

Speaking for Myself

The Miracle-worker

PRABHA DESIKAN

In a country like India, which is endemic in *Mycobacterium tuberculosis*, work at our national reference laboratory for tuberculosis was in full swing. Samples were being received and processed; *M. tuberculosis* was being detected, isolated and characterized; laboratory reports—some bearing good news, and some bad—were being dispatched. It was like any other uneventful winter day. During a break, staff camaraderie was evident over piping hot cups of tea. There were jokes, bouts of laughter, weekend tales and generous amounts of ribbing. As chief of the laboratory, it was heartening for me to witness the companionship so evident in the group.

One young technologist, however, looked troubled. Noticeably quiet, her thoughts seemed far away, unconnected with the proceedings in the room. I wondered about her, but, as the day wore on, forgot about it. The next day, she sent in a leave application citing personal reasons. Concerned, I made a mental note to talk to her after she came back to work. During the day, she called up to speak with me. She said that her 16-year-old sister had not been well for over a month. Treatment by a physician near her home had not relieved her symptoms. The physician had eventually requested a chest X-ray. Then, on a radiological suspicion of tuberculosis, he had referred her to our hospital. She wondered if I could talk to the pulmonologist in our hospital and request for an early appointment.

This 16-year-old had fever for over 4 weeks. There were no other symptoms. With a tentative diagnosis of pyrexia of unknown origin, she had been investigated for various infectious and other causes of pyrexia. All investigations had drawn a blank. Away from school for more than a month now, febrile, with no appetite whatsoever, she was exhausted. Her parents were weary. Much as they loved her, there were her siblings to provide for. Finances were a concern. Resources were stretched thin. At this time, a follow-up visit to the local physician was scheduled. A noticeable loss of weight alerted him to the possibility of tuberculosis, even in the absence of respiratory symptoms. The chest X-ray was done which showed multiple miliary shadows.

It was, therefore, with a mixture of hope and trepidation that she was brought to our hospital. High-resolution computed tomography (CT) showed randomly distributed miliary nodules. Bronchoalveolar lavage was collected and sent to our laboratory. Acid-fast bacilli were seen on microscopy and a line probe assay confirmed the presence of a drug-sensitive strain of *M. tuberculosis*. She was started on antitubercular therapy and registered with the Revised National Tuberculosis Control Programme for free, regular treatment. In a few days, she was discharged from the hospital. Hope prevailed.

Our young technologist was back at work. She still looked concerned, but went about her work with a focus typical of her. One week down the line, she brought her sister back to the hospital with complaints of sudden shortness of breath. A chest X-ray showed a pneumothorax on the right side. An intercostal drain was inserted. The pneumothorax resolved, the drain was removed, and she was discharged in a few days. Five days later, she was back again, with pneumothorax on the left side. An intercostal drain was inserted on the left. A week later, during her stay in the hospital, she developed a right pneumothorax once again. She now had drains in place on both sides of her chest. Unable to change her position comfortably on the bed, she started getting a bedsore. Attempts were made to shift her position regularly with pillows. With gradual improvement of the pneumothorax on the left side, the drain on the left was removed. Mobility improved and the bedsore resolved. Ten days later, sudden shortness of breath prompted a chest X-ray and CT again. Bilateral pneumothorax was seen, massive on the left side, with a collapsed left lung. Multiple cysts and reticular opacities were visible in both lungs. The intercostal drain was back on the left side again. She was in pain and in constant need of medical attention, and was in hospital continuously for 2 months. The prognosis was going from poor to worse. Her pulmonologists explained the scenario to her family.

Our technologist worked day and night with her sister in the hospital. All this took its toll on her. She was noticeably tired, and looked thinner than before. She was also in close contact with her sister—a smear-positive case of pulmonary tuberculosis. I told her about my apprehensions regarding her susceptibility to tubercular infection. She said she would get herself investigated. It was obvious that she needed rest. She needed to sleep. She needed to take leave. However, absence from work for a long duration would have meant loss of pay. She could not afford that. Her mother had not been keeping well too. Other siblings needed to be cared for. At the young age of 26, she had seamlessly taken responsibility for home and hearth, siblings, parents, medical aid and income for the family.

Our hospital is a part of the public health system. Investigations and treatment are free for eligible patients. Our technologist was aware of this. Fortunately, her sister fulfilled the eligibility for free healthcare at our hospital. However, there was only so much that science, medicine and technology had to offer. With precious little viable lung tissue left, prospects of recovery were bleak.

Still, our technologist did not give up hope. One day, she asked me about lung transplant surgery. While I empathized with her desire to understand the available options, I was uneasy about the implications of my answer. Aware of her trust in what she viewed as my ability to provide her with informed guidance, I was apprehensive that she might offer to be a donor. Even so, I described the surgery, its potential benefits and possible

complications. I also voiced my doubts as to whether her sister could be a candidate for lung transplant, given that she had active tuberculosis.

After having heard me, our technologist looked distressed. The finality of it all seemed to have ultimately hit home. Even then, the possibility of losing her sister was something that she could not accept. Almost child-like faith in medicine and science, she wanted me to find out whether the pulmonologists had anything to offer. She seemed to feel that there might be something that the pulmonologists would be able to offer, if I, as a member of the medical fraternity, spoke to them instead of her.

I was certain that there was nothing else that I could reasonably expect the pulmonologists to have in their therapeutic armamentarium. But concern for her prompted me to indulge her, and speak with them. As I had already known, they had done their best. The disease process had destroyed most of her viable lung tissue. They had already clearly explained the bleak prognosis to her family, and they did the same to me, albeit in medical terms. They could only continue with antitubercular therapy, ensure nourishment, and ask the family to hope and pray.

Our young technologist hoped and prayed in full measure. Since there was nothing else on offer medically, she requested for early discharge, and took her sister home. She was incredibly confident that she could nurse her back to health. I had my

reservations, but the decision was hers. I was not certain about the wisdom of exposing the entire family to an open case of tuberculosis. Our technologist, however, felt that home, a familiar environment, and home-cooked food would make her sister brighten up. Free antitubercular therapy, through the National Tuberculosis Control Programme, was provided at home. She was advised to bring her sister for regular follow-up visits to our hospital. I wondered what the future held in store for the family.

As the days went past, my regular enquiries about her sister were met with an assurance that she was feeling better. Our technologist said that she brought her sister regularly for follow-up visits. Looking at her tired face, I reiterated the importance of protecting herself from the infection with *M. tuberculosis*. Five months went by. One warm summer morning, a young girl and her mother were waiting in the reception area. As our technologist walked towards them, I recognized her sister. She had put on weight—5 kg, I was told. A cheerful teenager, with twinkling eyes, there was no sign of the ordeal she had been through. She was still on treatment, and definitely recovering!

Over the years, we did learn that there is much more to the treatment of tuberculosis than timely diagnosis, appropriate therapy and adequate nourishment. Be that as it may, I could not help but wonder—was this a triumph of medical science; or a miracle wrought by filial love?

Attention Subscribers

The subscriptions for *The National Medical Journal of India* are being serviced from the following address:

The Subscription Department
The National Medical Journal of India
 All India Institute of Medical Sciences
 Ansari Nagar
 New Delhi 110029

The subscription rates of the journal are as follows:

	One year	Two years	Three years	Five years
Indian	₹600	₹1100	₹1600	₹2600
Overseas	US\$ 85	US\$ 150	US\$ 220	US\$ 365

Personal subscriptions paid from personal funds are available at 50% discounted rates.

Please send all requests for renewals and new subscriptions along with the payment to the above address. Cheques/demand drafts should be made payable to **The National Medical Journal of India**. Subscription amounts may be transferred electronically to State Bank of India, Ansari Nagar, New Delhi account no 10874585172, IFSC code SBIN0001536. Please send a scanned copy of the the money transfer document to nmji@nmji.in along with your name and address.

If you wish to receive the Journal by registered post, please add ₹90 per annum to the total payment and make the request at the time of subscribing.