Essay by :
DS

TOPIC: PATIENT WHO WAS EXPECTED TO DIE BUT SURVIVED.

NAME OF PATIENT:- Mr HM
AGE OF PATIENT: 47 YRS
SEX: MALE
WT: 70 KILOGRAM
HOSP # 1234

PRE OP DIAGNOSIS: ACUTE ABDOMINAL DISTENTION

This male adult was admitted 3 days ago with the history of herbal ingestion to relieve constipation.

Pre-operative assessment and examination revealed distended abdomen, icteric sclera, scanty and concentrated urine after catheterisation, sunken eyeballs (dehydration), shallow diaphragmatic respiration. X-ray of the abdomen showed high fluid level. Hematocrit was 24 vol%. ASA classification after assessment was class IV moribund.

ANESTHESIA PLAN SELECTED WAS BALANCED ANESTHESIA

The patient was induced with 150mg Ketamine instead of 210mg because of lethargy. Atropine 0.5mg was given prior to Ketamine. 75mg Scoline was given to facilitate oral endotracheal intubation.

Maintenance of Anesthesia was done with Pancuronium bromide 0.05mg/Kg initially followed by 0.25mg/Kg subsequently at an interval of 30 mins. Tramadol, Ketamine drip, Diazepam. Nitrous Oxide and Oxygen were added with intermittent positive pressure ventilation (IPPV) with a Drager Fabius Ventilator at a rate of 16 breaths per minute with a Tidal Volume of 600ml/min. A 26G Naso-gastric tube was inserted and attached to an intermittent suction machine.

An exploratory Laparotomy was done. The findings were hemo-peritoneum and gangrenous small bowel about 18ins in length.

The bowel was resected, end to end anastamosis was done and the peritoneum lavaged. 2 tube drains were placed in the abdomen, the layers closed up to the subcutaneous tissue. Halothane was not added to the maintenance regimen for fear of LIVER TOXICITY as the patient was already ICTERIC. At the end of the surgery the patient was reversed with 2.5mg Neostigmine combined with 1.5mg Atropine. Patient was asked to take out the Endotracheal tube by himself which he did.

Fluid maintenance was done with Ringer’s lactate and Sodium chloride solutions to replace the electrolytes loss through the bowels and the suction of NG tube. Urine

output during surgery was 1,500ml after challenging the Kidneys with 40mg Furosemide (Diuretic).

Monitoring of the patient was done by pre-cordial stethoscope and on the spot monitor that comprises BP machine, Pulse Oximeter and Pulse monitor. The patient developed hiccup the first post op day but responded to 25mg Chlorpromazine. The patient was taken to the OR four days later for the advancement of the drains, and closure of the wound.

Post op analgesics were prescribed by the Surgeon. The patient left hospital ten days later uneventful.