PRACTICE OBSERVED

Practice Research

Prevention of cardiovascular disease in general practice: a proposed model

ERIK E ANGGARD. JOHN M LAND. CHRISTINE J LENIHAN. CHRISTOPHER J PACKARD. MELVYN J PERCY, LEWIS D RITCHIE. JAMES SHEPHERD

Abstract

A screening model based in general practice for the detection of subjects at risk of premature cardiovascular disease is described. Opportunistic screening is performed by a trained nurse who also gives initial advice on management. Immediate feedback to patients is possible since a rapid dry chemistry exchingules is used analysis of data are achieved using a microcomputer. A central deidentified databack is incorporated to allow epidemiological studies and intervention strategy evaluations to be made. Nine-teen health centures have evaluated the model, and 40 000 subjects have been screened; 10% had dassiotic blood pressures of over 95 mm Hg and 15% had a blood cholesterol concentration over 7 mmod (1270 mg 100 ml) and 25% over 9 mmod (1477 mg 100 ml). The initial data suggest that the model is acceptable to both health centre personnel and the general public and that the offer of screening is taken up by all elements of the target population.

Medical Department, Bestol-Myers Pharmaceuticals, Usbridge UB18 BNS BRIK E ANGGARD, run wu, director of research and development JOHN MI AND, ass. run: ardiovasular medical advisor (HRINTINE) LENHIAN, sus. nursing advisor MELVNY) PREIV, winner, press, transper

Department of Biochemistry, Glasgow Royal Infirmary, Glasg (HRISTOPHER J PACKARD). 80. PHD. principal biochemist JAMES SHEPHERD, 80. PHD. reader

The Health Centre, Peterhead AB4 6XP
LEWIS D RITCHIE, MRCGP, MH M, general practitioner

Correspondence to: Dr Ritchie.

Introduction

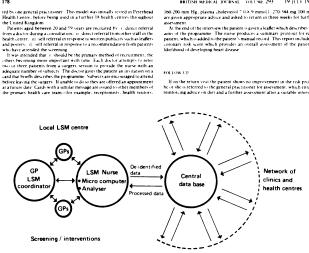
Coronars heart doesaes is the primary cause of death in industrialised countries, accounting for 27%-of all mortality in England. It places a considerable burden on the resources of the primary health care system in Britain, which at present mainly trates exhibited dilness rather than prevents potential disease. Several major risk factors contribute to the development of premature cardiovas-cular disease such as hypertenson, hypercholesteroleema, smoking, and a second product of the product of the

The model is designed to be used in large health centres (fig. 1... A room is set aside which accommodates a specially trained nurse and equipment Screening takes place during normal surgery hours and overall is coordina-

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160-200 mm Hg, plasma sholesterol 7-0.8 9 mmol 1-270-444 mg 100 ml are given appropriate advise and asked to return in three weeks for turther assessment. The proposed process of the programme of the forest produce a summary printing the arms of the programme. The nurse produce a summary printing for each patient, which is added to the patient in amount return of the programme and the produce a summary printing for each patient, which is added to the patient is manual record. This report includes a coronary risk score which provides an overall assessment of the patient's likelihood of developing heart deserved.

If on the return visit the patient shows no improvement in the risk profile he or she is referred to the general practitioner for assessment, which entails reinforcing advice on diet and a further assessment after a suitable interval



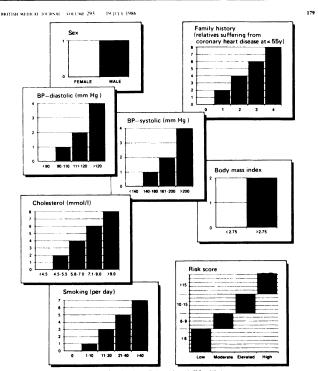
110.1 The litestyle management. LSM: model

and other nursing staff who also participate in patient recruitment. The case records of patients who have been screened are annotated with a coloured sticker.

ation. If the procedures can be accomplished within 10 minutes. The nurse iscusses the findings with the patient and offers specific advice, using all from the Health Education Council and diet sheets. The advice egives reflects health centre policy and practice. Superior presents with weretry raised blood pressure: (dastolic >120 specific procedures) of the procedure of the procedure of the procedure of the month (147 mg) from the patients in referred mimediately to his or nearly practitioner. Patients who have smaller increments in ablood of and cholestered concentration (dastolic 95-110 mm Hg, systolic

mmol J 200 mg, 100 m.

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to risk. It is difficult to unravel the independent part played by body mass index, but because of its value in the Pooling protect, we have included it beer as a madex contributor to overall risk. The relations between family between and coronave risk, though generally accepted, in on well-defined. We under the age of N Sears—which approximately equals that which would be obtained from a high-cholestered concentration or a high blood pressure. The association between cholestered concentration to blood pressure and soronave risk differs between the series, and to account for this we increase the overall score for a man by one Stretch speaking, these data apply only to developing richardine, contains vascular decision in a symptomistic population. The care therefore only applications with earlier in asymptomistic population.

The study is practicable because of the use of microcomputers for the large volume of data collected. Consequently, each health centre excupped with an Aprico XL (OE. This has three and Aprico XL (OE. This has three minimised. It is a study of the properties of a patient's response to intervention in readily available, and cold are treated in rapid and unique. At weekly intervals the nurses make a copy of the patient data on disterties and forward than to a central data leads where the patient data on disterties and forward than to a central data leads where the patient data on disterties and forward than to accurate data leads where the patient data on disterties and forward than to central data leads where the control destination cannot an addition are passed to the central facility to maintain confidentiality.

BRITISH MEDICAL JOURNAL VOLUME 293 19 JULY 1986 Screening NURSE Follow up

Results

The health seritors together can screen 1800 patients a week, and or lar serie 40000 patients have perturbated. As fig. 35 Nows reterrals by the North Second Town 470 of the told. The Second more method of recruitments by recommendation from trends or relative.

Of the subservision was even over the range 50-05 years. Fewer men, and the age distribution was even over the range 50-05 years. Fewer subsers in their transitions of the second more than 1800 per second to the second more than 1800 per se

Discussion

The medical profession continues to debate the relative merits of the two approaches to attacking coronary heart disease. One approach is to search out individuals at high risk, whereas the other is based on population wise declarational strategies. "The model presented here adopts the former methic are setting as an immediate meritary and approaches to the program that care setting as an immediate at interview. This has been made possible only by advances in information handling and biochemical analysis. The model addresses many of the recommendations in the Canterbury report." Central to the working of the model is a specially trained practice nurse, to whom the initial screening and follow up of the patients has been delegated. The extended role of the nurse in primary care remains controversial. "Our preliminary results, however, suggest nurse can their details of a patient's lifestyle, record risk factors, and offer appropriate advice.

The model has several distinctive features. The patient has immediate feedback on his or her level of risk, which is achieved without a formal interview with the doctor. Such a procedure may circumvent many of interaction implies. "Mocovers, a large percentage of the population can be servered, reassured, and in many cases

adequately counselled by the screening nurse without making extra demands upon general practitioners' time, which is already heavily committed [8]. The model is flexible and allows the development of health, centre policy and practices which reflect local vesepoints on particular treatment strategies, both in cardiovascular and in other disorders that are related to lifestyle. There is soope for multidisciplinary participation in the model, and although it was initially designed so that a trained nurse would perform the primary screening, others such as dictitians can undertake this. The use of the microcomputer for information processing and retrieval permits efficient follow up of patients who are identified as having an increased risk of cardiovascular disease. The central database provides interesting possibilities for research for both local and national intervention initiatives and strategies.

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