A memorable patient

A 93-year-old lady was referred in from her nursing home as an emergency medical admission late one evening. The history from the co-operative GP was that of a sudden onset of expressive dysphasia, associated with left-sided weakness leading to falls. His presumed diagnosis was that of an acute intracerebral event.

On her arrival, the patient looked well, but had obvious difficulties with speech. There was no neurological abnormality, and she had a positive urinalysis suggestive of a urinary tract infection (UTI). Her unsteadiness improved with treatment of her UTI.

The patient explained that her speech problems had started quite recently. She had shared a room in her nursing home with another elderly lady, who had recently died. When the deceased’s possessions were removed from her room, the nursing home staff accidentally took with them the dentures belonging to the patient, and left the deceased’s dentures for her. The patient felt that there was no alternative but to use the dentures she had available, and hence started wearing the ill-fitting dentures. This led to her features of ‘expressive dysphasia’, and her presumed diagnosis of a cerebrovascular accident.

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Excess help in the home?

One day during the winter we received a request for a visit to a 70-year-old patient in a ground floor flat in Hove with multiple sclerosis, who ‘had gone off her legs’ and needed hospital care.

On entering her ground floor flat one was assailed by a very strong aroma of gin, so concentrated that a few deep breaths would have produced instant passive intoxication. The patient was bedfast and hopelessly drunk with a cheeky and familiar affect being unable to stand or walk. There was no evidence of bottles either empty or full. It was a puzzle as to how such a disabled person could obtain supplies or dispose of the empties. During examination the front doorbell rang. On going to the door I was confronted by a middle aged lady holding two full Off Licence plastic bags and steadily swaying from side to side; she too exuded a strong smell of gin. ‘What is your business and who are you?’ said I. ‘I am the home help’ was the slurred swaying response. The source of supply and bottle removal was now clear as was the cause of the patient’s disability. The point is that disabled drinkers need a regular fresh supply, in this case by a Social Services employee. An explanatory letter to the GP with a copy to the Social Services Director were made.

On reflection it is a debatable point that when a chronically disabled patient with no prospect of cure, finds solace, comfort and happiness through Ethanol excess, any step to stop the situation may not be indicated or should one interfere? On the down side is increasing dependence and disability, pressure sores, possible incontinence, falls and fractures so continued supervision is needed.

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