Destroyed

Vidushi Rathi[1], Pranav Ish[2]

Once upon a time there was a disease called consumption. For thousands of years, it ravaged through lands, killing millions in its wake. This disease, also known as the white plague, was a death sentence until the advent of anti-mycobacterial drugs. While improved living conditions allowed the western countries to be nearly rid of it, consumption (now known as tuberculosis) continues to plague the developing countries.

As a medical student in India, one learns to keep tuberculosis as a differential diagnosis in most if not every case of chronic illness. There is no subject where it does not warrant special emphasis and no surer way to fail in undergraduate examinations than to get anti-tubercular therapy wrong. Despite its ubiquitous presence, to me as an undergraduate, this ancient disease never appeared terrifying – simply because it had an effective cure. As long as I was not dealing with multi-drug resistance, all I had to do was to treat the patient with the standardized regimen and all would be well – or so I thought – until I joined residency.

I was in the third week of my residency in pulmonary medicine, when I met Ravi (name changed), a 45-year-old gentleman, who was admitted in our ward the night before. He had presented with complaints of dyspnoea and productive cough of a few days and had had little to no relief in his symptoms. A quick history revealed him to be suffering from chronic dyspnoea and cough for nearly ten years with repeated exacerbations and hospital admissions. On auscultation, I found that like a badly tuned musical instrument, his chest was producing notes of varied pitches and frequencies. From polyphonic wheeze all over the chest, decreased intensity of breath sounds in some regions to amphoric breath sounds in other with a few coarse crepitations thrown in as well, his respiratory examination was a student's nightmare. Thoroughly confused, I took out his chest radiograph in hope of some clarification. With extensive fibrosis, bilateral cavitary lesions, deviated trachea, pulled up right diaphragm and a tubular heat pulled to right, there was nothing that was left normal in that X-ray. This was the first time I had seen an X-ray of a destroyed lung and I realized it was probably the only way to describe it. Ten years ago, Ravi had been diagnosed with tuberculosis and though treated, the disease left its mark forever. His diagnosis read, post-tubercular bilateral fibro-cavitary disease with destroyed right lung.

In my three weeks of residency, I had seen many cases of pulmonary tuberculosis, but I had not yet wizened up to what havoc even old treated tuberculosis could lead to. The emphasis in undergraduate teaching had been so much on effective treatment that somehow one did not fully register that all may not be well even after completion of treatment. Despite having ever smoked a cigarette, Ravi's clinical condition was not unlike that of an elderly patient with severe COPD. Ever since he was diagnosed with tuberculosis ten years back, he had been on a downhill course, despite having completed a full course of anti-tubercular regimen and having been declared cured. I realized then, that with tuberculosis, being cured is not the same as being healed. With damaged lungs prone to recurrent infections, airway obstruction only partially relieved with bronchodilators and corticosteroids, Ravi had become a regular visitor to our ward, so much so that my seniors knew his case history like the back of their hand.

Over the course of next few days, as we treated Ravi with bronchodilators, antibiotics and high dose of systemic steroids, his dyspnoea was significantly relieved but not without a price. Previously non-diabetic, he now required daily insulin to combat steroid-induced hyperglycemia. Systemic steroids spoiled his glycemic control but any attempts to taper

[1]Post Graduate Resident, Dept of Pulmonary Medicine, VPCI.

[2]DM Resident, Dept of Pumonary, Critical Care and Sleep Medicine, SJH and VMMC, New Delhi.

Correspondence: Dr. Pranav Ish, Dept of Pumonary, Critical Care and Sleep Medicine, SJH and VMMC, New Delhi.

E-mail Id: pranavish2512@gmail.com

Orcid Id: http://orcid.org/0000-0003-1701-4970

How to cite this article: Rathi V, Ish P. Destroyed. *Epidem Int* 2017; 2(4): 29-30.

Digital Object Identifier (DOI): https://doi.org/10.24321/2455.7048.201721

ISSN: 2455-7048

down steroids resulted in uncontrolled dyspnoea. Finally, after two weeks of meticulous management and delicate balancing of steroids and insulin, Ravi was stable enough to be discharged home but he was back two days later with fever and a new patch on chest X-ray, this time on left side. His sputum cultures were never positive for pyogenic or fungal organisms, neither were blood or urine cultures. However, empirical therapy seemed to work, and Ravi improved again. I was feeling victorious that I had helped him come out on the top, until the day he was supposed to be discharged.

I was swarmed in Monday morning OPD when I got a call from the duty nurse in ward. "Doctor! Come fast. You had advised bed 47 to be discharged, but he has developed hemoptysis and has become very dyspnoeic." I rushed back to the ward. There Ravi was, leaning against the wall, too breathless to speak, clutching a sputum container, half filled with blood. His family stood perplexed, a few feet away, their bags packed, all ready to leave the cubicle that had become their second home. By then, the duty doctor brought back Ravi's blood gas reports. He had developed acute type-2 respiratory failure and was soon shifted to ICU with requirement of near continuous, non-invasive ventilator support with high oxygen demand. By fifth day in ICU, Ravi started showing signs of psychosis. Always a mild mannered person, he now had to be restrained. Although I was not posted in ICU, his wife would always look for me for any update in his condition. One of the most cooperative relatives I had seen, she had always been by her husband's side taking care of him and informing us about any sudden deteriorations, but never bothering us unnecessarily. Every time I saw her outside the ICU, she would have her hands folded, her eyes pleading hoping I would give her some positive news and I realized how woefully unprepared a new first-year resident is to deal with such a situation.

Eventually, Ravi's condition improved and he was shifted out of ICU after eight days. But by now his family was drained – physically, mentally and emotionally. Exhausted, they took him home the same night, against medical advice and I cannot really say I blame them. He went home with his wife and kids and I have not seen him since. He never followed up in OPD and I do not even know if he is dead or alive. But what I do know now is that tuberculosis scares me much more than before. Never again will I be able to tell a new case of pulmonary tuberculosis that all you need to do is take complete treatment and you will be fine. One may get rid of mycobacterium but may never be rid of tuberculosis.

Date of Submission: 2017-11-15
Date of Acceptance: 2017-12-16