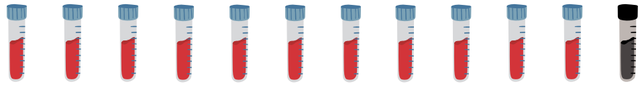
WHY WE SHOULD ALL CONSIDER OPTIMAL TESTING

1 THE PERILS OF CASTING A WIDE NET



For every **12** parameters tested...

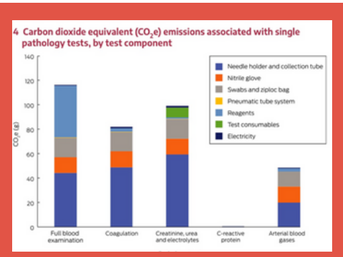
(e.g. there are >12 parameters in a U&E/Cr and a FBC)

...you will statistically get **one** abnormal result.

3

Another consideration is the cost of "cascade testing" as a result of finding abnormal results. The cost is both financial, and in terms of patient experience. Click here for Fran's story:

2

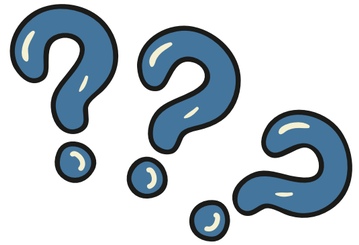


The carbon footprint of common pathology tests is dominated by those of sample collection and phlebotomy

CARBON FOOTPRINT OF TESTING

The carbon foot print of testing comes mainly from **patient journeys** to and from the testing site.
See this talk for an overview

So what should we do?



> **Has my test really changed doc?**

Click on this tool for use during the consultation to help your patient see if a result has significantly changed compared with last time, or not

Click on thses icons for more information about specific tests:

- **cholesterol**
- **vitamin D**
- **inflammatory markers**
- **annual review bloods**

TIPS FOR CHRONIC DISEASE TESTING

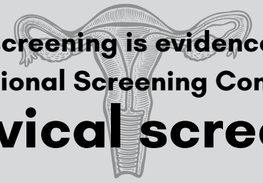
- Group tests into fewest visits possible
- Go paperless and bagless for samples
- Get a centrifuge so samples don't deteriorate in cold weather
- Work with your local lab to create a chronic disease monitoring profile in their ordering system, and encourage your team to stick to this.
- Deprescribe where possible. Fewer drugs = less monitoring

JOIN THE OPTIMAL TESTING GROUP TODAY!

SCREENING: what is the evidence?

Some screening is evidence based and agreed by the National Screening Committee, e.g.

cervical screening

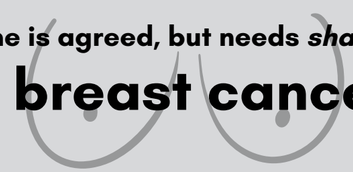


Some is *not* evidence based, and trials are ongoing e.g.

AF screening

Some is agreed, but needs *shared decision-making* e.g.

breast cancer screening



Some is not agreed by the National Screening Committee, but still heavily promoted by disease-specific charities e.g.

prostate cancer screening

So what should we do?

It is important to understand the uncertainties, and offer shared decision-making before offering tests

> For every 2000 women invited for screening throughout 10 years, one will avoid dying of breast cancer, and 10 healthy women who would not have been diagnosed if there had not been screening, will be treated unnecessarily. Furthermore, more than 200 women will experience significant psychological distress including anxiety and uncertainty for years because of false positive findings

CHOLESTEROL: how often do we need to test?

obesity

CV risk is higher in some people

lower socio-economic groups

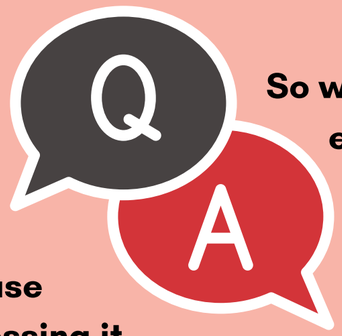
on anti-psychotics

hazardous drinkers

CHOLESTEROL IS ONLY ONE OF A NUMBER OF RISK FACTORS FOR CARDIOVASCULAR (CV) DISEASE

So what should we do?

Remember, you can only see the impact of one change, at once.
The first 2 changes a patient makes will make the greatest impact in reducing their risk.
Subsequent changes add little.



So why don't we test everyone for CV risk long-term?

Because addressing it is a wider public health issue not fixed by checking a blood test. The end outcome of CV death or disability which matters to the patient, is actually changed by lifestyle improvement, social prescribing, being employed, addressing health inequalities, weight loss, and sometimes by medicines. Checking bloods could be a distraction both to outcomes which really matter to the patient, and the ways you will change their risk.

This video covers the simple logic and maths around why measuring lipid levels more than once in a person's LIFETIME is pretty much a waste of time and money

Arrange for your patient to see a Social Prescriber or someone who can help them lose weight or find employment.

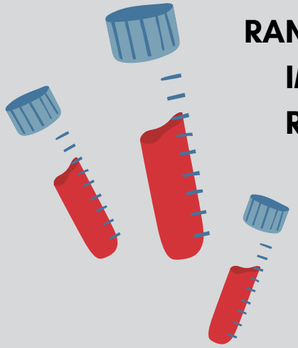
> **Measuring lipids more than once in a lifetime is unnecessary**

Click on this tool for use during the consultation to help your patient decide which changes, if any, they would like to make to reduce their cardiovascular risk (excludes FH)

FATIGUE: how likely is a blood test to be helpful?

Big Dutch Study in General Practice

325 PATIENTS WITH FATIGUE (71% WOMEN)



RANDOMISED TO:

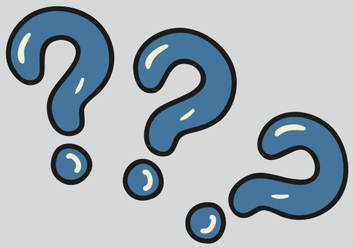
IMMEDIATE VS DELAYED TESTING

RESTRICTED NUMBER OF TESTS VS AN EXPANDED NUMBER OF TESTS

ONLY 8% HAD A DIAGNOSABLE CONDITION SHOWN ON THE TESTS

Many more tests = many more false positives

So what should we do?



Here's what the RACGP and Dutch College have endorsed:

FULL CLINICAL ASSESSMENT

IF NIL OBVIOUS, CONSIDER DIPPING URINE FOR SUGAR

IF RED FLAGS ABSENT & SOMATIC DISEASE UNLIKELY (MOST PEOPLE)...

- Lifestyle advice & offer review in 4 weeks
- Give appropriate explanation

CRP/PV/ESR not necessarily recommended

AT 4 WEEKS, IF PERSISTING FATIGUE:

- FBC, HBA1C & TSH (AND FERRITIN IN WOMEN)
- THEN FURTHER TESTS AS NEEDED (E.G. FOR A HIGH HB)