One night when I was on call during my internal medicine residency, a code blue was called from the orthopaedics floor. A woman in her eighties who had undergone a total hip replacement that morning had been found apneic and pulseless by a nurse. By the time I arrived on the floor, the resuscitation cart was already there and cardiac monitoring had been started, which showed a perfect sinus rhythm. Curiously, the patient had no heartbeat, no respirations, and no reflexes, and her pupils were dilated. A surgical resident had also just arrived, and we started CPR. My initial impression of the patient’s condition was electromechanical dissociation due to a pulmonary embolism, so we started calcium boluses along with other standard resuscitative interventions. The orthopaedic surgeon arrived about 15 minutes later, and we explained the puzzling situation: the patient’s body was definitely becoming cold, but the monitor still showed a perfect tracing.

After every effort that we made failed, we decided that the patient was indeed brain and cardiovascularly dead, but for some inexplicable reason electrical activity in the heart continued, so she couldn’t be pronounced dead. We sent the patient’s body to the ICU to wait until the tracing was flat, and I went to bed.

The next morning, I met with the surgical resident at breakfast.

“So, what happened?”

“Turns out she had a pacemaker! One of those early ones that show no spike and to boot it was placed right below the right costal margin. And since it wasn’t mentioned in her history and she had no relatives who knew about it...”

It seems we had spent an hour resuscitating a pacemaker.

—Fausto Fernandez, MD
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