Ridiculous 2 Sublime

STORIES, PUNDITRY, MUSINGS, AND OBSERVATIONS OF
CHUCK GOLDSTONE
SPOKESPERSON FOR OUR SPECIES

My Favorite Endoscopy

INVASIVE PROCEDURES

Despite all of our medical advances, there are still plenty of diagnostic tests that rely on hostile invasion, where the most thorough way to get a "quick look-see" is just by going inside.

The human body will occasionally exhibit some very obvious out-of-character behavior, a clue that something potentially serious may be occurring underneath the surface, and that a doctor should be consulted to see if you are perhaps in suffering from Phase One of a two phase health dilemma, with Phase Two being death.

Anatomically, we have many organs that graciously come in pairs, ensuring a back up in the event of cataclysmic failure of either one of them. For example, if one of your kidneys or lungs malfunctions, the other one can carry on the duties satisfactorily all by itself, though certainly working much harder now and no longer able to count on getting every other weekend off.

On the other hand, any symptoms that indicate a non-redundant organ has fallen into disrepair---- a heart, stomach, spleen or pancreas---raises a red flag to the doctor to check out the condition immediately because once the solitary organ ceases to function, important work inside you will go undone. There are very few organs whose work would be considered superfluous. As the seriousness of the medical condition increases, so too does our willingness to agree to more disquieting medical procedures.

For whatever reason, not many activities provoke the level of anxiety as those diagnostic test that requires some metallic trespass, incision, or puncture. Doctors tend to minimize these tests as routine, because they will conveniently be the ones on the blunt and friendlier side of the probing instruments. These are the procedures doctors call "invasive," a stronger-than-necessary choice of terms indicating that you, like any others

vanquished by invasion, will be entered against your will and occupied by an hostile aggressor. Invasion brings to mind images of the unsolicited attack on Pearl Harbor, throngs of Normans in chain mail swinging swords and battle axes, or the uninvited arrival of long legged tripod alien space vehicles in *The War of the Worlds*. The term sets fearful expectations for discomfort in a way that more considerate, a more euphemistic terms, such as "a peek" does not. To make these tests less stressful for patients, I would suggest the medical community be a little more sensitive, by cataloguing all procedures as either "a picnic" and "no picnic."

Perhaps anxiety mounts because an invasive test can be uncomfortable or in some cases outright painful or perhaps just because it is because the experience is dehumanizing, as we are arranged on a table, Johnny flapped open, some part of us exposed to air and light, perhaps even an area we usually prefer to modestly keep in darkness, and suddenly we are no longer Mr. or Ms. Whomever and become instead, a cyst, an inflamed esophagus or a little patch of skin that will soon be violated. But perhaps a test procedure is most disquieting because we know that it might uncover what could be the "ultimate bad news."

For some patients, event the thought of a routine procedure, say a simple blood test, can produce paralyzing terror. An ex-Marine friend of mine proved how even battle seasoned soldiers can bravely stare down a sniper but shrink at the sight of a middle aged nurse wielding a tiny needle. This is a man who endured months of nearly unendurable torture during basic training, a guy trained to subjugate his own instinctive fears in battle, a warrior weathered by a tour in the deserts of Iraq, and an example of the kind of man who would happily accept a clip full of bullets to his midriff, wrap himself in some torn newspaper, and stoically claim he's OK, promising to seek medical attention as soon as he finishes working on the jeep.

Men and women both share this apprehension, especially during a diagnostic test where our protective covering of skin and nerve endings must be breeched by needle or blade or where our bodily openings are probed with cold metal instruments. Studies show that women are more likely to override their fears and follow through in ways men often do not, which is to say by showing up. Statistically, the life expectancy of women is 4 years more for women than for men, not because of any biological advantage, but because men will often die of diseases that could have been diagnosed early and will not normally agree to visit a physician to check out an anomaly until more serious symptoms appear, such as an atrophied limb or the unexplained shedding of body parts..
"I'll call next week," a typical frightened male response may be, "these explosive lesions covering my entire body will probably go away on their own."

It is quite possible that woman are more likely to seek medical care early and face frightening or painful procedures dispassionately because they have been genetically programmed to endure the agony that accompanies child birth, where they bravely pass a wholly developed human through a narrow passageway, while men on the other hand can barely withstand passing tiny kidney stones, which are much smaller and less restless than a newborn.

I have luckily only undergone one such invasive test. The problem in making a limiting statement like this in a book, is that here I am, many months before you are reading this making a claim, which at this point is true, but in the meantime, sometime during the long process of editing, proofing and typesetting, anything can happen. In theory, by the time you are reading this, I may have gone through dozens of uncomfortable tests, each one more invasive than the last. There could even be news items contradicting my now-in-print claim, with headlines like, "Author Undergoes Really Painful Intrusive Examination of Every Organ of his Body with Pincers and Electrical Shock." Until we can shorten the timeline between writing a book and getting it on the store shelves, we will be burdened by such unreliable and inaccurate claims.

But for the sake of convenience, I can personally report on only one invasive test thus far practiced on me, save the occasional urine test, which incidentally isn't very invasive at all, except for those that the doctor decides to "go inside for."

ENDOSCOPY

I do not normally worry about the little anomalies that occasionally occur somewhere within the boundaries of my body or the tricks some organ will play on me when it has nothing else autonomically to do. Once in a while, however, some unconventional behavior will get my attention, evidenced by a new marking on my body, a change of colors of some anatomical part that is clearly supposed to be another hue, or the presence of a never-previously-seen fluid part that is emerging from an area that either is or is not supposed to be associated with fluid. I tend to heed any attention getting symptoms that begs the question, "Is this something that may cause me die?"

I experienced one of these "This can't be right" medical scenarios, in this case in the form of behaviors not normally associated with a properly working throat and stomach. The sensation, as I would describe it to my internist, was "Sort of like I had swallowed some kind of small mammal. And it was on fire." I went on to depict the acute pains in my chest when my body was not in full upright position and that I had privately thrown up a few times. He suggested I come by and could squeeze me in I came over, right now.

Most doctors won't scare you unless they know for sure you would benefit from being scared, or when they are certain that you are exhibiting some potentially dangerous symptom that requires immediate attention.

He looked down my throat as far his little doctor light would shine, felt me about the neck, listened to my lungs, and thumped on me as if I were a cantaloupe.

"I'd like to schedule a test for you, for a more detailed look at your esophagus and stomach" he said as he removed his stethoscope's caliper like grip from his ears.

"It's probably nothing," he continued, using a carefully worded phrase meant to be reassuring, though it's subtext is entirely different from the more preferred phrase, "It is

nothing," the latter ensuring that the concept of death or suffering is not even remotely possible, but the former leaving open some options.

"We just ought to do this to be safe on the safe side."

He used "we," which I took to mean if this turns out to be something life threatening, he was willing to die along with me trying to treat it."

The gastrointestinal system is a continuous, winding tube, outfitted with a number of specialized organs along the way to transform food into the fuel that runs the organic generators keeping us alive. Through a complex biochemical process, the GI tract takes peaches, hot dogs, spring rolls, chicken, tubers, or any other edible substance we can ingest, extracting caloric energy that is either used immediately or stored for later use as mounds of fat in a gelatinous "safe deposit box" which we wear like a money belt around our waists.

As essentially a long visceral pipeline with both a beginning and end that vent to the outside, the digestive tract can be visited from one of two portals. Until recently, doctors could look inside from either direction only part way and relied on an X-Ray techniques using radioactive barium to light up the area in need of investigation. The Barium Swallow, as its name implies requires the gulping of a sickeningly bland radioactive cocktail, taken a swallow at a time to coat the esophagus. An Upper GI test includes pictures of the stomach as well. The Lower GI calls for the injection of liquid barium through the nether opening of the alimentary track, but in this case requires the use of a small handheld pump, since the rectum obviously cannot draw fluid in without some help. The X-Ray films resulting from these tests are conventional high contrast, two dimensions representations.

Using a new family of medical burrowing tools, it is now possible for physicians to see every lineal inch of the entire digestive system with a fiber optic tube and tiny color camera, giving the physician a full spectrum, real time video image, as if he were sliding through a patient's throat, stomach or intestines on his stomach wearing a miner's hat. Using this new technology, a gastroenterologist can spelunk the once secret regions of the alimentary track from either direction, viewing the food duct using a now common procedure known as endoscopy, from the Greek word, "scope," meaning "to observe with an obtrusive, oversized viewing tube," and "endo," which doesn't take a Greek scholar to figure out.

My doctor suggested I have an upper endoscopy, a kind of glass bottom boat tour of my digestive track from my tonsils downward, terminating at the upper region of my *intestina minora*. Unlike an X-Ray, an endoscopic view is taken from inside, and would offer up a full color, high resolution TV image of my tract in real time. A fiber optic camera would worm its way through my gastrointestinal tract, documenting the route routinely traveled by my food while a tiny bulb would illuminate the path and expose to light for the first time organs that had lived in darkness for many decades. On a color video screen, the doctor would view the shimmering ringlets of my esophagus, a

muscular tube that squeezes food even against gravity toward digestion, onto the valve-like esophageal sphincter at the gateway to my stomach that prevents the bubbling acids below from splashing their way upstream and saves me from, in effect, digesting myself. Next, the camera would submerge into the foreboding cauldron of the stomach itself---the churning smelter of digestion where food is dissolved in an unforgiving chemical reaction---finally ending its invasive trip at the duodenum, the tubular portal to the small intestine.

It is from the duodenum onward, in the small and large intestines, that any last remnant of nutrition will be sucked from the acidic slurry produced in the stomach above. The digested food slowly moves through the final 26 foot of our inboard food processing plant toward farthest reaches of the colon, which jettisons any solid by-products and accompanying odors that could not be used elsewhere. The trip into the labyrinth of entrails is too far for the endoscope to reach from above, so if the doctor wishes to peer further, he must arrange for bottom access sometimes later.

To perform a thorough upper inspection, my internist explained, a specialist known as a gastroenterologist, will insert a flexible tube containing this miniature surveillance camera through my mouth and gently push it as far down as it would go.

"The tube is about the same thickness as my thumb," my doctor continued, holding his own up so I could see it, to remind me of the approximate size and shape of the human thumb just in case I had forgotten.

Until now, I had never given much thought to the circumference of the adult opposable thumb, but now that my comfort would be influenced by its girth, I stared at it attentively, concluding that if the tube were only the size of the smallish tip of his thumb, the process would not be too bad, but sadly, the thumb seems to bunch out a bit near the knuckle and shoving a tube full of knuckles down someone's gullet cannot be very pleasant.

He described the tube containing the camera assembly and little Swiss Army Knife implements that could take core samples if suspicious tissue were observed. The gastroenterologist and his technician sidekick would be sliding this garden hose through my esophagus, which I remembered wasn't much wider than a garden hose, and further that people have choked to death on little pieces of unchewed food considerably smaller. If an emergency were to arise, I doubt that even aggressive Heimliching could get me to cough back up 4 feet of fiber optic tubing.

I kept staring at my doctor's hands, wondering how much better off I would be if only I had a physician with smaller thumbs.

Although the test is considered minor, it takes place in a hospital, a place that by its very nature raises the emotional ante. A procedure performed in the doctor's office seems much friendlier, more casual and less risky. Even the doctor's office waiting room is less formal, filled with comfortable chairs, reading material, music in the background, and

sometimes even a fish tank. "How dangerous could a procedure done here be," you will think to yourself, "if a doctor still has time to worry about fish?"

On the other hand, it doesn't take a paranoid personality to figure out that perhaps one reason the procedure is done in the hospital is because it is so much more dangerous. But understand that just by being in the hospital increases the chances for something serious to go wrong. The likelihood of an administrative error in the hospital resulting in the accidental removal of one or more of your healthy parts is significantly greater, as is the likelihood that death could be an outcome, evidenced by the mere fact that hospitals are prepared for such contingencies by having a Morgue, but doctors offices do not.

The hospital faxes me over instructions a few days in advance. On the day of the test, I am forbidden to eat anything, as a courtesy to the doctor who will not have to navigate the viewing tube around a sandwich or Pad Thai. I am told that they will be injecting me with some pleasure drug, and therefore I should arrange someone to pick me up after the procedure, because driving myself home in the sedated grogginess that will linger might just land me right back in the hospital again.

The hospital has a fairly substantial Enterology suite, with its own waiting room. Here, I fill out some of the initial paperwork, while all around me people who do not look very healthy are reading magazines and watching a TV hanging from the ceiling.
It is often a measure of just how serious a problem you may be experiencing, by the condition of the other people here to have the identical test.

The door beyond the waiting room opens and a nurse, who has seen more than her share of oral and rectal openings, calls out my name, loudly enough so that total strangers in the rest of the waiting room will know who is about to get a tube shoved in one end or the other presently. The nurse greets me by nodding, telling me her name and pointing me in the direction of the changing room. Here she hands me an ill-fitting cotton johnny, faded and flimsy from frequent use and an equal number of launderings. I look at the light blue gown, imagining it has been worn by hundreds of previous patients, many of them who may be long dead. The johnny is basically a large opening, surrounded by the strangely patterned cloth with short sleeves. I am told to remove my shirt and put the johnny on, with the opening in the back. The Johnny closes only at the top, which makes me grateful that I am allowed to retain my pants. It will stay closed only by (1) a flimsy knot I will secure with two short strips of cloth at the neck and (2) the absence of any breeze that will blow open the other 95% of the gown not protected by cloth closures.

I reach behind my head and blindly attempt a knot which will withstand the jostling of doctors, nurses and various technology. I also remember from a brochure sent to me in advance that I will still be under some sedation after the procedure and whatever secure, complex knot I tie, I will have find a way to untie it while hindered by impaired judgment. So I will need to balance the need for privacy with the assurance that I will not being trapped in this garment until tomorrow morning.

Walking into the hospital, I could have easily been mistaken for a doctor. I am the right age and I can walk with an authoritative gait. Now that I am encased in the humbling hospital johnny, there is no question that I am a patient, the lowest and least respected of life forms in the hospital, and that includes everything sitting in trays in pathology. I was positioned face up on a gurney, a blood pressure cuff Velcroed™ around my upper arm and a little clothes pin device to measure my pulse suckling the end of my finger. Above me in clear view, a monitor displayed my blood pressure and heartbeats, so if flat-lined during the procedure, I would be able to watch it without having to ask my doctor to move to the side.

"We'll be sedating you with a mild tranquilizer," a nurse explained. She was holding my submissive and lifeless right hand, looking for an easily accessible swatch of skin to insert an IV, flipping it over and back as if she was checking the freshness of a mackerel,. looking for a visible and easily punctured spot to insert an IV needle. The drug used will not knock me unconscious, but may cause me to hum embarrassingly and to tell everyone in the room my ATM personal identification number.
"Will the sedative prevent me from gagging?" I asked.
"No," she replied, "but gagging will be so much more enjoyable."

I will be forced to sign a consent form, a legal document that says I understand the risks and will not blame them even if they screw up miserably. I will sign the consent form under duress, knowing the longer I dilly-dally, the more time I am giving to any malignancies inside to reproduce out-of-control. By this time, they may already be priming me with sedative, so I could easily be handing the clipboard back, granting the doctor salvage right if he discovers something valuable.

The Gastroenterologist entered the room, introduced himself, and explained the procedure in more detail.

I understood that I would be asked to lean onto my left side, and as the sedative was cranked up, I might choke for a moment as the tube was inserted. I may want desperately to gag, but I will find I cannot because the muscles responsible for the reflex will be quietly intoxicated and rendered temporarily incompetent. From the description, I assumed that it will feel like I am being strangled, but from the inside.

I warned my doctor that I am classified in the dental community as a "gagger," meaning that my throat will make every effort to expel anything inserted in it without its consent, and such items as pieces of cotton wadding placed far enough back in my mouth will induce an involuntary reflex that will propel the now soggy piece of cotton across the dental exam room.
"I gag at the slightest provocation," I explained, remembering the awful feeling that accompanies the gag reflex--eyes squinting and watery, diaphragm heaving, breathing momentarily curtailed.

"Don't worry," the doctor pointed out, "that won't be a problem for me."
He rather missed my point.

I had the option of looking at the video monitor about me to see what the lining of my own gullet looked like in real time. I declined.

The specialty that looks at the upper GI tract is also responsible for care and maintenance of the lower tract, and a similar test is performed routinely on people whose entrails have logged sufficient mileage.

The colon is susceptible to dangerous diseases which can readily show up after 40 or so years of continuous operation. And why not, since the colon's job through life was to accommodate the most digesting, filthy, germ-laden material the human body can produce, having to store the disgusting residue left after every conceivable speck of productive, nutritional decency has been sucked out of our food

The large intestine is in many ways the body's basement, where discards are stored until we can get them carted away. Barely a day goes by without the colon being stuffed, which certainly cannot be doing the tubing much good.

So somewhere between age 40 and 50, a patient is advised to submit to yet another invasive if not humiliating tests. Like the upper endoscopy, these tests also explore the gastrointestinal track with a remote controlled camera, in a search for cysts, polyps, or malignancies that are better found early. Two types of tests are popular today, the first being the more traditional colonoscopy, by which a scope enters the U-shaped colon, traveling upward, making a left turn at the top and continuing laterally across the top of the intestine, making yet another left turn downward and traveling to what is the beginning of the colon at the very bottom. It is a good idea to be under some heavy sedation during this procedures, and even better if you are in a coma.

An alternative to the colonoscopy is a procedure called the flexible sigmoidoscopy, using the fiber optic probe to survey only the first third of the colon most easily accessible. Even at face value, the name itself sounds less intimidating merely with the inclusion of the word Flexible.

"We gently glide a wispy, flexible probe into your colon," the doctor will describe matter-of-factly, probably because it is not his colon that is about to be violated.

While the more comprehensive colonosopy is more thorough, recent studies show that there is no measurable difference between tests in reliability and accuracy in rooting out potential danger, so with a more tasteful example, why go traipsing all the way through a filthy, disheveled, foul-smelling house when you can see all you need from the foyer?

I should also point out that while these two tests are humiliating, neither one is as physically uncomfortable for the patient as the esphopheal endoscopy, since the ass, as a rule, does not gag.

Yet as bad as this process is for the patient, it cannot be any more pleasant for the doctor and technician either, who are forced to work in and about one of the less appealing regions of the anatomy. I personally find it hard to believe that a doctor would choose this specialty voluntarily as a lifelong career, especially if more highly respected, prestigious and unsullied organs were available for treatment.

"You are late," the medical school preceptor would tell a student entering a filled amphitheater, "and the good specialties have already been taken**."**
"I'm sorry, Doctor, I was tied up in traffic."
"We only have two residency programs left," the mentor will unsympathetically offer, "One focusing on diseases of the sphincter and the other dealing with pustules."
Just as a courtesy, it is best to treat the GI specialist with some respect, since it is apparent that neither of you are there by choice.

As I lay on the gurney, IV ready to render me drowsy and compliant, waiting for the doctor to slither his miniature TV camera down my gullet, I am grateful that I am not having the same humiliating lower endoscopy that the patient just before me had. I also pray that they use two different machines.