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Special Article

Recommendations for Care of the Asymptomatic Patient

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We present a set of reasonable guidelines for the care of healthy, asymptomatic individuals based upon recommendations prepared by an Internal Medicine review committee of Henry Ford Hospital. There recommendations have four goals: to prevent disease, to detect disease in an asymptomatic and potentially curable state, to enhance the patient's quality of life, and to help physicians teach patients good health habits. Recommendations are made for infectious diseases, cancer, metabolic diseases, neurosensory conditions like visual and hearing loss, and general health habits. Some recommendations are at variance with those of well recognized authorities and should be viewed only as a suggested protocol for the care of the asymptomatic patient. Results of ongoing studies may alter our understanding of some areas of controversy and mandate revision of these guidelines periodically.

Appropriate medical care for asymptomatic individuals has been the subject of several recent articles (1-4). In December 1981, the American College of Physicians tabulated the recommendations of these articles but did not suggest guidelines in instances where the recommendations disagreed with each other (5).

In March 1982, a committee was formed at the request of the Chairman of the Department of Internal Medicine to make recommendations about the care of asymptomatic patients at Henry Ford Hospital. The aim was to develop guidelines that would be applicable to all asymptomatic adults and would represent a uniform standard of care within the institution. It was felt that such uniform guidelines would serve as a reasonable program to help the physician faced with the asymptomatic patient. In addition, such guidelines would be a teaching aid to train house officers in outpatient care.

In making its recommendations, this committee compared various reviews, researched relevant literature, and sought the advice of specialists within Henry Ford Hospital. Our final report represents a consensus of the committee, often obtained after much debate and modification. Debate and compromise were necessitated by the fact that in many areas data currently are not available to make firm, scientifically based recommendations. Results of studies under way at present will no doubt make it necessary to revise some of our conclusions in the future. In any case, our recommendations represent an appropriate program to guide the physician when seeing healthy patients. These recommendations are not meant to limit the options of the individual physician in dealing with individual patients.

The Asymptomatic Patient

The committee defined an asymptomatic patient as a person who perceives his or her health to be good and who does not have known genetic, environmental, or historic risk factors, or adverse personal habits that place that person at high risk for a disease. Therefore, a woman who has two sisters with breast cancer does not fit the definition, and the physician caring for her should follow screening procedures for breast cancer other than those we recommend. Likewise, although we did not recommend a routine venereal disease research laboratory (VDRL) screening test for syphilis, a young patient with many sexual partners is at higher risk and should be screened accordingly.

A second important point in defining the asymptomatic patient is that a person who already has known disease is

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still a candidate for the types of screening we advocate. The proposed guidelines would still be a good tool with modifications made according to particular circumstances for the long-term care of patients with chronic medical problems. For example, cancer screening should not be overlooked in the middle-aged patient who is being followed for stable coronary artery disease. These guidelines are applicable in specialty clinics.

Goals

Several goals should be considered in the care of asymptomatic individuals. The first and most desirable goal is disease prevention. This goal is best exemplified by the success of vaccinations in preventing some infectious diseases. Conceivably, physician counseling might be a means of disease prevention. Urging patients to follow a low cholesterol diet, to stop smoking, and exercise regularly might reduce the incidence of symptomatic coronary artery disease.

A second goal for physicians attending healthy individuals is to detect disease while it is asymptomatic and potentially curable. The committee found the criteria suggested by Frame and Carlson (3) for judging the efficacy of screening tests to be helpful:

1) The disease being screened must have significant morbidity and mortality.
2) The disease must have a significant asymptomatic period.
3) There must be a procedure capable of detecting the disease in an asymptomatic state.
4) The procedure must not carry excessive morbidity or cost, especially compared to the benefit gained from early detection.
5) There must be a treatment which will favorably alter the course of the disease when applied in the asymptomatic period.

Some screening tests which the committee considered were rejected because they failed to meet these criteria. For instance, the chest x-ray as a screening test for lung cancer was not recommended because, when applied to asymptomatic patients, this procedure does not significantly alter the course of the disease. Other screening maneuvers fit the criteria only imperfectly. For example, the committee recommended screening for diabetes at intervals of five years, although it is debatable whether early detection and treatment will prevent long-term morbidity.

A third goal for the asymptomatic patient is to enhance the quality of life. This goal was crucial in the decision to recommend routine visual and auditory testing. Enhancement of quality of life is also inseparable from disease prevention and knowledgable physician counseling.

A fourth goal is to use the physician's encounter with asymptomatic patients to enhance health teaching. Physicians should teach patients good health practices, e.g., breast or testicular self-examination. Acquainting the patient with the outlined protocol or the guidelines of the American College of Physicians would also be appropriate. Subjects that should be covered in a discussion of good health habits are presented below.

Recommendations

Recommendations cover five general areas: infectious diseases, cancer, metabolic diseases, neurosensory conditions, and health habits. Tables I and II present the suggested frequency of screening by sex and age.

Infectious diseases

Adults without a documented history of immunization against tetanus should receive a primary series at one, two, and six months using adult diphtheria-tetanus (dT). Boosters should be given at ten-year intervals. For rubella, non-immunized women of childbearing age should have the rubella titer determined at the first visit. If titers are less than 1:8, they should be vaccinated and should be advised to avoid pregnancy for three months after immunization. Polio vaccine is necessary only for specific high risk populations in adults. Influenza vaccine is advised yearly for patients over 65, while pneumococcal vaccine should be given to patients over 65 and to those with chronic diseases, including splenectomy, sickle cell anemia, chronic obstructive pulmonary disease, diabetes, alcoholism, liver and renal disease.

The committee also considered the secondary prevention of tuberculosis, syphilis, and gonorrhea. Patients should have a purified protein derivative (PPD) skin test for tuberculosis at the first visit and again in ten years if they are under 35 years old. Although routine VDRL tests for syphilis do not appear to be justified, homosexual men and patients with many sexual partners should be screened annually. Similarly, the use of cultures for gonorrhea is recommended only as a screen for asymptomatic disease in high risk groups: women with many sexual partners, sexually active women under 25, and prostitutes.

Cancer

The recommendations of the American Cancer Society (ACS) form the basis of our recommendations on cancer

TABLE I

SCREENING IN THE ASYMPTOMATIC ADULT (AGES 20-54)

Patient's Age	20	24	25	27	30	34	35	37	40	43	45	46	47	48	49	50	51	52	53	54
Alcoholism / *Review	M/F	F	M		M/F	F	M		M/F		M/F					M/F				
Auto Accidents / *Seat Belts	M/F	F	M		M/F	F	M		M/F		M/F					M/F				
Blindness / *Acuity Check	M/F	F	M		M/F	F	M		M/F		M/F					M/F				
**Breast Cancer / *Self-exam	F	F			F	F			F		F					F				
*MD exam	F	F		F	F	F		F	F	F	F	F	F	F	F	F	F	F	F	F
*Mammogram											F			F			F			F
**Cervical Cancer / *Pap Smear	F	F		F	F	F		F	F	F		F				F		F		
Colon Cancer / *OB x 3											M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F
Coronary Heart Disease / *Exercise	M/F	F	M		M/F	F	M		M/F		M/F					M/F				
*Cholesterol	M/F	F	M		M/F	F	M		M/F		M/F					M/F				
*Diet Review	M/F	F	M		M/F	F	M		M/F		M/F					M/F				
Diabetes / *FBS	M/F	F	M		M/F	F	M		M/F		M/F					M/F				
Glaucoma / *Tonometry									M/F		M/F					M/F				
Habits / *Review	M/F	F	M		M/F	F	M		M/F		M/F					M/F				
Hypertension / *Blood Pressure	M/F	F	M	F	M/F	F	M	F	M/F	F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F
Lung Cancer / *Smoking Hx.	M/F	F	M		M/F	F	M		M/F		M/F					M/F				
**Osteoporosis / *Review											F					F				
**Rubella / *Titer/Vaccine	F				F															
***Testicular Cancer / *Self-exam	M		M		M		M		M		M									
Tetanus / *Vaccine	M/F				M/F				M/F							M/F				
Tuberculosis / *PPD	M/F				M/F				M							M				

*Recommended Action
**Female Condition Only
***Male Condition Only

M = Male F = Female M/F = Both

TABLE II

SCREENING IN THE ASYMPTOMATIC ADULT (AGES 55-74)

Patient's Age	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74
Alcoholism *Review	M/F					M/F					M/F					M/F				
Auto Accidents *Seat Belts	M/F					M/F					M/F					M/F				
Blindness *Acuity Check	M/F					M/F					M/F					M/F				
**Breast Cancer *Self-exam	F					F					F					F				
*MD exam	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
*Mammogram	F			F			F			F										
**Cervical Cancer *Pap Smear	F			F			F			F										
Colon Cancer *OB x 3	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F
Colon Cancer Proctoscopy	M/F																			
Coronary Heart Disease *Exercise	M/F					M/F					M					M				
*Cholesterol	M/F					M/F					M					M				
*Diet Review	M/F					M/F					M					M				
Deafness *Audiogram	M/F					M/F					M/F					M/F				
Diabetes *FBS	M/F					M/F					M/F					M/F				
Glaucoma *Tonometry	M/F					M/F					M/F					M/F				
Habits *Review	M/F					M/F					M/F					M/F				
Hypertension *Blood Pressure	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F
Influenza *Vaccine											M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F	M/F
Lung Cancer *Smoking Hx.	M/F					M/F					M/F					M/F				
**Osteoporosis *Review	F																			
Pneumococcal *Pneumovax											M/F									
Tetanus *Vaccine		M				F					M					F				

*Recommended Action
**Female Condition Only

M = Male F = Female M/F = Both

screening (2). Our recommendations about use of the Papanicolaou (Pap) smear to screen for cervical cancer are the same as those of the ACS. We accept the argument that chest x-rays for early detection of lung cancer do not, at present, significantly improve the patient's outcome. However, the physician should be reminded of the obligation to counsel the patient against cigarette smoking.

Initially, the committee accepted the ACS recommendation that mammography should be performed yearly in women over 50 to screen for breast cancer. However, a significant number of our medical staff do not find evidence sufficiently convincing to support annual screening. Accordingly, our recommendation is that mammography be done every three years after age 45. Breast self-examination should be reviewed and recommended at age 20 and at least every five years thereafter. Physician breast examination should be performed every three years in women over 20 and every year after age 45.

Men should be taught testicular self-examination to screen for carcinoma, and this should be reviewed every five years.

Our recommendations for sigmoidoscopy also differ from those of the ACS. A single sigmoidoscopic examination at the age of 55 is considered a reasonable screening procedure. The ACS recommends sigmoidoscopy every three to five years after two initial negative sigmoidoscopies one year apart beginning at age 50. The low yield of sigmoidoscopy coupled with its cost and the low but significant risk of perforation led the committee to decide against such frequent sigmoidoscopy examinations. We do recommend that all adults over 45 have three consecutive stools tested for occult blood yearly. Stool collections preferably should be done with patients on a meat-free, high fiber diet for three consecutive days.

Metabolic diseases

Recommendations for coronary artery disease include a cholesterol determination every five years between ages 20 and 60 and low cholesterol diets. Although definitive evidence is not available that lowering serum cholesterol through diet or medication protects against coronary artery disease, epidemiologic evidence is strongly supportive (6). Our recommendation is prudent.

Similar considerations influenced our recommendations to obtain a fasting blood glucose test every five years to screen for diabetes. Early therapy of diabetes with diet, oral medication, or insulin has not been proven to reduce subsequent morbidity. However, we agree with those physicians who optimistically believe that good diabetic control favorably affects the course of the disease.

The evidence is even more conclusive that physicians can treat hypertension with favorable results (7). A blood pressure check at each patient visit is an inexpensive means to screen for this treatable condition.

Osteoporosis in postmenopausal women can be retarded by adequate calcium intake. The committee recommends that women in this group be urged to maintain a calcium intake of 1.5 grams daily, using supplemental tablets if necessary (8).

Health habits

The physician seeing healthy patients has an obligation to promote good health habits. Topics that should be discussed include the use of seat belts, maintaining proper weight, eating regular meals including breakfast, moderation in the use of alcohol, abstinence from cigarettes, promotion of an active life style, and regular sleeping habits. Statistical evidence indicates that people who maintain healthy life styles benefit through increased longevity (9). As yet, there is no evidence that physician counseling can modify the health habits of patients. However, the benefits obtained from good health habits are likely to be great and the effort required to review and encourage them small.

Neurosensory conditions

Visual and hearing loss and glaucoma are all conditions which adversely affect quality of life, and all can be asymptomatic to a degree. Because testing visual acuity is inexpensive and simple, we recommend that it be done every five years in adults. Screening for hearing loss is more expensive, but improvements in hearing aid technology make it likely that a high percentage of patients can be helped. We recommend audiometry at age 55 and every five years thereafter. Although tonometry is only one element in the diagnosis of glaucoma, its utility in general medical clinics led us to advocate its use at age 40 and every five years thereafter.

Summary

We have presented a set of reasonable guidelines for the care of healthy, asymptomatic individuals. Some recommendations are at variance with those of well recognized authorities and should be viewed only as a suggested protocol for the care of asymptomatic patients. We anticipate that the results of ongoing studies will alter our understanding of some areas of controversy and mandate revision of these guidelines periodically.

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Cheiroarthropathy in the Young Diabetic

Known for many years but only recently highlighted (Rosenbloom AL, et al. N Engl J Med 1981;305:191), cheiroarthropathy (limited joint mobility, diabetic hand syndrome) in the young person with diabetes correlates with retinal and renal microangiopathy. Chronic hyperglycemia accentuates glycosylation of collagen (Kohn RR, Schnider SL. Diabetes 1982;31(Suppl 3):46), which may lead to stiffening of peri-articular tissue.

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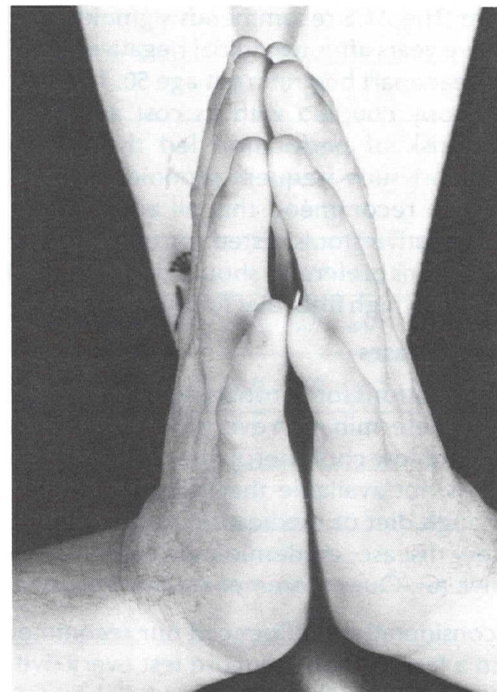

Cheiroarthropathy: Failure to approximate palmar surfaces of the proximal and distal interphalangeal joints in a young diabetic. Note flexor deformity of the finger joints.