

## The Teaching Point

On the Telemetry Floor

“Code Blue...Yunker 8. Code Blue...Yunker 8.” A new surgical intern, I nervously slung my stethoscope around my neck and trotted down the hallway in that comical flat-footed gait necessary to keep medical paraphernalia from flying out of the bulging pockets of my lab coat as I ran. Arriving on the telemetry floor, I entered a room already bustling with first responders and curious ancillary personnel. A plaid suitcase lay on its side in one corner.

“She was supposed to go home today,” a young nurse murmured almost apologetically.

I nodded, pushing my way to the head of the bed. Grateful to find the patient edentulous, I slipped in an endotracheal tube and the respiratory therapist initiated bag ventilations. After confirmation of no pulse, someone started chest compressions.

I asked the nurse about the patient’s history. Quickly, she recited the facts: 68-year-old woman, 6 days post urgent coronary artery bypass grafting, unremarkable convalescence, found down and pulseless in her room shortly before final discharge to home.

The attending cardiothoracic surgeon strode into the room. I turned my attention to placing a central venous catheter in the groin, while he ran through the advanced cardiac life support protocol of her various rhythms. Sinus tachycardia degenerated to ventricular fibrillation that, after defibrillation, settled into a seemingly resistant ventricular tachycardia, and finally—after a series of shocks—*asystole*.

“Still no pulse,” a paramedic trainee duly noted before resuming chest compressions.

“We should crack her chest,” I heard myself say, almost more a question than a statement.

The attending frowned. “It’s probably ventricular wall rupture. She’s been down a long time. I think we should call it.”

“She’s right; it is protocol,” a voice rose from the back. The chief resident stood leaning against the doorway, an amused smile on his face. “Besides,” he said, with a subtle gesture and nod in my direction, “she’s got to learn sometime.”

The attending shrugged his consent and someone produced a chest tray. My hands shook as I assembled the pieces to the sternal retractor. The freshly operated on skin separated easily. Underneath, blood began pressing through the closure as the sternal wires were

cut and pulled free. The retractor was placed and the mediastinum was a pool of dark blood, obscuring the heart. I reached in gingerly and fumblingly began open heart massage.

“Careful of the grafts,” the attending said irritably.

After a few compressions, the heart quivered and spasms of contractility settled into a pattern of regular motion. The blood was suctioned from the cavity and a hole on the anterior surface of the aorta with active bleeding became visible. The attending placed his finger over it and the bleeding stopped. The heart filled as fluids and then blood were pumped in by hand squeezed intravenous bags.

“We’ve got a heartbeat, but I doubt we’ve got much else. Someone better call the family,” the thoughtful-looking paramedic muttered.

I stared down at the woman’s ashen face. She still wore remnants of the lipstick she had applied in anticipation of leaving the hospital. What degree of complexity had my educational pursuit now burdened the lives of this woman’s family? Had my desire to learn a novel procedure converted an unexpected—but simple—death into long hours or days of painful end-of-life decisions? The scenario took on the uncomfortable aura of a science experiment gone horribly awry.

Suddenly, the woman’s eyes opened, her back arched, and she cast her eyes about the room, seemingly searching. People screamed and pushed back from the bedside, then sheepishly exchanged glances and embarrassed smiles.

“Call the OR!” the attending barked. “Let’s roll!”

The patient was whisked out of the room, a finger still pressed against the hole in her aorta, past the shocked onlookers crowding the hallway.

Weeks later, my sleep-deprived consciousness recalled the event long enough to ask the cardiothoracic surgeon about the outcome. He looked at me blankly.

“Who? Oh, yes. We repaired her aorta. She was in the hospital another 2 weeks and was discharged to rehab. She’s home now and doing well.”

He paused and looked at me wryly. “So, doctor, do you think you know how to do a postoperative resuscitative thoracotomy now?”

We shared a smile. “Yes, sir. Thank you, sir, I do.”

—Meredith McBride, MD  
*Lewiston, ID*