FIFTY YEARS ON

a not so modern medical career

Harry Proctor, retired general practitioner

This is the first of two short reminiscences by Dr Proctor, who was a partner at the Stoneleigh Medical Practice in Milnthorpe until his retirement in the early 1990s.

Fifty years ago, to within a month or two, I was finishing my first house job. I was house physician on Unit M5 at the Manchester Royal Infirmary, and on reflection, arguably the happiest six months of my medical career, in spite of my take home pay of just over £18 per month, one half day off every five weeks, sleep regarded as a privilege, no holidays and very few weekends. Once a week, the house physician on M5 had to do a stint on call for any medical emergency arriving in Casualty between 8.00pm and 8.00 the next day. Here is an account of one very memorable patient and follow up!

The patient

I was asked to see an 18-year-old girl who was obviously quite ill. The story was that she had been 'off colour' for a few weeks, was losing weight and had a poor appetite, but over the past few days had started to vomit and was becoming at times drowsy and a little incoherent. She was pale and looked quite ill.

On examination, she had obviously lost some weight, had no rash, her chest was clear, heart sounds were normal, BP 100/65, no palpable liver, spleen or other 'lumps or bumps'. She answered questions slowly and rather monotonously, as if she 'could not be bothered'.

She was reluctant to bend forward, however, which I noticed on listening to the back of her chest. This prompted me to have a closer look for neck stiffness, but I could not convince myself that it was present. There were no other neurological signs that I could initially detect. The ophthalmoscope (the only medical instrument that I would never be without) revealed all. On one retina I noticed two pale oval-shaped lesions about 2mm wide and 4mm in length. Fortunately, there was no papilloedema but the diagnosis of miliary tuberculosis with TB meningitis was immediately obvious. She was very likely not to be infective and was admitted to the ward and, in those days, treated with streptomycin and isoniazid. After only a few days she was a different girl – actually an extremely attractive, vivacious asset to the ward!

The follow up

On duty that night as a surgical SHO was an extremely nice young man (affectionately known as Tubby). He was, I always felt, an academic rather than a clinician. He realised this himself and returned to medical school, where he eventually finished up as a professor of anatomy. I had lost touch with him for 25 years when I received a call one evening from his parents. They lived out of our GP area, but

Tubby remembered me from the Manchester Royal Infirmary. He had just returned from South Africa where he had been examining for the first part FRCS. He had arrived home not well and decided to visit his parents for a week to recuperate, but had unexpectedly become quite ill and asked if I would visit, which I did.

On my arrival, he admitted that he could not give me much history except that he felt 'bloody awful'. Whilst in Africa he had taken a week off to go on safari and had a great time, in the jungle and on the plains, watching wildlife.

On examination, I found nothing! I did the usual blood tests, FBC and ESR, tested his urine (no sugar, no albumen). I decided on my favourite treatment (masterly inactivity) and arranged to call the following morning with the blood test results from the path lab.

The next day he was more ill. He had a temperature, was dyspnoeic on exertion, had an unproductive cough and on examination there were rales in one lower lobe (I have forgotten which and cannot even remember on which side). His ESR was raised to about 30 and his WBC suggested an infection. His urine contained no abnormality. I started him on antipyretics and said I would call later in the day, which I did. He was by then really ill and volunteered the information that he had not passed urine all day, in spite of having drunk a lot of water, and also felt he had an empty bladder.

Hell's teeth! Pneumonia, renal shutdown, high temperature, darkest Africa; it all added up to be the Ebola virus or some such devastating import only known to readers of the *Lancet* or *The News of the World*! Within moments I was in touch with Dr AK Brown, consultant physician, who acted very promptly. He saw Tubby and ordered immediate transfer to a specialist unit at Crumpsall Hospital.

The sight of a special ambulance with ambulance men covered from head to toe in protective clothing must have been quite a shock to the neighbours!

However, things are not always what they seem. The diagnosis eventually turned out to be legionnaire's disease; the first and last case I have ever seen. I hate getting the diagnosis wrong! Happily, our professor made a full recovery.

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