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?	If 'yes' the original script was provided by:	For what condition/s?	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
☐ Yes	☐ Neurologist	☐ Epilepsy	1. _____	<1 / 2-6 / 7-12 / 13-24 / >24	☐	☐	☐	☐
☐ No → *end questions here*	☐ Pain specialist	☐ Neuropathic pain	2. _____	<1 / 2-6 / 7-12 / 13-24 / >24	☐	☐	☐	☐
	☐ Other specialist	☐ Other_____ *(please specify)*	3. _____	<1 / 2-6 / 7-12 / 13-24 / >24	☐	☐	☐	☐
	☐ GP	**Private prescription?**	4. _____	<1 / 2-6 / 7-12 / 13-24 / >24	☐	☐	☐	☐
BL70B	☐ Hospital emergency physician	☐ Yes ☐ No	☐ 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)* ☐ transdermal fentanyl ☐ oral slow-release morphine ☐ control-release oxycodone ☐ psychotropics ☐ NSAIDS / Cox-IIs ☐ weaker opioids *eg tramadol; codeine prep'ns* | *initiated by* GP/spec GP/spec GP/spec GP/spec GP/spec GP/spec *(please circle)* | *duration of use* ___wks/mths/yrs ___wks/mths/yrs ___wks/mths/yrs ___wks/mths/yrs ___wks/mths/yrs ___wks/mths/yrs *(please circle)* | ☐ antidepressants ☐ antiepileptics ☐ rescue medication *for breakthrough pain* ☐ laxatives ☐ acid suppressants ☐ no medication ☐ other ____ *(please specify)* **Is pain management adequate?** | GP/spec GP/spec GP/spec GP/spec GP/spec GP/spec ☐Yes | ___wks/mths/yrs ___wks/mths/yrs ___wks/mths/yrs ___wks/mths/yrs ___wks/mths/yrs ___wks/mths/yrs ☐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   ☐ side effects _____ *(please specify)*
☐ cost
☐ withdrawal after successful Rx   ☐ 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 <u>next 30 PATIENTS</u> 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 <u>leave this section BLANK.</u>

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:

(see key list on card - circle as many as apply)

Name & Form	Strength	Dose	Freq	Initiated by *(please circle)*	Reason for use *(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.

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?

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**.

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?	How long since the medication ceased?	Is the patient likely to commence another medication for osteoporosis?
_____ *wks / mths / yrs (please circle)*	_____ *wks / mths / yrs (please circle)*	☐ 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.

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.

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.

Hypolipidaemic medication regimen

For patients taking a **statin** and/or **fibrate** and/or **cholestyramine**, please **write the medication regimen** details in the space provided.

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'.

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.

Does this patient have:-	The patient's most recent total cholesterol level was:	Is the patient currently being treated with any of the following medications?	Statin/fibrate/cholestyramine currently taken is:				If taking statin, has the patient had tolerance problems?	Current treatment for patients with diabetes is:			
☐ Diabetes Type I	_____ mmol/L		**Name & Form**	**Strength**	**Dose**	**Frequency**	☐ No	☐ Diet and exercise only			
☐ Diabetes Type II →	In your clinical opinion is this patient's cholesterol adequately controlled?	☐ Statin					☐ Yes _____ *(please specify)*	☐ Diet and exercise plus prescribed medication *as below:-*			
☐ Coronary Heart Disease	☐ Yes	☐ Fibrate	1. _____				If 'Yes' was the statin dose?	**Name & Form**	**Strength**	**Dose**	**Frequency**
☐ None of the above - **end**	☐ No	☐ Cholestyramine	2. _____				☐ Reduced	1._____			
BL72C **questions here**		☐ None of the above	3. _____				☐ Not increased	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.

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**.

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**.

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.

Does this patient have any of:-

- ☐ Hypertension
- ☐ Left ventricular hypertrophy
- ☐ Coronary heart failure
- ☐ Microalbuminuria
- ☐ Diabetes
- ☐ Impaired glucose
- ☐ None of the above → end

If 'Yes' the patient's current therapy is:-
('current' = prior to today)

- ☐ ACE inhibitors
- ☐ Calcium Channel Blocker
- ☐ β-Blocker
- ☐ Diuretic
- ☐ Angiotensin II Receptor Blocker
- ☐ Other _____
- ☐ None   (please specify)

The patient's current medication regimen for these conditions is:-

	Name & Form	Strength	Dose	Frequency
1.	_____			
2.	_____			
3.	_____			
4.	_____			
5.	_____			

In your clinical opinion does this medication regimen adequately control the patient's condition?

- ☐ Yes
- ☐ No

As a result of today's consultation, has this patient been prescribed new/additional/changed medication for these conditions?

- ☐ Yes - new / additional medication
- ☐ Yes - changed dose
- ☐ No change

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.

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**.

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.

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.

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.

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.**

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