THE ROLE OF FAMILY MEDICINE IN THE EARLY RECOGNITION OF MEDICAL EMERGENCIES

Igor Maslać
Department of Family Medicine, Health Center Mostar, Hrvatskih branitelja bb, 88 000 Mostar, Bosnia and Herzegovina
Received on 4 February 2026. Revised on 25 March 2026. Accepted on 8 May 2026.

ABSTRACT

Background: Family medicine often represents the first point of contact for patients with acute and potentially life-threatening conditions. In primary health care, clinical decision-making is frequently performed under conditions of diagnostic uncertainty, time pressure, and limited resources, particularly in the early or atypical stages of emergency conditions.

Objective: to highlight the role of family medicine in the early recognition of common medical emergencies, with emphasis on warning signs, practical management in primary health care, and timely collaboration with emergency medical services.

Methods: A narrative literature review was conducted using PubMed/MEDLINE, Google Scholar, and relevant international guidelines and consensus documents. The review focused on acute coronary syndrome, stroke and transient ischemic attack, sepsis, anaphylaxis, and acute respiratory failure. The selected literature was analyzed qualitatively to identify key warning signs, diagnostic challenges, and recommended clinical actions in the primary care setting.

Results: Emergency outcomes are strongly time-dependent, and atypical clinical presentations are common in primary care, especially among older adults, women, and patients with chronic diseases. Structured assessment of vital signs, mental status, and respiratory function, together with recognition of red flags, supports timely referral and reduces the risk of delayed diagnosis. NEWS2 may support early detection of physiological deterioration, but it does not replace clinical judgment.

Conclusion: Early recognition of medical emergencies in family medicine depends on structured clinical reasoning, timely referral, and effective communication with emergency medical services.

Keywords: Family medicine; primary health care; medical emergencies; early recognition; red flags
Corresponding author: Igor Maslać; igor.maslac@fzs3.sum.ba

INTRODUCTION

Primary health care, and family medicine in particular, plays a crucial role in the functioning of health care systems, as it represents the first and often the only point of contact between patients and the health care system. Physicians and nurses working in family medicine assess a large number of patients on a daily basis, many of whom present with heterogeneous and often nonspecific symptoms that may include early manifestations of life-threatening medical emergencies. In this context, early clinical judgment and the timely recognition of serious conditions are of paramount importance for subsequent management and patient outcomes. Numerous studies in the field of primary health care indicate that emergency conditions such as acute coronary syndrome, stroke, sepsis, and anaphylaxis are frequently initially manifested by atypical or mild symptoms, particularly in the early stages of disease. Such presentations substantially increase the risk of diagnostic delay, especially in settings characterized by limited diagnostic resources and high workloads among health care professionals (1). It has been particularly emphasized that older adults, women, and patients with chronic diseases are more likely to present with atypical clinical manifestations, which further complicates timely clinical decision-making in the primary care setting (2). The specific characteristics of work in family medicine, including time constraints, a high patient volume, administrative burden, the need to simultaneously manage acute and chronic conditions, and limited access to advanced diagnostic modalities, make the early recognition of so-called clinical warning signs ("red flags") critically important. The literature emphasizes that a systematic assessment of vital signs, mental status, and respiratory function, together with clearly defined thresholds for urgent referral, can substantially reduce the risk of clinical deterioration and adverse outcomes (3). In urban settings with a well-developed network of family medicine services, such as the City of Mostar, primary health care is organized through a large number of family medicine teams that cover a substantial proportion of the population. Within such an organizational framework, family medicine plays a pivotal role not only in the continuous management of patients with chronic diseases but also in the initial assessment of acute symptoms and the timely activation of emergency medical services. Clearly defined collaboration between family medicine and emergency medical services represents an important element of patient safety in the out-of-hospital setting. Therefore, the role of family medicine within the emergency care continuum extends beyond administrative referral and includes active clinical assessment, early identification of potentially life-threatening conditions, and the initiation of basic patient stabilization measures. The aim of this paper is to present the role of family medicine in the early recognition of the most common medical emergencies, with particular emphasis on clinical warning signs, practical approaches in primary health care, and the importance of effective collaboration with emergency medical services.

METHODS

This paper was conducted as a narrative review of the literature with the aim of synthesizing available scientific evidence and professional guidelines related to the role of family medicine in the early recognition of emergency conditions. The selected approach enabled a comprehensive and contextual overview of the topic, with particular emphasis on clinical practice in primary health care.

The literature search was performed in the electronic databases PubMed/MEDLINE and

Google Scholar, with additional inclusion of relevant international guidelines and consensus documents issued by leading professional organizations. Combinations of keywords and MeSH terms were used in the search strategy, including "primary care," "family medicine," "emergency conditions," "early recognition," "red flags," "acute coronary syndrome," "stroke," "sepsis," and "anaphylaxis." The search was limited to publications in the English language, without strict time restrictions, in order to include seminal publications relevant to clinical practice. The literature search was conducted from database inception up to January 2026.

The review included narrative and systematic review articles, original research studies, clinical guidelines, and consensus documents addressing the early recognition of emergency conditions in primary health care or out-of-hospital settings. Studies exclusively focused on in-hospital management without a direct connection to primary care were not systematically considered. The selected literature was analyzed qualitatively, with the aim of identifying common thematic areas, key clinical warning signs, and recommended approaches in family medicine.

Particular emphasis was placed on guidelines and recommendations issued by relevant international organizations, including the European Society of Cardiology (ESC), the European Resuscitation Council (ERC), the National Institute for Health and Care Excellence (NICE), and the World Health Organization (WHO), which provide standardized frameworks for the early recognition and initial management of emergency conditions. The findings were integrated to provide a practice-oriented overview of the role of family medicine in everyday clinical practice.

Given the review-based nature of the study, no original clinical data were collected and no statistical analysis was performed. The methodological approach was focused on synthesizing existing evidence and interpreting it within the context of primary health care, with the aim of improving the clinical recognition of emergency conditions and enhancing patient safety.

Common medical emergencies in family medicine can be recognized using clinical warning signs

The key warning signs and immediate actions for the most common medical emergencies encountered in family medicine are summarized in Table 1.

Table 1. *Key clinical warning signs and immediate actions for common medical emergencies in family medicine*

Medical emergency	Warning signs	Immediate actions
Acute coronary syndrome (ACS)	Chest pain at rest >10-15 min; recurrent chest pain; dyspnea; diaphoresis; syncope; arrhythmias; hemodynamic instability; atypical symptoms in older adults, women, and patients with diabetes	Treat as time-critical; assess vital signs and SpO2; obtain 12-lead ECG if available and without delaying transfer; arrange urgent referral / EMS activation
Stroke / transient ischemic attack (TIA)	Facial droop; unilateral weakness; speech disturbance; visual symptoms; balance disturbance; sudden severe headache; altered consciousness	Use FAST/BE-FAST; document last known well time; avoid outpatient delay; arrange immediate transfer
Sepsis	Altered mental status; hypotension; tachypnea; hypoxemia; oliguria; prolonged capillary refill; purpura/petechiae; clinical deterioration; NEWS2 deterioration	Perform urgent assessment of vital signs and mental status; recognize early organ dysfunction; use NEWS2 as an adjunct; arrange urgent hospital referral
Anaphylaxis	Rapid onset after likely allergen exposure; stridor; wheezing; dyspnea; angioedema; urticaria with respiratory or circulatory compromise; hypotension; collapse	Administer IM epinephrine immediately; perform ABC assessment; activate EMS urgently; monitor for rapid deterioration
Acute respiratory failure / hypoxemia	Silent hypoxemia; low SpO2; respiratory distress; accessory muscle use; inability to speak full sentences; cyanosis; altered consciousness; respiratory fatigue	Assess SpO2, respiratory rate, mental status, and work of breathing; initiate basic supportive measures; recognize urgent deterioration; arrange urgent referral

Note: The table summarizes the main warning signs and immediate actions relevant to early recognition of common medical emergencies in family medicine. ACS, acute coronary syndrome; TIA, transient ischemic attack; SpO2, peripheral oxygen saturation; ECG, electrocardiogram; NEWS2, National Early Warning Score 2; FAST, Face Arm Speech Test; BE-FAST, Balance Eyes Face Arm Speech Time.

Acute Coronary Syndrome

In family medicine, chest pain represents one of the most common and most critical clinical presentations due to its broad differential diagnosis and the extremely limited time window during which maximal therapeutic benefit can be achieved in acute myocardial infarction. The clinical challenge is further compounded by atypical presentations, particularly among older adults, women, and patients with diabetes mellitus, in whom symptoms such as dyspnea, generalized weakness, epigastric discomfort, nausea, or syncope may predominate, often in the absence of typical retrosternal chest pain. In this context, the approach in family medicine must be focused on the timely recognition of potentially life-threatening conditions and on maintaining a low threshold for urgent hospital referral when even minimal suspicion of acute myocardial ischemia exists, rather than delaying diagnostic and therapeutic interventions (4).

High-risk clinical features of acute coronary syndrome require immediate action

These features include chest pain occurring at rest with a duration exceeding 10-15 minutes or exhibiting a progressive or recurrent pattern, as well as associated symptoms such as dyspnea, cold sweating, and pronounced generalized weakness, which reflect autonomic activation and impaired cardiovascular function. Episodes of syncope or presyncope, the occurrence of clinically significant arrhythmias, and signs of hemodynamic instability further indicate a high-risk clinical state. Particular attention should be given to the coexistence of acute neurological deficits alongside chest pain, as this may signal complex or overlapping vascular emergencies. Finally, electrocardiographic evidence of myocardial ischemia or the presence of a new-onset left bundle branch block in the context of compatible clinical symptoms represents a critical diagnostic finding and should prompt immediate emergency management without delay.

Early assessment in family medicine should focus on rapid risk stratification

Early assessment in family medicine should be oriented toward rapid risk stratification, beginning with a focused medical history that emphasizes the time of symptom onset, pain characteristics, associated autonomic symptoms, prior cardiovascular disease, and current therapy. This should be accompanied by prompt assessment of vital signs, oxygen saturation, and rapid evaluation of cardiac rhythm. A 12-lead electrocardiogram should be obtained as early as possible; however, in clinically unstable patients, ECG acquisition must not delay urgent transport. The use of rapid cardiac biomarker testing in primary health care is determined by local protocols, but clinical judgment, sustained suspicion, and timely referral remain the key determinants of effective early management.

Acute Stroke and Transient Ischemic Attack (TIA)

The outcome of acute stroke largely depends on the time to initiation of specific treatment

and timely integration into an organized stroke care system. In this context, family medicine plays a crucial role in the early recognition of suspected stroke and urgent referral, without loss of time due to extensive outpatient diagnostic evaluation. Simple clinical screening tools, such as FAST and BE-FAST, have demonstrated good utility in the early identification of the most likely cases, with the clear limitation that a negative screening result does not exclude stroke (5,6).

High-risk clinical signs of stroke indicate the need for immediate action

High-risk clinical signs of stroke include the sudden onset of focal neurological deficits, particularly unilateral weakness of the face, arm, or leg, speech disturbance, or impaired language comprehension. Acute visual symptoms, such as sudden loss of vision, diplopia, or transient monocular visual loss described as a "curtain" descending over the eye, are also indicative of possible ischemic events. Sudden disturbances of balance or coordination, especially when accompanied by focal neurological deficits, further raise suspicion of posterior circulation stroke. The abrupt onset of a severe headache of maximal intensity should prompt consideration of subarachnoid hemorrhage, while new-onset impairment of consciousness or epileptic seizures occurring in association with focal neurological deficits represent critical warning signs that require immediate emergency management.

Management in family medicine should prioritize timely referral and clear communication

Management in family medicine should prioritize timely referral and clear, structured communication to ensure rapid integration of patients with suspected acute stroke into organized stroke care pathways. A critical element of this process is the precise documentation of the time when the patient was last known to be without neurological symptoms, as this information directly determines eligibility for reperfusion therapies. The use of standardized clinical frameworks, such as FAST or BE-FAST, facilitates clear and efficient communication with emergency dispatchers and receiving emergency departments. Any delay caused by additional outpatient diagnostic evaluation should be avoided, given the strict time dependence of reperfusion treatment effectiveness. Timely and appropriate referral from primary health care has been consistently associated with higher-quality acute management and improved patient outcomes (7).

Sepsis

Sepsis represents a paradigmatic example of a medical emergency that often begins with nonspecific symptoms in the primary care setting and subsequently escalates. The clinical risk in family medicine does not lie in a "lack of knowledge," but rather in the masked early phase, in which symptoms may resemble those of a benign infection. Studies conducted in primary care settings highlight variability in the application of diagnostic criteria and in the recognition of disease severity, supporting the need for a structured assessment of vital signs and a "red flags"-based algorithm (8). Given the diagnostic uncertainty inherent to early presentations, the use of structured clinical tools may assist clinicians in systematically identifying patients at risk of deterioration and in guiding timely escalation of care.

High-risk clinical signs of sepsis indicate the need for urgent referral

High-risk clinical signs of sepsis require urgent recognition and immediate referral, as they

indicate evolving organ dysfunction and a high risk of rapid deterioration. These include new-onset altered mental status, hypotension or a significant decline from baseline values with prolonged capillary refill, and respiratory compromise manifested by tachypnea or reduced oxygen saturation. Additional warning signs include oliguria, marked generalized weakness, a clinical impression of severe overall deterioration, and the presence of purpura or petechiae, particularly when accompanied by fever.

Early assessment should be supported by structured tools and guideline-based recommendations

Early assessment should be supported by structured tools and guideline-based recommendations, with NICE guidelines emphasizing a systematic approach to the early recognition and assessment of sepsis across all levels of health care to enable timely escalation of treatment (9). In addition, the National Early Warning Score 2 (NEWS2) is widely used to detect physiological deterioration and to guide clinical decision-making regarding further management and referral (10).

Anaphylaxis

Anaphylaxis is a high-risk medical emergency, as clinical deterioration may occur within minutes. In the family medicine setting, rapid clinical identification and the timely administration of epinephrine as first-line therapy are crucial. International guidelines consistently emphasize intramuscular epinephrine as the cornerstone of management, while delays in its administration are associated with an increased risk of adverse outcomes (11).

High-risk clinical signs of anaphylaxis require immediate recognition and action

High-risk features of anaphylaxis require immediate recognition and prompt intervention due to the risk of rapid progression to airway, respiratory, or circulatory compromise. These include the sudden onset and rapid worsening of symptoms after allergen exposure, respiratory distress such as stridor, wheezing, or hypoxemia, and circulatory instability manifested by hypotension, collapse, or syncope. Generalized urticaria or angioedema accompanied by respiratory or hemodynamic involvement, as well as gastrointestinal symptoms as part of a systemic reaction, particularly in children, should prompt immediate treatment and urgent referral, with close overlap in early presentation and management principles shared with acute respiratory failure.

Standard-of-care management of anaphylaxis requires rapid recognition and immediate safety measures

Standard-of-care management requires rapid recognition and immediate implementation of safety measures, with European Resuscitation Council guidelines emphasizing the clear identification of anaphylaxis and prompt first-aid interventions, including timely activation of emergency medical services to prevent further clinical deterioration (12).

Acute respiratory failure and hypoxemia require urgent escalation of care

Acute respiratory failure in the primary care setting most commonly presents with dyspnea; however, a particularly dangerous scenario is “silent hypoxemia” or clinical deterioration in the absence of marked dyspnea, as may occur

in older adults, patients with chronic lung disease, or those with pneumonia. Rapid differentiation between a primarily respiratory cause, acute heart failure, pulmonary embolism, or mixed conditions is essential, guided by the pragmatic rule that any hypoxemia accompanied by clinical deterioration warrants urgent referral (13).

High-risk signs of acute respiratory deterioration indicate the need for urgent escalation of care

High-risk signs of acute respiratory deterioration warrant immediate escalation of care, as they indicate impending respiratory failure. These include a significant or persistent reduction in oxygen saturation despite initial measures, severe respiratory distress with accessory muscle use or inability to speak in full sentences, and signs of hypoxemia such as cyanosis or altered level of consciousness. The presence of hemodynamic instability or new-onset pleuritic chest pain accompanied by tachycardia and/or hypoxemia should raise suspicion of life-threatening conditions, including pulmonary embolism, and prompt urgent referral.

DISCUSSION

This narrative review confirms that one of the fundamental characteristics of clinical practice in family medicine is decision-making under conditions of pronounced diagnostic uncertainty, particularly in the early or atypical phases of medical emergencies. In contrast to the hospital setting, where diagnostic algorithms, laboratory parameters, and imaging modalities are readily available, primary health care operates within a context of limited time, heterogeneous symptom presentation, and frequently incomplete information. Under such circumstances, patient safety does not derive from exhaustive outpatient diagnostic evaluation, but rather from the timely recognition of clinical risk and appropriate decisions regarding escalation of care (14). The emergency conditions analyzed-acute coronary syndrome, stroke, sepsis, anaphylaxis, and acute respiratory deterioration-share the common characteristic that treatment outcomes are directly dependent on the time to initiation of specific therapeutic interventions. This time dependency has been consistently demonstrated in international guidelines and large clinical studies, further underscoring the responsibility of family medicine in the early recognition of these conditions and the urgent referral of patients (15). One of the key findings of this review is the pronounced frequency of atypical clinical presentations in primary health care. Numerous studies indicate that older adults, women, and patients with diabetes mellitus and other chronic conditions often do not present with “classic” symptoms of acute coronary syndrome or stroke; instead, nonspecific complaints such as weakness, dyspnea, confusion, or gastrointestinal symptoms frequently predominate. Such patterns of presentation substantially increase the risk of diagnostic delay and underestimation of disease severity (16). In the context of sepsis, early symptoms in primary care often resemble those of benign infections, a phenomenon that is particularly pronounced in out-of-hospital settings. For this reason, contemporary guidelines, including the Sepsis-3 definitions, emphasize the importance of recognizing organ dysfunction and changes in vital signs rather than relying solely on the presence of fever or laboratory parameters (17). These findings confirm that diagnostic safety in family medicine must be based on the dynamics of symptoms and the physiological response of the organism, rather than on isolated clinical signs. The central concept of this paper is the use of clinical warning signs (“red flags”) as a structured yet flexible tool for

clinical decision-making. Unlike rigid algorithms, a red flags-based approach enables rapid identification of situations in which further outpatient evaluation is unsafe, without the need to establish a definitive diagnosis. Literature from the field of primary health care confirms that a systematic assessment of vital signs, mental status, and respiratory function significantly reduces the risk of missing serious conditions (18). In this context, tools such as NEWS2 serve as aids in the detection of physiological deterioration but cannot replace clinical judgment (19). This paper emphasizes that red flags do not represent a diagnostic category, but rather a signal for action, thereby reducing the cognitive burden on physicians working under conditions of high workload and time pressure. A substantial body of evidence supports the assertion that delays in the escalation of care are directly associated with poorer treatment outcomes. In sepsis, delays in timely treatment have been consistently associated with increased mortality, and prolonged hypotension before initiation of effective antimicrobial therapy has been identified as a critical determinant of survival in septic shock (20). Similarly, in acute ischemic stroke, each minute of delay in reperfusion therapy is associated with the loss of approximately 1.9 million neurons, reinforcing the concept that “time is brain” (21). In acute myocardial infarction, prolonged time to reperfusion is associated with increased mortality, with evidence suggesting a possible association with more severe heart failure (22). These data clearly demonstrate that “waiting for additional certainty” in primary care often represents a false sense of security. In situations of clinical uncertainty, the clinically appropriate decision is early escalation of care, even at the cost of a higher number of negative referrals, as the consequences of a missed medical emergency are incomparably greater.

CONCLUSION

Although the majority of available evidence originates from highly developed health care systems, its message is particularly relevant for countries such as Bosnia and Herzegovina, where primary health care plays a central role in the management of acute conditions. In urban settings such as Mostar, family medicine covers a large proportion of the population and frequently represents the first point of contact for patients presenting with emergency symptoms. Within such an organizational framework, clear and timely collaboration between family medicine teams and emergency medical services is essential for ensuring continuity of care and patient safety. The limited availability of local registries and systematic outcome data on emergency conditions managed in primary care further underscores the need to strengthen clinical competencies and standardized approaches in family medicine. The implementation of structured red flags recognition, in accordance with international guidelines, represents a realistic and feasible step toward improving care without the need for substantial additional resources.

Given the limited availability of local registries, this review may also serve as a basis for future prospective studies on the early recognition, referral pathways, and outcomes of medical emergencies in family medicine settings in Bosnia and Herzegovina.

This review confirms that improving patient safety in primary health care does not necessarily require additional technology, but rather the consistent application of structured clinical reasoning, clearly defined thresholds for escalation of care, and effective communication with emergency medical services. In this sense, family medicine does not function as an administrative filter, but as an active and accountable participant within the emergency care continuum, playing a

pivotal role in reducing delayed diagnoses and improving patient outcomes.

GENERATIVE AI STATEMENT

During the preparation of this manuscript, ChatGPT (OpenAI) was used for language translation and improvement of scientific writing style in English. All generated content was critically reviewed, edited, and approved by the authors, who take full responsibility for the integrity, accuracy, and originality of the manuscript.

REFERENCES

1. Loots FJ, Arpots R, van den Berg R, Hopstaken RM, Giesen P, Smits M. Recognition of sepsis in primary care: a survey among GPs. BJGP Open. 2017 May 3;1(2):bjgpopen17X100965.
2. Sivanesan S, Gąsecka A, Van Der Sangen NMR, Van Den Broek WWA, Azzahhafi J, Chan Pin Yin DRPP, et al. Sex differences in the presentation and management of acute coronary syndrome patients: Insights from the FORCE-ACS registry. IJC Heart Vasc. 2026 Feb;62:101849.
3. Fernholm R, Pukk Härenstam K, Wachtler C, Nilsson GH, Holzmann MJ, Carlsson AC. Diagnostic errors reported in primary healthcare and emergency departments: A retrospective and descriptive cohort study of 4830 reported cases of preventable harm in Sweden. Eur J Gen Pract. 2019 Jul 3;25(3):128–35.
4. Byrne RA, Rossello X, Coughlan JJ, Barbato E, Berry C, Chieffo A, et al. 2023 ESC Guidelines for the management of acute coronary syndromes. Eur Heart J. 2023 Oct 12;44(38):3720–826.
5. Crause K, Stassen W. The accuracy of the FAST stroke assessment in identifying stroke at initial ambulance call into a South African private emergency call centre. South Afr J Crit Care Off J Crit Care Soc. 2020;36(1).
6. Rudd M, Buck D, Ford GA, Price CI. A systematic review of stroke recognition instruments in hospital and prehospital settings. Emerg Med J. 2016 Nov;33(11):818–22.
7. Harbison J, Hossain O, Jenkinson D, Davis J, Louw SJ, Ford GA. Diagnostic Accuracy of Stroke Referrals From Primary Care, Emergency Room Physicians, and Ambulance Staff Using the Face Arm Speech Test. Stroke. 2003 Jan;34(1):71–6.
8. Mulders MCF, Loots FJ, Van Nieuwenhoven J, Ter Maaten JC, Bouma HR. Use of sepsis-related diagnostic criteria in primary care: a survey among general practitioners. Fam Pract. 2021 Sep 25;38(5):617–22.
9. Gildea A, Mulvihill C, McFarlane E, Gray A, Singer M. Recognition, diagnosis, and early management of suspected sepsis: summary of updated NICE guidance. BMJ. 2024 Jun 18;q1173.
10. Mhd Yunin NS, Tan TL. National Early Warning Score 2 (NEWS2) as a prognostic tool for adult patients in emergency department: A retrospective observational study. Al-Worafi YM, editor. PLOS One. 2025 Jun 16;20(6):e0326058.
11. Cardona V, Ansotegui IJ, Ebisawa M, El-Gamal Y, Fernandez Rivas M, Fineman S, et al. World Allergy Organization Anaphylaxis Guidance 2020. World Allergy Organ J. 2020 Oct;13(10):100472.
12. Zideman DA, Singletary EM, Borra V, Cassan P, Cimpoesu CD, De Buck E, et al. European Resuscitation Council Guidelines 2021: First aid. Resuscitation. 2021 Apr;161:270–90.
13. Lagina M, Valley TS. Diagnosis and Management of Acute Respiratory Failure. Crit Care Clin. 2024 Apr;40(2):235–53.
14. Vally ZI, Khammissa RAG, Feller G, Ballyram R, Beetge M, Feller L. Errors in clinical diagnosis: a narrative review. J Int

Med Res. 2023 Aug;51(8):3000605231162798.
15. Berge E, Whiteley W, Audebert H, De Marchis G, Fonseca AC, Padiglioni C, et al. European Stroke Organisation (ESO) guidelines on intravenous thrombolysis for acute ischaemic stroke. Eur Stroke J. 2021 Mar 1;6(1):I–LXII.
16. Patel A, Vishwanathan S, Nair T, Bahuleyan CG, Jayaprakash VL, Baldridge A, et al. Sex Differences in the Presentation, Diagnosis, and Management of Acute Coronary Syndromes: Findings From the Kerala-India ACS Registry. Glob Heart. 2015 Dec 1;10(4):273.
17. Singer M, Deutschman CS, Seymour CW, Shankar-Hari M, Annane D, Bauer M, et al. The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3). JAMA. 2016 Feb 23;315(8):801.
18. Vukoja M. Checklist for early recognition and treatment of acute illness: International collaboration to improve critical care practice. World J Crit Care Med. 2015;4(1):55.
19. Smith GB, Redfern OC, Pimentel MA, Gerry S, Collins GS, Malycha J, et al. The National Early Warning Score 2 (NEWS2). Clin Med. 2019 May;19(3):260.
20. Kumar A, Roberts D, Wood KE, Light B, Parrillo JE, Sharma S, et al. Duration of hypotension before initiation of effective antimicrobial therapy is the critical determinant of survival in human septic shock*: Crit Care Med. 2006 Jun;34(6):1589–96.
21. Saver JL. Time Is Brain—Quantified. Stroke. 2006 Jan;37(1):263–6.
22. Koul S, Andell P, Martinsson A, Gustav Smith J, Van Der Pals J, Scherstén F, et al. Delay From First Medical Contact to Primary PCI and All-Cause Mortality: A Nationwide Study of Patients With ST-Elevation Myocardial Infarction. J Am Heart Assoc. 2014 Mar 4;3(2):e000486.

ULOGA OBITELJSKE MEDICINE U RANOM PREPOZNAVANJU HITNIH MEDICINSKIH STANJA

Igor Maslać
Služba obiteljske medicine, Dom zdravlja Mostar, Hrvatskih branitelja bb, 88 000 Mostar, Bosna i Hercegovina

SAŽETAK

Uvod: Obiteljska medicina često predstavlja prvi kontakt bolesnika sa zdravstvenim sustavom pri pojavi akutnih i potencijalno životno ugrožavajućih stanja. U primarnoj zdravstvenoj zaštiti kliničke se odluke često donose u uvjetima dijagnostičke nesigurnosti, vremenskog pritiska i ograničenih resursa, osobito u ranim ili atipičnim fazama hitnih stanja.

Cilj: prikazati ulogu obiteljske medicine u ranom prepoznavanju najčešćih hitnih stanja, s naglaskom na znakove upozorenja, praktično postupanje u primarnoj zdravstvenoj zaštiti i pravodobnu suradnju s hitnom medicinskom službom.

Metode: Proveden je narativni pregled literature pretraživanjem baza PubMed/MEDLINE i Google Scholar te relevantnih međunarodnih smjernica i konsenzusnih dokumenata. Analizirana su akutni koronarni sindrom, moždani udar i tranzitorna ishemijska ataka, sepsa, anafilaksija i akutna respiratorna insuficijencija. Literatura je kvalitativno analizirana radi prepoznavanja ključnih znakova upozorenja, dijagnostičkih izazova i preporučenih kliničkih postupaka u primarnoj zdravstvenoj zaštiti.

Rezultati: Ishodi hitnih stanja snažno ovise o vremenu, a atipične kliničke prezentacije česte su u primarnoj skrbi, osobito kod starijih osoba, žena i bolesnika s kroničnim bolestima. Strukturirana procjena vitalnih znakova, mentalnog statusa i respiratorne funkcije, uz prepoznavanje znakova upozorenja, podupire pravodobno upućivanje i smanjuje rizik od odgođene dijagnoze. NEWS2 može pomoći u ranom otkrivanju fiziološkog pogoršanja, ali ne može zamijeniti kliničku prosudbu.

Zaključak: Rano prepoznavanje hitnih stanja u obiteljskoj medicini ovisi o strukturiranom kliničkom razmišljanju, pravodobnom upućivanju i učinkovitoj komunikaciji s hitnom medicinskom službom.

Ključne riječi: Obiteljska medicina; Primarna zdravstvena zaštita; Hitna stanja; Rano prepoznavanje; Znakovi upozorenja

Osoba za korespondenciju: Igor Maslać; igor.maslac@fzs3.sum.ba