Trends in cholesterol testing in general practice

Trudy van der Weijden, Ron AG Winkens, Berna J Schouten, J André Knottnerus, Richard PTM Grol

Objectives: To assess trends in the ordering of cholesterol tests by general practitioners (GPs), and to assess whether the trend in ordering cholesterol tests is consistent with the recommendations in the Dutch guidelines for GPs.

Methods: Analysis of total cholesterol and lipid fraction tests at the Maastricht diagnostic centre, which serves all 85 GPs in the region* over the years 1984-1992. Main outcome measures are the number of cholesterol, HDL, LDL and triglyceride tests per year, and the number of cholesterol tests per GP per year. The frequency of cholesterol and lipid fraction testing in 'new patients' (patients presenting for cholesterol testing for the first time) are indicators for adherence to the guidelines on the diagnostic procedure. Data on new patients were available for the years 1989-1992.

Results: There was an overall increase in the total number of cholesterol tests of 173% between 1984 and 1992. There is considerable and stable inter-doctor variation. In new patients, 13.5% of male and 23.0% of female patients did not fulfil the age criteria according to the national guidelines. Repeat testing regarding diagnosis of hypercholesterolaemia as recommended was not performed in 86% of the new patients in 1989, which increased to 94% in 1992. Lipid fraction testing during the first contact with a new patient was not recommended; nevertheless this was done in 38% of the cases in 1989, decreasing to 31% in 1992.

Conclusions: The strong increase in the number of cholesterol tests ordered over the years was accompanied by a large and sustained inter-doctor variation in cholesterol testing. The diagnostic procedure improved slightly for lipid fraction testing, but deteriorated for repeat testing. Improvement on these topics should be sought, to prevent non-rational cholesterol management, which can have a relevant impact on the GP's workload and the resources of the public health system. In pursuing improvement, more attention should be given to effective implementation strategies as well as to the scientific validity of the guidelines.

Introduction

Important developments on the cholesterol issue took place in the 1980s. Results of large cholesterol intervention studies were published, the HMG coenzyme-A reductase inhibitors were introduced, quickly followed by cholesterol guidelines for all Dutch physicians. These developments, and the ongoing debate about the controversial character of cholesterol testing, have raised questions whether a specific trend in GPs' behaviour in ordering cholesterol tests has developed over the last decade. Specific guidelines for cholesterol management in the general practice setting were published by the Dutch College of GPs in November 1991. Caution with regards to testing characters these guidelines; selective case finding is only indicated for people aged 18-65 years with an unfavourable coronary risk profile. Diagnosis of hypercholesterolaemia requires the mean of three serum cholesterol tests to be higher than 6.5 mmol/L. Determination of HDL and triglycerides is only indicated if cholesterol-lowering drugs are being considered.

Considerable discrepancy between usual care and the guidelines was reported for Dutch GPs before publication of these guidelines. Simply disseminating cholesterol guidelines does not change daily practice. To promote implementation of new guidelines, more insight into actual behaviour of GPs is required. In many countries a low adherence to cholesterol guidelines by GPs has been reported. A study of possible trends in ordering cholesterol tests will further explore the relation between usual care and the guidelines. It might improve insight into possible external factors that have the power to influence GPs in their cholesterol management, or factors that restrain GPs from working according the guidelines.

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The need for information on trends in the ordering of cholesterol tests regarding implementation of the guidelines, together with the controversial character of cholesterol testing over the years, stimulated us to address the following questions:

1. What is the trend in cholesterol and lipid fraction testing in general practice over the period 1984-1992, and which patients are being tested?
2. What is the trend in diagnostic performance in relation to the guidelines for selective case finding, repeat testing and lipid fraction testing?

Methods

Materials

Data were used from the Diagnostic Coordinating Centre Maastricht (DCC). Since 1979, this centre has processed all diagnostic requests of GPs (about 85) in Maastricht and surroundings, covering a region with 187,000 inhabitants. All requests have been stored in a computerised database which provides a good opportunity to describe time trends. Every day these GPs 'refer' 125-150 patients to the diagnostic centre; that is, 30,000-35,000 patients yearly. A standardised form is used for diagnostic requests. Only tests requested regularly are printed on the form. Cholesterol and triglycerides are printed, while high density lipoproteins (HDL) and low density lipoproteins (LDL), if requested, have to be written on the form by the GPs themselves. The GPs are also invited to register clinical data on the patient and the reason for the request.

Trends in cholesterol testing

To analyse the volume of test ordering in the course of time, the total number of tests per year for cholesterol, triglycerides, HDL and LDL were extracted from the database. The age and sex characteristics, the reasons for request, as well as the prevalence of hypercholesterolaemia were analysed in all patients. An increase in compliance with the recommendations specified by the Dutch guidelines should subsequently result in a decreased inter-doctor variation in ordering tests. For a trend analysis of inter-doctor variation in ordering cholesterol tests, GPs who had not been participating for the whole year were excluded, still leaving an average of 81 GPs per year for this analysis. Due to skewed distribution, inter-doctor variation was not expressed using means and standard deviations, but using the median (= quartile 2) and quartiles 1 and 3 as indicators for inter-doctor variation. A higher inter-doctor variation, expressed as the distance between quartile 1 (Q1) and quartile 3 (Q3), may just be the consequence of an increasing median. Therefore we corrected the inter-doctor variation for the higher median by calculating the ratio (Q3-Q1)/median.

Trends in diagnostic performance related to the guidelines

According to the national guidelines, cholesterol testing in 'new patients' (patients presenting for the first time for cholesterol testing) should be restricted to people aged between 18 and 65 years. Technical advances made it possible to identify the subgroup of new patients for the years 1989-1992. The age and sex distribution of this subgroup, repetition of cholesterol testing, as well as the frequency of triglyceride and LDL testing were analysed. Repeat testing is indicated for patients with a cholesterol value higher than 4.9 mmol/l. Proper repeat testing in 6 weeks' time was described, in addition to a milder variant: at least one repetition of cholesterol testing in 6 months' time. As lipid fraction testing is only indicated if cholesterol-lowering drugs are being considered, there should not be an indication for HDL or triglyceride testing in new patients. Instead of taking a sample, full population data of the diagnostic centre could be used; statistical testing was not indicated.

Results

Trends in cholesterol testing

Figure 1 illustrates the trend in the total number of total cholesterol, HDL, LDL and triglyceride tests in the Maastricht region. There was an increase of 219% in cholesterol testing in the period 1984-1990, which stabilised and slightly decreased by 21% in the period 1990-1992, resulting in an overall increase of 173% between 1984-1992. There were no clear trends in triglyceride and HDL testing. Triglyceride testing was performed about twice as often as LDL testing in new patients. Instead of taking a sample, full population data of the diagnostic centre could be used; statistical testing was not indicated.

Figure 1. Trend in total number of cholesterol and lipid fraction tests at the Diagnostic Coordinating Centre Maastricht, 1984-1992.
Figure 2. Trend in inter-doctor variation of cholesterol testing per GP, 1984-1992.
Median (=quartile 2) of number of tests per GP; quartile 1 (Q1) and quartile 3 (Q3) indicating inter-doctor variation.

Table 1. Age and sex of new patients, 1989-1992. Percentages per total number of new patients per year.

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<td>Sex</td>
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<td>♂</td>
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<td>46</td>
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<td>&lt;18 or ≥65 yrs</td>
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<td>13</td>
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<td>24</td>
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<td>Total new patients:</td>
<td>2616</td>
<td>3131</td>
<td>2439</td>
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which no feedback was given, decreased compared to a reference diagnostic centre. The reference diagnostic centre showed a much steeper increase in cholesterol testing of high-risk groups, or outreach visits from academically-qualified representatives or local opinion leaders. To increase the likelihood of the guidelines changing medical practice, the feasibility of the guidelines should be discussed at local level.

In addition to a discussion on the implementation of the guidelines, the results prompt a critical look at the scientific validity of the guidelines. The ongoing debate about which high-risk groups benefit most by cholesterol screening needs clarification. It is remarkable that the practice of cholesterol guidelines seems to be influenced more by moral and economic factors than by evidence of health benefit. The method of developing the guidelines determines the scientific validity of the guidelines. Recently, a method for grading health care recommendations was proposed in which both scientific validity and cost-effectiveness considerations (number of patients that need to be treated) are combined.

We conclude that the strong increase in the number of cholesterol tests ordered over the years was not accompanied by a decrease in inter-doctor variation and improvement in quality of testing. We recommend that improvement on these topics should be sought, to prevent non-rational cholesterol management. In pursuing improvement, more attention should be given to effective implementation strategies as well as to the scientific validity of the guidelines.

Table 2. Trend in number of tests for diagnosis of hypercholesterolaemia in new patients, 1989-1992. Column percentages of the group of new patients with cholesterol higher than 4.9 mmol/l per year.

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<tr>
<td>One test only</td>
<td>86.3</td>
<td>86.3</td>
<td>89.0</td>
<td>93.6</td>
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<tr>
<td>&gt; 1 test in 6 months</td>
<td>13.3</td>
<td>13.4</td>
<td>10.7</td>
<td>6.1</td>
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<td>Repeat testing according to the guidelines*</td>
<td>0.4</td>
<td>0.3</td>
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New patients with cholesterol > 4.9 mmol/l

* Diagnosis of hypercholesterolaemia requires the mean of three serum cholesterol tests, determined in a period of six weeks, to be higher than 6.5 mmol/l. If the first test-value is lower than 5.0 mmol/l, or the mean of two values is lower than 6.5 mmol/l, there is no indication for (further) repetition of testing.

References