

EDITORS' NOTE

Chronic Disease: Increasing Prevalence Yet Better Control

In this November-December 2008 issue of the *Journal of the American Board of Family Medicine (JABFM)*, we have collected multiple articles related to chronic diseases using methodologies from basic science, epidemiology, and clinical science. As Dr. Parchman¹ notes, the prevalence is so great and the complexity so high, that we would all like to quickly cut through the Gordian knot of chronic diseases. In this issue, to highlight the potential impact of chronic disease, Smoley et al² report some startlingly discouraging data about the amazingly high 75% prevalence of hypertension and prehypertension in a young, fit US military population.

Most of the articles within this issue report findings from primary care offices or population-based data sources, which are particularly useful for family physicians. These include articles on high blood pressure,^{2,3} kidney disease,^{4,5} heart disease,^{6,7} influences on obesity,^{8,9} adolescents' obesity,¹⁰ negative effects of obesity,¹¹ and diabetes.¹² Although our focus is on chronic disease, there is also good news in this issue—we feature articles highlighting just what can be done in family physician offices to improve chronic disease: both hypertension³ and diabetes¹² have become better controlled and interventions have improved the prevention of kidney disease.⁵

The articles related to obesity are particularly exciting. Obesity is increasingly prevalent, has many negative health and social consequences, and is an area of interest for the editorial team. Dr. Bowman has been involved in research to help create lifestyle changes for people with obesity,¹³ and over the past 3 years, several related papers on obesity have been published in the *JABFM*.¹⁴⁻¹⁹

Perhaps a favorite in the current issue is the article about grandparent/grandchild obesity.⁸ Possibly genetic, conceivably behavioral, or probably both, the rate of obesity in grandparents, Davis et al⁸ have now shown, is associated with obesity in

children even when both parents are normal weight. In another recent *JABFM* article, Young et al¹⁸ had found that maternal weight is associated with child overweight and also that parents often do not acknowledge that their child is overweight. As family physicians are more likely than other clinicians to see multiple generations of family, they are in a special position to observe these family patterns in practice, and this should cue us to action.

Family physicians may also be cued to action by learning Greenwood et al's⁹ 3 specific eating behavior questions that can be asked of their patients. The 3 behaviors are: eating full portions at restaurants; drinking sugar-containing beverages; and eating fewer fruits and vegetables. These are 3 relatively quick questions and potential areas for behavioral intervention counseling. Fagan et al¹⁰ further reports that most overweight and obese adolescents recognize their overweight status and would like to lose weight. We should help them to do so.

Mathew et al⁶ discuss both the basic science of what is known of the association of obesity itself—not its associated metabolic syndrome—with heart disease and also provides information on the unique associations of obesity with various cardiovascular diseases: heart failure, coronary artery disease, high blood pressure, arrhythmias, strokes, and difficulties in diagnosing heart disease in those with obesity. Mainous et al¹¹ note that elevated liver function tests should make us think of diabetes: this is probably related to steatosis, which is certainly a common problem in people with diabetes and obesity.

In another article with much substance, and much food for thought, Shani et al¹² find that good control of diabetes does not occur randomly but is more likely for patients of some physicians than others. First, we should note, overall control of diabetes improved over the time of the study. This is wonderful news. Second, "While some physicians had all their uncontrolled diabetic patients in 2001 become well controlled in 2003, others had none." Medical directors had a higher percentage

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of patients become well controlled. Another potentially important fact was that more money was spent for medications in the first year for those patients who became well controlled in the final study year than for those patients who did not become controlled. This may be because greater intensity of medical regimens early may help achieve control as well as signal to the patient that the physician believes excellent control is important, although patient factors also play a role. Patients from the poorly controlled group were also more likely than patients in the well controlled group to change to a different primary care physician (because of patients' choice or physician replacement). This suggests that continuity of physician-patient relationships are important to the level of diabetes control attained.

Newman⁷ shows us that stress testing in family medicine offices can have excellent negative predictive value. We also have 2 excellent associated case reports, both pertinent to diabetes: one about a malfunctioning insulin pen,²⁰ and one about a local trauma apparently inducing angiotension-converting enzyme inhibitor-associated edema.²¹

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