

Unexplainable death under anesthesia occurs almost daily in American Operating Rooms. TERRO.R. is a contemporary maze of intrigue and frightful medical investigative discoveries in such cases of cardiac arrests on the O.R. table. Hopefully, this timely novel is fiction...

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The cardioscope was showing a fast but regular sinus rhythm. Philip made the customary abbreviated entries on the anesthesia record, *RSR...RSR* and marked down all other monitored information (pulse, blood pressure, temperature, etc). Boring but important liability prevention. The daily red tape of an anesthesiologist.

About 15 minutes into the operation, Phil observed a premature ventricular contraction, an unexpected strangely shaped squiggle on the cardioscope screen, very different from the *RSR*. He checked the blood pressure in a hurry: 140/86. One single *PVC* is usually no big deal. However, the pulse was also going up. It was now 134, higher than the first reading on patient's arrival in the OR. The oxygen saturation was unchanged. A second *PVC* soon appeared, followed by a third.

From his six foot two height, Maloney observed the changes in his anesthesiologist and the disappearance of the relaxed atmosphere behind the anesthesia screen. "What's going on, Phil?"

"I don't know, Jesse, but I don't like it. We had a few premature ventricular contractions on his EKG. I hate unexplainable *PVC*'s in a young healthy patient with absolutely no history of cardiac disease. Maybe it's due to the Epi?"

"The epinephrine? Yeah, you're probably right. Should I continue the surgery?"

"Please continue, but only if you don't inject anymore of the local with epi until I tell you. How much did he use so far, Linda?"

The scrub nurse checked her syringes, "46 cc's, Phil."

The *PVC*s became more and more frequent. The plastic surgeon worked faster and faster, trying to finish the removal of the tattoo from the left arm.

Patients often exhibit a premature heartbeat known as an *extrasystole* when surgeons are pulling on bowels or other internal organs and the excitable vagus nerve produces a *vagal reflex*. But a *vagal reflex* during tattoo removal? In desperation, Newman injected 0.4 mg of intravenous Atropine Sulfate, the antidote for such reflexes. It was to no avail. Instead of the expected acceleration of the heart rate and normalization

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of the EKG tracing, the *PVCs* became more frequent. Soon, each normal beat was followed by a premature one. Newman reached for the cardioscope to increase the sound volume... beep, BEEP...beep, BEEP...beep, BEEP...

Maloney looked at the cardioscope screen. "What's going on Phil? *Bigemini?*"

"Yeah! Stop the surgery!" Newman replaced the Propofol solution with a 5% dextrose-in-water bag. "Get the crash cart in the room, STAT! Bob, call *Code Blue!*"

Newman removed the anesthesia screen and used his surgical mask to wipe his forehead before throwing the now wet mask into a bucket. It's easy to forget important cardiopulmonary resuscitation steps when under pressure and Phil knew it. Usually, he only helped other doctors with their CPR's and regularly trained on *Resusci-Anne* the CPR teaching doll. But his own patient in cardiac distress? This was uncommon. Thank God for that brainwashing alphabetical training!

A for *AIRWAY*.

Inject a quick 100 mm of succinylcholine into the now temporarily wide-open IV tubing to help paralyze the patient and allow tracheal intubation.

Phil ventilated the unresponsive, unconscious patient as well as he could with 100% oxygen by mask. As soon as the neck muscles stopped fasciculating, indicating that his jaw was relaxed, he opened his mouth to illuminate the vocal cords with the laryngoscope. Hastily, he introduced a number 8 cuffed endotracheal tube in the windpipe, and then quickly inflated the cuff with an air syringe to prevent leaks. After connecting the endotracheal tube to the anesthesia hoses, he exposed the chest.

B for *BREATHING*.

Squeezing the black rubber anesthetic bag to force oxygen into the lungs, Phil watched the satisfactory up and down movement of the chest and listened with his stethoscope to both lungs, before turning on the automatic ventilator.

The massive stainless steel crash cart was now in the room. Peggy Kane, the 40-year-old OR supervisor, came in through a side door. Linda covered the unfinished surgery site with a sterile towel. Mask and gloves

off, Jesse Maloney was ready to help. The bigeminal rhythm continued...beep, BEEP...beep, BEEP...beep, BEEP...

Phil injected 100 milligrams of 100% Lidocaine into the IV tubing and let the intravenous drip run fast again. Lidocaine, the local anesthetic, also has a calming effect on irritable heart muscles.

The automatic blood pressure machine showed a sudden drop: 72/48. Pulse 188, O2 saturation 72, lips getting bluish. Bad sign! He pushed the button again: 58 over nothing! Darn!

C for *CIRCULATION*.

“Start cardiac massage, Jesse! The pressure is going down to zero!”

“Drop the table, Phil,” Maloney replied.

Phil pressed the pedal at the OR table base with his right foot to lower it. Standing on the left side of the comatose patient, Maloney started pushing on his chest, right hand over left and counting “one, one thousand...two, one thousand... three, one thousand...” to simulate a regular cardiac massage rhythm. After “five, one thousand,” he took a short break to allow Philip, who had gone back to manual ventilation, to inflate the lungs with oxygen. The counting restarted, “one, one thousand...two, one thousand...”

An electrocardioscope is useless when performing chest compressions. Newman knew the importance of checking the scope during respiratory pauses. In the beginning, the tracing simply indicated tachyarrhythmia, a rapid irregular heart. But now, after inspecting all the wires to make sure they were still connected, he was dismayed to observe a classical ventricular fibrillation pattern. The heartbeat and pulse were out of sync.

D for *DRUGS*.

“Bob! Epi and sodium bicarb, IV STAT!” The Marine veteran knew how to execute orders. He administered the ready-to-use medications within seconds. His calm assurance was almost unnatural. For someone who treated blown-apart soldiers in Vietnam, what’s an unexpected cardiac arrest?

E for...?

What in the world does E stand for? Phil hesitated, but quickly remembered.

E for *ELECTROCARDIOGRAM*.

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The patient was already attached to the machine. But not having a printed record in the chart at a time like this, could come back to haunt you.

“Linda, start the graph please. Mark on the paper the time for each medication given. Jesse, stop the massage for a few seconds. Let’s get some undisturbed tracing.”

Linda and Jesse complied. They knew that during a CPR, the anesthesiologist is in command. The EKG paper started rolling out, like an oversized ticker tape. Phil glanced at the printed tracing. No doubt...ventricular fibrillation!

F for *FIBRILLATION*.

“Peggy, the defibrillator. Jesse, resume the massage.”

Giving orders to Peggy Kane made Phil feel uneasy. It’s hard enough having to work with an ex-mistress who hates you. But giving her orders? The OR supervisor spread skin-contact jelly on the defibrillating paddles. She was the only person in the room still wearing a mask. “An old antiseptic nursing school habit,” was always her explanation. Philip remembered teasing her once, “Bullshit Peg! I call it vanity! The mask emphasizes your beautiful eyes and hides your wrinkles! It makes you look like a gorgeous and mysterious TV nurse.” He instantly regretted the “hides your wrinkles” comment but she had just ignored his words.

“Ready?” Peggy inquired.

“Ready.” Maloney removed his hands from Walker’s chest. Newman disconnected the hoses from the endotracheal tube. With the exception of Kane, everybody took a backward step. Peggy put the paddles on the patient’s chest. The anesthesiologist counted, “three, two, one...SHOOT!”

Bob Raye pressed the blinking defibrillator button. Walker’s body jerked, as if he was trying to get off the operating room table. During this time, the cardioscope tracing was unreadable. Phil waited for the tracing to retake its place in the middle of the screen. Darn! Still ventricular fibrillation.

“Epi, cardiac massage, Bicarb. Get ready to shock him again!” ordered Newman. He checked Walker’s lips and fingernails. They looked bluish, but under artificial OR lights, color changes are always accentuated.

G for *GASES*.

“Quick, call the lab, Linda. I need blood gases STAT!” After reconnecting the hose to the endotracheal tube, Phil started squeezing the bag again.

“Five, one thousand...” Maloney took a short break. He checked the cardioscope tracing for a second. Pulling on the funnel shaped OR light, the surgeon brought the powerful beam above Walker’s glassy eyes to observe the pupils. They were dilated and not responding. “We’re losing him, Phil. Maybe we should quit?”

“Not yet, Jesse. You must be exhausted, I know. Let me take over. I’m putting him back on automatic ventilation.” Phil went over to the left side of the table. The sweating Maloney sat dripping on the vacated anesthesiologist’s chair. Phil restarted the massage energetically. No point to open the chest, he thought. Open cardiac massages are not indicated when patients don’t respond to CPR.

Peggy Kane checked the flashing orange button. “The defibrillator is recharged.” She lifted the paddles. “Ready...move back, Phil!”

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