Comorbidities in general practice

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Comorbidity is more of a concern for general practitioners than ever before. In nearly one-third (33.1%) of general practice consultations, more than one problem is managed.[1] Furthermore, in 18.7% of encounters more than one prescription medication is prescribed. European general practice encounter studies report a similar prevalence of comorbidity. The Dutch Transition Project identified an average of 1.6 problems per encounter.[2]

Recently, the Australian government has prioritised the comorbid pairing of mental health and alcohol and other drugs, and has just released a study on comorbidity in Australia.[3] In this issue of *Australian Family Physician*, David Pierce and Ian Wilson's article highlights the impact of comorbidity between psychiatric and addictive disorders; it identifies a comprehensive range of 'traps to avoid' and effective management strategies for the GP. Case studies by Mark Harris, Joachim Sturmberg and Mark Nelson highlight different aspects of preventing and managing comorbidity in general practice. These case studies are a sobering reminder of the complexity and challenge of our daily work.

Apart from a direct causal relationship between risk factors and certain diseases – such as smoking and heart disease – little is known about how other clusters of diseases or conditions are recognised and managed in general practice. Will a patient who has hypertension, diabetes, obesity and osteoarthritis receive a different range of antihypertensive medications and treatment advice at one consultation, but different management at a subsequent consultation if, for example, they lose weight but don't increase their physical activity?

The Transition Project used the ICPC to construct a framework for understanding consultations in which more than one health problem is managed.[4] Four types of comorbidity are identified: concurrent, causal, complicated, and cluster comorbidity. Concurrent comorbidity is defined as comorbidity that occurs randomly, eg. ear wax and digital warts. Causal comorbidity was described as comorbidity that shared a common cause, eg. ischaemic heart disease and aortic aneurysm. Complicated comorbidity occurred when the causal relationship was not clearly defined but the conditions were still related, eg. hypertension and left ventricular hypertrophy. Cluster comorbidity (including causal and complicated comorbidity as special subtypes) was defined as conditions that occurred together more often than would be expected by chance, eg. hypertension and diabetes.

Recognising comorbidities in a consultation is only the first step. Appropriate management must follow. All theme authors in this issue of *AFP* have agreed that patients with comorbidities require a team approach to management. Setting priorities is next. This is a new concept for clinical practice where everything is urgent until proven otherwise.

Albert Einstein was attributed with saying that when the number of factors coming into play in a phenomenological complex is too large, scientific method in most cases fails. This is true with comorbidity. There are no comorbidity guidelines to assist us and we must rely, as our four theme authors have, on the tried and true method of assessing each patient on a consultation by consultation basis.

The challenge is to make the complexity of comorbidity clusters seem quite simple and grounded in best practice. For example, take the major cluster of hypertension, diabetes, obesity and osteoarthritis. When GPs record blood pressure readings in the notes of the target population for this cluster, a pop-up screen could remind them to monitor aspects of obesity. If a nonsteroidal anti-inflammatory agent is prescribed at the same time, a pop-up screen will request information about diet and exercise prescriptions. When these series of actions are completed, an item number could be automatically generated for a comorbidity incentive payment.

Prioritisation of treatment and systematising response to changes over time could be more effectively addressed, translated to other contexts and appropriately remunerated. Clearly identifying comorbidity in general practice has the potential to inform clinical decisions and funding in a way that has never occurred before.

References

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