A woman with recurrent anaemia and the Malawian health system

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A 22 year old woman presented to the general medical clinic in 2005 with a six month history of generally feeling tired. She had been seen a number of times in the accidents and emergency department with similar symptoms and a diagnosis of anaemia was made at each visit. Iron tablets and albendazole were prescribed. She took the iron tablets for about two months but there was no improvement. It was at this time that she was referred to the general medical clinic. A review of her medical history showed that she had grown up well and had completed all her immunizations. She attained menarche at the age of 13 years and had a regular menstrual cycle. Her periods were not heavy and she was not sexually active. Her diet was normal. She had no other sites of blood loss that she could point to. A physical examination showed a well-developed 22 year old woman with normal blood pressure. The only abnormality was a pale conjunctiva. In the chest, heart, skin and abdomen, there were no abnormalities.

The womn brought with her a full blood count result which showed an HB of 4.9g/dL, MCV of 88fl, RBC count of 2.3 x 1012/L and a platelet count of 78,000/uL. The rest of full blood count report was normal. A peripheral blood film was requested and the patient was admitted to hospital for a blood transfusion. She received two units of blood and felt much better. A peripheral blood film was reported as showing no specific important features. An HIV test was negative. A bone marrow aspirate was reported as showing features of aplastic anaemia. A detailed drug history was taken which yielded no positive leads. She was treated with 60mg of prednisolone daily for one month. A month later at a predetermined clinic review, there was no improvement. Her HB at this visit was 3.8g/dL. She was readmitted to hospital for another two units of blood transfusion. Prednisolone was tapered to stopping over one month. She was transfused blood almost every four to six weeks for six months until her referral to a haematology unit in South Africa.

A review of her history and physical examination was done in South Africa and confirmed the findings in the referral letter. In the hematology unit, a direct antiglobulin test; a bone marrow aspirate was reported as showing features of aplastic anaemia. A detailed drug history was taken which yielded no positive leads. She was treated with 60mg of prednisolone daily for one month. A month later at a predetermined clinic review, there was no improvement. Her HB at this visit was 3.8g/dL. She was readmitted to hospital for another two units of blood transfusion. Prednisolone was tapered to stopping over one month. She was transfused blood almost every four to six weeks for six months until her referral to a haematology unit in South Africa.

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meets to decide which patients should be referred for further management. The majority of the patients are either children or adolescents with valvular heart disease. It would cost the country less if capacity for conducting such operations was made available at one of the hospitals in Malawi and experts brought once or twice a year to carry out these operations. Coming back to our patient, she illustrates availability of diagnostic tests (some simple e.g. the direct antiglobulin test and others complex) in some national unit may save the government of Malawi large sums of money while at the same time providing quality health care to its people. We are not privy to the amount of money the government of Malawi paid for this patient's care. It is likely to run into millions of Kwacha. However if a national laboratory (dedicated to the task) was available that could do all these tests (with quality control/ and quality assurance that is required) for the nation, we could save a lot of money. Many more patients like this young woman are not investigated to their logical conclusion because of logistical handicaps and end up either living long with disabilities or dying prematurely. It is imperative that antiglobulin tests be made available at the main referral hospitals and technologists trained to perform these tests to the highest quality possible. QECH and Kamuzu Central Hospitals being teaching hospitals, need to be provided with the capacity to carry out such tests for the nation.

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