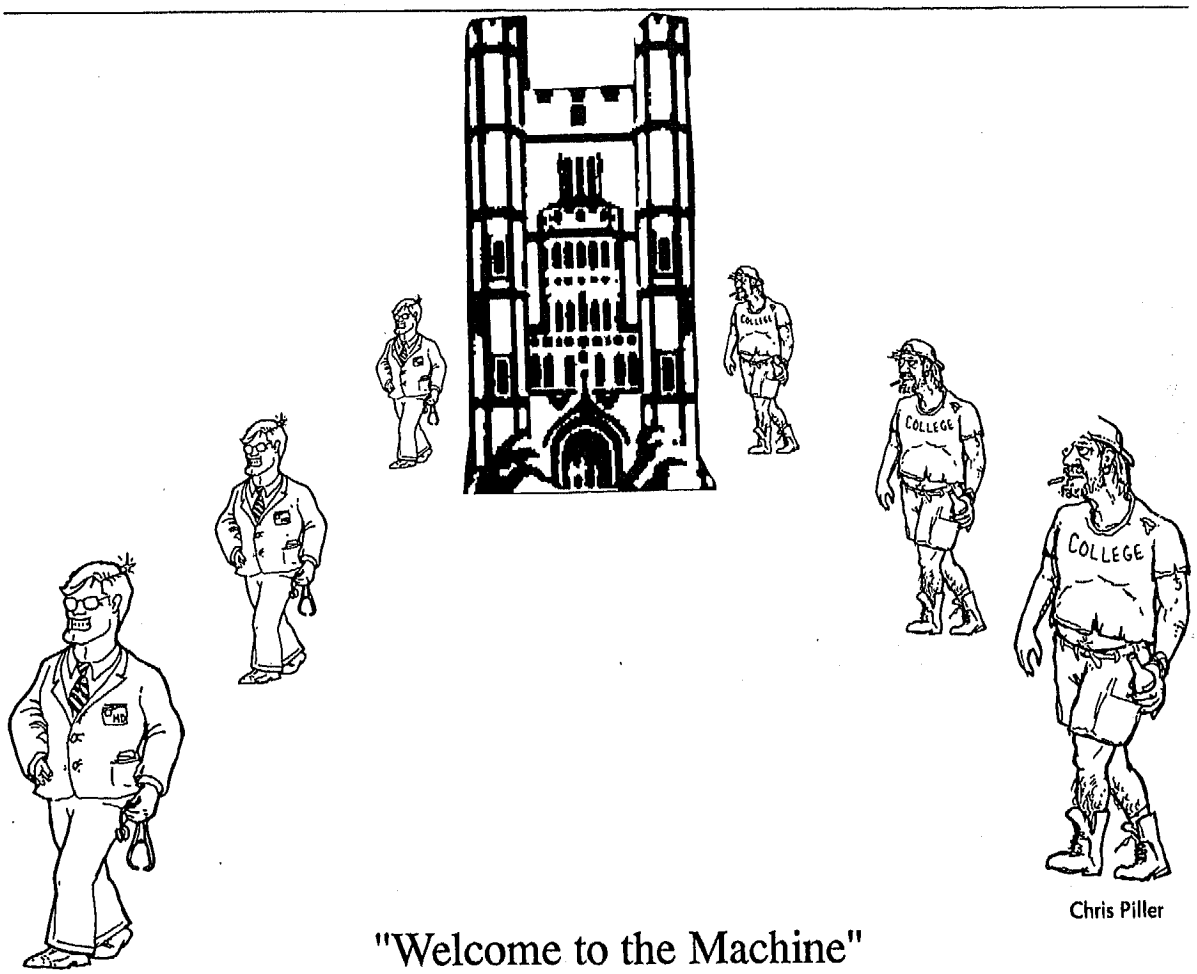
Shifting Dullness

August 1993



Chris Piller

"Welcome to the Machine"

Inside this issue:

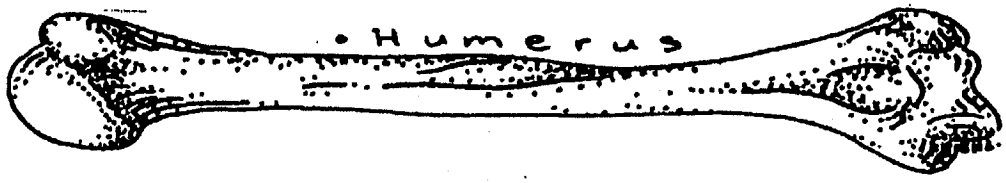
Sure, everybody thinks they have the funniest story from the wards!

. . . *But can you prove it?*

Shifting Dullness is sponsoring a contest for the most amusing story from the wards. All entries will be judged by Dr.s Blazer, Gianturco and Pounds, with judges blinded to identity of the author.

First Place: $50 gift certificate to the Magnolia Grill.

Direct entries to the Shifting Dullness box by the candy area or box 2865. Please include name and phone number. The decision of the judges is final.



Annoucements

Book Cooperative

An effort is currently underway to initiate a "Medical Book Cooperative" in the new medical student lounge in the basement of Duke South. The Book cooperative is basically a means by which students may buy and sell books from one another. Students may drop off books at any time, which will subsequently be placed in an enclosed bookshelf for all to see and admire. Potential buyers may leave "dibs" for a book and then return to purchase it when the cooperative is staffed. All prospective buyers and sellers are encouraged to stop down and take a look. Additional information is posted in the student lounge. Please contact Thomas Jones, MSII with questions.

ACLS Course

The Advanced Cardiac Life Support Class that was originally scheduled for May 2-7, 1994 will rescheduled to two courses offered on November 15-20, 1993 and May 16-21, 1994. The ACLS course has broad application to any clinical rotation and is required for residency. Certification lasts for two years following successful completion of the course and test. The class is one credit and cannot be taken if it causes the student to exceed five credits in a four week rotation or 10 in an eight week rotation. Basic Cardiac Life support is a prerequisite and a thorough perusal of the Textbook of Advanced Cardiac Life Support is recommended prior to beginning the course. All third and fourth year students are encouraged to consider registering.

Outreach Corner

Hello and welcome to all new MSIs. As you are filling out your calendars with the overwhelming number of activities, events parties, labs and tests which will comprise the beginning of your first year. Please keep the following in mind:

1. Activity Fair - Tuesday, Sept., 7 from 5:30-7 p.m. This is after the first test, so no excuses to miss. This annual event is really the best way to get a feel for all the activities and projects in which Duke Med students are involved. Representatives will be on hand from Curriculum committee, Davison Council, Habitat for Humanity, AIDS volunteer network, Lenox Baker volunteers, Family Medicine Interest Group, IM sports and many others.

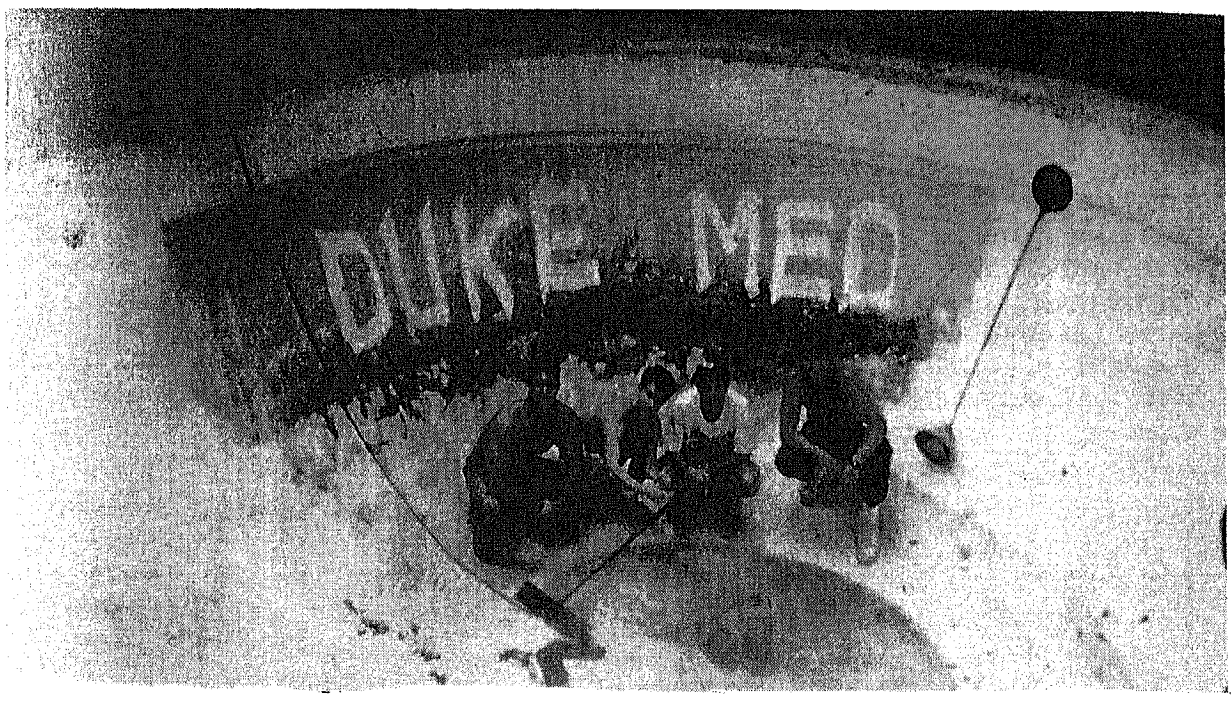
2. Adopt-a-Highway will be held on a Sunday soon and provides a good bonding activity which will allow you to really get a taste and feel of your new home of Durham.

3. Soup kitchen volunteers. Join a group of Med students prepare and serve food to Durham's homeless. The group ventures out every second Sunday of the month and would love to hear from interested people. Please contact Darin Smith at 383-9650 for questions.

Please contact Katie Moynihan, service chairperson for the Davison Counsil, at 383-1211 if you have any questions or new ideas for service and community opportunities. See you at the fair.

Steve Chul

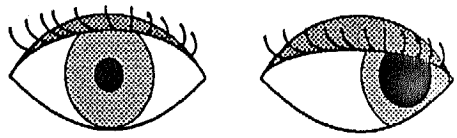
New MSIs mingle with their big sibs.



Steve Chul

In the fetted sewer of medical schools, Duke is undoubtedly the top.

Journal Watch



Greg Lucas

Digoxin has been used for congestive heart failure for centuries, yet it has only been very recently that its efficacy for this indication has been demonstrated in prospective trials. Recently much attention has been paid to the survival benefits of employing ACE inhibitors in CHF, and some studies have suggested that the continued use of digoxin in this setting is unneccesary. However, a recent study in NEJM vindicated the utility of the 200-year-old ionotrope. One hundred and eighty CHF patients who were clinically stable on digoxin, diuretics and an ACE inhibitor were randomly assigned to either digoxin replacement by placebo or continued digoxin administration. During the three month follow-up, 23 patients from the placebo group had worsening CHF requiring medical intervention, while only 4 from the digoxin group required such intervention. Additionally, treadmill exercise tolerance and perceived quality of life was significantly worse in the placebo group. *New England Journal of Medicine, July 1, 1993.*

The ultimate goal of pursuing detailed biochemical information on carcinogenesis is, of course, the development of designer drugs that will be tremendously specific for the reactions in question. Recently two separate teams have reported development of drugs which apparently block the ability of mutated *ras* genes to make cells cancerous.

The *ras* oncogene has been implicated in the genesis of as many as 20% of all cancers, including 50% of colon cancers. In transformed cell lines, the ras gene is permanently "turned on." However, the *ras* gene product is initially an inactive protein that must undergo a series of biochemical modifications before it can attach to the cell membrane and carry out its nefarious task of producing uncontrolled cell proliferation. Two drugs have recently been developed that competitively inhibit the enzyme farnesyl transferase, a key factor in the early modification of the Ras protein. Initial studies in cell cultures of cells made cancerous by introduction the mutated *ras* oncogene, demonstrated that the inhibitors prevented attachment of the Ras protein to the cell wall and restored normal growth characteristics to the colonies. *In vivo* trials are forthcoming. *Science, June 25, 1993.*

It has long been observed that many diabetics on insulin therapy still develop long term microvascular complications of the disease and it has been unknown whether fastidious control of blood glucose levels has any benefit over a less rigorous regimen of control.

Recently the final results of the The Stockholm Diabetes Intervention Study were reported. This extensive study randomly assigned 100 patients with IDDM to either an intensified insulin regimen, with daily self-monitoring and adjustment of insulin doses, or a standard insulin regimen that was modified only by a physician at regular four month visits. Over the course of the entire study the mean glycosylated hemoglobin level for the intensive regimen group was significantly less than the standard regimen group at 7.1 and 8.5 respectively. Over the eight year follow-up, the incidence of retinopathy was 25% less, nephropathy 16% less, and deterioration of nerve conduction velocity significantly less in the intensified treatment group than the standardized treatment group.

As might be expected, the incidence of serious hypoglycemic episodes, requiring the assistance of another was higher in the intensive therapy group at 1.1 episodes per patient year as compared to .4 in the standard treatment group. *New England Journal of Medicine, July 29, 1993.*

A Buyers Guide to Macintosh Computers

There has never been a better time to buy a Mac. The campus store is running a back to school promotion, so we will give you our opinion on the various bundles.

A few notes about all of the machines. Some of the less expensive bundles include the Apple Basic Color Display. This monitor is not nearly as clear and crisp as the Macintosh Color Display, so before you buy a computer, make sure you carefully evaluate the display. Always spend a little more now for a larger hard drive, because eventually you will run out of room. Although 80 MB seems like a big drive now, some programs are 5-10 MB each. Finally, most machines come with 4MB of ram, but to run anything more than the basic programs, you will need at least 8MB. Probably the least expensive upgrade is to order the memory from a mail order company, and, if you don't feel you can install it yourself (it is really easy) the store will install it for a small fee. The bookstore pricesfor memory are very expensive.

The best feature of the **Color Classic** ($999) is the all in one design. The price is good, but the machine is slow, the monitor is small, and the expandability and upgradeability is very limited.

The **Macintosh LC III 4/80** ($1,329) and **4/160** ($1,449) have proven to be the most popular models for good reason. The price is great, the machine is relaively fast (25 mHz 68030), and it is small. This would be a good machine for most students for word processing, spreadsheets and simple drawing programs.

The **Macintosh Centris 610 4/80** ($1,559) and **8/230 w/CD-ROM** ($2,329) would be my choice for a machine. They are much faster than the LC III (20 mHz 68LC040) for only slightly more cost.

The most expensive bundle, the **Macintosh Centris 650 8/230 w/CD-ROM** ($2,749) is a fast, (25 mHz 68RC040 with a math coprocessor) expandable system (3 Nubus slots) but probably more than the average student needs.

In terms of portables, avoid the **Powerbook Duo 4/120** ($2,429). While the idea of having a portable machine that may be expandable by docking it is appealing, the price and inconvenience are not worth it.

The **Powerbook 145B** ($1,349) is a great student machine. It is fast, has a reasonably good screen, and a great price. However, I would recommend waiting until the end of August for the new **Powerbook 165B** (around $1,600). The portable will be about 30% faster, but most importantly, it will have a video out port. If you plan to be spending large amouts of time in front of the screen, it is worth your money to have the option of hooking up an external monitor.

In January 1994, Apple will introduce the next generation of the Macintosh, the PowerPC. This is a RISC based system that initially will be anywhere from 2 to 10 times as fast as the fastest current Macintosh (faster than the new Intel Pentium), and will be priced under $2,000. The Centris series will definitely be upgradable, so bear this in mind when buying a machine now. However, don't holdoff buying a computer now if you think you will need one, as the current Macs will be around for awhile.

Shifting Dullness Staff

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THE NARCOLEPTIC AND GUT-RETCHINGLY MUNDANE ADVENTURES OF

SCUT BOY!

OUR HERO GREW UP IN A SMALL TOWN WHERE HE EXCELLED IN THE CLASSROOM, ON THE PLAYING FIELD, AND UNDER THE BLEACHERS WITH A CHEERLEADER DURING A PEP RALLY. HIS PARENTS DOUBLE-MORTGAGED THEIR HOUSE FOR HIS IVY-LEAGUE EDUCATION, SO HE COULD LEARN TO POUR A PITCHER OF BEER DOWN HIS THROAT IN UNDER 3 SECONDS. HE WAS ACCEPTED TO ALL THE BEST MEDICAL SCHOOLS, AND CAME TO DUKE SO HE COULD REALLY MAKE A DIFFERENCE. HE ARRIVED AT THE GOTHIC WONDERLAND, NOT KNOWING FATE HAD A GRANDER PURPOSE PLANNED FOR HIM...

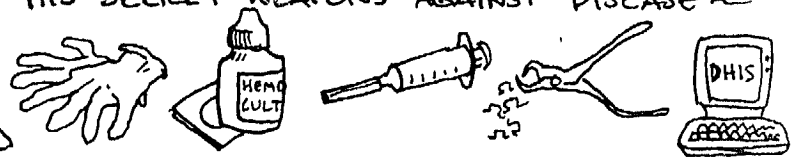
WATCH IN AMAZEMENT AS HE ~

~ ENTHUSIASTICALLY TRACKS DOWN LAB RESULTS!

~ HOLDS A RIB RETRACTOR FOR 6 HRS IN THE O.R. USING ONLY HIS FLEXOR DIGITI MINIMI!

~ FACES THE HORROR OF OB-GYN OUTRIDER CLINICS WITHOUT A CHEMICAL-WARFARE SUIT!

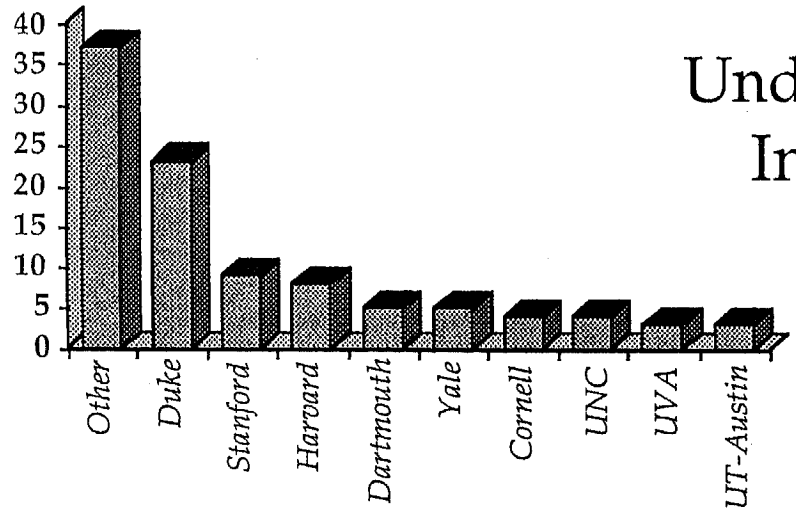
HIS SECRET WEAPONS AGAINST DISEASE ~



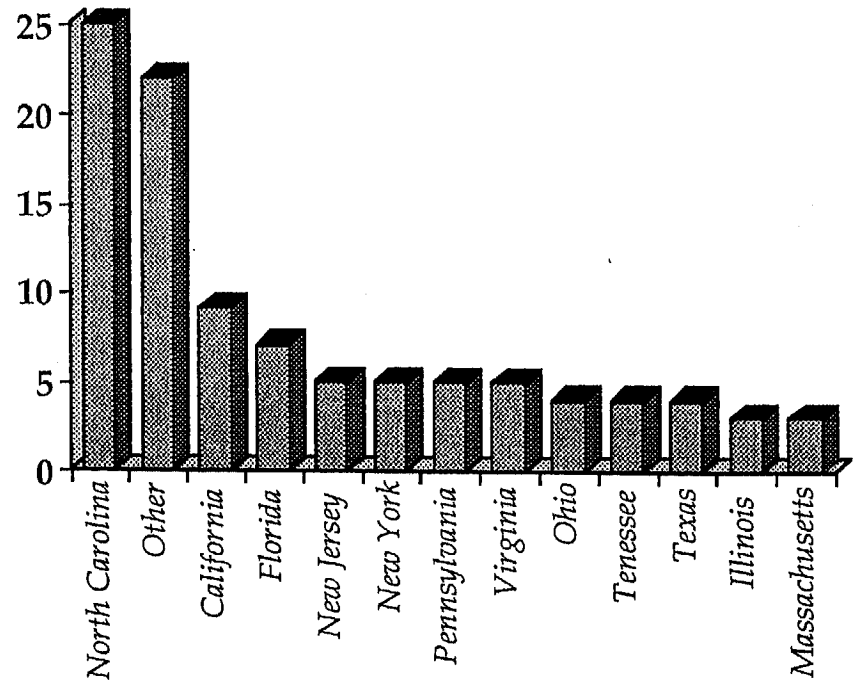
Chris Piller

A Look at the

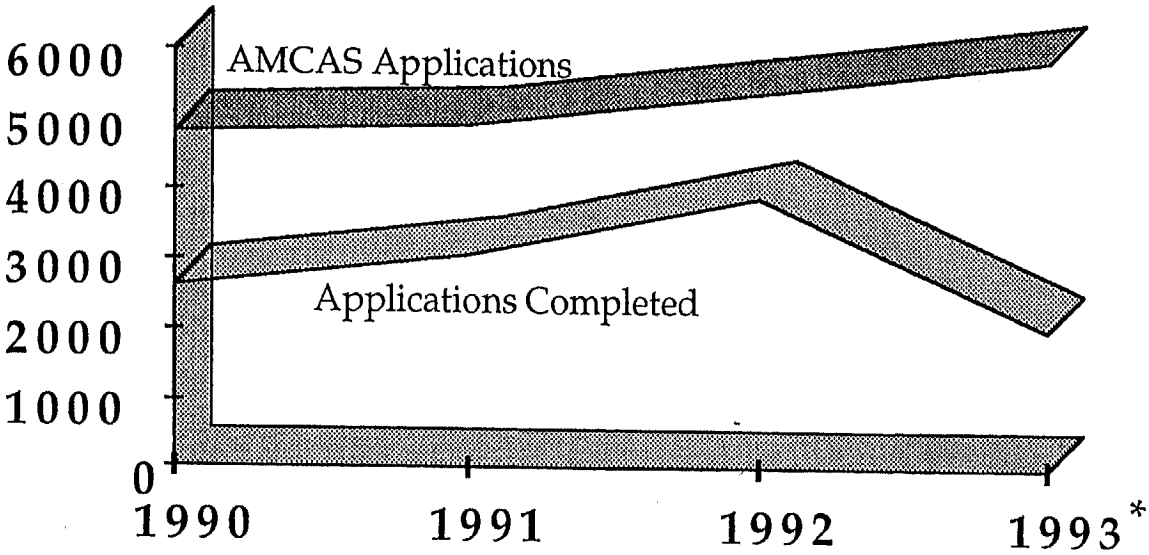
Undergraduate Institution



State of Residence



Class of 1997



*In 1993 a new screening policiy was implemented; only 2,300 secondary applications were sent.

Quick Facts

AMCAS applications received: 5,922
Applications completed: 2,029
Interviewed locally: 719
Interviewed by regional representative: 79
Male: 63
Female: 38
Minority: 10
Total Students: 101

Thanks to Barbara Franklin in the Admissions Office for the information.

August in Medical History

Moshe Usadi

•The Italian physician Girolamo Fracastoro (1483-1553) of Verona died on the sixth of this month. A poet, classicist, physicist, geologist, astronomer, and pathologist, he was known as one of the finest physicians in Europe, and was one of the first individuals to believe that microorganisms cause disease, as he discussed in his *De Contagione* (1546). In this work he provided a theoretical basis for the spread of communicable diseases and offered practical methods for limiting their spread. While Fracastoro helped to provide an intellectual foundation for the germ theory of disease, his suggestions concerning the treatment of the individual patient - which include activities such as chilling, heating, evacuation, and bloodletting seem somewhat primitive to modern observers.

•Many scientific discoveries arise not from methodical effort at solving a problem, but from a sort of cultivated serendipity in which the researcher trains him or herself to be alert for unplanned but significant findings. Alexander Fleming was born on the sixth day of August in 1881. During the course of his studies in bacteriology, he developed the habit of keeping used cultures for two weeks to see if anything interesting happened to them. When one of his *Staphylococci* cultures became contaminated with mold, he was struck by the fact that the bacteria failed to gow in the area surrounding the mold. In 1929 he reported his observations on the bactericidal action of *Penicillium* in the *British Journal of Experimental Pathology*. Fleming demonstrated *Penicillium's* low toxicity, and used with some success as a topical agent on wounds. However, he was frustrated by his inability to purify the substance, and in the ensuing years maintained only a low interest in it. It was not until 1941 that Howard Florey (1898-1968) and Ernst Chain (1906-1979) were able to demonstrate that they had found efficient ways to purify and mass-produce penicillin, thereby making it a clinically important drug. Fleming himself claimed that his role in the development of penicillin was overemphasized. However, Fleming, Florey, and Chain were jointly awarded the Nobel Prize in 1945.

•Before the adoption of antiseptic technique, wound infection in hospital settings was so common that the pus often seen to be pouring out of wounds was known as "laudable pus," and was thought to be essential to the healing proccess. Joseph Lister (1827-1912) doubted this, and decided to apply Pasteur's experimental findings in a clinical setting. On August 12, 1965, while performing surgery on a compound fracture, Lister used carbolic acid as an antiseptic for the first time in his battle against what was known as "hospitalism" - postsurgical infections such as erysipelas, pyemia, septicemia, and gangrene. He described his technique of antiseptic surgery in 1867. When, many years later, a large number of physicians assiduously adopted Lister's use of carbolic acid, many continued to use the same instrument on multiple patients without cleaning them in between, or continued to use instruments that had been droped on the floor.

Many Scientific discoveries arise not from methodical effort at solving a problem, but from a sort of cultivated serendipity.

•On August 8, 1865, Ludwig Ignaz Philipp Semmelweiss (1818-1865) died of septicemia at the

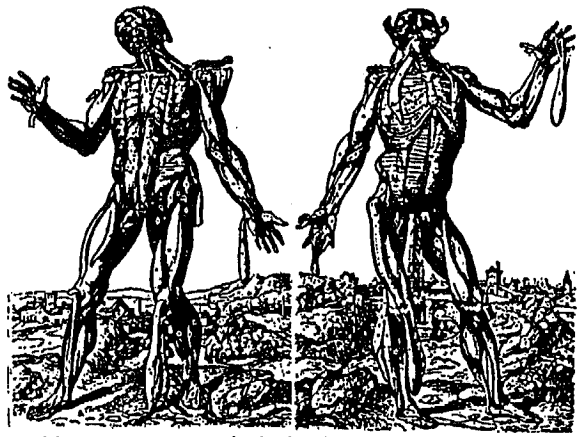
(please see History, next page)

History, cont. from previous pg.

age of 48 in an insane asylum. In 1849, he presented a statistical analysis of the happenings on the obstetrical wards in the Allgemeines Krankenhaus in Vienna to support the theories presented by Oliver Wendell Holmes six years earlier concerning the contagiousness of puerperal fever and the need for aseptic conditions during deliveries. He observed that on wards where medical students were trained, post partum mortality ranged between 10-20%, whereas on wards attended by midwives, mortality was under 3%. He was confounded by these statistics until learning that a professor who had been cut by a scalpel during an autopsy of a woman dead from puerperal fever died of a disease nearly identical to that afflicting the patients on the maternity wards. From this he surmised that medical students, who participated in autopsies, transferred the disease to previously healthy women, while the midwives, who participated only in clinical and classroom didactics, did not do so. When Semmelweiss prevailed upon students to scrub between deliveries and after autopsies, mortality dropped to and unprecedented 1%. This represented the first statistically tested system of asepsis, but Semmelweiss was harshly criticized by his colleagues and demoted by his superiors, and returned o Budapest. In 1861 he formally presented his work in *Die Aetiologie der Begriff und die Phophylaxis des Kindbettfiebers.* However, his work was once again vehemently opposed by many prominent European figures, including Virchow. Semmelweiss went insane shortly thereafter.

•Astley Cooper (1768-1841), a noted British surgeon and pupil of the brilliant English surgeon and experimentalist John Hunter was born on the twenty-third of August. He worked at Guy's Hospital in London where, along with the physicians Bright, Addison and Hodgkin, he was one of the "great men of Guy's". Coopers careful anatomic studies led to the naming of a fascia and hernia after him. His followers were later known as fascists. His recognition of the need for human bodies to disect led him to provide the economic, legal and political support for ressurectionists, individuals who illegally dug up dead bodies and sold them to anatomists.

•Albert Sabin, developer of the Sabin polio vaccine, was born on August 26, 1906. The polio virus was isolated by Landsteiner and Popper in 1909, and Salk's vaccine reduced paralytic poliomyelitis from 55,000 in 1955 to less than 200 in 1958. Sabin's live attenuated virus is taken by mouth, provides long lasting immunity, and has largely replaced Salk's vaccine in the U.S.



•Hermann von Helmholtz (1821-94) was born in Germany on August, 31. His first love was physics, but since this field offered little chance of livelihood he entered medicine instead. However, his interest in physics continued and while a young army surgeon he published *Uber die Erhaltung der Kraft* (the Conservation of Energy). After thirty fruitful years of medical practice and investigation, he became a full time physicist and professor of physics in Berlin in 1871. Helmoltz's greatest impact on medicine was through quantitative determination in the physiology of sight, sound and perspective. He built upon the original work of Thomas Young, an English ophthalmologist, to develop the Young-Helmholtz theory of color vision. After developing the first ophthalmoscope he exclaimed about the "great joy of being the first to see a living human retina."

Home Visit provides insight into patient

Katerine Kevill

Editor's Note: Minnie B is a seventy two year old woman who lives alone on a farm in Durham. She has been a patient of Dr. Vicky Johnson for well over ten years. The following is a description of a "home visit" made by a Duke medical student during her Family Medicine clerkship.

Mrs. B's address is a P.O. Box off Route 2 in Durham, N.C. She neither reads nor drives, which makes finding her place by her directions difficult. She is, however, very encouraging to those who call repeatedly and ask for more clues.

Although the drive from the four lane highway to Mrs. B's home lasts less than one minute, her house is located in a surprisingly rural area. From her mailbox, a curved dirt path, about one hundred yards in length, arrives in front of a small but well maintained home. The highway cannot be heard from her house. She states that the place is nice - "no crowds." The only folks who walk by her house are generally members of a family who are well known - and well loved - to her. It is quite possible on arrival to find Minnie B sitting on a chair on the front porch, *watching* - an occupation which she greatly enjoys.

From the porch, one can enter a small but tidy kitchen. Although it's not a fancy place, the room contains one full refrigerator/freezer, a second larger freezer (the kind which a child from the suburbs associates with the ice cream at a local deli), and what appears to be a microwave. The kitchen also apparently serves as the dining room, since a sturdy table and a set of four chairs sit in its center. The living room looks about the same size as the kitchen, maybe ten by thirteen feet. It offers several worn, but comfortable-looking, leisure chairs, a couch, and two televisions. The smaller TV is hooked up to a VCR.

Throughout my Internal Medicine rotation at the VA, my attendings were geriatrcians. Because of my training, I looked immediately for signs of difficulty with ADL's - Activities of Daily Living - as soon as I entered her house. Minnie B looked about ten years younger that the lady I recalled seeing with Dr. Johnson; I wondered for a moment if she might be Minnie B's daughter, or a younger relative. Mrs. B's sleeveless shirt revealed muscular arms which a city dweller would not have possessed at any age. She rose from her chair with no apparent effort, and lead me into her kitchen.

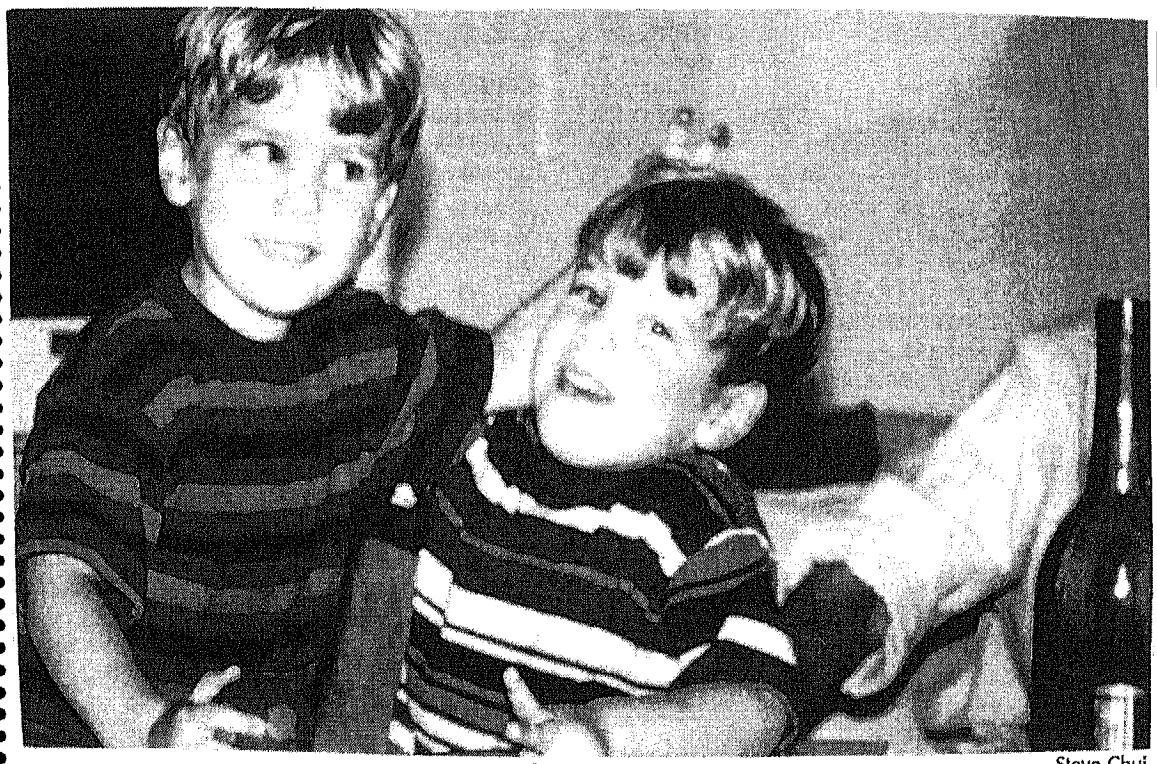
Daily chores such as fixing meals pose no significant difficulty for Minnie. Procuring her foods, however, pose a potential problem to her regular eating patterns. Since she lives alone and does not drive, she must get someone to "carry" her to the food store. She points out that folks are not always reliable when it comes to "carrying" her places. But, as she says, "There's no use in gettin' mad." She has many friends and relatives in the area, and usually gets to the grocery store once or twice a month. She also gets fresh vegetables from the little garden which her neighbors "fix" for her. Sometimes, she cans these vegetables, and thus can keep them for an extended time.

Each morning after breakfast, Mrs. B. sets her pills out on the dresser. After taking them, she replaces the bottles back into the drawer so that she knows that she's taken them.

Her brothers and sisters have on numerous occasions suggested that Minnie move in with them. However, Mrs. B enjoys living alone, and prefers to maintain her own place, as well as her independence. She speaks a bit of days long in her past when she learned some of the disadvantages of living with other people: "There's just no doin' enough to get along with some of 'em."

Mrs. B is a widow of approximately two years, and retired ten years ago from a job with the Duke Food Service. She has an income of $600 per month, almost all of which goes towards utilities and food. This come mostly from social security. Without the generosity of the neighbors who own the land on which she lives, Mrs. B. could not afford

(See Home Visit, following pg.)



Steve Chui

After a few too many drinks at the MSI mixer, the old Harvard vs. Yale argument gets a little out of hand.

Home Visit, from previous pg.

to remain in her present home. These neighbors have told her that she can stay on the land rent-free for as long as she lives. They also bring her wood at no charge in the winter, and look after the garden which they want her to have.

For the most part, Minnie spends her time alone at her house. She enjoys watching the TV, sitting on the porch, listening to the CB radio which her husband set up years ago. On Sundays, she occasionally attends the Methodist church in Apex.

Her brother visits her almost every evening, and she gets periodic visits from members of her family. Minnie B has one son, three grandchildren, and three great-grandchildren. She regards the visits from the great-grandchildren as a mixed blessing - "They run all 'round the house and don't pay no heed to no one." She is both eager for them to come, and eager for them to go.

Minnie B is the third-born of twelve children. Eight of her siblings are still alive; six live near Durham. Of the life on the farm, Mrs. B. says, "Oooh, it was terrible! Such hard work!" Despite her views, Mrs. B. married a farmer. However, she found a job serving food to undergrads at Duke. She recalls that the students were all quite sweet to her, and that she got on well with her fellow employees. Daily life with the Duke Food Service apparently was far preferable to working the fields. Nonetheless, she intends to remain alone on that farm, and keep doing what she's doing, for as long as God sees fit to allow her.

Dear E Bach...

Dear E Bach:

I have recently found a distressing explanation for my paucity of romantic encounters. One remarkable aspect of my physique is brought into strong outline by comparision to other men my age: I utterly lack bodily hair. E Bach, I've always looked young because of my hairless face, chest and legs, but at the age of 25 I feel I ought to have an expression of masculinity in the form something other than lanugo! I beg for one wisker, just one!

I have tried all the games. I proudly explained that I did not waste any hormones growing hair. I cajoled myself with the notion that women prefer hairless men, but I've learned that in fact *men* prefer hairless men. Sure, I am quick in the swimming lanes and efficient on a bicycle, and I previously considered my bald, sleek hide an artifact of my evolutionary superiority. I reasoned that more women would line up for a piece of my lustrous integument which would give me a greater number of viable progeny. Darwin himself would applaud such an efficient amplification of an individual's genome! Alas, I am alone with less body hair than a Georgia peach. Even my tainted theories cannot restore my happiness.

E Bach, I am weary with fatigue as sleepless nights rob me of my usual vigor. Am I destined to swim and bike with minimal resistance, yet live either a solitary or "alternate" lifestyle? Can you help me? Is there respite and neperthe for my ever present sorrow? Will minoxidol alleviate my glossy symptoms and restore color to my wan visage? Please, quench my anguish before I perish in lonely, hairless grief.

Yours truly,
The Ladge

Dear L with an Adage,

My sources tell me that you have already amplified your genome with greater facility than the best PCR machine. I'm sure we can locate other deficiencies that explain your unintentioned piety.

First of all, the E Bach is no stranger to baldness. When looking at old family pictures of men from both sides of the family, I see nothing short of Teutonic Telly Savalas disciples. I choose, however, to define bald as "unadorned or lacking ornament" as opposed to some physical deficiency. Not being one for advertising, I rationalize that a balding pate weeds out the superficially interested. It is considered a medical fact that increased testosterone can cause male pattern baldness, so let's keep 'em thinking on that one. Kinda makes you go "Hmmmmmm"

E Bach comes from a different generation. While you were worshipping the prepubescent Scott Baio/ Leif Garrett/Kristy McNichol look, I was being victimized by role models that included Burt Reynolds and Lucan the Wolf Boy. Now I see your generation embracing New Kids, and my duodenum becomes acidic. We are not peers, my son. How have I survived until today, when I'm seen as a nude mouse in a wild type colony?

The harried hairyed have a lot to explain for themselves. More than once, I have heard women recoil at the site of a forrested back and shoulders. When you are working out at your yuppie health club, accoutered in little else but a Speedo suspensory, have you ever seen the men who shave their shoulders around their tank tops? Is their great fear that women should see them as barbaric and inchoate, and capable of only limited continuous contact? The aerodynamic, shredded look is enviable by those who get the 11AM shadow. I would delight in your sleek integument, and leave Atilla the Hunk in his cut-off blue jean trunks in the lane next to you in your awesome wake.

When it all comes down the pike, men don't really have any idea what women desire anyway. Psychologists say that one of the strongest archetypes that women reveal is the figure of a tall, dark, wild wooly man who is every manifestation of the brute masculinity that they so boldly decry. So while you're sweatin' to the oldies (I think I know who you are) and doin arm curls for two straight hours, remember what really may titillate a woman is the image of some bad-ass warrior on a Harley, which you ain't. I've said it before. We idolize Dolph, Claude and Arnold not because we think they are successful womanizers - although second consideration of their wives convinces me otherwise. Why else would so many young men

(see next pg. for more E Bach)

Skeptic, cont. from back pg.

to develop the primary disease. Cure for either manifestation of this disease lies mainly in social ostracism.

Like the monkeys who were raised by cold, hard, wire mothers in those behavioral experiments in the 60's, Social Apraxics grow up completely unable to interact with members of their own species. Although they are an irritation at best, they become a huge hazard on the wards, mainly due to the inappropriate things they say and do to their patients ("Yeah, you've got lung cancer Ms. Jones. I think. Lemme check the path report again. Anyway, whatever you've got is pretty bad..."). While they often cause their colleagues acute embarrassment by their general ineptitude, they further complicate matters by being unable to work with anyone on the care team, often doling out orders to everyone in sight. Most irritating is the social apraxic with primary hypergunneremia, who manages to hold his/her stuff together barely long enough to look good on rounds (often complimenting the attending's choice of apparel that day) before they lapse into another bout of incompetence. Like hypergunneremia, the best management method is avoidance and scorn.

People with Humorigenesis Imperfecta look like they chronically need an enema. These folks never crack a smile (unless they also have hypergunneremia, in which case they will laugh heartily at all jokes made by high level residents and attendings). They generally have a pinched, worried look about them which seems to state, "Dammit, Jim, I'm a doctor. Nothing here is remotely amusing." Even when faced with the most patently ludicrous situation (say, an esteemed hospital reserving most of a ward so a bunch of rich oil barons can lounge in an atmosphere of potted palms during Mom's colon surgery while sick Medicare patients lie dying on the streets of Durham), they nod solemnly, furiously scribble down notes, and later underline the most pertinent facts with yellow highlighter. If forced to work with a fun loving team, they will smile wanly and constantly redirect the conversation back to the latest issue of JAMA. Although many people feel that the cure of HI is increased sexual activity, this is unproven in controlled studies and current therapy revolves around avoidance.

It is imperative to know these diseases, especially for folks about to hit the wards. You see, while most of these ailments begin in childhood, many medical students are prone to acquiring them (classic biphasic pattern of incidence). There exists evidence that if one recognizes the signs of one or more of these diseases within him or herself, and engages in behavioral modification, seroconversion can be aborted. It is unfortunate, however, that a few cases decide they enjoy the way they perform while enduring one of these illnesses. Often, they never recover.

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consume gonad-reducing steroids if the very reward for their sculptured physique were unattainable?

I think it all comes down to the beauty myth, but I'm worried about this topic lest I wax serious. Let women make a nice discovery about you. Despite your case of end-stage alopecia, you have quite a healthy libido (I'm editorializing for effect now). Prove our detractors wrong. Even Gloria Emerson noticed that men need more appreciation, in her book Some American Men, when she said "In a decade when so much has changed at last for American women, it has been odd, and even unsettling, to keep making discoveries about men during a time when they have been denounced as childlike, brutish, inchoate, unfeeling, bullies, and deficient in both decency and imagination." She begs to differ. At least you can look childlike and inchoate.

So hold your head high, but try not to let the sun glance off of your newly polished head at a barbecue. Walk with the aplomb of a man secure in his athletic skill, intellectual vigor and masculine vitality. No one really notices a lack of hair anyway, as far as you know.

As always, I will remain unexceptionable in advice and truly yours,

E Bach

Septic Skeptic

BY FRED RIMMELE

"It is scarcely necessary to state that it is unethical for a swimmer under attack by a group of sharks to counter the attack by diverting them to another swimmer. It is, however, common to see this done by novice swimmers..."

- Gregory Fuller, M.D., "How to Swim with Sharks: A Primer."

The wards can bring out the best in people, and make them a pleasure to be around. Working with fellow students (many of whom you probably didn't know very well before) is usually a highly rewarding experience - most medical students at Duke are genuinely interesting and pleasant individuals. Unfortunately, there is a very small (but

Unfortunately, there is a very small minority who are a real pain in the ass to share oxygen with.

significant) minority who are a real pain in the ass to share oxygen with. After studying the problem, I've decided that three types of these people exist: the Hypergunneremics, the Social Apraxics, and those afflicted with Humorigenisis Imperfecta. Of course, there exists a significant Overlap Syndrome in which a person can suffer from two or even all three processes.

A little known medical fact is that the hypothalamic-pituitary axis, long known for such well-loved and cherished hormone combinations as TRH/TSH and GnRH/LH-FSH, actually controls another finely tuned set - GuRH/GuH (gunner-releasing hormone and gunner hormone). In most people, positive and negative feedback loops suffice for normal levels of these hormones, allowing for the balance of aggressive and passive impulses and a normal, productive social life. Most medical students have higher than normal levels of GuH, but fortunately still have an intact feedback loop. Others, however, have chronically unresponsive GuRH levels ("primary hypergunneremics"). Whether this is due to a childhood insult (low molybdenum diet in the critical developmental years, lack of parental approval, a general sense of inferiority) or an inherent CNS defect is unclear. These people continually seek to outperform and to overimpress others, often resorting to socially unacceptable behavior (trying to shame their colleagues on rounds, hording knowledge, grabbing admissions, baking brownies for the Team, flirting with the residents). They often have a distinctive oral-anal propensity. As these people engender such negative feelings towards themselves, it is easy to diagnose them with primary hypergunneremia. Secondary hypergunneremia, however, is much more insidious. Like the viral encephalidities, it can strike previously healthy young adults and change their lives forever. Generally, GuH levels can, like cortisol, become elevated during bodily or emotional stress (repeated call nights, presenting to The Man, etc). Symptoms are identical to primary hypergunneremia, although social reactions to secondary hypergunneremics are often much more negative (ie "I can't believe he/she became such a brown nosing, back stabbing turdball during that rotation. What a jerk!"). This is most likely due to the fact that most people already know primary hypergunneremics are weeneies and have grown accustomed to the fact, whereas the developments of secondary hypergunneremia in a previously normal person is usually quite a shock. While secondary hypergunneremia is potentially reversible with removal of the stress, many med students go on

(see Skeptic, pg. 15 for more griping)