A guide to identifying, diagnosing and treating non-communicable diseases (NCDs)

**Ministry of Health**

**Non-Communicable Diseases:**

**Diagnosis and Treatment Deskguide**



Contents

[Introduction and Acknowledgements 2](#_Toc1394835)

[NCD Care Model 4](#_Toc1394836)

[Consultation 6](#_Toc1394837)

[Symptoms suggestive of cancer 7](#_Toc1394838)

[Hypertension 9](#_Toc1394839)

[Diabetes Type 2 11](#_Toc1394840)

[Mental Health 14](#_Toc1394841)

[Depression 16](#_Toc1394842)

[Epilepsy 18](#_Toc1394843)

[Asthma 22](#_Toc1394844)

[Abbreviations 24](#_Toc1394845)

[Additional Information and References 24](#_Toc1394846)

# Introduction and Acknowledgements

This desk guide is a concise ‘quick reference’ for uncomplicated non-communicable disease (NCD) and mental health (MH) cases for qualified clinicians, eg doctors outpatient care, Community Health Officers (CHOs) in Community Health Centres (CHCs) clinicians and mental health nurses, etc. The guide, which is mainly for adults and adolescents, includes how to identify, screen/test, refer as applicable, and provide follow up care for non-complicated NCD patients. The guide is adapted to the essential drugs list and available policies and guidelines of the Ministry of Health and Sanitation (MoHS). It should be a useful, practical and appropriate document to help manage NCDs in Sierra Leone.

The initial assessment pages are designed to be used with any adult (and in some cases, adolescents) presenting at an outpatient department or CHC. The objective is to enable effective opportunistic screening, diagnosis, treatment and follow-up care for patients with hypertension, type 2 diabetes mellitus (‘Diabetes’), cardiovascular disease (CVD), common mental health conditions, epilepsy, asthma, and their underlying risk factors. The desk guide covers how to diagnose, treat and systematically monitor patients with these diseases and prevent and identify complications. It indicates when to refer patients (including possible cancer) to hospital doctor/ specialist review. After being assessed in hospital, non-complex cases should then be referred back to the nearest facility, for example, the CHC, for follow-up care. This Diagnosis and Treatment Desk Guide only includes brief lifestyle education messages. It is accompanied by a Lifestyle Desk Guide for use by the healthcare professional/ health educator. In addition, there are training modules and a facilitator’s guide.

This desk guide incorporates recommendations from WHO Package of Essential Non-Communicable Disease Interventions (PEN) for Primary Health Care and the Global Guidelines for Type 2 Diabetes. Refer to the list of additional information on the last page for links to these documents.

This guide has been prepared by thoroughly reviewing current eg WHO guidelines, systematic reviews and other relevant literature and pilot tested by Professor John Walley, Dr Cath Snape and colleagues of COMDIS-HSD of the Nuffield Centre for International Health, LIHS, University of Leeds. <http://comdis-hsd.leeds.ac.uk>.

In Sierra Leone adaptation MoHS NCD technical working group (TWG) in January 2019. The adaptation and TWG process was led by Dr Santigie Sesay the MoHS NCD Director, Dr Koroma and Mr Reynold Senesi of the MoHS/NCD and MH department. Other members of the TWG were: Mr Abu Conteh (Chief CHO) and CHO A Kabba of the MoHS; Dr Brima M Sesay (MS, Makeni Government Hospital) and CHO Rosaline Bangura (Bombali district health management team); Dr Paul van den Bosch and Dr Kiran Cheedella, both of VSO/RCGP; Dr Martha Lado of Kono Regional hospital – Partners in Health NCD clinic; Mr Brima Anneru (Chief Nurse at the Sierra Leone Psychiatric Teaching Hospital and nurse Hawanatu of GGH mental health clinic. The TWG was facilitated by John Walley of LIHS/Nuffield Leeds, with the support of COMAHS/ RUHF. Technical details have also been reviewed and revised by Dr Gibrilla Deen (diabetes), Dr James Russell (cardiologist) and Professor Radcliffe Durodami Lisk (neurologist), Dr Isaac Smalle (surgoen specialist) and Alhaji Dr Alusine Jalloh Consultant Paediatrician and Paediatric Neurologist)

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# NCD Care Model

Although we refer to a number of different diseases as non- communicable diseases (NCDs) there are some common features that are different from acute illness.

1. Often there are few or no symptoms – so awareness and screening of ‘at risk’ people when they are seen for other things is key
2. Early diagnosis and treatment can reduce complications and/or improve duration and quality of life
3. Communication skills are vital as information for and engagement with the patient is crucial – their role in management is *at least* as important as the healthcare worker
4. Regular review and monitoring is essential
5. Target level is set for control (e.g. of BP) and treatment is stepped up gradually until targets are met

Good management of NCDs reduces complications and prevents early deaths. The systems and monitoring needed are similar to those for TB and HIV-ARV care.

Do HIV counselling and testing and TB symptom screening in all patients

Check blood pressure in ALL patients over 40 years, unless done in last 12 months

Check a random blood glucose if >40 years and looks over weight or high waist circumference ( >104 cm in men, >88cm in women) -unless done in last 12 months

**For each patient:**

* Make diagnosis
* Explain disease and complications
* Agree treatment, set targets and do lifestyle planning (a two-way discussion about reducing risks)
* Start a treatment card
* Give a date for a follow-up appointment

* Principles of Follow-up for NCDs:
* Ask about symptoms and consider side-effects.
* If not acutely unwell and there are no serious side effects and condition is not controlled then:
* Lifestyle review and planning
* Step up treatment
* Offer drugs that are readily available in the pharmacy and affordable.
* If possible, offer drugs to take only once per day. Start with the lowest dose.
* Increase doses step by step to the maximum tolerated dose to achieve disease control.
* If on maximum dosage, or the highest tolerated dose, and their condition is not controlled, then add another drug.

Monitor according to the disease for side effects. If present, lower the dose or change the drug.

Depression is more common in those with NCDs and can complicate treatment so ask if sad/unhappy or lost enjoyment of life. If this is a problem for them ask the other depression questions.

**Treatment supporter:**

* A treatment supporter can be very helpful to a person with NCD to ensure they take treatment correctly, attend appointments and make lifestyle changes.
* A treatment supporter is a trusted friend or family member chosen by the patient. Make sure you have patient consent before talking to anyone else about their condition.

**If referring a patient**

* Explain why you are referring them, give a referral note with brief details, check how they can travel.
* If feasible, create a communication platform to support follow up at the HCW-HCW level
* Ask them to return to your health centre for continuing care, bringing their treatment or discharge note.

# Consultation

Before diagnosing NCDs assess current problem and treat acute illness. If the patient is seriously ill, manage as emergency: see standard treatment (Tx) guide e.g. WHO’s IMAI acute care guide (see references on last page)

**Serious illness**

Symptoms:

* Chest pain lasting more than 30 minutes (heart attack)
* One-sided: vision loss, weakness/ numbness of the face/arm/leg (Transient Ischaemic Attack/Stroke)
* Breathing difficulty (maybe worse when lying flat) and/or ankle swelling (infection/ heart failure)
* Unconsciousness

If patient looks very ill, eg has chest pain or is short of breath, examine for signs of severe illness eg as below:

* Respiratory rate >20/min (6-12 years >30/min)
* Pulse >100 bpm (6-12 years >120bpm)
* BP <90mmHg systolic (i.e. shock) or > BP >180 systolic or >120 diastolic
* Fever >39°C (102°F)
* Altered consciousness
* Glucose <4 or>20mmol/l (<72 or> 360mg/dl)

If present, give urgent treatment, reassess and arrange transfer to a hospital/ doctor

Otherwise, ask the patient about:

* the presenting problem – allow them to describe it in their own words
* other symptoms
* any concerns or issues relevant to the presenting problem including e.g. duration of symptoms, current medication, past issues.
* if symptoms are <2 weeks, ask about symptoms and signs related to diagnosis and treat acute disease
* if symptoms > 2 weeks consider chronic disease

# Symptoms suggestive of cancer

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| **Symptoms** | **History and examination**  And specifically: | **Consider & Manage** |
| **Unintended weight loss** | HIV, TB, Hb  Blood Sugar  Depression symptoms, eg ‘frustration’  Chest X-ray | HIV, TB  Diabetes  Cancer  Depression |
| **Persistent Weakness/ Tiredness** | HIV, TB  FBS, Hb  Depression symptoms, eg ‘frustration’ | HIV, TB Diabetes, anaemia  Depression  Cancer |
| **Abdominal Symptoms** |  |  |
| Persistent discomfort, pain or swelling | If long standing pain and/or swelling  US scan, Hb  HBsAG | Cancer  Chronic liver disease |
| Change in bowel habit especially with weight loss | Stool microscopy,  Hb  USS  Rectal Examination | Parasitic Infections  Infection  Inflammatory bowel disease  Cancer in older patients |
| Blood in stools (bright red or black stool)  If persistent in >45 year old | Ask symptoms of cancer  Stool Microscopy  Rectal Examination  Hb  If black stools do a Helicobacter Pylori Test | Acute infectious diarrhoea  Parasitic infections  Haemorrhoids (piles)  Cancer if persistent in >45yrs |
| Anaemia | Hb  FBC  Stool microscopy | Parasitic infections  Nutritional  HIV, TB, GI, Genitourinary problems, malignancy, etc. |
| **Blood in Urine** | Hb  Urine microscopy, urine dipstick for blood, protein, white cells, nitrites  Abdominal Ultrasound scan | Urinary Infection  Schistosomiasis  Bladder or Prostate Cancer |
| **Breast lump, nipple retraction, axillary nodes, Ulcer, bloody nipple discharge** | Clinical examination | Breast cancer ~~(older women)~~  Exclude abscess especially if breast feeding/ young women, benign breast problems |
| **Vaginal bleeding:** between periods, after intercourse or after menopause | Speculum examination  HIV test  Pregnancy test | Cervical or uterine cancer  Miscarriage/ectopic pregnancy (if positive pregnancy test)  Infection |
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# Hypertension

**Check BP in every adult patient > 40 years old**

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| **Symptoms** | **No symptoms in most people**. Headache and dizziness can rarely be caused by severe (Grade 3) hypertension. Consider alternative diagnosis if persistent symptoms. |
| Risk Factors for CVD | 1. Smoking 2. Overweight 3. Excess alcohol  4. Diabetes mellitus 5.Physical Inactivity |
| **Take BP** <140/90 normal | Take the BP. If >140/90, let them rest, position the cuff correctly, repeat after 5 min, 3 times. If still >140/90, say the ‘pressure was higher than normal today’, and give an appointment to check again in 2+ days, if still high, follow the guidelines below: |
| **Grade 1** 140/90-  159/99 | Lifestyle planning, not drug, when grade 1 BP confirmed at second visit. Review progress on lifestyle planning at 1 month  (But start medications **If** also has **diabetes** (see below)**/stroke/heart or kidney disease)** |
| **Grade 2** 160/100-179/109 | Lifestyle planning and start medications if grade 2 confirmed on second visit  Follow up appointment initially every 2 weeks then **monthly** when BP is controlled |
| **Grade 3** BP ≥180/110 | Start treatment **today** (see below) and lifestyle planning.  Give appointment every **week** until BP <180/110 and then monthly until BP is lower |
| **Refer**  BP >200/110 | Possible malignant hypertension. If severe headache, confusion, breathless or oedema (other symptoms on p3 consultation) consider urgent referral but start treatment with a calcium channel blocker |
|  | |
| **Management** | **See monthly** until BP at target (usually normal) level then 6-monthly (but grade 3 see weekly until grade 2) |
| **Aim** | Reduce blood pressure to <140/90. Consider lower target (130/80) in diabetes and in secondary prevention. Always discuss lifestyle changes to reduce BP and CVD risk |
| **At diagnosis** | *History:* \* Previously told has High BP or given antihypertensives \*Symptoms of CVD eg Chest pain and Breathlessness \*Current medication  *Examination:* \*Heart disease: Pulse rate and rhythm, Heart- listen for murmurs  \*Heart Failure: Lungs- fine crepitation, Legs- bilateral swelling  *Test:* \*Blood glucose \*Urine dipstick for protein  *Complete treatment card and arrange follow up* |
| Consider **routine referral** or **seek advice** | Pregnancy – immediately to CEmONC if Systolic ≥160 or Diastolic ≥110 or a danger sign  Age <40yrs - possible secondary causes eg to have kidney function tests/ultrasound   * Urine dipstick +ve for proteinuria or haematuria on ≥2 occasions (rule out infection and schistosomiasis if at risk) * Examination suggests heart disease or heart failure or stroke * BP is still significantly >140/90 despite taking 3 drugs and lifestyle changes   **REMEMBER resume care after referral as above once immediate problem dealt with** |
|  | |
| **Medication** | If BP not controlled, increase dose, as required, up to the maximum. If still not down to normal, then add the drug from the next step, until the BP is normal. If patient is diabetic, start with an ACEi as step 1 |
| **Step 1** | Calcium channel blocker eg Amlodipine 5mg once daily (max 10mg), or Nifedipine 20-80mg daily (only use the slow release or extended release forms). Side Effects: constipation/swollen legs,headaches, erectile dysfunction.  Or, Thiazide Diuretic eg Hydrochlorothiazide (HCTZ) 12.5mg once daily (max 25mg) or Bendroflumethiazide (BFZ) 2.5mg.  Note: Thiazides may increase glucose. Can also cause Gout |
| **Step 2** | ADD the second drug, either: Thiazide or Calcium channel blocker (whichever was not used in Step 1) |
| **Step 3** | ADD 3rd drug. Angiotensin Converting Enzyme inhibitors (ACEi) eg Lisinopril 10mg, usual 20mg (max 80mg) daily or Enalapril 5mg once daily (max 20mg). Do not use ACEi in pregnancy or women of child bearing age.  Stop in acute illness/sepsis (can cause Acute Kidney Failure).  Side Effects: dry persistent cough, angioedema |
| **Alternative step 3** | Add a Beta-blocker eg Atenolol 50mg once daily (max 100mg) (never if asthmatic). Is especially good for patients with angina and after a Heart Attack |
| **Pregnancy** | Refer to BEmONC or CEmONC. Rule out pre-eclampsia and consider Methyldopa 250mg x 2 or 3 times daily (max 3g/daily). (**Use methyldopa for pregnant women only**) |
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| **Patient Education** | * Hypertension cannot be cured, but is manageable through **life-long** lifestyle changes and, if required, medication. * Hypertension medication: Warn them about possible side effects and ask them to report any new symptoms promptly. * Treating hypertension reduces the risk of strokes, heart, blood vessel, vision and kidney problems and death.   Diabetes and hypertension are linked diseases - patients with diabetes often develop hypertension and the other way around. Control of one is key to limiting complications from the other. Plan lifestyle changes  These following actions can all reduce BP with less medication and reduce the risk of complications. Share the messages with family and community:   * Increase physical activity * Eat less salt, Maggi, mayonnaise, ketchup, oil, fried foods, sugar (eg soft or energy drinks), meat * Eat more fruit, vegetables, fish, nuts, steamed or boiled foods) * Drink Little or no alcohol * Stop smoking   Be the correct weight  People cannot give hypertension to others, but relatives and children at increased risk. |

# Diabetes Mellitus (Type 2)

**Check blood sugar if >40 years and overweight or hypertensive or family history of diabetes**

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| **Symptoms** | No symptoms in many people but ask about:  Thirst and frequent urination (rule out urinary tract infection with a urine dipstick)  Unexplained weight loss, weakness, tiredness  Recurrent infections (e.g. boils or itchy vulva +/- dysuria [vaginal thrush])  Pins and needles sensation in feet | |
| **Risk Factors** | Waist circumference (>104cm for men and >88cm for women) or BMI >25kg/m2Family history of diabetes, especially if age (>40 years)  Inadequate physical activity – advise to increase  High alcohol intake – advise to reduce  Smoking history - advise to stop  Pregnancy | |
| **Complica-tions** | CVD including heart attacks, stoke and death  Vision problems including blindness; Kidney Problems including failure  Problems with blood vessels (vascular disease) and nerves (neuropathy) | |
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| **Normal** | Random BS (RBS) <7.8 mmol/l (<140 mg/dl)  Fasting BS (FBS) <6 mmol/l (<110 mg/dl) | |
| **Pre-diabetes** | RBS 7.8-11 mmol/l (140-200mg/dl)  FBS 6 -7 mmol/l (110- 125mg/dl)  Or had diabetes in pregnancy | |
| **Diabetes** | **RBS ≥11 mmol/l (≥200 mg/dl)**  **FBS ≥ 7.0 mmol/l (>126 mg/dl)** | |
| **Urinalysis** | Urinalysis should not be used for screening for diabetes | |
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| **At diagnosis** | * Two positive tests are required to make a diagnosis. If typical symptoms one test is sufficient. The second test should be a FBS on a different day * Check BP and if >140/90 treat and aim for BP <130/80   Examine feet, eyes and if possible test urine for protein and ketones   * Check Kidney Function at diagnosis and then annually (if available) * Start with Lifestyle planning, and drug treatment if FBS> 10 * Complete treatment card | |
| **Follow up** | | * Follow up Pre Diabetic every 6 months. Explain the risk of diabetes - lose weight, advice as below for diabetics * Follow up after: 3 months if starting with diet and exercise   1 month if started on medication, 6 months once at target |
| **Consider routine referral if** | | * Pregnant – see also the midwife/diabetes guideline * Leg ulcers and/or infection; vision loss (retinopathy, cataract) * Urine dipstick +ve: Proteinuria on ≥2 occasions * Blood sugar not controlled on maximum tolerated oral medication |
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| **Medication** | If FBS still not controlled after ~~2-~~4 weeks on medication, increase dose gradually to maximum, then move to next step until controlled. Take with meals. | |
| **Step 1** | Metformin 500mg daily– increase in steps each week if not controlled to twice, and then three times a day, to a max 1g twice a day – caution with kidney disease. | |
| **Step 2** | Add Sulphonylurea e.g. Glibenclamide 5mg once daily (to max 15mg daily)- increase gradually. Not for drivers due to risk of hypoglycaemia | |
| **Step 3** | Refer | |
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| **At review appointments** | Discuss knowledge and beliefs around diabetes and foot care  Check BP and blood glucose (ask patients to come fasted, for FBS, if possible)  Review annually: 1. Lifestyle 2. Feet 3. Neuropathy (Erectile Dysfunction, pins and needles/numbness feet or legs. 4. Eyes- ask about changes to vision and if so refer to eye clinic. 5.Family planning: if they use, or want  Ask about correct use of medication, healthy eating and exercise  Discuss side effects from medication eg if persistent diarrhoea on Metformin, change to Sulphonylurea  Treatment can sometimes be stepped down if patient has hypoglycaemia or the FBG results are very low. This may happen if patients make major lifestyle changes.  Send patient to the nurse educator and/or use the health educator’s guide. | |

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| Foot Examination | Examine feet at diagnosis and annual review or more frequently if any problems  Inspect both feet for any ulcers or deformity. If present, patient needs careful follow up. Look at footwear - advise if poorly fitting |
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| Patient Education | Explain diabetes is when the body cannot properly use the food we eat causing too much sugar in your blood.  Give information on complications for example heart attack, stroke, blindness, leg ulcers, erectile dysfunction and when to seek urgent medical help.  Give the patient lifestyle advice  exercise  healthy eating: 2 to 3 times per day as smaller portions, eg of rice, cassava, potatoes, fruit and vegetables,  little or no alcohol,  stop smoking and  lose and control weight  These lifestyle changes can all reduce blood sugar, so need less medication and reduce risk of complications – see Health Educator’s guide for details.   * People with diabetes have a high risk of infection, including TB. If they have a cough for more than 2 weeks they should see a doctor.   Fasting blood tests are important – that means no food and only water to drink overnight (for 8hrs) before the morning blood test is taken |
| * Advise about Foot Care: * Do not walk with bare feet. Wash and dry your feet regularly. * Make sure shoes fit properly and do not hurt. * Check your feet regularly for any broken skin. If broken skin, go to the health facility to be seen, even if it is painless. * Do not cut calluses or corns – go to the clinic for treatment. * If you have numbness in your feet, be careful near fires and hot water. |
|  | |
| Key Messages | * Diabetes is a life-long condition, but treatable and controllable with lifestyle changes and medication. Treatment is also life-long. * Treating diabetes reduces the risk of strokes, heart, blood vessel, vision and kidney problems and death. * Diabetes and hypertension are linked diseases – made worse by an unhealthy lifestyle. It is important to control both. * Healthy eating, increased physical activity, less alcohol and no smoking are essential * A person cannot give diabetes to others (but relatives and children are at increased risk) * Encourage patients to share the message about healthy eating and increased activity with their relatives, to reduce their risk of diabetes and other diseases. |

## Mental Health

If the patient looks unhappy, depressed, agitated or unkempt, consider a mental health problem. Similar symptoms e.g. tiredness can be due to a physical cause e.g. anaemia, HIV, or due to a mental health cause. Depression is more common in people with a chronic illness, e.g. HIV, TB or diabetes.

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| **Presentation and management of common mental health conditions** | | | | |
| **Depression** | | | | |
| **Symptoms/Signs** | | **What to ask** | | **What to do** |
|  | * Low energy, fatigue, sleep or appetite problems * Persistent sadness or anxious mood/Irritability * Low interest or pleasure in activities that used to be interesting or enjoyable * Multiple symptoms with no clear physical cause (e.g. aches and pains, feeling of rapid heartbeat, numbness) * Difficulties in carrying out usual work, school, domestic or social activities | Do you feel down or depressed?  Have you lost interest/pleasure in things you usually enjoy? | | If **yes** ask ‘depression’ questions **on p9**  If severe refer to mental health unit |
| **See mhGAP, link last page** | | | | |
| **Anxiety can be linked with depression (exclude physical causes before diagnosing anxiety)** | | | | |
| **Symptoms/Signs** | | **What to ask** | | **What to do** |
|  | * Restlessness, feeling very worried, feeling that something bad or terrible might happen, loss of focus, quick tempered * Physical symptoms- tiredness, muscle aches and tension, a feeling palpitations), shortness of breath, dry mouth, nervousness or shaking, excessive sweating, stomach ache, bowel or bladder upset, feeling sick, headache, a sensation of pins and needles | Do you have sudden episodes of anxiety?   * Do you have anxiety in specific situations? eg crowds * Are you able to relax? | | Assess also for depression as above as often linked  Counsel patient on managing anxiety  Avoid medication such as diazepam as easy to become addicted.  If severe refer to mental health unit. |
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| **Self-harm/suicide– can be seen in depression** | | | | |
| **Symptoms/Signs** | | **What to ask** | **What to do** | |
|  | * Current thoughts, plan or act of self-harm or suicide * History of thoughts, plan or act of self-harm or suicide | Do you have thoughts of death or harming yourself? If yes, ask:  Do you have a plan?  or attempted suicide before?  Is your family aware? | Refer if active thoughts of suicide/self-harm  + manage as severe depression | | |
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| **Psychosis** | | | | |
| **Symptoms/Signs** | | **What to ask** | **What to do** | |
|  | * Abnormal or very disorganised behaviour * Senseless speech, abnormal or messy dressing and appearance, self-neglect * Delusions (a false firmly-held belief or suspicion) * Hallucinations (hearing voices or seeing things that are not real) * Neglecting usual work, school, home or social responsibilities * Manic symptoms: several days of being abnormally happy, energetic, too talkative, irritable, not sleeping, reckless behaviour). | Assess the way people speak. Is it incoherent or confused)  Ask about any unusual or abnormal beliefs and suspicions. If present, ask them to explain more (i.e. *what do you think is the cause of this?)*  Ask about hallucinations? *(Can you see or hear anything no one else can?)*  **Ask family and friends about the patient’s behaviour** | Counsel patient and family.  Listen, be kind.  Don’t argue against traditional beliefs,  Say daily tablets help.  Refer to hospital mental health nurse. | |
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| **Dementia (old people)** | | | | |
| **Symptoms/Signs** | | **What to ask** | **What to do** | |
|  | * Family notice a change in the patient eg: getting lost, becoming more stubborn and difficult or repeating themselves * Memory decline, lack of awareness of time, place and person * Mood or behavioural problems such as appearing uninterested or irritable, easily upset or tearful * Difficulties doing home or social activities | **Ask family and friends about patient’s behaviour**  Ask about memory and assess their orientation (they know the time i.e. day, month, year, place where they are i.e. PHU/hospital name, and person - i.e. your name and position).  Do they look confused? | Rule out infection (delirium) or depression.  HIV test, BP, RBS  Counsel patient and family. Consider referral.  See mhGAP - links on last page | |
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| **Alcohol use disorders** | | | | |
| **Symptoms/Signs** | | **What to ask** | **What to do** | |
|  | * Looks drunk, smells of alcohol or hangover * Injury, eg from a fight * Insomnia, fatigue, anorexia, nausea, vomiting, indigestion, diarrhoea, headaches * Difficulties with daily activities | Screen using CAGE questions  **Have** you ever felt the need to --**C**ut down your drinking?  **A**nnoyed you by criticising your drinking, or got into a fight?  **G**uilty about your drinking?  Need an **E**ye-opener (a drink first thing in the morning?)  If is ‘yes; to 2 or more, consider alcohol use disorder | Consider underlying depression or anxiety, see p12  Advise to cut down slowly– ask if willing to change  Ask if family or friends are willing to support them  See mhGAP – links on last page | | |
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| **Drug use disorders** | | | | |
| **Symptoms/Signs** | | **What to ask** | | **What to do** |
|  | * Under influence of drugs e.g. low or extra energy, agitated/fidgeting, slurred speech * Signs of drug use (injection marks, skin infection, appearance) * Financial difficulties, crime problem * Can’t do usual activities | Which drugs and how often taken  Depression or anxiety | | Consider underlying depression or anxiety, see p8  See mhGAP - links on last page |

## Depression

If looks unhappy, depressed, worried, or have many symptoms with no clear physical cause (eg crying spells, aches/pains, tremor, palpitations, numbness) or not talking or moving slowly; or family concern.

**If eg fatigued/energy loss, also consider medical causes e.g. anaemia, HIV or other infection**

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| **Ask** | How are you feeling? (Listen without interrupting and ask further probing questions)   * If yes to the following 2 questions, assess symptoms and severity: * Do you feel sad, down, or depressed? * Have you lost interest/pleasure in things you usually enjoy? |
| **Symptoms** | * Feeling tired all the time, having little energy * Sleep problems (too much or too little/ early morning waking) * Poor appetite or overeating * Blaming yourself / feeling guilty * Low focus/ poor concentration * Moving very slowly so other people would notice, or very restless * Thoughts of giving up on life or killing yourself (assess suicide risk as below)   (Symptoms of anxiety may also be present) |
| **Risk Factors** | Ask about any other problems, stress or difficult life events: e.g. ‘have you or your family had any bad or sad news’? |
| **Suicide Risk** | If thoughts of death or suicide, assess risk by asking:   * Do they have a plan about suicide? if yes, how and when? * Have they attempted suicide before? If so how, and how serious was it? * Is the family aware?   **If they have a plan including how and when, they are high risk. See below.** |
|  | |
| **How to diagnose** | Ask questions as above and assess severity: |
| Difficult Life Events/Bereaved | Do not routinely give anti-depressants or any other medication  Give support and reassurance of normal bereavement process |
| Mild Depression/ Complicated Bereavement | **Less than 5 depression symptoms and duration > 2 weeks**  **or after bereavement** not getting on with normal life >6 months after the loss   * Counsel to counter depression * Start anti-depressant medication only if serious difficulty doing normal activities * Help them plan to address stresses eg with family, friends, work relationships. * Help them plan any previously enjoyable activities they can re-start eg to church or mosque, meeting friends etc. * Arrange follow up 2 - 4 weeks depending on severity |
| Major Depression | **5 or more depression symptoms and duration > 2 weeks or suicidal thoughts**   * Start anti-depressant medication * Educate patient and family about depression and medication * Help them plan to address stresses and to re-start enjoyable activities (as above) * Arrange follow up - weekly initially, once improving or stable, every 2-4 weeks |
| Suicidal Thoughts | * As well as following actions for major depression * Provide support and discuss with the family * Ensure they are not left alone * Remove anything they could use to harm themselves * Discuss with patient and family about transfer to mental health unit/hospital |
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| **Treatment** | **See patient regularly until symptoms stable or resolved** |
| Aim of treatment | Resolve symptoms, improve function and reduce suicide risk |
| At diagnosis | Counsel all patients – see below  Ask whether this can be discussed with family and friends. In major depression it may be difficult to get consent and you need to act in patient’s best interest  Assess suicide risk  Ensure patient has a family or other treatment supporter |
|  | |
| **Medication** | Check local availability and cost  Start with a low dose and gradually increase until symptoms settle. If side effects, slowly reduce dose and start new medication. Remember the **delay in onset of effect. Ask the family member to keep the tablets** until stable eg 6 weeks |
| **First Choice:** | Tricyclic antidepressants (TCAs) e.g. **Amitriptyline**  TCAs are especially useful for patients having problems with sleeping  TCAs are very dangerous in overdose – don’t use with suicidal patients.  Start Amitriptyline 50mg at night, increase by 25 - 50mg to max 150mg daily depending on response and tolerability.  Sleep, aches and pains usually improve after a few days, depression takes longer.  In 4 - 6 weeks review response and consider a dose increase:  Side effects: common – low BP on standing (fall risk), dry mouth, constipation, difficulty urinating, dizziness, blurred vision and sedation. Rare– palpitations |
| **Second Choice:** | **Fluoxetine** (an SSRI). Is on essential drug list for hospitals  Fluoxetine 20mg daily, after 4-6 weeks if no or part response increase dose by 20mg (max 60mg daily). In 4 - 6 weeks review response, consider a dose increase.  Side effects: common - restlessness, nervousness, insomnia, anorexia, nausea, diarrhoea, headache, sexual dysfunction –reduce or change drug. Serious but rarely – restlessness/can’t sit still, bleeding or suicidal thoughts – change drug |
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| At review appointments | Counsel the patient – see below  Discuss medication and side effects and review if patient is taking them correctly.  Reassess severity and assess for suicide risk |
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| Counselling  Patient and family/ treatment supporter | Advise about medication:  Say it usually takes a few weeks for treatment to work  Potential side effects and to seek help if distressing to patient  **Not to stop** medication unless on advice; as possibility of withdrawal symptoms if patient stops medication abruptly***.*** Anti-depressants are not addictive  If they forget a tablet **not** to take an extra dose next time |
| **Counsel** - Allow the patient to talk about their feelings, and give supportive advice to the patient and family/treatment supporter – to help you keep going with treatment:   * Explain that depression and/or anxiety is common and can happen to anybody. * Discuss beliefs about the cause of their problems. Explain this is not witchcraft. * Help them plan to manage stresses eg with family, friends, work relationships. * Ask what were previously enjoyable activities that they have stopped doing. * Ask which of these they feel they can re-start eg to church/ Friday prayers, meeting friends, walking, listening to music etc. * Agree which they feel ready to restart. Review progress/add activities at next visit. * Identify any negative thoughts about the self, future or world, and work with them to replace negative thoughts with more realistic and optimistic ones. * Encourage the patient to engage often in positive self-talk. * Ask about sleep and encourage them to have a regular bed-time * Identify things that they usually enjoy and encourage them to continue. * Encourage patient to continue with their usual social activities (eg family gatherings, outings with friends, religious activities) * Explain that continuing regular physical and social activity helps them get better. * Discuss eating healthy foods and regular physical exercise. * Explain about the possible thoughts of self-harm or suicide and encourage them to immediately tell a confidant and come back for help if this happens. |
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# Epilepsy

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| Types and typical symptoms:   * **Epilepsy is a medical condition due to abnormal electrical activity in the brain.** * **The main types are: a) tonic/ clonic epilepsy in which there is shaking of arms and legs frothing of the mouth, biting tongue and loss of urine; b) absence seizure where they go blank for a few seconds but don’t fall. This is usually in children; c) focal (also fomally called partial epilepsy where the arm or leg shakes or the head twisted to one side; d) myoclonic epilepsy, with brief sudden contraction/jerking of the body or one or more limbs as if shocked by electricity.** * Differentiating between epilepsy and fainting**, is it due to low blood sugar, or** * **If a history of a loss of consciousness it is important to decide if the person has had a fit (seizure) or a faints (syncope), eg a temporary drop in the BP. Get a detailed history from an eyewitness if possible.**   A seizure in a young child with a high fever is not epilepsy. | | |
| Symptoms | **Seizure (electrical discharge of the brain)** | **Fainting (syncope) due to temporary drop in blood pressure** |
| Posture at onset | * Any posture | * Usually standing |
| Pallor and sweating | * Uncommon | * Usually present |
| Onset | * Sudden / aura | * Gradual |
| Injury | * Common | * Rare |
| Convulsive jerks | * Common | * Not common |
| Incontinence | * Common | * Sometimes |
| Unconscious-ness | * For minutes | * For seconds |
| Recovery | * Usually slow | * Rapid |
| Post-episode confusion | * Common | * Rare |
| Precipitating factors | * Rare (flashing lights) | * Crowded places, pain, lack of food, antihypertensive drugs, health problems |
| * A diagnosis of epilepsy is made if a patient has more than one seizure eg within the last 12 months. * A single seizure is not classed as epilepsy (though still advise about not driving for a year) | | |

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| **Exclude other causes of convulsion** | | | e.g. a faint  e.g. medical eg infection, injury, low blood sugar, overdose, alcohol withdrawal | |
| **Risk Factors epilepsy** | Family History of Epilepsy  Previous Head Injury, birth injuries, cerebral malaria or meningitis | |
| **Complications** | | Injury from falls, burns, drowning or continuous seizures (status epilepticus) which requires urgent treatment. | |
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| **How to diagnose** | | | Is made on the history from the eyewitness as described in the left column of the table above |
| Single Seizure | | | This is not confirmed epilepsy and no is treatment required but warn that there is a risk of a further seizure.  Advise patient not to drive for 1 year (if no further seizures)  Ask patient to return if they have any further seizures |
| >1 seizure | | | Start medication |
| Treat and  Refer urgently | | | A fit lasting longer than 5-10 minutes should be treated. Refer if more than 30 mins  Give diazepam rectal by syringe (no needle) or IV |
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| **Management** | | | Review regularly until seizures controlled |
| Aim | | | Reduce seizures and associated stigma, improve quality of life, reduce risk of complications |
| At diagnosis | | | Assess seizure frequency  Exclude underlying causes – see above  Educate the patient and family – see below, at each visit. Add the patient to the disease register and complete a treatment card |
| Refer routinely | | | Patient is a child. Send to district hospital epilepsy clinic. (Check child doses by weight) |

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| **Medication** | Check local availability and cost. DO NOT stop suddenly – as this increases the risk of serious seizures |
| **Step 1** | Start medication – single drug – see below for options |
| **Step 2** | Increase slowly until seizures controlled (or if they have mostly stopped, and if reached the maximum tolerated dose, then this may be accepted) |
| **Step 3** | If still not controlled, change medication but **reach the effective (therapeutic) full dose of new medications before reducing old medication slowly** |
| **Step 4** | Reconsider diagnosis or refer hospital epilepsy clinic |
| For children dose by weight | |
| **Phenobarbitone** | All types except absence epilepsy  Adults: Start on 60mg, increase monthly according to response by 30 mg (to max 120mg) as a single dose at night (avoid if possible, in people on ARVs).  **Child:**  **Oral (tab)** initially 3.5- 5mg/kg, at night increase gradually over two weeks period to Max 10mg/kg.  **May be used in children under six months of age**  **Not recommended as maintenance therapy for children > 2 years, except in situations where there is poor adherence too other drugs**  ***Status Epilepticus***  ***IV : 20mg/kg immediately after attention to ABC***  ***If still convulsing 20 minutes after first dosage, can repeat IV phenobarbital 20mg/kg over 5 min.***  ***If still convulsing after two dasges, refer urgently to the next level hospital or specialist/ Senior***  ***Where Parenteral access or supply of parenteral phenobarbital is lacking, nasogastric phenobarbital may be given at a dosage of 20mg/kg( oral formulation mixed with 20 ml of water) to patients with good airway protection and capacity for nasogastric absorption.*** |
| **Phenytoin** | All types except absence epilepsy. Monitor carefully as some types may have increase in seizures. Adults start at 200 mg daily at night. Increase monthly if necessary, by 100mg to a max of 400mg daily) (avoid if ART or TB treatment).    Child:  Oral( Sus, cap):Initially 5mg/kg daily in two divided doses, titrate at 7-10 day intervals . usual maintenance dose 4-8mg/kg daily. Maximum 300mg daily. Split daily dose to give twice a day.  Status Epilepticus:  Loading dose  IV : 18mg/kg infused over 20 minutes in glucose free solution; max rate: 1-3 mg/kg/min or 50mg/min which ever is slower |
| **Carbamazepine** | 1st choice for focal epilepsy, monitor carefully as may sometimes be an increase in seizures  Adults: start at 200mg twice daily – increase **slowly** by 200mg every monthly as necessary according to response (max 800mg twice a daily).  Child:  All focal seizures( With or without impaired awareness)  Avoid if child or adult on HIV on ARVs or TB isoniazid.  Oral (Suspension):  Initial 2mg/kg 8 hourly; titrate by 5-10 mg/dose, 8 hourly at two weeks interval; max 20mg/kg/24 hours  Oral( Immediate release tab): Initial: 2mg/kg. 12hourly; titrate by 5-10 mg/dose, 8 hourly at two weeks interval; max 20mg/kg/24 hours |
| **Sodium Valproate** | 1st choice if on ART or TB treatment. Adults: initially 200mg twice daily, increase by 150-300mg weekly (max 2000mg daily in divided doses).  **Avoid in women of child bearing age**  **Child:**  ALL GENERALISED SEIZURES/ EPILEPSY  eg for absence seizures. Initially 20mg/kg daily in divided doses. Increase slowly, max 35mg/kg daily.  Daily dose of > 100mg should be administered in divided doses |
| **Caution** | Women of child-bearing age: **Oral contraception** is less effective, give 2 pills a day or a 50 microgram pill, or consider alternative. Advise on risks of medication to baby if planning pregnancy. Avoid Sodium Valproate, use carbamazepine and Phenobarbitone as lower risk.  On ARVs or isoniazid: use Sodium Valproate (avoid Carbamazepine, Phenytoin or Phenobarbitone). |
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| At review appointments | Discuss medication and side effects and review if patient is taking them correctly.  Ask carefully about frequency of seizures and increase dose or change drug as above  In some types of epilepsy the drug may actually increase seizures - if so to change drug.  Ask about (plans for) pregnancy – may need to change medication BEFORE pregnancy  Ask if taking ARV or isoniazid for TB – may need to change medication  If not sure, refer to the epilepsy clinic.  Ask 2 screening questions for depression: Over the last few weeks, have you feeling sad, down or depressed?  Have you had little interest or pleasure in doing things you used to enjoy?  If they answer yes to either, refer or do a full assessment – see p12 above |
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| Patient Education | Epilepsy is not contagious and is not due to ‘spirit’ possession  Explain the importance of taking tablets every day - seizures may worsen if medication is stopped  Epilepsy is a long-term condition but seizures can be controlled in most patients (70%) with tablets  Advise them to carry a card with the diagnosis of epilepsy  Do not drive, swim or cook by open fire alone unless certified seizure free for 1 year |
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# Asthma

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| **Symptoms** | Wheeze, cough, difficulty breathing, chest tightness, particularly if:  Frequent and recurrent, **or** worse at night and early in the morning  Symptoms variable from day to day  Worse after exercise/triggers e.g. exposure to animals, smoke or sprays  If cough >2 weeks screen for TB with sputum smears |
| **Risk Factor history** | Personal or family history of hay fever, eczema or asthma (atopic disease)  Smoking makes asthma worse  Usually in young patient (though can also be an older adult) |
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| **How to diagnose/ Signs** | Respiratory distress. Widespread wheeze heard, often worse on breathing out. If severe can be a silent chest. Symptoms improve in after inhaled Salbutamol |
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| **Management** | **Review regularly until symptoms controlled** |
| Aim | Few symptoms, no limitation of activity, and no ‘attacks’ (no exacerbations) |
| At diagnosis | Educate patient (see below)  Assess severity  Measure Peak Expiratory Flow Rate (PEFR) if available,  Explain treatment, including inhaler  Show inhaler technique – **refer to Health Educator’s Guide**  Ask about smoking – strongly advise to stop  Complete a treatment card |
| Refer routinely if | Asthma remains poorly controlled despite treatment and/or regular oral prednisolone is repeatedly required to maintain control.  The diagnosis of asthma is uncertain |
|  | |
| **Medication** | Check local availability and cost.  Start treatment at the step most appropriate step.  Increase treatment stepwise if uncontrolled, but always check using inhalers correctly If still not responding - reconsider diagnosis  May step down treatment if well controlled for at least 6 months. |
| **Step 1** | Salbutamol as needed as a reliever, use inhaler if affordable, if not use oral) |
| **Step 2** | Salbutamol as needed and inhaled steroids (a preventer) if affordable eg beclomethasone 200 - 400 microgram daily as a controller, if affordable |
| **Step 3** | Increase dose Steroid inhaler 400 – 1000 microgram daily, continue Salbutamol |
| **Step 4** | Add low dose theophylline, continue other treatment |
| **Step 5** | **Refer,** while continuing step 4 treatment |
| Well controlled asthma - all of these features are OK: | Minimal limitation of daily activities (daytime symptoms 2 times a week or less)  Needing Salbutamol no more than 3 times a week to control symptoms  Night time asthma symptoms two times per month or less  No severe attacks (i.e. none needing oral steroids or being in hospital) |
| Mild asthma attack | Increase the puffs and frequency of the inhalers, until improved, and go back to previous dose. |
| Acute more severe asthma attack | Add oral prednisolone child 1-2mg/kg daily adults 40mg daily (or dexamethasone 0.6mg/kg daily all age groups) for 3 - 5 days (max), Amoxicillin and Salbutamol, see step treatment above. Do not use steroids long term (more than one week) |
| Refer urgently if severe/ continues | To hospital, continue using inhaler etc as line above and oxygen if available. |
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| At review appointments | Ask about any new symptoms (side effects?) or any attacks  Assess severity asking the 3 questions, have you had:   * difficult sleep due to asthma (including cough)?, how often? * your usual asthma symptoms during the day? If so how often? * asthma interfering with your usual activities e.g. work/school?   Ask about / any problem taking of their treatment  Ask if smoking, advise and support to stop  See them use their inhaler and if not show how – see Health Educator’s Guide  Listen to their chest and assess wheeze  Assess need to step up treatment if asthma uncontrolled  Record symptoms and signs on treatment card and/or in the patient’s notebook. |
|  | |
| Patient Education | That asthma is not infectious so cannot be passed from one person to another.  It is a narrowing of the airways and the reliever opens them up.  Smoking makes asthma much worse – advise to stop.  Explain the symptoms of controlled asthma and asthma attacks (as above)  If worse to increase the Salbutamol and other inhaler - if symptoms not controlled or persist to attend a health facility.  **To seek urgent care if** unable to speak in sentences or very short of breath. Asthma attacks can be fatal.  If they have exercise-induced asthma, to take Salbutamol before exercise  Avoid things that can trigger their asthma e.g. animal fur, smoke - eliminate them  Explain importance of coming for review appointments, give the date. |
|  | |

See the Health Educator’s guide for how to make a spacer – which is useful for younger children to use an inhaler

# Abbreviations

ART – Anti-Retroviral Treatment

ACEi – Angiotensin Converting Enzyme inhibitor

BP – Blood Pressure

bpm – beats per minute

CCB – Calcium Channel Blocker

CVD – Cardiovascular Disease

FBS – Fasting Blood Sugar

Hb – Haemoglobin

HIV – Human Immunodeficiency Virus

IMAI –Integrated Management of Adult and Adolescent Illness (WHO guide)

IV – Intravenous

MoH –Ministry of Health

NCD - Non-Communicable Disease

NG – Nasogastric

OD – Once Daily

ORS – Oral Rehydration Solution

p – page (number)

PEFR – Peak Expiratory Flow Rate

PHC – Primary Health Centre

RBS – Random Blood Sugar

TB – Tuberculosis

Tx – Treatment

WHO – World Health Organization

# Additional Information and References

**Common Illnesses**

WHO IMAI acute care <http://www.who.int/hiv/pub/imai/imai2011/en/>

WHO District Clinician Manual <https://www.who.int/hiv/pub/imai/imai2011/en/>

**Cardiovascular Disease**

WHO CVD-risk management package for low- and medium-resource settings (2002)

<http://www.who.int/cardiovascular_diseases/resources/pub0401/en/>

**Mental Health**

WHO mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings. Version 2.0 (2016)

<http://www.who.int/mental_health/publications/mhGAP_intervention_guide/en/>

**Medication**

Essential Medicines List Sierra Leone.

This clinical deskguide and tools have been adapted, prepared technical working group of the MoHS NCD-MH department, and are the responsibility of the MoHS/ NCD-MH.

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