

More Than the Sum of His Symptoms

By Allsion Nogi

I reviewed Mr. Jones's chart

first thing in the morning. His seemed to be a simple case: a fifty-one-year-old man diagnosed with dehydration that had resulted in acute vertigo. His lab values were all within normal ranges, and he did not suffer from co-morbidities such as type II diabetes, peripheral vascular disease, coronary artery disease, or hypercholesterolemia. His history noted that prior to admission he was fit, exercised frequently, and did not have any substance abuse issues. "Easy," I thought to myself. My evaluation would most likely have no major red flags, so I would be able to do a quick gait assessment and stair evaluation, and then be able to clear him for discharge. Since he had been on intravenous fluids for the past twenty-four hours, he would probably not demonstrate any acute vertigo and would most likely feel completely better. Looking back on my thoughts prior to treatment, I now realize that my prediction could not have been more wrong.

When I walked into the room, my confidence quickly started to wane as the patient picture I had in my mind differed from the man sitting in the recliner before me. It was difficult to wake him from his nap and he was struggling to concentrate. I brushed off these warning signs, as I have a tendency to

overanalyze everything. When I interviewed him, another red flag popped up: he mentioned that he had had dizzy spells for the past few months and said they tend to be worse after he worked out, completed yard work, or if he had been really stressed. I continued with the evaluation and found that the patient had slight numbness in his right arm and weakness in his leg. I knew this was not typical, and I was aware that it did not follow a post-stroke symptomatology, but his deficits were on opposite sides, so I wrote these signs off as his baseline normal.

When I walked with him in the hall after the evaluation, he appeared to be completely normal. Deciding that he was fine to complete a stair assessment, we turned to the hospital stairway. He ascended the first flight within functional limits and appeared to be in no distress. After we descended the stairs, he began to sway more, grab on to the rail with both hands, and slurring his words, told me that he was having one of his dizzy spells. While trying to remain calm, I asked my clinical instructor to grab a chair, and asked the patient to hold onto the hospital hall's rail while trying to brace him and prepare myself to catch a 6'5" muscular man. Luckily, my clinical instructor and I were able to get the patient sitting,

avoiding a fall. Once he was seated, I asked the patient how often his dizziness happens, and he responded it usually occurs when he finishes exercise or does yard work. Then I thought back to the red flags I previously had noted and decided to check his sensation. I found he had more numbness on his right extremity, which complimented the exacerbated left-leg weakness apparent in his change of gait. Thinking all these pieces of information through my mind was racing, quickly trying to make sense of what had just happened, and wondering what I could have missed in his chart or in my evaluation. After a few minutes, I reassessed his vitals. His heart rate was almost back to resting, and his left-sided weakness and right arm numbness had resolved. He then commented without any dysphasia that his “dizzy spells like that have been happening for a few months now.” It hit me—I realized what I had just seen. I wanted to immediately tell the patient that I think he had just had a transient ischemic attack, something that was most likely occurring in his brainstem, resulting in bilateral symptomatology. After his symptoms had resolved, my clinical instructor and I walked the patient back to his room. The patient was feeling completely normal.

When I left the room, I immediately turned to my clinical instructor and told her that I thought this gentleman had had a transient ischemic attack in his brain stem/cerebellum, since he presented with bilateral weakness, numbness, and dysphasia that were caused by increased exertion and that resolved in a few minutes. My clinical instructor smiled and agreed with me. I was ecstatic. The hours that I spent studying had paid off! I was able to use a physical

presentation and link observed signs and symptoms to a medical problem. Moreover, my clinical instructor, who had 30 years of experience, agreed with me. The rest of the day I was on a high, feeling a great sense of accomplishment.

It wasn't until I was talking to a classmate that I realized one crucial thing. The man whom I had identified was having a TIA was an actual person, rather than just a case study. I realized that in my pursuit to be right and classify his presentation, I forgot that he was an individual. My excitement about recognizing a TIA masked the severity and implications of his situation. I treated this patient like a written case study rather than an individual, a person. In that moment, I realized that to be an effective healthcare provider, I would need to balance analyzing symptoms and presentation with compassion for my future patients.

Overall, this scenario taught me a very important lesson: it will not matter if I am able to accurately diagnose and treat every symptom if I lack compassion and the ability to treat patients as individual people, rather than as instances of pathology. Because of this experience, I plan on reminding myself to think more about patients' feelings and the implications of a diagnosis. I am hopeful this will prevent me from becoming wrapped up in the pathophysiology and simply labeling symptoms with a potential diagnosis.

About the Author



Allison Nogi is in her second year in Emory University's Doctor of Physical Therapy Program. Her reflection essay was written as part of the DPT class requirements during each student's clinical rotation and is a response to her first acute medical clinical experience. Originally from Marietta, Georgia, she received her undergraduate degree in exercise sport science with a minor in Spanish from Elon University. She was drawn to physical therapy because of her interest in non-invasive medicine, in rehabilitation, and because of her passion for improving people's quality of life. Currently she is considering specializing in neurology, focusing on spinal cord injury research. Alli is also an avid Braves baseball and University of Georgia football fan.

When she is not cheering on her sports teams, she enjoys running marathons, cooking new recipes, and spending time with her family. She also spends her spare time reading anything written by Robert Sapolsky. In fact, her new favorite book is *Why Zebras Don't Get Ulcers*.