Preface

Common Symptoms in the Ambulatory Setting

Evaluating Common Symptoms Correctly: The Core of Internal Medicine

This issue is devoted to the evaluation and management of common symptoms seen in the ambulatory care setting. The art of medicine is recognizing when a symptom is a clue to an underlying disease and when a symptom is just a symptom. Recognizing when to aggressively work up a symptom, and when to patiently watch, is a crucial skill. The Choosing Wisely campaign was started by the American Board of Internal Medicine and has now been adopted by over 50 specialty societies. Consumer Reports has also become involved to share the campaign directly with patients. The goal of this campaign is to reduce unnecessary risk and costs in medical care. Initial evaluation of the most common symptoms patients present with is a key area of emphasis.

In a recent Mayo Clinic study, half of the 10 most common reasons for visiting a physician were for symptom-based visits (headache, back pain, joint/neck pain, skin problems, and upper respiratory symptoms). Skin problems were present in 42% of patients, joint symptoms in 33%, back problems in 22%, respiratory symptoms in 21%, and headache in 13%. All these symptoms are covered in this issue. Active symptoms motivate patients to seek advice and treatment more than management of chronic, symptomless conditions.

Appropriate use of the history and physical examination is crucial in evaluating patients’ symptoms. Most symptoms covered in this issue can be appropriately evaluated with appropriate history-taking and physical examination. Dizziness is an
excellent example of a symptom where the use of history and physical examination is far superior to any form of imaging in making a diagnosis. The article in this issue on dizziness emphasizes the nuances in history-taking and physical examination that leads to accurate diagnosis. Accurate and confident diagnosis can reduce diagnostic testing.

No symptom has evolved in the approach to diagnosis and treatment more than back pain. In the 1960s and 1970s, back imaging with radiography was done on everyone with back pain. If patients had sciatica and evidence of disk herniation on examination, then back surgery was done. If surgery was not done, in the 1970s, then chymopapain injections into the disk space were given. By the 1970s, anyone presenting with significant back pain was advised to do a week of solid bed rest. As the 1980s came, CT scanning became widely available, and with it, even more surgery and chymopapain injections, as so many patients had herniated disks on CT scanning. In the 1990s, realization of the prevalence of disk herniations present in the asymptomatic population came to light, and much needed outcome studies of surgical interventions of back pain were published. Bed rest recommendations shrunk to 3 days, and eventually to no mandatory bed rest. In the last decade, well-established guidelines have been published that outline an evidence-based approach to imaging and therapy. Studies have shown early mobilization and activity are the best approach.

Evaluating and treating common symptoms is our bread and butter. For many of the symptoms covered in this issue, there have been significant advances in our understanding of the pathophysiology of the symptoms, and the diseases that commonly cause the symptoms. There has also been increased knowledge of what works and what doesn’t work in treating these symptoms and the diseases that cause the symptoms. There is still a great deal to learn about why patients get certain symptoms, and what these symptoms mean. There is even an article on medically unexplained symptoms and how to appropriately care for the patients who suffer from multiple unexplained symptoms. To recognize rare symptoms is exciting in medicine, but to handle the common symptoms appropriately and skillfully is what defines our skillset.

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