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Case Report

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Value of a Detailed Clinical Examination

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Abstract

The role of a physician in modern medicine has changed in recent times. The advances in technology, easy access to modern diagnostic investigations, workload and time constraints seems to a deterrent to the physical examination skills of modern doctors [1]. There are many recent studies suggesting the failure of modern doctors to correctly identifying physical signs [2]. The restrictions on face-to-face consultations imposed by the COVID-19 pandemic adds to the challenge in examining patients. This at times induces a huge threat to patients' safety, leading to missing vital diagnoses, unnecessary investigations, and prolonged treatments with drugs causing harmful adverse effects [4]. Here, we present a case of post-herpetic neuralgia which was misdiagnosed initially as Giant Cell Arteritis due to insufficient history and physical examination.

Introduction

A great cause of concern in recent times is the gradual decline in clinical skills of modern physicians. This is often attributed to the advances in technology, rapid assess to reliable diagnostic investigations, imaging technologies as well as increase in the patient work load and above all the restrictions imposed due to the recent COVID 19 pandemic impacting physical examination of the patients [4]. As a result, there is a significant delay in correctly diagnosing the medical conditions, which are sometimes misdiagnosed early on leading to prescription of harmful drugs causing significant side-effects. Through this case, we re-emphasize the need of a thorough history and physical examination before arriving to a diagnosis.

Case Presentation

A 59-year-old female presented to Emergency Department with a history of right sided hemi cranial headache for 3-4 days. She was a chronic smoker, with elevated Body Mass Index (28), and was on Hormone Replacement therapy. Initial evaluation by emergency physicians led to a clinical diagnosis of Giant Cell Arteritis as she scored 3/5 in the diagnostic criteria of American College of Rheumatology: Age > 50 years, new onset headache, and temporal region tenderness. She was started on high dose steroids and discharged with advice to follow up for a Temporal Artery Biopsy.

Investigations: CT Head: No intracranial lesion.

Initial Investigation Results
29 June 2020

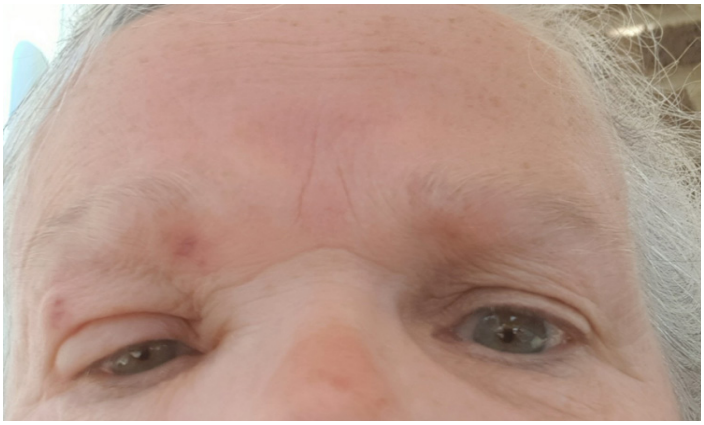
ESR						
Erythrocyte Sedimentation Rate			(>1 to 19)		mm/h	2
C-REACTIVE PROTEIN						
<5.0)	mg/L	<5	-		*7	
UREA,CREAT + ELECTROLYTES						
Creatinine			(45 - 84)		umol/L	61
Potassium			(3.5 - 5.3)		mmol/L	4.6
Sodium			(133 - 146)		mmol/L	137
Urea			(2.5 - 7.8)		mmol/L	4.9
eGFR/1.73m2 (CKD-EPI)					mL/min	>90

ULL BLOOD COUNT				
White Cell Count		10.45	10^9/L	
RBC		4.44	10^{12}/L	
Haemoglobin		141	g/L	
Haematocrit		0.43	L/L	
MCV		95.9	fL	
MCH		31.8	pg	
MCHC		331	g/L	
Platelets		283	10^9/L	
RDW	*	15.9		
Neutrophils	*	8.67	10^9/L	
Lymphocytes		1.55	10^9/L	
Monocytes	*	0.19	10^9/L	
Eosinophils		0.01	10^9/L	
Basophils		0.03	10^9/L	
LOTTING SCREEN WSM				
Prothrombin time		10.2	s	
INR		1.0		
APTT		< 20.0		
APTT ratio		<0.75		
Fibrinogen		2.0	g/L	
D-DIMERS				
D-dimers		232		

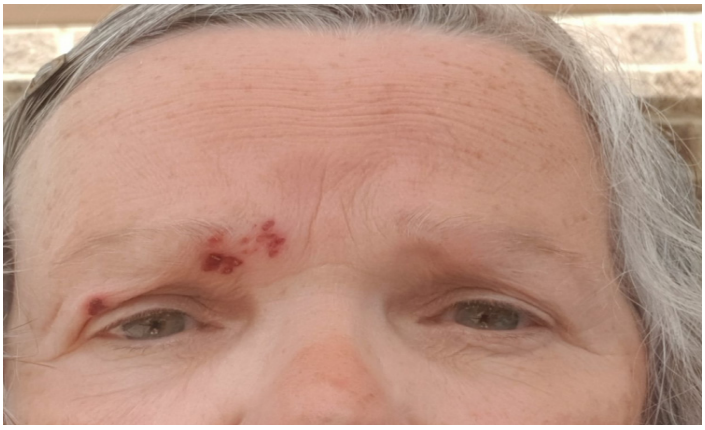
Subsequent disruption due to Covid pandemic meant that face to face consultation was restricted, hence she was followed up with telephonic consultations with the rheumatologist. She became better symptomatically with headache showing mild improvement after starting her on steroids. She was advised to continue taking the steroids with a gradual plan of tapering the dose of steroids in the following weeks.

As she started tapering the steroids in the next few weeks, her headaches appeared again; along with this she developed pain inside the oral cavity and difficulty in swallowing food. She was advised for a follow up in Ambulatory Emergency Care. On follow-up we noticed a small rash around her right eyebrow. After obtaining a further detailed history she revealed that she had developed a few rashes in and around her right eye a few days prior to the onset of headache. This was further collaborated by obtaining her previous photographs which showed herpetic lesions spread along the ophthalmic division of right trigeminal nerve. She had developed evidence of oral candidiasis which could be attributed to use of high dose steroids prescribed to her. She was started on oral pregabalin, antifungals, advised to rapidly taper off her steroids and discharged.

Upon follow-up, she demonstrated a significant clinical improvement with a near complete recovery with the medication.



Picture at follow-up visit in AEC (Patient's consent documented)



Picture demonstrating herpetic rashes (a few days before onset of symptoms)

Discussion

There are several studies demonstrating the importance of thorough physical examination, lack of which causes a delay in identifying correct diagnoses, unwanted investigations and prescription of harmful medications to patients that may lead to undesirable side effects [2]. However, the examination skills of doctors have declined considerably over the years. This is attributed to increased reliance on modern technology and tests, increased work load on doctors, insufficient bed side teaching, among others [3]. In addition, the recent COVID-19 pandemic has proven to be a deterrent in face-to-face consultations and examination of patients.

Our case aims to highlight the importance of clinical examination and recognizing the clinical signs. This patient was initially diagnosed as a case of Giant Cell Arteritis based on symptoms and American College of Rheumatology classification criteria. However, obtaining a detailed past history and careful examination of the patient would have established a clear diagnosis of Post Herpetic Neuralgia, thereby preventing unwanted expensive investigations, harmful treatments, saved time and caused less discomfort to the patient.

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