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Qualitative analysis of the communications to the WONCA group Vasco De Gama annual meeting 2018, Porto. Report to the VDGM group

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ID	Type	abstract	3CGP codes	explaining QO
01		<p>Title: Complementary and Alternative Therapies: strategies we can no longer ignore. Proponents: Inês Antunes, Ana Cláudia Monteiro Pereira, Ana Margarida Gomes, Ana Rute Marques, Mafalda Lemos Caldas. Keywords: Complementary therapies, alternative therapies; primary care. Abstract: 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.</p>	<p>QD1 Communicator QD5 Complementary and Alternative Medicine QP25 Acceptability QS1 Primary care setting QS41 Family doctor</p>	
02	Ignite	<p>Title: Having a vegetarian/vegan diet during pregnancy and breastfeeding: what do we need to know? Proponents: Ana Rute Marques, Ana Cláudia Monteiro Pereira, Ana Margarida Gomes, Ines Antunes, Mafalda Lemos Caldas. Keywords: Vegetarian; vegan; pregnancy; breastfeeding; nutrition. Abstract: 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 wellbeing 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 counselling 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</p>	<p>*45 Observation/health education/advice/diet QO4 consider new code QP44 Patient cultural background QP51 Patient alimentation issues QS44 Allied health professionals W19 Breast/lactation symptom/complaint</p>	<p>QO4 Nutritionist to add in QS44</p>

03	Ignite	<p>Title: Palliative Care and Sexuality: Giving life to a relationship. Proponents: João Ribeiro. Keywords: palliative medicine.</p> <p>Abstract: 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 the patient's 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 patient's life as in his/her partner. In our Primary Care Unit, we initiate a Palliative Medicine consultation where all of this 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. Were asked their concerns about sex life and how to deal with their physical and emotional problems.</p>	<p>QD26 Palliative care QP52 Patient's sexuality QR36 Case report QS1 Primary care setting</p>	
04	Ignite	<p>Title: ACTIVE STEPS: New steps for health. Proponents: Mariana Moura Relvas, Rosário Pires, Margarida Pereira, Tatiana Pinto, Alice Jeri, Daniela Silva, Maria João Ribeiro, Clara Ferreira, Mário Gomes. Keywords: exercise; cardiovascular disease; healthy eating.</p> <p>Abstract: 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, 5 days a week), or 60-75 minutes per week of vigorous intensity aerobic activity (20-25 minutes per day, 3 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.</p>	<p>K Cardiovascular K22 Risk factor for cardiovascular disease QO4 consider new code QP42 Patient knowledge QP5 Health behaviour</p>	<p>QO4 Physical activity to consider for QP5 Patient behaviour</p>
05	Ignite	<p>Title: Young Doctors Antimicrobial Resistance Network - A new special interest group. Proponents: Kasper Lorenz Johansen, Ana Lúcia Gomes Costa. Keywords: antimicrobial resistance; antibiotics.</p> <p>Abstract: 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.</p>	<p>QD325 Prescribing behaviour QR21 Pharmacoepidemiology QR4 Research network</p>	

06	Ignite	<p>Title: HIV Pre-Exposure Prophylaxis - whose business is it? Proponents: Carla Rodrigues, Andreia Silva, Ana Filipa Vilaça, Helena Marques, Sara Rita, Ana Beatriz Figueiredo. Keywords: PrEP; HIV; primary care. Abstract: 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 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 behaviours 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.</p>	<p>B90 Hiv-infection/aids QD41 Primary prevention QE1 Personal ethical view QS11 Management of practice QT32 Guideline</p>	
07	Ignite	<p>Title: Through the mouth dies the fish! A proposal of oral health care integration in the General Practice appointment. Proponents: João Toscano Alves, Carlota Veiga de Macedo, Hugo Pissarra, Maria Teresa Costa. Keywords: Oral Health; oral pathologies; examination of oral health; precocious referencing. Abstract: 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 referencer, 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.</p>	<p>D20 Mouth/tongue/lip symptom/complaint QD24 Clinical competence QO4 consider new code QS32 Referral & counter-referral QS44 Allied health professionals</p>	<p>Q04 Consider to add Dentist to QS44 Allied health professional</p>
08	Ignite	<p>Title: An ICPC-based educational project. Proponents: Jacopo Demurtas, Gabriella Pesolillo, Stefano Celotto, Alberto Vaona, Ferdinando Petrazzuoli, Marc Jamouille Keywords: education; job description; core curriculum; ICPC Abstract: 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 academic side of Family Medicine and the issues related to patient context, such as continuity and accessibility of care.</p>	<p>Q Q-Codes taxonomy QD24 Clinical competence QR51 Classifications, terminologies and ontologies QT1 Teaching family medicine</p>	

09	Ignite	<p>Title: The Gen-Equip Project. Proponents: Ana Sequeira. Keywords: genetics; primary Care; education. Abstract: 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</p>	<p>QD34 Genetic issues QS1 Primary care setting QS4 Primary care provider QT23 Continuous medical education QT42 Online knowledge-sharing</p>	
10	Ignite	<p>Title: The SISCOS Project - Italian Society for the Development of Competencies of Healthcare Professionals. Proponents: Jacopo Demurtas, Stefano Celotto, Gabriella Pesolillo, Alberto Vaona Keywords: education. Abstract: 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?</p>	<p>QD24 Clinical competence QR4 Research network QS41 Family doctor QT4 Knowledge translation QT42 Online knowledge-sharing</p>	
11	Special session	<p>Title: What's the Right Thing to Do? Tom & Lukas' Corner on Ethical Issues. Proponents: Tom Axelrod, Lukas Heschl. Keywords: ethics; dilemma; decision making. Abstract: 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. The discussion will be guided using a 4 stages tool developed by Dr. Rhona Knight (a GP and member of the RCGP Ethics Committee). The 4 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. 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 facilitators will summarize the issues raised up and emphasizing practical applications in light of the relevant values.</p>	<p>QD21 Problem solving QD323 Shared decision making QE Medical ethics</p>	
12	Special session	<p>Title: The migrants, the refugees and the crisis of Europe: Are we all equally human? Proponents: Yusianmar Mariani, Sara Rigon, Özden Gökdemir, Elena Klusova, Ana Nunes Barata, Nina Monteiro, Fabrizio Cossutta. Keywords: migrants; refugees; human rights. Abstract: 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 treated as human beings again. What happens to the unseen ones? "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.</p>	<p>QC3 Social high risk QC32 Refugees & migrants QE2 Professional ethics QR1 Philosophy of science</p>	

13	Special session	<p>Title: A 21st century Hamlet: to care or to consume? Proponents: Jan-Jakob Delanoye. Keywords: economization; neoliberalism; consumerism; ethics. 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. The aim is to have a vivid discussion among the attendees. During the event, the facilitator will both introduce the questions and summarize the most important arguments, in order to bring the session in the final minutes to a conclusion.</p>	<p>QE Medical ethics QR1 Philosophy of science QR7 Economics, primary health care</p>	
14	Special session	<p>Title: ASPIRE Global Leaders Collaborative Eureka Session. Proponents: Candan Kendir, Tugba Onat, Maria João Nobre, Claire Thomas, Job Metsemakers, Jose Castellanos. Keywords: leadership; young doctors; primary care. Abstract: Background & 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. This special session will be facilitated by Anna Stavdal (President of WONCA Europe) and Job Metsemakers (WONCA World Executive Member-at-Large 2016-18 & WONCA World Honorary Treasurer & Immediate Past President of WONCA Europe). 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. In the end of the special session, we will create a curriculum for ASPIRE Global Leaders Program workshop to improve the related leadership skills of the young doctors.</p>	<p>QD3 Care manager QO4 consider new code QR Research and development QT3 Quality assurance</p>	<p>QO4 consider to add Managerial competence to QS. QS15 could fit</p>
15	Special session	<p>Title: Web-based reporting in primary care: structured and evidenced-based. Proponents: Stefan Heinmueller Keywords: web-based; online; evidence; evidence-based, guideline; guidelines; primary care; general practice; documentation; reporting, structured. Abstract: Background: Digital documentation of patients' medical informations (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.</p>	<p>QS1 Primary care setting QT4 Knowledge translation QT42 Online knowledge-sharing QT43 Digital library</p>	

16	Special session	<p>Title: VdGM SIG Research Special Session: What makes us do research? Proponents: Vanja Lazić, Ana Luísa Neves, Patrick O'Donnell, Gabriella Pesolillo, Gaetano Lops, Luís Monteiro, Katarzyna Nessler, Rosy Tsopra, Sarah Moore. Keywords: research; general practice; motivation; early career. Abstract: 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. In this session, the group will discuss motivation of early career GPs to do research and address ways to help them do research.</p>	<p>QR Research and development QR3 Research methods QR4 Research network QS41 Family doctor</p>	
17	Workshop	<p>Title: Derma for dummies - dermatological challenges in Primary Health Care. Proponents: Elena Klusova, Rocío García-Gutiérrez Gómez, Sara Correia, Manuel Soto, Adrian Castellote. Keywords: dermatology; primary health care; dermoscopy; image, collection. Abstract: Introduction: Primary care doctors are frequently exposed to dermatological challenges. Skills in recognition of common dermatological disease is imperative for effective management and insufficient knowledge is a frequent cause or delayed or missed diagnosis. Objectives: 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 Primary Care dermatology society Methods: 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 summarise 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.</p>	<p>*43 Other diagnostic procedure QD24 Clinical competence QS1 Primary care setting QT1 Teaching family medicine S Skin</p>	

18	Works hop	<p>Title: A bomb exploded. Are you ready to help? Proponents: Miriam Rey Seoane, Rabee Kazan, Anna Fernandez Ortiz. Keywords: mass casualty incidents; triage; prehospital care. Abstract: 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 prehospital 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 organised (security, post-disaster medical care, evacuation...). Also we will practice the fundamentals of the START triage and its criteria. Facilitators: - Miriam Rey Seoane: GP in an Emergency Primary Care setting in Barcelona. - Rabee Kaza: 4th Year trainee-GP in Barcelona - Anna Fernández Ortiz: 3rd Year trainee-GP in Barcelona. Methods: 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). Conclusion: 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.</p>	<p>QD24 Clinical competence QO4 consider new code QT1 Teaching family medicine</p>	<p>QO4 consider Mass casualty accident as subcategory of a new category Emergency primary care setting</p>
19	Works hop	<p>Title: Myths in nutrition: everything we have been led to believe. Proponents: Marta Barbado Villalba, Andrea María Artime Artime, Verónica Rodríguez Fernández, Elena Klusova. Keywords: myths; nutrition; food; scientific evidence. Abstract: 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 '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 aim 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 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.</p>	<p>QD24 Clinical competence QD27 Family planning QP51 Patient alimentation issues QS4 Primary care provider T Metabolic & Nutritional</p>	

20	Works hop	<p>Title: Telemedicine: a powerful tool we must learn to use. Proponents: Ana Cláudia Monteiro Pereira, Ana Margarida Gomes, Ana Rute Marques, Ines Antunes, Mafalda Lemos Caldas. Keywords: telemedicine; asynchronous appointments; group discussion. Abstract: 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 no 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. 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.</p>	<p>QC32 Refugees & migrants QP21 Accessibility QS11 Management of practice QT42 Online knowledge-sharing Z01 Poverty/financial problem Z04 Social cultural problem</p>	
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21	Works hop	<p>Title: Brave New World: Creating a vision for the future of Family Medicine. Proponents: Claire Thomas, Anna Stavdal Keywords: family medicine; future proofing; creative thinking. Abstract: Introduction: 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. Methodology: 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 ie 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 realising those goals? Results: Groups will be asked to summarise 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. Conclusion: 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 3 SMART actions they will take forward following this workshop.</p>	<p>QD14 Systems thinking QD21 Problem solving QR1 Philosophy of science QS41 Family doctor</p>	
22	Ignite	<p>Title: ASPIRE Global Leaders Program Workshop: How to facilitate a team in difficult situations? Proponents: Candan Kendir, Claire Thomas, Job Metsemakers, Jose Castellanos. Keywords: leadership; facilitation; difficulties. Abstract: Background & 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. The aim of this workshop is 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 a 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.</p>	<p>QO4 consider new code QS11 Management of practice QT11 Pedagogic methods QT3 Quality assurance</p>	<p>QO4 consider to add Managerial competence to QS. QS15 could fit</p>

23	workshop	<p>Title: The legacy of Intimate Partner Violence. Heterosexual and Gay (LGBTQ) communities. New challenges for the family doctor.</p> <p>Proponents: Elena Klusova, Ula Chetty, Sara Conde-Valvís Fraga, Fabrizio Cossutta, Hagit Dascal Weichendler, Özden Gökdemir, Raquel Gomez Bravo, Yusianmar Mariani, Nina Monteiro, Maria João Nobre, Ana Nunes Barata, Lodewijk Pas, Christopher Patrick Reichel, Sara Rigon, Claire Thomas.</p> <p>Keywords: intimate partner violence; domestic violence; communication methods, total; primary health care.</p> <p>Abstract: 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 nor 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.</p> <p>This WS is a joint work of two special interest groups of VdGM Europe, Family Violence and Equally different.</p> <p>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.</p> <p>We will provide the listeners with the links to specific pages of literature sources of great interest and reliability.</p>	<p>QC2 Gender issue QC24 Transgender QC51 Gender-based violence QD1 Communicator QD24 Clinical competence QS1 Primary care setting QT1 Teaching family medicine Z25 Assault/harmful event problem</p>	
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24	workshop	<p>Title: Making Genetics easy – GP consultation survival kit. Proponents: Ana Sequeira, Vera Araújo. Keywords: genetics; family history; inheritance patterns; red flags. Abstract: 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 proper 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. 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 dominant conditions, autosomal recessive conditions, X-linked conditions and red flags. Discussion: Understanding the basis of adequate family history taking, genogram and inheritance patterns plays 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 participants will be able to learn more after the workshop.</p>	<p>QD24 Clinical competence QD34 Genetic issues QS41 Family doctor QT1 Teaching family medicine</p>	
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25	worksh op	<p>Title: Providing primary care to multicultural communities - the challenge of overcoming health inequalities in migrant populations.</p> <p>Proponents: Cristiano Marta Figueiredo, Ana Cebola, João Sousa, Martino Gliozzi, Ricardo Antunes, Sara Antunes, Sofia Correia Pinto, Tânia Bonifácio, Tatiana Consciência, Tiago Lopes, José Lima.</p> <p>Keywords: migrant care; international health; health literacy; health policy.</p> <p>Abstract: 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 endemicity 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.</p> <p>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.</p> <p>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.</p> <p>How do we want to achieve it? 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.</p>	<p>QC3 Social high risk QC32 Refugees & migrants QD24 Clinical competence QP23 Cultural competency QS1 Primary care setting Z04 Social cultural problem Z08 Social welfare problem</p>	
26	worksh op	<p>Title: Management of the infertile couple.</p> <p>Proponents: Filipa Rafael, Ana Beatriz Figueiredo, Nuno Ramos.</p> <p>Keywords: female infertility; male infertility; initial study; medically assisted procreation.</p> <p>Abstract: 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.</p> <p>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.</p> <p>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 imaging 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.</p> <p>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.</p>	<p>*45 Observation/health education/advice/diet QS33 Coordination of care QT23 Continuous medical education W15 Infertility/subfertility female Y10 Infertility/subfertility male</p>	

27	worksh op	<p>Title: How do you satisfy your patient? Proponents: Rianne van Vliet, Maïke Eppens, Nadia Tuomi. Keywords: communication skills. Abstract: In this workshop facilitators will focus on patient’s expectations of a doctor visit. Why does the patient comes to you and what does he wants? Is it medication, reassurance or maybe a referral? Or is it something else? What questions can you use to explore patients ideas and concerns? What are (non-) verbal clues and hints? How do you structure this within the short consultation time you have? We will talk and practise consultation techniques to effectively meet your patient’s needs. If you as a doctor connect with your patient’s concerns and idea’s, your patient will be more satisfied. And if the patient is satisfied, so are you as a doctor as well, right?</p>	<p>QD1 Communicator QD11 Encounter QD24 Clinical competence QP4 Patient perspective</p>	
28	worksh op	<p>Title: The medical actuality in recreational drugs. Skill-building workshop of the training of the approach to the patient intoxicated by recreational drugs. Proponents: Elena Klusova, Rocío García-Gutiérrez Gómez, Sara Correia, Kelly Patricia Baldeon Cuenca, Manuel Soto, Raquel De León Contreras, Cristina González Ruiz, Alba Gomez Zahino, Claire Thomas. Keywords: Drugs, Recreational; Substance-Related Disorders; Organic Mental Disorders, Substance Induced; Substance Use Disorders; Toxicity; Diagnosis; Algorithms; Emergency Treatment; Life Support Care. Abstract: Since 1960-s 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. -Presentation of: 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. -Take-away messages.</p>	<p>P18 Medication abuse P19 Drug abuse QC42 Street drug addict QT23 Continuous medical education</p>	

29	workshop	<p>Title: Choosing wisely in the Emergency Room. Proponents: Rafael Beijinho do Rosário, Ayose Perez, Augusto Saldana, Magdalena Canals, Rosario Bosch. Keywords: emergency medicine; choosing wisely; evidence based medicine Abstract: Background: The use of unnecessary tests and treatments contributes to health care waste (overutilization, overuse, overtreatment). 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 (link). 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.</p>	<p>QD32 Health issue management QD445 Overdiagnosis QO4 consider new code QR6 Expert advice QS1 Primary care setting QT33 Critical reading</p>	<p>QO4 consider emergency primary care setting to add to QS</p>
30	workshop	<p>Title: S.W.O.T Analysis for primary care doctors and workers. Proponents: Tugba Onat, Süheyla Atalay, Alexandra Tshipou, Ilyas Erken. Keywords: primary care; SWOT. Abstract: Background: 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 it's 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 viewpoints, and educates everyone involved to create a common ground about the elements and the necessary future planning. Methods: Participants will be divided in four groups, each assigned 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 recognise the workshop datas and talk for 15 minutes about datas, 'What is currently being done or has been done?' -'What still needs to be done?' Goals: 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 developed the main strategic actions for the future in primary care practice.</p>	<p>QO2 acronym QR52 Scales and questionnaires QS11 Management of practice QS4 Primary care provider QT3 Quality assurance</p>	<p>QO2 Acronym in the title. Not understandable for dummies</p>

31	workshop	<p>Title: More than just drugs in your prescription. If the health problems are BIOPSYCHOSOCIAL, the solutions must be...</p> <p>Proponents: Kelly Patricia Baldeon Cuenca, Elena Klusova, Sara Correia, Adrian Castellote, Sara López Puche, Flávia Fernandes Neves, Lucía Gutiérrez García.</p> <p>Keywords: community; empowerment; interdisciplinary communication.</p> <p>Abstract: 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.</p> <p>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.</p> <p>Structure:</p> <p>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).</p> <p>Part 2: We will tell the participants about the most interesting projects of community health programs currently developed in our country.</p> <p>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.</p> <p>Part 4: Now is the time for the participants to tell us what they are doing in their countries: how do you help your patients apart from issuing the drugs prescriptions? what projects do you carry out in your community? Open to dialogue and debate.</p> <p>Part 5: take-away messages resume.</p> <p>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.</p>	<p>QD22 Comprehensiveness QO4 consider new code QP6 Patient's participation QR22 Community-based study QR36 Case report QS11 Management of practice QS33 Coordination of care</p>	<p>QO4 Consider to introduce Community medicine as a category</p>
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32	workshop	<p>Title: Unpuzzling type 2 antihyperglycemic drugs. Matching the sweetest pill with the right patient. Proponents: Sara Correia, Helena Alonso-Valencia. Keywords: diabetes; antihyperglycemic drugs; combination therapy. Abstract: 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. 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 mints) 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.</p>	<p>*50 Medication/prescription/renewal/injection QS41 Family doctor QT23 Continuous medical education T89 Diabetes insulin dependent T90 Diabetes non-insulin dependent</p>	
33	workshop	<p>Title: Spirometry Made Easy. Proponents: Pedro Fonte, Claudia Vicente. Keywords: respiratory function; chronic lung diseases; obstruction; restriction. Abstract: 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, the Portuguese Primary Care Respiratory Group, presents this interactive workshop. After a short presentation, open discussion among participants will be led by a team of practising 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.</p>	<p>*39 Physical function test QR4 Research network QS41 Family doctor QS44 Allied health professionals R95 Chronic obstructive pulmonary disease R96 Asthma</p>	

34	workshop	<p>Title: Intermediate care for young GPs. From Lecce to Porto. Proponents: Simone Cernesì, Jacopo Demurtas, Stefano Celotto, Alice Serafini, Gabriella Pesolillo, Francesca Mele, Alessandra Boni, Giulia Cusmano. Keywords: intermediate care. Abstract: 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 Intermediate Care 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 intermediate care (IC), especially in regard to an international perspective. Method: classroom contract (5 min); Presentation and Ice Breaking games (10 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 Intermediate care. 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.</p>	<p>Q01 unable to code, unclear QS41 Family doctor QT11 Pedagogic methods QT2 Field training in medicine</p>	<p>Q01 Unclear title for unclear concept</p>
35	workshop	<p>Title: Shifting boundaries, international opinions of euthanasia? Proponents: Rianne van Vliet, Maïke Eppens. Keywords: euthanasia. Abstract: In this 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.</p>	<p>A20 Euthanasia request/discussion QD8 Work-life balance QE31 Euthanasia QS41 Family doctor QT32 Guideline</p>	

36	workshop	<p>Title: Doctor, can I have a safe home birth experience? Proponents: Irene Pizarro Sanz, Lucía Gutiérrez Garcí, Rocío García-Gutiérrez Gómez, Alberto Sanchez Bernal. Keywords: home childbirth; delivery, obstetric; birth injuries; general practitioners; midwifery; evidence-based practice. Abstract: Introduction: 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 hospitalary care. Rising patients empowerment about their health decisions. Obstetric violence. - Alternative options practiced in different countries and scenarios (urban, rural, low resources areas...). Group and multidisciplinary work: nurses, midwives, family doctors, GyOb and their roles in pregnancy and birth. - Evidence-based data: morbidity and mortality differences between hospitalary versus home births. A final space will be offered for participants to express their conclusions. Conclusions: We can not 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.</p>	<p>QP6 Patient's participation QS11 Management of practice QS31 Practice collaboration QS41 Family doctor QS43 Midwife W78 Pregnancy W90 Uncomplicated labour/delivery livebirth Z25 Assault/harmful event problem</p>	
37	Keynote	<p>Room: "Salão Nobre". Keynote: "Stronger Together: Networking Across Borders in Primary Care". Keynote speaker: Dr Anna Stavdal, President of WONCA Europe. Keywords: social networking; primary health care.</p>	<p>QP61 Social network QS1 Primary care setting</p>	

38	case report	<p>Title: (Accident...aloma) squared -Regarding a case on quaternary prevention.</p> <p>Authors: Sofia Vale Pereira, Ana Pinho Lopes, Sophia Martins, José Assis Viveiros, Sara Dinis, Ana Leon Mota.</p> <p>Keywords: quaternary prevention; pulmonary lesion; occupational exposure; incidentaloma.</p> <p>Abstract: 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 non-diseases, inducing alarmism, iatrogenic procedures and patient stress. This scenery paints the picture of “Disease Mongering” or “Sickness Phenomena”.</p> <p>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 8 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 reveal benign tertiary justapleural lymphoid tissue in case, bronchus-associated lymphoid tissue (BALT) hyperplasia.</p> <p>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”.</p>	<p>QD21 Problem solving QD324 Incidentaloma QD44 Quaternary prevention QD442 Disease mongering QR36 Case report</p>	
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39	case report	<p>Title: Importance of domiciliary visits for polypathological patients. Authors: Ana Cláudia Monteiro Pereira, Cláudia Ho. Keywords: home visits.</p> <p>Abstract: 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.</p> <p>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 ciphoscoliosis which he overcame during the years and proved himself that he could be sucessfull 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.</p> <p>It was through the domiciliary visit that we we're 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.</p> <p>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.</p>	<p>QD22 Comprehensiveness QD322 Multimorbidity QP4 Patient perspective QR36 Case report QS11 Management of practice</p>	
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40	case report	<p>Title: Two cases of “not so innocent” back pain. Authors: Eduarda Cerdeira, Joana Queiroz-Machado, Abílio Malheiro. Keywords: back pain; neoplasm metastasis; prostate neoplasms; early detection of cancer; biomarkers. Abstract: Introduction: Prostate cancer is far the most incident malignant tumor in Portugal with a standardized mortality rate of 36/100.000 habitants in 2014. Use of prostate-specific antigen (PSA) screening has been considered a point of controversy as several studies showed that the precise mortality benefit of early detection of prostate cancer is unclear and potential harms from overdiagnosis may be significant. However evidence towards its indication in monitoring patients with previous prostate carcinoma after treatment seems to be consensual. The aim of this report is to raise awareness about refractory pain as a red flag for serious diseases such as metastatic cancer and issues concerning prostate cancer and the use of PSA level. Case description: 68-year-old male, history of prostate cancer in 2007, identified in the context of elevated PSA level with no symptoms and submitted to prostatectomy with consequent erectile dysfunction and urinary incontinence. Last PSA in July 2017: 0,17ng/mL. On December 2017 he came to his Family Doctor complaining about refractory dorsal pain with two weeks of evolution and no other symptoms. No response to analgesics. Normal thoracic and dorsal X-ray. As no improvements were observed, a CT was performed and revealed a lytic/blastic lesion at D4 level which was suggestive of a metastasis. Search for an occult tumor showed a pulmonary lesion that was biopsied and compatible with a prostate adenocarcinoma metastasis; PSA level 1,63ng/mL. Patient underwent hormonal, radio and chemotherapy with progression of disease and side effects such as diabetes and infections with need for hospital admission. PSA level remained stable. Comment: This case highlights not only the controversy surrounding the use of PSA level as a screening test but also its value as biomarker in the follow-up of patients with history of prostate cancer urging the need for more accurate biomarkers that can be more reliable specially in castration-resistant tumors. It also brings to discussion the limit for medical intervention in oncologic aggressive disease.</p>	<p>*34 Blood test A01 Pain general/multiple sites L02 Back symptom/complaint QD446 Overtreatment QR36 Case report Y77 Malignant neoplasm prostate</p>	
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41	case report	<p>Title: Piriformis syndrome: a form of non-discogenic sciatica. Authors: Sara Coelho, José Eduardo Mendes, Carolina Gil. Keywords: sciatica; piriformis syndrome.</p> <p>Abstract: 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.</p> <p>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.</p> <p>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.</p>	<p>L86 Back syndrome with radiating pain QD32 Health issue management QR36 Case report</p>	
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42	case report	<p>Title: The psychological impact of infertility. Authors: Natalina Rodrigues, Cristina Serra, Miguel Pereira. Keywords: infertility; psychological stress. Abstract: Introduction: 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-conceptual 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 shown 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.</p>	<p>P74 Anxiety disorder/anxiety state QD14 Systems thinking QD22 Comprehensiveness QD446 Overtreatment QR36 Case report W15 Infertility/subfertility female Y10 Infertility/subfertility male</p>	
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43	case report	<p>Title: Thyroid autoimmunity and postpartum affective disorder: causal relationship or not? Authors: Marta Barroca, Diogo Coelho Correia, Susana Pacheco. Keywords: thyroiditis, autoimmune; depression, postpartum. Abstract: 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, 2 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. 7 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, wich was effective in controlling thyroid function about 1 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.</p>	<p>P76 Depressive disorder QD25 Continuity of care QD322 Multimorbidity QO2 acronym T85 Hyperthyroidism/thyrotoxicosis W18 Post-partum symptom/complaint other</p>	<p>QO2 Acronym like; "phase III of Duvall's life cycle" not understandable for dummies</p>
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44	practic e report	<p>Title: To be a Family Doctor beyond the Atlantic. Authors: Ana Margarida Gomes, Ana Rute Marques. Keywords: Brazil; family medicine; family doctor; exchange.</p> <p>Abstract: 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 them 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.</p> <p>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.</p> <p>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) contribute to facilitate the activities in the community and personalized domiciliary visits.</p> <p>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.</p> <p>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.</p>	<p>QS1 Primary care setting QS11 Management of practice QS3 Practice relationship QS31 Practice collaboration QS41 Family doctor QT2 Field training in medicine QT22 Vocational training</p>	
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45	practice report	<p>Title: Childhood obesity: experience in a primary care setting. Authors: Susana Rita. Keywords: pediatric obesity; primary care. Abstract: 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 a 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. 32 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 9 years. 4 cases began before the first year of life, 13 cases between 2 and 5 years, 10 cases between 6 and 9 years and 5 cases between 10 and 18 years of age. An inadequate diet was the main factor found to be responsible, with only 2 cases attributed to a secondary etiology. Family history most commonly revealed cases of obesity (20 cases) and cardiovascular diseases (28 cases) in close relatives. 22 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 7 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.</p>	<p>QC12 Child QD322 Multimorbidity QR2 Epidemiology of primary care QR323 Cross-sectional study T82 Obesity</p>	
46	practice report	<p>Title: Challenges in primary care practice when dealing with older people. Authors: Gergana Foreva, Radost Asenova, Pepa Ferreira, Kiril Elenski. Keywords: primary care practice; older people; geriatric consultations; patient education. Abstract: 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 4200 patients. Despite of older people being approximately 20%, they consume around 50% of the general practitioner's time. The model, presented here, consist of specialised geriatric consultations and educational sessions for patients and their relatives. Our goal is to help older people to maintain their health and independence</p>	<p>QC15 Elderly QD23 Health education QS1 Primary care setting</p>	

47	practic e report	<p>Titlemi: Faly-Focused Approach to Vulnerable Patients: A Challenge to New Family Physicians. Authors: Ma. Loida Sajonas, Allan Rod Pasuelo, Kashmir Engada, Reggiena Lachica. Keywords: mental health; transition; palliative; LGBT. Abstract: Background: Family Medicine physicians encounter patients from vulnerable populations such as children, the elderly, the developmentally disabled/mentally ill, and from the LGBT community; bringing a unique set of biopsychosocial issues that need to be addressed. Four families from vulnerable populations have been managed by new family physicians using an individualized approach to medical and biopsychosocial care, which proved to be a challenging but rewarding experience. Objectives: This presentation aims to highlight the role of Family Medicine physicians encompassing a patient-centered, family-focused and community-oriented approach to medical and biopsychosocial care of vulnerable populations. Materials and Methods: A profile of Families admitted to Family Health programs published in family medicine journal will be presented. Four family cases will be presented : 1) A family struggling with a developmentally disabled member 2) A family with mental health issues 3) A family with a terminally-ill child undergoing palliative treatment 4) A family coming to terms with an LGBT family member. Different family assessment tools and interventions were utilized. The cases will be synthesized at the end of the presentation. Results: The family physicians were able to assess family resiliency, address health concerns and emotional issue, guide decision making, coordinate with an interdisciplinary team, identify community resources, and integrate the family unit. Conclusion: A patient-centered, family-focused, and community-oriented intervention to the medical and psychosocial care of the patients and their families were facilitated successfully. A greater understanding of what a family physician is has been imparted not only to these patients but to these physicians as well.</p>	<p>QC3 Social high risk QP2 Patient-centredness QR22 Community-based study QR52 Scales and questionnaires QS41 Family doctor QT33 Critical reading</p>	
48	practic e report	<p>Title: Missing in the ladder. Authors: Yusianmar Mariani, Elena Klusova, Sara Rigon, Özden Gökdemir, Nina Monteiro, Ana Nunes Barata. Keywords: gender diversity, salary gap, equity. Abstract: 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 ideias to be applied. 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.</p>	<p>QC2 Gender issue QO4 consider new code QR1 Philosophy of science QS11 Management of practice</p>	<p>QO4 Consider to introduce Managerial competence as a category</p>

49	practic e report	<p>Title: A Travel Medicine Clinic in Primary Care - a new challenge! Authors: Ana Costa. Keywords: travel medicine; tropical medicine; global health. Abstract: 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 AlbaSaude in Sintra. The team is comprised of 2 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 adhesion 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.</p>	<p>*67 Referral to physician/specialist/clinic/hospital QD24 Clinical competence QO3 out of scope of family medicine QO4 consider new code QS1 Primary care setting QS32 Referral & counter-referral QT42 Online knowledge-sharing</p>	<p>QO3 Travel medicine is out of scope of Family Medicine. Maybe more exactly Out of scope of Q-Codes as it would be challenging to list all the possible subspecialties available for GPs</p>
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50	practic e report	<p>Title: Presbyphagia: When eating becomes hard to swallow. Authors: Joao Ribeiro, Sandrina Rodrigues. Keywords: deglutition disorders.</p> <p>Abstract: 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, presysphagia 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 this patients.</p> <p>Objectives: To make a practice report of a partnership between Family Doctor and Speech Therapist in order to guarantee presbyphagia early detection.</p> <p>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.</p> <p>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.</p> <p>Discussion: Family Doctors has 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.</p> <p>Conclusion: It's important sensitize Family Doctors to presbyphagia and warning signs and symptoms. The exchange of experiences with the Speech Therapist allows to sensitize and better know the needs and how to help patients with presbyphagia. It would be importante to Family Doctors to know and to apply some screening methods in order to early detect this frequent but often neglected health problem.</p>	<p>D21 Swallowing problem QC15 Elderly QD32 Health issue management QD33 Health status assesment QO4 consider new code QS41 Family doctor QS44 Allied health professionals</p>	<p>QO4 Consider to add speech therapist to QS44</p>
51	practic e report	<p>Title: How can GPs talk about sex? Authors: Carla Rodrigues, Andreia Silva, Ana Filipa Vilaça, Helena Marques, Sara Rita, Ana Beatriz Figueiredo. Keywords: GP; sexuality; consultation.</p> <p>Abstract: 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.</p>	<p>QD1 Communicator QP2 Patient-centredness QP52 Patient's sexuality</p>	

52	practic e report	<p>Title: Emergencies in Primary Care in Spain for immigrant population. Authors: María Belén Arellano-Cobos. Keywords: emergencies; primary care.</p> <p>Abstract: Spain is one of the southern european countries that welcomes 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 extrahospitalary 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 recibing 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-theatening diseases and where to find the most suitable medical care in Spain.</p>	<p>QC15 Elderly QD23 Health education QP42 Patient knowledge QP44 Patient cultural background</p>	
53	Quality study	<p>Title: Reducing the risk of blood borne infection through sharps injury in a non-governmental organisation in India. Authors: Amy Dehn Lunn. Keywords: needlestick injury; healthcare workers; occupational exposure; accident prevention; blood borne pathogens.</p> <p>Abstract: 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.</p> <p>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. 35 episodes of phlebotomy and intramuscular injections were observed. Gloves were not worn for any episode. Recapping of needles occurred in all episodes. 10 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.</p> <p>Interventions A staff training programme and protocol for the safe handling of sharps were 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.</p> <p>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.</p> <p>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</p>	<p>B90 Hiv-infection/aids D97 Liver disease nos QD31 Health risk management QD41 Primary prevention QP1 Patient safety QR35 Action research QS11 Management of practice QT3 Quality assurance QT36 Quality indicator</p>	

54	Quality study	<p>Title: Quality improvement in antibiotic prescription for uncomplicated lower urinary tract infections. Authors: Ana Luisa Marcelino, Cátia Barão, Ana Isabel Silva, Candida Teixeira, Mariana Carvalho, Sara Santos. Keywords: low urinary tract infections.</p> <p>Abstract: 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 has 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 3 groups to study, group A before intervention, group B studied 10 days after intervention (awareness and information of primary care doctors) and group C was study 3 months after intervention. The sample included patients from 5 primary healthcare units in the westcoast region of Portugal diagnosed with uncomplicated LUTI. The search was made based on the electronic medical record system on ICPC-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 3 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 3 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.</p>	<p>QD325 Prescribing behaviour QR325 Intervention study QS1 Primary care setting QS13 Health information management QT3 Quality assurance U71 Cystitis/urinary infection other</p>	
55	Research study	<p>Title: Determination of the factors and perceptions which affect the health behaviour of women: a qualitative research from Turkey. Authors: İkbal Hümay Akyıldız, Elif Demirtaş Okumuş, Nan Je Lay, Kader Topçu, Özlem Sarıkaya, Pemra Cöbek Ünalın. Keywords: women's health; perception; unmet needs; Turkey.</p> <p>Abstract: Aim: To determine the perception, behaviors and expectations about health and sickness of women from our society, and to evaluate the socio-cultural 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 were 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.</p>	<p>QC22 Women's health QP4 Patient perspective QP44 Patient cultural background QR31 Qualitative study</p>	

56	Research study	<p>Title: Core Content Classification in General Practice/Family Medicine (3CGP). A New indexing system for General Practice Knowledge management.</p> <p>Authors: Marc Jamouille, Ariana Tavares, Susana Medeiros, Luís Miguel Santiago.</p> <p>Keywords: osteoporosis; urban population; dual energy X-ray absorptiometry.</p> <p>Abstract: 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 nor 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).</p> <p>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.</p> <p>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 8 languages. In addition, a methodology for building a lightweight ontology (in OWL-2) was applied to Q-Codes, adding object and datatype 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 8 languages have been integrated in a healthcare terminology service (www.hetop.eu/q) with a companion website (http://3cgp.docpatient.net)</p> <p>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 1746 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.</p>	<p>QR Research and development QR33 Mixed method research QR51 Classifications, terminologies and ontologies QS13 Health information management</p>	
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57	Research study	<p>Title: Modifiable risk factors for dementia. Authors: Sofia Santos, Ivone Rodrigues, Maria Teresa Tomé, Emilia Nina. Keywords: dementia; risk factors.</p> <p>Abstract: 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 9 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) are 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@.</p> <p>Results: We found 4628 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, 1183 patients (25,8%) presented at least 1 RF. We found 3456 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, 1306 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.</p>	<p>P70 Dementia QC14 Adult QD31 Health risk management QD43 Tertiary prevention QR2 Epidemiology of primary care QR323 Cross-sectional study QS41 Family doctor</p>	
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58	Research study	<p>Title: Total energy intake and dietary risks associated with the use of alcohol among urban Sri Lankan adults. Authors: Nishan Silva, Shaluni Tissera, Pasindu Malaka, Thusitha Bandara, Geethanjana Malsha. Keywords: calorie intake; alcohol consumption; alcohol and calories; alcohol NCD risks. Abstract: 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 al,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 8. 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.</p>	<p>P15 Chronic alcohol abuse P17 Tobacco abuse QP51 Patient alimentation issues QR323 Cross-sectional study QR52 Scales and questionnaires</p>	
59	Research study	<p>Title: The effect on the patient flow in a local health care after closing a suburban primary care emergency department: a controlled longitudinal follow-up. Authors: Katri Mustonen, Jarmo Kantonen, Timo Kauppila. Keywords: distance; emergency department; primary care; suburban. Abstract: 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 quasiexperimental 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.</p>	<p>QP21 Accessibility QR324 Longitudinal study QS1 Primary care setting QS11 Management of practice</p>	

60	Research study	<p>Title: Delayed antibiotic prescribing for respiratory infections. Authors: Nuno Parente. Keywords: delayed prescriptions; respiratory infections; antimicrobials resistance. Abstracts: 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 reevaluation 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.</p>	<p>QD325 Prescribing behaviour QP41 Patient satisfaction QT3 Quality assurance QT33 Critical reading R74 Upper respiratory infection acute</p>	
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61	Research study	<p>Title: Psychiatric and Psychosomatic manifestations on the skin: An approach to Psycodermatologic symptoms in the Primary Care Setting.</p> <p>Authors: Gustavo Gomes Oliveira, Catarina Rocha Vieira, Cátia Lírio.</p> <p>Keywords: psychodermatology; psychocutaneous medicine; psychiatric symptoms; psychosomatic symptoms; skin symptoms; skin diseases; primary care.</p> <p>Abstract: 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.</p> <p>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.</p> <p>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.</p> <p>Results: Psychodermatologic manifestations are classified as psychophysiologic, 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.</p> <p>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.</p>	<p>P Psychological QD32 Health issue management QS1 Primary care setting QT33 Critical reading S Skin</p>	
62	Keynote:	<p>Room: "Salão Nobre".</p> <p>Keynote: "Stronger Together: Teamwork in Healthcare".</p> <p>Keynote speaker: Prof. Nadim Habib, Nova School of Business and Economics.</p> <p>Keywords: healthcare team; interdisciplinary health team; case managers; crew resource management, healthcare; primary health care.</p>	<p>QS1 Primary care setting QS11 Management of practice QS31 Practice collaboration QS4 Primary care provider</p>	
63	Keynote:	<p>Room: "Salão Nobre".</p> <p>Keynote: "Stronger Together: Teaming up with Patients".</p> <p>Keynote speaker: Prof Amanda Howe, President of WONCA World, and Prof. Helena Canhão, medical director at Patient Innovation.</p> <p>Keywords: patients; patient advocacy; patient empowerment; patient preference; patient satisfaction.</p>	<p>QP4 Patient perspective QP41 Patient satisfaction QP6 Patient's participation QP7 Patient advocacy</p>	

64	Poster	<p>Title: Heart failure diagnosis in primary care from nowadays to the future. Authors: Sara Carmona, Maria do Rosário Novo, Carolina Resende, Paula Nunes Oliveira, Helena Oliveira, Maria Helena Febra, Teresa Libório. Keywords: heart failure; b-type natriuretic peptide; n-terminal pro-brain natriuretic peptide; point-of-care test. Link to spotlight: https://youtu.be/j8DrBo-GsHU Abstract: 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.</p>	<p>*34 Blood test K77 Heart failure QD32 Health issue management QO4 consider new code QS14 Practice equipment</p>	<p>QO4 Point of care testing to add to QS (POCT is a MeSH)</p>
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65	Poster	<p>Title: Patient, community and health professionals: charting the course together for better health. Authors: Ana Luísa Esteves, Diogo Silva, Elvira Teles Sampaio, Líliana Silva. Keywords: primary care; teamwork. Link to spotlight: https://youtu.be/iB2KhH1U55I Abstract: 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 5 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 teamskills 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 multiprofessional 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”</p>	<p>QS1 Primary care setting QS11 Management of practice QS3 Practice relationship QS31 Practice collaboration</p>	
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66	Poster	<p>Title: Establishing a First5 Group: getting started, the successes and the pitfalls. Authors: Jodie Blackadder-Weinstein, Mike Smith. Keywords: networking; support; newly qualified; First5; CCT Link to spotlight: Authors have not made their Poster Spotlights available. Abstract: Background: 'The Success-Satisfaction paradox of Military General Practice trainees' by Dr Toby Holland revealed that although examination results depicted high calibre 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:</p> <ol style="list-style-type: none"> 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. <p>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 has been initial successes with positive feedback received from First5s, the use of lecture sharing, live event video steaming and local CPD groups must now be explored.</p>	<p>QO1 unable to code, unclear QO2 acronym QT22 Vocational training QT23 Continuous medical education</p>	<p>QO2 First5 group is an acronym like not understandable for non UK resident</p>
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67	Poster	<p>Title: Structured conversations: the impact of the structure of DNACPR forms on facilitating end-of-life discussions with patients and relatives.</p> <p>Authors: Noam Roth, Omome Etomi, Charlotte Lau, Joanna Aithie.</p> <p>Keywords: end-of-life.</p> <p>Link to spotlight: https://youtu.be/ZqBtS_fmDFk</p> <p>Abstract: 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.</p> <p>Aim: Audit cycle to assess the impact of new DNACPR forms on the rate of DNACPR discussions.</p> <p>Secondary end points include: rates of new form use, documented escalation plans, completion rates and senior counter-signatures.</p> <p>Methods: 2 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.</p> <p>Initial audit results were presented to the department with recommendations for improvement, followed by a repeat audit in May/June 2017.</p> <p>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%</p> <p>Conclusions: An increase was found in the use of new DNACPR forms following the department education following the original audit.</p> <p>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.</p> <p>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.</p>	<p>QE42 Informed consent QO2 acronym QR323 Cross-sectional study QT3 Quality assurance</p>	<p>QO2 Acronym in the title and CPR not explained in the text</p>
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68	Poster	<p>Title: Magnesium supplements in the treatment of muscle cramps - An evidence-based review. Authors: Rita Pedro, Jéssica Perpétuo. Keywords: magnesium; muscle cramps. Link to spotlight: https://youtu.be/JZAdMKKc84Q Abstract: 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.</p>	<p>*50 Medication/prescription/renewal/injection L18 Muscle pain QT33 Critical reading</p>	
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69	Poster	<p>Title: Polypharmacy and potentially inappropriate medications in very old patients. Authors: Joana Rita Bento, Denise Alexandra Velho, Célia Mata, André Rainho Dias, Bruno Pereira Carreira, David Tonelo, Patrícia Angélico, Rita Lopes Ferreira, Nadina Sousa. Keywords: polypharmacy; potentially inappropriate medications; Beers criteria. Link to spotlight: https://youtu.be/wYa7zvQkmdM Abstract: 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 (#5 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 enable 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.</p>	<p>QC15 Elderly QD325 Prescribing behaviour QR323 Cross-sectional study</p>	
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70	Poster	<p>Title: Infectious mononucleosis: importance of Group A Streptococcus rapid antigen detection test. Authors: Nuno Parente, Joana Castro. Keywords: Infectious mononucleosis; Group A Streptococcus; rapid antigen detection test. Link to spotlight: https://youtu.be/b-YgpaKd8MI Link to spotlight: Authors have not made their Poster Spotlights available. Abstract: 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 a 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 50 mg/Kg/day PO for an 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 1 mg/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.</p>	<p>A75 Infectious mononucleosis QR36 Case report QS14 Practice equipment R72 Strep throat</p>	
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71	Poster	<p>Title: One more minute could save a life. Authors: Raquel Georgina Padin Perez, Elena Torices Picon, Maria dolores Vazquez Garcia, Marta Colón Más. Keywords: appointments and schedules. Link to spotlight: https://youtu.be/XOyDsNttjUk Abstract: 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 kilometres. In the presence of cardiovascular risk factors and electrocardiographic changes that suggest myocardial ischemia, the same day, the patient is referred to the hospitals 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.</p>	<p>*67 Referral to physician/specialist/clinic/hospital K83 Heart valve disease nos QD32 Health issue management QD43 Tertiary prevention QR36 Case report</p>	
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72	Poster	<p>Title: When bone fracture led to Turner Syndrome diagnosis. Authors: Ana Sequeira, Vera Araújo, Ana Maria Pires. Keywords: Turner syndrome; primary care management. Link to spotlight: https://youtu.be/cxAojIsiaSI Abstract: 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 2000) 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.</p>	<p>A90 Congenital anomaly nos/multiple QD25 Continuity of care QD32 Health issue management QD34 Genetic issues QR36 Case report QS41 Family doctor</p>	
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73	Poster	<p>Title: Pulmonary embolism - What if anxiety is not just psychological? Authors: João Ribeiro. Keywords: pulmonary embolism; anxiety. Link to spotlight: https://youtu.be/PtgTsD9DfiY Abstract: 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 - To 36.1, BP 121/64 mmHg, HR 121 bpm, O2 saturation 97% - Pulmonary auscultation: Can't deep breath because of the pain. - Cardiac auscultation: Ritmic, taquicardia. - 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 are 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 importante 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.</p>	<p>K93 Pulmonary embolism P72 Schizophrenia QD32 Health issue management QR36 Case report QT52 Adverse event & pharmacovigilance</p>	
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74	Poster	<p>Title: Hypertension in 34 years old male.</p> <p>Authors: Alba Gomez Zahino, Matteo Mannucci, Sara Guerrero Bernat, Laura Crespo Leza, Jordi Martínez Gisbert, Maria Dolores Acerete Hueso.</p> <p>Keywords: hypertension; primary care; IgA glomerulonephritis; nephropathy; proteinuria.</p> <p>Link to spotlight: https://youtu.be/zaLT3hU34q4</p> <p>Abstract: 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 110 mmHg 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 180/100 mmHg, 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 83 mg 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 (150 mg/dl) and microalbuminuria (989 mg/l). His calculated glomerular filtrate (CDK-EPI) was 71,9 ml/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 2 months later, because of poor control of high pressure. Since it took some month (5) to reach the diagnosis of IgA Glomerulonephritis we kept this treatment and nephrologist started with immunosupresor treatment (corticoids and mycophenolate mofetil). From diagnosis, the patient have had a positive development with control and maintenance of the optimum blood pressure without proteinuria. He continue with periodical tests in primary attention and nephrology.</p>	<p>*67 Referral to physician/specialist/clinic/hospital K87 Hypertension complicated QR36 Case report U88 Glomerulonephritis/nephrosis</p>	
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75	Poster	<p>Title: Rhinosinusitis - Are we treating it properly? Quality work. Authors: Rita Oliveira da Silva, António João Costa e Silva. Keywords: rhinosinusitis. Link to spotlight: https://youtu.be/o5en6n7G00A Abstract: Justification: The Rhinosinusitis (RS), frequent in primary health care (PHC), according to the European Position paper on rhinosinusitis and nasal polyps (EPOS) 2012, results from the nose and sinus inflammation with # 2 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 PHC 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 an family health unit (FHU) with “A” of SOAP coded: R75 of the ICPC-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: No 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 PHC.</p>	<p>QR325 Intervention study QS1 Primary care setting QT3 Quality assurance QT34 Peer review R75 Sinusitis acute/chronic</p>	
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76	Poster	<p>Title: Relationship between general practitioners' job characteristics and their attitudes towards self-assessment glycaemic control (S-AGliC) practices.</p> <p>Authors: Jurate Peceliuniene, Irena Zukauskaite, Antanas Norkus.</p> <p>Keywords: self-assessment of glycaemic control; job characteristics; job satisfaction; general practitioner; supervisor; diabetic primary care patients.</p> <p>Link to spotlight: https://youtu.be/8jQ0zoWb82U</p> <p>Abstract: Introduction: The systematic adherence to S-AGliC is a key element to obtain a positive therapeutic effect in diabetic patients.</p> <p>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. 24 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.</p> <p>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.</p> <p>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.</p>	<p>*34 Blood test QD8 Work-life balance QR323 Cross-sectional study QS41 Family doctor QT3 Quality assurance T89 Diabetes insulin dependent T90 Diabetes non-insulin dependent</p>	
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77	Poster	<p>Title: Refugee crisis – Integration of asylum applicants in Portugal. Authors: Vera Pires da Silva, Susana Calejo Rios. Keywords: refugee; asylum; Portugal. Link to spotlight: Authors have not made their Poster Spotlights available. Abstract: Introduction or background: In the last years, European countries have registered a significant increased number of refugees applying for asylum as a result of the migratory flows becoming progressively more intense, from different countries and for diverse reasons. Therefore, the creation and establishment of strategies within EU in order to assess and approve applications has been considered an international priority. However, each country has its own specific procedures, which can include a diversity of organizations and institutions responsible for integrating these populations. Aim: With this work we aim to present the Portuguese procedure regarding the integration, namely health care provision and other essential aspects, of the refugees in the country. We also aim to have feedback from participants from other countries about their legal procedures and voluntary regarding this vulnerable group Method and Results: In this work we review the major resources available for refugees in Portugal, namely shelter centers, social and labor integration, language learning and health care provision. Legal aspects including barriers and limitations will also be discussed. Discussion: Portugal has been engaged in integrating asylum applicants in the country. Although it's not the most requested EU country by refugees, efforts have been made and resources have been mobilized to best fit the required demands. With this oral presentation we hope to dis-cuss with other colleagues what can be improved, specially, but not exclusively, concerning primary care and health care. Conclusion: Refugees are a vulnerable group, not only in terms of risk management, but also concerning health requests, social and cultural differences, and language challenges. Providing the best health care possible is essential for positive outcomes regarding refugees' inclusion in a new environment and society. GP's as primary care professionals but also as citizens in their communities can play an important role in this process.</p>	<p>QC32 Refugees & migrants QP21 Accessibility QP23 Cultural competency QP24 Affordability QP3 Quality of health care</p>	
78	Poster	<p>Title: What should a General Physician know about baby led weaning? Authors: Carlota Veiga de Macedo, João Toscano Alves. Keywords: infant health; food introduction; breastfeeding; baby led weaning. Link to spotlight: https://youtu.be/kbqkBWxvK8M Abstract: Baby led weaning (BLW) is the name given to a new/ancient method of complementary food introduction. With this method the baby has the control of what and how much he eats while becoming in love with the textures, colours and flavours of the food itself. This way the child to be will have a better notion of satiety and a good relationship with food. The idea is presenting to the baby from the age of six months, approximately, the same food the family is having during any meal. This way the meal has a meaning of pleasure, not only from the food but also from the social environment. The food has to be healthy, and other rules have to be assured to prevent choking, low calorie intake and lack of some nutrients, like iron. In this presentation, we focus on what the physician should know about BLW to support and advise the parents that want to initiate this kind of method. Having this knowledge a physician has the power to help in altering not only the child's future, preventing diseases that start with unhealthy food habits, but also improve all the family's health.</p>	<p>QC11 Infant QD24 Clinical competence QP51 Patient alimentation issues W19 Breast/lactation symptom/complaint</p>	

79	Poster	<p>Title: Vaccination for teenage pertussis - kills less and saves more? Authors: Catarina Ferreira, João Vieira Fonseca, Paula Neves, Nuno Amaral, Pedro Apolinário. Keywords: vaccination; pertussis; adolescence. Link to spotlight: https://youtu.be/fkFFfQ4qC8w Abstract: 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 5: 2 prospective cohorts, 2 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 2. 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.</p>	<p>QC13 Adolescent QD41 Primary prevention QT33 Critical reading R71 Whooping cough</p>	
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80	Poster	<p>Title: What do young doctors know of Palliative Care; How do they believe the concept should work? Authors: G Chamath Fernando, Shamini Prathapan. Keywords: palliative care education; medical education; undergraduate curriculum Link to spotlight: https://youtu.be/nhhufEDpLqg Abstract: 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 analysed 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>=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.</p>	<p>QD26 Palliative care QE2 Professional ethics QR323 Cross-sectional study QT13 Teaching evaluation QT21 Undergraduate in medicine</p>	
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81	Poster	<p>Title: A different type of seizures - a case report. Authors: Inês Ferreira Santos, Pedro Vasconcelos, Rita Bernardino Figueiredo. Keywords: epilepsy; pseudoseizures; depression; suicidal thoughts. Link to spotlight: https://youtu.be/mlct5j7eVD8 Abstract: 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 hyperpnea, 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.</p>	<p>N88 Epilepsy P76 Depressive disorder P77 Suicide/suicide attempt QD22 Comprehensiveness QD32 Health issue management QR36 Case report</p>	
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82	Poster	<p>Title: Urinary tract infection complicated by a ureteral stone. Authors: Emanuela Gomes, Pedro Namora, Salete Gomez, Helena Ribeiro, Fernando Carvalho. Keywords: urinary tract infection (UTI); UTI complicated; ureteral stones. Link to spotlight: https://youtu.be/NPRSpW7caxM Abstract: 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 signalling 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.</p>	<p>QD32 Health issue management QP24 Affordability QR36 Case report QS1 Primary care setting QS33 Coordination of care U95 Urinary calculus Z11 Compliance/being ill problem</p>	
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83	Poster	<p>Title: What if it's ALS? Authors: Maria João Sousa, Maria José Almeida. Keywords: fasciculations; anxiety; Benign Fasciculation Syndrome. Link to spotlight: https://youtu.be/8Tbz_83Z278 Abstract: 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.</p>	<p>L29 Musculoskeletal symptom/complaint other N27 Fear of neurological disease other N99 Neurological disease other QD321 Medically unexplained symptom QR36 Case report QS41 Family doctor</p>	
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84	Poster	<p>Title: Discovering polygamy through infertility - a case report. Authors: Tatiana Macedo Pinto, Margarida Pereira, Mariana Moura Relvas, Maria do Carmo Gonçalves. Keywords: polygamy; infertility; family medicine. Link to spotlight: https://youtu.be/x9AFu1PZohU Abstract: 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 amenorrhoea 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</p>	<p>QD12 Doctor-patient relationship QP23 Cultural competency QP44 Patient cultural background QR36 Case report QS41 Family doctor W15 Infertility/subfertility female Z04 Social cultural problem</p>	
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85	Poster	<p>Title: "Thinking outside the box" - about a red blood cell count prescription. Authors: Ana S. Fernandes, Diana Coelho, Maria Antónia Alvito. Keywords: red blood cell count; guidelines; gastrointestinal stromal tumor. Link to spotlight: https://youtu.be/WLfk_fWxsMM Abstract: 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 refered 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.</p>	<p>B80 Iron deficiency anaemia D78 Neoplasm digestive system benign/unspecified QD32 Health issue management QD42 Secondary prevention QR36 Case report QT32 Guideline</p>	
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86	Poster	<p>Title: In the eye of a host: a Hippokrates exchange. Authors: Süheyla Atalay. Keywords: Vasco da Gama Movement; exchange; primary care training. Link to spotlight: https://youtu.be/1nY9am4M1to Abstract: 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 specialising in Family Medicine/General Practice and junior Family Doctors/General Practitioners (within 5 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, 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.</p>	<p>QS41 Family doctor QT14 Academic organization QT2 Field training in medicine QT22 Vocational training</p>	
87	Poster	<p>Title: Child abuse prevention month on USF Carcavelos. Authors: Catarina Assis Catroga, Nuno Basílio, Alexandra Fradeira, Ana Brites. Keywords: child abuse; preventive medicine. Link to spotlight: https://youtu.be/Pa9QTKQ-rd4 Abstract: 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 pf 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 pf 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.</p>	<p>QC12 Child QC52 Child abuse QD23 Health education QP6 Patient's participation QS1 Primary care setting</p>	

88	Poster	<p>Title: Gastric carcinoid tumor: an uncommon challenge. Authors: Isabel Padrão Tadeu, Mário Tadeu. Keywords: gastric carcinoid; pernicious anemia. Link to spotlight: https://youtu.be/-nc4Cq2wsD4 Abstract: 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, conjunctiva normal. HF 115 bpm, BP 127/62 mmHg, BF 18 cpm, O2sat 99%, temperature 37.6oC. Cardiac and respiratory auscultation normal. 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 28000), 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 recognise that the treatment of anemia is, not only the supplementation, but also the investigation to provide a cure.</p>	<p>B81 Anaemia vit b12/folate deficiency D74 Malignant neoplasm stomach QD32 Health issue management QO2 acronym QR36 Case report</p>	<p>QO2 abstract full of unexplained acronyms</p>
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89	Poster	<p>Title: An occult cause for weight loss. Authors: Ana Rita Cunha, Conceição Martins. Keywords: weight loss; anxiety Link to spotlight: https://youtu.be/zAVzxKWtqTU Abstract: 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 5 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 <i>Helicobacter pylori</i> (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 (3 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.</p>	<p>D07 Dyspepsia/indigestion QD32 Health issue management QD321 Medically unexplained symptom QR36 Case report T08 Weight loss Z14 Partner illness problem</p>	
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90	Poster	<p>Title: Amiodarone-induced hyperthyroidism. Authors: Raquel Sanches, Sara Carmona, Sofia Figueira. Keywords: amiodarone; hyperthyroidism. Link to spotlight: https://youtu.be/4oAB0pzAeHU Abstract: Background: Amiodarone is an effective class III anti-arrhythmic drug, commonly used to treat ventricular and supraventricular taquiarrhythmias. 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 uUI/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.</p>	<p>A85 Adverse effect medical agent QD32 Health issue management QR36 Case report QT52 Adverse event & pharmacovigilance T85 Hyperthyroidism/thyrotoxicosis</p>	
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91	Poster	<p>Title: Diagnosing collagenous colitis is stopping diarrhea. Authors: Sofia Rocha Teixeira, Mariana Madureira. Keywords: collagenous; colitis. Link to spotlight: https://youtu.be/x59IPsNTOyo Abstract: Background: Microscopic colitis is a chronic inflammatory disease of the colon. There are two main subtypes: 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 have 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 tabagism 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 8 days of ciprofloxacin for suspected acute enterocolitis, with favourable evolution. Colonoscopy with mucosal biopsy was compatible with CC diagnosis. He started loperamide (4mg daily) with partial response. Then, was added budesonide (9mg daily, 4 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.</p>	<p>D11 Diarrhea D99 Disease digestive system other QD32 Health issue management QR36 Case report</p>	
92	Poster	<p>Title: Overdoing in community medicine: a case report coping with a renal incidentaloma. Authors: Tom Axelrod. Keywords: overdoing; overdiagnosis; overtreatment; renal incidentaloma. Link to spotlight: https://youtu.be/eR_fyLqaFao Abstract: Case presentation: A 71 years-old lady with a 4 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 2 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 overtreatment.</p>	<p>QD324 Incidentaloma QD445 Overdiagnosis QR36 Case report T90 Diabetes non-insulin dependent</p>	

93	Poster	<p>Title: When we believe in a miraculous oil. Authors: Ana S. Fernandes, Diana Coelho, Maria Antónia Alvito, Alexandra Fernandes. Keywords: cannabis oil; alternative treatment, conventional treatment; metastatic neuroendocrine tumor. Link to spotlight: https://youtu.be/lcsXumkil40 Abstract: 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 metastasis. 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, that in this case were fundamental to the patient cooperation in his treatment.</p>	<p>D76 Malignant neoplasm pancreas QD32 Health issue management QD5 Complementary and Alternative Medicine QP43 Patient autonomy QR36 Case report</p>	
94	Poster	<p>Title: Thoracic Outlet Syndrome in primary care, a clinical case report. Authors: Matteo Mannucci, Gabriel Trucco, Alba Gomez Zahino. Keywords: primary care; thoracic outlet syndrome; cervical rib syndrome. Link to spotlight: https://youtu.be/dix3V-KCvFg Abstract: 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 yo 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 27 cm). 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</p>	<p>L04 Chest symptom/complaint QD32 Health issue management QR36 Case report QS1 Primary care setting</p>	

95	Poster	<p>Title: Biophysical attributes, bone densitometry scanning revealed dimensions and interrelations between them; an urban Sri Lankan study.</p> <p>Authors: Kavijaya Wijayasinghe, G Chamath Fernando, Chandima Jeewandara, Shyamalee Samaranayaka.</p> <p>Keywords: osteoporosis; urban population; dual energy X-ray absorptiometry.</p> <p>Link to spotlight: https://youtu.be/habhztRboHM</p> <p>Abstract: 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.</p> <p>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.</p> <p>Methods: A descriptive study where all the retrospective data of patients who underwent DEXA scanning were analysed in terms of percentages of and interrelations (with Pearson’s Chi-square-#2) between biophysical data and densitometry parameters (e.g. T,Z-scores, fat mass etc.).</p> <p>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), (#2=53.403, p<0.001); (#2=108.253, p<0.001); (#2=64.002, p<0.001) respectively. WB, Hip and Spine T-scores also had significant inverse correlations with age (#2=177.312, p<0.001); (#2=104.073, p<0.001); (#2=135.173, p<0.001), years elapsed since menopause in females (#2=147.863,p<0.001); (#2=76.864, p<0.001); (#2=150.689, p<0.001) and females being included in ‘metabolic syndrome’ defining waist circumference category (#2=22.576,p<0.001); (#2=58.717, p<0.001); (#2=19.667, p<0.001) correspondingly.</p> <p>Conclusion: More than a third of the screened urban population were 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</p>	<p>*43 Other diagnostic procedure L95 Osteoporosis QR323 Cross-sectional study QS1 Primary care setting</p>	
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96	Poster	<p>Title: Effective tracking for abnormal screening test results in Bateen Health Care Center, Abu Dhabi, United Arab Emirate.</p> <p>Authors: Fatma Nasser, Amira Elhassan, Shamma elmazroie, Melanie Bardelosa, Eman Lahloub.</p> <p>Keywords: follow-up; abnormal screening tests results.</p> <p>Link to spotlight: https://youtu.be/XFtmwYDMk-0</p> <p>Abstract: Introduction & 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.</p> <p>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</p> <p>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.</p> <p>Intervention: A list contained all patients who did the cancer screening test for the study period (weekly updated)</p> <ul style="list-style-type: none"> - Tracking list : For patients with abnormal test results, to be recalled on the same day / or maximum in the second day (maximum in 2 days from the release of result) and to schedule an appointment with Bateen’ doctor for result discussion and management. - 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. . - We used the two by two table and P value for calculating the results. <p>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)</p> <p>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.</p> <p>Recommendations: Redesign the system to adopt an effective and simple tracking method for abnormal results (electronic or paper-based).</p>	<p>*63 Follow-up encounter unspecified A91 Abnormal result investigation nos QD25 Continuity of care QD42 Secondary prevention QR325 Intervention study QS1 Primary care setting QS11 Management of practice QT3 Quality assurance</p>	
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97	Poster	<p>Title: Enhancing management of obesity in Al Bateen health care center in Abu Dhabi, United Arab Emirate, in 2016. Authors: Bushra Ghaliani, Fatma Nasser, Asma Mazroie, Mouza Neimie, Eiman Alshehi. Keywords: obesity. Link to spotlight: https://youtu.be/7Mgyd-cGe4 Abstract: Introduction & 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 dietician and obesity clinic. We targeted patients who have BMI of 25 and above and aged between 18-60 years. 2618 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 lifestyle 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 dietician. 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.</p>	<p>*45 Observation/health education/advice/diet abstract QD23 Health education QD32 Health issue management QD4 Clinical prevention QR325 Intervention study QT32 Guideline T82 Obesity</p>	
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