Honduras Journal #6

During this visit, we were able to work in the new neurology and psychiatry suite; this was just built out. It is 3 rooms, one for the nurse (Luci), one for the psychiatrist (Dr. Laura Mendoza, excellent young, idealistic psychiatrist) and one for neurology (Dr. Jose Estrada or Dr. Sofia Dubon, both young and idealistic doctors).

We also had several people filming for a short "Honduras Video" that we are putting together (mostly for promotional purposes). It was a very busy day, many pacientes waiting, when we heard a blood-curdling scream from outside our neurology rooms. We ran out, to find a young man (20 y.o. or so) covered in blood in SEVERE, SEVERE pain. They run a 24/7 ER in our medical clinic, albeit without much equipment. However, some medical care, or ER care, is better than none. The docs and nurses who staff our ER are incredibly devoted and skillful. They do a lot with very little.

SO, the director of the entire clinic, Daisy, was cutting the young man's pants off, in order to clean one of the gunshot wounds. We found some IV Valium, and a skilled nurse managed to get an IV into him. I had one Vicodin (hydrocodone) on me, and I gave him ½ only (I did not want to induce respiratory depression with Vicodin and Valium, and he received 10mg IV Valium, a hefty dose). He calmed down. He had 2 major wounds: one bullet sticking into a leg bone, another passed thru his wrist. His hand was flexed (I assume the median nerve was injured or severed). In the U.S., in most areas, a hand trauma surgeon would possibly repair the damage. This would involve a complicated 6 to 9 hour operation. Not going to happen in Honduras, so he will most likely be left without use of his hand, and in moderate or severe chronic pain.

SO, now what to do: we needed to get him to Tegucicalpa, a long, harrowing journey, but they could not afford a private ambulance. I said I would pay (in Honduras it would be $55), but then the one "public" ambulance in town showed up. You need permission from the mayor to use it, but he gave his permission, so off the young man went.

His younger sister was crying inconsolably, obviously severely traumatized. She will suffer from PTSD. SO, what happened in the shooting? Turns out, this made the nightly news. The young man's stepfather was yelling at him: so, his older brother came to his defense, as did his mom. His mom had suffered abuse from the stepfather (common in Honduras, unfortunately). The stepfather went and retrieved a gun and shot mom, plus the 2 brothers. He spared the younger sister. We don't know what happened to any of the other 3; the older brother was shot in the stomach, and on TV looked pallid, so he may have died. Police were searching for the stepfather.

I had been seeing a young man during this crisis that has an unusual peripheral neuropathy. He may have CMT (Charcot Marie Tooth neuropathy, a hereditary form of peripheral nerve illness). There is no treatment, but at least we can (maybe) tell him what he has. We will have to make a clinical diagnosis, as obtaining tests are unlikely.

During the last several trips I had been surveying patients regarding demographics; these are as follows:

DEMOGRAPHICS OF OUR HONDURAS NEUROLOGY CLINIC:

Lawrence Robbins,M.D.: Honduras Neurology Clinic:
1. Numbers of Patients,
2. Diagnoses,
3. Reasons Why Patients Come To See Us,
4. Patient Satisfaction, and
5. Demographics

1. Numbers of Patients: As of November 2019, the clinic has approximately 575 active patient charts. We had accomplished 2,150 patient visits. These include: neurology visits, psychiatry visits, and psychology sessions.

2. Diagnoses: We see approximately 33% migraine (and other headaches), 28% epilepsy, 10% psychiatric (various diagnoses), 7% Parkinson's, 5% neck or back pain, 5% children with developmental delay, cerebral palsy, or similar, 4% dementia, and 8% various neurologic conditions.

3. Reasons Why Patients come to See Us: We did a survey of patients: #1= to obtain an opinion, or in some cases a 2nd opinion, about their condition. Only 10% of these patients have access to private neurology or psychiatry. The other 90% cannot afford the visits, travel, and medicines. After the first visit, the reasons for returning include: 1. Ongoing care, and the relationship (with Lucy, and the doctors) is cited as very important, and 2. To obtain free medicines.

4. Patient Satisfaction: We have asked, the satisfaction rate is very high (90%+); this seems to hold up even when the medicines are not working, and the patient is not any better. Patients consistently express that they are happy to at least have a relationship with a neurologist or psychiatrist, and access to care, even when the condition is not improved.

5. Demographics: We see all ages, 2 months old to 98 years old. Approximately 50% F to 50% M (which is surprising: in the US, in our office, it is 70% F). The majority (90%) are very poor. The patients travel from all over the country. We have many patients from the 2 large cities, Tegucicalpa (one hour away), and Danli (2 hours away).

PATIENTS: I saw an 86 y.o. man with advanced Parkinson's. We do see more and more Parkinson's: for one, as our clinic's reputation grows, more patients from around the country hear about us, and come for the diagnosis and care. They also like our free meds, such as the Parkinson's meds we bring in. He had not been previously diagnosed. I hope the carbidopa-levodopa (Sinemet: the usual Parkinson's med, we bring in a ton of it) will help. He has a severe tremor, and poor postural stability, poor gait, masked facial expressions, very slow movements, and muscle rigidity). He was brought in by his daughter; the level of family support in Honduras is incredible, families take care of each other (usually).

I saw a 20 y.o. return epilepsy patient. After putting her on topiramate for her seizures (she had been on Dilantin, an older drug, not as effective, many side effects), she went from 25 seizures per month down to 3. That was good. She does have daily headaches and migraines, and the sumatriptan helps to stop her migraine once it begins Unfortunately, the topiramate does not help prevent her headaches. Amitriptyline helps her sleep and headaches. We bring all of these meds in from the States.

I treated a 17 y.o. young man with focal (minor seizure, no loss of consciousness) seizures; he does not have major "Grand Mal" attacks. He was on the old Dilantin, with all of its shortcomings; we did switch him to the Keppra, which we cart in. He is in school, probably will have less side effects on the new medicine. As usual, his mom brought him in, and she watches over him.

I saw an unfortunate 7 y.o. with severe cerebral palsy. I think (although the history is not all that clear) that there was significant birth trauma (probably needed a C-Section, but those are not easily available). He is spastic (very tight, cannot walk), verbalizes only a little. I do have him on seizure medicine.

A 21 y.o. young woman with severe migraines had them under control since the last visit (4 months ago). However, she ran out of the daily med (amitriptyline), which I restarted. The sumatriptan ("as needed" migraine medicine) has been a miracle for her, but she also ran

out of that. I realize that she, as do many others, comes from a long way; 2 buses and walking. SO, I am trying to give 2 months, or even 3, of medicine at one time, instead of just 1 month.

Luci (the nurse who helps manage and run the clinic) sends me a list of all meds, and number of pills, in our neurology pharmacy. We go through a lot of Keppra, which I use for most seizure types. We also seem to run out of Parkinson's meds very easily.

We had a 5 y.o. boy come in, who is violent at home. He probably had hit his head and suffered a concussion as a 1 or 2 years old, but the history is murky. His 8 y.o. brother abused him last year, by touching his genitals. SO, this child needs some type of therapy (play therapy etc.), and the family needs an evaluation. I am not sure how rigorously, or how often, "authorities" look into these families. It is relatively unlikely the boy will get the therapy he needs.

Another mom came in with her 9 y.o. daughter; she has tonic clonic (grand mal) epilepsy. The seizures are somewhat controlled on Dilantin; I do worry about long-term side effects from Dilantin. These include gum hypertrophy (thickening and swelling of the gums), skin changes, poor coordination (cerebellar atrophy), and others. Ideally, maybe we can change her slowly over to the Keppra (levitiracetam), which is better long term. Another terrific mom, sacrificing all for her children.

PSYCHOTHERAPY FOR WOMEN IN NEED

Therapy is extremely limited. One has to have quite a bit of money, and therapists are few. There is a great need. Depression and anxiety are common, and early trauma is a major issue. In addition, domestic abuse is fairly prevalent. The women have little outlets; they do have friends and family, but are often unable to vent or discuss problems. In Zimbabwe they have a program where they train older women volunteers to be "listening coaches', providing support. Outcomes have been good, with a significant impact on depression. Unfortunately, it may be difficult to get a similar program going in Honduras. However, we will continue to try to expand therapy services, one way or another.

In comes a nicely dressed (neatly pressed jeans, white shirt) 72 y.o. man, an agricultural worker. He has Parkinson's, mild-to-moderate, does reasonably on the Sinemet (levodopa/carbidopa). Very polite. He says to Cato and me, "god bless you all", and points up to the sky. Nice man.

A 61 y.o. woman came in with weakness in her "proximal" muscles(upper arms, shoulder, and hips, thighs, hamstrings); I thought she probably has (adult onset) "fascioscapulohumeral" muscular dystrophy, which is not all that uncommon. Unfortunately, it is progressive, with no cure.

Movement disorders, particularly in kids, are very interesting. I have seen kids here with: "stereotypy", which often is seen in those in the autism spectrum. The person has this urge to scrunch up their face or hands, tenses muscles, may let out a grunt or even a scream, and then it is over. It releases tension, and is voluntary, sort of. It is somewhat like having the urge to sneeze, and they just have to do it. There are some meds that could help, but not very much. This may improve over time.

Another movement disorder that is common is tremor; usually essential, or familial. It may present in the teens, or wait until the 60's or 70's. Most people have some tremor, worse with action or moving their hands/arms. It is usually gone with rest. I have seen quite a bit of that in Honduras, as in the U.S. There are meds that help, that we can obtain in Honduras (propranolol, or similar ones, and benzodiazepines (clonazepam, etc.). For some reason, in Honduras they have only higher doses of benzos available. On the other hand, they use relatively low amounts of opioids, much, much less than in the U.S. I see significantly less addiction than in the U.S. Most here cannot afford cocaine, marijuana, even alcohol.

Some patients do come in with advanced testing; MRIs, DNA tests etc…..they have money, and usually live in the major city (Tegucicalpa). This one very nice 52 y.o. man had APOE-4 genetic test results with him, which tests genetic susceptibility to heart and dementia issues…..that was impressive. Usually we are very lucky to get very basic blood tests;

we pay for some, but for some reason in Honduras they are somewhat expensive.

Several patients came from Guatemala, 2 long bus rides, as they heard we diagnose and have free meds…….

A 53 y.o. pastor came in, his daughter lives in Holland, Michigan, near me…small world…he spoke perfect English…….

In came a nicely dressed 81 y.o. woman, took a bus from 3 hours away; she has 11 kids. She wants an evaluation for possible dementia; I do think she has early dementia, but is doing well. She is independent, her balance and gait are fine, and she is on no meds. We do evaluate a fair number of patients here for dementia. There are some meds available, but none of the dementia meds are all that effective. Here in Honduras the family often takes care of, and lives with, the older person with dementia. There do not seem to be many nursing homes, and the vast majority of the people cannot afford them.

Our mediation sheet seems to be a big hit; I suggest certain meditation apps, but most people cannot afford a smartphone.

I saw a 63 y.o. woman with anxiety, depression, and insomnia. I asked my usual questions about "the soft (mild) end of the bipolar spectrum". I do think she is in the mild end of the bipolar spectrum. I prescribed one of the mood stabilizers that are available. Mood stabilizers work better in the bipolar patient than do the antidepressants. There are 3 classes of mood stabilizers: atypicals (Seroquel, Abilify, Zyprexa, Risperdal, etc.), Lithium (which is underused), and anticonvulsants (Lamictal, Oxcarbazepine, Depakote). In Honduras we do have, and I bring in, a number of these mood stabilizers. This woman has 14 kids, 2 of whom died. 5 more of her children have major mental health issues. This makes it very tough on her, as she is coping with her own mood issues.

Adios and until Journal #7……..