Peabody's Corner

". . . for the secret of the care of the patient is in caring for the patient."
— FWP

TB or not TB?

That Was My Question

Herbert L. Fred, MD, MACP

The evidence for active pulmonary tuberculosis was compelling: a dry cough and malaise of 2 months' duration, a chest film that showed a cavitary lesion in the posterior segment of the right upper lobe, and a stain of induced sputum that revealed a single acid-fast bacillus.

I'll never forget that Saturday in 1986 when my doctor, an infectious disease specialist, said to me, "Herb, TB is the best bet at the moment, and I recommend 4-drug therapy, starting today. I also suggest that you wear a mask in public and that your wife begin prophylaxis with isoniazid."

Stunned by this sudden turn of events and cognizant that my manner of living was about to change substantially, I reluctantly agreed with his plan. Still, perhaps in denial, I doubted the diagnosis of TB. Several days later, I called 3 of America's leading TB experts—one in San Francisco, one in New Orleans, and one in Denver. After hearing the available evidence, each of them had the same response: "You have TB and should continue your therapy for a year."

Despite their opinions, I remained skeptical. I even considered a cavitary malignancy as an unlikely but viable possibility. So I persuaded my doctor to have me undergo bronchoscopy on day 7 of therapy. The procedure, which included transbronchial biopsy, yielded normal findings. At this point, I stepped back, reflected on the details of my illness, and was able to come up with what I believed to be my real diagnosis. The first thing to catch my attention was the fact that, 24 hours after treatment began, my incessant coughing had decreased substantially, and, within 72 hours, it had stopped altogether. Such rapid cessation of coughing almost never occurs in active pulmonary TB.

Although my doctor had intended to get a follow-up chest film at 1 month, I asked him to repeat it much sooner. Accordingly, a repeat chest film on day 5 of therapy showed that the cavity in the right upper lobe had closed. A tuberculous cavity doesn't close that quickly.

Next, I remembered that when I coughed, a mild pleuritic pain had appeared high up on the right side of my chest posteriorly. Pleurisy is typical of pleural TB but rarely, if ever, occurs in parenchymal TB. In addition, with each cough, my breath smelled to me like rotten eggs. No one else, including my wife, could smell any bad odor. Putting the pleurisy and odor together with the abrupt cessation of coughing and the rapid cavity closure made pyogenic lung abscess the logical conclusion. But how did I get a lung abscess? The answer was easy.

Shortly before the onset of my symptoms, I had experienced 2 episodes of intractable coughing and a sense of choking that had awakened me from a deep sleep. Each episode lasted about 30 minutes. During the second episode, I coughed up a small amount of pus with streaks of blood in it. With pyogenic lung abscess now certain in my mind, I could explain why I quit coughing so quickly and why my cavity closed so soon: one of my medications was rifampin, an antibiotic.

I discussed my analysis of the evidence with my doctor, but he refused to make any change in treatment until the culture of my sputum had been observed for 10 weeks. When that time arrived, the single acid-fast bacillus seen on my initial sputum stain had not grown and, as a result, was never identified. At that juncture, my doctor, along with a prominent microbiologist and a senior pulmonologist, concurred that I had never had TB and that a pyogenic lung abscess consequent to aspiration was the culprit from the outset. I then switched to oral penicillin therapy for 6 weeks, after which my chest film returned to normal. To reduce the risk of aspirations in the future, I elevated the head of my bed and began taking an acid-blocking agent. I have continued that regimen ever since and have had no further respiratory difficulties.

Dr. Fred is an Associate Editor of the Texas Heart Institute Journal.

Address for reprints:
Herbert L. Fred, MD, MACP, 8181 Fannin St., Suite 316, Houston, TX 77054

If I had not been a physician, especially one who is interested in chest diseases, the diagnosis of TB would not have been challenged, I would have taken a year's worth of inappropriate and unnecessary medications, and the diagnostic mistake would have escaped recognition. No doubt, my case is not the first in which TB was misdiagnosed, nor will it be the last.

As the patient in this drama, I learned what it's like to carry the diagnosis of TB. You feel dirty, unable to cleanse yourself of those filthy bugs living in your body. Equally hurtful, your friends and relatives don't want to come near you for fear of catching your disease. And wearing a mask everywhere you go immediately identifies you as someone to avoid. Loneliness rules. It's bad enough when you do have TB, but I think it's worse when you have been wrongly diagnosed and neither you nor your doctor knows it.

The interaction between my doctor and me was a crucial element of this story. He and I knew from the beginning that having me as the patient could pose problems for both of us, particularly considering that we were longtime friends and colleagues. There were times when our discussions about my case became testy, but we always kept the tensions manageable. I was the pushy one and he was the tolerant one, always there when I needed him. I fully understood the position he took regarding my care, and my faith and trust in him never wavered. In fact, I think that the bond we exhibited throughout my sickness would have made Francis Peabody proud.

Submissions for Peabody's Corner should 1) focus on the interpersonal aspects of a specific patient–doctor experience; 2) be written in storybook fashion; 3) contain no references; and 4) not exceed 5 double-spaced typescript pages.