

History Taking in TB Patients at Likuni Mission Hospital In Malawi

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Summary

In the file audit for patients diagnosed and treated at Likuni Mission Hospital from January to July 1997 the results show unsystematic recording of patient history. Out of 88 case notes reviewed none contained patients' events before diagnosis was made. 34% had no duration of symptoms recorded and 19% had no presenting symptoms recorded at all. Not all the patients had their ages or sexes specified. This calls for more attention and training for better TB control.

Introduction

TB disease is a threat to the world today mainly because of the influence of the HIV pandemic. World-wide in the 1990s there are 8 million new cases every year out of which 3 million deaths occur. In Malawi in the second half of the decade the number of notified cases has risen to up to 20000 new cases per year with approximately 20% deaths in the sputum positive pulmonary TB group and 50% deaths in the sputum negative pulmonary TB group. Such a devastating disease requires special attention at all levels of health care.

One such level is where TB suspects seek care is the hospital. The International Union Against TB and Lung Diseases (IUATLD) and the World Health Organisation (WHO) advise that a patient with the following signs and symptoms should be suspected of having pulmonary TB:- 1) a cough lasting 3 weeks or more, not responding to a course of an available broad spectrum antibiotic, 2) weight loss and 3) night sweats. Pulmonary TB should be investigated in the appropriate way according to guidelines from the Malawi National Tuberculosis Control programme. A good history recorded in patient case files is an essential part of this process. There is no substitute to a systematic history taking.

We reviewed case files at Likuni Mission Hospital to determine whether a proper history had been obtained in pulmonary TB suspects who were later diagnosed as having the disease.

Method

As part of the on-going Lilongwe decentralisation TB project we got authority from the Likuni Mission Hospital management to review patient files of adult TB cases diagnosed and treated in the hospital in the first six months of 1997. We specifically searched the case files for patient information such as age, sex, number of visits to other health facilities prior to diagnosis, duration of symptoms, pre-diagnosis treatment and associated signs and symptoms. The data was collected on standardised proforma.

Results

Eighty-eight case files were reviewed. The pattern of TB in all 88 cases was: smear positive in 38 patients (43%), smear negative in 28 patients (32%) and extra-pulmonary TB in 22 patients (28%). Age of the patients (mean age 34 years) was recorded in 82 (93%) patients. Gender of the patients was recorded in 78 (89%) patients: there were 39 men and 39 women. In none of the files was there any record of 1) visits to other health facilities prior to diagnosis or 2) pre-diagnosis treatment. Duration of symptoms was recorded in 58 (66%) patients - 3 patients were ill for less than 1 week, 4 between 1 to 3 weeks and 51 for more than 3 weeks.

Table 1 shows the number of patients with recorded symptoms and the type of symptoms in relation to the type of TB. In 19% of the patients no information was recorded.

Discussion

The results of this study showed that systematic recording of vital patient information was poor in patients who were ultimately diagnosed as TB in Likuni Hospital. This hospital is a well run institution where general patient records are well kept. This study suggests that priority given to TB suspects is low with respect to systematic recording, and it is possible that worse results are to be found in other hospitals throughout the country.

There are guidelines as to the appropriate symptoms and signs which render a patient a pulmonary TB suspect. It is possible that the appropriate questions were used but their responses not recorded. However, this is poor practice and we strongly encourage all health workers to take systematic histories, not just in TB patients, but at all levels of the health care system.

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References

1. WHO Report on the Tuberculosis Epidemic
2. A D Harries et al; Treatment outcome of an unselected cohort of Tuberculosis patients in relation to HIV serostatus in Zomba Hospital, Malawi. Transactions of the Royal College of Tropical Medicine and Hygiene (1998) 92, 343-347.
3. H J Wright, D B Macadam; Clinical thinking and practice: Diagnosis and Decision in Patient Care (UK, 1979), p 76.

TABLE 1

FREQUENCY OF RECORDED DURATION OF SYMPTOMS PER TB TYPE

<u>Recorded Symptoms</u>	<u>Smear +</u>	<u>Smear -</u>	<u>EPTB</u>	<u>Total</u>
Cough	28	18	7	53
Chest pain	3	3	3	9
Oedema	0	0	0	7
Enlarge glands	0	0	5	5
Fever	1	3	1	4
Weight loss	0	4	0	4
Headache	0	1	1	2
Abdominal pains	1	1	0	2
Haemoptysis	1	0	0	1
Night sweats	0	0	0	0
<u>Symptoms Not recorded</u>				
None recorded	10	5	2	17