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Short Communication

Semiology and Diagnosis: Appraisal of a Thinkable Break in Medical Tutoring

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Introduction

Medical semiology, which includes the objective definition and analysis of signs and symptoms of somatic and psychiatric syndromes as one of the first instructive approaches in medical training, has a decisive role in apprentices' clinical workouts and aptitudes. On the other hand, the gap between the academic definition of clinical signs or symptoms and their practical understanding may take time, which may differ individually and may depend on a beginner's scholastic and perceptive physiognomies. Consequently, while objective aspects of signs may designate them more objectively than symptoms, which are mostly subjective expressions of inner problems, neither of them is exempt from plausible fault or misinterpretation. Likewise, cultural dissimilarity between examiner and examinee, including linguistic variances, may intensify the incomprehensibility of dialogue and disturb mutual communication. Inappropriate rapport, an unwilling patient, and a tired clinician, too, may worsen or deepen likely miscalculations. Besides, too much depending of primary care physicians on other specialists or sub-specialists and undervaluation of personal examinations or overestimation of others' checkups, may lost the final solution amid a lot of results and valuations. Also, the multifactorial characteristics of many diseases, which include continual interaction between environment and genes, may not disaffirm, entirely, the inner sense of the clinician while, at the same time, cannot be undervalued through clinical assessments. Besides, it seems that personal experience of symptoms by a clinician may offer a better understanding of signs in others, which may enhance his or her diagnoses and may fill a bit of the of the aforesaid cultural gap. Accordingly, though it may not be accounted for as a generalizable formulation, a clinician who has never experienced a specific symptom may never comprehend its dimensions scrupulously. Likewise, witnessing signs or symptoms in friends and relatives may, in addition, enhance and expand the medical intuition of clinicians, though an endless challenge between chance, medical practice, and scientific insight is not, in any case, deniable. The following case may clarify, to some degree, the current debate. Around two decades ago, a middle-aged woman who was also a foreign national was referred to an associate psychiatrist for consultation and further evaluation. Her problem had started a few months before her appointment, which included a sense of unsteadiness and wooziness without any actual fall, slide, or collapse. As stated by her, the said subjective sense of unevenness during walking and daily activities had caused her to avoid stairs and to decrease some of her outward activities, like shopping, hiking, cycling, and taking part in parties, and so had, unfavorably, restricted many of her usual accomplishments. Her primary care doctor initially tried to manage the said weary complaints by means of available medications, but since there was no subjective improvement, he referred her, first, to an otolaryngologist, and next, to a neurologist, for further checkups. Neither brain imaging nor laboratory and clinical checks could find any important problems. Prescribed medicines, too, while not devoid of helpful effects, could not meaningfully terminate her fear of instability, lightheadedness, and imminent dropping. As a result, eventually she was advised to see a psychiatrist to investigate the plausible psychogenic roots of her complications. After an initial interview and mental status examination, the said psychiatrist could find, in her past psychiatric history, some episodes of mild to moderate episodes of anxiety and depression, which had started during her adolescence and repeated a few times during the last decades and were usually managed successfully by customary psychotropic drugs. Furthermore, as she said, her last episode of depression was a few years ago, with no significant psychosocial dysfunction or sequel. Hence, based on her present mental status, which could not find any important difficulty except concern regarding the said teething troubles, her past psychiatric history, and recent assessments by other associates and specialists, she was diagnosed as a case of unspecified anxiety disorder, and, so, she had been prescribed sertraline 25–50 milligrams per day. After two weeks, she stated that while the prescription had made her subjective restiveness better, her behavioral alterations had not been influenced meaningfully. Thus, sertraline had been increased to 100 milligrams per day, which, while unable to reverse the said negative consequences, caused some gastrointestinal side effects as well. Nevertheless, after a few weeks, she returned to her native country, and the said questionable therapeutic process was inevitably terminated.

Twenty years later, the said consultant psychiatrist had a trip to tropical areas, where he caught a viral infection, possibly a common cold, along with laryngitis and, also, lowered audible range, perceived ringing in the

ears, decreased appetite, and fatigue. After remission of acute symptoms, which lasted no more than a week, one day, in the convalescence period, after waking up in the morning, he felt a severe giddiness, and it seemed to him as if he were spinning or floating. After a few seconds, the said sense was greatly diminished, and he started walking in the room and going to the bathroom, where he again lost his equilibrium after trying to pick up something from the floor and fell in the bathtub. The said drop scared him a lot, though he attributed it to otitis media, a diagnosis that probably was right because all the said complications vanished after a few days. But there was a new problem, which he had never experienced before, which included a disturbing fear of dropping, unsteadiness, lightheadedness, and giddiness, without any real fall since the remission of initial warning signs. As a result, those new clusters of subjective feelings caused him to postpone some of his daily activities, appointments, and social endeavors. On the other hand, he brought to mind, out of the blue, the abovementioned woman, who had experienced nearly the same symptoms and difficulties. In addition, he could not remember any primary or secondary psychiatric illness for himself. Now he could understand that maybe his management at that time as regards her complaint could not be accounted for as a substantial therapeutic method because her problem, perhaps, had, essentially, an organic root, like viral otitis media, not a merely psychogenic ground, though it could be manipulated by neurosis, too. Since, etiologically, important reasons for balance disorder, like benign paroxysmal positional vertigo, Meniere's disease, vestibular neuritis, and acoustic neuroma, had been ruled out by related specialists, it was possible that, in the same way, a viral otitis media had resulted in giddiness or light-headedness, which had continued to some extent for a while without other usual symptoms, like ear pain, muffled hearing, perceived ringing in the ears, difficulty sleeping, a decrease in appetite, irritability, fatigue, fever, or a cloudy or yellowish fluid that dribbles out of one ear. On the other hand, there are other factors that may cause otitis media, like allergies, exposure to cigarette smoke, drinking while lying horizontally, and sudden changes in elevation that cause the ears to clog, such as during an airplane takeoff and landing, which cannot be ignored or denied easily (1-3). Similarly, though psychotropic medications might decrease her psychological vulnerability, they could not rebalance her earlier-experienced disequilibrium, which had ignited a precautionary concern about further volatility in different circumstances. The said psychiatrist, though he had experienced symptoms of common cold and otitis media for only a few days and symptoms of true vertigo for a few hours, had an unfavorable fear of tremulousness and shakiness for a few weeks, which caused him to take extra safety measures and behavioral modifications or limits. As stated by the said psychiatrist, the major problem for him was that he himself had never experienced such a cycle of symptoms, a problem that could encompass other colleagues, too. So, maybe, they could not decipher their patient's complications meticulously, though they could analyze her signs medically. On the other hand, perhaps linguistic diversity had intensified, inadvertently, the said un-understanding. Anyhow, it seemed that more assurance, along with proper medications, could manage her successfully if an appropriate frame of time existed and other somatic issues were not deterring, incidentally. Management of probable psychiatric complications, as well, could be valid if essential, reliable criteria were evident. Anyhow, and in spite of every fault or misunderstanding, the present case may indicate that personal experience of clinical conditions or warning signs, though not a generalizable or recommendable formulation, may increase physicians' awareness, insight, and pragmatism during clinical practice. Also, it may decrease clinicians' slipups or incorrect conceptions, especially with respect to ailments or symptoms that have more subjective elements in their presentations in the initial phases, in comparison with later stages, like paraneoplastic syndromes or some endocrine, autoimmune, or neurological disorders. Likewise, any mismatch between an inexperienced clinician and an upset patient may induce an unsolicited gap between primary complaints and later diagnosis, which may be catalyzed or galvanized by an unwanted misconception or an inapt rapport. Finally, the said process shows that while miscarried management is not effortlessly forgettable, the pedagogic process or feedback, too, is not absolutely terminable [4, 5].

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