A Peculiar Code

On the General Medicine Floor

I participated in an unforgettable code during my second year of residency when I was working the night shift on a floating rotation. It was around 6 AM, and I was thinking about grabbing a cup of coffee before sign-outs when my pager beeped. I guessed correctly that I had gotten another admission. There was a fairly steady flow of admissions that night, but the floors otherwise had been very quiet. Just as I set off to admit what would probably be the last patient of my shift, there was an overhead page indicating a code blue: "TEAM ONE to 3 North." I immediately rushed to the site. As I entered the room, I saw the name of the patient and recalled admitting her a day ago. She was an obese woman with multiple medical conditions (congestive heart failure and chronic obstructive pulmonary disease).

To the surprise of myself and the 2 other residents who were first to reach the scene, the patient was sitting on the commode in the rest room and was not responding. Initially, she had a pulse, but we soon realized she was not breathing. To resuscitate her, we needed to remove her from the commode. The 3 of us hurried into the rest room and managed to lift her up, but we could not hold her due to her weight and she landed on the floor of the rest room. By then, she had no pulse, and we had to start CPR even though she was not in an appropriate place for resuscitation.

The room was very cramped with all the rescuers, but the patient needed to be ventilated while CPR with ACLS protocol was performed regardless of where she was. We began administering oxygen with a manual resuscitator and I began to awkwardly compress her chest. Luckily, peripheral access had been obtained before the code, so we had IV access if we needed it. Then, an anesthetist arrived at just the right time, and he was able to intubate the patient despite being wedged against the lower part of commode.

After 8 minutes of resuscitation, the patient's pulse returned, and I stopped chest compressions. With the help of transporters, we placed the patient into a hospital bed. We then obtained central venous access after hooking her up to a ventilator. By then, the patient was becoming restless and was fighting with the ventilator, so we had to sedate her. Shortly after, we transferred the patient to the ICU with improved vital signs. Although she had 2 failed extubation trials during her stay in the ICU, she was ultimately discharged in her baseline clinical condition 2 weeks later.

Of course, everyone felt good about this successful code, especially as it occurred in a peculiar place and under difficult circumstances. The next day, though, both another resident and I almost called in sick because of back strain from moving this heavy patient.

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