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CLINICAL RESEARCH

Fine Wigns

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Abstract There are three categories of diagnostic data collected during the physical examination—sign, symptom, and that in between—but only two words to describe them. To fill that gap, I modestly propose here that examination responses that are vocalized (and thus symptomlike) yet thought to be specific (hence signifiers) be classified as wigns. I define a wign as the subjective reaction to a provocative examination maneuver deemed to have some valid relationship to the underlying pathology. This word is pronounced "whine" to remind us it is a spoken response, and its spelling echoes that of sign, reminding us likewise a wign is more definitive than a generalized complaint. The distinctions between sign, symptom, and wign are worthy of preservation, particularly regarding their probative value: treatments offered on the basis of signs can be said to be most rigorously indicated, as symptoms, unlike signs, pass through (and are affected by) the prism of patients' perceptions. Remaining skeptical about the value of information provided by our patients is in the interest of these patients, as our skepticism might save them from unnecessary treatments and procedures.

The Holy Roman Empire, Voltaire noted, was neither holy, nor Roman, nor an empire [7]. If Voltaire were a physician today, I imagine he would point out accordingly that the so-called impingement sign [2] is neither a result of physical impingement nor a sign: impingement is only a metaphor for the etiology of rotator cuff disease [1] (as the contact with the acromion does not incite tendon damage [4]), and the complaint of pain when the arm is elevated is a subjective response, not an objective phenomenon, as a sign must be.

The medical lexicon [3] makes clear the distinction between signs and symptoms. A symptom is that which is perceived and reported by the patient, whereas a sign is that which is observed by the examiner, independent of the subject's awareness.

Because symptoms have passed through the prism of patients' perceptions, to label a finding a sign is to assign to it greater probative value. To be sure, there are instances where objective signs may mislead. For example, convictions for witchery during the Inquisition often were based on objective signs such as buoyancy or skin blemishes denoted as stigmata diaboli. (These were objective findings, just not objective proof of witchery.) Likewise, so-called black discs seen on lumbar MR images may be identified unambiguously, but the relationship of black discs to back pain may be no more meaningful than that of black bile to depression. By the same token, symptoms alone may be enough to prompt treatment. We applaud the surgeon who operates for presumed appendicitis on the basis of anorexia, nausea, and tenderness localized to McBurney's point. Similarly, a recent survey [9] reported surgeons rate the clinical history more useful than pressure measurements in the diagnosis of acute traumatic compartment syndrome. Nevertheless, despite these examples, signs typically trump symptoms.

Where do the impingement sign and those like it rate on this hierarchy? An impingement sign is detected when a patient reports pain with glenohumeral elevation greater

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than 90°, but only then [2]. Because the test relies on a vocalized response, this response is not a true sign; yet because of its (presumed) specificity, it would be unfair to disparage the patient's response as a mere symptom either.

To fill the gap between the words sign and symptom, I propose a new term, the wign. A wign is defined as the subjective reaction to a provocative examination maneuver deemed to have some valid relationship to the underlying pathology. This word is pronounced "whine" to remind us it is a spoken response, and its spelling echoes that of sign, reminding us likewise a wign is more definitive than a generalized complaint. When a patient reports pain with glenohumeral elevation greater than 90°, but only then, the finding is more aptly designated the "impingement wign."

The category of wigns would be limited to only the spoken description of a subjective reaction: secondary signs of pain, such as tachycardia, diaphoresis, or, in a brave new world, changes on functional MRI of the brain are not included.

Common investigations producing wigns include the venerated Tinel's test for carpal tunnel syndrome, for example. The response to Tinel's test can be considered a wign because it is credited only when the complaints match the distribution of the median nerve. Radiating paresthesia to the fifth finger—ulnar nerve territory—would not be classified as a positive wign. Other findings better classified as "wigns" include Lasègue's sign, Kernig's sign, and Lhermitte's sign, to name a few.

Unless the medical practitioner in question is a quack or a veterinarian, he or she will want to hear what patients have to say: these comments yield valuable diagnostic information. Patients alone know what they are feeling. In formal philosophical terms, it is said first-person cooperative reports of sensation are incorrigible. That is, when an individual (first person) describes what he or she is feeling (a report of sensation), and is not trying to deceive us (cooperative), those descriptions are not subject to an outsider's correction, ie, incorrigible. (As noted by Robinson [6], such reports are "incorrigible" in the sense that "only the percipient has the last word on what the percipient is experiencing"—there is no suggestion of bad behavior, necessarily.) To say "you are not feeling hot; you are feeling cold" is obviously silly.

Nevertheless, even if patients alone know what they are feeling, examiners would be wise to proceed with caution before assimilating all first-person reports of sensation into their understanding of the patient's condition. For one thing, not all statements to doctors are "cooperative." The lack of cooperation is not limited to malingerers: even well-intentioned patients may simply be deceiving themselves [5]. Beyond the issue of deception is the issue of meaning. As Wittgenstein [10] famously pointed out with his "Beetle in the Box" example, what you designate as "a burning pain in my index finger" may not be what a similar phrase means to me. In sum, particular sensations reported by patients are medically meaningful, but for physicians, hearing the patient describe something is not the same thing as experiencing it firsthand.

In a more perfect world perhaps, patients would have Shakespearean powers of description, complete and faithful recall, no tendency to mislead themselves or others, and no urge to placate the examiner by providing correct responses. We do not practice in such a world. We need to know when reports are especially credible. Recognizing that certain responses are wigns provides a useful guide to better reasoning. To be sure, one can be misled by either signs or symptoms, but recalling signs are more resistant to bias and even specific symptoms are not equivalent to signs promotes healthy (and healthful) skepticism.

It is unlikely the word wign will enter the dictionary any time soon. If nothing else, the term is hampered by its connotation of kvetching and will meet resistance on that count alone. Nevertheless, this newly coined word points to a distinction worthy of preservation: namely, there are three categories of diagnostic data, sign, symptom, and that in between, but only two words to describe them. Rejection of this proposed solution does not make the problem disappear.

So what are we to do? If Voltaire were a physician today, I imagine he would embrace this term, as qualifying the certainty of our understanding of a patient's condition might—just might—slow down an otherwise relentless march toward more and more treatment. After all, it was Voltaire who noted, "The art of medicine consists in amusing the patient while nature cures the disease" [8]. Yet most physicians today are rewarded for action, not amusement. Unless and until that changes, we must be particularly mindful of how sure—or unsure—we are of our diagnoses. Remaining skeptical about the value of information provided by the patient is not a hostile stance; to the contrary, if our skepticism saves patients from unnecessary procedures, we are acting as their true friends. Adding the wign category to our hierarchy of knowledge can only help in that regard.

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