A Messy Resuscitation

In the Emergency Department

Beep…beep. I looked down at my pager to see what was coming in—a 52-year-old man who had been involved in an auto-pedestrian accident. As I walked to the ED for the consultation, I thought that this would be a routine trauma. There was a commotion and, as I entered the ED, I saw a homeless man covered in dirt and cut rags. He was furious and was thrashing and yelling, "Let go of me! I gotta go!"

My colleagues told me to watch out for his right foot. It seemed alive, crawling like a mound of disturbed ants. As I moved closer, the stench was overwhelming. There were maggots enveloping the patient's foot, dropping to the ground as the patient struggled. I slowly made my way toward the head of the bed to better assess the problem.

As I swiftly rechecked the fundamental ABCs, the monitor showed a heart rate of 140 bpm and a systolic pressure of 70 mm Hg. There were no intravenous lines, as the belligerent patient had ripped them out. Fortunately, radiography and CT scans had already been performed, and they showed bilateral comminuted clavicle fractures and an open right tibia-fibula fracture…nothing else. Still, the patient's chest was growing in size with every breath. What was going on?

I talked to the patient and tried to calm him down. "I still gotta go!" he yelled. As I quickly explained to him that we had to place central lines, I noted that his neck and upper chest were now so swollen that his anatomy was becoming distorted. As I prepared to place a central line, he was still yelling but was not swinging as violently. I proceeded with the femoral line, and then he yelled out, "Here we go!" The patient let out a large bowel movement that would turn the stomachs of even the toughest of people. "And that's not all I've got!" he screamed. Urine then sprayed like a geyser out of the patient's penis. I had never been involved in a resuscitation like this.

Fluid and blood poured into his body from the central line. The patient's chest and neck became tight masses, but his airway was still intact. After a short time, his airway was becoming compromised and I had to intubate him. I explained to him what I was going to do, and he sincerely told me to do whatever was necessary. After an uncomplicated intubation, he was taken to vascular radiology where we discovered that his fractured clavicles had punctured a branch of his subclavian artery, causing his chest to expand. The arteries were successfully coiled, and the patient was taken to the ICU for further stabilization.

On the first day of my ICU rotation 3 weeks later, I did not recognize the patient. He was well groomed and clean; no maggots remained. Only an intubated patient with multiple drips and the whirring of the dialysis machine were evident. As I examined his multivolume chart, I recognized my handwriting. I read the history and remembered who he was. During his ICU stay, he had become septic and never regained consciousness. After consultation with the ethics committee, it was determined that the patient would not survive. Despite all of the pressors, the patient's vital signs could not be maintained on his own, and he died within minutes after the machines were turned off.

I will never forget this patient. He had only wanted to use the bathroom, but it was not exactly the best time to do so. He had been polite to me during our brief, yet messy, interaction, and the last words he spoke were of kindness.

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