Western Cape Government
Health

PACK
Practical Approach to Care Kit

Practical Approach to Care Kit

Primary Care Guide for the Adult· 2020
Western Cape Edition

Contents

Symptoms

Chronic conditions

Tuberculosis (TB)

HIV

Chronic respiratory disease

Chronic diseases of lifestyle

Mental health

Musculoskeletal disorders

Epilepsy

Women's health

Palliative care

Other pages

Seizures/fits

Give urgent attention to the client who is unconscious and fitting:

- If current head injury →15.
- Place in left lateral lying (recovery) position and give 100% face mask oxygen.
- Establish IV access.
- If glucose < 3 or unable to measure, give dextrose 10%[1] 5mL/kg IV. If known alcohol user, give thiamine 100mg IM/IV before dextrose. Recheck glucose after 15 minutes: if still < 3, give further dextrose 10%[1] 2mL/kg IV. Once glucose ≥ 3, continue dextrose 5% 1L 6 hourly.
- If ≥ 20 weeks pregnant up to 1 week postpartum →145.
- If not pregnant or < 20 weeks pregnant, give diazepam[2] 10mg IV slow infusion over at least 5 minutes or lorazepam[2] 4mg IM/IV. If still fitting after 10 minutes, repeat dose.
- If still fitting 5 minutes after second dose of diazepam/lorazepam *or* client does not recover consciousness between fits:
  - Give phenytoin[3] 20mg/kg IV over 60 minutes (give phenytoin through different line to diazepam/lorazepam). If still fitting, repeat phenytoin[3] 10mg/kg IV over 30 minutes.
  - Refer urgently.

Approach to the client who is not fitting now

Confirm that client indeed had a fit: jerking movements of part of or the whole body, usually lasting < 3 minutes. May have had tongue biting, incontinence, post-fit drowsiness and confusion.

Yes

Refer client same day if any of:

- Temperature ≥ 38°C, neck stiffness or purple/red rash, **meningitis** likely: give ceftriaxone[4] 2g IV/IM.
- New/different headache or headache getting worse/more frequent
- Client with HIV and no known epilepsy
- Decreased consciousness > 1 hour after fit
- Glucose < 4 one hour after treatment or client on glimepiride/insulin
- Glucose > 11 →14
- New sudden asymmetric weakness or numbness, difficulty speaking or visual disturbance
- BP ≥ 180/130 more than 1 hour after fit has stopped
- Alcohol/drug use: overdose or withdrawal
- Recent head injury
- Pregnant or up to 1 week postpartum. If ≥ 20 weeks pregnant and just had fit →145.

Approach to the client who had a fit but does not need same day referral

Is the client known with epilepsy?

Yes

Give routine **epilepsy** care →140.

No

- Doctor to check full blood count, eGFR, urea, sodium, calcium, magnesium and review results.
- If focal seizures or new fits after meningitis, stroke or head trauma, discuss with specialist.
- If client had ≥ 2 definite fits with no identifiable cause, doctor to consider epilepsy and give routine care →140.

No

New sudden asymmetric weakness or numbness of face, arm or leg; difficulty speaking or visual disturbance

Stroke or **TIA** likely →124.

Collapse with twitching lasting < 15 seconds following flushing, dizziness, nausea, sweating and with rapid recovery

Common faint likely →25.

If diagnosis uncertain, refer.

[1]If dextrose 10% unavailable: mix 1 part dextrose 50% to 4 parts water for injection to make dextrose 10% solution. [2]If no doctor available, nurse to get telephonic prescription from doctor. [3]IV phenytoin can cause low blood pressure and heart dysrhythmia: maximum infusion rate is 50mg/minute; monitor ECG and BP. If IV phenytoin unavailable, continue face mask oxygen and refer urgently. [4]If severe penicillin allergy (previous angioedema, anaphylaxis or urticaria), discuss with doctor.

Headache

Give urgent attention to the client with headache and any of:

- Decreased consciousness →13
- BP ≥ 180/130 and not pregnant →120
- Pregnant or 1 week postpartum, and BP ≥ 140/90 →145
- Sudden weakness/numbness of face/arm/leg or speech problem →124
- New vision problem or eye pain →28
- Sudden severe headache or dizziness
- Headache that is getting worse and more frequent
- Headache that wakes client or is worse in the morning
- Neck stiffness, drowsy/confused or purple/red rash: **meningitis** likely
- Persistent nausea/vomiting
- Persistent headache since starting ART
- Following a first seizure
- Recent head injury
- Unequal pupils

Manage and refer urgently:

- If temperature ≥ 38°C or **meningitis** likely: give ceftriaxone[1] 2g IM/IV.
- If recent positive cryptococcal antigen test, give fluconazole[2] 1200mg (avoid if pregnant, breastfeeding or known liver disease).

Approach to the client with headache not needing urgent attention

Has client had recent common cold and now any of: thick nasal/postnasal discharge, pain when pushing on forehead/cheeks, headache worse on bending forward?

Yes

Sinusitis likely

- Give paracetamol 1g 6 hourly as needed for up to 5 days.
- Give sodium chloride 0.9% nose drops as needed.
- Give oxymetazoline 0.05% 2 drops in each nostril 8 hourly as needed for a maximum of 5 days. Advise against overuse which may worsen blocked nose.
- If symptoms ≥ 10 days, fever ≥ 38°C, purulent nasal discharge, face pain ≥ 3 days or symptoms worsen after initial improvement, give amoxicillin 500mg 8 hourly for 5 days. If penicillin allergy, give instead azithromycin 500mg daily for 3 days.
- If recurrent, test for HIV ↩ 102.
- If tooth infection or swelling over sinus/around eye, refer same day.

No: does client have fever and body pain?

Yes

- If in a malaria area in past 3 months, arrange same day malaria test[3]. If positive, **malaria** likely, refer same day.
- If client has a tick bite (small dark brown/black scab) or tick present, **tick bite fever** likely →21.

Influenza likely

- For pain, give paracetamol 1g 6 hourly as needed for up to 5 days.
- Advise on cough/sneeze hygiene, to wash hands regularly, rest and adequate hydration.
- Advise that antibiotics are not needed.
- Advise to return if symptoms persist > 7 days, or if fever returns and any of:
  - Cough →35
  - Ear pain →30
  - Pain over cheeks, **sinusitis** likely (see adjacent)
- Advise yearly influenza vaccination if > 65 years, pregnant, health worker, HIV, chronic heart/lung disease.

No: does client get recurrent headaches that are throbbing, disabling with nausea or light/noise sensitivity, that resolve completely within 72 hours?

Yes

Migraine likely

- Give immediately and then as needed: paracetamol 1g 6 hourly or ibuprofen[4] 400mg 8 hourly with food for up to 5 days.
- If nausea, also give metoclopramide 10mg 8 hourly up to 3 doses.
- Advise to recognise and treat migraine early, rest in dark, quiet room.
- Advise regular meals, keep hydrated, regular exercise, good sleep hygiene.
- Keep a headache diary to identify triggers like lack of sleep, hunger, stress, caffeine, chocolate, cheese. Avoid if possible.
- Avoid oestrogen-containing contraceptives ↩ 142.
- If ≥ 2 attacks/month, refer/discuss for medication to prevent migraines.

No

- Check BP. If ≥ 140/90 ↩ 120.
- Ask about type and site of pain:

Tightness around head or generalised pressure-like pain

Tension headache likely

- Give paracetamol 1g 6 hourly as needed for up to 5 days.
- Assess for stress and anxiety ↩ 79.
- Advise regular exercise.

Constant aching pain, tender neck muscles

Muscular neck pain likely →57.

Client > 50 years, pain over temples

Giant cell arteritis likely

- Check ESR.
- Give paracetamol 1g 6 hourly for up to 5 days.
- Review next day: if no better and ESR raised, discuss with specialist same day.

Advise to only use analgesia when necessary. Chronic overuse may cause headaches: if using analgesia > 2 days/week for ≥ 3 months, advise to reduce amount used. Headache should improve within 2 months of decreased use.

If diagnosis uncertain or poor response to treatment, discuss/refer.

[1]If severe penicillin allergy (previous angioedema, anaphylaxis or urticaria), discuss with doctor. [2]If no doctor available, nurse to get telephonic prescription from doctor. [3]Test for malaria with parasite slide microscopy or if unavailable, rapid diagnostic test.
[4]Avoid ibuprofen if peptic ulcer, asthma, hypertension, heart failure, kidney disease.

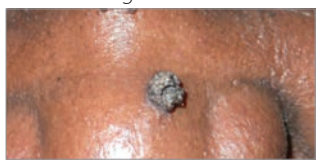
Skin lump/s

Refer same week the client with a mole that:

- Is irregular in shape or colour
- Changed in size, shape or colour
- Differs from surrounding moles
- Is > 6mm wide
- Bleeds easily
- Itches

If painful, firm, red, warm lump which softens in the centre to discharge pus, **boil**/**abscess** likely →61.

Round, raised papules with rough surfaces



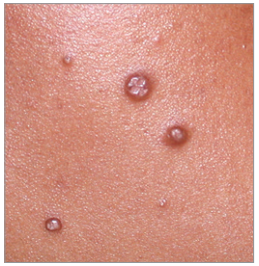
Source: University of Cape Town

Warts likely

- Usually on hands, knees or elbows but can occur anywhere.
- Plantar warts on the soles of the feet are thick and hard with black dot/s.

- Reassure that warts often resolve spontaneously.
- If treatment desired:
  - Soften wart/s by soaking in warm water for 5 minutes at night and scrub gently with clean nail file.
  - After drying well, apply salicylic acid 15-30% to wart. Protect surrounding skin with petroleum jelly and cover with plaster.
  - Repeat every night and continue for a week after wart has come off.
- If extensive warts, refer.

Small, skin-coloured pearly bumps with central dimples

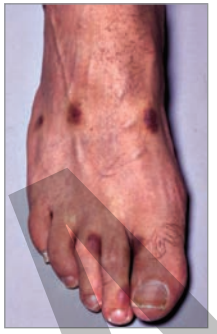


Source: University of Cape Town

Molluscum contagiosum likely

- Test for HIV ↩ 102.
- Reassure that lesions often resolve spontaneously after several years or with ART.
- If treatment desired: open molluscum with sterile needle and apply tincture of iodine BP to center of each lesion.
- Refer if:
  - Extensive
  - Lesions on eyelid
  - Intolerable and not responding to treatment

Painless, purple/ brown lumps on skin



Source: BMJ Best Practice

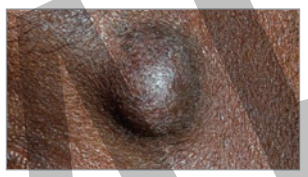
Kaposi's sarcoma likely

- Lesions vary from isolated lumps to large ulcerating tumours.
- May also appear in mouth and on genitals.

- Test for HIV ↩ 102.
- Refer for biopsy to confirm diagnosis and for further management.

Smooth, well defined lump beneath skin

Round, firm lump. May have central hole and discharge white substance.

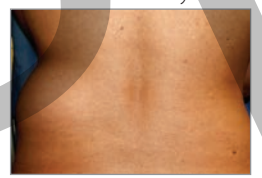


Source: University of Cape Town

Epidermoid cyst likely
Usually found on face and trunk, uncommon on limbs.

- If not infected, reassure there is no need to treat.
- If infected (skin red, warm, painful):
  - If fluctuant, arrange incision and drainage. If on face, refer instead.
  - Give flucloxacillin 500mg 6 hourly for 5 days.
  - If penicillin allergy, give instead azithromycin 500mg daily for 3 days.
- If intolerable or recurrent infections, arrange for excision once infection resolved.

Soft, doughy lump which is painless and moves easily.

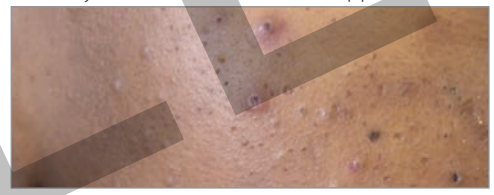


Source: University of Cape Town

Lipoma likely
Usually found on trunk or upper limb.

- Reassure lump will not become cancer and usually does not need removal.
- Refer if:
  - > 3cm
  - Causing pain or discomfort
  - Getting bigger
  - Firm or deep beneath skin
  - New lump that persists > 1 month
  - Intolerable

Red papules, pustules, nodules and blackheads, usually on face.
May involve chest, back and upper arms



Source: University of Cape Town

Acne likely

- Advise to wash skin with mild soap twice a day and to avoid picking, squeezing and scratching.
- Advise to avoid oily cosmetics and hair products.
- If blackheads only:
  - Apply tretinoin 0.05% cream sparingly at night until better, for at least 6 weeks. Limit sun exposure. Acne may worsen before improving.
- If red and swollen areas:
  - Apply instead benzoyl peroxide 5% gel to affected areas in morning. Wash off in evening.
  - If no better and tolerating gel, apply twice daily and give doxycycline[1] 100mg daily for 3 months.
- If woman needing contraception, advise combined oral contraceptive ↩ 142.
- Advise that response may take several weeks to months.
- If severe or no response after 6 months of treatment, refer.

If diagnosis uncertain, refer.

[1]Doxycycline may interfere with oral contraceptive, advise client to use condoms as well. Avoid if pregnant or breastfeeding.

HIV: diagnosis

Encourage the client and his/her partner to test for HIV.

Obtain informed consent

- Educate client about HIV, methods of HIV transmission, risk factors, treatment and benefits of knowing one's HIV status.
- Explain test procedure and that it is completely voluntary. Children < 12 years need parental/guardian consent.
- If consent is granted, proceed to testing immediately.

Test

Do first rapid HIV test on fingerprick blood.

Positive

Do a confirmatory[1] rapid HIV test on fingerprick blood.

Positive

Negative

Repeat both the first and the confirmatory rapid HIV tests above.

Both tests positive

One positive and one negative

Send blood for an HIV ELISA test and advise client to return for result within 7 days.

ELISA positive

ELISA inconclusive

ELISA negative

Client has HIV.

- Give routine HIV care at this visit ⮌ 103.
- Encourage HIV testing for sexual partner/s and children.
- Refer for community health worker support.

- HIV cannot be confirmed or excluded.
- Advise client to repeat rapid HIV tests in 6 weeks.

Negative

Both tests negative

HIV test result negative

Was client at risk of HIV infection in the past 6 weeks (new or multiple sexual partners, or unprotected sex)?

Yes

Repeat HIV test after 6 weeks.

No

- Client does not have HIV.
- Encourage client to remain negative and advise when to re-test:
  - If sexually active: 6-12 monthly
  - If pregnant: around 20 and 32 weeks gestation
  - If breastfeeding: 3 monthly
- Offer referral for male circumcision to diminish risk of HIV infection.

Support

- Ensure client understands test result and knows where and when to access further care.
- Encourage client to follow safe sex practices. Demonstrate and give male/female condoms.

[1]Use a different rapid test for the confirmatory test.

Cardiovascular disease (CVD) risk: routine care

Assess the client with CVD risk

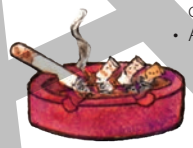
Assess	When to assess	Note
Symptoms	Every visit	Ask about chest pain ↻ 34, difficulty breathing ↻ 35, leg pain ↻ 58 and symptoms of stroke/TIA ↻ 124.
Modifiable CVD risk factors	Every visit	Ask about smoking, diet, alcohol/drug misuse, stress, exercise and activities of daily living. Manage as below.
BMI	At diagnosis, yearly or 3 monthly if trying to lose weight	BMI = weight (kg) ÷ height (m) ÷ height (m). Aim for < 25.
Waist circumference	At diagnosis, yearly or 3 monthly if trying to lose weight	Measure while standing, on breathing out, midway between lowest rib and top of iliac crest. Aim for < 80cm (woman) and < 94cm (man).
BP	Every visit	If known hypertension ↻ 121. If not, check BP: if ≥ 140/90 ↻ 120.
CVD risk (if no known CVD[1])	At diagnosis, then depending on risk	If risk 10-20%, reassess after 1 year. If risk > 20%, reassess after 6 months.
Diabetes risk	At diagnosis, then depending on result	If known diabetes ↻ 118. If not known with diabetes, check glucose ↻ 14.
Random total cholesterol	At diagnosis	If cholesterol > 7.5, check TSH and refer to doctor.

Advise the client with CVD risk

- Discuss CVD risk: explore the client's understanding of CVD risk and the need for a change in lifestyle. Support the client to change ↻ 161.
- Invite client to address 1 modifiable CVD risk factor at a time: help plan how to fit the lifestyle change into his/her day. Explore what might hinder or support this. Together set reasonable target/s for next visit.

Physical activity
- Aim for at least 30 minutes brisk exercise at least 5 days/week.
- Increase activities of daily living like gardening, housework, walking instead of taking transport, using stairs instead of lifts.
- Exercise with arms if unable to use legs.

Diet
- Eat a variety of foods in moderation. Reduce portion sizes.
- Increase fruit, vegetables, nuts and legumes.
- Choose whole grain bread/rice or potatoes rather than white bread/rice.
- Replace brick margarine/butter with vegetable oil or soft tub margarine. Remove skin and fat from meat.
- Reduce salty processed foods like gravies, stock cubes, packet soup. Avoid adding salt to food.
- Avoid/use less sugar.



Smoking
Alert client to the risks and urge to avoid or stop ↻ 136.

Weight
Aim for BMI < 25, and waist circumference < 80cm (woman) and < 94cm (man). Any weight reduction is beneficial, even if targets not met.

Stress
Assess and manage stress ↻ 79.

Screen for alcohol/drug misuse
- Limit alcohol intake to < 2 drinks[1]/day and avoid alcohol on at least 2 days of the week.
- In the past year, has client: 1) drunk ≥ 4 drinks[2]/session, 2) used illegal drugs or 3) misused prescription or over-the-counter medications? If yes to any ↻ 135.

- Identify support to maintain lifestyle change: health education officer or dietician/nutritionist, friend, partner or relative to attend clinic visits, a healthy lifestyle group, helpline ↻ 162.
- Be encouraging and congratulate any achievement. Avoid judging, criticising or blaming. It is the client's right to make decisions about his/her own health. For tips on communicating effectively ↻ 160.

Treat the client with CVD risk

- If known CVD[1]: give simvastatin[3] 40mg daily. If on amlodipine, give instead simvastatin[3] 10mg daily. Avoid if pregnant or liver disease.
- If no known CVD: if CVD risk > 20%, give simvastatin[3] 10mg daily. Avoid if pregnant or liver disease.

Review the client with CVD risk ≤ 20% yearly. Review the client with CVD risk > 20% 6 monthly. If trying to lose weight, review 3 monthly.

[1]Cardiovascular disease (CVD) includes ischaemic heart disease, peripheral vascular disease and stroke/TIA. [2]One drink is 1 tot of spirits or 1 small glass (125mL) of wine or 1 can/bottle (330mL) of beer. [3]If on lopinavir/ritonavir or atazanavir/ritonavir, avoid simvastatin, give instead atorvastatin 10mg daily.

Epilepsy: routine care

- If fitting now →16. If not known with epilepsy and has had a recent fit →16 to assess further.
- A doctor must confirm the diagnosis of epilepsy and start long term anticonvulsant medication.

Assess the client with epilepsy

Assess	When to assess	Note
Symptoms	Every visit	Ask about fit frequency and review fit diary. Manage other symptoms as on symptom pages.
Adherence	Every visit	If difficulty with adherence, give adherence support ⮌ 157.
Side effects	Every visit	Ask about side effects of treatment ⮌ 141. If side effects intolerable, switch anticonvulsant.
Other medication	Every visit	If client on any other medication (especially TB treatment, ART or contraceptive), consider possible interactions: check SAMF or discuss with MIC hotline ⮌ 162.
Family planning	Every visit	• Assess client's contraceptive needs ⮌ 142. • If pregnant: refer to neurologist. If on sodium valproate, continue sodium valproate and also refer to high risk antenatal clinic within 2 weeks.
Depression	Every visit	In the past month, has client: 1) felt down, depressed, hopeless or 2) felt little interest or pleasure in doing things? If yes to either ⮌ 129.
Alcohol/drug use	Every visit	In the past year, has client: 1) drunk ≥ 4 drinks[1]/session, 2) used illegal drugs or 3) misused prescription or over-the-counter medications? If yes to any ⮌ 135.

Advise the client with epilepsy

- If newly diagnosed, link with Epilepsy South Africa ⮌ 162 and help to get a MedicAlert® bracelet ⮌ 162.
- Advise to keep a fit diary to record frequency and duration of fits, triggers and changes in medication. Educate about the need for adherence and to continue treatment even if no fits.
- Help identify and avoid triggers like lack of sleep, alcohol/drug use, dehydration, flashing lights and video games.
- Help reduce chance of injury: advise to avoid dangers like heights, fires, swimming alone, walking/cycling on busy roads, operating machinery. Advise to avoid driving until fit free for 1 year.
- Advise client there are many medications that may interact with anticonvulsants (see table ⮌ 141) and to discuss with doctor before starting any new medication.

Treat the client with epilepsy

- **If not on treatment:**
  - Choose an anticonvulsant based on if client is a man or woman, child-bearing potential and other medication ⮌ 141.
  - Start a single anticonvulsant at low dose and increase until fits stop or side effects intolerable.
- **If already on treatment:**
  - If woman of child-bearing potential on sodium valproate, discuss risks[2] and advise to switch anticonvulsant. If client refuses, ensure reliable contraception[3] and refer to specialist.
  - If no further fits, continue same dose.
  - If still having fits:
    - If difficulty with adherence: give adherence support ⮌ 157, continue same dose and review client in 2 weeks.
    - If medication interactions: adjust medications as needed and review client in 2 weeks.
    - If none of above: increase anticonvulsant dose ⮌ 141. If already on maximum dose for 4 weeks, switch anticonvulsant once ⮌ 141. If already on second anticonvulsant or on lamotrigine or levetiracetam, avoid switching and refer instead.
- **If switching medication:** add new anticonvulsant and increase as needed. Continue old anticonvulsant for first 2 weeks, then slowly reduce dose over 6-8 weeks, until old anticonvulsant stopped.

[1]One drink is 1 tot of spirits, or 1 small glass (125mL) of wine or 1 can/bottle (330mL) of beer. [2]If woman on sodium valproate becomes pregnant, risks to baby include problems with development of spine, brain and other learning problems. [3]Reliable contraception includes intrauterine device (IUCD), subdermal implant or sterilisation.

Medication	Dose	Notes	Side effects
Carbamazepine	• **Starting dose:** 100mg 12 hourly for 1 week, then 200mg 12 hourly for 1 week. If needed, increase every week by 100-200mg/day. • **Usual maintenance dose:** 300-600mg 12 hourly • **Maximum dose:** 600mg 12 hourly	• Avoid if on/needing ART. • May interact with isoniazid, rifampicin, warfarin, fluoxetine, amitriptyline, theophylline, other anticonvulsants, oral/subdermal contraceptive: check SAMF or discuss with MIC hotline ↩ 162.	• **Urgent:** rash ↩ 60 • **Self-limiting:** drowsiness, dry mouth, dizziness, nausea
Phenytoin	• **Starting dose:** 200mg daily. If needed, increase up to 300mg daily (or 150mg 12 hourly). • **Maximum dose:** 300mg daily	• Avoid if a woman or on/needing ART. • May interact with isoniazid, rifampicin, warfarin, fluoxetine, fluconazole, theophylline, folate, other anticonvulsants, oral/subdermal contraceptive: check SAMF or discuss with MIC hotline ↩ 162. • If on > 300mg daily, monitor drug levels regularly.	• **Urgent:** - Rash ↩ 60 - If unsteady on feet, blurred/double vision or slurring, doctor to check phenytoin level for toxicity. • **Self-limiting:** drowsiness • **Other:** large gums; facial hair/course features in women: switch medication.
Sodium valproate	• **Starting dose:** 300mg 12 hourly. If needed, increase *each dose* by 100mg every 3 days. • **Usual maintenance dose:** 500-1000mg 12 hourly • **Maximum dose:** 1000mg 12 hourly	• Avoid if woman of child-bearing potential. • May interact with AZT, warfarin, aspirin, other anticonvulsants: check SAMF or discuss with MIC hotline ↩ 162.	• **Urgent:** - Jaundice: stop medication and refer same day. - Nausea/vomiting/abdominal pain: check ALT and review result within 24 hours: if ALT > 100, stop medication and refer same day. • **Self-limiting:** nausea, diarrhoea, constipation, drowsiness
Lamotrigine (may only be initiated by a designated prescriber)	• **Starting dose:** 25mg daily for 2 weeks, then increase by 25mg/day every 2 weeks until 50mg 12 hourly. If needed, increase every 1-2 weeks by 50mg/day. • **Usual maintenance dose:** 50-100mg 12 hourly • **Maximum dose:** 250mg 12 hourly **If switching from sodium valproate:** • Continue sodium valproate while starting lamotrigine. • Start lamotrigine on alternate days and increase more slowly. • Once on full dose of lamotrigine, slowly reduce sodium valproate dose over 4-6 weeks until stopped.	• If on lopinavir/ritonavir, higher doses of lamotrigine may be needed. • If known liver or kidney disease, discuss with specialist.	• **Urgent:** rash ↩ 60 • **Self-limiting:** nausea, vomiting, blurred or double vision, dizziness, drowsiness, insomnia, fatigue
Levetiracetam	• **Starting dose:** 250mg 12 hourly for 2 weeks, then increase to 500mg 12 hourly. If needed, increase every 2-4 weeks by 500-1000mg/day. • **Usual maintenance dose:** 500mg 12 hourly • **Maximum dose:** 1500mg 12 hourly **If switching from sodium valproate:** • Continue sodium valproate while starting levetiracetam. • Once on levetiracetam 500mg 12 hourly, slowly reduce sodium valproate dose over 4-6 weeks until stopped.	• Only use if: - Woman of child-bearing potential *and* - On/needing ART or switching from sodium valproate *and* - Lamotrigine not suitable or not tolerated • Avoid if previous depression or aggressive behaviour. • If known liver or kidney disease, discuss dose with specialist.	• **Urgent:** - Suicidal thoughts or behaviour: manage ↩ 76 and discuss/refer same day. - Psychosis: manage ↩ 78 and discuss/refer same day. • **Other:** depression, aggression, irritability: discuss with specialist.

Review the client with epilepsy

- If no further fits, review 6 monthly.
- If still fitting, doctor to review monthly until fits stop.
- Refer if any of:
  - Newly diagnosed for CT scan
  - Seizures other than generalised tonic-clonic seizures (e.g. absence and focal seizures)
  - Fits increasing in frequency or changing in type
  - No fits for ≥ 2 years, for possible treatment withdrawal
  - Client has switched anticonvulsant once and is adherent but still fitting after 4 weeks on maximum dose of second anticonvulsant.

Western Cape Government
Health

PACK
Practical Approach to Care Kit

Primary Care Guide for the Adult· 2020· Western Cape Edition

This **PACK Primary Care Guide for the Adult** is a clinical practice tool designed for use in Western Cape public sector primary care consultations with adults. It uses a symptom-based approach to the client's problem and a standardised integrated approach to the routine care of the client with one or more chronic conditions, covering 40 symptoms and 20 chronic conditions including HIV, TB, cardiovascular risk and disease, mental health, chronic respiratory diseases, epilepsy, women's health, musculoskeletal disorders and palliative care.

PACK Primary Care Guide for the Adult complies with and integrates Western Cape Provincial and South African National policies including recent updates for TB, HIV, diabetes and contraception. Prescribing provisions are displayed clearly for each medicine, its dose and indication, to capacitate staff to manage clients with common chronic conditions.

The development and revision of the guide was a collaborative process with substantial input from managers, clinicians and academics, as well as feedback from end-users of previous editions (see cknowledgements inside front cover). A more thorough explanation of the development process and role of contributors can be found at ***www.knowledgetranslation.co.za.***

This **PACK Primary Care Guide for the Adult** was compiled by the Knowledge Translation Unit, University of Cape Town Lung Institute. The Knowledge Translation Unit declares it has no competing interests in pharmaceutical companies whose products or services are related to the guide topics.

This **PACK Primary Care Guide for the Adult** forms part of a suite of clinical tools designed for use in primary care. In various stages of development and pilot are **PACK Child** for the child under 13 years, **PACK Adolescent** for the 10-19 year old, **PACK Community** for use by community health workers and **PACK Information** – health promotion and educational leaflets. These clinical tools are supported by Training Manuals and an Implementation Toolkit to ensure the programme is embedded in the health system to streamline the delivery of primary care.

Practical Approach to Care Kit

Knowledge TranslationUnit
University of Cape Town LUNG INSTITUTE

University of Cape Town LUNG INSTITUTE