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Official Journal of the Academy of Family Physicians of Malaysia
and Family Medicine Specialist Association of Malaysia

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About MFP

The ***Malaysian Family Physician*** (MFP) is the official journal of the Academy of Family Physicians of Malaysia (AFPM). It is jointly published by the Family Medicine Specialist Association (FMSA) of Malaysia. The MFP is published three times a year. It also started an Online First section in January 2021, where accepted articles are published online ahead of the issue.

Starting from January 2023, the MFP is adopting continuous publication as soon as each article is ready for publication. This is to ensure knowledge is disseminated in a timely manner.

Goal: The MFP is an international journal that disseminates quality knowledge and clinical evidence relevant to primary care. The journal acts as the voice of family physicians, researchers and other members of the primary care team on clinical practice issues.

Scope: The MFP publishes:

i. Research – Original Articles and Reviews
ii. Education – Case Reports/Clinical Practice Guidelines/Test Your Knowledge. We only encourage case reports that have the following features:
    1. Novel aspects
    2. Important learning points
    3. Relevant to family practice
iii. Invited debate, commentary, discussion, letters, online, comment, and editorial on topics relevant to primary care.
iv. A Moment in the Life of a Family Physician – We encourage submission of a short narrative to share perspectives, voice, views and opinions about a family physician's experience that has affected their practice or life.

Read our Information for Authors section to learn more about these article types.

Strength: MFP is the only primary care research journal in Malaysia and one of very few in the region. It is open access and fully online. The journal is indexed in Scopus and has a strong editorial team and an established pool of readers with increasing recognition both locally and internationally.

Circulation: The journal is freely available online.

Publisher: Academy of Family Physicians of Malaysia

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Publication Ethics

Ethics: Evidence of ethics approval from a recognised ethics committee and informed consent should be included in the manuscript for studies involving animal experiments or human participants. When manuscripts describe studies with vulnerable populations (refer ICH-GCP guideline) and there is a risk of coercion or incomplete consent, the manuscript will undergo further evaluation by an internal editorial oversight committee (Chief Editor, Deputy Chief Editor and Editorial Advisors). Consent is necessary for all personally identifiable data, encompassing biomedical, clinical, and biometric information. If requested, documentary proof of consent must be provided.

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2. Drafting the article or revising it critically for important intellectual content; and
3. Final approval of the version to be published.
4. Agreement to be accountable for all aspects of the work ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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Policy Adherence: The editorial board conducts regular review of the journal's contents to ensure they are up to date and adhere to the journal's policies.

Editorial Board

Information for Authors

The Malaysian Family Physician welcomes articles on all aspects of family medicine in the form of original research papers, review articles, CPG review, case reports, test your knowledge and letters to the editor. The journal also publishes invited debate, commentary, discussion, letters, comment, A Moment in the Life of a Family Physician and editorials on topics relevant to primary care.

Articles are accepted for publication on condition that they are contributed solely to the Malaysian Family Physician. Neither the Editorial Board nor the Publisher accepts responsibility for the views and statements of authors expressed in their contributions. All papers will be subjected to peer review. The Editorial Board further reserves the right to edit and reject papers. Authors are advised to adhere closely to the instructions given below to avoid delays in publication.

All manuscripts must be submitted through the Open Journal System (OJS).

SUBMISSION REQUIREMENTS

1. The author must declare that the manuscript has not been previously published, nor is it being considered for publication in another journal concurrently.
2. **The Main Manuscript** should be submitted in electronic form only and in **Microsoft Word**.
    - The manuscript **contains all the sub-headings required** for the article type (refer below).
    - The manuscript uses a **single-spaced, 12-point font and uses italics rather than underlining** (except URL addresses).
    - **All figures, tables and illustrations are placed at the appropriate sections in the manuscript file** rather than at the end of the manuscript or submitted separately.
    - Use left-aligned paragraph formatting rather than full justification.
    - Follow the instructions in Ensuring a Blind Review (refer below).
    - Follow the referencing style provided in the References section below.
    - Provide URLs for references where available.
    - Where available, URLs for the references have been provided.
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4. A **Cover Letter** must be signed by the corresponding author on behalf of all authors. This letter must include this statement "this manuscript is my (our) own work, it is not under consideration by another journal, and this material has not been previously published."
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TITLE PAGE

For all types of manuscript, please include all the sub-headings below in the Title Page (you can use this template):

- **Article Type:** Original Research / Review / CPG Review / Case Report / Test Your Knowledge / Letter To Editor
- **Title:** Please state the title in detail to include the study design, particularly for original research.
- **Author(s):** The full names, professional qualifications and institutions of all authors.
- **Shortened name of author(s):** should be written in the style of surname or preferred name followed by initials, e.g. Abdullah KS, Rajakumar MK, Tan WJ, for future indexing.
- **Corresponding Author:** Corresponding author's mailing address, designation, institution and contact details (email, telephone and fax numbers)

MAIN MANUSCRIPT

For every article submitted, please follow the requirements according to the type of article.

Original Research (Including Clinical Audit Article)

The original research (including clinical audit) should be conducted in the primary care setting on a topic of relevance to family practice. Both qualitative and quantitative studies are welcome. The length should **not exceed 3000 words with a maximum of 5 tables or figures and 30 references**. Please include the following sub-headings in the manuscript:

1. **Title:** State the title based on PICO, including study design.
2. **Abstract:** Structured abstract (Introduction, Methods, Results and Conclusion) of no more than 250 words.
3. **Keywords:** 3-5 keywords, preferably MeSH terms.
4. **Introduction:** Clearly state the purpose of the article with strictly pertinent references. Do not review the subject extensively.
5. **Methods:** Describe the study in sufficient detail to allow others to replicate the results. Provide references to established methods, including statistical methods; provide references and brief descriptions of methods that have been published but are not well known; describe new or substantially modified methods, give reasons for using them, and evaluate their limitations. When mentioning drugs, generic names are preferred (proprietary names can be provided in brackets). Do not use patients' names or hospital numbers. Include numbers of observation and the statistical significance of the findings. When appropriate, state clearly that the research project has received the approval of the relevant ethical committee. For an RCT article, please include the trial registration number) and follow the CONSORT checklist. Other study designs must also follow a reporting checklist, which can be found at https://www.equator-network.org/.
6. **Results:** Present your results in logical sequence in the text, tables and figures. Tables and figures may be left at the respective location within the text. These should be numbered using Arabic numerals only. Table style should be "Simple" (as in Microsoft Word). Do not repeat table or figure data in the text.
7. **Discussion:** Emphasise the new and important aspects of the study and conclusions that follow from them. Do not repeat data given in the Results section. The discussion should state the implications of the findings and their limitations and relate the observations to the other relevant studies. Link the conclusions with the aims of the study but avoid unqualified statements and conclusions not completely supported by your data. Recommendations, when appropriate, may be included.
8. **Acknowledgements:** Acknowledge the people who have contributed significantly to the study (but do not qualify for authorship).
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10. **Ethical Approval:** Please state if the study was approved; if so, by which institution and the approval ID.
11. **Conflicts of interest:** All authors must declare any conflicts of interest.
12. **Funding:** Please state if the study was funded; if so, by which institution and the funding ID.
13. **Data sharing statement:** Please describe your data sharing plan. State if your raw data is uploaded in publicly available databases, shared via controlled access repositories or only available upon request.
14. **How does this paper make a difference in general practice?:** This section should be written in bullet points (up to five points) and must not exceed 100 words.
15. **References:** Refer to the References section below for more details.

Review

All types of review articles, including narrative review, scoping reviews and systematic reviews are accepted for publication in MFP. A comprehensive review of the literature with a synthesis of practical information for practising doctors is expected. For a systematic review, the PRISMA checklist (https://www.equator-network.org/reporting-guidelines/prisma/) must be followed. For a scoping review, the PRISMA-ScR checklist (https://www.equator-network.org/reporting-guidelines/prisma-scr/) should be followed. The length should **not exceed 4000 words with a maximum of 5 tables or figures and 40 references**. Please include the following sub-headings in the manuscript:

1. **Title:** Include the topic and type of review in the title.
2. **Abstract:** Structured abstract (Introduction, Methods, Results and Conclusion) of no more than 250 words.
3. **Keywords:** 3-5 keywords, preferably MeSH terms.
4. **Introduction:** Describe the topic and objective of the review.
5. **Methods:** All types of review articles (including narrative review) must report the search strategy, database and keywords used to obtain the literature. The PRISMA and PRISMA-ScR checklists should be followed for systematic and scoping reviews, respectively.
6. **Results (*for systematic and scoping reviews):** This section is required for systematic and scoping reviews. Please follow the guideline in the PRISMA and PRISMA-ScR checklists.
7. **Discussion (*for systematic and scoping reviews):** This section is required for systematic and scoping reviews. Please follow the guideline in the PRISMA and PRISMA-ScR checklists.
8. **Any relevant subheadings (*for narrative review):** A narrative review may have any other relevant sub-headings according to needs.
9. **Conclusion:** Provide a conclusion by linking to the objective of the review.
10. **Acknowledgements:** Acknowledge the people who have contributed significantly to the study (but do not qualify for authorship).
11. **Author contributions:** Describe the contributions of every authors in the study.
12. **Review protocol registration:** Please state where the study protocol was registered and the approval ID.
13. **Conflicts of interest:** All authors must declare any conflicts of interest.
14. **Funding:** Please state if the study was funded; if so, by which institution and the funding ID.
15. **How does this paper make a difference in general practice?:** This section should be written in bullet points (up to five points) and must not exceed 100 words.
16. **References:** Refer to the References section below for more details.

Case Report

Case reports should preferably be less-commonly seen cases that have an educational value for practising doctors. Only case reports that are **novel, have important learning points and relevant to family practice** will be accepted for publication in this journal. The case report must be written in a **patient-centred manner instead of a disease-centred focus**. The length should **not exceed 1500 words and cite no more than 20 references**. Before submitting the case report, the authors must ensure that the patient's identity is protected both in the text and pictures. This patient consent form must be signed and uploaded during submission. Please include the following sub-headings in the manuscript:

1. **Title:** Use an interesting title to show the new learning points and include the term "case report" in the title.
2. **Abstract:** Unstructured abstract between 100-250 words.
3. **Keywords:** 3-5 keywords, preferably MeSH terms.
4. **Introduction:** Describe the condition and aim of the case report.
5. **Case Presentation:** Describe the case in detail.
6. **Discussion:** Discuss the case with existing literature.
7. **Conclusion:** Provide the key learning point from the case report.
8. **Acknowledgements:** Acknowledge the people who have contributed significantly to the study (but do not qualify for authorship).
9. **Conflicts of interest:** All authors must declare any conflicts of interest.
10. **Author contributions:** Describe the contributions of every authors in the study.
11. **Patients' consent for the use of images and content for publication:** Was consent obtained from the patient(s)? Was the consent written or verbal? Has the patient consent form been signed?
12. **What is new in this case report compared to the previous literature?:** This section should be written in bullet points (up to five points) and must not exceed 100 words.
13. **What is the implication to patients?:** Describe any potential implication to patients based on the learning points from this case report.
14. **References:** Refer to the References section below for more details.

CPG Review

The CPG should be relevant to primary care. Its length should **not exceed 4000 words and 40 references**. An abstract is required (no more than 300 words) together with the keywords. The CPG review should be written with case vignettes to illustrate its application in primary care practice.

1. **Title:** State the scope of the CPG, include the latest version or year for revised CPGs.
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5. **Development process of the CPG:** Describe the development process of the CPG, e.g.: who are the team members involved, what methodology was used, how was the evidence gathered, how was the decision made on the recommendations, was the outcomes validated, how was the CPG disseminate and implementation, etc. Follow the AGREE Reporting Checklist (https://www.equator-network.org/wp-content/uploads/2016/03/AGREE-Reporting-Checklist.pdf) wherever possible.
6. **Key recommendations of the CPG:** Describe the key recommendations primary care doctors should know.
7. **Key changes in the CPG (only applicable for revised CPGs):** Describe the key changes or updates from the previous CPG.
8. **How to apply the CPG into practice in primary care?** Explain how the CPG can be used in primary care practice.
9. **Case vignettes as examples of application:** Use case vignettes to illustrate the application of the CPG.
10. **Conclusion:** Summarise the key learning points.
11. **Acknowledgements:** Acknowledge the people who have contributed significantly to the study (but do not qualify for authorship).
12. **Author contributions:** Describe the contributions of every authors in the study.
13. **Conflicts of interest:** All authors must declare any conflicts of interest.
14. **Funding:** Please state if the work was funded; if so, by which institution and the funding ID.
15. **How does this paper make a difference in general practice?:** This section should be written in bullet points (up to five points) and must not exceed 100 words.
16. **References:** Refer to the References section below for more details.

Test Your Knowledge

A Test Your Knowledge article should be relevant to primary care and preferably be about less-commonly seen cases that have an educational value for practising doctors. The length should **not exceed 1000 words and no more than 20 references**. If the article involves a patient, the authors must ensure that the patient's identity is protected both in the texts and pictures; and this patient consent form must be signed and uploaded during submission. Please include the following sub-headings in the manuscript:

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2. **Abstract:** Unstructured abstract between 100-250 words.
3. K**eywords:** 3-5 keywords, preferably MeSH terms.
4. **Case Summary:** Describe the case.
5. **Questions:** State the questions.
6. **Answers with discussion:** Provide the answers and discuss them with support from the literature.
7. **Acknowledgements:** Acknowledge the people who have contributed significantly to the study (but do not qualify for authorship).
8. **Author contributions:** Describe the contributions of every authors in the study.
9. **Conflicts of interest:** All authors must declare any conflicts of interest.
10. **Funding:** Please state if the study was funded; if so, by which institution and the funding ID.
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A letter to the editor should be of relevance to primary care and in response to an article or topic published in previous issues of this journal. The length should **not exceed 1000 words and cite no more than 20 references**. Please include the following sub-headings in the manuscript:

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4. **Acknowledgements:** Acknowledge the people who have contributed significantly to the study (but do not qualify for authorship).
5. **Author contributions:** Describe the contributions of every authors in the study.
6. **Conflicts of interest:** All authors must declare any conflicts of interest.
7. **Funding:** Please state if the study was funded; if so, by which institution and the funding ID.
8. **References:** Refer to the References section below for more details.

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We encourage submission of a short narrative to share perspectives, voice, views and opinions about a family physician's experience that has affected their practice or life. It could be about being a doctor, educator, administrator/management, researcher, student or even patient. This type of article should be a **reflective piece of about 500 words in length**, and can be accompanied with photo(s). The journal also accepts articles which anchor on the photo(s) as the main content, this can be accompanied with captions (not more than 100 words) that describe the photo(s) with author's reflection on it.

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- ***Standard journal article:*** List up to six authors only; when more than six, list only the first three and add et al. Connor EM, Sperling RS, Gelber R, et al. Reduction of maternal-infant transmission of human immunodeficiency virus type 1 with zidovudine treatment. Pediatric AIDS Clinical Trials Group Protocol 076 Study Group. *N Engl J Med*. 1994 Nov 3;331(18):1173–1180. doi:10.1056/NEJM199411033311801
- ***Standard journal article-Corporate Author:*** International Committee of Medical Journal Editors. Uniform requirements for manuscripts submitted to biomedical journals. *N Engl J Med*.1997 Jan 23; **336**(4):309–316. doi:10.1056/NEJM199701233360422
- ***Books and other monographs-Personal Author(s):*** Stewart M, Brown JB, Weston WW, et al. Patient-Centered Medicine: Transforming the Clinical Method. Thousand Oaks, California: Sage Publications; 1995.
- ***Books and other monographs-Corporate Author:*** Wonca International Classification Committee. International Classification of Primary Care, ICPC-2. 2nd ed. Oxford: Oxford University Press; 1998.

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To ensure the integrity of the blind peer-review for submission to this press, every effort should be made to prevent the identities of the authors and reviewers from being known to each other. This involves the authors, editors, and reviewers (who upload documents as part of their review) checking to see if the following steps have been taken with regard to the text and the file properties:

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    2. Author, 2019
    3. Author, 2016
    4. Hashim S, Ayub ZN, Mohamed Z, et al. The prevalence and preventive measures of the respiratory illness among Malaysian pilgrims in 2013 Hajj season. J Travel Med. 2016;23(2):tav019. Published 2016 Feb 8. doi:10.1093/jtm/tav019
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Articles are accepted for publication on condition that they are contributed solely to the Malaysian Family Physician. Neither the Editorial Board nor the Publisher accepts responsibility for the views and statements of authors expressed in their contributions. All papers will be subjected to peer review. The Editorial Board further reserves the right to edit and reject papers.

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MFP is an open access journal and levies **Submission and Publication Fees for original research, review and case report articles starting from 1 Jan 2025**. These fees help ensure the sustainability of the journal's operations, including copy editing, design and open access costs for the authors' articles.

All authors are needed to submit a **RM50 Submission Fee** electronically when submitting these types of articles. Payment of the submission fee does not guarantee article acceptance. Therefore, authors should ensure that their article is relevant to primary care/family medicine; contains new important learning points; is methodologically sound; and follows all the formatting requirements before submitting it to our journal. The article will only be processed and reviewed after the payment has been received.

The Publication Fee will be payable once the article is accepted for publication. The fee is based on the categories below:

- Academy of Family Physicians of Malaysia (AFPM) members = RM250
- Malaysian Family Medicine Specialists' Association (FMSA) members = RM250
- Non-AFPM/FMSA members (Malaysian) = RM450
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All fees are non-refundable.

Authors who have reviewed manuscripts for MFP within the past one year may enjoy a **waiver of the Submission and Publication Fees**. Only one article is waived for one article reviewed.

For those who are interested in joining the AFPM or FMSA as a member, please visit these websites:

- AFPM: https://www.afpm.org.my/
- FMSA: https://fms-malaysia.org/

For further details regarding the submission process, fees, or any other inquiries, please do not hesitate to email us at: editor_mfp@afpm.org.my.

PEER REVIEW PROCESS AND TIMELINE

- **Editorial Review:** When a manuscript is submitted to MFP, it will go through an initial screening by the associate editors. The associate editors assess the manuscript's alignment with the journal's scope and general quality. If there is disagreement between the associate editors, the Chief Editor/Deputy Chief Editor will be involved to make the decision. The **first editorial decision** whether an article can be sent for peer review will be made **within one month**.
- **Peer Review Assignment:** If the manuscript meets the basic criteria, one associate editor will be assigned to handle the manuscript and appoint two peer reviewers who are qualified experts in the field to evaluate the manuscript. The associate editor may consider the reviewers that authors nominated during the manuscript submission or invite other reviewers deemed suitable.
- **Anonymous Review:** Peer reviewers conduct an in-depth analysis of the manuscript, considering aspects such as methodology, data analysis, results, and conclusions. Reviews are typically anonymous (double-blinded authors and reviewers) to encourage impartial feedback.
- **Peer Reviewer Report:** Each peer reviewer provides a detailed report assessing the originality, methods, contents, conclusions, tables, figures and legends, language as well as strengths and weaknesses of the manuscript. They may suggest revisions or raise concerns about the methodology and interpretation of result.
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CCR / CS23

Chest X-ray 'starry sky' appearance: A Miliary Tuberculosis disguise

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[1]*klinik Kesihatan Padang Rengas, Klinik Kesihatan Padang Rengas, Kuala Kangsar, Malaysia*

Introduction: Chest X-ray is commonly used in diagnosing tuberculosis (TB). There are many diseases that can masquerade as pulmonary tuberculosis (PTB)/ miliary TB. The case illustrated below is a good example.
Case Presentation: A 63-year-old smoker presented with 10 months history of right sided neck swelling associated with chesty cough and nocturnal fever. He also had difficulty in swallowing, voice change, loss of appetite and significant weight loss in 5 months. No hemoptysis / PTB contact or family history of malignancy. On examination, there were multiple hardened and tender lymph nodes over right side of the neck. There were no other remarkable systemic examination findings. Investigations showed ESR 111 mm/hour, sputum acid fast bacilli direct smear negative and chest X-ray with miliary-like pattern. FNAC of the lymph node revealed metastatic adenocarcinoma with immunohistochemical profiling in favor of lung origin. CT thorax and neck was reported as lung carcinoma with nodal and bone metastasis with contralateral lung nodules. The final diagnosis was stage IV lung carcinoma T3N3M1. As patient refused biopsy, he was managed palliatively and deceased three months after the diagnosis.
Discussion: In this case, biopsy is the gold standard in diagnosing malignancy. Multidisciplinary team collaboration from ENT, chest and radiology is also crucial. Miliary nodules that are larger (>3mm) with variation in sizes and more localized distribution should prompt clinician to consider differential diagnoses like lung cancer.
Conclusion: This case highlighted the importance of exploring differential diagnoses of miliary TB to ensure timely correct diagnosis and proper treatment.
Keywords: lung cancer, miliary tuberculosis

CCR / CS24

Community-Based Rehabilitation in a Pediatric Patient with Japanese Encephalitis: A miracle made possible

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Introduction: Japanese Encephalitis (JE) is a mosquito-borne viral infection caused by the JE virus, a flavivirus transmitted primarily by Culex mosquitoes. JE can result in significant neurological morbidity and mortality, particularly among children. Survivors of JE frequently experience long-term complications, including cognitive impairment, motor dysfunction, speech disturbances, and behavioural changes, which severely impact their quality of life.
Case Presentation: This case report describes the remarkable recovery of an 8-year-old Malay boy diagnosed with JE, following a presentation to primary care with fever, lethargy, vomiting, and status epilepticus. His condition was complicated by multiple failed extubation attempts, prolonged ventilatory support, and severe deconditioning. Upon enrolment into a domiciliary care program, he was functionally dependent, scoring 0 on the Modified Barthel Index (MBI) and required Ryle's tube feeding and tracheostomy care.
Discussion: A multidisciplinary rehabilitation plan was implemented through domiciliary team, involving physiotherapists, occupational therapists, and speech therapists. Over the course of his care, the patient demonstrated significant improvement which are regaining independent ambulation, oral feeding ability, and achieving an MBI score of 86. His caregiver also gained confidence in managing his tracheostomy independently.
Conclusion: This case illustrates the challenges of delivering complex rehabilitation in a non-hospital setting and emphasizes the pivotal role of community-based care in supporting pediatric patients with prolonged recovery needs. It underscores the effectiveness of integrated domiciliary rehabilitation in improving functional outcomes, reducing caregiver burden, and enhancing overall quality of life.
Keywords: Domiciliary Rehabilitation Japanese Encephalitis

CCR / CS25

Cornual Ectopic Pregnancy in Primary Care: A High-Risk Diagnostic Challenge

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Introduction: Cornual ectopic pregnancy is a rare but life-threatening variant, accounting for 2-4% of ectopic pregnancies. Due to its ability to grow longer before rupture, it presents a diagnostic challenge, especially in primary care. Early recognition is crucial for maternal safety.
Case Presentation: A 34-year-old multiparous woman presented to a primary care clinic with two weeks of minimal per vaginal bleeding and mild lower abdominal pain. She was haemodynamically stable. Abdominal exam showed mild suprapubic tenderness. A transabdominal ultrasound (used due to equipment limitations) revealed a gestational sac in the right cornual region with fetal heart activity and no free fluid. The patient was a chronic smoker.
Discussion: Cornual pregnancy can present subtly, even in stable patients. Risk factors such as smoking may impair tubal motility, increasing ectopic risk. Literature shows diagnostic delays are common due to non-specific symptoms. This case underscores the need for high clinical suspicion in early pregnancy with atypical bleeding. While transvaginal ultrasound is preferred, transabdominal imaging may still yield crucial findings in resource-limited settings. The patient was referred urgently and underwent successful laparoscopic surgery. Primary care physicians must recognise red flags and refer promptly.
Conclusion: Cornual ectopic pregnancy is rare but serious. This case highlights the importance of vigilance in primary care to

ensure early diagnosis and timely referral, ultimately improving maternal outcomes.
Keywords: Cornual Pregnancy, Primary Health Care

CCR / CS26

Cutting Weight, Not Corners: The Unseen Struggles After Bariatric Surgery

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Introduction: Obesity is a chronic, multifactorial disease that affects both physical and mental health. While lifestyle changes are first-line therapy, some patients fail to achieve targeted results. Bariatric surgery can be effective, but its success depends on careful patient selection, thorough preoperative counselling, and consistent follow-up. Primary care doctors play crucial in guiding and supporting patients throughout this journey.
Case Presentation: A 50-year-old woman with type 2 diabetes, hypertension, dyslipidaemia, and morbid obesity (BMI 48.4 kg/m^2; 135 kg) was under regular follow-up at KK Sandakan. Her obesity was complicated by knee osteoarthritis and obstructive sleep apnea. Despite dietary and physical activity interventions, she could not achieve weight loss. Although she did not receive anti-obesity medications, her high BMI, along with multiple comorbidities, made her a suitable candidate for bariatric surgery. Her strong commitment to follow-up and willingness to change her lifestyle further supported this decision. She was counselled on surgical risks and postoperative expectations. However, she developed complications post-operatively, which required reoperation and contributed to the onset of depressive symptoms. Even with the challenges, she markedly reduced her weight and no longer needed insulin.
Discussion: This case highlights the vital role of primary care in supporting patients living with obesity who have undergone bariatric surgery. It highlights personalised care and the importance of selecting motivated patients, preparing them thoroughly, and providing continuous care after surgery to manage both physical and emotional challenges.
Conclusion: Obesity care goes beyond surgery. Long-term, holistic support from primary care is essential for sustained patient outcomes.
Keywords: Obesity Primary care Bariatric

CCR / CS27

Discovering The Missing X: The Crucial Role of Primary Care in Turner Syndrome

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Introduction: Primary amenorrhea, defined as absence of menstruation by age of 15 in girls with normal puberty or by age 13 without, can have various causes. One key but often overlooked etiology is Turner syndrome (TS), a chromosomal disorder that requiring timely diagnosis and multidisciplinary management. We report a case of 16-years-old girl with primary amenorrhea diagnosed with TS.
Case Presentation: A case of 16-year-old female presenting with primary amenorrhea. Upon physical examination, revealed features of TS: short stature, cubitus valgus, and delayed puberty.Bone age assessment showed a 4-year delay. Laboratory investigations reported elevated gonadotropins indicating hypergonadotropic hypogonadism(FSH:79.3 IU/L; LH:15.47 IU/L). Pelvic MRI revealed a hypoplastic uterus with rudimentary ovaries. Chromosomal analysis confirmed monosomy X(45,X), establishing the diagnosis of TS.She was started on somatotropin and oral Vitamin D by the pediatric endocrinologist. Oral estradiol was commenced by the the gynecologist but was later temporarily withheld to optimize final height. After 12 months of hormonal therapy, she demonstrated 5cm height gain(1.29m to 1.34m) and pubertal progression from Tanner stage I to II.
Discussion: TS affects approximately 1 in 2,500 live female births, characterized by complete or partial absence of one X chromosome. In adolescents, it presents with primary amenorrhea, short stature, and delayed puberty. Subtle clinical and physical cues in such cases should prompt early evaluation.
Conclusion: This case highlights the pivotal role of primary care in early recognition and coordinated management, which significantly improves growth, sexual, and psychological outcomes in TS patients, reinforcing the importance of vigilance and continuity in primary healthcare practice.
Keywords: amenorrhoea, short stature, delayed puberty

CCR / CS28

Drug Interaction Between a Macrolide Antibiotic and a Second-generation Antihistamine

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Introduction: Drug interactions play a crucial role in patient safety and treatment outcomes. This report discusses a clinically significant interaction between erythromycin and loratadine, prescribed together for an upper respiratory infection. Erythromycin, a macrolide antibiotic, inhibits the cytochrome P450 3A4 (CYP3A4) enzyme, which metabolizes loratadine, a second-generation antihistamine. This inhibition can elevate loratadine plasma levels, increasing the risk of adverse effects such as QT prolongation and cardiac arrhythmias.
Case Presentation: A 30-year-old male presenting with cough, nasal congestion, and mild fever was prescribed erythromycin (500 mg twice daily) for bacterial coverage, and loratadine (10 mg once daily) for allergy relief. He had no history of cardiovascular disease or significant comorbidities. Two days after starting treatment, he reported palpitations and dizziness. While