CPD (CASE MANAGEMENT REPORT)
Title: FOREIGN BODY IN THE EYE OF A VILLAGE CHIEF: CULTURE SENSITIVITY IN PATIENT MANAGEMENT

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Declaration of Conflict of Interest
I declare that I have no financial or personal relationship(s) which may have inappropriately influenced me in writing this paper.

Abstract
This was a case report of a village chief who had foreign body in the eye while performing obligatory cultural activities. It highlights the need for patient centredness and attention to patient's cultural background in order to achieve optimum cooperation and satisfaction in outcomes.

Case Report
I.A. was a 60 years old Amo village head and farmer who was brought in by his sons to the accident and emergency unit with complaints of foreign body sensation and redness of the left eye of one day duration.
He was participating in a cultural display in his village when he suddenly felt a foreign body sensation in the left eye, associated with redness and increased lacrimation. There was associated visual impairment of the left eye due to discomfort caused by the foreign body sensation. There was however no bleeding, eye pain, eye discharge or fever.
It was an annual two-day cultural festival of his village held in the harvest season where celebrations were made in thanksgiving for a bumper harvest. It involved throwing residues of burnt maize husks into the air amid loud singing, vigorous dancing and merriment. He, as a village chief, was leading the dance when he felt the symptoms above.
He suspected the maize husk residues must have entered his eyes and had other people blow into his eyes and also used water to wash his eyes in order to clear out the foreign body, but it was not successful. He also used an unnamed eye medication from a drug store with no improvement. The symptoms prevented him from continuing with the celebrations and having a sound sleep necessitating his presentation to the hospital. He hoped to get treatment from the hospital in time to participate in the rest of the ceremony.
He had no other symptoms and no known co-morbid illnesses, and did not use visual aid.
He was a farmer and the village head of his community. He had no formal education, was married to two wives, and had 13 children with most of them having left home to get married or pursue various trades. They, however, maintained close family ties.
They lived in a 6-bedroom apartment. Their source of drinking water was the village bore hole and sewage disposal was via a pit latrine. Average family income was approximately 75,000 naira monthly and his healthcare financing was out-of-pocket.
He was a Christian but only attended church occasionally attributing it to his tight schedule from community engagements. He saw himself as a custodian of the culture and tradition of his people. He drank about 42 units of alcohol weekly but did not use tobacco in any form.

Examination revealed a patient in some discomfort, repeatedly blinking his left eye. He had an axillary temperature of 37.0°C.

On eye examination, his visual acuity was 6/6 on the right eye and 6/12 on the left. He had normal ocular movement. His eye brows, eyelids and lashes were normal. There was increased lacrimation of the left eye with generalized conjunctival injection and a tiny black oblong object located on the left upper palpebral conjunctiva. There was no swelling or thickening of the conjunctiva. The corneas were clear and anterior chambers were of normal depth. His pupils were about 3mm in diameter and reacted to both direct and consensual light reflex. The lenses were transparent and intact. The fundi were normal.

Other systemic findings were normal.

A diagnosis of left red eye due to retained conjunctival foreign body was made and allergic conjunctivitis was considered as a differential diagnosis.

The diagnosis, plan and procedure for removal of the foreign body were explained to him. He was reassured, and anxiety allayed. He was told that the object did not seem to have caused any serious injuries and could be removed safely from the eye, but he might experience some discomfort during the procedure. He gave verbal consent for the procedure.

A drop of Amethocaine solution was instilled into the left eye and the left upper palpebral conjunctiva was exposed by everting the upper eye lid. A small piece of burnt residue and a grain of sand were found at the upper palpebral conjunctiva and removed using a wet cotton-tipped applicator. The left eye was then irrigated with Normal saline, he rested and was observed for an hour. He felt much better afterwards. The possibility of avoiding such an environment where missiles and dust particles were deliberately thrown into the air was discussed with him. He acknowledged the dangers of such an environment but revealed that it was the custom of his people hence he, as the custodian, could not stay away from it or support any move to stop it. He was then educated on different measures to prevent foreign bodies in the eye to benefit both himself and his community including wearing protective eye wear when in such an environment and encouraging people to only throw the dust away from people rather than into them. These modalities were acceptable to him and he promised to implement them. He was also counselled on general health and wellbeing.

He was discharged home on Penicillin eye ointment, once daily for five days and was given one-week appointment.

He had an uneventful follow-up with disappearance of all symptoms. He was then discharged from clinic.

Discussion: Red eye is one of the most common ophthalmologic conditions in the primary care setting and conjunctivitis, foreign body (FB), trauma, episcleritis, subconjunctival haemorrhage, glaucoma and uveitis are among the most frequent causes. In the index case, the non-recurrent nature of his symptoms and a direct visualization of the foreign body made conjunctival foreign body a more likely diagnosis than conjunctivitis (allergic and infective) which is the commonest cause of red eye. It was found lodged on the palpebral conjunctiva away from the cornea with no affectation of his vision and had normal intra-ocular findings. Extraocular foreign bodies such as this are usually caused by splinters of wood, dust, coal, grains of sand and seed husks as seen in the index case. They can be removed under direct vision and irrigation, followed by prophylactic topical antibiotic cover, as was done for the index patient. If the foreign body was intraocular or affected vision, ophthalmology consultation would have been necessary. The procedure is inexpensive and was easily affordable to him considering his use of out-of-pocket financing.

The main risk for FB in the index patient was his participation in the cultural ritual of throwing dust in the air in celebration of the harvest season. The optimum modality to reduce the morbidity from foreign body in the eye is prevention and should involve stoppage of the ritual or his removal from the risky environment completely.[5] He, however, declined these modalities. These risk elimination strategies would indeed be very difficult for him, the traditional leader and defender of his culture, to agree to. They are at odds with his culture and would not gain his cooperation, leading eventually to poor adherence.[5] By communication, negotiation and shared decision making, alternative techniques that may not eliminate the risk but would mitigate it to a large extent were agreed upon. These were culturally acceptable alternatives that would help reduce his risk of having foreign body in the eye without violating his culture. This respect and consideration for his culture would assure his full

participation in the management of his condition and hence increase the likelihood of his adherence. Patient-centred consultations showing these sensitivities improve the patient-doctor relationship and make for a more satisfied patient.

The Family Physician, and indeed every doctor seeing a patient, should understand the cultural background of the community in which he practices. He should take this into cognizance in patient management to ensure that treatment options proffered are socially and culturally acceptable in the spirit of Primary Health Care. The temptation to force an option on the patient should always be resisted. As a team player, the patient is an equal partner in care delivery. Negotiation, patient-centeredness and shared decision making should be employed in dealing with culturally sensitive cases such as the index case. This will aid arrival at treatment decisions that meet patients' needs and ensures their satisfaction at the end of the consultation.

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