PATH TO DIAGNOSIS: PERSPECTIVE

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Dear Editor,

Medical schools beds are filled with many a difficult cases, so much so that the new clinician is more able in the treatment of diabetic ketoacidosis, then managing diabetes itself. The path to those difficult diagnosis is presumed as an eventuality of hospitalization, consequently, when things aren't clear about diagnosis, the clinician invariably insists—hospitalization. Outpatient (OP) based pursuit of such conditions is an 'unknown territory' to a medical student and clinicians alike.

A proper history[1] although emphasized, in practice, it takes the following two directions: letting it pass (LIP) approach, that is, waiting it without listening till the presumed noise is over, or, not uncommonly frequent interjections by the clinician with clinically loaded paths the moment the opportunity arises in the 'history' process. Such methods although dilutes the clinical sense, allows the clinician to make his way through the volume of patients.

Medical science remains imperfect since its inception, yet perfect doctors [2-6] have been produced by the system, ironical it may sound but 'imperfection' had been the edifice for such perfection. Science may have failings but the man in the science [2-6] had always means to pass through it. In clinical practice an attendant's description of history is considered 'burden' akin to a one-plus-one commercial offer. The mothers words in the description of adolescents illness is considered unworthy of attention at best, at worst a nuisance. Nevertheless, the most crucial information can be imparted by parents (the first physicians).

Described herewith is the path of diagnosis whereby adherence to basic clinic etiquettes allows a clinician to reach an extremely rare diagnosis, eventually preventing prolonged hospitalization.

An otherwise reasonable looking boy came along with his father to the OP, the father demanded attention by his demeanor more than his words. I 'moved on' from listening-to-listening, he frequently said a lot by both his manners and words, both had a profound impact on me—I heard nothing. I moved on to the next patient, and he came with the reports. Again to my chagrin, he narrated the whole episode, with the same impact on me. I wrote some prescription, when the episode had formally ended, it appeared to me that his jeans were unduly falling down, I immediately diagnosed it as 'fashion' and kept it to me. I could have kept my eye's down and got on coldly to business as usual mode, but I felt the story teller (the father) would be tired by now, and I cannot be harmed any further. I wanted to see them off with a smile, the father again initiated the process and I was about to 'switch off', but this time luckily he touched the matter of my observation—the jeans, and I was waiting to say the concluding words 'fashion'. Alas! I said: "fashion", the father said that this used to be a fit jeans, not long ago, and further added: signifying exactly what he meant to say by the repetitive use of the word "weak" since morning.

I re-examined the X-ray Chest, although still looking absolutely clear, I took my time, the father mean while continued to say all over again, probably for the fourth time, my ears got 'on' this time. He informed that the son remains in 'hostel' and they thought that his 'weakness' is due to that, but notwithstanding that diagnosis, the father observed that in night when his son is in deep sleep, he gets 'quiet hot' almost having high grade fever and in morning the son is active again as if the day took away the problem as it can from the gloominess of night. It clicked me, evening (although night here) rise of temperature (EROT), I kept listening and looking busy as I had done it on multiple occasions since morning, only that now I was analyzing and appreciating a thorough workup the father had done, the different disease entities he had ruled out and pursued with his clear and concerned mind.

Now having important medical clues: EROT, weight loss, and suddenly a possible paratracheal shadowing on CXR, a mild raised ESR; I went with HRCT Chest, the father had 'means' and was pleased with the time the doctor had devoted to them, complied with and came with the film and report in the evening. The report read: rule out small blue round cell tumour, multiple vertebral lesions and sternal lesions including ribs.

I kept my stunned mind dissociated from my countenance (pretending to appear professional) and said the boy to lie down on the examination table (for the first

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time), said him to disrobe (for the first time). I could see an emaciated boy, there was lymph node palpable prominently on the left cervical chain. I planned for a referral, but to whom? Which specialty? What is the boy's primary diagnosis? I wanted to do a cervical lymph node FNAC, but would it be worth the wait, am I going to do away with the workup of a malignancy considering the paper evidence of report suggesting it so strongly. The mind of the clinician was having a field day. I kept the CT for myself on request, which the father happily handed over and said him to meet me tomorrow for further guidance. He wanted to know: "is everything OK", I smiled and holding his 'hand' said: "it is".

I went through medical literature that night and the next morning, wanted to match the CT finding (unmarked in the film and hence unknown to me) with the literature, went through multiple themes of 'search' and by the time I started the routine again the next morning things remained unclear. Among other waiting patients the father brushed his way in, the receptionist and the OP managers weren't happy, but I obliged and gave my number informing him to report me the proceedings at 'all times' and 'not to worry'. His own brother in law was a radiologist, and when he came to know all that, expectedly things changed course.

But I had taken a promise from the father to report me at all times, the next morning the father reported, said he is waiting for his sons turn for "PET CT", he couldn't heed me anymore. The 'C-Fear' had gripped him. I said him to take the PET-CT report and approach the pulmonologist, I wanted koch's as the diagnosis, I had figured out the CT earlier in the day (it just clicked), it looked like multifocal skeletal tuberculosis (almost exactly), I didn't want him to move from "C" to "T" (cancer to tuberculosis), but the other way around if it was to be the C. I risked. I had left the defense (defensive medicine [7]).

I called the pulmonologist, he wanted to rule out cancer first, in that case: from where to take the biopsy. I tried to force my way, but what was my way? What does a primary care physician has any way? I offered to him the lymph node, withholding the invasion of bone for the time. I wanted koch's, like I would have any my own close friends. I wanted.

The lymph node was heeded with, GeneXpert turned out to be positive, he was initiated on ATT and discharged the next day, the orthopedic advised for utmost caution, lest the vertebral collapse risked the spinal cord. The child fortunately had no drug reaction to it, and as is the rule with 'repetition'—days passed away soon. The Multifocal tuberculosis/Multifocal spinal tuberculosis got healed for the boy.

A parent is the first physician in the event of a Child's illness, ignoring them and brushing them aside by a presumed scientific background on part of clinician and lack of it in the parents can have serious drawbacks. The physicians journey has always been the journey into the 'unknown' and as any frequent traveler knows to move through an unknown path a local help is the best ally, in a clinicians case the local help is the wife, the mother, the parent, the friend. The very many whom we try to put mute at the very initiation of our diagnostic path. Not surprisingly our path to diagnosis is frequently tortuous.

CONCLUSION

The practice of medicine needs special skills which goes beyond the science of it. A patient listening of patient complaints (however irrelevant it might appear at the outset) and insightful pursuit in the desired direction of patient care allows the patient to feel they are cared for and simultaneously allows the proper usage of health care. Health care primary role remains to apply itself for patient welfare. The first step to it is a thorough listening of patient complaints or otherwise; followed by a thorough physical examination. Even in this age of immense diagnostic advance, patient and their seemingly 'irrelevant methods' remains the best teacher to the physician.

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