Health care for the homeless

Sir,
The Manchester and Salford Health Care for Homeless Persons Project was established in February 1984 by three district health authorities (North Manchester, Central Manchester and Salford). The brief of this project is to improve the standard of health care provision available to homeless people in Manchester and Salford and to examine and recommend ways in which they can be channelled and integrated into statutory primary health care services.

Surveys in the hostels in the area revealed a high prevalence of chest, gastrointestinal and skin diseases, and identified large numbers of people suffering from psychiatric and alcohol-related problems. There is still a high prevalence of pulmonary tuberculosis among hostel dwellers compared with the national average. Some health problems are directly related to the life-style of some of the homeless, for example foot problems, trauma and the adverse effects of misusing tranquillizers and hypnotic drugs.

Homeless people tend to cluster in city centres, where there may be no general practitioner cover and tend instead to use hospital accident and emergency departments. The size, isolation and separation of most hostel-type accommodation militates against the integration of health care provision and local health services and general practitioners in particular have often expressed a fear of being inundated with demand should they accept homeless patients onto their lists.

The registration status of homeless people is complex and needs to be systematically checked with the assistance of the family practitioner committee service. Although most hostel residents are registered with general practitioners before they become homeless, the hostels are usually away from the original practice area. This means that many homeless people are registered as temporary residents with local general practitioners because it is anticipated that they are transient and will be moving on.

A general practitioner attempting to work with the homeless on a full-time basis is in a very different situation from orthodox practice. Consultations are carried out in a variety of 'surgeries' within the hostels and day centres, with widely varying facilities and degrees of privacy. There is no help from receptionists and the National Health Service records are kept in the individual hostels or carried around by the doctor.

The project is continuing and an interim report giving details of the scheme is available.

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Minor surgery in general practice

Sir,
There is a school of thought which advocates that minor surgery in general practice should be encouraged.[1] If general practitioners undertake work that is now done in hospital, costly services can be saved and patients spared long waits in outpatient departments. A wide range of surgical procedures are within the competence of general practitioners and these include excision of such lesions as cysts, lipomas and lymph nodes.[2] The comparative costs for such operations has been estimated as £5.00 in general practice and £78.24 in hospital practice (at 1979 prices),[3] so general practice surgery is cost-effective. However, the following case report demonstrates that such surgery must be backed up by an adequate laboratory service for diagnostic histology and the practitioner should routinely submit surgical specimens for histopathological assessment.

Case report

A 66-year-old divorcee (Mrs C), previously of excellent health, lives with her 40-year-old son who is mentally defective and schizophrenic. The son has chronic hypertension which is well controlled and they manage well at home together, with no obvious stress.

Mrs C first attended the surgery in January 1985 complaining of two lumps, one on the back of her neck which she had had for 17 years and another on the scalp. The lump on the neck had recently become larger and through rubbing on her collar was causing some irritation. Examination revealed a 3 cm motile lesion whose consistency suggested a sebaceous cyst — in keeping with the long history. The smaller lump on the scalp was more tense but neither lump appeared unusual.

It was decided to remove the neck lesion in the practice surgery. The lump was infiltrated with xylocaine and the skin opened through a longitudinal incision. This revealed a solid mass, not a cyst, which appeared to be a lipoma and it was excised. The lump was sent for histopathological assessment mainly out of academic interest. The laboratory report read 'Well differentiated keratinizing squamous cell carcinoma. Lymphoid tissue at the edge suggests a secondary carcinoma replacing lymph node' which was completely unexpected.

An urgent medical referral was made and the patient was admitted to hospital for investigation to find the primary tumour. Extensive investigations failed to identify a source and upon review of the sections the pathologists finally felt that the lesion was in fact an unusual 'primary skin adnexal tumour' or tricholemmoma. This is a rare tumour, a variety of clear-cell tumour of the skin, which arises from the outer root sheath of the hair follicle.[4]

This type of tumour rarely metastasizes, but in view of the nature of the report, a surgeon was asked to excise the area further. At the same time he removed the sebaceous cyst from the scalp. The biopsy findings from both operations were normal and in particular there was no evidence of the original tumour in the pieces examined indicating that the original operation had achieved complete clearance. Follow up of the patient over six months showed no evidence of recurrence and it is believed that the patient is now 'cured'. Mrs C coped well with the six months of stress and now seems reassured that it is likely that she is completely cured.

The lesson of this case is that when surgical excision is undertaken in general practice, the specimen should be routinely investigated histologically irrespective of its appearance to the naked eye. Reluctance to request histology is based on considerations of economy, but since hospital specimens are routinely referred, the cost must be the same in both instances, so that general practice surgery is still cost-effective.

It is clear from the second exploration that the original dissection had been effective in clearing the lesion, reinforcing the view that such surgery in general practice is safe and it has the added advantage of speed.

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