If I could have gone into hospital, had the operation, and come home afterwards it would have been OK. But because I had to stay there it destroyed me. It destroyed Bill. He couldn't handle it. He thought as soon as I went into hospital I would die, because before I met him he'd lost two premature babies. He said, "I'm not going to be the same after this. Something inside me has changed." He scratched "HELP ME" across his tummy with a knife—that's how stressed he was.

Two weeks after I came home, Bill woke up feeling very tired and complained of heartburn. I called an ambulance, but before it arrived he had died from a heart attack. He was 38.

Competing interests: None declared.

- 1 Heathcote J. Abnormal liver function found after an unplanned consultation: case outcome. *BMJ* 2004;329:500.

Commentary: Imaging in biliary obstruction

Adrian M K Thomas

Mrs Prior was referred for ultrasonography after identification of abnormal liver function.¹ Imaging of the liver and biliary tree is a common problem, and advances in ultrasonography, computed tomography, and magnetic resonance imaging have improved our diagnostic ability.² Ultrasonography is the first investigation for suspected biliary disease. This patient's scan showed stones in the gall bladder and in the lower common bile duct. Ultrasonography should be available with only a short wait for more urgent cases.

Her biliary tree is dilated with intrahepatic and extrahepatic biliary dilatation, and the common bile duct measured 11 mm. In over 95% of healthy people the diameter of the common bile duct is less than 4 mm. In patients with gall stones it can measure up to 7 mm without implying obstruction. The common bile duct can also dilate in elderly people secondary to degeneration in the ductal wall, reaching diameters of up to 9 mm, and change in size physiologically in relation to meals.

Mrs Prior had gall stones readily visible in the lower common bile duct on ultrasonography. However, even if the stones had not been visible, a diameter of over 10

mm would suggest their presence. Ultrasonography often fails to detect stones in the common bile duct, partly because of the presence of obscuring gas in the duodenum.³

The ultrasonogram also showed a swollen pancreas. Enlargement of the pancreas may have various causes, and if a stone is lodged in the distal common bile duct the patient may develop pancreatitis with pancreatic enlargement. The liver abnormalities were unexplained and caused concern. However, computed tomography excluded any disease.

Gall stones are common, with an incidence over 10% in the population. They are often found in patients who have no symptoms of gallbladder disease. In fact, patients can have appreciable radiological pathology with few if any symptoms. Mrs Prior will probably have had her stones for some time.

Competing interests: None declared.

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Commentary: Itching for a diagnosis

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This real patient illustrates real challenges of general practice: incomplete information, evolution of illness, clinical uncertainty, and providing good care in an imperfect system.¹

Mrs Prior caught the attention of her general practitioner during her husband's scheduled consultation. Caring for the "secondary patient" is part of general practice, occurring in up to 18% of encounters.² This initial evaluation was necessarily brief, yet dealt with three problems: itch, rash, and cystitis.

Blood tests are sometimes used as a temporising tactic, but in this case they identified cholestatic liver disease before jaundice became evident. By the time Mrs Prior returned for a consultation of her own, she was frankly jaundiced and her liver tests results were very high.³

Painless jaundice made some respondents on bmj.com predict cancer. Itching made many put

primary biliary cirrhosis at the top of their list. Macrocytic anaemia suggested chronic disease, including alcohol misuse. The rapid rise in bilirubin and liver enzyme concentrations suggested a more acute process.⁴ Mrs Prior deserved the early ultrasound examination she had to pay for privately.

The patient and her family were most worried about ovarian cancer. The ultrasonogram showed no evidence of that malignancy but could not rule out cancer obstructing the common bile duct or infiltrating the liver. The consulting gastroenterologist recommended routine referral with a possible delay of 21 weeks. Respondents wanted to fast track this patient to consultation, diagnostic tests, and treatment. Few felt it was appropriate or necessary to call this a cancer case just to get the patient prompt care.

After the ultrasonogram we knew that Mrs Prior had gall stones and obstruction.⁵ Even if she had

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another coexistent disease, she needed urgent relief of the obstruction. Chronic progressive liver disease and even metastatic cancer are not emergencies; obstruction of the common bile duct is.

The general practitioner faced two communication challenges. Firstly, what to tell the patient? Respondents agreed they would tell her she has a liver problem that may be serious and she needs more tests. The second challenge was for the general practitioner to be the patient's advocate and negotiate prompt assessment in secondary care.

Mrs Prior's general practitioner worked the patient into his schedule, identified her problems, ordered key diagnostic tests, followed her course, recognised the

urgent need for intervention, and helped the patient and her family understand the process. What more can you hope for? Only that the consultant system meets this patient's needs.

Competing interests: None declared.

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Commentary: The gap between doctors' and patients' perceptions

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During her husband's consultation Mrs Prior mentioned three symptoms of her own: itching, cystitis, and a rash.¹ She mentioned them as a "by the way," and her general practitioner saw her and did some blood tests. Would you be so patient? Or would you ask her to come back? There is no right answer to this question but, reading between the lines, perhaps the primary purpose of the consultation was to discuss her problems. Respondents on *bmj.com* thought that this was common and that the reasons for it included not wanting to have to make a separate appointment or to wait and, in some countries, not wanting to have to pay. Maybe she thought her problems were trivial or maybe she was afraid that they were not and wanted to downplay them to herself and her husband and her doctor.

Whatever her reasons, the literature suggests that doctors could be better at finding out why patients come to see them. One study showed that in routine consultations 45% of patient's concerns are not elicited.² In half of visits the doctor and the patient do not agree on the nature of the presenting problem.² And doctors often assume that patients' first complaint is their chief one, but in fact the order in which patients present their problems is often unrelated to their clinical importance.³ These are all strong arguments for longer appointment times in primary care.

Readers were also asked what they would tell the patient about the results of her tests. The responses varied: most people said they would tell her that she had abnormal liver function and that she needed further investigations. Some said that they would tell her that she had septicaemia or a bug or something nasty. It is striking that nobody discussed how to tell her this news, how much information to give her, or how much she would be able to take in at this stressful time. Respondents were expansive about the differential diagnosis but clammed up when talking to the patient. Maybe it's not surprising then that, while most patients say they want more information than they receive, doctors vastly overestimate the time they spend on explanation and planning for the future.^{4 5}

Competing interests: None declared.

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Commentary: "Double loop" learning

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As well as sympathising with the patient, many respondents to this case commentary found themselves engaging in the difficulties faced by the general practitioner.¹ Donald Schon, in *Educating the Reflective Practitioner*, described a "swampy lowland" wherein lie the problems of greatest human concern and where "messy, confusing problems defy technical solution."² Schon contrasts beautifully the technical and rational

approaches of the theoretical high ground with the reflective approaches we often need in professional practice.

In interactive case reports, readers are asked how they would react to a given situation. The usual response for professionals is to delineate what Schon and his co-author, American psychologist Chris Argyris, call our "theory of action."³ They describe this