Cabbages & Kings

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FOR EXAMPLE

When osteoarthritis affects the hands of old people, it often strikes the first carpometacarpal joint. Sometimes it lies dormant, like a cranky child finally gone to sleep; at other times, it rages like a wounded animal. The victim's (patient's) pain is often subtle, just a twinge at times to let you know that one of your joints is different, but sometimes it blossoms forth in full expression, producing pain, tenderness, swelling, redness, and even heat. This is arthritis in all the intensity of the meaning, and as the bones grind away at each other, year after year, with less and less cartilaginous covering, a bulge appears on the dorsal radial aspect of the back of the wrist, at the base of the first metacarpal. Incredulous at first, the patient eventually recognizes that this hand is unusual, a little bit deformed, and will never be the same.

I have that. Familiar with the usual afflictions of advanced years (our patients are much older, on the average, than 10 years ago), I was never in doubt about the diagnosis. A posteroanterior radiograph of my left hand showed what was expected: narrowed joint spaces, articular irregularity, subchondral sclerosis, and a geode or two. When it flares up, I take ibuprofen, and after awhile it feels better. If I get busy and forget to take the medicine, after awhile it feels better anyway.

What sent me to the hand specialist in our Department of Orthopedics was not the pain or swelling or even the grinding sensation when I deeply palpated with the thumb of my other hand. It was the fact that I had developed a very mild but quite noticeable (to me) adduction deformity of my thumb, and I thought I could detect the least bit of atrophy in the thenar eminence of my left hand. Should I do exercises, squeezing a rubber ball over and over to strengthen my hand? Is some other rare disease running rampant in my joints? Are those smooth little subchondral cysts really metastases in disguise?

He said to come right up to his office, he would see me at once, making me realize again how privileged we physicians are to have physician friends all around us who promptly care for us. He examined my hand and my radiographs, agreeing with my diagnosis. Then we sat down to talk about what to do, and I waited for him to say something about the obvious adduction deformity. That's why I had really come. He would not be hurried, and he told me that he was going to talk to me as though I were any other patient of his, telling me all the possibilities for treatment, surgical and nonsurgical, ignoring the fact that I was a physician. That sounded good to me, so I sat back and listened.

"Osteoarthritis in this location is common in people your age," he intoned, going on to recite, almost mantra-like, the natural history of the disease and its prognosis. He told me about ibuprofen, about braces and splints, and about the several surgical options available. Finally, unable to remain silent for another minute, I pointed to my slightly adducted thumb and said, "What about that?"

"Oh, that's an expected mild deformity caused by the arthritic changes between your wrist and your metacarpal, altering the axis of the metacarpal and pulling your thumb in a little bit. It's nothing to worry about...just part of the disease."

Feelings of relief and gratitude surged through me, even, I think, into my sometimes tortured wrist. At that moment I understood as I never had before the importance to the patient of the knowledge that something terrible and feared was not present, that the dark hounds of disease and incapacity were not going to haul one off quite yet. Never again will I balk at a marginally indicated diagnostic examination if the real reason is to allay the patient's anxiety.

I placed the radiograph of my hand in the teaching collection, parts of which I show to the residents from time to time, usually between gastrointestinal or genitourinary cases, when we have a moment to spare, to teach and learn. I hand them the radiograph with my arthritic left hand, holding it the same way the radiograph depicts, giving them a chance to realize that it's my hand they are looking at. My wide wedding band, on my hand and on the radiograph, is a giveaway that some of them recognize.

I've become an example to my students.

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LUNCH

The unmistakable saliva-stimulating smell of popcorn wafted from the open door of the office of my faculty colleague across the hall. This fellow always has popcorn for lunch, and the smell of it reminds us that it's time to go to the noon conference, time to eat.

When I became chairman of my department in 1976, I decided three things about the noon conference: Conference would begin on time and end not more than 45 minutes later; everyone, faculty and residents alike, whose presence was not required for patient care elsewhere, would attend; and eating during the conference would not be permitted. Ending the conference at 15 minutes before 1 o'clock allowed time for everyone to eat lunch and still return to work at a reasonable