*Doctor's Narrative*

# The Invisible Side of Medicine

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**Abstract**

**Background:** Clinical decision-making in nephrology often requires balancing diametrically opposed treatment risks. This case highlights the cognitive challenges of managing a critical conflict between life-threatening infection (sepsis) and organ-threatening inflammation (active lupus flare) in a young patient.

**Key words:** Systemic Lupus Erythematosus; Sepsis; Polyserositis

Some cases stay in your mind not because they were dramatic, but because they quietly change something inside you.

A 22-year-old girl was brought to emergency room with recently diagnosed Systemic Lupus Erythematosus. She had already been treated with intravenous antibiotics elsewhere for Pneumonia. When she came to us, she was very sick. Her heart rate was around 140/min. Her respiratory rate was close to 38/min

She had polyserositis with signs of an active lupus flare. Her kidneys were involved too, with a serum creatinine of 2 mg/dL, and she was oliguric.But there was another problem. Her procalcitonin was 24.6.

Now, I was standing between two possibilities:

An untreated active lupus nephritis flare requires pulse steroids. Delayed initiation could compromise renal recovery. But severe sepsis could be catastrophically worsened by steroids.

I escalated her antibiotics. The next day her creatinine rose to 3.2 mg/dL. I knew this was active lupus nephritis - her complement levels were low and antidsDNA was positive. But the patient was not stable enough to undergo a renal biopsy as well.

Medicine is rarely about choosing between right and wrong. Most of the time, it is about choosing between two risks.

I hesitated because the timing of initiating pulse steroids mattered. I was constantly weighing the risk of worsening sepsis against the risk of losing a window to salvage her kidneys.

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I asked for a pulmonologist's opinion. They felt the pneumonia consolidation was resolving and that this level of sepsis did not fully correlate with the chest findings. There was also a loculated pleural effusion that needed ultrasound- guided tapping and fluid analysis.

The interventional radiologist advised blood transfusion before any procedure as her hemoglobin was only 7.2 g/dL. The situation was getting increasingly complicated. Meanwhile, her creatinine kept climbing. I decided to wait one more day, and watch the trends carefully.

After 48 hours, the procalcitonin dropped from 24.6 to 6. That gave me some confidence that the antibiotics were working.

The next day, the pulmonologist reassessed her and felt that the loculated effusion was reducing in size, so tapping was deferred. Her procalcitonin was now 1.6, but the creatinine had risen to 4 mg/dL.

But I still needed to decide about the biopsy, as she remained tachypneic and tachycardic.I asked her gently," Can you try lying down prone for five minutes?" She agreed immediately.

Despite everything she was going through, she was co-operative, calm and trusting.She tolerated it. That same day, we proceeded with the renal biopsy. Immediately after the biopsy, I started pulse methylprednisolone 500 mg daily for 3 days. I ensured her blood culture and urine culture reports were negative before proceeding. Still, the creatinine continued to rise to 4.6 mg/dL. Then 5.3 mg/dL.

She was already on mycophenolate. I kept thinking whether I should escalate to cyclophosphamide. But she was unmarried, very young, financially struggling. Fertility preservation itself would be difficult for them to afford.

I discussed the case with a nephrologist friend, wondering what else I could do. I remember feeling disturbed those days. I prayed silently.

I didn't want this girl to land up on dialysis. I didn't want her family to enter the exhausting cycle of dialysis, transplant discussions, financial burden and lifelong dependence at the age of 22.

I explained everything to the attenders. The seriousness of her kidney injury, the possibility of dialysis and the uncertainty. Then slowly, something changed.

After completing the pulse steroids, her creatinine began to fall.5.3 became 3.6.

By the time of discharge, her creatinine was 2.6 mg/dL, with a urine output of 1.3L per day. Her renal biopsy report was received shortly thereafter and confirmed class IV active lupus nephritis, as expected.

But the part I remember most happened a week later during outpatient follow-up. Her serum creatinine had fallen to 0.8 mg/dL, completely normal!

Her father stood there with folded hands, repeatedly thanking with tears in his eyes. And that experience taught me something important about medicine.

People often underestimate nephrology as a specialty. They think it is only about dialysis or managing creatinine numbers. But many nephrology decisions are deeply cognitive. They require patience, timing, interpretation and emotional steadiness in the face of uncertainty.

This case reminded me that medicine is not only about knowledge, but also about judgement. Knowing when to wait, when not to wait, how to balance infection and immunosuppression and when to trust your clinical instincts even before a biopsy confirms what you already intuitively sense.

As a young nephrologist, this case gave me something I had been silently searching for: evidence. Evidence against my own imposter syndrome.

There have been many moments during my medical journey where I wondered if I truly belonged here, whether I was capable enough, whether I was fit for medicine at all. But sometimes, one patient changes the way you see yourself. Not because you performed a miracle, not because medicine suddenly became easy.

But because in the middle of uncertainty and pressure – you stayed calm enough to think clearly. And that was enough. Some victories in medicine are loud.

Others arrive quietly – in falling creatinine values, improving urine output, and a patient who gets to go home without dialysis.