

11-14 June 2024 | Turku, Finland

**NC**  
**GP**  
**2024**

**General Practice – the bedrock of healthcare – Respecting the core values**

23<sup>rd</sup> Nordic Congress of General Practice 2024 | [ncgp2024.fi](https://ncgp2024.fi) | [#ncgp2024](https://twitter.com/ncgp2024) [#visitturku](https://twitter.com/visitturku)

# Miksi, Mitä, Miten – Minäkin?



# Sidonnaisuudet 2020–2023

Päivi Korhonen

- **Koulutus:** yleislääketieteen ja sisätautien erikoislääkäri  
erityispätevyys: diabeteksen hoito, lääkärikouluttaja
- **Päätoimi:** yleislääketieteen professori, Turun yliopisto
- **Sivutoimi:** yleislääketieteen ylilääkäri, Varsinais-Suomen hyvinvointialue
- **Koulutustoiminta:** luentoja lääkealan yritysten koulutuksissa  
(Orion, Novo Nordisk), koulutusmateriaalin tuottaminen (Orion)
- **Käypä hoito –työryhmän jäsen:** Kohonnut verenpaine, Obstruktiivinen uniapnea
- **Saatuja apurahoja:** Suomen Kulttuurirahasto, Valtion tutkimusrahoitus

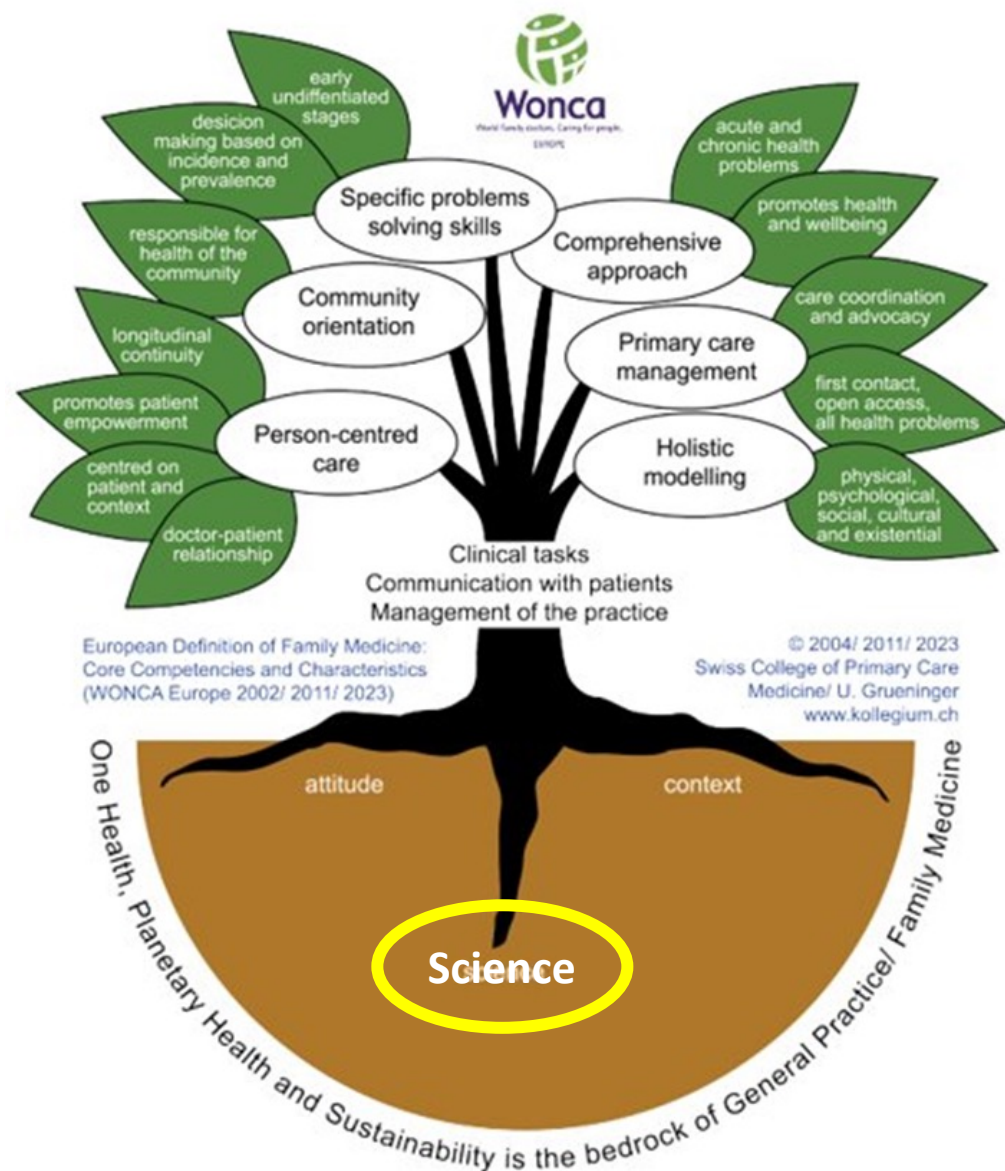


**TURUN  
YLIOPISTO**

**varha**

Varsinais-Suomen hyvinvointialue

Lääketieteellisen tutkimuksen  
päämäärä on ehkäistä  
ja hoitaa sairauksia  
sekä lievittää kärsimystä



THE WONCA TREE - AS PRODUCED BY THE SWISS COLLEGE OF PRIMARY CARE

(Revised 2011 and 2023)

## CORE VALUES AND PRINCIPLES OF NORDIC GENERAL PRACTICE/FAMILY MEDICINE



1. We promote continuity of doctor-patient relationships as a central organising principle.

The doctor-patient relationship is based on personal involvement and confidentiality. Continuity of care helps build mutual trust and enable high-quality person-centred care.

2. We provide timely diagnosis and avoid unnecessary tests and overtreatment. Disease prevention and health promotion are integrated into our daily activities.

We care for our patients throughout their lives, tending to them through disease and suffering while encouraging progress toward health. We help patients understand their own health - to confront and manage their limitations, improve and maintain their well-being.

Overexamination, overdiagnosis, and overtreatment can harm patients, consume resources and indirectly lead to harmful underdiagnosis and undertreatment elsewhere. When equally effective interventions are available, we choose those that cost less.

3. We prioritise those whose needs for healthcare are greatest.

We aim to minimise inequalities in how health services are provided. We organise our practices to devote the most time and effort to those whose needs for treatment and support are greatest.

4. We practice person-centred medicine, emphasising dialogue, context, and the best evidence available.

We engage professionally with our patients' current life situations, biographical stories, beliefs, worries, and hopes. This helps us to recognise the links between social factors and sickness, and to deepen our understanding of how life and life events leave their imprint on the human body. We promote patients' capacity to make use of their individual and communal resources.

To safeguard our long-term resilience as caregivers, we attend to our own well-being.

5. We remain committed to education, research, and quality development.

We engage actively in the training of our future colleagues. We implement and promote research that is suited to the knowledge needs of General Practice/ Family Medicine. We take a constructively critical view of new knowledge and approaches within our areas of specialisation.

6. We recognise that social strain, deprivation, and traumatic experiences increase people's susceptibility to disease, and we speak out on relevant issues.

Respect for human dignity is a prerequisite for healing and recovery.

We acknowledge that many circumstances contribute to health inequalities: childhood experiences, housing, education, social support, family income/ unemployment, community structures, access to health services, etc.

We recognise our duty to speak out publicly on specific factors that cause or worsen disease, increase inequality in health outcomes, or make resources less accessible to certain people.

7. We collaborate across professions and disciplines while also taking care not to blur the lines of responsibility.

We engage actively in developing and adapting effective ways to cooperate.



# TURUN YLIOPISTO

## YLEISLÄÄKETIEDE RESEARCH PROJECTS

### Treatment of Insomnia in Primary Care

**(TIP) Study 2023-**  
Päätutkijat Elina Bergman ja Ansa Rantanen

**Turku Senior Health Clinic (TSheC) Study 2020-**  
Päätutkija Laura Viikari (GER)



**Kielimentorointi-projekti 2019-**  
Päätutkija Tanja Eriksson



**PORTAAT Study 2014-**  
Päätutkija Päivi Korhonen

**HARMONICA Project 2005-**  
Päätutkija Päivi Korhonen

**KESÄLATU-tutkimus 2017-**  
Päätutkija Mikael Ekblad

**SePe Study 2019-**  
Päätutkija Pieta Sundqvist

**Heart Talk Study 2020-**  
Päätutkija FT Jenny Paananen

**Lieta Study 1998-**  
Päätutkija Raimo Isoaho

# Harjavallan Valtimo-projekti 2005-



PYLL-indeksi 1998–2002  
Potential years of life lost

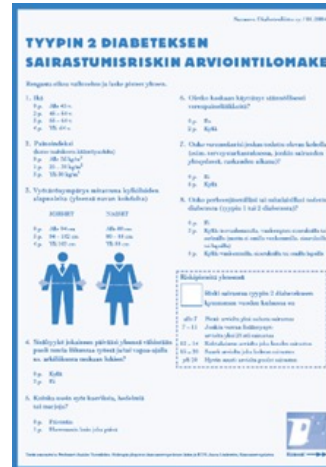
	Koko maa 	Harjavalta 	Kokemäki 	Nakkila 	Kiukainen 
<b>Valtimo- taudit</b>	759	1 006	639	561	500

# HARMONICA Project 2005-2008

Harjavalta Risk Monitoring for Cardiovascular disease

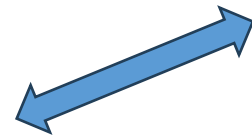
## Questionnaires

- sociodemographic factors
- physical activity
- dietary habits
- smoking
- alcohol use (AUDIT)
- Beck's Depression Inventory
- quality of life (EQ-5D, SF-36)
- sleep (ESS, Berlin, PSQI)
- erectile function (IIEF-5)



**The Care Register for Health Care**  
National Institute of Health and Welfare

**The Official Statistics of Finland**  
Statistics Finland



**Invited subjects N = 9348**  
Inhabitants 45–70 years of age



**Respondents n = 6728 (72%)**  
women 56 %, men 44 %

**Risk persons n = 4472**  
WC ≥80 cm in women, ≥94 cm in men  
FINDRISC ≥12  
BP ≥140/90 or antihypertensive medication  
History of gestational hypertension or diabetes  
Family history of myocardial infarction or stroke

**Nurses' appointment for risk persons n = 4126**  
Questionnaires  
OGTT, plasma lipids, WC, BMI  
BP, if ≥140/90, home BP monitoring  
Lifestyle recommendations



**Physician's appointment for high-risk persons**  
**n = 2773**  
Laboratory tests, ECG  
ABI in Harjavalta





# Metabolic Syndrome

## Glucose Homeostasis in Hypertensive Subjects

Päivi Korhonen, Pertti Aarnio, Tarja Saaresranta, Pekka Jaatinen, Ilkka Kantola

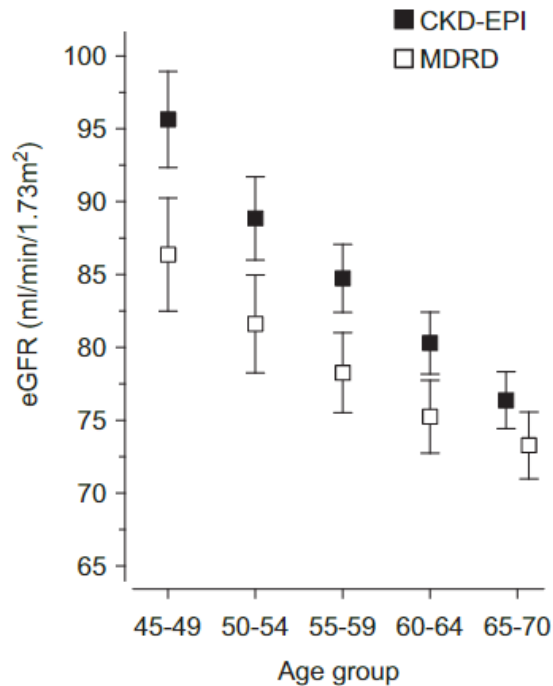
**Abstract**—The objective of this study was to estimate the prevalence of undiagnosed impaired glucose homeostasis in hypertensive subjects in the general population. The most reasonable screening strategy for glucose disorders was also assessed. We carried out an oral glucose tolerance test for 1106 hypertensive subjects aged 45 to 70 years without previously diagnosed diabetes or cardiovascular disease. Blood pressure, waist circumference, body mass index, and plasma lipids were also measured. Type 2 diabetes was found in 66 (6%) of the subjects, impaired glucose tolerance in 220 (20%), and impaired fasting glucose in 167 (15%). If we had carried out an oral glucose tolerance test only for those hypertensive subjects with a fasting plasma glucose  $\geq 5.6$  mmol/L, we would have missed  $\approx 40\%$  of the patients with impaired glucose tolerance. The International Diabetes Federation criteria of metabolic syndrome identified 96% of all cases of impaired glucose tolerance. The prevalence of central obesity was 22% of the men had a waist circumference  $\geq 80$  cm or  $\geq 94$  cm, respectively. Impaired glucose tolerance and central obesity are common in hypertensive subjects. An oral glucose tolerance test is an important screening tool for the hypertensive subjects with metabolic syndrome. Weight stabilization is an important

Ole ajan  
hermoilla!



ORIGINAL ARTICLE

### Estimating glomerular filtration rate in hypertensive subjects: Comparison of the Chronic Kidney Disease Epidemiology Collaboration (CKD-EPI) and Modification of Diet in Renal Disease (MDRD) Study equations



**Tutkimusta yleislääkärin potilailla!**

European Journal of Internal Medicine 23 (2012) 355–357

Contents lists available at SciVerse ScienceDirect

ELSEVIER

European Journal of Internal Medicine

journal homepage: [www.elsevier.com/locate/ejim](http://www.elsevier.com/locate/ejim)

Original article

### Time to change the glomerular filtration rate estimating formula in primary care?

Päivi E. Korhonen <sup>a,b,\*</sup>, Hannu Kautiainen <sup>c,d</sup>, Salme Järvenpää <sup>e</sup>, Sirkka-Liisa Kivelä <sup>f,g,h</sup>

<sup>a</sup> Central Satakunta Health Federation of Municipalities, Harjavalta, Finland  
<sup>b</sup> Institute of Clinical Medicine, Family Medicine, University of Turku, Turku, Finland  
<sup>c</sup> Unit of Family Practice, Finland Central Hospital, Jyväskylä, Finland  
<sup>d</sup> Unit of Primary Health Care, Kuopio University Hospital, Kuopio, Finland  
<sup>e</sup> Medcare Foundation, Finland  
<sup>f</sup> Unit of Family Medicine, University of Turku, Turku, Finland  
<sup>g</sup> Helsinki University of Health Services, Helsinki, Finland  
<sup>h</sup> Pori, Finland

**A B S T R A C T**

**Background:** The most commonly used equation for estimated glomerular filtration rate (eGFR) is nowadays the four-variable Modification of Diet in Renal Disease (MDRD) equation. This formula was derived from patients with non-diabetic chronic kidney disease (CKD) with mean GFR 40 ml/min.

**Objective:** We compared the MDRD study equation and the recently developed Chronic Kidney Disease Epidemiology Collaboration (CKD-EPI) equation by applying the two formulas in 1747 middle-aged cardiovascular risk persons in primary care.

**Results:** The prevalence of renal insufficiency defined as eGFR < 60 ml/min was 6.7% (95% CI 5.6–8.0) according to the MDRD formula, and 3.6% (95% CI 2.8–4.6) according to the CKD-EPI formula. The subjects who were classified as having CKD according to the MDRD equation, but no-CKD according to the CKD-EPI formula, were mostly women (86%) and slightly younger than the subjects having CKD according to both formulas.

**Conclusion:** The characteristics of the subjects commonly treated in primary care resemble more closely the population from which the CKD-EPI than the MDRD study equation was derived from. Thus, we suppose that in general practice, the CKD-EPI equation is more suitable for estimating renal function than the MDRD equation.

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## Original Article

# The shorter the person, the higher the blood pressure: a birth cohort study

Päivi E. Korhonen<sup>a</sup>, Hannu Kautiainen<sup>b,c,e</sup>, and Johan G. Eriksson<sup>b,c,d</sup>

**Objective:** Short adult stature is known to be associated with increased cardiovascular morbidity and mortality, but the underlying explanatory mechanisms remain largely unknown. The purpose of the current study was to evaluate the relationship between height and blood pressure (BP), a major determinant of cardiovascular disease (CVD).

**Methods:** We performed BP measurements including 24-h ambulatory BP measurements in 534 participants (mean age  $61 \pm 3$  years, 51.3% women) from the Helsinki Birth Cohort Study. None of the study participants had medication affecting vasculature or BP. We assessed the influence of height on CVD risk factors with a standardized z-score representing the difference from the mean value for the whole study cohort.

**Results:** Daytime SBP, pulse pressure, and mean arterial pressure showed significant inverse associations with height (adjusted for age, leisure-time physical activity, body fat percentage, and smoking). Height was by itself a strong determinant of pulse pressure independently of BMI. In addition, total cholesterol, triglycerides, and apolipoprotein B concentrations decreased with increasing height.

**Conclusion:** Shorter individuals have higher BP levels than taller individuals. This may at least partly explain the inverse association between height and CVD. In normal weight and slightly overweight individuals, the relationship between BP and height is independent of BMI and adiposity.

**Keywords:** blood pressure, BMI, cardiovascular risk

associations have also been reported [1–16]. In these previous studies, height has been grouped into sex-specific categories regardless of ethnicity. For example, in Japanese and Danish studies, the shortest height category in men was less than 158 cm and less than 170 cm, respectively [1, 2]. Thus, comparing the results of these previous studies is impossible.

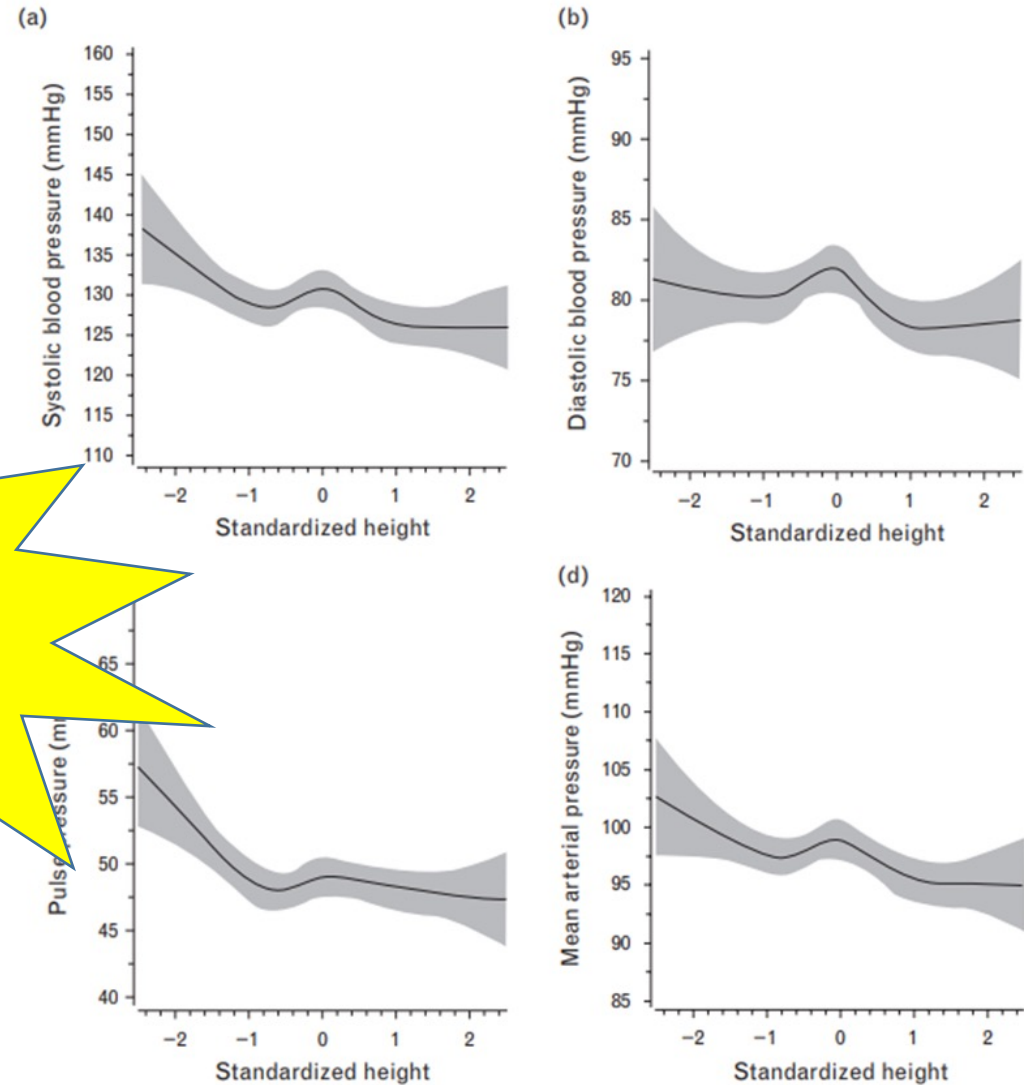
The mechanisms which lead to atherosclerosis are a major determinant of CVD.

represents a major determinant of CVD risk. In antihypertensive treatment, which a subjective measure of pulse pressure (PP) is a major determinant of CVD risk.

In these studies, conventional BP measurements were taken at one time point.

We had the opportunity to assess the relationship between adult height and BP in participants who were not on vasoactive medication. BP was measured as conventional brachial BP and by 24-h ambulatory BP monitoring (ABPM) with adjustment for several established CVD risk factors. As height is normally distributed in the general population, we assessed the influence of height on CVD risk factors with a standardized z-score representing the difference from the mean value for the whole cohort. Because shorter individuals have smaller lumen diameter of arteries [19–21], we hypothesized that according to the law of Poiseuille, they

Yhteistyöllä  
enemmän!



## Research: Epidemiology

### Adult height and glucose to importance of body mass in

S. K. J. Rehunen<sup>1,2</sup>, H. Kautiainen<sup>3,4,5</sup>, J. C.

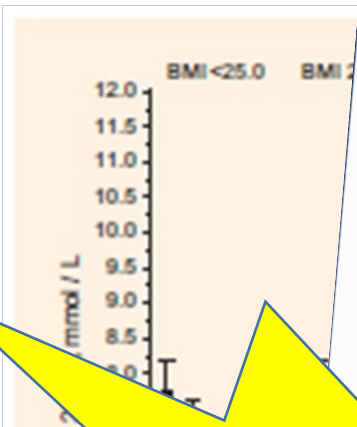


FIGURE 2 Age-adjusted mean 2-h PG of BMI group and BMI group. Error bars represent standard deviation.

**SIMO REHUNEN**  
yleislaaketieteen erikoislaakari  
Rauman terveyskeskus

**JOHAN ERIKSSON**  
yleislaaketieteen ja sisätautien  
erikoislaakari  
yleislaaketieteen professori  
Helsingin yliopisto

**PÄIVI KORHONEN**  
yleislaaketieteen ja sisätautien  
erikoislaakari  
yleislaaketieteen professori  
Turun yliopisto

## Glukoosirasituskokeesta voidaan hyvin luopua

Lääkärilehden 36/2017 pääkirjoituksessa sisätautien erikoislääkärit Tuula Pienimäki ja Juha Saltevo pohtivat, voisiko yhden tunnin glukoosirasituksella seuloa diabeteksen riskiä (1). Diabeteksen Käypä hoito -suosituksessa suuren riskin potilaille esitetään kahden tunnin glukoosirasituskoetta, koska pelkällä plasman glukoosipitoisuuden paastoarvon mittauksella tai HbA<sub>1c</sub>-arvolla löydetään vain osa diabetes-tapauksista (2).

Esitämme vastikään julkaistussa artikkelissamme (3) harkittavaksi päivävastusta eli luopumista koko glukoosirasituskokeesta. Tutkimme painoindeksin (BMI) suhdetta glukoosirasitukseen; tutkimuksessa oli mukana 2 659 tervettä keski-ikäistä länsisuomalais- ja havaitimme, että pitkällä oli matalampi yhden tunnin sokeriarvo kuin lyhyillä aina 25 kg/m<sup>2</sup> asti, mutta vaikeasti lihavilla (BMI > 35 kg/m<sup>2</sup>) pituudella ei ollut vaikutusta sokeriarvoon. Lisäksi osoitimme, että mitä suurempi BMI, sitä suurempi oli kahden tunnin sokeriarvo. Löydöstemme perusteella glukoosirasituskoe on joko jatkossa vakioitava pituuden ja BMI:n suhteen tai sen käyttö on lopetettava etenkin vaikeasti lihavilta, jotka ovat jo lähtökohtaisesti "glukoosi-intoleranteja" (4).

Glukoosirasituskokeen käyttöä on perusteltu sen ennustenyhtälöllä kuolleisuuteen (5). Koska tuloksia ei ole vakioitu pituudella, ennustenyhtälön luotettavuus on kyseenalaistettava. On vaara, että glukoosirasituskokeen perusteella lyhyemmät henkilöt yli diagnosoidaan heikentyneitä sokerinsietoa tai tyypin 2 diabetesta sairastaviksi ilman tietoa, että diagnoosilla olisi vaikutusta komplikaatioiden kehittymiseen.

Terveystieteellisesti tarvitaan tietoa siitä, onko potilaan terveysongelma julkisten varojen panostuksen arvoinen. Sen sijaan, että jatkaisimme glukoosirasituskokeen rutiinimaista käyttöä tai vieläpä alkaisimme investoida ja altistaa ihmisiä mahdollisesti väärin päätelmiin johtavaan seulontaan, panostus tulee tehdä terveysvaikuttavammin, esimerkiksi ehkäisevästi eli ohjaamalla terveellisiin elintapoihin (6).

5 The DECODE Study Group. Glucose tolerance and cardiovascular mortality: comparison of fasting and 2-hour diagnostic criteria. *Arch Intern Med* 2001;161:397-405.  
6 Tuomilehto J, Lindström J, Eriksson J ym. Prevention of type 2 diabetes mellitus by changes in lifestyle among subjects with impaired glucose tolerance. *N Engl J Med* 2001;344:1343-50.

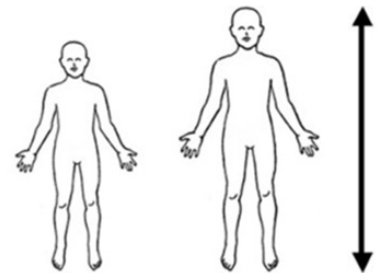
Uskalla kertoa!



... - The  
hour plasma

... en<sup>d,e</sup>, Johan G. Eriksson<sup>d,f,g</sup>,

BMI 25 kg/m<sup>2</sup>



175 cm  
77 kg

200 cm  
101 kg

1,9 m<sup>2</sup>

2,4 m<sup>2</sup>



Original article

## Renal hyperfiltration revisited—Role of the individual body surface area on mortality

Päivi E. Korhonen<sup>a,\*</sup>, Mikael O. Ekblad<sup>a</sup>, Hannu Kautiainen<sup>b,c</sup>, Satu Mäkelä<sup>d</sup>

<sup>a</sup> Department of General Practice, Turku University and Turku University Hospital, 20014 Turku, Finland

<sup>b</sup> Folkhälsan Research Center, 00250 Helsinki, Finland

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<sup>d</sup> Department of Internal Medicine, Tampere University Hospital, 33520 Tampere, Finland

### ARTICLE INFO

#### Keywords:

Glomerular filtration rate  
Renal hyperfiltration  
Body surface area  
Primary care  
Prevention  
Mortality

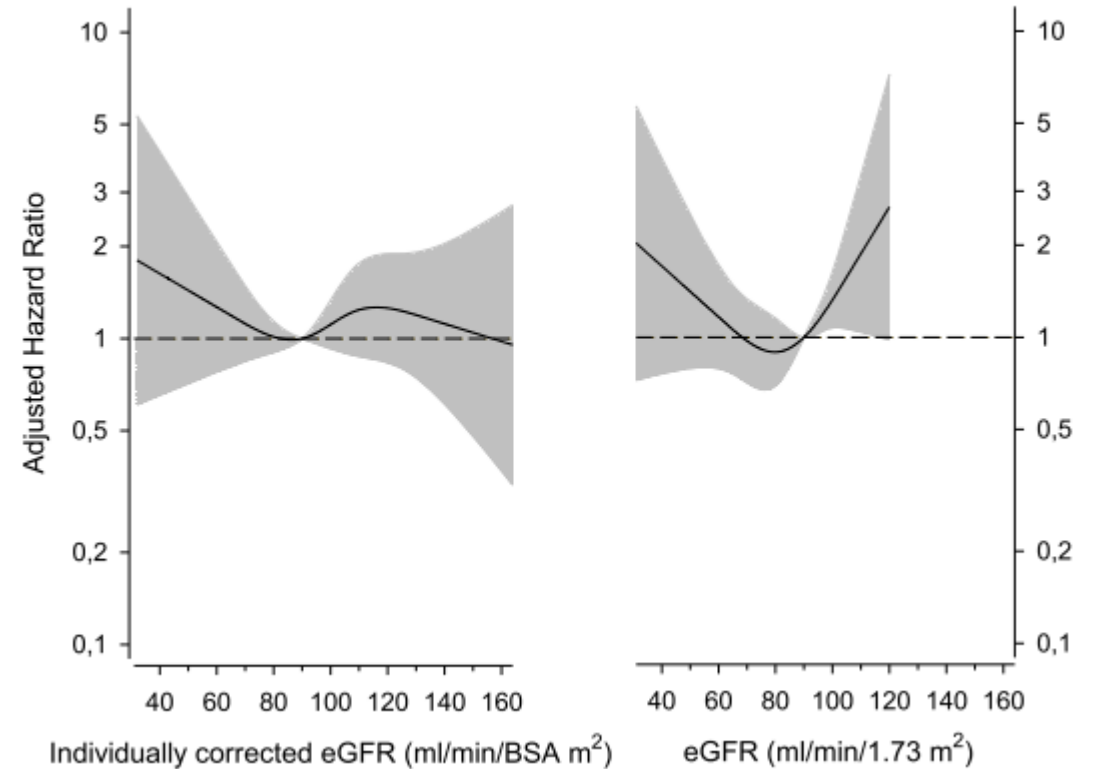
### ABSTRACT

**Background:** Higher than normal estimated glomerular filtration rate (eGFR), i.e. renal hyperfiltration (RHF), has been associated with mortality.

**Methods:** A population-based screening program in Finland identified 1747 apparently healthy middle-aged cardiovascular risk subjects in 2005–2007. GFR was estimated with the creatinine-based Chronic Kidney Disease Epidemiology Collaboration (CKD-EPI) equation indexed for 1.73 m<sup>2</sup> and for the actual body surface area (BSA) of the subjects. This individually corrected eGFR was calculated as  $eGFR (ml/min/BSA m^2) = eGFR (ml/min/1.73 m^2) \times (BSA/1.73)$ . BSA was calculated by the Mosteller formula. RHF was defined as eGFR of more than 1.96 SD above the mean eGFR of healthy individuals. All-cause mortality was obtained from the national registry.

**Results:** The higher the eGFR, the greater was the discrepancy between the two GFR estimating equations. During the 14 years of follow-up, 230 subjects died. There were no differences in mortality rates between the categories of individually corrected eGFR ( $p = 0.86$ ) when adjusted for age, sex, body mass index, systolic BP, total cholesterol, new diabetes, current smoking, and alcohol use. The highest eGFR category was associated with increased standardized mortality rate (SMR) when CKD-EPI formula indexed for 1.73 m<sup>2</sup> was used, but SMR was at the population level when individually corrected eGFR was applied.

**Conclusions:** Higher than normal eGFR calculated by the creatinine-based CKD-EPI equation is associated with all-cause mortality when indexed to 1.73 m<sup>2</sup>, but not when indexed to actual BSA of a person. This challenges the current perception of the harmfulness of RHF in apparently healthy individuals.



## The feasibility and outcome of a community-based primary prevention program for cardiovascular disease in the 21st century

Susanna M. Kuneinen<sup>a,b</sup>, Johan G. Eriksson<sup>c,d,e,f</sup>, Hannu Kautiainen<sup>c,g</sup>, Mikael O. Ekblad<sup>a</sup> and Päivi E. Korhonen<sup>a,b</sup>

<sup>a</sup>Department of General Practice, Turku University and Turku University Hospital, Turku, Finland; <sup>b</sup>Central Satakunta Health Federation of Municipalities, Harjavalta, Finland; <sup>c</sup>Folkhälsan Research Center, Helsinki, Finland; <sup>d</sup>Department of General Practice and Primary Health Care, University of Helsinki and Helsinki University Hospital, Helsinki, Finland; <sup>e</sup>Department of Obstetrics and Gynecology, Yong Loo Lin School of Medicine, National University of Singapore, Singapore, Singapore; <sup>f</sup>Agency for Science, Technology and Research (A\*STAR), Singapore Institute for Clinical Sciences (SICS), Singapore, Singapore; <sup>g</sup>Unit of Primary Health Care, Kuopio University Hospital, Kuopio, Finland

### ABSTRACT

**Objective:** There is no evidence that systematic screening and risk factor modification in an unselected, asymptomatic population will reduce cardiovascular disease (CVD) mortality. This study aimed to evaluate the effectiveness of a primary prevention program in a community during a 13-year follow-up.

**Design:** A risk factor survey was sent, followed by a nurse-led intervention for participants with at least one CVD risk factor, and a general practitioner-led intervention for high-risk persons. Screening and interventions were performed over 13 years.

**Setting:** A public health care centre in the town of Turku, Finland.

**Subjects:** All home-dwelling 45–70-year old inhabitants of Turku, Finland.

**Main outcome measures:** All-cause and CVD mortality.

**Results:** Altogether 74% (2121/2856) inhabitants responded to the survey. A total of 1465 individuals (52% of the invited) received an appointment with a nurse, followed by an appointment with a general practitioner. During the follow-up, 370 persons died. Mortality was significantly lower in the intervention group compared to the participants'. In subjects who received the intervention, the adjusted hazard ratio for all-cause mortality was 0.44 (95% CI: 0.28–0.70) compared to subjects who did not receive the intervention.

**Conclusions:** Reducing mortality is possible in a primary care setting by raising awareness in the community with screening, by targeted lifestyle counselling and evidence-based preventive medication for persons at high risk for CVD. Subjects not willing to participate in health surveys have the worst prognosis.

### HISTORY

17 November 2020

25 January 2021

Tee vertailuja!

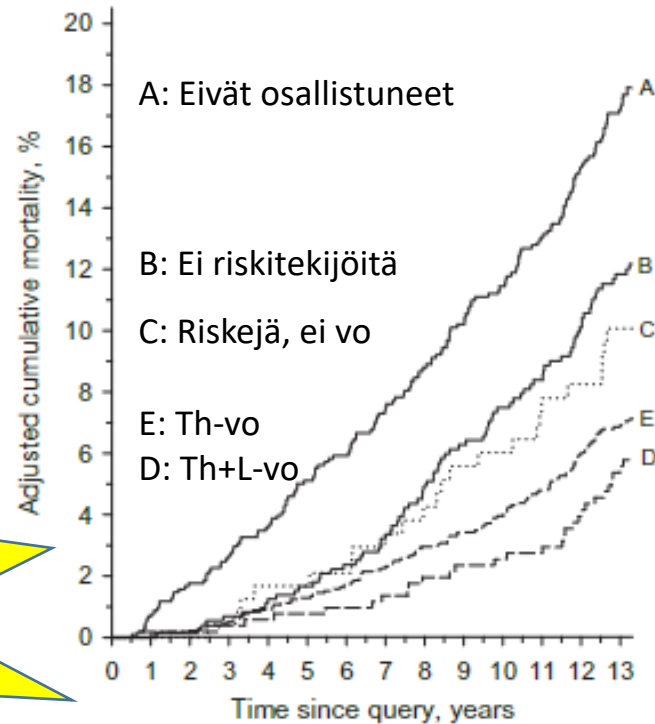
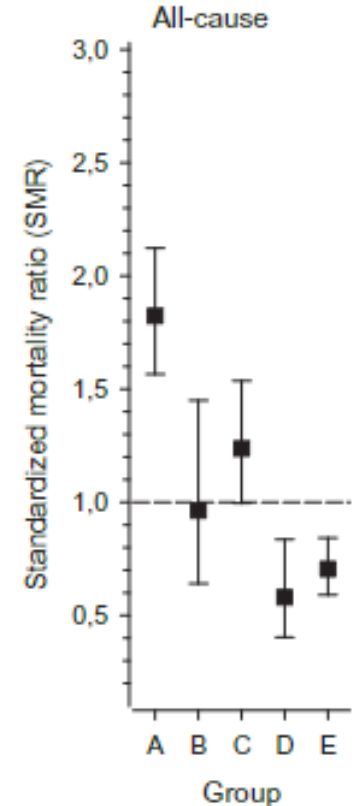


Figure 2. Cumulative all-cause mortality curves adjusted for age and gender.





# HELSINGIN SANOMAT

Perjantaina 10. maaliskuuta 2023 Viikko 10. N:o 67 (44523). Irttonumero 4,90 €, kotiin tilattuna alk. 1,55 €/pv (12 kk:n jatkuva tilaus). 84 sivua



## Sdp: Kaikille säännölliset terveystarkastukset

**Puolueet** | Alimman tuloluokan terveyden parantaminen toisi 1,9 miljardin säästöt, Sdp perustelee ehdotustaan.

Nina Törnudd STT

**JOKAINEN** täysi-ikäinen suomalainen pitäisi kutsua 2–5 vuoden väliajoin vapaaehtoiseen terveystarkastukseen, ehdottaa Sdp. Siinä käytäisiin läpi tervey-

dentila ja riskitekijät. ”Hyvinvointipysäkkiksi” nimitettyjen tarkastusten esikuvana olisi lasten terveyttä edistävä neuvolotoiminta.

Tarkastukset olisivat osa kansallista hyvinvointiohjelmaa, jolla parannettaisiin varsinkin pienituloisimpien ihmisten terveyttä.

Parantamalla erityisesti alimman tuloluokan ihmisten terveyttä olisi Sdp:n teettämien laskelmien mukaan mahdollista saada 1,9 miljardin euron säästöt kahdessa vaalikaudessa. Tähän päästäisiin, jos alimman tuloviihdenneksen ihmiset saataisiin huolehtimaan terveydestään

keskimäärin yhtä hyvin kuin toiseksi alimman tuloluokkaan kuuluvat.

”Vielä suurempi vaikutus olisi, mikäli saisimme kaikki tuloluokat huolehtimaan terveydestään yhtä hyvin kuin parhaiten toimeentuleva viidennes keskimäärin, ja tätä Sdp tavoittelee”, visioi kansanedustaja **Antti Rinne** (sd) tiedotteessa.

Laskelmat säästöistä on tehnyt konsulttiyhtiö FCG Finnish Consulting Group. Yhtiön mukaan nettovaikutus julkiseen talouteen olisi 10,5 miljardia euroa, jos keskimääräinen sairastavuus saataisiin vähennettyä samalle

tasolle kuin ylimmässä tuloluokassa.

Sdp toteaa, että sosioekonomisen asema ja terveydentila ovat selvästi yhteydessä toisiinsa. Ylimpään tuloluokkaan kuuluvat ihmiset ovat keskimäärin terveempiä ja elävät pidempään, kun taas alimpaan tuloviihdenneksen kuuluvien terveys on keskimäärin kaikkein heikoin, ja he myös käyttävät vähiten terveyspalveluita.

**HYVINVOINTIOHJELMAN** tavoite on hakea vaikuttavia keinoja edistää ihmisten hyvinvointia, kaventaa terveyseroja ja ennalta-

ehkäistä sairauksien syntyä ja syrjäytymistä, hilliten samalla niistä syntyviä kustannuksia.

Terveystarkastuksia tehtäisiin kahden vuoden välein riskiryhmien jäsenille, alle 25-vuotiaille ja juuri eläköityneille. Muille kutsu tarkastukseen tulisi 3–5 vuoden välein. Tarvittaessa kävijät ohjattaisiin jatkotutkimuksiin ja muiden palveluiden piiriin, esimerkiksi liikunta- tai ravintoneuvontaan.

Ohjelmassaan Sdp laskee, että terveystarkastusten vuosikustannus olisi 116–305 miljoonaa euroa. Edullisimmillaan hintaan kuuluisi terveydenhoitajakäynti ja suppea laboratorioanalyysi.

”Moikka! Mun kuukausi huipentuu aina 10. päivä, kun silrrän Bonukset asiakasomistajien pankkitileille. Tänäpäni tilitin yli 35 miljoonaa euroa. Kurkkaa S-mobiilista, kuinka paljon bonuseuroja sun tilille tupsahti.”

- Eero, Osuuskaupan Bonustilittäjä







# HELSINGIN SANOMAT

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Yhteiskunnallinen keskustelu!

## Terveyspalvelut tulee varmistaa niitä eniten tarvitseville

Sdp ehdottaa kaikille aikuisille terveystarkastuksia 2–5 vuoden välein (HS 9.3.). Siinäpä talkoot!

Vuonna 2005 – jolloin hoitajapula ei vielä ollut – kutsuimme Harjavallan (tuolloin 7 700 asusta) kotona asuvat 45–70-vuotiaat ”Valtimo-projektiin”. Postitimme näille 3 000 henkilölle kyselyä, jonka 73 prosentilla palautti terveystarkastuksen. Jopa 92 prosentilla oli jokin krooninen sairaus, kuten sydän- ja verisuonitautien tai diabeteksen lisäksi, kun myös lievä vyörytys otettiin lukuun. Kaikki saivat terveydenhoitajalta elintapaneuvoja, ja erityisen riskin potilaat (50 prosenttia) päättivät vielä lääkärintarkastukseen.

Kun 13 vuoden kuluttua tarkastelimme kuolinsyyrekisteriä, oli terveystarkastukseen osallistuneiden riskihenkilöiden kuolleisuus pienempi kuin saman-

ikäisen suomalaisväestön vastaavana aikana. Mutta niiden, jotka eivät osallistuneet projektiin (25 prosenttia kutsutuista), kuolleisuus oli kaksinkertainen.

Pienen kunnan 45–70-vuotiaiden terveystarkastuksia teki päivittäin kaksi kokenutta terveydenhoitajaa ja yksi lääkäri vuoden ajan. Lisäksi tarvittiin projektisihteeri ja laboratorionäytteiden ottaja. Terveystarkastusten nykyisessä työvoimapulassa vastaavan projektin toteutus lienee mahdotonta, varsinkaan 2–5 vuoden välein. Jos terveystarkastuksia seuloaan, pitää varmistaa myös niiden hoito ja hoidon jatkuvuus.

Kaikille aikuisikäisille suunnattujen terveystarkastusten hyödyistä ei ole tutkimusnäyttöä. Sitä paitsi suurimmassa riskissä näyttävät olevan ne, jotka eivät terveystarkastuksiin osallistu.

Jos suomalaisten terveyseroja halutaan kaventaa realistisella tavalla, pitäisi terveyspalvelut varmistaa niitä eniten tarvitseville. Ikäihmiset, monisairaat, työttömät, vähäosaiset ja mielenterveyden ongelmista kärsivät jäävät liian usein vailla ammattilaisen apua. Vahvin tieteellinen näyttö perusterveydenhuollon toimintatavoista on potilas-lääkärisuhteen jatkuvuudesta.

Olen tismalleen samaa mieltä kuin kokenut lääkäri Timo Teinonen (HS Mielipide 12.3.): terveystarkastuksiin tarvitaan pikaisesti tuhat lääkärin virkaa lisää. Ja näille lähilääkäreille työtovereiksi hoitajia. Se on mahdollista, jos auttajille annetaan aikaa auttamistyöhön.

**Päivi Korhonen**  
lääkäri, Harjavalta  
yleislääketieteen professori,  
Turun yliopisto



## Relationship of non-melancholic and melancholic depressive symptoms with all-cause mortality: A prospective study in a primary care population

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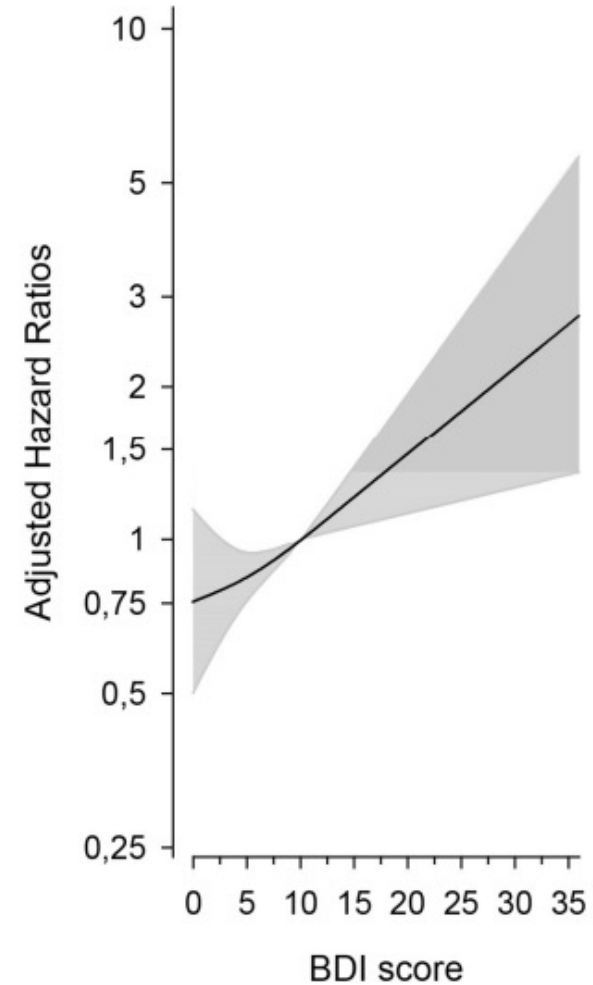
### ABSTRACT

**Objective:** To assess relationship of non-melancholic and melancholic subtypes of depressive symptoms with all-cause mortality among cardiovascular risk persons.

**Methods:** A population-based prospective study of 2522 Finnish middle-aged persons with elevated cardiovascular risk was conducted. Depressive symptoms were assessed by the Beck's Depression Inventory. Data on mortality were obtained from The Official Statistics of Finland after 11-year follow-up.

**Results:** At baseline, the prevalence of non-melancholic and melancholic depressive symptoms was 14.9% and 5.2%, respectively. During the mean follow-up time of 11 years, 8.1% ( $n = 164$ ) of those without, 13.9% ( $n = 52$ ) of those with non-melancholic, and 10.7% ( $n = 14$ ) of those with melancholic depressive symptoms died. Compared to non-depressive subjects, the hazard ratio for time to all-cause mortality was 1.67 (95% CI: 1.21–2.32,  $p = .002$ ) in non-melancholically depressive and 1.01 (95% CI: 0.56–1.83,  $p = .97$ ) in melancholically depressive subjects, when adjusted for age, gender, education, smoking, alcohol use, BMI, hypertension, dyslipidaemia, and glucose disorders. In comparison to the mortality rate in the general population throughout Finland over the same period, non-depressiveness was associated with a decreased standardized mortality rate.

**Conclusion:** Non-melancholic depressive symptoms seem to be associated with excess all-cause mortality. In clinical settings, recognition of non-melancholic depressive symptoms should be emphasised.



**Fig. 1.** Adjusted (age, gender, education, current smoking, alcohol use, BMI, hypertension (systolic BP  $\geq 140$  mmHg or diastolic BP  $\geq 90$  mmHg, or anti-hypertensive medication), dyslipidaemia (total cholesterol  $\geq 5.0$  mmol/l or medication for lipid disorders), and glucose disorders) hazard ratios for all-cause mortality according to Beck's Depression Inventory (BDI) summary score. Hazard ratios were derived from a 3-knot restricted cubic flexible parametric survival models, with BDI score 10 as the reference value. The 95% confidence intervals are denoted by the grey area.

## ARTICLE OPEN



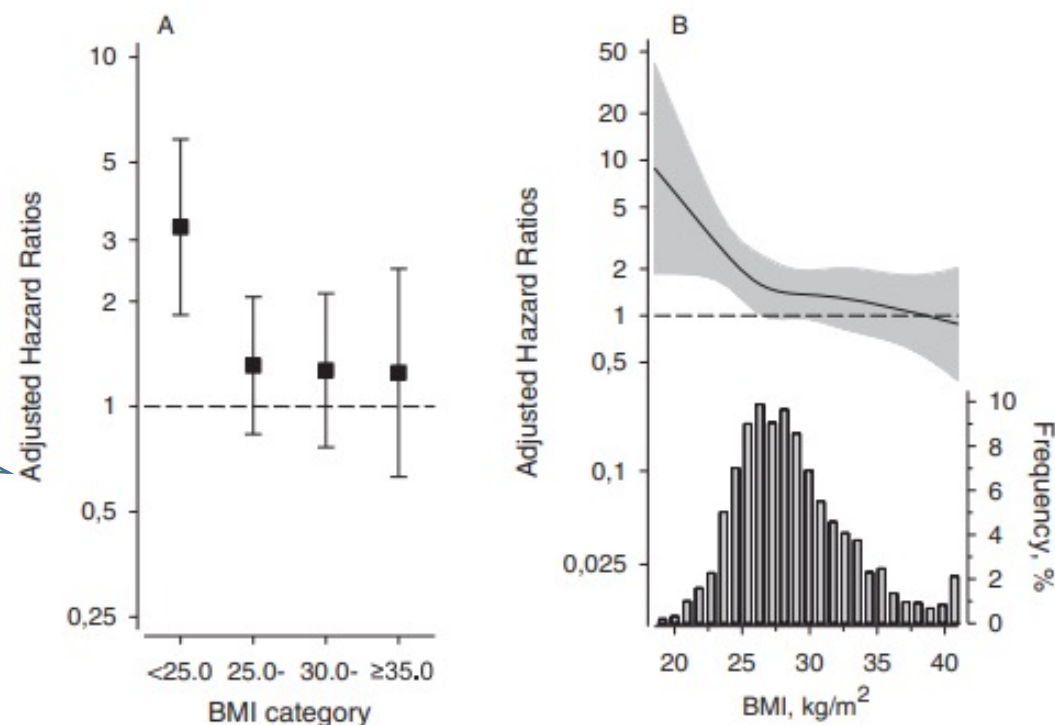
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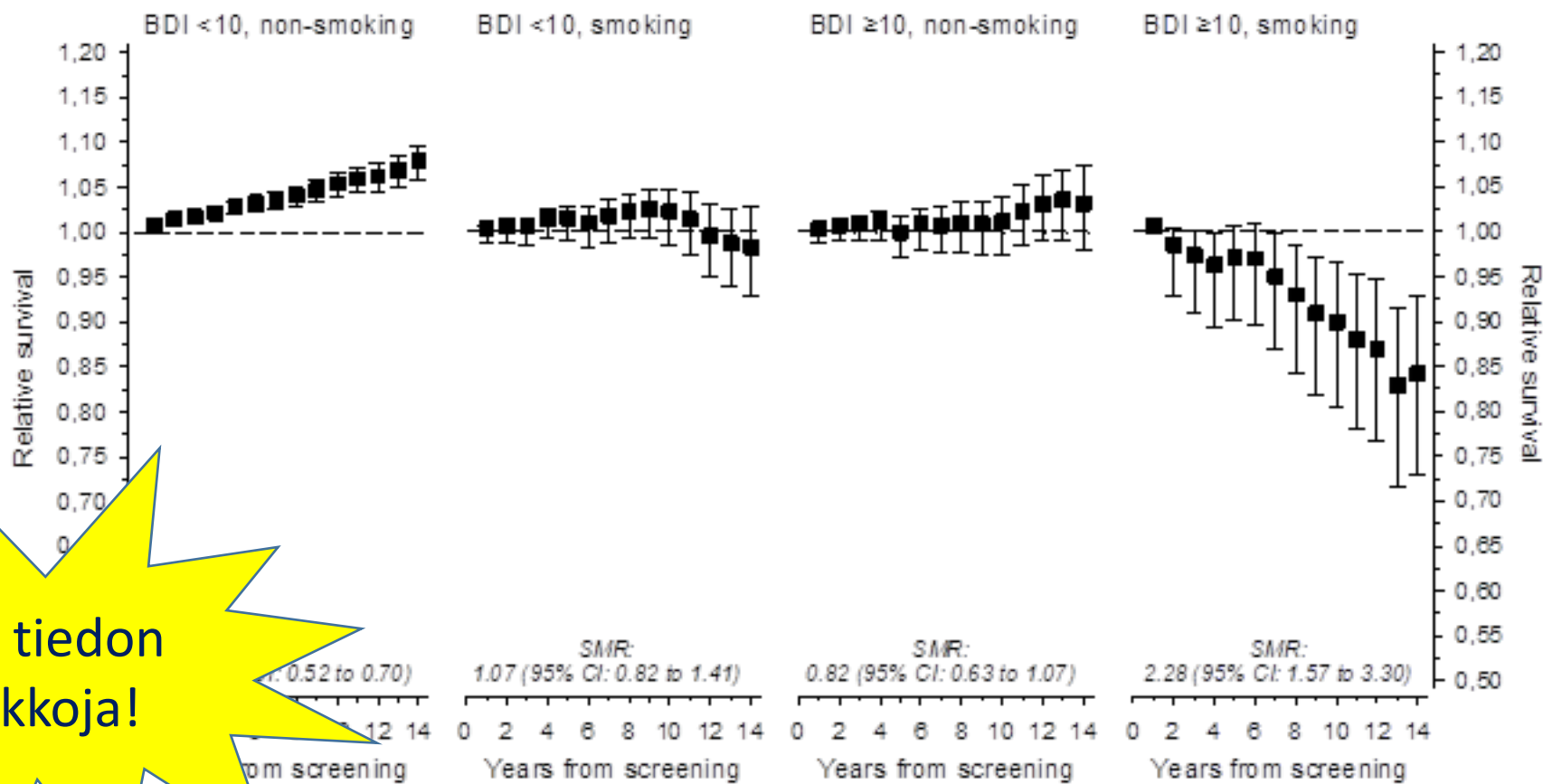
Ansa Talvikki Rantanen<sup>1</sup>, Hannu Kautiainen<sup>2,3</sup> and Päivi Elina Korhonen<sup>1</sup>

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Laajenna  
näkökulmiasi!



**Fig. 3** Adjusted hazard ratios for all-cause mortality between subjects with and without increased depressive symptoms according to body mass index (BMI). **A** BMI as a categorized variable, **B** as a continuous variable. Distribution of BMI is shown in **(B)**. The continuous model **(B)** was derived from a 4-knots restricted cubic splines Cox regression model. Increased depressive symptoms, Beck's Depression Inventory (BDI) score  $\geq 10$ ; not increased depressive symptoms, BDI  $< 10$ . The models were adjusted for age, sex, education years, current smoking, Alcohol Use Disorders Identification Test score, leisure-time physical activity, total cholesterol, systolic blood pressure, and glucose disorders. Whiskers and grey area represent 95% confidence intervals.



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