

Making a Difference

In the Radiology Suite

In the late 1980s, I was a medical oncology fellow at a university hospital. The oncology service was split between 2 units: a research floor where investigational protocols were carried out and a second unit where standard chemotherapy treatments were administered to non-protocol patients. I was in-house on-call for the entire service on this particular evening.

During "sign-outs," one of the attendings informed me that he had a 24-year-old woman, a young mother with metastatic melanoma, who was receiving high-dose interleukin-2 (IL-2) on the research floor. The patient had a progressively deteriorating mental status over the preceding 24 hours, and the attending was becoming increasingly concerned. (These were the early days of IL-2 investigational trials, when all of its toxicities had not yet been appreciated.) The patient was scheduled for a computerized tomography (CT) scan of the brain that evening, and the attending wanted me to call him with the "wet reading" as soon as it was available.

It was still early in the evening and I was busy on my unit when I heard a code blue called in the CT suites. I had a premonition that it was for the patient I had been told about. My unit was not far from the CT scanners, so immediately I ran down to radiology.

When I arrived, the patient was lying unresponsive on the CT scanner, without respirations or pulse. She had arrested while being transferred from a stretcher to the scanner. Fortunately, the radiology technicians had just placed electrocardiogram leads on the patient, and I quickly saw she was in ventricular fibrillation. By this time, the crash cart was in the room. I charged the paddles, yelled "clear," and defibrillated the patient. To my amazement and, I think, to that of the others in the room, she converted to sinus tachy-

cardia and within a few seconds took a breath and began to move. By the time the "official" code team arrived, she was responsive, somewhat oriented, and did not require intubation.

During the post-code commotion, the patient asked me, "What happened?"

I flippantly said, "Oh, nothing you need to know about right now!"

She was started on a lidocaine drip and transferred to the intensive care unit. I called the attending to let him know what had happened.

Two days later, I walked on to our research unit for rounds. As I did, I heard someone shriek, "You! You!" As I turned around, the patient came running up to me and threw her arms around me, giving me a big hug.

She said, "I could kill you for not telling me what happened the other night!" Her attending obviously had told the patient of the events that had transpired.

"Under the circumstances, we were working on a need-to-know basis," I replied. "You didn't need to know what had happened at the time."

We both began to laugh. She thanked me over and over again, despite her sore chest from the defibrillation. She ultimately had the CT scan, which was read as normal, and her episode was attributed to IL-2 toxicity.

Although the patient did not respond to the IL-2, she survived for another 3 years and was able to spend this time with her child and family. As an oncologist, I am often asked how can I do what I do for a living. Events like this let me know that maybe sometimes, even in the most hopeless of circumstances, I do make a difference (at least for awhile).

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