THE IMPACT OF STRUCTUAL BARRIERS AND VULNERBAILTY: A DERMATOLOGIC CASE REPORT

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Introduction

Standard population health metrics may not fully illustrate the necessity to provide empathetic care for socially and medically complex patients [1,2]. Numerous harmful and unjust social, political, and economic structural barriers contribute to patients' vulnerability and exacerbate their medical problems [3].

Discussion

In recent years, studies have shown that high engagement with healthcare management teams decreased the rates of hospital readmissions for high-risk and complex populations [1,2].

This man's story illustrates that he was within a structurally vulnerable patient demographic, characterized by his financial insecurity, risk environments, lack of social networks, criminal status, and community discrimination [3].

Our team hopes, that when taken together, these research findings, and our case report's narrative, demonstrate that compassionate care should be offered to all patients in need, regardless of engagement, and that there is a need for structural competency and humility across healthcare [1-3].

Case Presentation

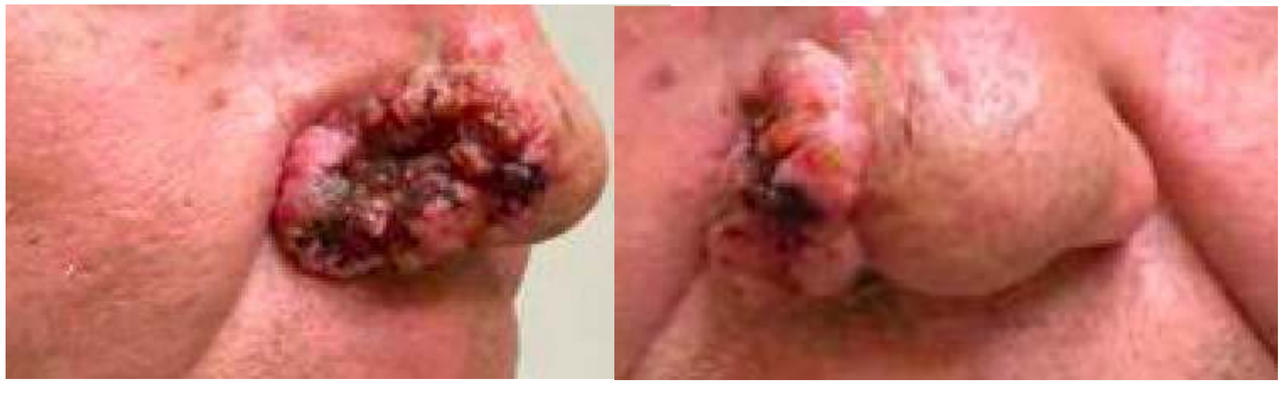
We present a case of a 62-year-old Caucasian male with numerous comorbidities, a substantial smoking history, and PMH of hypertension who presented to our primary care clinic on 11/27/2023 for an approximately 3x4cm centrally ulcerated and fungating mass, which encompassed the right nasal ala, with a partial intranasal component, and expanded along the dorsum with pearly edges and hypervascularity. The patient reports that the lesion has been slowly enlarging for 3-3.5 years, becoming increasingly pruritic and intermittently bleeding. He noted that he had been caring for the lesion by applying rubbing alcohol and Iodine. The patient denied any localized pain, fever, chills, night sweats, unintentional weight loss, neck mass, enlarged lymph nodes outside of the head or neck, odynophagia, dysphagia, globus sensation, voice changes, cough, hemoptysis, shortness of breath. The remainder of his review of systems and physical examination was unremarkable. The patient noted that the lesion developed on a wound he received after being assaulted while incarcerated.

The patient is uninsured and lives with a caregiver/social worker and finds casual work as a handyman, taking jobs a roofer/carpenter mostly. He was noted to have extensive gaps in his healthcare maintenance, including missed screenings and vaccines. The man reported that he did not seek medical advice and treatment sooner because he felt neglected during his prison stint, stigmatized and isolated by his community upon his release, and confused by the complicated health insurance process.

This man was referred to have his management coordinated between the campus dermatology and ENT-oncology departments. Over the next three days, the patient underwent a punch biopsy and CT-neck and chest to evaluate for nodal involvement and given his history of chronic tobacco use. Pathology showed the lesion to be a basal cell carcinoma and imaging demonstrated a soft tissue mass involving the right lateral nose without evidence of underlying bone destruction and a 5 mm soft tissue density pulmonary nodule within the right middle lobe.

With an expedited evaluation and interdisciplinary collaboration, over the next two months, the patient underwent excision of the basal cell carcinoma and complex nasal reconstruction with subsequent staged repair.

Figures 1-2. Pictures of patient's chronically untreated basal cell carcinoma



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