his social circumstances are unlikely to change, so it is probably wiser to refer him to the surgeon and not to attempt medical treatment.

Gastric ulcers have a tendency to recur, and the prevention of this tendency is the most difficult and frustrating aspect of the management of the disease. So far, no drug has been marketed which will lessen this tendency. It is possible, however, that the recurrence rate could be reduced if a careful search for the factors which precipitated the development of the ulcer in the first instance were made, and if the patient could avoid these in the future.

REFERENCES


Personal Experience

L. SCHAMROTH

SUMMARY

Three attacks of infective endocarditis with consequent emergency surgery to the aortic and mitral valves leave their mark. These are the impressions of a physician at the receiving end of his medical environment, an experience which entailed 4 periods of hospitalisation in 2 hospitals.


Clinical observation is always a fascinating exercise, and no less so when the observation is directed at oneself. The following, in particular, left an impression.

PERSONAL OBSERVATION

Clubbing of the Fingers: A Method of Assessment

The recognition of finger clubbing dates back to the original observation of Hippocrates. Yet, early clubbing with 'filling in' of the nail bed is often difficult to evaluate if the finger is viewed in isolation. I found that the assessment of my own clubbing was facilitated by the simple expediency of placing together the dorsal surfaces of the terminal phalanges of similar fingers — particularly the ring fingers (Fig. 1). In the normal individual, a distinct aperture or 'window', usually diamond-shaped, is formed at the bases of the nail beds (arrow in diagram A of Fig. 1). The earliest sign of clubbing is obliteration of this 'window' (diagram B of Fig. 1).

Fig. 1. Diagrams illustrating (A) normal finger contour, and (B) clubbing of the fingers.

Another aspect of clubbing which becomes evident from this manoeuvre is the formation of a prominent distal angle between the ends of the nails. This angle is normally minimal, virtually non-existent, and does not extend more than half-way up the nail bed (diagram A of Fig. 1). Clubbing manifests with an abnormally wide and deep angle which extends more than half-way up the finger nails (arrow in diagram B of Fig. 1). In my case, the 'window' reappeared 2 months after the infection had been
controlled, but the distal wide and deep angle is still present 8 months after control of the infection. This clinical sign obviously requires further scientific evaluation (size of aperture and duration of obliteration, size and duration of the abnormal distal angle), and I hope that someone will take it from here.

**DYSPNOEA THRESHOLD**

Some 10 weeks before the crisis, and immediately before embarking on an overseas trip, I developed a very persistent non-productive cough with pinpoint tracheal irritation. This worsened in London, and since I well knew that left ventricular failure could present in this way, the thought occurred to me that this might, in fact, be the case. However, I dismissed the notion as impossible, since I experienced no breathlessness whatsoever. The cough and ‘tracheitis’ persisted while I was in Israel, and I once more dismissed the notion of left ventricular failure as impossible, for I again experienced no breathlessness and was able to perform such feats as snorkelling in the Red Sea, negotiating the 100 or so steps from the upper cable station to the top of Masada, and climbing several flights of hospital steps without any difficulty. I only became conscious of difficulty with breathing during the 24 hours immediately preceding the operation. Postoperatively, however, the relief was such that it became abundantly clear to me that my breathing had been impaired for the 10 preceding weeks, despite my ability to undertake the physical endeavours outlined above, but that I had been unaware of it. Indeed, I soon realised that I had been functioning at a below-par physical level for many years, and had accepted it as the norm. There had clearly been an adaptation to a rising threshold of dyspnoea, and I only became aware of this retrospectively. This is probably analogous to the adaptation of a patient with pernicious anaemia to the steadily progressive anaemia, or the adaptation of a patient to an error of lens refraction, of which he becomes aware only when he uses spectacles for the first time, and incredulously realises his past handicap.

**CRISIS**

The Question of a Second Opinion

Clinical deterioration was so rapid during the 24 hours preceding the operation that I was advised at 16h30 to have the operation that very evening. I was also offered a second opinion, and categorically rejected this. Well-meaning friends have since asked me why I did not seek a second opinion, and I have as a result reflected considerably on the role of the second opinion.

There is no doubt that in clinical cases which do not constitute a surgical emergency, the advice of a colleague or colleagues may at times be profitably sought. Specialised experience in a particular field or aspect may make such advice invaluable and reassuring. I wonder, however, whether this is so in the case of a surgical emergency. Under this circumstance further opinion may possibly be contra-indicated, and could even be potentially hazardous. Assuming that Dr A advises operation and Dr B does not, does Dr C’s advice then become decisive. Is there a majority vote in such a case? Clearly not. Furthermore, the resulting procrastination could constitute a distinct hazard. One of the most reassuring aspects of the whole experience was the knowledge that I had the advice of an outstanding and vitally concerned cardiologist, who had painstakingly come to the conclusion that an emergency operation was necessary. I had no hesitation in accepting his judgement, the correctness of which was amply confirmed by the subsequent haemodynamic and anatomical findings.

**Surgery**

The Cardiothoracic Surgery Department of the Johannesburg General Hospital Group and the University of the Witwatersrand is centred at the J. G. Strydom Hospital. My recollections of the surgery are of necessity confined to the immediate pre- and postoperative periods. I did, however, obtain a fairly good impression of the whole procedure from medical colleagues and from my son, who is a doctor. The juggernaut of technical complexity associated with an open heart operation was put into emergency procedure with an almost ‘casual’ routine efficiency, such as comes about only through carefully planned, highly competent, and much-practised repetitive teamwork. Routine it certainly was. I believe that I was the 94th patient thus far (10 July 1975). In the drama of a major operation such as this, one could possibly overlook the so-called associated ‘trivia’. I refer to the cheerful, infectious confidence inspired by the Chief Surgeon, when he conveyed to me that the operation was routine, and to his kindness in telephoning my sister-in-law and conveying the same confidence. These so-called ‘trivia’ loom large in importance when one is at the receiving end.

I firmly believe that the tone of any institution, department, school or business, etc., is dependent on and determined almost entirely by its head, and the Transvaal Provincial Hospital Service and the University of the Witwatersrand are indeed fortunate to have a Thoracic Surgical Department and Postoperative Intensive Care Unit (see below) of international calibre. I am quite certain that had I been given 3 months’ notice of an elective procedure, I would not have had it done anywhere else in the world.

**Intensive Care**

I had hitherto been under the mistaken impression that intensive nursing care largely involved an added expertise of electronic gadgetry. How wrong I was. I was soon to learn that intensive nursing care meant precisely that. I had not realised that a few degrees in the angle of a pillow could make such a profound difference. Nor did I realise that the shifting of a virtually immobilised patient in and out of bed could be done with such consummate skill. Moreover, these nurses were obviously intensely — almost
emotionally — involved with their patients, and conveyed the very real impression that they cared. Lest anyone should remotely entertain the thought that my rank evoked the thought that my rank evoked Peretz.

It was also most impressive to note that the intensive care nurses could dispense such drugs as prewritten atropine, morphine, lidocaine and isoprenaline at their discretion, that they could measure blood gases and react accordingly, and could do such procedures as arterial ‘push-ins’. If nurses can be trained to this degree of sophistication, why in this country, where there is an acute shortage of medical practitioners, can they not be trained or discouraged from drawing venous blood samples, or always puzzled me why the nursing sister is prohibited from setting up intravenous infusions. It is paradoxical that the newly-qualified intern has had no specific instruction in this, and learns (on the patient) by trial and error.

CONVALESCENCE

Unsung Heroine

Physiotherapy begins the day after the operation. This consists of postural drainage with deep breathing against moderate resistance, encouragement to cough, and chest percussion. These procedures, when one has a split sternal, can be excruciatingly painful. Knowing full well that the physiotherapy was absolutely necessary (almost all patients have some basal atelectasis), that the procedure was scientific, and that it was for my benefit, and at all times co-operating to the utmost of my ability, I can yet recall the momentary resentment I experienced every time the physiotherapist entered the ward. How much more must this resentment build up in the untrained mind, which cannot appreciate the necessity for this refined, but vitally essential form of scientific ‘torture’. These physiotherapists perform their chores undaunted and with cheerful encouragement, probably receive very little praise or thanks, and are possibly even subconsciously cursed by the layman. Their efforts — largely unsung — are truly praiseworthy.

It would seem to me that for the elective surgical case, pre-operative briefing and physical demonstration of what is to be expected postoperatively would be of great value. I understand that this is already the case in some institutions.

Wheelchair Luxury

Gentamicin was part of my drug regimen, and regular audiometry was therefore necessary. The audiology clinic was in a building separated from the main hospital, and this necessitated a 5-minute wheelchair ride in the open air, both there and back. These two-way 5-minute excursions in the fresh winter air and away from the clinical atmosphere of the ward were indeed a treat. I often regretted that the clinic was not a little further away, so that the ride could be prolonged. If so minor an experience could engender a feeling of such appreciation, why should it not be enjoyed by many of the other patients who stay in hospital for prolonged periods? I do not visualise a mass exodus of patients during visiting hours, but an occasional wheelchair ride with a relative or friend would be a significant morale-boosting experience for the patient.

Visitors’ Gifts and Hospital Food

Any gift — be it even a simple handwritten note — is always appreciated. It is the thought and the gesture that count, and not the intrinsic value of the gift. If, however, the gift is going to be something edible, why must it almost invariably be a box of chocolates or boiled sweets, when there is so much the visitor can do to relieve the monotonous, insipid, lack-lustre quality of hospital food? Let me cite a few examples.

One of my sisters-in-law brought me a single freshly-baked warm buttered roll. What luxury! And how strongly it brought to mind the theme of one of the greatest of all short stories, Bontshe the Silent by I. L. Peretz. My other sister-in-law gave me a few tangerines (not oranges, which are difficult to peel). A very good friend brought a bottle of home-made beetroot soup — a favourite of mine. I deliberately mention the sources of these gifts because people less close might have been mistakenly embarrassed that such gifts were too mundane. How wrong they would have been! Some other such gifts which were, and could be given, are (diet permitting): biltong, strawberries, assorted small packaged cheeses.

Radio Programmes

As a patient, one is ipso facto a semi-captive of the radio. Even more so, since the blare of transistor radios belonging to neighbouring patients cannot easily be subdued. The first and most overwhelming impact is the appalling drivel that passes for entertainment on the commercial programmes; and one readily sympathises with Oliver Wendell Holmes when he writes that ‘... silence like a poultice comes to heal the blows of sound’. By careful study of the standard Afrikaans and English programmes, and by judicious juggling between the two, it is possible to obtain a measure of euphonious equanimity. The situation could, perhaps unkindly, be likened to the description by someone (whose name eludes me) of a Wagnerian opera: ‘Beautiful moments interspersed with awful half-hours’. This latter criticism of the Afrikaans and English programmes is probably a little unfair, but why can there not be a special transmission of continuous, uninterrupted, even unannounced music, featuring, in particular, the music of Schubert, Mendelssohn and Mozart (how I longed to hear the second movement of his 21st piano concerto), interspersed with music of the ‘Palm...
Court' type; a continuous broadcast in the style of the Sunday morning one-hour programme called 'Divertimento'. This would be of benefit not only to the sick and the elderly, but to all who wish to escape, and have some respite, from the cacophony of the modern megalopolis.

SOME ‘GRIPES’

The following in no way diminish my respect for, and admiration of, the excellence of our nursing profession. But:

(a) Why must the bedclothes always be so firmly tucked in at the foot of the bed, thereby inhibiting essential foot movement and effectively splinting the foot in the foot-drop position? The bed, of course, looks very neat.

(b) Why must there be the inevitable global 05h00 to 05h30 arousal of patients, irrespective of medication or other therapy? I was even, on occasion, hauled out of bed at this hour to be weighed! In heaven's name, why?

(c) Why is it that some nurses are able to administer deft, dart-like and painless intramuscular injections, whereas with others they are slow, painful, steady-pressure bores?

(d) Why must there be such a periodic clatter from the ward kitchen? This is a most disturbing experience if you are situated nearby. It would be of interest to measure, from a nearby ward, the decibels emanating from the kitchen immediately after lunch, when one is trying to catch a midday nap, essentially to make up for the 05h30 arousal.

(e) Why must the wooden chest board and X-ray film cassette holder invariably be so cold? A hospital admission usually necessitates an X-ray film of the chest, and placing the bare chest against this chest board — particularly in winter — is decidedly unpleasant. It would seem to me to be a simple matter to warm the chest board with an electric heating pad, which could be removed just before the radiological examination.

(f) Why can a depilatory paste not be used in the pre-operative preparation of the patient? One of my hospital admissions was for the excision of a fissure in ano, the suspected source of the infection. The pre-operative shaving by a ham-handed and crude hospital porter was decidedly traumatic — both physically and mentally. The razor cuts were still present 2 weeks after the operation.

INTROSPECTION

While I at no time experienced any real apprehension, depression did set in during the immediate pre- and post-operative periods. Having lost my wife but 8 months previously, having 3 of my 4 sons launched or almost launched on their careers, having made some contribution to academic medicine, and feeling, mistakenly, that there would be little opportunity or inclination to contribute further, and having the mistaken impression that one could turn out to be a potential cardiac cripple, there was a tendency to question whether it was really worth while carrying on. There was, in other words, a distinct tendency to ‘throw in the sponge’. But then there was the particular necessity to be both ‘mother’ and father to my youngest son, and the very real, very sincere, morale-boosting encouragement of my medical colleagues, relatives and friends. They were there when needed. And this is surely what it’s all about. It is good, and I am grateful, to be alive.

REFERENCES