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An insider's guide to acute myeloid leukaemia treatment

As a GP for over 30 years I was surprised at how little I knew about the treatment of acute myeloid leukaemia. My case was a little unusual in that my leukaemia presented as a lump on the tongue but with a normal bone marrow. I may add that the only physically painful part of the whole experience was the bone marrow biopsy. It is not possible to anaesthetise the bone (the posterior iliac crest) although they did give me an intravenous sedative. I felt like I had been kicked by a horse for 3 days after the procedure. The decision was made to give me standard chemotherapy in case there was a hidden problem in my bone marrow. I should add that often patients with full acute myeloid leukaemia are often quite sick and require transfusions and antibiotics as soon as they are admitted.

The first surprise was the stress of waiting. I realise that in general practice I refer someone for investigation and by the time they have returned and completed treatment I have not seen them experience the waiting (for them usually at home). The day the haematologist sat with us and discussed the diagnosis and the treatment was such a relief for me, my wife, and my daughter. Prior to that my uncertainty had me thinking I could be dead in a month or living to 90. It reminded me that uncertainty is not a good state for the human mind. The other unexpectedly tiring task was informing people of the diagnosis and ensuring that if one party knew then their colleagues/family should know.

Prior to starting my treatment I had had a useful conversation with one of my patients whom I had told of my upcoming treatment. She had had bowel cancer and was disappointed that she did not get chemotherapy after her surgery. She developed a metastatic lesion and then had chemotherapy and was pleased with the outcome. I decided to cultivate her attitude of 'bring on the chemotherapy' and to consider it as a means to getting myself better rather than a harmful process in itself. I was informed that once treatment began I would need blood transfusions, platelet transfusions, and get infections requiring admission for intravenous antibiotics. In my mind I thought this won't happen to me.

Day one in the ward started well. I was put into a four-bedded room and immediately

felt an affinity with the other three men in the room knowing that they all had some similar diagnosis. The additional benefit of being with others is the educational information they provide either verbally or by viewing their experience. The nurses were also great on the educational side as they decided not to treat me as a doctor but rather a regular patient. This suited me as the experience was way beyond any medical experience I had had. The badge we all wear is the Groshong line which is a line inserted into the superior vena cava (and exits via the skin on the chest wall) and has two ports for administering fluids, taking bloods, and giving medications. This is inserted under radiological control and local anaesthetic and left *in situ* for months and essentially eliminates the need for venepuncture.

The unexpected joy was discovering the anti-nausea properties of ondansetron, a drug which has transformed chemotherapy. The nurses describe the old days of chemotherapy when patients were given 20 vomit containers and then spent their days filling them. So far I have not seen a single patient vomit. The trial evidence on ondansetron looks pretty good and I am much too afraid of nausea and vomiting to not have it.

One of the consultants describes the treatment process as being iatrogenic infectious diseases. In other words they cause your bone marrow to fail and then keep you alive with blood and platelet transfusion and intravenous antibiotics until your bone marrow recovers. In the process the chemotherapy drugs kill any cancer cells in your bone marrow. You realise that your white count is all that comes between you and the bacteria of the world that can kill you in a few days without antibiotics. I eventually required two blood transfusions. Getting the blood of another human being was surprisingly uneventful psychologically. I had anticipated that my first blood transfusion would cause me some angst. It did not. Contrary to my denial state I did require three admissions for septicaemia requiring IV antibiotics. I also had 12 blood transfusions, 12 platelet transfusions, and three admissions for septicaemia.

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