**INTERNAL MEDICINE:**

**CASE 1:**

CASE 1

Atypical presentation of TB

Name: A.O. Marital Status: Single Occupation: Fashion Designer

Age: 42 years Religion: Christianity Ethnicity:Yoruba

Sex: Female Domicile: Ogba, Lagos State Hospital Number: 039247

Managed at: General Hospital, Lagos. Date of Presentation: Jan 10th, 2022

Presenting Complaints: Hoarseness of voice of a month duration.

Fever of two weeks’ duration.

History of Presenting Complaints: A.O. developed hoarseness of voice one month prior to presentation, there was no history of voice overuse, cough, no acid reflux/ bitter regurgitation, exposure to smoke or any other irritant.

A.O. also developed fever of two weeks’ prior presentation that has been recurrent, which she described as low grade, associated with chills, malaise, generalized body pain and weakness at times associated with difficulty in breathing and poor sleep at night. There was no history of headaches, ear or eye discharge, sore throat or dysuria.

Recently she noticed weight loss of about 5kg from her last measurement also evidenced by loose clothes, comments from friends and relatives. There was no history of taking unpasteurized milk. She denied any history of night sweats or contact with anyone with chronic cough. She had no history of recent travel.

A.O. had been to a private hospital where she was treated for malaria and typhoid fever with no improvement. She then decided to present at the general hospital for further investigations and management.

AO was concerned about her worsening health and thought she was reacting to something she may have eaten. It had affected her business as she did not go to work everyday. She expected to get well with effective treatment.

Review of systems: A.O. had no palpitation, no dizziness, chest pain or difficulty in breathing. There were no orthopnoea, paroxysmal nocturnal dyspnea, abdominal nor leg swelling. She had no anterior neck swelling, heat or cold intolerance. She had no abdominal pains, nausea, vomiting, loss of appetite, yellowness of eyes, diarrhea, or change in bowel habit. She had no frequency, dysuria, nocturia or urinary symptoms.

Past Medical and Surgical History: A.O. had no history of surgery or blood transfusion. She was not a known hypertensive, diabetic, asthmatic, peptic ulcer patient. Her genotype was AA.

Drug and allergy history: She had no known drug or other allergies.

Obst and Gynae – She was para1+0, attained menarche at 13years, bled for three days in a regular cycle of 28days. Her last menstrual period was 13/9/2021. She attained coitarche at 18years, had a single sexual partner and used male condom. She has no history of dysmenorrhea nor menorrhagia. She has a single sexual partner and use Family and social history: AO was a single parent who lives alonebut she was in a stable relationship. She has a 23-year old daughter who runs her own shop and does not live with her. A.O is a fashion designer and had secondary school leaving certificate. She earns about N80, 000/month and healthcare cost was borne by her (out of pocket payment). She lived in a rented one-room apartment with a private toilet and kitchen. It had cross ventilation with windows. She ate home cooked meals (mostly healthy diet) and they drank sachet water. Sewage disposal was by water closet. She had adequate rest/sleep (at least 7- 8 hours daily). She had no time for recreation, but often attends church service.

She did not smoke cigarette, use recreational drugs or take alcohol. There was no family history of such symptoms, cancer or chronic illnesses.

Physical Examination: A.O. was a young woman, calm,not pale, anicteric, warm to touch (T-37.70C), acyanosed, not dehydrated, had no pedal oedema and had no peripheral lymphadenopathy.

Her weight was 61kg, height was 1.74m and BMI was 20.15kg/m2 which was normal.

Respiratory system: She had a respiratory rate of 22 cycles per minute. Her trachea was central. Chest expansion was reduced in left hemi thorax. Tactile and vocal fremitus were increased and percussion notes were dull over the left upper lung zone. Breath sounds were bronchial. There were reduced breath sounds in left upper and middle zone and he had bilateral fine crepitation in the lower lung zones posteriorly.

Central nervous system: She was conscious and alert. There was no neck stiffness. All cranial nerves were intact. The muscle bulk, power, tone and reflexes were normal. Examination of her motor and sensory modalities showed no abnormalities.

Cardiovascular system: Her PR was 100 bpm, normal volume and regular. The BP was 110/72mmHg and the apex beat was at the left 5th intercostal space along the mid-clavicular line. Only the first and second heart sounds were heard.

Abdomen: Her abdomen was full and moved with respiration. It was soft with no area of tenderness. The liver and spleen were not palpably enlarged. Kidneys were not ballotable. Bowel sounds were normo-active. Digital rectal examinations revealed no abnormalities.

Urogenital examination: Normal female external genitalia

Provisional Diagnosis – 1.? Pulmonary tuberculosis to rule out RVD kiv laryngeal tumor.

The differential diagnoses were lobar pneumonia, laryngeal CA and bronchogenic cancer.

Management: The possible diagnosis was explained to AO. She was asked to perform the following investigations: chest X-ray, sputum AFB x3, complete blood count, Erythrocyte sedimentation rate, Mantoux test, urinalysis and HIV screening. The RBG was 82mg/dl and the rapid diagnostic test for malaria was negative. She was given an antipyretic- paracetamol tablets 1g 8hourly for three days.

FOLLOW UP

First follow up, 13/1/2022– Her laboratory results revealed: PCV-32%, WBC-9.8x103/μl, neutrophils-57%, lymphocytes-36.6%, monocytes-7.2%, eosinophils-0.9%, basophils-0.4% and platelet count-250x103/uL. ESR-115mm/hour (elevated), urinalysis-normal, Mantoux test was greater than 10cm (reactive) and RVS was negative. Her chest X-ray showed homogenous opacity on the right upper and middle lung zones with apical fibrosis and widespread streaky opacities.

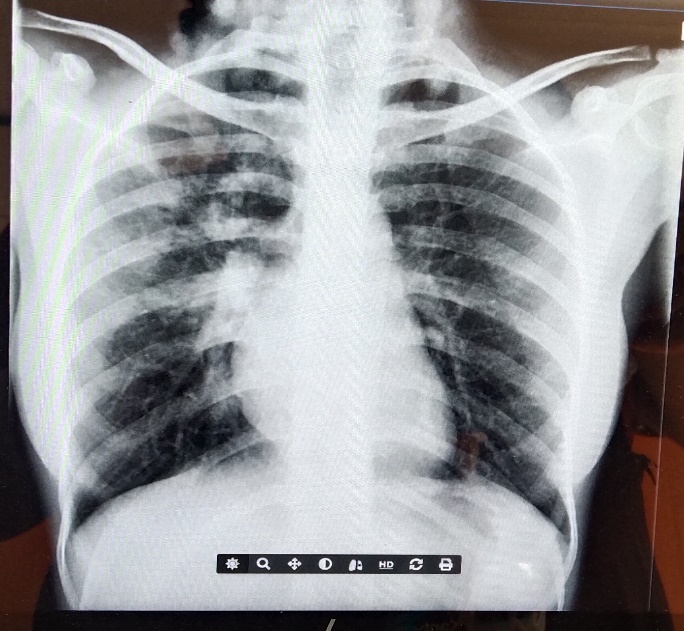


Figure I: Xray for AO as at 13thJan, 2022.

She was counselled that her clinical features were highly suggestive for pulmonary tuberculosis and further tests were required. A gene Xpert test was requested for, to be reviewed when the result was ready, so she was given another appointment in three days.

2nd follow up, 19/1/2022 – A.O. came with the result of the gene Xpert test which revealed Rifampicin sensitive pulmonary tuberculosis. A definitive diagnosis of pulmonary tuberculosis was made and he was commenced on anti-Koch’s medications and asked to do a baseline LFT. She was counselled on medication adherence and possible side effects of the drugs. She was also educated on cough etiquette and the need for her close contacts to be screened. The wrong idea about the cause, of her illness was corrected. She was then, given an appointment for two weeks.

3rd follow up, 9/2/2022 – A.O. came accompanied by her significant other. She had commenced the intensive phase of category one anti- Koch’s medications (150mg of Rifampicin, 75mg of Isoniazid, 400mg of Pyrazinamide and 275mg of Ethambutol) for two months. She was also placed on 25mg of pyridoxine daily. The liver function test that was done showed normal findings. Medication adherence was emphasized.

17th Feb, 2022– A.O.’s came with the Mantoux results for her fiancé and daughter, they were negative. He was counselled on supporting her and to ensure she completed the anti Koch’s regimen.

A.O. accepted our request for a home visit and it was scheduled for the two weeks.

Feb, 2022 – Home Visit: The family was visited on a Saturday evening. A.O. and her fiancé were met at home. After an exchange of pleasantries, A.O. offered to show the author round their house. The building was aboysquarters with a room self-containedwhere A.O. stays and another room and parlour where their neighbors’ lived. It has an uncompleted building in front. The ground was well-paved. Their source of water was a private bore hole which was situated in the compound. The compound was neat with good drainage. The floor of the whole interior was made with tiles. The house was well ventilated and there were mosquito nets on all the windows. The room had its toilets and bathroom with kitchen. Her bathroom was neat and floor had non slip tiles. A.O. is now opening her windows regularly as agreed to allow cross ventilation. A.O. was counselled on healthy diet and the need to add fruit/fresh juice and vegetables to her diet and limit sweetened refined drinks and snacks. Adequate water intake of up to 3L per day were advised. A.O. was advised to place safety non slippery mat in front of the bathroom. She was also advised to keep the tiles dry. She was counselled on routine PAP smears, mammogram after the age of 40 and monthly self-breast examination. Her significant other on PSA. After the discussions and attending to other specific health questions, they expressed their appreciation and the home visit ended.

Three- six months follow up on anti-Koch’s medication – A.O.’s weight steadily increased to 64kg. After two months of intensive phase and four months of 150mg of Rifampicin and 75mg of Isoniazid x4 (continuation phase). She completed her anti-koch’s medications in six months.

The chest X-ray after completing treatment was clear and she was given a 6month appointment after counselling on good nutrition was reiterated.

Summary – A.O. was a 42-year-old fashion Designer who presented with Hoarseness of voice of a month and low grade fever and associated with weight loss. She was diagnosed of Pulmonary Tuberculosis based on her chest Xray report, confirmed by a gene Xpert test. She was treated and monitored on anti-Koch’s for six months and outcome was satisfactory.

**DISCUSSION:** Tuberculosis (TB) is an infectious disease caused by the bacillus Mycobacterium tuberculosis (M. tuberculosis), which most commonly affects the lungs (pulmonary TB) and spreads when individuals with pulmonary TB expel the bacteria into the air.1 The disease is a global treat and Nigeria is among the high TB, TB/HIV and DR-TB countries globally. The country ranks 7th among the 30 high TB burdened countries globally and 2nd in Africa, accounting for 4% of the estimated incidence globally.2 In Abeokuta, Ogun State, South–Western Nigeria a prevalence of 16.7% of Mycobacterium tuberculosis infection among 241 respondents was found.3 A prevalence of 22.1% among 868 respondents was reported in Enugu State, South-Eastern Nigeria.4 According to Adejumo et al, Lagos State contributes 9.4% of the national TB notification. Males are usually affected more than females. Although about 90% to 95% of the people infected with M. tuberculosis do not develop the active disease and remain asymptomatic, about 5% to 10% of those infected develop the disease. Young adults have the highest rates of active tuberculosis globally, butolder individuals experience the highest rates of disease in developed countries.6 The elderly and immunosuppressed are at risk of progressing to active disease. The index patient is a 42-year-old female. Risk factors for contracting active disease include: co-infection with HIV, which is 20 to 30 times more likely to develop active tuberculosis, presence of other immunocompromised states, including immunosuppressive agents such as long-term corticosteroids and anti-TNF medications, chronic lung diseases, use of tobacco products or alcohol (greater than 40 g per day), intravenous drug abuse, indoor pollution, silicosis, end-stage renal disease etc.7 A.O. had none of this risk factors. The classic symptoms of pulmonary tuberculosis are chronic cough often with haemoptysis (blood-tinged sputum), fever, malaise, wasting, anorexia, night sweats, breathlessness, and weight loss (the last giving rise to the formerly prevalent colloquial term "consumption").3 A.O. presented with a hoarseness of voice of one month duration, recurrent fever and weight loss. The diagnosis of pulmonary tuberculosis is made by radiology (commonly chest X-rays), blood tests, as well as microscopic examination and microbiological culture of bodily fluids.3 Diagnosis was made for A.O. based on clinical presentation,Investigation revealed chest X-ray report and confirmed by a gene Xpert test. The drug therapy of active tuberculosis is divided into two main phases: the intensive phase (lasting for two months) and followed by the continuation phase (lasting at least four months). The standard drug choice for the intensive phase is isoniazid (INH), ethambutol (EMB), rifampin (RIF), and pyrazinamide (PZA). The continuation phase drugs are usually isoniazid and rifampin.8 Medications was administered through what is known as directly observed therapy (DOT), in which is observing the patient directly ingesting the medicine to enhance patient compliance and therapy adherence in this case a relative. AFB culture should be done monthly during treatment until at least two consecutive negative samples.9 The index patient was managed using the anti-Koch’s medications with good outcome. Tuberculosis prognosis is variable as it could be a multi-system disease and is affected by many factors. Patient characteristics such as age, immune status, comorbidities, time of treatment initiation, and compliance have a significant impact on the outcome. In general, treatment is successful in about 85% of cases.10 Pulmonary tuberculosis has a variety of complications. Bleeding from bronchial, pulmonary, and intercostal arteries lead to hemoptysis.7,10 A.O was managed successfully without complications.

**Conclusion:**

**Lesson Learnt:** early intervention and medication adherence is crucial in a recovery and prevention of complication.

Role of Family Physician: As first point of contact, should have high index of suspicion and take time to obtain a comprehensive history and adequately investigate their patient in order to achieve a favourable outcome in management of their patient

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**CASE 2:**

CASE 7: HYPERTENSIVE CRISIS: A CONSEQUENCE OF MEDICATION NON-ADHERENCE.

Name: A.S Hospital no:15698 Age: 55 years

Sex: Male Address: Abule-Egba, Lagos Tribe: Yoruba

Religion: Islam Occupation: Security Officer Marital Status: Married

Date first seen: 01/02/2022

Presenting complaint Headache x 5 days

History of presenting complaint: The headache started insidiously about five days prior to presentation and gradually increased in intensity, it was localized mostly to the posterior part of the head, non-radiating, throbbing and persistent in nature and only slightly relieved by paracetamol tablets. There was no history of weakness of any part of the body, facial hemiparesis, chest pain, back pain, cough, swollen feet or intermittent claudication. He was not on any medication such as steroid at presentation and he did not use illicit drugs. There was no history of fever, blurring of vision, eye pain, nausea, vomiting, dizziness. He slumped two days prior to presentation while at work, he was given some medications in his company clinic and his Blood Pressure was found to be elevated. He was then referred to government facility for proper investigation and follow up.

He was diagnosed to be hypertensive about six months earlier, placed on some prescribed medications, which he discontinued after it got finished. He was not adherent to life style modifications and clinic attendance. He claimed he was not adherent because he thought his BP had returned to normal and was using herbal medications.

He expressed fear that this high blood pressure could make him have a stroke and the idea that the headache was due to the stress of not having enough money as he was forced to trek long distance at times which made him to be less active at work. He expected a cure for his headache. Review of systems: He had no dribbling of urine, hesitancy or straining on micturition and his urinary stream was normal.

Drug and allergy: He had no known drug allergy.

Past medical history: He was not a known diabetic, asthmatic or epileptic. He had no prior admission to the hospital for any medical or surgical condition.

Family and social history: He was married with three children in a monogamous setting; two of whom were married. His wife died five years earlier at 48 years from car accident. His mother died of stroke, he was not aware of any sibling with hypertension.

He and his last child lived together in two rooms in a tenement house with detached toilet facility. Source of drinking water was bore-hole located in the compound and waste disposal was into bins evacuated by the government liaised refuse collectors.

He was a security guard with primary level of education. His monthly income was an average of forty thousand naira. He had no health insurance, but was supported financially by his company.

He ate whatever was available and was not aware of “DASH” diet. He did not smoke cigarette but occasionally drank alcohol at social functions. He enjoyed eating bitter kola and kola-nut. He did not engage in any scheduled physical exercise but did not lead a sedentary lifestyle because of the nature of his work. There was no family history of diabetes, asthma or epilepsy.

Examination: He was a middle aged man who was not pale, anicteric, afebrile (temperature of 36.50C), not dehydrated with no pedal oedema and no palpable peripheral lymphadenopathy. He was 72kg, with a BMI of 27kg/m2.

Cardiovascular system: His pulse rate was 96 beats per minute, regular and of full volume. His blood pressure was 200/110 mmHg, the jugular venous pressure was not elevated and apex beat was at the fifth left intercostal space in the mid-clavicular line. The first and second heart sounds were heard with no murmur.

Respiratory system: His respiratory rate was 18 cycles per minute and was not dyspnoeic. His trachea was central and chest expansion was symmetrical. Percussion notes were resonant and the breath sound were vesicular in all lung fields with no added sounds.

Abdomen: His abdomen was full, moved with respiration. It was soft and there was no area of tenderness. His liver and spleen were not palpable and kidneys were not ballotable. No renal bruit was heard. Bowel sound was normoactive.

Central nervous system: He was conscious, alert, well oriented in time, place and person. There was no sign of focal neurological deficit and no sign of meningeal irritation.

Eye examination: His visual acuity was 6/6 in both eyes and visual fields were normal. There was normal pupillary reflex. Eye position and movement were normal. Eyelids were normal. Conjunctiva, sclera, and cornea were normal. The lenses were clear and anterior chamber was normal. Fundoscopyrevealed normal red reflex. Optic disc ratio which was normal for both eyes was 0.2 for right eye, 0.3 for left eye; and macula was normal.

Diagnosis: A diagnosis of hypertensive (urgency) crisis with no end organ damage was made and differential was; Transient ischaemic attack.

Management: The diagnosis was explained to patient. He was educated on the course, causes, management and was also informed that prompt treatment will prevent complications of hypertension. He was educated that non-adherence to antihypertensive medications may have resulted in his degree of elevated blood pressure and was counselled on the dangers of hypertensive crisis. The care plan was explained to him that it would be initial care in the hospital for observation while being investigated for possible causes and complications that may have developed. The blood pressure would need to be urgently reduced gradually, with prevention of a reoccurrence in the long term. The goal of treatment was agreed upon to prevent disabilities. He was admitted into male medical ward and the following investigations requested for; chest X-ray (CXR), electrocardiography (ECG), renal ultrasonography, serum electrolytes, urea and creatinine(E/U/Cr), lipid profile, liver function test (LFT), fasting blood glucose (FBS), full blood count (FBC) and urinalysis. He was commenced on tablets

amlodipine 10mg daily, Telmisatan 80mg daily and fixed combination hydrochlorothiazide 50mg/amiloride 5mg daily.

1hr on admission: He was reviewed by the consultant who agreed with the diagnosis. His pulse rate was 88beats per minute, BP was 185/105 mmHg and respiratory rate 20 cycles per minute. Bromazepam at 3mg at night for 5 days was added to his medications.

3hours on admission: Investigation results were as follows; Urinalysis was normal with a pH of 5.0 and others nil. ECG was normal sinus rhythm and LVH. Renal ultrasound scan was normal with normal sized, bean shaped kidneys with good cortico-medullary differentiation. CXR found cardiomegaly (CTR 16.5/30.5) with unfolding of the aorta. BP was 180/100mmHg.

Second day on admission: His headache had ceased and he appeared calm. Other investigations were; FBS was 85mg/dl and FBC was normal with packed cell volume of 42%, white blood cell count of 7,400/mm3, lymphocyte of 58%, neutrophils of 40%, eosinophil 1% and basophil 1%. E/U/Cr, LFT and lipid profile were normal. E/U/Cr: Na+ - 148, K+ - 4.0, Cl- - 98, HCo3- - 24mmol/l,Blood Urea 36 mmol/l, Cr – 0.93mmol/l. lipid profile result revealed: total Cholesterol- 145mg/dl, HDL- 40 mg/dl, LDL- 120mg/dl, TG- 128mg/dl. His pulse rate was 88bpm, regular, good volume. BP was 165/100mmHg. Respiratory rate was 16cpm and breath sounds were vesicular. Tab. Atorvastatin 20mg nocte was added to his medications.

His fear of long term medication use was addressed as he was educated that to prevent complications that could be fatal, it was more realistic to adhere to medications. He was informed that he had the cardiovascular risk factors of hypertension with hyperlipeademia and to avoid a cardiovascular event that may lead to mortality or severe disabilities, he will need to ensure strict drug adherence. He was told that effectiveness of drugs and dosage will be regularly reviewed with his BP check at clinic attendance on a regular basis. Mr. A.O was educated that to complement his drug therapy, reduce stress, maintain adequate weight, ensure adequate rest and dietary approaches to stop. Hypertension (DASH diet); stopping or cutting down alcohol and reduction of dietary salt. He was advised on scheduled regular pattern of exercise. He was counselled on DASH diet; diet rich in fruits, vegetables, whole grains, low-fat dairy foods, limited sugar sweetened foods and beverages, reduced red meat and reduced added fats. He agreed with the line of management and expressed regret at not utilizing services from this facility as he was better informed about his condition. He was discharged on current medications and booked for appointment to see a week later in the clinic.

First follow-up: He was seen a weeklater, he was in a cheerful mood and had commenced DASH diet. He was anxious to resume work; he had been on sick leave since the incident and he requested to know the type of exercise he could engage. His pulse rate was 84 beats per minute, BP 140/80mmHg and respiratory rate 18 cycles per minute. He was informed that scheduled brisk walking of a minimum of 30 minutes on most days of the week (at 5days a week) was a good exercise pattern. He was educated on the benefits of such exercise to include; good BP control and prevention of heart diseases, obesity and diabetes; boosts the immune system; prevent depression, control stress and promote self-esteem. He was educated that he would benefit from stopping alcohol or cutting down to not more than 21 unit/week i.e maximum of 3unit/day. He was told that 500mls of beer and 1 shot of local gin were equal to 1 unit. The quantity of the average Nigerian brewed beer has 600mls in bottle and 300mls in can. He had his drugs refilled and booked for appointment in three weeks.

Second follow-up visit: He had no complaints. He had been adherent to his medications and had commenced a dash diet and was maintaining a regular exercise pattern of brisk walking of 30 minutes morning or evening on alternate days to and from work that he constantly looked forward to. His BP was 120/70mmHg. He was counselled on the need to sustain clinical improvement by remaining adherent to his medications and to keep clinic appointment. He was booked for follow-up visit in 6 weeks.

Third follow-up visit: He had done very well when he came as scheduled one and half month later. Though he had returned fully to work. He was still maintaining his exercise pattern and attested to a better feeling of well-being. He however requested a referral letter to a nearby government owned hospital close to his house. His blood pressure was 124/80mmHg. He had his drugs refilled for 6 weeks. He was obliged and issued a referral letter with a request for feedback. He was counselled on the benefit of good adherence to medication, diet, exercises and lifestyle changes. He was educated on the features of hypotension. Adherence was encouraged through telephone follow-up.

Summary: A.O. was a 55-year-old hypertensive, non-adherent to medications who presented with persistent headache. He was managed for hypertensive crisis and remained stable on oral anti-hypertensives following counselling on the need for adherence. He had been referred to a nearby hospital because of distance.

Discussion: Over 70% of patients who visit the emergency department with a hypertensive emergency, or a hypertensive urgency have previously been diagnosed with hypertension.1 Such is the case of the index patient. Hypertension or high blood pressure (BP), is defined by two levels by 2017 American College of Cardiology/American Heart Association (ACC/AHA) guidelines: Elevated BP is diagnosed when systolic blood pressure is consistently >130mmHg, and diastolic pressure >80 mm Hg. According to WHO, hypertension, with a SBP of 130 to 139 mm Hg or a DBP of 80 to 89 mm Hg.2,3 Hypertension is the most common primary diagnosis. An estimated 1.28 billion adults aged 30-79 years worldwide have hypertension. In the United States,4 It affects approximately 86 million adults (≥20 years)5 and is a major risk factor for stroke, myocardial infarction, vascular disease, and chronic kidney disease.4 From individual study estimates, the highest prevalence of HTN in Nigeria was recorded in an urban community in Kaduna State, North-west Nigeria, at 55.9% in 2018,6 Drug nonadherence is assumed to play an important role in development of hypertensive urgency and hypertensive emergency, but exact numbers are lacking.1 A.O. was 55-year-old hypertensive male who presented with headache localized to the posterior part of his head. He admitted to not being adherent to his hypertensive drugs because he thought his blood pressure had been restored to its normal form after using the drugs for some time. Hypertension may be primary, which may develop as a result of environmental or genetic causes, or secondary, which has multiple etiologies, including renal, vascular, and endocrine causes. Primary or essential hypertension accounts for 90-95% of adult cases, and a small percentage of patients (2-10%) have a secondary cause.8 According to the world health organization there are modifiable and non-modifiable risk factors for hypertension. Modifiable risk factors include unhealthy diets (excessive salt consumption, a diet high in saturated fat and trans fats, low intake of fruits and vegetables), physical inactivity, consumption of tobacco and alcohol, and being overweight or obese. Non-modifiable risk factors include a family history of hypertension, age over 65 years and co-existing diseases such as diabetes or kidney disease.9 A.S was 5 years old, with no family history of hypertension, but was however diagnosed with hypertension 6 months prior to presentation. Nose bleeds, early morning headaches, abnormal heart rhythms, visual alterations, and ear buzzing are some of the symptoms that can arise. Fatigue, nausea, vomiting, confusion, anxiety, chest pain, and muscle tremors are all symptoms of severe hypertension.9 A.S presented with a headache of 5 days’ duration around the posterior part of his head. There was no history of nose bleeding, fever, cough or facial hemiparesis. The diagnosis of hypertension requires measurement of BP in the proper environment under optimum conditions. It requires that the patient be relaxed in a chair for at least 5 minutes with the arm resting. In order to establish diagnosis, ≥2 readings of elevated BP on ≥2 occasions are needed.2 The evaluation of hypertension involves accurately measuring the patient’s blood pressure, performing a focused medical history and physical examination, and obtaining results of routine laboratory studies. The 2017 ACC has set a blood pressure reading above ≥130/80 mmhg to be considered hypertensive while the European Society of Hypertension guidelines have maintained a blood pressure reading of ≥140/90 mmHg to be considered to be hypertensive.2 A.S blood pressure was 220/140 mmHg during presentation, based on this premises he was adjudged hypertensive. The management of hypertension involves both pharmacological and non-pharmacological interventions. Lifestyle modification in predisposed individuals such as reduction in salt and fatty diet intake, increased physical activity and regular exercises for weight management, reduction in alcohol consumption and cessation of cigarette smoking, consumption of fruits and vegetables as well as stress reduction and management also play a key role, the introduction of medications depending on the patient’s response.2,5Gachomo in his study on hypertension in Nigeria found that respondent in the study conducted responded well to thiazide diuretics and calcium channel blockers either as monotherapy or in combination therapy and recommended the medication use in Africans.10 Antihypertensive combination therapy was administered for A.O.

Lesson learnt: Social support and lifestyle is essential in successful management of chronic illness

Family physician as a front liner and expert in management of chronic illness should advocate for life style in order to maintain health and prevent serious morbidity and reduce mortality associated with chronic illnesses.

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