Gastrointestinal Symptoms

CLINICAL INTERPRETATION

BERK
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To our teachers, colleagues, and students
—and especially to our patients—
who taught us to appreciate the value of the matters
that are the concern of this book.

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History Taking: The Art of Dialogue

PREFACE

"Listen to the patient—he will tell you the diagnosis." Wise indeed was this admonition of a medical sage of yesteryear.

Patients consult a physician because of symptoms that are distressing or worrisome. Still to be devised is a machine capable of competing with a perceptive and astute physician in eliciting, understanding, and interpreting these symptoms. Yet, detailed solicitation and precise description of what actually troubles the patient seem all too often to be given short shrift. Insufficiently appreciated as well is the fine distinction between a "symptom" and a "complaint." Witness, for example, the woman who uncomplainingly endures heartburn for years, even neglecting to mention it (unless or until specifically asked) when driven to consult her doctor because of difficulty swallowing. She has had a "symptom" (heartburn) but for her it is not a "complaint." Consider similarly the man who placidly pursues his daily chores despite a liver riddled with cancer from a previously resected cancer of the colon. He clearly has "disease," but is not "ill" and is not complaining. In contrast is his neighbor, a woman with an irritable bowel who tells all who will listen (including, on innumerable visits, her doctor) of her torment. The neighbor has an abundance of symptoms, all uttered as complaints, and considers herself ill, as indeed she is in the sense that there is disturbed function of a bodily structure. Although she is in no real jeopardy, her subjective response to the derangement renders her pitifully distraught. These simple examples illustrate that, as physicians, we have a good deal to sort out in evaluating our patients.

All of us who undertake to solve clinical problems, perhaps especially those involving the digestive system, have come to rely heavily on the laboratory, imaging methods, endoscopy, and other special techniques that aid us in

establishing our diagnoses. We are grateful, of course, for the advances in technology that have engendered these resources and enhanced our diagnostic prowess. There are times and circumstances, however, wherein we may become unduly reliant on such tools to furnish a diagnosis. It is all too easy to succumb to the fallacy of "5 minutes of history and 5 days of tests." A purposeful effort to elicit a thorough history often can guide us to a more discriminating choice of tests or narrow the need to fewer tests. Attentiveness to the patient's complaints, and ferreting out unproferred associated symptoms, fortified by a careful, informed, and perceptive analysis of the information so obtained may well, in the long run, save time, conserve valuable resources, reduce risk, and lessen the cost of diagnosis.

Concern about these matters, and a desire to reawaken interest in them, motivated the preparation of this book. The primary aim is to reaffirm the fundamental role of clinical symptom evaluation in the diagnosis of gastrointestinal disorders. To this end, the component chapters center on the thought processes that the clinician follows in seeking to elucidate and assess the complaints presented by a given patient. Concentration is on clinical diagnostic evaluation, based on the history and physical findings within the setting of the office, the clinic, or the bedside.

Initiated by a discourse on history taking and the art of dialogue, the chapters that follow deal with the principal symptoms or physical changes that relate to the digestive system. The nature of these symptoms, or such alterations as jaundice and ascites, makes rigid uniformity in presentation neither possible nor desirable. In each chapter, however, the underlying mechanisms, the clinical features, and key clinical pointers that may help in eliciting and interpreting a given symptom are stressed. Brief mention is also made of more objective studies that may confirm or exclude the impressions formed from clinical analysis alone. Wherever suitable, illustrative cases are narrated to highlight and underscore important elements.

The contributors of the component essays are all seasoned gastroenterologic clinicians who share in common a deep appreciation of symptom evaluation in the diagnostic process. If their expositions should succeed in directing attention to the need to probe, analyze, and interpret symptoms arising from digestive disturbances, the purpose of this work will have been most gratifyingly met.

To our colleagues who so kindly contributed to this work, we extend our thanks for their willingness to share their knowledge and experience. We are grateful to them as well for their gracious responses to the many requests we made of them.

We also wish to acknowledge our indebtedness and express our gratitude to Ms. Mary Mansor, Medical Editor, B.C. Decker, Inc., for her unfailing encouragement and sage advice.

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William S. Haubrich, M.D.

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HISTORY TAKING: THE ART OF DIALOGUE

Stewart G. Wolf, M.D.

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History taking, the initial step in the patient–physician encounter, perhaps more than any other aspect of the diagnostic process, differentiates the highly skilled physician from his or her more plodding and less perceptive colleague. History taking is a high art that must be carried out in such a way as to enable the patient to respond to questions in a frank and unguarded manner. He or she must be made to feel safe and reassured that, no matter what is said in the doctor's presence, there is no danger of censure, ridicule, or betrayal. Through the dialogue, the physician's ears and eyes must be alert to subtle and fleeting cues that may illuminate the patient's account of the illness and thereby lead to relevant directions of diagnostic inquiry and to helpful tactics in therapy.

I have often asked consultants what enabled them to arrive at a correct diagnosis that had eluded the referring physician. Nearly always, the crucial clue had come from something the patient had said or the way in which he or she had said it.

Today, gastroenterologists can make a positive tissue diagnosis in a very large proportion of digestive system lesions through endoscopy or biopsy. The decision to carry out these invasive and uncomfortable procedures, however, should be guided by the findings of a thorough and penetrating history. Moreover, the history may add etiologic evidence to an otherwise purely anatomic finding. Also, as it facilitates understanding of the patient, the history may provide valuable leads to effective treatment and recruitment of the patient as a cooperating partner in the therapeutic plan.

Establishing Rapport

Skill in gaining a patient's confidence is not merely a matter of technique. It depends on the physician's personal qualifications, interest and belief in people, and ability to give encouragement and support even in the face of the patient's intransigence or hostility.

Success or failure in communication often depends heavily on the patient's initial impression of the physician. Repeatedly, one hears patients say of a physician, "He's such a busy man that I didn't want to burden him with my troubles" or "He didn't have time to talk to me." The physician who, even unintentionally, has given the patient such an impression has placed himself or herself at a disadvantage and has perhaps denied himself or herself important diagnostic data.

> *"History taking is best done in private, without interruption, and by the physician."*

Other reactions to an encounter with a physician were "I was a little afraid of him" or "He didn't seem interested" or "He seemed to be having troubles of his own." These remarks imply, of course, a defect in the attitude of the physician who was unable to put the patient at ease and inspire his or her confidence. Confidence and trust are fostered when history taking is done in private, without interruption, and by the physician himself or herself. Furthermore, subtle and valuable clues to the diagnosis often emerge in the initial encounter. Perceptions and intuitions honed and refined by training and experience can be processed by no computer other than the human one—the physician's brain.

The history is a useful device for getting to know and understand the patient, but its main purpose is to evaluate evidence that may lead to a correct diagnosis and may help to guide therapy. The history is not an exercise in serial questions and answers; on the contrary, it is an instrument that can be effectively applied only in proportion to the skill of the physician. Simply asking all the prescribed questions will not necessarily provide useful clues to the patient's problem. The history should take the form of an inquiry in which one piece of information leads to another. Although the process of history taking must be thorough, there is no such thing as a complete history. Each history differs from every other, depending on the nature of the patient and his or her illness. The history remains the most powerful diagnostic tool because diagnosis is still in essence an intellectual process, an exercise in clinical analysis. Technical aids can be of enormous help but cannot replace the physician's perspicacity and reasoning power. To supplement effectively his or her radiologic and electronic diagnos-

tic tools, as well as his or her endoscopes and imaging techniques, the physician must know how to elicit as well as to evaluate pertinent historical data.

Medical curricula once required students to refine the diagnostic possibilities by a penetrating analysis of the clinical data, allowing only a parsimonious approach to laboratory testing. Today, however, it is common practice to order occasionally irrelevant, often costly, and sometimes arduous and uncomfortable diagnostic procedures on the outside chance that "something might be picked up." The very multiplicity of tests in such a diagnostic strategy increases the opportunity for error and the risk of accident. Appropriate sophisticated tests and procedures many times are indispensable in confirming a correct diagnosis; however, just as often they are not needed at all. Premature testing without adequate attention to the data directly available from the history and physical examination is always wasteful and may actually derail the diagnostic inquiry.

The following case illustrates the baneful consequences of substituting tests and referrals for the traditional dialogue with the patient.

Illustrative Case

Mr. Taylor was 56 years old when he became concerned about discomfort in his upper abdomen, mainly on the right side. He was not sure how long he had felt it, but it seemed to have been getting more troublesome recently. "It was not exactly a pain," he said, "more of an aching or a sense of fullness." Occasionally he would be nauseated after meals. Nothing of significance was elicited by review of his previous medical history except for periodic episodes of urticaria over the past several years. Mr. Taylor worked in an editorial office of a newspaper, had not traveled outside of the United States, and had no known contact with tuberculosis, toxic chemicals, or other suspicious environmental agents.

> *"Studies made without attention to the data obtained from the history and physical findings may derail diagnosis."*

Physical examination disclosed slight icterus, a fever of 100°F, slight tenderness in the right upper quadrant, and an indefinite right upper quadrant mass that was thought to be either liver or gallbladder.

The attending physician ordered a urinalysis, a complete blood count, liver function tests, and a radiographic examination of the gallbladder. The urine revealed no abnormalities, and the blood count was unremarkable except for a

slight eosinophilia. The gallbladder radiograph was normal. The tests of hepatic function showed only a moderate elevation of bilirubin, mainly in the direct fraction.

On the strength of these findings, and the persistence of low-grade fever, the physician abandoned his initial impression of gallbladder disease and began to suspect cancer, either primary in the liver or metastatic from some other site. A liver scintiscan was ordered, and it showed a solitary nodule approximately 3 cm in diameter that did not take up the radioactive contrast medium.

At this point, the physician admitted Mr. Taylor to the hospital for a battery of tests and radiographs in search of a primary source for a metastasis in the liver; none was found. The fever, slight icterus, and tenderness in the right upper quadrant persisted. After 2 weeks in the hospital—at a cost of nearly $14,000 for room and board, nursing care, tests, radiographs, and consultations—a needle biopsy of the liver was attempted; however, the nodule apparently was located too deep for the needle to reach.

One Sunday morning, as the puzzled but determined physician was making his rounds and seriously considering exploratory surgery, he noted that his patient was reading a foreign newspaper with printing in another language. "It's Greek," explained the patient. "It's the paper we publish here for Greek-speaking people." "But your name—are you Greek?" asked the physician. The patient explained that he had come to the United States at 12 years of age with his parents, and that the immigration clerk had recorded his father's name as an anglicized version of the name his father had pronounced in Greek.

This small item of information, which would have turned up in a proper medical history, immediately suggested the correct diagnosis: an echinococcus cyst. This disorder is commonly encountered in Mediterranean countries, including Greece, but is seen rarely in the United States, and then usually in patients who were infected earlier elsewhere. It is well known that an echinococcus cyst may form and remain in the liver for many years without producing symptoms.

Comment. Had the Greek connection been brought out initially and linked to the history of urticaria and the slight eosinophilia, the patient would have been spared 2 weeks of hospital confinement and discomfort. Furthermore, the financial cost of the diagnosis and treatment would have been much reduced.

Technical Considerations

"It is much more important that pertinent information be recorded in the doctor's mind than on a card or in a file." Lack of thoroughness in establishing the patient's background, evident in the case of the patient just cited, is only one among many pitfalls that may seriously hinder a diagnostic inquiry. Another is faulty reasoning, relying on the volume instead of the pertinence of the data;

believing, like Conan Doyle's Inspector Lestrade, that toting up the clues will lead to a correct diagnosis. In contrast, the skilled diagnostician keeps his or her intellectual motor running during history taking. Instead of simply compiling the data and judging it later, he or she begins to consider likely diagnoses from the moment of first greeting the patient, or shortly thereafter. Then, like Sherlock Holmes,* the physician may approach a correct diagnosis by pursuing a bit of evidence that does not fit an otherwise plausible impression. At this point, the selection of appropriate confirmatory tests or procedures can be made with maximal economy and precision.

Physicians who practice medicine with such an attitude of active inquiry, exercising keen senses and incisive reasoning, usually enjoy the greatest prestige among their medical colleagues. Today, unfortunately, diminishing numbers of physicians are willing to take on such an elaborate, painstaking, but satisfying intellectual exercise. Some leave the history taking to a relatively untutored assistant or to a computer terminal. Others may have the physical examinations of their patients performed by a surrogate. The resulting body of data, collected by less practiced eyes and ears and without the sensitive nose of a trained medical sleuth, will likely suggest two or three, or even more, diagnostic possibilities. Some of these would have been eliminated promptly by careful attention to incompatible data.

Teaching the Art of Interviewing

With the aim of sharpening students' perceptions of important clues and encouraging continuous attention to potentially significant data, my associates and I monitored and recorded history taking by fourth-year medical students in the outpatient clinic. Verbatim quotes from the recordings led to quick recognition of weaknesses in a student's method of interviewing, which could be classified as errors of commission or omission.

Errors of Commission

- By seeking rapid accurate answers to a prepared list of questions and failing to frame their questions in view of replies to earlier ones, students lost the opportunity to make of the history an exploration whose direction is suggested by each previous step. Moreover, they failed to take into account the possibility that many questions may elicit answers that may be politely or protectively misleading or entirely incorrect.
- By forcing the patient to express his or her "chief complaint" in a few words, students often failed to get on the right track. Sometimes the chief

*It is more than coincidence that Sir Arthur Conan Doyle patterned the perspicacity of the famous detective after that of his former medical preceptor, the astute diagnostician Dr. Joseph Bell of Edinburgh.