

my father, who was naturally quite upset by his attitude. After carrying out innumerable blood & urine tests, I was told to wait for the results. The only blood result given to me was the routine blood report. All the others were "lost"! I later discovered that the required blood tests were not performed at the hospital, & were normally sent to the Hammersmith Hospital. My blood samples never reached the Hammersmith.

On December 21st, my father decided to transfer my case to another doctor at a different hospital. The physician rather intrigued by the appearance of my tongue! (I remember being mildly amused by their interest in my tongue!) They also explained that my thyroid & parathyroid hormone levels would be checked, because elevated levels were sometimes found in association with a phaeochromocytoma.

On the 22nd of December, A CT scan of the neck & abdomen were done at the Cromwell Hospital. A tumour of the left adrenal gland was seen. No other abnormalities were noted. On the same day, I received the V.M.A. reports: the levels were high (These reports were given to me after a lapse of 11 days).

On the 25th of December, I was admitted to a private Hospital in London & treated with Phenoxybenzamine in increasing dosage for 10 days prior to surgery, the tumour being confirmed as a phaeochromocytoma of the left adrenal gland. The confirmation of a phaeochromocytoma gave me a feeling of relief, because now I knew the cause of my hypertension, & the other symptoms, & I also knew that surgical treatment was possible, & that I would in all probability be cured. During the last few days prior to surgery, a cardio-selective beta-blocker was also given, in view of my history of bronchial asthma. I had extreme nasal stuffiness & a dry mouth for the first few days, & noticed a tachycardia on the 1st night in hospital. I developed a significant postural hypotension during the 10 days pre-op.

The operation was performed on the 6th of January, '84. Following the operation, I was kept in the intensive care unit for two nights. My recollection of that period in hospital is somewhat hazy. I do recall that intra-arterial & intravenous lines were attached to my left wrist, & IV drip was attached to the right side of my chest, I had a nasogastric tube, & was catheterized. I also had an oxygen mask on my face, which, for some inexplicable reason, I kept trying, without much success, to pull off.

I was taken back to my room on the morning of 8th

Jan. During the two days in ICU and for another day in the room, I was given Omnopon I. M. for pain. That night I was given a tablet, DF 118 (Dihydrocodeine) for pain. I did not get much sleep for the rest of the night, due to what I thought were nightmares. The next day, I was again given DF 118: this drug did not suit me, & I felt very strange the whole day — it was like a dream state: I imagined conversations with people who were not there, I thought I was watching television when in fact it was switched off & so on. When these effects were off, I complained about them, & DF 118 was discontinued. I was told these side effects were common in people connected to the medical profession!

The rest of my stay in hospital was by & large uneventful, except for bouts of nausea & flatulence (which was to be expected following major abdominal surgery), & a mild urinary infection, which was treated with Septrin. I was very impressed by the hospital, my doctors, & the nurses, who were extremely efficient & kind.

I was investigated post-operatively as an out-patient at the Hammersmith Hospital where they told me that they were going to do an ethanol stimulation test for calcitonin levels. This entailed fasting for 8 hours before the test. I was given vodka in orange juice & was told to drink it within 2 minutes. Blood samples were then taken immediately before, & on consuming the ethanol, and every 5 minutes thereafter for 20 minutes.

I was extremely relieved when all the results were normal.

I will be obliged if you will publish my letter as it gives some insight into the feelings and reactions of a patient to the side effects of drugs and the attitudes of doctors, the apprehensions of a medical student who is uncertain of his diagnosis and the relief that follows a definite diagnosis.

Yours sincerely
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Letters to the Editor

Biography of an illness — Phaeochromocytoma.

Dear Sir,

I am 24 years old and enjoyed good health until June '83, at which time I started getting occasional severe headaches, which persisted for a few hours at a stretch. These headaches were not relieved on taking Aspirin. My blood pressure was checked & found to be abnormally high — around 150/100 mm Hg. At this time I did not attach a great deal of importance to the hypertension.

On 6th June '83, an E.C.G. was taken and found to be normal. A routine blood and urine examination revealed nothing abnormal except a raised cholesterol level. A urine V.M.A. was also done and was found to be normal. At that time, since the hypertension was attributed to stress & anxiety, (I was going through my exams) I was given an anxiolytic (Frisium) twice daily, till the 5th of July. Thereafter the symptoms disappeared.

In late October '83 the generalised headaches started again, sometimes throbbing & sometimes constant. I found that I was feeling tired very easily. My blood pressure was checked twice or thrice daily for a week and was found to fluctuate between 135/85 and 170/100 mm Hg. An I.V.P. & hypertensive I.V.P. were advised. The thought of an I.V.P. made me quite apprehensive, perhaps because I was afraid of what the results might show up.

On 12th Nov. '83, at 9.00 A.M. the I.V.P. was done. Before the test, my B.P. was recorded to be 135/85 mm Hg. Solucortef was injected intravenously before the iodine dye in view of my history of allergy. I did not react to the test dose. Immediately after the dye was injected, I complained of "feeling funny", & my B.P. was found to be 220/130 mm. Hg. Diazepam was administered I.V. Thereafter I was taken home, & I went to sleep. When I awakened at 2.00 p.m. I had an extremely severe headache. The pain felt like a lot of hot, sharp knives slicing through the head. I had never experienced such severe pain before, & I was very frightened & depressed. Being a medical student

does not help — one tends to apply one's limited knowledge to come to a diagnosis, and comes up with some unnerving thoughts. I was given two tabs. Paracetamol 500mg, but these were ineffective. The dose was repeated six hourly, but the pain was not relieved for over 24 hours. Thereafter, my headaches, though slightly less severe than on the first day, recurred every day. The pain was of great intensity at times, & often woke me up during the night. I also had urinary hesitancy, though there was no dysuria or polyuria. I occasionally had palpitations, mostly at night. I also noticed tremors in my hands; these were not present all the time, & when present, were more noticeable when I used my hands; for example, when eating soup from a spoon most of it spilt before it reached my mouth. This was a very frightening and depressing experience, & I believe that these tremors were the side effects of methyl dopa. At this time I was taking the hypotensive drugs methyl dopa & captopril, the analgesic Paracetamol, & Phenergan 50mg at bedtime.

I was admitted to a hospital in London on 6th December '83, where methyl dopa was stopped, and I was given Metoprolol. I was also put on a vanilla-free diet, & underwent blood & urine tests at the hospital. I was growing rather disgusted with the seemingly endless blood & urine tests that were being done. The vanilla-free diet was also not to my liking, because the restricted items included chocolates, sweets, ice-cream, desserts, cakes, nuts, tomatoes, tea coffee, & cocoa. I myself was not eating cheese & eggs, because the raised cholesterol levels found in June were playing on my mind. I did not want to be a candidate for atherosclerosis.

An ultrasound scan revealed an enlargement of the left adrenal gland. I was discharged from hospital on 16th of December. Even though I was in the private wing of a hospital, I was treated in many ways just like a non-fee paying patient. There was too much red tape involved, & my physician was too busy to even talk to