

Breathless

En Route to the Operating Room

Thirty-five years ago, I was serving my cardiology fellowship in a university hospital on the East Coast. When I walked into the cardiac catheterization room late one afternoon, I saw a senior cardiologist, board-certified in internal medicine and cardiology, performing a cardiac catheterization on a patient scheduled for the operating room. The patient was a 45-year-old, heavysset woman with a suspected pulmonary venous thromboembolism.

The patient's pulmonary artery pressure was 90 mm Hg. The cardiologist pressure-injected the pulmonary angiogram, which documented the massive pulmonary embolism. The patient was immediately placed on a gurney for transport to the operating room.

"Doctor, I can no longer breathe!" the patient said.

"You'll be fine," the cardiologist replied. He gave her an oxygen mask, moved her onto the elevator, and said, "Josh, take her up. They're waiting for her in the OR."

The elevator door closed, and it was just me and the patient. Again, the patient said, "Doctor, I can no longer breathe!" And then she stopped breathing.

Cardiopulmonary resuscitation was performed immediately. Endotracheal intubation and pulmonary embolectomy were also performed instantly. And yet, the patient did not survive.

For decades, I have wondered about this patient: Would a hand injection of contrast dye in the cardiac catheter laboratory, in the presence of a pulmonary artery pressure of 90 mm Hg, have been safer than a pressure injection? Could the demonstration of dyspnea (air hunger) have been any more clear than what was provided by the suffering of this patient with massive pulmonary venous thromboembolism?

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