Correspondence

The Editorial Board will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words, and must be typewritten, double-spaced and submitted in duplicate (the original typescript and one copy). Authors will be given an opportunity to review any substantial editing or abridgment before publication.

Adult Kawasaki Disease—Three Occurrences in the Same Patient

To THE EDITOR: Medical journals are reporting similar syndromes which have been called "adult Kawasaki disease" or "staphylococcal toxic-shock syndrome."[1,2] Infectious disease experts throughout the country are obviously highly interested in the description of a possible new disease entity. I understand there are only one or two cases in which the illness has recurred once and wish to report a case in which, I feel, the illness occurred three times in the same patient.

Report of a Case.

A 16-year-old woman was first seen July 8, 1977, with complaints of fever, abdominal pain, nausea and severe headache. She had just started her menstrual period and there was no diarrhea. On physical examination the woman appeared very ill and the following findings were noted: tachycardia of 130, temperature 40°C (104°F), a reddened throat, with moderate cervical adenopathy, tenderness in the right upper quadrant of the abdomen, and a fine maculopapular erythematous rash on the face, chest and extremities. Cultures of the blood, throat, urine and spinal fluid were negative. Leukocyte count and serum glutamic oxaloacetic transaminase were elevated, as were the alkaline phosphatase and serum glutamic pyruvic transaminase. The patient appeared to be going into shock, with a blood pressure of 80/44 mm of mercury within eight hours of admission. Myalgias remained prominent during the first 72 hours. Mononucleosis spot and hepatitis associated antigen (HAA) tests were negative. Results of nuclear binding antibody and rheumatoid titer studies were within normal limits. Following treatment with ampicillin and kanamycin, the patient was discharged on the fifth hospital day after being afebrile 24 hours. Within two weeks, results of all liver function tests were normal.

One month later, on August 11, the patient returned with similar symptoms of fever, headache, myalgia, and chest and abdominal pain; vomiting had occurred but not diarrhea. One day after the onset of symptoms her menstrual period started. Her lowest blood pressure measured 74/34 mm of mercury, and right upper quadrant tenderness again was noted. The initial leukocyte count and serum amylase value were elevated. All cultures were negative except that *Staphylococcus aureus*, coagulase-positive, greater than 10^5 per cu mm, was cultured from the urine. X-ray and ultrasound studies of the gallbladder as well as an intravenous pyelogram, showed no abnormalities. This time the patient was treated with chloramphenicol and became afebrile three days after admission. Two weeks later all laboratory data were within normal limits including urine culture.

The third and most serious episode occurred two years later, in September 1979, when the patient was admitted on the third day of her menstrual period with complaint of hip pains, fever and general myalgia. On examination the patient again appeared ill, with a flushed face, fever, tachycardia, red throat and some upper abdominal tenderness. Puffiness of the face, wrist and hands was quite noticeable. Initial leukocyte count equalled 10,400 but rose to 15,600 within a few hours. All cultures were initially negative, and HAA antigen, nuclear binding antibody and febrile agglutinin studies showed no abnormalities. Antistreptolysin-O (ASO) titers were 166 Todd units on two occasions. The patient again appeared to be going into shock, this time having a decreased urinary output 24 hours after admission with rising blood urea nitrogen and creatinine values. A second urine culture grew *Staphylococcus aureus* from a catheterized specimen. During this hospital stay liver function tests were normal. For the first time the erythrocyte sedimentation rate became elevated, rising from 4 to 52 mm per hour during her hospital stay of eight days. The muscle pain was more severe, and the

rash more extensive with this third bout. Peeling of the fingers and palms of the hands was noted and had also occurred following her hospital admissions two years before.

Her illnesses resemble the staphylococcal toxic-shock syndrome described by Todd,[3] and further discussed in the *Utah State Communicable Disease Newsletter*.[4] Awareness of this syndrome (which does not appear to be rare), and further reporting by clinicians will aid those investigating its cause and management.

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2. Schrock CG: Disease alert (Letters). JAMA 243:1231, Mar 28, 1980
3. Todd J, Fishaut M, Kapral F, et al: Toxic-shock syndrome associated with phage group 1 staphylococci. Lancet 2:1116, 1978
4. Utah State Department of Health: Communicable Disease Newsletter, Feb 1980

Holistic Advice for Life-Threatening Conditions

TO THE EDITOR: Dr. Robert Raskind is to be commended for his straightforward statement of skepticism [Holistic Medicine for Neurosurgeons] in the March 1980 issue of the journal. His is a valid criticism of those proponents of holistic medicine who tell him that he " '. . . should not treat the tumor, but should treat the patient' " without telling him what he might say or do for the patient and how this fits with his role as physician.

It is not reasonable to expect those not having an intuitive appreciation of this approach to medical care to begin to understand it through philosophical discussions about treating the patient and not the disease. Most physicians evolved their sense of their roles and responsibilities vis-a-vis their patients through the repetitive experience of the clinical encounter, beginning as medical students with the observation of their teachers (the most highly esteemed of whom were generally researchers in the esoterica of subspecialties, and showed it), and progressing through the often tedious experiences of the years of residency. Any change in this sense will be achieved only through the same avenue—the specific clinical situation.

Unfortunately, Dr. Raskind could only give a very general description of the case he provided as an example. Nevertheless, I will risk some concrete observations. First, I would suggest that there are several antecedent questions that Dr. Raskind would do well to ask to help determine what his role in the patient's care might be: (1) What is the likely course of this patient's disease after craniotomy and excision of the lesion, and how does that compare with what it would be without a surgical operation? (2) How does the patient feel about the different outcomes presented by these alternatives? Indeed, unless the patient has indicated a wish for his life to be preserved whatever this may cost in residual impairment, simply asking how to go about preserving the patient's life, Dr. Raskind's first question, is irrelevant.

In this respect I would fault Dr. Raskind's critics for strongly (and blindly) advising against a surgical procedure, as much as I might fault him for the opposite. The essence of holistic medicine is a regard for the uniqueness of the patient's life, and to the extent that we cannot stand in another's place, we must be cautious about the advice we give. Where the risk of the disease is significant and the risk of the treatment insignificant (for example, in the use of diuretics for hypertension) this obviously is of minor consequence. But where the disease is life-threatening regardless of treatment and the available treatment carries its own set of complications, as is the case here, then due respect for the patient requires that when we go beyond presenting alternatives for the patient's choice (to answer the almost invariably asked question, "What do you advise I do, Doctor?"), we make clear that we are stepping out of our positions as experts and are answering on the purely personal basis of what we would do were we to find ourselves in a similar situation.

One guideline for the management of these life-threatening conditions, which Dr. Raskind requested and which he might find useful, is that a well-informed patient is the person best equipped to make the critical decisions affecting his or her life, and the physician is in the best position to assure that the patient is well informed about the relevant issues regarding the illness and its treatment.

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