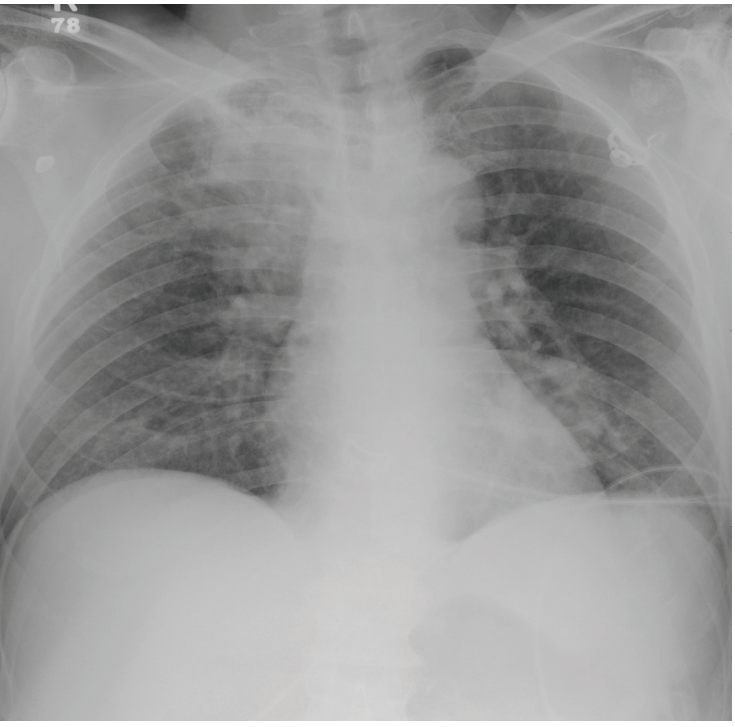
More to the Story Than a Skull Fracture



A 63-year-old man is transferred to your facility with a skull fracture secondary to a fall. He thinks he tripped and fell, hitting his head. He does not recall experiencing dizziness or syncope. He states he was momentarily dazed but does not think he lost consciousness.

He is complaining of a mild headache and has reported drainage from his left ear. He denies any noteworthy medical history and takes no medications regularly. He admits to smoking one to one-and-a-half packs of cigarettes per day.

Initial assessment reveals an older-appearing male who is awake, alert, oriented, and in no obvious distress. His vital signs, including O_2 saturation, are normal. His pupils are equal and react briskly. He does have obvious otorrhea from his left ear. He is moving all his extremities well and appears to have no deficits.

You review his imaging studies, which include a chest radiograph (shown). What is your impression?

see answer on page 10 >>

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FROM THE **PA EDITOR-IN-CHIEF**

is not the end game. Perhaps competence is really a *minimum* standard. Competence (albeit novice) is measured by completion of the PA or NP curricula (meeting the course objectives) and passage of board/licensure exams, just as, essentially, physician competence is.

Most, if not all, would agree that mastery is achieved by the acquisition of knowledge coupled with sound practice and experience. Mastery or expertise, some say, is what we should focus on, the achievement of which is quite individual. All clinicians can move toward mastery, but not all will actually achieve it. Therefore, how can we mandate a minimum standard, beyond competence, for PAs and NPs but not for other providers?

So, after all the rhetorical ranting about when a PA or NP becomes fully competent, the answer is ... It depends! There are too many moving parts. I would suggest that competency is the starting point and mastery (expertise) is a journey.

What do you think? Share your thoughts with me via PAEditor@frontlinemedcom.com. **CR**

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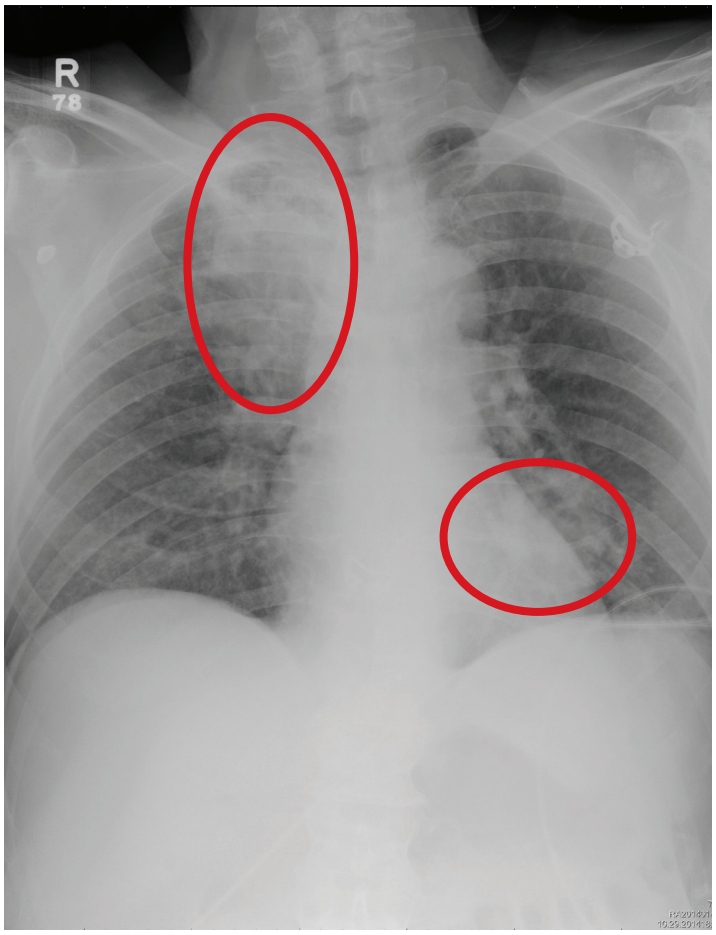

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ANSWER

The radiograph shows two areas of concern: Within the apex of the right lung, there is a vague haziness that, in the setting of trauma, is suggestive of a contusion or even aspiration pneumonia. Another possibility is some sort of neoplasm. In addition, the patient has what appears to be a rounded density within the left lung, also suspicious for neoplasm. Additional work-up with contrast-enhanced CT is warranted.

Through further questioning, the patient denies any current symptoms or previous/recent diagnosis of cancer. CT of the chest confirmed the presence of masses in the right upper and left lower lobes. Subsequent biopsy was consistent with a moderate to poorly differentiated squamous cell carcinoma. **CR**

DERMA**DIAGNOSIS**

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Transposing these types of skin changes to other locations would make them considerably more worrisome, specifically in the context of possible incipient T-cell lymphoma—one of the very few types of skin cancer that can take years to evolve into frank cancer. But the atrophy, telangiectasias, and discoloration signaling early cutaneous T-cell lymphoma are usually seen in non–sun-exposed skin, particularly in the waistline and groin.

Poikiloderma vasculare atrophicans is only one of several manifestations termed *premycotic*. This refers to mycosis fungoides, one of the two most common forms of T-cell lymphoma. Serial biopsy, sometimes over the span of several years, is often used to track such changes.

Pulsed light devices and certain types of lasers have been used successfully to treat PC. Our patient, however, declined treatment, declaring her firm intention to maintain "a healthy tan" year-round. **CR**