

## life

# Back from the brink

*Managing to fool even colleagues, a physician's downward spiral toward suicide is interrupted by a chance event*

by Shane Neilson

SOMETHING WAS WRONG when I noticed our hospital's coffee-shop balcony looked like an attractive place from which to jump. I started taking occasional five-minute breaks from shifts in the emergency department to linger there, staring at the ceramic tile and potted plants of the terrace below. Toward the end I even had my tile marked: an off-colour one, its edges cracked. I ruminated on how far I'd have to jump in order to hit my spot.

I was a father and husband, a doctor and a writer; I was also very ill. But priorities were family first, medicine second, writing third and myself last. I took care of my daughter when I wasn't working; spare moments when not in the ER were spent in front of a computer screen, spinning something out of nothing. Through it all I remained productive: I continued to write and work. My schedule didn't permit illness; I couldn't fit it in.

I attempted a semblance of competence during my last shift. I saw patients in the cranky, backlogged ER. I can't remember the details of those clinical encounters: who I saw, what I diagnosed, who I sent home. What I remember is the feeling of release at the end of the shift, the freedom of escaping the hospital and the ledge that had a hypnotic hold on me.

I'd been suffering for a year, riding out the steep decline toward a bottom where my thoughts were slow, my sanity gone. Mere attendance at work became a superhuman effort. The numbers of patients I saw per shift began to dip, then plummet as I laboured over the simplest of decisions—what tests to order, what medications to give. My mind kept returning to the coffee shop balcony; sometimes I lost my train of thought to that place, my conversations tailing off. I got a lot of odd looks. Once automatic, the easiest of procedures now required great deliberation; I was a run-down automaton, alone with my broken parts. That no colleagues or other staff mentioned my deterioration isn't surprising, since I had even fooled myself, thinking I was fine and needed no help. But I did need help. Here is the symptom countdown:

**Mood:** For months a deep, darkening cloud threatened the mental horizon. At first it crept over my days, but soon it blotted out my entire outlook. Isolated bad days become streaks as neurotransmitters abandoned my synapses. My limbs were lead; each action came from a conscious exercise of will, always undertaken with the bleakest expectation.

**Sleep:** I slept in epic proportions, in elevators and on ward desks. I slept in cafeterias and cars, in the surgery lounge, in the locker room. I parented my daughter from our king-size bed. I woke up to go to work, and home was a posturepedic plain with plush pillows and duvet until I

had to wake up again. But sleep was a poor drug, for I felt no restorative hit, just a bottomless need that meant frequent trips to the mattress.

**Interest:** One by one my hobbies, activities and passions were dropped: jogging was the first to go, and next was television—my favourite shows fell in sequence. Then reading became a chore. Sex was the final casualty: I felt like a slug. The only interest that held on was appearance, but this was because of the disease's canniness. If hygiene were to deteriorate, the depression risked detection, so I showered, shaved and dressed neatly to maintain my disguise.

**Guilt:** I slept while my wife took care of our daughter and woke up to my general dereliction of duty. On days off I used to take my little girl to the park; at least I'd make a meal or wash the dishes. Now I presided over a neglected domestic empire. Mail piled up. Phone calls went unanswered. I turned inward, failing as a father, retreating further and further each day. Each task that went undone added to an escalating guilt that was second among my preoccupations. The first preoccupation was, of course, suicide.

I am glad I was oblivious to a factor that would have multiplied my guilt: the disservice I was doing the profession and my patients by continuing to work. Looking back, I'm lucky I didn't make any malpractice-worthy errors.

**"I wondered if a steering-wheel turn would be appropriately ambiguous and quick—a simple 'slip,' and the life-insurance policy would still be paid."**

**Energy:** I ran on diminished reserves. Fear—of losing my job, failing residency and ruining my home life—gave just enough of a kick to get me going and on my way to the hospital. Walking to the kitchen was an odyssey, to the hospital cosmic. In idle moments I had a mental image of a ponderous clock, hands impossibly slow and counting down the time before I could go to sleep again.

**Concentration:** My mind became compartmentalized, each section hopelessly alienated from the other. Thoughts got lost in my mind's bureaucracy. The language faculty seemed an impossible administrative distance from motor areas, and what I thought one moment wouldn't be the same as what I said the next. I registered this fact in a detached kind of way; to linger on why I couldn't say what I meant would be to enter the bureaucracy and get hopelessly lost again.

I used to be a great reader of newspapers, two national and one local, but trying to follow their narratives became an

exercise in blankness—zero retention after hours of trying. I could still write, but as I go over what I had written, I recognize large gaps in logic. The writing was meandering, Byzantine and often bizarre. Here's a choice excerpt:

*The baby sat quiet; the television flickered. Jake entered the room and decided he had better go to the store. He dressed and exchanged his tickets for some cigarettes. The noonday sun beat down on his head; he needed to cover the baby's eyes with his hands so she wouldn't cry. Probably hungry, Jake thought. I should go back to the store and buy her some food. . . .*

**Appetite:** I shed the weight packed on since medical school; minus 30 pounds,

my belt tightened to the point where I had to score a new notch so it would fit snug around my waist. Despite my gaunt and distant face, people complimented me on my looks. I preferred not to eat at all, and it became difficult to think up new excuses to avoid mealtimes and, when forced to sit down and endure meals, to secret the food off my plate when my wife wasn't looking. The only substance that passed my lips some days was black coffee—and I needed that as a stimulant, not as sustenance.

**Psychomotor depression:** My response time, which once was fast—I was the kind of student who practised suturing on an orange to be efficient, the keener who'd mock-intubate Laerdal dummies over and over to streamline technique—went to molasses. My impassive, sombre face reflected a general lack of body movement; my most effortful gesture was getting up from a chair. When in the ER I watched the chart rack deepen as torpor descended, responding to each patient

arrival in a decelerating slo-mo.

**Suicide:** The idea should have been abhorrent, but an adieu from this world became an obsession: I stared at bridges and high windows, I wondered if a steering-wheel turn would be appropriately ambiguous and quick—a simple "slip," and the life-insurance policy would still be paid. Increasingly, though, the balcony fronting the hospital coffee shop became my method of choice. I'd stand there, comforted just to be so close to death, and stare at the terrace's traffic underneath, wondering if it'd be right to plunge into their midst. Sipping a hot black coffee, I'd elect instead to go back to my shift.

I had all of the symptoms, or they had me. When did I seek help?

It sought me. I held onto the rails of the balcony with one hand and sipped a coffee with the other. Patients and families streamed below on their way to get blood drawn, to have X-rays taken, to the information desk. A few pregnant ladies were going for ultrasounds and obstetrical appointments. Smokers pulling I.V. poles headed outdoors. My chosen tile was clear.

My foot rested on the bottom rung of the railing. It was 8:20 a.m. and my shift was scheduled to begin at 8:30. I had 10 minutes to go to work. The clock above the information desk counted down.

A few minutes before the shift was to start, I noticed my wife and daughter come through the main doors of the hospital. My little girl carried a paper-bag lunch—I had forgotten it at home. I took my foot from the lower railing and walked down to meet them. I insisted we leave the hospital; I haven't been back.

It's been over a year now. To ward against depression descending again, I go over the symptom checklist every day, take my mental temperature and write down the subjective impressions on a chart. Soon, I'll be ready to return to work. Soon.

*Shane Neilson is a doctor now working in Erin, Ont.*



Joe Weissmann

## life

SPIRIT OF MEDICINE

Blind  
to all the  
signs

*Sometimes a doctor is so concerned with offering care and support, he misses the truth entirely*



Joe Weissmann

by William Hay

SHE WAS ATTRACTIVE in a raw, in-your-face kind of way. At other times, she was timid and demure. With flirty blond hair, her costume would be blue jeans with a frisky little tank top one day—the next, a business-like pant suit. She could be a variety of people; always engaging and intense. In many ways, she was a perfect psychotherapy patient; so co-operative. She kept all her appointments, at least at first. She shared her trials in an intimately engaging manner. Listening to her was a bit like being invited to read a person's diaries while sitting beside them, or look at the photo album of their recent trip.

I had diagnosed her as having an acute stress disorder when she first came to see me. She was clearly the survivor of sexual assault. A member of the military reserve, she'd been sexually assaulted in the back seat of a car returning from furlough to the city. I'd heard how the officer had used his hands and made crude comments. There was another officer with him and they were clearly obscene and disgusting in the testoster-

one-driven madness, coupled with the booze so prevalent in military settings.

The patient had bravely told me the story as I listened, taking notes and feeling such empathy and sadness at the tragedy she'd experienced. She'd just wanted to go into town and hang out with her mates. And instead they'd tried to rape her in the

psychiatrist in the Canadian health-care system, I didn't share the biases of the counselors and private psychologists. I was paid regardless of the diagnosis and never had to look for patients, since my waiting list was months to a year long.

I completed a formal consultation report that the military subsequently used in their disci-

### I had only begun to delve into her family and childhood issues when the latest assault occurred.

back seat of a car.

I was early in my experience with sexual assault victims. This was decades ago, before the law increasingly required the interviews to be taped. At the time "victim's compensation" legislation had made it possible for counsellors to be paid for providing services "only if sexual abuse" was found. Obviously, this was a conflict of interest but mostly people were concerned for the victims. In those days, only men were being accused. It would be years before anyone would know different. As a

plinary procedures on the men. My patient continued to see me for therapy after that. The men suffered serious consequences. Eventually, my patient left and took an office job in the private sector.

It was then that she was date-raped by a new boyfriend. This went further than touching. When she came to my office deeply traumatized by this appalling degradation, I encouraged her to file a complaint with the police. A policewoman who had been extremely sensitive and helpful with other patients

of mine came out to see her and charges were laid. The young man, however, left the country when he was accused. I don't remember what transpired after that, because it wasn't much later that she was forcibly raped by a fellow employee in the coffee room.

I'd only begun to delve into her family and childhood issues when the latest assault occurred. This young woman's childhood was fairly impoverished and her parents were mostly sick when she was growing up. She'd been made fun of a bit because she didn't have nice clothes.

The man went to jail. I think he was put on the dangerous sexual offender list that was being expanded around that time. It was originally conceived for pedophilia, which is generally thought to be a condition without treatment so public safety measures were thought appropriate until some proven effective therapy could be found or developed. I think also repetitive violent rapists were put on the lists in those days to protect the public safety while still allowing these individuals to be discharged from jails despite their high potential to

re-offend. It wasn't long before politics intervened.

The man in jail was sentenced to several years.

The whole matter was extremely devastating to my patient, who required a variety of antidepressant medications and anti-anxiety medications at that time. All this had happened over two years. Yet there was clearly literature suggesting that people who have been victimized once are at greater risk of being victimized again.

Indeed, when I was involved in a large group therapy process conducted predominantly by experienced social worker/group therapists, for female victims of rape, much of our work was on normalizing the women's reactions to allow them to avoid being identified by predators. We taught the women to laugh rather than cry when bullied, self-esteem exercises and even basic crisis self-defence.

My patient was also really very beautiful and sensual. She had a little girl quality about her, but her voice could take on a huskiness that was called "smoky" in old movies. And indeed in my practice, sexual abuse seemed to be more likely for the very attractive and the very disabled. The mundane seemed to be in the middle of the pack and less likely to attract problems.

I was glad my patient was still working and had taken a night school course to improve herself. I thought it was terrific that she had tried to date after her first horrendous experience. Often that's the hardest part of therapy, addressing the patient's tendency to generalize from one male rapist to "all men are rapists."

It was around then I received a phone call from the police. My patient had moved into a very fine apartment building with an excellent security system. She was living on the 5th floor but somehow a man had broken into her room and she'd been raped yet again.

The police wanted to talk to me in person.

Before I saw them, though, my patient appeared in my office utterly distraught and disheartened. It was a heart rending interview. She showed me the abrasions and bruises and I was inwardly furious that men would do these terrible things. All I could do was listen and prescribe a benzodiazepine. I had other patients, and my secretary had slipped her in before my next appointment who was already in the waiting room. An emergency appointment was scheduled for the next day. I remember giving her tissue for her tears, touching her shoulder

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# Wondering how I could have been a better doctor

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as she left.

The police officers came. A pair. They seem to travel that way. Big men in blue. They asked me about my patient. I could not speak openly because of issues of confidentiality. I'd told my patient that they were coming and as before, she was glad that I was going to "be there for her."

Except this time, the burly sergeant explained, "We answered her call to the apartment and searched the grounds for the assailant. But I'm afraid there doesn't seem to have been any assailant."

"What?" I responded.

"We've had a police doctor involved. He's examined your patient and her wounds are all self-inflicted. We'd never have known except the owner of the apartment building was afraid his building's reputation would be negatively affected by this."

Apparently, the building caters to single women who appreciate the latest in security. That's what occasioned a more involved search. She said the man came in the window, but there was simply no way a man could do that on the fifth floor with no alarms being tripped. The video cameras showed nothing. The scene also was quite obviously "contrived."

"When you've been to a lot of these you recognize that right away," the police officer said. "The police doctor clinched it, though, when he said her injuries were self-inflicted. We just wondered if you could tell us more about her mental state, you being a psychiatrist."

You could have heard the proverbial pin drop when he finished his statement. He'd been looking down at his notes and up at me and now was just looking at me as the time passed ever so slowly. The silence demanded a response.

I told them then I'd never had any idea and mentioned that this was the last of several cases. They knew it wasn't the first.

I showed them out and had difficulty all day seeing my other patients and focusing on their care.

## Burning her own skin

I'd treated several "factitious disorders." My favourite teaching case, because it was relatively spectacular, had been the former hospital administrator who was covered with sores caused, unbeknown to us, by burning her own skin with cigarettes and putting feces in the wound. She was hospitalized for a couple of months while infectious disease and internal medicine tried unsuccessfully to diagnose and cure the condition. Then one wise old bat of a nurse caught her doing her mischief on late-night rounds. That's when psychiatry was consulted. The woman was truly venomous now that she was exposed. She was very angry at

hospitals, doctors and nurses after being fired for incompetence. It turned out she had a drinking problem, too, and had liked the pain medication. But it was suddenly apparent now that all her lesions were within easy reach, not quite the distribution one would expect. Indeed, once that nurse had made the diagnosis correctly through simple good-night nursing rounds, no one could imagine how they'd missed it.

## The grace of God

I've treated many like that.

There are conscious and unconscious reasons for weird behaviour. I continue my work in psychiatry mostly because I accept that it's so very sad that people feel no other choice but to do these things. There but for the grace of God go I.

So the next day I had a chance to confront the patient. I'd

phoned the police doctor in the morning so I had all the facts. At first the patient held to her story and began to treat me as the "enemy" and bolt for the door. I was able to say very clearly that, "I've stood by you through all this, and I'll stand by you now, but I can't help you if you keep running from the real problem."

Well, as *Portnoy's Complaint* so aptly stated in its rather crude brilliance, therapy began then. I learned how truly deprived her childhood was with a couple of very infantile parents who celebrated their own cunning nature. Over time I learned the "whole truth." But then what is the "truth," I often wonder?

She eventually met a good man, moved far away from her parents, and that was the last I heard of her.

I did phone the military doctor and he was subsequently most impressed with how his

men improved in their careers and performance as the telephone call transpired. I was left amazed at how quickly the military could correct an "error" without ever admitting fault.

## The fellow in jail

The same was not true for the fellow in jail. The mechanisms for such a travesty were beyond my capabilities. For all I know, he's the latest in a list of Monte Christos.

I also learned that it was easy to get someone on a sex offender list but never did learn how one got one off. It was clearly outside my time and capability. People really do not like to admit fault or correct errors. I wasn't too happy at eating humble pie myself, and I'd had more than my full measure on this one. As for the fellow who left the country, he was gone.

It all happened a long, long

time ago and not exactly as I've told it either because to tell it exactly as it occurred might reveal the identity of the victims. I failed and did my best to clean up some of the mess, while I know I wasn't above letting some of the dirt get swept under the carpet. Some events and some people are just plain frightening.

Some things don't occur officially and officially some things do occur.

Some nights I don't sleep wondering how I could have been a better doctor. I was glad to have talked to the police and military doctors at the time. Some colleagues are right there in the front lines with you and judge you far less than you do yourself when it's late at night and you can't sleep.

Mostly I wonder what I'm missing today. I know I'm missing something.

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Cyproterone acetate and ethinyl estradiol tablets

### THERAPEUTIC CLASSIFICATION

Acne Therapy

### ACTION AND CLINICAL PHARMACOLOGY

DIANE-35 (cyproterone acetate and ethinyl estradiol) is a combination antiandrogen-estrogen for use in the treatment of androgen-dependent dermatological conditions in females.

Cyproterone acetate is a steroid compound with potent antiandrogenic, progestogenic and antigonadotrophic activity. It exerts its antiandrogenic effect by blocking androgen receptors. It also reduces androgen synthesis by a negative feedback effect on the hypothalamic-pituitary-ovarian systems. The estrogen component (ethinyl estradiol) of DIANE-35 increases levels of sex hormone binding globulin (SHBG) and thus reduces the free circulating plasma levels of androgens. Cyproterone acetate has no tendency to reduce SHBG levels.

If used alone in women, cyproterone acetate leads to menstrual cycle disturbances which are avoided when combined with ethinyl estradiol. When DIANE-35 is administered in a cyclic manner it has the added effect of preventing ovulation and possible conception. The components of DIANE-35 are rapidly absorbed after oral administration. Due to the long terminal half-life of cyproterone acetate, a 4-fold increase in plasma levels occurs after 6 to 12 days of daily dosing. Long-term therapy (36 months) with DIANE-35 did not have a significant influence on lipid metabolism. A trend to increased plasma cholesterol and triglyceride levels was observed. There was a slight decrease in low density lipoprotein (LDL) with a simultaneous increase in high density lipoprotein (HDL).

### INDICATIONS AND CLINICAL USE

DIANE-35 (cyproterone acetate and ethinyl estradiol) is indicated for the treatment of women with severe acne, unresponsive to oral antibiotic and other available treatments, with associated symptoms of androgenization, including seborrhea and mild hirsutism.

Note: DIANE-35 should not be prescribed for the purpose of contraception alone. However, when taken as recommended (see DOSAGE AND ADMINISTRATION), DIANE-35 will provide reliable contraception in patients treated for the above clinical conditions. If patient compliance is uncertain and contraception is necessary, then a supplementary non-hormonal contraceptive method should be considered.

1. DIANE-35, as with all estrogen/progestogen combinations, is contraindicated in women with thrombophlebitis, thromboembolic disorders, or a history of these conditions.
2. DIANE-35 users appear to have an elevated risk of venous thromboembolic events compared to users of combination oral contraceptives in some published studies. Estrogen and/or progestogen should not be taken during treatment with DIANE-35.
3. DIANE-35 should not be prescribed for the purpose of contraception alone.
4. During treatment with DIANE-35, other oral contraceptives should not be used.
5. DIANE-35 should be discontinued 3 to 4 cycles after signs have completely resolved.

### CONTRAINDICATIONS

1. History of or actual thrombophlebitis or thromboembolic disorders;
2. History of or actual cerebrovascular disorders;
3. History of or actual myocardial infarction or coronary arterial disease;
4. Active liver disease;
5. Previous or existing liver tumours (benign or malignant);
6. History of cholestatic jaundice;
7. Known or suspected carcinoma of the breast;
8. Known or suspected estrogen-dependent neoplasia;
9. Undiagnosed abnormal vaginal bleeding;
10. Any ocular lesion arising from ophthalmic vascular disease, such as partial or complete loss of vision or defect in visual fields;
11. When pregnancy is suspected or diagnosed;
12. Severe diabetes with vascular changes;
13. A history of otosclerosis with deterioration during pregnancy;
14. Known or suspected hypersensitivity to any of the components of DIANE-35.

### WARNINGS

#### 1. Predisposing Factors For Coronary Artery Diseases

Cigarette smoking increases the risk of serious cardiovascular side effects and mortality. In women with predisposing factors for coronary artery disease (such as

cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, and increasing age) the use of estrogen/progestogen combinations have been reported as an additional risk factor.

**After the age of 35 years, estrogen/progestogen combinations should be considered only in exceptional circumstances and when the risk/benefit ratio has been carefully weighed by both the patient and the physician.**

Cigarette smoking increases the risk of serious adverse effects on the heart and blood vessels from the use of DIANE-35. This risk increases with age and heavy smoking (15 or more cigarettes per day) and is more marked in women over 35 years of age. Women who use this medication should not smoke.

DIANE-35, like all estrogen/progestogen combinations, is associated with an increased risk of venous thromboembolism (VTE) compared with no use.

Based on a review of the published literature, cases of non-fatal VTE ranging in incidence from 1.2 to 9.9 events per 10,000 women-years have been observed in users of DIANE-35 (Spitzer 2003). As context, the incidence of VTE in non-users of any oral contraceptive is estimated to be 0.5 to 1 event per 10,000 women-years, and increases to 4 events per 10,000 women-years in long-term users of low estrogen content (< 50 µg ethinyl estradiol) combination oral contraceptives. These event rates are rare, but still justify caution in the use of DIANE-35.

Since market introduction in 1998 to 2003, Health Canada has received 11 reports of VTE (deep vein thrombosis, pulmonary embolism, and stroke) equivalent to a reporting rate of 0.33 events per 10,000 women-years. One of these cases involved a death. It should be noted that reporting rates determined on the basis of spontaneously reported post-marketing adverse events are generally presumed to underestimate the risks associated with drug treatments.

Women with androgen-related conditions (e.g., severe acne or hirsutism) may have an inherently increased cardiovascular risk.

The excess risk of VTE is highest during the first year a woman ever uses a combination estrogen/progestogen combination.

Estrogen/progestogen combinations may cause an increase in plasma lipoproteins and should be administered with caution to women known to have pre-existing hyperlipoproteinemia. Lipid profiles should be determined regularly in these patients.

The combination of obesity, hypertension, and diabetes is particularly hazardous to women who are taking DIANE-35. Should this triad of conditions develop, the patient should be placed on an alternate form of therapy for acne.

#### 2. Discontinue Medication at the Earliest Manifestation of the Following:

- A. Thromboembolic and Cardiovascular Disorders such as thrombophlebitis, pulmonary embolism, cerebrovascular disorders, myocardial ischemia, mesenteric thrombosis, and retinal thrombosis.
- B. Conditions that predispose to Venous Stasis and to Vascular Thrombosis (e.g., immobilization after accidents or confinement to bed during long-term illness). Non-hormonal treatment for acne should be used until regular activities are resumed. For use of DIANE-35 when surgery is contemplated, see PRECAUTIONS.
- C. Visual Defects - Partial or Complete. D. Papilledema, or Ophthalmic Vascular Lesions. E. Severe Headache of Unknown Etiology, or Worsening of Pre-existing Migraine Headache. F. Onset of Jaundice or Hepatitis. G. Itching of the Whole Body. H. Significant Rise in Blood Pressure. I. Onset of Severe Depression. J. Severe Upper Abdominal Pain or Liver Enlargement.

3. Fetal abnormalities have been reported to occur in the offspring of women who have taken estrogen/progestogen combinations in early pregnancy. Rule out pregnancy as soon as it is suspected.

4. The use of estrogen/progestogen combinations during the period a mother is breastfeeding her infant may not be advisable. The hormonal components are excreted in breast milk and may reduce its quantity and quality. The long-term effects on the developing child are not known.

5. This drug may cause fluid retention. Conditions such as epilepsy, asthma, and cardiac or renal dysfunction require careful observation.

6. Recognized first-line tests of genotoxicity gave negative results when conducted with cyproterone acetate. However, further tests showed that cyproterone acetate was capable of producing adducts with DNA (and an increase in DNA repair activity) in liver cells from rats and monkeys and also in freshly isolated human hepatocytes. This DNA-adduct formation occurred at exposures that might be expected to occur in the recommended dose regimens for cyproterone

acetate. One *in vivo* consequence of cyproterone acetate treatment was the increased incidence of focal, possibly pre-neoplastic, liver lesions in which cellular enzymes were altered in female rats.

The relevance of these findings does not appear to be clinically significant based on the results of a multicentre international liver tumour case control study which demonstrated that there is no evidence of an increased risk of hepatocellular carcinoma associated with contraceptive steroids containing cyproterone acetate, even after long-term use.

### PRECAUTIONS

**1. Physical Examination and Follow-up:** Before estrogen/progestogen combinations are used, a thorough history and physical examination should be performed including a blood pressure determination. Breasts, liver, extremities, abdomen and pelvic organs should be examined. A Papanicolaou smear should be taken if the patient has been sexually active and a urinalysis should be done.

The first follow-up visit should be done 3 months after the initial prescription. Thereafter, examinations should be performed at regular intervals during treatment and more frequently for those patients at greater risk for adverse effects.

**2. Hepatic Function:** If there is a clear-cut history of cholestatic jaundice, especially if it occurred during pregnancy, other methods of treatment should be prescribed. The development of severe generalized pruritus or icterus requires that the medication be withdrawn until the problem is resolved. If a patient develops jaundice that proves to be cholestatic in type, therapy should not be resumed. In patients taking estrogen/progestogen combinations, changes in the composition of the bile may occur and an increased incidence of gallstones has been reported. Hepatic nodules (adenoma and focal nodular hyperplasia) have been reported, particularly in long-term users of estrogen/progestogen combinations. Although these lesions are uncommon, they have caused fatal intra-abdominal hemorrhage and should be considered in women presenting with an abdominal mass, acute abdominal pain, or evidence of intra-abdominal bleeding.

**3. Hypertension:** Patients with essential hypertension whose blood pressure is well controlled may be given the drug but only under close supervision. If a significant elevation of blood pressure in previously normotensive or hypertensive subjects occurs at any time during the administration of the drug, cessation of medication is necessary.

**4. Migraine and Headache:** The onset or exacerbation of migraine or the development of headache of a new pattern that is recurrent, persistent, or severe, requires discontinuation of medication and evaluation of the cause.

**5. Diabetes:** Diabetic patients, or those with a family history of diabetes, should be observed closely to detect any alterations in carbohydrate metabolism. Patients predisposed to diabetes who can be kept under close supervision may be given estrogen/progestogen combinations under strict medical supervision. Young diabetic patients whose disease is of recent origin, well-controlled, and not associated with hypertension or other signs of vascular disease such as ocular fundal changes, should be closely observed.

**6. Metabolic and Endocrine Diseases:** In metabolic or endocrine diseases and when metabolism of calcium and phosphorus is abnormal, careful clinical evaluation should precede medication and a regular follow-up is recommended.

**7. Ocular Disease:** Progressive astigmatic error, possibly leading to keratoconus, has been noted in some myopic women receiving drugs of the estrogen/progestogen class. In women who developed myopia at or near puberty, and in whom myopia stabilized in adult life, estrogen/progestogen combinations after some 6 months of use have increased the refractive error 2 to 3 fold. Women with a family history of myopic astigmatism or keratoconus who are using such therapy may experience rapid advancement of the ocular disorder. **Contact lens wearers** who develop visual changes or changes in lens tolerance should be assessed by an ophthalmologist and temporary or permanent cessation of wear considered.

**8. Connective Tissue Disease:** The use of estrogen/progestogen combinations in some women has been associated with positive lupus erythematosus cell tests and with clinical lupus erythematosus. In some instances exacerbation of rheumatoid arthritis and synovitis have been observed.

**9. Breasts:** Increasing age and a strong family history are the most significant risk factors for the development of breast cancer. Other established risk factors include obesity, nulliparity, and late age for first full-term pregnancy. The identified groups of women that may be at increased risk of developing breast cancer before menopause are long-term users of estrogen/progestogen combinations (more than eight years) and starters at early age. Special judgement should be used in prescribing such medications for women with fibrocystic

disease of the breast. Women receiving such medications should be instructed in self-examination of their breasts. Their physicians should be notified whenever any masses are detected. A yearly clinical breast examination is also recommended, because, if a breast cancer should develop, drugs that contain estrogen may cause a rapid progression if the malignancy is hormone-dependant.

**10. Vaginal Bleeding:** Persistent irregular vaginal bleeding requires special diagnostic judgement to exclude the possibility of pregnancy or neoplasm.

**11. Fibroids:** Patients with fibroids (leiomyomata) should be carefully observed. Sudden enlargement, pain, or tenderness requires discontinuation of the use of the medication.

**12. Age:** In general, women in the later reproductive years gradually assume an increasing risk of circulatory and metabolic complications which become more prominent at 35 years of age. In view of this, closer observation, shorter duration of estrogen/progestogen combination use and avoidance of cigarette smoking is advisable. Alternatively, adoption of other means of therapy should be considered for this age group. Estrogen/progestogen combinations may mask the onset of climacteric.

**13. Emotional Disorders:** Patients with a history of emotional disturbances, especially the depressive type, are more prone to have a recurrence of depression while taking estrogen/progestogen combinations. In cases of a serious recurrence, a trial of an alternate method of therapy should be made which may help to clarify the possible relationship. Women with premenstrual syndrome (PMS) may have a varied response to estrogen/progestogen combinations, ranging from symptomatic improvement to worsening of the condition.

**14. Laboratory Tests:** Results of laboratory tests should be interpreted in light of the fact that the patient is taking estrogen/progestogen therapy. The following laboratory tests could be modified.

A. **Liver function tests:** Aspartate serum transaminase (AST) - variously reported elevations. Alkaline phosphatase and gamma glutamine transaminase (GGT) - slightly elevated.

B. **Coagulation tests:** Minimal elevation of test values reported for such parameters as prothrombin and Factors VII, VIII, IX and X.

C. **Thyroid Function Tests:** Protein binding of thyroxine is increased as indicated by increased total serum thyroxine concentrations and decreased T<sub>3</sub> resin uptake.

D. **Lipoproteins:** Small changes of unproven clinical significance may occur in lipoprotein cholesterol fractions.

E. **Gonadotropins:** LH and FSH levels are suppressed by the use of estrogen/progestogen therapy. Wait two weeks after discontinuing the use of estrogen/progestogen therapy before measurements are made.

**15. Tissue specimens:** Pathologists should be advised of estrogen/progestogen therapy when specimens obtained from surgical procedures and Papanicolaou smears are submitted for examination.

**16. Return to Fertility:** After discontinuing therapy, the patient should delay pregnancy until at least one normal spontaneous cycle has occurred in order to date the pregnancy. The patient should be instructed to use a non-hormonal method of contraception during this time period.

**17. Amenorrhea:** Women having a history of oligomenorrhea, secondary amenorrhea, or irregular cycles may remain anovulatory or become amenorrheic following discontinuation of estrogen/progestogen combination therapy. Amenorrhea, especially if associated with breast secretion, that continues for 6 months or more after withdrawal, warrants a careful assessment of hypothalamic-pituitary function.

**18. Thromboembolic complications - Post-surgery:** There is an increased risk of thromboembolic complications in estrogen/progestogen combination users after major surgery. If feasible, such drugs should be discontinued and a non-hormonal method of treatment substituted at least one month prior to major elective surgery. Such medication should not be resumed until the first menstrual period after hospital discharge following surgery.

**19. Drug Interactions:** The concurrent administration of estrogen/progestogen combinations with other drugs may result in an altered response to either agent (see Tables 1 and 2). It is important to ascertain all drugs that a patient is taking, both prescription and non-prescription, before estrogen/progestogen therapy is prescribed.

**20. Pregnancy:** Estrogen/progestogen combinations should not be taken by pregnant women. Rule out pregnancy before treatment is begun. Because of the antiandrogenic action of DIANE-35, feminization of male fetuses has occurred in animal studies and may possibly occur in humans.

*“When I look closely and listen carefully, I see a part of me in each of them and I see the strength to carry on.”* —Dr. Larry Kramer

## SPIRIT OF MEDICINE

# Seeing beyond despair

*Making rounds at a community hospital, a doctor strives to observe, appreciate and learn*

by Larry Kramer

THIRTY YEARS AGO something happened to him. It was the defining moment of his life.

And now he's admitted to hospital every few weeks. It's getting worse. The time between visits is shorter, his stays are more complicated. So many years ago he went into a small surgical procedure as a young man and came out as a tragedy. He hasn't moved anything below his neck since 1975.

Although not old in years, he is ancient in suffering. Moment to endless moment his reality unfolds like a play from which he has been removed. He can only watch.

His world is so remote and the doors so narrow that I cannot begin to imagine what lies inside. Can he close his eyes and be somewhere else? Is he living another life inside his head, a life where he can walk and talk and dress himself and brush his teeth and scratch an annoying itch and to go to work and visit friends and . . .

Most recently he's had a stroke. It was hard to tell. His speech is garbled at the best of times, but the transient facial weakness and the CT findings gave it away. He could no longer swallow the pureed food that normally made up his diet. I think he blinked “yes” when I asked him if he wanted a PEG tube. Secretly I wanted it to be “yes” so that I could feel I had something to offer.

So many years of inactivity have left him contracted and immobilized in a near fetal position. I appreciate the irony. Beginning and end. Not much difference.

Yet he can still laugh. I marvel as that sound greets my tortured Italian. His wife has painstakingly taught me a few words, which I mangle beyond recognition. His response encourages me to play the fool.

She has cared for him at home for more than 30 years. There must be a special place in heaven for her. Every day she is there. All day long, or as long as visiting hours allow, she sits quietly in the gentle sunlight by the window. Occasionally she gets up, talks to him, feeds him or cleans him, in a way that only love can explain.

She is much less than five feet tall. Her hair is short and speckled with grey. She must be about his age, but despite a lifetime living in Canada her speech is so heavily accented I can barely understand. For a moment I think this is odd. Then I

realize he has been her world 24 hours a day, seven days a week. How has she raised their family as well? I am in awe of her strength and courage.

Does she ever wonder about how her life could have been, about the “what-ifs” and “if-onlys,” that surely come to her in dark and quiet moments? Perhaps, like the comfort fantasies we all have about winning the lottery, she plays with these ideas. But I think such introspection is at the bottom of her psychological need-to-do list. Navel gazing is more often the reserve of those whose burden is light and whose time is plentiful.

Does he wonder how his life came to turn on such a small event? Is there joy? Does he still wonder why? Anger, denial, bargaining, acceptance. Are the stages complete?

As usual, more questions than answers accompany me up the stairs to my next lesson. Mr. B. was admitted last night through the ER. After so many years of practice I was surprised to be surprised. Food can be in the same category as drugs and alcohol. Self destruction through gluttony. This is an epiphany of sorts.

Packing more than 180 kg on his 1.72 metre frame, his heart was failing and he could breathe only with great difficulty and continuous oxygen. His mobility was limited to a few steps and he nodded off while talking to me. He said he wanted to see his grandchildren grow up and had plans for the future.

But he ate huge amounts and squirreled away candy bars despite being diabetic. The distance between what he said and what he did was immense and rarely travelled. No surprise there. The knowledge-action gap exists for most of us in one way or another. I told him he would die if he didn't change. He agreed, but

didn't change. I don't understand the psychodynamics that drive him to slow suicide. What force, what compulsion is so undeniable? I am sad that I can do so little to help him.

More slowly now I move on to Mr. C. just down the hall and review his chart. Another revelation. Hope dies easily. A frail emotion at the best of times, it succumbs timidly to the quick march of illness. And when that illness is catastrophic the abyss at the end of hope is bottomless.

He is 58 years old and of sound mind. From the neck down he is 90% dead. From the neck up he wishes he were 100% dead. It's hard not to agree with him. A brainstem stroke has left him quadriplegic. I try to tell him inspirational stories of others who have lives after devastating events. The psychiatrist tells him most people eventually learn to cope. He seems to find neither of us particularly encouraging. Zolof is added.

Today he has to decide on the nursing home in which he will spend the rest of his life. There are sadder stories. But I don't know many and it doesn't help to tell them.

I move on. Next, I see a patient whom I have followed for several days. As we talk my thoughts gain a tangential life of their own. I have a drink now and then. A glass of wine—or two—at supper, some days. And in younger, more foolish (and less painful) days, perhaps too many on occasion. But Mr. D's life is devoted to alcohol. Has been for years. No family, never had time. No job, too busy drinking. No connections other than the bar. Liver failure is in his unrepentant future. He staggers toward it without hesitation. Has he accepted his role, his fate?

His life seems beautifully simple. There is one focus, ever clear and irre-

sistible. He is “Leaving Las Vegas” personified, although not as well preserved or as good-looking as Nicolas Cage. But this deduction is too easy and superficial. I'm sure his life is as complex as it is difficult.

Doctors are prone to use the word dishevelled when describing street people, alcoholics or other of “nature's noblemen” as one of my older colleagues once put it. It implies an unkempt, bedraggled appearance, hair uncombed, face unshaven, a body that would make clothes wrinkle. But I think the word must apply to his soul as well. And then I wonder which came first, the tattered psyche or the tortured body?

Once he gets over the DTs and the nurses have cleaned him up, he is anxious to leave. Phone numbers and agency addresses are given to him. They will not be used. My legal friends tell me we all have the right to make bad decisions. Of this he has made a career.

I make rounds almost every day in a community hospital of 275 beds. There are at least that many stories. I try not to make judgments and strive (often failing) only to observe, appreciate and learn. It is so easy to dismiss a patient as the M.I., the cancer, the postop. Paint them by numbers and the stories often remain untold. A good friend of mine says all this is too depressing. He's probably right. Yet in my more lucid moments I think I can see beyond the despair. Maybe it's my imagination. But when I look closely and listen carefully, I see a part of me in each of them and I see the strength to carry on. I don't think there's much difference between any of us. As I walk out of the hospital at the end of each day, “There but for the grace of God” never has more meaning.

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Joe Weissman