

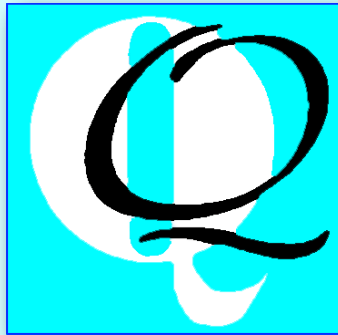
Year XIII - n 1

Periodico Trimestrale di Ricerca e
VRQ in Medicina Generale fondato nel 1996
da SIQuAS VRQ (area Cure Primarie)
e SIMG sezione di Verona.

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In collaborazione con <http://www.netaudit.org>



La Qualità e le Qualità In Medicina Generale

Iscrizione Tribunale di Verona
n. 1187 del 12/12/95

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Redazione: c/o Ordine dei Medici di Vicenza,
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HEALTH EDUCATION AND ENVIRONMENT

Mario Baruchello

Today as GPs not only do we have a personal relationship with our patients but also an undeniable social function, with an ethical duty tied to our responsibilities towards the community and health organizations. This is even truer for GPs, which reflect on the environment in a wider view of medicine, paying great attention to individual and community prevention, while maintaining deep trust between GPs and patients. GPs are opinion leaders and finally our Deontological Code added in Art. 5 a reference to the duty of "promoting a civil culture using natural resources appropriately, to guarantee our future generations a sustainable environment" (http://portale.fnomceo.it/Jcmsfnomceo/cmsfile/attach_3819.pdf).

Individual risk factors, collective behaviours and environmental health are elements closely connected to an ecological vision that must be re-launched in the western world, perpetrator of terrible negative changes in life quality. Italy is now lining up with all the GPs in the world that have already been pursuing this as an important step in their training and profession. The World Medical Association, most important medical association in the world dedicated to medical ethics, to which Italy shamefully has not adhered to yet, and that had as President in 1984 a GP from Vicenza, has been spreading since 1976 its testimony in defence of the environment with in-depth studies on air, acoustic and water pollution in direct relationship with human health promotion. (<http://www.wma.net>)

A civil commitment is taking place and it's noteworthy that FNOMCEO formed an alliance with a scientific society - ISDE – that has won respect in these years even with a small number of members (<http://www.isde.it>) characterised by stability and thematic competence. It's

a daring challenge that we must pursue in and out of our practice, which included in these last months as precursors the Medical Associations of Modena and Padua, which confronted with clear-cut ability the anathemas of various Italian Ministers, for having recommended precautions for the incinerators in Emilia Romagna.

1	<i>Health education and relationships with the environment</i>
2	<i>Oral Anticoagulant Therapy home management</i>
4	<i>Net-Prostate: Audit on Benign Prostatic Hypertrophy in 621 patients</i>
8	<i>Short Netaudit on the prescription of the HIV test IN patients over 18</i>

In this number you will read a Netaudit on Benign Prostatic Hypertrophy with a vast number of cases. For such a widespread pathology we were surprised to see the lack of two simple technologies: 57 GPs out of 63 do not perform rectal examinations on their patients (Not enough time or crowded offices? Patient reluctance that prefer going to the specialist? Defensive medicine? Lack of instruments? Growing "Domineering" role of the PSA?). We must highlight that today physical semeiotics is risking to become "Cinderella". Most of us don't perform pelvic examinations anymore and don't look into our patient's mouths whereas a fast look could make the difference in preventing oral cancer. Not using the IPSS questionnaire is a problem; we should encourage its use, able to rapidly clarify conditions and monitor BPH in time. Keeping a few copies of the questionnaire on our desk could be substituted by a having copy on our PC: see:

<http://www2.radio24.ilsole24ore.com/esserebenessere/IPSS.doc>.

The Netaudit group has already supplied its support to all members in this direction.

Not controlling OAT represents a medical act that could cause damages, whether transitional or permanent to our

patients also due to an incorrect treatment management. In general, each GP should be in the conditions of performing a correct OAT control, with up-to-date knowledges deriving from medical literature and the major scientific and health authority recommendations. Each patient should have in his clinical record a recording of the first clinical examination and lab tests, the follow-ups, the therapy prescription and set dates for the next follow-ups. A correct education of the patient is duty of who is monitoring the therapy. Parma's positive experience collected by Paolo Schianchi proves though other realities in rapid expansion in Italy, the potentials of GP in managing complex cases. Helping the citizens in our office and at home can cause:

- Major efficiency of the clinical processes
- Reduction of waiting time
- Rapidity and simplicity in accessing the services
- Increase of the possibility of satisfying the territorial health demand
- Easier treatment continuity and patient management
- Integration between patients and welfare system.

Facing important economical investments in health technology, come other considerations:

- 1) even without sophisticated softwares many GPs, once stabilised the patient in the initial phase, will be able to make changes in the dosages of the oral anticoagulants on a logical criteria basis, which will derive from a practical clinical experience and will do this on a daily-basis
- 2) a dedicated software will stimulate us to collect all the data in our PC giving us a further impulse for a OAT Audit
- 3) the trickiest problems remains in the logistic-relational field: insufficient collaboration of the patient and/or care-giver with mistakes in drug intake; interaction with other drugs; intake of high quantities of vitamin K with food; metabolic alterations (hypothyroidism, hypercholesterolemia).

In the end, the low number of HIV tests in the Netaudit group suggests a substantial consideration on an active planning of preventive measures in GP. Undergoing campaigns promoted by the Ministry of Health and regional councils, sees GP remaining back to watch. AIDS continues representing a serious health threat with over 3.500 new cases each year, and sexually transmitted diseases strike more than 500 thousand people in Italy each year.

(<http://www.ministerosalute.it/hiv/paginaDettaglioHiv.jsp?id=185&menu=test>)

The Italian Law (135 June 1990) guarantees that the test be prescribed after consent, and rightfully the Netaudit group suggests the need of an appropriate counselling with patients having a behaviour at risk. In most services the test can be carried out without a prescription: it's free and anonymous. Foreigners, even without a residence permit, can take the test at the same conditions of an Italian citizen and there are good websites (in 9 languages), which GPs and citizens can refer to. But it's necessary that GPs talk about this to their patients.

(<http://www.helpaids.it/wContents/Helpaids/prevenzione/testcounseling/counseling.aspx>)

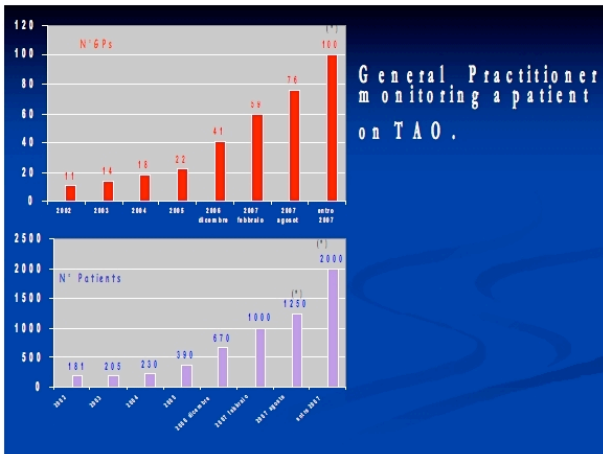


ORAL ANTICOAGULANT THERAPY HOME MANAGEMENT

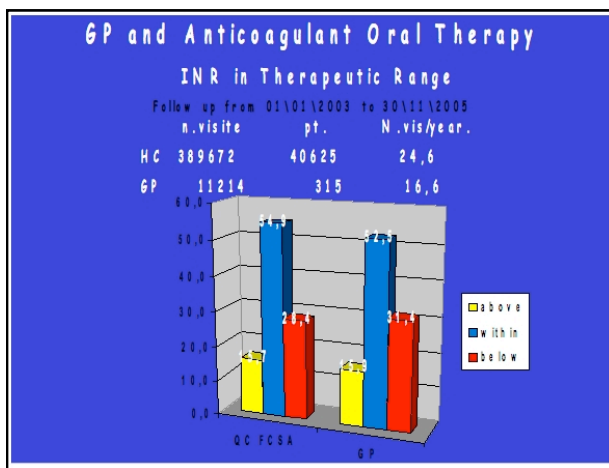
Paolo Schianchi - GP - Felino (PR); **Paola Demicheli** - Trainee (University of Parma); **Cesare Manotti** - OAT Project Manager – Parma Local Health Authority

“Web Parma” is a computerized network that will allow patients in the province of Parma undergoing Oral Anticoagulant Therapy (OAT) to take check-ups and receive prescriptions directly from their GPs, saving trips and hours in the waiting room. The Emilia-Romagna Region, the General Hospital and Local Health Authority of Parma financed the pilot project. GPs will have a direct access to the database of the Homeostasis Centre in Parma, containing all the data of OAT patients (3.500 per year, the largest Homeostasis Centre in Italy per number of patients being followed) using P.A.R.M.A. software (Program for Anticoagulation Monitoring Report Filing) in order to obtain a personalized therapeutic indication. Web PARMA allows patients to easily go to their GP and undergo an INR capillary measurement using a portable coagulometer.

The GP connects via Internet to the server of the Parma Hospital, accesses the patient's record, inserts the new data and obtains the complete drug prescription in return (drug dosages and date of the next check-up). All is left to do is print it. Necessary time: approximately 10 minutes. Each GP is identified by a personal user ID that allows him to see only the records of his patients. However, the presence of the data on the network allows sharing information with other specialized colleagues of the centre, in case a consultancy is necessary. In Italy people affected by thromboembolic and cardiovascular illness are about half a million; 7.000 only in the province of Parma. Half of them are followed by the Homeostasis. The adherence to the Web Parma project is voluntary-based and inserted in the local 2005-07 agreement: each GP that adheres is supplied with the necessary tools by the Local Health Authority and receives a remuneration equivalent to 220 euro/patient/year.

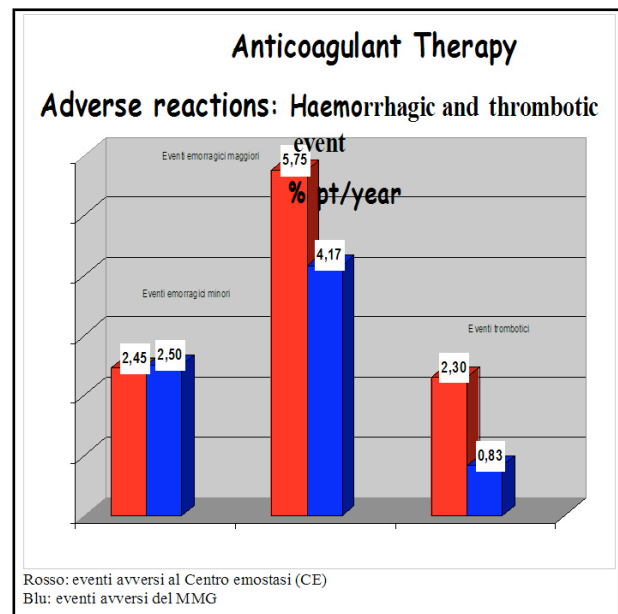


There are currently about 60 active GPs in this project (Fig. 1), while other 20 are being trained; the aim is to reach 100 GPs, one third of Parma's GPs. All the GPs involved receive a specific training; during the last year another distance training option was experimented (DLT), which is structured with two lessons in class and 14 hours of e-learning on the pertinent website. The project's quality data is collected centrally. Those currently available refer to the first 11 GPs that joined, all operating in the province. Most likely they "effectively" meet the difficulties of those assisted patients affected by multi-pathologies, which otherwise would have to travel quite a long way to reach the Homeostasis Centre. The GPs that adhered to the project work in the whole province of Parma: Marcello Bergonzani (Collecchio), Giorgio Bernier (Medesano), Enrico Bertani (Berceto), Giuseppe Ercolini (Sala Baganza), Andrea Manotti (Corcagnano), Rodolfo Mingolla (Sorbolo), Mariangela Rigoni (Felino), Paolo Rodelli (San Secondo), Roberto Salsi (Collecchio), Paolo Schianchi (Felino), Andrea Zorandi (Medesano).

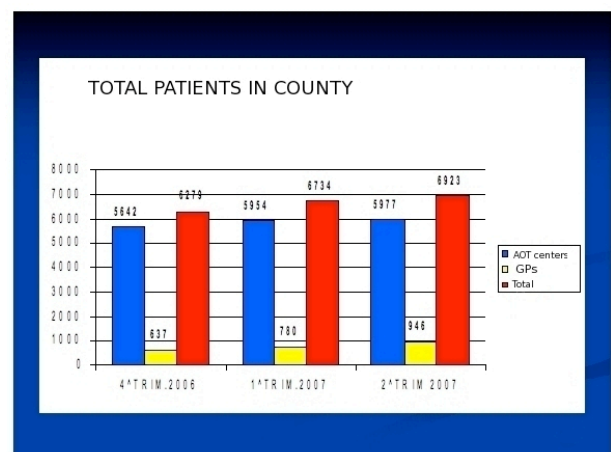


In Fig. 2 the INR values have been separated according to the range: blue within the limits, yellow above the range and red under the range. As you can see there aren't big variations between the check-ups carried out in hospitals respect to those carried out in the GP offices. Only data worth mentioning is the number of visits/year that has sensitively reduced in the GP office. The explanation resides in the fact that the patient is followed

after the coagulation has been stabilized, therefore averagely after 2-3 months from the beginning of the treatment. Adverse events have been separated in haemorrhages, major or minor, and thrombotic.



(Fig. 3). You can notice that the data can be superimposed in the comparison between the two groups examined: Centre and GP. Interesting, for the validity of the project is the data regarding the OAT patients. The number of patients undergoing Oral Anticoagulant Therapy (OAT) increases progressively in the province of Parma, as in the rest of Italy, because of the indications of this therapy in atrial fibrillation. This progression has a stable number of patients in the Homeostasis Centre while there is an overall numeric increase due to the increase of (from 637 to 946 in 2006) followed by the GPs on the territory.



(Fig. 4). In conclusion, this positive experience that began in Parma demonstrates the potential of general practice in managing the complexity of an OAT patient. Thanks to information technology developments, it's possible to follow such patients on the territory, reducing the inconveniences of periodical trips to the city's downtown, and managing them in the same way and

with the same tools of a specialist, without being in competition, but working with a mutual effort.

**NET-PROSTATE: AUDIT ON
BENIGN PROSTATIC
HYPERTROPHY IN 621 PATIENTS**

Barbaro Marchetto (PD), Filippo Seren (PD), Stanislao Caputo (BA), Luciano Bertolusso (CN), Enzo Brizio (CN), Franco Del Zotti (VR) and Netaudit list (www.netaudit.org)

BACKGROUND

Benign Prostatic Hypertrophy, common in elderly males is becoming more and more frequent in Italy, since it has a demographic primacy in Europe for advanced age groups. Even though it's not life threatening, it can be a problem for good life-quality and for the use of medical and surgical resources. Often GPs have delegated the pathology to the specialist, but the need to manage information during these last decades on watchful waiting, on certain common diagnostic tests, on drugs (α -blockers, first of all; and 5- α reductase inhibitor, in selected cases), on timing indications and on the consequences of eventual surgery (i.e. TURP) requires an upturn in the GP role.

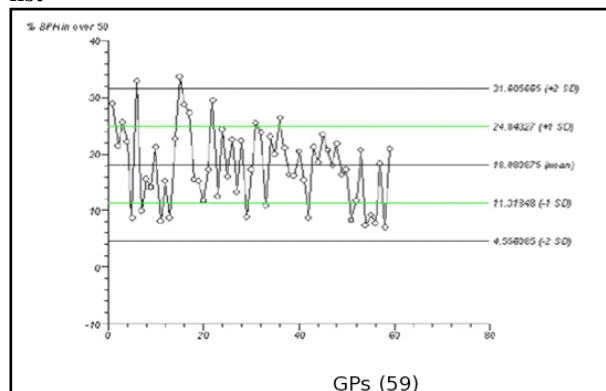
AIMS

- a) Find in the GP's database the prevalence of the problem and its variability among the different Netaudit GPs.
- b) After an acknowledgement of the best Guidelines and evidence available, evaluate the way in which the Netaudit GPs relate to the problem and the ways they record in the clinical record the most relevant diagnostic and therapeutic "decisional" data.
- c) Evaluate the information and counselling degree of the patient regarding the need that he becomes the main character in the therapeutic choices, in a field where death risks are low for an illness where the LG indicates the patient as the principal decision-maker.

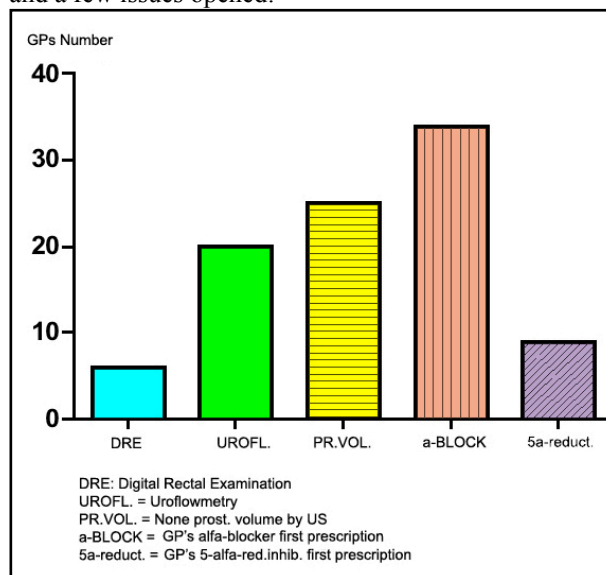
1st Phase: Prevalence and Questionnaire for the GP

In the first phase, 63 Netaudit GPs supplied prevalence data and answered a simple questionnaire regarding some semeiotic and instrumental manoeuvres and the use of α -lytics and a 5- α reductase inhibitor. The average age of the participating GPs was 51,2 years (minimum 42; maximum 57); the gender of the participants was mainly male (60/63). Every GP has an average of 52.7 cases of BPH, (minimum 15; maximum 116). The average prevalence of prostatic hypertrophy among the over-fifty was 18%, with a strong variability among the GPs, from a minimum of 7% to a maximum of 33,7% and a coefficient of variation of 37%

Fig.1: Variability of the proportion of patients with BPH among the over-fifty was 59 GP of the Netaudit list



Subsequently the answers of the 63 GPs were evaluated and a few issues opened:



Proneness towards the practice of RECTAL EXPLORATION: most GPs (57/63) declared they did not have the habit of performing rectal explorations.

REQUEST for a UROFLUXOMETRY before sending the patient to a specialist: only one third (20/63) of the GPs had the habit of requesting this test before sending the patient to the specialist.

ACKNOWLEDGEMENT OF PROSTATE VOLUME in the ultrasound scans reports: in moderate proportion (25/63) the GPs complained about the absence of this data in the radiological reports.

DRUG PRESCRIPTIONS: a little more than half of the GPs 34/63 declared using α -lytics, before requesting the view of a specialist; while only 9/63 GPs declare using first a 5- α reductase inhibitor, before sending the patient to the specialist.

2nd phase: The Audit

Variables and Indicators

Descriptive variables were taken into consideration to better assess the issue, in general not explored very much by General Practice, and the Audit variables, deriving from evidence (see the box in the glossary and bibliography). In particular the following variables were

evaluated: age, symptomatology, questionnaire, PSA, urofluxometry, pelvic ultrasound scan with post-void residual urine volume, in reference to different severity degrees and consequent correlation to the therapeutic options (watchful waiting; α -blockers; α -blockers plus a 5- α reductase inhibitor; surgery). Last but not least, we evaluated the counselling level for the PSA and for the various therapeutic options.

Study Inclusion/Exclusion CRITERIA

In the study we included patients over-fifty years of age, assisted by the GP for at least 6 months, with a diagnosis in their clinical record of Benign Prostatic Hypertrophy. Patients affected by dementia, brain damages, terminal and those that underwent prostate surgery with clear clinical or instrumental signs of Prostate cancer were excluded.

Audit CRITERIA and STANDARDS

The pathology does not compromise life-quality and this is the first audit recognition of the problem, where in many practices it is present in a percentage that is lower than 50%.

In any case, in order to define a benchmark, particular attention was given to the verification of:

- Percentage of use of the Questionnaire (at least once in the clinical record);
- Percentage of presence in the clinical record of at least one Qmax (urofluxometry) datum;
- Percentage of presence in the clinical record of at least one suprapubic ultrasound scans with relative prostate volume datum;
- Percentage of presence in the clinical record of prescriptions of α -blockers;
- Percentage of therapies combining 5- α reductase inhibitor in patients with PSA > 4 or prostate volume > 40 ml, risking progression and complications;
- Percentage of data in the clinical record on PSA counselling;
- Percentage of data in the clinical record on "strategic" counselling regarding the various therapeutic options and on the decisional role in BPH of the patient's preferences.

WORK LOAD and Randomisation

Each GP evaluated record per record, up to a maximum of 15 patients with BPH, randomising them. Who had only 15 patients (or less) with BPH obviously did not need randomisation. The cases were chosen with the usual web-randomisation method, which was created in these years by the Netaudit group. Softwares used: for the data entry Epidata© was used; for the data analysis Epi-info© and Statdirect©.

RESULTS part II (table 1 and figure 3)

Participating GPs

43 participating GPs, with overall 621 randomised prostatic patients, half of which with average age of 69,9 years (SD: 9.5; minimum: 50 – maximum: 95yrs)

Diagnostics

The most relevant data that results in this area is the insufficient use of the questionnaire: the IPSS questionnaire was used in only 47 cases. Regarding the urofluxometry, useful for diagnostics and for the follow-up, the maximum flow data (Qmax) is present only in 76 patients; the Qmax medium was 13,6 ml/sec. Considering the answers with numeric values we observed that 26/76 (34%) have in the clinical record a pathological Qmax (inferior 10 ml/sec).

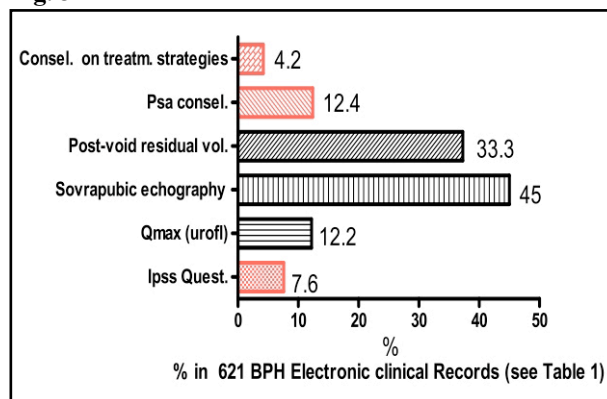
Table 1: Audit Variables

Variable in in Electronic clinical record (ECR)	Number/ Total	% (Confidence Interval)
IPSS Questionnaire (presence)	47/621	7.6% (6%-10%)
Qmax (urofluxometry) presence	76/621	12.2% (10%- 15%)
Sovrapubic echography	279/621	44.9% (41%-49%)
Post void residual urine volume data	232/621	37.3% (33%-41%)
Alfa-blocker drugs.	248/621	40% (36%-44%)
5alpha-reductase inhibitor drugs in patient with > volume or PSA>4	19/57	33.3% (21%-47%)
PSA counselling	77/621	12.4% (10%-15%)
treatment strategies	26/621	4.2% (3%-6%)

Regarding the PSA, useful for a differential diagnosis and to evaluate the volume of the organ, we have observed that the PSA is missing only in 67/621 clinical records (10.7%: CI from 8% to 13%). The average of the last PSA in a clinical record was 3.4 (SD: 3,5). Note that 380/621 patients have a PSA that is 1.4 (hypertrophy indicator) and above; 157 with a value over 4 (first level of alarm for eventual presence of cancer); only 32 patients presented a value greater than 10 (high alarm).

The use of the suprapubic ultrasound scans appeared to be limited in less than half of these cases; the specific prescription of a post-void urine volume evaluation was even less significant (232).

Fig. 3



Drug therapy

NO DRUGS: 203 patients do not take drugs.

ALPHA BLOCKERS: the therapy guidelines indicate the effectiveness of α -blockers in presence of obstruction symptoms. However, in general symptom complications and data on life-quality are quite insufficient, as we have also found inadequate the use of the questionnaire and the urofluxometry.

For this reason, the data we are presenting on the use of α -blockers only has a “descriptive research” value more than of a quality evaluation: 248 patients used these drugs out of 621 (40%, with an interval from 36% to 44%), in monotherapy or associated with 5- α reductase inhibitor.

Therapy with 5- α reductase inhibitor

The above-mentioned considerations are the same also regarding most of these drugs. In fact, following the reference sources, we have found that these drugs should be administered when the prostate has reached a certain volume; which means when the volume is greater than 40 ml or when the PSA makes you think of an enlargement or of a possible surgical evolution (value 4 or greater). We know that this data has been collected in an inadequate manner, both for external reasons (reports of ultrasound technicians) and internal ones. Therefore, at the moment, as for α -blockers the data presented has more a descriptive value than being quality verification.

Only 57/621 cases had one of the two characteristics shown above (volume>40 or PSA>4). Among the 57 with a suspect of enlarged volume, only one third (19 patients): IC 21%-47% takes 5- α reductase inhibitors alone or in combination with α -blockers. Note that the number of patients with data in their clinical record regarding hypertrophy is slightly lower than those that take this category of drugs, whether in monotherapy or in association: 148 cases. Nevertheless, the patients with an indication for these drugs receive in proportion more 5- α reductase inhibitor (19/57) of those without these indications (with PSA<4 and prostate volume <40:58/322): 33% respect to the 18%, with a confidence interval of the difference that goes from 4% to 28%. In most patients undergoing therapy, it has been managed according to the guidelines that suggest a therapy that lasts more than 6 months: 127/148 patients have been in therapy for at least 6 months.

Pre-PSA Counselling

The guidelines recommend that an appropriate counselling precede the PSA. Even if the majority of the cases have at least a PSA in the clinical record, there are only few cases with a documentation of this type of counselling: 77. Counselling regarding watchful waiting and therapeutic strategies is present only in a small number of clinical records (26/621) in which you can actually spot counselling that activates the patient's decisions on the different possibilities in relation to the clinical conditions: (watchful waiting; α -blocker; α -blocker plus 5- α reductase inhibitor; surgery).

CONCLUSIONS

From the data analysis it is immediately evident that benign prostatic hypertrophy, quite frequent in general practice, does still not have an univocal definition and attention: the strong prevalence variability shows a inadequate use of diagnostic tools: insufficient use of a standardised questionnaire, use and interpretation of the urofluxometry, of the ultrasound scan with a calculation of the prostate volume and of the post-void urine

residual. Even if this limited use, declared in the GP's questionnaire, appears comprehensible because of a “relational timidity”, a limited reliability of the manoeuvre in the general practice context and no strong evidences supporting this, without doubt there is still very much to do in BPH continuing education for the other diagnostic tests. However, the improvement in the requests and answers to urofluxometry, and even more regarding ultrasound scans and post-void urine residual, is also tied to the professional interpersonal relationships with urologists and to a logistic optimisation of their services. On this basis it is not simple to figure out in terms of appropriateness the GP's prescriptive behaviour. If the criteria in the clinical records regarding the diagnostic definition is vague or inadequate, the attribution of a percentage of different drugs becomes relative. A first datum regarding drug prescription ought to be emphasized: in a sensible number of cases – about one third – the patients were not taking any drugs; this could be due to some defect in the diagnostic process or to the frequent mildness of the course of the illness. Broadly speaking, concerning the drugs used, we can obtain data from the results of the questionnaire, in which it appears evident that within GP there is a relative familiarity with α -blockers and a minor propensity to start 5- α reductase inhibitors. This behaviour partially explains the differences in absolute numbers of the use between the two classes (248 α -blockers against 19 5- α reductase inhibitor). The sporadic use of these last ones could also be explained by the fear of GPs get involved in the quicksands of the PSA. The drug could be a sort of collateral victim of the “requirement” to periodically evaluate the PSA, with all the succession of problems concerning counselling and the consequent differential diagnosis. Perhaps a way to reduce the problems could be to spread a news update, since it is still not well-known to GPs that PSA induces a strongly and rather precise “reliable” reduction of the PSA: 50%. There is still a lot to improve in the field of PSA counselling recording, required for most of these patients, this datum is present in patient clinical records in only 12% of these cases. A similar deficiency can also be noticed in the counselling recording of the different therapeutic strategies that should become an essential part of the management of this illness, which does not compromise life-quality and therefore deserves a guided management via an informed patient. Counselling probably takes place in many circumstances, but it isn't recorded. We think that in the future we must encourage an increase of these recordings in patient clinical records, both for documentation and attentiveness reasons and eventual medico-legal disputes, and for Audit and self-training purposes. The development of data recording must be simplified by guidelines between GPs, between GPs and urologists and also in clinical record softwares. To conclude, we can assume from this study that BPH, even if not a major illness, represents in it's own small way a model to interpret complex challenges in contemporary GP.

GPs Participating in the 1st phase

ARZENTON Ermanno, AUGRUSO Angelo, BARUCHELLO Mario, BATTAGLIA Alessandro, BELLERI Giuseppe, BERTOLUSSO Luciano,

BEVILACQUA Massimo, BONETTI Dario, BRASESCO Pier Claudio, BRIZIO Enzo, CAMPO Salvatore, CAPUTO Stanislao, CARACENI Luciano, CAROSINO Claudio, CIANCA Mario, CIOLINA Giovanni, COVANTI Massimo, DE BARI Antonio, DEL ZOTTI Francesco, DOLCI Alberto, ERRICO Cosimo Giuseppe, FARESin Florio, FARINARO Carmine, FATIGATI Domenico, FRANCHINI Carlo Andrea, FRAPPORTI Guglielmo, GIANNOBILE Filippo, GRASSI Marco, IVIS Stefano, LAZZARI Giorgio, LIPPA Luciano, LUPI Lorenzo, MAGLIOZZO Francesco, MANGIONE Marcello, MARCHETTO Barbara, MARCHIONNE Maurizio, MARULLI Carlo Fedele, MASSIGNANI Dino Mario, MAZZI Marco, MAZZOLA Vincenzo, MERLINO Giovanni, NOVELLA Guido, PAOLINI Italo, PASCULLI Domenico, PASQUATO Paola, QUATTROCCHI Piero, RIGON Giorgio, RUBICINI Giuseppe, SABBI Diego, SCALA Antonio, SCHIANCHI Paolo, SEREN Filippo, SFRAGARA Ignazio, STRAMENGA Carlo, TARALLO Nicola, TEDESCHI Luca, TONELLO Paolo, VALENTE Biagio, VALLETTA Domenico, VISENTINI Emanuele, VISONÀ Eugenio, ZADRA Alessandro

GPs participating in the 2nd phase

ARZENTON E., AUGRUSO A., BARUCHELLO M., BATTAGLIA A., BERTOLUSSO L., BEVILACQUA M., BRASESCO P.C., BRIZIO E., BRUNO B., CAPUTO S., CARACENI L., CAROSINO C., CIANCA M., CIOLINA G., DE BARI A., DEL ZOTTI F., DOLCI A., ERRICO C.G., FARINARO C., FRANCHINI C.A., GRASSI M., LIPPA L., LUPI L., MAGLIOZZO F., MARCHETTO B., MARULLI C.F., MAZZOLA V., NOVELLA G., PASCULLI D., QUATTROCCHI P., RIGON G., RUBICINI G., SABBI D., SCALA A., SCHIANCHI P., SEREN F., SFRAGARA I., STRAMENGA C., TONELLO P., VALENTE B., VISENTINI E., VISONÀ E., ZADRA A.

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By the NETAUDIT List (<http://www.netaudit.org>)

QUESTIONNAIRE IPSS-QoL

The most used symptom evaluation scale is the IPSS-QoL (International Prostate Symptom Score). There is an Italian version available, which has not yet been validated.

Interpretation of the IPSS THRESHOLD values:
0 - 7 average → observation

8 - 19 moderate → drug therapy

20 - 35 severe → surgery

EVALUATION of Life QUALITY

Beyond the use of the IPSS, sources agree on the need to evaluate life-quality, patient's sexual function and therapeutic requests (watchful waiting; medical therapy; surgery)

PSa in BPH

It must be requested only after giving information of PSA risks and after an Informed Consent. It must not be requested if life expectation is less than 10 years.

PSA Threshold VALUES in BPH Evaluation

Values over 1.3 → correlated to volumes over 30-40 ml

Values over 4 → risk of BPH complications

UROFLUXOMETRY

Insignificant test with empty volume < 125 cc

Mainly evaluate the Qmax maximum flow rate (it must be at least 10 ml/sec)

PROSTATIC VOLUME (with suprapubic US)

Useful for the evaluation of an eventual combined therapy between α -blockers and 5- α reductase inhibitors more indicated if the value is over 40 ml.

POST-VOID RESIDUAL (with suprapubic US)

Attention if over 200-300 ml or if over a third of the empty volume (course less optimistic; major severity)

WATCHFUL WAITING

More than 90% patients with SLIGHT LUTS that have been submitted to watchful waiting don't require another intervention after one year from the initial observation. Watchful waiting doesn't mean a worsening of the symptoms or major incidence of severe complications in patients with average general symptoms. Even if watchful waiting isn't able to improve post-void urine residual or maximum urine flow rate, it improves the symptom score after one year.

Watchful waiting is the preferred treatment in patients with slight LUTS and that don't have an impact on life-quality; it represents a possible therapeutic option where LUTS are average and don't have an impact on life-quality.

DRUG THERAPY

alpha-blockers

After 12 months α -lytics produce an increase of the maximum urine flow rate of approximately 2-3 ml/sec, which is maintained in time. Alternative symptomatic drugs to α -lytics: Serenoa (contrasting evidence)

COMBINED THERAPY (α -blockers and 5- α reductase inhibitors): only if there is risk of progression (PSA >4 or Volume >40). 5 α -reductase inhibitors must be administered for at least 6 months.

FOLLOW-UP

I-PSS - Urofluxometry - Post-void residual volume

SURGICAL INDICATIONS

- Symptoms don't respond to the medical therapy
- Acute or chronic urinary retention
- Recurring urinary tract infections
- Recurring haematuria
- Kidney failure
- Bladder stones
- Increase of the post-void residual volume

TURP: is the reference surgery in case of total gland volume less than 40-50 ml; it's indicated in patients that have developed complications consequent to the BPH and is an acceptable option in patients with cervico-urethral obstructions and medium/severe symptoms that involves a worsening of life-quality. It reduces the symptom score in 70% of the patients.



SHORT-NET AUDIT ON THE PRESCRIPTION OF THE HIV TEST IN PATIENTS OVER-18

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Partecipants: Arzenton E., Augruso A., Brizio E., Caraceni L., Cianca M., Ciolina G., Dalla Via A., Del Zotti F., Farinaro C., Franzoso F., Lipa L., Lupi L., Marulli C.F., Pasculli D., Quattrocchi P., Sabbi D., Scala A., Schianchi P., Seren F. and Netaudit list (www.netaudit.org – www.rivistaqq.it)

BACKGROUND

The prevalence of HIV infection continues increasing worldwide and constitutes a severe threat for public health. On the other hand, in these last years, the discovery of antiviral drugs gave patients the possibility of lowering death risks. Therefore, according to experts and international authorities, it's advantageous to increase screenings in sexually active patients (age ≥ 18 years). (1) The GP is in a delicate situation, between not

using an inquiring and censuring attitude, risk that is always present when talking about HIV, and suggesting a manoeuvre that can have important repercussions on individual and social health. Therefore, this means handling with precaution and tact the invitation of international authorities, discussing the opportunity of administering the test to young people and heterosexual adults and not only to patients at risk by means of general personal and not censuring information. From a first investigation-test of the members of the Italian Netaudit list it seems that 1 HIV test in a clinical record is rather low, and inferior to the one established (at least 30%) in a recent survey published on MMWR (2). The short Netaudit wants to supply both a more accurate general outline and a baseline for a 12-month follow-up.

AIMS

Evaluate the number of patients over 18 years that have at least one Test in their clinical record, independently from the result (negative, positive, "empty")

- evaluate the proportion of tests males respect to females, and compare it to what was expected (the literature supplies a relationship males/females that varies between 3:1 and 4:1).
- The two recordings were carried out once (baseline) evaluating the entire database. After 12 months, at the end of 2008, we will carry out the 2nd phase of the Audit.

RESULTS

19 Italian GPs of the Netaudit list participated in this survey that have 24.402 assisted patients of age (above 18 years).

NUMBER of patients over 18 with at least one HIV test in their clinical record: 2.899 patients had a prescription for an HIV test in their clinical record. This is a rather low percentage: 11,8% (95% IC: 11,4% - 12,3%). There was a fairly good variability among the 19 GPs (figure 1), with a minimum percentage of 3.5% tests carried out per GP up to a maximum of 22% per GP, with the highest percentage (variation coefficient: 44%).

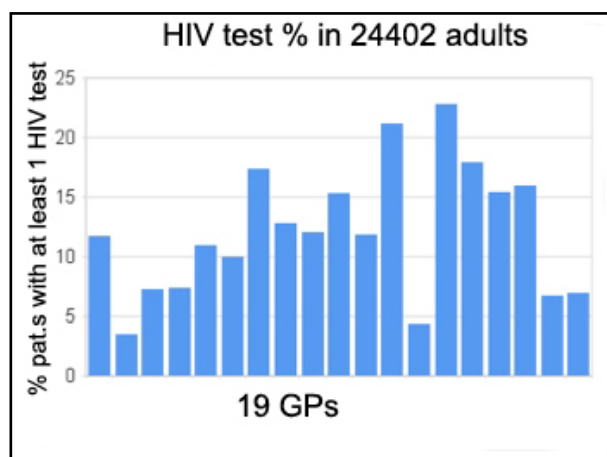


Fig. 1: Variability of % in patients with at least 1 HIV test among 19 Italian GPs

NUMBER of Tests and patient gender (figure 2): females took the test at least once in a significantly higher manner than males. In figure 2 there are 2.899

patients with at least 1 test, 1.870 are females (Proportion = 0,64505 Exact Clopper-Pearson 95% confidence interval = 0,62732 to 0,662487) against 1.029 males (Proportion = 0,35495 - Exact Clopper-Pearson 95% confidence interval = 0,337513 to 0,37268). The relationship in the M/F Test results being approximately 1:2, far from the expected (>3:1).

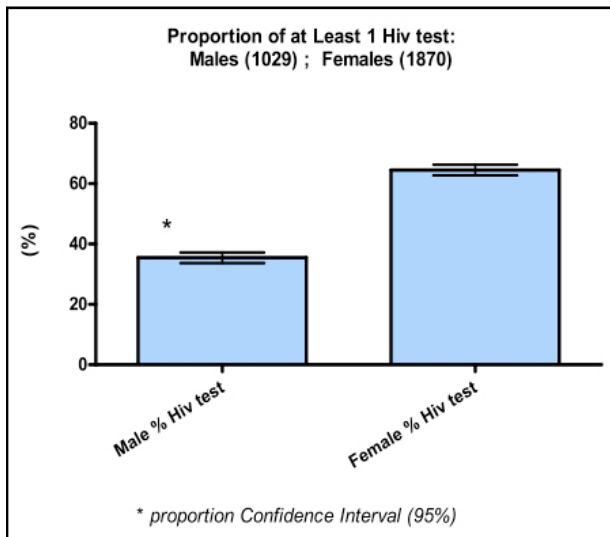


Fig. 2

COMMENTS AND CONCLUSIONS

This pilot study with 19 GPs demonstrates a great deficiency in the prescriptions of HIV Tests: less than 12% of adult patients have in their clinical record at least 1 HIV test. The datum is deficient also considering that the Netaudit GPs were self-selected in a group that from 7 years carry out voluntary Audits through the Net.

Further element that disturbs derives from the data regarding patient gender: the males, which epidemiologists say are exposed to a risk that is 3-4 times greater, in our survey have a Test quota that is significantly lower respect to females.

How do we interpret this deficiency? Probably, most GPs expect that the request come from the patient, or upon indications of field specialists: in particular by gynaecologists, perhaps during pregnancy check-ups, which would explain major test prescriptions to females; or by surgeons, i.e. for pre-operative routines. Without doubt GPs could use an "opportunistic" medicine, not only to improve the number of prescriptions but also the data collection in clinical records, if they do not underestimate the delicate moment of pregnancy and surgery; and an analogous improvement could take place if they have a good relationship with the great number of "blood donors" or with transfused patients.

But the great leap will take place only if we understand that GPs cannot exclude doing some counselling with all young and adult patients and not only with patients at

risk, which are a great disease reservoir. This obviously means a considerable relational stress: one thing is giving a direct and upright suggestion to a long-term drug addict, which we see very far from us; another is to give a nondirective and non-intrusive suggestion to patients that are even close friends or to our niece or child. And we must manage relapses of those prevention methods that couples should adopt. This means finding a happy means between systematic and neutral information - less censured - and an interpersonal more intimate but less intrusive and moralistic dialogue. A sophisticated job that supposes a tight relationship with lab technicians, colleagues expert in infectious diseases and dedicated psychologists, which is often absent.

A difficult but obligatory path must force us to organize a task force among health operators, where in first position there must be Audit groups among GPs. For this reason we decided to repeat this Audit a year from now, to see if we were able to modify this deficiency in such an important field.

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Winter Tree
(Mario Baruchello)