

Preface



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Guest Editors

Primary Care physicians (PCPs) are on the front lines of patient care. In addition to treating patients with chronic illnesses, they also evaluate and treat patients with acute complaints. This includes patients with complaints that may be potentially life-threatening, such as headache, chest pain, and abdominal pain. Most of these patients will not have a life-threatening cause of their symptoms. The astute PCP must always be vigilant for that patient who presents with serious disease masquerading as a benign illness.

This issue of *Primary Care: Clinics in Office Practice* focuses on disease entities that absolutely must be recognized by PCPs. While providing a general review of each topic, the guest editors' goal is to focus on atypical presentations and high-risk patient populations. Most outpatient practice facilities do not have the capability to perform extensive testing to rule out all of these life-threatening conditions. The aim of this issue is to increase awareness of some of these "masqueraders" and to encourage PCPs to always consider the worst case first. In some cases, the worst case may be ruled out simply by considering it and discarding it as a possibility, at which point more benign diagnoses may be considered. An example is the patient who presents with headache. A focused history and physical may be all that is required to rule out subarachnoid hemorrhage, meningitis, temporal arteritis, acute glaucoma, and stroke. At this point, more benign causes such as tension headache or migraine (which are much more common etiologies of headache) may be entertained. Conversely, if a patient's headache is labeled "tension" or "migraine," and subarachnoid hemorrhage is never even thought of, you may not get a second chance to make the diagnosis!

We have all been taught that diagnoses such as pulmonary embolus present very dramatically. This is unequivocally false. As this issue highlights, many serious, life-threatening diseases present quite subtly. Knowledge of risk factors for various diseases and an idea of their atypical presentations will serve the astute clinician well.

The job of a PCP is undeniably difficult. As noted above, most patients who present with symptoms of potentially life-threatening disease will actually have a more benign entity. It is simply not feasible or prudent to refer every patient with abdominal or chest pain to the emergency department or a subspecialist. A busy PCP may go days, weeks, or even months without seeing a true emergency. The trick is to avoid becoming complacent to the point that when a patient does have an emergent condition, it is missed. The guest editors sincerely hope that this issue of *Primary Care: Clinics in Office Practice* will be useful in your day-to-day practice in detecting those emergencies and intervening in a timely fashion.

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