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.

<u>INSTRUCTIONS</u>

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? ☐ Yes → ☐ No → *End questions* BL48B	If 'Yes', was their current gastro-intestinal problem diagnosed - ☐ Today OR ☐ At a previous encounter (by you or by another GP or Specialist)	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.	Name & Form	Strength	Dose	Frequency	Initiated by	Sample given	No. of samples
			_____				GP / Specialist	Yes / No	____
		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	For former smokers -		For current smokers -		
☐ Current smoker - daily.	How long since you last smoked?	**From the Key list**, what method/s did you use (or are currently using) to stop? (circle as many as apply)	In the **past 5 years** have you tried to stop smoking?	If 'YES' how long since your last quitting attempt?	**From the Key list**, what method/s did you use in this last attempt? (circle as many as apply)
☐ Current smoker - occasional.					
☐ Former smoker - daily		1. 2. 3. 4. 5. 6.	☐ Yes.		1. 2. 3. 4. 5. 6.
☐ Former smoker - occasional.	_____		☐ No ⇨ END	_____	
☐ Never smoked ⇨ END QUESTONS	(yrs /mths /wks /days)	7. 8. 9. 10. 11. 12.	QUESTIONS.	(yrs /mths /wks /days)	7. 8. 9. 10. 11. 12.

BL50B

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?

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'.

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.**

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.

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.**

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.**

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

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.

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.

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| In the past six months has this patient experienced an adverse event in response to use of a medication?

☐ Yes
☐ No ⇨ END QUESTIONS

BL52B | If 'Yes' how many different events?

_____ | The most recent event was most likely the result of:

(tick ONE box only)

1☐ Recognised side effect of the medication

If you tick <u>THIS</u> box, <u>END the QUESTIONS HERE</u> | 2☐ Drug interaction
3☐ Contraindication
4☐ Allergy
5☐ Drug sensitivity

6☐ Overdose
7☐ Dispensing error
8☐ Don't know
9☐ Other

If you tick <u>One of THESE</u> boxes, CONTINUE ⇨ | Was the event -

☐ Mild
☐ Moderate
☐ Severe
☐ Don't know | Was the patient hospitalised as a result of this event?

☐ Yes
☐ No |

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.

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.**

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.

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**.

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Does this patient have Chronic Heart Failure (CHF)?	If 'Yes' what management is currently being used?	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)*	This patient was initially referred to a cardiac specialist	What clinical investigations were used to diagnose the CHF?
Yes - mild ☐ ☐ - moderate ☐ - severe ☐ → END BL52C	**Name & Form** **Strength** **Dose** **Freq** **initiated by** 1. _____ GP/spec 2. _____ GP/spec 3. _____ GP/spec 4. Other _____ GP/spec	Increase survival 1 2 3 Relieve symptoms 1 2 3 Improve quality of life 1 2 3	☐ <12 months ago ☐ 1-3 years ago ☐ > 3 years ago ☐ never referred	*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.

Is this patient currently taking a lipid lowering medication?

☐ Yes - please specify

Name & Form	Strength	Dose	Frequency

☐ No ➔ END QUESTIONS

Under which qualifying criteria was/is the patient eligible for subsidy?
(Tick as many as apply)

1☐ Existing CHD **and** cholesterol > 4.0 mmol/L

2☐ Cholesterol > 6.5 mmol/L
OR
☐ Cholesterol > 5.5 mmol/L **and** HDL <1.0 mmol/L
AND ONE OF ➔

☐ Diabetes Mellitus
☐ Familial hypercholesterolaemia
☐ Family history of CHD (1° relative<60yo)
☐ Hypertension (include treated patients)
☐ Peripheral vascular disease

3☐ Cholesterol > 7.5 mmol/L
OR
☐ Triglyceride >4.0 mmol/L
AND ONE OF
☐ Male 35 to 75
☐ Post menopausal woman up to 75 yrs

4☐ Cholesterol > 9.0 mmol/L
OR
☐ Triglyceride >8.0 mmol/L

5☐ Not eligible

BL53B

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.

<u>INSTRUCTIONS</u>

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.

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?**

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.

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.

Previous medication

Please advise which **medications** the patient had taken **prior to commencing the combination medication.** Tick as many boxes as apply.

| Does this patient currently have hypertension? (either controlled or uncontrolled) ☐ Yes ☐ No BL53C | Is the patient taking a combination product? ☐ ACE/diuretic ☐ A2RA/diuretic ☐ neither → END QUESTIONS | The patient has been taking the combination ACE/diuretic or A2RA/diuretic for - ☐ < 3 months ☐ > 3 months | The combination therapy was initiated by ☐ a GP ☐ Specialist | Blood Pressure is currently ☐ Well controlled ☐ Too high ☐ Too low | Prior to taking the combination product, did the patient take - ☐ a diuretic ☐ a beta-blocker ☐ amiloride ☐ an ACE inhibitor ☐ an A2RA ☐ none of the above ☐ no previous treatment | The patient's blood pressure on <u>previous</u> treatment was ☐ Well controlled ☐ Too high ☐ Too low | Combination product was prescribed - ☐ for simpler therapy ☐ to add a second drug ☐ to reduce adverse effects ☐ to improve BP control ☐ to reduce cost to patient ☐ don't know |

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.

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?**

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.

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 BL54B	☐ Yes ☐ No ⇨ END QUESTIONS	How severe is the patient's GORD? ☐ 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 - Duration of Name & Form Strength Dose Frequency Usage (mths) _____					☐ Yes ☐ No Has the patient had any recurrence of GORD symptoms while on the PPI? ☐ Yes ☐ No	☐ Yes (please specify) _____ ☐ No