Surprisingly mundane. How do we remain vigilant?

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My days in general practice bring me both the mundane and the surprising. I resist boredom for the first and unreserved excitement for the second.

I remember once saying to a patient, 'Oh, you've got Post-Infection Saffron Spot Disease (not its real name). I haven't seen this for ages!' My patient looked shocked. My enthusiasm for the disease causing her such distress was hardly welcome. Curbing my excitement, I went on to treat her and it resolved as predicted.

Another patient turned up with what looked like Post-Infection Saffron Spot Disease. To me this was now mundane. Only, it didn't resolve. After much trial and error, a biopsy eventually showed it to be a one-in-a-million condition.[1] He was not impressed either. I expected the mundane, and I almost missed the surprising.

The opposite is true too. The mundane can masquerade as the surprising or hide itself among its fellow mundanities. It takes a vigilant GP to spot something common when it is unexpected. The two case studies in this edition of the JPHC highlight this necessity of searching for and recognising the ordinary.

The first case is an immunocompromised elderly gentleman with an eye condition.[2] This is ordinary. An STI affecting the eye is also ordinary. Asking a seventy-three-year-old gentleman about his sexual history when he has an eye infection is not so ordinary, for both the patient and the doctor.

Maybe this is from the underlying awkwardness around our parents having sex. What is certain is that I need to work on having these discussions with my older patients. We live in a different health climate to previous generations. My grandfather was frail elderly at sixty-five-years-old, but my father is not going to be frail elderly until much later. The number of men in his age group who ask me for sildenafil would suggest that the potential for sexually transmitted infections among them is high.

Perhaps asking these questions will get easier as I get older. Maybe I'll be surprised with how ordinary it is to see pubic lice in the eye of a seventy-year-old man.[3]

The second case is more sobering.[4] Ordinarily, elderly + fall + pain = fracture. In this case, other factors clouded clarity and diagnosis was delayed, resulting in tragedy.

Between this elderly lady's multiple health conditions and medications, she had a wide range of what could be considered common symptoms. After falling in her house, she was sent into respite where she, not uncommonly, continued to fall. She had osteoarthritis upon which her nightly knee pain was blamed. Her pain, limp, and unsteadiness were assumed to be the reason why she was in the respite facility. All these blanket assumptions of 'common' meant the respite care staff missed another common among so many. They don't know which fall caused the fracture.

The writer goes on to discuss multimorbidity and polypharmacy, things that we battle with daily in general practice. Just the other day I was discussing the number of medications I could stop in my elderly patient who has diabetes, hypertension, osteoarthritis, mental health issues, and cancer. A picnic of pills for breakfast, lunch and dinner. It's not fun but it is what we end up managing. Trying to look out for another health condition among this milieu of disease, pills, and side effects requires experience and vigilance. When we see patients regularly we briefly discuss how they are going, put their new complaint down to one of their many conditions, and do not investigate more thoroughly.

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Reading cases like these can feel like yet more examples of how GPs can fail to diagnose. Delay in diagnosis has many causes.[5] However, it is hard to recognise the cause of our own delays if we do not have something to learn from.

As GPs we need to keep our zeal for all of the mundane, the ordinary, the common, and the surprising. We are told 'common things are common', 'limit testing', 'time heals all wounds', and other adages that discourage us from exploration and over-investigation. But our role goes beyond just choosing wisely from a catalogue of tests and watching a disease progress. We are tasked with vigilance and with being attuned to what is the surprising and what is more of the mundane in the tangled web of disease and treatment.

The moral of these case studies? Looking for the ordinary among the ordinary takes extra effort but is completely necessary. Sometimes, you will just be surprised.

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