The mechanism by which ferritin is raised is probably related to the cytokines released in Still's disease, and therapeutic studies are investigating the role of blocking interleukin 6 and 18 as well as anakinra, the interleukin 1 receptor antagonist.⁵ These should allow much more effective targeted therapy. New drugs are urgently needed because many patients with this condition respond poorly to low dose methotrexate, the standard drug for arthritis, and high doses produce a high incidence of side effects, including serious infection.

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Commentary: Management of uncertainty

Dee Mangin

This patient had adult onset Still's disease with atypical features.¹ For general practitioners the presentation of the disease itself is atypical—uncommon enough not to make it on to the initial list of differential diagnoses. The case highlights broader issues around recognition of patterns of illness and dealing with medically unexplained signs and symptoms.¹

Pattern recognition

General practitioners often see the pattern of symptoms described at presentation: a young person with a febrile illness, myalgia, and sore throat. This pattern would prompt a working diagnosis of infection, most likely viral. What triggered the general practitioner to recognise that this woman's symptoms deviated from the pattern and raised enough concern to prompt hospital referral? The duration of symptoms was important. There were red herrings, including the overseas travel and the rash in response to amoxicillin (increasing suspicion of infectious mononucleosis).

We can see the complex and subtle nature of pattern recognition, which is the core of clinical experience, by altering just one aspect of the presentation. Let us assume the patient was aged 69. The initial management and working diagnosis might then have included polymyalgia rheumatica and giant cell arteritis, and with a high C reactive protein concentration this woman would probably have received anti-inflammatory treatment with steroids as initial management, albeit with an incorrect diagnosis.

With no definitive test, the diagnosis relies on a collection of diagnostic criteria. In the same way as the presenting features led to uncertainty for the patient's general practitioner, the unusual and serious complications reduced the hospital doctors' certainty that this pattern represented Still's disease. As the rapid responses show, the list of potential alternative infectious and inflammatory causes for such a presentation is extensive.² The question then arises: when have enough investigations been done to satisfy exclusion of other, increasingly uncommon, diagnoses?

This leads to another interesting aspect of the progression of the case: the difficulty of teasing out

inflammation from infection. Here, even after thorough and thoughtful investigation in a secondary care setting, the distinction remained elusive. There might be a pragmatic argument for treating both in this case.

Good communication

Diagnostic uncertainty is not unusual in primary care, 10-20% of presentations in general practice fall into this category.³ Patients and doctors will tolerate this diagnostic uncertainty, especially if communication of that uncertainty can be confident and clear: "I do not know what it is, but I am confident we have ruled out serious causes."

In primary care, the framework of a long term therapeutic relationship and the luxury of time support this. Tolerance of uncertainty when the patient is seriously ill and deteriorating is quite different. This was clearly expressed by the parents in their wish to have a second opinion. It is not just the doctors and patient but also the patient's family who must deal with this uncertainty, and the willingness of the team to initiate a second opinion promptly was therapeutic in this case. An independent opinion may also be therapeutic for the doctors.

Although the patient was in hospital, there is an opportunity here for primary and secondary care to work together. When a family member is seriously ill in hospital, relatives often turn to their general practitioner for help in translating or understanding what is going on. Prompt communication between secondary and primary care to ensure the family is getting consistent and clear information from both is valuable.

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