SWAMP RAT

Recently, as I caught the distinctive sulphurous odour wafting from the pan while peeing shortly after recent consumption of asparagus, my thoughts drifted. Should I feel unlucky that I am among the 40% of the population that produces this smell or relieved that I not only produce it but can also actually smell it? A limited literature search suggests that the ability to produce methanethiol and other metabolites of asparagusic acid is inherited in an autosomal dominant fashion and affects about 40% of the UK population but more Americans and Chinese and 100% of a small sample of French citizens. Moreover, a specific hyposmia or anosmia appears to exist, particularly among Israelis (95%) and Chinese (75%) rendering them unable to detect the sulphurous fumes. Therefore many may produce the odour but may not be able to smell it even though their associates can.

However, that was only the beginning of my drifting thoughts as I contemplated the smells associated with medical practice. There are many smells in the swampy lowland of general practice. Most are offensive, unlike the sanitised smell of surgical spirit that characterises the higher ground. Abraham Verghese refers to some of the smells of medicine in his book *My own country: A doctor's story.*[1]

'We are nearing Luther Hines's room. I know. I can smell it. There are so many distinct smells in medicine: the mousy, ammoniacal odor of liver failure, an odor always linked to yellow eyes and a swollen belly; the urinelike odor of renal failure; the fetid odor of a lung abscess; the acetonelike odor of diabetic coma; the rotten-apple odor of gas gangrene; the freshly-baked-bread odor of typhoid fever. But this new smell that is not yet in the textbooks tops them all. Now, the redolence is so strong my nose wrinkles. I ask the students and residents if they smell it? They look at me strangely; one student, an obliging fellow, says, "I think I do."

It is the smell of unremittent fever in AIDS, fever that has gone on not for days or weeks, but for months. It is the scent of skin that has lost its luster and flakes at the touch, creating a dust storm in the ray of sunshine that straddles the bed. It is a scent of hair that has turned translucent, become sparse and no longer hides the scalp, of hair that is matted by sweat, and molded by a pillow...'

Do you think that you can smell it too? I suspect that with modern laboratory investigations and sophisticated diagnostic technology we are losing some of our clinical

This is a column written from the swamp. The term is taken from the book by Donald Schon[1] where he talks about the crisis of confidence in professional knowledge thus:

In the varied topography of professional practice, there is a high, hard ground overlooking a swamp. On the high ground, manageable problems lend themselves to solution through the application of research-based theory and technique. In the swampy lowland, messy, confusing problems defy technical solutions.

1. Schon DA. Educating the reflective practitioner. Jossey-Bass Publishers 1990.

Contributions

We invite amusing contributions to this column which should be relevant to the swamp and not more than 600 words.

acumen, in particular the use of our noses as diagnostic tools. Although Dr Verghese refers to some of the smells of medical practice, most GPs are not going to experience all of these in a practising lifetime. But his story does remind me of an older colleague who some years ago told me that he had been on the stage at a school prize-giving and couldn't help noticing the smell of acetone on the breath of the invited speaker. He knew nothing about this gentleman and was not sure whether or not he should broach the subject.

A similar embarrassing story was related by a GP teacher who had a registrar with offensive BO in the practice and was quite uncertain about how to deal with the situation. In our everyday general practice we will more commonly smell the fetor of acute appendicitis or the fishy whiff of bacterial vaginosis. We have all experienced the characteristic smell of malaena, sepsis, necrosis and the dying (on occasions all intermingled). There is no mistaking the smell of a newly opened epidermal cyst, the stool of giardiasis or the stench of the 'lost' tampon.

Patients will be embarrassed by halitosis, particularly when we feel the need to put our noses to their mouths to validate their concerns. They will apologise for their smelly feet but seldom for their unwashed bottoms. The smell of alcohol and cigarettes can tell us things about our patients that they may not want to talk about. A young receptionist recently accused me of having a sly cigarette. This took me by surprise as she was giving up and I had never acquired the habit. I realised that I may have missed an opportunity for some preventive care during my last consultation.

So where is all of this leading? I'm not sure really. Is the sense of smell a clinical skill that we should cherish or would we be better off developing anosmia? The problem with anosmia is that, although my senses would no longer be assaulted by the offensive smells of medical practice, neither would I be able to taste the delicate flavour of freshly barbecued asparagus.

References

1. Verghese A. My own country: A doctor's story. Vintage; Reprint edition, 1995.