Help From an Untapped Resource

In the Intensive Care Unit

My patient was a young man who drank more alcohol than 10 men his age. He had experienced multiple episodes of alcoholic pancreatitis, and he had variceal bleeding secondary to portal hypertension and alcoholic cirrhosis. Earlier in the month he had presented to our emergency room with massive variceal bleeding and liver failure. His hospital course had included sclerotherapy and recurrent hematemesis complicated by aspiration pneumonia.

As a resident, I met him one night in the intensive care unit (ICU). The patient had been in and out of shock despite aggressive inotropic therapy and multiple surgical and gastrointestinal interventions to manage the bleeding. Earlier in the night, I had achieved balloon tamponade of the recurrent esophageal bleeding with a Sengstaken-Blakemore tube. The need for the use of this medieval device only served to confirm the patient's dire predicament.

As is true for many fights for life in the ICU, the battle was slowly lost. Multiple transfusions and aspiration pneumonia resulted in the patient being increasingly difficult to oxygenate. Higher doses of inotropic agents were required to maintain a marginal blood pressure. It was little surprise when the patient coded with ventricular tachycardia at 2 AM. We used the cardioverter and began aggressive advanced cardiac life support resuscitation.

After 30 minutes it was apparent that our efforts were hindered because the cardiopulmonary resuscitation (CPR) was inadequate for his large body habitus. The drugs were not circulating, and my nurses and I were exhausted from performing CPR. Watching the spectacle of our entire performance was the burly ICU housekeeper named John, who had the body and strength of an Olympic weight lifter. Seeing this untapped source of energy, I recruited him to do CPR.

Under John's hand, the patient went from an inadequate blood pressure to systolic over 100 bpm. The housekeeper's powerful movements were able to depress the sternum and compress the patient's left ventricle. The drugs and John's efforts took effect where cardioversion and others' efforts had failed. The patient regained spontaneous circulation.

This victory was but a small skirmish in the overall effort. The patient succumbed to another code later that morning and died after rounds. After that night, John the housekeeper benefited from my and the nursing staff's knowledge of his heroic effort. I was told by the nursing staff that all the ancillary personnel had training in CPR and basic cardiac life support. This occasion was the first in anyone's recollection that one of the ancillary personnel trained in basic cardiac life support had the opportunity to use that skill.

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