

## On a Quiet Friday Morning

### A Hospital Transplant Ward

**T**hursday evening rounds in the hospital transplant service had been uneventful and all the patients were doing well, but I still felt uneasy about this relatively painless night on rounds. At 6:35 AM on Friday, I received a panic call from the floor. A patient was having trouble breathing. Every resident who had served on rotation in the transplant service for the past year knew this patient. He had been receiving steroids for several years as an anti-rejection medication, which had caused his weight to increase from 180 to 275 lbs.

I took a quick primary survey and noticed that the patient's respiration was shallow at a rate of 30 breaths/min and scattered crackles could be heard in his lungs. The room-air arterial blood gas value of partial pressure of carbon dioxide (PCO<sub>2</sub>) was 52%. I was unsure if I had hit an artery or a vein, so I took a venous blood gas measurement from the only venous access we had, the Permcath. When I saw the venous PCO<sub>2</sub> value of 65%, I knew the patient had to be intubated.

After administering 100% oxygen to the patient and obtaining a normal electrocardiography reading, I called the senior resident in anesthesia. His response was, "Why don't you call the first-year anesthesia resident responsible for intubation?" When I described the body proportions of this patient, the senior anesthesia resident agreed that he should bring the fiber optic laryngoscope.

As the anesthesia resident prepared for intubation, he noticed the patient had a short thick neck. The resident asked the patient to open his mouth and stick out his tongue to evaluate the airway. The patient's compli-

ance with this request provided a moment of humor in this serious situation—the resident could not see any of the patient's mouth because the patient's tongue completely blocked the view. At this point, the resident suggested that I call the otolaryngology resident in case the patient could not be intubated.

The otolaryngology resident examined the patient and suggested that he be intubated in the operating room in case a tracheostomy was needed because this procedure would be much easier to perform there. At this point, I called the operating room and said, just like they say on television, "I need an operating room right now! We are coming down!" The standard procedures of waiting were thrown out, and, as in a trauma case, we pushed the patient to the operating room.

When we arrived, the attending anesthesiologists filtered into the operating room and wondered what all the commotion was. One attending physician walked into the room, looked at the patient, and asked for an endotracheal tube. Before anyone knew what was happening, he had nasotracheally intubated the patient. Immediately, the patient was ventilated via the endotracheal tube.

All the residents and I stood there in amazement at the ease with which the attending physician had intubated this patient. While I was mentally recovering from the havoc, I remembered why physicians go through so much training. Physicians are trained not only to do what is right, but to know what to do when something goes wrong.

—**Michael A. Sanford, MD**  
New York, NY

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