

Lessons from a stitch in time

Physician assistants are detectives of sorts, looking for clues in the form of symptoms, a history, and examination findings; thinking outside the box; coming up with a diagnosis. So when I inherited Mom's old but working sewing machine, I tried to apply the very principles I use at work to figure out how to get the machine to sew.

After threading the machine and the bobbin, I tried sewing a strip of material, but the thread kept breaking. I checked the bobbin tension and the thread tension and rethreaded. The machine kept skipping stitches, so I oiled it and tried again. Same problem. Now I considered the zebras, listening for murmurs, bruits, or rales. No luck.



Frustrated, I got out the instruction book and carefully rechecked everything again. The motor sounded good. I changed the thread. Still, the machine would not sew.

Finally, I phoned Curtis at the local sewing machine store. Like some surgeons I know, Curtis always claims that the

things I bring in for repair need replacement. I am a real "let's try to fix it" person, a great believer in the recuperative powers of duct tape. When I called, Curtis said predictably, "Sounds like you need a new machine." "This *is* a new machine," I countered. I could hear the reluctance in his voice. "Okay, well, bring it in."

When I got to the store, the machine would not sew. Curtis rethreaded it. Still it would not sew. He thought for a while. "Maybe there's a problem with the needle?" he suggested. No way, I thought, although that was something I hadn't checked. He was right on the money. The needle had been put in backwards. I felt like a darn fool. The machine purred like a kitten with nice, even stitches.

This incident reminded me of two patients I had seen recently. A 72-year-old college professor came to the emergency department (ED) with chills, fevers, and abdominal pain, saying, "I just don't feel good." He looked terrible. His WBC count was mildly elevated, and he had a low-grade fever. His wife noted that he was "not a complainer," and I could tell the ED was the last place he wanted to be. His liver enzymes were in the 200s. On ultrasonography, his gallbladder and liver appeared normal. I found no jaundice or increased liver span, but when I removed his shirt to listen to his lungs, there was a large round red rash on his back. Although there was no central clearing, I immediately thought of a tick-related pathogen. We admitted him, started doxycycline, and ordered some exot-

ic laboratory tests. The results were positive for ehrlichiosis, a rare illness I had not thought of since studying for my initial PA boards. The only clue I had came from that most basic physical assessment tool: *inspection*.

The second patient was a 26-year-old male with abdominal pain and a negative abdominal CT. No elevated WBC count. No fever. I examined him, explaining that appendicitis is always a possibility and is known as "the great masquerader." Still, given his test results and radiograph, appendicitis seemed remote. I palpated his abdomen, starting with the left side, while watching his face. When I moved to the right mid and lower quadrant, he winced and tried to remove my hand. Yet he had no rebound, no obturator or Rovsing's sign. Perhaps I was pushing too hard on his abdomen. A repeat exam yielded the same results. I asked the radiologist to look again at the CT. "Hmmm," I could hear him thinking aloud, "that appendix is obscured behind the cecum and elevated, but it might be a bit thickened." A CT the next day showed that the appendix was clearly infected. Only one clue here: *palpable pain*.

Curtis didn't need to make me feel dumb after righting the needle. He loves sewing machines. He took out screws and oiled the machine's inner parts, pointing out each nuance along the way. He taught me about bobbin tension, throat plate removal, foot pressure, and what to consider if one side of the stitch looked uneven. He spent a good half hour teaching me about my new/old machine.

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Curtis did a good job figuring out what was wrong with my sewing machine, and then he took an extra step. He did some effective teaching. I determined to keep this experience in my lab coat pocket. Solving the problem is only one part of our work. Good teaching gives that diagnosis meaning.

I asked Curtis what I owed him. He said, "No charge, but if you like, go over to The Beanery (our local coffee spot) and get me a #34." Chock-full of appreciation, I drove to the coffee place. When I ordered a #34, the girl behind the counter said, "So was the needle in backwards?" Speechless, I returned a humble smile. **JAAPA**

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