

# When A Physician Takes An Unforgettable Vacation

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## Case Resolution:

She had no symptoms suggestive of giant cell arteritis. She was started on 40 mg of Prednisone with very rapid resolution of her symptoms. A year later, she is still requiring 4 mg of Prednisone.

**Discussion:** The diagnosis of PMR requires the exclusion of other rheumatological and musculoskeletal conditions.

Complexity of this case was augmented by recent travel and commonly observed behaviors when health care providers become patients: self-diagnosis, anchoring heuristic, curb consults, and “driving from the back seat”.

**Evaluation:** Exam showed normal vital signs. She had decreased active and passive ROM in both shoulders without sensory deficit. Lab work revealed elevated ESR, platelet count and TSH, with normal CPK. She was certain that her pain was due to cervical stenosis and requested cervical spine MRI which was unrevealing.

## Differential Diagnoses:

**Cervical spine disease:** Now less likely as symptoms were very extensive, without MRI evidence of radiculopathy or myelopathy.

**West Nile Virus & Dengue:** both became less likely due to the duration of symptoms and lack of fever or supporting exam findings. She declined serological testing.

**Rheumatological disease:** notably Polymyalgia Rheumatica (PMR)

**Background:** about 20 % of outpatient visits to primary care practices involve musculoskeletal complaints. While some diagnoses can be made at bedside, few require extensive testing. In this case, complexity was compounded by physician’s self-diagnosis.

**Patient presentation:** A 75-year old physician with known injection requiring degenerative cervical spinal stenosis, and s/p thyroidectomy for papillary thyroid carcinoma presented with a 3-week history of bilateral neck and shoulder pain that started during the fall season while on vacation at a Red Sea resort, with new pain in the low back and hips. She denied fever, chills, or URI symptoms. She reported a few mosquito bites during her trip.