Letter from . . . Chicago

Experts galore

GEORGE DUNEA

On this sweltering day I work hard to develop a type B personality by hiding in my cool office while the troops fight the glorious battle in the stifling tropical swamps of the outpatient clinic. A swivel chair pushed up against the desk makes an ideal hammock. Only the cucumber sandwiches are missing, and from what Lady Bracknell would have called the semirecumbent position I half earnestly scan the daily newspapers and learned journals for interesting items. Alas, not everything interesting is also suitable—at least not for a peer reviewed scientific publication with a high rejection rate. No need then to elaborate on this book review from a national newspaper about the 15 year old nymphet in colonial Vietnam and her Chinese lover: "They kiss, they cry, they make love—then they repeat the cycle," but the reviewer thinks that "the fantasy is too sweet and mixed with too much nonsense."

At least the nonsense is not ennui, unlike one expert's pronouncements about the loss of the human element in medicine and how the admissions committees are to blame. All types A should become type B and learn to love life and people and flowers and trees; they should not bother about the clinic or at least not feel guilty about skipping it. Another innovative mind has discovered that advances in medical technology place great constraints on resources. Meanwhile he is having his type A coronaries photographed while waiting for a reaming out. A multimillion dollar study has raised the searching problem of who should pay for heart transplants. A non-semirecumbent student of the medical landscape has concluded that marketing (the bazaar approach) is essential for physician survival. Environmentalists think that acid rain causes $5 billion worth of damage each year, but the government wants more studies. Doctors are admonished to keep abreast of new developments in nutrition (? eat more type B foods) and should advise their patients (? at least the type A ones at risk) on prudent diets. How often have we heard all this before?

More exciting, during this precarious transitional type AB state, is the news of the treasure find in the Caribbean off the coast of Florida. Here deep sea divers have recovered the $400 million gold and silver contents of the Spanish galleon, *Atocha*, sunk during a storm in 1622. The treasure was to finance Spain's wars and its loss at the time caused a severe recession. Now the courts have ruled that the galleon's cargo, being outside United States territorial waters, rightfully belongs to the entrepreneur divers. Many politicians in Washington now hope that such treasures will turn up periodically in the Potomac to allow then to balance the budget without cutting back on weapons, pensions, or Medicare. Even the immigration department could use some extra funds to monitor the new arrivals to this country. Only the other day a swarm of new immigrants flew in across the southern border. They were discovered in an oil field in California, where they had already killed a crow and a fox, and had colonised a rabbit so thickly that his fur was completely obscured. Aggressive and inclined to attack men and animals, these so called Africanised killer bees are commonly found in South America, having been brought to Brazil by a scientist who wanted to study them. But the experimental subjects escaped from the laboratory and have since gained a foothold in the New World, breeding with ordinary bees and threatening to supplant them. Such then are the wonders of science and the fruits of research.

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"Sounding off" over Mr Reagan

Perhaps the most newsworthy item this summer was Mr Reagan's illness. This was wildly exploited by a daily press long ago freed from the notion that the pains and pleasures of the body are an indelicate topic of conversation. Every detail was splashed on the first page of our polite newspapers. We learned from our all too free press that doctors would remove a polyp from the colon, explore the colon with a long instrument, cut out the abnormal excrescence with a tiny wire snare, and send the stuff to the pathologist. We read that the presidential stool had given a positive test for blood even after a meat free diet, and that the presidential *x* ray examinations showed diverticulosis. For good measure there were drawings from the encyclopaedia showing the intestine and its relations, and notes explaining the natural history of polyps. Even more valuable was the running commentary from one of the local but also the world's leading experts on gastrointestinal problems. It takes only 45 minutes to look at a presidential colon, he explained, and only five minutes to cut out a presidential polyp.

When subsequently a second larger polyp turned up behind the first one, the world's leading experts throughout the country had a field day. "From what we know at this stage this is a totally curable situation," explained one of them; and there were pictures and diagrams of what the colon does and how it looks, how large polyps may grow, and how they behave quite well even if they have spread a little into the bowel wall. Other experts wrote on anaesthesia (1% to 2% mortality), on colostomies (a pouch attached to the abdomen to collect wastes), and on the contrasting merits of horizontal and vertical incisions. Soon every American had at his fingertips the aetiology and epidemiology of colorectal cancer, including the Duke's classification. Then the president took the unprecedented step of turning over his powers to the vice president for the duration of the anaesthesia; and the political experts were upset because Mr Bush kept a low profile and did nothing exciting, like overrun Afghanistan or liberate Namibia, during those eight long hours. At last a team of 11 surgeons operated in unison, taking out three feet of bowel and a polyp subsequently found to contain cancer cells. Most experts thought that the tumour was type B, optimists argued that it really was type A, but nobody mentioned the precarious transitional type AB.

Then we heard about what nurses love to call short term and long term care plans, projects that they pursue so busily that rarely do they have time to visit the bedside, speak to patients, hold hands, rub backs, or wipe brows and other parts. Of course, announced the experts, there would be "methodic periodic surveillance, with colonoscopies, blood tests, computed tomography scans, *x* ray examinations, and stool examinations." But then the experts had a bad falling out, some agreeing with the president's care, others

critical that an air contrast barium enema or a colonoscopy had not been done a year earlier. There was much wrangling about who should have routine sigmoidoscopies and at what age and how often, if at all. Some experts proposed to sigmoidoscope every American over the age of 50 every other year, undaunted by the suggestion that they might perforate more bowels than cure cancers. Yet despite this beneficial raising of the public's awareness of this potentially curable disease, many people resented that the local and also the world's leading experts had been so free in offering their opinions. Mr Donald Regan, White House chief of staff, fresh from his altercation with the vice president during the critical eight hours, criticised doctors for second guessing the president's care. It was unprofessional for them to be "sounding off," he thought, particularly as they may not have been entirely familiar with the case. Mrs Nancy Reagan, a doctor's daughter herself, was likewise critical of the ethics of the world's leading experts. Her father, she said, had always believed that no doctor should comment on another's handling of a case.

First the colon, then the nose

But non-medical experts also had much to say. Some worried about the president's political future, others thought the engendered sympathy might help. An insurance man wondered if Medicare would pay for the polyp removal, which nowadays is supposed to be outpatient surgery. Someone else wondered if the time spent in hospital was within the allowance of the new prospective reimbursement system. And a house officer, accustomed to the ways of municipal hospitals, was surprised that the biopsy specimen had not been lost or that the histological report had not gone astray. Then came the news that a "spot," a "rough place," an "irritation," a "piling up of skin," was to be removed from the president's nose. Even "under prolonged and intense questioning by the White House press corps" an official spokesman denied that the spot was either a "mole," a "cyst", or a "growth." When the "spot" or "pimple" turned out to be a basal cell carcinoma, it was explained that it was benign, caused by the sun, and unrelated to the polyp in the colon.

But now some of the world's greatest skin experts began to "sound off," worried that not all the cancer cells had been removed. They were greatly concerned because the White House had not released all the details, where the procedure was done, and by whom. Why wasn't Mr Reagan informed about the biopsy results immediately? Why had the White House physician denied that a biopsy was done at the very moment when the pathologists were pouring over the specimen? And why had the lesion not been picked up earlier?

One of the experts was concerned because no local anaesthesia had been used. Clearly they must have done the wrong thing and not taken out the whole cancer, because curettage and electrodesiccation, the procedure of choice, would have been too painful to bear. In fact, electrodesiccation has been used as a form of torture. Then the White House spokesman had to explain that indeed anaesthesia had been used and that the right procedure had been done. But the experts remained suspicious. Why had the White House not announced what kind of basal cell carcinoma had been found? There are three types—superficial, nodular, and sclerosing—and it makes quite a difference in selecting the right treatment. After all, it had been described as a pimple, so it may well have been the nodular kind, the most difficult to remove. Surely in a democracy we have a right to know everything, to publish everything, to probe into even the most personal aspect of our leaders' lives?

Trouble from corned beef and wine

In Chicago, meanwhile, our local experts were still struggling with the salmonella. This persistent troublemaker hid and survived in a crack in a pipe, then came back with a vengeance to haunt the delicatessen store with the tainted corned beef, having it closed down for a second time after another 15 people developed food poisoning. Still in the aftermath of the salmonella epidemic, a local but prominent rheumatologist explained that 7% of people are genetically inclined to develop arthritis after a salmonella infection, and that of that group 10% to 20% may end up with clinical symptoms of arthritis. Wine experts were concerned when traces of diethylene glycol were found in Austrian wines, but the Austrian farmers explained that they were being undermined by a "wine mafia" adding the chemical to their vintage products. At the Red Cross the experts have at last come round to Dr Heimlich's way of treating café coronaries, agreeing that for choking an abdominal thrust works better than a backslap. Which leaves us with the regrettable news that type B personalities are no less likely to have heart attacks than type A—suggesting that I might as well go to the outpatient clinic after all.

What would be the most appropriate antiarrhythmic agent to use in a patient with severe asthma who has frequent, unpleasant unifocal ventricular ectopic beats? Disopyramide upset her and had to be discontinued.

My immediate response to patients with ventricular extrasystoles is to try and avoid treatment if at all possible. Naturally it is important to exclude the possibility that the patient may also be suffering from a more serious arrhythmia such as short runs of ventricular tachycardia. This does usually require facilities for ambulatory monitoring. I also usually perform an exercise test if the ectopics are frequent as in this patient, since benign ectopics usually disappear or appreciably reduce in frequency on exercise, and also exercise may occasionally bring out a more severe malignant arrhythmia. Having done this, it is important to exclude any precipitating causes. In particular, drug treatment has to be considered, especially terbutaline and salbutamol (Ventolin) either by mouth or by inhaler and diuretics. Having come to the conclusion that the ectopics are benign, as they frequently are, I think the first course of action is strong reassurance. Quite often once the patient knows that he is not going to die or have a blackout during these ectopic beats, he will go away much happier. Also it is important to tell the patient that treatment is possible, but that this arrhythmia may be very resistant to treatment and often the side effects from the drugs are worse than the actual arrhythmia itself. Occasionally, patients' symptoms are such that they demand treatment, and in such circumstances it is really a matter of trial and error. Disopyramide was a reasonable first course of action after which I think virtually any other of the class I antiarrhythmic agents—for example, quinidine in the form of Kinidin durules, mexiletine, etc—may be used in a patient with asthma. Although likely to be effective, I would not recommend amiodarone in these circumstances. It is far too toxic to be used for such a benign condition. —K M FOX, consultant cardiologist, London.

A 35 year old man with severe longstanding atopic eczema has tried many treatments but remains in trouble, although he can control it with 7·5-10 mg prednisone daily. Is it reasonable to allow him to take this amount constantly? If not what is a reasonable amount to take continuously?

Systemic steroids are in general much more disappointing in the long term management of atopic dermatitis than for asthma. They certainly can be helpful in suppressing the symptoms but all too often the dose required—for instance 15 mg prednisone daily—is one that may carry an unacceptable risk of long term side effects. Prednisone 7·5 to 10 mg daily is indeed a fairly modest dose to use for a few months but may still cause problems if used over several years. Short courses of oral steroids are used quite widely for exacerbations of atopic dermatitis. Our preference is to avoid this by using short courses of a very strong topical steroid lavishly for a half to two weeks, often with the patient as an inpatient. This is then tailed off to a weaker topical steroid. In general, treatment should include the weakest topical steroid that will control the symptoms, not forgetting the value of emollients, antipruritic drugs, control of emotional aspects, and even evaluation for an allergic factor. The occasional case of severe atopic erythroderma which can be life threatening will indeed justify oral steroids, perhaps for many months. Such cases, however, are rare. For example, in our department with 6000 cases of atopic dermatitis seen over several years we have just three patients on maintenance doses of oral steroid for their eczema.—R H CHAMPION, consultant dermatologist, Cambridge.