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Validating long term morbidity recording

Chris Van Weel

Abstract

Study objective – To assess the validity of diagnosis made in a general practice based morbidity recording from 1967–90.

Design – Clinical features of patients with a diagnosis of migraine headache and diabetes mellitus were compared with international diagnostic criteria for these conditions. For migraine headache the International Classification of Health Problems in Primary Care (ICHPPC) definition was used, while diabetes mellitus was defined according to World Health Organization (WHO) criteria.

Setting – The continuous morbidity registry of the Department of General Practice and Social Medicine, University of Nijmegen, has been recording data from four general practices (12 000 patients) continuously since 1967. The database is used for longitudinal clinical research.

Patients – All patients with migraine headache and living in the practice area at the time of study and matched controls with tension headache received a questionnaire asking about ICHPPC criteria symptoms of migraine. The medical records of all patients with diabetes mellitus at the time of diagnosis were compared with WHO criteria.

Main results – In 85% of patients with migraine headache, the questionnaire confirmed the ICHPPC defined criteria. Twenty nine per cent of the matched controls reported migraine features. In 74% of the patients with diabetes mellitus the diagnosis was made in agreement with the WHO criteria: in 12% no clinical information from the time of diagnosis could be traced.

Conclusions – The diagnoses of migraine headache and diabetes mellitus in the registry largely agreed with international criteria. The quality control of recorded data is satisfactory, and the registry might serve as a model for other primary care based databases.

Methods

The study analysed recorded cases of migraine headache and diabetes mellitus. Each case recorded in the database was compared with external criteria for these two conditions. The comparison was made by researchers who were not concerned with the data collection for the registry.

The database: general features

The continuous morbidity registry is a network of four general practices in the Nijmegen region (seven general practitioners). The network has monitored morbidity in general practice on a continuing basis since 1971 (in two practices since 1967). All new episodes of illness are recorded, including diagnoses made after referral. The database is used to analyse general practice morbidity and morbidity trends since 1971, and as an index for the recruitment of groups of patients for additional research. The practices’ population is about 12 000 patients and has been stable over the years. The relevance and the limitations of the register are directly influenced by the Dutch health care
structure. Two aspects of this structure are of particular importance in this respect. Firstly, in the Dutch health care system, the general practitioner has a "fixed" list of patients (the practice population), and, secondly, he or she is the gate keeper of access to specialist medical care. As a consequence, the system collects all morbidity data in a defined population for which specialist medical care is sought.

Each episode of morbidity presented to the general practitioner is recorded, including the cause of death. The general practitioner who diagnoses the episode provides the diagnostic coding. An episode of morbidity is defined according to the international glossary for family practice.11 Follow up data on already recorded morbidity are not recorded. The morbidity data are stored according to the date of presentation/diagnosis, in relation to the demographic data of the patient (sex, age, social class, and family composition). Registration began in 1967 and has been uninterrupted since. The population of the four practices has been remarkably stable over the years, and as a consequence it is possible to analyse long term individual morbidity. Table 1 details longitudinal studies based on the register.4-12,17 Longitudinal studies of morbidity in general practice have become the main objective of the register and efforts to secure the validity of the data must be seen in this light.

INTERNAL QUALITY CONTROL OF DATA
Quality control of recorded data involves the following activities.

The diagnostic classification and the diagnostic definitions
At the start of the register in 1967, the only morbidity classification for general practice available was the Dutch translation18 of the British E-list.19 For reasons of consistency over time, the classification was not changed when classification more suitable for general practice became available.7,8 But the list has been made compatible with the International Classification of Health Problems in Primary Care (ICHPPC),7 and the ICHPPC definitions have been introduced.

The procedure of classifying and coding
Each episode of morbidity is classified and coded by the general practitioner who is involved in the case. This should be done as soon as possible after the consultation, and must reflect the highest level of diagnostic interpretation of the patients' condition. Where there is uncertainty, the classification/coding may be postponed until more certainty has been achieved (from the natural history of the disease, diagnostic tests, or specialists' assessment).

Training and support of general practitioners
All general practitioners involved in the register have been trained in the use of the classification list and the application of the ICHPPC definitions (using case studies). There is a monthly meeting of all general practitioners to discuss coding problems and to monitor the application of diagnostic criteria. The practice assistants are trained and supervised in collecting the demographic data of the patients.

Completeness of the data
The practice assistants supervise the transfer of the coded data to the Department of General Practice and Social Medicine, where analysis takes place. By comparing the patients' files and the patients' coded diagnoses, the assistants monitor the completeness of the data.

EXTERNAL VALIDATION OF THE RECORDED DATA
The validity of the recorded data was studied for two conditions — migraine headaches and diabetes mellitus.

Migraine headache
This was defined according to the ICHPPC criteria.7
- Recurrent episodes of unilateral headache with either/or —
- Nausea/vomiting,
- Aura,
- Neurological (visual) disturbances,
- Family history of migraine, or
- Recurrent episodes of bilateral headache with three or more of the above features.

All patients with the diagnosis migraine6 who were still on the practice list at the time of study (1990) were selected from the register. They were invited to complete a mailed questionnaire detailing the features of their headache. For each migraine patient a sex, age, and practice matched control was selected from patients with the diagnosis, tension headache.9

Diabetes mellitus
For diabetes mellitus the WHO criteria20 were applied:
- Symptoms (thirst, polyuria, pruritus, weight loss);
AND
- Raised blood glucose concentrations (fasting values >6.7 mmol/l or two hours after meal >11.1 mmol/l).
OR
- In the absence of symptoms, a raised blood glucose value (as defined) on two occasions.

The data for all patients on the register in whom diabetes mellitus had been diagnosed between 1967 and 1989, were analysed10 including patients who at the time of study (1989)
had died or moved to another area. The diagnostic criteria applied at the time of diagnosis were reconstructed from their medical files.

Results

MIGRAINE HEADACHE (TABLE 2)
There were 150 patients who had been diagnosed as having migraine headache and were still registered with the practice at the time of the study. The questionnaire was returned by 140, of whom 85% confirmed the diagnostic criteria. The matched controls with tension headache had migraine features that met the ICHPPC migraine criteria in 29% and photophobia or phonophobia were reported in more than 50%.

DIABETES MELLITUS (TABLE 3)
There were 427 cases recorded but no clinical data could be traced in 50. In another 61, normal blood glucose values only were found in the records. Diabetes mellitus according to the WHO criteria was present in 316 (74%). This included all cases diagnosed after 1985.

Discussion

The continuous morbidity registry applies strict rules to control the quality of collected data. An external comparison of the recorded cases of migraine headache and diabetes mellitus with international diagnostic criteria showed satisfactory agreement — in most cases of recorded migraine headache and in three quarters of the cases of recorded diabetes mellitus the criteria could be confirmed. Both migraine headache and diabetes mellitus provide problems of their own in coding of morbidity. Migraine is a diagnosis based entirely on the information provided by the patient and represents his or her perception of signs and symptoms. The finding that about one in three of the controls with tension headache reported migraine-like symptoms and more than half of them had migraine associated signs of photophobia and phonophobia could point to a lack of sensitivity in general practitioner diagnosed migraine. On the other hand, a diagnosis of migraine will usually be more easily accepted by patients than one of tension headache, which suggests a psychosocial rather than a somatic background of the disorder. Consequently, the general practitioner might tend to over diagnose rather than under diagnose migraine. That migraine headache and tension headache overlap in their symptoms seems more probable. This underlines the genuine problems of primary care based morbidity databases.

Diabetes mellitus is based on objective criteria, but these have been revised on two occasions in the past 15 years. The confirmed diagnostic agreement in three quarters of the cases should be seen in this light. In some cases, no confirmation was possible because clinical data were no longer available from the time of diagnosis. Thus, external confirmation of three quarters of the registered cases in this study is a minimum estimate only. Normal blood glucose concentrations only were frequently found in the records of patients diagnosed as having diabetes mellitus. A variety of factors can (temporarily) increase blood glucose values. Surveys of diabetes mellitus in general practice found that in up to 10% of patients under treatment for diabetes, the diagnosis could not be confirmed at the time of survey.

The findings should be considered in the context of the long term data collection. Patients were questioned about features of migraine that in some cases might have occurred more than 20 years before. Furthermore, the practice records were searched for diagnostic tests used at a time when general practice was much more restricted in its laboratory support. Nevertheless, the diagnoses recorded over more than 20 years were largely in touch with today’s requirements.

The continuous morbidity registry provides data for longitudinal clinical research in general practice. Efforts are made to safeguard the quality of collected data and this strategy has resulted in satisfactory data. This study may indicate what should be done to guarantee the quality of general practice based morbidity data recorded in daily patient care.

7 Classification Committee of WONCA in collaboration with WHO. ICHPPC-2 defined (International classification of
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24 Verhoeven S. Behandeling, controle en metabole instelling van patiënten met diabetes mellitus type-II en de prevalentie van late complicaties bij deze patiënten. Rotterdam: Erasmus University Rotterdam, 1989. (Thesis) [Summary in English]