A practical lesson in clinical communication

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- Bronchiectasis
- Bronchography
- Clinical communication
- Medical history

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My new patient is in his early eighties, in reasonably good health. He has a long-standing pulmonary problem which has been fairly stable; as this was recently noticed in a chest film he had for some other reason, he decided to have it checked. He tells me this was first picked up when he was doing his mandatory army service, and has a document to prove it. Out of the plastic cover of his insurance booklet he draws out a folded hand-written note. There is no date on the piece of paper, a page torn from a military hospital notepad, which has a few lines of text on both sides and a crude, yet pretty accurate drawing of the patient's problem [see Figure below]. A branched tree-like structure fills a hemithorax, bearing 'fruit' that looks like black olives. An icon of bronchiectasis, as it would appear on bronchography, the state-of-the-art imaging modality of the 1960's.

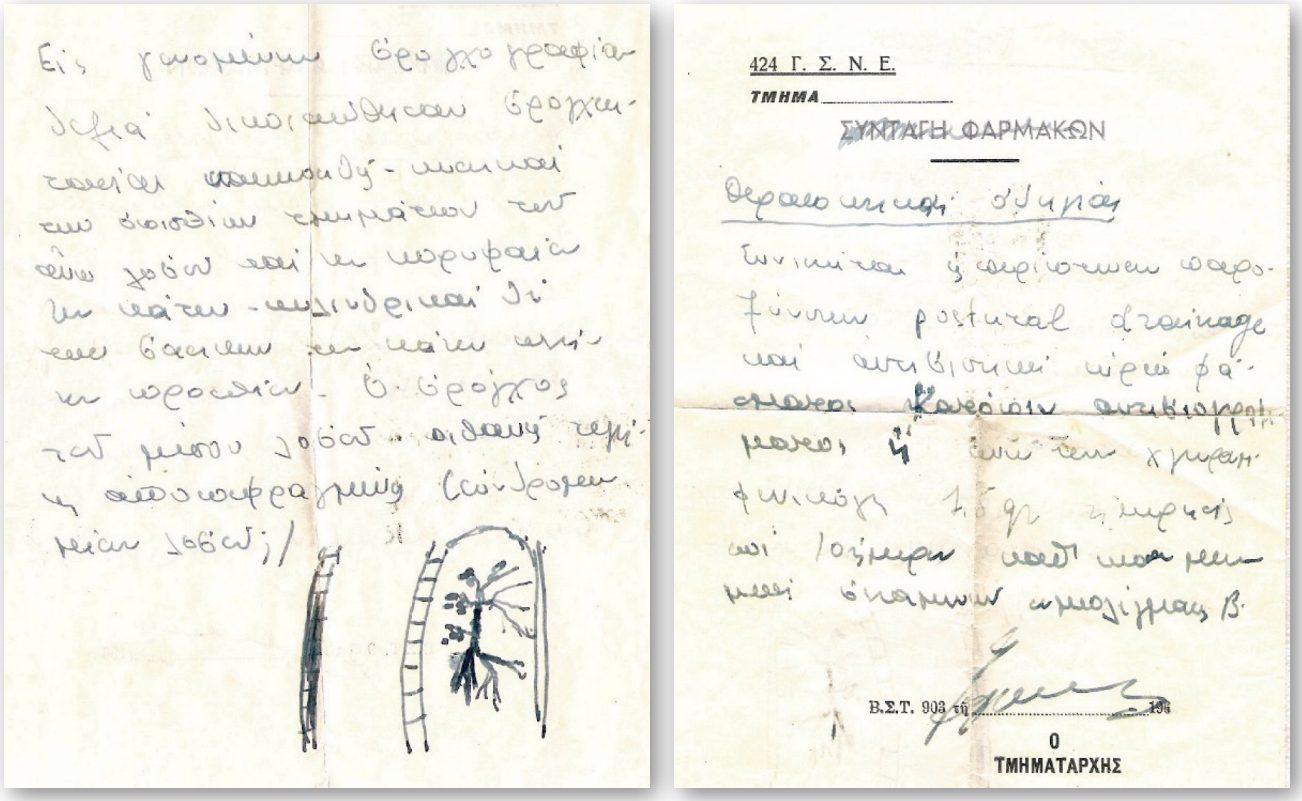
The patient provides me with the necessary background history. As a soldier he had been admitted with pleurisy, underwent bronchography (a not particularly pleasant procedure, which has virtually vanished from everyday practice with the advent of computed tomography), and this brought to light the underlying pathology. The treating physician gave him the appropriate instructions for regular postural drainage and antibiotics in case of exacerbation, but also took the additional step of providing a written record for posterity. As compact disks or even typewritten discharge summaries were unimaginable in those days, he used what he had ready to hand: pen and paper. His brief note is as informative today as it was six decades ago. I am sure he never imagined that it would last that long.

The signature of the doctor on the note is indecipherable. However I can make out the text, and here is its translation:

Bronchography was performed on the right side, and this showed saccular-cystic bronchiectasis in the posterior segment of the upper lobe and the apical of the lower, and cylindrical (bronchiectasis) in the basal and anterior (?) segments. The middle lobe bronchus is probably occluded (middle lobe syndrome?).

Therapeutic instructions: In case of exacerbation postural drainage is recommended, as well as use of broad spectrum antibiotics following sensitivity testing, or, failing that, chloramphenicol 1.5g daily for 10 days along with vitamin B complex supplements.

At the mention of chloramphenicol my mind takes another flight back in time. I am not sure how many of the readers have ever used it, but I recall that as late as 1989 we were advised by our consultants to prescribe it in difficult cases of chest infection (bronchiectasis or exacerbations of COPD) in the late Monsall Hospital for Infectious Diseases in Manchester. There was



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[Το Ελληνικό κείμενο:
Εις γενομένην βρογχογραφία δεξιά διαπιστώθηκαν βρογχεκτασίαι σακκοειδείς-κυστικαί των οπισθίων τμημάτων του άνω λοβού και του κορυφαίου του κάτω, κυλινδρικαί δε του βασικού (?) του κάτω και προσθίου (?). Ο βρόγχος του μέσου λοβού πιθανώς τελεί αποπεφραγμένος (σύνδρομον μέσου λοβού;).
Θεραπευτικαί οδηγίαι: Συνιστάται εις περίπτωσιν παροξύνσεων postural drainage και αντιβιοτικά ευρέος φάσματος κατόπιν αντιβιογράμματος ή άνευ τούτου χλωραμφενικόλη 1,5 gr ημερησίως επί 10ήμερον καθώς και ?βιταμινών συμπλέγματος Β.]

a fear of side effects (especially bone marrow suppression and aplastic anemia), which we had been taught in third-year pharmacology, but thankfully we had never seen it, and our patients usually did well. I have not met or prescribed it again, and modern reference books only mention it in the formulation of eye ointment, and as a rarely used treatment for exotic infections such as plague and tularemia. I suspect it was pushed out of fashion by newer, fancier and more expensive antibiotics with a better safety profile. I ask my patient whether he had ever needed to take the drug: the answer is negative.

With these thoughts I scan and save the note for my patient record, and also for its historical value, and bless the memory of the unknown army physician for his very practical communication skills. And congratulate my patient for meticulously preserving this 'holy relic' of medical history.

Postscript: A few days later, modern imaging confirms the patient's history and adds fine detail to the hand-drawn bronchographic sketch. The CT scan report states that there are confluent cystic bronchiectases in the right upper and lower lobe as well as local pleural thickening on the right side. Sixty years later, the initial diagnosis is still valid, and the patient remains well.