CGPSL

MY COLLEGE

NEWSLETTER OF THE COLLEGE OF GENERAL PRACTITIONERS OF SRI LANKA

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MCGP DIPLOMA 2019
CONVOCATION AND AWARD CEREMONY

The Convocation and Award Ceremony of the MCGP Diploma 2019 of the College of General Practitioners of Sri Lanka was held on the Sunday, 9th February 2020, Professor Harendra de Silva, President of Sri Lanka Medical Council was the Chief Guest.

We extend our sincere good wishes and every success to the new MCGP Diplomates, in this new phase of their professional development. We also proudly acknowledge the contribution and dedication of the Members, Teachers and the Mentors of the College of General Practitioners in making this MCGP Course a great success.

In This Issue

ANTICOAGULATION IN A NUTSHELL

Warfarin

Warfarin is an age old anticoagulant which has been in use since 1954. It inhibits the gamma carboxylation of Vitamin K dependent clotting factors II, VIII, IX and X. It takes about 72 hours after the initiation or change in dose of Warfarin for the maximum effect to be seen as factors already in circulation need to decay. Thus a patient who is started on warfarin will have the full expected effect in 72 hours (3 days).

INR (International Normalised Ratio) is a laboratory test that is used to measure the effect of the action of Warfarin.

The expected INR is usually given as a target INR. However it can be expressed as a range of +/- 0.5. For example target INR of 2.5 is usually given as a target range of 2 – 3.

Indications for anticoagulation

- Venous thrombotic events (Deep Vein Thrombosis (DVT), Pulmonary Embolism (PE)), and Atrial Fibrillation (AF) are common indications for the use of anticoagulation.
- Patients with bioprosthetic heart valves need anticoagulation for only 3 months after surgery. However mechanical heart valves need long term anticoagulation and the target INR ranges from 2.5 to 3.5 depending on the type of valve thrombogenicity and patient risk factors.
- Sometimes anticoagulation with Warfarin may be initiated following Myocardial Infarction (MI) with an INR target of 2·5. Patients with dilated cardiomyopathy are anticoagulated to prevent systemic embolism and again target INR is 2·5.

Monitoring Warfarin therapy

Although a loading dose regime of 10mg, was practiced previously at Warfarin initiation, there is no evidence to suggest a 10mg loading dose is superior to a 5mg loading dose. Therefore lower dose Warfarin initiation is now practiced with dose escalation if appropriate INR has not been achieved.

The target range for INR for different clinical conditions varies but is usually between 2 - 3 or 2.5 - 3.5. The expected target range will be documented in the patients clinical notes by the cardiologist, physician or haematologist who follows up the patient. If high INR of over 4.0 are seen the patient is over anticoagulated and is at risk of bleeding. Inquire of any bleeding manifestations – haematuria, bleeding from gums, purpura and examine the patient for any skin bleeding. Ask about any drug or food interactions in the few days before that which may have led to the increase in INR.

Major bleeding is treated with 5mg intravenous vitamin K and prothrombin complex concentrate.1-3mg intravenous vitamin K is used for non-major bleeding. Patients who are not bleeding but with an INR >5·0 should have 1-2 doses of Warfarin withheld and patients with an INR >8 and not bleeding should be given 1-5mg of oral vitamin K.

Drugs and food that cause increase/decrease in INR

The drugs and food that potentiate and inhibit the action of Warfarin are many. It is not possible to include a comprehensive list. The highly probable drugs/foods listed in literature are short listed below.

Drugs which potentiate anticoagulant effect of Warfarin

- Antibiotics (Cotrimoxazole, Erythromycin, Fluconazole, Isoniazid, Metronidazole, and Miconazole)
- Cardiac drugs (Amiodarone, Clofibrate, Propafenone, Propranolol, and Sulfinpyrazone)
- Phenylbutazone
- Piroxicam
- Alcohol
- Cimetidine
- Omeprazole

Drugs which inhibits anticoagulant effect of warfarin

- Antibiotics (Griseofulvin, Rifampin, and Nafcillin)
- Drugs acting on the CNS (Barbiturates, Carbamazepine, and Chlordiazepoxide)
- Cholestyramine and
- Sucralfate
- Foods high in Vitamin K
    - Green leaves (spinach)
    - Green vegetables (broccoli, lettuce)
    - Fruits (avocado, kiwi fruit)
    - Soya beans

If the INR is subtherapeutic then factors that have to be looked into include, drug /food interactions- (usually increase in the intake of green leaves and other vit K containing foods), compliance and tablet strengths. If no cause is found the warfarin dose is increased and INR is checked in 3 days to assess the effect. If the patient is in stable INR range the INR can be checked every 6 weeks but any dose adjustments need to be followed up by more frequent INR tests to assess the effect of the change.

Anticoagulation in procedures/surgery

Warfarin need not be stopped for procedures such as joint injections, simple cataracts, endoscopic procedures including mucosal biopsies, bone marrow examinations.

Warfarin can be stopped 5 days prior to the procedure and procedure done, if INR is less than 1.5 without bridging with heparin for low thrombotic risk patients (low risk AF, bileaflet aortic mechanical heart valve, more than 3 months after DVT).

For high risk patients [Venous Thromboembolism (VTE) less than 3 months ago, AF with previous stroke or multiple other risk factors, Mitral mechanical heart valve]"Bridging with Low Molecular Weight Heparin (LMWH)" is indicated.

Warfarin is omitted 5 days prior to procedure and the patient in commenced on therapeutic dose of LMWH (e.g. Enoxaparin 1mg/kg bd). The INR can be checked on day of surgery or procedure and procedure can be done if INR is less than 1.5. LMWH needs to be stopped 24 hours before procedure (omit evening dose if procedure is in the morning).

Warfarin can be commenced at the dose he was on previously, on the evening of the procedure if haemostasis is satisfactory. INR is monitored and Warfarin continued daily until therapeutic range is reached. LMWH at the therapeutic dose is continued till INR is in range for two consecutive days.

Direct Oral Anticoagulants

Several new oral anticoagulants that have been developed are Dabigatran, rivaroxaban, apixaban. Most act by inhibiting thrombin or activated factor X (factor Xa). They have advantages over Warfarin such as rapid onset and off set of action, absence of an effect of dietary vitamin K intake on their activity, fewer drug interactions, absence of requirement for routine monitoring. The oral route of administration is a definite advantage over heparin and it's low molecular weight forms. Research suggests that direct oral anticoagulants are safe and effective as warfarin. However the lack of availability and cost factor remain a restrain for wider use in Sri Lanka.

Warfarin and antiplatelet

Since patients already on Warfarin for above indications may also sometimes require antiplatelet drugs for Acute Coronary Syndrome (ACS) and following coronary artery stenting, there is an increasing population of patients on combined treatment (both warfarin and antiplatelets). The risk of bleeding is higher for these patients. Discontinuation of antiplatelet agents for surgical procedures needs to be done in consultation with cardiologists.

Bernadene Fernandopulle
Consultant Haematologist/ Senior Lecturer, Department of Pathology, Faculty of Medical Sciences, University of Sri Jayawardenepura

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LOL²

(Living our Lives Laughing out loud…)

BENCH DEDICATED TO A GENERAL PRACTITIONER IN OXFORD

This bench in the garden of Oxford University in the U.K.is dedicated to General Practitioner Martin Lawrence.

Martin Lawrence was an outstanding teacher, who made contributions to medical student teaching, General Practice vocational training and continuing medical education.

He joined the Oxford University Department of General Practice in 1984. Dr. Lawrence became university lecturer in 1993 and was acting Head of Department in 1998, pending the appointment of a new Professor. He was well known for his interest in medical education, medical audit and quality improvement on which he authored several books and papers. He died of cancer aged just 55 years in February 1999.

In recognition of his contribution to General Practice this bench was dedicated to him.

When I visited Oxford University for a conference in palliative care, Dr. Michael Minton who took us around the university premises, knowing that I was in General Practice drew my attention to this bench.

Ref: www.tandfonline.com-Scand J Prim Health Care 1999;17:191Issn 0281-3432

Pushpa Weerasinghe

MCGP 7th Batch

ORIENTATION PROGRAMME FOR THE 7TH BATCH OF MCGP TRAINEES

The Orientation Programme for the 7th batch of MCGP trainees was held on Sunday, 26th of January 2020 with the participation of 40 trainees. The programme began with the traditional lighting of the oil lamp of learning and continued with a series of lectures and interactive sessions which were aimed to familiarize the trainees with the various aspects of the MCGP Course. The inaugural lecture of the new MCGP batch was delivered following the conclusion of the Orientation Programme.

CGPSL PEDURU PARTY

Sunday, 8th December 2019 @ OPA, Colombo 7

Workshop

WORKSHOP ON
"DEVELOPING THE FAMILY MEDICINE MD PORTFOLIO"
AT FACULTY OF MEDICINE, UNIVERSITY OF KELANIYA

Portfolios are used for postgraduate training, appraisal, revalidation and continuing professional development worldwide. It is more a formative assessment tool in the program under Postgraduate Institute of Medicine (PGIM), University of Colombo.

Family Medicine was one of the very first MD programmes of the PGIM to introduce the portfolio. It was first introduced in 2000 and consisted of evidence of learning during each clinical attachment, summary of the research, clinical audit, critical appraisal of research articles and community activities.

With the curriculum revisions it was included to the MD Family Medicine Prospectus. Further weightage was added to the portfolio with subsequent prospectus revisions. To acquire the maximum benefit of the portfolio as a learning tool it is essential that it suits the needs of the trainers as well as the trainees. With the intent of obtaining the views and suggestions from multiple stakeholders to improve the current portfolio as a learning tool, a workshop on "Developing your portfolio" was held on the 26thFebruary 2019 at the boardroom of the Faculty of Medicine, University of Kelaniya. It was organized by the department of Family Medicine, Faculty of Medicine, University of Kelaniya.

Members of the Board of Study (BOS) Family Medicine, pre MD and post MD trainees in Family Medicine, a cross section of DFM trainees and invited members of the College of General Practitioners of Sri Lanka participated in the workshop.

Our objective was to create a forum to share the experience of past trainees on learning through portfolio, share the challenges faced by current trainees, explore digital resources for developing a portfolio and conduct a discussion on how portfolio could be used as a more effective tool for learning.

Dr. Randula Haththotuwa, a UK GP trainee expressed her experience and described the UK GP portfolio. Dr Jayantha Jayatissa, President of College of General Practitioners of Sri Lanka shared his expertise as a portfolio examiner.

Trainees referred to the areas they needed clarification in writing the portfolio. Many suggested the need for a Mentor for each Trainee.

Trainees requested a more detailed guide in the prospectus on how to prepare the portfolio. Trainers highlighted the need for more explicit information on portfolio evaluation and the need to train mentors on how to guide trainees. Trainers also raised the need of an incentive for mentors. Many also appreciated the mentor programme of the MCGP and suggested to adopt a similar strategy.

Despite the current drawbacks, the majority accepted the current portfolio as an important tool enhancing competency based learning, reflective practice and as a resource for preparing for clinical examinations. The group activities generated helpful suggestions for improving the utility of the portfolio and the supervisors' role.

A detailed report of the workshop was submitted to the Board of Study in Family Medicine.

This activity with the contribution of multiple stakeholders generated suggestions which could be used in future curriculum and prospectus revisions

Aruni de Silva

KEEPING THE CLIENT IN THE EXTRA CELLULAR COMPARTMENT

The title refers to an exercise which was hitherto regarded as the province of the legal fraternity. Since of late doctors in Sri Lanka too have been called upon to handle this responsibility. Using the word client rather than patient is appropriate as here the person seeking the doctor's service is not necessarily sick. An appropriate analogy would be a couple requesting advice on fertility control. They are clients not patients. Keeping the client in the 'extracellular compartment' is a challenge. I am referring here to the commonplace practice where individuals who are about to be arrested by the police seek the assistance of doctors to avoid arrest.

My interest about the topic is because doctors are involved in it. Ciicero, the Roman philosopher said "Let nothing human be alien to me" (*Nihilhumanialienum a me puto).* We need not be alien to anything "medical" leave apart "human". The phenomenon existed earlier only in State hospitals and a teaching hospital owned by a statutory body. In 2020 a single case surfaced in the private sector.

The phenomenon is important as it raises doubts about the integrity and honesty of the medical professionals who service these clients. It is quite reasonable for the members of the public to question the honesty and integrity of our colleagues, who have this kind of practice. The reason for this is that most individuals who avail of this 'service' look quite healthy prior to hospitalization. They address large public gatherings, travel long distances, appear in public talk shows and in the media behaving very aggressively before arrest. When an order for their arrest is made they suddenly fall ill. Later when the court order is removed, on the way home they give "voice cuts" to media quite vociferously and become healthy the very next day. The public may conclude that these individuals are probably, malingering and that medical professionals supports such individuals.

We must realise that when this conduct is, carried out in a dishonest background it leads to a serious violation of trust that the State and the community at large have placed in the medical profession. Moral implication of this violation is more severe, if the medical professional is a product of free education.

There seems to be many reasons for this conduct of some doctors. They could be pecuniary, being under threat, social or political. Combination of the factors are probable. Unless a person is acquainted with the doctor as a friend or a relative he is unlikely to request this service. The client may be the friend or the relation but declining to offer the service may put the doctor under serious threat. On the other hand obliging may have vast financial and other benefits that can be activated through State machinery like employment promotions and transfers to near and dear ones. The subject being a friend or a relation is a social factor. It is very unlikely for a medical professional to voluntarily offer this unique service. On the other hand compliance may be achieved with quite a lot of coaxing. Deliberating on all these possibilities one should not cultivate a hostile attitude towards the doctors involved. Most of us have the experience of being requested to perform unethical and dishonest acts. We have experienced the lingering unpleasant feeling of working against our conscience when we acquiesce to such requests.

The demand for this "service" will become more and more frequent in future. It is a complex problem. Therefore we must discuss this issue. Team work in this kind of situation will reduce the stress on the doctor picked upon for this activity. State hospitals can have a multidisciplinary team including administrators and judicial medical officers when admitting a person scheduled to be in custody or imprisonment, Even private health institutions can have similar teams. Private Health Services Regulatory Council can assist private hospitals to organize a team.

This will discourage individuals from approaching doctors to carry out this illegal activity and hopefully attempts to exploit doctors making use of social acquaintances, threats or bribes will cease.

The medical profession has to be ready to deal with it. The necessity to preserve our dignity, minmise threats to our personal security and to maintain our peace of mind seems to be necessary rather than looking for culprits.

B G D Bujwansa

The Chronology - CGPSL

ESTABLISHMENT OF THE COLLEGE OF GENERAL PRACTITIONERS OF SRI LANKA – THE CHRONOLOGY

The fourth Congress of the Royal Australian College of General Practitioners was held in Brisbane, Australia on the 19th May 1969. It was attended by Dr. A M Fernando President of the Independent Medical Practitioners Association (IMPA), as a delegate.

At this Congress, a meeting of delegates was convened by the Presidents of the Royal Australian College of General Practitioners (RACGP) and the Royal College of General Practitioners UK (RCGP UK), to discuss the prospect of establishing Colleges of General Practitioners in Asian countries.

At the meeting it was suggested that each Asian country could either form a chapter affiliated to the RACGP or RCGP UK or else establish a College of their own.

Dr. A M Fernando had then conceived the idea of a College of General Practitioners in Ceylon.

On his return, he revealed the idea to the IMPA and it was discussed at length, by its members.

As Dr A M Fernando later said, the idea conceived by him may have aborted, if not for the keen interest taken by several members of the IMPA Council, specially Dr. G M Heennilame and Dr. M P M Cooray and the advice given by Mr. L H R Peiris, Hon. Legal Advisor to the IMPA.

In 1971 the IMPA made a final decision to establish a College of General Practitioners and a group of members of the IMPA became the founder members of the College that was to be established.

In 1973 the Founder Members appointed an interim Council which made plans for the College and formulated the laws necessary for its establishment with the help of the legal advisor.

By 1974 the laws to establish a College of General Practitioners were ready for presentation to the National State Assembly for certification and by that time “Ceylon” had been renamed “Sri Lanka”.

Thus the College of General Practitioners of Sri Lanka was born on the 19th August 1974 when Incorporation Law No 26 was certified by the National State Assembly of the Republic of Sri Lanka.

Leela de A Karunaratne

New Website, coming soon.

The Website Subcommittee of the College of General Practitioners of Sri Lanka (CGPSL) has initiated the revamping of the Website.

We are pleased to inform you that the College has purchased its own web-server and web-address for the betterment of its members. (www.cgpsl.lk, www.cgpsl.com, www.cgpsl.net)

The new face of our upgraded Website would present the following remarkable features to the members and associates:

- Better access to information about the CGPSL
- Access to the database of members. Could be used as a GP directory.
- Separate area for the Past Presidents, Fellows, Hon. Fellows
- An App like experience allowing members to access the Website through a mobile phone, which will improve the user experience
- Automatic sharing of posts on social media, which will enhance the membership growth and getting important messages across to Members and Associates
- CGPSL would be able to track performance of posts and events
- Enhanced event management, online booking, and online payment (for Associates, Members, MCGP Trainees and for participants of Annual Academic Sessions)
- Free access to point of care web pages like BMJ
- A permanent web home for Annual Academic Sessions
- Professional & updated outlook to the local and foreign web visitors.

The committee is looking forward to launching the new and improved Website of the CGPSL.

Website Subcommittee: Dr. Dumindu Wijewardana (Chairperson), Dr. Supun Sandeepa Withana (Secretary), Dr. Jayantha Jayatissa, Dr. Preethi Wijegoonewardene, Dr. Pushpa Weerasinghe (Chairperson–Publications Committee), Prof. Kumara Mendis, Dr. Kalpanie Wijewardana (Editor–Newsletter Subcommittee), Dr. M. Rikaz Sheriff, Prof. Janaka Ramanayaka (Editor)

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Co-opted Member:*Prof. Janaka Ramanayaka*

Type setting, page setting & formatting: *Dimuthu C Weerasekera*

CONTINUING PROFESSIONAL DEVELOPMENT (CPD)
THE NEED OF THE HOUR

During working hours, while interacting with medical delegates, at home visits, when talking to friends and relations, we sometimes, get confronted with medical facts and procedures that we are not aware of. All of us have experienced this.

As time goes by our knowledge diminishes and skills become less precise. Remember we are in general practice and there would be younger updated keen doctors who move into our areas. Thus, we all have to remain updated. Our patients' lives and our practices too depend on that.

In order to fulfill the need of updating ourselves, we usually access print (text books, journals), electronic (e.g. websites) human (e.g. peers. specialists) resources or even attend meetings (eg seminars, academic sessions). In this manner we improve our knowledge, skills and sometimes our attitudes too.

The process is clear. It begins with the need to improve our knowledge, skills etc., Next, we access whatever the source that is accessible to us to meet our needs. Having updated ourselves we complete the process by applying the new learning into our practices. This process continues till we stop working or till we die. We do this by ourselves and at our convenience.

If you think back you will remember the many instances when this process has played out in your life. This then is the basis of Continuing Professional Development or CPD.

CPD is a learner driven process. On the other hand, you have the provider (e.g. College, Association, University) driven programs which present a "package" of teaching. This is Continuing Medical Education or CME.

RACGP
QI&CPD
Accredited Activity
CATEGORY 2

For more than 20 years, now health authorities in many countries have begun to implement mandatory assessments for continuing in practice. This is the formal CPD process. In Sri Lanka there is a rudimentary CPD process in place with the SLMA, setting up a national CPD committee.

The College in turn is in the process of setting up a CPD program to support our Members and Associates so that they could continue in practice without being found wanting, when the national CPD program kicks in.

There will be real benefits for those who remain CPD updated

- Patients will appreciate the care given by updated and experienced GPs
- As a result, their practices will improve
- GPs will be officially recognized by the College of General Practitioners of Sri Lanka (CGPSL) and the Sri Lanka Medical Council (SLMC).
- The insurance companies may offer better rebates for clients who go to CPD updated doctors. This will be a win-win situation for both clients and their GPs.

When we think of CPD we always think in terms of attending academic sessions and workshops. Is this correct? What are the key features of CPD?

CPD activities are;

- Self-directed & driven by the learner's identified needs
- Integrated into an individual's learning program
- Supportive of active participation
- Cognizant of the GP's prior knowledge, skills, behaviors and attitudes
- Inclusive of reflection and evaluation of what has been learnt by the GP.

So, aims of a meaningful CPD program for GPs must address all of the above, to be effective. It must support GPs to maintain and improve their professional knowledge and skills in order to provide the best possible care for patients and their communities.

A meaningful CPD programs should;

- Provide GPs with opportunities to improve patient safety and quality outcomes
- Support continuous quality improvement within the general practice setting
- Enable GPs to fulfill their individual and vocational continuing professional development (CPD) requirements
- Also include technological and personal development.

Members and Associates of the College have the opportunity to meet their CPD needs through the CGPSL's educational programmes which are given below. The members and associates who have identified their needs could pick on any activities of the College to meet them.

Activities which could be utilized by Members and Associates to meet their needs in CPD

Face to face sessions ➢ Academic sessions (Annual and Months) ➢ CME sessions, workshops etc ➢ GP's Café of CGPSL ➢ NCD programs ➢ GP's gatherings ➢ Health camps ➢ Health education programs for children, other non-medical professionals ➢ Hospital clinical meetings ➢ Hospital academic sessions ➢ Other GP organizations clinical meetings ➢ Special CME courses (e.g. CPR programme)	Reading material ➢ Sri Lanka Family Physician, IMPA Journal, CMJ, BMJ etc. ➢ Newsletter ➢ Print CPD ➢ Websites ➢ Bulletins ➢ Guidelines By following ➢ Research Committee activities ➢ Social media educational activities ➢ Community services Higher education ➢ Certificate courses ➢ Diplomas (DFM / MCGP) ➢ MD Family medicine

The way forward

CPD Committee of the CGPSL is in the process of developing a meaningful CPD program based on a CPD point scheme, introduced by the SLMA in 2010. Our committee will present a proposal titled "**CPD program for GPs"** to the Council of the College.

So dear colleagues, I will come back to you in the next newsletter with the details of proposed CPD program for GPs.

Deshan Kotugodella

The
GPs' Café

Gather • Discuss • Enjoy

An arthritis with high uric acid, is it gout?
A narrative of one Mr. Ivan

Presented by
Dr. A. A. K. Jayanath, MBBS, DFM, PgDCP, MCGP, MRCGP [INT] MD (Family Medicine)
Family Physician
GP's Café @ CGPSL @Spice Route – Sri Lanka

Mr. Ivan, a 48-year-old patient, worked in Italy for past 8 years and returned to Sri Lanka a week back to participate in his daughter's wedding in 5 days' time. He was accompanied to the surgery by his wife as she noticed her husband being weaker and experiencing tiredness easily. She opened up the consultation, "Doc my husband is very weak and pale. Earlier, he was like a tusker. Now he can't do even a simple thing and gets tired easily."

Ivan stated that he had a troublesome ankle and neck pain for two years and he took many medications while abroad but with no improvement. Furthermore, he had been experiencing tiredness and weakness for the past 6 months. Ivan had a 10-year history of diabetes mellitus and his last documented fasting blood glucose in Sri Lanka was 234mg/dL, which was 8 years back. Nevertheless, he continued taking the same medications prescribed in the Island without checking sugar control or visiting a doctor until two years back.

Ivan first experienced his neck and ankle pain 2 years ago. He had swelling, temperature and tenderness in the joints without redness. He also had stiffness in the joints which lasted for about an hour in the morning and it was worse in the winter months. However, there were no other joint involvement and he did not suffer from rashes, fever, malaise, loss of weight and anorexia. Ivan underwent number of investigations abroad which revealed arthritis with high serum uric acid. As a result, he was managed as gout with allopurinol. For his diabetes, he had been on Metformin and Gliclazide and visited his overseas GP once in about 6 months because he believed that his blood glucose was under control. He was neither a smoker nor an alcoholic. Unfortunately, his diet control was poor and he did not do regular exercises. Mr. Ivan worked as a barber in Italy and was financially stable. Unfortunately, this problem affected his daily activities including his job. Regarding his family medical history, his mother and elder sister had diabetes and hypertension. On examination, his BMI was 23 and he seemed mild dyspneic and pale. There was mild bilateral ankle oedema and no tophi. His pulse rate was 100 and blood pressure was 180/100 and there was a systolic murmur and a few bilateral lung basal crepitation. His ankle joints were inflamed and movements were tender. There were no other joint involvement.

Mr. Ivan's list of medical problems could be summarized as poorly controlled diabetes mellitus and oligoarthritis due to gout or? something else. Moreover, his pallor, tachycardia, high blood pressure and oedema could be explained either as chronic kidney disease or as anemia complicated heart failure. However, their sudden worry about Ivan's weakness (the reason for encounter) might be his erectile dysfunction. In addition, he had social problems including his daughter's wedding in 5 days' time as well as he had returned to the country after 8 years.

In the evaluation, there were some factors not in favor of gout. Ivan had continuous articular inflammatory signs for 2 years. In contrast, acute gout is characterized by severe pain, erythema, warmth, and swelling of 1 or more joints, peaking within 24 hours and with spontaneous resolution within 7-14 days. Unlike in Ivan's case, gouty people do not complain of morning stiffness and axial joints like neck involvement. It commonly affects first metatarsophalangeal joint and sometimes midfoot, ankles, and knees.

Hyperuricemia may be caused by number of factors including:

- Medications – Aspirin (low dose), frusemide, thiazide, theophylline, levodopa, ethambutol, pyrazinamide etc.
- Alcohol
- Increased nucleic acid production – inborn errors of purine metabolism, malignancies, psoriasis, haemolytic disorders, obesity (BMI>30), lack of exercise
- Under-excretion of uric acid – CKD, drugs, HPT

In order to explain Ivan's hyperuricemia, diabetes complicated CKD would be the reasonable hypothesis though it does not clearly reason out the possible cause for his oligoarthritis. As a result, number of lab tests were urgently ordered and followings were the test results.

Hb% - 8.3g/dL
ESR - 80cm/1st hour
HbA1C% - 9.4
Rheumatoid factor - 36 IU/L (high)
eGFR - 6mL/min/1.73m2
Urine albumin/ creatinine Ratio - 600mg/mmol/L
S. Uric acid - 6 mg/dL (upper range)
SE – Na+ - 136mmol/L K+ - 6.2 mmol/L
ECG – Sinus tachycardia, LV strain

Consequently, Ivan's problem list was readjusted as below:

- Poorly controlled DM
- CKD – G5 A2 complicated with severe hyperkalemia, anaemia and heart failure
- Rheumatoid arthritis

It is obvious that Ivan needs urgent hospital admission for probable renal replacement therapy. Unfortunately, he declined hospital admission as his daughter's wedding was due on the day following. He insisted that he had been like this for sometime. He requested some treatment until he got admitted after the wedding.

The unpredictability, dilemma and challenge is inevitable in patient-centered care in general practice. Ivan's argument is quite rational although its accomplishment is challenging in primary care. There are no rights or wrongs in dilemma in 10 minutes consultation unless you do no harm and do what is in the best interest of the patient. That is challenge-taking in general practice.

The urgent worries that Ivan had in medical point of view were severe hyperkalemia, developing left ventricular failure (LVF) and hyperglycemia. To reduce the level of hyperkalemia, he was nebulized back to back with salbutamol in the surgery and was referred to a colleague-VP in the private sector for IV calcium gluconate + insulin + dextrose. Furthermore, he was administered IV Lasix 60mg stat for LVF and gliclazide was continued, and linagliptin was added instead of ESR - 80cm/1st hour HbA1C% - 9.4 Rheumatoid factor - 36 IU/L (high) eGFR - 6mL/min/1.73m2 Urine albumin/ creatinine Ratio - 600mg/mmol/L S. Uric acid - 6 mg/dL (upper range) SE – Na+ - 136mmol/L K+ - 6.2 mmol/L ECG – Sinus tachycardia, LV strain metformin for hyperglycemia.

As an intermediate management, he was put on Enalapril 2.5mg bd, amlodipine 2.5mg bd, frusemide 20mg bd, atorvastatin 10mg nocte, aspirin 75mg daily, 1α CCF 0.25mg daily, $CaCO_3$ I tab bd with meal and allopurinol 100mg daily until he visits the nephrologist.

Next, Ivan was counselled on impending renal replacement therapies and importance of blood glucose and pressure control, adherence to medication and the life style modification. Later, a shared care was initiated with the nephrologist who immediately commenced renal replacement with haemodialysis, continued same medications and followed up once a week. He had prescribed erythropoietin twice a week and it was administered in the GP surgery. In addition, sildenafil 25mg was commenced in order to overcome his erectile dysfunction and dose increment was planned after cardiac assessment. As a long term management, Ivan is awaiting for donor transplant and he will be referred to the rheumatologist for the management of rheumatoid arthritis in future.

Reflection Diagnosis and management of a disease depends on factors related to the patient, health care provider and the availability of health care resources. In this case, poor patient participation in health services has majorly affected this poor outcome. However, it seemed that he had been mismanaged as having gout for two years. This might be due that fact that healthcare provider had just considered the probability pattern of diseases in the particular country, neglecting the country of origin of the patient, his comorbidities and their complications. The general practitioner should always formulate diagnostic hypotheses not only based on the probability patterns but also thoughtfully considering the red flags, common pitfalls, masquerades, hidden agenda and possible psychogenic aspects.

If undelivered please return to:
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