Patient-based substudies from BEACH: abstracts and research tools 1999–2006

Australian GP Statistics and Classification Centre

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The Australian General Practice Statistics and Classification Centre (previously Unit) is a collaborating unit of the Australian Institute of Health and Welfare and the University of Sydney, situated within the Family Medicine Research Centre at Westmead Hospital. It fulfils the obligation of the Australian Institute of Health and Welfare to collect statistics regarding general practitioners, their patients and their patients' care.

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Recent related publications

Britt H, Miller GC, Charles J, Pan Y, Valenti L, Henderson J, Bayram C, O'Halloran J, Knox S 2007. General practice activity in Australia 2005–06. General practice series no. 19. AIHW cat. no. GEP 19. Canberra: Australian Institute of Health and Welfare.

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Knox S, Britt H, Pan Y, Miller GC, Bayram C, Valenti L, Charles J, Henderson J, Ng A, O'Halloran J 2005. Locality matters: the influence of geography on general practice activity in Australia 1998–2004. General practice series no. 17. AIHW cat. no. GEP 17. Canberra: Australian Institute of Health and Welfare.

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Bettering the Evaluation And Care of Health

Patient-based substudies from BEACH: abstracts and research tools 1999–2006

Australian GP Statistics and Classification Centre

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Foreword

General practice remains the cornerstone of Australia's health service. One has only to look at countries that do not have general practice or something similar, to see what a shambles follows. One of the troubling features about health care in the US is that primary care is often provided by specialists, at specialist rates and with concomitant use of special investigations. At the other end of socioeconomic spectrum, sub-Saharan African countries struggle to dispense medication for HIV and malaria because of a lack of primary care capacity.

Given the importance of general practice, then, it is refreshing to read the following studies that have emerged from the productive collaboration of the investigators with general practitioners in Australia. Many pharmaceutical companies, health departments and other interest groups have supported the studies. The sheer diversity of sponsorship, combined with the constancy of the research methods, diminishes the risk of biased results.

The BEACH substudies presented in this report address many aspects of health and health care of patients attending general practice. The data gathering has been appropriately parsimonious and economical of practitioners' time, but within those constraints information is remarkably rich. Whether the point in question is asthma (study 104) or cultural background of patients attending general practice (study 95), each study summary provides clear, concise and helpful insights on which we may base strategies for assisting general practitioners the better to care for their patients or to do other things in the health service that could assist them and their patients. I defy anyone to pick up this volume and find a boring study!

The investigators who have conducted these studies deserve a sustained round of applause. Research of this sort requires strength of vision and great good will. Any research program that has run for over 10 years is truly astonishing and deserves an award for longevity. I also applaud the generosity of the sponsors and research team in making the tested research implements freely available. It is interesting to observe the growth in precision, focus and feasibility that has occurred over the two decades since their first national study in 1990–91

I saw BEACH when it began and it has matured wonderfully. I congratulate the research workers and commend this fine report to all who have an interest in general practice in Australia.

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We also thank the following organisations for their financial support and their contribution to the ongoing development of the BEACH program since it began in April 1998:

- AstraZeneca Pty Ltd (Australia) (1998–2006)
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- Merck, Sharp and Dohme (Australia) Pty Ltd (2002–2006)
- Pfizer Australia (2003–2006)
- National Prescribing Service (2005–2006)
- Abbott Australasia (2006)
- Sanofi-Aventis Australia Pty Ltd (2006)
- Australian Government Department of Health and Ageing (1998–2004)
- National Occupational Health and Safety Commission (1998–2000)
- Australian Government Department of Veterans' Affairs (1998–2000)
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We acknowledge the support of the Royal Australian College of General Practitioners, the Australian Medical Association, the Australian Divisions of General Practice, the Australian College of Rural and Remote Medicine, and the Consumers Health Forum, and the contribution of their representatives to the BEACH Advisory Board.

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We appreciate the cooperation of the Primary Care Division of the Australian Government Department of Health and Ageing in regularly supplying general practitioner random samples and national Medicare data.

Ethics approval for the BEACH study was obtained by the Human Ethics Committee of the University of Sydney and the Ethics Committee of the Australian Institute of Health and Welfare. Ethics approval for all the substudies reported here was obtained from the Ethics Committee of the Australian Institute of Health and Welfare, on behalf of the Institute and the University of Sydney.

Contents

1 Introduction

This publication includes abstracts for, and research tools used, in 104 general practice substudies conducted as part of the BEACH (Bettering the Evaluation and Care of Health) national study of general practice between April 1999 and December 2006.

These substudies are usually patient-based though a few investigate issues related to the general practitioner (GP). Most investigate the prevalence of a selected morbidity among the respondents and the current management of that morbidity. Some also investigate status of the disease under current management while others cover past management and reasons for change in management.

The subjects of these substudies are largely morbidity based. The GPs ask the questions of the patient but when completing the forms may also use their own knowledge of the patient and the patient's health record (where it is available) in addition to the patient responses. These studies may therefore provide a more reliable measure of prevalence and management than is usually available from patient self-report alone.

All these substudies have been approved by the Australian Institute of Health and Welfare (AIHW) Ethics Committee (on behalf of the Institute and the University of Sydney).

BEACH is a continuous national study of general practice activity that began in April 1998. It is a paper-based data collection program which requires a random sample of GPs to each complete a one-page structured data form for 100 patient encounters (for more details see Chapter 2—Methods). Each year there are about 1,000 GPs involved in the BEACH program, providing an annual database of about 100,000 encounter records.

At the bottom of every encounter recording form is a section called SAND (Supplementary Analysis of Nominated data). SAND substudies investigate aspects of patient health or health care delivery in general practice not covered by the encounter-based data. It is the research tools from, and results of, these SAND substudies that form the content of this report.

Each GP's pack of 100 forms includes 3 separate SAND substudies. A group of 40 forms in every recording pad measure consultation length and selected patient health risk behaviours (body mass index, smoking and alcohol consumption). Every participating GP completes these, when possible, so the sample size for each of these topics is 30,000–40,000 per year (depending on whether all age groups are included in the topic). The results for these standard subjects are presented in each BEACH annual report, but are also summarised in Chapter 4 of this report.

For other SAND substudies, the usual sample is approximately 3,000 forms from about 100 participating GPs. We can therefore conduct up to 20 additional substudies per year. However, sometimes the topic is repeated to increase the statistical power of the substudy, so sample sizes for these changing topics range from about 3,000 to 12,000 patients from 90 to 400 participating GPs.

Encounter data collected in BEACH provides a reliable overview of the content of GP–patient encounters, the morbidity managed and the treatments provided on that occasion. However, at the encounter the GP does not always manage all the patient's health problems at a single encounter. For example, a patient with multiple morbidity (e.g. diabetes, ischaemic heart disease, osteoarthritis and asthma), will not necessarily have all these managed at a recorded encounter. Therefore the absence of a problem being managed does

not suggest it is not present in the patient. In contrast, the SAND substudies ask about the presence or absence of one or more specific diseases, risk factors or health behaviours, regardless of whether the problem was managed at the encounter. Current management, past management and current disease control level can also be investigated for those who have the disease/risk factor.

The advantages of SAND substudies are:

- The data needed for a reliable response can be gained from the patient, plus the GP and where available, the patient's health record.
- The substudies can be conducted as an addition to an ongoing program, at far less cost than would be incurred if each study was undertaken independently.
- Data from the substudies can be readily cross-analysed with information available in the encounter form about the patient (e.g. age, sex, Commonwealth concession card status, Indigenous status etc.), and the GP characteristics (collected through the GP Profile questionnaire completed by each GP participant).

Since BEACH began in 1998 there have been 172 substudies—in addition to the standard topics of length of consultation and patient risk factor status. Those conducted in the first year of BEACH (1998–99) were reported in *Measures of health and health care delivery in general practice in Australia* available from <www.fmrc.org.au/publications/Books3.htm>.[1] These topics are cross referenced in the subject bibliography of this report, so the reader is aware of subjects covered in the other publication, but they are not reproduced here. Some topics have been repeated in two or more data periods and in most cases interim reports are not provided as abstracts. In total there are therefore 104 abstracts presented in Chapter 5.

With such a large number of substudies it is not possible to publish a full paper on each. To date we have published an abstract for each SAND study on our website <www.fmrc.org.au> and on the National Library's archive PANDORA <http://nla.gov.au/nla.arc-14007>, in parallel with the release of the BEACH annual report each year. The topics are wide ranging and the results would therefore be of interest to a broad range of researchers, some of whom may be unaware of the availability of the abstracts. Further, on the web we do not provide the research tools developed for each SAND topic.

We hope that this report will assist GPs, GP divisions/networks, and other researchers by providing them with a wide range of tools that have demonstrated acceptability and utility, that are useable in the confines of general practice patient encounters, and which have already been approved by recognised ethics committees. We also believe that the results will be of interest to anyone studying morbidity and its management in general practice, or researchers planning a study to be undertaken in the future. For those preparing research protocols for studies based in general practice, the prevalence estimates provided in these abstracts will be particularly useful, as they give the researcher an indication of the likely number of patients who have the disease of interest, who are passing through the GPs' surgery. This allows them to better estimate the required GP sample size and project time required for recruitment of patients with the morbidity of interest.

1.1 Using this publication

This report includes four major sections and a subject bibliography.

(1) Methods—including a summary of the BEACH methods and a description of the methods used in the SAND substudies—are provided in Chapter 2. Where additional methods have been used for an individual SAND substudy these are described in the specific abstract for that SAND topic.

(2) Lessons we have learnt during the development and conduct of over 170 substudies, and some interesting methodological issues are discussed in Chapter 3.

(3) Chapter 4 contains a summary of results from 2000 to 2006 for:

- length of consultation for Medicare claimable A1 items of service and
- patient self-reported risk behaviours, including:
  - body mass index (BMI) (calculated from self-reported height and weight)
  - current smoking status
  - usual alcohol intake.

These are the four topics surveyed consistently since April 2000, included on 40 of the 100 encounter forms in every participating GP's research pack. Though the results are reported in the BEACH annual report in December each year (rather than as abstracts on the web), we felt that a summary of these results should be included in this report for completeness.

(4) In Chapter 5—Abstracts and research tools, the 104 SAND abstracts and their research tools are presented in order of their data collection period.

- The abstracts are single page summaries of the topic, rather than abstracts of the type produced for conference presentations or journal papers. They do not include an introduction/background, nor a discussion or conclusion. They have a standard structure using the following headings:
  - Organisation supporting this study
  - Issues
  - Sample
  - Method
  - Additional methods for this study (where applicable)
  - Summary of results.

When reading this report it would be useful to keep the following points in mind:

- In any one SAND substudy the denominator changes frequently, reflecting the step down approach of most SANDs from broader to more specific subjects. We have aimed to include a statement of these changing denominators in each SAND abstract but admit this has been done better in later rather than in earlier years.
- Keep in mind that where missing data are greater than 5% the reliability of the result is in question (see Chapter 3—Lessons learnt).
- Each abstract is identified by a number, from 1—104, so the lower the abstract number, the older the study.
- Each abstract is followed by a copy of the questions asked in that SAND study and the instructions given to the GP for completing them (the research tools).

In practise, this instruction sheet and example form is on green paper, and designates the beginning of a new SAND topic within the recording pack. It alerts the GP to the change of topic for the bottom section of the form, so she/he can tear out the instruction sheet from the pad and keep it for reference during the next set of encounters. The SAND topic is then included as part of the normal encounters for the next 30 (or 40 in the case of patient risk factors) SAND forms.

- Where additional tools were used in the conduct of a SAND substudy, these are also presented in the pages following the SAND abstract. Such additional tools include:
  - patient cards, where a number of options and/or definitions are offered for patient selection (e.g. the asthma severity levels patient card for Abstract 3)
  - other patient cards such as the Standard Drinks Chart shown to the patient by the GP in assessing usual alcohol intake (Chapter 4, Section 4.4)
  - option cards given to the patient when a number of options are available (in a pick list), thus saving the GP reading out all the options to each patient. Two examples of these are the smoking cessations methods (Abstract 53), and the methods used for weight loss attempts (Abstract 55).
- Any text or footnotes that have been added to the original abstract published on our website are in italics—in the majority these provide more details about the methods used in that SAND.
- At the bottom of each abstract other related abstracts are listed, and where peer-reviewed articles have been published using the data or on that topic, the paper(s) are cited.
- The subject bibliography. Each abstract has been designated a series of logical keywords. These have been used to create a subject bibliography (see page 264). One abstract can be listed under multiple subject headings: for example you will find SAND substudies about *hypertension* are listed in the bibliography under *Hypertension, National Health Priority Areas, Cardiovascular, Circulatory, Management, Prevalence, and Risk factor.* Where a study was conducted in the first year of the BEACH program (1998–99) and therefore published elsewhere,[1] it is listed in the subject bibliography, but is not included as an abstract in this report.

1.2 Interpreting the prevalence estimates

Most SAND substudies provide an estimate of the prevalence of a condition(s) among patients attending general practice. This means that they measure the number of patients who have the condition, among those who happened to see their GP during the SAND recording period.

SAND substudies do not measure disease prevalence among the total Australian population, because not everyone attends a GP. Approximately 85% of the population visit a GP at least once in any given year, (personal communication, Australian Government Department of Health and Ageing, August 2002), but the remaining 15% who do not attend have no chance of being selected in a SAND subsample.

These studies also do not measure the prevalence of the condition among the population of general practice patients (i.e. the population of patients who attend a GP at least once). In BEACH the unit of selection is the GP, who completes information for a cluster of patient encounters. Patients who attend more frequently have a higher chance of being 'selected'

than those who attend fewer times in a year. Each SAND sample therefore is not a random sample of all patients who attend at least once.

SAND data can be used to estimate the prevalence of a condition among all general practice patients, but you have to adjust the raw results for the GP attendance rates of each age group of patients, using Medicare Benefits Schedule (MBS) data (see Abstract 89).

1.3 Background

General practitioners are the first port of call in the Australian health care system. They act as gatekeepers to the secondary and tertiary sectors, and in 2006 they conducted more than 90 million consultations, most of which were claimed through Medicare Australia (the national health insurance system).[2] The BEACH program provides information about the content of these GP–patient encounters and the services and treatments provided by GPs to the Australian community.

The BEACH program is the only continuous randomised study of general practice activity in the world, and the only national program that provides direct linkage of management actions to the problem under management. It relies on the participation of an ever-changing random sample of about 20 GPs per week (about 1,000 per year), with each GP providing details about 100 consecutive patient encounters. The database therefore incorporates details of approximately 100,000 encounters per year. To date BEACH has involved approximately 9,000 participants (representing more than 7,500 individuals), providing details for approximately 900,000 GP–patient encounters.

The BEACH encounter form (see example at the end of this chapter) provides information about some characteristics of the patient, tells us the problems managed by the GP at the encounter, and how she/he manages each problem. It gives a cross sectional view of morbidity and its management rather than longitudinal patient-based view. By their nature the encounter data do not provide estimates of disease prevalence. They describe how often a morbidity is managed in general practice and how it is managed.

However, the program also facilitates collection of information about other aspects of the health of general practice patients through a continuous series of subsample studies, known as SAND (Supplementary Analysis of Nominated Data).

The SAND substudies allow us to measure prevalence and management of a selected disease among a sample of patients attending general practice, utilising the GPs clinical knowledge of the patient, patient recall and patient notes to provide more reliable information.

SAND substudies

Since BEACH began in April 1998 a section on the bottom of each encounter form has been allocated to investigate other aspects of patient health or health care delivery not covered by the consultation-based information. These substudies are referred to as SAND. Each organisation supporting the BEACH program has access to two subsamples of 3,000 encounter forms per year in which questions can be asked on a subject or subjects of their choice. This means that through the BEACH program we have the potential to study 20 different topics each year at marginal additional program cost. Detailed methods for SAND can be found in Section 2.2.

Population health and health improvements resulting from interventions and strategies need to be monitored. General practice is commonly identified as a significant intervention point for health care and health promotion because GPs have considerable exposure to the health of the population. As about 85% of the population visit a GP at least once in any single year (personal communication, Australian Government Department of Health and Ageing, August 2002), general practice would appear to provide a suitable basis from which to monitor many aspects of the health of the population.

Gaining reliable estimates of morbidity prevalence in the Australian population is important for health promotion and health services planning. The real prevalence of any morbidity in a population is difficult to establish due to unrecognised and untreated cases that by definition cannot be enumerated, except perhaps by population-wide screening programs. Estimates from tertiary health services data such as hospital separations mostly deal with more severe cases, and health services data are often counted as treatment events (or episodes) rather than individual cases.[3]

The National Health Survey (NHS) provides estimates of population prevalence based on self-reported morbidity from a representative sample of the Australian population using a structured interview to elicit health related information from participants. Surveys are currently conducted every 3 years.[4] Such community surveys have the advantage of estimating health states among the general population—including those who do not attend a general practitioner. However, self-report relies heavily on the patient's knowledge and recall, and has been demonstrated to be susceptible to misclassification, due to lack of clinical corroboration of diagnoses.[5] The assistance of a medical practitioner in recording a patient's health problems should go some way to reducing under-reporting and misclassification found in patient self-report alone.[5,6]

The concept of asking the GP to collect patient-based data about a sample of the patients they encountered while recording for the BEACH program was conceived by Geoffrey Sayer (a PhD student and staff member of the centre at the time) in 1997, with input from Janice Charles and Alice Bhasale. One aspect of Sayer's thesis was to investigate the extent to which the inclusion of the patient risk factor questions in SAND influenced the content of the encounter—whether completing the SAND section on patient risk factors, led the GP to give more attention in the encounter to the health risk behaviours asked of the patient—therefore jeopardising the validity of the encounter data recorded. He found no statistically significant effect.[7]

These substudies clearly demonstrate that it is possible to gain a large amount of reliable information in a relatively small space, with the addition of a single instruction sheet for each topic, and (where required) a patient card listing response options or defining specific morbidity. They also show that such brief surveys are acceptable and feasible for a GP to complete in the limited time of GP–patient encounters and that patients find it acceptable for GPs to ask such questions.

BEACH (Bettering the Evaluation And Care of Health) - Morbidity and Treatment Survey - National DOC ID

Encounter Number	Date of encounter ___/___/___	Date of Birth ___/___/_ _ _ _	Sex M ☐ F ☐	Patient Postcode

	Yes / No
New Patient	☐ ☐
Health Care/Benefits Card	☐ ☐
Veterans Affairs Card	☐ ☐
NESB	☐ ☐
Aboriginal	☐ ☐
Torres Strait Islander	☐ ☐

PATIENT SEEN BY GP ☐
PATIENT NOT SEEN BY GP ☐

Medicare Item Nos: (if applicable)
1. _____
2. _____
3. _____

Workers comp paid ☐
State Govt/Other paid ☐
No charge ☐

START Time ___:___ AM / PM (please circle)

Patient Reasons for Encounter
1.
2.
3.

Diagnosis/ Problem ① : **Problem Status** New ☐ Old ☐ Work related ☐

Drug Name AND Form for this problem	Strength of product	Dose	Frequency	No. of Rpts	OTC	GP Supply	Drug status New	Drug status Cont.
1.								
2.								
3.								
4.								

Procedures, other treatments, counselling this consult for this problem
1. Prac Nurse? ☐ 2. Prac Nurse? ☐

Diagnosis/ Problem ② : **Problem Status** New ☐ Old ☐ Work related ☐

Drug Name AND Form for this problem	Strength of product	Dose	Frequency	No. of Rpts	OTC	GP Supply	Drug status New	Drug status Cont.
1.								
2.								
3.								
4.								

Procedures, other treatments, counselling this consult for this problem
1. Prac Nurse? ☐ 2. Prac Nurse? ☐

Diagnosis/ Problem ③ : **Problem Status** New ☐ Old ☐ Work related ☐

Drug Name AND Form for this problem	Strength of product	Dose	Frequency	No. of Rpts	OTC	GP Supply	Drug status New	Drug status Cont.
1.								
2.								
3.								
4.								

Procedures, other treatments, counselling this consult for this problem
1. Prac Nurse? ☐ 2. Prac Nurse? ☐

Diagnosis/ Problem ④ : **Problem Status** New ☐ Old ☐ Work related ☐

Drug Name AND Form for this problem	Strength of product	Dose	Frequency	No. of Rpts	OTC	GP Supply	Drug status New	Drug status Cont.
1.								
2.								
3.								
4.								

Procedures, other treatments, counselling this consult for this problem
1. Prac Nurse? ☐ 2. Prac Nurse? ☐

NEW REFERRALS, ADMISSIONS

	Problem(s)
1. _____	1 2 3 4
2. _____	1 2 3 4

IMAGING/Other tests

	Body site	Problem(s)
1. _____	- _____	1 2 3 4
2. _____	- _____	1 2 3 4

PATHOLOGY

	Problem(s)
1. _____	1 2 3 4
2. _____	1 2 3 4
3. _____	1 2 3 4

PATHOLOGY (cont)

	Problem(s)
4. _____	1 2 3 4
5. _____	1 2 3 4

SAND questions are inserted here

2 Methods

2.1 BEACH

The BEACH program is a continuous national study of general practice activity in Australia. It uses details of about 100,000 encounters between GPs and patients (about a 0.11% sample of all general practice encounters) from an ever changing random sample of 1,000 recognised practising GPs. The methods are described in detail in *General practice activity in Australia 2005–06*.[8]

In summary:

- each year BEACH involves a random sample of approximately 1,000 GPs
- the GP sample is a rolling (ever-changing) sample
- approximately 20 GPs participate each week, for 50 weeks a year
- each GP can be selected only once per RACGP (Royal Australian College of General Practitioners) quality assurance triennium
- each GP records details about 100 doctor–patient encounters of all types
- information is recorded by the GPs on structured paper encounter forms
- each GP participant also completes a questionnaire about themselves and their practice
- the program generates records for about 100,000 encounters per year.

Random samples of GPs who claimed at least 375 general practice Medicare items of service in the previous 3 months are regularly drawn from Medicare Australia data by the Primary Care Division of the Australian Government Department of Health and Ageing (DoHA).

- We approach the randomly selected GPs by letter, posted to the address provided by DoHA.
- Over the following 10 days we use the electronic telephone books to check the telephone numbers generated from the Medicare data. This is necessary because many of the telephone numbers provided from the Medicare data are incorrect.
- We then telephone the GPs in the order in which their letters were posted and, referring to the approach letter, ask whether they will participate.
- On initial telephone contact with the practice we often find that the selected GP has moved elsewhere, but is still in practice. Where forward address and/or telephone number can be obtained, we try to contact the GPs at their new address.
- GPs who agree to participate are set an agreed recording date several weeks ahead.
- We send a research pack to each participant about 10 days before the planned start date.
- A telephone reminder is made to each GP in the first days of the agreed recording period—this also provides the GP with an opportunity to ask any questions they have about the recording process.
- We follow-up non-returns by regular telephone calls for up to 3 months after the set recording time.

- Participating GPs earn up to 60 Clinical Audit points towards their quality assurance (QA) requirements through the RACGP. As part of this QA process, each receives an analysis of his or her results compared with those of nine other de-identified GPs who recorded at approximately the same time. Comparisons with national averages are also provided. In addition, GPs receive some educational material related to the identification and management of patients who smoke or consume alcohol at hazardous levels.

Previous work has demonstrated the reliability of the methods adopted in BEACH.[5,6,9–14]

Detailed methods are described in all BEACH annual reports, the most recent of which is *General practice activity in Australia 2005–06* and can be downloaded from <www.fmrc.org.au/publications/Books3.htm>.[8]

2.2 SAND—Supplementary Analysis of Nominated Data

A section on the bottom of each recording form investigates aspects of patient health or health care delivery in general practice not covered by the consultation-based data. Each component covers a specific topic, and involves a line of questioning that is asked of the patient and/or the GP in addition to the encounter-based information.

- In every GP's pack of 100 forms there are 40 forms that contain questions about patient risk factors: patient height and weight (used to calculate body mass index, BMI), alcohol intake and smoking status (patient self-report), and start time and finish time of the encounter (for calculation of and the length of consultation measured by recorded finish time minus recorded start time for Medicare claimable A1 items of service).
- The remaining 60 forms in each pack are divided into two blocks of 30. Different questions are asked of the patient/GP in each block of 30 forms and these vary throughout the year.
- The annual BEACH data collection period is broken down into 10 five-week periods of recording and new SAND substudies are introduced (unless the topic is to be repeated) at the end of a five-week block.
- With the exception of the standard risk factor SAND substudies that run throughout the year, other topics run for a five-week period collecting information from about 100 GPs (20 recording per week), with a potential sample size of about 3,000 patient encounters in each topic.
- The order of SAND sections in the GP recording pack is rotated, so that the 40 patient risk factor forms may appear first, second or third in the pad. Rotation of ordering of the components ensures there is no order effect on the quality of the information collected.

Each organisation supporting the BEACH program has access to a subsample of 6,000 encounter forms per year (or two subsamples of 3,000 each) in which to insert a series of questions on a subject or subjects of their choice.

The development of the tools for SAND substudies

Organisations supporting the BEACH program financially are given set dates for the two blocks they can use in the coming BEACH year. Consideration is given to any specified seasonal needs (such as studies of patient influenza vaccination status which are of more value in winter than in January before the annual round of vaccinations).

Organisations are actively encouraged to select subjects that will arise with sufficient frequency in the sample to make the study worthwhile. For example, while prostate cancer is an increasingly important risk for men's health, asking questions about its management among males attending general practice would provide a very small sample of respondents since: 60% of the respondents in the 3,000 sample would be female (and therefore not asked the question); of the remaining 1,200 males encountered by the GP in that sample, only about 220 would be aged 45 years or over (on average). Since those at highest risk are patients aged 75 years and over, and GPs are advised against routine screening for prostate cancer, the chances of picking up more than a couple of cases are minimal.

The organisation sends their nominated topic and a series of research questions to the SAND coordinator in the BEACH team. Sometimes the research questions could be seen as a 'wish list' and the challenge is to design a SAND substudy that will answer as many of these questions as possible within the limited space available and without demanding too much of the GP.

The characteristics of tools that can be used within the confines of the GP–patient encounter, by GPs pressed with time issues, are brevity, face validity and simplicity. The tool should be easy to administer verbally and quick to complete.

The SAND coordinator works with the representatives of the organisation to refine the objectives to a workable level, and prepares an initial draft of questions and instructions. It then becomes an iterative process between the researchers and the client organisation. At various stages of development input is gained from other members of the research team. The analysts' comments are useful to ensure that at the end of the process, the data can be analysed in a manner that will satisfactorily answer the research questions. The view of the database manager is important in ensuring that the new SAND database can be built in a manner that assists the coding staff. Coder training staff views are useful in picking up questions which have the potential to generate wide ranging responses and present coders with problems in reliable data entry. Often the input of the Medical Director is required to ensure clinical accuracy and relevance of the questions being asked, but most importantly to ensure that the final set of questions and its accompanying instructions will 'make sense' to the GP in a clinical setting. Throughout this process the research team use their extensive experience to hypothesise the many likely responses to the questions and revise response options as appropriate.

By the time the questions are completed and ready to be sent to the Ethics Committee for approval, an average of five drafts will have been developed over a period of about 4 weeks.

The final tools, (and where appropriate the rationale for this SAND study) are then sent to the AIHW Ethics Committee for approval (on behalf of the Institute and the University of Sydney) prior to printing and distribution to the GPs.

Wherever possible we try to use questions and definitions that have been validated and published elsewhere. For example, the definitions for severity of asthma in adults and in children (Abstract 96) rely on the severity classifications produced by the National Asthma Council. If all the questions utilise internationally or nationally accepted published tools, there is no need to apply for Ethics approval. However this is rarely the case.

The relationship of the SAND substudies to the data elements collected in the total BEACH program is graphically presented in Figure 1. It demonstrates that the SAND data can be cross analysed with data about the GP, the patient, or the content of the encounter.

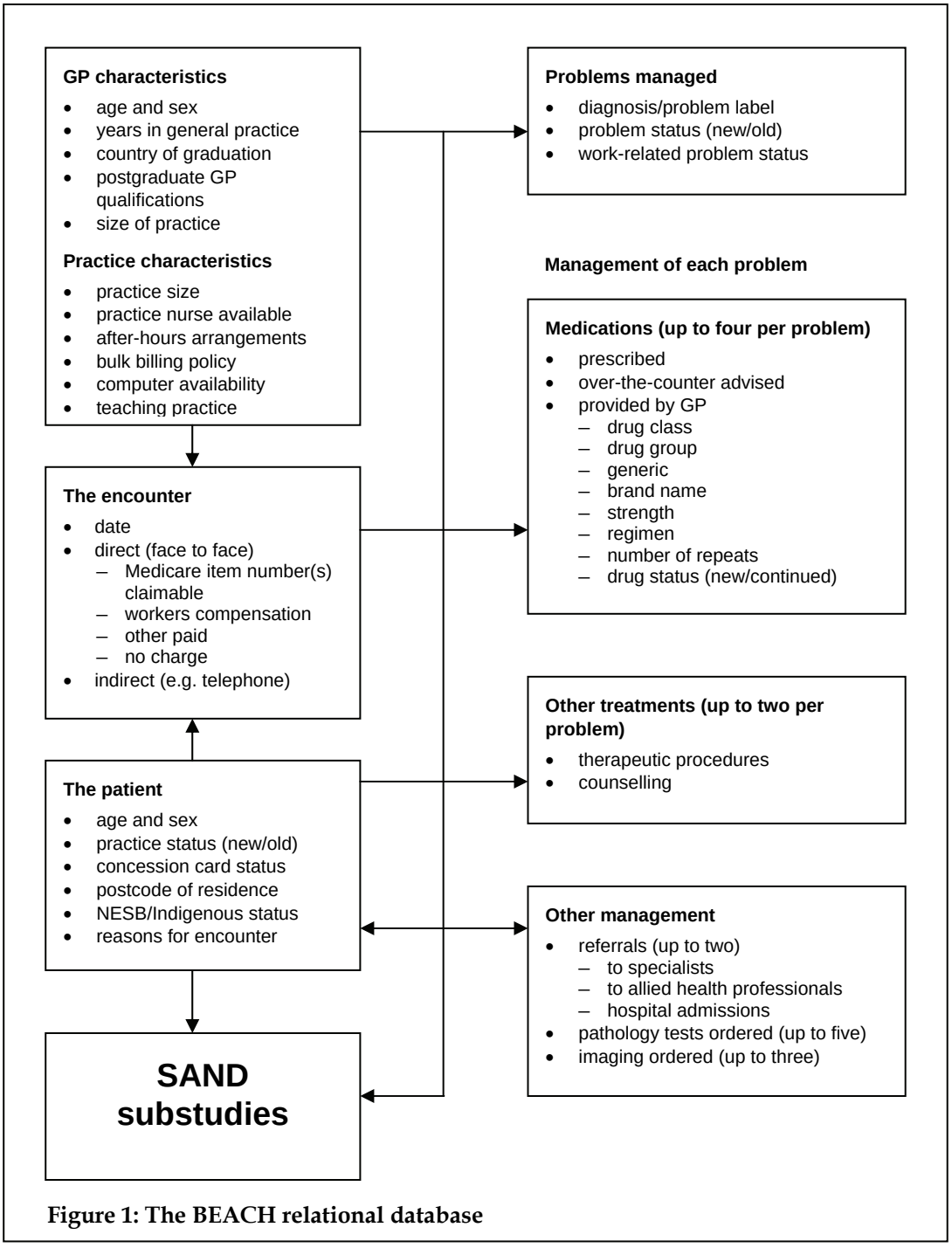


Figure 1: The BEACH relational database

Statistical methods

The analysis of the SAND substudies included in this report were conducted with SAS version 6.12[15] for all studies conducted between 1999–00 and 2004–05. Topics investigated since then were analysed using SAS 9.1.[16]

The BEACH study is a random sample of GPs, each providing data about a cluster of patients on a specific topic. We use the patient as the unit of inference when the data are analysed and interpreted. However, the cluster sampling study design violates the simple random sample (SRS) assumption of equal probability of selection of a patient, because the

probability of a patient being included is a function of the probability of the GP being selected.[17] Cluster samples also violate the assumption of independence of observations, as there is an inherent relationship between patients sampled in the same cluster. Therefore the certainty that the sample estimates reflect the true underlying population values is reduced by cluster sampling, and decreases the precision of prevalence or management estimates. When a study design other than SRS is used, analytical techniques that consider the study design must be employed.

In this report, the standard error calculations used in the 95% confidence intervals accommodate the single-stage clustered study design according to Kish's description of the formulae.[18] SAS version 9.1 includes procedures that calculate the robust standard error to adjust for the intra-cluster correlation of the cluster sample. In contrast, SAS version 6.12 is limited in its capacity to calculate the standard error for the current study design, so additional programming was required to incorporate these formulae, in earlier years.

Classification of data

If recorded in free text in a SAND substudy, the following data elements are classified according to the International Classification of Primary Care—Version 2 (ICPC-2), a product of the World Organization of Family Doctors (Wonca):[19]

- problems managed
- clinical treatments (e.g. counselling, advice) and therapeutic procedures
- referrals to specialists and allied health providers, pathology and imaging tests ordered.

Pharmaceuticals recorded in free text in SAND substudies are coded and classified according to an in-house classification, the Coding Atlas for Pharmaceutical Substances (CAPS).

- This is a hierarchical structure that facilitates analysis of data at a variety of levels, such as medication class, medication group, generic composition, brand name. Strength and regimen are independent fields which, when combined with the CAPS code, allows us to derive prescribed daily dose for any prescribed medication or group of medications.
- CAPS is mapped to the Anatomical Therapeutic Chemical (ATC)[20] classification which is the Australian standard for classifying medications at the generic level. The ATC has a hierarchical structure with five levels. For example:
  - Level 1: C—Cardiovascular system
  - Level 2: C10—Serum lipid reducing agents
  - Level 3: C10A—Cholesterol and triglyceride reducers
  - Level 4: C10AA—HMG CoA reductase inhibitors
  - Level 5: C10AA01—Simvastatin (the generic drug).

3 Lessons learnt

It is relatively rare for a research team to have the opportunity to conduct so many studies with the same basic methodology, among the same population, over such a long period. We have learnt many things over the last nine years in the SAND substudies and we have developed a number of rules of thumb when designing SAND research tools. We freely admit that the later SANDs are far better than the earliest SANDs, as we have moved through a continuous quality improvement program over the years.

In SAND substudies we are using the GP as an expert interviewer of his/her patient and are utilising his/her knowledge of the patient rather than relying purely on patient recall. The GP is an ideal person to ask patients about their health and health issues. Patients expect GPs to ask them questions about their health and their health behaviours and (we hypothesise) are likely to be more honest with their GP than with an interviewer (unknown to the respondent) approaching them for self-reported health information.

Some GPs have reported that some patients appear relieved when asked for specific information about their, for example, alcohol intake, as if this had concerned them but they had not raised it with their GP, or had not made their consumption levels clear to their GP on earlier occasions. Others report that they find completing the patient risk behaviours SAND provides them with an 'excuse' to raise these issues with their patients.

However, while some of the SAND substudies may assist the GP in initiating discussion with their patient about a specific topic, the GPs time must always be considered. If the additional time needed to ask the questions is too great they will simply drop out of the BEACH study altogether.

In an environment of increasing workforce shortages, many GPs are strapped for time. The tools we design for SAND must therefore be brief, simple to administer verbally and quick to complete. However, they must also provide valid and reliable results.

3.1 Rules of thumb in SAND tool design

Remember your research impacts on a busy GP's day

Completing the questions on the SAND form can sometimes be difficult for the GP. We tell GPs to leave the SAND section blank if they feel unable to ask the questions of a particular patient. This approach considers the nature of general practice, for example:

- the patient may not be seeing their regular GP and may not be comfortable answering specific health questions not related to the problems managed at the encounter
- the type of encounter (e.g. telephone encounter) and the parallel need for patient agreement for their data to be included in the BEACH program may make completion of the questions impossible
- the morbidity being managed (e.g. crisis situation such as suicide attempt, relationship breakdown, acute bereavement) may mean it is inappropriate for the GP to ask the SAND questions, which are not related to the crisis under management
- the patient (e.g. the cognitively impaired) may not be competent to give informed consent to the use of their data, or to answer the questions being asked.

Impact on GP time

In any study using GPs to complete information about clinical activity or about patients, the participating GPs are being very generous in giving their time to the study. If you ask for too much it can result in GP overload and withdrawal from the study.

Each GP has three sets of SAND forms across their 100 BEACH forms. Therefore we have to consider the GP workload in terms of the combined effect of the three SAND topics. Some topics require the GP to ask every patient encountered all questions in that SAND. Examples include *Patient cultural background* (Abstract 95) and *Prevalence of chronic illnesses identified as National Health Priority Areas (*Abstract 61). Other SAND surveys have a filter question that limits the remainder of the questions to those who say 'Yes' to the first question. Examples are: *Prevalence and management of chronic pain* (Abstract 82) and *Lipid management in patients with high risk conditions (*Abstract 99*).*

In the 40 patient risk factor SAND forms in each GP's research pack (see Chapter 4), start and finish times for the consultations, and patient-reported height and weight are required for all patients and the alcohol and smoking questions are asked of all patients aged 18 years or more. We try to ensure that in a research pack we do not include two other SAND topics that require all questions to be asked of all patients, so that the GP will get at least one SAND topic that relies on a filter question, thus reducing the overall workload.

Filter questions

When possible, for the topic under investigation we use a filter question to identify the patients of interest who meet certain criteria. For patients who have been identified (for example, patients with a specific condition) GPs are asked to complete additional questions. For patients who do not meet the criteria for inclusion, GPs are instructed to end the questions. Examples of filter questions are provided in Box 1.

Box 1: Examples of filter questions used as the first question in a SAND survey

Does this patient have Type 2 diabetes? ☐ Yes ☐ No→ end questions	Does this patient have any of the following risk factors? (Tick all that apply) ☐ Existing CHD ☐ Diabetes mellitus ☐ Familial hypercholesterolaemia ☐ Elevated cholesterol ☐ Family history of CHD ☐ Peripheral vascular disease ☐ None of the above→end questions

Enumerating and describing not judging or criticising

The BEACH study aims to describe what is really happening in general practice. We therefore try to avoid creating scenarios where the GP might feel that his/her management is being questioned or judged. The last thing we want (for both data reliability and continued participation) is for clinicians to feel they have to justify their management. For example, the box at the top of the GP instructions for *Prevalence, cause and severity of adverse pharmacological events* (Abstract 56), emphasises that this SAND is an investigation of the impact of pharmacological adverse events in the community, and that the GP may be unaware of the event, either because the patient did not inform them, or the event was related to a medication provided elsewhere. The study is not asking about clinician error or seeking to assign blame anywhere or to anyone for the adverse event.

Not intruding on the GP–patient relationship

When designing a SAND the relationship between the GP and patient is always considered.

A simple example is our choice not to ask patients aged between 14 and 17 years the SAND questions on current smoking status and usual alcohol consumption. While it is certainly legal for the GP to ask such questions of patients in this age group we believe that they would often be intrusive on the GP–patient relationship. Teenagers show a massive decrease in attendances with GPs at about 15 years of age (boys more so than girls)[21] so this is a patient group that should be encouraged to build a relationship with their GP. Such questions (purely for research purposes) may well challenge the likelihood of further visits.

In other SANDs, such as the study on the prevalence of premature ejaculation (Abstract 93) we specifically tell the GP to stop the questions 'if you feel at any stage that these questions intrude too greatly on your relationship with this patient'.

Sensitive topics

Some topics covered in SAND can be sensitive. With practice we have learnt that in these cases we should provide the GPs with information about the issue and the reason we are investigating. For example, for the study on premature ejaculation (Abstract 93), we provided background information about the lack of data generally available on this topic.

Some questions may appear somewhat invasive if asked directly so in such circumstances we have found it best to 'couch' the sensitive issue as one part of multiple categorical options with tick boxes. For example, *Management of depression and anxiety (*Abstract 47) in the third question, the research interest really centred on the possible effect of the specified medications on sexual function. Rather than ask a direct question on this possible effect, we 'buried' it among a series of six possible effects, softening the question asked of the patient.

The question of patient honesty

Sometimes we need to find out whether a patient is doing something that they are not supposed to be doing. The question might then arise as to the likelihood of an honest patient response. We therefore avoid using questions where honesty may be compromised.

Again the questions about smoking status and alcohol consumptions among patients of 14–17 years are good examples. We are uncertain of the likelihood of receiving an honest answer from these young people if they are accompanied by a parent/relative/carer or where the GP is the usual doctor seen by other members of their family.

The way you ask the question has a direct effect on the result

The use of tick boxes versus free text

Whenever possible we use categorical response variables (tick box options) rather than open ended questions requiring free text entry. This provides a more reliable response. For example in the first study on patient comorbidity (*Prevalence of common morbidities in patients encountered in general practice,* Abstract 37) we simply asked the GP to list in free text all (up to 12) *'other significant diagnoses/problems… not managed at today's encounter'*. In later studies (e.g. *Prevalence of chronic illnesses identified as National Health Priority Areas among general practice patients*, Abstract 61) we asked '*Does this patient have any of the following conditions which require ongoing management?*' and offered a series of tick boxes of morbidities related to the National Health Priority Areas (categorical responses). We believe the later method generated more reliable results, which demonstrated repeatability in a later study (*Estimates*

of the prevalence of chronic illnesses identified as Health Priority Areas among patients attending general practice, Abstract 89*)*.

Three different measures of the prevalence of asthma among general practice patients

The structure of the question (described above), combines with the independent influence of the SAND topic, on the final results. For example, we have undertaken 10 SAND studies that include a filter question on whether or not the patient has asthma, to generate estimates of asthma prevalence among patients attending general practice.

Sample sizes range from 2,500 to 11,300 respondents. These are summarised in Table 1.

- Between March 1999 and December 2004 there were six SAND studies that used a filter question. GPs were instructed to ask each patient if they *'currently suffer from asthma?'* The six studies produced remarkably consistent results, even without age–sex standardisation for minor difference in the age–sex distribution of the respondents in each sample. Prevalence of asthma was consistently estimated to be between 12.8% and 14.7%, with no significant differences between results, as judged by overlapping 95% confidence intervals around the estimates (see Abstracts 3, 22, 39, 48, 63, 70).
- In the midst of this 1999–2004 period, we ran a SAND which asked the GP to describe in free text the patient's major comorbidity not managed at the encounter, including: '*chronic illnesses or other health problems that requires continuing management or surveillance; past problems with may need consideration in future care; any significant health influencing social problems'*. Spaces were provided for up to 12 free text descriptors (Abstract 37). The estimated prevalence for asthma was significantly lower at 8.8% (95% CI: 8.1–9.5).
- In late 2003–early 2004 we again investigated the issue of comorbidity using categorical tick box responses for a list of selected national health priority areas (including asthma). The GP was asked: *'Does this patient have any of the following conditions which require ongoing management'*. This method generated an asthma prevalence estimate of 11.4% (95% CI: 10.5–12.3) (Abstract 61). Using the same method in 2005 we gained an estimate of 10.7% (95% CI: 9.8–11.6) (Abstract 89).

Table 1: Summary of methods, samples and results for asthma prevalence across multiple SANDs

Method	Abstract no.	Page	Number of respondents	Data collection period	Estimated prevalence (95% CI)
Filter question	3	32	4,285	03/99–06/99	14.7 (13.3–16.1)
Filter question	22	75	5,495	11/00–01/01	12.8 (11.4–14.3)
Free text—Comorbidity	*37*	*109*	*11,342*	*08/01–03/02*	*8.0 (95% CI: NA)*
Filter question	39	113	3,070	04/02–05/02	13.9 (12.0–15.7)
Filter question	48	132	2,686	09/02–10/02	14.5 (12.7–16.2)
Categorical (NHPAs)	*61*	*160*	*8,911*	*08/03–01/04*	*11.4 (10.4–12.3)*
Filter question	63	164	2,527	09/03–10/03	14.5 (12.6–16.1)
Filter question	70	181	7,919	09/04–12/04	13.0 (11.9–14.0)
Categorical (NHPAs)	*89*	*223*	*9,156*	*07/05–11/05*	*10.7 (9.8–11.6)*
Filter question	96	238	5,911	02/06–06/06	11.6 (10.6–12.7)

Note: NHPAs—National Health Priority Areas; NA—not available.

- Most recently, in mid-2006 we repeated the asthma filter question (Abstract 96) and gained a similar result 11.6 (10.6–12.7) to previous asthma SAND substudies with filter

questions but one that is suggesting a trend towards lower prevalence of asthma among patients attending general practice. It will be interesting to see if this trend continues.

We conclude that the use of a filter question centred on the topic of asthma provides a slightly higher estimate of prevalence than the inclusion of asthma as one of many morbidities with tick boxes provided, and that free text recording of comorbidity present in the patient gives the lowest prevalence estimate. Considering the relative consistency of the results, we would regard the free text recording of comorbidity as less reliable than the other two approaches.

Structures to assist in counting the true level of missing data

The structure of the questions should ensure that a response is possible from all who should answer it, even if the response is 'Don't know'. For example: if you only offer 'Yes' and 'No', where the information is not available the GP will leave it blank. If you offer 'Don't know' in addition to the other options, where the information is not available the GP can tick this option, thus reducing the size of the missing data. Such methods allow a better estimate of the true size of missing data. Keep in mind that where missing data for a question are greater than 5% the reliability of the result is in question.

Questions on clinical opinion

In SAND we sometimes ask GPs to make a judgement based on their clinical opinion rather than based on, for example, formal guideline objectives. Judging a patient's progress based purely on guidelines does not consider the rest of the patients 'health picture'. The patient may have other complex morbidities or personal history which means that they may not meet the guideline targets for management but in the GPs clinical opinion are meeting targets that are as good as could be expected in that patient. This is a wholistic approach rather than a clinical trial approach. An example can be found in *Diabetes Types 1 and 2 and coronary heart disease* (Abstract 86) where the question on the adequacy of the current control of the patient's cholesterol relies on clinical opinion.

The need for definitions

In many cases the diagnostic label applied to a problem is clinical opinion rather than proven by tests, or by strict application of definitions (many of which have been designed in secondary and tertiary care). If asking whether the patient has been managed for depression in the previous 12 months, there is no point in providing a DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th edition) definition of depression—the patient either has, or has not, been managed for depression in the past 12 months, however it was defined at the time by the GP, a psychologist or a psychiatrist.

At other times providing a definition is essential to gain internal consistency among GP responses. For example in *Prevalence and management of chronic pain* (Abstract 42) we relied purely on the GP's clinical judgement in deciding whether or not the patient suffered from 'chronic pain'. When trying to publish the results internationally we were criticised for not selecting and providing the GPs with any one of a myriad of available definitions of 'chronic pain'. In Abstract 82 we repeated this topic and included a definition of 'chronic pain' to gain more reliable results.

We also provide definitions for disease attributes when there are standard definitions available. Abstract 48 is an example. We provided definitions for asthma severity among children and among adults, using the National Asthma Council's severity classification.

Questions that are not answered well

Some questions we have tried are answered poorly compared with others. These include:

- Questions that require the GP to look back over their clinical notes to find the answer. For example, lipid levels prior to starting medication—the patient may have started medication for lipid treatment more than 5 years ago and locating the record of the lipid level at the start of medication treatment may be difficult. Further, the patient may have started on treatment when at another practice and records may not be available to the current GP. Reliability of patient recall of such a result would probably be poor.
- Medication regimen information (i.e. complete dosage information). This is well recorded in the encounter form but not in the SAND form (unless the medication was prescribed today). Though the medication name appears to be easily recalled by the GP or patient, strength and dosage information are poorly reported. We hypothesise that this is because the GP may not be the prescribing doctor and the patient does not recall the details. Alternatively the GP may need to look through past notes to find the regimen data.
- Questions on duration of condition or duration of a treatment or medication, for example, *How long ago was the patients diagnosed with condition x? Specify number and circle weeks/months/years*. Depending on the time that has lapsed, if the data are not in the medical record the recall of the patient or the GP may be limited. If the research question can be answered with multiple choice, then use this option (e.g. <1 year, 1–3 years, > 3 years) as reliability will be far greater.

Always remember that in the current Australian health care system a single patient may have multiple complex problems, may see multiple GPs and may be managed simultaneously by many health professionals. Do not assume that a complete health record for the patient is available to the GP.

Use of a suitable timeline for patient/GP recall

Length of accurate recall by patients and GPs can be limited. 'Within the last 6 months', 'during the last 12 months' or 'in the past' will provide results with varying degrees of accuracy. However, the most suitable recall time period will depend on the subject under investigation. For example: a question on whether the patient had been hospitalised could be asked for the previous 12 months, as it is a reasonably major event in anyone's life and therefore likely to be recalled. It also has a high chance of being in the patient's medical record.

However, when asking about the grade of pain suffered by people with chronic pain (see Abstract 82), we limited the time period to the last week. Using a 12 month recall period here would require the patient to try and average all his/her ups and downs in pain levels over a 1 year period and would be highly unreliable.

Inadequate planning with insufficient space on the form

In a few SANDs we have asked about current medication for the morbidity of interest and allowed space for only one medication to be recorded. On receipt of the completed forms we found a number where the GP had recorded two medications by squeezing them into the allotted space. This means that at least two spaces should have been provided. However, having limited the GPs to one, we cannot assume that those who recorded only one, did so

even in cases where multiple were involved. Such errors lead us to question the validity of the final result about medications for that SAND.

Is general practice an appropriate setting for the subject?

Not every subject of patient health and lifestyle is appropriate to investigate in a GP-based study of this type. There is one SAND study not reported in this book because it failed. The subject of the SAND was the amount and type of physical activity performed by the patient in the week prior to this encounter. So many patients reported that they had no exercise in the previous week, due to ill health, that we rejected the study as inappropriate. A question on average exercise levels over the previous month may have been more productive.

3.2 Methodological issues

Test–re-test reliability of the SAND studies

Where a SAND question has been repeated on a number of occasions we have an opportunity to investigate test–re-test reliability of the measure among different groups of GPs asking the questions of different sets of patients. If the method is to be regarded as reliable, prevalence estimates of a morbidity should remain constant, except where there has (in truth) been a change in the prevalence of the morbidity in the population at large.

Henderson et al. compared estimates of asthma prevalence generated from four SAND studies conducted in four different 5-week periods between March 1999 and October 2002. They demonstrated no significant difference in the estimated prevalence of asthma and no significant differences in severity levels over time for either adults or children.[22]

Similarly, Miller et al. demonstrated consistent results among three SAND studies that investigated adverse drug events experienced by responding patients over the previous 6 months. The subject was repeated twice because we were surprised by the result in the first SAND block—that 10% of patients seen by the recording GPs had experienced an adverse pharmacological event during the previous 6 months. The repeats produced the same result, demonstrating the reliability of the method.[23]

Recording effect

It is possible that asking SAND questions about a specific topic will affect the frequency of management of that problem at the encounter, and/or the management actions at the encounter for the morbidity studied in the SAND. This has been investigated for the patient risk behaviours: weight (BMI), alcohol and smoking, to test whether asking these questions results an in increased likelihood of them being managed at the encounter. This investigation found no significant effect.[7] However, through our observation of the data we believe it may influence GPs' encounter behaviour in certain circumstances, though probably only for the encounters including that SAND topic. For example, we hypothesise that asking for the most recent HbA1c result for a patient with diabetes, and the time since that last test was done, may increase the chance that the GP will order a HbA1c at that encounter for the patients who have not had this tested for more than 6 months. We plan to undertake further analysis to determine if a range of SAND substudies influence the content of that encounter.

4 SAND substudies conducted continually since April 2000

Issues: Four topics have been included in all research packs for all GPs, since 1 April 2000. These are:

- patient-reported height and weight, from which patient BMI is calculated separately for adults and for children
- patient-reported current smoking status (adults aged 18 years and over)
- patient-reported alcohol consumption (adults aged 18 years and over)
- length of consultation for encounters claimable as A1 Medicare items of service (in minutes).

Results for these studies are reported every year in each annual BEACH report[8,24-28] and are only summarised here.

Sample: GP completion of questions about the three patient risk measures and start and finish times for the encounter was requested in 40 encounter forms out of every 100 forms completed by each GP from April 2000 to March 2006. Although the patient risk factor questions were asked of subsamples of patients in 1999–00, all three questions were not asked of the same patient until 2000–01. The results presented here are limited to the study years of 2000–01 to 2005–06 as the three questions were asked of the same patient subsample.

Method: Detailed SAND methods are provided in Chapter 2.

4.1 Body mass index of adults

Sample: Patients aged 18 years and over, total sample from 2000 to 2006=191,580 comprising: *n*=31,957 in 2000–01; *n*=31,789 in 2001–02; *n*=32,367 in 2002–03; *n*=31,890 in 2003–04; *n*=30,476 in 2004–05; *n*=33,101 in 2005–06.

Methods for this study: The BMI for an individual is calculated by dividing weight (kilograms) by height (metres) squared. Metric conversion tables (feet and inches; stones and pounds) were provided to the GP.

In 2005–06 the WHO recommendations[29] for BMI groups were adopted. These specify that a person with a BMI:

- less than 18.5 is underweight
- greater than or equal to 18.5 and less than 25 is normal
- greater than or equal to 25 and less than 30 is overweight
- of 30 or more is obese.

This has affected the division between underweight and normal weight, which in previous reports was set at a BMI of 20, but is now set at 18.5. For more detailed data refer to *General practice activity in Australia 2005–06*[8] in which the BMI data for previous years have been re-calculated according to the WHO criteria.

Results: The proportion of patients classed as overweight or obese has remained relatively steady over time with between 54.3% and 57.0% of patients classed as overweight or obese. From 2000–01 to 2005–06 there was a statistically significant increase in the proportion of adults classed as obese from 20.2% (95% CI: 19.5–20.8) to 22.2% (95% CI: 21.5–22.9). There was no change in the proportion of patients classified as overweight (34.1% compared with 34.6%).

These results are consistent with those of the 1999–00 AusDiab study[30] and the results reported for each BEACH year from 2000–01 onwards.[27] They are also broadly consistent with the Australian Bureau of Statistics 2001 figures from the National Health Survey of 58% of adults aged 18 years or more being overweight or obese.[31]

For other related abstracts see: 55 Patient weight, perception of weight and weight loss, 68 Patient weight, perception of weight and weight loss in adults, 69 Patient weight, methods and medications tried for weight loss in adults, 71 Patient BMI, morbidity and medication use in adults.

Further reading:

Charles, J., Britt, H., & Knox, S. 2006, 'Patient perception of their weight, attempts to lose weight and their diabetes status', *Australian Family Physician*, vol. 35, no. 11, pp. 925–928.

4.2 Body mass index of children

Sample: Children aged between 2 and 17 years, total sample from 2000–06=21,066, comprising: *n*=3,831 in 2000–01, *n*=3,692 in 2001–02; *n*=3,579 in 2002–03; *n*=3,301 in 2003–04; *n*=3,184 in 2004–05; *n*=3,479 in 2005–06.

Methods for this study: Metric conversion tables (feet and inches; stones and pounds) were provided to the GP.

The standard BMI calculation described above is not appropriate for children. Cole et al. developed a method which calculates the age–sex-specific BMI cut-off levels for overweight and obesity specific to children.[32] This method, based on international data from developed Western cultures, is applicable in the Australian setting. There are three categories defined for childhood BMI: underweight/normal, overweight and obese.

Results: There has been no change in the proportion of children classed as overweight/obese since 2000–01, when 13.6% (95% CI: 11.0–16.2) were classed as obese and 17.8% (95% CI: 16.2–19.4) as overweight, in total 31.4% (29.4–33.4) being overweight or obese. In 2005–06 the results demonstrated that 11.9% (95% CI: 10.6–13.2) were classed as obese, and 18.6% (95% CI: 17.2–19.9) as overweight, a total of 20.5% (95% CI: 28.6–32.3) being overweight or obese. For more detailed data about BMI of children attending general practice refer to *General practice activity in Australia 2005–06.*[8]

4.3 Smoking

Sample: Patients aged 18 years and over, total sample 2000–06=194,312, comprising: *n*=32,124 in 2000–01, *n*=31,966 in 2001–02; *n*=32,651 in 2002–03; *n*=32,718 in 2003–04; *n*=31,295 in 2004–05; *n*=33,558 in 2005–06.

Methods for this study: Respondents were limited to adults aged 18 years and over because there are concerns about approaching the younger patient group to ask for information on smoking for survey purposes. In addition, the reliability of this information from patients aged 14–17 years may be compromised if a parent is present.

Results: The proportion of adults attending general practice who are daily smokers has decreased from 19.3% (95% CI: 18.5–20.1) in 2000–01 to 17.1% (95% CI: 16.3–17.8) in 2005–06. For more detailed data about the smoking status of patients attending general practice refer to *General practice activity in Australia 2005–06*.[8]

For other related abstracts see: 12 Smoking and passive smoking in general practice patients, 35 Smoking status of adults and their attempts to quit, 53 Smoking status of adults and their attempts to quit, 74 Smoking and passive smoking in the home.

Further reading:

Doran, C. M., Valenti, L., Robinson, M., Britt, H., & Mattick, R. P. 2006, 'Smoking status of Australian general practice patients and their attempts to quit', *Addict.Behav.*, vol. 31, no. 5, pp. 758–766.

Valenti, L., Charles, J., & Britt, H. 2005, 'Passive smoke in Australian homes: 1999 to 2004 [letter]', *Australian and New Zealand Journal of Public Health*, vol. 28, no. 4, pp. 387–388.

Degenhardt L, Knox S, Barker B, Britt H, Shakeshaft A. The management of alcohol, tobacco and illicit drug use problems by general practitioners in Australia. *Drug Alcohol Rev* 2005; 24(6):499–506.

4.4 Alcohol consumption

Sample: Patients aged 18 years and over, total sample 2000–06=190,130 comprising: *n*=31,543 in 2000–01; *n*=31,559 in 2001–02; *n*=32,140 in 2002–03; *n*=31,721 in 2003–04; *n*=30,414 in 2004–05; *n*=32,753 in 2005–06.

Methods for this study: Respondents were limited to adults aged 18 years and over because there are concerns about approaching the younger patient group to ask for information on alcohol consumption for survey purposes. In addition, the reliability of this information from patients aged 14–17 years may be compromised if a parent is present.

To measure alcohol consumption, BEACH uses three items from the WHO Alcohol Use Disorders Identification Test (AUDIT),[33] with scoring for an Australian setting.[34] Together, these three questions assess 'at-risk' alcohol consumption in adult patients. The scores for each question range from zero to four. A total (sum of all three questions) score of five or more for males or four or more for females suggests that the person's drinking level is placing him or her at risk.[34] A standard drinks chart is provided to each GP to help the patient identify the number of standard drinks consumed.

Results: There has been a statistically significant increase in the proportion of adults reporting at-risk levels of alcohol consumption from 24.1% (95% CI: 23.3–24.9) in 2000–01 to 25.9% (95% CI: 25.0–26.8) in 2005–06. For more detailed data about alcohol consumption refer to *General practice activity in Australia 2005–06*.[8]

Further reading:

Proude, E. M., Britt, H., Valenti, L., & Conigrave, K. M. 2006, 'The relationship between self-reported alcohol intake and the morbidities managed by GPs in Australia', *BMC Fam Pract*, vol. 7, p. 17.

Degenhardt L, Knox S, Barker B, Britt H, Shakeshaft A. The management of alcohol, tobacco and illicit drug use problems by general practitioners in Australia. *Drug Alcohol Rev* 2005; 24(6):499–506.

4.5 Length of consultation

Sample: Encounters for which an A1 Medicare item of service was claimable, a total of encounters 196,346 encounters 2000–06, comprising: *n*=30,961 in 2000–01, *n*=35,104 in 2001–02, *n*=34,886 in 2002–03, *n*=31,863 in 2003–04, *n*=30,683 in 2004–05, *n*=32,849 in 2005–06.

Methods for this study: GPs were asked to record the encounter start-time and finish-time in hours and minutes. Consultation length was calculated only for A1 Medicare-claimable consultations, as finish time minus start time in minutes.

Results: The length of A1 Medicare-claimable encounters has remained steady over time. In 2000–01 the mean length of these encounters was 14.8 minutes (95% CI: 14.5–15.1) and the median length was 13.0 minutes. In 2005–06 the mean length was 14.9 minutes (95% CI: 14.6–15.1) and median length was 13.0 minutes.

For other related abstracts see: 2 Anxiety/stress, consultation time, level of education, 10 Length of consultation; after-hours arrangements; co-morbidity.

Further reading:

Bindman A.B., Forrest C., Britt H., Crampton P., Majeed A. 2007, 'Diagnostic scope of and exposure to primary care physicians in Australia, New Zealand and the United States: cross sectional analysis of results from three national surveys', *British Medical Journal* (Epub ahead of print).

Britt, H., Valenti, L., & Miller, G. 2002, 'Time for care. Length of general practice consultations in Australia', *Australian Family Physician*, vol. 31, no. 9, pp. 876–880.

Britt, H., Valenti, L., Miller, G. C., & Farmer, J. 2004, 'Determinants of GP billing in Australia: content and time', *Medical Journal of Australia*, vol. 181, no. 2, pp. 100–104.

Britt, H. C., Valenti, L., & Miller, G. C. 2005, 'Determinants of consultation length in Australian general practice', *Medical Journal of Australia*, vol. 183, no. 2, pp. 68–71.

The following pages contain:

- *the recording form and instructions with which the data in this chapter were collected*
- *the standard drinks chart provided to the GPs*
- *the metric conversion tables provided to the GPs.*

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **TIME OF CONSULTATION, & PATIENT RISK FACTORS (BMI, smoking & alcohol).**

You may tear out this page as a guide to completing the following 40 forms.

START Time

:

AM / PM
(please circle)

START TIME

Record the time the consultation STARTED in hours and mins and circle whether the time was AM or PM.

eg. 9: 10

(AM) PM

ASK THE PATIENT:

What is their height (without shoes) ?
What is their weight (unclothed) ?

(You are NOT REQUIRED to weigh or measure the patient, but if the patient is unsure, you may either do so or take information from the medical records.)

ASK THE PATIENT
if over 18 years:

Which category best describes their smoking status?

Tick one box.

Alcohol use

ASK THE PATIENT (if over 18 years old):

1. How often they have a drink containing alcohol?

2. How many standard drinks they have on a typical drinking day? (Use the standard drinks chart supplied if necessary).

3. How often they have more than 6 standard drinks on one occasion?

PLEASE ANSWER ALL 3 ALCOHOL QUESTIONS.
or we cannot determine safety of drinking levels.

FINISH TIME

Record the time the consultation FINISHED in hours and mins and circle whether the time was AM or PM.

eg. 9:28

(AM) PM

Patient's
Height:

cm

Weight:

kg

To the patient if 18+:
Which best describes your smoking status?

- Smoke daily ☐
- Smoke occasionally ☐
- Previous smoker ☐
- Never smoked ☐

To the patient if 18+:
How often do you have a drink containing alcohol?

- Never ☐
- Monthly or less ☐
- Once a week/fortnight ☐
- 2-3 times a week ☐
- 4+ times a week ☐

How many 'standard' drinks do you have on a typical day when you are drinking?

How often do you have 6 or more standard drinks on one occasion?

- Never ☐
- Less than monthly ☐
- Monthly ☐
- Weekly ☐
- Daily or almost daily ☐

FINISH Time

:

AM / PM
(please circle)

BA8

BEACH

Weight Conversion Chart - Stone/pounds (st lbs) - Kilograms (kg)

Weight st lbs	kg	Weight st lbs	kg	Weight st lbs	kg	Weight st lbs	kg	Weight st lbs	kg	Weight st lbs	kg
1'	6	4'	25	7'	44	10'	64	13'	83	16'	102
1'1"	7	4'1"	26	7'1"	45	10'1"	64	13'1"	83	16'1"	102
1'2"	7	4'2"	26	7'2"	45	10'2"	64	13'2"	83	16'2"	103
1'3"	8	4'3"	27	7'3"	46	10'3"	65	13'3"	84	16'3"	103
1'4"	8	4'4"	27	7'4"	46	10'4"	65	13'4"	84	16'4"	103
1'5"	9	4'5"	28	7'5"	47	10'5"	66	13'5"	85	16'5"	104
1'6"	9	4'6"	28	7'6"	47	10'6"	66	13'6"	85	16'6"	104
1'7"	10	4'7"	29	7'7"	48	10'7"	67	13'7"	86	16'7"	105
1'8"	10	4'8"	29	7'8"	48	10'8"	67	13'8"	86	16'8"	105
1'9"	10	4'9"	29	7'9"	49	10'9"	68	13'9"	87	16'9"	106
1'10"	11	4'10"	30	7'10"	49	10'10"	68	13'10"	87	16'10"	106
1'11"	11	4'11"	30	7'11"	49	10'11"	68	13'11"	88	16'11"	107
1'12"	12	4'12"	31	7'12"	50	10'12"	69	13'12"	88	16'12"	107
1'13"	12	4'13"	31	7'13"	50	10'13"	69	13'13"	88	16'13"	108
2'	13	5'	32	8'	51	11'	70	14'	89	17'	108
2'1"	13	5'1"	32	8'1"	51	11'1"	70	14'1"	89	17'1"	108
2'2"	14	5'2"	33	8'2"	52	11'2"	71	14'2"	90	17'2"	109
2'3"	14	5'3"	33	8'3"	52	11'3"	71	14'3"	90	17'3"	109
2'4"	15	5'4"	34	8'4"	53	11'4"	72	14'4"	91	17'4"	110
2'5"	15	5'5"	34	8'5"	53	11'5"	72	14'5"	91	17'5"	110
2'6"	15	5'6"	34	8'6"	54	11'6"	73	14'6"	92	17'6"	111
2'7"	16	5'7"	35	8'7"	54	11'7"	73	14'7"	92	17'7"	111
2'8"	16	5'8"	35	8'8"	54	11'8"	73	14'8"	93	17'8"	112
2'9"	17	5'9"	36	8'9"	55	11'9"	74	14'9"	93	17'9"	112
2'10"	17	5'10"	36	8'10"	55	11'10"	74	14'10"	93	17'10"	112
2'11"	18	5'11"	37	8'11"	56	11'11"	75	14'11"	94	17'11"	113
2'12"	18	5'12"	37	8'12"	56	11'12"	75	14'12"	94	17'12"	113
2'13"	19	5'13"	38	8'13"	57	11'13"	76	14'13"	95	17'13"	114
3'	19	6'	38	9'	57	12'	76	15'	95	18'	114
3'1"	20	6'1"	39	9'1"	58	12'1"	77	15'1"	96	18'1"	115
3'2"	20	6'2"	39	9'2"	58	12'2"	77	15'2"	96	18'2"	115
3'3"	20	6'3"	39	9'3"	59	12'3"	78	15'3"	97	18'3"	116
3'4"	21	6'4"	40	9'4"	59	12'4"	78	15'4"	97	18'4"	116
3'5"	21	6'5"	40	9'5"	59	12'5"	78	15'5"	98	18'5"	117
3'6"	22	6'6"	41	9'6"	60	12'6"	79	15'6"	98	18'6"	117
3'7"	22	6'7"	41	9'7"	60	12'7"	79	15'7"	98	18'7"	117
3'8"	23	6'8"	42	9'8"	61	12'8"	80	15'8"	99	18'8"	118
3'9"	23	6'9"	42	9'9"	61	12'9"	80	15'9"	99	18'9"	118
3'10"	24	6'10"	43	9'10"	62	12'10"	81	15'10"	100	18'10"	119
3'11"	24	6'11"	43	9'11"	62	12'11"	81	15'11"	100	18'11"	119
3'12"	24	6'12"	44	9'12"	63	12'12"	82	15'12"	101	18'12"	120
3'13"	25	6'13"	44	9'13"	63	12'13"	82	15'13"	101	18'13"	120

Height Conversion Table - Feet/inches (ft in) - Centimetres (cm)

Height			Height			Height		
	ft in	cm		ft in	cm		ft in	cm
1'		30	3'		91	5'		152
	1"	33		1"	94		1"	155
	2"	36		2"	97		2"	157
	3"	38		3"	99		3"	160
	4"	41		4"	102		4"	163
	5"	43		5"	104		5"	165
	6"	46		6"	107		6"	168
	7"	48		7"	109		7"	170
	8"	51		8"	112		8"	173
	9"	53		9"	114		9"	175
	10"	56		10"	117		10"	178
	11"	58		11"	119		11"	180
2'		61	4'		122	6'		183
	1"	64		1"	124		1"	185
	2"	66		2"	127		2"	188
	3"	69		3"	130		3"	191
	4"	71		4"	132		4"	193
	5'	74		5"	135		5"	196
	6"	76		6"	137		6"	198
	7"	79		7"	140		7"	201
	8"	81		8"	142		8"	203
	9"	84		9"	145		9"	206
	10"	86		10"	147		10"	208
	11"	89		11"	150		11"	211

STANDARD DRINKS

Because drinks vary a lot in strength, it is useful to know how much alcohol is in each common drink. A STANDARD DRINK is one which contains about 10 grams of alcohol. In the table below, you can see that common servings of different kinds of alcoholic drinks in fact contain about the same amount of alcohol.

Low alcohol beer 2x285ml (2x10oz)	Ordinary beer 285ml (10oz)	Table wine 100 -120ml (3 - 4oz)	Fortified wine 60 ml (2oz)	Spirits (nip) 30ml (1oz)

5 Abstracts and research tools

1 Allergic rhinitis

Organisation supporting this study: AstraZeneca (Australia) Pty Ltd

Issues: Point prevalence allergic rhinitis; current treatment; previous treatment.

Sample: 4,077 encounters from 102 GPs; data collection period: 17/08/1999 – 20/09/1999.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: GPs were asked to ascertain (either by asking the patient or from their knowledge of the patient) whether the patient currently had allergic rhinitis.

If the patient did have allergic rhinitis the GP was asked to determine if the patient was currently taking medication for the problem; if so, which medications; and what previous medications had been used and for how long, to manage their allergic rhinitis.

Summary of results

The age–sex distribution of the respondents was similar to that of the total BEACH sample. The majority of the respondents were females (57.5%).

The point prevalence of allergic rhinitis among the survey population was 18.7% (95% CI: 16.5–20.9). The highest prevalence was among people aged 25–44 years old (24.4%) and the prevalence of allergic rhinitis was similar for males and females (17.0% and 20.0%, respectively).

Among people with allergic rhinitis, 34.4% of people were currently using medication to manage the condition. Roughly half (49.6%) of those currently taking medication used nasal corticosteroid. The most common generic medication was budesonide topical nasal, used by 30.9% of those using medication for allergic rhinitis.

Antihistamines were the most common medication previously used by people with allergic rhinitis. Of people who had previously used antihistamines, 32.4% had used them for over 1 year.

Among people currently using nasal corticosteroids, 40.8% had previously used antihistamines and 13.1% had used no previous medication.

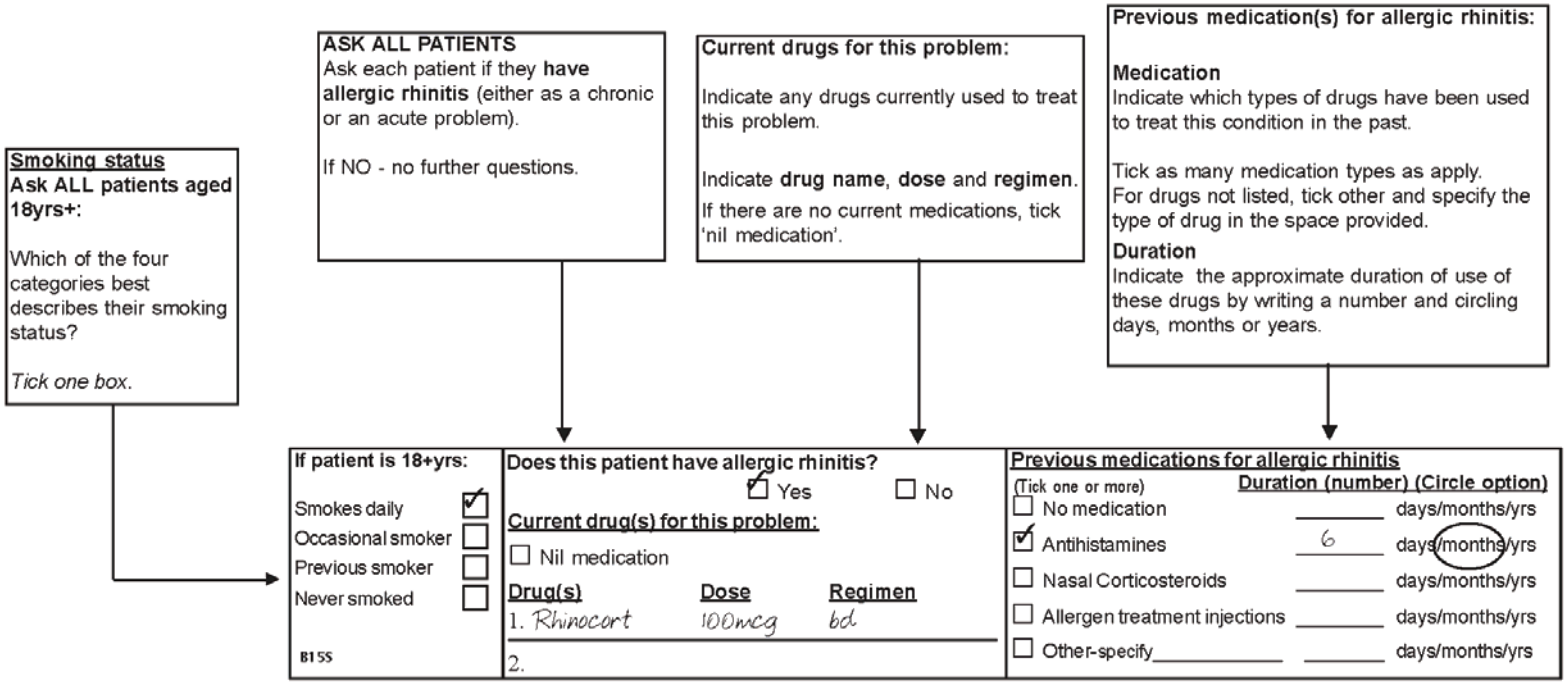
The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **RHINITIS and SMOKING.**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

This form has been filled in as an example.



2 Anxiety/stress, consultation time, level of education

Organisation supporting this study: Commonwealth Department of Veterans' Affairs

Issues: Prevalence of stress and anxiety in general practice and Veterans' Affairs patients; seeking help; level of education; consultation time.

Sample: 3,684 encounters from 100 GPs; data collection period: 18/01/2000 – 18/02/2000.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: There were two components to this SAND. One provided information on patients relating to level of stress and anxiety while the other concerned level of education and length of consultation. The effects of stress and anxiety on the patient and help seeking behaviour were investigated for patients who reported experiencing stress or anxiety in the previous 12 months. The highest level of education obtained by the patient and the length of time each consultation had taken were reported.

Summary of results

Female patients made up 59.4% of the 3,684 respondents, a finding similar to that of the total sample. The age distribution of patients also corresponded with that of the total BEACH sample, with 21.0% of patients aged less than 25 years, and approximately 26% in each of the age groups 25–44, 45–64 and 65 years or older.

Forty per cent (95% CI: 36.8–43.0) of respondents reported experiencing a period of anxiety or stress lasting 2 weeks or more in the previous 12 months. This rate was similar to prevalence reported by those patients who indicated they held a Department of Veterans' Affairs health card (39.6 %, 95% CI: 27.2–52.0). Females (44.6 %, 95% CI: 39.9–49.3) were more likely to have experienced anxiety or stress than males (33.0 %, 95% CI: 28.3–37.8). The highest prevalence of stress and anxiety was among females aged 45–64 years (55.6%, 95% CI: 43.5–67.7).

Among the 1,470 patients who had experienced anxiety or stress, a significant proportion reported that sleep had been affected (79.1 %, 95% CI: 75.8–82.3), and more than half felt their relationships had been affected (55.1 %, 95% CI: 51.0–59.2). Seventy-five per cent (95% CI: 71.5–78.6) of patients who had experienced stress/anxiety had sought help or treatment. Patients were significantly more likely to have sought help from general practitioners (57.9%, 95% CI: 53.6–62.2) than from other health professionals (16.3%, 95% CI: 13.9–18.7) or from family/friends (33.5%, 95% CI: 28.5–38.6).

The average length of these consultations was 16.6 minutes (95% CI: 15.2–18.1). Consultations ranged from approximately 12 minutes for patients in the 5–14 age group to 18 minutes for patients over the age of 75 years.

The highest level of education reached by these patients was most commonly lower secondary school. Patients with TAFE/post secondary other than university level apparently had the longest consultations, but no significant differences were found in consultation length between patients with different levels of education.

For other related abstracts see: 10 Length of consultation; after-hours arrangements; co-morbidity, 13 Perceived stress, 16 Effect of day and time of GP visit on billing method, 41 Time of visit and billing status, 47 Management of depression and anxiety and Section 4.5 Length of consultation.

Further reading:

Bindman A.B., Forrest C., Britt H., Crampton P., Majeed A. 2007, 'Diagnostic scope of and exposure to primary care physicians in Australia, New Zealand and the United States: cross sectional analysis of results from three national surveys', *British Medical Journal* (Epub ahead of print).

Britt, H., Valenti, L., & Miller, G. 2002, 'Time for care. Length of general practice consultations in Australia', *Australian Family Physician*, vol. 31, no. 9, pp. 876–880.

Britt, H., Valenti, L., Miller, G. C., & Farmer, J. 2004, 'Determinants of GP billing in Australia: content and time', *Medical Journal of Australia*, vol. 181, no. 2, pp. 100–104.

Britt, H. C., Valenti, L., & Miller, G. C. 2005, 'Determinants of consultation length in Australian general practice', *Medical Journal of Australia*, vol. 183, no. 2, pp. 68–71.

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 **CONSULTATION TIME, EDUCATION, ANXIETY & SMOKING.**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

This page has been filled in as an example (see below).

START TIME

Record the time the consultation STARTED in hours and mins and circle whether the time is AM or PM.

Ask the patient:

In the past 12 months - was there ever a time lasting 2 weeks or more, when you felt anxious or stressed ?

Tick 'Yes' or 'No'.

If YES,ask the 3 questions shown in the section below:

1. Did this affect your sleep, appetite etc?
Tick one box for each 'Yes' response.

2. Did you seek help from, a GP / other health professional / family or friends?
Tick a box for each correct option, or leave blank if no help sought.

3. Did you take medication:
Tick 'Yes' or 'No'.

Smoking status
Ask patients aged 18yrs+:

Which of the four categories best describes their smoking status?

Tick one box.

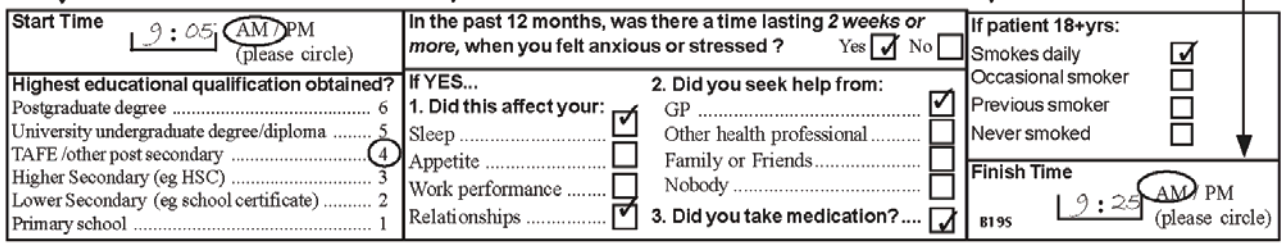
FINISH TIME

Record the time the consultation FINISHED in hours and mins and circle whether the time is AM or PM.

Highest educational qualification obtained

Ask the patient their highest educational qualification obtained.

Circle **ONE** option only.



3 Asthma

Organisations supporting this study: AstraZeneca (Australia) Pty Ltd and Aventis Pharma Pty Ltd

Issues: The prevalence of asthma in the general practice patient population; its severity; current medications for asthma; their effectiveness and any adverse effects of medications.

Sample: 4,285 encounters for 213 GPs; data collection period: 30/03/1999 – 07/06/1999

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: *Levels of severity of asthma for children and adults were listed on a patient card with descriptions of each level. Severity classes for children included infrequent episodic, frequent episodic, and persistent. For adults, the severity classes were very mild, mild, moderate and severe. The severity levels were adapted from the National Asthma Council Asthma Management Handbook 1998.*

Summary of results

The age–sex distribution of the respondents was similar to the distribution for BEACH overall, with the majority (55.8%) of patients being female.

The prevalence of asthma among the 4,285 respondents was 14.7% (95% CI: 13.3–16.1). The highest prevalence was found among patients aged 5 to 14 years (26%, 95% CI: 14.2–37.8). Among children (aged<18) with asthma, 68.5% had infrequent asthma, 21.0% had frequent and 4.9% had persistent asthma. Among adults, 32.9% had very mild asthma, 27.3% had mild asthma, 27.7% had moderate and 7.9% had severe asthma. There was no gender difference in the distribution of asthma severity for children or adults.

Ninety per cent (90.3%, 95% CI: 87.7–93.0) of patients with asthma used some form of medication to manage their asthma. Eighty-three per cent of these patients used reliever medications, 49% used preventer medications and 7% used controller medications. Use of relievers alone was the most common treatment regimen and salbutamol inhaler was the most common single medication used. Twenty-one per cent of patients taking medication used a spacer device, 30% using a small device and 68% using a large device.

Treatment regimens differed by the severity of asthma among children and adults. Relievers alone were the most common regimen for children with infrequent asthma and adults with very mild asthma. Relievers and preventers were most common among children with frequent or persistent asthma and adults with mild or moderate asthma. Ipratropium plus other medications was most common among adults with severe asthma. Salbutamol inhalers were the most common single medication used by patients in all severity categories, except children with persistent asthma who were more frequently prescribed salbutamol nebules.

Among patients taking medication, the effectiveness of the current regimen was rated 5 (effective) on a scale of 1–5 for 46.4% (95% CI: 40.8–51.9). Patients taking relievers only medications were most likely (60.4%) to have a rating of 5 for effectiveness of the medication. Multivariate logistic modelling showed that severity of asthma was associated with effectiveness of treatment but the treatment regimen was not. Seventy-one per cent of patients taking medication reported no adverse effects of the current regimen. Adverse effects were most likely for patients taking ipratropium alone (45%). The most common adverse effect reported was tremor/shakes followed by palpitations. Multivariate logistic modelling showed that severity of asthma was associated with adverse effects of treatment but that medication regimen was not.

For other related abstracts see: 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, 96 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 1 to 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.**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

CHILDREN

Severity*	Common features
Infrequent episodic	Episode 6-8 weeks or more apart; 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; increasing symptoms between attacks; normal examination and lung function except when symptomatic.
Persistent	Symptoms most days; nocturnal asthma > 1/wk; attacks 4-6 weeks apart; daily use of beta2 agonist; 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 admissions in past year; FEV_1 may be significantly reduced between exacerbations.

*Severity categories are adapted from the NAC Asthma Management Handbook, 1998 Edition

ASK ALL PATIENTS
Ask each patient if they **currently suffer from asthma.**

If NO asthma - no further questions.

Severity of asthma
Ask the patients with asthma about the severity of their asthma (see tables above):

Note that your research pack contains a card copy of these tables for easy reference.

Current medications used:
Describe the current medications used in the treatment of asthma listing dose and regimen.

The medication form (metered dose inhaler/ dry powder inhaler / nebules) for each listed drug should be circled.

Spacer device used:
Is any spacer device used?
If so, tick whether it is a large or small volume spacer and circle a number(s) to indicate the drug(s) for which the spacer is used. *(Multiple response allowed).*

Effectiveness of current regimen:
Circle on the scale the effectiveness of the current medication regimen used in the treatment of the patient's asthma.

Adverse effects of current regimen:
Circle on the scale the level of adverse effect ('withdraw' indicates the patient will cease the drug due to adverse effects).

List up to two adverse effects (if any) experienced by the patient with the current regimen, regardless of the effect's severity.

FOR ALL PATIENTS

Asthma? Yes ☐ No ☐ →*End*

Severity

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

B11L

Current drug(s)	Dose	Regimen	Form*
1.			MDI / DPI / NEB
2.			MDI / DPI / NEB
3.			MDI / DPI / NEB

*MDI=metered dose inhaler DPI=dry powder inhaler NEB=nebules

Spacer device used: Large vol. ☐ For drug(s) 1/ 2/ 3
None ☐ Small vol. ☐ For drug(s) 1/ 2/ 3

Effectiveness of current regimen *(circle)*

1 2 3 4 5
Not effective — Effective

Adverse effects of current regimen *(circle)*

1 2 3 4 5
None — Minor — Withdraw

1. 2.

4 Cardiovascular disease

Organisation supporting this study: Aventis Pharma Pty Ltd

Issues: Prevalence of selected cardiovascular disease; recent cardiologist consultations and hospital admissions for these cardiovascular diseases (CVDs); current medication.

Sample: 2,119 encounters from 106 GPs; data collection period: 17/07/1999 – 16/08/1999

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

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

One in four (26.0 %, 95% CI: 22.5–29.6) respondents had been diagnosed at some time with hypertension, congestive cardiac failure, stroke, or ischaemic heart disease (IHD) (including IHD with or without angina, myocardial infarction). Prevalence in males (25.1%) and females (26.8%) was similar. CVD was more prevalent in males aged 45–64 years than in women in this age group but in elderly patients (75+years) it was more prevalent in women than in men. The condition of highest prevalence was hypertension (20.6%, 95% CI: 17.4–23.7) followed by IHD of any type (8.5%, 95% CI: 6.0–10.9). Within the IHD group stable angina was the most prevalent condition (4.9%, 95% CI: 2.11–7.6). The prevalence of Congestive Cardiac Failure (CCF) was estimated to be 3.9% but the small sample size generated wide confidence intervals (0.0–8.4). The same could be said of the prevalence estimates for stroke (2.1%, 95% CI: 0.0–7.5). As expected, the prevalence of each condition increased with age.

Of the 551 patients with a CVD 24.3% (95% CI: 18.9–29.7) had seen a cardiologist in the previous 12 months and 15.8% (95% CI: 8.5–213.1) had been admitted to hospital in the previous year for the condition.

Fifteen per cent of these 551 respondents had an angiogram at some point and 8.0% had undergone a coronary artery bypass graft (CABG).

Ace inhibitors were the most common medication group, being taken by 37.0% of CVD patients and a third of these were taking no other medication for their CVD. Aspirin was also taken by about one-third of respondents with CVD (33.4 %, 95% CI: 28.5–38.3).

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 **CARDIOVASCULAR DISEASE.**

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

INSTRUCTIONS

Has the patient ever been diagnosed with any of the options shown.

- *Tick one or more boxes to* indicate the condition(s) with which the patient has been diagnosed.
  You may tick as many boxes as apply to the patient.

NB. Ischaemic heart disease may refer to stable angina, unstable angina, myocardial infarction or other ischaemic heart disease not specified.

- If the patient does not have any of these conditions, NO FURTHER questions need be asked.

In the past 12 months, for the condition(s) described, has the patient had:

- a cardiologist consultation
- a hospital admission for this problem.

Tick one or more boxes

Has the patient had any of the treatments listed? (either during a hospital admission or as an outpatient)

- indicate which treatment(s) the patient has had *(at <u>any</u> time)*.

Tick one or more boxes

Which cardiovascular medication(s) is the patient currently taking?

Tick the types of cardiovascular medications currently being taken by the patient.

Tick one or more boxes

Patient ever diagnosed with: *(✓ one or more)*	**In the past 12 months (for this condition/s), has the patient had:**	**Has the patient had any of these treatments:** (Tick one or more)	**Which cardiovascular medication(s) is the patient currently taking?** (Tick one or more)	
Ischaemic heart disease ☐		Angiogram ☐	Nitrate-sublingual spray/tablet ☐	ACE inhibitors ☐
Stable angina ☐		Angioplasty ☐	Nitrate - transdermal / oral ☐	A2 antagonists ☐
Unstable angina ☐		Stenting ☐	Beta blocker ☐	Aspirin ☐
Myocardial infarction ☐		CABG (bypass) ☐	Ca channel blocker ☐	Other anti-platelet agents ☐
Hypertension ☐	Cardiologist consult ☐	Thrombolysis ☐	Potassium channel opener ☐	Warfarin ☐
Congestive cardiac failure ☐	Hospital admission ☐	Not known ☐	Diuretic ☐	Heparin (UFH / LMWH) ☐
Stroke ☐				
If NONE of the above - END here				B14L

5 Depression

Organisation supporting this study: Commonwealth Department of Health and Aged Care (Pharmaceutical Branch)

Issues: The point prevalence of depression in general practice patients, the types of depression and methods of management by GPs.

Sample: 8,333 encounters for 309 GPs; data collection periods: 13/07/1999 – 17/08/1999, 26/10/1999 – 30/11/1999, 22/02/2000 – 27/03/2000.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: 'Major depressive disorder' was defined according to DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th edition) criteria to provide guidance for general practitioners reporting this condition.

Summary of results

The age–sex distribution of the respondents was similar to the expected distribution for general practice in BEACH, with the majority (59.4%) of patients being female.

The prevalence of depression among the respondents was 14.4% (95% CI: 13.1–15.7). The prevalence of depression for females (16.2%, 95% CI: 14.7–17.7) was significantly higher than for males (11.8%, 95% CI: 9.6–14.0). The highest prevalence rate of depressive disorder was among patients aged 45–64 year (20.3%, 95% CI: 18.4–22.4).

For nearly half (44.0%) of the patients reported by the GP as having depression, the GP classified the depression as a major depressive disorder. This represents a prevalence of major depression of 6.4% for the total sample. Prevalence of major depression among females was 7.1%, (95% CI: 6.0–8.3) and males 5.3% (95% CI: 3.2–7.4), indicating that there was less difference between males and females in prevalence rates of major depression compared with rates of depression overall.

Of all those with depression, 61% were receiving medication (with or without counselling), 25% were receiving counselling only, and 7% were receiving no treatment. Of those with major depression 85% were receiving medication and 2% were receiving no treatment.

89% of medications taken for depression were antidepressants. The most common medication (generic) reported was sertraline, which accounted for 19.1% of medications for depression and 21.4% of medications for major depression. Selective serotonin reuptake inhibitors was the most common subgroup of antidepressants recorded, accounting for 49% of medications.

For those respondents who were currently taking antidepressant medication, a GP had initiated the course of medication in the majority of cases (72.9%).

Counselling was provided by a GP in 48.5% of cases where the respondents were reported to have depression.

For other related abstracts see: 23 Depression, 47 Management of depression and anxiety.

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 **DEPRESSION and SMOKING STATUS.**

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

INSTRUCTIONS

This form has been filled in as an example.

BOX 1

Criteria for major depression* *DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th edition).

At least FIVE (5) of the following symptoms for at least TWO WEEKS (symptom 1 or 2 must be present):

(1) Depressed mood
(2) Loss of interest or pleasure
(3) Significant appetite or weight loss or gain
(4) Insomnia or hypersomnia
(5) Psychomotor agitation or retardation
(6) Fatigue or loss of energy
(7) Feelings of worthlessness or excessive guilt
(8) Impaired thinking or concentration; indecisiveness
(9) Suicidal thoughts/thoughts of death

In your opinion, does the patient currently have a depressive disorder?

Tick 'Yes' or 'No'.

If you believe the patient's depression is a MAJOR depressive disorder **according to the criteria shown above in Box 1** - *tick 'yes'*

If NO - tick 'No'
and describe the type of depression that in your opinion the patient is suffering from.

For example...

- depression & anxiety (not major)
- manic-depression
- chronic mild depression
- adjustment disorder with depressed mood

Indicate the **current treatment** for the patient's depression.
Tick ONE or MORE of the following options.

Medications
If the patient is taking medication:
- write the medication name(s)
- indicate whether the medication was initiated by a GP or specialist *(circle response).*

Counselling / therapy:
Who is providing the counselling or therapy ?
You may circle more than one option if necessary.

No treatment - if the patient is not currently receiving any treatment, *tick this option.*

Does this patient currently have a depressive disorder?
☑ Yes ☐ No → ***If No, End here***

Is this a major depressive disorder?
☐ Yes ☑ No

***If NO...*How would you describe it?**(specify)
Mild depression and anxiety

How is the patient's depression currently being treated?

☑ Medication (name)	Initiated by
1. Fluoxetine hydrochloride	(GP) / Specialist
2.	GP / Specialist

Provided by
☑ **Counselling / therapy** GP / Specialist / (Other)
☐ **No treatment**

B17L

6 Employment status and workers' compensation claims

Organisation supporting this study: National Occupational Health and Safety Commission

Issues: Employment status; work-related problems and workers' compensation claims

Sample: 8,833 encounters from 221 GPs; data collection period: 21/09/1999 – 26/11/1999

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age–sex distribution of the respondents was similar to the expected distribution of general practice patients, with 51% in the 25–64 age group and the majority of patients (59%) being female.

Of the 8,833 respondents, 52.3% were not in the labour force. Those not in the labour force were mainly retirees (27.0%) and those engaged in home duties (12.9%).

The problems managed at encounter were analysed in relation to total encounters, employment status and workers' compensation claims. Hypertension was the most common problem managed in the total sample (at a rate of 7.7 per 100 encounters, 95% CI: 6.7–8.7). Upper respiratory tract infection (URTI) was the most common problem managed for employed persons (6.4, 95% CI: 5.0–7.7), though this rate was lower than the URTI rate in the total sample. Common problems managed at a higher rate for employed persons than for all persons were back complaints (3.2 per 100 encounters, 95% CI: 0.7–5.6 compared with 2.9, 95% CI: 2.1–3.6) and sprains/strains (2.6, 95% CI: 0.8–4.4 compared with 1.7, 95% CI: 1.0–2.5). Overlapping confidence intervals show no significant differences were found.

Back complaint was managed at the higher rate of 3.9 per 100 encounters with self-employed persons, compared with a rate of 2.9 per 100 total encounters. Malignant neoplasms of the skin were also more often managed among the self employed, at a rate of 2.8 per 100 encounters (compared with 0.9 per 100 encounters in the total data), but numbers were small at this level of analysis precluding statistical comparisons.

Of the 8,833 encounters, 272 (3.1%) included the management of at least one problem that was work-related. A workers' compensation claim was made for 182 (67.0%) of the work-related encounters. Back complaint was the most common problem managed at an encounter where a workers' compensation claim was made.

Of the 90 respondents who stated they had a work-related problem but did not make a claim, only 50 gave a reason why a claim was not made. The most common reason given was 'not serious enough' (22.0%). The 'other' category made up 48% of reasons for not claiming, and an examination of this category showed that most of the reasons given (18% of all reasons) were that respondents were 'self employed'. Another 18% of patients gave 'not covered by employer' as their reason for not making a claim.

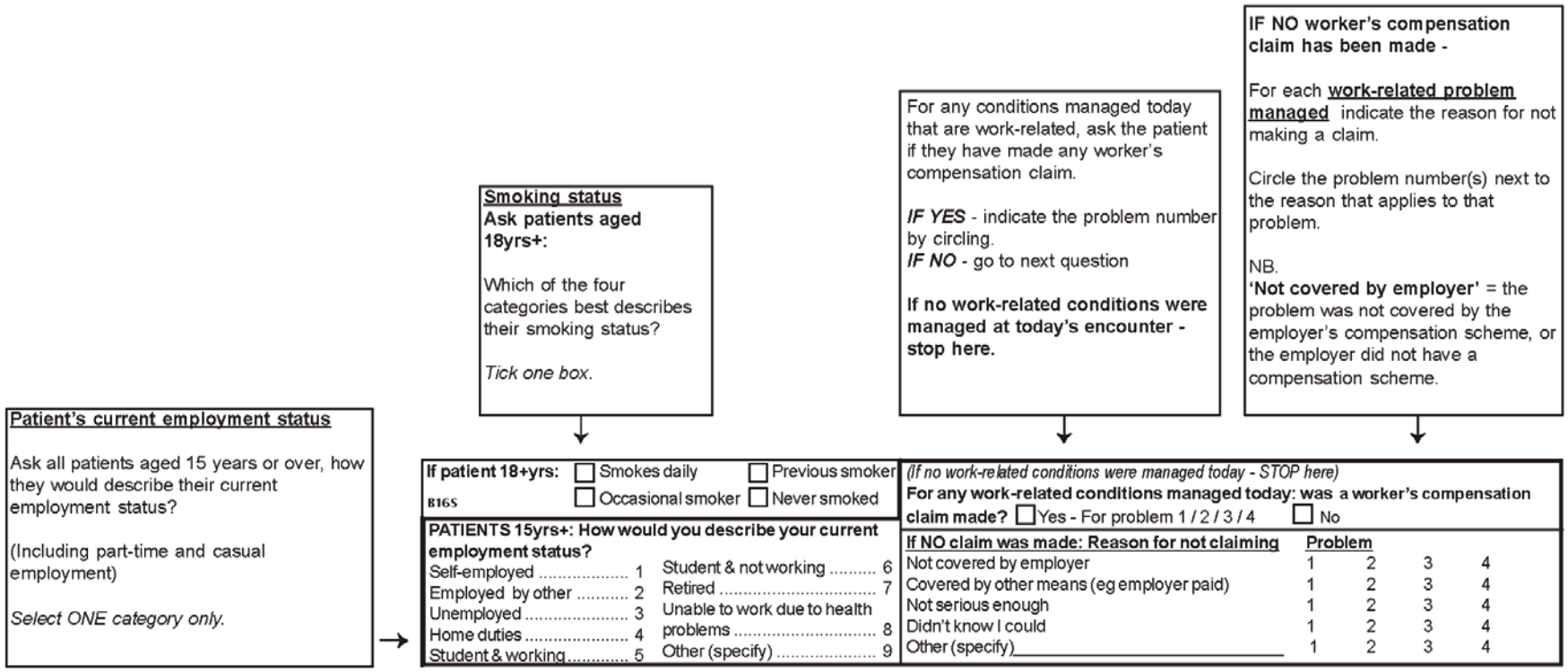
For other related abstracts see: 80 Employment status and workers compensation claims in general practice patients, 11 Patient employment status and occupation.

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 **EMPLOYMENT STATUS, WORKERS' COMPENSATION CLAIMS & SMOKING.**

INSTRUCTIONS



7 Health service utilisation, lifestyle status and chronicity

Organisation supporting this study: Commonwealth Department of Veterans' Affairs

Issues: GP visits; hospital admissions; medications taken; independent living; institutionalisation

Sample: 2,124 encounters from 106 GPs; data collection period: 08/06/1999 – 09/07/1999

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age–sex distribution of patients was similar to that of the total BEACH sample.

At least one prescribed medication had been taken routinely in the past 6 months by 69.6% of the respondents. Between one and three medications had been taken routinely by 47.0% of respondents. Almost two-thirds of respondents (60.8%) had routinely taken at least one over-the-counter (OTC) medication. Relatively more older patients were routinely taking either prescribed and/or OTC medications. The proportion of females who routinely took at least one prescribed medication was 74.2% compared with 63.1% of males. Similarly, a greater proportion of females (43.3%) than of males (32.3%) had routinely taken at least one OTC medication over the past 6 months.

The majority of respondents (52.1%) had visited a GP on between one and four occasions in the preceding 6 months. Again, elderly patients reported more GP visits, with 41.5% of patients aged over 75 years visiting the GP between five and eight times. At least one admission to hospital in the previous 6 months was reported by 18.0% of respondents. Allied health consultations were reported by 17.3% of respondents, while 37.2% had visited a specialist at least once in the past 6 months.

Of the 2,124 respondents, 11.5% were dependent on a carer, with a high proportion of patients aged 75 and over being dependent. Almost 3.0% of respondents resided in an institution.

At least one indicator of chronicity (e.g. falls, cognitive impairment, social isolation, incontinence) was reported for 19.8% of respondents. One indicator only was reported for 64.0% of respondents, with three or more reported for 10%. The prevalence of all indicators of chronicity increased with age. Falls/poor mobility was reported for 7.5%, and 6.0% were reported to be cognitively impaired. There were 5.6% who were socially isolated and 2.3% incontinent. Amongst those who were dependent on carers and others, and particularly for those living in institutions, individual indicators were more often reported, especially falls/poor mobility (21.7% and 66.7%) and cognitive impairment (14.0% and 53.7%). Almost one-third of the 54 patients living in institutions (30.8%) had been taking seven or more medications routinely in the past 6 months.

GPs reported that there were health plans for a relatively small number of respondents, with around 1% having either Department of Veterans'Affairs health care plan or another health care plan.

For other related abstracts see: 37 Prevalence of common morbidities in patients encountered in 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 USE OF HEALTH CARE AND DEPENDENCE.**

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

INSTRUCTIONS

ASK ALL PATIENTS

These questions refer to the past 6 months.

*Write a **number** in the space provided for:*

- How many medications they take/ have taken on a routine basis.
- Please distinguish between OTC (over the counter) and prescribed medications.
- The number of times they have visited any GP.
- The number of times they have visited a specialist.
- The number of hospital admissions.

Tick the appropriate box for:

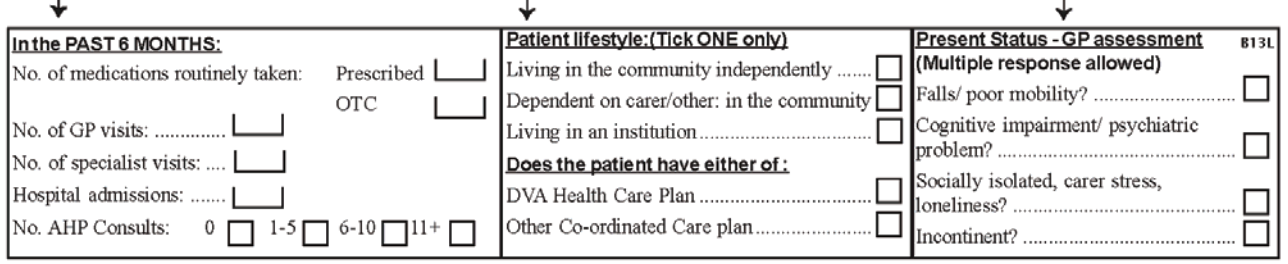
- The number of times they have consulted an allied health professional (AHP).

Patient lifestyle:
Choose ONE option to describe the patient's lifestyle at the moment.

Health Care plans
Indicate whether the patient has a Department of Veterans' Affairs care plan or any other co-ordinated care plan.

Present status:
As far as you are aware, do any of the following options apply to the patient?

Please note that 'incontinent' applies to normally continent individuals (ie not infants).



8 Hormone replacement therapy (HRT)

Organisation supporting this study: Aventis Pharma Pty Ltd

Issues: Menopausal status among female patients; proportion taking hormone replacement therapy (HRT).

Sample: 2,063 encounters (females aged 18 years +); data collection period: 30/11/1999 – 14/01/2000

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: GPs were asked to ascertain (either by asking the patient or from their knowledge of the patient) for female patients aged 18 and over, whether the patient was premenopausal, perimenopausal or post menopausal. The GP was also asked to determine whether the patient had previously had a hysterectomy or experienced menopausal symptoms, was currently on HRT and (if so), whether they were taking HRT for symptom management, to avoid bone loss, for cardiovascular protection, or for another reason, which they were asked to specify.

Summary of results

Four thousand encounter forms were completed with the HRT questions. The age and sex distribution of these respondents were similar to those for general practice as a whole. The majority of respondents (59.3%) were females, with 2,063 of these aged 18 years and over.

Six per cent of the women in this subsample were perimenopausal. Thirty-two per cent of these women were aged between 40 and 59 years. Three hundred and thirty-three women (16.1% of respondents) had a past history of menopausal symptoms and 362 (17.6%, 95% CI: 15, 20.1) had had a hysterectomy.

Eleven per cent of respondents were taking HRT. The use of HRT was most common in perimenopausal women and among women aged 50 to 59 years. Among women with a history of menopausal symptoms the proportion taking HRT was 37.5%.

The most common single reason for taking HRT was symptom management (62.7%) followed by bone loss avoidance (50.4%) and cardiovascular protection (23.3%). Even when all the reasons for taking HRT were combined, symptom management only remained the most common reason, followed by the combination of all three reasons—symptom management, bone loss avoidance and cardiovascular protection (19.0%).

Oestrogen alone was the most common HRT used by women irrespective of menopausal status. Almost half of the 34 perimenopausal women on HRT were taking oestrogens alone.

For other related abstracts see: 84 Menopausal status, symptoms and treatment of women aged 18 and over.

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 **HORMONE REPLACEMENT THERAPY and SMOKING.**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

This form has been filled in as an example.

MENOPAUSAL SYMPTOMS
include the following:

- hot flushes
- sleep disturbances
- excessive sweating
- dyspareunia
- urinary incontinence

For all female patients 18yrs +:

- Has the patient had a hysterectomy?
- Does the patient have a past history of ***any*** menopausal symptoms (for example those listed above)? **That is, have they had symptoms in the past, but do not have them anymore.**

Circle 'Yes' or 'No' for each question.

Indicate

- whether the patient is currently on HRT?
  Tick 'yes' or 'no'
- reason(s) for taking HRT
  Tick one or more options

FOR ALL FEMALE PATIENTS aged 18 years and over:

- Classify all female patients according to their menopausal status.

Tick one box

Current HRT medications
Is the patient taking:

- any medication containing *oestrogen only*
- any medication containing *progesterone only*
- any medication containing a *combination of oestrogen & progesterone* (either combination pack or combined tablet)
- another medication for HRT

Brand name

- write the brand name of the medication prescribed

Monthly regimen

- write the ***daily dose*** of each medication
- for doses which change through the cycle, write the days of the cycle and the corresponding dose
- if the medication is taken continuously, write the dose or number of tablets and the regimen - *eg 1 tab daily.*

Smoking status
Ask ALL patients aged 18yrs+:

Which of the four categories best describes their smoking status?

Tick one box.

FOR FEMALES:	Currently on HRT .... (Yes) No
Menopausal status:	**Reason(s) for HRT (if using):**
Premenopausal ..... ☐	Symptom management ..... ☑
Perimenopausal ..... ☑	Avoid bone loss ..... ☐
Post menopausal ..... ☐	Cardiovascular protection .... ☑
	Other *(specify)* _____ ☐
Past history of:	Hysterectomy ..... Yes (No)
	Menopausal symptoms ..... (Yes) No

CURRENT HRT DRUGS	Brand name	Monthly Regimen					
Generic		Dose	Days	Dose	Days	Dose	Days
Oestrogen (O)	Premarin	0.3mg	1-21				
Progesterone (P)	Provera	10mg	1-10				
Combined O & P							
Other *(specify)*							

If patient 18+yrs: Smokes daily ☐ Occasional smoker ☐ Previous smoker ☑ Never smoked ☐

B18S

9 Influenza and absenteeism

Organisation supporting this study: Roche Products Pty Ltd

Issues: Prevalence (previous 12 months), days of absence from work/study, days off advised, hospitalisation, medical certificate given at consultation.

Sample: 4,228 encounters from 106 GPs, data collection period: 04/05/1999 – 07/06/1999

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age–sex distribution of the respondents was similar to the expected distribution for general practice, with the majority (56.9%) of patients being female.

The prevalence of influenza in the previous 12 months among the respondents was 14.9% (95% CI: 11.2–18.6). The highest prevalence was found among patients aged 15 to 24 years (22.3%, 95% CI: 16.9–27.7), there was no difference between males and females in the prevalence of influenza.

One in five (19.8%, 95% CI: 15.1–24.4) patients who were working/studying reported having had influenza in the previous 12 months. Forty-four per cent of these patients reported having 3 or more days absent from work, 33% reported having less than 3 days absent, and 23% had not had any days absent.

Only 1.6% (95% CI: 0.0–11.8) of patients in work/study had been hospitalised due to influenza in the previous 12 months. In comparison, 3.5% (95% CI: 0.0–9.9) of all patients (irrespective of employment status) had been hospitalised.

For 53 of the patients, influenza was a problem being managed at the current encounter. On average the patient had already had 1 day absent for influenza when seen by the GP and the GP advised a further 1.6 days off at the consultation. Thus the average number of days taken off work/study for influenza was 2.6 days.

A medical certificate was given at 7.8% (95% CI: 5.8–9.8) of the encounters in this sub–sample of encounters. Among those for whom influenza was managed at the encounter, 52.8% (95% CI: 40.2–65.4) were issued a medical certificate.

For other related abstracts see: 27 Prevalence and management of influenza.

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 **INFLUENZA, ABSENTEEISM & SMOKING STATUS.**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

INFLUENZA
These questions ask about influenza and should be asked of all patients (or carers on their behalf).

Ask the patient if they have had influenza in the past 12 months?
Use the following definition of influenza to determine whether the patient had influenza or another condition.

Definition of Influenza*
a) viral culture or serological evidence of influenza virus infection,
or
b) Influenza epidemic, plus four of the criteria in (c),
or
c) six of the following:

- sudden onset (within 12 hours)
- cough
- rigors or chills
- fever
- prostration and weakness
- myalgia, widespread aches and pains
- no significant respiratory physical signs other than redness of nasal mucous membrane and throat
- influenza in close contacts

*Definition used by the Australian Sentinel Practice Research Network.

Absence due to influenza.

1. Ask the patient how many days the patient was absent from work or study due to influenza?

Write the number in the space provided.
- *Include halfdays as .5 days.*
- ***If no absences, write '0'.***

OR
If the patient is **NOT working or studying** tick the appropriate box.

2. Ask the patient if they have been hospitalised due to influenza.
Write the number of days in hospital.
If not hospitalised, write '0' .

Absence due to problems managed at today's consult.
These questions refer to the problems managed at today's encounter.

1. Indicate if the patient is usually in paid work, studying (including school) or neither, by ticking ONE box.
Note that if the patient is not working or studying, the following questions about work absence need not be answered.

2. If patients
- usually work or study **AND**
- are **currently absent** because of the problems managed at today's encounter:

3. Write the number of days already absent up until and including today. (Include half-days, and write nil as '0')
- Indicate the **problem(s)** which caused them to be absent by *circling one or more number.*

4. If you advised them to take time off at today's encounter, *write the number of days in the box provided.* Include half-days as .5 days.
- Again, indicate the **relevant problem(s)**, by *circling one or more number.*

5. Was a medical certificate provided at today's consultation? *Tick Yes or No.*

Smoking status
Ask ALL patients aged 18yrs+:

Which of the four categories best describes their smoking status?

Tick one box.

This form has been filled in as an example.

Ask the patient (or carer):

Have you had influenza in the past 12 months? Yes ☑ No ☐

Number of days absent from work/study due to influenza? 2 • (days absent) or ☐ Not working or studying

Number of days in hospital as a result of influenza? 0 • (days in hospital)

Is the patient usually in paid work or study?
Paid work ☑ Study ☐ Neither ☐

If currently absent from work/study for problems managed today-

How many days have they been absent so far? 0 • 5
For which problem(s)? ..... (1) / 2 / 3 / 4

How many days off work/study have you advised today? 3 •
For which problem(s)? ..... (1) / 2 / 3 / 4
Was a medical certificate given? ..... Yes ☑ No ☐

If patient is 18+yrs:

Smokes daily ☑
Occasional smoker ☐
Previous smoker ☐
Never smoked ☐

B12S

10 Length of consultation; after-hours arrangements; co–morbidity

Organisation supporting this study: Commonwealth Department of Health and Aged Care (General Practice)

Issues: Length of consultation; after–hours arrangements; co–morbidity

Sample: 6,328 encounters from 210 GPs; data collection periods: 08/06/1999 – 13/07/1999 and 17/08/1999 – 21/09/1999

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age–sex distribution of the patients was similar to the expected distribution of general practice patients, with the majority of patients (57.2%) being female.

Of the 210 participating GPs, 71.9% were male and 53.9% were aged 35–54 years. Most of the GPs worked 6–10 sessions per week (65.9%) and had graduated in medicine in Australia (70.2%). Solo practitioners accounted for 22.8% of the sampled GP population.

The median length for the 5,803 direct consultations (patient is seen) was 12 minutes, and the mean was 14.7 minutes (95% CI: 14.1–15.4). The median consultation length for male and female patients was similar at 11 and 12 minutes respectively. The median consultation length increased with patient age; patients under 15 having a median of 10 minutes, and those aged 45 years or more had a median of 14 minutes.

Three-quarters (77.7%) of direct consultations were between 5 and 19 minutes duration. Only 1.7% of direct consultations were of less than 5 minutes duration, and 2.7% were of 40 or more minute's duration. Of all direct and indirect consultations, the vast majority (93.9%) were held between the hours of 08:00 and 18:00.

At 7.3% of encounters, GPs stated that there were 'special' after-hours arrangements for that particular patient. One in five of these patients (20.5%) were aged 75 years or more. There was no apparent difference in the types of problems being managed at this encounter for these patients when compared with the problems managed for patients with 'normal' after-hours arrangements.

There were 338 encounters (5.7%) at which the GP reported that this service was provided when the practice was closed. These out–of–practice–hours services were provided by 79 (37.6%) of the 210 GPs. Only 22.5% of the consultations provided when the surgery was closed were between the hours of 18:00–23:00, with the majority (71.9%) being provided between the hours of 08:00–18:00. The consultations when the surgery was closed were longer (11.2% were 40 minutes or more) than all direct consultations (2.7% were 40 minutes or more). The patients seen when the surgery was closed were older (24.3% were aged 75 or older) than patients in the total study (13.1% aged 75 or older).

GPs indicated a variety of arrangements for their normal provision of after-hours service. Sixty-five GPs (31%) used a deputising service alone, while 87 (41%) of GPs used a deputising service together with another arrangement. The next most common arrangement was for 59 GPs (28%) who stated that their practice arranged their own after-hours service. Only two of the 210 GPs had no after-hours service arrangement. None of the GPs in rural or remote areas used a deputising service.

The length of consultation increased with the number of co–morbidities (requiring on–going management or surveillance) not managed at this encounter. Of patients with no unmanaged

co–morbidities, 6.8% (95% CI: 5.7–7.8) had a consultation of 30 minutes or longer, compared with 18.7% (95% CI: 8.1–29.3) of patients with four unmanaged co–morbidities.

Similarly, the length of consultation increased with the number of problems managed at this encounter. For patients with 1, 2, 3 and 4 problems managed there were respectively 5.7% (95% CI: 4.7–6.8), 8.3% (95% CI: 7.1–9.5), 13.5% (95% CI: 10.6–16.4) and 20.1% (95% CI: 11.5–28.8) of consultations which were 30 minutes or longer.

For other related abstracts see: 2 Anxiety/stress, consultation time, level of education, 32 Patient use of after-hours medical services, 37 Prevalence of common morbidities in patients encountered in general practice, 61 Prevalence of chronic illnesses identified as National Health Priority Areas among general practice patients, 89 Estimates of the prevalence of chronic illnesses identified as Health Priority Areas and Section 4.5 Length of consultation.

Further reading:

Bindman A.B., Forrest C., Britt H., Crampton P., Majeed A. 2007, 'Diagnostic scope of and exposure to primary care physicians in Australia, New Zealand and the United States: cross sectional analysis of results from three national surveys', *British Medical Journal* (Epub ahead of print).

Britt, H., Valenti, L., & Miller, G. 2002, 'Time for care. Length of general practice consultations in Australia', *Australian Family Physician*, vol. 31, no. 9, pp. 876–880.

Britt, H., Valenti, L., Miller, G. C., & Farmer, J. 2004, 'Determinants of GP billing in Australia: content and time', *Medical Journal of Australia*, vol. 181, no. 2, pp. 100–104.

Britt, H. C., Valenti, L., & Miller, G. C. 2005, 'Determinants of consultation length in Australian general practice', *Medical Journal of Australia*, vol. 183, no. 2, pp. 68–71.

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 **TIME OF CONSULTATION, CO-MORBIDITY & AFTER-HOURS SERVICES.**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

After-hours consults
Was this service provided at a time when your practice is normally closed?
Indicate whether you provided this service after your *normal practice hours*. i.e. You were called out or called back to your practice.

What are the usual after-hours arrangements for this patient:

- None - no special arrangements
- Normal practice - the usual after-hour arrangements that apply to this practice.
- Special arrangements - particularly for this patient.

START TIME

Record the time the consultation STARTED in hours and mins and circle whether the time was AM or PM.

eg. 9:15
(AM) / PM

Patient morbidity

Does the patient have significant morbidity that was not managed at this consultation?

eg. chronic illnesses or other health problems that require continuing management or surveillance.

(If more than 4 select the most important)

FINISH TIME

Record the time the consultation FINISHED in hours and mins and circle whether the time was AM or PM.

eg. 9:25
(AM) / PM

Start Time	Patient morbidity NOT MANAGED at this consult?	Was this service provided at a time when your practice is normally closed?	Finish Time
:	1.	☐ Yes ☐ No	:
AM / PM (please circle)	2.	What are the usual after-hours arrangements for this patient?	AM / PM (please circle)
	3.	None ☐	
	4.	Normal practice ☐	
		By special arrangement ☐	

B15L

11 Patient employment status and occupation

Organisation supporting this study: General Practice Statistics and Classification Unit (GPSCU)

Issues: Employment status, occupation, problems managed for retirees, unemployed and occupational groups

Sample: 4,385 encounters from 110 GPs; data collection period: 30/03/1999 – 30/04/1999

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age and sex distribution of the respondents was similar to the expected distribution of general practice patients, with the majority (58.1%) being female.

Of the 4,385 respondents, 59.8% were not in the labour force. Those not in the work force were mainly retirees (22.9%) and students (19.7%).

The main industries that the respondents in the work force were currently employed in were retail trade (15.4%), manufacturing (11.8%) and health and community services (11.7%).

Current occupation was analysed using the Australian Standard Classification of Occupations (ASCO) major groups, subgroups and individual occupations. Current occupation by major group showed most patients describing themselves as 'intermediate clerical/sales/service' workers (20.0%), followed by 'professionals' (17.3%). The most common current occupations at the ASCO 6 digit level were 'sales assistant' (8.0%), 'general clerk' (6.7%) and 'school teacher' (2.8%).

Problems managed at the consultation were analysed in relation to the occupation group and employment status of the patient and compared with problems managed at all patient encounters from the same period.

For all respondents, the most common problems managed were immunisation, upper respiratory tract infection and hypertension. Hypertension was managed at a lower rate for employed patients than for all respondents but managed at a significantly greater rate for retirees (17.0 per 100 encounters, CI: 13.0–20.9) than for all respondents (6.9 per 100, CI: 5.4–8.4). Back complaints were managed at an apparently higher rate amongst labourers (5.4 per 100 encounters) than amongst all respondents (2.2) but number of encounters with labourers were too small to test for significance. Likewise, depression (4.1) was managed at an apparently higher rate for professionals than for all respondents (2.9).

For other related abstracts see: 6 Employment status and workers' compensation claims, 80 Employment status and workers compensation claims 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 **OCCUPATION & SMOKING STATUS.**

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

INSTRUCTIONS

Occupation and work activities

Ask patients (aged 15 years or more) each of the four questions about occupation and work. Two examples are shown below.

Example 1: Chris has worked for many years as a factory worker in a clothing company.

Current occupation:	Process worker
Industry of current employment:	Clothing
Main lifetime occupation:	Process worker
Main work activity:	Making clothing

Example 2: The second, Pat was the manager of a retail outlet until recently being retrenched.

Current occupation:	Unemployed
Industry of current employment:	None
Main lifetime occupation:	Manager
Main work activity:	Running hardware store

Patient's current employment status

Ask all patients aged 15 years or over, how they would describe their current employment status?

(Including part-time and casual employment)

Select ONE category only.

NB: **Main work activity** may be thought of as the ***main tasks*** performed by the person in their work. The aim of this question is to help us clarify occupation.

Work activity usually relates to **current occupation**. However, if the patient is retired or unemployed, then work activity relates to their **main lifetime occupation.**

Smoking status

Ask patients aged 18yrs+:

Which of the four categories best describes their smoking status?

Tick one box.

Hours in paid employment

Ask all patients how many hours they would spend in paid jobs each week, on average.
(Including casual work).

Write the number of hours in the box shown.

PATIENTS 15yrs+: How would you describe your current employment status?

Self-employed	1	Student & not working	6
Employed by other	2	Retired	7
Unemployed	3	Unable to work due to health problems	8
Home duties	4	Other (specify)	9
Student & working	5	.....	

How many ***hours*** do you normally spend in all paid jobs each week? ☐ hrs per week

What is your current occupation?

In what industry are you currently employed?

What was/is your main lifetime occupation?

What was/is your main work activity?

If patient is 18+yrs:

- ☐ Smokes daily
- ☐ Occasional smoker
- ☐ Previous smoker
- ☐ Never smoked

B11S

12 Smoking & passive smoking in general practice patients

Organisation supporting this study: General Practice Statistics and Classification Unit

Issues: Exposure to passive smoke at home; current smoking status; proportion of daily smokers who attempted to quit.

Sample: 3,784 encounters from 197 GPs; data collection period: 30/11/1999 – 18/02/2000.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age–sex distribution of the patients was similar to the expected distribution of general practice patients, with the majority of patients (59.7%) being female.

When asked about smoking in the home, one-third of respondents (32.9%, 95% CI: 29.3–36.4) reported 'people are not permitted to smoke anywhere'. A further 38.7% (95% CI: 35.0–42.4) indicated 'smoking is permitted outside only', and in 5.0% 'people are permitted to smoke in certain areas only'. 'Smoking in the home occasionally' was allowed by 10.4% of respondents and 13.0% (95% CI: 11.4–14.5) said 'people frequently smoke in the house'.

These results show that in over two-thirds of patient households there was no passive smoke in the home (71.6%, 95% CI: 69.4–73.8). In a further 15.4% of household there was limited passive smoke (where smoking is permitted only in certain areas, or smoking in the home is only occasional), and in 13.0% (95% CI: 11.4–14.5) there was unlimited passive smoke.

Patients aged 18 years and over were asked to indicate their smoking status. About half (49.5%) had never smoked and 27.8% were previous smokers. Daily smokers accounted for 18.2% of the patients and a further 4.5% reported smoking occasionally.

There was no passive smoke in the home of 30.1% of daily smoker households (95% CI: 26.2–34.0), 45.1% (95% CI: 35.3–55.0) of occasional smokers' households, and 84.5% (95% CI: 82.2–86.8) of never smokers' households.

Adult daily smokers were asked about their quit and reduction attempts during the previous 12 months. Of the 578 adult daily smokers, data on their quit/reduction attempts was available for 553. They could indicate more than one quit/reduction option attempted. Just over one in ten (10.3%, 95% CI: 7.8–12.9) had successfully given up smoking for 1 month or more (but subsequently started again), and almost one-third (31.5%, 95% CI: 26.7–36.3) had a failed quit attempt during the past 12 months. About one in five adult daily smokers (19.4%, 95% CI: 14.9–23.8) had changed brand of cigarettes to a lower tar or nicotine brand, and about a quarter (26.4%, 95% CI: 21.8–31.1) had reduced the number of cigarettes smoked a day during the previous 12 months.

In the previous 12 months: four in ten adult daily smokers (39.4%, 95% CI: 34.2–44.7) attempted to quit smoking; over a third (36.4%, 95% CI: 30.9–41.8) attempted to reduce smoking effects by changing brand and/or reducing the number of cigarettes smoked; 26.9% tried to quit but did not try to reduce smoking; 23.9% attempted to reduce but not to quit; 12.5% tried both quitting and reduction; 36.7% (95% CI: 31.5–41.9) did not attempt to quit or reduce smoking.

For other related abstracts see: 35 Smoking status of adults and their attempts to quit, 53 Smoking status of adults and their attempts to quit, 74 Smoking and passive smoking in the home and Section 4.3 Smoking.

Further reading:

Valenti, L., Charles, J., & Britt, H. 2005, 'Passive smoke in Australian homes: 1999 to 2004 [letter]', *Australian and New Zealand Journal of Public Health*, vol. 28, no. 4, pp. 387–388.

Doran, C. M., Valenti, L., Robinson, M., Britt, H., & Mattick, R. P. 2006, 'Smoking status of Australian general practice patients and their attempts to quit', *Addict.Behav.*, vol. 31, no. 5, pp. 758–766.

Degenhardt L, Knox S, Barker B, Britt H, Shakeshaft A. The management of alcohol, tobacco and illicit drug use problems by general practitioners in Australia. *Drug Alcohol Rev* 2005; 24(6):499–506.

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

PLEASE READ CAREFULLY

The shaded section in the following forms asks questions about **SMOKING.**

PLEASE FILL IN QUESTIONS FOR ALL PATIENTS SEEN. Note: The home smoking question is asked of all patients, but smoking status is only asked of patients over 18.

INSTRUCTIONS

This form has been filled in as an example.

NB The term 'smoking' here is used to mean tobacco smoking of any kind, including cigarettes, pipes, and cigars.

ASK THE PATIENT

Which category best describes their home situation ?

If the patient is a child, their carer may answer the question about the child's home situation.

Tick one box.

ASK THE PATIENT if over 18 years:

Which category best describes their smoking status?

Tick one box.

Only for patients who described themselves as"Daily smokers",

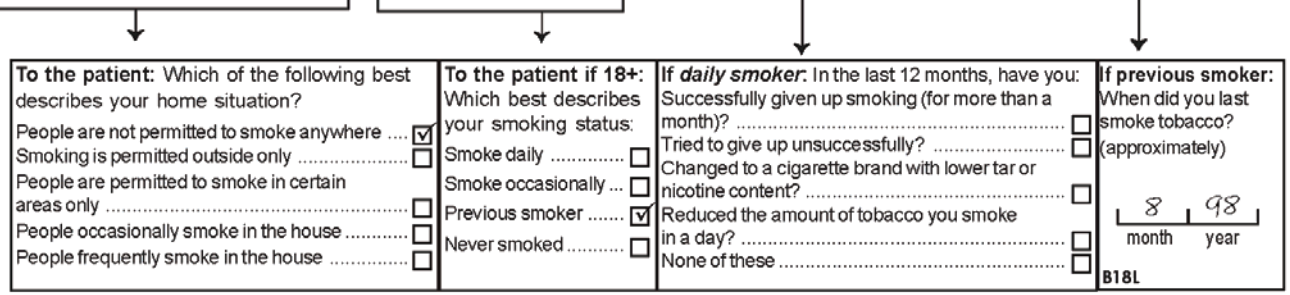
In the past 12 months, has the patient tried any of the options listed ?

Tick as many of the options listed as apply.

Only for patients who described themselves as "previous smokers ".

About when did the patient last smoke tobacco?

Fill in the month and year that the patient quit smoking (approximately).



13 Perceived stress

Organisation supporting this study: General Practice Statistics and Classification Unit (GPSCU)

Issues: Perceived stress in general practice patients in Australia

Sample: 2,891 encounters from 90 GPs; data collection period: 22/02/2000 – 27/03/2000

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: A four-item version of the Cohen Perceived Stress Scale (PSS) Instrument was used to measure the degree to which the patient regarded situations in their life as stressful.[1] *This was provided on a card to patients at the encounter.*

Summary of results

A Perceived Stress Scale (PSS) score was calculated for 2,891 patients over the age of 15, seen by 90 randomly selected GPs in March 2000. The PSS score ranges from zero, indicating no perceived stress, to sixteen, which indicates the highest level of perceived stress.

Of the 2,891 respondents aged over 15 years, 12.6% were aged between 16 and 24 years of age. The majority of patients (61.3%) were aged between 25 and 64 years of age, and 26.1% were 65 years or older, and likely to be retired from the workforce. Almost two-thirds (64.2%) of respondents were female.

The mean PSS score for all responding patients was 5.0 (95% CI: 4.7–5.2). The mean PSS score for male patients (4.7) did not differ significantly from that of female patients (5.1). However, significant differences in PSS score were apparent between different age groups. Respondents aged 65 to 74 and 75 years or older (i.e. those likely to be retired) had significantly lower PSS scores than patients aged 25–64.

A review of the literature did not locate any published grading of PSS scores to indicate the severity of stress. We therefore classified a PSS score between 9 and 16 as 'high' perceived stress, as a score above 8 indicates that a patient perceives their life to be stressful more than just 'sometimes'. All other patients (PSS score of between zero and 8) were classified as 'low' perceived stress for ease of reference.

A comparison of the patient demographics of 'high' and 'low' perceived stress was conducted. There were no significant differences in the age distribution, sex, non-English-speaking background (NESB) status or rurality of respondents with 'high' perceived stress and those with 'low' perceived stress. However, patients with 'high' perceived stress were more likely to hold a health care card than those with 'low' perceived stress.

1. Cohen S, Kamarck T, Mermelstein R. A global measure of perceived stress. J Health Soc Behav. 1983 Vol. 24:385–396.

For other related abstracts see: 2 Anxiety/stress, consultation time, level of education.

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 **STRESS & SMOKING.**

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

INSTRUCTIONS

This form includes four items about stress, and one smoking question.

You will need to read each question to the patient and ask for their response.

A patient response card has been included in your pack.

You may give the *response card* to the patient to assist them in making their response.

Ask all patients aged 16 and over:

Ask the patient how often, in the last month, they have experienced each of the items described.

Circle ONE option for each question.

Smoking status

Ask patients aged 18yrs+:

Which of the four categories best describes their smoking status?

Tick one box.

Ask patients 16yrs and over: IN THE LAST MONTH, how often have you felt....

Unable to control the important things in your life?	**Difficulties were piling up so high that you could not overcome them?**	**Confident about your ability to handle your personal problems?**	**That things were going your way?**
Never 1	Never 1	Never 1	Never 1
Almost never 2	Almost never 2	Almost never 2	Almost never 2
Sometimes 3	Sometimes 3	Sometimes 3	Sometimes 3
Fairly often 4	Fairly often 4	Fairly often 4	Fairly often 4
Very often 5	Very often 5	Very often 5	Very often 5

If patient is 18+yrs:

Smokes daily ..... ☐

Occasional smoker .. ☐

Previous smoker ..... ☐

Never smoked ..... ☐

B20S

Ask patients 16yrs and over: IN THE LAST MONTH, how often have you felt....			
Unable to control the important things in your life?	**Difficulties were piling up so high that you could not overcome them?**	**Confident about your ability to handle your personal problems?**	**That things were going your way?**
Never 1	Never 1	Never 1	Never 1
Almost never 2	Almost never 2	Almost never 2	Almost never 2
Sometimes 3	Sometimes 3	Sometimes 3	Sometimes 3
Fairly often 4	Fairly often 4	Fairly often 4	Fairly often 4
Very often 5	Very often 5	Very often 5	Very often 5

14 Co-medications

Organisation supporting this study: General Practice Statistics and Classification Unit (GPSCU)

Issues: This substudy investigated the extent to which the medications received at the encounter (prescribed, supplied or advised for over-the-counter purchase), reflect the total medications currently used by the patient. It assessed: the proportion of patients taking medications not received at the encounter ('other medications'); the number and type of other medications; the relationship between encounter medication, other medication and all co-medication; and GP knowledge of patient other medications.

Sample: 12,318 respondents from 211 GPs; data collection period: 28/03/2000 – 05/06/2000

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to the distribution of the total BEACH sample with 58.5% being female. Respondents who had no encounter or other medication made up 17.2% of all respondents. Over two-thirds (69.5%) received encounter medication. Almost half (43.4%) indicated they were currently using at least one other medication. One-third (30.1%) had encounter medication and were currently using other medication. Females were significantly more likely to be using at least one other medication (47.5%, 95% CI: 43.3–51.6) than were males (37.7%, 95% CI: 33.9–41.6). The likelihood of use of other medication increased with age. The highest prevalence of use was among female patients aged 75 years and over (65.8%). One other medication was being used by 28.9%, 19.2% used two medications, 12.5% three medications, and 22.2% four or more medications.

There were in total 27,764 co-medications (encounter medication plus other medication) recorded, an average of 2.25 per respondent or an average of 3.2 per respondent who was taking at least one medication (n=8,569). Other medications accounted for half (49.4%) of all co-medications. This suggests that data on encounter medications represent half the total medications being used by patients

The difference between the numbers of co-medications and encounter medications ranged from 0.1 medications in male infants to a maximum mean of 3.7 medications in elderly women (75 years +). Encounter medication for male infants far more closely represents their co-medication than that recorded at encounters with elderly women.

The largest proportion of other medications were cardiovascular which accounted for 21.3% of the total, followed by those acting on the central nervous system (13.0%) and those for nutrition and metabolism (10.7%). Other medications accounted for 86.3% of medications for nutrition, 61.4% of urogenital co-medications, 60.1% of anti-neoplastics, 60.0% of contraceptives hormones and 58.3% of cardiovascular medications. In contrast, over 90% of the antibiotics were prescribed at that encounter.

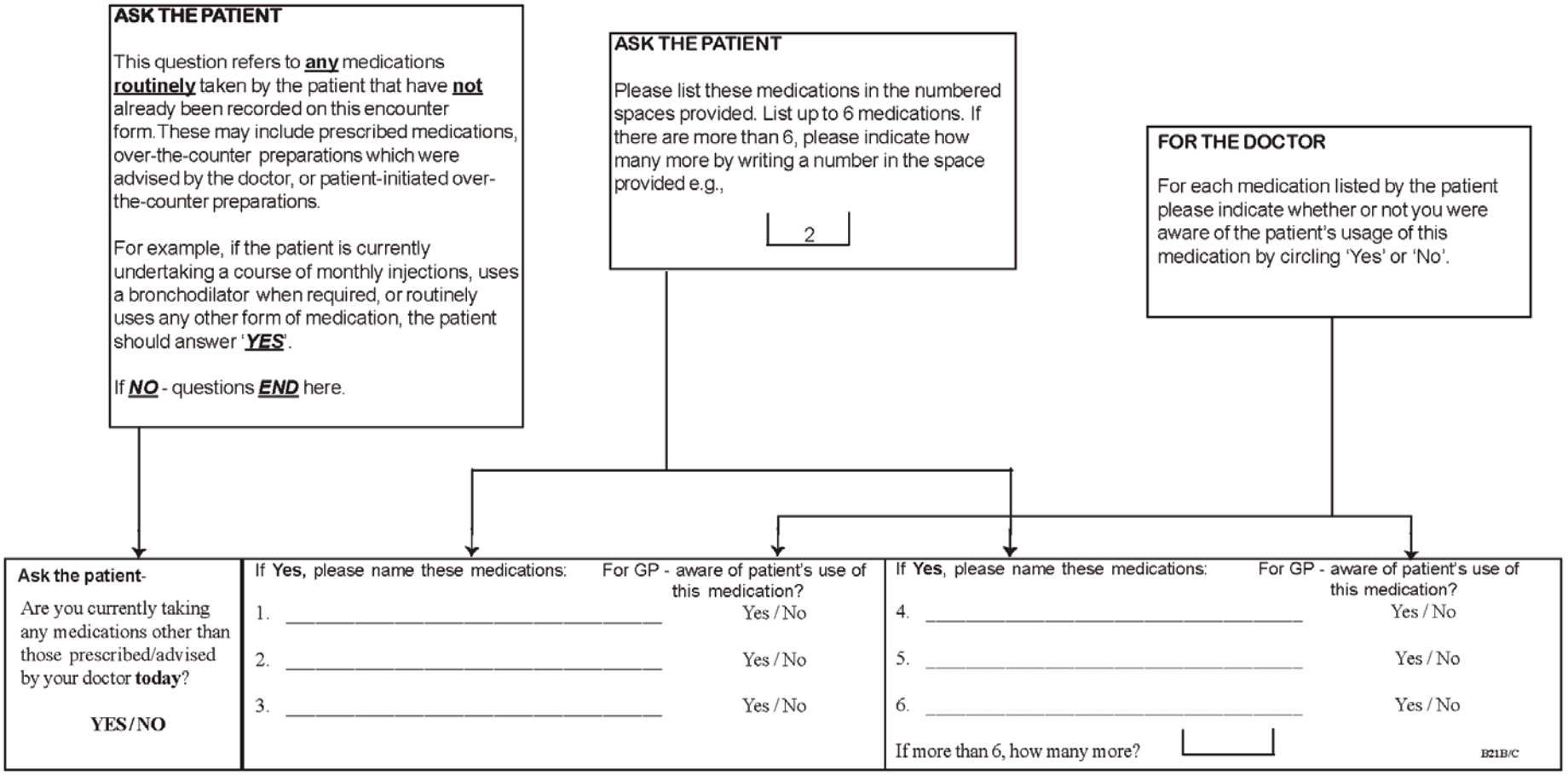
The GP stated they were aware that their patient was using 86.6% of other medications. Awareness was highest for cardiovascular medications (98.2% aware), lowest for vitamins (34.8% aware) and minerals and tonics (67.4% aware).

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 USE OF CONCURRENT MEDICATIONS.**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS



15 Lipid lowering medication

Organisation supporting this study: Commonwealth Department of Health and Ageing (Pharmaceutical Benefits Branch).

Issues: This substudy investigated the proportion of general practice patients receiving lipid lowering medications and for those on lipid lowering therapy the prevalence of coronary heart disease (CHD) and risk factors for CHD. The types of medications used for lipid lowering therapy and the levels of cholesterol for different risk factors were examined.

Sample: 5,669 patients from 189 GPs; data collection periods: 06/06/2000 – 10/07/2000, 15/08/2000 – 18/09/2000.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age–sex distribution of the respondents was similar to the distribution for BEACH overall, with the majority, (57.7%) of patients being female.

Overall, 10.2% of respondents were taking lipid lowering drugs (*n*=576) at the time of the encounter. Rates of lipid lowering drug therapy were comparable for males (11.0%) and females (9.5%). Patients aged 45 years and over were more likely than younger patients to be on lipid lowering therapy. Those most likely to be on lipid lowering drugs were aged between 65 and 74 years (27.2%).

Five per cent of respondents on lipid lowering therapy (29/530) were commencing therapy at the encounter. There were 564 medications used for lipid lowering therapy, very few patients using more than one lipid lowering medication. The most common generic medication used was simvastatin, accounting for 40% of all lipid lowering medications, followed by atorvastatin (36.5%) and pravastatin (13.5%). CHD was reported as present in 35.0% (*n*=203) of those on lipid lowering therapy.

Hypertension was the most common risk factor, reported by 55.0% (*n*=317) of those on lipid lowering therapy. Hypertension without CHD was reported for 31.3% of those on lipid lowering therapy. One in six (16.3%, *n*=94) of those on lipid lowering therapy had diabetes, 26.2% (*n*=151) had a family history of hypercholesteraemia and 23.7% (*n*=137) had a family history of coronary heart disease. One in ten (10.6%, *n*=61) had peripheral vascular disease. Sixteen per cent (*n*=91) of those on lipid lowering therapy did not report any of the listed risk factors/conditions.

For those commencing therapy the mean cholesterol level of the most recent test was 6.9 mmol/L. For those continuing therapy the mean cholesterol level at the start of therapy was 7.2 mmol/L.

There were few differences in cholesterol levels for patients with different risk factors, although those with coronary heart disease had started therapy at lower levels of cholesterol (mean 6.9 mmol/L) than those without coronary heart disease (mean 7.4 mmol/L, p <0.001).

For other related abstracts see: 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, 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 **PATIENT USE OF LIPID LOWERING MEDICATIONS.**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

FOR THE DOCTOR

This question refers to any **lipid lowering drug therapy** taken by the patient which may have been prescribed today or at a previous encounter.

For example, if the patient is currently undertaking a course of lipid lowering medication or is about to commence a course of lipid lowering medication as a result of today's consultation, you should answer '***YES***'.

If ***NO*** - questions ***END*** here.

ASK THE PATIENT

Please indicate by ticking the corresponding box/es whether the patient has **existing coronary heart disease** or any of the **risk factors** listed.

FOR THE DOCTOR

For patients who are **commencing** therapy today, please write the patient's present total levels of Cholesterol, Triglycerides and HDL in mmol/L i.e the levels shown from the most recent test.

For patients who are **continuing/changing** therapy which commenced at a previous encounter, please write the patient's total cholesterol level prior to commencement of treatment (if known).

If **'YES'** please tick a box to indicate whether the therapy is commencing or continuing.

Please write the **name of any lipid lowering medications** the patient is using/commencing.

If the patient is **changing** their lipid lowering medication as a result of this encounter (i.e. trying a new lipid lowering drug) please write the name of the **medication/s they are changing to.**

Is this patient currently using lipid lowering drug therapy?

☐ **YES** - continue ⇨

☐ **NO** - end questions

If '**YES**' is the patient

☐ commencing therapy or

☐ continuing/changing therapy

Name of medications currently used

1 _____

2 _____

Does the patient have (please tick)

☐ existing coronary heart disease?
☐ diabetes mellitus?
☐ familial hypercholesterolaemia?
☐ family history of coronary heart disease (1st degree relative <60 yrs of age)?
☐ hypertension?
☐ peripheral vascular disease?

(for patients commencing therapy)
From the most recent test, what is the patient's **present** total level of

Cholesterol _____ Triglycerides _____ HDL _____ mmol/L

(for continuing/changing patients)
What was the total cholesterol level when treatment was commenced?

_____ mmol/L

BL23B

16 Effect of day and time of GP visit on billing method

Organisation supporting this study: Commonwealth Department of Health and Aged Care (General Practice Branch).

Issues: This substudy investigated the effect of day and/or time of the GP–patient consultation on billing method (bulk billed versus patient billed).

Sample: 5,201 Medicare claimable encounters from 196 GPs; data collection period: 06/06/2000 – 10/07/2000 and 19/09/2000 – 23/10/2000.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

For the 5,201 Medicare claimable encounters, three-quarters (74.3%) were bulk billed and the remainder (25.6%) were patient billed.

Patients aged 65 years and over were bulk-billed significantly more often than younger patients. The difference was most striking when comparing the 45–64 with the 75+ age group, who were bulk billed at 68.1% (95% CI: 63.1–73.0) and 86.7% (95% CI: 83.0–90.5) of Medicare-claimable encounters respectively.

The billing method (bulk or patient billed) was related to the day of the encounter (X^2_6=41.5, p<0.001). Encounters on Saturday (n=248) were significantly more likely to be bulk billed (84.7%) than encounters on Tuesday (n=1,413, 69.9% bulk billed). More generally, the billing method and whether the encounter was during the week or on the weekend were significantly related (X^2_1=15.0, p<0.001). Weekend consultations (n=274) were more likely to be bulk billed (84.3%) than weekday consultations (n=4,927, 73.8% bulk billed).

Most encounters on any day (55.4%) were during the 8am–1pm ('morning') session, 38.3% were during the 1pm–6pm ('afternoon') session, and 6.4% were 'over-night' (6pm–8am). Billing method was significantly related to time of consultation (X^2_2=9.0, p<0.001). If an encounter was during the 'afternoon' session, it was significantly less likely to be bulk billed (72.2%) than if it was 'over-night' (77.3% bulk billed).

Billing method was significantly related to the combination of day (weekday or weekend) and time (morning, afternoon or over-night) of the encounter (X^2_5=26.7, p<0.001). Weekend morning sessions (n=227) were significantly more likely to be bulk billed (87.2%), than weekend afternoon sessions (n=32, 71.9% bulk billed) and weekend over-night sessions (n=14, 71.4% bulk billed).

Weekend morning encounters (n=227) had the highest bulk billing rate (87.2%), followed by weekday over-night encounters (n=316, 77.5% bulk billed). The lowest bulk billing rates were on weekend afternoon (n=32, 71.8%) and weekend over-night encounters (n=14, 71.4%).

For other related abstracts see: 41 Time of visit and billing status.

Further reading:

Pegram, R. W. & Valenti, L. 2004, 'Factors influencing billing status in general practice [letter]:, *Medical Journal of Australia,* vol. 181, no. 2, p. 115.

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 **TIME OF VISIT AND BILLING STATUS.**

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

INSTRUCTIONS

FOR THE DOCTOR

This question refers to the weekday on which the consultation is taking place.

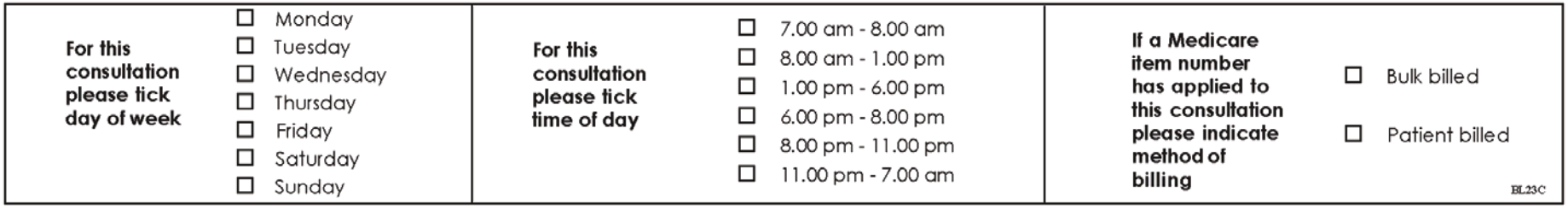
Please indicate by ticking the appropriate box which day of the week this encounter is taking place.

FOR THE DOCTOR

Please indicate by ticking the corresponding box, the time of day during which the consultation is taking place.

FOR THE DOCTOR

If a Medicare item number is applicable to the consultation, please indicate by ticking the appropriate box whether the consultation was bulk billed to the government or whether the patient has been billed.



17 Private prescription products

Organisation supporting this study: Roche Products Pty Ltd

Issues: This substudy investigated the proportion of patients receiving, or being considered for, private prescription products, and the conditions for which the products were being considered. Reasons why these products were or were not being prescribed, were also examined.

Sample: 5,222 respondents from 192 GPs; data collection period: 11/07/2000 – 14/08/2000 and 19/09/2000 – 23/10/2000

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age and sex distribution of the 5,222 respondents was similar to those for BEACH as a whole, the majority of respondents (59.8%) being female.

GPs prescribed or considered prescribing a private prescription product for 647 (12.4%) of the 5,222 respondents. Eleven per cent of male patients and 13.3% of female patients were prescribed or considered for a private prescription product.

The conditions for which private prescription products were most frequently prescribed or considered were obesity, female contraception, acne, back pain, arthritis, immunisation and osteoarthritis. Other conditions for which these products were prescribed or considered included pain, asthma, insomnia, migraine and anxiety.

GPs discussed the probable cost of the private prescription product with 464 (79.2%) of the 647 respondents considered for a private prescription product, prior to prescribing. Multiple responses were allowed, and for the majority of patients the GP had indicated one (64.9%) or two (15.9%) reasons for prescribing. The most common reason given by GPs for prescribing a private prescription product (for 346 (53.5%) of the 647 respondents) was that no equivalent PBS product was available. Other reasons given by GPs for prescribing a private prescription product, in order of frequency, were: at doctor's initiative (*n*=163, 25.2%), at patient's request (*n*=124, 19.2%), doctor believed patient could pay (*n*=69, 10.7%), patient privately insured (*n*=33, 5.1%) and other (*n*=30, 4.6%).

The most frequent response for electing not to prescribe a private prescription product, which would have been a suitable treatment for the patient's condition, was that the patient could not pay (*n*= 55, 8.5% of 647 respondents). Other reasons include: a non drug therapy used instead (*n*=23, 3.6%), other (*n*=22, 3.4%) and therapy available on PBS (*n*=15, 2.3%).

The patient's capacity to pay for treatment is a major consideration for GPs in the management of a variety of problems.

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 **PRIVATE PRESCRIPTION PRODUCTS.**

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

INSTRUCTIONS

FOR THE DOCTOR

This question refers to any **private prescription product** which you have prescribed, or considered prescribing, for this patient **for any condition** in the past **12 months**.

Please tick the appropriate box to indicate whether or not you have prescribed/considered a private prescription product for this patient during this time.

If **'YES'** please write the condition/s for which you have prescribed/considered the private prescription product/s (e.g., cardiovascular/obesity/sexual dysfunction/ influenza/other).

For example, if you have prescribed/ considered prescribing for a cardiovascular condition during one encounter and for an obesity condition at another encounter within the past 12 months, please write

1. *Cardiovascular*
2. *Obesity*

Please indicate by ticking the appropriate box whether or not you **discussed the probable cost** of the product **with the patient** before you prescribed (or didn't prescribe) the private prescription product.

If you decided to prescribe a private prescription product, please indicate by ticking the appropriate box the **reason** you prescribed the private prescription product for this patient.

Please circle a number to indicate **which conditon** you are referring to **from the previous question**.

For example, if you prescribed because there was **no PBS product available** for the **cardiac condition** listed in the previous (example) question, please write

(for condition)

☑ No PBS product available (1) 2

If you did **not prescribe** a private prescription product for this patient where the private prescription product might have been appropriate for their condition, please indicate by ticking the appropriate box **why you did not prescribe** the product.

Please circle a number to indicate the condition to which you are referring.

For example, if a private prescription product may have been appropriate for the **cardiac condition** previously mentioned, but the patient indicated that they were unable to afford this product, please write

(for condition)

☑ Patient cannot pay (1) 2

Have you prescribed, or considered prescribing a **private prescription product** for this patient in the past **12** months?	If '**YES**' for what **condition/s** did you consider/prescribe a private prescription product/s?	Before prescribing, did you **discuss** the **probable cost** of the product?	**Why did you prescribe this product?**	(For condition)		If a product **was appropriate** and **NOT** prescribed, **WHY NOT?**	(For condition)	
☐ YES	1. _____	☐ YES	☐ No PBS product available	1	2	☐ Therapy available on PBS	1	2
☐ NO BL24B	2. _____	☐ NO	☐ At patient's request	1	2	☐ Patient cannot pay	1	2
			☐ Doctor's initiative	1	2	☐ Non drug option offered	1	2
			☐ Patient privately insured	1	2	☐ Disliked patient requesting specific therapy	1	2
			☐ Believed patient could pay	1	2	☐ Contra indicated with other drugs/conditions	1	2
			☐ Other	1	2	☐ Other	1	2

18 Drugs for the treatment of peptic ulcer and reflux

Organisation supporting this study: AstraZeneca (Australia) Pty Ltd

Issues: This substudy investigated patients who were currently taking omeprazole or other proton pump inhibitors (PPIs), histamine receptor antagonists (H_2RAs) or cisapride. Concurrent use of H_2RAs and antacids, the relationship between endoscopy and medication choice, and between diagnostic finding and medication choice were examined. The life prevalence of peptic ulcer disease and use of Helicobactor (H. pylori) eradication therapy were assessed independently of the other questions.

Sample: 95 GPs responded to questions on behalf of 2,856 patients; data collection period: 11/07/2000 – 14/08/2000

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of patients at encounters was similar to the distribution of the BEACH sample, with the majority (59.9%) of patients being female.

Of the 2,856 patients, 8.3% (*n*=236) were currently taking at least one PPI, H_2RA, or cisapride. The majority of these were taking H_2RAs (61.4%, 145/236), followed by omeprazole (28.4%), other PPIs (9.3%) and cisapride (5.5%).

Of the 133 respondents on H_2RAs who responded to a question on level of antacid use, 51.7% had never used antacids in conjunction with H_2RA medication. Twenty-two per cent (22.1%, 32/133) used antacids infrequently (<once per week) and more frequent use was reported by 18.0% (9.0% >once per week; 9.0% 'daily' use).

Of the 224 patients who were currently taking these medications and also indicated endoscopy status, 164 (73.2%) had undergone an endoscopy. It was common for patients currently taking omeprazole (92.5%, 62/67) and other PPIs (86.4%, 19/22) to have undergone an endoscopy. However, 37.2% (54/145) of those on H_2RAs had never undergone an endoscopy.

The predominant diagnosis on endoscopy was reflux oesophagitis (39.4%, 65/164), followed by ulcerative oesophagitis (21.8%, 36/164). Peptic ulcer disease (PUD) was diagnosed for 14.5% (24/164).

The most common diagnosis (post endoscopy) for patients on H_2RAs was reflux oesophagitis (39.3%, 33/84), while for those on omeprazole, reflux oesophagitis (40.3%, 25/62) and ulcerative oesophagitis (40.3%) were most common.

Of the total sample less than one in twenty (4.4%, *n*=125) reported having been diagnosed with PUD at some time. Of these, 39% had received H. pylori eradication therapy. For the 71 patients who had not, it was 'not considered appropriate' for 24 (32.4%), and the opportunity to undergo an H. pylori test was 'not available' to 27.

For other related abstracts see: 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, 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 **GASTRO-OESOPHAGEAL REFLUX DISEASE AND PEPTIC ULCER DISEASE.**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

PART 1

FOR THE DOCTOR
Please indicate by ticking the appropriate box whether this patient is **currently taking** any of the **medications listed**, even if they were not prescribed at today's encounter.

You may tick more than one box if more than one medication is being taken.

Beside each medication ticked, please write the length of time since the patient began taking this therapy. For example, the patient may have been taking omeprazole for 6 months and cisapride for 18 months.

If the patient is **not currently taking** any of these medications, please **go directly to PART 2** for the remaining questions.

If you have indicated in the first question that this patient is **currently taking H_2RAs**, please indicate by ticking the most appropriate box whether or not the **patient also uses antacids** and, if so, **how frequently**.

Please indicate by ticking the appropriate box **when** the patient last underwent **endoscopy**. If the endoscopy was **more than 3 years ago**, please write the **year** when the last endoscopy took place.

Please indicate by ticking the appropriate box, which of the options most closely matches the **predominant diagnosis** resulting from the patient's **most recent endoscopy.**

PART 2

FOR THE DOCTOR
Please indicate by ticking the appropriate box whether this patient has **ever** had **Peptic Ulcer Disease.**

If "NO" end questions.

If the patient has had **Peptic Ulcer Disease**, please indicate by ticking the appropriate box whether the patient was treated with **H. Pylori eradication** therapy.

If "YES" end questions.

If the patient has had **Peptic Ulcer Disease** and was **not treated** with **H. Pylori eradication** therapy, please indicate by ticking the appropriate box **why** the patient was **not given** this therapy.

Is this patient currently taking any of the following? (Duration)	For patients currently taking **H_2RAs**, do you also take **antacids?**	The patient's **last endoscopy** was	The predominant **diagnosis resulting from endoscopy** was	**Part 2**	Was the patient given **H.Pylori eradication** therapy?	If 'No' **why not?**
☐ omeprazole _____ mths	☐ Never	☐ Never	☐ Reflux oesophagitis	Has this patient ever had **Peptic Ulcer Disease?**	☐ Yes **(end)**	☐ contra-indicated for medical reason
☐ other PPIs _____ mths	☐ < once per week	☐ 1 year ago	☐ Peptic Ulcer Disease	☐ Yes →	☐ No →	☐ not considered appropriate
☐ H_2RA _____ mths	☐ > once per week	☐ 2 years ago	☐ Ulcerative oesophagitis	☐ No **(end)**		☐ H.Pylori test not available
☐ cisapride _____ mths	☐ daily	If **>3 yrs** ago, what year? 19 _____	☐ No finding			☐ other reason
If 'No' go to Pt 2→			☐ Other diagnosis			BL24C

19 Osteoporosis

Organisation supporting this study: Aventis Pharma Pty Ltd

Issues: This substudy examined patients with risk factors for osteoporosis and whether any patients had sustained fractures after minor trauma. The screening and diagnosis of osteoporosis, and medications being used to treat the disease, were also investigated.

Sample: 2,710 respondents from 90 GPs; data collection period: 15/08/2000 – 18/09/2000

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: The One-Minute Osteoporosis Risk Test designed by the International Osteoporosis Foundation was used as a risk factor list provided to patients on a card. Risk factors included family or personal history of fracture following minor trauma, menopause prior to 45 years of age or amenorrhoea (women), low testosterone (men), long term corticosteroid use, height loss >5cm, regular heavy alcohol use, coeliac or Crohn's disease.

Summary of results

The age–sex distribution of respondents was similar to the distribution for BEACH as a whole, with the majority (57.5%) of patients being female.

One in five (22.2%) of the 2,710 respondents reported having one or more risk factor for osteoporosis, such as early menopause or prolonged corticosteroid use. In gender specific terms, 17.1% of males and 22.4% of females had risk factors. The presence of risk factors increased steadily with age from 1.25% of patients aged 15–24 to almost half of those aged 75 years or more.

Of the 2,332 patients who responded to the question on fractures following minor trauma, 134 (5.8%) had at some time suffered such fractures, and they made up 3.2% of male and 7.5% of female respondents. Again, these proportions increased with age up to 20.0% of those aged 75 years or over. One hundred and five patients responded to the question on how many fractures they had suffered, and 90 of these (85.0%) reported having sustained one or two fractures, with the most common fracture sites being the wrist and the vertebral column. Patients who reported having risk factors were more likely to have sustained fractures.

The question on screening for osteoporosis was answered by 2,016 patients and 249 (12%) had previously been screened for osteoporosis either by x-ray or bone mineral density scan (BMD). Of these, 95 (40.0%) had been diagnosed with osteoporosis.

Eighty-four respondents, 90.0% of patients diagnosed with osteoporosis, were taking medication for that disease. Calcitriol accounted for almost 30.0% of these medications, followed by calcium carbonate (27.4%) and alendronate (17.7%). A greater proportion of medications had been initiated by a GP (69.0%) than by a specialist (31.0%).

For other related abstracts see: 85 Management of osteoporotic fractures.

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 **RISK FACTORS FOR OSTEOPOROSIS.**

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

INSTRUCTIONS

FOR THE DOCTOR

This question refers to the **risk factors listed on the card** which the patient has previously read through.

(NB - *The patient is **not required** to indicate **which** risk factor/s.)*

Please ask the patient if they have **1 or more** of the **risk factors** listed and tick 'yes' or 'no' to indicate the patient's response.

Please ask the patient if they have ever suffered **fracture/s** following **minor trauma** such as a bump or light fall. Please tick the appropriate box to indicate the patient's response.

If the patient has suffered fracture/s 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

The question refers to the **screening** techniques of **X-ray** and **Bone Mineral Density** (**BMD**). Please indicate by ticking the appropriate box 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?	

If previously screened, was the patient **diagnosed** as having **osteoporosis** as a result of that screening?

If 'No' end questions.

If the patient has been **diagnosed** as having **osteoporosis**, please indicate by ticking the appropriate box the patient's **current treatment regime**. You **may tick more than one** box. Please write the **name of any medications** for this condition and circle an option to indicate who **initiated** this medication, or who is **providing any counselling**. For example, if the patient is taking Rocaltrol which was prescribed by a specialist, is receiving counselling from you, and is also having other treatment such as hydrotherapy, please write:

If 'Yes' the patient's **current treatment regime** is -

☑ Medication **(name)**	Initiated by
1. Rocaltrol	GP (Specialist)
2. _____	GP / Specialist

☑ Counselling **(provided by)** (GP)/Specialist /Other

☑ Other

☐ No treatment

Do you have **1 or more** of the **risk factors** listed on the card?	Have you 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 -	Type of Screen	If previously screened, was the patient **diagnosed** with **osteoporosis?**	If 'Yes' the patient's **current treatment regime** is -
☐ Yes ☐ No	☐ Yes → ☐ No		☐ referred today for screening?	X-ray/BMD/both	☐ Yes → ☐ No (**END**)	☐ Medication **(name)** Initiated by 1. _____ GP / Specialist 2. _____ GP / Specialist ☐ Counselling **(provided by)** GP /Specialist /Other ☐ Other ☐ No treatment
			☐ screened previously?	X-ray/BMD/both		
			☐ never screened or referred?			

BL258

Please read this card and tell your doctor if you answer '**yes**' to **1 or more** of the questions. You **do not** have to tell the doctor **which questions** you have answered 'yes' to, unless you wish to do so.

The One-Minute Osteroporosis Risk Test**

1. Have either of your parents broken a hip after a minor bump or fall?

2. Have you broken a bone after a minor bump or fall?

3. For Women: Did you undergo menopause before the age of 45?

4. For women: Have your periods stopped for 12 months or more (other than because of pregnancy)?

5. For Men: Have you ever suffered from impotence, lack of libido or other symptoms related to low testosterone levels?

6. Have you taken corticosteroids tablets (cortisone, prednisone, etc) for more than 6 months?

7. Have you lost more that 5 cm (2 inches) in height?

8. Do you regularly drink heavily (in excess of safe drinking limits)?
   (Safe = 4 standard drinks daily for men, 2 daily for women)*

9. Do you suffer frequently from diarrhoea (caused by problems such as coeliac disease or Crohn's disease)?

** Test designed by the International Osteoporosis Foundation

* Pols R.G. & Hawkes D.V (1992) *Is there a safe level of daily consumption of alcohol for men and women?* Australian Government Publishing service, Canberra

20 Screening and management of blood cholesterol

Organisation supporting this study: AstraZeneca (Australia) Pty Ltd

Issues: This substudy investigated the proportion of general practice patients having existing coronary heart disease (CHD) or risk factors for CHD, the proportion who had their blood cholesterol tested and the treatments used in the management of 'high cholesterol level' and the effectiveness of different management in decreasing cholesterol level.

Sample: 2,905 respondents from 97 GPs; data collection period: 24/10/2000 – 27/11/2000

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: Risk factors included: existing coronary heart disease, diabetes, familial hypercholesteraemia; family history of coronary heart disease, hypertension and peripheral vascular disease.

Summary of results

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

Over one-third (37%) of the 2,905 respondents had at least one risk factor related to CHD.

Overall, more than half (55.0%) of the 2,771 patients who responded to the question on cholesterol tests, stated that their cholesterol had been tested. Of the 1,027 patients who had one or more risk factors for high cholesterol and responded to the question about initial cholesterol test, 14.0% had never had a cholesterol test.

The mean cholesterol level for those with one or more risk factors (n=834) was 5.88 mmol/L compared with 5.35 mmol/L for those with no risk factors (n=604). Of the 764 respondents using some form of treatment(s) for 'high cholesterol level', 61.3% were relying on diet/exercise only, 23.3% were on both diet/exercise and any statin medication, and 13.6% were using any statin medication only.

Among 415 respondents who were under cholesterol management and had both initial and most recent cholesterol levels recorded, a significant decrease in cholesterol levels was found for those using both diet/exercise and any statin (t_{224}=9.7, p<0.001), or using any statin alone (t_{111}=–7.9, p<0.001), compared with those using diet/exercise only. There was no significant difference between those using diet/exercise and any statin compared with those using any statin alone in the extent of cholesterol reduction (t_{225}=0.2, p=0.82).

There was a significant reduction in cholesterol levels for those using any statin compared with those on diet/exercise only (t_{386}=11.6, p<0.001). Patients using any statin had a significantly greater decrease in cholesterol levels than those not using any statin (t_{402}=10.8, p<0.001).

For other related abstracts see: 15 Lipid lowering medication, 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, 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 **PATIENT BLOOD CHOLESTEROL LEVELS & MANAGEMENT.**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

FOR THE DOCTOR

This question refers to **any initial cholesterol test** for this patient.

If the patient's **total cholesterol** has been tested as a result of a previous encounter, please **write in the result** in mmol/L.

If ***NO*** - questions ***END*** here.

This question refers to **subsequent cholesterol testing** for patients whose cholesterol level was 'high' at the initial test.

Please write in the **patient's cholesterol level** at the **most recent test** if re-testing occurred, regardless of whether the result was high or normal.

If the patient's cholesterol was **not re-tested** since the inital test, **end questions** here.

ASK THE PATIENT

Please indicate by ticking the corresponding box/es whether the patient has **existing coronary heart disease** or any of the **risk factors** listed.

If the patient's cholesterol level was 'high' please tick the appropriate box which best describes the treatment regime commenced by the patient. **You may tick more than one box if more than one option applies** e.g. if you have recommended a diet & exercise program and prescribed a statin you should tick both boxes and write the name of the statin prescribed.

You do not need to write the name of drugs other than statins.

If the patient' cholesterol was re-tested, please tick the appropriate box to indicate the **next step in the patient's cholesterol management**. You may tick **more than one box** if more than one option applies.

Does the patient have (please tick)
- ☐ existing coronary heart disease?
- ☐ diabetes mellitus?
- ☐ familial hypercholesterolaemia?
- ☐ fam. history of cor. heart disease (1st degree relative <60 yrs of age)?
- ☐ hypertension?
- ☐ peripheral vascular disease?

Has this patient ever had a cholesterol test?
- ☐ Yes - the result was _____ mmol/L
- ☐ No - **end questions**

If 'high' was the patient treated with -
- ☐ diet / exercise
- ☐ HMG CoA reductase inhibitor (statin) - which statin? _____
- ☐ other drug therapy

Has the patient's cholesterol been re-tested?
- ☐ Yes - level at most recent test was _____ mmol/L
- ☐ No - **end questions**

If 'Yes', the next step in cholesterol management was
- ☐ initiate statin - which one? _____
- ☐ prescribe same statin, same dose (for previous users)
- ☐ prescribe same statin, increased dose
- ☐ change statin - to which one? _____
- ☐ additional therapy - which one? _____
- ☐ other - specify - _____
- ☐ stop therapy

BL27B

21 Diabetes—prevalence, management and screening

Organisation supporting this study: Aventis Pharma Pty Ltd

Issues: This substudy investigated the prevalence, management and risk factors for diabetes in general practice patients. Blood glucose screening for patients with risk factors for diabetes was also examined.

Sample: 2,810 respondents from 95 GPs; data collection period: 24/10/2000 – 27/11/2000

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: A risk factor list provided to patients on a card was based on information from the International Diabetes Institute and the Diabetes Association. Risk factors included ethnic background, family members with diabetes, age > 50, history (females) of gestational diabetes, babies >4.5kg at birth, multiple miscarriages/still births, personal history of central obesity, hypertension and lipid disorders.

Summary of results

The age and sex distribution of these respondents was similar to those for BEACH as a whole, the majority of respondents (57.3%) being female.

The prevalence of diagnosed diabetes in this patient population was 7.2% (*n*=201), patients with Type 1 diabetes comprising 1.1% (*n*=32) while 6.0% (*n*=169) of patients had Type 2 diabetes. On average, diabetic patients were older (mean age 65.7 yrs) than non diabetic patients (mean age 43.3 yrs).

Medication was part of the treatment regime for 75.6% (*n*=152) of the 201 diagnosed diabetic patients, and 71.1% (*n*=133) of these medications were initiated by the GP. The most common generic medications used in the management of diabetes for these patients were metformin, gliclazide, glibenclamide and insulin products. A diet program was part of the treatment regime for 84.1% (*n*=169) of patients, while 62.7% (*n*=126) of patients used an exercise program as part of the treatment regime.

One in four respondents (*n*=759, 27%) had not been diagnosed with diabetes, but were identified as having two or more risk factors for diabetes. Of these patients 706 (93.0%) had previously had their blood glucose levels tested. The GPs nominated 179 patients (23.6%) with two or more risk factors for diabetes who would have their blood glucose tested as a result of this encounter, 26 (14.3%) of these being tested for the first time.

For 90 (50.3%) of the 179 patients who were to be tested as a result of this encounter, the GPs nominated that they would implement a diet program for the patient if the test results indicated hyperglycaemia. Exercise programs would be introduced by GPs for 67 (37.3%) patients if test results indicated hyperglycaemia, while 13 (7.5%) of these patients would be referred to a specialist on indication of hyperglycaemia.

As 93% of patients with two or more risk factors for diabetes had already been tested for hyperglycaemia, it would appear that GPs are playing a pro-active role in screening for diabetes among the general practice population. Diet plans and exercise programs are the preferred initial management option for newly diagnosed hyperglycaemic patients.

For other related abstracts see: 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, 94 Type 2 diabetes – investigations and 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 **DIABETES.**

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

INSTRUCTIONS

FOR THE DOCTOR

Please indicate by ticking the appropriate box whether or not this patient has **ever been diagnosed** as having **Diabetes.**

If the patient has been diagnosed with Diabetes, either today or at a previous encounter, please indicate by ticking the appropriate box what **the patient's current treatment regime** consists of, and who initiated the regime.

You **may tick more than one box** if several options apply. The remaining questions need not be answered if the patient has Diabetes - **end questions** here.

If the patient **has not** been diagnosed with Diabetes, please indicate whether or not they acknowledge having **two or more** of the **risk factors** listed on the **diabetes risk card.**

Please indicate whether the patient's **fasting or random blood glucose level** has been **tested** on a **previous** occasion, will be **re-tested** as a result of **today's** encounter, will be tested for the **first time** as a result of this encounter, or **will not be tested** as a result of today's encounter.

If a test has r**esulted from today's encounter** and the patient's blood glucose level indicates **hyperglycaemia**, please indicate by ticking the appropriate box what the action plan for **management** of this condition will be.

Does this patient have diagnosed diabetes?	**If 'Yes' what is their current treatment regime?**		**If 'No' does the patient have 2 or more of the risk factors listed on the diabetes risk card?**	**If 'Yes" to risk factors, the patient's fasting or random blood glucose:**	**If, from a test initiated/taken today, blood glucose level indicates hyperglycaemia, will the patient:**
☐ Yes - Type 1	☐ Medication (specify)	**Initiated By**	☐ Yes	☐ has been tested in the past	☐ Be referred to specialist for further assessment
☐ Yes - Type 2	1. _____	GP/Specialist	☐ No	☐ will be re-tested today	☐ Commence a diet program?
☐ No	2. _____	GP/Specialist		☐ has never been tested but will be tested today	☐ Commence an exercise program?
BL27C	☐ Diet Program	GP/Specialist/other		☐ will not be tested today	☐ Commence oral anti-diabetic treatment?
	☐ Exercise Program	GP/Specialist/other			☐ Other (specify) _____
	End questions				

Please read this card and tell your doctor if you answer '**yes**' to **2 or more** of the questions. If you do not understand some of the risk factors, please ask your doctor to tell you what they mean.

Diabetes Risk Factors **

1. Is your family background Aboriginal or Torres Strait Islander, Pacific Islander, Chinese, Southern European or from the Indian sub-continent?

2. Does either of your parents, or any of your brothers or sisters have Type 2 Diabetes?

3. Are you over 50 years of age?

4. For Women: Have you ever had gestational diabetes (i.e. while you were pregnant), a history of babies born heavier than 4.5 kg, multiple miscarriages or stillbirths?

5. Do you:
   - carry a lot of excess weight around your waist and stomach area (central obesity)?
   - have high blood pressure (hypertension)?
   - have a blood lipid (fat) disorder (dyslipidaemia)?

** McMarty DL, Zimmet P, Dalton A, Segal L & Wellborn TA. (1996) The Rise and Rise of Diabetes in Australia, 50-51. International Diabetes Institute & Diabetes Association.

22 Asthma—prevalence, severity and management

Organisation supporting this study: General Practice Statistics and Classification Unit

Issues: This substudy investigated the prevalence of asthma in general practice patients, and the severity of asthma using the National Asthma Campaign's severity classification. For those asthmatic patients, management of asthma, the effectiveness and adverse effects of treatment were examined.

Sample: 5,495 respondents from 95 GPs; data collection periods: 28/11/2000 – 15/01/2001.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: Levels of severity of asthma for children and adults were listed on a patient card with descriptions of each level. Severity classes for children included infrequent episodic, frequent episodic, and persistent. For adults, the severity classes were very mild, mild, moderate and severe. The severity levels were adapted from the NAC Asthma Management Handbook 1998.

Summary of results

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

The prevalence of asthma among the respondents was 12.8% (95% CI: 11.4–14.3). Asthma was significantly more prevalent in patients aged 5 to 14 (22.2%, 95% CI: 14.4–29.9) than in the total sample. Of the 118 children (age <18) with asthma who responded to the severity question, 74.6% had infrequent asthma, 20.3% had frequent and 5.1% had persistent asthma. Among 543 adults (age≥18) with asthma who responded to the severity question, 70.0% had very mild or mild asthma, 24.5% had moderate asthma and 5.5% had severe asthma.

Of the 132 asthmatic children (age<18) 39.4% had an asthma action/management plan, while 27.1% of asthmatic adults (age≥18) (*n*=547) had such a plan. Nine out of ten patients with asthma (90.8%, *n*=704) were taking medications for asthma. Of asthma patients, 82.0% used reliever medications, 48.7% preventer medications and 7.8% controller medications.

The distribution of treatment regimen for asthma varied with asthma severity levels. Reliever alone was the most common regimen among the 88 children with infrequent asthma (53.4%) and among the 232 adults with very mild asthma (62.1%). The combination of relievers and preventers was most common among the children with frequent asthma (15/24), children with persistent asthma (4/6), adults with mild asthma (46.6%, 69/148), adults with moderate asthma (63.9%, 85/133), and adults with severe asthma (63.3%, 19/30).

For the 614 respondents taking medications for their asthma, GPs rated the effectiveness of the current treatment regimen as 5 (effective) in 54.9% of cases. Reliever medications alone (270 patients) had the highest proportion (64.1%) of a '5' rating for the effectiveness of current treatment regimen. Of the 602 patients on asthma medications, 82.9% had no adverse effect from current treatment regimen. Patients only taking reliever medications, recorded the highest proportion (90.0%, *n*=259) of 'no adverse effect' of current treatment regimen.

For other related abstracts see: 3 Asthma, 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, 96 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.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **ASTHMA.**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

CHILDREN

Severity*	Common features
Infrequent episodic	Episode 6-8 weeks or more apart; 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; increasing symptoms between attacks; normal examination and lung function except when symptomatic.
Persistent	Symptoms most days; nocturnal asthma > 1/wk; attacks 4-6 weeks apart; daily use of beta2 agonist; 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 admissions in past year; FEV_1 may be significantly reduced between exacerbations.

*Severity categories are adapted from the NAC Asthma Management Handbook, 1998 Edition

ASK ALL PATIENTS
Ask each patient if they **currently suffer from asthma.**

If **NO** asthma - no further questions.

Severity of asthma
Ask the patients with asthma about the severity of their asthma (see tables above):

Note that your research pack contains a card copy of these tables for easy reference.

Action / Management Plan

Ask the patients with asthma whether or not they have a written asthma action and / or management plan.

Current medications used:
Describe the current medications used in the treatment of asthma listing dose and regimen.

The medication form (metered dose inhaler/ dry powder inhaler / nebules) for each listed drug should be circled.

Spacer device used:
Is any spacer device used?
If so, tick whether it is a large or small volume spacer and circle a number(s) to indicate the drug(s) for which the spacer is used. *(Multiple response allowed).*

Effectiveness of current regimen:
Circle on the scale the effectiveness of the current medication regimen used in the treatment of the patient's asthma.

Adverse effects of current regimen:
Circle on the scale the level of adverse effect ('withdraw' indicates the patient will cease the drug due to adverse effects).

List up to two adverse effects (if any) experienced by the patient with the current regimen, regardless of the effect's severity.

Does this patient suffer from Asthma?

☐ Yes
☐ No → ***End questions***

B28B&C

If 'Yes' how severe is the asthma? **(See reference cards)**

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

Does this patient have a written asthma action and/ or management plan?

☐ Yes
☐ No
☐ Don't know

Current drug(s)	Dose	Regimen	Form*
1.			MDI / DPI / NEB
2.			MDI / DPI / NEB
3.			MDI / DPI / NEB

*MDI=metered dose inhaler DPI=dry powder inhaler NEB=nebules

Spacer device used: Large vol. ☐ For drug(s) 1/ 2/ 3
None ☐ Small vol. ☐ For drug(s) 1/ 2/ 3

Effectiveness of current regimen *(circle)*

1 2 3 4 5
Not effective — Effective

Adverse effects of current regimen *(circle)*

1 2 3 4 5
None — Minor — Withdraw
1. 2.

Severity of asthma reference card

Children

Severity*	Common features
Infrequent episodic	Episode 6-8 weeks or more apart; 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; increasing symptoms between attacks; normal examination and lung function except when symptomatic.
Persistent	Symptoms most days; nocturnal asthma > 1/wk; attacks 4-6 weeks apart; daily use of beta2 agonist; 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 admissions in past year; FEV_1 may be significantly reduced between exacerbations.

* The severity classes are adapted from the NAC Asthma Management Handbook 1998 edition.

23 Depression

Organisation supporting this study: Commonwealth Department of Health and Ageing (Pharmaceutical Benefits Branch)

Issues: This substudy examined the GP perceived rate of depression managed among general practice respondents, and the rates of management of different types of depression.

Sample: 5,624 respondents for 196 GPs; data collection period: 16/01/2001 – 26/03/2001.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: 'Major depressive disorder' was defined according to DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th edition) criteria to provide guidance for GPs reporting this condition.

Summary of results

Males were slightly under-represented in the SAND sample (39.8 %, 95% CI: 37.9–41.7) compared with the expected distribution for BEACH (42.7%, 95% CI: 42.0–43.5).

The GPs recorded managing depression at 12.1% of encounters (*n*=682). Depression was noted for 13.8% of females (95% CI: 11.4–16.2) and 9.4% of males (95% CI: 95% CI: 6.3–12.5). Among adults aged 45–64, 16.6% were managed for depression (95% CI: 12.1–21.2) compared with 9.3% of young people aged 15–24 (95% CI: 0.6–18.0). Differences in sex specific and age specific rates however, were not significant, possibly due to the relatively small numbers in certain age groups.

The most frequent type of depression was 'depression with anxiety disorder', seen in 4.0% (*n*=223) of SAND respondents, followed by 'chronic mild depression' (3.5%, *n*=196) and 'adjustment disorder with depressed mood' (2.9 %, *n*=162). 'Major depression' was seen in 2.6% (*n*=147) of SAND respondents. Alcohol/drug related depression (*n*=28) and bipolar disorder (*n*=7) were very infrequently managed among SAND respondents.

In this SAND analysis GPs reported managing depression at 3–4 times the rate normally reported at BEACH encounters (3.4 depression problems per 100 encounters). The discrepancy between SAND and BEACH in the management rates of depression, suggests that GPs perceived many more of their patients as depressed than they explicitly managed for depression. It is also possible that GPs consider GP–patient encounters as involving implicit management of depression, regardless of the explicit problems managed. Some GPs may have perceived depression as part of the patient problem with which they were dealing, or as an inherent part of the patient's disease complex, and not as a separate problem managed in the encounter. This study suggests that depression is recognised in general practice patients far more frequently than suggested by GPs' explicit recording of depression as a diagnosed problem under management.

For other related abstracts see: 5 Depression, 47 Management of depression and anxiety.

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

INSTRUCTIONS

BOX 1

Criteria for major depression* *DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th edition).

At least FIVE (5) of the following symptoms for at least TWO WEEKS (symptom 1 or 2 must be present):

(1) Depressed mood
(2) Loss of interest or pleasure
(3) Significant appetite or weight loss or gain
(4) Insomnia or hypersomnia
(5) Psychomotor agitation or retardation
(6) Fatigue or loss of energy
(7) Feelings of worthlessness or excessive guilt
(8) Impaired thinking or concentration; indecisiveness
(9) Suicidal thoughts/thoughts of death

Please indicate whether **depression** is one of the problems you are managing for this patient today.

If **'Yes'** please continue on to the next question.

If **'No'** end questions here.

If you believe the patient's depression is a **MAJOR** depressive disorder **according to the criteria shown above in Box 1** please tick the corresponding box to indicate this.

Otherwise, please tick the appropriate box which **best describes** the **type of depression** the patient is suffering from. You may tick more than one box if more than one description applies. If none of these options apply, please choose 'other' and write a brief description.

Is depression one of the problems being managed at today's encounter?

Yes ☐ → continue

No ☐ → end questions here

If 'Yes' how would you describe this depressive episode?

Major depression ☐
Adjustment disorder with depressed mood ☐
Chronic mild depression ☐
Alcohol / drug induced ☐
Depression associated with anxiety or anxiety disorder (e.g., generalised anxiety, panic, phobia, obsessive compulsive etc) ☐
other (please describe) ☐

_____
_____
_____
_____
_____

BL29B

24 Gastro-oesophageal reflux disease (GORD) in general practice patients

Organisation supporting this study: Janssen-Cilag Pty Ltd

Issues: This substudy was designed to gain further understanding of patients in general practice who have been diagnosed with gastro-oesophageal reflux disease (GORD) and the specific medications used in its treatment. Other elements such as medication regimen, patient level of satisfaction with medication effectiveness, and the person who initiated treatment were also explored.

Sample: 93 GPs responded to questions on behalf of 2,767 patients; data collection period: 20/02/2000 – 26/03/2001

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age–sex distribution of patients in this sample was similar to the distribution of the total BEACH sample. Females were represented at 60% of encounters. Patients aged between 25 and 64 years represented over half the sample (51.9%).

The estimated point prevalence of GORD in general practice for this sample was 15.6% (*n*=433). For the majority of these patients, GORD had been diagnosed at a previous encounter (86.4%, *n*=374). The prevalence of GORD was most common among patients aged 65 or over, approximately 30% of whom had been diagnosed with GORD. The prevalence of GORD did not differ between males and females.

Seventy-eight per cent (*n*=339) of patients with diagnosed GORD (*n*=433) indicated taking medications (*n*=364) specifically for GORD. Very few patients were taking more than one medication (7.08%, 24/339).

Over half of the medications that were currently being taken by patients were H_2-receptor antagonists (H_2Ras) (53.6%, 195/364) followed by proton pump inhibitors (PPIs) (29.1%, 106/364). Analysis of medications at the generic level indicated that Ranitidine was the most common generic medication being taken (37.6%, 137/364).

Seventy-five per cent (*n*=254) of medications for which a drug regimen was recorded (*n*=337) were taken by patients on a 'daily' basis as opposed to an 'as required' (prn) basis.

An indication of whether each medication was initiated by a GP, specialist or other source was provided for 329 medications. The GP was the most common source of medication prescriptions (58.4%) and approximately one-third (32.5%) of medications were initiated by a medical specialist.

Patients were also asked to specify their level of satisfaction with each medication using a scale from 1 (unsatisfied) to 5 (very satisfied). A large proportion of patients were at least satisfied ('4'–34.7%; '5'–44.3%), and 20.8% were less satisfied ('3'–12.5%; '2'–3.4%; '1'–4.9%).

For other related abstracts see: 18 Drugs for the treatment of peptic ulcer and reflux, 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, 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 **GASTRO-OESOPHAGEAL REFLUX DISEASE & MEDICATIONS.**

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

INSTRUCTIONS

FOR THE DOCTOR

These questions refers to any patient who has been diagnosed with **gastro-oesophageal reflux disease** either today or at a previous encounter.

If 'Yes' to **either** option please continue the questions.

If ***NO*** - questions ***END*** here.

This question refers to **medication/s currently being taken** by the patient to treat their reflux disease.

Medication - please write the name of reflux medication in the space provided. There is room to write up to 3 medications.

Regimen - along side the medication name please circle a response to indicate whether the patient has been advised to take the medication daily or only when required (p.r.n.) to treat symptoms.

Initiated by - along side the regimen please circle a response to indicate whether the patient originally began taking this medication as a result of a prescription from a GP, a prescription from a specialist, or a recommendation from another source (if the medication is an 'over-the-counter' preparation).

Patient satisfaction - please ask the patient to rate how satisfied they are with the effectiveness of each medication by circling a response from 1 to 5, where **1 is unsatisfied** and **5 is very satisfied.**

Medication regimen - if the patient has been instructed to take any of their reflux medications on a daily basis, please ask the patient to nominate an option from those listed which best describes how often the medication is actually being taken.

Previous medications - please write the names of any medications the patient has previously used for the treatment of their reflux disease.

Has this patient been diagnosed with **gastro-oesophageal reflux disease?**	What medication is currently being taken for treatment? ☐ None				For 'daily' regimen medication is actually taken:	Which medications have you previously used for this condition?
	Medication	**Regimen**	**Initiated by**	**Patient Satisfaction**		
☐ Yes - at this encounter	1._____	Daily / p.r.n	GP/Spec'st/other	1 2 3 4 5	☐ one per day	1._____
☐ Yes - at a previous encounter	2._____	Daily / p.r.n	GP/Spec'st/other	1 2 3 4 5	☐ > one per day	2._____
☐ No ➔ **end questions**	3._____	Daily / p.r.n	GP/Spec'st/other	1 2 3 4 5	☐ < one per day	3._____

BL30C

25 Prevalence of diabetes, medications and control

Organisation supporting this study: Aventis Pharma Pty Ltd

Issues: The prevalence of diagnosed diabetes and the specific medications used in its treatment; hypoglycaemic attacks in diabetic patients including the number of attacks, action taken because of the attacks and the number of days off work due to the attacks over the past 12 months.

Sample: 2,810 encounters from 95 GPs; data collection period: 01/05/2001 – 11/06/2001.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to the distribution for all BEACH encounters, with the majority (56.7%) being female. Patients aged 25–44 years accounted for 28.1% of the sample.

The prevalence of diagnosed Type 1 diabetes in this sample was estimated to be 0.8% (95% CI: 0.0–2.7), and the prevalence of diagnosed Type 2 diabetes was 6.0% (95% CI: 4.6–7.3). On average, patients with diagnosed diabetes were older (66.5 years, 95% CI: 63.6–69.4) than patients without diabetes (42.4 years, 95% CI: 40.2–44.6).

All patients with Type 1 diabetes were currently using insulin, with the majority (54.6%) taking intermediate/long acting insulin only. Only 7.9% of patients with Type 2 diabetes were currently using insulin. Non-insulin diabetic medication (defined as sulfonylurea, metformin, glitazone or repaglinide) was being taken by 71.3% (95% CI: 63.7–79.0) of patients with Type 2 diabetes. Of these medications, metformin (50.6%) and sulfonylurea (41.5%) were the most commonly prescribed for patients with Type 2 diabetes. Almost a third (31.8%) of patients with Type 1 diabetes and almost half (43.3%) of those with Type 2 diabetes were also taking anti-hypertensive medication.

The proportion of patients with diabetes who indicated having any hypoglycaemic attacks in the previous 12 months was 11.0% (*n*=20), 13 (65.0%) of these reporting between one and three hypoglycaemic attacks in the previous 12 months.

Of the 20 patients who had hypoglycaemic attack/s during the previous 12 months, 17 provided information on where they sought treatment. Eight visited their GP as a result of an attack, three visited a community nurse, three attended casualty, three were hospitalised and none had a glucagon injection. Only one of the six working age patients with diabetes who had hypoglycaemic attack/s in the previous 12 months had any time off work as a result.

For other related abstracts see: 21 Diabetes – prevalence, management and screening, 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, 94 Type 2 diabetes – investigations and 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 **DIABETES MELLITUS.**

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

INSTRUCTIONS

FOR THE DOCTOR

Please indicate by ticking the appropriate box whether or not this patient has **ever been diagnosed** as having **Diabetes.**

The **remaining questions need not be answered** if the patient **does not have Diabetes - end questions** here.

If the patient has been diagnosed with Diabetes, either today or at a previous encounter, please indicate by ticking the appropriate box **the patient's current medication**.

You **may tick more than one box** if several medications are being used.

If **none** of these medications are being used by this patient, tick '**none of the above**'.

ASK THE PATIENT

Please write in the **approximate number of hypoglycaemic attacks/ events** experienced by this patient during the past 12 months.

ASK THE PATIENT

Please write in the **approximate number of times** the following actions were taken for this patient as a result of a **hypoglycaemic attack/ event** during the past 12 months.

ASK THE PATIENT

If the patient has been **absent from work** because of **hypoglycaemic attacks/ events**, please write in the number of **lost work days** during the past 12 months.

Does this patient have diagnosed diabetes?	Which of the **following medications** is this patient **currently using?**	**In the past 12 months** how many times has this patient had a **hypoglycaemic attack/event?**	**In the past 12 months,** how many times have the **following actions resulted from a hypoglycaemic attack/event?**	**In the past 12 months** how many days has this patient been absent from work due to a **hypoglycaemic attack/event?**
☐ Yes - Type 1 ☐ Yes - Type 2 ☐ No - **end questions**	☐ Insulin (intermediate/long acting) ☐ Insulin (short-acting) ☐ HMG-Co-A inhibitor ☐ ACE-inhibitor ☐ Other Antihypertensive ☐ Sulfonylurea ☐ Metformin ☐ Glitazone ☐ Repaglinide ☐ None of above	_____ **times** BL32C	Glucagon injection _____ times Community Nurse consultation _____ times GP consultation _____ times Casualty visit _____ times Hospitalisation _____ times	_____ **days**

26 Prevalence of diagnosed hypertension and difficulties in treatment

Organisation supporting this study: AstraZeneca (Australia) Pty Ltd

Issues: Prevalence of diagnosed hypertension in general practice and degree of difficulty of treatment; current medication used; medication changes in the past year; previous medications used.

Sample: 2,746 respondents from 93 GPs; collection period: 12/06/2001 – 16/07/2001.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age–sex distribution of patients was similar to the distribution of the total BEACH sample, with the majority (58.9%) being female. Patients aged over 65 years accounted for 26.6% of the sample.

The prevalence of hypertension among the respondents was 23.2% (95% CI: 20.6–25.8). Of the 638 hypertensive patients, 539 had simple hypertension and 99 had complicated hypertension, demonstrating a prevalence of 19.6% for simple hypertension and 3.6% for complicated hypertension. Prevalence did not differ for males, but female patients aged 65 years or more were significantly more likely to have hypertension (53.1%, 95% CI: 43.8–62.4), compared with the overall prevalence.

The GPs stated that it was easy to control the hypertension of 42.8% of patients with simple hypertension but only 5.2% of those with complicated hypertension. They found it difficult or very difficult to control 12.8% of simple and 54.6% of complicated hypertension.

Of the 630 patients with hypertension who answered the questions on medications, only 7.3% were not currently taking any medication, while just over half (54.6%) were taking one medication. The remaining 38.1% were taking two or more medications. Patients with complicated hypertension were taking more medications than those with simple hypertension, and 70.4% of patients with complicated hypertension reported using two or more hypertension medications. The most common current medications were atenolol (10.7% of all current medications), amlodipine (7.1%) and irbesartan (6.9%).

Among the 587 patients who responded to the question about change of medication, over a quarter (27.3%) reported that their hypertension medication(s) had been changed in the past 12 months. Change in medication was reported by a quarter (25.8%) of patients with simple hypertension, and almost half of patients (49.4%) with complicated hypertension. Of the 372 previous medications recorded for all patients with hypertension, enalapril maleate was the most common (8.6%). It was followed by irbesartan (7.3%), atenolol (7.3%) and indapamide (6.7%).

For other related abstracts see: 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.**

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

INSTRUCTIONS

Hypertension.

Does this patient have diagnosed hypertension?

If Yes ...indicate whether it is SIMPLE or COMPLICATED by ticking the appropriate box.

If No ...questions **END** here.

Current Medication for Hypertension.

Please write the name of any medication the patient is currently taking to control their hypertension.

Please indicate the approximate length of time each medication has been taken by circling an option for each.

Previous Medication for Hypertension.

If the patient has ceased taking a medication previously used for hypertension please write in the name/s of the last three medications used.

Please indicate the approximate length of time since the use of each medication ceased by circling an option for each.

Control of patient's hypertension.

In your management of this patient's hypertension, how difficult has it been to gain control of the hypertension?

Change of Medication

Please indicate whether **any** of the patient's hypertension medication/s has been **changed** within the past 12 months.

Does this patient have hypertension?	**Has getting control of this patient's hypertension been ..**	What medication/s is this patient **currently** taking for hypertension and how long have they been on each?	Has this patient's hypertension medication/s changed in the last 12 months?	What medication/s were **previously** taken for hypertension and how long ago was each of these stopped?
YES Simple ☐ Complicated ☐ NO ☐ → *END* BL33B	Easy ☐ Relatively easy ☐ Difficult ☐ Extremely difficult ☐	**Medication** — **Duration** (circle one) _____ <1mth / 1-12 mths / >12 mths _____ <1mth / 1-12 mths / >12 mths _____ <1mth / 1-12 mths / >12 mths ☐ NONE	☐ Yes ☐ No	**Medication** — **How long since stopped?** _____ <1mth / 1-12 mths / >12 mths _____ <1mth / 1-12 mths / >12 mths _____ <1mth / 1-12 mths / >12 mths ☐ NONE

27 Prevalence and management of influenza

Organisation supporting this study: Roche Products Pty Ltd

Issues: This study was designed to gain a better understanding of the prevalence and management of influenza in general practice patients. Topics explored included the prevalence of influenza vaccinations; the annual incidence of influenza in general practice patients and their immediate families; the impact on their daily activities; medications used for management; from whom treatment was sought.

Sample: 2,784 respondents from 94 GPs; data collected between 12/06/2001 – 16/07/2001.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: Patients were provided with an information card outlining the symptoms of influenza compiled with advice from the Australian Influenza Working Party. Symptoms included sudden onset of fever, chills, body aches and pains, headache, dry cough and fatigue. This card also included an explanation of the scale of impact on daily activities used.

Summary of results

The age-sex distribution of respondents was similar to the distribution for all BEACH (general practice) encounters, with the majority of patients (57.5%) being female and aged 25–44 (25.2%, 95% CI: 22.8–27.6) or 45–64 (25.1%, 95% CI: 22.8–27.4) years.

One-third of respondents had received an influenza vaccination in the previous 12 months. The rates for males and females were equivalent. Among adults the vaccination rate increased significantly with age, from 15.1% of 25–44 year olds to 82.8% of respondents aged 75 years and over.

Less than 10% of respondents reported experiencing influenza in the last 12 months. Of the influenza sufferers, half sought treatment from a GP, whilst one-quarter did not seek any advice or treatment. Two-thirds of those who had suffered influenza reported that it interfered moderately to greatly with their daily activities.

One-quarter of respondents who had suffered influenza had not taken any medications. Of the remainder, 46% had taken one medication only. The most common medication was paracetamol (24.0%, *n*=71).

Forty-three per cent of respondents who had experienced influenza reported another member of the family also having influenza in the previous 12 months.

For other related abstracts see: 9 Influenza and absenteeism.

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 **INFLUENZA.**

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

INSTRUCTIONS

ASK THE PATIENT...

to read through the checklist of symptoms on the enclosed card and then answer the following question/s.

Have you had influenza in the past 12 months?

If Yes ... please continue with the remaining questions.
If No ... the questions **END** here.

Impact on daily activities.

Please ask the patient to nominate the response which best indicates the level of interference their bout of 'flu' had on their ability to perform their daily activities.

Refer to the symptom card for a guide to gauging the level of interference.

Others with 'flu'.

Please indicate whether any other members of the patient's household also suffered from 'flu' during the same period as this illness. If 'Yes' please circle whether 'child' or 'adult'. You may circle both if both apply.

Vaccination for 'flu'.

Has the patient been vaccinated for influenza during the past 12 months?

Treatment / advice.

Please ask the patient to indicate from whom they sought treatment or advice and tick the most appropriate response.

Please circle a response which best indicates how soon the patient sought this treatment or advice following the onset of symptoms.

Medications.

Please ask the patient to list the medications taken for treatment of this 'flu'. Include any medications prescribed and any 'over-the-counter' preparations used.

Have you been **vaccinated** against 'flu' in the past **12 months**?	**Have you had influenza in the past 12 months?**	**Treatment/advice** was sought **from whom** and **how soon** after onset of symptoms? *(please circle)*	How much did it **interfere** with your **daily activities**?	What **medications** did you take **for treatment?** (include prescriptions ***and*** 'over-the-counter' medications)	Did any **other member** of your household **also suffer from 'flu'?**
☐ Yes ☐ No BL33C	☐ Yes → ☐ No - **end questions**	☐ Pharmacist <24hrs / 24-48hrs / >48hrs ☐ GP <24hrs / 24-48hrs / >48hrs ☐ Hospital outpatients <24hrs / 24-48hrs / >48hrs ☐ None sought	☐ Not at all ☐ Slightly ☐ Moderately ☐ Greatly	1. _____ 2. _____ 3. _____ 4. _____	☐ Yes → child / adult ☐ No

Influenza

** SYMPTOM CHECKLIST

Sudden onset of ...

- fever - 38 decrees C. or more, and/or
- chills
- body aches and pains

possibly also ...

- headache
- dry cough
- fatigue

IMPACT ON DAILY ACTIVITIES

Not at all - you were able to carry out your normal daily routine

Slightly - you were unable to carry out some of your normal daily activities

Moderately - you were unable to carry out at least half of your normal daily activities

Greatly - you were unable to carry out most of your normal daily activities.

**compiled with advice from the Australian Influenza Working Party

28 Prevalence of Alzheimer's disease and dementia

Organisation supporting this study: Janssen-Cilag Pty Ltd

Issues: Prevalence of Alzheimer's disease and dementia in adult general practice patients; prevalence of current cognitive impairment, difficulties with daily living or behaviour changes in patients not diagnosed with Alzheimer's disease or dementia; proportion of patients who (in the GP's opinion) were likely to have dementia or the early signs of Alzheimer's; proportion of patients who had taken a Mini Mental Health Assessment (MMHA).

Sample: 2,194 encounters (with adults) from 88 GPs; data collection period: 17/07/2001 – 20/08/2001.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: *Patients were provided with an information card outlining the signs of cognitive impairment, examples of difficulties with daily living and examples of behavioural changes.*

Summary of results

The age and sex distributions of the respondents was similar to the distribution for BEACH overall. The prevalence of diagnosed Alzheimer's disease in this adult general practice patient population was 1.6% (95% CI: 0.0–4.4), and the prevalence of diagnosed dementia was 2.4% (95% CI: 0.0–5.4).

Of adult patients not diagnosed with dementia, 4.2% displayed cognitive impairment, 4.9% encountered difficulties with daily living and 5.6% experienced behavioural changes. Only 1.4% of patients displayed all three of the above symptoms, while 2.7% had two of the three symptoms, and 5.0% displayed one symptom.

A MMHA had been used for only 2.4% of the 2,046 patients without diagnosed dementia or Alzheimer's for whom a response to this question was provided. MMHA use was rare (0.9% assessed) for patients with no symptoms of dementia but more common (51.7% assessed) with patients who had all three dementia symptoms.

GPs were asked whether it was likely that patients without diagnosed dementia actually had signs of dementia or early Alzheimer's. GPs indicated that 59 patients (2.9%) were likely to have dementia not yet diagnosed, and 20 patients (1.0%) were likely to have early Alzheimer's, as yet not diagnosed. Combined, GPs indicated that 63 patients (3.1%) were likely to have undiagnosed dementia and/or early Alzheimer's and more than half of these patients were aged 75 years or more. By far the majority of these expressed opinions were based on clinical opinion rather than on results of a MMHA.

For other related abstracts see: 102 Alzheimer's disease or dementia 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 **DEMENTIA / ALZHEIMER'S DISEASE.**

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

INSTRUCTIONS

Dementia.

Has this patient ever been diagnosed with any form of dementia either today or at a previous encounter?

If Yes ...questions **END** here.

If No ....please continue.

Alzheimer's Disease.

Has this patient ever been diagnosed with Alzheimer's disease, either today or at a previous encounter?

Cognitive impairment.

From the symptom card please indicate whether or not this patient shows signs of cognitive impairment.

Difficulties with daily living.

From the symptom card please indicate whether or not this patient has difficulties with daily living activities.

Behavioural changes.

From the symptom card please indicate whether or not this patient often experiences behavioural changes.

Mini Mental Health Assessment.

Please indicate whether or not this patient has ever undergone a Mini Mental Health Assessment, either under your care or, to your knowledge, that of another physician.

Likelihood of dementia / Alzheimer's.

Please indicate the likelihood of this patient having demential, signs of early dementia, or signs of early Alzheimers disease.

Basis of previous response.

Please indicate whether you have based your answer to the previous question (i.e. the likelihood of this patient having dementia, signs of early dementia or signs of early Alzheimer's disease) on the results of a Mini Mental Health Assessment, on your clinical opinion, or both. You may tick both options if both apply.

Has this patient ever been diagnosed with **Alzheimer's Disease?**	Has this patient ever been diagnosed with **any form of dementia?**	Does this patient have **any cognitive impairment?** *(see card)*	Does this patient have **any difficulties with daily living?** *(see card)*	Does this patient **often experience behavioural changes?** *(see card)*	Has this patient undergone a **Mini Mental Health Assessment?**	Is it likely that this patient has:-			Is your answer to the previous question based on
						Dementia? (currently)	Signs of **early dementia?**	Signs of **early Alzheimers?**	
☐ YES	☐ YES → ***END Questions***	☐ YES	☐ YES	☐ YES	☐ YES	☐ YES	☐ YES	☐ YES	☐ **results** of a Mini Mental Health Assessment?
☐ NO BL34B	☐ NO →	☐ NO	☐ NO	☐ NO	☐ NO	☐ NO	☐ NO	☐ NO	☐ **Clinical opinion?**

Dementia / Alzheimer's

** SYMPTOM CHECKLIST

Cognitive impairment ...
* forgetting to pay bills
* misplacing car keys, or
* word finding difficulties.

Difficulties with daily living ...
* meal preparation,
* telephoning,
* housework,
* difficulty in handling finances and correspondence

Behavioural changes ...
* depression,
* anxiety,
* mood swings,
* delusions and hallucinations,
* aggression and agitation.

**based on NSW Alzheimer's Association symptom list

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29 Non-steroidal anti-inflammatory drugs (NSAIDs) and acid suppressant use

Organisation supporting this study: AstraZeneca (Australia) Pty Ltd

Issues: This substudy was designed to investigate non-steroidal anti-inflammatory drugs (NSAIDs) and acid suppressant use by general practice patients. Specifically, the use of NSAIDS, Cox–2 inhibitors and acid suppressants by patients with upper gastro-intestinal (UGI) problems was explored.

Sample: Responses were recorded by 88 GPs for 2,551 patients; data collection period: 16/07/2001 – 20/08/2001.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age–sex distribution of patients in this sample was similar to the distribution of the total BEACH sample, with the majority (58.8%) being female. Patients aged between 25 and 64 years represented over half the sample (53.2%).

One in seven (13.9%) of the 2,551 respondents were currently taking a non-steroidal anti-inflammatory drug (NSAID). Of those who reported NSAID use, 46.6% (*n*=165) were using a Cox–2 inhibitor alone; 38.7% (*n*=137) were using another NSAID alone; 5.1% were using aspirin alone; 1.1% were using both a Cox–2 and aspirin; and 0.9% were using aspirin with another NSAID.

Among the 325 patients for whom the type of NSAID was specified, Cox–2 inhibitors were the most commonly used (59.4%). Regimen was recorded for 132 of those using Cox–2 inhibitors, 59.1% of whom listed continual use and the remainder (40.9%) were taking them when required.

A total of 422 respondents using NSAIDS answered the UGI questions. The prevalence of UGI in these patients was estimated at 75.4% (CI: 69.7–81.0). At least one UGI problem was listed by 38.8% of the 165 patients using Cox–2 inhibitors; 25.4% of the 138 other NSAID users, and 32.3% of the 130 taking low dose aspirin.

Of the 422 respondents with at least one UGI problem, three-quarters (75.4%) were using acid suppressant medication. For the 480 patients currently taking NSAID and/or aspirin, almost one in three (30.2%) were using acid suppressant medications.

Acid suppressants were used prophylactically by 39.1% of the 307 patients using acid suppressants, the remainder using these medications only when required for symptom relief.

For other related abstracts see: 78 NSAID & acid suppressant use in general practice patients, 88 Arthritis rates and NSAID use in general practice patients, 49 Health status and management of patients on 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 **NSAID and ACID SUPPRESSANT USE.**

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

INSTRUCTIONS

Patient use of NSAIDs and / or Aspirin

Please indicate by ticking the appropriate box/es whether this patient is **currently taking a non-steroidal anti-inflammatory drug (NSAID)** and / or **low dose aspirin**. If the **'non-specific'** NSAID option is ticked, please **write the name** of the NSAID being used.

Tick as many options as apply.

Please **circle an option** from the **'taken'** column to indicate whether the medications are taken **as required** or **continually**.

Please **circle an option** to indicate the approximate **length of time** (months) that the patient has been taking this medication.

Symptoms of Upper GI Problems

Please indicate by ticking the appropriate box whether the patient is **currently experiencing**, or **currently being treated for**, symptoms of **upper gastro-intestinal** problems.

Tick as many options as apply.

Acid Suppressant Medication

Please indicate whether this patient is currently taking any **acid suppressant medication** (either prescribed or over-the-counter). If **'YES'** please **specify these medications** in the spaces provided.

Please **circle an option** from the **'taken'** column to indicate whether the medications are taken **as required** or for **prophylactic** purposes.

Please **circle an option** to indicate the approximate **length of time** (months) that the patient has been taking each medication.

Is this patient currently taking - **a non-steroidal anti-inflammatory drug (NSAID)** ?

	taken	*for how many months*
☐ YES - Cox 2 inhibitor	pm / continually	<3 / 3-6 / 6-12 / >12
☐ YES - non-specific	pm / continually	<3 / 3-6 / 6-12 / >12

(which one?) _____

and / or low dose aspirin?

☐ YES *for how many months* <3 / 3-6 / 6-12 / >12

☐ NONE of the ABOVE

BL34C

Does this patient have, or are they being treated for, **symptoms of upper GI problems** such as -

- ☐ dyspepsia / indigestion
- ☐ reflux symptoms / heartburn
- ☐ ulcer (duodenal, peptic)
- ☐ bleeding ulcer
- ☐ none of the above

Is this patient taking **any acid suppressant medication** (eg PPI's, H2RAs, misprostol, OTC preparations etc)

☐ YES (please specify)

	taken	*for how many months*
1. _____	pm / prophylactically	<3 / 3-6 / 6-12 / >12
2. _____	pm / prophylactically	<3 / 3-6 / 6-12 / >12

☐ NO

30 Lipid lowering medications and coronary heart disease

Organisation supporting this study: Commonwealth Department of Health and Ageing

Issues: This substudy investigated the proportion of general practice patients receiving lipid lowering medications. For those taking lipid lowering medication therapy the prevalence of coronary heart disease (CHD) and risk factors for CHD were also investigated. The types of medications used for lipid lowering therapy and the levels of cholesterol for different risk factors were examined.

Sample: 2,661 respondents from 90 GPs; data collected between 21/08/2001 – 24/09/2001.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: Risk factors for CHD included: diabetes mellitus, familial hypercholesteraemia; family history of coronary heart disease (1st degree relative <60 yrs of age), hypertension and peripheral vascular disease.

Summary of results

The age–sex distribution of respondents was similar to the distribution for BEACH overall, with the majority (58.6%) of patients being female.

More than 1 in 10 (12.6%) respondents indicated they were currently taking lipid lowering medications. The sex-specific rate of lipid lowering medication use was similar for males and females. The highest age-specific rate of lipid lowering medication use was for the age group 65–74 years. However, 36.1% of respondents taking lipid lowering medications were aged between 45 and 64 years of age.

Most respondents on lipid lowering medications were continuing therapy (*n*=292), while very few were starting medication therapy at the current encounter (*n*=12).

For those on a lipid lowering medication 41.1% had existing coronary heart disease (CHD), a further 25.9% had one of the listed risk factors for CHD, 21.1% had more than one of the listed risk factors, and 9.2% had none of the listed risk factors, although these may have had high cholesterol (not familial) which was not included on the CHD risk factor list. Approximately 2.7% did not provide information on risk factors.

For those without CHD, hypertension was the most common risk factor (30.1% of respondents on lipid medication therapy).

There were 330 medications listed for lipid lowering therapy. Statins accounted for nearly all the listed medications. Atorvastatin accounted for 41.5% of lipid lowering medications, prescribed for 42.1% of respondents on lipid lowering therapy.

For other related abstracts see: 15 Lipid lowering medication, 20 Screening and management of blood cholesterol, 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, 97 Statin medication use among high CHD risk patients attending general practice, 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 **PATIENT USE OF LIPID LOWERING MEDICATIONS.**

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

INSTRUCTIONS

FOR THE DOCTOR

This question refers to any **lipid lowering drug therapy** taken by the patient which may have been prescribed today or at a previous encounter.

For example, if the patient is currently undertaking a course of lipid lowering medication or is about to commence a course of lipid lowering medication as a result of today's consultation, you should answer '***YES***'.

If ***NO*** - questions ***END*** here.

If **'YES'** please tick a box to indicate whether the therapy is commencing or continuing.

Please write the **name of any lipid lowering medications** the patient is using/commencing.

If the patient is **changing** their lipid lowering medication as a result of this encounter (i.e. trying a new lipid lowering drug) please write the name of the **medication/s they are changing to.**

Please indicate by ticking the appropriate box whether or not this patient has **existing coronary heart disease** which has been diagnosed at a previous encounter.

If ***YES*** - questions ***END*** here.

If ***NO*** please continue.

Please indicate by ticking the corresponding box/es whether the patient has any of the **risk factors** listed.

Is this patient currently using lipid lowering medication therapy?	If '**YES**' is the patient	**Name of medications currently used**	**Does this patient have existing coronary heart disease?**	**Does the patient have** (please tick)
☐ **YES** - continue ⇨	☐ commencing therapy	1 _____	☐ **YES** - end questions	☐ diabetes mellitus?
☐ **NO** - end questions	or		☐ **NO** - continue ⇨	☐ familial hypercholesterolaemia?
BL35B	☐ continuing/changing therapy	2 _____		☐ family history of coronary heart disease (1st degree relative <60 yrs of age)?
				☐ hypertension?
				☐ peripheral vascular disease?
				☐ **none of the above?**

31 Prevalence and severity of chronic heart failure

Organisation supporting this study: Roche Products Pty Ltd

Issues: The prevalence of mild, moderate or severe chronic heart failure (CHF) in general practice patients; the medications used for management; whether current treatment provided adequate control of CHF; clinical investigations used to diagnose CHF and the proportion of CHF patients referred to a specialist.

Sample: 2,618 encounters from 89 GPs; data collection period: 25/09/2001 – 29/10/2001.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The prevalence of diagnosed chronic heart failure (CHF) in the general practice patient population was estimated to be 3.5% (95% CI: 2.0–5.1). Mild CHF had been diagnosed in 2.0% of general practice patients, while 1.0% and 0.5% had been diagnosed with moderate and severe CHF respectively. In male patients, 4.0% (95% CI: 0.0–8.7) were diagnosed with CHF compared with 3.1% (95% CI: 0.9–5.3) of female patients. Patients aged 75 + had the highest age-specific rates, with 20.6% diagnosed with CHF.

The medications most commonly used for the control of CHF were frusemide, followed by digoxin and perindopril, used by 58.7%, 22.8% and 16.3% of patients respectively.

GPs were satisfied that the current treatment provided satisfactory control of CHF in all patients with mild and moderate CHF. GPs felt that four out of 13 (30.8%) patients with severe CHF were not having their CHF adequately controlled by their medications.

The majority (80.0%) of patients diagnosed with CHF had, at some point, been referred to a cardiac specialist. Of these, 51.4% were referred more than 3 years ago, 19.4% were referred between 1 and 3 years ago and 29.2% were referred less than a year ago. All 13 patients with severe CHF had been referred to a cardiac specialist.

The most common clinical investigations used to diagnose CHF were 'diagnostic imaging/radiology—general' (which includes chest x-ray), 'diagnostic imaging/radiology cardiovascular' (which includes echocardiography) and 'cardiovascular electrical tracings' (which includes ECG). The three groups respectively accounted for 39.1%, 34.9% and 17.2% of all clinical investigations undertaken. GPs ordered 47.0% of clinical investigations used to diagnose CHF, while cardiac specialists ordered the remaining 53.0%.

For other related abstracts see: 75 Prevalence, management and investigations for chronic heart failure, 90 Prevalence, management and investigations for chronic heart failure, 38 Prevalence of chronic heart failure, its management and control, 57 Prevalence and management of chronic heart failure 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 **CHRONIC HEART FAILURE.**

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

INSTRUCTIONS

Chronic Heart Failure (CHF)

Please indicate by ticking the appropriate box whether this patient has **Chronic Heart Failure (CHF)** at either a **mild, moderate** or **severe** level.

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

Satisfaction with treatment

Please indicate whether or not you feel that this treatment is providing **satisfactory control** of this patient's CHF.

Clinical investigations

Please advise what **clinical investigations** were used in **diagnosing** this patient's CHF, e.g. ECG, Chest X-ray, ECHO, Angiogram, FBC, Blood chemistry, Thyroid function tests etc.

Please indicate by circling an option **who ordered each test.** e.g.

test	*ordered by*
1. Chest X-ray	(GP) / specialist
2. Echocardiogram	GP / (specialist)

CHF management

If **'YES'** please write in the **name** and **dosage** of any **medications** currently being used to treat this patient's CHF.

Please also list any **non-pharmacological management** e.g cardiac rehabilitation, physiotherapy etc.

Referral

If this patient has been referred to a **cardiac specialist** for management, please indicate **when they were initially referred.**

Does this patient have Chronic Heart Failure (CHF)?	If 'Yes' what management is currently being used?	Is this treatment providing satisfactory control of CHF for this patient?	This patient was initially referred to a cardiac specialist	What clinical investigations were used to diagnose the CHF?
Yes - mild ☐ - moderate ☐ - severe ☐	Name / Dose 1. _____ 2. _____ 3. _____	YES ☐	☐ <12 months ago ☐ 1-3 years ago	*test* / *ordered by* 1. _____ GP / specialist
No - ☐ → END	4. Other _____	NO ☐ BL36C	☐ > 3 years ago ☐ never referred	2. _____ GP / specialist 3. _____ GP / specialist 4. _____ GP / specialist

32 Patient use of after–hours medical services

Organisation supporting this study: Commonwealth Department of Health and Ageing

Issues: This substudy investigated the proportion of general practice patients who received any after-hours medical service in the previous 12 months. The study further examined what facility/service provider was used; how many times each facility/service provider was used; how many times payment was required, and how much the patient was required to pay prior to any subsequent Medicare claim.

Sample: 2,544 respondents from 88 GPs; data collected between 30/10/2001 – 3/12/2001.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

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

Of the 2,544 respondents, 595 (23.4%, 95% CI: 20.2–26.5) had received after-hours medical services in the past 12 months. These services included attendance at an emergency department (public or private), a GP visit from the patient's usual practice, a deputising service, a co-operative service, or a service from a GP where the patient was uncertain of the service provider. Attendance at after-hours services was most common among patients aged 1–4 years (46.4%), and least common in children aged less than 1 year (18.0%).

Of the 595 patients who had received after-hours medical services during the past 12 months, 590 indicated one or more service types used. More than half (59.7%) had attended a public emergency department, 9.0% a private emergency department, 16.4% a GP from their current practice, 14.2% a deputising service, 6.6% a co-operative service, and 6.6% a service from an unspecified GP (multiple response was allowed).

These 590 patients reported after-hours service attendance on 664 occasions. For 624 of these visits, the patient recorded the frequency with which they had been asked to pay for each service type or how much they had been asked to pay usually. Of these 624 patient-service type combinations, 95 (15.2%) were usually charged more than $30 and 25 (4.0%) were charged $1–30. Altogether, 121 patients (19.4%) had been asked to pay for after-hours services on at least one occasion. None of those who attended a public emergency department was asked to pay for after-hours services.

For other related abstracts see: 10 Length of consultation; after-hours arrangements; co-morbidity.

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 **AFTER HOURS SERVICES.**

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

INSTRUCTIONS

After hours medical service in the past twelve months.

Please ask the patient whether or not they have sought medical care outside of the normal operating hours of your practice during the past 12 months.

Details of after hour care

If **'YES'** please complete the following details

- **facility/service provider** - please tick a box to indicate what type of facility or service provider provided the after hours medical service/s. If more than one type of service was used, tick as many options as apply.
- **times attended** - please write in the approximate number of times care was sought at each type of facility.
- **times asked to pay** - please write in the approximate number of times the patient was asked to pay any of the cost of these after hours services.
- **how much? (usually)** - please circle an option to indicate the approximate amount the patient was usually asked to pay at each facility when after hours services were sought. **NB - this is the full amount prior to any subsequent claim to Medicare**.

Have you received any after hours medical services in the past 12 months?

☐ Yes - continue ⇨

☐ No - END QUESTONS

BL37B

If 'YES', please indicate the type of facility, the number of times you attended, the number of times you were required to pay any of the cost, and how much you were usually asked to pay prior to any subsequent Medicare claim.

Facility/Service Provider	Times attended	Times asked to pay	How much? (usually)
☐ Private Emergency Dept.	_____	_____	$1-10 / 11-20 / 21-30 / >30
☐ Public Emergency Dept.	_____	_____	$1-10 / 11-20 / 21-30 / >30
☐ GP from this practice.	_____	_____	$1-10 / 11-20 / 21-30 / >30
☐ Deputising service.	_____	_____	$1-10 / 11-20 / 21-30 / >30
☐ Co-operative service.	_____	_____	$1-10 / 11-20 / 21-30 / >30
☐ GP - unsure of service provider.	_____	_____	$1-10 / 11-20 / 21-30 / >30

33 Prevalence and management of cardiovascular risk factors

Organisation supporting this study: Aventis Pharma Pty Ltd

Issues: This study was designed to measure the prevalence of cardiovascular risk factors in general practice patients. The issue explored was whether those with risk factors were using any preventive therapies to manage them, and if so which medications were being prescribed.

Sample: 3,108 encounters from 105 GPs. Data collected between 04/12/2001 – 21/01/2002.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: A list of risk factors for cardiovascular disease included: hypertension, high total cholesterol (>5.2 mmol/L), low HDL (<0.9 mmol/L), current smoker, microalbuminuria, evidence of previous vascular disease, none of the above. A list of cardiovascular conditions included: hypertension, coronary artery disease, peripheral vascular disease, stroke (including previous), diabetes (any type), none of the above.

Summary of results

The age-sex distribution of respondents was similar to the distribution for all BEACH (general practice) encounters, with the majority (58.3%) of patients being female.

The prevalence of at least one cardiovascular risk factor in this general practice patient population was 39.5% (95% CI: 36.4–42.5), the majority (58.8%) having only one risk factor. The most prevalent cardiovascular risk factor was hypertension (25.7%, 95% CI: 23.1–28.4), followed by high cholesterol (17.8%, 95% CI: 15.8–19.8). The most common risk factor/combination of risk factors was hypertension only, which was found in 365 (29.9%) patients. Other common risk factor combinations were hypertension and high cholesterol, followed by current smoker only, which were the risk profiles of 17.9% and 13.7% of patients respectively.

Almost a third (31.5%, 95% CI: 28.6–34.5) of patients had at least cardiovascular disease. The most common cardiovascular disease was hypertension (alone or in combination), diagnosed for 26.0% (*n*=796) of the 3,063 patients who provided these data. Other cardiovascular diseases were considerably less common, with 7.9% of patients having coronary artery disease and 7.6% having diabetes. Of those 796 patients with hypertension 49.6% had no other cardiovascular disease.

Of the 966 patients with at least one cardiovascular disease, 72.0% were prescribed at least one preventive medication by their GP. The three most common medications prescribed were aspirin (13.4% of preventers), atorvastatin (7.3%) and simvastatin (6.8%). Of patients with at least one of the listed cardiovascular diseases, 43.2% (95% CI: 39.2–47.1) were taking an ACE inhibitor. The majority of ACE inhibitors prescribed were for management of hypertension (76.9%), but other indications included elevated blood pressure (4.8%), IHD (4.5%) and heart failure (3.3%).

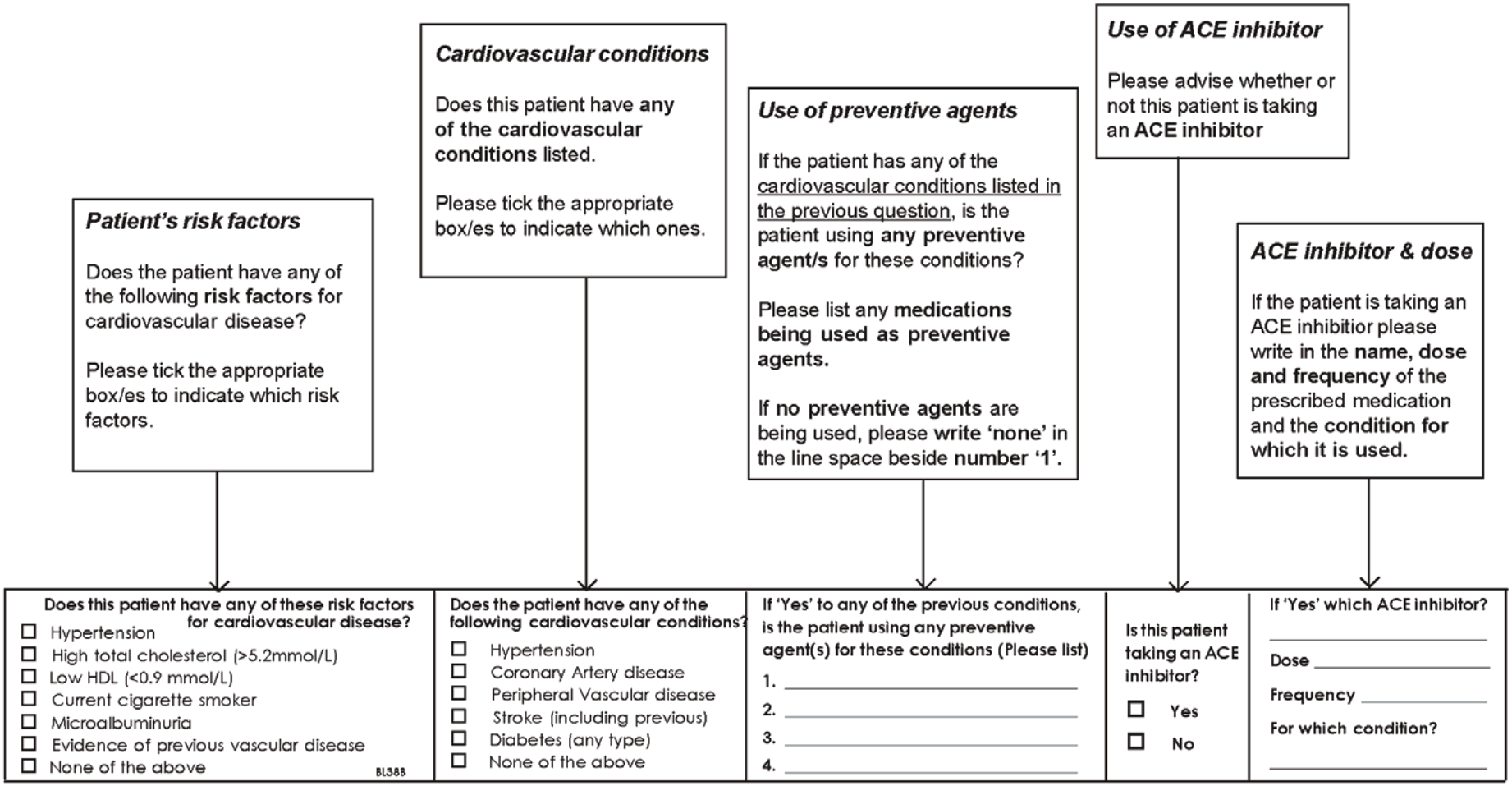
For other related abstracts see: 103 Cardiovascular risk in patients attending general practice.

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 **CARDIOVASCULAR RISK FACTORS, CONDITIONS AND PREVENTIONS**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS



34 Gastro-oesophageal reflux disease (GORD)

Organisation supporting this study: Janssen-Cilag Pty Ltd

Issues: Prevalence of gastro-oesophageal reflux disease (GORD) in general practice patients; medications used for treatment of GORD; medication regimen; patient level of satisfaction with medication effectiveness; initiator of prescribed treatment; and changes in medication during the past 12 months.

Sample: 3,018 respondents from 102 GPs; data collection period: 04/12/2001 – 21/01/2002

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to the distribution for all BEACH encounters, with the majority (57.1%) of patients being female.

The prevalence of diagnosed GORD in this population was estimated to be 19.9% (*n*=599, 95% CI: 16.8–22.9). The proportion of patients with GORD who had been diagnosed at the current encounter was 12.5% (*n*=75), while 87.5% (*n*=524) had been diagnosed at a previous encounter. The prevalence of GORD increased significantly with age, being far higher in older patients (34.3% of 65+ age group) than in younger patients (3.4% of under 25 age group). There was no significant difference in the rates of GORD between males (20.7%) and females (19.2%).

Of the patients with GORD, 80.0% (*n*=479) were currently taking medication for its management. The majority of these patients (96.7%) were taking one medication only.

Proton pump inhibitors (PPIs) made up 51.1% of the total GORD medications. The most common (generic) medication taken for GORD was omeprazole, which accounted for 34.1% of all GORD medications, followed by ranitidine (28.7%).

Three-quarters (75.0%) of those taking GORD medications reported that a daily regimen had been recommended, while 25.0% were taking their GORD medications as required (prn). Over two-thirds (69.1%) of GORD medications had been initiated by the GP, while specialists initiated 25.2% of medications. Of the patients taking GORD medication, 18.9% (*n*=99) had changed their medication over the previous 12 months. The medications previously taken were most commonly ranitidine (50.3%, *n*=74) and omeprazole (15.0%, *n*=22). Forty-eight per cent of patients were completely satisfied with their GORD medication while 4.2% said they were dissatisfied.

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, 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, 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 **GASTRO-OESOPHAGEAL REFLUX DISEASE & MEDICATIONS.**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

FOR THE DOCTOR

These questions refers to any patient who has been diagnosed with **gastro-oesophageal reflux disease** either today or at a previous encounter.

If 'Yes' to **either** option please continue the questions.

If ***NO*** - questions ***END*** here.

This question refers to medication/s currently being taken by the patient to treat their reflux disease.

Medication - please write the name of reflux medication in the space provided. There is room to write up to 3 medications.

Regimen - along side the medication name please circle a response to indicate whether the patient has been advised to take the medication daily or only when required (p.r.n.) to treat symptoms.

Initiated by - along side the regimen please circle a response to indicate whether the patient originally began taking this medication as a result of a prescription from a GP, a prescription from a specialist, or a recommendation from another source (if the medication is an 'over-the-counter' preparation).

Patient satisfaction - please ask the patient to rate how satisfied they are with the effectiveness of each medication by circling a response from 1 to 5, where **1 is unsatisfied** and **5 is very satisfied.**

Changed medication - please indicate, by ticking the appropriate box, whether or not the patient's **reflux medication has been changed** in the **past 12 months**.

If ***'NO'*** - ***END QUESTIONS*** here.

Previous medications - If **'YES'** to the previous question, please write the names of any **reflux medications** the patient used **prior to that change**.

Has this patient been diagnosed with **gastro-oesophageal reflux disease?**	What medication is **currently** being taken for treatment? ☐ None								Has this patient's reflux medication been **changed in the past 12 months**	Which medication/s has the patient **previously used** for this condition?
	Medication	**Regimen**	**Initiated by**	**Patient Satisfaction**						
☐ Yes - at this encounter	1._____	Daily / p.r.n	GP/Spec'st/other	1	2	3	4	5	☐ Yes	1._____
☐ Yes - at a previous encounter	2._____	Daily / p.r.n	GP/Spec'st/other	1	2	3	4	5		2._____
☐ No ➔ **end questions**	3._____	Daily / p.r.n	GP/Spec'st/other	1	2	3	4	5	☐ No ➔ **end questions**	3._____

BL38C

35 Smoking status of adults and their attempts to quit

Organisation supporting this study: Commonwealth Department of Health and Ageing

Issues: The smoking status of adult patients and their levels of success, the methods used by current and former smokers in attempts to quit, the time since they last smoked or last attempted to quit were examined.

Sample: 5,823 encounters with patients aged 18 and over, from 231 GPs; data collection period: 21/01/2002 – 01/04/2002.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: A Quit Smoking Key List with 12 quitting methods, including 'cold turkey', nicotine patches and bupropion (Zyban), was made available to patients to indicate which methods they had used to quit (former smokers) or attempt quitting (current smokers).

Summary of results

The majority of patients aged 18 or more had never smoked (51.7%, 95% CI: 49.6–53.8). Former daily smokers accounted for 19.5% of patients (95% CI: 18.2–20.9), followed by current daily smokers, representing 18.6% (95% CI: 17.1–20.1). Former occasional smokers and current occasional smokers accounted for 6.8% and 3.4% of patients respectively. Grouping daily and occasional together, former smokers accounted for 26.3% (95% CI: 24.8–27.9) and current smokers 22.0% (95% CI: 20.2–23.7) of patients.

Female patients were significantly more likely than males never to have smoked (59.9% compared with 37.2%). Significantly more male patients were current daily (23.7%) and former daily (29.5%) smokers, compared with female patients (15.8% and 13.9% respectively). Levels of occasional smoking were similar for male and female patients.

There were 1,473 former smokers who indicated a quitting method from the Key list, and 91.9% of these indicated using only one method. Of these, the most frequent single method used was 'cold turkey' (89.0%) followed by nicotine patches (3.5%). Bupropion had been used by 26 patients (1.8%), of whom 17 used only this method.

Of the 1,280 current smokers, 53.3% had tried to quit smoking during the previous 5 years, and the majority (82.6%) of these had used only one method. The most frequently used methods were 'cold turkey' (62.9%) followed by nicotine patches (26.3%) and Bupropion (12.9%).

Of the 1,703 patients who had tried to quit 'cold turkey' (+/– other methods) 75.7% (95% CI: 73.1–78.3) reported they were not currently smoking. Of the 348 who tried using nicotine replacement therapy (i.e. patches/gum/inhaler) (+/– other methods), one-third had quit (37.4% 95% CI: 31.1–43.7). Of the 85 who tried to quit with bupropion, one in four (23.4%, 95% CI: 5.9–40.9) were not currently smoking but the small numbers involved rendered this estimate somewhat unreliable (as shown by the wide confidence intervals).

For other related abstracts see: 12 Smoking and passive smoking in general practice patients, 53 Smoking status of adults and their attempts to quit, 74 Smoking and passive smoking in the home and Section 4.3 Smoking.

Further reading:

Doran, C. M., Valenti, L., Robinson, M., Britt, H., & Mattick, R. P. 2006, 'Smoking status of Australian general practice patients and their attempts to quit', *Addict.Behav.*, vol. 31, no. 5, pp. 758–766.

Valenti, L., Charles, J., & Britt, H. 2005, 'Passive smoke in Australian homes: 1999 to 2004 [letter]', *Australian and New Zealand Journal of Public Health*, vol. 28, no. 4, pp. 387–388.

Degenhardt L, Knox S, Barker B, Britt H, Shakeshaft A. The management of alcohol, tobacco and illicit drug use problems by general practitioners in Australia. *Drug Alcohol Rev* 2005; 24(6):499–506.

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 SMOKING STATUS AND ATTEMPTS TO STOP SMOKING**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

THE FOLLOWING QUESTIONS REFER TO THE SMOKING OF ALL TOBACCO PRODUCTS

Patient smoking status

Please ask the patient to describe their current smoking status from the pick list on the 'Smoking status and Key list' card. Tick a box to indicate their answer.

If the patient has **'NEVER SMOKED'** please **END** the **QUESTIONS HERE**

For former smokers

If the patient is a **former smoker** please ask them to advise **how long ago they last smoked**. Please write the patient's response in the space provided.

Quit Smoking key list

Please ask the patient to read the **list of options on the card**. **Circle the numbers** which correspond with **any method** on the list thay they **used to *finally* quit smoking**. If a combination of methods were used to finally quit, please **circle all methods used**.

For current smokers

If the patient is a **current smoker** please ask them if they **have tried to quit smoking in the past 5 years**. Please tick the appropriate box to indicate the patient's response. If **'NO'** please **END QUESTIONS HERE**.

If **'YES'** ask the patient to advise **how long ago they last attempted to quit smoking**. Please write the patient's response in the space provided.

Quit Smoking key list

Please ask the patient to read the **list of options on the card** and to tell you which **method** they used in **their *most recent attempt* to quit smoking**.

Circle the numbers which correspond with any methods used. If a combination of methods were used please **circle all applicable numbers**.

Please describe your smoking status

- ☐ Current smoker - daily.
- ☐ Current smoker - occasional.
- ☐ Former smoker - daily
- ☐ Former smoker - occasional.
- ☐ Never smoked ⇨ **END QUESTONS**

BL39B

For former smokers -

How long since you last smoked?

_____
(yrs /mths /wks /days)

From the Key list, what method/s did you use (or are currently using) to stop? (circle as many as apply)

1. 2. 3. 4. 5. 6.
7. 8. 9. 10. 11. 12.

For current smokers -

In the **past 5 years** have you tried to stop smoking?

- ☐ Yes.
- ☐ No ⇨ **END QUESTIONS.**

If 'YES' how long since your last quitting attempt?

_____
(yrs /mths /wks /days)

From the Key list, what method/s did you use in this last attempt? (circle as many as apply)

1. 2. 3. 4. 5. 6.
7. 8. 9. 10. 11. 12.

CURRENT SMOKING STATUS

Please describe your smoking status

- ☐ Current smoker - daily.
- ☐ Current smoker - occasional.
- ☐ Former smoker - daily
- ☐ Former smoker - occasional.
- ☐ Never smoked

QUIT SMOKING KEY LIST

Listed below are methods available to assist smokers to stop smoking. In this study, 'smoking' includes all tobacco products.

1. **'Cold Turkey' i.e. immediate cessation with no method of assistance**
2. **Nicotine patches**
3. **Nicotine gum**
4. **Nicotine inhaler**
5. **Hypnotherapy**
6. **Herbal preparations**
7. **Support / counselling eg 'SmokeStop', 'Quitline'**
8. **Zyban (Bupropion)**
9. **Other medication**
10. **Self-help material e.g. quit smoking manual**
11. **GP assistance other than above eg counselling**
12. **Other methods not listed above**

36 Patient use of complementary therapies

Organisation supporting this study: General Practice Statistics & Classification Unit (GPSCU)

Issues: The prevalence of complementary therapy use among general practice patients; the conditions for which complementary therapies are used; the patient perceived benefits of complementary therapy use; the attitude to complementary therapy use as a treatment in the future.

Sample: 5,567 respondents from 193 GPs; data collection period: 16/01/2001 – 19/02/2001 and 27/03/2001 – 30/04/2001.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of patients was similar to the distribution of the total BEACH sample with the majority (58.3%) being female. Patients aged 45–64 years accounted for 29.4% of the sample.

The proportion of patients indicating use of complementary/alternative therapies during the previous 12 months was 21.9% (95% CI: 19.7–24.0). Almost half (46.7%, 95% CI: 43.2–50.1) indicated they would consider using complementary/alternative therapies in the future, while 51.7% (95% CI: 48.3–55.2) had not used complementary therapies in the previous 12 months and would not consider using them in the future.

Of the 1,216 patients who indicated having used a complementary therapy, 40.3% (95% CI: 35.6–44.9) had used chiropractic therapy, 31.6% (95% CI: 26–37.2) had used naturopathy (which includes herbal medicine), 22.7% and 20.8% had used remedial massage and acupuncture respectively.

In 89.5% of problems managed with chiropractic therapy, the problem was musculoskeletal. Problems managed with naturopathy were more general in nature (33.5% of problems), including preventive/health maintenance and general weakness/tiredness. Remedial massage and acupuncture were mainly used for musculoskeletal problems, both at a rate of 68.5% of problems managed by that therapy.

For other related abstracts see: 101 Types of medicine use and patient use of medicines list.

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 **COMPLEMENTARY / ALTERNATIVE THERAPIES.**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

ASK THE PATIENTS

Ask each patient if they have used any of the **complementary / alternative therapies** listed during the last 12 months.

If **NO** please go to the last question.

NB - Naturopathy includes herbal remedies e.g., St John's Wort, Evening Primrose etc. Please **do not** include Vitamin & Mineral supplements.

If '**Yes**' please write in the space beside the therapy name, the **condition this therapy was used to treat / relieve**. If the patient has used one of these therapies for **health maintenance** or **preventive care** rather that to treat or relieve a specific condition, please write this in the 'condition' space.

Please **circle a response** to indicate the patient's opinion of the **therapy's benefit** in treating or relieving the condition.

Please indicate whether or not the patient would **consider using** complementary / alternative therapies for conditions which may arise **in the future**, or for conditions which currently exist, but for which they have not previously considered complementary / alternative therapies.

Q.1

1. In the past 12 mths have you used any of the following complementary/ alternative therapies?

☐ Yes

☐ No ➔ go to Question 3.

Q.2

For what conditions? Were they beneficial?

	Condition	*Beneficial?*	*Condition*	*Beneficial?*
1. Chiropractic	_____	Yes / No / unsure	_____	Yes / No / unsure
2. Acupuncture	_____	Yes / No / unsure	_____	Yes / No / unsure
3. Hypnotherapy	_____	Yes / No / unsure	_____	Yes / No / unsure
4. Naturopathy	_____	Yes / No / unsure	_____	Yes / No / unsure
5. Remedial Massage	_____	Yes / No / unsure	_____	Yes / No / unsure
6. Other _____	_____	Yes / No / unsure	_____	Yes / No / unsure

Q.3

In the future would you consider using complementary / alternative therapies

☐ Yes

☐ No

BL31C

37 Prevalence of common morbidities in patients encountered in general practice

Organisation supporting this study: General Practice Statistics & Classification Unit (GPSCU)

Issues: The prevalence of significant morbidity affecting general practice patients irrespective of whether or not the morbidity was managed at the encounter; the number of times general practice patients consult a GP annually.

Sample: 11,342 respondents from 378 GPs; data collection period: 21/08/2001 – 31/12/2001 and 22/01/2002 – 30/03/2002.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: Visit frequency and morbidity were directly standardised against the known age-sex distribution of all patients who attended general practice in Australia between April 2000 and March 2001.

Summary of results

The age–sex distribution of patients was similar to the distribution of the total BEACH sample with the majority (59.1%) being female. Patients aged 25–44 years (26.7%) or 45–64 years (25.1%) accounted for more than half of the sample, with the mean patient age being 46 years.

The most common morbidities were hypertension (19.5% of respondents), depression (10.2%), lipid disorder (9.1%) and asthma (8.0%). After direct standardisation the estimated prevalence rates for the general practice population were hypertension 13.5% (95% CI: 12.5–14.4), depression 9.5% (95% CI: 8.6–10.3), asthma 8.8% (95% CI: 8.1–9.5) and lipid disorders 6.9% (95% CI: 6.2–7.6).

The respondents attended a GP on average 8.8 times per year. The age-sex standardised average was 7.8 visits per year (95% CI: 7.4–8.2), increasing among older adults. The standardised mean number of annual visits for all reasons was 13.0 (95% CI: 12.0–14.1) for patients with diagnosed diabetes, 12.6 (95% CI: 11.7–13.5) for patients with depression, 9.2 (95% CI: 8.5–9.9) for patients with asthma and 6.1 (95% CI: 5.5–6.6) for patients with current upper respiratory tract infection.

For other related abstracts see: 7 Health services utilisation, lifestyle status and chronicity, 61 Prevalence of chronic illnesses identified as National Health Priority Areas among general practice patients, 89 Estimates of the prevalence of chronic illnesses identified as Health Priority Areas.

Further reading:

Knox, S. A. & Britt, H. 2004, 'The contribution of demographic and morbidity factors to self-reported visit frequency of patients: a cross-sectional study of general practice patients in Australia', *BMC.Fam Pract.*, vol. 5, no. 1, p. 17.

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 **CO-MORBIDITY.**

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

INSTRUCTIONS

GP consultations in the previous year.

Please check with the patient and write in the approximate number of times this patient has consulted you or any other GP at this or any other practice within the past 12 months.

Co-morbidity

Please write in **any other significant** present or past health problems of this patient that were **not managed at this consultation** e.g. -

- **chronic illnesses** or other health problems that require **continuing management** or **surveillance**;
- **past problems** which may need **consideration in future care** e.g. mastectomy;
- any significant **health influencing social problems** e.g. marital disharmony.

i.e. enter any problem you would **include in a health summary**.

How many times (approximately) has this patient consulted a GP at any practice in the last 12 months?	What other significant diagnoses / problems does this patient have which are not being managed at today's encounter?			
_____	1. _____	5. _____	9. _____	
	2. _____	6. _____	10. _____	
	3. _____	7. _____	11. _____	
	4. _____	8. _____	12. _____	

BL35C

38 Prevalence of chronic heart failure, management and control

Organisation supporting this study: Roche Products Pty Ltd

Issues: Chronic heart failure (CHF) is a condition with high mortality and a major burden in public health. This study investigated the prevalence of chronic heart failure (CHF) in general practice patients; management being used to treat CHF; whether the management was initiated by general practitioners or specialists; referrals to a cardiac specialist; clinical investigations being used to diagnose CHF; initiation of the clinical investigation of CHF.

Sample: 3,082 encounters from 106 GPs; data collection period: 02/04/2002 – 06/05/2002.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to total BEACH sample of general practice encounters, with the majority (60.4%) of encounters with female patient and 18.7% of encounters with patient aged 65 years or over.

Of the 3,082 respondents, 3.2% (95% CI: 2.2–4.1) were diagnosed with CHF. Among these respondents, 51 (1.7%) were diagnosed with mild CHF, while 33 (1.1%) and 13 (0.4%) were diagnosed with moderate and severe CHF respectively. Patients aged 75 years or more had the highest age–specific-rate, 21.6% being diagnosed with CHF.

Diuretics were the most commonly used medication group in treating CHF, being taken by 64.9% of CHF patients. These were followed by ACE inhibitors (single or combination) (32.0%) and cardiac glycosides (10.5%). At generic level, frusemide was most commonly used in 52.6% of CHF patients, and was followed by digoxin and potassium chloride, being used in 20.6% and 11.3% of CHF patients respectively. Of the 182 medications being used to treat CHF, 51.6% was initiated by a GP and 48.4% by a specialist.

GPs indicated that on average increasing survival, relieving symptoms, and improving quality of life were equally important in managing CHF.

Of the 92 CHF patients who responded to the referral question, 81.5% were referred to a cardiac specialist at some point of time. Among these CHF patients, 24 (26.1%) were referred in the previous 12 months, 15 (16.3%) between 1 and 3 years ago, and 36 (39.1%) more than 3 years ago.

In order to diagnose CHF, chest x-ray had been used in 71.1% of CHF patients, echocardiogram (ECHO) had been used in 69.1%, and electrocardiogram (ECG) in 60.8%. GPs ordered 60.3% of chest x-rays, 19.0% of ECHO tests and 52.0% of ECGs, while specialists ordered the remaining tests.

For other related abstracts see: 31 Prevalence and severity of chronic heart failure, 57 Prevalence and management of chronic heart failure in general practice patients, 75 Prevalence, management and investigations for chronic heart failure, 90 Prevalence, management and investigations for chronic heart failure.

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

INSTRUCTIONS

Chronic Heart Failure (CHF)

Please indicate by ticking the appropriate box whether this patient has **Chronic Heart Failure (CHF)** at either a **mild, moderate** or **severe** level.

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

Main treatment objective

Please indicate your **main objective** in this patient's management, **ranking the options** in order of importance from 1 to 3, where **3** is the **least important.**

CHF management

If **'YES'** please write in the **name and form** of any **medications** currently being used to treat this patient's CHF. Please indicate the regimen (i.e. **strength, dose and frequency**) of the medication and circle an option to advise whether this treatment was initiated by a GP or Specialist.

Please also list any **non-pharmacological management** e.g cardiac rehabilitation, physiotherapy etc.

Referral

If this patient has been referred to a **cardiac specialist** for management, please indicate **when they were initially referred.**

Clinical investigations

Please advise using the tick boxes what **clinical investigations** were used in **diagnosing** this patient's CHF. If tests other than ECG, ECHO or Chest X-ray (e.g angiogram, FBC, blood chemistry, thyroid function tests etc) were used, please list in 'other'.

Please indicate by circling an option **who ordered each test.** e.g. GP or specialist.

Does this patient have Chronic Heart Failure (CHF)?

Yes - mild ☐
- moderate ☐
- severe ☐

No - ☐ → END

BL41B

If 'Yes' what management is currently being used?

Name & Form	Strength	Dose	Freq	Initiated by
1.				GP/spec
2.				GP/spec
3.				GP/spec
4. Other				GP/spec

What is most important in managing this patient's CHF?
(please circle a number for each option, ranking 1-3 where 3 is least important)

Increase survival	1	2	3
Relieve symptoms	1	2	3
Improve quality of life	1	2	3

This patient was initially referred to a cardiac specialist

☐ <12 months ago
☐ 1-3 years ago
☐ > 3 years ago
☐ never referred

What clinical investigations were used to diagnose the CHF?

test	ordered by
☐ ECG	GP / spec
☐ ECHO	GP / spec
☐ Chest X-Ray	GP / spec
☐ Other _____	GP / spec

39 Severity of asthma, medications and management

Organisation supporting this study: AstraZeneca (Australia) Pty Ltd

Issues: The prevalence and severity of asthma managed in the general practice patient population; the use of asthma medications; asthma management tools; and patient confidence in predicting changes in their asthma.

Sample: 3,070 encounters from 105 GPs; data collection period 02/04/2002 – 06/05/2002

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-sex distribution of respondents was similar to the distribution for all BEACH (general practice) encounters, with the majority (59.9%) of patients being female. The prevalence of asthma among the respondents was 13.9% (95% CI: 12.0–15.7, *n*=426). Patients aged 5–14 years had the highest prevalence of asthma (26.3%, 95% CI: 15.1–37.4), this was significantly higher than all other age groups (12.9%, 95% CI: 11.0–14.8).

Among 312 adult patients (18 years and over) with asthma, 35.9% had very mild, 31.4% had mild, 27.2% had moderate and 5.5% had severe asthma. Of the 97 children (aged <18 years) with asthma, 82.5% had infrequent asthma, 15.5% had frequent and 2.1% persistent asthma.

Of the 426 patients with asthma, 87.8% were currently taking asthma medications, at an average rate of 142.7 medications per 100 asthma patients. Reliever medications were the most common medication used to treat asthma, being taken by 85.9% of asthma patients. These were followed by preventer medications (34.5%), combination medications (16.7%) and symptom controllers (5.2%). The use of relievers alone (37.8%) was the most common treatment regimen for asthma patients, followed by a combination of relievers and preventers (24.4%). The most common medication taken for asthma was salbutamol which was used by 70.0% of patients with asthma, followed by fluticasone/salmeterol (16.7%). Of the 298 patients using salbutamol, 62.8% had been using it for more than 6 months. Almost one-third (30.4%) of patients reported decreased use of relievers in the past 6 months.

Among the asthma patients, 150 (35.2%) used at least one asthma management tool (note that multiple response was allowed), 120 (28.2%) had an asthma action/management plan, 50 (11.7%) used asthma symptom diary cards, and 43 (10.1%) used asthma drug diary cards. Of the 108 asthma action/management plan users who responded to the question about the frequency of use of this plan, 66.7% reported using it less than monthly, 22.2% monthly, 8.3% weekly and 2.8% daily.

The patients with asthma were asked to rate their confidence in predicting changes in asthma due to weather, exercise etc. on a scale of 1 (confident) to 5 (not confident). The mean score of confidence was 2.5 for the 398 asthma patients who responded to the question.

For other related abstracts see: 3 Asthma, 22 Asthma – prevalence, severity and management, 48 Asthma prevalence and management, 63 Asthma-prevalence, management and medication side-effects, 70 Inhaled corticosteroid use for asthma management, 96 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.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **ASTHMA.**

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

INSTRUCTIONS

ASK ALL PATIENTS

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

If **No** asthma - no further questions

Current medications used

Please list the **current asthma medications** being used by this patient for the management of their asthma. Please include the **name & form, strength, dose & frequency** for each, and **circle an option** to indicate whether the patient has been taking this medication for **more than 6 months** or **less than 6 months** e.g.

What asthma medication is currently being used?

	Name & Form	Strength	Dose	Freq	6mth duration
1.	Pulmicort Turb	400mcg	800mcg	bd	(more) / less
2.					more / less

Ask the patient whether the **use of their reliever medication** has **increased, decreased or not changed** in the past 6 months. Tick the appropriate box to indicate their response.

Asthma self monitoring

Please ask the patient **how confident** they are at **monitoring** their own asthma eg **predicting changes** due to weather, exercise etc. Circle a number to indicate the **degree of confidence** they feel.

Severity of asthma

If **'YES'** please ask the patient with asthma about the **severity** of their asthma. Show them the '**Severity of asthma reference card**' included in your research pack and tick the appropriate box to indicate their response.

Asthma management tools

Ask the patient if they use any of the listed **asthma management tools** and use the tick boxed to indicate their response. Please circle an option to indicate **how frequently** they **refer** to these tools.

Does this patient suffer from Asthma?

☐ Yes

☐ No

↓

End questions

If 'Yes' how severe is the asthma? (See cards)

Severity

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

BJ41C

What asthma medication is currently being used?

Name & Form	Strength	Dose	Freq	6mth duration
1.				more / less
2.				more / less
3.				more / less

In the past 6 mths use of reliever medication has

☐ increased ☐ decreased ☐ no change

How often do you use an asthma management tool?

☐ Action/management plan	daily / weekly / monthly / less
☐ Symptom diary cards	daily / weekly / monthly / less
☐ Drug diary cards	daily / weekly / monthly / less
☐ Other _____	daily / weekly / monthly / less
☐ Never	

How confidently can you predict changes in your asthma due to weather, exercise etc?

1 2 3 4 5

Confident Not confident

Severity of asthma reference card

Children

Severity*	Common features
Infrequent episodic	Episodes 6-8 weeks or more apart and from 1 to 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

40 Type 2 diabetes mellitus, prevalence and management

Organisation supporting this study: Roche Products Pty Ltd

Issues: The prevalence of type 2 diabetes among general practice patients; the treatments being utilised for type 2 diabetes management; HbA1c levels and regularity of testing; frequency of GP consultations for diabetes management.

Sample: 2,876 respondents from 97 GPs; data collection period: 07/05/2002 – 10/06/2002.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to the distribution of the total BEACH sample with the majority (58.8%) being female and those aged 25–44 and 45–64 years accounting for 23.6% and 26.3% of the patient population respectively.

A total of 205 patients (7.1%, 95% CI: 5.6–8.7) had confirmed type 2 diabetes. Prevalence for patients aged 65–74 years was 17.6% (95% CI: 8.9–26.2), while patients aged 45–64 and those aged 75 or more had similar rates (11.0%, 95% CI: 4.7–17.3 and 12.4%, 95% CI: 0.0–26.4 respectively). There were no significant differences between any of these age groups. There was also no significant difference between the prevalence for males (8.0%, 95% CI: 4.3–11.8) and for females (6.2%, 95% CI: 3.5–8.9).

Diet and/or exercise was the most commonly used treatment, being utilised by 75.9% of patients with type 2 diabetes, either alone or in combination with other methods. Metformin was the current treatment for 50.7%, sulfonylurea for 33.5% and insulin for 16.3% of patients with type 2 diabetes. Almost half (44.3%) of the patients with type 2 diabetes used one treatment method only, 35.0% used two treatment methods, and the remaining 20.7% used between 3 and 5 treatments. Diet/exercise in combination with one or more medications was used by 50.3% of patients with type 2 diabetes, diet/exercise alone was used by 25.6%, and medication(s) alone was used by 24.1%.

The most recent HbA1c level was available for 182 of the 205 patients with type 2 diabetes. The mean HbA1c level for these patients was 7.3% (95% CI: 7.0–7.6), the median was 7.0% with a range of 5.1% to 13.2%. Patients using only one treatment method had a mean HbA1c level of 6.8% (95% CI: 6.6–7.1) while those using 2 treatments and 3–5 treatments had mean levels of 7.5% (95% CI: 7.1–8.0) and 7.7% (95% CI: 7.2–8.2) respectively. Patients using diet/exercise only had a mean HbA1c level of 6.4% (95% CI: 6.2–6.5) which was significantly lower than the mean level for patients using medication(s) only (7.6%, 95% CI: 7.0–8.1) and those using diet/exercise plus medication(s) (7.6%, 95% CI: 7.2–8.0). The average number of months since their last HbA1c test was 3.6 (95% CI: 3.0–4.2) with a median of 3 and a range 0.03–22 months. The average number of GP visits during the previous 12 months for patients with type 2 diabetes was 6.6 (95% CI: 5.5–7.6) visits with a median of 5 visits and a range of 0 to 30 visits.

For other related abstracts see: 21 Diabetes – prevalence, management and screening, 25 Prevalence of diabetes, medications and control, 45 Diabetes mellitus prevalence, management and risk factors, 94 Type 2 diabetes – investigations and related conditions, 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

FOR THE DOCTOR

Please indicate by ticking the appropriate box whether or not this patient has **confirmed Type 2 diabetes**.

If 'Yes' continue to the next question.

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

DIABETES MANAGEMENT

Please use the tick boxes to indicate how the patient's diabetes is **currently being managed.**

Tick as many options as apply.

If you tick the box labled 'other' please **write the type of management** being used in the space provided.

HBA1C LEVEL

Please write in the space provided **the patient's HbA1c level** at their **most recent test.**

HBA1C TESTING

Please write in the space provided the approximate length of **time since the patient's HbA1c was last tested** i.e. when the most recent test occurred. Please circle an option to indicate whether **days, weeks or months.**

GP CONSULTATIONS

Ask the patient to help you determine the **approximate number of times** they have **consulted you or any other GP about their diabetes** in the **past 12 months.** Please **include today's consultation** in your estimate.

Does this patient have confirmed type 2 diabetes?	If 'Yes' what treatment is currently being used to manage this patient's diabetes? (*Tick as many options as apply*)	What was the patient's most recent HbA1c level?	How long since their HbA1c was last tested?	Approximately how many times in the past 12 months has this patient consulted you or any other GP about their diabetes? (Including today's visit)
☐ Yes - continue ➔ ☐ No - **end questions** BL42B	☐ diet / exercise ☐ metformin ☐ sulfonyurea ☐ glitazone ☐ insulin ☐ other _____ ☐ none of the above	_____ %	_____ **days/wks/mths** (*Please circle*)	_____ **times**

41 Time of visit and billing status

Organisation supporting this study: Australian Government Department of Health and Ageing

Issues: The relationship between after-hours status of a consultation and patient billing status.

Sample: 5,546 Medicare-claimable encounters, from 200 GPs; data collection period: 07/05/2002 – 10/06/2002 and 16/07/2002 – 19/08/2002.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

Of the 5,546 Medicare-claimable consultations recorded in these data collection periods in 2002, 69.8% (95% CI: 65.4–74.3) were bulk billed, and 30.2% were patient billed; comparable to previous GPSCU data (June-Oct 2000, *Abstract 16*) with 74.4% (95% CI: 70.4–78.3) of general practice consultations bulk billed.

Consultations with patients aged 75+ were bulk-billed at a significantly higher rate than younger patients; those with patients aged 45–64 were bulk billed at 63.5% (95% CI: 58.0–69.1) of Medicare-claimable encounters compared with 82.1% (95% CI: 76.4–87.9) of those aged 75 or more.

The DoHA definition of after-hours was used, 'standard office hours' includes weekdays 8am to 6pm and Saturday 8am to 1pm, while 'after-hours' is weekday nights 6pm to 8am and Saturday 1pm to Monday 8am. Of the Medicare-claimable encounters, 92.8% (95% CI: 90.9–94.8) occurred during 'standard office hours', while the remaining 7.2% occurred 'after-hours'. The comparable results from 2 years previously were that 7.4% of consultations occurred 'after-hours'.

'After-hours' consultations had a bulk billing rate of 77.1%, compared with 69.3% of consultations during 'standard office hours', and these proportions are not significantly different. Therefore, without adjusting for any other variables, billing status of patient and whether a consultation occurred 'after-hours' were not related.

Simple logistic regression modelling with billing status as the outcome found that whether the consultation occurred during 'standard office' or 'after-hours' was not related to patient billing status. However, the multiple model, including all significant descriptor variables found that 'after-hours' consultations were significantly more likely to be bulk billed than those held during 'standard office' hours (adjusted OR=1.92).

Other significant descriptors in the model were patient age, whether the patient was from a non-English-speaking background, whether they lived in an urban or rural setting, whether they held a health care card and whether they were from a low SES background. A paper fully describing these results is in preparation.

For other related abstracts see: 16 Effect of day and time of GP visit on billing method.

Further reading:

Pegram, R. W. & Valenti, L. 2004, 'Factors influencing billing status in general practice [letter]:, *Medical Journal of Australia,* vol. 181, no. 2, p. 115.

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 **TIME OF VISIT AND BILLING STATUS.**

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

INSTRUCTIONS

FOR THE DOCTOR

This question refers to the day on which the consultation is taking place.

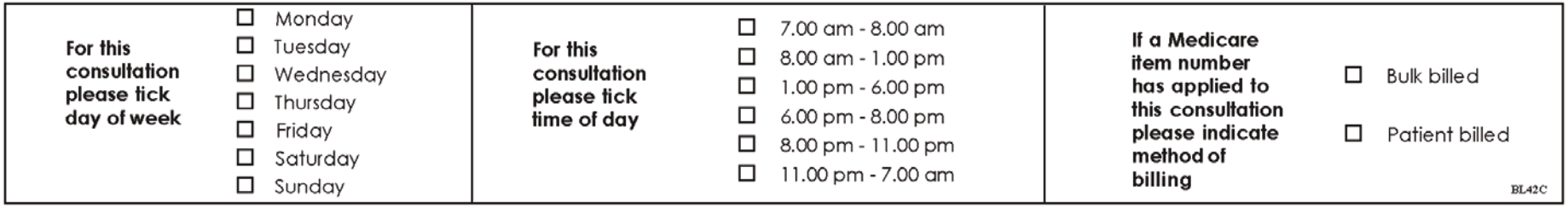
Please indicate by ticking the appropriate box which day of the week this encounter is taking place.

FOR THE DOCTOR

Please indicate by ticking the corresponding box, the time of day during which the consultation is taking place.

FOR THE DOCTOR

If a Medicare item number is applicable to the consultation, please indicate by ticking the appropriate box whether the consultation was bulk billed to the government or whether the patient has been billed.



42 Prevalence and management of chronic pain

Organisation supporting this study: Janssen-Cilag Pty Ltd

Issues: The prevalence of chronic pain among general practice patients; the conditions causing chronic pain; the anatomical sites most affected; the managements being utilised by GPs; duration of medication usage; management of medication side effects.

Sample: 2,800 respondents from 99 GPs; data collection period: 11/06/2002 – 15/07/2002.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to the distribution of the total BEACH sample with the majority (57.0%) being female and 54.0% aged 45 years or over.

A total of 507 patients (18.1%, 95% CI: 15.4–20.8) were reported as having chronic pain. Prevalence was significantly higher for patients aged 45 years or more (25.8%, 95% CI: 20.5–31.1) than for patients aged less than 45 years (8.8%, 95% CI: 6.7–10.9). There was no significant difference between the prevalence for males (16.3%) and females (19.5%).

Causal conditions were identified for 490 of the 507 chronic pain sufferers. In total, 82 different causal conditions were reported, 41.8% of these (*n*=205) being forms of arthritis including osteoarthritis (30.8%), arthritis not otherwise specified (NOS) (5.9%), and rheumatoid arthritis (5.1%).

Anatomical sites were recorded for 472 patients. A total of 618 responses (multiple sites were affected for some patients) were recorded for 14 different body sites, those most commonly affected being the back (32.5%), knee (12.9%) and the neck/cervical spine (7.9%).

Medication usage was recorded for 495 patients. More than two-thirds (70.3%) took analgesics, either alone or with another medication. One-third (33.1%) took NSAIDs, 8.1% took psychotropics and 7.1% took oral sustained release morphine (OSRM).

For each medication type, the back was the main body site affected (other analgesics–44.2%; NSAIDs–45.8%; psychotropics–30.0%; OSRM–60.0%). Types of arthritis were the main cause of chronic pain for patients in 3 of the medication groups (other analgesics–41.6%; NSAIDs–60.1%; psychotropics–17.5%). The main cause of chronic pain for patients taking OSRM was back problems (28.6%) followed by malignant neoplasm (20.0%) and musculoskeletal conditions (17.1%).

Medication groups were similar across time periods of usage. Forty eight patients took medication to manage side effects. Of 57 medications listed, 66.7% (*n*=38) were laxatives and 8.7% (*n*=5) were omeprazole.

For other related abstracts see: 82 Prevalence and management of chronic pain.

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

FOR THE DOCTOR

Please indicate by ticking the appropriate box whether or not this patient suffers from **chronic pain.**

If 'Yes' continue to the next question.

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

CONDITION & SITE AFFECTED

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

Please write the **anatomic site/s** which the patient nominates as being **most affected by pain.**

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 more than one if applicable.

For **each medication** please **circle an option** to indicate the **approximate length of time** the patient has been using **any type of this medication** for management of pain associated with their **current condition** (i.e., the condition nominated in the previous question).

MANAGEMENT OF SIDE EFFECTS

Please advise whether the patient is using any **other medication** for the **management** of any **side effects caused** by the **morphine/other analgesic.**

Does this patient suffer from chronic pain?	If 'Yes' from what condition?	What medications (if any) are currently being used for pain management? For each, please indicate the approximate duration of usage.	What other medication/s is the patient using for management of any side effects of the morphine/ other analgesic?
☐ Yes - continue ➔	_____	☐ Oral Slow Release Morphine _____ wks / mths / yrs	☐ Laxative
☐ No - **end questions**	**The anatomic site/s most affected by pain is/are -**	☐ Other analgesics _____ wks / mths / yrs	☐ Other _____
	_____	☐ Non-steroidal anti-inflammatories _____ wks / mths / yrs	☐ None of the above
BL43B	_____	☐ Psychotropics _____ wks / mths / yrs	
		☐ None of the above (*Tick as many as apply*) (*Please circle*)	

43 Initiation and purpose of pathology orders

Organisation supporting this study: Australian Government Department of Health and Ageing

Issues: There is scant evidence in assessing the effectiveness and appropriateness of pathology ordering by GPs. This study investigated pathology orders at general practice encounters, specifically to determine the initiation of tests (i.e. the proportion of tests suggested by the GP compared with the proportion requested by the patient); the purpose of the tests (i.e. considered investigative, monitoring or preventive by a GP); and whether or not the test was considered 'opportunistic' by the GP (e.g. the GP had decided on a full blood count for the patient, and took the 'opportunity' to have the patient's cholesterol or blood sugar checked).

Sample: 3,001 encounters from 100 GPs; data collection period: 11/06/2002 – 15/07/2002.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to total BEACH sample of general practice encounters, with the majority (56.9%) of encounters with female patients.

There were 491 (16.4%) encounters at which 1,101 pathology test orders were placed, at a rate of 36.7 (95% CI: 31.4–41.9) per 100 encounters and 224.2 (95% CI: 209.0–239.5) per 100 encounters involving pathology.

Of the 1,036 pathology tests for which the GP responded to the initiation question, 84.9% were initiated by the GP and the remainder (15.1%) were requested by the patient. Among the 213 haematology test orders, 199 tests (93.4%) were initiated by the GP. Of the 575 chemistry test orders, 85.9% were initiated by the GP. Within the microbiology group, 80.8% of the 151 microbiology test orders were initiated by the GP. Only 35.6% of the 45 cytopathology tests (mainly pap smear) were initiated by the GP, compared with 100% of the 20 histopathology (mainly skin histology) and 14 immunology tests.

Of the 1,047 pathology test orders for which the GP indicated the purpose of a test, approximately a half (50.8%) were for investigative purposes, one-third (34.8%) for monitoring purposes, and one-sixth (14.4%) for preventive purposes.

Among the 577 chemistry test orders, 258 (44.7%) tests were for monitoring purposes, 232 (40.2%) were investigative and 87 (15.1%) were for preventive purposes. All orders for immunology, histopathology, pregnancy and simple test were considered investigative. The 46 cytopathology tests were mainly ordered for preventive purposes (63.0%) and were less likely to be used for investigative (19.6%) or monitoring purposes (17.4%).

Of the 920 pathology test orders for which the GP responded to the 'opportunistic' question, 18.0% were regarded as opportunistic. Approximately one-quarter (24.7%) of the 518 chemistry test orders were opportunistic. In contrast, among the 139 microbiology test orders, 10 (7.2%) tests were regarded as opportunistic.

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 **PATHOLOGY.**

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

INSTRUCTIONS

FOR THE DOCTOR

In the 'pathology' section of these forms there is room to record up to **5 different tests** ordered today which are **associated with the problems being managed for this patient at today's encounter.**

For each of the next 30 forms, if you have ordered pathology for the patient, please complete the following questions. **Only complete this section if you have ordered pathology at the encounter.**

INITIATION OF TESTS

For **each** of these tests, please circle an option to indicate whether the test was **suggested by you** or **requested by the patient.**

eg.	*Pathology*	*Initiated by*
	Test 1	GP / (patient)
	Test 2	(GP) / patient

PURPOSE OF TEST

For **each pathology test** ordered at today's consultation, please circle an option to indicate whether the **purpose of the test** was to **investigate / diagnose** a new condition, to **monitor** an existing condition, or for **prevention / screening** purposes.

eg	*Pathology*	*Purpose of test*
	Test 1	(investigative) / monitoring / preventive
	Test 2	investigative / (monitoring) / preventive

OPPORTUNISTIC TESTS

Please circle an option to indicate whether any of today's tests were **'opportunistic'** - for example, having decided on a full blood count for the patient, did you **take the 'opportunity'** to have their cholesterol or blood sugars checked?

eg.		
	Test 1 -	Yes / (No)
	Test 2 -	(Yes) / No

If pathology tests were ordered today please indicate whether each test was suggested by you or requested by the patient.	*Pathology*	*Initiated by*
	Test 1	GP / patient
	Test 2	GP / patient
	Test 3	GP / patient
	Test 4	GP / patient
	Test 5	GP / patient
		(*please circle ONE option*)

For each pathology test ordered today, please indicate whether the purpose of the test was investigative/diagnostic for a new condition; monitoring of an existing condition; or for prevention/screening.	*Pathology*	*Purpose of test*
	Test 1	investigative / monitoring / preventive
	Test 2	investigative / monitoring / preventive
	Test 3	investigative / monitoring / preventive
	Test 4	investigative / monitoring / preventive
	Test 5	investigative / monitoring / preventive
		(*please circle ONE option for each test*)

Were any of today's tests 'opportunistic' e.g. cholesterol added to full blood count?	
	Test 1 - Yes / No
	Test 2 - Yes / No
	Test 3 - Yes / No
	Test 4 - Yes / No
	Test 5 - Yes / No
	(*please circle ONE option*)

BL43C

44 Severity of illness

Organisation supporting this study: General Practice Statistics and Classification Unit (GPSCU)

Issues: This study was undertaken to explore the complex interrelationships between the severity of patient health problems managed at the encounter and the frequency of patient visits and length of consultation. These interrelationships cannot be explored using BEACH encounter data or Medicare data.

Sample: 6,742 encounters from 225 GPs. Data collected between 26/02/2002 – 01/04/2002 and 16/07/2002 – 19/08/2002.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: The Duke University Severity of Illness (DUSOI) analogue scale was used to assess the severity of each problem managed at the encounter and to calculate a total score for each encounter.[1] The GP recorded the start and finish time for the encounter and determined the number of GP visits in the preceding 12 months in consultation with the patient.

Summary of results

The age and sex distribution of the 6,742 respondents was similar to the distribution for all BEACH encounters.

The mean total DUSOI score was 5.6 (95% CI: 5.3–5.9) based on 5,612 scored encounters. Encounters with patients aged 65 years and over had a significant higher mean total DUSOI score (6.9, 95% CI: 6.3–7.5) than all scored encounters. There was a significant positive linear relationship between total DUSOI score and number of GP visits reported in the previous 12 months (p<0.001). Patients reporting 11 or more GP visits had the highest mean total score of 6.8, and those reporting nil GP visits had the lowest total mean score of 4.2.

There was a significant positive linear relationship between mean total DUSOI score at the encounter and the length of consultation with the consultation length increasing by 0.5 minute for each one unit increase in DUSOI (p=<0.001). The DUSOI range was 4.26 for consultations of less than 5 minutes to 8.80 for consultations of more than 25 minutes.

The DUSOI from the 8,118 scored problems had a mean and a median of 4.0. Significantly higher DUSOI scores were recorded for the following problems compared with the DUSOI for all problems (mean 4.0, 95% CI: 3.8–4.2): depression (mean 5.4, 95% CI: 5.1–5.8), back complaint (mean 5.3, 95% CI: 4.8–5.7), ischaemic heart disease (mean 5.2, 95% CI: 4.6–5.9) and fracture (mean 4.9, 95% CI: 4.2–5.6).

Significantly lower DUSOI scores were recorded for the following problems: hypertension (mean 3.4, 95% CI: 3.1–3.7), lipid disorder (mean 3.2, 95% CI: 2.7–3.8), acute upper respiratory infection (mean 3.1, 95% CI: 2.8–3.3), menopausal symptom/complaint (mean 3.0, 95% CI: 2.5–3.5), contact/allergic dermatitis (mean 3.0, 95% CI: 2.5–3.4), and solar keratosis/sunburn (mean 2.5, 95% CI: 2.0–3.1).

1 Parkerson GR, Jr., Broadhead WE, Tse CK. The Duke Severity of Illness Checklist (DUSOI) for measurement of severity and comorbidity. J Clin Epidemiol 1993; 46:379–393.

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 SEVERITY OF ILLNESS**

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

INSTRUCTIONS

START Time
:
AM / PM
(please circle)

START time
Record the time the consultation STARTED in hours and mins and circle whether the time was AM or PM.

eg. 9: 10
(AM) PM

GP consultations in the previous year.

Please check with the patient and write in the approximate number of times this patient has consulted you or any other GP at this or any other practice within the past 12 months.

SEVERITY OF ILLNESS - GP estimates for each patient*.

Estimate the severity of illness for **EACH problem managed at this encounter**. Please mark with an 'X' the appropriate place along the line to indicate how you would rate the patient's overall severity of illness **for that problem during the past week**.

Lowest severity applies to the fewest symptoms and complications, the least disability and threat to life, and the best expected response to treatment if needed. ***Lowest severity = '0'.***

Highest severity applies to the most symptoms and complications, the most disability and greatest threat to life, and the worst expected response to treatment. ***Highest severity = '10'.***

*Duke Severity of Illness Analog Scale (DUSOI-A), Parkerson et al, 1993.

FINISH time
Record the time the consultation FINISHED in hours and mins and circle whether the time was AM or PM.

eg. 9: 28
(AM) PM

How many times (approximately) has this patient consulted a GP at any practice in the last 12 months?	Severity of Illness - *GP estimate for each patient.* Please mark with an 'X' the appropriate place along each line to indicate how you would rate the patient's **overall severity of illness** during the past week **for each problem being managed at today's encounter.** *Lowest severity = 0; Highest severity = 10.*	Diagnosis/Problem 1 0 1 2 3 4 5 6 7 8 9 10 Diagnosis/Problem 2 0 1 2 3 4 5 6 7 8 9 10 Diagnosis/Problem 3 0 1 2 3 4 5 6 7 8 9 10 Diagnosis/Problem 4 0 1 2 3 4 5 6 7 8 9 10	FINISH Time : AM / PM (please circle) BL44B
_____			

45 Diabetes mellitus prevalence, management and risk factors

Organisation supporting this study: AstraZeneca (Australia) Pty Ltd

Issues: Prevalence and treatment of types 1 and 2 diabetes mellitus in general practice patients; cholesterol levels in patients with diabetes; occurrence of risk factors in patients without diabetes.

Sample: 3,165 encounters from 108 GPs; data collection period: 20/08/2002 – 23/09/2002.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to the distribution for all BEACH (general practice) encounters, with the majority (58.2%) being female, and a quarter of patients aged over 65 years.

The prevalence of type 1 and type 2 diabetes mellitus was 1.0% (95% CI: 0.5–1.3, *n*=30) and 7.2% (95% CI: 5.9–8.5, *n*=226) respectively with similar rates for male and female patients. Diabetes was most common in patients aged 65 to 74 years at 2.3% for type 1 and 18.4% for type 2.

The most common treatment regimen for type 1 diabetes patients was insulin, either alone or in combination with a diet and exercise program (41.4%). For type 2 diabetes patients, diet and exercise alone was the most frequent treatment (33.3%), followed by an oral anti-diabetic agent (most commonly a biguanide) either alone or in combination with diet and exercise (32.0%).

Among the 25 type 1 diabetes patients, for whom the GPs recorded data on recent cholesterol test results, 56.0% were in the normal range and 32.0% had mixed dyslipidaemia. Recent test results for 38.0% of the 208 type 2 diabetes patients were in the normal range. Fifty-seven per cent of patients had results outside the normal range, most commonly predominant high LDL and/or total cholesterol, while almost 5.0% of patients had never been tested.

Risk factor status was recorded for 2,907 patients without diabetes. Seventy-one per cent of patients had no risk factors, 17.1% had hypertension, 14.1% central obesity, 7.7% dyslipidaemia and 2.0% had abnormal glucose. The highest prevalence of abnormal glucose and dyslipidaemia was in 65 to 74 year olds, while hypertension and central obesity were most prevalent in patients 75 years or older.

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, 86 Diabetes Types 1 and 2 and coronary heart disease, 87 Management of cardiovascular or diabetes related conditions, 94 Type 2 diabetes – investigations and 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 **DIABETES.**

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

INSTRUCTIONS

FOR THE DOCTOR

Please indicate by ticking the appropriate box whether or not this patient has **ever been diagnosed** as having **Diabetes.**

If **'Yes'** proceed to the **next question**.

If **'No'** go to the **last question**

From recent tests, please indicate whether the patient has

- **predominant high LDL or Total Cholesterol (TC)** (**LDL** ≥ 3.5 mmol/L and / or **TC** ≥ 5.5 mmol/L)
- **Mixed dyslipidaemia** (**HDL** ≤ 1.0 mmol/L and / or **Triglycerides** (**TG**) ≥ 2.0 mmol/L)
- **Combined** (**LDL** ≥ 3.5 mmol/L and / or Total Cholesterol (**TC**) ≥ 5.5 mmol/L **AND HDL** ≤ 1.0 mmol/L and / or Triglycerides (**TG**) ≥ 2.0 mmol/L)
- been tested, all parameters in a normal range
- never been tested

If the patient has been diagnosed with Diabetes, either today or at a previous encounter, please indicate by ticking the appropriate box **the patient's current treatment regimen for diabetes**.

You **may tick more than one box** if several options apply.

If **none** of these treatments are being used by this patient, tick '**none of the above**'.

If 'NO' to diabetes, please indicate whether or not this patient has ever had, or currently has -

- an abnormal glucose test i.e. impaired fasting glucose (IFG) or impaired glucose tolerance (IGT)
- hypertension
- central obesity
- Mixed dyslipidaemia (HDL ≤ 1.0 mmol/L and / or Triglycerides (TG) ≥ 2.0 mmol/L)

Does this patient have diagnosed diabetes?

- ☐ Yes - Type 1
- ☐ Yes - Type 2
- ☐ No → **last question**

BL45B

If 'YES' what is their current treatment regimen?

- ☐ Diet and/or exercise
- ☐ Biguanide
- ☐ Sulphonylurea
- ☐ Alpha-glucosidase inhibitor
- ☐ Glitazones (PPAR)
- ☐ Insulin
- ☐ Other (specify)

_____

_____

- ☐ None of the above *(tick as many as apply)*

From test results, does this patient have

- ☐ Predominant high LDL and/or TC?
- ☐ Mixed dyslipidaemia (low HDL, high TG)?
- ☐ Combination of the above?
- ☐ Tested, all levels normal?
- ☐ Never been tested?

If 'NO' has this patient ever had, or have they currently

- ☐ An abnormal glucose test i.e. IFG or IGT?
- ☐ Hypertension?
- ☐ Central obesity?
- ☐ Mixed dyslipidaemia (HDL ≤ 1.0 mmol/L and/or TG ≥ 2.0mmol/L)? *(tick as many as apply)*

46 Coronary heart disease, risk factors and lipid lowering medication

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

Issues: The prevalence of coronary heart disease (CHD) and risk factors for CHD among general practice patients; the proportion of patients who had had a cholesterol test; the proportion of patients on lipid lowering medication; the medications being taken and the cholesterol levels at commencement of therapy.

Sample: 3,151 encounters from 108 GPs; data collection period: 20/08/2002 – 23/09/2002.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to the distribution for all BEACH encounters, with over half aged 25 to 64 years and the majority (59.5%) being female.

Sixty-seven per cent of patients did not have coronary heart disease or any of six listed risk factors (95% CI: 63.4–69.7). A total of 224 respondents (7.2%) had existing CHD. Of patients without CHD but with risk factors for CHD, 17.7% had hypertension, 7.0% family history of CHD, 5.7% family history of hypercholesterolaemia and 3.8% had diabetes. The risk factors for cerebrovascular disease and peripheral vascular disease accounted for 1.9% and 0.9% respectively.

As expected, CHD or its risk factors were more prevalent in older patients, with a significant increase between 45–64 year olds (43.3% 95% CI: 39.3–47.3) and 65–74 year olds (66.2% 95% CI: 60.3–72.1). The prevalence for patients over 75 years was 73.4% (95% CI: 68.3–78.6). Risk factors were evenly spread between male and female patients. CHD was marginally more common among males (9.1%, 95% CI: 7.0–11.1) than females (5.8%, 95% CI: 4.2–7.4) though the difference did not reach statistical significance.

Of the 3,098 patients who answered the question on cholesterol testing, more than half (52.9%) had previously had a cholesterol test, and of the 2,726 respondents to the question on lipid lowering medication status, 12.7% were either starting or continuing such medication.

The most popular lipid lowering generic medications were Simvastatin, which accounted for 41.8% of lipid lowering medications and Atorvastatin (40.9% of medications). For those on lipid lowering medications the average total cholesterol at the commencement of therapy was 6.9 mmol/L, the mean level of triglycerides was 2.7 mmol/L and HDL 1.5 mmol/L.

For other related abstracts see: 15 Lipid lowering medication, 20 Screening and management of blood cholesterol, 30 Lipid lowering medications and coronary heart disease, 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, 97 Statin medication use among high CHD risk patients attending general practice, 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 **LIPID LOWERING MEDICATIONS.**

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

INSTRUCTIONS

FOR THE DOCTOR

Please indicate by ticking the appropriate boxes whether or not this patient has **existing coronary heart disease** or any of the risk factors listed.

Tick as many as apply.

Please tick the appropriate box to indicate whether this patient will be -

- **commencing lipid lowering medication therapy** as a result of this consultation
- **continuing a current lipid lowering medication** prescribed at a previous consultation **OR changing to another lipid lowering medication** from one previously prescribed
- **will not require lipid lowering medication** following today's consultation

If no lipid lowering medication is required please end the questions here.

Please write the **name and regimen** of any **lipid lowering medication** to be used by the patient **following today's consultation**, regardless of whether it was **prescribed today or at a previous encounter.**

Please list the patient's levels of **Total Cholesterol, Triglycerides and HDL at the commencement of their lipid lowering medication therapy**. For patients commencing therapy today, this may be a recent test result. For patients continuing or changing lipid lowering medications, this will be the test result **prior** to their commencement of **any lipid lowering medication.**

Please advise by ticking the appropriate box whether or not this patient has **ever had their blood cholesterol levels tested.**

Does this patient have? *(tick as many as apply)*

- ☐ Existing CHD
- ☐ Familial hypercholesterolaemia
- ☐ Family history of CHD (1° relative <60yo)
- ☐ Peripheral vascular disease
- ☐ Diabetes mellitus
- ☐ Hypertension *(include treated patients)*
- ☐ Cerebrovascular disease
- ☐ None of the above

Has this patient ever had a cholesterol test

- ☐ Yes
- ☐ No

Is this patient (today)

- ☐ About to commence lipid lowering medication? (to next question ➔)
- ☐ Continuing / changing lipid lowering medication? (to next question ➔)
- ☐ Not requiring lipid lowering medication

If Not required, END QUESTIONS HERE

BL45C

What lipid medication(s) are to be used following today's visit?

	Name & Form	Strength	Dose	Frequency
1.				
2.				

At the commencement of medication what is/ was the level of -

Total Cholesterol _____ mmol/L

Triglycerides _____ mmol/L

HDL _____ mmol/L

47 Management of depression and anxiety

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

Issues: Prevalence of depressive and/or anxiety disorders in general practice patients; medications being taken for management of depression and anxiety disorders; side effects of management medications; management of side effects of antidepressant or anxiolitic medications.

Sample: 2,698 encounters for 92 GPs; data collection period 24/09/2002 – 28/10/2002.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

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

The majority of patients (84.3%, 95% CI: 82.2–86.4) did not have a current anxiety or depressive disorder. The most common Depression/Anxiety disorder being experienced was 'Mixed anxiety/Depressive disorder' reported for 5.5% (95% CI: 4.3–6.6) of respondents. Only 2.5% (95% CI: 1.7–3.2) of respondents were experiencing major depressive disorder. Anxiety and depressive disorders were more common among adults, there were no significant differences in the rates of anxiety or depression between the sexes.

Of those patients experiencing major depressive disorder, 90.9% (95% CI: 84.1–97.8) were taking medication. The disorder with the lowest percentage of patients taking medication was 'Other anxiety/depressive disorder', where 45.1% (95% CI: 31.1–59.1) of these patients were taking medication. The four most commonly prescribed generic medications for anxiety/depressive disorders combined were Citalopram, Sertraline, Diazepam and Venlafaxine.

Of the 169 patients taking a selective serotonin reuptake inhibitor (SSRI) or selective noradrenaline reuptake inhibitor (SNRI), 14 (8.3%) were experiencing nausea and vomiting, 10 (5.9%) had experienced weight gain, 9 (5.3%) had experienced insomnia and 8 (4.7%) had experienced sexual dysfunction as side effects of SSRI/SNRI use. There were no significant differences between side effects in impact on the patients' lives. Of the patients with side effects from SSRI/SNRI use, 24 (63.2%) were not having their side effects managed. Of those patients having side effects managed, four were taking additional medication, eight had changed their medication and one had stopped the medication.

For other related abstracts see: 5 Depression, 23 Depression.

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 **DEPRESSION.**

*You may **tear out this page** so you can **access the list in Box 1 for the following section of forms.***

INSTRUCTIONS

BOX 1

Criteria for major depression* *DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th edition).

At least FIVE (5) of the following symptoms for at least TWO WEEKS (symptom 1 or 2 must be present):

(1) Depressed mood
(2) Loss of interest or pleasure
(3) Significant appetite or weight loss or gain
(4) Insomnia or hypersomnia
(5) Psychomotor agitation or retardation
(6) Fatigue or loss of energy
(7) Feelings of worthlessness or excessive guilt
(8) Impaired thinking or concentration; indecisiveness
(9) Suicidal thoughts/thoughts of death

FOR THE DOCTOR

Please indicate by ticking the appropriate box whether or not this patient has **any of the listed depressive or anxiety disorders.**

Use the criteria shown above in Box 1 to help assess whether the patient's depression is a 'MAJOR' depressive disorder.

If **'None of the above' end questions here.**

Medications for anxiety / depressive disorder

Please write the **name and form** of any medications currently being used to treat this patient's anxiety or depressive disorder. Also, please indicate the regimen (i.e. **strength, dose and frequency**) of the medication.

Ask the patient about ...

Side effects of medication

If the patient is using a Selective Seretonin Reuptake Inhibitor **(SSRI)** or a Serotinin Noradrenaline Reuptake Inhibitor **(SNRI)** please use the tick boxes to indicate whether or not the patient is experiencing any of the listed **side effects from taking this medication** recorded in the previous question.

Ask the patient to **rank** each existing side effect according to how it **impacts on their quality of life. Circle a number** on a scale of 1 to 5, where **1 = the least impact and 5 = greatest impact.**

Management of side effects

Please use the tick boxes to indicate how you will attempt to manage any side effects of medication for this patient.

Does this patient currently have a -

- ☐ Generalised depressive disorder
- ☐ Major depressive disorder **(from criteria in Box 1 above)**
- ☐ Mixed anxiety /depressive disorder
- ☐ Other anxiety or depressive disorder
- ☐ None of the above → **end questions**

Please list any medications currently being used to treat the anxiety or depressive disorder.

	Name & Form	Strength	Dose	Frequency
1.				
2.				
3.				

4. None → **end questions**

BL46B

If an SSRI or SNRI is being used:

Any side effects from this medication?

If YES, ask the patient to rank the impact of each side effect on their quality of life

	Circle to rank
☐ No side effects	
☐ Nausea and vomiting	1 2 3 4 5
☐ Weight gain	1 2 3 4 5
☐ Insomnia	1 2 3 4 5
☐ Sexual dysfunction	1 2 3 4 5
☐ Other _____	1 2 3 4 5

(tick as many as apply) *(1= least impact; 5= greatest impact)*

How will side effects be managed?

- ☐ additional med'n
- ☐ change med'n
- ☐ stop medication
- ☐ further lab tests
- ☐ No management

48 Asthma prevalence and management

Organisation supporting this study: Australian Government Department of Health and Ageing

Issues: This study investigated the prevalence of asthma in general practice patients; medications taken for asthma management; severity of asthma for adults and children at commencement of Long Acting Beta Agonist (LABA); reason for prescribing a combination product (LABA plus inhaled corticosteroid (ICS)); changes in asthma control since taking combination product; patient preference for product type; patient use of spacer device.

Sample: 2,686 encounters from 92 GPs**;** data collection period: 24/09/2002 – 28/10/2002.

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-sex distribution of respondents was similar to the distribution for all BEACH (general practice) encounters, with the majority (59.9%) of patients being female.

The prevalence of asthma among the respondents was 14.5% (95% CI: 12.7–16.2). Prevalence was significantly higher among patients aged 5 to 14 years (24.0%, 95% CI: 17.3–30.7) compared with the patients from the other age groups (13.7%, 95% CI: 12.0–15.5).

Of the 382 patients who answered the question about current medication, 29.8% were taking the combination LABA/ICS product, 22.3% were taking inhaled ICS alone, 3.7% were using both LABA and ICS (2 single drugs), and 3.9% were using LABA alone. The remaining respondents (40.3%) were not taking these medications.

Of the 16 children taking LABA (single or combination), 8 had frequent asthma, 4 had persistent asthma and 4 had infrequent asthma, when LABA was commenced. Of the 113 adults taking LABA (single or combination), 59.3% had moderate asthma, 20.4% had severe asthma, and 20.4% had very mild to mild asthma, when LABA was commenced.

There were 109 responses to 'purpose of prescribing' the combination product. For these, 34.9% (*n*=38) replaced 2 products with one, 30.3% (*n*=33) commenced both medications at the same time, 28.4% (*n*=31) added LABA to therapy, and 6.4% (*n*=7) added ICS to therapy. Asthma control level was 'improved' for 84.4%, 'same as before' for 12.8%, and 'worse' for the remaining 2.8%.

The majority (52.3%, *n*=193) of patients preferred the combination product, 21.8% the single ingredient product, and the remaining 25.9% had no preference.

The question on the use of a spacer device was answered by 176 patients to whom it was relevant. Of these, 52.3% reported that they never used a spacer device and the remainder were equally likely to report its use 'always' or 'sometimes' (23.1% in each case).

For other related abstracts see: 3 Asthma, 22 Asthma – prevalence, severity and management, 39 Severity of asthma, medications and management, 63 Asthma-prevalence, management and medication side-effects, 70 Inhaled corticosteroid use for asthma management, 96 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.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **ASTHMA.**

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

INSTRUCTIONS

ASK ALL PATIENTS

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**.

Severity of asthma

If the patient is using a Long Acting Beta Agonist (LABA) for asthma management, please indicate the **severity** of their asthma **at the commencement of the LABA**.

Please 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.

Commencement of Combination product

If the patient is using a combination product, please use the tick boxes to indicate whether it was prescribed to **add Beta 2 Agonist to therapy**, to **add Inhaled Cortio-costeroid to therapy,** to **commence both medications at the same time,** or to **replace 2 single medications with the combined product.**

Assessment of asthma control

Please use the tick boxes to indicate whether the **control of this patient's asthma has improved, worsened or remains the same** since using the combination product.

Changes in dose of ICS in Combination Product use

If the patient is using a combination product, please advise whether you have **changed the dose of inhaled cortioco-steroid** in response to the patient's condition. This may be by changing the puffs per dose or prescribing a different strength combination.

Patient preference

Please use the tick boxes to indicate whether this patient **prefers** the combination product, single ingredient products, or has no preference.

Please indicate how frequently the patient uses a **spacer device to assist with medication delivery**. If a self actuating device is used tick 'Not applicable'.

Does this patient suffer from Asthma?	If 'Yes' their current medication is	If LABA used how severe was the asthma when LABA commenced? (See cards)	If Combination product is used, was it pescribed to	Since starting the Combination product asthma control level is:-	In response to asthma control, dose of the Inhaled Cortiosteroid in the combination product has:	Patient prefers	Patient uses spacer device
☐ Yes →	☐ Long Acting Beta Agonist (LABA)	Child / Adult	☐ add LABA to therapy	☐ Worse	☐ Increased	☐ Combination product	☐ Always
☐ No	☐ Inhaled Cortico-steroid (ICS)	☐ Infrequent ☐ Very mild	☐ add ICS to therapy	☐ Same	☐ Decreased	☐ Single ingredient product	☐ Sometimes
↓	☐ Combination product (LABA + ICS)	☐ Frequent ☐ Mild	☐ start both medications at the same time	☐ Improved	☐ Not changed	☐ No preference	☐ Never
End questions	☐ None of above - END	☐ Persistent ☐ Moderate	☐ replace 2 single drugs with combined product				☐ Not applicable
		☐ Severe					
		BL46C					

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

49 Health status and management of patients on non-steroidal anti-inflammatory drugs

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

Issues: Prevalence of non-steroidal anti-inflammatory medication (NSAID) use in general practice patients; self-reported general health status of general practice patients taking NSAID medications; prevalence of rheumatoid arthritis among these patients; patient corticosteroid use among these patients; rate of hospitalisation associated with gastrointestinal problems for general practice patients taking NSAID medications; other gastrointestinal side effects for general practice patients taking NSAID medications.

Sample: 5,554 encounters from 192 GPs; data collection period 29/10/2002 – 21/12/2002 and 21/01/2003 – 24/02/2003.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: *Current health status was reported by patients based on five listed categories: excellent, very good, good, fair and poor. Each patient was provided with a card that listed these categories.*

Summary of results

The age-sex distribution of respondents had a somewhat greater proportion of female patients (62.5%, 95% CI: 60.1–64.8) than the total BEACH (general practice) encounters (57.4%, 95% CI: 57.0–58.6).

NSAIDs were taken by 14.3% (792/5554) of respondents—7.8% (95% CI: 6.8–8.8) were taking a cox-2 inhibitors and 6.5% (95% CI: 5.6–7.3) were taking another NSAID. Only two respondents were taking both a cox-2 inhibitor and another NSAID. Over one-third (37%, 294/788) of respondents on NSAIDs were aged between 45 and 64 years, while the age group most likely to be on NSAIDs were respondents aged 65 years and over (27% of those aged over 64 years were taking an NSAID). Of those on NSAIDs 6.8% had rheumatoid arthritis and 13.0% had taken corticosteroids in the previous 12 months, most for less than 1 month's duration.

Of those on NSAIDs, 5.7% (44/796) had previously been hospitalised with a gastrointestinal complaint. Of those previously hospitalised most were currently on cox-2 inhibitors (34/44). A further 31% of respondents on NSAIDs had experienced some adverse gastrointestinal side effects that did not lead to hospitalisation.

Using the Standardised Calculator of Risk Events (SCORE) to assess risk of future gastro-intestinal events, two-thirds of respondents on NSAIDs had a moderately increased risk of a serious GI side effect associated with taking NSAIDs (SCORE > 10). The mean risk levels for respondents on cox-2 inhibitors were significantly higher than for respondents on other NSAIDs (mean SCORE 14.6, 95% CI: 13.9–15.2 versus 10.8 95% CI: 10.0–11.6).

For other related abstracts see: 29 Non-steroidal anti-inflammatory drugs (NSAIDS) and acid suppressant use, 78 NSAID & acid suppressant use in general practice patients, 88 Arthritis rates and NSAID use 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 **PATIENTS ON NON-STEROIDAL ANTI-INFLAMMATORY MEDICATIONS.**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

Current NSAID use

Please advise whether this patient is **currently taking a COX 2 inhibitor or any other non-steroidal anti-inflammatory (NSAID) medication.** This includes any Cox 2 or NSAID medication prescribed today or at a previous encounter by you or another GP.

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

Ask the Patient

Please show the patient the card of options and ask them to give their opinion of **their current health status** in general terms. Use the tick boxes to indicate the patient's response.

Rheumatoid arthritis

Please indicate whether or not this patient has been diagnosed, either today or at a previous encounter, with **rheumatoid arthritis**.

Patient corticosteroid use

Please advise whether or not this patient has been taking **prednisone** or any other **corticosteroid, orally** or by **injection (but not by oral inhalation)** during the past year.

Duration of corticosteroid use

If **'Yes' to corticosteroid use**, please use the tick boxes to indicate the **approximate length of time** the patient has been taking the corticosteroid.

If there were **several separate occasions** of use, please **combine them for total duration**
e.g. prednisone taken for 10 days in March and 10 days is June = 20 days in total.

Hospitalisation

Please advise whether or not the patient has **ever been hospitalised** for **stomach or intestinal problems** such as **bleeding or an ulcer**?

If **'Yes'** you should **end the questions here**.

Side effects

If **'No'**, please advise whether or not the patient has **ever experienced gastrointestinal side effects** such as heartburn, stomach pain, nausea or vomiting, **while taking NSAIDs**.

Is this patient currently taking -?	If 'Yes', in general would you say your health is (show card)	Does the patient have *rheumatoid* arthritis?	Has the patient taken prednisone or other corticosteroids by mouth (not by oral inhaler) or by injection during the past year?	If 'Yes', how many months have they taken them in the past year?	Has the patient been hospitalised for a stomach or intestinal problem such as bleeding or an ulcer?	If 'No' has the patient ever had gastrointestinal side effects (heartburn, stomach pain, nausea, vomiting)when taking NSAIDs?
☐ a COX 2 inhibitor →	☐ Excellent?	☐ Yes	☐ Yes	☐ < 1month	☐ Yes	☐ Yes
☐ any other NSAID →	☐ Very good?	☐ No	☐ No	☐ 1 - 3 months	☐ No	☐ No
☐ None of above	☐ Good?			☐ 4 - 6 months	(If 'Yes', end questions here)	
↓ *End questions*	☐ Fair?			☐ 7 - 10 months		
BL47B	☐ Poor?			☐ 11 - 12 months		

In general would you say your health is -

- Excellent?
- Very good?
- Good?
- Fair?
- Poor?

51 Use of proton pump inhibitors for gastrointestinal problems

Organisation supporting this study: Janssen-Cilag Pty Ltd

Issues: Proton pump inhibitors (PPI) are frequently used in the management of gastrointestinal (GI) disease. This study measured the number of patients on PPIs for GI problems (as defined by the GP), the numbers prescribed for new GI problems, the types of PPIs prescribed currently or in the past, whether initiated by GPs or specialists and if supplied as samples.

Sample: 2,648 encounters from 91 GPs**;** data collection period: 03/12/2002 – 20/01/2003.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to the expected distribution for general practice encounters, with the majority (58.4%) of patients being female.

Of the 2,648 respondents, the GP indicated that 10.4% (95% CI: 8.6–12.2, *n*=275) of patients were currently taking a PPI for a GI problem. These patients were significantly older (mean age 63.3 years) than patients not taking PPIs (mean age 46.8 years). There was no difference in gender of patients taking PPIs (42.1% male) compared with those who were not (41.6% male).

Of the 275 patients currently on a PPI for gastrointestinal problem/s, 9.1% (95% CI: 0–18.5, *n*=25) were diagnosed with the problem/s at the reported encounter (i.e. a new problem). The remaining 90.9% had their gastrointestinal problem diagnosed previously.

Only one medication (the current PPI) was prescribed for almost two-thirds of patients (62.2%; 171 patients). One previous medication had been prescribed for 31.3% of patients and two previous medications for 6.6%.

The most common current PPI for GI problems was Omeprazole (42.6%), followed by Pantoprazole (26.2%) and Esomeprazole (17.1%). The 'new generation' Rabeprazol and Esomeprazole account for 48% of PPIs for new GI problems, compared with 20.4% of current PPIs for old GI. Omeprazol comprised 16% of PPIs prescribed for new problems compared with 45.2% for old GI problems.

Of the 397 medication listed, 64.2% were initiated by a GP, 31.0% by a specialist.

GPs stated they had given sample packs of the current PPI medication to 13.8% of patients (38), and samples of previous medications to 3.6% (10 patients).

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), 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, 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 **PROTON PUMP INHIBITORS for GASTROINTESTINAL PROBLEMS.**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

FOR THE DOCTOR

Please indicate by ticking the appropriate box whether or not this patient is **currently taking a Proton Pump Inhibitor medication** for a **gastrointestinal problem**, (prescribed previously) or **will be as a result of today's encounter.**

If **'No' end questions here.**

Diagnosis of current problem

Please indicate whether the patient's current gastrointestinal problem was **diagnosed today** at this encounter, **or diagnosed at a previous encounter** either by you or by another doctor.

Proton Pump Inhibitors

Please write the **name, form and strength** of any **Proton Pump Inhibitor medications currently being used** to treat this patient's gastrointestinal problem. Also, please indicate the regimen (i.e. **dose and frequency**) of the medication.

Please **circle an option** to indicate whether this medication was **initiated by a GP or by a Specialist**, whether **the patient was given a sample** of their current medication at any time (either by you or by another doctor), and if so, how many sample packs were given.

If the patient has **changed medications since the diagnosis** of their **current gastrointestinal problem**, please list the details of the **medications previously taken** as indicated above.

Is this patient currently taking PPI medication for a gastrointestinal problem?	If 'Yes', was their current gastro-intestinal problem diagnosed -	Please list any PPI medications currently being used to treat the gastrointestinal problem, indicating who initiated the PPI, whether samples of the PPI were given to the patient at any time, and if so, how many sample packs. If treatment has changed since original diagnosis, please list details of medications previously used.
☐ Yes →	☐ Today	Name & Form / Strength / Dose / Frequency / Initiated by / Sample given / No. of samples
☐ No → *End questions*	OR	_____ GP / Specialist Yes / No ___
BL488	☐ At a previous encounter (by you or by another GP or Specialist)	Previous medications *(please circle)*
		1. _____ GP / Specialist Yes / No ___
		2. _____ GP / Specialist Yes / No ___

52 Language and cultural background of patients

Organisation supporting this study: Australian Government Department of Health and Ageing

Issues: Previous research suggests that health surveys are inclined to under-enumerate persons from culturally diverse and in particular, Indigenous backgrounds. This study aimed to validate the routine BEACH questions on language background and Indigenous status, using more extensive questions that focussed on the patient's cultural background.

Sample: 8,943 encounters with 294 GPs; data collection period: 03/12/2002 – 05/05/2003.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: Based on the 2001 Census questions, patients were asked about their country of birth, parents' countries of birth, whether the patient was of Aboriginal or Torres Strait Islander origin and what language was spoken at home.

Summary of results

Sixty-one per cent of respondents were female (95% CI: 59.0–62.7) compared with BEACH (57.4%, 95% CI: 57.0–58.6%).

Two hundred and four (2.4%, 95% CI: 1.3–3.4) respondents identified as of either Aboriginal or Torres Strait Islander origin, twice the rate routinely recorded in BEACH (April 2001 – March 2003 unweighted, 1.2%, 95% CI: 0.8–1.6,). Although not statistically significant this increased identification rate provides some evidence that the structured question may be more successful in identifying Aboriginal and Torres Strait Islander respondents in general practice.

Seventeen per cent of respondents reported speaking a language other than English at home (95% CI: 14.5–19.6), more than twice the rate routinely identified in BEACH (7.5%, 95% CI: 6.5–8.5). However, the SAND question is broader and includes those who speak mainly English plus another language, while the routine BEACH question only includes those who mainly speak a language other than English. Languages were classified according to the Australian Classification of Languages 1997 (*source:* Australian Bureau of Statistics). After English, Southern European languages (Italian, Greek, French, Spanish etc.) were the most common group of languages, spoken by 5.5% of respondents.

Three-quarters of respondents (75.3%) were born in Australia and two out of five respondents (41%) had at least one parent born overseas.

For other related abstracts see: 65 Language and cultural background of general practice patients, 95 Cultural background of 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 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
- ☐ England
- ☐ Scotland
- ☐ Greece
- ☐ Italy
- ☐ New Zealand
- ☐ Viet Nam
- ☐ Other (please specify) _____

BL48C

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, Italian
- ☐ Yes, Greek
- ☐ Yes, Cantonese
- ☐ Yes, Mandarin
- ☐ Yes, Arabic
- ☐ Yes, Vietnamese
- ☐ Yes, other (please specify) _____

53 Smoking status of adults and their attempts to quit

Organisation supporting this study: Australian Government Department of Health and Ageing

Issues: The smoking status of adult patients, the methods used by current and former smokers in attempts to quit and the success of these methods, and time since they last smoked or last attempted to quit were examined. This is a follow-up to abstract No. 35.

Sample: 2,510 encounters with patients aged 18 and over, from 97 GPs; data collection period: 25/02/2003 – 30/03/2003.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: A Quit Smoking Key List with 12 quitting methods, including 'cold turkey', nicotine patches and Bupropion, was made available to patients to indicate which methods they had used to quit (former smokers) or attempt quitting (current smokers).

Summary of results

The greater proportion of patients aged 18 or more had never smoked (49.9%, 95% CI: 46.5–53.3). Former daily smokers accounted for 22.6% of patients (95% CI: 20.0–25.1), followed by current daily smokers, representing 17.1% (95% CI: 15.0–19.3). Former occasional smokers and current occasional smokers accounted for 7.1% and 3.4% of patients respectively. Grouping daily and occasional together, former smokers accounted for 29.6% (95% CI: 27.0–32.3) and current smokers 20.5% (95% CI: 18.1–22.8) of patients.

Female patients were significantly more likely than males never to have smoked (58.0% compared with 36.3%). Significantly more male patients were former daily smokers (32.4%) then female patients (16.6%). Levels of occasional smoking were similar for male and female patients.

There were 734 former smokers who indicated a quitting method from the Key list, and 92.8% of these indicated using only one method. Of these, the most frequent single method used was 'cold turkey' (89.4%) followed by nicotine patches (3.5%). Bupropion was used by 10 former smokers (1.4%), of whom 6 used only this method.

Of the 514 current smokers, 55.4% had tried to quit smoking during the previous 5 years, the majority (74.1%) using only one method. The most frequently used methods were 'cold turkey' (59.6%) followed by nicotine patches (31.9%) and Bupropion (13.7%).

Of the 814 patients who had tried to quit 'cold turkey' (+/– other methods) 80.2% (95% CI: 76.7–83.7) reported they were not currently smoking. Of the 164 who tried using nicotine replacement therapy (i.e. patches/gum/inhaler) (+/– other methods), one-third had quit (36.6%, 95% CI: 27.2–46.0). Of the 47 who tried to quit with Bupropion, one in four (21.3%, 95% CI: 1.0–41.5) were not currently smoking but due to small numbers this estimate is somewhat unreliable (as shown by the wide confidence intervals).

For other related abstracts see: 12 Smoking and passive smoking in general practice patients, 35 Smoking status of adults and their attempts to quit, 74 Smoking and passive smoking in the home and Section 4.3 Smoking.

Further reading:

Doran, C. M., Valenti, L., Robinson, M., Britt, H., & Mattick, R. P. 2006, 'Smoking status of Australian general practice patients and their attempts to quit', *Addict.Behav.*, vol. 31, no. 5, pp. 758–766.

Valenti, L., Charles, J., & Britt, H. 2005, 'Passive smoke in Australian homes: 1999 to 2004 [letter]', *Australian and New Zealand Journal of Public Health*, vol. 28, no. 4, pp. 387–388.

Degenhardt L, Knox S, Barker B, Britt H, Shakeshaft A. The management of alcohol, tobacco and illicit drug use problems by general practitioners in Australia. *Drug Alcohol Rev* 2005; 24(6):499–506.

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 SMOKING STATUS AND ATTEMPTS TO STOP SMOKING**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

THE FOLLOWING QUESTIONS REFER TO THE SMOKING OF ALL TOBACCO PRODUCTS

Patient smoking status

Please ask the patient to describe their current smoking status from the pick list on the 'Smoking status and Key list' card. Tick a box to indicate their answer.

If the patient has **'NEVER SMOKED'** please **END** the **QUESTIONS HERE**

For former smokers

If the patient is a **former smoker** please ask them to advise **how long ago they last smoked**. Please write the patient's response in the space provided.

Quit Smoking key list

Please ask the patient to read the **list of options on the card**. **Circle the numbers** which correspond with **any method** on the list thay they **used to *finally* quit smoking**. If a combination of methods were used to finally quit, please **circle all methods used**.

For current smokers

If the patient is a **current smoker** please ask them if they **have tried to quit smoking in the past 5 years**. Please tick the appropriate box to indicate the patient's response. If **'NO'** please **END QUESTIONS HERE**.

If **'YES'** ask the patient to advise **how long ago they last attempted to quit smoking**. Please write the patient's response in the space provided.

Quit Smoking key list

Please ask the patient to read the **list of options on the card** and to tell you which **method** they used in **their *most recent attempt* to quit smoking**.

Circle the numbers which correspond with any methods used. If a combination of methods were used please **circle all applicable numbers**.

Please describe your smoking status

- ☐ Current smoker - daily.
- ☐ Current smoker - occasional.
- ☐ Former smoker - daily
- ☐ Former smoker - occasional.
- ☐ Never smoked ⇨ **END QUESTONS**

BL50B

For former smokers -

How long since you last smoked?

_____
(yrs /mths /wks /days)

From the Key list, what method/s did you use (or are currently using) to stop? (circle as many as apply)

1. 2. 3. 4. 5. 6.
7. 8. 9. 10. 11. 12.

For current smokers -

In the **past 5 years** have you tried to stop smoking?

- ☐ Yes.
- ☐ No ⇨ **END QUESTIONS.**

If 'YES' how long since your last quitting attempt?

_____
(yrs /mths /wks /days)

From the Key list, what method/s did you use in this last attempt? (circle as many as apply)

1. 2. 3. 4. 5. 6.
7. 8. 9. 10. 11. 12.

CURRENT SMOKING STATUS

Please describe your smoking status

- ☐ Current smoker - daily.
- ☐ Current smoker - occasional.
- ☐ Former smoker - daily
- ☐ Former smoker - occasional.
- ☐ Never smoked

QUIT SMOKING KEY LIST

Listed below are methods available to assist smokers to stop smoking. In this study, 'smoking' includes all tobacco products.

1. **'Cold Turkey' i.e. immediate cessation with no method of assistance**
2. **Nicotine patches**
3. **Nicotine gum**
4. **Nicotine inhaler**
5. **Hypnotherapy**
6. **Herbal preparations**
7. **Support / counselling eg 'SmokeStop', 'Quitline'**
8. **Zyban (Bupropion)**
9. **Other medication**
10. **Self-help material e.g. quit smoking manual**
11. **GP assistance other than above eg counselling**
12. **Other methods not listed above**

54 Secondary prevention of heart attack or stroke

Organisation supporting this study: Australian Government Department of Health and Ageing

Issues: This study investigated the proportion of general practice patients with a cardiovascular risk factor; the proportion of patients with at least one risk factor who are taking anti-platelet or coagulant medication for secondary prevention of heart attack or stroke; the reasons for non-use of these medications for secondary prevention by patients with cardiovascular risk factors.

Sample: 2,833 encounters from 97 GPS; data collection period: 25/02/2003 – 30/03/2003

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to the expected distribution for general practice encounters, with the majority (59.7%) of patients being female.

Of the respondents, 34.7% (95% CI: 30.7–38.6) had at least one cardiovascular risk factor—22.2% had one risk factor and 12.4% had two or more risk factors. The most common risk factor was hypertension reported by 25.7% of patients. The second most common risk factor was 'other risk factors' (8.2%) followed by stable/unstable angina (4.1%).

Of the patients with at least one risk factor (*n*=982), 58.0% were on at least one anti platelet/anti-coagulant medication, the majority taking only one medication (56.6%). The most common medication taken by patients to manage their risk factor(s) was aspirin (taken by 46.0% of the 982 risk factor patients). The second most common medication was warfarin (5.4%), followed by clopidogrel (4.7%).

Of the 412 patients who had at least one risk factor and indicated that they were not taking anti-platelet/anti-coagulants, 86% had a reason for not taking a preventative medication. Of the risk factor patients who were not currently taking a preventative medication (*n*=412), 45.9% were not doing so because it was not clinically indicated, 15.8% because the patient had a history of PUD or GORD, and 11.7% listed 'other' reasons.

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 **SECONDARY PREVENTION OF HEART DISEASE & STROKE**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

These questions relate to the use of aspirin and other anti-coagulation therapy for the secondary prevention of heart attack and stroke in high-risk patients. Our aim is to identify patients with risk factors; estimate the prevalence of patients taking aspirin, aspirin like medications or herbal preparations with similar anti-coagulant effects; and to estimate the proportion of patients with stated intolerance or allergy to aspirin or similar medications.

Patient risk factors for heart attack or stroke.

Please use the tick boxes to indicate whether or not this patient has any of the listed **risk factors or comorbidities for heart attack or stroke.**

Tick as many boxes as apply.

If the patient has **NONE** of the listed risk factors, please **END** the **QUESTIONS HERE.**

Medications

Please tick the box beside any **anti-platelet or anti-coagulant medications** currently being taken by this patient for secondary prevention of heart attack or stroke. Include **prescribed** and **over the counter** medications such as **aspirin** or **herbal preparations** used for anti-coagulant effects eg **garlic, ginger, ginseng, feverfew, ginkgo, chamomile, bromelain** (ask the patient about any over the counter preparations so that these may be included).

Tick as many boxes as apply.

Reasons for non-use of anti-platelet or anti-coagulant medication for secondary prevention

If the patient is not currently taking an anti-platelet / anti-coagulant medication or other preparation for secondary prevention, please use the tick boxes to indicate the main reason/s for non-use by this patient.

If you tick the '**other**' box, **please write the reason** beside it in the space provided.

Does this patient have any of these risk factors for heart attack/stroke?

- ☐ Hypertension
- ☐ Atrial fibrillation
- ☐ AMI
- ☐ Stroke/TIA
- ☐ Stable/unstable angina
- ☐ Peripheral vascular disease
- ☐ Previous CABGs
- ☐ Previous PTCA
- ☐ Other _____ (please specify risk factor)
- ☐ None of above ⇨ **END QUESTONS**

BL50C

Which medications are currently being taken?

- ☐ Aspirin
- ☐ Dipyridamole
- ☐ Dipyridamole with aspirin
- ☐ Clopidogrel
- ☐ Ticlopidine
- ☐ Warfarin
- ☐ Heparin
- ☐ Low mol. weight heparin
- ☐ Danaparoid
- ☐ Herbal prep. _____
- ☐ None of the above

Despite presence of risk factors, aspirin or anti-coagulants are not taken because of:-

- ☐ History of PUD or GORD
- ☐ Expected adverse effect on GIT
- ☐ Concurrent NSAID therapy
- ☐ Other adverse effect including hypersensitivity
- ☐ Not clinically indicated
- ☐ Other _____

55 Patient weight, perception of weight and weight loss

Organisation supporting this study: Roche Products Pty Ltd

Issues: Body mass index (BMI) of patients aged 18 years and over; patient perception of overweight; weight loss attempts and methods; the proportion who have type 2 diabetes.

Sample: 2,969 respondents from 99 GPs with 2,612 respondents aged 18 or over; data collection period: 01/04/2003 – 05/05/2003.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: *A card listing methods of weight loss was provided to patients to assist with answering these questions.*

Summary of results

The age distribution of the sample was similar to that of patients at all BEACH encounters but under 18 year-olds were removed from these calculations. Female patients made up 60.9%, a slightly larger proportion than the average. Response rates (and therefore denominators) for the following questions varied.

Underweight patients accounted for 8.8% of respondents (95% CI: 7.4–10.2), 35.1% (95% CI: 32.6–37.7) were within normal range, 33.6% (95% CI: 31.2–35.9) were overweight and 22.5% (95% CI: 20.3–24.8) were obese. Overall, almost half saw themselves as overweight and over a third had attempted to lose weight in the previous 12 months. Diet and/or exercise was the most common method tried and the most frequently reported as successful in all weight groups. The prevalence of type 2 diabetes was 8.8% (95% CI: 7.4–10.3) among respondents.

In the underweight group, 5.5% (95% CI: 2.4–8.6) considered themselves to be overweight and approximately 9% had made at least one recent weight loss attempt. Type 2 diabetes prevalence was 2.4% (95% CI: 0.0–4.8). In the normal weight group, 18.4% (95% CI: 15.5–21.4) considered themselves to be overweight and approximately 20% had made at least one recent weight loss attempt. Type 2 diabetes prevalence was 3.9% (95% CI: 2.6–5.2).

In the overweight group, 58.5% (95% CI: 54.1–63.0) considered themselves to be overweight and approximately 41% had made a recent weight loss attempt. The prevalence of type 2 diabetes in this group was estimated to be 9.5% (95% CI: 7.3–11.7). In the obese group, 90.3% (95% CI: 88.1–92.6) considered themselves to be overweight and approximately 66% had made at least one weight loss attempt during the previous 12 months. Over 60% reported trying diet and/or exercise and almost 30% had received GP advice. Weight loss programs were tried by almost 17% and meal plans by about 14% of respondents. Only 8.7% (95% CI: 6.0–11.4) had tried prescribed medication for weight loss in the previous 3 years. The prevalence of type 2 diabetes in this group was estimated to be 18.1% (95% CI: 14.5–21.6).

BMI calculations for patients with type 2 diabetes showed 2.3% (95% CI: 0.0–4.7) were underweight, 15.7% (95% CI: 10.9–20.5) were normal, 35.9% (95% CI: 29.5–42.4) were overweight and 46.1% (95% CI: 38.6–53.6) were obese. Nearly two-thirds considered themselves overweight and over half had made at least one recent weight loss attempt.

For other related abstracts see: 68 Patient weight, perception of weight and weight loss in adults, 69 Patient weight, methods and medications tried for weight loss in adults, 71 Patient BMI, morbidity and medication use in adults and Section 4.1 Body mass index of adults.

Further reading:

Charles, J., Britt, H., & Knox, S. 2006, 'Patient perception of their weight, attempts to lose weight and their diabetes status', *Australian Family Physician*, vol. 35, no. 11, pp. 925–928.

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

INSTRUCTIONS

ASK THE PATIENT ALL the following questions

Self assessment

In their own opinion, does the patient consider himself/herself to be overweight?

Patient height & weight

What is the patient's **height** (without shoes)? What is their **weight** (unclothed) ?

(*You are **NOT REQUIRED** to weigh or measure the patient, but if the patient is unsure, you may either do so or take information from the medical records.*)

Weight loss attempts

How often in the past 12 months has this patient **attempted** to lose weight? This includes commencing new diets, meal replacement programs, exercise programs, joining organisations, or seeking specific advice **with the objective of losing weight**.

Weight loss methods

Please tick the box beside any **weight loss methods** the patient has tried in the past 3 years in an attempt to lose weight.

Tick as many boxes as apply.

* **Weight loss programs** e.g. Jenny Craig, Weight Watchers, Gutbusters, Gloria Marshall etc.

* **Meal Plans** e.g. Lite N Easy, Easy Slim, Nu-Shape etc.

* **Over-the-counter (OTC) Products** available from pharmacies, supermarkets, health food stores etc, e.g.Slimfast, Optifast, Cenovis NutriPlan, Fat Blaster, Trim It, Opti Slim, Sure Slim, Exo Fat, Chitosan etc.

* **Diet and/or exercise program** e.g. commencing a structured diet plan other than those listed above and / or commencing an exercise program not usually undertaken such as walking, joining a gym, jogging, or participating in some other physical activity for the purpose of losing weight.

* **Specific advice sought from the GP** to help with weight loss or acting on advice offered by the GP.

* **Prescribed medication** e.g. Xenical, Reductil, Duromine, Tenuate etc prescibed for weight loss.

* **Specific advice sought from a Specialist or Dietitian** for the purpose of losing weight.

* **Any other method** not listed e.g. seeking advice from a pharmacist, herbalist etc, for the purpose of losing weight.

Successful methods

Write in the weight loss method nominated by the patient as the one they considered to be the **most successful.**

If the patient did not consider any method to be successful, write 'none'.

Type 2 diabetes

Please advise whether or not the patient suffers from type 2 diabetes

Ask the patient their	*Ask the patient...*	In the past 12 months how often have you attempted to lose weight?	In the past 3 years which weight loss methods have you tried?	Which method (if any) did you find most successful?	Do you suffer from Type 2 Diabetes?
Height: _____ cm **Weight:** _____ kg	Do you consider yourself to be overweight? ☐ Yes ☐ No	☐ Never ☐ Once ☐ 2-4 times ☐ 5 or more times	☐ Weight loss programs ☐ Meal Plans ☐ OTC products (pharmacy/retail) ☐ Diet and/or exercise program ☐ GP advice ☐ Prescribed medication ☐ Specialist/dietitian advice ☐ Other _____	_____	☐ Yes ☐ No

BL51C

Weight loss methods

Please tick the box beside any **weight loss methods** the patient has tried in the past 3 years in an attempt to lose weight.

Tick as many boxes as apply.

* **Weight loss programs** e.g. Jenny Craig, Weight Watchers, Gutbusters, Gloria Marshall etc.

* **Meal Plans** e.g. Lite N Easy, Easy Slim, Nu-Shape etc.

* **Over-the-counter (OTC) Products** available from pharmacies, supermarkets, health food stores etc, e.g.Slimfast, Optifast, Cenovis NutriPlan etc.

* **Diet and/or exercise program** e.g. commencing a structured diet plan other than those listed above and / or commencing an exercise program not usually undertaken such as walking, jogging, or participating in some other physical activity for the purpose of losing weight.

* **Specific advice sought from the GP** to help with weight loss or acting on advice offered by the GP.

* **Prescribed medication** e.g. Xenical, Reductil, Duromine, Tenuate etc prescibed for weight loss.

* **Specific advice sought from a Specialist or Dietitian** for the purpose of losing weight.

* **Any other method** not listed e.g. seeking advice from a pharmacist, herbalist etc, for the purpose of losing weight.

56 Prevalence, cause and severity of adverse pharmacological events

Organisation supporting this study: Australian Government Department of Health and Ageing

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, main cause and severity of these adverse events was investigated.

Sample: 8,215 encounters from 282 GPs; data collection period: 06/05/2003 – 09/06/2003, 15/07/2003 – 18/08/2003 and 20/01/2004 – 23/02/2004.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

GPs reported that 852 patients (10.4%. 95% CI: 9.4–11.4) had experienced an adverse event in response to using a medication in the past 6 months. Older patients aged 45–64, 65–74 and 75+ were significantly more likely to have experienced an adverse medication event (12.4%, 15.4% and 15.3% respectively) than younger patients. Also, female patients (11.4%, 95% CI: 10.1–12.6) were significantly more likely than male patients (8.9%, 95% CI: 7.7–10.0) to have experienced a medication related adverse event in the previous 6 months.

Of those experiencing an adverse event the majority (83.5%) had experienced only one adverse event, with 10.7% and 5.8% experiencing two and three or more adverse events respectively. From a list of nine reasons, 89.7% of patients specified only one reason for their most recent adverse event(s), with another 9.4% and 0.9% indicating two and three reasons respectively.

The most frequently specified reason for the most recent adverse event(s) was recognised side effect (65.7% of all reasons), followed by drug sensitivity (11.8%) and allergy (11.0%).

GP 'severity' ratings for the adverse event(s) were collected July/August 2003 and January/February 2004 only. Of the 580 patients indicating an adverse event from 5,500 encounters, severity rating was available for 551 patients. Over half of patients (53.9%, 95% CI: 48.3–59.5) were rated as having a 'mild' event(s), with another 35.8% (95% CI: 31.1–40.4) rated as 'moderate'. A 'severe' rating was given to 55 patients (10.0%, 95% CI: 6.9–13.1).

For 76 of 327 patients (23.2%, 95% CI: 17.4–29.1) GPs classified the adverse event as preventable. Adverse events were listed as preventable for 19.9% of 'mild' events, 25% of 'moderate' events and 32% of 'severe' events. The severity specific rates were not significantly different due to small numbers and wide confidence intervals.

Further reading:

Miller, G. C., Britth, H. C., & Valenti, L. 2006, 'Adverse drug events in general practice patients in Australia', *Medical Journal of Australia*, vol. 184, no. 7, pp. 321–324.

Miller, G. C., Britt, H. C., Valenti, L., & Knox, S. 2006, 'Adverse drug events: counting is not enough, action is needed [letter]', *Medical Journal of Australia*, vol. 184, no. 12, p. 646.

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 (eg. hospital inpatient, outpatient, primary care etc).

If you are interested in our previous work on this topic, please visit our website publications list at www.fmrc.org.au

ASK THE PATIENT

Please ask the patient if they have **experienced any adverse events 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.**

An 'event' refers to different occasions of use or use of different medications. Ask the patient **how many times** they experienced an adverse event in response to medication use.

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 **ONE box ONLY**. If the event was a recognised side effect of the medication in use, please tick **box 1** and **end the questions here**. If you tick one of the remaining **boxes (2 - 9)** please **continue with the remaining questions**.

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.

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?	If 'Yes' how many different events?	The most recent event was most likely the result of: (tick ONE box only)	Was the event -	Was the patient hospitalised as a result of this event?
☐ Yes ☐ No ⇨ END QUESTIONS	_____	1☐ Recognised side effect of the medication 2☐ Drug interaction 3☐ Contraindication 4☐ Allergy 5☐ Drug sensitivity 6☐ Overdose 7☐ Dispensing error 8☐ Don't know 9☐ Other If you tick THIS box, END the QUESTIONS HERE If you tick One of THESE boxes, CONTINUE ⇨	☐ Mild ☐ Moderate ☐ Severe ☐ Don't know	☐ Yes ☐ No

BL52B

57 Prevalence and management of chronic heart failure in general practice patients

Organisation supporting this study: Roche Products Pty Ltd

Issues: Prevalence and severity of chronic heart failure (CHF) among general practice patients; types of management (whether the management was initiated by a GP or specialist, and the main objective of management); proportion of patients referred to a cardiac specialist; clinical investigations used to diagnose CHF.

Sample: 2,641 encounters from 91 GPs; data collection period: 06/05/2003 – 09/06/2003.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to the distribution of patients at all BEACH encounters, with the majority (56.6%) of patients being female.

The prevalence of CHF in this general practice patient population was estimated to be 4.5% (95% CI: 3.3–5.8). Mild CHF was diagnosed in 2.3% of patients, while 1.9% and 0.4% were diagnosed with moderate and severe CHF respectively. Males were more likely to be diagnosed with CHF (4.9% of male patients) than females (4.4% of female patients). Patients aged 75 years and over had the highest age-specific rate of CHF (17.9%).

The medications most commonly used for the control of CHF were Frusemide (28.0% of CHF medications), followed by Digoxin (10.1%), Ramipril (7.1%) and Spiractolone (7.1%). Pharmacological treatment was more likely to be initiated by a specialist (59.4% of medications) than by a GP (40.6%).

GPs considered the factors of 'symptom management' and 'quality of life' to be equally important in the management of CHF, but significantly more important than 'survival'.

The majority (83.5%) of patients diagnosed with CHF had been referred to a cardiac specialist; 69.6% of those with mild CHF, 95.9% with moderate CHF and 100% of patients with severe CHF.

Chest x-ray had been used to diagnose CHF in 78.3% of cases, ECHO had been used in 69.2% of cases and ECG in 66.7% of cases. GPs had ordered 50.6% of chest x-rays, 15.8% of ECHO and 41.6% of ECG, with cardiac specialists ordering the rest.

For other related abstracts see: 31 Prevalence and severity of chronic heart failure, 38 Prevalence of chronic heart failure, its management and control, 75 Prevalence, management and investigations for chronic heart failure, 77 Heart failure-underlying causes and medication management, 90 Prevalence, management and investigations for chronic heart failure.

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 HEART FAILURE.**

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

INSTRUCTIONS

Chronic Heart Failure (CHF)

Please indicate by ticking the appropriate box whether this patient has **Chronic Heart Failure (CHF)** at either a **mild, moderate** or **severe** level.

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

Main treatment objective

Please indicate your **main objective** in this patient's management, **ranking the options** in order of importance from 1 to 3, where **3** is the **least important.**

CHF management

If **'YES'** please write in the **name and form** of any **medications** currently being used to treat this patient's CHF. Please indicate the regimen (i.e. **strength, dose and frequency**) of the medication and circle an option to advise whether this treatment was initiated by a GP or Specialist.

Please also list any **non-pharmacological management** e.g cardiac rehabilitation, physiotherapy etc.

Referral

If this patient has been referred to a **cardiac specialist** for management, please indicate **when they were initially referred.**

Clinical investigations

Please advise using the tick boxes what **clinical investigations** were used in **diagnosing** this patient's CHF. If tests other than ECG, ECHO or Chest X-ray (e.g angiogram, FBC, blood chemistry, thyroid function tests etc) were used, please list in 'other'.

Please indicate by circling an option **who ordered each test.** e.g. GP or specialist.

Does this patient have Chronic Heart Failure (CHF)?

Yes
- ☐ mild
- ☐ moderate
- ☐ severe

☐ → END

BL52C

If 'Yes' what management is currently being used?

Name & Form	Strength	Dose	Freq	Initiated by
1.				GP/spec
2.				GP/spec
3.				GP/spec
4. Other				GP/spec

What is most important in managing this patient's CHF?

(please circle a number for each option, ranking 1-3 where 3 is least important)

Increase survival	1	2	3
Relieve symptoms	1	2	3
Improve quality of life	1	2	3

This patient was initially referred to a cardiac specialist

- ☐ <12 months ago
- ☐ 1-3 years ago
- ☐ > 3 years ago
- ☐ never referred

What clinical investigations were used to diagnose the CHF?

test	ordered by
☐ ECG	GP / spec
☐ ECHO	GP / spec
☐ Chest X-Ray	GP / spec
☐ Other _____	GP / spec

58 Lipid lowering medications: patient eligibility under the PBS

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

Issues: Lipid lowering medications (LLMs) are increasingly prescribed for the management of hyperlipidaemia and cardiovascular disease. Eligibility for the Pharmaceutical Benefits Schedule (PBS) subsidy is restricted to patients meeting at least one of four criteria defined in the PBS. This study measured the number of patients on LLMs, their prescribed medication and dose regimen and the proportion of patients eligible for PBS subsidy under each criteria.

Sample: 2,732 encounters from 93 GPs; data collection period: 10/06/2003 – 14/07/2003.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age distribution of respondents was similar to the expected distribution for general practice encounters. There was a small but significant difference in the sex distribution, with females making up 61.1% (95% CI: 58.2–64.0) compared with 57.4% (95% CI: 56.7–58.1) in the total sample.

Of the 2,732 respondents, the GP indicated that 12.5% (*n*=341) were currently taking a LLM. No patient under the age of 15 was taking a LLM. The rate of LLM use increased with age until it peaked with patients aged 65–74 years (33.5%). Male patients were 1.5 times more likely to use LLM (16.1%, 95% CI: 13.4–18.8) than female patients (10.2%, 95% CI: 8.5–12.0). The highest use of LLM was in male patients aged between 65 and 74 years (38.5%).

Atorvastatin was the most common, being used by 50% of patients taking a LLM. The next most common was simvastatin (34.4%). Pravastatin was used by 12.6% of patients. Gemfibrozil and fluvastatin were rarely used, together being used by only 3%of patients on a LLM. While atorvastatin had the highest maximum daily dose taken of the three top LLMs, it had the lowest average (26.3 mg) daily dose taken. Conversely, while pravastatin had the lowest maximum dose taken (40 mg) it had the highest average daily dose taken (31.6 mg), with over half the patients taking it at the maximum recorded dose (40 mg).

While respondents were allowed to indicate more than one eligibility criterion for the prescription of an LLM, virtually all respondents recorded only one criterion. For all patients taking a LLM, 40.1% met criterion one for PBS eligibility, 49.7% met criterion two, only 11.3% met criterion three and even less criterion four (1.0%). Only two patients (0.7%) who were on a LLM were recorded as being ineligible according to the PBS criteria.

Patients taking pravastatin had the highest proportion of eligibility through criterion one compared with patients on the other common LLMs. Patients on atorvastatin had the highest proportion of eligibility through criteria two and four compared with patients on the other common LLMs. Patients on simvastatin had the highest proportion of eligibility through criterion three compared with patients on the other common LLMs.

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, 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, 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 **LIPID LOWERING MEDICATIONS.**

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

INSTRUCTIONS

ABOUT THE PATIENT

Please advise whether this patient is taking a lipid lowering medication which was prescribed either today or at a previous encounter.

If **'YES'** please write the name and regimen of the lipid lowering medication.

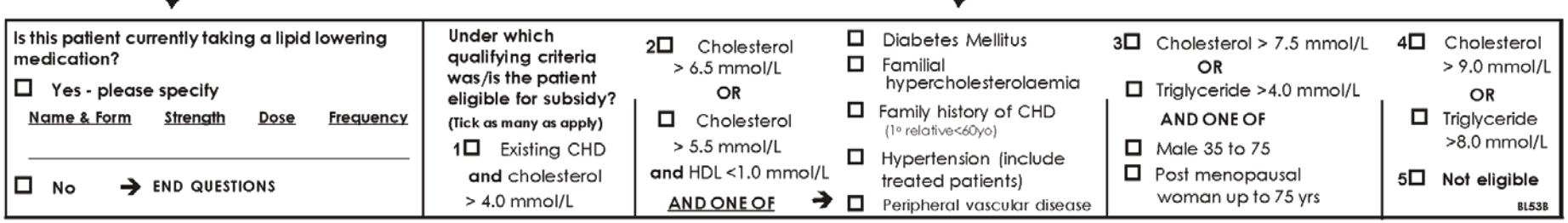
If **'NO'** lipid lowering medication is being taken by this patient, **end the questions here.**

PATIENT CRITERIA FOR ELIGIBILITY

The list below are the **qualifying criteria** for **patient eligibility** for **subsidised lipid lowering medications** under the **Pharmaceutical Benefits Scheme.**

From this list, please advise **which risk factors** the patient presented with **at the commencement** of their lipid lowering medication therapy.

Tick as many as apply.



59 Hypertension management and control in general practice patients

Organisation supporting this study: Australian Government Department of Health and Ageing

Issues: The prevalence of hypertension (either controlled or uncontrolled), proportion of patients with hypertension taking a combination angiotensin converting enzyme (ACE) inhibitor/diuretic or angiotensin II antagonist (A2RA)/diuretic, length of time on the combination medication, who initiated the combination medication, control of blood pressure after taking this combination.

Sample: 2,647 respondents from 92 GPs; data collection period: 10/06/2003 – 14/07/2003.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age–sex distribution of respondents was similar to the distribution for all BEACH encounters, with the majority (59.5%) of patients being female.

Of the 2,647 respondents, 23.8% had either controlled or uncontrolled hypertension. Among the 611 hypertension patients who responded to the question about combination product use, one in five (20.0%, *n*=123) were taking either an ACE inhibitor/diuretic (9.5%, *n*=58) or an A2RA/diuretic (10.6%, *n*=65).

Of the 123 patients taking a combination medication, 122 reported the duration of its usage. The majority (82.8%) of these 122 patients had been using the combination for more than 3 months and the remaining (17.2%) had been using it for less than 3 months.

The majority (86.1%) of the combination medications were reported as initiated by a GP and the remaining combination medications (13.9%) by a specialist. GPs indicated that blood pressure was well controlled for the majority (81.8%) of patients since commencing their combination medication, and was too high for the remaining 18.2%.

Of 117 respondents, 94.9% had used at least one medication for hypertension prior to commencing the combination products. More than one previous medication could be recorded for each patient. More than half (52.1%) of these patients had previously used an ACE inhibitor, 27.4% had used an A2RA, 17.9% a beta-blocker, and 15.4% a diuretic.

The GP reported that for 83.5% of patients currently taking a combination product and previously using medication other than a combination product, their blood pressure had been too high on previous medication. The remainder (16.5%) had been well controlled on previous medication.

The reasons for prescribing the combination medication were to improve blood pressure control (66.7%), to simplify therapy (29.3%), and to add a second drug (17.1%) for the care of 123 patients currently taking a combination medication. More than one reason could be chosen per patient.

For other related abstracts see: 26 Prevalence of diagnosed hypertension and difficulties in treatment, 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 **COMBINATION THERAPIES IN HYPERTENSION.**

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

INSTRUCTIONS

Hypertension

Please advise whether or not this patient has **Hypertension** (controlled or uncontrolled) as a problem currently under management, i.e. the patient takes medication for the management of hypertension which was prescribed either today or at a previous encounter, by you or by another doctor.

Management

Is the patient currently taking a combination ACE inhibitor/ diuretic or A2RA/diuretic? **For your convenience, a list of these medications** can be found on the 'Patient Health Status Information Section - Instructions' (green single sheet) in your research pack.

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

If **'Yes'** continue - please advise the **duration of usage** of the combination medication and **who initiated this combination treatment** i.e. a GP (yourself or another GP) or a specialist.

Current BP control

How well controlled is the patient's blood pressure **since commencing** the combination medication?

Previous BP control

How well controlled was the patient's blood pressure while managed with the **previous medication**?

Previous medication

Please advise which **medications** the patient had taken **prior to commencing the combination medication**. Tick as many boxes as apply.

Reasons for prescribing combination medication

Please advise the main **reasons** for the decision **to prescribe a combination** ACE inhibitor/diuretic or A2RA/ diuretic for this patient.

Tick as many options as apply.

If **you do not know** the reason for prescribing, tick the '**don't know**' box.

Does this patient currently have hypertension? (either controlled or uncontrolled)	Is the patient taking a combination product?	The patient has been taking the combination ACE/diuretic or A2RA/diuretic for -	The combination therapy was initiated by	Blood Pressure is currently	Prior to taking the combination product, did the patient take -	The patient's blood pressure on previous treatment was	Combination product was prescribed -
☐ Yes ☐ No	☐ ACE/diuretic ☐ A2RA/diuretic ☐ neither → END QUESTIONS	☐ < 3 months ☐ > 3 months	☐ a GP ☐ Specialist	☐ Well controlled ☐ Too high ☐ Too low	☐ a diuretic ☐ a beta-blocker ☐ amiloride ☐ an ACE inhibitor ☐ an A2RA ☐ none of the above ☐ no previous treatment	☐ Well controlled ☐ Too high ☐ Too low	☐ for simpler therapy ☐ to add a second drug ☐ to reduce adverse effects ☐ to improve BP control ☐ to reduce cost to patient ☐ don't know

BL53C

60 Prevalence of GORD and associated proton pump inhibitor use

Organisation supporting this study: AstraZeneca (Australia) Pty Ltd

Issues: The prevalence of gastro-oesophageal reflux disease (GORD) in patients attending general practice; severity of GORD in these patients; the proportion of patients with GORD being treated with proton pump inhibitors (PPIs); treatment of GORD using PPIs, including medications utilised, duration of use, and effectiveness of the medication.

Sample: 2,538 respondents from 88 GPs; data collection period: 15/07/2003 – 18/08/2003.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to the distribution of the total BEACH sample with the majority of patients (60.7%) being female. Patients aged between 25 and 44 years accounted for 26.7% of the sample, and 25.5% of the patients were aged 45–64 years.

GORD was reported in 412 patients (16.2%, 95% CI: 14.1–18.4). Prevalence was higher in patients aged 65–74 years (30.0%) and those aged 75+ (30.2%) than in those aged 45–64 years (19.8%) or 25–44 years (12.6%).

Of the 412 patients with GORD, 241 (59.1%, 95% CI: 52.6–65.5) were currently being treated with PPIs. The GP rated the majority (54.9%) as having 'moderate' GORD when initially diagnosed, while 21.7% of patients had 'mild' GORD, and 23.4% had 'severe' GORD. The severity of GORD was estimated by endoscopy alone for 51.6% of patients, while a doctor's opinion was the only estimation for 42.2% of patients. A combination of endoscopy and doctor's opinion was used in only 6.3% of patients.

Omeprazole (35.7% of patients, 95% CI: 27.5–43.9) was the most common generic PPI medication currently being used to treat GORD, followed by pantoprazole (24.0%) and esomeprazole (19.3%). The majority of patients had been using their current PPI medication between one and 6 months (40.6%, 95% CI: 31.8–49.3). Over 20% of patients had been using their current PPI for 7–12 months (22.1%, 95% CI: 15.5–28.8).

There were 84 patients who had taken another PPI or other GORD medication prior to their current medication. The majority of these patients had taken ranitidine (40.5%, 95% CI: 29.5–51.5) or omeprazole (16.7%, 95% CI: 8.4–25.0).

Almost 90% of patients reported that their current PPI provided adequate symptom control (88.2%, 95% CI: 83.6–92.8). However, 29.6% of patients (95% CI: 21.8–37.3) reported a recurrence of GORD symptoms while being treated with a PPI. This was most common in patients with severe GORD (48.9%, 95% CI: 34.9–63.0). Only 14.7% of patients were taking other medications for symptom control of GORD in conjunction with PPIs. The most common of these was mylanta (50.0% of other medications).

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, 62 Use of proton pump inhibitors by general practice patients, 91 Prevalence and management of gastrointestinal symptoms, 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 **PROTON PUMP INHIBITORS for GASTRO-OESOPHAGEAL REFLUX DISEASE.** *You may tear out this page as a guide to completing the following section of forms.*

INSTRUCTIONS

FOR THE DOCTOR

Does this patient suffer from diagnosed Gastro-Oesophageal Reflux Disease (GORD)?

If **'Yes'** continue to the next question.

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

PPI Medication

If **'Yes'** is this patient currently taking a Proton Pump Inhibitor (PPI) for GORD management?

If **'Yes'** continue.

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

Severity of GORD

Please use the tick boxes to indicate the **level of severity** of this patient's GORD **at the time of initial diagnosis or presentation.**

Also, please advise whether this **assessment of severity** was based on a **clinician's opinion** of the patient's symptoms, from **endoscopic evidence** or **both** (i.e. tick both boxes if both apply).

Current and Previous Medication

Please write in the first space provided details of the patient's **current PPI medication** including **regimen** and **duration of usage**.

In the second space provided, please write in the details of any **previous PPI or other GORD medication** i.e. any GORD medication (including other PPIs) **taken prior to the current PPI** medication, or a **different dose** of the **current** PPI medication. Include **regimen** and **duration of usage**. If **no other GORD medication** was taken prior to commencing the current PPI, please write **'None'** in this space.

Other medication for symptom control

Please advise whether or not the patient is taking any **other medication for symptom control** in conjunction with the PPI.

If 'Yes' please write the name of this medication in the space provided.

Patient Satisfaction with current PPI treatment

Use the tick boxes to indicate whether or not the patient feels they have **adequate symptom control** from the **current PPI medication**.

Please advise whether or not the patient has had any **recurrence of GORD symptoms** since commencing the **current PPI treatment?**

Does this patient suffer from Gastro-oesophageal Reflux Disease (GORD)?	If 'Yes', is GORD currently being treated with a Proton Pump Inhibitor (PPI) medication?	How severe is the patient's GORD?	Current PPI medication is -	Does the patient feel the PPI gives adequate symptom control?	Is the patient taking any other medication for symptom control (as well as the PPI?)
☐ Yes ☐ No ⇨ END QUESTIONS	☐ Yes ☐ No ⇨ END QUESTIONS	☐ Mild ☐ Moderate ☐ Severe **The severity at initial diagnosis was estimated via:** ☐ Dr's opinion of symptoms ☐ endoscopic assessment	Name & Form / Strength Dose / Frequency / Duration of Usage (mths) Previous GORD medication was - Name & Form / Strength Dose / Frequency / Duration of Usage (mths)	☐ Yes ☐ No Has the patient had any recurrence of GORD symptoms while on the PPI? ☐ Yes ☐ No	☐ Yes (please specify) ☐ No

BL548

61 Prevalence of chronic illnesses identified as National Health Priority Areas among general practice patients

Organisation supporting this study: General Practice Statistics and Classification Unit (GPSCU)

Issues: What proportion of general practice patients have chronic conditions which require ongoing management by their GP, in particular those health problems identified as National Health Priority Areas (Cardiovascular health, asthma, arthritis, depression, diabetes).

Sample: Patients at 8,911 encounters from 299 GPs; data collection periods: 19/08/2003 – 22/09/2003 and 28/10/2003 – 19/01/2004

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: The GP was presented with a list of morbidities and asked: 'Does this patient have any of the following conditions which require ongoing management?'

Crude rates for each problem were calculated as the proportion of the patient sample with each listed morbidity.

Estimates of the prevalence of each morbidity in the general practice sub-population were obtained by weighting each patient age group by the mean number of annual GP visits for that age group (MBS unpublished data).

Summary of results

The sex distribution of the SAND sample was similar to the total BEACH sample, however the SAND substudy sampled a significantly larger proportion of patient aged 75 years and over (17.0 95% CI: 15.4–18.6) compared with the total BEACH sample (12.7%, 95% CI: 11.9–13.4).

Crude rates: Around 30% of patients sampled had a diagnosed cardiovascular problem, of which ischaemic heart disease was the most common (11.0%). Eighteen per cent of patients had uncomplicated hypertension. Asthma was recorded for more than one in ten patients (11.4%, 95% CI: 10.5–12.3). Nine per cent of patients had diagnosed diabetes, 7.3% Type 2 diabetes (NIDDM). Osteoarthritis was common among the patients sampled (20.0%). Fifteen per cent of patients had depression recorded as a health problem.

Adjusted rates: After weighting for the age–sex distribution of the sample against the population of general practice patients, the adjusted prevalence estimates were generally lower than the crude sample rates. In particular cardiovascular disease (19.0%) and osteoarthritis (11.9%), which are related to older age were less prevalent after adjustment. The estimated prevalence of asthma (11.6%) and depression (13.5%) were largely unaffected by adjustment.

Conclusion: By adjusting for age we calculated what might be a better estimate of the prevalence of diagnosed health problems among all general practice patients after taking into account the frequency of GP visits related to age.

For other related abstracts see: 37 Prevalence of common morbidities in patients encountered in general practice, 89 Estimates of the prevalence of chronic illnesses identified as Health Priority Areas.

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 **CO-MORBIDITY AND CHRONIC DISEASE.**

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

INSTRUCTIONS

Co-morbidity and chronic disease

The aim of these questions is to determine the prevalence of **co-morbidity** and some of the **chronic illnesses** or **conditions** in the **National Goals and Targets** priority areas.

Most of the conditions listed below require continual management or surveillance and may need consideration in future care.

Please use the tick boxes to indicate whether the patient has any of the listed conditions even if you have already managed one of these problems today. Tick as many as apply.

If the patient **does not** have any of these conditions or problems, please tick the box marked **'none of these conditions'**.

Does this patient have any of the following conditions which require ongoing management?

(tick as many as apply, even if you have managed the problem today)

Cardiovascular disease
- ☐ Ischaemic heart disease
- ☐ Cerebrovascular disease
- ☐ Peripheral vascular disease
- ☐ Congestive Heart Failure
- ☐ Hypertension - complicated
- ☐ Hypertension - uncomplicated
- ☐ Other

Psychological problems
- ☐ Depression
- ☐ Anxiety
- ☐ Insomnia
- ☐ Other psych problem

Respiratory problems
- ☐ Asthma - Mild
- ☐ Asthma - Moderate
- ☐ Asthma - Severe
- ☐ Chronic Obstructive Airways Disease

Arthritis
- ☐ Osteoarthritis
- ☐ Rheumatoid
- ☐ Other arthritis

Diabetes
- ☐ Type 1
- ☐ Type 2
- ☐ Other

- ☐ Hyperlipidaemia
- ☐ Chronic back pain
- ☐ Malignant neoplasm
- ☐ Gastro-oesophageal Reflux disease

☐ **None of these conditions**

BL55B

62 Use of proton pump inhibitors by general practice patients

Organisations supporting this study: Janssen-Cilag Pty Ltd and the Australian Government Department of Health and Ageing

Issues: The proportion of general practice patients who are taking, or have taken, a proton pump inhibitor (PPI) medication; the conditions for which patients are being prescribed a PPI; whether different PPIs (or regimens) are being prescribed at different stages of the disease process; which PPI medications are being taken by patients with gastro-oesophageal reflux disease (GORD) at various stages of the disease process.

Sample: 5,245 encounters from 182 GPs; data collection period: 19/08/2003 – 27/10/2003.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to the distribution for all BEACH encounters, with the majority of patients (59.5%) being female. Patients aged 65 years and over accounted for 27.9% of the sample.

The proportion of general practice patients who had either taken a PPI in the past 12 months or were commencing a PPI was 13.4% (95% CI: 11.9–14.9). There were 733 conditions for which a PPI was prescribed. Oesophageal reflux accounted for 58.9% of these conditions (95% CI: 54.6–63.3), almost a quarter were oesophagitis (23.6%, 95% CI: 19.6–27.6), 10.5% (95% CI: 7.9–13.1) were peptic ulcer disease, and the remainder (7.0%, 95% CI: 5.0–8.9) were conditions other than those listed.

The stage of the condition for which a PPI was prescribed was recorded for 669 patients. Four out of five patients (80.0%, 95% CI: 76.7–83.2) were on maintenance treatment, 16.0% were having initial treatment or were in the healing phase, and the remainder (4.0%) were at other stages of disease.

Both initial and maintenance PPI medications were recorded for 313 patients. Of these, 90.1% (*n*=282) had the same PPI (at the generic level), while 9.9% (*n*=31) had different PPIs for initial and maintenance treatment. Of the 438 initial PPI medications, 46.4% were omeprazole, 21.2% were pantoprazole, 17.6% were esomeprazole, 7.8% were lansoprazole, and 7.1% were rabeprazole.

The proportion of patients who were on initial treatment for GORD was 14.4% (*n*=61). There were 206 initial PPI medications recorded with a specific strength for oesophageal reflux. Of these, omeprazole 20 mg was the most common at 42.7% (*n*=88). Pantoprazole 40 mg (22.3%, *n*=46) and esomeprazole 40 mg (13.6%, *n*=28) followed. The proportion of patients who were on maintenance treatment for oesophageal reflux was 81.4%. There were 299 PPI maintenance medications recorded with a specific strength for GORD. Omeprazole 20 mg was the most common (44.2%, *n*=132), followed by pantoprazole 40 mg (17.1%, *n*=51) and esomeprazole 20 mg (12.0%, *n*=36).

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, 91 Prevalence and management of gastrointestinal symptoms, 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 **PROTON PUMP INHIBITORS for GASTRO-INTESTINAL DISEASE.**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

FOR THE DOCTOR

Has this patient taken a **Proton Pump Inhibitor (PPI)** medication in the **past 12 months** OR will they be **commencing a PPI** as a result of today's consultation?

If **'Yes'** continue to the next question.

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

Indication for PPI medication

If **'Yes'** please advise the condition for which the PPI was indicated.

If the indication is not one of those with tick boxes, please write the indication beside the box marked 'other' in the space provided.

Stage of Disease / illness

Please use the tick boxes to indicate the patient's **stage of disease or illness** i.e. the initial (acute) treatment or healing phase, the maintenance phase, or other phase.

If you tick the box marked **'other'** please **write your response** in the space provided.

PPI for INITIAL treatment

Please use the tick boxes to advise **which PPI** the patient is / was / will be taking for disease management in the **initial (acute) treatment or healing phase**. Please circle an option to advise the strengh of the PPI.

Please advise the **frequency** of medication use (i.e. daily / bd) and the **duration of usage** of the PPI for treatment of this stage of the patient's illness.

PPI for MAINTENANCE phase

Please use the tick boxes to advise **which PPI** the patient is / was / will be taking for disease management in the **maintenance phase**. Circle an option to advise the **strength** of the PPI.

Please advise the **frequency** of PPI medication use (i.e. daily / bd / prn) and the **duration of usage** of the PPI for treatment of this stage of the patient's illness.

Has/is this patient:	If 'Yes', for which indication?	In which stage of the disease is the patient?	PPI used for INITIAL treatment - *(please circle strength)*	Frequency / Duration	PPI used for MAINTENANCE - *(please circle strength)*	Frequency / Duration
• taken a PPI in the past 12 months **or** • commencing a PPI today? ☐ Yes ☐ No ⇨ **END QUESTIONS**	☐ Oesophageal reflux ☐ Oesophagitis ☐ Peptic Ulcer Disease ☐ Other _____ *(please specify)*	☐ Initial treatment or healing ☐ Maintenance ☐ Other _____ *(please specify)*	☐ Esomeprazole **20mg / 40mg** ☐ Lansoprazole **15mg / 30mg** ☐ Omeprazole **10mg / 20mg** ☐ Pantoprazole **20mg / 40mg** ☐ Rabeprazole **10mg / 20mg**	**Frequency** ☐ daily ☐ twice daily **Duration** ☐ 1 month ☐ 2 months ☐ >2 months	☐ Esomeprazole **20 mg / 40 mg** ☐ Lansoprazole **15 mg / 30 mg** ☐ Omeprazole **10 mg / 20 mg** ☐ Pantoprazole **20 mg / 40 mg** ☐ Rabeprazole **10 mg / 20 mg**	**Frequency** ☐ daily ☐ twice daily ☐ prn **Duration** ☐ 1-2 months ☐ 3-6 months ☐ >6 months

BL55C

63 Asthma—prevalence, management and medication side-effects

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

Issues: The prevalence and severity of asthma among general practice patients; the medications being utilised for asthma management; side effects of asthma medications.

Sample: 2,527 respondents from 87 GPs; data collection period: 23/09/2003 – 27/10/2003.

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–sex distribution of respondents was similar to the distribution of the total BEACH sample with the majority (56.6%) being female and those aged 25–44 and 45–64 years accounting for 24.3% and 27.0% of the patient population respectively.

A total of 367 patients (14.5%, 95% CI: 12.6–16.4) had asthma. No significant differences emerged in asthma prevalence for patients across age groups. There was also no significant difference between the prevalence for males (12.7%, 95% CI: 10.4–15.0) and females (15.9%, 95% CI: 13.5–18.2).

The majority of asthma cases were reported in the least severe categories for both adults and children. One in four children (23.0%) with asthma had frequent or persistent asthma, while 28.0% of adult asthma sufferers had asthma rated as moderate or severe.

Of the 367 patients with asthma, 52 (14.2%) were not currently taking any asthma medication. Salbutamol was the most common asthma medication, accounting for 45.1% (*n*=223) of all asthma medications. The fluticasone/salmeterol combination was the second most frequently used, accounting for 14.8% (*n*=73) of asthma medications. Budesonide, fluticasone propionate and terbutaline each accounted for approximately 7.5% of asthma medications being taken by these patients.

Of the 353 patients who provided responses about corticosteroid use, 17.9% (*n*=63) had been prescribed oral corticosteroids in the previous 12 months. Of the 337 patients who responded to the hospitalisation question, 7.7% (*n*=26) had been hospitalised for asthma during the previous 12 months.

Thirty-seven (11.8%) of the 315 patients taking at least one asthma medication reported a side effect. The most common side effect was hoarseness of voice (reported by 18 patients), most of these (*n*=13) being reported as mild. Sixteen patients reported 'other' side effects, the majority (8) of these being rated as moderate in severity. Height reduction was reported by 5 patients, 2 of which were rated as severe. Oral candidiasis was reported by 4 patients (all mild), and adrenal suppression was reported by 3 patients (all rated as moderate).

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, 70 Inhaled corticosteroid use for asthma management, 96 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.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **ASTHMA.**

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

INSTRUCTIONS

ASK ALL PATIENTS

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

If **'NO'** asthma - no further question.

Current medications used

Please list the **current asthma medications** being used by this patient for the management of their asthma. Please include the **name & form, strength, dose & frequency** for each e.g.

What asthma medication is currently being used?

	Name & Form	Strength	Dose	Frequency
1.	Pulmicort Turb	400mcg	800mcg	bd.
2.				

Side effects of asthma medication

Please use the tick boxes to advise of **any side effects** being experienced by the patient as a result of taking their **asthma medication**.

If **no side effects** are experienced, tick the box marked **'None'**.

If side effects are experienced please tick as many as apply. Please circle an option to advise (from your clinincal opinion) whether they are **mild, moderate or severe.**

Severity of asthma

If **'YES'** please ask the patient with asthma about the **severity** of their asthma. Show them the **'Severity of asthma reference card'** included in your research pack and tick the appropriate box to indicate their response.

Corticosteroid use or Hospitalisation

Please use the tick boxes to advise whether this patient has -

- been **given oral corticosteroids for asthma**
  and / or
- been **hospitalised for asthma**

at any time during the past 12 months.

Does this patient suffer from Asthma?	If 'Yes' how severe is the asthma? (See cards)	What asthma medication is currently being used?	In the past 12 months has the patient been -	Does the patient have any side effects of medication?
☐ Yes ☐ No ⇨ **END QUESTIONS**	Severity **Child**: ☐ Infrequent ☐ Frequent ☐ Persistent **Adult**: ☐ Very mild ☐ Mild ☐ Moderate ☐ Severe	Name & Form / Strength / Dose / Frequency 1. _____ 2. _____ 3. _____	• given oral corticosteroids ☐ Yes ☐ No ☐ Unsure • hospitalised for asthma ☐ Yes ☐ No ☐ Unsure	☐ None ☐ hoarseness of voice — mild / moderate / severe ☐ oral candidiasis — mild / moderate / severe ☐ height reduction — mild / moderate / severe ☐ adrenal suppression — mild / moderate / severe ☐ other _____ (please specify) — mild / moderate / severe (please circle)

BL56B

Severity of asthma reference card

Children

Severity*	Common features
Infrequent episodic	Episodes 6-8 weeks or more apart and from 1 to 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

64 Current use of statins by general practice patients

Organisation supporting this study: AstraZeneca (Australia) Pty Ltd

Issues: The proportion of patients currently using statins, cholesterol level at the commencement of statin therapy, proportion of patients have existing cardiovascular disease or risk factors for cardiovascular disease, initial statin regimen and duration of usage at the commencement of statin, current statin regimen and duration of usage, most recent cholesterol levels since the commencement of statin, GPs' clinical opinion on control of their patients' cholesterol levels.

Sample: 3,202 respondents from 109 GPs; data collection period: 02/12/2003 – 19/01/2004.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The sex distribution of the sample was similar to that of total BEACH encounters, with the majority (59.0%) of female patients. Patients aged 1–24 years made up 17.1%, lower than national average (21.2%) during April 2002 – March 2003 BEACH period.

Of the 3,202 respondents, 14.4% (*n*=462) were currently taking a statin, most commonly by patients aged 65–74 years (35.1%). The use of statin was significantly more likely in male (17.5%, 95% CI: 14.7–20.3) than in female patients (12.3%, 95% 10.2–14.4).

At the time of commencing statins, mean total cholesterol (TC) was 6.84 mmol/L, the mean of higher density lipoprotein (HDL) was 1.34 mmol/L, the mean of low density lipoprotein (LDL) 4.44 mmol/L, and the mean of triglycerides (TG) 2.44 mmol/L. After commencing statins, mean TC was 4.80 mmol/L, mean HDL 1.45 mmol/L, mean LDL 2.57 mmol/L, and mean TG was 1.83 mmol/L.

Of the 432 current statin users responding to the risk factor question, 66.9% had hypertension, 41.7% had existing coronary heart disease, and 24.5% had diabetes mellitus. None of the listed risk factors were recorded for 18.1% of the respondents. (Multiple response was allowed).

Details of initial treatment were available for 366 statin users. Of these, atorvastatin (42.4%), simvastatin (39.6%) and pravastatin (15.0%) accounted for 97.0% of initial medications.

Details of current statin medication were available for 398 statin users. There were 398 statins in the current treatment. Atorvastatin (47.0%), simvastatin (38.9%) and pravastatin (13.3%) remained the most common and accounted for 99.2% in total.

GPs reported that cholesterol level was adequately controlled for the majority (69.9%) of the 419 current statin users responding to management plan question. The remainder (30.1%, *n*=126) were the patients whose cholesterol level was not sufficiently controlled. Of these 126 patients, GPs had other management plans for 61.9%, increased the dose of statin for 37.3%, changed the statin being used for 6.4% and had additional therapy for 4.0%.

Of the 73 other managements proposed for patients whose cholesterol was not adequately controlled, 28.8% were lifestyle changes, which included change of diet, weight loss, or exercise.

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

INSTRUCTIONS

FOR THE DOCTOR

Please advise whether this patient is **currently taking a statin medication.** This includes any statin medication either prescribed today or at a previous encounter by you or another GP.

If **No** - 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 **commencing statin medication** therapy.

Risk factors

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

Statin therapy

Please write the **name, regimen and duration of usage** of the **initial statin medication** taken by this patient.

(e.g. statin 10mg/day 6 mths).

Please write the **same details for the current statin** (if medication has changed since treatment began). If statin medication or regimen **has not changed** since statin treatment commenced, please write '**as above**' in the '**current statin**' space.

Cholesterol monitoring

If the **patient's blood cholesterol** has been re-tested since **statin treatment commenced,** please write in the **results** of the **most recent** test.

Management plan

In your **clinical opinion**, please advise whether the patient's cholesterol is **adequately controlled**.

If the patient's cholesterol is **not adequately controlled,** please use the remaining tick boxes to advise **what measures will be utilised to improve control.**

'Other' may include (e.g.) lifestyle advice or referral to a specialist, etc.

Is this patient currently taking a statin?	At the start of statin use what were the patient's levels of (in mmol/L):	Does this patient have?	Patient's initial statin regimen was- / Patient's current statin regimen is-	Has cholesterol been re-tested since statin commenced?	What is the current management plan?
☐ Yes →	TC _____	☐ Existing CHD	Name / Dose / Duration of use	☐ YES - most recent levels are:	☐ Adequately controlled
☐ No	HDLC _____	☐ Diabetes mellitus	_____	(in mmol/L) TC _____	☐ Same statin - Increase dose
↓	LDLC _____	☐ Hypertension	Name / Dose / Duration of use	HDLC _____	☐ Change statin _____ (name and dose)
End questions BL588	TG _____	☐ None of the above	_____	LDLC _____	☐ Additional therapy _____ (name and dose)
		(tick as many as apply)		TG _____	☐ Other _____ (please specify)
				☐ NO	

65 Language and cultural background of general practice patients

Organisation supporting this study: Australian Government Department of Health and Ageing and General Practice Statistics and Classification Unit (GPSCU)

Issues: Previous research suggests that health surveys are inclined to under-enumerate persons from culturally diverse and in particular, Indigenous backgrounds. This study aimed to validate the routine BEACH questions on language background and Indigenous status, using more extensive questions that focussed on the patient's language and cultural background.

Sample: 311 GPs and 9245 patients surveyed between 20/01/2004 – 03/05/2004.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: Based on the 2001 census questions, patients were asked about their country of birth, parents' countries of birth, whether the patient was of Aboriginal or Torres Strait Islander origin and what language was spoken at home. Languages were classified according to the Australian Classification of Languages 1997 (Australian Bureau of Statistics).

Summary of results

Fifty-eight per cent of respondents were female which is comparable with the total BEACH sample. There was a somewhat greater proportion of patients aged 65 years and over in the SAND sample (28.5%) compared with the BEACH sample (23.0%).

Two hundred and forty-one (2.6%, 95% CI: 1.5–3.7) respondents identified as of either Aboriginal or Torres Strait Islander origin. In the sixth year of BEACH, GPs who did not participate in the cultural and language SAND study asked patients the routine BEACH question on Aboriginal and Torres Strait Islander origin and recorded encounters with Indigenous patients at 2.1% (95% CI: 1.3–2.8, unweighted) of their encounters. This routine BEACH rate was substantially higher than recorded in previous BEACH years where the sample rate of Indigenous encounters was around 1.0% (unweighted).

Nearly 16% of respondents reported speaking a language other than English at home (15.8%, 95% CI: 13.6–17.9), more than twice the rate routinely identified in BEACH (7.5%, 95% CI: 6.5–8.5). However, the SAND question is broader and includes those who speak mainly English plus another language, while the routine BEACH question only includes those whose main language is NOT English. After English, Southern European languages (Italian, Greek, French, Spanish etc) was the most common group of languages, spoken by 6.5% of respondents.

More than three-quarters of respondents (77.1%) were born in Australia and two out of five respondents (39.5%) had at least one parent born overseas.

For other related abstracts see: 52 Language and cultural background of patients, 95 Cultural background of 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 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
- ☐ England
- ☐ Scotland
- ☐ Greece
- ☐ Italy
- ☐ New Zealand
- ☐ Viet Nam
- ☐ Other (please specify) _____

BL59B

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, Italian
- ☐ Yes, Greek
- ☐ Yes, Cantonese
- ☐ Yes, Mandarin
- ☐ Yes, Arabic
- ☐ Yes, Vietnamese
- ☐ Yes, other (please specify) _____

66 Anti-psychotic medication use by general practice patients

Organisation supporting this study: Janssen-Cilag Pty Ltd

Issues: The prevalence of anti-psychotic medication use (current or in the last 12 months), indications for anti-psychotic medication, length of time on anti-psychotic medications, GP perceived patient compliance in taking anti-psychotic medications, who is responsible for the management of the condition for which these medications are/were taken.

Sample: 3,338 patients from 117 GPs; data collection period: 24/02/2004 – 29/03/2004.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The sex distribution of respondents was similar to the distribution of the total BEACH sample with the majority (58.4%) being female. The sample was slightly older than average, with a significant over representation of patients aged 75 years or more and fewer young people aged less than 15 years.

A total of 71 patients (2.1%, 95% CI: 1.5–2.7) were currently taking, or had taken in the previous 12 months, anti-psychotic medication. There was no significant difference between the proportion of males (2.3%, 95% CI: 1.4–3.3) and females (2.0%, 95% CI: 1.3–2.8) taking anti-psychotic medication.

For these 71 patients, the most common indication for anti-psychotic medication was schizophrenia (*n*=26, 36.6%), followed by behavioural disturbance in dementia (*n*=12, 16.9%), bipolar mania (*n*=11, 15.5%) and schizoaffective disorder (*n*=10, 14.1%).

A total of 84 anti-psychotic medications were recorded. The most common was olanzapine, taken by 23 patients and accounting for 27.4% of these medications. Fewer than one in ten patients were taking risperidone (8 patients, 9.5% of medications) or haloperidol (7 patients, 8.3% of medications). Those on olanzapine had been taking this medication for an average 30 months, those on risperidone for an average 22 months and those on haloperidol for an average of almost 7 years. Only 12 patients had been prescribed another anti-psychotic prior to their most recent medication. Olanzapine was also the most common of these (*n*=3).

GPs thought the majority of their patients were compliant (*n*=55, 88.3% of the 66 responses to this question) in taking their anti-psychotic medication. They thought that 11 patients (16.7%) were partially compliant. None of the patients were thought to be non-compliant in taking their medication.

Responses were received for 69 patients regarding who managed them for their condition. The GP was involved in the management of almost all (94.2%) of these patients, most often in combination with a specialist/psychiatrist (47.8%) but often alone (34.8%). Only 8 patients (11.6%) were being managed by a community team in collaboration with the GP.

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

INSTRUCTIONS

FOR THE DOCTOR

Is this patient **currently taking**, or have they **taken in the past 12 months**, an **antipsychotic** medication OR will they be **commencing an antipsychotic** as a result of today's consultation?

If **'Yes'** to any please continue to the next question.

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

Indication for antipsychotic medication

If **'Yes'** please advise the **condition** for which the antipsychotic was indicated.

If the indication is **not** one of those listed, please write the indication beside the box marked 'other' in the space provided.

Medication management

Please write the **name and form** of the **most recent** antipsychotic taken by this patient in **line 1**. Please indicate the regimen (i.e. **strength, dose and frequency**) of the medication and the **duration of usage** (in months or years - **please circle** as appropriate).

If **two different antipsychotics,** or **two strengths** of the **same antipsychotic** were/are prescribed, please provide these details in **line 2**.

If the patient was **previously treated** with **antipsychotic** agents **other than the current or most recent** therapy, please provide these details in **line 3**.

Patient compliance

This question applies to patients who are currently taking antipsychotic medication.

Please use the tick boxes to provide **your opinion** of the **patient's compliance**, in regard to their **medication usage**.

Patient management

Please use the tick boxes to advise **which care providers** are responsible for the management of the condition for which this patient is / was taking the antipsychotic.

Has/is this patient taken/ taking antipsychotic medication -	If 'Yes' , for which indication?	The most recent antipsychotic used for treatment was -	In taking the anti-psychotic medication, do you believe this patient to be -	Is this patient managed by -
☐ YES - now or in the past 12 mths ☐ YES - starting today ☐ No ⇨ **END QUESTIONS** BL60B	☐ Schizophrenia ☐ Schizoaffective Disorder ☐ Bipolar mania ☐ Schizophreniform disorder ☐ Behavioural disturbances in dementia ☐ Other _____ *(please specify)*	*Name & Form* / *Strength* / *Dose* / *Freq* / *Duration of use* 1. _____ mths/yrs 2. _____ mths/yrs **Previous antipsychotic (if any) used for treatment was -** 3. _____ mths/yrs	☐ Well compliant ☐ Partially compliant ☐ Non compliant	☐ GP only ☐ GP & specialist/ psychiatrist ☐ Specialist/psychiatrist only ☐ GP & community team ☐ Other _____ *(please specify)*

67 Risk factors of patients on lipid lowering medications

Organisation supporting this study: Australian Government Department of Health and Ageing and the Australian General Practice Statistics and Classification Centre (AGPSCC)

Issues: Proportion of patients currently taking lipid lowering medications. Risk factors for cardiovascular disease and blood cholesterol levels at the start of lipid therapy among patients on lipid lowering medications.

Sample: 10,233 respondents from 353 GPs. Data collection periods: 29/10/2002 – 2/12/2002, 28/10/2003 – 01/12/2003, 30/03/2004 – 07/06/2004.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age distribution of the sample of patients was similar to the age distribution for the BEACH annual encounters. The proportion of respondents who were female (60.5%, 95% CI: 58.8–62.2) was significantly higher than that of the annual BEACH (2003–2004) encounters (57.4%, 95% CI: 56.7–58.2).

Of the 10,233 respondents, 1,302 (12.7%, 95% CI: 11.8–13.7) were currently using lipid lowering medication. The use of lipid lowering medication was significantly higher among patients aged 65 years or over (28.0%, 95% CI: 26.0–30.1) compared with those aged less than 65 years (7.6%, 95% CI: 6.8–8.4). The use of lipid lowering medication was significantly higher in males (15.8%, 95% CI: 14.3–17.2) than in females (10.7%, 95% CI: 9.7–11.7).

Of those on lipid lowering medications nearly half (47.5%) had existing cardiovascular disease at the start of therapy: 25.2% had diabetes, 3.5% had renal failure, 37.2% were overweight/obese and 31.7% had a family history of heart disease. One in eight (13.6%) had none of the listed risk factors at the start of therapy.

The mean age at the start of lipid medication therapy was 61 years. The mean length of lipid lowering medication use was 5.3 years. The mean total cholesterol at the start of therapy was 7.0 mmol/L and the mean HDL cholesterol reading was 1.5 mmol/L. The mean systolic blood pressure reading at the start of therapy was 140 mmHg and the mean diastolic blood pressure reading was 82 mmHg.

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, 79 Hypertension and dyslipidaemia – comorbidity and management in general practice patients, 97 Statin medication use among high CHD risk patients attending general practice, 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 ON LIPID LOWERING MEDICATION THERAPY.**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

This study is looking at the **whole cardiovascular risk** for patients when they commenced medication treatment for high lipids. Please try to record the patient's status **when they commenced therapy** - not the current levels which indicate how they have improved under care. If you don't know the pre-treatment levels for cholesterol and BP, please leave these blank.

FOR THE DOCTOR

Please advise whether this patient is **currently taking lipid lowering medication therapy.** This includes any lipid lowering medication either prescribed today or at a previous encounter by you or another GP.

If **No** - end the questions here.

Existing cardiovascular disease

Please use the tick boxes to indicate whether this patient, **prior to commencement of lipid lowering medication therapy,** had **existing cardiovascular disease** (cardiac, cerebral or peripheral), **diabetes, renal failure, overweight or obesity,** or **a family history of premature heart disease** (i.e. a parent, brother or sister younger than 65 years when diagnosed with heart disease).

Family history of heart disease

Please indicate whether, **at the time of commencing therapy**, this patient's **family history** was a **major factor** in your **decision to prescribe** a lipid lowering medication.

Patient's age

Please write in the **patient's age** at the **time of commencing lipid lowering medication therapy**

Patient's smoking status

Please advise whether the patient -

1. smoked tobacco at the time of commencing lipid lowering medication therapy and/or

2. currently smokes tobacco.

Cholesterol and BP

Please advise the patient's levels of -

- **Total Cholesterol,**
- **High Density Lipoprotein** (HDL) Cholesterol, and
- **Blood Pressure** (systolic / diastolic)

at the time of commencing lipid lowering medication therapy.

Is this patient currently using lipid lowering medication therapy?

☐ Yes →

☐ No

↓

End questions

BL61C

If 'Yes', prior to commencement of therapy did the patient have

☐ Existing cardiovascular disease
☐ Diabetes ☐ Renal failure
☐ Overweight/obesity
☐ Family History of heart disease (1st degree relative < 65 years)
☐ None of the above

At the commencement of lipid therapy ...

Was the patient's family history a major factor in your decision to prescribe lipid medication?

☐ Yes
☐ No

What was the patient's age?

_____ **years**

Did the patient smoke?

☐ Yes ☐ No

Does the patient smoke now?

☐ Yes ☐ No

At the commencement of therapy what were this patient's levels of:

Total Cholesterol _____ mmol/L

HDL Cholesterol _____ mmol/L

Blood Pressure _____ / _____ mm Hg

68 Patient weight, perception of weight and weight loss in adults

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

Issues: Body mass index (BMI) of patients aged 18 years and over; patient perception of overweight; weight loss attempts and methods; the proportion who have type 2 diabetes.

Sample: 2,116 respondents aged 18 years or over from 82 GPs; data collection period: 04/05/2004 – 07/06/2004.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: *A card listing methods of weight loss was provided to patients to assist with answering these questions.*

Summary of results

The age distribution of the sample was similar to that of adult patients at all BEACH encounters. Female patients made up 61.7%, a slightly larger proportion than the average. Response rates (and therefore denominators) for the following questions varied.

Underweight patients accounted for 7.2% of respondents (95% CI: 5.8–8.5), 36.3% (95% CI: 33.5–39.1) were within normal range, 33.4% (95% CI: 30.8–35.9) were overweight and 23.2% (95% CI: 20.5–25.9) were obese. Overall, almost half saw themselves as overweight and over a third had attempted to lose weight in the previous 12 months. Diet and/or exercise was the most common method tried and the most frequently reported as successful in all weight groups. The prevalence of type 2 diabetes was 8.3% (95% CI: 6.7–10.0) among respondents.

In the underweight group, 3.6% considered themselves to be overweight and 9.8% had made at least one recent weight loss attempt. Type 2 diabetes prevalence was 4.6% in this group. In the normal weight group, 15.5% considered themselves to be overweight and 20.4% had made at least one recent weight loss attempt. Type 2 diabetes prevalence was 3.9%.

In the overweight group, 59.6% considered themselves to be overweight and 43.2% had made a recent weight loss attempt. The prevalence of type 2 diabetes in this group was estimated to be 8.7%. In the obese group, 87.5% considered themselves to be overweight and 61.1% had made at least one weight loss attempt during the previous 12 months. There were 56.6% who reported trying diet and/or exercise and 26.2% had received GP advice. Weight loss programs were tried by 17.5% and meal plans by 13.3% of respondents. Only 7.9% had tried prescribed medication for weight loss in the previous 3 years. The prevalence of type 2 diabetes in this group was estimated to be 14.2%.

BMI calculations for patients with type 2 diabetes showed 3.8% (95% CI: 1.0–6.6) were underweight, 20.3% (95% CI: 11.9–28.6) were normal, 35.4% (95% CI: 28.8–42.1) were overweight and 40.5% (95% CI: 33.8–47.3) were obese. Nearly two-thirds considered themselves overweight and over half had made at least one recent weight loss attempt.

For other related abstracts see: 55 Patient weight, perception of weight and weight loss, 69 Patient weight, methods and medications tried for weight loss in adults, 71 Patient BMI, morbidity and medication use in adults and Section 4.1 Body mass index of adults.

Further reading:

Charles, J., Britt, H., & Knox, S. 2006, 'Patient perception of their weight, attempts to lose weight and their diabetes status', *Australian Family Physician*, vol. 35, no. 11, pp. 925–928.

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

INSTRUCTIONS

ASK THE PATIENT ALL the following questions

Self assessment

In their own opinion, does the patient consider himself/herself to be overweight?

Patient height & weight

What is the patient's **height** (without shoes)? What is their **weight** (unclothed) ?

(*You are **NOT REQUIRED** to weigh or measure the patient, but if the patient is unsure, you may either do so or take information from the medical records.*)

Weight loss attempts

How often in the past 12 months has this patient **attempted** to lose weight? This includes commencing new diets, meal replacement programs, exercise programs, joining organisations, or seeking specific advice **with the objective of losing weight**.

Weight loss methods

Please tick the box beside any **weight loss methods** the patient has tried in the past 3 years in an attempt to lose weight.

Tick as many boxes as apply.

* **Weight loss programs** e.g. Jenny Craig, Weight Watchers, Gutbusters, Gloria Marshall etc.

* **Meal Plans** e.g. Lite N Easy, Easy Slim, Nu-Shape etc.

* **Over-the-counter (OTC) Products** available from pharmacies, supermarkets, health food stores etc, e.g.Slimfast, Optifast, Cenovis NutriPlan, Fat Blaster, Trim It, Opti Slim, Sure Slim, Exo Fat, Chitosan etc.

* **Diet and/or exercise program** e.g. commencing a structured diet plan other than those listed above and / or commencing an exercise program not usually undertaken such as walking, joining a gym, jogging, or participating in some other physical activity for the purpose of losing weight.

* **Specific advice sought from the GP** to help with weight loss or acting on advice offered by the GP.

* **Prescribed medication** e.g. Xenical, Reductil, Duromine, Tenuate etc prescibed for weight loss.

* **Specific advice sought from a Specialist or Dietitian** for the purpose of losing weight.

* **Any other method** not listed e.g. seeking advice from a pharmacist, herbalist etc, for the purpose of losing weight.

Successful methods

Write in the weight loss method nominated by the patient as the one they considered to be the **most successful.**

If the patient did not consider any method to be successful, write 'none'.

Type 2 diabetes

Please advise whether or not the patient suffers from type 2 diabetes

Ask the patient their	*Ask the patient...*	In the past 12 months how often have you attempted to lose weight?	In the past 3 years which weight loss methods have you tried?	Which method (if any) did you find most successful?	Do you suffer from Type 2 Diabetes?
Height: ____ cm **Weight:** ____ kg	Do you consider yourself to be overweight? ☐ Yes ☐ No	☐ Never ☐ Once ☐ 2-4 times ☐ 5 or more times	☐ Weight loss programs ☐ Meal Plans ☐ OTC products (pharmacy/retail) ☐ Diet and/or exercise program ☐ GP advice ☐ Prescribed medication ☐ Specialist/dietitian advice ☐ Other _____	_____	☐ Yes ☐ No

BL62C

Weight loss methods

Please tick the box beside any **weight loss methods** the patient has tried in the past 3 years in an attempt to lose weight.

Tick as many boxes as apply.

*** Weight loss programs** e.g. Jenny Craig, Weight Watchers, Gutbusters, Gloria Marshall etc.

*** Meal Plans** e.g. Lite N Easy, Easy Slim, Nu-Shape etc.

*** Over-the-counter (OTC) Products** available from pharmacies, supermarkets, health food stores etc, e.g.Slimfast, Optifast, Cenovis NutriPlan etc.

*** Diet and/or exercise program** e.g. commencing a structured diet plan other than those listed above and / or commencing an exercise program not usually undertaken such as walking, jogging, or participating in some other physical activity for the purpose of losing weight.

*** Specific advice sought from the GP** to help with weight loss or acting on advice offered by the GP.

*** Prescribed medication** e.g. Xenical, Reductil, Duromine, Tenuate etc prescibed for weight loss.

*** Specific advice sought from a Specialist or Dietitian** for the purpose of losing weight.

*** Any other method** not listed e.g. seeking advice from a pharmacist, herbalist etc, for the purpose of losing weight.

69 Patient weight, methods and medications tried for weight loss in adults

Organisation supporting this study: Roche Products Pty Ltd

Issues: Body mass index (BMI) of patients aged 18 years and over; patient perception of overweight; weight loss attempts and methods; products and medications tried for weight loss.

Sample: 1,721 adult respondents from 70 GPs; data collection period: 08/06/2004 – 19/07/2004.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: *A card listing methods of weight loss was provided to patients to assist with answering these questions***.**

Summary of results

The age distribution of the adult sample was similar to that of patients at all BEACH encounters. Female patients made up 60.9%, a slightly larger proportion than the average. Response rates (and therefore denominators) for the following questions varied.

BMI calculation was possible for 1,701 respondents—6.5% (95% CI: 5.2–7.7) were underweight, 35.3% (95% CI: 32.2–38.4) were within normal range, 32.9% (95% CI: 30.3–38.4) were overweight and 25.4% (95% CI: 22.0–28.7) were obese. Almost half perceived themselves as overweight and 40.0% had attempted to lose weight in the previous 12 months. Diet/exercise was the method most frequently tried, and was the method reported as the most successful in all weight groups. Respondents had tried 47 over-the-counter or prescribed weight loss medications in total, 25.0% of these being Orlistat (mean duration of use 2.4 months). Sibutramine (19.2%) was used for a mean duration of 3.5 months and Phentermine (17%) for a mean of 2.1 months.

Of those underweight (*n*=106), 6.6% considered themselves overweight and 5.5% had made at least one recent weight loss attempt. Five underweight patients had tried diet/exercise programs in the previous 12 months. In the normal weight group (*n*=586), 18.4% considered themselves to be overweight and 20.2% (of 519 respondents) had made at least one recent weight loss attempt. Diet/exercise had been tried by 17.4%, and was again the most successful method (53.6% of 97 respondents). Ten weight loss medications were tried by this group.

In the overweight group (*n*=545), 60.0% considered themselves to be overweight and approximately 47% (of 519 respondents) had made a recent weight loss attempt. Diet/exercise, again reported as the most successful method, had been tried by 38.7%, 11.3% had received GP advice, 4.9% had tried meal plans, and 4.7% had tried a weight loss program in the previous year. Ten weight loss medications were tried by this group also. In the obese group (*n*=425), 89.3% considered themselves to be overweight and approximately 65% had made at least one weight loss attempt during the previous 12 months. Over 50.0% reported trying diet/exercise, 20.1% had received GP advice, 10.4% had tried a weight loss program, 9.2% had tried meal plans and 5.9% had tried prescribed medications. Diet/exercise was again reported to be the most successful method. There were 25 weight loss medications recorded for this group, 28.0% of which were Orlistat, which was used for a mean duration of almost 3 months.

For other related abstracts see: 55 Patient weight, perception of weight and weight loss, 68 Patient weight, perception of weight and weight loss in adults, 71 Patient BMI, morbidity and medication use in adults and Section 4.1 Body mass index of adults.

Further reading:

Charles, J., Britt, H., & Knox, S. 2006, 'Patient perception of their weight, attempts to lose weight and their diabetes status', *Australian Family Physician*, vol. 35, no. 11, pp. 925–928.

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

Weight loss methods

Please tick the box beside any **weight loss methods** the patient has tried in the past 3 years in an attempt to lose weight.

Tick as many boxes as apply.

* **Weight loss programs** e.g. Jenny Craig, Weight Watchers, Gutbusters, Gloria Marshall etc.

* **Meal Plans** e.g. Lite N Easy, Easy Slim, Nu-Shape etc.

* **Over-the-counter (OTC) Products** available from pharmacies, supermarkets, health food stores etc, e.g.Slimfast, Optifast, Cenovis NutriPlan etc.

* **Diet and/or exercise program** e.g. commencing a structured diet plan other than those listed above and / or commencing an exercise program not usually undertaken such as walking, jogging, or participating in some other physical activity for the purpose of losing weight.

* **Specific advice sought from the GP** to help with weight loss or acting on advice offered by the GP.

* **Prescribed medication** e.g. Xenical, Reductil, Duromine, Tenuate etc prescibed for weight loss.

* **Specific advice sought from a Specialist or Dietitian** for the purpose of losing weight.

* **Any other method** not listed e.g. seeking advice from a pharmacist, herbalist etc, for the purpose of losing weight.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **PATIENT WEIGHT and WEIGHT LOSS.**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

ASK THE PATIENT ALL the following questions

Self assessment

In their own opinion, does the patient consider himself/herself to be overweight?

Patient height & weight

What is the patient's **height** (without shoes)? What is their **weight** (unclothed) ?

(*You are **NOT REQUIRED** to weigh or measure the patient, but if the patient is unsure, you may either do so or take information from the medical records.)*

Weight loss attempts

How often in the past 12 months has this patient **attempted** to lose weight? This includes commencing new diets, meal replacement programs, exercise programs, joining organisations, or seeking specific advice **with the objective of losing weight**.

Weight loss methods

Please tick the box beside any **weight loss methods** the patient has tried in the past 12 months in an attempt to lose weight.

Tick as many boxes as apply.

* **Weight loss programs** e.g. Jenny Craig, Weight Watchers, Gutbusters, Gloria Marshall etc.

* **Meal Plans** e.g. Lite N Easy, Easy Slim, Nu-Shape etc.

* **Over-the-counter (OTC) Products** available from pharmacies, supermarkets, health food stores etc, e.g.Slimfast, Optifast, Cenovis NutriPlan, Fat Blaster, Trim It, Opti Slim, Sure Slim, Exo Fat, Chitosan etc.

* **Diet and/or exercise program** e.g. commencing a structured diet plan other than those listed above and / or commencing an exercise program not usually undertaken such as walking, joining a gym, jogging, or participating in some other physical activity for the purpose of losing weight.

* **Specific advice sought from the GP** to help with weight loss or acting on advice offered by the GP.

* **Prescribed medication** e.g. Xenical, Reductil, Duromine, Tenuate etc prescibed for weight loss. (**NB**. Xenical S3 since 1st May 2004).

* **Specific advice sought from a Specialist or Dietitian** for the purpose of losing weight.

* **Any other method** not listed e.g. seeking advice from a pharmacist, herbalist etc, for the purpose of losing weight.

Effectiveness of methods

Using the scale beside each weight loss method, circle a number to represent how effective the patient considered each method/s tried, where:-

1 = most successful
2 = somewhat successful
3 = undecided
4 = not very effective and
5 = not at all effective.

Product use and duration of usage

If an **over-the-counter product** or a **prescribed medication** was used to attempt weight loss, please advise **which products/ medications** were tried and approximately **how long** they were used.

Ask the patient their	*Ask the patient...*	In the past 12 months how often have you attempted to lose weight?	In the past 12 months which weight loss methods have you tried? Please rank their effectiveness *(circle **1** for most effective, **5** for least effective)*	If OTC products or prescribed medication were used, which one/s and for how long?
Height: ____ cm **Weight:** ____ kg	Do you consider yourself to be overweight? ☐ Yes ☐ No	☐ Never ☐ Once ☐ 2-4 times ☐ 5 or more times	☐ Weight loss programs 1 2 3 4 5 ☐ Meal Plans 1 2 3 4 5 ☐ OTC products (pharmacy/retail) 1 2 3 4 5 ☐ Diet and/or exercise program 1 2 3 4 5 ☐ GP advice 1 2 3 4 5 ☐ Prescribed medication 1 2 3 4 5 ☐ Specialist/dietitian advice 1 2 3 4 5 ☐ Other _____ 1 2 3 4 5	Product/med'n ____ Duration (mths) ____ ____ ____ ____ ____

BL63B

70 Inhaled corticosteroid use for asthma management

Organisation supporting this study: Australian Government Department of Health and Ageing

Issues: Prevalence of asthma in general practice patients and distribution of current severity; proportion with asthma taking any asthma medication, proportion taking inhaled corticosteroids (ICS) and current regimen; proportion adequately managed on ICS; proportion of patients with ICS dosage altered since resolution of last exacerbation and reason for alteration.

Sample: 7,919 respondents from 269 GPs; data collection period: 08/06/2004 – 19/07/2004 and 28/09/2004 – 06/12/2004.

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 general practice encounters, with the majority (59.4%) of patients being female.

Of 7,919 respondents, 1,030 had asthma. Patients aged 5–14 were significantly more likely to have asthma (24.2%, 95% CI: 19.8–28.6) than all patients in the sample (13.0%, 95% CI: 11.9–14.1). Female and male patients were not significantly different in their rate of asthma.

One in ten (10.9%) asthma patients reported they did not take any asthma medication. About half (47.7%) took only one medication, and another 35.1% took two medications to manage asthma.

The medications most frequently used to manage asthma were short acting beta agonists (67.0% of patients with asthma), combination (long acting beta agonist and inhaled corticosteroid) product (36.7%) and inhaled corticosteroid (22.0%). Long acting beta agonists (single formulation) were taken by 4.2% of patients.

Of the 1,030 patients with asthma, medication data were available for 1,022. Of these, over half (57.2%) were taking an inhaled corticosteroid (ICS), alone or as a combination product. More than 4 in 5 asthma patients (83.5%) were taking a reliever (beta agonist alone or in combination). Of all patients with asthma over half (52.7%) were taking a reliever and preventer, while a further 30.7% were taking a reliever only. Relatively few asthma patients were taking a preventer only (4.5%).

Severity of asthma in children was low, with 78.0% having infrequent asthma, 14.4% having frequent and 7.6% persistent asthma. In adults, severity was also low with about one-third each having very mild (37.1%) or mild (34.0%) asthma. Only 24.0% had moderate and 5.0% severe asthma.

Of asthma patients taking an ICS, half were taking fluticasone/salmeterol (50.6%), followed by fluticasone propionate (17.3%), budesonide (13.7%) and budesonide/eformoterol (12.8%).

GPs indicated that most asthma patients taking an ICS (85.6%) were adequately managed by the current ICS dose. Only 8.4% of asthma patients on an ICS were not adequately managed, and in another 6.0% they were unsure if the ICS dosage was adequately managing asthma.

The ICS dose was not altered since last asthma exacerbation for 58.0% of asthma patients on an ICS. Over half (51.6%) gave stability of the asthma as the reason for not altering the

dosage. A further 14.9% decreased their ICS dosage since last exacerbation and 9.8% stopped the ICS.

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, 96 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 PATIENTS

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

BL&3C

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 _____

71 Patient BMI, morbidity and medication use in adults

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

Issues: The proportion of general practice patients who are underweight, in a normal weight range, overweight or obese *according to their body mass index (BMI)*; the selected conditions for which adult patients are being prescribed a medication; the types of medications that are being prescribed for these conditions; the duration of each of the conditions since diagnosis.

Sample: 1,913 adult respondents (18 years and over) from 75 GPs; data collection period: 20/07/2004 – 23/08/2004.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age–sex distribution of the adult respondents was similar to the distribution for all adult BEACH encounters, with the majority of patients (57.1%) being female. Patients aged 45–64 years accounted for 26.8% of the sample.

In this analysis, the standard method of BMI was applied to adults (aged 18+ years) only. Therefore, the sample size was 1,913 adult patients. Of the 1,735 patients for when BMI could be calculated, more than half (56.8%, 95% CI: 51.0–62.5) were overweight or obese and 7.6% (95% CI: 6.1–9.0) were underweight. One-third (35.7%, 95% CI: 32.8–38.6) had a normal BMI.

Of 1,913 adult respondents, one-quarter (25.4%) were taking a prescribed medication for hypertension, 12.1% for elevated cholesterol, 11.5% for osteoarthritis, 8.9% for depression, 7.3% for cardiovascular disease (CVD) or peripheral vascular disease (PVD), and 6.1% were taking a prescribed medication for diabetes type 2.

There were 649 prescribed medications for hypertension in adult patients. Perindopril and irbesartan were the most common medications (10.5% and 10.3% respectively). They were followed by ramipril (9.2%) and atenolol (8.9%).

Of 411 adult patients taking a prescribed medication for hypertension and responding to the question about duration of hypertension since diagnosis, 84.9% had suffered from hypertension for more than 24 months, 4.9% for about 24 months and 6.3% for approximately 12 months. The remainder (3.9%) had hypertension newly diagnosed.

In the overweight or obese adult respondents (n=985), about one-third (32.0%) were taking a prescribed medication for hypertension, 15.8% for elevated cholesterol, 14.2% for osteoarthritis, 10.0% for depression, 8.6% for diabetes type 2, and 8.5% for CVD or PVD.

Of the 750 underweight or normal weight adult respondents, 18.0% were taking a prescribed medication for hypertension, 9.2% for osteoarthritis, 7.9% for depression, 7.3% for elevated cholesterol, 6.3% for CVD or PVD, and 2.4% for diabetes type 2.

Overweight or obese adult patients were more likely to be taking a prescribed medication for hypertension, elevated cholesterol, and diabetes type 2, when compared with their underweight or normal weight adult counterparts.

For other related abstracts see: 55 Patient weight, perception of weight and weight loss, 68 Patient weight, perception of weight and weight loss in adults, 69 Patient weight, methods and medications tried for weight loss in adults and Section 4.1 Body mass index of adults.

Further reading:

Charles, J., Britt, H., & Knox, S. 2006, 'Patient perception of their weight, attempts to lose weight and their diabetes status', *Australian Family Physician*, vol. 35, no. 11, pp. 925–928.

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 CONDITIONS and MEDICATION USE.**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

ASK THE PATIENT ALL the following questions

Patient height & weight

What is the patient's **height** (without shoes)? What is their **weight** (unclothed) ?

(*You are **NOT REQUIRED** to weigh or measure the patient, but if the patient is unsure, you may either do so or take information from the medical records.)*

Other conditions and prescribed medications

Please advise whether or not the patient has **any of the listed conditions** for which they may currently be taking **any prescribed medication.**

If the patient has **none of the listed conditions**, please **tick the box marked 'none'.**

Along side each condition ticked, please **write details of the prescribed medication** being taken for this condition.

If the patient **has a condition**, but is **not taking a prescribed medication** for its management, please tick the '**no medication**' box.

Duration of condition

Please **circle an option** to indicate the approximate **length of time** the patient has had the nominated condition.

Ask the patient their	Does the patient have any of the following conditions for which they are taking a prescribed medication?		Name & Form	Strength	Dose	Freq	No medication	Duration of condition since diagnosis (please circle)
Height: ____ cm	☐	None of the conditions					☐	
Weight: ____ kg	☐	Overweight					☐	new / 12 mths / 24 mths / >24 mths
	☐	Hypertension					☐	new / 12 mths / 24 mths / >24 mths
	☐	Osteoarthritis					☐	new / 12 mths / 24 mths / >24 mths
	☐	Diabetes Type 1					☐	new / 12 mths / 24 mths / >24 mths
	☐	Diabetes Type 2					☐	new / 12 mths / 24 mths / >24 mths
	☐	CVD or PVD					☐	new / 12 mths / 24 mths / >24 mths
	☐	Elevated cholesterol					☐	new / 12 mths / 24 mths / >24 mths
	☐	Depression					☐	new / 12 mths / 24 mths / >24 mths

BL64B

72 Contraception use among female general practice patients aged 16–44 years

Organisation supporting this study: Janssen-Cilag Pty Ltd

Issues: The prevalence of contraception use in female patients aged 16 years or more and the type of contraception used; where an oral contraception pill (OCP) was prescribed for contraception, the name of OCP used; the type of prescription for the OCP, and the patient reported level of compliance with the OCP regimen.

Sample: 536 female patient respondents (aged 16 to 44 years) from 76 GPs; data collection period: 13/07/2004 – 30/10/2004.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

Five hundred and thirty-six women aged 16 to 44 years answered the questions on contraception. Nearly half (49.8, 95% CI: 42.9–56.8) were on a form of contraception. Of those on contraception, the majority were using an oral contraceptive (63.2%), 8.7% (23/266) were using implants, 5.3% (14/266) were using pharmacological injections, and 15.0% (40/266) were using condoms. Only 2 women were using diaphragms for contraception.

Just over half of young female patients aged 16–24 years were using a form of contraception (56.1%). Slightly fewer than half the women aged 25 to 44 years were using a contraceptive (47.4%). Women aged 25–44 years were less likely to be using oral contraceptives (27.8%, 95% CI: 22.3–33.4) than younger women (40.8%, 95% CI: 33.5–48.2).

Nearly one-quarter (24.4%) of women on oral contraceptives reported obtaining the contraceptive through private prescription. For private prescriptions the most common medication was cyptroterone/ethinyloestradiol (51.3%), followed by drospirenone/ethinylestradiol (20.5%) and levonorgestrel/ethinyloestradiol (20.5%). The most common oral contraceptive medications overall were levonorgestrel/ethinyloestradiol (63.3%), cyproterone/ethinyloestradiol (13.9%) and norethisterone/ethinyloestradiol (7.8%). Over half of the patients on oral contraception (56.0%) reported that they never or very rarely forgot to take their oral contraceptives.

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 USING CONTRACEPTIVES.**

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

INSTRUCTIONS

FOR THE DOCTOR

Ask these questions of your **female patients aged 16 years and over**.

Is this patient **currently using any type of contraceptive?**

If **'Yes'** please continue to the next question.

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

Type of contraceptive

If **'Yes'** please advise the **type of contraceptive** currently being used.

Tick as many as apply.

Oral contraceptive

If the patient is taking an **oral contraceptive**, please write in the details of the **medication and its prescribed regimen** (i.e. **name, form, strength, dose and frequency**)

Prescription status

Please advise whether the prescription was provided under the **PBS**, as a **private** prescription, or **other** status (eg DVA).

If you did not provide the prescription and the patient does not have this information, please tick the '**don't know**' option.

Medication compliance

Please ask the patient to advise on their **level of compliance** with the oral contraceptive medication i.e. **if they forget** to take it, **how often?**

Is this patient currently using any form of contraception?	If 'Yes', which type?	If an oral contraceptive is being taken, please give details	Is the oral contraceptive prescription -	How often do you forget to take the oral contraceptive?
☐ YES ☐ No ⇨ END QUESTIONS BL64C	☐ Oral ☐ Implant ☐ Injection ☐ Diaphragm ☐ Condom ☐ Other _____ *(please specify)*	*Name & Form* _____ *Strength* _____ *Dose* _____ *Freq* _____	☐ PBS ☐ Private ☐ Other ☐ Don't know	☐ Never forget ☐ once per year ☐ 2 - 3 times per year ☐ once per month ☐ once per week

73 Warfarin use in patients with qualifying morbidity

Organisation supporting this study: AstraZeneca (Australia) Pty Ltd

Issues: The prevalence of conditions (or history of conditions) indicating anticoagulants as appropriate therapy; the proportion of these patients taking warfarin; the reasons for not taking warfarin for those conditions.

Sample: 2,572 respondents from 89 GPs; data collection period: 24/08/2004 – 27/09/2004.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age and sex distribution of this subsample was similar to the annual BEACH sample. Three per cent (*n*=79) had/had a history of atrial fibrillation, 1.3% (*n*=33) had/had a history of stroke, 1.2% (*n*=32) transient ischaemic attack, 1.2% (*n*=30) deep vein thrombosis and 0.7% (*n*=17) had/had a history of pulmonary embolism. Multiple listed conditions were allowed for a patient.

The majority of the 2,572 respondents, 93.2%, (95% CI: 91.4–95.0) had none of the listed conditions, and 159, 6.2% (95% CI: 4.5–7.9), had/had a history of one. Only 16 patients, 0.6% (95% CI: 0.3–1.0), had/had a history of two conditions.

Of 173 patients having/with a history of at least one listed condition and for whom age could be calculated, more than three-quarters (77.5%) were aged 65 years and over, 16.2% were between 45 and 64 years, and 6.4% were 25–44 years old. Of 173 patients having/with a history of at least one of the listed conditions and their sex recorded, about half (49.1%) were male.

Of 174 patients having/with a history of at least one of the listed conditions, 52.3% (95% CI: 39.3–65.3) were currently taking warfarin. Of 78 patients having/with a history of atrial fibrillation and responding to the question about warfarin use, 69.2% were currently taking warfarin. Among 17 patients having/with a history of pulmonary embolism, 14 (82.4%) were using warfarin. Of 30 patients having/with a history of deep vein thrombosis and responding to the warfarin use question, 70% (*n*=21) were currently taking warfarin.

Patients having/with a history of stroke or transient ischaemic attack, were less likely to use warfarin. Of 33 patients having/with a history of stroke and responding to the warfarin use question, eight (24.2%) were taking warfarin. Among 32 patients having/with a history of transient ischaemic attack and responding to this question, four (12.5%) were using warfarin.

Of 83 patients having/with a history of at least one of the listed conditions and responding to the question about reason(s) for not using warfarin (multiple response allowed), 30.1% (*n*=25) indicated that the risk of bleeding outweighs risk reduction, four (4.8%) indicated there were contraindications, three (3.6%) recorded drug interactions, eight (9.6%) were due to patient preference, nine (10.8%) patients were unable to cope with monitoring/dose adjustment, 47 (56.6%) were using anti-thrombotics other than warfarin, and 22 (26.5%) suggested other reasons.

There were 42 anti-thrombotics other than warfarin being used for the listed conditions. Of these aspirin was most common (54.8%, *n*=23), followed by clopidogrel (*n*=7, 16.7%) and aspirin +dipyridamole (*n*=6, 14.3%).

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 USE OF WARFARIN.**

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

INSTRUCTIONS

Patient conditions

Please advise using the tick boxes, whether or not the patient **has any of the listed conditions**, or **has a history of any of the listed conditions**.

Tick as many as apply.

If the patient has **none** of the listed conditions, you may **end the questions** here.

Warfarin use

If the patient has any of these conditions, please advise whether or not he/she is **taking warfarin.**

If the patient **is taking warfarin** you may **end the questions here**. Otherwise, continue to the final question.

Reason for non-use of warfarin

If the patient is **not taking warfarin** for their condition/s, please advise **why not**.
Tick as many as apply.

If a different anti-thrombotic is being taken, please **write the name of this other medication** in the space provided.

If the reason is not one of those listed, (e.g. 'history of Peptic Ulcer Disease or GORD' ; 'not clinically indicated' etc) please **write the other reason** in the space provided.

Does the patient have (or have a history of) any of the following conditions?

- ☐ Atrial fibrillation
- ☐ Deep vein thrombosis
- ☐ Pulmonary embolism
- ☐ Stroke
- ☐ Transient ischaemic attack
- ☐ No → **END QUESTIONS**

BL65B

If 'Yes' to any, is the patient currently taking Warfarin?

- ☐ Yes → **END QUESTIONS**
- ☐ No

If 'No', warfarin is not being taken by the patient because:

- ☐ Risk of bleeding outweighs risk reduction
- ☐ Contraindications
- ☐ Drug interactions
- ☐ Patient preference
- ☐ History of poorly controlled INR levels
- ☐ limited access to INR tests
- ☐ Patient unable to cope with monitoring / dose adjustments
- ☐ other anti-thrombotic is being used

_____
(please specify which)

- ☐ Other reason _____
(please specify)

74 Smoking and passive smoking in the home

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

Issues: Exposure to tobacco smoke in the home environment (all patients); the current smoking status of adult patients; attempts of daily smokers to quit or reduce tobacco use; years since quitting for previous smokers.

Sample: 2,789 respondents from 96 GPs; data collection period: 24/08/2004 – 27/09/2004.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to the distribution for all BEACH encounters, with the majority of patients (57.1%) being female. Patients aged 45–64 years accounted for 28.1% of the sample.

When asked about smoking in the home, almost half the respondents (47.8%) indicated 'smoking is permitted outside only' and a further one–third (32.2%) indicated that 'people are not permitted to smoke anywhere'. Smoking was permitted only in certain areas inside the home in 4.5% of respondents' households, in the house occasionally in 5.8%, or in the house frequently in 9.7% of households.

So, in the majority of households there was no passive smoke in the home (80.1%, 95% CI: 77.2–83.0). In a further 10.3% (95% CI: 8.3–12.3) of households there was limited passive smoke (where smoking is permitted only in certain areas, or smoking in the home is only occasional), and in 9.7% (95% CI: 7.8–11.6) of households there was unlimited passive smoke.

Patients aged 18 years and over were asked to indicate their smoking status. About half (49.1%) had never smoked, and 28.5% were previous smokers. Daily smokers accounted for 17.9% of the responding patients and a further 4.5% reported smoking occasionally.

Of the 434 adult daily smokers, data on their quit/reduction attempts during the previous 12 months was available for 420. Each could indicate more than one quit/reduction option attempted. Only 7.4% had successfully given up smoking for 1 month or more (but subsequently started again), and one-third (33.1%) had a failed quit attempt during the past 12 months. About one in ten adult daily smokers (11.2%) had changed to a lower tar or nicotine brand cigarette, and about a quarter (23.1%) had reduced the average number of cigarettes smoked per day.

In the previous 12 months: over one-third of adult daily smokers (37.9%) had attempted to quit smoking by either quitting for 1 month or more (then starting again) and/or having an unsuccessful quit attempt; over a quarter of all adult daily smokers (28.1%) had attempted to reduce smoking effects by changing brand and/or reducing the number of cigarettes smoked.

For other related abstracts see: 12 Smoking and passive smoking in general practice patients, 35 Smoking status of adults and their attempts to quit, 53 Smoking status of adults and their attempts to quit and Section 4.3 Smoking.

Further reading:

Valenti, L., Charles, J., & Britt, H. 2005, 'Passive smoke in Australian homes: 1999 to 2004 [letter]', *Australian and New Zealand Journal of Public Health*, vol. 28, no. 4, pp. 387–388.

Doran, C. M., Valenti, L., Robinson, M., Britt, H., & Mattick, R. P. 2006, 'Smoking status of Australian general practice patients and their attempts to quit', *Addict.Behav.*, vol. 31, no. 5, pp. 758–766.

Degenhardt L, Knox S, Barker B, Britt H, Shakeshaft A. The management of alcohol, tobacco and illicit drug use problems by general practitioners in Australia. *Drug Alcohol Rev* 2005; 24(6):499–506.

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 **SMOKING**

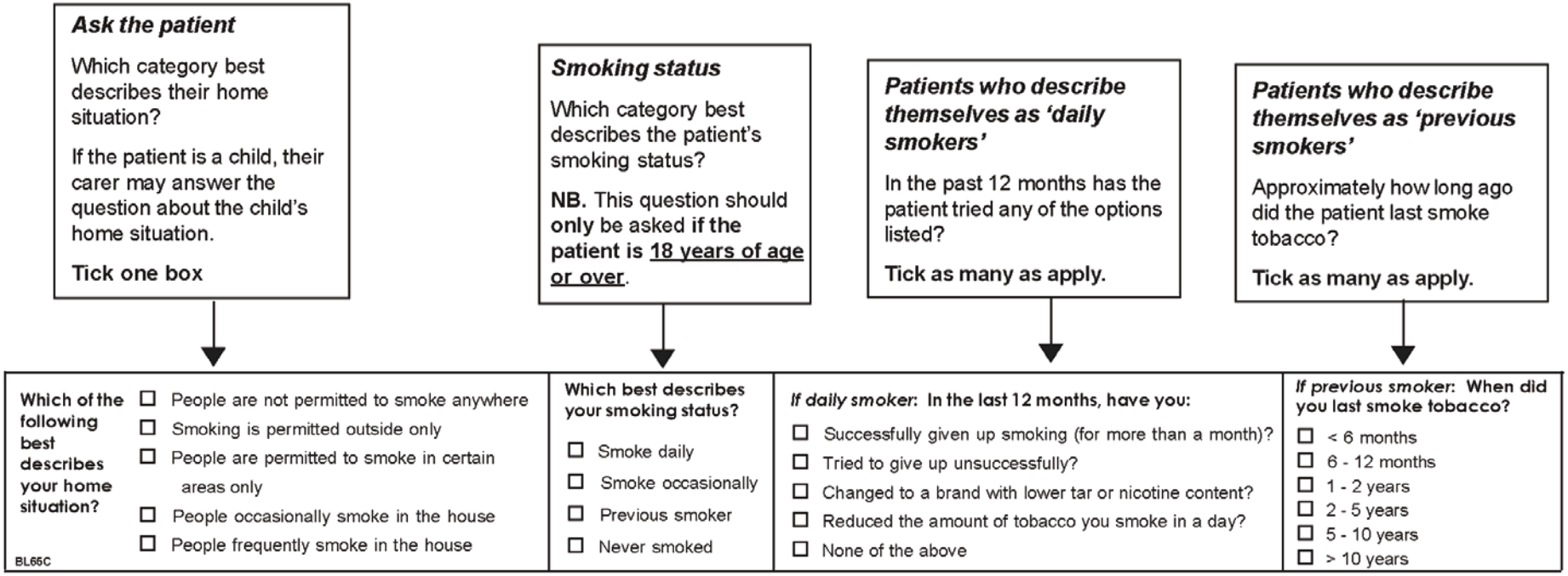
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

PLEASE NOTE:

The home smoking question is asked of all patients, but smoking status is only asked of patients 18 years of age and over.

The term 'smoking' here is used to mean tobacco smoking of any kind, including cigarettes, pipes and cigars.



75 Prevalence, management and investigations for chronic heart failure

Organisation supporting this study: Roche Products Pty Ltd

Issues: Prevalence and severity of chronic heart failure (CHF) among patients attending general practice; types of management (whether the management was initiated by a GP or specialist, and the main objective of management); proportion of patients referred to a cardiac specialist; clinical investigations used to diagnose CHF.

Sample: 2,735 respondents from 95 GPs; data collection period: 28/09/2004 – 01/11/2004.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to the distribution of patients at all BEACH encounters, with the majority (60.4%) of patients being female.

The prevalence of CHF among the 2,735 respondents was estimated to be 4.2% (95% CI: 3.1–5.2). Mild CHF was diagnosed in 2.2% of patients, while 1.4% and 0.6% were diagnosed with moderate and severe CHF respectively. Of male patients, 4.8% were diagnosed with CHF compared with 3.7% of female patients. Patients aged 75 years and over had the highest age–specific rate of CHF (18.1%).

The medications most commonly used for the control of CHF were frusemide (30.3% of CHF medications), followed by digoxin (8.8%), ramipril (8.0%) and perindopril (5.6%). Specialists initiated 59.4% of CHF medications and GPs initiated the remainder (40.6%).

GPs used a scoring system (1=most important to 3=least important) to rank the factors they considered most important in the management of CHF. The factors of 'symptom management' (score 1.4, 95% CI: 1.2–1.6) and 'quality of life' (score 1.6, 95% CI: 1.4–1.8) were rated equally important in the management of CHF, and these were significantly more important than 'survival' (score 2.2, 95% CI: 2.0–2.4).

The majority (85.1%) of patients diagnosed with CHF had been referred to a cardiac specialist: 46.7% were referred more than 3 years ago, 21.5% were referred between 1 and 3 years ago, and the remainder (16.8%) had been referred during the previous 12 months.

Multiple investigations could be used in diagnosing CHF. Chest x-ray had been used in diagnosing CHF in 71.9% of cases, ECHO had been used in 74.6% of cases and ECG in 65.8% of cases. GPs had ordered 60.8% of chest x-rays, 25.3% of ECHOs and 56.7% of ECGs, with cardiac specialists ordering the rest.

For other related abstracts see: 31 Prevalence and severity of chronic heart failure, 38 Prevalence of chronic heart failure, its management and control, 57 Prevalence and management of chronic heart failure in general practice patients, 77 Heart failure-underlying causes and medication management, 90 Prevalence, management and investigations for chronic heart failure.

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 HEART FAILURE.**

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

INSTRUCTIONS

Chronic Heart Failure (CHF)

Please indicate by ticking the appropriate box whether this patient has **Chronic Heart Failure (CHF)** at either a **mild, moderate** or **severe** level.

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

Main treatment objective

Please indicate your **main objective** in this patient's management, **ranking the options** in order of importance from 1 to 3, where **3** is the **least important.**

CHF management

If **'YES'** please write in the **name and form** of any **medications** currently being used to treat this patient's CHF. Please indicate the regimen (i.e. **strength, dose and frequency**) of the medication and circle an option to advise whether this treatment was initiated by a GP or Specialist.

Please also list any **non-pharmacological management** e.g cardiac rehabilitation, physiotherapy etc.

Referral

If this patient has been referred to a **cardiac specialist** for management, please indicate **when they were initially referred.**

Clinical investigations

Please advise using the tick boxes what **clinical investigations** were used in **diagnosing** this patient's CHF. If tests other than ECG, ECHO or Chest X-ray (e.g angiogram, FBC, blood chemistry, thyroid function tests etc) were used, please list in 'other'.

Please indicate by circling an option **who ordered each test.** e.g. GP or specialist.

Does this patient have Chronic Heart Failure (CHF)?

Yes - mild ☐
- moderate ☐
- severe ☐

No - ☐ → END

BL66B

If 'Yes' what management is currently being used?

Name & Form	Strength	Dose	Freq	Initiated by
1.				GP/spec
2.				GP/spec
3.				GP/spec
4. Other				GP/spec

What is most important in managing this patient's CHF?

(please circle a number for each option, ranking 1-3 where 3 is least important)

Increase survival	1	2	3
Relieve symptoms	1	2	3
Improve quality of life	1	2	3

This patient was initially referred to a cardiac specialist

☐ <12 months ago
☐ 1-3 years ago
☐ > 3 years ago
☐ never referred

What clinical investigations were used to diagnose the CHF?

test	ordered by
☐ ECG	GP / spec
☐ ECHO	GP / spec
☐ Chest X-Ray	GP / spec
☐ Other _____	GP / spec

76 Patients with risk factors for metabolic syndrome

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

Issues: Prevalence of the following risk factors in patients attending general practice.
All patients: triglycerides >150 mg/dL (1.68 mmol/L); blood pressure >130/85 mmHg; fasting glucose >110 mg/dL (6.1 mmol/L).
Males: waist circumference >102 cm (>40 ins); HDL cholesterol <40 mg/dL (1.03 mmol/L).
Females: waist circumference >88 cm (>35 ins); HDL cholesterol <50 mg/dL (1.29 mmol/L).

Sample: 2,845 encounters from 96 GPs; data collection period: 02/11/2004 – 06/12/2004.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of 2,845 respondents was similar to the distribution for all BEACH encounters, with the majority of patients (58.1%) being female.

None of the risk factors were present in 57.2% of the sample. One in five patients (22.7%) had one listed risk factor, 10.9% had two, 5.6% had three, 2.7% had four, and 1.1% (n=30) had all five.

However of the 674 male patients without any risk factors 81% did not know or had never been tested for at least one factor. This represented 45% of the 1,190 male patients surveyed. Only one-third of male patients (33.0%) knew their status on all five factors. Of the 1,654 female patients with no recorded risk factors, 89% did not know their status for at least one factor. Only one-third (31.8%) of female patients knew their status on all five factors. The number of risk factors present increased with age.

Among the 1,190 male respondents, 23.6% had blood pressure >130/>85 mmHg, 18.8% had a waist circumference >102 cm, 18.1% had triglyceride levels >150 mg/dL, 10.7% had HDLC <40 mg/dL and 10.3% had fasting glucose >110 mg/dL.

Among the 1,654 female respondents, one in five (20.7%) had blood pressure >130/>85 mmHg. Nearly one-quarter (23.3%) had a waist circumference of >88 cm and 14.9% had triglyceride levels >150 mg/dL, 7.6% had HDLC <50 mg/dL and 13.4% had fasting glucose >110 mg/dL.

Considering these results in terms of the number of patients for whom status was known: 26.9% of 1,275 females had blood pressure >130/>85 mmHg; 36.2% of 1,065 females had a waist circumference >88 cm; 29.3% of 873 females had triglyceride levels >150 mg/dL; 17.7% of 713 females had HDLC <50 mg/dL; 13.4% of 941 females had fasting glucose >110 mg/dL; 32.9% of 851 males had blood pressure >130/>85 mmHg; 28.7% of 780 males had a waist circumference >102 cm; 33.8% of 637 males had triglyceride levels >150 mg/dL; 23.5% of 541 males had HDLC <40 mg/dL and 18.9% of 646 males had fasting glucose >110 mg/dL.

Of the total respondents, 9.3% had metabolic syndrome defined as 3 or more of the nominated risk factors (4.8% males and 4.5% of females). For males, 392 had been tested for all risk factors and 103 (31.3%) had metabolic syndrome defined as 3 or more of the nominated risk factors. For females, 525 had been tested for all risk factors and 102 (19.4%) had metabolic syndrome defined as 3 or more of the nominated risk factors.

For other related abstracts see: 92 Metabolic syndrome and ethnic origin.

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 **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.

The **first three questions** are for **all** patients.

The last two questions are slightly different for **male** and **female** patients because health risks occur at different levels for males and females when assessing abdominal obesity and HDL (high density lipoprotein) cholesterol.

For **each risk factor**, if you do not know a level because the patient is someone you have not seen before, or if the patient has never been tested, please tick the '**don't know / never tested**' option.

Does this patient have any of the following:-	Yes	No	Don't know / never tested
Triglycerides >150 mg/dL (1.68 mmol/L)	☐	☐	☐
Blood pressure >130/>85 mmHg	☐	☐	☐
Fasting glucose >110 mg/dL (6.1 mmol/L)	☐	☐	☐

	Yes	No	Don't know / never tested
(Male patients)			
Waist circumference >102 cm (>40 ins)	☐	☐	☐
HDL cholesterol <40 mg/dL (1.03 mmol/L)	☐	☐	☐
(Female patients)			
Waist circumference >88 cm (>35 ins))	☐	☐	☐
HDL cholesterol <50 mg/dL (1.29 mmol/L)	☐	☐	☐

BL67C

77 Heart failure—underlying causes and medication management

Organisation supporting this study: Janssen-Cilag Pty Ltd

Issues: The prevalence of heart failure in patients attending general practice; severity of heart failure in these patients; the underlying causes of heart failure; the health professional who initially diagnosed the heart failure; current medication management, and the rate of hospitalisation of patients with heart failure.

Sample: 2,660 respondents from 91 GPs; data collection period: 07/12/2004 – 17/01/2005.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to the distribution of the total BEACH sample with the majority of patients (56.3%) being female. Patients aged over 75 years accounted for 16.9% of the sample.

The severity of heart failure was defined using the New York Heart Association Classification. There were 4 classes, Class I (least severe) to Class IV (most severe). Class I heart failure was diagnosed in 2.1% of general practice patients, while 2.7%, 0.9% and 0.2% were diagnosed with Class II, III and IV heart failure respectively.

The prevalence of diagnosed heart failure in the general practice patient sample was 6.1% (95% CI: 4.7–7.6) (n=163). In male patients, 6.3% had been diagnosed with heart failure compared with 5.9% of female patients. Patients aged 75+ had the highest age-specific rates, with 23.3% diagnosed with heart failure.

Multiple responses were allowed to the question about the underlying causes of heart failure. A total of 241 causes were given. Of the 163 patients with heart failure, 93 (57.1%) had hypertension and 89 (54.6%) had ischaemic heart disease as the underlying cause(s) of heart failure. Twenty (12.3%) had acute myocardial infarction, and 39 (23.9%) had causes other than the three above-mentioned conditions.

Initial diagnosis of heart failure was made by a GP for 61.9% of patients, by a cardiologist for 33.1%, and the remaining patients (5.0%) were diagnosed by an 'other health professional'.

For each heart failure patient, up to five medications for heart failure could be recorded by the GP. Three or more medications for heart failure were taken by one-third (33.8%) of heart failure patients. On average each patient took two medications for heart failure. There were a total of 338 medications listed for the 163 heart failure patients.

The medication most commonly used for the control of heart failure was frusemide, followed by digoxin, perindopril, and carvedilol (23.1%, 9.8%, 7.4% and 5.9% of heart failure medications respectively).

Of the 153 heart failure patients responding to the question about hospitalisation for heart failure, the majority (83.0%) had not been hospitalised in the past 12 months. Eighteen (11.8%) were hospitalised for decompensated/exacerbated heart failure, four (2.6%) were hospitalised for medication change, and nine (5.9%) were hospitalised for other reasons.

For other related abstracts see: 31 Prevalence and severity of chronic heart failure, 38 Prevalence of chronic heart failure, its management and control, 57 Prevalence and management of chronic heart failure in general practice patients, 75 Prevalence, management and investigations for chronic heart failure, 90 Prevalence, management and investigations for chronic heart failure.

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 **HEART FAILURE.**

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.

Heart failure

Please indicate by ticking the appropriate box whether this patient currently has **heart failure** at a level **classified as follows**:-

Class I - patients with no limitation of activities; they suffer no symptoms from ordinary activities.
Class II - patients with slight, mild limitation of activity; they are comfortable with rest or with mild exertion
Class III - patients with marked limitation of activity; they are comfortable only at rest
Class IV - patients who should be at complete rest, confined to bed or chair; any physical activity brings on discomfort and symptoms occur at rest. *(New York Heart Association Classificaton)*

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

Underlying cause(s)

If **'YES'** please advise the **underlying cause(s)** of this patient's heart failure.

Initial diagnosis

Please advise who **initially diagnosed** heart failure in this patient (i.e., GP / cardiologist / other health professional).

Medications

Please advise which **medication/s** this patient is taking for heart failure management, including the **name & form**, the **strength**, **dose** and **frequency of use** for each medication.

Hospitalisations

If the patient was **hospitalised *because of their heart failure*** during the previous 12 months, please incidated the **reason** using the tick boxes. Tick as many reasons as apply.

In the spaces provided, please write in the **number of times** the patient was hospitalised and the **length of stay** (in days) for their **most recent** hospitalisation.

Does this patient suffer from heart failure?

- ☐ Yes - Class I
- ☐ Yes - Class II
- ☐ Yes - Class III
- ☐ Yes - Class IV
- ☐ Yes - Class unknown
- ☐ No → ***End questions***

Underlying cause(s) of the heart failure are:

- ☐ Hypertension
- ☐ IHD
- ☐ AMI
- ☐ Other:-

_____ *(please specify)*

Heart failure was initially diagnosed by:

- ☐ GP
- ☐ Cardiologist
- ☐ Other health professional:-

_____ *(please specify)*

Heart failure medications currently taken are?

	Name & Form	Strength	Dose	Frequency
1.				
2.				
3.				
4.				
5.				

How many times has this patient been hospitalised *because of their heart failure* in the past 12 months?

	No. of times	*Most recent Length of stay*
☐ None		
☐ Decompensated/ exacerbated	_____	_____ days
☐ Medication change	_____	_____ days
☐ Other _____ *(please specify)*	_____	_____ days

BL68B

78 NSAID & acid suppressant use in general practice patients

Organisation supporting this study: AstraZeneca (Australia) Pty Ltd

Issues: Proportion of patients taking non-specific non-steroidal anti-inflammatory drugs, COX-2 inhibitors or aspirin, the indications for their use, therapeutic regimen and duration of therapy; proportion also taking an acid suppressant medication, their therapeutic regimen and duration of therapy; proportion of patients on all NSAIDs with existing or pre-existing gastrointestinal disorders; the relationship of acid suppressant and NSAID use and the reason for that relationship.

Sample: 2,783 respondents from 96 GPs; data collection period: 07/12/2004 – 17/01/2005

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age and sex distributions of respondents were similar to the distribution for all BEACH (general practice) encounters, with the majority (56.2%) of patients being female.

Three-quarters (75.8%) of the patients were not on any NSAID or aspirin medication. Eleven per cent were taking aspirin, 7.7% were taking a non-specific NSAID and 6.9% were taking a COX-2 inhibitor. Regimens combining two or more of the medications were uncommon (1.3% of patients).

Non-specific NSAIDS were most commonly (71.0%) used as necessary. However most (52.8%) patients had been taking them for over 12 months with 16.3% taking NSAIDs continuously for more than 12 months. Most (54.0%) COX-2 inhibitors were used continuously and 34.0% had been used continuously for over 12 months. Almost all (89.2%) patients reported in this study as taking aspirin were taking it continuously and most (82.1%) for more than 12 months.

A quarter (25.0%) of 144 patients were taking non-specific NSAIDs for various forms of arthritis while this was the indication for almost three-quarters (70.8%) of the 127 patients taking COX-2 inhibitors. In contrast 9 out of 10 (90.2%) of 204 patients were on aspirin for preventive care.

About one-third (31.5%) of NSAID patients had at least one gastrointestinal (GI) condition. The vast majority (27.8%) of these were GI symptoms with small numbers of peptic ulcers (3.4%) or GI bleeds (2.2%).

Almost a third of patients on NSAIDS were taking acid suppression medication (32.0%). The rate of acid suppression medication use was significantly higher for those on COX-2 inhibitors (40.9%, 95% CI: 33.0–48.8), than for those on non-specific NSAIDS (22.1%, 95% CI: 16.2–28.0) but not statistically different from the rate for patients on aspirin (34.2%, 95% CI: 27.6–40.8).

The most common acid suppression medication was a proton pump inhibitor (65.2% of listed medications) followed by H2RA inhibitors (17.8%) and antacids (17.0%). Acid suppressants were most commonly taken for treatment of GI symptoms with smaller numbers being taken for prevention of symptoms (16.0%). Almost a third (31.6) of acid suppressants were being taken for reasons unrelated to NSAID therapy.

For other related abstracts see: 49 Health status and management of patients on non-steroidal anti-inflammatory drugs, 88 Arthritis rates and NSAID use in general practice patients, 29 Non-steroidal anti-inflammatory drugs (NSAIDS) and acid suppressant use.

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 **NSAID and acid supressant use.**
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.

Medication use

Please indicate by ticking the appropriate box whether this patient is **currently taking a NSAID and/or aspirin** and write in the space provided the **reason for** the NSAID/ aspirin use.

NB - selective Cox-2 NSAIDs include coxibs (Celebrex) **AND** meloxicam (Mobic)

Please **circle an option** to advise whether the NSAID and/or aspirin is **taken as required (prn) or continually** and the **duration of usage** (in months). Include any NSAID and/or aspirin that will be **commenced following today's consultation.**

If **no NSAID or aspirin** is being taken you should **tick the box marked 'None of the above' and end the questions here.**

If a NSAID and/or aspirin **is** being taken please advise whether the patient is **also taking any acid suppressant medication**, either prescribed or an over-the-counter (OTC) preparation. Write in the space provided the **name of the acid suppressant** and **circle an option** to indicate whether it is being **taken as required or continually**, and the **duration of usage** (in months).

Conditions

Please use the tick boxes to indicate the **patient's status** regarding the listed conditions.

Circle an option to advise whether **this condition currently exists** or is **one of which the patient has a history**.

Related medication use

If the patient's **acid suppression** use is **related to their NSAID / aspirin use**, please use the tick boxes to **indicate the reason**.

Is this patient taking any of the following medications? →	Medication	Reason	Taken	For how many months?
	☐ Non-specific NSAID	_____	prn/continually	<3 / 3-6 / 6-12 / >12
	☐ Cox-2 NSAID	_____	prn/continually	<3 / 3-6 / 6-12 / >12
	☐ Aspirin	_____	prn/continually	<3 / 3-6 / 6-12 / >12
	☐ None of the above → *End questions*		*(please circle)*	*(please circle)*
If so, are they also taking any acid suppressant medication (prescribed or OTC) *(please specify)* →	☐ Yes _____		prn/continually	<3 / 3-6 / 6-12 / >12
	☐ Yes _____		prn/continually	<3 / 3-6 / 6-12 / >12
	☐ No		*(please circle)*	*(please circle)*

Does this patient have any of the following?

- ☐ GI Bleeding ..... existing/history of
- ☐ Peptic ulcer .... existing/history of
- ☐ GI symptoms ... existing/history of (eg dyspepsia, reflux) *(please circle)*
- ☐ None of the above

BL68C

Is the acid suppression use related to the patient's NSAID/aspirin use?

- ☐ Yes - treatment of GI symptoms
- ☐ Yes - prevention of GI symptoms
- ☐ Yes - treatment of ulcer or bleed
- ☐ Yes - prevention of ulcer or bleed
- ☐ other _____ *(please specify)*
- ☐ No

79 Hypertension and dyslipidaemia—comorbidity and management in general practice patients

Organisation supporting this study: Pfizer Australia Pty Ltd

Issues: The prevalence of diagnosed hypertension and/or dyslipidaemia in patients attending general practice; comorbidities experienced by patients with diagnosed hypertension and/or dyslipidaemia; current medications used to treat diagnosed hypertension and/or dyslipidaemia; other treatments used for diagnosed hypertension and/or dyslipidaemia.

Sample: 2,874 respondents from 97 GPs; data collection period: 18/01/2005 – 21/02/2005.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to the distribution of the total BEACH sample, with the majority of patients (56.9%) being female. Respondents aged between 45 and 64 years accounted for 29.3% of the sample, and 27.2% of the respondents were aged 65 years or more.

Diagnosed hypertension was present in 1,050 patients (28.1%, 95% CI: 25.1–31.0), while 24.0% of patients had diagnosed dyslipidaemia (95% CI: 20.9–27.0). Both conditions were present in 423 of these patients (15.2% of the 2,789 encounters where the status of both conditions was known). Just over one-third of patients (36.7%) had either hypertension and/or dyslipidaemia.

The presence of listed comorbidities was questioned for patients with diagnosed hypertension and/or dyslipidaemia. Of the 832 respondents diagnosed with hypertension and/or dyslipidaemia who completed the question on comorbidities, half (49.9%) did not have any of the listed conditions (49.9%). The most common condition listed as a comorbidity was diabetes (27.0%), followed by ischaemic heart disease (21.9%). Heart failure (8.1%), peripheral vascular disease (6.5%), stroke (6.3%) and renal disease (5.5%) were less common.

Details regarding the use of 14 specified medications were also asked of patients with diagnosed hypertension and/or dyslipidaemia. Four of the medications listed were lipid lowering medications, and 10 were anti-hypertensives. The majority of patients with hypertension and/or dyslipidaemia who responded to the question on medications (n=1,032) were taking only one medication (39.9%), while 31.3% of patients were taking two of the medications listed. There were 12.2% of patients not taking any of the listed medications.

Of the listed lipid lowering medications, the most frequently used was atorvastatin (23.7%). Other statins were used by 24.0% of patients. The most commonly used anti-hypertensives were ACE inhibitors (31.3%), followed by beta-blockers (17.3%) and angiotensin-2 receptor antagonists (13.2%).

For the 126 patients not taking medications for the treatment of hypertension and/or dyslipidaemia, the most common reasons for non-medication (multiple response allowed) were treatment of the condition with diet (82.5%), followed by treatment with exercise (53.2%).

For other related abstracts see: 15 Lipid lowering medication, 20 Screening and management of blood cholesterol, 26 Prevalence of diagnosed hypertension and difficulties in treatment, 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, 59 Hypertension management and control in general practice patients, 64 Current use of statins by general practice patients, 67 Risk factors of patients on lipid lowering medications, 97 Statin medication use among high CHD risk patients attending general practice, 98 Management of hypertension and angina in general practice patients, 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 **HYPERTENSION and DYSLIPIDAEMIA.**

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 dyslipidaemia

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

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

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**'.

Medications

Please use the tick boxes to advise which **medication/s** this patient is **currently** taking for **hypertension** or **dyslipidaemia.** Tick as many as apply.

Non-use of medication

If the patient has **hypertension** or **dyslipidaemia** but is **NOT taking a medication** for management of either condition, for what **reason** is a **medication not being taken?**

If the reason is not listed, please **write it in the space provided**. Tick as many as apply.

Does this patient have diagnosed

- **Hypertension** ☐ Yes ☐ No

and / or

- **Dyslipidaemia** ☐ Yes ☐ No

*If neither, **end questions here***

If 'yes' to either, do they also have:

- ☐ Diabetes - type I or II
- ☐ Ischaemic heart disease
- ☐ Peripheral vascular disease
- ☐ Renal disease
- ☐ Stroke (current or history)
- ☐ Heart failure
- ☐ None of the above

Tick all patient's current medications for hypertension or dyslipidaemia

- ☐ atorvastatin
- ☐ other statin
- ☐ fibrate
- ☐ bile acid sequestrant
- ☐ diuretic
- ☐ beta-blocker
- ☐ ACE inhibitor
- ☐ ACE inhibitor combination
- ☐ AT2 antagonist
- ☐ AT2 combination
- ☐ amlodipine
- ☐ other DHP CCB
- ☐ non-DHP CCB
- ☐ other (including alpha-blocker)

☐ **none** →

(tick as many as apply)

If the patient is taking NO medication for hypertension or dyslipidaemia, why not? *(tick as many as apply)*

- ☐ treated with diet
- ☐ treated with exercise
- ☐ intolerance to medication
- ☐ Other _____ *(please specify)*

BL69B

80 Employment status and workers compensation claims in general practice patients

Organisation supporting this study: Australian General Practice Statistics and Classification Centre (AGPSCC) on behalf of the National Occupational Health and Safety Commission

Issues: Types of problems managed for patients aged 15 years and over from different workforce categories and industries; work-related problems; workers' compensation claim status of work-related problems; reasons for not claiming workers' compensation for work-related problems.

Sample: 5,513 respondents aged 15 years and over from 211 GPs; data collection period: 18/01/2005 – 28/03/2005.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: *A card listing the industries of employment was provided to participating GPS. Patients were asked to select the industry in which they are currently employed.*

Summary of results

The age–sex distribution of patients was the same as the average BEACH results for 2003–2004, with the majority (57.4%) being female. Employment data were recorded for 5,486 patients aged 15 years and over, and 41.5% (95% CI: 38.9–44.2) of them were employed or self-employed.

Of the 2,205 currently employed or self-employed patients who answered the question on industry of employment, 19.1% (95% CI: 17.2–21.1) worked in health and community services, 11.1% (95% CI: 8.7–13.4) worked in manufacturing and 10.1% (95% CI: 8.6–11.6) were in the retail trade.

A total of 3,095 problems were managed for the employed/self-employed patients, most commonly skin or musculoskeletal problems which together made up about one-quarter of these problems. Musculoskeletal problems were the most common problems managed for patients working in the manufacturing, transport, construction and recreational services industries, while skin problems were most common for those in health and community services and the retail industry. Respiratory problems were the most common for government, defence and education workers.

There were 235 work-related problems managed, accounting for 5.7% of the total. Almost one-third of skin injuries managed for these patients were work-related as were almost 30.0% of back complaints and sprains/strains. One-quarter of fractures and acute stress reactions managed for these patients were work-related.

Of the 235 work-related problems, almost 70.0% were managed at workers' compensation claimable encounters. The most common of these problems was back complaint, followed by sprain/strain. At encounters not covered by workers' compensation, the most common work-related problem managed was complete medical examination, followed by acute stress reaction.

For the 67 problems that were managed at encounters where a workers' compensation claim was not made, GPs recorded 37 reasons for not claiming. Most frequently the reason given was 'not serious enough'. Less frequently the reason was that the patient was self-employed.

For other related abstracts see: 6 Employment status and workers' compensation claims, 11 Patient employment status and occupation.
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 **WORK RELATED CONDITIONS.**

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 employment status

Ask all patients 15 years of age and over, how they would **describe** their **current employment status**.

Include part-time and casual employment.

Select **ONE** category only.

Industry of employment

Please **give the patient** the **Industry of employment card from your research kit** and ask them to advise the **industry** in which they are **currently employed** (either self-employed or employed by another). Use the tick boxes to indicate the patient's response.

For industries **not** on the tick box list, select a number from this list →
and **write it in the box labelled 'other'.**

1 - 5 are listed in the section below

6. Mining
7. Electricity, Gas & Water Supply
8. Wholesale Trade
9. Retail Trade
10. Accommodation, Cafes & Restaurants
11. Communication Services
12. Finance & Insurance
13. Property & Business Services
14. Government Administration & Defence
15. Education
16. Cultural & Recreational Services
17. Personal & Other Services

Workers' compensation claims

If the patient had a **work-related problem** managed at today's encounter but has **NOT made** or **WILL NOT make a workers' compensation** claim for that problem, please advise the **reason for not claiming**.

What is this patient's current employment status?

- ☐ Employee
- ☐ Self-employed
- ☐ Student and employed
- ☐ Unemployed
- ☐ Home duties
- ☐ Student (not employed)
- ☐ Retired
- ☐ Not working due to health problems
- ☐ Other _____ *(please specify)*

BL69C

If currently employed or self-employed, in what industry is the patient mainly working?

- ☐ 1. Manufacturing
- ☐ 2. Health & Community Services
- ☐ 3. Transport and Storage
- ☐ 4. Construction
- ☐ 5. Agriculture, Forestry & Fishing
- ☐ Other *(please enter number from card)*

If no workers' compensation claim was made for a work related condition managed today, what was the reason for not claiming?

- ☐ Not serious enough
- ☐ Self-employed
- ☐ Covered by other means (eg employer paid)
- ☐ Didn't know I could claim
- ☐ Other _____ *(please specify)*

Industry of employment

1. Manufacturing
2. Health & community services
3. Transport & storage
4. Construction
5. Agriculture
6. Mining
7. Electricity, gas & water supply
8. Wholesale trade
9. Retail trade
10. Accommodation, cafes & restaurants
11. Communication services
12. Finance & insurance
13. Property & business services
14. Government administration & defence
15. Education
16. Cultural & recreational services
17. Personal & other services

81 Prevalence and indications for gabapentin use by patients attending general practice

Organisation supporting this study: Pfizer Australia Pty Ltd

Issues: The rate of gabapentin use in general practice patients; indications for gabapentin use; clinician initiating treatment with gabapentin; use of private prescriptions for gabapentin.

Sample: 3,095 respondents from 105 GPs; data collection period: 22/02/2005 – 28/03/2005.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to the distribution for all BEACH encounters, with the majority of patients (56.7%) being female. Patients aged 45–64 years accounted for 29.3% of the sample.

The proportion of respondents who were using gabapentin was small, GPs indicating that only 18 of 3,095 patients (0.6%) were currently taking gabapentin. The rates of gabapentin use did not differ between the sexes, being 0.5% among males and 0.7% among females.

Further details from patients on gabapentin were only provided for 6 of the 18 patients.

Epilepsy was being managed with gabapentin for two of the six patients and neuropathic pain for five of the six patients (one patient had both conditions). One of the patients with epilepsy had their gabapentin treatment initiated by a neurologist, and the other by a pain specialist. The medications taken prior to gabapentin included carbamazepine (Tegretol) and sodium valproate (Epilim). Gabapentin was not prescribed as first line treatment for either patient with epilepsy. Data on whether the prescription was private was available for one of the two patients with epilepsy. This patient was not given gabapentin on a private prescription.

Among the five patients with neuropathic pain, data on who initiated the gabapentin therapy were available for four patients; gabapentin treatment was initiated by a neurologist for one patient, by a pain specialist for two patients and by a GP for one patient. Medications taken prior to gabapentin included carbamazepine (Tegretol), amitriptyline (Endep), doxylamine and sodium valproate (Epilim). Gabapentin was prescribed as first line treatment for one patient with neuropathic pain, by the neurologist. Data on whether the prescription was private was available for four of the five patients with neuropathic pain. Only one of the four prescriptions for gabapentin was a private prescription.

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 USE OF GABAPENTIN.**

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.

Gabapentin use

Please advise whether this patient is currently taking **gabapentin.**

If the patient is not taking this medication, you should **end the questions** here.

Original prescription

If 'yes' please use the tick boxes to advise which practitioner provided the patient's **original prescription for gabapentin.**

Condition/s being managed with gabapentin

Please indicate the **diagnosed condition/s** for which this patient is taking **gabapentin** as management. If other please specify.

Please use the tick boxes to advise whether this is a **private prescription.**

Previous medication use for condition/s now being managed with gabapentin

Please write the **medications previously taken** by this patient (i.e. medications no longer being taken) to manage the condition now being managed with **gabapentin.** If more than one condition is managed with gabapentin please indicate previous medications for the primary condition.

Beside each of the previous medications please circle an option to indicate the approximate **duration of usage** (in months), and please tick the **reason(s) this medication was ceased** for management of this condition.

NONE - If there was **no medication prior to** the current management with **gabapentin**, please advise the **reason for gabapentin** being prescribed **in the first instance.**

Is this patient currently taking gabapentin?

- ☐ Yes
- ☐ No → *end questions here*

BL708

If 'yes' the original script was provided by:

- ☐ Neurologist
- ☐ Pain specialist
- ☐ Other specialist
- ☐ GP
- ☐ Hospital emergency physician

For what condition/s?

- ☐ Epilepsy
- ☐ Neuropathic pain
- ☐ Other_____ *(please specify)*

Private prescription? ☐ Yes ☐ No

Previous medications for the condition were?	Duration of usage *(in months - please circle)*	Previous medication ceased because - *(tick as many as apply)*			
		Side effects	Poor efficacy	Start gabapentin	Other
1. _____	<1 / 2-6 / 7-12 / 13-24 / >24	☐	☐	☐	☐
2. _____	<1 / 2-6 / 7-12 / 13-24 / >24	☐	☐	☐	☐
3. _____	<1 / 2-6 / 7-12 / 13-24 / >24	☐	☐	☐	☐
4. _____	<1 / 2-6 / 7-12 / 13-24 / >24	☐	☐	☐	☐

☐ None → **why was gabapentin prescribed first?** _____

82 Prevalence and management of chronic pain

Organisation supporting this study: Janssen-Cilag Pty Ltd

Issues: Prevalence of chronic pain among patients attending general practice; conditions causing chronic pain; anatomical sites most affected; severity of chronic pain; managements being utilised by GPs; clinical opinion of GPs on adequacy of pain management for patients with chronic pain.

Sample: 3,211 respondents from 109 GPs; data collection period: 29/03/2005 – 02/05/2005.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: Chronic pain was defined as 'pain experienced every day for 3 months in the 6 months prior to this consultation'.[1] Severity was ranked using Chronic Pain Grades.[2]

Summary of results

The age-sex distribution of respondents was similar to the distribution of patients at all BEACH encounters, with the majority (55.6%) of patients being female and 59.9% aged 45 years or over.

Of the 3,211 respondents, 586 (18.3%, 95% CI: 15.8–20.7) suffered from chronic pain. Prevalence was significantly higher for patients aged 45 years and over (25.1%) than for patients aged less than 45 years (8.6%). There was no significant difference between male (15.7, 95% CI: 13.1–18.2) and female (20.4%, 95% CI: 17.2–23.6) patients.

Conditions causing chronic pain were recorded at 535 encounters. More than one condition could be reported and a total of 538 recordings of 69 different causal conditions were listed. Osteoarthritis (29.0%), back problems (17.4%), arthritis NOS (10.8%), musculoskeletal problems (6.0%) and varieties of cancer (4.1%) were conditions most often listed.

Anatomical sites were reported for 502 patients. More than one site could be detailed and a total of 633 recordings of 14 different body sites were reported. Sites most commonly affected by chronic pain were the back (33.3%), knee (15.2%), neck/cervical spine (6.8%), and hip (6.8%).

Of the 570 patients for whom severity of chronic pain was reported, 30.0% had grade I pain (low disability, low intensity), 37.0% had grade II pain (low disability, high intensity), 23.2% had grade III pain (high disability, moderately limiting), and 9.8% had grade IV pain (high disability, severely limiting).

Medications and/or treatments for chronic pain management and/or side effects of pain medication were reported for 579 patients. A total of 838 recordings of 33 different medications and/or treatments were reported. Over one-third (35.1%) took non-steroidal anti-inflammatory drugs (NSAIDS)/Cox-2s, a similar proportion used weaker opioids (32.0%), and simple analgesics were taken by 29.7%. Other treatments included herbal analgesics, and physiotherapy. Forty nine patients (8.5%) were taking no medication for pain management. GPs offered an opinion on adequacy of pain management for 40 of these 49 patients, reporting that pain was adequately managed for 33 of them (82.5%). Adequacy of pain management was reported for 506 patients using medication and/or other management. GPs reported that pain was adequately managed for 75.1% of these patients.

1 Blyth FM et al. 2001. Pain 89(2–3):127–34.
2 Von Korff M et al. 1992. Pain 50(2):133–49.

For other related abstracts see: 42 Prevalence and management of chronic pain.
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*

Medication for pain management and medication side effects

Please use the tick boxes to indicate whether the patient is **currently taking** any of the **nominated medications for pain management**, or to **relieve side effects of pain medication** (eg laxatives, acid suppressants etc). Tick as many as apply.

Beside the box labelled '**other**' you may write in **other medication**/s (not listed) or **other forms of treatment** used for chronic pain management instead of / as well as medication e.g. acupuncture

If **no medication** is being taken for pain management please tick the box labelled 'no medication'.

Beside each medication please **circle an option** to advise whether the medication was **initiated** by a GP (yourself or another) or a specialist, and the **approximate duration of usage in months or years**.

Condition and anatomical site/s affected

Please advise the **condition** you identify as being the **cause** of the patient's chronic pain.
Please write the **anatomical site/s** nominated by the patient as being **most affected by pain**.

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.

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

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

Adequacy of pain management

In **your clinical opinion**, is the current pain management **adequate** for the control of this patient's chronic pain?

Does this patient suffer from Chronic Pain?

☐ Yes →

☐ No - *end questions here*

BL71B

If 'yes', from what condition?

☐ Cancer

☐ Other _____ *(please specify)*

The anatomical site/s most affected by pain is/are?

_____

In the past week how severe was the pain?

☐ Grade I
☐ Grade II
☐ Grade III
☐ Grade IV

(Pain Grades on card or green instruction page)

Current medications for pain management (and side effects) are:

medication *(tick as many as apply)*	***initiated by***	***duration of use***
☐ transdermal fentanyl	GP/spec	___wks/mths/yrs
☐ oral slow-release morphine	GP/spec	___wks/mths/yrs
☐ control-release oxycodone	GP/spec	___wks/mths/yrs
☐ psychotropics	GP/spec	___wks/mths/yrs
☐ NSAIDS / Cox-IIs	GP/spec	___wks/mths/yrs
☐ weaker opioids *eg tramadol; codeine prep'ns*	GP/spec *(please circle)*	___wks/mths/yrs *(please circle)*
☐ antidepressants	GP/spec	___wks/mths/yrs
☐ antiepileptics	GP/spec	___wks/mths/yrs
☐ rescue medication *for breakthrough pain*	GP/spec	___wks/mths/yrs
☐ laxatives	GP/spec	___wks/mths/yrs
☐ acid suppressants	GP/spec	___wks/mths/yrs
☐ no medication		
☐ other _____ *(please specify)*	GP/spec	___wks/mths/yrs

Is pain management adequate? ☐Yes ☐No

Management of menopausal symptoms & related health risks -

Reasons for medication use

Please circle as many as apply.

1. menopausal symptom management;
2. prevention of osteoporosis
3. treatment of osteoporosis
4. cardiovascular protection
5. breast cancer prevention
6. vaginal atrophy
7. decreased sexual interest
8. other reason - please **specify** this in the space provided.

Severity of Chronic Pain -

Chronic Pain Grades

I. low disability - low intensity
II. low disability - high intensity
III. high disability - moderately limiting
IV. high disability - severely limiting

83 Prevalence and management of migraine

Organisation supporting this study: Janssen-Cilag Pty Ltd & Australian General Practice Statistics and Classification Centre (AGPSCC)

Issues: Prevalence of migraine among patients attending general practice; frequency of migraine attacks; current and previous prophylaxis medications; current acute medications.

Sample: 5,663 respondents from 191 GPs; data collection period: 07/06/2005 – 11/07/2005 and 29/11/2005 – 16/01/2006.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to that of patients at all BEACH encounters. Of the 5,663 respondents, 649 (11.5%, 95% CI: 10.0–12.9) suffered from migraine attacks. Prevalence of migraine was significantly higher among female respondents (14.9%, 95% CI: 13.0–16.7) than among males (6.1%, 95% CI: 4.7–7.4).

Almost two-thirds (64.3%) of migraine sufferers experience less than 1 migraine per month. About one in ten sufferers experience 1, 2 or 3+ migraines per month (12.8%, 10.5% and 12.3% respectively). Reported number of migraine attacks per month was similar for males and females.

Only 8.3% (95% CI: 6.0–10.6) of migraine patients were on current prophylaxis medication. Patients with 2 or more migraines per month (22.1%) were significantly more likely to be taking prophylaxis medication than those having less than 1 migraine per month (2.3%). As migraine frequency increased, rates of current prophylaxis medication use increased (trend test; p <0.0001), the most frequently used being pizotifen followed by propranolol.

Previous prophylaxis medication had been used by 15.0% of general practice migraine patients. The most frequently used previous prophylaxis medication was pizotifen, followed by propranolol. The most common reason for discontinuation of prophylaxis medication was lack of efficacy (45.8%), followed by side effects (28.1%). Of the 96 patients who took previous prophylaxis medications, only 16 (16.7%) were switched onto another prophylaxis. Therefore, the majority of these patients (83.3%) were not taking second line prophylaxis when the first prophylaxis medication failed.

In contrast, four in five (79.3%, 95% CI: 75.2–83.5) general practice migraine patients currently use acute medication as needed for migraine. About three-quarters (72.9%) of migraine sufferers having less than 1 migraine per month were taking acute medication, compared with around 90% of those with 1, 2 or 3+ migraines per month. As migraine frequency increased, rates of current acute medication use increased (trend test; p=0.0044). The most frequently used acute medications were paracetamol, paracetamol/codeine, ibuprofen and sumatriptan.

Overall, less than 10% of migraine patients were currently on prophylaxis medication, with most on pizotifen or propranolol. In contrast, most used acute medication as needed.

Further reading:

Stark, R.J., Valenti, L., Miller, G.C. 2007, 'Management of migraine in Australian general practice', *Med J Aust*. [In press].

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 MIGRAINE.**

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.

Migraine

Please indicate by ticking the appropriate box whether this patient suffers from **migraine** attacks, either initally diagnosed today or at a previous encounter in the past 12 months or more than 12 months ago (by you or by another GP).

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

Migraine frequency

If 'Yes' please advise the approximate **number of times** the patient would usually experience a **migraine** episode **during a month**.

Current migraine medication

Please write the **name and regimen** of the **current prophylaxis medictation** being taken by the patient to prevent migraine.

If **no** prophylaxis medication is **currently** being taken please tick the box labelled '**none**'.

In the space below, please write the **name and regimen** of any **medication** (oral, nasal spray or injection) taken during an **acute attack** or as **'rescue' medication** taken acutely for **breakthrough** migraine.

If **no** acute or rescue medication is usually taken please tick the box labelled '**none**'.

Previous prophylaxis medication

If the patient was taking a **different** prophylactic medication **prior to the one currently taken**, please write the **name and regimen** of the **previous prophylactic medication** and use the tick boxes to advise **why** this medication was **discontinued**.

If discontinuation occurred because of **side effects**, please **write** the main side effect/s experienced in the space provided.

If **no** prophylaxis medication was taken **prior** to the current one, or if prophylaxis medication is **not being taken at all**, please tick the box labelled '**none**'.

Patients seeking rescue medication

Please advise **how frequently** the patient **consults a GP** or **an after hours service**, at the time of a migraine episode, **for rescue medication**.

Does the patient suffer from migraine attacks?

- ☐ Yes - diagnosed...
  - ☐ today
  - ☐ in past 12 mths
  - ☐ > 12 mths prior
- ☐ No → **end questions**

BL78C

If 'Yes' migraine frequency per month is:

- ☐ <1
- ☐ 1
- ☐ 2
- ☐ ⩾3

Current prophylaxis medication taken is: ☐ NONE

Name & Form	Strength	Dose	Frequency	Duration of use
				___wks/mths/yrs *(please circle)*
				___wks/mths/yrs

Acute or 'Rescue' medication for migraine attack is: ☐ NONE

Name & Form	Strength	Dose	Frequency	Duration of use
				____ days

Previous prophylaxis medication (if any) was: ☐ NONE

Name & Form	Strength	Dose	Frequency	Duration of use
				___wks/mths/yrs *(please circle)*

Reason for discontinuation was:-

- ☐ lack of efficacy
- ☐ cost
- ☐ withdrawal after successful Rx
- ☐ side effects _____ *(please specify)*
- ☐ other _____ *(please specify)*

Does the patient consult GP/Out of Hours Service at the time of migraine for rescue medication?

- ☐ Never /almost never (0-20%)
- ☐ Some of the time (21-40%)
- ☐ Half of the time (41-60%)
- ☐ Most of the time (61-80%)
- ☐ Always/almost always (81-100%)

84 Menopausal status, symptoms and treatment of women aged 18 and over

Organisation supporting this study: Pfizer Australia Pty Ltd

Issues: The proportion of female general practice patients aged 18+ years who are pre-, peri- or postmenopausal; the proportion of these patients who have a history of hysterectomy and/or menopausal symptoms; patients experiencing specific menopausal symptoms or having an associated risk factor; pharmacotherapy associated with menopausal symptoms.

Sample: 1,590 female respondents aged 18 and over from 106 GPs; data collection period: 29/03/2005 – 02/05/2005.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The majority of female patients aged 18 years or more at encounters with the GP were postmenopausal (59.8%, 95% CI: 55.2–64.3), with another third being premenopausal (33.3%). Only 110 of the 1,590 women (6.9%) were perimenopausal. Of 1,365 respondents to the question about hysterectomy status, 19.5% had had a hysterectomy.

There were 27.8% of patients who had a history of menopausal symptoms. From a list of eight menopausal symptoms (hot flushes, sleep disturbance, excessive sweating, dyspareunia, urinary incontinence, osteoporosis, decreased sexual interest and vaginal atrophy), 68.2% of perimenopausal patients were experiencing symptoms (8.0% had one symptom and 60.2% two or more symptoms). Of postmenopausal women, 63.3% were experiencing symptoms (26.4% had one symptom and 36.9% two or more symptoms). The symptoms most frequently experienced were hot flushes (28.3% of all peri/postmenopausal patients), followed by sleep disturbance (26.2%), vaginal atrophy (26.0%), decreased sexual interest (20.8%) and osteoporosis (18.5%). Excessive sweating (13.9% of all peri/postmenopausal patients), urinary incontinence (10.4%) and dyspareunia (6.7%) were less common.

From a list of 3 risk factors associated with menopause (osteoporosis, cardiovascular and breast cancer risk), just over one-third (35.2%) of perimenopausal patients were currently at risk of one condition, 8.0% at risk of two conditions, and 2.3% at risk of all three conditions. For postmenopausal patients the figures were 31.4% at risk of one condition, 14.3% at risk of two, and 2.75 at risk of all three conditions. For 30.6% of peri/postmenopausal patients, cardiovascular risk was indicated. For 27.3%, a risk of osteoporosis was indicated, and for 9.2%, a risk of breast cancer was recorded.

The most frequently prescribed medication for these patients was alendronate, which accounted for 10% of all medications recorded at these encounters. Calcium carbonate, oestrogen, oestriol topical vaginal, oestradiol pessaries, and oestradiol/norethisterone were also among the most common medications.

For other related abstracts see: 8 Hormone replacement therapy (HRT).

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 **MANAGEMENT OF MENOPAUSAL SYMPTOMS & RELATED HEALTH RISKS.**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

Ask the **next 30 PATIENTS** the following questions, where appropriate, **in the order in which the patients are seen.**

Please **DO NOT select patients** to suit the topic being investigated i.e. if the patient is **NOT** female and 18+ years, you may leave this section BLANK.

This form has been filled in as an example

For all female patients aged 18 years and over

Menopausal status: please indicate the patient's menopausal status.

Past history:
- has the patient had a hysterectomy?
- does the patient have a past history of ***any*** menopausal symptoms (such as those listed in Box 2 below)? **That is, have they had symptoms in the past, but do not have them anymore.**

Symptoms and health risks associated with menopause

Please advise whether the patient **is experiencing** or **at risk** of any of the listed symptoms or health risks associated with menopause. Tick as many as apply.

Medication for menopausal symptom or health risk management

Medication: Is the patient taking, either **prescribed** or **purchased over-the-counter**, any medication or product for management of symptoms or health risks associated with menopause. Please write the **name & form** of the medication, its **strength, dose** and **frequency**.

Initiated by: please circle an option to indicate whether the medication was **initially prescribed / recommended** by a GP (yourself or another); an obstetrician/gynaecologist; an orthopaedic specialist; an endocrinologist; or some other specialist (please specify type of specialist in the space

Reason for medication use: beside each medication, please advise the menopause symptoms or associated health risks **for which the medication is being taken.** To do this, please read the numbered options on the key list and circle the number which corresponds to the reason/s for use of each medication. The key list (at right) is also printed on the laminated card in your research kit.

Key list for 'reason for medication use'
(this list is also on the laminated card in your research kit)

1. menopausal symptom management;
2. prevention of osteoporosis
3. treatment of osteoporosis
4. cardiovascular protection
5. breast cancer prevention
6. vaginal atrophy
7. decreased sexual interest
8. other reason - please **specify** this in the space provided.

NB. If more than one reason per medication, **circle as many as apply.**

FEMALES 18yrs+: menopausal status?
- ☐ Premenopausal
- ☑ Perimenopausal
- ☐ Postmenopausal

The patient has a past history of:
Hysterectomy ..... Yes/(No)
Menopausal symptoms ... (Yes)/No

BL71C

Is the patient experiencing / at risk of any of the following? *(tick as many as apply)*

- ☑ hot flushes
- ☑ sleep disturbances
- ☐ excessive sweating
- ☐ dyspareunia
- ☐ urinary incontinence
- ☐ osteoporosis
- ☑ decreased sexual interest
- ☐ vaginal atrophy
- ☐ osteoporosis risk
- ☐ cardiovascular risk
- ☐ breast cancer risk
- ☐ no symptoms / risk factors

Medication/s for menopausal symptom or health risk management is/are:

Name & Form	Strength	Dose	Freq	Initiated by (please circle)	Reason for use (see key list on card - circle as many as apply) (please circle)
Livial Tab	2.5mg	1 tab	od	(GP)/ObsGyn/Orth.Spec/Endo/ other (specify) ____	(1) 2 3 4 5 6 7 8* (*specify) ____
				GP/ObsGyn/Orth.Spec/Endo/ other (specify) ____	1 2 3 4 5 6 7 8* (*specify) ____
				GP/ObsGyn/Orth.Spec/Endo/ other (specify) ____	1 2 3 4 5 6 7 8* (*specify) ____
				GP/ObsGyn/Orth.Spec/Endo/ other (specify) ____	1 2 3 4 5 6 7 8* (*specify) ____

Management of menopausal symptoms & related health risks -

Reasons for medication use

Please circle as many as apply.

1. menopausal symptom management;
2. prevention of osteoporosis
3. treatment of osteoporosis
4. cardiovascular protection
5. breast cancer prevention
6. vaginal atrophy
7. decreased sexual interest
8. other reason - please **specify** this in the space provided.

Severity of Chronic Pain -

Chronic Pain Grades

I. low disability - low intensity
II. low disability - high intensity
III. high disability - moderately limiting
IV. high disability - severely limiting

85 Management of osteoporotic fractures in general practice patients

Organisation supporting this study: Roche Products Pty Ltd

Issues: The proportion of general practice patients who currently have, or have a history of, osteoporotic fractures; the proportion of these patients taking medication for the problem; the proportion who have ceased taking osteoporosis medication; the proportion enrolled in a patient support program; the current management status of patients.

Sample: 3,071 respondents from 105 GPs; data collection period: 03/05/2005 – 06/06/2005.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was the same as the distribution for all BEACH encounters in 2004–05, with the majority of patients (60.2%, 95% CI: 57.0–63.4) being female. More than half of the patients were aged 45 years or over.

Of the 3,071 respondents, 170 (5.5%, 95% CI: 4.2–6.9) had current or previous osteoporotic fracture/s. Prevalence increased significantly with age to 23.2% among patients aged 75 years and over. More female patients (7.9%, 95 % CI: 6.0–9.9) had osteoporotic fracture(s) than male patients (2.0%, 95% CI: 1.2–2.8). Of the patients with current or previous osteoporotic fracture, 79.3% were taking a prescribed osteoporosis medication and one in six (17.4%) was enrolled in a patient support or information program for osteoporosis.

Current management status was reported for 163 of the 170 respondents with current or previous osteoporotic fracture/s. Of these, 72.4% (n=118) were continuing their osteoporosis medication, and 11.0% (n=18) were no longer taking prescribed osteoporosis medication. Eleven patients (6.8%) had never had and were not starting any osteoporosis medication, and 11 (6.8%) were commencing a first prescription.

Data about the period since osteoporosis medication ceased was available for 16 of the 18 patients no longer taking prescribed osteoporosis medication. Of these 16 patients, 10 had ceased the medication for 1 year or longer.

The likelihood of commencing another osteoporosis medication was provided for 17 of 18 patients no longer taking prescribed osteoporosis medication. GPs indicated that eight patients were unlikely to commence another osteoporosis medication.

For other related abstracts see: 19 Osteoporosis.

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 OSTEOPOROTIC FRACTURE/S.**

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.

Osteoporotic fractures

Please indicate by ticking the appropriate box whether this patient **currently has**, or **has previously had**, osteoporotic fracture/s.

If **no** osteoporotic fractures have been experienced by this patient you should **end the questions** here.

Osteoporosis medication

Please advise whether the patient is currently taking a **prescribed medication for osteoporosis** treatment.

Ask the patient which of the listed options would be their **preferred** medication regimen, **even if they are not currently taking any.**

Patient support program

Please advise whether the patient is **enrolled in a patient support** or **information program** for osteoporosis.

Patient status re osteoporosis diagnosis and medication

Please use the tick boxes to advise which of these scenarios best describes the patient's situation in regard to **diagnosis** and **prescribed medication for osteoporosis**.

Patients who have ceased medication

If the patient has **previously taken** a medication for osteoporosis but is **no longer doing so**, please write the **duration** of their medication usage in the space provided. Please also write in the approximate **time since the medication was stopped**. For both of these questions, please write the answer in the space provided, and **circle** an option to indicate weeks, months or years.

If the previous medication has ceased, is the patient **likely to commence another** medication for osteoporosis?

Does this patient have:-

- ☐ Current osteoporotic fracture/s → *(continue)* **and / or**
- ☐ History of osteoporotic fracture/s → *(continue)*
- ☐ Never had osteoporotic fracture/s - ***end questions here***

BL72B

Is the patient taking a prescribed medication for osteoporosis?

☐ Yes ☐ No

Patient would prefer to take

- ☐ 1 tablet once a day
- ☐ 1 tablet once a week
- ☐ 1 tablet once a month

Is the patient enrolled in a patient support or information program for osteoporosis?

- ☐ Yes
- ☐ No

The patient's situation regarding osteoporosis medication is:-

- ☐ newly or previously diagnosed, **commencing** first prescription
- ☐ previously diagnosed, **continuing** prescribed medication
- ☐ previously diagnosed, **changing** prescribed medication
- ☐ **no longer taking** prescribed osteoporosis medication
- ☐ newly/previously diagnosed, **never had/not starting** medication
- ☐ unknown

For patients no longer taking osteoporosis medication:

For how long did the patient take the medication?

_____ *wks / mths / yrs (please circle)*

How long since the medication ceased?

_____ *wks / mths / yrs (please circle)*

Is the patient likely to commence another medication for osteoporosis?

- ☐ Yes
- ☐ No
- ☐ Don't know

86 Diabetes Types 1 and 2 and coronary heart disease

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

Issues: Prevalence of diabetes types 1 and 2 and coronary heart disease (CHD); total cholesterol level and management for these patients; indicators of statin intolerance; management regimens for these patients.

Sample: 3,099 patient encounters from 105 GPs; data collection period: 03/05/2005 – 06/06/2006.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age and sex distribution of all patient encounters was the same as the distribution for all BEACH encounters in 2004–05, with the majority (59.1%) of patients being female.

Of the 3,099 respondents 455 patients (14.7%, 95% CI: 12.5–16.8) had either diabetes (type 1 or 2) and/or CHD: 26 (0.8%, 95% CI: 0.3–1.4) had diagnosed type 1 diabetes, 239 (7.7%, 95% CI: 6.4–9.0) had type 2 diabetes, and 257 (8.3%, 95% CI: 6.5–10.1) had CHD. Both diabetes and CHD were present in 66 respondents (2.1%, 95% CI: 1.5–2.7).

The most recent cholesterol levels were provided for 412 of the 455 patients with diabetes and/or CHD. Their mean cholesterol level was 4.7 mmol/L (95% CI: 4.6–4.8), the median was 4.6 mmol/L and the range was 2.1 to 9.9 mmol/L.

Information on whether the cholesterol level was adequately managed was provided for 404 of the 455 patients with diabetes and/or CHD. In the clinical opinion of their GP, 7 in 10 (68.8%, 95% CI: 63.3–74.3) patients with diabetes (either type 1 or 2) and/or CHD currently had their cholesterol adequately controlled. Adequate control had been achieved for 65.1% of all patients with diabetes, 76.1% of all patients with CHD, and 81.7% of patients with both diabetes and CHD.

Of the 455 patients with diabetes and/or CHD, medication management information was provided for 429. Of these, 63.4% (95% CI: 57.1–69.7) were currently taking a statin, and 1.6% (95% CI: 0.3–3.0) were taking a fibrate. No patients were taking a cholestyramine. A further 35.2% of patients with diabetes and/or CHD were not taking any of these medications. The most frequently used statins were atorvastatin (45.5% of patients with diabetes and/or CHD) and simvastatin (40.1% of patients with diabetes and/or CHD). One-quarter (24.7%) of patients with diabetes were managed with diet and exercise only, with the remainder being treated with diet and exercise plus medication.

Information about tolerance problems was provided for 261 of the 272 patients taking statins, and 18 (6.9%) of these had experienced some intolerance in relation to their statin use. Muscle pain (myalgia), nausea and coordination problems were the most common problems experienced.

For other related abstracts see: 21 Diabetes – prevalence, management and screening, 25 Prevalence of diabetes, medications and control, 30 Lipid lowering medications and coronary heart disease, 40 Type 2 diabetes mellitus, prevalence and management, 45 Diabetes mellitus prevalence, management and risk factors, 46 Coronary heart disease, risk factors and lipid lowering medication, 87 Management of cardiovascular or diabetes related conditions, 94 Type 2 diabetes – investigations and 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 **PATIENTS WITH DIABETES AND / OR CORONARY HEART 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.

Diabetes and / or Coronary Heart Disease

Please indicate by ticking the appropriate box/es whether this patient has **Diabetes Type I, Diabetes Type 2,** and/or **Coronary Heart Disease**.

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

Cholesterol control

Please write in the patient's **total cholesterol** level at their **most recent test**.

Use the tick boxes to advise whether, **in your clinical opinion**, the patient's cholesterol is **adequately controlled**.

Hypolipidaemic medication

Please advise whether the patient is currently taking any of the listed **prescribed medications** for **serum lipid reduction**.

If the patient is not taking any of these medications please tick the box labelled 'none of the above'.

Hypolipidaemic medication regimen

For patients taking a **statin** and/or **fibrate** and/or **cholestyramine**, please **write the medication regimen** details in the space provided.

Patient tolerance for statin medication

If the patient is **taking a statin** medication, please use the tick boxes to advise whether the patient has experienced **problems** because of **limited tolerance to the statin**. If '**yes**' please **specify the indicator of intolerance** eg increased CK, muscle pain, etc.

Please also advise whether the **dose** of statin **was reduced** or **not increased** because of the patient's tolerance problems.

Treatment regimen for patients with diabetes

If the patient has **diabetes (either type I or type II)** please advise their **current treatment regimen**. If this treatment regimen includes prescribed medications, please **write the medication details** (up to 3 medications) in the space provided.

Does this patient have:-

- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Coronary Heart Disease

→

- ☐ None of the above - ***end questions here***

BL72C

The patient's most recent total cholesterol level was:

_____ mmol/L

In your clinical opinion is this patient's cholesterol adequately controlled?

- ☐ Yes
- ☐ No

Is the patient currently being treated with any of the following medications?

- ☐ Statin
- ☐ Fibrate
- ☐ Cholestyramine
- ☐ None of the above

Statin/fibrate/cholestyramine currently taken is:

	Name & Form	Strength	Dose	Frequency
1.				
2.				
3.				

If taking statin, has the patient had tolerance problems?

- ☐ No
- ☐ Yes _____ *(please specify)*

If 'Yes' was the statin dose?

- ☐ Reduced
- ☐ Not increased

Current treatment for patients with diabetes is:

- ☐ Diet and exercise only
- ☐ Diet and exercise plus prescribed medication as below:-

	Name & Form	Strength	Dose	Frequency
1.				
2.				
3.				

87 Management of cardiovascular or diabetes related conditions

Organisation supporting this study: AstraZeneca (Australia) Pty Ltd

Issues: The prevalence of hypertension; left ventricular hypertrophy; coronary heart failure; microalbuminura; diabetes and impaired glucose, among patients attending general practice the proportion of these patients taking medications for the management of these conditions; and their current medication regimen; level of control with current medication regimen; changes to medication regimen resulting from the current encounter.

Sample: 3,015 patient encounters with 104 GPs; data collection period: 07/06/2005 – 11/07/2005.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age–sex distribution of the respondents was similar to the distribution for all BEACH encounters, with the majority of patients (59.1%, 95% CI: 56.2–62.0) being female. Patients aged 45–64 accounted for 27.4% of the sample and those aged 65 or more years for 23.2%.

Of the 3,015 respondents 837 (27.7%, 95% CI: 24.9–30.6) had at least one of the listed conditions: 3.5% having hypertension; 7.9% diabetes; and 3.0% coronary heart failure. Left ventricular hypertrophy (2.1%), impaired glucose (1.3%) and microalbuminuria (1.0%) were less prevalent. One in five patients had only one of the listed conditions (19.4%), while 8.4% had two or more of the conditions.

Detail of the current medications used for the listed conditions were provided for 821 of the 837 patients with one or more of these conditions. Of these, 94.4% were taking at least one of the medication types listed: 42.6% were taking an ACE inhibitor (ramipril and perindopril being the most common); 35.3% were taking a diuretic; and 32.3% were taking an angiotensin II receptor blocker (irbesartan being the most common). One-quarter of patients were taking either a calcium channel blocker (24.7%) or a beta blocker (23.1%).

The GPs clinical opinion of the level of control of the patient's condition was provided for 7764 patients for whom medication was recorded. For 88.2% of patients, the GP felt that the current medication regimen was adequately controlling the patient's cardiovascular or diabetes related condition.

Details of any changes made in medication regimen at the current encounter were provided for 789 patients. At the current encounter, new or additional medication was prescribed for 5.2% of patients with at least one cardiovascular or diabetes related condition, and changes in the dose for existing medication was ordered for 2.3% of patients.

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, 94 Type 2 diabetes – investigations and 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 **PATIENTS WITH CARDIOVASCULAR AND DIABETES ASSOCIATED CONDITIONS.**

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.

Cardiovascular and diabetes associated conditions

Please indicate by ticking the appropriate box/es whether this patient has **any of the listed condtions** associated with **cardiovascular disease or diabetes**.

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

Current medications

(NB - 'Current' medication includes medication **being taken prior to today's consultation)**

Please advise whether the patient is currently taking any of the listed **prescribed medications** for the **conditions advised in the previous question**.

If the patient has one or more of the previously listed conditions and **has not been taking** a prescribed medication for any of these conditions prior to today's consultation, **and will not be starting one at this consultation**, please tick the box labelled **'none'**.

Medication regimen

Please **write the medication regimen** details in the spaces provided, for **each** of the medications being taken by this patient, **as advised in the previous question**.

Change in medication resulting from this encounter

Please advise whether, **as a result of today's encounter**, the patient's **medication** for the previously listed conditions **has been changed**.

Changes to medication include **new medications** being **prescribed for the first time**, new medications prescribed **in addition** to the current regimen, new medications prescribed **to replace one** from the current regimen, or a **change in dosage** of an existing medication.

Condition control

Please advise whether, **in your clinical opinion**, the patient's HT / LVH / CHF / Microalbuminuria / Diabtes / Impaired glucose condition is **adequately controlled by their current medication regimen**.

Does this patient have any of:-	If 'Yes' the patient's current therapy is:- ('current' = prior to today)	The patient's current medication regimen for these conditions is:- Name & Form / Strength / Dose / Frequency	In your clinical opinion does this medication regimen adequately control the patient's condition?	As a result of today's consultation, has this patient been prescribed new/additional/changed medication for these conditions?
☐ Hypertension	☐ ACE inhibitors	1.	☐ Yes	☐ Yes - new / additional medication
☐ Left ventricular hypertrophy	☐ Calcium Channel Blocker	2.	☐ No	☐ Yes - changed dose
☐ Coronary heart failure	☐ β -Blocker	3.		☐ No change
☐ Microalbuminuria	☐ Diuretic	4.		
☐ Diabetes	☐ Angiotensin II Receptor Blocker	5.		
☐ Impaired glucose	☐ Other _____ (please specify)			
☐ None of the above → **end**	☐ None			BL73C

88 Arthritis rates and NSAID use in general practice patients

Organisation supporting this study: Pfizer Australia Pty Ltd

Issues: The proportion of general practice patients with arthritis; proportion of these that are on NSAIDs; current NSAID regimen and duration of use; proportion with dyspepsia and/or anaemia; therapy for dyspepsia and/or anaemia; proportion with other possible causes of anaemia.

Sample: 3,076 patient encounters with 104 GPs; data collection period: 12/07/2005 – 15/08/2005

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age and sex distributions of respondents were similar to the distribution for all BEACH (general practice) encounters, with the majority (62.5%) of patients being female.

Of the 3,076 respondents 26.5%, (95% CI: 23.4–29.7) had diagnosed arthritis: 23.6% had osteoarthritis, 0.9% rheumatoid arthritis, and 2.7% 'other' arthritis. There was no difference in the prevalence of diagnosed arthritis among male and female patients.

Of the 816 arthritis patients, 807 reported NSAID status. Over 40% of these (43.9%, 95% CI: 39.4–48.3) used an NSAID for arthritis during the previous 12 months. The most commonly used were celecoxib (27.5%), meloxicam (23.8%) and diclofenac (20.3%).

The median reported prescribed daily dose (PDD) for celecoxib was 200 mg and for meloxicam was 15 mg. The mean duration of NSAID use was 20.8 weeks. Almost a third of patients (28.3%) were taking the NSAID medication continually rather than intermittently.

Of the 354 arthritis patients on NSAID during the previous year, 347 answered the question about dyspepsia. Of these, 156 (45.0%, 95% CI: 38.7–51.3) had dyspepsia over that 12 month period. However, the dyspepsia and the taking of NSAIDs were only linked in time for 73.3% of these patients. The rates of dyspepsia did not differ between arthritis patients taking Cox-2 inhibitors, meloxicam and other non-selective NSAIDs.

Of the 156 arthritis patients on NSAIDs with dyspepsia, 154 responded to the question on medication taken for the dyspepsia. More than four in five (81.8%) of these patients were taking a medication for dyspepsia, the most common being omeprazole, esomeprazole and pantoprazole. The median PDD for omeprazole and esomeprazole was 20.0 mg. The mean duration of dyspepsia medication use was 31.2 weeks. Two-thirds (65.6%) of patients on dyspepsia medication were taking the medication continually.

Only 26 arthritis patients on NSAIDs (representing 8.0% of the 326 respondents to this question, 95% CI: 4.6–11.4) had anaemia during the previous 12 months. Half of these were taking a medication for anaemia, the most common ferrous sulphate + folic acid (n=6). Of all 354 arthritis patients on NSAIDs, 13.3% had another chronic disease which may cause anaemia, 10.5% having a hiatus hernia, 0.9% being vegetarian and 0.3% pregnant.

For other related abstracts see: 29 Non-steroidal anti-inflammatory drugs (NSAIDS) and acid suppressant use, 49 Health status and management of patients on non-steroidal anti-inflammatory drugs, 78 NSAID & acid suppressant use 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 **PATIENTS with ARTHRITIS.**

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 arthritis status

Please indicate by ticking the appropriate box whether this patient has **osteoarthritis**, **rheumatoid arthritis** or **arthritis** (unspecified).

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

Current NSAID medication

Please indicate whether the patient has taken a **Non-steroidal anti-inflammatory drug (NSAID)** in the **past 12 months** (eg. Celebrex, Mobic or any non-selective NSAID) **for any type of ARTHRITIS.**

If 'Yes' please write the **name**, **regimen** and **duration of use** of the NSAID **currently** or **most recently** taken. Please advise whether the medication was **taken intermittently or continuously.**

Dyspepsia and/or Anaemia

Please advise whether the patient experienced any episodes of **dyspepsia** and/or **anaemia** (confirmed on a blood test as a haemaglobin level below the lower limit of normal) in the last 12 months.

If **YES** please advise whether the dyspepsia and/or anaemia **occured during treatment** with the current / most recent NSAID.

Medication for dyspepsia and / or anaemia

Please write the **name, regimen and duration of use** of any **medication** taken by the patient for treatment of **dyspepsia or anaemia**, either currently, or for the management of their most recent episode. Please advise whether the medication was **taken intermittently or continuously.**

If **no** medication is/was used for dyspepsia or anaemia, please **tick the box labelled 'none'** in the **relevant section**.

Other patient conditions

Please use the tick boxes to advise whether the patient has either of the **listed conditions**, whether the patient is currently a **vegetarian**, or currently **pregnant**.

Does this patient have:

- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Other arthritis
- ☐ None of the above → **end questions**

BL74B

If 'Yes' has this patient used a NSAID for arthritis in the last 12 months?

☐ YES ☐ NO

Current/most recent NSAID in the past 12 mths:

Name & Form	Strength	Dose	Frequency	Duration
				___wks

Taken ☐continually **or** ☐intermittently **over 12 mths?**

During the last 12 mths has this patient had:

Dyspepsia?
☐ Yes → During NSAID use? ☐ Yes ☐ No
☐ No

Anaemia?
☐ Yes → During NSAID use? ☐ Yes ☐ No
☐ No

Dyspepsia medication taken (if any): ☐ NONE

Name & Form	Strength	Dose	Frequency	Duration
				___wks

Taken ☐continually **or** ☐intermittently **over 12 mths?**

Anaemia medication taken (if any): ☐ NONE

Name & Form	Strength	Dose	Frequency	Duration
				___wks

Taken ☐continually **or** ☐intermittently **over 12 mths?**

Does the patient have:.

- ☐ Other chronic disease that may cause anaemia?
- ☐ Hiatus hernia?

Is the patient currently:

- ☐ Vegetarian?
- ☐ Pregnant?

89 Estimates of the prevalence of chronic illnesses identified as Health Priority Areas among patients attending general practice

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

Issues: The prevalence among patients attending general practice, of chronic conditions that require ongoing management by their GP, in particular those health problems identified as National Health Priority Areas.

Sample: 9,156 respondents from 305 GPs; data collected from 12/07/2005 – 19/09/2005 and 25/10/2005 – 28/11/2005.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to the distribution for all BEACH encounters, with the majority of patients being female (60.7%).

The crude sample morbidity rates showed that of the 9,156 patients sampled approximately 30% had a diagnosed cardiovascular problem, of which ischaemic heart disease was the most common (9.5%). Eighteen per cent of respondents had uncomplicated hypertension. One in five had osteoarthritis (20.0%) and one in ten had asthma (10.7%, 95% CI: 9.8–11.6). Psychological problems were common (24.7%), with depression recorded for 14.2% of respondents and anxiety for 10.7%. Diabetes was reported for 8.3%, the majority being type 2 diabetes (7.2%).

The crude sample morbidity rates were adjusted for visit frequency related to age and sex, by weighting the SAND sample against the age-sex distribution of the population of Australians who visited a GP at least once in the 12 months from April 2004 to March 2005 (MBS unpublished data). This method adjusted the estimates for any over-representation related to age and sex. The adjusted rates may give a better estimate of the prevalence of selected morbidity among all patients attending general practice in a 12 month period, with less bias towards those who attend more frequently. Crude rates on the other hand can be interpreted as prevalence rates among patients found in the GP's waiting room at any one time.

The estimated prevalence after adjustment was generally lower than the crude sample rates. In particular cardiovascular disease (21.8%), arthritis (16.4%) and diabetes (6.5%), which are related to older age, were significantly less prevalent after adjustment. The estimated prevalence of asthma (10.6%) and psychological problems (21.8%) were largely unaffected by adjustment.

These adjusted rates are likely to be more accurate (as the diagnosis is made by a GP), than other studies relying on self-reported morbidity (such as the National Health Survey). The results were consistent across multiple subsamples suggesting reliability of method. The prevalence of important chronic conditions in the general practice population can be estimated relatively reliably and economically by using an existing study that regularly samples general practice patients across Australia and by adjusting for the effect of visit frequency bias in the sample.

For other related abstracts see: 37 Prevalence of common morbidities in patients encountered in general practice, 61 Prevalence of chronic illnesses identified as National Health Priority Areas among 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 **CO-MORBIDITY AND CHRONIC 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.

Co-morbidity and chronic disease

The aim of these questions is to determine the prevalence of **co-morbidity** and some of the **chronic illnesses** or **conditions** in the **National Goals and Targets** priority areas.

Most of the conditions listed below require continual management or surveillance and may need consideration in future care.

Please use the tick boxes to indicate whether the patient has any of the listed conditions even if you have already managed one of these problems today. Tick as many as apply.

If the patient **does not** have any of these conditions or problems, please tick the box marked **'none of these conditions'**.

Does this patient have any of the following conditions which require ongoing management?
(tick as many as apply, even if you have managed the problem today)

Cardiovascular disease
- ☐ Ischaemic heart disease
- ☐ Cerebrovascular disease
- ☐ Peripheral vascular disease
- ☐ Congestive Heart Failure
- ☐ Hypertension - complicated
- ☐ Hypertension - uncomplicated
- ☐ Other cardiovascular problem

Psychological problems
- ☐ Depression
- ☐ Anxiety
- ☐ Insomnia
- ☐ Other psych problem

Respiratory problems
- ☐ Asthma - Mild
- ☐ Asthma - Moderate
- ☐ Asthma - Severe
- ☐ Chronic Obstructive Airways Disease

Arthritis
- ☐ Osteoarthritis
- ☐ Rheumatoid
- ☐ Other arthritis

Diabetes
- ☐ Type 1
- ☐ Type 2
- ☐ Other

- ☐ Hyperlipidaemia
- ☐ Chronic back pain
- ☐ Malignant neoplasm
- ☐ Gastro-oesophageal Reflux disease

☐ NONE OF THESE CONDITIONS

BL75C

90 Prevalence, management and investigations for chronic heart failure in general practice patients

Organisation supporting this study: Roche Products Pty Ltd

Issues: The proportion of general practice patients with chronic heart failure (CHF); its severity and management; who initiated therapy; objectives of management; proportion referred to a specialist; investigations ordered to diagnose CHF.

Sample: 2,859 encounters from 98 GPs; data collection period: 16/08/2005 – 19/09/2005.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to the distribution for all BEACH encounters, with the majority (57.8%) of patients being female.

The prevalence of chronic heart failure (CHF) in this general practice patient sample was 4.1% (95% CI: 2.8–5.3). In male patients, 4.7% were diagnosed with CHF compared with 3.6% of female patients. Patients aged 75+ had the highest age-specific rates, with 19.8% diagnosed with CHF. CHF was classified as mild in 50.0% of these 116 patients, moderate in 28.5% and severe in 21.6%.

Medication data were provided for 112 of the CHF patients. Medications most commonly used for the management of CHF were diuretics (33.6% of all listed medications), followed by anti-hypertensives (31.0%), beta-blockers (13.7%) and cardiac glycosides (8.0%). The diuretic commonly used was frusemide (median reported prescribed daily dose (PDD) 40 mg). The most common anti-hypertensive medications were perindopril (median PDD 4 mg), ramipril (median PDD 5 mg) and irbesartan (median PDD 300 mg), and the beta-blocker commonly used was carvedilol (median PDD 25 mg). Digoxin had a median PDD of 0.125 mg. Sixteen (66.7%) of the 24 patients with severe CHF were on three or more CHF medications, while only 8 (4.3%) of the 56 patients with mild CHF were on three or more CHF medications.

Pharmacological treatment was initiated by a GP (47.1% of CHF medications) or by a specialist (52.9%) at similar rates.

GPs considered the factors of 'symptom management' and 'quality of life' significantly more important than 'increased survival' as an objective of management.

The majority (80.2%) of patients diagnosed with CHF had been referred to a cardiac specialist; 38.7% were initially referred more than 3 years ago; 21.7% were referred between 1 to 3 years ago; and 19.8% were referred during the previous 12 months.

Multiple investigations could be reported as being used in diagnosing CHF. Chest X-ray was used to diagnose CHF in 72.3% of cases, echocardiography was used in 63.4% of cases and ECG in 58.9% of cases. GPs ordered 64.9% of chest X-rays, 13.4% of echocardiography and 59.3% of ECGs, with cardiac specialists ordering the rest.

For other related abstracts see: 31 Prevalence and severity of chronic heart failure, 38 Prevalence of chronic heart failure, its management and control, 57 Prevalence and management of chronic heart failure in general practice patients, 75 Prevalence, management and investigations for chronic heart failure, 77 Heart failure-underlying causes and medication management.

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

INSTRUCTIONS

Chronic Heart Failure (CHF)

Please indicate by ticking the appropriate box whether this patient has **Chronic Heart Failure (CHF)** at either a **mild, moderate** or **severe** level.

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

Main treatment objective

Please indicate your **main objective** in this patient's management, **ranking the options** in order of importance from 1 to 3, where **3** is the **least important.**

CHF management

If **'YES'** please write in the **name and form** of any **medications** currently being used to treat this patient's CHF. Please indicate the regimen (i.e. **strength, dose and frequency**) of the medication and circle an option to advise whether this treatment was initiated by a GP or Specialist.

Please also list any **non-pharmacological management** e.g cardiac rehabilitation, physiotherapy etc.

Referral

If this patient has been referred to a **cardiac specialist** for management, please indicate **when they were initially referred.**

Clinical investigations

Please advise using the tick boxes what **clinical investigations** were used in **diagnosing** this patient's CHF. If tests other than ECG, ECHO or Chest X-ray (e.g angiogram, FBC, blood chemistry, thyroid function tests etc) were used, please list in 'other'.

Please indicate by circling an option **who ordered each test.** e.g. GP or specialist.

Does this patient have Chronic Heart Failure (CHF)?

Yes - mild ☐
- moderate ☐
- severe ☐

No - ☐ → END

BL75B

If 'Yes' what management is currently being used?

Name & Form	Strength	Dose	Freq	Initiated by
1.				GP/spec
2.				GP/spec
3.				GP/spec
4. Other				GP/spec

What is most important in managing this patient's CHF?
(please circle a number for each option, ranking 1-3 where 3 is least important)

Increase survival	1	2	3
Relieve symptoms	1	2	3
Improve quality of life	1	2	3

This patient was initially referred to a cardiac specialist

- ☐ <12 months ago
- ☐ 1-3 years ago
- ☐ > 3 years ago
- ☐ never referred

What clinical investigations were used to diagnose the CHF?

test	ordered by
☐ ECG	GP / spec
☐ ECHO	GP / spec
☐ Chest X-Ray	GP / spec
☐ Other _____	GP / spec

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:**
BL76B ☐ No → **end**	☐ < once per week ☐ once per week ☐ several times/wk ☐ daily ☐ mild ☐ moderate ☐ severe	☐ < once per week ☐ once per week ☐ several times/wk ☐ daily ☐ mild ☐ moderate ☐ severe	☐ < once per week ☐ once per week ☐ several times/wk ☐ daily ☐ mild ☐ moderate ☐ severe	☐ < once per week ☐ once per week ☐ several times/wk ☐ daily ☐ mild ☐ moderate ☐ severe	☐ disrupted sleeping ☐ feel unwell/worn out ☐ difficulty with work and/or daily activities ☐ difficulty socialising ☐ diet restrictions ☐ none of the above	☐ unknown ☐ GORD ☐ peptic ulcer ☐ NSAID use ☐ diet/ lifestyle ☐ other *(please specify)* _____	☐ no treatment ☐ PPI_____ ☐ H2RA *(please specify)* ☐ Antacid ☐ Remove cause (eg stop NSAID) ☐ other *(please specify)* _____	☐ well controlled ☐ partly controlled ☐ poorly controlled

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 **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.

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 ≥ 85 cm (males) or ≥ 75 cm (females)?	* If 'Yes' does the patient also have any of the following:-	Yes	No	Don't know/ never tested
☐ Yes = _____ cms ☐ No → end questions BL76C	Raised **Triglycerides** ≥150 mg/dL (1.7 mmol/L) **or specific treatment for this lipid abnormality**	☐	☐	☐
	Raised **blood pressure** ≥130/≥85 mmHg **or treatment of previously diagnosed hypertension**	☐	☐	☐
	Raised **fasting plasma glucose** ≥100 mg/dL (5.6 mmol/L) **or previously diagnosed type 2 diabetes**	☐	☐	☐
	(Males) Reduced **HDL cholesterol** <40 mg/dL (1.03 mmol/L) **or specific treatment for this lipid abnormality**	☐	☐	☐
	(Females) Reduced **HDL cholesterol** <50 mg/dL (1.29 mmol/L) **or specific treatment for this lipid abnormality**	☐	☐	☐

*** This patient's continent of origin was:-**

- ☐ Europe/UK/North America/Australia
- ☐ South Asia/Pacific region
- ☐ China
- ☐ Japan
- ☐ South or Central America
- ☐ Sub-Saharan Africa
- ☐ 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

***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:	☐ OTC products	☐ ☐
☐ Never → end questions	☐ 2-10 years	☐ 1-25% of occasions	☐ Partner ☐ Relative ☐ Friend ☐ Other *(Please specify)*	☐ Physical eg >1 condom	☐ ☐
BL79B	☐ >10 years	☐ 26-50% of occasions	☐ Pharmacist ☐ GP ☐ Counsellor ☐ Other health professional *(Please specify)*	☐ Behavioural	☐ ☐
		☐ 51-75% of occasions		☐ Alcohol / drugs	☐ ☐
		☐ 76-100% of occasions		☐ Herbal remedy	☐ ☐
				☐ 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.

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.

Patient's HbA1C level

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

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's blood pressure

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

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 ACE inhibitor use

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

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?	If 'Yes' what was their most recent HbA1C level?	The patient's most recent HbA1C test was approximately	The patient's blood pressure level today is:	Is the patient currently taking:	Is the patient currently taking an ACE inhibitor?	Does the patient have:
☐ Yes ☐ No → **end questions**	_____ %	_____ **wks/mths ago.** *(Please circle)*	____ /____ **mmHg**	☐ Aspirin (prescribed)? ☐ Aspirin (OTC)? ☐ Clopidogrel? ☐ None of the above	☐ Yes ☐ No	☐ Ischaemic heart disease? ☐ Cerebrovascular disease? ☐ Peripheral vascular disease? ☐ Microalbuminuria/proteinuria? ☐ None of the above

BL79C

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

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, Italian
- ☐ Yes, Greek
- ☐ Yes, Cantonese
- ☐ Yes, Mandarin
- ☐ Yes, Arabic
- ☐ Yes, Vietnamese
- ☐ Yes, other (please specify) _____

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 **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.

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

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.

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.**

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.

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.

Does this patient have?	Is this patient currently taking/ commencing a statin?	Has this patient achieved NHF target for lipid levels? *(see definition)*	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 ☐ Coronary heart disease ☐ Familial hyperlipidaemia ☐ Diabetes mellitus ☐ Cerebrovascular disease ☐ Peripheral vasc. disease ☐ None of the above → End questions BL81B	☐ No → **End questions** ☐ Yes - initiated today ☐ Yes - prescribed previously *(Please specify)* ***Name & Form*** ***Strength*** ***Dose*** ***Freq*** _____ _____ _____ _____	☐ Yes → **End questions** ☐ No	☐ Yes → **End questions** ☐ No	☐ Intolerance of higher dose ☐ Higher dose is contraindicated ☐ Patient does not want increased dose ☐ Patient is taking maximum dose ☐ Increased dose did not/is unlikely to achieve further lipid lowering ☐ Other *(Please specify)*_____	☐ Maintain current statin ☐ Change statin ☐ Add an additional lipid lowering medication ☐ Discontinue statin and use an alternate lipid lowering medication

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

- **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.				
2.				

☐ No hypertension medication

What medication is currently being taken for ANGINA?

	Name & Form	Strength	Dose	Freq
3.				
4.				

☐ No angina medication

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?

- ☐ Existing CHD *(tick as many as apply)*
- ☐ 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 med'n is- ☐ None

Name **Dose** **Duration of use**

_____

_____

Previous lipid med'n 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 dyslipidaemia managed by a specialist?

- ☐ Yes - _____ *(please specify type of specialist)*
- Because of _____
- ☐ No

BL83B

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)*

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)*

- ☐ Yes - currently
- ☐ Yes - over the last 12 months
- ☐ Yes - in the past, now resolved
- ☐ No → **End questions**

BL83C

If 'Yes' symptoms typically were experienced:

- Day / night / both *(please circle)*
- 1° Symptom * = 1 2 3 4 *(see definition on card)* *(please circle)*
- Duration _____ *(hours)*
- Frequency** = 1 2 3 4 *(see definition on card)* *(please circle)*

How severe♣ are/were the symptoms? *(see definition on card)*

- ☐ mild
- ☐ moderate
- ☐ severe
- ☐ very severe

How long were episodes experienced/ since episodes began?

_____
weeks / mths / yrs
(please circle)

Has the patient sought treatment?

- ☐ No → **End questions**
- ☐ Yes, **please specify** *(tick all that apply)*
  - ☐ Self-medication - supermarket
  - ☐ Self-medication - pharmacy
  - ☐ Pharmacist/OTC medication
  - ☐ GP
  - ☐ Specialist
  - ☐ Emergency department

If treatment was sought, describe management:

Diagnosis *(please specify)* _____
Investigation *(please specify)* _____
Referral *(please specify)* _____
Medication *(please specify)*

Name & Form	Strength	Dose	Freq

☐ Unknown ☐ Advice only

***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.

101 Types of medicine use and patient use of medicines list

Organisation supporting this study: National Prescribing Service

Issues: To determine: the proportion of general practice patients who regularly take medicine and the type(s) of medicines they take; the types of medicines recorded in the patient's medical record; the use of Medicines Lists in general practice patients who regularly take medicines; the types of medicines included in the Medicines List.

Sample: 5,528 encounters with 187 GPs; data collection period: 11/07/2006 – 18/09/2006

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age distribution of respondents differed a little from the average for BEACH, with fewer patients aged 25–44 years and more aged 75+ at these encounters; sex distribution was similar to BEACH (general practice) encounters, the majority (55.7%) being female.

At the 5,528 patient encounters, GPs indicated that 3,829 (69.3%; 95% CI: 66.5–72.0) patients regularly took at least one of the medicine types listed. Of these, 3,767 specified whether they had as Medicines list, and 31.0% (95% CI: 27.3–34.6) stated they did.

Prescription medications

Overall, 3,493 (63.2%, 95% CI: 60.3–66.1) regularly took prescription medicines and these were said to be recorded in the medical records for 3,415 (98.4%) of 3,470 respondents. Of 3,453 respondents 1,128 (32.7%) had a medicines list. The prescribed medications were said to be on the medicines list by 1,080 (99.7%) of 1,084 patients responding to this question.

Non-prescription medications

Overall, 790 (14.3%, 95% CI: 12.1–16.5) regularly took non-prescription medicines and these medications were said to be in the medical records for 354 (45.3%) of 781 respondents.

A medicines list was held by 234 (30.4) of 771 respondents and the non-prescription medications on the medicines list was confirmed by 148 (65.2%, 95% CI: 56.7–73.7) of 227 respondents to this question

Herbal/natural medicines

Overall, 495 (9.0%, 95% CI: 7.5–10.4) regularly took herbal/natural medicines. For 88 (18.0%) of 488 respondents the herbal/natural medications were in the medical records.

Of 487 respondents 147 (30.2) had a medicines list and the herbal/natural medications was on the medicines list of 72 (51.8%) of 139 respondents

Vitamins/minerals

Overall, 874 (15.8%, 95% CI: 13.4–18.2) regularly took vitamins/minerals and the presence of these vitamins/minerals in the medical record was confirmed for 195 (22.7%) of 861 patients responding to this question.

Of 856 respondents using vitamins/minerals who responded to the medicines list question, 253 (29.6, 95% CI: 23.7–35.4) had a medicines list. The presence of the vitamins/minerals on this list was confirmed by 149 of 240 respondents to this question (62.1%, 95% CI: 52.2–72.0).

For other related abstracts see: 36 Patient use of complimentary therapies.

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 **TYPES OF MEDICINES AND PATIENT USE OF MEDICINES LIST.**
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.

Definitions

Prescription medicines: require a prescription

***Non-prescription medicines:** any tablets, syrups, ointments, inhalers or drops that can be bought over the counter at a chemist, health food or grocery store without a prescription. This category excludes herbal and other natural medicines, and vitamins and minerals.

***Herbal and other natural medicines:** includes herbal products, homeopathic remedies and traditional medicines.

***Vitamins and minerals:** any type of vitamin or mineral available without a prescription.

* These medicines can be self-prescribed or recommended by a health professional, alternative health practitioner or other person. They can be used in place of or in addition to prescription medicines

Regular use of medicines: medicines taken on an ongoing basis or taken for short term treatment of a specific problem.

Medicines List: a document or card where details of the medicines (e.g. name, dose taken, frequency of use, reason for medicine, date of commencement) taken by the patient are recorded. Medicines Lists are carried by patients and provided to health professionals (e.g. GPs, pharmacists) involved in their management.

Types of medicines

Please indicate by ticking the appropriate box/es whether this patient **regularly** takes any of the **listed types of medicines**. *(See definitions)*

Tick as many as apply.

If the patient does not take any medicines **please end the questions** here.

Medicines recorded in the medical record

Please indicate by ticking the appropriate box/es which **types of medicines** are **recorded in the patient's medical record**. *(See definitions)*

Tick as many as apply.

Medicines List

Please advise if the patient keeps a **list of the medicines** they take regularly. *(See definitions)*

If **'no'** or **'unsure'** please **end the questions** here.

Medicines included in the Medicines List

If the patient has a Medicines List, either from you or from another source, please advise the **types of medicines included in the list.**

Does the patient regularly take any of the following? *(tick all that apply)*

- ☐ Prescription medicines
- ☐ Non-prescription medicines
- ☐ Herbal and/or other natural medicines
- ☐ Vitamins and/or minerals
- ☐ None → **End questions**

BL84B

What medicines are recorded in the patient's medical record? *(tick all that apply)*

- ☐ Prescription medicines
- ☐ Non-prescription medicines
- ☐ Herbal and/or other natural medicines
- ☐ Vitamins and/or minerals
- ☐ None

Does the patient keep a list of any of the medicines they take regularly?

- ☐ Yes
- ☐ No → **End questions**
- ☐ Unsure → **End questions**

Which of the following are included in the patient's Medicines List? *(tick all that apply)*

- ☐ Prescription medicines
- ☐ Non-prescription medicines
- ☐ Herbal and/or other natural medicines
- ☐ Vitamins and/or minerals

102 Alzheimer's disease or dementia in patients attending general practice

Organisation supporting this study: Pfizer Australia

Issues: The proportion of general practice patients with diagnosed or suspected Alzheimer's disease or dementia; the proportion of these patients who have had cognitive assessments; the provider who performed these assessments; severity of diagnosed Alzheimer's disease; medications prescribed for diagnosed Alzheimer's disease.

Sample: 2,863 respondents from 99 GPs; data collection period: 15/08/2006 – 18/09/2006.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The sex distribution of patients was similar to the distribution for all respondents, with 55.4% of the patients being female. There were a significantly larger proportion of patients aged 75 years or more at these encounters (19.2%, 95% CI: 15.9–22.5) than at overall BEACH encounters in 2004–05 (13.9%, 95% CI: 13.1–14.7), and significantly fewer aged 25–44 years.

At least one of the listed conditions was indicated for 119 patients, with an overall prevalence of 4.2%. Prevalence increased with age from 1.3% among 45–64 year olds to 17.1% in those aged 75 years and over. The prevalence of diagnosed Alzheimer's disease was 1.3%, while suspected Alzheimer's disease had a prevalence of 1.3%, diagnosed dementia 1.1% and suspected dementia 1.4%. One patient had been diagnosed with both Alzheimer's disease and dementia.

Of the 37 patients with diagnosed Alzheimer's disease, GPs answered the question on cognitive assessment using the Alzheimer's disease Assessment Scale Cognitive Test (ADAS-Cog) for 17 patients, of whom six had been assessed, all by specialists. None of the patients with suspected Alzheimer's disease has been assessed using the ADAS-Cog. Information about assessment using the ADAS-Cog for patients with either diagnosed or suspected dementia was provided for 39 of the 67 patients with these conditions. Seven patients had been assessed, four by a specialist, two by a GP and one by another health provider.

Severity of diagnosed Alzheimer's disease was provided for 34 patients. Of these, 38.2% were regarded as having severe Alzheimer's disease, while 41.1% had a moderate level of severity.

Of patients on current medication for Alzheimer's disease (*n*=14), details were provided for 13 patients. Donepezil hydrochloride was the most common medication, taken by 9 patients, 3 patients were taking galantamine hydrobromide and one patient was taking olanzapine. Of the six patients who had changed medication, reasons for this change were listed for 5 patients. Lack of efficacy was the reason for change for two patients and two patients changed due to side effects.

For other related abstracts see: 28 Prevalence of Alzheimer's disease and dementia.

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 ALZHEIMER'S DISEASE OR DEMENTIA.**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

Answer the following questions for **ALL** of the **next 30 PATIENTS**
in the order in which the patients are seen.
Please **DO NOT select patients** to suit the topic being investigated.

Alzheimer's disease or dementia

Please indicate by ticking the appropriate box/es whether this patient has **diagnosed Alzheimer's disease or dementia, or suspected (i.e. early signs of) Alzheimer's disease or dementia.** Tick as many as apply.

If the patient does not have diagnosed or suspected Alzheimer's disease or dementia **please end the questions** here.

Diagnostic cognitive assessment

Please advise whether the patient has been assessed using the **Alzheimer's Disease Assessment Scale cognitive subscale (ADAS-Cog)**, the **Mini-Mental State Examination (MMSE)** and/or **other cognitive assessments**. If yes please indicate:

- **who performed the test** - a GP, specialist or other health provider (tick appropriate box)

For **other cognitive assessments** please indicate the **name of the assessment tool** used.

Future management plan

For patients who **have not had an ADAS-Cog or a MMSE** please select **one option** that best describes your **future management plan** for this patient.

Medications prescribed for Alzheimer's disease

Please indicate if the patient is currently taking a **prescribed medication for Alzheimer's disease**. Please specify the **name of the current medication**.
If the patient has changed medications or is no longer currently taking a previously prescribed medication **please indicate the name of the previous medication** and the **reason for change or cessation**.
If the patient has never had a medication prescribed for Alzheimer's disease, please tick the box labelled '**no medication ever prescribed**'.

Severity of Alzheimer's disease

For **patients with diagnosed Alzheimer's disease** please advise the **level of severity** of disease for this patient as determined by cognitive assessment and your clinical opinion.

Does the patient have? *(tick all that apply)*
- ☐ Diagnosed Alzheimer's
- ☐ Suspected Alzheimer's
- ☐ Diagnosed dementia
- ☐ Suspected dementia
- ☐ None of the above → **End questions**

Has the patient had cognitive assessment using:

- **ADAS-Cog** *(see definition)*
  - ☐ Yes - done by
    - ☐ GP
    - ☐ Specialist
    - ☐ Other
  - ☐ No
  - ☐ Don't know
- **MMSE** *(see definition)*
  - ☐ Yes - done by
    - ☐ GP
    - ☐ Specialist
    - ☐ Other
  - ☐ No
  - ☐ Don't know
- **Other cognitive assessment**
  - ☐ Yes - _____ *(please specify assessment)*
    - done by ☐ GP ☐ Specialist ☐ Other
  - ☐ No
  - ☐ Don't know

Future management plan for patients who have not had an ADAS-Cog or a MMSE is: *(tick only one)*
- ☐ Patient is awaiting specialist appt.
- ☐ Referral to specialist for assessment
- ☐ I plan to perform assessment
- ☐ Currently no plan to assess
- ☐ Other _____ *(please specify)*

For those with diagnosed Alzheimer's disease:

- **Severity:** *(see definition)*
  - ☐ mild
  - ☐ moderate
  - ☐ severe
  - ☐ unsure

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- **Alzheimer's meds:** *(please specify)*
  - ☐ Current med_____
  - ☐ Previous med_____
    - Reason for medication change:
      - ☐ lack of efficacy
      - ☐ side effects
      - ☐ other_____ *(please specify)*
  - ☐ No medication ever prescribed

103 Cardiovascular risk in patients attending general practice

Organisations supporting this study: The Australian General Practice Statistics & Classification Centre on behalf of The George Institute.

Issues: Smoking status of patients attending general practice aged 18 years or older; proportion who have an existing cardiovascular disease (CVD)/risk factors for CVD; medications taken for management of existing CVD/risk factors for CVD (statins, antiplatelet therapy, ACE inhibitors, angiotensin receptor blockers, beta blockers, other antihypertensives); blood pressure (BP), serum creatinine, and cholesterol levels, and the proportion of these that are unknown.

Sample: 2,618 adult respondents (18 years and over) from 99 GPs; data collection period: 19/09/2006–23/10/2006.

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 were similar to all adult BEACH encounters for the 2005–06 data collection period, with 60.3% of patients being female.

Smoking status: Data on patient smoking status was available for 2,583 patients. About one in six (16.8%) patients were current smokers, 4.0% had quit within the last 12 months, and 22.6% had quit >12 months ago. Smoking was defined as a cardiovascular risk factor for current smokers and smokers who quit less than 12 months ago. Therefore, 20.8% of patients had a cardiovascular risk factor related to their smoking status.

Existing CVD/risk factors: Of 2,615 adult patients whom CVD/risk factor status could be determined, 1,614 (61.7%, 95% CI: 58.6–64.8) had at least one of eight risk factors. Prevalence of at least one CVD/risk factor was similar for males and females (65.9% c.f. 59.0%), but significantly different by age, increasing from 42.7% for ages 18–24 to 75.0% for 75+.

Prescribed medications for CVD/risk factors: Of 2,553 respondents, 1,006 (39.4%) were currently taking at least one of six listed medications (statins 20.4%, antiplatelet therapy 18.1%, ACE inhibitors 17.6%, angiotensin receptor blockers 11.6%, beta blockers 10.8%, other antihypertensives 14.4%). Males were significantly more likely to be taking a medication (45.0%) than females (35.8%). Likelihood increased significantly from 1.3% of those aged 18–24 to 80.5% of those aged 75+.

Measured BP & serum creatinine: BP was not known for 11.0% of adult patients. Of the 2,282 patients for whom BP was known, 514 (22.5%) had normal BP, 1,142 (50.0%) had high-normal BP, and 10.0% had high BP.

Measured total and HDL cholesterol & triglycerides: Of 2,552 respondents to the total cholesterol question, 2,457 to HDL question and 2,534 to the triglycerides question, levels were not known/never tested for 38.6%, 53.2% and 41.8% respectively. For those with test results supplied, mean total cholesterol level (n=1,568) was 5.07 mmol/L (95% CI: 5.00–5.13), mean HDL cholesterol (n=1,151) was 1.53 mmol/L (95% CI: 1.49–1.57) and the mean triglycerides (n=2,534) was 1.56 mmol/L (95% CI: 1.50–1.63).

For other related abstracts see: 20 Screening and management of blood cholesterol, 33 Prevalence and management of cardiovascular risk factors, 46 Coronary heart disease, risk factors and lipid lowering medication, 97 Statin medication use among high CHD risk patients attending general practice, 103 Cardiovascular risk 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 **CARDIOVASCULAR RISK FOR PATIENTS.**

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

INSTRUCTIONS

These questions investigate the **whole cardiovascular risk** for **patients aged 18 years or more**. For the **next 30 PATIENTS,** ask every adult (18+) the following questions. If the patient is less than 18 years of age leave the questions blank. Please **DO NOT select patients** according to their age or to suit the topic being investigated.

ASK THE PATIENT

If this patient is 18 years of age or older please ask which category best describes their **smoking status**.

Current therapy

Please indicate whether, this patient is currently taking **statins**, **antiplatelet therapy**, **ACE inhibitors**, **Angiotensin receptor blockers**, **Beta blockers** or **other antihypertensives**.

Cholesterol levels

Please advise, **at the time of most recent testing**, the patient's levels of -

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

If you do not know the patient's cholesterol levels or this patient has never been tested tick '**don't know**'.

Please indicate **when the most recent tests were performed** (i.e.<12 months ago or >12 months ago) for each of the TC, HDLC and TG levels.

Existing cardiovascular disease and risk factors

Please use the tick boxes to indicate whether this patient has any of the listed diseases or risk factors (**overweight** = BMI>25; **obesity** = BMI>30; **family history of premature heart disease** = a mother or sister younger than 55 years, or a father or brother younger than 65 years when diagnosed with heart disease; **proteinuria** includes microalbuminuria, albuminuria and proteinuria).

Blood pressure / Serum creatinine

Please advise the patients **most recent blood pressure (BP) reading**.
If you do not know the patients blood pressure please tick 'don't know'.

Please also indicate this patient's **most recent serum creatinine level**. If never tested or unknown please tick 'don't know'.
(Please use micromole/L - µmol/L)

For patients aged 18+ years:

Which best describes your smoking status?

- Current smoker ☐
- Quit <12 months ago ☐
- Quit >12 months ago ☐
- Never smoked ☐

Does the patient have: (tick all that apply)	Yes	No	Don't know
Coronary heart disease	☐	☐	☐
Cerebrovascular disease	☐	☐	☐
Peripheral vascular disease	☐	☐	☐
Overweight/obesity	☐	☐	☐
Family History of heart disease	☐	☐	☐
Proteinuria	☐	☐	☐
Diabetes	☐	☐	☐

Is this patient currently taking:	Yes	No
Statins	☐	☐
Antiplatelet therapy	☐	☐
ACE Inhibitors	☐	☐
Angiotensin receptor blockers	☐	☐
Beta blockers	☐	☐
Other antihypertensives	☐	☐

What was this patient's most recent BP reading?

_____ / _____ mmHg

☐ Don't know

What was the most recent serum creatinine level?

_____ µmol/L

☐ Don't know

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What were the most recent levels of:	Don't know
Total Cholesterol _____ mmol/L	☐
HDL Cholesterol _____ mmol/L	☐
Triglycerides _____ mmol/L	☐

Most recent tests were: **Don't know**

<12 mths ago for - ☐ TC ☐ HDLC ☐ TG ☐

>12 mths ago for - ☐ TC ☐ HDLC ☐ TG ☐

104 Asthma management and medication use among patients attending general practice

Organisation supporting this study: AstraZeneca Pty Ltd

Issues: The proportion of general practice patients with asthma; frequency of asthma management by a GP; frequency of asthma medication alterations; inhaled corticosteroid (ICS) use by patients with asthma; short acting beta agonist use by patients with asthma.

Sample: 2,862 respondents from 97 GPs; data collection period: 19/09/2006 – 23/10/2006.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age and sex distributions of respondents were similar to the distribution for all BEACH (general practice) encounters, with the majority (60.3%) of patients being female.

Of the 2,862 respondents, 442 patients (15.4%; 95% CI: 13.6–17.3) had been diagnosed with asthma. Prevalence was highest among patients aged 15–24 years (22.0%; 95% CI: 16.8–27.1), followed by those aged 5–14 yrs (16.1%, 95% CI: 8.8–23.5), and lowest in patients aged 1–4 years (11.4%; 95% CI: 5.0–17.8). There was no difference in the prevalence of diagnosed asthma among male (15.3%) and female (15.5%) patients.

Of the 442 asthma patients, 421 responded about the number of GP visits in the previous 12 months. In that time, 34 patients (8.1%) had not visited a GP prior to the current visit, 111 (26.4%) had visited 2–4 times, and 71 patients (16.9%) had visited a GP more than 15 times. At these visits, 246 patients had had asthma managed—102 (24.3%) had asthma managed once, and 95 (22.6%) had asthma managed at 2–3 visits. A further 174 (41.3% of the 421 respondents) had not had asthma managed in the previous 12 months. Of these respondents, 168 provided details of when their asthma was last managed. For 72.6% of these, it had been more than 2 years. Approximately half (48.6%) of the 246 patients with asthma managed in the previous 12 months had not had their asthma medication altered during that time, 33.5% had medication altered once, and 13.9% had medication altered two or three times.

Of the 414 asthma patients who provided responses about asthma medication, 225 (54.3%) used an ICS and 189 (45.7%) did not. More than one third (36.2%) of ICS users took an ICS daily. Details of generic medication were available for 213 patients. Fluticasone/salmeterol in combination was used by 43.7%, budesonide by 19.3%, fluticasone by 16.0% and the budesonide/eformoterol combination was used by 14.1% of patients. The median daily dose reported for the most frequently recorded ICS, fluticasone/salmeterol, was 1,100 mcg.

Of the 442 patients who had been diagnosed with asthma, 398 (90.1%) used a short-acting beta agonist (SABA). Of the 246 patients who had had their asthma managed in the previous 12 months, 232 (94.3%) used a SABA. The most common regimen (for 13.8% of these 232) was twice daily, and just over 10% responded that they used a SABA less than once per year. Of the 174 patients who had no asthma management in the previous year, 91.4% used a SABA.

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, 96 Inhaled corticosteroid use for asthma management.

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.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **FREQUENCY OF ASTHMA MANAGEMENT & OF MEDICATION USE.**

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

Has this patient ever been diagnosed with **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 estimation**.

Number of visits to a GP

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

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.

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.

Changes to management

Where the patient **has** had their asthma managed during the past 12 months, please advise the approximate **number of occasions** when **either** the **asthma medication** or the **dose** and/or **regimen** were **altered** for any reason?

Inhaled Corticosteroid Use

Please advise whether the patient is using an **Inhaled Corticosteroid (ICS)** either as a single or combination product, and if so, **when** the ICS is used i.e. daily, seasonally (during winter or high allergy times), only during periods when asthma worsens. If an ICS is **not** used, please tick the box labelled '**not at all**'.

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

Short-acting beta agonist use

Please ask the patient approximately **how frequently** they use a **short-acting beta agonist** for their asthma.

Has this patient ever been diagnosed with Asthma?	If 'Yes' 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, approximately how long ago was the asthma last managed?	How many times has ANY asthma medication and/or dose been altered in the past 12 months?	When does the patient use an Inhaled corticosteroid?	How often does the patient use a short-acting beta agonist?
☐ Yes →	☐ none	☐ none	☐ < 1.5 yrs	☐ never	☐ not at all	_____ times / day
☐ No	☐ once only	☐ one only	☐ > 1.5 yrs	☐ once only	☐ daily	_____ times / week
↓	☐ 2-4 times	☐ 2 - 3	☐ < 2 yrs	☐ 2 - 3	☐ when asthma worsens	_____ times / month
End questions	☐ 5-7 times	☐ 4 - 6	☐ > 2 yrs	☐ 4 - 5	☐ seasonally (e.g winter, high allergy, etc)	_____ times / year
	☐ 8-10 times	☐ > 6		☐ > 6	If used please advise:	☐ < once / year
	☐ 11-15 times				*Name & Form* *Strength* *Dose* *Freq*	BL86C
	☐ >15 times				_____ _____ _____ _____	

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Glossary

A1 Medicare items: Medicare item numbers 1, 2, 3, 4, 13, 19, 20, 23, 24, 25, 33, 35, 36, 37, 38, 40, 43, 44, 47, 48, 50, 51, 601, 602.

Aboriginal: The patient identifies himself or herself as an Aboriginal person.

Activity level: The number of general practice A1 Medicare items claimed during the previous 3 months by a participating GP.

Allied and other health professionals: Those who provide clinical and other specialised services in the management of patients, including physiotherapists, occupational therapists, dietitians, dentists and pharmacists.

Complaint: A symptom or disorder expressed by the patient when seeking care.

Consultation: See Encounter.

Diagnosis/problem: A statement of the provider's understanding of a health problem presented by a patient, family or community. GPs are instructed to record at the most specific level possible from the information available at the time. It may be limited to the level of symptoms.

- *New problem:* The first presentation of a problem, including the first presentation of a recurrence of a previously resolved problem but excluding the presentation of a problem first assessed by another provider.
- *Old problem:* A previously assessed problem that requires ongoing care. Includes follow-up for a problem or an initial presentation of a problem previously assessed by another provider.

Encounter (enc): Any professional interchange between a patient and a GP.

- *Indirect:* Encounter where there is no face-to-face meeting between the patient and the GP but a service is provided (e.g. prescription, referral).
- *Direct:* Encounter where there is a face-to-face meeting of the patient and the GP.

  Direct encounters can be further divided into:

  - *Medicare-claimable:* Including Surgery consultations, Home visits, Hospital encounters, Residential aged care facility, Health assessments, Chronic disease management items, Case conferences, Incentive payments, Other MBS encounters.
  - *Workers compensation:* Encounters paid by workers compensation insurance.
  - *Other paid:* Encounters paid from another source (e.g. state).

General practitioner (GP): A medical practitioner who provides primary comprehensive and continuing care to patients and their families within the community (Royal Australian College of General Practitioners).

Medication: Medication that is prescribed, provided by the GP at the encounter or advised for over-the-counter purchase.

Medication rates: The rate of use of all medications including medications that were prescribed, supplied by the GP and advised for over-the-counter purchase.

Medication status:

- *New:* The medication prescribed/provided at the encounter/advised is being used for the management of the problem for the first time.
- *Continuation:* The medication prescribed/provided at the encounter/advised is a continuation or repeat of previous therapy for this problem.
- *Old:* See *Continuation.*

Morbidity: Any departure, subjective or objective, from a state of physiological wellbeing. In this sense, sickness, illness and morbid conditions are synonymous.

Prescribed rates: The rate of use of prescribed medications (i.e. does not include medications that were GP-supplied or advised for over-the-counter purchase).

Problem managed: See *Diagnosis/problem.*

Provider: A person to whom a patient has access when contacting the health care system.

Reasons for encounter (RFEs): The subjective reasons given by the patient for seeing or contacting the general practitioner. These can be expressed in terms of symptoms, diagnoses or the need for a service.

Recognised GP: A medical practitioner who is:

- vocationally recognised under Section 3F of the Health Insurance Act, ***or***
- a holder of the Fellowship of the Royal Australian College of General Practitioners who participates in, and meets the requirements for, quality assurance and continuing medical education as defined in the RACGP Quality Assurance and Continuing Medical Education Program, ***or***
- undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the Fellowship of the Royal Australian College of General Practitioners or undertaking an approved placement in general practice as part of some other training program recognised by the RACGP as being of equivalent standard.[35]

Referral: The process by which the responsibility for part or all of the care of a patient is temporarily transferred to another health care provider. Only new referrals to specialists and allied health professionals and for hospital and residential aged care facility admissions arising at a recorded encounter are included. Continuation referrals are not included. Multiple referrals can be recorded at any one encounter.

Torres Strait Islander: The patient identifies himself or herself as a Torres Strait Islander person.

Abbreviations

AGPSCC	Australian General Practice Statistics and Classification Centre, University of Sydney, a collaborating unit of the Australian Institute of Health and Welfare
AIHW	Australian Institute of Health and Welfare
ATC	Anatomical Therapeutic Chemical (classification)
AUDIT	Alcohol Use Disorders Identification Test
BEACH	Bettering the Evaluation And Care of Health
BMI	Body mass index
CAPS	Coding Atlas for Pharmaceutical Substances
CHD	Coronary heart disease
CI	Confidence interval (in this report 95% CI is used)
DoHA	Australian Government Department of Health and Ageing
Enc	Encounter
GI	Gastrointestinal
GORD	Gastro-oesophageal reflux disorder
GP	General practitioner
GPSCU	General Practice Statistics and Classification Unit (now the Australian General Practice Statistics and Classification Centre, AGPSCC)
HbA1c	Haemoglobin, type A1c
ICPC-2	International Classification of Primary Care (Version 2)
ICPC-2 PLUS	A terminology classified according to ICPC-2
IHD	Ischaemic heart disease
MBS	Medicare Benefits Schedule
NESB	Non-English-speaking background (i.e. a language other than English is spoken at home)
NOS	Not otherwise specified
NSAID	Non-steroidal anti-inflammatory drug
OTC	Over-the-counter (i.e. medications advised for over-the-counter purchase)
PBS	Pharmaceutical Benefits Scheme
QA	Quality assurance (in this case the Quality Assurance Program of the Royal Australian College of General Practitioners)
RACGP	Royal Australian College of General Practitioners
SAND	Supplementary Analysis of Nominated Data
SAS	Statistical Analysis System
WHO	World Health Organization
Wonca	World Organization of Family Doctors

Subject bibliography

BILLING

BODY MASS INDEX (BMI)

See also: Body mass in: Measures of health and health care delivery in general practice in Australia (pg 11).

CARDIOVASCULAR

See also: Hypertension in: Measures of health and health care delivery in general practice in Australia (pg 55).

CHOLESTEROL

See also: Cholesterol in: Measures of health and health care delivery in general practice in Australia (pg 31).

CHRONIC HEART FAILURE

CHRONIC ILLNESS

CHRONIC PAIN

CIRCULATORY

DEMENTIA

DEPRESSION

See also: Depression in: Measures of health and health care delivery in general practice in Australia (pg 44).

DIABETES

DIGESTIVE

Also see, in: Measures of health and health care delivery in general practice in Australia: Hepatitis (pg 68) and Prevalence of upper gastro-intestinal conditions and NSAID use (pg 26).

DRUG UTILIZATION

EDUCATION

EMPLOYMENT

See also: Employment and occupation in: Measures of health and health care delivery in general practice in Australia (pg 73).

ENDOCRINE, METABOLIC AND NUTRITIONAL

Also see, in: Measures of health and health care delivery in general practice in Australia: Body mass (pg 11) and Cholesterol (pg 31).

ETHNIC

FEMALE GENITAL

See also: Vaccination and mammography in: Measures of health and health care delivery in general practice in Australia (pg 35).

GABAPENTIN

GASTROESOPHAGEAL REFLUX

GASTROINTESTINAL

Also see, in: Measures of health and health care delivery in general practice in Australia: Hepatitis (pg 68) and Prevalence of upper gastro-intestinal conditions and NSAID use (pg 26).

GENERAL AND UNSPECIFIED

Also see, in: Measures of health and health care delivery in general practice in Australia: Alcohol use (pg 20); Co-morbidity (pg 61); Consultation time and GP satisfaction (pg 51); Employment and occupation (pg 73); Health care utilisation (pg 40); Physical activity (pg 23); Severity of illness (pg 58); Smoking (pg 15); The effect of the introduction of therapeutic group premiums on patient care (pg 47); Vaccination and mammography (pg 35) and Wellbeing (pg 7).

GORD

GP SATISFACTION

See also: Consultation time and GP satisfaction in: Measures of health and health care delivery in general practice in Australia (pg 51).

HEALTH PRIORITY AREAS

Also see, in: Measures of health and health care delivery in general practice in Australia: Alcohol use (pg 20); Body mass (pg 11); Cholesterol (pg 31); Depression (pg 44); Hypertension (pg 55); Musculoskeletal conditions and NSAID use (pg 64); Physical activity (pg 23); Prevalence of upper gastro-intestinal conditions and NSAID use (pg 26) and Smoking (pg 15).

HEART ATTACK

HEART FAILURE

HEPATITIS

See also: Hepatitis in: Measures of health and health care delivery in general practice in Australia (pg 68).

HORMONE REPLACEMENT THERAPY

HYPERTENSION

See also: Hypertension in: Measures of health and health care delivery in general practice in Australia (pg 55).

INFECTIONS

See also: Hepatitis in: Measures of health and health care delivery in general practice in Australia (pg 68).

INFLUENZA

LANGUAGE

LENGTH OF CONSULTATION

See also: Consultation time and GP satisfaction in: Measures of health and health care delivery in general practice in Australia (pg 51).

LIFESTYLE

LIPID

MALE GENITAL

MAMMOGRAPHY

See also: Vaccination and mammography in: Measures of health and health care delivery in general practice in Australia (pg 35).

MANAGEMENT

MEDICINES

Also see, in: Measures of health and health care delivery in general practice in Australia: Musculoskeletal conditions and NSAID use (pg 64); Prevalence of upper gastro-intestinal conditions and NSAID use (pg 26); The effect of the introduction of therapeutic group premiums on patient care (pg 47) and Vaccination and mammography (pg 35).

MENOPAUSAL

METABOLIC SYNDROME

MIGRAINE

MORBIDITY

MUSCULOSKELETAL

Also see, in: Measures of health and health care delivery in general practice in Australia: Musculoskeletal conditions and NSAID use (pg 64) and Prevalence of upper gastro-intestinal conditions and NSAID use (pg 26).

NEUROLOGICAL

NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDs)

Also see, in: Measures of health and health care delivery in general practice in Australia: Musculoskeletal conditions and NSAID use (pg 64) and Prevalence of upper gastro-intestinal conditions and NSAID use (pg 26).

OCCUPATION

See also: Employment and occupation in: Measures of health and health care delivery in general practice in Australia (pg 73).

OSTEOPOROSIS

PATHOLOGY

PEPTIC ULCER

PHYSICAL ACTIVITY

See also: Physical activity in: Measures of health and health care delivery in general practice in Australia (pg 23).

PREGNANCY, CHILD-BEARING, FAMILY PLANNING

PREMATURE EJACULATION

PRESCRIPTION

PREVALENCE

See also: Prevalence of upper gastro-intestinal conditions and NSAID use in: Measures of health and health care delivery in general practice in Australia (pg 26).

PROTON PUMP INHIBITORS

PSYCHOLOGICAL

See also: Depression in: Measures of health and health care delivery in general practice in Australia (pg 44).

REFLUX

RESPIRATORY

RISK FACTORS

Also see, in: Measures of health and health care delivery in general practice in Australia: Alcohol use (pg 20); Body mass (pg 11); Cholesterol (pg 31); Hypertension (pg 55); Physical activity (pg 23) and Smoking (pg 15).

SEVERITY

See also: Severity of illness in: Measures of health and health care delivery in general practice in Australia (pg 58).

SEXUAL DYSFUNCTION

SMOKING

WELLBEING

See also: Wellbeing in: Measures of health and health care delivery in general practice in Australia (pg 7).

WORKERS COMPENSATION

SAND abstracts from the first year of BEACH (1998–99) have been published in *Measures of health and health care delivery in general practice in Australia* available from <www.fmrc.org.au/publications/Books3.htm>. Topics investigated included:

- Wellbeing
- Body mass
- Smoking
- Alcohol use
- Physical activity
- Prevalence of upper gastro-intestinal conditions and NSAID use
- Cholesterol
- Vaccination and mammography
- Health care utilisation
- Depression
- The effect of the introduction of the therapeutic group premiums on patient care
- Consultation time and GP satisfaction
- Hypertension
- Severity of illness
- Co-morbidity
- Musculoskeletal conditions and NSAID use
- Hepatitis
- Employment and occupation.

Other SAND abstracts from BEACH 2006–07 will be published in *General practice activity in Australia 2006–07* in December 2007. The topics under investigation include:

- Severity of illness using the DUSOI scale
- Weight loss
- Diabetes
- Adverse pharmacological events
- Type 2 diabetes
- Secondary prevention of heart attack and stroke
- Erectile dysfunction.