

EDITORS' NOTE

A Typical Day in the Family Medicine Office

Clinical medicine and prevention in primary care practice are the themes of this issue, wherein we present new research with practical information on common subjects: cardiovascular outcomes with specific medications, vitamin D, calcium supplements, vaginitis, smoking, stroke and allergies, headaches and depression, hepatitis C, skin infections, general prevention examinations, sore throat, laboratory results notification, and patient medication lists. Looks like a typical day in the family medicine office! Although most of the authors are from university family medicine departments and residency programs,¹⁻¹⁰ we also welcome contributions with implications for primary care from others outside the field.¹¹⁻¹³

We have 2 evidence-based clinical review articles. Ong¹¹ examined many randomized trials and has determined that angiotensin-converting enzyme inhibitors and angiotensin receptor blockers are not uniquely able to improve **cardiovascular outcomes** over and beyond their effects on blood pressure. This is important. One of the major bad outcomes that we try to prevent by controlling blood pressure is cardiovascular disease. In choosing among medicines for blood pressure control, we often consider their other known effects and the other risks patients may have. This review suggests that drugs from either category should not be selected solely based on potential excess benefit on cardiovascular disease, but if they are otherwise a good option and actually do control the blood pressure well.

Kulie et al¹ reviewed the current literature about **vitamin D**. These reviews are time consuming, and we appreciate the authors' efforts. I recently read in a lay newspaper that maybe, finally, we will find that some vitamin (ie, vitamin D) is worth taking regularly to prevent disease. Folate, of course, already fits that category for many; calcium, though not a vitamin, is a similar supplement, with evidence to support its use. However, it is often easier to detect what blood levels lead to obvious nutritional deficiency syndromes than to determine the

ideal blood levels to prevent some entity that might be many years off and be impacted only by subtle deficiencies over a long time. We certainly still have much to learn about vitamins. This review provides up-to-date information in several categories and reminds us that actual randomized controlled trials of efficacy of supplementation for vitamin D are few. In the meantime, I (MAB) have been checking vitamin D in a number of my patients, such as those with rheumatoid arthritis or those taking long-term steroids, or sometimes that patient with idiopathic chronic muscle aches, and finding that most everyone tested has had low levels. Some patients have reported symptomatic response to supplementation and some have not. I also routinely recommend that calcium supplementation be accompanied by vitamin D supplementation.

Turning to original research reports, Matheson et al² extend their previous work¹⁴ on the association between **stroke and allergic respiratory conditions**. We do not think that most physicians or patients have thought there would be such an association. This data builds on previous work by showing that actual positive allergy tests, not just reported allergic conditions, are associated with stroke. The authors present an excellent discussion of potential explanations for this finding. As yet, we do not know what we should do about this potential association.

Calcium creates confusion among patients. Many accept they should take calcium supplements, yet they worry: Why are we giving them calcium channel blockers when they are taking calcium? Does one negate the other? Having calcium in your coronaries is associated with higher rates of heart disease, so patients and their physicians sometimes wonder what we do know about the impact of calcium supplements. Bhatka et al¹² look at the progression of calcium scores in coronary arteries or aortic valves in women taking **calcium supplements** and thankfully find no relationship.

Practical information about common problems are addressed in 2 randomized trials completed by our university family medicine colleagues. Anderson et al⁴ find that historic information may be as

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good as doing wet preparation when determining the treatment for **vaginitis**, a thorny and time-consuming (in the case of the wet preparation) issue in our offices. More data from larger populations are needed, but this is a good start. In another interventional study using an electronic medical record, McCullough et al³ found that adding prompts for 2 questions related to smoking was associated with increased documentation of provider counseling for **smoking**. A next step will be demonstrating that such prompts actually lead to decreased smoking.

Marlowe et al⁷ find that presentation for **headache** in a family physician office is associated with depression. I (MAB) have always thought that patients presenting with head, abdominal, or back pain and no trauma have high rates of depression. The practical implication is that we should inquire about depression—not just with 1 or 2 questions, but with some probing.

National recommendations for a variety of diseases are conflicting across various recommending authorities, and family physician offices are where the rubber meets the road—what is actually done? Family physicians do not seem to shy away in these circumstances, and for **hepatitis C**, Leverence et al⁵ took into account their knowledge of the patient and the medications, as well as the recommendations to deal with this problem in their patient-centered clinical practice. Patient factors are often paramount but are commonly neglected or not well addressed in these national recommendations.

Crawford et al¹³ provides evidence that purulence is key with **skin infections**; purulence suggests susceptibility to clindamycin in skin infections at a much higher rate than those infections without purulence. Grover et al⁸ found high rates of screening and treatment for osteoporosis among older women who received a **general preventive examination** compared with those who did not. More evidence supporting the recommendation of a routine physical is needed to encourage completion of needed prevention items.

Tiemstra and Miranda⁶ found that non-group A streptococcal (GAS) infections were associated with **sore throat**, fever, and headaches, similar to GAS infections. Non-GAS infections also had more lymphadenopathy and exudates than those culture negative (presumed viral). We treat GAS not just for symptoms but for prevention of later complications of the infection, specifically rheumatic fever.

Because this would not apply to non-GAS infections, we need more data on the outcomes of treating non-GAS pharyngeal infections.

In our ongoing series of information helpful to the family physician office as a medical home, we have articles about **notification of laboratory test results** and **patient medication lists**. Grimes et al⁹ note that patients want to be notified about their laboratory test results; patients most commonly prefer a letter for notification of normal results and a telephone call from their physician for notification of abnormal results. Satisfaction with their current physician was associated with satisfaction of current method of notification. However, there was substantial variation in preferences; asking the patient which method is preferred could help but will be insufficient for all circumstances. Chae et al¹⁰ found that a medication card list given to patients was used by a minority, but those patients then felt more personal responsibility for their medications.

Yes, it is just another day in a family medicine office, but every day—every visit—is designed to prevent some type of negative outcome, whether physical, emotional, or financial. We hope the articles in this issue of the *Journal of the American Board of Family Medicine* make your office visits more effective and more rewarding for you and your patients.

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