EGPRN Co-ordination Centre: Mrs. Hanny Prick
Netherlands School of Primary CaRe Research (CaRe), Universiteit Maastricht
P.O. Box 616, NL 6200 MD Maastricht, The Netherlands.
Phone: +31 43 388 2319, Fax: +31-43-3671458 E-mail: hanny.prick@hag.unimaas.nl

European General Practice Research Network

Kavala – Greece

19th – 22nd October,2006

SCIENTIFIC and SOCIAL PROGRAM

THEME: Community Orientation in Primary Care

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

Place
The Lucy Hotel
Akti Kalamitsas, Kavala-Greece
www.lucyhotel.gr

This EGPRN-meeting in Kavala-Greece has been made possible through contributions of the following sponsors:

- **Novartis**
- **ELPEN**
- **Wyeth**

The meeting is co-hosted by:

- **ELEGEIA**
- **the Prefecture of Drama-Kavala-Xanthi**

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

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

“COMMUNITY ORIENTATION IN PRIMARY CARE”.

Dear friends and colleagues,

ELEGEIA (the Greek Association of General Practitioners) has accepted the great honour to organize the EGPRN autumn meeting of 2006. It is, therefore, a privilege for us to invite all EGPRN members to this important event. The city of Kavala in Northern Greece has the credit to host this meeting, which addresses the theme “Community Orientation in Primary Care”.

The theme of the meeting refers to the historical concept of Community–oriented primary care (COPC): a systematic approach to health care which combines principles from epidemiology, primary care, preventive medicine and health promotion (Kark and Cassel, 1952). A COPC can be seen historically as an effort to bridge the traditional public health methodology with primary care medical practice. Today, although COPC undeniably constitutes a fertile ground in teaching family medicine/general practice (FM/GP), the need for further elaborating and understanding this concept as well as implementing it in the wider setting of primary care has been recognized (Longlett et al, 2001). Nowadays at a time when WONCA Europe is re-defining FM/GP placing its emphasis on the community orientation of the discipline (http://www.woncaeurope.org), the debate on the community orientation of primary care is resurfacing in the European agenda. The challenging issues put forward by the EGPRN meeting in Kavala are: community epidemiology, needs assessment, intervention studies, multidisciplinary collaboration. Further, the research methodology will be discussed with the aim to highlight the uniqueness of the discipline.

Thus, the Kavala meeting is willing to see GPs and researchers from all over Europe in order to share experiences in a warm and friendly atmosphere, at an historical passage from Greece and Balkan countries to Europe: a real authentic crossroads of many European cultures. We are certain that all participants will enjoy not only the beautiful Mediterranean and south European setting, but also the scientific and social programme, as well as the pre-conference workshops, where new ideas and innovative schedules will be implemented.

We are looking forward to meeting you in Kavala.

Stella Argyriadou
National Representative Greece

Associate Prof. Christos Lionis
EGPRN Vice-President

MEETING EXECUTIVE BOARD

GENERAL COUNCIL MEETING

Executive Boardmeeting
Thursday 19th October, 2006

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

(location : The Lucy Hotel, Kavala-Greece)

General Council meeting with the National Representatives
Thursday 19th October, 2006

14.00 - 17.00 : Executive Board members and National Representatives

(location : The Lucy Hotel, Kavala-Greece)

REGISTRATION FOR ALL PARTICIPANTS:

Friday 20th October 2006:

08.00 – 08.30 h. **Location: The Lucy Hotel (Room A, B)**

Non-EGPRN-Members are asked to pay the undermentioned membershipfee

For non-EGPRN-members:

The following payments are requested:

- **EGPRN Membership fee for 3 years 120 € or congress fee 50 €**
  - **Eastern European countries: 45 or 20 €**
  - **WONCA direct members: 60 or 50 €**

Social night Greek Night (dinner, dance, music and Beach Party)
at the Lucy Hotel: € 30,=

Please address to EGPRN Registration Desk.

E G P R N 19th – 22nd OCTOBER, 2006

PROGRAMME OF THE EUROPEAN GENERAL PRACTICE RESEARCH NETWORK IN KAVALA – GREECE

THURSDAY 19th OCTOBER, 2006:

Location : **The Lucy Hotel**
Address: Akti Kalamitsas, Kavala-Greece

09.30 - 12.30 : **Executive Board Meeting**
(only for Executive Board Members)

09.30 - 16.00 : **Pre-Conference Workshops (only for participants who have registered beforehand)**

09.30 – 12.00 : **2 EGPRN Pre-Conference Morning Workshops** (€ 25 each p.p.)
Parallel workshops:

"Community Oriented Primary Care"
Chair: Teresa Pawlikowska (U.K.)
and

"Invitational Workshop for Young Inexperienced Researchers"
Chairs: Sophia Eilat-Tsanani (Israel), Davorina Petek (Slovenia) and Martin Beyer (Germany).

13.30 – 16.00 : **2 EGPRN Pre-Conference Afternoon Workshops** (€25 each p.p.)
Parallel workshops:

"Open Research Market-Marketplace for Research Proposals"
Chairs: Pinar Topsever (Turkey) and Christos Lionis (Greece).
and

"Research using Electronic Patients Records"
Chair: Jean-Karl Soler (Malta).

14.00 - 17.00 : **EGPRN General Council Meeting.**
Meeting of the Executive Board Members with National Representatives (only for Council Members).

Social Program:

18.00 – : **For ALL EGPRN-participants of this meeting who are present in Kavala at this time.**
Welcome Reception at Kavala City Hall.
(Entrance Free)

FRIDAY 20th OCTOBER, 2006:
Location: The Lucy Hotel

08.00 - 08.30 : Registration at EGPRN Registration Desk.

08.30 - 08.35 : Welcome.
Opening of the EGPRN-meeting by the Chairman of the EGPRN, Prof. Dr. Paul van Royen.

08.35 - 08.50 : Welcome.
Opening of the EGPRN-meeting by the president ELEGEIA, Dr. B.P. Merkouris.

08.50 - 09.15: 1st Keynote Speaker Prof. Christos Lionis, Greece.
Theme: "Implementing GP/FM research in a non privileged country: the case of Greece."

09.15 – 09.35: 2nd Keynote Speaker Prof. Konstantinos Sakelarides, Portugal.
Theme: "Social capital and community-oriented primary care".

09.35 – 10.35 : 2 Theme Papers

1. **Steve Iliffe (United Kingdom)**
   Promoting community oriented primary care in Britain: a critical analysis of current policy.

2. **Theodoros Vasilopoulos (Greece)**
   A medical students training in COPC: experiences gained from rural Crete.

10.35 - 11.00 : Coffee Break

11.00 – 12.30 : Theme Papers

3. **Anders Halling (Sweden)**
   Validating the Johns Hopkins ACG Case-Mix System of the elderly in Swedish primary health care.

4. **Jean-Marc Lefebvre (France)**
   Is it necessary to institutionalize old dependent patients for their caregivers' wellbeing?

5. **Christof Hillemans (Belgium)**
   Case management to train dealing with violence in the community?

12.30 - 14.00 : Lunch

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

14.00 – 15.30 : A. Parallel session Freestanding Papers

6. Arian Plat (The Netherlands)
Family history for common diseases in the genomic era: What is the evidence?

7. Rachel Dahan (Israel)
Patients' attitudes towards physician self-disclosure during the patient-physician encounter.

8. Ferran Galí (United Kingdom)
Spanish GP's working in Durham and Tees Valley, UK: Exploring their cultural and professional experience in clinical consultations.

14.00 – 15.30 : B. Parallel session Freestanding Papers

9. Johannes Hauswaldt (Germany)
Clinical decision making – a synopsis of concepts.

10. Erik Stolper (The Netherlands)
Gut feelings in General Practice: Significance and Consequence.

11. Martin Beyer (Germany)
Evidence-based and normative recommendations in guidelines.

15.30 – 16.00 : Coffee/Tea Break

16.00 – 17.30 : C. Parallel session Theme Papers

12. Jean-Yves Le Reste (France)
Biological survey of anti vitamin K treatment.

13. Alevizos Alevizos (Greece)
Perception, attitudes and treatment of hypertension in an elderly people nursing home of an urban area in Greece.

14. Jørund Straand (Norway)
Cardiovascular risk interventions.

16.00 – 17.30 : D. Parallel session Theme Papers

15. Zaida Azeredo (Portugal)
Skin diseases: a patient perspective.

16. Laurence Coblentz Bauman (France)
Psychological consequences of a car accident in the general population.

17. Mehmet Akman (Turkey)
How do mothers feed their 6-12 month old babies: knowledge, attitude and behaviours.

18.00 – 19.00 : Meeting of EGPRN Working Groups
- **Research Strategy Committee**
- **Electronic Website Committee**
- **Educational Committee**

Location: **Health Centre of Chrissoupolis**
Meeting point: **The Lucy Hotel**

<u>Social Program :</u>

18.00 – : Practice Visit to local Health Centre of Chrissoupolis (26 km from the Kavala city centre)

Meeting point: **Lucy Hotel**

SATURDAY 21st OCTOBER, 2006:
Location: The Lucy Hotel

08.40 – 09.05: **3rd Keynote Speaker Prof. Brendan Delaney, U.K.**
Theme: "The Electronic Primary Care Research Network: harnassing the power of distributed computing for primary care RCT's".

09.05 – 09.30: **4th Keynote Speaker Prof. Anastasios Philalithis, Greece.**
Theme: "Health needs assessment in Primary Health Care".

09.30 – 10.30 : Theme Papers

18. **Vasileios Vareltzis (Switzerland)**
Evaluating the local health impact of fine particle air pollution.

19. **Paul Wallace (United Kingdom)**
Randomized controlled trial of an early presentation and intervention service for patients with exacerbations of COPD.

10.30 - 11.00 : **Coffee Break**

11.00 – 12.30 : **Posters**
In five parallel sessions (5 groups of 5/4 posters)

11.00 – 12.30: **Parallel group Posters 1**

20. **Steve Iliffe (United Kingdom)**
Promoting community oriented primary care in Britain.

21. **Isabel Montaner (Spain)**
Implementing a community-oriented primary care process in a primary health center.

22. **Anna Roig (Spain)**
The integration of the community-oriented primary care model with other methods of community intervention.

23. **Martha Andreou (Greece)**
General practitioner and primary mental care.

11.00 – 12.30: **Parallel group Posters 2**

24. **Zaida Azeredo (Portugal)**
Home Care: who are the patients ?

25. **Donka Dimitrova (Bulgaria)**
Access to primary healthcare services – patients' perspective.

26. Outi Valkonen (Finland)
The functionality of Finnish Health Centres had increased during the National Health Project.

27. Valentina Madjova (Bulgaria)
Introducing a new educational programme for general practitioners from distant community centres in counselling young people.

28. Tolga Gunvar (Turkey)
What do Medical School Residents think and know about family medicine in Turkey?

11.00 – 12.30: Parallel group Posters 3

29. Pinar Topsever (Turkey)
Determinants of smoking among university students in Sakarya/Turkey.

30. Witold Lukas (Poland)
Comparative evaluation of the applicability of different prediction models for coronary risk in the family practice's (FP) patients.

31. Alicja Malgorzata (Poland)
Patient's knowledge about the safety of oral anticoagulant treatment and the occurrence of major haemorrhagic and thromboembolic events.

32. Christos Pogonidis (Greece)
Working again after an acute cardiac infarct.

33. E. Xenodohidou (Greece)
Sexual life after a cardiac infarct: still a controversial issue?

11.00 – 12.30: Parallel group Posters 4

34. Ferdinando Petrazzuoli (Italy)
Methodological issues in assessing type 2 diabetes mellitus prevalence using data from Italian GP's Electronic Patients Records.

35. Selcuk Mistik (Turkey)
Evaluation of Diabetes Mellitus Patients' the knowledge, attitude and behaviour regarding immunization.

36. Domingo Orozco (Spain)
Risk factors for diabetes which could be included as a screening strategy in primary care.

37. Radost Asenova (Bulgaria)
GP's and children with overweight and obesity.

38. Marco Zoller (Switzerland)
Implementation of a behaviour modification programme for weight loss in primary care.

11.00 – 12.30: Parallel group Posters 5

39. Ramazan Tetikcok (Turkey)
The importance of early diagnosis of congenital hypothyroidism.

40. Vildan Mevsim (Turkey)
Evaluation of the training of peer trainers in sexual and reproductive health.

41. Dimitris Kounalakis (Greece)
Can patients and new technologies influence the use of a microbiology lab in a rural health centre?

42. Dimov Rossen (Bulgaria)
Attitudes, predispositions and behavior of GP's towards screening program for colorectal carcinoma.

12.30 – 14.00 : Lunch

14.00 - 14.30 : Chairman's report : Report of Executive Board and Council Meeting.

Introduction on the next EGPRN-meeting in Nijmegen/The Netherlands by the Dutch national representative.

14.30 – 15.10 : One-Slide/Five Minutes Presentations
In two parallel sessions (5 groups of 4 one-slide/five minutes presentations)

14.30 – 15.10: Parallel group One-slide/five minutes presentations 1

43. Sharon Shabtai (Israel)
Identifying and assessing the needs of different subgroups of patients in an urban setting.

44. Alain Mercier (France)
Management and referral system of depressive patients.

45. Ediz Yildirim (Turkey)
Periodic health examination in the elderly.

46. Ida Liseckiene (Lithuania)
Organizational and structural changes in PHC centres during health care reform in Lithuania.

14.30 – 15.10: Parallel group One-slide/five minutes presentations 2

47. Andreas Frank Jørgensen (Denmark)
The degree of attainment of European guidelines concerning diabetes care in general practice.

48. **Juhani Miettola (Finland)**
Shared understanding in Lapinlahti.

49. **Nese Yeniceri (Turkey)**
Efficacy of family physician's practice on weight loosing programme.

50. **Dimitris Kounalakis (Greece)**
Onset of type 2 diabetes and normal fasting blood glucose levels in general practice.

15.10 – 15.30 : Coffee/Tea Break

15.30 – 17.00 : E. Parallel session 1 Theme paper and 2 Freestanding papers

51. **Sonja Belaid (France)**
Prevalence of vitamin D deficiency among women from 18 to 49 years wearing concealing clothes and living in Lyon.

52. **Heidi Keller (Germany)**
Different from what the textbooks say: how GP's diagnose coronary heart disease.

53. **Serap Cifcili (Turkey)**
Perceptions and opinions of the women with climacteric symptoms about menopause and hormone replacement therapy.

15.30 – 17.00 : E. Parallel session Freestanding papers

54. **Janez Rifel (Slovenia)**
Prediction of depression in European general practice attendees: the PREDICT study.

55. **Kristin Hendrickx (Belgium)**
Personality factors of medical students and their influence on self-esteem and 'taking initiative' related to intimate examinations during internship.

56. **Stathis Giannakopoulos (Greece)**
Determinants of self-rated health among elderly living in the community.

Social Program :

20.00 - : Social Night
Greek Night (dance, music) and Beach Party.
Entrance fee: Euro 30,= per person.

SUNDAY 22nd OCTOBER, 2006:
Location: The Lucy Hotel

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

PRESENTATION 1: Friday 20st October, 2006 THEME PAPER
09.35 – 10.05 h.

TITLE: Promoting community oriented primary care in Britain: a critical analysis of current policy.

AUTHOR(S): Steve Iliffe, Penny Lenihan

ADDRESS: Department of Primary Care & Population Sciences
University College London, Rowland Hill St.
London NW3 2PF-United Kingdom
E-mail: rmjlsri@ucl.ac.uk

Background: The primary care trusts (PCTs) of Britain's NHS require primary care teams to improve the community health by addressing health needs and working with other organisations to deliver effective, appropriate care. One British general practitioner has already likened the introduction of primary care trusts to community oriented primary care (COPC)[1]. (51 words)

Research Question: What are the lessons from international experience of COPC methods for the NHS reforms of primary care? (17 words)

Methods: A review of the literature on community oriented primary care including theoretical papers, commentaries, reviews and empirical studies published over a 20 year period. We analysed case studies of community oriented primary care to identify collaborating agencies, target populations, factors promoting or impeding implementation of COPC methods, interventions designed and delivered, outcomes and sustainability. (54 words)

Results: The COPC model has been developed mainly but not exclusively in under-served populations to integrate public health objectives and primary care through inter-disciplinary approaches to population needs, with active involvement of the target population. The descriptions of the outcomes of most community oriented primary care initiatives are limited, but COPC methods are time consuming, can create problems with professional boundaries and are vulnerable to socio-economic changes. They can also deliver complex packages of care that have an impact on target populations, particularly in poor areas under-served by traditional medical services. (90 words)

Conclusions: British primary care reforms may be seen as an unplanned, uncontrolled, nation-wide experiment in the application of COPC methods. They differ from COPC as applied elsewhere because change has been introduced from above rather than below, into a well developed primary care system rather than under-served communities. (47 words)

Point for discussion: What factors promoting COPC approaches exist in your health care system, and what obstacles exist?

---

[1] Koperski M & Rodnick JE Recent developments in primary care in the United Kingdom: from competition to community oriented primary care J Fam Practice 1999;48(2):140-5

PRESENTATION 2: Friday 20st October, 2006 THEME PAPER
10.05 – 10.35 h. Study proposal/idea

TITLE: A medical students training in COPC: experiences gained from rural Crete.

AUTHOR(S): Theodoros Vasilopoulos, Ch. Eftymiou, An. Papaioannou
Al. Zariba, G. Arseni, A. Philalethis, C. Lionis

ADDRESS: Univ. Crete - Social Medicine, Heraklio/ Crete-Greece
Phone: +30-6947076813; Fax: +30-2894022313
E-mail: thvasilop@yahoo.gr

Background: Community-oriented primary care (COPC) correlates the pragmatics of critical practice with the population principles of epidemiology and public health. Many studies refer to COPC being implemented for resident training, however only a few portray the adaptation of COPC in undergraduate education programmes. The Department of Social Medicine, University of Crete, introduced a COPC-based student-training programme of 4-week duration in Primary Health Care (PHC). In order to demonstrate the efficacy of this COPC model in PHC, public health reports compiled by students during their training, were assessed with regard to clinical issues, methods used and validity of results.

Methods: All the public health reports from the rural area of Agia Varvara, Heraklion, were identified and reviewed, using a previously tested pre-forma for critical appraisal. Students' reports were evaluated, regarding content, quality and research methods over the last 2 years.

Results: 8 reports were reviewed and classified into 3 major categories: (i) Management of chronic illness (n=2), (ii) Prevalence of chronic disease (n=4), (iii) Descriptive epidemiology of health habits (n=2). These reports, with observation length 2-4 weeks, were based on non-experimental research. The main instruments utilized: (1) AUDIT questionnaire, (2) Mini Nutritional Assessment, (3) Rome II criteria for IBS, (4) St. Vincent's criteria for T2DM, (5) ATP III classification, (6) Geriatric Depression Scale.

Principle Findings: Arising from their reports were: (a) The majority of the population studied, consume large amounts of alcohol frequently, (b) Child accidents prevail between 6-10 years of age, (c) Poorly regulated blood-glucose is mainly due to poor patient compliance, (d) Child obesity is annually increasing, (e) IBS prevails in women aged 22-36 years.

Conclusion: The results suggest that rural general practice provides a more substantial role in medical student education. The PHC course achieved the objectives of introducing students to comprehensive COPC and enlightens them on the major health problems encountered by primary care practitioners.

Relevance to EGPRN: This COPC training programme provides students with a spherical view of the community-based health needs. Furthermore, the students' reports illustrate the pragmatics of PHC practice and confirm the existing perception of common community health problems. We expect that the medical students presenting this report, will share views with primary care teachers and researchers and portray their experiences gained in the field of rural primary care.

Points for discussion at EGPRN:
1. Methods of training in COPC
2. Feasibility of the COPC – based training

PRESENTATION 3: Friday 20st October, 2006 THEME PAPER
11.00 – 11.30 h. Finished Study, but the project is ongoing

TITLE: Validating the Johns Hopkins ACG Case-Mix System of the elderly in Swedish primary health care.

AUTHOR(S): Anders Halling, Gerd Fridh, Ingvar Ovhed

ADDRESS: Blekinge Institute for Research and Development,
Erik Dahlbergsvägen 30, S-734 37 Karlshamn-Sweden
Phone: +46-703125337; Fax: +46-455735548
E-mail: anders.halling@ltblekinge.se

Background: Individualbased measures for comorbidity are of increasing importance for planning and funding health care services. No measurement of individualbased healthcare costs exist in Sweden.

Research question: To validate the Johns Hopkins ACG Case-Mix System´s predictive value of polypharmacy (regular use of 4 or more prescription medicines) used as a proxy for health care costs in an elderly population. To study if the prediction could be improved by adding variables from a population based study i.e. level of education, functional status indicators and health perception.

Methods: The ACG Case-Mix System was applied to primary health care diagnoses of 1402 participants (60-96 years) in a cross-sectional community based study in Karlskrona, Sweden. The predictive value of the ACG Case-Mix System was modeled against the regular use of 4 or more prescription medicines, also using age, sex, level of education, instrumental activity of daily living- and measures of health perception as covariates.

Results: In an exploratory biplot analysis the ACG Case-Mix System, was shown to explain a large part of the variance for regular use of 4 or more prescription medicines. The sensitivity of the prediction was 31.9%, whereas the specificity was 88.5%, when the ACG Case-Mix System was adjusted for age. By adding covariates to the model the sensitivity was increased to 46.3%, with a specificity of 90.1%. This increased the number of correctly classified by 5.6% and the area under the curve by 11.1%.

Conclusion: The ACG Case-Mix System is an important factor in measuring comorbidity, however it does not reflect an individual´s capability to function despite a disease burden, which has importance for prediction of comorbidity. In this study we have shown that information on such factors, which can be obtained from short questionnaires increases the probability to correctly predict an individual´s use of resources, such as medications.

Points for discussion at EGPRN:

1. How can measures of comorbidity be used to plan and direct interventions to the elderly in a primary care district?

PRESENTATION 4: Friday 20st October, 2006 THEME PAPER
11.30 – 12.00 h. Ongoing Study, no results yet

TITLE: Is it necessary to institutionalize old dependent patients for their caregivers' wellbeing?

AUTHOR(S): Virginie Lebas Gilles, Jean-Marc Lefebvre

ADDRESS: Dépt. de Médecine Générale, Faculté de Médecine Henri Warembourg, Université de Lille 2, 59045 Lille Cedex-France Phone: +33(0)3 20 62 69 21
E-mail:docteurjml@numericable.fr

Background: A few GPs are worried about the depressive syndrome seen in many caregivers accompanying handicapped old people, and it probably has a detrimental impact on the quality and the perennially of the care provided.

Research question: Is it possible to show the increased incidence of depressive syndrome in caregivers, according to the types of responsibility assumed, care being provided at home or in institution?

Methods: This is a randomized control trial including anybody aged 65 or more (WHO definition) dependent, by loss of physical and/or mental autonomy, and residing in "Nord/Pas-de-Calais Area". Every of them is followed up by one of the 226 ambulatory clinician teachers, all members of the "Collège des Enseignants de Médecine Générale de la Faculté de Médecine Henri Warembourg de l'Université de Lille 2".

Once the starts date, each doctor will include the first two institutionalized dependent patients, and the first two home dependant patients, irrelevant of the needs in care during one month. The definition of caregivers is given within the framework of an institutionalization as those who filled out the admission form, and within the framework of home keaping as the first person with the patient at the time of the doctor's visit.

The questionnaire is the Mini International Neuropsychiatry Interview (MINI).
Every doctor fills out the questionnaires, with the details of the caregivers of the first patients met, either by interviewing them, or if the doctor is treating them, basing it on his record.

Expected results: This is an on going study. We expect that the incidence of depressive syndrome might be increased in caregivers coping with dependant old people living in their usual residences than it is in those providing care in an institution. But it is possible that link should be shown between the existence of a depressive syndrome in caregivers coping with old dependant people and the level of responsibilities they assume.

Points for discussion at EGPRN:
- Try to establish a correlation between institutionalization, maintenance in residence of the dependent old patients and the quality of life of their caregivers.
- Try to identify the factors of risk of the appearance of a depressive syndrome in caregivers.
- Try to propose a protocol of tracking and follow-up of the depression of caregivers.

PRESENTATION 5: Friday 20st October, 2006 THEME PAPER
12.00 – 12.30 h. Ongoing Study with preliminary results

TITLE: Case management to train dealing with violence in the community?

AUTHOR(S): Leo Pas, Christof Hillemans, Lutgart De Deken, Klara Ampe

ADDRESS: De burburelaan 38, 970 Wezembeek-Oppem, Belgium
Phone: +32 (0)2 7313030 ; Fax: +32 (0)2 7318062
E-mail: leo@pas.telenet.be

Background: By Delphi study we developed a multidisciplinary consensus how to deal with child abuse, domestic violence and elderly abuse. The results were distributed as a manual by the Ministry of health to all recognised GP circles and upon request.

Research Question(s): 1. What are the needs of GP for training in multidisciplinary community care on violence?
2. What should be the content and methodology for such training in Flanders?

Methods: A telephone enquiry was performed in 2005 among an a-selective sample of GP and GP quality circle coordinators. Based on these results three expert panels synthesized the manual in short sized documentation charts submitted during training in Gp-quality groups. Feedback was collected by scoring sessions and direct observation from September 2005-June 2006.

Results: Domestic violence is a very frequent psycho social problem in Flemish General Practice. Family violence scores highest on the priorities for training. However the manual was not read thoroughly. At the training meetings many frustrations were ventilated by the participants about collaboration with special services. Best response and evaluation were obtained when questions for reflection about their own cases were forwarded and the card was applied progressively at the meeting. The message we apply to all psycho-social problems in primary care is now: Ask Assess Advice Agree Assist Assure follow up.

Conclusions: Unclearity of GP's role and many frustrations in collaborative care hinder guideline application. A European research to test learning through case management using adapted flow charts, internet and community networks is proposed.

Remaining questions: How can we facilitate GP involvement in multidisciplinary community care? Are the charts applicable to the large number of problems met by GP in the community? How can we integrate our model into an internet learning and problem solving package?

Points for discussion at EGPRN:
1. Can such flow charts be applied for case management and learning in the community?
2. Are similar training models available or useful in other European countries?
3. What suggestions have participants got for further protocol and network development?

PRESENTATION 6: Friday 20st October, 2006 FREESTANDING PAPER
14.00 – 14.30 h. Work in Progress/Ongoing Study

TITLE: Family history for common diseases in the genomic era: What is the evidence?

AUTHOR(S): Arian W Plat[a,b], Abraham A Kroon[b]
Constant P van Schayck[a], Peter W de Leeuw[b]
Henri EJH Stoffers[a]
a.Department of General Practice, Care And Public Health Research Institute (CAPHRI), Maastricht University
b.Department of Internal Medicine, Cardiovascular Research Institute Maastricht (CARIM), Maastricht University and University Hospital Maastricht

ADDRESS: Dept. of General Practice, Maastricht University
PO Box 616, 6200 MD Maastricht-The Netherlands
Phone: +31 43 388 28 83; Fax: +31 43 361 93 44
E-mail: Arian.Plat@HAG.unimaas.nl

Background: Since the start of the Human Genome Project, a renewed interest in family history has been expressed in editorials and descriptive reviews. Because family members share many genetic and non-genetic risk factors, family history is considered an important tool for diagnosis and risk assessment of common, multi factorial disorders. Moreover, family history promises to serve as a critical element to identify candidates for genetic testing. Given the community orientation of general practitioners (GPs), one can argue that GPs are in an ideal position to practice genomic-based medicine. Furthermore, family history taking is supposed to be well established in primary care.

Research question: What is the evidence for the presumed value of family history in primary care?

Methods: We conducted a systematic review of the literature using Medline (1966 – 2006), Embase (1986 – 2006) and Cochrane. Search terms reflected 'primary care', 'family history' and 'genetics'. Data concerning study population, method of family history taking and outcome were extracted. Twenty-two studies met our inclusion criteria. A qualitative analysis was performed, since the papers were heterogeneous in focus, methods and outcomes.

Results: We found evidence on perceived competence (5 papers), current practice (8 papers) and family history as a genetic tool (9 papers). Many GPs, but not all, consider family history taking as a primary care task. Family history taking is done to a maximum of 60% of new patients visits; however, only half of those are updated. Few data is available concerning decision support aids for family history taking in primary care.

Conclusions: The evidence for the presumed value of family history in primary care seems poor. More research is needed to investigate standardised methods, feasible in primary care, of recording data useful for a family history that can respond to future advances in genetic knowledge.

Points of discussion:
1. What might be the reasons that so little research on family history and primary care has been performed so far?
2. Does family history taking offer the right opportunities for primary care to involve GPs in genomic-based medicine?

PRESENTATION 7: Friday 20st October, 2006 FREESTANDING PAPER
14.30 – 15.00 h. Finished Study

TITLE: Patients' attitudes toward physician self-disclosure during the patient-physician encounter

AUTHOR(S): Rachel Dahan, Neta Yoeli
Khaled Karkabi, Doron Hermoni

ADDRESS: The "Technion" medical school Haifa - Family Medicine
Moshav Yaad, Misgav 20155-Israel
E-mail: mrdahan@netvision.net.il

Background: Physician self disclosure (PSD), which is defined broadly as any statement or gesture made to a patient that describes the physician's personal experience, is a controversial way of communication. Although it was found to occur in more then 15% of office consultation, little is known about its impact on medical encounter.

Research question: What are the consequences of physician self-disclosure during the patient-physician encounter?

Methods: A questioner bases on qualitative research findings was developed, validated on a pilot study and completed by convenient sample from ten different primary practices.

Results: 357 patients filled the questioner, 66% women and 34% men. Their average age was 47 years, range 18 to 97 years. 37% of the patients are treated by the same physician over 10 years. 59% of the patients have knowledge about their physician's personal life (PPL). 22% of the patients believe that PSD improve patient- doctor relationship and improve there quality of care. 36% were interested to know about PPL but believe it has nothing to do with quality of medical care. 20% of patients reported physicians using personal example in order to convince them to take treatment or to do a diagnostic procedure. The use of PSD convinced 76% of them. Patients that defined their health status less good were less interest in PSD (p=0.005). No relationship was found between patients' attitude toward PSD and their age, sex, education level or duration of treatment by the same physician.
Patients that were interested PSD reported higher satisfaction when physician disclosed himself.

Conclusion: The use of PSD might be an effective way to communicate with some of the patients. It is imported to study more about PSD in order to learn, who are the patients that gain from this way of communication, and its influence on patient-doctor relationship and patients' health.

Points for discussion:
1. Do these research findings represents the influence of PSD in family practice outside Israel?
2. Does PSD skills should be taught during the residency program?
3. How can we learn more about PSD?

PRESENTATION 8: Friday 20st October, 2006 FREESTANDING PAPER
15.00 – 15.30 h. Almost Finished Study

TITLE: Spanish GP's working in Durham and Tees Valley, UK: Exploring their cultural and professional experience in clinical consultations.

AUTHOR(S): Ferran Gali, Barbara Griffin, Jacqui Merchant, Greg Rubin.

ADDRESS: Centre for Primary and Community Care
University of Sunderland, Priestman Building
Green Terrace, Sunderland. SR1 7PZ, United Kingdom
Phone: 44+ 191 515 2597
E-mail: fgalig@hotmail.com

Background: Many Spanish physicians have been recruited by the NHS to work in the UK. Some studies have considered the recruitment and retention of GPs from France and Spain, but none, have yet explored the cultural differences.

Research question: The description of the working experience of Spanish GPs from their cultural and professional perspective focusing upon the clinical consultation.

Methodology: Qualitative method, using one-to-one in-depth interviews, drawing upon grounded theory. Between 9 and 12 out of 27 selected Spanish GPs will be interviewed.

Results: [From the first eight interviews]. There is a complex interactive phenomenon with a variety of interpersonal opinions but with some clear trends. UK's Patients show great respect and trust for GPs, being more polite and resilient than in Spain, identifying better mental health problems. UK's Health System looks structured, tight, with health triage, 10 minutes consultations, professional career-development, with more other independent professionals (emergency-care-practitioners, counselors, district nurse), and more rational and evidence-based prescribing; whereas the Spanish's looks more open and too easy access, higher demand, and with less time per consultation. GPs, in the UK are gatekeepers, business-oriented, communicating well by letters with consultants, and with less burn-out.

Conclusions: The health care system in UK is more flexible, offers more professional opportunities and Spanish GPs feel satisfied.

Points for discussion:

1. Methodological issues (interview, analysis, validity, bias).
2. Dr's Migration, the Health System and Culture interactions.

PRESENTATION 9: Friday 20st October, 2006 FREESTANDING PAPER
14.00 – 14.30 h. Finished Study

TITLE: Clinical decision making – a synopsis of concepts

AUTHOR(S): Johannes Hauswaldt

ADDRESS: Abteilung Allgemeinmedizin, OE 5440, Medizinische Hochschule Hannover, Carl-Neuberg-Str. 1
D-30625 Hannover-Germany
Phone: +49-511-532-5855; Fax: +49-511-532-4176
E-mail: Hauswaldt.Johannes@mh-hannover.de

Background: Intuitive elements of clinical decision making are poorly described or understood. Research into the differences, how novices, intermediates, and experienced physicians decide, may help to understand, "how does the doctor tic", and thus contribute to improved clinical education.

Research questions: What is known about clinical decision making at different stages of physicians' career?
Has intuition been described as part of professional approach during patient-doctor-encounter?

Methods: Systematic literature review from the last 30 years, for selected cases also back to the 1940s, into "clinical decision making" and "intuition".

Results: Found evidence reflecting the physician's part of shared decision making and underlying concepts was arranged into 10 fields of synopsis.
Starting from (1) existing terms for concepts and structures of clinical decision making, it was stated that (2) for the novice facts and figures form the natural scientific basis of medicine, which (3) the professional beginner and intermediate re-arrange into lists of illness scripts, which they apply deductively. (4) In contrast, the experienced practitioner recognizes patterns in an inductive and holistic approach. In this, the latter (5) masters automatisms and short-cuts in which analytic and non-analytic processes are interwoven, (6) may select different ways of proceeding as from a tool-kit, and (7) gains extra time and attentional surplus. (8) His clinical impression may depend crucially on singular surrounding conditions. (9) If, furthermore, the practitioner is open for introspection into his doing, (10) the grounds for good clinical education may be laid.

Conclusion: Clinical decision making is a highly individual process, originating from physician's professional and personal biography, and, therefore, neither can be educated nor transferred directly.
The underlying attitude, on the other hand, of being a "reflective practitioner" can be lived and exemplarily analysed by clinical teachers. The learner may be supported through supervised exercise and accompanied own practice.

PRESENTATION 10: Friday 20st October, 2006 FREESTANDING PAPER
14.30 – 15.00 h. Finished Study

TITLE: Gut feelings in General Practice: Significance and Consequence.

AUTHOR(S): Erik Stolper[1], M.A. van Bokhoven[1], T. van der Weijden[1]
Paul van Royen[2], Paul Houben[1], M. van de Wiel[3],
Geert-Jan Dinant[1],
[1] Dept. General Practice, Maastricht University
[2] Dept. General Practice, Antwerpen University
[3] Dept. Psychology, Maastricht University

ADDRESS: Machteldskamp 19, 8181 ZN Heerde-The Netherlands
Phone: +31-578-695499; Fax: +31-578-692728
E-mail: praktijk@stolper.nl

Background: GPs do not only use rational reasoning in their diagnostic decision-making. Also "gut feelings" (synonyms: sixth sense, sensation of alarm, bad feeling in the stomach) play a role in this process. They can be described as feelings there is something wrong with the patient without objective alarming symptoms. It is not known what the impact is of this non-rational aspect of GPs' diagnostic decision-making.

Research question: What is the definition and diagnostic value of "gut feelings" among Dutch GPs in daily practice?

Method*:* We conducted a qualitative study with 4 focus groups (n= 28 Dutch GP's). Analysis was done with a grounded theory approach.

Results: According to the participating GPs, gut feelings are common in daily practice and are considered useful. There are two types of gut feelings: those that reassure the GP since he is sure about the prognosis of his patient and about the therapy and those that alarm the GP. In the latter case he distrusts the situation without knowing why: some kind of intervention seems necessary to prevent severe health-problems. Gut feelings are triggered by unexpected changes in the pattern of disease or the patient's presentation: something doesn't fit in. GPs said they become aware of gut feelings, sometimes even before the rational-diagnostic process starts. Gut feelings require an explanation, which may lead to a diagnosis. Most GPs declared they take it seriously, even if they cannot make a diagnosis. Context-knowledge is an important determinant just like experience. Getting gut feelings can be learned. Gender does not play a role

Conclusions: Gut feelings act as a compass in situations of uncertainty. The majority of GP's trust this guide. This can be important for medical education. Optimizing the value of this phenomenon might improve early recognition of alarming symptoms.

Points for discussion at EGPRN:

2. How important seem gut feelings for the quality of GP's work in other European countries?
3. Are there possibilities to do together the same research in other European countries?
4. Are there suggestions about a design to measure the test properties of gut feelings in general practice?

PRESENTATION 11: Friday 20st October, 2006 FREESTANDING PAPER
15.00 – 15.30 h. Finished Study

TITLE: Evidence-based and normative recommendations in guidelines. Results of a systematic guideline review as the basis for the development of a german guideline on congestive heart failure.

AUTHOR(S): Christiane Muth, Martin Beyer, Jochen Gensichen
Ferdinand M. Gerlach

ADDRESS: Institute for General Practice, Johann Wolfgang Goethe University, Theodor-Stern-Kai 7,
D-60590 Frankfurt-Germany
Phone: +49-(0)69-6301-83877 (Sekr. -5687)
Fax: +49-(0)69-6301-6428
E-Mail: Beyer@allgemeinmedizin.uni-frankfurt.de

Aim and methods: We developed a method of a systematic and rigorous Systematic Guideline Review to facilitate the development of a guideline on Congestive Heart Failure (CHF) for German general practice. By that method clinical practice guidelines are systematically retrieved, which are recent and of high quality following predefined criteria. The recommendations of these guidelines are systematically extracted to evidence tables and checked for the underlying primary evidence. A comparison of the recommendation leads to topics of inconsistency or lacking evidence ('grey zones') which require prioritisation of issues and further search for primary evidence by the development team.

Results: Out of 511 citations we identified 16 international relevant, comprehensive, and high-quality guidelines on CHF in primary care. We identified 92 relevant topics which were condensed to 27 clinical questions. The recommendations were extracted to evidence tables. In the content analysis a good overall consistency was found with considerable grey zones of lacking or insufficient evidence, particularly in diagnostics and non-pharmacological therapy. To validate consistency of pharmacotherapy recommendations 28 original publications were re-evaluated. Considering the inconsistencies we could not always find sufficient basis in evidence, but normative issues played a considerable role. Normative influences can arise from values, ethical reasoning etc. in a given society, structures, availability of certain procedures in a given health system, professional attitudes, preferences, or group processes in the guideline developing group, and clinical experience or opinions of an individual developer. The fact that such normative influences cannot always be resolved by superior evidence will be exemplified by the controversial recommendations on the use of BNP (brain natriuretic protein) testing in the diagnosis of CHF.

Conclusion: The systematic guideline review offers a valid and resource saving method to develop a new evidence based guideline in making use of existing guidelines. Normative recommendations cannot always be avoided; but the influences of social values, conditions of the health care system, of the preferences of groups or individuals have to be taken into account in adaptation of guidelines.

Rlevance for EGPRN:

- § Between European countries there is often the problem of the transferability of recommendations
- § With the increasing importance of clinical guidelines there is a requirement for a valid and 'slim' method for developing them
- § The German guideline on CHF tackles some recent clinical issues in CHF care
- § The relation of evidence and issues of normativity is often tackling in various fields

PRESENTATION 12: Friday 20st October, 2006 16.00 – 16.30 h.

THEME PAPER Published

TITLE: Biological survey of anti vitamin K treatment: a study of practice and coordination between patients and health professionals (GP, Nurse, Biologist) in the north finistere (Brittany)

AUTHOR(S): Cécile Lucas-Barbré, Jean Yves Le Reste, Philippe Bail

ADDRESS: Dépt. de médecine générale, Faculté de médecine de Brest Rue Camille Desmoulins, 29200 Brest-France
E-mail: lerestejy@aliceadsl.fr

Background: Oral vitamin k antagonists (VKA) are a risky, but common, therapy in primary care. The surveillance needs coordination between patients, general practitioners (GPs) nurses and biologists/laboratory services. Cognitive skills of the patients need to be evaluated to give them adapted surveillance. The cost to the community is high as complications are common. Very few studies have described the coordination between patients and health professionals.

Research Question: Which are the practices of the health professionals involved in the VKA surveillance in our region? How could we improve those practices?

Methods: In 2005, we did a study with all local biologists and a randomized sample of general practitioners and nurses. We send a specific form to each type of professionals with a mix of closed and open ended questions about professional backgrounds, practices, professional experience and coordination between professionals. We analysed them with epi-info software, normal distribution, student test and fischer-snedecor test to find recommendations for the coordination between them.

Results: Nurses often used pro thrombin time instead INR. 98.5 % of The GPs follow national referral but 14% of the GPs do not respect the referral target because of bleeding accident fear. The biological tests in use have an international sensitivity index (ISI) of thromboplastin too high and only 67 % of the biologists are involved in a quality control system. The coordination between the professionals is described as good because of a 100 % of transmission of the results to the final user but slow with a maximum of 12 hours time between the laboratory and the patient. When the therapy is not balanced the GP is the one that changes it.

Conclusions: To prevent complication of VKA therapy and to lower the cost for the community we found that initial formation of the nurses should be modified, GPS should follow recommendations and biologists should be involved in quality control system.

Points for discussion at EGPRN:

1. Are the GPs aware of the isi of thromboplastine in other country?
2. How is the coordination about VKA between nurses, GPS and biologist through Europe?

PRESENTATION 13: Friday 20st October, 2006 THEME PAPER
16.30 – 17.00 h.

TITLE: Perception, attitudes and treatment of hypertension in an elderly people nursing home of an urban area in Greece.

AUTHOR(S): C. Mihas, V. Gizlis, M. Papathanasiou
Alevizos Alevizos, A. Mariolis

ADDRESS: Health Centre of Vyronas, Athens, Greece
E-mail: alevisos@gmail.com

Background: Hypertension is the most common CVD risk factor. Even though a lot has been done towards health promotion projects for elderly people who have access to primary care units and doctors, it seems that an information gap is still prevalent among those people living in long-term care. The aim of this study was to evaluate the patterns of antihypertensive drug therapy and their conformity with the modern guidelines (JNC-7) in elderly people (>65 years old) in nursing homes of an urban area in Vyronas, Athens, Greece.

Methods: The sample of our study consisted of 352 participants (151 men, 201 women) >65 years old (75.7+/-5.9 years) living in 3 nursing homes in the municipality of Vyronas, Athens, Greece. The research team included one General Practitioner and one Health Visitor who recorded data regarding the health status and treatment of the participants. Multivariate logistic regression was used in order to evaluate the impact of comorbid conditions on anti-hypertensive treatment.

Results: Hypertension was diagnosed in 311 patients (88.35%). 121(38.90%), 108(34,72%) and 92(29.58%) had concomitant diagnoses of coronary heart disease, congestive heart failure and cerebrovascular disease, respectively. 265(85.20%) of patients were treated pharmacologically. Calcium channel blockers were the most common drugs (28%), followed by diuretics (26%), angiotensin-converting enzyme inhibitors (23%) and beta-blockers (17%). The odds ratio of receiving anti-hypertensive therapy was significantly lower for the oldest participants (>80 years old)(OR=0.86, p=0.02) and those with significant impairment of cognitive functions (OR=0.71, p<0.001).

Conclusion: The newest guidelines for hypertension seem not to affect the treatment patterns followed in old people living in nursing homes, even in an urban area full of hospitals and clinics. The functional status and the age of the patients influence the treatment they are given. More has to be done to improve the health status of those that are isolated and far away from primary care.

PRESENTATION 14: Friday 20st October, 2006 THEME PAPER
17.00 – 17.30 h.

TITLE: Cardiovascular risk interventions: Should size limits for the targeted population decide risk algorithms' cut-off levels instead of vice versa? The Norwegian Hordaland Health Study (HUSK)

AUTHOR(S): Mette Brekke[1], Magne Rekdal[2], Jørund Straand[3]
[1]Dept. of General Practice and Community Health, University of Oslo, Norway
[2]Dept of Public Health and Primary Health Care, University of Bergen, Norway
[3] Professor, Section for General Practice, Department of General Practice and Community Health, University of Oslo, Norway

ADDRESS: Seksjon for allmennmedisin, Institutt for allmenn- og samfunnsmedisin, Universitetet i Oslo
Postboks 1130 Blindern, 0318 Oslo-Norway
Phone: +47-22 850 647; Fax: +47-22 850 650
E-mail: jorund.straand@medisin.uio.no

Objective: To assess level of cardiovascular risk factors in a non-selected, middle aged population. To estimate the proportion target for risk intervention according to present guidelines and according to different cut-off levels for two risk algorithms.

Design: Population survey, modelling study.
Setting: The Norwegian Hordaland Health Study (HUSK) 1997-99.
Subjects: 22 298 persons born 1950-57.

Main outcome measures: Own and relatives' cardiovascular morbidity, antihypertensive and lipid lowering treatment, smoking, body mass index, blood pressure, cholesterol. Framingham and Systematic Coronary Risk Evaluation (SCORE) algorithms. The European guidelines on cardiovascular disease (CVD) prevention in clinical practice were applied to estimate size of targeted risk groups.

Main results: 9.7 % of men and 7.6 % of women had CVD, diabetes mellitus, a high level of one specific risk factor, or they received lipid lowering or antihypertensive treatment. Applying a SCORE (extrapolated to 60 years) cut-off level at 5 % to the rest of the population, selected 52.4 % of men and 0.8 % of women into a primary prevention group, while a cut-off level at 8 % included 22.0 % and 0.06 % respectively. A cut-off level for the Framingham score (60 years) of 20 % selected 43.6 % of men and 4.7 % of women, while a cut-off level of 25 % selected 25.6 % of men and 1.8 % of women.

Conclusion: Our findings illustrate how choices regarding risk estimation highly affect the size of the target population. A community oriented perspective towards CVD risk interventions should probably first be to decide the appropriate maximum share of the population to be targeted and adjust the risk algorithms' cut-off levels accordingly, rather than vice versa.

PRESENTATION 15: Friday 20st October, 2006 THEME PAPER
16.00 – 16.30 h.

TITLE: Skin diseases: a patient perspective

AUTHOR(S): Zaida Azeredo, Beatriz Tomaz

ADDRESS: Instituto de Ciências Biomédicas Abel Salazar
Largo Prof. Abel Salazar 2, 4099-003 Porto-Portugal
E-mail : Zaida@cscarvalhosa.min-saude.pt

Introduction: Skin diseases can be a psycho-social problem which needs a multidisciplinary approach. The dicotomy between disease and health it is something which worry all human being through the life cycle. The disease means something which is not "normal" (in biological, psychological and/or social ways).
The skin is an important organ which everybody see and can be touch. The skin diseases can have origin in the skin or to be a reflex of a disease in other organ.

Aim: To know how the feelings about skin diseases of patients who attended a GP consultation in Porto.

Material and Methodology: The GP interview 50 patients about psycho-social implications of skin diseases. It was an opportunistic sample and the patients were interviewed to data saturation.
The Authors used an interview guideline.
A context data analyse was made and we establish some categories

Results: Most of the patients feel bad when they see someone with a skin disease, special if they are bleeding, itching or with erosions or lumps: The main feelings are disgusting, pity or fear (to be malignant or contagious).
Most say they which never to have such disease, but if any time they will have they will be discomfort. They don't want to have the disease in visible parts of the body (face, neck, hands). They refer as psycho social consequences changes in the relation life, in the occupational life and future doubts.

Conclusions: In the perspective of the patients skin diseases are something they don't want to suffer, because they have afraid to be rejected by the other people. Also the fear to be something malignant is present.
Often the patient feelings are neglected and overshadowed by the GPs scientific knowledge about the diseases who forget how important is what is behind the skin signals and how much it can interfere in the patient life.
Patients should also feel free to talk about and how skin diseases affects their state of mind. Discussing concerns is itself therapeutic.

PRESENTATION 16: Friday 20st October, 2006 THEME PAPER
16.30 – 17.00 h.

TITLE: Psychological consequences of a car accident in the general population

AUTHOR(S): Laurence Coblentz Bauman

ADDRESS: CNGE, 4 rue du 18 Juin, 95120 Ermont-France
E-mail: Bestdoctorintown@intersystems.fr

In France, in 2002, more than 100 000 serious road accidents occurred, causing 72000 deaths and 140000 injured persons.
Very little is known about the psychological consequences of a car accident in the general population.
Post Traumatic Stress Disorder (PTSD) has been well known in DSM-IV (Diagnosis and Statistical Manual) since the Vietnam war. A trauma can happen in civilian life as well, on a large scale (earthquake) or on an individual scale (aggression, accident, death of relatives).

Research question: What is the prevalence of PTSD after a car accident in a GP patient population?

Method: It is a descriptive study including 1000 patients who have consulted a GP between March and December 2005 in a Parisian suburban town.
We first identified eligible patients by asking two questions (criteria A) :

- were you ever exposed to or did you ever witness a potentially life-threatening car accident ?
- did you feel intense fear, distress or horror ?

If the answers are yes, we asked them to complete a 17 item questionnaire with criteria of numbing (B), avoidance (C) and hyperexcitability symptoms (D). Duration has to have been more than one month (E) and the patient must have described a modification in his everyday life to be considered as a PTSD.

Results: Among 1000 patients, 158 answered positively to the two first questions, authorizing the inclusion in the study. Within this group, 15 complete PTSD were discovered (1 item of criteria B, 3 of C, 2 of D and criteria E and F). If we consider the « partial PSTD » according to Stein studies as one criteria of each, 53 more patients could be included.

Conclusion: Our results show a surprisingly high rate of PTSD after a car accident, none of which have been treated. If these results are confirmed by other studies, it would seem to be a significant health care problem. Thus, early diagnosis and specific care should be offered.

PRESENTATION 17: Friday 20st October, 2006 THEME PAPER
17.00 – 17.30 h. Finished Study

TITLE: How do Mothers Feed Their 6-12 Month Old Babies: Knowledge, Attitude and Behaviors

AUTHOR(S): Mehmet Akman, S. Arabul, Z. Akar, B. Dalkilic, F. Tiber
F. Igit, S. Cifcili

ADDRESS: Dogancilar cad. no:12773 Uskudar-Istanbul, Turkey
Phone: +90 216 3275612
E-mail: makman4@hotmail.com

Background: 6-12 months is a vulnerable period for infants especially in terms of developmental deficits and iron deficiency anemia which may result from defective maternal feeding practices.

Research question: What do mothers know, what are their attitudes and what is their practice in relation to starting solid foods for their 6-12 month old babies?

Method: This descriptive study was conducted in Tasdelen municipality of Istanbul. 100 Mothers of 6-12 month infants were accepted to complete a face to face questionnaire and to fill in one day feeding diary. 50 of them were interviewed in their homes which were located on the randomly selected streets of Tasdelen (Group A) and the other 50 mothers were interviewed in Mother and Child Health Center(Group B). Feeding information brochure and feed back on the daily diaries were given to the mothers immediately. For the statistical analysis Chi-square test and student t-test were used.

Results: 66% of the mothers were primary school graduates and 40% of the infants were 6-8 month old. 28% of the Group A infants and 40% of the group B infants were fed with solid foods starting with 6th month. Most frequent reasons to start solid food were decrease of the mother's milk (40%) and estimating that it is the time(27%). Average correct answer was 10.69 among 14 knowledge statements. 63% of the mothers continue breastfeeding in general. 42% of the mothers gave fruit juice or vegetable soup and 39% gave industrial formulas as a first food additional to, or in place of breastfeeding. The analysis of the food diaries indicated that 49% of the mothers showed a feeding behavior without any error. Average starting times for minced meat, red meat/chicken, yolk of egg were 10.09, 10.60, 9.08 respectively and these solid foods started earlier in group B($p<0.05$).

Conclusions: Generally mothers start foods containing proteins of animal origin later than recommended and this is more evident in group A.
1. What could be the possible ways to analyze food diaries? What is the best?
2. What could be suggested (especially from the point of community oriented research) to plan a further study to determine whether the difference found between the groups is a reality or a coincidence?
3. What could be done to improve infant feeding practices shown in this study with the community oriented primary care perspective?

PRESENTATION 18: Saturday 21st October, 2006 09.30 – 10.00 h. THEME PAPER

TITLE: Evaluating the local health impact of fine particle air pollution

AUTHOR(S): Vasileios (Basil) Vareltzis, Jean Paul Humair

ADDRESS: Departement de Médecine Communautaire, Hôpital Cantonal Universitaire de Genève (HUG)
24 rue Micheli du Crest, CH 1211 Genève 3-Switzerland
E-mail: Vasil.Vareltzis@hcuge.ch

Background: Swiss cities experienced fine particulate air pollution (PM10) in early 2006 leading to health alerts, speed limit restrictions and calls for mandatory fine particle filters for all new diesel powered cars and trucks to reduce pollution levels.

Research question: What was the local health impact of elevated PM10 levels as measured by university hospital emergency room (ER) visits for acute asthma exacerbation and respiratory symptoms?

Method: We searched the air quality monitoring database for Geneva for the period January 2000 – February 2006 and identified 3 periods with average PM10 concentrations exceeding the limit of 50 mcg /m3 and lasting at least 5 consecutive days. We compared ER visits for respiratory symptoms and asthma during the 23 days with average urban values exceeding 70mcg/m3 to visits during 20 days of low pollution. Low pollution periods were selected to precede as close as possible in time the periods of high pollution in order to control for seasonality, temperature and other confounders. The local university hospital ER is the primary facility of its type in the Geneva metropolitan area, caring for the majority of the local population.

Results: The sample included over 4000 ER patient visits coded for symptoms suggestive of acute asthma exacerbation. Outcome measures included confirmed diagnosis of asthma and whether patients were hospitalized or returned home. We expected Asthma in 2.1% of visits based on Swiss population estimates and respiratory symptoms in 5%. In preliminary analysis, only 0.43% of patient visits evaluated mentioned asthma as part of their chief complaint while 7.7% of patients had respiratory complaints during the study period. We concluded that the sample size was insufficient to find a statistically significant health impact of fine particulate air pollution.

Conclusions: Given the public concern, a mutlicentre collaboration is needed to determine whether we can discern an acute health effect.

Points for discussion at EGPRN:
1. how to obtain relevant environmental health information to facilitate community based research?
2. what to do when the prevalence of the problem is lower than expected, leading to low probability of finding statistically significant results?
3. what was the local health impact of elevated fine particulate air pollution in a large Swiss city?

PRESENTATION 19: Saturday 21st October, 2006 THEME PAPER
10.00 – 10.30 h.

TITLE: Randomized controlled trial of an early presentation and intervention service for patients with exacerbations of chronic obstructive pulmonary disease (COPD)

AUTHOR(S): Wisia Wedzicha, Marta Buszewicz, Paul Wallace

ADDRESS: Dept Primary Care and Population Sciences, University College London, Rowland Hill Street, London NW3 2PF
Phone: +44 207 830 2338; Fax: +44 207 830 2339
E-mail: p.wallace@pcps.ucl.ac.uk

21st October

Introduction: COPD exacerbations are a major cause of morbidity, mortality and are now the commonest causes of hospital admission in the UK (15.9% of hospital admissions). Research has shown that that failure to report exacerbations increases the risk of hospitalisation, and that self-management programmes are ineffective. There is evidence that early treatment of exacerbations is associated with faster recovery, but little is known about its ability to prevent hospital admission and improve quality of life.

Methods: A randomized controlled trial will be conducted of an early presentation and intervention service (EPIC) for patients with exacerbations of COPD.
Eligibility will be restricted to patients with moderate to severe COPD with FEV1 less than 50% predicted and at least one exacerbation in the previous year. Three general practice-based commissioning clusters will take part in the trial, each including around 25 GP principals with a total registered population of some 50,000 patients.
The intervention will be delivered by a community-based team of EPIC nurses, recruited and trained to educate and treat COPD patients using an algorithm. The education programme will focus on the nature of exacerbations and their consequences. Each nurse will regularly monitor their allocated patients, and encourage them to recognise and report their exacerbations early. Patients will be provided with symptom diaries, pulse oximetry, and direct telephone access to their EPIC nurse.
Patients satisfying the eligibility criteria will be identified from the electronic records of the participating practices, and invited to take part in the study. Consenting patients will be randomised to EPIC or treatment as usual, and followed for 12 months.
The primary outcome will be the numbers of hospital admissions for acute exacerbations of COPD. Secondary outcomes will be length of hospital stay, healthcare professional consultations, exacerbation length and severity, health-related quality of life, mortality and healthcare costs.

Discussion: It is anticipated that the presentation will stimulate discussion of both the proposed community orientated service for patients with COPD and of the selected trial methodology.

PRESENTATION 20: Saturday 21st October, 2006 POSTER
11.00 – 12.30 h.

TITLE: Promoting community oriented primary care in britain: 2 management & public health perspectives

AUTHOR(S): Steve Iliffe, Kalpa Kharicha, Penny Lenihan

ADDRESS: Department of Primary Care & Population Sciences
University College London, Rowland Hill St.
London NW3 2PF-United Kingdom
E-mail: rmjlsri@ucl.ac.uk

Background: COPC is a method of planning, implementing and evaluating beneficial and wanted changes in local community health and social care using a dynamic and inclusive model. As such it may be a useful tool for changing health care systems, but its actual utility in the British context is unknown. (49 words)

Research Question: What are the advantages and disadvantages of COPC methods in an established primary care system? (15 words)

Methods: PARTICIPANTS: We interviewed 28 staff from management roles in the NHS, using a semi-structured interview schedule derived from a literature review of COPC studies. A snowballing approach to recruitment was used within a framework of disciplines and positions in the hierarchy, to maximise the range of participants. SETTINGS: A purposive sample of health service organisations representing inner city, outer city and rural/small town communities. INTERVIEWS: A semi-structured interview was constructed and piloted. Interviews were taped and transcribed verbatim. ANALYSIS: The original transcripts were read and the categories agreed by the research team, and thematic analysis was carried out. Interviewing ceased when no new themes emerged. (105 words)

Results: We identified six major areas of understanding of the COPC approach:1) conceptual strengths of the COPC model; 2) weaknesses of the COPC model; 3) fit with present NHS policy; 4) congruence with current reform initiatives; 5) probable clinician responses to COPC methods; and 6) attitudes within health care to public involvement. Invitations to communities to participate in decision making about health care may be counterproductive “unless they carry a commitment of time and effort to allow people to feel that they are active partners, and unless policies and plans are open to change as a result of their contribution”. (99 words)

Conclusions: Although involving citizens in a COPC approach is a way to make services more responsive to needs and to produce better health outcomes, there are forces working against community involvement. (30 words)

Point for discussion: Could COPC approaches strengthen health care management and the development of public health perspectives in your health care system?

PRESENTATION 21: Saturday 21st October, 2006 POSTER
11.00 – 12.30 h. Ongoing Study with preliminary results

TITLE: Implementing a community-oriented primary care process in a primary health center

AUTHOR(S): Isabel Montaner, Rosa de la Iglesia, Natalia Amoros
Monica pret, Antonia Ollero, Carme Colomer

ADDRESS: CAP El Carmel. C/ Murtra 130-140. Barcelona 08032-Spain
Phone: +34933571853; Fax: +34933572122
E-mail: isabelmontaner@gmail.com

Background: The Community-Oriented Primary Care (COPC) is a methodology that integrates individual clinical care with community care. It has been criticized for its difficulty to be aplicated at Primary Health Care level. In our Primary Health Centre (PHC) we decided to use the COPC methodology to approach the most important health problems of our community.

Research question: Is it feasible to work with the COPC methodology in a PHC?

Methods: The COPC process consisted in: Community definition and characterization, Prioritization, Community Diagnosis, Intervention and Evaluation.
To start it on we settled an interdisciplinary team (doctors, nurses, social workers and administratives). The planification of the activities was organized with the participation of the population and other social district services.

Results: In 2003 finished the preliminary step, which brought out the most important health problems and needs of our community.
In 2004 the health team, in cooperation with community representatives, prioritized the childhood obesity as the first problem to work on.
From January to June 2005 a selective community diagnosis was done in a sample of children from 6 to 9 years old. The main results of the survey showed a prevalence of overweight and obesity of 21.7%, 58.7% with sedentary life style and 47.6% with inadequate nutrition. Based on this results, we planed the intervention and quantified the objectives. The program, started in 2005, is based on preventing and promoting healthful feeding and physical exercise in the pediatric and teenager population. The evaluation will be done in 2007.

Conclusions: It is feasible to carry out a COPC project at primary health care level on the condition of agreement of all the team, reorganization of daily clinical work and involvement of different professionals and services of the community.

Points for discussion at EGPRN:

1. Is it feasible to work with the COPC methodology in a PHC?

PRESENTATION 22: Saturday 21st October, 2006 POSTER
11.00 – 12.30 h. Ongoing Study with preliminary results

TITLE: The integration of the community-oriented primary care model with other methods of community intervention

AUTHOR(S): Anna Roig, Maria del Carmen Mas, Pilar Saéz
Sònia Burch, Rosa Gurpegui, Cristina Maseras

ADDRESS: CAP El Carmel. C/ Murtra 130-140. Barcelona 08032-Spain
Phone: +34933571853; Fax: +34933572122
E-mail: amroig.pbcn@ics.scs.es

Background: In our primary health centre (PHC) we have always been interested in orienting the practice to the community. Different professional backgrounds have conducted to implement diverse initiatives from health and social services and local associations. The experience that we present tries to clarify the process that has allowed us to unify interests and integrate different methodologies

Research question: It is useful and effective to work in the same community with different methodologies?

Methods: The main methodologies used by the local services and community associations in our neighbourhood (21.000 inhabitants) are the Participatory-Action-Research (PAR), Community Development Plan (CDP) and Community-Oriented Primary Care (COPC). The process of integration of different methodologies consisted of supporting permanent dialogue. We started with simple activities and the favourable outcomes encouraged us to increase the number and complexity of activities and finally conducted to a common District Project ("Proyecto de Barrio"), with preserving the own methodology structure.

Results: Since 2005 the COPC project has been integrated into the Discrit Project, which has developed a healthy habits work line. The main outcome of this integration has been "The Week for Health in the street" which took place in Spring 2006 with an important community participation. On the other hand, the PAR project is integrated in another work line that concentrates in family. Its main outcome are annual local meetings (4 editions since 2001) that approach old people's problems.

Conclusions: Meetings between different professionals and associations within the District Project have allowed knowing each other, working on net, planning joint activities and settling shared conclusions. To establish future proposals and continue this slow but positive process is important to emphasize strong points and keep in mind aspects to improve. Our experience shows the feasibility to integrate different work methodologies in the same community.

Points for discussion at EGPRN:

1. It is useful and effective to work in the same community with different methodologies?

PRESENTATION 23: Saturday 21st October, 2006 POSTER
11.00 – 12.30 h. Finished Study

TITLE: General Practitioner and primary mental care

AUTHOR(S): Martha Andreou, Georgia Dina, Dulgerhs Haralampos

ADDRESS: Health Center Stavroupolis, General Hospital Xanthi
Kosta Varnali 13, 67100 Xanthi-Greece
E-mail: marand@panafonet.gr; hcstavr@otenet.gr

Background: The management and treatment of mental disorders in primary care is a fundamental step which enables the largest number of people to get easier and faster access to services- it needs to be recognized that many are already seeking help at this level. (WHO/ The World Health Report: 2001)

Research question: Can the General Practitioner (GP) in a rural area, offer an effective primary mental care?

Method: We register in a year all mental patients who came to emergency room (ER) of Health Center (HC) of Stavrupolis, the chronic mental patients under observation of G.P. with specialization in Social Psychiatry and the interventions for avoidance of a recurrence as well to the community education.

Results: 161 mental patients came to ER of HC Stavrupolis. The majority of them were between 40 and 80 years old and the sex ratio was 1:2 (54 men/107 women). 99 patients reported subjective symptoms while 62 patients reported objective symptoms. Case history of mental disease had 114 patients. Supporting psychotherapy has given almost to all patients while 70% of them was examined again as outpatients- so the diagnostic procedure and treatment to be completed and from the last, 20% was send to a psychiatrist. Regularly- once a month – 19 chronic mental patients were followed up from a GP under psychiatrist' s supervision (4 men:15 women). Intervention into the family and social circle was necessary five times- once by order of the district attorney. Community education included nurses and the rest of the HC staff, the priests, the municipal social program "help at home" and the parents and relatives of the patients.

Conclusions: Our results demonstrate that the GP can offer an effective primary mental care when he has been trained, has support from the mental health specialists and the community education is achieved.

PRESENTATION 24: Saturday 21st October, 2006 POSTER
11.00 – 12.30 h.

TITLE: Home Care: who are the patients?

AUTHOR(S): Zaida Azeredo* P. Jullamate**, E. Matos*
* Institute for Biomedical Sciences of Abel Salazar, University of Porto, Portugal
** Faculty of Nursing, Burapha University, Chonburi, Thailand

ADDRESS: Instituto de Ciências Biomédicas Abel Salazar
Largo Prof. Abel Salazar 2, 4099-003 Porto-Portugal
E-mail : Zaida@cscarvalhosa.min-saude.pt;
jjullamate@yahoo.com

Introduction: Home care is an interesting issue in family medicine.
Population around the world become older and older increasing the care needs and the prevalence of disability. The higher proportion of very old people and the existence of mobility barriers increase the demand of home care and home visits Home care means continuity of care for patients/ family, at home setting.
Home care provides to all acute and chronic ill patients who can't absolutely or partially go to the primary health care unit.

Aim: To know who the people requiring home care are.

Materials and methodology: The authors studied the patients of a GP's list in Porto (Portugal) who cannot come to the office by several reasons. The GP provided them with a continuity of care at home between 2004-2005 (May).

Results: Most of patients received home visit were elderly patients. The mean age of the patients was over 84,5 years old; 53,3% of the patients were 80 years old and 77,7% female. The youngest patient was 63 years old and the oldest 97 years.26,7% of the patients were living in a nursing home; 26,7% with a couple (also old) and 17,8 % alone. 44,4% of the patients lay in a bed.
Most of the patients suffered from chronic diseases or terminal diseases such as cancer. Home and nursing home were the main places where the patients died
The most reason family doctors provide home visit was the vigilance of consequences of chronic diseases or on terminal ill patients. One of reasons why these elderly patients did not attend to primary health care unit was the barrier in accessibility.

Conclusion: Home care is an important part of primary health care. The more the population is getting older, the more important is the home care. It is an essential care for elderly people and terminal patients who don't want to die in a hospital, but must be provided by a team and must be supported by a social care. In this study most of the patients were old or very old; 44,5% of the patients live alone or with a couple also old.

PRESENTATION 25: Saturday 21st October, 2006 POSTER
11.00 – 12.30 h. Ongoing Study with preliminary results

TITLE: Access to primary healthcare services – patients' perspective

AUTHOR(S): Donka Dimitrova, Nevena Ivanova, Rositza Dimova
Radost Asenova

ADDRESS: Medical University-Plovdiv, dept. Healthcare
V.Aprillov 15a, 4002 Plovdiv-Bulgaria
E-mail: donka_d@hotmail.com

Background: Realized access compared to potential access to primary care is important in determining the characteristics and effectiveness of the healthcare systems.

Research question: to study patient access regarding availability, accessibility, acceptability and affordability of primary healthcare form the patients' points of view as well as the realized access, predispositions and healthcare seeking behaviour patterns of different population groups.

Method: We conducted individual interviews using a specially designed semi-structured questionnaire including 65 questions in 14 sections.

Results: Discussed are primary results of 31.8% \202 patients\ sample.
The study revealed that 96% (194) of the participants had a regular source of care within the national health insurance program, but 27.7% (56) consulted physicians other than the GPs their were registered with. 75,2% (152) of the patients had been registered with a certain general practice for more than 2 years, but 33.7% (68) had changed their GPs mainly because of dissatisfaction with the personal or the practice. There was open access in most of the practices, but 25.3% (51) of the patients had given up visits because of waiting and working time related factors. 46.6% (94) had experienced financial limitations using primary care services.
77.2% (156) of the respondents reported self-limiting their use of primary healthcare. 54% (109) commonly "treated their health problems themselves" and 39% (79) would use professional medical services only in emergencies.
48% (97) patients irrelevant of their gender reported that they had not had a check up in a period of 12 months and 76.7% (155) had never discussed screening and prophylactics with their GPs.
85.2% (172) believed that there were inequalities in healthcare between rural and urban areas.

Conclusions: Patients experienced problems and limitations accessing healthcare that modified their health behaviour. The development of adequate access indices would help optimizing healthcare system performance.

PRESENTATION 26: Saturday 21st October, 2006 POSTER
11.00 – 12.30 h. Ongoing Study with preliminary results

TITLE: The Functionality of Finnish Health Centres has increased during the National Health Project

AUTHOR(S): Arto Vehviläinen, Outi Valkonen, Esko Kumpusalo

ADDRESS: Maaherrankatu 40 as 1, 50100 Mikkeli-Finland
Phone: +358407680959
E-mail: outi.valkonen@jupusu.fi

Background: In recent years, there has been growing problems in arranging primary care in some parts of Finland. In 2002, the Council of State declared a national project to secure the future of health care. The aim of the project was to evaluate the existing and threatening problems of the health care system and to start a programme to eliminate these problems. One of the missions was to improve the functionality of primary care by e.g. increasing the amount and expertise of health centre personnel. In Finland, primary health care is provided mainly in communal health centres. There are about 270 health centres in Finland employing approximately 3300 physicians.

Research question: What are the effects of the National Health Project to the functionality of health centres evaluated by Finnish GPs'?

Method: A postal questionnaire was sent to all GP's working at a health centre, before launching the National Health Project in spring 2002, and again in spring 2006. The questionnaire consisted of 24 questions concerning functionality of different aspects of health centre work. A general functionality score was summated.

Results: Assessed by GP's, the functionality of health centres has increased in all parts of Finland during the National Health Project. Although, in Northern parts of the country, the change was minimal. The biggest improvements were found in GPs' access to further professional education, patient information flow from secondary to primary care, GPs' own occupational health care, and getting a locum when needed. The co-operation with other GP's and other health centre staff was evaluated to work very well.

Conclusions: The functionality of health centres has increased in all parts of Finland and in almost all aspects of health centre work.

PRESENTATION 27: Saturday 21st October, 2006 POSTER
11.00 – 12.30 h. Ongoing Study with preliminary results

TITLE: Introducing a new educational program for general practitioners from distant community centres in counseling young people

AUTHOR(S): Valentina Madjova, Svetlana Christova
Paraskeva Mancheva, Andrei Zabounov

ADDRESS: Dept. of Family Medicine, Medical University of Varna
Bld. "Christo Smirnensky" 1, 9010 – Varna Bulgaria
Phone: +359-300-262; Fax: +359-52-302-874
E-mail: v_madjov@abv.bg

Background: The democratic processes in the Eastern European countries lead to liberal sexual behaviour, a high rate of abortions, an epidemic raise of HIV positive and drug users among young people. Continuous medical education of GPs in remote community practices stays behind these processes and doctors' promotional activities are still not sufficient because of lack of knowledge and experience.

Research Question: Is it necessary to introduce a new educational program for GPs from distant community centres for counselling young people in reproductive and sexual health and prevention and control of HIV/AIDS

Methods: A study includes 2 stages: 1) an assessment of the basic knowledge and attitudes of GPs from distant community centres to family planning, prevention and control of HIV/AIDS and counselling young people. An anonymous inquiry among 218 rural GPs, mean age 40.25 ± 6.5 years and mean years of doctor's practice 13.5 ±8.3 years was made. They had to answer to 18 MCQ; 2) a preparing of a new educational program according to GPs' necessities by the Department of FM of Varna Medical University, which will be consulted by Ministry of Health and UNFPA – Bulgaria.

Results: The preliminary data from the inquiry show that 62.28% of rural GPs haven't enough information about actual HIV/AIDS data and 74.56% haven't good communication skills for counseling young people in family planning and prevention of HIV/AIDS.

Conclusions: Our results demonstrate that we have to introduce a new educational training program for GPs from distant community centres focused on communication skills orientated to young people. The program will include reproductive and sexual health problems and especially prevention and control of HIV/AIDS.

Points for discussion at EGPRN:

5. What is the level of basic knowledge of GPs from distant community centres in family planning, prevention and control of HIV/AIDS in other EGPRN-member countries?
6. What is the educating process of GPs from distant community centres in family planning, prevention and control of HIV/AIDS in other EGPRN-member countries?
7. Is there a special education for GPs focused on communications skills for young people in other EGPRN - member countries?

PRESENTATION 28: Saturday 21st October, 2006 POSTER
11.00 – 12.30 h. Finished Study

TITLE: What do Medical School Residents Think and Know About Family Medicine in Turkey

AUTHOR(S): Zeynep Gunayi, Tolga Gunvar, Nilgun Ozcakar, Dilek Guldal

ADDRESS: Dokuz Eylül Üniversitesi Tıp Fakültesi Aile Hekimliği
Anabilim Dalı – İnciraltı/İzmir TURKEY
Phone: 0 232 412 49 51 – 0 232 412 49 52
E-mail: tolga.gunvar@deu.edu.tr

Background: In Turkey, despite most of the universities have family medicine departments and academicians, especially between doctors, knowledge level about this discipline is not well known.

Research Question: What are the thoughts and level of knowledge of assistant doctors about family medicine in our faculty?

Method: 155 of 430 residents (mean age 28,26; mean graduation time from school 4,37 year) in our Faculty of Medicine participated in our study. Physicians have been asked to fill out a questionnaire, which consists of two parts; the first part aimed to collect demographic information, and the second contained statements about characteristics of family medicine. Data collected were analyzed with SPSS 11.0 using Pearson's Chi-Square test.

Results: More than 75 % of participants gave positive response to 8 questions about missions of family physicians while 81,2 % of residents do not believe that retraining physicians in practice with a one-week course would help to improve quality of primary care in our country. Female participants are more likely to believe that maternal – child care and family planning services are tasks of family physician, as compared to male participants (p= 0,014 and p= 0,017 respectively). Male participants have more tendency to believe that in Turkey "General Health Insurance" will have negative effect on the community's access to health care as compared to their female colleagues (p=0,033). The doctors with medical practice experience before their education on specialization are more likely to believe that new "health system model" in our country would threaten job security of doctors (p=0,017), increase health expenditures (p=0,020) and have a negative effect on community's access to health care (p=0,015)

Conclusions: The level of knowledge of the participants is fairly high about the mission of family physician. On the other hand, the level of knowledge about the genesis of the discipline is low.

Points for discussion at EGPRN:

1. Perception of family medicine among other medical disciplines.

PRESENTATION 29: Saturday 21st October, 2006 POSTER
11.00 – 12.30 h. Ongoing Study with preliminary results

TITLE: Determinants of Smoking among University Students in Sakarya/Turkey

AUTHOR(S): Pinar Topsever, Müge Filiz, Nursan çinar, Ismail çakar Cemile Dede, Funda Sevgi Aktuna, Süleyman Görpelioğlu

ADDRESS: Kocaeli University Faculty of Medicine, Dept of Family Medicine, Umuttepe Campus
Eski İstanbul yolu 10.km, 41380 Kocaeli-Türkiye
Phone: +90 262 303 7405; Fax: +90 262 303 7003

Background: Smoking is still the most important modifiable health risk. Especially smoking habits among young people today determine population health risks of tomorrow.

Research Question: What are determinants of smoking among university students in our area?

Methods: A 15-item questionnaire investigating socio-demographics, as well as family and smoking behaviour (developed by the researchers) was piloted and applied to students of seven different faculties and one vocational school of Sakarya University, Turkey. In 2005-2006, total number of registered students at these faculties/schools was 17541. Sample size estimation revealed 2200 students as representative for this population. Finally, questionnaires of 2252 consenting participants were analyzed. Self rated school success (poor-intermediate vs. good-excellent) and self declared income (low-satisfactory vs. high-very high) level were dichotomized. Descriptive results are presented as %, mean±SD. Logistic regression with smoking as dependent and variables of interest as covariates was used to calculate odds ratios (OR) (exp. beta) with 95% Confidence intervals (95% CI).

Results: More than half of the participants (1128 males, 1124 females, mean age 21.4±2.1 years, 603 (26.8%) smokers, 110 (4,9%) ex-smokers, 1516 (67.3%) non-smokers) were not satisfied with their school success (poor-intermediate n=1312 (58.8%) vs. good-excellent n=918 (40.8%)). Income level was declared as follows: low-satisfactory n=1394 (62.6%) vs. high-very high n=834 (37.4%). Logistic regression revealed age (OR 1.2, 95% CI 1.1 to 1.2), male gender (OR 2.1, 95%CI 1.7 to 2.6), self-declared high income (OR 1.8, 95%CI 1.4 to 2.2) and self-rated low school success (OR 1.7, 95% CI1.4 to 2.1) as independent determinants of smoking.

Conclusion: Nearly one third of the students in the studied setting were smoking. The results of this study give implications for health promotion and preventive care in terms of special risk groups who are to be addressed more rigorously during anti-smoking health education campaigns. Reasons for the impact of school success and income level on smoking habits should be investigated further in a qualitative manner.

Points for discussion at EGPRN :

1. What should be the next step according to the present results?
2. What should be the design of the qualitative study?

PRESENTATION 30: Saturday 21st October, 2006 POSTER
11.00 – 12.30 h. Finished Study

TITLE: Comparative evaluation of the applicability of different prediction models for coronary risk in the Family Practice's (FP) patients.

AUTHOR(S): Witold Lukas[1,2], Ireneusz Szymczyk[1,2], Joanna Skorupka[2]
[1]Department of Family Medicine, Medical University of Silesia, Katedra i Zakład Medycyny Rodzinnej] ul. 3-go Maja, 41-800 Zabrze.
[2]Family Medicine Practice [Modelowa Praktyka Lekarzy Rodzinnych], ul. Medyków 22, Katowice.

ADDRESS: Dept. of Family Medicine, Medical University of Silesia, [Katedra i Zakład Medycyny Rodzinnej] ul. 3-go Maja, 41-800 Zabrze, Poland
Phone: 1 – 00482719122 - 2 – 00482046399
Fax: 2 - 00482046399
E-mail: REDPMR@POCZTA.ONET.PL

Background: Primary prevention of CHD is one of the most important issues aimed at by the family physicians. Meanwhile, the diversity of applied, Framingham-based risk algorithms operating on different risk factors as well as data's categorization constitute the eminent source of bias when comparing their results.

Research Question: Which of the commonly applied algorithms for the CHD risk assessment is the most reliable when referenced to the Framingham equation?

Methods: The risk factor data obtained on 200 patients (100 with T2DM) without manifest coronary heart disease were used to compare the diagnostic performance of the Framingham risk equation (F) against the Cardiac Risk Assessor (CRA), Joint European Society Guidelines (JES), Joint British (JB), revised Sheffield table (S) and Procam (P). The essential coronary risk was assumed to be of 20% or more within the next 10 years (except for 5% risk within 1 year in S). Kappa and tau-b Kendall's coefficients were calculated to assess the bilateral agreement of both qualitative and rough (quantitative) data between each of the algorithms.

Results: Guidelines were applicable to different subsets of cohort, ranging from 109 (P) to 200 (F,CRA,JES) patients. On the whole, a good compatibility with Framingham was achieved in CRA (κ=0,664), moderate in JES (κ=0,538), P (κ=0,492) and JB (κ=0,418) while poor in S (κ=0,233). The highest diagnostic sensitivity was found in CRA (0,667) and JES (0,667) while the specificity performed similarly in each case (0,863-0,972). Kendalla's correlation confirmed the best or equally well bilateral agreement of each of the coronary risk prediction models with the Framingham equation comparing to the compatibility between other algorithms. Essential coronary risk was found approximately threefold more frequently among T2DM patients.

Conclusions: Although more time-consuming, the Framingham equation seems to be the most recommendation-worth coronary prediction model to apply in the primary care setting.

PRESENTATION 31: Saturday 21st October, 2006 POSTER
11.00 – 12.30 h. Almost Finished Study

TITLE: Patients knowledge about the safety of oral anticoagulant treatment and the occurrence of major haemorrhagic and thromboembolic events.

AUTHOR(S): Jolanta Sawicka-Powierza, Alicja Malgorzata Oltarzewska

ADDRESS: Ul. Daktylowa 18, 15-791 Bialystok, Poland
Phone: +48 85 7326-820; Fax: +48 85 7327-848
E-mail: jolasawicka@gmail.com

Background: Oral anticoagulation using coumarin derivatives (OAC) is being prescribed to a steadily increasing number of patients as a life-long therapy for conditions such as atrial fibrillation, mechanical heart valves and vascular thromboembolism.

Research question: Is there any relationship between a patient's knowledge about the safety of OAC treatment and the occurrence of serious haemorrhagic and thromboembolic events during OAC therapy?

Methodology: 140 patients on long-term oral anticoagulant treatment for atrial fibrillation, mechanical heart valves and vascular thromboembolism, were included in the study. They were interviewed using a questionnaire specifically scripted by the authors. The questions concerned their understanding of the reasons for the treatment, target INR ratio, frequency of INR examination, complications during therapy; plus questions specifically designed to check the patients' knowledge about factors influencing INR values e.g. drugs, food, alcohol and the like.

Results: General knowledge about the safety of OAC treatment was very low. The average score of patients in the group without complications (99 individuals) was 4.01 out of 10 questions; the standard deviation was ± 2.2; in the group with major complications it was 3.0 ±1.7.
41 of the 140 patients interviewed had suffered complications. Ten of these cases were very serious with seven needing hospitalization and three requiring specialized care.

We did not find any significant statistical relationship between major complications and the level of patients' knowledge.

There is relationship between the frequency of INR examination and the occurrence of major complications ($p<0.05$).

6 of the 7 cases of major haemorrhage followed the use of Aspirin or non-steroid anti-inflammation drugs.

Conclusions: Patients on OAC therapy need more education to be able to self-manage the treatment and avoid dangerous major haemorrhagic and thromboembolic events. Patients should have free access to INR examination.

Points for discussion at EGPRN:

1. What is the best place to educate patients with life-long oral anticoagulant therapy to avoid complications – the primary care or special anticoagulant clinics?
2. How is organized care about these patients in other countries?

PRESENTATION 32: Saturday 21st October, 2006 POSTER
11.00 – 12.30 h. Finished Study

TITLE: Working again after an acute cardiac infarct

AUTHOR(S): Christos Pogonidis, E. Xenodoxidou, Ir. Christodoulou
L. Borgi, O. Koutsogiannis, X. Apostolidou
Th. K. Konstantinidis

ADDRESS: Mikras Asias 78-82, Xanthi, Greece
Phone: +30- 2541023057 / 6977714292
E-mail: cpogonidis@yahoo.gr

Background: Acute cardiac infarction is a common cause for hospital admission and absence from work. The prevalence of acute infarction is increasing in men older than 40 years, and the social cost of health turns out to be considerable in many cases.

Research Question: Is it possible for patients to regain their professional status after an acute cardiac infarct?

Methods: A questionnaire was used to investigate prominent limitations and problems and the approximate percentage of successful rehabilitation in 437 patients after an acute infarction, reported during past decade. The patients were studied in 3 groups, according to their age (A= < 45 years old, B= 45-55, C= 55-65 years old). In total, only the 12, 8% were female. A stent was needed for 34,6 % and an operation was reported in 16,25% of cases.

Results: In total, 14% of cases stated that they returned to their work in 3 months after their admission in Hospital, 46,5% in 6-8 months and 22,7% in 1 year. The 16,8% did not manage to come back to their work. The longer period of absence from work was noticed in group C (p=0,03) and in workers in rural areas(p=0,01). Comparing group A and B there was a noticeable difference in rehabilitation rates, the ejection fraction and the achievement of every day activities.

Conclusions: Capability for work after an acute infarct depends on the severity of the cardiac episode and the kind of the patients' work. Considering the successful rehabilitation, 83,2% manage to return to their work, without radical changes.

PRESENTATION 33: Saturday 21st October, 2006 POSTER
11.00 – 12.30 h. Finished Study

TITLE: Sexual life after a cardiac infarct: still a controversial issue?

AUTHOR(S): E. Xenodohidou, C. Pogonidis, Ir. Christodoulou
X. Apostolidou, Ch. Koutis, A. Thomoglou
Th. K. Konstantinidis

ADDRESS: Mikras Asias 78-82, Xanthi, Greece
Phone: +30- 2541023057 / 6977714292
E-mail: exenodo@yahoo.gr

Background: Sexual life is affected after an acute cardiac infarct in many cases for a period that varies according to a considerable number of factors.

Research question: Is sexual life still an issue of controversy for patients after a cardiac episode?

Material-methods: In total 41 patients with a cardiac infarct in their medical history were included in our study. The median age of the participants was 40±5,67 έτη. The 75% had received a thrombolytic therapy, an angioplasty had been executed in the 34%, and the 15% had been operated.

Results: The 67% of patients stated that they regained their sexual life after a period of rehabilitation. The 23% did not manage to have a sexual contact during the first year after the infarct, because of recurrent symptoms, anxiety disorders and/or depression. The 23% referred to the absence of every sexual function and desire during the first post-infarct year. The patients with serious sexual dysfunction had synchronous bad prognostic factors (diabetes, hypertension, smoking). The medical advice they needed derived more commonly from the cardiologist or their family doctor (73%). Complementary questions that were given from the family doctor only were reported in a percentage of 53%. A help line for medical advice via telephone contact was useful for 3 patients. Antidepressants were used from the 17%. Awareness on adverse effects of cardiologic drugs was present in 23% of cases. The 82% were fully informed about alterations of sexual life to protect themselves from a new episode.

Conclusions: In young patients, the post- infarct period is stressful and is determined by a considerable number of factors. Sexual life during this period is regained gradually and medical advice and support is always needed.

PRESENTATION 34: Saturday 21st October, 2006 POSTER
11.00 – 12.30 h. Finished Study

TITLE: Methodological issues in assessing Type 2 diabetes mellitus prevalence using data from Italian GPs' Electronic Patients Records

AUTHOR(S): Filippo D'Addio, Ferdinando Petrazzuoli, Nicola Buono

ADDRESS: Via Orientale, 3, 81010 Ruviano (CE)-Italy
Phone: +390823860032;Fax: +390823860032
E-mail: 0823860032@iol.it

Background: Type 2 Diabetes Mellitus (T2DM) is a chronic illness widespread all over Europe. with a variable prevalence in the different countries. In Italy GPs' Electronic Patients Records (EPRs) are very useful to assess the prevalence of T2DM. Because GPs have a fixed list of patients, they are the gatekeepers of Health Expenditure, their EPRs are very accurate and complete about the data of T2DM, a chronic and very expensive illness! The main statistical bias is related to the different greatness of classes of age in GPs patients in respect with the whole population: Italian GPs don't care neonates and children under six.

Research Question: Is it feasible to assess the prevalence of T2DM using Italian GPs' EPRs data?

Methods: EPRs of five (about 6000 patients) GPs living in rural towns (less than 5000 inhabitants, located on the hills) and eleven (about 15000 patients) GPs in not-rural towns in the Province of Caserta, were screened to assess the classes of age of patients and the number of diabetic patients. Data of the population of the towns in which GPs lived and worked were taken by archives of town councils. The authors calculated the T2DM prevalence in two groups GPs samples and the corrected T2DM prevalence in the two populations.

Results: The T2DM prevalence in the rural GPs' sample was 7,5%, the corrected prevalence in rural population was 7,1%. The T2DM prevalence in the urban GPs' sample was 6%, the corrected prevalence in urban population was 5,1%.

Conclusions: The T2DM prevalence data computed with the screening of EPR in Italy overestimate the real T2DM prevalence in whole population, the bias is more important in urban population.
The T2DM prevalence is higher in rural population.

Points for discussion at EGPRN:
1. Is useful to search the main issues in assessing the epidemiological power of data stored in EPR in each European Country?

PRESENTATION 35: Saturday 21st October, 2006 POSTER
11.00 – 12.30 h.

TITLE: Evaluation of Diabetes Mellitus Patients' the Knowledge, Attitude and Behaviour Regarding Immunization

AUTHOR(S): Selcuk Mistik*, Dilek Toprak**, Abdullah Ozkiris*
Gul Unsal*, Hulya Sahan*, Hasan Basri Ustunbas*
*Erciyes University Medical Faculty
**Afyon Kocatepe University Medical Faculty

ADDRESS: Family Medicine Erciyes University Medical Faculty
Dept. of Family Medicine 38039 Kayseri-Turkey
E-mail: smistik@erciyes.edu.tr

Background: Influenza causes a lot of deaths every year and diabetes mellitus patients are a target group for influenza vaccination because of their increased risk.

Research question: Are our diabetes mellitus patients getting vaccinated for influenza?

Method: Diabetes mellitus patients who have applied to the Family Medicine and Ophthalmology Departments of Erciyes University Medical Faculty and Family Medicine Department of Afyon Kocatepe University Medical Faculty between June-September 2005 were included in the study. A questionnaire comprised of 25 questions has been administered to the patients. Thirty patients had training on influenza and influenza vaccination in September 2005.

Results: Two hundred three diabetes mellitus patients were enrolled in the study. Of these, 112 were women and 91 were men, and the mean age was 57±10 years. Fifty-two percent (n=105) of the patients were housewives, and 25% (n=52) were retired. The rate of influenza vaccination in the previous influenza season was 9% (n=18), which was the same with the previous rate of having influenza vaccination ever. The rate of patients who want to be vaccinated the next season was 28% (n=54). The most common reason for not being vaccinated the previous season has been stated as 'did not know to need for vaccination' with 49% (n=76). The ones who wanted to be vaccinated the next season stated that they were suggested most commonly by doctors (56%, n=25).

Conclusions: Our study demonstrated that diabetes mellitus patients in our study group have been vaccinated with a very low percent with influenza vaccine and there was no one who had pneumococcal vaccine. In order to prevent influenza, which causes considerable morbidity and mortality in diabetes mellitus patients, it is important to get the patients vaccinated or at least suggest them to get their influenza vaccine.

PRESENTATION 36: Saturday 21st October, 2006 POSTER
11.00 – 12.30 h. Almost Finished Study

TITLE: Risk factors for diabetes which could be included as a screening strategy in primary care

AUTHOR(S): Domingo Orozco, S. Pita, B. Alvarez
M.C. Carratalá, V.Pugliese

ADDRESS: Centro de salud Alicante -San Blas
c/ Maestro Latorre 5, 03005 Alicante, Spain
Phone: 655347768; Fax 965919450
E-mail: dorozcob@meditex.es

Research question: To identify risk factors for diabetes other than age that could be included as a better screening strategy.

Methods: Sample of 18953 people from the Comunidad Valenciana Spanish region, who were between 40 and 78 years old, and for whom complete data were available by October-December 2004. Sensitivity, specificity, predictive values, and likelihood ratios for detection of undiagnosed hyperglycemia (positive screening) were calculated. ROC curves were plotted, and area under the curve (AUC) values and their CIs were estimated. Of the 18953 participants in the Study, data were missing in 3771, so 17595 patients were analized. 1358 (7.7%) had known diabetes, leaving 16327 people who could be included in the screening procedure, but 2168 drop out. So, 14069 finalized the screening programme.

Results: Age: 54.1 (40-90) years; female 56.1%, smokers 23.3%. BMI>30 24.7%; BMI 25-30 46.1%; BP>=140/90 32.5%; Glycaemia (≥ 126mg/dl) or positive screening (PS) was 4%. Factors associated: logistic regression model by using positive screening test as dependent variable (adjusted by different co variables): Age, (OR 1.03) (95% CI 1.02-1.04),(p=0.000); BMI, (OR 1.10), (95% CI 1.08-1.13),(p=0.000); Sex (woman), (OR 0.63, (95% CI 0.5-0.8),(p=0.000); HT, (OR 1.6), (95% CI 1.3-1.9),(p=0.00); Total Cholesterol, (OR 0.9), (95% CI 0-9-1.01),(p=0.14).

Conclusions: Variables associated with positive screening by order of importance (ROC curve) were : Body Mass Index, Blood pressure and Age.

Points for discussion at EGPRN:
1. Diabetes Screening.
2. Risk factors
3. Applicability in primary care

PRESENTATION 37: Saturday 21st October, 2006 POSTER
11.00 – 12.30 h. Finished Study

TITLE: GPs and children with overweigh and obesity

AUTHOR(S): Radost Asenova, Donka Dimitrova, Plamen Konstantinov

ADDRESS: Dept General Practice, 15 A Vasil Aprilov street
MU-Plovdiv-Bulgaria
Phone: +359 32 602533; Fax: +359 32 602 500
E-mail: r_assenova@yahoo.com

Background: Overweight and obesity in children are major spread and important risk factor. Health education is a main instrument for achieving the aims of obesity prevention among children and to great extent determines the result of struggle with overweigh. Because of permanent contacts with their patients (parents - children) the GPs have real possibility of preventing overweigh with children through health education.

Research question: The aim of the study was a followed up assessment of the frequency of overweight and obese in children from first to third grade and the activities of the GPs in children with overweight and obesity.

Method: A study of 4.05% \387\ random sample of children in the city of Plovdiv was conducted measuring of the anthropometrical indicators – height and weight. Overweigh and obese children were defined as those with a BMI at or above the age-sex-specific standard value. We followed up 80.41% of overweight and obese children in two years. We also conducted content analyses of their patient records and interviewed their GPs. SPSS software 13 version was used.

Results: We established that 25.06%, Sp – 2.20% from children were overweight or obese at the beginning in 2003. The study reveals that 28.21% of overweight children normalized their BMI and 7.69% of them became obese. 55.56% of obese children reduced their BMI. The GPs reported that they had advised the children and their families about the risks of overweight and obesity but there was insufficient data of it in the patient records.

Conclusions: Approximately one in four children in Plovdiv is overweight or obese. The activities of the GPs concerning overweight and obesity in children need to be improved.

PRESENTATION 38: Saturday 21st October, 2006 POSTER
11.00 – 12.30 h. Finished Study

TITLE: Implementation of a behaviour modification programme for weight loss in primary care: a prospective interventional study

AUTHOR(S): Klaus Eichler[1], Marco Zoller[2], Johann Steurer[1]
Lucas M. Bachmann[1]
[1] Horten Centre for patient oriented research, University hospital of Zurich, Switzerland
[2]Zürcher Ärztegemeinschaft zmed, Grütlistrasse 36, 8002 Zurich, Switzerland. marco.zoller@hin.ch

ADDRESS: Allgemeine Medizin FMH
Limmattalstrasse 177, CH-8049 Zürich-Switzerland
Phone: +41 (44) 341 8600; Fax: +41 (44) 341 8626
E-mail: mzoller@dplanet.ch

---

*Background:*Cognitive behaviour modification programmes (CBT) have shown to be effective in treating obese patients, but difficult to implement in primary care setting.

Objectives: We aimed to implement a CBT weight loss programme for overweight and obese adults into routine care of Swiss general practitioners network in cooperation with a community centre for adult education.

Methods: Based on evidence reports, we choose an organisational intervention rather than addressing individual physician behaviour. A team of network physicians and scientists planned the intervention, a multidisciplinary core group of trained CBT weight-loss-instructors acted as the central element.
To monitor the results we prospectively collected data for participant characteristics, weight change, self reported physical activity, and quality of life (SF-36) until 1 year of follow-up.

Results: The CBT-programme for weight loss was implemented successfully. 25 courses, with 16 group meetings each, were initiated over a period of 3 years. Median weight loss after 1 year in a cohort of 190 participants was - 4.0 kg (IQR: - 1.5 to - 7.5 kg). Changes in quality of life were modest, attrition rate was 25%.

*Conclusions:*Based on an organisational change a CBT programme for weight loss is now available as an easily accessible therapeutic option for family doctors and their overweight patients as well as for overweight persons from the community.

Points for discussion at EGPRN:
1. Role of GP's in obesity management?
2. Interaction of practices with community institutions?

PRESENTATION 39: Saturday 21st October, 2006 POSTER
11.00 – 12.30 h.

TITLE: The importance of early diagnosis of congenital hypothyroidism

AUTHOR(S): Ramazan Tetikçok, Musa Kazim Çağlar
Fatma Şemsa Altugan, Işil Özer

ADDRESS: Gaziosmanpaşa Üniversitesi, Tip Fakültesi, Aile Hekimliği AD Tokat-Turkey
Phone: +90 542 6257757; Fax: +90 356 2133179
E-mail: rmznttkck@yahoo.com.tr

Introduction: Newborn screening and thyroid therapy started within 2 weeks of age can normalize cognitive development in congenital hypothyroidism (CH). The incidence of CH in Turkey has been found to be 1/2326. We would like to present six cases with CH seen in our clinic during last six months.

Cases: Descriptive features and time of diagnosis of patients were given below.

Cases	Age(y)	Age at the time of CH diagnosıs	Height (cm)	Height percentile	Free T4(ng/dl) (N:0.8-2.3)	TSH(µIU/ml) (N:0.7-6.4)	Mental status
1	4	4 y	75	< 3	0.09	100+	MR
2	4.5	4.5 y	83	< 3	0.09	100+	MR
3	8	8 y	100	< 3	0.2	100+	MR
4	5.5	12 days	86	< 3	0.28	27.86	MR
5	8	10 days	128	25-50	0.51	100+	N
6	3.5	15 days	99	25-50	1.63	6.5	N

MR:Mental retardation, N:Normal

Discussion: The first three patients recognised late had marked failure to thrive and mental retardation. Even though the fourth case has been identified early, she had both failure to thrive and mental retardation due to improper treatment. The fifth case had been treated appropriately till the last four months. The fifth and sixth cases showed that continuously proper treatment resulted in normal development from the point of both physically and mentally. The population of Tokat is approximately is 880 000. Since the crude birth rate is 2% in our region, 8 new permanent CH have expected for every year.

Conclusion: Although newborn thyroid screening is not currently carried out in our country, they have been brought to pediatric clinics for other reasons, mainly for failure to thrive. Since we have confronted with 6 CH cases during the last 6 months, Turkey should make

implementation of neonatal CH screening. Close and continuously follow-up is also essential for normal development.

Points for discussion at EGPRN:

1. Congenital hypothyroidism represents one of the most common preventable causes of mental retardation.
2. Hypothyroidism can become manifest or acquired after the screening tests have been carried out. When clinical symptoms and signs suggest hypothyroidism, regardless of newborn screening results, serum fT4 and TSH determinations should be carried out.
3. Close and continuously follow-up is also essential for normal development.

PRESENTATION 40: Saturday 21st October, 2006 POSTER
11.00 – 12.30 h. Ongoing Study with preliminary results

TITLE: Evaluation of the training of peer trainers in sexual and reproductive health

AUTHOR(S): Vildan Mevsim*, Dilek Güldal*, Nilgün Özçakar*
Levent Buda**, Özge Saygın**, Hülya Özönen**
*Dokuz Eylul University Medical Faculty Department of Family Medicine
**Dokuz Eylul University Service Department of Health, Culture and Sports

ADDRESS: Dokuz Eylül Üniversitesi Aile Hekimliği,
AD 35340 İnciraltı/Izmir-Turkey
Phone: +90 232 4636760; Fax:+90 232 4648161
E-mail: vildan.mevsim@deu.edu.tr

Background: Sexual and reproductive health (SRH) trainings for the adolescence is an important issue that deserves special attention and perspective. The adolescence, because of the nature of the period, learn about great many things from their friends and peer groups.

Research question: To what extent does the training of peer trainers that will provide counselling on SRH improve knowledge and attitude of the peer trainers?

Method: 198 students in total have participated in the training of peer trainers. Training of peer trainers was structured as a 40-hour program in total. The training curriculum consists of three main topics, which are reproductive health, peer education and counselling. Various active learning methods have been utilized to teach these three topics.

In order to measure the efficiency of the training, before and after test with 45 questions was applied. At the end of the course, Short Education Evaluation (SEE) Form was filled in by the participants. Efficiency of the training was measured taking into account the proportion of the correct answers in the before- and after-test as well as the SEE average. In addition to the descriptive analysis, Wilcoxon t-test has been run.

Results: According to the test evaluation obtained at the end of the training, trainings have brought about an average of 21 % increase in the knowledge and attitude of the participants (from 70.7% to 91.7%), the difference between two rates is statistically significant ($p<0,05$). When the change in knowledge is examined; the biggest knowledge change was observed in counselling (increase rate 41%), and then came family planning (increase rate 37%), reproductive physiology (increase rate 21%), different sexual preferences and substance addiction (increase rate 20%), The SES average is 2,89 point.

Conclusions: With the methods utilized, the peer trainers to provide counselling in reproductive health can be said to have been well equipped with knowledge in peer training and counselling.

Points for discussion at EGPRN:

1. What can be the other method for evaluation of training of peer trainers?

PRESENTATION 41: Saturday 21st October, 2006 POSTER
11.00 – 12.30 h. Ongoing study, no results yet

TITLE: Can patients and new technologies influence the use of a microbiology lab in a rural health centre?

AUTHOR(S): Dimitris Kounalakis[1], Spyridon Klinis[1], Eirini Ikonomou[1]
Thanasis Alegkakis[2], Maria Koziraki[1], Manolis Tsafantakis[1]
[1.] Primary Health Center of Anogia
[2.] Biostatistics Lab, University of Crete

ADDRESS: Korinthou 9, 71409 Heraklion. Crete, Greece
Phone: +306977606667, +302810211694
Fax: +302810361944
E-mail: dcoun@medsite.info

Background: The primary health centre of Anogia has electronic records for blood tests results since 2000. The last five years, resident general practitioners were added in the staff replacing existing provisional doctors without speciality, and an electronic patient record system was introduced the last 18 months. Doctors issue a request for blood tests but it is not uncommon to have the patient requesting from the doctor to repeat blood tests in a more frequent than recommended basis.

Research question: Can we identify differences in the use of Microbiology lab services during this period of time that could reflect the committed changes? What are the patterns of its use from patients and healthy persons?

Method: The results of the blood examinations that were undergone between 15/9/2000 and 30/6/2006 in the Microbiology lab were transferred to a database program. General queries were run to extract data and a custom program was used to reorganize data for statistical analysis. We focused on selected blood tests examinations (eg. Lipid levels), and for a limited number of patients reasons for encounter and medication were included in the analysis from the patient records. One-way anova and Kruskal-Wallis tests were used in the initial analysis.

Results: Our data include 17864 visits for blood tests with 4161 patients. Preliminary results studing Cholosterol with 2777 patients(2-102 years old, mean age 58.21) revealed 1677 test results with >6.15 mmol/l and statistical significance with age. Initial increased cholesterol levels tend to decrease in the following blood examinations for most patients, and the total number of number of blood tests measuring cholesterol descreased the last four years. More precise results will be presented as it is an ongoing study
Conclusions: Our first results suggest that changes were undergone with selected blood test examinations and this possibly has to do with continuity in care and use of new technologies.

Relevance to EGPRN: We expect to discuss weak points of our methodology with EGPRN participants and share views and proposals on an approach to identify and study patients' attitudes to blood tests examinations.

PRESENTATION 42: Saturday 21st October, 2006 POSTER
11.00 – 12.30 h. Finished Study

TITLE: Attitudes, predispositions and behavior of GPs towards screening program for colorectal carcinoma – a cross sectional survey in the town of Plovdiv

AUTHOR(S): Dimova Rossitsa, Dimov Rossen, Asenova Radost
Dimitrova Donka

ADDRESS: Medical University - Health Care
15a V. Aprilov Street, Plovdiv 4000, Bulgaria
Phone: +359-32602 533
E-mail: ros_dimova@yahoo.com

Background: Health professionals worldwide agree on the significance of colorectal carcinoma as an important health problem causing high morbidity and lethality. It is the second commonest cancer causing death in Western Europe.

Research question: The aim of the study is to assess attitudes, predispositions, possibilities and behavior of GPs of usefulness of faecal occult blood test in asymptomatic, health insured patients as part of a national screening program.

Method: A cross sectional representative survey of 35% random sample of GPs from the town of Plovdiv was performed. We used two of the social research methods – direct interviews and semi-structured telephone interviews. The interviews provided data about demographic characteristics as well as answers to open-ended questions revealing attitudes, predispositions and actual behavior of GPs when referring patients or performing FOBT in their practices.

Results: Only 47(62%) of the respondents approved the occult blood testing in primary care. 39(52%) of them reported that they would rather refer patients to a laboratory for the tests and only two GPs had positive attitude and were willing to perform themselves the tests in their practices. Only 76%(58) reported that they usually convince patients with positive test results to comply with further investigations.

Conclusions: The study revealed that GPs' attitudes, motivation, qualifications and training to perform FOBT, as a routine screening procedure in their practices, were inadequate. Health promotion and prophylactics need to be priorities of much more effective programs for postgraduate and continued medical education focused on GPs and nurses. The study revealed that the insufficient financial resources were among the main reasons for the compromised performance of general practices in colorectal screening.
Key words: General Practitioners, Fecal occult blood test (FOBT), screening, colorectal carcinoma.

PRESENTATION 43: Saturday 21st October, 2006 ONE-SLIDE/FIVE MINUTES
14.30 – 14.40 h. Study proposal / idea

TITLE: Identifying and assessing the needs of different subgroups of patients in an urban setting- applying the first steps of COPC into practice

AUTHOR(S): Sharon Shabtai, Rachel Dahan

ADDRESS: Family Medicine Department, Haifa and Western Gallilee County, of "Sherutei Briut Klalit", Technion , Haifa
POB 166, Ein-Ya'akov, 25135-Israel
Phone: 972-4-9572040; cellular 972-52-8888211
Fax: 972-4-9572040
E-mail: runnsh@gmail.com

Background: There is increasing recognition, in the past few years, of the need for a community-centered approach to primary care, which assists in defining patients' health needs, and allowing focusing resources in order to address those needs. Community-oriented primary care (COPC) is thus becoming a widely accepted theoretical approach, although, in practice there still remain many obstacles to its implementation, including funds, time, and required skills. Further research of implementing the different steps of COPC is of great need. Most of the research done in this area regards a defined community as a whole, rather than recognizing the different subgroup population needs. Defining the common denominator of health needs for specific subgroups in a community according to gender, age, socioeconomic status, and health perception, and giving high priority to relevant issues for these different subgroups is the basis for developing future more focused and beneficial intervention plans.

Research question: What are the specific health needs of different subgroups of a community of patients in an urban setting in the north of Israel?

Methods: A validated community needs assessment questionnaire will be translated to Hebrew and validated in Israel. It will be distributed to a random sample of patients registered with a primary care clinic in the north of Israel. The questionnaire comprises of statements regarding the need for help or advice in different areas, including preventive medicine, chronic conditions, community services, and psychosocial assistance, each ranked according to degree of need. It also includes patients' characteristics, such as, gender, age, socioeconomic status, smoking status, personal health perception, and marital status. Data will be analyzed statistically by the SPSS program to seek correlation between specific health needs and specific patients' characteristics.

Points for discussion:

1. Is a questionnaire a valid way to assess patients' needs?
2. What are the differences between doctors' perceptions of "needs", as opposed to patients' perceptions of "needs"?
3. What are the expected differences in health needs between different countries?

PRESENTATION 44: Saturday 21st October, 2006 ONE-SLIDE/FIVE MINUTES
14.40 – 14.50 h. Study proposal / idea

TITLE: Management and Referral System of Depressive patients: a European Comparison of General Practitioners' Perceptions

AUTHOR(S): Nolwenn Kerhuel, Alain Mercier
P. Czernichow, F. Becret

ADDRESS: Dept. of General Medical Practice and Dept. of Public Health,
Faculté deMédécine de Rouen, Bd Gambetta
76100 Rouen-France
E-mails: nolwennkerhuel@hotmail.com, amercier001@rss.fr

Background: Depression is an important public health problem in developed countries. In France the situation seems to be comparatively different, with high drug consumption, and a low referral to psychologists. The health care system is currently changing with a more restrictive access to psychiatrists. In other countries with a restricted access of secondary care, e.g. in the UK, GPs have stated that they do not have enough time to manage depressive patients. An international study is currently underway regarding different EU health care systems and physician's satisfaction. We were therefore prompted to explore difficulties perceived by French GPs in the context of this reform and compare our results.

Research question: What are the difficulties and perceptions of the GP, in managing depressive patients within the context of the French health care system? What are the differences with those perceived by other GPs in the European Union?

Methods: A questionnaire will be send to the GPs regarding the management of patients they consider as depressive. The questions will focus on GPs difficulties and aptitudes perceived to deal with these types of patients. It will be as close as possible to the validated questionnaires used in other studies. After translation, the questionnaire will be initially tested on a small sample population, and after validation, dispatched to 800 general practitioners (200 of each 4 Northwest departments of France) in order to possibly compare local differences. The results should be available at the end of 2007.

Points of discussion for EGPRN: What could be considered the validity and feasibility for a comparison with other countries results?

PRESENTATION 45: Saturday 21st October, 2006 ONE-SLIDE/FIVE MINUTES
14.50 – 15.00 h. Ongoing study, no results yet

TITLE: Periodic Health Examination in the Elderly

AUTHOR(S): Ediz Yildirim

ADDRESS: Aile Hekimligi Anabilim Dali, Dokuz Eylul Universitesi
Tip Fakultesi, Derslikler Binasi 2. Kat
35340, İnciralti, Izmir-Turkey
Phone: +90.232.4124951
E-mail: ediz.yildirim@deu.edu.tr

Background: Protection from diseases and health promotion by early diagnosis are to be considered as basic aims of health services for the elderly. In order to make a suggestion for their well- being it is essential to make a questionnaire, a physical examination and to get laboratory findings.

Research question: Do periodic health examinations have an effect on detecting and solving the clinical problems which are known or not known by the elderly?

Methods: From January 2006, academic and administrative staff of Dokuz Eylul University (Izmir, Turkey) who are over 50 years old (n=552) are being examined for this purpose.The setting of the study is the Medico-Social Services Unit at Tınaztepe campus of Dokuz Eylul University. İnitially, is a questionnaire relevant with daily life and with health problems administered to the subject by a trained nurse. Afterwards, is a sophisticated physical examination performed. Essential laboratory findings are maintained. The criteria of the questionnaire, physical examination and necessary laboratory findings are decided to include in the study according to the guidelines followed: American Academy of Family Physicians Summary of recommendations for Clinical Preventive Services (Item No:968), Massachusetts Health Quality Partners (MHQP) Adult Periodic Health Examination Guidelines-2004, Canadian Task Force on the Periodic Health Examination 2003 Guide. Findings which are relevant with each other for health problems mostly seen in the elderly will be assessed in cross tables and chi-square tests.

Results: Knowing that this is an ongoing study it doesn't make sense to give the preliminary results because of the limited number of the subjects examined. At the end of this study we are expecting to make early diagnosis for diseases that are threatening the health of the elderly, to determine signs and symptoms which will enable us to foresee main clinical problems and to promote health in the elderly.

Points for discussion at EGPRN:
1. What are the main clinical problems which can not be foreseen in the elderly who who do not attend periodic health examinations?
2. What should be done for these kind of problems?

PRESENTATION 46: Saturday 21st October, 2006 ONE-SLIDE/FIVE MINUTES
15.00 – 15.10 h. Finished Study

TITLE: Organizational and structural changes in PHC centres during health care reform in Lithuania

AUTHOR(S): Ida Liseckiene[1], Wienke Boerma[2], Z. Milasauskiene[3]
L. Valius[1], I. Miseviciene[3], Peter Groenewegen[2]
[1]Kaunas University of Medicine, Kaunas (LT)
[2]NIVEL (Netherlands Institute for Health Services Research) Utrecht (NL)
[3]Institute for Biomedical Research of Kaunas University of Medicine, Kaunas (LT)

ADDRESS: Family medicine clinic, Kaunas Medical University CLINIC
Eiveniu 4, Kaunas 3000-Lithuania
Phone: + 370 6875 29 29; Fax: +370 37 337506
E-mail: idakaunas@gmail.com

Background: The increasing health care inequalities and morbidity, inefficient payment system challenged to a new health care reform with its priority – primary health care after Lithuania's independence in 1990. Former district doctors have been re-trained to become GPs and former policlinics have been modernized and decentralized. The private medicine was introduced. This paper is an evaluation of structural and organizational changes in PHC centres between 1994 and 2004.

Research question: Are PHC centres better organized after PHC reform? Are there any differences between private and public PHC centres in 2004?

Methods: In 1994 and 2004 identical questionnaires have been completed by random samples of primary care physicians about the: workload, working arrangement, practice equipment. Data entry, processing and analysis were carried out using SPSS software.

Results: In 1994 the response among district doctors was 333 (87%) and among primary care pediatricians 262 (87%). In 2004 the response among GPs was 298 (73%). The number of the patients per GP decreased in 2004, but the number of office contacts, consultations by phone and workload increased in 2004. There were more equipment items in 2004. The number of home visits decreased in 2004. The distance of PHC centres were longer and there were less possibility to make an advanced appointment for a consultation in 1994. Comparing private and public PHC centres there were some differences: more patients per GP in public practice, but normal working hours higher in private PHC centres. The public PHC centres had more equipment.

Conclusions: PHC centres are better organized then they were ten years ago. Private PHC centres have less equipment and less patients per GP, but private GPs have more time for their patients. Continued efforts, finance and time will be needed to reach the organization principles of western European countries.

PRESENTATION 47: Saturday 21st October, 2006 ONE-SLIDE/FIVE MINUTES
14.30 – 14.40 h. Study proposal / idea

TITLE: The degree of attainment of European guidelines concerning Diabetes Care in General Practice. A cross-sectional comparative study between Denmark and Sweden.

AUTHOR(S): Andreas Frank Jørgensen

ADDRESS: Research unit for General Practice in Frederiksborg County, Hillerød Hospital, Helsevej 2 entry 50B, Hillerød-Denmark
Phone: +45 4829 4871; Fax: +45 4829 4859
E-mail: afjo@fa.dk

Background: Management of diabetic care has accelerated and greatly improved over the last decades. Randomized controlled trials have shown that a wide structured effort in concordance with the diabetic patients, can postpone/prevent late onset complications and diminish the community expenses.
There is an estimated prevalence of 200.000 patients with diabetes in Denmark (5,3mio inhabitants) and the number is expected to incline in the future.
In order to slow down, to diminish the community expenditure and keep up with this development it is crucial to focus on what steps needs to be taken to improve the quality of diabetic management and attainment of treatment guidelines.

Research Question: Do Danish general practitioners follow diabetes management guidelines and attain these goals to the same extent as the Swedish general practitioners do.

Aim: to explore the quality in treatment of diabetes and evaluate previously collected databases in General practice in Denmark and Sweden in cooperation with Swedish General Practice research.

Design: a cross-sectional descriptive/comparative study on databases retrieved form general practitioners in Sweden and Denmark

Methods: usage, development and evaluation of previous collected databases to the aid of health services in Denmark and Sweden.
This project will be part of a PhD-study and the protocol is to be finished in 2006. The project will hopefully be supported by Oeresund Diabetes Academy within Medicon Valley Academy.

Points for discussion at EGPRN:
1. usage of previously collected databases.
2. Methods: how to retrieve and evaluate data from different countries

PRESENTATION 48: Saturday 21st October, 2006 ONE-SLIDE/FIVE MINUTES
14.40 – 14.50 h. Ongoing study with preliminary results

TITLE: Shared understanding in Lapinlahti - Community based prevention of MBO

AUTHOR(S): Juhani Miettola, Esko Kumpusalo

ADDRESS: School of Public Health and Clinical Nutrition
University of Kuopio, P.O Box 1627, 70211 Kuopio-Finland
Phone: +35817162962 or +358503815466
Fax: +35817162937
E-mail: juhani.miettola@uku.fi

Background: Metabolic syndrome (MS) has become a central health concern. It is an increasing challenge in clinical practice. The main strategy in its prevention and management is prevention and modification of harmful life-styles.

Research question: How to influence on the life-style of community members' at risk of MS through culture-sensitive and client-friendly approaches?

Method: All adult citizens (N=760) of eight birth cohorts (30-65 years) of Lapinlahti semi-rural community in Finland were invited. Of them, 480 (64%) participated in the study in 2005 involving a structured interview, anthropometric measurements and laboratory tests. MS diagnosis was based on the IDF 2005 consensus. Of all 480 study participants, 41 underwent a tape-recorded interview in 2006. The GPs of the same community will be invited to focus group discussions in 2006.

Preliminary results: MS-related conditions were common in the 1st degree relatives of the study subjects (High BP in 72%, diabetes in 42%, lipid disturbances in 53% and IHD in 48%). In the whole sample, 72% were smokers, 52% had insufficient amount of physical activity and 45% were irregular vegetable eaters. Only 22% had previous knowledge about possible causes of MS. The prevalence of MS was 37%, MS-positive waist girth 61% and MS-positive blood glucose level 42%. Scarce vegetable use (P=0.002), physical inactivity (P=0.003), depression (P=0.017), prolonged unemployment (P=0.017), low vocational education (P=0.023), and lack of hobbies (P=0.005) were associated with MS.

Conclusions: There are several factors (genetic, socio-cultural, and personal) that are associated with MS. With this study, we are exploring modifiable factors for relevant community-based and client-centred prevention and management of MS.

Points for discussion at EGPRN:
1. Are the new IDF criteria realistic for community interventions of MS?
2. How to combine the collected quantitative and qualitative data?
3. What are relevant areas for the focus group discussions of the GPs?

PRESENTATION 49: Saturday 21st October, 2006 ONE-SLIDE/FIVE MINUTES
14.50 – 15.00 h. Study proposal / idea

TITLE: Efficacy of family physician's practice on weight loosing programme

AUTHOR(S): Neşe Yeniçeri, Zerrin Padem, Vildan Mevsim, Dilek Güldal

ADDRESS: Özel Yücel Polikliniği Emirbeyazıt mah
Stadyum sokak No: 26/9, Muğla-Turkey
Phone: 0.252.2148877; Fax: 0.252.2148877
E-mail: onderyeniceri@hotmail.com

Background: Obesity is a global life-threatening clinical problem with its complications causing morbidity and mortality and needs long duration of treatment.

Research question: Do behavioural treatment for obesity in a "diet clinic" effect more when supported by family physician's practice?

Method: Starting point of this study project, was evaluation of 97 overweight and obese patients applied to "obesity and diet clinic". 97 patients were evaluated for behavioural factors predisposed to obesity. These behavioural factors were; having no regular physical activity, overeating, high fat food intake, snacking habit, night eating and sedantery lifestyle like spending hours by watching TV. After the third session we have started to follow up these patients, only % 18.5 of them remained. It seemed that despite all efforts in a diet clinic, there was a compliance problem for weight loosing programme. Then we questioned how we can be more effective. We thought that participating in a long duration of a weight loss programme and with patient's family physicians who have continuing relationships with trust, would be more effective on compliance to the treatment; and for this, we wanted to enroll a randomized controlled study .
In this study, appropriate amount of patients who accepted to attend a weight loosing programme will be followed up by a dietician in a "diet clinic" till they reach their ideal weight and keep following up for 1more year, while the other same amount of patients will also be followed up by his/her family physician for the same amount of time. A convenient calorie diet and health risks of obesity, portion size and calorie knowledge will be given to all patients in a "diet clinic". For the patient group who will also be followed up by his/her family physician will be given support for weight loss and continuing weight loosing programme and will be checked and reported about compliance to the programme during every visit, no matter why the patient applies.
Weight loss outcomes will be estimated in each group 1 year after they reach ideal weight.

Relevance to EGPRN: Obesity is a rising, serious and chronic clinical state like HT and DM which primary care physicians have to deal.

Points for discussion at EGPRN:

1. For methodology, we want this study to be discussed and according to suggestions in EGPRN meeting we want to reshape the study design.

PRESENTATION 50: Saturday 21st October, 2006 ONE-SLIDE/FIVE MINUTES
15.00 – 15.10 h. Ongoing study, no results yet

TITLE: Onset of Type 2 Diabetes and normal fasting blood glucose levels in general practice

AUTHOR(S): Dimitris Kounalakis[1], Spyridon Klinis[1], Eirini Ikonomou[1]
Andreas Ksanthos[2], Maria Koziraki[1], Nikos Antonakis[1]
Manolis Tsafantakis[1], Christos Lionis[3],
[1]. Primary Health Center of Anogia
[2]. Primary Health Center of Perama
[3]. Clinic of Social & Family Medicine, University of Crete

ADDRESS: Korinthou 9, 71409 Heraklion. Crete, Greece
Phone: +306977606667, +302810211694
Fax: +302810361944
E-mail: dcoun@medsite.info

Background: Higher fasting plasma glucose levels within the normoglycemic range have received a prompt attention in the current literature and there is some evidence that they constitute an independent risk factor for type 2 diabetes (T2DM) among young men (Tirosh, et al, N Eng J Med 2005). There is also a growing body of knowledge that general practice is a suitable place in monitoring health conditions and highlighting the natural course of chronic illness. An electronic records patient system based on ICPC-2-R has been established at the Anogia Health Centre in rural Crete and it constitutes the basic mean for monitoring population health conditions.

Research question: Do high normal fasting blood glucose levels in normoglycemic range suggest a subclinical T2DM? Which cut-off points of normal fasting blood glucose levels (FBG) are accompanied by acceptable sensitivity in general practice? To what extent the high normal FBG levels could predict a high probability of coronary artery disease?

Method: In a pilot study that was performed in a rural health center in Crete, all patients who have been recorded in the local laboratory archive with more than one result of >5.5 mmol/l FBG in the last 6 years and without an established diagnosis of DM were retrieved. All selected patients undergo two new FBG measurements, an oral glucose tolerance test (OGTT) with 75gr glucose and Hb1Ac. All patients with an abnormal OGTT result, Hb1Ac>5.5% or FBG levels >5.5 mmol/l, were eligible and data from somatometric measurements and health as well as dietary habits were obtained. All patients without a diagnosis of DM are monitored every year for 3 years with the FBG measurements and Hb1Ac and their health status, while co-morbidity and particularly cardiovascular events are recorded in the local EPR. A multivariate model with high normal FBG values as, among others, dependent variable and T2DM as an independent variable is going to be performed.

Results: This study is on the progress and the prelimenary findings indicate that patients with <6.1mmol/l have different Hb1Ac results in the same FBG group and could have a positive OGTT.

Relevance to EGPRN: We expect to discuss our idea of monitoring general practice patients with high normal FBG levels on a prospective basis with EGPRN participants and share views and proposals on a potential international study that would provide to the European general practice useful nomograms for determining risk for T2DM and Number Need to Treat.

PRESENTATION 51: Saturday 21st October, 2006 THEME PAPER
15.30 – 16.00 h. Finished Study

TITLE: Prevalence of vitamin D deficiency among women from 18 to 49 years wearing concealing clothes and living in Lyon.

AUTHOR(S): Marie-France Le Goaziou, Sonja Belaid

ADDRESS: Dépt. de Médecine Générale, Université Claude Bernard
Lyon I Domaine Rockefeller, 8, avenue Rockefeller
69373 Lyon Cedex-France
Phone: +33-478777286; Fax: +33778777288
E-mail: belsony@yahoo.fr

Background: Morbidity and mortality of the vitamin D deficiency are well studied in elderly and childhood, while it is symptomatic, doctors do not consider hypovitaminosis D as a diagnosis of first intention in young adults. This causes the prescription of many paraclinic examinations, and a delay in the diagnosis. A preliminary pilot study showed many cases of severe hypovitaminosis D among women from 18 to 49 years who wore concealing clothing. A follow-up investigation of the prevalence of the vitamin D deficiency in this community appeared necessary.

Research questions:
- What is the proportion of women deprived?
- What is the degree of the deficit?
- Do GP know this problem?

Methods: A cross sectional study was carried out in Lyon, latitude 45N. Women from 18 to 49 years, who wore concealing clothing, who consulted their GP from November 2005 to March 2006, and who were safe of diseases responsible for hypovitaminosis D, were included. A questionnaire and a serum dosage of vitamin 25 (OH)D were realized. Correlations between hypovitaminosis D and several factors: age, parity, existence of associated pathologies, clinical signs, were looked for.

Results: 96 women were included. 82,5% of these women had a serum rate of vitamin D lower or equal to 30 nmol/l, threshold below which appears a secondary hyperparathyroidism, responsible for a reduction of osseous capital, 71% of these women were symptomatic. Considering the threshold of 53 nmol/l, it appeared the prevalence of 99% with 72,6% symptomatic women. Concerning the attitude of GP, 99% of these women did not receive any supplementation of vitamin D during the three previous months.

Conclusions: These results highlighted the endemic character of vitamin D deficiency in a young population usually in good health and able to procreate. The GP's are involved in targeted action of screening and prevention of vitamin D deficiency among this population especially with concealing clothes and alimentary deficiency.

Points for discussion at EGPRN:
1. Does exist a policy of tracking of vitamin D deficiency among certain communities in the other countries?
2. Which posology could we propose to prevent vitamin D deficiency in the communities at risk?

PRESENTATION 52: Saturday 21st October, 2006 FREESTANDING PAPER
16.00 – 16.30 h. Finished Study

TITLE: Different from what the textbooks say: how GPs diagnose coronary heart disease

AUTHOR(S): Heidi Keller, Maren Abu Hani
Norbert Donner-Banzhoff, Frances Griffiths

ADDRESS: Dept of General Practice/Family Medicine
University of Marburg, D-35032 Marburg-Germany
Phone: +49-6421-286-5119; Fax: +49-6421-286-5121
E-mail: KellerH@gmx.ch

Background: Chest pain is a common symptom in primary care. Although only a small proportion of presenting patients have coronary heart disease (CHD), these have to be identified reliably. Time pressure and minimal equipment may render this difficult. We diagnostic pathways at secondary care level.

Research Question: which diagnostic criteria do GPs use to differentiate CHD from other causes of chest pain?

Methods: We asked 23 GPs to explain their individual diagnostic decision criteria in two of their patients with chest pain, according to the methods of "stimulated recall" and the "critical incident technique". The semi-structured interviews were transcribed and analyzed using an inductive coding system.

Results: The histories of 39 patients were covered in 23 interviews. In 17 of these patients the GP assumed CHD and/or an indication for an emergency hospital admission. The Interviewees judged the current presentation of the patient with chest pain in the context of previous consultations. A presentation that differs from previous episodes was identified a sign pointing to serious causes of chest pain. Apart from the classical criteria, e.g. cardiovascular risk factors or pain on exertion, this "person specific discrepancy" is unique for primary care.

Conclusions: Although GPs frequently claim their diagnostic methods to be different from those at the secondary of tertiary care level, these methods are rarely specified. In this explorative study, we identified specific criteria and heuristics adapted to the primary care settling. In a current diagnostic cross-sectional study we are evaluating the criteria thus identified with regard to their diagnostic effectiveness.

Points for discussion at EGPRN:

1. Do the criteria we identified apply to other countries or medical cultures?
2. Are the better study designs or methods to approach this subject?

PRESENTATION 53: Saturday 21st October, 2006 FREESTANDING PAPER
16.30 – 17.00 h. Almost Finished Study

TITLE: Perceptions and opinions of the women with climacteric symptoms about menopause and hormone replacement therapy

AUTHOR(S): Serap Cifcili, Mehmet Akman, Emine Kıvrakoglu
Huseyin Arikan, Burak Ersoy, Ismail Ertugrul Gedik

ADDRESS: Aydin s. No:7/8 34662 Altunizade, İstanbul-Turkey
Phone: +90-216-3275612; Fax: +90-216-3250323
E-mail: serapcifcili@superonline.com

Background: After the results of Women's Health Initiative were published, indications of hormone replacement therapy(HRT) were reviewed and climacteric symptoms remained the only clear indication for HRT. According to the consesus report of European Menopause and Andropause Society(2005), HRT was reported to be the most efficient therapy to releive the climacteric symptoms.

Research question: What are the perceptions and cognitions of women with climacteric symtoms about menopause and HRT by means of personal, social and cultural points of view?

Methods: In this qualitative study, 16 in depth interviews were held. All of the participants were experiencing climacteric symptoms, half of them had admitted to a physician with climacteric symptoms and half of them hadn't seek help. Semi-structured questions about, the women's understanding, perceptions and feelings about menopause and HRT were used. Two researchers made all interviews. All interviews were recorded by a tape and transcribed within 48 hours. Two researchers made thematic analysis afterwards.

Results: The average menopause age was 49.4(SD:3.5). All of the participants defined manopause as "natural", and "meant to be". The positive meanings atributed to manopause were; "cleanness", "maturity" and "comfort", the negative meanings were; "feeling less women", "getting old", "getting fat". All the participants complained of emotional symptoms like; "agression", "irritability" and "emotional lability". The factors which thought to ease to decide taking HRT were; "to bring liveliness to life", and "to relieve their symptoms". "Spoiling the nature", "being harmful to some part of the body while being beneficial to some other part"and the possibility to affect health negatively were the main barriers against taking HRT.

Conclusion: The most prominent perception among all of the participants about menopause seemed to be "natural is healthy" which also seemed to affect the participants' desicion making process about HRT.

Points for discussion at EGPRN :
1. What may be the methods for investigating how people's health beliefs and practices may influence their decision making about their health?
2. What could be suggested to plan a further study to investigate physicians' opinions about HRT and whether they are comfortably discussing the topic with their patients.

PRESENTATION 54: Saturday 21st October, 2006 FREESTANDING PAPER
15.30 – 16.00 h. Ongoing Study with preliminary results

TITLE: Prediction of depression in European general practice attendees: the PREDICT study.

AUTHOR(S): Janez Rifel, Igor Švab, Irwin Nazareth

ADDRESS: Katedra za družinsko medicino, Poljanski nasip 58
1000 Ljubljana-Slovenia
Phone: +386 14386914; Fax:+ 386 1 4386910
E-mail: janez.rifel@gmail.com

Background: The impact of anxiety disorders on the morbidity and disability of the general population shouldn't be neglected. Anxiety disorders are highly prevalent in primary care and take up a lot of the health services resources. The prevalence of generalised anxiety disorder is estimated around 8% and prevalence of panic disorder varies between 4-6%. The prevalence, incidence and risk factors of anxiety disorders for the Slovenian population are not known.

Research questions: 1) What is prevalence and incidence of anxiety disorders including panic disorder across Europe? 2) What are the determinants of anxiety across Europe? 3) How does the prevalence and determinants of anxiety and panic disorders in Slovenia differ that in the other European countries?

Method: In the PREDICT study more than 6000 thousand people in six European countries were recruited and interviewed using anxiety section of the PHQ, a short questionnaire assessing psychiatric symptoms specifically designed for the use in primary care settings. Interviews were carried out twice with six months interval and in some countries (Slovenia and UK) also for the third time 24 months after the first interview. The depression section of the Composite International Diagnostic Interview (CIDI) was used to diagnose depression and various socio-demographic characteristics of the participants were also collected.

Results: Only preliminary results that have not yet been published are available at the moment.

PRESENTATION 55: Saturday 21st October, 2006 FREESTANDING PAPER
16.00 – 16.30 h. Finished Study

TITLE: Personality factors of medical students and their influence on self-esteem and « taking initiative » related to intimate examinations during internship

AUTHOR(S): Kristin Hendrickx, F. De Fruyt, B.Y. De Winter
D. Avonts, W. Tjalma, J.J. Wyndaele

ADDRESS: University of Antwerp, Dept. family medicine
Universiteitsplein 1, 2610 Wilrijk-Belgium
E-mail: kristin.hendrickx@telenet.be

Background: The University of Antwerp implemented in the fifth year of the new curriculum, a project with simulated patients (Intimate Examination Associates, IEA). Students learn uro-genital, rectal, gynecological and breast examination in healthy, trained volunteers. Earlier research (Hendrickx K, 2005) assessed the project with different measurement instruments. The final conclusion was that the IEA project had a positive learning effect with realtion to intimate examinations IE, on the performance and the self-esteem of medical students during internship.

Research question: The question raised if student's personality factors PF influence their performance and if IEA training could meet determining factors in student's medical practice due to PF.
This new study investigates: (1) correlations between PF of the student, and self-esteem concerning IE, (2) correlations between PF and the number of IE performed during their internship, and (3) the influence of the new curriculum IEA training on the impact of PF.

Method : Two groups of students were compared after their internship year: former curriculum FC students without IEA training and new curriculum NC students with IEA training.
Measuring instruments were: (1) a questionnaire (12 questions) on self-esteem and self-confidence concerning IE, (2) a self-report questionnaire (72 items), on gynecological and urological skills and performance during internships, and (3) the NEO-PI-R, a personality inventory. Analysis by SPSS.

Results: The results demonstrate correlations between PF and self-esteem, self-confidence for IE, and the number of performed examinations during internship. For FC students as well as for NC students a positive correlation is showed between "Extraversion" and "Conscientiousness" and the number of IE during internship. There is a negative correlation for the factors "Agreeableness" and "Neuroticism". Gender effects from students ànd patients are investigated in relation to personality characteristics. Correlations between PF and performance variables for FC and NC are explored. The Extraversion subfactor "excitement seeking" is important related to the performance of IE in patients of the opposite sex, for FC students. For the NC students, who are trained by the IEA's, these individual differences disappear (significant).

Conclusion: PF of the student are related to self-esteem and self-confidence concerning IE and to the number of performed IE during internship. The impact of PF could be less important for students who received IEA training.
The NEO-PI-R personality inventory could be a valuable tool for training and coaching students in IE. More timid, unobtrusive and less enterprising students could be traced and could receive more attention and counseling.

PRESENTATION 56: Saturday 21st October, 2006 FREESTANDING PAPER
16.30 – 17.00 h. Finished Study

TITLE: Determinants of self-rated health among elderly living in the community

AUTHOR(S): Stathis Giannakopoulos, Magda Gavana
Niki Kavaka, Theodore Zdoukos, Alexis Benos

ADDRESS: 10 Priamou st., 54453 Thessaloniki-Greece
Phone: +306977598818; Fax: ++302310999131
E-mail: gianstat@med.auth.gr

Background: Self-rated health is an important indicator of elderly people health status, associated with morbidity and mortality. Despite its frequent use, most studies do not perform a global evaluation, tackling the question from social, psychological or medical perspective alone.

Research questions: To estimate the parameters affecting self-rated health in the elderly living in the community.

Method: A cross-sectional population-based study among all the elderly inhabitants of an urban area of Thessaloniki, Greece was performed. All 635 (83.1%) people aged 65 and over who participated underwent a home interview with a structured questionnaire. Data collected included demographic information, socioeconomic status, social context evaluation, self-reported health problems and self-rated health. Also, diagnosis of chronic diseases was recorded using ICPC2 and dementia and depression screening was performed using MMSE and GDS respectively. Outcome measure was self-rated health. A logistic regression model was used to investigate the effect of different parameters.

Results: Coronary heart disease (OR=2.4), low back pain OR=2.3), other musculoskeletal symptoms (OR=2.2), inability to offer help to friends when needed (OR=2.0), number of reported health problems (OR=1.5), number of drugs used daily (OR=1.3), depression (OR=1.2) and impaired function regarding activities of daily living (OR=1.05) were found to have a statistically significant association with worse self-rated health, while the progress of age was associated with better self-rated health (OR=0.93).

Conclusions: Elderly people adapt their expectations for their health to their age and are greatly affected by conditions that restrict their mobility and social function.

Points of discussion at EGPRN:
1. Self-rated health assessment
2. Population-based research design