Personal Paper

In memory of a brain tumour

J A McCOOL

Everything began with an apparently innocuous headache as I awoke one December morning. It cleared up around 11 am and I thought nothing of it, though virtually my only experience of headaches had been during "the morning after." The next morning, however, I again woke with an identical headache—a diffuse, throbbing pain in time with the pulse, brought on by head movement, stopping abruptly after seven to eight beats, then recurring with the next head movement. It, too, abated by midday. And so it went on. Each morning I would awake with the headache, be clear of it by noon, only for it to reappear the following morning. This pattern continued for three months; during this time the headaches had become gradually more severe and were lasting longer throughout the day, sometimes till early evening.

Then, suddenly, things changed. I woke one morning with a catastrophically severe headache, constant and boring, refusing to go away. From then on I also began to feel nauseous and to develop a slight unsteadiness on my feet. When the "effortless" vomiting started there could be no more delay in presenting myself to the neurologist. At this stage I was only two months from my final examinations. When no physical signs whatever were found on examination, and the skull x ray examination and blood tests were normal, the consensus of opinion was that I was suffering from "tension" headaches. This diagnosis was completely unacceptable to me; I *knew* that these were not "tension" headaches. Everyone else knew five days later. I had had to wait five days in hospital, without further investigation or treatment, for a computed tomography scan, there being only one scanner in Northern Ireland at that time. The scan confirmed my fears—a tumour. It was Holy Thursday.

The next day all the doctors, apart from the houseman, went off on holiday. Their sudden absence left me feeling somewhat abandoned, and the irony of my hapless position, during Easter, a time of celebration, was not lost on me.

"You're with the first division"

I was glad, a week later, when the day of the operation dawned. I felt no apprehension that morning, happy that the waiting was at an end. I had complete confidence in my surgeon, and I just wanted to get the thing over with, so that I could get on with the business of recovery. As I was wheeled out of the ward towards the theatre, it seemed odd to be lying flat on my back, being trundled along corridors that I had trodden many times as one of "us"—now I was indisputably one of "them." The last thing that I remember was admiring the skill of the anaesthetist as he painlessly fed an arterial line into my arm. "Don't worry," he said, "You're with the first division." And then oblivion.

I do not remember being in the recovery room or returning to the

ward; I spent the first 24 hours in a shadowy state of consciousness, dimly aware of my surroundings, occasionally drifting awake to find myself with an atrocious headache. Fortunately, and to my surprise, this was effectively controlled by dihydrocodeine tartrate given intramuscularly. I was out of bed the day after the operation, and, once out, I was eager to attempt a short walk. I expected to be completely ataxic and was a little apprehensive about actually confirming this to myself, but I was delighted to find that, although I was slow, I was fairly steady, and felt no giddiness or dizziness at all. So encouraged was I that I wanted to walk all round the ward and had to be firmly directed back to bed by my supporting nurses.

In other respects, for the first couple of days, I was virtually helpless and completely reliant on the nursing staff. Having the most basic and intimate things done for me was an odd experience, but I felt no sense of embarrassment, only of necessity. During this time, the kindness and sympathy of the nursing staff was overwhelming, and this, together with the highest level of efficiency and competence, made their care unsurpassable.

During my postoperative period many of my friends thought that I had undergone a personality change: I was irritable, tetchy, and sullen. The houseman on the ward told me some months later that, at one stage, I had been suffering from a mild acute confusional state and had even been a little dysarthric at times. This was certainly news to me. I was completely unaware of any of it and had considered myself to have been at all times in a perfectly normal state of mind. I do admit to being somewhat irritable, but surely this was understandable after such an operation, when you are scarcely likely to feel at your best.

Cacophony of television noise

In fact, the main thing responsible for my irritability was noise and especially television noise. It seemed to come at me from all sides and was as demoralising as it was unrelenting. The patients' sitting room in the neurological ward in which I stayed before my operation was dominated by a large television set. This was left on all day at ear shattering volume. The door to the television room was open, of course, at all times, and the noise reverberated constantly throughout the ward, making any semblance of peace and quiet impossible.

Even in the neurological ward television noise was a persistent torment. Many patients had a portable television by their bedside and often three or four would be blaring away, each one switched to a different channel and each seemingly trying to outdo the other. The resulting cacophony was intolerable. Surely in any ward, but especially in a neurosurgery ward, where many patients have had a craniotomy, this should not be allowed to go on? Each patient has as much right not to listen to television if he does not want to, as another has to listen. Many patients may be suffering, as I was, from headaches, and they were made a great deal worse by this continual noise. Headphones should be mandatory for those wanting to watch television, so that the thoughtlessness of some is not allowed to disturb the peace and privacy of others.

After the operation I found that I had become more sensitive to noise in general, and that any loud noise, if in any way sustained,

Ballymena, Co Antrim

J A McCOOL, final year medical student

Correspondence to: 12 Antrim Road, Ballymena, Co Antrim, Northern Ireland BT42 2BJ.

was liable to precipitate an immediate headache. I could accept the necessity of the clamour of busy ward activity. It was the unceasing barrage of television noise to which I objected, and which seriously undermined my morale and confidence. This was by far the most dispiriting aspect of my entire hospital stay.

I was discharged home 10 days after the operation. By this time, my weight had fallen to eight and a half stone from a combination of postoperative sickness and no great love for hospital food. I was so thin and had lost so much weight from my legs during my weeks of inactivity that my greater trochanters bulged like a pair of budding horns; they made lying on my side and trying to get to sleep at night most uncomfortable.

Radiotherapy and its after effects

Anyhow, I managed and the following week I was off to hospital again for radiotherapy. Before the actual treatment began a few days were spent on making a mask. This included the disagreeable business of having my face covered with Vaseline and my head encased in plaster of Paris. Yes, they do leave a hole to breathe through.

The treatment itself was painless but within a few hours of it starting I developed headaches and vomiting almost identical to my original symptoms. It seemed that radiation induced local inflammation and oedema were blocking the cerebrospinal fluid and giving rise to another spell of raised intracranial pressure. Dexamethasone was duly prescribed and it was immediately effective; little did I realise that this was the beginning of a long running steroid saga. For the duration of the treatment the dexamethasone remained necessary to control the headaches and vomiting, and I expected to be able to stop it within around two weeks of the treatment coming to an end. The effects of the radiotherapy, however, persisted well beyond the end of the treatment period, and I found myself still needing the steroid during all this time. The continued intake led to progressive stomach problems, requiring the introduction of cimetidine and an antacid; I felt continually unwell since I was always testing myself against the lowest possible dosage, and I began to despair of ever being able to get off the stuff. In fact, it was four months after the radiotherapy had ended before I succeeded in stopping the drug—four months of convincing demonstration of the problems of steroid usage.

The course of radiotherapy lasted four weeks, and the option of attending as an outpatient was available from the end of the first week. I took it without delay—even though it meant a 60 mile round trip from home to hospital—for one main reason. Each morning in the hospital, despite being in the “relaxed environment” of the radiotherapy unit, I was abruptly wakened at 6 30 am sharp. I found this extremely discouraging and unnecessary—I did not get my breakfast until at least a full hour later. For some reason I was being deliberately deprived of a valuable hour's sleep. Similarly, in both of my previous wards, I was usually awoken between 6 30 and 7 00 am.

Certainly, never once was I allowed to sleep beyond 7 30 am. I had always assumed that a basic premise of hospital treatment was to promote rest, but obviously I had been mistaken. As a hospital patient, weakened and ill, I needed as much rest as possible, yet it was wittingly taken from me. I fail to comprehend this policy of denying rest to the ill. Why was this practice originally adopted and why, in these “enlightened” days, does it continue?

As a medical student, I have been repeatedly taught about the importance of confidentiality. I acknowledge that I may be more sensitive to this issue than many of my colleagues, but I admit to being most upset that within hours of my tumour being diagnosed most of the students in my year knew about it. I suppose that they had to talk about it—the shock of seeing one of themselves “struck down” must have made them suddenly aware of their own mortality and their vulnerability even as healers. And to talk of these things allowed them to reassure each other and to re-establish their sense of security as doctors as opposed to being patients.

Importance of full information

It is often said that hospital patients feel unhappy that information concerning their condition is deliberately kept from them by the doctors. Having now been a patient myself, I fully understand and endorse other patients' grievances about the lack of information given to them; although no information was withheld from me—being a medical student—I would have found it intolerable had I suspected otherwise. It is the patient's body and the patient's illness and, if he so desires, he must be told the whole truth. It seems to me sheer arrogance for anyone to decide that such and such a person would be better off not knowing, for example, that his illness was terminal. The patient must be given the full details about his diagnosis and prognosis because it is his future, not anyone else's, and it is only he who can make the necessary decisions about it.

Lest the foregoing may suggest otherwise, let me make it clear that I was impressed and happy with most of the care that I received while a patient. This was especially true of the early postoperative stage when the nursing staff were kind and helpful. For when something awful happens it is help and understanding that you need—not pity. I discovered what a useless commodity pity is.

A lot of people these days mourn the passing of the old time doctor, the family friend, always available, and always ready to listen and dispense advice. They decry contemporary “hi-tech” medicine for its loss of intimacy and warmth, and for its increasing distance between doctor and patient. Yet who would argue that today's medicine is not infinitely preferable to the “old time medicine,” impotent and largely ignorant, for all of its warmth and wealth of reassurance. For in the end, to paraphrase Lewis Thomas, if I develop a brain tumour I want as much comfort and friendship as are available, but mainly I want quick and effective treatment so that I may, if that is possible, survive.

Erythromycin for oral use is available both as the basic drug and, at greater cost, as esters of the drug. Is the cost disadvantage of these esters offset by any significant superiority in antibacterial potency, in plasma or tissue concentrations, or in the incidence of adverse effects?

There are no important differences between erythromycin base and the other forms of the drug, and erythromycin base is satisfactory for most patients. Nevertheless, minor differences affect the administration of the drug and the choice of preparation in particular circumstances. Because erythromycin base is inactivated by gastric acid it should be given as enteric coated tablets. Absorption of these may be delayed or incomplete and in a few patients may not achieve adequate blood concentrations. The absorption of both the base and the stearate may be impaired by food and they are best taken on an empty stomach. The two erythromycin esters, the estolate and the ethylsuccinate, are acid stable; absorption of the estolate is more complete than with the base or stearate, and is unaffected by food. It has,

however, to be hydrolysed to the free base before becoming active, and some of the circulating drug is the inactive ester. Thus although blood concentrations may be higher than with the base, there is disagreement about the extent to which this represents the presence of the inactive ester.

Unlike the base, the esters are tasteless and are available as liquid preparations. They may be preferred for young children. Erythromycin estolate if given for more than 10 days is more likely to damage the liver than the other forms of erythromycin, but hepatotoxicity has occasionally been reported with these also. The estolate should be avoided where treatment for longer than 10 days is expected and in pregnancy, where the risk of hepatotoxicity is increased.—LINDA BEELEY, consultant clinical pharmacologist, Birmingham.

Garrod LP, Lambert HP, O'Grady F. *Antibiotic and chemotherapy*. 5th ed. London: Churchill Livingstone, 1981:186-9.