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“Clarifying Misperceptions”

As a urologist/surgical subspecialist, I really enjoy operating on patients, especially when I know in advance that a job well done will be rewarded by a better quality of life or increased life expectancy for my patient.

Another gratifying--although less dramatic--event is experienced almost daily in the office. This involves unraveling and reassembling pieces of a patient’s medical puzzle, using logic and sound medical principles to move toward the right answer. Not necessarily due to mistakes or oversights from other health care providers, **many patients have misperceptions about their health and medical care.** Frankly, part of the problem is the anxious or poorly prepared patient not giving a clear/succinct/“prioritized” history of his/her past health or current symptoms; as well as not listening to the doctor or inability ask the right questions.

A “week in the life” of a busy urologist (myself, just this past April 4-9) will illustrate how a bit of “old fashioned medicine” and clear thought applied to a clinical problem without excessive tests or treatments can often clarify misperceptions and help the patient.

1. 62 year old man with a history of kidney stones, on blood thinners for a heart arrhythmia/stroke history, has urinary bleeding. CT scan read by Radiologist as showing a few inconsequential tiny kidney stones. Cystoscopy (scoping inside bladder) normal. On my further review of the CT (i.e., illustrating that an ordering doctor really should look at x-ray studies he requests!) showed a relatively large 7 mm. left ureteral stone, likely the cause of his bleeding.
2. “Chronic urinary infections”. First is a 53 year old woman with two surgeries for obstruction of the ureter (“UPJ”) near the kidney (2nd successful) with nonetheless alleged recurrent kidney/ bladder infections and right flank pain. Urinated specimen in my office reveals white blood cells and possible bacteria in urine. Catheterized urine taken by me is totally normal--suggesting contaminants from the vagina led to erroneous voided result now [and, likely, in the past]. Review of other tests, including ultrasound and nuclear renogram, support the contention her “right kidney pain” does not likely represent either persistent kidney blockage or recurrent infection. Second woman, 57, has chronic vaginal and bladder infections with “strep”. She is getting repeated doses of oral and vaginal antibiotics by others. Her symptoms do not sound to me like urinary infection. As was the case with the 1st lady, this patient had a

discrepancy between office voided and catheterized urine, suggesting a false past diagnosis of chronic urinary infection. The presence of strep overgrowth (possibly not even a GYN "infection") gave prior treating doctors the notion she had recurrent bladder infections.

3. A 15 year old boy has recurrent right groin discomfort when he swims competitively in a cold pool; but no testicular pain or tissue swelling. He was told he had a hernia by a pediatric urology specialist; and was advised to have surgery. He did not have a hernia by my exam (most childhood hernias are "congenital" and are associated with a hydrocele—fluid swelling within the scrotum surrounding most of the testicle).

It seemed more likely to me the cold water was making right testicle pull up into the groin, a reflex seen, sometimes asymmetrically, in boys/adolescents. He was told to self-inspect the scrotum and groin "when this happens" to actually help me make the correct diagnosis.

4. 53 yo man suspected of prostate cancer due to a fairly recent rise in PSA from its usual 2's to 5's. EXAM was normal—but my office urinalysis revealed microscopic white blood cells in urine ("pyuria"), a common finding with subclinical prostatitis (prostatic inflammation "below the radar screen"). Prostatitis is an not infrequent cause of temporary PSA elevation. Without any treatment, a follow-up PSA was down to 2.5, thus making a prostate biopsy unnecessary @ this time.
5. A 62 yo man with "high risk" pathology after robotic prostatectomy for prostate cancer was advised to have radiation to the pelvis (a potentially deleterious intervention) for several adverse features discovered at surgery, felt to put him at higher risk for recurrence—as well as death from prostate cancer. Radiation therapist gave him an article demonstrating that radiation after surgery could lengthen patient's disease-free survival (i.e., make death from prostate cancer less likely) but the journal article specifically stated that men in their study with seminal vesicle (an organ contiguous with the prostate) involvement were excluded from this post-surgery radiotherapy study. Turns out this man not only had seminal vesicle involvement but had very high Gleason scores (4/5 and 5/5) on his pathology report—which are variables known to lead to radiation failure, since men with such "unfavorable and aggressive tumor biology" far more likely have cancer recurrences outside the radiation field.

Yes, there's a lot of bad information out there, along with lack of thinking (and sometimes, unfortunately, self-aggrandizing motives) by health care providers—and mistaken beliefs on the part of patients as to the benefits-versus-risks of different diagnostic tests and treatments.

Temporarily leaving out of the equation the role of insurance companies, malpractice attorneys and government with its quasi-solutions to the “health care crisis”, clarification of misperceptions by improved patient education and doctor-patient communication will undoubtedly lead to better health care at a lower cost.

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