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Zagreb
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Pod visokim pokroviteljstvom
predsjednice Republike Hrvatske Kolinde Grabar Kitarović
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Hrvatske komore medicinskih sestra

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DEPRESCIBING AND WHAT PATIENTS WITH POLYPHARMACY THINK OF IT

Sven Streit¹



ABSTRACT

Polypharmacy has become a consequence of the increased prevalence of patients with multimorbidity. Patients on too many drugs or drugs with more risks than benefits suffer from more hospitalizations, contribute to higher health care costs and often report a lower quality of care. General practitioners (GPs) are a center stone in optimizing polypharmacy, starting the necessary and stopping or reducing the unnecessary medication, a process defined as ‘deprescribing’. In recent years, several studies and even first randomized-controlled trials came to light to assess the benefits and safety of deprescribing. However, these studies also reported implementation issues, the barriers and facilitators to deprescribing in both GPs and patients.

This talk focuses on the reasons for polypharmacy and the rapidly growing evidence of deprescribing, with a special focus on what GPs and patients think of deprescribing. The aim is for GPs to learn from several national and international initiatives how to implement deprescribing in their clinical work and how to approach their patients to implement a patient-centered medication review to facilitate deprescribing.

Prof Sven Streit, MD, MSc PhD, is a practicing GP in a rural community and an Assistant Professor in Primary Care at the University of Bern, Switzerland. In addition to his work with patients, he conducts medical research and promotes the GP specialty to young doctors, e.g., through attractive postgraduate GP training programs. He actively teaches medical students, nurses, residents and young GPs. Prof Streit is an ex-president of the Swiss Organisation of Young GPs (JHaS, www.jhas.ch) and served as the chair of the European Organisation of Young GPs (VdGM, www.vdgm.eu).

Prof Streit was promoted to a medical doctor (MD) and Senior Lecturer at the University of Bern. He is board-certified in General Internal Medicine and Primary Care, and trained in epidemiology (MSc) at the London School of Hygiene and Tropical Medicine (www.lshtm.ac.uk) and at Leiden University (www.universiteitleiden.nl) in the Netherlands (PhD). He leads international collaborative research projects to optimize polypharmacy and implement deprescribing (he is the PI of the OPTICA and LESS study and others) and represents Switzerland in the European General Practice Research Network (EGPRN, www.eprn.org).

¹ PhD, Assistant Professor in Primary Care at the University of Bern, Switzerland
E-mail: sven.streit@biham.unibe.ch

PREVENTING STROKE IN ATRIAL FIBRILLATION AND THE CONTRIBUTION OF PRIMARY CARE RESEARCH

Professor Richard Hobbs¹



ABSTRACT

Background importance of atrial fibrillation. Atrial fibrillation (AF) is the most common cardiac arrhythmia, present in around 1% of the population and 7% of over 65's,¹ with US data suggesting incidence may double by 2050.² The most important clinical significance of AF is the associated five-fold increase in the risk of stroke. Furthermore, AF-related strokes tend to be more severe and have higher mortality.³ However, AF related strokes are potentially preventable.

What is the evidence base for preventing stroke in atrial fibrillation?

There is a huge evidence base to support guideline recommendations in relation to AF and stroke risk. The treatments that modify stroke risk are confined to anticoagulants, but with a big relative treatment effect, and key primary care trials have shown the benefits even in the elderly and the lack of beneficial effect of aspirin.

The relative benefits of treated AF with anticoagulation are best determined by risk stratifying patients with AF on the basis of their CHA₂DS₂-VASc score. Despite this evidence base, many AF patients at high risk of stroke do not receive treatment.

Screening for atrial fibrillation. One area under much debate is whether we should adopt population-based screening for AF as part of a public health initiative, since AF meets many of the National Screening Committee (NSC) criteria. Several factors have led to an increased interest in AF screening:⁴

- The prevalence of AF is increasing due to a combination of population ageing, changing patterns of risk factors and improved survival rates in other, contributory forms of cardiovascular disease.
- Newer treatments are available in the form of Direct Oral Anticoagulants (DOACS) which are probably safer and as effective in elderly patients with AF as the existing treatment mainstay of Vitamin K antagonists, but simpler to use, albeit at a higher cost.
- A number of relatively inexpensive screening devices for detecting AF in the community have been developed and the field may evolve rapidly as new technologies and algorithms emerge.

The most recent European Society of Cardiology (ESC) guidelines recommend opportunistic screening for AF by pulse taking or ECG rhythm strip in patients >65 years of age.⁵ This was based on a primary care study - previously undiagnosed AF was found in 1.4% of those aged >65 years, suggesting a number needed to screen of 70.¹

This presentation will describe the burden of atrial fibrillation, its importance in stroke, and summarise the risk reduction options for GPs and patients. I will also consider the debate on AF screening and what this means for general practice. Primary care studies, led by the speaker, have substantially informed this evidence base in relation to the epidemiology, the best treatment options,⁶ and the most cost-effective method of screening for AF¹ and these data will inform the talk.

¹ University of Oxford, UK

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WHAT AND HOW TO TEACH MILLENIALS

Igor Švab¹



ABSTRACT

Millenials (generation y) is a generation following the x generation. There are no precise dates for when this cohort started or ended; demographers and researchers typically use the early 1980s as starting birth years and the mid-1990s to early 2000s as ending birth years.

They are often described as problematic children, who want instant gratification and lack endurance, maturity, and a good work ethic. Because of that, they are considered problematic as learners.

They have grown up with high-speed Internet which enables them to have instant access to all sorts of information. They have access to knowledge at a level unseen by any generation. This is a revolution similar to the invention of the printing press.

In approaching the issue of teaching them, one must consider that they will enter an era of civilization where work will change to tasks which cannot be performed by machines.

This means a need for radical change in education, especially the goals and methods. In the future, less emphasis will have to be put on teaching facts and more on teaching skills and attitudes. Teaching methods should involve the use of modern technologies and should be more active. Practical work will become more important, which is an opportunity for family medicine.

Teachers will probably have to drastically change their teaching methods and assessment, which involves a huge amount of work. Moreover, teachers will have to abandon their position of authority and realise that this generation is much more skilled than expected. They will also face their own weaknesses in the modern world.

¹ Professor, Faculty of Medicine, University of Ljubljana
E-mail: igor.svab@mf.uni-lj.si

CONSTRUCTION OF VALID AND RELIABLE DIAGNOSTIC HYPOTHESIS IN FAMILY MEDICINE

M. Mumtaz Mazıcıoğlu¹

ABSTRACT



Previously, medical practice was based on therapeutic interventions. Improvements in scientific literature and developed medical technology based on these improvements have provided opportunities for early intervention which, at least, may alleviate the symptoms or, at most, eradicate disease. It was the development of basic medical sciences which provided the opportunities of establishing right diagnosing procedures. Then, an inability to establish a full (100%) diagnosis for a great variety of disorders related to confounding factors even in cases of a unique disease process led us to criticizing our diagnostic procedures for validity and reliability. Improvement in basic sciences gave us much more

precise tools to improve our diagnostic abilities. On the other hand, both the difficulty in establishing valid diagnoses with the provided highly precise tools and a coexistence of several disorders require progressive and frequent updates of clinical practice guidelines.

Precision in our measures (determined by standard error), the validity of a diagnostic sign or symptom (determined by specificity), and the reliability of our diagnostic decisions (determined by inner- or inter coefficient of variation) may be regarded as the preliminary tools to be checked frequently in the diagnostic decision process. In addition to these preliminary tools we must also consider that in a multilevel or multi parameter decision process, the total error is calculated, not by addition, but by the multiplication of error frequency in each parameter or level. Even in the genetic diagnostic process above, mentioned fundamental measures limit us in establishing an absolute diagnosis. Recent improvements in genetic laboratory testing provided the opportunity of receiving a laboratory test result in a couple of days at relatively low costs compared with tests performed in the recent decades. Even in this genetic testing process it is stated that the genetic material in centromeres and telomeres does not completely appear in laboratory results which correspond with about 900 unique genes. The coexistence of several genetic structural deficiencies for a given disease is another characteristic that may increase the probability of diagnostic errors.

In case of psychiatric disorders establishing a diagnosis may not be precise, valid for a certain disorder, or reliable neither internally nor externally. Even for some relatively newly described disorders like restless leg syndrome, defining a certain condition may not be easy, precise, completely valid, nor reliable.

From the clinical point of view, evidence based guidelines are necessary to establish the right diagnosis and give the most appropriate treatment or describe a preventive measure for all clinicians. They are documents relieving us from our incorrect diagnosis-anxiety and providing quality healthcare service to individuals whom we are responsible for in their health and disease statuses. Over-diagnosing, over-treatment, over-medicalization and misuse may be great obstacles in our future practice.

¹ Erciyes University, Medicine Department
E – mail: mumtaz33@hotmail.com

THE HISTORY OF FAMILY MEDICINE IN TURKEY, CURRENT PROBLEMS AND THE STATUS OF GUIDELINES IN PRIMARY HEALTH CARE

İlhami Ünlüoglu¹



ABSTRACT

The term “Family Physician” was used by I. Ethem Murat in an Ottoman translation book in 1891. Specialization in Family Medicine was included in Physician Specialization Regulations by 05.07.1983. According to the regulation, the legal mandatory minimum duration of FM residency training is 3 years and it consists of block rotations of five major departments; internal medicine, pediatrics, obstetrics and gynecology, surgery /emergency medicine, and psychiatry.

The first Family Medicine Department was set up in 1984 and family medicine specialization education started in the Ministry of Health Education Hospitals by 1985 in Ankara, Istanbul and Izmir.

TAHUD (Turkish Association of Family Medicine) was established in 1990 to serve as a professional organization for family physicians (FPs) (specialists with vocational training) and to improve the academic clinical discipline of FM.

According to YOK (The Council of Higher Education of the Republic of Turkey) decree from 16 July 1993 (number: 12547), it is suitable to set up family medicine departments in medical faculties. On 17 September 1993, Family Medicine Department was set up and resident training started at Trakya University. Family physician specialists started to be included in academic personnel in 1994.

Journal of Turkish Family Medicine has been published since 1997 as a refereed journal. National Family Medicine Conferences have been organized since 1993.

“Law in Family Medicine Pilot Application” in 2004, and “Ordinance in Family Medicine Pilot Application” in 2005 were the first steps in education, the latter as a ten-day course based on fundamental requirements to work in primary care as a family doctor. The Pilot Application started in Duzce in 2005 and the new system covered the whole country in 2010.

Our current problems are: an insufficient number of family physicians, too few specialists and excessive workload showing that the system is not yet fully adjusted.

In our country guidelines are not for PHC, they are usually for secondary/tertiary health care hospitals. We need guidelines for PHC.

¹ Prof., Eskişehir Osmangazi University, Medical Faculty, Department of Family Medicine, Eskişehir/Turkiye
E-mail: iunluog@yahoo.com

GUIDELINES AND MINDLINES IN THE DIGITAL AGE

Alan Shirley¹



ABSTRACT

The original conception of evidence based medicine (EBM) was of the integration of the best available evidence with clinical expertise incorporating patients values and preferences. In the early days of the EBM movement the problems were overvalued experts and the inaccessibility of good quality information nowadays the problems are the deluge of overvalued information and the under appreciation of clinical expertise, throughout the patient perspective is almost completely absent. Greenhalgh et al have produced a critique of EBM and called for “real” evidence based medicine which makes the ethical care of the patient its top priority, is characterised by expert judgment rather than mechanical rule following, shares decisions with patients through meaningful conversations, builds on a strong clinician-patient relationship and the human aspects of care, and demands individualised evidence in a format that clinicians and patients can understand.

Information sources have been transformed since the early days of EBM Google and Wikipedia compete with traditional sources but have been shown to be surprisingly effective. GP trainees in Australia and the Netherlands accessed a variety of information sources on and off line.

There is a powerful body of evidence, mainly from cognitive psychology, about how humans make decisions. This is often not taken into account when considering clinical reasoning. Stanovich proposes three forms of processing Type 1 intuitive processing, Type 2 processing divided into algorithmic and reflective.

Gabbay and LeMay’s concept of “mindlines” provides an understanding of the mechanism behind the development of empirical individual and team based ways of informing clinical decisions in situations of complexity and uncertainty. In 2004 they described mindlines as “collectively reinforced, internalised tacit guidelines, which were informed by brief reading, but mainly by their interactions with each other and with opinion leaders, patients, and pharmaceutical representatives and by other sources of largely tacit knowledge that built on their early training and their own and their colleagues’ experience.” In 2015 a systematic review of mindlines concluded that mindlines are more than information; they can be individual and collective. Crucially they are more than heuristics, shortcuts, or rules of thumb; rather they are the application of tacit knowledge with practical wisdom or phronesis.

Wieringa et al have described how general practitioners in three online communities (UK, Netherlands, Norway) construct collective mindlines.

This showed how case narratives often of outliers were used to develop practical knowledge and pragmatic reasoning in the contextual reality of their practice. The GPs were extending knowledge where guidelines and/or individual mindlines were not working. Often, there was not a single answer but various viewpoints informed a practical decision. This allowed practitioners to manage uncertainty by using “knowledge-in-context-in-practice” within a community of practice. They contrast the “naïve rationalism” of guidelines with the “polyphonic truth” of mindlines.

¹ The University of Sheffield
E-mail: a.shirley@sheffield.ac.uk

Ultimately, we need good quality guidelines but we need to recognise their limitations and recognise the importance of clinical expertise and the patient's perspective. We should value the other forms of knowledge and scholarship in family practice that inform our mindlines.

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OPĆA/OBITELJSKA MEDICINA – IZAZOVI I BUDUĆI KORACI, SURADNJA ASOCIJACIJE I DNOOM-A

Lj. Sukriev¹

SAŽETAK



Važna je zadaća primarne zdravstvene zaštite (PZZ-a) briga za ljude, a ne samo za liječenje određenih bolesti ili stanja. PZZ pokriva niz usluga, od prevencije (cijepljenje i planiranje obitelji) do skrbi o kroničnim zdravstvenim stanjima i palijativne skrbi, odnosno od prevencije i liječenja do rehabilitacije i palijativne skrbi. PZZ pruža sveobuhvatnu i kontinuiranu skrb za građane tijekom njihova života. Uloga obiteljskog liječnika nije samo liječiti, nego i otkriti bolest. Zdravstveni sustav s jakim javno-privatnim partnerstvima karakterizira veća učinkovitost i bolja kvaliteta skrbi u usporedbi s drugim modelima. Uloga je PZZ-a da osigura uvjete za provedbu zdravstvene skrbi, uključujući zanemarene i marginizirane skupine, a u koordinaciji sa sekundarnim i tercijarnim zdravstvom, javnim zdravstvenim ustanovama u zajednici i drugim sektorima (kućna skrb), kako bi se bolje odgovorilo na potrebe stanovništva. Skrb je usmjeren na ljude i ova je vrsta skrbi organizirana na temelju zdravstvenih potreba i očekivanja ljudi, a ne bolesti.

Na razini Asocijacija Jugoistočne Europe postoji odlična suradnja s nacionalnim udružama zemalja članica Asocijacija, pri čemu je suradnja s DNOOM-om svih ovih deset godina izvrsna. Ovo razdoblje karakterizira razmjena iskustava, rješavanje problema i podizanje statusa općeg/ obiteljskog liječnika na razini jugoistočne Europe. Tijekom proteklih deset godina održano je deset kongresa na kojima su bili organizirani okrugli stolovi između DNOOM-a i Asocijacije: *Edukacija – zalog dobre prakse* (I. Kongres DNOOM-a), *Kako poboljšati zbrinjavanje bolesnika sa šećernom bolesti* (II. Kongres DNOOM-a), *Značaj plućne bolesti u radu obiteljskog liječnika* (III. Kongres DNOOM-a), *Prevencija srčanožilnih bolesti* (IV. Kongres DNOOM-a), *Bol u ordinaciji obiteljske medicine* (V. Kongres DNOOM-a), *Palijativna skrb u obiteljskoj medicini i Organizacije rada obiteljske medicine u Hrvatskoj* (VI. Kongres DNOOM-a), *Specijalizacija iz obiteljske medicine* (VIII. Kongres DNOOM-a), *Kontinuirana medicinska edukacija i Zakon o zdravstvenoj zaštiti* (IX. Kongres DNOOM-a). Ove godine održava se deseti Kongres na kojem će se raspravljati o smjernicama u radu liječnika opće/obiteljske medicine.

Ključne riječi: DNOOM, Asocijacija, primarna zdravstvena zaštita

¹ Centar obiteljske medicine, Medicinski fakultet Skoplje
Udruga liječnika opće/obiteljske medicine, R. Makedonija (ZLOM SM)
JZU Univerzitetska klinika za dečje bolesti Skopje

SAOPĆAVANJE LOŠIH VIJESTI PACIJENTIMA

Zaim Jatić¹



SAŽETAK

Saopćavanje loših vijesti (SLV) pacijentima jedan je od najtežih i najstresnijih zadataka za ljekare. Loše vijesti se definiraju kao "sve vijesti koje imaju loš i ozbiljan učinak na percepciju pojedinaca o njihovoj budućnosti." Većina liječnika nije dovoljno educirana za ovaj zadatak u toku dodiplomske i postdiplomske nastave, odnosno specijalizacije. Liječnici u procesu SLV pokazuju suosjećanje, razumijevanje, poštenje, brigu i optimizam. Stavovi i praksa ljekara o SLV značajno variraju od geografske regije, specijalnosti, obiteljske situacije, dobi i spola. Postoje tri glavna stila saopćavanja loše vijesti: otvoren, predviđanje i odugovlačanje. Uspješno SLV smanjuje stres pacijentima, mijenja njihovu percepciju bolesti i poboljšava njihovu suradljivost. Dobar odnos između pacijenta i ljekara značajno poboljšava pacijentovu sposobnost da prihvati liječenje i da se emocionalno prilagodi. Međutim, brojna istraživanja pokazuju da pacijenti nisu zadovoljni procesom saopćavanja loše vijesti. Postoji mali broj strukturiranih smjernica za SLV od kojih je najpoznatiji SPIKES protokol u šest koraka. Ova smjernica može poslužiti kao uspješno sredstvo koje može pomoći ljekarima da saopće lošu vijest. Također, ove smjernice se uspješno koriste za edukaciju studenata i liječnika kako saopćiti lošu vijest. SPIKES protokol u šest koraka je akronim od engleskih riječi i sadrži sljedeće korake: S (*setting up the interview*) – obezbjedenje uvjeta za razgovor, P (*perception of the patient*) – pacijentova percepcija (bolesti), I (*invitation by the patient*) – pacijentova saglasnost za saopštavanje loše vijesti, K (*knowledge to the patient*) – saopćavanje vijesti, E (*emotions of the patient*) – pacijentove emocije i S (*strategy and summary*) – strategija za buduće liječenje i sažetak.

Ključne riječi: saopćavanje loših vijesti, smjernice, komunikacija, bolesnik-liječnik

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¹ Katedra za porodičnu/obiteljsku medicinu, Medicinski fakultet Univerziteta u Sarajevu

MANAGING THE DELIVERY OF BAD NEWS

Zaim Jatić¹

ABSTRACT

Delivering patients bad news is one of the most difficult and stressful tasks for doctors. Bad news is defined as “any information which adversely and seriously affects an individual’s view of his or her future”. Most doctors are insufficiently educated for this task during their undergraduate and post-graduate study, or specialisation. Doctors show compassion, understanding, honesty, care and optimism. Doctors’ attitudes and practice regarding this process significantly vary depending on the region, specialty, family situation, age and sex. There are three main styles of giving bad news: blunt, forecasting and stalling. A successful delivery of bad news reduces patients’ stress, changes their perception of disease and improves their cooperability. A good relationship between the patient and the doctor significantly increases the patient’s capability of accepting treatment and emotionally adjusting to the situation. However, a number of studies show that patients are not satisfied with the process of delivering bad news to them. There are few structured guidelines for delivering patients bad news, the best known being SPIKES protocol in six steps, which can greatly help doctors deliver their patients bad news. These guidelines are also used in the process of students and doctors education about how to deliver bad news. SPIKES - a six-step protocol for delivering bad news is an acronym comprising: S (setting up the interview), P – (assessing the patient’s perception), I – (Obtaining the patient’s invitation), K – (giving knowledge to the patient) – delivering the news, E – (addressing the patient’s emotions with empathic responses) and S (strategy and summary) – strategy for further treatment and summary.

Key words: Delivering bad news, guidelines, communication, patient-doctor

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¹ Department of Family Medicine, Faculty of Medicine, University of Sajarevo

KRHKOST I/ILI KOMORBIDITETI KOD STARIJIH OSOBA S AORTNOM STENOZOM

Dimitra Kalimanovska-Oštrić¹

SAŽETAK



Aortna stenoza (AS) kod starijih osoba često postoji s komorbidnim stanjima, invaliditetom, polifarmom, rizikom pada i drugim promjenama u tijelu zbog starenja koje imaju složen i pretežno negativan utjecaj na pobol i smrtnost. Odluke o liječenju, posebice prikladnosti zamjene aortnog zalistka, bilo kirurške ili transkaterne, temelje se na kompletnoj kliničkoj procjeni, ozbiljnosti bolesti i bodovnim sustavima koji se rabe za predviđanje rizika za intervenciju prema očekivanoj prirodnoj povijesti AS-a. Kako bi se povećala točnost stratifikacije i prognoze rizika, smjernice Europskoga kardiološkog društva (ESC) iz 2017. godine za bolesti srčanih zalistaka uključile su procjenu krhkosti kao dodatni i važni čimbenik rizika (1). Krhkost je definirana kao sindrom smanjene fiziološke pričuve da osoba može tolerirati stres povezan sa starenjem, bolesti i čak terapijom (2). Prevalencija krhkosti kreće se od 10 do 60 % kod starijih bolesnika. Kao cjelokupan marker za oštećeni funkcionalni, kognitivni i nutritivni status, krhkost je povezana s trostrukim porastom postoperativne smrtnosti ili većeg morbiditeta nakon valvularne operacije (3). Procjena krhkosti ne bi trebala biti subjektivna, već se treba oslanjati na kombinaciji objektivnih markera. Najčešće je citirana Friedova ljestvica krhkosti koja obuhvaća sporost, slabost, nisku tjelesnu aktivnost, iscrpljenost i smanjenje (nenamjerni gubitak težine). Dijagnoza krhkosti temelji se na prisutnosti ≥ 3 od 5 kriterija. Za razliku od bilo kojeg dugotrajnog upitnika s mnoštvom stavki, zagovarano je određivanje brzine kretanja na 5 metara kao jedinstvene, jednostavne, ali moćne mjere krhkosti. Nepostojanje optimalnog mjerila krhkosti u kliničkom okruženju može se prevladati sveobuhvatnom procjenom krhkosti koju provodi obiteljski liječnik. Informacije o brzini nastanka i stupnju iscrpljenosti i neuhranjenosti, slabosti, sporosti i neaktivnosti pacijenata, kao i podrške njihovih obitelji, životnih uvjeta i lokalnog okruženja važni su prediktori rizika i prognoze u ovoj rastućoj populaciji pacijenata. Krhkost se ne smije smatrati razlogom za uskraćivanje suvremenog liječenja i njege, već kao argument za njihovu veću prilagođenost pacijentu (4). Multidisciplinarni pristup s obveznim uključenjem gerijatara od velike je važnosti pri vaganju rizika i prednosti kardijalnih intervencija u odnosu na konzervativno liječenje. Ishodi kod starijih osoba s AS-om mogu se poboljšati optimalnim liječenjem komorbiditeta i krhkosti. Intervencije za umanjenje krhkosti uključuju vježbanje (rezistentno i aerobno tjelovježbanje), dijetu (podršku kalorija i proteina), dopunu vitamina D i modifikaciju polifarme (4).

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¹ Sveučilište u Beogradu – Medicinski fakultet, Beograd, Srbija, E-adresa: kalimdim@gmail.com

FRAILTY AND/OR COMORBIDITIES IN ELDERLY WITH AORTIC STENOSIS

Dimitra Kalimanovska-Ostric¹

ABSTRACT

Aortic stenosis (AS) in the elderly often exists with comorbid conditions, disability, polypharmacy, a risk of falling and other changes in the body occurring with aging which have complex and predominantly negative impact on morbidity and mortality. Decisions about treatment, especially appropriateness of either surgical or transcatheter aortic valve replacement are based on complete clinical assessment, disease severity and scoring systems used for predicting the risk of intervention against the expected natural history of AS. In order to increase the accuracy of risk stratification and prognosis, the 2017 European Society of Cardiology (ESC) guidelines for Valvular Heart Disease have included the assessment of frailty as an additional and major risk factor¹. Frailty is defined as a syndrome of decreased physiologic reserve that a person has to tolerate the stress associated with aging, disease and even therapy². The prevalence of frailty ranges from 10% to 60% in older patients. As an overall marker of impaired functional, cognitive and nutritional status, frailty is associated with a 3-fold increase in post-operative mortality or major morbidity after valvular surgery³. The assessment of frailty should not rely on a subjective approach, but rather on a combination of objective markers. The most frequently cited has been the Fried frailty scale which encompasses slowness, weakness, low physical activity, exhaustion, and shrinking (unintentional weight loss). Diagnosis of frailty is based on ≥ 3 of 5 criteria. In contrast to any time-consuming multi-item frailty scale, 5-m gait speed has been advocated as a single, simple but powerful measure of frailty. The lack of optimal tool to measure frailty in the inpatient setting can be overcome with a multi-component frailty assessment by the family physician. Information on the rapidity and magnitude of wasting and malnutrition, weakness, slowness and inactivity of the patients as well as the support of their families, living conditions and local surrounding are important predictors of risks and prognosis in this growing population of patients. Frailty should not be viewed as a reason to withhold contemporary treatment and care but rather as an argument for delivering it in a more patient-centred fashion⁴. A multidisciplinary approach with a comprehensive geriatric assessment is of great importance when weighing the risks and benefits of cardiac interventions versus conservative treatment. The outcomes in the elderly with AS can be improved by an optimal treatment of comorbidities and frailty. Interventions to reduce frailty include exercise (resistance and aerobic), dietary counselling (caloric and protein support), vitamin D supplementation and a modification of polypharmacy.

¹ University of Belgrade - Faculty of medicine, Belgrade, Serbia
E-mail: kalimdim@gmail.com

PRISTUP LIJEČENJU PNEUMONIJA U OBITELJSKOJ MEDICINI

Nina Bašić-Marković,¹ Roberta Marković¹

SAŽETAK

Pneumonija je učestala akutna upalna bolest plućnog parenhima, a u starijih ljudi nerijetko je teška i pogibeljna bolest (1). Bolest je klinički karakterizirana povišenom temperaturom uz nesatalne simptome donjeg dišnog sustava (otežano disanje, ubrzana frekvencija disanja, kašalj, probadanje u prsima). Na početku bolesti kod starijih osoba mogu izostati navedeni simptomi. Stoga su za kliničku dijagnozu pneumonije potrebitni anamneza s epidemiološkim podatcima, podaci o rizičnim čimbenicima (kronične bolesti i stanja bolesnika), klinička slika bolesti s fizikalnim pregledom te radiološka verifikacija pneumoničnog infiltrata. Procjena težine bolesti i stupnja ugroženosti te odluka o načinu i mjestu liječenja – ambulantno (kod kuće) ili u bolnici, donosi se nakon postavljanja kliničke dijagnoze, a na osnovi dobi i rizičnih čimbenika bolesnika te kliničke prezentacije pneumonije. Jednostavan sustav za procjenu težine pneumonije naziva se CURB-65, a naziv je akronim engleskih pojmoveva: *Confusion* – konfuzija, *Urea* – $> 7 \text{ mmol/l}$, *Respiratory rate* – respiratorna frekvencija ($> 30/\text{min}$), *Blood pressure* – sniženi krvni tlak (sistolički $< 90 \text{ ili dijastolički } < 60 \text{ mmHg}$), **65** – stariji od 65 godina. Svaki se pokazatelj vrednuje jednim bodom, a bolesnici s dva ili više bodova zahtijevaju hospitalno liječenje (2, 3).

Dijagnostički postupci kod pneumonije uključuju radiološku obradu i laboratorijske nalaže (kompletna krvna slika, CRP, šećer u krvi, urea, kreatinin, aminotransferaze i elektroliti) (3, 4). Zbog racionalnog antimikrobnog liječenja potrebno je pneumonije razvrstati na bakterijske i atipične. Najčešći uzročnici bakterijskih pneumonija su *Streptococcus pneumoniae*, *S. aureus*, *Moraxella catarrhalis*, anaerobne i aerobne gram-negativne bakterije (4). Odgovarajuća antimikrobna terapija uključuje primjenu penicilina i drugih beta-laktamskih antibiotika te makrolida, uz napomenu da je rezistencija *S. pneumoniae* na makrolide u porastu. Prvi izbor za liječenje bakterijskih pneumonija je amoksicilin $3 \times 500\text{--}1000 \text{ mg}/7\text{--}10 \text{ dana}$. Atipični uzročnici pneumonije (klamidije, legionele, mikoplazma, rikecija – *Coxiella burnetii*) nisu osjetljivi na beta-laktamske antibiotike, a rezistencija na makrolide, tetracikline i kinoline nije značajna. Prvi izbor u liječenju je azitromicin $1 \times 500 \text{ mg}/3 \text{ dana}$, ili klaritromicin $2 \times 500 \text{ mg}/10 \text{ dana}$ ili doksicilin $2 \times 100 \text{ mg}/10 \text{ dana}$, a pri sumnji na Q-groznici najbolje je odmah primijeniti doksicilin. Kod starijih osoba te mlađih s kroničnim bolestima mogući uzročnici su *S. pneumoniae* i *H. influenzae*, pa se tada može ordinirati peroralni oblik koamoksiklava u dozi od $2 \times 1 \text{ g}/10 \text{ dana}$ ili alternativno cefalosporini ili respiratori fluorokinoloni. Opće mjere za sprječavanje pneumonije uključuju prestanak pušenja te cijepljenje pneumokoknim cjepivom i cijepljenje protiv influence (2, 5).

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¹ Specijalistička ordinacija obiteljske medicine Rijeka

APPROACH TO TREATING PNEUMONIA IN FAMILY MEDICINE

Nina Bašić-Marković,¹ Roberta Marković¹

ABSTRACT

Pneumonia is a common acute inflammation of the lung parenchyma, and often a severe and perilous disease in the elderly. The disease is clinically characterized by fever and symptoms of the lower respiratory system such as heavy breathing, tachypnea, cough or chest pain. The mentioned symptoms may be absent at the beginning of the disease in the elderly. Anamnesis with the epidemiologic data, risk factors (chronic diseases), clinical manifestation with physical exam and radiological evaluation of the pulmonary infiltration are needed for the clinical diagnosis. The disease severity assessment is based on the patient's age, risk factors and the clinical manifestation. A simple system of risk prediction is called CURB-65 and consists of the following terms: *Confusion, Urea (>7mmol/l), Respiratory rate (>30/min), Blood pressure (systolic < 90 or diastolic <60 mmHg), 65 – older than 65*. One point is scored for each indicator. If the score is 2 or higher, the patient requires hospital admission. Diagnostic procedures in assessing pneumonia include radiological and laboratory evaluations (complete blood count, CRP, blood glucose levels, urea, creatinine, aminotransferases and electrolytes). For the purpose of rational antimicrobial therapy pneumonia is divided in bacterial and atypical. The most common bacterial pathogens are *Streptococcus pneumoniae*, *S.aureus*, *Moraxella catarrhalis*, anaerobic and aerobic Gram-negative bacteria (4). The appropriate antimicrobial therapy includes the use of penicillin and other beta-lactame antibiotics and macrolides, with the caution of *S. pneumoniae*'s increasing resistance to macrolides. The first-choice antibiotic for bacterial pneumonia treatment is amoxicilline 3x500-1000mg/7-10 days. Atypical pathogens (chlamydiae, legionellae, mycoplasmae, rickettsiae – Coxiella burnetti) are not sensitive to beta-lactames, and their resistance to macrolides, tetracyclines and quinolones is not significant. The first-choice antibiotic is azytromicine 1x500mg/3days, clarithromycine 2x500mg/10 days or doxycycline 2x100mg/10 days. In case of Q-fever suspicion, it is best to use doxycycline immediately. *S.pneumoniae* and *H.influenzae* are possible causes of pneumonia in older patients or young patients with chronic diseases and should be treated with peroral form of co-amoxiclav 2x1g/10 days or, alternatively, with cephalosporines or fluoroquinolones. General measures for pneumonia prevention are smoking cessation and vaccination against *S. pneumoniae* and influenza.

¹ Department of Family Medicine, Rijeka

EUROPSKE SMJERNICE ZA FARMAKOLOŠKI TRETMAN ARTERIJSKE HIPERTENZIJE 2018. – ZA I PROTIV

Olivera Batić-Mujanović,^{1,2} Larisa Gavran^{3,4}

SAŽETAK

Uvod: Usprkos dobro toleriranim strategijama liječenja lijekovima, hipertenzija ostaje glavni preventabilni uzrok kardiovaskularnih bolesti (KVB).

Metode: Nove Europske smjernice za liječenje arterijske hipertenzije 2018 sumiraju najbolje strategije menadžmenta za pacijente s povišenim krvnim tlakom (KT). Postoji nekoliko novih ključnih aspekata. Prvi i najvažniji je cilj tretmana KT koji bi trebao biti $\leq 130/80$ mmHg u većine pacijenata, pod uvjetom da je liječenje dobro tolerirano. Ciljni raspon sistoličkog krvnog tlaka (SKT) od 120-129 mmHg preporučuje se u većine pacijenata < 65 godina. Ciljni raspon SKT od 130-139 mmHg preporučuje se u starijih pacijenata (≥ 65 godina), kao i u > 80 godina, ako se tolerira. Velike meta-analize randomiziranih kontroliranih studija pokazale su smanjenje svih glavnih kardiovaskularnih ishoda snižavanjem SKT na < 130 mmHg. Dijastolički krvni tlak (DKT) < 80 mmHg treba razmotriti kod svih hipertenzivnih pacijenata, neovisno o razini rizika i komorbiditeta. Ove smjernice preporučuju započinjanje antihipertenzivnog liječenja kombinacijom dva lijeka, poželjno u jednoj piluli. Iznimke su stariji pacijenti slabijeg zdravlja i oni s niskim rizikom i hipertenzijom stupnja 1 (SKT < 150 mmHg). Kombinacije dva lijeka kao početna terapija pokazale su se sigurne i dobro podnošljive, bez ili s malim povećanjem rizika od hipotenzivnih epizoda. S druge strane, obiteljski liječnici u svojoj kliničkoj praksi imaju problem postići ciljni KT $\leq 130/80$ mmHg. Preporučeni cilj za SKT $< 140-130$ mmHg (ako se tolerira) i DKT $< 80-70$ mmHg za pacijente > 80 godina smatra se teško ostvarivim jer ovisi o liječenju i promjenama načina života pacijenta također. Strategija jedne pilule može poboljšati pridržavanje liječenju, ali može i povećati troškove zdravstvene skrbi. Osim toga, pitamo se jesu li obiteljski liječnici sudjelovali u izradi smjernica, uzimaju li se u obzir pacijentove odluke o liječenju, postoje li sumnja u utjecaj farmaceutskih tvrtki i povećavaju li se troškovi liječenja s novim oblicima lijekova u jednoj tableteti.

Zaključak: Usprkos dokazima koji ukazuju na to da kontrola KT $< 130/80$ mmHg ima bolju prognostičku vrijednost, teško ju je postići kod većine pacijenata, osobito u starijih osoba.

Ključne riječi: smjernice, hipertenzija, tretman

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¹ Katedra za obiteljsku medicinu, Medicinski fakultet Univerziteta u Tuzli, Tuzla, Bosna i Hercegovina

² Edukativni centar za obiteljsku medicinu, Dom zdravlja Tuzla, Tuzla, Bosna i Hercegovina

³ Edukativni centar za obiteljsku medicinu, Dom zdravlja Zenica, Zenica, Bosna i Hercegovina

⁴ Medicinski fakultet Univerziteta u Zenici, Zenica

Adresa za dopisivanje:

Olivera Batić-Mujanović, Katedra za obiteljsku medicinu, Medicinski fakultet Univerziteta u Tuzli, Univerzitetska 1, 75000 Tuzla, Bosna i Hercegovina, e-adresa: oliverabaticmujanovic@yahoo.com, ORCID ID: <http://www.orcid.org/0000-0002-1002-0692>.

EUROPEAN GUIDELINES FOR PHARMACOLOGICAL TREATMENT OF HYPERTENSION 2018 - PROS AND CONS?

Olivera Batic-Mujanovic,^{1,2} Larisa Gavran^{3,4}

ABSTRACT

Introduction: Despite well-tolerated drug treatment strategies, hypertension remains the major preventable cause of cardiovascular disease (CVD).

Methods: The new European Guidelines for the management of arterial hypertension 2018 summarize the best management strategies for patients with a high blood pressure (BP). There are a few new key aspects. The first and most important is the treatment BP goal which should be $\leq 130/80$ mmHg in most patients, provided that the treatment is well tolerated. Systolic blood pressure (SBP) target range of 120–129 mmHg is recommended in most patients <65 years. SBP target range of 130–139 mmHg is recommended in older patients (≥ 65), as well as in >80 , if tolerated. Large meta-analyses of randomised controlled trials showed a reduction of all major CV outcomes lowering SBP to <130 mmHg. A diastolic blood pressure (DBP) <80 mmHg should be considered for all hypertensive patients, independent of the level of risk and comorbidities. These Guidelines recommend the initiation of antihypertensive treatment with a two-drug combination preferably in a single-pill combination. The exceptions are frail older patients and those at low risk and with grade 1 hypertension (SBP <150 mmHg). Two-drug combinations as initial therapy have been shown to be safe and well tolerated, with no or only a small increase in the risk of hypotensive episodes. On the other hand, family physicians in their clinical practice have a problem to achieve target BP $\leq 130/80$ mmHg. Recommended target for SBP of <140 - 130 mmHg (if tolerated) and DBP of <80 - 70 mmHg for patients >80 is difficult to achieve because it depends on treatment and patient's lifestyle changes. One pill strategy can improve adherence to treatment but can also increase health care costs. In addition, we wonder whether family physicians have participated in creating the guidelines and whether the patient's decision on treatment is taken into consideration. Suspicions towards pharmaceutical companies influence and increasing costs with new forms of medications in a single pill need to be considered, too.

Conclusion: Despite the fact that evidence which indicates that BP control at $< 130/80$ mmHg shows a superior prognostic value, it is difficult to achieve it in most patients, especially in the elderly.

Key words: guidelines, hypertension, treatment

¹ Department of Family Medicine, Faculty of Medicine, University of Tuzla, Tuzla, Bosnia and Herzegovina

² Family Medicine Teaching Center, Public Health Center Tuzla, Tuzla, Bosnia and Herzegovina

³ Family Medicine Teaching Center, Public Health Center Zenica, Zenica, Bosnia and Herzegovina

⁴ Faculty of Medicine, University of Zenica, Zenica, Bosnia and Herzegovina
Corresponding address:

Olivera Batic-Mujanovic, Department of Family Medicine, Faculty of Medicine, University of Tuzla, Univerzitetska 1, 75000 Tuzla, Bosna i Hercegovina, e-mail: oliverabaticmujanovic@yahoo.com, ORCID ID: <http://www.orcid.org/0000-0002-1002-0692>.

SMJERNICE ZA PREPOZNAVANJE I LIJEČENJE IRITABILNOG KOLONA

Munevera Bećarević¹

SAŽETAK

Sindrom iritabilnog kolona (SIK) funkcionalni je poremećaj probavnog sustava karakteriziran bolovima u trbuhu te nelagodom i promjenama ritma pražnjenja crijeva i izgleda stolice u obliku zatvora, proljeva ili kombinacije navedenih. Sindrom se ne može povezati s nekom organskom bolesti, niti se mogu dokazati patohistološke promjene na crijevima. Od SIK-a obolijevaju sve dobne skupine (djeca, starije osobe, učestalije u < 35 godina), češće obolijevaju žene. Globalna prevalenca SIK-a iznosi između 10 i 15 %, širom svijeta. SIK je kronična bolest koja remeti kvalitetu života pacijenata, ali i finansijski optereće zdravstveni sistem i u svijetu je drugi po redu razlog odsustovanja sa posla. Zbog netipičnosti simptoma liječnici obiteljske medicine troše puno vremena i sredstava na dijagnostiku i tretman oboljelih od SIK-a. Postoje tri podtipa SIK-a, SIK-D sa predominantnom diareom, SIK-C sa predominantnom konstipacijom i SIK-M mješoviti tip. Dijagnoza SIK postavlja se na osnovu anamnestičkih podataka (IV Rimski kriterijumi) i fizičkog pregleda. IV Rimski kriterijumi za dijagnozu SIK su ponavljeni abdominalni bol, u prosjeku najmanje jedan dan/tjedan u posljednja tri mjeseca, povezan s dva ili više sljedećih kriterija: povezano sa defekacijom, povezano sa promjenom učestalosti stolice, povezano sa promjenom oblika (izgleda) stolice (kriteriji ispunjeni za posljednja tri mjeseca sa pojmom simptoma najmanje šest mjeseci prije dijagnoze). Daljnja dijagnostička obrada zavisi od postojanja eventualnih alarmanih simptoma ili postojanja drugih znakova koji upućuju na postojanje druge bolesti i/ili komorbiditeta, a podrazumijeva laboratorijsku analizu, UZ, Rtg, endoskopske pretrage. Diferencijalna dijagnoza SIK vrlo je široka te je potrebno isključiti sljedeće dijagnoze: malignitete, celijakiju, ulcerozni kolitis, bakterijsku infekciju itd. Povjerenje između liječnika i pacijenta te promjena načina života su ključ u tretmanu SIK-a jer specifična terapija ne postoji. Simptomi se tretiraju farmakološki i simptomatski prema pojavi i potrebi (spazmoliticima, probioticima, antidepresivima, tretmanom diareje ili opstipacije).

Ključne riječi: sindrom iritabilnog kolona, defekacija, diareja, konstipacija

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¹ JZU Dom zdravlja Banovići, Medicinski fakultet Univerziteta u Tuzli, Tuzla, Bosna i Hercegovina

GUIDELINES ON THE MANAGEMENT AND DIAGNOSIS OF IRRITABLE BOWEL SYNDROME

Munevera Bećarević¹

ABSTRACT

Irritable Bowel Syndrome is a common condition that affects the digestive system, causing symptoms like stomach cramps, bloating, diarrhoea and constipation, or a combination of those. Syndrome is not connected to any organic disease or bowel pathohistological changes. All age group suffer (children, elderly people, most frequently those <35), and mostly women. Global prevalence of IBS is between 10 and 15% worldwide.

IBS is a chronic disease that disturbs the quality of patients' life and financially burdens the Health care system. It is globally the second reason for absenteeism. It takes a lot of time for the family physician to diagnose and treat IBS patients. There are 3 subtypes of IBS: IBS – diarrhoea, IBS – constipation, and mixed IBS.

IBS is diagnosed by anamnestic data (IV Rome criteria) and physical examination. Rome IV criteria: repeated abdominal pain at least 1 day/weak during the last 3 months, connected with 2 or more of the following: change in defecation, change in the frequency of defecation, feces shape change. Criteria have to be met for the last 3 months with the symptoms onset at least 6 months before diagnosis.

Further diagnostic processing depends on eventual alarming symptoms or signs indicating some other disease or comorbidity, and it includes ultrasound, X-ray, endoscopy etc. Differential diagnose of IBS is comprehensive. It is necessary to exclude malignancies, celiac disease, ulcerative colitis, bacterial infection etc. The trust between the physician and the patient and a change of lifestyle are the key of IBS treatment because specific therapy does not exist. Symptoms are treated pharmacologically as necessary depending on the symptoms (by spasmolitics, probiotics, antidepressants, and the treatment of diarrhoea and constipation).

Key words: Irritable Bowel Syndrome, defecation, diarrhoea and constipation).

¹ Public Health Centre Banovići; Faculty of Medicine, Tuzla University, Tuzla, Bosnia and Herzegovina

PREPREKE IMPLEMENTACIJI SMJERNICA U PRAKSI OBITELJSKIH LIJEČNIKA

Sanja Bekić,^{1,2} Ljiljana Trtica Majnarić³

SAŽETAK

Kliničke smjernice definiramo kao „sustavno razvijene tvrdnje koje pomažu zdravstvenom djelatniku“ donijeti odluku o prikladnoj zdravstvenoj skrbi za specifično kliničko stanje. Smjernice su korisne u situacijama kada je znanstveni dokaz manjkav, kada postoje višestruke mogućnosti liječenja ili nesigurnost u pojedinim mogućnostima liječenja. Razvoj i primjena smjernica podupiru donošenje kliničkih odluka kako bi se poboljšala kvaliteta zdravstvene skrbi, ishoda liječenja i isplativosti. Smjernice su osobito važne kod bolesti koje dovode do prerane smrtnosti, kada je bolest moguće izbjegći te kod negativnih učinaka zdravstvenih navika na kvalitetu života.

Istraživanja su pokazala da se kliničke smjernice često ne primjenjuju. Nepridržavanje smjernica može dovesti do nepotrebne dijagnostike i nezadovoljavajućeg ili čak neodgovarajućeg liječenja. Procjenjuje se da se kod oko 30 – 40 % pacijenata primjenjuje liječenje koje se ne temelji na znanstvenim dokazima, a njih 20 – 25 % prima terapije koje nisu potrebne ili su potencijalno štetne. Prepreke za provedbu smjernica mogu se podijeliti u tri glavne kategorije: prepreke vezane uz osobne stavove liječnika, prepreke vezane uz kliničke smjernice i vanjske prepreke. Presudno je da se liječnici pridržavaju smjernica kako bi preporuke dovele do poboljšanih rezultata. Prepreke vezane uz osobne stavove liječnika uključuju nedostatak osvještenosti, nedostatak zbog nepoznavanja teme, nedostatak zbog neslaganja, nedostatak samoučinkovitosti, nedostatak očekivanog ishoda i nedostatak motivacije. Na osobne stavove može utjecati niz čimbenika. Znanje, zajedno s pozitivnim stavom prema promjenama i poboljšanju kvalitete, nužno je, ali ne i dovoljno da osigura poštivanje smjernica. Prepreke vezane uz smjernice uključuju smjernice koje nisu jednostavne za korištenje ili koje nisu prikladne. Nemogućnost uskladivanja preferencija pacijenata s preporukama smjernica predstavlja prepreku od strane pacijenta. Vanjske prepreke obuhvaćaju nedostatak vremena ili sredstava te organizacijska ograničenja.

Liječničke odluke trebale bi se temeljiti na preporukama smjernica, ali sve odluke moraju biti individualizirane u skladu s omjerom rizika i koristi za pacijenta te uključivanjem preferencija pacijenta pri zajedničkom doноšenju odluka. Ako se kliničke smjernice ne primjenjuju u liječničkoj praksi, i dalje će postojati razlike između dijagnostičkog i terapijskog napretka te poboljšanih zdravstvenih ishoda.

Ključne riječi: provedba kliničkih smjernica, prepreke, obiteljska medicina

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¹ Specijalistička ordinacija obiteljske medicine dr. Sanja Bekić, Višnjevac

² Katedra za internu medicinu, obiteljsku medicinu i povijest medicine, Medicinski fakultet Sveučilišta J. J. Strossmayera, Osijek

³ Katedra za internu medicinu, obiteljsku medicinu i povijest medicine, Medicinski fakultet Sveučilišta J. J. Strossmayera, Katedra za javno zdravstvo, Fakultet za dentalnu medicinu i zdravstvo, Osijek
Adresa za dopisivanje:

Mr. sc. Sanja Bekić, dr. med., specijalist obiteljske medicine, Specijalistička ordinacija obiteljske medicine dr. Sanja Bekić, N. Š. Zrinskog 3, 31 220 Višnjevac, e-adresa:sanja.bekic1@gmail.com, orcid identifikator: 0000-0002-4416-4862

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BARRIERS TO IMPLEMENTING GUIDELINES IN FAMILY PRACTICE

Sanja Bekić,^{1,2} Ljiljana Trtica Majnarić³

ABSTRACT

Clinical practice guidelines can be defined as “systematically developed statement to assist practitioners” decisions about appropriate health care for specific clinical circumstances. Guidelines are valuable tools in situations where scientific evidence is sparse, where multiple therapies are available, or where uncertainty in terms of treatment options exists. The development and implementation of guidelines support clinical decision making in order to improve the quality of care, patient outcomes and cost effectiveness. Guidelines are particularly important for diseases leading to premature mortality, avoidable morbidity or negative effects on health-related quality of life.

Research indicates that clinical guidelines are often not applied. Non-adherence to guidelines may lead to unnecessary diagnostics and suboptimal or even inadequate treatment. It is estimated that about 30%-40% of patients receive treatment that is not based on scientific evidence, and 20%-25% receive treatments that are either not needed or are potentially harmful. Barriers to guideline implementation can be classified into three main categories: barriers related to physician's personal factors, guideline related factors and external barriers. Physician adherence is critical in translating recommendations into improved outcomes. Barriers to physician adherence include: lack of awareness, lack of familiarity, lack of agreement, lack of self-efficacy, lack of outcome expectancy and lack of motivation. Behaviour modification can be affected by a variety of factors. Knowledge pertinence, together with a positive attitude toward change and quality improvement, is necessary but not sufficient to guarantee guidelines adherence. Guideline-related barriers include guidelines that are not easy to use or that are not convenient. The inability to reconcile patient preferences with guideline recommendations represent patient's barrier to adherence. Environmental barriers include lack of time or resources and organisational constraints.

Clinical decisions should be based on guideline recommendations, but all decisions must be individualised according to the patient's risk –benefit ratio, incorporating patient preferences through shared decision-making. If guidelines recommendations are not applied in clinical practice, gaps between diagnostic and therapeutic advances and improved health outcomes will persist.

Key words: guideline implementation, barrier, family practice

¹ Family Medicine Practice, Sanja Bekić, MD, Višnjevac

² Department of Internal Medicine, Family Medicine and History of Medicine, Faculty of Medicine, University JJ Strossmayer, Osijek

³ Department of Internal Medicine, Family Medicine and History of Medicine, Faculty of Medicine, Department of Public Health, Faculty of Dental medicine and Health, University JJ Strossmayer, Osijek
Address for correspondence:

M.Sc. Sanja Bekić, MD, Family Medicine Specialist

Family Medicine Practice Sanja Bekić, MD

N.Š.Zrinskog 3, 31 220 Višnjevac, e-mail:sanja.bekic1@gmail.com, orcid identification number: 0000-0002-4416-4862

SMJERNICE ZA ZBRINJAVANJE AKUTNOG INFARKTA MIOKARDA, PRILAGOĐENO OBITELJSKOJ MEDICINI

Biserka Bergman Marković,^{1, 2, 3} Ines Diminić Lisica,^{4, 5}
Nikola Bulj^{6, 7}

SAŽETAK

Zbrinjavanje pacijenta s akutnim infarktom miokarda (AIM) u obiteljskoj medicini počinje već pri postavljanju sumnje na mogući infarkt miokarda (IM). Liječnik obiteljske medicine (LOM) mora biti senzibiliziran na IM i kada simptomi s kojima pacijent dolazi nisu tipični. Dalja procedura u zbrinjavanju pacijenta je standardizirana zbog ozbiljnosti problema, ugroze života te hitne intervencije. Svim pacijentima s bolom u prsnom košu potrebno je snimiti EKG unutar 10 minuta od dolaska u prvi kontakt s izvanbolničkom zdravstvenom službom (liječnik obiteljske medicine, medicinska sestra, paramedicinsko osoblje ili druga osoba koja je obučena za hitne intervencije izvan bolnica) ili u hitnoj službi bolnice. Međutim, kako su minute dragocjene u spašavanju ljudskog života, pacijente treba educirati u zvanju hitne službe prije nego na odlazak LOM-u, jer se često gube dragocjene minute. Situacija se mijenja u ruralnim područjima ili na otocima, gdje je svaka pomoć liječnika dobrodošla. Nakon preboljenog IM-a mjere sekundarne prevencije od prvorazrednog su značaja sa zadaćom prevencije recidiva i sprječavanja kasnih komplikacija. One obuhvaćaju promjene životnog stila, umanjivanje rizičnih čimbenika i farmakološku terapiju.

Ključne riječi: akutni infarkt miokarda, obiteljska medicina

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¹ Specijalistička ordinacija obiteljske medicine prof. dr. sc. Biserka Bergman Marković, dr. med., spec. obiteljske medicine, Zagreb

² Katedra za obiteljsku medicinu, Škola narodnog zdravlja „Andrija Štampar“, Medicinski fakultet Sveučilišta u Zagrebu

³ Akademija medicinskih znanosti Hrvatske

⁴ Katedra za obiteljsku medicinu, Medicinski fakultet Sveučilišta u Rijeci

⁵ Ustanova za zdravstvenu skrb dr. Ines Diminić-Lisica, specijalistička ordinacija obiteljske medicine

⁶ Klinika za bolesti srca i krvnih žila, Klinički bolnički centar „Sestre milosrdnice“

⁷ Katedra za internu medicinu, Medicinski fakultet Sveučilišta u Zagrebu

Adresa za dopisivanje:

Specijalistička ordinacija obiteljske medicine prof. dr. sc. Biserka Bergman Marković, dr. med., spec. obiteljske med., Albaharijeva 4, 10 000 Zagreb, e-adresa: bbergmanmarkovic@gmail.com

GUIDELINES FOR THE TREATMENT OF ACUTE MYOCARDIAL INFARCTION, ADAPTED TO FAMILY MEDICINE

Biserka Bergman Marković,^{1, 2, 3} Ines Diminić Lisica,^{4, 5}
Nikola Bulj,^{6, 7}

ABSTRACT

Taking care of myocardial infarction (MI) in general practice / family medicine (GP/FM) begins when the GP /FM suspects possible MI. A GP/FM must be sensitized to MI and if the symptoms with which the patient comes are not typical. A further patient care procedure is standardized due to the severity of the problem, how life threatening it is, and the emergency intervention. All patients with chest pain should receive an ECG within 10 minutes of their first contact with the outpatient healthcare service (family doctor, nurse, paramedic staff or other person trained for emergency intervention outside the hospital) or emergency hospital service. However, as the minutes are precious in saving a human life, patients need to be educated about the emergency service before going to the GP because there they often lose precious minutes. The situation is changing in rural areas or islands, where every help from the GPs is welcome.

After overcoming IM, secondary prevention measures are of paramount importance with the task of preventing a recurrence and preventing late complications. They include life-style changes, risk factors and pharmacological therapy.

Key words: acute myocardial infarction, family medicine

¹ Private Family Physician Office affiliated to University of Zagreb, School of Medicine, Zagreb, Croatia “Prof. Biserka Bergman Marković, MD, PhD“, Zagreb, Croatia

² Department of Family Medicine, School of Public Health “Andrija Štampar”, Medical School University of Zagreb, Croatia

³ Croatian Academy of Medical Sciences

⁴ Department of Family Medicine, Medical School University of Rijeka, Croatia

⁵ Department of Health Care „Prof. Ines Diminić-Lisica, MD, PhD family medicine medical office“, Rijeka, Croatia

⁶ Clinic for Heart and Blood Vascular Diseases, Clinical Hospital Center “Sestre milosrdnice”

⁷ Department of Internal Medicine, Medical School University of Zagreb, Croatia

Address:

Private Family Physician Office “Prof. Biserka Bergman Marković, MD, PhD“, Albaharijeva 4, 10 000 Zagreb, E-mail: bbergmanmarkovic@gmail.com

IZAZOVI PRIMJENE SMJERNICA ZA ŠEĆERNU BOLEST U SVAKODNEVNOM RADU

Valerija Bralić Lang¹

SAŽETAK

Šećerna bolest je kompleksna kronična bolest kod koje dobra kontrola glikemije rezultira smanjenjem nastanka i progresije mikro- i makrovaskularnih komplikacija. Da bi se to postiglo, potrebna je stalna medicinska skrb, ali i značajan angažman oboljelih. Suvremeni farmakoterapijski pristup uvjetuje utvrđivanje postojanja aterosklerotske kardiovaskularne bolesti (AKVB) kod oboljelih od šećerne bolesti. Glavne kliničke manifestacije AKVB-a kod oboljelih od šećerne bolesti jesu koronarna bolest, ishemski moždani udar, periferna arterijska bolest i zatajenje srca. Što se tiče kontrole glikemije, preporučuje se individualni pristup uz opći cilj HbA1c ≤ 7,0 %, izbjegavanje hipoglikemija i uvjet toleriranja polifarmakoterapije. Za slučaj da se polifarmakoterapija slabije podnosi i da nepovoljno utječe na intenzivno liječenje kardiovaskularnih čimbenika rizika, može se tolerirati manje intenzivan cilj s HbA1c ≤ 7,5%. Pacijentima bez poznatog AKVB-a cilj je agresivnije spuštanje HbA1c ≤ 6,5% jer značajno smanjuje rizik mikrovaskularnih komplikacija šećerne bolesti, a može pridonijeti i smanjenju AKVB-a. Pri odabiru terapije neophodna je procjena kardiovaskularne sigurnosti lijekova te je važno imati na umu rezultate dobivene iz randomiziranih istraživanja u koje su uključeni najvulnerabilniji bolesnici. Uz optimalnu regulaciju glikemije neophodno je agresivno liječenje kardiovaskularnih čimbenika rizika, posebno LDL kolesterola i arterijskog tlaka, čime se značajno poboljšavaju kardiovaskularni ishodi. Promjene životnih navika (smanjenje tjelesne mase, zdrave prehrambene navike i povjerenje tjelesne aktivnosti) potrebno je preporučiti svima oboljelimu od šećerne bolesti bez obzira na njihov kardiovaskularni rizik. Specifičnost skrbi za ove bolesnike u obiteljskoj medicini jest stalni nadzor postojanja komplikacija, kontrola glikemije, postavljanje ciljeva i aktivno praćenje, prepoznavanje kliničkog konteksta i prognoze te edukacija pacijenta.

Ključne riječi: šećerna bolest, kardiovaskularne bolesti, liječenje, obiteljska medicina

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¹ Specijalistička ordinacija obiteljske medicine dr. sc. Valerija Bralić Lang, dr. med., spec. obiteljske medicine, Zagreb

Adresa za dopisivanje:

dr. sc. Valerija Bralić Lang, dr. med., spec. obiteljske med., Zvonigradska 9, 10000 Zagreb, Hrvatska,
E-adresa: valerija.bralic.lang@gmail.com, <http://orcid.org/0000-0002-9142-1569>

CHALLENGES OF GUIDELINES FOR DIABETES IMPLEMENTATION IN PRACTICE

Valerija Bralić Lang¹

ABSTRACT

Diabetes mellitus is a complex, chronic disease in which glycaemic control reduces the development of micro- and macrovascular complication. In order to achieve that, continuous medical care and self-management is required. According to the guideline after metformin monotherapy, the clinician is advised to determine whether atherosclerotic cardiovascular disease exists. Key manifestations of atherosclerotic cardiovascular disease in diabetes mellitus include advanced atherosclerosis, which manifest as coronary heart disease, ischemic stroke, peripheral artery disease, and heart failure. Regarding glycaemic control, a goal HbA1c $\leq 7.0\%$ is recommended if multiple diabetes mellitus drugs are tolerated, and polypharmacy does not diminish the intensity of cardiovascular risk management; however, if this is not the case, a less intensive goal of HbA1c $\leq 7.5\%$ is recommended. For patients at high risk of atherosclerotic cardiovascular disease, an HbA1c $\leq 7.0\%$ would be reasonable, if this can be achieved with minimal hypoglycaemia. For patients without known atherosclerotic cardiovascular disease who are at moderate risk, an aggressive goal of HbA1c $\leq 6.5\%$ will substantially reduce the risk for microvascular complications and may contribute to eventual reduction in cardiovascular disease, reduce the risk for microvascular complications and may contribute to eventual reduction in ASCVD. A history of cardiovascular disease very early in the process of treatment selection is necessary keeping in mind the results of large cardiovascular outcomes trials, especially those that enrolled vulnerable individuals. Best cardiovascular outcomes are achieved with optimal glycaemic control, along with aggressive control of all cardiovascular risk factors (especially LDL cholesterol and blood pressure). Regardless of cardiovascular history, all patients should receive lifestyle management counselling (including weight loss, medical nutrition therapy, physical activity). Constant monitoring of complications, glycaemic control, target setting and active monitoring, clinical context recognition and prognosis as well as patients' education are specific tasks set for the family medicine specialist.

Key words: diabetes mellitus, cardiovascular disease, therapy, family medicine

¹ Family Physician Office, Zagreb, Croatia

Corresponding address:

Valerija Bralić Lang, MD, PhD, Family Medicine Specialist, Zvonigradska 9, 10000 Zagreb, Croatia,
e-mail: valerija.bralic.lang@gmail.com, <http://orcid.org/0000-0002-9142-1569>

SMJERNICE ZA DIJAGNOSTIKU I LIJEČENJE DEPRESIVNIH POREMEĆAJA

Leonardo Bukmir^{1,2}

SAŽETAK

Smjernice za dijagnostiku i lijeчењe depresivnih poremećaja uspješno implementiraju nove znanstvene spoznaje te promoviraju načela suvremene medicine zasnovane na dokazima. Podjednako su korisne u edukaciji i rutinskom radu obiteljskom liječniku. Olakšavaju mu postupanje u probiru, postavljanju dijagnoze, procjeni suicidalnog rizika i procjeni potrebe za bolničkim liječeњem te psihobiosocijalnoj formulaciji bolesti na osnovi koje se planira i provodi individualno liječeњe i prevenira recidiv. Psihofarmakološke smjernice temeljene su na znans-tvenim činjenicama o terapijskoj djelotvornosti lijekova s препоруком prvoga, drugog i trećeg izbora. Primjena antidepresiva treba biti individualizirana. Izbor i trajanje farmakoterapije ovisi o fazi bolesti, simptomima, komorbidnim stanjima. Posebna pozornost i prilagodba farmakoterapije potrebna je kod djece i adolescenata te osoba starije životne dobi, kod kojih treba uzeti u obzir fiziološki status i involutivne promjene. U primjeni lijekova važno je voditi se indikacijom koju su препоруčila stručna društva te poznavati moguće nuspojave i interakcije s drugim lijekovima. Za poboljšanje skrbi potrebno je izgraditi partnerski odnos uz aktivniju ulogu samog pacijenta. Njegovo ospozobljavanje za liječeњe i odgovornost mogu bitno utjecati na kvalitetu i ishode lije-čenja. Kod velikog broja pacijenata suportivna psihodinamska psihoterapija ima povoljne učinke, no nažalost psihoterapijsko liječeњe nije dostupno velikom broju pacijenata. Samo liječeњe mora biti praćeno i kvalitetno evaluirano.

¹ Sveučilište u Rijeci, Medicinski fakultet, Katedra za obiteljsku medicinu

² Specijalistička ordinacija opće medicine, Rijeka, e-adresa: leonardo.bukmir@gmail.com

GUIDELINES FOR DIAGNOSIS AND TREATMENT OF DEPRESSIVE DISORDERS

Leonardo Bukmir,^{1, 2}

ABSTRACT

Guidelines for diagnosis and treatment of depressive disorders successfully implement new scientific knowledge and promote principles of evidence-based contemporary medicine. They are equally useful in the education and routine work of general practitioners. They help them in screening, diagnosing, suicidal risk assessments, decisions on hospitalization, psycho-biosocial formulations of disease on the basis of which the individual treatment is planned and a recurrence is prevented. Psychopharmacological guidelines are based on scientific facts about therapeutic efficacy of drugs with recommendation of the first, the second and the third choices. The antidepressant treatment should be individualized. The selection and duration of pharmacotherapy depends on the stage of disease, symptoms and comorbid conditions. A special attention and adjustment of pharmacotherapy is needed in children, adolescents and elderly persons, where physiological status and involuntary changes as well as present comorbidities should be considered. When administering medication, it is important to consider the indications recommended by the professional guidelines and to know the possible side effects and interactions with other drugs. To improve the treatment outcomes, a doctor-patient relationship that includes a more active role of the patient should be built. In a large number of patients, the supportive psycho-dynamic psychotherapy has beneficial effects but, unfortunately, psychotherapeutic treatment is not available to a large number of patients. The treatment should be monitored and evaluated.

¹ Sveučilište u Rijeci, Medicinski fakultet, Katedra za obiteljsku medicinu

² Specijalistička ordinacija opće medicine, Rijeka

E-adresa: leonardo.bukmir@gmail.com

SMJERNICE ZA DIJAGNOSTIKU I LIJEČENJE ZATAJENJA SRCA U PRIMARNOJ ZDRAVSTVENOJ ZAŠTITI

Nikola Bulj,^{1,2} Ines Diminić Lisica^{3,4}

SAŽETAK

Uvod: Zatajenje srca (engl. *Heart failure – HF*) klinički je sindrom povezan sa značajnim morbiditetom i smanjenim očekivanim trajanjem života, koji pogda oko 1-2 % odraslih u razvijenim zemljama.

Raspava: Vrsta HF-a određena je prema ejekcijskoj frakciji lijeve klijetke (LVEF): HF sa smanjenom ejekcijskom frakcijom (HFrEF) obično se definira kao LVEF < 40 %, HF s očuvanom ejekcijskom frakcijom (HFpEF) definira se kao LVEF ≥ 50 % s dokazom dijastoličke disfunkcije ili strukturnih promjena srca. Nedavno je Europsko kardiološko društvo (ESC) dodalo treću skupinu – HF s ejekcijskom frakcijom srednjeg raspona (HFmrEF), za sivu zonu između HFrEF i HFpEF. Smjernice preporučuju da bolesnici sa sumnjom na HF trebaju biti dodatno obradeni određivanjem vrijednosti natriuretskih peptide, gdje vrijednosti NT-proBNP iznad 125 pg sugeriraju dijagnozu. Ehokardiografija se upotrebljava za određivanje tipa zatajenja srca i drugih strukturalnih ili funkcionalnih abnormalnosti, kao što je valvularna bolest srca. HFrEF je, kao što ime sugerira, karakteriziran smanjenom ejekcijskom frakcijom, dok je u HFpEF-u ejekcijska frakcija normalna, ali su evidentne ostale abnormalnosti, kao što su povećana krutost lijeve klijetke i restriktivno punjenje. U liječenju zatajenja srca diuretici su od posebne važnosti, poglavito u početnoj fazi liječenja kada je potrebno volumno rasteretiti bolesnike i reducirati simptome, što vrijedi za sve oblike zatajenja srca. Inhibitori enzima koji konvertiraju angiotenzin, beta-blokatori i antagonisti mineralokortikoidnog receptora pokazali su značajno poboljšanje preživljivanja i kvalitete života i smanjenje broja hospitalizacija kod pacijenata s HFrEF-om, te predstavljaju temeljnu terapiju u svih bolesnika u odsutnosti kontraindikacija. Nedavno je uvedena i nova klasa lijekova inhibitora neprilizina i receptora angiotenzina (pokraćeno ARNI). Ta skupina lijekova ima dvostruko djelovanje kroz inhibiciju renin-angiotenzinskog sustava i pojačavanje učinka zaštitnih vazoaktivnih neuropeptida sprječavanjem njihove razgradnje. Predstavnik ARNI-ja sakubitril-valsartan odobren je i u Republici Hrvatskoj, ali zasada samo uz preporuku specijalista kardiologa.

Zaključak: Radi unaprjeđenja kliničkih ishoda u bolesnika sa zatajivanjem srca od ključne je važnosti, na primarnoj razini zdravstve zaštite, u okviru obiteljske medicine sustavno provođenje preporuka iz smjernica za dijagnostiku i liječenje bolesnika sa zatajivanjem srca.

Ključne riječi: zatajenje srca, ejekcijska frakcija

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¹ Klinika za bolesti srca i krvnih žila, Klinički bolnički centar „Sestre milosrdnice“

² Katedra za internu medicinu, Medicinski fakultet Sveučilišta u Zagrebu

³ Katedra za obiteljsku medicinu, Medicinski fakultet Sveučilišta u Rijeci

⁴ Ustanova za zdravstvenu skrb dr. Ines Diminić Lisica, Specijalistička ordinacija obiteljske medicine

GUIDELINES FOR HEART FAILURE DIAGNOSIS AND MANAGEMENT IN PRIMARY CARE

Nikola Bulj,^{1,2} Ines Diminić Lisica^{3,4}

ABSTRACT

Introduction: Heart failure (HF) is a common and costly clinical syndrome, associated with significant morbidity and reduced life expectancy, affecting around 1–2% of adults in developed countries.

Discussion: The type of HF is determined according to left ventricular ejection fraction (LVEF): HF with reduced ejection fraction (HFrEF) is commonly defined as LVEF <40%. HF with preserved ejection fraction (HFpEF) is defined as LVEF ≥50% with evidence of diastolic dysfunction or structural cardiac changes. Recently, the European Society of Cardiology (ESC) added a third group, HF with midrange ejection fraction (HFmrEF), for the grey area between HFrEF and HFpEF. Guidelines suggest patients with suspected HF should be further investigated initially with natriuretic peptide (NP) testing with cut-off levels at NT-proBNP above 125 pg/m. Echocardiography is used to determine the type of heart failure and other structural or functional abnormalities, such as valvular heart disease. HFrEF is, as the name suggests, characterised by a reduced ejection fraction whereas in HFpEF ejection fraction is normal but other abnormalities, such as increased left ventricular stiffness and a restrictive left ventricular filling pattern, are evident. Diuretics are vital in the initial phase of treatment to offload fluid and improve symptoms in patients with all types of HF. Angiotensin converting enzyme inhibitors (ACEi), beta-blockers (BB), and mineralocorticoid receptor antagonists (MRA) have been shown to significantly improve survival and quality of life, and to reduce hospital admissions in patients with HFrEF. A new class of drug has recently been introduced to HF management options. Angiotensin receptor neprilysin inhibitors, or ARNIs, exert a dual action through inhibition of the renin-angiotensin system and potentiation of protective vasoactive neuropeptides. ARNI representative sacubitril-valsartan has been approved but may only be initiated by specialists.

Conclusion: In order to improve clinical outcomes in heart failure patients, on the primary level of health care, within family medicine, a systematic implementation of recommendations from Diagnostic Guidance and Treatment of Heart Failure Patients are of crucial importance.

Key words: heart failure, ejection fraction

¹ Klinika za bolesti srca i krvnih žila, Klinički bolnički centar „Sestre milosrdnice“

² Katedra za internu medicinu, Medicinski fakultet Sveučilišta u Zagrebu

³ Katedra za obiteljsku medicinu, Medicinski fakultet Sveučilišta u Rijeci

⁴ Ustanova za zdravstvenu skrb dr. Ines Diminić Lisica, Specijalistička ordinacija obiteljske medicine

STRATEGIJE ZA BOLJU IMPLEMENTACIJU SMJERNICA U PRAKSI

Mario Ćurković,¹ Ivon Matić²

SAŽETAK

Smjernice su okosnica kvalitetnog i sigurnog rada te objektivnog pristupa rješavanju zadanih problema kod gotovo svih struka, uključujući i medicinu (1). Određen broj tih smjernica zadovoljava potrebe korisnika, kako iz perspektive medicinskog osoblja, tako i pacijenata (2). Osnovna premla dobre smjernice jest da sadržaj mora biti usmjeren na ciljanu problematiku (npr. osvještavanje pojedinaca o bolesti, protokol za zbrinjavanje pacijenta primjenjiv za određeno zdravstveno stanje itd.) (3). Dio smjernica uglavnom je neiskorišten zbog loše ili nedostatne implementacije u praksi (3). Razlozi su različiti: loše adaptiran sadržaj, nejasno formuliran koncept shvaćanja i korištenja smjernica (4). Većina smjernica pasivno je distribuirana te su neiskoristive zbog svoje neuobičajljivosti (5).

Implementacija podrazumijeva konkretne aktivnosti i intervencije s ciljem postizanja boljeg ishoda (6). Za strategiju implementacije stoga je nužno razviti elemente i instrumente za implementaciju (7). Implementacija ovisi o brojnim tehničkim čimbenicima (npr. sadržaju, kontekstu i grafičkom prikazu smjernica) koji mogu predstavljati prepreke prilagodbe za više djelatnosti medicine, različita geografsko-kulturološka područja koja zahtijevaju tehničku prilagodbu smjernica (7). Prilikom implementacijskog procesa važno je primijeniti sljedeće elemente strategija: mišljenje profesionalaca, uvođenje smjernica u praksu, edukacija pacijenata, uporaba edukativnih materijala, lokalna adaptacija smjernice i stimulacija (7). Za kvalitetnu implementaciju i maksimalnu iskoristivost smjernica preporučljivo je da smjernice imaju razrađenu strategiju primjenjivosti (7). Danas u razvoju smjernica postoje „radni okviri“ implementacije koji postaju nezaobilazan korak u izdavanju smjernica kao standardiziran i transparentan proces (8). Za bolju iskoristivost smjernica također postoje smjernice (ADAPTE, EBCPG, Alberta Ambassador Program, GRADE – ADOLOPMENT itd.) te svojevrsni *feedback* mehanizmi (npr. eGlia – *Guideline Implementability appraisal*) kojima se uočavaju nedostatci/problemsi smjernica, uključujući i one koji se odnose na implementaciju (9). Vrlo korisna stavka implementacijskog procesa su implementacijski alati – informacije, algoritmi, *checkliste*, sažetci smjernica, upute za samozbrinjavanje (10). Za razvijanje strategija implementacije nužne su razvojne grupe – zadužene i formirane sa zadatkom da postojeće smjernice od interesa poboljšaju ili *de novo* prilagode potrebama medicinskih situacija, čime se povećava njihova primjenjivost.

Poboljšavanje smjernica nužna je stavka unaprjeđenja kliničke prakse koja utječe na izvrsnost struke, poboljšanje medicinske usluge i smanjenje broja profesionalnih pogrešaka. Razvijenost sustava izrade smjernica ujedno upućuje i na stupanj razvoja zdravstvenog sustava društva, stoga se također predstavlja kao poželjna karakteristika medicinske djelatnosti u smislu kvalitetnog pružanja zdravstvene skrbi.

Ključne riječi: smjernice, implementacija, strategija, radni okvir, implementacijski alati

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¹ Dom zdravlja Osijek, dr. med., specijalist obiteljske medicine

² Dom zdravlja Županja, dr. med., specijalizant obiteljske medicine

Ivon Matić, dr. med., Health Center Županja, Dr. F. Račkog 32, 32270 Županja, mob.: +385996968600, e-adresa: ivon.matic@live.com, ORCID ID: <https://orcid.org/0000-0002-0137-6638>

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STRATEGIES FOR BETTER GUIDELINES IMPLEMENTATION IN PRACTICE

Mario Ćurković,¹ Ivon Matić²

ABSTRACT

Guidelines represent the backbone of high-quality work and an objective approach to solving problems in nearly all professions, including medicine. Medical guidelines play an important role in the provision of adequate, good quality and safe services to end users – patients, as well as to the society as a whole. Some guidelines satisfy users' needs from both the medical and the patients' perspective.

The basic postulate of good guidelines is that the content must focus on the target issue (e.g. raising individuals awareness about disease, protocols for patient care applicable for a particular condition, guidelines for antibiotics prescription, etc.). Some of the guidelines are largely unused due to a poor or insufficient implementation in practice. By definition, implementation implies specific activities and interventions performed aiming at achieving a better outcome. In order to form a strategy of implementation, elements and instruments must be developed.

The implementation of guidelines depends on a number of technical factors (e.g. content, context, graphical excellence) that may pose obstacles in adjusting the issued guidelines to multiple fields of medicine or for different geographic and cultural areas which require the necessary technical customization of the guidelines (e.g. linguistic adaptation to certain dialects).

During the implementation process, it is important to rely on the following: professional opinions, introducing the guidelines into practice, patient education, educational materials, local adjustment and stimulation for the implementation of the guidelines. For a high-quality implementation and maximum usability, having an elaborate strategy of guidelines applicability is recommended.⁷

Nowadays, there is a consistent implementability framework, a standardized and transparent process, which is unavoidable in developing and issuing guidelines.

Moreover, there are guidelines for a better implementability (ADAPTE, EBCPG, Alberta Ambassador Program, GRADE – ADOLOPMENT, MAGIC, RAPADAPTE, RCN, SRG, GIN –McMaster, etc.) and certain feedback mechanisms (e.g. –*GuideLine*) used to detect the shortcomings and inconsistencies in the guidelines, including those related to their implementation.

The key aspects in the implementability framework are the implementation tools — information, algorithms, checklists, guideline summaries, instructions for self-care — which represent useful factors in the implementation process.

To develop a strategy of implementation, development groups are necessary. These groups work on improving or adjusting the guidelines to the needs of a given medical situation, thus increasing their applicability. Improving guidelines is necessary for the improvement of clinical practice, it affects professional excellence, improves medical services and reduces the number of professional errors in clinical practice.

The level of development of the guideline system also indicates the level of development of a society's healthcare system; it is therefore a desirable characteristic of the medical profession in terms of providing high-quality healthcare.

Key words: guidelines, implementation, strategy, framework, implementation tools..

¹ Health Center Osijek

² Health Center Županja Ivon Matić, MD, Health Center Županja, Dr. F. Račkog 32, Županja 32270, Mobile: +385996968600, e-mail: ivon.matic@live.com, ORCID ID: <https://orcid.org/0000-0002-0137-6638>

IZVOD IZ SMJERNICA ZA HITNA STANJA U OBITELJSKOJ MEDICINI

Rudika Gmajnić,^{1, 3, 4} Sanda Pribić^{2, 3, 4}

SAŽETAK

Uvod: Obiteljska je medicina (OM) najdostupniji dio zdravstvene zaštite i često mora postupati u najrazličitijim hitnim stanjima.

Rasprava: Odgovornost je liječnika kao voditelja tima procijeniti potrebu za hitnom intervencijom, stupanj hitnosti, vlastite mogućnosti u određenim stanjima, primjenu dostupne dijagnostike, aktiviranje nadležnih hitnih služba, potrebu za transportom i eventualno osiguranje stručne pratište (katkad je liječnik OM-a nužna pratišta). Kad se pojavi potreba za hitnom intervencijom, OM najčešće ima ograničene dijagnostičke mogućnosti. U tim uvjetima potrebno je donijeti odluke koje mogu rezultirati kratkoročno i dugoročno najrazličitijim ishodima. Postupci se naknadno mogu pokazati opravdano ili neopravdano hitnim. Osim stručnih dvojba postoji i niz tehničkih i administrativnih prepreka, pravnih, etičkih i socijalnih čimbenika koji utječu na pristup potencijalno hitnom bolesniku.

Zaključak: Kontinuirana edukacija, obnavljanje znanja i vještina o postupanju u hitnim stanjima jačaju osobnu snagu pojedinca da bi postupio temeljem najboljih znanja i iskustava.

Ključne riječi: hitna stanja, obiteljska medicina

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¹ Specijalistička ordinacija obiteljske medicine prof. dr. sc. Rudika Gmajnić

² Specijalistička ordinacija obiteljske medicine doc. dr. sc. Sanda Pribić

³ Katedra za obiteljsku medicinu, Medicinski fakultet Sveučilišta u Osijeku

⁴ Medicinski fakultet Evropskog univerziteta „Kallos“ Tuzla

Prof. dr. sc. Rudika Gmajnić, dr. med., Specijalistička ordinacija obiteljske medicine prof. dr. sc. Rudika Gmajnić, Adresa: Park kralja P. Krešimira IV/6, 31000 Osijek, E-adresa: rudika.gmajnic01@gmail.com, Telefon: +385 98 253 988

EXCERPT FROM THE EMERGENCY GUIDELINES IN FAMILY MEDICINE

Rudika Gmajnić^{1, 3, 4} Sanda Pribić^{2, 3, 4}

ABSTRACT

Introduction: Family Medicine (FM) is the most accessible part of health care and often needs to be treated in a variety of emergency situations.

Discussion: It is the responsibility of the physician as a team leader to evaluate the need for immediate intervention, the degree of urgency, his/her own ability in certain situations, the utilisation of available diagnostics, the activation of emergency services, the need for transportation and possibly the provision of professional escorts (sometimes the family physician is required). When there is an urgent need for intervention, the FP usually has limited diagnostic capabilities. In these circumstances it is necessary to make decisions that can result in short-term and long-term variations. Procedures can subsequently be shown as justified or unjustifiable urgency. In addition to professional dilemmas, there are a number of technical and administrative obstacles, legal, ethical, social elements that affect access to potentially urgent patients.

Conclusion: Continuous education, knowledge acquisition and skills in emergency treatment strengthen the individual's personal strength to act on the basis of the best knowledge and experience.

Key words: emergency situations; family medicine

¹ Private family practice professor Rudika Gmajnić, PhD/GP

² Private family practice professor Sanda Pribić, PhD/GP

³ Department of Public Health and Family Medicine, Faculty of Medicine, University of Osijek

⁴ Medicinski fakultet Evropskog univerziteta „Kallos“ Tuzla

Prof. Rudika Gmajnić, MD, FP, PhD, E-mail: rudika.gmajnic01@gmail.com

Prof. dr. sc. Rudika Gmajnić, dr. med., Specijalistička ordinacija obiteljske medicine prof. dr. sc. Rudika Gmajnić, Adresa: Park kralja P. Krešimira IV/6, 31000 Osijek, E-adresa: rudika.gmajnic01@gmail.com, Telefon: +385 98 253 988

STRUČNA RADIONICA: SAOPĆAVANJE LOŠIH VIJESTI – NAJČEŠĆE GREŠKE

Džanana Jatić,¹ Mevlida Avdagić,¹ Ilnis Bišćo,² Amer Tahirović,³
Amela Kečo,¹ Selma Hadžibajrić,¹ Zaim Jatić^{1,3}

SAŽETAK

Uvod: Loša vijest se definira kao "vijest koja ima loš i ozbiljan učinak na percepciju pojedinaca o njihovoj budućnosti". Saopćavanje loše vijesti je jedan od najtežih i najstresnijih zadataka za ljekare, a također i za pacijente.

Ciljevi: Uz pomoć video primjera, igre uloga i diskusije ukazati na najčešće greške prilikom saopćavanja loših vijesti i ukazati na dobar način kako obaviti ovaj zadatak.

Opis: Polaznicima će biti prikazani orginalni video snimci sa primjerima najčešćih pogrešaka u procesu saopćavanja loše vijesti. Pored toga biće naglašeni koji su opći elementi loše neverbalne i verbalne komunikacije.

Biće predstavljena smjernica SPIKES protokol u šest koraka koji je akronim od engleskih riječi i sadrži sljedeće korake: S (*setting up the interview*) – obezbjedenje uvjeta za razgovor, P (*perception of the patient*) – pacijentova percepcija (bolesti), I (*invitation by the patient*) – pacijentova saglasnost za saopštavanje loše vijesti, K (*knowledge to the patient*) – saopćavanje vijesti, E (*emotions of the patient*) – pacijentove emocije i S (*strategy and summary*) – strategija za buduće liječenje i sažetak.

Nakon pogledanih videoa polaznici će komentirati pogreške i predlagati kako izbjegći pogreške i poboljšati saopćavanje loše vijesti. Polaznici će biti ohrabreni da iznesu osobna iskustva i primjere iz prakse. Na kraju radionice svi polaznici će donijeti zajednički zaključak o komunikaciji.

Ključne riječi: komunikacija, verbalna, neverbalna, pogreške, porodična medicina

¹ JU Dom zdravlja Kantona Sarajevo

² JU Kantonalna bolnica Zenica

³ Medicinski fakultet Univerziteta u Sarajevu

WORKSHOP: DELIVERING BAD NEWS – COMMON MISTAKES

Džanana Jatić,¹ Mevlida Avdagić,¹ Irmis Bišćo,² Amer Tahirović,³
Amela Kečo,¹ Selma Hadžibajrić,¹ Zaim Jatić^{1,3}

ABSTRACT

Introduction: Bad news is defined as “any information which adversely and seriously affects an individual’s view of his or her future.” Delivering patients bad news is one of the most difficult and stressful tasks for both doctors and patients.

Aim: The aim of this workshop is to drawing attention to common mistakes made while delivering bad news as well as to good methods of fulfilling this task. We will use video examples, role-play and discussion.

Description: Participants will be shown authentic video materials with the examples of common mistakes made in the process of delivering bad news and with common elements of bad non-verbal and verbal communication. Guidelines SPIKES – a six-step protocol for delivering bad news which is an acronym comprising: S (setting up the interview), P – (assessing the patient’s perception), I – (Obtaining the patient’s invitation), K – (giving knowledge to the patient) – delivering the news, E – (addressing the patient’s emotions with empathic responses) will be presented. Having watched the video materials, the participants will comment on the mistakes and suggest how these may be avoided in order to improve delivering bad news. They will be encouraged to share their personal experience and examples from practice. At the end of the workshop, they will make a joint conclusion on the issue.

Keywords: communication, verbal, non verbal, family medicine

¹ Health Centre, the Canton of Sarajevo

² Cantonal hospital Zenica

³ Faculty of Medicine, University of Sarajevo

KLINIČKE SMJERNICE U HRVATSKOJ – TRENUTAČNO STANJE, VALIDNOST I KVALITETA DOKAZA

Ana Jerončić,¹ Davorka Vrdoljak,^{2,3} Tanja Kovačević,⁴
Slavica Jurić Petričević,⁵ Željko Krznarić,⁶ Ana Marušić¹

SAŽETAK

Uvod: Kliničke su smjernice sustavno razvijene preporuke koje bi trebale pomoći zdravstvenim djelatnicima i pacijentima u donošenju na dokazima temeljenih, informiranih odluka o prikladnoj zdravstvenoj skrbi u specifičnim kliničkim okolnostima. Cilj je rada bio ispitati metodološku kvalitetu svih kliničkih smjernica u Hrvatskoj objavljenih u razdoblju od 2001. do 2017. godine.

Metode: Četiri su istraživača neovisno procijenila kvalitetu 63 objavljene kliničke smjernice korištenjem validiranog AGREE-II upitnika. Ukupni bodovi za pojedinu smjernicu, te njeni bodovi pridruženi domenama upitnika, izraženi su kao postotak maksimalno mogućeg broja bodova.

Rezultat: Hrvatske kliničke smjernice koje su objavljene u razdoblju od 2001. do 2017. godine u pravilu su metodološki slabe. Čest nedostatak tih smjernica jest neprovodenje sustavnih pretraga literature, ali i izostanak adekvatne procjene kvalitete dokaza te nezadovoljavajuća sinteza dokaza. Smjernice izrađene od radnih skupina Ministarstva zdravstva i neovisnih autora ocjenjene su najvišim brojem bodova u svim AGREE-II domenama.

Zaključak: Kako bi se poboljšala kvaliteta kliničkih smjernica u Hrvatskoj, kreatori smjernica trebali bi usvojiti stroži metodološki okvir, moguće uključivanjem znanstvenih metodologa, biostatističara, informatologa, ali i ostalih stručnjaka u radne skupine te dodatnom edukacijom. Neovisnost radne skupine pokazala se važnom odrednicom kvalitete.

¹ Katedra za istraživanja u biomedicini i zdravstvu, Medicinski fakultet Sveučilišta u Splitu

² Katedra obiteljske medicine, Medicinski fakultet Sveučilišta u Splitu

³ Ordinacija obiteljske medicine, Sućidar 79/II, 21000 Split

⁴ Zavod za intenzivnu pedijatriju KBC Split

⁵ Klinika za neurologiju KBC Split

⁶ Hrvatski liječnički zbor, Zagreb

Adresa za dopisivanje:

Ana Jerončić, e-adresa: ana.jeroncic@mefst.hr, <https://orcid.org/0000-0003-1621-1956>

CROATIAN CLINICAL GUIDELINES – THE CURRENT STATE, VALIDITY AND QUALITY OF EVIDENCE

Ana Jerončić,¹ Davorka Vrdoljak,^{2,3} Tanja Kovačević,⁴
Slavica Jurić Petričević,⁵ Željko Krznarić,⁶ Ana Marušić¹

ABSTRACT

Introduction: Clinical guidelines are systematically developed recommendations aimed at helping healthcare professionals and patients in making evidence-based, informed decisions on appropriate health care in specific clinical circumstances. The aim of the paper was to examine the methodological quality of all the clinical guidelines published in Croatia in the period 2001 - 2017.¹⁻⁶
Methods: The quality of 63 published clinical guidelines was assessed using the validated AGREE-II questionnaire. The total points for each guideline, and the points assigned to a particular domain of the questionnaire, were expressed as a percentage of a maximum possible number of points.

Results: Croatian clinical guidelines published in the period 2001 - 2017 are, as a rule, methodologically weak. A common shortcoming of these guidelines is the failure to perform systematic literature searches, but also the lack of adequate quality assessment and/or evidence synthesis. Guidelines made by working groups of the Ministry of Health and by independent authors are evaluated with the highest number of points across all of the AGREE II domains.

Conclusion: In order to improve the quality of clinical guidelines in Croatia, the guidelines developers should adopt a more rigorous methodological framework, possibly by including scientific methodologies, biostatistical, informatics and other experts into working groups or by additional education. Independence of a working group proved to be an important quality determinant.

¹ Department of Research in Biomedicine and Health, University of Split School of Medicine

² Department of Family Medicine, University of Split School of Medicine, Split, Croatia

³ Family Medicine Surgery, Sućidar 79/II, 21000 Split

⁴ Department of Paediatrics, Paediatric Intensive Care Unit, University Hospital Split, Croatia

⁵ Department of Neurology, University Hospital Split, Croatia

⁶ Croatian Medical Association, Zagreb, Croatia

Corresponding address:

Ana Jerončić, ana.jeroncic@mefst.hr, <https://orcid.org/0000-0003-1621-1956>

PROGRAM OBVEZNOG I PREPORUČENOG CIJEPLJENJA OD ZARAZNIH BOLESTI – IZAZOVI I DILEME

Vesna Jureša¹

SAŽETAK

Uvod: U Hrvatskoj postoji duga tradicija obveznog cijepljenja djece i program koji se vrlo uspješno provodio do unatrag petnaestak godina. Velikim obuhvatom cijepljenjem osiguravala se dobra zaštita od zaraznih bolesti, što je rezultiralo niskom učestalosti zaraznih bolesti protiv kojih se cijepi. Prve naznake da se stav o cijepljenju mijenja, javile su se sa zahtjevima da se dotadašnje „domaće“ cjepivo protiv ospica zamjeni „novim i uvoznim cjepivima“, potom kad se uvodilo cjepljenje protiv hepatitis-a B i posljednje povezano s neobveznim cijepljenjem protiv HPV-a. Ova pojava tzv. „antivakcinalni pokret“ zahvatila je cijeli svijet. Zemlje, kao što su Belgija i Nizozemska, koje imaju dobrovoljno cijepljenje i visoku procijepljenost, su imale neočekivano vrlo loš odaziv za cijepljenje protiv HPV-a.

Prikaz: U Hrvatskoj je procijepljenost djece vrlo različita i obuhvat je u pojedinim područjima (županijama) ispod granica koji osiguravaju dobru zaštitu populacije. Jedna od naših specifičnosti je da roditelji koji su uredno cijepili svoju djecu u predškolskoj dobi odbijaju cijepljenje protiv istih bolesti u školskoj dobi ili traže cijepljenje posebnim vrstama cjepiva (monovalentna cjepiva, određenih proizvoda i drugo). Posljednjih desetak godina počele su i prve oštре reakcije roditelja upućene cjepiteljima (prvenstveno pedijatrima i školskim liječnicima) nakon pokušaja da se savjetovanjem i opetovanim pozivima roditeljima poveća procijepljenost djeca. Reakcije na ove pokušaje bile su: traženje roditelja da se samo pojedina cjepiva isključe, traženje jasnih i detaljnih odgovora o mogućim nuspojavama i reakcijama na svako pojedino cjepivo, traženje da se provjeri imunološki odgovor na prethodna cijepljenja i tada odluci o cijepljenju, zahtjevi o podacima o sastavu cjepiva (konzervansi, stabilizatori...), zahtjevi da liječnici potpišu da će odgovarati za moguće posljedice cijepljenje ili potpišu da cjepivo neće naškoditi djetetu, do tužbi protiv liječnika radi otkrivanja liječničke tajne u slučaju prijave roditelja radi neprovedenog cijepljenja. Prije provedbe dobrovoljnog cijepljena učenika protiv HPV-a školski liječnici provode edukaciju roditelja i uz svu moguću informiranost, napore i besplatno cjepivo obuhvat je ispod 20% ciljane populacije.

Zaključak: Za promjenu stava prema cijepljenju potrebno je imati uvid u specifičnosti razloga za odbijanje cijepljenja u svakoj pojedinoj sredini. Profesionalcima je potreban jedinstveni, strukturirani i razrađeniji pristup roditeljima, posebice onima koji trebaju pomoći pri donošenju odluke.

Ključne riječi: cijepljenje, dileme

¹ Sveučilište u Zagrebu, Medicinski fakultet, Škola narodnog zdravlja “Andrija Štampar”, Zagreb, Hrvatska
Vesna Jureša, Škola narodnog zdravlja “Andrija Štampar”, 10000 Zagreb, Rockefelleova 4. vjuresa@snz.hr

COMPULSORY AND RECOMMENDED VACCINATION PROGRAM FOR INFECTIOUS DISEASES - CHALLENGES AND DILEMMAS

Vesna Jureša¹

ABSTRACT

Introduction: In Croatia, there is a long tradition of compulsory vaccination for children and a program that has been successfully implemented until the last fifteen years. Comprehensive vaccine coverage provided good protection against infectious diseases, resulting in a low incidence of infectious diseases. The first indication that the stance on vaccination is changed has been the rise of requests to replace the former "domestic" measles vaccine with "new and imported vaccines", then when a hepatitis B vaccine was introduced and lastly linked to a non-mandatory vaccine against HPV. Anti-vaccination movement affected the entire world. Countries like Belgium and the Netherlands who have voluntary vaccination and high coverage had an unexpectedly poor response to HPV vaccination.

Review: In Croatia, the prevalence of children vaccination is very different and the coverage in some areas (counties) is below the limits that ensure good protection of population. One of our specifics is that parents who have neatly vaccinated their children at preschool age refuse vaccination against the same illness at school age or seek vaccination with specific vaccine types (monovalent vaccines, certain manufacturers....). In the last ten years, reactions of parents to vaccinators (pediatricians and school doctors) began after the attempts to increase the prevalence of vaccination by counseling and appeals to parents. Reactions to these trials were: parents seeking to exclude certain vaccines, to explain in details vaccinations contents, possible side effects and reactions to each vaccine, to check the immunological response to previous vaccination, and demands that doctors should sign a liability consent to the possible consequences of vaccination, as well as possible harm to the child, along with the law sue against doctor in case of his/hers report on parents rejecting child's vaccination, claiming the breach of medical information. Prior to HPV vaccination of students, school doctors educate parents, but regardless all the information and the fact that the vaccination is free of charge, coverage is below 20%.

Conclusion: To change the attitude towards the vaccination, it is necessary to have an insight into the specificity of the reasons for rejecting the vaccination in each population. Professionals need unique, structured and elaborated approach to parents, especially to those who need help with decision-making.

Keywords: vaccination, dilemma

¹ University of Zagreb, School of Medicine, Andrija Štampar School of Public Health, Zagreb, Croatia

AKTUALNE SMJERNICE ZA SKRB O BOLESNICIMA S MOLTIMORBIDITETOM U OBITELJSKOJ MEDICINI – GDJE JE KLJUČ USPJEŠNE SKRBI?

Đurđica Kašuba Lazić¹

SAŽETAK

Uvod: Svjetska zdravstvena organizacija pojam multimorbiditet (MM) definirala je kao istovremenu prisutnost dviju i/ili više kroničnih bolesti (KB) u jedne osobe. Međutim, gledajući na MM istovremeno s aspekta bolesnika, liječnika obiteljske medicine (LOM), sustava zdravstvene zaštite i društva u cjelini, pored zbrajanja broja bolesti u pojedinca, nameće se važnost sagledavanja brojnih osobnih i okolinskih čimbenika, neodvojivih od MM-a, koji pojedinačno ili sinergijski uvelike mogu modificirati težinu kliničkog stanja bolesnika s MM-om, utjecati na ishode bolesti, smanjiti kvalitetu života i dovesti do pojave nemoći. Premda u kategoriju bolesnika s MM-om ubrajamo enorman broj oboljelih, analizom pojedinih, specifičnih čimbenika poput loših biopsihosocijalnih znacajki, učestalog korištenja zdravstvene službe i bolesnikovih poteškoća da se nosi s teretom bolesti i razvojem nemoći, iz te velike i vrlo raznolike skupine bolesnika s MM-om može se izdvojiti posebna skupina bolesnika koja bi mogla imati koristi od pružanja specifične skrbi. Ciljevi su takve skrbi: kvaliteta života bolesnika, liječenje temeljeno na bolesnikovu izboru i racionalizirano korištenje zdravstvenih resursa. Način postizanja navedenih ciljeva pažljivo je razrađen u smjernicama za kliničku procjenu i menadžment multimorbiditeta (engl. *Multimorbidity: clinical assessment and management*) Nacionalnog instituta za izvrsnost u liječenju i skrbi (engl. *National institute for health and care excellence*, NICE) iz Engleske. Ovaj pregledni rad donosi prikaz tih smjernica.

Rasprava: NICE smjernice sadrže preporuke i instrumente koji liječniku olakšavaju izabratiti bolesnike s MM-om koji će imati koristi od njihove primjene, omogućuju planirati i provoditi tu skrb te razvijati standarde skrbi. Također, preporuke se odnose i na način i kvalitetu komunikacije liječnika i bolesnika prilikom zajedničkog donošenja odluke o daljem liječenju odnosno neliječenju. U smjernicama se nalaze i instrumenti koji olakšavaju liječniku prepoznavanje stanja „nemoći“ bolesnika te dobivanje ocjene o možebitnoj koristi ili šteti od nastavka farmakološkog liječenja.

Zaključak: Zahvaljujući sveobuhvatnom pristupu ovih smjernica za skrb o bolesniku s kompleksnim zdravstvenim problemima, LOM će imati pomoći i oslonac u prepoznavanju, vođenju i daljoj skrbi o skupini bolesnika s MM-om koji bi promjenom pristupa liječenja KB-a mogli imati koristi od posebne, bolesniku usmjerene skrbi. Ipak, smjernice su samo pomoći, a ne zamjena za liječnikovo ekspertno znanje i vještine koji su potrebni za skrb o navedenim bolesnicima.

Ključne riječi: multimorbiditet, smjernice, NICE

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¹ Katedra za obiteljsku medicinu, Škola narodnog zdravlja „Andrija Štampar“, Medicinski fakultet Sveučilišta u Zagrebu, Dom zdravlja Zagreb-Centar
Adresa:

Prof. prim. dr. sc. Đurđica Kašuba Lazić, specijalist obiteljske medicine, Rockefellerova 4, Zagreb,
e-adresa: durdica.lazic@mef.hr, djlazic@gmail.hr, <https://orcid.org/0000-0002-4091-8313>

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CURRENT GUIDELINES FOR CARE OF PATIENTS WITH MULTIMORBIDITY IN FAMILY MEDICINE - WHERE IS THE KEY FOR SUCCESSFUL CARE?

Đurđica Kašuba Lazić^{1,2}

ABSTRACT

Introduction: The World Health Organization has defined multimorbidity (MM) as the concurrent presence of two or more chronic diseases (CD) in one person. However, looking simultaneously at MM from the point of view of patients, family physicians (FPs), health care systems and society as a whole, apart from calculating the number of diseases of an individual, it is important to take into consideration numerous personal and environmental factors which are inseparable from MM and can, by themselves or synergistically, greatly modify the severity of the clinical condition of the patient with MM, affect the outcomes of disease, reduce the quality of life and lead to the onset of frailty. Although the category of patients with MM includes an enormous number of affected individuals, specific factors such as their poor biopsychosocial characteristics, a frequent use of health services, difficulty to cope with the burden of disease and frailty development can contribute to identify, in this large and very heterogeneous group of patients with MM, those patients who could benefit from receiving specific care. The objectives of such specific care are patient's quality of life, treatment according to patient's preferences and a rationalised use of health resources. The method of how to achieve these objectives was carefully elaborated in the guidelines for clinical assessment and management of multimorbidity of the National Institute for Health and Care Excellence (NICE) from England (hereinafter referred to as "Guidelines"). Here presented is an overview.

Discussion: NICE guidelines encompass recommendations and instruments for physicians on how to identify patients with MM who will benefit from their application and how to plan and carry out this care, as well as further develop the standards of care. Also, the guidelines recommend the style and quality of communication between physicians and patients when making a mutual decision on further treatment or not treatment. The guidelines also include tools for helping physicians in identifying patient's frailty and evaluating possible benefits or damages from pharmacological treatment continuation.

Conclusion: These guidelines represent a comprehensive approach to the care of patients with complex health problems and provide physicians with help and support in identifying, guiding and further caring for the group of patients with MM, which could greatly benefit from the change in treatment of CD through a specific, patient centred care. Nevertheless, guidelines are only an aid, not a substitute for the expert knowledge and skills of the physician which are necessary for a good care of these patients.

Key word: multimorbidity, guidelines, NICE

¹ Department of Family Medicine, School of Medicine

² University of Zagreb, Health Centre Zagreb - Center, Zagreb
Corresponding address:

Prof. prim. dr. sc. Đurđica Kašuba Lazić, Family medicine specialist, Department of Family Medicine, Medical School, University of Zagreb, Rockefellerova 4. Zagreb,
E-mail: djlazic@gmail.hr, durdica.lazic@mef.hr, <https://orcid.org/0000-0002-4091-8313>

KRATAK PREGLED SMJERNICA ZA LIJEČENJE BOLI U OBITELJSKOJ MEDICINI

Milica Katić,^{1,2} Mira Fingler,³ Rajka Šimunović^{1,4}

SAŽETAK

Uvod: Bol je subjektivno iskustvo na koje utječu fizički, psihički, socijalni i duhovni čimbenici. Za učinkovito lijeчењe boli nužno je odrediti uzrok i vrstu boli, njen intenzitet, trajanje, pridruženi komorbiditet ili psihološke probleme te potom odabrat primjeren lijek. Za procjenu težine boli najvažnije je uvažiti ono što sam bolesnik iskazuje i uz to se koristiti ljestvicama za procjenu boli. Suvremena farmakoterapija boli temelji se na konceptu „tri stepenice liječenja boli“ Svjetske zdravstvene organizacije, koji je univerzalno primjenjiv i omogućuje fleksibilnost u izboru i primjeni analgetika. Liječeњe boli započinje se neopiodnim lijekovima, a ako se time ne uspijeva suzbiti bol, dodaju se slabi opioidi i potom jaki opioidi. U svakoj stepenici moguće je primjenjivati adjuvantne lijekove sukladno specifičnim potrebama bolesnika. Cilj je ovoga rada prikazati neke od najvažnijih novijih preporuka za liječeњe boli značajnih za liječnika obiteljske medicine.

Najvažnije preporuke za liječeњe boli: Neovisno o etiologiji akutna bol nastaje podražajem nociceptora i ubičajeno se razriješi u razdoblju do tri mjeseca. Nesteroidni protuupalni lijekovi (NSAIL) najčešći su primjenjivani analgetici u liječeњu akutne boli. NSAIL imaju brojna ograničenja u primjeni zbog nuspojava i interakcija, neprimjereno doziranja i duljine primjene. Bol u bolesnika s rakom najčešće je miješana nocicepcionska i neuropatska bol, a prema trajanju kronična, progredirajuća bol. Pri uvođenju opioida u terapiju treba provesti primjerenu titraciju kako bi se što je brže moguće postigao odgovarajući učinak. Kronična nemaligna bol najčešće je miješana bol ili neuropatska bol koja traje dulje od šest mjeseci. U kroničnoj boli aktivacija nociceptora je trajna što dovodi do trajnih promjena u središnjem živčanom sustavu i kronifikaciji boli. Kronična bol treba se sagledati kao kompleksan somatski i psihosocijalni problem, te je u liječeњu nužan specijaliziran i multidisciplinarni pristup. Dnevna doza opioida za liječeњe kronične nemaligne boli ne bi trebala biti veća od 100 mg morfina ili drugog ekvivalentnog opioida, a primjena opioida ne dulja od tri mjeseca uz povremenu rotaciju. Nefarmakološko liječeњe, kao što je kognitivno bihevioralna terapija, vježbanje i biopsihosocijalna rehabilitacija te različiti oblici fizikalne terapije mogu biti od velike pomoći u liječeњu kronične boli. Invazivne metode liječeњa kronične boli provode se u specijaliziranim ustanovama. Neuropatska bol uzrokovana je oštećenjem ili bolešću somatosenzornog živčanog sustava, može nastati zbog brojnih uzroka i može imati različitu distribuciju. Lijekovi izbora za neuropatsku bol su antidepresivi i antikonvulzivi.

Zaključak: Poznavanje bolesnika i blizak odnos s bolesnikom, kontinuirana skrb i sveobuhvatni pristup uz poznavanje smjernica o liječeњu boli omogućuje liječniku obiteljske medicine uspješno liječeњe boli.

Ključne riječi: liječeњe boli, smjernice, obiteljska medicina

¹ Sveučilište u Zagrebu, Medicinski fakultet, Škola narodnog zdravlja „Andrija Štampar“, Katedra za obiteljsku medicinu

² Dom zdravlja Zagreb-Centar

³ Hrvatsko društvo za liječeњe boli Hrvatskoga liječničkog zborna

⁴ Specijalistička ordinacija opće medicine, Matije Gupca 10, Požega

Adresa za dopisivanje:

Milica Katić, Dom zdravlja Zagreb-Centar, Ordinacija Dugave, Kauzlaricev prilaz 7, Zagreb,

e-adresa: milica.katic@gmail.com, ORCID ID 0000-0001-8496-5165

A BRIEF OVERVIEW OF THE GUIDELINES FOR PAIN MANAGEMENT IN FAMILY MEDICINE

Milica Katić,^{1,2} Mira Fingler,³ Rajka Šimunović,^{1,4}

ABSTRACT

Introduction: Pain is a subjective experience, influenced by physical, psychological, social, and spiritual factors. Pain management should include a thorough assessment of the cause, type, severity and duration of pain, the underlying causes, any associated co-morbidities or psychological problems and choosing the appropriate treatment. Pain severity is best assessed by patient self-report and may be aided by analogue scales. Current pharmacotherapy is based on the WHO concept of an analgesic ladder which has been extensively validated and allows flexibility in the choice and use of analgesics. The ladder suggests that clinicians should start with a non-opioid and if pain is not controlled, progress to a weak opioid and then to a strong opioid. Analgesic drugs should be combined with adjuvant drugs in every step of analgesic ladder according to specific needs of the patient. The aim of this paper is to present some of the most recent recommendations for the treatment of pain that are important to family medicine practitioners.

Most important recommendations for the pain management: Regardless of etiology, acute pain is caused by the stimulation of nociceptors and is usually solved over a period of up to three months. Non-steroidal anti-inflammatory drugs (NSAIDs) are the most commonly used analgesics in the treatment of acute pain. NSAIDs have numerous limitations in administration due to side effects and interactions, inappropriate dosage and length of application. Pain in cancer patients is most commonly mixed nociceptive and neuropathic pain and in respect of duration, it is chronic, progressive pain. Opioid doses should be titrated to achieve an appropriate effect as rapidly as possible. Chronic non-malignant pain is usually mixed nociceptive and neuropathic pain or chronic neuropathic pain and lasts longer than six months. Chronic pain must be recognized as a complex somatic and psychosocial disease state. The treatment of such pain requires a specialized and multidisciplinary approach. The daily dose of opioids for the treatment of chronic non-malignant pain should not be greater than 100 mg of morphine or another equivalent opioid, and the opioid use should not last more than three months with intermittent rotation. Non-pharmacologic treatments such as cognitive-behavioral therapy, exercise therapy, biopsychosocial rehabilitation and various types of physiotherapy appear the most promising with the least amount of risk in pain treatment. Invasive methods of treating chronic pain are performed in specialized institutions. Neuropathic pain is a term used for a group of conditions with a wide range of causes and different pain distributions. Drugs for treatment of neuropathic pain are antidepressants and anticonvulsants.

Conclusion: The knowledge about patients, a close relationship between the family practitioner and his/her patient, a continuous and comprehensive approach and the knowledge of the pain treatment guidelines enables the family practitioner to treat pain successfully.

Key words: pain management, guidelines, general practice/family medicine

¹ University of Zagreb, Medical School, "Andrija Štampar" School of Public Health Department of Family Medicine

² Health Centre Zagreb Centre

³ The Croatian Pain Society

⁴ General practitioner office, Matije Gupca 10 Požega

Address for correspondence:

Milica Katić, Dom zdravlja Zagreb Centar, Ordinacija Dugave, Kauzlarićev prilaz 7, Zagreb,
e-mail: milica.katic@gmail.com, ORCID ID 0000-0001-8496-5165

NACIONALNE SMJERNICE ZA LIJEČENJE DIJABETESA U ZEMLJAMA JUGOISTOČNE EUROPE I NJIHOVA PRIMJENJIVOST U SVAKODNEVNOM RADU

Katerina Kovachevikj,¹ Biljana Chekorova Mitreva,¹
Katarina Stavric,^{1,2} Ljubin Shukriev,¹ Marta Tundzeva,¹
Katerina Kikerkovska,¹ Elizabeta Kostovska-Prilepcanska,¹
Jasminka Zarevska Popovska,¹ Sashka Janevska¹

SAŽETAK

Uvod: Dijabetes je globalna epidemija. Potrebne su učinkovite mjere za nadzor, prevenciju i kontrolu dijabetesa i njegovih čimbenika rizika u svrhu razvijanja vodiča na temelju razvijenih standarda za dijagnozu i brigu o bolesniku s dijabetesom. Upotreba smjernica kliničke prakse pokazala je da one poboljšavaju kvalitetu skrbi, međutim, postavlja se pitanje: Mogu li obiteljski liječnici primijeniti smjernice u svakodnevnoj praksi?

Cilj: Ispitati primjenjivost nacionalnih vodiča za dijabetes u svakodnevnom radu obiteljskog liječnika u zemljama Jugoistočne Europe.

Metode: Koristili smo se nacionalnim smjernicama za dijabetes iz šest zemalja A OM/OM JIE (Slovenija, Hrvatska, Bosna i Hercegovina, Srbija, Makedonija, Bugarska) i ocijenili njihovu primjenjivost na razini primarne zdravstvene zaštite (PZZ).

Rezultati: Liječnici obiteljske medicine provode preventivne pregledne prema preporukama za rano otkrivanje dijabetesa. Dijagnostički postupci za dijabetes dostupni su na razini PZZ-a. Postoji nedosljedna i neujednačena provedba smjernica među ocijenjenim zemljama zbog sljedećih čimbenika: nezadovoljavajuće razine zdravstvene svijesti stanovništva, nedovoljnog samozbrinjavanja pacijenata s dijabetesom, ograničenja propisanih za neke od terapijskih mogućnosti i nedostupnosti drugih, novih terapija, nedostatka obrazovanoga zdravstvenog osoblja, ograničavanja zdravstvenih usluga liječnika obiteljske medicine, nejasne definicije uloge liječnika obiteljske medicine, nedostatka multidisciplinarnih timova, fragmentacije zdravstvene zaštite i nedovoljne međusobne suradnje. Zbog tih čimbenika liječnici obiteljske medicine ne mogu u potpunosti primijeniti individualizirani pristup usmjeren na pacijenta pri donošenju odluka o zbrinjavanju dijabetesa.

Zaključak: Da bi smjernice bile u potpunosti primjenjive, potrebno je provesti nacionalne programe za dijabetes: za prevenciju dijabetesa – podizanje svijesti i edukaciju o rizicima od dijabetesa te čimbenicima za smanjenje rizika s posebnim naglaskom na prekomjernu težinu i pretilost, osobito u djetinjstvu i mlađim dobnim skupinama; za zbrinjavanje dijabetesa – edukacija pacijenata za samopraćenje i samozbrinjavanje, kontinuirana medicinska edukacija medicinskog osoblja i prihvaćanje raznih terapijskih mogućnosti. Potrebno je preciznije definirati uloge medicinskog osoblja na svim razinama zdravstvene zaštite, kao preduvjet za uspješno zbrinjavanje dijabetesa. U izradi nacionalnih smjernica trebaju sudjelovati sve strukovne udruge, uključujući i udruge stručnjaka obiteljske medicine. Potrebno je i objedinjavanje kompetencija liječnika obiteljske medicine u zemljama A OM/OM JIE i međusobna suradnja u izradi smjernica u PZZ-u.

Ključne riječi: smjernice, dijabetes, obiteljska medicina

¹ Centar za obiteljsku medicinu, Medicinski fakultet Skoplje

² Klinika za pedijatriju, Skoplje

Adresa za dopisivanje:

Katerina Kovachevikj, 33/10 1000 Skopje, Makedonija, e-adresa: vitakaterina@gmail.com

NATIONAL DIABETES TREATMENT GUIDELINES IN SOUTH EAST EUROPE AND THEIR APPLICABILITY IN EVERYDAY PRACTICE

Katerina Kovachevikj,¹ Biljana Chekorova Mitreva,¹
Katarina Stavric,^{1,2} Ljubin Shukriev,¹ Marta Tundzeva,¹
Katerina Kikerkovska,¹ Elizabeta Kostovska-Prilepcanska,¹
Jasminka Zarevska Popovska,¹ Sashka Janevska¹

ABSTRACT

Diabetes is a global epidemic. Effective measures for prevention, early detection and management of diabetes and its risk factors, incorporated in the guidelines based on developed standards for diagnosis and care of diabetic patients are required. Implementing the guidelines for clinical practice has been proven to improve the quality of care, however, the question remains whether family physicians can implement the guidelines in their everyday practice.

The aim of this study is to evaluate the applicability of national diabetes guidelines in the daily work of family physicians in the countries of South East Europe.

Methods: We used national diabetes guidelines from 6 countries A GP/FM SEE (Slovenia, Croatia, Bosnia and Herzegovina, Serbia, Macedonia and Bulgaria) and evaluated their applicability in primary health care (PHC).

Results: Family physicians conduct preventive examinations following the recommendations for early detection of diabetes. Diagnostic procedures for diabetes are available at PHC level. The implementation of guidelines in the evaluated countries is not consistent nor uniform, due to the following factors: unsatisfactory level of healthcare awareness among the population, insufficient diabetic patients' self-care, prescription limitations for some and unavailability of other therapeutic options, novel therapies, a lack of educated staff, the limitation of health care services provided by the family physician, an unclear definition of the role of family physicians, a lack of multidisciplinary teams, the fragmentation of health care and insufficient mutual collaboration. Due to these factors, family physicians cannot fully apply individualized patient-centred approach in making diabetes management decisions.

Conclusion: For the guidelines to be fully applicable, it is necessary to implement national diabetes programmes for: diabetes prevention - raising awareness and providing education for diabetes risks, risk mitigating factors with special emphasis on overweight and obesity, especially in childhood and younger generations; diabetes management - patient education for self-care, the continuing medical education of medical staff and access to a variety of therapeutic options. What is required, is a more precise definition of the roles of medical staff at all levels of health care, as a prerequisite for a successful diabetes management. It is necessary that all professional associations, including associations of family medicine specialists participate in the creation of national guidelines. The unification of the competences of family physicians in AGP/FM SEE countries and mutual collaboration in developing guidelines in PHC is also required.

Key words: Guidelines, Diabetes, Family Medicine

¹ Centar for family medicine Medical faculty Skopje

² University Children Hospital Skopje

Corresponding address:

Katerina Kovachevikj, 33/10 1000 Skopje, Macedonia, E-mail: vitakaterina@gmail.com

GOLD SMJERNICE ZA PREVENCIJU, DIJAGNOZU I ZBRINJAVANJE KOPB-A

Ksenija Kranjčević^{1,2}

SAŽETAK

Kronična opstruktivna plućna bolest (KOPB) četvrti je uzrok smrtnosti u svijetu i jedna od najčešće neprepoznatih bolesti (1). To je multisistemna bolest progresivnog tijeka koju karakterizira stalni smanjeni protok zraka kroz dišne puteve, što je posljedica abnormalnosti bronha i/ili alveola. Zbog važnosti ranog prepoznavanja, pravovremenog dijagnosticiranja i pravilnog liječenja još je 2011. godine Globalna inicijativa za kroničnu opstruktivnu plućnu bolest (engl. *The Global Initiative for Chronic Obstructive Lung Disease*, GOLD) objavila smjernice za dijagnozu, zbrinjavanje i prevenciju KOPB-a, koje se u suradnji s nacionalnim pulmološkim društvima svake godine obnavljaju (2). Smjernice sadrže upute o procjeni težine KOPB-a temeljene na težini simptoma, riziku od egzacerbacija, stupnju opstrukcije bronha utvrđenom spirometrijom i identifikaciji prisutnih komorbiditeta. Ovogodišnje smjernice pojednostavnile su način procjene težine bolesti i liječenja oboljelih što je primjenjivo u praksi obiteljskog liječnika koji je najčešće liječnik prvog kontakta. Liječnik obiteljske medicine morao bi posumnjati na KOPB u svakog pacijenta sa simptomima zaduhe, kašla i/ili prisutnim iskašljajem i izloženosti rizičnim čimbenicima, te učiniti spirometriju ili ga uputiti na taj pregled. Postbronchodilatacijski omjer forsiranog izdisajnjog volumena u prvoj sekundi i forsiranog vitalnog kapaciteta (FEV1/FVC) < 70 % potvrda je prisutne stalne opstrukcije bronha. Kako bi se liječniku olakšao izbor terapije, s obzirom na težinu simptoma i rizik od egzacerbacija, oboljeli sa stabilnim KOPB-om podijeljeni su u četiri skupine, A, B, C, D, s podskupinama 1, 2, 3 ili 4 (ovisno o FEV1). Oboljele skupine C i D potrebno je uputiti specijalistu pulmologu. Prilikom svakog posjeta nužno je provjeriti način primjene inhalacijskog lijeka, procijeniti težinu simptoma i suradljivost bolesnika te potrebu za eskalacijom odnosno deeskalacijom terapije uz izvođenje spirometrije barem jednom godišnje. Zaključno možemo reći da su GOLD smjernice primjenjive u praksi obiteljskog liječnika nudeći mu pomoći i sigurnost u dijagnozi i zbrinjavanju oboljelih od KOPB-a.

Ključne riječi: KOPB, smjernice, liječnik obiteljske medicine

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¹ Specijalistička ordinacija obiteljske medicine dr. sc. Ksenija Kranjčević

² Katedra za obiteljsku medicinu, Medicinski fakultet Sveučilišta u Zagrebu,
Škola narodnog zdravlja „Andrija Štampar“

Adresa:

Specijalistička ordinacija obiteljske medicine dr. sc. Ksenija Kranjčević, H. Macanovića 2a, Zagreb,
e-adresa: ksenija.kranjcevic@inet.hr

GOLD GLOBAL STRATEGY FOR THE DIAGNOSIS, MANAGEMENT, AND PREVENTION OF COPD

Ksenija Kranjčević^{1,2}

ABSTRACT

Chronic Obstructive Pulmonary Disease (COPD) is currently the fourth leading cause of death in the world (1). COPD is a common, preventable and treatable disease characterized by persistent respiratory symptoms and airflow limitations due to airway and/or alveolar abnormalities usually caused by a significant exposure to noxious particles or gases. In 2011, the Global Initiative for Chronic Obstructive Lung Disease (GOLD) released a consensus report Global Strategy for the Diagnosis, Management, and Prevention of COPD, renewed each year in cooperation with national pulmonary societies. The assessment of COPD proposed by GOLD has been based on the patient's level of symptoms, the future risk of exacerbations, the extent of airflow limitation, the spirometric abnormality, and the identification of comorbidities. This year's guidelines have simplified the way of assessing the severity of the illness and the treatment of the patients so that it is practicable in the family physician's practice, the family physician most often being the first contact physicians. A risk score based on routine data from electronic health records in primary care facilitate case-finding. Spirometry is required to make the diagnosis and the presence of a post-bronchodilator forced expiratory volume in one second/forced vital capacity (FEV1/FVC) <70% confirm the presence of persistent airflow limitation. A model for initiation of pharmacological management of COPD is developed according to the individualized assessment of symptoms and exacerbation risk following the ABCD assessment. Following the implementation of therapy, the patient should be reassessed for the attainment of treatment goals and an identification of any barriers for successful treatment. Escalation and de-escalation strategies based on available efficacy as well as safety data are suggested.

In conclusion, we can say that the GOLD guidelines are acceptable for family physicians offering them assistance and safety in diagnosing and treating COPD patients.

Key words: COPD, guidelines, family physicians

¹ General practice office PhD Ksenija Kranjčević

² Department of Family Medicine, School of Public Health „Andrija Štampar“, Medical School University of Zagreb, Croatia

Corresponding address:

General practice office PhD Ksenija Kranjčević, H. Macanovića 2a, Zagreb,
E-mail: ksenija.kranjcevic@inet.hr

PRIMENLJIVOST VODIČA ZA RACIONALNU UPOTREBU ANTIBIOTIKA U LEČENJU NAJČEŠĆIH INFEKCIJA U OPŠTOJ MEDICINI

Branka Lazić,¹ Vesna Janjušević,¹
Ana Janjušević,² Tijana Lazić³

SAŽETAK

Uvod: Antibiotici danas čine 15-30 % svih propisanih lekova u svetu, a posledica njihove neracionalne primene je pojava bakterijske rezistencije. Srbija spada u zemlje sa visokom stopom propisivanja antibiotika, pri čemu se na nivou primarne zdravstvene zaštite (PZZ) propiše oko 80 % svih antibiotika. Postoje brojni dokazi da neracionalno propisivanje antibiotika za respiratorne i urinarnе infekcije, doprinosi nastanku bakterijske rezistencije, pa je primena smernica i vodiča dobre prakse posebno važna u opštoj/porodičnoj medicini zbog široke i nekritične primene antibiotika u lečenju akutnih respiratornih i urinarnih infekcija. Cilj istraživanja je analiza primenljivosti „Nacionalnog vodiča dobre kliničke prakse za racionalnu upotrebu antibiotika“, 2018. godina, u delu lečenje akutnih respiratornih i urinarnih infekcija u opštoj medicini u Srbiji.

Metod: Analizirano je da li postoje jasno izdvojeni delovi za lečenje akutnih respiratornih i urinarnih infekcija, da li su navedeni najčešći uzročnici infekcije, da li je navedena terapija prvog izbora i alternativna terapija, da li je terapija u saglasnosti sa preporukama Liste lekova Republičkog fonda zdravstvenog osiguranja (RFZO), da li postoje izdvojene preporuke za terapiju kod trudnica, dojilja i starih.

Rezultati: Uvidom u vodič, utvrđeno je da postoje odvojeni segmenti za respiratorne i urinarnе infekcije. Svaki od segmenata posebno obrađuje najverovatnije uzročnike, terapiju prvog izbora i alternativnu terapiju. U delu terapije precizno su navedeni generički nazivi lekova i njihove doze i način primene, preporučena dužina lečenja kao i moguće zamene u slučaju postojanja alergije. Vodič sadrži detaljne tabelarne prikaze puteva izlučivanja najčešće korišćenih antibiotika, preporuke za primenu u trudnoći i kod dojilja, faktore koji utiču na ispoljavanje neželjenih dejstava, glavna neželjena dejstva odabralih antibiotika, tabelarni prikaz interakcija sa drugim klasama lekova i tabelu prilagođenog doziranja prema visini glomerularne filtracije.

Zaključak: Vodič sadrži sažete najnovije smernice za lečenje akutnih respiratornih i urinarnih infekcija u opštoj medicini. Navedeni preporučeni antibiotici su dostupni na tržištu Republike Srbije i mogu se propisati na teret RFZO-a. Pregledno je napisan i lak za upotrebu u svakodnevnom radu. Primena jasnih i sažetih smernica zasnovanih na dokazima u svakodnevnoj praksi doprineće smanjenju antimikrobne rezistencije kao i podizanju kvaliteta lečenja i bezbednosti pacijenata.

Ključne reči: smernice, antibiotici, opšta medicina, infekcije.

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¹ Dom zdravlja Stari grad, Beograd, Srbija

² Institut za virusologiju, vakcine i serume Torlak, Beograd, Srbija

³ Physical, specijalistička ordinacija, Beograd, Srbija

Branka Lazić, Svetozara Markovića 9, Beograd, Srbija, e-adresa: branka.lazic.rs@gmail.com,
ORCID broj 0000-0002-1447-0375

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GUIDELINES FOR ANTIBIOTIC TREATMENT OF THE MOST COMMON INFECTIOUS DISEASES IN GENERAL MEDICINE

Branka Lazić,¹ Vesna Janjušević,¹
Ana Janjušević,² Tijana Lazić³

ABSTRACT

Introduction: Antibiotics account for 15-30% of all prescribed medicine in the world and a consequence of irrational use is an occurrence of bacterial resistance. Serbia is a country with a high rate of antibiotic prescription, with about 80% of all antibiotics being prescribed at the primary health care level (PHC). There is ample evidence that an irrational prescription of antibiotics for respiratory and urinary infections contributes to the emergence of bacterial resistance, and the application of guidelines and good practice guidelines is particularly important in general / family medicine due to the wide and uncritical use of antibiotics in the treatment of acute respiratory and urinary infections. The aim of the research is the analysis of the applicability of the "National Guideline of Good Clinical Practice for the Rational Use of Antibiotics", 2018, in the treatment of acute respiratory and urinary infections in general medicine, in Serbia.

Method: It was analyzed whether there are specific parts for the treatment of acute respiratory and urinary infections, whether the most common causes of infection are listed, whether the first choice therapy and alternative therapy are indicated, whether the therapy is in compliance with the recommendations of the List of Medicine of the Republic Health Insurance Fund (RFZO), whether there are separate recommendations for therapy in pregnant, breastfeeding and old women.

Results: Examining the guide, it has been established that there are separate segments for respiratory and urinary infections. Each segment specifically deals with the most probable causes, empirical first-line treatments and alternative therapy. In the part regarding the therapy , the generic names of drugs and their dosages and route of administration, the recommended length of treatment, and possible replacements in the event of an allergy are precisely listed. The guide contains a detailed tabular overview of the routes of excretion of the most frequently used antibiotics, recommendations for use in pregnancy and in breast-feeding, factors that influence the manifestation of adverse effects, the main adverse effects of selected antibiotics, a tabular presentation of interactions with other classes of drugs, and a custom dosage table according to the height of glomerular filtration.

Conclusion: The guide contains the most recent guidelines for the treatment of acute reproductive and urinary infections in general medicine. The recommended antibiotics are available on the market of the Republic of Serbia, the majority can be prescribed by RFZO. It is reprinted and easy to use in everyday work. The application of clear and concise guidelines based on evidence in everyday practice will contribute to the reduction of antimicrobial resistance as well as to the improvement of the quality of treatment and patient safety.

Key words: guidelines, antibiotics general medicine, infections

¹ Healthcare center Stari grad, Belgrade, Serbia

² Institute of Virology, Vaccines and Serums Torlak, Belgrade, Serbia

³ Physical, specialist office , Belgrade, Serbia

Branka Lazić, Svetozara Markovića 9, e-mail adresa: branka.lazic.rs@gmail.com,
ORCID broj 0000-0002-1447-0375

SMJERNICE ZA BUDUĆA ISTRAŽIVANJA MULTIMORBIDITETA U OBITELJSKOJ MEDICINI

Vanja Lazić,¹ Milica Katić¹

SAŽETAK

Način na koji je multimorbiditet tradicionalno definirala Svjetska zdravstvena organizacija i recentno, 2016. godine, redefinirao Nacionalni institut za izvrsnost u zdravstvu i njezi (engl. *National institute for Health and Care Excellence – NICE*) zbog velike širine tog pojma komplikirano je shvatiti, a kamoli istraživati. Kompleksna međuovisnost čimbenika koji tijekom vremena pridonose zdravlju i dobrobiti pacijenata koje bismo opisali kao multimorbidne, neistraženo je područje u obiteljskoj medicini. Sve je jasnije da bi podatci koji dolaze iz sustava primarne zdravstvene zaštite mogli imati ključnu ulogu u otkrivanju načina na koji dolazi do bržeg pogoršanja zdravlja multimorbidnih pacijenata u odnosu na njihove „manje bolesne“ vršnjake. To znanje moglo bi pridonijeti razvoju boljih sustava zdravstvene zaštite s golemlim zdravstvenim, socijalnim i ekonomskim potencijalom. Smjernice NICE prvi put pružaju uvid u važnost na multimorbiditet usmjerene skrbi u dobro opisanim slučajevima, što predstavlja velik iskorak u obiteljskoj medicini kao kliničkoj disciplini. Smjernice bacaju novo svjetlo na stara pitanja kojima se istraživači multimorbidnosti odavno bave: Možemo li kvantificirati multimorbiditet? Može li plan skrbi koji je fokusiran na multimorbiditet dati bolje rezultate od onoga koji je fokusiran na pojedine bolesti? Kada je pravo vrijeme za prestanak propisivanja lijekova u prevenciji? Koliko bi zdravstvene skrbi i od koga pacijent s multimorbiditetom idealno trebao primati? Pronalazak pravih odgovora na ta pitanja mogao bi promijeniti način na koji funkcionira primarna zdravstvena zaštita s neslućenim socioekonomskim učincima na društvo, promijeniti način na koji rade obiteljski liječnici i promijeniti živote pacijenata s multimorbiditetom.

Ključne riječi: multimorbiditet, smjernice, NICE

¹ Dom zdravlja Zagreb-Centar; Vanja Lazić, doktorand, specijalizant obiteljske medicine; prof. dr. sc. Milica Katić, specijalist obiteljske medicine
e-adresa: vanja.lazic@dzz-centar.hr, ORCID <https://orcid.org/0000-0002-9336-3534>

RESEARCH RECOMMENDATIONS FOR MULTIMORBIDITY IN FAMILY MEDICINE

Vanja Lazić,¹ Milica Katić²

ABSTRACT

Multimorbidity as traditionally defined by the World Health Organisation, and more recently redefined by the National institute for Health and Care Excellence (NICE) in their 2016 guidelines is a broad concept, difficult to comprehend let alone research. The complex interplay of different factors that over time contribute to health and wellbeing of the patient which we would identify as multimorbid, is an unexplored theme in Family medicine research. It is becoming increasingly clear that the data coming from primary care might play a critical role in discovering some of the pathways that lead to the faster health decline of multimorbid patients compared to their “less morbid” peers. These pathways might then inform the development of improved health care systems with a huge health, social and economic potential. The NICE guidelines showcase, for the first time, the importance of multimorbidity care in well defined scenarios, which is, in itself, a great leap forward in family medicine as a clinical discipline. A new light is shed on the old questions which have long occupied multimorbidity researchers — Can we quantify multimorbidity? Can a different care plan, focused on multimorbidity outperform traditional single-disease focused care plans? When is the right time to stop prescribing preventive medicine? How much care and from whom should a multimorbid patient receive? Finding the right answers to these questions could affect the way in which primary care is delivered in the future and could have tremendous socio-economic impact on the society, changing the way family physicians practice medicine and changing the lives of patients with multimorbidity.

¹ Health Centre Zagreb – Centar

² Department of Family Medicine, School of Public Health „Andrija Štampar“, Medical School University of Zagreb, Croatia

Corresponding address:

Vanja Lazić, family medicine resident, E-mail: vanja.lazic@dzz-centar.hr,
<http://orcid.org/0000-0002-9336-3534>

RIZIČNI ČIMBENICI ZA NASTANAK KARDIOVASKULARNIH BOLESTI KOD PACIJENATA S TRANSPLANTIRANIM BUBREGOM

Daniela Lončar,¹ Denis Mršić,¹ Senada Selmanović²

SAŽETAK

Transplantacija bubrega je najuspješnija metoda liječenja teške kronične insuficijencije bubrega. Prva uspješna transplantacija bubrega provedena je 1954. godine u Bostonu, graft je bio u funkciji sedam godina, a pacijent je umro zbog bolesti srca. Kardiovaskularne bolesti vodeći su uzrok smrti u pacijenata s transplantiranim bubrežima. Pacijenti s transplantiranim bubrežima izloženi su aterogenom riziku koji je povezan s prethodnim liječenjem dijalizom i uporabom imunosupresivnih lijekova. Pretransplantacijska kardiovaskularna bolest glavni je čimbenik rizika za razvoj kardiovaskularnih bolesti nakon transplantacije bubrega. Čimbenici rizika za razvoj kardiovaskularnih bolesti u pacijenata s transplantiranim bubrežima podijeljeni su na tradicionalne i netradicionalne. Tradicionalni čimbenici rizika su nepromjenjivi (dob, spol i nasljedivanje) i promjenjivi (pušenje, hiperlipidemija, hipertenzija, pretlost, dijabetes, fizička aktivnost, stres). Netradicionalni čimbenici rizika su čimbenici povezani sa statusom transplantacije i njenim liječenjem te čimbenici rizika povezani s kroničnom regresijom u funkciji alografta. Najčešće kardiovaskularne bolesti u pacijenata nakon transplantacije bubrega jesu ishemiska bolest srca, kongestivno zatajenje srca i hipertrofija lijeve klijetke. Pacijenti na hemodializu imaju 10 – 20 puta veći rizik od razvoja kardiovaskularnih bolesti u usporedbi s općom populacijom. Netradicionalni čimbenici rizika posljedica su uremijskog miljea i povezani su s tehnikom dijalize, a podijeljeni su na hemodinamske i metaboličke čimbenike rizika. Hemodinamski čimbenici rizika su anemija, zadržavanje natrija i vode te arteriovenska (AV) fistula, a metabolički su čimbenici rizika hiperhomocisteinemija, hipoalbuminemija, oksidativni stres, mikroinflamacija i sekundarni hiperparatiroidizam. U našem istraživanju uspoređivali smo učestalost čimbenika rizika za razvoj kardiovaskularnih bolesti i učestalost kardiovaskularnih bolesti u pacijenata s transplantiranim bubrežom i pacijenata na hemodializi. U studiju je bilo uključeno 90 pacijenata. Svim pacijentima uzimali smo anamnestičke podatke, napravili kompletan fizički pregled, elektrokardiogram, biokemijske nalaze i ehokardiografski pregled. Rano otkrivanje visokorizičnih pacijenata za razvoj kardiovaskularnih bolesti omogućuje pravodobnu primjenu odgovarajuće terapijske strategije koja osigurava visoku stopu preživljjenja bolesnika s transplantiranim bubrežima.

¹ JZU Univerzitetski klinički centar Tuzla, Klinika za interne bolesti, Tuzla, Bosna i Hercegovina

² JZU Dom zdravlja Tuzla, Tuzla, Bosna i Hercegovina

RISK FACTORS FOR CARDIOVASCULAR DISEASE IN PATIENTS WITH TRANSPLANTED KIDNEY

Daniela Lončar,¹ Denis Mršić,¹ Senada Selmanović²

ABSTRACT

Kidney transplantation has become the primary method of treating severe chronic renal failure. The first successful kidney transplant was performed in 1954 in Boston, the graft was in function for 7 years, and patient died because of heart disease.

Cardiovascular disease is the leading cause of death in patients with a transplanted kidney. Patients with a transplanted kidney are exposed to atherogenic risk which is associated with previous dialysis treatment and the use of immunosuppressive drugs. Pre-transplant cardiovascular disease is a major risk factor for the development of post-transplant cardiovascular disease.

Risk factors for the development of cardiovascular diseases in patients with a transplanted kidney are classified into traditional and nontraditional. Traditional risk factors can be immutable (age, gender, and inheritance) and variable (smoking, hyperlipidemia, hypertension, obesity, diabetes mellitus, physical inactivity, stress). Nontraditional risk factors are risk factors related to the status of transplantation and its treatment and the risk factors associated with chronic regression in allograft function.

The most common cardiovascular diseases in patients after kidney transplantation are as follows: ischemic heart disease, congestive heart failure and left ventricular hypertrophy. Patients on hemodialysis have a 10-20 times greater risk of developing cardiovascular disease compared to the general population. Non-traditional risk factors are the consequence of the uremic milieu and are related with the dialysis technique itself, and they are divided in hemodynamic and metabolic risk factors. Hemodynamic risk factors are anemia, retention of sodium and water, arteriovenous (AV) fistula, while the metabolic risk factors are hyperhomocysteinemia, hypoalbuminemia, oxidative stress, microinflammation and secondary hyperparathyroidism. The risk of cardiovascular disease may differ in hemodialysis patients and kidney transplant patients.

In our study, we compared the frequency of risk factors for cardiovascular disease and the incidence of cardiovascular disease in kidney transplant patients and hemodialysis patients.

We conducted a study that included 90 patients. All patients had their anamnestic data taken, complete physical examination, electrocardiogram, biochemical analysis and echocardiography. Early detection of high-risk patients for the development of cardiovascular diseases allows timely application of an appropriate therapeutic strategy that ensures high survival rates for patients with a transplanted kidney.

¹ The Public Health Institution University Clinical Center Tuzla, Tuzla, Bosnia and Herzegovina

² The Public Health Institution Health Center Tuzla, Tuzla, Bosnia and Herzegovina

VAŽNOST SMJERNICA ZA OCJENU PREDVIĐENOG TRAJANJA PRIVREMENE NESPOSOBNOSTI ZA RAD KOJE UTVRĐUJE IZABRANI DOKTOR MEDICINE PRIMARNE ZDRAVSTVENE ZAŠTITE

Srebrenka Mesić¹

SAŽETAK

Ocjena privremene nesposobnosti za rad (PNR) uključuje aktivnu suradnju bolesnika s izabranim doktorom obiteljske medicine, specijalistom medicine rada u primarnoj zdravstvenoj zaštiti, specijalistima sekundarne zdravstvene zaštite i s poslodavcem. Razgraničenje ocjene privremene nesposobnosti za rad i opće, trajne nesposobnosti za rad zahtijeva suradnju s medicinskim vještačima Hrvatskog zavoda za mirovinsko osiguranje. Individualan pristup u ocjeni trajanja privremene nesposobnosti za rad djeluje na prevenciju bolesti i očuvanje zdravlja bolesnika te smanjenje rizika koji bolesniku ugrožava život. Liječnici pri ocjeni privremene nesposobnost za rad stručno i u skladu s načelima medicinske etike direktno utječu na negativne gospodarske čimbenike vezano uz neopravdanu odsutnost s posla.

Povratak na posao nakon vremena potrebnoga za dijagnostičku obradu, liječenje i rehabilitaciju unutar stručno postavljenih vremenskih okvira, uz podršku društva i motivaciju bolesnog radnika, djeluje na sprječavanje dugotrajne nepotrebne odsutnosti s posla.

Slijedom navedenoga u namjeri ujednačivanja kriterija za ocjenu privremene nesposobnosti za rad stručna društva Hrvatskoga liječničkog zabora (Hrvatsko društvo medicine rada, Hrvatsko društvo vještaka mirovinskog osiguranja, Hrvatsko društvo medicinskih vještaka zdravstvenog osiguranja), koristeći se svojim stručnim znanjima i relevantnom medicinskom literaturom, ujedinila su se na izradi nužnih i potrebnih Smjernica za ocjenu predviđenog trajanja privremene nesposobnosti za rad zbog bolesti, ozljede ili drugih okolnosti koje utvrđuje izabrani doktor medicine primarne zdravstvene zaštite u skladu s pravilima medicinske struke. U smjernicama su navedeni orijentacijski vremenski rokovi opravdane duljine liječenja, potrebeni za obavljanje neophodne dijagnostičke obrade, liječenja i rehabilitacije, odnosno predvidena dužina trajanja privremene nesposobnosti za rad prema tijeku i rezultatima liječenja bolesti ili ozljede.

Zaključak: Smjernice predstavljaju suvremenu ocjenu vremenskog razdoblja privremene nesposobnosti za rad temeljenu na znanstvenim i stručnim spoznajama. Analiza kretanja stope privremene nesposobnosti za rad upućuje na potrebu ujednačivanja kriterija za ocjenu privremene nesposobnosti za rad, edukaciju uz multidisciplinarni pristup te rad na smanjivanju broja dana pojedinačnih slučajeva privremene nesposobnosti za rad uz ciljane i stručne kontrole.

Ključne riječi: privremena nesposobnost za rad, smjernice za ocjenu PNR-a, kretanje stope privremene nesposobnosti za rad u RH

¹ Hrvatski zavod za zdravstveno osiguranje, Regionalni ured Zagreb

IMPORTANCE OF GUIDELINES FOR DETERMINING THE LENGTH OF TEMPORARY DISABILITY BY THE PRIMARY HEALTH CARE PHYSICIAN

Srebrenka Mesić¹

ABSTRACT

Evaluating work disability includes an active cooperation between the patient and the family physician, the occupational medicine specialist in primary health care, the consultant specialist and the employer. Differentiating between temporary and permanent disability requires cooperation with the Croatian Pension Insurance Fund medical experts. An individual approach in determining work ability affects the prevention of disease and patients' health maintenance; it also reduces risks threatening patients' lives. Determining the length of temporary work disability, doctors professionally and following the ethical principles in medicine directly influence on negative economic factors related to unjustified absenteeism.

Returning to work after the time necessary for diagnostic procedures, treatment and rehabilitation within the professionally set time limits, with the community support and motivation of the sick worker help in preventing unnecessary absence from work.

Consequently, with the intention of regulating the evaluation criteria for temporary work disability, professional associations of the Croatian Medical Association (the Croatian Society of Occupational Medicine, the Croatian Society of Pension Insurance Medical Experts, the Croatian Society of Health Insurance Medical Experts), utilising professional knowledge and relevant medical literature, assembled in producing the necessary Guidelines for determining the length of temporary work disability due to disease, injury or other circumstances as diagnosed by the primary health care physician in compliance with medical professional principles. Guidelines contain the anticipated time limits of the justified length of time necessary for diagnostic procedures, treatment and rehabilitation, i.e. the length of temporary work disability according to the course and outcome of disease or injury treatment.

Conclusion: Guidelines represent a model of determining the length of temporary work disability based on contemporary scientific and professional knowledge. The analysis of trends in the prevalence of temporary work disability requires the unification of criteria in evaluating temporary work disability, education and multidisciplinary approach, and efforts in reducing the number of temporary work disability days, followed by planned professional control.

Key words: temporary work disability, guidelines for determining the length of temporary work disability, trends in the prevalence of temporary work disability in the Republic of Croatia

¹ Croatian Insurance Fund, Regional Office Zagreb

PLUĆNA REHABILITACIJA

Jasmina Milašinčić¹

SAŽETAK

Plućnu rehabilitaciju čine dokazano djelotvorni postupci u liječenju kroničnih bolesti dišnog sustava. U novije vrijeme postala je obvezni dio intervencija u bolesnika s umjerenom i teškom kroničnom opstruktivnom plućnom bolesti (1). Pod pojmom plućne rehabilitacije razumijeva se sveobuhvatni niz intervencija baziran na temeljitoj individualnoj procjeni svakog bolesnika. Svrha provođenja postupaka plućne rehabilitacije jest poboljšanje psihičkog i fizičkog stanja bolesnika i njegovo dugotrajno pridržavanje takva načina ponašanja uz periodično ponavljanje i dalju edukaciju. Osnovni je cilj rehabilitacije smanjenje simptoma bolesti, a samim tim i bolja kvalitet života bolesnika. Najčešće se provodi ambulantnom terapijom uz individualni pristup. Program rada u tijeku plućne rehabilitacije uključuje fizikalnu terapiju, savjete o prehrani, tjelesnoj aktivnosti, edukaciju o bolesti i načinima samopomoći te pravilnoj primjeni inhalacijske odnosno medikamentne terapije. Za provođenje kvalitetne plućne rehabilitacije potreban je educirani interdisciplinarni tim sastavljen od pulmologa, radnih terapeuta, terapeuta fizikalne rehabilitacije, nutricionista, psihologa, medicinske sestre i liječnika obiteljske medicine (2). Optimalno provođenje plućne rehabilitacije traje tri tjedna uz periodično ponavljanje usvojenih vježba u ustavovi, a svakodnevno u kućnim uvjetima. Provođenje postupaka plućne rehabilitacije dovodi do vidljiva poboljšanja simptoma i kvalitete života te smanjenja broja hospitalizacija.

Ključne riječi: plućna rehabilitacija, liječnik obiteljske medicine, medicinska sestra

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¹ Specijalistička ordinacija obiteljske medicine dr. sc. Ksenija Kranjčević

Adresa:

Specijalistička ordinacija obiteljske medicine dr. sc. Ksenija Kranjčević, H. Macanovića 2a, Zagreb,
e-adresa: jasmina.milasincic@gmail.com

PULMONARY REHABILITATION

Jasmina Milašinčić¹

ABSTRACT

Pulmonary rehabilitation consists of procedures and treatments that have been proven to be effective in the treatment of chronic respiratory diseases. It has recently become a mandatory part of the interventions in patients with moderate to severe Chronic Obstructive Lung Disease (1). The term pulmonary rehabilitation refers to a comprehensive set of interventions based on a detailed individualized assessment of the patient. The purpose of pulmonary rehabilitation treatments is to improve patient's mental and physical condition along with a long-term adherence to that kind of behaviour with periodical repetitions and continual education. The fundamental goal of rehabilitation is a decrease in the disease symptoms and a better quality of life. The most common setting employed is outpatient clinics with a personalized pulmonary rehabilitation programme. The programme includes physical therapy, nutrition and physical activity advice with the component of self-care and interactive participation, as well as the appropriate use of inhalers and medications. It should be delivered by an interdisciplinary team of a pulmonologists, occupational therapist, physical therapist, dietitian, psychologist, nurse and general practitioner (2). The optimal implementation of pulmonary rehabilitation includes 3 weeks of periodic repetitions of an exercise training programme in a healthcare facility as well as home-based day-to-day exercise. The implementation of pulmonary rehabilitation has demonstrated improvements in symptoms and the quality of life and is associated with a reduction in subsequent hospital admissions.

Key words: pulmonary rehabilitation, general practitioner, nurse

¹ Specialist family practice dr.sc. Ksenija Kranjčević

Corresponding address:

Jasmina Milašinčić, nurse, H. Macanovića 2a, Zagreb, E-mail: jasmina.milasincic@gmail.com

NUTRITIVNE SMJERNICE ZA ŠEĆERNU BOLEST TIPO 2

Tina Milavić¹

SAŽETAK

Uvod: Pravilan pristup prehrani važan je i u prevenciji i u liječenju šećerne bolesti (ŠB) tipa 2 te komorbiditeta koji ju prate. Ciljevi koji se nutritivnom potporom žele postići jesu održati HbA1C< 7 %, krvni tlak < 140/80 mmHg, LDL < 3 mmol/L, trigliceride < 1,8 mmol/L, HDL > 1,3 mmol/L za muškarce i > 1,1 mmol/L za žene, postići i održati ciljnu tjelesnu težinu te preventirati ili odgoditi komplikacije bolesti. Cilj je ovoga kratkog pregleda upozoriti na važnost prehrane u liječenju šećerne bolesti i predstaviti najnovije smjernice.

Metode: Pregledana je literatura dostupna u bazama PubMed i Medline prema ključnim riječima nutritivna potpora, dijabetes, odrasli, smjernice, prehrana.

Rezultati: Iako je broj dnevnih obroka ovisan o medikamentnoj terapiji, općenita preporuka za osobe koje imaju ŠB tipa 2 jest pet obroka raspodijeljenih u tri glavna obroka i dva međuobroka. Snižavanje tjelesne mase može odgoditi progresiju preddijabetesa u ŠB-u tipa 2, a smanjenje tjelesne mase i njenog održavanje povezano je sa smanjenjem HbA1C i lipida u serumu. Preporuka za unos ugljikohidrata jest zastupljenost 45 – 60 % dnevног energetskog unosa. Naglasak treba biti na ugljikohidratima niskog glikemijskog indeksa, pri čemu se ne preporuča konzumirati rafinirane ugljikohidrate te prehrambene proizvode "nonfat" i "low fat". Dnevni udio proteina treba biti 15 – 20 %, a masnoće ne smiju prijeći 35 % od ukupnog energetskog unosa, pri čemu je kvaliteta masnoća važnija od ukupnog udjela masnoća. Kako je poželjno smanjiti količinu zasićenih masnih kiselina (< 7 %), tako je poželjno povećati konzumaciju jednostruko nezasićenih i višestruko nezasićenih masnoća, a nikako smanjenje količine zasićenih masnoća zamijeniti rafiniranim ugljikohidratima. Savjetuje se i ograničen unos kolesterola, do 200 mg/dan, te izbjegavanje trans masnoće. Preporuča se unos natrija ograničiti na 2300 mg dnevno, a preporuke za prehrambena vlakna vrijede kao i za opću populaciju, 14 g/1000 kcal/dnevno ili 25 g/dan za žene i 38 g/dan za muškarce. Konzumiranje alkohola treba ograničiti na jedno piće za žene i dva za muškarce.

Zaključak: Pri planiranju i kreiranju obroka važno je voditi računa o količini ukupne energije i o udjelu makro- i mikronutrijenata. Veoma je važna edukacija o pravilnoj prehrani koja se može provoditi grupno ili individualno uz stručno vođenje dijetetičara.

Ključne riječi: nutritivne preporuke, šećerna bolesti tipa 2

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¹ Poliklinika Dermaplus, Kaptol 25, Zagreb

Adresa za dopisivanje:

Dr. sc. Tina Milavić, prof., nutricionist, Vinogradnska cesta 103, Zagreb,
e-adresa: tina.milavic@hotmail.com, Orcid ID: 0000-0002-6224-628X

NUTRITION MANAGEMENT FOR TYPE 2 DIABETES

Tina Milavić¹

ABSTRACT

Introduction: The appropriate approach to nutrition is important not only in preventing but also in treating diabetes type 2 and accompanying comorbidities. The desired goals are to maintain Hb A1C < 7%, the blood pressure < 140/80 mmHg, LDL < 3mmol/lmmol/L, triglycerides < 1,8 mmol/L, HDL > 1,3 mmol/L for men and >1,1 mmol/L for women, to achieve and maintain the desired body weight and to prevent or delay diabetic complications. The aim of this short review is to draw attention to the importance of nutrition in the treatment of diabetes mellitus and to present recent guidelines.

Methods: PubMed and Medline data bases were searched with key words: nutrition support, diabetes, adults, guidelines, nutrition.

Results: Although the amount of daily meals is dependent on medicinal treatment, the general recommendation for adults affected with type 2 diabetes is 5 meals a day, divided into 3 main meals and 2 brunches. There is a strong evidence that the reduction of body weight can delay the progression of prediabetes type 2. To achieve body weight reduction and maintain it, is connected with reducing the levels of HbA1C and lipids in the serum. by replacing carbohydrates with high glycemic index with food with low glycemic index, whereby it is not to consume refined carbohydrates and „non fat“ and „low fat“ products. The daily intake of proteins should be 15-20%, and fats shouldn't cross 35% of the total energy intake, although the quality of fats is more important than their percentage. As it is desirable to reduce the amount of saturated fatty acids (<7%), it is therefore, also desirable to increase the consumption of monosaturated fatty acids and polyunsaturated fatty acids, but saturated fatty acids should not be replaced with carbohydrates. A limited cholesterol intake is also advised, up to 200 mg per day, as well as avoiding trans fats. It is recommended to limit sodium to 2300 mg a day, and recommendations for dietary fibers should be applied as follows: 14g/1000kcal a day for the general population or 25 g a day for women and 38 g a day for men.

Conclusion: While planning and creating meals it is important to keep track of the total amount of energy intake and the ratio of macro and micronutrients, the education on appropriate nutrition, which can be organized in groups or individually, under the guidance of a dietitian, is very important.

Key words: nutrition guidelines, diabetes mellitus

¹ Poliklinika Dermaplus, Kaptol 25, Zagreb

Correspondence address:

Tina Milavčić, PhD, Nutritionist, Vinogradnska cesta 103, Zagreb, e-mail: tina.milavčić@hotmail.com,
Orcid ID: 0000-0002-6224-628X

CAPACITY BUILDING THROUGH DISTANCE LEARNING – CASE OF ANTIBIOTIC STEWARDSHIP ONLINE COURSE FOR HEALTH PRACTITIONERS IN MACEDONIA

Neda Milevska Kostova,¹ Golubinka Boshevska,² Katarina Stavrikj,³
Nikola Panovski,⁴ Sebastian von Schreeb¹

ABSTRACT

Background: Provider education strategies to combat antimicrobial resistance have been demonstrated to be successful in both large university/academic medical centers and in community hospitals and clinic settings, albeit, predominately in western health care settings. There has recently occurred a growing trend in utilising online tools to improve knowledge on prudent antibiotic prescribing. However, most resources are not available in languages spoken by smaller populations.

Methods: In an effort to jumpstart stewardship interventions in Macedonia, we adapted existing online stewardship training material developed for the US-based audience for use by a group of physicians in Macedonia. Participants completed a pre- and post- intervention questionnaires to assess the impact of online learning modules on the physicians' knowledge about antimicrobial stewardship principals and practice. Participants also completed a satisfaction survey to measure the provider perceptions of this format for provider education about appropriate antimicrobial use in a foreign language.

Results: For 100% of respondents the course length was just right, however only two declared time spent in the course (5-10 hours and up to 5 hours). Twenty-two respondents took the CME test, and those who had not taken it, stated other competing engagements as the main reason. In total, 75% stated that they had watched all the videos and about 21% watched more than a half, while 4% sincerely admitted to have watched no videos at all. Nearly half of the respondents reported to have reached their personal goal and felt more confident on issues regarding antimicrobial resistance, whereas nearly two thirds considered the course to be intellectually stimulating. In the free-form comment box, participants provided suggestions for improvement, related to the availability of the course in their native language, reduction of the number of questions, relating the material to national clinical guidelines, and a use of more real cases, in particular from the primary care level.

Conclusions: Internationally available training materials are an exceptional resource, especially for small countries and resource-limited settings. While language might not be particularly challenging, an adjustment of the material to the local context, particularly related to clinical guidelines, is a key prerequisite for an appropriate knowledge acquisition.

Keywords: antimicrobial stewardship, massive open online courses

¹ Centre for Regional Policy Research and Cooperation ‘Studiorum’, Skopje, Macedonia

² Institute of Public Health, Skopje, Macedonia

³ University Clinic for Children Diseases, University ‘Ss. Cyril and Methodius’, Skopje, Macedonia

⁴ Medical Faculty, University ‘Ss. Cyril and Methodius’, Skopje, Macedonia

ISKRA SMJERNICE - INFEKCIJE MOKRAĆNIH PUTEVA

Nataša Mrduljaš-Đujić¹

SAŽETAK

Uvod: Infekcije mokraćnog sustava (IMS) ubrajaju se u najčešće bakterijske infekcije i jedan su od najčešćih razloga propisivanja antimikrobnih lijekova. Cilj liječenja IMS-a jest nestanak kliničkih simptoma i eradikacija infekcije u svrhu prevencije nastanka recidiva.

Rezultati: Infekcije u 95 % slučajeva izaziva jedna vrsta bakterija. Nalaz većeg broja raznih bakterijskih vrsta u urinu obično predstavlja kontaminaciju. Pojam „signifikantna bakteriurija“ podrazumijeva nalaz od 10^5 ili više bakterija/ml urina i uz prisutnost simptoma upućuje na infekciju mokraćnog sustava. Asimptomatska bakteriurija česta je u zdravih pojedinaca, a posebno u osoba sa strukturnim ili funkcionalnim abnormalnostima i u starijih osoba, i ne treba je liječiti. Izuzetak su trudnice i bolesnici s invazivnim urološkim intervencijama. Isto tako, asimptomatska bakteriurija i leukocituirija česte su u bolesnika s kateterom i ne treba ih liječiti antibioticima. Prema smjernicama, za akutne nekomplikirane infekcije MS-a donjem urotraktu u žena prvi izbor je nitrofurantoin ili fosfomicin, a kao alternativna terapija koamoksiklav, cefaleksin, cefuroksim aksetil, ili cefixim, zatim norfloksacin kroz tri dana. Za akutni nekomplikirani pijelonefritis prvi izbor je koamoksiklav, a alternativna terapija su cefalosporini II. ili III. generacije te ciprofloksacin. U komplikiranih infekcija MS-a u žena lijek prvog izbora je koamoksiklav, a alternativna terapija je ceftibuten odnosno ciprofloksacin, a za akutne infekcije MS-a muškaraca koji imaju i sustavne simptome, lijek prvog izbora je ciprofloksacin, a alternativna terapija je koamoksiklav odnosno ceftibuten. Kod IMS-a trudnica, prema kliničkom sindromu, trajanju trudnoće i antibiogramu uzročnika, preporuča se terapija 7–14 dana: ceftibuten, koamoksiklav, nitrofurantoin, amoksicilin ili fosfomicin. U liječenju bakterijskog prostatitisa lijek prvog izbora je ciprofloksacin kroz četiri tjedna, a alternativna terapija su trimetoprim/sulfametoksazol ili ceftibuten. Treba napomenuti da je akutni prostatitis rijedak entitet i čini 0,02 % bolesnika sa sindromom prostatitisa.

Zaključak: Potrebno je liječiti sve simptomatske infekcije mokraćnog sustava i asimptomatsku bakteriuriju u odabranih primjenom najmanje toksičnog i najjeftinijeg antimikrobnog lijeka u adekvatnoj dozi i u dovoljno dugom razdoblju za eradikaciju infekcije, i pri tome što je moguće manje poremetiti normalnu crijevnu floru.

Ključne riječi: smjernice za antibiotsko liječenje, ISKRA smjernice, NICE smjernice, uroinfekcije, liječnik obiteljske medicine

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¹ Specijalistička ordinacija obiteljske medicine Postira, otok Brač
Katedra obiteljske medicine, Medicinski fakultet Sveučilišta u Splitu
e-adresa: md.natasa@gmail.com

ISKRA GUIDELIES - URINARY TRACT INFECTIONS

Natasa Mrduljaš-Đujić^{1,2}

ABSTRACT

Introduction: Urinary Tract Infections (UTI) are the most common bacterial infections and are one of the most common reasons for prescribing antimicrobial drugs. The goal of treating UTI is the disappearance of clinical symptoms and the eradication of infection in order to prevent recurrence. Results. In 95% of cases, infections are caused by one type of bacteria. Finding a large number of different bacterial species in urine is usually a contamination. The term "significant bacteriuria" implies a finding of 10^5 or more bacteria / ml of urine and, in the presence of symptoms, indicates the infection of the urinary system. Asymptomatic bacteriuria is common in healthy individuals, especially in people with structural or functional abnormalities in the elderly and should not be treated. Exceptions are pregnant women and patients with invasive urological interventions. Likewise, asymptomatic bacteriuria and leukocyturia are common in patients with a catheter and should not be treated with antibiotics. According to the guidelines, for acute uncomplicated UTI lower urotracts in women, the first choice is nitrofurantoin or phosphomycin, and as *alternative therapy* coamoxiclav, cephalexin, cefuroxime axetil, or cefixim, then norfloxacin for 3 days. For acute uncomplicated pyelonephritis, the first choice is co-amoxiclav and *alternative therapy* is cephalosporin II or III generation, and ciprofloxacin. In complicated UTI in women, the first choice of medication is co-amoxiclav, and *alternative therapy* is ceftibuten, or ciprofloxacin, and for acute UTI in men with systemic symptoms, the first choice medicine is ciprofloxacin and the *alternative therapy* is co-amoxiclav or ceftibuten. In UTI in pregnancies, according to clinical syndrome, duration of pregnancy and antibiogram of the agent, 7-14 days therapy is recommended: ceftibuten, co-amoxycyclav, nitrofurantoin, amoxicillin or phosphomycin. In the treatment of bacterial prostatitis, the first choice medicine is ciprofloxacin for 4 weeks and *alternative therapy* is trimethoprim / sulfamethoxazole or ceftibuten. It should be noted that acute prostatitis is a rare entity and makes up 0.02% of patients with prostate syndrome.

Conclusion: All symptomatic UTI and asymptomatic bacteriuria should be treated in selected low-toxic and cheapest antimicrobial drugs at an adequate dose and for a sufficiently long period of time to eradicate the infection and minimize a disruption of the normal intestinal flora.

Keywords: guidelines for antibiotic treatment, ISKRA guidelines, NICE guidelines, uroinfection, family medicine physician.

¹ Specialist practice in family medicine Postira, Island of Brac

² Department of Family Medicine, Faculty of Medicine, University of Split

Corresponding address:

e-mail: md.natasa@gmail.com

SMJERNICE I NEFARMAKOLOŠKO LIJEČENJE ŠEĆERNE BOLESTI KAKO PRIDOBITI PACIJENTA

Ivančica Peček¹

SAŽETAK

Nove smjernice američkog (ADA) i europskog (EASD) dijabetološkog društva iz 2018. godine stavljuju poseban naglasak na promjenu životnog stila te na edukaciju i suport samoliječenju (*self-management*) dijabetičara. Osim promjene životnog stila, to uključuje i *nutricionističku terapiju*, prestanak pušenja, savjetovanje o smanjenju tjelesne težine i psihološku podršku.

Cilj: Prikazati važnost provođenja DSMES (*diabetes self-management education and support*) programa u Domu zdravlja Zagreb-Zapad.

Metode i ispitanci: Preporuka je da svim dijabetičarima s tipom 2 dijabetesa treba biti ponuđena mogućnost edukacije u nekom od DSMES programa. Pod imenom DSMES razumijeva se individualno ili grupno savjetovanje dijabetičara koje provodi educirani zdravstveni djelatnik, pri čemu dijabetičar dobije osnovna znanja o svojoj bolesti te razvije sposobnost i vještinu da prikladnim ponašanjem svakodnevno sam kontrolira svoju bolest i aktivno sudjeluje u liječenju. U Domu zdravlja Zagreb-Zapad na dvjema se lokacijama provodi edukacija dijabetičara radom u maloj grupi s prvostupnicom sestrinstva – patronažnom sestrom i liječnikom specijalistom obiteljske medicine. Kao edukacijski alat upotrebljavaju se konverzacijske mape koje su poticajne za smisleni razgovor u grupi, a voditelj grupe samo je moderator pri vođenju sastanka. Sa svakom grupom (5-10 dijabetičara) obrade se četiri teme: „Živjeti sa šećernom bolesti“, „Kako šećerna bolest djeluje“, „Zdrava prehrana i tjelesna aktivnost“ i „Početak terapije inzulinom“. Cilj je positići aktivno sudjelovanje svih članova grupe u edukaciji i razgovoru tijekom sastanka te potaknuti sudionike na aktivno sudjelovanje u vlastitom liječenju i preuzimanje odgovornosti za svoje liječenje. Cilj je pridobiti pacijenta na odgovorno zdravstveno ponašanje u svrhu boljih ishoda liječenja i izbjegavanja komplikacija.

Zaključak: Uvjeti rada u primarnoj zdravstvenoj zaštiti idealni su za provođenje programa edukacije DSME (11). Pacijenti već imaju izgrađen terapijski odnos sa svojim obiteljskim liječnikom i s patronažnom sestrom, koji trebaju samo osigurati vrijeme da iskoriste taj terapijski odnos s pacijentom, prenesu mu informaciju – znanje i pridobiju ga za aktivno sudjelovanje u liječenju.

Ključne riječi: DSMES, samoliječenje dijabetičara

¹ Dom zdravlja Zagreb-Zapad, ordinacija obiteljske medicine, e-adresa: ivanica.pecek@dzz-zapad.hr

GUIDELINES AND NON-PHARMACOLOGICAL TREATMENT – MOTIVATING PATIENTS

Ivančica Peček¹

ABSTRACT

The New Guidelines of the American (ADA) and European (EASD) Diabetes Society from 2018 put a special emphasis on changing one's lifestyle as well as education and support for diabetes self-management . In addition to lifestyle changes, this includes nutrition therapy, smoking cessation, weight loss counseling and psychological support.

Objective: To demonstrate the importance of implementing a DSMES (diabetes self-management education and support) programme at the Health Center Zagreb West.

Methods and Respondents: It is recommended that all type 2 diabetes patients should be given the opportunity of education in one of the DSMES programmes. DSMES depicts individual or group diabetes counselling conducted by an educated healthcare worker, whereby the diabetics acquire a basic knowledge of their illness and develop abilities and skills to manage their illness on a daily basis and actively participate in the treatment. In the Health Center Zagreb West diabetes education is being taught in two locations in small groups with a BSN nurse or a home care nurse and a physician specialist in family medicine. Conversational folders, used as an educational tool, encourage meaningful group participation, whereas the group leader functions only as a moderator. Each group, consisting of 5 to 10 diabetics, addresses four topics; "Living with diabetes," "How does diabetes work," "Healthy nutrition and physical activity" and "Starting of insulin therapy" ... The goal is to encourage all members to actively participate in group meetings and in their own treatment as well. Furthermore, in order to avoid medical complications and to achieve better treatment results, patients should develop responsible health behaviour.

Conclusion: Primary health care conditions are ideal for implementation for DSMES (11) programme. A family doctor and a home care nurse, who have already built a therapeutical relationship with their patients , should find time to use that relationship to relay information – knowledge and to persuade the patients to actively participate in the treatment.

Key words: DSMES, self-management of diabetics

¹ Health Care Center Zagreb-Zapad, family physician office

TKO I ZA KOGA RADI SMJERNICE ZA KRONIČNE NEZARAZNE BOLESTI: JESU LI LIJEĆNICI OBITELJSKE MEDICINE U JUGOISTOČNOJ EUROPI ŽRTVE GLOBALIZACIJE?

Tanja Pekez-Pavliško,¹ Larisa Redžepagić-Gavran,²
Dinka Jurišić³

SAŽETAK

Liječnici obiteljske medicine (LOM) u zemljama bivše Jugoslavije imaju velikih problema prilikom propisivanja lijekova za kronične nezarazne bolesti (KNB). Najveći je problem potpuno nesuglasje smjernica zdravstvenih fondova i međunarodnih smjernica, osobito u slučaju hiperlipidemija i kronične opstruktivne plućne bolesti. Postoje velika ograničenja u samostalnom propisivanju lijekova za KNB za liječnike obiteljske medicine (razlikuju se u pojedinim zemljama, najmanja su u Sloveniji i Hrvatskoj). S druge strane, velik broj kroničnih bolesnika pod nadzorom je bolničkih specijalista koji se prilikom određivanja terapije striktno vode najnovijim međunarodnim smjernicama ne vodeći računa o smjernicama zdravstvenog fonda. S obzirom na finansijske mogućnosti pojedinih zemalja bivše Jugoslavije ova ograničenja fondova čine se opravdanima. Tomu u prilog ide činjenica da u zemljama članicama Europske unije (EU), ali i u Bosni i Hercegovini (BiH) koja nije u EU, postoje goleme razlike u izdvajaju za zdravstvenu zaštitu po glavi stanovnika. Tako Švedska izdvaja više od 5000 eura, Slovenija 1500 eura, Hrvatska oko 700 eura, a BiH oko 330 eura. Ima li se sve to u vidu, postavlja se pitanje tko i kako radi međunarodne smjernice i možemo li se u kreiranju međunarodnih smjernica voditi samo rezultatima studija ili treba voditi računa i o finansijskim mogućnostima pojedinih zemalja. Autori europskih smjernica za većinu kroničnih nezaraznih bolesti uglavnom dolaze iz zemalja gdje je izdvajanje za zdravstvenu zaštitu pojedinca veće od 4000 eura. Također, te zemlje imaju veće očekivano trajanje života i manju smrtnost od KNB-a u odnosu na jugoistočnu Europu.

Trebaju li nam smjernice koje će biti više orijentirane na javnozdravstvene akcije, s košaricom usluga za dijagnostiku i liječenje bolesti i komplikacija, koje su primjerene našim novčanim mogućnostima, ali i onima naših pacijenata? Ovog trenutka zbog ovakvih smjernica ugroženi su pacijenti svojim izdvajanjima za lijekove koji ne idu na teret fonda, ali i liječnici obiteljske medicine koji vrlo često doživljavaju verbalno nasilje od pacijenata zbog nemogućnosti propisivanja određenih lijekova na teret fonda.

Ključne riječi: međunarodne smjernice, kronične nezarazne bolesti, obiteljska medicina

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¹ Ordinacija Dr. Tanja Pekez-Pavliško, spec. obiteljske medicine, Kutina

² Katedra obiteljske medicine, Medicinski fakultet, Univerzitet u Zenici, Bosna i Hercegovina

³ Ordinacija Dr. Dinka Jurišić, spec. obiteljske medicine, Žažina, Hrvatska

Adresa za dopisivanje:

Specijalistička ordinacija obiteljske medicine dr. Tanja Pekez Pavliško , A. G. Matoša 42, 44 320 Kutina, e-adresa: tashamed@gmail.com, orcid: <https://orcid.org/0000-0002-1004-0036>, orcid: <https://orcid.org/0000-0001-6035-6496>

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BY WHOM AND FOR WHOM GUIDELINES FOR CHRONIC NON-COMMUNICABLE DISEASES IS MADE: ARE FAMILY MEDICINE PHYSICIANS IN SOUTHEAST EUROPE VICTIMS OF GLOBALIZATION?

Tanja Pekez-Pavliško,¹ Larisa Redžepagić- Gavran,² Dinka Jurišić³

ABSTRACT

Family Medicine physicians (FMPH) in former Yugoslavia countries have major problems in prescribing medicines for chronic non-communicable diseases (CNCDs). The biggest problem is complete disagreement between health care guidelines and international guidelines, especially for hyperlipidemia and chronic obstructive pulmonary disease. There are large limitations in prescribing of medications for CNCDs done by FMPH (differ in some countries, smallest in Slovenia and Croatia). On the other hand, a large number of chronic patients are under supervision of hospital specialists, strictly guided by the latest international guidelines when deciding about therapy, without taking into account guidelines of the Health Insurance Fund (HIF). By the financial capabilities of some countries in the former Yugoslavia, this limitation of HIF seems justified. This is supported by the fact that in States of European Union (EU) but also in Bosnia and Herzegovina (B&H) which is not in EU, are huge differences for health care per capita. Thus, Sweden allocates over 5000, Slovenia 1.500, Croatia 700 and B&H of 330 Euros. Huge question is who and how international guidelines is made, and whether we can lead by study results or take into account the financial capabilities of individual countries in creating international guidelines. Authors of European guidelines for CNCDs, come from countries where individual health care allocations are greater than 4000 Euros. Also, these countries have a longer life expectancy and lower mortality of the CNCDs than in South-eastern Europe. Do we need guidelines more focused on Public health, with a range of diagnostic services, treatment and complications of diseases, appropriate to our budgets and our patients' budgets? At this moment, because of these guidelines, patients are endanger due to their payment for the medicine, instead of being paid by the HIF, as well as FMPH, who are often experience verbal violence by patients due to the impossibility of prescribing certain medicines by HIF.

Key words: international guidelines, chronic non-communicable diseases, family medicine

¹ General practitioner

² Department of Family Medicine, School of Medicine, University of Zenica

³ General practitioner

Corresponding address: Private general practice office Tanja Pekez-Pavliško, A. G. Matosa 42, 44320 Kutina, Croatia, E-mail: tashamed@gmail.com, orcid: <https://orcid.org/0000-0002-1004-0036>, orcid: <https://orcid.org/0000-0001-6035-6496>

SMJERNICE ZA LIJEČENJE OPIJATSKIH OVISNIKA

Branislava Popović,¹ Ivana Šutić¹

SAŽETAK

Bolesti ovisnosti ubrajamo u skupinu kroničnih, recidivirajućih bolesti, čije se liječenje dugotrajno provodi. Provođenje zdravstvene edukacije, rano otkrivanje bolesti i praćenje zdravstvenog stanja osoba ovisnih o različitim psihoaktivnim tvarima dio je sveobuhvatne i kontinuirane skrbi za ovisnike. Liječenje ove skupine bolesnika provodi se prema važećim Smjernicama za farmakoterapiju opijatkih ovisnika metadonom (2006.) i Smjernicama za farmakoterapiju opijatkih ovisnika buprenorfinom (2007.). Smjernice predstavljaju temelj na kojem ovlašteni liječnik i liječnik obiteljske medicine individualno provode program liječenja ovisnika. Metadon je bolji lijek izbora za bolesnike koji inzistiraju na daljem uzimanju metadona ili iskazuju jaku žudnju za heroinom, u osoba koje imaju teškoće u kontroli ponašanja te ustraju u uzimanju droge unatoč štetnim posljedicama. Buprenorfin se zbog svojih farmakoloških osobina češće upotrebljava u liječenju jer djeluje kao parcijalni opijatski agonist μ -opioidnih receptora, pri čemu dobro pokriva žudnju za opijatima i sprječava pojavu apstinencijskih smetnja. Visoke doze buprenorfina bolje se podnose od visokih doza metadona. Bolesnici koji duže vrijeme uzimaju buprenorfin i stabilne su zdravstvenog stanja, imaju veću šansu za odvikavanje. Tijekom liječenja ovisnici mogu proći kratku ili dužu detoksikaciju s ciljem uspostave potpune apstinencije. Postupnom redukcijom doze zamjenskog lijeka bolesniku se nastoje olakšati tegobe koje se mogu javiti zbog naglog prekida uzimanja opijata. Ipak se većina bolesnika nalazi u tretmanu kratkotrajnog ili dugotrajnog, često doživotnog održavanja zamjenskom terapijom. Terapija omogućuje funkcioniranje u okviru vlastitih psihosocijalnih kapaciteta, ima za cilj smanjiti štetne posljedice za samog bolesnika, njegovu obitelj i cijelu zajednicu, jer se zadržavanjem bolesnika u sustavu liječenja smanjuje kriminalno djelovanje i povećava se mogućnost uspješne radne i socijalne rehabilitacije. Duljina trajanja liječenja, propisivanje i priprema zamjenske terapije, prekid liječenja u slučaju ovisnikova neredovitog uzimanja lijekova, nedoličnog ponašanja i pokušaja „prevarare“ s ciljem preprodaje, samo su neka od pitanja koja muče obiteljske liječnike. Procjena remisije bolesti, praćenje komorbiditeta, promjene životnog stila, ekonomska samostalnost, čimbenici su koji utječu na povoljnije ishode bolesti i pridonose boljoj kvaliteti života ovisnika.

Ključne riječi: bolesti ovisnosti, buprenorfin, metadon, obiteljska medicina, smjernice

¹ Katedra za obiteljsku medicinu, Medicinski fakultet Sveučilišta u Rijeci
Adresa za dopisivanje:

Doc. dr. sc. Branislava Popović, dr. med., spec. obiteljske medicine

Katedra za obiteljsku medicinu, Medicinski fakultet Sveučilišta u Rijeci

Braće Branchetta 20, 51000 Rijeka, Hrvatska

e-adresa: branislava.popovic@ri.t-com.hr, <https://orcid.org/0000-0003-1671-7957>

GUIDELINES FOR THE TREATMENT OF OPIATE ADDICTION

Branislava Popović,¹ Ivana Šutić¹

ABSTRACT

Addictive diseases are included in the group of chronic, recurrent diseases, whose treatment is long-lasting. Health education, early detection of illness, and monitoring the health of people dependent on various psychoactive substances is part of the comprehensive and ongoing care for addicts. Treatment is carried out in accordance with the Guidelines for Pharmacotherapy of Opioid Addicts Methadone (2006) and Guidelines for Pharmacotherapy of Opioid Addicts Buprenorphine (2007). Methadone is a better choice for patients who insist on further methadone taking, or express a strong craving for heroin, people with difficulty in controlling their behaviour, and who persist in taking drugs despite adverse consequences. Buprenorphine is more frequently used in the treatment because it acts as a partial opiate agonist of μ -opioid receptors, which well covers the craving for opiates and prevents the occurrence of abstinence disorders. High doses of buprenorphine are better tolerated than high doses of methadone. Patients who take buprenorphine for a longer period of time and have a stable health condition have a greater chance of being overdosed. During treatment, addicts may undergo short or longer detoxification with the aim of establishing complete abstinence. Subsequent reduction of the dose of the substitution drug is applied when the patient is trying to alleviate the problems occurring due to sudden discontinuation of the opiate. However, most patients are in the short-term or long-lasting treatment, often a lifelong maintenance by substitution therapy. Therapy enables functioning within the patient's own psychosocial capacities, with the aim of reducing the adverse consequences for the patient, his/her family, and the entire community, because the retention of patients in the treatment system reduces criminal activity and increases the possibility of successful work and social rehabilitation.

The duration of treatment, prescribing and preparation of substitution therapy, the termination of treatment in the event of misuse, inappropriate behaviour, and drug addicts' attempts to resell are just some of the issues encountered by family physicians. Evaluation of disease remission, the monitoring of comorbidity, lifestyle changes, economic independence are factors affecting more favourable outcomes of the disease and contribute to the better quality of life of the addicts themselves.

Keywords: Addiction, Abuse; Buprenorphine; Family Medicine; Guidelines; Methadone.

¹ Department of Family medicine, Medical Faculty, University of Rijeka
Corresponding address:

Assist. prof. Branislava Popović, MD, PhD, Family Medicine Specialist, Department of Family Medicine, Medical Faculty, University of Rijeka, Braće Branchetta 20, 51000 Rijeka, Croatia, e-mail: branislava.popovic@ri.t-com.hr, <https://orcid.org/0000-0003-1671-7957>

SMJERNICE ZA DIJAGNOSTIKU I LIJEČENJE GERB-A I INFEKCIJE BAKTERIJOM *HELICOBACTER PYLORI*

Sanda Pribić,^{1, 2, 3} Željko Vojvodić^{2, 4}

SAŽETAK

Uvod: Prevalencija GERB-a i infekcije bakterijom *Helicobacter pylori* u Republici Hrvatskoj dosegnula je 65 – 73 %. Zbog toga ti entiteti predstavljaju značajan problem u svakodnevnom radu liječnika obiteljske medicine, zauzimaju velik dio vremena i troše zdravstvene resurse. Stoga je u prepoznavanju i liječenju nužno slijediti najnovije stručne smjernice.

Rasprava: Europsko društvo za proučavanje *Helicobacter pylori* (*The European Helicobacter Study Group – EHSG*) promovira multidisciplinarna istraživanja patogeneze i donosi smjernice o postupanju. Strategija „testiraj i liječi“ preporuča bolesnike s dispeptičkim tegobama mlade od pedeset godina i bez alarmantnih simptoma neinvazivno testirati na infekciju *H. pylori*. U svih pozitivnih bolesnika potrebno je provesti liječenje. Preporučeni neinvazivni testovi su urejni izdisajni test (UIT) i monoklonski test antigena u stolici. Određivanje titra protutijela na *H. pylori* u serumu može se također rabiti u bolesnika koji nikada prije nisu bili liječeni zbog infekcije *H. pylori*. U svih bolesnika starijih od pedeset godina, kao i u svih onih s alarmantnim simptomima neovisno o dobi, potrebno je postupiti prema strategiji „endoskopiraj i liječi“, što znači uputiti ih na endoskopski pregled jednjaka, želučane sluznice radi testiranja. U svih pozitivnih bolesnika potrebno je provesti liječenje infekcije *H. pylori*. Racionalno je započeti „sekvencijskom terapijom“, koja se sastoji od petodnevног uzimanja inhibitora protonskе pumpe (IPP) plus amoksicilin, a potom sljedećih pet dana IPP-klaritromicin-metronidazol/tinidazol. Četverostruka „konkomitantna terapija“ uključuje istodobno davanje IPP-a uz tri antibiotika (amoksicilin, klaritromicin, metronidazol) tijekom sedam do deset dana. Terapija zasnovana na levofloksacinu i terapija uz dodatak bizmuta novije su metode.

Zaključak: Racionalni aspekt „sekvencijske terapije“ temelji se na istraživanjima koja dokazuju učinkovitost do 80 %, nakon čega treba primijeniti ostale dostupne metode liječenja. Liječnici obiteljske medicine liječenju *H. pylori* trebaju pristupati odgovorno, racionalno i ustrajno.

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¹ Specijalistička ordinacija obiteljske medicine prof. dr. sc. Sanda Pribić

² Katedra za obiteljsku medicinu, Medicinski fakultet Osijek

³ Medicinski fakultet Evropskog univerziteta „Kallos“Tuzla

⁴ Specijalistička ordinacija obiteljske medicine mr. sc. Željko Vojvodić

Adresa za dopisivanje:

Prof. dr. sc. Sanda Pribić, Park kralja Petra Krešimira IV./6, Osijek, e-adresa: sandamfos@gmail.com

DIAGNOSTIC AND TREATMENT PROTOCOL IN CASE OF GERB AND INFECTION WITH HELIOCOBACTER PYLORI BACTERIUM

Sanda Pribić,^{1, 2, 3} Željko Vojvodić^{2, 4}

ABSTRACT

Introduction: The incidence rate of GERB and infections with bacteria Helicobacter pylori has reached 65 – 73% in Croatia. Due to this high prevalence, the family doctors are confronted with the significant problem in their work. The patients diagnosed with these conditions take a lot of time and spend a lot of resources. Therefore, besides the accurate diagnosis and a proper treatment, the newest guidelines and diagnostic procedures are required.

Discussion: The European Helicobacter Study Group – EHSG has promoted studies of pathogenesis and created the guidelines for treatment. The strategy “test and treat” is recommended for the patients with dyspeptic symptoms, younger than 50 and without severe symptoms. Uninvasive methods for H. Pylori diagnosis are recommended. All positive patients need the prescribed treatment. The recommended uninvasive procedures include UCT and monoclonal test for antigens in feces. The degree of antibody sensibility on H. Pylori in the serum can also be used in patients who have never been treated for H. pylori infection before. All patients older than 50 or those with severe symptoms should undergo an endoscopy of oesophagus, stomach and duodenum, in order to have a proper treatment prescribed. In all cases of endoscopy a biopsy of the stomach mucosis has to be performed and the necessary treatment has to be prescribed in case of a H. pylori infection. The “sequence therapy” must be started rationally. It consists of a 5 day therapy of a proton pump inhibitor (PPI), followed by amoxicillin, and then 5 days of PPI and claritromycin-metronidazole/tinidazole. Four folded “concomitant therapy” consists of a simultaneous intake of PPI with 3 antibiotics (amoxicillin, claritromycin, metronidazole) from 7 up to 10 days. New therapies include levofloxacin and therapy with bismuth supplement.

Conclusion: The rational aspect of sequence therapy is based on the studies, proving 80% of therapy efficiency. If necessary, the disease should be treated with other available therapies. Family physicians should treat H.pylori infection rationally, with great responsibility and, if necessary, for a longer period of time.

¹ Family practice office prof. dr. sc. Sanda Pribić

² Department of Family medicine ,Faculty of Medicine Osijek

³ Faculty of Medicine European university „Kallos“Tuzla

⁴ Family practice office Željko Vojvodić, Master of Science

Corresponding address:

Prof. dr.sc. Sanda Pribić, Osijek, Park kralja Petra Krešimira IV/6, E-mail: sandamfos@gmail.com

SMJERNICE ZA FIBRILACIJU ATRIJA

Vjekoslav Radeljić,^{1,2} Biserka Bergman Marković^{3, 4, 5}

SAŽETAK

Dijagnostika fibrilacije atrija (FA) unatoč jednostavnoj detekciji elektrokardiogramom predstavlja velik izazov moderne kardiologije. To se ne odnosi na bolesnike koji su jasno simptomatski, već na one koji su asimptomatski ili oligosimptomatski. Niti posljednjim preporukama nije definirana skupina bolesnika koja je pod povišenim rizikom za razvoj FA-e. Poznato je da bolesnici s ishemijском bolesti srca, valvularnom srčanom bolesti i kardiomiopatijama imaju veći rizik za nastanak FA-e, ali izvan navedenih skupina postoji velik broj bolesnika koji razviju fibrilaciju atrija bez jasne uzročno-posljedične veze. Prema preporukama za dijagnozu FA-e nije nužan klasični EKG ili holter EKG zapis, već se FA može detektirati i dijagnosticirati i drugim uređajima kao što je to elektrostimulator ili neki od modernih, pametnih uređaja (engl. *gadget*), a imaju mogućnost snimanja atipičnog ili tipičnog EKG kanala.

Pretraživanje populacije na fibrilaciju atrija ima velik javnozdravstveni značaj zbog sve više dokaza koji govore u prilog lošeg djelovanja FA-e na smrtnost i na kvalitetu života. To se odnosi ne samo na cerebrovaskularni inzult tromboembolijske geneze nego i na deteriorizaciju kognitivnih funkcija i drugih mehanizama kojima FA povećava ukupnu kardiovaskularnu smrtnost i pobol.

Svakog pacijenta s novootkrivenom fibrilacijom atrija (paroksizmalna, perzistentna ili permanentna) liječnik obiteljske medicine treba uputiti kardiologu na obradu. Kako je UZV srca dio obrade, potrebno ga je napraviti i prije upućivanja kardiologu ako je lakše dostupan. Liječenje varfarinom (lijekom koji je nesporno učinkovit) stvar je prošlosti zbog njegovih farmakokinetskih svojstava koja ga čine nestabilnim i nepouzdanim. Prije uvođenja NOAC-a potrebno je osim dobi pacijenta voditi računa i o funkciji bubrega (kreatinin, pGFR, albumin/kreatinin omjer), provjeriti još jednom indikaciju za liječenje CHA₂DS₂VASc tablicom i rizik od mogućeg krvarenja HAS-BLED tablicom.

Ključne riječi: fibrilacija atrija

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¹ Klinika za bolesti srca i krvnih žila, Klinički bolnički centar „Sestre milosrdnice“

² Katedra za internu medicinu, Medicinski fakultet Sveučilišta u Zagrebu

³ Specijalistička ordinacija obiteljske medicine prof. dr. sc. Biserka Bergman Marković, dr. med., spec. obiteljske medicine, Zagreb

⁴ Katedra za obiteljsku medicinu, Škola narodnoga zdravljia „Andrija Štampar“, Medicinski fakultet Sveučilišta u Zagrebu

⁵ Akademija medicinskih znanosti Hrvatske
Adresa: Doc. dr. sc. Vjekoslav Radeljić, KBC Sestre milosrdnice, Vinogradska cesta 29, Zagreb

GUIDELINES FOR ATRIAL FIBRILLATION

Vjekoslav Radeljić^{1,2}, Biserka Bergman Marković^{3,4,5}

ABSTRACT

Atrial fibrillation (FA) diagnosis, despite simple electrocardiogram detection, is a major challenge of modern cardiology. This does not apply to patients who are clearly symptomatic but to those who are asymptomatic or oligosymptomatic. No recent group recommendations have defined a group of patients at increased risk for FA development. It is known that patients with ischemic heart disease, valvular heart disease and cardiomyopathies have a higher risk of developing FA, but there are a large number of patients developing AF without a clear cause of causation.

According to FA recommendations, it is not necessary to have a classic ECG or Holter ECG record, but the FA may also detect and diagnose other devices such as an electrostimulator or some of the modern, smart devices (gadget) and have the ability to record an atypical or typical ECG channel.

Researching the population at the FA has a great public health significance due to the increasing number of evidence supporting the FA's bad performance on mortality and quality of life. This does not only apply to cerebrovascular inhibition of thromboembolic genes, but also to the deterioration of cognitive functions and other mechanisms by which the FA increases total cardiovascular mortality and morbidity.

Any patient with a newly diagnosed FA (paroxysmal, persistent or permanent) family medicine physician should refer the treatment to the cardiologist. Since the UZV heart is part of the treatment, it is also necessary to make it before referral to the cardiologist if it is more readily available. Warfarin treatment (a drug that is undeniably effective) is a thing of the past because of its pharmacokinetic properties that make it unstable and unreliable. Prior to observing NOAC, it is necessary, besides the age of the patient, to take account of the kidney function (creatinine, pGFR, albumin / creatinine ratio), check again for treatment CHA₂DS₂VASc score table and risk of possible bleeding with HAS-BLED score table.

Key words: atrial fibrillation

¹ Clinic for Heart and Blood Vascular Diseases, Clinical Hospital Center "Sestre milosrdnice"

² Department of Internal Medicine, Medical School, University of Zagreb, Croatia

³ Private Family Medicine Office „Prof Biserka Bergman Marković, MD. PhD. Zagreb, Croatia.

⁴ Deptment of Family Medicine, School of Public Health "Andrija Štampar", Medical School, University of Zagreb, Croatia

⁵ Croatian Academy of Medical Sciences

„KLINIČKE SMJERNICE U EU – REGULATORNA OSNOVA“

Marko Rađa^{1,2}

SAŽETAK

Kliničke smjernice su važan dio „zападне“ medicine ili medicine utemeljene na dokazima, a definiraju se kao „sustavno razvijene preporuke za pomoć liječnicima i pacijentima u odabiru odgovarajuće skrbi kod određenog specifičnog problema (bolesti)“. Što se tiče pravne regulative za izradu, kontrolu kvalitete, primjenu, uporabu i evaluaciju u EU i zemljama članicama postoji jako velika varijabilnost. Sama EU nije donijela pravne osnove niti regulirala ovo područje međutim EU je osnovala EMA-u koja je između ostalog zadužena i za pripremu kliničkih smjernica. Samo par zemalja ima nekakav oblik zakonske regulative u razvoju smjernica dok velika većina zemalja članica EU nema zakonsku regulativu za razvoj smjernica. U svim zemljama postoji svijest o tome koliko je važno razvijati smjernice međutim u velikoj većini zemalja razvoj smjernica je prepusten dobrovoljnoj aktivnosti pojedinih stručnih društava. Zemlje koje imaju najbolje uspostavljen sustav kliničkih smjernica (kao Velika Britanija, Njemačka, Nizozemska, Francuska, Finska, Švedska) uglavnom imaju agencije osnovane od strane vlade ili krovne stručne udruge koje su zadužene za ovu problematiku (središnji sustav izrade i primjene), a kao najbolji primjer je *The National Institute for Health and Care Excellence (NICE)* u Velikoj Britaniji ili *„Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften e.V.“* u Njemačkoj. U zemljama u kojima postoji mehanizam kontrole kvalitete smjernica glavni instrument je AGREE II koji procjenjuje metodološku kvalitetu i transparentnost smjernica. Ovaj instrument je dobro validiran i testiran, a sadrži 23 pitanja grupirana u 6 domena. Sama primjena kliničkih smjernica kao obaveza u liječenju također nije posebno zakonski regulirana i najčešće ovisi o zahtjevima pojedinog osiguravajućeg društva.

Ključne riječi: kliničke smjernice, zakonska regulativa

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¹ Dom zdravlja Splitsko-dalmatinske županije

² Katedra obiteljske medicine, Medicinski fakultet Sveučilišta u Splitu

Adresa za dopisivanje:

A.G. Matoša 2, 21000 Split, e-mail: markoradja@gmail.com, orcid: 0000-0002-4706-6272

CLINICAL GUIDELINES IN THE EU – REGULATORY BASIS

Marko Rađa^{1, 2}

ABSTRACT

Clinical guidelines are an important part of “western” medicine or medicine based on evidence, and are defined as “systemically developed recommendations meant to assist doctors and patients in choosing appropriate care for a specific problem (illness)”. There is a very high degree of variability regarding legal regulation for drafting, quality control and application, implementation and evaluation in the EU and member states. The EU itself has not established legal grounds or regulated this area, but it has established the EMA, which is responsible, among other things, for the preparation of clinical guidelines. Only a few countries have some sort of legal regulation for the development of guidelines, while the vast majority of EU member states does not. In all countries there is awareness of how important it is to develop guidelines, however in most of the countries the development of the guidelines is left to the voluntary activity of some professional societies. Countries with the best established clinical guidelines (such as the United Kingdom, Germany, the Netherlands, France, Finland, and Sweden) mainly have agencies established by the government or the professional organizations responsible for this issue (a central system of preparation and implementation). The best example is the National Institute for Health and Care Excellence (NICE) in the UK or the “**Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften eV**” (AWMF) in Germany. In the countries where there is a quality control mechanism, the main instrument is AGREE II, which evaluates the methodological quality and transparency of guidelines. This instrument is well validated and tested and contains 23 questions grouped into 6 domains. The application of clinical guidelines as an obligation in treatment is also not specifically regulated by law and it most often depends on the requirements of the individual insurance company.

Key words: clinical guidelines, legal regulations

¹ Health center of Split county

² Department of Family Medicine, School of Medicine, University of Split

Corresponding address:

Marko Rađa, MD, GP, A.G. Matoša 2, 21000 Split, E-mail: markoradja@gmail.com,
orcid: 0000-0002-4706-6272

ZDRAVSTVENA ANKSIOZNOST VS. HIPOHONDRIJA

Mirjana Resanović¹, Biserka Bergman Marković²

SAŽETAK

Zdravstvena anksioznost i hipohondrija su dvije vrste anksioznosti. Obično se javljaju u sklopu GAP-a (generaliziranog anksioznog poremećaja) ili paničnog poremećaja. Liječnici obiteljske medicine se često susreću sa anksioznim pacijentima u svakodnevnom radu. Imaju mogućnost kako farmakološkog tako i nefarmakološkog liječenja svojih pacijenata. Mogu primjenjivati supportivnu psihoterapiju za koju su educirani tijekom specijalizacije iz obiteljske medicine ili strukturiranu psihoterapiju poput RE&KBT(racionalno emotivna & kognitivno bihevioralna terapija) kao i psiholozi i psihijatri.

Ključne riječi: zdravstvena anksioznost, obiteljski liječnik

UVOD: Većina ljudi je ponekad zabrinuta za svoje zdravlje, što je normalno i korisno jer ih motivira da vode računa o svom zdravlju. Normalna zabrinutost za sopstveno zdravlje varira i pojačava se samo kada osoba ima neke zdravstvene probleme. Zdravstvena anksioznost i hipohondrija predstavljaju štetan, pretjeran i kronični vid brige i anksioznosti pri čemu osobe stalno brinu o svom zdravlju, neprestano nadgledaju i osluškuju svoje tijelo.

Cilj rada: Pacijenti bolje prihvataju termin zdravstvena anksioznost od termina hipohondrija koji je opterećen lošim značenjem i pacijenti ga tumači kao izraz nerazumijevanja i nemara liječnika, terapeuta, prijatelja, obitelji. Nezadovoljstvo i bijes su najčešće emocionalne reakcije na ponašanje liječnika. Terapija objašnjavanjem sa ciljem razuvjerenja nije preporučljiva, jer potkrepljuje disfunkcionalni obrazac koji pacijenti inače upotrebljavaju sa svojom okolinom. Stalno uvjerenje pacijenta da je s njim sve u redu održava zdravstvenu anksioznost.

Rasprava: Osobe sklone hipohondriji često pričaju drugima o bolesti i svojim tegobama, odlaze liječniku, aktivno tragaju za informacijama i tretmanu bolesti, na dramatičan i upadljiv način, u nadi da će reducirati anksioznost koju kronično osjećaju, a zapravo održavaju svoj pretjerani strah. Osobe sa zdravstvenom anksioznosti su također zabrinute za svoje zdravlje i pogrešno tumače tjelesne senzacije i simptome koje osjećaju, međutim ne žele pričati o bolesti, plaše se ići liječniku te na taj način rizikuju da zaista ugroze svoje zdravlje. Te osobe ne brinu samo o bolesti već o puno drugih stvari. Rad na rješavanju problema podrazumijeva ne samo otklanjanje sklonosti pretjerane brige o zdravlju već i generalno mijenjanje sklonosti brige povodom mogućih negativnih ishoda u životu. Pored akutne anksioznosti, javljanju ove vrste problema doprinosi i dosada, neispunjenošt i nedostatak ciljeva i osjećaja smisla života.

ZAKLJUČAK: Psihoedukativni pristup podrazumijeva da pacijent dobije novi model razmišljanja o svom problemu. Usvajanje novog modela razmišljanja omogućava pacijentu da se distancira od starih disfunkcionalnih kognitivnih i bihevioralnih strategija. Ponavljano razuvjerenje podrazumijeva ponovno uvjerenje pacijenta u benignost njegovih simptoma i davanje informacija koje pacijent već ima. Ponavljano razuvjerenje je obično u formi persuazivnog uvjerenja ili ponavljanih medicinskih ispitivanja.

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¹ dr. Mirjana Resanović, specijalizant obiteljske medicine, RE&KBT terapeut pod supervizijom Dom Zdravlja Sisak, Kralja Tomislava 1, Sisak

² prof. dr. sc. prim. Biserka Bergman Marković, specijalist obiteljske medicine „Ordinacija opće medicine prof. dr. sc. prim. Biserka Bergman Marković, spec. obiteljske med“, Albaharijeva 4, Zagreb

HEALTH ANXIETY VS. HYPOCHONDRIA

Mirjana Resanović,¹ Biserka Bergman Marković²

ABSTRACT

Health anxiety and hypochondria are two types of anxiety. They usually occur as part of GAP (generalized anxiety disorder) or panic disorder. Family medicine doctors often encounter anxiety in patients in their daily work. They have the possibility of pharmacological and nonpharmacological treatment of their patients. They can, as well as psychologists and psychiatrists, apply supportive psychotherapy for which they are educated during family medicine specialization or structured psychotherapy like RE & KBT (rational emotional & cognitive behavioral therapy). Most people are sometimes worried about their health, which is normal and useful because it motivates them to take care of their health. Normal concern for one's health varies and intensifies only when a person has some health problems. Health anxiety and hypochondria are a harmful, exaggerated and chronic aspect of anxiety and anxiety whereby the person constantly takes care of their health, constantly supervising and listening to their body. Patients better accept the term anxiety than the term hypochondria, which is burdened with bad connotations and is interpreted by patients as an expression of misunderstanding and neglect by doctors, therapists, friends, and families. Discomfort and anger are the most frequent emotional reactions to doctors' behavior. Exploration therapy is not recommended because it supports the dysfunctional model the patients utilise in their environment. Permanent persuasion of the patient that all is well maintaineds health anxiety. People who are prone to hypochondria often talk to others about illness and their problems, go to the doctor, actively seek information and treat illness, in a dramatic and intuitive way, hoping to reduce the anxiety they chronically feel and actually maintain their excessive fear. People with health anxiety are also worried about their health and misinterpret bodily sensations and the symptoms they feel, but they do not want to talk about the disease, are afraid to go to the doctor and thus risk being real threat to their health. These people do not only care about the illness but about a lot of other things. Working on solving problems implies not only eliminating the tendency to exaggerate health concerns but also generally alter the tendency to worry about possible negative outcomes in life. In addition to acute anxiety, the onset of this type of the problem also contributes to the unprecedented lack of goals and meaning in life. A psychoeducational approach implies that patients acquire new models of thinking about their problems. Adopting new models of thinking allows patients to distance themselves from old dysfunctional cognitive and behavioral strategies. Repeated disturbance involves reassuring patients into the benignity of their symptoms and giving them the information they already have.

Keywords: health anxiety, family doctor

¹ Dom zdravlja Sisak, Kralja Tomislava 1, Sisak

² "Ordinary General Medicine Prof. dr. sc. prim. Biserka Bergman Marković, family medicine specialist", Albaharijeva 4, Zagreb

Corresponding address:

Mirjana Resanović, MD, Family Medicine Specialist, RE & KBT therapist under supervision, Kralja Tomislava 1, Sisak, Croatia, E-mail: mresanovic@yahoo.com

DILEMMA OF PARENTS ASSOCIATED WITH VACCINATION

Katarina Stavrikj^{1,2}

ABSTRACT

Introduction: Vaccination is a powerful tool against preventable diseases. Successful vaccination programmes with a coverage rate of over 95% led to a substantial drop in the incidence of infectious diseases. However, we have been encountering a strong anti-vaccine movement of parents for the past several years.

Discussion: The context in which parents obtain health information has changed dramatically with the internet and social media who have undoubtedly become important sources of information. On the other hand the trust in health providers has been shattered due to different, inaccurate information given to parents. Certain population groups started to question the benefits of vaccination, the public is becoming more concerned about the adverse effects of vaccines than about diseases. Cognitive development, autism, autoimmune diseases and their association with vaccination are the most common dilemmas of parents.

These six principles are important in communication with patients: understand patient's fears and beliefs, restore trust by giving correct and answers and transparent, clear and accurate information, share dilemmas, collaborate with all organizations and media, communicate clearly explaining known science and show compassion and empathy for parents who have children with some health problems.

Key words: vaccination, parents, trust, anti-vaccine movement

¹ University children's hospital Skopje

² Center for family medicine, Medical Faculty Skopje

SHORT EDUCATION INTERVENTIONS AND IMPLEMENTATION OF CLINICAL GUIDELINES: ANTIBIOTIC PRESCRIBING FOR ARI IN PRIMARY CARE IN MACEDONIA

Katarina Stavrikj,¹ Valentina Risteska Nejashmikj,²
Neda Milevska Kostova³

ABSTRACT

Background: Acute respiratory infections (ARIs) are one of the most common reasons for visiting the Primary Health Care (PHC) doctors. Unjustified and unnecessary prescribing of antibiotics (AB) for ARIs is a global health problem. Doctors in PHC play a key role in the increased prescribing of AB. At PHC level, 80% of AB are prescribed for ARIs. Implementation of evidence-based guidelines in practice may result in a reduction of prescribing AB for ARI.

Aim: To determine the impact of targeted education for PHC doctors in establishing proper diagnoses and choosing appropriate antibiotic therapy, in accordance with the guidelines.

Subjects and methods: The national study was part of the multi-centric project for AB prescribing for ARIs, implemented by the International Primary Care Respiratory Group (IPCRG). The case-control study was implemented in November 2015 at the PHC level in seven regions in Macedonia. The research group consisted of 95 PHC doctors divided into two groups (intervention and control group). Before the survey, the intervention group of 49 doctors received one-day targeted education for ARIs treatment based on national guidelines. The control group of 46 PHC doctors did not receive any prior targeted education. The survey consisted of a research questionnaire completed for all patients with ARIs who visited the clinics of both the intervention and the control group of doctors. The data was statistically analyzed using MS Excel software.

Results: The analysis of a sample of 8259 patients showed similar AB prescribing rates in both groups (intervention group – 60.5%, control group – 59.7%) with no statistically significant difference between groups ($p = 0.4644$). The most prescribed AB in both groups was Amoxicillin + clavulanic acid. We found very low percentage of prescribed Penicillin V (5.1%) in both groups, and as a result, a significantly greater prescribing of Amoxicillin in the intervention group and an increased use of third-generation cephalosporins in the control group. AB prescribing due to patient/parent pressure was significantly higher in the control group. The most AB were prescribed for ICD10 diagnoses for which AB treatment is not recommended by the guidelines: 25.39% for common cold, 15.85% for acute pharyngitis, 19.58% for acute tonsillitis and 15.26 % for acute bronchitis.

Conclusion: We concluded that the short-term targeted education of PHC doctors did not have a significant influence on the rate of AB prescribing for ARIs. The most commonly used AB was found to be amoxicillin + clavulanic acid, despite different recommendations in the national guidelines. Unnecessary prescription of antibiotic was done for 2/3 of patients. Our study suggests that continuous and guideline-specific education would give better results in AB prescribing based on guidelines.

Keywords: antibiotics, prescribing, acute respiratory infections, education, guidelines

¹ University clinic for children diseases, University “Ss. Cyril and Methodius”, Skopje, Macedonia

² Center for Family medicine, Medical Faculty, “Ss. Cyril and Methodius”, Skopje, Macedonia

³ Centre for Regional Policy Research and Cooperation “Studiorum”, Skopje, Macedonia

NEURALGIJA NERVUSA TRIGEMINUSA

Šefket Šabanović¹

SAŽETAK

Bol je neugodan individualni osjećaj koji je teško definirati, svatko od nas bol drugačije doživjava i podnosi. Svjetsko udruženje za bol (IASP) definira bol kao neugodan emocionalni i osjetni doživljaj povezan sa stvarnim ili potencijalnim oštećenjem tkiva. Neuropatska bol uzrokovana je oštećenjem somato-senzornog dijela živčanog sustava. Uzrok neuropatske boli oštećenje je ili disfunkcija perifernog ili središnjega živčanog sustava, a ne podražaja receptora za bol. Bol čija jakost nije proporcionalna oštećenju tkiva, pojava dizestezija (žarenje, mravinjanje) znaci su koji upućuju na dijagnozu neuropatske boli.

Čak 7-8 % stanovništva Europe pati od neuropatske boli. Vrlo često u ambulantama obiteljske medicine imamo klasične primjere neuropatske boli: dijebetičku polinervopatiiju, postherpetičku neuralgiju, trigeminalnu neuralgiju, radikularnu bol, bol nakon ICV-a, bol nakon ozljede kralježnične moždine i postkiruršku bol. Kao posljedica patološkog zbivanja u živčanom sustavu nastaje neuropatska bol. Obično se javlja spontano i u mirovanju kao pečenje, žarenje, sijevajuća ili ostra ubodna bol.

Ključne riječi: neuralgija trigeminusa, neuropatska bol, neuralgija, bol

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1. Barda A. Neuropatska bol. Medikus 2014; 23: 139–43.

¹ Specijalistička ordinacija obiteljske medicine dr. sc. Šefket Šabanović

Adresa za dopisivanje:

Specijalistička ordinacija obiteljske medicine dr. Šefket Šabanović, Dr. Franje Račkog 32, 32 270 Županja, e-adresa: obiteljska6@gmail.com

TRIGEMINAL NEURALGIA

Šefket Šabanović¹

ABSTRACT

Pain is an unpleasant individual feeling that is difficult to define. Each of us perceive and tolerate pain differently. The World Association for Pain (IASP) defines pain as an unpleasant emotional and sensory experience associated with actual or potential tissue damage.

Neuropathic pain is caused by the impairment of the somatic-sensory work of the nervous system. The cause of neuropathic pain is the damage or dysfunction of the peripheral or central nervous system, not the stimuli of the pain receptors. Pain whose strength is not proportional to tissue damage, the occurrence of paresthesia (burning, tingling) signal the diagnosis of neuropathic pain.

Even 7-8% of Europe's population suffers from neuropathic pain. In our offices, we often have classical examples of neuropathic pain: diabetic polyneuropathy, postherpetic neuralgia, trigeminal neuralgia, radicular pain, pain after a cerebral ischemic stroke, pain after a spinal cord injury and post-surgical pain. Neuropathic pain develops as a consequence of pathological events in the nervous system. It usually occurs spontaneously and at rest, including sensations such as burning, flaking or sharp stinging pain.

Keywords: trigeminal neuralgia, neuropathic pain, neuralgia, pain.

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¹ Family Medicine Practice PhD Šefket Šabanović
Family Medicine Practice Dr. Šefket Šabanović, 32270 Županja, Dr. Franje Račkog 32,
Tel: 032/831-715, e-mail: obiteljska6@gmail.com

ULOGA LIJEČNIKA OBITELJSKE MEDICINE U SVJETLУ NOVIH SMJERNICA AHA/ASA ZA LIJEČENJE AKUTNOGA ISHEMIJSKOGA MOŽDANOG UDARA

Svjetlana Šupe¹

SAŽETAK

Moždani udar (MU) prvi je uzrok invalidnosti i drugi uzrok smrtnosti i u Hrvatskoj i u Europi. S obzirom na rezultate *Interstroke* studije, koja je upozorila na to da je deset rizičnih čimbenika, na koje se može utjecati, odgovorno za 90 % svih moždanih udara, liječnik obiteljske medicine (LOM) bitan je u prevenciji tih rizičnih čimbenika, njihovu ranom otkrivanju i liječenju. Važna uloga LOM-a jest u senzibilizaciji populacije (i bolesnika i njihovih obitelji) u pogledu činjenice da je akutni MU stanje koje se može liječiti, u edukaciji o simptomima MU-a i važnosti što ranijeg reagiranja pri pojavi akutnoga neurološkog deficit-a. Tragična je činjenica da je u organizaciji skrbi bolesnika s akutnim MU-om to stanje još uvijek nedovoljno rangirano na ljestvici hitnih stanja, a često i neprepoznato, posebno kod MU-a u vertebrobasilarnom slijevu. Stoga je presudna uloga LOM-a kod akutnog MU-a u brzini: brzini prepoznavanja simptoma MU-a i brzini upućivanja do bolnica koje mogu primijeniti hitno reperfuzijsko liječenje. Mogućnost revaskularizacije parenhima mozga nakon uvođenja trombolize i mehaničke tromboektomije bitno je poboljšala klinički ishod bolesnika s akutnim IMU-om. Najnovije smjernice AHA/ASA za liječenje akutnog IMU-a naglašavaju važnost što ranijeg prepoznavanja simptoma i skraćenja vremena transporta, u čemu iznimnu važnost ima LOM i hitna medicinska služba. Navedeni postupci uz skraćenje vremena hitne bolničke obrade rezultiraju skraćenjem „door-to-needle“ i „door-to-puncture“ vremena, pridonoseći većoj učinkovitosti reperfuzijskog liječenja, a time i boljem kliničkom oporavku bolesnika s akutnim IMU-om.

Ključne riječi: moždani udar, reperfuzija, liječnik obiteljske medicine, AHA/ASA

¹ Klinika za neurologiju, KBC Zagreb, Kišpatićeva 12, Zagreb, ssupe2@hotmail.com

THE ROLE OF PRIMARY HEALTH CARE PHYSICIAN IN THE LIGHT OF THE NEW AHA/ASA GUIDELINES FOR THE TREATMENT OF ACUTE ISCHEMIC STROKE

Svetlana Šupe¹

ABSTRACT

Introduction: Stroke is a heterogeneous and multi-factorial disease caused by the combination of vascular, environmental and genetic risk factors. Acute ischemic stroke(AIS) is an intracranial circulation disorder caused by a number of etiopathogenic factors. It is an acute condition requiring urgent diagnostic and therapeutic procedures, since the AIS with new reperfusion methods can be successfully treated. An important role of primary health care physicians (PHCP) is to increase public awareness of stroke, that stroke is an acute condition that can be treated, to educate about stroke symptoms and about the importance of the early intervention in cases of the occurrence of acute neurological deficit.

Aim: Acute stroke is a state of emergency that can be successfully treated, in the light of new therapeutic guidelines highlighting urgency (in the recognition, transportation, diagnosing, and treatment).

Discussion: Stroke is the leading cause of disability and the second cause of death in Croatia, as well as in Europe. The tragic fact is that in the organization of care for patients with acute stroke, this condition is still not ranked high enough on emergency scales, and often is unrecognized, especially with stroke symptoms in vertebrobasilar circulation.

Therefore, the crucial role of the PHCP dealing with acute stroke lies in speed: the prompt symptoms recognition, exclusion of other causes (e.g. hypoglycaemia) and urgent transportation to the hospital which can apply emergency reperfusion treatment. The possibility for revascularisation of the brain parenchyma after the introduction of thrombolytic treatment and mechanical thrombectomy has improved the clinical outcomes of stroke patients. The latest AHA/ASA guidelines for the acute stroke treatment emphasize the importance of an early recognition of stroke symptoms and shorten the time of transportation, in which the PHCP and the emergency medical service are of exceptional importance. The specified procedures with the shortening of time of the emergency diagnosing procedures, including neurological examination using the NIHSS scale, neuroimaging and laboratory parameters, result in the reduction of “door-to-needle” and “door-to-puncture” time, contributing to a greater effectiveness of treatment, and thus a better clinical recovery of patients with acute stroke.

Conclusion: Ischemic stroke must be treated as an emergency. In light of the new guidelines for acute stroke treatment, speed is considered to be critical, both in recognizing the symptoms, where PHCP play an important role, and in diagnostic and therapeutic procedures aiming at better clinical outcomes.

Key words: stroke, reperfusion, primary health care physician, AHA/ASA guidelines

¹ Klinika za neurologiju, KBC Zagreb, Kišpatičeva 12, Zagreb, ssupe2@hotmail.com

ISKRA, HRVATSKE NACIONALNE SMJERNICE ZA PRIMJENU ANTIBIOTIKA – RAZVOJ I SVRHA

Arjana Tambić-Andrašević¹

SAŽETAK

Uvod: Interdisciplinarna sekcija za kontrolu rezistencije na antibiotike (ISKRA) Ministarstva zdravstva RH osnovana je 2006. godine sa zadatkom osmišljavanja i koordiniranja različitih aktivnosti usmjerenih na kontrolu širenja otpornosti na antibiotike u Hrvatskoj. Razvijanje nacionalnih smjernica za primjenu antibiotika kod najčešćih kliničkih sindroma bitna je aktivnost predviđena hrvatskim nacionalnim programom za kontrolu širenja rezistencije i u skladu je s globalnim akcijskim planom Svjetske zdravstvene organizacije.

Metodologija razvoja smjernica: Podatci o potrošnji antibiotika u Hrvatskoj pokazuju da se više od 90 % antibiotika potroši pri izvanbolničkom liječenju, te su za prve teme nacionalnih smjernica odabранe grlobolja kao najčešća bakterijska infekcija gornjih dišnih puteva i infekcije mokraćnih puteva kao najčešće bakterijske infekcije u ljudi. U bolničkom liječenju smjernice za kontrolu širenja meticilin rezistentnog *Staphylococcus aureus* (MRSA) i smjernice za uporabu antibiotika u kirurškoj profilaksi prepoznate su kao inicijative kojima bi se relativno lako mogla postići racionalizacija u bolničkoj potrošnji antibiotika. Pri pisanju smjernica korištena je *Appraisal of Guidelines for Research & Evaluation* (AGREE) metodologija koja podrazumijeva da su smjernice nastale kao konsenzus svih zainteresiranih stručnih društava i institucija koje su imenovale svoje predstavnike u radnu skupinu za pisanje smjernica te da predstavljaju dokument medicine zasnovane na dokazima. Prijе objave smjernice su bile pokusno ispitane i otvorene za primjedbe kako bi u konačnom obliku bile što prihvatljivije za primjenu u praksi. Podrazumijeva se da primjena nacionalnih smjernica ne osigurava uspjeh liječenja svakog pacijenta i razumljivo je da pristup pacijentu treba biti individualan, no pridržavanje smjernica osigurava standardizirani pristup većini pacijenata. Odstupanje od preporučenog liječenja trebalo bi biti dobro argumentirano, a načelno neslaganje s odrednicama smjernica trebalo bi objaviti radnoj skupini kao poticaj za reviziju postojećih smjernica.

Zaključak: Postojanje nacionalnih smjernica utemeljenih na lokalnim podatcima o rezistenciji najučestalijih patogena može značajno pridonijeti kvaliteti primjene antibiotika. Nacionalne smjernice mogu poslužiti kliničarima kao potpora za racionalno propisivanje antibiotika i odupiranje defenzivnoj medicini.

¹ Zavod za kliničku mikrobiologiju, Klinika za infektivne bolesti „Dr. Fran Mihaljević“

Adresa za dopisivanje:

Prof. dr. sc. Arjana Tambić-Andrašević, Zavod za kliničku mikrobiologiju, Klinika za infektivne bolesti „Dr. Fran Mihaljević“, Mirogojska 8, 10000 Zagreb, e-adresa: arjana.tambic@bfm.hr

ISKRA CROATIAN NATIONAL GUIDELINES ON THE USE OF ANTIBIOTICS – DEVELOPMENT AND GOALS

Arjana Tambić-Andrašević¹

ABSTRACT

Introduction: The Interdisciplinary Section for Antibiotic Resistance Control (ISKRA) of the Croatian Ministry of Health was established in 2006 with the task of designing and coordinating various activities aimed at controlling antibiotic resistance spread in Croatia. The development of national guidelines for the use of antibiotics in the most common clinical syndromes is an important activity envisaged by the Croatian national program to control the spread of resistance and is in line with the global action plan of the World Health Organization.

Methodology of guideline development: Antibiotic consumption data in Croatia indicate that more than 90% of antibiotics are consumed in ambulatory care, so the first national guidelines were developed for sore throat as this is the most common bacterial infection of the upper respiratory and urinary tract which is the most common bacterial infection in humans. In hospital care guidelines for controlling the spread of methicillin resistant *Staphylococcus aureus* (MRSA) and guidelines for surgical prophylaxis have been recognized as initiatives that could most effectively achieve rationalization in the hospital use of antibiotics. When writing the guidelines, the Appraisal of Guidelines for Research & Evaluation (AGREE) methodology was used, which implies that the guidelines were created as a consensus of all the interested societies and institutions that appointed their representatives to the guideline working group and that they are evidence-based documents. Prior to publication, the guidelines were piloted and open to remarks in order to be as acceptable as possible for use in everyday practice in their final form. The application of national guidelines does not ensure the treatment success for every patient and it is understandable that treatment approach should be tailored to the individual patient, but compliance with the guidelines provides a standardized approach to most patients. The deviation from the recommended treatment should be well-argued and, in principle, any disagreements should be disclosed to the working group as an incentive to revise the existing guideline.

Conclusion: The existence of national guidelines based on local antibiotic resistance data for the most common pathogens may significantly contribute to the quality of antibiotic use. National guidelines can serve clinicians as a support for rational prescribing of antibiotics and resisting defensive medicine practice.

¹ Department of Clinical Microbiology, University Hospital for Infectious Diseases “Dr. Fran Mihaljević”, Mirogojska 8, 10000 Zagreb

Address for correspondence:

Prof.dr.sc. Arjana Tambić Andrašević, Department of Clinical Microbiology, University Hospital for Infectious Diseases “Dr. Fran Mihaljević”, Mirogojska 8, 10000 Zagreb, arjana.tambic@bfm.hr

OSPICE – NEOPRAVDAN STRAH ILI REALNA OPASNOST?

Goran Tešović¹

SAŽETAK

Epidemije ospica koje su u tijeku u mnogim (čak i visokorazvijenim!) europskim zemljama ponovno naglašavaju važnost i utjecaj nastavka kontinuiranog cijepljenja usprkos smanjenju incidenциje bolesti. Mogućnost prijenosa na prijempljive kontakte zahtijeva visoku razinu procijepljenosti kako bi se prevenirala ponovna uspostava endemske bolesti. Posebnu pažnju treba usmjeriti na visokorizične skupine, poput migranata i marginalnih populacija, te na odrasle osobe koje putuju u područja s endemskim ospicama. S obzirom na visoku zaraznost bolesti važno je provesti seroepidemiološke studije kako bi se identificirale nezaštićene skupine te u slučaju izloženosti provela pravovremena postekspozicijska profilaksa.

¹ Prof. dr. sc. Goran Tešović, dr. med.,
Klinika za infektivne bolesti „Dr. Fran Mihaljević“, Zagreb, Zavod za infektivne bolesti djece,
Medicinski fakultet Sveučilišta u Zagrebu

ISKRA SMJERNICE ZA DIJAGNOSTICIRANJE I LIJEČENJE GRLOBOLJE

Marion Tomičić¹

SAŽETAK

Uvod: ISKRA smjernice za dijagnosticiranje i lijeчење grlobolje olakšavaju liječniku obiteljske medicine (LOM) postavljanje dijagnoze i odabir odgovarajućeg antibiotika za liječeњe upale grla uzrokovane bakterijom *Streptococcus pyogenes* skupine A (β -hemolitički streptokok skupine A (BHS-A)). Cilj je rada prikazati značajke tih smjernica, važne za svakodnevni rad LOM-a.

Ispitanici i metode: Osim ISKRA smjernica pregledani su članci pronađeni pretraživanjem baze PubMed/Medline prema ključnim riječima *Streptococci, Tonsillitis, Pharyngitis, Antibiotics prescription, Antibiotic-resistant*.

Rezultati: Na osnovi kliničke slike diferencijalno-dijagnostički ponekad je teško razlikovati virusne i bakterijske uzročnike, pa stoga upotrebljavamo Centorove ili modificirane Centorove (McIsaacove) kriterije. Osjetljivost i specifičnost Centorovih kriterija nije dostatna (55 – 75 %), pa kliničku dijagnozu treba nadopuniti mikrobiološkom obradom. Brzi streptokokni test (BST) jest imunokromatografska metoda kojom se uz pomoć monoklonskih protutijela otkrivaju antigeni BHS-A. Uzima se kao standardan obrisak, a rezultati se dobiju nakon 20-30 minuta. Osjetljivost pravilno uzetoga BST-a je 86 %, a specifičnost 95 %. Zbog visoke specifičnosti pozitivan nalaz je dovoljan da se u bolesnika s grloboljom postavi dijagnoza streptokokom uzrokovane grlobolje i započne terapija antibiotikom. Sukladno ISKRA smjernicama, penicilin V i G prvi su lijek izbora. Rezistencija BHS-A na penicilin nikad nije zabilježena, a peroralnim liječeњem fenoksimetilpenicilinom u trajanju od deset dana bolesnik dobije antibiotik uskoga spektra, dokazane učinkovitosti, s malo nuspojava. U slučaju preosjetljivosti na penicilin lijek izbora je azitromicin. U slučaju ponavljajućih, rekurentnih akutnih angina, preporučuje se promjena terapije i primjena amoksicilina s klavulanskom kiselinom ili klindamicina. Eradicacija BHS-A u asimptomatskih kliničima provodi se samo u strogo određenim uvjetima, a primjenjuju se azitromicin i klindamicin.

Zaključak: Kako liječnici obiteljske medicine propisu većinu antibiotika izvan bolnice, važno je osvijestiti činjenicu da je neracionalno propisivanje antibiotika glavni uzrok porasta bakterijske rezistencije na svjetskoj razini. Ispravim dijagnosticiranjem i racionalnim propisivanjem antibiotika sukladno smjernicama liječnici obiteljske medicine mogu zaustaviti rast bakterijske rezistencije.

Ključne riječi: BHS-A, tonsilofaringitis, propisivanje antibiotika, rezistencija

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¹ Katedra obiteljske medicine, Medicinski fakultet Sveučilišta u Splitu,
Specijalistička ordinacija obiteljske medicine

Adresa:

Specijalistička ordinacija obiteljske medicine, Trg Hrvatske bratske zajednice 4, Split,
e-adresa: marion.tomicic@mefst.hr, orcid: 0000-0003-2148-3227

ISKRA GUIDELINES ON SORE THROAT: DIAGNOSTIC AND THERAPEUTIC APPROACH

Marion Tomičić¹

ABSTRACT

Introduction: ISKRA guidelines on sore throat assist GPs in diagnosing and selecting adequate antibiotic treatment of strep throat caused by Group A Streptococcus pyogenes (Group A β-haemolytic streptococcus (BHS-A)). The goal of this article is to describe important features of these Guidelines for GPs in their everyday practice.

Sample and methods: In addition to ISKRA guidelines, the author reviewed articles found through key word search in the PubMed/Medicine base using the following key words: Streptococci; Tonsillitis; Pharyngitis; Antibiotics prescription; Antibiotic-resistant

Results: When establishing differential diagnosis, it is sometimes difficult to distinguish between viral and bacterial causes based on the clinical presentation. Therefore, we use Centor or modified Centor (McIsaac) criteria. Sensitivity and specificity of Centor criteria is insufficient (55-75%), and clinical diagnosis requires additional microbiological testing. Rapid strep test (RST) is an immunochromatographic assay using monoclonal antibodies to detect BHS-A antigens. It uses standard swabbing with results available in 20-30 minutes. The sensitivity and specificity of a properly performed RST are 86% and 95% respectively. Due to high specificity, a positive result is sufficient to diagnose the patient with sore throat with streptococcal throat infection and start antimicrobial treatment. According to ISKRA guidelines, penicillin V and G are the drugs of choice. BHS-A resistance to penicillin has never been recorded. Treatment with oral phenoxymethylpenicillin in the course of 10 days provides the patient with a narrow-spectrum antibiotic with proven efficacy and little side effects. In case of hypersensitivity to penicillin, the drug of choice is azithromycin. For recurrent throat infections, a change in treatment is recommended with amoxicillin and clavulanic acid or clindamycin. Eradication of BHS-A in asymptomatic carriers is performed only in strictly defined cases, with azithromycin and clindamycin.

Conclusion: Bearing in mind that most antibiotics are prescribed by GPs in outpatient care, it is important to raise awareness of the fact that irrational prescribing of antibiotics is the leading cause of the global rise in bacterial resistance. GPs can curtail bacterial resistance by proper diagnosing and rational prescribing of antibiotics.

Key words: BHS-A, tonsillopharyngitis, prescribing of antibiotics, resistance

¹ University of Split School of Medicine, Department of Family Medicine

Corresponding address:

Marion Tomičić, MD, PhD, General Practitioner's office, Trg hrvatske bratske zajednice 4, Split,
E-mail: marion.tomicic@gmail.com, <http://orcid.org/0000-0003-2148-3227>

SMJERNICE ZA POTHRANJENOST KOD KRONIČNE UPALNE CRIJEVNE BOLESTI – ULOGA OBITELJSKOG LIJEČNIKA

M. Tundzeva,¹ Lj. Sukriev,¹ K. Stavrikj,^{1,2} K. Kovacevikj,¹ B. Tanevska¹

SAŽETAK

Uvod: Upalne crijevne bolesti (UCB) učestale su, a potencijalni se prehrambeni čimbenici uzimaju u obzir u njihovoј etiologiji. Neuhranjenost je vrlo česta kod kronične upalne bolesti crijeva (KUBC), osobito u Crohnovoj bolesti. Liječenje pothranjenosti u ovih bolesnika razmatra se u općem kontekstu potpore bolesnicima koji su neuhranjeni. Cilj ovog rada bio je prikazati mjesto obiteljskog liječnika kao dijela multidisciplinarnog tima u vođenju KUBC-a prema smjernicama, kao i preporuke, ankete i izvješća iz susjednih zemalja.

Zaključak: U R. S. Makedoniji ne postoje jedinstvene smjernice za neuhranjenost kod KUBC-a. Ne postoji jedinstvena prehrana za sve bolesnike. Svakom bolesniku s KUBC-om treba individualni pristup. Također je potvrđeno da neke od preporuka nije moguće provesti u nekim zemljama Europe i većini zemalja u razvoju. Prosječne plaće od oko 250 eura mjesečno ne dopuštaju određene radnje koje bogatije zemlje uzimaju zdravo za gotovo, pa se primjena umjetne prehrane može odrediti samo uz pristanak pacijentove obitelji ili pacijenata i njihovu kupnju. U većine se bolesnika KUBC javlja zbog nepoznatih vanjskih uzroka, uključujući crijevnu mikrofloru, koja djeluje na genetski predisponiranog domaćina, a kod djece u dobi od 15 do 25 godina (obiteljska bolest) javlja se teža manifestacija bolesti, koja utječe na normalan psihofizički razvoj. Obiteljski liječnik ima značajnu ulogu u ranom otkrivanju tih bolesti pomoću instrumenata za procjenu pothranjenosti, energetskih potreba i sustava tijela, u kontroli farmakoterapije i štetnih učinaka lijekova, izboru prehrane u akutnom pogoršanju, laboratorijskim istraživanjima, enteralnoj prehrani kao potpori, unosu proteina, intervenciji u kontroli anemije, drugih nedostataka minerala i deficita vitamina, unosu omega-3 i probiotika, kontroli osteoporoze, podršci u postupnoj regulaciji tjelesne težine i prehrambenom održavanju. Nutritivna potpora važna je u bolesnika s KUBC-om u prevenciji i liječenju pothranjenosti, a njezino ciljano i pragmatično dodavanje poboljšava ishod. Pristup je multidisciplinaran i kod djece s ovim bolestima.

Ključne riječi: pothranjenost, prehrana, KUBC

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¹ Centar za obiteljsku medicinu, Medicinski fakultet Skoplje

² JZU Univerzitetska Klinika za dečje bolesti Skopje

KORONARNA BOLEST I BOLESNIKU USMJERENA SKRB: KOMPLEKSNI MOZAIK SMJERNICA, KOMORBIDITETA I LIJEČENJA U OBITELJSKOJ MEDICINI

Sunčana Vlah,¹ Lucija Murgić,² Lanatina Mihaljinec,³
Đurđica Kašuba Lazić,²

SAŽETAK

Uvod: Bolesnici s koronarnom bolesti (KB) zahtijevaju učestalu i kompleksnu skrb temeljenu na preporučenim mjerama sekundarne prevencije kardiovaskularnih bolesti (KVB). Unatoč uloženim naporima u postizanje kvalitete skrbi parametri kontrole bolesti često nisu zadovoljavajući. Jedan od razloga tomu mogao bi biti taj što sustavno prikupljene brojne informacije o bolesniku i rizičnim čimbenicima u elektroničkom zdravstvenom zapisu, u kratkom vremenu konzultacije s liječnikom obiteljske medicine (LOM), često nisu u potpunosti dostupne i ili pregledne. Cilj rada bio je prikazati rezultate istraživanja kvalitete skrbi za bolesnike s KB-om referirajući se na aktualne smjernice za KVB, te prikazati idejno slikovno kompjutorsko rješenje koje bi moglo pridonijeti učinkovitosti konzultacije i kvaliteti skrbi u ordinaciji LOM-a.

Metode: Provedeno je opservacijsko istraživanje u svibnju 2017. godine, u devet (9) specijalističkih ordinacija LOM-a na 169 bolesnika koji su ili preboljeli infarkt miokarda i ili su bili podvrgnuti perkutanoj koronarnoj intervenciji i ili operaciji aortokoronarnog premoštenja. Bolesnici su ispunili upitnik o životnim navikama, načinu i učestalosti uzimanja lijekova, tjelesnoj aktivnosti, suradljivosti u liječenju te prihvatanju bolesti i promjeni životnog stila. Dodatni podatci o bolesniku prikupljeni su iz elektroničkoga zdravstvenog zapisa (e-karton).

Rezultati: Od 169 ispitanih muškaraca je bilo 74 %, a prosječna dob ispitanih bila je 66,8 godina. Ispitanici, njih 83 %, doživjelo je infarkt miokarda, njih 74 % imalo je stent, a 17,1 % srčanu premosnicu. Od komorbiditeta KB-a trećina je imala šećernu bolest, njih 76,3 % hipertenziju, 12 % KOPB, 12 % insuficijenciju bubrega, a 27,2 % depresiju. Od čimbenika rizika: arterijski tlak \leq 130/80 mmHg imalo je 63,2 % ispitanih, a LDL kolesterol $<$ 1,8 mmol/L njih 19,4 %. Od farmakoterapije acetilsalicilnu kiselinu uzimalo je 75,7 % ispitanih, beta-blokator njih 84 %, ACEI ili ARB 79,3 %, a hipolipemik 87,6 % ispitanih. Suradljivima u liječenju smatralo se 80 % ispitanih, a nešto ih je više od 50 % promijenilo životni stil nakon incidenta. Budući da najveći broj navedenih informacija, premda postoje u e-kartonu, nije lako ni brzo dostupan u ograničenom vremenu konzultacije, osmišljeno je vizualno rješenje u programu Adobe® Illustrator® koje bi moglo olakšati praćenje rizičnih čimbenika.

Zaključak: Skrb LOM-a za bolesnike s KB-om je kompleksna, a ishodi mjera sekundarne prevencije nisu zadovoljavajući. Poboljšanje skrbi mogla bi unaprijediti predložena jasna vizuelna prezentacija vrijednosti čimbenika rizika ažurirana svakim novim unosom njihovih vrijednosti.

Ključne riječi: koronarna bolest, sekundarna prevencija, obiteljska medicina

¹ Dom zdravlja Zagreb-Istok

² Katedra za obiteljsku medicinu, Medicinski fakultet Sveučilišta u Zagrebu,
Škola narodnog zdravlja „Andrija Štampar“

³ Dom zdravlja Zagreb-Centar

Adresa za dopisivanje:

Sunčana Vlah, dr. med., Dom zdravlja Zagreb-Istok, Švarcova 20, Zagreb,
e-adresa: suncanav@gmail.com, <http://orcid.org/0000-0001-7461-5866>

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CORONARY ARTERY DISEASE AND PATIENT ORIENTED CARE: COMPLEX MOSAIC OF GUIDELINES, COMORBIDITIES AND TREATMENT IN FAMILY MEDICINE

Sunčana Vlah,¹ Lucija Murgić,² Lanatina Mihaljinec,³
Đurđica Kašuba Lazić²

ABSTRACT

Introduction: Patients with coronary artery disease (CAD) need a regular and complex care based on recommended secondary prevention guidelines for cardiovascular disease (CVD). Despite all the efforts in providing good care quality, the results of disease control are often not achieved. One reason could be that the gathered information about patients and risk factors in electronic health card (e-health card) are not easily accessible and visible in the short time of doctor – patient consultation. The aim of this study was to show the results of care quality for patients with CAD in correlation with current guidelines for CVD and to present a visual solution that could improve the work and care for those patients in family practice.

Methods: An observational study was conducted in nine (9) family medicine practices throughout Croatia in May 2017 and it included 169 patients who suffered from myocardial infarction and/or underwent percutaneous coronary intervention and/or bypass surgery. Patients filled up a questionnaire about their life habits, pharmacotherapy, physical activity, compliance with treatment, acceptance of their disease and lifestyle changes. Additional data about the patients were collected from e-health card.

Results: Most of 169 patients were men (74%), and average age of all the patients was 66.8. Eighty-three percent of them had myocardial infarction, 74% had a stent, and 17.1% had a coronary bypass. A third of all patients suffered from diabetes mellitus, 76.3% had arterial hypertension, 12% COPD, 12% had kidney disease, and 27.2% suffered from depression. Risk factors were: blood pressure $\leq 130/80$ mmHg in 63.2% and LDL cholesterol < 1.8 mmol/L in only 19.4% of the patients. Acetylsalicylic acid was used by 75.7% of the patients, beta blocker was taken by 84%, ACEI or ARB by 79.3%, and hypolipidemic drugs by 87.6% of the patients. Over 80% of the patients claimed to be cooperative in their treatment and more than half of all patients changed their lifestyle after the coronary incident. Although all the mentioned information are in e-health card they are not clearly shown and easily accessible so we came up with a visual solution for risk factors with the help of software Adobe® Illustrator® that could simplify the follow-up of secondary prevention measures.

Conclusion: Care for CAD patients is complex and the measures taken for secondary prevention are insufficient. The quality of care could be improved by clear visual presentation of the risk factors updated with all new values.

Key words: coronary artery disease, secondary prevention, family medicine

¹ Health Center Zagreb - East

² Department of Family Medicine, University of Zagreb, School of Medicine, School of Public Health "Andrija Štampar", Zagreb

³ Health Center Zagreb - Center

Address for correspondence:

Sunčana Vlah, dr. med., Health Center Zagreb - East, 20 Ladislav Švarc Street, Zagreb,
e-mail: suncanav@gmail.com, <http://orcid.org/0000-0002-9142-15690000-0001-7461-5866>

SMJERNICE ZA PREOPERATIVNU OBRADU NAJČEŠĆIH STANJA U OBITELJSKOJ MEDICINI

Jasna Vučak,¹ Julija Šerić,² Karmela Bonassin,³
Jadranka Karuza,⁴ Dragan Soldo⁵

SAŽETAK

Uvod: Preoperativna obrada (PO) prethodi svakom elektivnom operativnom zahvatu. Cilj je PO-a procjena operativnog rizika, a vezana je uz složenost operacije i karakteristike bolesnika, izbor vrste anestezije, preveniranje mogućih komplikacija i planiranje postoperativnog liječenja. U pristupu PO-u potreban je individualni pristup koji uzima u obzir funkcionalni kapacitet, komorbidite i rizičnost planiranog zahvata.

Cilj: Donijeti pregled smjernica za PO kod stanja s kojima se liječnik obiteljske medicine najčešće susreće: operacija mrene, koronarografija, artroskopija i ugradnja endoproteze kuka/koljena.

Rasprrava: Operativni zahvati (OZ) dijele se na zahvate malog, srednjeg i velikog rizika. Podjela je definirana prepostavljenim mogućim maksimalnim gubitkom krvi, predviđenim trajanjem hospitalizacije i stupnjem očekivanih komplikacija. Važna je i podjela rizika prema karakteristikama pacijenta. Najčešće se rabi klasifikacija funkcionalne sposobnosti Američkog udruženja anesteziologa – Klasifikacijski sustav fizikalnog statusa (*American Society of Anesthesiologists – Physical Status Classification System*, ASAPS) po kojoj se pacijenti dijele na šest grupa. Prva grupa ASA I su zdravi, ASA II s blagom sistemskom bolesti, ASA III s težom sistemskom bolesti, ASA IV s težom sistemskom bolesti koja predstavlja trajni rizik pogoršanja zdravstvenog stanja/smrti, dok su ASA V i VI moribundni i pacijenti s moždanom smrti. Rutinski se preoperativni testovi ne preporučaju. U zdravih osoba imaju slabu prediktivnu vrijednost i postoji mogućnost lažno pozitivnih rezultata koji povećavaju opseg pretraga, a u konačnici ne utječu na ishod. Dokumentacija i PO za operacije niskog rizika koji se rade bez prisutnosti anesteziologa (operacija mrene, koronarografija) trebaju biti učinjeni na razini LOM-a, a sadržavaju klinički pregled, osnovne laboratorijske nalaze i ispunjene pripadajuće upitnike. Za operacije srednjeg/visokog rizika PO se planira sukladno karakteristikama pacijenta i specifičnog OZ-a, te je potrebno prirediti odgovarajuću dokumentaciju za anesteziološku obradu.

Zaključak: U zaključku možemo reći da je potrebno uključiti stručnjake svih profila te donijeti racionalne i svrshodne nacionalne smjernice. Time bismo postigli značajne uštede s boljim utjecajem na ciljeve PO-a – smanjenje komplikacija zahvata.

Ključne riječi: preoperativna obrada, smjernice, liječnik obiteljske medicine

¹ doc. dr. sc., spec. obiteljske medicine, Specijalistička ordinacija obiteljske medicine

² dr. med., spec. anesteziologije i reanimatologije, Opća bolnica Zadar

³ dr. med., spec. obiteljske medicine, Istarski domovi zdravlja

⁴ dr. med., spec. obiteljske medicine, Katedra za obiteljsku medicinu, Medicinski fakultet u Rijeci

⁵ dr. med., spec. obiteljske medicine, Katedra za obiteljsku medicinu, Medicinski fakultet Sveučilišta u Zagrebu

Adresa za dopisivanje:

jasna.vucak@yahoo.com, <https://orcid.org/0000-0003-4328-531X>

GUIDELINES FOR PREOPERATIVE EVALUATION OF MOST COMMON CONDITIONS IN FAMILY MEDICINE

Jasna Vučak,¹ Julija Šerić,² Karmela Bonassin,³
Jadranka Karuza,⁴ Dragan Soldo⁵

ABSTRACT

Introduction: Preoperative evaluation (PE) is preceded by every elective operative procedure. The aim is to evaluate the operational risk associated with the complexity of the operation and characteristics of the patient, the choice of anesthesia, the prevention of possible complications and the planning of postoperative treatment. In the preoperative evaluation, an individual approach is required that takes into account the functional capacity, comorbidity, and the risk of the planned procedure.

Aim: To give an overview of the PE guidelines for the conditions most frequently encountered by a family physician, cataract surgery, coronary angiography, arthroscopy and total hip/knee arthroplasty.

Discussion: According to complexity, operational procedures are divided into small, medium and high risk. Another important breakdown is the patient's characteristics. The most commonly used is the classification of the functional ability of the American Association of Anesthesiologists – Classification system of physical status by which the risk is divided into six categories. According to this Classification system, ASA I group are healthy patients, ASA II are patients with mild systemic illness, ASA III are those with more severe systemic disease, ASA IV with severe systemic disease, that is a constant threat to life / morbidity while ASA V and VI are dying and brain dead patients. Preoperative evaluation for cataract surgery and coronarography should be done by the family physician. Routine preoperative tests are not recommended. The predictive value of tests done on healthy people is poor and there is a possibility of false positive results that increase the scope of the search and ultimately do not affect the outcome. Documentation and PE for low risk operations performed without the presence of anesthesiologists (cataract surgery, coronarography) should be performed at FP level and include clinical examination, basic laboratory findings and filled out questionnaires. For medium / high risk operations, PE is planned according to the patient and specific surgery characteristics and adequate documentation for anesthetic treatment is required.

In conclusion we can say that it is necessary to include professionals of all profiles and to develop rational and meaningful national guidelines. This would result in significant savings with a better impact on PO goals – reducing the complications of the procedure.

Key words: preoperative evaluation, guidelines, family medicine physician

¹ Ass.prof. PhD, GP, MD, Family medicine practice Sukošan

² Anesthesiology and reanimation specialist, General hospital Zadar

³ MD, specialist in family medicine, Istrian health centers

⁴ GP, MD, Department of Family Medicine, Medical School, University of Rijeka

⁵ GP, MD, Department of Family Medicine, Medical School, University of Zagreb,
Corresponding author:

jasna.vucak@yahoo.com, <https://orcid.org/0000-0003-4328-531X>

**PRIKAZI SLUČAJA
CASE REPORTS**

EMBOLIZACIJA PROSTATE – PRIKAZ SLUČAJA

Antea Džapo,¹ Valerija Bralić Lang^{2,3}

SAŽETAK

Uvod: Benigna hiperplazija prostate (BHP) benigno je povećanje tkiva prostate koje zahvaća 50 do 60 % muškaraca u dobi od 60 do 70 godina života. S povišenjem životne dobi sve je veća učestalost bolesti, te se u dobi između 70 i 90 godina očekuje u 80 do 90 % muškaraca (1). Nikturija, otežan, isprekidan, oslabljen mlaz mokraće, retencija urina i osjećaj nepotpuno ispraznenog mokraćnog mjehura obilježja su bolesti koja bitno smanjuje kvalitetu života. Uz dosadašnje medikamentno i kirurško liječenje u literaturi je sve više opisanih slučajeva liječenja BHP-a embolizacijom prostate.

Prikaz slučaja: U kolovozu 2018. godine liječnik obiteljske medicine (LOM) dobiva poziv za kućni posjet od kćeri sedamdesetogodišnjeg bolesnika zbog učestalog mokrenja, bolova u abdomenu i pečenja pri mokrenju. Radi se o slabije suradljivom bolesniku koji duži niz godina liječi šećernu bolest, esencijalnu hipertenziju, hiperlipidemiju, glaukom i benignu hiperplaziju prostate. Od kronične terapije uzima ramipril 5 mg 1, 0, ½, tamsulosin 0,4 mg 1 x 1, atorvastatin 10 mg 1 x 1, inzulin aspart 22 j., 0, 16 j., sitagliptin/metformin 50/1000 mg 2 x 1, timolol/dorzolamid 5 mg/20 mg/ml 2 x na dan u oba oka. Prilikom kućnog posjeta bolesnik je orijentiran, kontaktibilan, slabo pokretan, afebrilan, uredne lumbalne suksije, mekanog abdomena uz bolnu suprapubičnu palpaciju. Stolicu ima redovito, bez patoloških primjesa, uredne konzistencije, mokri u pelenu te se saznaže da je pelena po noći bila „kompletno puna“. Uvidom u dnevnik šećera vidljive su jutarnje vrijednosti od 10 mmol/L do 16 mmol/L te se u razgovoru s bolesnikovom kćeri doznaže da bolesnik niti ne bilježi još lošije vrijednosti glikemije. Postavljena je dijagnoza infekcije donjega mokraćnog sustava, te je preporučena oralna antibiotika terapija amoksicilin/klavulonskom kiselinom 875 mg/125 mg 2 x 1. Zbog slabe pokretljivosti bolesnika preporučeno je tijekom sutrašnjeg jutra vađenje krvi i urina kod kuće i kontrola liječnika isti dan nakon dospijeća laboratorijskih nalaza. Tijekom noći došlo je do retencije urina, te je bolesnik preko hitnog prijma hospitaliziran u trajanju od pet dana. Provedena je parenteralna antibiotika terapija i postavljen urinarni kateter. Otpušten je kognitivno deterioriran s dijagnozom kronične bubrežne insuficijencije i infekcije urinarnog sustava, te je preporučena dalja antibiotika terapija cefuroksim aksetil 500 mg 2 x 1 u trajanju od osam dana uz preporuku pokušaja vađenja ili zamjene katetera za 14 dana. Povišenjem doze korigirana je antihipertenzivna terapija, a brigu o inzulinskoj terapiji preuzeo je kći koju je LOM dodatno educirao. U nadolazećem periodu postignuta je dobra kontrola krvnog tlaka i glikemije, a kognitivno stanje bolesnika bitno se popravljalo. Četrnaesti dan od otpusta učinjena je obrada u primarnom medicinsko-biokemijskom laboratoriju, koja pokazuje E 4,03x10¹²/L, Hgb 127 g/L, Htc 0,380 L/L, TPSA 6,21 µg/L, HbA1c 8,9 % uz ostale uredne vrijednosti. U dva je navrata učinjena kontrola urologa s pokušajem vađenja katetera. Zaključeno je da je retencija urina posljedica hiperplazije prostate te da se neće uspjeti ukloniti kateter. Zbog visoke životne dobi i komorbiditeta uklonjena je mogućnost opće anestezije i transuretralne resekcije prostate, te je indicirana embolizacija prostate. CT angiografija abdomena i zdjelice pokazala je prostatu veličine 6 x 5 cm u promjeru, urednu prohodnost abdominalne aorte, ilijačnih

¹ Dom zdravlja Zagreb-Zapad

² Specijalistička ordinacija obiteljske medicine dr. sc. Valerija Bralić Lang, dr. med., spec. obiteljske medicine

³ Katedra za obiteljsku medicinu, Škola narodnog zdravlja „Andrija Štampar“, Medicinski fakultet Sveučilišta u Zagrebu

Adresa za dopisivanje:

Antea Džapo, dr. med., Dom zdravlja Zagreb-Zapad, Matije Ilijika Vlačića 2,
e-adresa: anteadzapo@gmail.com

unutarnjih, vanjskih i zajedničkih arterija bez značajnih stenoza i okluzija, bez znakova dilatacije kanalnog sustava. U siječnju 2019. godine bolesniku je učinjena embolizacija prostate te je bolesnik prvi postoperativni dan otpušten kući s urinarnim kateterom, terapijom cefuroksim aksetil 500 mg 2 x na dan kroz pet dana. Preporučena je kontrola urologa kroz mjesec dana prilikom koje će se pokušati trajno izvaditi kateter.

Zaključak: Bolesnici s BHP-om i multimorbiditetom predstavljaju velik izazov za LOM-a. Sukladno kliničkom stanju liječenje uključuje adekvatno zbrinjavanje zahtjevnih akutnih stanja u kućnim uvjetima, ali i primjenu novih dijagnostičko-terapijskih procedura u suradnji s kolegama konzultantima. Neophodna je trajna edukacija LOM-a i poznavanje novih metoda dijagnostike i liječenja.

Ključne riječi: benigna hiperplazija prostate, embolizacija prostate, multimorbidnost

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PROSTATE EMBOLISATION: CASE REPORT

Antea Džapo,¹ Valerija Bralić Lang^{2,3}

ABSTRACT

Introduction: Benign prostatic hyperplasia (BPH) is a benign enlargement of prostatic tissue with a prevalence of 50 to 60 % for men aged 60 to 70. With an increased life expectancy there is an increase in its prevalence. It is expected to affect about 80 to 90 % of men between the ages of 70 and 90.¹ Nocturia, hesitancy, weak flow, urinary retention and a feeling of incomplete urination are signs of the disease, which significantly decreases the quality of life. With the current medication and surgical therapy, the current literature describes increasingly more cases of BPH treatment with prostate embolisation.

Case Report: In August of 2018 a family physician receives a call from a seventy-eight year old patient's daughter requesting a home visit because of her father's frequent urination, abdominal pain and burning sensations at urination. He is a non-compliant patient who has been treated for diabetes mellitus, essential hypertension, hyperlipidemia, glaucoma and benign prostatic hyperplasia for many years. His chronic therapy was ramipril 5 mg 1, 0, ½, tamsulosin 0.4 mg 1x1, atorvastatin 10 mg 1x1, insulin aspart 22 j., 0, 16 j., sitagliptin/metformin 50/1000 mg 2x1, and timolol/dorzolamide 5mg/20mg/ml 2x per day in both eyes. During the home visit the patient is oriented, in contact, slow in movements, afebrile, with negative lumbar succussion, with abdominal softness and painful suprapubic palpation. His stool has been regular, without pathological signs, regular in consistency. He urinates in a diaper, informing that the diaper was „completely full“ last night. Viewing his blood sugar diary it is evident that his morning values are between 10 mmol/L and 16 mmol/L and the daughter reveals that the patient does not record worse values. His diagnosis is an infection of the lower urinary tract and he is recommended peroral antibiotic therapy amoxicilin/clavulanic acid 875mg/125mg 2x1. Because of the patient's weak movements, taking blood sample and urine specimen is recommended at his home the following morning. He will check-up with his physician immediately after the laboratory test findings are available. During the night the patient experiences urine retention and is hospitalized by the emergency service for five days. Parenteral antibiotic therapy and a urinary catheter are applied. The patient displays cognitive deterioration, he is diagnosed with chronic kidney insufficiency and urinary tract infection, and is released with further cefuroxime axetil 500 mg 2x1 antibiotic therapy over eight days and with a recommendation of catheter removal or change in 14 days. Treatment is modified with an increase in antihypertensive therapy, and the family physician educates his daughter, who takes over administering insulin therapy. In the upcoming period, good glycemic and blood pressure control is achieved, and the cognitive status of the patient is improved. On the 14th day following hospital discharge laboratory findings show E 4.03x10¹²/L, Hgb 127 g/L, Htc 0.380 L/L, TPSA 6.21 µg/L, HbA1c 8.9 %, with other regular parameters. The replacement of the catheter is tried twice by a urologist. It is concluded that the urine retention is the result of benign prostatic hyperplasia and that catheter should not be removed. Because of the patient's advanced age and comorbidity, the possibility of performing transurethral resection under general anesthesia is eliminated, while prostate embolization is indicated. A CT angiography of the abdomen and pelvis show the prostate is 6 x 5 cm in diameter and a regular passability of the abdominal aorta,

¹ Family medicine resident, Health Care Center Zagreb – Zapad

² PhD, Family Medicine Specialist , Family Practice, Zagreb, Croatia

³ Department of Family Medicine, School of Public Health „Andrija Štampar“, Medical School University of Zagreb, Croatia

Address:

Health care center Zagreb West, Matije Ilijika Vlačića 2, Zagreb, E-mail: anteadzapo@gmail.com

iliac internal, external and common artery without stenosis and occlusion, and without signs of urinary system dilatation. In January 2019 prostate embolization is performed, and the patient is discharged on the first post-procedural day with a urine catheter and cefuroxime axetil 500mg 2x1 therapy over five days. A follow-up examination by the urologist is recommended in one month, when also an attempt at permanent removal of the urinary catheter will be made.

Conclusion: Patients with multimorbidity and BPH are a big challenge for the family physician. In accordance with the patient's clinical condition, treatment includes adequate care for acute demanding conditions in a home visit environment as well as the implementation of new diagnostic – therapy procedures in cooperation with consultant colleagues. It is necessary to continually educate family physicians and keep them updated about new diagnostic and therapy procedures.

Key words: benign prostatic hyperplasia, prostate embolization, multimorbidity

MYCOPLASMA PNEUMONIAE – PRIKAZ SLUČAJA

Dragan Gjorgjievska¹

SAŽETAK

Uvod: Infekcija *M. pneumoniae* obično uzrokuje infekciju dišnog sustava. Mlade odrasle osobe podložnije su infekcijama. Kod djece se pojavljuju simptomi infekcije gornjih dišnih puteva, dok je kod mlađih odraslih osoba čest uzrok upale pluća u zajednici. Infekcija *M. pneumoniae* je blaga bolest s produljenim trajanjem respiratornih i nerespiratornih simptoma. Cilj je ovoga rada povećati svijest o atipičnom uzroku infekcije respiratornog sustava kod pacijenta s dugotrajnim znakovima.

Prikaz slučaja: Pacijent V. D. iz Skoplja, u dobi od dvadeset godina, javlja se liječniku s bolovima u grlu, kihanjem, curenjem iz nosa i temperaturom od 38,2 stupnja Celzijevih.

Pregledom se otkriva hiperemija ždrijela bez gnojnih nalepa krajnika, bez oticanja vrata, supra- i infraklavikularnih i aksilarnih limfnih čvorova. U nosu je prisutan serozni sekret. Pacijent je febrilan na pregledu. Auskultacija pluća praćena je vezikularnim disanjem bez popratnih tonova, a terapija paracetamolom tretira se kao antipiretik svakih 6-8 sati, pastile za grlo svaka 3-4 sata, dekongestija u nosu svakih 8 sati, dvije kapi u svaku nosnicu. Povlačenje simptoma u roku tri dana. Pacijent odlazi na odmor izvan zemlje. Tjedan dana nakon povratka javlja se suhi irritantni kašalj, promuklost i bol u prsima. Učinjena je laboratorijska analiza krvi: sedimentacija eritrocita 12, leukociti 6, limfociti 1,1; granulociti 70 i C-reaktivni protein 10. Auskultacijom pluća nađeno je vezikularno disanje sa suhim strugavim bronhitičnim tonovima. Bolesnik je upućen na radiografiju (RTG) pluća na kojoj su bile vidljive intersticijalne sjene. *Mycoplasma pneumoniae* izolirana je na pneumoslajdu. Ordiniran je klaritromicin 500 mg dva puta na dan tijekom deset dana. Nakon deset dnevnih tretmana simptomi se povlače, kontrolni RTG i auskultacija pluća bili su urednog nalaza.

Zaključak: Bakterije *M. pneumoniae* obično se javljaju s atipičnom kliničkom slikom. Kod pacijenata koji imaju dugotrajni kašalj i koji žive u područjima s vlažnom klimom i borave u prostorijama koje su klimatizirane, treba razmisiliti o atipičnoj infekciji.

Ključne riječi: pneumonija, *Mycoplasma*, vlažna klima, mlade odrasle osobe

¹ Centar obiteljske medicine, Skopje, Makedonija

Adresa za dopisivanje:

Dragan Gjorgjievska, dr. med., spec. obiteljske medicine, doktorand, Mirka Ginova 25-1000 Skopje, Makedonija, e-adresa: dragan_gjorgjievska@yahoo.com

MYCOPLASMA PNEUMONIA- CASE REPORT

Dragan Gjorgjievski¹

ABSTRACT

Introduction: M.pneumoniae infection usually causes respiratory infections. Young adults are more susceptible to infections. Children experience symptoms of upper respiratory tract infections, while in younger adults it is a common cause of pneumonia in the community. Infection with M. pneumoniae is a mild disease with prolonged duration of respiratory and non-respiratory symptoms. The aim of this case report is to increase awareness of the atypical cause of the respiratory tract infection in a patient with long lasting signs.

Case report: The patient is V. D from Skopje, 20 years old, with sore throat, sneezing, nasal congestion and 38.2°C temperature. The examination reveals the hyperemia of the tonsils without pus of tonsils, without a swelling of the neck, supra and infra-clavicular and axillary lymph nodes. A serous secret is present in the nose. The patient is febrile at checkup. Auscultation is followed by vesicular breathing without accompanying tones. Paracetamol therapy is administered as anti-pyretic for 6-8 hours, pastilles for 3-4 hours, nose decongestion for 8 hours, two drops in each nostril. There is a removal of symptoms within 3 days. The patient travels out of Macedonia. One week after there is a dry irritable cough and chest pain.

Laboratory tests are performed and the following results are obtained: sedimentation rate 12, leucocytes 6, lymphocytes 1.1; granulocytes 70 and C- reactive protein is 10. In auscultation, vesicular breathing with dry scratching bronchial tones is audible. In radiography (RTG), there are of interstitial shadows. Mycoplasma pneumoniae is isolated on pneumoslide.

Outcome and follow-up: Clarithromycin 500 mg twice daily is prescribed for 10 days. After ten daily treatments, the symptoms are withdrawn, the control radiography and the auscultation show normal finding.

Conclusion: M.pneumoniae bacteria usually occur with an atypical clinical picture. In patients with long-lasting cough and living in areas with humid climate and in air-conditioned rooms, an atypical infection should be considered.

Keywords: Pneumonia, Mycoplasma, Humid Climate, Young Adult

¹ Center for Family Medicine Skopje, Macedonia

Address:

PhD Dragan Gjorgjievski, general practitioner, Mirka Ginova 25-1000 Skopje Makedonija,
E-mail: dragan_gjorgjievski@yahoo.com

REZISTENTNA HIPERTENZIJA – PRIKAZ SLUČAJA

Tamara Hrvojić Gradečak,¹ Ksenija Kranjčević^{2,3}

SAŽETAK

Uvod: Rezistentna hipertenzija definira se kao vrijednost krvnog tlaka viša od 140/90 mmHg, potvrđena kontinuiranim mjerjenjem arterijskog tlaka (KMAT-om) ili dnevnikom vrijednosti tlaka mjerene kod kuće, a uz promjenu životnog stila i odgovarajuću terapiju koja uključuje najmanje tri antihipertenzivna lijeka: diuretik, blokator angiotenzinskih receptora (engl. *angiotensin receptor blocker*, ARB) ili inhibitor angiotenzin konvertirajućeg enzima (engl. *angiotensin converting enzyme inhibitor*, ACEI) te blokator kalcijevih kanala (engl. *calcium channel blocker*, CCB). Rezistentna hipertenzija javlja se u 10 – 30 % hipertoničara i povezana je s visokim rizikom od oštećenja ciljnih organa, odnosno s lošijim ishodom cerebrovaskularnih i bubrežnih bolesti. Prema smjernicama Europskoga kardiološkog društva takve je pacijente potrebno dodatno obraditi kako bi se isključili sekundarni uzroci hipertenzije (Cushingov sindrom, feokromocitom, primarni hiperaldosteronizam, hipertireoza i sl.), redovito ih pratiti s ciljem traženja oštećenja ciljnih organa uz uvođenje niskih doza antagonistika mineralokortikoidnih receptora ili neke druge skupine diuretika odnosno β - ili α -blokatora u terapiju.

Prikaz slučaja: Bolesnica u dobi od 75 godina, hipertoničar je unatrag četrdeset godina. Otprije tri godine ne uspijevaju se postići ciljne vrijednosti krvnog tlaka kombinacijom najprije ACEI-ja (perindopril), a potom ARB-a (valsartan), diureтика (hidroklorotiazid ili indapamid) i CCB-a (amlodipin ili lerkadipin). U više navrata dolazi u ordinaciju zbog visokih vrijednosti krvnog tlaka izmjerenih kod kuće, često iznad 170/100 mmHg, te povremenih palpitacija. Unatrag desetak godina boluje i od hipotireoze (u terapiji levotiroksin 50 meg dnevno). Obiteljska anamneza je bez osobitosti. Ne puši, alkohol ne konzumira i tjelesno je aktivna, a smanjila je i sol u prehrani. Preporučenu terapiju uzima redovito. U kliničkom statusu, uz visoke vrijednosti krvnog tlaka, nađen je povećan indeks tjelesne mase 29 kg/m^2 i sistolički šum nad aortalnim ušćem, a ostalo je bilo bez osobitosti. Laboratorijskom obradom vidljive su povećane vrijednosti ukupnog ($6,3 \text{ mmol/L}$) i LDL-kolesterolja ($4,53 \text{ mmol/L}$), dok su ostali parametri unutar preporučenih. Procijenjena glomerularna filtracija (pGFR) bila je $80 \text{ mL/min}/1,73 \text{ m}^2$, a ukupni kardiovaskularni rizik umjeren (4%). Učinjen je i KMAT kojim se potvrdila dijagnoza rezistentne hipertenzije. S obzirom na nepostizanje ciljnih vrijednosti krvnog tlaka bolesnica je upućena u ambulantu za hipertenziju gdje je učinjena proširena obrada (laboratorijska analiza krvi, ultrazvuk srca, bubrega i nadbubrežnih žljezda, *color doppler* renalnih i karotidnih arterija, katekolamini u 24-satnom urinu, kortizol i aldosteron, holter elektrokardiogram). Učinjenom obradom verificirani su povišeni indeksi otpora renalnih arterija (RI 0,73) i isključeni su ostali oblici sekundarne hipertenzije. Ultrazvukom srca nađena je hipertrofija lijeve klijetke, a laboratorijskom obradom proteinurija (omjer albumin/kreatinin $33,9 \text{ mg}/\text{mmol}$) što upućuje na oštećenje ciljnih organa. Nalaz očne pozadine bio je bez promjena. Uz dosadašnju terapiju (perindopril, indapamid i amlodipin) uveden je β -blokator (bisoprolol), moksonidin i urapidil u maksimalnim dozama, no i dalje bez postizanja ciljnih vrijednosti krvnog tlaka. Pri posljednjem pregledu u ordinaciji bolesnica donosi dnevnik mjerjenja krvnog tlaka kod kuće; vrijednosti sistoličkog tlaka bile su između 140 i 180 mmHg. Po

¹ Dom zdravlja Zagrebačke županije, ispostava Velika Gorica

² Specijalistička ordinacija dr. sc. Ksenija Kranjčević, dr. med.

³ Katedra za obiteljsku medicinu, Škola narodnog zdravlja „Andrija Štampar“, Medicinski fakultet Sveučilišta u Zagrebu

Adresa za dopisivanje:

Tamara Hrvojić Gradečak, dr. med., Mate Lovraka 6a, 10 410 Velika Gorica,
e-adresa: tamara.hrvojic@gmail.com

preporuci specijalista nefrologa planira se učiniti biopsija bubrega u slučaju perzistiranja proteinurije i višeslojna računalna tomografija (MSCT) renalnih arterija.

Zaključak: Rezistentna hipertenzija je dijagnoza koja često ostaje neprepoznata i neadekvatno liječena. Prije postavljanja same dijagnoze potrebno je isključiti pseudorezistentnu hipertenziju koja se javlja zbog nesuradljivosti pacijenta, uzimanja lijekova koji djeluju na povišenje krvnog tlaka (poput kortikosteroida, oralnih kontraceptiva, nesteroidnih antireumatika, simpaticomimetika, amfetamina, antidepresiva itd.), neadekvatnog mjerjenja krvnog tlaka, neadekvatne terapije, prevelike konzumacije alkohola ili kuhijske soli te u pacijenata s opstruktivnom apnejom u spavanju. Dodavanje četvrtoga, petog i šestog antihipertenziva u terapiju je individualno, a ovisi o komorbiditetima te o bolesnikovu podnošenju terapije. Na kraju se radi radiološka obrada s ciljem izdvajanja bolesnika pogodnih za invazivnije metode liječenja.

Ključne riječi: rezistentna hipertenzija, liječnik obiteljske medicine, KMAT

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RESISTANT HYPERTENSION: CASE REPORT

Tamara Hrvojić Gradečak,¹ Ksenija Kranjčević^{2,3}

ABSTRACT

Introduction: Resistant hypertension is defined as a blood pressure higher than 140/90 mmHg confirmed by ambulatory blood pressure monitoring (ABPM) or home blood pressure monitoring (HBPM) with lifestyle changes and adequate treatment involving at least three antihypertensive drugs; a diuretic, an angiotensin receptor blocker (ARB) or an angiotensin-converting enzyme inhibitor (ACEI) and a calcium channel blocker (CCB). Resistant hypertension occurs in 10-30% of patients with treated hypertension and is associated with a high risk of target organ damage or a worse outcome like cerebrovascular and renal disease. According to the guidelines of the European Cardiology Society, such patients need to be further processed to exclude secondary causes of hypertension (Cushing's syndrome, phaeochromocytoma, primary hyperaldosteronism, hyperthyroidism, etc.), regularly monitored seeking target organ damage with the addition of low doses of mineralocorticoid receptor antagonists (MRA), some other groups of diuretics and β or α blockers in therapy.

Case report: A female patient aged 75 has had hypertension for 40 years. Since 3 years ago, blood pressure target has not been achieved by combining first ACEI (perindopril) followed by ARB (valsartan), diuretics (hydrochlorothiazide or indapamide) and CCB (amlodipine or lercadipine). She often comes to the office because of high blood pressure values at home, often over 170/100 mmHg, and occasional palpitations. For the last 10 years she has been treated for hypothyroidism (levothyroxine 50 mcg daily). Family history is without distinction. She does not smoke or consume alcohol, she is physically active and has decreased dietary sodium intake. She takes recommended therapy regularly. In physical examination, with high blood pressure values, an increased body mass index of 29 kg/m² is also found, as well as the systolic murmur of the aortic valve, while the rest is without distinctions. Laboratory tests show increased values of total (6.3 mmol/L) and LDL cholesterol (4.53 mmol/L), other parameters being within the recommended range. The estimated glomerular filtration (eGFR) is 80 mL/min/1.73 m² and the total cardiovascular risk is moderate (4%). ABPM is also performed, confirming the diagnosis of resistant hypertension. Since target blood pressure has not been achieved, the patient is referred to a hypertension specialist where extensive diagnostics is performed (laboratory blood analysis, echocardiography, ultrasound of the kidneys and adrenal glands, color doppler of the renal and carotid arteries, catecholamines in 24 hour urine, cortisol and aldosterone, continuous measurement of electrocardiogram). The resistive index of renal artery is increased (RI 0.73) and other forms of secondary hypertension are excluded. Echocardiography shows left ventricular hypertrophy, and laboratory tests detect proteinuria (albumin/creatinine ratio 33.9 mg/mmol) which indicates target organs damage. Fundoscopy exam excludes hypertensive retinopathy. With the previous therapy (perindopril, indapamide and amlodipine), β blocker (bisoprolol), moxonidine and urapidil are included in maximum doses, but still without achieving blood pressure target values. At the last checkup in the office, HBPM shows systolic blood pressure between 140 and 180 mmHg. The nephrologist recommends a kidney biopsy in case of persisting proteinuria and multi-slice computed tomography (MSCT) of the renal arteries.

¹ Health center of Zagreb County, Velika Gorica

² General practitioner office, Ksenija Kranjčević, PhD

³ Department of Family Medicine, School of Public Health „Andrija Štampar”, Medical School University of Zagreb, Croatia
Address:

MD Tamara Hrvojić Gradečak, Mate Lovraka 6a, 10410 Velika Gorica, E-mail: tamara.hrvojic@gmail.com

Conclusion: Resistant hypertension is a diagnosis that often remains unrecognized and inadequately treated. Before confirming the diagnosis, it is necessary to exclude causes of pseudo-resistant hypertension due to patient noncompliance, taking medicines that increase blood pressure (such as corticosteroids, oral contraceptives, non-steroidal anti-inflammatory drugs, sympathomimetics, amphetamines, antidepressants, etc.), inadequate blood pressure measurement, inadequate therapy, an excessive consumption of alcohol or kitchen salt and in patients with obstructive sleep apnoea. Addition of the fourth, fifth and sixth antihypertensive drug to the therapy is individual, and depends on the comorbidities and patient's adherence to prescribed medicine. Ultimately, radiologic exam is used to diagnose patients who can benefit from invasive treatment methods.

Key words: resistant hypertension, family medicine physician, ABPM

BENIGNI PAROKSIZMALNI POZICIJSKI VERTIGO – PRIKAZ SLUČAJA

Nataša Ivković,¹ Valerija Bralić Lang^{2,3}

SAŽETAK

Uvod: Benigni paroksizmalni pozicijski vertigo (BPPV) najčešći je oblik vrtoglavice (20 do 40 % ukupnog broja vrtoglavica u općoj populaciji, dok je u starijih osoba i više od 50 %). Karakteriziran je kratkotrajnim napadajima jake vrtoglavice, mučninom, povraćanjem i pojavom nistagmusa. Dijagnoza bolesti potvrđuje se Dix-Hallpikeovom pozitivnom položajnom probom za stražnji polukružni kanalić, a testom kotrljanja glave za bočni kanalić.

Prikaz slučaja: Muškarac u dobi od 55 godina, dolazi liječnici obiteljske medicine (LOM) u pratnji supruge. Zaposlen je, radi u uredu, otac dvoje odrasle djece, redovito vježba. Navodi da od jučer ujutro ima jaku vrtoglavicu praćenu mučninom i povraćanjem, te da nije mogao ustati iz kreveta. Pozvao je u kućni posjet liječnika hitne medicinske pomoći, te je dobio diazepam i *thiethylperazin* intramuskularno. Iz osobne anamneze izdvaja se dijagnoza epilepsije, za koju od 2010. godine ne uzima nikakvu terapiju, dok se drugih bolesti ne nalazi. Negira nedavnu prehladu. Prilikom dolaska u ambulantu osjeća se bolje u odnosu na dan ranije, povraćanje se prorijedilo, dalje je nestabilan u hodu. Pri minimalnim pokretima glave javlja se jaka mučnina i nagon na povraćanje.

Iz statusa se izdvaja nesiguran hod po široj osnovi uz pridržavanje, pri pogledu krajnje lijevo horizontalno i gore nelagoda i mučnina te horizontalni nistagmus, zjenice su izokorične, urednih reakcija na svjetlo i akomodaciju, nestabilnost u Rombergu. Krvni tlak bio je uredan.

Zbog izrazito lošeg kliničkog statusa i ranije neurološke bolesti pacijent se upućuje u hitnu neurološku ambulantu s uputnom dijagnozom vertigo, BPPV. Dijagnostičkom obradom (višeslojna kompjutorizirana tomografija: nema znakova akutne ishemije, hemoragije, ekstraaksijalnih kolekcija ili ekspanzivnog procesa) isključen je centralni uzrok vrtoglavice, a Dix-Hallpikeovim testom, koji je bio pozitivan uljevo, potvrđena je dijagnoza BPPV-a. Preporučen je diazepam 2 mg, *thiethylperazin* supp 2 x 6,5 mg, mirovanje i vježbe vestibularne ravnoteže. Preporučena je i ultrazvučna obrada krvnih žila vrata te pregled otorinolaringologa u slučaju perzistiranja tegoba.

Tijekom sljedeća tri tjedna pacijent je kontroliran u ambulantni LOM-a, praćen je učinak vestibularnih vježba koje je provodio kod kuće, a u nekoliko navrata učinjen je Epleyev manevar. Nesigurnost u hodu, blaža vrtoglavica pri pokretima glave lateralno ili pogledu u stranu obostrano bili su jače izraženi ujutro, a tijekom dana tegobe su bile manje intenzivne. *Thiethylperazin* supozitorije uzimao je petnaest dana. Oftalmološki nalaz bio je uredan uz korekciju dioptrije za naočale. Tri tjedna nakon pojave prvih simptoma pacijent je bio urednog neurološkog statusa i sposoban za povratak na posao. Preporučeno mu je još neko vrijeme provoditi vježbe vestibularne ravnoteže.

Zaključak: BPPV najčešći je uzrok vrtoglavica u ordinacijama LOM-a koji se dobrom anamnezom i položajnim probama jednostavno dijagnosticira. Uz jako izražene simptome i

¹ Specijalizantica obiteljske medicine, Dom zdravlja Zagrebačke županije

² Specijalistička ordinacija obiteljske medicine dr. sc. Valerija Bralić Lang, dr. med., specijalist obiteljske medicine

³ Katedra za obiteljsku medicinu, Škola narodnog zdravlja „Andrija Štampar“, Medicinski fakultet Sveučilišta u Zagrebu

Adresa za dopisivanje:

Nataša Ivković, dr. med., Dom zdravlja Zagrebačke županije, Ferida Galijaševića 4, Zaprešić,
e-adresa: natasa.ivkovic11@gmail.com

anamnistički podatak ozbiljne neurološke bolesti važno je isključiti centralni uzrok vrtoglavice. LOM mora znati uzroke i terapiju vrtoglavice, a u slučaju BPPV-a pacijentu jasno objasniti način i važnost provođenja vestibularnih vježba.

Ključne riječi: benigni paroksizmalni pozicijski vertigo, položajna proba, vestibularne vježbe, liječnik obiteljske medicine

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BENIGN PAROXYSMAL POSITIONAL VERTIGO: CASE REPORT

Nataša Ivković,¹ Valerija Bralić Lang^{2,3}

ABSTRACT

Introduction: Benign paroxysmal positional vertigo is generally the most common cause of vertigo (20 do 40% of the total dizziness in the general population, and more than 50% in the elderly). It is characterized by short term strong episodes of vertigo associated with nausea, vomiting and abnormal rhythmic eye movements (nystagmus). The diagnosis is established by a positive positioning test, Dix-Hallpike for the posterior and the supine roll test for the lateral canal.

Case report: Man aged 55, accompanied by his wife, comes to his family physician. He is employed, working in the office, father of two grown children, and exercises regularly. He says since yesterday morning he has had a strong dizziness with nausea and vomiting and could not get out of bed. Yesterday he called Emergency medical assistance, he got diazepam and thiethylperazine. Out of personal medical history we can identify epilepsy, for which he has not been taking any therapy since 2010. He does not have no other illnesses. Denies a recent cold.

When he arrives at the general practitioner's (GP) office he feels better compared to the day before, vomiting has sagged, he is still unstable in walking. Minimal movements of the head cause strong nausea and vomiting.

From the status: walks with assistance, on a wider basis, when looking to the extremely left and up, he feels dizziness and nausea; horizontal nystagmus, the pupils react equally to light both directly and consensually, reacts to accommodation and convergence equally bilaterally, unstable in Romberg. Blood pressure is normal.

Due to his extremely poor clinical status and earlier neurological illness, the patient is referred to an emergency neurological clinic with a Vertigo vrs BPPV diagnosis. Diagnostic Treatment (Multislice Computed Tomography, MSCT: No Signs of Acute Ischemia, Hemorrhage, Extra-Stretchy Collection, or Expansion Process) exclude the central cause of dizziness, performing the Dix Hallpike test that is positive to the left. BPPV diagnosis is confirmed and diazepam 2mg, thiethylperazin supp 2 x 6.5 mg, pacification and vestibular equilibrium exercise are recommended. Ultrasonography of the carotid artery is recommended, and in case of persistent symptoms otolaryngology specialist should be contacted.

During next three weeks the patient is monitored at the GP, following-up the effects of vestibular equilibrium exercise performed at home, and Epley maneuver is performed on several occasions. Walking instability and dizziness when looking to extremely left and up are worse in the morning, and during the day the problems are less intense. Thiethylperazin suppositories are used for about 15 days. Ophthalmologist's review is good with a correction in his glasses diopters.

Three weeks after the appearance of the first symptoms, the patient has a normal neurological status and is able to return to work. The patient is recommended to continue doing the vestibular rehabilitation exercises.

¹ Family medicine resident, Primary care center Zagreb county

² Family medicine practice Valerija Bralić Lang, MD, GP, PHD

³ Department of Family Medicine, School of Public Health „Andrija Štampar“, Medical School University of Zagreb, Croatia

Address:

Nataša Ivković, dr. med., Health Care Center Zagrebačke županije, Ferida Galijaševića 4, Zaprešić,
E-mail: natasa.ivkovic11@gmail.com

Conclusion: BPPV is the most common cause of vertigo in primary care which is simple to diagnose with a good anamnesis and postural tests. Among the clearly visible symptoms and anamnestic evidence of serious neurological disease it is important to identify the main cause of dizziness. The GP must know the main causes and therapy for dizziness, while in case of BPPV it is important to clearly explain the importance and procedures of vestibular exercises to the patient.

Key words: benign paroxysmal positioning vertigo, postural test, vestibular exercises, general practitioner

DIJAGNOSTIČKE GREŠKE U PORODIČNOJ MEDICINI – VAŽNOST POZNAVANJA SMJERNICA DOBRE KLINIČKE PRAKSE

Marijana Jandrić-Kočić¹

SAŽETAK

Uvod: Dijagnostičke greške podrazumijevaju propuštene, zakašnjele ili netačne dijagnoze. Porodična medicina, kao mjesto najvećeg broja kliničkih susreta, ima najveću učestalost istih. Ljekari u svom radu prave dvije vrste kognitivnih dijagnostičkih grešaka, slučajne i namjerne. Osim nedostatka vremena, preopterećenosti i umora, nepoznavanje dijagnostičkih algoritama je najznačajniji faktor u nastanku dijagnostičke greške. Postoji nekoliko faktora koji su povezani sa bolešću koje doprinose nastanku dijagnostičke greške, kao što su: atipična prezentacija, nespecifična prezentacija, niska prevalencija, prisutni komorbiditeti i perceptivne smetnje. I sami pacijenti mogu doprinijeti nastanku dijagnostičke greške. Neadekvatna komunikacija između primarne i sekundarne zdravstvene zaštite i poteškoće u dostupnosti dijagnostičkih metoda mogu ugroziti dijagnostički proces. Rad ima za cilj ukazati na faktore odgovorne za nastanak dijagnostičke greške i mjere za njihovo prevazilaženje.

Prikaz slučaja: Pacijent rođen 1953. godine, koji nije registrovan u Domu zdravlja Krupa na Uni, dolazi na pregled zbog problema sa urolitijazom. Prvi napad renalne kolike je imao prije šest godina, kojom prilikom su mu urađene laboratorijske analize, ultrazvuk abdomena i konsultativni pregled urologa. Urolog je postavio dijagnozu urolitijaze i zakazao kontrolu po potrebi. U narednih šest godina je imao u prosjeku po jednu renalnu koliku. U terapiji je koristio antibiotik iz grupe ciprofloksacina, analgetik i spazmolitik. Prije godinu dana je ponovljen ultrazvuk koji je potvrdio dijagnozu. Brinula ga je nešto veća sedimentacija u proteklih šest mjeseci. Druge tegobe negira, ne koristi redovnu terapiju. Negira druge ranije bolesti i bolesti od značaja za heredite. Fizikalnim pregledom pacijenta nađena je osjetljivost desne renalne lože na sukusiju.

Laboratorijski nalazi verifikovali su povećanu sedimentaciju, C reaktivni protein (CRP), kreatinin, anemiju i uroinfekt. Ultrazvučni pregled: desni bubreg lagano uvećan, bilateralne bubrežne simpleks ciste i mikrokalkulusi, lijevo hidronefroza gradus I, desno gradus II/III. Dilatacija desnog uretera tumoroznom lezijom. U području sigmoidnog kolona velika tumorozna lezija dijameda 8 cm koja naliježe na mokraćnu bešiku. Crijevne vijuge distendirane, žive peristaltike. Ubrzo nakon pregleda u Domu zdravlja pacijent je operisan. Sa prvim ciklusom hemoterapije došlo je do značajne redukcije metastatskih promjena. U toku je druga hemoterapijska kura.

Prilikom prve epizode urolitijaze nije ispoštovan dijagnostički algoritam. Prihvaćen je nalaz konsultanta kao konačan, uprkos činjenici da nije urađena kompjutersko tomografska urografija koja predstavlja metodu izbora u konačnoj dijagnozi urolitijaze. Recidivantni ataci nisu ponovno urološki evaluirani, kako to predviđaju smjernice. Takođe nije urađen skrining malignih bolesti koje su mogle dovesti do urinarne staze, ponavljanju infekcija i rekurentne urolitijaze. Svaka od ovih pogreški bila je rezultat nepoštovanja smjernica dobre kliničke prakse.

Zaključak: U nedostatku sistemskih rješenja koja bi omogućila unapređenje položaja ljekara u primarnoj zdravstvenoj zaštiti, neopodno je da odgovorno obavljamo svoj posao, pratimo smjernice dobre kliničke prakse, da kroz kontinuiranu medicinsku edukaciju, razvijanje novih kliničkih vještina i unapređenje komunikacije sa pacijentom napredujemo u svom radu i smanjimo mogućnost nastanka dijagnostičke greške.

Ključne riječi: smjernice, porodična medicina

¹ Dom zdravlja Krupa na Uni

Adresa za dopisivanje: Marijana Jandrić-Kočić Stevana Jakovljevića 23, 78 000 Banjaluka,
e-adresa: marijanajandrickocic@gmail.com

DIAGNOSTIC ERRORS IN FAMILY MEDICINE – THE IMPORTANCE OF KNOWING THE GUIDELINES OF GOOD CLINICAL PRACTICE

Marijana Jandric-Kocic¹

ABSTRACT

Introduction: Diagnostic errors include missed, delayed or incorrect diagnoses. Family medicine, as the site of the largest number of clinical meetings, has the highest frequency of these. In their work, doctors make two types of cognitive diagnostic errors: random and intentional. Apart from a lack of time, overload and fatigue, the ignorance of diagnostic algorithms is the most important factor in the occurrence of diagnostic errors. There are several factors related to disease which contribute to setting diagnosis: atypical presentation, non-specific presentation, low prevalence, present comorbidities and perceptual disturbances. Patients themselves can contribute to a diagnostic error. Inadequate communication between the primary and secondary health care and poor availability of diagnostic methods can jeopardize the diagnostic processes. The paper aims at pointing out the factors responsible for diagnostic errors and the measures for overcoming them.

Case Report: A patient born in 1953, who is not registered at the Health Center Krupa na Uni, is coming for examination because of the problems with urolithiasis. The first attack of renal colics was 6 years ago, when he underwent laboratory tests, the ultrasound of the abdomen and a consultation with the urologist. The urologist diagnosed urolithiasis and scheduled a follow-up as needed. Since then, he has had renal colics once a year on average. His therapy has consisted of antibiotics from the group ciprofloxacin, analgetics and spasmyotics. A year ago, ultrasound confirmed the diagnosis. He is worried about his slightly elevated sedimentation rate over the past six months. He denies other symptoms and he does not take his therapy. He also denies previous disease as well as heredity. Physical examination of the patient finds the right costovertebral angle tenderness. Laboratory findings confirm increased sedimentation, C- reactive protein and creatinine, anaemia and urinary tract infections. Ultrasound examination findings: right kidney slightly enlarged, bilateral kidney simplex cysts and microcalculus, left hydronephrosis gr. I, right gr. II / III, a dilatation of the right ureter with a tumor lesion. In the area of the sigmoid colon, a large tumor lesion is about 8 cm in diameter pressing on the urinary bladder. Bowel loops are distended with lively peristaltic movements. Soon after the examination at the Health center Krupa na Uni the patient is treated. With the first cycle of chemotherapy there is a significant reduction in metastatic changes, which is followed by the second chemo-therapy cycle.

In the first episode of urolithiasis, a diagnostic algorithm was not followed. The consultant's finding was taken as final, despite the fact that no computer tomographic urography had been performed, which is the method of choice in diagnosing urolithiasis. Recurrent attacks were not re-evaluated by the urologist as recommended by the guidelines. A screening of malignant diseases which could lead to urinary tract repeated infections and recurrent urolithiasis, was not performed. Each of these errors was the result of a failure to comply with the guidelines of good clinical practice.

Conclusion: In the absence of systemic solutions that would enable an improvement of the position of doctors in the primary health care, it is indispensable that we work responsibly, follow the guidelines of good clinical practice, develop new clinical skills and improve communication with patients through continuing medical education, thus reducing the possibility of diagnostic errors.

Keywords: mistakes, guidelines, family, medicine

¹ Health center Krupa na Uni

Address: Jandric-Kocic Marijana, Stevana Jakovljevica 23, 78 000 Banjaluka,
E-mail: marijanajandrickocic@gmail.com

RACIONALNA FAMAKOTERAPIJA U BOLESNIKA STARIJE DOBI S MULTIMORBIDITETOM – DILEME LOM-A

Ana Kovačević,¹ Iva Jurčević,² Đurđica Kašuba Lazić³

SAŽETAK

Uvod: Racionalna farmakoterapija u osoba starije dobi s multimorbiditetom (MM) rastući je izazov za liječnika obiteljske medicine (LOM). Suvremena medicinska znanost i tehnički razvoj medicine doveli su do značajnog pročinjenja životnog vijeka bolesnika te neminovnog dijagnosticiranja sve većeg broja kroničnih bolesti (KB) koje zahtijevaju dodatnu farmakoterapiju. Jedan od informatičkih alata implementiranih u elektronički zdravstveni karton jest panel racionalne farmakoterapije namijenjen starijima od 65 godina koji uzimaju tri i više lijekova. On omogućuje redovitu reviziju propisanih lijekova te procjenu i praćenje suradljivosti bolesnika. Cilj rada bio je prikazati slučaj bolesnice s multimorbiditetom šest kroničnih bolesti koja je posjetila LOM-a zbog akutnog respiratornog infekta, te dileme koje je LOM imao analizirajući polifarmakoterapiju u osobe starije životne dobi.

Prikaz slučaja: Bolesnica M. Đ. (82 godine) posjetila je LOM-a u siječnju 2019. godine u pratinji kćeri zbog kašla koji se pojavio unatrag tri dana i otežanog disanja. Bila je supfebrilna. Kliničkim pregledom nad plućima nađe se oslabljeni šum disanja, produljeni ekspirij i kasnoinspiratorne krepitacije obostrano bazalno, jače desno. Uz radnu dijagnozu pneumonije, poveden je razgovor o uzimanju trajne terapije za astmu te se saznaje da je bolesnica samoinicijativno prestala uzimati salmeterol + flutikazon. U terapiju je uveden klaritromicin (alergična je na penicilin i cefaleksin), salmeterol + flutikazon, a salbutamol po potrebi. Ovaj posjet zbog akutne bolesti iskoristio je kako bismo naručili bolesnicu na reviziju farmakoterapije.

Bolesnica je umirovljena kućanica, udovica, živi sama u Zagrebu, trenutačno čeka smještaj u Dom za starije i nemoćne. Ima dvije kćeri i troje unučadi, koji je povremeno posjećuju. Sama se brine o uzimanju terapije, a u posljednje vrijeme i tijekom konzultacije s LOM-om pokazuje znakove kognitivnog popuštanja. Nepušać je, umjereno pretila (indeks tjelesne mase 30,1 kg/m²) i teže pokretna, a pri hodanju osjeća vrtoglavicu i slabost u nogama. Brigu o njoj vodi kći koja živi sa svojom obitelji. Unatrag 25 godina boluje od šećerne bolesti tipa 2 uz komplikaciju diabetičke polineuropatijske, ima esencijalnu hipertenziju, kroničnu ishemiju srca, bronhalnu astmu, gastroezofagealnu refluksnu bolest, osteoporozu, urinarnu inkontinenciju i poliartralgiju. Primijenjen je standardizirani upitnik za procjenu simptoma anksioznosti i depresije, koji je bio pozitivan na depresiju.

Na kontrolnom pregledu nakon pet dana došlo je do poboljšanja općeg stanja, saturacije kisika ($SpO_2 = 98\%$) i regresije auskultacijskog nalaza na plućima, uz dalju prisutnost suhog kašla. Krvni tlak bio je 130/80 mmHg, a razina glukoze u krvi 5,3 mmol/L. Revidirani su i ostali rizični čimbenici (dislipidemija, pušenje, tjelesna aktivnost). Revizijom farmakoterapije utvrđeno je kako bolesnica trenutačno u terapiji ima 15 lijekova, od čega osam lijekova uzima svakodnevno (inzulin glargin, linagliptin, karvediol, telmisartan, amlodipin, salmeterol + flutikazon, pregabalin,

¹ Klinički bolnički centar „Sestre milosrdnice“, Zagreb, dr. med., stažist

² Dom zdravlja Zagreb-Centar, dr. med., specijalizant obiteljske medicine

³ Katedra za obiteljsku medicinu, Medicinski fakultet Sveučilišta u Zagrebu, prof. prim. dr. sc., specijalist obiteljske medicine

Adresa za dopisivanje:

Ana Kovačević, dr. med., KBC Sestre milosrdnice, Vinogradska cesta 29, 10 000 Zagreb,
e-adresa: ms.anakovacevic@gmail.com

kolekalciferol), a sedam lijekova po potrebi (salbutamol, diazepam, ibuprofen, solifenacil, tramadol + paracetamol, furosemid, pantoprazol). Upitnikom o redovitosti uzimanja lijekova pacijentica je svrstana u skupinu „srednje suradljivih“ jer je navela da katkada zaboravi uzeti lijek. Također je upitana o poznavanju namjene svakoga lijeka, pri čem se pacijentica povremeno teško prisjeća koji je lijek za koju bolest. Oblikan je popis lijekova s detaljnim opisom i ubilježbom vremena uzimanja pojedinog lijeka te je prokomentiran s pacijenticom. Dogovoren je i plan praćenja.

Zaključak: Skrb LOM-a za bolesnike s multimorbiditetom i polifarmacijom treba biti usmjereni osobi, a ne pojedinačnoj bolesti. Dobar odnos liječnik-bolesnik uz jasnu komunikaciju kojom se uvažavaju obostrani stavovi i donose zajednički planovi liječenja, uz nezaobilaznu procjenu sposobnosti pacijenta da se nosi s teretom bolesti te socijalnog okružja, samo su neki od temeljnih preduvjeta adekvatne skrbi u obiteljskoj medicini. Dobro poznavanje kliničkih smjernica uz njihovu kritičku primjenu u svakog pojedinog bolesnika, stalna analiza dinamike razvoja kroničnih bolesti i korištenje alata za racionalno propisivanje u osoba starije dobi pretpostavke su kvalitetne skrbi za ovako kompleksnog bolesnika u obiteljskoj medicini.

Ključne riječi: multimorbidnost, polifarmacija, šećerna bolest tipa 2

RATIONAL PHARMACOTHERAPY IN ELDERLY PATIENTS WITH MULTIMORBIDITY- DILEMMAS FACING FAMILY PHYSICIAN

Ana Kovačević,¹ Iva Jurčević,² Đurđica Kašuba Lazić³

ABSTRACT

Introduction: Rational pharmacotherapy in elderly patients with multimorbidity (MM) represents a growing challenge for the family physician (FP). Medical science and the technological development of medicine have led to a significant prolongation of life expectancy and an increased number of chronic diseases (CD) requiring additional pharmacotherapy. One of the tools implemented in the electronic medical record is a panel of rational pharmacotherapy intended for patients older than 65 who use three or more medications. It enables regular revision of prescribed medications and monitors patients' compliance to medication-taking. The aim of this article is to present a patient with multimorbidity of 6 CD who has visited the FP and the dilemma the FMP has analyzing polypharmacy in older people.

Case report: Patient M.D. (82) presents to her FP due to cough and heavy breathing. She is subfebrile and gives the impression of a moderately ill patient. Clinical examination of the lungs reveal a weakened breathing noise, prolonged expiratory phase and bilateral basal crackles in the inspiratory phase, stronger on the right side. Along with the working diagnosis of pneumonia, discussion on taking permanent asthma therapy is held and we find out that she has stopped taking salmeterol + fluticasone. Clarithromycin (due to patient's allergy to penicillin and cephalexin), salmeterol + fluticasone, and salbutamol are prescribed. Another appointment with the patient is scheduled to review her pharmacotherapy.

Our patient is a retired housewife, a widow living alone. She is in charge of taking her medications, but she has lately started to develop symptoms of a mild cognitive impairment. She is a non-smoker and moderately obese (body mass index, BMI = 30.1 kg / m²) which makes it more difficult for her to walk. Her daughter who lives with her family takes care of her. Twenty-five years ago she was diagnosed with type 2 diabetes complicated with diabetic polyneuropathy. She also suffers from essential hypertension, chronic ischemic heart disease, bronchial asthma, gastroesophageal reflux disease, osteoporosis, urinary incontinence, and polyarthralgia.

A standardized questionnaire for assessing symptoms of anxiety and depression is conducted and our patients shows signs of depression.

Five days later on control examination our patient is in a better general condition, oxygen saturation (SpO₂ = 98%) and auscultatory findings on the lungs have improved, but with the persistence of dry cough. Her blood pressure is 130/80 mmHg, and blood glucose level is 5.3 mmol /L. Other risk factors (dyslipidemia, smoking, physical activity) are also reviewed. The review of pharmacotherapy reveals that she has currently been taking 15 medications, of which 8 are taken daily (insulin glargin, linagliptin, carvediol, telmisartan, amlodipine, salmeterol + fluticasone, pregabalin, cholecalciferol) and 7 as needed (salbutamol, diazepam, ibuprofen, solifenacil, tramadol + paracetamol, furosemide, pantoprazole). She has filled the questionnaire about the compliance to medication taking and is classified as "moderately compliant" (sometimes she

¹ University Hospital Centre „Sestre Milosrdnice“, Zagreb

² Community Health Centre Zagreb-Center

³ Department of Family Medicine, University of Zagreb, School of Medicine, prof. PhD Address:

Ana Kovačević, dr.med., KBC Sestre Milosrdnice, Vinogradnska cesta 29, 10000 Zagreb,
e-mail: ms.anakovacevic@gmail.com

forgets to take medications). Furthermore, we question her about the purpose of each medication she is taking, whereby she occasionally cannot remember the purpose of some of them. A list of medications with description and timing is printed out and commented with the patient. A follow-up plan is established.

Conclusion: Medical care for patients with multimorbidity and polypharmacy should be directed to the patient and not to the individual illness. Good relationship between the FP and the patient, clear communication that respects mutual attitudes and a common treatment plan represent the basic preconditions for adequate care in family medicine (FM). Good knowledge and critical use of clinical guidelines, together with constant follow-up of CD dynamics using rational prescription tools for an elderly person, is a precondition for quality care of such patients.

Key words: multimorbidity, polypharmacy, type 2 diabetes

HITNA INTERVENCIJA U AMBULANTI LIJEČNIKA OBITELJSKE MEDICINE

Maja Matijević¹

SAŽETAK

Jedan psihijatrijski pacijent utječe barem na pet ljudi u svojoj okolini što govori o kompleksnosti pristupa i liječenja samog pacijenta. Slabo poznavanje zakona o zaštiti osoba s duševnim smetnjama, problem prisilne hospitalizacije, oduzimanja ljudskih sloboda, strah od agresivnosti i nepredvidivosti pojedinih psihijatrijskih entiteta, problemi ovisnika i skupina ljudi s marginom društva samo su neke od prepreka u adekvatnom zbrinjavanju psihijatrijskih pacijenata u ordinaciji liječnika obiteljske medicine (LOM). Ovaj primjer iz prakse pokazuje ulogu LOM-a u liječenju psihijatrijskog bolesnika te njegovo djelovanje u ostvarivanju međusobne suradnje nadležnih institucija.

Prikaz slučaja: Koncem kolovoza policija i hitna služba izlaze na teren s uputnicama obiteljskog liječnika za prisilnu hospitalizaciju, prisutni dјelatnici Centra za socijalnu skrb (CZSS). Policija zamoljava dvije osobe koje su zatečene u dvorištu da odmah i bez suviše rasprave sjednu u vozilo hitne pomoći s policijom u nadzoru te se odvezu na odjel psihijatrije.

Ranije toga dana u ambulantu LOM-a dolaze dvije sestre i mlađi brat, u dobi od 30, 28 i 17 godina, te iznose obiteljsku problematiku. Navode kako otac i majka prijete susjedima, plaše sina opasnom okolinom, nepoznatim ljudima koji dolaze i šetaju po terasi i po kući dok svi spavaju. Majka svaku noć ide sa sjekirom po stepenicama jer misli da netko s kata kuće truje kupus u dvorištu. Mlađi sin je uplakan i uplašen. S vrata se vidi da je dječak slabije tjelesne građe, niska rasta. Posljednjih se nekoliko dana skriva u susjedstvu, dok sestre nisu došle. Navode kako otac smatra da ima nadnaravne moći, iscjeljuje ljudе na daljinu, ne izlazi izvan dvorišta jer su, kaže, bačeni uroci, a on se viskom i moćima bori protiv zla. Otac i majka su nezaposleni, bave se poljoprivredom i prave posude od šiba koje prodaju u selu.

Kćeri ne smiju dolaziti u kuću jer roditelji misle da su povezane sa sotonom, te i sinu govore da ih se kloni. U posljednjih deset godina samo je nekoliko puta video sestre i to kada su ga odvele pedijatru u Zagreb na pregled zbog zaostajanja u rastu. Tamo je obrađen, no roditelji su došli po njega i odveli ga kući. U školi je dobar, no roditeljima 'sotonska' škola nije bitna, već ga uče jesti iz svog vrta. U sobama se nalaze relikviji oko prozora i vrata kako demon ne bi ušao. Spremili su zimnicu u velikim količinama očekujući sudnji dan koji bi se po navodima oca trebao dogoditi do zime, a preživjet će samo oni koji vjeruju. Iz uvida u medicinsku dokumentaciju proizlazi kako roditelji nisu bili kod LOM-a posljednjih deset godina, što se i poklapa s vremenom ovih događanja. U dokumentaciji dječaka nalaz je pedijatra iz Zagreba, dječak nije redovito cijepljen, a roditelji nisu dolazili po terapiju za kronične bolesti.

Isključi se akutno moždano zbivanje (krvarenje, ishemija, tumorski procesi) i trauma. Pozove se CZSS na teren te izdaju uputnice za bolničko liječenje roditelja s radnom dijagnozom *psychosis*, pozove se HMP i MUP da odmah s CZSS-om izadu na teren. Kćeri i sin ostavljeni su u ambulantu dok se ne riješi situacija na terenu te će u ordinaciju doći socijalni radnik i pripadnik MUP-a. Sestrma je dodijeljeno skrbništvo nad bratom do punoljetnosti. Roditelji su nakon četiri mjeseca izašli iz dvije različite psihijatrijske ustanove te su se pod pratnjom CZSS-a vratili u obiteljsku kuću s obvezom redovitog liječenja i praćenja ambulantnim putem.

¹ Ambulanta obiteljske medicine Vinkovci
e-adresa: jukicmaja85@gmail.com

Zaključak: Multidisciplinarni pristup nam pokazuje središnju i nezamjenjivu ulogu LOM-a kao osobe koja povezuje naizgled različite struke u kvalitetnom i adekvatnom zbrinjavanju pacijenata.

Ključne riječi: LOM, multidisciplinarni pristup, prisilna hospitalizacija

EMERGENCY INTERVENTION IN FAMILY MEDICINE PRACTICE

Maja Matijević¹

ABSTRACT

One psychiatric patient affects at least 5 people in their environment, taken the complexity of access and treatment of the patient. The lack of knowledge about laws on the protection of persons with mental disorders, the problem of coerced hospitalization, the violation of human freedoms, the fear of aggression and unpredictability of certain psychiatric entities, the problems of addicts and groups of people on the margins of society are just some of the obstacles to adequately care of psychiatric patients in the general practice (GP). This example shows the role of the GP in the treatment of a psychiatric patient and steps in achieving mutual cooperation between institutions in charge.

Case report: At the end of August the police and emergency health unit with GP's instructions for coerced hospital admission and the Social welfare centre (SWC) workers come to the scene where the police invite the two people found on the patio to immediately and without hesitation take a seat in the emergency vehicle with the police and be taken to the psychiatry ward. Earlier that day, two sisters and a younger brother aged 30, 28, and 17 come to the GP office and report family issues. They say that their father and mother have been threatening their neighbours; they have also been threatening their son with dangerous environment; unknown people have been coming and walking on the terrace and at home while everyone was asleep. Their mother is on the stairs with an axe every night because she thinks that someone from the ground floor of the house has been poisoning the cabbage in the garden. The younger son is frightened. It is evident that the boy is weak and underdeveloped. He had been hiding in the neighbourhood for a few days until his sisters came. They report that their father thinks he has supernatural powers; he is able to heal people from a distance. He never leaves the patio because he has been believed to be throwing intoxicants, but he is fighting against the evil.

The parents are unemployed; they produce some agricultural products and pottery which they sell in the village. Daughters are not allowed to come to the house because their parents think they are related to the devil and they forbid their son to see them telling him to turn them away. In the past 10 years he has seen his sisters several times when they took him to a paediatrician in Zagreb for examination and treatment. However, during the treatment, his parents came for him and took him home. He is a good student but his parents do not care about the satanic school, instead they teach him to eat from their own garden. The rooms have relics around the windows and doors, so the demon does not enter. They have prepared the large quantities of cold storage, expecting judgment day due to happen before winter, according to their father's words, and only those who believe will survive.

Inspecting medical records, it is found that parents have not visited the GP for the past 10 years, which coincides with the time of these events. A boy has a paediatric report from Zagreb, he has not been regularly vaccinated, and his parents have not come for therapy for chronic diseases. Medical records exclude acute stroke (bleeding, ischemia, tumour processes) and trauma. The CWS release a document transferring the rights to parental care of the son, due to parents' psychosis diagnosis. They invite the Emergency Health Service and the Police to assist in the process. The daughter and son are waiting in the ambulance until the situation is resolved, and the social worker and the police officer come to GP's office.

¹ Family Medicine Practice, Vinkovci
Corresponding address:
jukicmaja85@gmail.com

The sisters are given custody of their brother until he is off age. The parents are discharged from two different psychiatric institutions after 4 months and they return to their family house under the care of the CWS worker, with the obligation of regular treatment and follow-up.

Conclusion: The multidisciplinary approach shows us the central and irreplaceable role of the GP as a person who connects seemingly different professions in order to provide patients with good quality and adequate care.

Key words: GP, multidisciplinary approach, coerced hospitalization

KRIŽOBOLJA: PRVE HRVATSKE SMJERNICE HRVATSKOGA VERTEBROLOŠKOG DRUŠTVA ZA DIJAGNOSTIKU I LIJEČENJE MINIMALNO INVAZIVnim PROCEDURAMA

Josipa Rodić¹

SAŽETAK

Uvod: Križoboljom označavamo lokalnu bol u području lumbalnog dijela (od rebara do gluteusa) koja se obično ne širi u noge, ako se širi u noge, obično ne ide ispod koljena. Problem križobolje važan je u svakodnevnom radu liječnika obiteljske medicine jer gotovo 80 % stanovništva barem jednom u životu osjeti tu tegobu. Među razlozima posjeta obiteljskom liječniku križobolja je na drugome mjestu, odmah nakon akutnih respiratornih bolesti, i među vodećim je uzrocima izostanka s radnog mjesta radno aktivne populacije. Prema Hrvatskom zdravstveno-statističkom ljetopisu za 2017. godinu, bolesti mišićno-koštanog sustava i vezivnog tkiva čine 10,8 % od ukupnog broja bolesnih stanja. Uzrok križobolje mogu biti genetska predispozicija, manjak tjelesne aktivnosti, pretjerana tjelesna težina, pušenje, teži tjelesni rad, nepravilna obuća, ravna stopala, prevelika duševna napetost i kronični stres. Prema zahvaćenim anatomske strukturama razlikujemo boli uzrokovane oštećenjem intervertebralnog diska, boli uzrokovane degenerativnim promjenama fasetnih zglobova ili sakroilijakalnog zgloba te boli uzrokovane stenozom spinalnog kanala. Najčešći uzrok mekotkvne stenoze kod mlađih bolesnika jest hernijacija intervertebralnog diska, dok je hipertrofija žutog ligamenta najčešći uzrok mekotkvne centralne stenoze kod starijih bolesnika. U minimalno invazivne dijagnostičke procedure ubrajamo stimulacijsku diskografiju, anesteziranje medijalnih ograna stražnje grane slabinskih spinalnih živaca, anesteziranje sakroilijakalnog zgloba i anesteziranje spinalnih živaca, a u terapijske procedure anuloplastiku, perkutanu radiofrekventnu (RF) neuroablaciјu medijalnih ograna stražnje grane spinalnih živaca, perkutanu RF neuroablaciјu lateralnih ograna stražnje grane sakralnih živaca, epiduralne steroidne injekcije i perkutanu pulsnu radiofrekventnu neuromodulaciju spinalnih živaca i spinalnih ganglija.

Prikaz slučaja: Ekonomist, u dobi od 52 godine, boluje od tegoba lumbosakralne kralježnice unatrag 15 godina. Godine 2013. pri jutarnjem pranju zuba kihnuo i od tada zakočen u uspravnom položaju. Javlja bol prema vizualno-analognoj ljestvici boli (VAS) > 10! Bol se širila u desnu nogu sve do prstiju. Zove odmah ujutro u ambulantu, te se odlazi u kućni posjet i izdaje uputnica za neurokirurga uz terapiju ibuprofen 600 mg 1,0,1 i diazepam 5 mg 1,0,1. Pacijent je odmah hospitaliziran (28. 10. – 31. 10. 2013.) te otpušten uz dijagnoze *Lumboischialgia lat dex*, *Hernia disci i.v. L4-L5, lat dex*, *Paresis n. peronealis lat dex*. Tijekom bolničkog liječenja učinjena interlaminektomija i ekstirpacija L4-L5. Po otpustu iz bolnice učinjena stacionarna rehabilitacija. Pacijent otpušten bez боли, funkcija lumbalne kralježnice kompenzirana, pokreti terminalno reducirani, *Lasegue* negativan, ali zaostaje umjerena pareza desnog stopala.

Zaključak: Prema smjernicama Hrvatskoga vertebrološkog društva predložen je niz minimalno invazivnih procedura koje u svakodnevici rijetko vidamo. Kod pacijenata s križoboljom od dijagnostike najčešće primjenjujemo Rtg dijagnostiku, EMNG dijagnostiku, CT spinalnog kanala i MR kralježnice te liječenje procedurama fizikalne terapije. No smjernica o svemu navedenome nema, pa je postupanje s križoboljom individualno prema osobnoj procjeni.

¹ Specijalistička ordinacija obiteljske medicine Josipa Rodić

Adresa za dopisivanje:

Specijalistička ordinacija obiteljske medicine Josipa Rodić, Vilima Korajca 19, Zagreb,
e-adresa: josipa.rodić@dedominis.com

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LUMBAGO: THE FIRST CROATIAN GUIDELINES OF THE CROATIAN VERTEBROLOGIC SOCIETY

Josipa Rodić¹

ABSTRACT

Introduction: By back pain we mean local pain in the lumbar region (from ribs to gluteuses) which usually does not spread to the feet. If it spreads to the feet it usually does not go below the knees. The problem of back pain is important in the daily work of the family physician, as almost 80% of the population experience this discomfort at least once in a lifetime. Among the reasons for visits to the general practitioner, lumbago is in the second place right after acute respiratory illness and among the leading causes of absenteeism in a work-active population. According to the Croatian Health and Statistical Yearbook for 2017, the diseases of the musculoskeletal system and connective tissue make 10.8% of the total number of diseases and conditions. The causes of lumbago may be a genetic predisposition, a lack of physical activity, an excessive body weight, smoking, a heavy physical activity, improper footwear, flat feet, excessive mental tension and chronic stress. According to the anatomical structures involved, we distinguish: pain caused by damage of the intervertebral disc, by degenerative changes in the facial or sacroiliac joint and by spinal canal stenosis. The most common cause of soft tissue stenosis in younger patients is herniation of the intervertebral disc, while yellow ligament hypertrophy is the most common cause of soft tissue central stenosis in older patients. Diagnostic procedures (minimum invasive) are stimulation discography, anaesthesia of the median branches of the backbone of the weak spinal nerve, of SI joint or of spinal nerves. Therapy procedures (minimum invasive) is annuloplasty: perceived radiopharmaceutical (RF) neuroablation of the median branches of the spinal nerve branch, RF neuroablation of the lateral branches of the sacral spinal nerve or epidural steroid injections percutaneous pulse radio frequency neuromodulation of the spinal nerves and spinal ganglia.

Case report: Economist, 52 years old, LSK problem 15 years back, but 2013 at home, while washing his teeth, he sneezed. Since then, his upper part of back is stiffened. Pain in LSK VAS:>10! The pain spreads in the R leg down to the fingers.

Conclusion: According to the directions of the Croatian Vertebrology Society, a series of minimally invasive procedures is proposed, which we rarely see in everyday life. In diagnosing, the most commonly used tests are Rtg, EMNG, CT of the Spinal Canal, MR of the Spine. The treatment is most often physical therapy procedures. However, there are no guideline for all of these, so the treatment for patients with lumbago is individually determined, according to personal assessment.

¹ Family Medicine Practice Josipa Rodić
Vilima Korajca 19, Zagreb, E – mail: josipa.rodic@dedominis.com

SURADLJIVOST BOLESNIKA SA SHIZOFRENIJOM I LIJEČNIKA OBITELJSKE MEDICINE U LIJEČENJU VENSKE POTKOLJENIČNE RANE

Tamara Sinožić,¹ Jadranka Kovačević,¹ Ksenija Baždarić²

SAŽETAK

Uvod: Kompresivna terapija osnovna je terapija u liječenju venske potkoljenične rane, a suradljivost je ključna za uspješnost liječenja, odnosno zacjeljenja, kao i za pojavnost recidiva. Nedostatna suradljivost susreće se u 9,7 – 80 % bolesnika. Mogući su razlozi nesuradljivosti psihička stanja i bolesti u kojima bolesnik ne može slijediti upute liječenja. Cilj je rada prikazati model skrbi kojim se unaprijedila suradljivost bolesnika sa shizofrenijom u liječenju venske potkoljenične rane.

Prikaz slučaja: Bolesnik u dobi od 41 godine u travnju 2018. dolazi na pregled u pratnji majke zbog teško cijelećih rana na lijevoj potkoljenici. Podaci o bolesniku dobivaju se od majke. Od rođenja ima cerebralnu paralizu s posljedičnom laganom mišićnom slabostu lijeve strane tijela. Od svoje 18. godine boluje od shizofrenije, sada je u stanju dobre remisije uz terapiju klonazepam, olanzapin i diazepam tabletama. Godine 2003. imao je duboku vensku trombozu lijeve potkoljenice, poplitealne i stražnje tibijalne vene, nakon čega se razvio postrombotski sindrom s ranama. Psihološkim vještinačenjem u 26.-oj godini utvrđeno je da se radi o somatski i psihički bolesnom ispitaniku, graničnih intelektualnih sposobnosti, koji nije sposoban za rad i privređivanje, te je u potpunosti ovisan o tuđoj pomoći i njezi. Bolesnik živi s umirovljenim roditeljima, materijalno su situirani. Tijekom kliničkog pregleda lijeva potkoljenica bila je edematozna uz hemosiderozu potkoljenice i stopala. Uz medijalni maleol bila je rana veličine 4 x 5 cm, a uz lateralni dvije rane 1 x 2 cm, srednje obilne sekrecije, u dnu fibrin, nisu bile bolne. Rana na stopalu bila je prekrivena krustom. Lijevo stopalo i palac su uvrnuti. Bolesnik je i samostalno iznašao tegobe, da zbog curenja iz rana nije mogao odlaziti volontirati u socijalnu samoposlužu, nije mogao nositi adekvatnu obuću, osjećao se prljavo i smrdljivo. Približavalo se ljeto, te se pribrojavao da se neće moći kupati u moru i zbog toga se osjećao tužno. U svakodnevnoj terapiji rana pomagala mu je majka koja mu zbog svojih fizičkih ograničenja nije mogla pomagati u kompresivnoj terapiji, dok otac nije pokazivao suradljivost. Ultrazvučnim pregledom obojenim doplerom vena lijeve noge utvrdila se insuficijencija dubokoga venskog sustava uz refluks na razini femoralne i poplitealne vene, te je dijagnoza bila kronična venska insuficijencija s ranama. Bolesniku i majci objasnio se terapijski plan koji je uključivao previjanje u ordinaciji dva puta tjedno i kompresivnu terapiju. Lokalna terapija bili su debridman i pokrivala za rane, a kompresivna je bila izvedena višeslojnim sustavom zavoja kratkog vlaka koji je na nozi ostajao do sljedećeg previjanja. Rane su zacijelile za pet tjedana. Bolesnik nije imao tegoba, veselio se napretku cijeljenja čime se smanjila tjeskoba. Ponovno je volontirao, pomagao je u kućanstvu jer je majka slomila podlakticu. Radi sprječavanja recidiva rana savjetovale su se kompresivne dokoljenke koje bi se postavljale i skidale uz očevu pripomoć, ali suradljivost nije postignuta. Moralo se pronaći pomagalo koje bi bolesnik mogao samostalno primjenjivati, te se izabrala kompresivna prilagodljiva nogavica (na „čičak“). Organizirala se edukacija bolesnika i majke o primjeni pomagala, koju je bolesnik svladao i redovito provodio. Recidivnu manju ranu imao je nakon tri mjeseca. Telefonski se savjetovalo kako pojačati kompresiju, te je rana zacijelila za tjedan dana. U prosincu je redovito volontirao, više je

¹ Specijalistička ordinacija obiteljske medicine dr. sc. Tamara Sinožić, dr. med.

² Katedra za medicinsku informatiku, Medicinski fakultet Sveučilišta u Rijeci

Adresa za dopisivanje:

Specijalistička ordinacija obiteljske medicine, dr. sc. Tamara Sinožić, dr. med., Barba Rike 5a,
51 417 Mošćenička Draga, e-adresa: sinozictamara@gmail.com

sati stajao na mjestu, te se pojavila manja rana koja je zacijelila za dva tjedna.

Zaključak: Suradljivost u primjeni kompresivne terapije u bolesnika sa shizofrenijom i venskom potkoljeničnom ranom poboljšala se ponajprije individualiziranim sveobuhvatnim pristupom uz empatiju i razumijevanje bolesnikova stanja i potreba. Edukacija bolesnika i bliskog člana obitelji, izbor optimalnog pomagala uz praktičnu demonstraciju primjene dodatno su pridonijeli suradljivosti. Postignuto je zacjeljenje rana u preporučenom vremenu i reduciralo se vrijeme cijeljenja recidivnih rana. Umanjila se bolesnikova tjeskoba i poboljšalo socijalno funkcioniranje, čime se poboljšala kvaliteta života bolesnika i obitelji.

Ključne riječi: kompresivna terapija, liječnik obiteljske medicine, shizofrenija, suradljivost, venska potkoljenična rana

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CONCORDANCE BETWEEN PATIENT WITH SCHIZOPHRENIA AND GENERAL PRACTITIONER IN TREATMENT OF VENOUS LEG ULCER

Tamara Sinožić,¹ Jadranka Kovačević,¹ Ksenija Baždarić²

ABSTRACT

Introduction: Compression therapy is the basic therapy in the treatment of venous leg ulcer, and concordance is the crucial element of a success of the treatment, i.e. healing, as well as of a manifestation of relapses; 9.7-80% of patients show insufficient concordance. Possible reasons for the lack of concordance are psychological conditions and illnesses resulting in the patient being unable to follow treatment instructions or to refuse therapy. The aim is to present the model of treatment which has improved the concordance between the patient with schizophrenia and the general practitioner in the treatment of venous leg ulcer.

Case study: A 41-year-old male patient, accompanied by his mother, comes to consultation in April 2018 due to wounds on his left lower leg. The patient has cerebral paralysis since birth with consequent slight muscular weakness of the left side of the body. He has been suffering from schizophrenia since he was 18, and is now in a state of good remission with the help of Clonazepam, Olanzapine and Diazepam therapy. In 2003, he had a deep venous thrombosis of the left lower leg, popliteal and posterior tibial vein, after which the post-thrombotic syndrome with wounds has developed. Psychological examination at the age of 26, determined that the subject was somatically and psychologically ill, with borderline intellectual abilities, unable to work and is, therefore, completely dependent on the help and care of others. The patient lives with retired parents, who are financially stable. Clinical examination shows that the left lower leg is swollen, with hemosiderosis of almost the entire lower leg and the upper part of the foot. There are a wound 4x5cm in size next to medial malleolus and two wounds 1x2cm in size next to lateral malleolus. Moderate wound leakage, wound bed is covered with fibrin, no pain. The small wound on the upper part of his foot is covered with crust. His left foot and big toe are twisted. The patient also talks about his difficulties, saying that the wound leakage stopped him from volunteering at the self-service for the needy, stopped him from wearing adequate footwear, made him feel dirty and smelly. Since the summer is approaching, he is afraid he will not be able to bathe in the sea, which makes him feel sad. His mother has been helping him with daily wound therapy. Due to her own physical limitations and illness, she is not able to help him with compression devices, while his father has not shown necessary cooperation. The diagnostic/therapeutic plan includes color Doppler vein ultrasound of his left leg, which shows deep venous system insufficiency and reflux of the femoral and popliteal vein. The working diagnosis is chronic venous insufficiency with a left leg ulcer as a part of post-thrombotic syndrome. The therapeutic plan is explained to the patient and his mother; it includes dressing changing in the practitioner's office twice a week and compression therapy. Local therapy is debridement and wound dressings, while compression therapy includes multi-layered short stretch bandages, which stay on day and night until the next dressing change. The wounds heal in 5 weeks. The patient does not have difficulties, he is happy with the healing progress, which reduces his anxiety. He goes back to volunteering; he helps more in the house because his mother has broken her forearm. In order to prevent a relapse, the patient is advised to use compression stockings. Education is organized in the practitioner's office, during

¹ Family Medicine Practice, Tamara Sinožić, MD-PhD

² Department of Medical Informatics, Rijeka University School of Medicine

Contact address:

Family Medicine Practice, Tamara Sinožić, MD, PhD, Barba Rike 5a, 51417 Mošćenička Draga,
E-mail: sinozictamara@gmail.com

which the patient and his mother are instructed on the device. The patient learns how to apply the device and continues to apply it regularly. He has a small relapse there months later; he asks for advice by phone on how to increase compression therapy, and consequently, the wound heals after a week. In December, he volunteers regularly, standing in place over several hours, which results in a smaller wound, which then heals in two weeks.

Conclusion: Concordance of compression therapy in the case of a patient with schizophrenia and venous leg ulcer improves primarily due to individualized, holistic approach with empathy and understanding of the patient's condition and needs. Education of the patient and a close family member as well as the choice of the optimal device with a practical demonstration of its use additionally contribute to the concordance. Wound healing in recommended time is achieved and healing time for relapses is reduced. The anxiety of the patient is also reduced and his social functioning is improved, thus improving not only the quality of life of the patient but also of his family.

Keywords: compression therapy, concordance, general practitioner, schizophrenia, venous leg ulcer

POSTERI
POSTERS

VAŽNOST TJELESNE AKTIVNOSTI I PRAVILNE PREHRANE U PREVENCIJI PRETILOSTI – PILOT-STUDIJA

Karmen Beljan,¹ Željko Jovanović,¹ Nives Radošević Quadranti,¹
Jelena Andesilić,¹ Ines Diminić-Lisica²

SAŽETAK

Hrvatska je među dvadeset osam članica Europske unije na visokom osmom mjestu po broju pretilih ljudi. Prema podatcima Eurostata, 18,7 % osoba u Hrvatskoj je pretilo, dok je europski prosjek 15,9 %. Posebno zabrinjava visoka učestalost pretilosti u dječjoj dobi (11,2 %), u čemu je Hrvatska na petom mjestu. Poznato je da je debljina jedan od najvećih javnozdravstvenih problema jer uzrokuje niz zdravstvenih posljedica koje smanjuju kvalitetu i dužinu života. Također je poznato da svaki poticaj za pridržavanje navika pravilne prehrane i redovite tjelesne aktivnosti ima veliku ulogu u unaprjeđenju zdravstvenog stanja društva. Cilj ovog pilot-istraživanja bio je ispitati povezanost između provođenja tjelesne aktivnosti i pravilne prehrane u očuvanju i unaprjeđenju zdravlja te potvrditi da osobe koje imaju pravilne prehrambene navike češće izbjegavaju sjedilački način života.

Ispitanici i metode: Ispitanici u ovoj pilot-studiji bile su zdrave ženske i muške osobe u dobi od 25 do 35 godina, redoviti korisnici fizioterapijskih usluga u cilju poboljšanja općeg zdravstvenog stanja. Uzorak je bio slučajan, a uključeno je 100 ispitanika, od čega 60 muškaraca i 40 žena. Korišten je anonimni anketni upitnik od 21 pitanja višestrukog izbora i četiri pitanja kod kojih su ispitanici dopisali odgovor po vlastitom izboru. Upitnik je sadržavao pitanja o dobi, spolu, tjelesnoj težini i visini, prehrambenim, sportskim i drugim životnim navikama.

Rezultati: Indeks tjelesne mase (BMI) usporeden je s obzirom na tjelesnu aktivnost ispitanika. Ispitanici koji su redovito tjelesno aktivni imali su niži prosječni BMI. Većina ispitanika redovito konzumira povrće i žitarice, a rijede brzu hranu i slatkiše. Ispitanici se većinom bave tjelesnom aktivnosti nekoliko puta tjedno, a kao razlog najčešće navode očuvanje zdravlja.

Zaključak: Osobe koje su redovito tjelesno aktivne rjeđe odabiru brzu i kaloričnu hranu te prednost daju pravilnoj i uravnoteženoj prehrani, što poslijedično za rezultat ima i normalan indeks tjelesne mase. Kao razlog bavljenja tjelesnom aktivnosti i provođenja pravilne prehrane navodi se ponajprije očuvanje i unaprjeđenje zdravlja. Ova pilot-studija predstavlja putokaz za izradu cjelevitog programa prilagođenoga svakodnevnoj primjeni u obiteljskoj medicini čime se u suradnji liječnika, ljekarnika, nutricionista i fizioterapeuta može osigurati usvajanje i pridržavanje zdravih životnih navika, redovite tjelesne aktivnosti i pravilne prehrane u cilju prevencije debljine i ostalih čimbenika kardiovaskularnog rizika.

Ključne riječi: tjelesna aktivnost, prehrana, indeks tjelesne mase, pretilost

¹ Fakultet zdravstvenih studija Sveučilišta u Rijeci

² Medicinski fakultet Sveučilišta u Rijeci

Željko Jovanović, Ede Jardasa 1, 51000 Rijeka; zeljko_jovanovic@icloud.com

IMPORTANCE OF PHYSICAL ACTIVITY AND REGULAR NUTRITION IN THE PREVENTION OF OBESITY – PILOT STUDY

Karmen Beljan,¹ Željko Jovanović,¹ Nives Radošević Quadranti,¹
Jelena Andesilić,¹ Ines Diminić-Lisica²

ABSTRACT

Croatia is ranked eighth among the member states of the European Union by the number of obese people. According to Eurostat data, 18.7% of people in Croatia are obese, while the European average is 15.9%. Of particular concern is the high prevalence of obesity in children (11.2%), where Croatia is ranked fifth. It is well known that obesity is one of the largest public health problems because of its health effects that reduce quality and length of life, and that every incentive to adhere to regular eating habits and regular physical activity plays a major role in improving the health status of society. The aim of this pilot study was to examine the correlation between physical activity and proper nutrition in the preservation and improvement of health and to confirm that people with the right nutritional habits are more likely to avoid sedentary lifestyle.

Subjects and methods: Subjects in this pilot study were healthy women and men at the age 25–35 years, regular users of physiotherapy services to improve the overall health status. The sample was random and included 100 subjects, of which 60 men and 40 women. An anonymous questionnaire of 21 multiple choice questions and 4 open response questions was used. The questionnaire contained questions on age, gender, body weight and height, nutritional, sports and other lifestyle habits.

Results: The body mass index (BMI) was compared with physical activity of the respondents. Subjects with regular physical activity had lower BMI. The majority of respondents regularly consumed vegetables and grains, and rarely fast food and sweets. Respondents were mainly engaged in physical activity several times a week, usually in order to preserve and improve health.

Conclusion: Respondents with regular physical activit rarely choose fast and calorie foods and prefer proper and balanced diet, which results in normal BMI. The preservation and improvement of health has been recognised as the main reason for physical activity and properly balanced nutrition. This pilot study represents a guidemap for the development of a comprehensive program adapted to everyday use in family medicine, which can be used by physicians, pharmacists, nutritionists and physiotherapists to ensure the adoption and adherence to healthy living habits, regular physical activity and proper nutrition in order to prevent obesity and other cardiovascular risk factors.

Key words. physical activity, nutrition, body mass index, obesity

¹ Faculty of Health Studies University of Rijeka

² Faculty of Medicine University of Rijeka

CELIAC DISEASE IN ADULTS IS RARELY DIAGNOSED - THE REASON FOR REMINDER ON SCREENING GUIDELINES IN FAMILY MEDICINE CLINIC

Silvija Čuković-Čavka,^{1,2} Đurđica Kašuba Lazić,^{1,3} Tomislav Benjak,⁴
Krunoslav Capak,⁴ Željko¹ Krznarić²

ABSTRACT

Celiac disease is a common disease with heterogeneous symptoms that may occur in genetically predisposed persons after ingestion of gluten at any age, more often in adults. Patients present with digestive or extraintestinal symptoms, but celiac disease can also be silent. Adults may have nonclassical symptoms that are not indicative of intestinal disease. The aim of this study was to analyze the number of celiac patients in Zagreb.

Materials and methods: The Croatian Institute of Public Health (CIPH) receives data from the Central Healthcare Information System of the Republic of Croatia (CEZIH), which records all persons visiting a family doctor. During the visit, the doctor records the diagnosis after finishing diagnostic workup. For the purpose of this paper, the CEZIH database of 2016 was searched for the diagnosis of celiac disease (MKB-10 Code K90.0).

Results: CEZIH recorded 678 persons with celiac disease in 2016. According to the Zagreb-based Health Statistics Yearbook the number of inhabitants in the City of Zagreb in 2016 was estimated at 802,338 inhabitants. The calculated prevalence of celiac disease in Zagreb is 8.4/10,000 and is 2.3 times higher in females than males.

Conclusion: The number of registered celiac disease patients in Zagreb is very low. The calculated prevalence of celiac disease is significantly lower than the real one and as reported by most European countries suggesting that physicians should be aware of celiac disease as differential diagnosis in their routine clinical work and be informed about screening guidelines in high-risk adults. A serological test for coeliac disease should be offered to: 1. people with any of the following symptoms or diagnosis (persistent unexplained abdominal symptoms, prolonged fatigue, unexpected weight loss, severe or persistent mouth ulcers, unexplained iron, vitamin B12 or folate deficiency, type 1 diabetes at diagnosis; autoimmune thyroid disease at diagnosis); 2. adults who meet the irritable bowel syndrome diagnostic criteria; 3. first-degree relatives of people newly diagnosed with coeliac disease. The delay in diagnosing is dangerous because persons with undiagnosed and untreated celiac disease can develop long-term complications like malnutrition, malignant disease, neurological deficits, and coronary disease.

Key words: celiac disease, screening, guidelines, public health, family medicine

¹ School of Medicine, University of Zagreb

² University Hospital Center Zagreb, Division of Gastroenterology and Hepatology

³ Andrija Stampar School of Public Health, Zagreb

⁴ Croatian Institute of Public Health, Zagreb

Presenter: Čuković-Čavka Silvija, KBC Zagreb, Kišpatićeva 12, email: silvija.cavka@gmail.com

RIJETKO POSTAVLJANJE DIJAGNOZE CELIJAKIJE U ODRASLOJ DOBI – RAZLOG ZA PODSJETNIK NA SMJERNICE ZA DIJAGNOSTIKU CELIJAKIJE U ORDINACIJI ZA OBITELJSKU/OPĆU MEDICINU

Silvija Čuković-Čavka,^{1,2} Đurđica Kašuba Lazić,^{1,3} Tomislav Benjak,⁴
Krunoslav Capak,⁴ Željko Krznarić^{1,2}

SAŽETAK

Celiakija je česta bolest šarene kliničke slike koja se može pojaviti u genetski predisponiranih osoba nakon ingestije glutena u svakoj dobi, češće u odraslih. Bolesnici se mogu prezentirati probavnim ili izvancrijevnim simptomima, ali može biti i tiha. Odrasle osobe mogu imati brojne neklasične simptome koji ne upućuju na bolest crijeva. Cilj ovog istraživanja bio je analizirati broj oboljelih od celiakije u Zagrebu.

Ispitanici i metode: Hrvatski zavod za javno zdravstvo (HZJZ) prima podatke iz Središnjega zdravstvenoga informacijskog sustava Republike Hrvatske (CEZIH), koji bilježi sve osobe koje posjećuju obiteljskog liječnika u primarnoj zdravstvenoj zaštiti. Tijekom posjeta liječnik bilježi dijagnozu celiakije (K90.0) nakon završetka dijagnostičke obrade. Za potrebe ovoga rada pretražena je CEZIH baza podataka za Zagreb u 2016. godini.

Rezultati: CEZIH je u 2016. godini zabilježio 678 osoba s celiakijom (K90.0), a prema podatcima Zdravstveno-statističkog ljetopisa Grada Zagreba, broj stanovnika u Gradu Zagrebu 2016. godine procijenjen je na 802.338 stanovnika. U skladu s navedenim, izračunana prevalencija celiakije u Zagrebu iznosi 8,4/10.000 stanovnika te je 2,3 puta veća u žena nego u muškaraca.

Zaključak: Broj registriranih bolesnika s celiakijom u Zagrebu je vrlo nizak. Izračunana prevalencija celiakije značajno je niža od realne te od one koju je prijavila većina europskih zemalja. To upućuje na potrebu uvođenja programa za podizanje svjesnosti o postojanju celiakije u sklopu trajne edukacije liječnika s ciljem da češće razmotre celiakiju kao diferencijalnu dijagnozu u rutinskom radu. Osobito je važno poznavanje smjernica za probir odraslih osoba s povišenim rizikom za pojavu celiakije. Preporuča se učiniti serološki test za probir na celiakiju sljedećim osobama: 1. s bilo kojim od sljedećih simptoma ili dijagnoza: uporni neobjašnjivi gastrointestinalni simptomi, dugotrajan umor, neočekivani gubitak težine, recidivi afta u ustima, nisko željezo nejasnog uzroka, nedostatak vitamina B12 ili folata, dijabetes tipa 1 u trenutku postavljanja dijagnoze, autoimuna bolest štitnjače u trenutku postavljanja dijagnoze; 2. osobama koje zadovoljavaju kriterije za dijagnozu iritabilnog crijeva; 3. rođacima u prvom koljenu osoba s dijagnozom celiakije. Kašnjenje u dijagnosticiranju celiakije može imati ozbiljne posljedice jer osobe s nedijagnosticiranom i neliječenom celiakijom mogu razviti dugotrajne komplikacije poput pothranjenosti, malignih bolesti, neuroloških deficitova i koronarne bolesti.

Ključne riječi: celiakija, probir, smjernice, javno zdravstvo, obiteljska medicina

¹ Medicinski fakultet Sveučilišta u Zagrebu

² Zavod za gastroenterologiju i hepatologiju, Klinički bolnički centar Zagreb

³ Škola narodnog zdravlja „Andrija Štampar“, Zagreb

⁴ Hrvatski zavod za javno zdravstvo, Zagreb

Izlagач:

Silvija Čuković-Čavka, KBC Zagreb, Kišpatićeva 12, E-adresa: silvija.cavka@gmail.com

PRIHVAĆANJE ODLUKE PACIJENTA O NAČINU LIJEČENJA KADA ONA NIJE U SKLADU S MEDICINSKIM SMJERNICAMA

Tamara Fable,¹ Karmela Bonassini²

SAŽETAK

Atrijkska fibrilacija (AF) najčešći je stalni srčani poremećaj ritma u općoj populaciji. Važan je čimbenik rizika za nastanak moždanog udara, koji je pet puta češći u osoba s AF-om. U cilju prevencije tromboembolije smjernice procjenu rizika temelje na CHA₂DS₂VASc bodovanju te preporučuju uvođenje oralne antikoagulantne terapije (OAT) pri rezultatu ≥ 1 za muškarce i ≥ 2 za žene. Te smjernice imaju razinu dokaza A, potvrđene su u više randomiziranih kliničkih ispitivanja ili metaanaliza. Cilj je ovoga rada prikazati kako se postaviti i što učiniti ako se preporuke iz smjernica ne mogu primijeniti u praksi, neovisno o ograničavajućim okolnostima, bilo da se odnose na pacijenta, liječnika ili zdravstveni sustav.

Prikaz slučaja: Osamdesetčetverogodišnji pacijent dolazi na pregled liječniku obiteljske medicine (LOM) zbog povišenog arterijskog tlaka i oticanja potkoljenica otprije desetak dana. Radi se o multimorbidnom pacijentu (arterijska hipertenzija, AF, hiperplazija prostate, perceptivna nalogluhost, sljepoča jednog oka nastala po operaciji katarakte). Živi sam, o njemu se brinu dva sina i snaha. Pregledom je utvrđen povišen arterijski tlak, tjestasti edemi potkoljenica, ostali fizički status bez osobitosti. Od terapije uzima beta-blokator, diuretik i lijekove za hiperplaziju prostate. Varfarin je odbio zbog čestih kontrola, otprije četiri mjeseca prestaje uzimati rivaroksaban zbog epistaksi i perindopril zbog niskog tlaka. Pacijentu se poveća doza diuretika, uvodi perindopril, upućuje se na laboratorijske pretrage krvi i urina te se preporuča OAT, koji odbija. Tijekom vi-kenda dolazi do pogoršanja stanja i odlazi u bolnicu. Iako je negirao smetnje mokrenja, utvrđuje se retencija urina zbog hiperplazije prostate s posljedičnom dilatacijom uretera i pogoršanjem bubrežne funkcije. Na kontrolnome pregledu LOM pacijentu i snahi u pratnji (medicinska sestra) predlaže OAT, prikladnim rječnikom objašnjene su dobrobiti i mogući rizici terapije. Pacijent zbog dosadašnjih loših iskustava i straha od nuspojava lijeka ne pristaje na OAT.

Zaključak: Smjernice su Europskoga kardiološkog društva za bolesnike s AF-om jasne i imaju visoku razinu dokaza. Preporučuju procjenu rizika od moždanog udara ili tromboembolije, a kod visokorizičnih pacijenata uvođenje OAT-a. Međutim, ponekad ih u svakodnevnoj praksi nije moguće primijeniti. Loša iskustva, život u udaljenom selu, kontrola terapijske doze ovisna o dolasku kućne njegе, otežan transport u laboratorij, neki su od razloga odbijanja terapije. S obzirom na holistički pristup, LOM uzima u obzir multimorbidnost pacijenta, socijalne uvjete, njegova uvjerenja i strahove, nesavršenost zdravstvenog sustava te na kraju, nakon pružanja informacija i davanja preporuke, s pacijentom postiže dogovor o liječenju.

Ključne riječi: smjernice, atrijksa fibrilacija, odluka o liječenju, liječnik obiteljske medicine

¹ Istarski domovi zdravlja, Labin

² Istarski domovi zdravlja, Žminj

Tamara Fable, Svetog Mikule 2, 52220 Labin, e-adresa: tamara.fable@gmail.com

ACCEPTING A PATIENT'S DECISION ABOUT A TREATMENT METHOD WHEN IT'S NOT IN AGREEMENT WITH MEDICAL GUIDELINES

Tamara Fable,¹ Karmela Bonassini²

ABSTRACT

Atrial fibrillation (AF) is the most common permanent cardiac rhythm disorder in the general population. An important factor is the risk of stroke, which is 5 times more frequent in people with AF. In order to prevent thromboembolism, the risk assessment guidelines are based on the CHA₂DS₂ VASc score and recommend the introduction of oral anticoagulant therapy (OAT) when the score is ≥ 1 for men and ≥ 2 for women. These guidelines have the level of evidence A, and they are confirmed in multiple randomized clinical trials or meta-analyses. The aim of this paper is to illustrate what to do if recommendations from the guidelines cannot be applied in practice, regardless of limiting circumstances, whether imposed by the patient, the physician or the health-care system.

Case report: The 84-year-old patient comes to the family physician (FP) for medical examination due to elevated arterial pressure and swelling of the lower legs for at least ten days. The patient is multimorbid (arterial hypertension, AF, prostate hyperplasia, perceptive hearing loss, blindness in one eye after cataract surgery). He lives alone and is cared for by his two sons and daughters-in-law. The examination finds elevated arterial pressure, pitting oedema in the lower leg, the rest of his physical status is not distinctive. For therapy, he uses beta-blockers, diuretics and medicines for prostate hyperplasia. He rejected the use of warfarin because of frequent controls, 4 months ago he stopped using rivaroxaban due to epistaxis and he stopped using perindopril due to low blood pressure. The patient's dose of diuretics is increased, perindopril is introduced and he is referred to laboratory blood and urine tests, OAT is recommended, which he refuses. During the weekend, the situation worsens and he has to be admitted to hospital. Although he denies urinary disturbances, urinary retention due to prostate hyperplasia, along with urethral dilatation and worsening of renal function is found. At the medical examination, the FP recommends OAT to the patient and the accompanying daughter-in-law (who is a nurse) and, using appropriate vocabulary, explains the benefits and potential risks of therapy. The patient refuses OAT due to previous bad experiences and fears of the side effects of the medicine.

Conclusion: The guidelines of the European Cardiac Society for AF patients are clear and have a high level of evidence. They recommended the assessment of the risks of stroke or thromboembolism, and the introduction of OAT in high-risk patients. However, sometimes the guidelines cannot be applied in everyday practice. Bad experiences with the medicine, living in a remote village, dependency on care at home, difficulties of transportation to the laboratory are some of the reasons for refusing therapy. With regard to the holistic approach, the FP takes into account the patient's multimorbidity, social conditions, beliefs and fears, imperfections in the health system, and finally, after providing information and giving recommendations to the patient, they reach an agreement on the treatment.

Key words: guidelines, atrial fibrillation, decisions for treatment, family physician

¹ Medical health centers of Istria, Labin

² Medical health centers of Istria, Žminj

Tamara Fable, Svetog Mikule 2, 52220 Labin, e-mail: tamara.fable@gmail.com

ACNES SINDROM – ČESTA DIJAGNOSTIČKA POGREŠKA

Nika Filipović,¹ Sara Haberle,¹
Stanislava Stojanović-Špehar^{2,3}

SAŽETAK

ACNES sindrom (*anterior cutaneous nerve entrapment syndrome*) kronični je bolni sindrom koji nastaje zbog uklještenja kutanih ogranača donjih torakoabdominalnih interkostalnih živaca u području lateralnog ruba mišića *rectus abdominis*. Ovaj sindrom najčešće se javlja kod mlađih žena, ali često i u dječjoj dobi te adolescenciji. Dijagnoza se temelji na anamnezi i detaljnijom kliničkom pregledu, a potvrđuje se aplikacijom lokalnog anestetika u *m. rectus abdominis*, koja značajno smanjuje ili uklanja bol. Pacijenti koji ne reagiraju na injekcije anestetika (često u kombinaciji s kortikosteroidima) liječe se kirurški.

Prikaz slučaja: Šesnaestogodišnja pacijentica, učenica, dolazi na hitni prijam zbog jake, oštре abdominalne боли u donjem desnom kvadrantu, koja se javila isti taj dan. Nakon kliničkog pregleda i abdominalnog ultrazvuka na kojem se vidjela zadebljana stijenka apendiksa postavljena je dijagnoza akutnog apendicitisa. No slijedom razvoja kliničke slike te nalaza laboratorijskih i radioloških pretraga nije bilo indikacija za operativno liječenje. Konzilijarno je bila ultrazvučno pregledana i od ginekologa, no nalaz je bio uredan. Tijek boravka na odjelu bio je uredan, uz parenteralnu nadoknadu tekućine i elektrolita pacijentica je bila dobrog općeg stanja, afebrilna, urednog apetita i stolice, bolovi su se smanjili. Sljedeći se dan na kontrolnom abdominalnom ultrazvuku video manji promjer apendiksa nego na dan primitka, a treći je dan apendiks bio fiziološke veličine za dob, te se pacijentica otpušta na kućnu njegu uz upute roditeljima. Pacijentica dolazi liječnici obiteljske medicine tri dana nakon otpusta iz bolnice zbog ponovnog javljanja boli u donjem desnom kvadrantu. Liječnica ju je nakon fizikalnog pregleda poslala na vađenje krvi i na konzilijarni pregled anesteziologu zbog sumnje na ACNES sindrom. Anesteziolog potvrđuje dijagnozu ACNES sindroma aplikacijom 40 mg 1 %-tnog lidokaina i 4 mg deksametazona u *m. rectus abdominis* u područje najjačih bolova pod kontrolom ultrazvuka. Nakon nekoliko minuta bolovi potpuno prolaze. Šest tjedana nakon prve injekcije pacijentica se ponovno javlja zbog jakih bolova, te ponovno prima blokadu.

Međutim, niti šest injekcija primljenih u tjedan dana nije u potpunosti suzbilo bol, te se kao konačno terapijsko rješenje planira operativni zahvat.

Zaključak: ACNES sindrom zbog relativne nepoznatosti često dovodi do velikih kašnjenja u postavljanju dijagnoze ili do pogrešnih dijagnoza što često rezultira nepotrebnim, invazivnim dijagnostičkim i terapijskim intervencijama. Stoga iz ovog prikaza slučaja možemo naučiti da ACNES sindrom treba isključiti kada god se javi pacijent s jakom i oštrom boli abdominalne stijenke, koja se pojačava prilikom naprezanja, pogotovo mlađe životne dobi.

Ključne riječi: ACNES sindrom, uklještenje, kronična abdominalna bol

¹ Medicinski fakultet Sveučilišta u Zagrebu

² Specijalistička ordinacija obiteljske medicine doc. dr. sc. Stanislava Stojanović-Špehar, spec. obiteljske medicine, Zagreb

³ Katedra za obiteljsku medicinu Medicinskog fakulteta Sveučilišta u Zagrebu,
Škola narodnog zdravlja „Andrija Štampar“

Nika Filipović, Mirkovečka ulica 29, 10 000 Zagreb, e-adresa: nikafilipovic07@gmail.com

ACNES SYNDROME - A COMMON DIAGNOSTIC MISTAKE

Nika Filipović,¹ Sara Haberle,¹
Stanislava Stojanović-Špehar^{2,3}

ABSTRACT

ACNES (anterior cutaneous nerve entrapment syndrome) is a chronic pain syndrome caused by the entrapment of the cutaneous branches of the lower thoracoabdominal intercostal nerves at the lateral border of the rectus abdominis muscle. Diagnosis is based on patient's history, physical examination and is confirmed by using an abdominal wall infiltration with a local anesthetic into rectus abdominis muscle which significantly reduces or eliminates pain. Patients who do not respond to anesthetic injections (often in combination with corticosteroids) are treated surgically.

Case report: A 16-year-old female patient, a student, came to emergency due to strong, sharp, abdominal pain in the lower right quadrant that occurred the same day. After a physical examination and an abdominal ultrasound, on which a thickening of the appendix wall was seen, an acute appendicitis was diagnosed. However, based on clinical condition, laboratory and radiological tests of the patient, there were no indications for surgical treatment. The patient was also examined by a gynaecologist and the ultrasound finding was normal. With parenteral fluid and electrolyte replacement the patient was in good general condition, afebrile, with good appetite and stool and the pain decreased. The following day, abdominal ultrasound showed a thinner appendix wall than the previous day and on the third day the appendix was normally sized for patient's age. The girl was then discharged from hospital and sent home. The patient came to her GP three days after the discharge because the pain in the lower right quadrant had returned. After the physical examination, the doctor sent her to an anaesthesiologist due to suspected ACNES syndrome. The anaesthesiologist confirmed the diagnosis of ACNES syndrome by administering 40 mg 1% lidocaine and 4 mg dexamethasone (ultrasound-guided) into the rectus abdominis muscle. Six weeks after the first injection, the patient came back because of severe pain and received the blockage again.

Six injections received in one week did not completely remove the pain and as a final therapeutic solution a surgical procedure was planned.

Conclusion: The relative unfamiliarity of ACNES syndrome often leads to significant diagnostic delays and misdiagnoses, often resulting in unnecessary, invasive diagnostic and therapeutic interventions. Therefore, from this case report we can learn that whenever a patient presents with strong and sharp abdominal wall pain, intensified during stomach tension, ACNES syndrome should be excluded.

Key words: ACNES syndrome, entrapment, chronic abdominal pain

¹ School of Medicine, University of Zagreb, Croatia

² GP office Stanislava Stojanović- Špehar GP/PhD

³ Department of Family medicine, University of Zagreb, School of Public Health „Andrija Štampar“

Nika Filipović, Mirkovečka ulica 29, Zagreb 10 000, nikafilipovic07@gmail.com

I STUDENTI SUDJELUJU U MEDICINSKOJ SKRBI – PRIKAZ SLUČAJA

Ana Gmajnić,¹ Nejra Bečarević,² Irma Huseinagić²

SAŽETAK

Obiteljska medicina po definiciji skrbi o pojedincu, sagledavajući ga u cjelini i u kontekstu društvene i socijalne okoline. U skrb uključuje sve čimbenike koji utječu na zdravlje i zdravo ponašanje.

Prikaz slučaja: U ambulantu dolaze roditelji dvadesetdvogodišnjeg pacijenta koji boluje od shizofrenije. Navode pogoršanje bolesti u smislu paranoičnih proganjanja demona i zvučnih halucinacija. U posljednje vrijeme odbija terapiju jer mu „glas odozgo“ govori da je štetna. Pacijent je u čekaonici, ali odbija pregled i bilo kakvu intervenciju. Posebice odbija hospitalizaciju pod bilo kojim uvjetima. Nije agresivan niti nasilan. Studenti Medicinskog fakulteta koji su u ordinaciji na praktičnim vježbama prepoznaju pacijenta kao mladića koji je povremeno u njihovu društvu u večernjim izlascima. Odlaze u čekaonicu, izdvajaju se od ostalih pacijenata i u prijateljskom razgovoru pokušavaju ga privoljeti na hospitalizaciju. Studenti primjenjuju naučene komunikacijske vještine i iskorištavaju osobno poznanstvo, te nakon dvadesetak minuta dogovore odlazak na psihijatrijsku kliniku. Studenti su u pratinji, prenose dežurnom psihijatru osnovne informacije, prezentiraju uputno pismo i rješavaju problem hospitalizacije na miran način.

Zaključak: Pri rješavanju problema i skrbi o pacijentima liječnik obiteljske medicine može i treba iskoristiti sve raspoložive resurse, pa i nazočnost studenata medicinskog fakulteta na praktičnim vježbama.

Ključne riječi: obiteljska medicina, studenti

¹ Medicinski Fakultet u Osijeku

² Medicinski Fakultet u Tuzli

STUDENTS PARTICIPATE IN MEDICINE CARE - CASE REPORT

Ana Gmajnić,¹ Nejra Bečarević,² Irma Huseinagić²

ABSTRACT

Family Medicine is, by definition, individual care of the whole patient including overcoming patients' social status and environment. This care includes all the factors affecting health and healthy behaviour.

Case report: Parents of a 22-year-old patient with schizophrenia are in the outpatient clinic. They report patient deterioration – paranoid persecutory auditory hallucinations. The patient has recently refused therapy because his “voice from above” tells him that it is harmful. The patient is in the waiting room, but refuses any examinations and interventions, especially hospitalization under any conditions. He is neither aggressive nor violent. Student trainees of the Faculty of Medicine recognize the patient as a young man who is occasionally in their company in the evenings out. They go to the waiting room and in a friendly conversation they try to get him hospitalized. Students use the acquired communication skills and personal approach and after about twenty minutes, the patient agrees to go to the psychiatric clinic. The patient is escorted, handed over to the psychiatrist with basic information and a referral letter and the problem of hospitalization is solved in a safe manner.

Conclusion: In solving problems and patient care, the family physician can and should use all available resources, including the attendance of medical students at practical exercises.

Keywords: Family Medicine, students

¹ Faculty of Medicine, Josip Juraj Strossmayer University of Osijek

² Faculty of Medicine University of Tuzla

NEURALGIJA TRIGEMINALNOG ŽIVCA – PRIKAZ SLUČAJA

Renata Grgurić,¹ Emanuela Ivković,¹ Rudika Gmajnić²

SAŽETAK

Trigeminalna neuralgija (TN) jest neuropatska orofacialna bol karakterizirana iznenadnim, obično jednostranim, jakim, kratkotrajnim, oštrim i ponavljajućim napadajima boli u području inervacije jedne ili više grana trigeminalnog živca (1). Dijeli se na klasičnu trigeminalnu neuralgiju (idiopatska ili uzrokovana vaskularnom kompresijom) i bolnu trigeminalnu neuropatiјu (postherpetična, posttraumska, uzrokovana demijelinizacijom ili tumorskim procesom) (2). Epizoda boli klasičnog TN-a najčešće traje nekoliko sekunda, maksimalno dvije minute, javlja se spontano ili stimulacijom suptilnim podražajem unutar inervacijskog područja trigeminusa s učestalošću od 1 do više od 50 napadaja na dan te mogućom kontinuiranom boli između napadaja (1). Karbamazepin ili okskarbazepin upotrebljavaju se kao prva linija liječenja klasičnog TN-a, dok se baklofen ili lamotrigin mogu upotrijebiti kao zamjenska ili dodatna terapija. Kod bolesnika koji ne reagiraju adekvatno na farmakoterapiju predlaže se neka od metoda operativnog liječenja: rizotomija, gama-nož ili mikrovaskularna dekomprezija (3). Liječenje neuralgije trigeminusa izazov je temeljen na individualnom pristupu bolesniku u cilju poboljšanja kvalitete njegova života, međutim uz često ograničavanje smjernicama HZZO-a nasuprot smjernicama stručnih društava.

Prikaz slučaja: Tridesetpetogodišnji bolesnik žali se na ponavljajuće, spontane napadaje boleva u desnom obrazu, sijevajućeg i probadajućeg karaktera, koji traju nekoliko sekunda, javljaju se više puta na dan i nekoliko puta na tjedan. Između paroksizama oštре boli osjeća tupu bol uz blago žarenje istog dijela lica. Pregledan je u neurološkoj, oftalmološkoj, otorinolaringološkoj i alergološkoj ambulanti. Stomatolog mu je izvadio desni gornji umnjak i uzimao je nesteroidne antireumatike, no bolovi se nisu smanjili. Osobna i obiteljska anamneza bez težih su bolesti. Bolesnik ima uredne fiziološke funkcije i klinički status. U neurološkom statusu javlja izmijenjen osjet na licu desno. Nalazi slikovnih, neurofizioloških i biokemijskih testova bili su uredni. Dijagnosticirana mu je idiopatska neuralgija trigeminusa. S obzirom na to da liječenje karbamazepinom 200 mg tbl. 2 x 1 dnevno nije smanjilo bolove, a bolesnik se prilikom uzimanja terapije žalio na mučninu i vrtoglavicu, neurolog mu je preporučio lamotrigin 100 mg tbl., koje mu u dozi 2 x 1 dnevno učinkovito kupiraju bol.

Zaključak: Dijagnoza idiopatske neuralgije trigeminusa postavljena je na temelju tipične kliničke slike uz prethodno učinjenu dijagnostičku obradu. Zbog nedovoljnog analgetskog učinka i razvoja nuspojava karbamazepin je zamijenjen lamotriginom u skladu sa smjernicama za liječenje neuralgije trigeminusa, no ne i u skladu sa smjernicama HZZO-a.

Ključne riječi: trigeminalna neuralgija, neuropatska bol, bol u licu, liječenje, karbamazepin, lamotrigin

¹ Dom zdravlja Osijek

² Medicinski fakultet u Osijeku

Izlagач: Renata Grgurić, dr. med.

Adresa za dopisivanje:

Dom zdravlja Osijek, Park kralja Petra Krešimira IV. 6, e-adresa: renata.grgurich@gmail.com

TRIGEMINAL NEURALGIA: CASE REPORT

Renata Grgurić,¹ Emanuela Ivković,¹ Rudika Gmajnić²

ABSTRACT

Trigeminal neuralgia (TN) is neuropathic orofacial pain characterized by sudden, usually unilateral, severe, brief, stabbing and recurring pain attacks in the area of the innervation of one or more branches of the trigeminal nerve (1). It is divided into classical trigeminal neuralgia (idiopathic or caused by vascular compression) and painful trigeminal neuropathy (postherpetic, post-traumatic, caused by demyelination or a tumor process) (2). The pain episode of classical TN usually lasts for a few seconds, maximum 2 minutes, and may occur spontaneously or stimulated by a subtle stimulus within the trigeminal innervation area with an incidence of 1 to more than 50 attacks per day and possible continuous pain between attacks (1). Carbamazepine or oxcarbazepine are used as the first line of treatment of classical TN whereas baclofen or lamotrigine can be used as substitute or additional therapy. To some patients who do not respond to pharmacotherapy adequately, some of the following operational treatment methods are suggested: rhizotomy, gamma-knife or microvascular decompression (3). Treatment of trigeminal neuralgia is a challenge based on the individual approach to the patient in order to improve the quality of his/her life, but is often limited by Croatian Health Insurance guidelines contrary to the guidelines of professional societies.

Case report: A 30-year-old patient complains about recurrent, spontaneous electric shock-like and stabbing pain attacks located in his right cheek that last for few seconds, occurring several times a day and several times a week. Between paroxysms of sharp pain, the patient feels a tense pain with the slight burning of the same part of his face. He is examined in the neurological, ophthalmological, otorhinolaryngological and alergological clinics. The dentist extracts his right upper wisdom tooth and the patient is prescribed nonsteroidal anti-inflammatory drugs, but they are not effective. Personal and family history are without any serious diseases. The patient has normal physiological functions and clinical status. During the neurological examination, the patient reports changed sensation on the right side of his face. The findings of radiology, neurophysiological and biochemical tests are normal. The patient is diagnosed with idiopathic neuralgia of the trigeminal nerve. Given that treatment with carbamazepine 200 mg tab. twice a day has not reduced pain, and the patient complained of nausea and dizziness while taking the therapy, the neurologist recommends lamotrigine 100 mg pills twice a day which relieves pain.

Conclusion: Diagnosis of idiopathic painful neuralgia is established based on typical clinical symptoms with previously performed diagnostic procedures. Due to insufficient analgesic effects and the development of side effects, carbamazepine is replaced with lamotrigine in accordance with trigeminal neuralgia treatment guidelines, but not in accordance with CHI guidelines.

Keywords: trigeminal neuralgia, neuropathic pain, facial pain, treatment, carbamazepine, lamotrigine

¹ Health Centre Osijek

² Faculty of Medicine, Josip Juraj Strossmayer University of Osijek

Presentation: Renata Grgurić, MD

Address for correspondence:

Dom zdravlja Osijek, Park kralja Petra Krešimira IV, 6, renata.grgurich@gmail.com

TIBOLA – RIJETKA INFECTIVNA BOLEST KAO IZAZOV LIJEĆNICIMA OBITELJSKE MEDICINE

Sara Haberle,¹ Nika Filipović,¹ Stanislava Stojanović-Špehar^{2,3}

SAŽETAK

Rikecije su unutarstanične gram-negativne bakterije koje se prenose putem vektora, kao što su krpelji, uši, grinje i buhe. Tibola (*tick-borne lymphadenopathy*) rijetka je infektivna bolest na području Republike Hrvatske koju uzrokuje *Rickettsia slovaca*, a očituje se simptomima poput eshare na mjestu uboda krpelja i regionalnom limfadenopatijom, dok su vrućica, glavobolja i osip puno rjedi. Dobro uzeta epidemiološka anamneza i klinička slika pomažu u dijagnosticiranju bolesti. Tibola se lijeći tetraciklinima, dok su ciprofloksacin i azitromicin moguća alternativa. Cilj je ovoga rada prikazati mogućnost zaraze rijetkom vrstom rikecije i senzibilizirati liječnike obiteljske medicine na dijagnozu tibile pri razvitku ove kliničke slike.

Prikaz slučaja: Desetogodišnji pacijent u pratnji majke dolazi u ordinaciju svog liječnika obiteljske medicine (LOM) zbog upaljenog grla i limfadenitisa retroaurikularno nakon ugriza krpelja dan prije u području skalpa. Na temelju anamneze i kliničke slike postavi se sumnja na streptokokni faringitis i Lyme borelioizu, uzme bris ždrijela i ordinira Amoksicilin sirup 3 x 450 mg tijekom tri tjedna. Nakon tri dana pacijent se javlja s vrućicom 37 °C, povećanim cervicalnim limfnim čvorovima i esharom, što sad pobuduje sumnju na rikeciju. Prisutnost eshare, odnosno ulceracije s crnim središtem u području ugriza i cervicalne limfadenopatije, ide u prilog tibile, zbog čega se pacijentu propiše Sumamed (Azitromicin), prvi dan 1 x 20 mg/kg, a sljedeća četiri dana 1 x 10 mg/kg. Pacijent je nakon tri dana terapije postao afebrilan, bez uvećanih limfnih čvorova, a ždrijelo je postalo potpuno mirno. Lokalni nalaz na glavi još je bio prisutan, ali u značajnijoj regresiji. LOM izdaje uputnicu za serologiju i upućuje na pregled specijalistu infektologije koji potvrđuje dijagnozu rijetke infektivne bolesti uzrokovane *Rikecijom slovacii*, tibile.

Zaključak: Klinička slika desetogodišnjeg pacijenta u početku se preklapala sa streptokoknom bolesti i Lyme borelioizom. Tipičan lokalni nalaz nekrotičnog ulkusa na skalpu, te cervicalne limfadenopatije doveo je do postavljanja, a kasnije i potvrde dijagnoze tibile. Ovaj slučaj pokazao je kako se netipične i rijetke infektivne bolesti mogu pojavit u ordinaciji LOM-a, a sumnja na njih i pravodobna dijagnoza dovode do kraćeg trajanja bolesti i bržeg ozdravljenja pacijenata.

Ključne riječi: Rikecija, tibola, liječnik obiteljske medicine

¹ Medicinski fakultet Sveučilišta u Zagrebu

² Ordinacija opće medicine Stanislava Stojanović-Špehar, Zagreb

³ Katedra za obiteljsku medicinu, Medicinski fakultet Sveučilišta u Zagrebu,
Škola narodnog zdravlja „Andrija Štampar“

Sara Haberle, Subotička 28, 10 000 Zagreb, e-adresa: haberle.sara@gmail.com

TIBOLA - RARE INFECTIOUS DISEASE AS A CHALLENGE TO THE FAMILY PHYSICIAN

Sara Haberle,¹ Nika Filipović,¹ Stanislava Stojanović-Špehar^{2,3}

ABSTRACT

The rickettsiae are intracellular gram-negative bacteria transmitted through vectors such as ticks, lice, mites and fleas. TIBOLA (tick-borne lymphadenopathy) is a rare infectious disease caused by *Rickettsia slovaca* and seen in the Republic of Croatia. It commonly manifests clinically as an eschar at the vector injection site and regional lymphadenopathy. Fever, malaise and/or rash are less common features. Focused history taking and clinical examination can lead to correct disease recognition. Tetracycline is the antibiotic of first choice while ciprofloxacin/ azithromycin are considered effective alternatives. This paper aims to present a rare infectious disease and sensitize family physicians to its clinical features.

Case report: A 10-year-old patient, accompanied by his mother, comes to the family physicians office complaining of pharyngitis and retroauricular lymphadenitis after being bitten on the scalp by a tick the previous day. Based on the patient's medical history and clinical features, the family physician suspects streptococcal pharyngitis or Lyme disease. A pharyngeal swab is taken for bacterial culture and antibiotic therapy is initiated (Amoxicillin syrup 3x450 mg for 3 weeks). Three days later the patient presents with temperature (37°C), increased cervical lymphadenopathy and eschar. This clinical constellation with marked eschar, ulceration with a black center in the bite area, suggests an infection with *Rickettsia slovaca* (TIBOLA) and proper antibiotic therapy with Azithromycin is initiated (Day 1: 1 x 20 mg/kg, Day 2-5: 1 x 10 mg/kg). After 3 days of antibiotic therapy, the patient is afebrile with complete regression of his lymphadenopathy and throat pain. The skin changes on his head are still present, but with significant regression. The patient is referred to an infectious disease specialist and the diagnosis of TIBOLA is confirmed via serology.

Conclusion: The clinical features of the 10 year-old patient initially overlapped with a common streptococcal pharyngitis or Lyme borreliosis. The typical findings of a necrotic ulcer and cervical lymphadenopathy led to the suspicion of TIBOLA and its subsequent serological diagnosis. This case shows how rare infectious diseases may present even in the office of the family physician, where clinical acumen and early initiation of antibiotic therapy can shorten disease duration and reduce its severity.

Keywords: *Rickettsia*, TIBOLA, family physician

¹ University of Zagreb School of Medicine

² GP Office Stanislava Stojanović – Špehar GP/PhD

³ Department of Family Medicine, University of Zagreb School of Medicine, School of Public Health "Andrija Štampar"

Sara Haberle, Subotička 28, 10 000 Zagreb, haberle.sara@gmail.com

PFAPA SINDROM – LIJEČIMO LI GA PRAVILNO?

Helena Hrkač,¹ Stanislava Stojanović-Špehar^{2,3}

SAŽETAK

PFAPA (periodična vrućica, adenitis, faringitis i aftozni stomatitis) sindrom je nepoznate etiologije, a karakteriziran je periodičnim javljanjem vrućice u trajanju od tri do šest dana uz koju se javlja oticanje limfnih čvorova na vratu, upala ždrijela, tonzila i/ili afte u ustima. Praćena je po-rastom upalnih parametara sedimentacije i CRP-a, ali ne i prokalcitonina. Javlja se do pete godine života i obično prestaje u adolescenciji. Terapija je simptomatska i kortikosteroidna (prednizolon 0,5 – 2 mg/kg). U pojedinim slučajevima preporučuje se tonzilektomija. U razdobljima između epizoda, djeca dobrog zdravlja i urednog razvoja.

Prikaz slučaja: Dječak u dobi od tri godine pregledan na Klinici za infektološke bolesti zbog febrilnosti i grlobolje koja traje 24 sata. Temperatura mjerena u uhu iznosi do 39,5°, žali se na grlobolju i slabije jede. Prije sedam tjedana bio je hospitaliziran na Klinici zbog tonsilitisa. U kliničkom nalazu dominira vrućica od 39°, hiperemične tonzile obložene sekretom, u vestibulumu usne šupljine afte. Ostali nalaz bez osobitosti. U laboratorijskom nalazu povišeni upalni parametri, CRP 100 mg/dL. Učinjenom mikrobiološkom obradom nije nađen uzročnik, te se kod pacijenta postavlja sumnja na PFAPA sindrom zbog ponovljenih epizoda vrućice i faringitisa bez dokazanog infektivnog uzročnika. U terapiju se uvodi paracetamol, ibuprofen, ceftriakson i solu-medrol. Navedenu terapiju pacijent prima u dnevnoj bolnici. Nakon primjene solu-medrola dolazi do pada temperature, sljedećeg dana na kontrolnom pregledu primio ceftriakson i antipiretik, trećeg dana bolesti klinički nalaz u znatnom poboljšanju, te se nastavlja sa simptomatskim liječenjem.

Zaključak: Dječak trenutačno u dobi od pet godina, posljednje dvije respiratorne infekcije liječene simptomatski kao nekomplikirana respiratorna infekcija. Pregledan i liječen po doktoru obiteljske medicine. Više nema visokofebrilne epizode praćene porastom CRP-a, a bez dokazanog mikrobiološkog uzročnika. Na PFAPA sindrom treba pomisliti kad liječimo dijete s rekurentnim vrućicama s kliničkom slikom oteklih tonzila, faringitisa, limfnih čvorova i/ili stomatitisa kod kojeg nismo pronašli uzročnika. Budući da se dijagnoza PFAPA sindroma postavlja na temelju kliničke slike, anamneze i isključivanja ostalih uzročnika bolesti, poznavanje pacijenta i mogućnost praćenja epidemiske anamneze ključna je prednost obiteljskog liječnika.

Ključne riječi: PFAPA, adenitis, kortikosteroidi

¹ Dom zdravlja Đakovo

² Ordinacija opće medicine Stanislava Stojanović-Špehar, Zagreb

³ Katedra za obiteljsku medicinu, Medicinski fakultet Sveučilišta u Zagrebu,
Škola narodnog zdravlja „Andrija Štampar“

Helena Hrkač, Voltino 44, 10 000 Zagreb, e-adresa: helena.hrkac@gmail.com

PFAPA SYNDROME

Helena Hrkač,¹ Stanislava Stojanović-Špehar^{2,3}

ABSTRACT

PFAPA syndrome (periodic fevers with aphthous stomatitis, pharyngitis, and adenitis) is a periodic fever syndrome with undefined aetiology and pathophysiology. It is characterised with periodic fever, lasting 3 to 6 days, pharyngitis, aphthous stomatitis, and adenopathy. Laboratory values of inflammatory parameters, sedimentation and CRP, are elevated, but procalcitonin is not. It is typically manifested by the age of 5 and spontaneously disappears by adolescence. Treatment is symptomatic and glucocorticoids (prednisolon 0,5-2 mg/kg), and in some cases tonsillectomy is recommended. Between episodes patients are in good health and have a normal growth.

Case report: A boy at the age of 3 is examined at the Clinic for infectious disease due to severe fever and sore throat lasting for 24 hours. The temperature measured in the ear is up to 39.5°, he complains of sore throat and poor appetite. Seven weeks before that, he was hospitalized for infectious disease due to tonsillitis. The clinical findings are dominated by fever of 39 °, swollen red tonsils covered with secretions and aphtous ulcers in the vestibulum of the oral cavity. Other findings are without peculiarities. There are elevated inflammatory parameters in the lab, CRP 100 mg/dL. No microbiological agent is found. The patient is suspected of PFAPA syndrome due to the repeated episodes of fever and pharyngitis without a proven infectious agent. Therapy consists of paracetamol, ibuprofen, ceftriaxone and solu-medrol. The patient receives therapy through the Day Hospital. After the application of solu-medrole his temperature drops. The follow up visit is the next day when ceftriaxone and antipyretic are administered. The third day of the disease the clinical findings are significantly improved and therapy continues with symptomatic treatment.

Conclusion: A boy currently at the age of 5, the previous two respiratory infections were treated symptomatically as uncomplicated respiratory infection. He is treated by the family physician. There are no longer high fever episodes followed by CRP growth without a proven microbiological agent. PFAPA syndrome should be considered when treating a child with recurrent fever and a clinical presentation of swollen tonsils, pharyngitis, lymph nodes and / or stomatitis without a known cause. Since the diagnosis of PFAPA syndrome is based on the clinical manifestation, anamnesis and exclusion of other pathogens, the role of the family physician is important because of the knowledge s/he has about the patient and the family epidemic anamnesis.

Key words: PFAPA, adenitis, corticosteroid

¹ Health Center Đakovo

² GP office MD Stanislava Stojanović- Špehar GP/PhD

³ Department of Family medicine, University of Zagreb, School of Public Health „Andrija Štampar“

DESET GODINA ZABLUDJE – PRIKAZ SLUČAJA

Klara Jermen,¹ Andrea Baćac,¹ Jasna Vučak²

SAŽETAK

Prema smjernicama Europskoga kardiološkog društva (ESC) iz 2017. za liječenje periferne arterijske bolesti, nakon ugradnje prostetičke premosnice na arterijama donjih ekstremiteta, preporuka je monoterapija acetilsalicilnom kiselinom (ASK) 75 mg – 100 mg ili kombinirana terapija ASK s dipiridamolom/klopodogrelom u trajanju najmanje mjesec dana do najdulje dvanaest mjeseci (razina preporuke I, razina dokaza A). Nakon ugradnje venskog autolognog grafta na arterijama donjih ekstremiteta preporuka je kombinacija ASK-a s varfarinom (razina preporuke IIb, razina dokaza B). Prohodnost venskog autolognog grafta jednaka je na monoterapiji ASK i na dualnoj terapiji ASK s varfarinom. Cilj: Prikazati smjernice provođenja antikoagulacijske i antiagregacijske terapije kod uznapredovale periferne arterijske bolesti.

Prikaz slučaja: Umirovljeni montažer na brodskim poslovima, u dobi 64 godine, bivši pušač (60 pack-years), bez tegoba s urednim kliničkim statusom, osim postoperativnih ožiljaka na objema potkoljenicama. Arterijski tlak je 135/80, TV 187, TT 102, BMI 32. Boluje od generalizirane ateroskleroze, mješovite dislipidemije i hiperplazije prostate. U kroničnoj terapiji ima fenofibrat 145 mg/simvastatin 40 mg i tamsulozin 0,4 mg. Prije dvanaest godina ugrađen mu je protetički graft na arteriji lijeve potkoljenice zbog aneurizme poplitealne arterije, te mu je uvedena antikoagulantna terapija varfarinom. Odmah po ugradnji došlo je do embolizacije grafta, kada je bolnički liječen radi rekanalizacije premosnice. Otprije četiri godine ponovno se javlja zbog sličnih smetnji desne noge. Obradom je nađena stenoza poplitealne arterije, te je ugrađena protetička premosnica i na desnoj nozi. Po otpustu iz bolnice nastavljena je terapija varfarinom. Tritiranje antikoagulantne terapije vodio je transfuziolog do unatrag četiri godine, kad je tritiranje doze varfarina postalo nadležnost liječnika obiteljske medicine. Suradljivost pacijenta cijelo je vrijeme loša jer se pacijent često nije pojavljavao na kontrolnim pregledima i nije se pridržavao dijeti s obzirom na moguće interakcije lijeka s hranom, tako da su vrijednosti INR-a bile uglavnom izvan preporučenih. Unatrag mjesec dana ukinuta mu je terapija Martefarinom radi vrlo niskog rizika od VTE-a te je uvedena antiagregacijska terapija ASK 100 mg.

Zaključak: Različiti su uzročno-posljetični mehanizmi koji dovode do tromboembolijskih incidenata u arterijskoj i venskoj cirkulaciji, a procjenjuju se općeprihvaćenim ljestvincama: SCORE rizik, Caprini, Padua ljestvice, CHADS2-VASc score kod kronične fibrilacije atrija. Pacijent je jedanaest godina bio na antikoagulantnoj terapiji, dok je prema ESC smjernicama trebao biti samo na antiagregacijskoj terapiji ASK 100 mg. U navedenom primjeru izostao je holistički pristup u procjeni rizika od tromboembolijskih incidenata nakon ugradnje premosnice na potkoljeničnim arterijama.

Ključne riječi: periferna arterijska bolest, premosnica poplitealne arterije, antiagregacijska terapija

¹ Dom zdravlja Zadar

² Specijalistička ordinacija obiteljske medicine Jasna Vučak

Adresa za dopisivanje: clare.jermen@yahoo.com

10 YEARS OF MISAPPREHENSION

Klara Jermen,¹ Andrea Baćac,¹ Jasna Vučak²

ABSTRACT

According to the guidelines of the European Cardiology Society (ESC) of 2017 on the treatment of peripheral arterial disease, following the implantation of the prosthetic bypass at the lower extremities, the recommendation is monotherapy acetylsalicylic acid (ASK) 75mg-100mg or combination therapy with dipyridamole / clopidogrel for at least one to no longer than twelve months (recommendation level I, level of evidence A). After the implantation of an autogenous vein bypass on the lower extremities, the recommendation is a combination of ASK with warfarin (recommendation level IIb, level of evidence B). The patency rate is equal with ASK monotherapy and with dual therapy of ASK with warfarin.

Objective: To show guidelines for anticoagulant and antiplatelet/antithrombotic therapy in advanced peripheral arterial disease.

Case report: A retired shipboard installer aged 64, a former smoker (60 pack-years) without any serious medical condition so far, clinically compensated, with visible postoperative scars on both lower legs. Artery pressure is 135/80, BH 187 cm, BM 102 kg, BMI 32. He has a history of generalized atherosclerosis, mixed dyslipidemia with hyperplasia of prostate. Chronic therapy fenofibrate 145mg / simvastatin 40mg and tamsulosin 0.4mg. Twelve years ago, a prosthetic bypass was implanted into the aneurysm of popliteal artery on his left leg and then an anticoagulant therapy was introduced. Immediately upon implantation, there was an embolisation of the graft and he was hospitalized for surgical recanalization. After 4 years similar symptoms occurred on his right leg. The stenosis of the right popliteal artery was found and the patient had another bypass implantation. After his release from hospital, warfarin therapy was continued. The titration of anticoagulant therapy was conducted by the transfuziologist up to 4 years ago, when the same was transferred to the general practitioner. Patient's adherence was bad all the time because he often missed checkups. Due to possible drug interactions, INR values were largely out of range. A month ago his anticoagulant therapy was discontinued due to a very low risk of VTE and the antiplatelet therapy of ASK 100mg was introduced.

Conclusion: Various causal and consequential mechanisms lead to thromboembolic incidences in arterial and venous circulation. They are evaluated by generally accepted scales: SCORE risk, Caprini, Padua scale, CHADS-Vas score in chronic atrial fibrillation. The patient was on anticoagulant therapy for 11 years, while according to guidelines of ESC he should only have been on antithrombotic therapy with ASA 100mg. In the mentioned example, there was no holistic approach in the assessment of the risk of thromboembolic incidents after the implantation of bypass in his lower extremities.

Keywords: peripheral arterial disease, bypass of the popliteal artery, antithrombotic therapy

¹ Health Center Zadar

² GP Office Jasna Vučak , GP PhD

PRIKAZ PACIJENTA S PANDAS SINDROMOM

Josipa Knežević,¹ Martina Vuknić,¹ Martina Rikert,¹
Sanda Pribić,^{2,3} Rudika Gmajnić^{2,3}

SAŽETAK

PANDAS sindrom (*pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections*) stanje je koje se opisuje kao tikovi i/ili opsivno komplizivni poremećaji u predisponirane djece, a povezuju se s autoimunim poremećajem bazalnih ganglija pokrenutih BHS-A-om. O PANDAS sindromu treba razmišljati u djece koja su imala streptokoknu infekciju, uz dokaz pozitivnih protutijela na antistreptolizin O (ASO) i anti DNA-aze, te potom razvila opsivno komplizivni poremećaj i/ili tikove s epizodnom pojavnostu.

Prikaz slučaja: Dječak u dobi od deset godina, živi s roditeljima, dvije starije sestre i mlađim bratom. Novorođenački i dojenački period uredni, kao i rani razvoj, osim zakašnjelog govora oko treće godine. Osim učestalih gnojnih angina, zbog kojih je liječen antibiotski, te u konačnici i tonzilektomiran, nije teže bolovao. Obiteljska anamneza bez neuroloških bolesti. Otprije godinu i pol roditelji primijetili pojavu tikova, prvo kao pucketanje prstima, potom tikiranje usnama, s kratkom stankom od dva mjeseca, te ponovnom pojavom jačeg intenziteta, kao mirisanje ruku, skakutanje, otvaranje usta, podizanje obrva, gledanje u stranu i ekstenziju šaka. Zbog sumnje na PANDAS sindrom dječak je pregledan i praćen po neuropeđijatu, infektologu, imunologu, psihologu, reumatologu, endokrinologu, kardiologu i oftalmologu. Po infektologu liječen je Klimicinom i Penicilinom G te je primao Extencillin 1 200 000 jj. i. m. Dječak je tri puta hospitaliziran na Odjelu neuropeđijatrije KBC Osijek radi provođenja terapije humanim imunoglobulinima, u trajanju od dva dana, u ukupnoj dozi od 50 g, bez komplikacija. Odlučeno je provoditi terapiju imunoglobulinima duži vremenski period kako bi se procijenio eventualni učinak same terapije. Također je savjetovano u sljedećoj fazi pogoršanja dati ibuprofen u dozi 2 x 300 mg nakon obroka.

Zaključak: Lijek izbora u liječenju PANDAS sindroma su antibiotici: penicilini ili klindamycin. Ako antibiotska terapija ne rezultira poboljšanjem, primjenjuju se imunoglobulini, kortikosteroidi i plazmafereza. S obzirom na to da se učinak terapije imunoglobulinima može procijeniti nakon dužeg razdoblja, potrebno ju je provoditi i dalje te pratiti stanje dječaka.

Ključne riječi: tikovi, streptokok, autoimune bolesti, imunoglobulini

¹ Dom zdravlja Osijek

² Katedra za internu medicinu, obiteljsku medicinu i povijest medicine Medicinskog fakulteta u Osijeku

³ Privatna specijalistička ordinacija obiteljske medicine

Izlagač: Josipa Knežević, Psunjska 54, 31 431 Čepin, e-adresa: josipa.knezevic0306@gmail.com

CASE REPORT OF MALE PATIENT WITH PANDAS SYNDROME

Josipa Knežević,¹ Martina Vuknić,¹ Martina Rikert,¹
Sanda Pribić,^{2,3} Rudika Gmajnić^{2,3}

ABSTRACT

PANDAS syndrome (paediatric autoimmune neuropsychiatric disorders associated with streptococcal infections) is a condition in which tics and/or obsessive-compulsive disorders in predisposed children have been associated with autoimmune disorders of basal ganglia initiated by the BHS-A. PANDAS syndrome should be considered in children who had a streptococcal infection, with the evidence of positive antibodies antistreptolysin (ASO) and anti-DNA, and who later on develop an obsessive compulsive disorder and/or tics with episodic manifestations.

Case report: The patient is a 10-year-old boy, living with his parents, 2 older sisters and a younger brother. The newborn and infant period, as well as the early developmental period were without any problems, except for delayed speech development occurring around the age of 3. Besides frequent strep throat, which were treated with antibiotics, and eventually led to tonsillectomy, he is a healthy child. Family history is without any neurological diseases. Around 1.5 years ago, his parents noticed tics, first as finger crackling and then lip movements. After a short pause of 2 months, tics reappeared stronger in intensity, as smelling his hands, jumping, mouth opening, raising eyebrows, looking aside and the hands extension. In suspicion of PANDAS syndrome the boy was examined and treated by the neuropaediatrician, infectologist, immunologist, psychologist, rheumatologist, endocrinologist, cardiologist and ophthalmologist. At the Department of infectology the boy was treated with clindamycin, penicillin G and Extencillin 1 200 000 i.u. He was hospitalized 3 times at the Neuropaediatric department in Osijek for treatment with human immunoglobulin in the total dose of 50g, during 2 days, without complications. It has been decided to conduct the immunoglobulin therapy for a longer period of time to estimate the effect of the therapy. It is also advised to administer ibuprofen 2x300g after meals in the next exacerbation of symptoms.

Conclusion: The medicine of choice in the treatment of PANDAS syndrome is an antibiotic: clindamycin or penicillin. If the antibiotic treatment proves ineffective, immunoglobulin, corticosteroids and plasmapheresis can be applied. Considering that the effect of immunoglobulin therapy can be estimated after a certain period of time, in this case it is advised to proceed with the initiated therapy and follow up the boy's health status.

Key words: tics, streptococcus, autoimmune diseases, immunoglobulin

¹ Health Center Osijek

² Department of internal medicine, family medicine and history of medicine, Faculty of Medicine, Josip Juraj Strossmayer University of Osijek

³ Family medicine private practice

Presenter:

Josipa Knežević, Psunjska 54, 31 431 Čepin, josipa.knezevic0306@gmail.com

VAŽNOST PREPOZNAVANJA I PRIJAVA NUSPOJAVA

Merhunisa Kočo,¹ Ivančica Peček^{1,2}

SAŽETAK

Nuspojava je svaka štetna i neželjena reakcija na lijek uključujući štetne i neželjene učinke koji su posljedica medikacijskih pogrešaka te primjene lijeka izvan uvjeta odobrenja, pogrešne uporabe i zlouporabe lijeka. Prepoznavanje i prijava sumnje na nuspojave lijekova veoma su važne te mogu pridonijeti sigurnijoj primjeni lijekova, a zdravstveni djelatnici, posebice liječnici i ljekarnici, najčešće su u prilici uočiti ih te potom pisano izvijestiti Hrvatsku agenciju za lijekove i medicinske proizvode, a u slučaju cijepiva Hrvatski zavod za javno zdravstvo. Tijekom 2017. godine HALMED je zaprimio ukupno 3840 prijava sumnji na nuspojave lijekova u Republici Hrvatskoj. Ukupni broj prijava bio je za 10 % veći u odnosu na 2016. godinu. Najveći udio prijava zaprimljen je od liječnika. Najveći broj nuspojava u 2017. godini zabilježen je za organski sustav *poremećaji probavnog sustava*.

Prikaz slučaja: Šezdesetdevetogodišnja pacijentica s arterijskom hipertenzijom pregledana je na hitnom priјmu zbog gubitka svijesti. Tijekom hospitalizacije učinjena je kompletna kardiološka obrada. Na učinjenom transtorakalnom ehokardiografskom pregledu prikazana je kalcificirana trikuspidna aortna valvula s teškom aortnom stenozom i očuvanom sistoličkom funkcijom lijeve klijetke. Obavljenom koronarografijom isključena je koronarna bolest te je indiciran hitni zahvat zamjene aortne valvule. Postoperativni tijek protekao je uredno, te se pacijentica otpušta na kućnu njegu s terapijom bisoprolol 2,5 mg, furosemid 40 mg, lerkanidipin 10 mg, pantoprazol 40 mg, urapidil 2 x 30 mg, varfarin 3 mg. Nakon operacije pacijentica dolazi u ordinaciju svog liječnika obiteljske medicine (LOM) i navodi da ima tegobe u smislu strahova, znojenja i nemira. Depresivnog je raspoloženja i paranoidnog razmišljanja. LOM ju na temelju anamneze upućuje na konzilijski pregled kardiologu zbog sumnje na nuspojavu lijekova. Kardiolog potvrđuje da je riječ o vrlo rijetkim nuspojavama ebrantila i mijenja terapiju. U sljedećim kontrolama pacijentica subjektivno bez tegoba, a LOM je prijavio sumnju na nuspojave lijeka Hrvatskoj agenciji za lijekove i medicinske proizvode.

Zaključak: Broj prijava nuspojava lijekova kontinuirano raste tijekom posljednjih godina, što upućuje na sve veću svijest o važnosti prijavljivanja nuspojava. Praćenjem nuspojava pacijentima se neprekidno osiguravaju kvalitetni i sigurni lijekovi te im se pruža bolja skrb.

Ključne riječi: nuspojava, lijek, HALMED, sigurnost pacijenta

¹ Dom zdravlja Zagreb-Zapad

² Katedra za obiteljsku medicinu, Medicinski fakultet Sveučilišta u Zagrebu,
Škola narodnog zdravlja „Andrija Štampar“

THE IMPORTANCE OF DETECTING AND REPORTING ADVERSE DRUG REACTION

Merhunisa Kočo,¹ Ivančica Peček^{1,2}

ABSTRACT

An adverse drug reaction (ADR) is very harmful and presents as unintended reactions, adverse and undesirable effects resulting from medication errors and administration of the drug outside the conditions for which the product was approved, including drug misuse and abuse. Each case report contributes to the patient safety. Healthcare professionals, particularly doctors and pharmacists, have opportunities to identify and are obliged to report any suspected ADRs. The Croatian Agency for Medicinal products and Medical Devices, and the Croatian Institute for Public Health, if vaccines are involved, need to be informed of the reports. During 2017 Halmed received a total of 3840 case reports for suspected ADR in the Republic of Croatia. The total number of case reports is 10% higher in 2017 than in 2016. Gastrointestinal tract is the most frequently involved organ system in 2017.

Case report: A 69-year old patient with arterial hypertension comes to emergency due to loss of consciousness. A transthoracic echocardiography examination shows ample calcification in the tricuspid aortic valve with severe aortic stenosis and a preserved left ventricular systolic function. Coronary angiography excludes coronary disease. An emergency surgical procedure is indicated in order to replace the aortic valve. The patient is discharged with therapy bisoprolol 2.5 mg, furosemid 40 mg, lercanidipin 10 mg, pantoprazol 40 mg, urapidil 2x30 mg, varfarin 3 mg. After hospital discharge the patient comes to her GP. She complains of excessive sweating, sleeplessness and irrational fears. She is feeling depressed and has paranoid thoughts. Based on the patient's medical history, the doctor sends her to the cardiologist due to suspected ADR. The cardiologist confirms very rare adverse effects of ebrantil and changes her therapy. In the later follow-up the patient reports no subjective difficulties. GP doctor reports suspected ADRs to the Croatian Agency for Medicinal products and Medical Devices.

Conclusion: The number of reported ADRs has been increasing over the last few years which indicates the rising awareness of the importance of reporting such cases. By continuously monitoring the ADRs, patients are provided with safe and high-quality medicaments thus granting the best possible treatment.

Keywords: adverse drug reaction (ADR), medicament, HALMED, patient safety

¹ Health Center Zagreb – West

² Department of Family Medicine, University of Zagreb School of Medicine, School of Public Health “Andrija Štampar”

NOVE SMJERNICE I „STARA“ SURADLJIVOST

Maja Kolega,¹ Jelena Buljat Mioković,¹ Iva Klara Milovac,¹
Mirjana Petrić,¹ Manuela Tomčić²

SAŽETAK

Godine 2019. objavljene su nove GOLD smjernice za liječenje i praćenje KOPB-a. Smjernice donose promjene u inicijalnom liječenju pacijenata s KOPB-om, ali i pri praćenju i liječenju ranije dijagnosticiranih pacijenata s KOPB-om. Algoritam praćenja farmakološkog liječenja može se primijeniti na sve pacijente koji uzimaju održavajuću terapiju za KOPB, bez obzira na GOLD skupinu određenu inicijalno. Za evaluaciju uspješnosti liječenja treba procijeniti potrebu za liječenjem primarno dispneje ili prevenciju egzacerbacija. Cilj je ovoga prikaza slučaja predočiti što nove smjernice nose u reviziji terapije pacijenta s KOPB-om te kako suradljivost utječe na liječenje.

Prikaz slučaja: Pacijent P. B., rođen 1945., neoženjen, umirovljenik, iz ruralne sredine, rijetko posjećuje ordinaciju obiteljskog liječnika. Lijeći se od arterijske hipertenzije, ima izrazitu kifoskoliozu torakalne kralježnice, pušač. Od siječnja 2016. lijeći se od KOPB-a (GOLD 4D), a u travnju iste godine uveden je LTOT (*Long-term oxygen therapy*). U kroničnoj terapiji uzima amlodipin 5 mg, budezonid/formoterol 320 mcg/9 mcg, umeklidinij bromid 55 mcg, teofilin 350 mg i LTOT (18 h/dan). Do studenoga 2018. imao je dvije egzacerbacije i jednu hospitalizaciju. Zadnja egzacerbacija (ožujak 2018.) manifestirala se febrilnošću i pogoršanjem dispneje uz obilan purulentni iskašljaj. Učinjenom spirometrijom (FEV1 45 %, FVC 46) i laboratorijskom analizom krvi (leukociti $10 \times 10^9/L$, segmentirani neutrofili 75 %, CRP 138 mg/L) uveden je azitromicin 500 mg 1×1 kroz 3 dana, nakon čega dolazi do smirivanja tegoba. Na kontrolnom pregledu pulmologa (svibanj 2018.) učinjena je revizija kronične terapije, te se uvodi beklomezon/formoterol/glikopironij bromid 87 mcg/5 mcg/9 mcg. Na kontroli u ambulantni obiteljske medicine (studeni 2018.) navodi da bolje podnosi napor uz poboljšan spirometrijski nalaz (FEV1 63 %, FVC 77).

Zaključak: Kod pacijenata s perzistentnim egzacerbacijama kombinirana terapija inhalacijskog kortikosteroida i dualne bronchodilatatorne terapije reducira pojavnost akutnih egzacerbacija te usporava gubitak plućne funkcije. Pacijenti s razinom eozinofila u krvi (> 300 eozinofil/ μL krvi) imaju bolji odgovor na ICS. U ovom prikazu možemo vidjeti kako je osim smjernica bitna i suradljivost pacijenta jer nakon što je uvedena olakšana shema doziranja, dolazi do poboljšanja pacijentova stanja. Egzacerbacije su najčešće uzrokovane *Streptococcus pneumoniae*, *Moraxella catarrhalis* ili *Haemophilus influenzae*, stoga su antibiotici prvog izbora beta-laktami ili makrolidi.

Ključne riječi: kronična opstruktivna plućna bolest, smjernice, suradljivost

¹ Dom zdravlja Zadarske županije

² Specijalistička ordinacija obiteljske medicine Manuela Tomčić

Jelena Buljat Mioković, Molatska ulica 11, Zadar, e-adresa: majakolega27@gmail.com

THE NEW GUIDELINES AND THE ‘OLD’ COMPLIANCE

Maja Kolega,¹ Jelena Buljat Mioković,¹ Iva Klara Milovac,¹
Mirjana Petrić,¹ Manuela Tomčić²

ABSTRACT

In 2019, the GOLD initiative published new guidelines for the treatment and monitoring of COPD. The guidelines bring changes in the initial treatment of patients with COPD, but also in the monitoring and treatment of previously diagnosed patients with COPD. The pharmacological treatment tracking algorithm can be applied to all patients taking maintenance therapy for COPD, regardless of the initially determined GOLD group. To evaluate the effectiveness of treatment, it is necessary to assess the need for the treatment of primary dyspnoea or for the prevention of exacerbations. The aim of this case report is to illustrate which new guidelines are included in the revision of COPD patients therapy and how patient compliance affects therapy.

Case Report: Patient P. B., born in 1945, unmarried, retired, from the rural environment, rarely visits the doctor's office. He is a smoker, suffers from arterial hypertension, severe kyphoscoliosis of the thoracic spine. Since January 2016, he has been diagnosed with COPD (GOLD 4D), and LTOT (Long-Term Oxygen Therapy) was introduced in April the same year. His chronic therapy is amlodipine 5 mg, budesonide/formoterol 320 mcg /9 mcg, umeclidinium bromide 55 mcg, theophylline 350 mg and LTOT (18 h / day). By November 2018 he had two exacerbations and one hospitalization. The last exacerbation (March 2018) presented with fever and worsening of dyspnea with an abundant purulent orifice. After spirometry (FEV1 45%, FVC 46) and laboratory blood tests (leukocytes 10x10e9 / L, segmented neutrophils 75%, CRP 138 mg / L). he was prescribed azithromycin 500 mg 1x1 for 3 days, after which the symptoms alleviated. In May 2018, the pulmonologist reviewed his chronic treatment, and beclomezone/formoterol/glycopyrionone bromide 87mcg/5mcg/9mcg was introduced. In November 2018, visiting his family physician, the patient said he was better, with an improved spirometry test result (FEV1 63%, FVC 77).

Conclusion: In patients with persistent exacerbations, combination therapy with inhaled corticosteroids and dual bronchodilator therapy reduces the incidence of acute exacerbations and slows down the loss of the pulmonary function. Patients with blood eosinophil levels (> 300 eosinophils / μ L blood) have a better response to ICS. In this case report we can see that apart from guidelines, the patient compliance is also important, because once the facilitated dosage scheme was introduced, there was an improvement in the patient's condition. Exacerbations are most commonly caused by *Streptococcus pneumoniae*, *Moraxella catarrhalis* or *Haemophilus influenzae*, therefore antibiotics of the first choice are beta lactams or macrolides.

Keywords. chronic obstructive pulmonary disease, guidelines, compliance

¹ Health Center Zadar County

² GP Office Manuela Tomčić

Exhibitor:

Jelena Buljat Mioković, Address: Molatska ulica 11, Zadar, Email: majakolega27@gmail.com

BOLESNIK S AUTIZMOM I KRONIČNOM VENSKOM INSUFICIJENCIJOM

Jadranka Kovačević,¹ Tamara Sinožić,¹ Karlo Novačić,²
Slaven Suknaić²

SAŽETAK

Cilj je prikazati potrebne kompetencije liječnika obiteljske medicine s dodatnom edukacijom iz flebologije u specifičnoj situaciji zbrinjavanja bolesnika s autizmom koji boluje od kronične venske insuficijencije s ranom.

Prikaz slučaja: Bolesnik u dobi od trideset jedne godine dolazi na pregled zbog rana i otičanja obiju potkoljenica. Bolesnik boluje od autizma i umjerene mentalne retardacije, teško se uspostavlja verbalni kontakt. Komunikacija je znatno otežana jer se samo neartikulirano glasa. Svi podaci vezani uz bolesnika dobiveni su heteroanamnestički od roditelja, koji su uvijek oboje u pratnji. Iz heteroanamneze: prije dolaska u našu ordinaciju bolesnik je više puta liječen u drugim ustanovama zbog ponavljanih krvarenja, varikoznih vena i kroničnih rana na objema potkoljenicama. Te tegobe u značajnoj mjeri umanjuju kvalitetu života bolesnika i članova njegove uže obitelji koja skrbi o njemu. Bolesniku je šest mjeseci prije dolaska na pregled operirana lijeva vena *safena magna* (VSM). Iz statusa: postoperativni ožiljci na lijevoj nozi nakon safenektomije. S ventralne strane lijeve potkoljenice postoperativna rana veličine 0,5 x 1,5 cm koja cijeli *per secundam*. Varikozne vene desne noge s izraženom *coronum phlebectaticum paraplantarum*. Ispod desnog lateralnog maleola rana veličine 0,5 x 0,5 cm. Na hrptu desnog stopala mjesto krvarenja iz proširenih vena. Nalaz ultrazvučne dijagnostike obojenim doplerom vena obje noge: lijevo stanje po safenektomiji; desno insuficijencija safenofemoralnog ušća s refluksom u varikoznu veliku safenalnu venu (VSM); obostrano insuficijencija safenopoplitealnog ušća s refluksom u varikozne male safenalne vene (VSP). Nalaz dubokog i perforantnog venskog sustava nogu uredan. Izbor metoda liječenja zasniva se ponajprije na suradljivosti bolesnika i na individualnom, holističkom pristupu bolesniku tijekom svake konzultacije. Prvi izazov bio je pridobiti bolesnika na suradljivost za kompresivnu terapiju kako bi se zacijelile rane. Tijekom lokalnog liječenja rana planira se etiološko liječenje rana, odnosno liječenje refluksa u površinskim venama.

U prvom aktu učini se mehanokemijska ablacija oba VSP-a. Zašto smo izabrali mehanokemijsku ablaciju, a ne endovensku termičku ablaciju? Zato što nema potrebe za tumescentnom anestezijom, manje je uboda, manje je nelagode za bolesnika koji ne voli ležati na trbuhi (ugrožena suradljivost tijekom zahvata). Budući da je bolesnik bio iznimno suradljiv, u drugom aktu odlučujemo se za endovensku termičku ablaciju desnog VSM-a. U nastavku liječenja učinjeno je nekoliko tretmana skleroterapije pjenom zaostalih varikoznih vena i područja *corone*.

Zaključak: Rezultat: šest mjeseci nakon intervencija kompletna obliteracija tretiranih VSP-a i VSM-a, bez recidiva ulkusa i krvarenja. Poboljšanje kvalitete života bolesnika i njegove obitelji. Istinski izazov kod ovog bolesnika bio je zadobiti njegovo povjerenje kako bismo mogli zajamčiti uspjeh terapije.

Ključne riječi: autizam, kronična venska insuficijencija, kvaliteta života

¹ Specijalistička ordinacija obiteljske medicine dr. sc. Tamara Sinožić, dr. med.

² Poliklinika VeNeS Zagreb

Adresa za dopisivanje:

Jadranka Kovačević, dr. med., Specijalistička ordinacija obiteljske medicine Tamara Sinožić, dr. med.

Barba Rike 5a, 51417 Mošćenička Draga, e-adresa: jadranka.kovacevic@ri.ht.hr

PATIENT WITH AUTISM AND CHRONIC VENOUS INSUFFICIENCY

Jadranka Kovačević,¹ Tamara Sinožić,¹ Karlo Novačić,²
Slaven Suknaić²

ABSTRACT

Aim: to show the required competencies of the general practitioner with additional education in phlebology in the specific situation of treating a patient with autism also suffering from varicose veins and a chronic wound.

Case report: A 31-year-old patient comes to consultation due to wounds and swelling on both lower legs. The patient suffers from autism and moderate intellectual disability; it is difficult to establish verbal contact with him. The patient is only able to produce unintelligible sounds, which makes communication very difficult. All information about the patient is collected through heteroanamnesis. The patient is always accompanied by both parents. From heteroanamnesis: prior to coming to our office, the patient was treated in other institutions on various occasions due to recurrent bleeding, varicose veins and chronic veins on both lower legs. These difficulties have diminished the quality of life of the patient and his immediate family members, who are his caregivers. Six months prior to the consultation, the patient had his left great saphenous vein (GSV) operated on. From the status: post-operative scars on the left leg following *saphenectomy*. On the ventral side of the left lower leg, there is a post-operative wound 0.5x1.5 cm in size that is healing per secundam. Varicose veins of the right leg show visible corona phlebectatica paraplanaris. Below the right lateral malleolus there is a wound 0.5x0.5 cm in size. On the upper part of the right foot a point of bleeding from varicose veins is found. Duplex ultrasound of both legs shows the situation after *saphenectomy of the left leg* and the insufficiency of the *saphenofemoral junction* with reflux in GSV, as well as the bilateral insufficiency of the *saphenopopliteal junction* with reflux in varicose small saphenous veins (SSV) of the right leg. The results of deep and perforating venous system examination of both legs are without abnormalities. Methods of treatment were chosen in agreement between the patient and the individual holistic approach to the patient during consultations. The first challenge was to obtain the concordance of the patient regarding compression therapy in order to heal the wounds. During local wound treatment, etiological treatment of the wounds is planned. Firstly, *mechanical ablation* of both SSV is performed. Why is *mechanical ablation chosen instead of endovenous thermal ablation?* There is no need for tumescent anaesthesia, there are fewer injections and less uneasiness for the patient who does not like to lie on his stomach (the concordance is being threatened during the procedure). Since the patient is extremely concordant, we then opt for *endovenous thermal ablation* of the right great saphenous vein (GSV). In continuation treatment, a few sessions of foam sclerotherapy on the remaining varicose veins are performed.

Conclusion: Six months after the interventions, a complete obliteration of the treated GSV and SSV, without relapses, ulcers and bleeding is achieved. The patient's and his family's quality of life is improved. The true challenge with this patient has been earning his trust in order to ensure the success of therapy.

Keywords: autism, chronic venous insufficiency, quality of life

¹ Family Medicine Practice, Tamara Sinožić, MD-FD, Mošćenička Draga

² VeNeS Vein Clinic, Zagreb

Contact information:

Jadranka KOVACEVIĆ, MD-GP, Family Medicine Practice Tamara Sinožić, MD-FD,
Barba Rike 5a, 51417 Mošćenička Draga, E-mail: jadranka.kovacevic@ri.hr

INDIKATORI KVALITETE ORDINACIJE OPĆE/ OBITELJSKE MEDICINE MURVICA U 2018. GODINI

Zlatko Kožar,¹ Silvija Šoša,¹ Nikolina Rakamarić,¹ Hrvoje Tiljak,²
Jasna Vučak³

SAŽETAK

Rad liječnika obiteljske medicine sve je više predmet vrednovanja. Prema definiciji Europskog udruženja za kvalitetu u općoj/obiteljskoj medicini (EQuIP) indikator kvalitete jest „mjerljivi element djelovanja prakse za koji postoje dokazi ili konsenzus da se može koristiti u procjeni kvalitete odnosno praćenju promjena u kvaliteti pružene skrb“¹. Poster prikazuje indikatore kvalitete u skribi za bolesnike s arterijskom hipertenzijom, dijabetesom i KOPB-om u ordinaciji opće/obiteljske medicine Murvica.

Ispitanici i metode: Uzorak su pacijenti ordinacije opće/obiteljske medicine Murvica pokraj Zadra s dijagnozom arterijske hipertenzije (I 10), dijabetesa (E 10 i E 11) te KOPB-a (J 44). S dijagnozom I 10 u 2018. godini bilo je 385 pacijenata, s dijagnozom E10 i E11 ukupno njih 135, a s dijagnozom J 44 ukupno 47 pacijenata. Podatci su vađeni pojedinačnim ulaskom u zdravstveni karton svakog pacijenta u programu za obiteljske ordinacije Softmed 2.

Rezultati: HZZO vrednuje u novčanom smislu indikatore kvalitete za arterijsku hipertenziju, dijabetes i KOPB za obiteljske liječnike (QI – indikator kvalitete: plaća se u iznosu 7,5 % od zbroja prihoda glavarine + DTP), odnosno kao kvalitetnu skrb nad navedenim populacijama pacijenata stavlja sljedeće odredbe:

- a) 70 % dijabetičara u skribi s određenom vrijednosti HbA1c u 12 mjeseci
- b) 70 % dijabetičara u skribi s vrijednošću HbA1c manjom od 8,0 %
- c) 70 % hipertoničara u skribi sa zabilježenom vrijednosti krvnog tlaka u 12 mjeseci
- d) 50 % hipertoničara u skribi sa zabilježenom vrijednosti krvnog tlaka nižom od 150/90 mmHg
- e) 50 % pacijenata s KOPB-om u skribi sa zabilježenom vrijednosti FEV1 u 12 mjeseci.

Od 135 dijabetičara upisanih u ordinaciju opće/obiteljske medicine u Murvici, u 2018. godini HbA1c određen je kod njih 49 %. Od tog broja, kod njih 62 % HbA1c bio je niži od 8 %. Od 385 hipertoničara, u 2018. godini tlak je izmjerен kod njih 51 %, a od pacijenata kojima je tlak izmjerен u 2018. godini, bio je niži od 150/90 mmHg kod njih 69 %. Od 47 pacijenata s dijagnozom KOPB-a, u 2018. godini FEV1 određen je kod njih 26 %.

Zaključak: Ordinacija opće/obiteljske medicine Murvica ne skribi zadovoljavajuće za pacijente s arterijskom hipertenzijom, dijabetesom i KOPB-om. Potrebna je izrada registra pacijenata koji boluju od navedenih bolesti i proaktivni pristup liječnika u liječenju njihovih bolesti. Savjetujemo kategorizaciju ordinacija opće/obiteljske medicine na razini Hrvatske sukladno indikatorima kvalitete.

¹ Ustanova za zdravstvenu skrb KOŽAR

² Ordinacija opće/obiteljske medicine prof. dr. sc. Hrvoje Tiljak, dr. med.

³ Specijalistička ordinacija obiteljske medicine doc. prim. dr. sc. Jasna Vučak, dr. med.

Adresa za dopisivanje:

Zlatko Kožar, dr. med., Trg sv. Nikole 1, 23 241 Poličnik, e-adresa: zlatkokozar@yahoo.com

QUALITY INDICATORS OF GENERAL / FAMILY MEDICAL PRACTICE IN MURVICA IN 2018

Zlatko Kožar,¹ Silvija Šoša,¹ Nikolina Rakamarić,¹ Hrvoje Tiljak,²
Jasna Vučak³

ABSTRACT

The work of family physicians has increasingly been the subject of evaluation. According to the definition of the European Quality Assurance Society in General/Family Medical Practice (EQuIP), the quality indicator is “a measurable element of practice actions for which there is evidence or consensus that they can be used in assessing quality and monitoring changes in the quality of provided care.” The poster shows quality indicators in the care for patients with arterial hypertension, diabetes, and COPD in the Murvica GP / Family Physician Practice.

Examinees and methods: The examinees sample are the patients of the GP / Family Physician Practice in Murvica near Zadar with a diagnosis of arterial hypertension (I 10), diabetes (E 10 and E 11) and COPD (J 44). There were 385 patients with the diagnosis I 10 in 2018, 135 patients with E10 and E11 diagnosis and 47 patients diagnosed with J 44. Data were taken individually by entering each patient's chart in the Family Practice software Softmed 2.

Results: The Croatian Health Insurance (CHI) evaluates quality indicators for arterial hypertension, diabetes, and COPD for family physicians. QI – quality indicator is paid as 7.5% of the sum of income per patient + DTP (diagnostic and therapy procedures)), i.e. as good quality care of the above-mentioned patient population with the following parameters obtained:

- a) 70% of diabetics with measured values of HbA1c in 12 months
- b) 70% of diabetics with recorded values of HbA1c under 8%
- c) 70% of hypertonic patients with measured and recorded blood pressure in 12 months
- d) 50% of hypertonic patients with measured and recorded blood pressure lower than 150/90 mmHg
- e) 50% of COPD patients with FEV1 values recorded in 12 months

Of the 135 diabetic patients in the GP / Family Physician Practice in Murvica, in 2018, HbA1c was measured for 49% of patients. Out of that number 62% of them had HbA1c values under 8%. Of the 385 hypertonic patients in 2018, the pressure was measured in 51% of them, and 69% of them had values under 150/90 mmHg. Out of 47 patients with COPD diagnosis in 2018, FEV1 was measured in 26% of them.

Conclusion: GP / Family Physician Practice in Murvica does not provide sufficient care for patients with arterial hypertension, diabetes, and COPD. It is necessary to form a register of patients with the above-mentioned diagnoses and physicians need to take a proactive approach in treating these diseases. We recommend the categorization of GP / Family Physician Practices in Croatia according to quality indicators.

¹ Healthcare facility KOŽAR

² General / Family Medical Practice prof. Hrvoje Tiljak, GP/PhD

³ Specialist Practice of Family Medicine assist. Prof. Jasna Vučak, GP/PhD

Correspondence address:

Zlatko Kožar, MD, Trg Sv. Nikole 1, 23 241 Poličnik, E-mail: zlatkokozar@yahoo.com

IZVORI INFORMACIJA MEDICINE TEMELJENE NA DOKAZIMA MEĐU STUDENTIMA ŠESTE GODINE MEDICINE

Ivon Matić,¹ Dunja Stolnik,² Zvonimir Bosnić,³ Mila Vasilj-Mihaljević,⁴
Sanja Bekić,⁵ Ljiljana Trtica-Majnarić⁶

SAŽETAK

Izvori informacija danas predstavljaju važan aspekt učenja i vrednovanja stručnosti u svijetu medicine. Različit broj izvora također može predstavljati i svojevrsno nesnalaženje u pretrazi određenog podatka. Iz perspektive studenata medicine, kvalitetan izvor informacija i mogućnost dolaženja do važnih, jasnih i lako dostupnih podataka u temeljima je budućeg djelovanja novoga liječničkoga kadra.

Ispitanici i metode: Ispitanici su bili studenti šeste godine Medicinskog fakulteta u Osijeku, njih sedamdeset ($N = 70$). Ispitanicima su dani upitnici o izvorima informacija kojima se koriste za učenje i pripremu seminara te izradu diplomskih radova. Upitnik se sastojao od trinaest (13) pitanja s više ponuđenih odgovora.

Rezultati: Od 70 studenata upitnik je ispunilo njih 55. Najčešći izvor informacija za učenje jesu knjige i udžbenici (75 %) te priručnici (57 %). Za pripremu seminara i izradu završnih radova najčešće korištena literatura jesu knjige i udžbenici (71 %), potom priručnici (44 %) te znanstveni radovi i članci u znanstvenim časopisima (43 %). Od oblika izvora ispitanici preferiraju digitalni oblik (58 %). PubMed (75 %) i Google Scholar (23–24 %) najčešće su korištene bibliografske baze podataka. Za program s Booleanovim načinom pretraživanja 75 % ispitanika navelo je da ga ne upotrebljava, a 66,6 % ispitanih studenata navelo je da se ne koristi MeSH terminima prilikom pretraživanja. Pune članke ispitanici nalaze u bazama PubMed Central (64–65 %) i Google Scholar (25–26 %). Glede dostupnosti e-knjiga, 50 % ispitanika preferira besplatne verzije, a 27 % njih knjige s internetskih stranica poznatih organizacija i institucija. U svrhe učenja 75 % ispitanika navelo je da ne upotrebljava Cochrane baze podataka, dok se Wikipedijom koristi 70–71 % ispitanika za uvid u temu/literaturu, njih 45–46 % za objašnjenje nepoznatih termina, a 37–38 % za preuzimanje oblika i grafova. O tvrdnji – Wikipedija kao izvor informacija – 42 % ispitanih studenata iskazalo je pozitivan stav. Ispitanici, njih 33 %, smatraju da su znanja i vještine koje su stekli prilikom pretraživanja baza podataka nedostatni, dok ih 54 % smatra da su dovoljni za osnovno znanje/vještine. Da imaju dobre informatičke vještine za neovisno pretraživanje baza podataka smatra 54 % ispitanika, zadovoljavajućim ih procjenjuje njih 20–21 %, dok jednak udio od 4 % ispitanika svoje informatičke vještine za neovisno pretraživanje baza podataka procjenjuje nedovoljnima odnosno odličnima.

Zaključak: Rezultati upitnika upućuju na to da ispitanici ne pokazuju dovoljno poznавanje suvremenoga, znanstvenog i poželnog (u akademskim zajednicama) načina pretraživanja te da su skloniji korištenju nedovoljno recenziranih i nepouzdanih baza podataka (npr. Wikipedije).

Ključne riječi: baze podataka, pretraživanje, medicina

¹ Dom zdravlja Županja

² Dom zdravlja Osijek

³ Opća županijska bolnica Našice

⁴ Dom zdravlja Vukovar

⁵ Privatna specijalistička ordinacija obiteljske medicine

⁶ Katedra za internu medicinu, obiteljsku medicinu i povijest medicine Medicinskog fakulteta u Osijeku
Predstavljajući:

Ivon Matić, dr. med., specijalizant obiteljske medicine, Baruna Trenka 33, 32270 Županja,

e-adresa: ivon.matic@live.com, ORCID ID: ORCID ID: <https://orcid.org/0000-0002-0137-6638>

SOURCE OF EVIDENCE-BASED MEDICINE INFORMATION BETWEEN STUDENTS OF THE 6TH YEAR OF THE FACULTY OF MEDICINE

Ivon Matić,¹ Dunja Stolnik,² Zvonimir Bosnić,³ Mila Vasilj-Mihaljević,⁴
Sanja Bekić,⁵ Ljiljana Trtica-Majnarić⁶

ABSTRACT

Introduction: Sources of information represent an important aspect of learning and the assessment of expertise in the world of medicine today. The variety of sources may also cause confusion in those searching data. From the perspective of a student of medicine, a reliable source of information and a possibility of extracting important, clear and easily available data are the basis of new physicians' work.

Sample and methods: Total of 70 sixth year students of the Faculty of Medicine in Osijek were given questionnaires on the sources of information they were using for learning, preparing seminars and diploma papers. The questionnaire consisted of 13 questions and multiple choice answers.

Results: Fifty-five out of 70 students participated in the study. The most common sources of information for learning were books and textbooks (75%), and manuals (57%). The most frequently used literature in the preparation of seminars / final papers were books and textbooks (71%), manuals (44%) and scientific papers/articles in scientific journals (43%). Digital format was preferred by 58% of respondents, while PubMed (75%) and Google

Seventy-five percent of respondents did not use the Boolean search model whereas 66.6% of them did not use the MeSH browser.

Respondents found full articles on PubMed Central (65%) and Google. Regarding e-book availability, 50% of respondents preferred free versions while 27% of them preferred books from known organisations and institutions websites. For the purpose of learning, 75% of respondents claimed they were not using the Cochrane databases, while 70-71% of them were using Wikipedia for topic/literature insights and 42% of them claimed they had a positive attitude towards Wikipedia as a source of information. Thirty-three percent of respondents believed that knowledge and skills acquired by searching databases were insufficient, while 54% believed that databases satisfied their needs for basic knowledge and skills. Furthermore, 54% of respondents considered their IT skills necessary to independently search through databases were good, 20-21% considered it to be satisfactory, while an equal percentage (4%) of them considered their skills insufficient vs. excellent.

Conclusion: The questionnaire showed that the students did not exhibit sufficient knowledge of modern, scientific and in the academic community preferable search methods. Therefore, they tended to use insufficiently reviewed and unreliable databases (e.g. Wikipedia).

Keywords: Database, search, medicine.

¹ Health Center of Županja

² Health Center Osijek

³ General County Hospital Našice

⁴ Health Center Vukovar

⁵ Private Medical Practice Specialist

⁶ Department of Internal Medicine, Family Medicine and History of Medicine
of the Faculty of Medicine in Osijek

Presenter: Ivon Matić, dr. med., family medicine resident, Baruna Trenka 33, 32270 Županja,
e-mail: ivon.matic@live.com, ORCID ID: <https://orcid.org/0000-0002-0137-6638>

PRIKAZ PACIJENTA S KONVULZIVNOM CEREBRALNOM ATAkom

Anamarija Mehić,¹ Rudika Gmajnić,² Sanda Pribić³

SAŽETAK

Epileptični napadaj klinička je manifestacija prekomjernog, abnormalnog i hipersinkronog izbijanja kortikalnih neurona. Epilepsija je češća u dojenačkoj dobi i pubertetu te dobi iznad 65 godina. Uzrok epilepsije može biti makrofaktor poput kongenitalne kortikalne displazije, tumor, malformacija krvnih žila mozga, moždani udar, neurodegenerativne bolesti, infekcije i intoksikacije. Osim ovisnosti o alkoholnim pićima, prestanak njihova uzimanja, kao i sustezanje od benzodiazepina, barbiturata ili psihotropnih lijekova, čest je uzrok epileptičnih napadaja.

Prikaz slučaja: Muškarac u dobi 51 godine, neoženjen, živi s roditeljima. Desetak godina liječi se kod psihijatra pod dijagnozom *schizophrenia simplex*, u terapiji sertralin 50 mg, biperiden 2 mg, flufenazin 2,5 mg, diazepam 5 mg po potrebi. Trajno je radno nesposoban, trajne afekcije ličnosti, te izrazitih kognitivnih smetnji. Hipertoničar, troši ramipril s hidroklorotiazidom, povremeno analgetike. Pacijent je u ambulanti obiteljske medicine u prijepodnevним satima u sjedećem položaju iznenada izgubio svijest, te je pao uz kočenje i trzanje cijelog tijela. Tijekom napadaja postao je cijanotičan, pomokrio se i ugrizao jezik. Pacijenta se postavi na sigurno, u bočni položaj, otvori se venski put te se primijeni iv. 5 mg diazepama, na što se napadaj postupno smiri. Pregledom se utvrđi da je pacijent blaže dispnoičan, SpO₂ 96 %, srčana akcija ritmična, tahikardna 100/min, RR 150/100. Po protokolu izmjerena temperatura 36,8 °C i glikemija 4,4 mmol/L. U grubom neurološkom statusu zjenice nešto šire, uredno reagiraju na svjetlost, meningealni znaci negativni. Pacijent sve vrijeme konfuzan, slabo suraduje pri pregledu. Iz heteroanamneze doznamo da je večer prije slabo spavao, nije doručkovao, stalnu terapiju nije pio redovito. Ovo mu je bio prvi gubitak svijesti. Uputi se na elektroencefalografiju i dalju obradu neurologa.

Zaključak: Jedan epileptični napadaj ne čini epilepsiju i potreban je detaljan neurološki pregleđ i obrada kako bi se postavila dijagnoza epilepsije. Potrebno je uzeti temeljitu anamnezu i heteroanamnezu, utvrditi uzrok napadaja, isključiti ostale moguće uzroke, odrediti opći i neurološki status bolesnika te učiniti elektroencefalogram (EEG). U liječenju ovog poremećaja potrebna je suradnja sa psihijatrom i neurologom.

Ključne riječi: epilepsija, shizofrenija, elektroencefalografija

¹ Dom zdravlja Osijek

² Katedra za obiteljsku medicinu i povijest medicine Medicinskog fakulteta u Osijeku

³ Privatna specijalistička ordinacija obiteljske medicine

Anamarija Mehić, Zagrebačka 9a, Osijek, e-adresa: anamarija.mehic@gmail.com

CASE REPORT – PATIENT WITH CONVULSIVE BRAIN SEIZURE

Anamarija Mehić,¹ Rudika Gmajnić,² Sanda Pribić³

ABSTRACT

An epileptic seizure is a clinical manifestation of an excessive, abnormal and hypersynchronous discharge of cortical neurons. Epilepsy is more common in infants, adolescents and persons older than 65. It may be caused by a macro-factor such as congenital cortical dysplasia, tumour, cerebral vascular malformations, stroke, neurodegenerative diseases, infections, and intoxications. Apart from addiction to alcoholic drinks, termination of alcohol drinking as well as failure to take benzodiazepines, barbiturates or psychotropic medications can also cause epileptic seizures.

Case report: A man aged 51, single, lives with his parents. He has been undergoing psychiatric treatment for 10 years and is diagnosed with schizophrenia simplex. His therapy includes sertraline 50 mg, biperiden 2 mg, fluphenazine 2.5 mg and diazepam 5 mg, when necessary. He is permanently unable to work, with a permanent personality disorder, and serious cognitive disabilities. He suffers from hypertonia and takes ramipril with hydrochlorothiazide, as well as analgesics occasionally. While sitting in the family medicine office in the morning, the patient suddenly loses consciousness and falls down. His body starts to stiff and twitch. During the seizure, he becomes cyanotic; he urinates and bites his tongue. The patient is then placed securely in the lateral position, with prepared intravenous route and with 5 mg of diazepam administered intravenously, after which the seizure gradually stops. The examination shows that the patient is slightly dyspnoic, SpO₂ is 96%, his heart rate is rhythmic, with signs of tachycardia, 100/min, and the blood pressure reading is 150/100. His body temperature is measured in accordance with the protocol and it reads 36.8 °C. Glycaemia is 4.4 mmol/L. In terms of general neurological status, his pupils are somewhat dilated, reacting normally to light with negative meningeal signs. The patient is confused all the time; his communication during the examination is poor. Heteroanamnesis shows that he did not sleep well last night, he did not have breakfast and that he did not take his regular therapy. This is his first loss of consciousness. He is referred to electroencephalography and further neurological treatment.

Conclusion: One epileptic seizure does not make epilepsy and a detailed neurological examination and treatment is required to set up a diagnosis of epilepsy. It is necessary to take thorough medical history and heteroanamnesis, determine the cause of seizures, exclude other possible causes and determine the general and neurological status of the patient and to perform an electroencephalogram (EEG). In treating this disorder, cooperation with a psychiatrist and a neurologist is necessary.

Key words: epilepsy, schizophrenia, electroencephalography

¹ Osijek Health Centre

² Department for Family Medicine and History of Medicine of the Faculty of Medicine in Osijek

³ Private Family Medicine Specialist Office

Anamarija Mehić, Zagrebačka 9a, Osijek, anamarija.mehic@gmail.com

DUGOGODIŠNJA NEPREPOZNATA AVNR TAHIKARDIJA

Josipa Milas,^{1,2} Pavao Mioč,^{1,2} Martina Cukor,^{1,3}

SAŽETAK

Atrioventricular nodal reentrant tachycardia (AVNRT) najčešća je paroksizmalna supraventrikularna tahikardija, uskog QRS kompleksa i pulsa oko 140–180/min. Dva do tri puta češća je u žena, a uobičajeno se javlja u prvim dvama desetljećima života. Mogu je precipitirati pušenje, kava, čaj i stres te sagibanje. Najčešći tip ove aritmije je sporo-brzi tip (90–95 %), zatim brzo-spori, a najrjeđi je tip sporo-spori tip (1 %). Cilj je ovoga prikaza slučaja upozoriti na bitnost uočavanja znakova ove aritmije pri prvom susretu pacijenta s liječnikom obiteljske medicine, jer se često ova aritmija pripisuje paničnom napadaju ili anksioznom poremećaju i tako provlači godinama kroz sustav bez pomaka u smislu izlječenja.

Prikaz slučaja: Petnaestogodišnjakinja dolazi u pratnji majke u ordinaciju LOM-a u ožujku 2009. zbog naglo nastale palpitacije koja se pojavila za vrijeme sportske aktivnosti. Djevojka je vidljivo uzrujana i u strahu. Opisuje tegobe kao „jako lupanje srca“, ali bez dispneje ili gubitka svijesti. Trajala je oko 30 minuta, zatim spontano, naglo uspori kod kuće. Ne uzima lijekove. Obiteljska anamneza negativna. U ordinaciji snimljen EKG, koji je uredan. Inače sportski aktivna, trenira tenis i odboku. Od tada obavlja redovite kardiološke obrade 2009., 2013., 2016., uredni nalazi; koncentracije hormona štitnjače unutar referentnih vrijednosti. Pacijentica se kao dvadesetogodišnjakinja 2017. javlja u HMP zbog palpitacije koja traje više od dva sata. Uredni ostali vitalni znakovi. EKG potvrđuje supraventrikularnu tahikardiju uskih QRS-ova, 167 otkucaja u minuti. Aritmija spontano prestaje prije ordiniranja terapije. Sljedećeg dana zaprimljena na kardiološki odjel gdje je ustanovljena aritmija po tipu atipičnog sporo-sporog AVNRT-a i u istom aktu učinjena RF ablacija alternativnih puteva.

Zaključak: AVNRT naglo i spontano započinje i završava, često praćeno osjećajem „da je srce preskočilo otkucaj“, nakon čega slijedi ubrzavanje pulsa, bez ubrzanja disanja, ili mučnine i vrtoglavice. Vrlo rijetko uzrokuje sinkope. U slučaju pacijentice precipitaciju aritmije uzrokovalo je sagibanje i brzo hodanje zbog napinjanja abdominalne muskulature. Posljedično, naglo povećanje venskog priljeva u srce i rastezanja desnog atrija dovelo je do pojave PAC-a. Obiteljski liječnik pri sumnji na ovaj poremećaj može savjetovati javljanje u najbližu službu HMP-a u slučaju sljedeće pojave sličnih simptoma kako bi se snimio EKG i tako ustanovila aritmija.

Ključne riječi: AVNRT, supraventrikularna tahikardija, paroksizmalna tahikardija, supraventrikularna aritmija, RF ablacija

¹ Dom zdravlja Istok, Švarcova 20, Zagreb

² Sveučilište u Zagrebu, Medicinski fakultet, Šalata 3, Zagreb

³ Ordinacija OM Martina Cukor, dr. med., spec. obiteljske medicine

Josipa Milas, Pilarova 32, 10000 Zagreb, e-adresa: josipa.milas@gmail.com

UNDETECTED PERSISTANT AVNRT

Josipa Milas,¹ Pavao Mioč,² Martina Cukor³

ABSTRACT

Atrioventricular nodal reentrant tachycardia (AVNRT) is the most common paroxysmal supraventricular tachycardia with narrow QRS complex and a pulse variation between 140-180 bpm. It is 2-3 times more common in women, usually manifesting in the first two decades of life. It may be precipitated by smoking, coffee, tea, stress and or by bending at the waist. The most prevalent is the slow-fast type (90-95%), followed by fast-slow and slow-slow type (1%).

The aim of this case report is to emphasize the importance of timely recognition of the signs of this arrhythmia during patients' first contact with the family medicine specialist, because it is easily ascribed to symptoms manifested in anxiety disorder and/or panic. That, in turn, delays making the correct diagnosis and, ultimately, administering efficient therapy.

Case report: A 15-year-old female, accompanied by her mother, presents to her family medicine specialist in 2009. She is visibly frightened and upset, reporting a palpitation occurring during her tennis play, describing the experience as "strong and fast heartbeats" but denies dyspnoea or a loss of consciousness. It lasted for 30 minutes before stopping spontaneously. She did not take any medications. Family anamnesis is negative. ECG shows no pathological rhythm. She actively trains tennis and volleyball. Cardiology assessments are performed in 2009, 2013 and 2016; no pathology nor thyroid dysfunction is found. In 2017 the patient presents to the ER with tachycardia that has lasted for over 2 hours. ECG confirms SVT with narrow QRS, 167 bpm. It stops spontaneously. The patient is admitted to hospital where the arrhythmia is demystified as a slow-slow AVNT. An RF ablation is performed to eliminate the alternative pathways.

Conclusion: AVNRT spontaneously begins and ends. It is usually preceded by a feeling that the "heart skips a beat", but is not followed by tachypnea, nausea or vertigo. Syncope rarely occurs. In the patient's case, arrhythmia has been precipitated by bending at the waist and fast walking - both of which cause the abdominal musculature to propel the venous reservoir to the right atrium – which in turn causes a PAC. The family medicine specialist should advise the patient to report to any nearby ER when the palpitation reoccurs for an ECG evaluation during the event itself.

Keywords: AVNRT, supraventricular tachycardia, paroxysmal tachycardia, RF ablation, supraventricular arrhythmia

¹ Health center Zagreb-East

² University of Zagreb, School of Medicine, Šalata 3, Zagreb

³ Family medicine practice Martina Cukor, M.D., family medicine specialist
Presenter:
Josipa Milas, Pilarova 32, 10000 Zagreb; josipa.milas@gmail.com

MELANOMA - CASE REPORT

Snežana R. Milutinović Matić¹

ABSTRACT

Skin as an organ is available for self-examination and examination as well as protection against ultraviolet radiation. Family physicians play a key role in the prevention and early detection of skin cancer. The aim is to show the importance of examining the skin of patients who appear for examination for any reason, and to suggest any suspected lesions for further treatment.

Case report: A patient aged 72 comes for a backpain examination. During the examination, a change is observed on his left upper arm. The patient noticed it a year ago, but it has not been hurting. He states that in the summer he takes off his shirt and does not mind the sun. Skin change is 65 x 40 mm in size, of irregular shape, with unclear edges and non-homogeneous pigmentation, with keratotic changes on the dark brown surface, without changes in the surrounding skin. Due to the clinical finding and anamnestic data, he is referred to the plastic surgeon for surgery. After the surgical intervention and obtained pathohistological diagnoses (melanoma cutis, superficial spreading type, pT1, aNxMx), further monitoring and treatment will be performed according to the recommendations of the oncology consilium or control examination in two months. Due to the frequency of pigmented skin (partly due to unreasonable exposure to UV rays), it is necessary to recognize skin changes in routine examinations and to respond adequately. Family physicians can estimate changes based on the ABCD acronym, as well as by using an available tool helping doctors to see the changes (e.g. enhancing the visibility of changes with a magnifying glass or the camera of the mobile device). The basic monitoring is dermoscopy.

Conclusion: Skin examination should be part of regular check-ups and examinations. Prevention is the best and the cheapest treatment. Therefore, it is necessary to educate patients for self-examination and for gaining healthy lifestyle habits.

Key words: melanoma, skin, self-examination, ultraviolet rays, education, prevention

¹ Public Health Institution, Health Center, Banja Luka, Family Medicine Service Banja Luka
Correspondence to:

Dr Snežana Milutinović Matić, M. Umjenovića, 78000 Banja Luka, snezana485@gmail.com

AKUTNI MIOPERIKARDITIS U DIFERNCIJALNOJ DIJAGNOZI BOLI U PRSIMA

Pavao Mioč¹, Josipa Milas¹, Martina Cukor²

SAŽETAK

Mioperikarditis se često naziva i "bolest s deset lica", zbog različite kliničke prezentacije, od asimptomatske pa sve do ozbiljne боли koja se ponekad pogrešno dijagnosticira kao akutni koronarni sindrom. To je ozbiljno stanje koje može rezultirati i akutnim zatajenjem srca, stoga je važno bol u prsimu shvatiti ozbiljno, diferencijalno dijagnostički razmišljati i o mioperikarditisu te anamnezom i kliničkim pregledom potvrditi ili otkloniti sumnje.

Prikaz slučaja: 31-godišnji pacijent dolazi u ambulantu zbog боли u prsimu, povišene tjelesne temperature i osjećaja opće slabosti. Bol je difuzno prisutna nad središnjim dijelom prsnog koša bez propagacije u okolne strukture. Pacijent je febrilan unazad 3 dana (do 38.7°C). Ne kašlje. U proteklih 2 dana imao je nekoliko proljevastih stolica. Arterijski krvni tlak je 110/70, SpO₂ 96%, puls 110/min, a tjelesna temperatura 38°C. Auskultacijski je ustanovljen normalan šum disanja te ritmična srčana akcija, jasni tonovi uz odsustvo šumova. Elektrokardiogram ukazuje na sinusnu tahikardiju uz intermedijarnu elektičnu os i bifazičan T val u odvodima V1-V4. Analiza kompletne krvne slike, iz laboratorija Doma zdravlja, pokazala je neutrofiliju (78%) i povišen CRP (18 mg/L). Nakon učinjene obrade pacijent je upućen na hitni bolnički prijem s uputnom dijagnozom mioperikarditisa. Laboratorijski nalazi u bolnici su pokazali povišene vrijednosti kardioselektivnih enzima, a ehokardiografski je utvrđena niska ejekcijska frakcija (55%) uz hipokontraktilitet posteriorne stijenke i zadebljan perikard (6mm), što je bilo dovoljno za dijagnozu mioperikarditisa. Nakon terapije bisoprololom, ramiprilom i ibuprofenom u trajanju od 7 dana, pacijent je afebrilan, dobrog općeg stanja, a u kontrolnim nalazima dolazi do normalizacije CRP-a te značajnog pada kardioselektivnih enzima. Ejekcijska frakcija se normalizira (70%) te se bolesnik pušta iz bolnice.

Zaključak: Difuzna бол над prsnim košem, febrilitet, tahikardija, povišeni upalni parametri, opće loše stanje i mlađa životna dob pacijenta, uz normalnu saturaciju, ekletkrokardiogram i uredan osatak statusa bili su ključni u postavljanju radne dijagnoze mioperikarditisa. Ovaj slučaj primjer je kako kvalitetna obrada na razini primarne zdravstvene zaštite, koja uključuje detaljan klinički pregled i svu tehnologiju koja je dostupna liječniku obiteljske medicine, mogu uspješno identificirati i manje česte kliničko-patološke entitete, kao što je mioperikarditis, što omogućuje ciljanu,a samim time i bržu definitivnu obradu na sekundarnoj, odnosno tercijarnoj razini.

Ključne riječi: mioperikarditis, bol u prsimu, tahikardija

¹ Medicinski fakultet Sveučilišta u Zagrebu

² Dom zdravlja Zagreb - Istok

Pavao Mioč, student 6. godine, Medicinski fakultet Sveučilišta u Zagrebu, Švarcova 7, 10000 Zagreb, e-mail: pavomic@hotmail.com

ACUTE MYOPERICARDITIS IN DIFFERENTIAL DIAGNOSIS OF CHEST PAIN

Pavao Mioč,¹ Josipa Milas,¹ Martina Cukor²

ABSTRACT

Myopericarditis is often referred to as “ten faces disease” due to various clinical presentations, from the asymptomatic to severe pain, which is sometimes misdiagnosed as acute coronary syndrome. This is a serious condition, which can result in acute heart failure, thus it is important to take the chest pain seriously, think of myopericarditis and, after taking the case history and the physical examination, confirm or eliminate any doubts.

Case report: A 31-year-old male patient presents to the GP with central chest pain, fever and fatigue. The patient has been febrile for 3 days (up to 38.7°C). He is not coughing and reports having diarrhea in the last 2 days. On presentation the arterial blood pressure is 110/70, SpO₂ 96%, pulse 110/min and body temperature is 38°C. On auscultation the breathing is normal, and the heart action is rhythmic with clear heart sounds and no murmurs. The electrocardiogram indicates the sinus tachycardia with normal electrical axis and biphasic T wave in leads V1- V4. The complete blood count, done in primary care laboratory, shows neutrophilia (78%) and elevated CRP (18 mg/L). After complete examination, the patient is referred to the emergency room with suspected diagnosis of myopericarditis.

Hospital laboratory findings show elevated cardioselective enzymes, and, echocardiographically, low ejection fraction (55%) with posterior hypocontractility. Thickened pericardium (6mm) is demonstrated, which is sufficient for the final diagnosis of myopericarditis. After bisoprolol, ramipril, and ibuprofen have been administered for 7 days, the patient is afebrile, in good general condition. In check-up findings normalization of CRP and cardioselective enzymes is found. Ejection fraction is normal now (70%) and the patient is discharged from hospital.

Conclusion: Diffuse chest pain with fever, tachycardia, elevated inflammatory parameters, poor general condition of the patient and his age, alongside normal saturation, electrocardiogram and no other abnormalities in the status are crucial in setting the working diagnosis of myopericarditis. This case is a perfect example of how a good primary care examination, which includes thorough physical examination and all the equipment available to general practitioners, can successfully identify even not so common diagnosis, such as myopericarditis, which helps to reduce the time of evaluating the patient in the emergency room and more immediate treatment.

Key words: myopericarditis, chest pain, tachycardia

¹ School of Medicine, University of Zagreb

² Health Center Zagreb – East

Pavao Mioč, student 6. godine, Medicinski fakultet Sveučilišta u Zagrebu, Švarcova 7, 10000 Zagreb,
pavomioč@hotmail.com

RAZMIŠLJAMO LI O POSLJEDICAMA BAKTERIJSKE INFEKCIJE DIŠNIH PUTEVA?

Silvana Mirčeta Šimunović,¹ Kristina Hrabrić,² Neva Coce,²
Biserka Bergman Marković^{3,4}

SAŽETAK

Izvanbolnička pneumonija (IP) upala je pluća stečena izvan bolnice. Uzrokuju je brojni mikroorganizmi uključujući bakterije, virusе, gljivice i protozoe. Klinički tijek može varirati od blage do teške upale s komplikacijama uključujući pleuralni izljev, empirijem, apses pluća i nekrozu plućnog parenhima. Za nekrotizirajuće upale pluća karakteristične su zrakom ispunjene šupljine (pneumatomokela) jer jednosmjerni prolaz zraka dovodi do nekroze bronhiola i alveola. Kada se nalaze blizu pleure, mogu nastati bronhopleuralne fistule. Liječenje tih komplikacija zahtijeva produljenu primjenu intravenskih antibiotika i drenažu prsišta, a ponekad i kirurške intervencije kako bi se zatvorila bronhopleuralna fistula.

Prikaz slučaja: Opisujemo petogodišnje prethodno zdravo dijete koje se javlja na hitni prijam zbog kašlja, otežana disanja, temperature i boli u ledjima. Na inicijalnom snimku torakalnih organa uočava se infiltrat u oba plućna krila s pleuralnim izljevom u desnom prsištu, što upućuje na upalu pluća. Kod pacijenta je započeta empirijska antibiotička terapija (ceftriaxon u visokoj dozi 2 x 50 mg/kg) i simptomatska terapija. Učinjena je i drenaža desnog prsišta iz kojeg se evakuira 350 ml gnojnog sadržaja. Iz nazofaringealnog brisa izoliran je *Streptococcus pneumoniae*. Unatoč liječenju na kontrolnim snimcima pluća prati se progresija bilateralnog upalnog infiltrata s novonastalim desnostranim pneumotoraksom. Pacijent je i dalje febrilan, tahipnoičan, sa smanjenom saturacijom kisika. Na učinjenoj kompjutoriziranoj tomografiji (CT) prsnog koša opisuje se konsolidat plućnog parenhima gornjeg desnog i oba donja režnja, sa zračnim bronhogramom, transparencama plina unutar konsolidata te pneumotoraks koji komunicira s konsolidiranim tkivom putem bronhopleuralne fistule. Antibiotička terapija je izmijenjena tako da uključuje ceftriaxon, vankomicin i klindamicin. Kontrolni CT prsnog koša pokazao je djelomičnu regresiju desnog infiltrata uz formiranje pneumatokele apikalno te veće pneumatokele lijevo, koja gotovo u potpunosti ispunjava plućno krilo, s posljedičnom atelektazom okolnog plućnog parenhima. Nastavljena je konzervativna terapija, zbog koje je pacijent postao afebrilan, a respiratorna funkcija se poboljšala. Na kontrolnim snimkama torakalnih organa vidi se djelomična reekspanzija oba plućna krila i dijete je otpušteno na kućnu njegu u dobrom općem stanju.

Zaključak: Nekrotizirajuća pneumonija sve je češća komplikacija dječjeg IP-a. Većina obojelih ima prateći pleuralni izljev ili empirijem. Na dijagnozu treba posumnjati tada kada unatoč odgovarajućim antibioticima dijete ne pokazuje znakove poboljšanja s izraženim znakovima respiratornog poremećaja. CT je standardni dijagnostički postupak. Unatoč kratkotrajnom teškom morbiditetu klinička prognoza dugoročno je izvrsna s minimalnim posljedicama.

Ključne riječi: izvanbolnička pneumonija, nekrotizirajuća pneumonija, pneumatomokela, bronhopleuralna fistula

¹ Dom zdravlja Krapinsko-zagorske županije

² Klinički zavod za dijagnostičku i intervencijsku radiologiju, Klinički bolnički centar Zagreb

³ Specijalistička ordinacija opće medicine

⁴ Katedra za obiteljsku medicinu, Medicinski fakultet Sveučilišta u Zagrebu,
Škola narodnog zdravlja „Andrija Štampar“

Silvana Mirčeta Šimunović, dr. med., Donje Svetice 35, 10000 Zagreb,
e-adresa: silvanamirceta7@gmail.com

DO WE THINK ABOUT THE CONSEQUENCES OF BACTERIAL INFECTIONS OF THE RESPIRATORY SYSTEM?

Silvana Mirčeta Šimunović,¹ Kristina Hrabrić,² Neva Coce,²
Biserka Bergman-Marković^{3,4}

ABSTRACT

Community-acquired pneumonia (CAP) is pneumonia acquired outside hospital. It is caused by numerous microorganisms including bacteria, viruses, fungi and protozoa. The clinical course may vary from mild to severe inflammation with complications including pleural effusion, emphysema, lung abscess, and necrotising pneumonia. Necrotising pneumonia is characterised by air-filled cavities (pneumatoceles) because one-way passage of air causes a necrosis of bronchioles and alveoli. When occurring adjacent to the pleura, bronchopleural fistulas may form. Treatment of these complications requires prolonged courses of intravenous antibiotics, chest drainage, and sometimes a surgical intervention in order to close the bronchopleural fistula.

Case report: We describe a five-year-old previously healthy child who comes in emergency with cough, breathing difficulties, fever, and back pain. Initial plain chest radiograph shows large airspace opacities in both lungs along with a right pleural effusion, consistent with pneumonia. The patient is initially treated with empiric antibiotic therapy, symptomatic therapy, and pleural fluid drainage where a large volume of pus was drained from the right chest cavity. *Streptococcus pneumoniae* was isolated from nasopharyngeal swab.

Despite treatment, control chest radiographs show a progression of bilateral pneumonia, and newly-formed right sided pneumothorax. The patient remains febrile and tachypneic, with decreased oxygen saturation. Computed tomography (CT) scan of the chest reveals a consolidation of lung parenchyma of the upper right, and both lower lobes, air bronchogram, multiple air filled cavities in the consolidated tissue and pneumothorax communicating with consolidated tissue via bronchopleural fistula. Antibiotic therapy is modified to include ceftriaxone, vancomycin and clindamycin. The control CT scan of the chest shows a partial regression of the right sided infiltrate with the formation of a small pneumatocele apically, as well as a large pneumatocele almost completely occupying the left lung lobe, causing atelectasis of the surrounding lung parenchyma. With continued conservative treatment, the patient becomes afebrile and the respiratory function improves. Control chest radiograph confirms a partial re-expansion of both lungs and the child is discharged for home care in good general condition.

Conclusion: Necrotising pneumonia is an increasingly detected complication of paediatric CAP. Most have an accompanying pleural effusion or emphysema. The diagnosis should be considered when, despite appropriate antibiotics, the child remains unwell with persistent signs of respiratory distress. CT scan is the standard diagnostic procedure. Despite the short-term severe morbidity, long-term clinical outcomes are excellent with minimal resultant sequelae.

Keywords: Community-acquired pneumonia, necrotising pneumonia, pneumatocele, bronchopleural fistula

¹ Health Center KZŽ

² Clinical Department of Diagnostic and Interventional Radiology, University Hospital Centre Zagreb

³ GP office prof. Biserka Bergman Marković GP/PhD

⁴ Department of Family Medicine, University of Zagreb School of Medicine, School of Public Health "Andrija Štampar"

Silvana Mirčeta Šimunović, dr.med., Donje Svetice 35, 10000 Zagreb,
e-mail: silvanamirceta7@gmail.com

STAVOVI LIJEČNIKA OBITELJSKE MEDICINE O STALNOJ PROVEDBI KONTROLE FARMAKOTERAPIJE

Tea Omanović Kolarić,¹ Nikola Raguž-Lučić,¹
Vjera Ninčević,¹ Martina Smolić¹

SAŽETAK

Jedna od najčešćih aktivnosti u svakodnevnome radu liječnika obiteljske medicine (LOM) propisivanje je lijekova. Također, kao glavni sudionik zdravstvenog sustava koji ima zadatak da u izvršnom smislu regulira provođenje racionalne farmakoterapije, LOM ima i veliku odgovornost. Dodatno je potrebno naglasiti da podatci pokazuju kako izvanbolnička potrošnja lijekova u Hrvatskoj čini čak 62,5 % ukupne potrošnje, čime uloga LOM-a postaje još bitnija. Zbog svega navedenoga cilj je ove studije bio analizirati stavove liječnika obiteljske medicine o stalnoj provedbi kontrole farmakoterapije i samoprocjenu vlastitih sposobnosti u odlučivanju o toj terapiji.

Ispitanici i metode: Istraživanje je provedeno kao presječna anketna studija u kojoj je sudjelovalo 195 ispitanika za koje je uključni kriterij bio rad u primarnoj zdravstvenoj zaštiti u Republici Hrvatskoj. Anketni upitnik, sastavljen za potrebe ovog istraživanja, odnosio se na stavove LOM-ova o nuspojavama i interakcijama lijekova te na samoprocjenu vlastite sposobnosti u odlučivanju o racionalnoj farmakoterapiji. Za statističku analizu korišten je program *MedCalc Statistical Software*, inačica 14.12.0 (*MedCalc Software bvba*, Ostend, Belgium; [http://www.medcalc.org/](http://www.medcalc.org;); 2014).

Rezultati: Istraživanje je pokazalo da se liječnici drugih specijalizacija, koji rade kao LOM, značajno više ne slažu s tvrdnjama da mogu propisivati lijekove samostalno na osnovi svoga znanja, kao i ispitanici do četiri godine radnog staža ($P < 0,05$). U skladu s tim liječnici koji imaju do četiri godine radnog staža naveli su značajno veću potrebu za edukacijom o racionalnoj farmakoterapiji u odnosu na liječnike s duljim radnim stažem ($P < 0,05$). Unatoč tomu gotovo 40 % svih ispitanika ne pohađa tečajeve o racionalnoj farmakoterapiji, navodeći kao glavne razloge nedostatak vremena (14,4 % ispitanika) i neinformiranost o njihovu održavanju (više od 50 % ispitanika).

Zaključak: Ispitanici su prepoznali važnost racionalne farmakoterapije u radu LOM-a, kao i svoju ulogu kao predvodnika u rješavanju problema u tom području. Problem racionalne farmakoterapije ipak zahtijeva i interdisciplinarni pristup, s obzirom na to da su posljedice koje iz njega proizlaze ne samo medicinske nego i društvene i ekonomski prirode. Jedan od prijedloga za poboljšanje rada i znanja LOM-a iz područja racionalne farmakoterapije jest smanjenje preopterećenosti LOM-ova brojem pacijenata i administrativnim poslovima, s obzirom na to da su ispitanici kao jedan od glavnih razloga nepohađanja tečajeva iz ovoga područja naveli nedostatak vremena. Potrebno je i bolje informiranje liječnika o održavanju edukacija i tečajeva te omogućivanje pristupa različitim medicinskim bazama podataka.

Ključne riječi: liječnici, primarna zdravstvena zaštita, farmakoterapija, stav, znanje

¹ Fakultet za dentalnu medicinu i zdravstvo u Osijeku, Medicinski fakultet Osijek
Tea Omanović Kolarić, Šandora Petefija 17, 31000 Osijek, e-adresa: tea.omanovic@mefos.hr

ATTITUDES OF PRIMARY CARE PROVIDERS ON THE ONGOING IMPLEMENTATION OF PHARMACOTHERAPY CONTROL

Tea Omanović Kolarić,¹ Nikola Raguž-Lučić,²
Vjera Ninčević,³ Martina Smolić⁴

ABSTRACT

One of the most common activities in the daily work of the primary care provider (PCP) is prescribing drugs. Also, as the major health system participant who has the task of regulating the implementation of rational pharmacotherapy, the PCP also has a great responsibility. Further, various data show that outpatient drug consumption in Croatia makes up 62.5% of total consumption, making the PCPs' role even more important. Considering all of these facts, the purpose of this study was to analyze the attitudes of PCPs on the ongoing implementation of pharmacotherapy control as well as a self-assessment of their own ability to decide on the above mentioned.

Materials and Methods: The study was conducted as a cross-sectional study involving 195 respondents for whom the including criterion was working in the primary health care in the Republic of Croatia. The survey questionnaire, compiled for the purpose of this study, referred to the evaluation of attitudes of PCPs towards side effects and drug interactions, and a self-assessment of their own ability to decide on rational pharmacotherapy. For statistical analysis, MedCalc Statistical Software version 14.12.0 (MedCalc Software bvba, Ostend, Belgium; <http://www.medcalc.org>; 2014) was utilised.

Results: The research has demonstrated that doctors of other specializations, working as PCPs, significantly disagreed with the claims that they could prescribe drugs independently, on the basis of their knowledge especially the respondents with up to 4 years of work experience ($P<0.05$). Consequently, doctors with up to 4 years of work experience showed a much greater need for education on rational pharmacotherapy compared to doctors with more working experience ($P<0.05$). Nevertheless, almost 40% of all respondents did not attend courses in rational pharmacotherapy, citing as main reasons a lack of time (14,4% respondents) and insufficient information about such courses (over 50% respondents).

Conclusion: Respondents recognized the importance of rational pharmacotherapy in PCPs work as well as their role as leaders in solving problems in this area. The problem of rational pharmacotherapy still requires an interdisciplinary approach, given the consequences that arise from it, and not only medical ones, but also those of social and economic nature. One of the suggestions on how to improve the PCPs work and knowledge in the field of rational pharmacotherapy is to reduce the overload of PCPs by the number of patients and administrative jobs, considering that the respondents indicated a lack of time as one of the main reasons for not attending such courses. It is also necessary to better inform physicians about education courses and to provide them an access to a variety of medical databases.

Keywords: primary care, physicians, drug therapy, attitude, knowledge

¹ Faculty of Dental Medicine and Health Osijek, Faculty of Medicine Osijek

² Faculty of Dental Medicine and Health Osijek, Faculty of Medicine Osijek

³ Faculty of Dental Medicine and Health Osijek, Faculty of Medicine Osijek

⁴ Faculty of Dental Medicine and Health Osijek, Faculty of Medicine Osijek

Tea Omanović Kolarić, Šandora Petefija 17, 31000 Osijek, tea.omanovic@mefos.hr

NEUROLOŠKA MANIFESTACIJA BECHETOVE BOLESTI U TRIDESETSEDMOGODIŠNJEG MUŠKARCA

Lora Orkić¹

SAŽETAK

Behcetova bolest je upalna reumatska bolest nepoznatog uzroka. Svrstava se u skupinu vaskulitisa, a tipično se prezentira u dječaka ulceracijama usta, spolovila, oka i upalom srednje očne ovojnica. U manjeg broja bolesnika (3/4) javlja se i jutarnja zakočenost, bolni i otečeni zglobovi. Neurološke komplikacije Behcetove bolesti u pravilu su rjeđe nego sve druge komplikacije. U ovome radu prikazuje se slučaj bolesnika kojemu je dijagnosticirana neurološka komplikacija, tj. nekrotična lezija u području nukleusa kaudatusa u sklopu vaskulitisa Behcetove bolesti.

Prikaz slučaja: Radi se o tridesetsedmogodišnjem muškarцу komu je postavljena dijagnoza Behcetove bolesti, čiji su simptomi započeli u dobi od trideset i jedne godine. Bolesniku se 2008. godine prvi put postavlja sumnja na Behcetovu bolest, koja se prvo prezentirala aftama i genitalnim ulceracijama. Godine 2009. bolesnik je hospitaliziran u Kliničkoj bolnici „Sveti Duh“ na oftalmologiji zbog uveitisa, liječen je azatioprimom, potom se od 2011. godine liječi po imunologu te je na terapiji ciklosporinom. Godine 2014. hospitaliziran je na odjelu urologije zbog nekrektomije ulkusa na skorumu. Bolesnik 14. 8. 2014. postaje febrilan do 38,8 °C, te se postavlja sumnja na akutni prostatitis i uvodi se peroralna terapija, koamoksiklav + ciprofloxacin. Bolesnik 21. 8. 2014. postaje usporen, afatičan i razvija ljevostranu hemiparezu. Učini se hitni MSCT mozga kojim se postavi sumnja na apses mozga. Pacijent se premješta na kliniku za infektivne bolesti gdje je bio liječen vankomicinom, ampicilinom, meropenemom i rifampicinom uz anti-edematoznu terapiju. Učinjeni su CT I MR mozga i vratne kralježnice. MR mozga, učinjen 22. 8. 2014., upućuje na promjene kod vaskulitisa odnosno na Mb. Behcet, a za prstenastu leziju u obzir dolazi i apses. MR vratne kralježnice učinjen 22. 2. 2014.: u meduli spinalis u visini C1 i densa uočava se promjena koja može odgovarati Mb. Behcet. Pulsnog liječenje metilprednizolonom 500 mg tijekom tri dana i jednokratno endoksanom od 1000 mg započeto je 27. 8. 2014. Nakon primjene imunosupresivne terapije dolazi do manjeg poboljšanja neurološkog deficit-a. Bolesniku je sada zaostala blaža pareza lijeve noge uz povlačenje oftalmoplegije (u početku disfazija, teška hemipareza, oftalmoplegija).

Zaključak: Nakon liječenja na KBC Zagreb bolesnik je premješten u Krapinske toplice radi neurorehabilitacije te od onda redovito ide na fizikalnu terapiju zbog zaostale pareze lijeve noge i dizartrije. Kroz godine bolesniku bolest napreduje, te je verificiran i kronični gastritis i kronična bolest crijeva, a također je razvio i malnutričijski sindrom i artritis. Scintigrafijom učinjenom 2016. godine utvrđen je i smanjen i afunkcionalan desni bubreg. Od 2016. bolesnik ima status invalida. Trenutačno od terapije uzima Medrol 4–8 mg naizmjениčno, vitamin D3 kapi, 5 kapi dnevno, Ibuprofen 400–600 mg, Depakine Chrono 500 mg, Ensure Plus Advance 2 x 1 dnevno, a zbog inkontinencije upotrebljava i pelene. Uloga obiteljskog liječnika u ovog je pacijenta kompleksna. Potreban je specifičan odnos prema bolesniku, redovite kontrole i intenzivan rad na prevenciji uobičajenih bolesti, koje bi ovom pacijentu mogle znatno naškoditi.

Ključne riječi: Bechetova bolest, vaskulitis, reumatska bolest, ulceracije, uveitis, artritis, neurobechet

¹ Dom zdravlja Osijek

Lora Orkić, dr. med., Dom zdravlja Osijek, Ljudevita Posavskog 2, Osijek,
e-adresa: jerkoviclor@gmail.com

NEUROLOGICAL MANIFESTATION OF BEHCET'S DISEASE IN A THIRTY-SIX-YEAR-OLD MAN

Lora Orkić¹

ABSTRACT

Behcet's disease or also known as Bechet's syndrome is an inflammatory rheumatic disease of unknown cause. It is classified into the group of vasculitis, and is typically presented in boys with ulcerations of the mouth, genitals, the eye and the inflammation of the uvea. In a smaller number of patients (3/4) there is also morning stiffness, painful and swollen joints. Neurological complications of Behcet's disease are usually less frequent than any other complications.

This paper presents the case of patients diagnosed with neurological complications; necrotic lesions in the area of the nucleus caudatus within the vasculitis of Behcet's disease.

Case report: It is a thirty-six-year-old man who has been diagnosed with Bechet's disease. His symptoms started at the age of thirty-one. In 2008, he was the first suspect of Behcet's disease, which was first presented with oral and genital ulceration. In 2009, the patient is hospitalized at the Sveti Duh Hospital ophthalmology ward, due to uveitis. In 2014, he is hospitalized at the department of urology for necrectomy of the ulcus in the scrotum. On 14 August 2014, the patient becomes febrile up to 38.8 and it raises suspicion of acute prostatitis. On 21 August 2014, the patient becomes slow, develops aphasia and left hemispheres. An emergency MSCT of his brain is made which raises suspicion of a brain abscess. The patient is transferred to the clinic for infectious diseases where he is treated with vancomycin, ampicillin, meropenem and rifampicin along with antiedematous therapy. CT and MRI of the brain and cervical spine are performed. MR of the brain is performed on 22 August 2014; lesions are consistent to vasculitis ie Mb Bechet and annular lesion can match the abscess. On 27 August 2014 pulse therapy is introduced with methylprednisolone 500mg for 3 days and one-time endoxane 1000mg was started. After the administration of immunosuppressive therapy, there is a slight improvement in the neurological status. The patient now suffers from a milder paresis of the left leg and there is a withdrawal of ophthalmoplegia (initially: dysphagia, severe hemiparesis, ophthalmoplegia).

Conclusion: After treatment at KBC Zagreb, the patient is transferred to Krapinske Toplice for neurorehabilitation, and after that he regularly goes to physical therapy because of dysarthria and left paresis. Throughout the year, the disease progresses, chronic gastritis and chronic bowel disease have been diagnosed, and malnutrition syndrome and arthritis have also been developed. Scintigraphy in 2016 is also associated with decreased right kidney function. Since 2016 the patient has had a disability status. Currently, his therapy is Medrol 4-8 mg alternately, vitamin D3 5 drops daily, Ibuprofen 400-600mg, Depakine Chrono 500mg, Ensure Plus Advance 2x1 per day and, due to incontinence, he uses diapers. Specific care, regular controls and intensive work on the prevention of common diseases, which could seriously harm this patient, are necessary for this patient.

Key words: Bechet's disease, vasculitis, rheumatic disease, ulceration, uveitis, arthritis

¹ Health Care Center Osijek

Lora Orkić, dr. med, Dom Zdravlja Osijek, Ljudevita Posavskog 2, e-mail: jerkoviclora@gmail.com

HEMOSIDERMIJA U AMBULANTI LIJEČNIKA OBITELJSKE MEDICINE

Ana Reschner Planinc,¹ Ivo Planinc,² Ana Planinc-Peraica^{3,4}

SAŽETAK

Povećana koncentracija željeza u krvi predstavlja ozbiljan zdravstveni problem koji se može previdjeti jer su simptomi često neupadni i nastaju postupno. Rano otkrivanje povećane koncentracije željeza i uzroka poremećaja, te pravodobno liječenje sprječavaju toksično djelovanje željeza i nastanak oštećenja organa. Najčešći uzroci povećane koncentracije željeza su hereditarna hemokromatoza, hemolitičke anemije, transfuzije eritrocita kod neučinkovite eritropoeze i bolest jetre.

Prikaz slučajeva: U jednog bolesnika (33 godine) i dvije bolesnice (45 i 56 godina) s normalnim fizikalnim nalazom, normalnom krvnom slikom, povećanom koncentracijom željeza u krvi i feritinom te smanjenim UIBC-om molekularnim metodama utvrdi se da su homozigoti za hemokromatozu. Bolesnik i jedna bolesница imali su članove obitelji s hemokromatozom. Druga bolesnica imala je godinama sideropeničnu anemiju, a dvije godine nakon što je u dobi od 39 godina histerektomirana zbog mioma, utvrdi se povećana koncentracija željeza u krvi. Niti jedan bolesnik nema znakova oštećenja funkcije jetre, mijelopoeze ili drugih organa iako se dvoje njih (bolesnik i bolesnica s 56 godina) počinju liječiti šest do deset godina nakon što im je prvi put otkrivena povećana koncentracija željeza u krvi. Bolesnici su liječeni venepunkcijama (400 ml krvi) nakon čega primaju 250 ml infuzije FO. Postupak se ponavljao jednom tjedno do normalizacije serumskog željeza i feritina. Četvrtom se bolesniku (67 godina) fizikalnim pregledom utvrdi sivkasta boja kože, bljedilo konjunktiva i palpabilna jetra (3 cm), a laboratorijskim pretragama pancitopenija (Hb 114 g/L, L 2,2 x 10⁹/L, Tr 53 x 10⁹/L), povišeno serumsko željezo, smanjeni UIBC (Fe/ UIBC 50/4 umol/L), povišeni gama-GT (59 U/L), povišeni amonijak (56,36 umol/L) i povišeni feritin (1738 ug/L). Molekularnom analizom isključena je hemokromatoza. Citološkom punkcijom koštane srži i biopsijom kosti dijagnosticiran je hipocelularni mijelodisplastični sindrom s ekscesom blasta (MDS-EB-1), a biopsijom jetre ciroza jetre. Bolesniku nije moguće smanjiti serumsko željezo venepunkcijama zbog već prisutne anemije. Intravenski kelatori željeza imali su kratkotrajan učinak. Peroralni kelatori željeza su kontraindicirani zbog lezije jetre. Provode se suportivne mjere liječenja ciroze jetre, a anemija se korigira transfuzijama koncentrata eritrocita kad je ona simptomatska.

Zaključak: Zbog toksičnog djelovanja željeza važno je otkriti povećanu koncentraciju željeza, dijagnosticirati poremećaj koji ga je uzrokovao i liječenjem ju smanjiti prije nastanka ireverzibilnih oštećenja organa.

Ključne riječi: hipersideremija, hemokromatoza, mijelodisplastični sindrom, ciroza jetre, liječenje

¹ Dom zdravlja Zagreb-Centar

² Klinički bolnički centar Zagreb

³ Klinička bolnica Merkur

⁴ Medicinski fakultet Sveučilišta u Zagrebu

Ana Reschner Planinc, Radnička cesta 20a, 10 000 Zagreb, e-adresa: anchice.reschner@gmail.com

HEMOSIDEREMIA IN FAMILY PHYSICIAN PRACTICE

Ana Reschner Planinc,¹ Ivo Planinc,² Ana Planinc-Peraica^{3,4}

ABSTRACT

Increased serum iron is a serious health issue that may easily be overlooked due to scarce and non-specific symptoms. Early detection of increased serum iron and its aetiology, along with prompt treatment prevents the toxic effects of iron and end organ damage. Most common causes are hereditary hemochromatosis, hemolytic anaemias, multiple blood transfusions in patients with inefficient erythropoiesis, and liver disease.

Case reports: A 33-year-old male patient, and 2 female patients (45 and 56) with normal physical examination findings, normal complete blood count (CBC), increased serum iron and ferritin, and low UIBC, were proven homozygous for hemochromatosis. Both the male patient and one of the female patients had family members with known hemochromatosis. The other female patient had a long-standing history of sideropenic anaemia, in whom increased serum iron was found 2 years after hysterectomy due to myoma. None of the patients had signs of liver dysfunction, dysfunctional myelopoiesis nor other organ damage. Nevertheless, 2 of the patients required treatment 6-10 years after initial diagnosis (33-year-old male patient and 56-year-old female patient). Patients were treated with therapeutic phlebotomy (400ml of blood), followed by volume replacement with 250ml of crystalloid solution. The treatment is repeated once weekly till the normalisation of serum iron and ferritin.

A 67-year-old male patient with greyish discoloured skin, pale mucous membranes, hepatomegaly (3cm), and pancytopenia (Hb 114g/L, L 2.2 x 10⁹/L, Tr 53 x 10⁹/L), along with increased serum iron, low UIBC (Fe/UIBC 50/4 umol/L), high gamma-GT (59 U/L), high ammonia (56.36 umol/L), and increased ferritin (1738 ug/L) had negative molecular analysis tests for hemochromatosis. Bone marrow cytology and biopsy revealed hypo-cellular myelodysplastic syndrome with excess blasts (MDS-EB-1), while liver biopsy showed cirrhosis. Therapeutic phlebotomy was not possible due to already present anaemia. Intravenous chelators had effect only for a short period of time, while oral chelators were contraindicated due to a hepatic lesion. Supportive measures are undertaken for liver cirrhosis, while symptomatic anaemia is corrected by blood transfusions.

Conclusions: Due to its toxic effects on end organs, it is important to detect increased serum iron early, to find the cause of increase, and timely start the treatment before irreversible damage occurs.

Keywords: iron overload, hemochromatosis, myelodysplastic syndrome, liver cirrhosis, therapy

¹ Health Centre, Zagreb-Centre

² University Hospital Centre Zagreb

³ University Hospital Merkur

⁴ University of Zagreb School of Medicine

Ana Reschner Planinc, Radnička cesta 20a, 10000 Zagreb, E-mail: anchice.reschner@gmail.com

AKUTNI KORONARNI SINDROM U ORDINACIJI LIJEČNIKA OBITELJSKE MEDICINE

Ana Reschner Planinc,¹ Ivo Planinc²

SAŽETAK

Ishodi liječenja bolesnika s akutnim koronarnim sindromom (AKS) uvelike ovise o pravovremenoj dijagnozi. Najčešći vodeći simptom u bolesnika s AKS-om jest bol u prsima, koja može biti tipična ili atipična. Tipična bol u prsima karaktera je pritiska, širi se u jedno ili oba ramena ili ruke, te se pogoršava tjelesnom aktivnosti, a brzo prestaje mirovanjem ili primjenom nitrata. Odsutnost takvih tipičnih simptoma karakteristična je za žene, starije bolesnike i bolesnike sa šećernom bolesti. U njih vodeći simptomi mogu biti npr. osjećaj žgaravice, zaduha ili podrigivanje.

Prikaz slučaja: Sedamdesetčetverogodišnji bolesnik s arterijskom hipertenzijom i šećernom bolesti, te anamnezom operacije zbog frakture klavikule i tendinitisom ramenog zglobova, javio se u ordinaciju liječnika obiteljske medicine (LOM) zbog bolova u lijevom ramenu trajanja tri dana. Bol je opisivao identičnom onoj za vrijeme tendinitisa ramena. Navedene tegobe javile su se nakon povratka s vikendice gdje je bio dosta tjelesno aktiviran. Bol je bila intermitentnog karaktera, a prestala bi u mirovanju. Nije imao zaduhe, palpitacija, mučnine ni preznojavanja. Odlučio se javiti LOM-u jer je tog dana osjetio intenzivniju bol praćenju žgaravicom koja nije popuštala primjenom NSAR-a ili antacida. U kroničnoj terapiji uzimao je blokator angiotenzinskih receptora, metformin i NSAR. Fizikalni pregled nije bio upadljiv, a vitalni znakovi su bili: krvni tlak 155/83 mmHg, frekvencija srca 80/min, frekvencija disanja 14/min te glukoza natašte 6,1 mmol/l. EKG nije bio dostupan u ordinaciji LOM-a. Zbog utvrđene sumnje na AKS bolesnik je upućen kolima HMP-a u pratnji liječnika u bolničku hitnu službu. U inicijalnom EKG-u opisuje se sinusni ritam s denivelacijom ST segmenta inferolateralno uz negativne T-vallove. Prvi nalaz koncentracije troponina T iznosio je 299 ng/l (normalno 0 – 14 ng/L). Hitnom ehokardiografijom opiše se teška hipokontraktilnost bazalne polovice inferiore i hipokontraktilnost posteriore stijenke. Učinjena je hitna koronarografija kojom se ustanovi subokluzivna desna koronarna arterija, te se u istom aktu učini perkutana intervencija s postavljanjem jednog stenta.

Zaključak: Od velike je važnosti misliti na sve atipične simptome AKS-a na koje se mogu žaliti bolesnici u ordinaciji LOM-a, posebno u kontekstu njihovih rizičnih čimbenika i osobne anamneze, pogotovo u odsutnosti laboratorijskih i ostalih dijagnostičkih metoda, s obzirom na to što propusti i kasno liječenje AKS-a imaju velik utjecaj na ishode bolesnika.

Ključne riječi: akutni koronarni sindrom, šećerna bolest, liječnik obiteljske medicine, bol u prsima

¹ Dom zdravlja Zagreb-Centar

² Klinički bolnički centar Zagreb

Adresa:

Ana Reschner Planinc, Radnička cesta 20a, 10 000 Zagreb, e-adresa: anchice.reschner@gmail.com

ACUTE CORONARY SYNDROME IN FAMILY PHYSICIAN PRACTICE

Ana Reschner Planinc¹, Ivo Planinc²

ABSTRACT

Timely diagnosis of acute coronary syndrome (ACS) is of paramount importance for improvement of patient outcomes. The most common leading symptom in patients with ACS is chest pain, however a substantial number of patients present with atypical chest symptoms. Absence of classical chest discomfort that radiates to both arms or shoulders or is worsened with exertion is especially common in women, elderly and patients with diabetes mellitus. More commonly they present with less typical symptoms like indigestion, dyspnoea and belching.

Case report. A 74-year-old man with a history of type 2 diabetes and hypertension with prior surgical intervention on the left clavicle due to clavicular fracture and history of left shoulder tendinitis, presented to the family physician's (FP) office complaining of left shoulder pain, similar to one accompanied with rotator cuff tendonitis. His shoulder pain started three days ago after extensive physical activity on his country side. Pain was intermittent and worsening with physical exertion. He denied shortness of breath; palpitations; nausea; or sweating.

He decided to visit FPs office because his shoulder pain was now accompanied with chest discomfort which he described as indigestion. Pain was refractory to NSAIDs and antacids he usually used. His medications at the time of review included an angiotensin receptor blocker, metformin and NSAID. Physical examination revealed a blood pressure of 155/83 mmHg, heart rate 80/min, breath rate 14/min and glucose 6.1 mmol/l. ECG was not available in GPs office. He was then accompanied to hospital emergency department. Patients initial electrocardiogram showed sinus rhythm Q waves in leads II, III, and aVF. An urgent echocardiogram showed marked motion abnormalities in the basal inferior (and posterior) wall. An initial troponin T was 299 ng/l (normal range 0- 14 ng/l). The patient was taken for emergent cardiac catheterization, that demonstrated sub-occlusive lesion of RCA that was opened with primary angioplasty and stent implantation.

Conclusion. It is very important that any less typical symptoms are carefully evaluated in FPs office through clinical examination and precise and complete history taking even in absence of laboratory and other diagnostic tools because if left untreated may have a significant impact on the outcomes of diabetics with coronary artery disease.

Keywords. acute coronary syndrome, diabetes mellitus, family physician, chest pain

¹ Health Centre, Zagreb-Centre, ²University Hospital Centre Zagreb

² University Hospital Centre Zagreb

Ana Reschner Planinc, Radnička cesta 20a, 10000 Zagreb, anchice.reschner@gmail.com

ANALGETICI U OBITELJSKOJ MEDICINI – TKO, ŠTO I ZAŠTO?

Dunja Stolnik,¹ Ivon Matić,² Tea Pandurić,³ Tereza Solocki-Matić³,
Stjepan Kelčić,⁴ Zvonimir Bosnić,⁵ Sanja Bekić,⁶
Ljiljana Trtica Majnarić⁷

SAŽETAK

Liječenje kronične boli učestali je problem u ambulantama obiteljske medicine. Uz povoljni izbor analgetika, liječnik treba imati u vidu o kojoj vrsti boli se radi, komorbiditetima pacijenta, mogućim interakcijama lijekova i nuspojavama analgetika. Značajno je procijeniti psihičko stanje pacijenta te ga informirati o mogućnostima liječenja boli zbog činjenice da kronična bol ima katastrofalne posljedice za fizički, psihički i socijalni život osobe. S obzirom na problematiku, autori su htjeli otkriti tko najčešće koristi analgetike, koju vrstu analgetika i za koje bolesti.

Ispitanici i metode: Ispitanici su pacijenti u dobi ≥ 40 godina iz triju ordinacija obiteljske medicine: Nijemci, Stari Jankovci/Srijemske Laze i Donji Miholjac; a koji su ≥ 3 mjeseca uzimali analgetike. Podaci su uzeti iz elektronskih medicinskih kartona 2016. godine. Ispitanici su podijeljeni prema spolu i grupirani u šest dobnih skupina (40-99 godina). Također su podijeljeni u tri grupe ovisno o kroničnom uzimanju opioidnih, ne opioidnih i kombinaciji opioidnih i ne opioidnih analgetika. Uzeti su i podaci o kroničnim bolestima pod šifrom M dijagnoze (po MKB 10 šifarniku).

Rezultati: 2/3 pacijenata koji uzimaju kroničnu analgetsku terapiju su žene. Najveća prevalencija propisivanja analgetika je u dobnim skupinama 50-79 godina. Najčešće su propisivani ne opioidi (55%), a podjednako su propisivani opiodi (23%) i kombinacija opioda i ne opioida (22%). Najčešće propisani ne opioid je bio ibuprofen, a od opioda tramadol. Analgetici su najčešće propisivani za bolesti pod dijagnozama M50-M54 (bolesti intervertebralnih diskova, dorzalgie i dorzopatije), zatim za M15-M19 (artroze) i za M05-M14 (dominantno reumatoidni artritis).

Zaključak: Rezultati ovog istraživanja u skladu su s rezultatima istraživanja drugih autora (Sarganas i sur., Dale i sur., Samuelsen i sur.). Zbog dozvoljene slobodne prodaje pojedinih ne opioidnih analgetika (paracetamol, acetosalicilna kiselina, ibuprofen,) nije se moglo zaključiti koliko pojedini pacijent zaista koristi analgetika. Međutim, u Republici Hrvatskoj opiodni analgetici se propisuju isključivo na recept tako da zloupotreba opioda nije raširena. Posebno zabrinjava činjenica da najviše analgetika koriste pacijenti u dobi 50-79 godina u kojoj je i najveća učestalost drugih komorbiditeta te poslijedno i korištenje drugih lijekova čime se povećava mogućnost pojave nepoželjnih interakcija lijekova kao i štetnih nuspojava analgetika. Istraživanja su pokazala da se mnogi liječnici obiteljske medicine ne osjećaju sigurnima kada je u pitanju liječenje boli pacijenata i najviše se oslanjaju na farmakološke metode, a vrlo malo se bave psihološkom komponentom boli što bi se u budućnosti trebalo promijeniti.

Ključne riječi: ne opioidni analgetici, opioidni analgetici, kronična bol

¹ Dom zdravlja Osijek

² Dom zdravlja Županja

³ Opća županijska bolnica Našice

⁴ Dom zdravlja Vinkovci

⁵ Dom zdravlja Slavonski Brod

⁶ Privatna specijalistička ordinacija obiteljske medicine

⁷ Katedra za internu medicinu, obiteljsku medicinu i povijest medicine Medicinskog fakulteta u Osijeku
Prezenter: Dunja Stolnik, Vjenac Ivana Meštrovića 26, 31000 Osijek, dunja.stolnik@gmail.com

ANALGESICS IN FAMILY MEDICINE - WHO, WHAT AND WHY?

Dunja Stolnik,¹ Ivon Matić,² Tea Pandurić,³ Tereza Solocki-Matić,³
Stjepan Kelčić,⁴ Zvonimir Bosnić,⁵ Sanja Bekić,⁶
Ljiljana Trtica Majnarić⁷

ABSTRACT

Dealing with chronic pain is a frequent problem in general practice. While choosing among a wide range of analgesics, the general practitioner (GP) should determine the type of pain, patient's comorbidities, possible drug interactions and the adverse effects of analgesics. It is important to estimate patient's mental state and inform the patient about all available therapeutic options because chronic pain has detrimental consequences on one's physical, mental and social life. Considering everything, authors wanted to find out who among patients most frequently used analgesics, which type of analgesics and for which condition.

Participants and methods: Participants were patients from three GP offices: Nijemci, Stari Jankovci/Srijemske Laze and Donji Miholjac; who were using analgesics ≥ 3 months. Data was used from their electronic health records in 2016. Participants were assigned to two groups depending on their sex, and six groups depending on their age (40-99). They were also assigned into three groups depending on their use of opioids, non-opioids and combination of both. Data about their chronic musculoskeletal diseases recorded as M diagnoses (MKB 10 classification) were used, too.

Results: Two thirds of the patients who were chronically using analgesics were female. The most prevalent analgesic prescription was in age groups of 50-79 year olds. Most frequently prescribed were non-opioids (55%); opioids and a combination of non-opioids and opioids was prescribed evenly (23% and 22%). The most frequently prescribed non-opioid was ibuprofen, and among opioids it was tramadol. Analgesics were mostly prescribed for diseases under M50-M54 diagnoses (intervertebral disc disorders, dorsalgias and dorsopathies), followed by M15-M19 (arthrosis) and M05-M14 (mostly rheumatoid arthritis).

Conclusion: Results of this research are confirmed in other similar studies (Sarganas et al., Dale et al., Samuelsen et al.). Some of non-opioid analgesics are OTC products (such as paracetamol, acetylsalicylic acid, ibuprofen) so the real use of non-opioids among patients in this research could not be determined. However, opioids must be prescribed by a GP and cannot be bought in drugstores, so an opioid misuse is not common in the Republic of Croatia. The most worrisome fact is that the highest prevalence of chronic analgesic use was in age group of 50-79 year olds which is also the highest prevalence of comorbidities and consequently chronic use of other medicines increasing the risks of unwanted drug interactions and harmful analgesics side effects. Studies have shown that many GPs do not feel confident in managing pain; they are mostly relying on pharmacological methods, and rarely deal with psychological aspects of pain which should change in future.

Key words: non-opioid analgesics, opioid analgesics, chronic pain

¹ Health Center Osijek

² Health Center Županja

³ General county hospital Našice

⁴ Health Center Vinkovci

⁵ Health Center Slavonski Brod

⁶ Family medicine private practice

⁷ Department of internal medicine, family medicine and history of medicine of The Faculty of Medicine in Osijek

Presenter: Dunja Stolnik, Vrijenac Ivana Meštrovića 26, 31000 Osijek, dunja.stolnik@gmail.com

ANAFILAKSIJA U ORDINACIJI OBITELJSKE MEDICINE

Livija Šapina,¹ Ivana Maslać,² Jelena Šakić Radetić,³
Rudika Gmajnić⁴

SAŽETAK

Anafilaksija se, prema Međunarodnom konsenzusu o anafilaksi, definira kao teška generalizirana ili sustavna reakcija preosjetljivosti koja ugrožava život, karakterizirana naglim razvojem problema dišnih putova i / ili cirkulacije. Prikazuje vrlo različite kombinacije simptoma i naizgled blage znakove i može nepredvidivo napredovati do fatalnog anafilaktičkog šoka. Intramuskularni epinefrin (adrenalin) je lijek izbora za hitno lijeчењe anafilaksije. Primjena kortikosteroida i H1-antihistaminika ne bi trebalo odgoditi primjenu epinefrina. Ovim prikazom slučaja htjeli smo upozoriti na važnost edukacije i sposobljenosti obiteljskih liječnika o liječeњu anafilaksije, kao i o važnosti dobre opremljenosti naših ordinacija, osobito onih u ruralnim područjima, kao što je ovdje bio slučaj.

Prikaz slučaja : Pacijentica u dobi od 45 godina, dolazi sama u ambulantu i žali se na osjećaj smetenosti u glavi i osjećaj pritiska u prsima nakon uboda dva stršljena u glavu. Ubodi su se dogodili prije 5-10 minuta. Bolesnica se polegne na ležaj. U početku pune svijesti, nešto usporenijeg govora. Izmjeri se tlak 90/60 nakon čega bolesnica ostaje bez svijesti i prestaje disati. Aplicira se 1 ampula adrenalina u natkoljenicu, nakon čega bolesnica počinje disati i dolazi k svijesti. Postave se 2 venska puta, ordinira 125 mg metilprednisolona iv., ampula kloropiramina im. uz 500 ml f.o. iv. te se pacijentica priključi na defibrilator (AED) uz praćenje vitalnih funkcija do dolaska ekipe HMP koja uputi pacijentu u KBCO.

Zaključak : Ordinacije obiteljskih liječnika, osobito u ruralnim sredinama, moraju imati svu medicinsku opremu koja je potrebna za rješavanje ovakvih po život ugrožavajućih stanja. Uz antišok terapiju, nužno je imati EKG aparat, defibrilator, bocu s kisikom, set za reanimaciju kao i sve nužno za intravensku primjenu lijekova. Nužno je da obiteljski liječnici kontinuirano obnavljaju znanje o liječeњu hitnih stanja.

Ključne riječi: anafilaksija, obiteljski liječnik, adrenalin

¹ Dom zdravlja Đakovo

² Dom zdravlja Osijek

³ Dom Zdravlja Đakovo

⁴ Ordinacija obiteljske medicine prof. dr.sc Rudika Gmajnić
prezenter: Livija Šapina, adresa: Hercega Kolomana 95, 31400 Đakovo, email: livijavracevic@gmail.com

ANAPHYLAXIS IN FAMILY MEDICINE PRACTICE

Livija Šapina,¹ Ivana Maslać,² Jelena Šakić Radetić,³ Rudika Gmajnić⁴

ABSTRACT

Anaphylaxis has been defined according to the International consensus on anaphylaxis as a severe life-threatening generalized or systemic hypersensitivity reaction characterized by rapidly developing airway and/or circulation problems. It presents a different combination of symptoms and apparently mild signs, and can unpredictably progress to the fatal anaphylactic shock. Intramuscular epinephrine (adrenaline) is the medication of choice for the emergency treatment of anaphylaxis. Administration of corticosteroids and H1-antihistamines should not delay the administration of epinephrine. In this case study, we wanted to warn of the importance of educating and training family physicians on the treatment of anaphylaxis, as well as the importance of good equipment in our practices, especially those in rural areas, as was the case here.

Case report: A 45-year-old female patient comes to the ambulance and complains of dizziness and a feeling of pressure in chest after two wasp stings in the head, which happened 5-10 minutes ago. The patient is immediately put in the lying position on the bed. She has full consciousness with a somewhat delayed speech. During the measurement of vital functions the patient becomes unconscious and stops breathing. 1 ampoule of adrenaline is applied in the thighs, after which the patient begins to breathe and regains consciousness. There is a venous route set, 125 mg of methylprednisololum iv., chloropyraminum ampoule im. with 500 ml saline iv. and the defibrillator electrodes are set. The ER team is called and the patient is referred to the Clinical and Hospital Centre Osijek.

Conclusion: Family medicine practices, especially those in rural areas, must have all the medical equipment needed to deal with these life-threatening conditions. It is necessary to have an ECG, a defibrillator, an oxygen bottle, a resuscitation set, as well as all the necessary equipment for intravenous drug administration. It is also necessary to take part in education on the treatment of emergency conditions.

Keywords: anaphylaxis, family medicine, epinephrine

¹ Health Care Center Đakovo

² Health Care Center Osijek

³ Health Care Center Đakovo

⁴ GP office prof. Rudika Gmajnić GP/PhD

DIJAGNOSTIKA I LIJEĆENJE INFKECIJA MOKRAĆNOG SUSTAVA U ORDINACIJI OBITELJSKE MEDICINE UZ PRIDRŽAVANJE ISKRA SMJERNICA: PRIKAZI SLUČAJEVA

Helena Trputac,¹ Senka Martinović-Galijašević²

SAŽETAK

Infekcije mokraćnog sustava jedan su od najučestalijih problema u ordinaciji obiteljske medicine (1). Cilj ovog rada je kroz dva tipična slučaja prikazati individualnu primjenu hrvatskih nacionalnih ISKRA smjernica antimikrobnog liječenja i profilakse infekcija mokraćnog sustava (2) u ordinaciji obiteljske medicine.

Prikaz slučaja 1: 50-godišnji pacijent javio se s tegobama pečenja pri mokrenju i osjećajem nemogućnosti izmokravanja do kraja koji su trajali sedam dana. Bio je febrilan s temperaturom do 38°C. Nije imao simptome perinealne boli niti seksualne disfunkcije čime se isključila dijagnoza klinički manifestnog akutnog prostatitisa. Lumbalna sukusija bila je obostrano bezbolna. U nalazu urina nadeno je: leukocitna esteraza +++, nitriti +, dosta leukocita i bakterija te >20(x400) eritrocita. Postavljena je dijagnoza akutne infekcije mokraćnog sustava. Propisana je terapija Xorimax tbl. 500mg (cefuroksim-aksetil) dva puta dnevno svakih dvanaest sati u trajanju od četrnaest dana. Nakon provedene terapije nastupio je potpuni prestanak simptoma. S obzirom na graničnu dob za pojavu uroinfekcija u muškaraca preporučeni su ultrazvuk urotrakta i određivanje PSA nakon smirivanja upale.

Prikaz slučaja 2: 39-godišnja pacijentica javila se s osjećajem pečenja prilikom mokrenja, bez febrilitet i drugih simptoma. S obzirom na simptome i odsutnost težih kroničnih bolesti, abnormalnosti urotrakta i trudnoće postavljena je dijagnoza nekomplikiranog cistitisa. Propisana je terapija Ninur caps. 50mg (nitrofurantoin) dva puta po dvije tablete dnevno tijekom sedam dana. Pet dana kasnije pacijentica se ponovno javila u ordinaciju zbog boli u ledima za koju je pretpostavila da je u području lijevog bubrega. Lumbalna sukusija bila je obostrano bezbolna. Nalazi KKS su bili uredni, uz CRP 11 mg/L i nalaz urina: leukocitna esteraza ++, nitriti 0, leukociti 10-20(x400) i nešto bakterija, čime je isključen pijelonefritis. Nakon provedene terapije javila je prestanak dizuričnih tegoba, no dva tjedna kasnije ponovno se javila zbog bolova u ledima. Tada učinjeni RTG kralježnice pokazao je kronične promjene koje su im najvjerojatnije bile uzrok. Nalaz urinokulture na koju smo se odlučili prije dospijeća nalaza RTG-a bio je negativan.

Zaključak ISKRA smjernice od velike su važnosti jer grupiraju pacijente s infekcijama urotrakta u različite kategorije te za svaku preporučuju najbolji način dijagnostike i liječenja, čime pomažu u izbjegavanju nepotrebnih pretraga i smanjenju antibiotske rezistencije bakterija. Unatoč tome, važno je prilagoditi ih svakom pacijentu individualno kako bi se postigao najbolji ishod liječenja.

Ključne riječi: infekcije mokraćnog sustava, ISKRA smjernice

¹ Klinička bolnica Merkur, , Zagreb, Hrvatska

² Dom zdravlja Zagreb-Centar

Helena Trputac, Crvenog križa 25, 10000 Zagreb, Hrvatska, e-mail: htrputac@gmail.com

DIAGNOSIS AND TREATMENT OF URINARY TRACT INFECTIONS IN FAMILY MEDICINE PRACTICE IN ADHERENCE TO THE ISKRA GUIDELINES: CASE REPORTS

Helena Trputac,¹ Senka Martinović-Galijašević²

ABSTRACT

Urinary tract infections are one of the most common complaints in family medicine practice (1). The main objective of this paper is to show, by using examples of two typical cases, the individual application of the Croatian national ISKRA guidelines on the antimicrobial treatment and prophylaxis of urinary tract infections (2) in family medicine practice.

Case report 1: A 50-year-old male patient presented with complaints of a burning sensation during urination and a feeling of incomplete bladder emptying in the duration of seven days. He was febrile with a temperature of up to 38°C. He did not have symptoms of perineal pain or a sexual dysfunction which excluded the diagnosis of a clinically manifest acute prostatitis. The costovertebral angle tenderness test was negative on both sides. In the urinalysis the patient had: leukocyte esterase +++, nitrites +, a plenty of leukocytes and bacteria, and >20 (x400) red blood cells. The diagnosis of acute urinary tract infection was established. He was prescribed Xorimax 500mg tablets (cefuroxime axetil) twice daily, every twelve hours, during fourteen days. After finishing the treatment, all of the symptoms disappeared. Considering the patient's borderline age for common urinary tract infections in men a urinary tract ultrasound and PSA level testing were recommended after the inflammation had completely reduced.

Case report 2: A 39-year-old female patient presented with complaints of a burning sensation during urination and was neither febrile nor had other symptoms. Taking into account her symptoms and the absence of any history of severe chronic illness, urinary tract abnormalities as well as pregnancy, the diagnosis of uncomplicated cystitis was established. She was prescribed Ninur 50mg capsules (nitrofurantoin) in a dose of two capsules twice daily during seven days. Five days later, the patient sought medical attention again with complaints of a moderate back pain which she assumed to be located in the left kidney area. The costovertebral angle tenderness test was negative on both sides. Her CBC was normal with CRP 11 mg/L and urinalysis: leukocyte esterase ++, nitrites 0, leukocytes 10-20(x400) and some bacteria, which excluded the diagnosis of pyelonephritis. After the treatment was finished all of the symptoms disappeared, but two weeks later she visited the practice again with complaints of a back pain located in the same area as before. This time an X-ray of her spine was performed and the finding showed chronic changes which were assumed to be the cause of the pain. Urine culture test, which we decided to perform while waiting for the X-ray finding, was negative.

Conclusion: ISKRA guidelines are of great importance because they divide patients with urinary tract infections into different categories and recommend the best possible diagnosis and treatment for each of them, which helps to avoid unnecessary diagnostics and reduces bacterial antibiotic resistance. However, it is also important that the guidelines are adjusted to every patient individually in order to achieve the best treatment outcome.

Key words: urinary tract infection, ISKRA guidelines

¹ Clinical Hospital Merkur, Zajčeva 19, Zagreb, Croatia

² Health Center Zagreb-Centar, Zagreb, Croatia

Helena Trputac, Crvenog križa 25, 10000 Zagreb, Hrvatska, htrputac@gmail.com

Društvo nastavnika opće/obiteljske medicine (DNOOM)
The Association of Teachers in General Practice/Family Medicine

III. KONGRES SESTARA U PRIMARNOJ ZDRAVSTVENOJ ZAŠTITI

3TH CONGRESS ON NURSING IN PRIMARY HEALTH CARE

**SMJERNICE U PRAKSI OBITELJSKOG LIJEČNIKA
FAMILY PRACTICE GUIDELINES**

Knjiga sažetaka / Abstract book

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SESTRINSKA SKRB PACIJENATA S MULTIMORBIDITETOM I ORGANIZACIJA RADA U AMBULANTI OBITELJSKE MEDICINE

Maja Ćužić,¹ Andrea Brossler Smrk¹

SAŽETAK

Multimorbiditet označava istodobnu prisutnost više različitih kroničnih bolesti kod istog bolesnika. Postoji pretpostavka da će do 2050. godine u Europi udio stanovnika starijih od 65 godina biti 60%. Starenjem populacije i istodobnim napretkom medicinskih znanosti koje dovode do uspješnijeg liječenja kroničnih nezaraznih bolesti predstavlja povećanje prevalencije bolesnika s multimorbiditetom u ambulantama obiteljske medicine. Cilj ovog preglednog rada je procijeniti kompetencije medicinske sestre u ordinaciji obiteljske medicine u skrbi za pacijente s multimorbiditetom i ukazati na postojanje razlike između zakonski predviđenih standardiziranih postupaka zdravstvene njage, stvarne prakse i stupnja obrazovanja medicinske sestre. Izvršena je analiza zakonskih odredbi, dostupnih standardiziranih postupaka zdravstvene njage i usporedjena sa stvarnim postupcima, dužnostima i kompetencijama medicinske sestre u tim obiteljske medicine. Skrb za pacijenta s multimorbiditetom je kompleksno i postoji opravdana potreba za uvođenjem prvostupnica u tim obiteljske medicine. Utvrđeno je da postoji potreba za uvođenjem kvalitetnije sestrinske dokumentacije čime bi se prikazao i kvalitetnije mjerilo njezin doprinos i primjena specifičnih znanstvenih spoznaja iz područja sestrinstva, prirodnih, medicinskih i humanističkih znanosti. Medicinska sestra u skrbi za pacijenta s multimorbiditetom prvenstveno se mora voditi holističkim načelima, koristiti sva znanja utemeljena na znanstvenim dokazima, biti spretan koordinator skrbi, poznavati komunikacijske vještine kako bi prepoznala stvarne potrebe pacijenta između više suprotstavljenih prioriteta.

Ključne riječi: medicinska sestra, obiteljska medicina, skrb, zdravstvena njega, kompetencije

¹ ms, Dom zdravlja Zagreb Centar, Zagreb

NURSING CARE OF PATIENTS WITH MULTIMORBIDITY AND WORK ORGANIZATION IN FAMILY MEDICINE PRACTICE

Maja Ćužić,¹ Andrea Brossler Smrk¹

ABSTRACT

Introduction: Multimorbidity indicates a simultaneous presence of various chronic illnesses in one patient. There is an assumption that by year 2050. the proportion of residents older than 65 in Europe, will be 60%. Ageing of the population and the simultaneous advancement of medical sciences, which are leading to a more successful treatment of chronic noninfectious diseases, represents an increase in the prevalence of patients with multimorbidity in a family medicine (FM) clinic. The goal of this review work is to assess the competences of a nurse in a FM clinic, in caring for patients with multimorbidity and to point towards the existence of a distinction between standardized statutory health care procedures, real practice and the level of education of the nurses.

Method: An analysis of the legal provisions, available standardized procedures of nursing care was done and then compared with the actual procedures, duties and competences of the nurse in the FM clinic's team.

Results: The care for a patient with multimorbidity is complex and there is a justified need for implementing bachelors in the family clinic's team. It was determined that there is a need for an introduction of a higher quality nurses' documentation. It would demonstrate and better measure contribution and application of specific scientific comprehension in the field of nursing, natural, medical and human sciences.

Conclusion: The nurse in care for the patient with multimorbidity must primarily be guided by holistic principles, must use knowledge based on scientific evidence, be a skilled caregiver, know communication skills in order to identify the real need of patients between more opposing priorities.

Keywords: nurse, family medicine, care, health care, competences

¹ nurse, Health Care Center „Zagreb Center“

ULOGA MEDICINSKE SESTRE U SKRBI ZA OSOBU SA DUŠEVNIM SMETNJAMA

Tajana Jovičić¹

SAŽETAK

Medicinska sestra često je prvi zdravstveni djelatnik koji je u kontaktu s bolesnicima. U cje- lokupnom životnom ciklusu bolesnika medicinska sestra sudjeluje vrlo intenzivno. U najužem kontaktu je s bolesnikom, ali i njegovom obitelji te tako može među prvima primijetiti promjene. Potom je u mogućnosti stručnom timu iznositи svoja osobna zapažanja, vrlo značajna za daljnje postupke skrbi i liječenja. Iz toga proizlazi da je osobito velika i bitna mogućnost terapijskoga djelovanja medicinske sestre. Ona je neophodan i nezamjenjiv član tima u psihijatrijskoj skrbi. Sestrinska praksa u psihijatrijskoj grani medicine temelji se na poznavanju mentalnog zdravlja i patoloških zbivanja kod osobe, ali i na poznavanju bioloških i socijalnih utjecaja. Medicinska sestra treba razumjeti bolesnika i njegovo ponašanje, odnosno protumačiti poruke koje simptomima osoba daje društvu. Za medicinsku sestru koja radi s osobama s duševnim smetnjama potrebna je uz znanje i vještina komunikacije. Verbalnom, ali i neverbalnom komunikacijom i načinom na koji djeluje medicinska sestra pokazuje poštovanje i čuva dostojanstvo pojedinca, kao i njegove obitelji. Terapijsko djelovanje medicinske sestre ovisi o djelotvornosti njezinih sposobnosti komunikacije i vještina.

U radu medicinske sestre odnos povjerenja i iskrenosti od iznimne je važnosti. Odnos s bolesnikom treba težiti ka pomaganju i izlječenju bolesnika. Putem profesionalnosti, empatije, komunikacijskih sposobnosti, stvaranjem odnosa povjerenja i međusobnog uvažavanja medicinska sestra ima nezamjenjiv značaj. Najvažnije načelo u radu medicinskih sestara je holistički pristup koji podrazumijeva promatranje bolesnika kao cjelovito, jedinstveno biće te ga se kao takvog poštuje.

Načelo pravednosti i jednakosti osigurava jednako kvalitetnu skrb svima, neovisno o spolu, dobi, vjerskoj ili nacionalnoj pripadnosti, kao i o vrsti oboljenja. Duševna bolest ne određuje karakterne osobine čovjeka, ne umanjuje njegovu dobrotu, povjerljivost i prijateljstvo. Stigmatizacija duševnih bolesnika ima negativne učinke na sastav zdravstvene zaštite. Dolazi do kasnog prepoznavanja, dijagnosticiranja bolesti, slabijeg terapijskog učinka i značajnog povećanja razine stresa koji dodatno narušava zdravlje pojedinca.

Ključne riječi: medicinska sestra, duševna bolest, komunikacija, stigma

¹ ms, Dom zdravlja Primorsko Goranske županije, Rijeka

THE ROLE OF NURSE IN CARING FOR PERSON WITH MENTAL DISORDERS

Tajana Jovičić¹

ABSTRACT

The nurse is often the first health professional who is in contact with the patients. Nurse participates very intensively in the entire life cycle of the patient. He / she is in close contact with the patient, but also with his family, so he / she can notice the changes first. After noticing those changes the nurse is able to provide his / her personal observations to a professional team, which is very important for further care and treatment. That is why the ability of the nurse to provide the therapeutic treatment is particularly important. She is a necessary and indispensable member of the team in psychiatric care. Nursing practice in the psychiatric branch of medicine is based on knowledge of mental health and pathology of the person, as well as knowledge of biological and social influences. The nurse needs to understand the patient and his behavior, or to interpret the messages that the person gives to society. For a nurse who works with people with mental disorders, apart the knowledge, it is essential to have good communication skills. Verbal and non-verbal communication, the way the nurse treats the patient shows respect and preserves the dignity of the individual as well as his family. Therapeutic effect depends on the effectiveness of communication skills and proficiency. In the work of a nurse the relationship based on trust and honesty is of utmost importance. It's important to found the relationship with a patient on the effort to help and cure the patient. The irreplaceable role of a nurse is determined by her professionalism, empathy, communication skills, and the effort to create a relationship of trust and mutual respect. The most important principle in the work of a nurse is a holistic approach that involves observing a patient as a whole, unique being and respected as such. The principle of equity and equality ensures equal quality of care for all, irrespective of sex, age, religious or national affiliation, as well as the type of illness. Mental illness does not determine men's character, does not diminish his goodness, confidentiality and friendship. Stigmatization of mental patients has negative effects on the structure of health care. It leads to late recognition and diagnosis of the disease, less effective therapeutic activities and significant increase of stress level that has a negative effect to the health of the patient.

Key words: nurse, mental illness, communication, stigma

¹ nurse, Health Care Center „Primorsko goranska county“, Rijeka

MEĐUPROFESIONALNA SURADNJA LIJEČNIKA OBITELJSKE, MEDICINE SESTRE U AMBULANTI OBITELJSKE MEDICINE I PATRONAŽNE SLUŽBE

Mateja Jurič,¹ Hrvoje Jurlina²

SAŽETAK

Primarna zdravstvena zaštita je prva stepenica u prevenciji, ranom otkrivanju kao i liječenju pojedinih bolesti. Da bi ona bila ostvariva potrebna je visoka razina međuprofesionalne suradnje zdravstvenih djelatnika koju svi zajedno čine prošireni tim primarne zdravstvene zaštite. Kroz ovaj rad nastojat ćemo ispitati razinu zadovoljstva međusobnom suradnjom i komunikacijom između liječnika opće medicine, sestre u ambulanti te patronažne sestre, kao i procijeniti najčešći razlog suradnje unutar tima. Također smo nastojali procijeniti stupanj zadovoljstva na samom radnom mjestu, kako bismo dobili što točniji uvid što bismo u budućnosti mogli promjeniti u svrhu osnaživanja tima. Cilj ovog istraživanja je prvenstveno unaprijediti međuprofesionalnu suradnju unutar timova. Osigurati opće zadovoljstvo svakog pojedinca na svom radnom mjestu. Definirati i evaluirati segment djelovanja patronažne službe i sestara iz ambulante opće medicine u timu primarne zdravstvene zaštite. U istraživanje smo uključili zdravstvene djelatnike, koji čine liječnici obiteljske medicine, patronažne sestre i sestara u ambulanti obiteljske medicine na terenu Doma zdravlja Zagreb Centar. Za metodu prikupljanja podataka odlučili smo koristiti namjenske upitnike koji su se sastojali od otvorenih i zatvorenih pitanja. U istraživanje smo uključili ukupno 119 zdravstveni djelatnika, od toga 43 patronažnih sestara, 40 liječnika obiteljske medicine te 36 sestara u ambulanti obiteljske medicine. Za metodu prikupljanja podataka odlučili smo koristiti upitnike koji su se sastojali od otvorenih i zatvorenih pitanja. Dok su upitnici namijenjeni liječnicima obiteljske medicine i patronažnim sestrama imali niz od 14 pomno odabranih pitanja, sestrama iz ambulante obiteljske medicine bilo je ponuđeno 15 pitanja. Patronažne sestre i liječnici obiteljske medicine prilikom obrade podataka svrstani su u dvije skupine, ovisno o dobi radi boljeg uvida u zadovoljstvo razinom komunikacije unutar tima primarne zdravstvene zaštite i patronažne službe. Rezultati samog istraživanju upućuju na slab odaziv i nezainteresiranost ispitanika. Evidentno je veće zadovoljstvo užeg tima primarne zdravstvene zaštite u odnosu na prošireni tim. Postoji slab uvid liječnika u djelokrug rada patronažne službe. Sestre iz ambulante obiteljske medicine podjednako su zadovoljne suradnjom s liječnikom obiteljske medicine i patronažnom službom. Zaključak nakon uvida u dobivene rezultate je ohrabrujuća činjenica da su sve skupine ispitanika složne da postoji potreba i volja za poboljšanjem međuprofesionalne komunikacije.

Ključne riječi: međuprofesionalna suradnja, timski rad, primarna zdravstvena zaštita

¹ bacc. sestr., Dom zdravlja Zagreb Centar, Zagreb

² dr. med., Dom zdravlja Zagreb Centar, Zagreb

INTERPROFESSIONAL COOPERATION BETWEEN FAMILY DOCTORS, GENERAL PRACTICE NURSE AND COMMUNITY NURSING SERVICES

Mateja Jurič,¹ Hrvoje Jurlina²

ABSTRACT

Primary medical care is the first step in prevention, early recognition and treating certain kind of diseases. If we want to make it achievable it is necessary to have high-level inter-professional cooperation of health working staff which together makes wider health care team. Through this research, we will try to analyze the level of satisfaction with communication between family doctors, nurses in polyclinics and health visit nurses, also we will try to find the most common reason of cooperation between them. One more thing we have tried to asses is the level of satisfaction in their workplace, so we would be able to get a better insight into what we could do in the future to improve satisfaction and empower a team. The goal of this research is firstly to promote inter-professional cooperation within teams. To secure general satisfaction of every individual in his workplace, and to define and evaluate the actions of health visit nurses and nurses that work in general health polyclinics as a team of primary health care. We have put many different health workers in our research group, such as family doctors, health visit nurses and nurses that work in polyclinics that are stationed in Zagreb Centar neighborhood medical centers. As our method for collecting data, we have decided to use questionnaires that contain an open and closed type of questions. Questioners for family doctors and health visit nurses had 14 questions, and nurses that work in polyclinics got 15 questions. While processing collected data, we have sorted nurses and family doctors in two groups (depending on their age) because of better insight into satisfaction with the level of communication inside of the teams of primary health care and health visit service. Research has shown us a weak response rate and disinterest of respondents. Higher satisfaction level was more evident in the narrow team of heal care workers than satisfaction in the general group. There is a pretty poor insight that family doctors have in the scope of work of health visit nurses. Polyclinic nurses of family medicine were evenly satisfied with cooperations with family doctors and health visit nurses. In conclusion, after we have got our results, the encouraging fact was that all groups of respondents were united that there is a will and need to improve inter-professional communication.

Key words: inter professional cooperation, team work, primary healthcare

¹ bacc. nurse, Health Care Center „Zagreb Center“, Zagreb

² general practitioner, Health Care Center „Zagreb Center“, Zagreb

SESTRINSKA DOKUMENTACIJA – INFORMATIZACIJA I ZAŠTITA PODATAKA

Ivana Kočić¹

SAŽETAK

Sestrinska dokumentacija predstavlja niz obrazaca koji su temelj kvalitetnog rada medicinskih sestara. Kroz povijest se razvijala usporedno sa sestrinstvom te je njeno postojanje važno za napredak sestrinske skrbi. Obrasci sestrinske dokumentacije služe praćenju pacijentovog zdravstvenog funkcioniranja, a popunjavaju se prema određenim pravilima koja su zakonski regulirana. Sestrinska dokumentacija je važan dokument koji se koristi u medicinsko sudskim procesima, edukaciji medicinskih sestara i analizama kvalitete provedene sestrinske skrbi.

U suvremeno vrijeme sestrinska dokumentacija je digitalizirana, bilježi se i elektronski kako bi se podaci prikupljali i čuvali sustavno. U Republici Hrvatskoj informatizacija zdravstva traje od devedesetih godina, te se i dalje nastavlja razvijati. Centralni informacijski sustav Republike Hrvatske (u dalnjem tekstu *CEZIH*) predstavlja temelj informatizacije kojim se služi cijelo zdravstvo, ovisno o potrebama pojedine zdravstvene ustanove, pa su tako opisane funkcionalnosti *CEZIH*-a kao što je elektronski zdravstveni karton, e-recepti i uputnice, mogućnosti umrežavanja, razni izvještaji i te portal e-zdravlje namijenjen pacijentima. Ustanove koje koriste *CEZIH* na njega se spajaju raznim aplikacijama, a u bolničkom sustavu je Bolnički informacijski sustav (*BIS*) čije su funkcije pri vođenju sestrinske dokumentacije predstavljene. Prikazan je i kompletno kompjuterski vođen zdravstveni pristup kao što je telemedicina, te su navedene njezine specifičnosti i korisnost. Pri svim ovim informatiziranim sadržajima nastaje prostor za krađu i zloupotrebu podataka koje je potrebno dobro zaštiti. Razmotreni su sigurnosni rizici i slabosti koje utječu na sigurnost podataka. Kako bi se štitila sigurnost povjerljivih podataka primjenjuje se kriptografija te razne vrste enkripcije kao što su simetrična, asimetrična te hibridna enkripcija te su navedene njihove prednosti i mane. S enkripcijom se koriste i razne metode sigurnog povezivanja kao što su pametne kartice, *VPN* i lozinke. Uz kriptografiju dan je i primjer drugačije vrste zaštite podataka koje se vrši sakrivanjem u sliku, a zove se steganografija te u kombinaciji s enkripcijom obećava mnogo na temu zaštite povjerljivih podataka.

Ključne riječi: sestrinstvo, dokumentacija, informacijski sustav, informatizacija, sigurnost podataka

¹ ms, Dom zdravlja Primorsko goranske županije, Rijeka

NURSING DOCUMENTATION- INFORMATIZATION AND DATA SECURITY

Ivana Kočić¹

ABSTRACT

Nursing documentation represents a series of forms that are the foundation of quality work for nurses. Documentation follows the development of nursing activities and it's important for advancing nursing care. The documentation forms serve to monitor the patient's health functions and are filled in according to certain rules that are legally regulated. Nursing documentation is an important document used in medical court proceedings, education and nursing care quality analysis.

In recent times, the nursing documentation has been digitized, meaning that the data is recorded electronically so that it can be collected and stored systematically. In the Republic of Croatia health informatization has started in the 1990s, and continues to develop till today. Central Information System of the Republic of Croatia is the basis of computerization that serves the whole healthcare system, depending on the needs of an individual healthcare institution. Due to that the functionalities of Central Information System of the Republic of Croatia has been described, such as electronic health card, e-receipts and referrals, networking capabilities, various reports and the e-health portal intended for patients.

In all these informatized facilities, there is room for theft and misuse of data that needs to be well protected. Security risks and weaknesses affecting data security have been described. In order to protect the confidentiality of information, there are used methods of cryptography and various encryption types, such as symmetric, asymmetric and hybrid encryption and their advantages and disadvantages are listed. Encryption also uses various secure connectivity methods such as smart cards, VPNs, and passwords. Alongside encryption, there is also an example of a different type of data protection that is done by hiding in the image, called steganography and in conjunction with encryption, promises much in the field of confidential data protection.

Key words: nursing, documentation, information system, informatisation, data security

¹ nurse, Health Care Center „Primorsko goranska county“, Rijeka

PRISTUP I ULOGA MEDICINSKE SESTRE U PREHRANI OSOBA STARIJE ŽIVOTNE DOBI U TIMU PRIMARNE ZDRAVSTVENE ZAŠTITE

Jasmina Manestar¹

SAŽETAK

Kao rezultat normalnog procesa starenja, tijelo podliježe promjenama koje utječu na prehran-bene navike. Starenje prati nedostatak esencijalnih hranjivih tvari, bilo zbog oslabljene resorpcije ili nedostatne i siromašne prehrane. U starijoj životnoj dobi dolazi do smanjivanja energetske potrošnje jer se smanjuje bazalni metabolizam, do 12%. Promjene osjetila okusa i mirisa utječu na odabir hrane, zbog atrofije jezika gubi se osjet okusa za čak 70%, zbog ispadanja zubi smanjuje se unos proteinских namirnica (žvakanje!), slabija je probava, izlučivanje sline, smanjuje se iskoristivost Fe, B12, Ca, folata zbog atrofije mukoze želuca, lošija je probava masti zbog smanjenog izlučivanja enzima gušterića, dolazi do opstipacije. Vodeći zdravstveni problemi starijih osoba koji se dovode u vezu s načinom prehrane su kardiovaskularne bolesti, prijelomi kostiju, poremećaji imuniteta, poremećaji bubrežne funkcije, depresije i poremećaji raspoloženja, artritis, poremećaji vida, poremećaji stanja uhranjenosti i tjelesne sposobnosti. Hrvatsko društvo za kliničku prehranu Hrvatskog liječničkog zbora objavilo je smjernice za prehranu starijih ljudi. Smjernice su izrađene s ciljem da se podrži procjena nutritivnog statusa starijih osoba definiraju specifične nutritivne potrebe osoba starije dobi. Glavna uloga medicinske sestre u radu s pacijentima starije životne dobi unutar primarne zdravstvene zaštite je savjetodavna uloga, kako pojedinca tako i obitelji. Edukacija pacijenata i obitelji o zdravim prehrabnenim navikama je proces tijekom kojeg medicinska sestra pomaže pacijentu i obitelji da se upoznaju s tegobama koje su nastale zbog bolesti i starenja te da što uspješnije savladaju promjene te spriječe moguće komplikacije. Proces edukacije ima za cilj poticati i usmjeravati samostalnost pacijenta i obitelji u prepoznavanju zdravog odabira namirnica kako bi se postigla što bolja kvaliteta života. Cilj sestrinskih prehrabnenih intervencija je poboljšanje kvalitete života, bolje psihičko i fizičko zdravlje pacijenata te smanjenje i ublažavanje nastalih tegoba. Planiranje prehrane je individualno te je potrebno prilagoditi fiziološkim promjenama i potrebama pojedinca starije dobi te bolestima koje nose specifične promjene vezane uz prehranu.

Ključne riječi: starija životna dob, starenje, promjene, medicinska sestra, uloga, prehrana

¹ Dom zdravlja Primorsko goranske županije, Rijeka

APPROACH AND ROLE OF A NURSE IN NUTRITION OF OLDER PEOPLE IN PRIMARY HEALTH CARE

Jasmina Manestar¹

ABSTRACT

As a result of the normal aging process, the body is subject to changes that affect eating habits. Aging follows the lack of essential nutrients, either due to impaired absorption or insufficient and poor food intake. In old age energy consumption decrease because ageing reduces the basal metabolic rate (to 12%). Changes to the senses of taste and smell influence the selection of food, due to atrophy of the tongue sense of taste is lost as much as 70%, falling out of teeth causes reduction of the protein foods intake (chewing), weaker digestion and salivation occurs. Utilization of Fe, B12, Ca , folate is reduced due to atrophy of gastric mucosa, reduced secretion of pancreatic enzymes makes digestion of fat weaker, constipation also occurs. The leading health problems of older people who are associated with the way of eating are cardiovascular disease, bone fractures, immune disorders, kidney function disorders, depression and mood disorders, arthritis, visual disturbances, impaired nutritional status and impaired physical abilities. Croatian Society for Clinical Nutrition Croatian Medical Association (CMA) issued guidelines for the nutrition of older people. The guidelines were developed in order to support the assessment of the nutritional status of the elderly and define the specific nutritional needs of older persons. The main role of nurses working with older patients in the primary health care is advisory role, both individuals and families. Education of patients and families about healthy eating habits is a process during which a nurse helps the patient and family to get acquainted with the problems that have arisen due to disease and aging, and to successfully master the changes and prevent possible complications. The process of education aims to encourage and direct the autonomy of the patient and family to recognize a healthy selection of foods, to achieve the best possible quality of life. The goal of nursing nutritional intervention is to improve the quality of life, better mental and physical health of patients and the reduction and facilitation of complaints. Planning a diet is individual and should be adjusted to physiological changes and the needs of individual elderly and diseases that carry specific changes related to food intake.

Key words: older age, aging, changes, nurse role, nutrition

¹ nurse, Health Care Center „Primorsko goranska county“, Rijeka

PROVOĐENJE KONTINUIRANOG ZBRINJAVANJA PACIJENATA U PRIMARNOJ ZDRAVSTVENOJ ZAŠTITI

Anica Math¹

SAŽETAK

Jedno od načela zdravstvene zaštite je i osiguranje kontinuiranosti. *Kontinuiranost zdravstvene zaštite postiže se ukupnom organizacijom zdravstvene djelatnosti, osobito na razini primarne zdravstvene zaštite, djelatnosti koja pruža neprekidnu zdravstvenu zaštitu stanovništvu kroz sve životne dobi.* Da bi se to osiguralo, sustav mora biti međusobno funkcionalno povezan i usklađen. Uloženi su naporci ali je i dalje potrebno kontinuirano djelovanje na unapređenju. To načelo odnosi se i na medicinske sestre u primarnoj zdravstvenoj zaštiti, bez obzira u kojoj organizacijskoj jedinici pružaju skrb. Od primarne zdravstvene zaštite se očekuje da bude preferirani način komunikacije i zbrinjavanja pacijenata, a tek nakon toga se očekuje upućivanje na ostale razine zdravstvene skrbi. Da bi sestrinstvo u tom sustavu moglo pratiti sve napretke skrbi i djelovati kao član tima, potrebno je unaprijediti sestrinsku praksu, planirati trajno usavršavanje medicinskih sestara, shodno potrebama zbrinjavanja korisnika. Naročito bi bilo potrebno izraditi protokole kod hitnih stanja, po kojima bi medicinske sestre postupale. Neophodno je razviti model evidentiranja sestrinskog rada, osigurati da sestrinska profesija bude odgovarajuće korištena, nagrađena i predstavljena. Dosadašnja praksa govori da u ordinacijama primarne zdravstvene zaštite veliki se dio postupaka medicinske sestre odnosi na rad na računalu i administrativne poslove. Ako se tom svemu pridoda zakonska obaveza da je medicinska sestra dužna evidentirati provedene postupke na svim razinama zdravstvene zaštite, a dokumentacije za sada nema, zaključak je da još puno napora treba uložiti da bi sestrinski rad bio pravilno valoriziran, a skrb kvalitetnija. U raznim studijama je naglašena potreba umrežavanja djelatnosti na nivou primarne zdravstvene zaštite, kako bi se olakšao radni proces i osnažila suradnja raznih profesija, te unaprijedila suradnja, dostupnost i brža usluga korisnicima.

Ključne riječi: primarna zdravstvena zaštita, zbrinjavanje pacijenata

¹ dipl. ms., prof., Dom zdravlja Zagreb Centar, Zagreb

IMPLEMENTATION OF CONTINUED CARE OF PATIENTS IN PRIMARY HEALTH CARE PROTECTION

Anica Math¹

ABSTRACT

One of the principles of health care is the ensuring of continuity. *Continuity of health care is achieved by the overall healthcare organization, particularly at the level of primary health care, i.e. a service that provides continuous health care for the population through all ages.* To ensure this, the system must be mutually functional linked and aligned. Enhanced efforts are made, but continuing efforts to improve are necessary. This principle also refers to the nurses in the primary health care, no matter in which organization they are caring for. Primary healthcare is expected to be the preferred way of communication and care for patients, and only after that it is expected to be send to other levels of health care. In order that the nursing in this system be able to follow all the advances of care and to act as a member of the team, it is necessary to improve nursing practice, to plan the continuous improvement of the nurses, according to the needs of the care of the users. In particular, it would be necessary to draw up protocols for emergencies, which would be used by nurses. It is necessary to develop a model for registering nursing work, to ensure that the nursing profession is appropriately used, rewarded and presented. The practice nowadays suggests that a large part of the nurses work in the primary health care offices is related to computer work and administrative affairs. If this is accompanied by the legal obligation that a nurse is indebted to record the procedures performed at all levels of health care, and the documentation is not available for the time being, it is concluded that much effort has to be made to ensure that nursing work is properly valorized and care is better. Various studies highlighted the need to network activities at the level of primary health care to facilitate the work process and strengthen the cooperation of various professions, and enhance co-operation, availability and faster customer service.

Key words: primary health care, patient care

¹ nurse prof., Health Care Center „Zagreb Center“, Zagreb

MULTIPROFESIONALNA SKRB OBITELJI I OSOBA KOJE BOLUJU OD NEIZLJEČIVE BOLESTI

Jasmina Nemeć¹

SAŽETAK

Sestrinska skrb u bolesnika s neizlječivom bolesti temelji se na pružanju pomoći u zadovoljavanju osnovnih ljudskih potreba s ciljem održavanja postojećeg stanja te pomoći obitelji da se nosi sa svakodnevnim izazovima koje nosi bolest. Pravila procjene situacije i probleme s kojima se obitelj nosi stavlaju na prvo mjesto holistički pristup gdje se sagledava pojedinačna/obiteljska u cijelini. Medicinska sestra u timu s liječnikom obiteljske medicine skrbe o pacijentu u ambulantne sve dok njegovo stanje dopušta dolazak u dom zdravlja. Medicinska sestra u timu s liječnikom obiteljske medicine tijekom dugogodišnjeg rada upoznaje pacijente te često pacijenti imaju veće povjerenje u sestru nego u liječnika. Medicinska sestra u timu liječnika obiteljske medicine objašnjava obitelji i samom bolesniku kako lakše doći do ostalih sudionika multiprofesionalnog tima gdje medicinska sestra u timu liječnika obiteljske medicine je nezaobilazna karika multiprofesionalne suradnje. Kada pacijent nema mogućnost doći do svog liječnika medicinska sestra najčešće obavještava patronažnu službu koja u dogovoru s timom liječnika obiteljske medicine procjenjuje da li je potrebno uključiti ostale sudionike multiprofesionalnog tima: Ustanovu za zdravstvenu njegu u kući, bolnica u kući, mobilni palijativni tim, radni terapeut u kući, fizikalna terapija u kući, gerontološki centar i druge. Zajedno mogu učinkovito surađivati za što adekvatniju skrb korisnika. Nadalje, mora poznavati mogućnosti za osiguranje finansijske i druge materijalne pomoći za zadovoljavanje potreba: članovi obitelji, socijalna služba. Sve informacije koje se daju trebaju biti razumljive. Multiprofesionalna suradnja treba uputiti obitelj o bolesti i načinu zbrinjavanja. U suradnji sa socijalnom službom može pomoći u dobivanju finansijske pomoći te smještaja u ustanovu ako obitelj ne može skrbiti bolesnika u kući. Preko udruga i drugih karitativnih organizacija se može organizirati psihološka potpora za obitelj, pomoći u skrbi za bolesnika te nabava potrebnih pomagala.

Ključne riječi: patronažna sestra, zdravstveno socijalna podrška, koordinacija, bolesnik, obitelj

¹ bacc. sestr., Dom Zdravlja Zagreb Centar, Zagreb

INTER-DISCIPLINARY CARE FOR FAMILIES AND PERSONS SUFFERING FROM AN INCURABLE ILLNESS

Jasmina Nemec¹

ABSTRACT

Nursing care for a patient suffering from an incurable illness is based upon providing assistance in meeting basic human needs with the aim of maintaining the existing situation as well as helping the family to cope with the everyday challenges that the illness presents. The rules for evaluating the situation and the problems with which the family must cope, call for a holistic approach which looks at the individual and family as a whole, to be paramount. A nurse in a general practitioner, GP team cares for patients in an outpatient clinic ambulance until his/her condition enables him/her to visit a Health Centre. A nurse in a LOM team gets to know the patient during many years of work and the patient often has more trust in the nurse than in the doctor. The nurse in the GP team explains to the family and to the patient himself/herself how to more easily get to the other member of the multi-disciplinary team where the nurse in the GP team is an unavoidable part of the multi-disciplinary collaboration. When a patient is not able to go to his/her doctor, the nurse usually informs the district nurse service which, in agreement with the GP team, assess whether it is necessary to include the other members of the multi-disciplinary team (health institution for home care, hospital at home, mobile palliative care team, occupational therapy at home, physical therapy at home, gerontological centre etc.) who together can effectively collaborate for as adequate care of the patient as possible. Furthermore, the nurse must know the possibilities for providing financial and other material assistance for meeting the needs of family members, social services etc). Any information provided must be as clear and logical as possible. A multi-disciplinary approach should involve explaining to the family about the illness and how to take care of it. In cooperation with social services, it can also help in obtaining financial assistance and accommodation in an institution, if the family cannot care for the patient at home. Psychological support for the family and assistance in caring for the patient, as well as getting the necessary aides can be organised through associations and other charitable organisations. Hospitalisation and/or accommodation in an institution should be recommended if the illness progresses or if the patient's condition worsens considerably in order to protect the family from exhaustion.

Key words: district nurse, a general practitioner's nurse , family, sources of assistance, incurable patient

¹ bacc. nurse, Health Care Center „ Zagreb Center“, Zagreb

ULOGA MEDICINSKE SESTRE U TIMU KOD LIJEČENJA BOLI

Danijela Ostojić,¹ Milana Topić Petričić²

SAŽETAK

Palijativna skrb je skrb kojom se poboljšava kvaliteta života pacijenata suočenih s uznapredovalom i neizlječivom bolešću, kao i njihovih obitelji. Skrb se ostvaruje kroz prevenciju i olakšavanje patnje putem ranog otkrivanja i dobre procjene u liječenju boli i drugih simptoma bolesti. Liječenje boli u kući palijativnog pacijenta važan je čimbenik u palijativnoj skrbi bolesnika u svrhu poboljšanja kvalitete života pacijenta i njegove obitelji. Liječenje boli u kući podrazumijeva timski rad zdravstvenih radnika uključenih u skrb palijativnog pacijenta, članova obitelji i njegovatelja. Mobilni palijativni timovi titriraju analgetsku terapiju koju pacijent ima u svom domu, parenteralno primjenjuju analgetike te putem pisanog nalaza, po potrebi, ostavljaju preporuku o daljnjoj analgetskoj terapiji. Bitna je brza i sveobuhvatna razmjena pravovremenih podataka o pacijentu među sudionicima u palijativnoj skrbi. U svrhu izbjegavanja osjećaja bespomoćnosti prisutne kod pružatelja palijativne skrbi potrebna je kontinuirana edukacija sudionika. Uloga medicinske sestre u timu je, osim same primjene lijeka, educirati pacijenta i obitelji vezano uz terapiju boli i liječenje mogućih nuspojava. Medicinska sestra u timu će uspostaviti odnos povjerenja s pacijentom, procijeniti stavove obitelji o pacijentovoj boli, savjetovati članove obitelji o boli i načinu doživljaja boli, toleranciji i reakcijama na bol. Farmakoterapija je temelj liječenja boli. Osim farmakoterapije potrebno je primjenjivati i nefarmakološke metode liječenja boli. Za liječenje boli primjenjuju se nesteroidni antireumatici, opioidi i pomoćni analgetici, antikonvulzivi i antidepresivi. Pri primjeni analgetika potrebno je voditi računa o zdravstvenom stanju bolesnika, farmakokineticici i farmakodinamici lijekova te interakcijama i nuspojavama lijekova. Kombinacijom lijekova u nižim dozama, onih koji imaju različit mehanizam djelovanja, moguće je uspješnije liječiti bol i smanjiti učestalost nuspojava. Nuspojave treba prevenirati, npr. opstipaciju, povraćanje i liječiti, pa time omogućiti daljnju uporabu lijeka ako je veća korist od toga da se s lijekom u terapiji nastavi.

Ključne riječi: bol, mobilni palijativni timovi, uloga medicinske sestre

¹ ms, Dom zdravlja Primorsko goranske županije, Rijeka

² dr.med. Dom zdravlja Primorsko goranske županije, Rijeka

THE ROLE OF NURSING TEAM IN TREATMENT OF PAIN

Danijela Ostojić,¹ Milana Topić Petričić²

ABSTRACT

Palliative care improves the quality of life of patients faced with advanced and incurable illness, as well as their families. Care is provided through preventing and alleviating suffering through early detection and good judgment in the treatment of pain and other symptoms of the disease. Treatment of pain in a palliative patient's home is an important factor in palliative patient care in order to improve the quality of life of a patient and his / her family. Treatment of pain inside patient's homemeans teamwork between medical staff, patient's family members and caregivers. Mobile palliative teams titrate the analgesic therapy the patient has in their home, parenterally apply the analgesics, and, if necessary, leave a recommendation on further analgesic therapy in written. It is important swift and timely exchange of accurate information among the participants in palliative care. In order to avoid feelings of helplessness present in palliative care providers, continuous training of participants is required. The role of nurses in the team, apart from the drug application itself, is to educate the patient and his / her family about pain therapy and treatment of possible side effects. The nurse in the team will establish a relationship of trust with the patient, assess the attitudes of the family about the patient's pain, counsel family members about the pain and the ways of experiencing pain, pain tolerance and reactions to pain. Pharmacotherapy is the foundation of pain management. In addition to pharmacotherapy, non-pharmacological methods of pain management should also be applied. Non-steroidal antireumatics, opioids and auxiliary analgesics (anticonvulsants and antidepressants) are used for treatment of pain. When administering analgesics it is necessary to take care of the patient's health status, pharmacokinetics, pharmacodynamics, as well as interactions and side effects of medication. With a combination of drugs that have a different mechanism of action in lower doses, it is possible to treat the pain better and reduce the frequency of side effects. Side effects (eg, constipation, vomiting) should be prevented and treated, thereby enabling further use of that particular drug if it is of greater benefit for the patient to continue with that exact therapy.

Key words: pain, mobile palliative teams, the role of a nurse

¹ nurse, Health Care Center „Primorsko goranska county“, Rijeka

² general practitioner, Health Care Center „Primorsko goranska county“, Rijeka

ULOGA MEDICINSKE SESTRE / TEHNIČARA U MULTIDISCIPLINARNOJ SKRBI OSOBE SA ŠEĆERNOM BOLESTI

Bojan Pavlović¹

SAŽETAK

Šećerna bolest je jedan od najznačajnijih javnozdravstvenih problema s uzlaznim trendom i vodeći uzrok krvožilnih bolesti, bolesti bubrega, sljepoće, amputacije udova i predstavlja značajno morbiditetno, mortalitetno i finansijsko opterećenje te se zbog toga ne može dovoljno naglasiti neophodnost suradnje timova obiteljske medicine sa sekundarnom specijalističkom zdravstvenom zaštitom u internističkim ambulantama, oftalmologima, neurologima, psihologima te patronažnom službom na terenu. Zadaća multidisciplinarnog pristupa primarne i sekundarne razine zdravstvene zaštite je prevencija, rano otkrivanje te edukacija pacijenata sa šećernom bolesti gdje će se tako postići sprječavanje i/ili odgoda komplikacija ali i smanjenje smrtnosti. Početak bolesti najčešće se otkriva u ordinaciji opće prakse kod obiteljskog liječnika i/ili na javnozdravstvenim akcijama gdje se pacijent može javiti sa simptomima pojačanog mokrenja, pojačane gladi i žedi, umorom, zamagljenim vidom ili već pojmom kroničnih komplikacija jer pacijenti sa šećernom bolesti tipa 2 bolju u prosjeku 8 - 10 godina prije nego što se pojavi dijagnoza za razliku od šećerne bolesti tipa 1 koji nastupa naglo s mogućim kriznim stanjima poput dijabetičke ketoacidoze. Tim primarne zdravstvene zaštite upoznaje pacijenta s novom i neočekivanom situacijom kako bi shvatio njezinu ozbiljnost i težinu bolesti te njenih komplikacija. Nakon što liječnik pacijentu objasni uzroke, tijek bolesti te odredi terapiju, uloga medicinske sestre / tehničara je od iznimne važnosti u edukaciji pacijenta i članova njegove obitelji o načinu provođenja odgovarajućeg dijetetskog režima, prilagođene tjelesne aktivnosti, samokontrole glukometrom te pravilne primjene inzulinske terapije. Osim edukacije, medicinska sestra/ tehničar bi trebala sa svakim pacijentom izgraditi odnos povjerenja kako bi rezultat bio zadovoljan i zbrinut pacijent koji će svojim redovitim kontrolama u ambulantni i promjenom načina života odložiti pojavu komplikacija. Edukacija pacijenta se može razlikovati prema dobi i spolu, trenutnom zdravstvenom stanju, religijskim uvjerenjima, načinu dosadašnje prehrane. Cilj suradnje zdravstvenih timova u liječenju šećerne bolesti je uklanjanje smetnji koje ona uzrokuje te sprječavanje razvoja akutnih i kroničnih komplikacija što se može postići samo uspostavom metaboličke ravnoteže u organizmu te postizanjem uvjetnog zdravlja uspostavljanjem radne sposobnosti i uključivanjem oboljelih od šećerne bolesti u društveni život.

Ključne riječi: šećerna bolest, prevencija, edukacija, timovi primarne zdravstvene zaštite, suradnja

¹ bacc. sestr., Dom zdravlja Zagreb Centar, Zagreb

THE ROLE OF THE NURSES / TECHNICIANS IN THE MULTIDISCIPLINARY CARE OF PEOPLE WITH DIABETES MELLITUS

Bojan Pavlović¹

ABSTRACT

Diabetes mellitus is one of the most significant public health problems with an upward trend and is the leading cause of vascular diseases, kidney disease, blindness, limb amputation and represents a significant morbidity, mortality and financial burden, and therefore it can not sufficiently emphasized the necessity of collaboration between primary care providers with secondary care specialists in internist clinics, ophthalmologists, neurologists, psychologists, and public health nurses.

The task of the multidisciplinary approach to primary and secondary health care is prevention, early detection and education of patients with diabetes where preventing and / or delaying complications will be achieved, as well as reducing mortality.

The onset of the disease is most commonly detected in a general practitioner's practice by a family physician (sometimes in public health actions) where the patient can experience symptoms of increased urination, increased hunger and thirst, fatigue, blurred vision or the onset of chronic complications because patients with type 2 diabetes are ill an average of 8-10 years before a diagnosis occurs as opposed to type 1 diabetes that occurs suddenly with possible crisis conditions such as diabetic ketoacidosis. The primary health care team informs a patient with a new and unexpected situation in order to understand the severity and seriousness of the disease and its complications.

After the doctor explains the cause, course of the disease, and determines the therapy, the role of the nurse / technician is of extreme importance in educating the patient and his family members about the way to carry out the appropriate diet regime, personal body function, self-control with glucometer and proper insulin therapy. In addition to education, a nurse / technician should build a relationship of trust with each patient to make the patient happy and cared for by the patient, who will regularly postpone complications with their regular checkups in the ambulance and lifestyle changes. Patient education can be distinguished by age and sex, current health status, religious beliefs, and current diet. The aim of co-operation of health teams in the treatment of diabetes is to eliminate the disturbances it causes and to prevent the development of acute and chronic complications, which can only be achieved by establishing a metabolic balance in the body and achieving conditional health by establishing work ability and involving diabetic patients in social life.

Keywords: teams, diabetes, prevention, education, cooperation

¹ bacc. nurse, Health Care Center „Zagreb Center“, Zagreb

INTEGRIRANA ZAŠTITA I ULOGA MEDICINSKE SESTRE U ZBRINJAVANJU BOLESNIKA S ARTERIJSKOM HIPERTENZIJOM I SNIMANJU EKG-A U PRIMARNOJ ZDRAVSTVENOJ ZAŠTITI

Iva Šogorić Stojanović,¹ Gordana Dlaka²

SAŽETAK

Arterijska hipertenzija je bolest karakterizirana povišenim vrijednostima arterijskog krvnog tlaka. Prema smjernicama SZO-a vrijednosti sistoličkog tlaka više ili jednake 140 mm/Hg i/ili dijastoličkog tlaka više ili jednake 90 mm/Hg u tri uzastopna mjerjenja tijekom jednog do tri tjedna smatraju se arterijskom hipertenzijom. Ona je jedna od najčešćih bolesti današnjice, te je glavni i neovisan čimbenik rizika za razvoj kardiovaskularnih i cerebrovaskularnih bolesti. Izrazito je važno pravovremeno otkrivanje arterijske hipertenzije. Za postavljanje dijagnoze arterijske hipertenzije uz višekratno mjerjenje krvnog tlaka kod liječnika obiteljske medicine ili u kućnim uvjetima, pacijentu je potrebno napraviti i dijagnostičku obradu, koja uključuje laboratorijsku analizu krvi i mokraće, pregled očne pozadine, snimanje EKG-a, UZV srca, UZV bubrega i nadbubrežnih žlijezda, a ponekad i ultrazvučni pregled moždanih arterija. U mnogim ambulantama obiteljske medicine pacijentima se može napraviti i holter tlaka, kako bi se utvrdile vrijednosti tlaka kod svakodnevnih aktivnosti, u mirovanju, po noći, i da li postoji razlika u vrijednostima izmjerena u arterijskog tlaka u ambulanti i izvan nje, s obzirom na to da mnogi pacijenti imaju sindrom "bijele kute" ili "zamaskiranu" arterijsku hipertenziju, a ujedno omogućava bolju procjenu učinka terapije. Izuzetno je važno da medicinska sestra zna pravilno snimiti EKG, kako bi se mogao dobiti adekvatan zapis i po potrebi što ranije zbrinuti pacijenta, a to zahtijeva od medicinske sestre pored znanja i izuzetnu spretnost i brzinu. Kod neregulirane arterijske hipertenzije najčešća promjena koju vidimo na EKG-u je hipertrofija lijeve klijetke. Uloga medicinske sestre u zbrinjavanju bolesnika s arterijskom hipertenzijom sastoji se od davanja preporuka za pravilnu prehranu, davanja savjeta za redovitu tjelesnu aktivnost, o važnosti redovitog uzimanja terapije, prestanku pušenja, gubitka viška tjelesne težine, samokontroli krvnog tlaka. Arterijska hipertenzija kod bolesnika ponekad se otkrije kod sistematskih pregleda, tijekom preventivnih akcija, pojedine bolesnike otkriju prilikom kućnog obilaska patronažne sestre, pa je od izrazite važnosti integrirana zaštita, a u skladu s tim suradnja primarne, sekundarne i tercijarne zdravstvene zaštite.

Cilj nam je kroz integraciju svih razina zdravstvene zaštite pacijentima osigurati najviši nivo zdravstvene zaštite i naglasiti ulogu medicinskih sestara, a sve u cilju prevencije ili što ranijeg otkrivanja bolesti, te sprečavanja ili barem smanjivanja komplikacija na najnižu moguću razinu, jer samo timskim radom možemo doći do tog najvišeg nivoa kao i zadovoljstva pacijenta.

Ključne riječi: arterijska hipertenzija, uloga medicinske sestre, integracija, zdravstvena zaštita, EKG

¹ bacc. sestr. Dom zdravlja Zagreb Centar, Zagreb

² ms. Dom zdravlja Zagreb Centar, Zagreb

INTEGRATED CARE AND ROLE OF NURSE IN TREATING PATIENTS WITH ARTERIAL HYPERTENSION AND CONDUCTING ECG TEST IN PRIMARY HEALTH CARE

Iva Šogorić Stojanović,¹ Gordana Dlaka¹

ABSTRACT

Arterial hypertension is a disease characterized by elevated values of arterial blood pressure. According to the guidelines of WHO values of systolic pressure higher or equal to 140 mm/Hg and diastolic pressure value higher or equal to 90 mm/Hg in three successive measurements through one to three weeks, that is considered arterial hypertension. It is one of the most common diseases of our modern times, and it is the main and independent risk factor for developing cardiovascular and cerebrovascular diseases. One of the most important things is timely diagnosing arterial hypertension. In order to diagnose arterial hypertension, beside multiple measurements of your blood pressure by your doctor of family medicine or conducted by yourself at your home, also it is important that the patient has gone through diagnostic processing that includes laboratory analysis of blood and urine, examination of the fundus, do the ECG test, a heart ultrasound, and ultrasound of kidneys and adrenal glands. Sometimes even the ultrasound of brain arteries. In many polyclinics of family medicine patients can do the holter monitoring of blood pressure, so that the blood pressure values would be determined during everyday activities, in a state of stillness, by the night, and it can be determined if there is a difference between the measured values of blood pressure in polyclinic and somewhere else, because it is not rare that patients may feel uncomfortable in a presence of a doctor or they have "masked" arterial hypertension. It is extremely important that nurse knows how to properly conduct ECG test, so the patient could get an adequate record, and if needed to inform the patient as soon as possible. Besides just the knowledge, that demands exceptional skill and rapidity. With unregulated arterial hypertension the most common change that we can see on ECG tests is left ventricular hypertrophy. Nurse role in helping patients with arterial hypertension consists of giving recommendations about proper nutrition, advising about regular physical activity, reminding the patient about regularly taking the therapy, quit smoking, losing weight, and regularly controlling their blood pressure. Arterial hypertension can be discovered while the patient has a general medical examination, or through preventive actions, some patients can be discovered through visits of health visit nurses, which brings us to the conclusion that it is very important to have integrated protection and accordingly cooperation of primary, secondary and tertiary health care. Our goal is through the integration of all levels of health care secure for the patients highest level of health care and to emphasize the role of nurses, all that in our common goal of prevention, early recognition or at least reduction of complications on the lowest possible level because only through teamwork we can come to the highest level of health care and patient satisfaction.

Key words: hypertension, nurse, healthcare, ECG

¹ Health Care Center „Zagreb Center“, Zagreb

PRIMJENA PANELA U PREPOZNAVANJU ČIMBENIKA RIZIKA ZA ZDRAVLJE OTOČKOG I KONTINENTALNOG STANOVNOSTVA

Draženka Tenšek,¹ Vesna Božan Mihelčić,² Tanja Lupieri³

SAŽETAK

Patronažne medicinske sestre samostalno provode zdravstvenu njegu u punom smislu te riječi te je njihova odgovornost tom činjenicom velika. Dobro educirana patronažna medicinska sestra svojim djelovanjem utječe na sveukupno zdravlje stanovništva, poimanje zdravlja stanovništva, način i stil života i životne navike. Sustavnim radom sa stanovništvom utječe na smanjenje broja invalidnih osoba, smanjenje broja komplikacija kod kroničnih nezaraznih bolesti, smanjenje broja ovisnika i njihovu rehabilitaciju, posebno na očuvanje zdravlja i mobilnosti starije populacije. U dobroj suradnji sa socijalnim službama i lokalnom samoupravom značajno utječe na životne navike iz kojih proizlaze rizična ponašanja i rano uočavanje pojave kroničnih bolesti. Kontinuiranim djelovanjem u zajednici utječe na rano otkrivanje malignih bolesti podukom stanovništva o ranim znakovima bolesti.

Medicinska sestra je ovdje u fokusu problema, ne samo kao osoba koja identificira pacijentove prisutne i potencijalne potrebe već i kao profesionalac koji registrira njegova očekivanja koja će biti na pravi način i na vrijeme prepoznata i to prije, za vrijeme i nakon postupaka sestrinske skrbi.

Činjenica je da stanovništvo otoka iz kulturoloških i geografskih razloga češće prakticira zdrave životne stilove. Užurbani način života u gradu svakako ostavlja posljedice na životni stil i navike. S druge strane osigurava bolju dostupnost zdravstvenim uslugama i informacijama. Cilj istraživanja bio je ispitati koji su faktori rizika za zdravlje kod otočkog i kontinentalnog stanovništva i definirati razlike. Istraživanje je provedeno u dvije skupine od po 300 ispitanika. Prva skupina uključuje stanovnike na otoku Visu, a druga u kontinentalnom dijelu, gradu Zagrebu. Kod svakog od ispitanika provedena su antropometrijska mjerenja u sklop zakonom određenih preventivnih panela. Panelima su dodani upitnici koji su uključivali zdravstvene navike i prehrambene navike, tjelesnu aktivnost i specifikaciju faktora rizika za nastanak bolesti na koje se može utjecati. Analizom se kod stanovništva otočkog podneblja kao faktori neurorizika na koje se može utjecati navode: povišeni krvni tlak (45%), utvrđene srčane bolesti (23%), povišene masnoće u krvi (40%), debljina (38%), nepostojanje samokontrole bolesti (90%) i kontrole bolesti (75% samo jednom godišnje). Kod stanovništva kontinentalnog podneblja kao faktori neurorizika se navode: pušenje (25%), utvrđene srčane bolesti (52%), šećerna bolest (30%), debljina (29%), značajno suženje karotidnih arterija (25%), nezdrava prehrana (55%), stres (65%) i tjelesna neaktivnost (50%). Analiza je potvrdila da otočko stanovništvo živi zdravije, zbog zdravijih prehrabnih namirnica i navika te mogućnosti boravka na svježem zraku. Isto tako analiza je potvrdila da je stres jedan od vodećih faktora neurorizika kod kontinentalnog stanovništva. Uspoređujući podatke obadvije skupine može se zaključiti da se u prevenciji bolesti treba fokusirati na faktore neurorizika na koje se može utjecati ovisno o potrebama određene populacije. Kod otočkog stanovništva to je utvrđena nedostupnost zdravstvene zaštite, a kod kontinentalnog usvajanje zdravih prehrabnenih i životnih navika.

Ključne riječi: preventivni paneli, javnozdravstvene akcije, čimbenici rizika, stanovništvo

¹ univ. mag. admin. sanit. dipl. ms., Dom zdravlja Zagreb Centar, Zagreb

² dipl. ms., Dom zdravlja Zagreb Centar, Zagreb

³ mag. sestr., Hrvatska udruga medicinskih sestara

APPLICATION OF THE PANEL IN RECOGNITION OF HEALTH RISK FACTORS OF ISLAND AND MAINLAND POPULATION

Draženka Tenšek,¹ Vesna Božan Mihelčić,¹ Tanja Lupieri²

ABSTRACT

Health visitors independently carry out health care in the full sense of the word and their responsibility is great. A well-educated health visitor has an impact on overall population health, understanding of population health, lifestyle and life habits. Systematic work with the population affects the reduction of the number of people with disabilities, the reduction of the number of complications in chronic non-communicable diseases, the reduction of the number of addicts and their rehabilitation, especially the preservation of the health and mobility of the elderly population. Good co-operation with social services and local self-government has a significant impact on life habits that result in risky behaviours and early detection of chronic diseases. Continuous community action through informing the population about early signs of illness, affects early detection of malignant diseases.

The nurse is here in the focus of the problem, not just as a person who identifies the patient's present and potential needs, but also as a professional who registers his expectations that will be properly and timely recognized before, during and after nursing care procedures.

The fact is that the island population is more likely to practice healthy lifestyles for cultural and geographic reasons. A busy lifestyle in the city certainly has a bearing on lifestyle and habits. On the other hand, it provides better access to health services and information. The aim of the study was to examine the health risk factors in the island and continental population and to define the differences. The study was conducted in two groups of 300 respondents. One group included residents on the island of Vis and the other, continental group, residents of the city of Zagreb. Anthropometric measurements were performed on all respondents within legally determined preventive panels. Panels included questionnaires that included health habits and nutrition habits, physical activity, and specification of modifiable risk factors for the onset of illness. The analysis of the island population has revealed the following modifiable risks: elevated blood pressure (45%), established cardiovascular disease (23%), elevated blood fat (40%), obesity (38%), lack of self-control of the disease (90%) and disease control (75% only once a year). In the continental population, factors include: smoking (25%), established heart disease (52%), diabetes mellitus (30%), obesity (29%), significant narrowing of carotid arteries (25%), unhealthy diet (55%), stress (65%) and physical inactivity (50%). The analysis confirmed that the islanders live healthier, due to healthier nutrition and habits and the ability to stay in the fresh air. Likewise, the analysis has confirmed that stress is one of the leading risk factors in continental population. By comparing the data of both groups, it can be concluded that the prevention of disease should focus on modifiable risk factors, depending on the needs of a particular population. The modifiable risk factor in island population is unavailability of health care, whereas in continental population it is unhealthy eating and life habits.

Key words: preventive panels, public health actions, risk factors, population

¹ Health Care Center „Zagreb Center“

² Croatian Association of Nurses

MODELI DOBRE PRAKSE I PRIMJENA MODERNIH TEHNOLOGIJA U SUSTAVU PRIMARNE ZDRAVSTVENE ZAŠTITE

Andželka Zeba,¹ Mateja Juric¹

SAŽETAK

Korištenje naprednih tehnoloških rješenja pospješuju učinkovitost i kvalitetu rada patronažne sestre.

Moderna tehnologija u radu patronažne sestre pridonosi boljoj kontroli kroničnih bolesti, kvalitetnijoj edukaciji bolesnika, osnaživanju samog bolesnika u kućnoj njezi i boljoj koordinaciji i integraciji zdravstvenih djelatnika. Primjer modela dobre prakse je javno zdravstveno istraživanje bolesnika vezano za korištenje ICT tehnologije u sklopu projekta Carewell. ICT tehnologija omoguće automatski prijenos i centralno spremanje podataka o pacijentu, jednostavan pristup podacima za zdravstvene djelatnike te komunikaciju zdravstvenih djelatnika putem EMH sustava.

U pilot projektu su sudjelovale : Italija, Španjolska, Wales, Poljska i Hrvatska. Predstavnik Hrvatske u navedenom projektu bio je Dom zdravlja Zagreb Centar u kojem je bilo uključeno šest lokacija s ukupno 120 pacijenata. 2014. regrutacijom pacijenata formirane su dvije grupe, intervencijska i kontrolna skupina pacijenata. Kriteriji za uključivanje pacijenata bili su dob od 65 i više, pacijenti koje obilazi patronažna služba, pacijenti koji imaju njegovatelja, pacijenti s primarnim dijagnozama: kronična opstruktivna plućna bolest, kronične vaskularne bolesti, šećerna bolest i jedan ili više komorbiditeta. Ciljana skupina projekta su bolesnici, njegovatelji, zdravstveni djelatnici Doma zdravlja Zagreb Centar, tehnička podrška Ericsson-a i Fakulteta Elektrotehnike i računarstva. U lipnju 2015. godine započeto je s upitnicima i mjerjenjima prilikom redovite kućne posjete od strane patronažne sestre u domu bolesnika. Prilikom kućne posjete sama mjerena kao i upitnici vršili su se pomoću EMH mobilne aplikacije na tablet uređaju, a izmjereni podaci pohranjivali su se u centralni sustav u digitalnom obliku kako bi im mogao pristupiti liječnik obiteljske medicine. Prema zakonu o zaštiti osobnih podataka, poduzete su mjere zaštite i enkripcije podataka tijekom rada s bazama podataka i podacima pacijenata. Prikupljeni rezultati u anonimnom obliku 2017. godine poslani su u zemlje Europske unije kako bi se na njima radila analiza. ICT tehnologija omogućila je liječniku obiteljske medicine bolji uvid u praćenju parametara vezanih za zdravstveni status pacijenta te integriranu zdravstvenu zaštitu kroz multidisciplinarnе programe, preventivno, edukativno i informativno. Izravnim ulaskom u dom pacijenta i obitelji kroz korištenje modernih tehnologija omogućen je viši stupanj pomoći kroz širenje znanja o bolesti, uzimanju terapije, preporučenom načinu života vezanom uz kroničnu bolest, podrška obitelji te bolji uvid za unapređenje zdravlja i sprečavanja komplikacija u svrhu produženja životnog vijeka. Moderne tehnologije su od velike važnosti i pomoći u svakodnevnom radu patronažne sestre jer omogućavaju kontinuitet skrbi no iziskuju dodatno vrijeme i vještine.

Ključne riječi: ICT tehnologija, multidisciplinarni tim, prevencija, edukacija

¹ bacc. sestr., Dom zdravlja Zagreb Centar, Zagreb

EXAMPLES OF GOOD PRACTICE AND APPLICATION OF MODERN TECHNOLOGIES IN THE SYSTEM OF PRIMARY HEALTHCARE PROTECTION

Andelka Zeba,¹ Mateja Juric¹

ABSTRACT

Use of advanced technology solutions accelerates the effectiveness and work quality of community nurses. Modern technology help community nurses in better control of chronic diseases, better quality of educating patients, empowering patient in home care ,better coordination and integration of health care workers. Afantastic example is Public Health research of patients with use of ICT (Information Communication Technologies) - Carewell. ICT has enabled us automatic transfer and central storing of data regarding patients, simple access to data about health care workers and communication between health care workers through the EHM system.

Countries that have participated in th pilot project are Italy, Spain, Wales, Poland, and Croatia. The Croatian representative was the Zagreb-Centar neighborhood medical center (with six locations and 120 patients in total). In 2014 by recruiting patients, two groups were formed (intervention and control group). Criteria for patient participation were: over the age of 65, the patient had to have been monitored by a community nurses, patients had to have some form of inhome care, and a primary diagnoses (KOPB, KVB, diabetes + comorbidity). Target groups were: patients, health carers, health workers of the medical center Zagreb-Centar neighborhood, Ericsson's technical support, and Faculty of Electrical Engineering and Computing in Zagreb.

In June 2015 we started with questionnaires and measurements conducted by community nurses in patients homes. All measurements and questionnaires were conducted through the EMH application and all data was stored in a central data system in digital form so it could be accessible to doctors of family medicine. By new GDPR regulations, all data was encrypted while transferring patients data to the database. Collected data was sent in 2017 in anonymity form to European Union countries to further analyze the data.

ICT has enabled doctors better insight into parameters connected to the health status of patients, and also integrate health protection through multidisciplinary programs (preventively, educatively and informatively). Through direct contact with the patient and thier family and by using advanced technologies, it enabled us a higher level of careregarding educating pacient about thierillnesses, regarding thier mediction use and recommended a life style to make life more comfortable with chronical diseases.

Modern technologies have a very important part in everyday work of community nurses, because they allow continuous care, but they require extra effort, time and skill.

Key words: ICT technology, integrated health care, prevention, education

¹ bacc. nurse, Health Care Center „Zagreb Center“, Zagreb

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