

The surgery burden for an anaesthesiologist: Frustration cries for an answer

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Citation

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Abstract

Dear Sir

I wish to bring to your attention and your good readers a brief description of a clinical situation that may have been encountered by most Anaesthetist.

A clinical scenario where Anaesthetist has to care for patients with massive internal haemorrhage presented for exploratory laparotomy.

The minute surgery had commenced the Anaesthetist would have gathered as much information about the provisional diagnosis, patient's history, when was he last fed or drank and what he had, State of health, illness, medications, allergies ..., previous surgery and anaesthetics, reviewed his laboratory results blood counts haemoglobin, coagulation profile, U&E, enzymes, possibly ECG and chest x rays as well as any relevant CAT scans or MRI. He or She would have examined the patient in the very brief allocated time assessed the state of shock hydration temperature of peripheries Neurological status and GCS, assessed patients airway breathing and heart conditions by auscultation.

Briefly and concisely have cannulated two preheal veins or had inserted a central venous line, perhaps an arterial line and may have requested ABG.

In the light of this brief and very efficient evaluation Anaesthetist would have used his clinical judgment based on his or her previous clinical acumen and requested so much isogrouped blood as well as FFP and Cryoprecipitate. Or he may have alerted the Haematologist and requested his guidance and advice.

Simultaneously the Anaesthetist would have instructed his assistant on the need for preparing an infuser, a blood warmer, Invasive measuring kits for arterial and central

venous pressure measurement, The need for rapid sequence induction and tracheal intubation also what drugs to make available. And possibly ordered an epidural kit if deemed necessary.

At surgical procedure start the Anaesthetist in a state of extreme vigilance preventing any physiological trespass maintaining hemodynamic, maintain blood gaseous homeostasis, electrolyte and acid base balance transfusing blood and or blood products authorising the timing and need for arterial blood sampling and managing drugs administration perhaps via multiple syringe pumps and observing as well as recording data all along.

The patient's hemodynamic improves slightly and surgeons have not controlled the bleeding, again all the work elicited above resumed by the anaesthetist and more blood transfused. Time passing and the surgeon seems to be having problems controlling the bleeding, again time passes and all the work resumed.

By enlarge the more time passes the more bleeding and the worse the outcome as far as patient's status. Naturally the Anaesthetist should alert the surgeon to the seriousness of the patient's condition. And he might suggest to the surgeon to seek surgical help from one of the reachable senior surgical colleagues.

The core of this letter is the question I place before you all, Should our senior academic authorities worldwide state a guide line to help ease this frustration by giving the Anaesthetist the legitimate right to call a senior more competent surgeon to come for help, I should imagine that if this were presented to surgical academic authorities, It may gain their support and hence eliminate this extremely frustrating seen where the Anaesthetist even with all his enormous efforts feels as if his or her hands were

handcuffed. And perhaps patients would lose their life in the face of surgeon arrogance and regardless of the agonizing long hours of hard work done by all involved.

I welcome any response or suggestions and hope this letter

may initiate an action that may save our junior colleagues of new anaesthetist generations the agony that we suffer for so long alliance preventing any physiological trespass in silence.

References

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