The Optimist

Vigilance and Valetudinarianism

"I've got this pain in the pit of my stomach," a pleasant 77 year old told me a while back. "None of the doctors can find what's wrong," she continued, "and they seem terribly concerned." Always wary of the patient who disparages previous care, I felt my spirits sink just a little. After the usual badinage that I find sets up an informally human approach (I never wear a white coat, either), it was clear that her abdominal pain had little relation to gut function, either to eating or to evacuation.

It had come on first after a heart attack six months before, when she had undergone dilation and stenting of her cranky coronary arteries. Ischemic bowel disease from cholesterol emboli, the specter of pancreatic cancer, and other dire possibilities had all been excluded by her physicians, but the pain continued unabated.

As we talked, the patient sadly related all the restrictions that had assailed her after the heart attack. No longer was she allowed to eat salty or fatty foods, and in place of her customary breakfast sausage, she took five or six medications. She and her 77 year old husband, as caring as he was robust, had been enthusiastic travelers, but now their physician had advised them to stay close to home in case she needed help in a crisis. They were both bewildered by her persistent abdominal pain.

Much of my patient's abdominal pain seemed to me to stem from her depression at the change of her life, or "life style," as one now says. I described my own disgust with low-salt bouillon after my cardiac operation some years ago, and with her husband, we laughed about the conviction of cardiologists that people could live forever if only they were careful about "healthy" rules. We praised the blessings of a sudden death and the quality of life over its quantity.

I made some suggestions, not all according to the modern canon, and we parted. I do not know whether our conversation or the antidepressant medications I recommended helped, but the exchange raised one more question about the therapeutic zeal of our time.

Heart attack patients in the 1940's lay in bed for three or four weeks, fed by nurses spoon by spoon, in a therapeutic caution that must have generated many a cardiac neurosis, but today's doctors add to their patients' anxiety by following one diagnostic test with another, to "pinpoint" the cause of abdominal or chest pain. It is one thing to confess, "I doubt that much is wrong, but a few tests will make us both feel better." It is quite another to warn, "Let's get some tests to see what's wrong," an approach that drains the diagnostic cornucopia but begs for an answer. When there is none, the patient is still left with foreboding.

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"Ageism" is now allegedly illegal in the United States, but physicians should still take age into account. A friend and I foresaw the rise of hospitalists when we suggested many years ago that older physicians should work in outpatient clinics or offices while younger doctors were more suited for hospital work, given the burgeoning of technology. Old physicians, their perspective less distorted by the technological imperative, know that many complaints disappear with time and reassurance.

Old physicians do deserve a place in intensive care units, not horizontal as patients but vertical as friends, to ask questions about why some things are done, and as guardians, to make sure that physicians there talk regularly with the families. No one quite shares the perspectives of the elderly as well as physicians of the same vintage. Younger doctors learn empathy, but there is little substitute for the shared partnership of survival. Yet in 1999, the young rejoice to teach the old in the delusion that experience brings only anecdotes.

Over the past 50 years, technology has changed the character of hospital and medical practice. A while ago I saw the portrayal of a gastroenterologist gowned against blood and masked against AIDS, the flexible scope draped over his shoulder as the up-to-date symbol of our specialty or of our technology. The ears of the endoscopist were not plugged, but they might as well have been, for few listen any more.

"The eye is for accuracy, but the ear is for truth" is an aphorism I have never been able to trace, but it is one I hold dear. With so much visual data to scan, more than ever physicians must try to be mediators between the images and our patients. I need to find out whether the description of abdominal pain makes me think of an ulcer or biliary colic, or whether, as so often, the pain is simply "there," unrelated to gut or bowel function, persistent but unpredictable, like that of the woman I described earlier, and if that is the case, I suspect its origin somewhere beyond the belly.

When the pain seems unlikely to have a gastrointestinal origin, I look to neuromuscular problems,

especially for Carnett's sign of abdominal wall tenderness mistaken for abdominal pain, in the recognition that not all belly pain comes from inside the peritoneum. I do look to other stimuli as well, for what to the gastroenterologist the patient calls pain may be sorrow to the psychiatrist or suffering to the priest.

The ease of the laparoscopic procedure has led to many a "diagnostic" cholecystectomy for unexplained abdominal pain, to test whether the gallbladder with stones might be the source of belching, heartburn, or other qualms. Should abdominal pain recur or worsen after operation, there is so much more the gastroenterologist can do that will not help.

More than a few such patients have ended up with several ERCP's, one after the other by different experts ("let's see what *I* can find"), sphincterotomy following balloon dilation, and stents in the pancreatic duct. Those who listen to such luckless patients are often convinced that their pain never did resemble biliary colic, so it is hardly surprising that taking out the gallbladder did little to dissipate the complaint.

The new "pathway" approach to a complete evaluation also enhances the perception of abdominal pain by fostering vigilance. The ideal of "completeness" has gone through three stages in my professional lifetime. The first, which I learned as a medical student, was the complete physical examination. Once having missed a coarctation of the aorta, let us say, a physician was unlikely ever again to fail to feel for the dorsalis pedis artery.

Automated laboratory procedures ushered in the second stage of completeness in the 1960's. The numeric display led early to an epidemic of hyperparathyroidism in New Haven County and to the loss of quite a few pituitaries for "prolactinoma" until physicians learned the wide range of normal values that screening brings.

The third stage, complete imaging of the body, came along about 20 years ago and has not peaked. "Get the data and then find out what's wrong with the patient" seemed to be its watchword.

The pathway approach, once denominated algorithmic, scorns probabilities or likelihoods and lays out the route to diagnosis without regard for specific patients. The 35 year old physician who develops nonspecific abdominal pain when she hears her lawyer husband opening the garage door might not want to indict the marital relationship and so has her choice of subspecialists to consult.

The urologist will tell her of "interstitial cystitis," the gynecologist of "endometriosis" or an "ovarian cyst," while the gastroenterologists after wielding the colonoscope will call for a high-fiber diet, rejoicing in the diagnosis of "spastic colon." All are sure that pain must have a site somewhere in the body, and to a colleague they will avoid any discussion of trouble at home.

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That specialists do what they are trained to do because they are paid to do so seems obvious and even sensible. "My job is to rule out disease," a friend once asserted, "not to worry about the patient's nerves." The urge to do tests for which payment follows is reinforced by the need for certainty, which has grown almost obsessively with malpractice litigation. Then, too, there is a surfeit of diagnostic studies waiting to be done.

Certainty comes at more than a monetary cost, for it raises the level of vigilance in the patient. Some people, especially those of an artistic sensibility, have always been known for oversensitivity to their internal workings. Once called valetudinarian, they are accorded the diagnosis of "heightened visceral sensitivity," but they can hardly be blamed for paying increased attention to their abdominal sensations when doctors torment them with doubt and raise the level of their vigilance by doing one study after another.

Anesthesiologists have given us a clue, for they have learned how to reduce postoperative pain by employing what they call "preemptive analgesia," preventing pain impulses from an operation from ever reaching the cerebral cortex or even the spinal cord by giving pain relief before even the first incision. Preventing such pain lowers the amount of drugs needed for postoperative relief.

Most of us doctors have had to deal at some time or other with patients who have phantom limb syndrome. In my own field, I have become convinced that there is a "phantom organ" syndrome as well, thanks to a number of patients whose abdominal pain persists after a diseased organ has been removed. I attribute that to their vigilance about abdominal pain more than to a lower threshold for pain in the spinal cord, and I accept it as the cost of helping the patient with, for example, Crohn's disease.

My point in all this is simply that enough is enough. After listening to the patient, do the simple things that are called for. Then try reassurance and suggestion, enlisting, may I say, the power of hope.

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