

survey was conducted using a diagnostic index to record morbidity. The coding of morbidity was based on a modified version of the ninth *International classification of disease (ICD-9)* which was compatible with that used in the second national morbidity survey and also with the *International classification of health problems in primary care — second series (ICHPPC-2)*. The coding was designed to minimize large entries in the remainder categories. The population denominator for the study was obtained from the practice age–sex registers which had been validated against the registers held by the family practitioner committees. It has to be recognized that both population figures may be inflated by a small unknown amount — probably by about 5%.¹ Also like its predecessor, the third survey was conducted in a year of national census and, through a confidential linkage procedure, the material will be analysed with respect to census information.

A full analysis of the study material from which this *OPCS Monitor* provides extracts will be published later this year and analysis of the census-linked information is scheduled for publication in 1987. The survey covers one year's recording in 48 practices with a total registered population of approximately 300 000 persons served by 146 general practitioners. The study population was representative of the national population in respect of age and sex. The behaviour of the general practitioners in the study, however, may not be representative of the national pattern and there are weaknesses in the precision of diagnostic labels in general practice. Nevertheless, the size of the survey ensures that the morbidity events recorded and the data on use of health care obtained provide a good guide to the national picture of general practice in 1981.

Consultation rates are one of the areas where a superficial

comparison can be made with the second morbidity survey. In 1971, 62.2% of the male population and 70.0% of the female population consulted the general practitioner (rates standardized to the population of the present study); in this study the figures are 65.2% and 76.6%, respectively. The mean consultation rates in 1971 were 2.30 per annum for males and 3.14 per annum for females; in the 1981 survey they are 2.71 and 4.02 respectively. Rates for home visits as a percentage of all consultations were 14.0% for males and 15.8% for females in 1971 and 11.1% and 12.7% respectively in 1981. A more detailed comparison of the results for 1981 with those for 1971 will follow in due course.

One strength of the morbidity data from the third national survey lies in the rigorous methods of recording — standardized methods were employed and exhaustive validation exercises were carried out. The participating practices are to be congratulated on the high quality of recording of information and this aspect should not be forgotten when looking to the future and in particular towards 1991, the year of the next census. The arrival of computers in practices has greatly increased the accessibility of data on morbidity and the use of primary care facilities but we should be careful that the increasing quantity of information does not blind us to the need to maintain the highest standards in the recording of information in general practice.

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Delay in diagnosing asthma — is the nature of general practice to blame?

IN 1978 Speight drew attention to the underdiagnosis of childhood asthma in the community.¹ He ascribed this mainly to general practitioners' reluctance to use the term asthma. Subsequent studies confirmed that asthma was underdiagnosed and as a result undertreated in the community.²⁻⁴ An audit in general practice found a delay in the recognition of childhood asthmatics.⁵ In this study it was found that children consulted their general practitioner with respiratory symptoms on average 16 times before a diagnosis of asthma was entered in the records.⁵ In the same practice it was found that asthmatic children consulted significantly more frequently than children without asthma.⁶ Toop found that general practice records predicted asthma in 50% of his population sample of asthmatics.⁷ Although most asthmatic children consult their doctors, often repeatedly, with respiratory symptoms, only 50% of cases of asthma are diagnosed by the age of five years.^{5,8,9} The consequences of not diagnosing asthma are all too evident in the literature.^{2-4,10} Failure to recognize asthma, and therefore to treat it appropriately, may result in loss of schooling, misery due to being left out in sport, growth retardation, family distress and in some tragic cases, death during an attack of asthma.

With all this information available, why then are we not diagnosing asthma earlier? As general practitioners, we are in a favourable position to recognize and manage asthma in the community. The nature of our work enables us to continually supervise and educate families with chronic illness such as

asthma. It is sad that we are failing to relieve the family distress which results from an undiagnosed asthmatic child, and we need to look at the weaknesses in the present organization of general practice to find possible aetiological factors.

The average consultation still only lasts about six minutes. It is therefore understandable that asthma can be overlooked, since often the diagnosis depends upon taking a good history.

Even in single-handed practices it is conceivable that a patient may see a number of different doctors when consulting over a period of time. As a result a child may consult repeatedly for respiratory symptoms, without the doctor realizing how often the child has attended. If the doctor consulted does not take a past medical history, or check back in the records for previous respiratory consultations, asthma will often go undiagnosed. The clues are in the records,^{5,7} but as with most medical problems, if asthma is not considered the diagnosis will be missed. More emphasis should be given to establishing personal lists to avoid patients consulting many doctors in a practice.

When patients change general practitioners their records often take many months to be transferred. It is conceivable therefore that the new doctor could be unaware of past recurrent respiratory consultations unless a detailed past medical history is obtained from new patients.

The disadvantages of using a term such as wheezy bronchitis or other euphemisms for asthma far outweigh the advantages. The belief that patients and parents need to be protected against

the word asthma was disproved by the Tyneside study.^{3,4} Many parents were relieved to know what the problem was and could then begin to tackle the task of learning about the disease.

It may well be that the busy nature of general practice inhibits some doctors from using the term asthma. It may seem to be quicker just to treat the symptoms and so avoid taking the time which educating a patient with asthma involves.

There may be self-deception on the part of the doctor that wheezy bronchitis and other euphemistic diagnoses are temporary diseases which will resolve spontaneously or with antibiotics or antitussives. This prevents us from thinking in terms of managing a chronic illness.

Although it is true to say that asthmatic children will in general improve as they get older, it is not true to say that they will all grow out of asthma.^{9,11} In Blair's study of childhood asthmatics 28% of those he followed up for 20 years were symptom-free after that time.⁹ In another study, only one-third of 331 childhood asthmatics were free from wheezing at the age of 21 years.¹¹

Although a detailed history would in most cases lead to diagnosis, asthmatics often present with atypical symptoms of asthma. The diagnosis will be missed if the doctor fails to realize that coughing is a symptom of asthma. Failure to enquire about exercise-induced cough or shortness of breath, sleep disturbance due to cough or 'colds which always go on to the chest', or which 'last for weeks' may result in a delayed diagnosis.

Asthma is a common disease of childhood affecting at least one in 10 children³⁻⁵ and should be considered in any child consulting repeatedly with respiratory symptoms. In one study undiagnosed asthmatic children were prescribed antibiotics (43%), antitussives (38%) and bronchodilators (19%), indicating that infection rather than asthma was predominant in the minds of the prescribers.⁵

Although difficult to accept, perhaps Speight was correct in laying the blame for the underdiagnosis and undertreatment of asthma on the shoulders of general practitioners.¹ Perhaps we should examine our practices and see where we can improve our diagnosis of asthma and thereby our management of a condition which is amenable to treatment.

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