Personal Paper

Was the vasectomy necessary after all?

LLOYD NICHOLAS

Eighteen months after the birth of our second healthy daughter the decision to have a vasectomy was straightforward. A quiet chat with a urologist—a personal friend—and everything was arranged. The preliminary interview and examination were efficient and professional: no corners cut, no break with routine; I wanted nothing to go wrong as a result of short circuiting normal procedure.

"The left one has been larger than the right for a long time now. No, it doesn't hurt, but I've got a small varicocele, haven't I?"

The varicocele was confirmed, we talked about my likely hypotensive reaction to local analgesia, and the date was set.

Compared with what followed I can honestly say that the procedure was uneventful. I was even able to avoid telling anyone of it and returned to work after a long weekend. I avoided wearing jeans and made excuses for not riding my bicycle. I hoped that the now bilateral testicular swelling would soon subside and that all would return to normal.

Diagnosis

At eight weeks I was given the all clear from the laboratory. Two months later the left testis not only was still tender but had increased in size quite dramatically; the right one was by then normal. It is hard now to recollect what my thoughts were at that stage: that it might be a tumour had certainly occurred to me, but I considered it more likely to be related to the vasectomy coupled with the varicocele. I could see from his concern that my urologist did not share my opinion. Ten minutes after examining me he watched me perform my own ultrasound examination.

I don't know about a person's past flashing before them when they are about to die, but at that moment my immediate future became clear to me. Large, solid and homogeneous could only mean tumour, and that meant surgery, staging, and possible chemotherapy. If life has turning points this was a hairpin bend. I believe I was quite rational. It should be a seminoma, I was told; the prognosis was excellent. I told this to my wife, a state registered nurse. I felt an overwhelming sense of frustration and impatience: impatient to know the whole story and frustrated by my inability to affect the outcome.

My wife was outwardly stoical, loving, and unstintingly supportive. Inwardly she was devastated. Explaining to an intelligent 7 year old why Daddy had to go into hospital when he had been well enough to cut the hedge and mow the grass the day before was not easy. If coping with patient's relatives is normally considered to be awkward it is doubly so when they are your own and non-medical. I found myself trying to reassure my parents and others when desperately needing support myself. I was physically so well that I felt confident I would have stage 1 disease. Nevertheless, I well remember the feeling of relief as I looked at my chest *x* ray film, and I showed it to a colleague just to make sure.

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I wanted everything to be completed as quickly as possible. I needed to know for certain that my prognosis was good. This is a natural response, but I now understood the anxiety of a patient who has to wait for his appointment, operation, and result. The operation was performed three days after my ultrasound examination. The weekend in between was a time for thought, discussion, and "sorting things out at home." It was a routine orchidectomy, but as I had never had a general anaesthetic before this was a totally new experience. I declined postoperative papaveretum when it was offered, which was an error. I did not feel pain but spent the night disurbed by strange thoughts and a feeling of intense discomfort—a complete inability to be comfortable. Nurses continued to ask if I needed something for pain. I found it curious that I felt little pain, though my discomfort was subsequently much relieved by oral analgesics.

Prognosis

The histology confirmed a pure seminoma, which perversely was good news as it made the possibility of chemotherapy unlikely. Next on the agenda was computed tomography, and I experienced a second wave of relief as I hobbled from the table to the viewing room to see my normal para-aortic nodes. All the signs were now pointing towards stage 1 disease, but my radiotherapist, also a close friend, wanted me to have lymphography before my prophylactic radiotherapy. So off I went to the Royal Marsden Hospital. This was one of the most disturbing events of this whole episode. I was treated with kindness, patience, and efficiency in the *x* ray unit, but neither my wife nor I was ready for the spectacle of so many young people looking so desperately ill. No matter how optimistic my prognosis I could not rid myself of the premonitory feelings of foreboding, remembering that at this time my staging was incomplete. The emotional tension was relieved temporarily in a splendid Italian restaurant nearby. The meal was excellent but less memorable than the expression on the face of the man who entered the gents while I was passing bright blue urine. I pretended I hadn't noticed.

That evening I felt dreadful. I had been warned that I might get flu like symptoms due to the oily contrast medium. This surprised and shamed me as I had never given my patients similar warning before they underwent lymphography. I do now.

The final hurdle

The lymphogram was clear and only the final hurdle remained. General consensus dictated that I should now have a course of radiotherapy. A current study at the Marsden was assessing the results of surgery alone for stage 1 disease. In view of my daily contact with patients with cancer I elected to have the radiotherapy and thereby consider myself cured. I thought that this would take the pressure off and reduce the frequency of follow up tests. In retrospect the decision would not have been so easy had I known how the treatment would affect me.

I had expected to feel nauseated and tired, but I was not prepared

for the severity and duration of these symptoms. Within two hours of the first treatment I vomited. This heralded the beginning of what was to be four weeks of continuous nausea the like of which I had previously experienced only below decks in a small yacht in rough sea. After the second day's exposure I required an intravenous antiemetic and sedation. It was decided to reduce the daily dose of radiation. This increased the duration of treatment, but at least I was no longer vomiting every evening. I was given some suppositories which also helped in the evenings and brought blissful sleep. I lived like an automaton for the next four weeks. Each trip to the radiotherapy department was another dose of aversion therapy. I knew that each visit would increase my nausea and, in addition, every evening I felt as if I had flu. In such circumstances it required enormous willpower to continue. I think that without the support that I received from my wife at this time I would have thrown in the towel.

Reflections

It is now four months since my treatment finished. The nausea resolved quite quickly but was rapidly replaced by the irritable bowel syndrome. This is inconvenient but tolerable. It is undoubtedly exacerbated by red wine. I am assured that this should resolve; meanwhile I am enjoying the discovery of some fine whites. The tiredness remains, at some times worse than others. I resumed work 12 weeks ago, though my stamina is far from normal.

Apart from the physical and mental scars what other memories endure? Perhaps the most surprising and at times upsetting was the reaction of friends, family, and colleagues. There were those who helped immensely by their regular visits, telephone calls, and offers of help. There were others who seemed unable to broach the subject of health even by asking, "How are you?" Perhaps they feared the reply. I know this attitude is not the result of an uncaring nature—indeed, sometimes the opposite. But "Hello, how are you?" is such a normal, everyday greeting that its absence draws attention to the abnormal state of affairs. Now I have to think before I reply. I dread becoming a health bore so I usually say, "Fine, thank you." But it's nice to be asked.

Has this episode changed the way I practise? I hope not. I hope I was sufficiently patient and caring before this, though more than one person has suggested that I will be a better doctor as a result of it. Without the vasectomy I don't know if the tumour would have been diagnosed later than it was. The irony is that with the combination of orchidectomy and radiotherapy I probably didn't need it.

Lesson of the Week

Dangers of lumbar puncture

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It has long been known that lumbar puncture in the presence of an intracranial mass may lead to rapid deterioration and death. Despite this, inappropriate lumbar punctures are still performed. We present two cases in which this occurred and discuss the lesson that may be learnt from them.

Papilloedema may be absent despite the presence of an intracranial mass lesion; hence any patient who presents with increasing drowsiness and a stiff neck and for whom doubt exists about the safety of lumbar puncture should first be examined by CT.

Case 1

A 17 year old previously healthy youth went drinking one evening, saying on arrival home in the early hours of the morning that he had drunk 9 pints (5 l) of beer and eaten a Chinese meal. He mentioned that he had fallen over but apart from being drunk he was thought to be well and was put to bed. That morning he slept in, but when his parents came to rouse him in the afternoon he was very drowsy, though rousable, and mumbled incoherently on vigorous shaking. His general practitioner was called and arranged admission to hospital.

On arrival at the local general hospital his level of consciousness fluctuated between drowsy but rousable and completely unrousable. Temperature was 37·5°C and he had a maculopapular rash extending from face to trunk. There was mild neck stiffness but no focal neurological signs: in particular, there was no papilloedema. The history that he had fallen was not elicited. A full blood count showed a peripheral leucocytosis of $22{\cdot}5 \times 10^9$/l. The drowsiness associated with neck stiffness, maculopapular rash, and a peripheral leucocytosis led to the diagnosis of meningococcal meningitis.

At lumbar puncture clear fluid at a pressure of 23 cm water was obtained. Within 15 minutes of the procedure both pupils became fixed and dilated and the patient had a respiratory arrest. He was intubated and ventilated immediately, given 50 g mannitol, and a skull radiograph showed a right frontal fracture. He was rapidly transferred to the regional neurosurgical unit.

On admission brain stem reflexes were absent. A CT scan showed a large right frontal extradural haematoma with considerable mass effect. Though the prognosis was thought to be poor, the clot was removed by craniotomy. Next day the criteria for brain stem death were fulfilled and ventilation discontinued.

Case 2

A 49 year old hypertensive man became acutely dizzy, then dysarthric, and vomited copiously. He was admitted to a general hospital and complained of headache. He was drowsy but able to speak and showed no focal neurological signs. Over the next 12 hours he became more drowsy and was found to have a stiff neck. There were no focal neurological signs and no papilloedema.

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