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## A Clinician's Pearls and Myths in Rheumatology

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John H. Stone  
Editor

# A Clinician's Pearls and Myths in Rheumatology

 Springer

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## Preface

Once when I was an intern, an attending rheumatologist bemoaned the number of decisions he had to make when caring for a single complex patient. *Which dose of prednisone? When to taper? Which steroid-sparing agent to add, or whether to add one at all? Was an ACE inhibitor a good idea in a patient with a serum creatinine of 3.5 mg/dL? When to employ Pneumocystis prophylaxis, and when to stop it?* These struck me as highly interesting questions, but as an intern more concerned that my beeper might sound again any moment to signal my next “hit,” I took only passing note of the remark and evinced little sympathy for the beleaguered attending. At least he was going to get some sleep that night!

Some years later, having differentiated into a rheumatologist myself, I pursued training in clinical investigation, wrote papers, conducted randomized clinical trials, and developed a stable of complex patients of my own. Only then did I recall the attending’s remark with empathy and observe just how few of the clinical decisions I made were based upon rigorous evidence. Indeed, even if the budget at the National Institutes of Health were once again to double within a short period of time and then to double again, the highly nuanced nature of rheumatic disease would yield to “Grade A evidence” on only a minority of important clinical decision points. In our discipline, there will always remain ample room for the keen clinical “*Gestalt*.”

This inevitably brings chagrin to advocates of comparative effectiveness studies, among whom I count myself a member. The application of clinical evidence (when available) to major treatment decisions is critical to conscientious and effective patient care. But the dozens of smaller decisions that comprise the craft of medicine are still rooted in a clinician’s direct experience; in clinical intuition; in nuggets of wisdom handed down from mentors; and in tips imparted to practitioners by patients themselves. Rheumatology training and practice rely, in short, on the understanding and application of clinical Pearls. Further, becoming a good clinician and an effective teacher also involves the ability to recognize and debunk Myths: those specious concepts and harebrained ideas that cling to the body of medical knowledge like gum to a shoe, despite being fundamentally wrong.

Pearls and Myths are a substantial, ancient, and ever-renewed portion of the medical canon. When Hippocrates sat beneath the shade of his plane tree on the island of Kos and formulated aphorisms, he generated Pearls that continue to influence the fabric of medical practice down to the present day. Rheumatology fellows on the wards today will do well to recall Hippocrates’ Pearl that “A woman does not take the gout, unless her menses be stopped”. And even great clinicians are not immune to the unwitting propagation of Myths from time to time. No less an authority than Sir William Osler advocated the use of arsenic for the treatment of pernicious anemia.

The discipline of rheumatology is more conducive than most to teaching and learning by Pearls and Myths. Rheumatologists pride themselves on the idea that no subspecialty relies so heavily upon the history and physical examination – the laying on of hands – for rendering diagnoses. Astute rheumatologists can leap broadly to speculations on prognosis after an examination of only a patient’s fingers and hands. At the same time, rheumatology rivals any subspecialty for its array of diagnostic tests that appear arcane to outsiders: *What are the clinical implications of a high-titer ANA with a speckled pattern? And the oligodot pattern?*

*Pearls and Myths in Rheumatology* is a compilation of the wisdom of some of the most experienced clinicians and insightful clinician-scientists whose work touches upon rheumatic disease. No fewer than 126 contributors, experts all, have written the Pearls and Myths for this book:

- 73 rheumatologists for adults
- 19 pediatric rheumatologists
- 2 dermatologists
- 1 dermatologist/rheumatologist
- 3 otolaryngologists
- 4 orthopedists
- 2 internists
- 3 pathologists
- 1 dentist
- 3 neurologists
- 1 endocrinologist
- 2 neuroophthalmologists
- 1 ophthalmologist
- 1 ocular immunologist
- 1 pediatric infectious disease specialist
- 1 nephrologist
- 4 pulmonologists
- 1 clinical immunologist
- 2 clinical geneticists
- 1 undifferentiated stem cell (medical student), but an expert nonetheless

Of course, nearly all of these contributors wear more than one hat. They are clinical investigators, educators, epidemiologists, basic scientists, or accomplished practitioners of other disciplines in which they engage when not doing clinical work. They hail from 13 countries: Austria, Belgium, Canada, Denmark, Germany, Great Britain, Greece, Italy, Japan, the Netherlands, Spain, Turkey, and the United States. Together, they have written 48 chapters of *Rheumatology Pearls and Myths*. Their chapters comprise a total of more than 1,400 such packets of knowledge (836 Pearls and 610 Myths, actually). Their points are driven home by 400 illustrative elements, including 300 clinical photographs.

Finally, a word about the book's dedication. *Pearls & Myths in Rheumatology* is dedicated to my father, Dr. John Stone III (1936–2008). My father served as the Director of Admissions at the Emory University School of Medicine for more than 20 years. He was a cardiologist, poet, teacher – and an extraordinary clinician. Much of what I know about taking a history I learned from hearing him recount the details of patients he had cared for. As a child, I was thrilled by opportunities to accompany him to the hospital or on the occasional home visit. From time to time as a young boy, some of my playmates were his pediatric patients from the institution that Atlanta once called the “Crippled Children's Clinic”: children with congenital or acquired heart disease. As an undergraduate pursuing pre-medical studies, I occasionally tagged along on Cardiology Consult Rounds, where I strained my ears to discern the pericardial friction rub of a 22-year-old woman with end-stage renal disease caused by lupus. And as a medical student performing a visiting clerkship at Grady Memorial Hospital and examining a man alleged to have syphilitic aortitis, I endeavored unsuccessfully to distinguish the potential Austin Flint murmur of aortic regurgitation from the rumble of mitral stenosis caused by rheumatic heart disease. (*I still wonder if the underlying cause of the patient's aortic regurgitation was not giant cell arteritis....*)

I regret that my father's superb cardiac auscultation skills, acquired by dint of many years of hard practice, were not bestowed upon me by right of primogeniture, but it is only fitting that *Pearls and Myths in Rheumatology* is devoted to him: in memory of my finest role model and in celebration of the many cases we enjoyed discussing together. How I wish that those discussions could continue, and go on and on.

I hope you will enjoy, learn from, and pass along the Pearls you deem worthy, all in the spirit of “See one, do one, teach one.” Moreover, I hope you will see fit to debunk loudly any Myths described herein (some of which have been passed off as “fact” for generations). Remember only that clinical medicine, described by Lewis Thomas as “The Youngest Science,” is ever changing. This will bring, in short order, not only a whole new generation of Pearls and Myths, but also the realization that some of today’s Pearls are to become tomorrow’s Myths. The converse is also true. These are the principal purposes, perhaps, of second editions.

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