

## 7 Summary

In the general population, dyspeptic symptoms are very common. Although only one quarter seeks medical treatment, dyspepsia is one of the most frequent reasons consulting general practitioners, causing extensive socioeconomic consequences. Little is known about medical care of primary care patients with uninvestigated dyspepsia. This case-study was carried out to evaluate the medical care situation of this significant group of patients, making a contribution to medical care research in general medicine.

For this purpose, from March 2001 to January 2002 eligible patients of a general community practice were examined by means of different self-rating instruments at first contact (t0) and after four weeks (t1): bodily complaints using the short form of Gießen complaint list (GBB-24); health-related quality of life (HRQL), via the Medical Outcome Study Short-Form 36 (SF-36); mental disorders and psychosocial stress, using the german version of the PRIME-MD Patient Health Questionnaire (PHQ-D), and psychosocial interventions, via the basic documentation „Psychosocial Primary Care“ (Bado PSGV). Dyspepsia-specific diagnostic and therapeutic procedures of participating doctors were also documented and evaluated in regard to guidelines.

More than the half of the patients examined presented with alarming symptoms at first contact. In almost half of all cases an oesophagogastroduodenoscopy (OGD) was performed. The rate of pathological endoscopic findings was unusually high with 85% (gastritis 47.5%, oesophagitis 17.5%, gastroduodenal ulcers 15.0%, carcinoma 2.5 %). 95% of patients with a definite endoscopic diagnosis received treatment according to the guidelines. Estimated diagnosis and diagnosis of OGD were often concordant. At t1, almost one third of patients were free of dyspeptic symptoms, and more than one third of patients had improvement in their symptoms. However, one third of patients reported persistent dyspeptic symptoms.

There was a highly significant reduction in the GBB-24 global score of discomfort (GSD) of the study sample. However, the GBB-24 global score at t1 was still almost twice as high as in the German standard sample after four weeks.

Improvements in the quality of life in patients with dyspepsia as measured by the SF-36 were significant to highly significant, although they did not reach standardised values of a comparison group from the German National Health Survey. Surprisingly, gender specific differences in the SF-36 values could not be confirmed in the study collective.

The psychiatric co-morbidity detected by PHQ-D was extraordinarily high (t0: 60,2%; t1: 48,2%). Compared to average primary care patients, depressive disorders occurred three to four times and anxiety disorders six times more often in the study sample. The incidence of psychosocial stressors was two to three times higher than in average primary care patients. Although in depressive patients and those with anxiety the treatment rate was doubled over time, only half of the patients with depressive disorders and a quarter of patients with anxiety disorders received psychotropic drugs. Contrary to expectations, in PHQ-D no gender-specific differences were found. In the study sample there was a nearly linear correlation between the severity of mental disorders (DSM-IV-categories) and the bodily complaints in GBB-24 as well as the health-related quality of life in SF-36.

Participating doctors were attributing bio-psychosocial strains of their patients more towards traditional aspects (pain, work-related stress, organic diseases). Only 16.9% of patients showed a psychosomatic understanding of their illness, whereas 77.1% of participants were focused on somatic causes. 96.4% of patients received an antacid, 50.6% of patients a sick certificate. Compared to average prescription rates, psychotropic drugs were prescribed less often (7.2% vs. 17%), whereas counselling services were given comparatively often (79.5% symptom-related advices, 37.7% psychodiagnostic interviews). Interventions in terms of psychosocial primary care were given only in 1.2% of patients. Although in 41% of the cases interdisciplinary cooperation was considered important by the general practitioners, it took place in only 3.6%. Psychosocial treatment was carried out independently of current psychosocial strains, but significantly more often in patients with a psychosomatic understanding of their illness. Compared to average primary care patients, the numbers of contacts as well as referrals were almost twice as high in the study patients. The mean duration of sick leave was 1.3 weeks; but only 10% of (employed) patients caused the longest

times of sick leave. Doctors recognised symptoms of depression and anxiety very often correctly: 68% of clinically depressed patients and 70% of patients with anxiety disorders were correctly identified in accordance with the results of PHQ-D.

The GBB-24 proved to be a feasible instrument to objectify the subjectively perceived bodily complaints of the patients, and allowed an evaluation of the treatment effect that was achieved. Also, measuring the HRQL over time with the SF-36 proved to be a very appropriate method of evaluating the success of therapy and – at the same time – of identifying those areas of daily routine in which patients showed persistent impairments of clinical relevance. Therefore, the implementation of regular measurements of the HRQL in primary care settings would represent an important progress in patient-centred therapy management. In parallel with the global situation of patients with mental disorders in primary care, treatment of the dyspeptic patients with a mental co-morbidity was insufficient. In view of the extraordinarily high prevalence of mental disorders as well as the considerable burden of psychosocial problems in study subjects, the high demand of psychosocial support of the investigated dyspeptic patients became apparent. Thus, in primary care patients with dyspepsia, routinely self-administered screening of psychosocial status with the PHQ-D can clearly be justified. However, this additional effort would only be beneficial if both, the doctors and patients concerned jointly draw the therapeutic consequences suggested by the screening results.

Due to the small sample size, the results of the present study are probably not representative. They will require verification in multi-centred studies. A long-term study of the quality of medical care, including secondary and tertiary medical settings, would be desirable for the evaluation of both the course of disease and the efficiency of interventions in this socio-medically important group of patients.