THE ROLE OF THE GP IN THE FOLLOW UP OF WOMEN WITH GESTATIONAL DIABETES

Dr Andrew Pennington

University of Melbourne, Dept of General Practice and Primary Care  
Bogong Regional Training Provider

Gestational Diabetes (GDM) affects about 3-5% of Caucasian pregnant women, and may be greater in other ethnic populations. These women have an approximately seven fold increased risk of subsequently developing type 2 diabetes (T2 DM). Given this increased risk it is important that we understand what factors may be involved in developing T2DM for this sub population and hence attempt to prevent or delay the onset of disease.

Currently there is no consensus on exactly who should follow up women with previously diagnosed GDM, when they should be reviewed and how best they can be advised to prevent the onset of T2DM. Literature review of the current guidelines for GDM in Australia, USA and UK, has revealed a range of different follow up guidelines. A “treatment gap” exists in this area, with potential for further research, development of evidence based guidelines and potential interventions especially in general practice and primary care.

A qualitative project, comprising interviews of women who have had GDM, focussing on the themes of follow up, barriers and enablers to care and their satisfaction with current care is being undertaken. Interviews will be thematically analysed, sampling will be purposive. The second phase of interviews will be of general practitioners providing care to these women exploring issues of follow up, future screening, ongoing management and practicalities of guideline implementation. Preliminary results will be available for discussion.
Overlapping relationships have a profound influence on doctors, especially in rural communities. Doctors who live and work in rural communities are more likely to interact with patients, as friends, employers, fellow parishioners, school parents or customers. The doctor patient boundary can become blurred easily.

Most studies on overlapping relationships have occurred in the fields of psychiatry and psychology. There has only been 1 study on their effects on general practitioners and none in Australia. We conducted in depth qualitative interviews on rural general practitioners in North Eastern Victoria, to assess the nature of these relationships and their effects.

The conclusions of the study can then be applied to general practice registrar training to enable future GPs to be better prepared for life as a rural GP.
DOES HAVING A PERMANENT RURAL GP AND POC TESTING REDUCE THE NUMBER OF RFDS RETRIEVALS IN A SMALL TOWN?

Dr Gerard Considine ¹, ², ³, Dr Scott Lewis ², ³, Mrs Vicki Coulls ³

¹ Adelaide to Outback GP, ² Wudinna Medical Practice, ³ Wudinna Hospital

Background
For many small towns on the Eyre Peninsula in South Australia, patients requiring urgent medical treatment beyond the scope of the local doctor and hospital are transferred to by air to Adelaide. For a period between 2004 and 2008, one such town was without a regular doctor. During this time, Wudinna was staffed by a rotating list of locum doctors. This project aims to address the question “does having a permanent doctor and point of care (POC) testing reduce the number of retrievals?”

Methods
The total number and type of Royal Flying Doctors Service (RFDS) retrievals from Wudinna have been collected over a period of over 10 years. Data were obtained from both Wudinna Hospital archives and RFDS Central Operations. The rate, case mix and acuity of retrievals were plotted temporally against the type of doctor (permanent/locum) working and also when different POC tests were introduced. Statistical analysis was performed using SPSS and Excel software.

Results
The current data suggest that once a permanent doctor had been established in, the number of retrievals was reduced. We will also present that the introduction of POC testing such as i-STAT and Rapid TropT in a small town can also impact on the number of types of retrieval and the rate.

Conclusion
Small country towns will always disadvantaged by limited resources and tyranny of distance. However, with a permanent doctor who knows the population armed with accurate and timely investigations, the number of retrievals required can be considerably reduced. This study shows that over a 10-year period, a greater number of patients were treated in the Wudinna Hospital without needing expensive and often unnecessary transfer to Adelaide.
HAEMOCHROMATOSIS: UNDER-DIAGNOSED BY HOW MUCH? A DECADE OF HFE TEST RESULTS IN BANANA SHIRE, CENTRAL QUEENSLAND

Dr Katie Goot

1 University of Queensland Rural Clinical School, 2 ACRRM Registrar, 3 Biloela Medical Centre

One in 200 Caucasian Australians is homozygous for the C282Y HFE mutation. Early diagnosis, though challenging, can prevent morbidity and mortality. Clinical suspicion is paramount as there is no population screening program.

Medicare benefits for HFE mutation testing were introduced in 1998 for cascade screening and investigation of abnormal iron levels. Over 509,000 HFE tests were billed to Medicare from 1998-2011.

There is no single database of HFE test results. Results are held by individual doctors, hospitals, pathology laboratories and research programs. Theoretically, it is a once in a lifetime test.

Purpose
To determine the gap between expected and observed C282Y homozygotes in a rural and metropolitan population identified HFE genotypes in both populations the number of duplicate HFE tests performed

Design
Pre-existing de-identified HFE test results were requested for all patients in two populations for the decade January 2001 – December 2011, restricted by postcodes. Data was sourced from one public and two private pathology companies who provide most of Queensland’s services.

The rural population was 15,500 people from Banana Shire, and the metropolitan population was 95,300 people from selected Brisbane suburbs, with both sharing similar demographics (www.oesr.qld.gov.au).

Implications
Results from this research will expand knowledge about the existing pattern of HFE gene test results, and provide a basis to comment on both adequacy of existing methods of haemochromatosis identification and the quantity of undiagnosed disease.