

Cheating death twice: surviving the Blitz and a brain haemorrhage

James M Mumford,¹ Colin J Mumford²

¹University of Liverpool,
Liverpool, UK

²Department of Clinical
Neurosciences, Western General
Hospital, Edinburgh, UK

Correspondence to

Dr Colin J Mumford,
Department of Clinical
Neurosciences, Western General
Hospital, Crewe Road South,
Edinburgh EH4 2XU, UK;
cmumford@staffmail.ed.ac.uk

Published Online First
10 March 2014

Jim's experiences: The first time I should have died I was 17. It was 20 December 1940, and the 'Christmas Blitz' on Liverpool had entered its second night. My family's house suffered a direct hit from a parachute mine (figure 1). I was buried for several hours, alongside the bodies of my father, two sisters and best friend. Somehow I managed to work one arm up through the rubble to the surface. I grabbed the trouser leg of a rescuer and heard a faceless voice shout, "There's one 'ere...". He used his bare hands to create a cone of clear air around my face. I could breathe easily again, and I was dug out of the wreckage of my home, with astonishingly little serious injury.

I was completing my secondary school education, and despite this harrowing event, won a place to study dentistry at Liverpool University the following spring. Life as a student in wartime Liverpool was challenging: rationing was in force, the tram route from the home of my cousin—where I now lived—to the dental school was disrupted by bomb craters, and the city suffered further damage as air raids continued, notably in the intense attacks of May 1941. But the undergraduate training ran its course, with the added novelty of earning pocket money by camping on the dental school roof watching for fires ignited by incendiary bombs.

Having cheated death in late 1940, I qualified in dentistry in summer 1945 and chose an academic career, moving from lecturer and senior lecturer to reader, finally being appointed Professor of Operative Dental Surgery in 1979.

The second time I cheated death was more recent. One evening in November 2012, I was gathering watercolour paints for my weekly painting group. I developed a headache that was somehow 'different'. I felt unsteady and had a curious difficulty reading. The left side of the page had become blurred, and the letters

made no sense. A close friend responded to my call for help. Recognising a serious medical problem, she telephoned my son, who is a neurologist. Apparently I spoke to him on the phone, but I remember nothing more about that night. Nor can I remember that week, nor that month, nor the next 4 months. So I missed the various celebrations for my 90th birthday, at which I was present in body, but not in mind. Life—and memory—only restarted 5 months later. The whole of the intervening period remains a complete blank.

Colin's comments on his father's haemorrhage and nursing care: Our phone discussion in November 2012 was our last normal conversation for half a year. He described ill-defined symptoms, but clearly presented features of a new-onset left homonymous hemianopia. When he confirmed the presence of an unusual headache, it was evident that he had suffered a right-sided cerebral haemorrhage. A CT scan showed a significant bleed into the right parietal lobe (figure 2). He was admitted to the stroke unit.

It is not possible to be a relative and a neurologist at the same time. The fears and anxieties of witnessing serious illness in a close relative displace virtually all medical knowledge. I had a mix of apprehension regarding the prognosis, worry about the suitability of the assigned ward and a sense of relief on recognising that the team looking after my loved one was caring and capable.

But 30 years of postgraduate medical training could not prepare me for the emotional traumas to come. Initially, emphasis was on survival. There were many hours of holding Dad's hand, observing periods of Cheyne–Stokes breathing and unsuccessfully trying to persuade a semi-comatose individual not to pull his urinary catheter out. He clambered from bed, commando-like, in the



To cite: Mumford JM,
Mumford CJ. *Pract Neurol*
2014;**14**:270–272.



Figure 1 Bianca Street, Bootle, following the air raid of 20 December 1940. Jim Mumford's house is left of centre. (Photo courtesy of National Museums Liverpool).

darkest hours and fell over, twice requiring sutures. The stroke team set up a system of one-to-one care right to the time of discharge. In effect, he had a personal nurse at his bedside 24 h a day, 7 days per week.

My daily visits were characterised by recurrent demands to be taken home, requests to know why he was 'in this prison' and whether this punishment related to his service in the Royal Navy at the end of the War. I learned later that such upsetting entreaties are common in individuals beginning their recovery from this type of cerebral insult. Repeatedly I was asked to explain inexplicable events—usually frightening scenarios from dreams. Some he found so distressing that there were tears and swearing, best illustrated by a bizarre assertion that the US President's crashed aircraft was on fire next to the nursing station. "Why is nobody rescuing the

passengers?" he furiously demanded, before breaking down sobbing. It was soul-destroying to watch.

Throughout this time, I benefitted from colleagues' reassurance that this was a normal part of recovery from a brain haemorrhage. But worse was to come. Following discharge, he was incapable of returning to his self-caring, car-driving, daily-golfing, existence. The blood had gone, but cerebromalacia replaced much of the right cerebral hemisphere (figure 3). A nursing home was required. The first to accept him struggled: his behaviour deteriorated, with nighttime wandering, disorientation, agitation and anger. The pinnacle was a night spent prowling around other residents' rooms, cleaning his teeth in four different bathrooms and finally peeing inside the clothes cupboard of the startled lady in the room opposite.

He then moved to an 'elderly mentally infirm' facility, but the distress and agitation mounted, with worsening aggression and violence. He had developed a poststroke psychosis. Psychogeriatric care was essential, and he was admitted to the regional unit. My own stress levels climaxed at this point, when he calmly explained that unless I took him home immediately, he would try to kill himself. A low point indeed. Looking back, I realise that there was little meaningful activity in his brain at that stage. How right my colleagues were that he 'would need six months' before assessing the level of recovery, and how quickly it became clear that the psychogeriatric unit was the best place.

When the recovery came, its suddenness was remarkable. Within just 1 week—5 months after the haemorrhage—there was a rapid improvement. Twenty-five years in neurology gave no forewarning that such a near-miracle could happen.

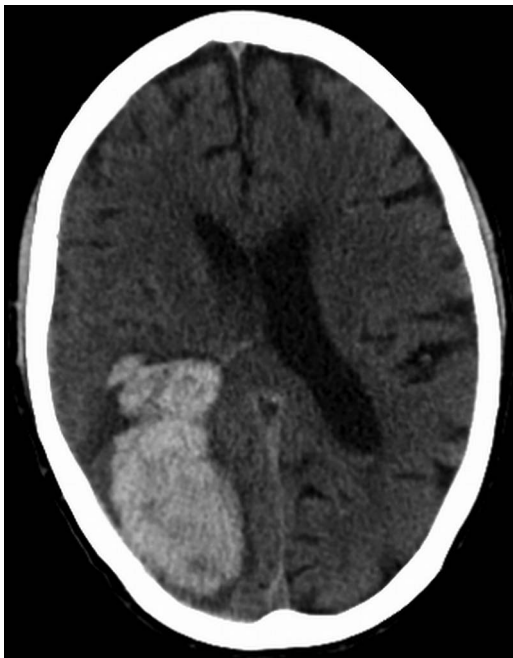


Figure 2 CT brain scan at presentation.

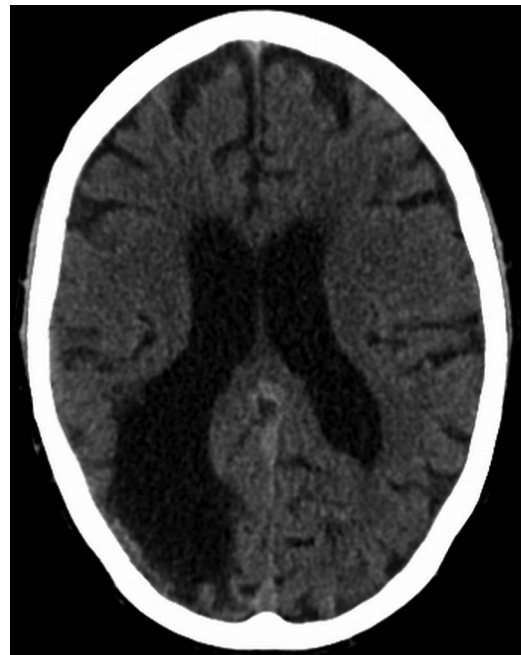


Figure 3 CT brain scan 12 weeks later.

Jim: I remember only part of my stay in the psychogeriatric unit. I cannot recall the events leading to my admission there. I thought sometimes that it was a ship, and sometimes that I was trapped in an undiscovered annexe of the old Walton Hospital in Liverpool where I used to consult. Vivid dreams stick in my mind: a regular one was being on a train that could turn left, right or go straight on. I used to anguish over which route was correct. Later I wondered if these dreams were a mechanism forcing my brain to retain some ability to make decisions.

Slowly I was able to understand the ward routine. I did not appreciate that I—uniquely—was enjoying one-to-one nursing care. In my confusion I assumed it was merely some supervisory mechanism to enforce good personal hygiene. Retention of the ability to walk was vital. The weakness in my left arm and leg resolved in a fortnight, and daily walks on the path around the psychiatric hospital were supremely welcome. How much quicker, I wonder, would the recovery of my fellow patients have been, had they shared my passion for regular exercise?

Colin: The recovery in the psychogeriatric unit was amazing. There was a persisting left homonymous hemianopia, and he remained unsteady. But to the delight of all the nurses he delivered a confident vote of thanks as he was discharged. Psychogeriatric medicine is seriously underappreciated.

Jim: There were times after my recovery when I wondered if survival was ‘worth it’. I had imposed disruption on my friends and son. But it has been an informative and educational experience. I marvel at

the brain’s ability to recover from such an insult, and I appreciate the importance of nurses having time to care. Moreover, I see the need for ongoing stimulation: clay modelling, painting and quizzes, all of which have benchmarked my recovery and boosted my morale. How I wish that I could encourage my fellow patients—many with dementia—to engage with these activities. Surely this would enhance their well-being?

So has it all been worth it? Yes. If it was worth surviving being buried at the age of 17, then it was worth surviving a brain haemorrhage at 89. Perhaps publishing these recollections will assist other people.

Colin: What have I learned? Witnessing this in a parent was difficult. The ability to share my worries with colleagues was invaluable. In retrospect, perhaps I should have stepped away from the situation, especially the psychosis. I should have listened to nurses who advised that the ‘take me home now’ cries were quickly forgotten once I left. And above all, I see that caring for a relative with a physical disability is challenging, but caring for a relative with cognitive impairment and disruptive or aggressive behaviour is infinitely more difficult.

Acknowledgements We thank the National Museums Liverpool for permission to use the photograph of Bianca Street, and we remain eternally grateful to all the nurses, doctors and support workers who provided such excellent, comprehensive and relentlessly cheerful care for so many weeks.

Competing interests None.

Provenance and peer review Commissioned; externally peer reviewed. This paper was reviewed by Christopher Kennard, Oxford, UK.