Please give generously …

Michael Norell

Consultant Interventional Cardiologist and PCI Programme Director, The Heart and Lung Centre, Wolverhampton, WV10 0QP

(Michael.norell@rwh-tr.nhs.uk)

We continue our series in which Consultant Interventionist Dr Michael Norell takes a sideways look at life in the cath lab…and beyond. In this column, he reveals the true impact of a disease that ravages victims in their millions.

This article is devoted to a condition that has, for far too long, been ignored by the medical profession, the media and the public. Having just survived a skirmish with this disease entity I feel more than qualified to write on the subject with an unparalleled degree of authority (which makes a change, I hear you say).

I refer of course to what is colloquially referred to as 'man flu'; named properly as *Influenza Hominis Gravis* or more commonly, IHG. The somewhat light-hearted way in which this illness is perceived by at least half the population (i.e. females) only adds to the professional, social and domestic impact of the condition.

Symptoms

The initial symptoms may be trivial; a nasal tickle culminating in the odd sneeze, the sensation of a fishbone caught in the back of the throat and a subtle perception by the soon-to-be future victim that all is not well. The subsequent natural history is all too familiar: runny eyes and nose that threaten the individual's fluid balance, uncontrollable sneezing and a more than usual reluctance to go for the habitual evening jog.

It is at this early stage (now technically referred to as 1b) that the merits of the rather old-fashioned handkerchief start to be realised. The absence of this fashion accessory means that we can no longer rely on the trusty ally up our sleeve or (thankfully) flamboyant extrusion from the top pocket of our suit jacket. Instead, any piece of absorbent material is pounced on: a newspaper, paper towel or tablecloth, or – if scrubbed up in the lab – the hem of a sterile gown (your own, ideally) or failing that, a gauze swab.

But this is just the beginning. This prodrome of 12 to 24 hours, which leaves the eyes red and the sides of the nose raw as a result of constant dabbing, is followed by stage 2, which comprises profound systemic upset. This is manifest as unusually heightened skin sensitivity, the odd muscular ache and, of course, pyrexia paradoxus.

The last of these is a well-recognised feature seen in a number of maladies: the prostrate sufferer places a palm on his forehead and knows full well that his temperature is raised. However, when traditional clinical methods are used to detect and confirm pyrexia, they fail to do so. The mercury thermometer, now discarded on the wards but still available in the home sideboard drawer, advances its silvery column no further than 36.5 degrees despite being steadfastly – and uncomfortably – held under the tongue for at least 20 minutes. The more modern devices on our wards (which I initially thought were telephones) are also too insensitive to detect any abnormality. This must seriously bring their clinical value into question.

Kill or cure

It is at this juncture that congestion supervenes and remedies of all types are exhibited. Vasoconstrictor nasal sprays are squirted repeatedly up one's 'shnoz' (anatomical term), and paracetamol in various forms is consumed in abundance. The most useful agent is Norellolol (patent pending and not yet CE marked): a combination of Lemsip, with added lemon juice, honey and tincture of Aqua Highlandia – or Johnny Walker Scotch whisky. (N.B. In the absence of randomised trial data, its use in this context is on compassionate grounds only and therefore must be regarded as 'Off Label', whether Red or Black – the whisky, that is).

The next, and more worrying, phase is one of delirium. The sufferer lies awake at night considering all the other possibilities that their symptoms and signs might represent. For us as cardiologists, endocarditis – of some form or other – is top of the list. If not culture-negative then the most probable causative agent will be a fungus or L-Form; the rarer the infection, the more likely we've got it.

We might breathe a sigh of relief that we do not work in other specialities in which such features might prompt even more lethal diagnoses to be considered. Even so, when we take our

own pulse and find it inappropriately slow given our poor condition, raised intracranial pressure or typhoid fever spring immediately to mind.

This phase is short and lasts until the next morning, when we notice with some relief that we are still alive. But worse is to come.

Social consequences

The domestic impact of IHG is now at its height. Mundane, day-to-day tasks become perceived as impossible. The dog cannot be walked, the dishwasher cannot be emptied or filled, and nappies cannot be changed. These are the sad – but hard – facts that underlie the devastating social consequences of this illness. It is now taking its toll on one's family and carers, who are showing the classic signs of sympatheticus exhaustus.

Nasal and sinus congestion progresses to a stage more like *concretion*, relieved only by the aforementioned sprays. As sniffing is now hydraulically impossible, ensuring that the active ingredients actually get to their target requires innovative thinking. One is left to drip these liquids into the offending orifice while in a suitable position to allow gravity to do the work, i.e. by hanging your head upside down and leaving it there for at least five minutes in order to allow for adequate tissue penetration.

Food and drink are only appreciated by temperature and texture. Coffee and tea are sensed merely as hot liquids, and as for wine ... don't even bother! In the absence of taste, eating becomes pointless and anyway the appetite is non-existent. (Weight loss is the only good thing to come out of this, by the way.) The syndrome is reflected in the sufferer's typical facies, now a cardinal sign of this malady and first described by Hippocrates as *Canis suspensio*, or 'hang dog'.

Crisis point

We are currently at stage 4a (or possibly 5c; mental obtundation is also a feature). This is sometimes referred to as the crisis point as recovery must now begin if the victim is to survive. Oddly, this process is often more rapid than when the illness was developing.

The prognosis is universally excellent and survival is 100%, but paradoxically it is also during this phase that the real tragedy of IHG becomes apparent.

Normality is resumed but an uneasy atmosphere supervenes as the patient returns to his usual activities. Despite its obvious seriousness, the lack of objective evidence of abnormality during the disease process itself is baffling. Similarly, the absence of any lingering clinical sequelae or signs of residual end-organ damage leaves the family in a state of denial. Even in retrospect, they fail to recognise the potential seriousness of IHG and just how close they came to losing a cherished partner, father and reliable source of finance. This lack of appreciation can produce a relapse culminating in a state of resento miserabilis; often worse than the original condition.

So much more research is needed but funds to support this are scarce. That is why your help is so important. No amount is too small; donations can be made by credit card, cheque or online...

Book review

Ischemic heart disease

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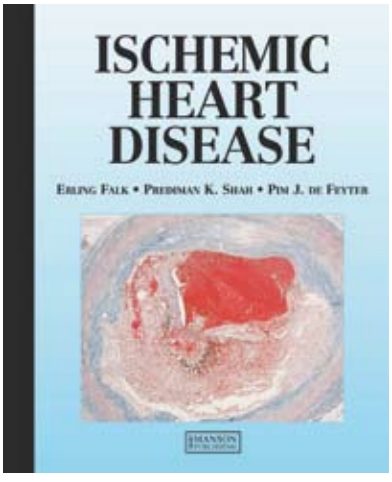

This book is aimed at cardiologists as well as more general medical practitioners wanting to improve their knowledge of this area.

The subject of ischaemic heart disease is very extensive and the authors set out to cover epidemiology, pathogenesis, investigations, diagnosis, treatment and prevention in a succinct and easily understandable manner. Topics are logically reviewed with all areas discussed in reasonable detail. This gives the reader the opportunity to gain understanding and an up-to-date knowledge of the subject. The illustrations and clinical images are of a high quality supplementing the various topics well, helping readers get to grips with complex subject material.

I especially enjoyed the chapters looking at investigations of ischaemic heart disease. The material here was particularly well set out. Starting with simple techniques, such as the interpretation of ECGs, the authors then go on to discuss more complex and newer procedures such as cardiac magnetic resonance imaging. In addition to a thorough review of clinical uses, potential clinical implications and possible drawbacks for the future are also considered critically.

In some places, however, the authors perhaps do not go into sufficient depth for the intended readership. This proviso notwithstanding, overall this book provides very good coverage of the subject matter. I can warmly recommend this book, on the one hand to cardiology trainees and clinicians who want to expand there understanding of ischemic heart disease, and on the other for all medical practitioners as an invaluable reference book.

Simon Duckett
SpR Cardiology
Department of Cardiology,
Southampton General Hospital