Routine admission to hospital for tuberculosis

Ten controlled clinical trials (the world literature³⁵) have produced no evidence that the sanatorium regimen of rest, good accommodation, good diet, nursing care, and airy surroundings is beneficial in the treatment of tuberculosis. The findings were particularly noteworthy in the Madras trial of treatment at home compared with treatment in a sanatorium. The very unfavourable home conditions were fully documented and every patient had smear positive disease and was followed up for five years, with intensive bacteriological and regular radiological monitoring.³⁶ We also found no greater transmission of infection (by tuberculin testing) and no more disease in the families of the patients treated at home than among the families of the patients isolated in a sanatorium.³⁷ This important finding has been confirmed in several other studies.³⁸ Clearly it is not necessary to admit patients to hospital unless there are special indications, such as complications.

Physicians' approach to hospital admission

Because the admission of patients to hospital as a routine policy has clearly been shown to be unnecessary and is so much more expensive (currently above £70 a day in England³⁹) than outpatient treatment, clinical practice is of particular interest. Information is available for Scotland for all patients with pulmonary disease who were started on treatment in the second

six months of 1977 and the whole of 1978 and 1979,³⁶⁻³⁸ and for patients notified and brought under treatment in England and Wales in the last three months of 1978 and the first three of 1979.⁴⁰ In both countries the proportion of the total number of patients with pulmonary disease admitted to hospital was high, ranging from 70% to 81%. In Scotland routine policy was reported to be "the main reason" in 22%, 15%, and 15%, respectively, of the patients admitted in 1977, 1978, and 1979. In England and Wales, where the clinicians were asked to indicate one or more of a list of possible reasons, routine policy was one of the reasons in 23% of patients. Thus, many years after it had been well recognised that "routine policy" was not in itself a reason for hospital admission, it was still a common practice in the United Kingdom.

Regimens of chemotherapy to improve patient compliance

The Madras study led directly to the development and introduction of fully supervised intermittent regimens,⁴¹ short duration regimens, and combinations of the two in attempts to overcome the problems of compliance during long term self administered daily regimens in outpatients.

This article will be continued next week. The references to both articles will appear at the end of the second article.

Personal Paper

Caesarean section under epidural: a personal account

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In August 1982 I had an emergency caesarean section under epidural anaesthetic for the delivery of my first baby. I am an anaesthetist and had never had an operation during my adult life, so the experience made quite an impression on me.

I was 12 days overdue and had been threatened with induction, when at last the contractions started spontaneously. My husband, also a doctor, enthusiastically helped me to record the contractions for several hours before taking me to the maternity hospital, where we were disappointed to find that I was only 1.5 cm dilated and not even in established labour.

Eventually, the following morning, I was transferred to the delivery room, where the nursing officer performed the artificial rupture of membranes and the intravenous cannulation. The latter was definitely the most uncomfortable, and the Hartmann's Solution produced a hot stinging sensation when first flushed through the vein. A fetal scalp electrode and intrauterine pressure

manometer were introduced with little discomfort, and we settled down to watch the monitors. Several members of the medical staff, including the anaesthetist, called in to assess my progress and to ask if I wanted an epidural. I replied to all of them that I was managing so far without, and persevered with the breathing exercises.

Several hours later, however, and still only 3 cm dilated, I had stopped coping with the increasing pain and was hanging on to the bed rails and groaning in a most undignified manner. The contractions would have been bearable but the constant severe backache was becoming intolerable, and I gratefully accepted the epidural.

Quick and pleasant relief

I was relieved to discover that I had been advising my obstetric patients correctly and that the insertion of an epidural catheter really is not painful. I flinched when the skin was infiltrated with lignocaine and could tell exactly what my colleague was doing, but there was no discomfort. The whole procedure was over remarkably quickly, and I realised that, despite the stories of doctors attracting complications, I had experienced an epidural without the dreaded dural tap. After 10 minutes warm waves of pleasant paraesthesia were lapping up both legs, the backache

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mercifully disappeared, and the contractions were reduced to a mere ache in one groin.

I was beginning to relax and enjoy myself again, when the problems suddenly started. The monitor showed severe fetal bradycardia despite my stable blood pressure, and I was quickly turned into the left lateral position and given oxygen to inhale. After a few minutes the fetal heart rate recovered, only to be followed by decelerations with or after each contraction. It really was the worst example of fetal distress I had ever seen. I had horrible visions of the baby becoming hypoxic and perhaps suffering brain damage. One look at my husband's drawn face told me that he had the same fears.

During this time midwives, obstetricians, and anaesthetists hurried to and fro and numerous discussions were held. A fetal blood sample was taken through an enormous speculum, which would have been most uncomfortable without the epidural analgesia. While we waited anxiously for the result I realised that a caesarean section was likely and asked the anaesthetist if I might be able to have an epidural anaesthetic. He immediately agreed and, after consultation with the obstetrician, set about topping up the epidural in anticipation.

A large dose of bupivacaine was injected into the epidural catheter, and soon another wave of warm paraesthesia coated my already rather numb legs. After 10 minutes I had no feeling up to the axillas and had motor loss to almost the same level. My legs now seemed completely detached from my body, and the abdominal and lumbar weakness caused me to slide helplessly sideways. I had some reduction in ventilatory power, so that, although I had no difficulty in breathing, I found it impossible to blow my nose properly. I was surprised not to feel any symptoms of hypotension, but the Hartmann's infusion and my own compensatory mechanisms must have been effective.

Emergency operation

The result of the fetal blood sample was normal, but the monitor still showed variable decelerations in the fetal heart rate. I was still only 5 cm dilated, so an emergency caesarean section was the only safe solution. I was quickly shaved, a consent form was brought for me to sign and magnesium trisilicate to swallow, and at 3 pm I was transferred tearfully to the theatre.

I was introduced to a consultant anaesthetist in the anaesthetic room and tried to take in my new surroundings but lost interest when I saw the familiar Boyle's machine. A blood pressure cuff and oxygen mask were secured, and I was relieved to be allowed to wear my spectacles as I am rather myopic. When I was transferred to the operating table with only one pillow I had the sensation of a heavy weight compressing my diaphragm from below and restricting my breathing. The left lateral tilt helped a little, and when I commented that I had paraesthesia in my fingers the head up tilt applied to the table relieved most of the discomfort.

While I was being prepared for surgery my husband reappeared at my side, looking strangely unfamiliar in theatre clothes. I received a great deal of comfort and reassurance from his presence and was grateful that he was allowed to stay throughout the whole procedure. Then I noticed the exchange of glances between surgeon and anaesthetist as the incision was made, but otherwise I would have been unaware that the operation had started.

It seemed only seconds before I felt a great deal of pulling on my abdomen, and a live baby girl was delivered, screaming loudly. My husband and I both strained our eyes towards the paediatrician as he completed his examination, and when he reassured us that she was in perfect condition our relief was overwhelming.

The rest of the operation seemed to take a long time in comparison and, although there was no pain, I experienced some discomfort and nausea from what felt as though my stomach was being pummelled. Intravenous Maxolon and Syntocinon were

given, while I wondered if I was bleeding and what my abdomen looked like inside. I noticed beads of sweat trickling down the surgeon's brow but felt no sensation of heat myself. At last the anaesthetist told me that the skin sutures were in place, and before long I was tidied up and lifted back into bed.

Impossible to breast feed

In the recovery room my first attempts at breast feeding were rendered impossible by completely anaesthetised nipples and an inability to support the baby and myself in the correct position.

After a few hours of much needed sleep my epidural catheter was removed and I was transferred to the postnatal ward. In retrospect the epidural would have been useful for postoperative analgesia, but at the time I was quite keen to be rid of the rather incapacitating weakness.

By 10 pm that evening, however, I was beginning to feel real discomfort, both from the wound and a distended bladder that I had no power to empty. The night sister relieved my discomfort with a catheter and 15 mg of intramuscular Omnopon, after which I fell asleep. I was frequently woken by more pain, the intense heat, and the sound of screaming babies. I resorted to more Omnopon and eventually at 5 am, had sufficient power and sensation to use a bedpan successfully, with immediate relief.

After that first dreadful night I recovered rapidly. The wound was fairly uncomfortable, but the worst pain was from my right shoulder and under the costal margin, which lasted for 48 hours. A small patch of skin over my sacrum remained anaesthetised for several months but was not associated with any other symptoms and gradually returned to normal.

During my seven days on the postnatal ward I received excellent care, but whether this was because I was a doctor I am not sure. I was given a single room, but this was usual after a caesarean section. My anaesthetic colleagues visited daily to check on any postepidural problems, while the obstetric and paediatric teams performed their routine follow up visits. The nursing staff were always friendly and ready to help while still allowing me plenty of privacy in which to get to know my baby.

What I have learnt

Looking back on my experience, I think that it has taught me several lessons. I have now learnt how it feels to be subjected to some of the procedures that before I had only ever performed on others.

I have now experienced not only severe pain but also the rapid and complete relief produced by regional analgesia, and having a caesarean section so painlessly performed under epidural anaesthesia has served to reinforce my convictions of its value.

I have learnt the degree of acute emotional distress that may be caused to both parents by complications occurring during labour, and the importance of the reactions and support shown by the medical staff during this time.

As a result of my experience I think that in future I will have more sympathy with obstetric patients in labour, and be able to explain more accurately the effects of the procedures to which they may be subjected.

Finally, I should like to thank the obstetric, anaesthetic, and nursing staff for the efficient way in which I was treated, and for helping to make this experience such a pleasant one.

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Correction

The Any Question ? on weight reduction (14 May, p 1567) should have read 500 kilocalories (2.1 MJ) and 1170 kilocalories (4.9 MJ).