



## It's not the noise, it's what you do with it

In his physician-coming-of-age novel *House of God*, published in 1978, Dr. Steven Bergman (aka Sam Shem) presented rules for an intern's survival devised by the senior resident, the Fat Man. Rule X was that there is no fever if you don't check the patient's temperature, implying that if the physician is unaware of an elevated temperature, no "fever workup" is warranted. A fever workup back then was not just a few keystrokes to order a chest x-ray, complete blood cell count, and blood cultures. The intern had to go to the bedside, awaken and examine the patient, draw the blood, perhaps transport the blood samples to the lab, do a urinalysis, and take the patient to the radiology department to get the chest x-ray. There was often little thought to the intern's action; a fever in the hospital automatically meant there needed to be a fever workup.

A covering senior resident might have gotten the same notification of a fever, quickly reviewed the chart, gone to the bedside, and assessed whether a bacterial infection was likely enough to warrant the time and annoyance of a full fever workup. As supervising faculty, I will accept that assessment from a senior resident in June more willingly than from an intern in July. Tests and physical findings must be evaluated in context, taking into consideration the patient as well as the skill and experience of the physician.

So how should we react to guidelines that seem to be based on the premise that a positive finding will result in reflexive ordering of additional tests or initiating a therapeutic intervention, and thus should be avoided by all of us—young intern and senior cardiologist alike?

In this issue of the *Journal* (page 855), Dr. Aldo Schenone et al discuss the management of the asymptomatic patient who has carotid artery stenosis. They put into perspective the risks and benefits of medical or surgical intervention as initially defined by several landmark trials, noting how those conclusions should now be modified by knowledge of the efficacy of current medical therapy.

The US Preventive Services Task Force (USPSTF)<sup>1</sup> has recommended against screening for asymptomatic carotid artery stenosis in the general population, noting the limited sensitivity (71%) and specificity (98%) of auscultation to diagnose significant stenosis and lumping it with other ineffective screening tests. In other words, we should not examine asymptomatic patients for carotid bruits, just as we should not look for the fever because finding it could lead to additional testing and potentially unnecessary therapy.

But there are broader implications when a bruit is discovered, beyond simply trodding the algorithmic path toward stenting or endarterectomy. A bruit can suggest occult atherosclerotic disease that warrants medical attention, even if traditional risk factors for atherosclerosis are not prominent. Its discovery can be a wake-up call to the patient (and physician) that the hackneyed admonitions to eat healthy, lose weight, and exercise are actually relevant. Its discovery may lead to medical intervention with

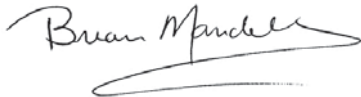
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a potent statin or with a more aggressive target for blood pressure control. It may color the interpretation of the patient's described vague arm tingling when bowling.

I may well be misleading myself, but I am more comfortable in dealing with whatever oddities I discover on a physical examination than not doing the examination at all. I'd rather know about the bruit (or the fever) and then think about our options. The stethoscope indeed has limited test reliability, but the real action takes place between its earpieces; the bruit is merely the catalyst for thought. There must be a guideline somewhere that says that a thoughtful, informed, commonsense evaluation is a useful contributor to patient care.



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1. LeFevre ML; US Preventive Services Task Force. Screening for asymptomatic carotid artery stenosis: US Preventive Services Task Force recommendation statement. *Ann Intern Med* 2014; 161:356–362.