

## Hunger and Intestinal Ischemia

### An Inpatient Ward

**M**aria, a 29-year-old bedridden paraplegic, was a well-known patient at our hospital. She was in the hospital so often that she called it her “second home.” When Maria was 21 years old, she was in a motor vehicle accident, the complications of which resulted in paralysis at the level of the third thoracic vertebrae (T3), left above-knee amputation, multiple stage IV decubitus ulcers, colostomy, chronic sepsis, depression, and recent gastrointestinal tube placement secondary to prolonged anorexia and malnutrition. Maria lived in a nursing home, where she was known to abuse intravenous drugs and refuse care for her wounds.

Most recently, Maria presented to our general surgery team with complications of her gastrointestinal tube site. When we saw Maria in the emergency department, she was finishing a chicken sandwich and a bag of chips and was seeking another sandwich, her appetite having returned with a vengeance since her tube placement 3 months ago. However, the usually snug hole in the abdominal wall had widened, and now gastric secretions and partially digested food were flowing freely around the tube and eroding nearly half the skin over her abdomen. Because of her T3 neuropathy she denied much pain. We explained our diagnosis and our plan to treat her with local wound care and bowel rest. She laughed, said that her only complaint was of persistent nausea, and then requested prochlorperazine maleate to be served with her second sandwich.

We realized that maintaining Maria off oral intake of food (NPO) would be a challenge. She relentlessly begged for food, for a soda, for juice. She did not seem to understand that the food, accompanied by gastric acid, was coming right out of her stomach onto her skin and that the fistula was getting larger with each meal. She only understood that she was hungry. Her first night, Maria devoured a cheeseburger that she convinced her aunt to bring because the hospital “would not feed” her. As we again explained the importance of not eating, Maria listened, but did not comprehend the consequences. During our conversation, greenish-brown fluid oozed uncontrollably out of her tube.

Signs were placed on Maria's door and above her bed stating that she could have nothing by mouth, yet she convinced her family to bring her food and drink. With careful ostomy care and earnest attempts at NPO maintenance, Maria's abdominal wounds began to

heal. On day four of her stay, we compromised by placing a nasogastric tube and letting her drink milk and water. The liquids were immediately suctioned out, and thus the output at her fistula remained minimal.

Suddenly, on hospital day seven, Maria's body temperature dropped to 35° F. She was confused, and her abdomen was greatly distended. Blood gas assessment showed severe lactic acidosis and she was urgently transferred to the intensive care unit. At that time, her systolic blood pressure dropped to 45 mm Hg. Maria was intubated and aggressively fluid resuscitated. An acute abdominal series showed portal venous gas and pneumatosis. We explained the radiographic and clinical findings of gut ischemia to the patient and her family who consented to an exploratory celiotomy. To my amazement, Maria requested a sandwich before the operation. Much to her dissatisfaction, the request was not granted and she was taken to the operating room.

We were hoping to remove only a section of bowel, but when we opened her abdomen, the entire bowel within the superior mesenteric artery distribution was already dead. There was nothing to save. Quietly, Maria was sewn back together and returned to the intensive care unit. As her status continued to spiral into worsening septic shock and acidosis, we explained to the family that Maria would live at most a few more hours and that she most likely would not regain consciousness.

But Maria was a fighter. She had endured much in the last 8 years, and she was not going to leave the world without a solid struggle. Her family crowded around her bed crying and praying. When Maria's systolic blood pressure was 55 mm Hg, amazingly, she awakened. She couldn't speak because of her endotracheal tube, so she motioned for a pen. Her systolic blood pressure was now 45 mm Hg on maximum doses of inotropic medications, yet she wanted to write! Was she cold? Was she scared? We all watched as she wrote her last wish. She slowly printed on the paper, “Chicken.” Although most of us were still recovering from the surprise of her request, one of the residents quickly prepared some chicken broth and swabbed it onto her mouth. Maria died a few minutes later.

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