THE GENERAL PHYSICIAN WHO ONLY ATTENDS “INTERESTING CASES”

Jose Luis Turabian*

Health Center Santa Maria de Benquerencia. Regional Health Service of Castilla la Mancha (SESCAM), Spain

Editorial

"By George!" cried the inspector. ‘How ever did you see that?’

‘Because I looked for it.’

Arthur Conan Doyle. The Adventure of the Dancing Men

When I look at the bulky files that contain the patients’ medical records, I must confess that, in view of such an abundance of material, it is very difficult to select the most interesting cases in themselves and, at the same time, to reveal the concept of general medicine… But, let’s see one of them…, because it turns out that I only attend “interesting cases”!

Mr. Minotauro [1], is a 41-year-old patient who presents with hypertension and is under treatment with enalapril with good BP control to date. He presented a hypertensive crisis vs. a hypertensive pseudo-crisis in an anxiety crisis. In the emergency room, another anti-hypertensive agent, an angiotensin II receptor blockers (ARB), irbesartan, an antidepressant and a benzodiazepine are prescribed.

Hummm … I wonder: What is the most cost-effective treatment of the hypertensive crisis and anxiety crisis? Is it OK to replace enalapril with irbesartan? When are ARB indicated?

Mr. Minotauro, requires me to give prescriptions of drugs prescribed in the emergency room (what seems to me an inadequate treatment); his behaviour is angry, threatening and demanding …; He already bought them and owes the money to the pharmacy.

Hummm …, I wonder: What are the psychosocial aspects of pharmacological prescription? What role does the doctor-patient relationship play, and the negotiation in an aggressive patient? -What is the help in the decision making in this case? [2].

I decide to broaden my knowledge about Mr. Minotauro by reviewing the background, experience of the patient, the family and the context: the patient is a frequent user, smokes 1 package a day, and abuses alcohol, presenting sometimes alcohol intoxication crisis. He has high blood pressure (HBP) with possible cardiomegaly, presented a doubtful transient ischemic attack (TIA) a few years ago while on vacation, he has extrinsic bronchial asthma, obesity, chronic urticaria, gastro-esophageal
reflux, personality disorder and somatoform disorder with “syncopes”, tension-type headache, atypical chest pain, and alcoholic liver disease. He has had Diabetes Mellitus (DM) for years. His family is dysfunctional; there was an autolytic attempt 9 years ago, separation of his wife 4 years ago, and he has had two new partners in the last 3 years. He has no relationship with his eldest son; His daughter “does not talk to him”, and her youngest child uses drugs and frequently asks for money; this youngest son sometimes steals food from the hypermarket and some takes it to his father, Mr. Minotauro, who says he cannot pay the mortgage on the house. Mr. Minotauro, now, he has just burned the engine of the car ... He sometimes does not buy medicines because he cannot pay for them. He has serious labor problems for 5 years; He has been with sick leave almost 1 year for “Neurasthenia”, and almost another year for knee pain! Their income is scarce, and part goes to their partners. There are legal problems related to your hostile behaviour. There is a lack of compliance about medical advice and treatment. He live in a marginal area...

Hummm ... I wonder: What is the best treatment for a patient of low social class with HBP, hypertension crisis, anxiety crisis, doubtful previous TIA, DM, obesity, depression, alcoholic liver disease, and alcohol abuse, which also presents legal, economic, and family problems? What are the “relevant actors” in this situation? What is the basis for a therapeutic decision? What is the clinical guide?

Its pharmacological treatment is: enalapril, amlodipine, chlorthalidone, acetylsalicylic acid, omeprazole, budesonide in inhaler, terbutaline in inhaler, metformin, simvastatin, and glibenclamide. I ask myself if an ARB is indicated, and in that case which one would choose; Irbesartan or what? [3]. During its evolution Mr. Minotauro ends up presenting heart failure and angina. He also has diabetic nephropathy. What is the best treatment of a patient with intoxication crisis due to excessive alcohol consumption, with HBP, DM, liver disease ..., depression, smoker, with legal, economic, and family problems, with noncompliance, which is a frequent attendant, with an occasionally hostile behaviour, and living in a marginal area, ... that has diastolic dysfunction ..., heart failure ..., angina ..., diabetic nephropathy ...? What pharmacological interactions can occur? What tools do I have to decide? [4-7]. Biological and social systems are inherently complex, so it is surprising that any human disease can be said to have a single cause or cure. To classify patients’ problems as Interesting or not interesting, or in other words, as easy or difficult, is a conventional one, which can only have pedagogical purposes: all problems are always very Interesting and very complex, and to characterize them only depends on where we arbitrarily stop our inquiry, our look [8]: the deeper you dig into the problem, the more interesting will be the case, the encounter, and the person [9,10].

References