



"Doctor, I think I May Have Been Exposed to Anthrax"



What happens when a scared patient appears in the office? This is a fictional account, but based on a real event in a nearby town. The web sites, and their contents, are very real.

Oct 17, 2001 - At 5:00 p.m., as the office was closing, the secretary to a local judge appeared requesting to be seen for an urgent matter. I knew her to be a very capable, no-nonsense kind of person, not given to exaggeration, who had always been in good health.

Her problem was one I had thought about, but had never expected to face in my own practice. She had opened a suspicious letter and was concerned about anthrax exposure, because she now had a sore throat and general aching.

"What did the letter look like?"

"It was hand addressed to the 'County Court.' I opened it and some gray dust fell out. Inside was a weird note."

"Weird? You mean threatening?"

"Well, I'm not really sure. Yes and no. I couldn't say. It made no sense. It was only about ten words, written in block letters. It was so strange; I just laughed at it and showed it to the law clerk, then threw it out. But it wasn't exactly funny, and I washed my hands after. That was six weeks ago; I never gave it a thought 'til now, with the anthrax thing."

She and the clerk couldn't recall, even after thinking back as hard as they could, what the note said. There had been no other symptoms, no fever, no other people ill at work, or at home.

"There's one other thing, doctor. I had some Cipro and started it yesterday. It was the prescription they gave dad before he died. I know I shouldn't have, but I heard that by the time you get symptoms of pulmonary infection it's too late."

I'd planned to play poker that night with the good old boys, but I sat down, resigned to my fate. At this time of day, the local Health Department was on phone tree answering machine mode. But with this scenario they wouldn't have done anything at this point anyway. Nor would the police.

I realized that now I, in my own myopic way, was also a victim of terror. Then I remembered the mythic e.net. I excused myself, went to my office, and mounted Browser, my net-horse, settling easily into my Windows Brand saddle for a pixel ride. I would go until I reached a place where a clear decision tree was laid out.

I knew that there was some sort of CDC national plan such that local police and health departments were terrorism first-responders. But here there was no longer a crime scene, so I urged Browser on expectantly to What Next.

The local health department did have an electronic information tree. But after a few minutes it became clear that it didn't yet include bioterror. Employment opportunities. Women's rights, Babies, Rabies and Scabies were the best there was. "Hell," I thought, "Why couldn't it be itsy bitsy mites jumping from the mail?"

"Well, "I thought, "I'll ride to headquarters, to the top: CDC.

"There it is! bt.cdc.gov; bt for bio terror! Maybe I'll get to the game before the beer is gone." There was a page of links. And links to links in an elegant chain to... where? I began to click on likely ones.

"Facts and FAQs about Anthrax. Botulism, Plague, Smallpox." Seven pages of them. But it was boilerplate, nothing about what to tell my patient at 5:20 p.m., PDST.

"Preparedness; Training; Laboratory issues; Info. Technology; National Pharmaceutical Stockpile." There was a phone number for Public Inquiries, another for Emergency Contacts and still others for CDC itself. But this wasn't an emergency after six weeks.

"Protocols" That should do it! I linked to: "Interim Recommended Notification Procedures for Local and State Public Health Department Leaders in the Event of a Biochemical Incident."

"Well," I thought, "at this point I'll take anything I can get." But it was actually what it claimed: "Health officer notifies local law enforcement and FBI, then State Health and other response partners per pre-established notification list," which of course I didn't have and wasn't pertinent to a 6-week-old unlikely exposure anyway.

I pushed Browser on to the Morbidity and Mortality Weekly Report where there was a 'Continuing Education Activity' based on vol. 49, RR-4, expiring April 21, 2001. But it didn't seem reasonable to take an obsolete e.course at the moment. Besides, the test questions were there, and in large part seemed clearly designed to help justify course perpetuation. But wait! There at bt.cdc.gov/documents/Anthrax etc was:

"How to handle anthrax and other biological agent threats" "Whoa, Browser!" After the Do Not Panic section were several scenarios starring powder - containing letters/packages all leading to police or 911. But they didn't apply to six weeks ago, no envelope, degraded site.

Reluctantly, I headed Browser to the 26-page April 21, 2001 MMWR report entitled "Biological and Chemical Terrorism: Strategic Plan for Preparedness and Response." Then a 15-page "National Bioterrorism Preparedness and Response Initiative Report" of May 8, 2000. Then a 15-page "Public Health Preparedness and Response for Bioterrorism" in which the last entry on a list of upcoming events, ironically, was a Sept 10-11 2001 meeting in Orlando, Florida. By the time I read all that my patient would have grown old or died from anthrax right in my office.

Nonetheless, it was clear that the answer to my question - what to do next or where to find the proper advice for this patient today - was not addressed. I would have to base a decision on the least wrong thing, most right thing. But isn't that what every doc does, with every patient, every day?

I decided: Do Nothing.

Back with my patient I reviewed the situation. I advised her again about the extremely favorable position she was in, statistically speaking. I allowed that she might as well continue the Cipro until I was able to review the case with our local public health officer. I suggested that if asked by people at work, or by her family or friends about risk to them, that was now a moot matter; no one actually had anthrax after six weeks, and the suspect mail was not available. I planned to see her again in a week, mainly to decide about stopping Cipro. Lastly I again explained why testing was not advisable.

She left. I corralled Browser and went to my poker game, assuming control of the last two beers.

Oct 18, 2001 - End of story? No.

As I had feared, the next morning the chief administrator for the court called about an anthrax test. I was aware that his daughter was a veterinarian, and wondered if he had spoken to her about the advisability of doing expensive and inaccurate tests requiring a number of days to perform, then in the end arriving back where you started, with a decision based on clinical evidence. He had. He understood. She had explained it perfectly. But...

"But doctor, isn't it possible to just do the test anyway? You know. To allay fears here. And your patient states she isn't sleeping well; she, too, feels a test would relieve her mind." There are times, actually more than a few, when it is right to do the wrong thing. I realized this was probably one.

"Of course. Please send her right over. The results will take a few days".

"But I read in the news that they do them in a few minutes."

"Well, that is true and not true. There is a test to find anthrax spores in the environment. Or in an envelope, places where contamination is very high. Then there are cultures. First, one looks for organisms like anthrax. If suspect organisms are seen, one must re-culture requiring more time. Then finally a capsular test can be used and may confirm that anthrax is even more likely, but still not certain. And ultimately a DNA test can be done, though that's not available except, I think, at CDC."

"But isn't there a blood test?"

"Yes, but that relies on the presence of antibodies. It requires that actual infection be present for at least a few days, and even so it is not diagnostic; as in the capsular test, other non-anthrax organisms can lead to a positive blood test."

"Well! It seems to me the news media has been great on sensationalism, the modern standard for professional journalism, and terrible on informing the public!"

"Of course; they still do best what pays best. But maybe, in large part, contradictions result because the best course is truly unclear yet. The solution, or solutions, are complex. We are all learning. A very qualified expert may never have personally seen a case of pulmonic anthrax, and read about less than a hundred in recent years, most all in foreign countries, and some 85 or so downwind from a Russian biological warfare facility in the former USSR. How does one decide, for example, what antibiotic is best? Only the makers of Cipro, an expensive proprietary antibiotic, did the research; it didn't pay to research the low cost antibiotics. But even then there was no work on real people. If I were cynical, which I'm not, I'd wonder if Bayer sent the envelopes. Sorry for the bad joke! This has me wierded out."

"No offense taken. I'll send her down, though. Thank you. I really do think doing a test will help."

So here we are; all waiting for the results of the nasal swabs. Today I spent more time on Browser, and rode him through the National Library of Medicine, at nlm.nih.gov. We galloped through dozens of article summaries, and nothing changed so far as my patient is concerned. I know a little more about vaccines, which, so far, are monumentally impractical for general use.

I also spoke with the local health officer, who confirmed that until I had an actual case, or credible evidence of high risk, neither they nor the police would get involved.

"But," I objected, "if the case is pulmonic, actually mediastinal, the first patient dies."

"That's right. Like the index case in Florida. The rest usually live."

"Cool," I said dryly. But those are the facts. That's state of the art, until we learn more. To paraphrase Pogo, "We have met the Leaders, and they is us."

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