication of a number of articles in the past decade and, in particular ADVANCE and ACCORD, it has been suggested that too tight control of type 2 diabetes mellitus in patients aged 65 years or older may not improve the outcome and, in fact, may be more dangerous. Also, elderly people tend to suffer from co-morbidities and therefore are subject to poly-pharmacy which in itself, can lead to complications.
Research question: Despite the recent recommendations regarding appropriate treatment targets for HbA1C in elderly patients (between 7% and 8%), how many of them are still being "over-treated" and what are their medical characteristics?
Method: We examined the computerized medical files of the patients from a primary care clinic in Northern Israel who were aged 65 years or older, had a diagnosis of type 2 diabetes mellitus and HbA1C level less than 7%. We examined a number of parameters including length of disease, co-morbidities, and their medications.
Results: In May 2015, there were a total of 282 diabetic patients in the clinic of whom 139 (49%) were aged 65 years or older. Amongst those patients, 82 (59% of the elderly) had a HbA1C level less than 7% and 91% of these patients were receiving some form of anti-diabetic medication. 33% had a diagnosis of diabetes for more than 10 years, 20% were diagnosed with 7 or more chronic illnesses, and 21% were taking 10 or more different medications on a daily basis.
Conclusions: In light of the recent recommendations for the treatment of elderly diabetic patients, these findings may represent over-treatment, which in turn, contributes to poly-pharmacy.

Points for discussion:
-In accordance with the recently published guidelines for the treatment of elderly diabetic patients, should we be reducing or even stopping anti-diabetic medication in certain elderly patients if their HbA1C is less than 7%?
-By reducing or even st

PRESENTATION 34: Monday 23rd May, 2016 POSTER
14.20–15.35 h. Ongoing study with preliminary results

How to train caregivers for sick doctors? Preliminary report of a french training program.

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Id 5

Background: Burnout, addictions and suicide are widespread among french active or in training general practitioners (GPs). Despite their recent development, the few existing dedicated help devices are still largely under-used, insufficient, uncoordinated, and often driven by non-specifically trained professionals.
Research question: The university diploma « CARING FOR CAREGIVERS » was set up in 2015. First progress report and questions for development.
Method: The course was launched in 2015 by two French universities (Paris Diderot and Toulouse) and 2 networks for doctor's help (AAPML and MOTS). Sixteen participants already involved in professional assistance were admitted: 8 GPs, 3 occupational physicians, 3 gynecologists, 1 dermatologist, and 1 otorhinolaryngologist. The training consists of 4 sessions of 2 days: 1) the physician as a particular patient, 2) doctors mental illnesses, 3) medical error, 4) tools for help and a day for presentation of each participant individual report-and-project. In addition of providing data, training is based on interactivity and case discussion about situations involving participants as patients or as helpers with colleagues. Between each course, participants are asked to make a self-analysis of 1) their own health, 2) the organization of their own work, 3) the relationship to their patients.
Results: Preliminary results : research themes of personal memories, learning methods, participant satisfaction, prospects of monitoring after training,impact measures, implementation modalities of inter vision and supervision devices, needs to assume the likely upgrowth of this device.
Conclusions: It is the first French training device for caregivers of sick doctors. Accordingly to epidemiological data, it is called to sustain and expand notably broadening to non-physician health care providers, It can help to get more stronger and structured institutions involvement for the management of vulnerability and suffering of doctors. Finally, it can help improving physician wellness and reducing overdiagnosis and overtreatment.

Points for discussion:
-Sharing of experiences to help sick doctors among other countries
-How to predict and assume the likely upgrowth of this sort of devices
-How to encourage institutions to become more involved in supporting car

PRESENTATION 35: Monday 23rd May, 2016 POSTER
14.20–15.35 h. Ongoing study with preliminary results

"It's a bit like in hospital" - general practitioners' experiences and strategies to perform nursing home visits

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Id 67

Background: Increasing numbers of nursing home residents will challenge medical care in this setting, and augment the collaboration of nurses and general practitioners (GPs) who deliver medical care for nursing home residents in Germany, usually through home visits.
Research question: How do German GPs currently experience home visits in nursing homes.
Method: Open guideline-interviews about interprofessional collaboration and the process of the visit were conducted with 30 GPs in three study centers, digitally recorded and transcribed, and with Grounded Theory Methodology. GPs were recruited via postal request and existing networks of the research partners.
Results: Four different types of nursing home visits were found: visits on demand, periodical visits, nursing home rounds and ad-hoc-decision based visits. We identified the core category "productive performance" of home visits in nursing homes which stands for the balance of GPs' individual efforts and rewards. Routine visits were mostly considered as having in high productiveness in contrast to urgent visits whose high workload lead to an imbalance of "productive performance" GPs used different strategies to perform a productive home visit: preparative strategies as scheduling and planning, on-site strategies and planning- ahead strategies (education, documentation).They feel the need to actively influence the structure of the visit and strive to balance their effort and perceived outcomes.
Conclusions: Our theory and findings can inform research, professional training as well as practice and nursing home management. Additional results of the interprof study will add perspectives of residents, relatives and nurses to inspire constructive discussions on how to improve interprofessional collaboration and quality of care in nursing homes.

Points for discussion:
-Implications in an international context, possible collaborative study

PRESENTATION 36: Monday 23rd May, 2016 POSTER
14.20–15.35 h. Ongoing study with preliminary results

The Same Lady in a Different Outfit - Mistakes in Medication Utilization Due to Different Names of the Same Drug

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Id 86

Background: Many studies have dealt with errors in medication usage and offered various methods to cope with them. Common ones are caused by different drugs having nearly similar names, or by packages or pills having similar colors or shapes. On the other hand, similar generic drugs may be produced by various pharmaceutical companies and bear different commercial names. Simultaneous usage of the same medication with different names may occur and remain unrecognized by patients and even by medical teams.
Research question: What is the prevalence of this phenomenon in the community and what are its side effects, particularly among patients using polypharmacy? Who are the patients at risk and the "medications at risk"?
Method: In this cross sectional study conducted at Clalit Health Services, 200 patients, 67 years old or older, who take at least 6 different medications on a continuous basis, will be requested to bring all their packages along when coming for prescriptions renewal. They will be interviewed by their family physicians who will examine all the medications, ask for the posology and the indication for each. If similar drugs with different names are taken inappropriately, then further exploration will be conducted concerning possible side effects. All the details will be recorded anonymously and reported by the family physicians for analysis in a quantitative and a qualitative manner.The project has received local Helsinki Committee approval.
Results: Results may increase the awareness of medical teams and prompt health care providers and drug companies to modify medication packaging and labeling with the generic name of the medication in bold letters, rather than the commercial name.
Conclusions: -

Points for discussion:
-Should some regulation be imposed on drugs companies concerning this issue?
-Could a computarized system alert the pharmacist about some potential error due to similarity?

PRESENTATION 37: Monday 23rd May, 2016 POSTER
14.20–15.35 h.

Rural and urban differences in Family Doctors' workload during seasonal flu epidemics: management in the Italian family medicine setting.

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Id 53

Background: Influenza like Illness (ILI) and Acute Respiratory Infections(ARI) continue to be a considerable health problem in Europe. During the winter there is an increased workload for FDs due to the diffusion of influenza virus and respiratory tract diseases. Although there are a few studies on FDs' flu management, differences between urban and rural FD's workload has not yet been analyzed in the Italian family medicine setting.
Research question: Are there any differences in FD's workload during flu management in rural and urban areas in the Italian family medicine setting?
Method: Over a period of four months 8 FDs registered the number and type of encounters, patient's reason for encounters, procedures adopted, ILI and ARI diagnoses, drugs prescriptions and referrals to other health care providers. FDs recorded details of their patients using electronic patients records based on the International Classification of Primary Care (ICPC) Italian version.
Results: Patients with suggestive symptoms for ILI and ARI were 1,536 (average age 48.1±18.7). RfEs and EoCs were respectively 3,800 and 1,536. The number of interventions made by FDs was 2,929. The total number of patient-doctor encounters was 1,715. Surgery encounters were 36.4% in rural and 26.0% in urban areas respectively. Urban doctors were more likely to have home (25.4% vs 15.9%) and phone consultations (28.8.% vs 13.7%;). More procedures in the ICPC component 2 (68.8%) and 3 (60.6%) were adopted by rural doctors.
Conclusions: There are several differences in FDs' workload during flu syndromes' management in rural and urban Italian family medicine areas. Rural patients are mainly seen at FDs' surgeries and more diagnostic, preventive and therapeutic procedures are likely to be adopted by rural doctors. FDs' workload seems to be harder in rural than urban areas during flu season in the Italian family medicine setting.

Points for discussion:
-Differences in FD's workload in rural and urban practices.
-Which classification is used to collect these data in the other Countries?

PRESENTATION 38: Monday 23rd May, 2016 POSTER
14.20–15.35 h.

Mental illness in the population of obrenovac before and after floods

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Id 78

Background: Obrenovac is 16.05.14. flooded. All the events of the flood are inevitably influenced the lives of many citizens of Obrenovac, as well as on their health, especially mental health.
Research question: The main objective of the study was to show whether the events of the flood in Obrenovac affected the mental health of citizens, with the hypothesis that they are in terms of increasing the number of mental illnesses.
Method: The e-database in HC Obrenovac where the recorded diagnoses related to the mental health (F00-F99) of the population in Obrenovac with 72522 inhabitants, from 1.5 year before and 1.5 years after the flood. The obtained data were analyzed by descriptive and inferential statistics.
Results: Total number of mental disorders according to ICD10 (F00-F99) for 1.5 years before the flood was 5725, and 1.5 years after - 4719. It is 1006 patients less in the period after the flood, which was not expected. The difference was statistically significant (P<.0001) in terms of reduction of mental illness in the population of Obrenovac. It does not support the hypothesis. From neurotic stressful and somatoform disorders-F40-F48 1.5 years before the flooding suffered in 2794 patients and 1.5 years after in 2538. Affective disorders-F30-F39 is 1.5 years before the flood was in 1476, and 1.5 years after -1186. The difference was statistically significant (P<.0001) in terms of reduction of disorders: F40-F48, F30-F39, which does not confirm the hypothesis.
Conclusions: The study did not confirm the hypothesis that the events of the flood in Obrenovac impact on the increase in the number of mental disease in the population. On the contrary, a statistically significant reduction the number of mental disorders. This could be explained by the need to solve the existential problem of population, who were primary, as opposed to dealing with their own personalities.

Points for discussion:
-Why was there a reduction in the number of people with mental illness after the floods in Obrenovac?

PRESENTATION 39: Monday 23rd May, 2016 POSTER
14.20–15.35 h. Ongoing study with preliminary results

Evaluation of Responses to Persuasive communication regarding excessive Medical Examinations using an educational video campaign

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Id 36

By now, it has become clear it is not enough to convince physicians to reduce unnecessary medical tests. Patients, who for decades have had their expectations for a cure reinforced by overuse of unnecessary medical procedures, must jump on the change bandwagon. Previous studies reveal that the public arena is ripe for an open discussion. Patients are both willing to discuss the risks involved in medical testing and able to understand complex scientific principles used in the decision-making process.

As a first step towards such a dialogue, Clalit Health Services in Israel (CHS) has developed a 6 minute educational video aimed at instigating the conversation about unnecessary tests - before patients arrive at their physicians' appointments. We focused on a few guiding principles: Patients' responsibility for their own health; The necessity of open dialogue with the family physician; Distincting between screening tests and tests conducted in response to a symptom; Visualization of complex medical principles; while preventing a backlash of fearing necessary tests.

Using the video, we conducted 40 Semi structured interviews with healthy CHS patients ages 30-55. Most participants were glad to talk about the subject, and had good general understanding of the content. Some themes helped us understand the challenges such a campaign might face. These include general suspicion towards the health system, coping with uncertainty, having to talk about medical terms as morbidity and mortality without being regarded as using a scare tactic.

We think campaign managers and physicians taking part in communication with the patients regarding this subject, should be aware be aware of these challenges.

Points for discussion:

-

PRESENTATION 40: Monday 23rd May, 2016 POSTER
14.20–15.35 h.

Disagreements about patient care between parisian General Practitioners in training and their supervisors. Study of 37 situations.

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Id 6

Background: Many studies have explored workplace conflicts, showing the negative impact on satisfaction and performance of work team.members.
Research question: To clarify and analyze disagreements about patients care between general practitioners in training (GPTs) and their supervisors.
Method: Five focus groups were conducted, involving 25 GPTs, stating 37 disagreement situations with their supervisor about patient care, in hospital or ambulatory settings. Interviews were recorded, transcribed and analyzed using a qualitative method to highlight the main encountered problems.
Results: A few potential sources of conflicts have been identified. We highlighted 1) factors likely to turn disagreement into an irreconcilable conflict, 2) consequences of these disagreements about quality of care and 3) their impact on GPTs empowerment. Many disagreements related to sensitive issues of end of life or palliative hospital care. The impact of the hierarchical link between senior and GPT on genesis and development of conflict has been confirmed. Main conflict factors are : GPT's personality, his conception of responsibility, knowledge exchange and "commercial" stakes.
Conclusions: We have highlighted and analyzed difficult situations. We identified practical solutions to help disagreements playing a positive role in empowering GPT and strengthening their professional ethics. Management training of proven or potential conflict can usefully clarify and optimize students hidden curriculum towards professionalism. Finally, it can help improving physician wellness and reducing overdiagnosis and overtreatment.

Points for discussion:
-How to help GPTs to explain their disagreements
-How to help their supervisors to accept these explanations
-How to help both and their patients to give and get better care thanks to that

PRESENTATION 41: Monday 23rd May, 2016 POSTER
14.20–15.35 h. Ongoing study with preliminary results

HEFESTOS Study: first stages of a European collaborative research project

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Id 42

Background: To develop a collaborative project involving different countries in a context of low financial resources is already a real challenge, even more so a cohort study in a General Practice setting focusing on a common reason for consultation: decompensated heart failure. We have conducted a first preliminary study in Spain and are now preparing to start the international part.

Research question: What are the preliminary study results and how could be implemented the international HEFESTOS Study?

Method: Presentation of the study outline/design from 2013 and extended critical discussion.

Results: This is a two phase study aimed at developing and validating a predictive model to foresee short-term hospitalization or mortality caused by a Heart Failure decompensation episode in a cohort of patients treated in primary care. Funding has been obtained by the Spanish Government and EGPRN. Researchers from 10 European countries are willing to participate. Phase one started in March 2015 in Spain to create the predictive model: - A total of 236 health professionals from 16 Primary Healthcare Centers in Barcelona attended information sessions; 117 (49.6%) agreed to participate. They received written information on the study design and the informed consent form for delivering to the patients.

- So far, 41.8 % of practitioners have included at least one patient. The median of recruitment was 2(IQ 1-28), and the highest rates were achieved during out of hours care.
- Among the 147 patients included, 67 died or were hospitalized (45.5%).

Conclusions: The recruitment progress of HEFESTOS study is good, in spite of the difficulties of carrying out a cohort study in primary care

Points for discussion:

-Are there any strategies to improve the recruitment of participants in cohort studies in primary care?
-Is it possible to carry out this kind of studies whithout important sources of funding?

PRESENTATION 42: Monday 23rd May, 2016 POSTER
14.20–15.35 h. Ongoing study with preliminary results

EIRA. A complex multi-risk intervention in primary health care to promote health behaviours in patients aged 45 to 75 years: preliminary results from phase 0, I and II. Design a complex multicentre cluster randomized clinical trial (Phase III)

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Id 66

Background: A challenge faced in Primary health care (PHC) is to integrated preventive interventions in order to obtain a synergistic effect of multiple components.
Research question: Is an evidence based complex health promoting intervention for people 45 to 75 years feasible and acceptable by PHC professionals and patients? Is it effective and efficient in a risk reduction of cardiovascular disease and depression?
Method: Recommendation of the Medical Research Council is follow to design and evaluate complex intervention. Phase 0. We systematically reviewed the literature in health promoting life styles and prevention of cardiovascular and mental health. Phase I. We determined the components, their interrelation and the relationship to health outcomes. Qualitative studies was conducted with different stakeholders. Phase II. We developed two-arm exploratory trial at 14 PHC centres. Feasibility, acceptability and potential effectiveness of the intervention was evaluated. Phase III: Cluster randomised clinical trial run in next three years.
Results: Phase 0: 13 literature reviews on PHC are published, most in Preventive Medicine Supplement Volume 76, Supplement, July 2015, we identify the most effective components of the complex intervention, and the theoretical framework (transteoretical and 5A's behaviour models).Phase I: The intervention designed includes patients motivated who accept participate to prevent in two o more components: tobacco, diet, physical activity, cardiovascular risk and depression. The intervention is individual, by groups and/or community. We identified barriers and facilitators of the intervention. See details in http://proyectoeira.rediapp.es/Phase II: in 14 PHC teams and 1006 patients included in the exploratory trial shows that the intervention was partially feasible an acceptable, some aspects can be adapted to Phase III.
Conclusions: We built a flexible intervention. We designed a Phase III clinical trial, planned to recruit 3264 patients in 28 PHC centers, to evaluate effectiveness to allow a proper implementation of PHC.

Points for discussion:
-Are there enough evidendence of efectiveness in promotion health life styles interventions based in PHC?
-Is the Medical Reseach Council Guidelines usefull to design and evaluate Complex Interventions?
-Is it possible to implement a intensive complex inte

PRESENTATION 43: Monday 23rd May, 2016 POSTER
14.20–15.35 h. Research in progress, without results

Does Current Medication Prescribed To the Young Hypertonic Male Correlate To Their Actual Cardiovascular Risk?

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Id 68

Background: A leading cause of death in Europe includes cardiovascular (CV) diseases (such as heart attack and stroke). 60% of male health loss appears at working age (16-64 years). However, there is no strong evidence that antihypertensive drugs used in the treatment of adults with mild hypertension would reduce mortality or morbidity. It is convenient for doctor to prescribe and for patient to adhere to pharmacological treatment.
Research question: In current practice do we value blood pressure numbers over cardiovascular risk when prescribing treatment? Does hypertension treatment of low- and high cardiovascular risk among hypertensive patients differ, how do patients perceive their disease and rate of adherence to prescribed medication?
Method: This study is part of intervention trial assessing the effect of decision aid to patient's CV risk reduction. Computer based decision aid ARRIBA_Herz Estonian version (www.Arriba-herz.de) created by Marburg, Düsseldorf and Rostock Universities calculates 10 year stroke and myocardial infarction risk. Study group included 123 males from GP practice, aged 18-50 with uncomplicated hypertension receiving pharmacological treatment. The clinical data of smoking status, weight , height, waist measurement, cholesterol level and its fractions, creatinine and glomerular filtration rate, urine albumine/creatinine rate and cardiogram were registered. Patients medication was registered and using data from e-prescription database we assessed the actual uptake of prescriptions. Patients filled Brief Medication Questionnaire and hypertension knowledge questionnaire.
Results: Currently analysis is being carried out and results will be presented at the conference. We intend to categorize patients into low risk (0-5%) and high risk (>10%) groups and compare their pharmacological treatment and their adherence to treatment. We also intend to evaluate how patient perceive their illness and the association to CV risk.
Conclusions: The conclusion will inform weather patients were treated according to CV risk or just hypertension level and how patients perceive their CV risk.

Points for discussion:
-Would it be beneficial to observe patients longer before prescribing medication?

PRESENTATION 44: Monday 23rd May, 2016 POSTER
14.20–15.35 h.

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

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Id 30

Introduction: The Hopkins Symptom Check list-25 (HSCL-25) is a widely used diagnosis and screening self-questionnaire for depression and anxiety. It was validated in Swedish General Practice (GP) in 1993, versus a psychiatric examination using the Present State Examination (PSE-9). Validity coefficients ≥1.75 on a maximum of 4 identify a depression case.
Research question: In France, what are the validity coefficients of the HSCL-25?
Method: Randomize control trial with 1100 GP outpatients. Two group of patients will be selected, one with a score <1.75 and one with a score ≥1.75. The PSE-9 will be applied by a PSE9 trained physician to 1 in 2 patients for the group HSCL-25 ≥1.75, to 1 in 16 patients for the group HSCL-25 <1.75. Analysis will be conducted to validate the HSCL-25 discriminant qualities: comparison of the frequency of depressive patients diagnosed by PSE-9 between the group HSCL-25 <1.75 and HSCL-25 ≥1.75. The values of sensitivity / specificity will be calculated from the predictive values and likelihood of being diagnosed depressive by HSCL-25, using Bayes' formula.
Preliminary Results: 1100 patients were included in less than 6 weeks using three group practices with 17 GPs. All PSE-9 examinations were achieved in 4 weeks time after inclusion. Statistical analysis is ongoing. Further results will be available in May 2016 for Tel Aviv Meeting.
Conclusion: The validation of HSCL-25 French version will allow a new standard for depression diagnostic in French GP and for research in French primary care. This pilot study will be extended throughout Europe with the FPDM team seeking for Horizon 2020 funds.

PRESENTATION 45: Monday 23rd May, 2016 POSTER
14.20–15.35 h.

Pre-diabetes: true of fiction?

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Id 43

Background: Clalit invests time and resources to deal with pre-diabetes. Recent article at the Family Practice journal casts doubts on the need to deal with this condition.
Research question: What was the rate of conversion from pre-diabetes to overt diabetes among Sharon-Shomron district adult population and which are the main variables that predict the conversion.
Method: we retrieved data of all members of Sharon-Shomron district of Clalit HMO, aged 45 or older, who on January 1 2004 who complied with the definition of pre-diabetes and checked what percentage developed overt diabetes since January 1 2009 to December 31 2014. we also retrieved data regarding demographic characteristics, as well as other risk factors: hypertension, cholesterol levels, usage of different medications which raise the risk for diabetes.
Results: 22% of the cohort developed diabetes during the 6 years follow-up period. We are still analyzing the data to locate the major risk factors and will have the results soon.
Conclusions: apparently, only 30% (extrapolated) of those with pre-diabetes develop diabetes within 10 years (more conclusions will be added soon)

Points for discussion:
-pre-diabetes- should we allocate time and energy to comply with it?
-which are the main risk factors which predict the transformation from pre-diabetes to overt diabetes

PRESENTATION 46: Monday 23rd May, 2016 POSTER
14.20–15.35 h. Ongoing study with preliminary results

Assessing the role of factors affecting the bone density in children and adolescents.

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Id 63

Background: Nowadays the problem of decreasing bone mineral density (BMD), osteoporosis and osteopenia has become very significant. There is evidence that the beginning of osteoporosis - osteopenia - can start in childhood and adolescence. The complicated economic situation in Ukraine affects all citizens of the country, but the most vulnerable are children of socially disadvantaged groups, including Roma especially in the rural area.
Research question: What factors can affect BMD in children and adolescents of different ages, social and ethnic groups including Ukrainian and Roma native groups who are the residents of western region of Ukraine (Transcarpathia) which is mainly rural.
Method: We examined BMD of 124 children and adolescents of different ages, social and ethnic groups using ultrasound densitometry (Hologic Sahara).
Results: The osteopenia has been observed in 20% of the examined individuals. It was detected that the frequency of osteopenia in Roma adolescents was significantly higher ($p<0.05$) that probably depended on significantly less consumed milk, milk products and spread of the risk factors like smoking and alcohol intake. However the duration of staying outdoors and their physical activity were not significantly different from the other groups.
Conclusions: It was established that the prevalence of the risk factors and an unbalanced diet are not compensated by high physical activity and staying outdoors in vulnerable groups of children and adolescents, and causes osteopenia in 20% of the examined cohort.

Points for discussion:
-Do the children of special cohort need the screening of osteopenia?
-What are the main factors, which can affect bone mineral density in children and adolescents of different ages, social and ethnic groups?

PRESENTATION 47: Monday 23rd May, 2016 POSTER
14.20–15.35 h.

European Study on Self-care for Common Colds: Gender differences in primary care practice samples from 14 European nations (COCO study)

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Id 23

Background: Self-care for common colds is frequent, yet little is known about gender differences in self-care of patients across Europe.
Research question: 1.Does self-care for common colds differ by gender with regard to a) the mean item use and b) type of practices?
2.Is there a gender difference in the disease-related discomfort?
Method: This cross-sectional study was performed at 27 sites in 14 European countries. Participating sites distributed questionnaires to 120 consecutive patients. The questionnaire provided a selection of 105 self-care practices and allowed for free-text answers. Results were age standardized using the 2013 European Standard Population.
Results: The final analysis included 2,724 patients, 62.5% were women, the mean age was 46.7 years (±16.8). The mean use of self-care items was higher in women than in men (12.1 vs. 10.4). The top 5 items were identical in females and males although the frequency of their use differed: water (women: 45.7% vs. men: 37.6%), honey (43.9% vs. 38.9%), oranges/juice (37.2% vs. 39.5%), stayed in bed (37.3% vs. 39.4%), bath/shower (36.0% vs. 34.3%). Gender differences of at least 4.0% were documented for 31% of all items. The largest differences were observed for 'water', 'opened window' (25.1% vs. 17.1%), 'paracetamol' (women: 41.0% vs. men: 33.4%), and 'hot water bottle' (13.7% vs. 7.1%). Men marked more frequently to use garlic (men: 18.1% vs. women: 13.4%), tea with rum (7.0% vs. 3.9%) and taking a day/days off (16.2% vs. 13.2%). The ratio of non-pharmacological versus pharmacological items was higher for women in 10 of 12 countries. Men reported alcohol use more frequently (17.8% vs. 7.9%), while discomfort was reported more frequently by women (70.5% vs. 62.1%).
Conclusions: This first cross-national study documented gender differences in self-care for common colds.

Points for discussion:
-How do our results fit with our perception of gender differences in health care and health behavior?
-What are the implications for the health professionals (regarding gender differences)?
-What subjects are worth further investigation and study

PRESENTATION 48: Monday 23rd May, 2016 14.20–15.35 h. **POSTER**

What tools are usable to assess Quality of life in general population. A systematic literature review.

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Id 25

Background: Quality of life (QOL) is important to assess quality of care from patient's point of view. Consecutively QOL could be used to diminish over diagnosis and overtreatment in daily practice. Nevertheless there is a need to achieve a consensus on quality of life evaluation.
Research question: what questionnaire are available in general population to evaluate QOL?
Method: a systematic review of literature according to the PRISMA (Preferred Reporting Items for Systematic reviews and Meta-Analyses) statement was conducted using Pubmed and Cochrane databases. Only articles containing QOL scales or indexes for humans were included. A control of the articles' quality was achieved with a scale from 0 to 18. All article below 9 were excluded.
Results: 1617 documents were identified, 78 articles were selected. 11 scales were found: scales resulting of World Health Organisation, the WHOQOL is composed of 6 domains and the WHOQOL-BREF is trained of 4 domains and a one global item score : overall quality of life ; scales resulting of MOS (Medical Outcome Study), the SF36 is composed of 8 scales, the SF36v2 is a modification of the previous scale, the SF12 contains the same SF36 scales but in 12 items, the SF12v2 is corrected version of SF12 ; the scales resuting of the EuroQolGroup, the EQ5D is composed of 5 dimensions and the EQ15D of 15 dimensions ; the NHP is composed of 6 domains ; the QLI contains a quality of life overall and 4 domains, and the QOLS is composed of 8 dimensions.
Conclusion: 11 QOL scales usable in general population were identified. Further studies looking at their psychometrics qualities have now to be realized to achieve a consensus on the best tool usable for practice or research purposes in general practice.

Points for discussion:
-who would like to join this new EGPRN team?

PRESENTATION 49: Monday 23rd May, 2016 POSTER
14.20–15.35 h.

The linguistic validation of the gut feelings questionnaire into three european languages: an intriguing process

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Id 28

Background: Physicians' clinical decision-making may be influenced by non-analytical thinking, especially when perceiving uncertainty. Incidental gut feelings in general practice have been described, namely, as "a sense of alarm" and "a sense of reassurance". A Dutch Gut Feelings Questionnaire (GFQ) was developed, validated and afterwards translated into English following a linguistic validation procedure.
Research question: The aims were to translate the GFQ from English into French, German and Polish; to describe uniform elements as well as differences and difficulties in the linguistic validation processes; to propose a uniform procedural scheme for future GFQ translations into other languages.
Method: We followed a structured, similar and equivalent procedure. Forward and backward-translations, repeated consensus procedures and cultural validations have been performed in six steps. Exchanges between the several research teams, the authors of the Dutch GFQ, and the involved translators continued throughout the process.
Results: 12 translators, 52 GPs and eight researchers in the field participated in the study from France, Germany, Switzerland and Poland. The collaborating research teams created three versions of the 10-item GFQ. Similar items generated discussions in the three different research teams. Each research team agreed on compromises between comparability and similarity on the one hand, and linguistic and cultural specificities on the other.
Conclusions: The GFQ is now available in five European languages: Dutch, English, French, German and Polish. The uniform procedural validation scheme presented can be used for translation of the GFQ into other languages. In five European countries, comparative studies of the predictive value of gut feelings, and the significance of main determinants are now possible.

Points for discussion:
-How to compare different linguistic validation procedures?

PRESENTATION 50: Monday 23rd May, 2016 POSTER
14.20–15.35 h. Ongoing study with preliminary results

Gut feelings in the diagnostic process of spanish family physicians: a focus group study

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Id 31

Background: Gut feelings (GF) have shown to have a place in family physicians (FP) diagnostic process according to studies carried out in the Netherlands, Belgium and France. The Gut Feelings Questionnaire (GFQ) determines the presence of GF during a FP's consultation.
Research question: Do Spanish FP recognize GF in their diagnostic reasoning? What are the main determinants of GF? How do Spanish FPs assess their diagnostic value?
Methods: Qualitative research approach using 3 focus groups with a purposive sample of 20 FPs working in Majorca Primary Care Centers (Spain) selected acording to characteristics such as sex, years of experience, experience as FP trainer, and rural vs non-rural practice. They were originating in different regions of Spain and South America. The transcriptions were coded performing a thematic analysis.
Preliminary results: Spanish FP recognize the existence of two kinds of GF: a sense of alarm (something is wrong here) and a sense of reassurance (everything is right), both with prognostic value.
- FPs' gender and their place of work do not seem to be determinants of GF.
- Both experienced and unexperienced FPs have GF but the diagnostic value assesement differs.
- Most FPs believed that GF can be taught to junior doctors and residents.
- FPs acknowledge that the sense of reassurance plays an important role in their diagnostic reasoning, enabling FPs to manage their workload meanwhile avoiding an overuse of diagnostic tests.
- FPs believe that nurses, patients and relatives also have GF.
- These results are in line with previous ones.
Conclusion: Spanish speaking FP recognize the existence of GF in their diagnostic reasoning process. A next step will be to study the predictive value of gut feelings among Spanish FPs, e.g. in cancer diagnostics, and how to teach GF to students and FP-trainees.

Points for discussion:
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PRESENTATION 51: **Monday 23rd May, 2016** **POSTER**
14.20–15.35 h.

Health behavior and utilization of health services in Ultra Orthodox Jews (UOJ) in Safed

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Id 57

Background: Ultra-Orthodox Jews live in a closed defined community with uniform life style. UOJ evaluate their health higher than other population, have higher levels of life satisfaction and lower levels of stress.
Research question: Is there a difference in utilization of health services and health parameters between UOJ and non UOJ living in Safed?
Method: A cross-sectional study in the patients of Clalit Health Services in Safed: UOJ as the study group and non-UOJ as the comparison. The groups were compared for sociodemographic parameters; hypertension, dyslipidemia, ischemic heart disease - prevalence and control; screening and immunisations, primary care and consultant visits; analgesics and respiratory medications.
Results: 2,652 participants were UOJ and 16,381 non-UOJ. The rate of visits for UOJ in a year was lower for primary care and consultants than for non-UOJ (78.7% vs 83.9%, p<0.001 and 45% vs 55%, p<0.001, respectively). UOJ were vaccinated against influenza less than non-UOJ, both in babies <2 y and elderly (8.4% vs 18.98%, p<0.05 and 51% vs 67.7%, p<0.05). Performance of mammography and tests for occult blood were similar in both groups. Chronic diseases were less prevalent in UOJ (19% VS 37%, P<0.0001). Control of hypertension and diabetes was similar but control of dyslipidemia was better in UOJ (76.6% vs 63.9%, P=0.012). Less medications were purchased by UOJ
Conclusions: UOJ rate their way of life more positively than the general population. Our research suggests that they also appear to utilise health services less, and have lower vaccination rates than non-UOJ, although screening for early detection of cancer is similar. Chronic diseases appear to be less, but control is similar or better than the general population suggesting that rates are not due to under-detection. Our research indicates a different, but not necessarily inappropriate utilization of health services although lower immunization rates are a concern.

Points for discussion:
-We would like to hear the audience advice on further investigations for that topic

PRESENTATION 52: **Monday 23rd May, 2016** **POSTER**
14.20–15.35 h. **Ongoing study with preliminary results**

The prevalence of cardiovascular disease (CVD) in obese people in Timis County - Romania

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Id 73

Background: The western part of Romania which includes Timis County has the highest number of obese persons. The death rate in 2012 in Romania was 1039.2 for circulatory diseases and 345.3 for ischemic heart diseases (per 100.000 inhabitants). Modifying the risk factors (obesity) can reduce it by 50 percent.
Research question: To determine the prevalence of overweight and obesity in adults from Timis County.To identify obese individuals with cardiovascular disease or cardiovascular risk factors.
Method: A cohort study which includes adult people from the lists of 5 GPs from Timis County (n=220 - partial results: 97 male, 123 female, mean age 52.39 years (18-87 years old). The GPs for filled a questionnaire with the dates of their patients: age, gender, profession, smoking status, BMI, abdominal circumferences, blood pressure, cholesterol, HDLc, LDLc, triglycerides, the presence of diabetes mellitus, cardiovascular diseases, physical activities. The GPs have created a data base and using statistical analyses, compared the presence of cardiovascular diseases in normal-weight (BMI 20-25), overweight (BMI 25-30) and obese people (BMI >30) and in gender groups.
Results: The preliminary results: 39.83% of female with CVD and 34.02% of male with CVD; 33.55% in normal-weight and overweight group and 43.95% in obese group have CVD. The probability of having CVD was 1.35 higher in obese compared to normal-weight and overweight group (statistical analyses shown a relative risk = 1.35). The results will be complete after more data. We need more patients to evaluate till May 2016 and we will present the final results for obesity and others cardiovascular risk factors.
Conclusions: The risk of CVD in obese people was higher than in non-obese people in our study group (relative risk =1.35) and close to the results from the other studies (the relative risk of 1.72 of having CVD for obese people).

Points for discussion:
-The role of GPs in reducing weight at obese people for decreasing the mortality of CVD
-Diet and bariatric surgery for obesity to evaluate on a possible next step of the study

PRESENTATION 53: Monday 23rd May, 2016 POSTER
14.20–15.35 h.

The General Ultrasonography as an Experimental Oncological Screening and a comparative statistical analysis of different type of ultrasound methods (Triplex Doppler or Strain Elastography) who can be significant in primary care.

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Id 39

Background: In the last years, big progresses have been made in oncology, both in therapy and in diagnostic. Ultrasonography is an investigation useful in the tumor diagnosis, establishing the topography, extension, consistency, tissues stiffness, vascular network analysis and even pathology elements connected to its nature. Our objective was early diagnosis and treat quickly in the earliest stages of malignant tumors through Oncology Ultrasound Screening at primary care level to the high risk population.
Research question: Do you know any "Ultrasonography Score System" for malignancy and for biopsy indications?
Method: We report a prospective oncology screening(abdominal, pelvic, breast, thyroid and soft tissues ultrasound) performed on a total of 5000 patients with oncology risk factors+, over 40 years, followed over five years, sex ratio=1:1. We used a questionnaire to identify presence of the risk factors as inclusion criteria. To patients aged 40-50 years, were made an ultrasound screening every two years and over 50 years annually, by an ultrasound guideline and archived into an electronic database designed by us. Positive patients had done the following ultrasound methods: Doppler with fractal geometry analysis, Elastography and "Malignancy Ultrasound Score" (M.U.S) developed by us.
Results: Were found a total of 310 patients with benign (n=157) and malignant tumors (n=153).The incidence of malignant tumors was 3.6% in the risk population. The sensitivity of screening was 81%,specificity 90,94% with a high accuracy of 90,54%,p<0,01, 5-year prevalence: 6,2%, PPV=37,32%, NPV=98,68%. ROC analysis confirmed a higher level of diagnostic accuracy of elastography compared with Doppler Ultrasound, AUC=0,996,95%CI=0,981to1,00,p<0.001. To ANOVA comparative analysis the very significant statistical method was M.U.S., p<0,001.
Conclusions: Both Doppler Ultrasound and Elastography proves to be very efficient methods with a high accuracy 90%in oncology screening for the early detection of hyper vascular tumors in asymptomatic stage, who can confirm malignancy and the need for biopsy.

Points for discussion:
-What is the gold standard method in oncology?
-Who can brings us important details in the differential diagnosis "benign versus malignant" of tumors?
-Who should diagnose oncological patients?

PRESENTATION 54: Monday 23rd May, 2016 POSTER
14.20–15.35 h.

Cancer Survivorship - Barriers Encountered by General Practitioners in Ireland

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Id 44

Background: Cancer survivors may experience a wide range of complex health issues as a result of their cancer type and treatment. Some health issues can have a lifelong impact on patients, while others related to cancer treatment can last up to five years post-treatment. Cancer survivors have increased rates of health care utilisation compared to non-cancer patients. During active cancer treatment, GPs may provide care to their patients. Post cancer treatment, patients routinely participate in follow-up care with their GPs. The transition back into the primary care setting can be difficult for both GPs and patients to navigate.
Research question: What are the current barriers encountered by general practitioners in Ireland in the area of cancer survivorship?
Method: The study consisted of a literature review and a quantitative survey of GPs for the National Cancer Control Programme in Ireland. Postal questionnaires were sent in April 2015 to 2,822 GPs in the Republic of Ireland. A total of 514 completed surveys were analysed, a response rate of 18.2%.
Results: A large portion of GPs (93.5%) had never attended a survivorship course, conference or workshop. Overall, 64.7% of respondents sometimes, rarely or never share follow-up care for their patients with oncology consultants. Only 17.2% and 19.7% of GPs respectively considered that they had enough information on the 'possible long-term issues from chemotherapy' and 'possible long-term issues from radiation therapy'. Over three-quarters of GPs considered that they did not have sufficient information on 'recommended evidence based surveillance for patients with a previous cancer'.
Conclusions: This survey provides some insight into the current situation in Ireland with regard to cancer survivorship from a GP perspective. GPs will increasingly follow-up with patients who are living through cancer treatment and after cancer survivorship. Further education for GPs is clearly indicated as necessary in this area.

Points for discussion:
-The challenges faced by GPs in delivering quality cancer survivorship care.
-The necessary supports GPs require to best deliver cancer survivorship care.

PRESENTATION 55: Monday 23rd May, 2016 POSTER
14.20–15.35 h. Ongoing study with preliminary results

Understanding non-compliance for occult blood test in the Jewish and Arab communities in Israel

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Id 84

Background: Colorectal cancer is the second most frequent malignancy in Israel. Fecal occult blood testing (FOBT) has proved to be an effective screening tool. In Israel it is offered to all persons aged 50 and above through an active reaching out and centralized public health system. Despite being noninvasive and free of charge, the program implementation is characterized by a low compliance rate.
Research question: A better understanding of the reasons for not performing FOBT could lead to remedial measures appropriate to the multi-cultural context.
Method: Adaptation of a validated questionnaire based on published literature and individual interviews of patients, translated and tested in Hebrew and in Arabic languages. Patients between 50-70 years old who have not performed the FOBT within a month are requested by their family physician to fill the questionnaire anonymously. Excluded are patients who have or are due to perform a colonoscopy. The project has received local Helsinki Committee approval.
Results: At present, about 200 hundred questionnaires have been collected, half from Jewish and half from Arabic patients, and are submitted to analysis. They include 13 closed and one open questions. Answers within the two communities will be compared and suggestions to improve the performing rate will be offered accordingly.
Conclusions: Research in progress. Results will be available at the Conference time.

Points for discussion:
-The strength of this research: previous publications in Israel had no clear conclusions, or included only 30 patients.
-Are there cultural differences between Jewish and Arab patients not performing the FOBT? There are no publications from Arab cou

PRESENTATION 56: Monday 23rd May, 2016 POSTER
14.20–15.35 h.

Vitamin B12 screening in metformin-treated diabetics in primary care: were elderly patients less likely to be tested?

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Id 89

Background: Low serum B12 concentration which may be clinically significant is a common occurrence in patients with type 2 diabetes (T2DM) treated with metformin. Nonetheless, there is lack of evidence concerning the primary care practice of testing of B12 levels for these patients, and current clinical guidelines make no recommendations on the detection or prevention of vitamin B-12 deficiency during long-term metformin treatment.
Objective: To examine the practice and clinical determinants of B12 testing in metformin treated diabetic patients within a large primary care health maintenance organization (HMO).
Methods: Data were collected from centralized electronic medical records (EMR) of LHS patients providing primary health care for over 730,000 people. Study population consisted of T2DM patients who were newly prescribed Metformin during 2008-2013. Patients were divided into two subgroups: patients whose family physicians referred them for a vitamin B12 blood test, and patients who did not receive such a referral. The demographic data and medical characteristics including co-morbidities and diabetes related complications of the two subgroups were compared.
Results: 5,131 patients began taking Metformin during the study period. Of these 2,332 (44.5%) had vitamin B12 tested. No significant differences were found between the groups in regard to glycosylated hemoglobin, low density lipoprotein or systolic blood pressure, as well as dyslipidemia, CRF, gender and disease duration. A significant positive association ($p<0.05$)was found between B12 testing and insulin treatment, retinopathy, neuropathy and hypertension. Significantly lower rates of testing for B12 levels were found in older (>75 years) patients ($p<0.05$).
Conclusions: Insulin treatment, hypertension, and chronic diabetic complications in metformin treated T2DM patients are associated with higher rates of B12 testing by primary care physicians. However, older patients 75 years and above are less likely to be tested for B12 deficiency.

Points for discussion:

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PRESENTATION 57: Monday 23rd May, 2016 15.55–16.25 h. **FREESTANDING PAPER**

The influence of social networking sites on health behavior change - meta-analysis

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Id 79

Background: Lifestyle risk behaviors are nowadays responsible for the global burden of non-communicable diseases.The fact that social networking sites (SNSs) are widely accessible across geographical barriers, and that they are increasingly being used by people on a daily basis (namely through mobile phones), turn them into especially interesting loci for public health interventions in the behavioral domain.
Research question: What is the effectiveness of interventions using social networking sites (SNSs) to change health behaviors?
Method: Five databases were scanned using a predefined search strategy. Studies were included if they focused on patients/consumers, involved an SNS intervention, had an outcome related to health behavior change, and were prospective. Studies were screened by independent investigators and assessed using Cochrane's 'risk of bias' tool. Randomized controlled trials were pooled in a meta-analysis.
Results: The database search retrieved 4656 citations; 12 studies (7411 participants) met the inclusion criteria. Facebook was the most utilized SNS, followed by health-specific SNSs, and Twitter. Eight randomized controlled trials were combined in a meta-analysis. A positive effect of SNS interventions on health behavior outcomes was found (Hedges' g 0.24; 95% CI 0.04 to 0.43). There was considerable heterogeneity (I2.84.0%; T2.0.058) and no evidence of publication bias.
Conclusions: To the best of our knowledge, this is the first meta-analysis evaluating the effectiveness of SNS interventions in changing health-related behaviors. Most studies evaluated multi-component interventions, posing problems in isolating the specific effect of the SNS. Health behavior change theories were seldom mentioned in the included articles, but two particularly innovative studies used 'network alteration', showing a positive effect. Overall, SNS interventions appeared to be effective in promoting changes in health-related behaviors, and further research regarding the application of these promising tools is warranted. In conclusion, our study showed a positive effect of SNS interventions on health behavior-related outcomes.

Points for discussion:
-How can social networking interventions be leveraged in General Practice to promote behavior change?
-What is the role of the GP in promoting healthy lifestyles through the use of health information technology?

PRESENTATION 58: Monday 23rd May, 2016 16.25–17.55 h. **FREESTANDING PAPER**

Acute Sinusitis -A common disease with overuse of diagnostic tool and medicine treatment

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Background: Acute sinusitis is one of the most common diseases in primary care. Guidelines consistently recommend against imaging for diagnosis and routine Antibiotic use.
Research question: To assess the level of adherence with guidelines of family doctors in Maccabi Healthcare.
Method: This observational study based on computerized databases, in Maccabi Healthcare Service all over the country from 2012-14. Patients who diagnosed by a family doctor with acute sinusitis (Icd9 - 461X), were included. We excluded patients with recurrent sinusitis or with immune compromised diseases. Data on Imaging and on antibiotics' purchase during the first months after diagnosis were collected.
Results: From 129,113 patients diagnosed with acute sinusitis 20,523 had imaging within 30 days of diagnosis, and 17,395 in the first week. CT scans were done in 0.27% and 15.6% had X-Ray. Youngers were doing less imaging 0.01% CT and 13% X-ray compared to older, with CT in 0.05% and x-ray 16.5%. Males had 17%, versus 14% of women. We found differences between regions. Only 24.5% of diagnosed did not buy any antibiotics. The young got less (71.6%) than the older -over 50 (81.9%). We found no differences among gender and regions. The rate of using imaging and antibiotics varied significantly among physicians. Patients who visit two doctors, ENT and family physician had 2-3 times higher chances to have imaging than if examined by one doctor (14% for visit a family doctor, 28% if previously visited ENT, and 38% if you visited the ENT doctor a week after).
Conclusions: We found a gap between the clinical guidelines and the practice in diagnosis and treatment of acute sinusitis. Clearly, there is great variation among physicians, their personal professional patterns. This has implications on the quality of medical care that patients receive and on the public Cost.

Points for discussion:
-What can we learn from a quantitative measurement on the quality of medical care that patients receive?
-What are the limitations of a study that examines individual events and not the process over time?
-What can affect the quality of diagnosis