

GUEST EDITORIAL

The most difficult of arts

In 1902 William Osler wrote in his essay, 'Chauvinism in medicine', that it is the ambition of the physician 'To wrest from nature the secrets which have perplexed philosophers in all ages, to track to their sources the causes of disease, to correlate the vast stores of knowledge, that they may be quickly available for the prevention and cure of disease.'^[1]

This writing remains as true today as it was then. With HIV landing on our shores and spreading through the land, wave upon wave of diseases related to a broken immune system followed rapidly in its wake, with tuberculosis (TB) being one of the most devastating. Finding many a susceptible host in poor and often malnourished communities, with or without HIV, the disease spread and is still spreading like wildfire. No doctor working in our health system would be reasonably accused of not considering TB in almost every patient who presents with the classic triad of fever, night sweats and weight loss, whether accompanied or not by a cough or lymphadenopathy. However, hidden within the beauty of pattern recognition, which is one of the hallmarks of the master diagnostician's working repertoire, there is the potential danger of missing the nuances of another, also potentially devastating (but often curable), disease, i.e. lymphoma. In their articles on the diagnostic approach to lymphadenopathy and lymphoma, Dr Antel and Prof. Verburgh^[2,3] elucidate these challenges and provide useful guidance on how to improve our ability to accurately and quickly (see Osler's statement above) distinguish between TB and lymphoma, the one mimicking the other. All in all, it is about recognising that lymphoma is no longer a needle-in-a-haystack diagnosis. It has become much more common in the HIV era, and the earlier it is diagnosed, the higher the likelihood of cure.

One could apply similar comparisons to myeloma and the problem of low backache, the latter being so common that expediency often directs one to a watchful waiting approach, while the more nuanced features, suggesting a more ominous diagnosis, are often missed in the busy general outpatient clinic or practice. Here, Dr Houston^[4] and Dr Fazel^[5] and their respective colleagues provide us with some very practical information on multiple myeloma and on an approach to a monoclonal protein in not only diagnosing myeloma, but also in detecting its precursor state, monoclonal gammopathy of uncertain significance (MGUS) and/or other plasma cell disorders.

We are dealing with old diseases in new clothing, often mimicking other common conditions, but also often appearing at a younger age, sometimes in a more aggressive form or with different manifestations than we are used to seeing in HIV-negative patients. Retaining a

high index of suspicion, and thoughtfully applying the guidance provided in the two pairs of articles in this edition of CME, our work of distinguishing between the odd pairs of TB and lymphoma, or myeloma and 'benign' backache, should be made much easier.

To provide full context to the abovementioned words by Osler, he continued with the following words, taken from the same passage: 'To carefully observe the phenomena of life in all its phases, normal and perverted, to make perfect that most difficult of all the arts, the art of observation, to call to aid the science of experimentation, to cultivate the reasoning faculty, so as to be able to know the true from the false – these are our methods.'^[1]

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