To Save a Life

In the MICU

When I started my residency, the most common question my friends asked me was, "Have you saved a life yet?" I thought this question would be easy to answer when the situation arose, but after my first code, I discovered that this was not the case.

The patient was a 35-year-old physician who originally presented with eye pain. Over time, he suffered numerous incapacitating ischemic events and was ultimately diagnosed with catastrophic antiphospholipid syndrome. The patient had been in a coma for several months by the time I started my MICU rotation. His hospital course was further complicated by numerous infections, and he recently underwent mitral valve replacement due to endocarditis. When the patient developed fever, tachycardia, and hypotension, sepsis was suspected. New antibiotics were added to his medication regimen, and new cultures were sent to the laboratory. Later, his heart rate slowly decreased, which eventually resulted in cardiac arrest. A code was called, and he returned to normal sinus rhythm after 1 shot of epinephrine. A second code was called an hour later, and again he responded to CPR and pharmacologic therapy.

Reviewing the patient's chest radiograph, I thought something looked strange. Was his heart shadow enlarged? There were no signs of cardiac tamponade on physical examination, and his clinical picture pointed to sepsis. However, given the patient's recent valve replacement and treatment with anticoagulation, he was certainly at risk for tamponade. An echocardiogram showing a large clot in the anterior chest compressing his heart confirmed my suspicion. As the surgeons began preparations for emergent surgical evacuation, the patient experienced another cardiac arrest, and a third code was called. This time, he did not respond immediately and was defibrillated, finally returning to normal sinus rhythm after 15 minutes of CPR. Knowing that the clot needed to be evacuated immediately and that the patient was not stable enough to make it to the OR, the thoracic surgery fellow decided to operate right there in the MICU. I had not seen a thoracotomy since medical school, and it had been years for most of the nursing staff as well. Nonetheless, emergency surgery was going to be performed in the middle of the MICU at 2 AM.

The surgeon opened the patient's chest wall. We scattered to find appropriate tools and instruments as the surgeon barked orders at us. Eventually, the instruments, anesthesiologists, and surgical support staff made their way to the impromptu surgery. Large blood clots were removed from around the heart, allowing the heart to pump more easily.

Miraculously, the patient survived that night, and he was taken off pressors by the next day. I knew that he would probably never leave the hospital or even regain consciousness, but I felt proud that I made the correct diagnosis and helped my patient, a fellow physician. I thought that I, together with everyone else who assisted, did help save his life that night, despite his overall poor prognosis. I still felt that way when I heard that the patient died a month later.

When I grapple with the issue of what it means to "save" a life, I am always reminded of this case. As I delved further into my residency and was exposed to more life and death situations, suffering, and palliation, I realized the complexity of the question. Nevertheless, I still feel that we save a life, even when it is only for a short time.

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