

## **21 Diabetes—prevalence, management and screening**

**Organisation supporting this study:** Aventis Pharma Pty Ltd

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

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

**Method:** Detailed SAND methods are provided in Chapter 2.

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

### **Summary of results**

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

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

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

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

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

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

*For other related abstracts see: 25 Prevalence of diabetes, medications and control, 40 Type 2 diabetes mellitus, prevalence and management, 45 Diabetes mellitus prevalence, management and risk factors, 86 Diabetes Types 1 and 2 and coronary heart disease, 87 Management of cardiovascular or diabetes related conditions, 94 Type 2 diabetes – investigations and related conditions.*

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

## **PLEASE READ CAREFULLY**

The shaded section of the following forms asks questions about **DIABETES**.

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

### **INSTRUCTIONS**

#### **FOR THE DOCTOR**

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

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

73

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

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

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

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

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

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

## **Diabetes Risk Factors \*\***

1. Is your family background Aboriginal or Torres Strait Islander, Pacific Islander, Chinese, Southern European or from the Indian sub-continent?
2. Does either of your parents, or any of your brothers or sisters have Type 2 Diabetes?
3. Are you over 50 years of age?
4. For Women: Have you ever had gestational diabetes (i.e. while you were pregnant), a history of babies born heavier than 4.5 kg, multiple miscarriages or stillbirths?
5. Do you:
  - carry a lot of excess weight around your waist and stomach area (central obesity)?
  - have high blood pressure (hypertension)?
  - have a blood lipid (fat) disorder (dyslipidaemia)?

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

## 22 Asthma—prevalence, severity and management

**Organisation supporting this study:** General Practice Statistics and Classification Unit

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

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

**Method:** Detailed SAND methods are provided in Chapter 2.

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

### Summary of results

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

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

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

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

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

*For other related abstracts see: 3 Asthma, 39 Severity of asthma, medications and management, 48 Asthma prevalence and management, 63 Asthma-prevalence, management and medication side-effects, 70 Inhaled corticosteroid use for asthma management, 96 Inhaled corticosteroid use for asthma management, 104 Asthma management and medication use among patients attending general practice.*

*Further reading:*

Henderson, J., Knox, S., Pan, Y., & Britt, H. 2004, 'Changes in asthma management in Australian general practice', *Prim.Care Respir.J.*, vol. 13, no. 3, pp. 138–143.

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

## **PLEASE READ CAREFULLY**

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

### **INSTRUCTIONS**

CHILDREN	Severity*	Common features
	Infrequent episodic	Episode 6-8 weeks or more apart; attacks generally not severe; symptoms rare between attacks; normal examination and lung function except when symptomatic.
	Frequent episodic	Attacks < 6 weeks apart; attacks more troublesome; increasing symptoms between attacks; normal examination and lung function except when symptomatic.
ADULTS	Persistent	Symptoms most days; nocturnal asthma > 1/wk; attacks 4-6 weeks apart; daily use of beta <sub>2</sub> agonist; abnormal lung function; history of emergency room visits or hospital admissions.
	Severity*	Common features
	Very mild	Episodic
	Mild	Occasional symptoms (up to 2/wk); exacerbations > 6-8 weeks apart; normal FEV <sub>1</sub> when asymptomatic.
Severe	Moderate	Symptoms most days; exacerbations < 6-8 weeks apart which affect day-time activity and sleep; exacerbations last several days; occasional emergency room visit.
	Severe	Persistent; limited activity level; nocturnal symptoms > 1/wk; frequent emergency room visits and hospital admissions in past year; FEV <sub>1</sub> may be significantly reduced between exacerbations.

#### **ASK ALL PATIENTS**

Ask each patient if they **currently** suffer from asthma.

If NO asthma - no further questions.

#### **Severity of asthma**

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

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

#### **Action / Management Plan**

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

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

#### **Current medications used:**

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

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

#### **Spacer device used:**

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

#### **Effectiveness of current regimen:**

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

#### **Adverse effects of current regimen:**

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

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

Does this patient suffer from Asthma?

- Yes
- No → **End questions**

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

#### Severity

Child

Adult

Infrequent

Frequent

Persistent

Very mild

Mild

Moderate

Severe

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

- Yes
- No
- Don't know

Current drug(s)

1.

Dose

MDI / DPI / NEB

Regimen

MDI / DPI / NEB

Form\*

MDI / DPI / NEB

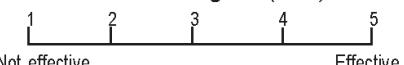
2.

MDI / DPI / NEB

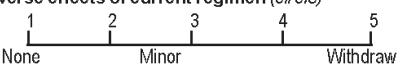
3.

MDI / DPI / NEB

Effectiveness of current regimen (circle)



Adverse effects of current regimen (circle)



\*MDI=metered dose inhaler DPI=dry powder inhaler NEB=nebulus

Spacer device used: Large vol.  For drug(s) 1/ 2/ 3

None  Small vol.  For drug(s) 1/ 2/ 3

### **Severity of asthma reference card**

#### **Children**

<b>Severity*</b>	<b>Common features</b>
Infrequent episodic	Episode 6-8 weeks or more apart; attacks generally not severe; symptoms rare between attacks; normal examination and lung function except when symptomatic.
Frequent episodic	Attacks < 6 weeks apart; attacks more troublesome; increasing symptoms between attacks; normal examination and lung function except when symptomatic.
Persistent	Symptoms most days; nocturnal asthma > 1/wk; attacks 4-6 weeks apart; daily use of beta2 agonist; abnormal lung function; history of emergency room visits or hospital admissions.

#### **Adults**

<b>Severity*</b>	<b>Common features</b>
Very mild	Episodic
Mild	Occasional symptoms (up to 2/wk); exacerbations > 6-8 weeks apart; normal FEV <sub>1</sub> when asymptomatic.
Moderate	Symptoms most days; exacerbations < 6-8 weeks apart which affect day-time activity and sleep; exacerbations last several days; occasional emergency room visit.
Severe	Persistent; limited activity level; nocturnal symptoms > 1/wk; frequent emergency room visits and hospital admissions in past year; FEV <sub>1</sub> may be significantly reduced between exacerbations.

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

## 23 Depression

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

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

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

**Method:** Detailed SAND methods are provided in Chapter 2.

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

### Summary of results

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

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

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

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

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

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

## **PLEASE READ CAREFULLY**

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

### **INSTRUCTIONS**

#### **BOX 1**

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

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

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

Please indicate whether **depression** is one of the problems you are managing for this patient today.  
  
If 'Yes' please continue on to the next question.  
  
If 'No' end questions here.

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

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

Is depression one of the problems being managed at today's encounter?  Yes <input type="checkbox"/> → continue  No <input type="checkbox"/> → end questions here	If 'Yes' how would you describe this depressive episode?  BL29B	Major depression <input type="checkbox"/> Adjustment disorder with depressed mood <input type="checkbox"/> Chronic mild depression <input type="checkbox"/> Alcohol / drug induced <input type="checkbox"/>	Depression associated with anxiety or anxiety disorder (e.g., generalised anxiety, panic, phobia, obsessive compulsive etc) <input type="checkbox"/>  other (please describe) <input type="checkbox"/>  _____  _____
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## **24 Gastro-oesophageal reflux disease (GORD) in general practice patients**

**Organisation supporting this study:** Janssen-Cilag Pty Ltd

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

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

**Method:** Detailed SAND methods are provided in Chapter 2.

### **Summary of results**

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

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

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

Over half of the medications that were currently being taken by patients were H<sub>2</sub>-receptor antagonists (H<sub>2</sub>Ras) (53.6%, 195/364) followed by proton pump inhibitors (PPIs) (29.1%, 106/364). Analysis of medications at the generic level indicated that Ranitidine was the most common generic medication being taken (37.6%, 137/364).

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

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

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

*For other related abstracts see: 18 Drugs for the treatment of peptic ulcer and reflux, 34 Gastro-oesophageal reflux disease (GORD), 51 Use of proton pump inhibitors for gastrointestinal problems, 60 Prevalence of GORD and associated proton pump inhibitor use, 62 Use of proton pump inhibitors by general practice patients, 91 Prevalence and management of gastrointestinal symptoms, 100 Gastrointestinal symptoms in patients attending general practice.*

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

## **PLEASE READ CAREFULLY**

The shaded section of the following forms asks questions about **GASTRO-OESOPHAGEAL REFLUX DISEASE & MEDICATIONS**.  
You may tear out this page as a guide to completing the following section of forms.

### **INSTRUCTIONS**

#### **FOR THE DOCTOR**

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

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

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

18

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

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

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

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

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

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

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

Has this patient been diagnosed with **gastro-oesophageal reflux disease**?

- Yes - at this encounter  
 Yes - at a previous encounter

No → **end questions**

BL30C

What medication is currently being taken for treatment?

None

**Patient Satisfaction**

**Medication**

**Regimen**

**Initiated by**

1

2

3

4

5

1. \_\_\_\_\_

Daily / p.r.n

GP/Spec'st/other

1

2

3

4

5

2. \_\_\_\_\_

Daily / p.r.n

GP/Spec'st/other

1

2

3

4

5

3. \_\_\_\_\_

Daily / p.r.n

GP/Spec'st/other

1

2

3

4

5

For 'daily' regimen medication is actually taken:

- one per day  
 > one per day  
 < one per day

Which medications have you previously used for this condition?

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

## **25 Prevalence of diabetes, medications and control**

**Organisation supporting this study:** Aventis Pharma Pty Ltd

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

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

**Method:** Detailed SAND methods are provided in Chapter 2.

### **Summary of results**

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

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

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

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

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

*For other related abstracts see: 21 Diabetes – prevalence, management and screening, 40 Type 2 diabetes mellitus, prevalence and management, 45 Diabetes mellitus prevalence, management and risk factors, 86 Diabetes Types 1 and 2 and coronary heart disease, 87 Management of cardiovascular or diabetes related conditions, 94 Type 2 diabetes – investigations and related conditions.*

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

## **PLEASE READ CAREFULLY**

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

### **INSTRUCTIONS**

#### **FOR THE DOCTOR**

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

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

83

#### **ASK THE PATIENT**

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

#### **ASK THE PATIENT**

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

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

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

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

Does this patient have diagnosed diabetes?

- Yes - Type 1
- Yes - Type 2
- No - end questions

Which of the following medications is this patient currently using?

- |   |  |
|---|--|
| <input type="checkbox"/> Insulin (intermediate/long acting) | <input type="checkbox"/> Sulfonylurea  |
| <input type="checkbox"/> Insulin (short-acting)             | <input type="checkbox"/> Metformin     |
| <input type="checkbox"/> HMG-Co-A inhibitor                 | <input type="checkbox"/> Glitazone     |
| <input type="checkbox"/> ACE-inhibitor                      | <input type="checkbox"/> Repaglinide   |
| <input type="checkbox"/> Other Antihypertensive             | <input type="checkbox"/> None of above |

In the past 12 months how many times has this patient had a **hypoglycaemic attack/event**?

\_\_\_\_\_ times  
BL32C

In the past 12 months, how many times have the following actions resulted from a **hypoglycaemic attack/event**?

- |                              |       |       |
|------------------------------|-------|-------|
| Glucagon injection           | _____ | times |
| Community Nurse consultation | _____ | times |
| GP consultation              | _____ | times |
| Casualty visit               | _____ | times |
| Hospitalisation              | _____ | times |

In the past 12 months how many days has this patient been absent from work due to a **hypoglycaemic attack/event**?

\_\_\_\_\_ days

## **26 Prevalence of diagnosed hypertension and difficulties in treatment**

**Organisation supporting this study:** AstraZeneca (Australia) Pty Ltd

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

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

**Method:** Detailed SAND methods are provided in Chapter 2.

### **Summary of results**

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

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

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

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

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

*For other related abstracts see: 59 Hypertension management and control in general practice patients, 79 Hypertension and dyslipidaemia – comorbidity and management in general practice patients, 98 Management of hypertension and angina in general practice patients.*

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

## **PLEASE READ CAREFULLY**

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

### **INSTRUCTIONS**

#### **Hypertension.**

Does this patient have diagnosed hypertension?

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

If No ...questions END here.

#### **Current Medication for Hypertension.**

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

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

#### **Previous Medication for Hypertension.**

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

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

#### **Control of patient's hypertension.**

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

#### **Change of Medication**

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

Does this patient have hypertension?

YES

Simple

Complicated

NO  → END

Has getting control of this patient's hypertension been ..

Easy

Relatively easy

Difficult

Extremely difficult

What medication/s is this patient **currently** taking for hypertension and how long have they been on each?

**Medication****Duration (circle one)**

<1mth / 1-12 mths / >12 mths

\_\_\_\_\_

<1mth / 1-12 mths / >12 mths

\_\_\_\_\_

<1mth / 1-12 mths / >12 mths

\_\_\_\_\_

**NONE**

Has this patient's hypertension medication/s changed in the last 12 months?

Yes

No

What medication/s were **previously** taken for hypertension and how long ago was each of these stopped?

**Medication****How long since stopped?**

<1mth / 1-12 mths / >12 mths

\_\_\_\_\_

<1mth / 1-12 mths / >12 mths

\_\_\_\_\_

<1mth / 1-12 mths / >12 mths

\_\_\_\_\_

**NONE**

BL33B

## **27 Prevalence and management of influenza**

**Organisation supporting this study:** Roche Products Pty Ltd

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

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

**Method:** Detailed SAND methods are provided in Chapter 2.

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

### **Summary of results**

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

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

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

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

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

*For other related abstracts see: 9 Influenza and absenteeism.*

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

## **PLEASE READ CAREFULLY**

The shaded section of the following forms asks questions about **INFLUENZA**.

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

### **INSTRUCTIONS**

#### **ASK THE PATIENT...**

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

**Have you had influenza in the past 12 months?**

If Yes ... please continue with the remaining questions.

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

#### **Impact on daily activities.**

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

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

#### **Others with 'flu'.**

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

#### **Vaccination for 'flu'.**

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

#### **Treatment / advice.**

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

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

#### **Medications.**

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

Have you been **vaccinated** against 'flu' in the past 12 months?

- Yes  
 No

Have you had influenza in the past 12 months?

- Yes →  
 No - end questions

Treatment/advice was sought from whom and how soon after onset of symptoms?

(please circle)

- |   |                            |
|---|----------------------------|
| <input type="checkbox"/> Pharmacist           | <24hrs / 24-48hrs / >48hrs |
| <input type="checkbox"/> GP                   | <24hrs / 24-48hrs / >48hrs |
| <input type="checkbox"/> Hospital outpatients | <24hrs / 24-48hrs / >48hrs |
| <input type="checkbox"/> None sought          |                            |

How much did it **interfere** with your **daily activities**?

- Not at all  
 Slightly  
 Moderately  
 Greatly

What **medications** did you take for treatment? (include prescriptions **and** 'over-the-counter' medications)

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_

Did any **other member** of your household also suffer from 'flu'?

- Yes ↗ child  
 No ↗ adult

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

## ***Influenza***

### **\*\* SYMPTOM CHECKLIST**

#### ***Sudden onset of...***

- ◆ fever - 38 degrees C. or more, and/or
- ◆ chills
- ◆ body aches and pains  
possibly also ...
- ◆ headache
- ◆ dry cough
- ◆ fatigue

### **IMPACT ON DAILY ACTIVITIES**

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

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

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

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

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\*\* compiled with advice from the Australian Influenza Working Party

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## **28 Prevalence of Alzheimer's disease and dementia**

**Organisation supporting this study:** Janssen-Cilag Pty Ltd

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

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

**Method:** Detailed SAND methods are provided in Chapter 2.

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

### **Summary of results**

The age and sex distributions of the respondents was similar to the distribution for BEACH overall. The prevalence of diagnosed Alzheimer's disease in this adult general practice patient population was 1.6% (95% CI: 0.0–4.4), and the prevalence of diagnosed dementia was 2.4% (95% CI: 0.0–5.4).

Of adult patients not diagnosed with dementia, 4.2% displayed cognitive impairment, 4.9% encountered difficulties with daily living and 5.6% experienced behavioural changes. Only 1.4% of patients displayed all three of the above symptoms, while 2.7% had two of the three symptoms, and 5.0% displayed one symptom.

A MMHA had been used for only 2.4% of the 2,046 patients without diagnosed dementia or Alzheimer's for whom a response to this question was provided. MMHA use was rare (0.9% assessed) for patients with no symptoms of dementia but more common (51.7% assessed) with patients who had all three dementia symptoms.

GPs were asked whether it was likely that patients without diagnosed dementia actually had signs of dementia or early Alzheimer's. GPs indicated that 59 patients (2.9%) were likely to have dementia not yet diagnosed, and 20 patients (1.0%) were likely to have early Alzheimer's, as yet not diagnosed. Combined, GPs indicated that 63 patients (3.1%) were likely to have undiagnosed dementia and/or early Alzheimer's and more than half of these patients were aged 75 years or more. By far the majority of these expressed opinions were based on clinical opinion rather than on results of a MMHA.

*For other related abstracts see: 102 Alzheimer's disease or dementia in patients attending general practice.*

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

## **PLEASE READ CAREFULLY**

The shaded section of the following forms asks questions about **DEMENTIA / ALZHEIMER'S DISEASE**.

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

### **INSTRUCTIONS**

#### **Dementia.**

Has this patient ever been diagnosed with any form of dementia either today or at a previous encounter?

If Yes ...questions **END** here.

If No ....please continue.

#### **Difficulties with daily living.**

From the symptom card please indicate whether or not this patient has difficulties with daily living activities.

#### **Mini Mental Health Assessment.**

Please indicate whether or not this patient has ever undergone a Mini Mental Health Assessment, either under your care or, to your knowledge, that of another physician.

#### **Basis of previous response.**

Please indicate whether you have based your answer to the previous question (i.e. the likelihood of this patient having dementia, signs of early dementia or signs of early Alzheimer's disease) on the results of a Mini Mental Health Assessment, on your clinical opinion, or both. You may tick both options if both apply.

#### **Alzheimer's Disease.**

Has this patient ever been diagnosed with Alzheimer's disease, either today or at a previous encounter?

#### **Cognitive impairment.**

From the symptom card please indicate whether or not this patient shows signs of cognitive impairment.

#### **Behavioural changes.**

From the symptom card please indicate whether or not this patient often experiences behavioural changes.

#### **Likelihood of dementia / Alzheimer's.**

Please indicate the likelihood of this patient having dementia, signs of early dementia, or signs of early Alzheimer's disease.

Has this patient ever been diagnosed with Alzheimer's Disease? <input type="checkbox"/> YES <input type="checkbox"/> NO      BL34B	Has this patient ever been diagnosed with any form of dementia? <input type="checkbox"/> YES → END Questions <input type="checkbox"/> NO →	Does this patient have any cognitive impairment? (see card) <input type="checkbox"/> YES <input type="checkbox"/> NO	Does this patient have any difficulties with daily living? (see card) <input type="checkbox"/> YES <input type="checkbox"/> NO	Does this patient often experience behavioural changes? (see card) <input type="checkbox"/> YES <input type="checkbox"/> NO	Has this patient undergone a Mini Mental Health Assessment? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is it likely that this patient has:- Dementia? (currently) <input type="checkbox"/> YES <input type="checkbox"/> NO	Signs of early dementia? <input type="checkbox"/> YES <input type="checkbox"/> NO	Signs of early Alzheimers? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is your answer to the previous question based on <input type="checkbox"/> results of a Mini Mental Health Assessment? <input type="checkbox"/> Clinical opinion?
--	--	--	--	---	--	--	---	---	--

## **Dementia / Alzheimer's**

### **\*\* SYMPTOM CHECKLIST**

#### *Cognitive impairment ...*

- \* forgetting to pay bills
- \* misplacing car keys, or
- \* word finding difficulties.

#### *Difficulties with daily living ...*

- \* meal preparation,
- \* telephoning,
- \* housework,
- \* difficulty in handling finances and correspondence

#### *Behavioural changes ...*

- \* depression,
- \* anxiety,
- \* mood swings,
- \* delusions and hallucinations,
- \* aggression and agitation.

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\*\*based on NSW Alzheimer's Association symptom list

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## **29 Non-steroidal anti-inflammatory drugs (NSAIDs) and acid suppressant use**

**Organisation supporting this study:** AstraZeneca (Australia) Pty Ltd

**Issues:** This substudy was designed to investigate non-steroidal anti-inflammatory drugs (NSAIDs) and acid suppressant use by general practice patients. Specifically, the use of NSAIDS, Cox-2 inhibitors and acid suppressants by patients with upper gastro-intestinal (UGI) problems was explored.

**Sample:** Responses were recorded by 88 GPs for 2,551 patients; data collection period: 16/07/2001 – 20/08/2001.

**Method:** Detailed SAND methods are provided in Chapter 2.

### **Summary of results**

The age-sex distribution of patients in this sample was similar to the distribution of the total BEACH sample, with the majority (58.8%) being female. Patients aged between 25 and 64 years represented over half the sample (53.2%).

One in seven (13.9%) of the 2,551 respondents were currently taking a non-steroidal anti-inflammatory drug (NSAID). Of those who reported NSAID use, 46.6% ( $n=165$ ) were using a Cox-2 inhibitor alone; 38.7% ( $n=137$ ) were using another NSAID alone; 5.1% were using aspirin alone; 1.1% were using both a Cox-2 and aspirin; and 0.9% were using aspirin with another NSAID.

Among the 325 patients for whom the type of NSAID was specified, Cox-2 inhibitors were the most commonly used (59.4%). Regimen was recorded for 132 of those using Cox-2 inhibitors, 59.1% of whom listed continual use and the remainder (40.9%) were taking them when required.

A total of 422 respondents using NSAIDS answered the UGI questions. The prevalence of UGI in these patients was estimated at 75.4% (CI: 69.7–81.0). At least one UGI problem was listed by 38.8% of the 165 patients using Cox-2 inhibitors; 25.4% of the 138 other NSAID users, and 32.3% of the 130 taking low dose aspirin.

Of the 422 respondents with at least one UGI problem, three-quarters (75.4%) were using acid suppressant medication. For the 480 patients currently taking NSAID and/or aspirin, almost one in three (30.2%) were using acid suppressant medications.

Acid suppressants were used prophylactically by 39.1% of the 307 patients using acid suppressants, the remainder using these medications only when required for symptom relief.

*For other related abstracts see: 78 NSAID & acid suppressant use in general practice patients, 88 Arthritis rates and NSAID use in general practice patients, 49 Health status and management of patients on non-steroidal anti-inflammatory drugs.*

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

## **PLEASE READ CAREFULLY**

The shaded section of the following forms asks questions about **NSAID** and **ACID SUPPRESSANT USE**.

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

### **INSTRUCTIONS**

#### **Patient use of NSAIDs and / or Aspirin**

Please indicate by ticking the appropriate box/es whether this patient is currently taking a non-steroidal anti-inflammatory drug (NSAID) and / or low dose aspirin. If the 'non-specific' NSAID option is ticked, please write the name of the NSAID being used.

Tick as many options as apply.

Please circle an option from the 'taken' column to indicate whether the medications are taken as required or continually.

Please circle an option to indicate the approximate length of time (months) that the patient has been taking this medication.

#### **Acid Suppressant Medication**

Please indicate whether this patient is currently taking any acid suppressant medication (either prescribed or over-the-counter). If 'YES' please specify these medications in the spaces provided.

Please circle an option from the 'taken' column to indicate whether the medications are taken as required or for prophylactic purposes.

Please circle an option to indicate the approximate length of time (months) that the patient has been taking each medication.

36

#### **Symptoms of Upper GI Problems**

Please indicate by ticking the appropriate box whether the patient is currently experiencing, or currently being treated for, symptoms of upper gastro-intestinal problems.

Tick as many options as apply.

Is this patient currently taking - **a non-steroidal anti-inflammatory drug (NSAID)** ?

taken for how many months

<input type="checkbox"/> YES - Cox 2 inhibitor	prn / continually	<3 / 3-6 / 6-12 / >12
<input type="checkbox"/> YES - non-specific (which one?) _____	prn / continually	<3 / 3-6 / 6-12 / >12
and / or low dose aspirin?		
<input type="checkbox"/> YES	for how many months	<3 / 3-6 / 6-12 / >12
<input type="checkbox"/> NONE of the ABOVE		

BL34C

Does this patient have, or are they being treated for, **symptoms of upper GI problems** such as -

- dyspepsia / indigestion
- reflux symptoms / heartburn
- ulcer (duodenal, peptic)
- bleeding ulcer
- none of the above

Is this patient taking **any acid suppressant medication** (eg PPI's, H2RAs, misoprostol, OTC preparations etc)

YES (please specify) taken for how many months

1. \_\_\_\_\_ prn / prophylactically <3 / 3-6 / 6-12 / >12

2. \_\_\_\_\_ prn / prophylactically <3 / 3-6 / 6-12 / >12

NO

## **30 Lipid lowering medications and coronary heart disease**

**Organisation supporting this study:** Commonwealth Department of Health and Ageing

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

**Sample:** 2,661 respondents from 90 GPs; data collected between 21/08/2001 – 24/09/2001.

**Method:** Detailed SAND methods are provided in Chapter 2.

**Methods for this study:** Risk factors for CHD included: diabetes mellitus, familial hypercholesterolaemia; family history of coronary heart disease (1st degree relative <60 yrs of age), hypertension and peripheral vascular disease.

### **Summary of results**

The age-sex distribution of respondents was similar to the distribution for BEACH overall, with the majority (58.6%) of patients being female.

More than 1 in 10 (12.6%) respondents indicated they were currently taking lipid lowering medications. The sex-specific rate of lipid lowering medication use was similar for males and females. The highest age-specific rate of lipid lowering medication use was for the age group 65–74 years. However, 36.1% of respondents taking lipid lowering medications were aged between 45 and 64 years of age.

Most respondents on lipid lowering medications were continuing therapy ( $n=292$ ), while very few were starting medication therapy at the current encounter ( $n=12$ ).

For those on a lipid lowering medication 41.1% had existing coronary heart disease (CHD), a further 25.9% had one of the listed risk factors for CHD, 21.1% had more than one of the listed risk factors, and 9.2% had none of the listed risk factors, although these may have had high cholesterol (not familial) which was not included on the CHD risk factor list.

Approximately 2.7% did not provide information on risk factors.

For those without CHD, hypertension was the most common risk factor (30.1% of respondents on lipid medication therapy).

There were 330 medications listed for lipid lowering therapy. Statins accounted for nearly all the listed medications. Atorvastatin accounted for 41.5% of lipid lowering medications, prescribed for 42.1% of respondents on lipid lowering therapy.

*For other related abstracts see: 15 Lipid lowering medication, 20 Screening and management of blood cholesterol, 46 Coronary heart disease, risk factors and lipid lowering medication, 58 Lipid lowering medications: patient eligibility under PBS, 64 Current use of statins by general practice patients, 67 Risk factors of patients on lipid lowering medications, 79 Hypertension and dyslipidaemia – comorbidity and management in general practice patients, 86 Diabetes Types 1 and 2 and coronary heart disease, 97 Statin medication use among high CHD risk patients attending general practice, 99 Lipid management in patients with high risk conditions.*

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

## **PLEASE READ CAREFULLY**

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

### **INSTRUCTIONS**

#### **FOR THE DOCTOR**

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

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

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

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

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

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

Please indicate by ticking the appropriate box whether or not this patient has **existing coronary heart disease** which has been diagnosed at a previous encounter.

If **YES** - questions **END** here.

If **NO** please continue.

Please indicate by ticking the corresponding box/es whether the patient has any of the **risk factors** listed.

**Is this patient currently using lipid lowering medication therapy?**

- YES** - continue ⇒
- NO** - end questions

BL35B

- If '**YES**' is the patient
- commencing therapy  
or
  - continuing/changing therapy

**Name of medications currently used**

1 \_\_\_\_\_

2 \_\_\_\_\_

**Does this patient have existing coronary heart disease?**

- YES** - end questions
- NO** - continue ⇒

**Does the patient have** (please tick)

- diabetes mellitus?
- familial hypercholesterolaemia?
- family history of coronary heart disease (1st degree relative <60 yrs of age)?
- hypertension?
- peripheral vascular disease?
- none of the above?**