

Grim Statistics

In the Surgery Building

The first code I ran as a resident will always stand out in my mind. During a night float rotation in the second year of my internal medicine residency, I was admitting a patient when I heard the code announced. As I was quite close to the room where the code was called, I knew I was going to be the first member of the code team there.

When I arrived, the patient was unresponsive and barely breathing, and she did not have a palpable pulse, although the monitor showed a rhythm that indicated pulseless electrical activity. I asked one nurse to start bagging the patient, another to start chest compressions, and a third to draw some epinephrine. I turned to the surgical intern and asked her about the patient's history.

"She has a TAA and an AAA and is here to undergo elective repair tomorrow," she reported.

Great, I thought, which one had ruptured? I knew that she needed to go to the OR, but I realized that I had to stabilize her first. The surgeons were not going to operate on a dead person. I asked the surgical intern if she could intubate the patient. She said she would try.

At this point, the rest of the code team along with the senior surgical residents arrived. While the surgical residents scrambled to call the attending, family, anesthesiologist, and the OR, the rest of the code team worked to stabilize the patient. After atropine and epinephrine were administered, she regained a pulse, and with fluids and careful titration of pressors, we

were able to keep her blood pressure at an acceptable level. She was successfully intubated, a central line was placed, laboratory studies were sent, blood arrived from the blood bank, and the patient was maintaining a decent blood pressure. The results of the laboratory studies showed a hemoglobin level of 6.7 mg/dL (down from 10 mg/dL previously), which supported our suspicion that one of the aneurysms had ruptured. The OR team reported that they were ready for the patient, and the surgical residents accompanied her to the OR.

Later, I learned that the AAA had indeed ruptured. She survived the surgery, but she had (not surprisingly) developed ischemic bowel and an ischemic gallbladder and had to return to the OR at least twice after the initial operation.

On the night of this code, though, I remember thinking: What are the odds of this happening? That someone who came in for an elective AAA repair would rupture the night before she was scheduled to undergo surgery? A senior surgical resident had once told me that the statistics for a ruptured AAA were not good: roughly 50% of patients do not make it to the hospital alive, and of those who do, 50% die in the OR, and of those remaining, 50% die before they are discharged from the hospital. Pretty grim statistics. The fact that she was in the hospital probably saved her life.

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