Peabody's Corner

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

Ellis Phillip Couch, MD

Surviving a Double Whammy

Valentine's Day 2014 also happened to be my 44th wedding anniversary. My wife, Mary Ann, and I had planned to attend a local Little Theater production after an early supper. However, because of my rather vague abdominal pain of 24 hours' duration, I encouraged her to attend alone.

That evening, my abdominal pain worsened. I settled in my recliner to read. I later stood up, promptly passed out, and awoke lying on the floor. I managed to crawl to the bedroom and drag myself into bed. The pain was so severe that I could not remember how to use the telephone. I did realize that Mary Ann's cell phone would be turned off during the theater performance, so I decided to wait until she returned. Fortunately, she came home at about 11 PM, and I asked her to call 9-1-1.

By the time the emergency team arrived, I had managed to crawl to a downstairs landing, to ease their transport. They folded me into a sheet and carried me down the back steps. I was placed on a gurney and loaded into an ambulance. My blood pressure was 60 over nothing, so they gave me fluids by vein. After my one-mile trip to the hospital, a swarm of emergency-room doctors and nurses attended to me and proceeded to do all sorts of helpful and comforting things. I began giving what was surely a confused and complicated medical history to the chief doctor, who immediately ordered a computed tomographic (CT) scan of my abdomen.

After he reviewed the scan results, he told me that I had a "belly full of blood" and a small, rounded lesion in my liver, probably a hemangioma. He asked whom I wanted as a surgeon. My choice—an old friend and colleague—was unfortunately on a skiing vacation. The only one available was a plastic surgeon whom I had never met. That surgeon responded by telephone and opined that our local blood bank did not have the resources to support my treatment. He recommended my transfer to a larger hospital, which was arranged. After an hour's ride, I arrived at about 2:30 AM. The very capable staff explained the treatment options for my presumed hepatic bleed. An interventional radiologist, consulted by telephone, believed that the lesion was too peripheral for embolization. A tagged red-cell scan showed no active bleeding. My vital signs were stabilizing, so no surgery was recommended. I was admitted to the intensive care unit for observation.

My hemoglobin level fell to 7 g/dL over the next several days; however, a transfusion was never necessary. Test results for tumor markers, parasites, and infection were all normal. Magnetic resonance images, obtained before my discharge from the hospital after a 5-day stay, showed a 3.5 × 4-cm liver lesion. The rounding physician (I remember seeing the same physician only twice) informed me that further studies would be necessary. In addition to giving me a standard sheet of discharge instructions, he recommended that I schedule an outpatient needle biopsy with a gastroenterologist.

While recuperating at home, I was able to ponder my situation. Most likely, I would need a surgical procedure and perhaps the outpatient biopsy. Realizing that I needed more options, I contacted a classmate who was a retired professor of surgery. He promptly referred me to the chairman of the Department of Surgery at our state medical school, who, 3 days later, repeated the abdominal CT scan. The new images showed not only the hepatic lesion, but also a tumor in the head of my pancreas. The results of an ultrasound-guided endoscopic biopsy confirmed an adenocarcinoma in the head of the pancreas. The liver lesion was solitary and was thought to be a hemangioma.

One month after the initial bleed had been diagnosed, I underwent a Whipple procedure at the University Hospital. Surprisingly, at surgery, the liver mass turned out to be a hepatocellular carcinoma. It was removed by simple resection. Other than the

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need to reinsert a nasogastric tube on the 4th postoperative day, my recovery was uneventful. I was discharged from the hospital 10 days after surgery.

After consulting with the hospital's oncology team, I opted not to undergo postoperative radiation. Instead, my treatment was a 6-month course of gemcitabine, administered by my local oncologist. All postoperative laboratory and scan results since then have been completely normal. I have passed my 2-year anniversary with no evidence of recurrence. There are no limitations to my diet or physical activity. Any current physical complaints are attributable to my age, rather than to pancreatic or liver disease.

After surviving such an ordeal, I cannot help but reflect on the changes in the practice of medicine that have occurred during my professional career. Fifty years ago, my case would most likely have been an interesting Saturday-morning clinical pathology case presentation instead of a success story. The source of my initial internal bleeding would have been debated by a team of venerable consultants and confirmed with an exploratory laparotomy. Instead, the diagnosis was immediately apparent from the results of a 15-minute CT scan. What we have lost in personal contact with our treating physicians has been replaced by technology that never tires and is available around the clock. Teams of alert professionals are now able to exchange information electronically and instantaneously.

I am immensely indebted to the healthcare professionals who have treated and advised me. Although it is far too early for complacency regarding my prognosis, my ability to write this narrative makes me feel incredibly lucky: after having been blindsided by a primary liver cancer and a primary pancreatic cancer, I have survived a true "double whammy."

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.

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