

Treat your patient, and not his MRI!

C Niek Van Dijk



Some years ago, I was asked for a medical report about a left-handed truck-driver, 60 years old, who'd had a neck lipoma removed, and then lost the use of his left-arm. All of which had cost him his job and his marriage.

It happened like this. The truck-driver was attracted by one of those professional-looking adverts, and undertook a total body-scan, which revealed a benign-tumour beside his adrenal gland. So he decided to have it removed. The day before surgery, however, he mentioned that he also had a fat-lump in his left-neck, and could that also be removed? The surgeon investigated, and said he would do both at the same time. A week later, however, and strength began to disappear from the truck-driver's shoulder. Gradually he lost all control of his upper arm.

A subsequent EMG revealed a complete lesion of the accessory nerve, and disappearance of the trapezius muscle.

As we are all aware, these periodical medical-check-ups have a limited value, if only because they lull the patient into a false sense of security. But it gets worse with false-positive outcomes. Benign incidentalomas (incidental imaging-findings) are found in up to 7% of total body scans, and their prevalence increases with age.¹

For instance, If you were considering a Prostate Cancer Test (PSA) as a screening-test for prostate cancer, I'd recommend

that you start by reading *The Great Prostate Hoax*.²

This book's subtitle is 'How Big Medicine Hijacked the PSA Test, and Caused a Public Health Disaster', and there is a dedication to 'the countless millions of men and their families who have suffered needlessly because of the misuse of the PSA Test'.

The problem is that many men—as advised by their PSA Test results—endure painful needle biopsies and radical prostatectomies. Few of them would die from such a slow-growing cancer, which most often never leaves the prostate. But many suffer a serious drop in their quality-of-life, because the treatment has made them incontinent or impotent.

The wider problem is that things that are bad for the group—statistically speaking—can sometimes be good (or at least ok) for an exceptional individual, and vice versa. And this latest patient—sitting across the desk from us? He might just be that exception. So we should not *treat-him-as-a-number*—as just another statistical problem. We should not automatically say: "Oh, it worked fine for x%, so it'll work for him!"

As we treat more patients, we gain wisdom about their types-of-problem. And part of that wisdom should be: "I am treating this person in front of me, and he is not a statistic or a trend. He is, quite simply, Number 1. That's how he regards himself, after all".

And we have to be careful with MRI results. We all have anxious patients who arrive with an MRI under their arm. "Dear Doctor, the report says I have damage to my rotator-cuff tendon, and labral damage. Please, can you help me!"

In this issue, Lee *et al*³ performed MRIs on the dominant shoulders of asymptomatic elite volleyball players. All of them (yes, 100%!) had pathological findings, ranging from (partial-) cuff tears in 65.4%, tendinopathy in 88.5 %, and labral tearing and/or fraying in 46.2%.

Such findings are not new. MRIs of lumbar spine of 98 elite junior tennis players (mean age, 18 years old) showed abnormalities in 94 of them. Disc degeneration was noted in 62.2%, and disc herniation in 30.6%.⁴

Are these findings specific for athletes? It appears not. They are only, perhaps, more extreme for athletes. In a study of asymptomatic non-athletes, the

prevalence of abnormal hip findings was 73%.⁵

And for 44 asymptomatic individuals (from 20 to 68 years) with no history of knee pain, injury or bone or joint disease, MRIs of the knee showed abnormality in 43 individuals.⁶

What should we conclude from all this? *Don't treat the MRI! Treat the patient!*

Last week I attended the 170th anniversary Congress of the **Royal Dutch Medical Association**, whose theme was 'Physicians and Patients in 2040'. The delegates were asked: "if you were a patient in 2040, what would you consider most important?", and their answer was "Being seen, being heard, being regarded as a human being, and not just a collection of laboratory-results and MRI Images".

As mentioned in earlier editorials: *Make eye contact with the patient, listen to the patient, the patient is always right!*

Getting-the-history (that is, by *listening to the patient*) will give you a working hypothesis. Physical examination can support this hypothesis, or reject it. And MRI is there to confirm or reject the findings. But if the MRI shows something unexpected, you should go back to the history, and to physical examination, and check whether the patient's complaint can be attributed to these unexpected findings. *If not, then don't treat them!*

All the elite volleyball-players in Lee's study were asymptomatic, but they all had cuff or labral lesions. Now, cuff and labral lesions in athletes have a bad prognosis for return to competition after repair. Several studies have shown that surgery for overhead-athletes is rarely successful. Andrews *et al* reported that 92% of overhead-athletes failed to regain their previous competitive standard, after rotator-cuff repair-surgery. That is, only one-in-ten were 'cured' (as they and their trainers and teams would say)!⁷ Another study showed that only 63% of overhead athletes were able to regain their previous competitive-level after SLAP lesion repair surgery.⁸

The truck-driver lost his job, and had to sell his sailing boat, which was also beyond him, after surgery. Night-times, he cannot sleep on his right-side, and daytimes he has consistent neck-pains, with episodes of headache. His consequent bad temper caused problems in his marriage, and eventually lead to divorce.

The good news, I suppose, is that he doesn't have to worry about his incidentaloma turning malign ...

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Funding The author has not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; internally peer reviewed.



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To cite Van Dijk CN. *J ISAKOS* 2020;**5**:1–2.

J ISAKOS 2020;**5**:1–2.

doi:10.1136/jisakos-2019-000419

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