

“Am I Wrong?”: A Case Report of Patient’s Experience With Unexpected Acute Symptom Onset During Hospitalization

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A postcardiac surgical patient developed cardiac tamponade the night before his scheduled discharge. There is no report about the patients’ feelings and thoughts while they are struggling to report their unexplainable symptoms. He reported his discomfort to clinicians but was not readily understood. He attributed such miscommunication to his communication skill and blamed himself. He thought it must have been wrong to have such symptoms. He wanted to apologize to clinicians for not being able to report his discomfort understandably.

A patient with acute symptom onset may experience both physical and psychological pain due to the symptoms per se and to limitations in communication. Such patient’s experience may be explained by the common-sense model developed by Leventhal. Clinicians need to be compassionate to the patients who are struggling to report their unexplainable symptoms.

Keywords: acute symptom onset, patient’s experience, thoughts, postsurgical, common-sense model

INTRODUCTION

Patients experience a variety of symptoms during the course of illness. Some symptoms are expected and others are unexpected. Postsurgical complications may be one of the unexpected events, and symptoms related to the complications may be also unexpected for the patients. Patients usually anticipate postsurgical pain (Bayman et al., 2019), fatigue (Paddison et al., 2009), and nausea with vomiting (Jolley, 2000). However, once the patient experiences unexpected symptoms, the patient may be embarrassed, wonder what is happening, and may doubt the significance of the symptoms. There is no report on those patients’ experience, therefore, there is no knowledge on how those patients actually feel and think at the time.

A patient who developed cardiac tamponade after cardiac surgery described his feelings and

thoughts when he experienced symptoms related to cardiac tamponade which was an unexpected event. Cardiac tamponade is known to exhibit nonspecific signs and symptoms (Spodick, 2003), and is difficult to diagnose (Roosen et al., 2000). The clinical staff had a difficult time linking his symptoms to any conditions, the patient had a difficulty in reporting his pain, and subsequently, he blamed himself because he thought it was his fault for not precisely communicating his pain to clinical staff. He thought his communication skills were bad. Blaming oneself is a form a psychological pain. Experiencing both physical and psychological pain at the same time is a significant burden placed on oneself.

This case report provides some insight on how patients feel and think when they experience the onset of an unexpected acute symptom. An interview was conducted as a part of a study

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to elucidate mood alterations associated with cardiac tamponade. Since the patient provided valuable information which can inform clinicians' responses, this case report sheds light on his thoughts at the symptom onset.

CASE PRESENTATION

A male patient in his 70s was admitted to a medical center in central Japan for coronary artery bypass surgery. His surgery and early recovery were eventless except occasional insomnia. His vital signs were stable, except for atrial fibrillation which was considered to be the common course of postcardiac surgery. He was scheduled for discharge on the 11th postoperative day. In the morning of the 10th postoperative day, he complained of orthopnea and insomnia due to wound pain. Since his vital signs were fairly stable, clinicians attributed his complaints to psychosomatic reasons, and an antidepressant was prescribed. His vital signs at 14:00 on that day were as follows: blood pressure 105/77 mmHg, heart rate 106 bpm with atrial fibrillation, respiratory rate 18 bpm, saturated hemoglobin by pulse oximeter 96% without oxygen therapy. At 21:50 on that day, he came to the nurse station saying "I am going home" in his bare feet. Two nurses escorted him back to his room. While assisting him back to bed, his eyes rolled back, he became unresponsive without a pulse so cardiopulmonary resuscitation was started. He was diagnosed with cardiac tamponade and underwent emergency surgical pericardial drainage. He was mechanically ventilated for 2 days and was extubated successfully. He developed bilateral pleural effusions which were drained 2 days after the extubation.

METHODS

Interview

An interview was conducted 7 days after pericardial drainage and 2 days after the pleural aspiration. The investigator explained the purpose, method, right to decline or withdraw from the study without any disadvantage, voice recording, data management, and anticipated publication to

the patient and his wife in his private room. The patient signed the informed consent form.

A trigger question was "Will you please tell me how you were feeling when you got sick?" and supplemental questions followed. Examples of additional questions are as follows:

- What was your mood or emotional state at that time?
- Can you tell me more about the mood you describe?
- Are there any other ways to describe how you were feeling?
- What did you think when this was happening?

The interview lasted about 17 minutes.

This study was approved by the ethics committee at the Nagoya University Graduate School of Medicine (Approval number: 2016-0173). As this study reports on the participant's experience only, the CARE (CAsE REport) guidelines were partially used to guide reporting (Gagnier et al., 2013).

RESULTS

The patient experienced difficult times having pain before drainage of the pericardial fluid. He also had a difficult time when he developed pleural effusions, that were then aspirated, a few days after the pericardial drainage. He occasionally mixed his remembrance of the two experiences. The interviewer tried to clarify which experience he was describing, but sometimes the patient could not distinguish between the events.

Somatic Sensations

The patient had sternal pain after the coronary bypass surgery, but he acknowledged this was the normal course after such a major surgery. His appetite fluctuated after the surgery, but he did not take it seriously. He experienced dyspnea supposedly while the pericardial effusion was accumulating. The dyspnea exacerbated immediately

before the cardiac tamponade and subsequent cardiopulmonary arrest.

He related that he had been bothered by being unable to sleep well before cardiac tamponade. He shared he had not been able to lie down on the day of cardiac arrest. He had been able to lie flat for only 30 to 40 seconds. After that, "My chest became excited" he said. He also said he felt rattled as if he were "driving my bed," the meaning of which was not understood by his nurses or physicians.

Thoughts

The patient spent a couple of days (he was not certain about the exact duration) with unexplainable symptoms. He wondered why he was not able to lie down in spite of approaching discharge. He said he had thought it should be alright because of the scheduled discharge.

He said that he had been thinking the symptoms might be psychogenic and he might have been confused. He had been also wondering if his cognition was distorted. He had reported that he was not able to lie down to the nursing staff, but it was not taken seriously. He had tried to find out a better way to describe his symptoms to nurses. He was still questioning himself about how to report his symptoms to nurses during the interview. He wanted to apologize to his nurses for not being able to report his symptoms appropriately.

DISCUSSION

Symptoms

This patient's symptoms were consistent with previously reported symptoms associated with cardiac tamponade. Respiratory distress is the most common symptom of cardiac tamponade (Ikematsu & Kloos, 2012; Press & Livingston, 1987; Shenoy et al., 2017). However, the mechanisms of the respiratory distress associated with cardiac tamponade have not been fully clarified.

Sznajder et al. conducted a canine experiment study to explore the mechanism of dyspnea associated with cardiac tamponade in late 1980s

(Sznajder et al., 1987). They found interstitial edema, which may contribute to increasing stiffness of lungs in dogs where saline was instilled into the pericardial space. Increased breathing workload was suspected to be the cause of dyspnea according to the authors. No subsequent study to further investigate the mechanism of dyspnea on humans has been conducted to date. Orthopnea is another common symptom associated with cardiac tamponade. However, the principal treatment of cardiac tamponade is to increase preload (Spodick, 2003). If this is true, lying flat may increase preload and it should improve the patient's condition. The mechanism of his syncope remains unknown.

The patient's "rattled sensation" has not been reported in previous literature. It can be attributed to sensing the heartbeat when the pericardial sac is enlarged. It is well known that apical pulsation is palpable in spite of diminished heart sound in cardiac tamponade patients (Spodick, 2003). The sensation may indicate enlarged heart with pericardial effusion. It needs to be examined if this sensation is experienced by other cardiac tamponade patients as well.

Thoughts

This patient struggled to report his symptoms to nurses and physicians. His complaints were not taken seriously, and he was not prescribed any treatment to alleviate his symptoms. He had questioned himself why the clinicians had not responded to his complaints. He thought he must have been wrong to feel such an unpleasant sensation because he was scheduled to be discharged the next day. He blamed himself for not being able to report his symptoms to clinicians in an understandable manner. Nurses and the team, however, knowing the vague presentation of cardiac tamponade, could have expanded on symptoms for diagnostic reasoning.

According to the Common-Sense Model for representation of illness, information of knowledge about disease threats of the patient consists of five domains: identity, timeline,

consequences, causes, and controllability (Leventhal et al., 2003). This patient's experience may be interpreted using this model.

First, he was unsure about his symptoms. He was unable to understand the identity or meaning of his experience. If he was educated that fluid could build up around his heart after surgery and what symptoms could occur he might have had the confidence to report his symptoms. Given that he may not have been able to identify his symptoms, the nurses and team who are knowledgeable about the symptoms of cardiac tamponade could ask specific questions and obtain a more detailed assessment including pulsus paradoxus and a three-dimensional echocardiograph.

His symptom onset occurred during the recovery phase from cardiac surgery. He struggled to align the symptoms he experienced with the anticipated postsurgical trajectory. He tried to persuade himself that he was all right because he was supposed to be discharged the next day. The discrepancy between his cognitive representation of the anticipated post-operative trajectory and the actual situation was confusing to him.

Since he was not aware of the nature of his symptoms, he was not able to predict the consequences. He was unsure as to what might happen next. If he knew that the symptoms would exacerbate and lead to a fatal outcome as a consequence, he might have insisted more intensely that clinicians do something for him. Because of a lack of knowledge about the consequences of his symptoms, he was inclined to think he might be wrong.

The patient was also unable to determine the cause of his symptoms. He tried to relate them to mental problems, because no clinician told him that he was having physical problem. A failure to diagnose his condition occurred. It is conceivable that his self-doubt and confusion could even exacerbate the pain he experienced. If he knew the cause of his symptoms and therefore could make sense of them it might help him cope with the

experience. His symptoms were uncontrollable. He repeatedly alternated between laying down and sitting up as described by other cardiac tamponade patients (Ikematsu, 2007). Loss of control over one's own body is a fearful experience. A sense of uncontrollability might seriously affect the patient's well-being during the symptoms.

In summary, patients with unexpected symptoms may have a difficult time because of the uncertain nature, timeline, consequences, causes, and controllability of the symptoms. Those patients may be prone to question themselves as to why their symptoms are not understood by the clinicians, and how to better report them to clinicians. They also tend to feel unsure about their symptoms and to wonder if they are wrong. Those thoughts may affect their well-being, add more distress, and heighten their pain due to the symptoms. Nurses are expected to alleviate patients' distress by showing compassion to the patients and assessing for other signs and symptoms with suspicion for development of cardiac tamponade.

CONCLUSION

No published reports on the thoughts of patients experiencing cardiac tamponade have been identified through our literature search. This may be the first report about patient's thoughts and interpretation of unexpected symptoms occurring in the setting of cardiac tamponade. The actual voice of patients provides valuable implications for nurses. Nurses should endeavor to maximize their efforts not only to capture the patient's pain and discomfort but also their thoughts. Self-blame and self-degradation may further decrease the well-being of distressed patients who have painful symptoms. Furthermore, with knowledge that cardiac tamponade is a rare yet lethal complication of cardiac surgery that presents with vague symptoms, acute appreciation of patient's communication of symptoms, however vague, warrants further assessment and notification of the team. Nurses are expected to be compassionate to the patients for their thoughts as well as symptoms.

Lessons Learned

Patients may struggle to communicate symptoms that are unexpected and unfamiliar and feel hesitant or question that the symptoms even need to be reported. It is incumbent on nurses and the team to listen with intention when patients report symptoms. The consequence of the patient's communication of symptoms that results in diagnosis and treatment also recognizes and validates the voice of the patient.

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