The Unique Experience Of Operating On The Hypercritically Ill

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I’m certain that if I hadn’t been just finishing a midnight appendectomy, Daphne would have died. Not fully balancing all the bad luck in her life, she fortuitously chose to exsanguinate when a surgeon and OR staff were immediately available. Nevertheless, vomiting all that blood, she damn near died before she got to the hospital.

Niceties like passing a scope to find the source go out the window when someone is bleeding to death from her stomach. When I’d gotten the call, I was writing orders for the previous patient. I let the OR know they’d be getting someone in a big hurry, flew down the stairs to the ER, and met Daphne, who wasn’t in a position to be sociable. In shock, confused, continuing to vomit blood, she was also very obese and showed obvious signs of Cushing’s syndrome: side effects of high dose steroids.

Whatever I might find and do, healing would be severely limited by those drugs. And you can’t stop them for surgery: it would cause general collapse. Daphne’s husband had ridden along in the ambulance. Compared to her, he was a tiny wisp of a guy, looking appropriately worried. I told him — no surprise — that she needed immediate surgery, and we’d see what we’d find, and do what we could. It was a very critical situation, I said. Blood had been drawn for cross-match, and I ordered a bunch of O-negative blood, started a couple of big IVs, told the OR we were on our way, talked to the anesthesiologist, and drove the gurney myself, pointed the way to the waiting area for her husband.

One thing about operating on the hypercritically ill: when you start from zero, there’s no downside: clearly, she’s going to die unless I can do something. No decision there; and, at some level, no pressure, in a perverse sort of way. Which is not to say I’m cavalier about it: I know that I’m the only hope she has. But unless I make a horrible judgment, or a monster technical error, a bad outcome is the default situation: I can’t make it worse. I think.

In the middle of the belly wall, the rectus muscles (the six-pack muscles, in the fine and fit) are separated by a fibrous band, called the linea alba, or “white line.” It’s pretty bloodless, and what you aim for in making a midline vertical incision. Off to either side, it can get bloody. But in the very fat, it can be hard to find rapidly. There’s a trick, for those of you trying this at home: after cutting through the skin, if you and your assistant pull the edges away from each other, hard, the fat splits apart like the Red Sea (the yellow Red Sea), right down to the white line, fast and smack on. Then you can split the linea sharply, fastly, and get in there.

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