Chapter

3

What to do about….

Age, indeterminant

Patients' ages can be misestimated on their visa documents. This can result in adults having to return to school, and not being able to access adult privileges (eg driving). Sometimes patients cannot undertake proposer-supported visa applications because their "visa" age is incompatible with being the parents of the children they are trying to sponsor out. The Medical Service guidelines include a recent document on age estimation for refugees, including the role of xrays of the forearm and the central importance of clinical assessment. You may need to fill out a statutory declaration about the age of the patient to support them having their formal documents amended.

See Appendix 1 for history dates for Sudan, Sierra Leone, Tibet, Burma, Afghanistan, Iran, Iraq, and Palestine that might help to correlate when a patient was born.

Anaemia or other blood abnormalities

Microcytosis – This may be due to thalassaemia or iron deficiency. If iron deficient, defer testing for thalassaemia until the patient has a normal iron count.

Neutopenia – This may be benign neutropenia of ethnic origin, which is frequent in Africans, and probably reflects different normal ranges in different ethnic groups. Patients who are otherwise well should not have further investigation of neutropenia.

Thrombocytopenia – This may be due to hypersplenism, the most common causes of which are repeated episodes of malaria or schistosomiasis. It may also reflect acute malaria.

Iron deficiency – Treat this with Ferro-liquid in children, and check for hookworm.

Eosinophilia – If the cause is not apparent, consider filariasis or strongyloides as causes.

Child protection issues

All doctors are required to report any concerns as mandated professionals. Further information is available in the Companion House Policies and Procedures manual. Be prepared to advocate to the courts sensibly and in conjunction with counseling staff at Companion House.

Circumcision (male)

It is not unusual for adult men to ask for circumcision, if it was a culturally valued procedure that was not performed in their childhood because of war and displacement. Circumcision cannot be performed in the ACT or NSW public hospital systems for non-medical reasons. This also applies for male children, though there are a number of private GPs who do it in their rooms when the baby is a neonate.

Currently neonatal circumcision for babies who are under 6-weeks old are performed in Canberra by Dr Tim O'Neill at Majura Medical Centre in Dickson.

Phone : (02) 6247 5833 Fax : (02) 6247 6286

Address: 3/151 Cowper St, Dickson, ACT 2906

Email : timon@majuramedical.com.au, admin@majuramedical.com.au

Contraception

Some cultures strongly disapprove of contraception, and women may therefore seek modes such as depo-provera or IUDs which are not immediately apparent. SHFPACT will insert IUDs upon request.

Vasectomies are performed at Marie Stopes Centre in Civic, and by Dr Ian Pryor in Tuggeranong.

The NSW Multicultural Health Communication has some excellent factsheets on the webpage on the topic of contraception for both men and women, which have been translated into a number of languages. They are:

- "*Contraception: Condoms and Diaphragms*", in Chinese, Croatian, English, Italian, Khmer, Macedonian, Russian, Serbian, Somali, Spanish, Turkish, Vietnamese

- "*Safe Sex. No Regrets. Anyone can get condoms*" in Arabic, Chinese, English, Indonesian, Khmer, Korean, Macedonian, Portuguese, Serbian, Spanish, Thai, Turkish, Vietnamese

The factsheets can be found at:
http://www.mhcs.health.nsw.gov.au/mhcs/topics/Womens_Health.html

Cysticercosis

This is due to *Taenia solium* tapeworm infection, from regions where pork is consumed (eg Papua New Guinea, South America). *Taenia solium* infection is often relatively unsymptomatic apart from passage of proglottids in stool. The main risk is the development of cysticercosis, the most common parasitic infection of the neurological system worldwide. The larvae of the tapeworm can spread via the blood stream to many organs where they form tissue cysts (cysticerci). These might evince themselves clinically as nodules in muscles, or abnormal heart rhythm if in cardiac muscle, or in neurological symptoms suggesting nodules in the brain (convulsions, headache, long tract signs indicating spinal cord compression etc). Diagnosis is by stool tests which will be positive three months after infection, or on biopsy of the infected area. The treatment is praziquantel or albendazole, and advice should be sought from the Infectious Diseases team at The Canberra Hospital. Only Albendazole is approved for treatment of the infection. This infection is rare among refugees from Muslim countries, for obvious reasons.

Dental problem

If the problem is acute the patient will need to be referred to ACT Health's Emergency Dentist. The medical service has written material with detailed instructions of how to access emergency dental services in Canberra, which can be given to patients.

Ear, nose and throat assessments

There is no public otolaryngology clinic at The Canberra Hospital. The private ENT surgeons operate in the public sector. Appointments should be made with the private ENT surgeon.

Female genital mutilation

The ACT is not a resettlement area for cultural groups which have practised FGM. Women who have had this procedure require specific support in childbirth and should deliver at The Canberra Hospital. Gynaecological referral may be required for cervical screening.

Guinea worm (dracunculiasis)

This rare condition remains endemic in six African countries, one of which is southern Sudan. The patient will report a fiery sense in the region where the worm is erupting from the skin. Seek advice from the ID clinic at The Canberra Hospital. Treatment involves slowly winding the worm around a piece of wood, which can take up to a

month, and is painful. Give adequate analgesia, watch out for secondary infection and ensure they are protected against tetanus.

Hearing

Australian Hearing will do hearing assessments and support, including subsidized hearing aids for children under 18, and pensioners. Accessing hearing aids for patients outside this age-group is very difficult.

Macquarie University and 'Self Help for Hard of Hearing' (SHHH) a not-for-profit organization provide cheap second hand or reconditioned hearing aids for the unemployed. However they are willing to make concessions for people who don't fall exactly into this group, such as refugees. Membership with SHH is $37 and all the appointments for hearing testing etc cost $100. Once this has been done individuals are sent over to Macquarie University to get an appropriate hearing aid for free. SHHH can be contacted on: (02) 9144 7586. Persevere with this number as SHHH is run by volunteers and sometimes the office is not staffed. Alternatively, they can be contacted via email: shhh@netspace.net.au

Helicobacter seropositivity/dyspepsia

See Appendix 5 and 6 for algorithm on treatment of *H. pylori* in patients with or without dyspeptic symptoms.

Hepatitis B chronic infection

All refugees in the ACT are entitled to free hepatitis B vaccination. We use the following monitoring guidelines (Reference: Australia and New Zealand Chronic Hepatitis B Recommendations, 2008).

	Tests	**Actions**
At diagnosis	Hepatitis BeAg, anti-Hepatitis e Ag, HBV DNA; AFP; HAV antibodies; Liver ultrasound; Hepatitis D antibody and antigen; INR	Refer to Liver Clinic if any abnormalities. Vaccinate against Hepatitis A if not immune.
Monitoring in persons with HBV <2000 levels and normal ALT at diagnosis	HBV DNA and LFTs every 12 months	Add on annual screening for HCC if at high risk (co-infection with hepatitis C, alcohol drinker, over 40 years, family history of HCC)

Hepatitis C seropositivy

Check viral load and genotype, AFP and arrange liver ultrasound. Most genotypes in refugees are amenable to treatment. (Reference: RACGP Guidelines 2003)

	Tests	Actions
At diagnosis	Hepatitis C viral load and genotype, LFTs, FBC, INR, Liver ultrasound	Refer to Liver Clinic if any abnormalities. Vaccinate against Hepatitis A if not immune.
Monitoring in persons with AST and ALT within the normal range	LFTs, platelets every 6-12 months	Consider referring for liver biopsy in older persons, or people from Egypt, even with normal liver function tests

Hydatid disease

This is not uncommonly found in refugees from Tibet. The treatment is both surgical and medical, using Albendazole (available on authority prescription for this purpose). They should have an ultrasound or CT and echincococcus serology testing. Refer for further advice to the Infectious Diseases clinic at The Canberra Hospital.

Immunisations (catch-up)

If facilities for imunisation exist, refugee children will have been immunized according to the schedule of the country they have been living in. National schedules are in a folder in the medical room. Catch-up immunization is complex; consult Appendix 4 for catch-up schedules using the vaccines provided by ACT Health. All refugees are entitled to free hepatitis B vaccination.

Most international schedules are monovalent measles, and do not confer protection against mumps and rubella. Predeparture screening have protection against mumps and rubella.

Malaria

Many people from malarious areas assume that their immunity will protect them when they return home, and do not take prophylaxis. There is an increasing incidence of malaria in returned travelers from Africa.

Because the vector for malaria is not native to the ACT, patients with vivax, ovale or malariae may be treated as outpatients. Some adult patients with falciparum malaria and mild disease may also be treated as an outpatient.

Urgent hospital treatment of severe malaria is essential if the patient has any of the following:

- **any degree of altered consciousness**, jaundice, oliguria, severe anaemia or hypoglycaemia.
- a parasite count above 100 000/mm3 **(>2% of red blood cells parasitised)**
- the patient is **vomiting or clinically acidotic**
- the **patient is pregnant**

For *falciparum* malaria:

- if the patient is clinically well, has a parasitaemia count < 2%, and is afebrile then they are suitable in Canberra for outpatient treatment with Atovaquone with proguanil (available as an authority script on the PBS) for "Treatment of suspected or confirmed *Plasmodium falciparum* malaria in a patient aged 3 years or older where quinine containing regimens are inappropriate". The dose of atovaquone+proguanil (250/100mg) is:
    - **adult:** 4 tablets orally with fatty food, daily for 3 days
    - **child 11 to 20 kg**: 1 tablet orally with fatty food, daily for 3 days
    - **child 21 to 30 kg**: 2 tablets orally with fatty food, daily for 3 days
    - **child 31 to 40 kg:** 3 tablets orally with fatty food, daily for 3 days
- if there is any doubt, refer to hospital. Patients with falciparum malaria can deteriorate quickly
- If falciparum malaria is treated as an outpatient, follow-up thick and thin films are required at 28 days

For *vivax, malariae* and *ovale*:

- chloroquine 620 mg base (= 4 tablets) (child: 10 mg base/kg up to 620 mg base) orally, initially, then 310 mg (= 2 tablets) (child: 5 mg base/kg up to 310 mg base) 6 hours later and on days 2 and 3, making a total adult dose of 10 tablets.

    - Chloroquine is currently available only through the Special Access Scheme.

To eliminate liver forms of *P. vivax* infections, add or follow within a few days with:

- primaquine 30 mg (child: 0.5 mg/kg up to 30 mg) orally, daily with food, or if nausea occurs 15 mg (child: 0.25 mg/kg up to 15 mg) orally, 12-hourly with food for 14 days.

To eliminate liver forms of *P. ovale* infections, add or follow within a few days with:

- primaquine 15 mg (child: 0.25 mg/kg up to 15 mg) orally, daily with food for 14 days.

Exclude G6PD **deficiency** prior to the use of primaquine, as **severe haemolysis may occur in these patients**.

If the patient relapses after the primaquine treatment, seek expert advice.

If the patient is unable to tolerate oral therapy, best taken with food, treat as severe malaria as above and consult a specialist.

Reports of chloroquine-resistant *P. vivax* have come from areas in Papua New Guinea, Indonesia and South-East Asia and this should be considered if a patient with *P. vivax* fails to respond to standard doses of chloroquine.

Neonatal or early childhood difficulties

Managing the first six months of a baby's life can be very difficult and isolating for women who do not have their mothers and other female relatives to provide support. The pathways into the Queen Elizabeth II Centre have been expedited for refugees. Telephone the service to ask for admission.

"OV fly", onchocerciasis (river blindness)

Onchocerciaisis is often referred to by patients as "OV fly", after the black fly *Onchocerca volvulus* whose bite can transmit the nematode which causes onchocerciasis.

Onchocerciasis is the second most common treatable cause of blindness in the world, with the blindness being due to the body's immune response to the microfilaraie across the cornea. As the adult worm can live within the body for 15 years, an infected person (diagnosed on serology and symptoms) will need ongoing six to twelve monthly treatment with Ivermectin for an extended period. They may have a pronounced Herxheimer reaction to Ivermectin, which to the patient may be indistinguishable from the subcutaneous migration of the microfilariae. The most marked clinical findings will be skin changes such as skin atrophy, "leopard skin" due to patchy depigmentation, and lichenified dermatitis. Discuss management with the ID department.

Pain

A hitherto underestimated cause of lower back and neck pain is vitamin D deficiency. If this is not the cause, and treatment is ineffective, refer to The Canberra Hospital's Pain Clinic.

Pregnancy and childbirth

Arrange the referral to the relevant antenatal clinic. For high risk patients, the medical service will provide outreach support through the pregnancy. Encourage iron and vitamin D supplementation when necessary.

Many Dinka patients are very concerned about caesarian sections as there are prevalent cultural beliefs that hysterectomy is routinely performed with a LUSCS, and therefore a woman who has had a caesarian is rendered infertile. If there is a possibility that she may require an elective LUSCS, raise this possibility and reassure her that she will be able to have children in future. Emergency LUSCS among Dinka patients can be highly charged emotional affairs where mothers have refused permission and the hospitals have threatened legal action.

Psychosis

❋ Counselling ✚ Medical Service

Acute psychosis is an emergency. There are olanzepine wafers in the drug cupboard in the doctor's room, if necessary. Place the patient in a quiet room and alert other staff members at Companion House. While awaiting the arrival of the CAT team, ensure the patient is safe and observed. Generally one or two staff members will wait with the affected persons.

Subacute psychosis is not uncommon in traumatized patients. Assess them formally and encourage them to be cared for in combination with the mental health team. If they are not a risk to themselves or others, and decline mental health referral, ensure

that family members are aware of the CAT team crisis number, and in concert with a counselor, begin medical management with frequent review.

Remanded patients

Patients in remand are likely to be very distressed. Liaise with doctors at the Alexander Maconochie Centre (eg Michael Levy, the Director of the Prison Health Service, or Liz Fraser at Interchange General Practice 62475742) if you are concerns about the patient's health.

Rickets

Those at risk are children who have not been exposed to sunlight (for example, dark-skinned refugees who have lived in flight in towns where it was not safe to go out during the day), or babies born to and breastfeeding from a vitamin D deficient mother. Suspect biochemical rickets if an infant after six months has musculoskeletal weakness, and seek this at the 6 and 12 month immunisation consultations. Tests include wrist Xray and Ca, PO4, ALP, Vitamin D and PTH. Treatment schedules should be worked out in collaboration with the pediatrics clinic (see Vitamin D schedules to start with). Babies will need admission to hospital to ensure that tetany is not triggered by Vitamin D replacement.

Schistosomiasis

A raised titre on serology is consistent with latent schistosomiasis. These patients have almost certainly not been treated in their home country. If they have been treated, they should be retreated as the failure rate of treatment is around 10%. These patients should also have a liver ultrasound assessing portal blood flow. Praziquantel is available on authority for schistosomiasis.

Dosage instructions:

Praziquantel 20 mg/kg/dose orally, for 2 doses after food, 4 hours apart.

Each tablet is 600mg. The dosage for people infected ***outside*** **South-East Asia** is as follows:

Weight (kg)	**Size of Individual Dose (in tablets)**
20-25	¾ tablet
26-33	1 tablet
34-41	1¼ tablet

42-48	1½ tablet
49-56	1¾ tablet
57-63	2 tablets
64-70	2¼ tablets
71-78	2½ tablets
79-86	2¾ tablets

For people *infected* **in south-east Asia** (note, they don't have to be from south-east Asia) a higher dose is required: The dose is praziquantel **30 mg/kg, for 2 doses after food, 4 hours apart** .

Weight (kg)	**Size of Individual Dose (in tablets)**
20-25	1 tablet
26-33	1½ tablet
34-41	2 tablets
42-48	2¼ tablets
49-56	2 ½ tablets
57-63	3 tablets
64-70	3¼ tablets
71-78	3¾ tablets
79-86	4 tablets

Each dose should be taken after food. The tablets can be broken into four pieces to ensure accurate dosing but should not be chewed because of their bitter taste.

** Some patients have a Herxheimer reaction to praziquantel treatment but it is generally well tolerated. Transient adverse effects include gastrointestinal upset, headache, dizziness and drowsiness.

School performance

❋ Counselling. The Children's counselors will provide ongoing support for the child when at school.

Some extra resources may be available at the school, for instance if the child is diagnosed with certain medical health conditions. Consult with the Children's Counsellors at Companion House about support they can provide and/or can facilitate.

Sexual performance

Erectile dysfunction in the post-settlement period is very common.

There are two excellent factsheets on the NSW Multicultural Health Communication Service webpage on the topic of Men's Sexual Health which have been translated into a number of languages. They are:

- "*A User's Guide. What every man needs to know about how his reproductive system works*" (Includes information about prostate health, male infertility, testosterone deficiency, testicular cancer and erection problems.) in Arabic, Bosnian, Chinese, Dari, English, Farsi, Greek, Italian, Khmer, Korean, Serbian, Turkish, Vietnamese.

- "*Successful treatment for impotence*" in Arabic, Chinese, Croatian, English, Italian, Khmer, Korean, Lao, Macedonian, Portuguese, Russian, Spanish, Thai, Turkish, Vietnamese

The factsheets can be found at:
http://www.mhcs.health.nsw.gov.au/mhcs/topics/Mens_Health.html#7650

Skin problem – undiagnosed

Many Africans have marked xerosis which is a significant cause of disability and discomfort for them. The first level of treatment is emulsifying ointment, which can be readily purchased in any supermarket. For advice about skin problems, refer patients to Dr Andrew Miller's public dermatology clinic at The Canberra Hospital. Bookings are made by ringing his private rooms.

Other conditions to consider are onchocerciasis causing lichenification (ask for a history of being bitten by the black fly vector for the disease and check serology for microfilaraie). If the main problem is patchy pigmentation especially on palms and soles of feet consider and test for secondary syphilis.

Substance abuse

Counselling Medical Community Development.

Alcohol and marijuana currently seem to be the most used drugs among our clientele, though injecting drug use is frequent in the camps in SE Asia. Both alcohol and THC are often used as a means of managing trauma. Collaborative work with the counselor is important. It is important that standard management be put into place for patients abusing drugs (for example, they may need to transfer to Drug and Alcohol clinic or to Interchange General Practice), and that Companion House is aware early and can respond to the social consequences of substance abuse.

Suicidality

Counselling. Medical Service

Suicidality is a Companion House emergency. All counselors will be familiar with the suicide protocol. If suicidality has been reported to another staff member, they will have filled in a suicide risk assessment form. A copy of this will be placed on Genie. Notify the CAT team. Notify the practice nurse and the senior counselor as this person will need a support system. If the person is psychotic, there are olanzepine wafers in the drug cupboard.

Syphilis

If the patient has a positive VDRL, the laboratory will undertake further testing, which should assist in assessing whether the patient has primary, or latent syphilis. Most patients diagnosed through screening have latent syphilis. This is treated with **3 x 1.8 g intramuscular injections of benzathine penicillin** over three or six weeks. If you are concerned about primary or secondary syphilis, ask advice from the Sexual Health Unit, TCH. You are obliged to ask about contacts!

Tallness

Very tall Dinka people often get musculoskeletal pain because the chairs, beds and working equipment they have is unergonomic. This is a particular problem for school children or for people working in the cleaning industry, as the equipment is often designed for people who are several feet shorter than they are.

Thyroid disease

Patients with euthyroid goitres will probably become hyperthyroid in Australia as they will be exposed to more iodine. Seek further advice and assessment from Dr Fred Lomas (NCDI).

Tinea capitis

This will not respond to topic treatment. The patient will need griseofulvin. The dose adjusted for children is **20 mg/kg/day** for six-eight weeks. The duration needed to treat tinea capitis with oral terbinafine is only 4 weeks, but this medication is not authorized by the PBS for children. There is a Woods lamp in the treatment room.

Visual impairment

If problem is refractive error, OPSM will assess patient's vision, bulkbilling them. The ACT Spectacle Subsidy Scheme will offset some of the cost of spectacles. The public ophthalmology service at The Canberra Hospital does not assess and treat cataracts (as of December 2010). For cataract surgery, refer to The Canberra Eye Hospital.

Vitamin D deficiency

Vitamin D deficiency is defined as a serum level of 25-hydroxyvitamin D less than 20 ng/mL or 50 nmol/L1. One international unit (IU) equals 25ng. Most people with significant vitamin D deficiency on arrival will need supplementation over winter.

The medical service has a supply of megadose vitamin D (100,000 IU/1.0mL) which may need to be given repeatedly to patients with very low levels of vitamin D. Children with rickets should be referred to a pediatric endocrinologist.

Persons with dark skin will need supplementation over winter with daily Ostelin, or a megadose of 100 000 IU in autumn. Pregnant African women or women wearing hijab probably need Ostelin supplements. See Appendix 2 and 3 for Vitamin D Protocols for adults and children respectively.