

## 16 SAND abstracts and research tools

Since BEACH began in April 1998, a section on the bottom of each encounter form has been used to investigate aspects of patient health or health care delivery not covered by general practice consultation-based information. These additional substudies are referred to as SAND (Supplementary Analysis of Nominated Data). The SAND methods are described in Section 2.5. All substudies have been approved by the AIHW Ethics Committee (on behalf of the AIHW and the University of Sydney).

The AGPSCC and participating stakeholders of the BEACH program select topics for investigation in each of the SAND studies. In each BEACH year up to 20 substudies can be conducted in addition to the study of patient risk behaviours (see Chapter 15). Topics are often repeated to increase the size of the sample and its statistical power.

Data from the SAND substudies conducted in the first year of BEACH (1998–99) were published in *Measures of health and health care delivery in general practice in Australia*.<sup>98</sup> Abstracts of results and research tools for the SAND studies undertaken in 1999–2006 were published in *Patient-based substudies from BEACH: abstracts and research tools 1999–2006* in July 2007.<sup>12</sup> Abstracts and research tools for substudies conducted in 2006–07 that were not included in that report are presented in this chapter. The subjects covered in the abstracts from 2006–07 BEACH year are listed in Table 16.1 with the sample size for each topic.

Abstracts of results from all SAND studies are also available from the FMRC's website <[www.fmrc.org.au/publications/SAND\\_abstracts.htm](http://www.fmrc.org.au/publications/SAND_abstracts.htm)>.

**Table 16.1: SAND abstracts for 2006–07 and sample size for each**

Abstract number	Subject	Number of respondents	Number of GPs
95	Cultural background of patients attending general practice <sup>(a)</sup>	6,035	202
96	Inhaled corticosteroid use for asthma management <sup>(a)</sup>	5,911	201
97	Statin medication use among high CHD risk patients attending general practice <sup>(a)</sup>	2,707	94
98	Management of hypertension and angina in general practice patients <sup>(a)</sup>	2,919	98
99	Lipid management in patients with high-risk conditions <sup>(a)</sup>	5,372	183
100	Gastrointestinal symptoms in patients attending general practice <sup>(a)</sup>	2,801	97
101	Types of medicine use and patient use of medicines list <sup>(a)</sup>	5,528	187
102	Alzheimer's disease or dementia in patients attending general practice <sup>(a)</sup>	2,863	99
103	Cardiovascular risk in patients attending general practice <sup>(a)</sup>	2,618	99
104	Asthma management and medication use among patients attending general practice <sup>(a)</sup>	2,862	97
105	Measurement of severity of illness in general practice	4,982	166
106	Weight loss attempts and methods	2,164	76
107	Type 2 diabetes and dyslipidaemia	2,331	89
108	Type 2 diabetes among patients attending general practice	2,832	96
109	Secondary prevention of heart attack and stroke	2,471	84
110	Erectile dysfunction	1,930	82

(a) The abstract of results and research tool for this study was published in *Patient-based substudies from BEACH: abstracts and research tools 1999–2006* and is therefore not included in this chapter.

# SAND abstract 105: Measurement of severity of illness in general practice

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

**Issues:** Severity of illness of each problem managed at the general practice encounter; length of the consultation and the GP consultation rate in the previous year; the relationship between the total severity score, consultation length and consultation rate.

**Sample:** 4,982 encounters from 166 GPs; data collection period: 24/10/2006 – 15/01/2007.

**Method:** Detailed in the paper entitled 'SAND Method 2006–07' on this website: <[www.fmrc.org.au/publications/SAND\\_abstracts.htm](http://www.fmrc.org.au/publications/SAND_abstracts.htm)>. The Duke University Severity of Illness (DUSOI) scale was used to assess the severity of each problem managed at the encounter and to calculate a total score for each encounter.<sup>1</sup>

## Summary of results

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

The mean total DUSOI score was 5.2 (95% CI: 5.0–5.5) based on 4,187 scored encounters. Encounters with patients aged 45 years and over had a significantly higher mean total DUSOI score than those aged less than 45. There was a significant positive linear relationship between total DUSOI score and number of GP visits reported in the previous 12 months ( $p < 0.001$ ). Patients reporting 11 or more GP visits had the highest mean total score of 6.4, and those reporting nil GP visits had the lowest total mean score of 3.6. The number of visits increased by 0.6 for every one point increase in total DUSOI score for the encounter

There was a significant positive linear relationship between mean total DUSOI score and the length of consultation, with the consultation length increasing by 0.55 of a minute for each one unit increase in DUSOI ( $p = <0.001$ ). The DUSOI range was 4.0 for consultations of less than 5 minutes to 7.3 for consultations of more than 25 minutes.

For 4,187 respondents, the mean total DUSOI score of encounters with at least one chronic problem managed was 6.7 (95% CI: 6.3–7.1), significantly higher than encounters with no chronic problems (4.1, 95% CI: 3.9–4.2). Linear regression demonstrated a significant positive linear relationship between total DUSOI score and the number of chronic problems managed ( $p < 0.001$ ). The total DUSOI increased by 2.4 points for each chronic problem managed.

The DUSOI from the 6,133 scored problems had a mean score of 3.7 (95% CI: 3.6–3.9). Significantly higher DUSOI scores were recorded for back complaint (5.1, 95% CI: 4.7–5.4), depression (4.9, 95% CI: 4.6–5.2), acute stress reaction (4.9, 95% CI: 4.4–5.4), osteoarthritis (4.8, 95% CI: 4.5–5.1), anxiety (4.6, 95% CI: 4.2–4.9) and fracture (4.5, 95% CI: 3.9–5.1).

Significantly lower DUSOI scores were recorded for acute upper respiratory infection (2.9, 95% CI: 2.7–3.2), hypertension (2.6, 95% CI: 2.4–2.9), solar keratosis/sunburn (2.4, 95% CI: 2.1–2.8), lipid disorder (2.3, 95% CI: 2.0–2.6) and pregnancy (1.3, 95% CI: 0.8–1.8).

1 Parkerson GR, Jr, Broadhead WE, Tse CK 1993. The Duke Severity of Illness Checklist (DUSOI) for measurement of severity and comorbidity. *J Clin Epidemiol* 46:379–93.

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

# PLEASE READ CAREFULLY

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

## INSTRUCTIONS

**START Time**  
 [ ] : [ ]  
 AM / PM  
 (please circle)

**START time**  
 Record the time the consultation STARTED in hours and mins and circle whether the time was AM or PM.  
 eg. 9: 10  
AM PM

**SEVERITY OF ILLNESS - GP estimates for each patient\*.**  
 Estimate the severity of illness for **EACH problem managed at this encounter**. Using the score key below, circle ONE number for each of: **Symptoms, Complications, Prognosis, and Treatability**.

**GP consultations in the previous year.**  
 Please check with the patient and write in the approximate number of times this patient has consulted you or any other GP at this or any other practice within the past 12 months.

**SEVERITY OF ILLNESS SCORING KEY**

	None	Questionable	Mild	Moderate	Major
SYMPTOMS (past week)	0	1	2	3	4
COMPLICATIONS (past week)	0	1	2	3	4
PROGNOSIS (next 6 months if untreated)	Disability		Threat to life		
	None	Mild	Moderate	Major	4
	0	1	2	3	
TREATABILITY	Need for treatment		Expected response to treatment		
	No	Questionable	If yes → Good	Questionable	Poor
	0	1	2	3	4

\*Copyright 1990 Dept of Community and Family Medicine Duke University Medical Centre, Durham, NC, USA.

**FINISH time**  
 Record the time the consultation FINISHED in hours and mins and circle whether the time was AM or PM.  
 eg. 9: 18  
AM PM

<b>How many times (approximately) has this patient consulted a GP at any practice in the last 12 months?</b> _____	<b>Severity of Illness - Please circle ONE number for each of: Symptoms, Complications, Prognosis and Treatability using the severity scoring key on the green instruction sheet to estimate the patient's overall severity of illness during the past week for each problem managed at today's encounter.</b>	<b>Diagnosis/Problem 1</b>	<b>Diagnosis/Problem 2</b>	<b>Diagnosis/Problem 3</b>	<b>Diagnosis/Problem 4</b>	<b>FINISH Time</b> [ ] : [ ] AM / PM (please circle) BL87B
		Symptoms 0 1 2 3 4	Symptoms 0 1 2 3 4	Symptoms 0 1 2 3 4	Symptoms 0 1 2 3 4	
		Complications 0 1 2 3 4	Complications 0 1 2 3 4	Complications 0 1 2 3 4	Complications 0 1 2 3 4	
		Prognosis 0 1 2 3 4	Prognosis 0 1 2 3 4	Prognosis 0 1 2 3 4	Prognosis 0 1 2 3 4	
		Treatability 0 1 2 3 4	Treatability 0 1 2 3 4	Treatability 0 1 2 3 4	Treatability 0 1 2 3 4	

# SAND abstract 106: Weight loss attempts and methods

**Organisation supporting this study:** Abbott Australasia.

**Issues:** BMI of child and adult general practice patients (calculated separately); prevalence of selected, related morbidities: hypertension, other cardiovascular disease, diabetes type 2 and depression; proportion taking selected medication groups: anti-hypertensives, statins/fibrates, antidepressants and antipsychotics; proportion who had tried to lose weight in past 12 months and methods used.

**Sample:** 2,164 encounters with patients aged 2 years or more from 76 GPs. Data collection period: 24/10/2006 - 27/11/2006.

**Method:** Detailed in the paper entitled 'SAND Method 2006-07' on this website: <[www.fmrc.org.au/publications/SAND\\_abstracts.htm](http://www.fmrc.org.au/publications/SAND_abstracts.htm)>. An international standard was employed to calculate BMI cut-off levels in children.<sup>1</sup> A card listing weight loss methods was provided to patients.

## Summary of results

The age and sex distributions were similar to all 2004-05 BEACH encounters with patients aged 2 years and over. Female patients accounted for 62.3% of the sample. Patients were divided into children (2-17 years) and adults (18 years and over) because the BMI cut-off levels for children differ from those used for adults. Of 212 child patients, 20.8% were overweight and 13.2% were obese. Of 1,862 adult patients, 34.4% were overweight and a further 22.5% were obese. Combining adult and child general practice patients, over half (54.6%; 95% CI: 51.4-57.7) were defined as overweight or obese.

Only six child patients had any of the listed comorbidities. Of 1,907 adult patients, 54.8% had at least one of the comorbidities. At least one of the comorbidities was indicated for a significantly greater proportion of overweight (58.0%; 95% CI: 53.1-62.9) and obese adult patients (66.2%; 95% CI: 60.8-71.6) than patients of normal weight (45.4%; 95% CI: 40.4-50.3).

Only one child was taking any of the medications. Of 1,893 adult respondents, 48.4% were taking at least one. The proportion of adult patients taking at least one medication rose significantly as weight increased, from 38.0% (95% CI: 33.3-42.8) of normal weight to 50.7% (95% CI: 46.2-55.3) of overweight and 61.5% (95% CI: 56.1-67.0) of obese patients.

Of 223 child respondents, only nine had attempted weight loss in the previous 12 months. Of 1,927 adult patients, 35.8% had made at least one attempt to lose weight in the previous 12 months. The proportion of adult patients attempting weight loss rose significantly by weight category, with 42.6% (95% CI: 36.6-48.5) of overweight and 67.6% (95% CI: 62.1-73.2) of obese patients attempting weight loss at least once during the previous 12 months. Female patients were significantly more likely to have attempted weight loss (41.8%; 95% CI: 37.5-46.1) than male patients (25.3%; 95% CI: 21.1-29.4). The majority (66.8%) of 689 adult respondents indicated exercise among weight loss methods tried, 38.6% had used a self-structured reducing diet, 30.8% indicated GP advice, 26.9% had used meal plans and 23.1% had used a weight loss program. Over-the-counter medications were indicated by 9.7% of these patients, specialist/dietitian advice by 8.6% and prescribed medications by 6.1% of patients.

1 Cole TJ, Bellizzi MC et al. 2000. Establishing a standard definition for child overweight and obesity worldwide; international survey. *BMJ* 320 (7244):1240-3.

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

**PLEASE READ CAREFULLY**

The shaded section of the following forms asks questions about **PATIENT WEIGHT LOSS ATTEMPTS and METHODS**.  
 You may tear out this page as a guide to completing the following section of forms.

**INSTRUCTIONS**

**These questions are for ALL PATIENTS**

**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**.

**Patient height & weight**  
 What is the patient's **height** (without shoes)?  
 What is their **weight** (uncloned)?  
 (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.)

**Morbidity** (tick all that apply)  
 Please use the tick boxes to advise whether the patient has **ever been diagnosed** with any of the listed conditions.

**Medications** (tick all that apply)  
 Please use the tick boxes to advise whether the patient is **currently taking** any of the listed medications.

**Weight loss methods** (tick as many as apply)  
 Please tick the box beside any **weight loss methods** the patient has tried in the past 12 months in an attempt to lose weight.  
 Tick as many boxes as apply.  
 \* **Weight loss programs** e.g. Jenny Craig, Weight Watchers, Gutbusters, Gloria Marshall etc.  
 \* **Meal Plans** e.g. Lite N Easy, Easy Slim, Nu-Shape etc.  
 \* **Over-the-counter (OTC) Products** available from pharmacies, supermarkets, health food stores etc, e.g. Xenical, Slimfast, Optifast, Cenovis NutriPlan, Fat Blaster, Trim It, Opti Slim, Sure Slim, Exo Fat, Chitosan etc. (NB. Xenical S3 since 1st May 2004).  
 \* **Other reducing diet** e.g. commencing a structured diet plan other than those listed above (self-structured).  
 \* **Exercise program** e.g. 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. Reductil, Duromine, Tenuate etc prescribed 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.

**Prescribed medications**  
 Please advise whether the patient has **ever used a prescribed medication** (e.g. Duromine, Reductil, Tenuate) **for weight loss?** (NB. Prior to 1st May 2004 Xenical (orlistat) was a prescribed medication - classified as S3 since. If this medication was used **prior** to 1st May 2004 please **count it as a prescribed medication**).  
 If a prescribed medication has **never been required**, please tick the 'No - never required' option and **end the questions here**. For other responses please continue on to the last question.

**Prescribed medication**  
 If a **prescribed medication** has **never been tried**, or **use was intermittent or discontinued**, please advise the **three most important reasons**. Write the number **1** beside the most important reason, **2** beside the second reason, and **3** beside the third (i.e. **rank the top 3 reasons**).

<p>Ask the patient their</p> <p><b>Height:</b></p> <p>_____ cm</p> <p><b>Weight:</b></p> <p>_____ kg</p> <p>BL87C</p>	<p>Has the patient ever been diagnosed with?</p> <p><input type="checkbox"/> Hypertension</p> <p><input type="checkbox"/> Other cardiovascular disease</p> <p><input type="checkbox"/> Diabetes T2</p> <p><input type="checkbox"/> Depression / mood disorder</p> <p><input type="checkbox"/> None of the above</p>	<p>Is the patient currently taking?</p> <p><input type="checkbox"/> Anti-hypertensives</p> <p><input type="checkbox"/> Statins / fibrates</p> <p><input type="checkbox"/> Anti-depressants</p> <p><input type="checkbox"/> Anti-psychotics</p> <p><input type="checkbox"/> None of the above</p>	<p><b>Ask the patient...</b></p> <p>In the past 12 months how often have you attempted to lose weight?</p> <p><input type="checkbox"/> Never</p> <p><input type="checkbox"/> Once</p> <p><input type="checkbox"/> 2-4 times</p> <p><input type="checkbox"/> 5 or more times</p>	<p>In the past 12 months which weight loss methods have you tried?</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Weight loss programs</p> <p><input type="checkbox"/> Meal Plans</p> <p><input type="checkbox"/> OTC products (pharmacy/retail)</p> <p><input type="checkbox"/> Other reducing diet</p> <p><input type="checkbox"/> Exercise program</p> <p><input type="checkbox"/> GP advice</p> <p><input type="checkbox"/> Prescribed medication</p> <p><input type="checkbox"/> Specialist/dietitian advice</p> <p><input type="checkbox"/> Other _____</p>	<p>Have you ever used a prescribed medication to lose weight?</p> <p><input type="checkbox"/> Yes - intermittently</p> <p><input type="checkbox"/> Yes - continuously</p> <p><input type="checkbox"/> Yes - but discontinued use</p> <p><input type="checkbox"/> No - never required</p> <p><input type="checkbox"/> No - other reason</p>	<p>Reasons for non / interrupted / discontinued use of a prescribed medication for weight loss are: (please rank the top 3 reasons by numbering 1 to 3)</p> <p>_____ cost</p> <p>_____ advice from health professional</p> <p>_____ not suitable or contra-indicated</p> <p>_____ prefer non-drug option</p> <p>_____ unsatisfactory outcome</p> <p>_____ side effects</p> <p>_____ satisfactory weight loss achieved</p>
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### ***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. Xenical, Slimfast, Optifast, Cenovis, NutriPlan, Fat Blaster, Trim It, Opti Slim, Sure Slim, Exo Fat, Chitosan etc. (NB. Xenical S3 since 1st May 2004).

\* **Other reducing diet** e.g. commencing a structured diet plan other than those listed above (self-structured).

\* **Exercise program** e.g. 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. Reductil, Duromine, Tenuate etc prescribed 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.

# SAND abstract 107: Type 2 diabetes and dyslipidaemia

**Organisation supporting this study:** Merck, Sharp and Dohme (Australia) Pty Ltd.

**Issues:** The prevalence of type 2 diabetes, dyslipidaemia and related morbidities among general practice patients; comorbidities and smoking status of patients with type 2 diabetes and/or dyslipidaemia; HbA1c and cholesterol levels of these patients; current management of blood glucose.

**Sample:** 2,331 patient encounters with 89 GPs. Data period: 28/11/2006 – 15/01/2007.

**Method:** Detailed in the paper entitled 'SAND Method 2006–07' on this website: [www.fmrc.org.au/publications/SAND\\_abstracts.htm](http://www.fmrc.org.au/publications/SAND_abstracts.htm).

## Summary of results

The age and sex distributions were similar to all 2005–06 BEACH encounters. Of the 2,331 respondents, 204 (8.8%; 95% CI: 7.1–10.4) had diagnosed diabetes, and 388 (16.7%; 95% CI: 14.2–19.1) had diagnosed dyslipidaemia. There were 478 respondents (20.5%; 95% CI: 18.1–22.9) who had diagnosed diabetes and/or dyslipidaemia.

Of the 2,331 patients, 569 (24.4%) had hypertension, 51 (2.2%) had congestive heart failure, 126 (5.4%) had coronary heart disease, and 42 (1.8%) had moderate or severe renal insufficiency. Of the 478 patients with diagnosed diabetes and/or dyslipidaemia, 56.9% had at least one of these conditions as a comorbidity: 52.7% had diagnosed hypertension, 4.6% had congestive heart failure, 14.4% had coronary heart disease and 4.0% had moderate/severe renal insufficiency. Of 437 respondents with diabetes and/or dyslipidaemia, 56 (12.8%) were current smokers and 25 of these smokers also had at least one comorbidity.

Of patients with type 2 diabetes and/or dyslipidaemia for whom HbA1c levels were known ( $n = 206$ ), 49.5% had a level of  $\leq 7$  and 50.5% had a HbA1c level  $> 7$ . Of 459 patients for whom total cholesterol levels were known, 42.5% had a level of  $> 5.0$ .

Of 201 diabetes patients who responded, 172 (85.6%) were taking at least one medication to manage blood glucose. Of 285 individual medications, 46.0% were metformin and 32.6% were sulphonylureas. Of 172 blood glucose medications for which details of duration of use were available, 47.1% had been taken for 1–4 years. Four-fifths (79.2%) of the 245 blood glucose medications for which data were available were initiated by a GP and one-fifth (20.8%) were initiated by a specialist. Only insulin was more commonly initiated by a specialist (66.7% of insulin medications) than by a GP (33.3%).

Information on diet and exercise was provided for 115 patients with type 2 diabetes, 90.4% of whom were using diet/exercise for blood glucose management. These patients can be divided into the 70.4% who were using diet/exercise and taking at least one medication, 20.0% who were using diet/exercise but were not taking medication, and 9.6% of patients who were not using diet/exercise but were taking medication.

Of the total 285 medications, there were 39 for which change was indicated for patients whose blood glucose target had not been reached. The plan was to stop four of the medications, increase the dose for 31 and decrease the dose for four.

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

## PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **DIABETES TYPE 2** and **HYPER/DYSLIPIDAEMIA**.  
You may tear out this page as a guide to completing the following section of forms.

### INSTRUCTIONS

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

### Morbidity

Please use the tick boxes to advise whether the patient has **ever been diagnosed** with any of the listed conditions.

Please respond for **all** conditions, and **continue** with further questions if the patient has either **Diabetes Type 2** and/or **hyper/dyslipidaemia**.

If the patient **does not have** either Diabetes Type 2 and/or hyper/dyslipidaemia you should **end the questions here**.

**NB - moderate/severe renal insufficiency defined as creatinine  $\leq$  50ml/min.**

### Patient smoking status (if 18+ years)

Please use the tick boxes to advise whether or not the patient is a **current smoker**.

### Test levels

Please advise the patient's **levels** at the **most recent testing**, of **HbA1c; total cholesterol; LDL cholesterol; HDL cholesterol**.

If you **do not know** one of these levels, or if the patient has **never had** one or more of these levels tested, please tick the box labelled '**don't know / never tested**'.

### Medication / management for blood glucose levels

Please advise the **name and regimen** of any **medication/s** currently being taken by the patient for **management of their blood glucose levels**. NB - if insulin is used, write the name only - regimen details are not required.

**Duration of use** - Please **write a number** in the space provided, and **circle an option** to indicate **months or years**, to advise the approximate **length of time** the medication has been taken by the patient.

**Initiation of medication** - **Circle an option** to advise whether the medication was **initiated by a GP** or a **specialist**.

**Management plan** - If the target blood glucose level for this patient has **not yet been achieved**, please **circle an option** to advise the **next step** you plan to take in relation to the patient's **medication**.

If you plan to **add** a medication to the current regimen, please **write the name of the medication** in the space provided.

If **no medication** is currently being taken for blood glucose management, please tick the box labelled '**no medication**'

Please **circle an option** to advise whether **diet and/or exercise** are part of the patient's blood glucose management.

Does this patient have diagnosed: <input type="checkbox"/> Diabetes type 2 <input type="checkbox"/> Hyper/dyslipidaemia <input type="checkbox"/> Hypertension <input type="checkbox"/> Cong. heart failure <input type="checkbox"/> Cor. heart disease <input type="checkbox"/> Mod/severe renal insuff. <input type="checkbox"/> None of the above	Is the patient a current smoker? <input type="checkbox"/> yes <input type="checkbox"/> no BL99B	At the most recent test what were the patient's levels of: HbA1c _____ % <input type="checkbox"/> Don't know/never tested Total chol _____ mmol/L <input type="checkbox"/> LDL-C _____ mmol/L <input type="checkbox"/> HDL-C _____ mmol/L <input type="checkbox"/>	The current medication / management for this patient's BLOOD GLUCOSE levels is / are: <small>(please circle selected options)</small> <table border="1"> <thead> <tr> <th>Name &amp; Form</th> <th>Strength</th> <th>Dose</th> <th>Freq</th> <th>Duration of use</th> <th>Initiated by</th> <th>Management plan* (if target for patient not yet reached)</th> </tr> </thead> <tbody> <tr> <td>1. _____</td> <td></td> <td></td> <td></td> <td>_____ (mths/yrs)</td> <td>GP / Spec'st</td> <td>no change/ stop / ↑ dose/ ↓ dose</td> </tr> <tr> <td>2. _____</td> <td></td> <td></td> <td></td> <td>_____ (mths/yrs)</td> <td>GP / Spec'st</td> <td>no change/ stop / ↑ dose/ ↓ dose</td> </tr> <tr> <td>3. _____</td> <td></td> <td></td> <td></td> <td>_____ (mths/yrs)</td> <td>GP / Spec'st</td> <td>no change/ stop / ↑ dose/ ↓ dose</td> </tr> <tr> <td>4. _____</td> <td></td> <td></td> <td></td> <td>_____ (mths/yrs)</td> <td>GP / Spec'st</td> <td>no change/ stop / ↑ dose/ ↓ dose</td> </tr> </tbody> </table> <input type="checkbox"/> No medication    Diet / exercise? Yes / No    *If adding a medication, addition would be? _____	Name & Form	Strength	Dose	Freq	Duration of use	Initiated by	Management plan* (if target for patient not yet reached)	1. _____				_____ (mths/yrs)	GP / Spec'st	no change/ stop / ↑ dose/ ↓ dose	2. _____				_____ (mths/yrs)	GP / Spec'st	no change/ stop / ↑ dose/ ↓ dose	3. _____				_____ (mths/yrs)	GP / Spec'st	no change/ stop / ↑ dose/ ↓ dose	4. _____				_____ (mths/yrs)	GP / Spec'st	no change/ stop / ↑ dose/ ↓ dose
Name & Form	Strength	Dose	Freq	Duration of use	Initiated by	Management plan* (if target for patient not yet reached)																																
1. _____				_____ (mths/yrs)	GP / Spec'st	no change/ stop / ↑ dose/ ↓ dose																																
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4. _____				_____ (mths/yrs)	GP / Spec'st	no change/ stop / ↑ dose/ ↓ dose																																



# SAND abstract 108: Type 2 diabetes among patients attending general practice

**Organisations supporting this study:** Pfizer (Australia) Pty Ltd.

**Issues:** The prevalence of type 2 diabetes in patients attending general practice; time since diagnosis of type 2 diabetes; current management; prevalence of sequelae of type 2 diabetes; HbA1c level of patients.

**Sample:** 2,832 respondents from 96 GPs; data collection period: 16/01/2007–19/02/2007.

**Method:** Detailed in the paper entitled 'SAND Method 2006–07' on this website: [www.fmrc.org.au/publications/SAND\\_abstracts.htm](http://www.fmrc.org.au/publications/SAND_abstracts.htm).

## Summary of results

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

Of the 2,832 respondents, 212 (7.5%; CI: 6.1–8.9) had diagnosed type 2 diabetes. There was no significant difference in the sex-specific rates, with 8.9% of male and 6.6% of female having diabetes. Prevalence was highest among patients aged 65–74 years at 16.9% (95% CI: 13.2–20.6). For 180 respondents from the 212 patients with type 2 diabetes, the median time since diagnosis was 6 years.

Diabetes management information was available for 209 patients. Management included diet and exercise for 64.1% of patients, metformin for 54.6% of patients, sulfonylurea for 30.6% and insulin for 20.6%. Glitazone and acarbose were each part of the management for 6.2% of patients. All patients were using at least one management type. Of 209 respondents, 55 (26.3%) were taking no medication and using diet and exercise only, 39.7% were taking one therapy, 27.3% were taking two and 6.7% were taking three therapies.

Sequelae information was available for 188 patients. Twenty-two per cent of respondents had no sequelae resulting from diabetes. Hypertension was a sequela of type 2 diabetes for 65.4% of respondents, other cardiovascular disease was a sequela for 28.2%, renal disease for 13.8%, and eye complications a sequela for 8.0%. Neuropathy, foot complications and skin complications each affected 10.6% of diabetes patients. Gastroparesis was a sequela for 8 patients (4.3%), depression for 2 patients (1.1%) and other sequelae of diabetes were recorded for 7 patients (3.7%).

HbA1c test levels were recorded for 209 patients. There were 8.2% of patients who did not know their level or had never been tested. Two-fifths of patients (38.9%) had a level  $\geq 6\%$  to  $\leq 7\%$ , and 89 patients (42.6%) had a level  $> 7\%$ . For the 89 patients with a HbA1c level  $> 7\%$ , 69 specified the duration their HbA1c level had been  $> 7\%$ : median duration was 10 months. Of the patients with a level HbA1c  $> 7\%$  and who were not using insulin, 56 gave reason(s) for not using insulin. Three-quarters (75.0%) responded that insulin was 'not yet necessary', for 7.1% the reason was 'needle phobia' and for 12.5% it was 'other patient resistance'.

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

**PLEASE READ CAREFULLY**

The shaded section of the following forms asks questions about **TYPE 2 DIABETES**.  
 You may tear out this page as a guide to completing the following section of forms.

**INSTRUCTIONS**

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

**Diabetes**

Has this patient been diagnosed with **Type 2 diabetes**.  
 If **No** you should **end the questions** here.

**Diabetes management**

Please use the tick boxes to advise how the patient is managing their type 2 diabetes.  
 Beside each medication ticked, please **write** the approximate **length of time** the medication has **been taken** by the patient, and **circle an option** to indicate whether the number written refers to **weeks, months or years**.

**HbA1c level**

Please write in the space provided, the patient's **HbA1c level** from the **most recent test**.  
 If you **do not know**, or the patient has **never been tested**, please tick the box labelled '**don't know/never tested**'.  
**NB.** If the patient's HbA1c is  $\leq 7.0\%$  you should **end the questions here**.

**Time since diabetes diagnosis**

Please advise the approximate length of **time since** the patient's diabetes was **initially diagnosed**. Please **write a number** on the line and **circle an option** to advise whether months or years.  
 e.g. 6 mths / **(yrs)**

**Sequelae of diabetes**

Please use the tick boxes to advise whether the patient has any of the listed **sequelae** of diabetes.

**For patients with HbA1c >7.0%**

If the patient's HbA1c level was **>7.0%** at the most recent test, please use the tick boxes to advise the approximate length of **time since the last test**.  
 Please advise (approximately) **how long** the patient's HbA1c level has been at **>7.0%**.  
 If the patient is **not on insulin**, please advise the **main reason for not using insulin** for diabetes management e.g. the patient fears needles; is resistant for other reasons; in your clinical opinion it is not yet necessary, or for another reason. Please **advise** this reason in the space labelled 'other'.

<p>Does this patient have Type 2 Diabetes?</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No ↴</p> <p><b>End questions</b></p>	<p>Approx. time since initial diagnosis</p> <p>_____ mths / yrs</p> <p>(please circle)</p>	<p>If 'Yes', the diabetes is currently managed with:</p> <p>(please tick all that apply)</p> <p>BL89C</p>	<p><b>Management</b></p> <p><input type="checkbox"/> Diet and exercise</p> <p><input type="checkbox"/> Metformin</p> <p><input type="checkbox"/> Sulfonylurea</p> <p><input type="checkbox"/> Glitazone</p> <p><input type="checkbox"/> Acarbose</p> <p><input type="checkbox"/> Insulin</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None of the above</p>	<p><b>Duration of use</b></p> <p>_____ wks/mths/yrs</p> <p>_____ wks/mths/yrs</p> <p>_____ wks/mths/yrs</p> <p>_____ wks/mths/yrs</p> <p>_____ wks/mths/yrs</p> <p>_____ wks/mths/yrs</p> <p>(please circle)</p>	<p>Does the patient have any of the listed sequelae of diabetes? (please tick all that apply)</p> <p><input type="checkbox"/> Hypertension</p> <p><input type="checkbox"/> Other CVD</p> <p><input type="checkbox"/> Renal disease</p> <p><input type="checkbox"/> Eye complications</p> <p><input type="checkbox"/> Neuropathy / nerve damage</p> <p><input type="checkbox"/> Foot complications</p> <p><input type="checkbox"/> Skin complications</p> <p><input type="checkbox"/> Gastroparesis</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None of the above</p>	<p>What was the patient's HbA1c level at the most recent test?</p> <p>_____ %</p> <p><input type="checkbox"/> Don't know/never tested</p>	<p><b>For patients with HbA1c level &gt;7.0% -</b></p> <table border="1"> <tr> <td data-bbox="1579 1203 1724 1441"> <p>How long since the most recent HbA1c test?</p> <p><input type="checkbox"/> &lt; 6 mths</p> <p><input type="checkbox"/> 6 - 12 mths</p> <p><input type="checkbox"/> &gt; 12 mths</p> </td> <td data-bbox="1724 1203 1870 1441"> <p>HbA1c has been &gt;7.0% for approx.</p> <p>_____ wks / mths</p> <p>(please circle)</p> </td> <td data-bbox="1870 1203 2069 1441"> <p>If the patient is not on insulin, why not?</p> <p><input type="checkbox"/> 'Needle phobia'</p> <p><input type="checkbox"/> Other patient resistance</p> <p><input type="checkbox"/> Not yet necessary</p> <p><input type="checkbox"/> Other (please specify)</p> </td> </tr> </table>			<p>How long since the most recent HbA1c test?</p> <p><input type="checkbox"/> &lt; 6 mths</p> <p><input type="checkbox"/> 6 - 12 mths</p> <p><input type="checkbox"/> &gt; 12 mths</p>	<p>HbA1c has been &gt;7.0% for approx.</p> <p>_____ wks / mths</p> <p>(please circle)</p>	<p>If the patient is not on insulin, why not?</p> <p><input type="checkbox"/> 'Needle phobia'</p> <p><input type="checkbox"/> Other patient resistance</p> <p><input type="checkbox"/> Not yet necessary</p> <p><input type="checkbox"/> Other (please specify)</p>
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# SAND abstract 109: Secondary prevention of heart attack and stroke

**Organisations supporting this study:** National Prescribing Service.

**Issues:** The proportion of patients attending general practice who have risk factors or comorbidities associated with heart attack or stroke; the proportion of these patients currently taking an antiplatelet or anticoagulant medication and which medications patients are taking; reasons given by patients with risk factors or comorbidities for not taking anticoagulant/antiplatelet medications.

**Sample:** 2,471 patient encounters with 84 GPs data collection period: 20/02/2007 – 26/03/2007.

**Method:** Detailed in the paper entitled 'SAND Method 2006-07' on this website: <[www.fmrc.org.au/publications/SAND\\_abstracts.htm](http://www.fmrc.org.au/publications/SAND_abstracts.htm)>.

## Summary of results

The age and sex distributions were similar to all 2005–06 BEACH encounters. One-third ( $n = 841$ ) of the sample of 2,471 patients (34.0%; 95% CI: 29.8–38.2) had at least one of the risk factors or comorbidities associated with heart attack or stroke and a high proportion of these patients were aged 65 years and over. Of 832 patients for whom age and sex was known, 27.5% were aged 65–74 and 32.7% were aged 75 years and over.

Of the 2,471 patients, 26.8% had hypertension, 4.4% had atrial fibrillation, and 3.6% had had an acute myocardial infarction. Stroke/transient ischaemic attack was recorded for 3.2% of patients, stable/unstable angina for 2.5% and peripheral vascular disease for 1.7%. There were 2.2% of patients who had a previous coronary artery bypass graft, and 1.1% who had a previous percutaneous transluminal coronary angioplasty. Other risk factors were indicated 211 times for 8.5% of patients, with diabetes the most common, followed by lipid disorders.

Of 779 respondents with at least one cardiac risk factor, 479 (61.5%) were taking antiplatelet/anticoagulant medication. Aspirin was being taken by 43.1% of respondents, warfarin by 11.7%, clopidogrel by 7.5%, and dipyridamole/aspirin by 1.5% of respondents. Herbal preparations with anti-coagulant effect were taken by 17 (2.2%) patients.

In terms of combinations of medications taken by the 479 patients taking at least one medication, 61.8% were taking only aspirin. Warfarin (only) was taken by 17.3%, clopidogrel (only) by 7.1% and a combination of aspirin and clopidogrel by 4.8% of these patients. Herbal preparations only were taken by 2.5% of patients and the dipyridamole/aspirin combination therapy was taken by 2.1%. Seven patients (1.5%) were taking a combination of aspirin and warfarin.

Of 300 (38.5%) patients with at least one cardiac risk factor who were not taking medications, 274 gave reasons for not taking them. For 54.4% of these respondents, the reason was stated as 'not clinically indicated'. For 20.8%, the reason was a history of peptic ulcer or gastro-oesophageal reflux disease, and for 9.5% it was an expected adverse effect on the gastro-intestinal tract. Concurrent NSAID therapy was cited as a reason for 5.5% of patients. Other reasons (14.2%) included new patient/newly diagnosed and patient resistance.

*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**

**INSTRUCTIONS**

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

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.

<p><b>Does this patient have any of these risk factors for heart attack/stroke?</b></p> <table border="0"> <tr> <td><input type="checkbox"/> Hypertension</td> <td><input type="checkbox"/> Previous CABGs</td> </tr> <tr> <td><input type="checkbox"/> Atrial fibrillation</td> <td><input type="checkbox"/> Previous PTCA</td> </tr> <tr> <td><input type="checkbox"/> AMI</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td><input type="checkbox"/> Stroke/TIA</td> <td>(please specify risk factor)</td> </tr> <tr> <td><input type="checkbox"/> Stable/unstable angina</td> <td><input type="checkbox"/> None of above ⇒ <b>END QUESTIONS</b></td> </tr> <tr> <td><input type="checkbox"/> Peripheral vascular disease</td> <td></td> </tr> </table>	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Previous CABGs	<input type="checkbox"/> Atrial fibrillation	<input type="checkbox"/> Previous PTCA	<input type="checkbox"/> AMI	<input type="checkbox"/> Other _____	<input type="checkbox"/> Stroke/TIA	(please specify risk factor)	<input type="checkbox"/> Stable/unstable angina	<input type="checkbox"/> None of above ⇒ <b>END QUESTIONS</b>	<input type="checkbox"/> Peripheral vascular disease		<p><b>Which medications are currently being taken?</b></p> <table border="0"> <tr> <td><input type="checkbox"/> Aspirin</td> <td><input type="checkbox"/> Warfarin</td> </tr> <tr> <td><input type="checkbox"/> Dipyridamole</td> <td><input type="checkbox"/> Heparin</td> </tr> <tr> <td><input type="checkbox"/> Dipyridamole with aspirin</td> <td><input type="checkbox"/> Low mol. weight heparin</td> </tr> <tr> <td><input type="checkbox"/> Clopidogrel</td> <td><input type="checkbox"/> Danaparoid</td> </tr> <tr> <td><input type="checkbox"/> Ticlopidine</td> <td><input type="checkbox"/> Herbal prep. _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> None of the above</td> </tr> </table>	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Warfarin	<input type="checkbox"/> Dipyridamole	<input type="checkbox"/> Heparin	<input type="checkbox"/> Dipyridamole with aspirin	<input type="checkbox"/> Low mol. weight heparin	<input type="checkbox"/> Clopidogrel	<input type="checkbox"/> Danaparoid	<input type="checkbox"/> Ticlopidine	<input type="checkbox"/> Herbal prep. _____		<input type="checkbox"/> None of the above	<p><b>Despite presence of risk factors, aspirin or anti-coagulants are not taken because of:-</b></p> <table border="0"> <tr> <td><input type="checkbox"/> History of PUD or GORD</td> </tr> <tr> <td><input type="checkbox"/> Expected adverse effect on GIT</td> </tr> <tr> <td><input type="checkbox"/> Concurrent NSAID therapy</td> </tr> <tr> <td><input type="checkbox"/> Other adverse effect including hypersensitivity</td> </tr> <tr> <td><input type="checkbox"/> Not clinically indicated</td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> </tr> </table>	<input type="checkbox"/> History of PUD or GORD	<input type="checkbox"/> Expected adverse effect on GIT	<input type="checkbox"/> Concurrent NSAID therapy	<input type="checkbox"/> Other adverse effect including hypersensitivity	<input type="checkbox"/> Not clinically indicated	<input type="checkbox"/> Other _____
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# SAND abstract 110: Erectile dysfunction

**Organisation supporting this study:** Pfizer Australia Pty Ltd.

**Issues:** Prevalence of erectile dysfunction (ED) in general practice patients/their partners (18 years and over); sources of advice utilised by patients/partners experiencing ED; remedies tried as management of ED; effectiveness of the remedies tried.

**Sample:** 1,930 patient encounters from 82 GPs; data collection period: 20/02/2007 – 26/03/2007.

**Method:** Detailed in the paper entitled 'SAND Method 2006–07' on this website: <[www.fmrc.org.au/publications/SAND\\_abstracts.htm](http://www.fmrc.org.au/publications/SAND_abstracts.htm)>. Participating GPs were provided with a card that contained information about ED and a clinical definition.

## Summary of results

Females were over-represented in this sample (65.0%) of adults when compared with all BEACH encounters with adults in 2005–06 (60.1%). The age distribution within adults paralleled that of patients at all BEACH encounters.

There were 1,930 patients aged 18 years and older, who responded to one or more questions. Of these, almost two-thirds (63.2%;  $n = 1,219$ ) were currently sexually active, 31.9% ( $n = 615$ ) were not, and 5.0% had never been sexually active. Patients aged 25 to 44 years were the most likely to be sexually active (82.7%, 95% CI: 77.4–88.0) and the proportion decreased with age to 11.6% (95% CI: 7.0–16.3) among patients aged 75 years or more. The proportion of patients who were either currently or previously sexually active was similar in males (94.5%) and females (95.4%).

Of the 1,834 (95.1%) patients who were currently/previously sexually active, 160 (8.7%) did not respond to the questions about their/their partner's experience of ED. Of the 1,674 respondents, 20.3% (95% CI: 17.0–23.6,  $n = 340$ ) stated that they/their partner had experienced ED. A significantly smaller proportion of female patients (16.2%, 95% CI: 12.7–19.7) reported their partner's having ED than male patients (27.5%, 95% CI: 22.6–32.4) reported having ED. The proportion of patients experiencing ED increased significantly with age from 2.3% among patients aged 18–24 years, to 35.5% among patients aged 65 years and over.

Of the 340 respondents who had experienced ED themselves or in their partner, 333 reported frequency of ED. Of these, 39.9% experienced ED on 1–25% of occasions, 22.5% on 26–50% of occasions, and the remainder (37.5%) on 51% or more of occasions.

Almost half ( $n = 158$ ) of the 332 respondents to the question on help-seeking had sought help for ED: 44.3% ( $n = 147$ ) from the GP and 6.0% from another health professional.

Of the 145 respondents who had sought help from their GP and who responded to the question about initiation of help, 72.4% stated that they/their partner initiated the discussion about ED, 21.4% indicated that their/their partner's GP raised this topic, and the remainder (6.2%) did not know/could not remember who initiated it.

Of the 340 patients/partners who had experienced ED, 210 responded to the question about remedies for ED (multiple responses allowed). Of these, 60% had tried at least one of the listed remedies. The most common remedy was prescribed medications (84.1%,  $n = 106$ ), followed by behavioural treatment (10.3%) and over-the-counter products (7.1%).

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



## For the Doctor...

Erectile Dysfunction (ED) is a common type of male sexual dysfunction. Epidemiological studies from various countries have found that 30-50% of men aged 40-70 years report some degree of erectile dysfunction.<sup>1</sup> A 2003 Australian study found that 21% of men in this age group reported moderate-severe erectile dysfunction.<sup>2</sup>

The personal nature of the condition and the reluctance of both patients and clinicians to raise the topic means that only a small proportion of those affected seek or receive help.<sup>3</sup> In recent years the internet has allowed the direct sale of medications to patients without the safeguard of supervision by a doctor or pharmacist, increasing the potential risks from contraindications or drug interactions.<sup>4</sup>

The purpose of this research is to determine the prevalence of ED in general practice patients, whether patients have sought help for the problem, what remedies, if any, have been tried, and the effectiveness of these.

It is important to capture this information for general practice patients. We recommend that you explain to the patient from the outset that these questions are about sexual dysfunction and not about other sexual health issues such as sexually transmitted diseases.

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

Thank you for your generosity.

1. Tharyan P, Gopalakrishnan G. Erectile Dysfunction. Clin Evid. 2006 Jun;(15):1227-51.
2. Holden CA, McLachlan RI, Pitts M, Cumming R, Wittert G, Agius PA, Handlesman DJ, de Krester DM. Men in Australia Telephone Survey (MATeS): a national survey of the reproductive health and concerns of middle-aged and older Australian men. Lancet 2005; 366:218-24.
3. Holden CA, Jolley DJ, McLachlan RI, Pitts M, Cumming R, Wittert G, Handlesman DJ, de Krester DM. Men in Australia Telephone Survey (MATeS): predictors of men's help-seeking behaviour for reproductive health disorders. MJA 2006 16 Oct; 185(8):418-22.
4. Armstrong A, Schwartz JS, Asch DA. Direct sale of sildenafil (Viagra) to consumers over the Internet. NEJM 1999 Oct 28; 341(18):1389-92.