91 Prevalence and management of gastrointestinal symptoms

Organisations supporting this study: AstraZeneca (Australia) Pty Ltd and the Australian General Practice Statistics and Classification Centre (AGPSCC)

Issues: Prevalence/taking medication for: dyspepsia, heartburn, reflux/regurgitation, epigastric pain (multiple response allowed); frequency and severity of symptoms and impact on patients' quality of life (current/prior to medication) (multiple response allowed); underlying condition causing GI symptoms; management and level of symptom control.

Sample: 5,310 patient encounters from 181 GPs; data collection period: 20/9/2005 – 24/10/2005 and 29/11/2005 – 16/01/2006.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age–sex distribution of all patient encounters was the same as the distribution for all BEACH encounters in 2004–05, with the majority (59.0%) of patients being female.

Of the 5,310 patients, 1,444 (27.2%, 95% CI: 25.1–29.3) suffered from or took medication for at least one listed GI symptom. Prevalence did not differ between the sexes but the prevalence of one or more listed GI symptom increased significantly with age, from 3.0% among patients aged less than 15 years to 41.3% among patients aged 75 years and more (p <0.0001).

Of the 1,442 patients with GI symptom(s), two-thirds (62.1%) had a single listed symptom; about a quarter (23.6%) experienced reflux/regurgitation, one-fifth (21.4%) heartburn, 9.9% dyspepsia, and 7.3% epigastric pain as their only GI symptom. There were 132 patients (9.2%) who had both heartburn and reflux.

One in five patients with reflux or epigastric pain reported daily frequency of symptoms, and 16.3% of patients reported the reflux or epigastric pain as severe. Approximately 16% of patients with either dyspepsia or heartburn experienced symptoms daily, and more than one in ten patients in each group reported their symptom as severe.

Of the 1,294 respondents on impact on their quality of life, 41.2% reported diet restrictions, 35.9% disrupted sleep, and 27.8% feeling unwell/worn out. About one-third (32.4%) reported that their GI symptoms did not impact on their life in any of the ways listed.

GPs specified the underlying cause of the symptoms for 1,358 patients: gastro-oesophageal reflux disease was specified for about half (51.0%) and the cause was not known for 21.4%.

Current management of GI symptoms was reported for 1,421 patients: 21.3% were receiving no treatment, proton pump inhibitors were used by 47.6% and antacids by 22.0%.

GPs estimated the level of symptom control with current management for 1,050 patients receiving treatment for their GI symptoms. GI symptoms were well controlled for 76.4% of these patients, partly controlled for 19.9%, and poorly controlled for the remainder (3.7%).

For other related abstracts see: 18 Drugs for the treatment of peptic ulcer and reflux, 24 Gastro-oesophageal reflux disease (GORD) in general practice patients, 34 Gastro-oesophageal reflux disease (GORD), 51 Use of proton pump inhibitors for gastrointestinal problems, 60 Prevalence of GORD and associated proton pump inhibitor use, 62 Use of proton pump inhibitors by general practice patients, 100 Gastrointestinal symptoms in patients attending general practice.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **PATIENTS WITH GASTRO-INTESTINAL SYMPTOMS.**

You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

Ask **ALL** of the **next 30 PATIENTS** the following questions **in the order in which the patients are seen.**

Please **DO NOT** select patients to suit the topic being investigated.

Gastro-intestinal symptoms

Please indicate by ticking the appropriate box/es whether this patient **regularly suffers from**, or **takes acid suppressant medication to control**, any of the listed **upper gastro-intestinal symptoms**.

Please use the tick boxes below each symptom to advise the **frequency** and **severity of symptoms** for the patient. For patients **taking acid suppressant** medication, please advise the frequency and severity of symptoms **prior to taking the medication.**

If the patient **does not** have any of these symptoms, you should **end the questions** here.

Impact of symptoms on the patient

Please use the tick boxes to advise how the **symptoms impact** on the **patient's quality of life**.

Please tick as many as apply.

Current management of symptoms

Please use the tick boxes to advise **how** this patient's upper gastro-intestinal **symptoms** are **currently being managed**. If a **Proton pump inhibitor** (PPI) is being taken, please **specify which in the space provided**.

If the current management is **not** one of those listed, please tick the box labelled 'other' and **write** the management **in the space provided.**

Please tick as many as apply.

Underlying cause of symptoms

Please use the tick boxes to advise the **underlying cause** of the patient's symptoms. If the underlying cause is **not** one of those listed, please tick the box labelled 'other' and **write** the underlying cause **in the space provided.**

Please tick as many as apply.

Symptom control

Where treatment has been undertaken for upper gastro-intestinal symptoms, please use the tick boxes to advise how **well controlled** the patient's symptoms have been **since the current treatment commenced**.

Does this patient suffer from, or take medication for, any of the following symptoms? Please advise frequency and severity of symptoms *(prior to medication use if applicable)*.	Dyspepsia	Heartburn	Reflux/regurgitation	Epigastric pain	Impact of symptoms (prior to medication if used)? *(tick all that apply)*	Underlying cause of symptoms is?	Current management is?	Where treatment is used symptoms have been:
	☐ < once per week	☐ < once per week	☐ < once per week	☐ < once per week	☐ disrupted sleeping	☐ unknown	☐ no treatment	☐ well controlled
	☐ once per week	☐ once per week	☐ once per week	☐ once per week	☐ feel unwell/worn out	☐ GORD	☐ PPI_____	☐ partly controlled
	☐ several times/wk	☐ several times/wk	☐ several times/wk	☐ several times/wk	☐ difficulty with work and/or daily activities	☐ peptic ulcer	☐ H2RA *(please specify)*	☐ poorly controlled
	☐ daily	☐ daily	☐ daily	☐ daily	☐ difficulty socialising	☐ NSAID use	☐ Antacid	
	☐ mild	☐ mild	☐ mild	☐ mild	☐ diet restrictions	☐ diet/ lifestyle	☐ Remove cause (eg stop NSAID)	
	☐ moderate	☐ moderate	☐ moderate	☐ moderate	☐ none of the above	☐ other *(please specify)*	☐ other *(please specify)*	
BL76B ☐ No → end	☐ severe	☐ severe	☐ severe	☐ severe		_____	_____	

92 Prevalence of metabolic syndrome

Organisations supporting this study: Merck Sharp and Dohme (Australia) Pty Ltd and the Australian General Practice Statistics and Classification Centre (AGPSCC)

Issues: Prevalence of metabolic syndrome (as defined by the International Diabetes Federation) among patients attending Australian general practice.

Sample: 5,594 patient encounters from 193 GPs; data collection period: 20/09/2005 – 28/11/2005.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: Methods for this study: Metabolic syndrome is defined by the International Diabetes Federation (IDF) as central obesity plus two or more of four factors: (i) raised triglycerides or treatment for this lipid abnormality, (ii) raised blood pressure or treatment for hypertension, (iii) raised fasting plasma glucose or previously diagnosed type 2 diabetes and (iv) reduced HDL cholesterol or treatment for this lipid abnormality. Central obesity is defined according to IDF as waist circumference ≥94cm for Europid men and ≥80cm for Europid women, with ethnicity specific values for other groups.

Summary of results

The age-sex distribution of respondents was similar to the distribution for all BEACH (general practice) encounters, with the majority (58.8%) of patients being female.

The prevalence of central obesity in this general practice patient group was 43.7% (95% CI: 41.1–46.4). Central obesity rates did not differ between male and female patients (42.0% and 45.2% respectively).

Just under one-third (29.6%) of respondents with central obesity had raised triglycerides (≥150 mg/dL (1.7 mmol/L)) or specific treatment for this lipid abnormality. Significantly more male patients had raised triglycerides or lipid treatment (34.5%) than females (26.5%).

Close to half (46.1%) of the respondents had raised blood pressure (≥130/85 mmHg) or treatment for previously diagnosed hypertension.

One-quarter (24.1%) of the respondents had raised fasting plasma glucose (≥100 mg/dL (5.6 mmol/L)) or previously diagnosed type 2 diabetes. Significantly more male patients had raised fasting plasma glucose (27.7%) than females (21.7%).

One-quarter (24.1%) of respondents had reduced HDL cholesterol (<40 mg/dL (1.03 mmol/L) for males or <50 mg/dL (1.29 mmol/L) for females) or specific treatment for this lipid abnormality. Significantly more male patients had reduced HDL cholesterol or lipid treatment (29.3%) then females (20.8%).

Of all 5,402 general practice patients surveyed, 842 (15.6%, 95% CI: 14.0–17.2) had metabolic syndrome, while 3,845 (71.2%) did not meet the IDF definition for metabolic syndrome. A further 715 (13.2%) had not been tested for enough of the four metabolic syndrome factors to be classified.

For other related abstracts see: 76 Patients with risk factors for metabolic syndrome.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **PATIENT RISK FACTORS for METABOLIC SYNDROME.**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

Ask **ALL** of the <u>next 30 PATIENTS</u> the following questions **in the order in which the patients are seen.**
Please **DO NOT** select patients to suit the topic being investigated.

Waist circumference

If possible, please **measure** the patient's waist circumference with a tape measure. If the patient's waist circumference **exceeds the nominated measurement** (according to the patient's gender) please tick the 'Yes' box and **write** the measurement in the space provided.

If **'No'** you should **end the questions** here.

Risk factors

If **"Yes"** please answer the following questions about the patient's triglyceride, HDL cholesterol, blood pressure and fasting plasma glucose levels.

Some of these questions are slightly different for **male** and **female** patients because health risks occur at different levels for males and females, and for patients of **differing ethnicity**, when assessing abdominal obesity and HDL (high density lipoprotein) cholesterol.

For **each risk factor**, if you do not know a level, are unable to determine whether the patient is currently taking specific treatment for the risk factor, or if the patient has never been tested for the risk factor, please tick the '**don't know / never tested**' option.

* The values and qualifiers used in this survey are in accordance with the International Diabetes Federation (IDF) Worldwide definition of the metabolic syndrome.

Patient background

Ethnic group specific risks are similar for people of the **same ethnic background wherever they are found**. In order to best assess the risk for this patient, please use the tick boxes to advise their **continent of origin**.

Is this patient's waist circumference	* If 'Yes' does the patient also have any of the following:-	Yes	No	Don't know/ never tested	* This patient's continent of origin was:-
≥ 85 cm (males) or ≥ 75 cm (females)?	Raised **Triglycerides** ≥150 mg/dL (1.7 mmol/L) **or specific treatment for this lipid abnormality**	☐	☐	☐	☐ Europe/UK/North America/Australia ☐ South Asia/Pacific region
	Raised **blood pressure** ≥130/≥85 mmHg **or treatment of previously diagnosed hypertension**	☐	☐	☐	☐ China
☐ Yes = _____ cms	Raised **fasting plasma glucose** ≥100 mg/dL (5.6 mmol/L) **or previously diagnosed type 2 diabetes**	☐	☐	☐	☐ Japan ☐ South or Central America
☐ No → end questions	**(Males)** Reduced **HDL cholesterol** <40 mg/dL (1.03 mmol/L) **or specific treatment for this lipid abnormality**	☐	☐	☐	☐ Sub-Saharan Africa
BL76C	**(Females)** Reduced **HDL cholesterol** <50 mg/dL (1.29 mmol/L) **or specific treatment for this lipid abnormality**	☐	☐	☐	☐ Eastern Mediterranean/Middle East

93 Sexual dysfunction—premature ejaculation

Organisation supporting this study: Janssen-Cilag Pty Ltd

Issues: Prevalence of premature ejaculation (PE) in general practice patients/their partners; sources of advice utilised by patients/partners of patients experiencing PE; remedies tried as management of PE.

Sample: 2,186 patient encounters from 90 GPs; data collection period: 17/01/2006 – 20/02/2006.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: Participating GPs were provided with a card that contained information about PE, a clinical definition and examples of questions that identify patients with PE.

Summary of results

The age–sex distribution of all patient encounters was the same as the distribution for all BEACH encounters in 2004–05, with the majority (55.6%) of patients being female. The questions about sexual dysfunction–premature ejaculation (PE) were asked only of patients aged 18 years and over.

There were 2,186 patients aged 18 years and older, who responded to one or more questions on PE. Two-thirds (66.6%; n=1,455) were sexually active, 31.0% were not currently sexually active and 2.4% had never been sexually active. A significantly larger proportion of males (71.3%, 95% CI: 67.7–74.8) than females (62.9%, 95% CI: 58.3–67.5) were sexually active. The proportion of patients aged 25 to 44 years who were sexually active (88.1%, 95% CI: 85.4–90.8) was significantly higher than the proportion in other groups.

Of the 1,455 sexually active patients, 1,450 reported the duration of their current relationship. More than half (53.7%) had been in their current relationship for more than 10 years, a quarter (25.0%) for 2–10 years, 15.0% for less than 2 years, and the remainder (6.2%) were not currently in a relationship.

Sixteen of the 1,455 patients did not respond to questions about their/their partner's experience of PE. Of the 1,439 respondents, 18.4% (95% CI: 14.2–22.5, n=264) stated that they or their partners had experienced PE. A smaller proportion of female patients (13.0%, 95% CI: 9.6–16.5) reported their partners having PE than male patients (24.0%, 95% CI: 18.3–29.7) reported having PE.

Of the 264 patients who reported experiencing PE, 10 did not report on the number of occasions PE was experienced. Of the remaining 254 respondents, 61.4% had experienced PE on 1–25% of occasions, 19.7% on 26–50% of occasions and the remaining 18.9% had experienced PE on more than 50% of occasions.

Of 257 respondents who reported where help/advice was sought, 28.4% had sought help for the problem. The most common sources of help/advice were a GP (18.7%), their partner (5.8%) and other health professionals (4.7%). Of the 212 respondents who reported the remedies tried for PE, 37.7% had tried at least one of those listed. The most common remedy was prescribed medications (16.0%) followed by behavioural treatment (13.7%) and alcohol/drugs (9.9%). Physical remedies (e.g. more than one condom) were used by 8.5% of patients, 7.6% had used over-the-counter products, 4.3% had used herbal remedies and 1.4% used a nasal spray.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **SEXUAL DYSFUNCTION - PREMATURE EJACULATION.**

You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

Ask **ALL** of the **next 30 PATIENTS** the following questions **in the order in which the patients are seen.**

Please **DO NOT select patients** to suit the topic being investigated.

IMPORTANT!! - Please read the laminated card in your pack before commencing this section

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*Clinical definition: DSM-IV-TR diagnostic criteria for Premature Ejaculation (PE)

A. Persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it. Clinicians must take into account factors that affect duration of the excitement phase, such as age, novelty of the sexual partner or situation, and recent frequency of sexual activity.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The premature ejaculation is not due exclusively to the direct effects of a substance (e.g., withdrawal from opioids).

Definition taken from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Copyright 2000 American Pyschiatric Association.

Only ask these questions if the patient is over 18 yrs of age

Sexual activity status
Please ask the patient if they are sexually active.

If the patient has **never** been sexually active you should **end the questions here** for this patient.

Premature ejaculation
Please ask the patient whether they or their current partner have **experienced premature ejaculation** (as defined in the box on the right).

If '**no**' you should **end the questions here**.

If '**yes**', please ask the patient **how often** they have had this problem.

Current relationship status

Please use the tick boxes to advise the **duration** of the patient's current relationship.

Help / advice sought
Please ask the patient whether they or their partner have **sought help or advice** about this problem.

If '**yes**' please use the tick boxes to advise **where** help or advice was sought. Tick as many options as apply.

Remedies and their effectiveness

Please ask the patient what **remedies** they/ their partner have tried in an attempt to solve this problem.

Beside each option, please use the tick boxes to advise whether the patient considered the therapy to be **effective** in addressing this problem.

For patients 18yrs and over: Is this patient sexually active?	The duration of the patient's current relationship (in years) is:	Has this patient/patient's partner experienced premature ejaculation*?	Has the patient/ patient's partner sought help/ advice for this problem?		Remedies tried were:	Effective?
☐ Yes	☐ None	☐ No → end questions	☐ No *(tick all that apply)*		☐ None *(tick all that apply)*	Yes No
☐ No	☐ <2 years	☐ Yes - on:	☐ Yes - from: ☐ Pharmacist		☐ OTC products	☐ ☐
☐ Never → end	☐ 2-10 years	☐ 1-25% of occasions	☐ Partner ☐ GP		☐ Physical eg >1 condom	☐ ☐
BL79B questions	☐ >10 years	☐ 26-50% of occasions	☐ Relative ☐ Counsellor		☐ Behavioural	☐ ☐
		☐ 51-75% of occasions	☐ Friend ☐ Other health		☐ Alcohol / drugs	☐ ☐
		☐ 76-100% of occasions	☐ Other professional		☐ Herbal remedy	☐ ☐
			(Please specify) *(Please specify)*		☐ Nasal spray	☐ ☐
					☐ Other prescribed med'n	☐ ☐

For the Doctor...

Premature (early, rapid) ejaculation (PE) is the most common type of male sexual dysfunction. It affects between 14% and 30% of males >18 years of age.[1-3]

The personal nature of the condition and the hesitancy of both patients and clinicians to raise the topic means that only a small proportion of those affected seek or receive help.[4]

The purpose of this research is to determine the prevalence of PE in general practice patients, whether patients have sought help for the problem, and what help, if any, has been provided.

It is important to capture this information for general practice patients. We recommend that you explain to the patient from the outset that these questions are about sexual dysfunction and not about other sexual health issues such as sexually transmitted diseases. In order to assess whether the patient meets the DSM-IV-TR criteria for defining premature ejaculation, you should ask them the questions on the other side of this card.

However, **if you feel at any stage that these questions intrude too greatly on your relationship with this patient, please stop the questions** and just return the form with the shaded section incomplete for this topic.

Thank you for your generosity.

1. Patrick DL, Althof SE, Pryor JL, Rosen R, Rowland DL et al. Premature ejaculation: an observational study of men and their partners. J Sex Med 2005; 2:358-67
2. Laumann EO, Paik A, Rosen R. Sexual dysfunction in the United States. JAMA 1999; 281:537-44.
3. Nicolosi A, Laumann EO, Glasser DB, Moreira ED Jnr, Paik A, Gingell C. Sexual behaviour and sexual dysfunctions after age 40: the global study of sexual attitudes and behaviours. Urology 2004; 63:991-7
4. Aschka C, Himmel W, Ittner E, Kochen MM. Sexual problems of male patients in family practice. J Fam Pract 2001; 50:773-8.

> ***Clinical definition: DSM-IV-TR diagnostic criteria for Premature Ejaculation (PE)**
>
> **A.** Persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it. Clinicians must take into account factors that affect duration of the excitement phase, such as age, novelty of the sexual partner or situation, and recent frequency of sexual activity.
>
> **B.** The disturbance causes marked distress or interpersonal difficulty.
>
> **C.** The premature ejaculation is not due exclusively to the direct effects of a substance (e.g., withdrawal from opioids).

Defining Premature Ejaculation

These are examples of the types of questions you could ask the patient in order to determine whether they meet the Diagnostic Criteria for Premature Ejaculation according to the DSM-IV-TR definition. [see square brackets]

***You do not need to report responses to these questions** - this is just a guide to help you decide whether the patient satisfies these criteria.*

• During sexual intercourse do you (if male patient) / does your partner (if female patient) often ejaculate before you wish?

    Yes / No   *[required answer to meet criteria = 'yes']*

• If 'Yes' how much of a problem is this for you?

    None / A little / Somewhat / Very much
[required answer to meet criteria = 'somewhat' or 'very much']

• During the time that this problem has been happening, has (the male partner) started taking, or stopped taking, any therapeutic/recreational substance?

    Yes / No   *[required answer to meet criteria = 'no']*

94 Type 2 diabetes—investigations and related conditions

Organisation supporting this study: National Prescribing Service

Issues: The prevalence of type 2 diabetes among patients attending general practice, the most recent HbA1c level and time since last HbA1c test; current blood pressure level; the proportion of type 2 diabetes patients taking aspirin, clopidogrel, and/or an ACE inhibitor; the prevalence of specified co-morbidities among the type 2 diabetes patients.

Sample: 2,713 patient encounters with 92 GPs; data collection: 17/01/2006 – 20/02/2006.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: In this study: specified co-morbidities included ischaemic heart disease (IHD), cerebrovascular disease (CVD), peripheral vascular disease (PVD) or microalbuminuria/proteinuria. Blood pressure levels were defined according to the classification from the Heart Foundation, available from <www.heartfoundation/downloads/hypertension_management_guide_2004>.

Summary of results

The age–sex distribution of the respondents was similar to the distribution for all BEACH encounters, with the majority of patients (58.0%) being female. Patients aged 45–64 years accounted for 26.5% of the sample.

Of the 2,713 respondents, 224 (8.3%, 95% CI: 6.7–9.8) had been diagnosed with type 2 diabetes. There was no significant difference in the prevalence between males and females.

The most recent HbA1c level was provided for 206 (92.0%) of these patients. More than half (53.9%) had an optimal HbA1c level of ≤7.0%, while 18.5% of patients had an HbA1c level of more than 8.0%. The mean HbA1c level was 7.2% (95% CI: 7.0–7.3). Two-thirds of these patients had their last HbA1c test within the previous 3 months. Only 4.9% of patients had not had their HbA1c tested for over 12 months.

For 217 Type 2 diabetic patients blood pressure readings were taken and recorded at the consultation. According to Heart Foundation definitions, 49.3% of the patients had 'high-normal' blood pressure and 7.4% had mild, moderate or severe hypertension.

For 223 type 2 diabetic patients questions about selected current medications were answered. Nearly half these patients (49.3%) were taking aspirin and a further 5.4% were taking clopidogrel. Over two-thirds (64.7%) were using an ace inhibitor medication. A combination of aspirin/clopidogrel and an ace inhibitor was reported for 41.3% of these respondents while 12.6% were taking aspirin/clopidogrel only and 23.8% an ace inhibitor only.

There were 217 patients for whom both medication and blood pressure data were complete. Of those with 'normal' blood pressure 51.7% were taking an ace inhibitor. Of those with 'high-normal' blood pressure 66.4% were taking an ace inhibitor and of those with 'high' blood pressure 75.0% were taking an ace inhibitor.

Two in five (42.1%) of respondents (n=216) had at least one of the four listed co-morbidities or risk factors, the most common co-morbidity being IHD (24.5% of patients with diabetes), followed by microalbuminuria/proteinuria (13.4%), CVD (7.8%) and PVD (7.9%).

For other related abstracts see: 21 Diabetes – prevalence, management and screening, 25 Prevalence of diabetes, medications and control, 40 Type 2 diabetes mellitus, prevalence and management, 45 Diabetes mellitus prevalence, management and risk factors, 86 Diabetes Types 1 and 2 and coronary heart disease, 87 Management of cardiovascular or diabetes related conditions.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **TYPE 2 DIABETES**.

You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

Ask **ALL** of the **next 30 PATIENTS** the following questions

in the order in which the patients are seen.

Please **DO NOT** select patients to suit the topic being investigated.

Patient's HbA1C level

From the results of their **most recent test**, please write the patient's **HbA1C level** in the space provided.

Patient's blood pressure

Please **check** the patient's **blood pressure** and write the result in the space provided.

Patient ACE inhibitor use

Please advise whether the patient is currently taking an **ACE inhibitor**.

Type 2 diabetes

Please advise whether this patient has Type 2 diabetes, diagnosed either today or at a previous encounter.

If 'No' you should **end the questions here** for this patient.

Time since last HbA1C test

Please advise the approximate **time since** the patient's **most recent HbA1C test**, and **circle an option** to indicate whether the time is in weeks or months e.g.

 4
 wks/(mths)ago.
 (Please circle)

Patient aspirin use

Please advise whether the patient is currently taking **aspirin** (either prescribed or advised for over-the-counter purchase by you or another clinician), or **clopidogrel** prescribed by you or by another clinician. If the patient is **not taking** either of these medications please tick the box labelled '**none of the above**'.

Patient cardiovascular history and risk factors

Please use the tick boxes to advise whether the patient has any of the listed conditions.

If the patient does **not** have any of these conditions please tick the box labelled '**none of the above**'.

Does this patient have Type 2 Diabetes?
☐ Yes
☐ No → end
 questions

BL79C

If 'Yes' what was their most recent HbA1C level?

——————— %

The patient's most recent HbA1C test was approximately

—————
wks/mths ago.
(Please circle)

The patient's blood pressure level today is:

____ / ____
mmHg

Is the patient currently taking:

☐ Aspirin (prescribed)?
☐ Aspirin (OTC)?
☐ Clopidogrel?
☐ None of the above

Is the patient currently taking an ACE inhibitor?

☐ Yes
☐ No

Does the patient have:

☐ Ischaemic heart disease?
☐ Cerebrovascular disease?
☐ Peripheral vascular disease?
☐ Microalbuminuria/proteinuria?
☐ None of the above

95 Cultural background of patients attending general practice

Organisations supporting this study: Australian General Practice Statistics and Classification Centre (AGPSCC)

Issues: The proportion of people attending general practice who were born in and/or have parents born in countries outside Australia; distribution of type of cultural background; the proportion who self identify as Aboriginal or Torres Strait Islander people; the proportion who speak a language other than English in the home.

Sample: 6,035 respondents from 202 GPs; data collection period: 20/07/2004–23/08/2004.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

Fifty-eight per cent of respondents were female which is comparable with the total BEACH sample. There were a greater proportion of patients aged 65 years and over in this SAND sample (31.7%) compared with the total BEACH sample (26.8%).

Nearly a quarter of respondents (25.4%) were themselves born overseas. Patients born overseas were most often born in England (n=333, 5.5%), Italy (n=131, 2.2%) and New Zealand (n=79, 1.3%). More than one-third (36.1%) of patients had their mother born overseas and 38.2% had their father born overseas. At least one parent was born overseas for two out of five respondents (41.5%).

Ninety-five (1.6%, 95% CI: 0.7–2.5) respondents identified as being of either Aboriginal or Torres Strait Islander origin.

Seventeen per cent (17.1%, 95% CI: 14.1–20.0) of respondents reported speaking a language other than English at home. Southern European languages (for example, Italian, Greek, French, Spanish) were the most common, spoken by 5.7% of respondents, followed by Eastern Asian Languages (for example, Cantonese, Mandarin, Korean, Japanese) with 2.6%, Southwest Asian and North African Languages (for example Arabic, Farsi) (2.1%) and Eastern European Languages (e.g. Russian, Czech, Croatian, Armenian) (2.0%).

For other related abstracts see: 52 Language and cultural background of patients, 65 Language and cultural background of general practice patients.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **PATIENT CULTURAL BACKGROUND.**

You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

> **Please ensure that you ask the patient all questions exactly as they are worded on the form. It is important that the responses are based on the patients' answers rather than assumptions or impressions.**

ASK THE PATIENT

Please ask the patient **where they were born.** If their country of birth is **not** on the list provided, please tick the box labled 'other' and **write in the country of birth.**

Ask the patient about where there **parents were born.** If the patient was **adopted** they should answer for their **natural parents if known.** If **not known,** leave this question blank.

Please ask the patient "**are you of Aboriginal or Torres Strait Islander origin?**"

For persons of **both** Aboriginal and Torres Strait Islander origin, **mark both 'Yes' boxes.**

Please ask the patient if they speak **a language other than English at home.** If more than one language (other than English) is spoken in the home, write the **one that is spoken most often.**

Include **Indigenous languages** in 'other'. Include **sign languages** in 'other' if these apply in the home.

For **babies and young children,** or **people who cannot speak,** write "**Not able to speak**" in the space provided.

In which country were you born?
(tick one box only)

☐ Australia ☐ New Zealand
☐ England ☐ Viet Nam
☐ Scotland ☐ Other
☐ Greece   (please specify)
☐ Italy

_____

BL80B

Was your father born in Australia or overseas?

☐ Australia
☐ Overseas

Was your mother born in Australia or overseas?

☐ Australia
☐ Overseas

Are you of Aboriginal or Torres Strait Islander origin?
(Mark both 'Yes' boxes if both apply)

☐ No
☐ Yes, Aboriginal
☐ Yes, Torres Strait Islander

Do you speak a language other than English *at home*?
(tick one box only)

☐ No, English only ☐ Yes, Arabic
☐ Yes, Italian ☐ Yes, Vietnamese
☐ Yes, Greek ☐ Yes, other
☐ Yes, Cantonese   (please specify)
☐ Yes, Mandarin

_____

96 Inhaled corticosteroid use for asthma management

Organisation supporting this study: Australian General Practice Statistics and Classification Centre

Issues: Prevalence of asthma among patients attending general practice; severity of asthma; proportion taking asthma medication, proportion taking inhaled corticosteroids (ICS); current ICS and its daily dose; proportion adequately managed on ICS; proportion of patients with ICS dosage altered since resolution of last exacerbation and reason for alteration.

Sample: 5,911 respondents from 201 GPs; data collection period: 21/02/2006 – 27/03/2006 and 02/05/2006 – 05/06/2006.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: Asthma severity was established using the National Asthma Campaign's severity classification, which was provided on a card to participating GPs. This severity classification differs for children (aged <18 years) and adults.

Summary of results

The age and sex distributions of respondents were similar to the distribution for all BEACH (general practice) encounters, with the majority (58.1%) of patients being female.

GPs indicated that 686 (11.6%, 95% CI: 10.6–12.7) of the 5,911 respondents had diagnosed asthma. Prevalence did not differ between the sexes and was highest (19.0%) among 5–14 year olds.

Medication data were provided for 671 of the 686 respondents with asthma. Only 9.4% of these did not take any asthma medication. About half (49.3%) were taking one asthma medication, 32.0% were taking two and 9.3% three or more. Short acting beta agonists were being used by 66.5% of asthma patients, combination products (long acting beta agonist and ICS) by 35.6% and ICS by 24.1%. ICS (alone or as part of a combination product) were used by 57.4% (95% CI: 52.6–62.2). Most asthma patients (86.3%) were taking a reliever (beta agonist alone or in combination). The majority (53.4%) were using both a reliever and preventer and 32.9% were taking a reliever only.

Classification of severity of the asthma was provided by the GP for 82 children. Of these, 76.8% (n=63) had infrequent asthma, 22% (n=18) had frequent asthma and 1.2% (n=1) had persistent asthma. For 503 adults, severity was recorded. About one-third (34.8%) had very mild asthma, 34.4% had mild asthma, 27.8% had moderate asthma and 3.0% had severe asthma.

Of the 395 patients taking an ICS (alone or in combination) details of current dose were provided for 361. Half of these patients were taking fluticasone/salmeterol (55.7%), 15.5% were taking fluticasone propionate and 15.5% were taking budesonide/eformoterol.

Adequacy of current management with the current ICS dose was judged for 327 of the 361 patients for whom ICS medication data had been provided. GPs indicated that for 88.4% of these patients the current ICS dose had provided adequate management of their asthma, for 6.7% it did not provide adequate management, and for 4.9% GPs were unsure.

Information about changes (or not) in ICS dosage since the last exacerbation was provided for 356 of the 361 for whom ICS details had been given. A further 35 responded to this question because they had ceased ICS medication since the last exacerbation. In all 391 responses were received. The ICS dose had not been altered since last exacerbation for 62.4%

of these respondents. The ICS dosage had been decreased for 12.8% and had been stopped for 9.0% since the last exacerbation.

For other related abstracts see: 3 Asthma, 22 Asthma – prevalence, severity and management, 39 Severity of asthma, medications and management, 48 Asthma prevalence and management, 63 Asthma-prevalence, management and medication side-effects, 70 Inhaled corticosteroid use for asthma management, 104 Asthma management and medication use among patients attending general practice.

Further reading:
Henderson, J., Knox, S., Pan, Y., & Britt, H. 2004, 'Changes in asthma management in Australian general practice', *Prim.Care Respir.J*, vol. 13, no. 3, pp. 138–143.

The following page contains the recording form and instructions with which the data in this abstract were collected.

Severity of asthma reference card

Children

Severity*	Common features
Infrequent episodic	Episodes 6-8 weeks or more apart and from 1to 2 days up to 1-2 weeks duration; usually triggered by URTI or environmental allergen; attacks generally not severe; symptoms rare between attacks; normal examination and lung function except when symptomatic.
Frequent episodic	Attacks <6 weeks apart; attacks more troublesome; minimal symptoms such as exercise induces wheeze between attacks; normal examination and lung function except when symptomatic; commonly troubled through winter months only.
Persistent	Symptoms most days; nocturnal asthma > 1/wk with sleep disturbance; early morning chest tightness; exercise intolerance and spontaneous wheeze; daily use of beta2 antagonist; abnormal lung function; history of emergency room visits or hospital admissions.

Adults

Severity*	Common features
Very mild	Episodic
Mild	Occasional symptoms (up to 2/wk); exacerbations >6-8 weeks apart; normal FEV_1 when asymptomatic
Moderate	Symptoms most days; exacerbations <6-8 weeks apart which affect day-time activity and sleep; exacerbations last several days; occasional emergency room visit.
Severe	Persistent; limited activity level; nocturnal symptoms > 1/wk; frequent emergency room visits and hospital admission in past year; FEV_1 may be significantly reduced between exacerbations.

* The severity classes are adapted from the NAC Asthma Management Handbook 1998 edition, updated March 2002

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **INHALED CORTICOSTEROID USE FOR ASTHMA.**

You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

Ask **ALL** of the next 30 PATIENTS the following questions in the order in which the patients are seen.

Please **DO NOT** select patients to suit the topic being investigated.

Presence of asthma

Ask each patient if they **currently suffer from asthma.**

If **No** asthma - no further questions

Current medications used

If '**Yes**', please use the tick boxes to indicate whether any of the listed types of **asthma medication** are being used by this patient for their asthma management.

If **none** of these medications are currently being used for asthma management you may **end the questions here**.

Inhaled Corticosteroid Use

If the patient is using an **Inhaled Corticosteroid (ICS)** please write the **daily regimen** including **name, form, strength, dose** and **frequency** - for example :-

Name & Form	Strength	Dose	Freq
Fluticasone (inhaler)	250mcg	1 puff	bd

Severity of asthma

Please indicate the **current severity** of this patient's asthma. Use the '**Severity of asthma reference card**' included in your research pack to estimate the severity level and tick the appropriate box to indicate the response.

Adequacy of management

In your **clinical opinion** is the current daily dose of ICS **adequately** managing the patient's asthma?

Dose change since resolution of last exacerbation

Please indicate whether or not the **dose of Inhaled Corticosteroid** has been **changed since the most recent exacerbation of asthma was resolved**. Where required, please indicate a **reason** for the change, for example :-

Was ICS dose altered since resolution of last exacerbation?
- ☐ No - because _____
- ☐ Yes - Stopped ICS because _____
- ☐ Yes - Increased ICS using **ICS alone / combination product** *(please circle)*
- ☑ Yes - Decreased ICS using ⟨**ICS alone /**⟩ **combination product** *(please circle)*
- ☐ Yes - ICS new in last month
- ☐ Don't know because _____

Does this patient suffer from Asthma?

☐ Yes →

☐ No

↓

End questions

If 'Yes' current medication is
- ☐ Short Acting Beta Agonist
- ☐ Long Acting Beta Agonist
- ☐ Inhaled Corticosteroid
- ☐ Combination product
- ☐ Leukotriene antagonist
- ☐ Cromolyn
- ☐ Other _____
- ☐ None of above - **END**

Currently, how severe is the patient's asthma? (See cards)

Child	Adult
☐ Infrequent	☐ Very mild
☐ Frequent	☐ Mild
☐ Persistent	☐ Moderate
	☐ Severe

BL80C

If the patient is taking an Inhaled Corticosteroid (ICS) what is the current daily dose?

Name & Form	Strength	Dose	Freq

Is the current daily dose adequately managing the asthma? ☐ Yes ☐ No ☐ Unsure

Was ICS dose altered since resolution of last exacerbation?
- ☐ No - because _____
- ☐ Yes - Stopped ICS because _____
- ☐ Yes - Increased ICS using **ICS alone / combination product** *(please circle)*
- ☐ Yes - Decreased ICS using **ICS alone / combination product** *(please circle)*
- ☐ Yes - ICS new in last month
- ☐ Don't know because _____

97 Statin medication use among high CHD risk patients attending general practice

Organisations supporting this study: Merck Sharp & Dohme (Australia) Pty Ltd

Issues: The proportion of patients attending general practice who are in a high risk category for coronary heart disease (CHD); the proportion of these patients taking statin medication; National Heart Foundation (NHF) lipid targets reached by patients taking statin medication; proposed treatment of patients who had not reached targets.

Sample: 2,707 respondents from 94 GPs; data collection period: 28/03/2006 – 05/05/2006.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: High CHD risk conditions of interest for this sample of patients were hypertension, diagnosed coronary heart disease, familial hyperlipidaemia, diabetes mellitus, cerebrovascular disease and peripheral vascular disease.

Summary of results

The age and sex distributions of respondents were similar to those for all BEACH encounters, the majority (60.0%) of patients being female. Of the 2,707 patients, 1,042 (38.5%, 95% CI: 35.2–41.8) had at least one of the high CHD risk conditions, hypertension being most common (29.6% of patients), followed by familial hyperlipidaemia (9.2%).

Of the 1,015 CHD high risk patients responding to the question on statin use, 489 (48.2%) were currently taking or commencing a statin medication. Statin use was highest for the 65–74 years age group, where 57.8% were taking a statin medication, and it was significantly higher for male patients (54.7%, 95% CI: 48.7–60.8) than for female patients (43.0%, 95% CI: 38.0–47.9). Statin use was highest (78.3%) among patients with diagnosed CHD, followed by those with familial hypercholesterolaemia (76.5%).

Of the 489 patients taking or commencing a statin, specific details on those medications were provided for 437 patients (89.4%). The most common statins taken (or commenced at that encounter) were atorvastatin (54.2% of all statins recorded) and simvastatin (31.1%).

Of the 477 responses to the question on NHF target for lipid levels, 328 patients (68.8%) had achieved the target. Of patients with coronary heart disease, 74.6% had achieved target levels, while 66.9% of patients with familial hyperlipidaemian had achieved target levels. There were no significant differences found in the rate of target lipid levels achieved with different statin medications.

There were 473 respondents for whom details on NHF targets and up-titration suitability were recorded. Of these, 145 (30.7%) had not achieved target levels. For 33 (22.8%) of these patients, up-titration was not possible. The most common reason given for not up-titrating the statin was that the patient was on maximum dose (53.1%). Intolerance of a higher dose was the second most common reason, given for 21.9% of these patients. The ongoing lipid treatment proposed for most of these patients, 59.3%, was to maintain the current statin.

For other related abstracts see: 15 Lipid lowering medication, 20 Screening and management of blood cholesterol, 30 Lipid lowering medications and coronary heart disease, 46 Coronary heart disease, risk factors and lipid lowering medication, 58 Lipid lowering medications: patient eligibility under PBS, 64 Current use of statins by general practice patients, 67 Risk factors of patients on lipid lowering medications, 79 Hypertension and dyslipidaemia – comorbidity and management in general practice patients, 86 Diabetes Types 1 and 2 and coronary heart disease, 99 Lipid management in patients with high risk conditions.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **PATIENTS TAKING STATIN THERAPY.**

You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

Ask **ALL** of the <u>next 30 PATIENTS</u> the following questions

in the order in which the patients are seen.

Please <u>DO NOT</u> select patients to suit the topic being investigated.

National Heart Foundation guidelines for lipid levels

Total cholesterol: <4.0 mmol/L
LDL - Low density lipoprotein: <2.5 mmol/L
(<2.0 mmol/L for patients with existing coronary heart disease)
HDL - High density lipoprotein: >1.0 mmol/L
TG - Triglycerides: <2.0 mmol/L

Source: National Heart Foundation, Position statement on lipid management 2005. www.heartfoundation.com.au

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Please advise whether the patient has any of the listed conditions.

If the patient has none of the listed conditions tick '**none of the above**' and **end the questions here** for this patient.

Target lipid level

Please indicate whether the patient has achieved the National Heart Foundation target lipid levels. See definition.

If 'yes' please **end the questions here** for this patient.

In your clinical judgement could the **medication dose be titrated up for this patient** to achieve target lipid levels?

If '**yes**' please **end the questions here** for this patient.

Current statin medication
Please use the tick boxes to advise whether this patient is currently taking a statin medication or commencing a statin today.

If '**no**' please **end the questions here** for this patient.

If '**yes**' please specify if the medication was initiated today or previously prescribed. Please also specify the **name & form** of the statin, its **strength, dose** and **frequency.**

Please specify the **main reason that up-titration is unsuitable** for this patient.

If '**other**' please specify the reason up-titration is unsuitable.

Tick one option only.

Between now and the next lipid test, please indicate the proposed **ongoing lipid treatment** for this patient.

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Does this patient have?	Is this patient currently taking/ commencing a statin?	Has this patient achieved NHF target for lipid levels?	Could the statin dose be titrated up to achieve target lipid levels?	The main reason up-titration is unsuitable is: *(tick only one)*	What do you propose as ongoing lipid treatment for this patient?
Hypertension ☐	☐ No → **End questions**	*(see definition)*		☐ Intolerance of higher dose	☐ Maintain current statin
Coronary heart disease ☐	☐ Yes - initiated today	☐ Yes → **End questions**	☐ Yes → **End questions**	☐ Higher dose is contraindicated	☐ Change statin
Familial hyperlipidaemia ☐	☐ Yes - prescribed previously			☐ Patient does not want increased dose	☐ Add an additional lipid lowering medication
Diabetes mellitus ☐	*(Please specify)*	☐ No	☐ No	☐ Patient is taking maximum dose	
Cerebrovascular disease ☐	*Name & Form* *Strength* *Dose* *Freq*			☐ Increased dose did not/is unlikely to achieve further lipid lowering	☐ Discontinue statin and use an alternate lipid lowering medication
Peripheral vasc. disease ☐				☐ Other *(Please specify)*_____	
None of the above ☐ → **End questions**					

BL81B

98 Management of hypertension and angina in general practice patients

Organisations supporting this study: Abbott Australasia Pty Ltd

Issues: The proportion of patients attending general practice with hypertension and/or angina; current and target blood pressure levels for those with hypertension; medication use for hypertension and/or angina; co-morbidities present in patients with hypertension and/or angina (diabetes type I or II, ischaemic heart disease (IHD), peripheral vascular disease (PVD), renal disease, stroke and isolated systolic hypertension).

Sample: 2,919 respondents from 98 GPs; data collection period: 02/05/2006–05/06/2006.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: Heart Foundation guidelines were used to classify blood pressure (available from <www.heartfoundation/downloads/hypertension_management_guide _2004>).

Summary of results

The age and sex distributions of respondents were similar to those for all BEACH encounters, the majority (60.6%) of patients being female. Of the 2,919 patients, 718 (24.6%, 95% CI: 21.4–27.8) had diagnosed hypertension. The prevalence of hypertension increased with age from <1% among those aged<25 years to 60.1% of patients aged 75 years or over. There was no significant difference in the sex–specific rate of hypertension.

Of 2,856 respondents, 133 (4.7%, 95% CI: 3.7–5.7) had diagnosed angina. Males were significantly more likely to have angina (6.5 per 100 encounters, 95% CI: 4.7–8.3) than females (3.5, 95% CI: 2.5–4.6). The rate of angina increased with age to 18.4% of patients aged 75 years or more. A quarter of all respondents (25.4%, n=740) had either hypertension or angina, and 3.8% (n=111) had both hypertension and angina.

Blood pressure (BP) was measured at the encounter for 696 of the 718 patients with hypertension. Almost half (46.7%) of these had high–normal, 6.2% normal BP, 28.2% isolated systolic hypertension and 18.9% had BP defined as hypertensive.

Target BP level was recorded for 667 patients with diagnosed hypertension, 75.1% of whom had a target BP classified as 'high–normal'. Of the patients whose BP was measured and target BP recorded (n=660), 50.6% met their targets. A further 15.3% had lower measured BP than target and 34.1% had higher BP than target.

Of the 718 patients with hypertension, 713 provided data on 933 medications. Most patients were on a single medication (n=423, 59.3%), 255 (35.8%) were taking 2 medications and 35 were not currently taking any medications. Of the 133 patients with angina, 130 provided data about 167 medications. Most patients were on a single medication (n=63, 38.5%), 52 (40.0%) were taking 2 medications and 15 were not currently taking any medications.

Information on co-morbidities was provided by 669 patients with hypertension and/or angina. Half of these (50.4%) had at least one of the listed co-morbidities (21.8% diabetes, 27.8%, 7.0% IHD, 8.1% PVD, 8.1% renal disease, 6.1% stroke).

For other related abstracts see: 26 Prevalence of diagnosed hypertension and difficulties in treatment, 59 Hypertension management and control in general practice patients, 79 Hypertension and dyslipidaemia – comorbidity and management in general practice patients, 98 Management of hypertension and angina in general practice patients.
The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **HYPERTENSION and ANGINA.**

You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

Ask **ALL** of the **next 30 PATIENTS** the following questions

in the order in which the patients are seen.

Please **DO NOT** select patients to suit the topic being investigated.

Hypertension and / or angina

Please indicate by ticking the appropriate box whether this patient currently has diagnosed **hypertension** and / or **angina**

If **neither condition** has been diagnosed, either today or previously, you should **end the questions** here.

Blood pressure - Hypertensive patients

Please **test** the patient's blood pressure **today** and **write the levels** in the space provided.

Also, please advise what **BP levels** you would like this patient **to achieve.**

Medications

Please write the name and regimen of the **medication/s** this patient is **currently** taking for the management of **hypertension** or **angina.**

If **no medication** is taken for either hypertension or angina, please tick the **'No hypertension medication'** and /or the **'No angina medication'** box/es.

Other co-morbidity

Please advise whether the patient **also has any of the listed conditions.** Tick as many as apply.

If the patient has **none** of these conditions, please tick the box labelled **'none of the above'.**

Does this patient have diagnosed	If 'yes' to hypertension, what is the patient's blood pressure (BP) today?	What medication is currently being taken for HYPERTENSION?	Does the patient also have:

Does this patient have diagnosed

- **Hypertension?** ☐ Yes
        ☐ No

   and / or

- **Angina?** ☐ Yes
        ☐ No

If neither, **end questions here**

If 'yes' to hypertension, what is the patient's blood pressure (BP) today?

Systolic _____ mmHg

Diastolic _____ mmHg

What is your target BP for this patient?

Systolic _____ mmHg

Diastolic _____ mmHg

What medication is currently being taken for HYPERTENSION?

Name & Form	Strength	Dose	Freq

1. _____ ☐ No hypertension medication

2. _____

What medication is currently being taken for ANGINA?

3. _____ ☐ No angina medication

4. _____

Does the patient also have:

☐ Diabetes - type I or II
☐ Ischaemic Heart Disease
☐ Peripheral vascular disease
☐ Renal disease
☐ Stroke (current or history)
☐ Isolated systolic hypertension
☐ None of the above

BL82C

99 Lipid management in patients with high risk conditions

Organisation supporting this study: AstraZeneca Pty Ltd and Merck, Sharp & Dohme (Australia) Pty Ltd

Issues: Prevalence of selected risk factors among patients attending general practice; current lipid levels; whether target levels had been met; lipid lowering management; proportion who had cholesterol test in conjunction with current encounter; proportion managed by a specialist for dyslipidaemia, type of specialist; future management plan.

Sample: 5,372 encounters with 183 GPs; data collection period: 06/06/2006 – 14/08/2006.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: In this study risk factors include: coronary heart disease (CHD), diabetes, hypertension, familial hypercholesterolaemia, elevated cholesterol, family history of CHD and peripheral vascular disease.

Summary of results

The age and sex distributions of respondents were similar to the distributions for all BEACH (general practice) encounters, with the majority (58.7%) of patients being female.

From the 5,372 patient encounters, 2,270 (42.3%, 95% CI: 39.8–44.7) patients had at least one risk factor, and age-specific rates increased with age to 77.7% (95% CI: 74.2–81.2) among patients 75+ years. The most common risk factor was hypertension (24.5%), followed by elevated cholesterol (17.8%). One-fifth of patients (21.3%) indicated they had only one of the listed risk factors and 21.0% had two or more.

Total cholesterol (TC) level was provided for 1,786 patients, and the average TC level was 5.1 mmol/L. Female patients had a significantly higher average level (5.3, 95% CI: 5.2–5.4) than males (4.9, 95% CI: 4.8–5.0). GPs felt 56% of 1,584 respondents had reached target TC levels. The average high-density lipoprotein (HDL) level was 1.5 mmol/L (from 1,461 respondents). GPs indicated that 83.1% (of 1,277 respondents) had reached target HDL level. The average low density lipoprotein (LDL) level was 2.9 mmol/L (from 1,402 respondents). GPs indicated that 60.4% (of 1,224 respondents) had reached target level. The average triglyceride (TG) level was 1.7 mmol/L (from 1,692 respondents). GPs indicated that 73.6% (of 1,277 respondents) had reached target TG level.

Of 2,057 patients for whom information on current lipid medication was available, 882 (42.9%) were currently taking 903 lipid medications. Atorvastatin accounted for 46.2%, simvastatin 35.1% and pravastatin 11.1% of these. Of 1,562 respondents, 56.2% indicated diet and/or advice was a current lipid management strategy, for 44.6% (n=697) this was a previous strategy and for 17.5% (n=274) this strategy had not been used.

Of the 2,119 respondents to the question on cholesterol monitoring, 31% were tested in conjunction with the current consultation.

Specialists managed 11% of 2,061 patients with dyslipidaemia. The most common type of specialist was a cardiologist (63.5% of 181 patients for whom type of specialist was recorded). Of the 2,106 respondents changes to medication were planned for 16.6%: 2.9% to increase the dose of the same medication; 1.9% to add a new medication.

For other related abstracts see: 15 Lipid lowering medication, 20 Screening and management of blood cholesterol, 30 Lipid lowering medications and coronary heart disease, 46 Coronary heart disease, risk factors and lipid lowering medication, 58 Lipid lowering medications: patient eligibility under PBS, 64 Current use of statins by general practice patients, 67 Risk factors of patients on lipid lowering medications, 79 Hypertension and dyslipidaemia – comorbidity and management in general practice patients, 97 Statin medication use among high CHD risk patients attending general practice.
The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **PATIENT LIPID LEVELS and MANAGEMENT.**

You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

FOR THE DOCTOR

Please use the tick boxes to indicate whether this patient has any of the listed **risk factors.**

Tick as many as apply.

If the patient has none of these conditions **please end the questions** here.

Cholesterol level

Please advise the patient's levels of -

- **Total Cholesterol (TC)**
- **High Density Lipoprotein Cholesterol (HDLC)**
- **Low Density Lipoprotein Cholesterol (LDLC)**
- **Triglycerides (TG)**

at the time of **most recent testing.**
Please circle an option to indicate whether, in your **clinical opinion, target lipid levels** have been reached for this patient.

Lipid-lowering therapy

Please write the **name, regimen and duration of usage** of the **lipid-lowering medication** taken by this patient *e.g. atorvastatin 10mg/day 6 mths.* If **no medication** is currently being taken please tick the box labelled '**none**'.

Please write the **same details for the most recent previous lipid-lowering medication** (if medication has changed). If medication or regimen **has not changed** since treatment commenced, please write '**as above**' in the '**previous medication**' space. If **no medication** was previously taken please tick the box labelled '**none**'.

If the patient's lipid levels are managed through **diet** and/or **advice about exercise or lifestyle changes,** please use the tick boxes beside the **diet/advice** label to advise whether this is a **current** or **previous** management strategy. If not, please tick the box labelled '**none**'.

Cholesterol monitoring

Please advise whether the **patient's blood cholesterol** has been **tested in conjunction with this consultation** i.e. for **review at** this consultation, or **as a result of** this consultation.

Referral

Please advise whether this patient's **dyslipidaemia** has ever been **managed by a specialist.**

If '**Yes**' please specify the **type of specialist.**

Please also indicate the initial **reason for referral.** For example:- change of medication, up- or down-titration of dosage, side-effect(s) of medication, etc.

Management plan

Please use the remaining tick boxes to advise your management plan for this patient.

Does this patient have?	If known, please advise the most recent lipid levels (in mmol/L):	Have target levels been reached? *(please circle)*	Current lipid med'n is- ☐ None	The patient's cholesterol has been tested for/will be tested as a result of this consultation?	Has this patient ever had their dyslipidaemia managed by a specialist?	The management plan for this patient is-
☐ Existing CHD *(tick as many as apply)*			**Name Dose Duration of use**			☐ No change
☐ Diabetes mellitus			_____			
☐ Hypertension			_____			☐ Same medication - Increase dose
☐ Familial hyper-cholesterolaemia	TC _____	Yes / No	Previous lipid med'n was- ☐ None	tested as a result of this	☐ Yes - _____ *(please specify type of specialist)*	☐ Change medication_____ *(name and dose)*
☐ Elevated cholesterol	HDLC _____	Yes / No	**Name Dose Duration of use**	consultation?		
☐ Family history of CHD	LDLC _____	Yes / No	_____	☐ Yes	Because of_____	☐ Additional therapy _____ *(name and dose)*
☐ Peripher. vasc. disease			Diet/advice- ☐ current ☐ previous ☐ None	☐ No		☐ Other _____
☐ None of above → End	TG _____	Yes / No	*(tick either or both as applicable)*		☐ No BL83B	*(please specify)*

100 Gastrointestinal symptoms in patients attending general practice

Organisation supporting this study: Janssen-Cilag Pty Ltd

Issues: The proportion of general practice patients with heartburn or reflux; the diurnal distribution of symptoms; predominant symptoms; duration and frequency of episodes; source and nature of management.

Sample: 2,801encounters from 97 GPs; data collection period: 06/06/2006 – 10/07/2006.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: A card was supplied to participating GPs to assist in defining the primary symptom, and the frequency and severity of gastrointestinal symptoms.

Summary of results

The age-sex distribution of respondents was similar to the distribution for all BEACH encounters, with the majority (58.5%) of patients being female.

In the 2,801 encounters, 827 patients (29.5%, 95% CI: 26.4–32.6) indicated that they had symptoms of heartburn and/or reflux. The proportion of patients with heartburn or reflux was similar among males and females. The likelihood of experiencing symptoms increased with age, with 44.0% of patients aged between 65 and 74 years experiencing such symptoms.

Of the 827 patients reporting symptoms 381 (46.1%, 95% CI: 41.4–50.7) indicated that they currently had symptoms, 255 (30.1%, 95% CI: 26.4–35.3) had symptoms over the past 12 months, and 245 (29.6%, 95% CI: 25.3–33.9) had past symptoms that had now resolved.

The predominant symptom was heartburn among 404 patients (54.4%, 95% CI: 48.6–60.2), followed by acid regurgitation in 251 patients (33.8%, 95%CI: 28.7–38.8). Almost half the patients, 350 (45.8%, 95% CI: 40.8–50.8) experienced their symptoms both day and night.

Episodes of symptoms lasted a mean of 2.5 hours, with a median of 1.0 hour. Three in ten patients (30.1%, n=220) stated they had experienced symptoms for 1 to 5 years, and 20.1% (n=147) indicated their symptoms had been present for less than 1 year.

Half the patients (51.1%, n=396) had symptoms on less than 25% of days, and 23.5% (n=182) had symptoms on 25% to 50% of days. Two in five patients (40.3%, n=326) ranked their symptoms as mild, 41.6% (n=337) as moderate and 18.1% (n=147) as severe or very severe.

Of the 816 patients who indicated whether they had sought treatment 80.4% (n=656) had sought treatment. The most common sources of treatment was a GP (70.3%, n=457), or a specialist (25.5%, n=166), while 20.9% (n=136) self-medicated using supermarket products.

The most common diagnosis was oesophageal reflux in 66.3% (327 of 493 recorded diagnoses) of patients, followed by oesophagitis in 10.8% (n=53) of patients.

The most common investigation was endoscopy constituting 84.1% of 277 recorded investigations. Patients were referred to gastroenterologists in 125 of 159 total referrals.

Of the 544 medications used in the treatment of gastrointestinal symptoms, esomeprazole was the most common (22.1% of all medications listed), followed by omeprazole (19.9%) and pantoprazole (15.1%).

For other related abstracts see: 18 Drugs for the treatment of peptic ulcer and reflux, 24 Gastro-oesophageal reflux disease (GORD) in general practice patients, 34 Gastro-oesophageal reflux disease (GORD), 51 Use of proton pump inhibitors for gastrointestinal problems, 60 Prevalence of GORD and associated proton pump inhibitor use, 62 Use of proton pump inhibitors by general practice patients, 91 Prevalence and management of gastrointestinal symptoms.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **PATIENTS WITH GASTROINTESTINAL SYMPTOMS.**

You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

Ask **ALL** of the **next 30 PATIENTS** the following questions

in the order in which the patients are seen.

Please **DO NOT** select patients to suit the topic being investigated.

Heartburn or reflux

Please indicate by ticking the appropriate box/es whether this patient has experienced **heartburn** or **oesophageal reflux** either **currently**, in the **past 12 months** or at another time in the past but which has **since resolved**. Tick as many as apply.

If the patient has not experienced these symptoms **please end the questions** here.

♣Severity of symptoms

Please refer to the **definitions** of severity on the laminated cards in your research kit and advise the **level of severity** for this patient's **symptoms**.

Treatment sought

The patient may or may not have presented to you for help with these symptoms. Please **ask the patient** if they have **sought treatment** for their GI symptoms from any source. If **'no'** you may **end the questions** here.

If **'yes'** please use the tick boxes to advise **where** the patient sought treatment.

Primary symptoms, duration and frequency

(definitions also on laminated card in research pack)

Please circle an option or write a response to advise:

• the **time of day** the patient typically experiences/ed symptoms

• the **primary (1°) or predominant symptom*** experienced

(**1** = heartburn/epigastric pain **2** = acid regurgitation **3** = bloating **4** = belching)

• the **duration** of each episode i.e. how long the symptoms last

• the **frequency**** of symptoms i.e how often they occur.

    (**1** = on <25% of days   **2** = ≥ 25% but <50% of days

    3 = ≥ 50% but <75% of days   **4** = ≥ 75% of days)

Time since onset or duration of episodes

Please advise the approximate **time since the episodes** of GI symptoms **commenced.**

If GI symptoms are **now resolved**, please advise **how long episodes were experienced.**

Management of GI symptoms

If the patient has sought treatment, either from you or from another source, please advise the **diagnosis, investigation/s, referral/s and current medication** taken for management. You may need to **ask the patient** for this information.

If the management was **advice only** e.g. to change diet, please tick the box labelled **'advice only'**. If the patient cannot provide information about management, please tick the box labelled **'unknown'**.

Has the patient experienced heartburn or reflux? *(tick all that apply)*	If 'Yes' symptoms typically were experienced:	How severe♣ are/were the symptoms?	How long were episodes experienced/ since episodes began?	Has the patient sought treatment?	If treatment was sought, describe management:
☐ Yes - currently	• Day / night / both *(please circle)*	*(see definition on card)*		☐ No → End questions	Diagnosis *(please specify)* _____
☐ Yes - over the last 12 months	• 1° Symptom * = 1 2 3 4 *(see definition on card) (please circle)*	☐ mild	_____	☐ Yes, **please specify** *(tick all that apply)*	Investigation *(please specify)* _____
☐ Yes - in the past, now resolved	• Duration _____ *(hours)*	☐ moderate	*weeks / mths / yrs*	☐ Self-medication - supermarket	Referral *(please specify)*_____
☐ No → End questions	• Frequency** = 1 2 3 4 *(see definition on card) (please circle)*	☐ severe ☐ very severe	*(please circle)*	☐ Self-medication - pharmacy ☐ Pharmacist/OTC medication ☐ GP ☐ Specialist ☐ Emergency department	Medication *(please specify)*

For the medication in the last column:

Name & Form	Strength	Dose	Freq

☐ Unknown   ☐ Advice only

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*Primary (1°) Symptom

Please categorise the patient's predominant symptom as one of the following:

1 = Heartburn or epigastric pain
2 = Acid regurgitation
3 = Bloating
4 = Belching

**Frequency of Symptoms

Please categorise the description that most closely resembles the patient's impression of symptom frequency over the total time they experienced their heartburn or reflux symptoms:

Rating	Criteria
1 = few	Occurring on <25% of days
2 = several	Occurring on ≥25% but <50%of days
3 = many	Occurring on ≥50% but <75%of days
4 = continual	Occurring on ≥75% of days

Adapted from Birbara C, Breiter J, Perdomo C, et al. *Eur J Gastroenterol Hepatol* 2000; Aug 12(8):889-897.

♣Severity of Symptoms

Please categorise the description that most closely resembles the patient's impression of symptom severity:

Rating	Daytime	Night-time
1 = mild symptoms	Symptoms are present, but causing little or no discomfort	Symptoms are disturbing, but you immediately go back to sleep
2 = moderate symptoms	Symptoms are annoying, but not interfering with your daily activities	Symptoms are annoying, you remain awake for a short time before going back to sleep
3 = severe symptoms	Symptoms are causing marked discomfort and some interference with your daily routine	Symptoms are disturbing, and you have difficulty returning to sleep
4 = very severe symptoms	Symptoms are disabling, interferes considerably with your daily routine	Symptoms are disabling, you are unable to return to sleep because of discomfort

Adapted from Birbara C, Breiter J, Perdomo C, et al. *Eur J Gastroenterol Hepatol* 2000; Aug 12(8):889-897.