Difficult-to-treat infectious diseases in migrants

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Outline

1. Refugee case
3. Clinical cultural competences
4. The need for specialised services
Diana from CAR

- 45 year old female
- UN refugee from Central African Republic
- Arrived in Denmark 2016
- HIV infected
- Widow with 4 children
Previous history

2013-2016

- After shooting, caesarian delivery with live born son

- Damages to urinary tract, JJ catheter

- 2014: Escape to Cameroon. Started on HIV treatment. Atripla (efavirenz, emtricitabine, tenofovir)
Initial presentation

- Weight loss, coughing.
- CRP 43
- ESR: 118
- Normal leucocytes and differential count
- CD4 count 390, virologically suppressed.
- Quantiferon positive
CT scan
Question 1.
What is the probable diagnosis?

1. Tuberculosis
2. Pulmonary aspergillosis
3. JJ-katheter infection
4. Granulomatosis with polyangiitis (GPA)
Work-up for TB not conclusive

- Initial BAL: TB PCR and culture-negative,
- Sputum, urine and feces investigations negative on several occasions
- Cervix swab culture-negative
- March 2018: BAL investigations negative
  March 2018: axillary lymph node with no evidence of TB
- Given 6 months' treatment from early in 2018 on clinical suspicion following diagnosis of active pulmonary TB in the patients 11 year old daughter
Primary diagnosis: Aspergillosis

- BAL: Strongly positive aspergillus galactomannan AND growth of aspergillus fumigatus. (Sensitive to Itraconazole, voriconazole and posoconazole)
  - Treatment with voriconazole/itraconazole for one year 2016-17. No pulmonary symptoms
  - Presents with pulmonary symptoms in late 2017. New 6 months course of treatment with itraconazole.
  - Serum Aspergillus continuously IgG positive with a high titer of 800 (<200)
Treatment, full overview - sedimentation in Red
PET-scans with progressing changes in pulmonary cavities and aorta in late 2018

Strongly enhanced signal from right side pulmonary cavity. Moderately enhanced signal from aorta ascendens and descendens as well as in the lower abdomen. Periaortitis. Multiple enlarged and normal-sized lymph nodes with enhanced signal in the neck, axilla, mediastinum, along aorta abdominalis.

Area behind the bladder with strongly enhanced signal. Gynecological examination recommended.
Question 2.
What may explain this course?

1. Aspergillus resistance
2. MDR-TB
3. Adherence issues
4. Wrong diagnosis – different infectious agent
5. Inflammatory disease – eg vasculitis
Sedimentation rate during 6 months' TB-treatment
HIV status and treatment

- Treated with Atripla (efavirenz, emtricitabine, tenofovir) prior to arrival.
- We have changed to TDF, emtricitabine and Dolutegravir.
Clinical challenges...

- Unexplained and increasing changes on repeated PET-scans showing aortitis/periaortitis.

- Chronic pulmonary aspergillos

- TB not treated sufficiently?

- Intermittant low grade viremia
Underlying issues

- Language barrier, speaks French, little trust in interpreters
- Refuses admittance to hospital, has no one to look after her 4 children
- Traumatized, not possible to conduct gynecological exam
- Memory issues, problematic adherence, possibly PTSD
- Husband turns out to be alive, under pressure for cash transfers
- On welfare, needs to meet demands from municipality for work-practice
Complex clinical course

- Aortitits currently treated with prednisolone
- Resumed treatment with antifungals regardless of no current positive tests on BAL
- TB sufficiently ruled out as cause of aortitis?
- Intermittant low grade viremia because of poor compliance?
- Massive social and cultural issues
- Co-morbidity + poor health literacy + language barriere + social issues = Complexity
Question 3.
What is needed to improve care for complex migrant patients?

1. Better diagnostic tools for infectious diseases
2. Stronger enforcement of border control
3. Specialised migrant health clinics
4. Training in tropical medicine
Solutions

• Migrant-friendly hospitals:
• www.mfh-eu.net

The Amsterdam Declaration
Towards Migrant-Friendly Hospitals in an ethno-culturally diverse Europe
Recommendations

1. Individually oriented solutions
2. Communication and care practice adapted to ethnic minorities.
3. Avoid stereotyping on the basis of ethnicity, cultural background and religion
4. Developing partnerships with local community organisations to facilitate the development of a more culturally and linguistically appropriate service delivery system.

The Amsterdam Declaration
Towards Migrant-Friendly Hospitals in an ethno-culturally diverse Europe
Clinical cultural competence

• “Cultural competence is having the knowledge, understanding and skills about a diverse cultural group that allows the health care provider to provide acceptable cultural care”

• “Competence is an ongoing process that involves accepting and respecting differences and not letting one’s personal beliefs have an undue influence on those whose worldview is different from one’s own”

• “Cultural competence includes having general cultural as well as cultural-specific information so the health care provider knows what questions to ask”

Disease = problem no. 117
Evidence of the effect of using interpretation

- Decreases the risk of wrong diagnosis
- Decreases risk and severity of complications
- Communication problems are the most important issue, in caring for patients with other ethnic origin

Interpretation

- Concepts about health and disease are often absent though the patient speaks host-language reasonable
- Especially when sick (somatic or psychiatric)
- Use of family as interpreter
  - Generally not and never for serious messages
  - Not children
- Video interpretation is to be preferred (telephone interpreting is possible)
- A good interpreter does linguistic as well as cultural interpretation.
Interpretation

- Inform about confidentiality
- Double consultation time
- Speak directly to the patient
  - Short, clear and meaningful sentences
- Avoid medical terms, slang and metaphors
- Sum up and check understanding
- Evaluation with interpreter
Interpretation should be used more..

- Interpretation must be used
  - At every consultation/ward round/examination etc.
  - Also when patients speak hostlanguage reasonably

- You will not accept not being able to access information in other aspects of medicine..

No hospital does question the use of electricity for light in the operating theatre!
Non-adherence among patients with different ethnic background

- 1/3 of patients do not comply with the doctor’s recommendations
- 38% took medications that are not prescribed for them
- Over 50% taking medication purchased in their countries of origin
- 50% are unaware that they take medication incorrectly

Afsaneh Ahmadi, pharmacist, Migrant Health Clinic, Odense
The need for specialised services

- Considerable language barriers
- Low health literacy
- PTSD causes distorted memory and cause severe pain
- Taboos (incontinence/abuse/handicaps)
- Medicine
  - compliance is difficult when other problems are larger
  - Substitution/medicine from the home country
  - All medicine should evaluated carefully
Migrant health clinics

- Introduced in Denmark in 2007 by Morten Sodemann, available in 4 major university hospitals
- Gate of entry into tertiary services. Modern public health systems are difficult to navigate in
- Comprehensive management involving specialized tertiary internal medicine diagnostics as well as management of social, pharmaceutical issues etc
- Clinical culturally competent staff with the scarce resource of TIME
- Case-managers to improve the course.
  - (Hansen, JRSM Cardiovascular Disease, 2014, Goldberg IJTL 2004)
- Support when lack of self care. Previous war trauma, social and family problems may prevent taking care of a disease
Summary

- Practical experience in order to increase your knowledge. Talk to patients and doctors and listen to the story behind. Ask questions.

- Look for the most important problem
  - Remember PTSD

- “undergoing the process of becoming a culturally competent clinician is to have the fundamental attitudes of empathy, curiosity and respect that are constantly being reshaped by self-reflection”
  Kodjo, Cultural Competences in a clinician communication, Pediatr Rev. 2009 February ; 30(2): 57–64

- Interpretation is important!
Thank you

For truly to be able to help someone else, I must be able to understand more than he - but first of all understand what he understands. If I do not do that, then my greater understanding will not help him.

Søren Kierkegaard