



There may be zebras running with the horses

Over the summer, I lectured in an internal medicine maintenance-of-certification course. Using a case-based discussion format, I presented real patients to review the breadth of rheumatic diseases that the course participants might encounter in their practices and on board examinations. At a break, one of the participants, obviously frustrated, approached me to say that he thought that I had mentioned too many uncommon situations, that he didn't need to know secondary treatment options and disease mimics—I should just have reviewed the common aspects of the common diseases he would encounter in practice (and on the exam).

I was a bit taken aback. I try hard to avoid emphasizing the arcane details that only a subspecialist needs to know. I reconsidered my approach: should I only review the common and the expected? But without knowing something about the clinical permutations and the mimics of the common diseases we encounter, I don't know how we can avoid making incorrect diagnoses due to the cognitive bias of familiarity. Common diseases are indeed common, but that doesn't mean patients with less-common ones don't find their way into our practices. As internists, we need to constantly humble ourselves with the knowledge that there is much in medicine, in every specialty, that we can't remember, do not recognize, or just don't know enough about. It is not just about "what will be on the test." When a patient exhibits atypical features of the common disease that they have been diagnosed with, or doesn't respond as expected to therapy, we need to remember that less-common mimics of that disease exist, even if we can't remember the specific names or the pathophysiology.

Peripheral vascular disease is common, is rarely diagnosed early, and is usually related to atherosclerosis. Significant disease is generally manifested by symptoms of exertional limb ischemia or even pain at rest and stigmata of distal tissue hypoxia and necrosis from the decreased supply of oxygen and nutrients. But there are nonatherosclerotic causes of limb claudication, distal ischemia, and livedo reticularis. In my clinic, patients with those symptoms and findings are quite likely to have a form of large vessel arteritis, Raynaud phenomenon, or both. In a patient with Takayasu or giant cell arteritis, pain with repetitive arm use is more likely from subclavian occlusion than rotator cuff disease, whereas the latter is the far more common cause of arm pain with repetitive motion when patients see a physician for "arm pain" before the diagnosis of arteritis is considered. We need to entertain alternative diagnoses in order to perform the appropriate physical examination, obtain appropriate diagnostic studies, and initiate the correct therapy.

Eun et al, in this issue of the *Journal* (page 741), highlight and briefly discuss nine nonatherosclerotic entities that cause limb ischemia. The diagnostic assessment of these can be invasive and expensive, yet may be warranted to provide the appropriate therapy. The diagnosis not pursued will rarely be made in a timely manner, and the diagnosis not considered will not be pursued at all. And with these diseases, the patient's history and examination usually provide the clues that the horse has stripes.


Eun et al highlight clinical features that may distinguish these entities from typi-

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cal atherosclerotic peripheral vascular disease. Recognizing the features that are atypical for atherosclerosis implies that we know the more typical features of the disease. Knowing something about the uncommon as well as the common helps prepare us for the real test—the patient in front of us. And that patient doesn't usually know that he or she is a zebra and not a horse.

Last month, I highlighted some staff changes in our editorial staff. I want to take this opportunity to introduce Craig Nielsen, MD, as our new deputy editor. Craig is a superb internist in both inpatient and outpatient arenas, a medical educator, and former director of our internal medicine residency program.



BRIAN F. MANDELL, MD, PhD
Editor in Chief



Craig Nielsen, MD



CME CALENDAR

2016

NOVEMBER

EXPLORING THE FUNCTIONAL MEDICINE MODEL: A CASE-BASED APPROACH
November 4
Cleveland, OH

52ND ANNUAL GASTROENTEROLOGY UPDATE
November 5
Warrensville Heights, OH

ADVANCING NEUROLOGICAL THERAPEUTICS
November 5
Las Vegas, NV

16TH ANNUAL MULTIDISCIPLINARY GENITOURINARY ONCOLOGY COURSE
November 10
Cleveland, OH

5TH ANNUAL COMPREHENSIVE NEUROTOXIN COURSE FOR NEUROLOGICAL CONDITIONS
November 11
Cleveland, OH

2ND CLEVELAND CLINIC BETA CELL THERAPY SYMPOSIUM: ADVANCES IN MANAGEMENT OF DIABETES
November 11–12
Cleveland, OH

DECEMBER

CLINICAL MANAGEMENT OF MDS/MPN: A MOUNTAIN OF EVIDENCE FOR TREATMENT SELECTION IN MDS/MPN
December 2
San Diego, CA

DR. ROIZEN'S PREVENTIVE, INTEGRATIVE, AND LIFESTYLE MEDICINE CONFERENCE
December 2–4
Las Vegas, NV

15TH ANNUAL LIVER UPDATE: A REPORT FROM THE AMERICAN ASSOCIATION FOR THE STUDY OF LIVER DISEASE ANNUAL MEETING
December 9
Beachwood, OH

CLINIC SEMINARS: DERMATOLOGY
December 9
Beachwood, OH

2017

FEBRUARY

19TH ANNUAL PAIN MANAGEMENT SYMPOSIUM
February 4–8
Orlando, FL

DIGESTIVE DISEASE INSTITUTE WEEK 2017
February 14–19
Boca Raton, FL

6TH ANNUAL GASTROENTEROLOGY AND HEPATOLOGY SYMPOSIUM
February 16–18
Boca Raton, FL

5TH ANNUAL BASIC AND CLINICAL IMMUNOLOGY FOR THE BUSY CLINICIAN: AN IMMUNOLOGY BOOT CAMP
February 17–18
Las Vegas, NV

BREAKTHROUGHS IN NEURO-COGNITIVE DISORDERS
February 25
Fort Lauderdale, FL

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