Critical Care Case Review

Voices in the Darkness

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It begins

- 55 year old male
- Arrives at community hospital P.O.V
- Initial symptom “chills”
- Seems slightly confused
- No prodrome
- Remote sz hx, no meds, NKDA

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Initial impression

- Emesis on clothing, has been incontinant
- Diaphoretic
- Affect a little off
- Asked for bathroom straight away
- Passes out in the bathroom

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Impression?

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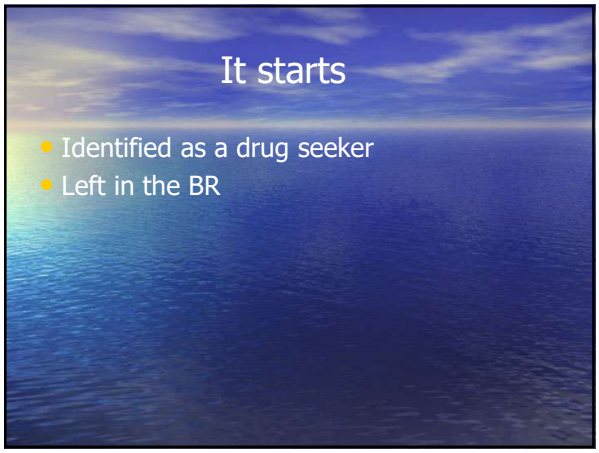
It starts
Identified as a drug seeker
Left in the BR

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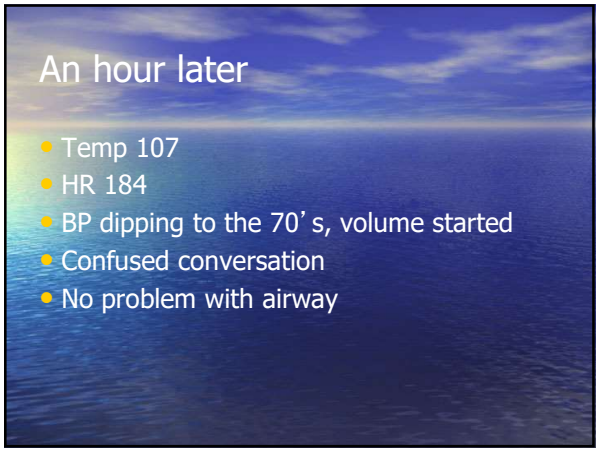
An hour later
Temp 107
HR 184
BP dipping to the 70's, volume started
Confused conversation
No problem with airway

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Work up

- Lactic acid 4 (0.4-2.5)
- Ammonia 51 (17-47)
- Alk phos 139 (25-125)
- GFR 48
- WBC 7, segs 92%
- 7.35 CO2-30 O2-96 HCO3-16 BE (+)7.2 96%

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It gets better

- Urine cloudy
- (+) protein
- Esterase (+)
- Clumps of wbc's
- Many bacteria
- (+) RBC

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OK

- Decision made to admit to med surg
- Dx prostatitis

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It gets even better

- Copious watery stools
- Sensorium decreasing
- BP 90 and falling, dopamine started
- Fiance arrives
- Requests transfer to tertiary care

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Life Flighted direct to AICU

- 7.29 CO2-27 O2-76 HCO3-13 BE-11
- CK-742, GFR 19
- BP 80's, Levophed added
- Responds to deep pain
- Respiratory distress- decision made to emergently intubate
- Started on A-Z Abx

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Oh boy

- Cannot ventilate D/T abdominal compartment syndrome
- Attempted CAT aborted when dye load aspirated
- Taken for emergent surgery 4 hrs after arrival
- Exploratory lap with decompression and exploration neck wound
- Bp continues to fall on dopamine and levo

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Post op surgery #1

- Lactic acid 7
- CPK 988
- GFR 14 (CKD5)
- Ammonia 84
- 58% bandemia
- ID decides to start IG therapy
- Returned briefly to O.R.

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Clinical status

- Unresponsive
- Fine rash on thorax and arms
- Urine output “grey sludge”
- Phenylepherine added, volume increased
- But at least we can ventilate him

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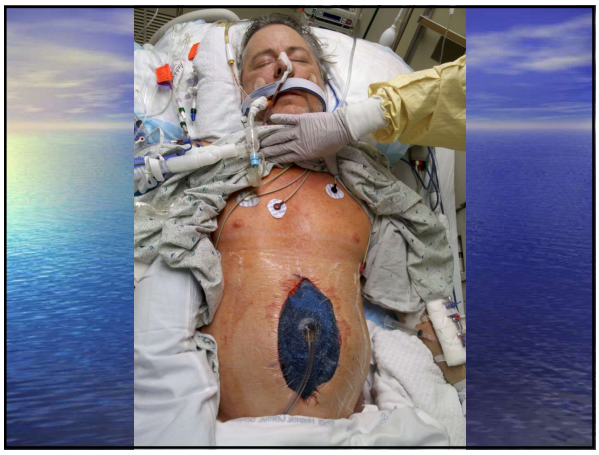

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Thoughts ?

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Surgery #3

- Continues to “dwindle” taken back to OR 12 hrs later for lactic acid 9
- CAT scan shows ? free air deep in neck. ENT will not operate, too unstable so Trauma Surg goes in
- Bowel becoming ischemic, resection of 65 cm small bowel, deep exploration of neck wound finds pocket of “dirty dishwater”
- Group A strep cultures out

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At last a diagnosis

- Group A Strep Toxic Shock Syndrome
- Rapid decline in clinical condition
- Refractory hypotension
- MOF
- Treatment is mostly supportive with addition of specific abx
- With tx mortality 50-70%

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Here we are

- Temp 105.6
- On neosynepherine, levo, dopamine, dobutamine, vasopressin and 1-2 liters/shift to keep BP at 50
- Completely obtunded
- Now developing DIC
- CK 1025- MB's and troponins starting to spike
- Liver enzymes out of the ball park
- CRRT started as last resort

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What do you think ?

- He is one of ours

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Input from learned men

- Nephrology- nothing to add, non survivable, CRRT probably won't help
- CCM- if he survives he will be a vegetable, not sure about source of rising lactic acid
- ID- full course of immunoglobulins almost done, nothing to add
- Lab values all off or becoming lethal
- Total of 6 surgeries so far

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It's 72 hours since arrival

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- Your thoughts now?

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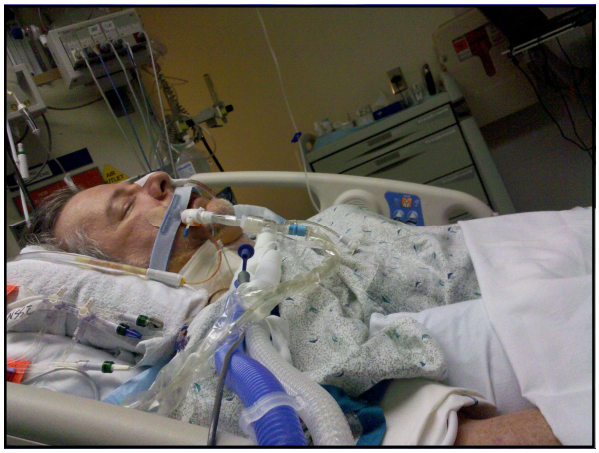

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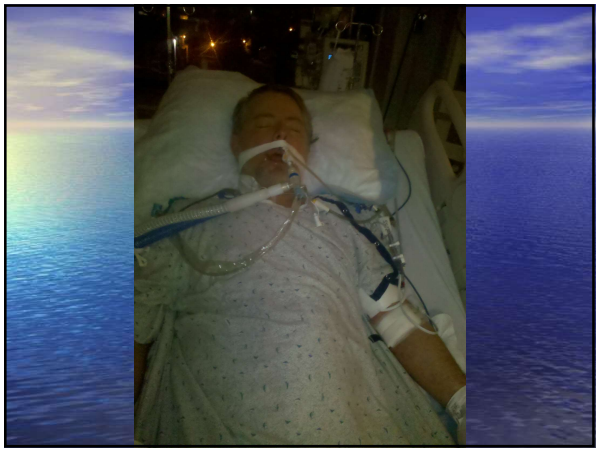

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Preparing the family

- Discussions about peg and trach
- Discussion about nursing home placement
- No hope for meaningful recovery

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And now your thoughts?

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The rest of the story

- 4 weeks in a coma
- Woke up the day I was to be peg and trached
- All labs normalized
- Everything works

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Perchance to dream

- Normal dreams with a theme
- Drug induced dreams
- Dreams and reality meld

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Things I Learned

- No higher functioning
- Belief systems can defy science
- ICU-itis- rhythms and routines
- Interactive does not mean oriented
- We know
- We hear

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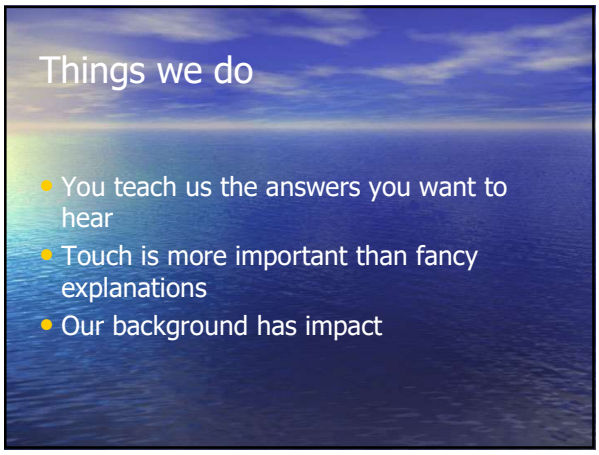
Things we do
You teach us the answers you want to hear
Touch is more important than fancy explanations
Our background has impact

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Care for the caretakers

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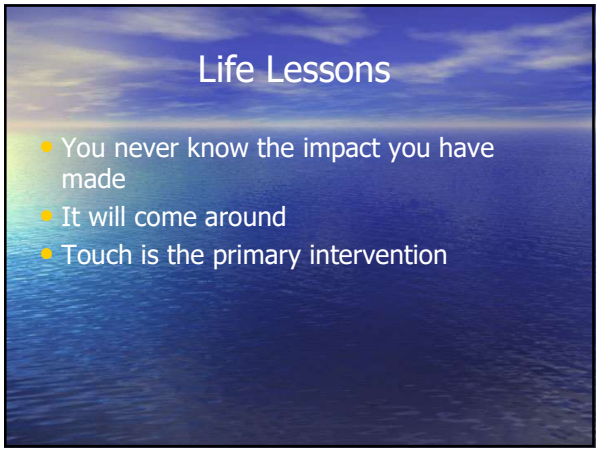
Life Lessons
You never know the impact you have made
It will come around
Touch is the primary intervention

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Parting shot

- The skills you learn here, at other conferences, and OTJ will help keep the candle lit in the window until we can return home
- But the most important thing for us, the patient, is your touch. Never lose that core value

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