Direct access GP referral for ETT functions as a virtual clinic

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The Canterbury District Health Board offers a service allowing GPs to refer a patient directly for a Direct Access Exercise Tolerance Test (DAETT). The service is for patients with chest pain who have been assessed as having a low probability of angina. Criteria for this were locally developed in a primary and secondary care collaboration as part of Canterbury HealthPathways. All referrals are triaged by the Cardiology Liaison GP, who can either accept the referral, upgrade to an outpatient Cardiology appointment if the patient is felt to be high risk for angina, or reject the referral if criteria are not met.

We prospectively followed 52 consecutive patients referred for DAETT in October 2014. The mean age was 60 years (range 38–84), 25 were male, 4 were smokers, and 3 had diabetes. In 15 of the referrals the GP had a taken TnI pre-referral. All of these were negative.

Of the 52 referrals, 43 (83%) were accepted for a DAETT. Thirty-nine of these went ahead; 1 patient opted for a private test, 1 was admitted to Christchurch Public Hospital in the interim for an overall decline in his health and 2 patients cancelled their tests as they reported the problem had resolved.

Five DAETT referrals were upgraded to Cardiology outpatient appointments. Three of these had further testing showing CAD. Of the other 2, 1 patient had a negative dobutamine stress echo and was discharged from follow up, and 1 cancelled their appointment as symptoms had resolved.

Four DAETT referrals were rejected. Two of these were advised to have further GP investigations. One did not have enough information on the referral and 1 was requested as a screening tool in an asymptomatic patient and therefore declined as not meeting criteria.

Thirty-nine DAETTs were performed. Thirty-three (84%) of these were negative. Three (8%) tests were reported as equivocal and 3 tests were positive. Of the positive tests, 1 patient was admitted and went on to have CABG, 1 had a coronary angiogram which showed severe stenosis in modest sized branch vessels, and 1 underwent CT coronary angiogram, which showed minimal coronary artery disease. Of the equivocal tests, 1 has been referred by GP for spirometry, 1 has ongoing symptoms that the GP feels are not cardiac, and 1 has resolved symptoms.

All 52 study patients were followed up with a phone call to their GP practice 20 weeks following the initial referral. In this time, the majority (58%) of the patients with a negative DAETT had been back to their GP. In only 2 cases was there ongoing concern about the symptoms that had led to the initial DAETT referral. One was now diagnosed as dyspepsia and 1 was referred back to Cardiology as the GP had been advised to do so if ongoing symptoms as the negative DAETT was submaximal.

These results show that the service is working well for patients and GPs. The patients with negative test results are almost always well reassured with a low

percentage having ongoing concerns. The importance of the triaging step in our DAETT pathway is also well demonstrated. The triaging is performed by our GP liaison, a general practitioner who works in the Cardiology Department. This results in the DAETT service in effect becoming a virtual clinic as the GP liaison works closely with the consultant cardiologists of the Department. The DAETT service is not just providing access to exercise tests and reassurance, it is appropriately targeting a full range of further cardiac appointments, investigations and management.

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