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Commentary

A Dose of One's Own Medicine

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It is not surprising that some of the classic reports of clinical syndromes have been physicians' descriptions of their own illnesses. Dr. Charles Aring, a neurologist, had migraine headaches for more than 30 years, and during the summer of 1970, he experienced 18 attacks of scintillating scotoma over a period of 3 months. He set down the details of this symptom, its onset, temporal progression, spatial characteristics, and the alterations in mental status that accompanied his attacks [1]. Dr. Aring remarked in that article: "Diagnostic confusion is fostered by premature interpretation and if the patient's history is allowed to remain undeveloped. It is well-known that sensations transcend vocabularies. It therefore devolves upon the physician to develop the description of a sensory syndrome."

In 1973, Dr. Alf Brodal, the Norwegian anatomist, set down the details of his own stroke, with particular attention to the "subjective experiences which are apparently only rarely considered in discussion of hemipareses" [2]. He spoke of the "force of innervation," the force needed to move a paretic muscle, and the exhausting expenditure of mental energy it required. His writing is filled with the frustration that the stroke patient feels. He tied a bow tie every morning for 40 years, and he related the difficulties of performing this simple task after his stroke: "Subjectively the patient felt as if he had to stop because his fingers did not know the next move. He had the same feeling as when one reads a poem or sings a song and gets lost. The only way is to start from the beginning."

While the writing of any articulate patient might have approached the lucidity of these reports, the entire spectrum of details could be listed only by a skilled clinician. In Dr. Aring's case, he not only experienced the syndrome but was able to attach importance to details that might have eluded a less well-informed observer. In the usual clinical situation, the patient does not know what parts of the experience are important to relate, and the physician, unaware of what the patient has experienced, may fail to question thoroughly.

The article by Dr. Hasso [3] in this issue is clearly in the tradition of those earlier articles, but in this instance, it focuses more on the physical and emotional experiences of diagnostic tests than on the disease that necessitated them. The "dissociation" associated with an injection into the vertebral artery, the inability to sense the level of the catheter, and the sensation of having a femoral artery punctured are phenomena of which all who do angiography should be aware.

The physician's account of a procedure or a syndrome also highlights the anxieties, phobias, and frustrations as well as the physical sensations that patients experience. Dr. Hasso wrote of the comfort of knowing the physician performing the arteriogram and the others who were taking care of him. There was an established level of trust between the doctor and the patient.

Even though Dr. Hasso knew what was going to happen, the arteriogram was far from a pleasant procedure for him. It is not difficult to imagine what these tests are like for even the bravest of lay persons. Most examinations that neuroradiologists perform are conducted with the patient awake. The room is usually cold, the table is uncomforable, the procedure seems unnecessarily long, and the appearance of the equipment borders on the surreal. To this alien landscape, add a circle of masked anonymous faces and a variety of noises

This article is a commentary on the preceding article by Anton Hasso.

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that can range anywhere from that of an automatic weapon to a modern day version of the "water torture." The sounds and the confinement under angiography drapes or in the bore of a superconducting magnet can produce dissociation, perspiration, and, perhaps most terrifying to patients, claustrophobia. Some patients have equated the experience of MR imaging with lying in a coffin with the lid closed; others recall it as more distasteful than their surgical procedures. Still others are reluctant to acknowledge their fear and choose to suffer in silence.

It is clearly incumbent on the neuroradiologist to be sensitive not only to those patients who express their anxiety but also to those who suffer in silence. Radiology personnel should start from the premise that all patients are claustrophobic, frightened, and disoriented in scanners and angiography suites and attempt to alleviate that anxiety whether it is or is not perceived to be present.

It would be unwise to suggest that all neuroradiologists have an arteriogram to become familiar with the patient's role (although a brief glide into the tunnel of a magnet probably would not hurt). However, in addition to the safe conduct of the procedure and the obtaining of beautiful images, the physician must recognize what the patient is experiencing and give priority to diminishing the unpleasantness. If that becomes part of what is practiced and what is taught to fellows, residents, and technicians, the patient and the neuroradiologist will reap the benefits.

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