Listening to Evelyn

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

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We physicians have been taught that if we listen to our patients, they will probably tell us their diagnosis. Our challenge is to have the skill and patience to hear what they say. Listening and hearing seem to be vanishing from our evolving medical-practice environment; it often seems easier to order extensive laboratory tests or imaging procedures (or, more likely, to have an assistant order them) before we even see the patient.

Relying chiefly on test results can mislead us and cause us to offer premature advice. Such advice can worsen the patient's condition and even create new problems. A striking example is the case of Evelyn, whom I saw in consultation.

Evelyn, in her early 70s, was married to a man 15 years her senior and in failing health. His refusal to attempt to reverse his decline was a source of great stress: Evelyn had painful tension in her neck muscles and head, and she had suffered excessive fatigue and depression for several years. Several weeks before our consultation, she had related this situation to personnel in the health clinic of an out-of-town spa where she and her husband were clients.

In reaction to Evelyn's report, the spa's medical assistant had ordered an extensive battery of tests, including the measurement of nearly every known hormone, "just to make sure." The results astounded the assistant. The equally startled physician who was summoned to explain the results told Evelyn that her pituitary and adrenal glands "were not working," because her blood levels of cortisol, progesterone, testosterone, dehydroepiandrosterone (DHEA), and adrenocorticotropic hormone were undetectable. The thyroid test results and the general blood counts and chemistries were normal. The physician told Evelyn that she might be in great danger and advised her to transfer to a local hospital. Evelyn became hysterical at this news; however, she refused the offer of transfer, because she and her husband were to return home the next day. Her husband's condition had improved during the previous week, and he was eager to leave.

The physician warned Evelyn that she might "collapse and die," especially if her travel were unusually stressful. An oral hydrocortisone supplement was prescribed: 60 mg in the morning and 40 mg in the evening, along with 25 mg/d of DHEA. She was advised to consult an endocrinologist immediately upon her arrival in her home city.

Evelyn was acutely agitated when I saw her in my office about 10 days after her return. Her first local consultant had deferred meeting with her until another battery of tests had been completed. A second endocrinologist was so uncongenial that Evelyn concluded, "He must be crazy, because he wouldn't listen to anything I said." There was certainly nothing amusing about the large bill that he submitted for a third round of tests.

Once Evelyn was in my office, I calmed her enough to converse rationally. I concluded that the hydrocortisone regimen might have prevented a dire outcome; however, it had also caused insomnia, a 10-lb weight gain, and puffiness in Evelyn's feet and face. Evelyn was not at all happy about these side effects. When I asked her about her chronic head and neck pain, she said that it had subsided after her "pain doctor" had injected her neck 2 months earlier.

At last, a presumptive diagnosis surfaced, but so did further questions. A call to her pain-management doctor revealed that, over a month before her trip to the spa, she had been given 8 mg of dexamethasone and then 10 mg of triamcinolone 2 weeks later, by injection into the cervical epidural space and multiple right cervical facet joints. Could these injections still be suppressing the pituitary–adrenal axis function, 2 months later? Could such a level of systemic corticosteroid, along with the generous dose of oral hydrocortisone recently prescribed, so rapidly result in cushingoid symptoms? The answer to both questions was clearly yes.

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Evelyn relaxed considerably when I reassured her that "collapse and death" was unlikely and that she should quickly improve after her medications were changed. We planned to taper and discontinue the hydrocortisone over 4 days and to immediately discontinue the DHEA supplement.

At her follow-up appointment, a much calmer Evelyn said that her puffiness, insomnia, and excessive appetite had improved and that she now generally felt well. Furthermore, the improvement in her neck tension and her husband's disposition were continuing.

In Evelyn's case, what was needed to deliver successful care was an open mind and the willingness to listen to her. Patients can indeed reveal the nature of their problem and answer our clarifying questions, if we actually hear what they say.

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.