COMMON HEALTH PROBLEMS IN MEDICAL PRACTICE

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Dedicated to

My mother, whose love and incredible self-sacrifice have made all things attainable,

My wife, whose patience and understanding have sustained me through this and many other formidable projects, and

My children, Evan and Katy who are quite simply the sunshine of my life.

E.S.M.

Preface

Common problems and diseases are common. The primary care physician and especially the family physician does not limit his or her practice to patients of any particular age or sex nor to patients with problems limited to any disease classifiction or organ system. The primary care physician may be called upon to see "anyone who walks through his door." For these reasons the author felt it necessary to create a textbook which dealt with the clinical management of common problems and diseases—a book which, like actual primary care practice, was not limited by specialty, age, sex, organ system, or disease category.

As the number of primary care physicians grows and the number of primary care residency training programs grows, medical students and residents are spending more of their training time in ambulatory settings, seeing patients with common problems—either undiagnosed or under chronic management. Up to now, students and residents either had to carry several specialty handbooks and manuals in their pockets or refer to voluminous comprehensive textbooks to read about the myriad of common "bread and butter" problems which they might encounter in these ambulatory settings.

The purpose of this book is to provide for the medical student, the primary care resident, and the practicing physician a book which can be read from cover to cover and then can be kept handy as a quick reference for the common problems one encounters in everyday practice. Other health care professionals such as nurses, physician assistants, pharmacists, and dentists (or students in any of these areas) might also find this book helpful.

There obviously may be disagreement with the choice of common problems which were selected for inclusion in this volume. The problems and diseases which were selected, however, are those which were most commonly seen in large surveys such as "the Virginia study" and in the experience of the author and his contributors.

The contributing authors are all family physicians or physicians and psychologists in various specialty areas who are primarily involved in patient care and who have spent the majority of their time in a primary care arena. Their charge was to write succinctly about common problems and their clinical management.

As for the organization of the text, in an attempt to present common problems not lim-

ited by age, the text is written in chronologic order, "from birth to death." So when a physician is confronted with a patient of a certain age, he or she can concentrate on problems most common in that particular age group. Also, care was taken to make the reader aware of the more complex and uncommon problems which the astute practitioner must always keep in mind when considering the differential diagnosis of a problem. Each disease or problem is approached through describing symptoms, signs, and practical, cost-containing methods of diagnosis and management. There will be some obvious overlap, as some problems and diseases can be represented in patients of various ages. For instance, it can be noted that the sections about nutrition and anemia appear in chapters involving various age groups, because these are problems which are common at many different ages. As can be seen in the table of contents, some sections are titled by symptoms, others by signs, and still others by disease. This categorization reflects the way patients present themselves to the physician in practice and is, therefore, the best way to present problems to the reader. Similarly, some diseases are called by their commonly used names, i.e. chickenpox and croup, while others are titled by their more commonly used medical names, i.e. impetigo and bronchiolitis.

Furthermore, if some sections seem "out of balance" and longer than others, it is because some common problems are very complex and also are poorly understood by many primary care physicians and students. It seemed appropriate, therefore, to devote more space to sections such as sexual dysfunction and dizziness.

The last several sections deal with problems such as patient education and patient compliance which are universal problems in any age group or population. Because subjects such as child abuse, nursing homes, and the laboratory in the physician's office have become so important (and, of course, common), they warranted inclusion also.

It is hoped that the physician or student who becomes familiar with this book will be able to develop an effective plan of diagnosis and management for most of the patients who "walk through his door."

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Contents

CHAPTER 1

The Newborn (Birth to 2 Weeks)

The Newborn Period

"A baby is God's opinion that the world should go on."
ANONYMOUS

EXAMINATION OF THE NEWBORN

After the newborn is initially stabilized in the delivery room and an Apgar score is determined, he/she is taken to the nursery where a more complete evaluation can be done. In an apparently normal, stable neonate with normal vital signs this initial evaluation in the nursery can be performed by a nurse. The family physician or pediatrician need not examine the child until a convenient time sometime during the first 24 hours of life. In fact, sometimes minor abnormalities, such as inconsequential heart murmurs, present at birth will disappear a few hours after birth, while at the same time significant murmurs may not appear at all until several hours after birth. Also, it is important that the infant be kept warm during the immediate postnatal period, and a prolonged examination at this time may chill the newborn unnecessarily. Nursery personnel must be trained, of course, to identify any early signs of instability or disease in a newborn and to notify the appropriate physician accordingly.

First, the child's vital signs, general appearance, activity, and quality of his/her cry should be assessed. The respiratory rate and any signs of respiratory distress are especially important to note at this time. Also, a general examination should be performed to assess the infant's gestational age. This latter assessment can be made by noting the length, head and chest circumference, and weight of the infant, the presence of ear cartilage, breast tissue, scrotal ruggae in the male, and creases on the soles of the feet. Forms are usually provided on which these items can be conveniently documented by nursery personnel.

The skin should be examined for cyanosis, pallor, jaundice, and any signs of trauma at birth. Acrocyanosis, or cyanosis of the hands and feet only, is a common, normal feature. Also, in the infant delivered with forceps, ecchymoses or erythema ("forceps marks") are commonly found over the malar regions. Slate blue "mongolian spots" and capillary hemangiomas are lesions which usually disappear in the first year of life. Transient petechiae are frequent over the face and neck.

The skull may be quite molded, especially in the neonate delivered vaginally in a primigravida. The normal caput succedaneum, a collection of fluid which is palpable diffusely over the vertex, must be differentiated from the more significant cephalhematoma, a subperiosteal hemorrhage of a cranial bone which is unilateral, overlying only one cranial bone and limited by suture lines. Caput succedaneum usually resolves in a few days, whereas cephalhematomas may persist for months or years and are often associated with underlying skull fractures. The eyes should be examined for the presence of bilateral "red reflexes" as the red-appearing optic fundus is at least transiently visualized through an ophthalmoscope. Anisocoria and subconjunctival hemorrhages are common and of no consequence. The tympanic membranes should be visualized. The mouth and oropharynx should be visualized to rule out a cleft palate. Epstein pearls are collections of epithelial cells which appear as firm nodules on either side of the raphe of the hard palate and usually disappear in a few days. The neck should be examined for goiters, sinuses, and webbing.

As was noted above, particular attention must be paid to the respiratory system in the neonate. A "systematic overview" of respiratory function can be attained by examining for respiratory rate, nasal flaring, and chest retraction as well as by percussing and auscultating the lungs. The table of criteria developed for this purpose by Silverman and Andersen more than 25 years ago is still highly applicable today (Table 1.1). The heart should be auscultated for murmurs and the abdomen palpated for organ enlargement, masses, and hernias. The liver is often palpable in the newborn, and umbilical hernias are quite common, especially in Negroes.

The external genitalia must be examined for their size and sex appropriateness and for

Table 1.1
Criteria of Respiratory Distress*

Condition	Upper Chest	Lower Chest	Xiphoid	Nares Dilatation	Expiratory Grunt
No respiratory distress	Synchronized breathing	No retractions	No retractions	None	None
Mild to moderate distress	Lag on inspiration	Retractions just visible	Retractions just visible	Minimal	Audible with stethoscope
Severe distress	"See-saw" unsynchronized breathing	Marked retraction	Marked retraction	Marked	Audible with naked ear

* Adapted from Silverman and Andersen: Pediatrics 17:1, 1956.

correct positioning and patency of orifices. The most common anomaly of the penis is hypospadias, which may vary considerably in severity. The scrotum should be palpated for the presence of both testes, since cryptorchidism occurs in as many as 3 to 4% of term male infants. Spontaneous descent of the testes will occur by 1 year of age in about 90% of these infants. As will be discussed later, hydroceles are also commonly found in the scrotum. The anus should be examined, although meconium is usually passed within the first 12 hours of life, ensuring anal patency.

Active and passive movement of all extremities should be tested. Evidence of birth injury, soft tissue and bony defects, or supernumerary digits should be noted. The neurologic examination is important but may be brief in the normal neonate. Abnormal movements or posturing and evidence of paralysis or hyper- or hypotonicity can be detected by observation. It is common for occasional spontaneous jerking movements to occur, especially when the infant is sleeping, but "jitteriness" may be a sign of hypocalcemia or hypoglycemia. Several reflex patterns are normally present in the newborn. These include the sucking reflex, the rooting reflex, and various postural reflexes. Deep tendon reflexes may be difficult to obtain, but the patellar reflex is usually present. The Babinski sign (plantar extensor sign) may be present until several months of age. Other observations about neurologic function can be attained by simply observing extraocular movements as the infant follows his examiner, watching facial musculature and mouth function as the infant sucks on a nipple, and noting his reaction to loud noises around him.

ROUTINE CARE IN THE NURSERY OR WHILE ROOMING IN

The infant must be kept warm and dry in transit from delivery room to nursery. The skin and umbilical cord will be cleansed in the delivery room or nursery with warm water and mild soap, and similar bathings will be repeated daily. Bathing with 3% hexachlorophene solutions (Phisohex) is unnecessary and may even be neurotoxic, especially to small infants. The likelihood of bacterial infection may be further lessened by painting the umbilical cord with bacterial dye solutions or alcohol daily. Other procedures performed routinely upon admission to the nursery include administration of vitamin K, 1 mg intramuscularly to prevent hemorrhage, and instillation into the eyes of 1% silver nitrate drops or a tetracycline (Achromycin) or erythromycin (Ilotycin) ointment to prevent gonococcal disease. A chemical conjunctivitis may result, but is less likely with the latter preparations. Of course, strict hand-washing procedures must be adhered to by all personnel entering the nursery and between the handling of different babies.

The infant's mother may want to keep the infant in her room in a rooming-in arrangement. This practice should be generally encouraged, especially in the case of primigravidas who might feel more comfortable learning to take care of their first newborn with the assistance of trained nursing personnel. Also, if the child is rooming in, the father tends to become more involved in the initial care of the infant, setting healthy patterns for his continued involvement in the infant's care at

home. Whether the infant stays in the nursery or the mother's room, his vital signs should be monitored about every 4 hours and he should be weighed daily or every other day. It is normal for an infant to lose weight for the first few days of life, but the birth weight should be reattained by the third or fourth day and continued weight gain should proceed thereafter. The rooming-in or nursery period is an excellent time to answer parents' questions about their newborn and to educate them in accepted child-rearing procedures.

If circumcision is desired for the infant by the parents it should be performed while the baby is still in the hospital. There are few contraindications to circumcision. If any congenital anomaly, such as hypospadias or epispadias, exists, circumcision should not be done, because the prepuce will be required later for reconstructive surgery. Although considerable controversy exists about the subject, there are probably no strict medical indications for circumcision beyond the desires of the parents.

NEONATAL SCREENING FOR METABOLIC DISORDERS

It has become increasingly evident over the past several years that the profound mental retardation caused by certain congenital metabolic disorders could be prevented if the disorder was detected and treatment was begun very early in infancy. Several states have developed routine detection programs for these disorders. These metabolic disorders include phenylketonuria, hypothyroidism, galactosemia, and maple syrup urine disease. They are oulined in Table 1.2. Although these

Table 1.2
Metabolic Disorders Detected by Neonatal Screening

Disorder	Genetic Defect	Component Measured in Screening Test	Treatment
Phenylketonuria	Absence of phenylalanine hydroxylase Phenylalanine not converted to tyrosine High levels of phenylalanine lead to retardation	Phenylalanine	Dietary restriction of phenylalanine
Hypothyroidism	Absence or deficiency of thyroxine or thyroid-binding globulin (TBG) Many causes—aplasia of the thyroid gland, defective synthesis of thyroxine, etc.	Thyroxine (T_4) Thyroid-stimulating hormone (TSH) measured if T_4 low	Thyroxine
Galactosemia	Deficiency of galactose-1-phosphate uridyltransferase Galactose-1-phosphate not metabolized, leading to many defects including hepatic failure and mental retardation	Galactose	Galactose-free diet
Maple syrup urine disease	Defect in oxidative decarboxylation of keto acids Leads to accumulation of valine, leucine, isoleucine	Leucine	Dietary restriction of valine, leucine, isoleucine