Sawbones 283: Yes, More Medical Questions Answered!

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Intro (Clint McElroy): Sawbones is a show about medical history, and nothing the hosts say should be taken as medical advice or opinion. It's for fun. Can't you just have fun for an hour and not try to diagnose your mystery boil? We think you've earned it. Just sit back, relax, and enjoy a moment of distraction from that weird growth. You're worth it.

[theme music plays]

Justin: Hello, dear friends. Welcome to Sawbones, a marital tour of misguided medicine. I'm your co-host, Justin McElroy.

Sydnee: And I'm Sydnee McElroy. Why did you change the intonation, and you added the dear friends?

Justin: 'Cause I was eating a bowl… a sort of a protein bowl with chicken and rice and beans.

Sydnee: Mm-hmm.

Justin: And it was spicy. And it's doing things to my mouth that, as a professional broadcaster, I should be above. But uh, as a human being, I am not. I am only a man. Flesh and bone.

Sydnee: You're gonna have to work on that. Our podcast listening audience enjoys the comfort of repetition. The familiarity.

Justin: Indeed. Indeed.

Sydnee: Of the rhythm of your intro.

Justin: I'm right there with them. Should I try it again, just so they have one they can…

Sydnee: Yeah. Just try it again.

Justin: Hello everybody, and welcome to Sawbones, a martial tour of misguided medicine. I'm your co-host, Justin McElroy.

Sydnee: And I'm Sydnee McElroy.

Justin: That was just for you, wasn't it? I'm just now realizing.

Sydnee: Mm-hmm. That was just for me.

Justin: That that was just for you.

Sydnee: I needed that to get in the right headspace. Justin, our listeners have questions.

Justin: Yes.

Sydnee: So many questions.

Justin: And we have a vacation coming up. [snorts] Which is perfect for us.

Sydnee: No, we have answers to the que—you act like these are so easy for me to put together, but here's a little… I'm gonna peek behind the curtain for everyone listening. I still, even if I know the answer to your wacky, wild, weird medical questions, even if I know deep in my heart, I still look them up. [laughs] Because I want to be—I want to make sure. I want to cross reference and double check.

And then, sometimes, these medical questions are more like, general science questions, or about the medical industry system stuff that I don't necessarily have, y'know, at my fingertips. So I do research these, is my point.

Justin: Well, I'm happy that you do, because they're some of my favorite… I always feel like I get a few new wrinkles in the old cerebellum when we do one of these episodes.

Sydnee: Well, our listeners have great questions. They're really thoughtful, interesting stuff I hadn't necessarily thought about questions, so…

Justin: Well, let's get right into it. There's no need for us to uh, waste any more time. Our first question comes to us from Rebecca. Uh, Rebecca says, um, "I had an osteochondroma on my shoulder for about half my life," and Rebecca is wanting to know why she can't get her… she can't keep her bones if you get them removed.

She had the osteochondroma, and she was joking about how she was going to keep it as a knick knack, but they said that uh, that Rebecca couldn't take it with her. Kept asking for it, parents got to see it in person, but she was still asleep. She's only seen pictures. Her mom thinks maybe she had to do some tests to make sure it wasn't cancerous, and Rebecca wants to know why she could not keep her bone.

Sydnee: So, this is a good question, and I think you could, uh, take it and generalize it to other things that we remove from your body. Why can't you keep them? She—and Rebecca mentions specifically, I've heard of people keeping kidney stones. Why was I not allowed to keep that?

And so, I had to look into this, because what we generally—what you might hear if you ask your surgeon, or one of the other staff in the operating room, or whoever it is you're gonna take. If you ask somebody, can I keep this piece of bone, my appendix, my gall bladder, whatever, they'll probably tell you you're not allowed.

Justin: Why?

Sydnee: Well, that might not be true. [laughs] So, some hospitals do have policies that are probably rolled into… y'know when you sign a permission to treat form at a hospital?

Justin: Mm-hmm.

Sydnee: You're agreeing to a lot of things. And among them, it might have in there, if we remove anything from your body, you're not allowed to keep it. And it's just a hospital policy. Probably one for, uh—

Justin: Gross.

Sydnee: Ease of… if you're gonna give something to somebody back, one, if you do need to do tests on it, if you need to do pathology, if you need to check and see if something's cancer as Rebecca mentioned, you do need to take it to the pathology lab first and do those studies.

Justin: Right.

Sydnee: And then you're gonna have to try to get through the logistics of making sure that, if there were any concerns for infectious disease or whatever, that it's not that. That it's all fine and safe to give back to someone. Uh, and there's a lot of logistics, time, money in doing that, and a lot of hospitals just don't want to mess with it.

Justin: That makes sense.

Sydnee: And they don't want to be liable if they don't do it right.

Justin: It's an organizational pain in the butt.

Sydnee: In some cases, there's a practicality. Sometimes, when they remove certain things from your body, they actually have to kind of crush them or destroy them as they remove them for ease of removal, so you can do like, a smaller surgical site, something like that.

Justin: Like the brains of the ancient Egyptian Pharaohs.

Sydnee: Y… yes. Yes. That's actually a good…

Justin: Scrambled up with a rod and pulled out the nose.

Sydnee: So we don’t necessarily do that with your brain.

Justin: Good. I need it.

Sydnee: Which is good.

Justin: For podcasting.

Sydnee: But for other things, that might happen. And so, in that case, you can't have it back, because it was destroyed in the removal process. Sometimes, they do need the entire thing to do testing on. If it’s a very small piece of tissue or something, they might need the whole thing. But there are other times where they just tell you no because… and honestly, as a physician, I can back this up.

We don’t know how that would work. I don't know. I put it in a jar and hand it off to someone else, who takes it to the other person, who looks at it under a microscope. I'm not really sure what happens after that. You might just be asking the wrong person, and you need somebody who’s more in like an administrative role to answer it.

Justin: The problem is, if you, as a layman myself, if you have to ask more than one person for your kneecap, you start to look like someone with a problem. If you say casually, like, “Hey, I'd like my kneecap after you remove it.” And they say, “Uh, I don't know,” and you're like, “Get me the person I need to talk to to take this kneecap home today!”

Sydnee: If you do that, and it is not… now, again, if it’s an internal hospital policy, it is what it is.

Justin: Yeah, but you look wild.

Sydnee: But if there isn’t one, which a lot—well, I mean, people have done this. I read a lot of stories of people who have kept… the story I was reading was uh, a young person who kept their foot that had to be removed. And carried it around with them.

Justin: I get that. I get that.

Sydnee: And you can do that. 'Cause there shouldn't be any reason that a removed piece of a human is any more dangerous from like, a biohazard standpoint, than any other sort of, um… I don't know.

Justin: Gross thing that you'd cut off and carry.

Sydnee: Meat that we have in our house or anything like that?

Justin: Ah—Sydnee!

Sydnee: I mean, as long as you—there wasn't some sort of incredibly infectious disease process, if we just removed it, there shouldn't be a problem, is what I'm saying. And it can be preserved appropriately.

So, you may be able to keep it. It's worth asking. If your doctor doesn't know, don't give them a hard time. We probably don't know. But you might just need to ask somebody in administration about it.

Justin: Yeah.

Sydnee: And if there's not a policy… now, there is some legislation, 'cause some will tell you it's illegal. That's not entirely true, again. Now, uh, there is something called the Native American Graves Protection and Repatriation Act, which makes it illegal to own or trade any remains of someone who is Native American. And so, that's actually… that is one legal issue.

And then there are a few states – Louisiana, Georgia, Missouri – they have specific bans on owning human body parts. [laughs] And that includes your own.

Justin: Cool state.

Sydnee: So if you're in those states, it may be a little more of an issue, but…

Justin: Fair enough. This next one is from MP, who asks, "What's your hot take on asexuality in medical stuff? For example, sometimes a "low libido" has been listed as something that might raise concern. I am asexual, so I straight up have no libido. Or when I get a pap smear, my body super rejects things going up my down there. It stings and burns, probably more than it should, but I can use tampons just fine.

Online asexuality forums tell me this is a common for asexual vagina-havers, but a lot of doctors don't seem to register that asexuality is a thing, so I don't bring that up. Do you all learn about that, and is there any research on the relationship between asexuality and "unusual symptoms"?" That's from MP.

Sydnee: I think this is a good question, because it draws some important distinctions that I would say, at least when I went through medical school, which is not that long ago, still. It's getting longer and longer ago. Uh, these were… we weren't trained in any way about asexuality.

Justin: Mm-hmm.

Sydnee: But I'm not saying that my medical school curriculum is necessarily indicative of every medical school in the country. But, I know that a focus on all types of diversity is a big movement within American medical schools today, because it has not been. Any kind of diversity that you can discuss has not been a focus previously, and I know that there are many medical schools who have made very intentional efforts to try to change that.

So the curriculum at my very school may be better than that today. But it is something that physicians you see who maybe even aren't that much older, are still not necessarily in the know. So, I'd say that you're probably right, that sometimes, doctors aren't quite certain what you're talking about. They may not be educated on this. And it's hard, because I don't want to say… it should not be on the patient to do the emotional labor of explaining that. It should be on our end to do better.

Justin: Mm-hmm.

Sydnee: And there are more and more… I have a whole collection of journal articles. There are more and more journal articles being published on these kinds of issues. But all that aside, if you see low libido as something that is like a diagnostic term or a complaint in a medical chart, that is almost certainly coming from the patient themselves.

Justin: The patient was complaining about a low libido, or low sex drive, right?

Sydnee: Yes, exactly. If a patient comes in and says, "I am concerned, because I did have a higher libido, and now I don't, and I am—my life is—I, personally, have less of a quality of life because of this, and I want you to address it. Tell me, diagnostically, what happened and how do I treat it? How do I fix it?"

Justin: If they come in and say, "I have no sex drive, but that is the way I do it. I'm still crushing it 24/7, that's just who I am. That's just how I roll." That's not going to be a medical complaint.

Sydnee: No, no. And I can't see any physician ever pushing past that. I don't—I personally wouldn't, uh… I mean, that's not something I would go digging for unless it was specifically relevant to whatever the medical complaint is. Whatever the patient has brought to me to address that day. And if a patient asks me, "I am concerned, I did have a libido, I don't know, can you help me address it?" Of course. And I will put that in the chart. Y'know, I mean, there's probably a code for low libido.

Uh, but, if it's not… if it's who you are, if you don't have a sex drive, and it's you, then that's not a problem. There's no pathology there, just like with asexuality in general. It's not a pathology.

Justin: Mm-hmm.

Sydnee: It's just a way a person is. Just like heterosexuality, or, y'know, whatever LGBTQ, everybody who's not straight, that's just the way people

are. So, there would be no pathology, so you shouldn't have a doctor trying to address that, or trying to change that or treat that in any way.

And I think that it involves a lot of open conversations with doctors, and on our end, a lot more focus on that kind of education in medical school, definitely needs to be done. Because in terms of your question about research, not that I'm aware of. And we certainly aren't teaching enough about these things in medical school.

Justin: Uh, here's one from Emily. "From a very young age, I had problems with my feet. I would be in constant pain, and it would get so bad that I couldn't walk. Finally, at 13, I went to an orthopedic surgeon instead of the podiatrist that I had been seeing since I was five. The surgeon told me I had an extra bone in each foot, and the left extra bone was pinching a nerve.

It was removed, but I still have the right extra bone. Is having extra bones common? I'm curious as to why the podiatrist never noticed extra bones in my x-rays, but the surgeon saw it right away."

Sydnee: So, I had to actually look up how common it is. I know that having an extra bones here and there, having an accessory bone, is what we would probably call it. It's an accessory.

Justin: Hmm. Sort of casual, fun, kicky bone.

Sydnee: Mm-hmm. It's an extra little… it's like an earring.

Justin: For all seasons.

Sydnee: But a bone. It's not as uncommon as I would've—I know that it happens. I've seen it incidentally on x-rays. And most of the time, people wouldn't know, because most of the time, they don't cause you problems. Obviously, they can. Most of the time, they don't. And so, you wouldn't know unless you just happened to get an x-ray and somebody went, "Hey, look, that's there."

I'm guessing the podiatrist just didn't notice, 'cause it was on both sides. And maybe it didn't click right away? I'm not gonna slam this podiatrist. Who knows. I would say it is not—

Justin: It's like one of those, um… [laughs] One of those two 'spot the differences' puzzles, y'know what I mean?

Sydnee: Yeah. They just looked, and they both looked the same.

Justin: They look the same to me. I don't know.

Sydnee: They look the same.

Justin: The fan has four blades. The cat is gray with a bushy tail. It looks the same.

Sydnee: I would never suggest that there is anything intrinsic to the training of an orthopedic surgeon versus a podiatrist that would make one better at spotting that than the other. Um, I'm glad your surgeon did, though. The most common extra bone that you're gonna have in your foot, if you have one, is an accessory navicular bone, which is what I wonder if it's just one of the bones in your feet.

And uh, it can occur in anywhere from two to 20% of the general population, so obviously, we have no idea. Uh, we don't know. [laughs] In a lot of people, this can happen. So it's not nearly as uncommon as you would think, and there is pain that can be associated with it. Most of the time, it isn't. But if it is pushing on other structures that cause pain, then they call that accessory navicular syndrome. We're so creative.

Justin: I love it.

Sydnee: In medicine. And then, y'know, you can have things… you can need things like, perhaps, surgery, but sometimes just things like a cast, or a boot, or ice, or physical therapy, or some sort of orthotic device. All those kinds of things. But it is not nearly as uncommon as you would think.

Justin: Certainly, you—

Sydnee: I'm glad your surgeon found it.

Justin: I hope you got to keep it.

Sydnee: Well, I guess it depends.

Justin: It's an extra weird bone that nobody's got.

Sydnee: Depends on where you live, and…

Justin: You can name it whatever you want at that point. Name it after yourself.

Sydnee: That's right.

Justin: You're the only one with that bone.

Sydnee: It could be—maybe it's an actual accessory, then. Make it into a necklace, or…

Justin: There you go. Uh, here's one from Aiden. "If two people who develop an immunity to a disease, like chicken pox, have a child, how come the child can still get the disease?"

Sydnee: This is a good question.

Justin: Reminds me of my favorite joke from My Brother, My Brother, and Me, 'cause it wasn't my joke, so I'm allowed to say it. Elizabeth Gilbert told us that um, if you feed poison ivy to a goat, and then drink the milk, that you'll develop an immunity to poison ivy. And Travis said that if you feed a goat your passport, and you drink the milk, you'll get diplomatic immunity.

Sydnee: [laughs] That's a good one.

Justin: [laughs] I always liked that one.

Sydnee: Good job, Travis.

Justin: Wasn't my joke.

Sydnee: So unfortunately, this is not the case that you will be immune if you are born to two people who are immune to chicken pox. Uh, in terms of the person who has the sperm in the equation, whether or not they are immune really doesn't factor into it. So that won't… it's just not… you're not gonna carry—what provides the immunity are antibodies, and the sperm's not gonna carry those antibodies. So that kind of is irrelevant.

Now, the person who actually carries the pregnancy, if they have antibodies to chicken pox, some of those antibodies are going to cross the placenta. There are a lot of different antibodies that cross the placenta, and can provide some transient immunity to the newborn baby.

Justin: Do I have this right that like… I'm probably mischaracterizing this. But is the sperm basically bringing like, information?

Sydnee: DNA.

Justin: DNA.

Sydnee: Yep.

Justin: And the egg is really like, the…

Sydnee: In the beginning, it's just DNA. But then, all that DNA programs all kinds of stuff to happen.

Justin: Okay.

Sydnee: In the beginning, it's just a bunch of information.

Justin: So why does the… why can the… I guess, is it 'cause the…

Sydnee: It's growing inside.

Justin: Okay. Got it.

Sydnee: The person who carries the pregnancy has antibodies in their bloodstream that will cross the placenta while the fetus is developing.

Justin: Okay, got it.

Sydnee: So it's the location. [laughs] It's not the egg or the sperm. It's the location. Location, location, location.

Justin: It's not the house, it's the neighborhood. [laughing]

Sydnee: And the neighborhood, in this sense, the pregnant person, is the one who can… their antibodies, to whatever they are immune to, can cross the placenta and provide immunity for a while. This is called passive immunity, meaning that the baby's body is not making antibodies, it just got some. Right? That some were just kind of handed over to it.

And those only last so long. And if you're not making new ones, then at some point, that immunity wears off. And it's usually after just a few weeks, those antibodies are gone, and then you are susceptible to whatever diseases again.

There's some more passive immunity that occurs from breastfeeding. You can pass antibodies through breast milk to the baby. But again, this is not permanent. The only way that this baby will be protected against chicken pox or whatever infection disease you're talking about… is by making sure that they are immunized according to the CDC childhood immunization schedule. On time. All their immunizations.

I mainly like this question, Aiden, 'cause you gave me an opportunity to talk about this again. Get your vaccines.

Justin: Well, now that you've used your bully pulpit, we can move onto the real reason that we're all here…

Sydnee: The billing department?

Justin: Making money. Exactly.

Sydnee: [laughs]

Justin: Let's go.

[theme music plays]

Justin: Folks, our first sponsor this week is Blue Apron. We have uh, been enjoying a lot of delicious Blue Apron meals lately. They're not too hard to make, and they are fun to eat. Not in like, a Spaghetti-Os kind of way. We're grownups. But it is nice to come upstairs after my wife has been preparing a meal, and it looks like a fancy one like you'd see at a restaurant. It makes me feel like a little gentleman.

Sydnee: When you say that, it makes it sound like, "My wife better make me a meal."

Justin: No, we have covered this before.

Sydnee: Yeah. No, this is… this is Sydnee time. This is Sydnee's private, have a beer and make dinner while Justin has the kids time.

Justin: Yes.

Sydnee: This is by choice.

Justin: It is a lovely oasis for my wife at the end of a long day.

Sydnee: I love making Blue Apron. I love it. It's my me time.

Justin: I love eating it. It's my eat time.

Sydnee: [laughs]

Justin: And that's their new slogan that we're introducing right here on the show. Blue Apron: It's my eat time.

Sydnee: Ehh…

Justin: Ehh, you're not sold on it 100%. I get it. Um, but uh, this is gonna help you develop your cooking skills. It's gonna help you develop your palate. It's gonna help you find new foods that you love, and new foods you love to cook. And you can start making delicious, brag-worthy meals at home without the hassle. Try Blue Apron.

You can check out this week's menu and get $60 off when you visit BlueApron.com/Sawbones. That's BlueApron.com/Sawbones. Blue Apron: A better way to cook.

Check this out. I'm gonna give you a couple ones, just to whet your appetite. Fresh basil fettuccini with heirloom tomatoes and goat cheese. Spiced chicken and saffron rice with almonds and lemon yogurt. Seared chicken and peach salsa with… okay, that's—anyway, it's good food. Get it.

Also this week, we have Postmates. Let's say you got the kid down for a nap, right? And then all of a sudden, you realize you want to drink a half gallon of wine. Well, I have good news for you. [laughs] You don't have to abandon your child in a story that they can tell a therapist someday, that daddy went out to get a half gallon of wine while I was taking a nap. You don't have to do that.

You could have Postmates deliver you a half gallon of wine. But it's not just half gallons of wine! Pretty much anything that you want delivered. Uh, whatever you need. Groceries, personal food, whatever. Breakfast burrito at eight AM? Ibuprofen at ten? They got you.

It’s the largest on demand network in the US, and they offer delivery from restaurants, grocery, and convenience stores 24/7.

Sydnee: I'm assuming they’re judgment free. They don’t say that, but I'm assuming it will all be…

Justin: Assumed judgment free.

Sydnee: Judgment free. [laughs]

Justin: For a limited time, Postmates is giving our listeners $100 off free delivery credit for your first seven days. Start your free deliveries. Just download the app, it’s called Postmates, and use the code ‘Sawbones.’ The code is ‘Sawbones,’ and you get $100 of free delivery credit for your first seven days when you download the Postmates app. Anything you need, anytime you need it. Postmate it.

That’s just a trip off the… Postmate it. Postmate it. Okay.

Uh, Shady Rays is our final sponsor, and you know we’re headed out to the beach right now. Sydnee, I'm going to be, uh, very thankful to have these on my face.

Sydnee: We both are.

Justin: But y'know what? I'll tell you what I like about it. Uh, I don’t have to panic about it. Like, I just bought, like… if I were to buy a very fancy pair of sunglasses that cost several hundred dollars, I wouldn’t bring it to the beach. Right? Because you lose them. You break them. The waves crush your face, and it’s very sad and depressing. Because to think of spending that much money on sunglasses, right?

Shady Rays, though… here’s what they’re doing. They have two things. One, it’s gonna cost you less than the pricy brands. But also, they’ve got the best warranty in the business. They’ve got free lost and broken replacements, no matter what happens. Right? So not only is it less to replace them – they’re doing it for free! And also, they were less expensive to begin with.

Sydnee: Plus…

Justin: Plus!

Sydnee: Plus, they provide ten meals to fight hunger in America with every order.

Justin: Now, they don't say that on here, but Sydnee's trying to push them into it.

Sydnee: It does say. It says is right—

Justin: Sydnee's trying to force this on them.

Sydnee: I'm looking at it. [laughs]

Justin: Called shot. Let's see if they do it, folks. No, they do do that, too.

Sydnee: Yeah. Over four million meals to date.

Justin: Amazing. Uh, we—I have a pair sitting on my dashboard now, ready for vacation fun. I am so excited to slip them on as we hit the open road, and I have already paid a flotilla of guards, so don't even try to break into this house. At this house? Come on. I feel stupid about telling people we're gonna be on vacation, in case they try to burglarize us.

Sydnee: It's okay.

Justin: Anyway. Go to ShadyRays.com and use the code 'Sawbones' for 50% off two or more pairs. That's buy one, get one free. BOGO. Get two pairs for $45? Are you kidding me? That's ShadyRays.com, code 'Sawbones.' Find all the newest, best shades right there.

Uh, okay Sydster. Who do we have next here? Uh, Grace. "Hi, Dr. Sydnee and Justin." It didn't say doctors. Well, it's a typo.

Sydnee: Uh-huh.

Justin: "Hi Dr. Sydnee and Justin. My friend recommended your podcast to me a few months ago, and I have loved working through the archive ever since." Thank you.

Sydnee: Thanks!

Justin: "Yesterday, my roommate made a comment that's so interesting and enlightening, that doctors don't actually let their friends and family follow the medical advice they give out to their patients." [blows raspberry]

"It's worth noting that she's obviously anti-vaxx, doesn't believe in mammograms, et cetera. She believes that doctors give different advice to loved ones, but they do it on the down low, because if they were really to advise their patients what they actually want to say, they would be fired and lose their medical license, et cetera.

I know there was a family practice doctor who was a friend of the family growing up that fed these ideas. She really feels like she can't trust the entire medical field, because doctors are in the pocket of being silenced by the government slash big pharma. There's no way to argue with her."

Sydnee: So… [sighs] I… okay, first of all—

Justin: There is a question here.

Sydnee: Oh.

Justin: Just like… um, is there any basis to this, basically?

Sydnee: Right. I think it's worth addressing this, because first of all, as a fellow family practice physician, it makes me so sad to think that someone in my beloved field…

Justin: Bad eggs everywhere.

Sydnee: Fed these ideas.

Justin: There's bad eggs everywhere.

Sydnee: Uh, there is no basis to the idea that doctors have secret clubs where we get together and like, share all the real stuff, and then, so that we can make sure and tell each other and tell our families and tell our friends, and then tell our patients something different. Uh, there is no… there is no truth to that. Which I think most people would probably expect.

And there is no pressure from… I mean, from any—certainly, administrative pressures on cost control and things can occur in different medical institutions. But at the end of the day, if other doctors are like the doctors in my department, we kind of feel like we should get to do what we want, 'cause we went to medical school. And whatever the costs are for the company, that's not our problem. Our job is to take care of people.

That tends to be the struggle most of the time. Justin can attest to me rambling about it.

Justin: If there was a secret thing that Sydnee could tell patients that would be good for them and would irritate her superiors, she would do it every single day, all day, every day. You would hear it from everybody.

Sydnee: And I—and not, maybe perhaps, not all, uh, physicians are chaotic good. [laughs]

Justin: Right.

Sydnee: But I think a lot of us are. So I think… most of us. You can't speak for all physicians. Most of us take very seriously the oath that we took, the promise we made, and we want to be right. We want to give people right information. We also can be a little arrogant, and we like to get it right, and that means giving you the right answers so that you can feel better and come back and say, "Oh, I feel so much better! You were right! That was great advice, thank you!"

That is our goal. For the majority. But I think it's worth noting that, while there is not an actual basis for the idea that doctors intentionally give you bad advice, we have a long history in medicine, of all members of the medical community. Not just physicians. Everybody, physicians included. Taking advantage of people who have less power, of minority populations, of anyone who is not able to necessarily have access to the information for themselves, or to speak up for themselves. Have the judicial power, have the systemic power… there are plenty of examples throughout medical history of those people being taken advantage of, and of being experimented on and used in the system.

And so, if you say, is there a historical basis for it? There are lots of examples. We do a whole podcast about it, in medical history, of times when vulnerable populations were mistreated by the medical establishment. So I can understand why some people approach medicine and the whole system with trepidation.

That is—I think that that is something that we as medical professionals could be better about understanding, having some sympathy and empathy for, and trying to work through with our patients, as opposed to just saying, "Well, that's not true!"

Justin: Right.

Sydnee: Y'know, now, again, it isn't true now. I mean, this is not the way things work. But if people are still nervous and a little concerned, I think that a conversation between them and the people they've trusted with their care, we should all be open to, the doctor included.

Justin: There you go. That's what you *would* say. [laughs]

Sydnee: [laughs] Thank you, Justin. Thanks for just undermining my entire argument. That was—by the way, that's the internet. We just—that's Twitter, right there.

Justin: Yes. That's Twitter.

Sydnee: Here's my well-reasoned, thoughtful response. And then, here's the tweet that undoes it all.

Justin: Uh, I will say also that these doubts are going to persist until medicine is removed from an inherently immoral, capitalist system that we live in.

Sydnee: [laughs] That's true. That's true. If we were in a more single payer system, it would be a lot easier. It would be a lot more transparent.

Justin: Yeah. Uh, Mike says, "My doctor could not answer this question when asked, and I wanted to reach out to you, since you've been such a great communicator on this subject. My sister refuses to vaccinate her child. My children are older, and we've kept them away from her family at a great emotional cost. My wife is about to have her third child, and we're worried about my mother acting as a carrier between families, because the mother often babysits my sister's child and sees our kid shortly after.

When I asked my mother not to visit us in the hospital, or until the new baby has had its vaccines, she wanted to know when it would be safe. And what I thought is, most kids have a majority of vaccines by age two, but I know there's more to it than that. What age is relatively safe for a vaccinated child to be around someone who is frequently near an unvaccinated one? Am I being overprotective?"

Now, I would imagine that if the mom has had her vaccines, like, that's not… I mean, we're not really worried about like, skin transference, or like, clothes transference, right? With this stuff?

Sydnee: No. I mean, I'm not saying that that is completely impossible, depending on what infectious illness we're talking about. But I think what the big concern would be is if the mom got something, and then gave it. Which, if your mom has been vaccinated against all these things, or had them, depending… I don't know how old she is. Depending on, y'know, when she was a kid and what vaccines we had.

If she either had the diseases or has been vaccinated, in theory, that should be protective. It's tough that this… I'm sorry that you're in this situation, 'cause this is a tough situation. And this question I have seen come up many times in various forums.

So, your kids are protected against the majority of childhood diseases, I would say… I wouldn't say two. I would say by the age of five, probably. With that last set of… if you think about, if you're a parent, you know your kids get a lot of vaccines early on, and there are several times you go, and they get like, five or six at once.

The last big chunk of those is between the ages of four and six, and it's what a lot of people think of as the kindergarten shots. The shots you have to get. And it's your last set of boosters for a wide variety of childhood diseases. And once you get those, you should be protected against those. Up until then, you're getting shots, and you're getting boosters, and you do have immunity to them.

But it's hard as a doctor and as a scientist for me to say that, at any given point, your child is 100% protected if they haven't finished out their entire series of boosters. Otherwise, we wouldn't do the boosters, right? That's why we do them.

That being said, y'know, even after the childhood vaccines are done after age five, we give another booster for tetanus, diphtheria pertussis later. We give another booster for meningitis later. The HPV… not that that's a concern in this case, but there are vaccines that come later that you're not getting yet. So it's hard.

Until everyone's vaccinated, they're not protected completely. I would say that the majority of childhood vaccines aren't done 'til five, would be… if you want a more concrete answer, that's probably it. I would say if your mom has been vaccinated, and the kids that the—your sister's kids aren't sick, then you're probably safe most of the time. But if your sister's kids get sick and they're not sure what it is, since they are now vulnerable, and I feel for those children, 'cause they're vulnerable since they're not getting any of their childhood vaccines.

Uh, if they get sick in any way, one, I hope they see a doctor very soon to be evaluated to make sure it's not one of those diseases. And two, I would keep everybody away from the new baby, and your kids in general, until you figure out what they have. But I'm sorry, Mike. I'm sorry you're in that situation. That's a rough one.

Justin: Me too. Uh, from Joe, "I'm hoping you can help me understand what seems like a serious oversight in the scientific study of medicine, and how scientific data is used by insurance companies in America. I'm a type one diabetic. I've been using Humalog 100 for about ten years."

Sydnee: This is a type of insulin.

Justin: Okay. Can you condense this question down for me? Because there are several paragraphs of it.

Sydnee: The important point that—I know. The important point that Joe wants to know is, uh, they were well controlled on Humalog, and then their insurance company, this month, chose to stop covering Humalog and has required all patients to switch to NovoLog, under the basis that these are scientifically equivalent.

And they are wondering, uh, why is there such a huge—why is there such a huge oversight in scientific studies? What can we do, collectively, to get the government to regulate insurance companies so they cannot force patients into dangerous medical situations by requiring medication switches without first funding studies on the effect of switches?

So, specifically, the question is about, y'know, why do we make patients switch? And if we are making them switch, have we done a study on the front end to say that, not only are Humalog and NovoLog equivalent, just because these are the two drugs being used in this case, but switching from one to the other won't affect anything. If you're well controlled on one, we can switch you to the other, and you'll be just as well controlled on the other.

‘Cause the act of switching is actually part of the problem, right? It’s not just in a lab, are the two equivalent? The switching itself is part of the problem. And part of this has to go to what a formulary is. Like, why does your insurance company have a formulary? Why do they only pay for certain drugs?

Justin: I’unno.

Sydnee: Why did they switch from Humalog to NovoLog?

Justin: Cheaper.

Sydnee: So, generally speaking, when they make a switch, it’s a money thing. Um, they have—

Justin: Again, inherently immoral, capitalist system.

Sydnee: The insurance companies have pharmacy and therapeutics committees, which is a panel of doctors, nurses, pharmacists, and other clinical experts who sit down and decide, what are the drugs we should cover? And they set those tiers. Y'know, your insurance company probably has like, a first tier, and a second tier, and a third tier, and all that stuff, and what your copays are for them. They set all that.

Now, as to the exact cost, they don’t do that part. But they set what drugs are on the different ones. Um, and if anything is equivalent, then they may replace it with something else, right? ‘Cause a lot of classes have more than one drug in that class that does the same thing.

The problem is that, if you've got a company that makes Humalog and a company that makes NovoLog, the two of them are in direct competition, because this is capitalism.

Justin: Right.

Sydnee: So one’s gonna try to undercut the other one with better pricing to get the deal with the insurance company to get on their formulary.

Justin: Right.

Sydnee: And they can do that at any time, which can have you switch medications halfway through the year. It switches every year. Every year, they redo the formulary. And you might stay the same. Your drugs might stay the same, or they might all change. They always do that once a year.

But in a lot of states, you can change it at any time. Now, there has been legislation in more recent years to try to stop this process, to try to at least pin insurance companies down so that they can't switch formulary mid-year. But even if you did that, they could still reevaluate their formularies once a year.

Justin: [sighs]

Sydnee: As a physician, I can tell you – January is always a disaster. It's always with um, proton pump inhibitors, PPIs, medicines like Nexium, Prevacid, Dexilant. Every formulary changes on every one, every January. I have no idea why.

Justin: [laughs]

Sydnee: Well, money. I know why. It's money.

Justin: Yeah, money. Inherently immoral, capitalist…

Sydnee: Money is the problem. But as long as there's all these behind-the-scenes monetary deals being made, uh, I don't think anybody's gonna fund any studies on this other stuff, because they can… they can switch it whenever they want to to get the best deal. And they'll tell you that they're doing it to get you, the consumer, the best deal.

Justin: Wink! [laughs] 'Cause you know how good companies are at passing those savings onto you.

Sydnee: But the concern is, well, in a lab, these two drugs were proven to be equivalent, so fine, we'll just switch between them. And y'know, studies in a—things that we observe in vitro, and the way something reacts across a whole population, doesn't always reflect how it does person to person, and what your personal experience might be.

So what I would say is, one, on a small level, you can lobby your elected officials to prevent insurance companies from switching formularies mid-year.

Justin: Mm-hmm.

Sydnee: But on a larger level, we need to completely redo the entire American healthcare system.

Justin: So, either one. Whatever you guys have time for this afternoon. If you want to do either one of those things, it'd be great. Uh, Chris wants to know… this is gonna be our final question, I believe.

Sydnee: Yes.

Justin: "Is there any benefit to medicated lip balm, or does it basically do the same thing as the regular kind?" This is one of those questions that we sometimes encounter, where like, just by asking the question, I already know the answer. Like, because I took a half second to think about it, like, I feel like I already know how this is gonna go.

Sydnee: So, first of all, I had to… Chris, I'm so glad you—well, I both am thrilled that you asked this question, because I've learned new things, and also dismayed, because I don't really like the things I've learned. [laughs] Uh, when you ask about medicated lip balm, first of all, I had to look up that. What do they mean when they say 'medicated'? Because—

Justin: I was gonna say menthol.

Sydnee: So yes. Most of the time, from what I can tell, if a Chapstick… I shouldn't say Chapstick, that's a brand. If some sort of lip balm…

Justin: They're gonna come after us.

Sydnee: Chapstick or otherwise, says 'medicated,' they're probably talking about including menthol or camphor, or something that makes your lips tingly when you use it. That is typically what 'medicated' means. There are other things you can put on your lips that actually have medicine in them, like, things for cold sores and stuff like that. But that is not what medicated… that is not the way I'm taking this question to mean.

Justin: Okay.

Sydnee: Medicated lip balm. I think we just mean like, Chapstick versus medicated Chapstick, right?

Justin: Got it. Yes.

Sydnee: Now, that tingly sensation doesn't actually do anything for you. A lot of people enjoy it, but it doesn't…

Justin: [laughs] They nasty.

Sydnee: But it's not helping you in any medical sense. And we've talked about this before, with stuff like… anything that's mentholated, right? Stuff you put on your skin, or like, inhale.

Justin: Yeah.

Sydnee: Like, it can make you feel like you're breathing better, but it's not.

Justin: But it's not. [laughs] It's just fake.

Sydnee: It's just a sensation.

Justin: It's pretend.

Sydnee: The thing about your lips is that uh, you have a barrier on all your skin, your lips included, called the stratum corneum.

Justin: Okay.

Sydnee: And it stops moisture from leaving your skin and evaporating out into the environment, right? Well, during the summer—or, during the winter when the air is dry, you can lose moisture more readily. And so, a lot of people like to use something like a lip balm. Some sort of protective coat that will prevent… that's all it does. It just coats your lips to try to prevent them from losing moisture so quickly, right?

Justin: Mm-hmm.

Sydnee: And there are times, like I said, like in extreme cold conditions, or when it's really dry or whatever, when this could be helpful.

Justin: Okay.

Sydnee: The problem is that… and people have actually accused these products of being addictive for this reason. It's not addictive, in the sense that like, when you talk about an addiction, you don't become physically dependent.

Justin: Right.

Sydnee: Right? On lip balm.

Justin: Your body doesn't work differently because of the introduction of lip balm.

Sydnee: No, and you don't go through withdrawal symptoms if you stop using it.

Justin: Right.

Sydnee: It's not that kind of thing. But, what can happen is that, because of some of these ingredients, specifically the menthol and the camphor and things like that, a lot of people tend to react to that with a little bit of irritation and dermatitis. So, what you might interpret as, "Oh, my lips are starting to itch and feel irritated, I must need more of this medicated lip balm," is actually the effect of the medicated lip balm on your lips.

Justin: Oh, we actually see a similar… if I remember correctly, see a similar phenomenon with like, antacids.

Sydnee: Yes. With things like Tums or Rolaids or things that can, over time, trigger more acid production, even though they can reduce your symptoms initially.

So, and this is not for everybody. We don't know. I mean, they've estimated like, ten to 15% of people are gonna have this reaction. It could be more, could be less. But it may be that every time you use your medicated lip balm, and then a few hours later, you go, "Ooh, my lips feel itchy, I need more of it." It's really the lip balm itself that's causing the problem. And if you just go cold turkey, stop using it and wait, your lips will heal, and then you'll find you didn't need it to begin with.

And this has blown my mind, as somebody who walks around with a tube of some sort of lip balm in my pocket, literally 24/7.

Justin: All the time.

Sydnee: I have one by my bed when I sleep at night. Again, I'm not addicted.

Justin: That's what you say. You're like, scratching your arm fervently.

Sydnee: I want to use some. Talking about it makes me want to put some on my lips.

Justin: You are addicted!

Sydnee: I'm not—no. Well, I mean, and obviously, there's more to addiction than just the physical addiction. There's psychological dependence as well. But, the point—it also smells really good.

Justin: [sings] Gonna have to face it, you're addicted to balm!

Sydnee: The one I'm using, you got me. It smells like coconut. I love it.

Justin: I feed your addiction. Oh man, I'm your dealer. [sings] Got any Chapstick? I'm cool.

Sydnee: This is not me railing against, by the way, lip balm. I think if you don't use the medicated ones, then it's probably just like… I mean, go for it, y'know? I mean, I don't think there's any reason to be concerned. But if you're using medicated lip balms, and you find that your lips feel itchy and irritated a lot, you might want to try an experiment. Don't use it for a few days, and see if you actually feel better without it.

It'll be a tough couple days. You're not withdrawing, but because your lips will feel kind of dry and itchy. But then, they might be better. So there's your… man, my mind exploded with this information.

Justin: Folks, that's gonna do it for us this week on Sawbones. We hope you've enjoyed yourself. Thanks to the Taxpayers for the use of their song, Medicines, as the intro and outro of our program. Thanks to the Max Fun network for having us as a part of their extended podcasting family. And thanks to you at home for listening to our podcast. We hope you've enjoyed it.

And if you have questions like this, I guess you can always send them to Sawbones at MaximumFun.org.

Sydnee: Yeah, please. Just title it something like 'medical question,' 'weird medical questions,' something like that in your email. Because I search for these. I save them up, so even if I didn't answer them this time, I save up your questions and try to get to them whenever we do one of these, so…

Justin: Perfect. Uh, folks, that’s gonna do it for us this week. So until next time, my name is Justin McElroy.

Sydnee: I'm Sydnee McElroy.

Justin: And as always, don’t drill a hole in your head!

[theme music plays]

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