Chen, a 76 year old, had suffered from colon cancer 15 years previously. Consequently, part of his colon was removed and had remained healthy ever since. Recently, he had not moved his bowels for an entire week and he had developed a palpable mass in his lower abdomen on the side of the surgery. Chen went to several hospitals for further examination, where all [of his medical council] recommended surgery and noted that the prognosis was poor.

Although Chen requested Chinese herbs, [his physicians] felt this was pointless and refused to prescribe for him. After this, the patient unexpectedly voided a hard pellet and immediately felt his lower abdomen relax.

The object was removed from the chamber pot with fire tongs, washed off with water, and then carefully examined. It was a "duck butt." The patient had attended a banquet about 10 days previously where he ate a piece of under cooked duck meat. Because of the circumstances he was too embarrassed to spit it out and reluctantly swallowed it resulting in the illness described above.

用火鉗從便穀中鉬出硬物，用水沖洗之後仔細辨認，原來是一個“鴨屁股”，是十幾天前赴宴，操得一塊鴨肉，覺得未煮熟，礙於親朋面前不便吐掉而囫圈吞下，於是發生前述的病症。

Chen’s medical council leapt to the conclusion that the mass in his abdomen was a recurrence of his cancer and recommended an unnecessary surgery. As appalling as this blunder may be, at one time or another, we all make erroneous clinical assumptions. Such errors may be based on our biases and personal beliefs, our incomplete or incorrect medical understanding, our patient’s misreporting or failure to report information, or as in this case, a simple lack of diligent inquiry.

In this column, the first of a series, we will explore clinical reality through the lens of its diagnostic and therapeutic pitfalls. Each installment will address a theme, some way in which other physicians, or we ourselves, have failed to accurately perceive the clinical landscape or to respond appropriately or effectively. This might include an erroneous assessment of etiology, the misattribution of a key symptom to a given pattern, an incorrect or incomplete identification of treatment principles or strategies, or the use of the wrong herb at the
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wrong moment. There is, of course, an almost infinite potential for misstep.

The primary means by which we will navigate this complex landscape is through the rich case history literature of Chinese medicine, both pre-modern and modern. Case records are the textual equivalent of clinical practice and as such, they are the next best thing to personally witnessing a physician at work. They are the records of theory and discourse put to practical application. The development of case records is virtually synonymous with development of Chinese medicine.

The first case records are traditionally attributed to Chun Yuyi (淳于意, born 205 BCE). Si Maqian’s biography of Chun Yuyi in the Annals of History (Shiji 史記, first century BCE) contains twenty five cases detailing Chun Yuyi’s use of pulse examination as a key criteria for diagnosis. In the ensuing twenty three hundred years, case records have taken a variety of forms, many of which bear little resemblance to what we would consider a proper case record today. The style in which these are written is often very terse, presenting only what the author thought to be the most essential information. For example, a large percentage of case records, especially pre-modern ones, mention no results and contain no follow-up visits. The purpose of these cases is to reflect a particular way of thinking as opposed to telling an elaborate clinical tale.

In a sense, such cases represent a code that one must learn to decipher if one hopes to extract their most important ideas. One facet of the rosetta stone for reading case records concerns the spirit in which they should be read. The reader is likely to glean the most from them if one focuses on trying to understand how particular doctors were thinking and why they made the decisions they did, rather than mulling over how one might have approached the situation oneself. As we present various cases we will point out some of these issues, exploring how to become more effective at interpreting and using case records.

Case records are most often recorded to illustrate how master physicians deal with real-life situations. Famous case studies are usually chosen because they demonstrate some important lesson that may not be readily apparent to other physicians. Most case records highlight something unique. Those records illustrating generally understood treatment methods for common diseases and patterns are of marginal interest. For example, for us, there is no point in documenting a case where Gui Zhi Tang (Cinnamon Twig Decoction) was given to a patient with fever and chills unrelieved by sweating, headache, nasal congestion, no particular thirst, a thin, white, and moist tongue coating, and a floating lax pulse. More common are interesting, difficult, complex or serious conditions, special disease patterns, or a unique variation of a "standard" treatment approach.

This is not to say that case histories should only record fringe occurrences. They often document frequent deviations from the textbook strategies, which correspond to a large percentage of the patient population. For instance, the benchmark formula for wind heat in the protective aspect is Wu Jutong’s (吳鞠通, 1758-1836) Yin Qiao San (Honeysuckle and Forsythia Powder). As students we learn a codified set of symptoms that go with this prescription. Yet, if we consider Ye Tianshi’s case records upon which Wu based this formula, we see a full spectrum of wind-heat presentations with highly nuanced use of herbs, selected to match each patient’s individual presentation.

Taken as a whole case records constitute a major genre of our literature; one that we believe is of utmost importance when it comes to translating concepts into actions. Most significant for us are the records of mismanaged or failed cases, which represent a significant subgenre. The influential 20th century physician Qin Bowei (秦伯未1901-1970) was a vocal advocate of the mismanaged or failed case. Qin believed that "we should not limit ourselves to those cases that achieve a cure. Cases where the treatment had no effect, where the patient is first mistreated and then the case is redeemed, or even cases where the patient dies, all equally merit collection. Failures are also a basis for experience and can keep us from repeating past mistakes as well as give us material for further study." It may well be that mismanaged cases are among the most useful kind of case records available to us.

Mismanaged case records illustrate an error that any of us could easily have made. Assuming that a specific symptom implies a specific pattern, regardless of the larger context in which it is presenting, is a classic example of erroneous thinking. For instance, one may mistake the subjective sensation of feverishness for a pattern of heat. The physician might then mistakenly administer a cooling formula even though the other signs and symptoms do not support this assumption.
The following case by Liu Duzhou (1917-2001) precisely illustrates this point.

[Patient] Li was a 53 year old female that suffered from paroxysmal feverishness and sweating for over one year. This would occur 2-3 times every day. A previous doctor had treated her for a yin deficiency fever, but after taking over 20 bags there was no result. When questioned, her diet, urination, and bowel movements were normal. She had a pale tongue with a white coat and a slack and soft pulse that lacked strength. The [correct] differential diagnosis was a pattern of disharmony between the nutritive and protective, whereby the protective was not safeguarding the nutritive. It was appropriate to harmonize the nutritive and protective, yin and yang, and use the method of promoting a sweat in order to stop a sweat. She was given two packets of 

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\text{Gui Zhi Tang}: \text{guizhi } 9, \text{bai shao } 9, \text{sheng jiang } 9, \text{zhi gan cao } 6, \text{and da zao } 12 \text{ p.}
\]

The medicinals were sipped warm with water gruel, and then she covered up obtaining a light sweat. After this, the disease was gone. [3]

The two cases recounted above illustrate the scope of our potential for blunder. In the first case, the physicians made the most general kind to error possible. They failed to do a proper assessment. In the latter case, the original physician latched onto single symptom upon which he evidently built a therapeutic castle in the sand. Both cases demonstrate that our inherent preconceptions can lead us to make assumptions that just do not fit the patient in front of us. The more we are exposed to the errors of others, the more sensitized we become to potential pitfalls in our own approach. In this, mismanaged case records are an antidote to complacency in one’s clinical thinking.

As important as mismanaged cases are in helping us avoid specific errors in our clinical practice, they also teach us to think about our own mistakes in a more useful manner. We all occasionally and inevitably give treatments that are suboptimal or quite simply incorrect. Such treatments almost always produce some side effects that we must make sense of within that specific clinical picture. While unfortunate, such missteps are in fact potential clues to the proper course of therapy. Unfortunately, there is no magical formula that states that side effect X means Y, which can be remedied by giving Z. A given side effect presenting in one patient may mean something completely different in another. In our next column we will specifically address this issue, further illustrating how the study of mismanaged cases helps us to better navigate each individual’s clinical terrain.

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