Letter from Chicago: Fallibility

God sent us here to make mistakes—
ELLA WHEELER WILCOX

Comes to the clinic a slender 20 year old Vietnamese girl carrying a crumpled slip that says "rule out renovascular hypertension." She speaks no English, but her older brother, who interprets, says that she has had high blood pressure for seven years. Like most of the other 87 hypertensives triaged at the clinic that afternoon she has no palpable physical signs, but her blood pressure is high and the electrocardiogram shows too much left ventricular strain for her age.

What to do? Intravenous pyelography is now deemed to be too insensitive, arteriography too invasive, digital arteriography too uninformative, and Hippuran scans too useless. A captopril technetium DPTA test is done: the renin levels double after captopril and the left kidney retains the dye longer than the right. As the duplex colour Doppler imaging is inconclusive an arteriogram is ordered: it shows a very tight stenosis of the left subclavian artery, the descending aorta itself gradually narrows down, and the left renal artery is severely stenosed at its origin. Only now it becomes clinically apparent that the pulsation of the left radial artery is markedly reduced.

In the widely read teaching exercises of the prestigious medical journal from New England this 20 year old woman would have been described as presenting with severe hypertension. All but one of the 23 students would have immediately picked up the decreased left pulse at the wrist and made a diagnosis of common or garden Takayasu's disease. They might have also recognised the one student who missed the decreased pulsation as an atypical example of cervical tabes dorsalis, with loss of deep sensation at C7 and C8. Some form of vasculitis would have been considered in the differential diagnosis.

Vasculitis was also high on the list of the clinicopathological conference reported in the 8 August issue of the same journal. It concerned a 35 year old man with mental changes and left sided focal neurological signs found to have several space occupying lesions. In addition to donating several pints of blood for common and esoteric laboratory tests, this man also underwent an MRI (magnetic resonance imaging), more MRI, a lumbar puncture, a computed tomography scan of the chest, a computed tomography scan of the abdomen, an ultrasonogram of the abdomen, another of the testis, an *x* ray of the lumbar spine, another computed tomography scan of the brain, a course of steroids, a radionuclide bone scan, a left radical orchiectomy, a stereotactic biopsy of the corpus striatum, another lumbar puncture, another computed tomography scan, and then a serological test for syphilis—which came back positive.

The attending physician in charge, who deserves the highest praise for reporting the case, described the experience as humbling. A well developed sense of self preservation generally prevents most of us from thus advertising our mistakes. The 22 wise medical students apparently also missed the diagnosis. The one with the tabes, who may have come up with the correct answer from personal experience, was away having his antineutrophil cytoplasmic antibody levels measured (not having an orchiectomy, one would hope) to rule out possible co existing polyarteritis nodosa.—GEORGE DUNEA, *attending physician, Cook County Hospital, Chicago, USA*