

Beyond the Textbook

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Sonia," 37, came to me desperate for help. She looked thin and pale and was hunched over in obvious pain when I first met her. She had already been to several doctors, a gastroenterologist among them, and had submitted herself to numerous tests to find out what was causing her extreme abdominal distress. No answer had yet been provided, and she was at the end of her rope. My first thought was, *Why does she think an NP will be able to figure out something that none of the specialists have?*

For two months, Sonia had been unable to eat any solid foods and had been surviving on a liquid diet. The moment that food of any kind entered her stomach, she suffered excruciating stomach pain and nausea. She had lost her appetite and had actually become fearful of eating. At 5'3", she weighed in at 109 pounds and reported having lost 30 pounds over the pre-

vious two months. She had gone on temporary disability leave from her job as a hospital respiratory therapist. Sonia and her family were understandably very worried.

The "rule out" work had already been done for me. Upper gastrointestinal exam, endoscopy, hepato-iminodiacetic acid scan, abdominal CT, colonoscopy, stool cultures, ova and parasites exam, fecal occult blood test, and extensive blood work (including work-up for *Helicobacter pylori*) revealed nothing.

The gastroenterologist, having explored all of the standard possibilities, suggested that Sonia's symptoms might have a psychosomatic origin and proposed psychotherapy as a way to get to the bottom of the problem. Sonia intuitively felt that this was not right and that something else was going on. She had a happy life, with a good marriage and a job that she loved.

Besides, she had started to

notice other new symptoms, including fatigue, joint pain, myalgias, and muscle weakness. Her gastroenterologist assumed these symptoms to be either related to the same presumed psychosomatic process or to poor nutritional status after two months of solid food avoidance.

And so Sonia came to me, seeking an explanation for her problem. I conducted a physical exam, which was unremarkable except for her obvious distress. Then, I asked about her family's health. There was nothing unusual, but something very interesting came up: Her sister had been diagnosed with Lyme disease the year before.

Sonia explained that she and her sister had lived in a rural setting six years earlier and had suffered many tick bites. In fact, as it turns out, Sonia had suffered a prolonged febrile illness in 1998, which resolved spontaneously and had always remained a mystery.

I remembered reading several articles about gastrointestinal manifestations of disseminated Lyme disease. What if this was the root of her problems? Sonia certainly had the exposure potential and had other signs of the illness, including fatigue and joint pain. The fact that she did not recall an erythema migrans, the classic “bull’s-eye” rash that is diagnostic of Lyme disease, did not concern me, as I had read that only about half of Lyme disease patients have this.

It certainly didn’t hurt to look. I ordered Western blots for Lyme disease through a lab in California that I knew reported all of the bands, not just the ones used for CDC epidemiologic criteria. Sure enough, Sonia was positive on both immunoglobulin G and immunoglobulin M.

I started treatment with intramuscular ceftriaxone sodium injections and gradually started adding metronidazole several days per week. I included ursodiol in the regimen to protect the gallbladder from the sludging that is a risk of ceftriaxone sodium therapy. I also encouraged Sonia to take numerous nutritional supplements, including milk thistle and alpha lipoic acid, to protect the liver from damage due to processing of the antibiotics.

The transformation was almost miraculous. Even one week after initiation of treatment, Sonia reported significant reduction of symptoms. Per the International Lyme and Associated Diseases Society’s published treatment guidelines, I continued treatment, changing the antibiotic protocol every few months, un-

til complete resolution of symptoms, which turned out to take seven months.

Sonia is now back to work and planning a trip to Italy; she could not be happier. She thinks I am a miracle worker!

Sometimes we need to look beyond the obvious when the cause of a patient’s distress seems elusive. Sir William Osler, the most famous physician, teacher, and philanthropist of the 19th century, couldn’t stress enough the importance of a thorough history in diagnosing a patient.

I think that the other important requirements for any clinician are an open mind and a willingness to realize the myriad of atypical presentations we can see for various illnesses. Maybe, in the real world, there’s no such thing “textbook case.” 