MEDICAL PRACTICE

Clinics in General Practice

A case of dysphagia

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British Medical Journal, 1977, 1, 1139-1141**The trainee's problem**

The patient is a newcomer to this part of the world but has consulted the practice six times during her first three months with us. She is 30 and engaged to the previously married managing director of a small construction firm whose appointment to this region led to her moving here. She is an attractive girl, physically and conversationally; she has previously worked as a business receptionist but is not working just now; she is on the pill but her probable or possible future husband is 20 years older and has already had to postpone the wedding date twice because of business pressures.

Her past history includes "a tendency to get strep throats that always need the strong form of penicillin"; menstrual disorders, which, after private consultation and a dilatation and curettage, led to private laparotomy and a diagnosis of pelvic inflammatory disease; private investigation for missed heart beats at which a pansystolic murmur was found and offered to the patient (it is not now audible); and headache diagnosed in an NHS hospital outpatient clinic as migraine.

Since joining our list she has accepted the reality that she is a girl with problems of adjusting to an insecure style of life and that she is in lay terms "neurotic." She has already established connections with a local gynaecologist (through the Health Service) and has seen a NHS dermatologist because of multiple warts on her hand.

I saw her for the first time two weeks ago with another of

her strep throats (normal on clinical examination) and a feeling of a lump in her throat. She wanted to see an ear, nose, and throat specialist. I assured her she had nothing physically wrong but today she was back again saying that she was now having difficulty swallowing solid food. She still wants to see a specialist. She says she is prepared to go privately. What should I do?

General practitioner's comments

The trainee in presenting this case has already constructed his hypothesis in interpreting the patient's symptoms. He is offering this hypothesis to his trainer, not so much for an opinion on its validity but rather to seek confirmation that his own development as a general practitioner has reached the point when he can challenge the hypothesis for himself by basing his management on it rather than, yet again, allowing the demand of this patient for a symptomatic response to frustrate her appeal for help.

The trainee has succeeded in presenting the history in a three-dimensional form containing reference to physical, psychological, and social factors affecting the patient. Nevertheless, clinically the history is superficial and would appear to be based more on the patient's statements than on objective data from records. We are invited to assume that she is a Caucasian from a relatively affluent cultural background who has lived in the district for some three months. She is engaged to a man, some 20 years her senior, who has already experienced an unsuccessful marriage, to the failure of which she may possibly have contributed. She is presented as a young woman whose sexual adventures have led to frustration rather than fulfilment and reflect a pattern of psychoneurotic illness. These assumptions, however, need to be examined critically.

The trainee might be asked to consider the importance and implication of a consultation rate that is at least six times above average. It would suggest, for example, that, although she was considered neurotic in the eyes of the practice and even in her

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own, nevertheless this convenient label had not allowed her to understand the relation between her physical symptoms and her emotional state. The trainee might be asked to comment on why she consulted him after at least four consultations with other doctors in the practice. These doctors had apparently invited her to accept "the reality that she is a girl with problems of adjusting to an insecure style of life," although her present problem would appear to be more related to her attempt to achieve a secure style of life through marriage. Why has the marriage not taken place, and what are her real feelings for her fiancé? Here the maturity of the trainee will be tested through his ability to explore easily with an older patient intimate aspects of her personal life.

The frustration that she has experienced, both in the practice and in her personal life, appear to have reached a point when she has decided to play an ace. Her symptom of difficulty in swallowing solid food is too important to be dismissed—and she probably knows it. The dilemma for the trainee, therefore, is to exclude any serious organic lesion causing dysphagia in such a way that his investigations can be allowed to reinforce, rather than weaken, his constructed hypothesis of a functional illness.

In diagnosing the cause of dysphagia, in this or in any other patient the history is all important since the results of physical examination will often be unrevealing. It might help to ask her why she thinks she has this difficulty in swallowing. This may allow her to give a clue to her feelings, and there is just the possibility of an anxiety, which she may find difficult to express, regarding a sexually transmitted infection linking her present symptoms to her tendency to "strep throats that always need the strong form of penicillin." The mode of onset is relevant to any dysphagia and will distinguish between a foreign body and the more sinister causes, which tend to be slowly progressive. Difficulty in swallowing solid food is seldom associated with globus hystericus, although there may be difficulty in swallowing saliva, and in view of the functional hypothesis this aspect will need direct questioning.

Physical examination will show the extent of any overt infection or ulceration in the pharynx and disclose the absence of adequate salivation. The rare cause of dysphagia from iron-deficiency anaemia (Plummer-Vinson syndrome), which may begin around her age, will virtually be excluded by examining the blood. A blood sample may also be needed to exclude glandular fever and for serological examination for sexually transmitted disease. No reference is made to a throat swab having been carried out, and one should certainly be sent for bacteriological examination using a transport medium. If, however, a possibility of genuine dysphagia to solid food persists then urgent referral is required for endoscopy, which is the most important investigative procedure for this symptom and which can be combined with radiological examination.

The trainee should now be able to outline his management plan to the patient and give her his interpretation of her present symptoms and their relation to her previous medical history. He can then explain why *he* wishes a consultant opinion, and it would certainly be appropriate to accede to her request for referral to an ear, nose, and throat specialist—and she can be asked whether she wishes this to be on a private or on an NHS basis. The wider issue of attitudes to private practice can then be discussed with the trainer indicating his own policy and the trainee being given an opportunity to develop his own views. The patient must be allowed her own freedom of choice and in this case there would appear to be definite advantages in a private referral to an individual consultant who may be able to spend rather more time with her than is sometimes possible in a busy NHS ENT clinic. The diagnosis will not be different, but this patient's confidence in it may be.

If the trainee can have his hypothesis validated against an ENT opinion, he has the opportunity to retain her confidence and, in so doing, advance his own maturity as a general practitioner. "What shall I do?" will then have become "What I shall do is"

Consultant's comments

The advantages and disadvantages of private medicine as against NHS medicine vary according to the patient's need and, unfortunately, what he can afford. Private medicine is primarily concerned with privacy and not money, although fees are paid. The privacy of consultation with the patient's or practitioner's choice of physician or surgeon may be invaluable, for enough time is allotted to make the consultation interesting and searching, and establishes good doctor-patient relations. If surgery or further investigations are needed the details may be fully discussed, and the patient may choose a private bed in a nursing home or NHS hospital or his name may be added to the NHS waiting list and given the priority that his disorder demands. Consequently a private patient can more conveniently adjust his commitments to his medical needs.

The hotel accommodation in many nursing homes is of a much higher standard than that provided by the NHS. Given a good matron and conscientious medical and nursing staff a higher standard of personal care can be provided for those problems that are within the capacity of that particular home. The deficiencies of a nursing home differ from place to place but generally they cannot provide the facilities for sophisticated radiology and laboratory investigations and the highly specialised techniques of some branches of medicine and surgery. Co-operation with the local NHS hospitals may overcome some of these defects.

The great advantage of the NHS is that it provides a relatively free service for all with better back-up facilities in most centres, and generally provides an excellent service for emergencies and highly sophisticated medicine and surgery. Nevertheless, the quality of the service provided outside this is deteriorating as the services become overstretched—money is in short supply and morale low. The best nurses have been promoted away from patient care to receive increased salaries; senior and junior medical posts remain unfilled in shortage specialties; and senior staff are too concerned with the committee round—often indulging in political in-fighting for status and the limited monies available for equipment and department improvement. Nurses are in short supply, and pupil nurses have to take responsibilities beyond their training. Industrial strife at all levels has led to disruption and insecurity within the service. Political reorganisation and "clogwheel" has broken up the "family pattern" of hospital life and replaced it by a mountain of committees, paper, and statistics to the detriment of patient care and the morale of all hospital grades. The stupid pay structure has only created further dissatisfaction and deterioration.

For example, in ENT surgery about three times the number at present working in Britain are needed to raise the level to that of Western European countries and North America. Therefore to give adequate consultation time the patients must wait months to be seen. Moreover, too many are usually seen at one clinic, each patient being given a brief period. Often they are passed on to junior staff, who may be inadequately supervised because of the seniors' commitments. In teaching hospitals there is little opportunity for privacy, and the patient may withhold useful information. Overall the patient's satisfaction or otherwise depends on chance.

Inpatient accommodation in many NHS hospitals lacks privacy; the wards may be poorly furnished and distastefully decorated; and indeed the bathing and lavatory facilities may not only be disgusting but actually filthy. Such conditions may be acceptable to the acutely ill bedridden patient, the shortstay patient, or those with no alternative choice, but are not always acceptable to the ambulant, intelligent, and house-proud. The standard of housekeeping appears to be falling.

Shortages of nurses, closures of wards, shortages of anaesthetists, the maldistribution of medical manpower are all leading to increasing waiting lists. Despite these criticisms the medical and nursing staff do the best they can within the facilities

provided but not necessarily the best they feel they could for an individual patient given good facilities.

The need to refer patients for an ENT opinion will depend on the standard of undergraduate and postgraduate training received by the practitioner; his skill in using the instruments for viewing the hidden structures; and his ability to recognise not only the abnormal but also the normal. Few practitioners seem prepared to devote the time to practise the skills required and therefore reference largely depends on the history obtained. All discharging ears of long standing need specialised treatment; hoarseness of more than one month's duration needs a laryngoscopy; and all cases of dysphagia need hospital investigation. Lumps in the neck must be referred and chronic nasal disorders need expert examination. If in doubt or in difficulty or the patient demands it referral is essential. Many minor symptoms are the early indications of a major disorder. It is better to seek expert advice rather than procrastinate with symptomatic treatment that in itself may be harmful.

This patient is obviously under emotional stress. The label of strep throat is loose terminology that may mean nothing. Were cultures done; had she pharyngitis or tonsillitis or just a feeling of something wrong with her throat? The use of strong penicillin does not mean that any abnormality was seen. It is often used as a placebo for want of a diagnosis but unfortunately convinces the patient that something serious may have gone wrong. Her present strep throat looked normal and was associated with a globus, all suggesting a stress reaction but now this is followed by a true dysphagia for solid foods, almost always indicative of an organic disorder. There is now an absolute need for a full oesophageal investigation by barium swallow and oesophagoscopy. No abnormality may be found, in which case the dysphagia for solid foods may be a hysterical

spasm or an early achalasia of the cardia. Occasionally, achalasia of the cardia in the young presents with precisely this type of history.

Referral for a second opinion is mandatory, and management will depend on the eventual diagnosis. Whether or not this opinion is sought privately or on the NHS will depend entirely on the background of the patient and the local facilities available. Certainly if she wishes a private consultation she is unlikely to be satisfied with less and if there is a problem in management the more senior and expert the consultant handling her the better.

Postscript to the problem

The patient saw an ENT specialist privately and had two long consultations. No radiological or endoscopic examinations were carried out and quickly a new symptom—tachycardia and missed beats—developed, with the dysphagia apparently disappearing. During the past nine months numerous consultations with one of the more experienced principals have taken place, most lasting about 15 to 20 minutes. Despite a growing insight into her various emotional problems, she has had two further separate referrals for private consultation to one general physician and has recently returned with renewed "gynaecological" symptoms. She has discussed these with a gynaecologist—again privately—but, two months ago, disappeared without notice from the practice. We did know she had given her fiancé an ultimatum about her twice postponed marriage; she could be on her honeymoon, or she may have left this area and returned home, or she may even have changed doctors.

Contemporary Themes

When a woman's place is not in the home

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A happy life for physically handicapped people includes independence—especially that of a job which supports them. In a society where a woman's place is no longer "in the home" a disabled woman has every chance that her career orientation will be accepted, but will the special importance of her *independence* be appreciated by those who guide her? It is in a profession intelligent severely handicapped people most easily achieve this. Muscular strength is often unimportant in a job which depends on brainwork. Consequently, schooling up to a standard which will lead to professional training is imperative for all who can benefit from it. Such schooling implies a staff of teachers trained to teach to advanced level.

It is increasingly stressed by those who are informed on the subject that there are overwhelming advantages in sending handicapped children to normal schools so that they rub shoulders with normal children. This is certainly true when the handicap is not severe. But when the child is severely handicapped, though a small expenditure on access to toilets and lifts might impress the fit, a handicapped person can often see just how much the child is having to do without. Can the child reach the laboratories, and make full use of the equipment? Have adequate adaptations been made to accommodate a wheelchair at the bench, to enable the child to reach taps, and use a suitable microscope or typewriter (fig 1)? Can the handicapped pupil take a full part in physical education—swimming, archery, table tennis, badminton—or is he an onlooker at hockey, tennis, football (probably getting chilblains out on the field)?

The only school in Britain entirely for girls with various physical handicaps, taking them up to several "A" levels in the general certificate of education is the Florence Treloar School at Holybourne, Alton, Hampshire. It celebrates its twelfth

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