Reading for Pleasure

Literary hors d'oeuvre

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A man of letters has an ability, denied to most other people, to see beneath the surface of things. D H Lawrence wrote *Kangaroo* after only six weeks in Australia. Although the political aims of its returned soldiers were a product of his imagination, his description of the Australian people, their way of thought, and the unspoken menace of the bush—never very far away in those days—was extraordinarily accurate. In *The Ambassador* Morris West captured the atmosphere of the Saigon of the middle 'sixties and described it exactly as it was—at least, to the Westerner temporarily resident there.

When J D Pringle came from England to edit the *Sydney Morning Herald* his impressions of a strange land and a near alien culture prompted him to write *Australian Accent*, a penetrating study of the mores of a new people. This makes it all the more surprising that he could not explain two of his own observations. He saw that many Australian men devoted some of their spare time each week to mowing grass and washing cars, and could not understand why. The reason is transparent—at that time most Australians lived in a detached house surrounded by lawn, and owned a car, or sometimes two. As the great majority of them could not afford a handyman (a species not commonly met with in times of full employment), they had the choice of neglecting their lawns and cars or attending to them themselves. Hence the pensive reflection: if only one could function on four or five hours' sleep a night, there would be a bonus of three extra hours every day to do some of the many things one would like to do, but can't. To grow roses, play bridge or chess, become fluent in a foreign language or proficient on a musical instrument, to dip into history or philosophy, to read for pleasure.

The medical practitioner has always read from a sense of duty, from a lifetime habit of study, or from a wish to do his work as well as he can. Nowadays, the endeavour to keep one's head above the flood of books and journals, often a pleasure in itself, has become a grimmer task with the advent of programmes of quality assurance and peer review, and even a threat of periodical compulsory examinations for recertification. The doctor who reads for pleasure will soon have to do it furtively, like the schoolboy of yesteryear with *La Vie Parisienne* tucked into the pages of his French exercise book.

Middle-brow tastes

As with food, drink, and hobbies, tastes vary in literature. Mine suffer from arrested development, never having risen above middle-brow. I expired in an arid stretch of *Voss* about the time

Voss was expiring in the desert. Miss Compton-Burnett's grown-up children in their draughty attics leave me cold. *The Waste Land* is wasted on me, and I rejoice that it was wasted on that great expatriate Senor Graves, whose *Goodbye To All That* is on my list of books to reread at some future date. Possibly one of the hallmarks of middle age is the beginning of the debate on the choice between trying new books and renewing acquaintance with old favourites. *Vanity Fair*, *Nostromo*, *Moby Dick*, *The Horse's Mouth*, *A Passage To India*, *A Farewell to Arms* must all improve after a lapse of years during which one's own experience has widened and one's ability to appreciate the issues raised has improved. *The Tempest* (who could forget Peter Brook's production of 1957?), any of the dramas of Synge and O'Casey could never fail to entertain, to enthrall, and one could look back at least with interest on *Look Back in Anger*.

To which of the moderns will I return with pleasure? With the statement that J P Donleavy wrote the same book over and over again I cannot altogether agree. *A Fairy Tale of New York* had echoes of *The Ginger Man*, but was substantially different—a brilliantly funny but sad story of the crushing of one private man's spirit by the pressures of a modern urban community. Of a profusion of work by the contemporary American-Jewish school I should single out Mordecai Richler's *St Urbain's Horseman*—a blend of the dream and the reality, which, like *The Green Cockatoo* and *The Secret Life of Walter Mitty*, leaves me wondering where the dream ends and the reality begins.

Those who have tried to write something funny know how hard it is. (The credits for each episode in the careers of The Two Ronnies and the Dave Allen Show list the many contributing authors.) To those who look for laughter as an outlet from the cares of the day I unreservedly recommend Lennie Lower's *Here's Luck*, probably the funniest book ever written. Set in Sydney, it's as Australian as the black stump—that celebrated but mythical place that is as far as you can get from anywhere. When *Portnoy's Complaint* was banned in Queensland—where censorship is still stricter than in the rest of Australia—I bought a copy in New Zealand and, the bus having very few passengers, was not too embarrassed to laugh out loud all the way from Mount Cook to Christchurch. Donleavy's many uproarious scenes are even better. "I say there, you in there, we are citizens out here . . . Sir, there are gurglings going on somewhere . . . We have come to see by what authority it is being emitted . . . Sir, my God, have regard you are without any garments, please . . . sir, attend to yourself. You are in a state of undress. I happen to be connected with the Admiralty and I am also a member of the Automobile Club . . .," and so on, page after hilarious page. And the most engaging of the beastly beatitudes, "Blessed are they who out of a sea of human frailty climb aboard a piece of arse when it floats by." (Contour Club members will recognise the vulgarity.)

Authors and their subjects

In a beautiful short story Hermann Hesse told of a young man who, wishing to learn to speak well, became a pupil of a master

orator of spell-binding virtuosity. The pupil duly graduated, though a century went by unnoticed before he succeeded to the title of "Meister des vollkommenen Wortes"—master of the perfect word. If anybody deserves this title, it must surely be James Joyce. One cannot absorb the full content of a building at first glance or of a symphony on first hearing. So with Joyce—it takes time to appreciate the measure of his genius. Read *Stephen Hero* and *Portrait of the Artist as a Young Man*, then read together *Ulysses* and a companion volume such as that by Stuart Gilbert; then read *Ulysses* again. For a suitable literary liqueur after this repast, listen to Siobhan McKenna reading "Anna Livia Plurabelle" from *Finnegans Wake*. Close your eyes and hear and see the Liffey as it runs from its source in a spring to its slow discharge into the sea, see the rising sea mists drift inland to form clouds, and then shed rain back over the green Irish hills to complete the cycle; and watch as the two old enchanted washerwomen turn slowly into tree and stone.

Where does one stop a catalogue of authors and subjects? Take war, for instance. Abhorrent, wasteful, in the long run often useless—but what a tremendous scope for the writer. On land—*All Quiet on the Western Front*; at sea—*The Cruel Sea*; in

the air—*Enemy Coast Ahead*; the anguish of the families at home—*Testament of Youth*; history—*August 1914*, and the *Alanbrooke Diaries*; civil war—*For Whom the Bell Tolls* with its unsurpassed dialogue; and Sartre's great trilogy *The Age of Reason*. There are other specialised topics. The early mountaineers were not only trailblazers but often brilliant writers—Whymper, Stephen, Young, and, more recently, Hunt, Noyce, and Rébuffat have made their contribution. Music and art—one can see Picasso through the eyes of Brassai and Françoise Gilot, though one needs a special vocabulary to understand what Timothy Hilton says about him. Cricket has a literature all of its own, as has sailing, while the enthusiast who cannot often get to the table will enjoy his bridge vicariously through the books and columns of Mollo, Reese, and Becker. Even medicine sometimes manages to combine clarity of instruction with elegance of prose, with the late Paul Wood's *Diseases of the Heart and Circulation* a pinnacle of medical literary achievement.

There is a school of thought that the path to learning lies through deep study of one, or at best a few authors. But surely it is better far to sample widely the many courses offered at literature's smörgåsbord.

What is the mechanism of urgency secondary to a urethral stricture when non-specific urethritis and prostatic secretions are apparently non-infectious?

During filling of the bladder there is normally little or no rise in intravesical pressure. Even when there is a strong desire to void the detrusor muscle remains inactive until voiding is voluntarily begun. Detrusor contractions that cannot be suppressed during bladder filling are known as uninhibited or unstable contractions and are usually, but not always, associated with an urgent desire to void. This is known as motor urgency. The symptom of urgency may also occur without detrusor activity, when it is known as sensory urgency and is associated with inflammatory or irritative lesions such as cystitis, stone, or tumour. When infection is not a factor and provided other causes of sensory urgency have been excluded then motor urgency is probable. We know from urodynamic studies that, in men, there is an association between outflow obstruction and instability of the detrusor muscle. This may be related to the muscle hypertrophy and high voiding pressures that occur in obstruction. Voiding pressures tend to return to normal levels after the obstruction has been relieved, and the symptom of urgency usually decreases. Confirmation of the diagnosis of motor urgency requires urodynamic studies, which could also be used to show whether or not the obstruction has been adequately relieved.

There are, of course, other causes of motor urgency, particularly neurological lesions, which may coexist with outflow obstruction. Where urgency remains a problem after relief of obstruction anticholinergic drugs, such as propantheline, emepronium, or dicyclomine may help. They must be given in adequate dosage, however, which usually results in some side effects, particularly dry mouth, and even then the response to treatment is unpredictable.

Can you advise on the management of a penicillin-sensitive staphylococcal endocarditis in a formerly fit 46-year-old man?

Penicillin-sensitive staphylococcal endocarditis should be treated by a combination of penicillin G with gentamicin. Penicillin remains the safest and most effective bactericidal antibiotic for treating infective endocarditis and should always be used provided the organism is sensitive to it. A sufficient blood level is required for the penicillin to diffuse along a concentration gradient through the avascular vegetations to reach the multiplying organisms. This means high doses and intravenous administration. Ten to 20 megaunits of penicillin G should be administered by bolus injection in divided doses four times a day to achieve high peaks of plasma concentration. This is most conveniently done by putting in a subclavian venous line by the infraclavicular route and under maximum sterile precautions. The penicillin is then injected into the side arm of the tap connecting the infusion of 5% dextrose with the subclavian venous cannula. Antibiotics should never be placed in infusion bottles because of the

risk of contamination, inactivation, and loss of the benefits of the bolus dose. When possible a constant infusion pump is preferable to an infusion bottle as it is convenient and minimises the amount of fluid needed to keep the line patent. If a constant infusion pump is used then a small amount of heparin may be added to it, 5000 units per 24 hours is adequate. The efficacy of the regimen should be verified in the laboratory against the patient's own staphylococcus to obtain a serum bactericidal activity at a dilution of at least 1 in 8 at the nadir of the plasma penicillin concentration, and the dose of penicillin should be adjusted in order to reach this.

Penicillin resistance may develop if bacteria start to produce penicillinase, and penicillin-sensitive staphylococcal endocarditis should be treated with a combination of penicillin plus an aminoglycoside from the start to reduce this possibility. Gentamicin is usually chosen. The average dose is 80 mg three times a day in divided doses and may be given intravenously by bolus injection into the subclavian line or intramuscularly. Gentamicin is a potentially toxic drug causing eighth nerve and renal damage so these functions should be carefully monitored and the blood concentrations of gentamicin measured, including both the peak and the trough levels. Peak concentrations should be over 5 µg/ml but under 15 µg/ml and troughs should be around 2 µg/ml. Both penicillin and gentamicin are excreted wholly through the kidneys so that poor renal function will determine higher levels. Very high levels of penicillin can cause convulsions, haemolytic anaemia, and renal failure, though such high levels are rarely seen unless probenecid is used or the patient develops renal failure. Probenecid is no longer advised. With gentamicin any reduction in renal function can lead to undesirably high gentamicin levels, and it is very important therefore to monitor the blood levels during the course of infective endocarditis, which can itself be associated with the development of renal dysfunction.

The duration of treatment depends on: (1) the duration of symptoms before diagnosis and the inception of treatment, (2) the sensitivity of the infecting organism, (3) the rapidity of the patient's clinical response, and (4) whether or not there is any foreign material in the heart, such as a prosthetic artificial valve. In the case of a fully sensitive staphylococcus the minimum period of treatment would be four weeks, though usually six weeks will be preferred. In any case the patient should be treated for a minimum of three weeks after a full clinical response in terms of loss of temperature and clinical symptoms. The development of penicillin allergy with a drug fever or rash or both may be countered by antihistamines but if persistent will lead to a need to change the antibiotic, in which case fusidic acid would be the drug of choice. The cephalosporins are less effective than penicillin in the treatment of endocarditis, and there is about 25% cross sensitivity in penicillin-sensitive patients. After completing such treatment the patient should be sent home right away without any further antibiotics and reassessed in a month's time. Relapse can take some months in patients who have been incompletely treated but is uncommon if full consideration is given to the principles outlined.

Oakley, C M, in *Today's Treatment* 3, p 252. London, BMA, 1978.