The Johns Hopkins Hospital 實習成果報告書

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前言

感謝國立陽明大學醫學系、財團法人臺北市清井醫學關懷慈善基金會、榮陽卓越醫師人才培育計畫，以及老師、家人、學長姐、同學及各單位行政人員的幫忙，讓我能有這個出國實習的經驗。一路走來，有許多的前輩鼓勵我，不要因為自己來自經濟狀況不好的家庭就畫地自限，而母親近來病況穩定，父親也希望我趁年輕時多去增廣見聞，苗栗家裡的狀況要我放心。

我喜歡醫學，是因為享受像個偵探般抽絲剝繭的過程，臨床決策的思路總是引人入勝，因此這次我選了兩個風格迥異卻都需要大量鑑別診斷的科別——風濕科(rheumatology)與急診醫學(emergecny medicine)。

行前劉瑞玲主任叮嚀，美國的醫療固然有許多令我們稱羨之處，但在讚賞之餘，也要反思在人力、資源與環境差異甚大的台灣，我們怎樣能讓醫療更好。除了自我的提升，我相信此行很重要的目的，是如何把這些經驗化為貢獻，回饋台灣！

風濕科會診(rheumatology consult team)

（上圖）熱愛教學的attending Dr. Haque, 希臘來訪的R2 Dr. Michailidou, 從問病史、做檢查到改病歷都細心指導的fellow Dr. Adler

"She is a so interesting case. None of my patients are not! "

主治有天查完房後有感而發，作為最後線醫院的風濕科，見到的疾病真的有夠複雜，有位病人在院外的醫師也說"I have no idea. Go to Hopkins"

風濕科在院本部(downtown hospital)沒有辦公室跟自己的病房（除了紅斑狼瘡門診在此，其他單位都在Bayview hospital，主治說是因為院本部的場地費用較貴，整個風濕科只有一個人付得起），因此每天就是從早走到晚的查房。

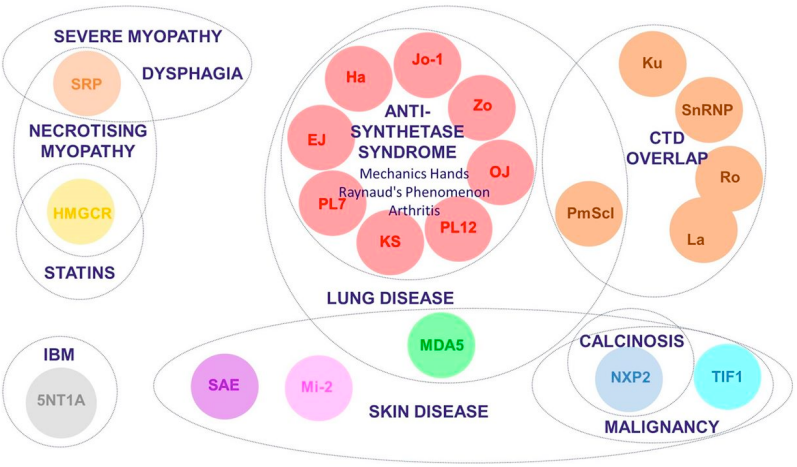
病人主要可以分成兩大群，分別在1-3床的CJ service（本科住院病人）與5-8床active consults（會診病人）。

早晨pre-round完自己的會診病人（醫學生大概負責3床左右）之後，是找研究醫師(fellow)討論今日評估與接下來的治療方案，接著跟主治醫師(attending)會合，把本科住院病人看過後，去住院醫師的辦公室討論本科住院病人的狀況，再一起把會診病人看完。中間可能穿插的行程，包括一夥人到影像科討論片子、到病理科一起看玻片討論鑑別診斷或與其他專科的團隊開會病人治療計劃。

每天最期待的時候，大概就是fellow的pager響起並說出"We got a new consult"的那刻，我與另一位希臘來的visiting R2輪流接會診病人。這裡會診很是扎實，病史詢問及其詳細、理學檢查也絲毫不馬乎流暢地近乎全做，病歷的部分最讓我印象深刻的是assessment&plan，在台灣時通常就用summary的方式條列帶過，但這邊喜歡旁徵博引許多論文，從最可能的鑑別診斷列到沒那麼像但還是要放心上的診斷，最後才是給發出會診的團隊的條列式建議。

我印象深刻的是，主治醫師很喜歡問我”What’s your plan?”，例如說一個急性痛風發作的病人，我知道oral prednisone是合理的選擇，但老師會緊接著追問”What’s your dosage? How long will the patient be on it?”還好在前幾天有閱讀過相關的研究，可以提到最近的實證建議是40-60mg prednisone QD使用五天，即可有不錯的止痛效果(Ann Intern Med. 2016;164(7):464)。在台灣常常是純粹遵從主治醫師的指示，但這裡則是接病人的人（可能是醫學生、住院醫師或研究醫師）要說出自己的計畫，整個團最再一起討論與修正，這樣的訓練感覺更能夠培養以後的獨立性。

至於討論會有多深入呢？記得有次聊到皮肌炎/多發性肌炎(dermatomyositis/polymyositis)，主治就請問大家能否系統性的講講有哪些autoantibodies，此時我心中只想到anti-Jo1跟PM與ILD有關、anti-SRP較嚴重還容易有cardiac involvement、anti-Mi2通常是表現典型的skin rash，頂多再次加上statin related myopathy有關的anti-HMGCR。殊不知，老師說「有沒有更有系統性的分類？」，接著便有同學拿出一篇最近讀過的paper，帶大家進入右圖的討論。最大的感觸是這邊似乎每個人都自己讀了許多文章，討論起來都有憑有據而較少只依循直覺。



J Intern Med. 2015 Nov 25. doi: 10.1111, Figure 2 (Myositis autoantibodies and their key clinical associations.)

老師也開始聊起這些autoantibodies有哪些是在Hopkins發表的，這讓我想起尚叡學長說道，這邊的演講常常會從歷史開始告訴你，當你覺得這些東西其來有自，而不再只是奇妙發音的陌生抗體時，認識他們變得有趣許多。

另一方面，有天的Rheumatology Friday Round討論到什麼是「好的會診」？講者Dr. Seo提到，永遠記得你的目標是在幫助病人——The purpose of the consult is to give advice, NOT to document how smart you are.那些華麗的鑑別診斷固然有趣，但提供簡明扼要的建議給發會診的團隊仍是重要的，如果他們感興趣，再回頭來看論述的過程。

對醫學生而言，拜讀他們每篇的assessment都獲益良多！我能清楚讀到這位老師從最初的症狀、到理學檢查，他懷疑了哪些疾病，因此分別要做哪些檢查加以證實或排除，如果那些檢查有哪些結果，我們下一步可能怎麼做等等……這算是這裡會診的特色，每一個病人不是只看一次，而是看了第一天後接下來每天都會follow，寫consult progress note，持續給予本team建議。在這段時間我也做了不少練習，書寫他們風格的評估與處置（如附檔）

最後是關於門診，fellow說在有同時顧病房時的門診通常一個上午是四個病人，如果是純粹的門診日，則一個上午大約八個，流程是病人報導之後在舒適的候診間等，然後進來診間後，會有詳細的問診、完整的理學檢查，做出簡單的評估後，會告知病人我們去找主治醫師討論做最後的決定，到辦公室與主治醫師簡短報告與討論決策後，會再一起去看一次病人，簡單說一下評估與處置，至於之後大概花20分鐘左右的時間，詳細紀錄剛才取得的病史、做的檢查，以及整體的思考脈絡與未來的處置。這樣的時間分配，以台灣的眼光來看是滿奢侈的，我們醫院的門診常常動輒一個半天就六、七十人，一個病人大概就花五分鐘，究竟是應該讓每個病人得到更詳盡的評估，而縮減門診的量，還是維持現有的門診量而精簡門診的內容，要取得平衡實在不容易。

結語

這兩個月以來，除了醫學知識上的增長、親眼見識到許多罕見的疾病（如anti-PL7 syndrome, relapsing polychondritis等等），更令我覺得值得學習的，是遇見的同學與老師都對知識充滿著熱忱——總是自動自發回去讀了兩三篇研究，隔天大家一起來討論。而又因為在團隊當中，可以感受到他們對醫學生的重視，更讓人願意回去讀更多東西，來共同修改決策讓病人的照護變得更好。

我記得有一次問fellow問題，說”Sorry it might be a stupid question…… ”，她便直接回”Every question is welcome, no question is stupid.” 在這裡討論的氣氛很好，真的不了解就問，就算是資深的教授也不會露出不屑的眼神，而會很誠懇的與你討論問題。在台灣時我往往會戰戰兢兢，想著「這是不是一個聰明的問題／回答？」才敢發言，但在Hopkins，只要你有想法都很歡迎提出來討論，我認為這樣的風氣是很值得被推廣的。

這兩個月是珍貴且難忘的經驗，我會好好應用所學的這些，繼續在台灣的醫界努力！

附檔一、36-year-old female with polyarthralgia, rash and episcleritis/scleritis

Ms. Barber is a 36-year-old female with underlying hydradenitis suppuritiva (was admitted to NW for I&D this Feb. with 2 left and 1 right axillary lesions, started getting boils since she was 12, some of them grew MRSA). She had sudden onset poly-arthralgia and skin rash since 1 month ago and left epislceritis/ scleritis diagnosed by ophthalmology on 04/02. Rheumatology is consulted because of concern for systemic disease given an episcleritis/ scleritis with these symptoms.

The systemic etiology of episcleritis/ scleritis is still unclear at this time. The most common concerns in scleritis patient is rheumatoid arthritis. However, she has no synovitis over her MCP, PIP and MTP joints. The symptoms didn't last longer than 6 weeks, no significant morning stiffness and negative RF making rheumatoid arthritis less likely. She denied history of sinusitis, hemoptysis and hematuria, and there was no livedo reticularis or purpura over her skin, which less favored to be ANCA-vasculitis. She denied bloody diarrhea, abdominal pain, family history of Crohn's disease or ulcerative colitis, so IBD was not indicative. UC occurs with HS in 14% of patients (Scheinfeld et al. 2013). The axial spondyloarthropathy was suspected due to history of back pain and an episode suspecting left index finger dactilytis. Evaluation of her sacroiliac joint and HLA-B27 should be tested. Besides, the sarcoidosis and HIV can involved multiple joints and also the eyes in all ways.

In regard to her hydradenitis suppuritiva, it did associated with several disorders. Crohn disease, ulcerative colitis and spondyloarthropathy were mentioned above. There are some reports of patients in whom hydradenitis suppuritiva has developed within a syndrome-like presentation. We concered about SAPHO syndrome -- synovitis, acne, pustulosis, hyperostosis and osteitis. She had acne and pustolosis history. There was a tender point over her anterior chest wall, which is the most common area involved in this syndrome. Besides, PASH syndrome (pyoderma gangrenosum, acne and suppurative hidradenitis) and PAPA syndrome (pyogenic arthritis, pyoderma gangrenosum and acne) are also considered.

In Summary:

- Please send HLA-B27 and X-rays of the SI joints to evaluate for a spondyloarthropathy
- Please obtain a bone scan to evaluate for osteitis. If this is negative, she would benefit from a MRI of her SI joints to evaluate sacroilitis
- Agree with sending anti-CCP, ANA, anti-dsDNA, C3, C4 to rule out lupus or rheumatoid arthritis
- Please rule out HIV
- Please obtain X-rays of the hands, feet, and wrists
- We will await the skin biopsy

Thank for this consult. We will continue to follow.

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附件二、59-year-old female with left hand pain and swelling in the setting of post-operation day 3

Ms. Menzies, a 59-year-old female with past medical history of rheumatoid arthritis, psoriasis is presenting with left hand pain and swelling in the setting of post-operation day 3. Rheumatology was consulted for the possible etiology of presenting acute left hand tenosynovitis.

For the acute tenosynovitis, infection or crystal deposition arthropathy should be considered. She has considerable soft tissue swelling, tenderness and warmth over her left hand and wrist. Cellulitis was suspected in this condition. The post-operation condition predisposes crystal deposition arthropathy, although she denied prior history of gout/ pseudogout. She had suspecting chondrocalcinosis on X-ray of her left wrist.

The left mid-foot warmth and tenderness raise concerns of gout and might be separate process from her hand.

As for morning stiffness, invlovement of small joints(left 1st MCP), the inflammatory arthritis was suspected. In rheumatoid arthritis, however, doesn't present with much soft tissue swelling like this case. Her swelling and tenderness doesn't limited to her wrist and the most of MCPs are relatively well, which make the rheumatoid arthritis flare less likely at this time.

In Summary:
- Please check uric acid level
- Please check HIV, HBV and HCV
- Please monitor if any systemic signs of cellulitis, further workup would be needed then
- Start 800 mg ibuprofen Q8H for suspecting inflammatory arthritis

Thank for this consult. We will continue to follow.

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