The Diagnosis I Missed in Myself

Brian Burroughs, PA-C

On long family car rides when I was a child, I was often the reason we stopped so often. Before we had even reached the highway, I would already be asking how far it was to the next rest area. At the time, I assumed this was simply how my body worked. Only much later did I begin to wonder whether the pattern I had lived with for so long might have had a name.

As I grew older, the pattern remained. Urinary urgency and frequency were a constant presence. At times there was also a vague bladder discomfort that was difficult to explain, an uncomfortable pressure that sometimes resembled the early stages of a urinary tract infection, though the infection never quite arrived.

For most of my life, I accepted these symptoms as a minor inconvenience.

Like many people with chronic symptoms, I adapted. I planned ahead before long meetings. I learned where restrooms were located in unfamiliar buildings. Travel required a bit more preparation. The symptoms waxed and waned over time, sometimes barely noticeable, other times intrusive enough to shape the day.

When symptoms persist without a clear explanation, it becomes surprisingly easy to normalize them.

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Years later, as a physician assistant, I began caring for patients whose stories sounded familiar. Many described chronic urinary urgency, frequency, and bladder discomfort. They had often been treated repeatedly for presumed urinary tract infections despite negative cultures. Their symptoms persisted, sometimes fluctuating unpredictably. The experience was frustrating for them and perplexing for the clinicians who had previously cared for them.

Through these encounters, and through collaboration with a urogynecologist colleague, I became more familiar with a condition that had received little attention during my training: interstitial cystitis.

Interstitial cystitis is characterized by urgency, frequency, and bladder discomfort in the absence of infection. It is often recognized only over time, as patterns begin to emerge.

The condition is most often discussed in the context of women's health, and many clinicians rarely consider it when evaluating male patients. As a result, some patients spend years searching for explanations while more familiar diagnoses are repeatedly considered.

As I listened to my patients describe their experiences, parts of their stories began to feel uncomfortably familiar. The urgency without infection. The unpredictable flares. The quiet adjustments required to navigate daily life.

Eventually, a thought surfaced that I had never seriously considered before. What if the symptoms I had lived with for years were the same condition affecting my patients?

Interstitial cystitis is often described as uncommon in men. Yet uncommon is not the same as impossible. Like many conditions without a single diagnostic test, it can exist for years before anyone recognizes the pattern. Looking back, the pattern in my own symptoms had been present since childhood. I simply had not learned how to see it.

What if the symptoms I had lived with for years were the same condition affecting my patients?

Recognizing this possibility was both clarifying and humbling. It provided an explanation for something that had long seemed vague, but it also raised a more difficult question: how had I not recognized this sooner?

Clinicians often assume that medical knowledge protects us from diagnostic blind spots. In reality, we are subject to the same habits of thinking as anyone else. We normalize symptoms that have always been present. We attribute them to stress, diet, or coincidence. Perhaps most importantly, we assume that illness happens to other people.

This experience changed how I approach patients with similar symptoms.

Urinary urgency and discomfort are common complaints across clinical settings. The reflex is often to evaluate for infection, treat when appropriate, and move on. But for some

patients, the story does not end there. Now, when patients describe persistent urgency, frequency, or bladder discomfort despite negative testing, I listen differently.

Conditions that rely on pattern recognition rather than definitive testing are easy to miss. They require time, attention, and a willingness to reconsider initial assumptions. In settings where continuity allows patterns to emerge, this kind of listening matters.

I am more likely to consider diagnoses that are not immediately obvious. I take greater care to validate patients' experiences, even when objective findings are limited. For many, simply having a name for what they are experiencing can be reassuring. More importantly, it affirms that their symptoms are real.

Living with chronic symptoms, even relatively mild ones, offers a different understanding of illness. It is not just the symptoms themselves, but the way they shape daily life: The constant awareness of restroom locations. The small decisions about what to drink before a long meeting. The quiet hope that symptoms will remain manageable during travel or work.

These details rarely appear in the medical record, yet they are central to the patient's experience.

Perhaps the most important lesson from this experience has been humility.

Medicine often rewards certainty. We prefer clear diagnoses, definitive tests, and straightforward treatments. Yet many of the conditions encountered in everyday practice exist in shades of gray. Symptoms develop gradually. Diagnoses emerge slowly. Understanding often comes only after careful attention to patterns over time.

Now, when patients describe symptoms that do not fit neatly into familiar explanations, I listen a little more carefully. Sometimes we learn medicine from textbooks and training. Sometimes we learn it from our patients. And occasionally, we learn it from ourselves.

In clinical practice, not every diagnosis is confirmed by testing. Some are recognized through patterns that emerge over time. Recognizing those patterns requires curiosity, attention, and humility.

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