Occasional essay

Everything old is new again

"Here's another beauty" John bellowed.

"Just add water to the canister containing calcium carbide, strike a match to the port at the top and an incandescent light is formed from the acetylene flame. Often used as a light in the early 1900's but now we use a torch with batteries at three times the cost. I guess that's progress".

John held his audience captive throughout the tour of his unique Birdsville working museum. Picking through the numerous items used in the early days by those who lived in the bush, he demonstrated to all how to make butter, heal wounds, trap flies, make candles and relieve headaches. All items were innovative, practical and cheap and all able to be made from components that appeared to be readily available from the outback.

One day later I was back at work. It was as though I had not been on a holiday. I was welcomed by an eternal number of letters, e-mails and faxes and was rostered on at the deep end of our group's clinical schedule. Moreover, within the first five minutes I was asked to see an 88 year old lady who 'needed to come to intensive care'.

The patient had been admitted to the accident and emergency (A & E) department, diaphoretic, cyanosed and struggling for breath. The diagnosis of pulmonary oedema seemed to be likely with her past history of ischaemic heart disease and a history of sudden onset of painless orthopnoea at 4 am that morning. A local medical officer who was called to see her recorded a pulse rate of 140 beats per minute, blood pressure of 200/120 mmHg and crepitations in all areas of her chest.

As I entered the A & E department the resident doctor rushed to show me a chest X-ray with apical venous congestion and interstitial and alveolar opacities, an ECG demonstrating sinus rhythm with a typical LBBB pattern and an arterial blood gas with a PaO_2 of 64 mmHg, PCO_2 of 58 mmHg and pH of 7.24.

"We have given her a 'GTN' infusion, 80 mg frusemide and 100% oxygen but she hasn't improved and I think she needs to come to you" the young doctor eagerly informed me. I probably smiled a little as I vaguely remembered the 'Gomer' in Samuel Shem's 'House of God'.

As I entered the bay to look at the patient, I glanced at the admission sheet and noted that she had not been given any intravenous morphine.

"You didn't give any morphine?" I inquired, and glanced up at the silence to see that I was alone with the patient.

I turned to the lady who was still struggling for breath.

"Mrs. Jones, my name is Dr. Worthley and I've been asked to see you regarding your breathing. In a minute or so I will give you something that will make you feel a lot better" I said attempting to put her at ease. She closed her eyes and just kept on gasping.

Suddenly, a nurse appeared. Before he could leave I said quickly,

"I wonder if you would draw up 10 mg of morphine and ask the 'resident' to come back please?"

After a few minutes, during which I examined Mrs. Jones to confirm the clinical findings, I was handed a syringe containing the required opiate. The resident doctor returned a minute or two later.

"What do you want me for?" he asked.

"The patient had not had any morphine so I thought that you may like to see its effect in acute pulmonary oedema" I replied, and without waiting for his response gave the patient the 10 mg as an intravenous bolus.

I looked up at the patient and said "In a little while your breathing will ease."

The 'resident' blinked in amazement. "I've never seen that done before" he blurted.

"That's a pity" I said "It's still recommended in the standard texts but nobody seems to use it anymore. I will be back in 10 minutes to see its effect".

I began to walk away with the 'resident' hurrying behind me.

"What happens if she stops breathing?" he said nervously.

"She won't" I replied and kept on walking.

"But if she does…" he implored.

I stopped and while feigning composure said quietly "I tell you what, we'll admit her to the ICU if you guarantee that you will come and see her in 30 minutes". I then turned and left.

Thirty minutes later, the 'resident' entered the intensive care unit to see the patient sitting comfortably in bed breathing oxygen at 4 L per minute through nasal canulae with a pulse oximetry recording of 96%. She was conversing easily and had not required CPAP or endotracheal intubation.

"I guess it's OK for you to use morphine because if they stop breathing then you can intubate them" the young doctor retorted.

"I've not intubated any one yet with acute pulmonary oedema who's been conscious and hypertensive and in whom I've given intravenous morphine." I explained and added, "I guess that it has happened, but it would be rare and you can see the effect morphine has had in this lady".

The 'resident' shrugged his shoulders and left, although I had a suspicion that this experience had left him none the wiser.

I began wondering about the fate of many of the 'older remedies'. Will morphine for acute pulmonary oedema be relegated to books about ancient medical therapies, in much the same way that digoxin for atrial fibrillation and penicillin for streptococcal infections seem to have been.

Suddenly, I thought of John at the Birdsville working museum.

"Doctors should file a class action lawsuits against the medical schools because of the flawed education they had received"

Lawrence Weed

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