

as multiple myeloma, lymphoma, and hepatitis C. Using standard techniques, serum samples were tested for lupus anticoagulant (functional tests), immunoglobulin M (IgM), and IgG anticardiolipin (ELISA).

Cryoglobulin was detected as follows: blood samples were obtained and kept at 37°C for 30 minutes before separation. The serum was prepared by centrifuging at 37°C for 10 minutes at 2500 pm. Fresh centrifugated serum was incubated at 4°C for 7 days after collection and examined for cryoprecipitate.

The mean age was 40.3 ± 10.9 years, 82% were female, and 73% Caucasian. The mean disease duration was 74.9 ± 51.9 months. Arterial thrombosis was seen in 59% of our patients, venous thrombosis in 32%, obstetric events in 18%, thrombocytopenia in 9%. Lupus anticoagulant was present in 82% of patients, and IgG/IgM anticardiolipin positivity in 68%. Remarkably, no patient was positive for cryoglobulinemia. No one had clinical evidence of vasculitis.

This letter is the first report to evaluate the presence of cryoglobulinemia in patients with PAPS. Due to the absence of these antibodies (cryoglobulin) in this coagulopathy, it is reasonable to speculate that different pathophysiological mechanisms are present in patients with APS. A possible explanation for the previously described cases of APS and cryoglobulinemia is concomitant diseases such as hepatitis C, lupus, and lymphoproliferative diseases, which may generate cryoglobulinemia or even a casual association [5].

Correspondence

Dr. J.F. de Carvalho

Dept. of Internal Medicine and Diagnostic Support,
Medical School, Federal University of Bahia, Salvador,
Bahia 41810-080, Brazil
email: jotafc@gmail.com

References

1. Miyakis S, Lockshin MD, Atsumi T, et al. International consensus statement on an update of the classification criteria for definite antiphospholipid syndrome (APS). *J Thromb Haemost* 2006; 4 (2): 295-306.
2. Shachaf S, Yair M. The correlation between antiphospholipid syndrome and cryoglobulinemia: case series of 4 patients and review of the literature. *Rev Bras Reumatol Engl Ed* 2016; 56 (1): 2-7.
3. Cajiao K, Gómez-Puerta JA. Coexistence of

antiphospholipid syndrome and cryoglobulinemia in a patient with rheumatoid arthritis. *Clin Rheumatol* 2020; 39 (9): 2833-5.

4. Ourique C, Chora I, Guimarães S, Júlio S, Vaz-Marques P. Nasal skin necrosis: a very rare manifestation of antiphospholipid syndrome. *Eur J Case Rep Intern Med* 2017; 4 (2): 000534.
5. Kolopp-Sarda MN, Miossec P. Cryoglobulins: An update on detection, mechanisms and clinical contribution. *Autoimmun Rev* 2018; 17 (5): 457-64.

Angst vividly depicted in sculpture

Daniel M. Gelfman MD FACC FACP

Division of Clinical Affairs, Marian University College
of Osteopathic Medicine, Indianapolis, IN, USA

TO THE EDITOR:

In observing an intriguing and engrossing sculpture at the Metropolitan Museum of Art in Manhattan, NYC, USA, I was reminded of the importance of recognizing body language in patient care. The statue I was observing is called *Ugolino and His Sons*. It was completed in 1867 by Jean-Baptiste Carpeaux (1827–1875). It demonstrates the anguished and excited state of Count Ugolino in the year 1288. The Count and his children are imprisoned and sentenced to die by starvation because of his act of treason. We know much of his story as it is told in Dante's *Inferno*. We know that he is aware that he and his children will die of starvation. Dante tells us that Ugolino must decide if he should cannibalize his children who are said to die of starvation before him [1].

When looking at this exquisitely detailed sculpture, one senses Ugolino's mental anguish. One sees his contorted face with his eyes open in an intense stare, his brow is furrowed, and he is not just biting his fingernails but gnawing on his fingers [Figure 1]. This body language has been compared to the facial expression of a repentant sinner in Michelangelo's *Last Judgement*. Michelangelo was known to have had a significant influence on Carpeaux [1]. There are two other findings suggesting emotional unrest present on this statue that are more subtle and for this reason valuable to discuss.

The first is the existence of (intermittent) jugular venous distention in the

upright position in the absence of heart failure, which is present in both Ugolino and is visible in his child in the foreground [Figure 1]. This finding has been described as *The David Sign* and is present in several of Michelangelo's sculptures of excited individuals. As a sculpture only shows one moment in time, this appears to be continuous and not intermittent [2]. It was postulated to imply a stimulated state with the presence of intermittent jugular venous distention representing episodic increases in right atrial pressure due to the excitement and resultant sympathetic activation causing venous constriction and thus increasing venous return coupled with grunting respiration increasing intrathoracic pressure [3]. This episodic external jugular venous distention is easily seen watching the exposed neck of a singer or an excited individual speaking vigorously.

The second finding is the implied motion and interlocked position of his feet and toes [Figure 1]. This reminded me of something I observed, in a less pronounced state, when I was still in private medical practice. I remember calling it the dancing feet sign, when communicating with other medical professionals during invasive cardiac procedures. I found it helpful in recognizing potential residual patient anxiety due to inadequate conscious sedation. I am sure my observation was not unique, although I could never find it in the literature. Textbooks on physical examination associate restlessness of the extremities with anxiety (when seen in individuals who do not have restless leg syndrome). There are discussions in the literature concerning the use of body language to improve effectiveness as a medical teacher [4] or to demonstrate empathy as a practitioner, but there is very little on using body language to recognize mild to moderate patient distress. This lack may be due to the difficulty in quantifying such a topic. However, the usefulness of observations of body language to understand a patient's psychological state is like *Levine's Sign* in the recognition of ischemic heart disease. It is not in its sensitivity and specificity; it is in the recognition

Figure 1. *Ugolino and His Sons*

Artist: Jen-Baptistery Carpeaux (French, Valenciennes 1827–1875 Courbevoie)
Medium: Saint-Béat marble
Dimensions: 197.5 × 149.9 × 110.5 cm, 2247.6 kg)
Classification: Sculpture
Public Domain Image (CC0): The Metropolitan Museum of Art, Manhattan, NYC, USA



of the higher possibility of the presence of a specific patient illness or state of mind.

Virtual medical encounters, which inherently limit physical examination, are becoming a growing part of medical practice. Thus, using observation for clues to a patient's state of mind as revealed through body language is now more important. How does one learn or teach this? Educators can describe what to look for when observing patient body language. It appears apparent that carefully observing this unforgettable sculpture as an example of patient emotional unrest would be even more effective.

As it is important and not commonly recognized, it should be mentioned that control of patient anxiety during invasive procedures is needed for safety as well as comfort. Calm patients are less likely to move, which on a narrow table with sharp objects is advantageous. Also, anxious patients with coronary disease can experience arrhythmias.

It is easy for physicians to concentrate primarily on completing computerized forms during medical encounters, or on the procedural findings and hemodynamics during invasive procedures, and not patient comfort. Good physicians must be

good observers of their patients as well as their computer screens. When artists reveal useful unforgettable clinical findings in their work, as has Jean-Baptiste Carpeaux in this sculpture, it is incumbent on us to study this carefully, using it to become better patient observers and ultimately improved medical practitioners.

Correspondence

Dr. D.M. Gelfman

Division of Clinical Affairs, Marian University College of Osteopathic Medicine, Indianapolis, IN 46222 USA
Phone: (1-317) 955-6000
email: dgelfman@marian.edu

References

1. Metropolitan Museum of Art. *Ugolino and His Sons* 1865-67. Jean-Baptiste Carpeaux Metrop [Image available from <https://www.metmuseum.org/art/collection/search/204812>]. [Accessed 19 February 2022].
2. Gelfman DM. The David sign. *JAMA Cardiol* 2020; 5 (2): 124-5.
3. Gelfman DM. The Valsalva maneuver, set in stone. *Am J Med* 2021; 134 (6): 823-4.
4. Hale AJ, Freed J, Ricotta D, Farris G, Smith CC. Twelve tips for effective body language for medical educators. *Med Teach* 2017; 39 (9): 914-19.

Osteoid osteoma of a finger

Ayman Khoury MD MHA^{1,2}, Gil Gannot MD^{1,2}, and Amir Oron MD^{1,2}

¹Department of Orthopedics, Hand and Microsurgery Unit, Kaplan Medical Center, Rehovot, Israel

²Hadassah Medical Organization and Faculty of Medicine, Hebrew University of Jerusalem, Israel

TO THE EDITOR:

Osteoid osteoma is a benign bone lesion. Characteristic symptoms are nocturnal pain alleviated by non-steroidal anti-inflammatory drugs (NSAIDs). The radiological unique hallmark is the central osteolytic nidus surrounded by reactive sclerosis [1] [Figure 1]. Histologically, the nidus comprises an osteoid matrix with variable mineralization, osteoblasts, and some osteoclast-type multinucleated giant cells interspersed by a loose fibrovascular stroma with inflammatory changes and reactive bone formation around the lesion [2].

Osteoid osteoma is diagnosed by the combination of both a typical clinical picture and the hallmark finding on X-ray

Figure 1. Typical depiction of the osteoid osteoma lesion

imaging [Figure 1]. Osteoid osteoma may regress spontaneously within 6–15 years [3]. NSAIDs may reduce the symptoms and may also shorten the period to osteoid osteoma regression, yet due to the adverse effects of prolonged use of these medications, long term NSAID treatment is reserved for exceptional situations only [4,5]. The more commonly utilized treatment is complete surgical resection of the nidus.

Night isolated finger pain that was treated well with NSAIDs with this typical depiction of the lesion shown in Figure 1 should include osteoid osteoma in the differential diagnosis.

Correspondence

Dr A. Khoury

Dept. of Orthopedics, Kaplan Medical Center, Rehovot 76100, Israel
email: ayman.khoury.md@gmail.com

References

1. Katz K, Kornreich L, David R, Horev G, Soudry M. Osteoid osteoma: resection with CT guidance. *IMAJ* 2000; 2 (2): 151-3.
2. Olvi LG, Lembo GM, Santini-Araujo E. Osteoid osteoma. In: Tumors and Tumor-Like Lesions of Bone. London: Springer, 2015: 127-49.
3. Boscainos PJ, Cousins GR, Kulshreshtha R, Oliver TB, Papagelopoulos PJ. Osteoid osteoma. *Orthopedics* 2013; 36 (10): 792-800.
4. Carpintero-Benitez P, Aguirre MA, Serrano JA, Lluch M. Effect of rofecoxib on pain caused by osteoid osteoma. *Orthopedics* 2004; 27 (11): 1188-91.
5. Bottner E, Roedel R, Wortler K, Grethen C, Winkelmann W, Lindner N. Cyclooxygenase-2 inhibitor for pain management in osteoid osteoma. *Clin Orthop Relat Res* 2001; (393): 258-63.