Delayed Diagnosis and Specialist Referral: A Persisting Dilemma in Medical Practice. A Case Report

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ABSTRACT

Delay in diagnosis and most importantly delays in specialist referrals have been known for many years. Despite intense efforts by the fathers of medical ethics to reverse the trend, it is still lingering in present times. This is even more pronounced in the rural settings of the low economic countries. The contending variables may be primary care physicians based, patient based and health care system based. On the part of the primary care physicians, it calls for a review of the medical ethics, concerns for continuing medical education backed up by attitudinal change to give priority to patient outcome and then make moves to correct patient and health care system based variables. This will translate to our patients receiving the best and timely care with good outcome. We report a sixty-five year old retired civil servant who presented to our facility with a two year history of penile growth that was first noticed in the incompletely circumcised prepuce. This was excised in a peripheral hospital within a month of noticing the growth followed by daily wound dressing. No histological examination of the excised tissue was done. The lesion grew and invaded proximally to involve the proximal third of the phallus which prompted him to abandon the care and came to University of Uyo Teaching Hospital. He was seen and an incisional biopsy taken for histology which turned out to be well differentiated squamous cell carcinoma. He was offered a total penectomy and a perineal urethrostomy to which he consented in writing. This report seeks to highlight preventable morbidity in medical care, identify some key variables that may account for delays and to suggest subtle solutions for better treatment outcome for our patient

Keywords: Diagnosis, Referral, Morbidity, Outcome.

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INTRODUCTION

Primary care physicians are the first medical contact in the health care system and so proper knowledge of early diagnosis and referral is paramount if the focus is truly good patients' outcome, of course no other interest should override this. Delays in diagnosis and referral have been shown to have a possible negative effect on the outcome associated with some solid tumours[1]. It is a fact that pathological diagnosis, staging, prognostication and therapy will usually translate into significant benefits for patients who are diagnosed and referred in a timely manner. Our main aim is to describe a preventable problem regarding referral and diagnosis which could have been avoided if the rules were followed. This index case shows that beyond the often overflogged arguments for illiteracy, poverty, ignorance, shame, embarrassment and late presentation as the underlying factors for poor health outcome, health care practitioners need to examine their roles and also audit their practice to fall in line with the expected medical norms. This index case definitely demonstrates that among the indices that influence the health care practice, the skill and knowledge base of the practitioner are major contributors to outcome. To expantiate on the concept of delay in diagnosis and referral, delay can occur at different levels and different definitions are used by authors. Patient delay is generally defined as the time from the patient's first awareness of a symptom to seeking their consultation with a health care professional[2], whereas professional delay is defined either as the time from first consultation with a healthcare professional to the first consultation with a treating specialist[3,] or to the definitive diagnosis being made[4]. It can also be defined as the time taken for the patient being admitted for definitive treatment[5,] or as the time from the first consultation until a referral letter is sent to a specialist unit[6.]There is no consensus on what should be considered excessive delay at each

stage[7]. Despite the lack of consensus regarding the timeline for delay, our index case demonstrates clearly a professional delay and we hereby present a case of severe preventable complication with attendant morbidity.

CASE REPORT

A sixty five year old retired male civil servant presented with a two-year history of penile growth. The growth started initially small in the incompletely circumcised prepuce which was excised in a peripheral hospital with no histological examination of the tissue. Patient was placed on antibiotics and daily wound dressing. The wound did not heal, instead it extended to invade the proximal penile tissue, just short of the base and exuding purulent materials and offensive odour. He also visited unorthodox practitioners who used herbal concuctions to dress the wound which worsened his condition with associated pain, weight loss, anorexia. He had no urinary symptoms. He presented to our facility when his condition got worse. Clinical examination showed an elderly man, anxious looking, mildly pale, anicteric and malodorous with no peripheral lymphadenopathy. Vital signs were within normal range. Examination of the external genitalia [fig.1] revealed a fungating mass involving the penile shaft up to about 3cm short of the penile base. The surface was undulating and bled on touch, edge was everted. The remaining apparently normal penile skin at the base was not indurated. There were no inguinofemoral masses. Abdominal and chest examinations showed no objective signs of masses which may point to metastatic deposits.

A diagnosis of penile cancer was made and an incisional biopsy done showed a well differentiated squamous cell carcinoma. His haemogram was 12.1g/dl, urine microscopy, culture and sensitivity yielded growth of *Staphylococcus aureus*sensitive to ceftazidimeand resistant to ciprofloxacin, ofloxacin, nitrofurantoin and genticin. Fasting blood sugar was 4.1mmol/l, renal function test was essentially normal and HIV Serology was non-reactive. Abdominopelvic ultrasound scan showed normal study. He was worked up for total penectomy and a perineal urethrostomy which he had successfully. He was discharged to void through the perineal urethrostomy for which he was counseled pre-operatively. (He did not have bilateral orchidectomy, the scrotum and content is held up in the picture).

Fig.1: Penile Lesion

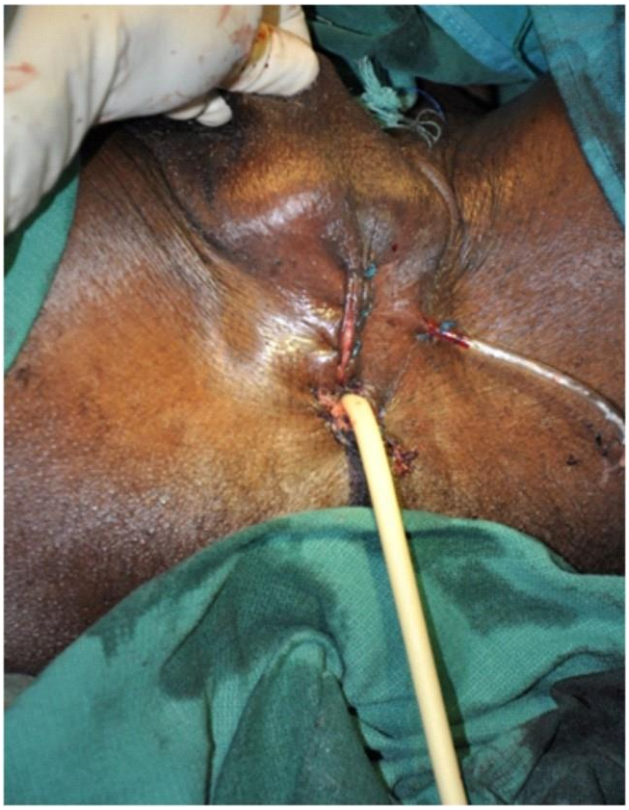

Fig. 2: Post Operative Picture. Total Penectomy and a Perineal Urethrostomy.

DISCUSSION

The primary care practitioner is frequently the first point of medical contact for patients with malignancy, and as such, serves a critical role in facilitating cancer diagnosis and treatment[8]. Great concerns have been given to

the area of histological examination of any tissues taken from the body and this coupled with early referral can make a whole lot of difference in patient management and treatment outcome. Despite this effort by great clinicians of the past and present generations, these issues still linger with poor outcomes for our patients. A descriptive work done by Richard Wender categorized barriers to optimal cancer detection by primary care practitioners into three categories: Practitioner based (e.g. lack of knowledge, financial disincentive to refer), patient based (e.g. fear about seeing physicians, financial barriers to receiving care), and healthcare system based (e.g. lack of specialists, lack of government support)[9]. Contrary to expected patient based factors for delay, our index patient presented within a month of noticing the growth which was excised with no histological examination and no referral. At that stage, patient would have benefited from a penile sparing surgery with normal standing posture while voiding and some reasonable level of sexual life.

Long waiting periods and delays between primary care physicians and specialist care are not only dissatisfying and inefficient, but also cause concerns about patients' clinical outcome deteriorating[10]. Delay in referral will certainly lead to the diagnosis of a more advanced stage of cancer which will preclude cure with noticeable grievous outcome. Upstaging of cancer consequent upon delays will lead to a more radical mode of treatment that will impact negatively on the patient's financial status, relationship issues and overall survival. On the other hand, early referral to a specialist can over-turn the outcome for good. Early diagnosis and treatment with curative intent will be offered to the patient with reasonable good quality of life and survival. Relationship between primary care physicians and specialist care physician can be fostered by this system of referrals for the ultimate good outcome. This will further widen the scope of patients care for the primary care physicians.

Whatever the source of delay, timeliness of care has become a priority and was identified as one of the six aims of quality improvement in the Institute of Medicine's 2001 crossing the quality chasm report[11].

The aim of this paper is to join the teaming clinicians in emphasizing the need for early diagnosis and referral for the overall good of our patients. Trained in rigorous and structured training programs, orthodox physicians should bring the advantages of their training to bear on the healthcare status of the communities they work in. This must include safe practices, a recognition of the finiteness of their skills and early referral[12]. Aside from the basic medical training that qualifies a physician to practice, continuing medical education should be enforced which will translate to maintenance and increase in knowledge, skill base and professional competence of physicians. At the same time, attitudinal change and discipline must be emphasized as patient's outcome is a priority in clinical practice.

Primary care physicians should take an interest in improving access to specialty care because their efforts will result in improved care, efficiency and satisfaction.

CONCLUSION:

Primary care-specialist care referrals are valuable tools in the quest for improved access to care across the health care continuum. This also fosters good relationship between them which inturn maintains the expected good outcome for our individual patients.

Conflict of interest:

Authors declare no conflict of interest.

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