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A FAILURE OF HEALTHCARE DELIVERY SYSTEM: LESSONS TO BE LEARNT FROM CLINICAL PRACTICE

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Abstract
There is a need to integrate medical care at the primary, secondary and tertiary levels. Failure to do so can result is serious adverse consequences for the patient. A 52 year-old businessman who had laryngectomy, followed by neck irradiation in the middle of 2001, was on regular follow-up of Oto-rhino-laryngologists. He was seen in Family Medicine Clinic after almost two years, for the evaluation of un-explained weakness. He was found to have hypothyroidism, hyperurecaemia, macrocytosis and a raised serum creatinine. Such cases should be followed up jointly by Oto-rhino-laryngologists and the Family Physician.

Key words: Patient Care Team, Medical care team, Health care team

Introduction

There is evidence to support the need for a strong primary health care team with well trained family physicians and trained health professionals as primary care practitioners to provide services on health promotion; curative; rehabilitation and supporting services1. In healthcare delivery systems that lack proper coordination between primary, secondary and tertiary healthcare delivery services, there is room for deficiency in providing appropriate care to the patient. The point in question is illustrated through a case report.

Hypothyroidism is a known complication in patients who receive neck irradiation, and thyroid function should be monitored in the follow-up (2). Hyperurecaemia is associated with hypothyroidism, therefore serum uric acid levels should be checked in those found to be hypothyroid (3). Macrocytosis is associated with hypothyroidism and therefore red cell indices should be checked (4). Hypothyroidism is known to be associated with a consistent elevation in serum creatinine levels, which is corrected once the euthyroid status is restored (5). Cholesterol levels are reported to be raised in hypothyroidism and should be monitored (1).

Case Report

A 52 year-old businessman who had laryngectomy, followed by radiation therapy in the middle of 2001, was on regular follow-up of an Oto-rhino-laryngologists. He was seen in Family Medicine Clinic after almost two years, for the evaluation of un-explained weakness. His past medical history and family history were unremarkable. He continued to chew tobacco. On examination he appeared pale, had a pulse of 60/minute, regular and his thyroid gland was not found enlarged.

Investigations showed a Haemoglobin of 12.3gram/dl, Mean corpuscular volume of 102.9 Fl, with macrocytosis on peripheral film. His Thyroid Stimulating Hormone was >75 uIU/ml, with reduced Serum free T4 and Serum T3. His Serum Cholesterol was 209 mg/dl while Serum Creatinine was 2.0 mg/dl. Both Serum B12 and Serum folate levels were normal. He was started on thyroxine replacement and tobacco use cessation program.

Conclusion

Follow-up of cancer patients is shown to be not in line with the standard recommendations (6). The role of Primary Care Physician is mandatory in the follow up of such cases. It is recommended and we strongly support follow-up of cancer patients jointly by the Primary Care Physician and the Sub-Specialist.