



The Patient, The GP, The Primary Care Team; their relationship, adherence to treatment and the implications for research



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INTRODUCTION

Arterial Revascularisation Trial (ART) is a multicentre, international, RCT; funded by both the MRC and the BHF

Aim is to evaluate whether using both IMA's during CABG improves survival and reduces the incidence of recurrent chest pain and/or further intervention, compared to using a single IMA

Patients are followed up yearly, by telephone and post, for ten years

Identified some points of interest:

- *Patient's non-adherence to medication and treatment post discharge following CABG*
- *Variation in GP's monitoring of cardiovascular risk*
- *Implications for research*

I have used the data from our cohort of 427 patients and have chosen to look at aspirin and statin MEDICATION and GP SURGERY VISITS

ART TRIAL

- 3102 Patients Recruited
- 28 Centres in 7 Countries
- Largest randomised trial of two cardiac surgical operations with a 10 year follow up in cardiac surgery
- Proposed ↓ in further interventions aims to ↑ QOL and have a direct economic benefit

FIGURES

- Sixth National Adult Cardiac Database Report (Blue Book 2008) CABG makes up 58% of all cardiac surgery
- However pts still at risk of CHD
- Therefore secondary prevention **VERY IMPORTANT**

PREVENTION

- Reports by NICE and ESC/EACTS guidelines on myocardial revascularisation
- Reinforce importance of RISK FACTOR MODIFICATION e.g. diet, smoking cessation, exercise
- Also PHARMACOTHERAPY e.g. Beta Blockers, Statins, ACE

TOLME et al (2006)

- Pt experiences and perceptions of health at 7yrs
- Non-adherence to medication, problems with diagnosis, effectiveness of medication, concern about side effects, 'experimenting' with medication, little knowledge of 'therapeutic benefits'
- Few modified their behaviour some patients either only in the short term or only one as they felt advice was often contradictory

HOBBS and ERHARDT (2002)

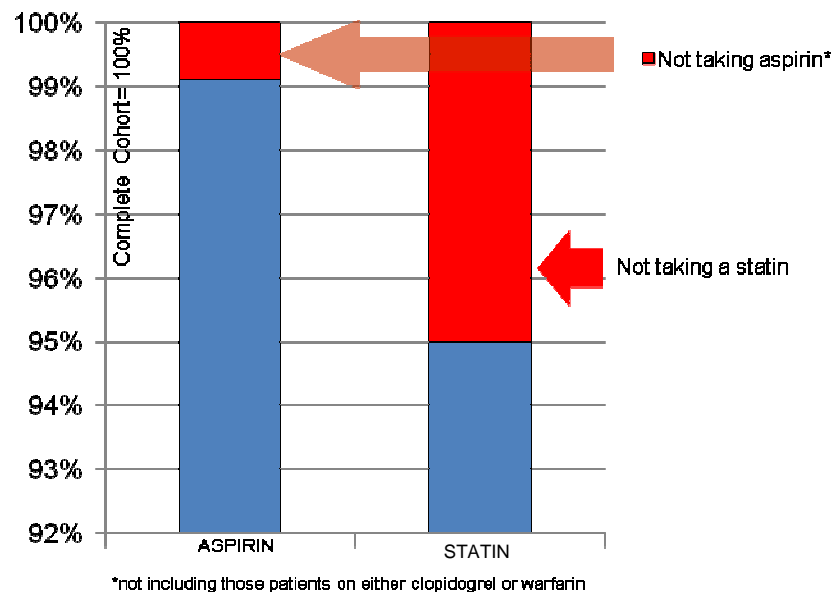
- Looked at how GP's in 5 European countries, France, Germany, Sweden, Italy and the UK, viewed and implemented guidelines on CHD
- Found that although they recognised them adherence was poor
- Reasons being time and financial constraints
- Recommendations of practicing 'preventative cardiology'
- QOL framework set up in UK

ART TRIAL

- ART secondary end points include examining the need for reintervention, clinical events and cost effectiveness
- Statistics from BHF database found that CHD costs the UK £7 billion/yr
- 27% directly attributed to health care costs

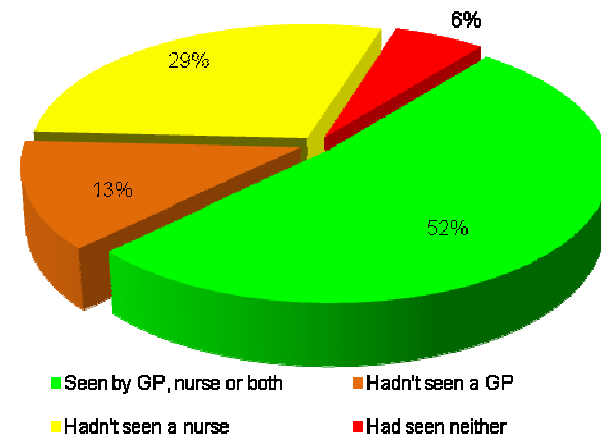
Therefore this vital 'therapeutic relationship' may be a variable which could influence the interpretation of results

ART DATA OXFORD – 427 patients



MEDICATION

- Some pts had stopped their medication due to unwanted side effects and had not informed their GP e.g. muscle problems with statins
- They had little knowledge of the importance of their medication
- Others had their GP stop it due to current contraindications but had no idea of when it would be restarted



VISITS

- Some had not seen a GP within twelve months and had received no blood tests, BP check or medication review. This could be due to either the GP surgery not performing these as a routine review or the patient not attending, despite several reminders.
- This left little opportunity for risk factor discussion
- Others had seen the nurse

CONCLUSIONS

- Discrepancies in health care management by pt and GP
- Pt's responsibility to take 'ownership' for their health
- GP's responsibility to carry out cardiovascular checks

FUTURE CONSIDERATIONS

- ❑ What percentage of follow up data is affected by the patient's non-adherence and the GP's varying adherence to treatment and guidelines respectively?
- ❑ How significant is this when analysing cardiac events, readmissions and reinterventions?

Is this an area yet to be explored...?