

How a Doctor Acting as His Primary Care Physician, With a Little Luck, Tracked Down His Own Cancer

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It started with a cough.

It started innocently enough with a cough. He assumed one of his patients gave it to him, although he always makes his coughers wear a mask. So he masked himself and made his patients mask as well when he coughed. He should have stayed home, but he had no back-up and didn't feel particularly sick. He had no fever and produced no sputum, so he presumed it was viral and took no antibiotics, but he brought his "bag of symptomatic treatments" to work, including aspirin, a cough suppressant, an expectorant, an antihistamine, and a decongestant. The cough persisted – two, four, then six weeks – and the bag grew bigger, but eventually it subsided. On a whim, he decided to get a chest X-ray to see if he had residuals of pneumonia. His wife said that was a bad idea (she disparaged medical tests because they often led to more tests and unnecessary procedures). Overriding her veto, he got an X-ray and thought it looked normal, but Russ, the radiologist, spotted a small area of pleural thickening. "Could be post-infectious. Have you ever been exposed to asbestos?" Russ asked.

"Insulated my house and barn in the 80s, but otherwise no," he said.

"Then you'll probably need a chest CT and a biopsy. I can do that under CT guidance," said Russ.

Great, he thought, I should have listened to my wife. "How about I take antibiotics first and see if it goes away?"

"You're the doctor," Russ said.

About that time, he noted the emergence of a new symptom – a minor ache in his left testicle. He had diagnosed his share of orchitis and epididymitis in his career,

but neither his testicle nor his epididymis was tender or swollen. He wondered what else it could be. Then he had an idea that probably would have been nixed by a proper primary care physician: Why don't I take an antibiotic that covers the lungs and the testes? He settled on levofloxacin, 500 mg per day for 14 days. He at least had the smarts to run it by his urologist in a neighboring town. Ruing not having the benefit of seeing and examining him, but trusting his diagnosis, she suggested extending the course to 21 days and adding a week of doxycycline somewhere in the middle. At least doxy hits the lungs too, he thought.

The ache persisted and nonsteroidal anti-inflammatory drugs had no effect, but a small amount of prednisone mysteriously took it away. This did not compute in his addled brain, which was more concerned with a pleural tumor than a resolving epididymitis. Three weeks later his pleural mass had grown on the plain film (Russ said it could have been positional and wondered why no one ever wanted to consider *that* when their masses grew *smaller*). He was set up for the CT. That showed three more small pleural masses that were not visible on the X-ray. It was time to talk with a pulmonologist.

The pulmonologist thought it should be biopsied, so he was referred to a chest surgeon, who was kind enough to discuss his case with him over the phone, saving him a day's trip out of town. The surgeon favored biopsying through a scope and not with a needle. "Those biopsies miss most of the time and never get enough tissue to make a diagnosis," the surgeon said. "We'll collapse your lung and you'll need a chest tube overnight."

Now he was really sorry he hadn't listened to his wife. But then the surgeon added, "If I biopsied everyone with a few small pleural plaques, I'd be driving a Porsche. Are you having any other symptoms?" In fact, he was. His back was hurting for no obvious reason and a small tender bulge had appeared in his thigh. "That ups the ante. You'd better come down and let me examine you," said the surgeon.

The surgeon was a very kind, soft-spoken man who

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thought the thigh mass was a femoral hernia and said he would present the case to his tumor board later that week. The next day, the doctor went to see his friend Ken, a general surgeon, who nixed the hernia theory and worried about it being a sarcoma. Now that sounded worrisome. “Let’s get a stat ultrasound and see where it goes,” said Ken. He was hoping for a cyst or even a fatty tumor. Unfortunately it was a solid mass. The doctor was whisked right into the MRI scanner, and the news wasn’t pretty. “You have extensive disease,” Russ said. “The thigh mass is just the tip of the iceberg. Let’s get you back tomorrow and biopsy it.” Well, the doctor thought, at least there’s no chance of a pneumothorax this time.

His wife cried all the way home, but he remained stoic. He had one more call to make. Even though his community hospital had only 26 inpatient beds, it had an infusion center with a hematologist/oncologist on staff. John answered the phone, “Hi. What’s up?”

All he could manage to say was, “John, I have cancer.”

Post-diagnosis

When you get a cancer diagnosis, everything gets a reset. You tend to think about things you never give a second thought to – your lawyer (is your trust in order?), your accountant (are your taxes ready to go so your wife doesn’t have to worry about them?), and your financial advisor (are your investments safe?). The minutia of your treatment escapes you because all the drugs you’re taking are above your pay grade and you’ve never heard of them. You take a giant leap of faith and go with the best possible treatment even if the standard of care has yet to be established. Things move apace, and after the biopsy returns a tissue diagnosis, you’re moved along the path to chemotherapy, starting with a bone marrow and lumbar puncture to rule out central nervous system involvement. It’s clear, but you still need six prophylactic intrathecal chemo injections just in case the cancer is hiding in your brain. Then you get a five-drug infusion over five days and you go home with a perfusion pump that delivers three of those drugs through a port-a-cath over 96 hours. That goes on for six cycles, three weeks apart. You’re on enough prednisone to make it hard to get up off the toilet, which is where your appetite is, and you worry about keeping weight. You wish you were overweight at the get-go and had a cushion, but you are thin as a rail and have no fat reserves, so you wonder how much weight you can lose and still recover. What keeps you going is that you read your treatment has “high efficacy,” and your oncolo-

gist believes he can get you into remission.

You are on your next to last intrathecal, and in three weeks you’ll be midway through your chemo. In the meantime you’ve discovered that your hair doesn’t like these drugs and, for the first time in your adult life, you see your bald head and don’t have to shave.

When you have cancer, you get to see how people respond. In a small community where you have doctored for 40 years, everyone knows. Some send cards, some visit and bring food, others call, and some just stay away. It’s all understandable. Cancer makes some people uncomfortable.

They see it as a death sentence and don’t realize sustained remission and even cure is possible. Still, it is a bit disconcerting when friends don’t call.

The worse part, though, is losing your routine. When you’re used to bouncing out of bed in the morning and heading off to work, it’s dis-

concerting to find that you no longer bounce; you linger, trying to figure out how you’re going to fill the next 12 hours until it’s time to go to bed again. You wish you had planned better for retirement and had projects you could lose yourself in, but you hadn’t planned for this and your extracurricular activities are all physical. Even stacking firewood is exhausting while undergoing chemo. Your wife has discovered jigsaw puzzles, but you have no patience for them. You want to get back to your patients, but you don’t know if it’s safe for you to be taking care of them. You visit your office after hours to read their charts and see how they’re doing, but you’re not sure you’re ready to be making decisions for them. It’s agonizing.

There is no way to prepare for this. You just hope you have a great doctor and a great support system and the treatment won’t kill you. But you have no choice; nothing else has been shown to work. You hear stories about other survivors with your disease, and you are heartened. Someday you hope to be able to look back on it all and say, “Now, *that* was a large bullet I dodged,” and then get back to doing what you were trained and love to do – taking care of your patients. **FPM**

Editor’s note: Read more of Dr. Brown’s story in “Keeping Your Practice Going When You Can’t,” *FPM*, May/June 2017, <http://www.aafp.org/fpm/2017/0500/p40.html>.

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