

Unpredicted Outcomes

In the Burn Unit

One of the most memorable resuscitations I took part in occurred when I was a fellow in the burn unit. An elderly woman was brought to the ED by ambulance due to an inhalation injury. The woman had witnessed her husband, a WWII veteran who was wheelchair bound, incinerate in the burning house. She tried to save him, but the smoke and flames were overwhelming. A neighbor found the collapsed body of this heroic 79 year old within the threshold of the doorway and dragged her out of the burning house.

The patient, whose medical history was significant for aorta valve replacement, hypertension, and chronic obstructive pulmonary disease, had sustained 1% total body surface area thermal injury and an inhalation injury. Upon admission to the ED, she was immediately intubated with a 7.0-Fr endotracheal tube. During this procedure, significant sputum mixed with soot was noted. Despite aggressive suctioning, the patient sporadically desaturated to 78% on the pulse oximetry due to repetitive occlusion of the endotracheal tube. Her hypovolemia and β -blocker use added to her circulatory instability. She continued in a cycle of hypotension, bradycardia, and desaturation over the next several hours.

During one of her long hypotensive episodes, I shouted her name, "Yoni! Yoni, don't die on me now. You hang in there, do you hear me? I know that you have been through a lot, but I need you to fight to come back. You are going to live!" After placing her on a volumetric diffusive respirator in the ICU and placing her on vasopressors in addition to the hospital's established protocols for inhalation injury, she eventually stabilized.

Due to her age, injury, and medical history, the patient's prognosis for survival was poor; however, she was successfully gradually weaned to lower settings on the ventilator and underwent a tracheostomy 2 weeks

later. A family meeting in the patient's room was scheduled. The patient, Yoni, was asked if she understood that she might remain on mechanical ventilation for weeks, months, or for the remainder of her life. She was able to scrawl on a pad, "*I want to live.*" After a month, she was transferred to an acute care step-down facility for ventilatory patients.

Three months later, I was exiting the hospital when I saw this patient slowly walking in the main entrance with a cane in one hand and the other hand resting on her son's arm. Her son stopped and greeted me with a brilliant smile.

"Mom, this is the doctor who saved you from the fire."

She pensively stared at my face as I told her what a privilege it was to see her walking and looking so well.

She continued to stare at me and finally said, "Oh, now I remember you. You're the angel with the mask and brown eyes. I remember hearing your words, that I was going to get better. But what I couldn't understand is why you kept shouting my husband's name whenever you spoke to me. My name is Yula, and my husband's name is Yoni."

I was shocked and had nothing to say at this both pleasant and yet embarrassing moment.

Yula, it seems, was erroneously registered under her husband's name. Ironically, calling her "Yoni" may have stimulated her during her medically critical moments, showing that names are important not only on charts. When she was oscillating in and out of consciousness, she recognized my voice and remembered my words—reinforcing the fact that patients can hear us and our words are powerful. She beat the odds with her will, her resilience, and medical technology. Yula's achievement should not be underestimated.

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