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Editorial
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A Palliative Medicine Code

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"My patient is coughing up blood", said a frantic nurse on the surgical unit. My patient was a sixty three year old Caucasian female who recently underwent an open liver transplant due to hepatitis C related cirrhosis and hepatocellular cancer. Her post transplant course was ridden with multiple hospitalizations, most of them related to acute transaminitis of unknown etiology. She was treated for acute allograft rejection, repeated endoscopic retrograde cholangiopancreatographies with stenting and multiple liver biopsies.

She lived at home with her husband in South Carolina. Due to repeatedhospitalizations, she was very debilitated and needed assistance with her activities of daily living. "My husband is my champion" she would say when she was lucid.

Her current admission was related to another episode of acute transaminitis, generalized abdominal pain and agitated delirium. Palliative medicine was consulted for assistance with symptoms and goals of care. She was followed by both;the transplant and surgical team. After extensive conversations with her husband, it was decided that a comfort based approach would be most beneficial for the patient given worsening liver failure now complicated with multi organ dysfunction.

It was Saturday morning. I remember that day, like it was yesterday. My attending and I were walking to the patient's room and I heard the nurse frantically saying "My patient is coughing up blood". Instantaneously, I said "team let's get some dark towels". I was surprised to see the quizzical faces of the nurses. Dark blue or black towels are often used in emergent situations as these to mask the amount of bleeding, which can otherwise be very distressful to patients and families. Unfortunately we did not have dark towels in the hospital. As I walked into the room, I found my patient sitting up in bed, awake with active hemoptysis. She was in dire respiratory distress due to aspiration. The room echoed with her death rattle. Her husband and daughter by bedside were tearful and afraid. Her husband came up to us and said, "Doctor, please make this stop, please relieve her of her suffering". I gripped his hand and responded, "I can't imagine what you must be going through at this time. I will do everything we can to make her comfortable".

Having witnessed a carotid blow out through a tracheostomy and active hematemesis in an end stage liver disease patient during my training at the inpatient hospice unit, this situation wasn't unfamiliar, but never the less very intense. The surgical team was happy to let us run this 'code'. The room was crowded with nurses trying to help this unfortunate lady and house staff frantically putting in orders. In a calm but loud voice, we ordered an increase in her fentanyl drip given severe respiratory distress. Deeply distressed by the situation, the nurse's trembling hands struggled to unlock the PCA. We ordered intravenous vitamin K to slow the bleeding. The bleeding eventually slowed down, but the aspiration and gurgling continued. The patient's husband repeatedly asked ''please end this'', while the daughter was tearful and grasped her mother's hand. To make the patient more comfortable, we ordered a benzodiazepine for her anxiety due to her inability to breathe. By this time, she appeared more comfortable, but clearly not as comfortable as we would like. Given the uncertainty of the origin of the bleeding, we tried using octreotide to slow down the bleeding. The most distressing part to everyone in the room was her loud death rattle due to aspiration of blood. We recommended deep suctioning by our respiratory therapists. This undoubtedly was the most important intervention in making the patient and everyone in the room more comfortable. The chaos in the room had now turned into calm.

After about thirty minutes, the situation was under control. The patient now was comfortable. The family was very appreciative of our efforts in helping the patient. The husband and daughter sat by the patient's bedside and said their good bye. My attending and I kept close follow up on the patient during the next couple of hours. After about four hours, the patient died. My attending pronounced the patient.

The liver transplant and surgical attendings applauded our efforts. The nursing staff felt supported by our presence. They were glad to have the assistance of the palliative medicine team during this intense emergency.

This was indeed a very rewarding and educational experience for me during my fellowship. I learned the importance of the respiratory therapist in such a situation. Responding to family requests to expedite death in such situations is always a challenge. I learned keeping calm in a frantic situation is key. And I now keep dark towels in the trunk of my car!

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