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EDITORIAL

Mario Baruchello

Networking People

Overwhelmed GPs, racked by a connection delirium or rather the triumph of communication? Did you try to observe yourself in one of your usual mornings in the office? In comes our patient with his daughter and they sit in front of us...

We work using simultaneously more than one technology. Two PCs on the table with many windows opened. On the first one you open the family's clinical record, which begins the daily activities.

The second one has a fast DSL Flat connection with 150 Mbps broadband Internet access. Near us one or two mobile phones (personal and for the office) and during the day we receive more than one SMS from a friend who needs attention and sends insistent messages or continues making calls. In the background a radio broadcasts in the various offices alleviating patients in the waiting room while entertaining the secretaries on the job. Then come the association colleague's emails that signal the disservice of the day or ask for a top specialist to refer.

A young colleague sends a picture because he isn't sure if the blisters he sees are Herpes zoster and doesn't want to give medications improperly to a 60 year old: he wants a fast answer. The secretary brings in some tests sent via fax by a patient, who is in his office far from home and needs to be reassured. The phone, even when professionally filtered and deferred by the secretaries rings, interrupting a dialogue that was already distracted by the people I was talking to. The door opens and I have to sign some prescriptions ... The web is really tempting ... a glance at the titles of the local news, a look at the scenery of the day, while I open the web cam on my favourite mountains; but what brings me back to earth is the question my two marvelled patients asked and that I needed to look up for a scientific clarification. It's a way to find with a *coup de foudre* professional authority: "... as you can see the operation that was suggested can be done in the

near University, where there is a reference centre that exposes excellent case histories right here ..."

I don't know how many of us really live this way, but I think that if we add up all the activities that more or less we simultaneously engage every day, we are not so far from this and that for all of us, it's just a matter of time. Who knows what happens to our patients during our processes, during this jumping from one thing to another, mixing work, research, study and leisure relationships. Will we still be able to read a book a few years from now? Or maybe books will become something different? Are we starting to govern this fragmentation calmly before the too many connections sweep us away? Even the most recent neuropsychiatric studies confirm that human beings, whether 50 year old GPs or young students, have a significant drop in their performances in presence of duties/activities that overlap. Do we use occasions for relationships with more intelligence than the web offers? It is absolutely necessary to create priorities and temporal sequences that include in our frenetic work "pauses" to restore the mind. <http://netaudit-storie.blogspot.com/>

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This number of QQ includes an interesting research on severe obesity among our patients. In the **European Health report 2002**, on health in Europe in 2002, published by the Regional European Office of the WHO, obesity is defined as a real epidemic. *In many European countries* - we read- *more than half the adult population is over the threshold of being "overweight" and about 20-30% of the adults can be put in the clinically obese category*.

The prevalence we found, the declared scarce knowledge of integrated centres by GPs, the distance from a specialist nutritionist and dietetic services, besides the rare integrated centres in the GP office, create a need for GP training. The LDL case doubly puts in evidence a separation between the development of the binomial "Research-Evidence" and the

involvement of patients and operators on the field. Once again General Practice is called to raise its attention level, helping patients build correct lifestyles, which can play a fundamental role in case of chronic pathologies. Let's be careful though how it's problematic to face, without a priority and collaborative vision, the great number of risk factors we have. Last but not least, our colleague Bastianon makes us reflect on the true challenge of simple medicine in home care. This means that when in a field you notice a continuous reduction in threshold values, comes an awareness that there may be a breach between the development of the binomial "Research-Evidence" and the relative reduction of patient and operator involvement, which a good GP must refine with a detective's perception. Treatment discontinuity in *long term* pathologies is a phenomenon we must investigate and go in-depth in a context as ours in which absolute adherence to treatments is not attainable.

NET-FAT: PREVALENCE OF SEVERE OBESITY IN TWO BMI SEGMENTS (35-40 YEARS; OVER 40) AND FAMILIARITY WITH PROFESSIONAL STRUCTURES FOR INTEGRATED TREATMENT AND/OR SURGERY AMONG 39 ITALIAN GPS OF THE NETAUDIT LIST (<http://www.netaudit.org/>)

Francesco Del Zotti (VR); Enzo Brizio (CN); Angelo Cervone (NA); Giovanni De Luigi (TO); lista Netaudit (www.netaudit.org)

BACKGROUND

Severe obesity, with a BMI higher than 35 represents a real discontinuity respect to simple overweight or initial obesity. Cardiovascular and secondary disease risks grow exponential and life expectancy shortens. Actually the most credited sources sustain that this type of patient not only needs a specialist, but a multi-discipline and integrated task force that guides the combination of clinical interventions on different axis, besides diet and psychological interventions. Moreover, in the last years some revisions in the Cochrane Library (1) have proved the effectiveness of a surgical approach in specialized centres, in particular in those cases where the following three conditions coexist:

- a) BMI > 40; or between 35 and 40, in presence of comorbidity
- b) If there has been already a conservative approach without success by a specialized team
- c) If there are not significant clinical contraindications for surgery, nor drug or alcohol abuse

AIM

The aim of our study is to create a simple recognition of the widespread problem of "severe obesity" in General Practice and on the other side, of familiarity and possible use – by the netaudit GPs – of modern services for a quality management of these groups of patients.

RESULTS

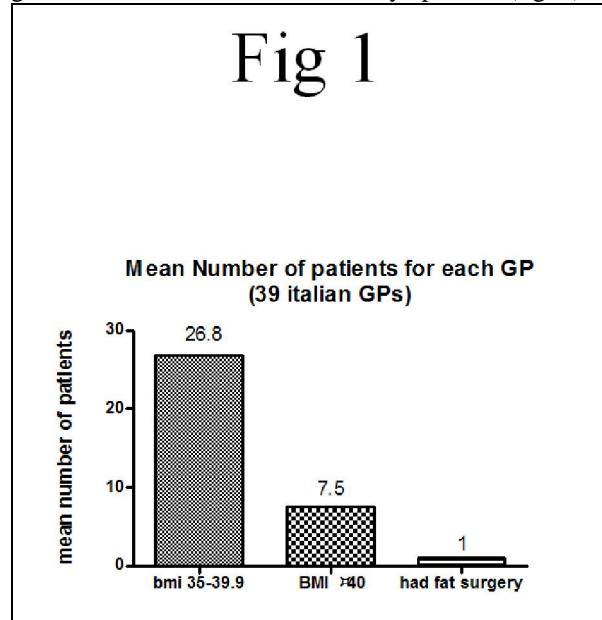
39 netaudit GPs that assist overall 52.308 patients participated in this study (Median: 1341 patients per GP). The GPs have in their lists 40 already operated patients, equal to a median of 1 operated patient per GP (minimum 0; maximum 4).

Knowledge of multi-team centres: Regarding the knowledge of a *multi-discipline* centre for severe obesity and relative distance from one's main office, more than half of the GPs (21/39) declare they don't know of any multi-discipline centre oriented towards an integrated management of obese patients; for 6 GPs the centre is rather far (in 3 cases more than 100 km; in 3 other cases from 50 to 100 km); 12 GPs have a centre at less than 50 km.

Knowledge and appreciation of a dietician operating under a public contract: only 7 GPs on 39 (18%) declare they regularly and with reliance consult a professional dietician operating under a public contract; while 32 GPs never (7) or rarely (15) consulted these specialists, or have done it sometimes without great reliance (10).

Number of patients potentially destined to complex interventions and/or surgery

BMI 40: overall 39 GPs with 294/52.308 patients having these BMI values, datum equal to 5 per 1000 patients; averagely each GP has 7.5 patients with these BMI values, which the guidelines indicate as threshold for eventual surgery; therefore, a number 7 times greater than the unit of those already operated (fig. 1).

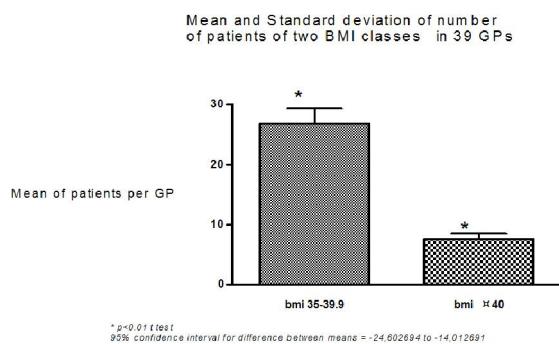


BMI from 35 to 39.9: there are 1047 patients with this BMI, equal to 2% of the patients; in average every GP has 26,8 patients in this BMI area that the guidelines indicate as risking surgery (however, in this area it's necessary to determine the absence of comorbidity, before opting for surgery). The number of patients with this BMI is significantly greater respect to those with BMI > 40 (fig. 2)

CONCLUSIONS

Grouping the patients with a BMI between 35 and 40 together with BMI > 40 we have 1341 patients, equal to 2.5% (Confidence Interval 2.4%-2.7%) of all assisted patients (52.308). Therefore, a GP with 1500 patients can expect to have at least 30-35 patients with severe obesity and with a potential for an integrated intervention and/or surgery. This datum assumes an epidemiological outline similar to the one for diabetes.

Fig. 2



The higher proportion of patients with BMI between 35 and 40, respect to those with BMI > 40, highlights the decisive role of the GP in the delicate evaluation of comorbidity before any surgical decision. The significant prevalence, the declared limited familiarity with integrated centres, the distance of many integrated centres from the GP's office and the inadequate relationship with dieticians, highlight the need for training, the need for professionals and integrated centres for severe obesity, and the need for a better connection between these centres, professionals and GPs.

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NOT ONLY SQUIRRELS ACCUMULATE FOR THE WINTER!

(GPs today: computerized and careful on costs, but not always is this enough...)

Giampaolo Bastianon - GP - Tezze sul Brenta (VI)

The case that happened to me these days is emblematical, but I imagine this doesn't happen only to me. Mrs. Domenica, is a 79 year old patient I follow in a planned home care program, affected by: - COPD in continuous O2 therapy – Insulin-dependent diabetes mellitus – Hypertensive cardiopathy – Horton's disease.

I go visit the woman regularly once a month to check her conditions and in that occasion I prescribe the medications necessary for the following month on the basis of her therapy and the prescriptions recorded and monitored in my personal record on my PC. I've been doing this for the passed two years. I should add that this patient lives alone because the relationship with her son and daughter-in-law has deteriorated and she is followed by a carer that does not last more than 6-7 months. Usually for financial reasons or because there is personality incompatibility these people are dismissed and replaced. Therefore, here it's difficult to develop a trusting and collaborative relationship that lasts with the same person. The woman's physical conditions have been stable in these last two years and after visits with a specialist her therapy has always been confirmed. Everything seemed to be proceeding normally except that I received a tip-off that made me discover a treasure of prescription drugs that the woman had accumulated and jealously preserved in the bedroom wardrobe, fearing that the "all free blessings" would end considering the lean years that seem to be approaching.

I insisted with Mrs. Domenica until finally she opened her wardrobe where I found:

- 10 boxes of Oxivent aerosol
- 10 boxes of Cordarone tablets
- 10 boxes of Deltacortene tablets
- 10 boxes of Zanedip tablets
- 20 boxes of glucose test strips

She candidly defended herself saying that she reduced her therapy because she felt good and had put on the side the extra medications in case of worse times. The episode tore all my pride and before the collapse of my self-esteem I asked myself a few questions:

1. Are we sure that it's enough for the GP to own a computerized system to control prescriptions and health costs? From the above-mentioned case it looks like it's not enough. Now I imposed my patient to keep a regular diary with her sugar count and I opened in her clinical record a page in flash with a note of all the medications I found in her home. The **compliance** (adhesion) is conditioned by many factors, but not actually by age.

However, about 40% of elderly patients do not take their prescriptions drugs as indicated by the GP, usually they tend to take less respect to the ones prescribed (insufficient compliance): see
http://www.msitalia.it/altre/manuale/sez22/3_042786b.html

2. Are the therapies, at times complicated, with which our patients are dismissed from geriatrics and general medicine wards, which many times are increased in the following specialist visits really always necessary? The case of Mrs. Domenica seems to highlight reservations in our daily work. The level of appropriateness in the use of delicate and expensive medications can be now evaluated using a database created by the local health units for administrative purposes. DPD (Daily Prescribed Dose), DRD (Daily Recommended Dose), DDD (Defined Daily Dose) became these years the measure of our adhesion to an EBM medicine, based on the knowledge and the adhesion to Guidelines.
<http://www.astazeneca.it/ncmprintchapter.aspx?type=article¶m=523027>

My patient self-medicated herself for two years reducing the therapy by one third and did not have any type of decompensation in spite of the power trips that at times catches GPs concerned of treating scientifically every diagnosed pathology, independently from the functional balance that every physical body creates with time.



MODALITY, FREQUENCY AND THRESHOLD OF LDL-CHOLESTEROL IN 4051 DIABETIC PATIENTS OF 49 GPs

Francesco Del Zotti (VR); **Enzo Brizio** (CN);
Carmine Farinaro (CE); **Anna Rita Di Paolo** (AQ);
Alberto Dolci (VI); **lista Netaudit** (www.netaudit.org)

BACKGROUND

Diabetes represents a known cardiovascular risk. The HPS study demonstrated how besides the initial cholesterol value, it is decisive to use statins to lower by one third the risk of heart attack in diabetic patients. According to the most accredited guidelines the marker of an efficient therapy is LDL. In particular, the guidelines claim that in diabetic patients we must take at least one LDL each year and preferably its value

must be less than 100 mg/dl or not greater than 130 mg/dl. The trend is even lower and some authors suggest an LDL lower than 80 mg/dl, in particular in patients with diabetes and cardiovascular disorders (1;2;3).

Informal preliminary surveys among the Netaudit members induce to believe that in Italian General Practice, LDL is still requested and recorded not enough in clinical records. Moreover, there seems to be a certain variability in the modalities for the requirement and calculation of this lipoprotein: there are GPs that request Cholesterol, Triglycerides and HDL tests and omit to calculate the LDL; others use a calculator or a software for computerized records to obtain the LDL; others request the calculation directly to the laboratory (which gives the lab a compensation of 0.6 euro) according to the Friedewald formula.

AIMS

- a) Evaluate the calculation modalities and the introduction of LDL in the PC by the participating GPs
- b) Evaluate the measurement of LDL in diabetic patients, at least every 2 years.
- c) Evaluate the proportion of diabetic patients with a LDL lower than 100 mg/dl
- d) Evaluate the proportion of diabetic patients with a LDL from 100 to 130 mg/dl

METHOD

The participating GPs were asked to use an algorithm and an ad hoc phrase in SQL to extract data from the database. To search in their database the GPs did the following operations:

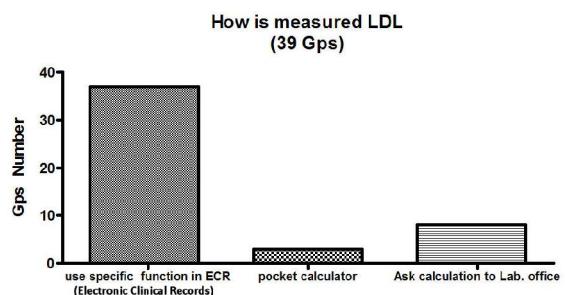
- a) first extract the diabetic patients
- b) then extract the list if patients that took an LDL (diabetic patients and non diabetic patients) in the 24 months in object (2004-2005)
- c) therefore, crossing the two lists, analyse how many diabetic patients had in the above-mentioned period at least one LDL measurement with a numerical value. LDL without answers or with nominal answers as "normal", "pathological" were not introduced in the calculation)
- d) Check how many diabetic patients have a LDL less than 100 (ideal) and how many between 100 and 130 (acceptable). The data analysis was carried out with *Epi-info* and *Statsdirect*

PARTICIPATING GPs

49 Italian GPs with 64.316 patients (in average 1.313 patients per GP) adhered. Most GPs belong to the *Netaudit* list (41/49) that promoted the initiative; other 8 GPs belong to Italian GP telematic circuits (*Forum Millewin*; *Lista Ippocrate*; *Lista med-marche*; *Lista Med-news Abruzzo*; *Lista MIR*; *Lista Simg-veneto*). The GPs have in their lists 4.051 diabetic patients, equal to 6% of all patients and an average of 82 diabetic patients per GP; most GPs (41/49) uses the software Millewin; the remaining 8 GPs used Iatros (2), Phronesis (2), Profim (1) and other softwares (3).

LDL ACHIEVEMENT MODALITIES (figure 1)
 Most GPs (37/49, equal to 75%) used the automated formula in their PC; 8 GPs required the lab to calculate the LDL; 4 GPs used a calculator.

Fig. 1



RESULTS (figure 2-3)

A) At least 1 LDL in the record in 24 months : 1.995/4.051 diabetic patients had at least 1 LDL in their record, equal to 49.2%: Confidence Interval at 95% from 47.6% to 50.8%

B) Last LDL less than 100: 577/4.051 patients (14,2%): CI 95% from 13,2% to 15,3%

C) Last LDL between 100 and 130: 694/4051 patients (17,1%): CI 95% from 15,9% to 18,3%)

D) Variability among GPs: as shown in figure 3 there is a strong variability in the percentage proportion of patients with LDL: actually the variation coefficient in the 1st group is (LDL less than 100) around 80% and in the 2nd group (LDL between 100 and 130) around 66%.

Fig.2

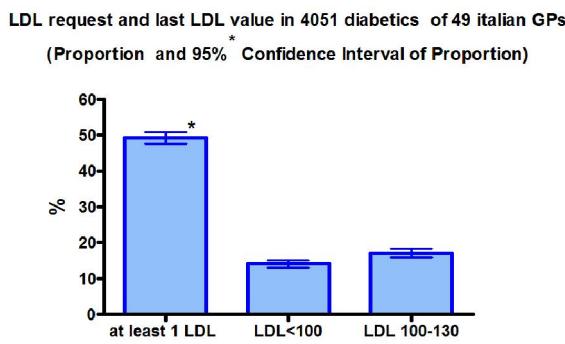
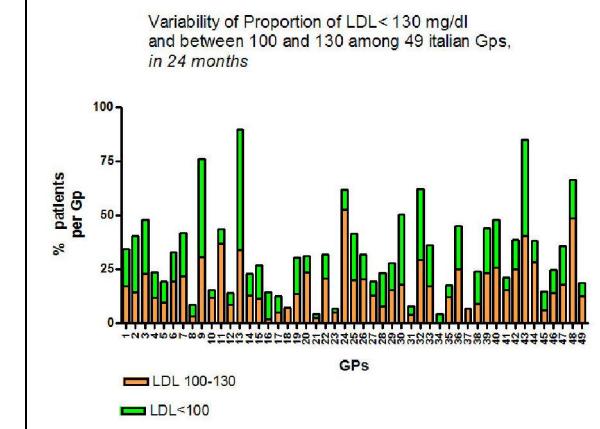


Fig 3



COMMENTS AND CONCLUSIONS

Our study highlights the gap between guidelines and daily practice in relation to the aim of lowering the threshold of LDL values. Respect to the “ideal” indications of a LDL every 12 months in diabetic patients and values lower than 100, the results of our motivated and voluntary GPs within our telematic circuits seem rather far. In the most permissive range of 24 months: a) only 1 patient out of two had a LDL in their records; b) only 1 patient out of 7 had a LDL lower than 100; c) only 1 out of 6 had a LDL between 100 and 130; d) only 31% of the patients has a LDL lower than 130.

Here is the contradiction: on one side there are experts racing to fix LDL limits that are lower, on the other side motivated GPs have a hard time reaching and maintaining sufficient standards. On one side we must encourage GPs towards realistic improvements in requesting measurements and making calculations more frequently, and in pursuing better therapeutic targets; on the other side, guideline extension experts must realize that this significant difference in LDL between theory and practice in diabetic patients is tied to a series of technical hitches. In the first place, we should understand how many cases of LDL cannot be calculated because of high triglycerides values; in these cases, recent studies highlight the usefulness of **non-HDL Cholesterol** obtained subtracting from Total Cholesterol, HDL Cholesterol (4,5,6). Moreover, we should analyse the adaptation and simplification of the realization norms and reimbursements of lab tests. Netaudit GPs highlighted in their discussion list that, if it were possible to request only the LDL instead of three tests, there would be a prescription simplification and a systematic LDL response. In the third place, it would be important that software-houses develop automatisms for the prescription/calculation of LDL in the computerized clinical records of diabetic patients. In the end, specialists, epidemiologists, GPs and patient representatives must confront on the eventual growth by number and dimension of costs (non only economical), to pursue ambitious aims for LDL values: a) more side effects due to statins (with high dosages or stronger ones); b) a growth of risky interactions

between statins and other drugs; c) a significant pressure on patient's freedom and lifestyle.

In conclusion, when in a field there is a continuous reduction of threshold values there should be a new awareness that there may be a split between the development of the binomial "Research- "Evidence" and relative reduction of patient and operator involvement

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Figure: *Old stretcher used by Fire Departments at the beginning of the 20th-century*