Personal Paper

Obese no longer

M J TARSH

You have to be fat to know what it is like. Thin physicians who look down on their fat patients as suffering from self-inflicted illness and orthopaedic surgeons, who regard a patient's excess weight as a culpable obstacle to surgery, simply do not understand.

At school, I was teased as a swot who was useless on the games field (fortunately I swam for the school and was popular in the summer term). It did not matter as an Oxford undergraduate, although I shall always remember my physiology tutor, who would puff sententiously on his pipe while saying that the laws of thermodynamics could not be denied (modern research on brown fat and impaired thermogenesis was still 25 years away).

It hurt when one rude physician said he would not have me as his house physician because it would set a bad example to his patients—although he said the same to smokers as he removed cigarettes from their mouths in hospital corridors. Psychiatrists, however, are allowed to be eccentric or overweight, and the only interference with work here was when I was over 140 kg and so big that patients sometimes said they felt physically overwhelmed.

Dieting and dental splinting

On the physical side there was the usual breathlessness, painful ankles, knees, and even hips later with increased liability to minor accidents. I was always afraid of dying young, like my father, who had a coronary at the age of 52. There had been ineffective diets and even a spell at 18 at a health farm before the first effective diet, when I was told as a senior registrar that no regional board would appoint a very heavy consultant who would be a health risk. This diet lasted two years and I lost 57 kg and gave myself an anal fissure from regular purgation. I then hoped to be able to eat more or less normally, but over the next 10 years as a consultant I gradually regained two-thirds of my former weight. I do not claim to be other than greedy, but like most fat people I would say that I did not eat as much as others might think I did. When I first heard about bypass surgery, I thought this might be the answer. I referred a patient for it, sending her almost as a herald. When she did well, I went myself, and the first suggestion was dental splinting.

Having my teeth wired together was effective in losing weight at first combined with a 1000-calorie diet, but after a year and with some cheating, I was stuck at a normal weight and could not lose any more. Teeth wiring was uncomfortable, but no worse. I was even able to lecture after a time, although pronunciation of some letters was difficult. The worst thing that happened was in the first week, when I mowed a bank on my lawn carelessly when I was probably also hypoglycaemic and, with a rotary mower, cut off my right big toe. I still remember the agony of waiting for wire cutters before I could be given morphine as premedication for surgery—and the ineffectiveness of the gas and air machine.

First bypass operation

I wanted to be permanently protected from myself, and I persuaded the surgeon, by showing him old photographs, that a bypass was justified. The first operation was largely uneventful, and I was only in hospital 10 days and off work for six weeks. He thought he had done enough with an unusual 70-cm bypass —35% longer than standard. Unfortunately, after three years I was regaining weight, and it became clear that I should have had the standard procedure. In this period I was able to eat generously: the diarrhoea was not a great nuisance, but there was, of course, pain. By some strange anatomical transposition I always feel colonic pain in the left renal area.

The only frightening sequel was after a long cold winter two years ago when I had been careless about my routine blood tests, and I developed strange tinglings in my legs and hands and later around the nose and jaw. Fortunately, I did not quite go into tetany and recovered with extra potassium, magnesium, and oral calcium after two days in hospital. En passant, Trousseau's sign, while dramatic for the doctor, is very painful for the patient.

Second bypass operation

It was not too difficult to persuade a second physician and surgeon, this time nearer home, when the procedure was no longer experimental, that revision of the bypass to standard length was necessary. The only part of the investigation that was unpleasant was the liver biopsy, which I found unexpectedly painful. I was not afraid of the second bypass in the autumn, and I did not know afterwards that anything had gone wrong. My wife saw I was ataxic and dyspnoeic and pushed for urgent investigation, which showed that I had suffered a silent pulmonary embolus—of which I saw fascinating gamma camera pictures later. I did not remember either any paranoid psychotic episode except that I thought the doctors who wanted to do an arterial puncture for blood gases at night might be trying to do me harm. About being in a space rocket for a week I remember nothing, and am even now somewhat mortified to know that my close colleague's visits were in a professional capacity rather than for friendship only. I do remember the frequent necessity for painful replacement of intravenous cannulae higher up the arm as the veins became infected lower down.

The first month in hospital was not pleasant, but the next six weeks at home were the worst of all. I developed faecal impaction and became increasingly distended, when, of course, I was supposed to have straightforward diarrhoea. Also something

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kept coming up painfully in my left upper abdomen as if there were a pair of bellows left inside. By the time that I had been readmitted to hospital for Christmas and the surgeon said that I had a subacute obstruction that could be cured by a further operation, my only feeling was relief at what earlier that month would have been unthinkable. After four pints of blood I felt well, and the second operation was not too bad at all. After it, however, I developed a high pyrexia of unknown origin for a week, which did not respond to parenteral antibiotics but disappeared magically with the sudden discharge of 300 cc of bile-stained pus from the abdominal drain.

Later I became anaemic again and required several transfusions, but I was told this was temporary bone marrow shut down that happened after intra-abdominal infection, and I was never too worried about this, once sternal puncture had shown nothing malign.

The worst part of what stretched to five months off work was the constant pruritus, particularly affecting the back. Local antipruritics and antihistamines were ineffective, but it was cured through what I regard as a brilliant clinical hunch that it might be due to zinc deficiency. The professorial unit of my own hospital turned out to be interested in trace metals, and there was no difficulty in obtaining a serum zinc estimation. This was very low, and the itching was cured after taking simple zinc sulphate capsules twice a day for a fortnight. After three months back at work, the final operative repair of an incisional hernia with three days in hospital was almost an anticlimax.

The future

And now—I am thin and at last not a freak and likely to stay normal. I will not always be getting fatter every year. I have pain sometimes and frequent steatorrhoea—especially if I eat too much. I get night cramps unless I watch my calcium concentration carefully: otherwise I am well, and it is no great nuisance to take pills twice a day—potassium, calcium, magnesium, zinc, iron, multivitamins, and vitamin D—nor is it a nuisance to have blood tests once a month.

What have I, as a doctor, learnt from this period of illness? Firstly, I never doubted the cleverness of physicians, but I have been lucky to be looked after by surgeons who are different certainly from those I knew years ago. They are exceptional in having a capacity for empathic understanding of what I might feel or want to know, and I cannot thank them too much.

Secondly, I have learnt that, for the patient, nurses are almost as important as doctors. While junior nurses in one hospital seemed frightened of me and seemed to stay away, I noted how much happier I was in a different smaller hospital later, where the nurses took looking after a consultant in their stride.

Would I have had it all done if I had known of the complications there would be? The answer to this is probably yes, but I must end with a feeling of gratitude that, as a patient, I did not know in advance exactly what was to happen!

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Letter from . . . Sri Lanka

Beetle marasmus

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The study of the natural history of disease in a spirit of clinical detachment and of cultural isolation from the affected indigenes was fashionable when the pioneers of tropical medicine made their first conquests. Today, this privileged perspective is, perforce, denied to doctors of the Third World. It is difficult for the latter to achieve the kind of objectivity which finds it both necessary and sufficient to separate the hard data of the disease-process from the life-style of the diseased person.

Dung-beetle infestation of the gut—in little children particularly—is quite common in Sri Lanka. That the developmental stages of certain beetles (*Scarabaeoidea, Coprinae*) can survive and even complete their life-cycle in the human intestinal tract is no more than a clinical and parasitological curiosity to the physician-naturalist of the West. We find the condition dismissed in the learned tomes on the subject as an example of "pseudoparasitism" arising from the accidental ingestion of the embryonic stages of these insects.

This is a lean view of a richly structured phenomenon. An extraordinary catenation of factors—including parasite logistics on the one hand and aspects of social life among Sri Lankans on the other—seems to promote this bizzare association between man and beetle. What follows is a discussion—necessarily superficial—of the "ecological interface" between these two species.

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Kurumini mandama

The scarabs are quite common in this country. Thanks to the assiduous attention of members of this tribe, it has been observed that substantial faecal masses are reduced overnight to loamy accumulations not very different from the "castings" of the larger types of earthworm found in the tropics. This transmutation of messy excrement into seemingly innocuous soil by the busy coleopteran is not without epidemiological importance. Precinct sanitation in our towns and villages takes the form of a daily sweeping of the "lot"—a characteristic early morning chore of the women of the household. Thus the "handiwork" of both the dung-beetles and of the ubiquitous earthworms, while being laid low by the careful housewife, is widely disseminated in terrain adjacent to the dwelling-place. The mixed soil is now the pabulum for a host of scatophagous species.

The picture must be completed by introducing the naked Third-World child gambolling on this compromised ground. In a flow-chart of the village ecosystem, the alimentary pathway