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MORNING REPORT

A CASE OF TESTICULAR CANCER IDENTIFIED IN A FREE CLINIC: OVERCOMING BARRIERS TO CARE FOR UNINSURED PATIENTS

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Introduction

Uninsured men with germ cell tumors (GCTs) are more likely to be diagnosed with advanced disease, and have an 88% greater likelihood of dying from GCTs than men with traditional health insurance[1]. Here we present the case of an uninsured man with a GCT, and discuss perspectives related to navigating the care of uninsured patients with serious health concerns.

The Case

Mr. K. is a 28-year-old man who presented to the Birmingham Free Clinic in Pittsburgh, Pennsylvania, reporting a painless left testicular lump that he first noticed four weeks prior. His exam revealed firmness to the posterosuperior portion of the left testis. In young men presenting with a testicular mass, guidelines recommend testicular ultrasonography, serum tumor markers and referral to urology to facilitate timely diagnosis and treatment of possible testicular cancer. Limited point of care ultrasonography of the scrotum was performed in clinic by the Internal Medicine resident and attending. This revealed a hypoechoic mass in the posterosuperior portion of the left testis measuring 1.8 cm.

The attending physician contacted a urologist who has previously provided care for uninsured patients referred from the clinic. The patient's history, physical exam, and ultrasound images were provided to the urologist via secure email. The patient was scheduled for an appointment with the urologist within 48 hours of his initial presentation. Tumor markers were noted to be elevated. The patient underwent a radical orchiectomy three days after seeing the urologist and five days after his initial presentation. Pathology revealed a malignant germ cell tumor, consistent with embryonal cell carcinoma. The neoplasm was confined to the testis.

Discussion

The Importance of Early Diagnosis in GCTs.

Testicular cancer is the most common malignancy in men between the ages of 15 and 34.*3* Early diagnosis and treatment is critical. The doubling time of a GCT is approximately 10 to 30 days.*4* In patients with a testicular mass, ultrasound accurately distinguishes intratesticular from extratesticular pathology.*3* Radical orchiectomy is the first step for both treatment and definitive diagnosis. Diagnostic delay, defined as delay from initial identification of symptoms to radical orchiectomy, can be substantial. Patients with a diagnostic delay of less than three months have less advanced disease, and better survival than those with longer diagnostic delay.[4] Uninsured patients have been shown to have higher mortality rates from GCTs.[2] In Mr. K.'s case, the time from presentation at primary care to radical orchiectomy was just 5 days, which is extremely rapid, even for a patient with insurance. We will now discuss factors involved in this case that enabled Mr. K. to receive care in such an expeditious fashion.

Access to Primary Care

Mr. K. identified the testicular mass and sought medical attention, which was fortunately available at the Birmingham Free Clinic. The Birmingham Free Clinic (BFC) provides free acute and preventive medical care to uninsured patients in the Pittsburgh Community. It serves as a continuity clinic site for Internal Medicine

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Residents in the Global Health Underserved Populations Track at the University of Pittsburgh Medical Center. Health navigation services are emphasized to enhance access to insurance and to other medical services. After referral and after being seen by the specialist, ongoing active follow-up by free clinic staff is important to ensure continued follow-up care in a population at high risk for falling between the cracks of our complex health system. This case emphasized the critical safety net role of free clinics and community health centers.

Point of Care Ultrasonography (POCUS) in the Free Clinic Setting
POCUS can be an important tool in aiding diagnosis and management particularly in resource limited settings. In this case, the internal medicine resident and attending had training in ultrasonography, but had limited experience performing scrotal ultrasound. Even still, the presence of a left intratesticular mass was clear. The role of ultrasound in this case was to clarify the physical exam finding, making certain the presence of an intratesticular mass that confirmed the sense of urgency for referral. A negative study would not have provided adequate evidence to rule out a testicular tumor.

This demonstrates a few points related to the use of POCUS in clinic:

1. Lack of extensive experience in a particular ultrasound study does not mean it should not be performed; however, the results must be interpreted with caution. In particular, high stakes studies requiring high sensitivity must be done only with very high standards. Markedly positive findings, such as those seen in this case, can be useful.
2. Images should be stored in the patient record for view by other providers and for quality assurance through independent corroboration. In this case, images were placed into the note in the medical record, and emailed to the urologist.
3. Residency training programs, particularly those geared toward global health and underserved populations, should include training in ultrasonography.

The Medical Neighborhood
This case demonstrates the importance of a referral network, which we will refer to as a *medical neighborhood*. The medical neighborhood includes healthcare providers of several disciplines who work together to fill gaps in the medical system to provide care for vulnerable patients. In this case the attending physician has cultivated relationships with several specialists, and directly contacted a urologist via e-mail to request assistance. From our experience making referrals from a free clinic to specialist physicians, we have observed the following:

1. Cultivating a shared mission, nurturing teamwork, and building relationships are key in developing a medical neighborhood.
2. Direct communication (ex: email, phone) leads to more effective coordination of care than working through traditional means of calling the office staff or placing a consult in the electronic medical record. Warm handoffs, with direct communication between physicians, is ideal for patient care and for cultivating relationships within the medical neighborhood.
3. Cases should be appropriately selected for referral. A non-urgent, or non-serious case could be deferred, to avoid overburdening specialists.

The Importance of Specialists Familiar with the Care of Uninsured Patients
Characteristics of specialist physicians and their offices beneficial for care of uninsured patient include:

1. Willingness to see patients in non-standard scheduling spots (for example, on lunch break or between cases). If flexibility is required, it is reasonable to ask a patient to wait in the office longer than usual, when services are provided for free.
2. Involvement of the office staff in coordination of care—sometimes a patient may call a doctor's office and be told that without insurance they cannot schedule an appointment. Involving clinic staff including appointment schedulers, secretaries, and nurses in the referral process can help to ensure smooth coordination of care and allow additional flexibility that may be necessary for uninsured patients.
3. Understanding that the patient should not be billed in the same manner as most insured patients. If there will be a cost to the patient, this should be discussed with the patient prior to proceeding. To recuperate costs to the organization, the patient may be able to obtain medical assistance or emergency medical assistance and gain retroactive coverage, or access charity care programs. The physicians (primary care and specialist) can assist this process through providing a letter stating that the patient would have death or disability if diagnosis and treatment were not provided. Involving specialized insurance navigators can be particularly useful in complex cases.

Conclusion

In this case, the delay from presentation at primary care to definitive diagnosis was a mere five days. In alternative scenarios using traditional models of care, the delay could have been much longer (on the order

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of several months), and the disease may have become more advanced at diagnosis, leading to additional costs, complications, or death. This case demonstrates how non-traditional methods, including access to a free clinic with associated health navigation resources, use of point of care ultrasound, development of a medical neighborhood, and specialist physicians accustomed to caring for uninsured patients can promote the provision of high quality, expeditious care for uninsured patients.

References

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