EDITORIAL

Second Chances

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"Sometimes life gives you a second chance because just maybe the first time you weren't ready."
– Author unknown

Our oldest functioning computer came with a free solitaire game called Freecell. I still play occasionally, but now I never register a loss. When I reach a dead end, I can reverse course, undo every card I played, and try again. So why give up when I can try over and over? Some games are frustratingly difficult to solve, but all can be won.

In medicine, some specialties provide more second chances than others. If you are a surgeon, you better get it right the first time: operate on the correct side, make sure all sponges and instruments are accounted for, and every suture is tied properly. If something goes wrong, a second surgery may correct matters, but no one will be happy.

The cognitive specialties are generally more forgiving. Some days, I'm on top of my game, recognizing a key triad of symptoms that point to a diagnosis, ordering just the right test to confirm a diagnostic hunch, and picking out the rare outliers from the many patients who have a more straightforward diagnosis. Other days, I recognize that I am tired or just not in the groove. Those days, more time is required, and nothing comes easily. If it is not an emergency, the best course may be to order appropriate tests, rebook the patient down the road, and rethink the situation. That strategy also provides time for matters to become more obvious: the patient with severe temporal headache and a high CRP develops a classic shingles rash in the V1 distribution, or the patient with apparent seronegative polyarticular rheumatoid arthritis (RA) develops clear-cut psoriasis.

A common second chance opportunity presents itself when a patient is referred back, often years after the initial consultation. I had a trio of those patients arrive in the same week recently.

The first patient had been seen in 2005 with a history of intermittent "sausage" and locking fingers, sometimes treated with antibiotics. This was followed by intermittent attacks of acute synovitis in the fingers, wrists, and knees, lasting up to 2 weeks at a time. Oral NSAIDs[1] were of limited benefit. Exam showed no evidence of psoriasis, and the only MSK[2] finding was slight tenderness of a single PIP[3]. Lab tests showed a high urate of 435, a negative RF[4], and an ANA[5] + 1:80. My working diagnosis was possible psoriatic arthritis. Palindromic rheumatism and gout appeared less likely.

The patient moved away. Sixteen years later, the patient was referred back with a 1-month history of swelling of the left hand PIPs and MCPs[6], decreased grip, and inability to make a full fist. This resolved after taking a course of an over-the-counter (OTC) NSAID. A dermatology appointment was pending regarding a scaly, flaky, itchy rash on the ears. In this case, the outcome was confirmation of the previously suspected diagnosis of psoriatic arthritis. Testing showed a normal CBC[7], ESR[8] 12, CRP[9] 5.4, negative RF and B27, and urate 366. X-ray of the hands was normal. Dermatology consult confirmed psoriasis.

The second patient was first seen in 2019 at age 70 regarding possible gout. Within the prior year, he had three acute episodes, all involving the right knee, with two ER visits. There was no redness, but he noted mild warmth, swelling, and pain on walking. Between episodes, he noted trouble kneeling. Each episode had responded to the standard ER acute arthritis prescription: Prednisone 50 mg to 0 over two weeks. Examination showed mild hand osteoarthritis (OA). The right knee was cool without an effusion or Baker's cyst, with tricompartmental crepitus, and flexion 0-110 degrees with stress pain. Gait was normal, but pain was noted in the right knee on squatting.

X-ray of the right knee showed moderate OA, particularly in the medial compartment, with meniscal chondrocalcinosis. Lab work revealed normal CBC, eGFR[10] 50, and urate currently 360 (previously no higher than 400).

With new onset of gout at age 70 being unusual, I thought most likely he was having episodes of osteoarthritis flares in the right knee, possibly related to CPPD/chondrocalcinosis. I stopped his prednisone, provided handouts about OA management, and injected the right knee with steroid. No fluid could be aspirated.

The patient was referred again recently, with episodic joint inflammation, involving the left wrist three times and the left ankle once. Short courses of colchicine 0.6 mg b.i.d. for a week and prednisone 30 mg/day helped. He had occasional pain at the right wrist and elbow, and both shoulders were limited in motion with some pain.

CBC was normal, ESR 73, CRP 57, eGFR 41, urate 350, RF negative, calcium 2.6, phosphate and other chemist-

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ries normal, and TSH[11] 5.6. With recurrent episodic arthritis involving knee, wrist, ankle, elbow and shoulders, the prior diagnosis of OA with possibly incidental chondrocalcinosis pivoted to CPPD arthritis with OA manifestations. X-rays of the hands, wrists, elbows and shoulders confirmed chondrocalcinosis at the elbows and shoulders, with OA changes in the hands, wrists, and shoulders.

Lastly, a 50-year-old woman was seen in early 2020 describing a 12-month history of diffuse joint and muscle pain in the upper and lower extremities and low back, the latter mechanical in nature by description. After prior neck pain, she was told she had arthritis at C5-C6.

Exam was unrevealing. CBC, ESR and CRP were normal, and RF and anti-CCP[12] were negative. I did not think she had an inflammatory arthritis.

The patient was referred back only five months later. Now, I was told that a first cousin had recently been diagnosed with ankylosing spondylitis, was B27+, and was about to start an anti-TNF[13] agent. New labs showed she was also B27+, while ESR and CRP remained normal. She continued to complain of sleep impairment and diffuse musculoskeletal discomfort in the hands, knees, shoulders, shoulder girdles, neck, upper and lower back, without inflammatory spinal pain by description.

On exam, there was no psoriasis or eye inflammation. No peripheral synovitis was present, nor any dactylitis, enthesitis or tenosynovitis. The neck and spine showed full normal range of motion. Gait was normal.

Imaging by the family doctor now included ultrasound of both wrists, both knees and the left elbow, all of which were normal. X-rays of both feet, ankles, knees, SI[14] joints, hips, hands, and wrists were normal.

My impression in this case was unchanged. Despite being B27+ with a family history of ankylosing spondylitis (AS), her symptoms were not those of seronegative spondyloarthropathy. I felt she had myofascial pain. I provided spinal posture and exercise advice sheets, a general stretching routine, and pain management strategies.

Three second chances: one opinion confirmed, one modified, one unchanged. Nothing major missed, which is always reassuring. Or at least I don't think so, but if any of these patients turn up a third time, further review will be in order.

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Glossary:
1. NSAIDs: non-steroidal anti-inflammatory drugs
2. MSK: musculoskeletal
3. PIP: proximal interphalangeal
4. RF: rheumatoid factor
5 ANA: anti-nuclear antibody
6. MCP: metacarpophalangeal
7. CBC: complete blood count
8. ESR: erythrocyte sedimentation rate
9. CRP: c-reactive protein
10. eGFR10: estimated glomerular filtration rate
11. TSH: thyroid stimulating hormone
12. anti-CCP: anti-cyclic citrullinated peptide
13. anti-TNF: anti-tumour necrosis factor
14. SI: sacroiliac