MILLER'S TALE

In flagrante delicto?

It was 2 am and the young man lay on the "crash" trolley with blood pouring from his nose and mouth, and cardiopulmonary resuscitation was under way. The "crash" team—including myself, as a rather naive preregistration house physician—was doing badly. Two peripheral lines were in place and plasma expanders were being squeezed in. Despite this, his blood pressure was falling, and every attempt at intubation was met with a wall of blood—and we were all covered in it. The patient—from the casualty card record—had first presented to the casualty department the day before. Speaking little English (he'd arrived in United Kingdom only a few days previously in order to study English at a language college) he had described some chest pain, possibly retrosternal and also possibly related to food. The casualty officer had prescribed some antacids and, as the patient had not yet got a GP, he had also arranged an outpatient appointment with the gastroenterology team. The onset of haematemesis—or was it haemoptysis?—at 1 am, had prompted the patient to walk the half mile to hospital. On arrival in casualty he'd had a massive bleed and "arrested." In spite of a prolonged attempt at resuscitation, an asystolic arrest was the agonal event.

A call to the coroner's office later that morning confirmed that a post mortem was necessary. Thirty six hours later the coroner's pathologist rang me. From the conversation (which was frosty, one sided, and depressingly long), I learned that the patient had died of a massive bleed caused by tuberculosis of the lung, which had caused a ruptured right pulmonary artery. I further learned that I should have been able to make this diagnosis in life!

Being a preregistration house physician I was used to being the "mushroom" in the system (you know, they kept me in the dark, fed me on "s–t," and expected me to deliver the "product"), so I thought nothing more of the conversation. The remaining two months flashed by—I was on my knees and utterly exhausted by the end of the job. The holiday—all 10 days of it—was spent getting up at lunch time and going to bed long before Trevor MacDonald appeared on TV each evening.

I arrived at my next job full of fear and trepidation—and still very tired. This was my first SHO post, my first job outside London in an eponymous hospital in a south of England provincial town, and the registrar was off on long term sick leave. All this added up to the "down" side of the job. On the "plus" side was the presence of the excellent and attractive preregistration house physician. She was known to all as "Dr D."

In every hospital in which I have worked there is always one person who should be avoided at all costs. In this case it was the night nursing officer—a fearsome woman in her late 50s, with a look that could wither a consultant at 50 yards (not that you would ever meet a consultant in the hospital at night!). She'd creep around the hospital like something from the afterworld. The only way you knew that she was there was if you heard her "sniff"—delivered in an imperious fashion. This signified her disapproval and invariably coincided with your own rapidly evolving feelings of inadequacy and embarrassment—regardless of what, and how competently, you were doing something!

It was the weekend from hell. I'd only been in post for a couple of weeks, still no registrar, and every GP in the district sending in the great and the good for possible admission. By Sunday evening both the preregistration house officer and I felt like we'd been living in casualty for the last couple of days—never quite clearing the queue of patients. I was so tired that I was beginning to imagine rats jumping out at me from under the casualty trolleys (this must have been a hallucination?). I was also worried that despite sleeping soundly on my nights off duty over the last week or so I was still very tired each morning: I also had a vague headache that would not shift, despite paracetamol. My occasional sweats, particularly at night, I'd ascribed to the unusually warm and humid weather in September.

By 2 am I had admitted the last patient and headed off around the back of the casualty department, to the staff room, for a well earned cup of coffee. Kettle on, granules in cup, someone else's bread in the toaster—bliss! I flopped back and lay on the sofa. My eyes were leaden and about to close, when I felt something scratching me in my right armpit. What was it? Another GP referral letter stuck in my pocket? Nothing was there. I sat up and the sensation went away. Lying back the sensation returned. Off came my white coat and I undid the buttons of my shirt. Sliding my stethoscope around my right side I heard it: a creaky noise—just like the sound of walking on freshly fallen snow. Bloody hell! I had a pleural rub. Stethoscope still in place I sat up, and the noise disappeared, only to return as I lay back again. Being a typical doctor I needed a second opinion. Now!

"Deus ex machina"—Dr D was walking into the staff room.

I rapidly explained my predicament. "Basically, I am male, neurotic (no gender association), and I'm sure I have a pleural rub." Dr D got out her stethoscope and came towards me. Leaning forward, which involved putting her knee on the sofa, just next to me, and also defying gravity, she slid the stethoscope around my back.

"Oh" she said, "I can definitely feel something."

Yes. You've guessed it: at this point there was a loud "sniff" from the doorway. I was caught in the act. My increasingly agitated explanations as to why Dr D was apparently lying on top of me, and my state of undress, were met with a stony silence. The night nursing officer, unlike me, clearly had the ability to contact my consultant at night. Fifteen minutes later he was there in the casualty department. A world first! An allusion to "gardening leave" was met with incomprehension on my behalf—as at the time I lived in a second floor flat in Stockwell. Thankfully, sense prevailed and my consultant examined me. He rapidly confirmed the physical signs, and a chest radiograph confirmed a pleural effusion. Dr D and I were off the hook—for the moment.

Two days later I had a pleural biopsy, using an Abram's needle. Let me tell you, this needle does not cut—it rips. During the biopsy I fainted. The good news was that this veterinary procedure resulted in a diagnosis of tuberculosis. I began six months of treatment and was cured.

Twenty two years later and what have I learned? Am I really any the wiser? You bet! Why do you think that I demand the presence of a chaperone (who is invariably the patient) when I am in the same room alone with the female SHO!

Rob Miller
rmiller@gum.ucl.ac.uk