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Improving Knowledge of the Patterns and Clinical Implications of Frequent Symptoms and Illnesses Found In Primary Care

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Introduction

Primary care epidemiology is needed to describe the incidence, prevalence, severity, and natural history (duration, remission, and recurrence) of symptoms and signs, as well as defined illnesses, that occur in the community; how these problems differ among different groups within the community (e.g., by age, gender, socioeconomic status, ethnicity, and place of residence); and how these problems cluster or relate to one another. The need for, and opportunities available, to consider the complex genetic, physical, psychological, social, and cultural influences on the onset and natural history of common symptoms and illnesses is highlighted by the long-term continuous nature of primary care, which often extends to entire families. The development of successful evidence-based interventions, such as cough pamphlets that minimise re-consultation rates [1], can be aided by understanding the natural course of symptoms. Deeper knowledge of the psychosocial aspects linked to attitudes about back pain and its primary care management has resulted in public health education campaigns that reduce work-related absenteeism and improve beliefs, [2] with effects that last three years [3].

Description

Most symptoms experienced in the community are managed without seeking medical help (the so-called symptom iceberg phenomenon), according to studies [4]. For different conditions, the proportion of visible (presented to health care services) and a submerged (non-presented) symptom varies. Although this phenomena is commonly thought to be limited to minor, self-limiting health issues, mounting evidence suggests that substantial submerged proportions also occur for major illness symptoms like as angina [5, 6] chronic back pain [7], and asthma [8]. Long-term repercussions could be significant [6], but further research is needed utilising a number of outcome indicators such as comorbidity, mortality, quality of life, economic expenditures, and use of health care services for other illnesses. This research will identify instances in which earlier involvement may be beneficial, as well as situations in which the medical profession should stay out of [9, 10]. For example, the introduction of genetic tests in primary care without appropriate epidemiological evaluation may lead to inappropriate 'medicalization,' either because 'illness' is diagnosed decades before symptoms appear (e.g. Huntingdon's chorea) or because genes are incompletely penetrant (e.g. only 1% of homozygotes develop frank hemochromatosis) [11].

The predictive usefulness of different symptoms or clusters of symptoms seen in the population, particularly for serious disease, is currently unknown. Positive predictive values of individual symptoms are expected to be quite low, given the great frequency of various symptoms and the low incidence of serious disease in the general population, especially among younger people. Rectal bleeding, for example, is seldom linked to bowel cancer [12] or headaches to a brain tumour [13]. If low predictive values like these may be improved by looking at clusters of symptoms in conjunction with individual and family variables including age, gender, family history, and comorbidity, more research is needed. Referral recommendations, such as those for probable cancer [14], are likely to remain ineffective without this information.

Providing information that will allow primary care services to be used more efficiently

Governments all throughout the world are working to create health-care systems that are safe, patient-centered, prompt, efficient, and equitable. Primary care plays a central referral (gatekeeping) function in various nations, such as the Netherlands, Spain, Denmark, Norway, and the United Kingdom (UK). Other countries, including as France, Germany, India, and the United States, give unfettered (parallel) access to primary and secondary care. The amount to which primary care serves as an entry point into the health-care system, as well as its comprehensiveness, community/population emphasis, and degree of centralization and computerization, all influence the scope and purpose of primary care epidemiology. Some of the issues that primary care epidemiology can address are system-specific, such as who is utilising health care services, when, and why. Others will be broader, such as what is the predictive value of (typically undifferentiated) symptoms presented to health care providers (whether they are a nurse, community pharmacist, general practitioner, or hospital specialist) for the first time? Primary care systems with patient registration lists are far more able to look at issues at the community level than those without, because the registration lists supply the essential denominators (at-risk groups) for research.

Conclusion

Primary care services are in high demand regardless of the health-care system. In the United Kingdom, for example, more than 250 million consultations with a general practitioner are anticipated to take place each year41, with hundreds of millions more with other members of the primary health care team. Small variations in demand (a few percentage points) can considerably relieve or strain the system with such enormous numbers. Primary care epidemiology not only describes what proportion of people with specific symptoms or clusters of symptoms seek health care, but it also shows how that usage varies depending on the characteristics of individuals and their symptoms, as well as the availability of various health care services.

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Conflict of Interest

None

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