Out of Hours

My personal diagnostic delay:

'Physician, prevent thyself'

As an epidemiologist, I knew that I had none of the main risk factors for colorectal carcinoma.[1] As a GP, I always had an irrational horror of per rectum investigation, colonoscopy being the one I prayed I would never need.

Therefore, when my only symptom was intermittent, painless rectal bleeding, I made the standard response of a clinical academic meeting a concept outwith his or her paradigm. I ignored it. Well, it was probably just haemorrhoids, or something; I was otherwise fit and healthy, and I was far too busy and important to spend all that time attending clinics and being investigated. I was probably also reluctant to expose myself to the indignity and vulnerability of intimate examination by my professional colleagues.

It was only after several months (or probably more) that I had an actual conversation with myself, in which part of me was a layman seeking informal advice from my medical self. Not until I heard my response — *'For goodness' sake, go and see your GP immediately!'* — did I take action. I swallowed my pride, made an appointment for a week on Wednesday, and an inevitable series of events was triggered. Despite my procrastination and self-induced postponement of the necessary, the NHS took over, and everything ran smoothly, promptly, and humanely.

As the day of my colonoscopy approached, and my trepidation grew, it never once occurred to me that the outcome would be anything other than, *'Thank goodness that's over!'* It was, in my mind, little more than a rather unpleasant box-ticking exercise. In the end (if you will pardon the expression), the investigation was perfectly tolerable, if not actually to be proposed as a preferred pastime, and my dignity remained intact. However, awake and alert throughout the procedure, and following events on the television monitor, I saw my tumour at the same time as did the colonoscopist. That was a life-changing moment.

'Yes,' he said later, *'there is something there, but we don't know what it is and it might be benign.'* However, I had seen its execrable, bleeding ugliness for myself, and it was already fulminating malignantly in my mind. Only now, for the first time in my life, did I stare cancer fearfully in the eye, and it stared defiantly back. You may well think, as I do now, that this fear, or at least its possibility, should have been my first response to the first episode of bleeding. Any medical student, never mind an experienced clinician, could tell you that. But it was not mine, and this now puzzles and bewilders me.

Delays in cancer diagnosis have been researched internationally, and have been attributed to three sources: the patient, the physician, and the healthcare system.[2] I am not aware of any research in which the patient is a physician, working in the system, but all three were relevant to my case.

The following weeks, although slow, emotional, and painful at the time, now seem a blur. Of course, adenocarcinoma was confirmed, scans performed, and surgery planned. Laparoscopic low anterior resection and functional loop ileostomy are easier to write than to experience (or perform) but are saving my life. Histological examination of the excised specimen found local lymphovascular invasion, but also that a sufficient margin of excision was included. For the latter finding, I therefore owe my surgeon a debt of gratitude for her skill that prevented my need of further surgery. However, for the former, I probably have myself to blame for the debilitating effects of my current chemotherapy, the above delay presumably having allowed the tumour to spread before excision.

Having learned the lesson of my passive approach to my own diagnosis, I now found two important areas in which I could be actively preventative. I was in a state of reasonable physical fitness at the time of diagnosis, and enjoyed regular running. In the time between diagnosis and surgery, I increased the frequency, intensity, and duration of my runs. My relatively healthy body mass index was probably instrumental (along with the meticulous skill of the surgical team) in allowing my operation to be completed laparoscopically, despite the tumour being even deeper in my pelvis than suspected. This and my corresponding level of cardiovascular fitness undoubtedly helped speed up an uncomplicated post-surgical recovery. In previously advising my patients to exercise and eat healthily, I had mainly been thinking about their risk of cardiovascular disease and diabetes[3,4] or other chronic illnesses such as persistent pain.[5] It is now clear to me that improving surgical risk is also important,[6] and that we can proactively influence our own surgical prognosis.

ADDRESS FOR CORRESPONDENCE

Blair H Smith
Division of Population Health Sciences, University of Dundee, Ninewells Hospital and Medical School, Mackenzie Building, Kirsty Semple Way, Dundee DD2 4RB, UK.

E-mail: b.h.smith@dundee.ac.uk

Finally, although none of the risk factors for colorectal cancer applied to me, it is important that my brothers, children, and (probably) parents now have one of the crucial ones: a family history. I have therefore exhorted them to examine the other risk factors enquiringly, and to take any apparent symptoms very seriously, seeking medical advice immediately should they develop. I recommend that you, unlike me but as fellow members of the medical profession, do the same.

Blair H Smith,
Professor of Population Health Science, University of Dundee and Consultant in Pain Medicine, NHS Tayside, Scotland.

DOI: 10.3399/bjgp15X684529

REFERENCES

1. Cancer Research UK. *Bowel cancer risk factors*. http://www.cancerresearchuk.org/cancer-info/cancerstats/types/bowel/riskfactors/bowel-cancer-risk-factors (accessed 17 Feb 2015).
2. Murchie P, Campbell NC, Delaney EK, *et al.* Comparing diagnostic delay in cancer: a cross-sectional study in three European countries with primary care-led health care systems. *Fam Pract* 2011; **29(1):** 69–78.
3. Warburton DER, Charlesworth S, Ivey A, *et al.* A systematic review of the evidence for Canada's Physical Activity Guidelines for Adults. *Int J Behav Nutr Phys Act* 2010; **7:** 39.
4. Fogelholm M. Physical activity, fitness and fatness: relations to mortality, morbidity and disease risk factors. A systematic review. *Obes Rev* 2010; **11(3)**: 202–221.
5. Geneen L, Smith B, Clarke C, *et al.* Physical activity and exercise for chronic pain in adults: an overview of Cochrane reviews (Protocol). *Cochrane Database Syst Rev* 2014; **(8):** CD011279.
6. Valkenet K, van de Port IG, Dronkers JJ, *et al.* The effects of preoperative exercise therapy on postoperative outcome: a systematic review. *Clin Rehabil* 2011; **25(2):** 99–111.