REVISTA BRASILEIRA DE MEDICINA DE FAMÍLIA E COMUNIDADE
RBMFC
www.rbmfc.org.br
EDITORIAL

# A personal approach, beyond disease

## De pessoa a pessoa passando pela doença

## *De persona a persona, pasando por la enfermedad*

Gustavo Diniz Ferreira Gusso. Universidade de São Paulo (USP). São Paulo, SP, Brasil. gustavo.gusso@usp.br *(Corresponding author)*
Paulo Poli Neto. Universidade Federal do Paraná (UFPR). Curitiba, PR, Brasil. ppolineto@gmail.com

The current issue of the Brazilian Journal of Family and Community Medicine (Pwortuguese acronym, RBMFC) presents a variety of articles that are quite representative of the performance of professionals who work routinely in Primary Health Care (Portuguese acronym, APS). The RBMFC would like, increasingly, to be an instrument for the dissemination of front-line acquired knowledge.

The two clinical cases deal with subjects that are essential for the performance of family and community physicians. The article concerning herpes zoster deals with a problem that is frequently encountered in practice, but that had an atypical presentation. At the university level, we often hear that the manifestation of the disease was “typical” or “textbook”. However, we learn in Family and Community Medicine (Portuguese acronym, MFC) that every person is unique and that health problems manifest in different forms in each person. This implies that, in practice, APS is complex and loaded with uncertainties. On the one hand, we observe problems that repeat themselves; on the other, we deal with people and their unique problems. Perhaps it is not possible to fully understand why a healthy adolescent contracts a severe case of herpes zoster. The solution to such uncertainty does not lie in exhaustively, and sometimes even compellingly, searching for some kind of immunodeficiency.

The second clinical case considers another crucial practical topic, i.e., the adverse effects of medication. The quantity of medication used clearly increases the chance of the risks outweighing the benefits. Therefore, it is imperative that medical professionals, especially physicians, have some handy research tool to evaluate adverse effects, such as Epocrates, the British National Formulary (BNF), or even Medscape. Because of their high level of incidence, the understanding of side effects of medications should be intrinsic to any consultation. Adverse effects that are frequent include symptoms, such as nausea, dizziness, and diarrhea; hamper the identification of medication adverse effects; and result in many health professionals avoiding the

**Como citar:** Gusso GDF, Poli Neto P. De pessoa a pessoa passando pela doença. Rev Bras Med Fam Comunidade. 2015;10(36):1-3. http://dx.doi.org/10.5712/rbmfc10(36)1218

**Funding:**
none declared.
**Ethical approval:**
not necessary.
**Competing interests:**
none declared.
Received: 04/10/2015.
Accepted: 06/26/2015.

topic. This avoidance may lead to the non-diagnosis of rarer and more specific adverse effects, such as osteonecrosis in patients who use bisphosphonate medication.

Some articles discuss MFC tools, such as quaternary prevention and the clinical record. The most well established Primary Care registry is the Medical Records Guided by Problems (Portuguese acronym, PMOP) and the resulting methodology, SOAP.[1] There is a lot of controversy regarding the proportion of data in these records that should be structured and the proportion that should be free text. The article tackles this dichotomy by means of a cross-sectional study of 318 consultations. The structured data path, for example, the International Classification of Primary Health Care (Portuguese acronym, CIAP),[2] assists in the evaluation of the quality of the care provided and in the calculation of the pre-test probability; however, entering the data takes up time that could be used for the description of the free text, which according to the author, helps in understanding what was actually done during the consultation. The register topic involves a constant search for correct and sufficient information - not too much, not too little. What is the most common error? Too little information or too much needless information? What is considered an adequate amount? Is the solution to invest, once again, in free text and in tools that can classify and structure the text? For the moment, in this field, there are apparently not many answers to these and other questions. Structural data continue to be important for future analyses, with the limitations indicated above.

Finally, quaternary prevention, which has been a much-studied tool in both Brazil and worldwide, is covered in another article and uses breast and testicular self-examination as an example. Frequently, there have been actions that have tried to encourage men's health to follow the same disastrous path followed by women's health, with its excessive medical interventions. As if the failure of the female hormone replacement therapy was not enough to alert doctors and the general population, there is now an intense marketing movement in favor of "testosterone replacement therapy". Something similar occurred with other types of screening, about which, perhaps, a parallel can be established - as is the case with screening for cervical cancer/penile cancer and breast self-examination/testicular self-examination. In general, female screening has a certain "scientific advantage", which reinforces men's culture of not consulting their physicians and the need for "screening tests", as if to imply that the only cause of early death is "the lack of screening and visits to the physician". In this context, social conditions, family relationships, stress, work relationships, diet, and all the social factors affecting health are mere "details".

As such, quaternary prevention, understood as a search tool, is related to over-diagnosis, inasmuch as both issues attempt to avoid interventions that are more harmful than beneficial. During the last congress, which dealt specifically with the issue of overdiagnosis,[3] some researchers' work raised a yellow flag. In other words, today the number of cases of over-diagnosis caused by certain types of screening is only known statistically and retrospectively. Some scientists expect to overcome this hurdle with genetic tests. Thus, they wish for a future situation in which there is no breast cancer, but rather a situation in which "Mrs. X's breast cancer is being treated with medication Y".

This reinvention of clinical research has been referred to as "stratified medicine" and "personalized medicine".[4] This strategy hampers the execution of randomized clinical trials, given that "each person has a different type of cancer". This is the distortion of one of the most important principles of family and community medicine, i.e., understanding the person who is ill is different from understanding the genome of the ill person.

## References


1. Weed LL. Medical records that guide and teach. N Engl J Med. 1968;278:593-600, 652-7. DOI: http://dx.doi.org/10.1056/NEJM196803142781105
2. World Organization of National Colleges, Academies, and Academic Associations of General Practitioners/Family Physicians Classificação Internacional de Atenção Primária (CIAP 2)/Elaborada pelo Comitê Internacional de Classificação da WONCA (Associações Associations of General Practitioners/Family Physicians Classificação Internacional de Atenção Primária (CIAP 2)/Elaborada pelo Comitê Internacional de Classificação da WONCA (Associações Nacionais, Academias e Associações Acadêmicas de Clínicos Gerais/Médicos de Família, mais conhecida como Organização Mundial de Médicos de Família); Consultoria, supervisão e revisão técnica desta edição, Gustavo Diniz Ferreira Gusso. - 2. ed. - Florianópolis : Sociedade Brasileira de Medicina de Família e Comunidade, 2009.
3. Preventing Overdiagnosis [home page on the Internet]. BMJ. [Acesso em 24 de Sep de 2015]. Disponível em http://www.preventingoverdiagnosis.net/
4. Realising the potential of stratified medicine [home page on the Internet]. Academy of Medical Sciences. [Acesso em 24 de Sep de 2015]. Disponível em https://www.acmedsci.ac.uk/viewFile/51e915f9f09fb.pdf