



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

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European General Practice Research Network

Budapest – Hungary

16th – 19th October, 2008

SCIENTIFIC and SOCIAL PROGRAMME

THEME: Integrated Management of Cardiovascular Disease

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

Place

**Hotel Mercure Budapest Buda
Krisztina Körút 41-43
H-1013 Budapest-Hungary**

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



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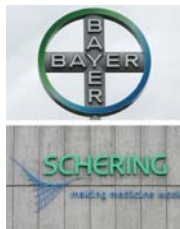
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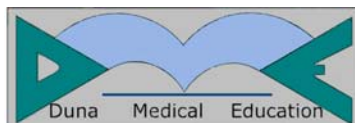
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The meetings of the European General Practice Research Network (EGPRN) have earned accreditation as official postgraduate medical education activities by the Norwegian, Slovenian, Irish and Dutch College of General Practitioners.

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

“INTEGRATED MANAGEMENT OF CARDIOVASCULAR DISEASE”

Dear Colleagues,

On behalf of the organizing committee we are delighted to invite you to participate at the 67th European General Practice Research Network Congress to be held in Budapest, Hungary.

Among all diseases cardiovascular diseases represent probably the greatest issue in Europe today. They affect a large proportion of the population and put a large burden both to the individual and the society. We have new insight to the development of atherogenesis, type 2 diabetes, myocardial infarction, cerebrovascular diseases. New risk factors of atherogenesis have been identified in addition to classical ones. Several principles and guidelines of diagnosis, therapy and chronic care of cardiovascular diseases have been elaborated. General practitioners see a high percentage of patients with cardiovascular diseases. Strategies for population screening and prevention are developing continuously in primary care. Today the life expectancy for Hungarian men is 68.6 years; for women 76.9 years, which ranks among the lowest in countries in the OECD. Sixty per cent of all deaths are related to cardiovascular diseases. According to the WHO data death rate due to cardiovascular diseases Hungary ranked second after the Russian Federation in 2006.

The most striking feature of the health crisis in many Eastern European countries is that cardiovascular disease affects those of working age, particularly middle-aged single men. In addition, it is estimated that more than one in three Hungarian men and nearly one in four women smoke. One in four men and one in 11 women reportedly puff at least 20 cigarettes a day. About 50% of the population is overweight or obese. A recent World Health Organization study concluded: "The reasons for the relatively high mortality in Hungary are complex and not fully understood." The report shows that many Hungarians do not go to the doctors as often as recommended. The level of stress is also evidently higher here than in Western European countries. We have to change our customs, our diet, how we think about our bodies. To reach this goal, different medical specialities should have to work together and we have to involve our patients, as well.

These facts and ideas prompted us to choose "Integrated management of cardiovascular diseases" as a topic of the European General Practitioners Research Network Conference in 2008. During this Congress we would like to share ideas about how we can educate patients, and how medical professionals (specialist, researchers, general practitioners, dieticians, physiotherapist, social workers etc.) should work together. We hope you will have a very successful Congress; to look at various aspects of cardiovascular disease thoroughly, to learn from each other, in order to bring home new ideas and methods of the cardiovascular disease management.

Budapest is one of Europe's most vibrant and cosmopolitan cities. Widely recognised as being among the world's most exciting cultural capitals, it is a friendly city, where the people are proud of their heritage and delight in making visitors feel welcome.

We look forward to seeing you in Budapest.

Yours sincerely,

Péter Kotányi National Representative of EGPRN-Hungary

On behalf of the Host Organising Committee

László Kalabay Professor, Department of Family Medicine, Semmelweis University
President, Research Organisation of Hungarian Family Physicians (CSAKOSZ)

Imre Rurik Head, Department of Family Medicine, University Debrecen

János Szabó President of Hungarian College of Teaching Family Physicians (MOCSAK)

Péter Torzsa Professor Assistant, Department of Family Medicine, Semmelweis University

Péter Vajer Professor Assistant, Department of Family Medicine, Semmelweis University

Also on behalf of

Ferenc Hajnal Professor, Institute of Family Medicine, University of Szeged, President, Hungarian College of Family Physicians, Hungarian Association of Family Physicians (MÁOTE)

István Ilyés Professor, Department of Family Medicine, University of Debrecen

Lajos Nagy Professor, Department of Family Medicine and 3rd Department of Medicine, University of Pécs

Sándor Balogh Director, National Institute for Primary Care

MEETING EXECUTIVE BOARD

GENERAL COUNCIL MEETING

Executive Boardmeeting
Thursday 16th October, 2008

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

**(location : Conference Venue Hotel Mercure Budapest Buda,
Room: Beatrix terem**

General Council meeting with the National Representatives
Thursday 16th October, 2008

14.00 - 17.00 : Executive Board members and National Representatives

**(location : Conference Venue Hotel Mercure Budapest Buda,
Room: Szent István terem**

REGISTRATION

► Thursday 16 October 2008

REGISTRATION FOR PARTICIPANTS OF PRE-CONFERENCE WORKSHOPS ONLY

Two locations: -Conference Venue Hotel Mercure Budapest Buda
- Dept. of Family Medicine, Semmelweis University, Kútvölgyi út 4

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

► Friday 17 October 2008

REGISTRATION FOR ALL PARTICIPANTS

Time: 08.00 – 08.30 h.

Location: Hotel Mercure Budapest Buda

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

FOR ALL EGPRN PARTICIPANTS

Social night on Saturday 18th October 2009

(Dinner, speeches and party)

at the Columbus Pub and Restaurant Állóhajó (anchored ship)

Address: in Hungarian: 4. számú kikötő Vigadó tér 1051 Budapest

in English: Dock No. 4 Vigadó Square 1051 Budapest

(30 minutes walk from Hotel Mercure)

Entrance Fee: € 30,= per person.

Please address to EGPRN Registration Desk.

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

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

PROGRAMME OF THE EUROPEAN GENERAL PRACTICE RESEARCH NETWORK IN BUDAPEST-HUNGARY

THURSDAY 16th OCTOBER, 2008:

Location : **Conference Venue Hotel Mercure Budapest Buda**

09.30 - 12.30 : **Executive Board Meeting**
(only for Executive Board Members)
in: room Beatrix terem

10.00 - 12.30 : **Pre-Conference Workshops (only for participants who have registered
beforehand)**

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

“Workshop on Collaborative Studies”

Chairs: Ferdinando Petrazzuoli (Italy), Isabelle Aubin (France).

in: room Krisztina terem

***“Workshop on How to start building GP Research in a low capacity
country. A Manual/Cookbook”***

Chairs: Lieve Peremans (Belgium), Patrick Chevallier (France) and Christos
Lionis (Greece).

in: room Szent István terem

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

14.00 - 17.00 : **2 EGPRN Pre-Conference Afternoon Workshops; €25 (€50) each p.p**
Parallel workshops:

***“Insights into Methodology for Primary Care Researchers. Bridging the
gap between statistical significance and real-life importance”***

Chairs: Pinar Topsever (Turkey), Christos Lionis (Greece) and Luc Martinez
(France)

in: room Krisztina terem

Location : **Dept. of Family Medicine, Semmelweis Egyetem Univ., Kútvölgyi út 4.**

“Cardiovascular Diseases: Teaching the teachers and the patients”

Chairs: Imre Rurik, Gábor Pavlik and Péter Jákó (Hungary)

in: big conference room

14.00 - 17.00 : EGPRN General Council Meeting.
Meeting of the Executive Board Members with National Representatives
(only for Council Members).
in: room Szent István terem

Social Program: For ALL EGPRN-participants of this meeting who are present in
18.00 - 19.30 : Budapest at this time. (Entrance Free)

Welcome Reception and Opening Cocktail for all participants.

Location: The Hungarian Academy of Sciences; Social Sciences
Research Centre Congress Hall

Address: In Hungarian: 1014 Budapest, Országház u. 30.
In English: Országház Str. 30; Budapest H-1014

FRIDAY 17th OCTOBER, 2008:

Location: Hotel Mercure Budapest Buda
Address: Krisztina Körút 41-43, H-1013 Budapest

08.00 - 08.30 : Registration at EGPRN Registration Desk.

08.30 - 08.50 : Welcome.
Opening of the EGPRN-meeting by the Chairman of the EGPRN, Prof. Dr. Paul van Royen.

08.50 - 09.10: 1st Keynote Speaker: *Professor Carlos Brotons*, chair of research unit in primary care at the Sardanya Primary Health Care Center in Barcelona, Spain and chair of the Europrev network.
Theme: "Research on the Integrated Management of Cardiovascular Diseases".

09.10 – 09.30: 2nd Keynote Speaker: *Professor Manfred Maier*, chairman, Dept.Gen.Practice and Family Medicine and head, Center for Public Health, Medical University of Vienna, Austria.
Theme: "Measuring the impact of family medicine research: scientific citations or societal impact?"

09.30 – 09.50: 3rd Keynote Speaker: *Professor László Kalabay*, Head of Department of Family Medicine, Semmelweis University, Budapest, Hungary
Theme: "GP Research in Hungary. The state of the art".

09.50 – 10.50 : 2 Theme Papers on ‘Prevention’
in: Mátyás I-II

- 1. Mary Byrne (Ireland)**
Secondary prevention of heart disease in gen.practice: a cluster randomised controlled trial of tailored practice and patient care plans.
- 2. Xavier Cos (Spain)**
Self monitoring blood glucose (SMBG) frequency and metabolic control. A prospective and multicentre cohort study.

10.50 - 11.20 : Coffee Break

11.20 – 12.50 : A Parallel session - 3 Theme Papers ‘Prevention’
in: Mátyás I-II

- 3. Hélène Vaillant-Roussel (France)**
What knowledge of their hypertension primary prevention-treated patients have?

4. **Annelies van der Linden (Belgium)**
Electronic health record systems and global cardiovascular prevention.
5. **Davorka Vrdoljak (Croatia)**
Cardiovascular risk and intervention study in Croatia-family medicine.

**11.20 – 12.50 : B Parallel session - 3 Theme Papers ‘Cardiology’
in: Szent István terem**

6. **Leanne van Heur (The Netherlands)**
Open access echocardiography in The Netherlands: an efficient service for detecting patients with (risk of developing) heart failure.
7. **Frank Peters-Klimm (Germany)**
Effects on quality of life of patients with chronic systolic heart failure by a practice-based complex intervention – results of the Heidelberg Integrated Case Management Trial.
8. **Lygidakis Charilaos (Greece)**
Arrhythmias in primary care: common treatment failures that could be adjusted.

12.50 - 14.15 : Lunch

After lunch, the meeting continues with parallel sessions till 18.10 h.

**14.15 – 15.45 : C. Parallel session - 3 Freestanding Papers
on ‘Musculoskeletal Disorders’
in: Mátyás I-II**

9. **Norbert Donner-Banzhoff (Germany)**
Are CME-journals corrupt? And if yes, how much?
10. **Isabelle Aubin-Auger (France)**
Patients’ perceptions of osteoarthritis handling.
11. **Pascale Santana (France)**
Muscular and skeletal disorders’ associations among employable French patients.

**14.15 – 15.45 : D. Parallel session - 3 Theme Papers
on ‘Prevention’
in: Szent István terem**

12. **Eeva-Eerika Helminen (Finland)**
Far from easy and accurate – metabolic syndrome diagnostics in Finnish primary care.

- 13. Ester Cornelis (Belgium)**
Cordiaal: a multi-faceted intervention program to implement a guideline on ‘Global Cardiovascular Prevention’.
- 14. Zoltan Jancso (Hungary)**
Decision support in gen.practice. Role of the Decision Support Module of RIGHT system in hypertension care.

15.45 – 16.15 : Coffee/Tea Break

**16.15 – 17.45 : E. Parallel session - 3 Freestanding Papers
on ‘Elderly/COPD’
in: Mátyás I-II**

- 15. Martin Beyer (Germany)**
A matter of attention: inconsistencies between prescription and drug intake in elderly multimorbid patients in primary care.
- 16. Tiny van Merode (The Netherlands)**
Gender differences in symptom reporting in COPD patients.
- 17. Séverine Lignot Maleyran (France)**
Management of chronic obstructive pulmonary disease (COPD) exacerbations: results of a French cohort study.

**16.15 – 17.45 : F. Parallel session - 3 Freestanding Papers
on ‘Various’
in: Szent István terem**

- 18. Caroline Huas (France)**
Eating disorders: description of population taken care in GP. How to compare with controls?
- 19. Jean-Francois Chenot (Germany)**
Adherence to low back pain guidelines in primary care: a systematic review.
- 20. Michael Kochen (Germany)**
Patient competence, self-management and the doctor-patient-relationship in the case of neck pain – a qualitative study.

17.45 – 18.10 : **Plenary Session in: Mátyás I-II**
Closing of the day by Prof. Carlos Brotons and Prof. Manfred Maier,
keynote speakers, who will summarize on today’s theme papers and on European and other guidelines on cardiovascular risk management.

- 18.30 – 19.30 :** **Meeting of EGPRN Working Groups**
- **Research Strategy Committee**
 - **Educational Committee**
 - **Communication and PR Committee**

Meeting point: **Hotel Mercure Budapest Buda - Main Entrance, colleagues will be waiting for you.**

Social Programme :

- 18.30 – :** **Practice Visits to local Health Centres in and around Budapest.**

Meeting point: **Hotel Mercure Budapest Buda - Main Entrance, colleagues will be waiting for you.**

SATURDAY 18th OCTOBER, 2008:

Location: Hotel Mercure Budapest Buda
Address: Krisztina Körút 41-43, H-1013 Budapest

08.30 – 08.50: 4th Keynote Speaker: *Professor Arno Hoes*, Professor of Clinical Epidemiology & General Practice, Julius Center for Health Sciences and Primary Care University Medical Center Utrecht, The Netherlands.

Theme: "Diagnosis and Diagnostics Measures/Instruments for Cardiovascular Diseases".

08.50 – 09.10: 5th Keynote Speaker: *Professor Richard Hobbs*, Professor and Head of Primary Care Clinical Sciences, University of Birmingham, United Kingdom.

Theme: "Epidemiology and Management and Cardiovascular Diseases".

09.10 – 10.40 : G. Parallel session - 2 Theme Papers
on 'Non-Cardiac'
in: Mátyás I-II

21. Sébastien Cadier (France)
Patients treated by anticoagulants wish more education.

22. Luc Martinez (France)
Type 2 diabetes mellitus control in Mediterranean countries: a collaborative survey in primary care settings.

09.10 – 10.10 : H. Parallel session - 2 Theme Papers
on '(Non)-Cardiac'
in: Szent István terem

23. Gerard Bury (Ireland)
Cardiac arrest in Irish general practice: preliminary incidence data.

24. Henri Stoffers (The Netherlands)
Alternative diagnosis after exclusion of deep vein thrombosis in symptomatic patients in general practice.

10.40 - 11.10 : Coffee Break

11.10 - 12.40 : Posters
In five parallel sessions (5 groups)
at: the corridor

11.10 - 12.40: Parallel group 1: Posters 'Cardiovascular' (3)

25. Denis Pouchain (France)

Is presbycusis a risk factor for dementia? ACOUDEM Study.

26. **Rudi Bruyninckx (Belgium)**
Signs and symptoms in diagnosing acute myocardial infarction and acute coronary syndrome: a diagnostic meta-analysis.
27. **Núria Fabrellas Padrés (Spain)**
The expert patient program at the Catalan health institute.

11.10 - 12.40: Parallel group 2: Posters 'Prevention' (5)

28. **Jean-Yves Le Reste (France)**
Home blood pressure measurement is anxiety during the measure a limit?
29. **Imre Rurik (Hungary)**
Obesity among Hungarian elderly.
30. **Rezso Zoller (Hungary)**
The prevalence of obstructive sleep apnea (OSA) in patients with difficult to control hypertension managed in family practices.
31. **Erika Zelko (Slovenia)**
We live healthy.
32. **Vytautas Kasiulevicius (Lithuania)**
The prevalence of cardiovascular risk factors and the control of blood pressure in elderly patients in Vilnius.

11.10 – 12.40 : Parallel group 3: Posters Freestanding 'GP' (5)

33. **Murat Unalacak (Turkey)**
Theses of family medicine residency in Turkey.
34. **Johannes Hauswaldt (Germany)**
'Chronic illness' and its determinants in gen.practitioners' medical records – A secondary data analysis.
35. **Indrė Rusakeviciūtė (Lithuania)**
GP home visits – should we go? One family medicine centre's experience.
36. **Magali Coppens (France)**
French consensus about gut feelings in general practice.
37. **Waltraud Fink (Austria)**
Robert N Braun's 'House of general practice'.

11.10 – 12.40 : Parallel group 4: Posters Freestanding 'Clinical' (4)

38. **Ildikó Gágyor (Germany)**

Randomised controlled trial of ciprofloxacin versus ibuprofen in the treatment of uncomplicated urinary tract infection – a feasibility study in German gen.practice.

39. **Peter Torzsa (Hungary)**
Socio-demographic and clinical characteristics, health behaviour and accident in snorers: a population survey.
40. **Andrea Dunai (Hungary)**
Does obstructive sleep apnea (OSA) correlates with sexual problem and impotence?
41. **Claude Piriou (France)**
Generalized anxiety disorder diagnosis.

11.10 – 12.40 : Parallel group 5: Posters Freestanding ‘Prevention’ (3)

42. **Frances Griffiths (United Kingdom)**
Discerning the dynamic of living with diabetes.
43. **Assumció Gonzalez Mestre (Spain)**
Type 2 diabetes patients with chronic renal failure. Do GP consider it.
44. **Nevenka Radosavljevic (Serbia)**
Prevention and therapy challenges of hypertensio arterialis.

12.40 - 14.10 : Lunch

14.10 - 14.40 : Plenary Session in: Main hall
●● **Chairman's report by Prof. Paul van Royen : Report of Executive Board and Council Meeting.**

14.40 - 15.00 : ●● Introduction on the next EGPRN-meeting in Bertinoro-Italy by the Italian national representative.

**15.00 – 15.20 : 2 One-Slide/Five Minutes presentations
in: Mátyás I-II**

45. **Mercier Alain (France)**
Caregivers of patients suffering from Alzheimer disease in primary care: difficulties and needs; consequences for the general practitioner.
46. **Osnat Melamed (Israel)**
A clinical decision tool to assist physicians' management of acute cystitis.

15.20 – 16.00 : Coffee/Tea Break

**16.00 – 17.00 : 2 Freestanding Papers on ‘Health Care’
in: Mátyás I-II**

47. **Hay Derkx (The Netherlands)**
Quality of communication during telephone triage at Dutch out-of-hours centres.
48. **Shlomo Vinker (Israel)**
Do doctors look after themselves as well as they could?

- 17.00 – 17.30 :** **Plenary Session in: Main hall**
- **Closing of the day by Prof. Richard Hobbs and Prof. Arno Hoes,** keynote speakers, who will both take the lead in summarizing on today’s theme papers.
 - **Presentation of the EGPRN Poster prize.**
 - **Closing of the conference by Prof. Paul van Royen, EGPRN chairperson.**

Social Program :

- 20.00 - :** **Social Night - Dinner, speeches and Party
at the Columbus Pub and Restaurant Állóhajó (anchored ship)**

Location: in Hungarian: 4. számú kikötő Vigadó tér 1051 Budapest
in English: Dock No. 4 Vigadó Square 1051 Budapest
(30 minutes walk from Hotel Mercure)

Entrance Fee: € 30,= per person.

SUNDAY 19th OCTOBER, 2008:

Location: Hotel Mercure Budapest Buda
Address: Krisztina Körút 41-43, H-1013 Budapest

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

FRIDAY 17th OCTOBER, 2008:

Location: Hotel Mercure Budapest Buda
Address: Krisztina Körút 41-43, H-1013 Budapest

08.50 - 09.10: 1st Keynote Speaker: Professor Carlos Brotons, chair of research unit in primary care at the Sardenya Primary Health Care Center in Barcelona, Spain and chair of the Europrev network.

Theme: "Research on the Integrated Management of Cardiovascular Diseases (mainly On the domain of prevention)".

National guidelines and most recent European Guidelines on cardiovascular disease prevention in clinical practice (1) encourage priorities and implementations strategies that are adapted to suit local conditions, both medical and economic. The encouragement of total risk estimation as a crucial tool to guide patient management has been a cornerstone of the Guidelines. It is recognized that CVD risk factors cluster and interact multiplicatively to promote vascular risk. This knowledge led to the development of multivariable risk prediction algorithms incorporating these risk factors that can be used by primary care physicians to assess in individual patients the risk of developing all atherosclerotic CVD, or specific components of CVD, ie, coronary heart disease, stroke, peripheral vascular disease, or heart failure. In addition to reducing the number needed to treat to prevent a CVD event, multivariable risk assessment also avoids overlooking high-risk candidates with multiple marginal risks factors and avoids needlessly alarming persons with only 1 isolated risk factor. Despite the availability of several validated risks prediction algorithms, their use has lagged in primary care and many high risk patients are still not reaching lifestyle and risk factors goals. The EUROACTION project showed that a nurse-lead multi-disciplinary team approach, coupled with the support and involvement of a patient's partner and family, can yield significant lifestyle improvements and risk factor reductions in coronary patients and patients at risk of developing cardiovascular disease (2). Also, the CHECK-UP study has demonstrated that discussing risk with the patients is associated with a small but measurable improvement in the efficacy of lipid therapy (3). However, it is unknown whether reducing the global risk of patients with an increased risk of CV disease- rather than decreasing isolated risk factors- also provides cardiovascular benefit in terms of morbidity and mortality.

Bibliography

1. Grahm I et al. European guidelines on cardiovascular disease prevention in clinical practice: full text. Fourth Joint Task Force of the European Society of Cardiology and other societies on cardiovascular disease prevention in clinical practice (constituted by representatives of nine societies and by invited experts). Eur J Cardiovasc Prev Rehabil. 2007; 14 Suppl 2:S1-113.
2. Wood D, et al. EUROACTION: Nurse-coordinated multidisciplinary, family-based cardiovascular disease prevention programme (EUROACTION) for patients with coronary heart disease and asymptomatic individuals at high risk of cardiovascular disease: a paired, cluster-randomised controlled trial. Lancet. 2008;371:1999-2012.
3. Grover SA, et al. Patient Knowledge of coronary risks profile improves the effectiveness of dyslipidemia therapy. The Check-UP study: a randomized controlled trial. Arch Intern Med 2007;167:2296-2303.

FRIDAY 17th OCTOBER, 2008:

Location: Hotel Mercure Budapest Buda
Address: Krisztina Körút 41-43, H-1013 Budapest

09.10 – 09.30: 2nd Keynote Speaker: *Professor Manfred Maier*, chairman,
Dept.Gen.Practice and Family Medicine and head, Center for Public
Health, Medical University of Vienna, Austria.

Theme: "Measuring the impact of family medicine research: scientific citations or societal impact?"

The ultimate goal of biomedical research is to improve the health of the population. This requires both the generation of new knowledge and its transfer into clinical practice; this means translation and implementation of scientific discoveries, in order to promote a change for the better in the practices of health professionals, in patient's behaviour or at the level of the society. Research should, therefore, be of the very best quality and assessment of its impact is important.

Attempts to assess the impact of scientific research are always difficult and to a large extent depend on the method of measurement and its goal. For example, is the identification of molecular mechanisms of health and disease and the development of new pharmaceuticals of prime importance or is it rather important to find ways to change patient's lifestyle or to increase their compliance with a drug regimen? Traditionally, both research and scientists are evaluated by means of the "scientific impact" of research output, e.g. publications in biomedical journals. Increasingly, the "scientific impact factors" of these journals, a measure of citation frequency, are also used to evaluate academics nominated for promotion and to allocate research funds to scientists or institutions.

Ideally, the scientific output of biomedical research should be assessed in terms of its relevance for the health of the population. Applied health research and in particular General Practice/Family Medicine has a dual mission of being both scientific and relevant to society. As a consequence, therefore, relevance to society could be assessed by the "societal impact (factor)" which should complement the "scientific impact" and its commonly used assessment instrument. Such an approach should be important since it would provide an incentive for all investigators to improve their performance in this respect and would avoid societal impact being considered as merely an option.

FRIDAY 17th OCTOBER, 2008:

Location: Hotel Mercure Budapest Buda
Address: Krisztina Körút 41-43, H-1013 Budapest

09.30 – 09.50: 3rd Keynote Speaker: Professor László Kalabay, Head of Department of Family Medicine, Semmelweis University, Budapest, Hungary
Theme: "GP Research in Hungary. The state of the art".

I. Introduction of primary care and research in Hungary

The 10 million population of Hungary is served by 6834 practices, i.e. a mean of 1500 persons per praxis are registered. Half of the practices serve adults, a quarter is paediatric and a quarter serves both, respectively. The number of unoccupied practices varies between 130 and 160. 95% of practices are privatised and work in the single office model. The mean age of GPs is 57 years. The equipment and working conditions will also be discussed shortly.

Research in primary care has had long traditions in Hungary. The first scientific organisation in primary care the Scientific Society of Hungarian General Practitioners (MÁOTE) was established 41 years ago. With its more than 300 members the Research Organisation of Hungarian Family Physicians (CSAKOSZ) is another dominant forum of GP research. The College of Hungarian Teaching Family Physicians (MOCSAK) plays in central role in education. Today the departments of family medicine of the four medical universities (in Budapest, Debrecen, Pécs and Szeged) and the National Institute for Primary Care (OALI) form the basis of research activity. Several large studies have been conceived and conducted in primary care. Most of them are epidemiologic and descriptive, and have been presented mainly at domestic conferences and publications. Much less of them were presented at international congresses or published in books and journals.

II. Brief description of some representative studies

- 2001, Department of Family Medicine Semmelweis University. Stroke Care in family practices. Physical status, stroke history, hospital treatment and medication of 7346 patients with stroke from 750 practices were assessed and analysed. The study was repeated on 2305 patients of 300 practices in 2004. Treatment became more effective over these 3 years.
- 2002, Department of Family Medicine Semmelweis University. Optimal hypertension care in family practices. 4402 patients were involved and followed for 7-8 months. The usefulness of home blood pressure monitoring and implementation of current guidelines were tested in everyday practice.
- 2003, Department of Family Medicine Debrecen University. The cardiovascular risk of 1320 patients was assessed. An other study on the effectiveness of treatment of risk factors indicated target values of blood pressure have been achieved fairly frequently even in international comparison. Target values of diabetes and hyperlipidaemias, however, were reached at an insufficient rate.
- 2005, OALI. Assessment of the cardiovascular risk factors of the Hungarian population involving 41111 persons.
- 2005, Department of Family Medicine Semmelweis University and OALI. The usefulness of self-questionnaires in estimating the frequency of severe drinking problems in an unselected patient population (17924 patients from 250 practices) was determined. 2622 (14.6%) patients with dangerous level of alcohol consumption were identified. Following a brief intervention 124 (6.9%) of the true alcohol patients volunteered to be treated (0.69% of the whole study population).
- 2007, Department of Family Medicine University of Pécs. The attitudes of 300 American and 339 Hungarian GPs towards hospice care of terminally ill patients were compared.
- 2007, Department of Family Medicine Semmelweis University and MOCSAK. The cross-sectional study HURAC (Hungarian Uric Acid Study) involved 11254 persons over 40 years from

360 practices with the aim to determine the prevalence of hyperuricaemia and its association with cardiovascular diseases in Hungarian population.

III. Current issues of conducting research in primary care

The lack of independent financing results in dependence on support from pharmaceutical companies. Rigorous application of scientometric indices, when compared to other fields of medicine, does not permit to get big grants for research in primary care. Ageing and increasing retirement of GPs, along with insufficient supplementation with freshly graduated doctors who are committed in research is also a serious problem. Heavy workload in the single office structure does not always favour research activity.

SATURDAY 18th OCTOBER, 2008:

Location: Hotel Mercure Budapest Buda
Address: Krisztina Körút 41-43, H-1013 Budapest

08.30 – 08.50: 4th Keynote Speaker: Professor Arno Hoes, Professor of Clinical Epidemiology & General Practice, Julius Center for Health Sciences and Primary Care University Medical Center Utrecht, The Netherlands.

Theme: "Diagnosis and Diagnostics Measures/Instruments for Cardiovascular Diseases".

A new test to diagnose cardiovascular disease. Should I use it in my practice?

Diagnosing cardiovascular disease (eg heart failure, myocardial infarction, pulmonary embolism) in primary care is notoriously difficult. This is at least partly attributable to the limited diagnostic value of signs and symptoms and the lack of availability of useful additional diagnostic tools in the primary care setting. With the identification of a number of potentially useful biomarkers (such as (BNP and D-dimer) and the development of rapid point-of-care tests to measure the levels of these parameters, the diagnostic management of suspected cardiovascular disease in primary care may change.

Before such tests, however, can and should be applied in daily practice, research proving the diagnostic value of these tests should be available. In contrast to research assessing the value of new therapeutic interventions, there is no real consensus about the methodological paradigm of such studies. Consequently, the evidence for novel diagnostic tests is often either lacking altogether or methodologically flawed. In addition, many studies are performed outside the primary care setting, hampering the applicability of the findings in general practice.

During the presentation, first the conditions that should be met in order to provide clinically relevant evidence on the diagnostic value of novel tests in the primary care setting will be discussed. These will be illustrated and discussed using examples from recently completed or ongoing studies, with emphasis on suspected heart failure and myocardial infarction.

SATURDAY 18th OCTOBER, 2008:

Location: Hotel Mercure Budapest Buda
Address: Krisztina Körút 41-43, H-1013 Budapest

08.50 – 09.10: 5th Keynote Speaker: Professor Richard Hobbs, Professor and Head of Primary Care Clinical Sciences, University of Birmingham, United Kingdom.

Theme: "Epidemiology and Management and Cardiovascular Diseases".

Disease burden and management of heart failure - evidence from a primary care research programme

Heart failure is an increasingly important problem for most developed healthcare systems. Unlike most cardiovascular diseases, which have declined in prevalence in developed healthcare systems over the last 20 years, the incidence of heart failure continues to rise,ⁱ due in part to improved survival following acute myocardial infarction and an increasing elderly population. However, until recently the community prevalence was not well elucidated, being based on small or hospital based cohorts. The Echocardiographic Heart of England Screening Study (ECHOES) systematically established the community prevalence, showing heart failure is almost as common in older adults as diabetes mellitus, occurring in around 2% of the adult population,ⁱⁱ rising to 30 per thousand in over 75 year olds. Prevalence of left ventricular systolic dysfunction (LVSD) in adults is better identified at between 1.8% and 2.9%,^{iii,iv} dependent on background cardiovascular risk. Around 50% of people with LVSD will be symptomatic and therefore classifiable as suffering heart failure.^{2,4} The prevalence of borderline systolic dysfunction is not as well elucidated, but was 0.8% in ECHOES.²

Symptomatic heart failure has a major impact on patients and healthcare systems and is only second to stroke in terms of healthcare utilisation costs, mainly due to high rates of hospitalisation.^v European health service burdens are of similar proportions, with 5% of all admissions in the UK linked to heart failure.^{vi} Heart failure has been described as a 'malignant diagnosis,' with a worse prognosis than breast or prostate cancer. However, again the data on mortality is based on mainly hospital diagnosed series and ECHOES has recently reported more generalisable 5 year mortality estimates. In addition to the high mortality rates, patients with heart failure do suffer from a grossly impaired quality of life,^{vii} with significant morbidity from symptoms such as dyspnoea and fatigue.

Accurate and early diagnosis is important since angiotensin converting enzyme (ACE) inhibitors improve both morbidity and mortality in all grades of symptomatic heart failure due to LVSD,^{viii} and can delay or prevent progression to symptomatic heart failure.^{ix,x} More recently, the significant prognostic benefits of beta-blockers and angiotensin receptor blockers^{xi} in heart failure due to LVSD,^{xii} and aldosterone blockade in severe heart failure,^{xiii} have been demonstrated.

Unfortunately, however, heart failure is difficult to accurately diagnose on clinical grounds. The principal presentations of shortness of breath and lethargy are extremely common and non-specific, especially in the elderly. It is therefore unsurprising that studies exploring the validity of a clinical diagnosis of heart failure in primary care, report high rates of misdiagnosis when patients are assessed against objective criteria (25-50% accuracy reported in different series^{xiv,xv,xvi}). To positively establish a diagnosis of heart failure requires, in most situations, cardiac imaging and, in some cases, specialist assessment. Given the practical limitations of such services, the potential role of natriuretic peptide assays as a triage tool for referral and to possibly guide treatment titration has been debated. Our ongoing heart failure research programme has contributed to this debate, reporting on the utility of these peptides in diagnosis^{xvii,xviii} and latterly, with the University of Oxford, in guiding therapy. This presentation will discuss how this research programme has delivered in a number of original areas and report where follow up work has not been possible.

PRESENTATION 1: Friday 17th October, 2008
09.50 – 10.20 h.

THEME PAPER

TITLE: Secondary prevention of heart disease in general practice: a cluster randomised controlled trial of tailored practice and patient care plans (ISRCTN24081411)

AUTHOR(S): Andrew Murphy, M.E. Cupples, S.M. Smith, Mary Byrne
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Background:

Key issues remain uncertain regarding interventions designed to improve outcomes in patients with established heart disease, including optimal design, frequency and duration.

Method:

Cluster randomised controlled trial involving 48 of 160 eligible general practices in two separate healthcare systems testing a multi-faceted complex intervention developed according to the MRC framework. The intervention included two elements: tailored practice care plans (comprising practice based training, individual practice support enhanced by a quarterly newsletter) combined with tailored patient care plans (based on motivational interviewing, goal identification and target setting for lifestyle change). Control practices continued to provide usual care. Primary outcomes, at eighteen months follow up, were blood pressure, total cholesterol, physical and mental health status (SF-12) and hospital admissions.

Results:

Of 903 participants, 838 (92.8%) completed follow-up and we analysed primary endpoints for a minimum of 762 (84%). No treatment effect, in terms of change from baseline, was found for three of the primary outcomes: systolic blood pressure (mean difference between interventions and controls 3.31mmHg [95% CI -1.02 to 7.63]), total cholesterol (mean difference 0.13mmol/l [95% CI -0.03 to 0.30]), SF-12 physical (mean difference -0.78 [95% CI -2.58 to 1.03]), and SF-12 mental (mean difference -0.02 [95% CI -2.40 to 2.35]).

However, hospital admissions were significantly reduced by a mean difference between interventions and controls of 0.15 admissions over 18 months [95% CI 0.01 to 0.29].

Conclusions:

This complex intervention resulted in significant reductions in hospital admissions but, possibly as a result of a ceiling effect related to improved anagement of cardiac disease in the community, did not provide other clinical benefits.

PRESENTATION 2: Friday 17th October, 2008
10.20 - 10.50 h.

THEME PAPER
Study proposal / idea

TITLE: Self monitoring blood glucose(SMBG) frequency and Metabolic control. A prospective and multicentre cohort study.

AUTHOR(S): Xavier Cos, Daniel Martinez, Manel Mata, Marti Birules, Julita Morro, Angels Conesa and Francesca Sancho

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Background:

Catalonian SMBG recommendations were published in 2001, but the accuracy was very difficult to check since most diabetic patients were visited by other professionals. Since 2002, our centre has undergone a progressive process of computer-assisted clinical recording.

Research question:

Is it the recommended SMBG frequency associated with a poorer metabolic control?

Aims:

to assess if T2D patients with an appropriate SMBG frequency according to our national guidelines have a worse control against those with other checking frequency.

Method:

Prospective cohort study. We'll study all type 2 diabetic patients, visited in 5 Primary Care Centres, taking antidiabetic drugs(oral therapy or insulin) with any HbA1c control between January to June 2008 in our reference lab centre.

We'll review computer clinical records collecting the following data: date of birth, gender, T2D treatment –secretagogues(SG),non secretagogues(NSG) drugs or insulin-,number of SMBG/week and HbA1c value. We'll classify SBMG use in three categories(cohorts): correct, overcheck and undercheck. During a year we'll register the variation in number of SMBG/week, in treatment and in patient's habits. Between the 9 and 15 months after the first HbA1c control we'll carry on a second one. We'll calculate the HbA1c difference and we'll classify in two categories: a poorer metabolic control (if HbA1c difference is higher to 2 SD(1%)) and a better or in the same way metabolic control (if HbA1c difference is < to 2SD (1%)).We'll calculate the global Prevalence Ratio and for each treatment category with 95% CI.

Conclusions:

With these results we would like to have hard data related to SMBG in our diabetic patients, considering them to readapt our recommendations.

The cohort study also will give us more information about the benefits of SMBG in this therapeutic subgroup.

Points for discussion:

- Usefulness of SMBG in Primary Care
- Are present recommendations equal in all European countries? (evidence based medicine and economics)

PRESENTATION 3: Friday 17th October, 2008
11.20 - 11.50 h.

THEME PAPER

TITLE: What knowledge of their hypertension primary prevention-treated patients have?

AUTHOR(S): Hélène Vaillant-Roussel, Philippe Vorilhon

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Background:

The frequency and complications of hypertension makes it a major issue in public health. Several studies have shown that treatment adherence are often imperfect. The purpose of this study was to explore the patients' representation of their hypertension risk as well as to inform their caregivers about meaningful education messages.

Research question:

What knowledge of their hypertension primary prevention-treated patients have?

Method:

Qualitative study by semi-structured interviews. In 2007, 24 patients were interviewed within three surgeries. The responses were recorded and transcribed and then analyzed thematically. Patients had to be at least 18 year-old and treated for hypertension in primary prevention for at least a year.

Results:

Patients had a good knowledge of their treatment and blood pressure goals. The lifestyle measures were known but were declared to be apply in a case out of two. Symptoms were heart-related, loss of self-control or a body malfunction. The main themes were the nerves, blood and blood-pressure. Nosological entity "nervous tension" was identified as a cause of hypertension, resulting from the interaction of social pressure and patient's temperament. When history existed in the entourage, the planned complications were related to the heart and brain in the form of disabling accidents.

Conclusions:

Representations of hypertension are heavily dependent on the personal experience of the patient, his fears and his entourage. The general practitioner should inform patients of treatment goals and feared complications in a non-threatening therapeutic alliance.

Points for discussion:

- patient's representations
- risks and adherence
- the therapeutic alliance

PRESENTATION 4: Friday 17th October, 2008
11.50 – 12.20 h.

THEME PAPER

TITLE: Electronic health record systems and global cardiovascular prevention.

AUTHOR(S): Annelies Van Linden, Nathalie Van de Vyver, Ester Cornelis,
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Background:

The Flemish guideline on □ Global Cardiovascular Prevention □ (GCP) for general practitioners (GPs) was published in September 2007. Electronic Health Record Systems (EHRS) are potentially important tools to facilitate the implementation. In Flanders there are 14 different EHRS, and they differ greatly from each other.

Research question:

Do the Flemish EHRS allow GPs to implement a GCP strategy?

Method:

From the guideline we extracted a set of 20 parameters, all of which are to be completed in the EHRS in order to end up with a global risk score that is necessary to choose the form and intensity of the therapy. Next, these parameters were discussed in group with user group key-representatives (practicing GPs) of the four most popular used EHRS and two others. Every representative then examined and described – by a live presentation of his EHRS - which parameters are allowed for in his EHRS. Last but not least, the resulting report will be discussed with the different EHRS vendors.

Results:

The results for the different EHRS varied a lot. For instance, in some of them the indicators that are necessary to calculate a patient's global risk (high, medium or low), had to be manually entered one by one into a separate calculator module, while others allowed for a fully automatic calculation based on indicator scores that were entered previously and elsewhere in the EHRS (i.e., when the purpose of calculating a global risk score was not yet envisaged). None of the systems allowed for an optimal registration of all parameters.

The results of the discussion with the EHRS vendors will be available in September 2008.

Conclusions:

The current versions of the most popular Flemish EHRS are not good enough to fully implement GCP. Important changes are to be made before they can fulfil their true potential.

Points for discussion:

1. How is it in other countries: does your EHRS allow for an easy/easier implementation of GCP?
2. Whom, in your opinion, should take action (and if so, what action?) to improve the degree to which EHRS allow for the implementation of good practices?

PRESENTATION 5: Friday 17th October, 2008
12.20 - 12.50 h.

THEME PAPER
Ongoing study, no results yet

TITLE: Cardiovascular Risk and Intervention Study in Croatia-family medicine.

AUTHOR(S): CRISIC-fm investigation group (Biserka Bergman Marković; leader;
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Background:

Cardiovascular diseases (CVD) are leading cause of death in Croatia and worldwide and great economic burden for health care systems. CVD prevention should include proactive approach to all with additional care for high risk groups. Total risk estimation significantly surpasses sum of individual risk factors and it is recommended.

Research question:

Assumption is that total CV risk estimation using SCORE (Systematic Coronary Risk Evaluation) risk-chart in primary prevention (PP) in intensive intervention group (IIG) (using measures accepted by professional societies guidelines) could result in greater primary CV endpoints reduction compared to single factor approach in conventional intervention group (CIG).

Method:

Multicentric, prospective, randomised, cohort study is planned. Sample of 64 general practitioners (GP) is stratified, each GP includes systematic random sample of 55 patients aged ≥ 40 who meet inclusion criteria and visit during two months period. Study questionnaire was created and validated [sociodemographic data, anthropometric measurements, family and personal medical history, current medication, nutritional, smoking and drinking habits, physical activity, QOL, blood and urine analyses, ECG, SCORE, Framingham risk-chart, MNA-scale (nutritional assessment for aged ≥ 65 yrs)]. GPs randomised in IIG (N=32) were educated to perform in systematic manner, risk factors follow-ups precisely set, GPs randomised in CIG (N=32) perform "the usual way". After 18 months period, cohort of CV at risk patients from both groups will be retested using identical methods. SSD (baseline and postinterventional parameters and total CV risk) between IIG and CIG will be tested (univariate multifactorial ANOVA, level of significance 95%; CI 95%; $P < 0,05$).

Results:

Survey is in progress.

Conclusions:

Concept of total CV risk estimation using SCORE risk chart in PP of CVD should substitute single CV risk factor approach in GP's practice. GP's systematic approach is considered to be more successful than conventional one in both PP and SP CV target groups.

PRESENTATION 6: Friday 17th October, 2008
11.20 - 11.50 h.

THEME PAPER

TITLE: Open access echocardiography in the Netherlands: an efficient service for detecting patients with (risk of developing) heart failure.

AUTHOR(S): Leanne van Heur, Marleen Tent, Leo Baur, Henri Stoffers

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Background:

In Eastern South Limburg an open access echocardiography service was started in 2002. It was the first service of this kind in the Netherlands. Main objective was to lower the threshold for evaluating patients suspected of heart failure. To prevent overload of the echocardiography department, referral indications were strict: dyspnoea, cardiac murmur or peripheral oedema.

Research question:

To evaluate demand for the service, GP participation, referral indications, echocardiography outcomes, and GP management.

Method:

The first 625 consecutive patients were evaluated (December 2002 – March 2007). Our data came from (1) GP referral forms; (2) echocardiography outcome letters; (3) a GP questionnaire on management. For the latter, GPs examined their electronic patient records for data on management after having received advice from the cardiologist.

Results:

The participation rate of GPs in using the service was 81% (105/129). 83% of all participating GPs returned the questionnaire on management. On average, a GP referred one patient per year to the service (range 0-9). Intended indications for referral were cardiac murmur (59%), dyspnoea (32%) and peripheral oedema (17%). Of the 'other' indications (22%), one-third was evaluated for suspected left ventricular hypertrophy (LVH). Main expected outcomes were left ventricular dysfunction (43%; 3% 'only systolic dysfunction') and valve disease (25%). An unexpected outcome was the proportion of LVH: 50% of all referrals. Only 24% of all echocardiograms showed no relevant disease. In patients with at least one abnormality, the cardiologist gave a specific advice in 47.5%. The GP followed the cardiologist's advice to refer the patient for further evaluation in 71%. Overall, 32% of patients with at least one abnormality (24% of all patients) were eventually referred to the outpatient department.

Conclusions:

Open access echocardiography was used efficiently and for good reasons by the GPs. Referral indications might be widened, e.g. with 'suspicion LVH'.

Points for discussion:

Open access echocardiography in other countries and health care systems. The use of regular patient care data for research purposes (ethics, quality). Medical students (first 2 authors) as novice researchers.

PRESENTATION 7: Friday 17th October, 2008
11.50 – 12.20 h.

THEME PAPER

TITLE: Effects on quality of life of patients with chronic systolic heart failure by a practice-based complex intervention - results of the Heidelberg Integrated Case Management (HICMan)-trial [ISRCTN30822978]

AUTHOR(S): Frank Peters-Klimm, A. Baldauf, T. Mueller-Tasch, J. Szecsenyi

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Background:

Patients with chronic systolic heart failure (CHF) have an impaired quality of life (QoL) and the delivery of care in General Practice is complex.

Research questions:

To test whether a comprehensive primary care-based case management (CM) can improve patients' QoL, decrease CHF-hospital admissions or death.

Methods:

HICMan is a randomised controlled trial conducted in German general practices with patients with ascertained left ventricular systolic dysfunction (EF≤45%) with a 12-months follow-up. Structured, standardised CM consisted of telephone monitoring, home visits with additional diagnostic screening (in 3 to 6 week intervals) by a prior trained doctor's assistant. Patients from control group received usual care (UC). GPs were introduced to guideline-oriented management and health counselling. Main outcome measurement for patients' QoL was the scale physical functioning (PF) (SF-36). One secondary outcome was disease-specific QoL (Kansas City Cardiomyopathy Questionnaire=KCCQ). To evaluate time and group effects for first overall analyses of QoL, an analysis of variance with repeated measurements was performed.

Results:

199 eligible patients (targeted: 188) were randomised to CM vs. UC group (n=99/100). 5vs.5 patients died and 7vs.2 discontinued the intervention. 11vs.7 patients accounted for 18vs.9 heart failure hospital admissions (combined endpoint 16vs.12). First analyses for the scale PF showed mean scores (SD) at baseline of 49.5(29.1)vs.50.7(27.1) and 50.7(27.1)vs.51.7(29.6) with no effects. Time x group effects could be shown for mean scores (SD) of the scale Vitality in favour of CM (at baseline 43.1(22.7)vs.47.7(22.3) and 47.6(23.9)vs.43.9(21.1 at follow-up) (p=.003). The KCCQ-domains Symptom Frequency and Self Efficacy showed positive time effects (p=.086/.006). Symptom Variability improved in favour of UC (p=.032).

Conclusions:

First overall analysis showed no significant changes with regard to the primary outcome. For other outcomes, mixed results were obtained. Differentiated results regarding adjustments of analysis will be presented at the meeting enabling for more definite conclusions.

Points for discussion:

- "Clinical relevant" changes in QoL scores
- Contamination

PRESENTATION 8: Friday 17th October, 2008
12.20 - 12.50 h.

THEME PAPER

TITLE: Arrhythmias in Primary Care: Common treatment failures that could be Adjusted.

AUTHOR(S): Charilaos Lygidakis, S. Argyriadou, A. Lygera, T. Georgiadou
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Background:

Although arrhythmias are a common symptom resulting frequently in serious implications on patient's health and their quality of life, they are often treated inadequately by the family doctors. Patients reporting recurrent arrhythmias or palpitations sometimes receive anti-anxiety medicines, such as Benzodiazepines, without any other specific treatment.

Research question:

Our study aimed at reporting on effectiveness of treatment and the personal health perception of the arrhythmic patients, in the Health Center of Chrisoupolis in Greece.

Method:

During the last semester of 2007, 212 patients reported for the first time or repeatedly, arrhythmic symptoms (90 males, 122 females; mean age=67.13; sd=9.97). Demographics, habits, history of arrhythmia and background regarding related chronic diseases, medicine treatment and the General Health Questionnaire – 12 (GHQ-12) to evaluate the personal health perception, were queried. Physical examination, auscultation and ECG were also performed. Finally, lab analysis or referrals were conducted when appropriate.

Results:

20.8% reported more than five arrhythmic episodes in the past 6 months. The most common type was the atrial fibrillation/flutter (65.1%); 72.5% of them received anti-anxiety therapy and 63.8% anti-arrhythmics. 30.7% of the arrhythmias were triggered by non-cardiac causes. 79.1% of the patients were diabetic, 26.4% of them didn't receive any anti-arrhythmic therapy ($p=0.001$) and 16.0% received anti-anxiety medicines ($p=0.006$). Only 25 of the 152 referrals to a specialist had a pathological ECG at the moment of the examination ($p<0.001$). Patients were 2.39 times more likely to be referred if presented more than one arrhythmic episode ($p=0.005$). Those having experienced few episodes of arrhythmia per day had a significantly worse GHQ (Mdn=13.00) than the ones having sustained few episodes per month (Mdn=10.50, $U=882.00$, $p=0.014$).

Conclusions:

The high percentage of arrhythmic patients with inappropriate therapy should enforce GPs' awareness to follow treatments according to the guidelines.

PRESENTATION 9: Friday 17th October, 2008
14.15 – 14.45 h.

FREESTANDING PAPER

TITLE: Are CME-journals corrupt? And if yes, how much?

AUTHOR(S): Norbert Donner-Banzhoff, F. Dörter, K. Eckhardt, M. Kochen
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Background:

For their prescribing GPs need unbiased information on drugs. For this, GPs only very rarely rely on original papers. Most information they use is processed to some degree. Despite the availability of electronic information print journals remain an important source of prescribing information. Journals read by GPs differ by the degree they depend on advertising by drug companies. On one hand there are CME-journals that rely heavily on advertising without paying subscribers. On the other hand there are drug bulletins that carry no advertisements to preserve their independence. Their income is based exclusively on subscription payments.

Research question:

Is there an association between the source of funding of a journal (advertising) and recommendations with regard to drugs (editorial content)?

Method:

Eleven periodicals typically read by German GPs we analyzed for a one year period. We defined three categories of journals: 1) no advertising, subscription only, 2) mainly advertising, no or negligible subscriptions, 3) mixed. Recommendations for or against ten recently introduced drugs in articles were systematically quantified. We selected clopidogrel, incretine enhancers, glitazones, insulin analogues, AT1-blockers, ezitimibe, acetylcholine-esteraseinhibitors, pregabalin, duloxetine, TNF-alpha-blockers. Raters were blinded to the source by scanning each article and pre-sending it in neutral format. The tendency (bias) of these recommendations were analyzed according to journal category and the amount of specific advertising. We also investigate "coincidences" of specific recommendations (editorial content) and advertising within one issue.

Results:

This is work in progress. Results will be presented at the upcoming EGPRN meeting.

Conclusions:

The above formulated hypotheses have been shown to apply to consumer information of financial services. If this kind of bias existed also for drug prescribing information, this would be a matter of concern.

Points for discussion:

1. These data require complex statistical analysis. Do EGPRN participants agree with our strategy?
2. What is the external validity of our results? Do countries differ?
3. What can be done to reduce bias in prescribing information for GPs?

PRESENTATION 10: Friday 17th October, 2008
14.45 - 15.15 h.

FREESTANDING PAPER

TITLE: Patients' perceptions of osteoarthritis handling.

AUTHOR(S): Isabelle Aubin-Auger, L. Baumann-Coblentz, D. Baruch, Y. Mazouz
A. Mercier

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Background:

Osteoarthritis is a very common pathology, concerning in France about ten million patients. It is a disabling disease leading to possible important changes in patients' life because of both pain and movement limitations. On GP's side, it is a very banal and mild pathology since it will not threaten life. EBM recommendations propose first non-pharmacological measures such as daily activity, weight reduction and physiotherapy. The first medication recommended is paracetamol. It appears that there could be a gap between patient's perception of his pathology and his everyday life impairment and the medical management.

Research question:

How do patients feel about their osteoarthritis treatment and its apparent simplicity?

Method:

Qualitative study. Patients with severe arthrosis leading to surgery have been excluded
Twenty Semi structured interviews have been conducted by four researchers - asking patients from Paris and its suburbs – which have been recorded, transcribed, coded and analysed.

Results:

Most of the patients had bad feelings about arthrosis: they considered it as a severe illness possibly leading to a wheelchair. They described a poor quality of life impaired by pain and movements limitation They felted that GPs and the other specialists as well as their relatives did not understand and trust them While doctors proposed walking and paracetamol, patients sought for help in non conventional medications and therapies

Conclusions:

there is a misunderstanding between patients and doctors concerning arthrosis management; it seems to be a gap between patients' and doctors' representations of this very common pathology . The information given by the doctors and the disease management did not appear to be clear , understandable and acceptable by the patients.

Points for discussion:

-how improve patients information about osteoarthritis?

PRESENTATION 11: Friday 17th October, 2008
15.15 - 15.45 h.

FREESTANDING PAPER

TITLE: Muscular and skeletal disorders' associations among employable French patients.

AUTHOR(S): Pascale Santana, P. Clerc, G. Hebbrecht

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Background:

A former study about chronic diseases in France showed a high prevalence of muscular and skeletal disorders (MSD) among patients aged 26-59. A discriminative analysis of this population showed that some patients suffered from multiple MSD. MSD are a major public health and occupational medicine concern in France.

Research question:

To assess the most frequent chronic MSD associations among employable French patients.

Method:

Descriptive cross sectional study between 2002 and 2004 using data collected by OGM, a French computerized network of GP using standardised clinical situations assessed by case definition and criteria. Data from 68 GP concerning 45,018 patients, 284,126 consultations for chronic disease, and 718,772 chronic problems were available. We included all patients aged 26-59 who consulted at least once for chronic MSD. The numbers of consultations, of overall chronic diseases, of different MSD were analysed using analysis of distribution and Chi2 test adjusted for gender, age, and both 26-39 and 40-59 age groups.

Results:

We found 21,880 patients presenting at least one MSD (48.6% of total population), in the majority females (55.7%) In 90% of the cases two or three different MSD were associated. Whatever the age, men had significantly more often lumbar pain associated with pain in another joint, including shoulder; epicondylitis appeared among the associations from 40 years onward. Among women, in the 26-39 year group lumbar and neck pain were significantly associated; from 40 years onward appeared articular pain and/or neuralgia associated with carpal tunnel syndromes. More detailed results by gender and age groups will be presented at the congress.

Conclusions:

GP have to carefully search for multiple MSD, the sooner the diagnosis, the better for the beginning of a prevention and care program, and an ergonomic adaptation of the workplace.

Points for discussion:

In France, public supported organisations developed an information media campaign ("Let's speak about them to make them recede") aiming at a better screening of MSD.

- How is it in your country?
- Did such a campaign prove efficiency?

PRESENTATION 12: Friday 17th October, 2008
14.15 - 14.45 h.

THEME PAPER

TITLE: Far from easy and accurate – metabolic syndrome diagnostics in Finnish primary care.

AUTHOR(S): Eeva-Eerika Helminen, Pekka Mäntyselkä, Irma Nykänen
Esko Kumpusalo

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Background:

Finland has been a pioneer in promoting the concept of metabolic syndrome (MetS) from the beginning of nineties. Nonetheless, it remains unclear how well the concept of MetS had been taken into practise by general practitioners. General practitioners hold a key role in recognising MetS.

Research question:

To assess how well general practitioners in Finland recognize MetS among patients with coronary heart disease or at least one of its risk factors.

Method:

The Heart 2005 study was performed in 26 randomly selected health centres around Finland representing all of Finnish primary care in terms of their size and location. The data was collected by 181 general practitioners. 1331 Finnish patients were collected from the natural patient stream during two working weeks in April 2005. 1180 of them filled in the patient's questionnaire and attended the nurse's appointment. The participation rate was 88.7%. We determined how many patients met the criteria for MetS according to measurements and records made at the nurse's appointment and answers in the patient's questionnaire. General practitioners' responded to a question about whether or not the patient had MetS. Modified National Cholesterol Education Program criteria for MetS were used in the study. Patients' answered to a question concerning whether or not they had been diagnosed with or treated for MetS.

Results:

Almost half of the study patients, 48.1 %, met the criteria for MetS. However, according to the general practitioners, only 28.5 % of the study patients had MetS. These groups did not match and the sensitivity of general practitioners diagnosis for MetS was 0.28 with a specificity of 0.71. Very few of the study patients, 7.1 %, themselves stated that they were suffering from MetS

Conclusions:

Metabolic syndrome is not being recognised by general practitioners in Finland. General practitioners' diagnostics of MetS is inaccurate.

Points for discussion:

1. What is the meaning of metabolic syndrome from the GP's point of view?
2. What could be the reasons why metabolic syndrome hasn't broken through for GPs?
3. What would be the best ways to investigate further what were the reasons for the GPs inaccuracy

PRESENTATION 13: Friday 17th October, 2008
14.45 – 15.15 h.

THEME PAPER
Ongoing study with preliminary results

TITLE: Cordiaal: a multi-faceted intervention program to implement a guideline on 'Global Cardiovascular Prevention'

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Background:

The 'Global Cardiovascular Prevention' (GCP) guideline for Flemish general practitioners (GPs) was published in September 2007. Two surveys show inappropriate implementation of GCP guidelines by GPs in Belgium (including Flanders). Researchers suggest multi-faceted approaches to overcome such underperformance.

Research question:

What interventions to implement the GCP guideline for Flemish GPs are feasible and effective?

Method:

Inspired by scientific literature and experience, the scientific association of Flemish GPs is coördinating a multi-faceted approach on different levels: the individual GPs, their practices, their local peer review groups, and their regional associations.

Interventions include: (1) written tools such as a guideline summary with a score card to calculate a patient's global cardiovascular risk, prescription decision aids, leaflets and other aids for patient communication, etc. (2) Product improvement suggestions for vendors of electronic health record systems. (3) A train-the-trainer program. (4) Facilitation of regional problem solving initiatives. (5) E-learning packages. (6) Sharing experience with European partners. (7) Lobbying to governmental bodies.

Intermediary results:

Feasibility: for some interventions it is very hard to find sufficient financial support (e.g., prescription decision aids and lifestyle oriented training modules). The pharmaceutical industry provided no funds, mainly because the guideline focuses on lifestyle interventions rather than medication and the scientific association declined offers that implied a sponsorship monopoly. This hampers a smooth progress and full roll-out.

Effectivity: we plan to evaluate all our interventions, but it is yet to be proven that our (inspired) expectations are valid. Most interventions haven't been completed yet. Only intermediary results can be presented.

Conclusions:

With the diverse interventions of our "Cordiaal" project, we tried our best to develop and implement a feasible and effective multi-faceted approach as suggested by scientific literature to overcome GCP underperformance. So far we learned mostly about its feasibility. The evaluation will prove or disprove its effectiveness.

PRESENTATION 14: Friday 17th October, 2008
15.15 – 15.45 h.

THEME PAPER
Ongoing study with preliminary results

TITLE: Decision support in general practice. Role of the Decision Support Module of RIGHT system in hypertension care.

AUTHOR(S): Zoltan Jancso, Attila Simay, Eszter Kovacs, Istvan Ilyes

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Background:

Diagnosis and treatment risk can be reduced by using IT support in general practices. This was a main conclusion of the conference of EU countries' health ministers in 2004, and the basis of RIGHT project (Reducing diagnosis and treatment risk by leveraging knowledge and practices of health care professionals) supported by EU's 6th framework.

Research question:

Is it possible to create an IT tool that can adequately support the diagnostic and treatment activities of GPs in everyday practice?

Method:

An international project consortium of 8 technical and "pilot" partners (one of them is the Department of Family Medicine, University of Debrecen) have been working on the development of RIGHT tool since 2006.

Results:

Now we have the prototype of the RIGHT tool with three modules (decision support module, semantic information retrieval module and collaboration module) that are integrated in electronic health record (eHR) used by Hungarian GPs and work in online connection with the system's server. In this presentation we demonstrate the functions of decision support module of the RIGHT system by running the hypertension care protocol.

Conclusions:

In this phase of the project our main task is to assess the opinions and feedbacks of GPs on the role of this IT tool in the care of patients with cardiovascular risks like hypertension.

Points for discussion:

1. Is the RIGHT tool useful enough to support GPs' work in everyday practice?
2. What are the limits of using decision support systems?

PRESENTATION 15: Friday 17th October, 2008
16.15 – 16.45 h.

FREESTANDING PAPER

TITLE: A matter of attention: Inconsistencies between prescription and drug intake in elderly multimorbid patients in primary care

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Background:

A major concern for patient safety is inappropriate medication use, in particular for elderly and multimorbid patients. Polypharmacy and prescriptions from different physicians combined with uncontrolled self-medication exaggerate the risks for inadequate pharmacotherapy.

Research question:

To determine the prevalence of inconsistencies between prescription and drug intake in elderly multimorbid patients in primary care.

Method:

Cross-sectional study collecting data on drugs prescribed by general practitioners (GPs) and, in a structured telephone interview with the patient, about medication use. In 20 general practices we randomly selected 15 from their most costly patients fulfilling inclusion (≥ 65 years, ≥ 3 chronic conditions, ≥ 5 drugs in long-term treatment) and exclusion criteria (living in nursing homes or unable to answer the telephone). Consecutively ten of these patients were included after giving written informed consent. Inconsistencies were defined as substances that were either not mentioned in the GPs' documentation or in the patient interview, or when dosages or dosing interval differed.

Results:

Of 162 included patients (50% male, median age 73 (range 65-97) years) 153 patients completed the interview. GPs documented 11 (4-33) diagnoses and 8 (5-16) prescriptions/patient. Patients reported a median intake of 9 (3-24) drugs. In 147/153 (96%) of the patients we found at least one inconsistency (median 5 (0-25)/patient): 224 drugs were prescribed for 104/153 patients, but not taken (1-9 drugs/patient); 284 drugs were taken by 110/153 patients (1-17 drugs/patient) without the GP's knowledge; 69 patients reported taking lower dosages than prescribed (1-4 drugs/patient); 63 patients reported higher dosages (1-5 drugs/patient); in 69 patients (1-5 drugs/patient) the actual dosing interval differed from prescription. Sixteen drug classes accounted for 80% of the variation in GP's documentation from interviews.

Conclusions:

Prescriptions and actual intake of drugs differed in most patients. Medication reconciliation by the GP may be time consuming but is necessary to improve patient safety.

PRESENTATION 16: Friday 17th October, 2008
16.45 – 17.15 h.

FREESTANDING PAPER
Ongoing study preliminary results

TITLE: Gender differences in symptom reporting in COPD patients

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Background:

In chronic obstructive pulmonary disease (COPD) it remains unclear whether there are substantial differences between men and women with respect to reported symptoms of the disease. Subjective complaints, however, are important for general practitioners in daily practice.

Research question:

The aim of our study was to determine the effects of gender on symptom reporting of COPD patients visiting primary health care. Subjective complaints included coughing, wheezing, phlegm production and nocturnal awakening.

Dyspnoea, scored by the MRC dyspnoea scale, and the frequency of exacerbations were also recorded. The impact of age and smoking behaviour was specifically taken into account.

Method:

We analysed clinical data of all patients in the region of Maastricht (the Netherlands) with an established diagnosis of COPD who had been automatically enrolled in a disease management program in general practice. Patients were asked for subjective and objective complaints in a structured way. Data from 1766 COPD patients (943 males and 823 females) from 42 general practitioners, gathered between May 2002 and June 2007 were included.

Results:

Subjective symptom analysis showed that younger men (age 41-55 years) reported more coughing, wheezing, phlegm and nocturnal awakening than women. After this age women showed more of these symptoms than men. Women aged 40-80 years reported not only more dyspnoea but also more exacerbations than men. Of the included patients, 432 (45, 8%) males and 516 (62, 7%) females were active smokers.

Conclusions:

Clear gender differences were found for both objective and subjective complaints in COPD patients, but a large impact of age and smoking behaviour was apparent as well. The typical reversal for subjective complaints around the age of 55 years might be explained by historical differences in smoking behaviour and the influence of paid work and type of peer groups on these complaints.

Points for discussion:

1. COPD and gender
2. subjective vs objective complaints

PRESENTATION 17: Friday 17th October, 2008
17.15 – 17.45 h.

FREESTANDING PAPER

TITLE: Management of chronic obstructive pulmonary disease (COPD) exacerbations: results of a French cohort study

AUTHOR(S): Denis Pouchain, J.L. Demeaux, Séverine Lignot Maleyran
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Background:

In 2001, the French Health Ministry developed a national plan to optimize antibiotics prescription. To this end it was deemed useful to describe the treatment interventions in disease situations where antibiotics are commonly used, such as COPD.

Research question:

To describe the management of COPD exacerbations by general practitioners (GPs) and pneumologists in France.

Method:

Prospective cohort study of patients with COPD exacerbations carried out with a representative sample of GPs and pneumologists. Patients diagnosed with COPD exacerbation were included from September 2006 to January 2007. Descriptive statistical analysis was weighted to take into account COPD exacerbation consultation activity and national distribution of GPs and pneumologists.

Results:

951 GPs and 89 pneumologists included 4575 and 419 patients respectively; 61.4% were male and mean age was 64.4 years. The mean COPD exacerbation case load of GPs and pneumologists was respectively 5.9 and 6.4 cases per month. Extrapolation to all GPs, pneumologists in France allows an estimation that GPs see 98% of the patients with COPD exacerbation. The main clinical signs of COPD exacerbation were: cough (93.7% for GPs, 94.3% for pneumologists), expectoration or increase of its volume (78.8%, 88.7% respectively) and dyspnea (74.1%, 93.6% respectively). Antibiotics were prescribed to 92.1% of GP patients and 79.8% of pneumologist patients. The most frequent antibiotics were co-amoxiclav (19.0%), telithromycin (10.1%) and clarithromycin (9.6%). Other prescribed drugs were oral corticosteroids (41.3% for GP and 51.5% for pneumologist patients), mucolytics (41.5%, 16.3% respectively) and beta2-agonists (30.4 %, 46.4% respectively).

Conclusions:

Most patients with COPD exacerbation were treated by GPs. Antibiotics and mucolytics were more frequently prescribed by GPs than pneumologists, oral corticosteroids and beta2-agonists were more frequently prescribed by pneumologists.

PRESENTATION 18: Friday 17th October, 2008
16.15 – 16.45 h.

FREESTANDING PAPER
Ongoing study preliminary results

TITLE: Eating Disorders: description of population taken care in GP. How to compare with controls?

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Background:

Prevalence estimates of eating disorders (ED) vary depending on assessment methods and on definitions used. It has been established that about 1% of young women have classic anorexia nervosa (AN) and that about 2%-5% meet criteria for bulimia nervosa (BN). Because most of patients deny their illness and its severity, treatments are often initiated with delay. Even if most of the GPs do not concern themselves with ED, only a minority of people with eating disorders, especially with bulimia nervosa, are treated in mental health care. One study showed that ED patients consulted significantly more in Primary Care than controls for gynaecologic and digestive symptoms over 6 months period prior to the diagnosis of the ED.

Research question:

Our study aims at 1/ describing patients consulting in GP for an ED 2/ comparing to control on frequency and type of care over the 6 months prior to diagnosis.

Method:

Descriptive study (1993-2007) on patients treated for eating disorder in the French GMO database, a computerized network of GP coordinated by French Society of General Medicine. We will analyze patient's characteristics: gender, age, episodes of care, frequency and type of care during the 6 months before the first contact for ED. The analysis is conducted with SAS 9.1.

Results:

Description: out of the 690 000 patients of the complete database, 1,300 patients (11-64 years old) were seen at least once for eating disorders by 100 GPs (range 1-68); 85.8% were females; mean age at first contact of is 30.3 years (ET=12.9). Analyses on frequency and type of care are in progress. A complete description will be presented in Budapest. The comparison rises some methodological questions.

Conclusions:

A better knowledge is necessary for a better screening. Hence better description among general practice population in this field is important.

Points for discussion:

- Which methodology to compare that ED population to others patients of the database? Matched control or analyses adjusted on age, gender, doctor, date of consultation? Others?
- What are the benefits or drawbacks to use either one or the other method?

PRESENTATION 19: Friday 17th October, 2008
16.45 – 17.15 h.

FREESTANDING PAPER

TITLE: Adherence to low back pain guidelines in primary care: a systematic Review.

AUTHOR(S): Jean-François Chenot, Carsten Oliver Schmidt

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Background:

Low back pain (LBP) is an epidemiologically and economically highly relevant disorder. Variation in care for low back pain (LBP) is substantial. Therefore national and European guidelines for management of LBP have been developed. To implement guidelines and assess their impact on patient care remains a difficult task.

Research question:

The aim of this review is to assess adherence to low back pain guidelines and the effect of guideline implementation strategies in primary care and patient relevant outcomes.

Method:

We performed a systematic literature search in Medline, EMBASE and some other data bases for studies on guideline adherence in LBP management in primary care. We searched studies published from 1994 when the Agency for Health Care Policy and Research guideline on LBP was issued to 2007.

Results:

We found three survey, seven observational studies and five controlled implementation trials. Most surveys and observational studies revealed low guideline adherence. Controlled trials showed mostly only moderate or minimal effects of targeted interventions. Criteria for guideline assessment were heterogeneous and often not clearly defined. Clinical data as modifiers of criteria for assessment of guideline adherence was not sufficiently taken into account. Most quality indicators are negative, e.g. no imaging or no prescription of physiotherapy within the first 4 to 6 weeks. Patient relevant outcomes like pain reduction and functional capacity have not been assessed.

Conclusions:

Adherence to low back pain guidelines is low. There is a lack of valid and consented quality indicators for assessing guideline adherence of management of LBP patients. Quality indicators reflecting patient relevant outcomes and clinical circumstances need to be developed. Future implementation trials should assess pain and functional capacity and not be limited to measuring guideline adherence.

Points for discussion:

Is LBP suitable for quality indicators at all?

Who should develop quality indicators for LBP?

How should patient expectations contradicting evidence be taken into account?

PRESENTATION 20: Friday 17th October, 2008
17.15 – 17.45 h.

FREESTANDING PAPER
Ongoing study, no results yet

TITLE: Patient competence, self-management and the doctor-patient-relationship in the case of neck pain - a qualitative study

AUTHOR(S): Helene Schaefer, Michael Kochen, Wolfgang Himmel, Martin Scherer

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Background:

There are two major problems for the management of neck pain in primary care: (1) most therapeutic approaches are not evidence-based; (2) many patients suffering from neck pain have also psychosocial problems. This constitutes a challenge for both general practitioners (GPs) and their patients.

Research question:

To find out how patients perceive and manage neck pain and what they expect from their doctors with the aim to find out how doctors can balance between prescribing ineffective treatments, supporting the patients' self-care activities and eliciting psycho-social aspects.

Method:

From a larger study of 432 neck pain patients in primary care, an initial random sample of ten patients was selected for semi-structured telephone interviews. Later a second sample was chosen according to the principles of theoretical sampling until data saturation was reached after a total of 20 interviews. Interviews were recorded, transcribed and labelled with ATLAS.ti. Labels were condensed to themes. Analysis was oriented to the approaches of Miles and Huberman and Ritchie, Spencer and O'Connor.

Results:

Patients described their pain in detail rather than using the term "neck pain". They often avoided psychosocial themes when talking to their doctors in order not to provoke a psychological hypothesis. Most people regarded themselves as competent and preferred self-care. When this was no longer sufficient they often visited their doctor with a precise demand for the treatment that they thought most effective. Patients were mostly satisfied with their GP but sometimes criticized specialists. Therapies like physiotherapy and massage were judged ambivalently, with massage considered as more effective.

Conclusions:

Patients use, and ask for, ineffective treatments. This could impede the conversation about reasons for neck pain and heighten the risk of medicalisation.

Points for discussion:

Should doctors avoid the term "neck pain" to encourage a broader conversation about the psychosocial background of the patients' complaints?
Should GPs refuse prescriptions and enforce a conversation about psychosocial issues?

PRESENTATION 21: Saturday 18th October, 2008
09.10 – 09.40 h.

THEME PAPER
Ongoing study with preliminary results

TITLE: The Influence of General Practice Opening Hours on Delay in Seeking Healthcare After Transient Ischaemic Attack and Minor Stroke.

AUTHOR(S): Daniel Lasserson, Arvind Chandratheva, Matthew Giles
Peter Rothwell, David Mant

ADDRESS:

CANCELLED

PRESENTATION 21: Saturday 18th October, 2008
09.40 – 10.10 h.

THEME PAPER

TITLE: Patients treated by anticoagulants wish more education.

AUTHOR(S): Sébastien Cadier, B. Cornec, N. Nabbe, M. Varnoux, P. Bail
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Background: anticoagulants are responsible for serious adverse effects like hemorrhage. Therapeutic education showed a decrease bleeding but we don't know neither what education the patients received in Finistère (France) nor their expectations for the management of their anticoagulant treatment.

Research question:

What therapeutic education on anticoagulants is received by patients in the Finistère, what is their knowledge and what are their expectations?

Method:

It is an opinion poll by postal questionnaire. We randomly selected 1,000 patients who have had a refund of an anticoagulant drug during the month of May 2007 in the Health Insurance Office's database. The questionnaire contains 20 items divided into 4 parts: patient characteristics and history of treatment, therapeutic education received and expectations, current management of treatment and knowledge's assessment. Analysis were performed with Epi Info 6 and SAS 9. The results are given in absolute and percentage of total respondents.

Results:

647 questionnaires were analyzed. 525 (81 %) received information about their treatment, 226 by their GP (35 %), by 163 hospital physician (25 %), or 96 both (15 %). Education was issued most often verbal 368 (57 %) sometimes associated with a written 108 (17 %). Knowledge control: 441 (68 %) managed correctly their treatment in case of INR too low. 419 (65 %) had a non-risky behavior in case of traumatism. 394 (61 %) of patients wish information about their treatment. 198 (31 %) wished double information (written and verbal) and 174 (27 %) in a face-to-face interview with their general practitioner. 189 patients (29 %) wished to learn self management.

Conclusions:

A majority of patients received verbal information about their treatment. Two third had good knowledge about the management. A majority wishes more verbal and written information and a third wish to learn self management. GPs are the most appreciated media.

PRESENTATION 22: Saturday 18^h October, 2008
10.10 - 10.40 h.

THEME PAPER
Study proposal / idea

TITLE: Type 2 Diabetes Mellitus Control in Mediterranean Countries: a Collaborative Survey in Primary Care settings.

AUTHOR(S): Ferdinando Petrazzuoli, Xavier Cos, Frank Dobbs, Christos Lionis
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Introduction and Aim:

Management of type 2 diabetes by general practitioners is often criticized for failing to achieve recommended clinical goals. This issue mainly explained by clinical inertia, which can be defined as failure to intensify treatment in patients who are poorly controlled. In the UK, an incentive scheme to improve quality of care delivered by primary health care was recently implemented. As a result, it has been shown that clinical indicators for quality management of type 2 diabetes have been greatly improved. The following study is aimed at measuring target's achievement for quality management of type 2 diabetes across different Mediterranean Countries. We also intend to compare our results with those achieved in UK.

Research question: What is the level of control of Type 2 diabetes among Mediterranean Countries in Primary Care settings?

Material and Methods:

We suggest to use a cross sectional design to describe management of patients. Data sources will be medical records of patients with type 2 diabetes having consulted in primary health care settings of different Mediterranean countries between January 2007 and December 2007. Records will be selected at random. The variables to be evaluated are: 1) sociodemographic parameters: educational level, age, sex...; 2) metabolic and clinical data: HbA1c, urinary albumine excretion rate (microalbuminuria), lipidemia (LDL cholesterol), blood pressure, diabetic complications, comorbidities. To assess quality of management, we will use the following targets: HbA1c<7% and SBP<130mmHg and/or DBP<80mmHg, microalbuminuria<30mg/day, and LDL<100mg/dl will be considered normal. We will obtain data from both rural and urban practices from each country involved.

Significance of this proposed study :

This study is purely descriptive. But we still think that it could be a reliable pilot study for future researches in this field.

Points for discussion:

relevance and feasibility of this study

PRESENTATION 23: Saturday 18th October, 2008
09.10 – 09.40 h.

THEME PAPER

TITLE: Cardiac arrest in Irish general practice: preliminary incidence data.

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Background:

Ireland has around 5,000 Sudden Cardiac Deaths (SCD) annually; estimates suggest up to 500,000 such deaths in the EU each year. Virtually no data exist on the role of general practice in the management of these events. SCD is common, usually occurs in the home, work or community and anecdotally involves many GPs at some point in their working careers. In Ireland, survival rates from out-of-hospital cardiac arrest are reported at less than 5%. Can a systematic initiative support GPs in the management of cardiac arrest in the community?

Research question:

What is the incidence rate of cardiac arrest in Irish general practices? What characterises these events and how do GPs respond? What outcomes occur?

Method:

The MERIT (Medical Emergency Responders Integration and Training) Project trains and equips GPs in BLS and ALS care, provides defibrillators and emergency care kit and supports practices with local Project Officers. MERIT is funded through state programmes in pre-hospital emergency care. Clinical audit data on cardiac arrest incidence and features are collected routinely by participating practices.

Results:

Since 2005, 429 practices (of a national total of 900) have taken part. Data on 529 'practice defibrillation years' are available, reporting 80 cardiac arrests in a 2 year period. More than half occurred in the surgery or patient's home, half are in a shockable rhythm and 18% of patients survive to hospital discharge.

Conclusions:

GPs are anxious to have training, equipment and support in a key area of practice. Cardiac arrests are managed regularly by GPs and have survival rates which compare well with other reported systems of care.

Points for discussion:

1. The role of general practice in cardiac arrest management has been completely unexplored to date: these data suggest it is an infrequent but key area of practice.
2. GPs respond enthusiastically to training and practical support in dealing with SCD.

PRESENTATION 24: Saturday 18th October, 2008
09.40 – 10.10 h.

THEME PAPER

TITLE: Alternative diagnoses after exclusion of deep vein thrombosis in symptomatic patients in general practice.

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Background:

Clinical diagnosis of deep vein thrombosis (DVT) in primary care is difficult. The differential diagnosis includes various alternative diagnoses.

Research question:

What is the frequency and management of alternative diagnoses in patients suspected of DVT in general practice? By what clinical features can these diagnoses be characterised?

Method:

Analysis of data of a management study on DVT (AMUSE), involving 1028 consecutive patients with complaints suspect for DVT. Consultation data were recorded by GPs one week after presentation and extracted from patient questionnaires and medical records after three months.

Results:

Besides DVT, the four most frequent alternative diagnoses were muscle rupture (18.5%), chronic venous insufficiency (CVI, 14.6%), erysipelas (12.6%), and superficial thrombophlebitis (SVT, 10.9%). Swelling (OR 8.6) and redness (OR 21.3) were strongly associated with erysipelas. Absence of swelling (OR 0.2-0.6) or redness (OR 0.6), and presence of leg trauma (OR 'absence' 0.5) were associated with muscle rupture. Painful palpation of a vein had a strong association with SVT (OR 3.7). A non acute onset (OR 0.5) of a painless (OR 0.4) swollen leg (OR 1.9) and malignancies (active/non-active, OR 2.4/2.1) were associated with CVI. A low risk of thrombosis and a negative D-dimer test were associated with muscle rupture, whereas previous SVT or DVT and a positive d-dimer test increased the probability of SVT. In almost 30% of cases no therapy was installed. The percentage of compression therapy in erysipelas (35%) and CVI (33%) was low. Of nine missed cases of DVT, three occurred in patients with the working diagnosis SVT, which is statistically unusual ($p=0.026$).

Conclusions:

Muscle rupture, CVI, erysipelas and SVT are the most common diagnoses in the differential diagnosis of DVT. These diagnoses have characteristic clinical features. A more active approach might be opportune in erysipelas and CVI (compression therapy) and SVT (anticoagulant medication).

Points for discussion:

Methodology: secondary analysis of data to describe features of alternative diagnoses for DVT in a diagnostic study designed for DVT?

PRESENTATION 25: Saturday 18^h October, 2008
11.10 - 12.40 h.

POSTER

TITLE: Is presbycusis a risk factor for dementia? ACOUDEM Study.

AUTHOR(S): Denis Pouchain

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Background:

Although it seems logical to postulate a relationship between presbycusis and cognitive disorders, no study has yet confirmed this. The objective of this research was to demonstrate that the prevalence of cognitive disorders was significantly higher in elderly patients with hypoacusis than in those with normal hearing.

Method:

This was a comparative transversal epidemiological study in a population of elderly institutionalized patients matched with respect to gender, age and educational level. A total of 319 subjects aged over 75 years were evaluated using verbal acoumetry to test auditory acuity and three validated tests to assess cognitive function. The prevalence of patients with cognitive disorders was compared between presbycusic patients and those with normal hearing, using the Chi2 test.

Results:

The mean age of the subjects was 85.3 ± 6 years. The groups with and without hearing disorders were comparable with respect to their other characteristics. The relative risk of developing cognitive disorders was 2.48 in patients with presbycusis (95% CI = 1.54-3.99, $p < 0.001$). Futhermore, the statistically significant odds-ratio between presbycusis and cognitive disorders persisted with the same effect size irrespective of gender and age range.

Conclusion:

This study is the first step in proving the relationship between presbycusis and cognitive disorders. The next steps will be to conduct a study in the general population to confirm this relationship, then a randomized controlled trial testing the efficacy of fitting a hearing aid in reducing cognitive decline in hypoacusic patients with mild to moderate dementia.

PRESENTATION 26: Saturday 18^h October, 2008
11.10 - 12.40 h.

POSTER

TITLE: Signs and symptoms in diagnosing acute myocardial infarction and acute coronary syndrome: a diagnostic meta-analysis.

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Background:
Prompt diagnosis of Acute Myocardial Infarction or Acute Coronary Syndrome is very important.

Research question:
We conducted a systematic review to determinate the accuracy of ten important signs and symptoms in selected and non-selected patients

Method:
Design: Diagnostic meta-analysis.
Data sources: Medline, Cinahl, Embase, tracing references, contacting experts.

Review methods:
Inclusion: studies have to describe one of the ten signs and symptoms. Exclusion: not based on original data. Validity assessment: QUADAS.
Data synthesis: pooling using a random effects model.

Results:
16 of the 28 included studies were about non-selected patients. In this group absence of chest wall tenderness on palpation had a pooled sensitivity of 92% (95% CI: 86 to 96) for acute myocardial infarction and 94% (95% CI: 91 to 96) for acute coronary syndrome. Oppressive pain followed with a pooled sensitivity of 60% (95% CI: 55 to 66) for acute myocardial infarction. Sweating had the highest pooled positive LR, namely 2.92 (95% CI: 1.97 to 4.23) for acute myocardial infarction. The other pooled positive LRs fluctuated between 1.05 and 1.49. Negative LRs varied between 0.98 and 0.23. Absence of chest wall tenderness on palpation had a negative LR of 0.23 (95% CI: 0.18 to 0.29)

Conclusions:
Based on this meta-analysis, we were not able to define an important role for signs and symptoms in the diagnosis of acute myocardial infarction or acute coronary syndrome. Only chest wall tenderness on palpation largely ruled out acute myocardial infarction or acute coronary syndrome in low prevalence setting

Points for discussion:
If this meta-analysis was not able to define an important role for signs and symptoms in the diagnosis of acute coronary syndrome, which diagnostic criteria GPs actually use in daily practice?

PRESENTATION 27: Saturday 18^h October, 2008
11.10 - 12.40 h.

POSTER

TITLE: The expert patient program at the Catalan health institute.

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Background:

The increase in life expectancy and lifestyle changes in recent times have increased the incidence of chronic diseases. In 2004, the Catalan HealthInstitute (ICS), developed the Disease Management Project in Heart Failure, including it within the framework of the Primary Care System in Barcelona. Heart failure was the first disease included in the project.

Within the project a set of strategies were developed to ensure the ongoing care of the patient. The Expert Patient Program (ICS) was included within the Disease Management Project with the aim of improving self-care, shared-responsibility and patient autonomy.

Research question:

Can these expert patient sessions help to promote life style changes, and the ability to improve quality of life and self-care of other fellow patients?

Method:

The Expert Patient Program is both theoretical and practical. It consists of nine, one and a half hour sessions, lead by an expert patient. This patient is trained and counselled by health professionals. One of the advantages of this program is that the leader has experienced the symptoms him (her)self.

Results:

So far, 10 Expert Patient groups from the ICS Program in heart failure have been carried out. The total number of participants was 78 (41 women and 37 men). At the end of the program, 21% of patients showed an improvement in their life style and 9% on the knowledge about the disease. After 6 months of starting this treatment, an improvement in life style was noted and an increase in knowledge of the disease was observed in 39 and 14%, respectively. The level of satisfaction of these participants was high in both quantitative and qualitative evaluations.

Conclusions:

The Expert Patient Program, similar to programs in other countries, is a positive step towards the improvement of life style and knowledge of the disease in patients with chronic diseases.

Points for discussion:

1. What do you think the about the contribution of the Expert Patient Program to the continuity of the process health-disease?
2. Do you think the Expert Patient Program can substitute the individual or group health education given by health professional

PRESENTATION 28: Saturday 18^h October, 2008
11.10 - 12.40 h.

POSTER

TITLE: Home blood pressure measurement is anxiety during the measure a limit?

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Background:

Home blood pressure measurement (HBPM) has been widely used for diagnosis and follow up of hypertension. However there are few data concerning its impact on patient's quality of life. And a "white coat effect" of this self-measurement itself has not yet been clearly evaluated.

Research question:

Which are the determinants of anxiety while performing a home blood pressure measurement ?

Method:

prospective study performed with six general practitioners in northern Finistere (Brittany France). Fifty non anxious patients included, twelve underwent HBPM for diagnosis and thirty eight for follow up. Three HBPM were performed every morning and every evening for five days. Within a week quality of life, anxiety and HBPM results were evaluated by a phone questionnaire and were re evaluated after three months. Data was Analysed with epidata 3.1 and SAS 9.1. Normal law was not available so we used Fisher and wilcoxon tests. Significativity was aimed for $p=0.05$.

Results:

36 % of patients considered that HBPM perturbed their everyday life. The incidence of anxiety caused by HBPM was 20 % in this study. Urban life and high educational level patients tended to be more anxious but with limited significativity ($p = 0.21$ and $p = 0.07$), anxiety was reduced by 40 % at three months. Main result is anxious patients had higher diastolic HBPM than non-anxious patients ($p=0.04$) even if they are lower than in practice.

Conclusions:

HBPM causes anxiety in 20 % of non anxious patients. Patients with High educational level are more anxious. It tends to give higher diastolic results for those patients and this even if anxiety reduces with time. This could still conduct practitioners to overtreatment for those patients. Longer and bigger studies should be done to confirm that unattended result.

PRESENTATION 29: Saturday 18^h October, 2008
11.10 - 12.40 h.

POSTER

TITLE: Obesity among Hungarian elderly.

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The epidemiological importance and serious health consequences of obesity is one of the most actual medical issues. Obesity alone or combined with others considered a cardiovascular risk factor and is common among elderly people. Could be the possible reasons of obesity explored in primary care individually? Are there any differences between eating habits in different life decades and BodyMassIndex (BMI) groups of elderly people?

Study design:

cross sectional, (including retrospective elements), consecutive selection, voluntary participation.

Participants: 266 elderly subjects (109 man, 157 women, over 60y).

The main topics of the questionnaire fulfilled by each person were: eating habit (frequency, timing and principal meal, economical issues), educational level, incidence of obesity among family members, retrospective life-long data on body weight in each decade, physical activity.

Nutritional assessment was performed with a standardized dietary record by 53 people (27 men, 26 women), analyzed by dietitians. Anthropometrical measurement was performed by all. Obese people were lower educated and represented a smaller proportion in the older decades.

People with recently normal BMI ate more frequently than overweight (BMI: 25-30 kg/m²) or obese persons (BMI>30 kg/m²). During the aging the meal frequency becomes more regular.

The daily physical activity was very low. Energy and fat intake was high in both genders.

The life-long increase of body weight was significantly higher in the obese group than in overweight or normal weighted categories. The food choices were influenced by economic reasons in two third of study population. Thirty percent of obese people had obese parents and 24% of them had obese children. Unfavorable nutritional habits and sedentary life style may have a prior responsibility for obesity. People without obesity, with less cardiovascular risk may have more chance for longer life. Obesity management should be started in time, recommended at primary health care level.

Points for discussion:

1. How could GP evaluate and explore the reasons by obese patient?
2. What contribution and compliance could be expected from obese patients?
3. Are the GPs advices always credible for patients?

PRESENTATION 30: Saturday 18^h October, 2008
11.10 – 12.40 h.

POSTER
Ongoing study, no results yet

TITLE: The prevalence of obstructive sleep apnea (OSA) in patients with difficult to control hypertension managed in family practices.

AUTHOR(S): Marta Novak, Nora Pinter, Andrea Dunai, Petra Horonyi
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Background:

Thirty percent of hypertensive patients have obstructive sleep apnea, but an even higher prevalence (60-86%) has been reported in patients with treatment resistant hypertension (HTN) referred to a tertiary care clinic.

Research question:

What is the prevalence of OSA in patients with difficult to control hypertension managed in primary care? Is this prevalence higher than the prevalence of the condition in patients with well controlled blood pressure (control group)?

Method:

In a cross sectional study a total of 200 patients with high blood pressure (BP) will be randomly selected from 10 primary care practices, 20 from each. Overnight polysomnography will be conducted and 24-hour blood pressure, weight, height, neck circumference and information on health-related demographics and medications will be obtained. Patients will be divided into two groups by the number of medications needed to control BP: difficult to control HTN: taking >3 antihypertensive medications and well controlled group needing only 1 or 2 antihypertensives. Chi-square will be used to compare the prevalence of OSA in difficult to control and in well controlled hypertensives. Multivariate analysis will be used to test if having difficult to control HTN is an independent predictor of OSA.

Results:

We expect that the prevalence of OSA will be higher in the difficult to control HTN group versus the well controlled group even after adjusting for important co-variables and risk factors.

Conclusions:

Family physicians need to be aware of the increased risk of OSA in patients with difficult to control HTN. OSA needs to be considered in such patients.

PRESENTATION 31: Saturday 18^h October, 2008
11.10 - 12.40 h.

POSTER

TITLE: We live healthy.

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Background:

Morbidity and mortality caused by cardiovascular diseases is in Slovenia high, but the highest rate is in the socioeconomic lowest developed nord east part of it. This was the reason why we decided to develop prevention programs in this region first.

Research question:

Is it possible to achieve improvement of health conditions with non-farmacological methods in the population in a local community?

Method:

For all members the participality Beltinci (8640) we used the same program for primary prevention, that contains twelve preventive activities. The effectivity of the program we tested on 303 coincidently chosen volontaire inhabitants. At the start (N= 186, Marc 2002) and at the end (N= 161, March 2003) of program we observed : fitness index, sistolic and diastolic blood pressure, cholesterol and body mass index. The measurements and the collection of data were taken with a questionnaire and the measure standards according to CINDI. The differences between the first and second measurement were tested with a pair test. Threshold of a characteristic $p < 0,05$.

Results:

The results of the analysis show the quantitatively expressed differences in a sense of a statistically typical improvement of health of the observed people: a reduction of the middle value of systolic blood pressure for 4,7% ($p < 0.001$), a reduction of the middle value of total cholesterol for 4.9% ($p < 0.001$), and a reduction of the middle value of body mass index for 3,2% ($p < 0.005$); an average index of capacity grew for 9,7% ($p < 0.003$). But research results do not show typical differences in consumption of alcohol, sweet drinks or smoking. The change of lifestyle can be seen in a statistically typical increase of observed people who consume healthier fat ($p < 0.0005$), milk with less fat ($p < 0.0005$) and more fruit and vegetables ($p < 0.0005$).

Conclusions:

The results are stimulative, they show the efficiency and confirm a need to expand and deepen the preventive measures.

Points for discussion:

- Preventive programs in the community and some special subgroups of the population (addicted persons, children, gypsies, low educated people)
- Who should make the work?
- Economical interest

PRESENTATION 32: Saturday 18^h October, 2008
11.10 – 12.40 h.

POSTER

TITLE: The prevalence of cardiovascular risk factors and the control of blood pressure in elderly patients in Vilnius.

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Background:

High blood pressure (BP) is estimated to account for 6% of deaths worldwide and is the most common treatable risk factor for cardiovascular disease (CVD). During the last 30 years, hypertension treatment has improved dramatically, but the majority of patients' BPs remain uncontrolled in all societies.

Research question:

The aim was to evaluate the control of blood pressure (BP) in elderly hypertensive patients and the prevalence of cardiovascular risk factors.

Method:

The study was performed in five primary health care centers in Vilnius in 2005. The sample consisted of 601 patients: 200 (33%) males and 401 (67%) females with arterial hypertension, receiving antihypertensive medication, aged 20 years and older, BP was measured according to WHO recommendations. Cardiovascular risk factors (overweight, hyperlipidemia, diabetes mellitus type 2 (DM2), smoking) were assessed referring to anamnesis and documents.

Results:

BP < 140/90 mmHg was found in only 5.8% of patients. DM2 was found in 108 (18%) patients - 41 males (38%) and 67 females (62%). 36 (6%) patients were smoking (23 males, 63% and 13 females, 37%). Hyperlipidemia was found in 228 (38%) - 75 males (33%) and 153 females (67%). 503 (84%) patients - 166 (83%) males and 337 (84%) females - had an increased body mass index (BMI).

Conclusions:

BP was insufficiently controlled ($p < 0.05$). BP in patients with cardiovascular risk factors (hyperlipidemia, DM2, smoking) was not statistically significantly higher ($p > 0.05$). Patients with overweight or obesity had a higher BP than patients with normal weight ($p = 0.002$), and a correlation between the BMI and BP was found (Spearman's correlation coefficient 0.195 and 0.167, $p < 0.05$).

PRESENTATION 33: Saturday 18^h October, 2008
11.10 - 12.40 h.

POSTER

TITLE: Theses of family medicine residency in turkey.

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Background:

Family medicine residency training duration is three years in Turkey. The right to have a residency education is gained by a national examination, and the educational period is completed by a thesis presentation and a competency examination.

Research question:

Are the Family Medicine theses in Turkey focused on the real field of Family Medicine? How a procedure is followed during preparation of theses in Turkey?

Method:

Theses of family medicine specialists were gathered via web sites of Ministry of Health and The Turkish Higher Education Committee, via e-mail group of family medicine residents and specialists, and from individuals. Theses completed between 01st January 2006 and 30th June 2008 were included in the study.

Results:

Of the family practitioners, 89 were male and 86 were female. Consultant was a family medicine specialist in 28.6% of the theses. Of the theses, 67.4% were produced at educational government hospitals, and 32.6% at university hospitals. Questionnaires were used in 75.4%, and laboratory tests were used in 36% of the theses. Most of the researches were cross-sectional (57.1%), followed by retrospective (23.4%) and prospective (19.4%) studies. Research was performed at secondary or tertiary care environment (hospitals) in 78.3%, and at primary care environment in 21.7% of the theses. Only 22.9% of the theses had consent of ethical committee, and only 6.3% got financial support from the institution.

Conclusions:

Preparation of a thesis is an important procedure in residency education. As so much time and effort is consumed for a thesis, it must be focused on the real aim of the residency education, for family medicine, it should be directed to primary care problems. Also it should improve academic qualifications of the resident.

Points for discussion:

1. What should be the criteria for deciding the topic of a thesis?
2. What should be the role of the consultant in the process of preparing a thesis?
3. What is the aim in preparation of a thesis?

PRESENTATION 34: Saturday 18^h October, 2008
11.10 - 12.40 h.

POSTER
Ongoing study with preliminary results

TITLE: "Chronic illness" and its determinants in General Practitioners' medical records – A secondary data analysis.

AUTHOR(S): Johannes Hauswaldt, I. Becker, M. Kersting, G. Theile
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1

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Background:

"Chronic illness" in Germany has been defined by the Federal Joint Committee (Gemeinsamer Bundesausschuss) as illness needing medical care at least for one year and at least once in a quarter (continuous care).

Research question:

Aim of this ongoing study was to identify patients being chronically ill, and to relate this to determinants of patients, diagnoses and practices.

Method:

Electronic patient's records from 472,775 patients of 156 general practices, from 1990 until 2007, were examined. "Chronic illness" was attributed to a patient having at least one contact with the practice in each of four adjacent quarters of year.

For determinants, practices were stratified according to type, location, and annual number of patients, patients according to sex, age, contacts per quarter, and ICD-diagnoses. Influence on "chronic illness (yes/no)" was modelled using logistic regression.

Results:

170,255 patients contacted general practices at least in four and up to 71 quarters, of which 123,805 (72.7%) patients were identified as to be chronically ill. Determinants for chronic illness were female sex (OR 1.31, 95%-CI 1.28 – 1.34) and age decade (OR 1.27, 95%-CI 1.27 – 1.28) of patient.

Of 20,331 patients attending the practices five years and longer, 20,127 were found to be chronically ill. Again, determinants were female sex (OR 2.49, 95%-CI 1.86 – 3.32) and age decade (OR 1.29, 95%-CI 1.22 – 1.37).

As determinants for chronic illness, further results for patients (number of contacts, diabetes, CHD, COPD, and others) and practices are expected.

Conclusions:

26.2% of unselected GP's patients were identified of being chronically ill, for which condition several determinants were found.

Points for discussion:

-What are definitions of "chronic illness" in other European countries?

-Which statistics may be helpful to identify GP's patients to be chronically ill or in need of continuous care?

PRESENTATION 35: Saturday 18^h October, 2008
11.10 - 12.40 h.

POSTER

TITLE: GP home visits – should we go? One family medicine centre's experience.

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Background:

In Lithuania (in 2006) home visits became the duty of the GP's.

Research question:

Determine the main reasons for GP home visits; rate the distribution during the year, among the age and gender; examine how many patients give wrong information about their condition.

Method:

Analysing home visits were taken notes about the main reasons for the home visits, their distribution, the age and status of the patients, the distribution among sex, the unconformity of the information that patients have stated.

Results:

1176 home visits, overall. Average - 22.6 (per week) (4–62, SD 12.9). 239 visits to adult men, 480 to adult women, 457 to children (410 of them - to ill children and 47 active visits to newborns). Newborns, infants and elderly people asked for most home visits.

41% home visits were to patients < 20 years old. Non-employable people asked more often for a doctor (60.97 %). The biggest part of visits were in winter – spring period, for non-complicated upper and lower respiratory tract infections (>50%, $p = 0.0055$). 25.2 % men and 17.4 % women with fever asked for GP ($p = 0.001$). Patients often were inclined to exacerbate their condition ($p < 0,001$). Women and men equally „lied“ about the status of their health. Only 11.07 % of whole visits were to the disabled patients. For a GP home visit only for the prescriptions of compensated drugs women asked more often than men ($p = 0.003$).

Conclusions:

1. The main reason for GP home visits were non-complicated upper respiratory tract infection.
2. The biggest part of home visits were in winter – spring period, non-employable people ask more often for a GP, women – more often.
3. Both gender equally „lied“ about the status of their health.

Points for discussion:

What are the ways to reduce the number of home visits?

PRESENTATION 36: Saturday 18^h October, 2008
11.10 - 12.40 h.

POSTER
Ongoing study with preliminary results

TITLE: French Consensus about Gut Feelings in general Practice.

AUTHOR(S): Magali Coppens, Alain mercier, Laurence Coblentz-Baumann
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Background:

General practitioners sometimes base their clinical decisions on gut feelings alone, even though there is little evidence of their diagnostic and prognostic value in daily practice. Research into the significance of this phenomenon with focus groups in the Netherlands provided a concept of gut feelings in general practice: a sense of alarm, a sense of reassurance and several determinants. A description of these two types of gut feelings was obtained with a Delphi consensus procedure with a heterogeneous sample of 27 Dutch and Belgian GPs or ex-GPs involved in academic programmes. A survey among members of the EGPRN show that the sense of alarm is a familiar phenomenon in general practices in Europe. To validate this concept in Europe we need comparable descriptions of gut feelings.

Research question:

Which consensus on gut feelings in general practice in France can be obtained, using the Dutch results and the same methods?

Method:

Translation of the 7 Dutch defining statements about gut feelings conducted as forward-backward translation. Qualitative research including a Delphi consensus procedure with a heterogeneous sample of 30 French GPs involved in university educational or research programmes, included by a randomised selection of the associated teachers □ list of General practice in France.

Results:

The first two translations were done by a Dutch speaking GP working in France and by the first author and adjusted by a French speaking native, interpreter at a Dutch university. The backward translation was performed by a Flemish GP. Two Dutch GPs, authors of the original research, compared this text with the original statements. After some final corrections the French text was accepted. We already recruited 25 GPs and will soon start the consensus procedure.

Conclusions:

The translation problems were solvable. It is an ongoing study. We will present the first results at the congress.

PRESENTATION 37: Saturday 18^h October, 2008
11.10 - 12.40 h.

POSTER
Study proposal / idea

TITLE: Robert N Braun's "House of General Practice"

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Background:

Research in primary care has been a recurrent topic ever since general practice was recognized as a special discipline/field of study. The Austrian pioneer researcher Robert N Braun (1914-2007) dedicated his life to build a solid, scientifically based knowledge on what is going on in everyday general practice. He characterized the dilemma, which GPs face as follows: How to adequately apply the huge current knowledge of medical science within a "six-minutes"-consultation? In association with his research activities, Braun imagined a "house of general practice" of which he had laid the foundation and whose fictitious rooms were only partly "furnished" by his research findings.

Research question:

To which extent can Braun's oeuvre contribute to "drafting" further rooms, i.e. establishing a research agenda?

Method:

Summaries of all eleven books, written by Braun (dating from 1945 to 2004), will be used to outline characteristic features of each of them. Their content will be linked to research areas, a) which he deemed important in primary care, and b) which are mentioned in the research agenda in correspondence with WONCA's core competencies.

Results:

The content of Braun's books relate to one, but often to two or three of the following areas: 1) basic knowledge, 2) practice-based epidemiology (statistics on cases frequencies), 3) concepts for the new special discipline: primary care, 4) intellectual "tools" (checklists, guidelines), 5) integration. And these correspond mainly with WONCA's core competencies: specific problem solving and primary care management.

Conclusions:

Braun's scientific work blends in to the topics discussed for a research agenda. For long periods of time Braun was a lone player in the field of primary care research and worldwide not known well enough. We find it worth exploring his legacy.

Points for discussion:

1. The poster should contribute to a fruitful discussion on the research agenda.
2. We want to raise curiosity for Braun's large oeuvre.
3. Would translations be worthwhile in order that it could become known more widely?

PRESENTATION 38: Saturday 18^h October, 2008
11.10 - 12.40 h.

POSTER
Ongoing study with preliminary results

TITLE: Randomised controlled trial of ciprofloxacin versus ibuprofen in the treatment of uncomplicated urinary tract infection - a feasibility study in German general practice.

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Background:

Uncomplicated urinary tract infections (UTI) are common in general practice and are usually treated with antibiotics. A double-blind randomised-controlled study was designed to assess whether symptomatic treatment with ibuprofen was equally effective than ciprofloxacin to treat women with uncomplicated UTI.

Research question:

First, a pilot-study was conducted to demonstrate the feasibility of a clinical drug-trial in German general practice and the safety of our treatment approach.

Method:

29 participating of 165 (18%) practices were trained to perform a clinical trial. Practices were asked to screen patients with uncomplicated UTI within a 6-month timeframe and to enroll suitable patients who had given their informed consent.

Inclusion criteria were typical symptoms of uncomplicated UTI. Patients were randomised to receive either ibuprofen (3x400mg/d) or ciprofloxacin (2x250mg plus a placebo) for 3 days. On day 4, 7 and 28, symptoms were checked by telephone interviews. Number of complications was one important aspect in this pilot/feasibility study, which is still underpowered for the the primary outcome "no symptoms on day 4." The secondary outcomes will be "no symptoms on day 7", relapses within 28 days.

Results:

A total of 80 patients were recruited, ranging from 0-12 per practice. 93% had pollakisuria, 86% dysuria, 54% sub-abdominal pain. The overall mean of the symptom-score was 5.5 (max. 12) on day 0, 1.2 on day 4 and 0.6 on day 7. 22 patients required secondary antibiotic treatment of symptoms, but nobody developed serious diseases or complications.

Data quality of included patients was good with few screening failures, protocol violations or missing data.

Conclusions:

The trial proved its feasibility; however, recruitment and data quality can be improved. In a follow-up study, we will investigate the non-inferiority of ibuprofen vs. ciprofloxacin with an adequate sample size.

Points for discussion:

1. Experience with clinical trials in GPs
2. Supervision and education of the practice team

PRESENTATION 39: Saturday 18^h October, 2008
11.10 - 12.40 h.

POSTER

TITLE: Socio-demographic and clinical characteristics, health behaviour and accident in snorers: a population survey.

AUTHOR(S): Peter Torzsa, Andras Keszei, Laszlo Kalabay, Eszter Panna Vamos Rezso Zoller, Istvan Mucsi, Marta Novak, Maria S. Kopp

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Background:

Increasing evidence suggests that snoring is part of the spectrum of sleep disordered breathing, from simple snoring on one end through loud snoring with breathing pauses to obstructive sleep apnea/hypopnea syndrome on the other.

Research question:

Here we assess the sociodemographic characteristics, pattern of health behaviour and comorbidity associated with snoring in the Hungarian population.

Method:

Data were collected within a framework of the "Hungarostudy 2002" crosssectional, nationally representative survey of the Hungarian population. The Hungarian National Population Register was used as the sampling frame and a clustered, stratified sampling procedure was employed. The study population represented 0.16% of the population over the age of 18 years according to age, sex and 150 sub-regions of the country. Interviews were carried out in the homes of 12,643 persons. Self-reported information on smoking, alcohol consumption, comorbidity, chronic pain, daytime sleepiness and accidents were also tabulated.

Results:

37% of males and 21 % of females reported loud snoring with breathing pauses. We found a significant increasing trend for alcohol and coffee consumption and smoking among nonsnorers, quiet and loud snorers, respectively. In an ordinal regression model male gender, the presence of smoking, the presence of 3 or more comorbid conditions and alcohol consumption (AUDIT) were the strongest predictors of snoring (OR=1.99, OR=1.76, OR=1.45, OR=1.22 respectively, P<0.001) after controlling for multiple sociodemographic and clinical variables. The prevalence of accidents was higher in the loud snoring group than among non snoring individuals (24% vs 17%, P<0.0001).

Conclusions:

Snoring is frequent in the Hungarian adult population. In contrast to quiet snoring, loud snoring with breathing pauses is strongly associated with high-risk health behaviour, higher number of comorbidity, and higher prevalence of accidents.

PRESENTATION 40: Saturday 18^h October, 2008
11.10 - 12.40 h.

POSTER

TITLE: Does obstructive sleep apnea (OSA) correlates with sexual problem and impotence?

AUTHOR(S): Andrea Dunaj, Mikos Molnar, Anett Lindner, Andras Szentkirályi, Maria Eszter Czira, Marta Novak, Istvan Mucsi, Rezso Zoller

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Background:

Earlier studies have shown that OSA is associated with impotence and decreased sexual drive.

Research question:

Is OSA associated with self-reported sexual problems and/or impotence in patients referred to a sleep laboratory?

Method:

In a retrospective analysis data obtained from 154 consecutive patients who visited our sleep laboratory were analyzed. Every patient had an overnight sleep study, they also completed a battery of questionnaires including the Center for Epidemiologic Studies-Depression (CES-D) and the Epworth sleepiness scale.

The following 2 questions were also included: Do you have a sexual problem?
And for men: Do you have any problem with erection?

Results:

94 of the 154 patients answered the first question, and 61 of 97 men answered the second question. 23% of the patients reported to have sexual problem (32% of men and 25 % of women), 18% of men reported to have problem with erection. The ESS score, BMI and age was not different between individuals with and without sexual problem. Men who reported erectile problems were older (54.2+-11 vs. 48.5+-12, $p<0.01$), but BMI and the ESS score was not different between these groups. The severity of sleep apnea (measured with apopnea hypopnoe index) was not significantly different between patients with and without sexual or erection problem: ($p=0.6$ and $p=0,2$ Man-Whitney test). The most prominent difference between patients with and without self-reported sexual problem was the score achieved on the CESD depression scale ($p<0.01$ Man-Whitney test).

Conclusions:

In our survey sexual problems and erection did were not associated with obstructive sleep apnea. The presence of self-reported sexual problems were associated with depression, and erectile dysfunction with age.

PRESENTATION 41: Saturday 18^h October, 2008
11.10 - 12.40 h.

POSTER

TITLE: Generalized Anxiety Disorder diagnosis.

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Background:

The Generalized Anxiety Disorder is one of the most frequent psychiatric pathologies in general practice. The DSM-IV defines this pathology according to very precise diagnostic criteria in terms of symptoms and length.

This definition remains controversial. In 2001, in front of these variations of practice, the National Agency of Accreditation and Evaluation of Care (A.N.A.E.S) of France published recommendations for the clinical practice in the diagnosis and the care of the G.A.D.

Research question:

What is the performance for the practice of the DSM IV definition of G.A.D. and which type of care is organized by the general practitioners for the patients affected by this disorder?

Method:

We carried out a descriptive retrospective epidemiological survey among general practitioners (GPs) from Yvelines (French county) to define how Generalized Anxiety Disorder is currently diagnosed and treated. A Paper questionnaire has been sent by mail way follow by a reminder letter.

Results:

Three hundred and forty one patients has been included. One third of these patients referenced by surveyed GPs didn't fit the DSM-IV diagnostic criteria. These patients didn't differ from other patients both from an epidemiologic point of view and the type of patient management offered by the GP. A high level of comorbidity with other psychiatric disorders – particularly depression - has been observed. Our study shows that serotonergic antidepressants and benzodiazepines are the most used treatments. They are very often prescribed together by the GP. Almost 96% of patients benefited from a psychotherapeutic help, which was most of time (74%) directly provided by the GP.

Conclusions:

These results highlight an inadequacy between the current definition for G.A.D. in DSM-IV and disorders actually observed and treated by GPs.

Points for discussion:

1. Which use of classifications for GAD diagnosis?
2. The revision of the DSM IV and the CIM 10

PRESENTATION 42: Saturday 18^h October, 2008
11.10 - 12.40 h.

POSTER
Ongoing study with preliminary results

TITLE: Discerning the dynamic of living with diabetes.

AUTHOR(S): Frances Griffiths, Antje Lindenmeyer, S. Reis, B. Crabtree, J. Borkan
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Background:

Dynamics, the pace and pattern of change over time and what influences this, are central to the experience of living with chronic illness such as diabetes. Our study responds to concerns that applying medical evidence can distract clinicians from assessing patient dynamics and tailoring interventions to fit with or challenge the dynamic. We report results of secondary analysis of interviews with patients living with diabetes. Our approach to analysis developed from an EGPRN collaboration.

Research question:

1. Can the dynamics of living with diabetes be characterised for individuals?
2. What is the diversity of dynamics of living with diabetes and how does it relate to wellbeing?

Method:

Our published pilot study included analysis of interviews with six adults living with diabetes and suggested an emergent dynamic could be identified from assessing each interview as a whole. Secondary analysis is underway of interviews with a further 22 adults living with type 2 diabetes. Analysis involves identifying descriptions of change, what influences it and the emergent dynamic and comparison between cases.

Results:

Initial analysis suggests there is a distinct phase after diagnosis of rapid change. Individuals then settle into dynamic patterns of varying duration from months to many years. Most participants were relatively stable. This stability could be positive (allowing for experimentation with food and exercise to find out about the body's responses) or more ambivalent, characterised by fear of a change for the worse. For others, dynamics were more changeable, and they oscillated between attempts at mastering their diabetes and denial or rebellion against dietary regimes. Our presentation will be of our final analysis including categories of these patterns and how these relate to wellbeing.

Conclusions:

Initial analysis indicates clinical assessment of patient dynamics has potential to improve tailoring of interventions to individuals.

Points for discussion:

Is the qualitative assessment of patient dynamics meaningful and useful for health professionals?

PRESENTATION 43: Saturday 18^h October, 2008
11.10 – 12.40 h.

POSTER
Study proposal / idea

TITLE: Type 2 Diabetic Patients with Chronic renal Failure. Do GP consider it.

AUTHOR(S): Jordi Artigas, Xavier Cos, Madaline Morna, Magda Pie
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Background:

Prescription of oral anti-diabetic agents (OA) in type 2 diabetes patients with chronic renal failure (CRF) in primary care is a controversial issue. In a recent pilot study we found that 41,12% of patients had some degree of renal failure and need a dose reduction of their treatment. Kidney disease in people with type 2 diabetes (T2D) is becoming an important health problem due to an increase of T2D prevalence and aging of our population.

Research question:

Do we consider CRF as a contraindication to use OA in T2D?

Which is the best strategy to improve quality of OA prescription in diabetic patients with CRF?

Method:

Prospective longitudinal study (basal audit, intervention and Inclusion criteria: all T2D patients visited in 2007 in 4 urban primary care centres (more than 60000 people.); lab test with serum creatinine, HbA1c and GFR calculated by the MDRD formula (CRF as a $GFR < 60 \text{ ml/min/1,73m}^2$).

Variables: sex, gender, T2D treatment, past clinical history of: Hypertension, Dislipidemia, Obesity, any cardiovascular events. Clinical & Lab variables: serum creatinine, HbA1C, albumin/creatinine ratio, LDL-c, HDL-c, TG, Total Cholesterol, SBP and DBP). GP data: age, gender, years in clinics. Intervention for improvement strategy: 1) teaching program and leaflet about management of oral anti-diabetic agents in patients with CRF, 2) A computer reminder (T2D patient with CRF) and 3) a control group. We would like to do a cluster intervention and statistical analysis with a previous randomization.

Comments: There is not strong data published related to this topic. Chronic renal failure is a difficult and not so much consider issue in Primary Care, and many of our T2D patients (elderly) have some level of CRF without any treatment changes.

Points for discussion:

To describe all those possible contraindications in T2D patients' treatment according their CRF degree as those related factors.

To assess the effect of two interventions for improving the prescription profile of our GPs in patients with T2D and chr.

PRESENTATION 44: Saturday 18^h October, 2008
11.10 – 12.40 h.

POSTER

TITLE: Prevention and Therapy Challenges of Hypertensio arterialis.

AUTHOR(S): Nevenka Radosavljevic, Natasa Filipovic

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Introduction:

Artery hypertension is an illness for itself as well as a risk factor to arteriosclerosis and all of its unpredictable consequences. A family doctor faces a challenge, as well as a responsibility to diagnose early and treat it efficiently. If we consider risk factors, heredity, life rhythm and habits and if we work preventively together with a patient we can prevent fatal result and improve individual quality of life. Success of pharmacological treatment depends on appropriate education of a patient as well as on the lifestyle change, stopping smoking, physical activities increase, individual solution of a stress problem and cultivation of a positive attitude towards one's health.

Objective:

To introspect distribution of the disease, according to age and sex, and treatment in order to enable preventive work and modern therapy. Work method: Insight in patients' files, follow up of prescribed therapy.

Results:

341 patients were examined - 20 female and 140 male had Hypertensio arterialis diagnosis that needed pharmacological treatment.

According to age distribution was following 40-50(12f/12m), 50-60(38f/26m) 60-70(71f/37m) and over 70(80f/65m)

Ac inhibitors were: 40-50(10f/4m), 50-60(47f/22m), 60-70(56f/28m) and over 70(88f/65m)

Ca channel antagonist: 40-50(6f/2m), 50-60(21f/12m), 60-70(49f/18m), over 70(49f/20m)

Beta inhibitors: 40-50(7f/7m), 50-60(22f/19m), 60-70(49f/19m), over 70(44f/18m)

Diuretics: 40-50(6f/2m), 50-60(43f/11m), 60-70(36f/21m) over 70(70f/28m)

Conclusion:

Sex(female) and age are risk factors.

Ac inhibitors medicaments are mostly used in the therapy.

In older patients combination of more medicaments is mostly used.

Points for discussion:

Hypertension, Disease distribution, Prevention, Treatment

PRESENTATION 45: Saturday 18^h October, 2008
15.00 – 15.10 h.

ONE SLIDE / FIVE MINUTES

TITLE: Caregivers of Patients Suffering from Alzheimer Disease in Primary Care: Difficulties and Needs; Consequences for the General Practitioner.

AUTHOR(S): L. Pellerin, A. Polet, P. Habault, J.P. Aquino, F. Becret, Alain Mercier

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Background:

850000 patients are currently suffering from Alzheimer disease in France. Familial caregivers are mostly in charge of daily care; their burden is highly demonstrated. The general practitioner (GP) has to take care of both Alzheimer patient and caregiver, especially in long term follow-up. A specific way of taking into account this burden and its consequences on their health seems to be needed. Specific practice is required to preserve the balance of care receiver and caregiver.

Objectives:

To identify caregivers and general practitioners difficulties and needs.
To establish the specific role of GP in caregivers healthcare.
To take advantage of various health systems proposals in France, United States and Canada

Method:

This study will be run in three parts. Firstly a qualitative research including semi directive interviews of caregivers and focus groups of general practitioners. This first process will lead to questionnaire design for each one. Secondly a quantitative process; we will collect data from the questionnaires, sent to GPs and caregivers. Eventually, we will compare results from American, Canadian and French participants.

Expected Results:

This study will help GPs to identify and to deal with specific health needs of caregivers, in order to improve their daily practices and caregiver's health. Ways and solutions of dealing with caregiver's problems could be tested.

Discussion:

What kind of difficulties while building up the questionnaire?

Points for discussion:

Difficult comparison of several care systems
Adhesion to qualitative research

PRESENTATION 46: Saturday 18^h October, 2008
15.20 - 15.30 h.

ONE SLIDE / FIVE MINUTES
Study proposal / idea

TITLE: A Clinical Decision Tool to Assist Physicians in Management of Acute Cystitis.

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Background:

Acute cystitis is highly prevalent among women of reproductive age. Lack of consensus regarding diagnosis and management has led to excessive use of empirical antibiotics and urine culturing. Applying a clinical decision tool (of 3 items; dysuria, dipstick leukocytes, dipstick nitrites) in each case could help primary care physicians differentiate women who need antibiotics or cultures from those who don't.

Research question:

Can a clinical decision tool successfully reduce the number of unnecessary antibiotic prescriptions and urine cultures in the setting of acute cystitis in women?

Method:

Female patients (aged 16-50) with suspected cystitis attending Maccabi Healthcare clinics would receive their usual physician care (antibiotics and/or urine cultures). Nevertheless, a urine culture and dipstick would be obtained in each case. This would render a 0-3 item score for each patient (e.g. clinical decision tool, CDT). This work will examine whether high scores (2-3) in CDT can correctly predict a urinary infection, thus requiring empirical antibiotics and sparing the need for a urine culture. Furthermore, low scores (0-1) would not rule out the diagnosis but would prompt culturing and subsequent treatment of positives, which could reduce unnecessary antibiotic prescriptions. The positive predictive value of the CDT would be calculated from the gold standard of a positive urine culture result. Also, reduction in prescriptions and cultures could be assessed and compared with usual physician care.

Points for discussion:

1. Diagnosis of acute cystitis in primary care. Is it a pure clinical diagnosis?
2. Empirical antibiotics vs. urine culture for all. Which is more cost-effective?
3. Uropathogens' resistance to antibiotics. A call for judicious antibiotic use.

PRESENTATION 47: Saturday 18th October, 2008
16.00 - 16.30 h.

FREESTANDING PAPER

TITLE: Quality of communication during telephone triage at Dutch out-of hours Centres.

AUTHOR(S): Hay Derkx, Jan-Joost Rethans, Bas Maiburg, Ron Winkens, Arno Muijtjens, Harrie van Rooij, André Knottnerus,

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Background:

Communication between doctors and patients has changed during the last few decades due to social shifts in our society. In the past communication focused on the disease process, whereas nowadays communication is increasingly patient-centred. The disease is no longer the main point of discussion but the communication is centered on the patient who feels unwell. The need for good communication skills in telephone triage is also recognised

Research question:

To assess the quality of communication skills of triagists, working at out-of-hours (OOH) centres, and to determine the correlation between the communication score and the duration of the telephone consultation.

Method:

Telephone Incognito Standardised Patients (TISPs) called 17 OOH centres presenting different clinical cases. The assessment of communication skills was carried out using the RICE-communication rating list (1). The duration of each telephone consultation was determined.

Results:

The mean overall score for communication skills was 35% of the maximum feasible. Triagists usually asked questions about the clinical situation mostly correctly and little about the patients' personal situation, perception of the problem or expectation. Advice about the outcome of triage and self care advice was usually given without checking for patients' understanding and acceptance of the advice. Calls were often handled in an unstructured way, without summarizing or clarifying the different steps within the consultation. There was a positive correlation of 0.86 ($p < 0.01$) between the overall communication score and the duration of the telephone consultation.

Conclusions:

Assessment of communication skills of triagists revealed specific shortcomings and learning points to improve the quality of communication skills during telephone triage.

Training in telephone consultation should focus more on patient-centred communication with active listening, active advising and structuring the call. Apart from adequate communication skills, triagists need sufficient time for telephone consultation to enable high quality performance.

Points for discussion:

Use of out of hours centres for primary care in your country.

Tools for assessment of quality of telephone triage.

Training of telephone communication at OOH centers.

PRESENTATION 48: Saturday 18th October, 2008
16.30 - 17.00 h.

FREESTANDING PAPER

TITLE: Do doctors look after themselves as well as they could?

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Background:

Doctors' health is an important issue. We thought that it was important to get objective data on this topic. Our HMO runs a program of quality indicators (QIs) measurement in the domains of primary and secondary prevention, follow up, treatment, and control of chronic diseases.

Research question:

Is there any differences in the QIs that are related to health behavior between doctors (as patients) and the general population (the patients they treat)

Methods:

Study populations: 429 physicians (51.7% women) aged 50.8 + 8.5 years and 1,621 age, gender, and socioeconomic matched controls from our HMO who are patients in our district.

Data extraction: All the medical records are fully computerized and data to calculate quality indicators is automatically extracted from the medical files and from the central database of the HMO.

Main outcome measure: Differences in the health behavior between doctors and the patient population.

Results:

We found that women doctors do mammography as much patients do (55.2% vs. 56.7%, NS) and that doctors measure their LDL at least as frequently as patients (85 % vs. 84%, NS) and undertake colorectal cancer screening at the same rate as patients (23.2% vs 27.3%, NS) . Doctors with hypertension have their blood pressure measured by their GP considerably less frequently than patients do (56.1% vs. 76.6%, $p < 0.001$). We found no areas that doctors health as measured by QI's are better than patients.

Conclusion:

Doctors health behavior as measured by standardized QI is poorer than the general population in some very important areas. In other areas it is only as good as but never better than the general population. This is of utmost importance to doctors themselves, their organizations and health systems as a whole as doctors seem to be not to take advantage of the health resources widely available to them.

Points for discussion:

Even when treated doctors Blood pressure and cholesterol levels are no better than patients
Doctors don't seem to take advantage of their better access to care and understanding that they have
Doctors prefer colonoscopy to faecal occult blood test

ⁱ Brown A, Cleland JGF. Influence of pattern of concomitant disease on patterns of hospitalisation in patients with heart failure discharged from Scottish hospitals in 1995. *Eur Heart J* 1998; 19: 1063-1069.

ⁱⁱ Davies MK, Hobbs FDR, Davis RC, Kenkre JE, Roalfe AK, Hare R, Wosornu D, Lancashire RJ. Prevalence of left ventricular systolic dysfunction and heart failure in the general population: main findings from the ECHOES (Echocardiographic Heart of England Screening) Study. *Lancet* 2001; 358: 439-445

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- ⁱⁱⁱ Morgan S, Smith H, Simpson I, Liddiard GS, Raphael H, Pickering RM, Mant D. Prevalence and clinical characteristics of left ventricular dysfunction among elderly patients in general practice setting: cross sectional survey. *BMJ* 1999; **318**:368-72
- ^{iv} McDonagh TA, Morrison CE, Lawrence A et al. Symptomatic and asymptomatic left ventricular systolic dysfunction in an urban population. *Lancet* 1997; 350:8 29-33
- ^v Gillum RF. Heart and Stroke Facts. *Am Heart J* 1993;126:1042-1047.
- ^{vi} McMurray J, Hart W, Rhodes G. An evaluation of the cost of chronic heart failure to the National Health Service in the UK. *Br J Med Econ* 1993;6:99-110.
- ^{vii} Hobbs FDR, Kenkre JE, Roalfe AK, Davis RC, Hare R, Davies MK. Impact of heart failure and left ventricular systolic dysfunction on quality of life: a cross-sectional study comparing common chronic cardiac and medical disorders and a representative adult population. *European Heart Journal* 2002; 23: 1867-76
- ^{viii} Garg R, Yusuf S, for the Collaborative Group on ACE Inhibitor Trials. Overview of randomized trials of angiotensin-converting enzyme inhibitors on mortality and morbidity in patients with heart failure. *JAMA* 1995;273:1450-56.
- ^{ix} The SOLVD investigators. Effect of Enalapril on mortality and the development of heart failure in asymptomatic patients with reduced left ventricular ejection fractions. *N Engl J Med* 1992;327:685-91.
- ^x Pfeffer MA, Brunwald E, Moy LA, Basta L, Brown EJ, Cuddy TE, for the SAVE Investigators. Effect of Captopril on mortality and morbidity in patients with left ventricular dysfunction after myocardial infarction.: Results of the Survival and Ventricular Enlargement Trial *N Engl J Med* 1992;327:669-77.
- ^{xi} McMurray J, Cohen-Solal A, Dietz R, Eichhorn E, Erhardt L, Hobbs FD, Krum H, Maggioni A, McKelvie RS, Pina IL, Soler-Soler J, Swedberg K. Practical recommendations for the use of ACE inhibitors, beta-blockers, aldosterone antagonists and angiotensin receptor blockers in heart failure: putting guidelines into practice. *Eur J Heart Fail.* 2005; 7(5): 710-21
- ^{xii} CIBIS-II Investigators and Committees. The Cardiac Insufficiency Bisoprolol Study II. *Lancet* 1999;353:9-13.
- ^{xiii} Pitt B, Zannad F, Remm WJ, Cody R, Castaigne A, Perez A, Palensky J, Wittes J, for the Randomised Aldactone Evaluation Study Investigators. The effect of spironolactone on morbidity and mortality in patients with severe heart failure. *N Engl J Med* 1999; 341: 709-717.
- ^{xiv} Weeldon NM, McDonald TM, Fluker CJ, McKendrick AD, McDevitt DG, Struthers AD. Echocardiography in chronic heart failure in the community. *Quarterly J Med* 1993; **86**: 17-20
- ^{xv} Hobbs FDR, Davis RC, McLeod S, Marshall T, Kenkre J, Lancashire R, Hare R, Davies MK. Prevalence of heart failure in 'high risk' groups. *Journal of the American College of Cardiology* 1998; 31: S5 : 85C
- ^{xvi} Remes J, Miettinen H, Reunanen A, Pyorala K. Validity of clinical diagnosis of heart failure in primary health care. *European Heart Journal* 1991; **12**: 315-321
- ^{xvii} Hobbs FDR, Davis RC, Roalfe AK, Hare R, Davies MK, Kenkre JE. Reliability of N-terminal pro-brain natriuretic peptide assay in diagnosis of heart failure: cohort study in representative and high risk community populations *British Medical Journal* 2002; 324 (7352): 1498-1502
- ^{xviii} Hobbs FDR, Roalfe AK, Davis RC, Hare R, Davies MK. Reliability of N-terminal proBNP (NT-proBNP) assay in diagnosing left ventricular systolic dysfunction within representative and high-risk populations. *Heart* 2004; 90: 866-70