GoldNet Research Network Event

The **GoldNet Research Network** is pleased to welcome you our research networking event. Here we will be discussing the **recent updates to the RACGP Red book: *Guidelines for preventive activities in general practice***.

Professor Paul Glasziou
Professor of Evidence-Based Medicine & Director, Institute for Evidence-Based Healthcare, Bond University

Professor Mark Morgan
Professor of General Practice
Head of Medical Doctorate
Faculty of Health Sciences and Medicine,
Bond University

Assistant Professor Laura Baxter
Clinical Practice Assistant Professor, Medical Program, Faculty of Health Sciences & Medicine, Bond University & Secretary, General Practice Gold Coast

Prof. Nick Zwar
Executive Dean, Bond University and
Chair of GoldNet Research Steering Committee

What's new in the Red book?

Presentations to commence at 6:30 pm

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Welcome

What's new in the Red book?

Professor Nick Zwar

Chair of GoldNet Research Steering Committee
Executive Dean of Faculty of Health Sciences and Medicine,
Bond University

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We acknowledge the Kombumerri clan of the Yugambeh language group as the traditional custodians of this land.

We pay respect to their Elders – past and present for their wisdom, teaching and cultural knowledge.

Artwork *by* Narelle Urquhart 2018

GoldNet Research

What's new in the Red book?

6:30 pm	Welcome and Introduction	Professor Nick Zwar – Chair & Dr Jerneja Sveticic - PHN
6:40 pm	Topic 1 - Frailty	Professor Mark Morgan – Bond University
6:55 pm	Topic 2 – Prostate Cancer Screening	Professor Nick Zwar – Bond University
7:10pm	Topic 3 - CVD	Professor Paul Glasziou – Institute for Evidence-Based Healthcare
7:25pm	Q&A Panel	Chaired by Assistant Professor Laura Baxter – GPGC & Bond
7:55pm	Closing remarks	Professor Zwar

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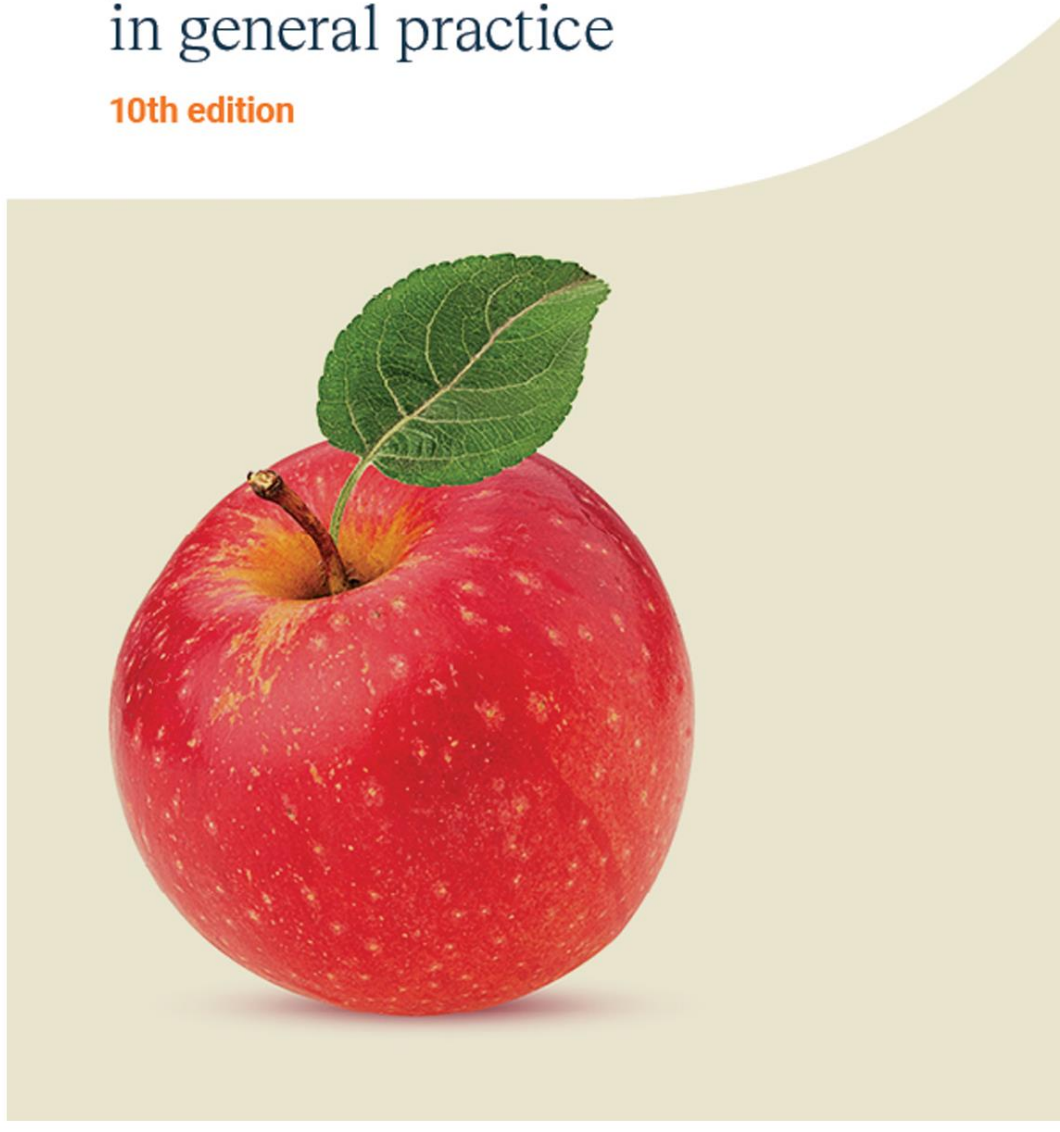
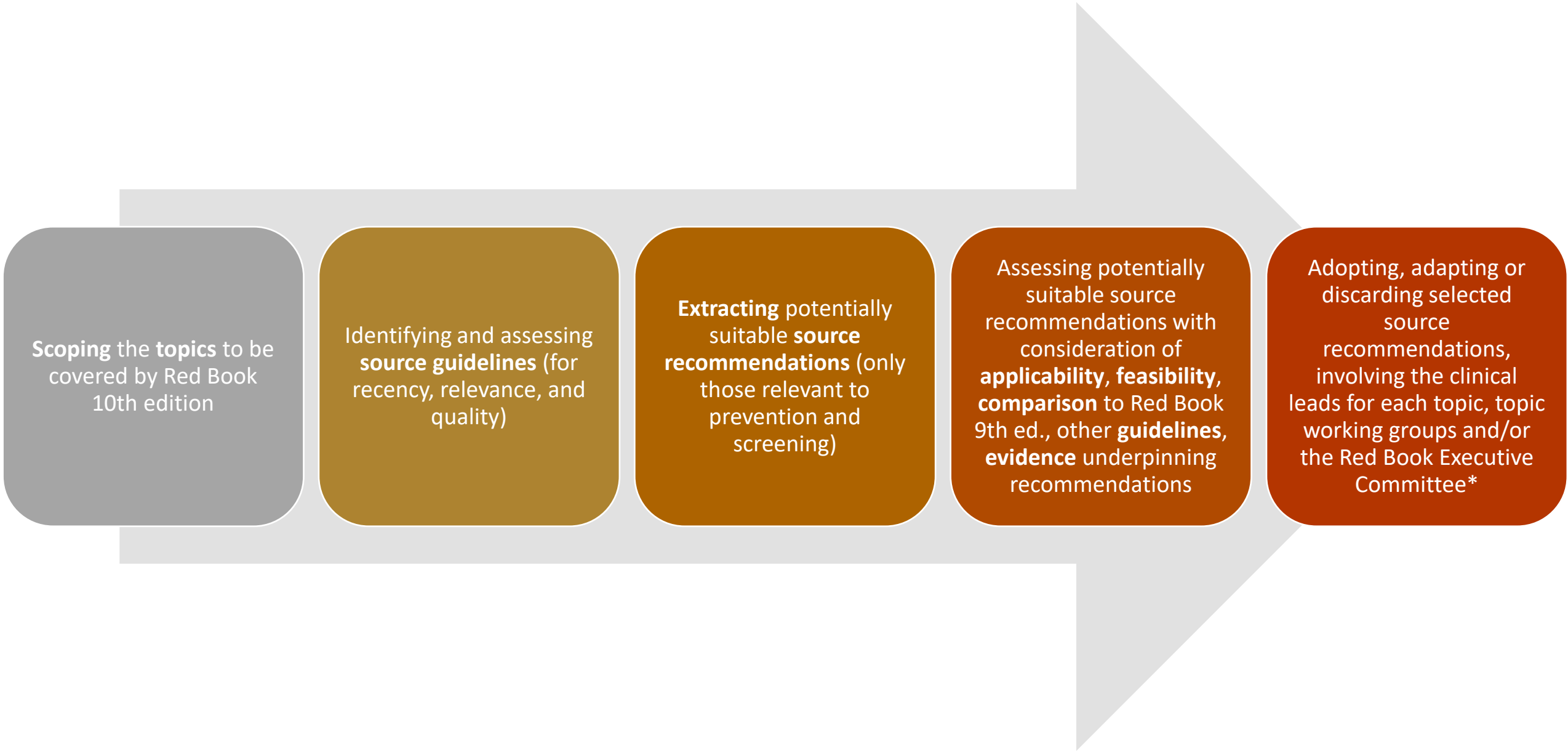
RACGP
Royal Australian College of General Practitioners

Guidelines for preventive activities in general practice

10th edition



Please scan the QR code to access a PDF of the Red Book



* Presenters are on the Red Book Executive Committee

Cancer	CVD	Development and behaviour	Genetics	Infectious diseases	Injury prevention	Mental health	Metabolic	Musculoskeletal disorders	Women's health	Miscellaneous	Screening and preventive activities of no proven benefit
Breast	Atrial Fibrillation	Developmental delay and autism		Hepatitis B and C	Bullying and child abuse	Alcohol	Coeliac	Developmental dysplasia of the hip	Pre-conception	Frailty	
Cervical	CVD Risk	Preventive activities in childhood		Immunisation	Elder abuse	Anxiety	Diabetes	Osteoporosis	Pregnancy - first antenatal visit	Hearing	
Colorectal				Sexually transmitted disease	Falls	Dementia	Nutrition	Scoliosis	Pregnancy - during pregnancy	Sleep and sleep-related disorders	
Prostate					Intimate partner violence	Depression	Overweight and obesity	Falls	Inter-conception	Oral health	
Skin						Eating disorders	Physical activity		Perinatal mental health	Urinary incontinence	
Bladder						Gambling	Thyroid		Post menopause	Vision	
Lung						Smoking and nicotine vaping					
Ovarian						Suicide					
Oral						Perinatal mental health					
Pancreatic											
Testicular											
Thyroid											

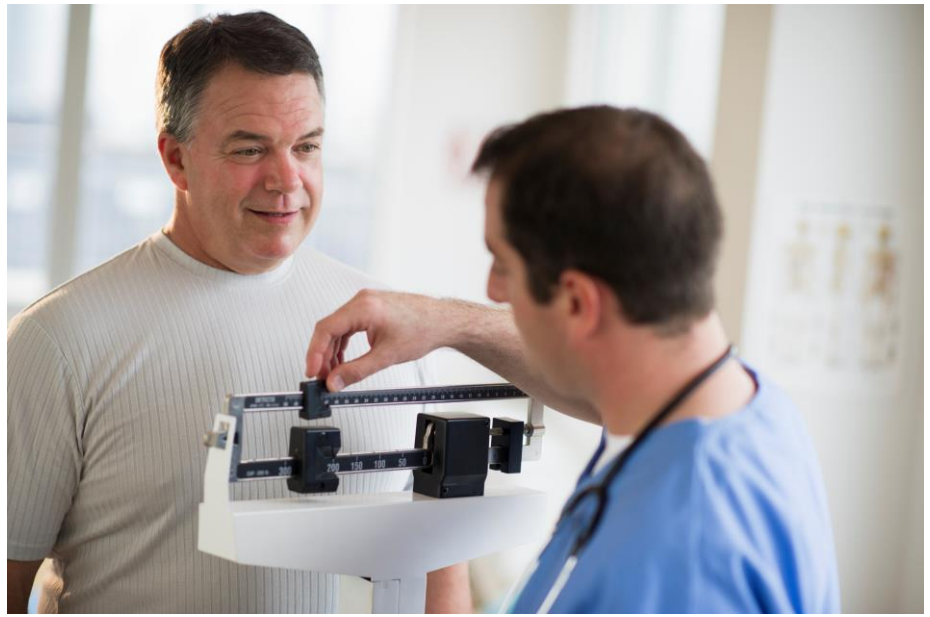
Case Study

GoldNet Research

- 50 year old man presents for check up
- Non smoker, 2 glasses wine most nights
- No long term medications
- Overweight 98kg 182cm BMI 29.6
- Office BP 142/90

Past history

- Renal colic



Preventive activities over the lifecycle – **Adults**

Screening Case-finding

Activity/topic	Age group														Frequency	Notes
	15–19	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69	70–74	75–79	≥80		
Cancer																
Breast															Screening: Every two years Case-finding: At least every two years	Screening: Women at average risk or slightly higher than average risk of breast cancer should participate in mammographic screening from ages 50 to 74 years as part of the national BreastScreen program. Case-finding: Undertake mammographic screening from ages 40 to 74 years for women at moderately increased risk.
Cervical															Every five years	Women and people with a cervix who are aged between 25-74 years, have ever had sexual contact and who are eligible for screening should have an HPV screening test for cervical cancer. This can be on a self-collected vaginal sample or on a clinician-collected sample.
Colorectal															Every two years	Immunochemical faecal occult blood testing (iFOBT) every two years is recommended starting at age 45 years and continuing to age 74 years for those at average risk of colorectal cancer.
Prostate															See chapter for frequency	See chapter for individual recommendations.
Skin															See chapter for frequency	See chapter for individual recommendations.
Cardiovascular																
Atrial fibrillation (AF)															Opportunistically	Opportunistic clinical palpation or auscultation to detect asymptomatic AF in people aged 65 years or more.
Cardiovascular disease risk	BP only	BP only	BP only	BP only	BP only	BP only									Blood pressure (BP) (18+ years) opportunistically, no more than every two years. CVD risk (age 45 - 79) every five years unless risk factors worsen.	See chapter for individual recommendations.
Infectious diseases																
Immunisation	Immunisation is recommended at particular ages throughout life, according to the Australian Immunisation Handbook.														See chapter for frequency	See chapter and Australian Immunisation Handbook schedule for recommendations.
Sexually transmitted disease															Opportunistically if indicated (evidence is unclear on testing interval).	Screening for chlamydia and gonorrhoea is recommended in all sexually active women 24 years or younger but only in those who are at increased risk (see Box 1) in women 25 years or older.
Injury prevention																
Bullying and child abuse															Opportunistically	See chapter for individual recommendations.
Mental health																
Alcohol															Every two years	Screen adults aged ≥18 years, including pregnant women, for unhealthy alcohol use. The Alcohol Use Disorder Identification Test – Consumption (AUDIT-C) tool can be used to assess this. Provide persons engaged in risky or hazardous drinking with brief behavioural counselling interventions to reduce unhealthy alcohol use.
Anxiety															As required	See chapter for individual recommendations.
Dementia															Opportunistically	See chapter for individual recommendations.
Depression															See chapter for frequency	See chapter for individual recommendations.
Gambling															Opportunistically	In patients experiencing stress, mental health issues or substance use problems; in people experiencing or perpetrating domestic violence; in people experiencing relationship breakdown; and/or in people with symptoms of compulsive gambling (see Box 1), ask about gambling behaviours (eg sports betting, wagering, card playing, pokies, casino gambling, online gambling). For example, 'In the past 12 months, have you or someone you are close to ever had issues with gambling?'
Smoking and nicotine vaping															At every opportunity starting from the age of 10 years	Ask patients whether they are currently smoking and document their smoking status. Also ask about and document the use of vaping products.
Metabolic																
Diabetes															Determined by individual risk. See chapter for recommendations.	General population of average risk (for screening of high-risk and highest-risk populations, see Diabetes chapter).
Overweight and obesity															Opportunistically	Assess height, weight and calculate BMI with caution in adults without a known eating disorder and who are not pregnant.
Physical activity															Every two years	Ask questions about frequency, duration and intensity of physical activity and sedentary behaviour.
Musculoskeletal disorders																
Osteoporosis															Do not routinely repeat BMD + FRAX® within two years except in special circumstances.	Use FRAX® to calculate absolute fracture risk in people aged ≥50 years with lifestyle and non-modifiable risk factors (eg parent with hip fracture). When the FRAX® risk for major osteoporotic fracture (MOF) is ≥10%, refer for dual energy X-ray absorptiometry (DXA). If the risk for MOF is <10%, DXA is not recommended. Refer for BMD assessment by DXA for people aged ≥50 years with diseases/chronic conditions/medications associated with increased fracture risk. Restratify risk with FRAX® after DXA using BMD reading and treat when: the BMD T-score is ≤−2.5, or when the BMD T-score is between −1.5 and −2.5 and the FRAX® risk for MOF is ≥20% and/or the hip fracture risk is ≥3%.
Metabolic																
Preconception															See chapter for frequency	See chapter for individual recommendations.
Pregnancy - First antenatal visit															See chapter for frequency	See chapter for individual recommendations.
Pregnancy - During pregnancy															See chapter for frequency	See chapter for individual recommendations.
Interconception															See chapter for frequency	See chapter for individual recommendations.
Perinatal mental health															See chapter for frequency	See chapter for individual recommendations.
Miscellaneous																
Frailty															Every 12 months (screening). Every one - three years (case finding).	Consider screening as part of an assessment of elderly patients. Case find as an assessment of patients (age 65-74) with risk factors.

Blood results

- Lipids
  - Fasting cholesterol 6.7mmol/L
  - Triglycerides 1.9 mmol/L
  - HDL-C 1.4 mmol/L
  - LDL-C 4.4 mmol/L
  - TC/HDL-C 4.8
- Biochemistry
  - Creatinine116 umol/L (60-110)
  - Urate 0.52 mmol/L (0.20-0.45)
  - ALT 61 U/L (<40)
- Other
  - PSA Total 0.50 ug/L, HbA1c 5.2%

GoldNet Research

What's new in the Red book?

Presentation:

Professor Mark Morgan

Professor of General Practice
Head of Medical Doctorate
Faculty of Health Sciences and Medicine, Bond University

Frailty

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What is frailty?

A state of increased vulnerability to stressors such as illness or injuries characterised by loss of reserve across multiple physiological systems.

Frailty Phenotype –weight loss, exhaustion, slowness, weakness and low physical activity

Cumulative deficit including symptoms, signs, functional impairments and laboratory abnormalities

Why is there a new chapter on frailty?

Frailty is common with 21% of >65yr olds in Australia[1]

Frailty changes the way we manage medical conditions

Frailty can be treated

Ref 1: Frailty prevalence in Australia: Findings from four pooled Australian cohort studies. Thompson et al 2018

Red Book recommendations

GoldNet Research

Screening and case-finding age bar

0-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	≥80

Screening

Recommended as of: 28/06/2024

Recommendation	Grade	How often	References
Consider screening for frailty as part of an assessment of elderly patients (aged ≥75 years) using a validated rapid frailty instrument suitable to the specific setting or context (refer to Further information).	**Practice point**	Every 12 months.	2

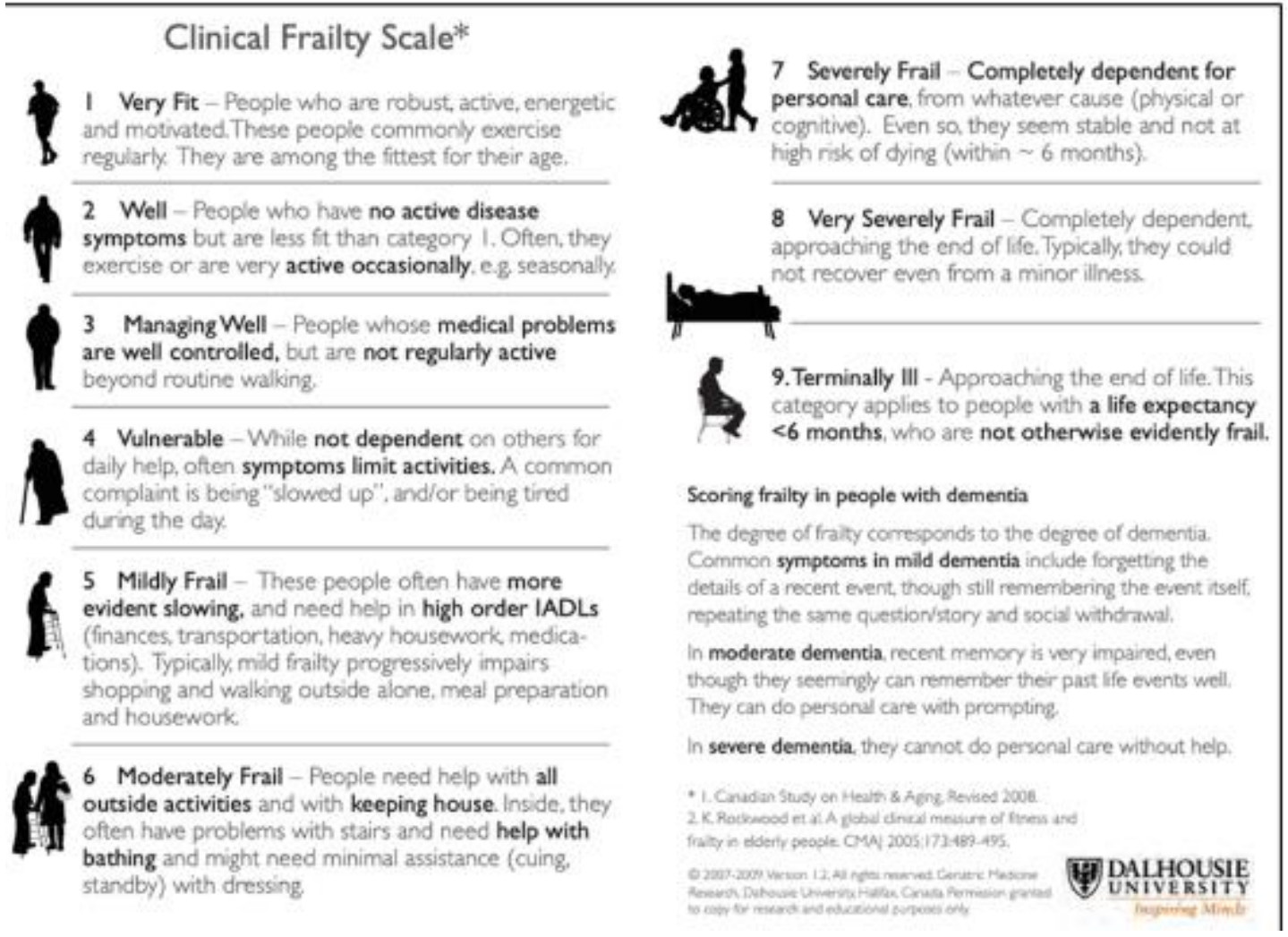
Case finding

Recommended as of: 28/06/2024

Recommendation	Grade	How often	References
Consider screening for frailty as part of an assessment of patients (aged 65–74 **and** who have factors associated with frailty) using a validated rapid frailty instrument suitable to the specific setting or context (refer to Further information).	**Practice point**	Every 1–3 years.	2

Implementing Red Book Recommendations

Clinical Frailty Scale



Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging. Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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Fried Phenotype (≥3 out of 5)

- **Unintentional weight loss (≥4 kg in the past year)**
- **Self-reported exhaustion**
- **Weakness (reduced grip strength)**
- **Slow gait speed**
- **Low physical activity.**

Primary Sense (cumulative deficit) soon to be validated

Red Book recommendations

GoldNet Research

Preventive activities and advice

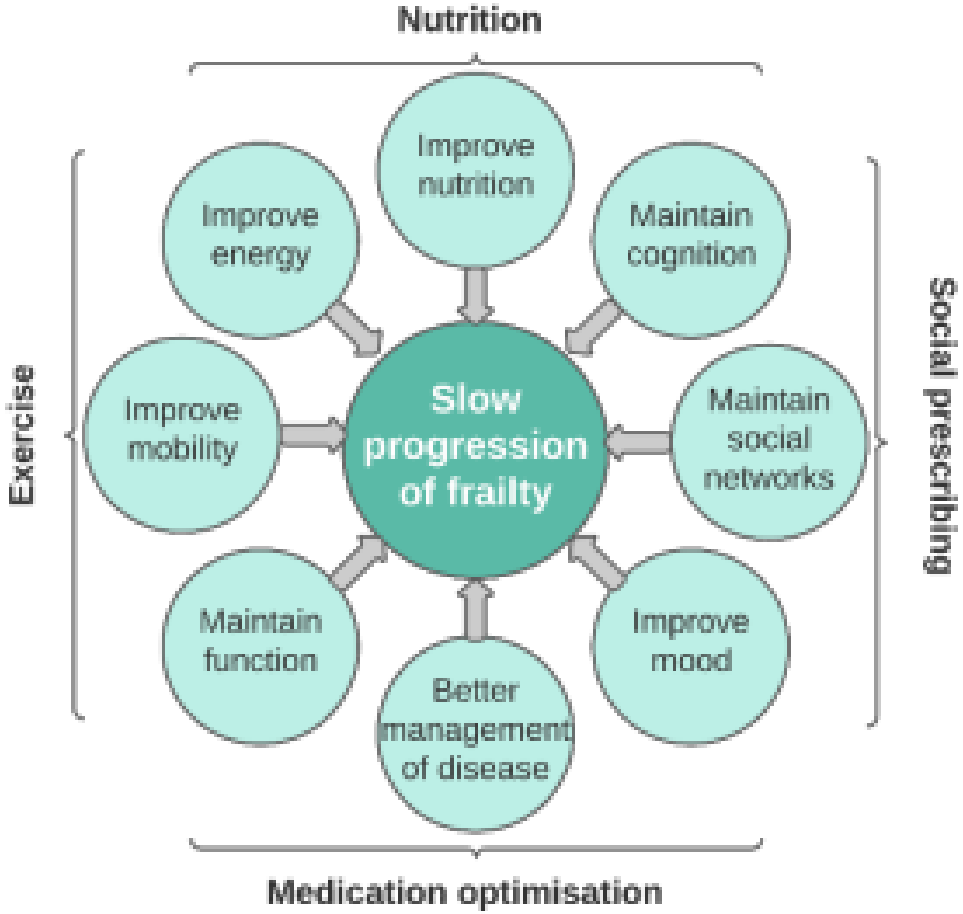
Recommended as of: 28/06/2024

Recommendation	Grade	How often	References
To slow or reverse the progression of frailty: • offer a multi-component progressive physical activity program, including resistance and aerobic exercise; consider early involvement of a physiotherapist or exercise physiologist if possible • encourage optimised nutrition • provide medication management • encourage enhanced social connectedness.	**Practice point**	N/A	2

Ref 2: Physical Frailty: ICFSR International Clinical Practice Guidelines for Identification and Management. J Nutr Health Aging 2019

Local research to reduce impacts of frailty

- Australian Frailty Network
- Hospitalised patient frailty monitoring technology
- FITTEST trial of intense vs self-managed 4-component intervention
- Validation of Primary Sense automated frailty index
- Primary care frailty toolkit



GoldNet Research

What's new in the Red book?

Presentation:

Professor Nick Zwar

Executive Dean, Faculty of Health Sciences and Medicine, Bond University Chair of GoldNet Research Steering Committee

Prostate cancer screening

Prostate cancer screening: what's new in the 10th edition Red Book?

Nick Zwar

Screening for prostate cancer

- Australian and international guidelines emphasise the need for men to be given the opportunity to discuss the potential benefits and harms of PSA testing before deciding whether or not to be tested.
- For men aged 50 to 69 years at average* risk of prostate cancer who have been informed of the benefits and harms of testing and who decide to undergo regular testing for prostate cancer, **offer PSA testing every 2 years**, and offer further investigation if total PSA is greater than 3.0 ng/mL.

*average risk = less than 2.5 times background risk

Screening for prostate cancer

- For men aged 50–69 years with initial total PSA greater than 3.0 ng/mL, offer repeat PSA within 1–3 months. For those with initial total PSA greater than 3.0 ng/mL and up to 5.5 ng/mL, measure free-to-total PSA percentage at the same time as repeating the total PSA.
- Do not offer PSA testing at age 40 years to predict risk of prostate cancer death.
- Advise men 70 years or older that the harms of PSA testing may be greater than the benefits at their age.

Reasons for the changes

- Changes in urological practice, including
  - Use of multi-parametric MRI. MRI is more accurate at diagnosing clinically significant prostate cancers and is recommended in international guidelines as the next step along the diagnostic assessment in men with raised PSA.
  - This approach reduces the proportion of men who require biopsy and also reduces the diagnosis of clinically insignificant disease.
  - Where biopsy is considered necessary, use of trans-perineal biopsy reduces risk of infection.
  - Active surveillance for low-risk prostate cancer reduces unnecessary treatment

GoldNet Research

What's new in the Red book?

Presentation:

Professor Paul Glasziou

Professor of Evidence-Based Medicine & Director, Institute for Evidence-Based Healthcare, Bond University

Cardiovascular Disease

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CVD changes

Previous Edition

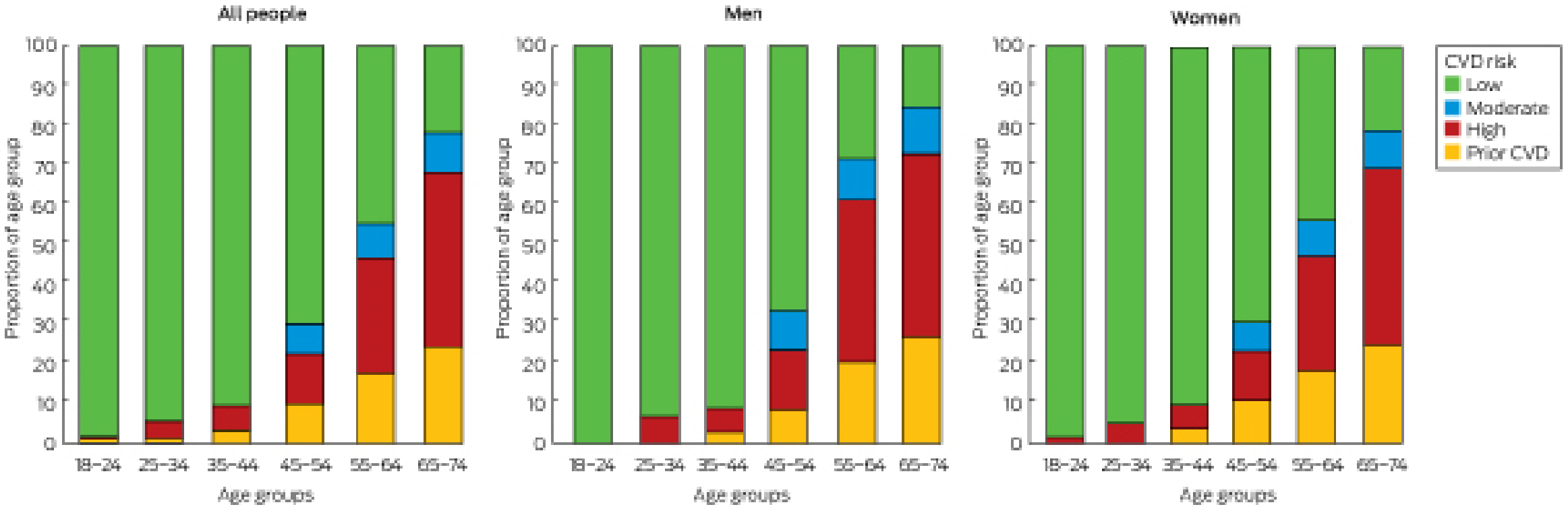
Prevention of vascular disease			
Absolute cardiovascular disease risk assessment	Every two years	Aged ≥35 years for Aboriginal and Torres Strait Islander patients	p 86, Section 8.1
Blood pressure	Every two years	Every 6–12 months for patients with moderate risk and every 6–12 weeks for patients with high risk.	p 87, Section 8.2
Cholesterol and other lipids	Every five years	Every two years for those with increased risk, and 12 months with increased cardiovascular risk and existing chronic disease. Aged ≥35 years for Aboriginal and Torres Strait Islander patients	p 89, Section 8.3
Type 2 diabetes	Every three years	Every 12 months for those with impaired glucose tolerance or impaired fasting glucose. Aged 18 years and older for Aboriginal and Torres Strait Islander patients	p 92, Section 8.4
Stroke	Assess patients with high absolute risk every 12 months		p 94, Section 8.5
Kidney disease	Every one to two years for those at high risk	Aged ≥30 years for Aboriginal and Torres Strait Islander patients	p 96, Section 8.6

New Edition – simplified as BP, Lipids, diabetes part of CVD risk assessment (including stroke)

Activity/topic	Age group													
	15–19	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69	70–74	75–79	≥80	
Cardiovascular															
Atrial fibrillation (AF)	New item					When you check BP; confirm with ECG									Opportunistically
Cardiovascular disease risk	BP only	BP only	BP only	BP only	BP only	BP only									Blood pressure (BP) (18+ years) opportunstically, no more than every two years. CVD risk (age 45 - 79) every five years unless risk factors worsen.

Why start at 45 years? The CVD risk by age

Box 4 – Estimated weighted distribution of 5-year absolute cardiovascular disease (CVD) risk categories for Aboriginal and Torres Strait Islander adults aged 18–74 years, by sex and age group



Calculated with the Australian National Vascular Disease Prevention Alliance algorithm – Calabria, MJA 2018

What about the “legacy effect” of early treatment?

Legacy effect of delayed blood pressure lowering drug treatment in middle-aged adults with mildly elevated blood pressure: systematic review and meta-analysis

Chau L. B. Ho[1,2] · Sharon Sanders[3] · Monique Breslin[1] · Jenny Doust[3] · Christopher M. Reid[2,4] · Barry R. Davis[5] · Lara M. Simpson[5] · Frank P. Brouwers[6] · Mark R. Nelson[1,4]

Received: 7 November 2019 / Revised: 16 February 2020 / Accepted: 26 February 2020 / Published online: 9 March 2020

Abstract

To investigate if there is evidence for a ‘legacy effect’ for blood pressure (BP) lowering treatment, that is, worse health outcomes from not initiating drug treatment at a systolic BP threshold of 140 mmHg in middle-age adults. We systematically reviewed studies comparing the effects of delayed BP treatment (placebo/untreated during the trial or no previous treatment at trial entry) vs. early treatment (actively treated during the trial or previous BP treatment at trial entry) on mortality in the short term (5-year in-trial period) and long term (≥10 years in total period). The data were pooled using Peto ORs. A subgroup analysis by 10-year Framingham risk score was performed. Three studies (ALLHAT, Oslo and PREVEND-IT) involving 4746 participants were included. The results were heavily influenced by the ALLHAT trial. We found no significant difference in all-cause mortality between ‘delayed BP’ and ‘early treatment’ in the short-term OR 0.95 (95% CI 0.68–1.32) or long-term OR 0.90 (95% CI 0.78–1.04), with similar results for mortality from cardiovascular disease (CVD). The effects of delayed BP lowering treatment on long-term all-cause and CVD mortality did not vary with baseline risk of CVD. The review showed no clinically adverse ‘legacy effect’ on mortality or major CVD event from not treating middle-

CVD changes

Previous Edition

Prevention of vascular disease	
Absolute cardiovascular disease risk assessment	Every two years
Blood pressure	Every two years
Cholesterol and other lipids	Every five years
Type 2 diabetes	Every three years
Stroke	Assess patients with high absolute risk every 12 mon
Kidney disease	Every one to two years for those at high risk

Blood pressure

Measure BP on at least two separate occasions with a calibrated mercury sphygmomanometer, or automated device that is regularly calibrated against a mercury sphygmomanometer. For the Australian CVD risk calculator (https://www.cvdcheck.org.au/calculator) , use the average of the last two seated, in-clinic BP measurements, or two measurements at least 10 minutes apart if at the same visit.[2] At the patient's first BP assessment, measure BP on both arms. Thereafter, use the arm with the higher reading.

New Edition – simplified as BP, Lipids, diabetes part of CVD risk assessment (including stroke)

Activity/topic	Age group														
	15–19	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69	70–74	75–79	≥80	
Cardiovascular															
Atrial fibrillation (AF)															Opportunistically
Cardiovascular disease risk	BP only	BP only	BP only	BP only	BP only	BP only									Blood pressure (BP) (18+ years) opportunstically, no more than every two years. CVD risk (age 45 - 79) every five years unless risk factors worsen.

Case Study – 50 year old man CVD risk check

- **Non smoker,** 2 glasses wine most nights
- **No long term medications**
- Overweight 98kg 182cm BMI 29.6
- **Office BP 142/90**
- Fasting cholesterol 6.7mmol/L
- Triglycerides 1.9 mmol/L
- HDL-C 1.4 mmol/L
- LDL-C 4.4 mmol/L
- **TC/HDL-C 4.8**
- Creatinine116 umol/L (60-110)

https://www.cvdcheck.org.au/calculator - not integrated yet ☹

Clinically determined high risk*
Clinical conditions that automatically confer high risk. If either of these apply, you will be redirected to management for high risk category

- Moderate-severe chronic kidney disease
- Familial hypercholesterolaemi
- [x] Neither present

Age* 50

Sex at birth* Female

Smoking status*
- (•) Never smoked
- Previously smoked
- Currently smokes

Systolic blood pressure* 142

Ratio of total cholesterol to HDL cholesterol* 4.8
OR enter mmol/L

Use of CVD medicines within last 6 months*
- Blood pressure-lowering medi
- Lipid-modifying medicines
- Antithrombotic medicines
- [x] None

History of atrial fibrillation
- (•) No

Australian CVD risk calculator

AusCVDRisk is a risk assessment, communication and management tool for health professionals. To learn more about how this calculator works, refer to the **Australian Guideline for assessing and managing cardiovascular disease risk**.

✓ Enter variables | 2 Consider reclassification factors | 3 Discuss risk result & management

3%
Low risk

0% | 3 | 5% | 10% | 15%
Low Risk | Intermediate Risk | High Risk

Consider reclassifying down a category if
- Coronary artery calcium score of 0
- East Asian ethnicity (Chinese, Japanese, Korean, Taiwanese, or Mongolian ethnicities)

Consider reclassifying up a category if
- Coronary artery calcium score > 99 units, or ≥ 75th percentile for age and sex
- First Nations people

Clinically determined high risk*

Clinical conditions that automatically confer high risk. If either of these apply, you will be redirected to management for high risk category

- [ ] Moderate-severe chronic kidney disease
- [ ] Familial hypercholesterolaemia
- [x] Neither present

Age* 50 Years

Sex at birth*

- ( ) Female
- (•) Male

Smoking status*

- ( ) Never smoked
- ( ) Previously smoked
- (•) Currently smokes

Systolic blood pressure* 142

Ratio of total cholesterol to HDL cholesterol* 6.7

OR enter mmol/L

Use of CVD medicines within last 6 months*

- [ ] Blood pressure-lowering me
- [ ] Lipid-modifying medicines
- [ ] Antithrombotic medicines
- [x] None

History of atrial fibrillation

- (•) No

Smoker; HDL of 1.0mmol/l

In people with an intermediate risk (5% to <10%) of a cardiovascular event within 5 years, who are not receiving pharmacological treatment to reduce CVD risk, reassess after 2 years. Reassess earlier if any of the following apply: • the most recent risk assessment was close to the threshold for high risk (≥10%). • risk factors worsen • new CVD risk factors are identified.	Conditional	Very low

s, refer to the

6%

Intermediate risk

Consider reclassifying down a category if

- [ ] Coronary artery calcium score of 0
- [ ] East Asian ethnicity (Chinese, Japanese, Korean, Taiwanese, or Mongolian ethnicities)

Consider reclassifying up a category if

- [ ] Coronary artery calcium score > 99 units, or ≥ 75th percentile for age and sex
- [ ] First Nations people

Panel Discussion

What's new in the Red book?

Our Panel:

Professor Mark Morgan
Professor of General Practice
Head of Medical Doctorate
Faculty of Health Sciences and Medicine,
Bond University

Professor Nick Zwar,
Executive Dean, Faculty of Health Sciences and Medicine, Bond University
Chair of GoldNet Research Steering Committee

Professor Paul Glasziou
Professor of Evidence-Based Medicine & Director, Institute for Evidence-Based Healthcare, Bond University

Chair:

Assistant Professor Laura Baxter
Clinical Practice Assistant Professor, Medical Program, Faculty of Health Sciences & Medicine, Bond University & Secretary, General Practice Gold Coast

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GoldNet Research - Online Journal Club
A member-selected Red Book topic

Scan the QR code to vote on the topic of our next journal club, or email goldnet@bond.edu.au

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Current Projects

e-HANDI - Feasibility & Acceptability Study

- The Institute for Evidence-Based Healthcare at Bond University invites you to participate in a pilot trial to understand the **feasibility and acceptability** of the recently co-designed “e-HANDI” for prescribing NDIs at point of care.
- Based on the RACGP **Handbook of Non-Drug Interventions**, e-HANDI has been **co-designed with GPs** and consumers.
- GPs will be asked to implement and use e-HANDI in their usual practice and complete feasibility and acceptability surveys and a short interview at the end of the study.
- **Compensation** and **CPD points** can be claimed

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Handouts available with QR code and email address to send EOI

Current Projects

Targeting Treatable Traits in COPD to Prevent Hospitalisations (TERRACOTTA)

- In the TERRACOTTA trial, disease management targeting treatable traits will be delivered by an **interdisciplinary team** of GPs, PNs, pharmacists, physiotherapists and other allied health professionals.
- This **cluster randomised trial** will offer tailored interventions targeting treatable traits in COPD in individuals at risk of exacerbations, to improve quality of life and avoid hospitalisations.
- Investigators are seeking expression of interest from general practice clinics with at least **500 patients** in their database and that have a **practice nurse** or are able to accommodate a practice nurse, to deliver the tailored intervention targeting treatable traits in COPD or provide usual care.

Scan the QR code for more

MONASH University

Current Projects

Understanding the Diagnosis And treatment of Secondary Hypertension (U-DASH)

- As leading clinicians managing hypertension, researchers from Monash University want your expert opinion on **how to better support the diagnosis and treatment of secondary hypertension**.
- You are eligible to participate if you are a primary care practitioner (**GP or nurse practitioner**) or **trainee** practising in Australia.
- Participation involves a short screening survey, followed by (if eligible) a **30-45 minute interview**.
- Interview participants will receive a **$100** gift voucher.

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What's new in the Red book?

Thank you!
Please scan the QR code for the event evaluation survey.

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