LEARNING FROM OUR PRACTICE

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INTRODUCTION

Primary care is the first contact with the patients'problems. Keeping in mind definition of general practice/family medicine the consultation process should follow-up some steps: carefully listening patients, obtain a complete personal and family medical history of the patient, complete physical examination, recommendation of necessary tests. To establish a good doctor-patient relationship is important as you need to inform patient about the diagnoses and prognoses of diseases and to explain the treatment.

There will be presented five patients who came to family doctor for acute complaints, but complete physical examination and screening tests changed the presentation diagnosis.

CASE NO. 1:

CR, 51 years old patient, male.
Smoker (60cigarettes/day); chronic obstructive bronchopulmonary disease (COBPD II GOLD) monitoring by his pneumologist; treated with Symbicort; with annualy chest x-ray (without pleuropulmonary lesions).
Complaints:
- acute pain in his left calf which started one day before the visit to my office.
Clinical exam:medium general condition; no pathological lymphadenopathy; bilateral diminished breath sounds; HR=80beats/minute; BP=150/80mmHg; no signs of venous thrombosis.
Neurological exam was recommended :sciatic nevritis
Two days more patient had another very painful crisis and a kind of muscle contractions which were registered by patient using his mobile; he showed images to his neurologist who considered that it was a focal seizers.
Cerebral IRM was done: frontoparietal brain tumours (mengioma/metastasis).
Lung CT was recommended: right pulmonary retrohilar tumour.
Bronchoscopy and histopatological exam: bronchopulmonary epidermoid carcinoma stg.IV (T3N2M1).
Diagnosis:
Bronchopulmonary epidermoid carcinoma. Cerebral metastasis.
Exploratory toracotomy showed right atrium invasion with no indication for surgery. The prognosis was very poor. Despide of chemotherapy,gamma knife therapy, the patient died after one year.

It is the case of a patient with risk factors and medical history of chronic bronchitis diagnosed with pulmonary cancer by brain metastases.

CASE NO. 2:

MV, 58 years old, male.
No pathological known medical history.
Complaints:
- right abdominal quadrant pain for one year.
Clinical exam: overweigt,HR=88/minute, **irregular**;BP=145/90mmHg; pulmonary normal; abdomen mobile with breathing, mild pain in the right abdominal quadrant, no palpable masses in his abdomen.
ECG: atrial fibrillation.
The patient was reffered to the cardiologist. The investigation for his abdominal pain were postponed.
Cardiovascular exam and echocardiograthy: dilated cardiomyopathy; stage I essential hypertension (JNC 7).
After his cardiovascular problems were under control we continued to investigate his pain:
Abdominal ultrasound: fatty liver.
Lumbar vertebral column: scoliosis, osteophitis.
Feces blood tests: positive.
Colonoscopy: six colonic polyps which were removed and histopathological exam diagnosed two of them with intraepithelial low grade neoplasia.
Diagnosis:
Colonic polyps.Dilated cardiomyopathy. Atrial fibrillation. Stage I Essential Hypertension(JNC 7) Lumbar spondylodiscopathy. Overweight.
The patient is under cardiological treatment. He will repeat colonoscopy in one year. He was also reffered to kinetotherapy and physioteraphy.

Physical exam could add new elements which influence or change the investigation plan and the treatment.

CASE NO. 3:

IG, 83 years old patient, male.
Multiple comorbidity (overweight, diabetes mellitus type2, hypertension, atrial fibrillation, stroke in personal medical history, chronic kidney diseases).
Complaints:
- headache.
Clinical exam: medium general condition; no pathological lymphadenopathy; pulmonary-clinically normal; HR=80beats/minute, irregular; BP=130/80mmHg; no other pathological changes.
Blood tests: mild anemia; leucocytosis; inflammatory syndrome; hypoalbuminemia.
ENT exam; athrophic rhinofaringitis.
Cerebral CT: no active cerebral lesions; no cerebral masses.
Dental exam: chronic periodontitis (acumulation of dental plaque).
A surgical dental intervention was done with relieving the headache, but no the inflammatory syndrome.
Tumour markers were done and the PSA was positive (>100U/L)

Urological exam and prostate punction established the diagnosis of prostate adenocarcinoma.

Diagnosis:

Prostate adenocarcinoma. Bone metastasis. Diabetes mellitus type2.
Stage II Essential Hypertension (JNC7). Atrial fibrillation, Chronic kidney disease.
Orchiectomy was done. The clinical course of the patient is stationary. He is under hormonotherapy and takes medication for bone pains.

This is the case of an old patient diagnosed with advanced prostate adenocarcinoma who was investigated and treated for multiple comorbidity but who didn't have screening tests done in time.

CASE NO.4:

NG, 52years old patient, female.
No relevant personal/family medical history.

Complaints:

- digestive symptoms: flatulence, pain in upper abdominal quadrant, nausea.

Clinical exam: overweight, medium physical condition, palmar erithema; HR=72 beats/minute; BP=120/80mmHg, hepatomegaly, hemorroiddes, varicose veins.
As I had never seen the patient before I recommended her some investigations and also screening tests (gynecological exam, Pap test, mamograthy, feces blood test).
Blood tests: liver cytolisis, hypoalbuminemia, anti HCV positive.
Abdominal ultrasound: hepatomegaly.
Abdominal and pelvis CT and abdominal IRM confirm the diagnosis of cirrhosis.
Unfortunatly the **mammograthy** showed right breast tumour.
It was done sectorectomy with lymphadenectomy.
Histopathological exam showed: ductal invasive carcinoma.
Diagnosis; Liver cirrohsis Child-Pugh score A with hepatitis virus C . Right breast tumour (Ductal invasive carcinoma).
We took care the patient four months but her condition became worst and she died.

Complete evaluation of the patient give information which could change the clinical course and prognosis of disease.

CASE NO.5

IM, 62years old patient; alchoholic, non-smoker.

Complaints:

- weight loss and weakness.

Clinical exam; medium general condition; hepatomegaly; mild splenomegaly; HR=96/minute; BP=140/80mmHg.
Blood tests: mild anemia, trobocytopenia, hyperglycemia, colestatic syndrome; hypoalbuminemia; hypergammaglobulinemia; Feces blood test: positive.
Abdominal ultrasound: hepatosplenomegaly, portal hypertension;
Chest x-ray: diffuse reticulonodular lesions.

Thoracic, abdominal and pelvis CT was done: multiple pulmonary dense lesions (kariokinesis?), multiple mediastinal adenopathy, hepatosplenomegaly, portal hypertension; abdominal adenopathy.
Esogastroduodenoscopy: esophageal varices grade I; portal hypertension gastropathy.
Bronchoscopy: diffuse bronchitis, no atypical or proliferative lesions.
Culture test for BK taken from bronchoalveolar lavage: positive at sixty days.
Diagnosis: Pulmonary tuberculosis. Toxic liver cirrhosis Child-Pugh A.
Diabettes mellitus type 2.

This is the case of a patient who was diagnosed with two serious diseases almost at the same time.That is why his general condition deteriorated very fast.

CONCLUSION

In primary care, even if we focus on the main problem of the patient,complete clinical assessment and recommendation for screening tests should be done to establish an accurate diagnosis and better appreciation of the prognosis. Working with colleagues from different specialities is necessary both for diagnosis and therapeutical intervention.

Thank you to my colleagues who contributed in taking care of the patients (pneumology, gastroenterology, cardiology, imagistic department, laboratory team)