Symptoms in general practice

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MANY studies have been carried out in the last two decades to measure morbidity in general practice, including the classic work reported by Logan and Cushion (1958). There has also been extensive research designed to measure 'work load' in general practice, which was comprehensively reviewed by Lees and Cooper (1963). By comparison, studies of symptomatology in this field *e.g.* Hull (1969), McFarlane and O'Connell (1969) have been uncommon.

Most of the current knowledge of symptomatology is derived from hospital experience. Three types of study, however, have been conducted in the community. The first depends on the identification of a specific symptom in the consulting room, and subsequently relating it to the diagnosis. Mestitz *et al* (1964) studied urinary symptoms in this way; Ward *et al* (1968) used the same technique to study low back pain and Partridge and Knox (1969) surveyed rheumatic complaints in general practice. More commonly the diagnosis in the consulting room is the starting point and is related retrospectively to the patients' symptoms. The College of General Practitioners (1960) survey of tonsillitis and the work of Stokoe (1969) on glandular fever are examples of this approach. The third method, widely used by epidemiologists, is to relate symptoms elicited by a questionnaire to objective physical findings *e.g.* Wood and Elwood (1966) in their studies of anaemia, and Holland *et al* (1966) in their work on respiratory symptoms.

In the medical care system in this country, the patient traditionally initiates contact with the doctor by presenting him with a symptom. This presenting symptom is the logical point at which to start prospective studies into the natural history of illness and of the diagnostic method in general practice, and retrospective studies into the human behaviour which leads to a consultation. The identification and classification of symptoms does, however, present formidable difficulties.

Only a proportion of consultations in general practice are provoked by a new illness experience. Many are undertaken for the follow up of established disease. In developing a system of symptom recording it is essential to separate these two types of consultation.

Miles (1969) pointed out that a verbatim record of the patients' initial complaint does not necessarily reflect the deviation from normal health which has prompted a consultation and, indeed, owing to the varied use of words, may lead to serious misinterpretation. In recording symptoms, it is therefore necessary to develop a method which allows the doctor to exercise judgment in recording the presenting symptom and this leads inevitably to some inter-observer variation. Many patients present a number

of symptoms and, ideally, detailed studies of symptomatology should allow for this and include facilities of weighting symptoms in order of importance.

Finally, it is necessary to aim at the greatest possible specificity in classification, whilst permitting a broader but meaningful grouping, where specific allocation of symptoms cannot be achieved. In so doing it is essential to reduce to a minimum the judgement required to allot a symptom to one category, rather than another.

This paper describes a method devised for recording symptoms in general practice. This is illustrated by describing the results obtained when the method was used in a general practice providing medical care for 4,500 patients for a period of one year.

Method

Three types of consultation were identified. The first type included all consultations at which the patient was instructed by the doctor to consult after an interval of time, to renew a prescription or certificate or 'if no better'. These were called 'doctor-initiated consultations'. All other consultations were regarded as patient initiated. They were divided into those concerned with a symptom or disease which had been presented to the doctor before, 'old patient-initiated consultations', and those which concerned a new symptom, 'new patient-initiated consultations'. A new symptom was defined as a symptom which had not been presented to any doctor in the previous 12 months and the doctors were obliged to ascertain this if necessary by asking the question, "Have you consulted any doctor about this symptom in the last year?" When the consultation was classified as a 'new patient-initiated consultation', the presenting symptom was recorded.

The presenting symptom was defined as the doctor's answer to the question, "To this patient, what is the most important deviation from normal health which has led him/her to consult?"

The system of classification was developed after a long period of symptom recording in general practice. Nine principle groupings were made, each of which was subdivided into from three to ten subgroups (Appendix). The first group 'Pregnancy, etc.' included mainly administrative requests in which there was no diagnostic activity, and the last group 'Special symptoms in the first five years of life' was provided to accommodate symptoms of early childhood which could not be readily classified elsewhere. In each of the other groups an anatomical or physiological classification was used and a miscellaneous subdivision 'Other' was employed to ensure that poorly defined symptoms were, where possible, allotted to the correct principle group.

A specially-designed record card bearing name, address, date of birth and occupation was inserted into the medical record envelope of each patient who consulted during the study. At every consultation, the date, type and place of consultation was recorded. The presenting symptom was recorded for every 'new patient-initiated consultation', one symptom only being permitted. At every consultation the principle diagnosis was recorded, the degree of certainty in making this diagnosis, and the action taken by the doctor in terms of examination, investigations, hospital referral, certification and prescribing. Diagnosis was coded according to the Royal College of General Practitioners modification of the International Classification of Diseases Index (1963). Coding was carried out, and all data were checked and extracted within 24 hours of recording.

Three doctors took part in the study and spent two months developing and testing the definitions employed and the method of symptom coding. This training included recording data on fictional case histories designed to detect errors in the interpretation of definitions, and a pilot trial lasting one week.

Results

Accuracy of recording. Methods were devised for checking the completeness of

recording in this study and have been described elsewhere, Morrell *et al* (1970). It was estimated that data were recorded at 99 per cent of the consultations taking place in the practice during the year.

Inter-doctor variation in the interpretation of definitions as tested by recording data on fictional case histories revealed differences in the interpretation of type of consultation in only one case history in forty. In recording some other variables, greater variation was detected and this was particularly apparent in recording diagnostic certainty.

Symptoms were coded by a research secretary and checked by one of the participating doctors. A one in eight sample of the symptoms recorded were recoded at the end of the year and a change in coding was considered necessary in 1.5 per cent of these records. This level of discrepancy was almost identical with that detected in the coding of diagnosis according to the Royal College of General Practitioners classification.

During the year 209 symptoms were allotted to the non-specific 'Other' subdivision of the principle symptom groups in the classification. In only one group 'Abnormal swellings' was this subdivision used to excess and this was due mainly to the failure to provide facilities for recording swellings of the skin.

Type of consultation. Of 21,098 consultations recorded in the practice in one year, 5,361 (25 per cent) were classified as 'new patient-initiated consultations'. The presenting symptom was recorded at 5,325 of these consultations and it is these symptoms which form the basis of this paper.

Symptoms recorded. The frequency distribution of the symptoms recorded during the year is given in the Appendix. With few exceptions, *e.g.* trauma, the proportion of symptoms presented by females was greater than the proportion of females in the practice (52 per cent). In addition to disturbance of menstrual function and bleeding from the genital tract, this discrepancy was particularly noted in 'Disturbances of function (psychological)', 'Changes of appearance', and certain specific symptoms, such as disturbances of bladder function, changes in balance and changes in energy.

Age and sex. The age and sex distribution of patients presenting new symptoms is compared in table I with the age and sex distribution of patients whose consultations

TABLE I

ANALYSIS BY AGE AND SEX OF THE PERCENTAGE OF CONSULTATIONS OF THREE TYPES

Type of consultation	*Age and sex groups*											
	0–4 years		*5–14 years*		*15–44 years*		*45–64 years*		*Over 65 years*		*Total*	
	M	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*
Patient-initiated old ..	*37.5*	*35.9*	*34.9*	*34.7*	*24.6*	*26.1*	*20.7*	*27.5*	*30.7*	*29.5*	*27.1*	*28.9*
Doctor-initiated ..	*31.7*	*35.3*	*28.0*	*30.6*	*43.8*	*44.3*	*59.5*	*50.6*	*55.6*	*56.7*	*47.2*	*46.0*
Patient-initiated new..	*30.8*	*28.8*	*37.1*	*34.7*	*31.6*	*29.6*	*19.8*	*21.8*	*13.7*	*13.8*	*25.8*	*25.1*
TOTAL	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*99.9*	*100.0*	*100.0*	*100.1*	*100.0*
No. of consultations	1,071	1,167	1,017	1,212	2,687	4,516	2,725	3,056	1,342	2,303	8,842	12,256

were classified as 'doctor initiated' or 'old patient initiated' in type. This demonstrates that new symptoms were presented at over 30 per cent of all consultations up to the age of 44 years, and formed a declining proportion of consultations with advancing age over 45 years.

New symptoms were presented by 2,865 patients during the year, 1,306 (45.6 per cent) by males and 1,559 (54.4 per cent) by females. The frequency distribution of new

consultations is illustrated in table II. There is little difference between the total numbers of males and females presenting one new symptom in the year, but more females than males presented two or more new symptoms, so that during the year, 3,062 symptoms were presented by females, compared with 2,263 by males. The difference between males and females was most marked in the age groups 15–44 years.

TABLE II

ANALYSIS OF THE PERCENTAGE OF MALES AND FEMALES IN DIFFERENT AGE GROUPS INITIATING ONE TO SIX NEW CONSULTATIONS DURING ONE YEAR

Number of new consultations	*Age and sex groups (per cent)*										*Number of patients*	
	0–4 years		*5–14 years*		*15–44 years*		*45–64 years*		*65+ years*			
	M	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*
One	*32.1*	*37.4*	*46.1*	*46.6*	*58.6*	*41.4*	*60.0*	*54.6*	*67.2*	*54.5*	718	725
Two	*32.9*	*33.6*	*31.4*	*24.0*	*23.8*	*27.0*	*25.7*	*27.4*	*20.2*	*30.5*	341	433
Three or four	*26.4*	*21.3*	*20.6*	*25.0*	*15.8*	*26.0*	*12.7*	*15.7*	*10.9*	*12.8*	215	332
Five or six	*8.6*	*7.8*	*2.0*	*4.3*	*1.8*	*5.6*	*1.5*	*2.3*	*1.7*	*2.1*	32	69
TOTAL	*100.0*	*100.1*	*100.1*	*99.9*	*100.0*	*100.0*	*99.9*	*100.0*	*100.0*	*99.9*		
Number of patients ..	140	155	204	208	505	626	338	383	119	187	1,306	1,559

Histograms have been prepared (figure 1) to illustrate the frequency of the ten most common symptoms presented in the year expressed as consultations per 1,000 patients at risk and analysed by age and sex. Three patterns of age and sex distribution are presented. Under the age of five years, the most common symptoms were disturbance of bowel function, cough and rashes. These became decreasingly common with increasing age. Pain was a rare presenting symptom under the age of five years. The second group of symptoms, pain in the throat, pain in the head, pain in the abdomen and spots, sores and ulcers, were most common in the age groups 5 to 24 years. Pain in the abdomen and head remained common in the older age groups. Pain in the back, pain in the chest and pain in the joints became increasingly common with increasing age up to 65 years. Little difference between the sexes in the frequency of presentation of these ten symptoms was revealed except in the symptoms pain in the throat, pain in the head and pain in the joints which were more commonly presented by females.

Social class. In this practice, there was a significant* association between age and social class. After adjustment, for age and sex the proportion of new symptoms presented by patients in Social Class I exceeded that of other social classes. No other significant difference was, however, revealed between social classes.

Diagnosis. A comparison is made in table III between the proportion of 'new' consultations in each of the diagnostic groups recorded in this study, and the proportion of all consultations in each diagnostic group. New symptom consultations were over-represented in the groups accidents, diseases of the eye and ear, acute respiratory and digestive diseases and communicable diseases. They were under-represented in chronic respiratory diseases, diseases of the cardiovascular system, mental illness and allergic and endocrine disorders.

Diagnostic and therapeutic activity. The doctors diagnostic activity and prescribing habits in response to new symptoms is compared with other types of consultations in table IV. Some form of physical examination was conducted at 85 per cent of consultations at which new symptoms were presented, compared with just over 50 per cent at other types of consultation. Laboratory and x-ray investigations were also carried

*Significant in this study indicates $P < .05$.

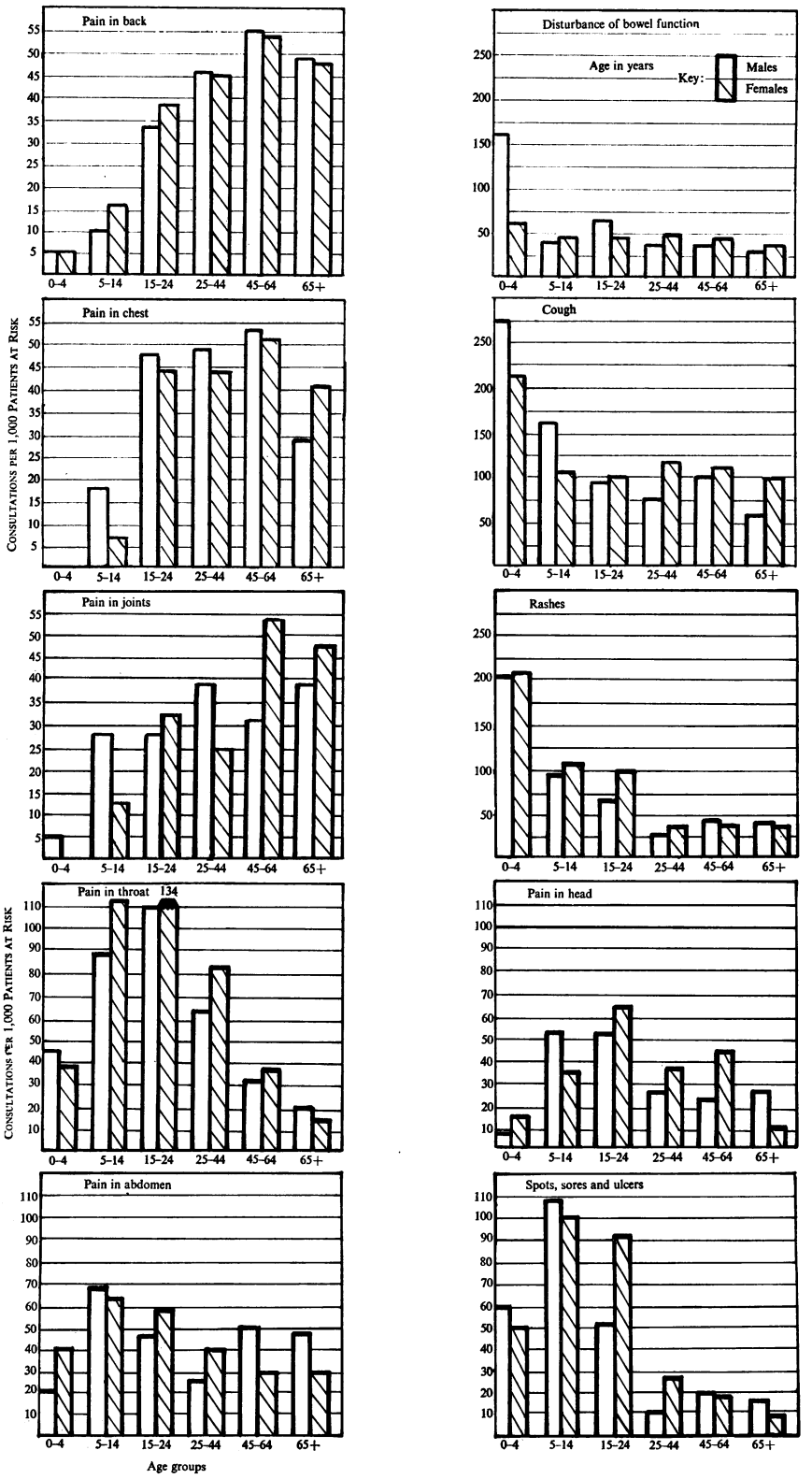
Pain in back
Disturbance of bowel function
Age in years
Key: Males Females
Pain in chest
Cough
Consultations per 1,000 Patients at Risk
Pain in joints
Rashes
Pain in throat 134
Pain in head
Pain in abdomen
Spots, sores and ulcers
0-4 5-14 15-24 25-44 45-64 65+
Age groups

Figure 1

out with significantly greater frequency, at 4.9 per cent of new symptom consultations, compared with 2.3 per cent of old patient initiated consultations and 3.8 per cent of doctor initiated consultations. Hospital referral was slightly more common at 'new'

TABLE III

COMPARISON OF THE PERCENTAGE OF ALL CONSULTATIONS AND 'NEW PATIENT-INITIATED' CONSULTATIONS RECORDED IN EACH OF 20 DIAGNOSTIC GROUPS

Diagnostic groups	*Per cent of total consultations*	*Per cent of 'new' patient-initiated consultations*
Communicable diseases	*2.61*	*4.85*
Neoplasms	*1.67*	*0.67*
Allergic, endocrine and metabolic disorders	*4.11*	*2.48*
Disorders of blood and blood-forming organs	*1.37*	*0.39*
Mental, psychoneurotic and personality disorders	*12.01*	*7.54*
Diseases of the nervous system	*2.75*	*1.90*
Diseases of the eyes	*1.63*	*3.71*
Diseases of the ear	*2.88*	*4.10*
Diseases of the circulatory system	*6.70*	*3.00*
Diseases of respiratory system (acute)	*19.63*	*22.46*
Diseases of respiratory system (chronic)	*5.56*	*1.79*
Diseases of digestive system	*7.85*	*11.08*
Diseases of genito-urinary system	*4.40*	*4.74*
Pregnancy	*1.63*	*1.53*
Diseases of skin and cellular tissue	*6.93*	*9.38*
Diseases of bones and organs of movement	*6.87*	*6.49*
Congenital malformations and certain diseases of infancy	*0.21*	*0.41*
Symptoms and ill-defined conditions	*1.26*	*1.27*
Accidents, poisoning and violence	*5.10*	*9.98*
Prophylactic and administrative procedures	*4.83*	*2.20*
TOTAL	*100.0* (21,094 consultations)	*100.0* (5,361) consultations

consultations than at other types of consultations. A prescription was issued in response to 75 per cent of new symptoms, compared with 86 per cent of 'old patient-initiated consultations', and 60 per cent of 'doctor-initiated consultations'.

Diagnostic certainty. The 12 most common symptoms have been related to diagnostic certainty and the extent of the doctors physical examination in table V. Diagnostic certainty was expressed at each consultation as symptomatic, provisional or presumptive. While it was never possible in the pilot stage of this study to ensure complete agreement between the doctors in the use of these terms, they nevertheless provide some measure of the doctors' confidence in their diagnoses. Wide differences in the doctors' certainty of diagnosis in respect of different symptoms are shown in the table. A presumptive diagnosis was reached at over 75 per cent of consultations at which the symptoms, pain in the throat, pain in the ear, cough, spots, sores and ulcers were presented, compared with less than 30 per cent when disturbances of gastric or bowel function or abdominal pain were presented. No consistent relationship was demonstrated between the doctors' lack of certainty in diagnosis and the extent of physical examination conducted, although examination of two or more systems of the body was more common in those consultations where a presumptive diagnosis was made at less than 50 per cent of consultations.

Discussion

Studies of morbidity in general practice in which the consultation rate is used as a

TABLE IV

ANALYSIS OF THE PERCENTAGE OF THREE TYPES OF CONSULTATION AT WHICH DIFFERENT DIAGNOSTIC AND THERAPEUTIC ACTIONS WERE RECORDED

Diagnostic and therapeutic action	*Type of consultations*		
	Patient-initiated new	*Patient-initiated old*	*Doctor-initiated*
History only	*15.0*	*45.8*	*48.6*
History and examination of one system of body	*73.8*	*49.9*	*48.1*
History and examination of two or more systems	*11.2*	*4.3*	*3.2*
TOTAL	*100.0*	*100.0*	*99.9*
Laboratory investigation	*3.3*	*1.4*	*2.3*
X-ray investigation	*1.3*	*0.8*	*1.3*
Laboratory and x-ray investigation	*0.4*	*0.1*	*0.2*
No investigation	*95.0*	*97.7*	*96.1*
TOTAL	*100.0*	*100.0*	*99.9*
No hospital referral	*96.6*	*98.4*	*97.1*
Referral as outpatient	*2.8*	*1.4*	*2.6*
Direct admission to hospital	*0.6*	*0.3*	*0.3*
TOTAL	*100.0*	*100.1*	*100.0*
Prescription issued	*75.4*	*86.1*	*59.8*
No prescription	*24.6*	*13.9*	*40.2*
TOTAL	*100.0*	*100.0*	*100.0*

TABLE V

TWELVE COMMON SYMPTOMS ANALYSED BY THE DOCTORS DIAGNOSTIC CERTAINTY AND PHYSICAL EXAMINATION CARRIED OUT EXPRESSED AS PERCENTAGE OF TOTAL NUMBER

Symptom	*Number of consultations*	*Diagnostic certainty*		*Physical examination*		
		Symptomatic or provisional	*Presumptive*	*History only*	*One system of the body*	*Two or more systems*
Pain in throat	287	*11*	*89*	*5*	*92*	*3*
Spots and sores	182	*19*	*81*	*2*	*97*	*1*
Pain in ear	108	*23*	*77*	*1*	*98*	*1*
Cough	527	*24*	*76*	*16*	*73*	*10*
Rashes	302	*35*	*65*	*2*	*93*	*5*
Pain in chest	168	*51*	*49*	*1*	*66*	*33*
Pain in joints	141	*55*	*45*	*1*	*94*	*5*
Pain in back	172	*60*	*40*	*5*	*83*	*12*
Pain in head	159	*67*	*33*	*10*	*57*	*33*
Disturbance of gastric function	141	*74*	*26*	*24*	*56*	*20*
Pain in abdomen	197	*78*	*21*	*5*	*60*	*35*
Disturbance of bowel function	187	*87*	*12*	*43*	*50*	*7*

measure of work load do not differentiate between those clinical situations in which the doctor is concerned with follow-up care of chronic or recurrent disease and those in which he is faced with a new diagnostic problem. Some workers such as Scott *et al* (1960) and Jacob and Pearson (1967) have devised methods of identifying new episodes of illness in order to relate the incidence to the prevalence of disease or to study the characteristics of patients who varied in their demand for episodic or continuing care.

In studying the diagnostic activity of the doctor in response to new symptoms it was essential to define different types of consultation. The definition used in this study was rigid and excluded those consultations involving recurrent episodes of the same illness. It was, however, easily interpreted and uniformly applied and is therefore repeatable and allows comparison between doctors in their response to specific symptoms. The differences demonstrated in the response of the doctors to 'new' consultations compared with other types, in terms of examination and investigation of patients, confirmed that the method was successful in identifying diagnostic situations, and the different morbidity diagnosed at 'new' consultations compared with other types, indicated those areas of medicine in which diagnostic skill is particularly demanded of the general practitioner.

The method also made possible, for subsequent study, the identification of groups of patients whose demand for medical care was characterized by the presentation of new diagnostic problems. Many workers have demonstrated the high consultation rates of patients at the extremes of life and women in the childbearing age groups. This study indicated that new diagnostic problems were most frequently produced by children under the age of five years and women in the age group 5 to 44 years. The design of this study made it possible for a patient who was attending with chronic disease to introduce a new symptom in the context of a doctor initiated consultation and in this case the symptom was not recorded. This may have reduced the frequency of new symptoms recorded in the older age groups.

The negative findings in respect of social class with the exception of Class I was not altogether surprising. The use of social class as a variable to reflect cultural differences in the use of primary medical care has, in the past, produced conflicting results, *e.g.* Logan and Cushion (1958), Kedward (1962), Scott and McVie (1962), and it seems possible that it is too gross a classification of culture to be of value in studies of this kind.

No serious difficulties were encountered in recording and coding symptoms. It was important, however, for the recording doctors to bear in mind the objective of the study and, if necessary, indicate in the record the nature of the diagnostic problem encountered. A patient, for instance, who dropped a brick on his toe, might complain of a painful, swollen or bruised foot, which could be coded 17, 68, 77 or 81. If it is known that trauma has occurred, both the diagnostic problem and the coding becomes straightforward. Once this was understood and the resources of the classification appreciated, a research secretary was able to handle the coding of symptoms. The fact that data were coded and extracted within 24 hours of recording greatly facilitated the solution of any problems.

Owing to different methods of defining and classifying symptoms, it is difficult to compare the frequency of symptoms recorded here with other studies. Two of the three most common symptoms in this study, cough and pain in the throat, were two most frequently recorded by McFarlane and O'Connell (1969), but there were wide differences between the studies in respect of many other important symptoms *e.g.* rashes, abdominal pain and diarrhoea.

Diagnostic certainty was recorded as presumptive at 58 per cent of all new consultations but varied from 12 to 89 per cent in the 12 most common symptoms studied in detail. On many occasions in general practice, it is not possible to reach a confident diagnosis at the first consultation and a policy of 'wait and see' is correct. By following a number of patients in this study through a series of consultations it was observed that

modification of the diagnosis was common and often accompanied by an upgrading in diagnostic certainty.

No clear relationship was demonstrated between the extent of the physical examination of the patient and the level of diagnostic certainty recorded, and, predictably, it was in dealing with symptoms which focus attention on clearly localized areas of the body, accessible to direct inspection, that the greatest certainty was recorded. It is necessary now to study those symptoms in which greater difficulty was experienced and attempt to relate them to the final diagnoses and the diagnostic pathways by which they are reached. In this way, it should be possible to calculate the probabilities of various diagnoses which follow the presentation of various symptoms, and to explore the type of facilities which will contribute to more accurate primary diagnosis.

Summary

A method of analysing presenting symptoms in general practice is described. The frequency with which 98 different symptoms were presented in a general practice providing care for 4,455 patients in one year has been recorded. The age, sex and social class of the patients presenting these symptoms has been described. The doctors' diagnostic and therapeutic activity in response to new symptoms has been analysed.

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APPENDIX

SYSTEM FOR CODING SYMPTOMS IN GENERAL PRACTICE ANALYSIS OF 5,325 SYMPTOMS

Main groups

Pregnancy etc.	00–02	Bleeding and abnormal discharges ..	50
Pain—Special organs	03–09	Trauma	60
Parts of body	10–19	Abnormal swellings	70
Disturbances of function—Psychological	20	Changes in appearance	80
Somatic ..	30	Ill defined symptoms	90
Autonomic	40	Special symptoms first five years of life ..	96–98

Code	Symptom (Sub groups)	Males	Females	Total
00	Pregnancy	0	3	3
01	Administrative requests	46	48	94
02	Child welfare requests	3	6	9
	TOTAL	49	57	106
	Pain (special organs)			
03	Eye	25	46	71
04	Ear	41	67	108
05	Mouth	22	30	52
06	Throat	125	162	287
07	Joints	66	75	141
08	Genital organs	15	29	44
09	Excretory organs	15	8	23
	TOTAL	309	417	726
	Pain (part of body)			
10	Head	70	89	159
11	Neck	20	34	54
12	Face	15	22	37
13	Chest	83	85	168
14	Abdomen	93	104	197
15	Back	82	90	172
16	Upper limb	20	30	50
17	Lower limb	66	95	161
18	Disturbances of sensation	4	11	15
19	Other pain	6	7	13
	TOTAL	459	567	1,026
	Disturbance of function (psychological)			
20	consciousness	9	18	27
21	orientation	1	4	5
22	memory	0	1	1
23	concentration	0	0	0
24	emotional response	14	59	73
25	anxiety	18	33	51
26	sleep	23	27	50
27	behaviour	7	8	15
28	sexuality	8	1	9
29	Other psychological disturbances	2	2	4
	TOTAL	82	153	235
	Disturbance of function (somatic)			
30	vision	22	28	50
31	hearing	54	56	110
32	speech	15	25	40
33	movement of head	0	1	1
34	movement of face	2	4	6
35	movement of neck	4	6	10
36	movement of trunk	0	0	0
37	movement of upper limbs	3	3	6
38	movement of lower limbs	5	4	9
39	Other disturbance of movement	2	5	7
	TOTAL	107	132	239

Code	Symptom	Males	Females	Total
	Disturbance of function (autonomic)			
40	appetite	10	25	35
41	swallowing	1	3	4
42	gastric function	61	80	141
43	bowel function	93	94	187
44	bladder function	21	50	71
45	menstruation	0	86	86
46	heart rate	7	5	12
47	breathing	32	29	61
48	cough	240	287	527
49	Other autonomic disturbances	1	3	4
	TOTAL	466	662	1,128
	Bleeding and abnormal discharges			
50	From the eye	25	25	50
51	From the ear	10	9	19
52	From the nose	35	50	85
53	From the lower respiratory tract	5	4	9
54	From the gastro-intestinal tract	15	12	27
55	From the urinary tract	3	0	3
56	From the genital tract	6	58	64
57	From the skin	4	8	12
59	Other bleeding or discharge	3	6	9
	TOTAL	106	172	276
	Trauma			
60	To skin	0	1	1
61	To eye	1	2	3
62	To face	14	8	22
63	To head	11	8	19
64	To back	8	7	15
65	To chest	3	1	4
66	To abdomen	2	1	3
67	To upper limbs	42	39	81
68	To lower limbs	26	43	69
69	Other trauma	13	24	37
	TOTAL	120	134	254
	Abnormal swellings			
70	Of head	2	2	4
71	Of face	20	27	47
72	Of neck	17	15	32
73	Of chest	0	1	1
74	Of breast	1	7	8
75	Of abdomen	10	7	17
76	Of joints	13	22	35
77	Of limbs	18	25	43
78	Of genital organs	3	4	7
79	Other swellings	36	39	75
	TOTAL	120	149	269
	Changes in appearance			
80	weight	4	13	17
81	skin colour	2	7	9
82	skin texture	5	3	8
83	skin sensation	19	43	62
84	Rashes	137	165	302
85	Spots, ulcers, sores	79	103	182

Code	*Symptom*	*Males*	*Females*	*Total*
86	Changes in hair	4	12	16
87	Changes in nails	1	1	2
88	Changes in eye appearance	11	20	31
89	Other changes in appearance	11	15	26
	TOTAL	273	382	655
	Ill-defined symptoms			
90	body temperature	26	27	53
91	energy	15	43	58
92	balance	22	52	74
93	Malaise	39	27	66
94	Whole body aching	37	33	70
95	Other ill-defined symptoms	11	23	34
	TOTAL	150	205	355
	First five years of life			
96	Irritability	19	27	46
97	Exessive dribbling	0	0	0
98	Refusing feeds	3	5	8
	TOTALS	22	32	54
	TOTALS	2,263	3,062	5,325

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Like those earlier Elizabethans and their successors who discovered and opened up new territories under the Crown overseas the members of the College research team are now beginning to explore a vast new territory of medicine which has escaped the surveyor's eye. Very little is accurately known of the incidence and geographical distribution of a variety of common ills which are daily met with in our surgeries or in our patients' homes. It seems probable, therefore, that the first years of our research will be profitably spent in seeking out essential facts about the structure of general practice, and most of this original work will fall to the lot of the ' interest groups.'

Work is under consideration in very many fields, the study of rheumatic diseases and ' fibrositis ', assessment of the value of prophylactic immunisation against pertussis and of the operation of tonsillectomy. An attempt may be made to define clearly some of the many hitherto undiagnosable rashes, and to identify the clinical patterns of presentation of diseases of the upper respiratory tract.

Our choice of fields for work is wide, and it will be the responsibility of all members of the Register, in whatever field their interests may lie, to ensure that the standard of work carried out will be set, and maintained, at the highest levels. The work we do will be assessed by our colleagues on merit alone, and the Research Organization of the College will stand or fall on the quality of the work undertaken by its members.