15 SAND abstracts and research tools

Since BEACH began in April 1998, a section on the bottom of each encounter form has been used to investigate aspects of patient health or health care delivery not covered by general practice consultation-based information. These additional substudies are referred to as SAND (Supplementary Analysis of Nominated Data). The SAND methods are described in Section 2.4. All substudies have been approved by the AIHW Ethics Committee (on behalf of the AIHW and the University of Sydney).

The AGPSCC and participating stakeholders of the BEACH program select topics for investigation in each of the SAND studies. In each BEACH year, up to 20 substudies can be conducted in addition to the study of patient risk behaviours (see Chapter 14). Topics are often repeated to increase the size of the sample and its statistical power.

Data from the SAND substudies conducted in the first year of BEACH (1998–99) were published in *Measures of health and health care delivery in general practice in Australia*.[78]

Abstracts of results and research tools for the SAND studies undertaken in 1999–2006 were published in *Patient-based substudies from BEACH: abstracts and research tools 1999–2006* in July 2007.[11] Abstracts and research tools for substudies conducted in 2006–07 that were not included in that report were published in *General practice activity in Australia 2006–07*.[2]

This chapter includes the abstracts and research tools for SAND substudies conducted from April 2007 to January 2008. SAND substudies conducted in February and March 2008 will be reported in *General practice activity in Australia 2008–09* to be published in 2009.

Abstracts of results from all SAND studies are also available from the FMRC's website <www.fmrc.org.au/publications/SAND_abstracts.htm>.

The subjects covered in the abstracts from 2007–08 BEACH year are listed in Table 15.1, with the sample size for each topic.

Table 15.1: SAND abstracts for 2007–08 and sample size for each

Abstract number	Subject	Number of respondents	Number of GPs
111	Adverse drug events in general practice patients	8,602	294
112	Prevalence and management of chronic pain	3,131	108
113	Management of hypertension and hypercholesterolaemia among general practice patients	3,160	112
114	Chronic kidney disease among general practice patients	5,924	195
115	Type 2 diabetes among general practice patients	2,784	86
116	Schizophrenia and bipolar disorder among general practice patients	3,374	116
117	Lipid management in patients with high-risk conditions	8,834	301
118	Risk factors for osteoporosis among general practice patients	2,613	89
119	Management of diabetes among general practice patients	5,989	204
120	Management of asthma among general practice patients	2,987	101
121	Gastrointestinal symptoms and management among general practice patients	3,293	112

SAND abstract number 111 from the BEACH program 2007–08

Subject: Adverse drug events in general practice patients

Organisation supporting this study: Australian GP Statistics and Classification Centre

Issues: The proportion of general practice patients who have experienced an adverse event resulting from the use of a medication during the preceding 6 months. The number, cause and severity of these adverse events, GP confidence in causation and number of resulting hospitalisations.

Sample: 8,602 encounters from 294 GPs; data collection period: 16/01/2007 – 19/02/2007; 17/07/2007 – 20/08/2007; 25/09/2007 – 29/10/2007.

Method: Detailed in the paper entitled *SAND Method 2007–08* available at <www.fmrc.org.au/publications/SAND_abstracts.htm>.

Summary of results

The age–sex distribution of respondents was similar to the distribution for all BEACH encounters, with the majority (60.1%) of patients being female.

Of the 8,602 respondents, 801 (9.3%; CI: 8.4–10.3) had experienced an adverse drug event in the previous 6 months. Among male patients, 7.5% (95% CI: 6.4–8.6) reported having an adverse drug event, significantly lower than the 10.5% (95% CI: 9.4–11.7) of female patients. The proportion of patients who reported an adverse drug event increased with age group of patient from 3.3% of infants <1 year to 13.1% of patients aged 75 years or more.

Selective serotonin reuptake inhibitors (SSRIs) were the medication group most frequently reported as the cause of adverse events, but only accounted for 6.1% of the medications, due to the wide variety of medications named. HMG CoA reductase inhibitors (statins) were the second most commonly reported, accounting for 5.0% of the total adverse event medications. Of the 822 medications, the most common individual medications causing adverse events were amoxicillin, which accounted for 3.9%, paracetamol/codeine (3.2%), perindopril (3.0%) and atorvastatin (2.9%).

Of 783 adverse drug events, GPs indicated that in 75% the cause was a recognised side-effect. Drug sensitivity was the reported cause in 9.5%, and allergy in 8.4%. Just 0.8% indicated drug interaction as the cause, and contraindication was recorded in only one case (0.1%).

For 48.1% of patients, the adverse drug events were classed as mild, for 41.3% they were moderate, and for 10.5% they were classed as severe.

Of 764 patients with an adverse drug event for whom this information was known, 35 (4.6%) were hospitalised due to the event. Of 369 patients with a mild event, two (0.5%) were hospitalised, of 317 patients with a moderate event, 9 (2.8%) were hospitalised, and of the 77 patients with a severe event, 24 (31.2%) were hospitalised.

Information regarding GP confidence in causality was available for 781 of the 801 patients with an adverse event. On a scale of 1 to 6 (1=not confident to 6=completely confident) the median level of confidence was 5. For almost 40% of events, the level was 'completely confident'.

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 **ADVERSE PHARMACOLOGICAL EVENTS.**

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

INSTRUCTIONS

These questions are about measuring the level of impact of medication events in the community. You will need to ask the patient for information when answering the following questions as you may not know if an adverse event occurred e.g. if the patient did not inform you of side effects they experienced or if the medication in question was prescribed / advised / supplied by another doctor / health professional in any setting (e.g. hospital inpatient, outpatient, primary care etc).

If you are interested in our previous work on this topic, please see Miller GC, Britt HC, Valenti L. Adverse drug events in general practice patients in Australia. Med J Aust 2006 Apr; 184(7):321-4.

ASK THE PATIENT

Please ask the patient if they have **experienced an adverse event from the use of any medication** in the **past six months.**

An adverse event is an unintended event which could have harmed or did harm the patient. 'Harm' includes physical, psychological or emotional suffering.

If **no** adverse events were experienced, **end the questions here.**

Medication involved in the event

Please **list the drug (or drugs** in the case of interactions) **that you suspect were the cause of the most recent adverse event.**

The drug(s) may be listed using the **generic** or **brand** name.

Severity of the event

Please indicate the **severity of the event** in terms of harm to the patient (in your clinical opinion).

Mild - a reaction of limited duration not requiring further treatment; minimum impact on daily activities.

Moderate - a reaction of longer duration or which requires further treatment; limits daily activities.

Severe - a reaction of any duration which results in hospitilisation and/or long term limitation of daily activities.

Cause of event

From the patient's description or your knowledge of the most recent adverse event, what do you think was the **most likely cause?**

Please tick as many options as apply.

Confidence of causality

Please indicate **how confident you are that the drug(s) listed caused the adverse event.**

Please **circle a number** on the scale to indicate your level of confidence that the drug(s) you nominated **caused the event**, where **1 = not confident,** and **6 = completely confident.**

*Scale adapted from Weingart SN et al. Arc Intern Med. 2005;

Hospitalisation

As a result of this adverse event, was the patient **hospitalised?**

In the past six months has this patient experienced an adverse event in response to use of a medication:	Please list the drug(s) you suspect caused the most recent event:	The most recent event was most likely the result of: *(tick all that apply)*		Was the event -	Was the patient hospitalised due to this event?	How confident are you that this / these drug(s) caused the event?
☐ Yes	_____	1☐ Recognised side effect	5☐ Drug sensitivity	☐ Mild		1 2 3 4 5 6
☐ No → **End questions**	_____	2☐ Drug interaction	6☐ Overdose	☐ Moderate	☐ Yes	Not confident Completely confident
BL96C	_____	3☐ Contraindication	7☐ Don't know	☐ Severe	☐ No	*(Please circle a number to indicate your level of confidence)**
		4☐ Allergy	8☐ Other	☐ Don't know		

SAND abstract number 112 from the BEACH program 2007–08

Subject: Prevalence and management of chronic pain

Organisation supporting this study: Janssen-Cilag Pty Ltd

Issues: The prevalence of chronic pain in patients attending general practice; causal conditions of the chronic pain: cancer, osteoarthritis, other arthritis, back problems, other conditions; the severity of pain; current methods for chronic pain management for these patients; reasons for non-use of opioids when opioids were not used.

Sample: 3,131 respondents from 108 GPs; data collection period: 27/03/07 – 30/04/07 and 21/08/07 – 24/09/07.

Method: Detailed in the paper entitled *SAND Method: 2007–08* available at <www.fmrc.org.au/publications/SAND_abstracts.htm>. Chronic pain grades were defined according to Von Korff M, Ormel J et al. *Pain* 1992; 50(2):133–149. Pain was graded from Grade I (low disability/low intensity) to Grade IV (high disability/high intensity).

Summary of results

The age–sex distribution of the sample reflected that of all BEACH participants. Of the 3,131 respondents, 548 (17.5%; 95% CI: 15.0–20.0) reported having chronic pain. The prevalence of chronic pain increased significantly with patient age (p<0.0001). Sex-specific rates showed no significant difference between males and females in the prevalence of chronic pain.

Of the 548 patient with chronic pain, 543 advised causal condition (multiple responses were allowed). Of these, 84.9% (*n*=461) reported one causal condition only, 13.4% (*n*=73) reported two and 1.7% (*n*=9) reported three conditions. Nearly half (49.7%; *n*=270) of patients with chronic pain indicated osteoarthritis as a cause, 30.4% (*n*=165) indicated back problems, 7.9% (*n*=43) other arthritis, 3.1% (*n*=17) cancer, and a further 25.6% (*n*=139) indicated 'other conditions' as a cause of their chronic pain. Of the 118 known 'other conditions' 49.2% were musculoskeletal in nature.

Of the 548 patients with chronic pain, 529 provided responses about severity of pain. Of these, 30.6% were at Grade I, 37.2% at Grade II, 25.5% at Grade III, and 6.6% at Grade IV. There was no significant difference in the average pain grading (Grade II) across causal conditions, although 11.8% of patients with back problems were at Grade IV compared with 5.0% of patients with osteoarthritis, and 2.4% of patients with other arthritis. Grade IV pain was also reported in 9.7% of patients with other conditions, and 2 of the 17 patient with cancer (11.8%).

Management method responses were provided for 538 of the 548 patients with chronic pain. The majority (79.2%; *n*=426) used medication only, while 11.7% (*n*=63) used medication and other methods, 2.6% (*n*=14) used other methods only (for example, physiotherapy, exercise, massage), and 6.5% (*n*=35) were using neither medication nor other methods. The most commonly used medications were 'other analgesics' (42.0%; *n*=226). NSAIDs/COX-IIs were taken by 29.6% (*n*=159) of patients, weaker opioids (e.g. tramadol, codeine preparations) by 28.6% (*n*=154), and antidepressants by 8.9% (n=48) of patients. The most common reasons for not taking opioids were that they were not needed (46%; *n*=134), side effects (14.8%; *n*=43), patient choice (12.1%; *n*=35), and concerns about dependence (5.0%; *n*=15).

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 CHRONIC PAIN.
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.

Chronic Pain

Please indicate by ticking the appropriate box whether this patient suffers from **chronic pain** *(defined* as 'pain experienced every day for three months in the six months prior to this consultation').*

If **no** chronic pain has been experienced you should **end the questions** here.

*Blyth FM et al. 2001. Pain 89(2-3):127-134

Causal conditions

Please advise the **condition** you identify as being the **cause** of the patient's chronic pain.

Tick as many as apply.

Severity

Ask the patient to rank the severity of their pain according to the Chronic Pain Grades**:

I = low disability - low intensity;

II = low disability - high intensity;

III = high disability - moderately limiting;

IV = high disability - severely limiting.

**Von Korff M et al. 1992. Pain 50(2):133-149

(this Chronic Pain Grade list is also on the laminated card in your research kit)

Medication for pain management

Please use the tick boxes to indicate whether the patient is **currently taking** any of the **nominated medications for pain management.** Tick as many as apply.

Below the box labelled **'other medication'** please write in **other medication/s** (not listed) that the patient is taking for pain management.

If **no medication** is taken, please tick the box labelled **'no med'n'**.

Beside the box labelled **'Other mgmt'** please advise what **other managements** are being used for **pain control** (e.g. acupuncture, physiotherapy etc), either **instead of** (for patients taking no medication) or **in conjunction with,** pain medication.

Choice of medication

(Where medication was **initiated by you)**

If the patient is **not taking an opioid,** please advise the **main reasons** for choosing a non-opioid medication over opioids.

If the medication was initiated by another GP or a specialist please tick the box labelled **'N/A - initiated by other'.**

Does this patient suffer from chronic pain?	If 'yes' from what condition?	In the past week how severe was the pain?
☐ Yes →	☐ Cancer ☐ Osteoarthritis ☐ Other arthritis ☐ Back problem ☐ Other cond'n	☐ Grade I ☐ Grade II ☐ Grade III ☐ Grade IIV
☐ No → End questions here	*(please specify)*	*(Pain grades on card or green sheet)*

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Current medications for pain management are: *(tick all that apply)*

Medication		initiated by	duration of use
☐ transdermal fentanyl		GP/Spec	_____ mths/yrs
☐ oral slow-release morphine		GP/Spec	_____ mths/yrs
☐ oral slow-release oxycodone		GP/Spec	_____ mths/yrs
☐ transdermal buprenorphine		GP/Spec	_____ mths/yrs
☐ NSAIDS / Cox-IIs		GP/Spec	_____ mths/yrs
☐ weaker opioids		GP/Spec	_____ mths/yrs
(eg tramadol, codeine prep'ns)			*(please circle)*

		initiated by	duration of use
☐ other analgesics		Gp/Spec	_____ mths/yrs
☐ psychotropics		GP/Spec	_____ mths/yrs
☐ anti-depressants		GP/Spec	_____ mths/yrs
☐ anti-epileptics		GP/Spec	_____ mths/yrs
☐ other medication		GP/Spec	_____ mths/yrs
			(please specify other med'n)
☐ NO medication			
☐ Other mgmt 1._____ 2._____			

If opioids are not used, the main reasons for non-use are?

1. _____

2. _____

3. _____

☐ N/A - initiated by other.

SAND abstract number 113 from the BEACH program 2007–08

Subject: Management of hypertension and hypercholesterolaemia among general practice patients

Organisations supporting this study: AstraZeneca Pty Ltd (Australia)

Issues: The prevalence of diagnosed hypertension (HT) and/or hypercholesterolaemia in general practice patients; the proportion of these patients who also have diagnosed chronic heart failure (CHF), microalbuminuria, diabetes type 2, left ventricular hypertrophy (LVH); the medications taken for the management of HT and/or hypercholesterolaemia, and the proportion that are taking no medication for either condition, or are managing their HT/hypercholesterolaemia with diet and exercise only; the proportion for whom a change to medication regimen was made at that encounter, and the reasons for change.

Sample: 3,160 respondents from 112 GPs; data collection period: 27/03/2007 – 30/04/2007 and 21/08/2007 – 24/09/2007.

Method: Detailed in the paper entitled *SAND Method 2007–08* available at <www.fmrc.org.au/publications/SAND_abstracts.htm>.

Summary of results

The age–sex distribution of the respondents was similar to the distribution for all BEACH encounters, with the majority of patients (59.3%) being female.

Of the 3,160 patients, 873 (27.6%, 95% CI: 24.6–30.7) had HT and 690 (21.8%, 95% CI: 19.5–24.2) had hypercholesterolaemia. Three and a half per cent of patients with HT and 5.6% of those with hypercholesterolaemia had been diagnosed at today's encounter. There were 1,115 patients (35.3%) who had HT and/or hypercholesterolaemia. Of the 3,160 patients, 13.5% had HT only, 7.7% had hypercholesterolaemia only, 14.2% had both conditions and 64.7% had neither condition. Of the 1,115 patients with HT and/or hypercholesterolaemia, 5.7% had CHF, 4.0% had microalbuminuria, 16.2% had type 2 diabetes mellitus, and 4.0% had LVH.

Of the 1,115 respondents, 1,110 provided information about current treatment, of whom 86.1% were currently taking at least one HT/hypercholesterolaemia medication and 13.9% were not currently taking medication. Of the 1,189 medications taken by 794 patients for the management of HT, perindopril was the most commonly prescribed medication (10.0% of HT medications). Of the 539 medications taken by 518 patients for the management of hypercholesterolaemia, atorvastatin was the most commonly prescribed medication (45.3% of hypercholesterolaemia medications). There were 154 (13.9%) patients who were not taking a medication for either condition.

One in twelve patients (8.7%) were managed with diet/exercise alone, 85.7% (*n*=951) were managed with medication alone, and 57 patients (5.1%) were not being managed with either medication or diet/exercise. A change in the medication regimen was made at today's encounter for 126 patients (11.4%). No change was made for 984 patients (88.7%). The reason for change was indicated for 113 patients, with lack of BP control being the main reason (52.2%).

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 CHOLESTEROL MANAGEMENT**.

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 conditions

Please use the tick boxes to indicate whether this patient has **hypertension** or **hyper-cholesterolaemia**, and whether the condition was **diagnosed at a previous encounter** (previous) or is a **new diagnosis** (new) resulting from **today's** visit.

If the patient **does not have hypertension** or **hyper-cholesterolaemia**, you should **end the questions** here. If the patient has either **hypertension** or **hyper-cholesterolaemia**, please advise whether or not they also have any of the other listed conditions. *Tick as many as apply.*

Current hypertension or high cholesterol therapy

Note: - for patients with hypertension or hypercholesterolaemia only

Please write the **name and regimen** for medications **currently taken** (i.e. prior to today's visit) for the management of **hypertension** or **hypercholesterolaemia.** Please use the **tick boxes** on the right hand column to indicate whether **each medication** is for hypertension (**HT**) or cholesterol (**Chol**) management.

If **no medications for hypertension** or **high cholesterol** were taken prior to today's encounter, please tick the box labelled '**No current HT/Chol medication**'.

If **cholesterol** is managed with **diet and exercise only**, please tick the box labelled '**Diet/exercise only**'.

Changes to medication

Please advise whether the patient's medication regimen for either condition **will change as a result of today's visit.**

If the medication/s or regimen for either hypertension or high cholesterol **will stop or change**, please **continue** with the questions.

If a medication is to be **stopped**, please **circle a number** to indicate which medication/s (from those listed in Q.2) will cease. **Change** to medication/s or regimen includes: **adding another** medication to those currently being taken; **changing a medication for a different one**; changing the **dosage** of a current medication, either by an **increase or decrease.**

If the medication/s and regimen for both will **remain unchanged** you should **END the questions here.**

Reason/s for regimen changes

Please use the tick boxes to advise the **main reason/s** for altering the patient's hypertension or cholesterol management medication regimen. *Tick as many as apply.*

Please **specify** a reason **not listed** by writing this reason in the space below the box labelled '**other reason**'.

New medication regimen

If changes were made to the regimen for **hypertension** or **cholesterol** medication please **write the new medication or regimen** in the space provided (i.e the medication to be added / changed to / dose changed). Only include the **additions/changes made today.**

Please use the tick boxes to advise whether the **new / changed** medication is for hypertension (**HT**) or cholesterol (**Chol**) management.

If high cholesterol will continue to be managed with diet and/or exercise only, please tick the box labelled 'Diet/exercise only'.

Does this patient have any of these conditions?	Diagnosis - previous	new
Hypertension (HT)	☐	☐
Hypercholesterolaemia	☐	☐
☐ Neither of the above → End here		
Chronic heart failure	☐	☐
Microalbuminuria	☐	☐
Diabetes T2	☐	☐
L. Ventricular hypertrophy	☐	☐

HT or high cholesterol therapy (prior to this visit):					(for)	
Name	strength	dose	freq		HT	Chol
1.					☐	☐
2.					☐	☐
3.					☐	☐
4.					☐	☐
5.					☐	☐
☐ No current HT/Chol medication ☐ Diet /exercise only						

From today's visit, the patient's regimen changed as follows:
☐ stopped medication
← 1 2 3 4 5 *(please circle)*
☐ add/change med'n
or regimen → *continue*
☐ NO CHANGE → **End**

The main reason/s for altering regimen is:
☐ Cough
☐ Lack of BP control
☐ Lack of lipid control
☐ Other side effects
☐ other reason
(please specify)

Medication added / changed to / dose changed:				(for)	
Name	strength	dose	freq	HT	Chol
1.				☐	☐
2.				☐	☐
3.				☐	☐
4.				☐	☐
5.				☐	☐
☐ Diet/exercise only					

B1.91C

SAND abstract number 114 from the BEACH program 2007–08

Subject: Chronic kidney disease among general practice patients

Organisation supporting this study: Abbott Australasia Pty Ltd

Issues: The proportion of patients attending general practice who have undergone a kidney function test in the previous 12 months; prevalence of chronic kidney disease among patients attending general practice; the stage of kidney disease for these patients; the comorbidities and risk factors of patients with chronic kidney disease; the management of chronic kidney disease for patients attending general practice.

Sample: 5,924 respondents from 195 GPs; data collection period: 01/05/2007 – 04/06/2007 and 25/09/2007 – 29/10/2007.

Method: Detailed in the paper entitled *SAND Method 2007–08* available at <www.fmrc.org.au/publications/SAND_abstracts.htm>. Stages of disease were defined according to National Kidney Foundation Guidelines.

Summary of results

The age–sex distribution of the sample reflected that of all BEACH participants. Of the 5,924 respondents, 2,960 (50.0%, 95% CI: 46.2–55.1) had had a kidney function test in the previous 12 months, 31.5% (n=1,867) a glomerular function test, 45.6% (n=2,699) a serum creatinine test, and 3.7% (n=219) another kidney function test. Age-specific test rates showed that the likelihood of being tested increased significantly with patient age, with 85.4% of patients aged 75 years and over having been tested. Sex-specific rates showed no significant difference between males and females in the proportion tested.

Of the 5,729 patients for whom a response was recorded, 332 (5.8%, 95% CI: 4.8–6.8) had been diagnosed with chronic renal failure/chronic kidney disease (CRF/CKD). Of the 332, 73.8% had been diagnosed by a GP and 26.2% by a specialist. While there was no difference in the diagnosed prevalence between males and females, the age-specific rate showed that 24.1% (95% CI: 20.5–27.7) of patients aged 75 years and over had diagnosed CRF/CKD.

Of the 322 diagnosed patients with a response about comorbidities, 75.8% had hypertension, 46.3% had dyslipidaemia, 34.2% had diabetes, 21.1% had proteinurea, 10.9% had anaemia and 1.6% had hyperparathyroidism. Of patients with CRF/CKD 6.8% were current smokers, and 9.3% had none of the listed conditions. Stage of disease was provided for 328 of the 332 diagnosed patients. The majority (55.8%) were at Stage 3. For patients aged 75 years and over 63.8% were at Stage 3, while only 1.1% of patients in this age group were at Stage 1 of the disease.

Management method responses were provided for 326 (98.2%) CRF/CKD patients. Half (51.1%) were being managed by a GP only, more that one-third (38.7%) by a GP and specialist, and 10.2% by a specialist only. Of the 222 respondents to questions about the type of management, 67.1% (n=149) were managed by diet; 14.4% (n=32) by Vitamin D supplements; and 56.3% (n=125) were managed with other methods, most commonly the management of risk factors and other diseases including: cardiovascular problems, diabetes, dyslipidaemia or anaemia. Less frequent managements were haemopoetic agents, dialysis, advice about fluids, and avoidance of non-steroidal anti-inflammatory drugs.

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 **CHRONIC RENAL FAILURE or CHRONIC KIDNEY DISEASE.**
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.

Assessment of renal function

Please use the tick boxes to advise whether this patient has had their **kidney function** tested in the past 12 months, and with **what test/s.** Please tick as many as apply.

Diagnosis

Please advise whether the patient has been **diagnosed** with **Chronic Renal Failure (CRF)** or **Chronic Kidney Disease (CKD),** either today or prior to today's consultation.

Also advise whether the diagnosis was made **by you or another GP**, or **by a specialist.**

If the patient has never been diagnosed with CRF or CKD **please end the questions here.**

Risk factors and comorbidities

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

If the patient has **none** of the listed risk factors or conditions please tick the box labelled 'none of the above'.

Stage of disease*

If the patient has been diagnosed with CRF or CKD, please advise what **stage of the disease** currently applies to this patient.

If you **do not know** (e.g if test results are not available) please tick the box labelled 'don't know'.

*Stages classified as per National Kidney Foundation Guidelines Part 4 - 'Definition and Stages of Chronic Kidney Disease'.

Perception of management

We are trying to **gauge whether** the CRF / CKD is being **actively managed in its own right,** rather than as a consideration in the management of other conditions.

Please advise whether the CRF / CKD is being managed by a **GP only,** by a **specialist only,** or by a **GP in conjunction with a specialist.**

If '**yes**' please **continue** to the final question.

If the CRF / CKD is **not** being actively managed, please **end the questions here.**

Management of CRF / CKD

If 'yes' please advise **how** the patient's CRF / CKD is being managed. Please tick all options that apply

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In the past 12 months has this patient had their kidney function assessed? *(tick all that apply)*

☐ Yes - glomerular filtration test
☐ Yes - serum creatinine test
☐ Yes - other _____ *(please specify)*
☐ No
☐ Don't know   **Please continue →**

Has the patient been diagnosed with Chronic Renal Failure (CRF) or Chronic Kidney Disease (CKD), today or prior to this encounter?

☐ Yes - by you or another GP
☐ Yes - by a specialist
☐ No → **end questions here**

If 'yes' does the patient have: *(tick all that apply)*

☐ Diabetes
☐ Hypertension
☐ Proteinuria
☐ Dyslipidaemia
☐ Hyperparathyroidism
☐ Anaemia
☐ Current smoker
☐ None of the above

At what stage* of CRF or CKD is the patient?

☐ Stage 1 - GFR >= 90 ml/min
☐ Stage 2 - GFR 60 - 89 ml/min
☐ Stage 3 - GFR 30 - 59 ml/min
☐ Stage 4 - GFR 15 - 29 ml/min
☐ Stage 5 - GFR <15 ml/min + dialysis
☐ Don't know

Is this patient's CRF or CKD being actively managed in its own right?

☐ Yes - by GP only
☐ Yes - by GP + Specialist
☐ Yes - by Specialist only
☐ No → **end questions**

If Yes, how is the patient's CRF / CKD being managed? *(tick all that apply)*

☐ Diet
☐ Vit D supplement
☐ Other _____ *(please specify)*

BL92B

SAND abstract number. 115 from the BEACH program 2007–08

Subject: Type 2 diabetes among general practice patients

Organisations supporting this study: National Prescribing Service Ltd

Issues: The prevalence of Type 2 diabetes among patients attending general practice, their most recent HbA1c level and the duration since their last test; their current blood pressure level; the proportion of these patients currently taking aspirin and/or clopidogrel, an ACE inhibitor; the proportion who also have ischaemic heart disease (IHD), cerebrovascular disease (CVD), peripheral vascular disease (PVD), microalbuminuria/proteinuria.

Sample: 2,784 respondents from 86 GPs; data collection period: 01/05/2007 – 04/06/2007.

Method: Detailed in the paper entitled *SAND Method 2007–08* available at <www.fmrc.org.au/publications/SAND_abstracts.htm>.

Summary of results

Of the 2,784 respondents, 215 (7.7%, 95% CI: 6.6–8.9) had Type 2 diabetes. Prevalence increased steadily by patient age from 0.4% of patients aged under 24 years to 18.8% of those aged 65–74 years. It then decreased slightly (though not significantly) to 15.3% among patients aged 75 years and over. Where patient sex was provided (n=2,758), prevalence was estimated as 8.9% (95% CI: 7.1–10.8) among males and 6.8% (95% CI: 5.6–8.1) among females, these results were not significantly different.

Of 192 patients with Type 2 diabetes for whom HbA1c levels were recorded, over half (54.7%) had an optimal HbA1c level of <= 7.0% (n=105), with the remaining 45.3% (n=87) having levels considered high (> 7.0%). Of the patients who had a HbA1c level > 7.0%, one-third had a HbA1c level greater than 8.0%.

The time since the last HbA1c was provided for 169 patients, 146 (86.4%) of whom had been tested in the previous 6 months and 18 (10.7%) in the previous 7–12 months, with 5 patients (3.0%) having not had a HbA1c test for more than 12 months.

Blood pressure (BP) was recorded for 192 of the 215 patients with Type 2 diabetes. Two-fifths (40.6%) of these had BP defined as high-normal according to the National Heart Foundation classification, 16.7% had normal BP, 34.4% had isolated systolic hypertension and 8.3% had high BP.

Of 205 respondents with Type 2 diabetes who provided medication information, half (48.3%) were taking aspirin only (39.0% prescribed; 9.3% OTC), and 5.9% were taking clopidogrel only. There were four patients (2.0%) who were taking both prescribed aspirin and clopidogrel. Overall, 56.1% of patients were taking aspirin, clopidogrel or both medications.

Two-thirds (n=136) of patients for whom ACE inhibitor status was provided (n=206) were taking an ACE inhibitor medication. Eighty-one patients (39.7%) were taking an ACE inhibitor with aspirin or clopidogrel, and 53 patients were taking the ACE inhibitor alone.

Almost half (47.6%) of 206 respondents with Type 2 diabetes also had at least one of the four listed cardiovascular related conditions/symptoms (IHD 33.5%, CVD 9.2%, PVD 15.1% and microalbuminuria/proteinuria 18.9%).

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.

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.

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

Patient's HbA1C level

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

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

_____ %

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)

The patient's most recent HbA1C test was approximately

_____ wks/mths ago.
(please circle)

Patient's blood pressure

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

The patient's blood pressure level today is:

_____ / _____ mmHg

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**'.

Is the patient currently taking:
☐ Aspirin (prescribed)?
☐ Aspirin (OTC)?
☐ Clopidogrel?
☐ None of the above

Patient ACE inhibitor use

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

Is the patient currently taking an ACE inhibitor?
☐ Yes
☐ No

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 the patient have: *(tick all that apply)*
☐ Ischaemic heart disease?
☐ Cerebrovascular disease?
☐ Peripheral vascular disease?
☐ Microalbuminuria/proteinuria?
☐ None of the above

BL92C

SAND abstract number 116 from the BEACH program 2007–08

Subject: Schizophrenia and bipolar disorder among general practice patients

Organisations supporting this study: Janssen-Cilag Pty Ltd

Issues: The proportion of patients attending general practice who had a history of schizophrenia or bipolar disorder; the management plans these patients were on (shared care plan with a community mental health centre (CMHC), private psychiatrist, treatment order or a discharge plan from hospital or CMHC); number of GP visits by these patients in the previous 3 months; management of general health risk factors in these patients.

Sample: 3,374 respondents from 116 GPs; data collection period: 5/06/2007 – 16/07/2007 and 30/10/2007 – 31/11/2007.

Method: Detailed in the paper entitled *SAND Method 2007–08* available at <www.fmrc.org.au/publications/SAND_abstracts.htm>.

Summary of results

Patient sex was provided at 3,353 encounters, with 60.7% (95% CI: 57.9–63.6) being female patients, which is slightly higher than the proportion in the BEACH 2006–07 data (56.3 95% CI: 55.5–57.1). Patient age was provided at 3,349 encounters. The age distribution of patients was similar to that reported for all 2006–07 BEACH encounters.

Of the 3,374 respondents, 50 had a history of schizophrenia (schizophrenia/schizoaffective/schizophreniform/paranoid psychosis) (1.5%, 95% CI: 1.0–1.9), and 36 had a history of bipolar disorder (1.1%, 95% CI: 0.6–1.5), with no differences in age- and sex-specific rates.

Of the 48 patients with schizophrenia who responded, 20 (41.7%) were being managed as part of a shared care program with a CMHC; 11 (22.9%) with a management plan with a private psychiatrist, and over one-third with none of the listed plans. Of the 32 patients with bipolar who responded, nearly half (*n*=15, 47%) were using none of the listed plans, one-third (*n*=11, 34%) had a management plan with a private psychiatrist, and 5 (16%) had a shared care plan with a CMHC.

Of the 46 patients with schizophrenia who responded, the median number of visits to a GP in the previous 3 months was 5.0, and for the 40 who responded, the median number of visits where schizophrenia was managed was 3.0. Of the 34 bipolar patients who responded, the median number of visits was 2.5, and for the 31 who responded the median number of treatment visits was 1.0. Nearly half of the bipolar patients (*n*=14, 45%) did not have their bipolar treated in the previous 3 months.

Of the 49 schizophrenia patients who responded, 27 (55%) had their cardiovascular risks/hypertension checked or managed; 25 (51%) had obesity/high BMI checked or managed; and 24 (49%) had diabetes/high blood glucose checked or managed, either at the current encounter or in the previous 3 months. Of the 33 bipolar patients who responded, 23 (70%) had their cardiovascular risks/hypertension checked or managed; 12 (36%) had obesity/high BMI checked or managed; and over half had diabetes/high blood glucose checked or managed (*n*=20, 61%), either at the current encounter or in the previous 3 months.

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 **SCHIZOPHRENIA and BIPOLAR DISORDER.**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

This question applies to the following section on Schizophrenia and Bipolar disorder, but as it relates to your practice rather than individual patients we will **only ask it once.**

PLEASE ANSWER THIS QUESTION HERE and then continue with the remaining questions for the next 30 patients.

Please note: In each category we are asking for the **number of nurses** and **how many days** (or part days) **per week** they work so that we can calculate the **full-time equivalents** for these.

Available support

In managing patients with **mental health problems**, do you have **support** in your practice from **any** of the following sources?

If **none** are available, please tick the box labelled 'none of the above'.

→

Do you have support in your practice from: *(tick all that apply)*

☐ Mental health nurse (employed by the practice) _____ nurse/s _____ days/wk

☐ Mental health nurse (employed by the area health service) _____ nurse/s _____ days/wk

☐ Practice nurse _____ nurse/s _____ days/wk

☐ GP Shared care liaison/coordinator

☐ None of the above

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **SCHIZOPHRENIA and BIPOLAR DISORDER.**
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.

Schizophrenia / Bipolar disorders

Please use the tick boxes to advise whether this patient has a history of any of the listed Schizophrenia / Bipolar disorder conditions.

If the patient does not have a history of any of these conditions **please end the questions here.**

Frequency of management

Please write in the spaces provided the approximate **number of times** the patient has visited a GP for any reason in the past 3 months. Use patient recall, your notes or knowledge, to give the best estimate. Please also write the approximate number of GP visits at which their **schizophrenia / bipolar disorder** was **managed** during that time. (Please include **today's** consultation in the total.) If you **do not know** the number for either, please tick the box labelled '**don't know**'.

Patient's social circumstances

Please use the tick boxes to advise the patient's **living situation.**

If the patient is aged between 14yrs 9 mths and 65 yrs, please use the tick boxes to advise what level of **employment** they are **capable of undertaking.**

Is the patient on a **disability pension?**

Health screening

Please use the tick boxes to advise whether the patient was **checked / managed** either at **today's visit, in the 3 months prior to today's visit**, or **both** (if both, tick both boxes), for any of the listed **conditions or risk factors.** Tick as many as apply.

If the patient was **not checked / managed** for any of these conditions or risk factors, either **today** or **in the 3 months prior to today's visit**, please tick the boxes labelled '**none of the above**'.

If you **do not know** whether any of these conditions were **checked / managed** in the past 3 months, please tick the box labelled '**don't know**'.

Management plan

If the patient has a history of any of the previously listed **schizophrenia / bipolar conditions,** please advise whether their condition is **being managed** via any of the methods below.

(CMHC = Community Mental Health Centre)

Does this patient have a history of:
- ☐ Schizophrenia
- ☐ Schizoaffective disorder /
- ☐ Schizophreniform / paranoid psychosis
- ☐ Bipolar disorder manic
- ☐ Bipolar disorder depressive
- ☐ Bipolar disorder mixed
- ☐ None of the above → **end here**

Is the patient being managed as part of: *(tick all that apply)*
- ☐ Shared care program with CMHC
- ☐ Management plan with private psychiatrist
- ☐ Discharge plan from hospital
- ☐ Discharge plan from CMHC
- ☐ Community / involuntary treatment order
- ☐ None of the above

Approx. how many times has this patient visited a GP in the past 3 months?

No. _____   ☐ Don't know

At approx. how many of these was the schizophrenia / bipolar disorder managed?

No. _____   ☐ Don't know

BL93B

Was the patient checked/managed for: *(tick all that apply)*

	Today	In past 3 mths	Don't know
Cardiovascular risk/hypertension............	☐	☐	☐
Obesity / ↑ BMI	☐	☐	☐
Diabetes / ↑ blood glucose................	☐	☐	☐
Women's / men's health screen............	☐	☐	☐
Alcohol abuse	☐	☐	☐
Other substance abuse................	☐	☐	☐
Smoking cessation	☐	☐	☐
None of the above	☐	☐	☐

Patient's social factors

Living situation
- ☐ hostel/supported
- ☐ alone
- ☐ with family/shared

Employment capability
- ☐ full time
- ☐ part time
- ☐ sheltered work
- ☐ none of above

Disability pensioner   ☐ Yes ☐ No

SAND abstract number 117 from the BEACH program 2007–08

Subject: Lipid management in patients with high-risk conditions

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

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

Sample: 8,834 patients from 301 GPs; data collection period: 06/06/2006 – 14/08/2006, 05/06/2007 – 16/07/2007 and 30/10/2007 – 03/12/2007.

Method: Detailed in the paper entitled *SAND Method 2007–08* available at <www.fmrc.org.au/publications/SAND_abstracts.htm>. High-risk conditions listed: coronary heart disease (CHD), diabetes, hypertension, familial hypercholesterolaemia, elevated cholesterol, family history of CHD and peripheral vascular disease. This abstract is an update of SAND abstract number 99, as additional data were collected in 2007–08.

Summary of results

The age and sex distributions of respondents were similar to the distributions for all BEACH encounters, with the majority (59.1%) of patients being female.

From the 8,834 encounters, 3,725 (42.2%, 95% CI: 40.2–44.1) patients had at least one of the listed high-risk conditions, the most common being hypertension and elevated cholesterol (24.6% and 18.1%, respectively). Age-specific rates increased with age to 79.7% (95% CI: 77.0–82.5) among patients aged 75 years and over. One-fifth of patients (21.7%) indicated they had only one of the listed high-risk conditions and 20.5% had two or more. The rest of these analyses are limited to the 3,725 encounters with patients with at least one listed high-risk condition.

Total cholesterol (TC) level was provided for 2,928 patients; the average TC level was 5.1 mmol/L. Female patients had a significantly higher average level (5.3, 95% CI: 5.2–5.3) than males (4.9, 95% CI: 4.9–5.0). GP opinion was 55.5% of 2,600 respondents had reached target TC levels. Average high density lipoprotein (HDL) level was 1.5 mmol/L (among 2,448 respondents), 82.8% (of 2,139 respondents) having reached target HDL level. Average low density lipoprotein (LDL) level was 2.9 mmol/L (among 2,367 respondents), 59.7% (of 2,069 respondents) having reached target level. Average triglyceride (TG) level was 1.7 mmol/L (among 2,783 respondents), 73.8% (of 2,364 respondents) having reached target TG level.

Of 3,410 patients for whom information on current lipid medication was available, 1,442 (42.3%) were currently taking 1,471 lipid medications. Atorvastatin accounted for 47.7%, simvastatin for 31.5% and pravastatin for 9.7% of these. Of 2,527 respondents, 57.7% indicated diet and/or exercise advice was a current lipid management strategy.

Of the 3,506 respondents to the question on cholesterol monitoring, 32.1% were tested in conjunction with the current consultation. Specialists had at some time managed 11.3% of 3,387 patients for dyslipidaemia, usually a cardiologist (63.1% of 287 patients for whom specialist type was recorded). Of the 3,462 respondents, changes to medication were planned for 15.1%: 2.9% to increase the dose of the same medication; 2.1% to add a new medication.

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

118

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

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.

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.

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**'.

Referral

If this patient has **elevated cholesterol** please advise whether the **elevated cholesterol** 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.

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.

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.

Management plan

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

Does this patient have?	*(Tick as many as apply)*
☐ Existing CHD	
☐ Diabetes mellitus	
☐ Hypertension	
☐ Familial hyper-cholesterolaemia	
☐ Elevated cholesterol	
☐ Family history of CHD	
☐ Peripher. vasc. disease	
☐ None of above → **END**	

If known, please advise the most recent lipid levels (in mmol/L):	Have target levels been reached? *(please circle)*
TC _____	Yes / No
HDLC _____	Yes / No
LDLC _____	Yes / No
TG _____	Yes / No

Current lipid medication is- ☐ None

Name	Dose	Duration of use

Previous lipid medication was- ☐ None

Name	Dose	Duration of use

Diet/advice- ☐ current ☐ previous ☐ None
(tick either or both as applicable)

The patient's cholesterol has been tested for/will be tested as a result of this consultation?
☐ Yes
☐ No

Has this patient ever had their elevated cholesterol managed by a specialist?
☐ Yes - _____ *(please specify type of specialist)*
Because of _____
☐ No

BL93C

The management plan for this patient is-
☐ No change
☐ Same medication - Increase dose
☐ Change medication _____ *(name and dose)*
☐ Additional therapy _____ *(name and dose)*
☐ Other _____ *(please specify)*

SAND abstract number 118 from the BEACH program 2007–08

Subject: Risk factors for osteoporosis among general practice patients

Organisation supporting this study: National Prescribing Service Ltd

Issues: The proportion of patients on medication for osteoporosis; type of medication taken: bisphosphonate, raloxifene, hormone replacement therapy, teriparatide, strontium, vitamin D, calcium; risk factors and history of fracture after minor trauma; proportion with history of fracture referred for bone mineral density (BMD) scan or x-ray; proportion diagnosed with osteoporosis.

Sample: 2,613 patients from 89 GPs; data collection period: 17/07/2007 – 20/08/2007.

Method: Detailed in the paper entitled *SAND Method 2007–08* available at <www.fmrc.org.au/publications/SAND_abstracts.htm>. Osteoporosis risk factor test from International Osteoporosis Foundation: <www.iofbonehealth.org>.

Summary of results

The age–sex distribution of respondents was similar to the distribution for all BEACH encounters, with the majority of patients (60.0%) being female.

Of 2,218 respondents to the medication question, 343 (15.5%, 95% CI: 12.7–18.3) were using at least one of the listed medications for osteoporosis: 204 patients (9.2%) used a calcium supplement; 142 (6.4%) a bisphosphonate, 84 patients (3.8%) a vitamin D supplement, and 52 patients (2.3%) used hormone replacement therapy.

There were 617 patients (23.8% of 2,592 respondents) who had at least one risk factor and/or had suffered a fracture after minor trauma, and the incidence was significantly higher for female patients (28.9%, 95% CI: 25.1–32.7) than for male patients (15.9%, 95% CI: 12.4–19.3). The likelihood of risk factor and/or fracture after minor trauma rose significantly with age of patient: 11.0% (95% CI: 8.0–14.1) among those aged 25–44 years, 30.2% (95% CI: 25.2–35.2) among those aged 45–64 years, 39.9% (95% CI: 33.9–45.8) among those aged 65–74 years, and a marginally higher rate, 52.9% (95% CI: 45.8–60.0), among patients aged 75 years and over.

More than half (51.9%) of the 617 patients who had at least one of the risk factors and/or fracture had been referred previously for screening. Of the 293 patients for whom screening method was known, 47.8% were referred for bone mineral density scan, 37.2% for both x-ray and BMD, and 15.0% for an x-ray only. A significantly greater proportion of female patients were referred for screening compared with male patients: of 446 female patients, 59.4% (95% CI: 53.0–65.9) had been referred for screening, while among 163 male patients, 31.3% (95% CI: 21.7–40.8) had been referred.

Of 312 respondents who had been screened, just over half (*n*=162, 51.9%) were diagnosed with osteoporosis. Over half (54.1%) of the 159 patients whose aged was known were aged 75 years and over. There was no significant difference between screened male and female patients in the likelihood of diagnosed osteoporosis. Fracture information was available for 154 of the 162 osteoporosis patients, with over two-thirds (68.2%) having had a fracture. Of 156 respondents with osteoporosis, 92.3% were taking at least one of the listed medications.

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 **OSTEOPOROSIS.**
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.

Medications

Please use the tick boxes to advise whether the patient is taking any of the **listed medications.**

For **bisphosphonate (including combination products), raloxifene** and **HRT**, please write the approximate **length of time** the patient has been taking these medications by writing a **number** in the space provided and **circling** either '**months**' or '**years**'

For **Vitamin D** and **Calcium supplement**, please write the **daily dose** in the space provided, eg 500mg.

Risk factors for Osteoporosis

This question refers to the **risk factors listed on the card.**
Please ask the patient to read the card and advise whether or not they have **1 or more of the risk factors** listed.

(NB - The patient in not required to indicate which risk factor/s they have, just whether they have one or more.)

Body site

If the patient has suffered **fractures** following **minor trauma**, please write the total **number** of fractures and which **body sites** were involved.

For example, if the patient fractured a wrist two months ago and a hip seven months ago, the total would be **2** and the body sites would be

1. ___wrist___
2. ___hip___

Fractures

Please ask the patient if they have ever suffered **fracture/s** following **minor trauma.**

Screening

This question refers to **X-ray** and **Bone Mineral Density (BMD)** testing. Please use the tick boxes to advise whether this patient has been **referred today** for screening, has ever been **screened previously**, or has **never been screened or referred** for screening. Please **circle** the **type** of screening which the patient has been referred for or previously received.

For example, if you are referring the patient today for BMD and the patient was previously screened with X-ray, please write:

                             Type of screen

☑ Referred today for screening?   X-ray / (BMD) / both

☑ Screened previously?   (X-ray) / BMD / both

☐ Never screened or referred?

Diagnosis from screening

If **previously screened**, was the patient diagnosed with **osteoporosis (i.e. BMD T-score of -2.5 or less)** as a result of that screening?

Is the patient currently taking:	Duration of use	
☐ Bisphosphonate	_____ mths/yrs	*(tick*
☐ Raloxifene (Evista)..........	_____ mths/yrs	*all*
☐ HRT	_____ mths/yrs	*that*
☐ Teriparatide (Forteo)		*apply)*
☐ Strontium (Protos)	**Daily dose**	
☐ Vitamin D supplement	_____	
☐ Calcium supplement	_____	
☐ None of the above		

BL94B

Does this patient have 1 or more of the risk factors listed on the enclosed card?	Has this patient ever suffered fracture/s following minor trauma?	If 'yes' how many fractures? _____ Which body site? (e.g.vertebral, hip, wrist) 1. _____ 2. _____ 3. _____	Has this patient been: *(tick all that apply)*	If previously screened, was the patient diagnosed with osteoporosis?
☐ Yes ☐ No If '**NO**' to both, end questions **HERE** If '**yes**' to either, please continue →	☐ Yes ☐ No		☐ Referred today for screening? ☐ Screened previously? ☐ Never screened or referred? **Type of screen** *(please circle)* X-ray / BMD / both X-ray / BMD / both	☐ Yes ☐ No

SAND abstract number 119 from the BEACH program 2007–08

Management of diabetes among general practice patients

Organisation supporting this study: Sanofi-Aventis Australia Pty Ltd

Issues: The prevalence of Type 1 and Type 2 diabetes in patients attending general practice; frequency and type of referrals given in past year for patients with diabetes; proportion of patients taking insulin or other medications for diabetes management; type of insulin used.

Sample: 5,989 patients from 204 GPs; data collection period: 21/08/2007 – 24/09/2007 and 01/12/2007 – 21/01/2008.

Method: Detailed in the paper entitled *SAND Method 2007–08* available at <www.fmrc.org.au/publications/SAND_abstracts.htm>.

Summary of results

The age and sex distribution of respondents was similar to the distributions for all BEACH encounters. Of the 5,989 respondents, 561 (9.4%, 95% CI: 8.3–10.4) had either Type 1 or Type 2 diabetes. The majority of patients had Type 2 diabetes (8.5% of respondents, 95% CI: 7.4–9.5, *n*=506), and 55 patients (0.9% of respondents, 95% CI: 0.6–1.3) had Type 1 diabetes.

The proportion of patients with Type 2 diabetes rose significantly with age of patient, to 17.7% of those aged 65–74 years. Males (10.6%, 95% CI: 9.1–12.0) were significantly more likely than females (6.8%, 95% CI: 5.7–7.9) to have Type 2 diabetes. Age and sex did not influence the prevalence of Type 1 diabetes.

Of the 55 patients with Type 1 diabetes, 47 responded to referral questions and 42 (89.4%) had received referrals in the previous year. Patients with Type 1 diabetes were most often referred to ophthalmologists (63.8% of patients, *n*=30), endocrinologists (59.6%, *n*=28) and diabetes nurses (38.3%, *n*=18). Of 481 respondents with Type 2 diabetes, at least one referral had been given to 86.9% of patients in the previous year (*n*=418). The majority of referrals were to ophthalmologists (63.0% of patients), followed by podiatrists (35.1%), diabetes nurses (34.9%), dietitians (34.1%) and endocrinologists (23.1%).

Of the 47 patients with Type 1 diabetes who responded to medication use questions, insulin use was reported by 59.6% (*n*=28). Of these, 25 patients (53.2%) were using basal insulin, 5 (10.6%) used intermediate-acting insulin and 15 (31.9%) used fast-acting insulin. Twenty patients (42.6%) were taking 27 diabetes medications other than insulin. Of these medications, metformin was taken by 11 patients (40.7%), gliclazide by 8 (29.6%) and glimepiride by 2 (7.4%).

For patients with Type 2 diabetes, 488 responded to medication use questions, and 70 (14.3%) were using insulin. Basal insulin was used by 49 patients (10.0%), intermediate-acting insulin by 17 (3.5%) and 16 used fast-acting insulin (3.3%). Medications other than insulin were taken by 341 patients (69.9%). Of these, more than half were taking metformin (53.3%) and 145 gliclazide (29.1%).

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 **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.

Diabetes

Please use the tick boxes to indicate whether this patient has either **Type 1** or **Type 2 dibetes**.

If the patient has **neither** Type 1 or Type 2 diabetes you should **end the questions here** for this patient.

Does this patient have:

- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Neither → **End questions**

BL95B

Referrals to other clinicians

Please use the tick boxes to advise whether the patient has been **referred** in the past 12 months to any of the listed **specialists** or **allied health workers**. For a referral to a specialist or allied health worker not listed, please tick the box labelled 'other' and **specify** in the space provided.

Please tick as many as apply.

If **no referrals** were made to a specialist or allied health worker, please tick the box labelled 'none of the above'.

In past year was a referral made to - *(please tick all that apply)*

- ☐ Diabetes nurse educator
- ☐ Practice nurse
- ☐ Endocrinologist
- ☐ Ophthalmologist
- ☐ Dietitian ☐ Podiatrist
- ☐ Other _____
- ☐ None of the above

Diabetes medication

If the patient has **either Type 1 or Type 2 diabetes**, please use the tick boxes to indicate the **insulin being used by the patient** (if insulin is being used for diabetes management).

If the patient is **not** taking insulin, please tick the box labelled '**No insulin**'.

In the second section, please write the **name and regimen** of **other medications** currently being taken by the patient to **manage their diabetes**.

If the patient's diabetes is managed with **diet and exercise only**, i.e. they are taking **no** medication, please tick the box labelled '**No medication - diet / exercise controlled**'.

If either type of Diabetes what medication is the patient taking?

Fast acting insulin	
☐ aspart	
☐ lispro	
☐ neutral	
☐ **NO insulin**	

Intermediate acting insulin
- ☐ aspart protamine suspension.
- ☐ lispro protamine suspension.
- ☐ neutral-ispohane (NPH)

Basal insulin
- ☐ glargine (Lantus)
- ☐ detemir (Levemir)
- ☐ ispohane (NPH) (eg. Humulin, Hypurin, Mixtard, Protaphane)

Oral/other diabetes medication is-

Name & form	strength	dose	frequency
_____	_____	_____	_____
_____	_____	_____	_____

☐ **No med'n - diet / exercise controlled**

Initiation of insulin

If the patient is currently taking **insulin** for diabetes management, please advise whether the insulin was **initiated by** yourself or another **GP only**, by a **GP in consultation** with an **endocrinologist**, or by an **endocrinologist only.**

If taking insulin, was the insulin initiated by -
- ☐ GP only
- ☐ GP in consultation with endocrinologist
- ☐ Endocrinologist only

SAND abstract number 120 from the BEACH program 2007–08

Management of asthma among general practice patients

Organisations supporting this study: AstraZeneca Pty Ltd (Australia)

Issues: The prevalence of asthma in the general practice population; severity of asthma; frequency of general practice visits by patients with asthma; frequency of general practice visits where asthma is managed; time since last asthma visit; medications taken for the management of asthma; type and provider of asthma management at the current encounter.

Sample: 2,987 patients from 101 GPs; data collection period: 30/10/2007 – 03/12/2007.

Method: Detailed in the paper entitled *SAND Method 2007–08* available at <www.fmrc.org.au/publications/SAND_abstracts.htm>. For this study, severity classes for children and adults were adapted from the National Asthma Council Asthma Management Handbook (1998).

Summary of results

The age distribution of respondents was similar to the distribution for all BEACH encounters, with patients aged 45–64 years accounting for 27.0% of encounters. There were significantly fewer male patients in this study (39.0%, 95% CI: 35.7–42.3) compared with all BEACH encounters (43.7%, 95% CI: 42.9–44.5).

Of the 2,987 respondents, 403 (13.5%, 95% CI: 11.9–15.1) had been diagnosed with asthma. Prevalence among children (0–17 years, *n*=398) was 17.1% (95% CI: 12.7–21.4), and among adults (*n*=2,577) was 13.0% (95% CI: 11.2–14.7). The age-specific rate of asthma was highest for those aged 15–17 years (33.3%), steadily declining to 9.9% of those aged 75 years and over. There was no difference in the prevalence of asthma between males (12.4%) and females (14.2%).

For 80.6% of children with asthma who answered the severity question (*n*=67), severity was 'infrequent'. Of the 330 patients aged 18 years and over with asthma, severity was 'very mild' for 42.7%, 'mild' for 29.4%, 'moderate' for 22.1% and 'severe' for 5.8%.

Of 392 respondents with asthma, 10.2% had not visited a GP for any reason in the previous 12 months, 9.4% had visited once, 28.8% had between 2 and 4 visits, and 51.5% had more than 4 visits. For 396 respondents, 46.2% had not had asthma managed in the previous 12 months, 23.5% once, and 30.3% twice or more. Of 171 respondents who had not had asthma managed in the previous 12 months, 70.2% stated that it was more than 2 years since their asthma had been managed by a GP.

Of 392 respondents who answered the question about medication use, 77.3% were taking at least one of the medications listed; over half (53.6%) a short-acting beta agonist (SABA); and 30.1% a combination inhaled corticosteroid/long-acting beta agonist (ICS/LABA). More than one in five patients (22.7%) were not taking any asthma medication.

Asthma had been managed at 76 of the encounters. Management of asthma by the GP most often involved general questions about asthma (72.4%, *n*=55). Asthma symptoms were discussed with the GP at 65.8% of encounters (*n*=50) and therapy was reviewed at 55.3% (*n*=42). Practice nurses were rarely involved in asthma management at these encounters.

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 **ASTHMA MANAGEMENT.**
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

Please use the tick boxes to advise whether this patient suffers from **asthma.**

If 'no' you should end the questions here.

If 'yes' please answer the following questions about the patient's asthma. You may need to ask the patient or check their notes. If you do not know the exact number please give your best estimations.

Severity of asthma

Please use the tick boxes to advise 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.

GP visits for asthma management

Please advise the approximate number of occasions when **asthma** was managed during the **past 12 months**, either as **the main or secondary reason** for the patient's visit.

Number of visits to a GP

Please use the tick boxes to advise the approximate **number of times** the patien has consulted a GP **for ANY reason, including asthma management,** during the past **12 months**. **Do not include today's visit** in this estimation.

Previous management

If the patient's asthma was **not managed** in the **past 12 months**, please advise how long since the **most recent visit** where asthma was managed.

Current medication use

Please use the tick boxes to advise the type of **medication** currently being taken by the patient for **asthma management.**

SABA = short acting beta agonist
LABA = long acting beta agonist
ICS = inhaled corticosteroid

Content of asthma consultation

If asthma was **managed at today's consultation** please describe the content of the **discussion** about asthma and whether the patient discussed their condition with the **GP**, the **practice nurse** (i.e. what the GP **intends** the practice nurse to discuss), or both.

Please tick **all** options that apply.

Form (shaded section)

Has this patient ever been diagnosed with asthma?	If 'yes' how severe is the patient's asthma?		How many times has the patient visited a GP for any reason in the past 12 months (apart from today)?		At how many visits was their asthma managed?	If the patient has NOT had their asthma managed in the past 12 months, how long (approximately) since asthma was last managed?	The patient's current asthma medication is:	Content of asthma consultation
	(see cards)							If asthma was **managed today how was it discussed and with whom?**
☐ Yes	**Child**	**Adult**	☐ None	☐ 8-10 times	☐ None ☐ 2-3	☐ <1.5 years	☐ SABA *(tick all that apply)*	☐ GP ☐ Practice nurse
☐ No → **End questions**	☐ Infrequent	☐ Very mild	☐ Once only	☐ 11-15 times	☐ Once only ☐ 4-6	☐ >1.5 and <2 years	☐ LABA	General question ☐ ☐
	☐ Frequent	☐ Mild	☐ 2-4 times	☐ >15 times	☐ >6	☐ >2 years	☐ ICS	Symptoms ☐ ☐
	☐ Persistent	☐ Moderate	☐ 5-7 times				☐ Comb'n ICS/LABA	Therapy review ☐ ☐
		☐ Severe					☐ None of the above	Compliance ☐ ☐
							(tick all that apply)	Repeat prescription ☐ ☐
								Asthma action plan ☐ ☐
								Device ☐ ☐
BL97B								Change of therapy ☐ ☐

SAND abstract number 121 from the BEACH program 2007–08

Subject: Gastrointestinal symptoms and management among general practice patients

Organisation supporting this study: Janssen-Cilag Pty Ltd

Issues: The proportion of patients who have had listed gastrointestinal (GI) symptoms: heartburn or epigastric pain, acid regurgitation, early satiety, nausea/vomiting, bloating, belching; severity of symptoms; the proportion of patients with GI symptoms who had sought treatment and the source of treatment; whether GP was the source of treatment, diagnosis and regimen of medication prescribed/advised.

Sample: 3,293 patients from 112 GPs; data collection period: 4/12/2007 – 21/01/2008.

Method: Detailed in the paper entitled *SAND Method 2007–08* available at <www.fmrc.org.au/publications/SAND_abstracts.htm>.

Summary of results

There were some differences in the age–sex distribution, with fewer patients aged 5–14 years and fewer males (40.0%, 95% CI: 37.3–42.8), compared with all 2006–07 BEACH encounters (43.7%, 95% CI: 42.9–44.5).

Of the 3,293 respondents, 990 (30.1%, 95% CI: 27.0–33.2) had experienced heartburn, reflux or other GI symptoms, and over two-thirds of these patients indicated the problem was current or in the previous 12 months. GI symptoms were significantly more common in the older age groups (40.6% of those aged 65–74 years and 39.5% of those aged 75 years and over). Heartburn or epigastric pain was indicated for 79.3% of 986 respondents, and acid regurgitation for 41.0%. Early satiety was the least common symptom, indicated for only 5.5% of patients. For the majority of patients the severity of GI symptoms was defined as mild or moderate. However, for 20.2% of patients with heartburn or epigastric pain, and for 17.2% of patients with bloating the symptoms were severe.

Of 980 respondents to a multiple response question on treatment, 768 (78.4%) had sought treatment. Of these, 28.5% had sought treatment from a supermarket/pharmacy, and, of 166 supermarket/pharmacy medications recorded, mylanta accounted for 41.0% and quick-eze for 25.9%.

Treatment had been sought from a GP by 654 patients (85.2% of those who sought treatment), and a diagnosis was recorded for 562 of these respondents: 437 (77.8%) were diagnosed with oesophageal disease, and for 89.9% of these patients the management was medication. Esomeprazole accounted for over one-quarter (26.9%) of the 581 initial medications prescribed by the GP, followed by omeprazole (20.7%) and pantoprazole (13.6%).

Medication review status could be calculated for 502 patients. For 296 patients (59.0%) on an initial medication, there was no change after review. Medication was ceased after review for 13 (2.6%) patients. For 104 patients (20.7%), the medication was changed to a new medication after review. Information was available for 308 patients on the approximate number of months into treatment when the initial medication was first reviewed. Of these, 47.4% were reviewed 1 month into treatment with an initial medication.

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 symptoms

Please use the tick boxes to advise whether this patient has experienced **heartburn or reflux symptoms** under the circumstances nominated. Tick as many as apply.

If 'no' you should end the questions here.

If 'yes' to any of the options, please answer the following questions about the patient's heartburn or reflux symptoms.

Type and severity of symptoms

Please use the tick boxes to indicate which of the **listed symptoms** are/were experienced by the patient and whether they were considered the **primary (1˚) (predominant) symptom or a secondary (2˚) symptom.** Tick as many as apply.

Beside each symptom experienced, please write in a number to indicate the **severity of the symptoms,** where:

1 = mild; **2** = moderate; **3** = severe; **4** = very severe.

(please see definition card in your research kit).

Treatment sought

Please advise whether the patient **sought treatment,** either as **self-medication** from a **supermarket** or **pharmacy,** or via specific **advice** from a **pharmacist.**

Please advise the **name** of any medication purchased for treatment of these symptoms, and the approximate **duration** of its usage in **weeks or months** per episode.

GP management

If treatment was sought from a **GP,** either today or at a previous encounter, please write the **diagnosis** in the space provided.

If the diagnosis is **unknown** (e.g. if the patient previously consulted another GP) please write '**unknown**' in the space provided.

Medication

Please write the name and regimen of any **advised or prescribed medication initially** taken by the patient for management of their GI symptoms, and the approximate **duration of its use** (in weeks or months per episode).

If the medication was **changed** for any reason **at review,** please write the same details for the **post review (current) medication** in the space provided.

If **no change** was made to the initial medication, please tick the box labelled '**as above**'.

Please also advise the approximate no. of **months** at which the **review occurred.**

If a **review** has **not yet** taken place (e.g. if the patient has recently commenced taking the medication) please tick the box labelled '**n/a**' (**not applicable**)

PPI use

If the patient was prescribed a **proton pump inhibitor,** please advise **how often** it was taken **after the first two months** of treatment (even if treatment has since stopped).

If two months has **not yet** lapsed, or a PPI was **never prescribed,** please tick the box labelled '**n/a**' '**not applicable**'.

Has this patient experienced heartburn or reflux symptoms?
☐ No → **End**
☐ Yes
→ End questions *(tick all that apply)*
☐ Currently
☐ In the past 12 mths
☐ > past 12 mths
☐ Symptoms resolved

If 'yes' symptoms and severity were:			
Symptom *(tick all that apply)*	1˚	2˚	Severity *(see cont.)*
Heartburn or epigastric pain	☐	☐	___
Acid regurgitation	☐	☐	___
Early satiety	☐	☐	___
Nausea/vomiting	☐	☐	___
Bloating	☐	☐	___
Belching	☐	☐	___

Did the patient seek treatment?
☐ No → **End**
☐ Yes - supermarket/pharmacy
_____
(medication name)
___ *wks/mths*
(duration of use)
☐ Yes - with pharmacist advice
_____
(medication name)
___ *wks/mths*
(duration of use)

(continued)
☐ Yes - from a GP
The diagnosis was:
_____
(please specify)
GP management was:
☐ Medication → cont.
☐ Advice only → **End**

Initial GP medication is/was:	Duration
_____	___ *(wks/mths)*
(medication name & regimen)	
Post-review medication is/was: ☐ as above	
_____	___ *(wks/mths)*
(medication name & regimen)	
☐ Medication was first reviewed at ___ mths
☐ n/a *(please specify)*

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If a PPI is/was taken, how often was it taken after the first two months?
☐ > once daily ☐ not applicable
☐ once daily
☐ 5-6 days per week
☐ 2-4 days per week
☐ ≤ once per week
☐ when symptomatic (prn)