Second Opinion, Please

Problems with Asthma

FRANK O. WELLS, CHARLES J. STEWART

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Leander House, 75 Corder Road, Ipswich, Suffolk.

Dear Charles,

Thank you for spending so much time with Mr. X; one of our main problems with him was his lack of confidence in himself, and in what we were doing for him and to him.

His first episode of breathlessness occurred in the summer, seven years before his death, when he had his first typical bout of bronchial asthma at the age of 23. He remarked at the time that this wheeziness was always worse at the beginning of each week when he went back to work, and I wondered whether his job was specifically the cause of his breathlessness, or whether his distaste of it (he was a carpenter) was the precipitating factor—but in fact he seemed to enjoy his work. There certainly did not appear to be any infective element, and his chest x-ray film was clear at the time. He responded well to Franol, and he hardly attended the surgery then, except for occasional further supplies of this drug. He had, incidentally, given up smoking, and this made him feel better.

He managed well for the next six years, avoiding chest infections each winter, but still using Franol occasionally. His only other surgery attendances were for soreness of the mouth, which lasted for three months, and for metatarsalgia, which lasted just one week; during this time he had two further normal chest x-ray films. Then—again in the summer—he had such an acute bout of asthma that he required intravenous aminophylline to control it. It did seem to be seasonal in that both the onset—and the worst attack to date—had occurred during June; this was after the beginning of the hay fever season, and the pattern of his asthma did not really fit in with a pollenosis. So I sent him to you with a request that, if you agreed, he should have sensitivity tests done to try and establish the cause of his asthma, if indeed this was of allergic origin.

Soon after he saw you, he had four further severe bouts of asthma, despite prednisone, Cholel, and Alupent, and for the first time I had to send him to hospital. When he came out of hospital at the end of the year, he had become increasingly lacking in self confidence, and I am sure this did not help him. Certainly he asked me to admit him each time he had an acute exacerbation of his breathlessness, and this I was always prepared to do, as nothing I was able to give him seemed to do any good.

After you had treated him further, he did indeed appear to improve slightly, but little things upset him far more

easily than they had done; for example, he became extremely agitated when his aerosol inhaler would not work properly, and then gave himself at least six times the usual dose. It became apparent that his exercise tolerance was becoming less when he decided to have his bed downstairs—an ominous decision, really, for a man of only 30.

I had great hopes of getting him past June the following year without a further acute bout of bronchospasm, but this was not to be, and he was again admitted under your care in hospital.

When he came home he was, however, even more apprehensive about himself than ever before, and I now feel sure he would have benefited from some form of sedation to relieve his anxiety, though the problem here was that he was adamantly against taking anything other than what had been prescribed for him at the hospital. What changed this attitude somewhat was the development of a florid iodine sensitivity rash, which disappeared when I stopped his medicine containing it. I am sure this shook his confidence in the hospital treatment rather more than he admitted, because he then developed all sorts of symptoms which he refused to accept until they had been thoroughly investigated. Thus he needed to see our ophthalmic colleague because of spots in front of his eyes, he was convinced he had developed bilateral ruptures, and in fact my very last comment on his notes states "thinks everything is the matter with himself." Perhaps he was right, because he was dead three weeks later.

If we could have successfully relieved his anxieties for just a few weeks during this last year, I think he would have had quite a different attitude towards his condition; as it was, we never really won, once he began to have his recurrent attacks of asthma, and he knew it. Nevertheless, I am convinced as a result of studying him, that the creation of confidence in our asthmatic patients is enormously important, and this is now the most important aspect that I, as a general practitioner, strive to achieve in the treatment of patients who have this particular condition.

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Dear Frank,

It is unfortunate that there is not more time to review our patients with our general-practitioner colleagues. I am sure we would each learn a great deal and be better doctors as a result. I am still not certain where we went wrong in the management of this patient. When I first saw him as an outpatient I started him on steroids, beginning with prednisone 10 mg three times a day, and reducing by 5 mg every five days, thus tailing off this therapy. It did work, but only for a little while, and I had to have him in hospital on three occasions before the end of the year. These were really one continuing episode of exacerbation

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of his asthma. It ran a course typical of many patients admitted to hospital for their first severe exacerbation. Anxiety, personality, allergy, and infection were all factors. Our failure to relieve his symptoms promptly resulted in increasing lack of confidence in his medical attendants and in his own ability to recover.

The prompt relief of a patient's symptoms relieves the tension and anxiety of those who surround him, whether relatives at home, or the nursing and medical attendants in hospital. The patients who are not anxious and exhausted respond more easily to the treatment of the other contributory factors such as infection and allergy. Some patients have a robust personality or are less sensitive to the terror and discomforts of an asthma attack and go through life determined to fight it out, losing little time from work or recreation, whereas others seem to find in their asthma a ready escape from the realities of life. I think our patient was one of the latter. While in hospital *Candida albicans* was repeatedly isolated from his sputum and thrush lesions appeared in his mouth and throat. It was not until this cleared after treatment with nystatin, both orally and by inhalation, Natamycin inhalations, and potassium iodide mixture that his asthma really began to improve. *Candida* was not isolated again until his last admission. I consider this infection was a contributory factor to the persistence of his asthma throughout 1966 and his relapse in late 1967. Incidentally, he gave nil reactions to all allergy skin tests except to intradermal *Candida*.

While out of hospital it appeared to me that his asthma had been controlled. I was therefore surprised to learn that you had such a difficult time with him. At his fifth and last admission to hospital his personality had deteriorated considerably. He was withdrawn, apathetic, and depressed. Determined efforts were made by medical and nursing staff

to get through to him and enlist his interest and co-operation, but with little effect. However, the comments of the nursing staff on the day before the fatal weekend was "lethargic and unco-operative." In an attempt to relieve the situation and boost his morale he was allowed to go home for a few hours, during which time he was taken to the accident department. But he was found to be dead on arrival and a postmortem showed that he had had a pulmonary embolus. His determination to live had gone by the first day of his last hospital admission and no drug or other therapy would have saved him.

We must obtain and keep our patient's confidence from the first attack of asthma for which our help is sought. With the drugs now available—steroids, corticosteroids, disodium cromoglycate, antibiotics, a bronchodilator given with a positive pressure respirator (either given separately or together as appropriate and in adequate dosage)—most attacks of asthma may be relieved in a few hours. The treatment may have to be repeated, but if the attacks are short-lived the patient's confidence is maintained. Many patients are timid about seeking early advice and many doctors are hesitant about using adequate amounts of drugs, particularly steroids.

Glossary

<i>Franol</i>	containing ephedrine hydrochloride, theophylline, and phenobarbitone.
<i>Choledyl</i>	Choline theophyllinate.
<i>Alupent</i>	Orciprenaline.
<i>Natamycin</i>	Pimifucin.

Medical History

Medical Teaching in St. Andrews University 1413-1972*

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By the Universities (Scotland) Act 1966 the University of St. Andrews ceased to hold qualifying examinations in medicine and to grant degrees in medicine other than to students who matriculated before the appointed day. The last medical graduation takes place this year. Up to 1862 St. Andrews granted 3,375 doctorates in medicine—a remarkably high proportion of British medical degrees at that time. The M.B. was introduced in 1860 but few took this qualification until clinical teaching started in Dundee in about 1900. Thereafter more than 3,000 students qualified M.B. St. Andrews and a proportionate number of higher degrees were awarded.

*An abridgement of a paper for the occasion of the last medical graduation at St. Andrews, 30 June 1972.

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Papal Bull

Medical teaching under the aegis of St. Andrews began with the original foundation of the university, ratified by a bull issued by Pope Benedict XIII from Avignon in August 1413. It was decreed that the "studium generale" should include "Theology, Canon and Civil law, Arts, Medicine and other lawful faculties." This mediaeval organization, based on that of the University of Orleans, was to consist of students and masters. Some of the early masters may have professed medicine, but at first teaching was sporadic and probably linked more with astrology than with clinical practice. Although the ecclesiastical foundation most certainly offered some accommodation for the sick, in general there was more interest in the soul than in the body.

In the mid-fifteenth century William Schevez, who had been a student at St. Andrews, returned as a doctor of medicine of Louvain. He rose successively to Archdeacon in 1474 and to Archbishop in 1478. He was physician to James III but whether or not his episcopal and political activities gave him time to teach medicine is uncertain. He did at least found a library, and one of his medical books survives. It was not unusual for a high