Pharmaceutical Practitioner

South African Association of Community Pharmacists

A day in the life of a PCDT pharmacist – "Peeling the Layers"

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Frans Landman is a PCDT pharmacist. He completed the PCDT course in 2012/2013 at NWU and his business partner did the same course a year later.

Frans describes a few case studies to highlight the contribution a PCDT pharmacist can make in primary health care, improving access to healthcare for patients.

Introduction

In the years since the moratorium on the qualification of PCDT (Primary Care Drug Therapy) was lifted, our business underwent some challenges regarding the demographics of independent pharmacy. The focus of our long standing clients moved mainly to corporate pharmacy and newly built malls. As the saying goes the only constant is change. At the time we had an active baby and family planning clinic.

Having completed the PCDT course brought a new dimension to the services we offered our clientele, from only family planning and immunization, we now also offered primary healthcare services.

After qualifying as a PCDT pharmacist, my world of pharmacy changed forever. I started to look at the patients visiting our pharmacy with new eyes. By just listening to the complaints of the patients, I could offer a more comprehensive service to their health outcomes.

Let me explain the statement **"Peeling the Layers"**. When a patient arrives and poses their complaint, our aim through thorough history taking, is to arrive at a differential diagnosis, which in many instances is different from the main complaint. In many cases, our role is to provide access to healthcare and where needed referral to a hospital, or to medical practitioners for follow-up treatment. To explain further, 4 case studies are shared below.

Case study I

We had a client stating that his relative was quite ill, and asked if he could bring him to the pharmacy. We said yes. On arrival a young man of 21 years presented with severe weakness, vomiting and body pains. During history taking, his friend stated that he was from Mozambique. My first reaction was to do a malaria test. I then found out that he had first arrived 3 months ago but could not attend the public hospital as he has no papers, i.e. no passport. Could we help him? My first thought was that if he had arrived 3 months ago it could not be malaria. I checked his vitals and found a temperature of 38°C. His blood pressure was normal, but he had a high pulse, his ears were bulging, his throat was red, and on palpation his lower abdomen was tender.

I decided that this could be a case of acute abdomen, as the patient started vomiting again; we phoned for an ambulance to admit him to hospital.

At the time of examination, I observed the outcome of the malaria test, and found it reacted positive to *Plasmodium falciparum*. On further questioning his friend, he stated that the patient's cousin had arrived a week ago from Mozambique.

We concluded that this was a case of Odyssean Malaria, or as it is otherwise known in medical circles, "taxi malaria". The patient was admitted to hospital and on following up we found that he had been discharged after three days with medicinal treatment and was doing well.

Case study II

A female patient of 41 years attended our clinic facility stating that she has lower abdominal pain, and that her lower abdomen feels extended. Her vitals, blood pressure, and blood glucose were normal. Testing her urine with a test strip, all seemed normal, but on performing a rapid pregnancy test, she had a positive HCG (Human Chorionic Gonadotrophin) value. She stated that she cannot understand this as she is on the three-monthly injection. With further questioning, I found that she had a negative HCG test at the clinic when she started with her 3 months Medroxy progesterone acetate injection, but that she had not used protection for the first month after receiving her injection.

Case study III

A male patient of 22 years, residing in an informal settlement, attended our clinic, lying on two chairs, and in severe pain. Upon examination his vitals were normal, but with a fast pulse, no fever, and no other abnormalities, except that we found that he had severe tenderness and pain in the right lower abdominal quadrant.

We phoned for an ambulance to transport him for admission to a public hospital; while waiting for the ambulance (which could sometimes be 40-60 minutes), we made a hot water bottle to ease his pain.

Two weeks later he brought a bunch of flowers to thank Christine, my business partner, for helping him with the hot water bottle. He had a severe case of appendicitis, and upon admission that afternoon his appendix was removed.

Case study IV

A patient attending our clinic, stated that she wants to make use of our family planning services, and after discussing her age (33 years) agreed to the 2 months Norethisterone enanthate injection method.

When we explained the history taking process and that we need to do an HCG test, she replied that she is currently on her menses, and that she has not used any method of contraception for the last year. We checked her vitals; weight and blood pressure were found to be normal, but she had a positive HCG test.

We explained that this is contra-indicated for receiving an injection. We referred her to the local public clinic for assessment and antenatal services.

Conclusion

In all four cases, the PCDT pharmacist played a vital role in providing accessible healthcare to patients who might otherwise struggle to receive timely medical attention. Conducting thorough assessments and diagnostic tests, also includes critical medical decisions and referrals and offering immediate care and interventions when necessary. PCDT pharmacists also bridge the gap between community healthcare needs and specialised medical services. These case studies underscore the importance of PCDT pharmacists in expanding access to quality healthcare, especially in underserved areas or for patients facing barriers to traditional medical services. Do we make a difference? Definitely!