The dying of Joseph Mpambane – a cautionary tale

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1996;17:241-242

Chris Ellis[1] mentions Van der Walt's[2] photo novel as a communication tool to help patients identify with others who are suffering from TB and help them in their struggle to overcome the illness. This reminded me of a story I wrote for health workers.[3] I would like to reproduce it here to help doctors 'identify with those suffering from TB and help doctors in their struggle to manage the illness'.

Joseph Mpambane lived far out of town in a so-called homeland. When he was young he was pensioned from the mines because of pulmonary TB. He mostly remembered long months in hospital taking medicines day after day. When it was all over he felt well but not up to much. He got breathless easily and never regained his weight, for by now Joseph had extensive cystic destruction of the lungs.

Years passed. Then Joseph began to get recurrent coughs. He began to produce sputum, especially in winter. There had been many changes in the district. Before, he would have visited the doctor in town when business took him there. But he seldom went these days. They told him to go the clinic and see the nurse. The clinic was near where he lived. There had been a lot of talk about the clinic – meetings, delegations to the magistrate and so on. They said it would be good for the children. He never realised it would be for him. Of one thing he was sure – he did not want to get into that hospital again!

The nurse asked him many questions, and about his illness on the mines. She wrote it all down. She said he must get an X-ray. She said he must spit into the little pots. He did all these things. The day he went for an X-ray was very exhausting and he got home very late.

The next few years were a nightmare for Joseph. When the nurse told him he had to go into hospital the people at home really forced him to agree. It never used to be like that – forcing old men. They said the doctors know. Then it was those injections again, and handfuls of tablets. He slept in a ward with many other men with a locker next to his bed. About all he had was his pipe and tobacco bag; they even wanted to take that away. After some months they said he could go home for treatment at the clinic. He didn't feel much better. It became very difficult – always going to the clinic. He seemed to cough even more, felt very ill, and there was this bad-smelling sputum. He was re-admitted to hospital several times. They always told him he would get better if he was regular with treatment. But he'd always been regular so what did they mean? he had taken so much treatment. Now he felt he couldn't keep going to the clinic. Now he often had to stay in bed. He got even thinner. He no longer enjoyed a smoke. There was always this bad-smelling sputum. He noticed his finger nails had changed. They grew big and swollen. He would rather stay at home and die. Even at home they now agreed about that. Yet somehow it didn't work that way. The nurse and the hospital always had their way.

One night Joseph died in hospital. At home they only got to know the following week.

Joseph had been fortunate, in those early days, to recover from PTB. But his lung destruction lead to recurrent bronchogenic infections and eventually gross superinfection. In fact throughout those re-admissions he was never

sputum positive. Ye he was repeatedly put on anti-TB drugs. Sometimes there were fluid levels, but otherwise the X-rays did not change in appearance. The significance of the purulence of the sputum, its offensiveness suggesting anaerobes, the consistently negative sputa, and the finger clubbing must have escaped the doctors (if indeed they saw Joseph himself and his sputum pot). He did receive antibiotics once or twice in short courses, but Joseph died from superinfection, not from reactive tuberculosis.

Anyone who had experience of tuberculosis treatment services knows how many patients are 'managed' without being seen, how the stigma of TB may affect clinical as well as social attitudes, and predispose to retreatment, and how such a safety first approach may never be reviewed by a clinician.

The moral of this story is to interpret all PTB X-rays and investigations in the light of clinical information. TB sputum must be seen as well as sent to the laboratory. Negative AFB reports must be evaluated, not ignored. The diagnosis of PTB is a triad of clinical information, X-ray and sputum examination.[4]

References:

1. Ellis CE. Tuberculosis. S Afr Fam Pract 1996;17(2):68-85.
2. Van der Walt H. The role of participatory research to enhance patient adherence to tuberculosis treatment. Proceedings of the 1993 International Symposium on Participatory Research in Health Promotion. Liverpool School of Tropical Medicine, 1994.
3. Ingle RF. You cannot see the patient in the X-ray. The story of Joseph Mpambane. Santa News 1988 June;27:2.
4. INgle RF. Is clinical information outmoded? Editorial. Tuberculosis Research Institute of the SA Medical Research Council. TBRI Bulletin 6(2). Tygerberg: MRC, 1985.