Case 1 - AJ: Lower Extremity Cellulitis

You are on your orthopedic surgery rotation. You are at your attending's office when you meet A.J., a 55 year-old man of First Nations descent. He is presenting for a six-month follow-up of his right below-knee amputation. His post-operative course was complicated by several infections, likely secondary to his poorly-controlled Type 2 Diabetes Mellitus. You check his chart and note that "no fixed address" is listed in his demographic information. He states he has been living in a convalescent wing of a local shelter to recover from his surgery and the post-operative wounds that ensued. He relies on the use of a wheelchair for ambulation, provided by the shelter.

Question 1: List three ways in which A.J.'s mobility restrictions can impact his health.

As you conduct the physical exam, A.J. comments that his left foot has been painful for the last few days whenever he applies weight to the limb. You examine his foot, noting a shallow, non-purulent ulcer to the heel. The surrounding skin is red, hot and indurated. He denies fever or other constitutional symptoms, but you suspect cellulitis.

Question 2: You discuss your concerns with A.J. and recommend that he needs antibiotic therapy. What are two important considerations when prescribing this treatment?

One week later, you are on your family medicine rotation in the inner city where again, you meet A.J. He managed to not require hospital admission and is slowly improving on antibiotics. You are checking his latest lab results and note that his glycemic control has been poor for several years, with an HbA1c ranging between 10-12%. He has not responded to oral antihyperglycemics and his physician is considering placing him on insulin therapy.

Question 3: While controlling his serum glucose is a priority, what are three concerns regarding the prescription of insulin?

You decide to go ahead with insulin therapy, but A.J. is concerned that he won't be able to afford the medication.

Question 4: What about A.J.'s social and health context could help with finding financial aid to help pay for his medications?

Case 2 – LT: Tuberculosis

L.T. is a 53-year-old recent immigrant from India who comes to your walk-in clinic today at his wife's prompting. For three months, he has felt tired and generally unwell, has had progressive weight loss, and has a worsening cough. He has also been experiencing fevers, night sweats, and occasional hemoptysis. He has a 20-pack-year smoking history, no significant medical history, takes no medications, and has not seen a doctor since his immigration medical check. He received the BCG vaccine as a child and has never had an HIV test.

L.T. and his family of four lived in a shelter for a few months after arriving in Canada. Recently, they moved into a cramped, two-bedroom apartment that they share with another family of three to share costs. L.T. is worried about providing for his family and that they may lose the apartment if he cannot find a job.

Question 1: How would you define L.T.'s housing status? Describe a link between housing and health status.

Question 2: What are some important diagnoses that you need to rule out and what social risk factors does he have?

At this time, you decide to order a chest x-ray to assess for evidence of pulmonary tuberculosis or lung cancer, an HIV test, and some basic blood work.

Question 3: List three things about L.T.'s current living situation that you need to take into consideration when planning further investigations and follow-up for L.T.

You were able to arrange a chest x-ray for the same day as L.T.'s initial appointment and a follow up appointment for him with you later this week. Your clinic provided him with tickets for public transportation for these.

The radiologist at the lab calls you the next day and faxes over L.T.'s report: it is positive for infiltrates and cavitary lesions in the right upper lobe. This plus his symptoms are indicative of pulmonary tuberculosis.

Question 4: What are your next steps in managing L.T.'s likely diagnosis?

Case 3 – NE: Myocardial Infarction and Risk Factor Management

You are working with the inpatient medicine/cardiology service at your hospital and are tasked with completing the discharge planning for patient N.E. N.E. is a 48 year old man who was admitted four days previously with a non-ST elevation myocardial infarction (NSTEMI). He presented to the emergency department with acute onset chest pain, leading to this diagnosis.

Prior to this visit, N.E. last saw a physician approximately fifteen years ago. His past medical history is significant for 30 pack years of smoking and a remote history of depression. On this admission, he is noted to have hypercholesterolemia and hypertension.

N.E. was on no medications at the time of admission to hospital. His current medications include: Aspirin, Metoprolol, Ramipril, Hydrochlorothiazide, and Atorvastatin. In accordance with the American Heart Association Guidelines, discharge planning also includes smoking cessation, a low-fat diet, and cardiac rehabilitation.

While discussing discharge planning, N.E. discloses that he has been staying at a homeless shelter for the past month. Prior to that time, he was working occasionally as a handyman and staying with a friend, who has since moved out of the city. At this point, both the patient N.E and the care provider (you) are feeling overwhelmed by the complexity of his discharge planning.

Question 1: How comfortable are you assessing housing status during discharge planning?
Do you regularly incorporate it into care planning for patients?
How might earlier knowledge regarding N.E.'s housing status have been helpful?

Question 2: How common is smoking amongst persons experiencing homelessness?
What unique barriers do you anticipate N.E. may encounter in trying to quit smoking?
What special considerations might you take in your approach to discussing smoking cessation with N.E?

Question 3: What barriers might N.E. encounter in acquiring and taking his medications?
How might you overcome some of these barriers?