

diagnosis. Disagreements between primary and secondary care assessments were reviewed by a multidisciplinary team. Those of clinical importance were included in the analysis. *Results:* 29 of 44 practices wanted to take part. In the six selected practices 312 tests were completed. Mean age was 64 years (19-94 yrs), 52% female, mean predicted FEV1 69% (16-127%). 77 of 185 tests reported as acceptable in primary care were judged unacceptable by the specialist. 136 tests were judged obstructive by the specialist of which 85 were identified as obstructive by the primary care teams. In 129 of 218 (59%) tests there was complete agreement about level of severity. Practices differed in the frequency of disagreement with the specialists but in all there were disagreements in more than 15% of tests. *Conclusion:* On-line reporting of primary care spirometry is feasible and primary care teams are interested in it. The level of disagreement between primary care and specialist interpretation of the tests suggests that specialist reporting of tests is essential in these practices if primary care spirometry is to be carried out to an acceptable standard.

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ABS49: Splitting COPD and asthma: Validation of the differential diagnosis questionnaire (DDQ) in Australian primary care

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Introduction: Diagnostic confusion between COPD and asthma abounds in clinical practice and epidemiological surveys, as symptoms are non-specific. Spirometry is essential for the diagnosis of COPD, but is neither widely used nor reliably performed in general practice. The DDQ was developed to help GPs differentiate patients with respiratory symptoms into the category 'likely COPD'. *Aims and objectives:* To validate the DDQ prospectively in Australian primary care. *Subjects and Methods:* Forty-two GPs in Adelaide, Brisbane and Sydney recruited patients aged >40 years with a previous diagnosis of asthma or COPD, or with recent respiratory medication prescription. Diagnostic validity - DDQ scores were compared to spirometry in 131 patients, using two pre-determined cutpoint scores: 24.5 = 'high likelihood' (HL) and 18.5 = 'low likelihood' (LL). Test-retest reliability was tested in 73 of these patients. *Results:* Subject characteristics - 79% smoked >10 pack-years; M:F=56:44; 57% were aged >60; previous diagnoses were asthma (64%), COPD (44%) or both (13%). Utility of DDQ - HL Cutpoint: Sensitivity=63%, Specificity=76%, Positive Predictive Value=67%. LL Cutpoint: Sensitivity=82%, Specificity=44%, Positive Predictive Value=77%. Area under the Receiver Operating Curve=0.72 (moderate diagnostic agreement between DDQ and spirometry). Reliability was good ($\kappa=0.78$). These characteristics are similar to those previously obtained from UK/US, though some symptoms in Australia appear less helpful in contributing to the differential diagnosis model. *Conclusions:* The DDQ is a valid and reliable tool for helping GPs in Australia differentiate patients with a high likelihood of COPD from those unlikely to have COPD. Further work may help to develop greater discriminative value for the DDQ in Australia, enabling the GP to prioritise patients more effectively for spirometry confirmation.

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ABS50: Study of resources in asthma and COPD in the community of Madrid (Spain)

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Introduction: Respiratory medicine is developing in primary care. We describe the resources available. In a second phase, we will study health results. *Aims and objectives:* To learn about resources (infrastructure and process) related with Asthma and COPD in the public centers of the Community of Madrid (Spain). *Subjects and methodology:* A descriptive, cross-sectional study. A postal survey addressed (2 mailings) to the leaders of all the health centers (227), between November (2000) and April (2001). Response: 156 (68.7%). A previous study over 44 coordinators (nominal group), added 10 items and changed 4. Variables of infrastructure: existence and/or revision of cardiopulmonary resuscitation equipment (CPRE), spirometry, pulse oximeter, peak flow, inhalation devices and educational tools. Variables of process: existence of protocol, quality control, health education, provision of systems, continued education, waiting list. *Results:* Spirometry was available in 102 centers (65.4%), calibrated habitually in 60 (38.5%), there was CPRE in 142 (91%), pulse oximeter in 19 (12.2%). peak flow in 53.8%, 27.6% and 43.6% of the medical consultations, infirmary and emergency departments. There was an asthma protocol in 53 centers (34%) and COPD in 131 (84%). There was quality control in asthma in 10 centers (6.4%) and COPD in 52 (38.3%). There was grouped education in asthma in 22.4% and 19.2% in COPD. 60.3% of asthmatics and 93.7% of COPD patients were referred to pneumology. 7.1% of the asthmatic patients waited less than 31 days to be attended in allergy, as opposed to 49.9% in pneumology. *Conclusions:* Some deficiencies in infrastructure and process were detected with evidence of less development in the attention to the asthmatic patient. Also, there was little activity in respect of health education.

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ABS51: Can you be a generalist and a specialist? Stakeholders' views on a respiratory General Practitioner with a Special Interest service

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Introduction: General Practitioners with Special Interests (GPwSIs) have a potentially important role in delivery care for people with long-term respiratory diseases. The development of a GPwSI service within a Primary Care Trust (PCT) involves a process of 'transitional change' which impacts on all stakeholders, who may embrace or resist change. *Aims and objectives:* The objective of the current study is to explore the attitudes and views of stakeholders to the provision of a respiratory GPwSI service within the six PCTs in Leicester, UK. *Subjects and methods:* Using a qualitative design, GPs, nurses, secondary care doctors, nurse specialists, physiotherapists, a healthcare manager and patients with respiratory disease took part in focus groups and interviews. *Results:* The 25 participants expressed diverse opinions about the challenge of integrating specialist services with generalist care and the specific contribution that GPs might make to the care of people