



revista portuguesa de medicina geral e familiar
portuguese journal of family medicine and general practice

ÓRGÃO OFICIAL DA ASSOCIAÇÃO PORTUGUESA
DE MEDICINA GERAL E FAMILIAR

ISSN 2182-5173 • Publicação Bimestral • Vol 34 • Suplemento • 10€

Abstract book of the 5th VdGM Forum
January 26-27th, 2018
Porto, Portugal

rpmgf

revista portuguesa de medicina geral e familiar
portuguese journal of family medicine and general practice

DIRECTOR / DIRECTOR

Rui Nogueira

EDITOR CHEFE / EDITOR-IN-CHIEF

Alberto Pinto Hespanhol

EDITORES ADJUNTOS / ASSISTANT EDITORS

Paulo Santos

Tiago Maricoto

ORGANIZING COMMITTEE & ABSTRACT REVIEWERS

ORGANIZING COMMITTEE

President:

Ana Nunes Barata

Scientific programme:

Luís de Pinho-Costa (chair)
& Vera Pires da Silva

Social programme:

Ana Luís Pereira (chair)
& Tiago Castanheiro

Exchange:

Nina Monteiro (chair)

Image:

Mariana Fidalgo Leite (chair),
Beatriz Figueiredo
& Sara Teotónio Dinis
Treasurer: Maria João Nobre

ABSTRACT REVIEWERS

Ana Margarida Cruz
André N. Van Nhieu
Berk Geroğlu
Bruno Heleno
Candan Kendir
Chloe Delacour
Christofer P. Reichel
Elvira Ensink
Enrique Alvarez
Harris Lygidakis

Ivana Babić
Joana Gomes
Job Metsemakers
Katarzyna Nessler
Liliana Laranjo
Lucia Kukuckova
Ludmila Resutiková
Luís Monteiro
Luís Pisco
Patrick O'Donnell

Persijn Honkoop
Raluca Zoitanu
Raquel Gomez Bravo
Rosy Tsopra
Simone Cernesi
Stefano Celotto
Tom Axelrod
Ulrik Kirk
Yusianmar Mariani

**Administração, Direção Comercial
e Serviços de Publicidade**

Medfarma – Edições Médicas, Lda
Alameda António Sérgio, 22, 4.º B
Miraflores – 1495-132 Algés
Tel: 214 121 142 • Fax: 214 121 146
E-mail: medfarma@mail.telepac.pt

Diretor de Publicidade

Manuel Magalhães
manuel.magalhaes@medfarma.pt

Impressão e Acabamento

Ligação Visual, Indústria Gráfica
Produção Gráfica: Paulo Veiga

Editor Técnico

Baltazar Nunes
Maria Luz Antunes
Pedro Aguiar

Secretariado da RPMGF

Cristina Miguinhas
secretariado@rpmgf.pt

Secretariado da APMGF

Avenida da República, n.º 97 - 1.º
1050-190 Lisboa
Tel: 217 615 250 • Fax: 217 933 145
e-mail: apmgf@apmgf.pt
www.apmgf.pt

Registo

Isenta de inscrição no I.C.S. nos termos da
alínea a) do n.º 1 do artigo 12.º do Decreto
Regulamentar n.º 8/99, de 9 de Junho.
ISSN: 2182-5173

Tiragem: 7.000 exemplares
Preço Avulso: 10 €

Assinatura anual 2017 (6 números)

Impressa 48 €; Digital 25 €; Imp. + Digit. 60 €

Estudantes e médicos até 3 anos pós-licenciatura
Impressa 39 €; Digital 20 €; Imp. + Digit. 50 €

Instruções aos autores:

<http://www.rpmgf.pt/instrucoesautores>

Revista indexada

SciELO
Portugal

Index
Revistas Médicas Portuguesas

Proibida a reprodução - mesmo parcial - de artigos e ilustrações, sem prévia autorização da RPMGF,
excetuando a citação ou transcrição de pequenos excertos, desde que se faça menção da fonte.



ORGANIZING COMMITTEE & ABSTRACT REVIEWERS	S1
ORAL PRESENTATIONS	S2
CASE REPORT	S2
RESEARCH	S5
QUALITY	S8
PRACTICE	S9
POSTERS	S14
CASE REPORT	S14
RESEARCH	S22
QUALITY	S25
PRACTICE	S28
WORKSHOPS	S30

ORAL PRESENTATIONS

CASE REPORT

THYROID AUTOIMMUNITY AND POSTPARTUM AFFECTIVE DISORDER: CAUSAL RELATIONSHIP OR NOT?

Marta Barroca,¹ Diogo Coelho Correia,¹ Susana Pacheco¹

¹USF Conde Saúde

martabarroca13@gmail.com

Background: Immunologic tolerance justifies the favorable evolution of autoimmune thyroid diseases during pregnancy and explains their exacerbation in the postpartum. Postpartum thyroiditis affects 4-10% of women up to 12 months postpartum, presenting as asymptomatic, with symptoms and signs of hypothyroidism or hyperthyroidism. In the later scenario, differential diagnosis with Graves' disease is clinically difficult, so positive anti-TSH receptor antibodies (TRABs) confirm this diagnosis. Maternal thyroid autoimmunity is still related to postpartum depression, a situation that should call for the attention of family doctors while they provide care to newly mothers.

Description: 34-year-old female, nuclear family in phase III of Duvall's life cycle, two daughters (5 years and 12 months-old), teacher. Past smoking history, hyperemesis gravidarum in both pregnancies, Graves' disease after the first pregnancy – in remission and without therapy since 2014. Seven months after the second delivery she presented symptomatic hyperthyroidism and thyroid evaluation revealed positive TRABs, which confirmed the recurrence of Graves' disease. She initiated therapy with thiamazole and propranolol, which was effective in controlling thyroid function about one month later, requiring therapeutic adjustment with levothyroxine. However she maintained marked irritability, sadness, lack of concentration and insomnia, with great impact on her relationship with her husband and daughters. After careful anamnesis we realized that this emotional lability were present since the first delivery, although lightly. She started escitalopram and zolpidem, with little efficacy, and the case was discussed with our psychiatry consultant, who suggested further evaluation in psychiatry consultation – for which the patient is presently waiting.

Discussion: Although there is an association between hormonal imbalances of the postpartum period (including thyroid hormones) and affective disorders, in this patient's particular case the causal relationship is not clear. Careful details of her anamnesis suggest that a psychiatric condition has been evolving in the past few years, though aggravated now by her hormonal alterations. At the same time, the recurrence of an autoimmune thyroid disease requires a differentiated support by endocrinology. In these cases, the family physician acts as a liaison and point of continuity of care for the patient, performing a watchful monitoring, early diagnosis and rapid referral.

IMPORTANCE OF DOMICILIARY VISITS FOR POLYPATHOLOGICAL PATIENTS

Ana Cláudia Monteiro Pereira,¹ Cláudia Ho¹

¹USF Travessa da Saúde

ana.monteiro89@gmail.com

Context: Nowadays, more and more people suffer not only from one pathology, but from several ones, which cumulatively contribute to their morbidity. Also, we reach a time where people could live longer but not as they wish to live or with dignified quality. As family doctors, we must seek better strategies to help them live their lives with quality and fulfillment of their wishes, trying to understand their families, environment and agenda.

Case report: 80-year-old man, retired, married, partially dependent on the activities of daily living, with a syndromic biotype: short stature, multiple face fibromas and severe congenital cyphoscoliosis which he overcame during the years and proved himself that he could be successful in life. At his 60's, it became severe enough to conditionate respiratory failure and his mobility capacity due to pain. Also, he was diagnosed with type II respiratory failure, moderate obstructive sleep apnoea, arterial hypertension with complications – stroke in 2014 with decreased left hemibody strength as sequelae, adrenal tumor (he refused to do a biopsy and further investigations), diverticulosis, moderate mitral stenosis, right bundle branch block, benign prostatic hyperplasia, hypoacusia, depression, social isolation and history of falls. He was also investigated for possible Crohn's disease and neurofibromatosis. Currently, the adrenal tumor grew from 47x37mm to 59x77mm, for which he still refuses biopsy and surgery, he needs ambulatory oxygen and he is under respiratory rehabilitation. It was through the domiciliary visit that we were able to find his main difficulties, different from those purely clinical, and that we could perceive his past, the way he faced and fought for all his life and the alternatives he found to feel good and live with quality. Rather than insisting on a treatment or on an exhaustive investigation, it is important to insist on the best way to meet his wishes and seek for his well-being.

Discussion: When we meet a patient with these characteristics it becomes crucial to know not only his clinical history, but also his biopsychosocial environment. Home visits are a good way to achieve this involvement, so important in family medicine. The follow-up of a patient with polypathology and multi-morbidity has its own characteristics and often the patient's agenda differs from ours. Therefore, it's key not only to use the available tools to evaluate family and social risk, but also to assess patient satisfaction.



(ACCIDENT... ALOMA) SQUARED: REGARDING A CASE ON QUATERNARY PREVENTION

Sofia Vale Pereira,¹ Ana Pinho Lopes,¹ Sophia Martins,¹
José Assis Viveiros,¹ Sara Dinis,¹ Ana Leon Mota¹

¹USF Trevim Sol
svalepereira@hotmail.com

Quaternary prevention is a concept present in our daily practice and with overwhelming patient lists and lack of time we see ourselves falling into this trap of diagnosing incidentalomas and treating nondiseases, inducing alarmism, iatrogenic procedures and patient stress. This scenery paints the picture of 'Disease Mongering' or 'Sickness Phenomena'.

Man, 40 years old, asymptomatic, belonging to a unitary family (Graffar scale: I; Apgar 3). Presents with history of trauma, 18 years ago, that left him tetraplegic for 10 years, having recuperated to paraplegia in the last eight years. In his first contact with his family physician, a regular physical examination was performed, and due to his family history of cancer, exposure to toxins – tobacco (26UMA) and chemicals – and low thoracic expansion, a routine workup and chest X-ray was performed. This exam revealed "oval opacity projection, 1.6 cm; in middle region right hemitorax, regular and well defined limits to be studied". In light of this a pulmonary CT scan was requested, having revealed: "in the anterior segment of middle lobe, nodular lesion with irregular and spiculate contour that must be studied and eventually accomplished with biopsy". In his laboratory results an anemia was diagnosed. He was then rapidly referenced to pneumology department. Despite having been submitted to various laboratory analyses, another CT scan, elective transthoracic biopsy (TTB), which complicated in pneumothorax and a positron emission tomography PET/CT scan, no clear diagnostic direction was achieved. Pneumologist referenced to the department of cardio-thoracic to perform a thoracotomy, with pulmonary wedge resection. The extemporaneous biopsy reveals benign tertiary justapleural lymphoid tissue in case, bronchus-associated lymphoid tissue (BALT) hyperplasia.

This case reflects some of our struggles in family medicine, having to balance decisions on probabilities and a few leads. This patient didn't present complaints but his family history, past traumatic experience combined with his exposures led the physicians to practice defensive medicine with various exams, some duplicated, and procedures that led to a benign discovery. We can't begin to imagine the anxiety and reduced quality of life provoked on this patient, during this episode. We must, then, ask ourselves if we proceeding in the best interest of our patients or if we are feeding into our own uncertainties and creating more 'worried wells'.

THE PSYCHOLOGICAL IMPACT OF INFERTILITY

Natalina Rodrigues,¹ Cristina Serra,¹ Miguel Pereira¹

¹USF Mondego
natalinarodrigues89@gmail.com

The impact of infertility can lead to psychopathological manifestations that condition marital, family and social lives. The stress caused by the inability to conceive children, combined with the demands of the whole process of diagnosis and treatment, leads to high levels of stress that easily aggravate anxious and depressive disorders.

Case description: A 37-year-old female, married, shop assistant and belonging to the middle class by the scale of Graffar. Past history is remarkable only for depression medicated and regularly followed in psychiatrist, with no history of gynecological problems. The patient reports good health and no problems were found at pre-conceptional study in 2010. Due to her difficulty in getting pregnant over a year, she was sent to the infertility clinic. The study carried out at the clinic revealed inflammation of the fallopian tube and her husband (with Crohn disease) presented hypomotility of the spermatozoa, therefore the couple began treatment with medically assisted procreation techniques as in vitro fertilization and embryo transfer. After treatment failure in 2012, she began with recurrent episodes of anxiety, worsening of her depressive disorder and nonspecific complaints (abdominal pain and headache). In 2015 she resumed new fertility treatment that failed as well thus presenting her first panic crisis. After this failed treatment, there was a further worsening of the anxious situation and the frequency of panic attacks, but presented new symptoms such as weight gain, palpitations, syncope and dizziness. She performed cardiac, analytical and imaging studies that diagnosed an autoimmune thyroiditis. Since 2016 she had multiple appointments with her family's physician due to work disability caused by her depressive illness and panic attacks. In June, after an episode of vulvovaginitis, the patient initiated pelvic pain and migratory arthralgia of the large joints. Posterior analysis showed increased sedimentation velocity and C-reactive protein. She was then referred to autoimmune diseases specialty.

Discussion: The present case report, show how infertility generates a range of feelings, such as distress, depression, panic disorder and social exclusion. However, even the treatment to infertility can be associated with some important symptoms. This clinical condition decreases the quality of life and directly affects the relationship between the couple, family and the work environment.



TWO CASES OF 'NOT SO INNOCENT' BACK PAIN

Eduarda Cerdeira,¹ Joana Queiroz-Machado,¹ Abílio Malheiro¹

¹USF São João do Porto

Introduction: Back pain is one of the most common reasons for medical consultations. Some cases can be related to systemic disorders. The red flags for further investigation are well described in several guidelines, including those about prescription of spine computed tomography (CT).

Description of the cases: (Case 1) Female, 64 years, caucasian. Married, accountant. History of high cholesterol. Current medication: rosuvastatine 10mg. Observed on 4-4-2017, reported mechanical diffuse middle back pain for two weeks, with associated muscle contracture. Diagnosed as common back pain, prescribed NSAIDs and rest. Visited again, four times in a month, for persistent pain (intensity 4-6/10) CT showed vertebral haemangioma on T8, no other significant problems. Combined tramadol/NSAID was prescribed. On 3-5-2017, she called emergency due to sudden lower limb paraparesis. On emergency room, stroke was excluded, and CT showed pleural effusion and a conglomerate of mediastinal ganglia suitable for lymphoma, also liver and spleen enlargement was found. Admitted on hematology for further diagnosis and treatment. She died at the hospital on 7-7-2017. (Case 2) Male, 58 years, caucasian. Truck driver. History of high cholesterol, colonic tubular adenoma removed on 2015, seafood allergy. Observed on 5-7-2017, reported lumbago for two weeks, no pain relief with oral diclofenac. Nocturnal back pain, pain intensity 4/10, worsened with movement. Physical exam with no signs of radiculopathy. Prescribed tramadol/paracetamol and NSAIDs, lumbar spine X-ray. Nine days later he reported uncontrolled pain, irradiating now for both lower limbs. X-ray showed spondylo disc arthrosis on T11-12 and L2-L4. CT followed. Quick clinical worsening reported with fatigue and weight loss, so he went to emergency room. Haemolytic anemia was diagnosed (Hb 5.8g/dL), so he was admitted on internal medicine for further study. Cancer of unknown primary origin was diagnosed, most likely a gastric carcinoma with bone metastasis. He died at the hospital on 10-8-2017.

Conclusion: Although red flags for severe causes of back pain are well described, sometimes it is difficult to quickly recognize them at primary care practice. Evidence-based guidelines on this topic should support the individualized medical care.

PIRIFORMIS SYNDROME: A FORM OF NONDISCOGENIC SCIATICA

Sara Coelho,¹ José Eduardo Mendes,¹ Carolina Gil¹

¹USF Mondego

saraalcobiacoelho@gmail.com

Introduction: Piriformis syndrome is a neuromuscular disorder related to the sciatic nerve, characterized by its compression through or around the piriformis muscle. Classically it presents as sciatica, with pain in the gluteal region that radiates along the lower limb, and is secondary to dysfunction of the piriformis muscle – non-discogenic. Like classic sciatica, it worsens with gait, running, squatting, and sitting and the intensity varies throughout the day, with asymptomatic periods. In the physical examination there is no neurological deficit and the straight leg raise test (Lasègue) is usually negative. Diagnosis is often difficult, and it is one of exclusion due to few validated and standardized diagnostic tests, compromising its definition.

Clinical case: A 48-year-old man presents with complaints of pain in the left thigh and hip, irradiating down the outside of the thigh and leg to the distal third of the leg, with months of evolution. It relieves with physiotherapy program, non-steroidal anti-inflammatories and laying down. It worsens in the sitting position. At physical examination there is no back pain during observation, and the straight leg raise test is negative, but there is tenderness over the gluteal region, and during flexion, adduction, and internal rotation of the hip. A CT scan of the lumbar spine was requested, which revealed no changes. The patient will meet new physiotherapy treatments. We also advised to perform regular physical activity, with stretches directed to the piriformis muscle.

Conclusion: Piriformis syndrome consists of a neuropathy due to compression of the sciatic nerve in the vicinity of the piriformis muscle, being a form of non-discogenic sciatica. Although it is a clinical entity well described in the literature, it still lacks validated and standardized diagnostic criteria and treatment. Thus, it requires the knowledge of the clinical presentation and the systematized exploration for suggestive signs. The course of the disease is generally favourable after analgesic and/or anti-inflammatory therapy and physiotherapy. Given the high prevalence of sciatica in clinical practice, it is important to consider this diagnosis in its approach, not only to avoid an exhaustive investigation to study presumed discogenic sciatica, but also to properly diagnose this syndrome and institute therapy.



RESEARCH

THE DETERMINATION OF THE FACTORS AND PERCEPTIONS WHICH AFFECT THE HEALTH BEHAVIOR OF WOMEN: A QUALITATIVE RESEARCH FROM TURKEY

Ikbal Hümay Akyildiz,¹ Elif Demirtaş Okumuş,¹ Nan Je Lay,¹ Kader Topçu,¹ Özlem Sarıkaya,¹ Pemra Cöbek Ünal¹

¹Marmara University Medical School, Family Medicine Department, Istanbul
ikbalhumay@gmail.com

Aim: To determine the perception, behaviors and expectations about health and sickness of women from our society, and to evaluate the sociocultural characteristics of these behaviors.

Method: This research is qualitative and criterion sampled. The research universe was 31 women who are aged between 17-77 and have different socio-cultural characteristics. 4 focused interviews were conducted. The researchers gave information about the topic and method before meeting. Participants filled a questionnaire for demographic characteristics. The interviews were made face-to-face at the participants' houses. There was one interviewer and two observers in each session. The voice recordings and the observers' notes of every interview were transcribed. No names have been transcribed. Each of the interviews was analyzed thematically, then some of the themes were commonised and research findings were reached.

Results: According to the analysis, there are five theme topics. These are: 1-physician (professionalism) characteristics affecting the choice of doctor (skills, attitude, gender, knowledge, etc.); 2-emotions and thoughts about women's health care services (shame-embarrassment, unable to choose a doctor, examination style, no need, etc.); 3-reasons for choosing health institutions (attitude of health workers, gender of doctor, hospital facilities, dental services, accessibility, prejudices, long waiting hours, etc.); 4-unmet health needs and perceptions of the causes (anxiety, fear of malpractice, crowd, long waiting hours, community prejudices); 5-thoughts about Family Health Centers (mistrust, lack of equipment, doctor's attitude).

Conclusion: The sociocultural characteristics that determine the perception of the individual, the health care system and the problems caused by the health care workers, significantly affect the individual's utilization of the health care service. Health care workers need re-education or reorganization and health system needs reform with guidance of these factors, which affect health perception and especially for unmet needs of health care for women. To emphasize patient centered approach continuously may be necessary for improvement.

THE EFFECT ON THE PATIENT FLOW IN A LOCAL HEALTH CARE AFTER CLOSING A SUBURBAN PRIMARY CARE EMERGENCY DEPARTMENT: A CONTROLLED LONGITUDINAL FOLLOW-UP

Katri Mustonen,¹ Jarmo Kantonen,² Timo Kauppila³

¹Helsinki University Hospital; ²Primary Care City of Vantaa; ³Department of General Practice and Primary Health Care
katrimustonen@gmail.com

Background: It has not yet been studied, what happens to patient flow to EDs and other parts of local health care system, if distances to emergency department (ED) services are manipulated as a part of health policy in urban areas.

Methods: The present work is an observational and quasi-experimental study with a control and is based on before-after comparisons. How terminating a geographically distant suburban primary care ED alters patient flow to doctors in local public primary care ED's, office-hour primary care, secondary care ED's and in private primary care was studied. The effect of this intervention was compared to another city and its primary care system where no similar intervention was performed. The number of monthly visits to doctors in different departments of health care was scored as the main measure of the study in each department studied (e.g. in primary care ED's, secondary care ED, office-hour public primary care and private primary care). Monthly mortality rates were also recorded.

Results: Increasing the distance to ED services by terminating a peripheral ED did not cause an increase in use of local office-hour services in those areas whose local ED was terminated, although use of ED services decreased by 25% in these areas ($P < 0.001$). The total use of primary care doctor services rather decreased – after this intervention, while use of doctor services in secondary care ED remained unaffected. Doctor visits to the complementary private primary care increased, but this was probably not associated with the intervention because a simultaneous increase in this parameter was observed in the control city. There was no increased mortality in any age groups.

Conclusion: Manipulating distances to ED services can be used to direct patient flows to different parts of the health care system. The correlation between distance to ED and the tendency to use ED by inhabitants is negative. If secondary care ED was available there were no life-threatening side-effects at the level of general public health when a minor ED was closed in a primary care ED system.



TOTAL ENERGY INTAKE AND DIETARY RISKS ASSOCIATED WITH THE USE OF ALCOHOL AMONG URBAN SRI LANKAN ADULTS

Nishan Silva,¹ Shaluni Tissera,¹ Pasindu Malaka,¹ Thusitha Bandara,¹ Geethanjana Malsha¹

¹International Institute of Health Sciences
snishansilva@gmail.com

Introduction: Evidence suggests that moderate amount of alcohol intake (14 units per week) reduces the risk for type 2 diabetes and heart diseases. But, Sri Lanka being a country with its own food habits and practices, calorie intake associated even with the recommended alcohol amounts, puts the appropriateness of the above recommendations to doubt.

Objectives: To identify the calorie intake for a unit of alcohol and to identify food patterns in related to alcohol consumption.

Method: Descriptive cross sectional quantitative study was done on 300 males and females who are consuming alcohol using convenient sampling method in the Gampaha District, Sri Lanka through a questionnaire.

Results: Among 261 eligible participants, mean age of the participants were 35 and mean BMI was 25.33 (over weight). Considering the mean values; on a drinking day, on average 14 units of alcohol is consumed and over a week at least 28 units are consumed in total. Nearly 234 kcal of food is taken with a unit of alcohol and approximately 27 kcal of chases are added to a single unit of alcohol. Majority of the participants (257) consume hard spirits mostly at all, average of 13 units per day. 36% of the respondents have cigarettes every time they consume alcohol and the mean usage of cigarettes in an average drinking day is eight.

Conclusion: Due to high intake of energy from food and chases when consuming alcohol, the recommended safe units of alcohol consumption given in western context cannot be applied to Sri Lanka.

DELAYED ANTIBIOTIC PRESCRIBING FOR RESPIRATORY INFECTIONS

Nuno Parente¹

¹USF Viver Mais, ACeS Grande Porto III – Maia/Valongo
nunomiguelpm@gmail.com

Context: Antimicrobials have revolutionized medicine. In the second half of 20th century as major contributors to life-expectancy increase. Today the level of resistance to antimicrobials is at its high and, accordingly to the European Centre for Disease Prevention and Control, 25,000 persons per year are infected with resistant bacteria. Besides, there's an estimated increase in health-related expenditures by 1.5 billion Euros. The inappropriate use of antimicrobials by healthcare professionals is the most significant factor perpetuating the resistance problem. Most of uncomplicated respiratory tract infections (uRTI) do not imply an antibiotic to improve its outcome, although the overprescribing is a reality.

Methods: It was performed a narrative review searching PubMed, The Cochrane Library, University of York Centre for Reviews and Dissemination databases for clinical guidelines, narrative reviews, systematic reviews and meta-analysis combining the subsequent keywords: 'antimicrobials', 'antibiotics', 'delayed prescri*'. The search was limited to publications in English and Portuguese and dated from January 1, 2000 to August 31, 2017.

Results: Immediate antibiotic prescribing in uRTI only confers modest symptomatic relief comparing with delayed prescribing. Patients' satisfaction was reported as high in both strategies. However, the antibiotic use is markedly lower with the delayed prescribing strategy (31% vs. 93%). Both strategies were similar on morbidity outcomes. The return for revaluation of clinical status resulted in the lowest antibiotic prescription rate.

Conclusions: There's some heterogeneity in studies design, mainly due to different antibiotics regimens and clinical presentations. Delayed prescribing was safe in terms of disease complications rate. Future research should focus in find the groups at higher risk, who truly benefit from antibiotics, and use a 'no antibiotic' arm as comparison.



MODIFIABLE RISK FACTORS FOR DEMENTIA

Sofia Santos,¹ Ivone Rodrigues,¹ Maria Teresa Tomé,¹ Emilia Nina¹

¹USF CelaSaúde

sofiapachecosantos@gmail.com

Introduction: With the ageing of the population, there has been an increase in dementia prevalence, a condition that leads to a significant disability without any disease-modifying treatment. There are nine potentially modifiable risk factors (RF) for dementia that, if effectively treated/managed, can prevent 35% of dementia cases. These RF are divided between the different phases of the life-span in which intervention is more important. The most important RF in midlife (45-65 years old) is hearing loss, hypertension and obesity. However, in later life (>65 years old) this importance shifts to smoking, depression, physical inactivity, social isolation and diabetes. Due to its prevalence and significant number of modifiable RF, dementia has an increasing role in the clinical practice of the Family Doctor. Intervention and prevention in this area can lead to important gains in quality of life.

Objective: To identify the prevalence of modifiable RF for dementia in a population with ≥45 years old.

Methods:

Study: Cross-sectional.

Population/Sample: Patients with ≥45 years old followed in a health unit.

Exclusion criteria: Dementia, developmental delay, neurological infection, neurological tumors and multiple sclerosis.

Study variables: Hearing loss, hypertension, obesity, smoking, depression, physical inactivity, social isolation and diabetes.

Data source: Clinical information obtained from MedicineOne@.

Data analysis: Microsoft Office Excel 2013@.

Results: We found 4,628 patients between 45-65 years old, from which 35 were excluded. In midlife, 808 patients (17.6%) had hypertension, 613 (13.3%) obesity and 56 (1.2%) hearing loss. In midlife, 1,183 patients (25.8%) presented at least 1 RF.

We found 3,456 patients >65 years old, from which 141 were excluded. In later life, 622 patients (18.8%) had depression, 601 (18.1%) diabetes, 168 (5.1%) physical inactivity, 157 (4.7%) smoking habits and 24 (0.7%) social isolation. In later life, 1,306 patients (39.4%) presented at least 1 RF.

Discussion: The family doctor has a privileged role in disease prevention, with detailed evaluation of RF and available resources. There is a significant preventive potential in our population. Between 45-65 years old, a good intervention in hypertension and weight control is essential. In later life, effective diabetes control and depression treatment is very important. Despite the importance of intervention in these key age groups, all of these RF must be frequently and effectively evaluated/controlled.

CORE CONTENT CLASSIFICATION IN GENERAL PRACTICE/FAMILY MEDICINE (3CGP): A NEW INDEXING SYSTEM FOR GENERAL PRACTICE KNOWLEDGE MANAGEMENT

Marc Jamoulle,¹ Ariana Tavares,² Susana Medeiros,³ Luís Miguel Santiago,⁴ Daniel Knupp,⁵ Melissa Resnick⁶

¹Gilly; ²Coimbra; ³USF AlphaMouro; ⁴USF Topázio, ACeS Baixo Mondego, ARS Centro IP; ⁵Sociedade Brasileira de Medicina de Família e Comunidade; ⁶Medical Librarian and PhD applicant, Health Science Center, University of Texas at Houston, Houston, TX, US

Background: Sharing the results of research with general practitioners (GPs) is crucial for the survival of the discipline of general practice/family medicine (GP/FM). Usual indexation systems like MeSH are not multilingual or adapted to the particular field of GP/FM. Consequently, the GP/FM abstracts are lacking bibliographic control and more than half of the research presented by GPs at congresses is lost. We propose a new multilingual indexing system. The existing International Classification of Primary Care (ICPC) has now been expanded with a taxonomy related to contextual aspects (called Q-Codes) such as education, research, practice organization, ethics or policy in GP/FM, currently not captured. The set is proposed under the name Core Content Classification in General Practice (3CGP).

Aim: The aim is to facilitate indexing of GP/FM specific scientific work and to improve performance in information storage and retrieval for research purposes in this field.

Research method/Procedure: Using qualitative analysis, a corpus of 1,702 abstracts from six GP/FM related European congresses was analyzed to identify main themes discussed by GPs, handled in a domain-specific taxonomy called Q-Codes and translated in eight languages. In addition, a methodology for building a lightweight ontology (in OWL-2) was applied to Q-Codes, adding object and data type properties to the hierarchical relations, including mapping to the MeSH thesaurus, Babelnet (www.babelnet.org) and Dbpedia. Finally, the ICPC-2 in 19 languages and Q-Codes in eight languages have been integrated in a healthcare terminology service (www.hetop.eu/q) with a companion website (<http://3cgp.docpatient.net>).

Anticipated Results of the research: Through better indexing of the grey literature (congress abstracts, master's and doctoral thesis), we hope to enhance the accessibility of research results of GP/FM domain and promote the emergence of networks of researchers. First result of experimental implementations of the new indexing system will be presented. The Brazilian congress of family and community medicine 2017 has been entirely coded by participants with ICPC and Q-Codes and 1,746 accepted and coded abstracts are ready to be analyzed and will be discussed. In Portugal 300 master theses have been coded with Q-Codes and the result will be also presented and discussed.



PSYCHIATRIC AND PSYCHOSOMATIC MANIFESTATIONS ON THE SKIN: AN APPROACH TO PSYCODERMATOLOGIC SYMPTOMS IN THE PRIMARY CARE SETTING

Gustavo Gomes Oliveira,¹ Catarina Rocha Vieira,² Cátia Lírio²

¹USF Garcia de Orta, ²USF Camélias
grandeoliveira@hotmail.com

Introduction: As both the skin and the CNS share the same origin from the embryonic neuroectoderm, physiological connections link the CNS functioning to the cutaneous expression. Dermatological symptoms can thus be a common sign of stress and psychiatric disorders. Despite their global crescent prevalence, patients still greatly resist to accept or acknowledge their psychiatric or psychosomatic symptoms, often withholding them from their physician. However, skin disorders, being visible and disturbing for the majority of people, represent one of the top causes of primary care consultation. Therefore, it's fundamental for the physician to know and be able to recognize and suspect skin manifestations as a reflection of psychosomatic or psychiatric illness.

Objectives: Bibliographic research about symptoms and skin diseases as a reflection of psychiatric and psychosomatic illness and its approach in the primary care setting, highlighting the current diagnostic and therapeutic recommendations.

Methods: Bibliographical research on the PubMed/MEDLINE databases, with the keywords 'psychodermatology', 'psychocutaneous medicine', 'psychiatric symptoms', 'psychosomatic symptoms', 'skin symptoms', 'skin diseases' and 'primary care', for articles published until June 2017.

Results: Psychodermatologic manifestations are classified as psychophysiological, primary psychiatric and secondary psychiatric. Their approach requires an evaluation of the skin symptoms and the social, family and occupational issues underlying the problem. Once a diagnosis has been established, both psychiatric and dermatological symptoms need to be addressed. Therapeutic options may include psychotropic drugs, stress management therapies and psychiatrist referral for the former and supportive dermatologic care and dermatologist referral for the latter. The primary care setting is thus an ideal place to manage and/or refer these conditions, and the family doctor's support may enhance the acceptance of psychiatric treatment and consultations.

Conclusion: The awareness to psychodermatologic manifestations is fundamental, not only because they allow the diagnosis and treatment of an underlying psychiatric problem, but also because these skin disorders can worsen them through depression, humiliation, frustration, social phobia, negative impact on self-esteem and body image. Being in the first line of care, family doctors, with their holistic approach, are the ones best positioned to help these patients.

QUALITY

QUALITY IMPROVEMENT IN ANTIBIOTIC PRESCRIPTION FOR UNCOMPLICATED LOWER URINARY TRACT INFECTIONS

Ana Luisa Marcelino,¹ Cátia Barão,² Ana Isabel Silva,³ Candida Teixeira,⁴ Mariana Carvalho,⁴ Sara Santos⁵

¹USF Ouriceira; ²USF Andreas; ³USF D. Jordão; ⁴USF Gama; ⁵USF Costa Campos
analuisamarcelino@hotmail.com

Introduction: Lower urinary tract infections (LUTIs) are the 2nd most common bacterial infection in the community and the most common bacterial agent is *Escherichia coli* which have a high resistance rate to quinolones and sulfamethoxazole/trimethoprim. Portuguese national guidelines for primary healthcare are: nitrofurantoin, fosfomycin and amoxicillin/clavulanic acid.

Objective: Assess guideline adherence for the empirical treatment of uncomplicated LUTI in primary care and the impact in prescription quality after local intervention.

Methods: We establish three groups to study, group A before intervention, group B studied ten days after intervention (awareness and information of primary care doctors) and group C was study three months after intervention. The sample included patients from five primary healthcare units in the west coast region of Portugal diagnosed with uncomplicated LUTI. The search was made based on the electronic medical record system on ICP-2 (International Classification of Primary Care). Discussion: The sample size was similar between the three groups. Fosfomycin was the most prescribed antibiotic drug. The rate of guideline adherence for the empirical treatment of uncomplicated LUTI was high in all three groups (Group A: 81.8%; Group B: 79.1%; Group C: 76.4%). After the intervention, the prescription rate of ciprofloxacin decreased, and this effect was maintained after three months. On the other hand, the prescription rate of other antibiotics (other than the first line drugs) increased. The study had some limitations, such as: was not possible to determine with certainty if the treatment prescribed was in fact empirical or either directed by results of antimicrobial susceptibility testing; study period might have been short; we were not able to assess the efficacy of the antibiotic treatment.

Conclusion: Guideline adherence for the empirical treatment of uncomplicated LUTI is high and our results were superior to those described by similar national studies. The local intervention had no impact toward a higher guideline adherence. Ciprofloxacin and other antibiotics continue to be significantly prescribed.



PRACTICE

REDUCING THE RISK OF BLOOD BORNE INFECTION THROUGH SHARPS INJURY IN A NON-GOVERNMENTAL ORGANISATION IN INDIA

Amy Dehn Lunn¹

¹Clinical Fellow in Global Health and Leadership (GP trainee)
amydehnlunn@gmail.com

Background: Healthcare workers handling sharps are at risk of blood borne infections such as HIV, hepatitis B and hepatitis C. A needlestick injury witnessed in a non-governmental organisation delivering primary care in Kolkata, India led to a programme to reduce the risk of blood borne infection through occupational exposure to healthcare workers.

Baseline audit: Sharps handling was audited over one week. Phlebotomy is carried out by external staff; all other sharps handling by the organisation's staff. Thirty-five episodes of phlebotomy and intramuscular injections were observed. Gloves were not worn for any episode. Recapping of needles occurred in all episodes. Ten episodes of scalpel use in wound care were observed: gloves were worn on all occasions. Sharps bins were available in all clinics. Staff had a sharps bin within reach in 85% of sharps handling episodes: 90% (18/20) of blood sampling, in 66% (10/15) of intramuscular injections and in all (10/10) wound care episodes. A survey revealed that only 57% of the organisation's staff members handling sharps (9/21) were immunised against hepatitis B. Interventions A staff training programme and protocol for the safe handling of sharps was implemented. External phlebotomists were invited to training but did not attend. A hepatitis B immunisation programme was started. A protocol for the management of body fluid exposure was implemented. A reporting system was established for occupational exposures, and training on its use was given to clinic managers and doctors.

Post-intervention audit: Practice was observed over one week one month post-intervention. Gloves were worn 80% of the time (all intramuscular injections and wound care and 39% (11/28) of blood samples). Needle recapping was observed in 35% of episodes (10% (2/20) intramuscular injections and in 60% (15/28) of blood sampling). Sharps bins were to hand in 93% of sharps handling episodes: all phlebotomy (28/28) and wound care (8/8) and 80% (16/20) of intramuscular injections. 89% (8/9) unimmunised staff members had commenced hepatitis B immunisations.

Conclusions: The project revealed a range of safety issues around sharps handling within the organisation. Post intervention, marked improvements in practice were seen (e.g. needle recapping reduced from 100% to 35%). Hepatitis B immunisation of healthcare workers at risk improved from 57% to 95%. This project demonstrates that a low cost series of interventions can have an important impact on staff safety.

PRESBYPHAGIA: WHEN EATING BECOMES HARD TO SWALLOW

Joao Ribeiro,¹ Sandrina Rodrigues²

¹USF O Basto, ²USF S. Tomé
jribeiro_14@hotmail.com

Introduction: Presbyphagia can be defined as any changes in swallowing oral, pharyngeal or esophageal phases that happens in the healthy elderly as a result of the natural aging process. According to a study carried out in 2012, presbyphagia prevalence in the elderly can be as high as 68%, so active attention by the family doctor is essential to detect it at an early stage. As the speech therapist is the professional with greater ability to diagnose and treat this problem, it would be beneficial to share experiences in order to learn and improve screening techniques that could be applied in primary health care, as well as to understand how an intervention is carried out in these patients.

Objectives: To make a practice report of a partnership between family doctor and speech therapist in order to guarantee presbyphagia early detection.

Relevance: Due to the growing number of elderly population, it's extremely important to recognize alert signs that raise suspicion of presbyphagia, as well as some informal screening tests that can be applied in primary health care that detect presbyphagia at an early stage.

Description: As we were developing this project, it has been possible to attend with a speech therapist in order to better understand some alert signs and symptoms of a possible oropharyngeal dysphagia. It was also possible to observe and train the application of screening tests in patients who presented some of these signs and to observe how an early intervention is performed in situations of presbyphagia.

Discussion: Family doctors have a very important role in early detection of many problems that may endanger our patients' health. Detecting presbyphagia, that can lead to serious consequences, as early as possible, we can make the difference in patients quality of life, turning also possible to avoid situations that harm our patients, whether due to affecting quality of life (considering that 'eating' is a social act) as problems that can lead to several uses of the emergency service and even endanger patients life, such as aspiration pneumonia.

Conclusion: It's important sensitize family doctors to presbyphagia and warning signs and symptoms. The exchange of experiences with the speech therapist allows sensitizing and better knowing the needs and how to help patients with presbyphagia. It would be important to family doctors to know and to apply some screening methods in order to early detect this frequent but often neglected health problem.



EATING HEALTHY AND MINDFULLY WHILE PREGNANT

Sara Andrade,¹ Cristina Bastos¹

¹USF Conde de Oeiras
sarandrade_15@hotmail.com

Introduction: Maternal nutrition in pregnancy and lactation is of considerable interest to women, their partners and their health care professionals. Poor maternal diet in these stages of life is a potential threat to maternal and child health. There is no doubt that a nutritious, well-balanced eating diet can be one of the greatest gifts that a mother can give to herself and to the developing baby. Mindful eating, a method of eating with awareness, also seems to be a way of achieving adequate nutrition and weight gain for pregnant women.

Some reports show that these groups are not appropriately consuming foods for their physiological status and reinforce a real need for improved education and community outreach programs.

Aim: This practice report pretends to present the work that we are doing with pregnant women that are participating in parenthood preparation courses of our health family center. We are developing nutrition group sessions with the purpose of promoting informed dialogue about nutrition, improving nutritional knowledge and encouraging healthy nutrition in pregnancy and lactation.

Description: The nutrition group sessions are being conducted by a general and family medicine resident who practiced nutrition prior to entering medical school. The themes included are: weight during pregnancy and lactation, nutritional myths and facts, macronutrients and micronutrients, food safety, tips to healthy cooking, ways to practice mindful eating. These sessions have an interactive and practical component, with realistic exercises, and provide a safe environment to ask questions and learn from others.

Discussion/Conclusion: During pregnancy and lactation women become more aware of the importance of healthy nutrition and seek for more nutrition-related information. A nutritional education intervention will have a positive effect on pregnant and breastfeeding women nutrition. It will help them to make better choices and enable them to improve their eating habits and their future child nutrition.

CHILDHOOD OBESITY: EXPERIENCE IN A PRIMARY CARE SETTING

Susana Rita¹

¹USF Samora Correia
susanarita@hotmail.com

Introduction: Childhood obesity is the most prevalent chronic pediatric disease, affecting 43 million children worldwide. Its numerous consequences include depression and diabetes. Being a preventable disease, with both social and familiar components, it is an important diagnosis in primary care.

Purpose: To describe the 17-month experience with childhood obesity in a primary care setting – USF Samora Correia.

Description: Between June 2015 and October 2016, we consulted 52 children with obesity. Thirty-two returned for follow-up appointments, while 20 patients either dropped-out, missed the next appointment, or were discharged. Out of those who remained in our care, 11 were female and 11 were male, with an average age of nine years. Four cases began before the first year of life, 13 cases between two and five years, 10 cases between six and nine years and five cases between 10 and 18 years of age. An inadequate diet was the main factor found to be responsible, with only two cases attributed to a secondary etiology. Family history most commonly revealed cases of obesity (20 cases) and cardiovascular diseases (28 cases) in close relatives. Twenty-two cases observed a steady improvement in the BMI. The most prevalent comorbidities included vitamin D deficiency (16), hyperlipidemia (6), insulin resistance (4), mental disorders (4) and hepatic steatosis (2). Only seven children had no comorbidities.

Discussion: We observed an important familial component in the etiology of childhood obesity, which was most frequently diagnosed in preschool children. Most cases responded positively to our individualized approach, with an improvement in BMI. The most frequent comorbidities found likely have an additional negative impact in bone metabolism and risk of cardiovascular diseases.

Conclusions: Childhood obesity is a major disease in the daily practice of the family physician, with a potential impact in the psychosocial development of children, as well as their future risk of disease. An individualized approach to these patients in primary care is able to successfully identify and manage the most frequent factors involved.



TO BE A FAMILY DOCTOR BEYOND THE ATLANTIC

Ana Margarida Gomes,¹ Ana Rute Marques¹

¹USF Travessa da Saúde
ana.rf.marques89@gmail.com

Introduction: Because exploring the reality of family practice (FP) in other places is essential, we participated in an exchange program at a health center (HC) in Rio de Janeiro (RJ). Brazil is a close relative of Portugal but it has its own epidemiological, organizational e cultural particularities. Therefore, we thought this was a unique opportunity to acquire new professional and personal skills.

Objectives: To state the differences between the Brazilian health system (BHS) regarding the way Primary Care (PC) works and how applying those to the Portuguese PHC could be relevant; to enhance the importance of multidisciplinary and community interventions in FP; to create an international bond, facilitating the residents' training and the exchange of experiences.

Relevance: To partake in team efforts of caring for the community and to instigate the experiences exchange beyond borders is relevant to the medical training, especially in FP.

Description: Since 2009, with the FAMILY HEALTH STRATEGY, RJ went from a population coverage of 3.5% to 70%, having the family doctor (FD) a key role in the evolution of PC. The BHS is similar to the Portuguese healthcare system regarding its core competencies in FP. Yet, there are important structural differences. The HC have a pharmacy, dental offices and complementary exams. The health team is multidisciplinary thanks to the Family Health Support Nucleus (FHSN) composed of psychologists, dieticians, physiotherapists, physical educators, occupational therapists and social workers. The Community Health Agents (CHA) contributes to facilitate the activities in the community and personalized domiciliary visits.

Discussion: Although it's an evolving model, it is supported by a strong foundation regarding teamwork and the holistic approach of the patient in its community. To this end, the multidisciplinary health teams play a critical role. To have taken part in this reality allowed us to reinforce the importance of PC and the essential role of the FD in close articulation with other professionals. Our goal is to share this knowledge with our peers, making a contribution to the enrichment of the daily clinical practice.

Conclusions: To have witnessed first-hand the activities of the professionals in a HC in RJ, particularly the work of the FD in the BHS was very beneficial. The attentive study of its particular characteristics was also a plus both to our individual growth and to the reinforcement of the essence of working as a team.

MISSING IN THE LADDER

Yusianmar Mariani,¹ Elena Klusova,¹ Sara Rigon,¹ Özden Gökdemir,¹ Nina Monteiro,¹ Ana Nunes Barata¹

¹VdGM Equally Different Special Interest Group
dra.mariani@gmail.com

TOPIC TO BE EXPLORED – The long-term and controversial unequal career advancement between genders. There is a well known history of inequity on professional success between women and men where women's participation to political, economic, professional and social life has been significantly limited by social norms. The most recent Financial Times Stock Exchange 100 Index reports that only 20 per cent of international assignees are women — a number that has barely shifted for more than a decade and this has not been different in the healthcare industry where has been proved how hard is for women to climb to the top of the ladder when there are rungs missing further down.

WHY THE TOPIC IS OF LIKELY INTEREST – Gender equality is intrinsically linked to sustainable development and is vital to the realization of human rights for all. The reality is that as well in another industry, the facts are similar in the healthcare sector and changes on this are yet to be made, so the society urge to make some progress to improve the numbers of female health care leaders as well as their impact on the field. By exploring and discussing the main barriers and issues related with this topic i.e: gender roles, stereotypes, family life and international policies, we aim the participants could reflect on it and came up with practical/possible ideas to be applied. By the end of the workshop we hope the attendees would able to inspire the primary health care community to break free of old paradigms and rethink its structure towards a future of equal opportunities and professional success regardless of gender.

KEY GUIDING QUESTIONS – Why aren't there more women in science? Job/career choices – free will or gender-based choices? Is this a concern for men? What prompts wage differences? What can a woman do against wage differences? What can political organizations and governments do? What about gender mainstreaming?

100% AVAILABILITY TO BE FACILITATOR: YES



HOW CAN GPs TALK ABOUT SEX?

Carla Rodrigues,¹ Andreia Silva,² Ana Filipa Vilaça,³ Helena Marques,⁴ Sara Rita,⁵ Ana Beatriz Figueiredo⁶

¹UCSP São Neutel; ²USF Casa dos Pescadores; ³USF Manuel Rocha Peixoto; ⁴USF S. Felix – Perosinho; ⁵USF Servir Saúde; ⁶USF das Conchas, ACeS Lisboa Norte
carla.veiga.rodrigues@gmail.com

According to the World Health Organization, sexuality is a key aspect of the human being, encompassing sex, gender identity, sexual orientation, eroticism, intimacy and reproduction. Sexuality is broader than the individual experience of sex and it can and should be addressed on consultations as part of a person-centered medical approach. Despite the elevated prevalence of sexual related problems, sexuality-related communication (SRC) is often neglected by the general practitioner. How can we do it and why are we so oblivious to this issue? Are we prepared to do so? Pre-graduate training is scarce and heterogeneous between the profusion of medical faculties. Post-graduate training is expensive and mainly focused on dysfunction rather than functionality or part of a relationship. Nevertheless, patients expect their doctors to address the topic and studies show that sexual health concerns may never be voiced if the patient is left with the responsibility to introduce it. The lack of comfort, the reluctance to talk about sexuality or the fear of offending the patients limits our performance and makes SRC less clear or objective than it should be, decreasing our ability to educate our patients regarding sexual health. Sexual health should be a cornerstone of preventive medicine. In order to improve our skills we must bring SRC to light, face our limitations. Only then we'll be able to enhance our performance on consultation and create strategies to improve our quality of care to populations.

A TRAVEL MEDICINE CLINIC IN PRIMARY CARE: A NEW CHALLENGE!

Ana Costa¹

¹USF Alpha Moura
analgcosta@gmail.com

Travel medicine is an emerging discipline whose main focus is travelers' health promotion, and personal safety, as well as the prevention of infectious diseases, and those related to important environmental risks. In Sintra, Portugal, there was a manifested need for the development of a regional Travel Medicine Clinic within primary care, given the rising numbers of travelers, many of whom are immigrants from tropical countries and often travel home to visit their families. Given my interest in this sub-specialty and global health, and having formal training in travel medicine, I was asked to join a small team of professionals in establishing a travel clinic in a family health centre in the Sintra region, to serve the needs of the community.

Objectives: To describe our practice, in terms of context, population, team, our main objectives and outcomes, our importance in the community, as well as our future aspirations.

Relevance: Our practice demonstrates how travel medicine can be well developed as a subspecialty by family doctors, providing the service in primary care. After acquiring the necessary specialized training in this area of medicine, we as family doctors are well positioned to provide this service at the community level, given our knowledge of the population we serve; our holistic vision in providing care; our ability to deal with multiple co-morbidities which is essential in the context of travel medicine; and our accessibility which will improve access to pre-travel consultation.

Description of our practice: Our travel clinic opened in October 2016 at USF Alba Saude in Sintra. The team is comprised of two doctors and one nurse. The pre-travel consultation consists of a global risk assessment, vaccination, and health education and promotion. Special areas of focus are viral infections and those transmitted by mosquitos; STDs; travelers' diarrhea; malaria prophylaxis; altitude sickness; and accident prevention. We developed an internal referencing system for the Sintra region, through an online form which reaches us electronically.

Conclusion: We are a perfect example of how travel medicine can be decentralized and provided in the primary care setting, thereby increasing access to the community and increasing adherence to pre-travel medical advice. This will not only have an impact on the health of our local population but on the global transmission of diseases and on morbidity and mortality.



EMERGENCIES IN PRIMARY CARE IN SPAIN FOR IMMIGRANT POPULATION

María Belén Arellano-Cobos¹

¹Orihuela-1 Primary Care Centre

Spain is one of the Southern European countries that welcome retired people from other European countries. Adapting to a new country implies adapting to a new healthcare system, apart from difficulties related to the new language. How is the Spanish healthcare system? Where should you go in case of emergency? What is the telephone number for an extra hospitalary emergency? Educating immigrant population about the knowledge and use of the Spanish public healthcare system should be a priority for family doctors. A thirty minutes oral presentation was performed by a resident of family medicine in a rural healthcare centre for a population of fifty people coming from the United Kingdom. Afterwards, attendants were allowed to make questions and solve their doubts. The oral presentation was totally performed in English so as to avoid the barrier of the Spanish language for immigrant population. Important topics such as how to recognize a myocardial infarction or how to proceed in case of fever in a patient receiving chemotherapy were explained by using slides. As a result, the immigrant community coming from the U.K. living in the town of St. Bartholomew (Orihuela, Alicante) learned how to recognize life-threatening diseases and where to find the most suitable medical care in Spain.

CHALLENGES IN PRIMARY CARE PRACTICE WHEN DEALING WITH OLDER PEOPLE

Gergana Foreva,¹ Radost Asenova,² Pepa Ferreira,³ Kiril Elenski³

¹Plovdiv; ²Medical University of Plovdiv; ³Primary care practice Plovdiv

The number of older people is growing rapidly in Bulgaria. The current health care system does not acknowledge their specific needs. Problems such as recurrent falls, polypharmacy, cognitive impairment, social isolation remain unrecognized for a long period of time and show themselves in health and/or social crises. The aim is to present a model of early intervention in primary care. Our general practice has a list of 4,200 patients. Despite of older people being approximately 20%, they consume around 50% of the general practitioner's time. The model, presented here, consist of specialized geriatric consultations and educational sessions for patients and their relatives. Our goal is to help older people to maintain their health and independence.

POSTERS

CASE REPORT



PULMONARY EMBOLISM: WHAT IF ANXIETY IS NOT JUST PSYCHOLOGICAL?

Joao Ribeiro¹

¹USF O Basto; Hospital de Santa Casa de Misericórdia de Vila Verde
jribeiro_14@hotmail.com

Introduction: Anxiety is many times associated to psychological illness, especially in young patients. It can be a diagnostic, but also a symptom of an underlying cause, like pulmonary embolism (PE). Although classic presentation of PE is the abrupt onset of pleuritic chest pain, shortness of breath and hypoxia, some patients can have atypical symptoms such as hemoptysis, wheezing and anxiety itself. In this case, is presented a report of a 24 year old man recently diagnosed with schizophrenia that came to his family doctor (FD) with chest pain, eructation and anxiety. A common situation in young patients, but... what if anxiety means something more than a psychological symptom?

Case report: J. 24 years old. Medical history: schizophrenia diagnosed last week, discharged three days ago. Medication: risperidone 4mg/day. Presented to FD with anxiety and chest pain since two days ago. Pain is worst during inspiration. Had been in otorhinolaryngologist yesterday because of his throat and asked her about this pain, who said he "should come to FD, it's probably anxiety because this recent diagnostic, but a clinical exam should be done". No more symptoms referred. Clinical findings: stressed, worried about this pain; T° 36.1, BP 121/64mmHg, HR 121bpm, O2 saturation 97%; pulmonary auscultation: can't deep breath because of the pain; cardiac auscultation: rhythmic, tachycardia; no other findings. It was decided to refer to emergency room. Two weeks later, he brought a letter from the hospital: he was hospitalized with a PE and right lung inferior lobe infarction.

Discussion: PE isn't a disease itself, but a complication of underlying deep venous thrombosis (DVT), when microthrombi are formed and lysed within the venous circulatory system. When it's not diagnosed in time, it can be fatal. Association between antipsychotic and increased risk for DVT/PE has been reported since the introduction of first-generation antipsychotic drugs. Usually occurs during the first three months of antipsychotic use and is more common with atypical and low-potency typical drugs than with high-potency conventional antipsychotics.

Conclusion: FD is the first line care for many patients who search for our help. Anxiety, many times undervalued by health professionals, can be hiding an underlying cause that needs emergency cares. It's important to value anxiety as it is and as the patient describes it. As FD, we must see our patient as a whole, seeking the underlying cause to psychological symptoms.

OVERDOING IN COMMUNITY MEDICINE: A CASE REPORT COPING WITH A RENAL INCIDENTALOMA

Tom Axelrod¹

¹The Hebrew University of Jerusalem and Clalit Healthcare Services
tom.chatul@gmail.com

Case presentation: A 71 years-old lady with a four years history of NIDDM discovered on routine lab tests and a well-balanced hypothyroidism. No other findings on history, anamnesis or physical examination. Laboratory exam was normal except for HbA1c and glucose values. After two years of balanced diabetes using oral medications only, her HbA1c starts to rise. She was put on insulin, but remained unbalanced. Upon her request, she was referred to an endocrinologist who suggested performing an abdominal CT to rule out pancreatic involvement that might explain the new-onset treatment-resistant diabetes. Her abdominal CT showed no pancreatic or other abdominal organs pathologies, apart from a 1.5mm non homogenous, irregular solid process on the cortex of the right kidney.

Discussion: The workup of renal incidentalomas is challenging, especially for the non-cystic middle-sized tumors. The differential diagnosis of such tumors ranges from benign (e.g. angiomyolipoma) to malignant (renal cell carcinoma) tumors. The guidelines are not straight forward due to lack of high quality evidence. The treatment approaches ranges from a partial nephrectomy to follow-up policy. It has been estimated that over half of those aged above 50 have at least one process on one of their kidneys, and that 30% of kidney tumors smaller than 3 cm are benign.

Conclusion: While data from Australia and US of the past 45 years show steady increased incidence of renal tumors, there is no changes in mortality from those tumors – suggesting a pendulum tilt toward overdiagnosis, which in turn might lead to over-treatment.



INFECTIOUS MONONUCLEOSIS: IMPORTANCE OF GROUP A STREPTOCOCCUS RAPID ANTIGEN DETECTION TEST

Nuno Parente,¹ Joana Castro²

¹USF Viver Mais, ACeS Grande Porto III – Maia/Valongo; ²USF Viver Mais
nunomiguelpm@gmail.com

Context: Infectious mononucleosis (IM) is defined as a classic triad of fever, pharyngitis and cervical adenopathy. In 90% of cases there's an Epstein Barr virus (EBV) infection. In childhood the primary infection is typically asymptomatic. Complications include meningoencephalitis, acute airway obstruction, spleen rupture and an increased risk of lymphoproliferative cancer.

In Portugal, acute tonsillopharyngitis has an incidence of 111,000 cases per year and is the respiratory disease responsible for the most antibiotic prescriptions in primary healthcare. Today, when an acute bacterial tonsillopharyngitis is suspected is advised confirmation with group A Streptococcus rapid antigen detection test (GAS-RADT).

Description: African Portuguese female, 8-year-old with previous records of allergic rhinitis and asthma exacerbations. No history of adverse drug reactions (ADR). Presented to the emergency department (ED) complaining of fever and odynophagia and was started on amoxicillin 50mg/Kg/day PO for an bacterial tonsillopharyngitis. She was on the third day of amoxicillin course when she presented to primary care setting with aggravated odynophagia, intense malaise, neck congestion, painful cervical lymphadenopathy and bilateral tonsillar exudate. Referral to the ED was made for thorough investigation. At admission she was clinically unwell and laboratory studies showed an absolute lymphocytosis, presence of atypical lymphocytes and a monospot-positive test. She was started on intravenous prednisolone 1mg/Kg and discharged on an oral corticosteroid. Parents were counseled on the potential complications.

Discussion: IM diagnosis demands clinical suspicion and analytical evaluation. The availability of GAS-RADT throughout primary care centres (PCC) will allow the reduction of overtreatment in viral infections that induces antibiotic selective pressure and exposes patients to ADR. The GAS-RADT, although operator-dependent, provide the most cost-effective solution. The inclusion of GAS-RADT in PCC clinical protocols and its systematic use can decrease health-care related expenditures by 42%. It's important to highlight the family doctor role in dealing with acute problems and sometimes in early undifferentiated stages.

URINARY TRACT INFECTION COMPLICATED BY A URETERAL STONE

Emanuela Gomes,¹ Pedro Namora,² Salette Gomez,³ Helena Ribeiro,¹ Fernando Carvalho¹

¹USF Novos Rumos; ²USF Famalicão I; ³USF Fafe Sentinela
emanuela.pgomes@gmail.com

Background: This case intends to address the relevance of the diagnostic and therapeutic individualization that should be applied to the complicated urinary tract infection, considering the patient's clinic their background and level of risk. The importance of patient follow-up is highlighted in order to monitor the clinical evolution, as well as early detection of associated complications and the prevention of additional acute episodes.

Case presentation: A 37 y/o women went to the emergency department (ED) for sudden severe low back pain, July/2015. The urine test strip showed leukocyturia and nitrituria. Abdominal radiography revealed a renal pelvis stone in the left kidney. The clinical condition was interpreted as cystitis and medicated with fosfomycin and butylscopolamine. The family doctor (FD) prescribed analgesia and changed the antibiotic for amoxicillin/clavulanic acid. Due to persistence of symptoms and renal echography with evidence of hydronephrosis associated with proximal ureteral stone, the FD immediately referred the patient to the ED. She was hospitalized with a obstructive acute pyelonephritis with need of a percutaneous nephrostomy. Following the failure of extra corporeal shockwave lithotripsy in Oct/2015, retrograde intrarenal surgery was proposed to May/2017. In the meantime, she went to the ED with new episodes of low back pain with subfebrile state, renal murphy, leukocyturia and nitrituria. She was hospitalized for surgery, which was prolonged and complicated by sepsis requiring broad spectrum antibiotic therapy.

Discussion: It is important to highlight the emotional and economic impact of the clinical situation presented. On one hand, the fear of new acute episodes and the risk of complications were present; on the other hand, the incapacity to perform their professional activity was also recurrent, which was extended to activities in the personal and family sphere. The maintenance of surveillance by the FD was essential in the emotional support. The support in the clinical aspect through the substitution of antibiotics and signaling of severe clinical picture it was also crucial. However, this clinical case also warns to the relevance of optimizing communication between primary and secondary healthcare. Only through a solid partnership between the two types of healthcare levels it will be possible to detect these conditions early, reduce the risk of complications and improve the health status and quality of life of the patients.



DIAGNOSING COLLAGENOUS COLITIS IS STOPPING DIARRHEA

Sofia Rocha Teixeira,¹ Mariana Madureira²

¹USF Alpendorada; ²USF Alto da Maia
sofiarochateixeira@gmail.com

Background: Microscopic colitis is a chronic inflammatory disease of the colon. There are two main sub-types: lymphocytic and collagenous colitis (CC). The incidence of CC is 1.1 to 5.2 per 100,000/year. The pathogenesis of CC is unclear despite some medications and smoking has been implicated. Patients present with insidious onset of chronic, non-bloody and watery diarrhea. Associated symptoms include fecal urgency, abdominal pain, fatigue, and weight loss.

Case presentation: 68 years-old male, with controlled hypertension, under lisinopril 20mg and active smoking since 18 years-old – 60 pack-year smoking. He went to the family doctor on January 2017 complaining with abdominal pain and intermittent episodes of watery, non-bloody diarrhea (2-3 dejections/day) starting one year ago. He had lost 6kg (6.9%) and had no fever or other associated symptoms. Physical examination revealed lower abdominal tenderness. Laboratory studies showed the absence of inflammatory markers and the abdominal ultrasound was normal. On February, he presented to the hospital urgency service complaining with >20 dejections and abdominal pain. He had lost more 7kg (14.9% ponderal loss). Laboratory findings indicated acute kidney injury. Stool cultures, serologies to HIV, HCV, HBV and CMV, and autoantibodies were negative. Stool leukocytes were positive, so he completed eight days of ciprofloxacin for suspected acute enterocolitis, with favorable evolution. Colonoscopy with mucosal biopsy was compatible with CC diagnosis. He started loperamide (4mg daily) with partial response. Then, was added budesonide (9mg daily, four weeks) with significant improvement of symptoms and weight gain.

Discussion: Microscopic colitis should be suspected in a patient with chronic diarrhea. It is important to make the differential diagnosis with irritable bowel syndrome, inflammatory bowel disease, malabsorption syndrome and chronic infections. A colonoscopy with mucosal biopsy is necessary to establish the diagnosis. The goal of therapy is to induce clinical remission (<3 stools/day or <1 watery stool/day) and includes avoid smoking and medications associated with CC. Antidiarrheals and budesonide are used in active disease. Cholestyramine and bismuth subsalicylate can be added. Anti-tumor necrosis factor agents and surgery are reserved to refractory CC. An early diagnosis is crucial. The family doctor has a very important role in diagnosis and correct referral. Nevertheless, all patients should be followed in gastroenterology.

DISCOVERING POLYGAMY THROUGH INFERTILITY: A CASE REPORT

Tatiana Macedo Pinto,¹ Margarida Pereira,¹ Mariana Moura Relvas,¹ Maria do Carmo Gonçalves¹

¹USF Porto Centro
tatianalmp@hotmail.com

Introduction: Foreign patients present many challenges in our daily clinical practice. The religious, cultural and social contexts often differ from our reality and the language barrier is one of the biggest struggles. The project of parenthood is held by many people and the importance that each individual attributes to parenthood may be influenced by many factors, including cultural ones. Infertility is defined by the World Health Organization as a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after twelve months or more of unprotected sexual intercourse.

Goals: With this case-report of a couple with infertility the authors aim to highlight difficulties in the clinical practice with foreign patients, particularly with patients from different cultural contexts and when there is a language barrier; to evidence the role of the family doctor in the foundation of a relationship of clinical proximity; and to contextualize polygamy in the Portuguese law.

Case description: This is a couple from an African country: T., female, 37 years old (now 45) and M., male, 42 years old (now 50). Muslim religion. They began their follow up at our health unit in 2009. Since the first consultations there were communication difficulties: T. did not speak Portuguese (only an African dialect) and M. spoke some Portuguese and translated. In the first appointment with the couple, they intended to continue the infertility study they initiated in private practice. They were married for 20 years, had no children of their own and denied having children with other partners. They had no medical history other than infertility (reported 10 years before) and obesity. With the years, the language barrier diminished. Eight years and many myths, treatments, negative pregnancy tests, appointments and a perimenopausal amenorrhea later, T. continues to pursue the idea of getting pregnant and having a child. And at this stage, digging deeper, we discover that M. practices polygamy and has married two other women, with one of whom he has a child.

Discussion: The continuity of care, characteristic of family doctors, allows us to get to know our patients. In this case, the establishment of a relationship of clinical proximity was fundamental for understanding the importance of preserving fertility for this patient. Discovering the practice of polygamy helped us better understand T.'s frailty and made us wonder about the legal framework of polygamy in our country.



ONE MORE MINUTE COULD SAVE A LIFE

Raquel Georgina Padin Perez,¹ Elena Torices Picon,¹ Maria Dolores Vazquez Garcia,¹ Marta Colón Más¹

¹Murcia Hospital Morales Messeguer
rgeorinapp@hotmail.com

In this clinical case, we present a 56-year-old male in which the clinical history, complete physical examination and prevention protocols allowed the diagnosis of a life-threatening disease in an asymptomatic patient.

This is a 56-year-old man who comes to his health centre for the first time to consult on the appearance of a dermic lesion. In the absence of information about the patient, and despite being asymptomatic, a complete medical history is made with the following findings: previous history of an unknown heart intervention performed during childhood without any further reviews, arterial hypertension, obesity grade I and a systolic murmur of moderate intensity. An electrocardiogram and an echocardiogram are prescribed. One month later, he returns with the results of the electrocardiogram, which reflects an elevation of the ST segment in V2 to V4 precordials. In view of this result, an electrocardiogram is repeated in that moment where normalization of the ST segment and negative T waves are observed in I and avL. The patient continues asymptomatic, in functional class I and daily cycling more than 50 kilometers. In the presence of cardiovascular risk factors and electrocardiographic changes that suggest myocardial ischemia, the same day, the patient is referred to the hospital's emergency service. During the following month and after undergoing complementary tests, the presence of a 7.1 cm aortic aneurism is discovered, as well as aortic valvulopathy with severe insufficiency due to ring dilatation and moderate pulmonary hypertension. Given these results, the patient is scheduled for cardiovascular surgery and is currently recovered.

With this case we intend to reflect the importance of following prevention protocols properly using a good clinical interview and detailed physical examination of our patients, without focusing only on the symptom or isolated sign that motivated the visit. This allows an adequate diagnosis and early treatment of potentially serious and preventable diseases from primary care.

A DIFFERENT TYPE OF SEIZURES: A CASE REPORT

Inês Ferreira Santos,¹ Pedro Vasconcelos,¹ Rita Bernardino Figueiredo¹

¹USF Viseu-Cidade, ACeS Dão Lafões
ines_f_santos@live.com.pt

Introduction: Pseudoseizures are psychogenic paroxysmal events, with semiological specificities, sometimes difficult to differentiate from epileptic seizures. They can coexist in a patient, which makes the differential diagnosis even more challenging.

Case report: 18-year-old male, with a functional family, rebuilt since 2014, with feelings of rejection since that period, due to his mother's absence. Past medical history of generalized epilepsy, diagnosed in 2014 (documented activity in the electroencephalogram (EEG)) and allergic rhinitis. Since then, he was submitted to multiple hospitalizations due to non-stereotyped episodes of knowledge loss, with pleomorphic clinical manifestations, preceded by anxiety and hyperpnoea, without sphincter incontinence or tongue bite, lately showing bizarre movements, with violent and arrhythmic spasms. Cranial computed tomography scans and a nuclear magnetic resonance were performed due to suspected head injury – both showed no abnormalities. Different antiepileptic regimens were tried, without success. In April 2007, he consulted his family doctor with his parents, who were worried about the increasing frequency of the episodes, aggressive motor behavior during the post-ictal period and recent mood deterioration, associated with suicidal thoughts. When questioned about it, he admitted having attempted suicide once. Objectively, he had a depressed mood and psychomotor lentification. Given the psychiatric manifestations, he was referred to the psychiatry emergency room and then hospitalized. He was diagnosed with major depression and initiated sertraline 50mg and trazodone 100mg, with significant mood improvement. Based on the absence of electroencephalographic translation of the events in the video-EEG, the neurologist excluded the diagnosis of epilepsy and classified the seizures as psychogenic. The antiepileptic medication was suspended and risperidone 1mg and alprazolam 0.25mg were introduced. The frequency of the events decreased and the patient is currently on follow-up in psychiatry and family medicine consultation.

Discussion: In this case, the high frequency of the events, the bizarre and incongruent behaviors and the refractoriness to antiepileptic drugs support the diagnosis of pseudoseizures. Family doctor can play a part on considering a psychogenic etiology and possible trigger factors, such as family problems and psychiatric comorbidities, integrating them on the patient's biopsychosocial model.



AN OCCULT CAUSE FOR WEIGHT LOSS

Ana Rita Cunha,¹ Conceição Martins¹

¹USF Viseu Cidade

anaritaecunha@gmail.com

A 52-year-old woman, from a nuclear family, with hypertension, anxiety, vitiligo and total hysterectomy and thyroidectomy, consulted her family physician due to dyspepsia and heartburn for five days. When questioned about stressor events, she denied any. There was no relevant family history except for her brother's gastric surgery. There were no findings on physical examination. An endoscopy of the upper digestive tract was proposed, but the patient refused. Thus, an abdominal ultrasound (AU) was requested and dimeticone was prescribed. A month and a half later, she complained of heartburn, upper abdominal pain and presented with a weight loss of 12 kilograms (16.7% of the total body weight). The AU only revealed two 5mm polyps in the gallbladder. The importance of the endoscopy was reinforced and the patient agreed to do it and initiated a proton pump inhibitor after it. Four weeks later, the biopsies revealed positivity to *Helicobacter pylori* (Hp) and gastritis. The patient initiated the Hp eradication treatment and repeated the endoscopy two months later, which revealed intestinal metaplasia. The patient had continued to lose weight (three more kilograms) and maintained the abdominal pain. An abdominal-pelvic computed tomography was performed and showed a renal simple cortical microcyst and no bladder polyps. The study also included a thyroid ultrasound, blood tests and cardiac exams – none with relevant alterations. Meanwhile, she accompanied her son on a primary care consultation and complained of degradation of his school performance. The presence of a stressor event, focusing on the familiar situation, was addressed again: the patient revealed she had left home because of her husband's drinking problems. Psychological support was offered to her and the son and the patient's husband agreed to be referred to an alcoholic center.

Discussion: The family doctor is in a privileged position to access familiar conflicts and its impact on the members' health. It is known that psychological disorders may traduce into physical symptoms. The study of the family and of its possible contribution to individual pathologies is an exclusive task of the family physicians and should always accompany the evaluation of non-specific symptoms. When needed, the family doctor should also request specific exams to exclude severe diseases, but always acting in the biopsychosocial sphere of the patient and, when possible, together with psychologist and secondary health care physicians.

GASTRIC CARCINOID TUMOR: AN UNCOMMON CHALLENGE

Isabel Padrão Tadeu,¹ Mário Tadeu²

¹UCSP Vila Real 2 – Mateus; ²Centro Hospitalar São João

Pernicious anemia (PA) commonly results from cobalamin deficit. The classic triad of presentation is weakness, sore tongue and paresthesias. The PA is related with a higher incidence of gastric cancer.

MLDP, female, 81 years old, previously autonomous. Personal history: alcohol consumption (5U/day), hemorrhoids. No medication. No allergies. Family history unknown. On 17th February 2017, MLDP complained of progressive weakness and shortness of breath started in January. Adding symptoms of heart palpitations, weight loss (7kg) with anorexia and lower limbs and hands paresthesias. She denied dysphagia, dyspepsia, heartburn, altered bowel habits or fever. Physical exam: alert and oriented. Pale skin, normal conjunctiva. HF 115bpm, BP 127/62mmHg, BF 18cpm, O₂sat 99%, temperature 37.6 °C. Normal cardiac and respiratory auscultation. Abdomen: normal bowel sounds, nontender, painless, no masses or organs palpated. Lower limbs hypoesthesia. No other neurologic symptom. Blood samples presented: pancytopenia (macrocytic hyperchromic anemia 7.8g/dL, leukopenia 1400 and thrombocytopenia 28,000), cobalamin deficit 101pg/mL, folic acid normal, AST 64U/L, ALT 18U/L. No other alterations.

MLDP was referred to the urgency department, where she received a blood transfusion. She was referred back to the Family Doctor for more investigation and cobalamin supplementation. During medical investigation, upper GI endoscopy showed "atrophy of the gastric mucosa of the body and fundus". Histologic findings: "Antrum fragments show carcinoid tumor, well differentiated, insular growth pattern (chromogranin A, NSE and CAM 5.2 positives). No signs of necrosis. Body fragments partially involved in the tumor previously described, moderated atrophy. H. pylori negative." Colonoscopy normal. MLDP was diagnosed with a gastric carcinoid tumor and referred to general surgery. In this case report, the identification of PA and further investigation allowed the diagnosis of a gastric carcinoid tumor. This uncommon disease represents 1% of the gastric cancers. We highlight the importance of the body and antrum histologies when an upper GI endoscopy is recommended. It is important to recognize that the treatment of anemia is not only the supplementation, but also the investigation to provide a cure.



THORACIC OUTLET SYNDROME IN PRIMARY CARE: A CLINICAL CASE REPORT

Matteo Mannucci,¹ Gabriel Trucco,¹ Alba Gomez Zahino¹

¹CS TRENCADORS (Palma), Palma de Mallorca
drmatteomannucci@gmail.com

Thoracic outlet syndrome (TOS) refers to a group of signs and symptoms due to the compression of the neurovascular bundle by various structures in the area above the first rib and behind the clavicle in the region of the thoracic outlet. This syndrome is known with different names, like cervical rib syndrome, scalenus anticus syndrome, costoclavicular syndrome and hyperabduction syndrome.

A 57-years male patient presented to his family doctor consultation with a complaint of a pain and swelling in the left elbow since a couple of weeks. Pain depends of movements and position; it increases with abduction of the left arm. He refers no previous traumatism. He also shows a long time edema in both hands associated with a past history of arthrosis due to his work as cook. He is active smoker (15-20 cigarettes per day). At physical examination no movement limitation or neurological abnormalities were shown. Mild increase of superficial venous circulation in the left hemithorax, not seen in the left arm. Soft swelling of left arm with 31 centimeters diameter (while on right arm, diameter was 27cm). Mild swelling of both hands, with no signs of inflammation. No lump in armpit was found. Selective pain in epicondyle. Radial pulse presents in any position of the arms. JVP was not raised; cardiac auscultation shows regular heart rate without murmurs, while pulmonary was clear to auscultation bilaterally, without wheezes or crackles.

With the diagnostic of epicondylitis and a suspect of a thoracic outlet syndrome we selected a chest X-ray as complementary test that didn't shown any abnormalities and prescribed a nonsteroidal anti-inflammatory drugs (NSAIDs) treatment. We sent him to an emergency angiology specialist consultation to realize Doppler ultrasound that didn't show any thrombus in cephalic, basilic, humeral, axillary, subclavian and jugular veins. No flow signal with hyperabduction of the left arm. With the suspicion of venous thoracic outlet syndrome he was discharged from emergency, added in waiting list for venography and referred to angiology specialist regular appointment. Images from the venography that showed stenosis in both subclavian veins with 90 degrees abduction of arm. After his appointment with the specialist they commented the clinical case in a Committee and decided for surgical first rib removal.

'THINKING OUTSIDE THE BOX': ABOUT A RED BLOOD CELL COUNT PRESCRIPTION

Ana S. Fernandes,¹ Diana Coelho,¹ Maria Antónia Alvito¹

¹USF Fernão Ferro mais
ana7466@gmail.com

As family doctors we follow a clinical thinking that is focused on the patient, having local guidelines has guidance. This case shows how, sometimes, our clinical practice must be individualized according to the patient and how the prescription of complementary exams can change a person's life.

This is a case of a male of 40 years old, autonomous in his activities of daily living, inserted in a stable nuclear family, with a daughter in school age, and a close relationship with his mother and brother. He presented to our routine hypertension appointment asymptomatic, with a normal physical examination and with laboratory tests showing a microcytic hypochromic anemia, that later was confirmed as a ferropenic anemia. In the etiological investigation performed later, in order to discover gastrointestinal blood losses, stands out: a colonoscopy without any relevant alterations and a upper gastrointestinal endoscopy with a subepithelial lesion of the second portion of the duodenum. To clarify the lesion he performed an abdominal and pelvic tomography with contrast which demonstrated the presence of an oval image with a soft tissue density and an upper gastrointestinal endoscopic ultrasound where it stands out, in the second portion of the duodenum, a subepithelial lesion suggestive of a gastrointestinal stromal tumor (GIST) of the duodenum, later confirmed by histology. Due to this diagnose the patient was referred to the specialty of general surgery, and submitted to duodenum pancreatectomy with cholecystectomy.

According to the local guidelines, the prescription of a red blood cell count obeys to very specific rules. However, as family doctors we have to adequate our clinical practice to individual particularities of the patient in front of us. This case report makes us reflect about the benefit of prescribing complementary exams, has a red blood cell count, in certain cases, rather than being strictly faithful to the local guidelines. In this case report, the anemia diagnostic allowed a fast etiological investigation, consequently allowing the diagnosis of a GIST in an initial phase. This early diagnosis was fundamental for a surgical treatment that has a high curative potential. For this patient, in particular, the prescription of a red blood cell count completely changed his and his family's life.



WHEN WE BELIEVE IN A MIRACULOUS OIL

Ana S. Fernandes,¹ Diana Coelho,¹ Maria Antónia Alvito,¹ Alexandra Fernandes¹

¹USF Fernão Ferro mais
ana7466@gmail.com

The patient-centred clinical method considers his customs and beliefs. In this context there are situations in which it is necessary to achieve a balance between the conventional medicine and alternative treatments proposed by the patient.

This is a case of a male of 64 years old, from Mozambique, twelfth grade of scholarship, autonomous in his activities of daily living, inserted in a nuclear family. He presented to our appointment with stomach fullness and severe weight loss. We observed a discrete hepatomegaly, without any chronic liver disease stigmata. It was requested an abdominal ultrasound and laboratory tests with liver parameters which revealed a severe hepatomegaly, hepatic, heterogeneity of liver parenchymal with multiple nodular formations and an increased cholestasis pattern. After reading the results of the exams the patient decided to start a treatment with cannabis oil, refusing conventional medicine therapeutics, until the end of it, which was accepted by the family doctor. It was prescribed an abdominal tomography that showed a severe hepatomegaly with multiple metastases. The patient was referred to the specialty of gastroenterology and was diagnosed with a neuroendocrine tumor of the tail of pancreas with liver metastasis. By the end of the alternative treatments he accepted to start chemotherapy.

With this clinical case we pretend to alert family doctors that our clinical practice must be individualized according to the particularities of the patient, namely his beliefs, which in this case were fundamental to the patient cooperation in his treatment.

HYPERTENSION IN 34 YEARS OLD MALE

Alba Gomez Zahino,¹ Matteo Mannucci,¹ Sara Guerrero Bernat,¹ Laura Crespo Leza,¹ Jordi Martínez Gisbert,¹ Maria Dolores Acerete Hueso¹

¹CS TRENCADORS (Palma), Palma de Mallorca
drmatteomannucci@gmail.com

A 34 years old male was referred by occupational health doctor to the finding high blood pressure rates, in a routinary control. Without any symptoms, the patient was found with systolic pressure 190 and 110mmHg of diastolic. He did not present past history of hypertension or cardiovascular diseases. His medical history included hyperlipidemia and ulcerative colitis. Her medication included sulfasalazine. On examination, he was afebrile. The blood pressure was 180/100mmHg, heart rate 80 beats per minute, the respiratory rate 13 breaths per minute, and the oxygen saturation 98% while he was breathing ambient air. He appeared healthy. Finding from heart, lung, abdomen examinations were normal. We realized blood and urine analysis that revealed a normal hemoglobin, white-cell count and platelets count. The serum electrolyte levels were normal, and the glucose level was 83mg per deciliter. The creatinine level was 1.29 mg per deciliter (the creatinine level was 1.0 per deciliter in last test one year ago). Urinalysis showed proteinuria (150mg/dl) and microalbuminuria (989mg/l). His calculated glomerular filtrate (CDK-EPI) was 71.9ml/min/1.73m². The results of other laboratory tests were normal. Our differential diagnosis included primary hypertension, secondary hypertension due to feocromocitoma, kidney and thyroid diseases, hyperaldosteronism (Conn's syndrome) and Liddle's syndrome. Second line complementary tests were realized, including metanephrines and renal ultrasonography with doppler. Eco-doppler results with no structural and vascular alterations in urinary tract. We derivate the patient to nephrology, for an accurate diagnosis by the realization of a kidney biopsy, compatible with IgA nephropathy. IgA nephropathy is the most common cause of primary (idiopathic) glomerulonephritis in developed countries of the world. A regimen of antihypertensive treatment was initiated with losartan, and renal function was strictly controlled. Amlodipine was added two months later, because of poor control of high pressure. Since it took some month (five) to reach the diagnosis of IgA Glomerulonephritis we kept this treatment and nephrologist started with immunosuppressor treatment (corticoids and mycophenolate mofetil). From diagnosis, the patient has had positive development with control and maintenance of the optimum blood pressure without proteinuria. He continues with periodical tests in primary attention and nephrology.



AMIODARONE-INDUCED HYPERTHYROIDISM

Raquel Sanches,¹ Sara Carmona,¹ Sofia Figueira¹

¹USF S. Julião
rql.sanches@gmail.com

Background: Amiodarone is an effective class III anti-arrhythmic drug, commonly used to treat ventricular and supraventricular tachyarrhythmias. However, it's usually associated with several adverse effects, related with cumulative doses, even after its withdrawal. Thyroid dysfunction is a common complication of amiodarone therapy, and depends on previous thyroid status and dietary iodine intake. Amiodarone-induced thyrotoxicosis (AIT) is more common than hypothyroidism in patients with underlying multinodular goiter or latent Graves disease and in iodine-deficient regions, and is more frequent in males. There are two types of AIT, and differentiation between them is critical, due to their distinct pathogenesis, treatment and outcomes. Sometimes, mixed forms of AIT exist, making both diagnosis and treatment challenging.

Case presentation: An 82-year-old Portuguese female medicated with amiodarone for atrial fibrillation since 2013, presented with complaints of heart palpitations, anxiety, weight loss, insomnia, dizziness and recent lipothymic episodes. At physical examination, the only abnormal findings were bradycardia and irregular heartbeat. She had no previous radiotherapy exposure, personal or family history of thyroid disease. Laboratorial evaluation showed low TSH (<0.004 uIU/mL) and high fT4 (2.14 pmol/L). Owing to these results, amiodarone was discontinued and the patient was referred with urgency to endocrinology service. Further investigation showed normal anti-thyroid antibodies and a micronodular pattern. In this context, the hypothesis of AIT was considered, and therapy with thiamazole and prednisolone was started, with clinical and analytical improvement in less than 5 months.

Conclusion: We describe a challenging case of AIT in a female, with no previous thyroid dysfunction, living in Portugal, where iodine intake is believed to be low. We have no information about thyroid vascularity, IL-6 or radioiodine uptake, which would help to distinguish the two types of AIT. When the distinction is difficult, partly because some patients may have a mixture of both mechanisms, it's reasonable to start a combined therapy. In this patient, the rapid response to therapy, along with the absence of previous thyroid dysfunction, may suggest prevailing type 2. This case shows the relevance of controlling thyroid function in patients treated with amiodarone and also the need to be aware about the side effects of medicines prescribed to our patients.

'WHAT IF IT'S ALS?'

Maria João Sousa,¹ Maria José Almeida¹

¹USF Infante D. Henrique
mjmsousa@gmail.com

Introduction: Fasciculations are a common symptom, occurring in about 70% of healthy individuals. They are rarely associated with serious disorders, but they appear to be a cause of anxiety, particularly among health professionals, since they can be an early symptom of serious diseases, such as amyotrophic lateral sclerosis (ALS).

Case report: A 24 year-old female, physician, with a functional nuclear family and history of migraine, consulted her family physician (FP) due to fasciculations "from head to toes" (more commonly in upper eyelids, upper and lower limbs, but also in the abdomen, thorax, face and tongue), that only occurred at rest, ceased immediately with movement and were visible under the skin. She started to experience this, but only in her legs, 1 year before, during her last year in medical school, while studying for an important exam. When the patient started working as a doctor, 2 months after the exam, the fasciculations got much worse in frequency, amplitude and extent and by this time were accompanied by sporadic episodes of paresthesias, especially in her feet, hands and face. There was no muscle weakness. She was extremely anxious and worried about the possibility of ALS. The neurological examination (NE) was normal. Magnesium was prescribed and blood tests requested, including thyroid function, sedimentation velocity, C-reactive protein and antinuclear antibodies, with no alterations in any of these. Because the patient was still worried and wanted to rule out the possibility of a serious condition, a neurology appointment at the hospital was requested. An electromyography and a global NE were performed; they were both normal. Therefore, the neurologist assumed the fasciculations were benign and stress-related. Diazepam in a SOS regimen was prescribed. Six months later, the patient had an appointment with her FP – she maintained the fasciculations and acknowledged they worsened when she was more anxious, but overall the symptoms had clearly improved.

Discussion: The majority of fasciculations are benign, but causes like motor neuron diseases must be ruled out before the diagnosis of benign fasciculation syndrome (BFS) can be made. Despite its benign course, in some cases BFS can be a source of physical and psychological morbidity and interfere with quality of life. The FP is frequently the first professional to whom these patients resort. Therefore, they play an essential role on the initial approach and on providing an adequate follow-up.



WHEN BONE FRACTURE LED TO TURNER SYNDROME DIAGNOSIS

Ana Sequeira,¹ Vera Araújo,¹ Ana Maria Pires¹

¹USF Lethes
asequeir@gmail.com

Background: First consultations with a general practitioner (GP) seldom start at 55 years. They usually begin with prenatal care, then neonatal care, first and second years of life, childhood, teenage years and adult life, providing longitudinal continuity of care until death (and grief period for relatives). Therefore, it is important to fully evaluate all patients the first time they enter in our consultation room, and take an adequate family history. However, such process is gradual, and may take several consultations.

Description: MDCV, female patient, 56 year-old, single, retired (farmer), belonging to a large family, had first contact with her GP on 16.06.2016. It was a non-presential consultation for registration of an emergency room (ER) letter referring surgical correction of diafisary fracture of both tibial and peroneal left bones (following an accidental fall), and pacemaker introduction due to a symptomatic complete atrial-ventricular blockade (unknown previously to this ER episode).

The GP then scheduled a presential consultation in order to access the patient. The GP took the clinical history, including family history and evaluation. During the interview the patient revealed absence of menarche. MDCV had an aged appearance and physical examination showed excess weight, short stature, high blood pressure, and short neck, as well as abnormal hairiness in the chest, poorly developed breasts and her vaginal inner labia were not visible. Considering the findings, further investigation (blood analysis and imagiology) took place in subsequent consultations and was also requested an endocrinology consultation. Hormonal study and karyotype were performed. The results showed hypergonadotrophic hypogonadism, and turner syndrome was genetically confirmed.

Currently, besides GP consultations, this patient also attends hospital consultations: endocrinology, cardiology, urology and otorhinolaryngology, due to syndrome complications; but with medication and close follow-up, she continues to live a normal functional life.

Discussion: Turner syndrome is a chromosomal condition that affects development in females (approximately 1 in 2,000) and its diagnosis is usually made at the age of five, due to its clear phenotype.

This case report highlights both the importance of adequate personal and family history taking and clinical awareness of genetic conditions by the GP and also his pivotal role in patient care management and coordination with secondary health care.

RESEARCH

MAGNESIUM SUPPLEMENTS IN THE TREATMENT OF MUSCLES CRAMPS: AN EVIDENCE-BASED REVIEW

Rita Pedro,¹ Jéssica Perpétuo¹

¹USF Horizonte – ULS Matosinhos

Introduction: Muscle cramps are a common presentation in primary health care. Although they may be associated with certain pathologies or medications, they most often occur without associated pathology, being especially common in pregnant women and the elderly. Magnesium supplements are widely marketed for various indications, namely prophylaxis of muscle cramps.

Objective: To review the available evidence on magnesium supplements in improving the frequency of muscle cramps in adults, including pregnant women.

Methodology: Research, in PubMed and in the evidence-based medicine databases, for clinical practice guidelines (CPG), meta-analyses (MA), systematic reviews (SR) and randomized clinical trials (RCT), published between July 2007 and July 2017 in English, French, Spanish and Portuguese, using the MeSH terms 'magnesium' and 'cramp'. To assess the quality of the studies and the strength of recommendation, it was used the Strength of Recommendation Taxonomy (SORT) from the American Family Physician.

Results: A total of 80 articles were found, of which four were selected because they met the inclusion criteria: one CPG, one MA and two SR. In adults, all studies state that there is no statistically significant difference between magnesium and placebo in reducing the frequency of muscle cramps. In pregnant women, one of the SR states that magnesium may be more effective than placebo in reducing the frequency of muscle cramps. Regarding the studies included in the MA and the other SR, some studies show benefit of magnesium when compared with placebo, in reducing the frequency of muscle cramps in pregnant women, while others do not.

Conclusions: In adults, the evidence is insufficient to recommend magnesium supplements to reduce muscle cramps frequency (strength of recommendation [SOR] B). In pregnant women, the evidence is contradictory and still inconsistent to recommend magnesium supplements to reduce muscle cramps frequency (SOR B). However, the available evidence is scarce and of reduced quality. Therefore, more RCTs, of better methodological quality, with a longer follow-up period and number of individuals, are needed to clarify the potential impact of this treatment on cramps.



POLYPHARMACY AND POTENTIALLY INAPPROPRIATE MEDICATIONS IN VERY OLD PATIENTS

Joana Rita Bento,¹ Denise Alexandra Velho,¹ Célia Mata,¹ André Rainho Dias,¹ Bruno Pereira Carreira,¹ David Tonelo,¹ Patrícia Angélico,¹ Rita Lopes Ferreira,¹ Nadina Sousa¹

¹USF Santiago, ACeS Pinhal Litoral II

Background: Ageing represents a worrying demographic phenomenon of modern societies. Ageing is associated with a gradual decrease in physiological reserves and increased risk of many diseases, leading to multimorbidity and polypharmacy (five drugs). Multiple studies have shown a relationship between polypharmacy and potentially inappropriate medications (PIM) – medications or medication classes that should generally be avoided in patients 65 years or older because they are either ineffective or pose unnecessary high risk and a safer alternative is available. Beers criteria are a widely used tool which enables providers to a safe prescription.

Aims: 1. To determine the prevalence of polypharmacy and PIMs in very old patients (80 years) of a Portuguese Family Health Unit (FHU), applying Updated 2012 Beers Criteria by the American Geriatric Society; 2. To verify if there is an association between polypharmacy and PIMs.

Methods: Cross-sectional study. Population: all elderly subjects aged 80 years old registered in the FHU ($n=419$). Exclusion criterion: patients without any prescription by one of the FHU's doctors during the chosen period of data collection. Electronic medical records were assessed to collect age, sex, number of chronic diseases, number of chronic medications and PIMs prescribed between September 2016 and August 2017. Software: Excel 2007® and SPSS 21.0. Test: Chi-squared test (L.s. 5%).

Results: 347 patients were included in the sample, with a mean age of 87.7 years ($SD=3.7$), 63.1% being female. The mean number of chronic diseases per patient was 4.9 ($SD=2.7$). Polypharmacy was found in 74.9% of the subjects, with a mean number of drugs per person of 6.6 ($SD=3.1$). A total of 182 (52.4%) subjects were prescribed at least one PIM. Benzodiazepines and nonsteroidal anti-inflammatory drugs were the drug classes more frequently prescribed. We observed a statistically significant association between polypharmacy and PIMs ($p<0.001$).

Discussion: Medication toxic effects and drug related problems can have profound medical and safety consequences in older patients. The obtained results evidence a concerning prevalence of polypharmacy and PIMs. This study triggered an urgent quality improvement cycle with future clinical audits in our FHU.

WHAT DO YOUNG DOCTORS KNOW OF PALLIATIVE CARE, HOW DO THEY BELIEVE THE CONCEPT SHOULD WORK?

G. Chamath Fernando,¹ Shamini Prathapan²

¹Department of Family Medicine, Faculty of Medical Sciences, University of Sri Jayewardenepura; ²Department of Community Medicine, Faculty of Medical Sciences, University of Sri Jayewardenepura
chemetf@sjp.ac.lk

Introduction: Education in the relatively modern discipline of palliative care is still evolving in developed parts of the world while it remains at an infantile stage in developing countries like Sri Lanka which has not also been formally assessed as of today.

Aims: To evaluate the level of palliative care knowledge among young medical graduates and to identify their opinions on the discipline

Methods: A descriptive cross-sectional study was carried out among pre-internship medical graduates of Sri Lanka through a social media based on-line survey. The sample size recruited was 351. The pre-tested questionnaire contained questions with regards to general principles, service organization, management, ethics related to palliative care and their opinions.

Analysis: The results were analyzed in the form of average and percentage scores overall and in each domain.

Results: The average score among the respondents was 37.25% with a standard deviation (SD) of 11.975. Specific knowledge on 'general principles' was adequate (score \geq 50%) with an average of 62.61%, $SD=24.5$ while 'ethics' was observed to be the area with poorest knowledge (average score=19.55%, $SD=22$). Average scores for 'service organization' and 'managerial aspects' were 34.54%, $SD=17.6$ and 32.26%, $SD=22.3$ respectively. The majority (>90%) believed that de-novo establishment of hospice, hospital and community-based palliative services would sustainably improve holistic patient care.

Inference: The fresh medical graduates are poorly knowledgeable about the basic concepts of palliative care and end-of-life issues. A sound palliative academic programme must be incorporated into the undergraduate medical curricula. It is worthwhile to assess the adequacy of learning of palliative care through postgraduate curricula.



BIOPHYSICAL ATTRIBUTES, BONE DENSITOMETRY SCANNING REVEALED DIMENSIONS AND INTERRELATIONS BETWEEN THEM: AN URBAN SRI LANKAN STUDY

Kavijaya Wijayasinghe,¹ G. Chamath Fernando,² Chandima Jeewandara,¹ Shyamalee Samaranayaka³

¹National Centre for Primary Care and Allergy Research; ²Department of Family Medicine, Faculty of Medical Sciences, University of Sri Jayewardenepura; ³Family Practice Centre, University of Sri Jayewardenepura

Introduction: Osteoporosis and osteopenia can be detected sensitively by dual energy X-ray Absorptiometry (DEXA) which then can be remedied by pharmacotherapy and lifestyle modification strategies, thus preventing foreseeable jeopardy to quality of life.

Objectives: To describe the biophysical attributes, bone densitometry scanning revealed dimensions of the patients undergoing DEXA scanning at an urban primary care centre and describe interrelations between them.

Methods: A descriptive study where all the retrospective data of patients who underwent DEXA scanning were analyzed in terms of percentages of and interrelations (with Pearson's Chi-square- χ^2) between biophysical data and densitometry parameters (e.g. T,Z-scores, fat mass etc.).

Results: A total of 604 (females=539, age range=30.61 – 88) were included in the analysis out of all individuals scanned. Based on the left hip T-scores, 6.8% were osteoporotic and 27.3% were osteopenic. Spine and Whole Body (WB) T-score results revealed that 34.8% and 35.1% were osteoporotic while 39.2% and 34.9% were osteopenic respectively. WB, Hip and Spine T-scores significantly correlated directly with Body Mass Index (BMI), ($\chi^2=53.403$, $p<0.001$); ($\chi^2=108.253$, $p<0.001$); ($\chi^2=64.002$, $p<0.001$) respectively. WB, Hip and Spine T-scores also had significant inverse correlations with age ($\chi^2=177.312$, $p<0.001$); ($\chi^2=104.073$, $p<0.001$); ($\chi^2=135.173$, $p<0.001$), years elapsed since menopause in females ($\chi^2=147.863$, $p<0.001$); ($\chi^2=76.864$, $p<0.001$); ($\chi^2=150.689$, $p<0.001$) and females being included in 'metabolic syndrome' defining waist circumference category ($\chi^2=22.576$, $p<0.001$); ($\chi^2=58.717$, $p<0.001$); ($\chi^2=19.667$, $p<0.001$) correspondingly.

Conclusion: More than a third of the screened urban population was osteoporotic while another third was identified to be osteopenic based on spine and WB T-scores. Overall T-scores were significantly influenced favorably by BMI and adversely by age, time since menopause and female waist circumference.

VACCINATION FOR TEENAGE PERTUSSIS: KILLS LESS AND SAVES MORE?

Catarina Ferreira,¹ João Vieira Fonseca,¹ Paula Neves,¹ Nuno Amaral,¹ Pedro Apolinário¹

¹USF Nova Mateus, ACeS Douro I

Introduction: Whooping cough is a respiratory infection caused by highly contagious *Bordetella pertussis*. Infants and young children are the most vulnerable group. The current Portuguese National Vaccination Program contemplates vaccination for pertussis at 2, 4, 6, 8 months and 5 years of age, as well as all the pregnant women, ideally at 32 weeks. However, this (Dtpa) vaccine's application in Portugal has been used instead of tetanus and diphtheria isolated at 10 years old or as an reinforcement in adolescence. This evidence-based review aims to assess the impact of the pertussis vaccination (Dtpa) in adolescents at two levels: mortality and cost-effectiveness.

Methods: In May 2017 articles were searched in the electronic databases PubMed, Cochrane Library, DARE, Bandolier, Guideline Finder, National Guideline Clearinghouse, National Institute of Health and Care Excellence and Index of Portuguese Medical Journals. There were included the following: systematic reviews, meta-analysis, randomized clinical trials, multicenter and observational studies. We aimed to compare the adolescent's population from 10 to 18 years old who were vaccinated with Dtpa with the ones who were not. The MeSH terms used were 'Whooping Cough' AND 'DTaP vaccine' AND ('adolescent' OR 'child') AND ('mortality' OR 'cost effectiveness'). The chosen languages were English, Spanish and Portuguese between the years of 2000 and 2016.

Results: Were found 23 articles and included five: two prospective cohorts, two cross sectional observational studies and one consensus of experts, which globally evidenced the benefit of pertussis vaccination in adolescence (Dtpa).

Conclusions: This review shows a potential gain with Dtpa vaccination between the ages of 10 and 18 with an average level of evidence of two. Although it does not appear to reduce the mortality rate associated with whooping cough, it reduces the number of hospitalizations, provides a better immunity and indirect protection for younger children. However, not only more effective studies of pertussis incidence are needed but also cost effectiveness studies with longer follow-up.



QUALITY

RELATIONSHIP BETWEEN GENERAL PRACTITIONERS JOB CHARACTERISTICS AND THEIR ATTITUDES TOWARDS SELF-ASSESSMENT GLYCAEMIC CONTROL(S-AGLIC) PRACTICES

Jurate Peceliuniene,¹ Irena Zukauskaitė,² Antanas Norkus³

¹Vilnius University Faculty of Medicine; ²Vilnius University Faculty of Philosophy;

³Lithuanian University of Health Sciences, the Institute of Endocrinology

peceliju@hotmail.com

The systematic adherence to S-AGLIC is a key element to obtain a positive therapeutic effect in diabetic patients.

Methods: Pilot study was performed to evaluate the impact of general practitioners (GPs) job characteristics and their attitudes towards S-AGLIC practices and adherence among diabetic primary care (PC) patients. Twenty-four consecutive GPs took part in the study. Five aspects of job satisfaction (current career, possibilities for qualification improvement, work in a team, cooperation and communication with specialists, and access to work equipment) and job satisfaction in general were measured on 5 item Likert type scales. Perceived supervisor (S) support was measured by short version of Greenhaus, Parasuraman ir Wromley (1990) scale. GPs had to indicate their fatigue at work as well as stress on 10 point Likert type scales.

Results: The importance of patients' S-AGLIC practices and adherence was related with different aspects of S support for GPs: the correlation with GPs' recognition was $r=0.438, p=0.035$; the correlation with the feedback provided to GPs by S was $r=0.462, p=0.027$; and the correlation with GPs' development conditions was $r=0.476, p=0.022$. GPs' satisfaction with possibilities for qualification improvement was related with three aspects: correlation with the impact of S-AGLIC on diabetes control/correction/HbA1C% was $r=0.416, p=0.043$; correlation with the time, needed for GPs to consume for patients' S-AGLIC was $r=0.413, p=0.045$; and correlation with perceived patients' harm and benefit ratio of S-AGLIC was $r=0.475, p=0.019$. The satisfaction with access to work equipment correlated significantly with the impact of S-AGLIC on diabetes control/correction/HbA1C% as well with the time, needed for GPs to consume for patients' S-AGLIC. Patients' S-AGLIC and cooperation with his/her GP were both significantly related with doctors' fatigue and stress at work.

Conclusions: The importance of patients' S-AGLIC is related with supervisor's support for GPs. GPs' fatigue and stress at work both are related with better GPs' and patients' cooperation regarding S-AGLIC.

ESTABLISHING A FIRST5 GROUP: GETTING STARTED, THE SUCCESSES AND THE PITFALLS

Jodie Blackadder-Weinstein,¹ Mike Smith²

¹Academic Department of Military General Practice; ²Senior Lecturer General Practice, Academic Department of Military General Practice, Edgbaston, Birmingham.

jodie.blackadder@gmail.com

Background: THE SUCCESS-SATISFACTION PARADOX OF MILITARY GENERAL PRACTICE TRAINEES, by Dr Toby Holland, revealed that although examination results depicted high caliber GP trainees, the study also revealed a sense of dissatisfaction with support and preparation for actually undertaking the MO role. As part of the response to this study, a quality improvement project was undertaken to improve the support for doctors in their first five years of becoming an independent, in line with the RCGP First5 Movement.

Aims: The aim of the project was to: 1. Develop a peer support network for MOD First5s; 2. Provide both CPD and social opportunities; 3. Develop an MOD GP First5 representative body to ensure the groups voices are heard both within the armed forces and externally, nationally.

Method: An initial First5 conference was arranged by a recently qualified GP, and from this two representatives were elected and given a two year term to develop the network. By reviewing attendance and feedback from conferences, and a survey sent to all MOD First5s initial interventions were assessed.

Results: Positive feedback was gained from all those able to attend the 'conferences' arranged twice a year, with particularly favourable feedback on special interest lectures' (speakers or workshops not usually found on civilian GP CPD events). However, the wider First5 survey outlined difficulty in attending face to face conferences, and a desire for more local and remote opportunities to interact.

Conclusions: Although there have been initial successes with positive feedback received from First5s, the use of lecture sharing, live event video streaming and local CPD groups must now be explored.



RHINOSINUSITIS: ARE WE TREATING IT PROPERLY? QUALITY WORK

Rita Oliveira da Silva,¹ António João Costa e Silva¹

¹USF Mondego

aritadasilva@gmail.com

Justification: The rhinosinusitis (RS), frequent in primary health care (CSP), according to the European Position paper on rhinosinusitis and nasal polyps (EPOS) 2012, results from the nose and sinus inflammation with two symptoms: one of which is nasal obstruction or rhinorrhea, facial pain and/or hyposmia. It impacts the quality of life, implying the need of medical care and incapacity for work. Adequate intervention and therapy in CSP allow a reduction in morbidity and absenteeism to work.

Objective: To evaluate and improve the quality of care provided by guaranteeing the clinical diagnosis of RS and adequate therapy according to EPOS.

Methodology: Analytical, cross-sectional and retrospective study, before and after internal educational intervention. Data collected from MIM@uf[®] and SCLínico[®] computer records and processed in Microsoft Excel[®] 2016. Population: Adults 18 years from a family health unit (USF) with 'A' of SOAP coded: R75 of the ICP-2 during an episode of the 1st semester 2016 (1st evaluation) and from 12/2016 to 05/2017 (2nd evaluation). Variables: age, sex, clinical findings, severity and therapeutics. Evaluation and quality criteria: N^o and % of patients with R75 diagnosis, clinical findings and adequate therapy, checking for improvement after intervention.

Results: In the 1st evaluation, 70 patients were eligible, 62.9% with symptoms compatible with the clinical diagnosis, 44.3% with severity criteria. In the prescribed therapy, 85.7% under antibiotic, 54.3% nasal corticosteroids, 40.0% NSAIDs, followed by antihistamines (AH) in 32.9% and nasal irrigation in 2.9%. In the 2nd evaluation, 80 patients were eligible, 72.5% with symptomatology compatible, 43.8% with severity criteria. Regarding therapeutics, 77.5% had antibiotic, 8.8% of which had a different dosage than the recommended one, 61.3% had a nasal corticosteroid, 31.3% NSAIDs, 13.8% nasal irrigation and 26.3% had AH prescription.

Discussion: There was a reduction in the prescription of antibiotics, good to avoid resistances. Of note is the improvement of symptomatic treatment through corticoid and nasal irrigation, which allow the significant reduction of the symptoms and morbidity associated with RS, often chronic and likely to limit quality of life. The omission of data in computer records and the comparison between selected samples at different times are some of the limitations of the study. It is important to undertake new peer intervention to improve multi-morbidity in CSPs.

STRUCTURED CONVERSATIONS: THE IMPACT OF THE STRUCTURE OF DNACPR FORMS ON FACILITATING END-OF-LIFE DISCUSSIONS WITH PATIENTS AND RELATIVES

Noam Roth,¹ Omome Etomi,¹ Charlotte Lau,¹ Joanna Aithie¹

¹Victoria Hospital Kirkcaldy, NHS Fife, Scotland

noam.roth.09@gmail.com

Background: Do Not Attempt CPR (DNACPR) forms are commonly used in hospital and community settings. However, patients are not always included in discussions over resuscitation when these forms are put in place. A new DNACPR form was introduced at the Royal Infirmary of Edinburgh, with a structure designed to encourage discussions between doctors and patients about end-of-life care. We describe an audit cycle to assess the impact of this new DNACPR form on the rates of discussions of end-of-life care.

Aim: Audit cycle to assess the impact of new DNACPR forms on the rate of DNACPR discussions. Secondary end points include: rates of new form use, documented escalation plans, completion rates and senior counter-signatures.

Methods: Two weeks data collection of details of DNACPR forms signed in the Acute Medical Unit (Combined Assessment Unit) of the Royal Infirmary of Edinburgh in April 2017.

Initial audit results were presented to the department with recommendations for improvement, followed by a repeat audit in May/June 2017.

Results: Number of patients recruited in original audit vs. re-audit: 35 vs. 33. Use of new form in original audit vs. re-audit: 54% vs. 84%. Discussion documented in original audit vs. re-audit: 34.3% vs. 60.6%. Escalation plan documented in original audit vs. re-audit: 29% vs. 64%. Incomplete forms in original vs. re-audit: 17% vs. 64%.

Conclusions: An increase was found in the use of new DNACPR forms following the department education following the original audit. An increase in the use of new DNACPR forms was associated with improved rates of DNACPR discussions, escalation plans and senior counter-signatures.

An increase in use of new DNACPR forms was found incidentally to be strongly associated with reduced rates of review date documentation on forms. This is likely related to the structure of new forms, where the review date was moved to the back of the form from the front.

We conclude that the structure of DNACPR forms and departmental education can have a positive impact on DNACPR discussions with patients. Both the structure of forms and regular education should be considered in facilitating behavioural change in medical practice and to encourage constructive communication between doctors and patients.



EFFECTIVE TRACKING FOR ABNORMAL SCREENING TEST RESULTS IN BATEEN HEALTH CENTER, ABU DHABI (AD), UNITED ARAB EMIRATE (UAE)

Fatma Nasser,¹ Amira Elhassan,¹ Shamma Elmazroie,¹ Melanie Bardelosa,¹ Eman Lahloub¹

¹Abu Dhabi, SKMC, Bateen clinic
fnasser@seha.ae

Introduction and background: Accurate and timely reporting of patient results as well as establishing a proper tracking system is an integral part of a safe and efficient practice that will improve outcome, patient's satisfaction and will also reduce liability. Studies have shown the adverse effects and negative outcome when results tracking has failed or got delayed. Cancer screening is only valuable and effective when the abnormal results are properly followed up. The World Health Organization (WHO) identified that the rates of test follow-up remain sub-optimal, resulting in serious lapses in patient care, delays to treatment and litigation.

We aimed to: 1. Figure out the root causes for the inadequate follow-up for the abnormal test results from the system point of view; 2. Improve management for abnormal screening test results via developing a tracking system for our clinic.

Methodology: A pre-test/post-test study design, used to evaluate whether implementation of abnormal test result tracking process will reduce the time to follow up in Bateen health care center (2015-2016), AD, UAE. Retrospective study for all Bateen patients with abnormal cancer screening test results (before intervention) total of 300 patients.

Intervention: A list contained all patients who did the cancer screening test for the study period (weekly updated): a) tracking list: for patients with abnormal test results, to be recalled on the same day/or maximum in the second day (maximum in two days from the release of result) and to schedule an appointment with Bateen' doctor for result discussion and management; b) finally, we check for proper management documentation in the file; if doctor documented that the patient referred either for further investigation or to the specialist for treatment; c) we used the two by two table and P value for calculating the results.

Results: We found that the two primary measures for the diagnostic resolution (timely follow-up appointment and effective management documentation) were improved after the intervention as follows: 98.3% and 100% respectively compared to 38.2% and 70.6% for the pre-intervention group ($p < 0.001$).

Discussion: Our intervention significantly improved the follow up for abnormal screening test results, and factors associated with inadequate follow up are combination of both system and patient barrier.

Recommendations: Redesign the system to adopt an effective and simple tracking method for abnormal results (electronic or paper-based).

ENHANCING MANAGEMENT OF OBESITY IN AL BATEEN HEALTH CARE CENTER IN ABU DHABI (UAE) 2016

Bushra Ghaliani,¹ Fatima Nasser,¹ Asma Mazroie,¹ Mouza Meimie,¹ Eiman Alshehi¹

¹UAE-Abudhabi-Sheikh Khalifa Medical City-Albateen clinic
f_nasseer@yahoo.com

Introduction and background: Obesity is a global epidemic that considered one of the biggest health problems currently. Obesity rates have been increasing according to the latest records of health authority's preventive program in Abu Dhabi. In 2013, they found that 2/3 of Emirati adults were overweight or obese. We aimed to evaluate and improve obesity management in Al Bateen clinic according to recommended guidelines.

Methodology: Retrospective study carried out in Al Bateen clinic during 2014 followed by re-audit in 2016. We implemented interventions like conducting frequent lectures and recommendations for dietitian and obesity clinic. We targeted patients who have BMI of 25 and above and aged between 18-60 years. 2,618 patients met our inclusion criteria. Systematic randomization was used with sample size of 366 based on sample size calculator 95% CI. Percentages, means and frequencies of overweight and obese patients were calculated for two visits through excel sheet. Documentation of life style modifications education and diabetes screening were checked.

Results: Average age of the patients was 42 years. 36% were males while 64% were females. Percentage of obese class III was 21.8% in 2014 and became 11.3% in 2016. On the other hand, obesity class II and obesity class I were 27% and 38.8% which increased to 32.1% and 52.1% respectively.

Overweight was 12.4% and became 4.5%. Furthermore, normal BMI in 2014 increased by 0.4% in follow up visit while it increased by 0.3% in 2016. Screening for diabetes in overweight and obese patients improved from 76% in 2014 to 89% in 2016 while documentation of lifestyle modifications education was dramatically increased from 87% to 96%.

Discussion: There was a notable increase in the assessment of CVD risk by checking blood sugar and assessment of lifestyle modification (diet and/or exercise) due to reminders, lectures and availability of dietitian. However, a decrease in normal BMI was observed due to limited insurance coverage for dietitian services.

Conclusion: Encouraging physicians to screen obese patients for diabetes and educate them about lifestyle modification have significantly improved quality of care.

Recommendation: We recommend doing educational campaigns for the public about obesity and distribute educational leaflets for obese patients. Also to continue periodic reminders of obesity management guidelines Re-auditing is essential to mark the progress which will be done in one year.



PRACTICE

IN THE EYE OF A HOST: A HIPPOKRATES EXCHANGE

Süheyla Atalay¹

¹Afyonkarahisar Dazkırı State Hospital
shyl.atalay@gmail.com

Introduction: There are different types of exchange programs under the roof of Vasco da Gama Movement. One of them is the Hippokrates Exchange which was launched 17 years ago. The Hippokrates Exchange is an exchange programme for medical doctors specializing in family medicine/general practice and junior family doctors/general practitioners (within five years of completing specialty training). The programme is supported by WONCA Europe and by the European Academy of Teachers in General Practice (EURACT). The aim of Hippokrates is to encourage exchange and mobility among young doctors in the course of their professional formation as general practitioners; thus providing a broader perspective to the concepts of family medicine at both professional and personal levels.

Aim: The aim of the abstract is to present the opportunities of participating as a host in a Hippokrates Exchange.

Methods: Between the dates of 15/05/2017 to 26/05/2017 Hippokrates Exchange for Nahla-El Eraky from UK took place in Istanbul hosted by me in Marmara University Training and Research Hospital, Family Medicine Department. Before her arrival, my tutors and I have prepared an educational two weeks program according to her learning objectives which includes family medicine residency education, home visits, primary care centers, refugee health, and research in primary care, etc. After her arrival we made minor needed changes on that program. During her stay, she also met local trainees and attended local teaching sessions. In one of them, Nahla gave us an excellent presentation about being a GP in UK. In our mutual free time with Nahla, we travelled around this beautiful city, Istanbul.

Results: Exchanges have shown to be beneficial for both visitors and hosts as they promote participants to get out of their comfort zone and to rethink how they may improve primary care provision for the population they work with. It became clear that there are differences between UK and Turkey health systems, on the other hand, we deal with the same problems in our daily clinic life and doctor patient relationships. The experience and the possibility of comparing both health systems enriched our vision. A Hippokrates Exchange gives a new skill to the host: multi-managing. Cooperating with the professors, the colleagues, other workers and putting a visit to them in order is not an easy task to achieve. All worth to see the learning objectives are achieved and reading the final report.

PATIENT, COMMUNITY AND HEALTH PROFESSIONALS: CHARTING THE COURSE TOGETHER FOR BETTER HEALTH

Ana Luísa Esteves,¹ Diogo Silva,¹ Elvira Teles Sampaio,¹ Liliana Silva¹

¹USF Serpa Pinto
lilianafloressilva@gmail.com

Introduction: The central attributes of primary care are accessibility, patient-oriented comprehensiveness and coordination. These are consistent with an integrated people-centred approach, placing people at the heart of health system. To achieve this goal, primary care units need to be high-quality, effective and efficient, trying to bring together the patient, the community and health team workers. In order to empower and engage people, the health care providers must be skilled and motivated. The Serpa Pinto Primary Care Unit identifies itself with the participatory management model, working to increase accessibility and promoting professional cohesion and satisfaction, through a panel of strategies.

Description: The Serpa Pinto Primary Care Unit project is based on three main pillars: patient, community and health team workers. To achieve patient's wellbeing, the Serpa Pinto Primary Care Unit has the daily support of LAUS (Serpa Pinto's Friends League, an institution of social solidarity), trying to improve patient social conditions, their health status and quality of life. Other strategies, such as team building activities, allow the health workers to increase teamwork skills and motivation. Some examples are: 5th Wednesday (a playful moment taking place when the month has five wednesdays), Serpa Pinto's Birthday, Christmas Party and weekly meetings, with specialists and residents, with five minutes of culture. Other projects, such as Actividade (health education project in a nursing home), celebration of Family Doctor's day (19th May) and the residents' newsletter (For our health!) are great opportunities to empower and interact with the community. The Serpa Pinto Primary Care Unit team believes that all of the strategies listed above contribute to strengthening the health system, improving team skills and healthcare delivery to people, their families and community.

Conclusion: As teamwork should be considered the basis of the health work process, relational skills are increasingly important. A regular contact and a coordinated action between the multi-professional teams, as well as a proper environment to their functioning, are essential for a better healthcare service.

Concluding, the Serpa Pinto Primary Care Unit team is developing a number of strategies in order to achieve team cohesion, minimize the distance between health care providers, patients and community and chart the course to navigate the future. Because we are 'stronger together'.



HEART FAILURE DIAGNOSIS IN PRIMARY CARE FROM NOWADAYS TO THE FUTURE

Sara Carmona,¹ Maria do Rosário Novo,² Carolina Resende,³ Paula Nunes Oliveira,⁴ Helena Oliveira,⁵ Maria Helena Febrá,¹ Teresa Libório¹

¹USF S. Julião; ²USF do Arco; ³USF Santo Contestável; ⁴USF Delta; ⁵SAMS, Lisboa
sara.o.carmona@gmail.com

Background and aims: Heart failure (HF) is a common condition and a major public health problem, affecting almost 26 million people worldwide. In Portugal, its estimated prevalence is 4.36% and rises to 16.14% when considering adults over 80 years old. With populational aging is predicted that HF would affect 25% of the global population until 2030. This is a complex condition often related with multimorbidity and polypharmacy with great impact on quality of life and mortality. Therefore, HF constitutes a challenge for family doctors as health managers. With this practice report, we aim to discuss how HF is diagnosed in primary care in Portugal, and how B-type natriuretic peptide (BNP) or its N-terminal fragment (NTproBNP) use as a point-of-care test could change it in the future.

From nowadays to future practice: If all classic symptoms and signs of HF were present this would be an easy diagnosis. However, this is not always true with diagnostic tests gaining a major importance. In our practice, if HF is suspected we will support our diagnosis in echocardiography. This is undoubtedly the most helpful tool, though it isn't immediately available in primary care as a non-acute setting. That way, we need a quick test to identify the patients at higher risk and who should go through further investigation for HF.

Recently, international guidelines are considering dosing natriuretic peptides as the first step evaluation if HF is suspected. When these biomarkers are in a normal range HF diagnosis is unlikely and could be excluded. Rapid tests for natriuretic peptides have shown to be useful distinguishing HF as the cause of acute dyspnoea in the emergency department and to accurately identify patients with left ventricular systolic dysfunction referred from general practitioners to specialized centers. Although more studies in primary care are needed, dosing BNP or NTproBNP seems to be a helpful and cost-effective measure when screening for HF, and some evidence has shown its superior accuracy when compared to the electrocardiogram.

Conclusion: In the future, the introduction of a rapid test for natriuretic peptides as a point-of-care test will improve our diagnosis accuracy, as well as, the health care provided, as we have seen in other situations like warfarin-induced hypocoagulation control based on a rapid test for International Normalized Ratio. Meanwhile, a solution could be the establishment of protocols with advanced HF centers.

CHILD ABUSE PREVENTION MONTH ON USF CARCAVELOS

Catarina Assis Catroga,¹ Nuno Basílio,¹ Alexandra Fradeira,¹ Ana Brites¹

¹USF Carcavelos
catarina.a.cat@gmail.com

Child Abuse Prevention Month was celebrated last April and USF Carcavelos associated with this cause by inviting a group of children between five and seven years old from a nearby preschool to get to know our health center and share activities related to this campaign. The professionals from USF Carcavelos gave the children a guided tour through the facilities followed by a visualization of a few films concerning the subject of child abuse. The initiative ended with an original song created by the professionals and played with the group of children followed by a blue balloon release.

This was a very enriching experience and we would like to share this initiative as an example to motivate primary health care centers to find new ways to send out important messages and connect with their community.

The professionals from USF Carcavelos gave the children a guided tour through the facilities followed by a visualization of a few films concerning the subject of child abuse.

The initiative ended with an original song created by the professionals and played with the group of children followed by a blue balloon release.

This was a very enriching experience and we would like to share this initiative as an example to motivate primary health care centers to find new ways to send out important messages and connect with their community.

WORKSHOPS



UNPUZZLING TYPE 2 ANTIHYPERGLYCEMIC DRUGS: MATCHING THE SWEETEST PILL WITH THE RIGHT PATIENT

Sara Correia,¹ Helena Alonso-Valencia¹

¹C.S. Teis, Vigo

saraecorreia@gmail.com

Diabetes is a complex, chronic illness requiring continuous medical care. That being said, the role of the general practitioner is one of utmost importance, as we are the ones who monitor the evolution of the disease, get to tailor the antidiabetic treatment and adjust it according to specific patient phenotypes and needs, thus optimizing the best combination.

According to recently compiled data, around 422 million people live with diabetes worldwide, and an estimated 193 million people have undiagnosed diabetes. Having all this in mind, we believe that the better the knowledge, the straighter the control and the lesser the negative outcomes, and so we decided to create this workshop to brush-up everyone's skills and unpuzzle type 2 antihyperglycemic drugs.

When entering the room, each participant will be randomly assigned to a group colour, in a way that we will form a total of four groups. By doing this, we hope to break the pre-established friend/country sets, and promote the dialogue with different colleagues.

The workshop will be held by the two of us. After a short introduction and welcoming words, we will start with a 15 minutes presentation, reviewing the main antihyperglycemic drugs and combinations used nowadays having in mind different types of patient profiles. After this, we will assign each group a clinical case. They should debate it among themselves (for about 10 minutes) and, afterwards, each group will share the answer with the rest of the participants and we can have an open debate about their options and different opinions.

At the end of the workshop, we will provide our attendees some extra material to take home which sums up the activity and hopefully will help them in their daily practice.

CHOOSING WISELY IN THE EMERGENCY ROOM

Rafael Beijinho do Rosário,¹ Ayose Perez,² Augusto Saldana,³ Magdalena Canals,⁴ Rosario Bosch⁵

¹Hospital Universitario Infanta Leonor; ²Hospital Universitario Insular de Gran Canaria; ³Hospital General de Requena; ⁴Centro de Salud Las Calesas; ⁵Hospital Universitario Doctor Peset

Background: The use of unnecessary tests and treatments contributes to health care waste (overutilization, overuse, over-treatment). Three years ago the Spanish Society of Family and Community Medicine (semFYC) set up an action called NOT TO DO and commissioned expert panel to identify some of such items on day-to-day GP consultation. The list was narrowed over a modified Delphi process. The top 15 tests and treatments were provided with Grading of Recommendation, Assessment, Development and Evaluation (GRADE) literature summaries. Afterwards it commissioned another expert panel of 15 GPs to produce a paper on Emergency Medicine with the same procedure. <https://www.semfy.com/biblioteca/15-recomendaciones-de-no-hacer-en-urgencias/>

Aim of the workshop:

- Share 15 recommendations of the document DO NOT DO IN THE EMERGENCY ROOM (choosing wisely)
- Provide scientific evidence or absence in usual practices in emergency services

Methods: Through the resolution of interactive clinical cases delegates will review the recommendations of the paper. The chair will bring about clinical cases in day-to-day situation, prior to clinical decision a question will be asked followed by the delegates voting 'Do' or 'Do Not'. After each question a debate will be held and the literature supporting final decision will be provided.

Results and conclusions: Making clinical decisions with a poor level of evidence is common in our daily practice. Papers such, as the one produced by SEMFYC is a landmark in family practice towards efficiency and efficiency because they are based on evidence-based medicine.



PALLIATIVE CARE AND SEXUALITY: GIVING LIFE TO A RELATIONSHIP

Joao Ribeiro¹

¹USF O Basto, Hospital de Santa Casa de Misericórdia de Vila Verde
jribeiro_14@hotmail.com

Palliative medicine is often mistakenly associated with terminally ill patients. Congestive heart failure (CHF), chronic obstructive pulmonary disease and other diseases with complex symptoms control can be criteria to act as a palliative medicine. As a consequence of this wrong conception, health professionals many times forget to access this patients concerns about other subjects that can be important for their quality of life, like sex and sexuality, and the impact that this changes can have either in patients life as in his/her partner. In our Primary Care Unit, we initiate a palliative medicine consultation where all of these questions can be discussed. In this session, we propose to share a case where man and wife were being consulted as palliative patients, as he has CHF NYHA IV (New York Heart Association grade IV/IV) with chronic dyspnea and she was receiving chemotherapy for estrogen receptor positive breast cancer. We asked their concerns about sex life and how to deal with their physical and emotional problems.

A 21ST CENTURY HAMLET: TO CARE OR TO CONSUME?

Jan-Jakob Delanoye¹

¹European Forum for Primary Care
janjakob.delanoye@ugent.be

Format: Special session.

Abstract: In the past few decades, both the language, the organization and the public profiling of health care has been influenced by words, patterns and publicity techniques related to the predominant economic logic of our time. The striving for efficiency, the birth of so called 'care brokers', the vision of the patient as a consumer. In parts of Europe it seems to become more and more common. Nevertheless, one could wonder if the values of caring and the laws of finance aren't contradictory. As such, a neoliberal approach to health care might turn out to be incompatible with the wants and needs of citizens all over the world. To care or to consume, that is the question for the generations to come.

As a general practitioner working in a doctor's office, as a research assistant partially employed by Ghent University and as a You&EFPC (European Forum for Primary Care) member, I would like to address the following questions throughout the interactive session:

* Is the described tendency towards the economization of care felt by the attendees? * Can the attendees give other examples of this so-called economization? * Do the attendees consider this a real threat? Why (not)? * How should we, as a group of health care providers, deal with this? Do we have to resist this evolution? * If we have to act against it: what can we do? Who (e.g. patients, stakeholders, politicians,...) should be involved? Can we be "stronger together"? The author considers either the 'fishbowl' or the 'musical chairs wonder wander' excellent designs for this session. The aim is to have a vivid discussion among the attendees.

During the event, I consider myself as the facilitator, both introducing the questions and summarizing the most important arguments, in order to bring the session in the final minutes to a conclusion.



ASPIRE GLOBAL LEADERS PROGRAM WORKSHOP: HOW TO FACILITATE A TEAM IN DIFFICULT SITUATIONS?

Candan Kendir,¹ Claire Thomas,² Job Metsemakers,³ Jose Castellanos⁴

¹EHESP; ²Vasco da Gama Movement; ³Maastricht University; ⁴Hospital Universitari de Tarragona Joan XXIII
candankendir@hotmail.com

Background and aim: The World Organization of Family Doctors (WONCA) recently published that "leadership training has a direct impact on the ability of physicians to make continual system improvements". Within this goal in mind, the ASPIRE Global Leader Program has been developed. It is a global leadership program aimed at increasing leadership abilities, international collaboration and engagement in Young Doctors Movements.

Aim of this workshop: To improve the facilitation skills of the participants within a team that consists of people that have mixed type of personalities.

Method: In the beginning, there will be five minutes of warm up; introduction of the facilitators, the ASPIRE program and outline of the workshop. After that, 10 minutes of presentation will be done about handling difficult situations in managing a team. Thereafter the participants will be asked to divide into three groups (max 10 people in each) and one pre-prepared scenario will be given to each group. It is expected to have max 30 people in the workshop. According to scenario, everyone will have one role and one facilitator within the group will be asked to handle the difficult situation of the team for 20 minutes. After group role-plays, feedbacks of the participants about their own difficulties will be got individually and management of difficulties will be discussed with the facilitators of the workshop for 45 minutes. In the last 10 minutes, there will be wrap up and feedbacks about the workshops and suggestions for future activities of ASPIRE.

Conclusion: In the end of the workshop, we expect participants to gain/improve their facilitation skills in management of a team.

SHIFTING BOUNDARIES, INTERNATIONAL OPINIONS OF EUTHANASIA?

Rianne van Vliet,¹ Maike Eppens²

¹The Hague; ²Utrecht
r.vanvliet@live.com

In our workshop we want to pay attention to what euthanasia entails in the Netherlands. We will talk about the guidelines and the role of the GP in this.

In the Netherlands, patients can choose euthanasia when they are in the terminal phase. In the Netherlands, 147,000 people die each year, of which 6,760 (4.6%) die through euthanasia or suicide aid. The number of patients who die through euthanasia grows each year. With the growing population of elderly people it is important to think about what our beliefs are of euthanasia. In this workshop we will compare the different views between the countries. We will discuss the pros and cons of euthanasia and talk about the grey boundaries as euthanasia in patients with dementia or psychiatric diseases. Also, we want to talk about the impact for us as a GP. Our aim is to inform, discuss and learn from each other.



HOW DO YOU SATISFY YOUR PATIENT?

Rianne van Vliet,¹ Maike Eppens,² Nadia Tuomi²

¹The Hague; ²Utrecht
r.vanvliet@live.com

In this workshop we will focus on patient's expectations of a doctor visit. Why does the patient come to you and what does he want? Is it medication, reassurance or maybe a referral? Or is it something else? What questions can you use to explore patient's ideas and concerns? What are (non-) verbal clues and hints? How do you structure this within the short consultation time you have? In this workshop we will talk and practice consultation techniques to effectively meet your patient's needs. If you as a doctor connect with your patient's concerns and ideas, your patient will be more satisfied. And if the patient is satisfied, so are you as a doctor as well, right?

ASPIRE GLOBAL LEADERS COLLABORATIVE EUREKA SESSION

Candan Kendir,¹ Tugba Onat,² Maria João Nobre,³ Claire Thomas,⁴ Job Metsemakers,⁵ Jose Castellanos⁶

¹EHESP; ²Omerli Hospital; ³UCSP Faro; ⁴Vasco da Gama Movement; ⁵Maastricht University; ⁶Hospital Universitari de Tarragona Joan XXIII
candankendir@hotmail.com

Background and aim: The World Organization of Family Doctors (WONCA) recently published "leadership training has a direct impact on the ability of physicians to make continual system improvements". Within this goal in mind, the ASPIRE Global Leader Program has been developed. It is a global leadership program aimed at increasing leadership abilities, international collaboration and engagement in Young Doctors Movements.

The aim of this session is to discuss the lacks and needs of young doctors as leaders of primary care and create a strategy document for further organizations of our program.

Questions to be raised during the discussion:

1. Who takes the responsibility as a leader in your working area?
2. If you are, what kind of difficulties do you face?
3. Could you give a few examples to the skills that the leader must have in your working conditions?
4. What are the main lacks/needs that you observe?

Conclusion: In the end of the workshop, we will create a curriculum for ASPIRE Global Leaders Program workshop to improve the related leadership skills of the young doctors.

We would like to invite Anna Stavdal and Job Metsemakers as invited guests (maybe to facilitate the session). Otherwise, main author and one of co-authors are also available for facilitation.



A BOMB EXPLODED: ARE YOU READY TO HELP?

Miriam Rey Seoane,¹ Rabee Kazan,² Anna Fernandez Ortiz³

¹Acut Delta, ICS; ²Valldoreix, Mútua Terrassa; ³UDACEBA
annafo2003@hotmail.com

Skills: Mass casualty incidents, incidents that involve more patients than the local resources can handle (terrorist attack, train crash...), can happen everywhere. A special management system is needed there, in order to give properly pre-hospital assistance and correct evacuation, which is important to reduce mortality. Most of the health care professionals are not well prepared in this area. In this Workshop GPs will learn how the scenario is controlled and how the assistance area should be organized (security, post-disaster medical care, evacuation...). Also we will practice the fundamentals of the START triage and its criteria.

How it will be conducted: Combination of theory (use of slides to introduce the basic knowledge of mass casualty systems) and skill training (use of START in practical cases with mass casualty victims, role playing in a terrorist attack with bomb scenario or similar).

Learn more after workshop: Indulging in emergency care and in catastrophe medicine could be a new focal point in the new European reality. How to start a triage and how to manage the chaos is basic knowledge physicians nowadays must have.

SPIROMETRY MADE EASY

Pedro Fonte,¹ Claudia Vicente²

¹USF Ponte; ²UCSP Mealhada
apedrofonte@hotmail.com

Objective: Measurement of respiratory function is a fundamental requirement in the diagnosis of many chronic lung diseases. It is important to be able to distinguish between obstructive and restricted lung disease, and often this is not possible to determine from history and physical examination. In addition it is sometimes impossible to distinguish between asthma and COPD without objective respiratory function testing. Spirometry has often been in the 'too hard' basket for many in general practice, but high quality technique is achievable and accurate interpretation is possible for 'on site' diagnosis and appropriate treatment. GRESP presents this interactive workshop – after a short presentation, open discussion among participants will be led by a team of practicing family physicians with a special interest in respiratory diseases and with experience of education and investigation in this field.

The session will be applicable to general practitioners and allied primary care health professionals. It will be pragmatic and concise. The main issues to be covered at the workshop will be: clinical vignettes and discussion of diagnosis, with a short theoretical introduction on pulmonary function and physiology; correct techniques achieve accurate results; interpretation of spirometry; tips traps and tricks in achieving accurate assessment.

GRESP is the Portuguese Primary Care Respiratory Group. Many of its members are very used and pleased to organize educational sessions dedicated to important issues among respiratory disease care.



TELEMEDICINE: A POWERFUL TOOL WE MUST LEARN TO USE

Ana Cláudia Monteiro Pereira,¹ Ana Margarida Gomes,¹ Ana Rute Marques,¹ Ines Antunes,¹ Mafalda Lemos Caldas¹

¹USF Travessa da Saúde
ana.monteiro89@gmail.com

As technology grows and time seems to never be enough, it's important for family doctors to manage alternative ways to facilitate access to health services.

We are young residents in family medicine in Camarate, just outside Lisbon. Our population is very poor and multicultural, with many migrants and young people. Sometimes, it's not easy for them to reach us and they can feel lost in our healthcare system. Since our practice is already highly dependent on technologies, why not use it on behalf of our patients?

Over the last few years, several initiatives and programmes were implemented on telemedicine or ehealthcare. In Portugal, telemedicine is contemplated in n° 8445/2014 dispatch from de 30th of July and a National Center of 'TeleSaúde' was implemented, with regional coordinators and internal promoters. To facilitate contact with patients is one of the advantages of telemedicine, for instance when hospital appointments multiply and patients are too busy to have close encounters with their family doctor. Yet, telemedicine can never replace face-to-face appointments and it must be used according to each individual situation. Despite it being a tempting tool, several issues remain to be solved. For instance, some softwares still don't allow for telemedicine to be considered as a type of appointment neither consider synchronous and asynchronous appointments. Also, we cannot allocate our time for this type of practice.

We bring telemedicine to this hands-on workshop to create discussion on this hot topic: What's the best way to use it on behalf of our patients? How many hours of should we dedicate to telemedicine? How is it done in other countries?

The participants of the workshop will be divided into five groups, where each author will give a short introduction and lead the discussion. The authors are Ana Cláudia Pereira, Ana Margarida Gomes, Ana Rute Marques, Inês Antunes, and Mafalda Lemos Caldas. Each group will focus on one of the following themes:

1. What are the major advantages of adopting telemedicine?
2. What are the main dangers of replacing regular appointments?
3. Which types of appointments are best suited for being done remotely?
4. How much time should be dedicated to asynchronous appointments?
5. Will the future of medicine include telemedicine or is it an utopia?

At the end, the main findings and recommendations will be shared and discussed with all the workshop participants.

COMPLEMENTARY AND ALTERNATIVE THERAPIES: STRATEGIES WE CAN NO LONGER IGNORE

Ines Antunes,¹ Ana Cláudia Monteiro Pereira,¹ Ana Margarida Gomes,¹ Ana Rute Marques,¹ Mafalda Lemos Caldas¹

¹USF Travessa da Saúde
ineslopantunes@gmail.com

Complementary and alternative medicine (CAM) is the term for medical products and practices that are not part of standard medical care, such as natural products and mind and body practices. CAM is considered the fastest growing area in health care today and it is estimated that 50% of primary care patients use at least one complementary therapy.

Although CAM therapies are popular, many patients are not comfortable discussing them with their doctors, and many physicians are uncomfortable with the topic as well. This communication gap represents an important opportunity for family physicians. Discussing CAM can lead not only to new insights into illness and health, but also to enhanced patient communication, satisfaction and quality of care.

Some primary care clinics already offer complementary therapies as part of their care and some family doctors have training in specific CAM therapies. As family doctors we can incorporate CAM into our practice by engaging in education, collecting key tools and reliable resources, considering new care models and learning how to identify patients who will profit the most with these therapies.



HAVING A VEGETARIAN/VEGAN DIET DURING PREGNANCY AND BREASTFEEDING: WHAT DO WE NEED TO KNOW?

Ana Rute Marques,¹ Ana Cláudia Monteiro Pereira,¹ Ana Margarida Gomes,¹ Ines Antunes,¹ Mafalda Lemos Caldas¹

¹USF Travessa da Saúde
ana.rf.marques89@gmail.com

Pregnancy and breastfeeding are unique situations. During these periods, the adoption of a healthy lifestyle and a diversified and balanced diet are of extreme importance for the health and well being of mother and child, as well as for the future adult. Each day, an increasing number of people choose to follow a vegetarian or vegan diet for the most varied reasons (socioeconomic, environmental, animal rights,...).

As family doctors, we should aim for a strong and trustful relationship with our patients, finding common ground fields and helping with their lifestyle options. However, this can be a very demanding task, as we need to be well informed in a huge variety of issues in order to be able to help our patients.

Moreover, regarding dietary habits and choices, in our country and specially in primary care, the access to nutritionists or dieticians is almost absent, even though a nutritional assessment and counseling is recommended for many patients. Again, we need to be prepared in order to fill in these gaps.

We bring the topic of vegetarian and vegan diets during pregnancy and breastfeeding to discussion because the vegetarian/vegan population is growing in our practice and we noticed a lot of misconceptions and lack of information amongst physicians.

In this ignite session, we will convey information about: vegetarian/vegan diets, food sources of the most important nutrients, deficits of nutrients in vegetarian diets, supplements that can be needed and how to manage vegetarian/vegan patients.

WHAT'S THE RIGHT THING TO DO? TOM & LUKAS' CORNER ON ETHICAL ISSUES

Tom Axelrod,¹ Lukas Heschl²

¹The Hebrew University of Jerusalem and Clalit Healthcare Services; ²Vienna
tom.chatul@gmail.com

In primary care we encounter almost every day ethical issues, and even a simple routine bureaucratic action may hold a big dilemma.

In this session we would like to explore, discuss and analyze everyday ethical issues and questions, but there is also a place for 'big' questions in terms of public health and health policy – depends on the attendees' preferences.

We are available to be the facilitators of the session, and as such we will guide the discussion using a four stages tool developed by Dr. Rhona Knight (a GP and member of the RCGP Ethics Committee). The four stages are:

1. Identify the ethical matters and dimensions of the consultation;
2. Identify the relevant facts;
3. Explore the relevant values;
4. Decide a justifiable way forward with the patient.

In addition, we will share our experience from our practices.

Question and dilemmas can stem from real clinical cases (better) but may also be raised as hypothetical thoughts. Here are some examples:

Is it ethical to lie in favor of the patient? Should I treat my family members or even be their family physician? Should I give a medical advice to a neighbor-patient on a street talk? Should I give a 30 days sick certificate for a patient who went over elective surgical breast augmentation? A friend resident encounters many sexual harassment from her patients but does not want to tell anyone: should I report to her tutor/clinic director? Is it ethical to refuse to treat a patient?

The facilitators may enrich and challenge the discussion by suggesting a different look at the question – from the patient's or the physician's position, from the public health system, the regulator and even the insurer points of view.

At the end of the session we will summarize the issues raised up and emphasizing practical applications in light of the relevant values.



MANAGEMENT OF THE INFERTILE COUPLE

Filipa Rafael,¹ Ana Beatriz Figueiredo,² Nuno Ramos³

¹CHAlgarve, Unidade de Portimão, Portugal; ²USF das Conchas, ACeS Lisboa Norte; ³Hospital Garcia de Orta, Portugal
filiparfl@gmail.com

Introduction: The prevalence of couples with infertility has been increasing, being a frequent reason to go to the general and family doctor consultation. The recent development in the knowledge and techniques regarding this topic has allowed an increasingly efficient response to these couples. Couples benefit from the correct and prompt diagnosis, since time fights against them for the resolution of their family project.

Objectives: In this workshop, we intend to review the essential aspects to study infertile couple with the objective of training all physicians with the knowledge and skills necessary for the best approach and orientation of these patients.

Discussion: In a practical way, the following topics will be reviewed: physiology of the menstrual cycle and fertilization, the main causes of anovulation and azoospermia; sexual dysfunction and male Infertility; the first approach to complementary analytical and imagiological tests and how to increase fecundity. The workshop will include a multidisciplinary approach, with the participation of professionals from general and family medicine, gynecology and urology, as well as psychology.

Conclusion: It is intended that a useful discussion will arise for all the included professionals, alerting to the subfertile and infertile couples existing in the consultation. In this way, allowing the earlier diagnosis that will eventually be of extreme importance in the success rate of medically assisted procreation.

WEBBASED REPORTING IN PRIMARY CARE

Stefan Heinmueller¹

¹Erlangen
stefan.heinmueller@uk-erlangen.de

Special Session Web based reporting in primary care: structured and evidence-based.

Background: Digital documentation of patients' medical information (i. e. history, test results, diagnoses, medication, etc.), which has become standard in western primary care practices, offers great possibilities for improvement (e. g. reduction of medical errors, lower GP-workload, closer adherence to clinical guidelines, better interprofessional cooperation, etc.) and subsequently higher-quality patient care. However, several challenges prevent these potential improvements from being used. These include among others deficient software functionality, a vast amount of software providers and a poor inter-software-compatibility.

Objective: To discuss with fellow junior doctors the idea of a web based reporting tool for primary care doctors, which comprises all the above-mentioned improvements and can be used additionally to any existing documentation software. Key questions for the special session: 1. How many of you use digital/electronic means and how many use paper-based health records for medical documentation? 2. Of those, who still document on paper: Would you like to or are you planning to switch to electronic documentation? If not, why? 3. Of those, who already use digital health documentation: Are you content with your software? Do you often experience problems with your software? To what extent does your software offer medical information (e. g. dosing of medications), support the export of previously documented information to other health care professionals and allow the extraction of cumulated medical data for quality/research analyses? What functions would you want your software to offer (which it does not at the moment)? 4. How do you think electronic medical documentation looks like in 10 years? 5. What do you think about the above-mentioned idea of a web based documentation tool? Do you think you would/could use it in your daily life as a GP?



PROVIDING PRIMARY CARE TO MULTICULTURAL COMMUNITIES: THE CHALLENGE OF OVERCOMING HEALTH INEQUALITIES IN MIGRANT POPULATIONS

Cristiano Marta Figueiredo,¹ Ana Cebola,² João Sousa,² Martino Gliozzi,³ Ricardo Antunes,² Sara Antunes,² Sofia Correia Pinto,⁴ Tânia Bonifácio,⁵ Tatiana Consciência,² Tiago Lopes,⁶ José Lima⁷

¹USF Ribeirinha; ²USF da Baixa; ³USF Arco, ACeS Lisboa Central; ⁴USF S. João do Porto; ⁵USF Cova da Piedade; ⁶USF Quinta da Lomba; ⁷USF Eça
cristianomartafigueiredo@gmail.com

Why is it relevant? As a consequence of globalization, doctors are confronted with a growing vulnerable migrant population and refugees, which have diverse epidemiological profiles and endemities of disease. Moreover, migrants present specific health problems, health needs and cultural health beliefs and practices. When delivering primary care, specific skills are required to deal with language and cultural barriers besides mixed somatic and psychosocial presentation of symptoms, the administrative complexity and often financial constraints and bad work conditions that this population usually tackles with.

Who are we? We are a team of family doctors working in Lisbon and providing care to a multicultural community. About 30% of our patients have other nationality than the Portuguese, being mainly from Bangladesh, Nepal, Brazil, India and China. We are developing a pilot project in order to improve the integration of the Bangladeshi immigrants into the Portuguese National Health Service named Bengalisboa Community Health Project. We are acting to be a model practice in migrant health care in Portugal, contradicting the poor performance of Portugal in health policies for immigrants stated by the MIPEX 2015.

What do we want to achieve? Raise the awareness about the specific health needs of migrants. Find solutions for the specific health needs of migrants. Provide resources for the family doctor to improve his capacity to respond to the specific health needs of migrants. Create a network of junior family doctors working with multicultural communities in order to share best practices between European countries – the beginning of a VdGM's Special Interest Group: Migrant Care, International Health & Travel Medicine.

How do we want to achieve? Facilitate a group discussion about the perceived specific health needs of migrants living in the participant's countries. Brief talk about the evidence regarding the specific health needs of migrants. Facilitate a group discussion about the solutions found in the participants' countries to minimize the health inequities and improve health care to migrants. Brief talk about the best evidence-based strategies to decrease the cultural and language barriers faced by migrants when accessing health services. Share resources to improve the family doctor's capacity to respond to the specific health needs of migrants. Collect the contacts of the interested participants to take part in the new VdGM's Special Interest Group.

THE MIGRANTS, THE REFUGEES AND THE CRISIS OF EUROPE: ARE WE ALL EQUALLY HUMAN?

Yusianmar Mariani,¹ Sara Rigon,¹ Özden Gökdemir,¹ Elena Klusova,¹ Ana Nunes Barata,¹ Nina Monteiro,¹ Fabrizio Cossutta¹

¹VdGM Equally-Different Special Interest Group
dra.mariani@gmail.com

More than a million migrants and refugees crossed into Europe in 2015, sparking a crisis as countries struggled to cope with the phenomenon at many levels from infrastructures to politics.

As health professionals we do what we can for the people who make it to Europe, the lucky ones who after a long and extremely dangerous journey, are not sent back, but they are given a chance to be and treated as human being again.

What happen to the unseen one? Are they less human only because we do not see them? "Are we all equally human", as the great Philosopher and refugee herself, Hannah Arendt said.

What's our role in this crisis? We are doctors but we are also European citizens. We would like to open a discussion on this crisis as well as the way the EU respond to it: 1. More than a million migrants and refugees crossed into Europe in 2015. 2. After the EU-Turkey agreement that closed the oriental door to Europe, the total number of migrant decreased in 2016. 3. With an increase of the total number of death as migrants are then forced to choose more dangerous way to reach Europe. 4. IOM estimate a total of 22,000 people disappeared trying to reach Europe since 2016. 5. Are refugees' lives, disposable lives? Have these people lost all their rights? Are we all equally human? 6. Migrants who try to reach our shore are more vulnerable to all sorts of violence, the greater risk being human trafficking of any kind. The number of potential victim of human trafficking coming by sea as increased of 600%. 7. Every minute 20 people are forced to live their homes by dramatic events in the world. 8. More than 20 million people are registered as refugees in the world and Europe is accepting merely a 6%. Lebanon, Turkey, Jordan and even Iraq have welcomed the great majority of Syrian refugees. 9. What about the unseen ones? The million who do not make it our shores. 10. International law treats political migrants (refugees status) and economic migrants (people fleeing from a poor country in search of a better life) differently. 11. What about the ones we send back to torture and abuse, they have already suffered during their journey to arrive to our shores. 12. Should we open the door to other human being if we fear that among them there is the very same smuggler who brought these people to our shore? 13. Should we let a woman holding a baby pass the frontline to escape from active war fighting if in the area women with children are suicide bombers? 14. What's our role in the crisis that will define the century we live in?



THE GEN-EQUIP PROJECT

Ana Sequeira¹

¹USF Lethes
asequeir@gmail.com

Equipping European primary care health professionals to deal with genetics is the basis of the Gen-Equip project. This is an innovative project, consisting of an online, free, continuing medical education program in genetics, using clinical relevant tools, hoping to improve care for our patients with genetic conditions or concerns.

Draft outline slide 1: The Gen-Equip project (title); slide 2: Background; slide 3: Project definition; slide 4: Project goals; slide 5: Project contents; slide 6: European partners; slide 7: Project online platform; slide 8: Registration; slide 9: Online learning modules; slide 10: Short education webinars; slide 11: Practical tools; slide 12: Real patient stories; slide 13: Evaluation; slide 14: Accreditation; slide 15: Exploring the online platform I; slide 16: Exploring the online platform II; slide 17: Exploring the online platform III; slide 18: Current experience; slide 19: Acknowledgments; slide 20: Questions and contact information.

'ACTIVE STEPS: NEW STEPS FOR HEALTH'

Mariana Moura Relvas,¹ Rosário Pires,² Margarida Pereira,¹ Tatiana Pinto,¹ Alice Jeri,³ Daniela Silva,² Maria João Ribeiro,² Clara Ferreira,⁴ Mário Gomes⁵

¹USF Porto Centro; ²USF Novo Sentido; ³USF Barão Nova Sintra; ⁴USF Covelo;
⁵USF Faria Guimarães
marianamrelvas@gmail.com

Introduction: Cardiovascular disease represents an important public health challenge and is a major cause of chronic morbidity and mortality throughout the world, with an estimated global mortality of 30% in 2013. There are several risk factors identified, such as elevated blood pressure, dyslipidemia, smoking, inadequate dietary habits, overweight/obesity, sedentarism, diabetes type 2 and excessive stress. The beneficial effects of physical activity are numerous, particularly in the reduction of cardiovascular risk. The international recommendations indicate that being sufficiently active in the adult age (18-64 years old) refers to at least 150 minutes per week of moderate intensity activity (30 minutes per day, five days a week), or 60-75 minutes per week of vigorous intensity aerobic activity (20-25 minutes per day, three days a week), or equivalent. The recommendations to adults are also applicable to the elderly (≥ 65 years old). With this project we pretend to sensitize the patients of our health units, who have cardiovascular risk factors, to the importance of exercise in the management of these, including promoting moderate physical activity, at leisure times, through collective walks; stimulating the continued practice of different intensity physical activities, through motivational strategies, like oral intervention or in the actions mentioned above; enhancing the knowledge about healthy eating and physical activity and its impact on the health and well-being. With these actions, our intent is to promote the control of cardiovascular risk factors and increase overall health of our patients.



MYTHS IN NUTRITION: EVERYTHING WE HAVE BEEN LED TO BELIEVE

Marta Barbado Villalba,¹ Andrea María Artime Artime,² Verónica Rodríguez Fernández,³ Elena Klusova,⁴ Noelia Diaz Salmeron⁵

¹Primare Care nurse consultation; ²Primary Care consultation; ³Albacete; ⁴semFYC; ⁵Colmenar de Oreja, Madrid

How many times a day should we eat? Do we have to eat less fat to lose weight? Is a glass of wine good for the heart? Are all diet products healthy? Is cholesterol so dangerous? Is the vegan diet safe? Should we eat more natural food? Everybody talks about nutrition and food... And that's why myths are so common among all people in general and healthcare professionals in particular; usually by contradicting what science says.

We propose a nutrition workshop about exploring different food myths using 'gaming' learning techniques. These techniques are a teaching strategy that aims to make learning more attractive and stimulating through play. A dynamic team based board game activity will be applied; a mix of Trivia and the Duck Goose Game. Participants will be challenged by different important questions about nutrition. The objective is to expand knowledge about nutrition, with a focus on scientific evidence. They will be encouraged through small debates to enrich the nutritional knowledge applicable in the family medicine consultation.

MAKING GENETICS EASY: GP CONSULTATION SURVIVAL KIT

Ana Sequeira,¹ Vera Araújo¹

¹USF Lethes
asequeir@gmail.com

Introduction: At least 10% of consultations in primary care are related to a genetic problem. Furthermore, it is expected of general practitioners (GPs) to being able to identify patients at risk of a genetic condition, to contribute to medical management of such patients and to communicate adequate genetic information to patients. However, studies show that GPs lack knowledge of genetics and genetic testing relevant for daily practice and lack confidence in dealing with genetic related conditions. Thus, we thought to be relevant proposing a skill-building workshop on Genetics, addressing basic principles, but relevant for GPs daily practice.

Objectives: Attending this workshop will enable participants to learn how to properly take a family history to detect possible genetic conditions, understand inheritance patterns of genetic diseases through genogram analysis and know red-flags that should prompt further evaluation.

Methods: The two presenters, who will develop the workshop, are GP residents with training in Genetics.

A computer, multimedia projector, white board and markers are the material resources required for this workshop.

The workshop has an expected duration of 90 minutes.

After a brief introduction of the participants (10 minutes), taking of family history will be done by active method using role-playing technique (30 minutes). The genogram rules will be presented using the expository method (5 minutes). Then, participants will form small groups for problem-solving activities – genogram analysis for inheritance patterns, active method (30 minutes). Red flags will be addressed along the workshop, but will be summarized, using the expository method (5 minutes). Finally, we consider a formal period for questions and/or comments in the end (10 minutes).

The contents of this workshop include family history, genogram, autosomal dominant conditions, autosomal recessive conditions, X-linked conditions and red flags.

Discussion: Understanding the basis of adequate family history taking, genogram and inheritance patterns play a pivotal role in GPs daily practice. And will be an important step in improving care for patients with genetic conditions.

Additionally, useful pocket-tools will be provided to the attendees on red flags and genogram representation, as well as showing online resources for continuing medical education, so that they will be able to learn more after the workshop.



TROUGH THE MOUTH DIES THE FISH! OR PROPOSAL OR ORAL HEALTH CARE INTEGRATION ION THE GENERAL PRACTICE APPOINTMENT

João Toscano Alves,¹ Carlota Veiga de Macedo,² Hugo Pissarra,¹ Maria Teresa Costa¹

¹UCSP Lapa; ²CHLC – Hospital Dona Estefânia
joaotoscanoalves@gmail.com

The global approach of the general practitioner (GP) using the person-centered method of consultation doesn't usually integrate the evaluation of the oral health. This floss is essentially due to the lack of knowledge established since the university medical education and to the depreciation of the importance of oral health in systemic health. The GP, when is able to invest its appointment time investigating oral pathologies, the most of the times he acts as a mere reference, many times unnecessary and others postponed or inadequately. We propose, in a simple, methodical and delineated way, the GP to carry through an examination of oral health, not relinquishing important pathologies and promoting a precocious referencing and/or treatments. We suggest an attached proposal of examination of the oral cavity carried out through the family doctor, with access to illustrative images, spending very little time of the consultation and with very low costs. In this way the GP would be able to identify the more frequent or urgent oral pathologies, in a precociously way, for prevention and precocious intervention of the oral cancer; as well as identifying the more frequent benign pathologies and learn to deal with them in the consultation in general practice, preventing the unnecessary referrals to the differentiated professionals.

THE LEGACY OF INTIMATE PARTNER VIOLENCE – HETEROSEXUAL AND GAY (LGBTQ) COMMUNITIES: NEW CHALLENGES FOR THE FAMILY DOCTOR

Elena Klusova,¹ Ula Chetty,² Sara Conde-Valvís Fraga,² Fabrizio Cossutta,³ HAGIT Dascal Weichendler,⁴ Özden Gökdemir,² Raquel Gomez Bravo,⁵ Yusianmar Mariani,⁶ Nina Monteiro,⁷ Maria João Nobre,⁸ Ana Nunes Barata,⁹ Lodewijk Pas,¹⁰ Christopher Patrick Reichel,¹¹ Sara Rigon,² Claire Thomas¹²

¹semFYC; ²VdGM FV group; ³UCSP Benfica; ⁴Department of Family Medicine, Clalit Health Services, Haifa and West Galilee District & Rappaport School of Medicine, Technion, Israel; ⁵SemFYC; ⁶USF Lethes; ⁷USF Garcia de Orta; ⁸UCSP Faro; ⁹UCSP Buraca; ¹⁰Catholic University Leuven; ¹¹Austrian Association of Young GPs, Vienna, Austria; ¹²Vasco da Gama Movement
ele.k@hotmail.es

The 'classic' gender violence of the heterosexual couples has left a painful legacy to the LGBT community. Recent researches show that rates of IPV in LGBT are similar to or higher than the rates found for heterosexual women. Though hardly worked, it seems to be that existing approach programs turn out to be incomplete and insufficient to address this problem in heterosexual women, being practically unknown in sexual minorities. The greater part of health professionals seems to have a vague and unclear knowledge of many basic LGBTQ+ concepts and specific health needs (social isolation, substance abuse, eating disorders, intimate partner violence, cancer prevention, etc.) The reality is that most of nowadays family physicians are not conscious nor trained to identify no manage the differences in professional help need between sexual minorities and heterosexual patients. The main objective of this workshop is to raise awareness of the characteristics and specific needs for the LGBTQ related to partner violence, contrasting them with those of the heterosexual couples and so to work specifically on communication skills. We want the participants, on one hand, to exercise how for the approach the aspects of sexual orientation and on the other, how to handle with family violence in homo and heterosexual couples. This WS is a joint work of two special interest groups of VdGM Europe, Family Violence and Equally different. We would like to start making the WS-topic review through the quiz, analyzing the initial knowledge/understanding of the differences between the gender-based violence and intimate partner violence in LGBTQ couples based on an understanding of the peculiarities and specific needs of the both types of the partner violence victims. We intend to organize the «Know and Win» contest, during which we will give the correct answers and explanations of the discussed issues, to provide a lively and animated learning. After this interactive theoretical part, we will exercise different scenarios of IPV LGBT and GBV victims in the FD consultancy for working directly on communication skills with this delicate patients and situations. In the end, will be given a list of practical suggestions for a family violence problem conscious, gender neutral and LGBTQ friendly practice. We will provide the listeners with the links to specific pages of literature sources of greater interest and reliability.



DERMA FOR DUMMIES: DERMATOLOGICAL CHALLENGES IN PRIMARY HEALTH CARE

Elena Klusova,¹ Rocío García-Gutiérrez Gómez,² Sara Correia,³ Manuel Soto,³ Adrian Castellote⁴

¹semFYC; ²Centro de Salud Las Calesas, Hospital 12 de Octubre, Madrid; ³Vigo; ⁴Hermigua
ele.k@hotmail.es

Objective: 1. Challenge our GPs with interesting clinical cases and generate dialogue and debate. 2. Inform and educate with a summary of the most common dermatological consultations in family medicine. 3. Hands-on skills training in dermoscopy in collaboration with the Primary Care Dermatology Society (PCDS). 4. Foster collaboration between young GPs and the PCDS.

Introduction: Primary care doctors are frequently exposed to dermatological challenges. Skills in recognition of common dermatological disease are imperative for effective management and insufficient knowledge is a frequent cause of delayed or missed diagnosis. Part 1: divide participants into teams and undertake a clinical case base quiz. Debate and discuss responses Part 2: interspersed with the quiz responses we will summarize the common presentations of skin pathology in primary care and important considerations to aid diagnosis Part 3: in collaboration with colleagues from the PCDS discover and practice the hands-on skill of dermoscopy.

Conclusions: In our daily routine, we have to pass through several dermatological cases, each one tougher than the one before. As family doctors, we have to deal with uncertainty all the time, but if we train ourselves we can improve our clinical eye, and reduce the number of derivations to other specialists and help our patients in a more effective way.

HIV PRE-EXPOSURE PROPHYLAXIS: WHOSE BUSINESS IS IT?

Carla Rodrigues,¹ Andreia Silva,² Ana Filipa Vilaça,³ Helena Marques,⁴ Sara Rita,⁵ Ana Beatriz Figueiredo⁶

¹UCSP São Neutel; ²USF Casa dos Pescadores; ³USF Manuel Rocha Peixoto; ⁴USF S. Felix – Perosinho; ⁵USF Servir Saúde; ⁶USF das Conchas, ACeS Lisboa Norte
carla.veiga.rodrigues@gmail.com

HIV pre-exposure prophylaxis (PrEP) substantially decreases HIV infection risk and brings a new possibility and tool on the long fight of HIV eradication. PrEP has been slowly accepted in some European countries and the European AIDS Clinical Society published its first guidelines on PrEP in 2015, bringing this controversial theme into the spotlight. But meanwhile governments and health ministers discuss its use for each country, what should GP's know about this subject? Is this something to be prescribed on a primary care level or a secondary care degree? PrEP is a subject that can also interfere with our own moral beliefs and many doctors are divided on accepting or rejecting this option. On one hand, PrEP has the ability to reduce the numbers of infected individuals. On the other hand, it is expensive and comes with risks and possible discrimination. One of the most controversial fear related to PrEP is the risk compensation that can arise from the alleged safety associated with PrEP, allowing patients to engage in riskier behaviors without using protection. Is this a real fear to be taken into account? All of these questions should be discussed and the reality of each country must be part of the equation. Our aim is to increase awareness for this new topic and shortly portray the reality of PrEP worldwide.



INTERMEDIATE CARE FOR YOUNG GPs: FROM LECCE TO PORTO

Simone Cernesì,¹ Jacopo Demurtas,² Stefano Celotto,³ Alice Serafini,⁴ Gabriella Pesolillo,⁵ Francesca Mele,⁴ Alessandra Boni,⁴ Giulia Cusmano⁴

¹"Casa Serena" Nursing Home Sassuolo; ²USL SudEst Toscana – Grosseto AFT Orbetello; ³Azienda per l'Assistenza Sanitaria n° 3, Alto Friuli, Collinare – Medio Friuli; ⁴Leece; ⁵National Health Care System – Abruzzo
dott.cernesì@gmail.com

Background: The definition of intermediate care (IC) is not clear yet. We think it's important to analyze it from the point of view of general practitioners (GPs). Although it can actually be considered one of the possible options when dealing with aging from a global perspective, many questions remain open, such as: What does IC really mean for GPs? Is it considered as just a riddle? Can we provide a different perspective? Why is IC marginalized in general practice?

Purpose: To generate hands-on solutions to increase awareness and involvement of young GPs in the innovation of IC, especially in regard to an international perspective.

Method: Classroom contract (five min); presentation and ice breaking games (ten min). We have planned three different tasks that can be developed either simultaneously or in sequence. First task (15 min): investigate the meaning of Intermediate care from the participants' point of view and design a conceptual map on a flip chart; second task (20 min): 'Cognitive Autopsy', which consists of an effort to identify similarities and differences between family medicine, palliative care and intermediate care; third task (25 min): highlight the barriers that junior GPs face when approaching IC.

Conclusions: This workshop could also be a great opportunity to: 1) share and collect different GP experiences and give voice and visibility to them; 2) discuss our IC 'Decalogue', first presented in WONCA Prague 2017 (what we need, what we can improve) and also promoted in the WONCA Working Group; 3) spread the best take-home messages on social media and also make our WS traceable and open for future ongoing discussion.

AN ICPC-BASED EDUCATIONAL PROJECT

Jacopo Demurtas,¹ Gabriella Pesolillo,² Stefano Celotto,³ Alberto Vaona,⁴ Ferdinando Petrazzuoli,⁵ Marc Jamoulle⁴

¹USL SudEst Toscana – Grosseto AFT Orbetello; ²National Health Care System – Abruzzo; ³Azienda per l'Assistenza Sanitaria n° 3, Alto Friuli, Collinare – Medio Friuli; ⁴Verona; ⁵Lund University; ⁶Gilly
eritrox7@gmail.com

The last job description of the Italian family doctor is a document from 1992. So far nobody has seriously tried to update that document considering the innovations and the implementation of family medicine and the shift in the doctor status and competences. The job description should be the base for a core curriculum, which encompasses the different fields of family medicine.

We would like to share and discuss an educational project based on the International Classification of Primary Care (ICPC), in which, starting from the various anatomical chapters of the classification, we will define together the competences of new family doctors with the methodological strategy to achieve those competencies. Moreover, since teaching in general practice also involves professional topics and patient-related ones besides the usual clinical subjects, we would like to explore the tools already available to us (such as Q-Codes or PERi) to better assess the managerial and academical side of family medicine and the issues related to patient context, such as continuity and accessibility of care.



THE SISCOS PROJECT

Jacopo Demurtas,¹ Stefano Celotto,² Gabriella Pesolillo,³ Alberto Vaona⁴

¹USL SudEst Toscana – Grosseto AFT Orbetello; ²Azienda per l'Assistenza Sanitaria n° 3, Alto Friuli, Collinare – Medio Friuli; ³National Health Care System – Abruzzo; ⁴Verona

eritrox7@gmail.com

In 2015 we established a new scientific association named SISCOS (Italian Society for the Development of Competencies of Healthcare Professionals), whose main target is family medicine, which brought us to define a part of SISCOS just for family medicine, called SiscoMed. Therefore, we built a platform, which provides different services and opportunities to Italian family doctors. The aim of this ignite session is to share the project with you and get feedback for further implementation. What is missing? What would you do differently? What are the possible strategies that need implementation?

VDGM SIG RESEARCH SPECIAL SESSION: WHAT MAKES US DO RESEARCH?

Vanja Lazic,¹ Ana Luísa Neves,² Patrick O'Donnell,³ Gabriella Pesolillo,⁴ Gaetano Lops,⁵ Luís Monteiro,⁶ Katarzyna Nessler,⁷ Rosy Tsopra,⁸ Sarah Moore⁹

¹Health Center Zagreb – Center; ²Faculdade de Medicina, Universidade do Porto;

³Graduate Entry Medical School, University of Limerick; ⁴National Health Care System – Abruzzo; ⁵ASL Bari; ⁶USF Esgueira+; ⁷Department of Family Medicine, Universidade de Lisboa; ⁸Bochenska Krakow, Poland; ⁹Université Paris; ⁹University of Exeter Medical School, Exeter, United Kingdom

vanjlaz@gmail.com

Starting out with research in the field of general practice is hard and not many early career GPs choose to do it. Motivation, opportunity, mentoring and support of peers are some of the factors that might influence a young GPs decision to pursue the elusive path of primary care research.

VdGM Special Interest Group on Research aims to help GPs make their first steps in research as well as to provide support to active early career researchers.

We have several suggestions for how to achieve this:

1. Organizing conference sessions promoting GP research as a goal for early career GPs, thus providing motivation and networking opportunities.
2. Showcasing collaborative research projects of the group and providing opportunities for interested GPs to do engage in research.
3. Developing an early career GP researcher networking website, where members can post their project ideas and search for partners, therefore enhancing networking and collaboration.
4. Offering research support to young GPs. Operative and communication strategy has to be developed to find the best means of support that would reach all in need. Support group could proactively reach to users of networking website.
5. Finally, the group will collaborate with EGPRN to provide education and a strong foundation in research methodology and to aid the transition to senior researcher.

What do you think is the best way to motivate early career GPs to do research? How to help early career GPs to do research? What is the best way to promote GP research in young GP communities? How do you go from 'I want to do research' to 'I'm doing research' in a low resource setting?



S.W.O.T. ANALYSIS FOR PRIMARY CARE DOCTORS AND WORKERS

Tugba Onat,¹ Suheyla Atalay,² Alexandra Tsipou,³ Ilyas Erken⁴

¹Omerli Hospital; ²Afyonkarahisar Dazkırı State Hospital; ³Public Health Center, Rafina Area, Attiki; ⁴Family Medicine Center, Turkey
tugba.onat@hotmail.com

The S.W.O.T. analysis is a classic diagnostic tool that looks at the four elements: strengths, weaknesses, opportunities and threats. When developing strategic plans for the future, every organization needs to understand what its internal strengths and weaknesses are, and what opportunities and threats are in the environment. Understanding these four elements creates an effective foundation for planning and we can use this method in our daily practice to improve our quality.

A S.W.O.T. analysis in a clinic, college or other health care establishment can be a simple and yet effective tool for ensuring that all appropriate factors are considered. Strengths, factors that are likely to have a positive effect on (or be an enabler to) achieving the clinic's objectives. Weaknesses, factors that are likely to have a negative effect on (or be a barrier to) achieving the clinic's objectives. Opportunities, external factors that are likely to have a positive effect on achieving or exceeding the clinic's objectives, or goals not previously considered. Threats, external factors and conditions that are likely to have a negative effect on achieving the clinic's objectives, or making the objective redundant or unachievable. This workshop engages participants' thinking, allows the sharing of different perspectives and view points, and educates everyone involved to create a common ground about the elements and the necessary future planning.

We will break the participants into two groups first (as nurses and doctors), and then into four groups. Assign each group one of the four elements of the S.W.O.T. analysis. We will give the group 15 minutes to list information on. Every person writes down each of his or the group's ideas with a black marker on a post-it note and puts it on the flip-over and can discuss among each other and exchange or improve existing ideas or experiences. Last part will be to recognize the workshop data and talk for 15 minutes about data: What is currently being done or has been done? What still needs to be done?

Goal of this workshop: To create a clear picture of the four elements needed in an effective future-oriented planning process, to engage participants thinking about strategic themes and to distill as a team the meaning of information that is generated, to develop the main strategic actions for the future in primary care practice.

MORE THAN JUST DRUGS IN YOUR PRESCRIPTION: IF THE HEALTH PROBLEMS ARE BIOPSYCHOSOCIAL, THE SOLUTIONS MUST BE...

Kelly Patricia Baldeon Cuenca,¹ Elena Klusova,² Sara Correia,³ Adrian Castellote,⁴ Sara López Puche,⁵ Flávia Fernandes Neves,⁶ Lucía Gutiérrez García⁷

¹C.S. Saja, Cantabria; ²semFYC; ³C.S. de Teis, Vigo; ⁴Hermigua; ⁵Palma de Mallorca; ⁶C.S. Casa del Barco, HURH Valladolid; ⁷C.S. Las Calesas, Madrid
kellybaldeon@hotmail.com

Introduction: Community medicine consists of the care based on the patient, family and/or its' immediate environment as a conditioner of health status and not on the disease itself. The health problem shows to be a BIOPSYCHOSOCIAL one, connecting the 'biological' medical illness in a direct or indirect way with all the complexity of the social and psychological setting of the patient. It is important the interplay between epigenome, social and biographical contexts, development of individual abilities, stress management, sense of internal coherence and behavioral development.

The limited time of the patient care and the high healthcare burden and organizational pressure in the current European health systems, makes doctors to reduce their intervention to just a pharmacological treatment, tending to forget or misspend all the resources, that the community can offer. Frequently we forget how working together with the multidisciplinary teams can benefit all the involved.

Part 1: We are going to offer a brief test clinical-case on the health situation of one of the media personalities, assessing the options of their multidisciplinary solutions that the audience can propose (such as therapy advice of sleep hygiene care, mindfulness, nocturnal meditation).

Part 2: We will tell the participants about the most interesting projects of community health programs currently developed in our country.

Part 3: The participants will form several groups, which will represent multidisciplinary teams, we are going to ask the participants to try to solve the clinical cases initially raised as medical ones, avoiding pharmacological measures and big economic investments.

Part 4: Now is the time for the participants to tell us what they are doing in their countries; How they help their patients apart from issuing the drugs prescriptions; What projects do they carry out in their communities? Open dialogue and debate.

Part 5: Take-away messages resume.

Conclusion: Our primary goal as physicians and community members should be: to achieve the perspective of equity in solving health problems, to learn to look for 'causes-of-cause' or cause-based approaches, and to potentiate an individual and group empowerment. We need to design associative strategies, promote health, increase the quality of life and social welfare, enhance the capacity of individuals and groups to address their own problems, demands and needs; it is a continuous process with a beginning but without an end.



THE MEDICAL ACTUALITY IN RECREATIONAL DRUGS: SKILL-BUILDING WORKSHOP OF THE TRAINING OF THE APPROACH TO THE PATIENT INTOXICATED BY RECREATIONAL DRUGS

Elena Klusova,¹ Rocío García-Gutiérrez Gómez,² Sara Correia,³ Kelly Patricia Baldeon Cuenca,⁴ Manuel Soto,⁵ Raquel De León Contreras,⁶ Cristina González Ruiz,⁷ Alba Gomez Zahino,⁸ Claire Thomas⁹

¹semFYC; ²C.S. Las Calesas, Hospital 12 de Octubre, Madrid; ³C.S de Teis, Vigo; ⁴Torreavega, Cantabria; ⁵Vigo; ⁶Las Palmas de Gran Canaria; ⁷MIR 3 MFYC; ⁸C.S. Camp Redó (Palma De Mallorca, Islas Baleares); ⁹Vasco da Gama Movement
e.k@hotmail.es

Since 1960s drug abuse-consequences started to form a significant public health issue. An increasing number of cases of life-threatening drug intoxication by so-called recreational 'club drugs' have shaken the planet in the last 15 years, and the use of chemical-submission psychoactive substances have recently acquired a new dimension owing to the atrocity of sexual crimes associated with drug use (DFSA).

For this, we believe it is imperative that physicians know the symptoms and signs of alarm of these pathologies, to improve their early recognition, to prevent a consecutive severe neurotoxic damage and to achieve the possibility of survival of these patients by providing an early and correct treatment.

We present a skill-building WS with a unique opportunity to exercise clinical-diagnostic thinking in the actual scenarios of overdoses by recreational drugs currently more popular in the European territory. We have the exclusive knowledge acquired in the emergency services of the main Ibiza's and Madrid's hospitals and the '061' service of the advanced life support of Balearic Islands.

Structure: Shocking ice-breaking video of the dangerous effects of recreational drugs popular now in Europe. Brushstrokes about the importance of approaching recreational drugs-addiction or its 'sporadic and compulsive consumption for the short and long-term mental health, explained by a group psychiatrist.

We will present: a) The two main theories of classification of 'design drugs', which will help us to understand the physiopathological mechanisms of drug's-action and facilitate the diagnosis and treatment in real situations; b) The list of illicit drugs, currently used for recreational purposes, the serious intoxication by which is attended currently in the medical services in Europe; c) The warning signs, essential to distinguish in intoxicated patient and the algorithms of the immediate diagnostic orientation; d) With the example of a real case video will hold the joint work of diagnostic evaluation and main lines of the therapeutic approach. In the main block of the WS, the teams of participants will have the videos of intoxicated by substances relevant to daily practice and must face the challenge of diagnostic evaluation of the patient, decision making, organization of the human team (nursing, witnesses, security agents, police), election of means of approach and finally, the pharmacological and non-pharmacological treatment of the patient

BRAVE NEW WORLD: CREATING A VISION FOR THE FUTURE OF FAMILY MEDICINE

Claire Thomas,¹ Anna Stavdal²

¹Vasco da Gama Movement; ²University of Oslo/ Bolteløkka legesenter
clairemariet@gmail.com

The young doctors of today will be charged with shaping the future of our profession. We will need to learn to navigate the emerging demographic, social, economic and technological trends to 'future proof' family medicine and the delivery of accessible primary care for all. This workshop, facilitated by the Presidents of VdGM and WONCA Europe, will engage young doctors in thinking critically about the challenges we face and applying creative problem solving techniques to build a vision for the future of family medicine. We aim for it to inspire and signpost participants to how they can become more involved with the world of family medicine outside the consultation.

We will open with an interactive exploration of the current challenges in family medicine: one at a time we will introduce an "issue" from the current landscape of GP/FM and key challenges that face us as a profession i.e. aging population, population increase, resource stretching, advancing technology and role of GP in face of this etc. Participants will be asked to move across a horizontal line in the room to rate on a scale of 1-10 how worried they are about this issue. This will be used as a tool to trigger facilitated discussion and debate.

Participants will then be divided into 3 small groups: 1) Local 2) National 3) International.

Each group will nominate a facilitator and a scribe. The groups will be asked to examine their 'level' of family medicine by applying creative problem solving methods, such as DE BONO'S 6 THINKING HATS and DISNEY'S IMAGINEERING. Facilitators will be given questions to help guide discussion i.e. what are the current pressures and forces at play? What is the young GPs role in responding to those forces? What goals do you set for the future of GP? What strengths and weaknesses, threats and opportunities are there in realizing those goals?

Groups will be asked to summarize and present their work by succinctly identifying core goals/activities for successfully developing the future of family medicine at their 'level'. These will be collated together as a 'Vision for the future of family medicine' after the workshop and disseminated appropriately.

To close the session participants will be signposted to how they can become more engaged in the future of FM through VdGM, WONCA and other associated networks. Each participant will be asked to set three SMART actions they will take forward following this workshop.



YOUNG DOCTORS ANTIMICROBIAL RESISTANCE NETWORK: A NEW SPECIAL INTEREST GROUP

Kasper Lorenz Johansen,¹ Ana Lúcia Gomes Costa²

¹Denmark; ²USF AlphaMouro
analgcosta@gmail.com

In 2014, the World Health Organization published their first global report on antibiotic resistance, predicting the coming of the 'post antibiotic era' unless serious measures are taken to halt the emerging resistance trends globally. Infections with multiresistant bacteria are difficult to treat and could lead to prolonged illness, hospital stays, or increased mortality. Given this imminent public health threat, there is an imperative not only to increase public awareness, but also to promote appropriate antibiotic use among doctors. In 2016 a few GP trainees set out to create a network for European GP's (first fives), GP trainees and medical students with a special interest in rational antibiotic usage in general practice. The aim of the Network is to highlight the impact of antibiotic resistance; to generate research; and to create a platform for the exchange of knowledge, ideas and strategies in order to formulate viable solutions to the challenges posed by antibiotic resistance. Topics include: patient education, appropriate prescribing patterns; quality improving tools; audits and research projects and public awareness. Through this network, GPs commit to becoming active partners in forging a solution to the global problem of antibiotic resistance. Proposed slides:

1. Flash History – pre-antibiotic era.
2. Dawn of antimicrobials – Fleming.
3. Surge of resistance – predicted by Fleming.
4. Where we are today.
5. WHO first report on AMR 2014 – what next?
6. AMR resistance in the news.
7. Impact on society.
8. How are GPs contributing to this problem?
9. What can GPs do to curb the trend?
10. What's already being done.
11. National policies – local impact?
12. Stewardship programs.
13. Creation of a AMR Network with VdGM.
14. Our vision – areas to which we can contribute!
15. How to go about doing this? – use the impetus of VdGM.
16. Funding.
17. Promotion of the network on media platforms.
18. Encourage the creation of national working groups.
19. Organize campaigns, workshops and annual meetings to coordinate projects.
20. The future.

DOCTOR, CAN I HAVE A SAFE HOME BIRTH EXPERIENCE?

Irene Pizarro Sanz,¹ Lucía Gutiérrez García,² Rocío García-Gutiérrez Gómez,³ Alberto Sanchez Bernal⁴

¹C.S. Barrio del Pilar, Madrid; ²C.S. Las Calesas, Madrid; ³C.S. Las Calesas, Hospital 12 de Octubre, Madrid; ⁴Pinto Health Center, Madrid
irenepzrsanz@gmail.com

It is emerging among women around Europe a request for a birth labor more human, without setting aside the safety and potential medical care that this process requires. As members of the community health, it is in our hands to move closer to this demand by being informed of the alternative options that exist in our working area. All of it, in order to inform and support women throughout the process in the assessed decision each one makes.

Objectives: To share scientific evidence involving planned home birth as an alternative option that women may demand, as well as creating a common space to share experiences in different countries and discussion about this topic.

Methodology: Since this workshop's fundamental aim is to learn and share experiences, our main tool will be open debate. Using diverse audiovisual resources, we will expose topics related to pregnancy and birth outside the hospital so that participants can offer their personal opinions, experiences and improvement ideas. Some of the addressed topics will be:

- Patients' and professionals' growing doubts and concerns about traditional hospital care. Rising patients empowerment about their health decisions. Obstetric violence.
- Alternative options practiced in different countries and scenarios (urban, rural, low resources areas, etc.). Group and multidisciplinary work: nurses, midwives, family doctors, GyOb and their roles in pregnancy and birth.
- Evidence-based data: morbidity and mortality differences between hospitalar versus home births. A final space will be offered for participants to express their conclusions.

Conclusions: We cannot neglect the fact that some changes are happening in the way patients, health professionals, and society experience the process of pregnancy and birth. Expectations and claims are changing, and so must do our clinical practice so there is a continuity in trust and good patient-doctor relationship. We aim to learn and share practical knowledge and tools to improve the way we face patients' new demands and expectations maintaining evidence-based counseling.