

The “in extremis” call: When your friend is the one calling!

Joseph Varon

Years ago, I remember vividly reading an article by the late Dr. Roger Bone, where he described his emotions and experience with his illness. (1) I was quite captivated by such description that I thought, eventually I would write a

similar piece. However, to my surprise, over the past weeks I have encountered an unprecedented feeling towards the practice of medicine that involved caring for one of my best friends.

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Everything started with a “frantic call” to my cell phone by my interventional cardiology friend who, gasping for air, said: “Joseph, I am going to die, I can not breathe. Have your hypothermia machine ready”. At that point, I asked him where he was and his last words were “at the office”. As a critical care practitioner, I commonly hear phrases such as “I am going to die”. However, when one of your best friends, who is a seasoned clinician calls and says it, the wording suddenly has a totally different meaning.

As this situation occurred after office hours, I sent 3 trained assistants to his office, who literally broke into his office, to find my colleague on the floor gasping for air. They promptly transported him to our emergency department (ED). The transport time elapsed no more than 10 minutes. As I was waiting for his arrival, I had everything I needed for any critical condition. The fact that he was complaining of dyspnea and an impending doom, as well as the fact that he was an experienced cardiologist complaining of these symptoms, made me think of cardiovascular pathologies.

Moreover, my friend had just returned from a trip to the Middle East and pulmonary vascular pathology was also high on my list. The number of different clinical conditions was countless; however, I had just a few in my mind: Acute myocardial infarction or acute pulmonary embolism.

What followed was the most striking of this story. My friend arrived to the ED gasping for air, truly “*in extremis*” and told me again “I am going to die....I am acidotic”. I immediately proceeded to intubate his airway. I personally have probably managed the airway of more than 40,000 individuals over my life-span, from the “easy airway” to the complex surgical airway. Yet, as I looked at my dying friend, I knew I had no option but to make sure the endotracheal tube was inserted on the first attempt. I took a deep breath and asked everyone around me to do the same. Knowing that my colleague was well known among everyone at the hospital, I needed to assure that he would be cared for as any other patient, and that the fact that he was a “very important person” wouldn’t delay or bias his medical treatment.

I was successful in securing his airway without difficulty. My initial examination had revealed clear lung fields, sinus tachycardia and tachypnea. His abdomen was soft and bowel sounds were present. Electrocardiogram confirmed the sinus tachycardia but not other abnormalities were seen. A post-intubation chest radiograph did not reveal any obvious pathology. Arterial blood gases prior to intubation had shown a pH of 7.40 with a pCO₂ 36 torr and a pO₂ of 242 torr, while he was receiving supplemental oxygen. His initial complete blood count was unremarkable except

From University General Hospital, The University of Texas Health Science Center at Houston, The University of Texas Medical Branch at Galveston, Houston, Texas, USA (Joseph Varon)

Address for correspondence:

Joseph Varon, MD, FACP, FCCP, FCCM
2219 Dorrington Street
Houston, Texas 77030, USA
Tel: +1-713-669-1670
Fax: +1-713-669-1671
Email: Joseph.Varon@uth.tmc.edu

a white blood cell count of 4,000/mm³ and his serum electrolytes were completely unremarkable. Was I wrong? The thought kept on crossing my mind. Did I intubate him too fast? Was his history reliable? Could this be just a “panic attack” that I had just intubated?

I looked at the data again and I knew something else was going on. My friend had been truly gasping for air. His blood pressure was borderline with wide open fluids being given. But again I asked, was I over reacting?

I elected to obtain a computed tomography of the chest, abdomen and pelvis looking for conditions such as pulmonary embolism and intrabdominal sepsis. Within 15 minutes, he was undergoing imaging studies that failed to reveal a pulmonary embolism. Nevertheless, as we were reviewing the abdominal computed tomography we found the culprit: My friend had an abnormal descending colon with a perforated contained diverticulum with phlegmon formation.

By the time I had the surgeon at his bedside; he had received close to 5 liters of isotonic solutions and was being started on vasopressors for blood pressure support. A second set of electrolytes now revealed a life-threatening hypophosphatemia, hypomagnesemia and numerous other abnormalities that had evolved over a period of less than one hour. At that time, in a way, I was relieved. My friend, indeed was critically ill, had severe sepsis, likely related to

the intra-abdominal pathology.

Over the next 24 hours, he had been covered with broad-spectrum antibiotics, had undergone an emergent left hemicolectomy with temporary colostomy formation and slowly had been weaned from pressors.

Within 48 hours it was time to take him off sedation and hope for an intact neurological function. As my friend opened his eyes, he looked at me and kept on pointing for me to get close to him. While he was still intubated, I was concerned about pain or something else he wanted to tell me but he couldn't. As I got close to his body, he extended his two arms and pulled me to give me a hug! The series of emotions that I felt then and I remember every day were very special. My colleague knew he had a severe illness that was going to kill him if he did not receive care, yet he knew he needed to thank me for helping him even before he was extubated. Once he got extubated, his first words were “You saved my life.....”, to which I replied “No....you saved your own life by calling me”.

For over three decades in medicine, I had never felt the way I did. Having one of your best friends almost die in front of you, and having to deal with the emotions associated to it, reminded me of why I practice medicine every day: “It is what I was meant to do”. I used the same reaction that I do with my other critically ill patients, take a deep breath and think what is best for them.

References

1. Bone RC. A piece of my mind. The taste of lemonade on a summer afternoon. *JAMA* 1995;273:518.