Experience

Expérience

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This is the first of a pair of articles by Dr. Bayne on the 2 faces of tuberculosis — that seen by the physician and that seen by the patient.

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I'm afraid it's bad news

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Although tuberculosis is becoming more prevalent, most Canadian physicians probably have little experience with it. When I was growing up in Quebec over 50 years ago, tuberculosis was common, even among young people. A positive Mantoux test was just a sign of maturity.

After I graduated in medicine from McGill University, I opted for a first-year internship in internal medicine. This consisted of 6 specialty rotations of 2 months each and included a period at the Grace Dart Hospital in the east end of Montreal. Now a long-term care facility, at that time it was designated for the active treatment of tuberculosis, and especially for surgical interventions.

Some patients were given a pneumothorax, the injection of air into the plural space to collapse the lung, or an experimental treatment of placing glass balls in the pleural space — both of these with a view to putting the lung "at rest." As there was no antibiotic therapy, all treatment was based on the concept that by minimizing the movement of the lungs, and of the body through rest, the tubercles would be contained and held in check by scar tissue.

Collapse of the lung was not successful, however, if inflammation of the lung had caused adherence of the pleural surfaces. Thoracoplasty was then recommended — that is, the cutting of the ribs anteriorly and posteriorly so that the rib cage fell in on the lung, preventing its expansion. Seven or 9 ribs would be cut, usually only on one side, since bilateral thoracoplasty severely reduced air exchange. The operation successfully restricted lung movement, but the efficacy and effectiveness of the treatment were limited.

The side effects of thoracoplasty were severe. Apart from the risks of surgery in patients with advanced disease, fever and (as was often the case) poor nutrition, recovery was slow and painful. Only the most determined person was able to regain a full upright posture, most were left with a hunched gait, and all had, of course, a deformed chest wall. Because of the risks of surgery, the procedure was usually performed on young people.

Consultants from McGill visited the Grace Dart Hospital once a week to advise on whether surgery was indicated; they reviewed the radiographs and the course of the illness, but usually did not see the patient. The surgery was performed the following day. The surgeon, who was also the medical director, left the hospital each day at about 5 pm, leaving the intern in charge during the night and on weekends. On the first day of my rotation I arrived in the afternoon, after the conference was over. The classmate I was replacing took me on a tour of the hospital. He was in a hurry to get away, but he explained my duties carefully. Our tour included the patients. There was a male and a female ward. All beds were occupied, and there was a waiting list for admission. Most of the patients were young, some in their teens.

As we entered the female ward, all faces looked up. There were 2 rows of young women, dressed in frilly nighties, their hair stylish, their cheeks flushed with fever and touched up with make-up and lipstick. They were expecting visitors: boyfriends and young husbands whose interest in them had to be maintained despite this illness and the long separation it caused.

My classmate and I were both inexperienced in the subtleties of human relationships and the skills of communication. He had a message to relay from the medical conference. Calling across the ward to one of the women, he said, "You're for it tomorrow… thoracoplasty," and we turned to go. But not so fast that I missed the flood of expressions that crossed her face. The collapse of hope, the fear, the reality of what lay ahead for her, were all evident. She sat on the bed and stared at us. We turned and closed the door. ❦