EUROPEAN GENERAL PRACTICE
EGPRN
RESEARCH NETWORK

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

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European General Practice Research Network

Edirne – Turkey

17th – 20th October, 2015

SCIENTIFIC and SOCIAL PROGRAMME

THEME: "Research on Active Ageing in Family Medicine/General Practice"

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

CONFERENCE VENUE

Balkan Congress Venue
Situated in Trakya University Balkan Campus
http://www-en.trakya.edu.tr/pages/balkan-congress-venue
Edirne - Turkey

EUROPEAN GENERAL PRACTICE EGPRN RESEARCH NETWORK

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

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

- ► Trakya University, Edirne
- ► Eurasian Society of Family Medicine
- ► Tahud Edirne Branch

Trakya University, Edirne

Tahud Edirne branch

Eurasian Society of Family Medicine

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

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

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

"Research on Active Ageing in Family Medicine/General Practice".

Dear doctors, researchers, and colleagues,

Population around the world is rapidly ageing. With the increase in life expectancy people not only want to live longer, they also want to have a high quality of life. The age to be considered older has variations and changes from country to country. According to WHO people over 60 years of age and over are considered "older people". Ageing has challenges and opportunities. To meet these challenges and turning them into opportunities will help to improve the quality in active ageing. Elderly population in Edirne is about 9% and rapidly increasing putting the city in the third row in ageing. Researchers from Trakya University Department of Family Medicine are conducting a project to establish an Active Aging Center which includes medical, rehabilitation and social facilities to improve health related quality of life among elderly inhabitants. This will be an important opportunity for the participants to contribute this center's early outputs and vision.

- Patient safety
- Chronical diseases and elderly
- Mental Health
- Substance abuse in elderly
- Elderly abuse and neglect
- Multimorbidity in elderly
- Prevention in elderly
- Integrated care for elderly
- Communication with elderly
- Ethical aspects in care for elderly
- Epidemiological issues
- Social Determinants in Active Aging

Local Organizing Committee:

-Assoc. Prof. Ayse Caylan, Trakya University, Dept. of Family Medicine (Local Host),
-Prof. Dr. H. Nezih Dağdeviren, (Dean of School of Health Sciences and Chair of the Dept. of Family Medicine),
-Assoc. Prof. Serdar Oztora, Trakya University, Dept. of Family Medicine,
-Assist. Prof. A. Gulsen Ceyhun, Ankara University, Dept. of Family Medicine
-Assist. Prof. A. Selda Tekiner, Ankara University, Dept. of Family Medicine

MEETING EXECUTIVE BOARD
GENERAL COUNCIL MEETING

Executive Boardmeeting
Saturday 17th October, 2015

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

Location: Balkan Congress Venue
Situated in Trakya University Balkan Campus
Edirne (Turkey)
in: Senate Room

General Council meeting with the National Representatives
Saturday 17th October, 2015

14.00 - 16.45 : Council Meeting
Executive Board members and National Representatives
Coffeebreak at 15.30

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

Location: Balkan Congress Venue
Situated in Trakya University Balkan Campus
Edirne (Turkey)
in: Senate Room

REGISTRATION

► Saturday 17 October 2015

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

Location: Balkan Congress Venue
Situated in Trakya University Balkan Campus, Edirne (Turkey)

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

► Sunday 18 October 2015

REGISTRATION FOR ALL PARTICIPANTS
Time: 08.00 – 08.30 h.

Location: Balkan Congress Venue
Situated in Trakya University Balkan Campus, Edirne (Turkey)

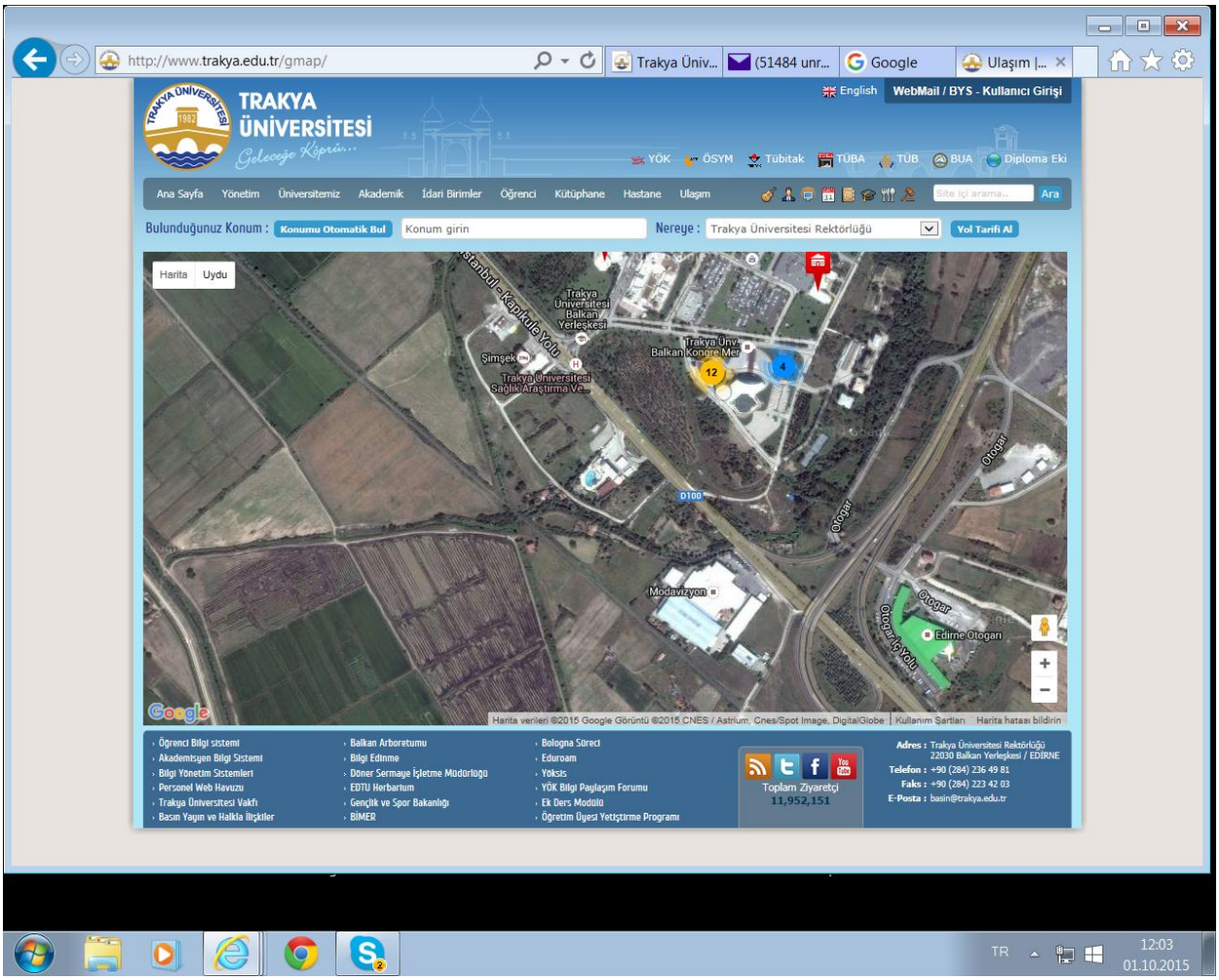
On arrival, every participant, who has not yet paid/registered online, will pay €450,= (or €250,= if an EGPRN-member) per person.
+ on site payment +€50 extra administration costs.

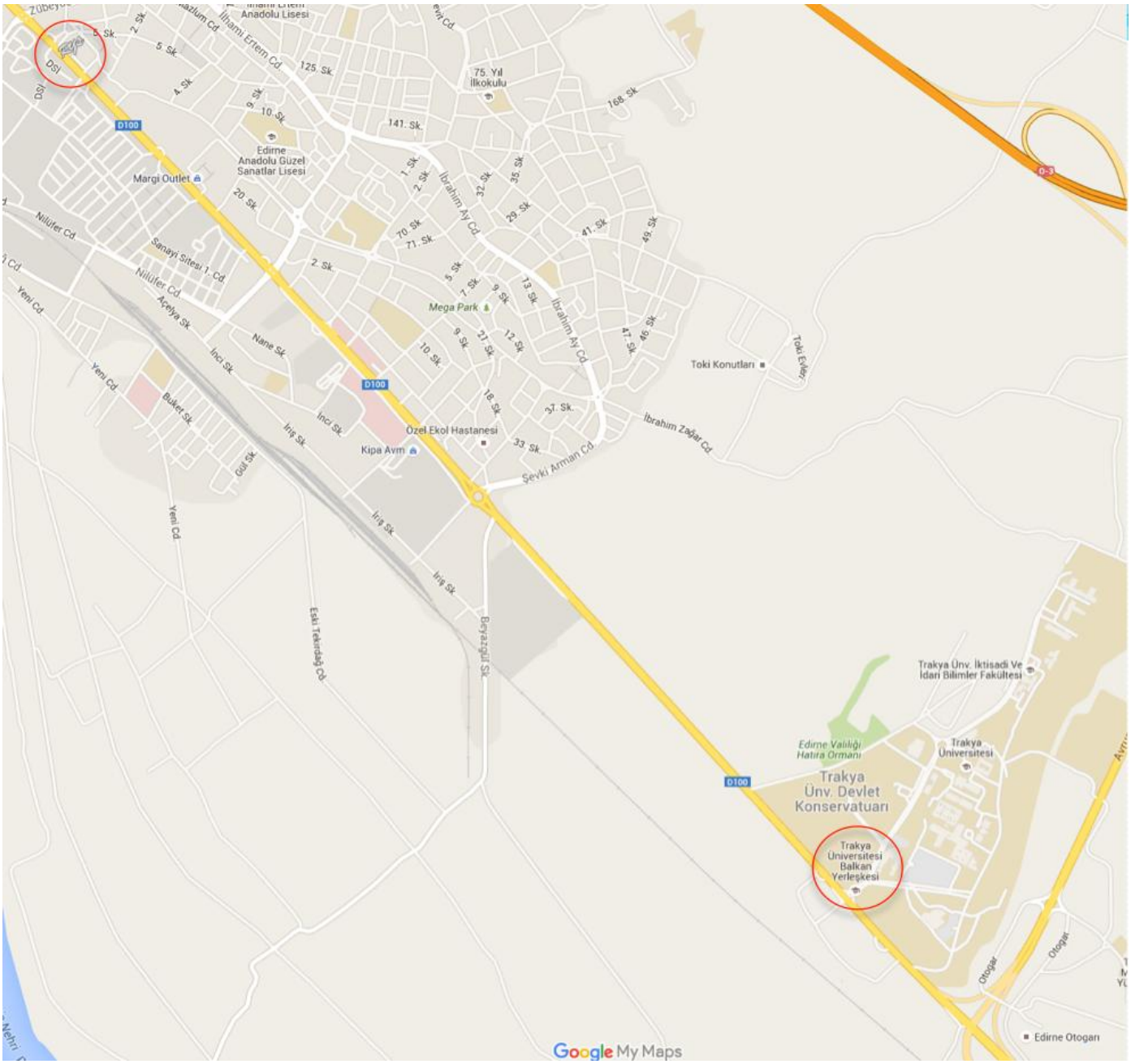
FOR ALL EGPRN PARTICIPANTS

Social night on Monday 19th October 2015 – 19.30 hrs.
Dinner, speeches and party.
Location: 'RYS Hotel – Blu Restaurant'
Address: 1. Murat Mah. Talatpasa Cd. No: 82 Merkez, 22030 Edirne-Turkey
Phone: Tel: +902842130797; Fax: +902842255800
Web: www.ryshotel.com - **(5km far from the venue (10 minutes by taxi)**
Entrance Fee: € 40,= per person.
Please address to EGPRN Registration Desk.

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

Map of the Edirne (Turkey)




Anadolu Lisesi
İlhami Ertem Cd
125. Sk
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168. Sk
141. Sk
Edirne Anadolu Güzel Sanatlar Lisesi
Margi Outlet
İbrahim Ay Cd
Nilüfer Cd
Sanayi Sitesi 1. Cd
Açelya Sk
Nane Sk
İnci Sk
Mega Park
Toki Konutları
Toki Evleri
Yeni Cd
Buket Sk
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Özel Ekol Hastanesi
Kıpa Avm
Şevki Arman Cd
İbrahim Zağar Cd
Eski Tekirdağ Cd
Beyazgül Sk
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Trakya Ünv. İktisadi Ve İdari Bilimler Fakültesi
Edirne Valiliği Hatıra Ormanı
Trakya Üniversitesi
Trakya Ünv. Devlet Konservatuarı
Trakya Üniversitesi Balkan Yerleşkesi
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E G P R N 17th – 20th OCTOBER, 2015

PROGRAMME OF THE EUROPEAN GENERAL PRACTICE RESEARCH NETWORK IN EDIRNE - TURKEY

SATURDAY 17th OCTOBER, 2015:

Location : Balkan Congress Venue
Situated in Trakya University Balkan Campus, Edirne (Turkey)

09.00 - 18.00 : **Collaborative Study Group**
"FPDM-1 EGPRN Collaborative Study"
(chair J.Y. Le Reste)
in: Room 2

09.00 - 18.00 : **Collaborative Study Group**
"FPDM-2 EGPRN Collaborative Study"
(chair J.Y. Le Reste)
in Room 3

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

10.00 - 12.30: **3 EGPRN Pre-Conference Morning Workshops**
€65 (€35 for EGPRN members) each per person.
Parallel workshops:

a. **Pre-conference Workshop *"How to read a paper - learning and using critical appraisal skills".***
Chair: Dr. Michael Harris (United Kingdom)
in: Hall A

b. **Pre-conference *Workshop "Approach to rational drug use in elderly".***
Chairs: Prof. Esra Saatçi, Prof. Ersin Akpinar (Turkey)
in: Hall B

c. **Pre-conference Workshop *"Qualitative research on active ageing".***
Chairs: Dr. Zekeriya Aktürk and Dr. Murat Ünalacak, (Turkey)
in: Room 4

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

13.30 - 16.00: **2 EGPRN Pre-Conference Afternoon Workshops**
€65 (€35 for EGPRN members) each per person.
Parallel workshops:

d. **Pre-conference *Workshop "E-health opportunities for the elderly".***
Chairs: Serkan Atagun (Software consultant in Ministery of Health)
Dr. Yavuz Selim Sılay MD, MBA (Turkey)
in: Hall A

e. **Pre-conference Workshop *"Prescribing physical activity for the elderly".*** (TR)
Chairs: Assoc.Prof.M. Mümtaz Maızıcıoğlu and Prof.Huseyin Demir – demirh90@gmail.com (Turkey)
in: Hall B

13.30 - 16.00 : **Study Group**
"Örenäs study"
(chair: M. Harris)
in: Room 4

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

During the last part of this Council meeting, the EGPRN Committees will take place as well: ►Educational Committee, ►Research Strategy Committee, ►PR & Communication Committee.

16.00 - 18.00 : **Study Group**
"PROCOPD study"
(chair: Ana Clavería)
in: Hall A

17.00 - 17.45 : **Business Meeting**
Meeting of the EGPRN Working Groups (last part of the Council meeting)
- Research Strategy Committee – in: Senate Room
- Educational Committee – in: Senate Room
- Communication and PR Committee – in: Senate Room

17.30 - 18.30 : **Collaborative Study Group**
"HEFESTOS Collaborative Study"
(chair: Miguel Muñoz)
in: Hall B

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

19.30 – : **Welcome Reception and Opening Cocktail for all participants.**

- **Welcome by Ass.Prof. Ayse Caylan, local host Edirne**
- **Welcome by Dr. Jean Karl Soler, Chair of EGPRN**
- **Welcome by Prof. Job F.M. Metsemakers, President Wonca Europe.**
- **Welcome by Prof. Dr. Yener Yörük, Rector of Trakya University**

Location: The Big Hall
Balkan Congress Venue
Situated in Trakya University Balkan Campus, Edirne (Turkey)

SUNDAY 18th OCTOBER, 2015

Location : Balkan Congress Venue
Situated in Trakya University Balkan Campus, Edirne (Turkey)

08.00 - 08.30 : Registration at EGPRN Registration Desk.

08.30 - 10.30 : Plenary Session
in: Senate Room
Chair: Jean Karl Soler

08.30 - 08.45 : Welcome.
Opening of the EGPRN-meeting by the Chairperson of the EGPRN, Dr. Jean Karl Soler

08.45 - 09.30: 1st International Keynote Speaker: *Prof. Partrik Midlöv, MD, PhD*;
(Professor Center for Primary Health Care Research, Department of Clinical Sciences, Lund University, Malmö, Sweden).
Theme: *"Healthy ageing: which primary health interventions work?"*

09.30 – 10.30 : 2 Theme Papers (plenary) – *"Primary Care and Older Complex Patients"*
in: Senate Room
Chair: Jean Karl Soler

1. id9 **Judith Sinnige (The Netherlands)**
   GP's considerations on medication management for older complex patients: a qualitative study.

2. id26 **Rodríguez-Pérez Mª Carmen (Spain)**
   Randomized clinical trial evaluating the effectiveness of a primary care intervention using the NintendoTM Wii console to improve balance and decrease falls in the elderly.

10.30 – 10.50: Coffee break
in: corridor area

10.50 - 12.20 : Parallel session A – 3 Theme Papers – *"Care of Older Patients"*
in: Hall A
Chair: Caroline Huas

3. id60 **Nadia Fartaoui (France)**
   Post hospitalisation of older people; which delay for the general practice consultation?

4. id63 **Marta Exposito Izquierdo (Spain)**
   GeriatrICS Project: Support to Chronicity and Prescription Adequacy in Nursing Homes for the Elderly.

5. id72 **Julien Le Breton (France)**
   Management of chronic disease in general practice.

10.50 - 12.20 : **Parallel session B – 3 Theme Papers – *"Miscellaneous 1"***
in: Hall B
Chair: Jan-Joost Rethans

6. id8 **Ferdinando Petrazzuoli (Italy)**
   Correlations between cognitive tests, and functional abilities in elderly primary care patients. A collaborative study between Sweden and Italy.

7. id33 **Regine Bölter (Germany)**
   Active aging? Patient's motivation to participate in a health check-up in general practice.

8. id74 **Paul Wallace (United Kingdom)**
   A randomised controlled non-inferiority trial of primary care-based facilitated access to an alcohol reduction website (EFAR-FVG): Preliminary results.

12.20 -13.45 : **Lunch**
in: corridor area

12.30 -13.30 : **The Educational Committee Lunch workshop – "Literature Review"** (or "How to conduct a Literature Review";
60 minutes with *Dr. Pemra Ünalan* and *Dr. Marija Petek Ster*, workshopleaders who will present, chair and discuss the theoretical and practical 'hands-on' session.
in: Hall A

13.45 -14.45 : **CELEBRATION 40 Years of EGPRN**
in: Senate Room

14.45 - 15.00: **Coffee break**
in: corridor area

15.00 - 17.00 : **Parallel session C – 4 Theme Papers – *"Frailty and Care Givers"***
in: Senate Room
Chair: ….

9. id7 **Pemra C. Ünalan (Turkey)**
Care burden of caregivers of home health care patients and related factors.

10. id28 **Assumpta Ferrer (Spain)**
Geriatric assessment and comorbidity to predict mortality in the oldest old. The Octabaix study: five year follow-up.

11. id34 **Francesc Orfila (Spain)**
Effectiveness of a multifactorial intervention to modify frailty parameters in the elderly.

12. id44 **Amalia Samoli (Greece)**
Frailty syndrome among younger and elder adults during times of austerity.

15.00 - 17.00 : **Parallel session D – 4 Theme Papers – *"Miscellaneous 2"***
in: Hall A
Chair: Paul Wallace

13. id22 **Evi Willemse (Belgium)**
Support measures for informal caregivers.

14. id24 **Luis Andrés Gimeno-Feliu (Spain)**
Is multimorbidity prevalence similar in immigrant and autochthonous populations? A Spanish comparative study based on primary care electronic health records.

15. id17 **Michal Shani (Israel)**
Uric acid levels within the normal range predict increased risk of diabetes mellitus: a community based cohort study.

16. id61 **Alberto Parada (Belgium)**
E-health in Elderly Patient : Promises and weaknesses of social media.

17.00 – 17.15: **Plenary Session**
in: Senate Room
Chair: Ferdinando Petrazzuoli

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

17.30 – 19.30 : **Collaborative Study Group**
"FPDM-3 EGPRN Collaborative Study"
(chair J.Y. Le Reste)
in: Hall A

Social Programme :

18.00 – 19.30 : Unfortunately, we cannot organize Practice Visits to various local Health Centres in Edirne, because the practices are not open on Sundays.

Instead we will visit an interesting historial place:
the Edirne Health Museum 'İkinci Bayezid Külliyesi'

Address:
Complex of Sultan Bayezid II Health Museum, Yeniimaret EDİRNE

We will go together by bus to the Health Museum

Pickup Time (from the Conference Centre) : 18.00 hrs. sharp

MONDAY 19th OCTOBER 2015

Location : Balkan Congress Venue
Situated in Trakya University Balkan Campus, Edirne (Turkey)

08.30 – 09.50 : Plenary Session
in: Senate Room
Chair: Paul van Royen

08.30 - 09.10 : 2nd Keynote Speaker: *Assoc. Prof. Ayse Caylan MD*; (Trakya University, Dept. of Family Medicine, Edirne, Turkey).
Theme: *"State of the Art of Family Medicine in Turkey".*

09.10 - 09.50 : 3rd International Keynote Speaker: *Prof. Christos Lionis, MD, PhD*; (Professor Department of Social and Family Medicine, University of Herakliou, Crete – Greece).
Theme: *"Prevention in elderly, healthy ageing in its essence?"*

09.50 -10.40 : Parallel session E - 1 Freestanding Presentation - *"From the Transition Project to a Learning Healthcare System"*
in: Senate Room
chair: Paul van Royen

17. id23 **Jean Karl Soler (Malta)**
From the Transition Project to a Learning Healthcare System for Primary Care – transforming the process of diagnosis in family practice.

09.50 - 10.45 : Parallel session F - 5 One Slide/Five Minutes Presentations
in: Hall A
chair: Esperanza Diaz

18. id30 **Ayşegül Uludağ (Turkey)**
Can Leisure Time Activities Prevent or Delay Cognitive Impairment in Geriatrics?

19. id64 **Claudia Iftode (Romania)**
Prevalence of cardiovascular diseases in obese and success rate of treatment in Timis County.

20. id69 **Daniela Hamulka (Croatia)**
What does the term "difficult patient" mean for the family physicians?

21. id70 **Canan Tuz (Turkey)**
What are the challenges of general practitioners towards vaccination in the elderly?

22. id71 **Seda Coşkun (Turkey)**
The risk of vitamin d deficiency in elderly patients with polypharmcy & management of rational polypharmacy.

****. Caroline Huas (France)**
A Horizon2020 call.

10.45 - 11.00 : Coffee break
in: corridor area

11.00 - 12.30 : Parallel session G - 3 Freestanding Papers – "Cognition and Self-Care"
in: Senate Room
chair: Kristin Hendrickx

23. id31 **Georgi Tsigarovski (Bulgaria)**
GP's attitude in consulting patients with erectile dysfunction in Bulgaria.

24. id38 **Thomas Frese (Germany)**
A Quick Test of Cognitive Speed: a normative study in German general practice population.

25. id47 **Anika Thielmann (Germany)**
Self-care for common colds across 14 European countries (COCO study): predictors for higher use of self-care measures.

11.00 - 12.30 : Parallel session H - 3 Freestanding Papers – "*Miscellaneous 3*"
in: Hall A
chair: Davorina Petek

26. id5 **Sibyl Anthierens (Belgium)**
Evaluating an international web-based behaviour change intervention to promote prudent antibiotic use by GPs: a triangulation of mixed methods data.

27. id11 **Clarisse Dibao (France)**
Changes in end-digit preference after two years of a cluster randomized trial : the ESCAPE-ABPMS2 study.

28. id36 **Jean Yves Le Reste (France)**
A RAND UCLA procedure to select the best reliable tool to assess Therapeutic Alliance. (TATA STUDY).

12.30 – 13.30 : **Lunch**
in: corridor area

13.30 – 14.30 : **Plenary Session – 'Special Methodology Workshop'**
in: Senate Room
Chair: Jean Karl Soler

29. id19 **Shlomo Vinker**
The impact of inclusion in a quality indicators program on anticoagulant treatment in atrial fibrillation

30. id49 **Kiril Slaveykov**
Telescreening for diabetic retinopathy in the elderly population.

The meeting continues with 4 parallel Poster sessions till 15.40 h.

14.30 – 15.40 : **Posters**
In four parallel sessions (4 groups)

14.30 – 15.40 : **Parallel group 1: Posters: *"Health Care Organisation"***
in: corridor area
chair: Sanda Kreitmayer

31. id6 **Nicola Buono (Italy)**
Informeg a new evaluation system for family medicine trainees: feasibility and effectiveness in an Italian rural setting.

32. id13 **Rositsa Dimova (Bulgaria)**
Validation of the Bulgarian version of EUROPEP-EUROPEP-instrument for patients' evaluations of general practice care - preliminary results.

33. id42 **Marija Petek Šter (Slovenia)**
Electrocardiogram in general practice in Europe – a key-informant survey.

34. id50 **Kalina Trifonova (Bulgaria)**
The use of internet for health information among patients– a sociodemographic comparison.

14.30 – 15.40 : **Parallel group 2: Posters: *"Care-givers and Organisation"***
in: corridor area
chair: Miguel Angel Munoz

35. id15 **Ana Clavería (Spain)**
1 dependent = 2 patients. The longer time with them, a higher burden for caregivers.

36. id39 **Ivan Ivanov (Bulgaria)**
Spiritual care and ageing focused on general practice patients.

37. id51 **Maria Karagianni (Greece)**
Governance, economic conditions, quality and continuity of primary health care services, during the health reforms in Greece.

38. Id55 **Nilüfer Demirsoy**
Ethical and legal issues encountered in elder patients in provision of primary health care.

14.30 – 15.40 : Parallel group 3: Posters: *"Cognition"*
in: corridor area
chair: Radost Asenova

39. id62 **Mireia Massot Mesquida (Spain)**
Deprescription of antidepressants, antipsychotics and benzodiazepines in nursing home residents with dementia.

40. id29 **Alejandra Paola Stivaletta (Spain)**
Agreement between brief neuropsicological tests for the detection of cognitive impairment in primary care.

41. id53 **Patrice Nabbe (France)**
FPDM (Family Practice Depression and Multimorbidity): the Hopkins Symptoms Checklist-25 items (HSCL-25), completed translation in 10 European languages.

42. id52 **Yordanka Staykova-Pirovska (Bulgaria)**
The use of alternative/complementary medicine in elderly patients in general practice.

14.30 – 15.40 : Parallel group 4: Posters: *"Clinical"*
in: corridor area
chair: Martin Beyer

43. id37 **Serap Çifçili (Turkey)**
One centered, randomized, double blind, phase III clinical trial comparing the effects of 1 mg/day oral colchicine and placebo being received for 3 months on pain, stiffness and physical function in patients with mild-severe knee osteoarthritis at primary care.

44. id43 **Ioana Gabriela Budiu (Romania)**
The incidence of acute upper respiratory tract infections in Timis County for the last 3 seasons autumn-winter (September - March).

45. id66 **Mustafa Kursat Sahin (Turkey)**
Prevalence and morphological distribution of anemia in elderly patients.

46. id68 **Zehra Dagli (Turkey)**
Is daily fluid consumption and notion of fluid adequate?

47. id 45 **Eleni Katmeridou (Greece)**
Epidemiology of Colorectal Cancer in Crete: Two decades of records and the role of GPs.

15.40 – 15.55 : Coffee break
in: corridor area

15.55 - 16.10: Plenary Session – 'Chairperson's Report' by Dr. Jean Karl Soler.
Report of Executive Board and Council Meeting.
in: Senate Room

16.10 – 17.10 : 2 Theme Papers (plenary) – *"Miscellaneous 4"*
in: Senate Room
Chair: Mehmet Ungan

48. id14 **Jelle Stoffers (The Netherlands)**
Medication knowledge of community-dwelling older patients with polypharmacy is related to the number of prescribed drugs, sex, age, and living situation.

49. id58 **Martin Beyer (Germany)**
Evaluation of a selective contract for GP-centred care in Baden-Wuerttemberg (Germany): Health care utilization and the care for the elderly.

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

17.10 – 17.25 : Closing of the day by *Prof. Christos Lionis,* keynote speaker, who will summarize on today's theme papers.

17.25 – 17.40 : Presentation of the EGPRN Poster Prize for the best poster presented in Edirne, by *Dr. Tiny van Merode.*

17.40 – 17.50 : Introduction on the next EGPRN-meeting in Tel Aviv-Israel, by *Dr. Joseph Azuri,* national representative of Israel.

17.50 – 17.55 : **Closing of the Scientific part of the conference, by *Dr. Jean Karl Soler,* EGPRN Chairperson.**

Social Programme :

19.30 - : **Social Night – Gala Dinner, Speeches and Party**

Dinner, speeches and party.

Location: **'RYS Hotel – Blu Restaurant'**

Address: 1. Murat Mah. Talatpasa Cd. No: 82 Merkez, 22030 Edirne-Turkey

Phone: +902842130797; Fax:+902842255800

Web: www.ryshotel.com

- (5km far from the venue (10 minutes by taxi)

Entrance Fee: € 40,= per person.

Please address to EGPRN Registration Desk.

Participants can take a taxi to RYS hotel.
Price taxi: €5 per taxi.

TUESDAY 20th OCTOBER 2015

Location : Balkan Congress Venue
Situated in Trakya University Balkan Campus, Edirne (Turkey)

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

SUNDAY 18th OCTOBER, 2015:

Location : Balkan Congress Venue
Situated in Trakya University Balkan Campus, Edirne (Turkey)

08.45 - 09.30: **1st Keynote Speaker: *Prof. Patrik Midlöv, MD, PhD*;** (Professor Center for Primary Health Care Research, Department of Clinical Sciences, Lund University, Malmö, Sweden).

Theme: *"Healthy ageing: which primary health interventions work?"*

Ageing is not a disease, but a natural developmental process (if we are lucky). As we age many of our bodily functions decline. Heart, lung, muscle, kidney and cognitive functions are some examples of expected decline with ageing. One should however be aware of the great variability within the elderly. Many different factors affect the variability in the elderly e.g. heredity, previous diseases, environmental factors, but also different coping abilities.
Healthy ageing means that everyone has a right to the highest attainable standard of physical and mental health, no matter what age. To accomplish this primary care has an important role to play.

Effective interventions within the following areas will be presented:
Appropriate use of medications is especially important for older people. Drug-related problems (DRPs) are a well-known cause of morbidity and mortality in the elderly - but are often preventable. Older people are vulnerable to DRPs for several reasons - including physiological alterations that affect pharmacodynamics and pharmacokinetics, resulting in enhanced and prolonged drug effects; increased prevalence of chronic diseases; and concomitant use of other medications. Medication review and other kind of interventions have successfully reduced the use of inappropriate medications and also led to positive health outcomes.
Physical activity has a number of positive effects for older people. The health benefits of exercise and risks of inactivity have 'have become increasingly evident in the 21st century. Physical activity improves quality of life in adults with chronic conditions, has positive effects on coronary heart disease as well as diabetes type 2 risk and reduces the risk of falls. Despite these facts, many older adults are physically inactive and this inactivity increases with age. It is not easy to increase physical activity in older adults but there are examples of effective interventions within primary care.
Falls are the most common cause of injuries among older people. A significant number of hospital admissions of patients older than 65 years are due to falls. Upper extremity fractures and hip fractures are the most common fall-related injuries that lead to emergency department visits. The risk of falls also affects quality of life and may cause social isolation. Some falls are due to inappropriate medications and this is an area where primary care is suitable for interventions.
Vaccination of older people affects morbidity and mortality. There is overwhelming evidence regarding the positive effects of vaccination for older people.
Loneliness increases with age, especially among the elderly. Loneliness and social isolation are important risk factors of ill health. There is a lack of evidence even if some smaller studies in primary care have been effective.

Patrik Midlöv, MD, PhD
Lund University, Center for Primary Health Care Research, Malmö-Sweden
e-mail: patrik.midlov@med.lu.se

MONDAY 19th OCTOBER, 2015:

Location : Balkan Congress Venue
Situated in Trakya University Balkan Campus, Edirne (Turkey)

08.30 - 09.10 : 2nd Keynote Speaker: *Assoc. Prof. Ayse Caylan MD*; (Trakya University, Dept. of Family Medicine, Edirne, Turkey).
Theme: *"State of the Art of Family Medicine in Turkey".*

Since 1978 Alma-Ata Declaration, the idea of "health-for-all" has played an important role in the development of health, giving priority to basic health care. According to the WHO, the health care system must provide good quality health care services for all. The services provided must be effective, affordable and socially acceptable.

The European Union has introduced a Public Health Programme for 2001-2006 with the aim of improving public health, preventing human illness and disease, and removing sources of danger to health. According to this programme, the family physicians have an important role in health prevention. Family physicians working in primary care have to pay certain attention to some certain populations, elderly population is beeing one of them. Maintanence of health in elderly population in a cost effective way is important and this also includes maintaining the active ageing of elderly. This key note will adress to the state of art of Family Medicine and as well as active ageing in Turkey.

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MONDAY 19th OCTOBER, 2015:

Location : Balkan Congress Venue
Situated in Trakya University Balkan Campus, Edirne (Turkey)

09.10 - 09.50 : 3rd International Keynote Speaker: *Prof. Christos Lionis, MD, PhD*;
(Professor Department of Social and Family Medicine, University of Herakliou, Crete – Greece).
Theme: *"Prevention in elderly, healthy ageing in its essence?"*

Prevention and health promotion are central issues in health care systems while primary care is considered as a key vehicle in implementing effective interventions. Prevention has been also defined as a core competence in the European General Practice/ Family Medicine (GP/ FM) definition and the subject has been also engaged by the EGPRN research strategy. However, both concepts as naturally we expect, have been widely discussed in the childhood or early adulthood leaving actions to be undertaken for the seniors. Nevertheless, the key factors that have an impact to an active and healthy ageing and explore existing potentialities for GP/FM are important. This keynote will address conceptually the subject of prevention in elderly and will attempt to illustrate the determinants of an active and healthy ageing based on evidence available in the current literature. There are efforts that need to be undertaken to assist seniors to live not only longer but also to decrease cognitive decline or dependency and the related consequences. This requires comprehensive and well-coordinated actions under a patient-centered approach, which will be focused on avoiding malnutrition, in strengthening of muscles and physical activity, prevention of falls and reduction of fractures, complete vaccination coverage as well as in reducing the side effects of polypharmacy in multimorbid patients. Assessment tools, that can be used in a primary care setting, can elucidate and analyse the concepts and the theory.

The European Commission has determined active and healthy ageing as a major societal challenge common to all Member States and to that direction a 2020 strategy that includes the European Innovation Partnership and aims "to improve the quality of life of older people and enable them to stay active for as long as possible" has been put forward.

Good practices that can be used in early diagnosis of frailty in the European setting are illustrated in the EU edition of an action group on "Prevention and early diagnosis of frailty and functional decline, both physically and cognitive, in older people". Data and first results of initiatives relevant to early diagnosis of frailty and improvement of the quality of life of older people undertaken by the Cretan Rural-practice based research network as well as their experiences can also shed light. Challenges of both family practice research and clinical practice exist, and can be resolved by indicating areas of high priority and suggesting collaborative work with EGPRN.

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PRESENTATION 01: Sunday 18th October, 2015 THEME PAPER
09.30–10.00 h. Ongoing study with preliminary results

GP's considerations on medication management for older complex patients: a qualitative study.

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Id9
Background: In older patients with multimorbidity attention for appropriate medicine prescribing is of major importance. Due to the heterogeneity of this complex patient group, it is often difficult for general practitioners(GP) to make decisions concerning medication management. It is unclear what kind of strategy GPs follow in the patient's medication management, how the GP takes decisions, and by what kind of factors medication management is influenced.
Research questions: What are the GP's considerations on medication management for older patients with multimorbidity and polypharmacy, and how does this differ between GPs? What are the GPs' perspectives, and needs, on decision making support to facilitate medication management for these patients?
Method: In this qualitative study, focus groups were organized with experienced GPs in the Netherlands. GPs completed a survey individually, presenting questions about medication management of four case vignettes of older patients with multimorbidity and polypharmacy. The vignettes were discussed plenary to answer our research questions. The focus groups were recorded, transcribed, and analyzed using the Framework approach.
Results: Twelve GPs participated in two focus groups. Preliminary results showed that variation existed in the medication management approach described by GPs. Four predominant themes were related to GPs' considerations on medication management: 1)Prioritizing treatment according to determined treatment goals; 2)Focus on one or two problems rather than treatment of all problems at once; 3)Clinical guidelines as the basis; 4)Influence of patient characteristics. As regards decision making support, GPs value the concept of medication reviews on consult and practice level, electronic decision aids, and interventions to identify frail elderly.
Conclusions: Several factors are related to GPs' considerations on medication management, and can complicate treatment of older patients with multimorbidity and polypharmacy. Yet, medication reviews, electronic decision aids, and insight into the practice's frail population seem promising tools to facilitate management.

Points for discussion:
1.In older patients with multimorbidity and polypharmacy, what do you think are the most important factors that contribute to your/a GP's decision to add or stop a medicine, and what do you consider useful tools to facilitate medication management?

PRESENTATION 02: Sunday 18th October, 2015 THEME PAPER
10.00–10.30 h. Ongoing study with preliminary results

Randomized clinical trial evaluating the effectiveness of a primary care intervention using the NintendoTM Wii console to improve balance and decrease falls in the elderly.

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Id26

Background: Balance alteration is a risk factor for falls. Even though there are quite a few publications about balance and consoles, trials with bigger samples and longer follow-up are required.
Research question: Can an intervention utilizing the NintendoTM console improve balance, thereby decreasing both the fear of falling as well as the number of falls?
Method: This is a controlled, randomized clinical trial, carried out on patients over 70 years in age, from five primary care centers in the city of Mataró (Barcelona). 380 patients were necessary for the intervention group (IG) that carried out the balance board exercises in 2 sessions per week for a 3-month period, and 380 patients in the control group (CG). Balance was evaluated using the Tinetti's test, the one foot stationary test and with the console, at the start of the study, at the end of the intervention (3 months) and one year later. Telephone follow-up was also conducted to keep track of falls and their consequences.
Preliminary Results: 951 patients. 461 CG and 490 IG. The sample got bigger since losses were more than expected. After 3 months, analyzing data from 312 patients in the CG and 214 in the IG we found improvement on the one foot stationary test in the IG (77.9% 1st visit and 89.4% after training p 0.001) and improvement of the fear of falling. On Tinetti's test we found just a trend, without achieving statistical significance.
At 1 year and after analyzing 34.7% of the whole sample, we found fewer falls in the IG, achieving statistical significance.
Conclusions: An easy and economical training by means NintendoTM Wii improves the one foot stationary test and reduce the fear of falling. It could reduce the number of falls but is prudent to wait for further results from the whole sample.

Points for discussion:
1. losses more than 20% expected (almost 40% in Intervention Group)

PRESENTATION 03: Sunday 18th October, 2015 10.50–11.20 h. **THEME PAPER**

Post hospitalisation of older people; which delay for the general practice consultation?

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Id60

Background: Post Hospitalisation of older people is a complex period, where adverse events can occur like rehospitalisation. The general practitioner has an important role for coordination, treatment adaptation. However, we don't know much about primary care consumption during this period, and its implications.
Research question: What is the delay between discharge hospitalisation of older people and first GP consultation, what are the associated factors?
Method: A chronological database of 4 years was created with:
-SNIIRAM 2005/2008, representative sample of older people, 65 years aged and over.
This system records all medical procedures of French National Health Service. We made an extraction of all hospitalisations and GP consultations.
-ESPS 2006 and 2008, a survey which studied declarated health status, health protection, education level, care renunciation.
Temporal indicators were created to measure the delay between discharge and first consultation, the occurrence percentage of that consultation within the first seven days after discharge, the correlation of that occurrence with rehospitalisation, and associated factors.
Results: The database included 11407 people (39.2% men), mean age 74.9 years, 13767 hospitalisations.
Within a 90 days period, the mean delay between discharge and first consultation was 18.15 days; 42.7% of hospitalisations were followed by a consultation within 7 days, and 78.9% within 30 days.
The occurrence within 7 first days wasn't associated with:
-sex, -social protection, -education level, -care renunciation
It increased with: -age, -chronic disease, -hospital stay
Early rehospitalisations, within 7 and 30 days, were associated with a lower occurrence of that consultation in this 7 days delay.
Conclusions: The first GP consultation generally occurs soon after discharge for elderly people. The contents of consultations and hospitalisations were not accessible, so we couldn't impute causality to these observations. The analyse of implications of that first consultation needs thorough studies.

Points for discussion:
1. avoidable rehospitalisation of older people
2. GP's coordination and how to record this role
3. health trajectories and indicators

PRESENTATION 04: Sunday 18th October, 2015 THEME PAPER
11.20–11.50 h. Ongoing study with preliminary results

GeriatrICS Project: Support to Chronicity and Prescription Adequacy in Nursing Homes for the Elderly.

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Id63

Background: The GeriatrICS project was originated by the need to improve the care of institutionalized elderly patients. Similarly to other diseases, these patients and their chronic conditions evolve until the end-of-life. This dynamic process requires a reorganization of the health care of institutionalized chronic patients, both by primary care teams and health providers.
Research question: Providing a high-quality, comprehensive care to elderly, with the guiding patient centred care would reduce hospital admissions and avoid unnecessary visits to ER (Emergency Room) in institutionalized patients.
Method: Geriatrics is a population based study with a pre-post intervention, involving 64 GP, 184 Nursing Home (NH) and 8.984 institutionalized patients (IP) in the geographical area of Metropolitan Nord, Catalan Institute of Health. Catalonia, Spain. The intervention was developed to ensure its consistency and to achieve healthcare objectives determined by proactive healthcare formulae with a reorganization of the health care of institutionalized chronic patient. Inclusion of the approach to a consistent quality end-of-life. As a primary outcome the reduction of the number of visits, hospital admissions and visits to ER (per 100 residents) was assessed. The reduction of yearly cost per resident in pharmacy was also considered as a secondary outcome.
Results: The intervention was being carried out in 181 NH (8,743 IP). 63.8% had >2 chronic conditions, 42.5% had dementia; mean of Barthel's was 47.52 and mean of Pfeiffer was 6.04. Hospital admissions were reduced by 26.9% (35.7 (2012) to 26.1 (2014)), attendance to ER by 16.1% (66.4 to 62.2). Use of internal health resources increased by 20.4% (primary care emergency services). Cost per resident decreased by 18.1% since 2012.
Conclusions: This project shows a change from the usual approach in the management of health care, it improves continuity of care, better use of health resources and increases patient safety and focuses on the primary care teams.

Points for discussion:
1. Reduction of preventable hospitalizations
2. Reorganization of the health care

PRESENTATION 05: Sunday 18th October, 2015 11.50–12.20 h. **THEME PAPER**

Management of chronic disease in general practice.

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Id72

Background: There is no consensus among researchers on definition of chronic disease. Some authors have proposed chronic diseases lists, but we do not know how the diseases are managed over time in general practice and it is sometimes difficult to characterize them as chronic or acute.
Research question: How to characterize management in the duration of diseases and list the most common chronic diseases in general practice?
Method: We conducted a cluster analysis of all diagnoses managed by 72 GPs during visits from 2007 to 2011. The active variables were chronic ratio (ratio of persistent cases / new cases), median duration of episode of care, number of recurrence of new cases.
Results: Analysis of 2,564,867 diagnoses identified a partition in six clusters:
1. Weakly recurrent acute diseases (N=166, 66%)
2. Acute diseases with evolution by crises (N=40, 16%)
3. Typical recurrent acute diseases (N=16, 6%)
4. Chronic diseases with potential decompensation (N=21, 8%)
5. Stable chronic diseases (N=4, 2%)
6. Chronic diseases with frequent imbalances (N=6, 2%)
Conclusions: 31 diagnoses were identified as being managed by GPs as chronic diseases (clusters 4,5 and 6), in total agreement with the international literature. Some chronic diseases were managed as acute diseases: management by crises (eg depression), secondary actor in monitoring (eg cataracts), episodic patient visits (eg asthma) or one-time request (eg obesity). The criteria discriminate management in the duration of diseases by GP and question the acute / chronic dichotomy.

Points for discussion:
1. We used an original method which allowed to investigate management of chronic disease over time in general practice.
2. These results question the acute / chronic dichotomy.
3. These results support to review guidelines and training.

PRESENTATION 06: Sunday 18th October, 2015 10.50–11.20 h. **THEME PAPER**

Correlations between cognitive tests, and functional abilities in elderly primary care patients. A collaborative study between Sweden and Italy.

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Id8

Background: Functional tests are used to assess the abilities necessary for independent living. They are based on informant reports; unfortunately literature data suggest that this information is not always trustworthy: too subjective, poor reliability, undisclosed interest of informants, and absence of informants. Thus, there is a need for objective tools that correlate with functional abilities and can help in the interpretation of functional tests.
Research Question: How do the cognitive tests, a quick test of cognitive speed (AQT) and the mini mental state examination (MMSE) correlate with the Functional Activities Questionnaire (FAQ) and the Instrumental Activities of Daily Living (IADL) in cognitively impaired patients in the primary care setting?
Methods: We examined 129 patients, 60 Italians (23M; 37F) and 69 Swedes (28M; 41F) aged from 42 to 92, mean age 76.8 years, attending primary care services with suspected mild cognitive impairment (MCI). Participants completed the cognitive tests: AQT (color, form, color-form) and MMSE. The functional scales (FAQ and IADL) were based on informant reports.
Results: Pearson correlation was used to assess the relationship between cognitive tests and functional tests. In Italian patients: MMSE and IADL: r= 0.344 (95% CI 0.10 – 0.55); AQT color-form and IADL: r= -0.425 (95% CI -0.13 – -0.72). In Swedish patients: MMSE and FAQ: r=-0.399 (95% CI -0.18– -0.58); AQT color-form and FAQ: r=- 0.584 (95% CI 0.40–0.72). All the correlations were significant, $p<0.001$.
Discussion and Conclusion: AQT showed higher correlation with functional scale scores compared to MMSE in both Italian and Swedish patients. We therefore suggest that AQT should be tested in future studies in the primary care setting in conjunction with MMSE for a first overall assessment in patients with suspected cognitive problems.

Points for discussion:
This was a feasibility study of cognitive assessments in Primary Care in two EGPRN countries. What tests are used to assess the cognitive abilities in primary care in EGPRN countries? What are the most popular functional tests in primary care in EGPRN countries.

PRESENTATION 07: Sunday 18th October, 2015 THEME PAPER
11.20–11.50 h. Ongoing study with preliminary results

Active aging? Patient's motivation to participate in a health check-up in general practice.
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Id33
Background: In 1989, the German health insurance system introduced "check-up 35" as a biennial tool for prevention and health promotion. Health goals should be avoiding chronic conditions, maintaining physical health and promoting well-being for active aging. Although this is used by about 50% of eligible over 35-years-olds, the motivation of these patients is underinvestigated. The 2012 Cochrane review reports that health checks did not reduce morbidity or mortality.
Research question: The aim of the study was to evaluate patients' motivation for this health check-up.
Method: A qualitative study was performed. Patients were interviewed to evaluate their motivation for participation in this check-up. Data analysis of the qualitative study was conducted using content analysis according to Mayring.
Results: To date, 10 patients (on average 56 years old) have been interviewed. 80% were female.
The main category "patient motivation" could be divided in four subcategories:
•Affirmation of good health
•Individual responsibility
•Follow up of pre-existing conditions
•Early diagnosis and healing.
Most participants wanted a full physical examination. They wanted to affirm themselves as being in good physical health. Their active participation was experienced as a form of individual responsibility for their own health. Furthermore, they wished for good monitoring of a pre-existing condition. Another motivation was early diagnosis in hope of better chances for full healing of a disease.
Conclusions: From the viewpoint of our participants, check-ups were important to confirm good physical health. Considering the background of the Cochrane review, there is a conflict existing between the expectations and the hopes of our participants for an affirmation of physical health and the existing scientific evidence. Opportunities and limitations of the check-up must be communicated clearly. General practitioners should support patients to enable them to live with uncertainty and enhance health education, in order to empower patient`s individual responsibility in active aging.

Points for discussion:
1. How can we teach patients to live with uncertainty?
2. How do we deal honestly with patients regarding prevention programs?

PRESENTATION 08: Sunday 18th October, 2015 THEME PAPER
11.50–12.20 h. Ongoing study with preliminary results

A randomised controlled non-inferiority trial of primary care-based facilitated access to an alcohol reduction website (EFAR-FVG): Preliminary results.

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Id74

Background: The effectiveness of brief interventions for risky drinkers by GPs is well documented. However, implementation levels remain low. Facilitated access to an alcohol reduction website offers an alternative to standard face-to-face intervention, but it is unclear whether it is as effective.
Research question: Is online brief intervention facilitated by GPs as effective for risky drinkers as face to face brief intervention?
Method: In a northern Italy region participating GPs actively encouraged all patients > 18 attending their practice, to access an online screening website based on AUDIT-C. Those screening positive underwent a baseline assessment with the AUDIT-10 and EQ-5D questionnaires and subsequently, were randomly assigned to receive either online counselling on the alcohol reduction website (intervention) or face-to-face intervention based on the brief motivational interview by their GP (control). Follow-up took place at 3 and 12 months and the outcome was calculated on the basis of the proportion of risky drinkers in each group according to the AUDIT-10.
Results: More than 50% (n= 3974) of the patients who received facilitated access logged-on to the website and completed the AUDIT-C. Just under 20% (n = 718) screened positive and 94% (n= 674) of them completed the baseline questionnaires and were randomised. Of the 310 patients randomised to the experimental Internet intervention, 90% (n = 278) logged-on to the site. Of the 364 patients of the control group, 72% (263) were seen by their GP. A follow-up rate of 94% was achieved at 3 months.
Conclusions: The offer of GP facilitated access to an alcohol reduction website is an effective way of identifying risky drinkers and enabling them to receive brief intervention. The preliminary study results will be available soon and I expect to be able to present these to the conference.

Points for discussion:
1. Is the non-inferiority trial design suitable in this case?
2. What do you think about using digital interventions to promote of healthy behaviours?
3. Are you familiar with the concept of facilitated access to websites?

PRESENTATION 09: Sunday 18th October, 2015 15.00–15.30 h. **THEME PAPER**

Care burden of caregivers of home health care patients and related factors.

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Id7

Background: Caregiver is the person who is helping the patient to deal with the illness and this help includes physical, emotional and tangible support. This intensive working effects the caregivers of the patients who are confined to house or bedridden.
Research question: what is the patients' and caregivers' characteristics, burden of care and potential factors effecting this?
Method: Caregivers of the registered patients of our home health care unit, aged 65 years or older, with Serebrovascular Disease were included. 69 caregivers were assessed using Zarit Caregiver Burden İnventory, sociodemographic information form, general self-efficacy scale, İnventory of socially Supportive Behaviors. All scales were 5-point Likert scale. Zarit Caregiver Burden İnventory consists of 22 items with total points of 88. 3 items selected from İnventory of socially Supportive Behaviors with total points of 12 and 5 items from General Self-efficacy Scale with total points of 25 were used for assessment. Chi-square and Student-T tests were used in the data analysis, $p<0,05$ was significant.
Results: Caregivers were at the mean age of 48,22 (±10,6) with the mean duration of caregiving of 4,61 (±3,64) years.Of the 69 caregivers, 85,5 % (n=59) were female, 63,8 % (n=44) had low education level (≤ 5 years) , 79,7% were giving care continuous. Social Support Point, Self-efficaccy Point and Zarit Caregiver Burden İnventory mean scores were 3,5 (±2,44), 19,8 (±4,43) and 54,9 (±11,24) respectively. Self-efficaccy scores were higher at male gender, intermittent caregivers and higher education level (>5 years) (p=0,033 p=0,006 p=0,006 respectively). These groups had no statistically significant association with Social Support and Caregiver Burden.
Conclusions: İn this study Burden of care was assessed at severe levels and Social support was poor among our patients. By comprehensive studies, exposure of the factors contributing to burden in caregivers would be beneficial for both the patient and the caregiver.

Points for discussion:
1. hat else factors would be effective to burden in caregivers?

PRESENTATION 10: Sunday 18th October, 2015 THEME PAPER
15.30–16.00 h. Ongoing study with preliminary results

Geriatric assessment and comorbidity to predict mortality in the oldest old. The Octabaix study: five year follow-up.

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Id28

Background: Due to the increase in the population of oldest old subjects (over 85 years), it is important to know whether the factors of mortality in young adults are similar in this age. Our group discovered that tools used in community geriatric assessment were useful for community-dwelling subjects aged 85 years at baseline to predict mortality at three years of follow up.
Research question: Which are the predictors of death in an oldest old cohort after 5 years of follow-up?
Method: The Octabaix study is a prospective, community-based study involving 328 subjects aged 85 in the geographical area of Baix Llobregat (Spain). The intervention consisted in a community-based multifactorial program. The control participants received usual care. Data on functional and cognitive status, comorbidity, nutritional and falls risk, quality of life, social risk, long-term drug prescription and laboratory analysis were collected. Proportional hazards and linearity assumptions were evaluated for the Cox models to determine the variables associated with five year mortality.
Results: Mortality after 5 years was 42.073%. Patients who survive were predominately women and had significantly better baseline functional status of daily living ($p<0.001$) (Barthel and Lawton Index), better cognitive performance ($p<0.001$) (Spanish version of the Mini-Mental State Examination), lower comorbidity ($p<0.001$) (Charlson), lower nutritional risk ($p< 0.001$) (Mini Nutritional Assessment), lower risk of falls ($p<0.001$) (Tinetti Gait Scale), less percentage of heart failure ($p= 0.002$) and COPD ($p=0.03$) and were taking lesser chronic prescription drugs ($p=0.02$). Cox regression analysis identified the Lawton Index (HR=0.83, 95%CI=0.75-0.91) and the comorbidity (HR=1.17, 95%CI=1.01-1.36) as independent predictors of mortality at 5 years. These are preliminary results of an ongoing study.
Conclusions: The ability to perform instrumental activities of daily living and the global comorbidity at baseline are the best predictors of an 85 old community-dwelling subjects after a 5 year follow-up period.

Points for discussion:
1. The increase in the pyramid of the population and the consequent increase in the number of oldest old (over 85 years) make it mandatory to reflect on their peculiarities.
2. Classical factors of mortality in young adults are similar in this age or not.

PRESENTATION 11: Sunday 18th October, 2015 16.00–16.30 h. **THEME PAPER**

Effectiveness of a multifactorial intervention to modify frailty parameters in the elderly.

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Id34

Background: The prevalence of disability increases with age. Identifying frail population to conduct effective interventions that can prevent or delay the loss of autonomy is a public health priority.
Research question: To evaluate the effectiveness of a multifactorial intervention based on physical activity, diet, memory workshops and medication review, to modify muscle strength and physical and cognitive performance in frail people 65 years or older.
Method: A randomized clinical trial with control group (CG) and blind evaluations, conducted in eight Primary Care Centers in Barcelona. A total of 352 patients,176 in each group. Inclusion criteria: ≥65 years old, Barber test≥1, Get up and go test (TGUGT) 10 to 30 seconds, no severe cognitive impairment. Intervention (IG): Rehabilitative therapy, hyperproteic shakes. Memory Workshop. Review of medication. Measurements: Short Physical Performance Battery (SPPB, range 0-12), Hand Grip Strength (HGS), neuropsychological evaluation (Barcelona Test) and number of prescriptions at baseline and after the intervention, in both groups.
Analysis of variance for repeated measures was performed between baseline and after intervention.
Results: 75,3% women, mean age 77.3 (DE:7.2). Mean number of prescriptions 7,5, mean TGUGT 14,8 seconds, mean SPPB 7.2, mean HGS 16,5. No differences between groups at baseline. After intervention, in the IG prescriptions decreased (7.7 to 6.9) and SPPB and HGS improved (7.1 to 8.1 and 16.5 to 18,7), $p<0.001$, while the contrary was observed in CG. Cognitive performance (Verbal Memory, Animal Naming Test, Evocation of words, Verbal abstraction) also improved in the IG, and compared to CG ($p<0.001$).
Conclusions: The intervention on frail patients has proved to be effective in terms of strength and cognitive performance at short term. Long term effectiveness and adverse outcomes (falls, disability, hospitalization, institutionalization, death) will be evaluated in the follow-up. The satisfaction among IG patients also encourages the continuity of this type of interventions.

Points for discussion:
1. Many different frailty definitions and screens available
2. How to achieve adherence to this type of interventions

PRESENTATION 12: Sunday 18th October, 2015 16.30–17.00 h. **THEME PAPER**

Frailty syndrome among younger and elder adults during times of austerity.

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Id44

Background: Frailty as a dynamic predictability has received prompt attention in the literature by research institutes and funding organizations, while it has been noted as one of the most challenging tasks for General Practitioners (GPs) in Greece. The Greek economic crisis that has increased unemployment, homelessness and leaving people uninsured is anticipated to impact vulnerable individuals with frailty.
Research question: Main aim wa to assess the burden of frailty among economically vulnerable population groups in the city of Heraklion in Crete? Which determinants can predict frailty?
Method: Participants (N=314; response rate= 98%) were all adults (over 18 years old) that attended any of the services of the "Social Space", a hospice (Foundation Kalokairinou). Frailty syndrome was assessed through the "Frail scale", along with WHO wellbeing index, EuroQol and several supplementary questions. All tests were performed in the SPSS 20.0 (a = 0.05).
Results: Frailty prevalence among all participants was 9.5% (pre-frailty=18.4%; frailty and pre-frailty= 28.1%). These rates increased among eldest adults (over 65 years) reaching the 55.5% (22.2% and 33.3% for men and women, respectively). Age, marital status, way of living, accommodation of children (away from the participants), low income, years of smoking, alcohol consumption and the number co morbidities were related to "frailty syndrome" (Pvalue<0.05). Wellbeing score and self-perceived health status were conversely related to frailty and pre-frailty stages (Pvalue <0.02). Exercise acts protectively on frailty (OR=0.2, 95% CI= 0-0.4, Pvalue=0.01) whereas living alone (OR=2.6), number of comorbidities (OR=2.5), years of smoking (OR= 1.4), alcohol consumption (OR=1.4) and age (OR=1.1) were the major risk factors (Pvalue<0.05).
Conclusions: The burden of the "Frailty syndrome" cannot be ignored during the period of austerity among elder adults. A diagnostic model based on the explored identified determinants of frailty that could be formed to guide GPs in its early diagnosis and intervention.

Points for discussion:
1. The role of GPs in the early recognition of frailty and what we can learn from the assessment exercise.
2. The role of GPs, School of Medicine and local authorities in frailty management among unemployed, uninsured and homeless people in Iraklion city.

PRESENTATION 13: Sunday 18th October, 2015 THEME PAPER
15.00–15.30 h.

Support measures for informal caregivers.

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Id22

Background: The number of very old people in Europe will increase drastically and there will be an increase in need of long-term care over time. Care provided by family members, friends and neighbours remains an essential piece of long-term care in all European countries. Providing informal care may have negative consequences on people's physical and psychological health and may affect labour market participation. How to support informal caregivers is an important topic on how to ensure the sustainability of the long-term care system.
Research question: What are the experienced advantages and short-comings of available support measures for informal caregivers in Belgium and in four other European countries?
Method: An empirical qualitative study using an embedded multiple case-study design was performed. Semi-structured interviews were done with 38 ICG, with at least 5 ICG living in each geographical region (Belgium, France, Germany, the Netherlands and Luxembourg). A thematic analysis was done per region.
Results: In all regions, ICG ensure the continuity of care through coordination of the services provided by health and care professionals. Information on available services often is provided at discharge from the hospital. Timely access to proactive information seems one of the key issues that is lacking in Belgium, this in contrast with the cases abroad.
Conclusions: Informal caregivers deal every day with the complex home care system in Belgium. Coordinators of care in close collaboration with the GP, can help to coordinate home care services and provide coordination support to dependent elderly and their informal caregivers. Existing tools such as the general medical record (GMD – DMG) and the BelRAI could help care workers to better support informal caregivers and elderly.

Points for discussion:
1. What is the perspective of the General practitioner on his/her central role to support the caregiver?

Is multimorbidity prevalence similar in immigrant and autochthonous populations? A Spanish comparative study based on primary care electronic health records.

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Id24

Background: Immigrants represent a growing part of the European population. They are generally young and healthy at their arrival in the host country, but little is known about how they are affected by multimorbidity depending on their country of origin and their length of stay. Primary care electronic health records offer great potential to further study this
Research question: To gain insight into the prevalence of multimorbidity and of the main chronic conditions among immigrants according to nationality, age, sex and length of stay in the host country
Method: Cross-sectional retrospective study of all adult patients registered within the public health service of Aragón - Spain (N=1,251,540), of whom 149,149 were immigrants. Adjustment for age and sex was performed through direct standardization and multivariable logistic regression
Results: The prevalence of multimorbidity was 33.6% (95%CI 33.5%-33.7%) in the autochthonous population, 14% (95%CI 12.3%-15.8%) in immigrants with a length of stay in Aragón of <5 years, and 20.7% (95%CI 19.5%-21.5%) in immigrants with a length of stay of ≥5 years. Asian immigrants showed the lowest probability of having multimorbidity (OR 0.16; 95%CI 0.13-0.20 if length of stay <5 years and OR 0.41; 95%CI 0.35-0.48 if length of stay ≥5 years), and Latin Americans the highest probability (OR 0.46; 95%CI 0.44-0.48 if length of stay <5 years and OR 0.75; 95%CI 0.72-0.78 if length of stay ≥5 years) compared to natives. The pattern of the top ten chronic conditions was similar in natives and immigrants, although the prevalence of individual diseases was lower among the latter
Conclusions: The prevalence of multimorbidity is lower in immigrants compared to natives, although it seems to become higher with longer lengths of stay in the host country. Differences are seen in the distribution both of multimorbidity and of individual chronic conditions depending on the area of origin.

Points for discussion:
1. Why is the prevalence of multimorbidity lower in immigrants compared to natives?
2. Are these findings related to the healthy migration theory?
3. What if the role of the social determinants on the worsening of immigrants' health status with

PRESENTATION 15: Sunday 18th October, 2015 16.00–16.30 h. **THEME PAPER**

Uric acid levels within the normal range predict increased risk of diabetes mellitus: a community based cohort study.

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Id17

Introduction: There is data describing that cardiovascular risks related to serum uric acid (SUA) levels may begin below the current diagnostic definition of hyperuricemia. Values from 5.2 to 6.0 mg/dL were positively associated with higher cardiovascular risk. The risk associated with lower SUA levels has not been fully assessed in healthy adults.
Aim: To evaluate whether normal SUA levels, might be related to an increased risk of Diabetes mellitus (DM), compared with low–normal SUA.
Methods: This cohort study was conducted in the largest HMO in Israel. Patients 40–70 years old, who had SUA levels screened during 2002, were eligible for the study. They were stratified according to baseline SUA, and were followed for 10 years. The study endpoint was any new diagnosis of DM during the ten years study period.
Results: During 10 years of follow–up, 4,932/42,894 (11.5%) men and 8,386/78,026 (10.7%) women developed DM. Compared with the SUA reference values (2–3 mg/dL), women with SUA within the normal range had a gradual, increased risk of developing new–onset MD, starting at values as low as 3-4 mg/dL. Adjusted OR was 1.3 (1.07-1.60) for SUA 3-4, 1.98 (1.63–2.40) for SUA 4-5, 2.79 (2.28-3.40) for SUA 5-6 and 3.48 (2.76-4.38) for SUA 6-6.8. Increased risk for DM among men started at SUA levels>5 Adjusted OR was 1.42 (1.09-1.84) for SUA 5-6 and 1.85 (1.41-2.41) for SUA 6-6.8. The gradual increased risk was observed both for obese and non-obese patients.
Conclusions: SUA within the normal range is associated with new–onset DM among healthy adults, compared with low–normal range values. Further study is warranted to determine new cutoffs of hypo–, normo-, and hyperuricemia, which might be far lower than current scales.

Points for discussion:
1. SUA within the normal range is associated with new–onset DM among healthy adults.

PRESENTATION 16: Sunday 18th October, 2015 THEME PAPER
16.30–17.00 h.

E-health in Elderly Patient : Promises and weaknesses of social media.

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Id61

Background: The use of social media by the elderly could offer valuable support to elderly patients (for illness but also in prevention and education), but does include the risks for elderly patients.
With the spread of user-friendly and mobile devices such as tablets and smartphones, older adults begin to practice social media, to use on online social networks and forums.
Research question: Examine the possible e-health applications and their potential in clinical practice
Method: Meta-analysis of existing studies on the possibilities of intervention via new media where seniors can share their health experiences
Results: The analysis shows that
• the successful uses of computing devices or the Internet, are associated in the elderly, a self-declared improvement for their own health,
• improved access to information and health level of health knowledge (better health education)
• sharing a positive and a break from isolation and loneliness through dialogue with other patients and at some sites, the doctor-patient dialogue,
• And, in parallel, these initiatives can bring to caregivers the opportunity to share, to receive or provide social support.
The possible negative consequences of the use of social media were also taken into account.

Some traps are revealed in studies; access to harmful information, misuse of personal data, negative effect of self-image, social comparisons or prejudices spread by social networks, lack of clarity on the management of contents published by the elderly, decreased cognitive abilities, ...
It remains the question of the handling of user data on a sick patient or lost mental / lost mental faculties.
Conclusions: There are insufficient data on possible clinical applications that look promising but there is still a lot of gaps in the use of e-health.

Points for discussion:
1. Impact of new technology on eldery patient
2. Abilities to the use and manipulation technology
3. E-health revolution (for on eldery patient)

PRESENTATION 17: **Monday 19th October, 2015** **FREESTANDING PAPER**
09.50–10.40 h. **Study proposal / idea**

From the Transition Project to a Learning Healthcare System for Primary Care – transforming the process of diagnosis in family practice.

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Id 23

Background: This is an update on research using data from routine family practice structured using Episodes of Care (EoC) and coded using ICPC to study the contribution of patients' reasons for encounter to the final diagnoses of common problems.We will review the current state of the art of research, demonstrate current tools to implement a Learning Healthcare System , and show how the research is to be expanded within an international collaborative study with the involvement of several EGPRN partners.
Objectives: To improve and extend data capture of all elements of the doctor-patient encounter in primary care through new optimised electronic medical record systems.
To make such tools available to keen researchers in clinical practice in many European countries to collect new datasets of such size and scope as were previously not available.
To extend the analysis of diagnostic associations with these new enlarged datasets, to create new evidence to support the process of diagnosis in primary care worldwide.
To perform new statistical analyses of the diagnostic process to allow the calculation of the effect of multiple predictors for a diagnosis, the calculation of the associations between reasons for encounter themselves, and the effect of time on a diagnostic association, during the development of an episode of care.
Method: Databases collected directly from the electronic patient records of participating family doctor (FD) practices in different European countries.The relationships between RfEs and episode titles have been analysed with Bayesian methods. The extension to Latent Class Analysis models shall be demonstrated.
Results: The relationships between patients' RfEs and doctors' diagnosis within EoCs of common health problems, as coded using ICPC, are presented, and practical applications demonstrated.
Conclusions: This research helps us understand the diagnostic process in family medicine and has direct applicability in developing diagnostic decision support systems for family practice.

Points for discussion:
1. Discussion of the utility of such empirical data on the international core of family practice in European populations
2. Discussion of the utility of analysis of diagnostic data from different populations
3. Discussion on the new LHS-Digital research.

PRESENTATION 18: Monday 19th October, 2015 ONE SLIDE-FIVE MINUTES
09.50–10.00 h. Study proposal / idea

Can Leisure Time Activities Prevent or Delay Cognitive Impairment in Geriatrics?

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Id 30

Background: Dementia is defined as one of the biggest problems faced by the elderly population. One of the model for developing dementia is active model theory. The leisure time activities have a protective effect from dementia according this theory.
Research questions: 1.Do the leisure time activities effect cognitive impairment in geriatric patients?
2. Can we standardize the leisure time activities for preventing the geriatric population from dementia?
3. Can we get any sufficient proofs that can be recommended for use in primary care in daily routine to geriatrics for preventing or delaying the development of dementia?
Method: The age of 65 and older people will be enrolled to randomized controlled study. The inclusion criterias of study are declared to accept the study and the mini mental test score is over 17. The exclusion criterias of the study are mini mental test score is above 17, the metabolic diseases that disrupt the cognitive function, receiving a diagnosis of mood disorder recent 3 months or the modify the treatment regimen, have a disease that avoiding the adoptation to study method (ie blindness, deafness, psychosis). There will be 50 participants will be enrolled as intervention group and the 50 participants to control group.
All of the participants will be applied the questionaire including the socio-demografic, disease spesific and life style behavours, daily and functional daily activities, the social support, leisure time activities. The Geriatric Depression Scale-SF, Standardized Mini Mental Test.
Leisure time activities: “Mental activities”, “Social activities” and Physical activities will be screened and will be prompted to increase in the intervention group. The intevention group will be called by phone the days 7-10, 25-35, and every month. After 6 months, the end of the study, all of the participants will visit in their home and the scales will be repeated.

Points for discussion:
1. Can any suggestions for standardizing the leisure time activities?
2. Do we suggest only specific leisure time activities like physical activity or diet or chess for intevention group?

PRESENTATION 19: Monday 19th October, 2015 ONE SLIDE-FIVE MINUTES
10.00–10.10 h. Study proposal / idea

Prevalence of cardiovascular diseases in obese and success rate of treatment in Timis County.
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Id 64
Background: The cardiovascular diseases are the first cause of mortality in Romania. Obesity is directly related to the risk of developing cardiovascular diseases. Lowering obesity rate will lower cardiovascular morbidity and mortality. In Romania obesity is a growing public health problem. The prevalence of obesity in adults is approximately 8%, but rising. There is no data about the prevalence of cardiovascular diseases in obese individuals in the Romanian population.
Research question: What is the prevalence of obese individuals with cardiovascular diseases in the obese population of Timis County?
What is the best treatment for obesity depending on cardiovascular diseases and BMI?
Methods: A cohort study which includes patients aged 18-65 from GPs of Timis County will be performed. The GPs will fill a form with the data of their patients regarding general information, bloodtests, risk factors, BMI, blood pressure, other morbidities, physical activities, lifestyle. The prevalence obese individuals with cardiovascular diseases in the obese population of Timis County will be determined. GPs will determine treatment based on cardiac diseases and BMI. Treatment can be by lifestyle change, lifestyle change + systhemic treatment, lifestyle change + systhemic treatment + bariatric surgery. There will be a five year follow-up to determine the rate of success of the chosen treatment.
Results: We expect to find that most of the obese patients have associated cardiovascular problems. Also, we will have an overview of obesity prevalence by stage, of the prevalence of cardiovascular diseases in obese individuals and the success rate at 5 years of the chosen treatment.
Conclusions: By finding out what is the prevalence of cardiovascular diseases in the obese population of Timis County, we can create a strategy in the future to address all these heath problems.

Points for discussion:
1. How can GPs improve the management of obese people
2. At what interval should patient be evaluated
3. Is a 5 year follow-up sufficient to determine weather patient relapses or not?

PRESENTATION 20: Monday 19th October, 2015 ONE SLIDE-FIVE MINUTES
10.10–10.20 h. Study proposal / idea

What does the term “difficult patient” mean for the family physicians?

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Id 69

Background: Each patient needs an understanding and a sort of relationship from his doctor, and in most of the cases it is not limited to \"technical\" management of the disease. Patients \"take” our time and emotions, but they also “provide\" satisfaction after the fair and t completed work. There are, however, \"difficult \" patients, who often leave a bitter taste in the mouth, often make us frustrated. They are emotional \"bottomless pit\" .Their requirements are increasing, and our ability to respond to these demands remains lower and lower as the time goes by. Their expectations from doctors are irrational, but it seems that they don’t even realize it.
Research question: What does exactly family physician allude when he or she think about the difficult patient? What idea a family physician has when thinking about the difficult patient? How to evaluate our own reactions and thoughts about such patients?
Method: The study will be conducted by the field method- semi-structured interview / on site/ in the office / without strictly formulated questions, but the content of the interview will be prepared by the researcher in advance. There is also a possibility to create a focus group of doctors, who would be selected according with their similarities in preferred characteristics. The optimal number might vary between 6 to 12 participants. The group would provide a better understanding of issues and questions, and also point out the non-verbal communication.
Results: We expect assorted descriptions what family physicians mean under the term “difficult” patient, but also expect the conclusion pattern about mechanisms how to improve the communications with those patients, for example in searching for more help, education and support.
Conclusions: There are much possibilities to estabilish the assessment tools in the daily work with the difficult patients.

Points for discussion:
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PRESENTATION 21: Monday 19th October, 2015 ONE SLIDE-FIVE MINUTES
10.20 –10.30 h. Study proposal / idea

What are the challenges of general practitioners towards vaccination in the elderly?

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Id 70

Background: The aging population is a well-known challenge for most European health care systems. General practitioners (GPs) have a key role in health care for elderly people; this applies also to Turkey. Consequently Turkey GPs will have to deal increasingly with typical conditions and health problems of old age and also vaccination of the eldery.
Research question: What are the challenges of general practitioners towards vaccination among older adults?
Method: All members of a national general pracitioners online forum would be asked to undergo a self-administered questionnaire. The questions would consist of knowledge of vaccination in the eldery, pneumococcal infection and immunization, influenza infection and immunization, perceived risk, personal normative beliefs, attitudes towards adult vaccines, and respondent characteristics. Of the questions, Likert scale would be used.
Results: These results would indicate general practitioners challenges of eldery vaccination. Probably they have the knowledge and importance of vaccination but not aware of the severity of the condition.
Conclusions: In order to increase the awareness of general practitioners, continuing education is important. Measures to encourage healthcare providers to offer the vaccine may help increase coverage.

Points for discussion:
1. Is it necessary to add another survey for eldery in order to understand the different reasons given by older persons accept or reject vaccination?
2. Will there be a volunteer to study the same subject in order to compare the results.

PRESENTATION 22: Monday 19th October, 2015 ONE SLIDE-FIVE MINUTES
10.30 –10.40 h. Study proposal / idea

The risk of vitamin d deficiency in elderly patients with polypharmcy & management of rational polypharmacy.

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Id 71

Background: Health care of the growing elder population has a great place in preventive medicine.. As the demographic changes modifying the mission of primary care physicians, preventive medicine requires a special approach.Changes with aging, polypharmacy, and diseases that affect vitamin D metabolism cause a risk of developing vitamin D deficiency in the old patients.
Research question: 1) When is polypharmacy rational in chronic disease management?
2) Is vitamin D supplement needed for every elderly patient receiving polypharmacy?
Method: We will perform a prospective cohort study to determine the prevalence of Vit D deficiency in elderly patients over a five-month period. The primary outcomes of the study is if Vit D deficiency associated with polypharmacy and how much polypharmacy effective in healthy aging in primary care. The study population will be categorized in two groups according to the number of drugs prescribed at family medicine out-patient clinic; no polypharmacy (<5 drugs) and polypharmacy (>5 drugs). Patients over 65 years attending to family medicine out-patient clinic will be included.
Results: The study will be determined by further research.
Conclusions: When vitamin D deficiency that creates health problems is observed in the elderly, rational polypharmacy and chronic disease management become important in primary care. Healthy aging possible with preventive health care.

Points for discussion:
Rational polypharmacy in the elderly, prevelance of Vitamin D deficiency in the elderly with polypharmacy, management of preventive medicine in the elderly

PRESENTATION 23: Monday 19th October, 2015 FREESTANDING PAPER
11.00–11.30 h. Ongoing study with preliminary results

GP's attitude in consulting patients with erectile dysfunction in Bulgaria.

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Id 31

Background: Erectile Dysfunction (ED) is a condition preceding or accompanying most socially significant diseases e.g. cardio-vascular, diabetes, etc. The potential role of the ED as a predictor of cardio-vascular diseases (CVD) makes it an important factor in their early diagnostic and prevention. In Bulgaria studies in this area are limited. Similar studies are not conducted in general practice setting.
Research question: The aim of the study is to investigate GP's attitude in consulting patients with ED.
Method: The study was done using self-designed questionnaire, included social-demographic data and closed questions on attitudes, barriers, knowledge and skills in consulting patients with ED among 34 GP`s during continuing medical education seminar on the topic; 11 (32,4%) male and 23 (67,6%) female on average age of 45,41±9,81; 55,9% work in cities with population over 200 000; 79, 4% are owners of their practices with average number of patients 1632±709.
Results: Most of the physicians (73,5%) determine ED as a main health problem in less than 2% of their consultations. Although the patient raises the question about ED (76,5%), most GP`s (85,3%) consider that it is a difficult problem to share. 73,5% of physicians discuss this issue only if the patient makes a request. The direct access, established long-term GP-patient relationship and the whole family care help both the patient and the doctor in discussion of the ED problem. Almost all (94,1%) GP`s declare readiness for training in ED.
Conclusions: The present study is a part of a PhD thesis and discusses preliminary results about GP`s attitude in consulting patients with ED. The problem is rarely posed during the consultation; both doctor and patient avoid commenting. Almost all GPs declare need of training. Further investigations are in process.

Points for discussion:
1. What is your experience with this topic in your country?
2. Are you interested in research about ED in general practice setting?

PRESENTATION 24: Monday 19th October, 2015 FREESTANDING PAPER
11.30–12.00 h. Ongoing study with preliminary results

A Quick Test of Cognitive Speed: a normative study in German general practice population.
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Id 38
Background: Testing cognition in general practice is often difficult, because many of the established tests do require more time than affordable. The AQT (A Quick Test of Cognitive Speed) can be performed in a short time and is based on naming of colors, forms and numbers.
Research question: The current investigation was set out to determine the time that mentally healthy German general practice patients need to perform tasks of the AQT to determine standard values.
Method: Consecutive patients (60 years or older) were recruited by their attending general practitioner from three practices in Saxony, Germany. SIDAM (Structured Interview for the Diagnoses of Dementia of the Alzheimer type) was performed as a pre-test to rule out cognitive deficits. The AQT was analysed based on audio-files using Audacity 2.1. All numbers are presented as mean ± SEM.
Results: Twenty two patients refused to participate, 10 were excluded due to a SIDAM-Score less than 34 points and data from 4 patients could not be included due to recording problems. Finally data of 204 patients (age 71.18 ± 0.41 years; 109 women) were analysed. The mean time for the different tasks were 27.34 ± 0.36 (color), 36.9 ± 0.63 (form), 70.31 ± 0.38 (color & form) and 27.08 ± 0.38 (color), 18.57 ± 0.23 (number), 57.1 ± 0.94 (color & number) seconds. There were no gender related differences. For most of the tasks the needed time increased with age statistically significant, comparing the groups from 60 to 69, 70 to 79 and 80 to 89 years.
Conclusions: With the preliminary results we report standard values for the AQT in German speaking patients. Further investigations should focus on the analysis of pauses in speech during the tasks, the reliability of the AQT and possible learning effects. Also the correlation to SIDAM-Score shall be assessed.

Points for discussion:
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PRESENTATION 25: Monday 19th October, 2015 12.00–12.30 h. **FREESTANDING PAPER**

Self-care for common colds across 14 European countries (COCO study): predictors for higher use of self-care measures.

Birgitta Weltermann, Biljana Gerasimovska Kitanovska, Anika Thielmann, Tuomas Koskela, Kathryn Hoffmann, Robert Hoffman, Enzo Pirrotta, Marija Petek Šter, Juliette Chambe, Slawomir Czachowski, Krzysztof Buczkowski, Andrzej Zielinski, Ferdinando Petrazzuoli, Selda Tekiner, Aysegül Uludağ, Tamer Edirne, Vildan Mevsim, Heidrun Lingner, Clara Guede, Hans Thulesius, Marita Reivonen, Hülya Yikilkan, Olimpia-Maria Varva, Sanda Kreitmayer Peštic for the European General Practice Research Network Working Group on Self-Care
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Id 47
Background: Patients use different self-care to relieve symptoms of common colds.
Research question: What factors influence the number of self-care practices used for common colds throughout European countries?
Method: This cross-sectional study was performed at 27 sites in 14 European countries. Participating sites were asked to distribute 120 questionnaires to consecutive patients (inclusion criteria: ≥18 years). A 27-item questionnaire provided a selection of 105 self-care measures and allowed for free-text answers. Multivariate logistic regression was used to identify predictors for using more self-care practices than 50% of the respective country population (country-specific cutoffs). Included variables were: age, gender, years of school (country-specific medians), chronic condition (yes/no), taking pills daily (yes/no), common cold related discomfort (yes/no), knowledge of the disease's self-limited nature (yes/no), and sources of information (e.g., family).
Results: The final analyses included 2809 participants (63% female, mean age 46.8 years). The average use of self-care practices for common colds was 11.4 (SD 6.68). Bivariate analyses showed that chronic condition(s), taking pills daily and smoking status were not associated with the number of practices used. Multivariate logistic regression showed that discomfort (OR: 1.9, CI: 1.5-2.3), lack of knowledge (OR: 1.3, CI: 1.05-1.6), female gender (OR: 1.7, CI: 1.4-2.1) and more years of education (OR: 1.3, CI: 1.04-1.5) are significant predictors for using more self-care practices. Various sources of information influenced self-care, e.g., newspaper and/or internet (OR: 2.6, CI: 1.9-3.4), family (OR: 2.5, CI: 2.0-3.0) to physician (OR: 1.8, CI: 1.5-2.3).
Conclusions: Our European study shows that a number of factors influence patients´ self-care when having a cold. Mass media, family and physician recommendations were most influential.

Points for discussion:
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PRESENTATION 26: Monday 19th October, 2015 11.00–11.30 h. **FREESTANDING PAPER**

Evaluating an international web-based behaviour change intervention to promote prudent antibiotic use by GPs: a triangulation of mixed methods data.

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Id 5

Background: Antibiotic resistance is increasing and effective interventions are needed to promote more prudent prescription of antibiotics in primary care. In a randomised controlled trial a multifactorial international intervention, GRACE/INTRO, showed to be effective at changing the prescribing behaviour of general practitioners (GPs).
Research question: The aim of this study was to triangulate qualitative and quantitative data, collected during the process evaluation of the trial, to assess convergence, complementarity and dissonance between the two data sets.
Method: Qualitative data were collected via interviews with 62 patients and 66 GPs. Quantitative data were collected via questionnaires completed by 346 GPs and 2886 patients. Data from all sources were triangulated in order to explore convergence, complementarity and dissonance between the evidence. Three researchers agreed on the main findings from each data set and then worked independently to compare findings across data sets. Final triangulation was agreed by consensus.
Results: Thirty-nine independent findings were identified across the four data sets. No instances of dissonance were identified. There were several instances of full agreement between data sets but more instances of partial agreement. Partial agreement highlighted some examples where GPs and patients held different perceptions of how the intervention had worked.
Conclusions: The triangulation of data collected as part of the process evaluation of the GRACE/INTRO intervention showed that the evidence from different sources was consistent. The combination of this data provides stronger evidence to explain how the intervention worked to change prescribing behaviour.

Points for discussion:
1. added value of mixed methods
2. implication for practice

PRESENTATION 27: Monday 19th October, 2015 FREESTANDING PAPER
11.30–12.00 h.

Changes in end-digit preference after two years of a cluster randomized trial : the ESCAPE-ABPMS2 study.

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Id 11

Background: In ESCAPE trial, 126 physicians in the intervention group (IG) and 32 of the 131 physicians in the control group (CG) used an electronic device to measure their patients' blood pressure (BP). Physicians in the IG were new users of electronic devices provided in the trial and physicians in the electronic control group (ECG) were former users of electronic devices.The mean patients' blood pressure at baseline was significantly higher in the IG than in the ECG. This difference was partly due to end-digit preference which was more important in the ECG.
Research question: The aim of the this study was to describe the evolution of end-digit preference practices in primary care after 2 years of trial.
Method: Descriptive analysis of the end-digit preference in the IG and in the ECG of the ESCAPE trial and comparative analysis of end-digit preference changes in blood pressure (BP) measures of both groups between baseline and 2 years. Hierarchical mixed-effects models were used for statistical analysis in this pragmatic cluster randomized controlled trial.
Results: After 2 years, the proportion of BP measures ending with a 0 or 5 was significantly higher in the ECG than in the IG: 50.4% vs. 33.4%, $P < 0.0001$. There was no significant change in EDP tendency between baseline and the end of the trial in the ECG (65.6% to 56.7%, $P = 0.39$) and in the IG (29.6% to 38.2%, $P = 0.07$), with a between groups P value of 0.11. Along two years, there was no significant change in systematic EDP in the ECG (18.8% to 20.0%, $P = 0.29$) and in the IG (4.8% to 10.6%, $P = 0.01$) with a between groups P value of 0.17.
Conclusions: End-digit preference is not eliminated by electronic devices and tends to increase with time for new users.

Points for discussion:
1. How to avoid EDP in general practice?
2. How to confirm this tendency?

PRESENTATION 28: Monday 19th October, 2015 12.00–12.30 h. **FREESTANDING PAPER**

A RAND UCLA procedure to select the best reliable tool to assess Therapeutic Alliance. (TATA STUDY).

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Id 36
Background: Inside communication skills, Therapeutic Alliance (TA) is a relevant research theme for Family Medicine. A systematic literature review identified scales to measure TA in adults. A consensus study should select the more reliable and efficient one.
Research question: Is the RAND/UCLA Appropriateness Method (RAM) appropriate to identify the best possible scale for therapeutic alliance.
Method: The scales were the « Working Alliance Inventory » (WAI) and its short form « Short-Revised » (WAI-SR), the « Helping Alliance Questionnaire », the « California Psychotherapy Alliance Scale », the « Kim Alliance Scale », the « Vanderbilt Therapeutic Alliance Scale », and the « Therapeutic Bond Scale ». A local university expert panel was recruited to rate reproducibility and reliability extracted from additionnal references. The primary endpoint was reproducibility, and the secondary endpoints reliability and ergonomics.
Results: Eight experts rated reproducibility and reliability during the first Delphi round. Analysis of median quotes by RAM classified appropriateness for each scale in three levels : « appropriate », « uncertain » and « inappropriate ». The WAI, WAI-SR and CALPAS had an appropriate reproducibility. Reliability was uncertain for every scale. Only the WAI gathered an appropriate validity median without disagreement and more than 70% of ratings in the appropriate area. The expert meeting was not necessary. The second Delphi round obtained the expert consensus for the WAI unanimously.
Conclusions: A consensus for the WAI was achieved. It was the most appropriate scale, according to its reproducibility and reliability to measure TA in adults. It could turn into an efficient teaching tool to assess TA in medical training, and to raise students' awareness on communication. Nevertheless the expert panel was too short and the consensus too quick. Those pitfalls of the RAM should be carefully avoided for the European study.

Points for discussion:
1. Would you like to participate in the TATA study and to ask for Horizon 2020 fundings?

PRESENTATION 29: Monday 19th October, 2015 SPEC.METHODOLOGY WORKSH. 13.30–14.00 h.

The impact of inclusion in a quality indicators program on anticoagulant treatment in atrial fibrillation.

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Id 19

Background: Oral anticoagulants are widely underused, despite their demonstrated effectiveness in decreasing the risk of stroke in individuals with atrial fibrillation.
Research question: Among adults with atrial fibrillation in a large healthcare system, the inclusion in a population under evaluation in a quality indicators program will have a small effect on oral anticoagulant utilization rates in comparison to the effect of risk for thrombo-embolic stroke.
Methods: This is a cross sectional study of purchases of oral anticoagulants by 72,177 adults with atrial fibrillation. A selected population of patients with atrial fibrillation and congestive heart failure (those who had been hospitalized in the previous two years) was incorporated in a quality indicators program, with no pay for performance incentive. Purchases were analyzed according to congestive heart failure and inclusion in the quality indicators program.
Results: Among high risk patients (score ≥ 2 on CHA2DS2Vasc), a higher proportion of those included in the quality indicators program (67.8%) than those not included in the quality indicators program (42.8% and 44.3% for those with and without congestive heart failure, respectively) was treated with oral anticoagulants. The proportions of high risk patients who purchased new oral anticoagulants were 27.6%, 15.4%, and 18.1%, respectively.
Conclusion: Contrary to our hypothesis, inclusion in a quality indicators program, and not the clinical risk for thrombo-embolic stroke, was associated with higher utilization of oral anticoagulants and new oral anticoagulants among high risk patients with atrial fibrillation.

Points for discussion:
1. The place of clinical judgement in the growing pressure for measures and indicators.
2. The risk of over-treatment, especially in the elderly in the face of administrative pressure for good scores in the indicators.

PRESENTATION 30: Monday 19th October, 2015 SPEC.METHODOLOGY WORKSH. 14.00–14.30 h.

Telescreening for diabetic retinopathy in the elderly population.

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Id 49

Background: As of 2014, an estimated 387 million people have diabetes worldwide. This represents 8.3% of the adult population. With increased life expectancy the frequency of diabetes in patients over 65 reaches 25,9%. This creates the need for a new and efficient method for screening for diabetes complications.
Research question: To study the benefits of using a telemedicine-based digital retinal imaging evaluation compared to conventional ophthalmologic fundus examination in elderly patients with diabetes mellitus.
Method: Elderly patients with diabetes were examined for eye complications with iExaminer system in 3 general practices in Stara Zagora, Bulgaria. The photos were send and evaluated by an off-site ophthalmologist. The results were compared to an on-site examination.
Results: Among the 42 patients screened 81 retinal images were available (due to opacities in the eye of one patient), 18 (22,22%) cases of diabetic retinopathy were identified by the on-site examination compared to 17 (20,98%) via off-site photos evaluation. Of the remaining 63 eyes as false positive were diagnosed 3 (4,76%). In the follow-up questionnaire as main benefits were listed cost and time saving, as well as no need to travel to an ophthalmologists due to being difficult for the patients.
Conclusions: Our analysis indicates that telemedicine-based diabetic retinopathy screening offers quality nearly as good as than of conventional retinal examination, while being preffered by patients due to greater convenience and access for the remote and indigent populations.

Points for discussion:
1. How to coordinate reimbursement from the government?
2. What additional training is required for general practitioners?

PRESENTATION 31: Monday 19th October, 2015 POSTER
14.30–15.40 h.

Informeg a new evaluation system for family medicine trainees: feasibility and effectiveness in an Italian rural setting.

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Id 6

Background: In Italy the course to become general practitioner (GPs) lasts 3 years and includes both theoretical and practical study. Until recently the practical activity has not been assessed at all.
The Emilia Romagna Regional Health Authority (Italy) has developed a programme called INFORMEG (Management of Tutoring during the Triennial Specific Training in General Practice) which includes a list of pre-defined cases coded with the International Classification of Primary Care (ICPC) and divided into 3 Classes A, B and C according to the relevance in primary care, aimed at assisting trainee' self-management and helping the tutor in the assessment of the trainee's performance.
Research question: Is Informeg effective and feasible of in a primary care rural setting?
Method: Programme evaluation took place in the second half of 2013 during GP's routine clinical activities. The following steps were accomplished: 1) consultation recording; 2) identification of the reason for the encounter (RfE); 3) classification of the diagnostic procedure(s) performed; 4) elaboration of the final diagnosis after the encounter.
Results: All in all, 98 type A cases, 57 type B cases and 22 type C cases were documented. A total of 605 RfE were collected for 376 type A cases, 147 type B cases and 82 type C cases. A total of 976 procedures were performed during the 6 months: 590 procedures for type A cases, 271 for type B cases and 115 for type C cases.
Conclusions: The pre-selected health problems were almost all addressed, the ICPC coding proved to have a high educational value in helping the trainee in the construction of the case according to the logical process of family medicine. Serious weak points to amend are: the absence of common arrhythmic conditions such as atrial fibrillation and the lack of assessment of minor surgery execution

Points for discussion:
1. Methods to evaluate the performance of a trainee?
2. Which classification is best for Educational purpose?

PRESENTATION 32: Monday 19th October, 2015 POSTER
14.30–15.40 h. Ongoing study with preliminary results

Validation of the Bulgarian version of EUROPEP-EUROPEP-instrument for patients' evaluations of general practice care - preliminary results.

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Id 13

Background: The EUROPEP-questionnaire for patient evaluation of general practice care is a useful tool for healthcare policy makers and contributes to the improvement of primary care systems in Europe. As Bulgaria was not included in the validation process in other European countries, important insights will be provided by means of validate the questionnaire.
Research question: The paper examine the psychometric characteristics of the Bulgarian version of the EUROPEP-instrument.
Method: The EUROPEP-instrument includes 23 items aggregated into two dimentions: "clinical behavior" (1-16 items) and "organization of care"(17-23 items). The survey is based on project of the Medical University in Plovdiv. Forward/backward translations of the original EUROPEP-questionnaire were completed by expert translators. A test re-test was conducted in 160 patients who completed questionnaire twice, four weeks apart. Internal consistency, intra-rater reliability and inter-rater reliability were evaluated. The Spearman correlation coefficient and the Wilcoxon signed-rank test were used.A level of 0.05 is considered significant.
Results: Validly completed and returned questionnaires are 148 (overall item-response rate is 92.5%). Mean age of the respondents is 46.76 years (SD 15.06), with prevalent proportion of women 71.6% (n=106) and respondents, residing in urban areas 87.8% (n=130). Over 32.7% of patients report having a chronic medical condition, however, the majority of all respondents 73.5% (n=108) give self-perceived general health as "good" or "very good". A reliability coefficient (Cronbach'alpha) is 0.95 for \"clinical behaviour\" and 0.81 for \"organisation of care\". It was found out that positive scores on "clinical behaviour" dimension correlated significantly only with positive scores on perceived health status (r=0.23, p=0.004).
Conclusions: The reliability and validity of the Bulgarian version of EUROPEP-instrument is very high. In conclusion, this survey confirmed that valid, reliable and feasible instruments can be used successfully in different countries and cultural settings.

Points for discussion:
1. Which aspects of primary medical care do patients find most satisfying?
2. Which aspects of primary medical care do patients find least satisfying?
3. Is it possible to develop a model for good practices based on insight into the differences in the

PRESENTATION 33: Monday 19th October, 2015 POSTER
14.30–15.40 h. Research in Progress, without results

Electrocardiogram in general practice in Europe – a key-informant survey.

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Id 42

Background: The electrocardiogram (ECG) is a basic diagnostic method in patients with cardiovascular and potential cardiovascular problems. It is simple to perform, not costly, but needs expertise in interpretation.
Research question: The aim of our survey is to find out the potential differences about the use of ECG's in general practices in Europe.
Method: We asked at least two key-informants - active members of European general practice research network (EGPRN) from each the membership country to fulfil for the purpose of survey prepared questionnaire. In case of inconsistency of answers, we asked the third person from the county to confirm the validity of the answers. Data about the clinical situation in which responders record ECG were also analyses.
Results: Representatives from 27 out of 31 (87.1 %) EGPRN membership countries responded. Complete data were eligible for analyses from 25 countries (80.6 %). In 23 (92 %) of countries GP's record and interpreted ECG, but in only 9 countries (36.0 %) ECG machine is obligatory part of the equipment. Education about ECG's at all levels of training in present in most of the counties (from 84.0 to 88.0 %). Based on the key-informants opinion, in 21 countries (84.0 %) GP's are skilled enough to interpret ECG's. There was no clear consensus about the use of ECG's in particular indications (eg. panic attack, preventive check-ups). National ECG guidelines have only in two (8.0 %) countries.
Conclusions: This is the first study exploring the situation about the use of ECG general practice in European countries. Lack of guidelines about ECG in general practice in most of the countries and organisational differences could be a reason for differences in indications for recording ECG's.

Points for discussion:
1. Limitations of the key informant survey
2. Do the European guidelines on the use of ECG in general practice would be helpful?

PRESENTATION 34: Monday 19th October, 2015 POSTER
14.30–15.40 h.

The use of internet for health information among patients– a sociodemographic comparison.
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Id 50
Background: The use of internet for health information has dramatically increased during the last decade and it is one of the main topics searched online.
Research question: What is the difference in the use of health information in different sociodemographic groups?
Method: A literature review was performed by two independent researchers using free search, Pubmed, Embase.
Results: The results of a large study of seven European countries show that 71 % of the Internet users have used the Internet for health purposes. According to an Italian multicenter survey people using the Internet more for health-related purposes were younger, female and affected by chronic diseases. Health status, taking care of somebody who is sick, and active Internet use were associated with higher frequencies of online health information seeking accorrding to a web-based survey conducted in France. A German survey shows that younger citizens and people with paid work used the Internet more often for health related purposes. The Internet was one of the less important sources of information (important for 27 % of respondents) in the elderly population compared to face to face contact with health professionals and family and friends (75 %) according to a Polish article.
Conclusions: Even though the widely spread and easy access to internet sources a gap still exist between differect sociodemographic groups.

Points for discussion:
1. How the use of internet health information changes the relationship between patients and physicians?
2. Inequity of the elderly in e-health setting regarding information search and services offered online.

PRESENTATION 35: Monday 19th October, 2015 POSTER
14.30–15.40 h.

1 dependent = 2 patients. The longer time with them, a higher burden for caregivers.

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Id 15

Background: It is important to detect the caregiver overload and their risk factors in general practice, to offer them support either individually, by specific groups, or through community interventions.
Research question: To measure the relationship between caregiver burden, their workload and dependents characteristics.
Method: Descriptive observational study by interviewing informal caregivers of adults with dependency to perform some or all of the basic and/or independent activities of daily living.
It is a convenience sample captured by Primary Care staff of Vigo Health District (Spain), during the years 2014-2015. Data collection was done mostly at home, conducting a structured interview (3 hours) by two junior GPs, a nurse and a social worker (co-authors).
Zarit abbreviated questionnaire, socioeconomic data (caregiver and dependent), number of hours dedicated to care, caregiver health, dependent pathology and dependency index were collected.
Descriptive analysis and logistic regression was performed, with Stata 12.
Results: The respondent's characteristics (N=97) are presented. The average burden of caregivers is 19.43, 61.9% have severe overload (Zarit≥17), and 18.56% over 26. The average time dedicated to the care of dependent is 6 hours and 45 minutes, 47.9% of them intended for basic activities of daily living.
The burden is highly correlated with the aggressiveness of the dependents (p = 0.0198) and also their level of dependence, measured by the number of hours of care received (>=7 hours significantly increases the burden of care).
Conclusions: 1 dependent=2 patients. GPs and nurses must identify caregivers and ask them about their experience.
The generalization of this study is limited due to the small sample size (motivated by the difficulty in finding people willing to collaborate), the type of study and the voluntary participation. It's accompanying an ongoing project, oriented to develop a cardinal indicator of dependence from preferences of the general population and caregivers.

Points for discussion:
Could be hours dedicated to care a brief and valid screening question in practice and research?

PRESENTATION 36: Monday 19th October, 2015 POSTER
14.30–15.40 h.

Spiritual care and ageing focused on General practice patients.

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id 39

Background: We focus on the spiritual care for vulnerable patients such as the elderly who have increased complex care needs. Patients were selected from our initial inquiry / anonymous questionnaire of 267 doctors, nurses and patients.
Research question: Are there differences in attitudes about spiritual care in the elderly compared to younger age groups?
Method: Selected 96 patients allocated in three age groups as follows: I. 30 patients (18 to 45y); II. 38patients (from 46 to 65y); and III. 28 patients (over 65 y). We compare the respondents positive answers by each group regarding: 13question \"Is available connection between spirituality and health\"; 24question \"Whether spiritual care would contribute to the health welfare/successful treatment\"; 14 question \"Whether focusing on questions of patient/healthcare professional concerning the spiritual realm\" and 23question \"Whether we listen to the advice that involve except prescribed treatment and spiritual care\". We compare the shares in percentages of the three age groups between each other and to the average share in percentages $\bar{x}$ of the total number of 96 patients for each question.
Results: Positive \"Yes\" answer as percentage of every group are respectively regarding 13question: I. 77; II. 55; III. 75; $\bar{x}$=68; regarding 24question: I. 90; II. 76; III. 79; $\bar{x}$=81. Positive \"Yes\" answer aspercentage of every group are respectively regarding 14question: I. 70; II. 61; III. 68; $\bar{x}$=66; regarding 23question: I. 80; II. 71; III. 75; $\bar{x}$=75
Conclusions: Elderly patients over 65 years and those between 18 and 45y have a larger share of positive attitudes towards the group of 46-65y, whose sole share is below the average. This assumes even greater receptiveness to spiritual care in the elderly over 65y compared to the average age (46-65y).

PRESENTATION 37: Monday 19th October, 2015 POSTER
14.30–15.40 h. Ongoing study with preliminary results

Governance, economic conditions, quality and continuity of primary health care services, during the health reforms in Greece.

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Id 51

Background: Lack of integrated and patient-centered Primary Health Care (PHC) in Greece is a major issue. There is a clear need for structural changes and emphasis on PHC, especially in the austerity period, that will lead to reduction of health inequalities.
Research question: Which PHC dimensions and characteristics have been affected the most in the austerity period and which ones should be the focal point of the health reform?
Method: The present study is part of a national funded project entitled "Operational integration of PHC units" (MIS 337 424) implemented by School of Medicine, University of Crete, with overall aim to assess operational integration in PHC. A total sample of 124 PHC units were recruited and provided information using the «Primary Care Assessment Tool» by the J. Hopkins University. The units were evaluated based on the theoretical framework of Kringos et al. (3 PHC levels, 10 dimensions, characteristics) jointly with the Simple Additive Weighted method (SAW). A Special focus was given to the dimensions of "Governance", "Economic conditions", "Quality" and "Continuity".
Results: All four dimensions proved to be of different levels among PHC units. However, 80% of the under study units presented poor levels in two dimensions ("Economic conditions", "Quality"). Dimensions of "Governance" and "Continuity" were highly evaluated in most of the units (85%). When focusing on the "Governance"; PHC needs and goals seemed to be set effectively, contrary to integration of PHC in the healthcare system (65%). Longitudinal "Continuity" of PHC was highly evaluated in 90% of the units, while information continuity was the most vulnerable characteristic (50%). Prescribing behavior of PHC providers was poorly evaluated in most units (80%), contrary to chronic disease management (90%).
Conclusions: Effective reforms in PHC during the austerity period could be achieved by taking targeted actions towards vulnerable dimensions and characteristics.

Points for discussion:
1. The role of GPs in Greece in a reformed Primary health care system.
2.The lessons learnt from the austerity period and the present study and the benefits for individuals, policy makers and research networks in Greece and Europe.

PRESENTATION 38: Monday 19th October, 2015 POSTER
14.30–15.40 h. Study proposal / idea

Ethical and legal issues encountered in elder patients in provision of primary health care.

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Id 55

Many professionals working in the discipline of medicine should find solution within ethical dilemmas. It is especially of a greater importance when the services provided to the elderly patients considered in the vulnerable groups are considered.

Elderly patients feel the severity of the disease more than younger patients, they come across with serious chronic diseases relatively more and they have to use a variety of medication and to resort to health institutions for diagnosis and treatment.

The first step in health care services requires the protection and guarding of the rights of the elderly people by health care team members and the right evaluation of the medication of the elderly person. During this period, the first step about the elderly people consists of the ethical and legal issues experienced by the professionals providing health care services. Some of them can be listed as follows:

- Confidentiality / privacy protection
- Determination of the decision-making capacity / consent
- Evaluation of the elderly from the sharing of limited resources,
- The inclusion of the elderly to medical research
- Abuse / neglect etc.

Many both national and international guiding legal documents and ethical codes are available for the professionals working in this field.

This study has been designed in order to recommend an ethical framework to the possible ethical dilemmas and to cope with related legal issues encountered by health care professionals providing elderly health care in primary health care services.

Considering disease as a biological concept may cause ignorance of personal values in humans. Such an approach means to ignore human dignity. The desire of elderly people to live and their individual values should not be considered less valuable and meaningless. In this regard, each health care professional should therefore realize and fulfil their own \"ethical responsibilities\

Points for discussion:

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PRESENTATION 39: Monday 19th October, 2015 14.30–15.40 h. **POSTER**

Deprescription of antidepressants, antipsychotics and benzodiazepines in nursing home residents with dementia.

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Id 62

Background: Behavioral and psychological symptoms of dementia (BPSD) are treated with neuroleptics which are associated with severe side effects. There is an incresing evidence of potencial harms associated with the use of these drugs and guidelines increasingly recommend restricting their use.
Research question: To evaluate the effectiveness of a support intervention for nursing home staff in reducing the number of neuroleptics in Nursing Homes (NH) patients with dementia.
Method: Multicenter, longitudinal, prospective study pre-post intervention.5 NH (441 residents, 42.94% dementia) in Barcelona.Participants: residents of 5 NH with dementia and prescription of >= 1 neuroleptics. Exclusion: residents with severe mental illness. Guideline for teatment of BPSD was created by multidisciplinary team. Family physician and a pharmacist conducted a medication review and elaborated a therapeutic plan (TP) per patient included, based on the guideline and focusing on alternatives to drugs for the management of BPSD. This TP was delivered to NH staff in a personalized interview. Pre-post intervention, 1 and 6 month (July'12-february'14). Primary:Number of neurolepyics prescribed before/after intervention, at 1 and 6 month. The differences within groups at pre and post intervention were assessed using paired t-test. All analysis was bilateral with a confidence of 95% and was carried out using Stata.
Results: N=182, mean age 96.85 (SD:7.45). Mean number of neuroleptics prescribed per patient before intervention was 2.78 (SD:1.53) and 1.93 (SD:1.25) after ($p<0.001$). Total number of neuroleptics before intervention was 508 and 332 after, with a withdrawal of 176 (34.65%). The reduction at 1 and 6 month was 39.57% and 40.55% respectively. Proportions of drop outs were 11.35% at first month and 16.22% at 6.
Conclusions: The intervention conducted by a multidisciplinary skilled team with the elaboration of a patient centred TP provides an effective reduction of neurolepyics use for management of BPSD. The effectiveness of this intervention continues after 6 month.

Points for discussion:
1. Difficult management of BPSD in primary care
2. Lack of effective treatments for these symptoms

PRESENTATION 40: Monday 19th October, 2015 14.30–15.40 h. **POSTER**

Agreement between brief neuropsicological tests for the detection of cognitive impairment in primary care.

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Id 29

Background: Early recognition of dementia would enable the family doctors, to manage the condition better. In many cases, an accurate cognitive test might help the family doctors to reduce the time lag between the onset of first symptoms and recognition of dementia. The Mini-Mental State Examination (MMSE), as the most commonly used cognitive test, has several drawbacks and is no longer recommended in recent guidelines.
Research question: Is there agreement between the results of MMSE and other brief test for the detecion of cognitive impairement?
Method: Crossectional study done in a health care centers. We included >49 years old patients, with memory complaints, cognitive IMPAIRMENT o A positive minimental test in the last 24 months (scoring>23). Measurements: sociodemografic and clincial characteristics, and 4 neurological test.
Results: 83 subjects were included, 41% women, mean age 71,4 (SD=9,3), 66% without studies or primary level. Comorbidity: 34,9% familiar history of dementia or cognitive impairment, 80,7% cardiovascular risk factors, 20,5% cardiovascular events, and 77,1% more than 2 primary symptoms of memory impairment. Acording to MMSE, 20 cases were clasified as pathological (24,1%), 1 of them with dementia. In the clock drawing test, 25 (30,5%) were pathological and 21 with the Eurotest (25,9%) 13 of them with dementia. With the Phototest, 26 pathological (31,3%) 10 of them with dementia. When we compared MMSE the clock test, the degree of agreement was (DA) was 0.63 and Kappa index 0.38. THEe MMSE and phototest, the Da was 0.78 and Kappa 0.46. For MMSE-Eurotest the DA was 0.79 and Kappa=0.42. The concordance between Eurotest with Fototest and with clock test was 0.47 and 0.49 respectivelly, and Fototest with clock test, 0.51.
Conclusions: The concordance between MMSE with other brief psichoneurological tests is moderate. The combination of two brief tests for the deteccion of cognitive impairment could improve the detection of future dementia.

Points for discussion:
1. Which could be the best test to dectect cognitive impairment in general practice?
2. The results of the study are about agreement but not MMSE validity

PRESENTATION 41: Monday 19th October, 2015 POSTER
14.30–15.40 h.

FPDM (Family Practice Depression and Multimorbidity): the Hopkins Symptoms Checklist-25 items (HSCL-25), completed translation in 10 European languages.

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Id 53

Background: The Hopkins Symptom Check list-25 (HSCL-25) is a screening instrument to identify common psychiatric symptoms. It is a self-questionnaire used to compare the assessment of psychiatric illness made by GPs.
Research question: In order to conduct European studies, HSCL-25 needs reproducible translations taking into account of cultural specificities.
Method: For each language, HSCL-25 has undergone a Forward/Backward translation. Two translators (an academic translator and a GP researcher) were recruited for the forward translation. A panel of each countries expert English practitioner, partly researchers, was build. The panel of experts finalised the forward translation by a Delphi procedure. A different translator who did not know the original version did an English backward translation. The comparison by linguist between the original and back English versions has allowed the analysis of the cultural impact. To avoid selection bias, the composition of each panel was strictly controlled. A minimum size of 15 experts was requested.
Results: The translations in Greek, Polish, Bulgarian, Croatian, Catalan, Galician, Castilian, Italian and French were completed. There were no agreements on the German version. One to two Delphi round was sufficient for each language. The respect of the meaning was ensured by cultural control.
Conclusions: Translations in Greek, Polish, Bulgarian, Croatian, Catalan, Galician, Castilian, Italian and French are finished. Each translation assumes a linguistic and meaning reliability. Next, the HSCL-25 will be validated quantitatively in each country.

Points for discussion:
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PRESENTATION 42: Monday 19th October, 2015 POSTER
14.30–15.40 h. Research in Progress, without results

The use of alternative/complementary medicine in elderly patients in general practice.
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Id 52
Background: Elderly people are very significant group in most general practices, most of this patients are polymorbid with chronic medical conditions. Most of the conventional methods of chronic diseases treatment in this group are not enough satisfactory and well accepted, therefore we should recommend the use of complementary medicine/CAM/ with significant benefits to elderly patient.
Research question: Could CAM benefit the life of the eldery patients?
Method: Literature search and analysis of English language peer-reviewed articles published between the years 2000 and 2010 (PubMed, MEDLINE,Springer Link etc). The search strategy included the following keywords singly or in combination: complementary medicine(s), alternative medicine(s), integrated medicine, holistic care, CAM, geriatric, elderly, aged, and old.
Results: The results show most common CAM methods used by elderly to be herbal medicine, chiropractic and massage,vitamins and dietary supplements,acupuncture,spiritual healing or prayer,and meditation. Self-medication with CAM is also known to be high among the elderly, particularly with excessive intake of vitamins and minerals, herbal products, and nutritional supplements. Studies suggest that elderly's satisfaction with CAM added to conventional medical care is high. CAM seems to contribute to quality of life and well-being. The most often conditions for which patients look up for CAM are particularly musculo-skeletal ailments and recurring pain, also emotional and mental health problems, to maintain physical health and social functioning.
Conclusions: This part of our study shows that CAM is appropriate, well-accepted and beneficial for managing health problems in ageing patients.

Points for discussion:
1. Does old patients are interested in CAM?
2. Which alternative therapies are most popular?
3. Why elderly patients are looking for CAM?

PRESENTATION 43: Monday 19th October, 2015 POSTER
14.30–15.40 h. Research in Progress, without results

One centered, randomized, double blind, phase III clinical trial comparing the effects of 1 mg/day oral colchicine and placebo being received for 3 months on pain, stiffness and physical function in patients with mild-severe knee osteoarthritis at primary care.

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Id 37

Background: Vast part of the primary care patient population consists of patients with osteoarthritis (OA). The treatment options are painkillers using as symptom modifiers. After being shown that calcium pyrophosphate dehydrate crystals play role in pathogenesis of OA, treatment with colchicine, beneficial in preventing calcium crystal-induced inflammation (pseudogout), has come to order. So, colchicine is thought to be effective in the treatment of OA both as a disease and symptom modifier. Therefore we aimed to investigate the effects of colchicine on pain, stiffness and physical function of our patient population with OA using Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC).
Research question: Will the colchicine be effective in the treatment of knee OA?
Method: Population consists of patients with OA admitting to a family medicine center, whose ages are 40-65 years, fulfilling the knee OA clinical criteria of American College of Rheumatology with a 20-29 score (mild to severe OA) of Oxford Knee Score. All patients will receive 3x1000 mg/day paracetamol for 4 weeks. Following these 4 weeks, for 3 months colchicine group will receive 2x0.5mg/day colchicine, placebo group will receive 2x0.5 mg/day starch both in capsules and all patients will continue receiving paracetamol. Visits will be held in the 0., 1., 2., 3. and 4. month; patients will be asked if they have any complaints, their physical examinations will be performed, blood tests will be done for hemogram and transaminase observations and WOMAC and VAS (Visual Analogue Scale) will be applied.
Results: Primary and secondary end points of the study are improvement in WOMAC and VAS, respectively. At comparison analysis, beside descriptive statistics the chi-squared test and, Student's t test; when parametric hypothesis aren't matched Mann-Whitney-U test, for comparison of before and after of each group Paired Sample t-test or its non-parametric variant Wilcoxon test will be used.

Points for discussion:
Because of being a new treatment option of OA, the duration of colchicine treatment and also feasibility of colchicine at hip and hand OA treatment can be discussed.

PRESENTATION 44: Monday 19th October, 2015 POSTER
14.30–15.40 h. Ongoing study with preliminary results

The incidence of acute upper respiratory tract infections in Timis County for the last 3 seasons autumn-winter (September - March).

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Id 43

Background:
GPs from Timis Couny observed in their practices more cases of acute upper respiratory tract infections (AURTI) in the last season (September to March) 2014-2015. We try to establish the proportion of cases compared to the last 2 seasons (2012-2013 and 2013-2014).
Research question: How does the number of visits for AURTI modify in the last season compared to the 2 previous seasons.
Method: An observational study including data base of 4 GPs from Timis County. We count the number of visits for AURTI in the last 3 autumn-winter seasons: season 1: 563 visits from 6744 patients, season 2: 550 visits from 7043 patients, season 3: 816 visits from 7321 patients. The 3 seasons were statistic compared using chi-square test (Extended Mantel-Haenszel chi square for linear trend=93.85) and p-value (p-value<0.0000001). We also showed the proportion on age-groups, gender-groups and chronic disease-groups.
Results: Statistically the chance of having an AURTI in the 3rd season was 78% higher than the first season, more visits in male than in women and in adults than in children with maximum in the 40-65 years group.
Conclusions: A statistically significant number of visits in the 3rd season than the first especially in healthy adults.

Points for discussion:
1. Importance of results for GPs daily work.
2. The costs implications for national insurer.
3. The need of flue vaccination for an higher number of patients.

PRESENTATION 45: Monday 19th October, 2015 POSTER
14.30–15.40 h.

Prevalence and morphological distribution of anemia in elderly patients.

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Id 66

Background: Anemia is an important disease often found in the clinical practice of hematological disorders in the elderly. In terms of frequency, iron deficiency anemia and secondary anemia are high, and the presence of underlying malignant tumor is not rare.
Research question: In this study, we aimed to find out the frequency and the morphological distribution of anemia in the elderly patients.
Method: The data were collected from 200 elderly patients between 2010 to 2013 who admitted to family medicine clinic. The history and physical examination of all patients were performed before hemogram. Anemia was defined with decreased hemoglobin concentrations (<13 g/dl for men and < 12 g/dl for women). Data were analyzed using SPSS 22.0 package program. In the analysis, frequency and percentage from descriptive criteria were used.
Results: There were 102 (51%) male and 98 (49%) female elderly patients. The average age of participants was 73.37 ± 6.81 year. The frequency of anemia was found to be 33.5 % (n=67) in our study population. Seventeen patients (25.4 %) had microcytic anemia (MCV<80 fl), 46 patients (68.7%) had normocytic anemia (MCV:80-100 fl), 4 patients (6.0%) had macrocytic anemia (MCV->100 fl).
Conclusions: Anemia is the most common problem in the elderly patients and anemia should never be accepted as a normal physiological response to aging. Elderly patients with anemia requires extensive investigations.

Points for discussion:
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PRESENTATION 46: Monday 19th October, 2015 POSTER
14.30–15.40 h.

Is daily fluid consumption and notion of fluid adequate?

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Id 68

Background: Water is a vital nutrient with numerous roles in the human body. The study was carried out to assess daily fluid intake, to find out the notion of fluid in individuals, and to determine the methods for increasing awareness of adequate water intake.
Research question: How much fluid do people consume? What does fluid mean to people? What should be done to increase awareness of adequate intake of water?
Method: Those (n=221; 44.8% male, 55.2% female) aged 17-86 (mean, 36.49±11.02) years who applied to our family medicine outpatient clinic were included in the study. Continuous and categorical variables were given as mean±standard deviation and percentages, respectively. The data were analyzed using chi-square and Spearman's correlation tests. Any $p<0.05$ was considered statistically significant.
Results: Mean daily intake of pure water was 5.56±3.13 glasses. Mainly, tea (mean, 4.15±2.60 tea glasses/day) and fruits/fresh vegetables (mean, 1.19±0.91 servings/day) were consumed as other sources of water. Mean consumption of coffee, herbal tea, fruit juice/soft drinks, milk/yoghurt juice, alcohol was <1 glass/day. Water intake decreased by age (r=-0.071, p=0.293) and increased as body weight and body mass index increased (r=0.144, p=0.032; r=0.126, p=0.061, respectively). Women consumed more water than men (p=0.062), but not statistically significant. Only 31.2% of the participants knew the sources of water, 46.6% considered daily amount of fluid intake as 1-2 litres, and 50.7% thought that the fluid they consumed other than water was adequate. Publicity by media was suggested to increase awareness of AI of water by 42.7%. Mainly a health problem (17.6%), physician recommendation (9.5%), and reminders (9%) would persuade the individuals to drink adequate water.
Conclusions: Family medicine is a discipline offering effective counseling. Dietary advice is an important aspect of primary care. Preparing primary care nutritional guidelines including adequate fluid consumption is important to streghten family medicine.

Points for discussion:
1. 5.5 glasses of pure water intake as an average, is it acceptable or not?
2. Can cultural variation play a role in fluid intake perception across Europe, for example, on average tea consumption is 4 glasses/day in our region, but alcohol intake is not

PRESENTATION 47: Monday 19th October, 2015 POSTER
14.30–15.40 h.

Epidemiology of Colorectal Cancer in Crete: Two decades of records and the role of GPs.
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Id 45
Background: Greece lacks systematic collection of data for cancer. Nevertheless, the Regional Cancer Registry of Crete (CRC) is an official entity that operates in Crete since 1992 with the aim to collect cancer mortality and morbidity data. Recent publications highlight the change of lifestyle in Crete, the increase of obesity and alcohol consumption: all predictors of colorectal cancer (CC).
Research question: To monitor CC mortality for the past two decades. To what extent do county disparities exist? Which are the observed and future spatio-temporal trends?
Method: Data of CC mortality cases from 1992 to 2013 were analyzed from the CRC's database. Age-standardized Mortality Rates (ASMR) and Age-standardized Mortality ratios (SMRs) were used to assess the CC burden. Furthermore, Kappa statistic, Moran's I index and Getis Ord G were estimated to capture the present status of CC (a=0.05). A prediction model (interpolation techniques) was proposed to estimate the expected mortality rates for the next decade.
Results: Mortality varied among the different regions with meanASMR to be equal to 5.3/100,000/year [men: 6.8/100,000/year and women: 4.7/100,000/year]. A significant increase was observed after 2003 (Pvalue<0.05) while CC mortality was most frequent among men than women for most of the municipalities (SMRsmale/female = 1.61; min-max = 0.95-2.18). Spatiotemporal analysis identified several CC clusters (hot spots) in the island and presented a reverse clockwise movement of CC time trends (increasing trends in Lasithi county]. This was verified by the prediction model that indicated significant increase in municipalities of Agios Nikolaos, Ierapetra, Sitia and other regions (predictedASMR = 7.0-7.5/100,000/year).
Conclusions: CC mortality in Crete is still lower than in Europe, but presents increasing trends. Future trends indicate further increase, probably due to the residents' lifestyle and poor preventive measures. Therefore, targeted preventive measures and comprehensive intervention programmes should be implemented, with GPs to alleviate the burden in the austerity period.

Points for discussion:
1. The effects of changes in the lifestyle of the Cretan population on CC mortality.
2. Annual reports of CC data can be a tool for prevention and management of disease. Which will be the role of GPs in a cancer control program and what would be the expe

PRESENTATION 48: Monday 19th October, 2015 16.10–16.40 h. **THEME PAPER**

Medication knowledge of community-dwelling older patients with polypharmacy is related to the number of prescribed drugs, sex, age, and living situation.

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Id 14

Background: Polypharmacy contributes to patients' non-adherence with physicians' prescriptions. Patients' knowledge of the indications for their medicines is one of the factors influencing adherence.
Research question: What factors are associated with appropriate knowledge of the indications for drugs prescribed to older patients with polypharmacy?
Method: In a primary care setting, using home interviews and postal questionnaires, patients aged 60 years and over who were taking five or more prescribed drugs simultaneously, were asked about their medication. With multiple logistic regression analysis, we evaluated the association (odds ratio, OR) between medication knowledge and explanatory variables like medication use, sex, age, living situation and educational level.
Results: Seven hundred and fifty-four participants reported an average daily intake of nine (SD 3.0) prescribed drugs. Only 15% of the patients could disclose the indication of all their prescribed drugs. Variables that were negatively associated with appropriate reporting of all indications were: taking many prescribed drugs (e.g. ≥10 vs. ≤5: OR 0.05, 95% CI 0.02-0.11), age 80 years or over (vs. 60-69 years: OR 0.47, 95% CI 0.24-0.91), and male sex (OR 0.53, 95% CI 0.32-0.88). Patients living with a partner were more knowledgeable than patients living alone (OR 2.11, 95% CI 1.17-3.81). We did not find an association with 'educational level'.
Conclusions: Among older patients using five or more prescribed drugs, there was little understanding of the indication for their drugs, in particular in patients taking the highest number of drugs, patients aged 80 years or over, and men.

Points for discussion:
1. A limitation of our dataset is that we could not perform a comprehensive analysis of what patients actually know about their medication, and - more importantly - whether they know how to act in case a medication issue might occur (e.g. dosing, interac

PRESENTATION 49: Monday 19th October, 2015 THEME PAPER
16.40–17.10 h. Ongoing study with preliminary results

Evaluation of a selective contract for GP-centred care in Baden-Wuerttemberg (Germany): Health care utilization and the care for the elderly.

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Id58

Background: For historical reasons a strong system of primary care with the GP as a gate-keeper never has been introduced Germany. However, since 2008 via selective contracting between statutory sickness funds and GPs a model of 'GP (general practitioner) centred health care ("Hausarztzentrierte ersorgung", HzV) was implemented. The HzV especially focuses on enhanced health care for insureds with chronic diseases and complex care needs We were able to evaluate the largest and most successful of these selective contracts in the federal state of Baden-Wuerttemberg, including more than 1 million insured, compared to a control group, based on administrative data.
Research question: We asked for care utilization (contact to GP, specialists, hospitalization, drug costs etc.) and the quality of care for the elderly (> 65 y).
Method: we adapted indicators for utilization and quality of care. We analyzed data sickness fund data on health care contacts, diagnoses, medications, services, hospital data of 3.5 mio persons. We used a multilevel regression model to compare HzV-group and control group and to adjust for differences between patient groups and practice properties.
Results: 610.000 HzV participants and 576.000 non-participants could be analyzed. A 16.6% increase in GP contacts and a 20.5% decrease in specialist visits without referral were found in the HzV group (adjusted differences). Hospitalizations for avoidable ambulatory care sensitive conditions were reduced by 5.3%. Drug costs were lower in the HzV group. In the quality of care for the elderly (299.000 in the HzV-group and 270.000 non-participants) we found differences in the visits to specialists, (emergency) hospitalizations, but not in drug therapy. Prevention (flu immunization, prevention of falls) was more successful in the HzV-group. Diabetes care was improved.
Conclusions: Positive effects were moderate to important. Fostering of primary care in Germany must be seen as a long-term process.

Points for discussion:
The paper was already accepted for the last (Timisoara) meeting as a 15 min-presentation which I could not attend for specific reasons. On request of the reviewers it could be enhanced by specific data about cardiovascular dieseases (available Sept 2015).