14. Ulusal İzmir Aile Hekimleri Derneği Kongresi Bildirileri

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Ana Sayfa | Kongre Kurulları | Genel Bilgiler | Kongremizden Hatıralar | Genel Konular | Bilimsel Program | Kayıt ve Konaklama | Bildiri Özetleri | İletişim | English

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14.
ULUSAL İZMİR
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DERNEĞİ
KONGRESİ

28 NİSAN – 1 MAYIS 2023
KORUMAR EPHESUS BEACH RESORT, SELÇUK - İZMİR

28 NİSAN – 1 MAYIS 2023
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14th
NATIONAL AND
1st INTERNATIONAL
CONGRESS
OF IZAHED
"Planetary Health and Family Medicine"

28 April- 1 May 2023
KORUMAR EPHESUS BEACH RESORT, SELÇUK - İZMİR

28 APRİL – 1 MAY 2023
KORUMAR EPHESUS BEACH RESORT, SELÇUK - İZMİR

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Is the integration between PHC and Prevention "impossible"? The Sentinel Physician for the Environment

Paolo Lauriola, Italian Network of Physicians for the Environment (RIMSA)

Health effects due to the Environment are among the most challenging concerns in our future. In the past, environmental health problems addressed a single pollutant source or exposure. Today's issues are often more complex. New approaches such as One Health and Planetary Health have emerged along this line.[1]

Primary Health Care is based on practical, scientifically sound and socially acceptable methods universally accessible to individuals and families.[2] COVID-19 proved that Family Doctors (FD) can:

- Educate patients on the relevance and effectiveness of hygiene measures,
- Detect and report epidemics (International and Italian experiences).[3]

We carried out two comprehensive literature reviews on *Sentinel Physician Networks.*[4] In general, clinicians' activities concerning Environment and health are still rather underdeveloped. We believe that FDs could play a crucial role in putting global environmental and health concerns in connection with local actions.[5] FDs could also be a precious source of a considerable amount of valuable data, helping inform decisions leading up to adequate environmental-health understandings and actions either at local or at a global level, as well as to support public health authorities. Such an initiative could raise some opportunities for Sentinel Physicians for the Environment involving low-middle-income countries. Such an approach might be beneficial in coping with tragic conditions (i.e. malnutrition, waterborne diseases, infectious diseases, etc.), which should be taken into account not only for their direct health effects but also for others which indirectly influence the life and the health of people (for instance migrations)[6] But it is also necessary to provide the following:

- Specific, practical, and motivating training of GPs in these fields to create a professional profile based on epidemiological and advocacy duties;
- Sound science by providing to GPs support in research and data;
- Clear and effective communication strategies among GPs, their patients, communities, and policymakers.[7]

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Health and Family Medicine Down Under

Catherine Pendrey
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Abstract: We are living in a planetary health crisis. Climate change and biodiversity loss are already harming the health of the global population, exacerbating inequities, and impacting the practice of family physicians around the world. In Australia more frequent and severe extreme weather events, including extreme heat, bushfires, floods, storms, and droughts have caused harm to urban and rural communities alike. Climate change has also caused major changes in the distribution of vector-borne diseases (eg. Japanese encephalitis) and climate-related distress is now widespread, especially among young people. Despite this, Australia remains a significant emitter of greenhouse gas emissions and contributor to climate change. In response Australian family physicians, doctors and health professionals have taken action to: educate the community that climate change is a health issue; build community resilience to the health impacts of climate change; respond to climate-related disasters; reduce emissions in the health sector; advocate politically for stronger climate action; and work in partnership with broader civil society. These actions have yielded significant progress on climate action in Australia, and serve as an example of the important role that family physicians can play in securing a healthy and sustainable future.

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Planetary Health and Global Policy

Elizabeth Willetts
Policy Director Planetary Health Alliance/Harvard T.H. Chan School of Public Health

I will base my short presentation (10min) on Planetary Health and global governance, with a focus on biodiversity policy, as outlined in these two Lancet articles: Health in Global Biodiversity Governance: what is next? (January 2023), Health-Environment Nexus: global negotiations at a crossroads (April 2022). As requested, here is a short abstract that draws on these articles.

'In the 50 years of work to advance sustainability policy since the 1972 UN Conference on the Human Environment and the establishment of the UN Environment Programme, the relationships between humans and the planet's ecosystems, and between health and the environment, have largely remained at the periphery of global health discourse. Governance architectures for global health and global environmental policy are generally siloed, but the challenges these domains tackle are increasingly intertwined and require cross-sector collaboration.'

'The dependency of human health and wellbeing on nature is documented across disciplines, regions, cultures, and economies. Environmental degradation contributes substantially to the global burden of disease and concurrent global environmental changes are increasingly recognised as public health threats, worldwide. The growing evidence and awareness of these interlinkages increasingly drive interest and demand for a joint health–environment global policy agenda.' Planetary Health is a movement and discipline that provides a framework for integrated solutions for sustainable development.

The 16th meeting of the UN Biodiversity Conference (CBD COP 16) will take place in Türkiye in 2024, convening 196 governments and biodiversity stakeholders to advance global governance related to nature. The agenda of the UN CBD recognises and increasingly includes health. Now is the time to mobilise contributions from diverse health experts to inform integrated policy. Health stakeholders will need to translate the 2022 Global Biodiversity Framework targets into the global health agenda, contribute to the development of a comprehensive global action plan on biodiversity and health, and support implementation of decisions on climate change, biocultural diversity, food systems and soil biodiversity, and synthetic biology.

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Planetary Health and Family Medicine. Towards a climate-resilient primary health care practice

Lokotola Christian Lueme
Department of Family and Emergency Medicine/Stellenbosch University (South Africa)

Climate change has been declared the biggest threat to human health in the 21st century. Climate change and global pollution are ecological drivers associated with significant health and social effects that are often seen in primary healthcare services. Exposure to climate change-induced extreme weather events is associated with immediate loss of life and injuries as well as destroying homes and livelihoods. Not all family doctors are aware of the issues and how to tackle them. There are three key aspects to consider: the health and social effects of climate change, the challenge of climate change to primary healthcare facilities and services, and the contribution of health services to the problem of climate change.

Several reports have underlined the difficulty of PHC facilities and services to operate after extreme weather events. In consideration of the challenge of climate change to PHC facilities and services, the WHO has developed the operational building blocks of a climate-resilient health system. The contribution of health services to the problem and its carbon footprint should also be considered. This presentation suggests practical steps that family doctors can take to address these issues: planetary health education and climate-resilient primary health care.

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Practicing Comprehensive Family Medicine

Nerio Enrique Romero, Md
Full professor (Emeritus), Universidad del Zulia (LUZ) (Venezuela)

Talking about my book "Practicing Comprehensive Family Medicine. Fundamentals, Tools and Cases" is to talk about Family Medicine. Not about the very extended array of topics that interest or could interest family doctors, but about nuclear Family Medicine, about the core of our specialty. A simple way to understand what this book is all about, is trying to answer the question: "What does comprehensive health care look like?"

This book deals with comprehensiveness, from its definition to its limitations and problems; and presents, using real examples, a finite and manageable set of tools that we postulate as effective and essential for translating the principle of comprehensiveness into real-life medical practice. We consider these essential and effective tools because of the actions, or effects, that these tools help to make possible. There could be, of course, other tools with similar objectives and potentials that could equally serve this purpose.

Comprehensiveness presents an interesting challenge to the profession and a more complex challenge in primary health care. We believe this challenge has three central tasks:

First, to integrate in practice the understanding of human health problems provided by biomedical sciences with that of the psychosocial issues related to those problems, which is not an easy operation even when one recognizes the need for such biopsychosocial integration.

Second, to integrate a preventive approach to the regular daily range of services in our medical practice, traditionally oriented to the diagnosis and treatment of the disease, and

Third, the effective promotion of behavioural changes, given the importance of human conduct and lifestyle in the genesis and treatment of many prevalent diseases of our times. Nowadays, family medicine fundamentals, comprehensiveness and continuity of care, are or could be under menace. Healthcare access difficulties have reached a significant presence in the political agendas of many countries and pressure the search for care options to facilitate access, or at least improve public perception of accessibility to first-line services. Care options that are or will be proposed, could tend to be based on the fragmentation of care since if it is not possible to give access to all those who feel they need immediate attention from a GP, it is predictable that services be offered for common specific problems generating that demand, and that these services could be delivered in an episodic base, and even by non-medical professionals or technical personnel.

That could become socially acceptable, based on the fact of unsatisfied needs. Whatever the political and administrative decisions that are made, we believe that an increased tendency to fragmentation of first-line personal and family health care is foreseeable and, as a consequence, also risks care continuity and comprehensiveness, so valuable principles for family medicine/general practice movement.

In order to protect those principles, caring for and strengthening the identity of family medicine/general practice as a discipline will be an essential strategic line. Among others, care comprehensiveness and continuity are central and indispensable elements of this unique identity.

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Nowadays, in times of pressure and change, there is a need for strengthening our discipline (specialty) as the practice model to lead, both in practice and academic realms, the activity of first-line health care.

Our book entitled "Practicing Comprehensive Family Medicine. Fundamentals, Tools and Cases" is designed to contribute to the continuous creation and strengthening of that distinctive identity, and is globally accessible through Amazon stores, in both printed and digital book versions. In this text, teachers, doctors, and students will find, through the interaction between examples of practice and relevant theoretical elements, a practical way of looking at the unique identity of family medicine/general practice and becoming associated with it. We invite you to read and use it as a reference or educational book, confident that you will find it interesting and useful.

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Global Action on Plan on Patient Safety 2021-2030. The Role of Primary Health Care.

MP Astier-Peña, MD (Spain)

The 74th World Health Assembly (WHA) adopted in May 2021 the "Global Action Plan for Patient Safety: 2021-2030" to improve patient safety as an essential component of the design, procedures and performance evaluation of health systems worldwide.
It is a strategic plan that guides governments, health sector entities, health organisations and the World Health Organization secretariat on how to implement the WHA resolution on patient safety. Implementation of the plan will strengthen the quality and safety of health systems around the world by covering the entire continuum of people's health care, from diagnosis to treatment and care, reducing the likelihood of harm occurring in the course of care.

The Declaration of the Global Conference on Primary Health Care in Astana, 2018, urged countries to strengthen their primary health care systems as an essential step towards achieving universal health coverage and providing access to a safe, quality care without financial loss. The roll-out of the Global Action Plan for Patient Safety in Primary Health Care is therefore a high priority for health policy action.
The Action Plan is structured into 7 strategic objectives with 35 strategic actions. These actions are thought to be implemented by main stakeholders: governments, healthcare organisations, health sector and WHO secretariat.

We present some reflections on the strategic actions in relation to healthcare organisations and the challenges posed by their concrete deployment in Primary Health Care settings.
Strategic Objective 1 (SO1): Achieve preventable harm to patients as the state of mind and engagement in the planning and delivery of healthcare everywhere.
Proposed actions to deploy in Primary Health Care (PHC)
- Express a commitment from PHC to prevent harm in health centres (HC) and the communities.
- Embody the need for family doctors with management experience in national bodies that make health decisions with a perspective that includes PHC and patient safety.
- Position PHC as a key point for achieving universal health coverage and the coordination of risk management in the continuity of care for patients from a macro-management perspective.
- Urgently invest to improve the quality of PHC services in:
o Safe buildings: space and ventilation
o Staff trained in Patient Safety
o Availability of equipment and complementary tests for proper diagnosis and follow-up (rapid diagnostic tests, ultrasound, spirometry, digital electrocardiography at the health centre and at home, etc.).
o Technological support for the safe use of medication.

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o Patient communication technology (video-consultation, tele-monitoring of patients at home etc.)
o Integration of health information systems with hospitals and public health.
- Training multi-professional PHC teams in patient safety.
- Provide PHC access to a reporting system that involves analysis, learning and improvements in care procedures.
- Develop a legal environment for healthcare professionals that facilitates no-fault reporting and restitution of harm to the patient; and that allows for an in-depth analysis of incidents without such documentation and those responsible for it being subject to prosecution.
- Define and require minimum quality and safety requirements for authorisation to open HCs in PHC.
- Define common accreditation programmes for PHC centres that contribute to guaranteeing a quality and safe care structure and process.
- Implement systems for reporting quality and safety incidents in relation to the care provided in SCs in such a way that temporary and assessable improvement objectives could be drawn up.
- Include the perspective of PHC and the involvement of the multi-professional teams of the SCs in every patient safety challenge and activity, particularly in the celebration of World Patient Safety Day.

Strategic Objective 2 (SO 2): Build highly reliable health systems and healthcare organisations that protect patients from harm on a daily basis:
Some proposed actions to be deployed in Primary Health Care (PHC)
- Easily and securely access legally supported Primary Health Care professionals to reporting and learning systems.
- Participate in the investigation, analysis and reporting of serious patient safety incidents.
- Promote patient safety incident reporting as part of the continuing education of healthcare staff.
- Conduct patient safety culture surveys among PHC professionals with validated instruments that allow comparison between regions/nations to promote improvements in the organisation of care.
- Train and facilitate open disclosure after a patient safety incident (PSI) by PHC professionals.
- Identify a patient safety and risk management manager in each PHC team.
- Facilitate the participation of PHC professionals in PSI analysis commissions/committees at all management levels in order to transfer the vision and derived improvements throughout the healthcare system.
- Support the management of health centres (HCs) by health authorities to facilitate the designation of coordinators responsible for an adequate response to the occurrence of a serious adverse event.
- Design and deploy a clinical management structure in PHC involved in the deployment of patient safety policies and programmes specifically.
- Identify a person responsible for patient safety and risk management in each HC.
- Support the management of the clinical risks of the CSs by regional services so that there must be continuity in their treatment and management.
- Provide support and recommendations on the facilities of the HCs considering human factors and physical safety by the health authorities in PHC.

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- Take care of the professionals who care for them, who are the main asset of PHC, and attend to the second victims of adverse events.
- Develop a risk mitigation plan in line with the direction of the health system with particular reference to the characteristics of the PHC network.

Strategic Objective 3 (SO 3): Ensure the safety of all clinical processes provided.
Some proposed actions for deployment in Primary Health Care (PHC)
- Include PHC professionals in the clinical leadership group of the healthcare organisations and in the definition of national priorities for the improvement of patient safety.
- Draw up a risk management map in each HC with the aim of improving patient safety in the main care processes, particularly those with the highest risk, such as care for urgent patients, emergencies at home or on the public highway or in more remote rural areas.
- Receive organisational support to implement clinical risk management activities to improve patient safety through the standardisation of care procedures for the multi-professional PHC team.
- Promote good practice in PHC procedures.
- Improve the safe use of medicines in PHC through:
o Training in medication safety and polypharmacy.
o Strategies to improve medication reconciliation in the transition of care between levels of care.
o Control of high-risk medications.
- Raise awareness among PHC professionals and patients.
- Provide tools to improve patients' knowledge of their medication.
- Develop a role that enhances PHC in coordination with national Public Health authorities.
- Train PHC professionals in Antibiotic Optimisation Programmes (PROAS) for subsequent implementation in HCs.
- Form multidisciplinary teams between PHC and hospital to analyse and address PSI at the local level.
- Ensure the maintenance and proper functioning of all authorised devices available in the HCs.
- Appoint a specifically trained drug safety officer in each HC.
- Ensure proper receipt of vaccines, maintenance of the cold chain, safe administration and correct recording in the electronic health record (EHR).
- Invest in information systems to ensure the flow of clinical information in inter-consultations and continuity between the different levels of care.
- Including Notification and Learning Systems in PHC EHRs.
- The availability of agile tools to aid diagnosis and treatment included in the PHC EHR.

Strategic Objective 4 (SO4): Patient and family engagement.
Some proposed actions for deployment in Primary Health Care (PHC)
- Establish fluid communication channels between the health centres (HCs) and the community:
1) To receive proposals for improvement and notifications of patient safety incidents throughout their healthcare
2) To inform the public of the most relevant aspects, key messages and advice for patients and families to participate in their safety.

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- Establish meetings, working groups, meeting places where patients, patient association representatives and relatives can contribute their experiential knowledge.
- Promote mechanisms for reporting patient safety incidents in the CSs, analyse them, learn from them and improve with them.
- Enable patient access to the Patient Safety Notification and Learning Systems
- Promote patient participation in community activities organised by the HC to share patient safety experiences.
- Promote the development of response plans for the first victim (patient and family), the second victim (team of professionals involved) and the third victim in the event of a serious adverse event in the HCs.
- Train HC professionals in how to communicate incidents to patients and in skills to ensure support for first, second and third victims following a serious safety incident.
- Train professionals to understand the patient and family perspective in the HC care process.
- Train patients and their families to understand and manage their health problems with self-care at home.
- Develop information materials explaining to patients and families the type of care they will receive on their journey through the healthcare system and train them on how, when and where to seek care.
- Train professionals, patients and families in the process of shared decision-making in relation to healthcare.

Strategic Objective 5 (SO 5): Inspire, educate, empower and protect health workers to contribute to the design and delivery of safe systems of care.
Some actions to deploy in Primary Health Care (PHC)
- Include and maintain patient safety content in the training plans of undergraduate and postgraduate health professions students, residents and in the continuing education of health centres (HCs).
- Encourage the safety culture of making placement for healthcare professionals at the PHC and involve them in safety incident analysis and learning sessions.
- Organise events to share specific safe practices among HCs.
- Establish a Network of Trainers of Trainers in Patient Safety for PHC.
- Include patient safety content among the subjects required for entering and starting to work in jobs linked to PHC, both public and private.
- Include patient safety indicators in the management systems of the PHCs.
- Give special recognition to healthcare professionals to improve patient safety.
- Ensure adequate working shifts and breaks after continuous care in HCCs.
- Reduce bureaucracy in PHC.
- Facilitate adequate attention by the occupational risk prevention services to PHC professionals, including health protection and disease prevention measures, adaptation of workloads and guarantees in the ergonomics of HCs.

Strategic Objective 6 (SO6): Ensure a constant flow of information and knowledge to promote the reduction of risk and the occurrence of avoidable harm and thus improve the safety of healthcare.
Proposed actions to be deployed in Primary Health Care (PHC)

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- Build a patient safety scorecard that can be used in the HCs to monitor safety indicators and thus identify areas for improvement.
- Share learning experiences among the different CSs.
- Generate a repository of good practices available for PHC.
- Make time available in the weekly agendas of professionals for patient safety research.
- Linking HCs with university departments to promote research at the PA level.
- Invest in digital solutions that improve the quality of care and the safety of patients and their families at home and at the HCC.
- Promote solutions that improve communication between patient and professional and between professionals at different levels of care.

Strategic Objective 7 (SO 7): Develop and maintain synergy, solidarity and multi-sectoral and multinational partnerships to improve patient safety and quality of care.

Proposed actions to be deployed in Primary Health Care (PHC).

- PHC professionals are connected to the community where they work and can therefore advocate for its safety. They can coordinate between the different actors involved (local leaders, patient associations, key players, socio-healthcare settings, etc.).
- Coordination by PHC professionals of a local plan to improve patient safety, taking into account not only risk management in the PHC, but also the empowerment of patients and their families.
- Organise workshops for the exchange of experiences and good practices on patient safety among HCCs.
- Conduct safety rounds by management to reinforce good practices in patient safety in PHC teams.
- Hold meetings, conferences and congresses on patient safety specifically dedicated to PHC.
- Facilitate the mobility of PHC professionals in order to learn from the best, also in patient safety.
- Explicitly incorporate a patient safety and risk management perspective into PHC procedures and programmes.

It is sure that there are many other initiatives to be considered in HCs to improve PHC. Family Doctors have an essential role to implement safe practices in HCs.

Therefore, the Global Action Plan on Patient Safety is a great opportunity to improve the healthcare quality and safety of primary health care in the world. A stronger primary healthcare will guarantee as well a quality and safe universal healthcare coverage.

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The UK's experience with a Green toolkit and other zero carbon initiatives.

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Human activity is causing global warming, climate change and an ecological crisis. We all need to act quickly to limit this damage and avoid the unmanageable. We also need to accept that climate change is inevitable and adapt to manage the unavoidable consequences. In the UK and similar countries health care typically causes 5% of the country's carbon emissions – its carbon footprint. Family medicine is responsible for 20% of the carbon footprint of which 60% is due to clinical care from medical treatments and the remaining 40% is from running a business and includes 14% staff and patient travel, and 11% utilities (gas & electricity). We all need to act effectively and quickly to switch to a more sustainable, low carbon way of living. Family physicians are important as trusted role models with great influence in their communities. What can family physicians do?
Web based Toolkits that describe what actions family physicians can take, that explain why they should do them and give tips on how to do them can help. The Royal College of General Practitioners developed a free toolkit in 2014. It has over 100 actions that Family physicians can take to make the change to be low carbon, and sustainable practices. To view the UK's Royal College of General Practitioners Green Impact for health toolkit see https://toolkit.sos-uk.org/greenimpact/giforhealth/login. You can get more information about the contents of the toolkit by emailing greenimpactforhealth@gmail.com. The recent scoping review of toolkits and aids is at https://academic.oup.com/fampra/advance-article/doi/10.1093/fampra/cmad006/7024812

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Green Inhalers: Breathing Responsibly & Sustainably

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While some solar radiation is absorbed by the earth's surface and warms it, some radiation is reflected by earth and atmosphere. Greenhouse gases including excess CO2, methane, nitrous oxide and fluorocarbons trap the reflected radiation and re-emitted in all directions causing increased temperature in earth surface and atmosphere. This leads to global warming and climate change. The carbon footprint is the total amount of greenhouse gases (including carbon dioxide and methane) that are generated by our actions, which means increased carbon footprint has more impact on climate change.

All medicines, including all inhalers - both dry-powder (DPIs) and metered-dose (MDIs), have an impact on the environment. Production process and discarding of DPIs mainly contribute to its carbon footprint. Adding to this, the vast majority (90-98%) of the carbon footprint of MDIs comes from the propellant gas in the canister. If the environmental impact of the MDIs and the DPIs is compared with a more practical example, the greenhouse gas emission of an MDI is similar to driving a small petrol car for 280km while a DPI is driving the same car for 6.5km. Before 1995, chlorofluorocarbons (CFCs) were used as propellant gases which are known to damage the ozone layer, but with the Montreal Protocol (1987) they are not used anymore. The Hydrofluorocarbons or HFAs are now used in the MDIs. There are two HFAs used in MDIs; HFA227 and HFA134. HFA227 is more harmful with a global warming potential (GWP) of 3320 times that of CO2. Inhalers such as Symbicort® and Flutiform® have HFA227. Most of the other MDIs use HFA134 as their propellant gas which has a GWP of 1300 times that of CO2. However, one good news is that MDIs with a lower GWP, such as HFC-152a and HFO, will become available probably in the next decade. In 2016, the Kigali agreement (an amendment to the Montreal protocol) was developed to phase out HFCs from 2020-2050 and was signed by 170 countries. Nevertheless, the regulation is less strict, countries are free to choose how to phase out HFCs during this period and most countries have started with regulations for refrigerators and air conditioners, obviously not inhalers! This is why the doctors have to work with their clients to mitigate the environmental impact of inhalers.

In this context, *what could a family doctor do?* First of all, ensure that your patient needs an inhaler! Do not forget other diagnoses and red flags and remember that not only underdiagnosis, but overdiagnosis and overtreatment is common in Asthma and COPD. Always consider whether DPI is an option for your patient. Patients over the age of 6 with good inhalation effort can usually successfully use DPIs. If available, Keep refillable DPIs as a first line option for the patients with financial difficulties. Always have a personalised discussion with your patients about the best inhaler for them; talk about advantages and disadvantages of MDIs and DPIs and how they can contribute to mitigate climate change by selecting DPIs. If you prescribe an MDI, always prescribe with a spacer to prevent coordination issues which could lead to undertreatment and prolonged use. It is a family

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doctor's duty to educate your patients on inhaler techniques and review frequently. Remember the importance of inhaled corticosteroids in achieving good asthma control. A good asthma control may help patients to use much less of their reliever medicine, which can in turn help the environment. Also, it avoids unnecessary emergency room visits, which increase hospital emissions. Continuity of care- regular follow up would be much important in stepping down doses when control is achieved. Consider discussing planetary resources and carbon footprint with the patient and community. Be cautious though not to make patients feel guilt or shame if a MDI is the most appropriate choice for them after consideration of age, inspiratory capability, and costs. The care of the individual patient is the priority. Advice on safe disposal of Inhalers. Advocate for having DPIs as a first line choice in medical guidelines, policies and health systems discussions.

In addition, WONCA Working Party on the Environment issued a statement on the Environmental Impact of Inhalers with recommendations to policy advocacy and pharmaceutical companies. It includes suggestions for sustainable inhaler therapy and production of greener inhalers.https://www.globalfamilydoctor.com/News/WPonEnvironmentSharesStatementontheEnvironmentalImpactofInh.aspx

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TAM METİN BİLDİRİLER

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A dynamic approach to healthy aging
Review of Charles Eugster, World's fittest 97-year-old, dentist, athlete

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To begin with his own words, “Society sealed us with an expiry date”. Undoubtfully, worldwide aging especially in the developed countries is a so long debated and critical topic in aspects of life quality, health expenditures, burden to society. Charles Eugster a fine, “dynamic” British-Swiss dentist with world records in sprinting and immense experience in rowing advices and leaves a will of great ideas for managing aging process in various extents.
Disease is not a natural consequence of aging. Pandemics of depression, obesity, musculoskeletal disorders mainly stem from modern life style. Globalization of high energy low nutrition foods with colorful brands have progressed into indulging entertainment, sneaky addiction, catching trends. Whereas eliminating nutrition rich animal food from our meals especially in elderly population has become a new health motto. The US obesity epidemic began almost simultaneously with the release of the low-fat dietary recommendations As Trans Fats and Vegetable Oils replaced Butter and Lard, the diseases of civilization increased in contrast France and Switzerland two leading butter consuming countries exhibits lowest CVD. As people cut back on their consumption of red meat and high-fat dairy products, the obesity epidemic began.
In a statement of Charles, those phrases are noted: “I start every day with a protein shake because, as you get older, your protein synthesis no longer functions as well,” he said. “I avoid sugar and eat lots of meat, especially fat. I’ve been on a fat trip lately. Fat! Piles of fat. Yet, I was in a supermarket the other day and was perplexed to find yogurt with zero fat. What on earth is that? The idea of the nutrition pyramid where, at the top, is a little fat and meat, and at the bottom a lot of carbohydrates, is, excuse me, non-sense
An elderly person goes through accelerating process of sarcopenia in a faster rate never then before which starts at mid forties, not only does that person loses lean functional muscle mass but also replaces that essential tissue with a total burden fat tissue. Pelvic fractures, knee and back pain, restricted mobility reduces life quality and increases expenditure.
Charles underlines importance of working as a headliner as he retires at the age of 75. Retirement brings mental and physical inactivity similar to unemployed population chronic disease and mental illness rates show increase. A suitable work or freshly acquired or practiced elderly hobby provides self worth, family esteem, standing a community. Importance of working is not ignored but vastly underestimated as Charles states. Charles maintained educational meetings until his death.
Particularly, Charles states that adrenaline rush and competition are a pearls for health in contrast to sedentary aging. Instead of peaceful long walking sessions, appropriate weight lifting, sprinting (world record), rowing in river are exercise elements in the routine of Charles.
Having lean muscle mass also functions as metabolic shield for inflammation, and provides properly working circulating system and increased mobility which all are mortality and morbidity causes among elderly population. Building adequate muscle tissue (multiple light sessions in a day) as a long term life goal gradually might be studied as new exercise method rather than long walking sessions based on Charles case.

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Evaluation Family Medicine Internship

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Physicians should consider several important factors when approaching their patients, including Empathy and Compassion: Physicians should approach their patients with empathy and compassion, showing them that they care about their well-being and are committed to helping them improve their health. Communication: Physicians should use clear and effective communication to explain medical conditions, procedures, and treatments to their patients in a way that they can understand. Active Listening: Physicians should listen actively to their patients and encourage them to express their concerns and questions, allowing for a collaborative and respectful relationship. Cultural Sensitivity: Physicians should be aware of and sensitive to their patient's cultural backgrounds, values, beliefs, and preferences. Privacy and Confidentiality: Physicians should respect their patients' privacy and maintain their confidentiality in all interactions and conversations. Shared Decision-Making: Physicians should involve their patients in the decision-making process by presenting options, weighing benefits and risks, and respecting patients' preferences. Continuity of Care: Physicians should strive to maintain continuity of care by keeping accurate and up-to-date records, coordinating care with other healthcare professionals, and ensuring smooth transitions between healthcare settings. The patient had URSI and the physician was prescribing regular symptomatic medications such as ibuprofen and pseudoephedrine. Instead of blindly renewing the prescription, I took the time to review the patient's medication history, including their past medical history and other medical conditions. I saw the patient has hypertension disorder which is a contraindication condition for pseudoephedrine. I consulted with the supervising physician to discuss the best treatment options for the patient. By taking these steps, I was able to prevent a potential medical error and ensure that the patient received appropriate and safe treatment. This event highlighted the importance of careful and thorough medication review and the value of collaboration with other healthcare professionals in preventing medical errors.

Keywords: Internship, Family Medicine, Education

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A Unique Case of Glabellar Ecchymosis Associated with Migraine-Type Headaches in a 45-Year-Old Man

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We present a unique case of a 45-year-old man who visited our outpatient clinic for evaluation of severe headaches and multiple episodes of glabellar discoloration. The patient experienced throbbing pain usually in the right side of the face, lasting 12 hours to a day, approximately 4-5 times per month, accompanied by nausea and photophobia. The ecchymosis-like lesions appeared after severe headache episodes and resolved over the following days.

Upon further investigation, the patient's medical history revealed no notable factors apart from migraines. Comprehensive evaluation, including high-resolution brain magnetic resonance imaging (2022), brain and orbital computed tomography (2022), and routine blood tests, yielded no remarkable findings. Both initial physical and neurological exams were normal.

Our patient was included in the study to investigate the effect of the “alternative nostril breathing technique “on the frequency and severity of migraine headaches in migraine patients after written consent was obtained. During the study, the patient continued his/her own pharmacotherapy (NSAIDs) as before and there was no known medication use other than nsaids also patient did not start any new medication.

After practicing “the alternate nostril breathing technique” at least 3 times every day for 3 months, the patient reported that the frequency and severity of headaches decreased and the ecchymosis lesion occurred only once, was smaller in diameter than before and disappeared sooner than before.

Glabellar ecchymosis has been reported in only a handful of cases associated with migraine-type attacks, and it's possible that autonomic vascular dysfunction is the underlying cause of this phenomenon.

Autonomic vascular dysfunction refers to the impaired function of the autonomic nervous system in regulating blood vessels. The autonomic nervous system (ANS) is responsible for controlling involuntary bodily functions, including blood vessel dilation and constriction.

In migraine-type headaches, the ANS may be dysfunctional, leading to abnormal vascular responses. This dysfunction can result in altered blood flow, inflammation, and increased vascular permeability, which may contribute to the development of ecchymosis. In the case of our patient, it is possible that autonomic vascular dysfunction contributed to the appearance of glabellar ecchymosis following severe headache episodes.

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The precise mechanisms behind the association between autonomic vascular dysfunction and migraine-type headaches are not fully understood. However, some studies suggest that migraine sufferers may have increased sensitivity to vasodilatory stimuli, such as nitric oxide, leading to greater vasodilation and blood flow changes during headache episodes.

Additionally, the activation of the trigeminal nerve, which is involved in the pathophysiology of migraines, may also contribute to autonomic dysfunction and abnormal vascular responses. Further research is needed to elucidate the exact relationship between autonomic vascular dysfunction and the formation of ecchymosis in migraine-type headaches. A deeper understanding of these mechanisms may lead to new therapeutic approaches for patients suffering from migraines and associated complications.

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ORAL PRESENTATIONS

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Integrating Health (Reproductive Health) And Climate-Experience From Africa (Uganda)

Submission Type: **Oral**
Topic Title: General Surgery > Hemorrhoids and anal fissure treatment

[1] Raymond Ruyoka, [2] Dr Peter Ibembe,
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[2] Reproductive Health Uganda

Integrating climate change strategies in Health(sexual reproductive health) programs and projects is key to health sector resilience to climate change shocks. Climate change has affected the health sector greatly leading to loss of lives and destruction of infrastracture such as roads and hospital facilities. This is an example from Uganda, a country in eastern Africa where climate change has greatly affected the health sector through flooding, mudslides, drought and famine wish harsh weather conditions which have exacerbated increased disease burden, malnutrition and water-borne diseases.
For example, in western part of Uganda, the flooding of River Nyamwamba in 2020, led to destruction of Kilembe hospital and other health facilities which affected the communities in the part of the country with reduced access to health services such as maternal health
services, immunization, HIV&AIDS care, family planning services and adolescent health service provision leading to loss of lives of more than 571 people, destruction of 25 health facilities and 3bridges. In eastern part of the country in 2017, there was the mudslides around Mount Elgon part of Bududa and Namisindwa which led to destruction of hospitals such as Butansi health center and Bushiyi health center in addition to destruction of homes and school infrastructure which led to loss of more than 345 people. In northern part of Uganda, there has been a long time drought leading to famine where more than 781 people living with HIV died due to malnutrition and drug resistance and low immunity. Climate has greatly affected the lives of people
not only in Uganda, but in other countries such as Ethiopia, South Sudan, Ghana, Malawi and Senegal. There is a great need for increased funding for health sector resilience interventions from climate change shocks such as investment in water and wind barriers around health facilities, afforestation, constant upgrading of road infrastructure, investing in renewable, clean and solar energy, integrating health outcomes in climate change policies, increased domesticfunding for health indicators in climate change GEF/GCF funding frameworks

Keywords: Integrating Health (SRHR) And Climate Change

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Fibroadenom İle Takipli Adolesan Kızlarda Vitamin B12 Düzeyleri

Submission Type: **Oral**
Topic Title: Pediatrics >Vitamin, mineral and fish oil supplements for children

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Giriş: Fibroadenom stromal ve glandüler dokuların lokalize nodüler hiperplazisidir, adolesanyaşta en sık görülen benign meme kitlesidir. Bu yaş grubunda meme biyopsilerinin %70-%95'inde fibroadenom saptanmıştır. Fibroadenomlar proliferatif epitelyal değişikliklerle hiperplazi, karsinoma insitu, nadir de olsa invaviz karsinom oluşturabilir. Vitamin B12 vücuttatüm hücreler için gerekli vitamindir. Düşük B12 vitamini seviyeleri kromozom kırıklarına ve DNA metilasyonunu etkileyerek DNA onarımının bozulmasına yol açar. Azalmış B12 vitamin düzeyi, DNA metilasyonu için gerekli olan S-adenosilmetiyonin aktivitesini azaltır ve gen ekspresyonunu bozar. Sonuç meme karsinogenezisine neden olabilir. Fakat bu konuda yayınlanmış az sayıda çalışma olduğundan Vitamin B12'nin meme kitlelerindeki rolü tam olarakanlaşılamamıştır. Bu bilgiler ışığında biz çalışmamızla adolesan çağda Vitamin B12 düzeyiyle fibroadenom arasında ilişki olup olmadığını göstermek istedik.
Yöntem: 2014-2022 yılları arasında hastanemizde tanı alıp takipleri sırasında B12 seviyeleri olan46 fibroadenom hastası ve 46 kontrol grubu olgusu çalışmaya dahil edildi. Kontrol grubu lenfadenopati tanısıyla takipli hastalardan oluşturuldu. Demografik özellikleri ve laboratuvardeğerleri tespit edildi. İstatistiksel olarak bu verilerin B12 ile ilişkisi analiz edildi.
Bulgular: Fibroadenom hastalarını ortalama tanı yaşı 14,7 (9-19), kontrol grubunun 14,2 (10-18) idi. Fibroadenom hastalarının vitamin b12 düzeylerinin ortalaması 304,54±79 pg/ml iken, kontrol grubunda ortalama 407 ± 137 pg/ ml bulundu. Vitamin B12 değeri 300 pg/ml altında olanların %88,9 (n:24) fibroadenom hastası idi. İki grup arasındaki fark istatistiksel olarak anlamlıydı (p: 0.006). Vitamin B12 değeri 340 pg/ml üzerinde olan fibroadenom hastası oranı %18,9 (n:7) iken kontrol grubunda bu oran % 81,1 (n:30) bulundu ve fark istatistiksel olarakanlamlıydı (p:0,019).
Tartışma: Çalışmamız fibroadenom ile takip edilen hastalarda vitamin B12 düzeyini gösterenilk çalışmadır. Kontrol grubuna göre anlamlı düşük düzeylerin bulunması fibroadenom etiyolojisinde vitamin B12 nin rolü hakkında literatüre yeni bilgiler eklemektedir. Bu konuda dahafazla sayıda olgu ve daha çok klinik parametre ile yapılacak ileri çalışmalara ihtiyaç vardır.
Keywords: Vitamin B12 eksikliği, fibroadenom, adolesan kız çocuk

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Aile Sağlığı Merkezine Başvuran Hastada Spironolakton Kullanımına Bağlı Gelişen Jinekomasti

Submission Type: **Sözlü sunum**
Topic Title: Family Physician > First step

[1] Merve Nur ALAGÖZ

[1] İzmir Karabağlar 1 Nolu Aile Sağlık Merkezi

Amaç: Bu olguda jinekomasti ile gelen erkek hastalarda ayırıcı tanıda hastaların kullandığıilaçların sorgulanması ve spironolaktonun bir etiyolojik faktör olarak hatırlanması amaçlanmıştır.

Yöntem: Aile Sağlığı Merkezine, bilenen kompanse kalp yetmezliği, diabetes mellitus, hiperlipidemi, hipertansiyon tanıları olan 66 yaşındaki erkek hasta öksürük şikayeti başvurması üzerine sistemik muayenesinin yapılması esnasında sol memede şişlik olduğu saptandı. Sol memede gelişen şişlik sorgulandığında 2 aydır mevcut olduğu ve ağrı şikayetinin olmadığını ifade etti. Testis tümörü açısından hasta sorgulandığında hasta impotans şikayeti olduğunu belirtti. Kullandığı ilaçlar: Linagliptin 5mg 1x1, Gliklazid 60 mg 1x1, Empagliflozin-Metformin 5/10002x1, Spironolakton 25 mg 1x1, Ramipril-Hidroklorotiazid 5 mg 1x1, Karvedilol 12,5 mg 1x1, Ivabradin 5mg 1x1, Atorvastatin 40 mg 1x1. Bilinen bir karaciğer hastalığı bulunmayan hasta öncelikle genel cerrahi, kardiyoloji ve üroloji polikliniklerine yönlendirildi.

Bulgular: Hastanın vital bulguları stabil olup vki:28,9 kg/m2 olarak saptanmıştır. Meme muayenesinde şişlik mevcut olup ele gelen kitle saptanmadı. Genel Cerrahi hekiminin değerlendirmesi sonucunda bilateral meme ultrasonografisinde; ‘’sağ meme subareoler alan olağandır. Sol subareoler bölgede yaygın bir alanda santralinde nodüler komponenti olan diffüz jinekomasti alanları izlenmektedir. Yer kaplayan lezyon saptanmamıştır. Sol aksillada radyopatolojik lenf nodu izlenmemiştir.’’ olarak belirtilmiştir. Kan tetkiklerinde bir patoloji saptanmamıştır.Ürolojiye de danışılan hastanın yapılan skrotal ultrasonografisinde herhangi bir patoloji saptanmamıştır. Kardiyoloji hekimi tarafınca değerlendirilen hastanın jinekomastisinin sprinolaktona bağlı olduğu düşünülüp ilk etapta ilacı kesilip yerine eplerenonbaşlanmıştır.

Sonuç: Erkeklerde jinekomastinin patogenizinde, androjen veya androjen duyarlılığındaki azalma ile memenin glandüler dokusunda östrojenin etkisinin artması sorumludur (1). Erkekte jinekomastinin etiyolojisinde; obezite, karaciğer hastalığı, meme kanseri, testis tümörü, endokrinolojik hastalıklar, ilaçlar bulunmaktadır. Kalp yetmezliğinde kullanılan spironolakton; androjen üretimini azaltır, meme dokusundaki östrojen reseptörleriyle etkileşerek jinekomastiye neden olur. Multidisipliner bir yaklaşım sergilenen olgumuzda jinekomastinin kalp yetmezliğine bağlı kullanılan spironolaktona bağlı geliştiği saptanmıştır.İlacı kesildikten sonra hastanın şikayetleri gerilemiştir.

Kaynaklar: 1.Göksun AYVAZ; Jinekomastili Hastaya Yaklaşım; Turkiye Klinikleri J Endocrin. 2003;1(2):85-7.

Keywords: Jinekomasti, Erkek, Spironolakton

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COVID-19'a Bilinen Maruziyetin Bireylerin COVID-19 ile İlgili Bilgi Düzeyleri ile İlişkisi

Submission Type: **Oral**
Topic Title: Family Physician > Research planning and execution

[1] Dr. Mehmet Yeral, [1] Uzm. Dr. Gizem Limnili, [1] Prof. Dr. Azize Dilek Güldal,
[1] Dokuz Eylül Üniversitesi Aile Hekimliği Anabilim Dalı

Giriş: Salgın yönetiminde hastaların hızla bulunması, temaslılar için önlemlerin alınması önemlidir. Ayrıca halkla etkili iletişim kurmak, engelleri analiz ederek iletişimi arttırmak gerekmektedir. Bu bağlamda, hastalıktan korunmada ve yayılımın önlenmesinde halkın bilgidüzeyi ve bildiklerini uygulaması önemlidir. Öğrenmenin mekanizması tam açıklanamasa dadeneyimlerden oluşan değişimler olarak bilgiye dönüştüğü söylenebilir. Hastalığa maruziyet, somut bir deneyim şeklidir. Deneyimin iyi bir öğrenme ortamı sağlayabildiği ve insanların deneyimi bilgiye dönüştürebileceği gösterilmiş olmakla birlikte hastalığa maruziyetle oluşandeneyimin ne kadarının doğru bilgiye dönüştüğüne dair bilgiler kısıtlıdır.
Amaç: COVID-19'a bilinen maruziyeti olan ve olmayan bireylerin bilgi düzeyinin ölçülmesi,aralarında bilgi düzeyi açısından anlamlı fark olup olmadığı; bunların sosyodemografik değişkenlerle ilişkisinin incelenmesi amaçlanmıştır.
Yöntem: Kesitsel-analitik planlanan çalışma, DEÜ Eğitim Aile Sağlığı Merkezleri'ne başvuran hastalarla yüz yüze gerçekleştirilmiştir. COVID-19 Bilgi Düzeyi Anketi (CBDA), literatürdeki çalışmalar ışığında, araştırmacılar tarafından; beş klinik, dört bulaşma yolları, sekiz korunma-kontrol olarak toplam 17 sorudan oluşmaktadır. Soruların doğru yanıtını bilenlere bir puan, yanlış yanıtlayan veya bilmiyorum şıkkını işaretleyenlere sıfır puan verilmiştir. Veriler, SPSS.25 programıyla değerlendirilmiş; p<0,05 anlamlı kabul edilmiştir.
Bulgular: Çalışmadaki 388 kişinin yaş ortalaması 41,87±14,60 olup %53,4 (n:207)'ü kadındır. Katılımcıların %50'si COVID-19 geçirmiştir. CBDA toplam puan ortalaması 13,22±3,71'dir. COVID-19geçirenlerin ve aşı olanların CBDA toplam puanı daha yüksektir (sırasıyla p<0.001; p<0.001).
COVID-19 geçirenlerde, kronik hastalığı olmayanlarda ve aşı olanlarda CBDA klinik puanı daha yüksektir (sırasıyla p<0.001; p=0.005; p<0.001). COVID-19 geçirenlerde, kronik hastalığı olmayanlarda ve aşı olanlarda CBDA bulaşma yolları puanı daha yüksektir (sırasıyla p<0.001; p=0.005; p<0.001). COVID-19 geçirenlerde ve aşı olanlarda CBDA korunma-kontrol puanı dahayüksektir (sırasıyla p<0.001; p<0.001).
Sonuç: COVID-19'a bilinen maruziyeti olan bireylerin bilgi düzeylerinin daha yüksek olduğu görülmüştür. COVID-19'a bilinen maruziyeti olmayanların bilgi düzeylerinin daha düşük olması,hastalığa maruz kalmadan önce önleyici bir faktör olarak bilgi düzeylerinin güçlendirilmesi ve buna bağlı olarak bireylerin COVID-19 karşısında daha doğru tutumlar geliştirmesinin gerekli olduğunu göstermektedir. Bunun için toplumdaki her bireyin hastalıklara maruz kalmadan önce bilgi düzeylerinin yükseltilmesi amaçlanmalıdır.
Keywords: COVID-19, COVID-19 maruziyeti, COVID-19 bilgi düzeyi

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Prevalence of Metabolic Syndrome, its risk factors and associated complications among the rural population of India

Submission Type: **Oral**
Topic Title: Internal Medicine > Obesity and Metabolic syndrome

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Introduction: Metabolic syndrome (MS), also known as syndrome X, is defined by WHO as a pathologic condition characterized by abdominal obesity, insulin resistance, hypertension, andhyperlipidemia. With a promising conquest over infectious diseases around the world, this non-communicable disease (NCD) entity has become a significant health hazard in the modern world.
Aim: The present study was done to estimate the burden of Metabolic Syndrome and to identify its risk factors and its complications among the rural adult population of India.
Methods: The study was carried out at 26 villages comprising 5 Primary Health Centres (PHCs)situated under a tertiary care setting in India, following approval from the Institutional ReviewBoard at Konaseema Institute of Medical Sciences and Research Foundation, India. It was a community-based cross-sectional study conducted among adults of both genders residing in the area of PHCs. A pretested structured questionnaire was used to collect information on socio-demography, diet, physical activity, perceived stress, tobacco and alcohol use,anthropometry, blood pressure, and lipid profile.
Results: The prevalence of MS was 35.8% among the study participants. Central obesity was found in 59.6% of the participants. In univariate analysis, age greater than44 years, female gender, higher socioeconomic status, refined sunflower oil usage for cooking,less consumption of fruits and vegetables, physical inactivity, perceived high stress, tobacco, and alcohol consumption were identified as risk factors to develop MS.
Conclusion: The prevalence of MS was found to be high. Due focus must be given to the promotion of healthy lifestyle practices among the community members; and provisions for early screening for risk factors such as obesity, lack of physical activity, and stress mustbe enacted. Further research work is necessary to explore in detail the pathophysiology of different causative factors contributing to the development of MS.
Keywords: Diabetes, Metabolic Syndrome, Non-communicable diseases, Rural Health

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Türkiye Aile Hekimliği Dergisi'nde son 5 yılda yayınlanan makalelerin analizi

Submission Type: **Oral**

Topic Title: Family Physician > Research planning and execution

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[2] SBÜ İzmir Tepecik Eğitim ve Araştırma Hastanesi Aile Hekimliği Kliniği

Amaç: Türkiye Aile Hekimleri Uzmanlık Derneği (TAHUD) ana yayın organı olan Türkiye Aile Hekimliği Dergisi Türk aile hekimlerinin ele aldıkları araştırma konularını, ana ilgi alanlarını yansıtan önemli bir gösterge olarak kabul edilmektedir. Bu çalışmada derginin son 5 yılındayayınlanan araştırmaların yapısal olarak incelenmesi amaçlanmıştır.
Yöntem: Tanımlayıcı nitelikteki çalışmada 2018-2022 yıllarındaki Türkiye Aile Hekimliği dergisinde yayınlanmış bilimsel çalışmalar incelendi. Çalışma türü, çalışmanın kimlerle yapıldığı, araştırmacıların cinsiyetlere göre dağılımı, araştırma yeri, veri toplama yöntemleri analiz edilmiştir.
Bulgular: Değerlendirilen 113 çalışmanın 87'si (%77) orijinal araştırma, 12'si (%10.6) derleme,11'i(%9.7) olgu sunumu, 3'ü (%2.7) editöre mektuptu. Orijinal araştırmaların %87'si (n=69)
kesitsel nitelikte, %13,7'si (n=12) retrospektif tasarımdaydı. İncelenen çalışmaların sadece ikisininmetodolojik tasarımda, ikisinin de müdahale çalışması olduğu gözlendi. Ortalama yazar sayısı 3,42±1,801(min:1 , max:11) araştırmacıdan oluşmaktaydı. Çalışmaların %31,1'i (n=35) 2, %22,1'i (n=25) 4, %19,5'i (n=22) 3 araştırmacı tarafından yürütülmüştü. Araştırmacı sayısının 6 ve üzeri olduğu 10 çalışma mevcuttu. Çalışmaların 16'sı saha çalışması iken, 15'i birinci basamak sağlıkkuruluşlarında tasarlanmıştı. Online anketlerin sadece 3 araştırmada uygulandığı gözlendi.
Araştırmaların 70'inde yüz yüze anket uygulanmıştı. Anket çalışmalarının ağırlıklı olduğu görüldü. Yazar ağırlığının kadın olduğu 5o çalışma (%44,2),erkek olduğu 37 çalışma (%32,7), kadın ve erkeğin eşit oranda olduğu 26 çalışma (%23) görüldü. 66 araştırmada (%58,4) birinciyazar kadındı.
Sonuç: Araştırmalarda sıklıkla anket uygulamalarının kullanıldığı anlaşılmaktadır. Orijinal araştırma çalışmalarının yoğunlukta olduğu ancak kanıt düzeyi yüksek deneysel ve prospektifçalışmaların kısıtlılığı dikkat çekmektedir. Yazarlar arasında kadın araştırmacıların çoğunluktaolduğu çalışmaların daha fazla olduğu görülmüştür. Birinci basamak hekimleri tarafından yürütülen ve saha tabanlı çok merkezli epidemiyolojik çalışmaların arttırılması aile hekimliği disiplini açısından önem arz etmektedir.
Anahtar Sözcükler: aile hekimliği dergisi, birinci basamak sağlık hizmeti, bilimsel araştırma, araştırmayöntemleri

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Bir Eğitim ve Araştırma Hastanesi Asistanlarının YNSA(Yamamoto New Scalp Acupuncture-Yeni Nesil Scalp Akupunktur) Hakkında Farkındalıklarının Değerlendirilmesi

Submission Type: **Oral**
Topic Title: Healthy Life > Functional medicine and Holistic Health

[1] As. Dr. Deniz Almak, [1] As. Dr. Alper Kalender, [1] Uzm. Dr. Serap Öksüz, [1] Doç. Dr. Esra Meltem Koç
[1] İKÇÜ Atatürk Eğitim Araştırma Hastanesi Aile Hekimliği Anabilim Dalı

Giriş ve Amaç: Organizmada fasya sistemi ile vücut bulan meridyen ağlarının bilimsel açıklamasının yapıldığı ve mikro akupunktur sistemlerinin bilimsel temellerinin atıldığı akupunktur dünyasındaYeni Nesil Scalp Akupunktur (YNSA) tanısal ve tedavi anlamında etkinliğinin farkına varılışıyla son zamanlarda önemli bir ilgi odağı olmuştur. Ülkemizde YNSA ‘ya olan ilginin günden güne artması sebebiyle workshoplar düzenlenmesine neden olmuş ve hekimler tarafındanöğrenilmeye başlanmış ve uygulanması artmıştır. Çalışmamızın amacı alanda etkin olarak çalışacak hekimlerin YNSA hakkında bilgi düzeylerinibelirlemek ve bu konuda farkındalıklarının artmasını sağlamaktır.
Yöntem: Tanımlayıcı tipteki çalışmamızın evrenini İKÇÜ Atatürk EAH'ta uzmanlık eğitimini almakta olan 630 asistan hekim oluşmaktadır ve örneklem büyüklüğü %95 güven aralığı, %5hata payı, %50 bilinmeyen sıklık ve %5 sapmayla en az 239 kişi olarak hesaplanmıştır. Veriler01.11.2022- 31.01.2023 tarihleri arasında online anket formuyla toplanmaktadır.
Bulgular: Devam etmekte olan çalışmamıza şimdiye kadar toplam 86 aile hekimliği asistanıkatılmıştır. Bunların %62,6'sı (52) kadındır. Katılımcıların %30,1'i (25) asistanlığının ilk yılında,
%40,9'ü (34) ikinci yılında, %29'u (24) üçüncü yılındadır. Asistan hekimlerin %19,2'si (16) YNSA'yı daha önce duyduğunu belirtmiştir. YNSA hakkında bilgi sahibi olmayanlar arasında konuyla ilgili eğitim almak isteyen katılımcıların sıklığı % 73,5'tir. YNSA'nın hangi hastalıkların tedavisinde kullanıldığı sorusuna katılımcıların %89,2'si başağrısı; %84,3'ü migren; %80,7'si kas iskelet hastalıkları; %78,3'ü fibromiyalji cevabını vermiştir. Asistan hekimler arasında 2. yıl eğitim düzeyinde olanlar diğer yıllardaki asistanlara göre YNSA'nın birçok hastalığın tedavisinde etkili olduğu(p=0,009) , kafa bölgesi uygulaması temelinde çalıştığı(p=0,004), ilk seanstan itibarenetkilerinin görüldüğü(p=0,006) ve somatotopik noktalardan oluşan bir sistem olduğu (p=0,000)konularında doğru bilgi sahibi olma bakımından istatistiksel anlamlı farklılık saptanmıştır.
Sonuç: Yeni Nesil Skalp Akupunktur başta olmak üzere akupunktur eğitimlerinin geleneksel ve tamamlayıcı tıp eğitimleri gibi Sağlık Bakanlığı onaylı olarak düzenlenmesinin ve bu hizmetlerin Sağlık Bakanlığı denetimindeki kurumlarda, eğitimini almış yetkin hekimlercesunulması, eğitimlerinin yaygınlaştırılması gerektiğini düşünmekteyiz. Bu konuda yapılan bilimsel araştırmalar yaygınlaştırılmalı, 'akupunktur ve özellikle YNSA' kavramı ile ilgili farkındalıkarttırılmalıdır.
Anahtar Sözcükler: YNSA, akupunktur, system

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Koroner Arter Bypass Greft Operasyonlu Hastalar ile Sağlıklı Bireylerin Birinci Basamakta Koruyucu Sağlık Hizmeti Alma Durumlarının Kıyaslanması

Submission Type: **Oral**

Topic Title: Cardiology > Diagnosis and follow-up in cardiovascular diseases

[1] Habib Çakır, [1] Köksal Dönmez, [1] Ertürk Karaağaç, [1] İsmail Yürekli, [1] Ali Gürbüz, [2] Meryem Çakır, [2]Kurtuluş Öngel,

[1] İzmir Katip Çelebi Üniversitesi Atatürk Eğitim Ve Araştırma Hastanesi, Kalp Ve Damar CerrahisiAnabilim Dalı

[2] İzmir Katip Çelebi Üniversitesi Atatürk Eğitim Ve Araştırma Hastanesi, Aile Hekimliği AnabilimDalı

Giriş ve Amaç: Birinci basamakta koruyucu sağlık hizmeti sunumu ile pek çok hastalığın önüne geçilebilmektedir. Özellikle toplumdaki en sık ölüm nedeni olan kardiyovasküler hastalıkların önlenmesine yönelik birinci basamak hekimlerine önemli bir görev düşmektedir. Bu çalışmada KABG operasyonlu kişilerin birinci basamakta koroner arter hastalığına yönelik koruyucu sağlık hizmeti alma durumlarının sağlıklı kontrol grubu ile kıyaslanması amaçlandı.

Yöntem: Kesitsel tanımlayıcı desende planlanan çalışmaya 151 KABG hastası ve 167 sağlıklı birey dahil edildi. Hastaların koroner arter hastalığından korunmalarına yönelik sağlık hizmeti alma durumlarını ve sosyodemografik özelliklerini inceleyen bilgi formu hastalara yüz yüze görüşme tekniği ile uygulandı.

Bulgular: Çalışmada KABG operasyonu olan hastaların sağlıklı kontrol grubuna göre, sigara ve alkolün koroner zararları, sağlıklı beslenme, kilo kontrolü ve asetilsalisilik asit kullanımının koroner yararları hakkında daha fazla bilgi aldıkları bulundu ($p<0.005$). Yine KABG hastalarınınbirinci basamakta daha sık kan basıncı, lipit ve kan şekeri kontrollerinin yapıldığı bulundu ($p<0.005$). İleri yaş, erkek cinsiyet, Hipertansiyon ve Diabetes Mellitus tanılı ve egzersiz yapmayan hastaların daha fazla KABG operasyonu geçirdiği saptandı ($p<0,005$).

Sonuç: Kişilerin koroner arter hastalığına yönelik birinci basamak sağlık kuruluşlarında koruyucuhizmet almalarının yaygınlaştırılması ve birinci basamak hekimlerinin bu konudaki bilgi ve deneyimlerini arttıracak stratejiler geliştirmek oldukça önemlidir. Birinci basamakta hastaların koroner risk değerlendirmelerinin yapılması ve gerekli durumlarda hastaların tedaviye erken yönlendirilmesi ile hastaların yaşam süresinin uzadığı unutulmamalıdır.

Anahtar Sözcükler: Birinci basamak, koruyucu, koroner risk, sağlık

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A Report on the Difficulties Faced by Female Syrian Migrants in Türkiye in Regards to Access to Sexual and Reproductive Health; compared with difficulties in Sweden

Submission Type: **Oral**

Topic Title: Gynecology and Obstetrics > Family planning and birth control methods

[1] Doğukan Pira,

[1] İzmir Ekonomi Üniversitesi

Introduction: More than a decade after the onset of the Syrian Civil War and the ensuring humanitarian crisis, the peoples displaced from their homes are still struggling to create a new,stable life for themselves away from violence. Syrian refugees yet face discrimination in manyfacets of public life; and are denied equitable opportunities in access to healthcare.

Aim: This report aims to compare the challenges Syrian migrants must overcome regarding sexual and reproductive health in the two European countries of Türkiye and Sweden; both ofwhich have political landscapes dominated by discussion of the ongoing refugee crisis.

Methods: This report was prepared via literature review of current reports on migrant health in Türkiye and in Sweden; and via the integration of direct observational findings in a fortifiedmigrant health-center in Türkiye.

Results: Migrants In both reviewed countries yet face many difficulties in accessing reproductive health services. Healthcare providers' discriminatory attitudes, poor integration into society, ignorance towards migrants' cultural norms and biases against reproductive health services and methods, and language barriers are cited as prevalent barriers to access.

Discussion: The international community has long been aware of the low living standards in refugee settlements. The immigrants must overcome innumerable challenges to establish their new life following forced displacement. The issue of sexual and reproductive health playsa critical role in the process of reintegration. Access to family planning and contraception cansignificantly enhance the quality of life in this population. As maternal and newborn health arevital indicators of the wellbeing of every society, it is critical to ensure every person has accessto quality healthcare.

Conclusion: Migrant access to holistic and preventative Sexual and Reproductive Healthcare is essential. Both countries must implement long term strategies for the proper integration andeducation of migrants to avoid an upcoming healthcare crisis.

Keywords: Health Equity; Sexual Health; Right to Health Care; Attitude of Health Personel; Migration Policy

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Balint groups: A supervision model in primary care

Submission Type: **Oral**
Topic Title: Family Physician

1 Genco Görgü, 2 Özden Gökdemir,
[1]Bandirma 1st Family Medicine Center
[2] İzmir Ekonomi University

Balint groups refer to a clinical supervision model developed by Mihaly Balint, a Hungarian- born physician who practiced his professional life in the United Kingdom. It can also be definedas a kind of consultation model between general practitioners, and a supervision process is run for the physician who has a difficult doctor-patient relationship experience. The purpose
of Balint groups; is to ensure the positive transformation of the uncertain, complex, and challenging doctor-patient relationship. In addition to clinical method differences in primarycare such as community-oriented perspective and low-prevalence medicine, there is a dynamic psychological dimension arising from the long-term patient-physician relationship. Solidarity, trust, and empathy among colleagues ensure themanagement of difficult cases and protect the family physician against burnout. Several physicians come together to form a Balint group under the leadership of a group leader who has experience in the Balint model. The leader asks the group who wants to presentthe case. The physician who wants to share a case comes forward and shares his experience. After completing his presentation, the physician withdraws and the participants take turns asking questions about the case.
These questions may be about the characteristics of the patient such as age, gender, and medical condition. In addition, it may be related to the pattern and flow of the event betweenthe patient and the doctor.
In the last stage, there is the discussion process in which the presenter and other participantsexchange their views together. The task of the group leader is to provide a flow in line with thebasic principles of the Balint model and to enrich the discussion with open-ended questions where necessary. Within the scope of this presentation, the dynamics of the relationship between a patient with a late diagnosis of colon cancer and a physician will be discussed.

Keywords: Balint groups, family medicine, leadership, supervision

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Online and Face to Face Education Perspective

Submission Type: **Oral**
Topic Title: Family Physician

[1] Ferhat Gündoğan,
[1] İzmir Ekonomi Üniversitesi

I am here as a student that took not all years of online education out of but that took 1,5 yearsout of 2,5 years, plus this month after the earthquake that affected 11 cities in Turkey. In highschool going to school was a burden for me but as the years proceeded and I got my place in the faculty I wanted in the university, that changed. I don't remember wanting to go to school this much, but online education kind of both stopped us, and mentioning it like this I think sounded unfair because it was also a savior in the years of Covid 2019 pandemic. Other than situations that require online education like pandemics and earthquakes, face-to-face education is way more effective than online education. Participation and attendance fall dramatically, the most crowded lecture sometimes has 20 participants and that's ⅓ -¼ of my class. Participation is another thing in online lectures, 5 of 20 speak at most. I did a quick research and couldn't find any data on this but this is what I have observed first hand. Thereare systems that record these lectures and luckily my university has one of those systems. I don't have data about the clicks or time spent on that replay system but I don't quite believe that it's as effective as attending online. The questions asked on face to face lectures are verylimited and it decreases with the transition to online, (which is also correlated with the total attendance) you can't ask any questions this way. In this section people prefer they get the "education," they want to take, which is only what the teacher tells them. Nobody wants to askanything that they think of. Which is utterly away from what the academy is for.

Keywords: education, face-to-face, online, student perspective

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Trigeminal neuralgia tension-type headache

Submission Type: **Oral**

Topic Title: Neurology > Headache differential diagnosis and treatment

[1] Ezgi Tatlıcı,

[1] İzmir Ekonomi Üniversitesi

The patient applied for treatment for right hemicranial, scorching, and electric shock discomfort in the back of her head that had been bothering her for two days. Her account revealed that the pain had moved to her jaw and, sometimes, her ear. The patient indicated that she had previously experienced a similar problem and that she was treated with Brufen (Ibuprofen), which was recommended at the time. There is no diabetes diagnosis (and no drug use), but earlier examinations reveal that there was overt diabetes based on the HbA1c level. BP: 139/82mmHg, all other vital signs normal. All system evaluations were normal, with noabnormal results.
A thyroid nodule has been discovered. She was under the care of the endocrinology department, but she has ignored it for a year and does not take any medications. Despite herusual diet, the patient reported waking up feeling hungry in the morning. Trigeminal neuralgiatension-type headache is the preliminary diagnosis.
Suggestions: She has no recognized hypertension diagnosis. Monitoring of blood pressure was advised and discussed. It was discovered that the patient attended an endocrinology appointment, and that blood sugar control and thyroid nodule control were indicated.
The characteristics of trigeminal neuralgia pain and tension-type headache, as well as the triggering elements, can be elucidated. The patient can be told about the indications for neurology referral. If the diagnosis is a tension headache, the patient can be informed aboutthe causes, effects, and complexities of chronic pain. The connection between pain and emotion thought and conduct can be described.
Alternative treatment approaches and different preventative strategies can be explained if the current treatment is unsuccessful. Psychotherapy and behavioral therapies may be indicated ifthe conditions are favorable.

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İzmir'deki Aile Hekimliği Asistanlarının SIBO Hakkındaki Bilgi ve Farkındalıklarının Değerlendirilmesi

Submission Type: **Oral**
Topic Title: Family Physician

[1] Merve Alban, [1] Pelin Tiryakioğlu, [1] Esra Meltem Koç, [2] Mehmet Burak Öztop,
[1] İzmir Katip Çelebi Üniversitesi Atatürk Eğitim Ve Araştırma Hastanesi Aile Hekimliği
[2] İzmir Bakırçay Üniversitesi Tıp Fakültesi Genel Cerrahi Abd

Giriş ve Amaç: İnce bağırsakta aşırı bakteri üremesi (SIBO) yaygın, ancak yeterince tanınmayan bir sorundur. Mide bulantısı, hazımsızlık, yorgunluk, ishal ve kabızlık gibi semptomlarla hastalarınkonforunu bozmakta malabsorpsiyon, kilo kaybı, anemi, vitamin ve demir eksikliği gibi ciddi belirtiler ortaya çıkabilmektedir. Bireyin ilk temas noktası olan aile hekimlerinin konu hakkında bilgi sahibi olması ve farkındalıklarının oluşması hastaların tedavisinin zamanında yapılmasına, yaşam kalitesinin artmasına, yapılan sağlık harcamalarının azalmasına katkı sağlayacak ve fonksiyonel tıp biliminin gelişmesi açısından önem taşımaktadır. Bu çalışmanınamacı İzmir'deki aile hekimliği asistanlarının SIBO hakkındaki bilgi ve farkındalıklarının değerlendirilmesidir.
Yöntem: Tanımlayıcı tipte planlanan çalışmanın evrenini İzmir'de aile hekimliği uzmanlık eğitimini almakta olan asistan hekimler oluşturmaktadır. 2022 Ekim ayı verilerine göre uzmanlık eğitimini almakta olan asistan hekim sayısı 440 kişi olduğundan %95 güven aralığı, %5 hata payı, %50 bilinmeyen sıklık ve %5 sapmayla en az 207 kişilik örneklem büyüklüğü hesaplanmıştır.Katılımcılara ilgili literatür doğrultusunda, araştırmacılar tarafından geliştirilen, 34 soruluk anket online uygulanacaktır.
Bulgular: Devam etmekte olan çalışmamıza şimdiye kadar toplam 61 aile hekimliği asistanı katılmıştır. Bunların %62,3'ü(38) kadındır. %29,5'i(18) asistanlığının ilk yılında, %36,1'i(22) ikinci yılında, %33,4'ü(21) üçüncü yılındadır. Örneklemimizin %67,2'si(41) daha önce İnce BağırsaktaAşırı Bakteri Üremesi (SIBO) kavramını duymuş, %32,8'i (20) duymamıştır. Risk faktörlerinden en fazla predispozan olduğu düşünülen ince bağırsak divertikülozu gibi anatomik anomaliler %73,8(45), gastrik bypass ve Roux-en-Y gibi cerrahiler %72,1(44), narkotikler, antikolinerjikler ve antidiyareikler gibi bağırsak hareketliliğini yavaşlatan ilaçlar %78,7(48), cerrahi, otoimmün gastrit veya PPI'lara bağlı bağlı hipo veya aklorhidri %78,7(48), inflamatuar bağırsak hastalığı %77(47), diabetesmellitus %70,5(43)'tür. SIBO ile ilgili eğitim, seminer almak isteyenler %90,2'sini(55) oluşturmaktadır.
Sonuç: İnce bağırsakta aşırı bakteri üremesi (SIBO) ile ilgili seminerler/eğitimler verilmesi aile hekimliği uzmanlarının bilgi düzeyi ve farkındalığının artırılmasına katkıda bulunacak ve yetkinliğini artıracaktır. Dolayısıyla birinci basamak sağlık hizmeti alan hastaların doğru tanı vetedaviyle hayat kalitesini artırıp sağlık hizmetlerinin etkinliğinin artmasına fayda sağlayacaktır.
Anahtar Sözcükler: sibo, ince bağırsakta aşırı bakteri üremesi, malabsorbsiyon, small intestinalbacterial overgrowth, bacterial overgrowth

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The Association of Diffuse Large B-Cell Lymphoma and Myelodysblastic Syndrome As a Rare Condition

Submission Type: **OralTopic Title: Oncology**

[1] Melis Kartal Yandım, [2] Kemal Aygün,
[1] İzmir Ekonomi Üniversitesi
[2] İzmir Atatürk Eğitim ve Araştırma Hastanesi

Non-Hodgkin’s lymphomas comprise several subtypes, with Diffuse Large B-Cell Lymphoma (DBBHL) being the most common, accounting for 58% of cases. DBBHL is typically diagnosed at advanced stages, with 40% of patients displaying extranodal involvement. Myelodysplastic
syndromes (MDS) are a group of hematological malignancies that are characterized by clonalhematopoiesis, one or more cytopenia, and abnormal cellular maturation.
A 59-year-old male patient, with a medical history of hypertension (HT) and coronary artery disease (CAD), was admitted to the emergency department of an external center, complainingof abdominal pain that had started 4-5 months prior. During abdominal examination, an irregularly contoured, heterogeneous internal mass lesion measuring 99x89 mm was detected in the mesenteric fatty tissues in the upper left quadrant, along with significant diffuse thickening of the adjacent jejunal walls. The patient underwent mass resection surgery, and thepathology report indicated that the mass was compatible with Diffuse Large B-Cell Lymphoma,with a CD3-, CD20+, CD5-, CD10+, CD23-, Bcl-2-, Bcl-6+, Cyclin d1-, CD117-, pancytokeratin-,
c-MYC-, and Ki-67 %85-90+ immunophenotype. The patient was assessed as having high-riskMDS according to the R-ISS score and treated with the 3+7 (idarubicin-doxorubicin) protocol. However, due to the blast rate being 19% during a bone marrow aspiration performed to evaluate the response, the treatment was deemed unresponsive and switched to IDA-FLAG (idarubicin-cytarabine-fludarabine). Unfortunately, the patient died due to refractory disease and septic shock.
Managing patients with concurrent MDS and NHL is complex due to various factors such as age, performance status, concomitant diseases, and the severity and subtype of NHL and MDS.

Keywords: dbbhl, mds

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A global epidemic! Obesity from Adipogenesis to its Clinical Consequences

Submission Type: **Oral**
Topic Title: Internal Medicine > Obesity and Metabolic syndrome

[1] Dilek Soysal, [1] Melis Kartal Yandım, [1] Ayşe Banu Demir, [1] Yasemen Adalı, [1] Özge Ertener, [1] ÖzdenGökdemir, [1] Elif Barış, [1] Gülfem Terek Ece,
[1] İzmir Ekonomi Üniversitesi

Since obesity is a global health problem that can lead to life-threatening morbidity and mortality, we emphasize its importance in our medical curriculum. We would like to draw attention to its importance and multifaceted effects by reviewing the whole process from its molecular basis to systemic effects. Obesity cannot be evaluated from a single point of view and it should be handled with different aspects from the cell level to the clinical consequencesat both individual and society level. We have written a book chapter explaining its mechanism from this perspective. Here, we would like to present our study.
Adipose tissue, with a huge cell signaling network, serves for energy storage, regulation of energy homeostasis, and as an endocrine organ causing ROS formation, while adipocytokines contribute to atherosclerosis via insulin resistance, systemic inflammation, deterioration in endothelial function and increased coagulation, and to carcinogenesis via changes in leptin/ adiponectin ratio, fat tissue signaling alterations, oxidative stress, molecular damage, systemicinflammation, and insulin resistance. Monogenic and polygenic factors, and epigenetic factors, including DNA methylation, histonemodifications, non-coding RNA mediated modifications, affect metabolic processes and
fat storage in the body and play role in obesity either through genetic variants or lifestyle mediated changes. The microbiota has been shown as effective in the development of obesity. Dyslipidemia, obesity-related nephropathy, obstructive sleep apnea, steatohepatitis,gastroesophageal reflux, gastric and intestinal dysfunctions, arthritis, balance disorders, polycystic ovary syndrome, colorectal, endometrial, postmenopausal breast cancers also associate with obesity. Obesity has a detrimental impact on COVID-19 infection prognosis andincreases its mortality.
In clinical practice, heterogeneity of obesity requires individual, social and medical effort for itsprevention and treatment. Although lifestyle changes as nutrition, exercise, behavioral therapyare recommended primarily in most obese individuals, pharmacological agents can be used depending on patients' comorbidities as these changes become insufficient over time.

Keywords: obesity, adipogenesis, management

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The effect of breathing techniques on the severity and frequency of migraine-like headaches

Submission Type: **Oral**
Topic Title: Neurology > Headache differential diagnosis and treatment

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[1] Dokuz Eylül University/Faculty of Medicine

Background:
Migraine is a common neurobiological disorder that causes increased excitability of the centralnervous system, resulting in significant morbidity worldwide. Migraine has a considerable economic and social impact, affecting the quality of life of patients and disrupting work, social activities, and family life. Reducing the frequency and severity of migraine attacks may be the first goal of treatment.
Methods:
This study is a randomized controlled trial designed to observe the effects of breathing techniques on migraine-like headaches, frequency, and severity. Participants will be assignedto either the intervention or control (treatment as usual) group using cluster randomization toprevent intergroup contamination. The intervention group will be taught breathing techniquesby the researcher, while both groups will continue to use pharmacotherapy for migraine.
The primary outcome of the study is to evaluate the effect of breathing techniques on the frequency and severity of migraine-like headaches, and the secondary outcome is to evaluatethe effect on the MIDAS score.
Results:
The study aims to provide information about the effect of breathing techniques on migraine- like headaches, which will contribute to the literature as pharmacotherapy options for migraineare limited. The results of the study will be evaluated using the migraine disability assessmentquestionnaire (MIDAS) at the beginning and end of the study.
Trial registration:
The trial has been registered with clinicaltrials.gov (NCT05536635) on 09/09/2022.
Keywords: Migraine, Headache, Breathing Techniques, MIDAS.

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Evaluation Family Medicine Internship

Submission Type: **Oral**
Topic Title: Family Physician

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[1] İzmir Ekonomi Üniversitesi

Physicians should consider several important factors when approaching their patients, including Empathy and Compassion: Physicians should approach their patients with empathyand compassion, showing them that they care about their well-being and are committed
to helping them improve their health. Communication: Physicians should use clear and effective communication to explain medical conditions, procedures, and treatments to their patients in a way that they can understand. Active Listening: Physicians should listen activelyto their patients and encourage them to express their concerns and questions, allowing for acollaborative and respectful relationship. Cultural Sensitivity: Physicians should be aware of and sensitive to their patient's cultural backgrounds, values, beliefs, and preferences. Privacyand Confidentiality: Physicians should respect their patients' privacy and maintain their
confidentiality in all interactions and conversations. Shared Decision-Making: Physicians shouldinvolve their patients in the decision-making process by presenting options, weighing benefitsand risks, and respecting patients' preferences. Continuity of Care: Physicians should strive to maintain continuity of care by keeping accurate and up-to-date records, coordinating care with other healthcare professionals, and ensuring smooth transitions between healthcare settings.
The patient had URSI and the physician was prescribing regular symptomatic medications such as ıbuprofen and pseudoephedrine. Instead of blindly renewing the prescription, I took thetime to review the patient's medication history, including their past medical history and other medical conditions. I saw the patient has hypertension disorder which is a contraindication condition for pseudoephedrine. I consulted with the supervising physician to discuss the best treatment options for the patient.
By taking these steps, I was able to prevent a potential medical error and ensure that the patient received appropriate and safe treatment. This event highlighted the importance of careful and thorough medication review and the value of collaboration with other healthcareprofessionals in preventing medical errors.

Keywords: Internship, family medicine, education

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The Role of Family Physicians in Wellness Programs: A Literature Review

Submission Type: **Oral**

Topic Title: Family Physician

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[1] Health Center Kraljevo, Serbia

Introduction: Wellness programs have gained prominence in recent years as a proactive approach to improving health outcomes and reducing healthcare costs. Family physiciansplay a crucial role in implementing and coordinating wellness programs, but their specific contributions have not been well-defined.
Aim: This review aims to examine the existing literature on the role of family physicians inwellness programs.
Methods: A search of relevant databases yielded 25 articles that met the inclusion criteria.
Results: The findings revealed that family physicians play multiple roles in wellness programs,including health risk assessment, health promotion, disease prevention, behavior change counseling, and care coordination. They provide personalized care plans, monitor progress, and facilitate referrals to other healthcare professionals or community resources.
Discussion: Family physicians address the social determinants of health and provide patient education and empowerment, acting as advocates for patients. However, barriers such as time constraints, lack of reimbursement, and limited training were identified. In addition, the importance of ongoing education for family physicians to enhance their skills in delivering wellness interventions and addressing barriers. Fostering strong collaborations among healthcare professionals and leveraging technology can further support family physicians in their role as wellness programs, leading to improved patient outcomes and population health.
Conclusion: Family physicians play a multifaceted role in wellness programs, serving as frontline providers for health promotion, disease prevention, and care coordination. Their holistic approach to patient care contributes to the success of wellness programs. However, addressing barriers and enhancing support for family physicians in their role as wellness champions is crucial for the effective implementation and sustainability of wellness programs.Further research and policy efforts are needed to optimize the contributions of family physicians in wellness programs and promote population health.

Keywords: Wellness, family physicians, education, health

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Family Health Care Center Visits-Solutions Suggestions

Submission Type: **Oral**

Topic Title: Family Physician

[1] İrem Çiftcioğlu, [1] Emirhan Talip Dinçel, [1] Zehra Kale, [1] Lara Sinem Karakundak, [1] Ali Tuna Serter, [1]
Sarp Tatlicioğlu,
[1] İzmir Ekonomi Üniversitesi

What are the problems?: Because of socio-economic difficulties, most patients are housed near the industrial area, which is not suitable for the residents' general well-being due to general pollution (like noise, etc), and due to socio-economic conditions around the area, people are generally low-income. Some patients could not afford to pay the amount for the medications prescribed to them. Even if they did, we observed that some common
medications like hypertension drugs were not available in the nearby pharmacies, which the elderly people have to go to. The doctor had to contact the pharmacists and actually prescribea hypertension drug that they had available. A lot of them also could not afford to buy enough of the required food groups like meat, fish, and fiber-containing vegetables. But a lot of patients that came to the FHC, especially men, were also smokers. Not coincidentally, there
are a lot of overweight people, especially women who are at home and not working. Another common problem of people is, they are generally not physically active enough. We also observed a lot of elderly hypertension patients coming in every day to get their blood tensionchecked, because they did not have the device at home.

What could be the solutions?: It is necessary to increase the number and variety of drugs and backup medication must be available for emergency times. Accommodation and/ or settlements in the vicinity of the industrial area should be minimized due to air and noise pollution. Seminars on smoking cessation can be organized with the FHC physicians together with the patients. Increasing cigarette prices may help to reduce the smoking rate. The cost ofthe HPV vaccine must be covered by SGK as a cancer prevention measure.

Keywords: family health care center, medical student perspective, evaluation

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Risk Management and Prevention: Obesity

Submission Type: **Oral**

Topic Title: Family Physician

[1] Özgenur Sabancı,

[1] İzmir Ekonomi Üniversitesi

The patient was a fifty-three-year-old woman. She is at risk for cardiovascular diseases-hypertension, obesity, and cancer that she may experience due to her lifestyle, age, and genetic predisposition. According to TEMD, while the patient is under the age of 55, there is norisk in terms of age, but she is at risk due to smoking and having a BMI over 25. In addition, theprevalence of cardiovascular disease on the father's side of the family is another risk factor for the patient. Her risk factors are evaluated in this way has hypertension and uses regular
medication. The risk of obesity, the patient is in a range that we can consider overweight, as herbody mass index is between 25 and 29.9. Although the changes in the diet of the patient that caused her to lose fifteen kilos prevent her from gaining weight, it is necessary to continue to follow the waist circumference and weight in order to prevent the problems caused by obesity,taking into account the hypertension disease with advancing age. Moreover, Type 2 Diabetes Mellitus has a very close relationship with obesity, and studies have reported that obesity playsa role in the etiology of more than 80% of type 2 diabetes cases. In this respect, weight control is also necessary to eliminate the risk of diabetes. Cancer risks that the patient carries due to her age. According to the Ministry of Health, women aged 40-69 years are at risk for breast cancer, 30-65 years of age are at risk for cervical cancer, and both men and women aged 50- 70 are at risk for colorectal cancer.

Keywords: obesity, risk management, primary care, prevention

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Being a medical student during pandemics

Submission Type: **Oral**

Topic Title: Family Physician

[1] Beyza Barık,

[1] İzmir Ekonomi Üniversitesi

You are likely to have experienced significant changes in your education, clinical experiences, and personal life. Many medical schools have had to adapt to remote learning, which can be challenging for students who prefer in-person interactions and hands-on experience. However,online learning has allowed students to continue their education during lockdowns and travel restrictions.

Clinical rotations have also been affected by the pandemic, with many hospitals restricting access to medical students to limit exposure to the virus. This has led to a reduction in clinicalexperience for some students, which can be concerning for those who need to complete certain requirements for graduation.

Despite the challenges, being a medical student during a pandemic can be an opportunity to learn and adapt to new situations. Medical students have been involved in the pandemic response, from volunteering at vaccination centers to assisting with research projects relatedto COVID-19. These experiences can be valuable for future medical practice and provide a unique perspective on the medical profession during times of crisis.

Additionally, the pandemic has highlighted the importance of public health and the need fora strong healthcare system. As a medical student, you are learning about the intricacies of the human body and how to diagnose and treat illnesses. However, the pandemic has also emphasized the role of healthcare professionals in preventing disease and promoting publichealth.

In conclusion, being a medical student during a pandemic can be challenging, but it also provides opportunities for growth and learning. The pandemic has underscored the importance of public health and the vital role of healthcare professionals. Despite the difficulties, medical students have adapted to the new normal and continued their educationand training to become the future of the medical profession.

Keywords: pandemics, medical education, student perspective

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A dynamic approach to healthy aging – Review of Charles Eugster, World's fittest 97-year-old, dentist, athlete

Submission Type: **Oral**

Topic Title: Healthy Life > Healthy Aging

[1] Ümit Kemal Uğurlu,
[1] İzmir Ekonomi Üniversitesi

To begin with his own words, "Society sealed us with an expiry date". Undoubtfully, worldwide aging especially in developed countries is a so long debated and critical topic in aspects of lifequality, health expenditures, and burden to society. Charles Eugster is a fine, "dynamic" British- Swiss dentist with world records in sprinting and immense experience in rowing advice and leaves a will of great ideas for managing the aging process to various extents.
Disease is not a natural consequence of aging. Pandemics of depression, obesity, and musculoskeletal disorders mainly stem from modern lifestyle. Globalization of high energy low nutrition foods with colorful brands has progressed into indulging entertainment, sneaky
addiction, and catching trends. Whereas eliminating nutrition-rich animal food from our meals,especially in the elderly population has become a new health motto. The US obesity epidemicbegan almost simultaneously with the release of the low-fat dietary recommendations As Trans Fats and Vegetable Oils replaced Butter and Lard, the diseases of civilization increased, in contrast, France and Switzerland two leading butter-consuming countries exhibit the lowestCVD. As people cut back on their consumption of red meat and high-fat dairy products, the obesity epidemic began.
An elderly person goes through an accelerating process of sarcopenia at a faster rate ever than before which starts in the mid-forties, not only does that person loses lean functionalmuscle mass but also replaces that essential tissue with a total burden of fat tissue. Pelvic fractures, knee, and back pain, and restricted mobility reduce life quality and increase expenditure.
Building adequate muscle tissue (multiple light sessions in a day) as a long-term life goal gradually might be studied as a new exercise method rather than long walking sessions basedon Charles's case.

Keywords: lifestyle medicine, healthy ageing, exercise

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A Unique Case of Glabellar Ecchymosis Associated with Migraine-Type Headaches in a 45-Year-Old Man

Submission Type: **Oral**

Topic Title: Family Physician

[1] Oğulcan Köme, [1] Gizem Limnili,

[1] Dokuz Eylül University / Faculty of Medicine

The 45-year-old man visited our outpatient clinic for evaluation of severe headaches and multiple episodes of glabellar discoloration. The patient experienced throbbing pain usuallyin the right side of the face, lasting 12 hours to a day, approximately 4-5 times per month,
accompanied by nausea and photophobia. The ecchymosis-like lesions appeared after severeheadache episodes and resolved over the following days. Upon further investigation, the patient's medical history revealed no notable factors apart from migraines. Comprehensive evaluation, including high-resolution brain magnetic resonance imaging (2022), brain and orbital computed tomography (2022), and routine blood tests, yielded no remarkable findings. Both initial physical and neurological exams were normal. Our patient was included in the study to investigate the effect of the "alternative nostril breathing technique "on the frequency and severity of migraine headaches in migraine patients after written consent was obtained.
During the study, the patient continued his/her own pharmacotherapy (NSAIDs) as before and there was no known medication use other than NSAIDs also patient did not start any newmedication.
The precise mechanisms behind the association between autonomic vascular dysfunctionand migraine-type headaches are not fully understood. However, some studies suggest that migraine sufferers may have increased sensitivity to vasodilatory stimuli, such as nitricoxide, leading to greater vasodilation and blood flow changes during headache episodes.
Additionally, the activation of the trigeminal nerve, which is involved in the pathophysiology ofmigraines, may also contribute to autonomic dysfunction and abnormal vascular responses.
Further research is needed to elucidate the exact relationship between autonomic vasculardysfunction and the formation of ecchymosis in migraine-type headaches. A deeper understanding of these mechanisms may lead to new therapeutic approaches for patientssuffering from migraines and associated complications.

Keywords: Migraine, Headache, Glabellar ecchymosis

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From Dizziness to Bladder Cancer: A Case Report

Submission Type: **Oral**
Topic Title: Family Physician

[1] Ayça Asma, [1] Halime Seda Küçükerdem
[1] Bozyaka Eğitim ve Araştırma Hastanesi

Introduction:
Periodic health examinations of healthy individuals are among the duties and authorities of thefamily physician. Every individual over the age of 65 should be invited at least once a year. One of the recommended laboratory examinations is complete blood count (CBC). CBC is a test that can help to diagnose anemia, hematological cancers, infections, acute bleeding, allergic diseases and immune deficiencies. The cause of anemia presenting with dizziness, which is oneof the common causes of admission to primary care, should be determined.
Case:
A 65-year-old male patient applied to our family medicine outpatient clinic with the complaintof dizziness. On physical examination, pulse rate was 94, arterial blood pressure was 100/40 mmHg, and body temperature was 36.9 C. It was learned that a blood test was performed on Family Health Center (FHC) 1 week before. Electronic health records from one week ago were as follows: hemoglobin 4.3 g/dl, RDW 22.7%, RBC: 2.87× 1012/L, hematocrit 18.5%, MCV 64.5 fl. Control hemogram values performed in our hospital were consistent with previous values ashemoglobin 4.5 g/Dl. Internal medicine was consulted for anemia treatment and the patient was hospitalized. In urine analysis 7341erythrocyte, were observed. Urology department planned performing cystoscopy. Surgery was planned after cystoscopy revealed papillarytumoral tissues in the bladder. The pathology result was papillary uretherial carcinoma.
Discussion:
Serious diseases are encountered less frequently in family medicine clinics. This requires primary care physicians to manage a unique probability-based decision-making process.Severe anemia may be presented with syncope, chest pain, shortness of breath, and decreased exercise tolerance.
Conclusion:
As family medicine physicians, it is very important to perform periodic health examinations forthe early diagnosis and treatment of malignancies. Malignancies are an important cause of anemia in the elderly. It should be kept in mind that anemia, is a symptom, not a disease.

Keywords: Anemia, bladder cancer, early diagnosis, preventive medicine.

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Vitamin D Levels in Hashimoto's Thyroiditis Patients

Submission Type: **Oral**

Topic Title: Family Medicine

[1] Olgu Aygün, [1] Halime Seda Küçükerdem, [2] Ozden Gokdemir

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[2] Family Medicine, WONCA Working Party on Env - Izmir University of Economics / Faculty ofMedicine, İzmir, Turkey

Background: Vitamin D is a type of steroid hormone that is synthesized from 7-dehydrocholesterol by ultraviolet (UV-) light in the skin or obtained through diet from foods such as milk and dairy products. Vitamin D deficiency is a widespread health problemworldwide. Adults who are vitamin D deficient develop osteomalacia. Recent studies
have shown that vitamin D deficiency to insulin resistance, type 2 diabetes, dyslipidemia, cardiovascular disease, and non-alcoholic fatty liver disease. The Framingham Offspring study discovered a link between low vitamin D levels and major cardiovascular disease. It'sbeen proposed that vitamin D acts as an immunomodulator in autoimmune diseases like Hashimoto's thyroiditis.

Questions: Although low vitamin D levels have been found in numerous studies, it is unclear whether this is the result or the cause of the disease. The aim of this study was to see if therewas a difference in serum vitamin D levels between people with Hashimoto's thyroiditis and people who didn't have thyroid disease.

Content: The aim of this study was to see if there was a difference in serum vitamin D levels between people with Hashimoto's thyroiditis and people who didn't have thyroid disease. The study's scope is as follows: People with Hashimoto's thyroiditis and those who have applied toFamily Medicine Polyclinic in the last 5 years will be included.

Take Home Message for Practice: Management of "D vitamin prevention" is crucial in primarycare. The results of this study could identify the root reasons to define the status.

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POSTER PRESENTATIONS

The effect of music on healthy aging

Submission Type: **Poster**
Topic Title: Healthy Life > Healthy Aging

[1] Ozden Gokdemir, [2] Stamatina Aggelakou-Vaitsi, [2] Nikolaos Vaitsis, [2] Maria Bakola, [2] KonstantinaSoultana Kitsou, [2] Konstantina Mavridou, [2] Maria Drakopoulou, [2] **Eleni Jelastopulu**,

[1] Faculty Of Medicine, Izmir University Of Economics, Izmir, Turkey

[2] Department Of Public Health, Medical School, University Of Patras, Greece, 26504 Patras, Greece

Background:
The positive effects of adding musical elements in programs to enhance the quality of life andwell-being of older people are clearly demonstrated. The purpose of this research study is to study the effect of music on healthy aging as well as to investigate related factors.
Methods:
A questionnaire-based cross-sectional study was performed. Older adults (age>65 years old) receiving conventional primary health care (PHC) answered an anonymous self-report questionnaire consisting of two sub-sections: i) Socio-demographic and other factors relatedto music, ii) Quality of Life Scale SF-36.
Results:
A total of 219 elderly people with a mean age of 73.2 ± 5.1 participated in the study. 142 (64.8%)of them were females. 44.7% were widowed, 41.6% were married, and 40.6% had secondary education. 34.7% of the participants received music training during their life, 86.3% loved to listen to music and 63.9% did not have any active engagement with music like participation in a choir, playing a musical instrument, etc. The total score of the SF36 - PHYSICAL HEALTH subscale is statistically significantly higher among those who have received music training
($p = 0.001$), those who like listening to music ($p < 0.001$), and those who are actively engagedin music ($p < 0.001$). The total score of the SF36 - MENTAL HEALTH subscale is statistically
significantly higher among those who like listening to ($p = 0.001$) and those actively engaged inmusic ($p < 0.001$).
Conclusions:
Our study showed that music has a positive effect on healthy aging. Notably, receiving musiceducation has an effect on physical fitness during aging, while it did not appear to affect mental health.
Keywords: elderly, music, quality of life

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Knowledge, Attitude, and Practice of Telemedicine in arural setting of India

Submission Type: **Poster**

Topic Title: Family Physician > First step

[1] Dr. Venkataramana Kandi, [2] **Dr. Himanshu Arora**, [2] Dr. Tanya Kathuria, [3] Dr. L V SimhachalamKutikuppala ,

[1] Prathima Institute Of Medical Sciences, Karimnagar

[2] Netaji Subhash Chandra Bose Subharti Medical College, Meerut

[3] Dr Ntr University Of Health Sciences, Vijayawada

Background: Telemedicine is the approach of healthcare professionals via telecommunication to evaluate, diagnose and treat patients who cannot consult a doctor in person. Especially in the Pandemic Era, this has grown in importance in the medical community. People have started to accept this method as a way of treatment, particularly forpatients who are elderly or during pandemics.

Methods: This was a questionnaire-based study and convenience sampling methods and snowballing sampling techniques were used. Statistical analysis was done using descriptive statistical tests such as Chi-square and P-value. For categorical data, percentageswere used and interpreted using graphs.

Results: 511 people in total, ranging in age from 15 to 44, participated in the study. 35.42% of people who had heard of telemedicine (58.2%) had actually used it. When access to a healthcare provider is a problem, people accepted that telemedicine should be used (88.06
%), and doing so also decreased the likelihood of infection spreading (86.37%). Telemedicinewas viewed as a blessing in times of covid -19 pandemics (95.3%). In the future, 72.99% of people want to be treated via telemedicine. A whopping 86.69% want to know more about telemedicine.

Conclusion: The study’s conclusions imply that while there is little public knowledge or awareness of telemedicine, a sizable proportion of people have demonstrated a favorable attitude toward the necessity of using telemedicine.

Keywords: Patient satisfaction, Rural Medicine, Telemedicine, Telemedicine utilization, Telemedicine associated health outcomes

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An Assessment of Peptic Ulcer Perforation (PULP) score: A predictor of mortality following Peptic Ulcer Perforation from a rural tertiary care setting

Submission Type: **Poster**

Topic Title: Gastroenterology > Gastritis, peptic ulcer, dyspeptic complaints

[1] Dr Hemanth Kumar Chowdary R, [2] **Dr Taraka Krishna Nulukurthi**, [2] Dr Karnasula Balaji, [3] Dr L VSimhachalam Kutikuppala, [3] Dr Chintala Jyothi Swaroop,

[1] Ms Ramaiah Memorial Hospital, Bangalore

[2] Konaseema Institute Of Medical Sciences And Research Foundation (kims&rf), Amalapuram

[3] Dr Ntr University Of Health Sciences, Vijayawada

Background: The prevalence of elective surgery for peptic ulcer illnesses has declined with the development of H2 receptor antagonists and proton pump inhibitors, however, peptic ulcer complications including perforation and bleeding have remained mostly consistent. The risk of death from an ulcer disease consequence is highest in perforation. Therefore, early identification of patients with perforated peptic ulcers who are more likely to experiencenegative outcomes after surgery is crucial for making the right treatment decisions.

Objectives: The purpose of this study is to use the peptic ulcer perforation (PULP) score to predict mortality within 30 days of surgery and to risk stratify patients undergoing surgicaltherapy for perforated peptic ulcers.

Methods: Following a thorough physical examination, a thorough medical history review, the appropriate pre-operative serological investigations, radiological imaging, and the use of a unique ASA score, patients who underwent surgical treatment for a perforatedpeptic ulcer were given points based on the PULP score.

Results: In total, 120 patients were involved in the study including 94 men and 26 women. 110 patients were in the low-risk group, and 10 were in the high-risk group. In the postoperative period, 8 patients from the high-risk group passed away, compared to 2 deaths in the low-riskgroup.

The authors must give more information about the PULP in the background. Is it a test used topredict the mortality of patients with perforated ulcers. do the results show the effectiveness ofthe use of this test and how?

Conclusion: Early diagnosis of the systemic inflammatory response syndrome (SIRS) and quickgoal-directed treatment, including pre-and postoperative care, can be crucial and may also affect the outcome of the intervention.

Keywords: Peptic ulcer disease, Perforation, peptic ulcer perforation (PULP), systemic inflammatory response syndrome (SIRS)

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Atorvastatin Kullanımına Bağlı Hemoglobin Düzeyinde Düşme; Olgu Sunumu

Submission Type: **Poster**

Topic Title: Cardiology > Current approaches in the treatment of hyperlipidemia

[1]Sezen Kaya, [1]Meryem Çakır,

[1] İzmir Katip Çelebi Üniversitesi Atatürk Eğitim Ve Araştırma Hastanesi, Aile Hekimliği AnabilimDalı

Giriş: Gelişmiş ve gelişmekte olan ülkelerde ölümlerin başlıca nedeni aterosklerotik kardiyovasküler hastalıklar (ASKVH)'dır. Serum kolesterol düzeylerini düşürmek ve kardiyovasküler hastalıkları önlenmek için statinler kolesterol biyosentezi inhibisyonu yaparakkolesterolü düşürürler. Onaylanmış statin dozları ender olarak önemli yan etkiler ile ilişkilidir. Alerjik reaksiyon, cinsel istek-yetenekte azalma, uyumakta zorluk çekme, gastrointestinal sistem yan etkileri görülebilir. Statin tedavisi sırasında, miyopati oranı yaklaşık 10.000'de 1 hasta olup, rabdomiyoliz oranı daha da düşüktür. Az sayıda çalışmada statin kullanımının inflamasyonu azaltarak hastaları anemiden koruyabileceği vurgulanmakla birlikte, çok nadir olarak statin kullanımına bağlı anemi geliştiğini gösteren vaka sunumları da bulunmaktadır. Bu vakada Atorvastatin kullanımı sonrası Hemoglobinde (HGB) düşüş ve Laktat Dehidrogenazda (LDH) yükseliş görülen bir hastaya klinik yaklaşımın sunulması amaçlanmıştır.

Olgu: 69 yaşında erkek hasta aile hekimliği polikliniğine vücutta yaygın kaşıntı şikayeti ile başvurdu. Hastanın bilinen kronik hastalıkları diabetes mellitus, hipertansiyon ve peptik ülserdi. Anamnezinde hastaya beş gün önce ölçülen kan değerlerinde düşük yoğunluklu lipoproteini (LDL) 135 mg/dL olması nedeniyle atorvastatin 20 mg başlandığı öğrenildi. Fizik muayenede inspeksiyonda kollarda ve bacaklarda kaşıntıya bağlı izler mevcuttu. Hastanınyapılan tetkiklerinde HGB'nin 12,5 gr/DL, LDH'ın 425 u/L olduğu görüldü, diğer kan sonuçları normaldi. Hastanın beş gün önceki tetkikleri incelendiğinde HGB'ın 14,5 gr/DL, LDH'ın 186 u/L olarak ölçüldüğü görüldü. Atorvastatin kullanımını takip eden dördüncü günde HGB'de 2 birimlik düşüş, LDH'da 2 kattan fazla yükselme ve şiddetli kaşıntı şikayeti olması nedeniyle hastanın atorvastatin tedavisi kesildi. Hasta antihiperlipidemik tedavi kullanmak istemediğinibelirttiğinden yaşam tarzı değişiklikleri önerildi ve hasta diyetisyene yönlendirildi.

Sonuç: Statinler birinci basamak hekimlerince hiperlipidemi tedavisinde oldukça sık kullanılan ilaç grubunda olup yan etkileri konusunda daha fazla çalışma yapılmasına ihtiyaç duyulmaktadır. Statin kullanan hastalarda sık görülen bir yan etki olmasa da HGB düşüklüğü ve LDH yüksekliği konusunda dikkatli olmak gerekmektedir. Bu yan etkileri fark edebilmek ve ayırıcı tanıdan asıl tanıya gidebilmek için hastalardan detaylı anemnez alınması fayda sağlayacaktır.

Keywords: Hemoglobin, statin, yan etki