The perils of being a patient…

Sharing the most important lessons that I learned in medical school from the other side of the stethoscope

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MS4

Overview

- Case presentation
- Lessons in bias and clinical decision making
- Lessons in communication
- Lessons in empathy
- Practical take-aways

Case presentation

- 25 year old female, second year medical student, with no significant past medical history
- 4-6 weeks of gradually worsening low back pain
- Increasing difficulty initiating urine stream over approximately same time frame
- Heat/anti-inflammatories/Tylenol/muscle relaxer from PCP
- No previous ED visits

Case presentation… the night before

Chills

Acute worsening of pain

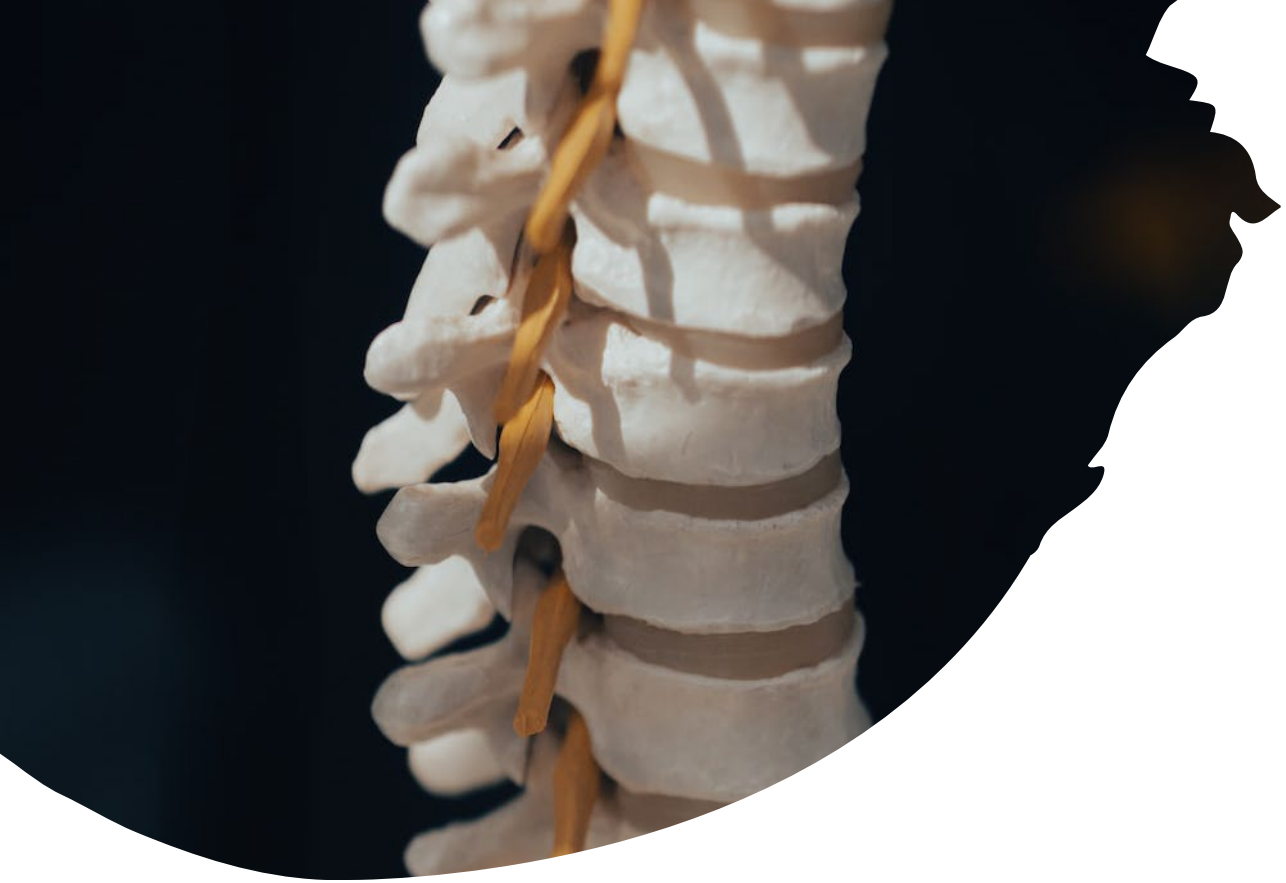
Unable to urinate

Case presentation… worst day of my life

- Acute exacerbation of pain requiring mobility assistance
- PCP contacted via phone
- LOC causing fall onto bathroom floor
- Unable to stand/move for 8 hours after fall due to pain
- Large doses of anti-inflammatories and Tylenol
- Driven to ED and dropped off

Case presentation… in the ED

- Afebrile and vitals otherwise unremarkable
- Triaged to low-acuity room
- Normal ECG
- IV Toradol administered
- 5/5 strength plantar and dorsiflexion
- Mild tenderness over lumbar region
- WBC >15,000 w/ 95% seg, lymphs 1.1%
- Normal lumbar x-ray, no other imaging
- Seen by NP, pharmacy student, attending
- Discharge challenges



Case presentation… After the ED

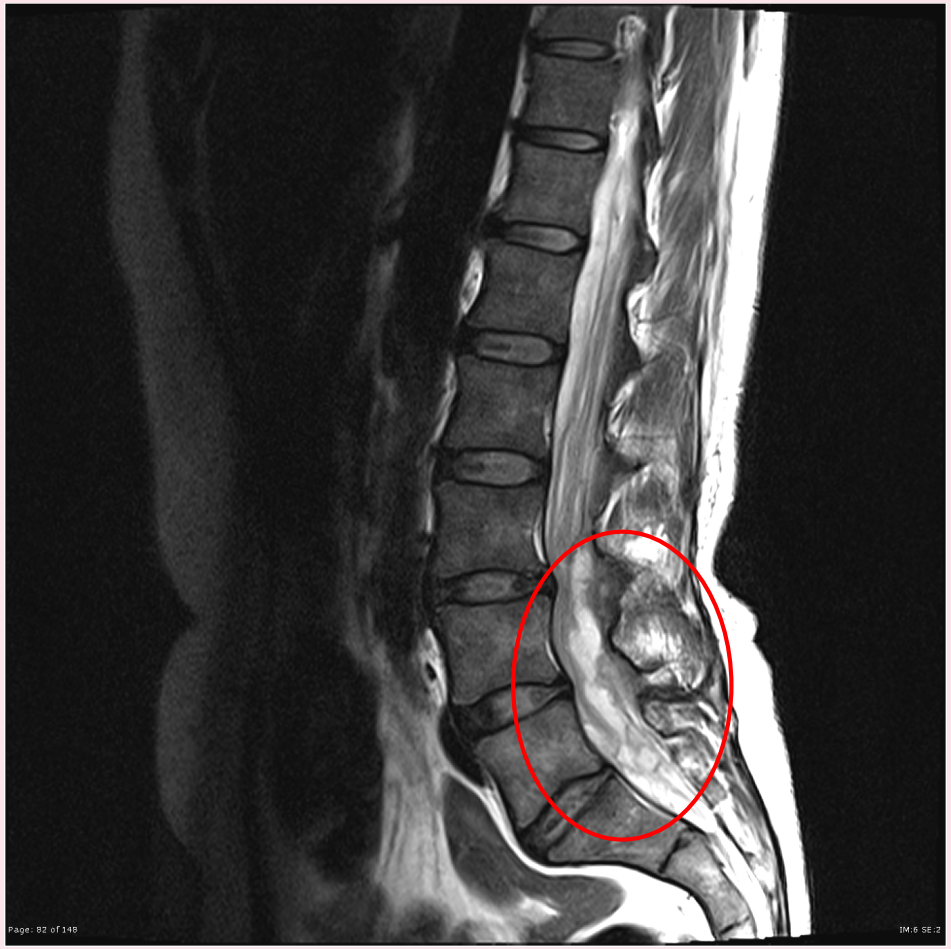
- 3 days of full-time caregiving
- Multiple PCP calls for uncontrolled pain
- Drove home to Michigan
- New neurological symptoms
- Acutely worsened pain

Case presentation… Second ED

- Gave my history “presentation style”
- Name dropped
- Emphasized neurological symptoms

Diagnosis and Outcome

- Epidural abscess with L4/L5 facet joint osteomyelitis and bacteremia
- Emergent laminectomy
- 5-day hospitalization
- 6 week course of IV antibiotics (via PICC)
- Full recovery approximately 5 months later



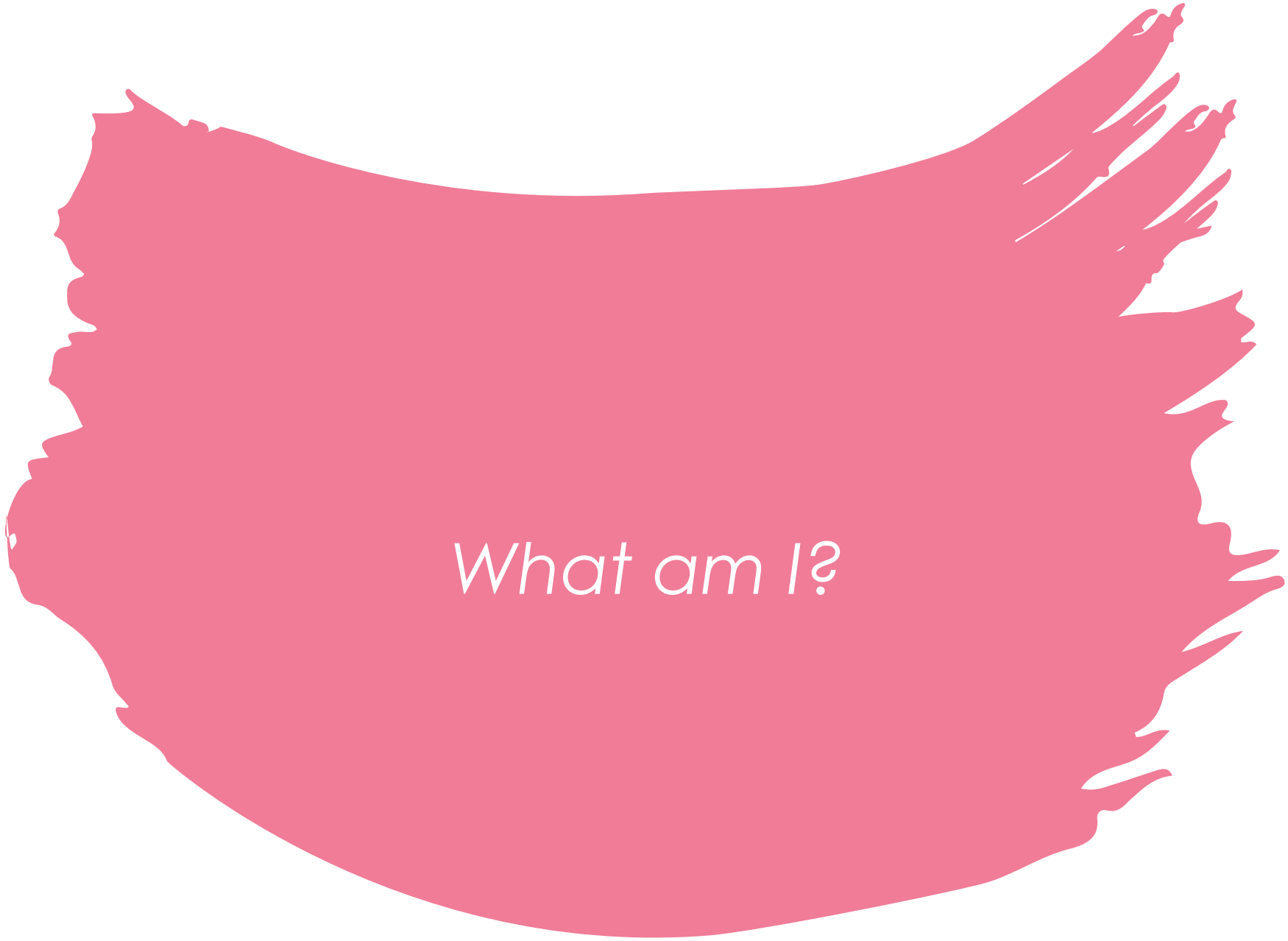
Case courtesy of Frank Gaillard, Radiopaedia.org, rID: 35584

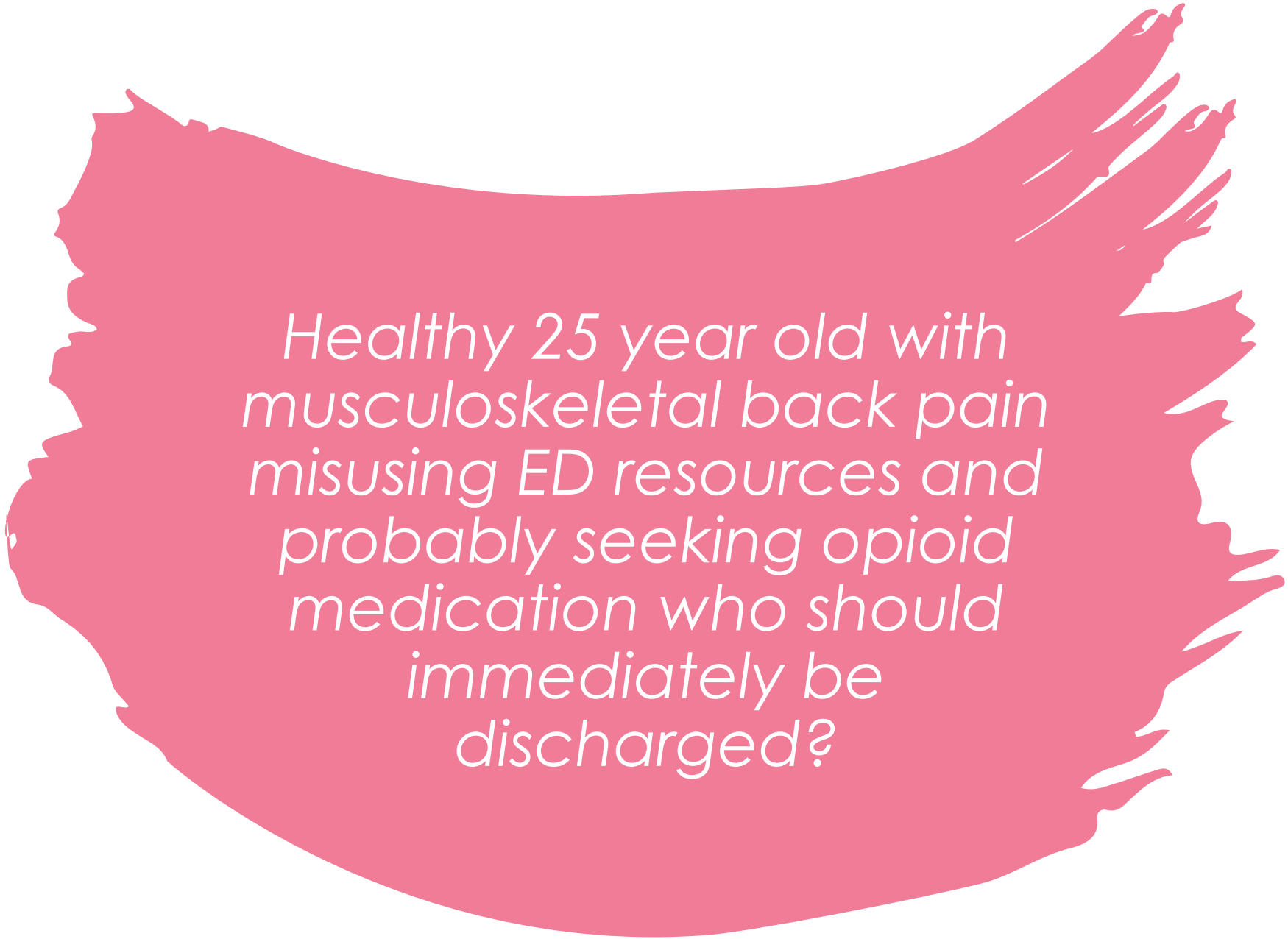
Bias and Clinical Decision Making

- **Recency bias**
  - Probably recently saw MSK back pain in this same environment
- **Availability heuristic**
  - More examples of non-emergent back pain
- **Confirmation bias/anchoring**
  - Young female with no PMHx
  - Able to ambulate
  - Coping prior to arrival
  - Seen by APP prior to supervising physician without attending follow-up interview

What was overlooked?

- Low back pain with urinary retention
- History of chills and syncope in previous 24 hours
- Possibility of fever masking due to overuse of antipyretics
- Elevated WBC with 95% segs, NLR 86.6
- No history to suggest drug seeking behavior, only regular follow-up with PCP for preventative care
- No request for opioid medication


What am I?


Healthy 25 year old with musculoskeletal back pain misusing ED resources and probably seeking opioid medication who should immediately be discharged?

Patient with back pain associated with urinary retention and fever, as well as laboratory evidence of a bacterial infection who requires further workup and urgent MRI imaging?

Communication… The script isn't enough

- **"80% of diagnoses can be made by history alone."**

- Red flags are not always obvious

- Most patients don't speak medicine

- Patients can read you

Maintaining Empathy

- Healthcare delivery is traumatic
- Face time matters
- Families are needy… and that's ok
- Their priorities may not be your priorities

Practical take-aways

Communication

- Ask things in more than one way when it's important
- Decide in advance to believe your patients
- Avoid judgement

Empathy

- Empower nurses
- Be considerate with orders
- Don't rush away/Circle back
- Give grace


Questions?

Bonus clinical pearls- Spinal Epidural Abscess

- Not everyone has a thermometer and subjective fever/chills may be all you have
- Antipyretics can mask a fever
- Fever may be present in only 55% of patients[2]
- Classic triad (pain, fever, neuro deficit) only present in 13% of patients[1]
- 68% of SEA patients have a normal exam[1]

Bonus clinical pearls- Spinal Epidural Abscess

- "Back pain may be indolent and non-focal for several weeks, and then advance to severe, localizable pain with radicular features prior to onset of cord compression and paralysis"[2]

- In tough diagnoses, consider graduated workup for risk stratification (in this case inflammatory markers)[2]

- Quantify how much Tylenol people are taking and consider screening for liver pathology

References

Peterson MC, Holbrook JH, Von Hales D, Smith NL, Staker LV. Contributions of the history, physical examination, and laboratory investigation in making medical diagnoses. *West J Med*. 1992 Feb;156(2):163-5. PMID: 1536065; PMCID: PMC1003190.

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