

DIAGNOSTIC CHALLENGES DURING A PANDEMIC

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PATIENT PRESENTATION

- A 52-year old woman with no significant past medical history who presented to her primary care providers office 3 weeks after being diagnosed with covid infection with complaints of persistent cough, myalgias and fevers.
- Vitals stable
- Labs: Cr. 1.58 (baseline 1.0) K: 5.5, Hgb 10.3
- CXR: Moderate bilateral COVID pneumonia (patchy and nodular opacities R>L)
- Outpatient Course: She was initiated on antibiotics for superimposed bacterial pneumonia. Her symptoms continued to persist, and she presented to the ED. Her symptoms were attributed to COVID pneumonia, and she was discharged home. She was sent back to the ED a week later with worsening creatinine and continued fevers and myalgias and once again her symptoms were presumed to be due to COVID long haul syndrome. The patient was eventually directly admitted to the hospital by her PCP for further workup.

VITALS

- BP: 116/56
- Pulse: 86
- Temp: 98.5
- Resp: 19
- Ht: 5'3"
- Wt: 60 kg
- SpO₂: 100%
- BMI: 23.43 kg/m²

PHYSICAL EXAM

- General: Alert, cooperative, conversive. No acute distress
- Skin: Warm, dry, no evidence of rash or other lesions
- HEENT: PERRL, EOMI.
- Respiratory: Non-labored respirations, normal respiratory effort. **Crackles auscultated in the bilateral lower lung bases.**
- Cardiovascular: Regular rate, regular rhythm. S1 and S2 present. No murmurs heard on auscultation
- Abdomen: Soft, **right upper quadrant tenderness**, negative Murphy's sign. Normoactive bowel sounds. No guarding or rebound, **right CVA tenderness**
- Neuro: Alert and oriented to person, place and time. No focal neurological deficits
- Psych: Appropriate mood and affect.

LABS

- BMP: Na: 139, **K: 5.4**, Cl: 108, CO2: 23, **BUN: 29**, **Cr: 2.36**, Glucose: 110
- CBC: **WBC: 12.6**, **HGB: 8.4**, PLT: 413
- Procal: <0.05
- CPK: 38
- CRP: 10
- UA: Hematuria and proteinuria
- Protein/Creatinine: **2,778**

CLINICAL COURSE

- Nephrology was consulted and patient was found to have elevated myeloperoxidase antibodies.
- Left kidney biopsy revealed a diagnosis of ANCA-Vasculitis and patient was initiated on steroids and transitioned to 6 months of Rituximab.

DISCUSSION

- This case brings to question how to approach clinical decision making during a time when resources and staffing are few and patients are presenting with similar clinical symptoms.

DISCUSSION

- Cognitive Bias
 - Confirmation Bias: The selective gathering and interpretation of evidence consistent with current beliefs and the neglect of evidence that contradicts them.
 - Anchoring Bias: The prioritization of information or data that supports an initial impression.

AVOIDING COGNITIVE BIASES

- Deliberate switching between intuitive and analytical reasoning
 - Dual process theory: Intuitive and Analytical reasoning when thinking through patient presentation
 - Intuitive reasoning: fast and uses information that is readily available, relies on pattern recognition. More prone to error.
 - Analytical reasoning, slower, more deliberative less error prone.
- Cognitive forcing strategies
 - Conscientious consideration of alternative diagnosis other than the ones that come intuitively.

CONCLUSION

- Cognitive biases are extremely prevalent in clinical decision making. No more so than during a pandemic. It is our responsibility as clinicians to acknowledge the existence of these biases and find practical ways to minimize its effect on patient care.

CITATION

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