

REFLECTIONS

Bloody Diamonds

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There are no paintings on the walls in the hospitals I have worked at in the capital of Liberia over the past five years. The bareness on the walls parallels the limited equipment I have on hand to care for patients with bacterial meningitis, pericardial tuberculosis, and malaria. Listening to some of these patients or looking at their chest films without the benefit of modern technology, I get the feeling I am seeing pathology in its most extreme form—the way people saw it when the diseases we now treat routinely in the United States were first discovered. Listening to the sandpaper sound of one man's pericardial rub, I think, "Oh! That's why we call it a 'rub!'"

Sometimes the challenges of this work, such as helping a grandmother survive a simple asthma attack, are rewarding. Other times my coworkers and I face the horror of losing a two-year-old before we have even made a diagnosis. Constantly, I struggle with the impulse to try to fix things when I know what I do may not fix anything and might even make the situation worse.

We admit many patients with septic vital signs, elevated leukocytes, and no obvious source of infection. I treat them with broad-spectrum antibiotics, and the young ones usually get better. It is frustrating not knowing what I am treating. There's a copy of *Manson's Tropical Medicine* in my office, and I have read the chapters on meningitis, malaria, tropical splenomegaly, cholera, and typhoid, but sometimes this information does not help. There is a section under splenomegaly that says: "Diagnosis of splenic disorders

in the Tropics relies mainly on the astute clinical observations of a practiced internist." In spite of six years as an academic hospitalist in the United States and posts with Doctors without Borders and other non-governmental organizations in Haiti, Liberia, Uganda, Colombia, and Ghana, I encounter some patients who make me wish for help from a "practiced internist." One patient like this was a 25-year-old man admitted in a febrile delirium. Even after treating him with everything I could think of, progress was slow. He was able to talk, but it was mostly nonsensical. While staring at his chart one morning, I looked over and noticed he was drooling. "Is he foaming at the mouth?! Maybe he's got rabies!" My PA laughed at me and said, "Rabies doesn't look like that." Undeterred, I rushed to the sink to fill a kidney basin full of water. Knowing rabid patients are sometimes hydrophobic, I flicked some drops of water on him to see what would happen. Immediately, he threw his arms up and started blessing himself because he thought I was baptizing him. I smiled awkwardly. "Well, I guess he's not hydrophobic."

We do have some success stories. One 29-year-old man came in with Stevens-Johnson Syndrome after taking a sulfa drug to treat malaria. In a horrific allergic reaction, he began shedding skin from almost every surface of his body, including his lips, eyelids, and genitalia. He was in excruciating pain, and the visiting dermatologist said he would certainly die a gruesome death of infection and dehydration if he lost more and more layers of skin. In the United States, we usually sedate

these patients and put them in the intensive-care unit. In Liberia, our patient was dying on a plastic mattress in a ward with five other people, one of whom had active pulmonary tuberculosis. I could not imagine how he could possibly survive. But my nurses and I tried the one thing available: Vaseline. We covered him from head to foot in it to seal the moisture in and keep the bacteria out. We told his family to feed him water and juice through a straw every hour as long as he could tolerate it, and, figuring vitamin C would help, I sent his brother to the market to bring back five oranges a day for the next week. The brother called an emergency family meeting after he thought I asked for 500 oranges a day, but, once we clarified the plan, the whole family agreed to help. We followed the same routine for seven days. Each morning, his brother arrived with the oranges and Vaseline, and my nurses and I covered his entire body with it and told him to eat the oranges after I left. We ran IV fluids and tried to keep his plastic mattress as clean as possible despite the oppressive heat. Each day, as I rubbed the Vaseline on him, chunks of skin that were as big as my hand and looked like wet rice paper sloughed off every surface of his body. His pain was almost unbearable to watch, but he said he could stand it without any narcotics. I have never seen anyone more bent on survival. Seven days after admission, I noticed new skin starting to cover up the gaping holes the old layers had left. Looking into his face, I knew he would walk out of our hospital alive.

And he did.