MEDICAL PRACTICE

Clinics in General Practice

A case of arteriosclerosis

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The trainee's problem

A company secretary aged 63 has been a heavy cigarette smoker (over 40 a day) and had chronic cough for as long as he can remember. Two years ago he had a fairly typical major convulsion with only seconds' warning, during which he was unconscious for some five minutes and incontinent. The electrocardiogram (ECG) was normal except for left ventricular hypertrophy (LVH) in keeping with a fairly severe degree of hypertensive illness (240/130 mm Hg), for which methyldopa was prescribed. Surprisingly, chest x-ray pictures were normal, as was the electroencephalogram. He stopped smoking but, against advice, continued to drive his car. His cough almost completely disappeared and all appeared well until two months ago, when he had a second convulsive episode similar to the first. During this his wife reported his pulse rate was 38/min, although by the time I arrived it was normal and the patient was recovering.

The general physician he had first seen had since retired and a second specialist—a cardiologist—confirmed the absence of a lung disease and again found an ECG with a normal P-R interval and no abnormality other than LVH, although the blood pressure was now 160/80 mm Hg (lying) on methyldopa 250 mg four times a day. My tentative diagnosis of heart block was turned down and the alternative one of cerebral arteriosclerosis made; the methyldopa was changed to a thiazide in view of possible postural hypotension; and the patient was again advised to stop driving.

The effect of this consultation and the significance of the diagnosis has been disastrous. The patient has stopped driving, is working only half-days, and, having twice been brought home after "weak turns" at work, is being advised by his colleagues to retire. His understandable and deep depression is possibly now settling, having been matched in severity only by his wife's anxiety, and the couple are dreading the future. The wife is probably clutching at straws but has been to tell me that after her husband's most recent feeling of illness at work the pulse rate was again under 40/min.

My problem is that the wife wants her husband to see another specialist but the patient does not want any more fuss to be made. Cerebral arteriosclerosis seems to be a sentence implying long-term decay, and I find myself wanting to escape to something more attractive. Would it be helpful to seek a further opinion from the same or different specialist? Should I persuade the wife to accept the apparent realities or kindle possibly false hope in the husband, whose adaptation to his new life is probably now under way?

General practitioner's comments

The impression I receive here is of a lonely, frightened man who all his life has made decisions for other people. He has forced himself by drive to the top and in so doing has strained a lot of his personal relationships. He has a high degree of self-control, yet he now finds himself needing help, does not know how to ask for it, or what to do with it when it is given.

The first point is that his first specialist was moderately successful in his management of the case, and the patient seemed able to deal with his assessment of his problem and appeared to trust him, although he wilfully rejected the sound advice to stop driving his car. It would be interesting to know how long after the physician's retirement the symptoms recurred. It is little wonder that the patient's condition has deteriorated over the past two months—he realises he has an uncontrolled, threatening disease, and the methyldopa has

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probably made him impotent—a frightening incident in a man of his nature. His wife, who probably has been overawed and over-protected by him during the marriage, does not know how to cope with the situation and is over-reacting and trying to help, even to the extent of trying to take a pulse for 30 seconds. One can only describe the result as chaotic, and the contribution of the second specialist has done little except make the patient worse. It seems that everyone is fed-up with the case and wishes to disclaim responsibility and to remove him from the scene as quickly as possible—“Why don’t you retire, old man . . . you’ve done your bit?” No wonder the patient wants no more fuss to be made.

What is to be done? Firstly, a proper history must be taken. An exact description of the fits and weak turns by someone who actually saw them would be helpful. Does the pulse really fall to a rate of 38/min, and if so what is its character? Are there any other symptoms or signs that might be relevant? Were there any precipitating factors, either psychological or environmental, before the occurrences? What is his intake of alcohol? To this end I would suggest that a skilled professional person (not necessarily a doctor: a district nurse, or practice sister could cope adequately) be sent immediately to make some objective observations the next time either of these events occur, so that a proper evaluation might be made. Possibly an on-the-spot ECG might help.

Armed with this, a longer talk with the patient and his wife about their fears and ideas on the illness might be helpful, and it might be well to find out what the patient thinks is wrong with him. He is probably a man who has been making decisions based on facts all his life; he would probably benefit from the same approach to these important events in his medical life.

At this stage, somewhat reluctantly, I think it is essential that a third opinion should be sought. I think the consultant should be a general physician chosen with the utmost care and briefed adequately, especially about the background of the case, and tacit approval should be given for a fuller discussion and assessment with the patient than usual. While waiting for this consultation, I think that a mild anxiolytic drug such as chlor-diazepoxide, 10 mg twice daily, should be given and nitrazepam at night to ensure reasonable sleep. If the wife is also a patient there might be a case for using some mild sedative to ease her distress.

It is essential that the turns be definitely diagnosed even if this means a short stay in hospital for assessment. This is especially relevant to the patient’s ability to drive and work. I would think that driving and all it stands for is an important part of his life and that being deprived of this activity would constitute a great sense of frustration and anger. Therefore, any treatment that might safely allow the patient to drive again must be tried. After a suitable interval this activity might possibly be resumed safely. In any case, it can be held out to the patient as a possibility, and this in itself may help to lighten his depression, giving him a goal to work toward. If there is any possibility whatsoever of continuing at work this also should be permitted.

After the full investigations have been made and the general practitioner has the full report, he should again talk to the patient and his wife. I think it important that his wife should be encouraged to ask questions about her husband’s illness in front of him, and to express her fears. There is the innuendo of the doctor and wife collaborating behind the patient’s back. This would be disastrous: the wife has probably been a dependent type of person all their married life, and I think the patient would prefer to remain in charge of the marriage so long as possible. If the outlook is gloomy and the prognosis uncertain the patient may well have adequate reserves to deal with the state of affairs, but he cannot deal with uncertainty. It may, however, be much more difficult to persuade his wife to accept reality.

A six-weekly consultation, ostensibly for the purpose of checking the blood pressure, would be helpful, but the time could be usefully used by listening to the further fears of the patient that will undoubtedly arise. These could be provoked

by the question, “Is there anything else you wished to ask me while you are here?”

Finally, it does seem that a diagnosis of transient cerebral hypertensive ischaemia is highly likely in this case, but one cannot assume the causes. It may well be that when the unspoken questions and feelings are ventilated a great deal of the tension in this man may be relieved.

Consultant’s comments

The information provided lacks some of the detail necessary to offer positive suggestions. The first attack must be assumed to be a major epileptic fit—at least in the descriptive sense. Cough syncope may produce such attacks because of cerebral hypoxia induced by repeated Valsalva manoeuvres but is probably excluded because the fit did not occur during a bout of coughing.

At this stage hypertension and LVH were established but in the absence of a story of past strokes there is insufficient reason to incriminate cerebrovascular disease as the cause of the first fit. It was correct after an isolated episode to withhold anti-convulsants and to treat the appreciable degree of hypertension; baseline radiographs of chest and skull, an ECG, an EEG, and serum creatinine estimations and urine analysis were presumably obtained.

The second attack was similar, but the wife’s observation of a pulse rate of 38/min raises the possibility of Stokes-Adams attacks. If her report was reliable this arrhythmia cannot be excluded by subsequent normal pulse rates and ECGs. It would have been helpful at this juncture to admit the patient to hospital for continuous cardiac monitoring for 48 hours and for both neurological and cardiological consultations. If there was evidence of partial or complete heart block the insertion of a transvenous pacemaker should have been considered; if there was no such evidence further investigation seeking a cause of epilepsy should have been undertaken. Much of his subsequent depression may relate to the admittedly great difficulty in securing a precise diagnosis and prognosis. This second attack confirms epilepsy—as defined as a recurrent disorder—and at this age a cause should be sought.

Diligent inquiry for a history of relevant head injury (with post-traumatic amnesia of 12 to 24 hours) and abuse of alcohol, barbiturates, or tranquillisers with fluctuating levels is important. Neurological tests for tumours, cerebral atrophy, and biochemical abnormalities (such as hypoglycaemia, hypocalcaemia), need not be enumerated here but were clearly indicated on a clinically selected basis. In many such cases test results are negative, and I would then have started treatment with prophylactic phenobarbitone, 30 to 60 mg twice daily, continuing hypotensive treatment with a thiazide or methyl dopa to maintain diastolic pressure under 100 mm Hg. Beta-blocking drugs are potentially hazardous in the face of possible heart block.

Treatment thereafter is supportive and expectant. Since the patient had had two attacks of unconsciousness undoubtedly he was correctly advised to stop driving his car. There is indeed a legal obligation to notify the licensing authorities of such occurrences. The prohibition obtains equally in patients in whom the precise factors determining the attacks are not fully understood, as in this case, because the risk of recurrence with its potentially serious risks still pertains. If at a later date the patient has been free of attacks while awake for three years, or has had exclusively nocturnal attacks in sleep, he would be eligible to reapply for his licence. This would probably be granted, often after the licensing authorities have obtained a consultant’s report. The terms of tenure of the licence for “a prescribed disability which is controlled”^{1, 2} may be subject to yearly (or longer if he continues free of fits) review. It is legally acceptable and often medically desirable that the patient continues on a stable anticonvulsant regimen; this may be monitored by plasma anticonvulsant assays according to the clinical state of control.

The effects of facing such issues may be difficult for the patient—as in the present instance. It is important to decide whether the patient is demoralised and lacking in confidence because of the uncertainties surrounding his problem or whether he is suffering from a late-life depressive illness precipitated by his physical afflictions. The former demands a strongly positive approach, attempting to get him back to his normal work in a graded manner; the latter may require a psychiatric consultation and, possibly, antidepressant drugs. Serious depressive illness may mean that he is temporarily unfit to work or carry a burden of responsibilities; hence the great importance of differentiating these two possible causes of his dilemma. After these issues have been carefully discussed by his GP and consultant advisers, and if he is deemed fit to work, a positive and constructive approach on what he can do, as opposed to a series of daunting prohibitions on what he can't do is important: such management might conceivably have averted his present state.

On the facts presented I can find no definite indication of intellectual decline or dementia, and in the absence of previous strokes or transient ischaemic attacks there is little justification for the label cerebral arteriosclerosis. An organic basis for the "weak turns" would need to be based on observations during such spells. If they last long enough he should be brought to his GP's surgery or to hospital when next they occur, because if as seems likely they are manifestations of anxiety, possibly with panic and phobic overtones, strong reassurance could then be soundly based.

Assessment of such patients is most difficult, but there is little doubt that the anxieties besetting the medical attendants may be transmitted to the patient with disastrous effect. With adequate rest and active recreational interests, the patient may

well be capable of return to work. The position should be explained to his colleagues (with the patient's consent), and if they are favourably inclined a programme of gradual renewal of his duties may be devised. Should his colleagues insist on his retirement, the golden handshake could be well used in the rediscovery of past hobbies and interests. But a positive attitude is vital in either case, both to the patient and to his wife, who seems as deeply involved in the gloom as the patient himself.

Postscript to the problem

The different emphases of these commentaries reflect well the difficulties this problem presented. The issue of further referral was evaded for several months and eventually resolved by a further acute episode of weakness at work. On this occasion a pulse rate of below 40/min persisted for 24 hours by which time a domiciliary visit had been arranged and the patient admitted as a case of heart-block. Since the installation of pace-maker—now three years ago—the patient has been free of attacks. He has officially retired but works two mornings a week, and he and his wife have resumed active roles as grandparents. The only problem is recurrent inflammation at the site of implantation of the pace-maker, and this is a cause of quite substantial discomfort and inconvenience.

References

- ¹ *Medical aspects of Fitness to Drive*, ed A Faffie, 3rd edn. London, Medical Commission on Accident Prevention, 1976.
- ² *British Medical Journal*, 1976, 2, 1235.

Where Shall John Go?

Nepal

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I flinch whenever I receive my copy of the *BMJ*, not from ingratitude—for I thoroughly appreciate the reduced "missionary" rate, whereby I can keep up with British and worldwide medicine—but because there's someone somewhere in one of the processing offices who insists on addressing my copy to "Shanta Bhawan Hospital, Kathmandu, Nepal, India." Nepal is a virile, proud, independent nation and has never been under Indian, British, or any other kind of foreign rule. The world's only Hindu kingdom, Nepal maintains dual relations with China and Chinese Tibet to the North, and India to the South; receives with equal courtesy the representatives of Soviet Russia and the United States; but owes sovereignty to none.

Imagine the Lake District in its most frequent mood: the summits of green hills draped with sombre clouds dripping over

the valleys. You now have a good image of Nepal in the monsoon, except that you must omit the lakes, add villages going all the way up to the ridges of the mountains, and extend it to about 500 by 80 miles. When the monsoon ends, though, the country escapes comparison with Britain. Under blue skies the middle hills are seen to be only the foreground for the great white turreted wall of the Himalaya, the Home of the Snows—the highest mountain range on earth.

The problems

After seven years here, I can imagine no more congenial place to practise medicine, provided one can adapt one's training to entirely different conditions, and one's thinking to deep cultural differences. Medicine, as we learnt it, is applicable to the wealthy of Kathmandu; the bulk of the population need the "medicine of poverty"—their problems are those of combined malnutrition and infection. Malnutrition is due less to poverty than to ignorance and traditional habits. Poor hygiene results in dysentery, enteric fever, cholera, poliomyelitis, hookworm, roundworm, and amoebiasis. Overcrowding, especially in towns,

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