Fastballs and Slow Diagnoses

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Equal Author Contribution:

Contributions:
Michael R Rose: Drafting/revision of the manuscript for content, including medical writing for content

Figure Count:
0

Table Count:
0

Neurology® Published Ahead of Print articles have been peer reviewed and accepted for publication. This manuscript will be published in its final form after copyediting, page composition, and review of proofs. Errors that could affect the content may be corrected during these processes.
My fastball was my best pitch. I threw a two-seamer with natural movement—down and in to right-handed hitters, down and out to lefties. My velocity was average, but when I was on, I could pinpoint my fastball across the strike zone. My junior season of college I walked just eight batters, and I led our starting rotation in earned-run-average. We finished second in the conference that season. The next year we hoped to win the league outright.

My arm made sure that didn’t happen.

In December, I started having wild throws. By January, I was misfiring so frequently that I couldn’t keep saying it slipped. It wasn’t that I was throwing more balls than strikes. I couldn’t play catch. Every two or three throws I’d miss my partner by a yard or four. My accuracy was somehow worse as a senior in college than it was when I was playing little league. After two decades of building muscle memory, my arm had become dumb. My muscles and nerves seemed to have lost the ability to communicate, coordinate, and fire.

Spring training started in February. When it did, I had to transition from embarrassing myself in front of Cooper, my catch partner, to doing so in front of our entire team and coaching staff.

Each practice started with playing catch. Beforehand I’d stuff two spare balls in each back pocket for my inevitable overthrows, and Cooper would pack a few of his own. Despite our ample supply he’d have to retrieve the lot numerous times. Baseball practice shifted from my favorite two hours of the day to the hours I dreaded the most. My accuracy was decreasing by the day. I needed help.

I visited my primary care doctor, who listened to my story and found nothing abnormal on his careful exam. He diagnosed me with performance anxiety, prescribed as needed benzodiazepines, and referred me to therapy. After that didn’t work we tried beta-blockers. The meds and therapy didn’t help, so I stopped. My problem seemed to be in the other direction. I didn’t get anxiety and then couldn’t throw; I couldn’t throw and then panicked. Ever the science major, I experimented. I would go to the gym on weekends and throw at a screen with no one watching. I felt completely relaxed but was wild as ever.

Our sports medicine staff examined, re-examined, and re-re-examined my shoulder, elbow, and wrist. Pitchers hurt their arms all the time. I prayed that they’d find something to fix, or rehab, or at least blame. But their exam and imaging confirmed what I knew: my muscles, cartilage, ligaments, and tendons were healthy.

The most accurate diagnosis seemed to come from our assistant coach: “the yips.” Every baseballer I talked with seemed to have a story of a friend or a teammate or an opponent they knew who’d caught them. A few offered hope with anecdotes of recovery, but no one could tell me what exactly the yips were or how I was supposed to overcome them.

After months of diagnostic dead-ends, emotional breakdowns, and hours wasted on extra catch and pitching sessions, I was without an answer. My coach Bucky decided it was time for a change.

My natural arm angle is what baseball folks call three-quarters – midway between sidearm and overhand. I’d been throwing that way my whole life, almost twenty years. Now with two months left in my career, we decided I was going to switch to throwing submarine, a wacky throwing motion where the pitcher stoops and throws the ball from as low of a launch point as possible. The style earned its name because the best at it can make the ball appear to, like a submarine, both rise up and dive down.
Suddenly, my errant throws went away. But the absence of wild pitches isn’t pitching. My velocity and command were far from what is required to compete at the collegiate level. Nonetheless, practice became bearable, and for the first time in months I dreamed of making it back on the mound.

With two games to go in the season, Bucky put his arm around me and said he wanted me to finish the game. We were losing badly, and our hopes of a conference championship had long been squashed. Despite the lack of implications, adrenaline flooded my veins. This was it.

That inning wasn’t one of fairy tales. I was average at best. I walked one, gave up a hit to another, and let two unearned runs scored on a fielding error. But I didn’t have any wild pitches. After the final out, I jogged off the field and hopped the foul line one final time. When my foot touched down in foul territory, I looked up. I couldn’t believe my eyes. The entire team was filing out of the dugout to swarm me, an honor which is usually saved for shutouts and no-hitters. Bucky wrapped me in a hug. Tears streamed down our cheeks, and we both couldn’t speak. The team understood without words.

I haven’t pitched since. But I never stopped wondering why I lost the ability to throw.

I finally found an answer five years later.

The epiphany came during my neurology clerkship. I was zoning in and out of a lecture on movement disorders when, amid descriptions of the proper diagnosis and treatment for Parkinsonisms, Huntington’s disease, and essential tremors, the neurologist described a diagnosis I had ever heard of: focal task-specific dystonia.

As great teachers do, he explained the obscure disease through stories. He taught us it was first described when scores of prolific penmen in the British Civil Service lost the ability to put words on the page due to “writer’s cramp”.1 Next he told us of master pianists, cellists, and guitar players robbed of their ability to make music. He paused his lecture then to show a YouTube video of a once-renowned concert guitarist who had the disease.2 Through determination and dexterity the musician overcame the dystonia by learning to play his six string left-handed.2 My mind whirred back to the airmailed throws and subsequent switch to submarine. Could it be? The next slide ended my diagnostic uncertainty. He showed pictures of two athletes who had been afflicted. The first was a golfer who suddenly shanked simple putts. The second was a baseball player who lost the ability to throw. Both had been told they had “the yips”.

Simultaneously, I felt the inimitable liberation of a patient who finally has a name for their mysterious malady and the earned satisfaction of a doctor who has diagnosed a perplexing patient.

Naming my pathology would appear unimportant, academic even. I no longer play baseball; therefore, I have no need for treatment. Even if the dystonia were caught sooner, it is doubtful that the limited treatments–botulinum toxin injections, physical therapy, and other minimally effective medications–would have been as helpful as switching my throwing motion.3 But what appears only academic to the clinician is often anything but for the patient. It is awful to suffer from an invisible, unrelenting, and unnamed disease. You feel frustrated by the lack of an answer, embarrassed that “it’s all in your head,” and alienated from all around you who, despite earnest effort, just can’t comprehend. Here, a diagnosis itself, even a late one, can be therapeutic.

However, many undiagnosed patients won’t ever get an answer. In these cases that medicine can’t solve or cure, what is most important for healing isn’t the work of doctors, nurses, and therapists. The most important things are having a catch partner like Cooper who doesn’t mind retrieving balls, a coach like Bucky waiting to hug you, and a group of teammates who love you no matter what your disease is.
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Neurology published online September 25, 2023
DOI 10.1212/WNL.0000000000207769

This information is current as of September 25, 2023

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