Sawbones 374: Hot Medical Question Summer

Published July 13, 2021

Listen here on themcelroy.family

Clint: *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 everybody, and [voice breaks] welcome to— wow! Got a little Greg Brady right from the jump!

Sydnee: I was gonna say, is your voice changing finally?

Justin: [laughs quietly] Hello everybody, and welcome to *Sawbones*: a marital tour of misguided medicine. My name is Justin McElroy.

Sydnee: And I'm Sydnee McElroy.

Justin: Welcome to the show. Sorry, that was very disconcerting. Wait a minute. Where do you think my voice is gonna go next?

Sydnee: Oh, I'm excited to see what happens.

Justin: [deep voice] You think it's gonna take it down here?

Sydnee: Hmm.

Justin: [goofy high-pitched voice] Or do you think it's gonna be more one of these guy— one of these numbers? Welcome to podcast!

Sydnee: [laughs] That's why I like best when we podcast early in the morning when we both have nice low voices.

Justin: Nice low voices.

Sydnee: Nice low voices. By the end of the day there's just nothing left.

Justin: Yeah. Nothing left in the tank. Syd, uh, this is one of my favorite episodes. It requires very little preamble. We've done 'em before, we're doin' it again, and I feel like this is the one where we can actually help people, you know what I mean? 'Cause they bring to us their weird, wild— wild and wonderful medical questions, and we— we actually help, together.

Sydnee: I don't know if I help people. I've thought about this a lot. I think that we try to, on this show, for myriad reasons, most of them that I want people to actually get help that they need that's appropriate to them and personalized and not just generic answers from a podcast-type health— help. Health help. That made sense.

So, I try never to answer actual medical, like, "I need a doctor to help me with a problem" questions, you know what I mean?

Justin: Yeah, I gotcha.

Sydnee: Because you should actually go see somebody who can evaluate you and do all the proper stuff, not just read your question on a podcast. So these are more like curiosity, I think. Just a "I also wanna know—"

Justin: Some medical curios.

Sydnee: Yeah. So, we try to stay on that level. If I actually do end up helping someone, that's a— that's a little icing on that podcast cake.

Justin: Uh, and let's cut into our first slice of podcast cake.

Sydnee: Hmm!

Justin: Right now.

Sydnee: What would a podcast cake taste like? What flavor would it be?

Justin: What flavor would it be? I don't know. That's a very big question.

Sydnee: Hmm.

Justin: Take it from me. I wrote the book about podcasting. There's not just one cake. [holding back laughter] There's lots of different cakes podcasts can be.

Sydnee: That's true. Some are deep and rich and some are light and fluffy.

Justin: And all of them are outclassed by pie at every turn. I think we can agree that— agree to that. No matter what kind of cake the podcast cake is, the pie will always be better.

Sydnee: I don't agree at all. Uh, we cannot rehash the cake versus pie argument on this show.

Justin: Okay.

Sydnee: Cheesecake is cake. First question!

Justin: [loudly] You can't just do that!

Sydnee: First question. Go for it.

Justin: "Immediately after getting a vaccine, before the doctor puts the band aid on, could you squeeze your deltoid and squirt the vaccine back out the hole?" [wheezes]

Sydnee: [laughs] I love this question.

Justin: [high-pitched, holding back laughter] I'm pretty sure it's no, right?

Sydnee: This is from Al.

Justin: Hi. Thanks, Al.

Sydnee: Uh, no, you can't— you can't. I do like this question. Okay.

Justin: It could also be— it's a lowercase l, so it could also be AI. So this could also be—

Sydnee: [laughs]

Justin: —some sort of learning routine that's trying to calculate how the human mind works.

Sydnee: So if you've ever given or received, like, especially a larger volume injection, you may have seen a little droplet, like, right outside the puncture, um, at the end. So I could see where the beginning of this concept would come from. But you have to remember— and I think I may have used this analogy on the show before— what you're injecting into is a lot more like a sponge in terms of the tissue.

Justin: Yes, it's absorbing it.

Sydnee: Yeah, it's not like a water balloon. So...

Justin: It's tissue. That's a good metaphor. It's tissue.

Sydnee: Yes. And so— tissue is a good metaphor, 'cause if you think about something like a Kleenex or a paper towel or something, you couldn't just, um, like, squeeze— like, lay it flat on a counter and push your hands on it and expect all the water to come out.

Justin: The absorbing— yeah, the absorbing has happened.

Sydnee: Yes.

Justin: Yeah.

Sydnee: So, like, if you immediately squeezed, could you, like, get a drop out? Like, the last drop that just went in that has not yet been absorbed? Possibly. But the whole vaccine would not come back out, or whatever your injection was. And I think this goes without saying. Don't do that. [laughs quietly] Don't do that.

Justin: Don't do this.

Sydnee: 'Cause whatever you just got injected in you, you probably— I mean, I hope you wanted it there.

Justin: It's good stuff.

Sydnee: So— and vaccines are great. So, I mean, I wouldn't try it, but even if you did, you wouldn't be able to—

Justin: It wouldn't work.

Sydnee: You wouldn't lose that vaccine power. Get vaccinated, everyone. Not just you, Al. Everybody. Thank you.

Justin: Everybody. Here's another question.

"In *M*A*S*H* they have a few episodes which centre around a hemorrhagic fever." Oh, C-E-N-T-R-E. I see we've got an intercontinental...

Sydnee: Mm.

Justin: ... listener here. Somebody who's a little fancier. "Centre around a hemorrhagic fever, which they treat/manage by restricting fluids. Is that an actual thing for certain hemorrhagic fevers, or was that a depiction of a 1950's/60's/70's medicine? I believe the episode is "Soldier of the Month" in season four when it was first brought up."

Sydnee: And that's from Freya.

Justin: Thank you, Freya.

Sydnee: Uh, so yes, I'm really glad that you asked this question, 'cause I love *M*A*S*H*. I think I've made that clear on the show. Love *M*A*S*H*. Uh, love the opportunity to dive back into an episode of

*M*A*S*H* to try to figure this out. And I think that this topic in general deserves a whole episode unto itself at some point.

Justin: Okay.

Sydnee: I did wanna briefly answer the question, though, without spoiling too much of what— like I said.

Justin: Of *M*A*S*H*.

Sydnee: Of *M*A*S*H*. [laughs quietly] I won't spoil *M*A*S*H* for you. For all those who still haven't gotten around to—[laughs quietly] to watching *M*A*S*H*. The hemorrhagic fever that they're talking about is one of the hantaviruses, hantaviridae, which is like a family of different viruses that— the hantavirus we know in the US usually causes lung problems.

There are also these hemorrhagic fever with renal syndrome, which is actually the way they're abbreviated, HFRS. Meaning you got one of those viruses, and they cause kidney problems. It was a huge problem during the Korean war. There were, it's estimated— the exact numbers aren't known 'cause at the time you didn't always know what you were dealing with, right?

Much like in the episode of *M*A*S*H*, I don't think they specifically say what it is. They talk about this in other episodes, too. But about 3000 soldiers got this syndrome. Estimates are that maybe 300 people died of it, so big deal. Um, and it would— like I said, it would cause fevers, headache, nausea, but also kidney failure was the hallmark of it.

And when your kidneys aren't working, one, they're not filtering stuff out right, so you can get really sick from all the stuff that's building up, the toxic stuff that's building up in your body. But the other thing is you get fluid overloaded, so you get a ton of, like, swelling. Your body can get swollen, your legs, um, but also your lungs can fill with fluid, which is bad for breathing.

Justin: Sure.

Sydnee: And can cause you to go into respiratory failure, which, you know, you stop breathing, and that's not really— that's not compatible with life, long term.

Justin: Yes.

Sydnee: To put it mildly. Especially if we're talking about someone who's out in the field.

Justin: Yeah.

Sydnee: So, uh, fluid management was the main thing that they had to do for these patients during the war, is restrict how much fluids they're bringing in, in order to make sure they didn't get too fluid overloaded, but still give them enough fluid to keep— so that they didn't have vascular collapse.

Anyway, yes, this would have been one of the main treatments at the time. We would probably manage this differently nowadays, and certainly they were managing this differently if they were actually, like, in a hospital somewhere where they could get the full range of critical care that was offered. But out in the field, this was— I mean, it must've been a huge task for the doctors and nurses who were out, you know, on the front lines, having to manage these patients, 'cause they were critically ill patients.

Uh, but yes, fluid restriction would've definitely been part of it, so... it's really interesting. Does make sense. Slightly different than what we'd do today. Similar, but we would— we'd be— you know. We'd use numbers and stuff. [laughs] We'd use labs.

Justin: "Yeast infections."

Sydnee: Yes.

Justin: "Why?" That's kind of a deep one.

Sydnee: Why?

Justin: "Why? Also, are there stages of yeast infections? Sometimes I experience discomfort in my bathing suit region, but when I use Vagisil, it helps right away. Is that a different situation, or is that an early stage of yeast infection? Also, can anybody get a yeast infection?"

Sydnee: Thanks.

Justin: That's from Ariel. I don't know why I keep forgetting to read people's names.

Sydnee: I don't know either. Um, so yeah, okay. First of all, why? I think it's inter— I don't know if we've ever talked about this before on the show.

Justin: You know, I don't know.

Sydnee: Maybe. I may have mentioned it. Um, so yeast grows when other— when it's out-competing other things that grow. We are supposed

to have, those of us who have vaginas, we are supposed to have natural flora there. There is bacteria that is supposed to be there, and it's fine. It's good. It's healthy. There's no problem with it.

Um, if something gets thrown off where yeast can grow better than that good, natural bacteria, then you can get a yeast infection. So, the yeast is out-competing for growth and space, right? Um, overpopulates. There aren't, like, defined stages in the sense that, like, I would look at a yeast infection and grade it, like, in my documentation. Like, "This is a grade 1, or a stage 3, or—"

Justin: [simultaneously] This is a class 2! We gotta get everybody in here!

Sydnee: I mean, certainly you can have more severe infections. Or, like, if you just begin the yeast growth, you know, to notice some symptoms, maybe you catch it before more severe symptoms happen. I wouldn't say it's a protocol or anything.

They're all treated fairly similarly in terms of there are pills that you can take that are prescription, and then there are also a variety of over-the-counter creams and things that you can both apply to the outside and then, um, some of the creams— and anybody who's ever had a yeast infection might know this— come with these little sort of injector things where you fill the tube with cream and then squirt it inside the vaginal cavity.

Anyway, the point is that anybody can get a yeast infection. You can get yeast infections anywhere that's sort of, like, warm and damp and not necessarily exposed to the air. So not just, like, in a vaginal area. You can get them in skin folds. They can happen under breasts, or anywhere where there is skin touching skin and a dark, moist area underneath.

Justin: You know, Syd, it figures, I try to get yeast to bloom for my conchas, for my sweet breads, and they die. But then somebody just have an armpit and just get it.

Sydnee: You just have to have an armpit.

Justin: Just get some— get some without any work at all.

Sydnee: It's worth noting, too, like, it's the same thing if you've seen thrush in babies, in the mouth. You can get yeast infections in the mouth or in the throat. Yeast can grow a lot of places. Um, if it's something that Vagisil clears up, if you have some sort of discomfort, that could just be some irritation or some dryness, those kinds of things. Especially, like, dryness of the outer tissues of the labia. It could just be that. Probably not yeast in that case. Um, but I think there's this inclination that

whenever vaginas are itchy it's gotta be yeast, and that's— it's a common misconception.

Justin: "[to the tune of "It's Gonna Be Me"] It's gotta be yeast!" Remember?

Sydnee: But if you're concerned, talk to your doctor.

Justin: "Hey, Dr. McElroy and Justin. My question is more about how the science of different SSRIs work. For example, why are my ADHD medicines an appetite suppressant and my OCD medicines an appetite increasing medicine?" That's nice. You're taking both. [clicks tongue] [holding back laughter] Levels you right out. "I thought the drugs fixed my brain! Why do they mess with my gut so much? Thank you in advance." That's from Clay in Champagne.

Sydnee: Uh, I thought it was a good question to ask, just because without knowing the specifics of your medications— and I'm not asking for that— it's hard to know exactly the mechanism of action and why they're doing what they're doing.

But generally speaking, what's interesting is that you gotta remember these medicines— they're not working on your gut directly. They are working on your brain, right? But it reminds us how much our brain influences our gut.

So, especially when it comes to appetite, so much of our idea of when we feel hunger, when we feel fullness, you know, those things, they're coming from your brain. Those are signals, chemical signals, hormonal signals that are sent from the brain, and certainly there are receptors on the gut, so you have responses in the gut, but I think that that's always helpful when it comes to diagnoses like irritable bowel syndrome.

And people will say, like, it has to do with chemicals from your brain, which can be misconstrued as, "So it's all in your head." Or, like, I've heard people just say, like, I have a quote, unquote, "nervous" tummy. But no, it's just that it's all connected.

Our brains and our bodies are all connected, which is why when you have a diagnosis that's primarily a psychiatric or a mental health diagnosis, it affects every bit of your body. It affects your gut, it affects your stomach, it affects your appetite and your bowels and your muscles and your joints, and... everything. Everything feels, you know, related to this brain, primarily brain process. So that's why, 'cause the medicines act on your brain, and that's— our brain regulates everything. It's the control center.

Justin: "I work in public health and I've been working on COVID response, like most of my colleagues, since March of 2020. About six

months after the response started, my office had a psychologist give us a presentation to explain how our brains are handling the situation. She explained that memory problems are super common. My question is, how long are we gonna have these memory issues? We are calling it response brain or COVID brain, and honestly, I feel like it's getting worse, not better, for all of us. At what point should we be concerned?" That's from Ariel.

[pause]

Sydnee: Go ahead, Justin. Did you have a— you look like you had a thought.

Justin: Well, no, my hand itched, so I was scratching it. As long as you've thrown the proverbial spotlight on me, I will say that I know that stress hormones like cortisol can have an impact on memory function.

Sydnee: I think— well, what you're hitting on is exactly— and we've mentioned this briefly on the show before, but I think it's always a good thing to reiterate, because it's been so distressing for many people in the past year. Certainly people who are working in— like, directly in the healthcare field or the public health field, you know, in response to COVID. But for everyone else as well.

Justin: Who, I should mention, by the way, if you are in a healthcare field, or maybe even you're somebody who, like, took it— to a lesser extent, took COVID extremely seriously for a very long time, uh, being in those fields and then seeing the world act like everything is fine now is gonna be continuing— it's just like a delicious Act 2 of trauma, because that is, like, *Twilight Zone* level wild to see how some people are sort of, like, acting in response to COVID right now.

Sydnee: Well, I think the phrase "gaslighting" gets thrown around a lot. Um, but in this case, it perfectly fits. A lot of us feel that way. Like, did— did— did— was no one, like—[laughs quietly] weren't we— didn't we all just live through the same thing this past year? What is happening, right? Like, this all just happened, right?

Justin: So we're just letting kids get... so we're just not worrying about kids at all?

Sydnee: We're just letting kids get COVID now. That's just the thing?

Justin: Is it just letting kids get COVID? No masks for kids. Okay, got it.

Sydnee: We're done? Okay.

Justin: Alright. Got it.

Sydnee: Um, so I think that— I think you're right. That would be why you are— why these problems are persisting. And I think that, um— I have still heard people say, like, "I think maybe this was sort of a question. I think maybe this pandemic has had some sort of effect on our healthcare workers and our—" and it's like, you don't know that? How are we not all rigorously addressing this issue? That you have been probably undergoing trauma, I would assume. A lot of us have.

When you are in those sort of stress-inducing environments, stress hormones like cortisol make it difficult for you to— you're not forming the memories, is the problem. It's not so much that you're forgetting as in the moment you aren't— your brain is not being able to do the things that allow you to retrieve that memory later. Does that make sense?

Um, and that can happen in states of extreme anxiety or depression as well. You just— the focus and attention that's necessary for it to be stored and remembered later is not happening, because you're also trying to process the constant threat of this virus, and worrying about your loved ones.

And then, if you're in public health, worrying about our response as a species, which has been less than stellar, I would say. I wouldn't necessarily say it should be getting worse for everyone, but it could still certainly be getting worse, and it needs to be addressed. Um, both on, like, company-wide levels, like businesses and healthcare facilities and all the different places where this work has been taking place should be bringing in people to— like, trauma counselors to work with people constantly.

We still need that support, all the time. Um, the fact that it's not happening in every healthcare facility across the nation, across the globe right now is, I mean, ridiculous. But you may also personally need somebody to talk to about this, because this has been an incredibly traumatizing year for many people, to different— for different degrees of severity. The idea that we should all just bounce back 'cause, like... it's hot girl summer...

Justin: [laughs]

Sydnee: Um... [laughs quietly] which, don't get me wrong, I want to! I wanna be there.

Justin: Yeah!

Sydnee: I wanna be out, like, feelin' great and... livin' the roaring 20's.

Justin: And we're obviously—

Sydnee: Like, I want that. It's just—

Justin: And we're obviously not living how we were living in April of 2020. I mean, like...

Sydnee: No. We have begun to venture out a little bit, and make, like, calculated risks with selected people, but we also have two young children, and the fact that the world seems to have forgotten that it matters if a kid gets sick, or it matters— if even a few children, you know, succumb to COVID, that that matters. It... it's been— it's— it's wild. It's hard. It's scary. And it's, um— it can make you feel very jaded, too.

Justin: Okay. We have many more questions to come, but first, we are going to go to the billing department. Let's go.

Sydnee: Let's go.

[ad break]

Justin: "Hi, guys! So, I recently learned about precordial catch syndrome, AKA Texidor's twinge. That is a heck of a name. And it's something I've been apparently dealing with for years now. It's characterized by a sudden stabbing pain in the left side of my chest, worsened by inhaling, and usually lasts only a few minutes before mysteriously subsiding. My question is, do you have any— there's more there, but my question is, do you have any idea what causes it? I can't find much info other than it's commonly seen in adolescents— I'm 27— and people with high stress— I'm thankfully not."

Sydnee: Uh, so it's really interesting. Um, I had never heard the term Texidor's twinge. I've heard precordial catch syndrome.

Justin: That sounds like some Gary Gygax, like, 5th Edition D&D nonsense. Like, Texidor's twinge is a wild name.

Sydnee: It is— it is one of the names that it goes by. I thought that was very interesting, 'cause I had never, um— I had never heard that. Um, precordial catch syndrome, you described it perfectly. That is exactly the sensation people have. Um, and a hallmark is that, as this listener noted, you have a bunch of tests to work it up, and everything seems okay. Your heart and lungs are fine. Um, because obviously you don't wanna just assume that it's nothing. You know, you wanna be evaluated.

Usually, these episodes are particular— are very short. Um, this listener mentioned that some could be up to 15 minutes, which is on the longer end. Um, but at one point, someone suggested that they lift their arms and take a huge, deep breath, and while it hurt to do it, it made the pain

go away. Which, this is all a very classic description of precordial catch syndrome. Why does it happen?

It's— the best guess is that it's probably— so, in between your ribs you have— there's space, right? And there is a neurovascular bundle, meaning nerves and blood vessels that run in those spaces. So our best guess is that it's either, like, a pinched— what we would call intercostal, between the ribs— nerve, or a muscle spasm occurring, 'cause there's also a muscle there, in between all those ribs. Um, and that is our best guess.

Now, it's hard to say exactly what it is because there's no real test. You know what I mean? Nobody— it happens so quickly, it's benign, you rule out the scary stuff, this is what it is. There's no test I can do to prove it. But that is what— that is the thought process behind what it is. It was— I just thought it was interesting.

It was originally named Huchard's syndrome for Henri Huchard, who was actually the first doctor who described it, back in 1893. But then later these other two doctors, Albert Miller and Teodoro Antonio Texidor, did a lot more work on it, and then I guess got to rename it Texidor's twinge.

Justin: Texidor's twinge! I love it! I'm gonna remember that forever!

Sydnee: It is more common in adolescents. Uh, it can happen at rest, it can happen with movement, it can happen because you're hunched over. They thought maybe posture-related. I don't know. There's still a lot we don't know. If you're having chest pain, you should always get checked out, but this is something, precordial catch syndrome or Texidor's twinge, that can just happen, and be no big deal, and, you know, hopefully it doesn't happen again. Stretching and moving or laying down has been known to fix it.

Justin: "Hi, there! I'm curious about the topic of breast milk versus formula. I've heard that once an infant goes on formula they cannot switch back to breast milk. I was wondering if this is true, and if so, why? Thank you so much. Love the show. Luca."

Sydnee: I thought this was important just to mention that, uh, there is no reason you can't do both. You can do breast milk, you can do formula, you can do one then the other, you can mix 'em together in the same day. This is all fine.

Um, so I think that where this misconception might come from is that there is always the fear that because there is gonna be a taste difference, that your infant might have a preference for one over the other, and it would make it hard to go back and forth, right? So if I introduce formula, what if my baby likes that better, and then I can't breastfeed anymore?

Um, in practice that's not usually an issue. Uh, most infants do find moving back and forth between the two— unless there are special nutritional needs or, you know, they have to get a certain kind of formula, or intolerances. But, um, both work great, and fed babies are healthy babies, so. It's fine.

Justin: "Does the clock on sunscreen start when you go into the sun or when you apply it? Like, can I put it on, sit in a totally dark room for two hours, and then go out there and be okay?"

That's from Devin.

Sydnee: I thought this was such a great question, 'cause I honestly didn't know.

Justin: Okay.

Sydnee: When I got this question I thought, "Well... I've never thought about it." So from what I can tell, nobody has ever really... I don't think anybody's doing this. Like, I don't think anybody's tried that. Like, I— I think the way that the studies are done is we put on sunscreen and then go out in the sun, and then measure the sun protectant factor as time goes on. Because—

Justin: I do know that water impacts it, so if you're swimming it can be— it's greatly reduced, the speed at which you need to reapply.

Sydnee: But so does just, like, sweating, and then the general, like, shedding of skin cells that we're constantly doing all the time.

Justin: Slough— sloughing off.

Sydnee: The sloughing, yes.

Justin: [laughs quietly]

Sydnee: So I don't— I mean... [sighs] there is— I guess there's room for a study here, where you have people sit in a room for two hours and then go out in the sun. Um, I would not do that at home, because you're naturally— it is going to wear off naturally just from being on your skin and, like I said, the sweating and the sloughing and the insensible fluid loss that we all do all the time. All those things, you're gonna lose effectiveness.

And it should be noted that that SPF 30 that you put on when you first went out in the sun, two hours later is not still SPF 30. The SPF has been dropping, which is why you have to reapply every couple hours. That's

why that is so essential. So I would— I would say for safety's sake, as soon as you put it on, that is when your clock starts tickin', even if it takes you another half hour to get the kids out the door. [laughs quietly] Which is my case.

Justin: "I don't know if you've answered this before, but sometimes when I get really anxious or I'm in a high stress environment, my mouth feels and tastes weird. It's almost like I've gotten dehydrated. Is there a medical reason behind it? Even better, is there a way to make it go away besides just waiting for the anxiety or stress-inducing event to pass?"

That's from Yours in Medical Interest, Emily.

Sydnee: Uh, this is actually a really common thing that can happen with anxiety. I don't know if you've experienced it.

Justin: It's cottonmouth.

Sydnee: Have you had this sensation?

Justin: Uh, yes, for sure.

Sydnee: And many people may have, if they've just—

Justin: I'm gonna rate it— I'm gonna go ahead and give it a thumbs down for unpleasant. [wheezes] Disconcerting? Oh yes.

Sydnee: There are a couple reasons. The most obvious that dry mouth or cottonmouth happens— I mean, 'cause that's what— that's probably at the root of this, is your mouth is dry. That's what the weird taste or sensation in your mouth, it's dry. The most obvious is that when you're anxious you aren't as— uh, you are more likely to breathe less efficiently through your mouth. And you may not process that you're doing that at the time, 'cause you're anxious, but you're probably breathing through your mouth and drying out your mouth. Um, also—

Justin: Folks, let go of that mouth breathing. No need for it. Don't— don't do it. Exercise, daily life? Give it up! Mouth breathing's no good. I read a whole book about it. You don't wanna mouth breathe anymore.

Sydnee: My nose is too small.

Justin: Well, Sydnee, it's time to make that special...

Sydnee: It's— my nose holes, the nostrils.

Justin: ... the special augmentation.

Sydnee: They're too—

Justin: Time to get a cybernose.

Sydnee: —they're stenotic. Also, higher levels of cortisol and norepinephrine, which are things that are released when you're stressed out or in a high anxiety state, can cause a taste change in your mouth. If you've ever had a metallic taste or a bitter taste in your mouth, that is associated with that.

Uh, it also changes how— I thought this was interesting. There's been studies done to say when you're anxious you do not taste as well. Like— well... hold on, let me rephrase that. [laughs quietly] When you're anxious, you're not able to taste salty things as well, or to taste sweet things, like the sensation of salty and sweet is diminished when you are in a high anxiety state. So it also changes, like, your actual taste ability.

Justin: Wild.

Sydnee: Um, so this is a very common thing. I would say there's not— I mean, certainly if your mouth is dry, drinking fluids can help with that. But in terms of the causative— you know, the anxiety itself, ways to cope with stress and manage your anxiety are the things you need to focus on.

Justin: "Alright. You asked for weirdest and grossest. I'm working on a screenplay about a chef who starts to use human flesh in his dishes, so I'm curious. What examples are there of cannibalism in medical history? Was there ever someone who swore by the medicinal properties of human flesh? Thank you, and please don't report me to the authorities."

Hey, listen. I can deal with this one, Syd.

Sydnee: This is why I did this. [laughs]

Justin: Really? We never do this! We never plug the back catalog. I'm telling you, we should just start recycling episodes. Greatest hits.

Sydnee: No, I just wanted to plug one of—

Justin: Do— run on reruns.

Sydnee: —one of my favorite episodes we've ever done.

Justin: That is from episode 38, April 8th, 2014: Medical Cannibalism.

Sydnee: That's right. There's a whole— listen to the— there's a whole— yes. Yes, there's a whole history there. That was the only reason I wanted to include that one.

Justin: That's good. I'm telling you, Syd, greatest hits. We've gotta start recycling these episodes, just run 'em as new.

Sydnee: It's one of my favorites.

Justin: No one's gonna go back and listen to hundreds of episodes of a podcast. Uh, who would do that?

"Sometimes there's gunk in a hair follicle. Sometimes at the end when I pluck a hair or in the follicle, almost like a blackhead, I can squeeze it out. I'm pretty sure it's not a blackhead. What's up with that?"

That's from Jackie.

Sydnee: Um, so at the bottom of a hair follicle, there's also, like, a gland, a little oil gland. Um, and so that— because there is an open space where oil is stored, one, there could be oil there. Two, any time there is, you know, an open space, dirt or skin cells can accumulate. Um, and that can look like a little plug of— it can be clear, yellow, brown, black... you know, a variety of different colors. Um, but that's pretty common at the end of a hair follicle. That is not unusual at all and it's nothing wrong, and it's not necessarily a blackhead, although you may have a blackhead there. Um, very common.

Justin: "Hi. Why don't doctors make house calls anymore? I personally suffer from migraines and would love house calls to come back in style. Thank you. Katie."

Sydnee: [laughs]

Justin: Dr. McElroy, who just made a house call yesterday?

Sydnee: I was gonna say, well, that's, uh, in part— some of still do do house calls. Um, I just did yesterday. And I know some of my colleagues do house calls, too. Less in COVID, I would say. I saw fewer of those occurring. Prior to COVID it was actually part of the curriculum when I was a resident. You had to do a certain number of house calls so that you learned how to do that. I would say, why don't doctors do it as much anymore? [sighs] And I'm gonna be very careful not to just use this as an opportunity to rail against the American medical system again, 'cause we already did that show.

Justin: A first. A first.

Sydnee: Um, a lot of it has to do with one, the logistics. If you have a doctor who is, like, in an office-established practice, and they're seeing lots of patients per day, like a busy family practice doctor would... you

know, in theory we're supposed to see a patient at least every 15 minutes, or 30 if it's a new patient.

You can see how it would be really difficult to fit a home visit into that structure, because that's how so much of it is structured these days. And if you do block off an afternoon to do a couple home visits, 'cause you could only do a few in that time period, then one, you can't see a lot of patients who need you, and two... the people who like to make money off medicine don't make as much money.

Um, home visits do bill a lot higher, I have noticed. Um, which is one reason I actually had patients who preferred— even though I offered it, they didn't want that, because they cost more.

Justin: Home visits do?

Sydnee: Huh?

Justin: Home visits, you mean?

Sydnee: They do. Now, there are— we do have practices that have become structured around that. I know there's one in our area where it is purely for patients who for whatever reason either prefer or can't make it to office visits.

Um, so you might look. There may be one of those in your area, but their whole business model is now structured around this. And they have, like, so many, like, doctors and nurse practitioners and physicians assistants, and they can, like, deploy a fleet of people out to do this kind of work, and I don't know. But it— I mean, money. Money is the shorthand.

It's not that you're— and it's not even about, like, the physician themself. I know a lot of my colleagues love to do home visits, and wish they could do more. There's just— unless you're gonna do it on evenings and weekends, there's no structure for that in the system we have, usually.

Justin: Now, before you get all excited, "Old Dr. McElroy is making house calls. She must be raking in the big bucks." Don't get too excited, listener. She— she's volunteering. I know. I'm bummed out too.

Sydnee: It was a free home visit.

Justin: I wanted her to start scraping in the— the cash.

Sydnee: As much as I can stop getting paid for my services, I'm trying.

Justin: [muffled laughter]

Sydnee: [laughs] While we still eat. [laughs]

Justin: [laughs]

Sydnee: This is my silent protest. I'm raging against the machine [through laughter] by not making money!

Justin: Not participating in capitalism. She's a conscientious observer to the capitalist system.

Sydnee: Objector.

Justin: Objector, there we go.

"When you have surgery, what happens to all the gas inside you?" [wheezes and laughs loudly] I have never had the visual of someone—

Sydnee: This is a legit question!

Justin: I know, it's just the visual—[wheeze-laughs] of a surgeon cutting into your stomach and it's just like, all the farts come out at once. Like, [blows raspberry]. Like, "Oh, there— that's where they were." Like we're big stinky balloons. [laughs loudly]

Sydnee: Um, this is actually— this is a good question, Tom!

Justin: I know it's real! I'm not making fun of the question, Tom. I just think it's a fun image.

Sydnee: If you've ever had a procedure like a colonoscopy, you know that, like, afterwards you're gonna—[laughs quietly] there's gonna be some gas. Because, like...

Justin: Where? What do you mean?

Sydnee: Inside your colon.

Justin: Okay.

Sydnee: Because we stuck a camera up there.

Justin: And shoved all the farts into one...

Sydnee: And then all the— well—

Justin: ... place.

Sydnee: —and extra air got in, so now it has to come back out.

Justin: Through your butt.

Sydnee: Um, and that does happen after a surgery, after, like, all the air is let back out of the abdominal cavity. 'Cause, like, it's usually inflated, so to speak, to— because so many surgeries these days are laparoscopic, right? We use a camera. So we sort of inflate the area so we can get the camera around in there better.

Um, the air is then removed, but there's extra that is then, like, resorbed into the colon, and you've gotta fart out later, or burp out later, whatever. But yeah. I mean, it comes out your butt. [laughs quietly] You don't have air bubbles inside you. Don't worry. That is not part of the surgical process. It is part of the aftermath. [laughs quietly]

Justin: "Sometimes when commercials for prescription drugs play, they say to tell your doctor if you or someone in your household has gotten vaccinated recently. I get why they need to do that if you had a vaccine, but what does it matter if someone else did? How would that affect your ability to take the drug?" From Confused Cass.

Sydnee: Um, I would say that in this case, what they're probably talking about are, one, vaccines that are live virus vaccines, which is not the COVID vaccine. Everybody already knows that probably, but just to throw that out there again, the COVID vaccine is not a live virus vaccine. When you do have a live virus vaccine, there is this, um, worry that after you get the live virus vaccine, could you shed some of the virus in your stool, in your bodily out— you know, in your... in your waste products. Is that possible?

Um, and because of that— and I'm guessing, again, that the medications they're talking about are medicines that suppress your immune system. Like medicines for, um, different autoimmune diseases and stuff like that.

And the combination of those two could be concerning. Uh, so in those very specific situations with live vaccines and people in the household who are on immunosuppressants who might be around those people, this is the— this is the concern that they're having. 'Cause it's the same reason that somebody who is immunosuppressed may not be a good candidate for a live virus vaccine.

Uh, but in all of these situations, they're very specific to the patient, the family, the disease, the drug, the vaccine, all that. So don't assume any of that based on a vaccine or medication. Please talk to your healthcare provider so that they can guide you in that situation, 'cause it would be very rare, but specific situations.

Justin: Uh, okay. Two more, Sydnee.

"When you have nasal congestion, why is it that sometimes one nostril will feel completely blocked or be runny while the other nostril is completely clear, and why does it shift sides occasionally, such as when you sleep on one side versus the other?" That's from Jonathan.

Sydnee: You have turbinates in your nose. These, like, outpouchings of tissue inside your nose that swell in response to allergens or, um, if it's an infection or a cold— you know, like, a cold or something, or an allergen or whatever, seasonal stuff, um, they swell and they alternate. One side swells and then it goes down, and then the other side swells. This is why one side of your nose feels stuffy, and then it doesn't, and then the other side feels stuffy. Um, and it does switch back and forth.

It is not a matter of blowing it out. That's what a lot of people think is like, "If I could just blow hard enough then they would both be clear in that moment," And it's not—like, if you stuck a camera up your nose [holding back laughter] you wouldn't see, like, a big plug of snot and boogers. It's that the tissue on the side of your nose is actually swollen. [laughs]

Um, but at least your body's nice enough to alternate it, so you can breathe out of one side or the other. I don't know if that's more or less frustrating, honestly.

Justin: Yeah. "What's the deal with dark under the eyes? Is it a situation like cellulite where skincare and beauty companies just want me to feel insecure so they can sell me products, or do they actually indicate a lack of sleep or nutrition? Why are they so darn dark in the first place?" And that is from Sam.

Sydnee: I would say that this is a combination of both. Um, you can— you know, you can see, like, darker circles under the eyes because of lack of sleep or fatigue or something like that, right? That is— that is a possible cause. Um, so, you know, I'm not gonna say that that part is untrue. But then there are lots of other reasons, um, that really aren't— the solution is probably not found in the beauty industry.

Um, one of the most common is allergies. They're called allergy shiners, allergic shiners, and it's dark circles under your eyes as a result of allergies that maybe aren't being managed as well as they could've. So seeking treatment for your allergies might help to alleviate that.

There is also a genetic component to this. Whether it's your actual, like, skin pigmentation or just genetically you have a darker area under your eyes. That's just— that just happens. Um, and that's not necessarily something you need to, like, address in any way, unless it bothers you. There isn't a cure, a fix for that.

Uh, it can be because of some sort of contact dermatitis or something like that. Obviously, like, inflammation of the skin. Um, it can be because you rubbed your eyes too much. The blood vessels around our eyes are very fragile, and if you're constantly rubbing your eyes you can see a darker area around your eyes, or scratching at your eyes, which may again be allergies.

Um, sun exposure can do this. Another good reason to wear your sunscreen. It also can just change with aging. Lots of reasons, not necessarily that you're tired, although that can play a part, too.

Um, and generally the causes are not something to be concerned about. Some of them can be addressed. Uh, but I do think it is something that has been made a lot of in the beauty industry as, like, "It is very undesirable, because it indicates that you are somehow dehydrated and tired every time we see dark circles."

Justin: I see it as, like— as, like, this person— I'm just, like, cranking it out 24/7 and I don't have time to sleep, 'cause I'm fulling getting the marrow of the whole thing.

Sydnee: But see, the— this is the— capitalism has made you feel this way. [laughs]

Justin: Finally, we found a bad thing that capitalism does.

Sydnee: It— you are— you are glamorizing exhaustion.

Justin: Not exhau— just— for me, it's just from partying with my buds.

Sydnee: I will say that no matter how much sleep I get I always have dark circles under my eyes.

Justin: They're very— and they're very fetching.

Sydnee: Are they fetching? Do you think they're fetching?

Justin: [simultaneously] We're— we all— we've all agreed on it.

Sydnee: No. I— I sympathi— if it's so— if you have that and it bothers you, I will say, I empathize with you. Because it bothers me, and no matter how many times I tell myself, like, "You're fine, it's not that big a deal, it's just the media making you feel bad about yourself," I [crosstalk].

Justin: But if you really don't like it, Preparation H.

Sydnee: [laughs quietly]

Justin: Butt cream. It works.

Sydnee: Does that really work for you?

Justin: The secret of the Hollywood elite, like myself. [wheeze-laughs]

Sydnee: There is— and there's also, I will say, if it—

Justin: If you can deal with people thinking that your face smells like butt cream.

Sydnee: If you're a little dehydrated, your eyes can look puffier by contrast. Um, but, like, this is not to say water is the great cure-all. I mean, water's important. Drink water.

Justin: It's good stuff.

Sydnee: Get sleep. Sleep is important. These are important things. Not so much for our under-eye circles, just for, like, our general functioning as humans.

Justin: Um, hey, that's gonna do it for us. Thank you so much for listening to this episode. Uh, hey, did you know you can buy *Sawbones* stuff if you go to mcelroymerch.com? We've got stuff there. Um, we also have a— there's pins and t-shirts.

We also have a book, uh, *The Sawbones Book*, actually. You can find it wherever fine books are sold. Uh, and we would really appreciate you doing that. Thank you for listening. Be sure to share the show with a friend if you haven't this week. This would be a great time to share *Sawbones* with somebody.

Sydnee: And if you've never listened to the episode where we talk about people eating mummies, oof, it's a good one.

Justin: It's a good one!

Sydnee: Not to toot our own horns, but...

Justin: [quietly] Doot-doodleoo!

Sydnee: Well, the history is good.

Justin: Thank you for joining us. Be sure to join us again next time for *Sawbones*. Until then, 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]

[chord]

Maximumfun.org.
Comedy and Culture.
Artist Owned.
Audience Supported.