CASE NOTES

FROM

A

FAMILY DOCTOR

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DEDICATION

This book is dedicated
to my wife Dorothy
and my children
Carolyn, Grace
and Kelvin

This book contains the case notes of my
Family Clinic of the different conditions seen in the Clinic.
The real names of the patients were not used in the writing of the book.

TABLE OF CONTENT

MY CLINIC

My clinic started in January 1974 in a newly established public housing estate which catered for mostly the low income and lower middle income groups of families as well as an old shanty part of Holland Village still occupied by slum like houses.
There were many poor families in the whole estate.

THE POOR

To me helping the poor is just part of being a family community doctor. For the poor I have been charging a minimal sum of medical cost. For those who can pay they will pay. For those who can not pay they do not have to pay.

During our recent relocation of our clinic in 2009(The clinic was relocated to a newer housing estate just across Holland Drive after 35 years because the buildings were getting old and developing drainage and structural problems) while going through the medical record cards in order to discard those patients who have not seen me for at least 10 years. I found that there were patients who still owed me money since 1974 when I first started the clinic.
I do not believe in chasing patients for their money.

There was this Indian foreman who was in charge of our estate rubbish removal. He was poor but he brought his family to see me asking the money to be owed. For 10 years he brought his family for medical treatment. Knowing that he was poor I did not expect any payment for all these treatments. Yet at the age of 55 years (the retirement age at that time) he was able to withdraw funds from the government Central Provident Fund (A compulsory saving scheme meant for retirement).
To my surprise he asked my nurses to calculate all the medical bills over the years to add up so that he can pay the whole sum.

It was a pleasant surprise for me.

FAMILY FRIEND

The family doctor knows the family of his patients like the back of his hands.

For example I see the father for his monthly review of high blood pressure, his wife for osteoporosis, the younger son for weekly injections of vitamin when he was suffering from leukemia and undergoing chemotherapy, the oldest son who is married and now worried about finances (I promised that I will help him out if he does not abort the child) because his wife is confirmed as pregnant.
The oldest son now has 2 children of school going age. The younger son whom the father was worried may be infertile as a result of his chemotherapy is now a proud father of a baby boy. The father himself had hoarseness of the voice which after not improving for 2 weeks was sent for biopsy of his vocal cord and found to have cancer of the larynx. He was treated for this cancer and has been free of cancer for 10 years.

Somehow the family of the patient becomes intertwined with your life and you find yourself asking the patient about his wife, sons and their children each time you meet.
That is only one family.

Another patient whose wife was diagnosed with cancer of the breast after routine mammogram found several lumps in her breast (one of which turned up to cancerous on biopsy) consulted me regarding the removal of the breast which her surgeon wanted to do. It was a small lump which showed early cancer.

My advice was to ask the surgeon to remove the lump and then do radiation therapy. However her surgeon thought otherwise and opted to remove the breast. The removed breast was found to be free of cancer. Apparently the cancerous cells had been removed during the earlier biopsy. So an unnecessary major operation was done. The wife asked me not to tell her teenage daughter about the removal of the breast and up to today her daughter who now has a six year daughter still does not know about her mother's breast removal.

Her husband who had been smoking cigarettes in the toilet for many years subsequently had a bypass operation for his coronary artery blockage. After the operation he asked for me to come to his house to remove all the stitches instead of going to the hospital.

His brother subsequently had cancer of the prostate and had a catheter inserted into his bladder in order for him to pass urine into a bag. One morning I was called to attend to him because the catheter had slipped out and he was unable to pass urine.

I had to go to the nearest pharmacy to get a similar catheter which could be inserted into his bladder and be retained inside the bladder. The extent that the family doctor goes out his way to make sure his patient is well showed his commitment to the family and their trust in him.

These are just another example of the trust between the family doctor and the patients. There are many other families whose trust in their family doctor makes us go all out to help and treat them like part of a family.

The family doctor not only diagnosed the pregnancy for a newly married couple. He also see pregnant woman for antenatal monthly reviews up to the 5th month of her pregnancy before sending to a obstetrician in a private or public hospital for her further checkup and delivery. He sees the baby as early as 5 days after their birth for treatment of the baby's jaundice or infection of the navel. He teaches the mother breastfeeding methods through pregnancy and baby guides Books published by milk companies and advises on how to feed the child and burping of the child. He also follows up with the necessary childhood vaccinations and medical checkups.

As the child grows older, treatment of infectious diseases like influenza, common cold, measles, rubella and mumps follows.

Once in a while you will have a child with high fever having fits coming to the clinic. These are attended to immediately because of the danger of damage to the brain.

Parents of the children will come to see you occasionally for cold, cough and diarrhea and sometimes conjunctivitis. Grandparents will see you for old age illness like rheumatism pains, diarrhea or incontinence. I remember frequent cases where I will have to catheterize the patient in order to relieve them of their urine

At that time a family doctor was really a family doctor looking after babies, children, pregnant mothers, working fathers and grandparents.

Times have changed since the 1990s.

Pregnant women go to see their obstetrician.

Babies and children are treated by their pediatricians.

Working parents are treated by their company doctors.

Grandparents may be treated by geriatricians.

FAMILY COUNSELOR

A family doctor is sometimes also a family counselor and a friend.

An aggrieved housewife whose husband and family I know very well came to see me for body aches and tiredness brought about by the chemotherapy for her breast cancer after mastectomy (removal of one breast as a result of the cancer).

I was asking about her family when she broke down and said that she was thinking of divorcing her husband. I was shocked because I know her husband who was a very pleasant person. He also had coronary bypass surgery about 8 years ago.
She complained that he was always out playing golf while she was suffering at home from the pain and depression of losing her breast and the side effects of the chemotherapy.

During her husband's bypass surgery she took good care of him making sure that he had enough rest and cook special soups for him to recover from his heart operation quickly. Now that she was suffering from a major illness, there appeared to be no sympathy from him and he spent his days playing golf every day. She would like him to at least show some concern about her and her illness.

I told her that as a man he probably did not realize that his behavior was uncaring. I told her not to worry too much and concentrate on getting herself well.

In the meantime I contacted the husband and asked him to come down to the clinic so that I could talk to him about his wife's illness.
He was worried and came down to the clinic direct from his golf game. I told him about his wife's complaints and her emotional outburst. He was surprised to hear that there was so much anger against him. He realized that he should have paid more attention to his wife and spends more time with her instead of playing golf.

Having the husband understand the situation, I was satisfied that he would do the right thing for his wife.

I was informed by a much happier wife that her husband did talk to her and apologized for his behavior saying that he did not realized how insensitive he was. Since then he had given up his golf and spent more time with her talking and helping her to overcome her illness.

It is indeed satisfying when you can help husband and wife reconcile their differences. In fact when you can help a couple talks about their unhappiness with each other, it helps them to realize what the other person is feeling about the spouse.

The wife thanked me for talking to her husband saying that if I had not spoken to him he would never realize how inconsiderate he was to her.
It was a happy ending.

PREGNANCY

I also did prenatal examinations for all pregnant women who wished to be under my care giving prenatal monthly checkups and vitamins until the fifth month of pregnancy when they were referred to Obstetricians in private or public hospitals.

There was a Malay woman from one of the islands of Singapore who was married to older Malay Man.
She was under my care for her first pregnancy. She was a naive and trusting woman and refused to go to Hospital until she was due to deliver. I advised her on the need to check on any pain or bleeding. Everything went well until the day when her water bag burst. I checked on her, confirmed that the head of the baby was inside her pelvis and sent her to hospital. She even asked me when she would deliver. I told her "about six hours". True enough she did deliver 6 hours later. It was her belief in her doctor that made her deliver exactly at that time.

HOSPITAL CASES

ANESTHESIA

My learning journey starts in the Operation theater of the Singapore General hospital with the Head of the Anesthetic department.
The patient has already being examined the night before to exclude any severe heart or lung disease or drug allergy which may affect his general anesthesia.
Outside the operation theater the patient was again examined to make sure that he is the correct patient and that he was fit for surgery. All dentures must be removed because they post an obstruction to the wind passages.

The patient was also asked whether he has taken any food or fluids at least 6 hours before the operation because of the danger of regurgitation of food or fluid into his windpipe.

Before entering the operation theater, the patient had an intravenous drip inserted into a vein of his hand.

This was in case blood transfusion may be needed during the operation.
Besides, injection of medicines can be done easily through the drip.
Once inside the operation theater, I was given the honor to give the intravenous thiopentone (25mg/kgm).
As the patient was asked to count to twenty, the injection was given. By the count of 7-8, the patient was already asleep.

A dose of succinylcholine injected was again given intravenously.
This was a muscle paralysis drug like curare (used by Amazons Indians to paralyze enemies or animals through their blowpipe).
The muscle paralysis is necessary so that there is no muscle movement during the operation.

A Laryngoscope was inserted into his throat to help the proper insertion of the endotracheal tube (a tube that leads from the mouth to the inside of the windpipe).
When done properly, the vocal cords or other parts of the windpipe will not be injured.
The endotracheal tube is then inflated to keep it in place.
Then the respiratory tube from the anesthetic trolley is attached to the endotracheal tube for the right mixture of oxygen and nitrous oxide (the infamous laughing gas or anesthetic gas) entered the patient's lung. The lungs must be checked to be sure that the gases are entering correctly.
Once the patient is fully anesthetized, he is handed to the surgeon to start operating.

During the operation, the patient will have his blood pressure, pulse and respiratory rate checked as well as the level of nitrous oxide and oxygen gases and the flow of the intravenous drip.
If there is any movement during the operation the surgeon will inform the anesthetist who will have to increase the dosage of nitrous oxide to improve the level of muscle paralysis.

Once the operation was over, the patient was handed back to the anesthetist to reverse the anesthesia.

A dose of neostigmine was injected intravenously to reverse the muscle paralysis and the nitrous oxide was stopped with oxygen still being given. Once the anesthetist feel that the patient muscle paralysis has passed and he is able to breathe on his own, the endotracheal tube is removed. The patient is then pushed outside the operation theater on the bed trolley and usually kept to one side with his face facing down. In rare cases there may be vomiting in spite of the empty stomach. This way the vomitus will not enter the windpipe. The danger of general anesthesia is generally exaggerated. There is only a risk of 3 fatalities in a million cases and not 1 per cent as some doctors has claimed. This was my first case of general anesthesia. Once you have done a few cases, it becomes easy and almost automatic.

There is also the danger of muscle relaxant reversal where the patient's anticholinesterase enzyme was insufficient to help reverse the muscle relaxant.

I remember a surgery where the anesthetist was a new trainee anesthetist. It was his first general anesthesia done under the instruction of the Head of the Anesthetic Department. Everything went well until after the surgery.

When he tried to reverse the muscle relaxant, he was horrified to find that the patient was unable to wake up. She was one of the patients who had this enzyme insufficiency. She had to be put on a respirator and intravenous drip for 2 days in the ward until the muscle relaxant was flushed out of her body.

KIDNEY TRANSPLANT OPERATIONS

One major operation occurred one night in 1973 when there was a major alert that there were 2 kidneys available for transplant to 2 kidney patients. All less important operations were cancelled and the theater was prepared for the transplants. Organ transplants were rare at that time.

The team of surgeons was summoned and 2 anesthetists were assigned to help in the operations. Since I was one of the anesthetists available, I was glad to help out in the transplant.

The set of 2 kidneys were removed by one of the surgeons in another theater and the kidneys were rushed to the 2 other teams of surgeons waiting to do the transplants. Blood transfusions were set up. In the meantime the recipients were put under general anesthesia by me and the other anesthetist.

The Head of the Anesthetic Department also arrived to help out in this rare operation.

It was a well organized team effort.
Although the 2 kidneys were successfully transplanted into the 2 patients, one of the patients died due to rejection of the kidney. It was quite sad for one patient and joy for the surviving patient.

RESUSCITATION:
During an emergency or code blue, the nurses will rush out all the resuscitation trolley and respirator to the bed of the patient requiring it for you to do the resuscitation.

If the resuscitation trolley was not ready, then we had to do mouth to mouth resuscitation until the mouth pieces arrive and you can use mouth piece to do the resuscitation.

In those days we do not think of possible HIV or H1N1 infection through the mouth to mouth resuscitation.
We only think of how to save the patient so that after a successful resuscitation, even if you end up with a bad taste of the patient saliva in your mouth, which also make you lose appetite for food, you were still happy because you have saved a life.
If you happened to be having lunch or dinner given to you while on duty when this happened, you will definitely be unable to eat your food especially with the bad taste in your mouth.

It was one of the reasons I ended up with gastric problems.

Once resuscitated (the heart rate and breathing returns), an endotracheal tube can be easily inserted into the windpipe and a respirator attached to it for the patient to breathe.

Only a handful of doctors were able to insert the endotracheal intubation. I was one of them because of my experience in the Anesthetic department.

My medical officer and I teamed up to do most of these resuscitation efforts.

I remember one particular old Malay man with heart failure whom we manage to resuscitate his heart stoppage to life 5 times.

Each time the relatives who have gathered were so happy to have him back. Then one morning we came to the ward and found him gone.

It seemed that the house woman who was on duty the previous night was called to the same patient. The nursing staff had prepared the resuscitation equipment all ready for the resuscitation. The house doctor instead just put her stethoscope to the heart and pronounced him dead.
She then signed the death certificate and went back to sleep.

That really made us mad. All our resuscitation efforts had come to naught.

BARBITURATE POISONING

There was a couple who had a bad quarrel in their home and the wife ended in the hospital after being discovered by the husband to have taken an over dosage of barbiturates.
She was a patient of our deputy head of the medical department.
She was kept under observation as she was still breathing at the time of admission.

When her respiratory rate reached a low critical level, we were summoned to start her on a respirator to assist her breathing.
As usual, I was the one to do the endotracheal intubation as I was the only one in the ward able to do the intubation having learned from the Anesthetic Department.
The intubation was done and the patient was put on the respirator. An intravenous drip was also inserted and her vital signs were kept under constant observation.

After 2 days she woke up from her so called sleep and was reconciled with her deeply stressed husband.

Of course the husband was very grateful to the consultant and insisted in taking him out for a grand dinner after the wife was well enough to go out.

We (the medical officers, housemen and nursing staff who did all the resuscitation) were not even mentioned by the couple.

CANCER CASES

NASOPHAYNGEAL CANCER

The Ear Nose and Throat Department treats all cancers of the ear nose and throat.
Some of the throat and mouth cancers are treated together with the Dental Surgery Department.
In the 1970s one of the most common and deadly cancer was the Nasopharyngeal Cancer which now is known to be linked with Epstein-Barr virus.
Treatment was difficult because of the closeness of the nose cancer to the brain and the frequently late diagnosis.
Surgical treatment is usually not considered unless it was at an early stage.
The treatment of choice was deep X-ray radiation to the affected area followed by chemotherapy in all cases spread of the cancer to other organs.

The mortality rate was high compared to the present modern treatment today of gamma knife treatment.

At the time of my assignment, there was a woman patient in the ward who was in the advanced stage of nasopharyngeal cancer and undergoing chemotherapy.
She was a teacher of 32 years of age who was mostly sick during the time there.
She was emaciated with vomiting during her chemotherapy and loss of appetite.
She was always in pain because the cancer has spread to the brain.
We had to give painkillers and anti-vomiting injections every now and then in order to relieve her symptoms.
Because of the injections, she was also in a sleepy state most of the time.
She has quite a few visitors including her family and her students, most of who were dejected at the state of her condition.
I tried talking to her on several occasions but she was most too tired to answer except in short sentences.
One morning her bed was cleared and we know that she has succumbed to her illness in the night.

It was sad but quite a lot of nasopharyngeal cancer patients had succumbed in this way including my father-in-law during my medical student days.

My father in law has NPC in the 1970. Treatment was concentrated on radiotherapy at the site of the cancer. Unlike the present gamma-ray knife treatment which can pin point the exact site of the cancer, in the past the old deep X-ray treatment could only target the area of the cancer. The side effects of burns to the skin and clotting of arteries to the brain caused a lot of discomfort to the patient. There is loss of smell and taste with loss of appetite.

LARYNGEAL CANCER

In contrast to the dangerous nasopharyngeal cancer (which was usually detected late), the Laryngeal Cancer is usually detected much earlier.

The symptom of hoarseness of voice was one of the easily symptom which prompts the patient to see a doctor.
Even then, some patient then to delay their checkup by an ENT surgeon preferring to see Chinese Sinsehs (Traditional Chinese healers) for treatment hoping to be cured of their condition.

We had an elderly female patient of 70 years who had an advanced stage of Laryngeal cancer which fortunately grows very much slower than the nasopharyngeal cancer.
Although it had spread just outside of her larynx or vocal box, surgical removal of her cancer was successful.
A tracheotomy (hole in her windpipe) was done in order that she could breathe through the hole.
Her vocal box was completely removed and closed so her only way of breathing was through the hole.
By covering the hole partially, she was able to utter some guttural sounds which required a speech therapist to teach her to talk again.
Nowadays there are mechanical and electronic devices which can place in the vocal box area to help the patient to talk
In the meantime she was recovering from her surgery in the ward.
Strict instructions were given to make sure the tracheotomy hole was not blocked and free of infection.
In the meantime I used to communicate with her through hand gestures and some written words.
She was cheerful in spite of her illness and I used to try to 'talk' to her with hand gestures and written words to keep her in good spirits.
Her relatives were also helpful and kind to her.
Once her condition was well enough to return home, she was discharged.
She even sent me a thank you card for taking good care of her.

This was the one of the satisfying things about being a doctor.

Cancer of the larynx is not that common in a family practice however there are fairly many cases in the ENT Department.

The only patient I saw in my clinic was an elderly man with loss of voice at the age of 55. He was referred to the ENT department after medication did not improve his voice. There a biopsy of the swelling in the larynx shows evidence of early cancer. He was treated by surgical removal of the swelling followed by radiotherapy. Happily he was well after the treatment except for still some hoarseness of the voice but there was no recurrence of the cancer.

The cases in the ENT department were different. Most have extensive surgery with tracheotomy. There has to be proper care of the tracheotomy. In most cases the tracheotomy can be closed after reconstructive surgery and speech therapy.

BREAST CANCER

Breast cancer is the second most common cancer in Singapore women. Fortunately with early detection and diagnosis, treatment for breast cancer has been very successful as compared to twenty years ago.

I have a patient who has seven lumps in both breasts one of which turned up to be cancerous.
The surgeon at that time 15 years ago suggested mastectomy (total removal) of the affected breast. She turned to me for advice.
I suggest lumpectomy because that was the latest treatment successfully done in USA at that time.
However the surgeon was adamant about removal of the breast.
So unfortunately for my patient that was done and the pathological Examination of the removed breast showed no evidence of cancer.
Nowadays breast lumpectomy has become the main treatment for breast cancer followed by chemotherapy. Rarely is mastectomy done unless there is extensive spread.

Another patient also had her left breast removed but bled heavily on the 4th day and I had to stop the bleeding, bandaged the wound and sent her back to hospital for treatment. 7 years later she had difficulty in swallowing was discovered to have a spread to the lung at the back of the gullet blocking her swallowing.

Chest X-ray could not detect the spread to the lung. Only a CAT scan of the lung a few months later found the lump in the lung.
Because of the late detection of the spread, she eventually succumbed to her illness.

BASAL CELL CARCINOMA

Basal cell carcinoma typically occurs on the face.

Although common for skin cancer, it is relatively rare in Singapore. The one patient that I saw was an old lady with a typical ulcerated popular skin swelling at the bridge of her nose. It was slow growing. She responded well to 5- fluorouracil cream with complete disappearance of the cancer after 1 month.

She had no recurrence since the treatment.

BLADDER CANCER

Bladder Cancer is more common in men than in women and always presents with blood in the urine. The bladder is examined with a cystoscope and if the cancer is detected early the tumor is removed surgically.
The one patient that I saw had his cancer removed and had chemotherapy irrigation into the bladder. Now 2 years after treatment there was no recurrence of the cancer but he complained of weakness of the legs and occasional body aches.

LEUKEMIA

One of the more common cancers in children is leukemia a blood cancer. The chances of a cure in 1970 is about 10% but now the chances of success in acute leukemia is almost 90% due to improvement in chemotherapy and marrow transplant.

One patient who was treated for leukemia came to my clinic for weekly injection of steroid and vitamin B12 in 1990 after his chemotherapy and is presently free of cancer and a father of a one year old child.

LYMPHOMA

Lymphoma is a blood cancer which causes the presence of large number of abnormal lymphocytes which is a type of white blood cell. It can cause the lymph nodes along the path of lymphatic vessels to enlarge appearing as lumps on the skin or inside the lung cavity or abdominal cavity.

In most cases the patient is detected through enlargement of lymph nodes on the body or inside the body (through CT Scan). There is corresponding loss of weight and large amounts of lymphocytes in the blood. Once detected treatment must instituted quickly as the abnormal cells can spread very quickly. Chemotherapy is the treatment of choice.

Bone marrow transplants can also help in fighting the cancer.

Our present Prime Minister has recovered from lymphoma and has been free from the illness since 2000

MULTIPLE MYELOMA

Multiple myeloma is a cancer affecting patients 50 years and above. It is sad because patients who have been working so hard and on the way to enjoying their retirement are stricken down by the disease.

One notable case was a good doctor friend of mine who was very fit and healthy. He was even able to climb mountain at the age of 60 years old.

He suddenly had breathing problem and went for a complete checkup only to be diagnosed as a multiple myeloma patient. He fought the illness for four years before finally succumbing to it.

BRAIN CANCER

Brain cancer can be very devastating to the cancer patients.
I have one patient who was put on dexamethasone to reduce cerebral edema (swelling in the brain) before and after surgery. She managed to live for 1 year before succumbing to the disease.

CERVICAL CANCER

Cervical cancer is a fairly common cancer in Singapore.
There is a relationship with the sexually transmitted human papilloma virus (or genital warts) so sexually active women should go for a Pap's smear at least once a year or once in 2 years. Treatment is effective if detected early. Unfortunately many cases may be detected late.

One patient was treated by a gynecologist when a Pap's smear showed very abnormal cells in the cervix (pre-cancer stage). She had a colposcopy (examination of the inner lining of the wall of the uterus) followed by a cone biopsy. Repeated Pap smears must be done to confirm that there is no recurrence of the cancer.

Now there are 2 vaccines Cervarix (GlaxoSmithKline) and Gardasil (Merck) which can be used to prevent infection by the human papilloma virus. There is wide spread vaccination of school girls and females in England.
One of the HPV vaccines, Gardasil, also prevents genital warts as well as anal, vulval and vaginal cancers. Both vaccines are given in 3 shots over 6 months.

COLORECTAL CANCER

Colorectal cancer has become the most common cancer in Singapore.
My own mother in law had it for 7 years before finally succumbing to it. She did not have any symptoms except for mild indigestion. One night she had severe abdominal cramps and was sent to hospital where she was operated and diagnosed with cancer of the colon with spread to the liver. She refused any chemotherapy and was well until 7 years later when another abdominal cramp strikes her.
Then the colonoscopy and MRI of the intestines showed spread throughout the whole abdomen. She was then put on palliative care (symptomatic relief of pain) because treatment would not help or cure her.

GASTRIC CANCER

Men are more often affected than women. So far the patients that I have seen were mostly men. One was a 27 year patient whom I sent for gastroscopy for suspected gastric ulcer. The surgeon who did the gastroscopy did a biopsy of the ulcer region.
The biopsy showed very early cancer cells.
He was treated with surgery followed by chemotherapy.
Now after 10 years he is in perfect health.

Another patient involved a 62 year old man who was still undergoing chemotherapy but his prognosis was poor. He was a devout Catholic and took his possible death very positively. He succumbed to the cancer just a few weeks before this post.

KIDNEY CANCER