Chronalgia

Kadrey, Richard

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About Kadrey:

Richard Kadrey is a novelist, freelance writer, and photographer based in San Francisco.

Kadrey's first novel, Metrophage, was published in hardcover in 1988 by Victor Gollancz Ltd., and went on to various other American and foreign printings in paperback. Mac Tonnies' Cyberpunk/Postmodern Book Reviews calls Metrophage "one of the quintessential 1980s cyberpunk novels," going on to describe "a gritty acid-trip through an ultraviolent L.A. where nothing is what it seems… . Alongside novels such as [William Gibson's] Neuromancer and Lewis Shiner's debut novel Frontera, Metrophage helped establish the cyberpunk aesthetic: relentless, paranoid and playfully cynical."

Kadrey's second novel, Kamikaze L'Amour, is described by the same source as "mesmerizing… a surreal (and distinctly Ballardian) account of synesthesia and mutant desire set in the jungle-choked ruins of L.A."

Kadrey's short story Carbon Copy: Meet the First Human Clone was filmed as After Amy.

The publisher website, Amazon booksellers, and other sources list a July 15, 2007 publication date for Kadrey's next book, Butcher Bird: A Novel Of The Dominion (Night Shade Books). Other works include collaborative graphic novels and over 50 published short stories.

His non-fiction books as a writer and/or editor include The Catalog of Tomorrow (Que/TechTV Publishing, 2002), From Myst to Riven (Hyperion, 1997), The Covert Culture Sourcebook and its sequel (St. Martin's Press, New York, 1993 and 1994); Kadrey also hosted a live interview show on Hotwired in the 1990s called Covert Culture. He was an editor at print magazines Shift and Future Sex, and at online magazines Signum and Stim. He has published articles about art, culture and technology in publications including Wired, Omni, Mondo 2000, the San Francisco Chronicle, SF Weekly, Ear, Artforum, ArtByte, Bookforum, World Art, Whole Earth Review, Reflex, Science Fiction Eye, and Interzone.

Source: Wikipedia

Also available on Feedbooks for Kadrey:

- *Metrophage* (1988)
- *Butcher Bird* (2005)
- *Zombie* (2002)

- *SETI* (2002)
- *A Cautionary Tale* (2002)
- *Ubiquitous Computing* (2002)
- *Second-Floor Girls* (2002)
- *Bad Blood* (2002)
- *Kabbalah Cowboys* (2002)
- *The Tears of the Moon* (2002)

Since the surgery I'm proposing is somewhat radical and there is no standard procedure for it, I'm going to have to adopt techniques from other surgeries and, frankly, improvise along the way. And since, if all goes well, this is the last surgery I will ever undergo, I'm feeling bold, willing to take some chances.

I'm going after the hippocampus, a curved structure of the cerebral cortex forming the floor of the inferior horn of the lateral ventricle. It's also the seat of human memory and, therefore, our primary connection to time. To attack the structure, I'll be performing my own modified version of an anterior temporal lobectomy (ATL). This is a procedure common used to treat temporal lobe epilepsy by attacking hippocampal sclerosis. With any luck, in a few hours, I will beat H.G, Wells at his own bold game: I will become my own Time Machine.

PREOPERATIVE CONSIDERATIONS

The morning of surgery I self-administer St. John's Wort, Valium and a 200 mg. tablet of vassopressin, with a few sips of water. Although the use of prophylactic antibiotics is debated in the medical literature on ATL, I go the conservative route and give myself 1g of cephalosporin intravenously one hour before making the first incision. I follow this immediately with 10 mg dexamethasone IV, an adrenocortical steroid, to control tissue inflammation during surgery.

Probably my biggest problem is choosing the right anesthetic and the right dosage. I go with 1% lidocaine (epinephrine 1:100,000), an effective topical anesthetic and one that, unlike morphine, isn't guarded as carefully. The clinic won't notice the bottles missing until it's too late. Since the brain itself doesn't feel pain, I only have to use enough anesthetic to numb my work on the scalp and skull. We don't want any sudden twinges of pain to shake our hands while slicing and dicing the interior cerebral tissue.

Another challenge to the surgery is the patient's (my) body position. Traditionally, the patient is placed supine on an alternating air mattress with their head held in a Mayfield 3-pin holder. I'm using the Mayfield to hold my head steady, but have decided that I need to be upright. Since the surgery attacks the zygomatic arch (cheekbone), I don't think this will cause any real problems.

Of course, like any surgeon, I need to be able to see what I'm doing. I've positioned a dozen mirrors, at different angles, in a ring around my head and borrowed a set of professional photo floodlights from my brother's adult film company. After checking out my line of sight in the

reflective glasses, I'm satisfied that I'll be able to get the job done, even with my head immobilized in the Mayfield.

THE OPENING

Since this procedure enters through the anterior of the face, it isn't necessary to shave my whole head, just the facial hair, so that I can make a standard curvilinear frontal temporal incision, similar to the pterional approach to the circle of Willis. With a little more lidocaine, I proceed to incise the temporalis muscle directly beneath the skin, making sure it's reflected with the scalp. I have to base the bone flap low in the middle fossa, so that it extends just above the sphenoid wing but remains within the confines of the temporalis muscle fan. After inserting earplugs (not an easy task while locked in the Mayfield), I use a high-speed cranial drill to enlarge the bone opening towards the middle fossa floor and anteriorly into the sphenoid wing for several centimeters. To optimize temporal tip exposure I open the dura with a cruciate incision extending about one cm above the Sylvian fissure. For the remainder of the operation, I'm going to have to proceed using the operating microscope.

We are prisoners of time, slaves to the passage of seconds, minutes and years. From the moment we're born we're dragged, like trophy animals, through a swamp of decades towards the death we can see coming at the end. Yet even as we experience it, we know that linear time is a lie. On a subatomic level, time is fluid, moving both backwards and forwards. Are we humans less than subatomic particles? I don't believe so, but a quark doesn't carry our disease of linearity. The site of this disease is the brain, the place where memory and time exist and are bound together, specifically in the hippocampus. While this growth was once useful and helpful — providing us with a link to our past and, therefore, a sense of self — it has continued to growth unchecked. The hippocampus is a cancerous tumor that locks us in a single, linear timestream. Like any dangerous internal growth, it must be excised, or the body will die.

To mark the posterior limit of the proposed lobectomy, I measure four centimeters from the temporal tip along the middle temporal gyrus posteriorly from the sphenoid wing, a tricky move since I have to do everything backwards while looking into a mirror. With a disposable scalpel I purchased under a false name through a veterinary catalog, I make an incision in the sulcus between the superior and middle temporal gyri and carry the cut mesially, entering the temporal ventricular horn.

Placing a cotton pledget into the ventricle helps me to maintain orientation. With an irrigating bipolar coagulator and sucker, the middle and

inferior temporal gyri come out easily as a single surgical specimen. I then remove the superior temporal gyrus, remembering (and here is where the long hours of study pay off) to use subpial dissection technique and maintaining an intact pia along the Sylvian fissure and basal temporal regions. With the superior temporal gyrus removed to the level of the ventricle, I can then partially remove the amygdala.

Working steadily while simultaneously trying to contain my excitement, I remove the remainder of the inferior temporal structures mesially until the parahippocampal gyrus is before me. At this point, only the mesial-temporal structures remain and I can see the ependymal surface of the hippocampus. I administer more lidocaine and take a sip of my favorite calmative, mint tea laced with vodka. I must proceed carefully from here on.

I understand that, to the casual reader, the procedure I'm describing comes across as more than a little extreme. When researching possible cures for Chronalgia, I was inspired by the story of Dr. Jerri Nielsen who in 2000, while locked in a prolonged ice storm at Amundsen-Scott South Pole Station in Antarctica, had to self-treat her breast cancer. This courageous woman's ability to perform such dangerous therapy to save her own life gave me the courage to go ahead with my experiment, one that I'm certain will benefit all of humanity. In fact, I can already feel it happening. Simply by beginning this journey, I've removed myself from the flow or ordinary time and have defeated the tumor. Of course, that's only half the job. After I remove the hippocampus, there's another step to free myself from time completely.

Making an anterior incision along the choroidal fissure, from the level of the posterior boundary of the cerebral peduncle, I reach the tip. I then make a posterior incision at the level of the posterior margin of the cerebral peduncle laterally to the lateral hippocampal margin, then bring anteriorly and laterally until it meets a lateral resection margin. From here, I can joyfully remove the hippocampus to the level of the superior colliculus, taking care to coagulate and cut the numerous small vessels and cerebral arteries without damaging vessels supplying the peduncle and thalamus.

The idea for my somewhat radical self-surgery came from an entry I stumbled across in a medical book. It detailed the symptoms of Korsakov's Syndrome, a form of retrograde amnesia usually occurring in the later stages of acute alcoholism. The sufferer is unhinged from the present and floats into his or her own past, literally. Years, decades are

lost and relived as the patient mentally grows mentally younger. But what if a healthy person were to induce a similar brain anomaly? Might that person not be able to move backwards and forwards along the brain's timeline? The key to Korsakov's Syndrome was in the destruction of the Mammillary Body, lying almost directly above the hippocampal tumor. Happily, this procedure was much simpler than removing the hippocampus itself. Since the cortex was already open to the proper level, all I had to do was lobotomize the offending organ by inserting the scalpel into the upper boundary of the cerebral peduncle and making a neat, lateral slice in the tissue, severing the MB, leaving it no longer an isthmus of tissue, but an island. I can feel the effects immediately. My body is loosened from itself, from the brain, from time. I must finish my work quickly.

Irrigating the resection cavity completely free of blood and closing the dura, I use tack-up sutures and secure the bone flap into place. The muscle, fascia, and galea I close with 2-0 Vicryl sutures, and the skin is closed with staples. No drain is needed and blood loss should not exceed 300 cc.

POSTOPERATIVE MANAGEMENT

The night of surgery I sit at the bedside and deep breathe for pulmonary toilet. I must watch for fever, infection, and seizures for the next twenty-four to forty-eight hours. I must keep my incision clean. I must return the lights to my brother's film company. Perhaps, under the circumstances, he'll come and retrieve them himself. I administer more lidocaine, drink my tea and vodka calmative and prepare to rest. Free from these cerebral tumors, my brain will do the rest of the job on its own.

I can feel physical and temporal shifts deep inside my body. It seems as if they are bubbling up from the center of the world, a subtle undulation from the earth's tectonic plates. I sense all this and believe I am feeling the first waves of geological time that have been locked away, hidden in my cerebellum. The sensation is both frightening and exhilarating.

Already, I am adrift in time. That, or I've overshot myself and gone forward in moment to my own death. And why shouldn't I? The end is much part of the journey as the beginning. I expect to experience my death and birth many times on this pilgrimage. Let it come. Let it all come. Birth or death or anything in between. I've paid for my ticket. I'm ready for the ride.

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