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The Weight

By Vik Reddy

Sallow. That's the word that best described the patient lying in front of me: a 65-year-old Caucasian male with a long, wiry beard, sunken eyes, and a sallow skin tone. Though, with the fluorescent lighting and the faded tiled floors, maybe I had a cadaveric appearance as well. I had been called by the Emergency Room physician to evaluate him for a bowel obstruction. The patient's hooded, brown eyes kept darting in different directions, and he occasionally muttered to himself.

This would be my first surgical consult at the Sacramento Veteran's Administration Hospital. I had just completed my intern year in general surgery: a year of rounding on patients, calling my senior residents, discharging patients, calling my senior residents, and writing post-operative orders…usually after speaking with my senior residents. I was excited at the prospect of autonomy, and like most surgical residents in American training programs, VA hospitals offered the chance to operate. In excited tones, other residents before me had boasted of performing extensive, complex procedures with only the surgical attending present. The trade-off for the access to the operating room meant that the two surgical residents assigned to the VA would alternate call every other night; the only back-up would be the attending at home. Like most of my colleagues, I thought this was eminently fair.

Being my first consult at the VA, I was relieved that this case seemed relatively straight forward. Like many things in surgery, blockages of hollow organs can be life threatening, but usually not a difficult diagnosis; for a small bowel obstruction: abdominal pain, distention of the abdomen, nausea, vomiting, and the inability to have a bowel movement or pass gas (hence the obstruction). I would order any confirmatory imaging studies based on the history and physical exam findings.

As I approached the patient's bed, one nurse was quickly getting his vitals and another aide was starting a second IV line for fluids. I noted a fever and a low blood pressure from the nurse's notes—could be an early sign of an infection.

I leaned next to his head and asked softly, "Are you in any pain?"

He gestured to his stomach.

"How long has it been going on for?"

"Two days," he whispered.

"When was the last time you had a bowel movement?"

"Today."

"Have you thrown up today?"

He shook his head.

"Do you feel like throwing up?"

He shook his head, again, and winced.

I leaned closer to his ear, and asked: "Have you been able to pass any gas out of your bottom?"

Those brown eyes darted right at me, and his expression turned to one of annoyance.

"I'm sorry, I just need to know if you have been able to pass gas out of your bottom."

He nodded his head.

After embarrassing him with my questions, I informed my new friend that I would be examining him. After lifting up his shirt, I looked at his abdomen: flat. I pressed my hand on it: soft. I pushed it back and forth and he did not react with any signs of pain. No symptoms of a bowel obstruction and no physical exam findings supporting the diagnosis.

The Emergency Department in the VA Hospital was small with perhaps a dozen beds, one physician, and a handful of nurses and aides. A central island housed the ER physician with a computer and a fax machine. Manning the ER was Dr. Howard Lee, a new graduate from the same University training program I was in; he had finished his Internal Medicine residency and was moonlighting at the VA until he was accepted into a fellowship. I was always impressed by how calm he remained when we had crossed paths at the University Hospital.

Dr. Lee was on the phone asking about a CT scan when he saw me and motioned me to come closer. He told the person on the phone to hold on.

"The guy with the possible bowel obstruction?"

Dr. Lee nodded.

"Not a bowel obstruction."

"Really," Dr. Lee exclaimed. He grabbed a sheet from the fax. "His labs came back. Looks like he's in liver failure. Well, thanks for coming in."

I nodded and left satisfied.

The next morning, I was at the coffee stand staring at an assortment of pastries behind a dusty, plastic sneeze guard: bear claw or an éclair? As I pondered how fresh the custard filling in the éclair might be, my pager went off. The number was tagged with Dr. Rosenberg, the surgeon who was on call with me last night. I left the coffee stand and called her from my cellphone.

"Dr. Rosenberg?"

"Were you consulted about a patient with abdominal pain last night?" She sounded a bit distressed. Dr. Marcia Rosenberg was a relatively new attending—she had graduated about 5 years ago from the same surgery program I was in. She took her job seriously but had a very dry sense of humor. Her favorite accessory was a pearl necklace which provided a nice contrast to her taste in Jack Kerouac

"Yes, it was for a bowel obstruction consult, but it wasn't one."

"You didn't write a note in the chart?" she asked in a raised tone.

"No."

"And you didn't' look at the labs?"

"No."

"He has cholangitis. You would have realized that if you looked at the labs. He's in the ICU now on maximum support dying. Please, go, examine him, and write a note."

"Yes…" Before I could say anything else, she had hung up. Heat began to rise in my face. I went to the nearest bathroom and grabbed a paper towel. I rubbed it against the sweat beginning to accumulate on my forehead. I stared at my face in the mirror. Flecks of grey had begun to spring up in my beard. I had grown it in college because I thought I looked too young.

Acute cholangitis is a serious medical condition where a blockage, often caused by a stone, of the common bile duct can lead to a life-threatening infection. The signs of acute cholangitis are associated with the medical eponym, Charcot's triad: right upper abdominal pain, fever, and jaundice (of the skin and eyes).

Sallow, indeed. The patient's most notable feature was his yellow skin tone. I shook my head and cursed: the brown irises of his eyes were probably swimming in yellow. Had I looked at the labs, it would have forced me to think about cholangitis. I would have ordered an ultrasound of his abdomen, and the patient would have undergone a procedure to remove the stone that night. No comfort that Dr. Lee and I had both missed the diagnosis. I left the bathroom and made my way to the Intensive Care Unit.

He died a day later. An autopsy came back with a report that the cause of death was a pulmonary embolism: a fatal blood clot in the lungs. The report was not exculpatory; the clot was most likely secondary to the overwhelming infection his body was going through. No, he died because of a missed diagnosis.

The remaining time at the VA was difficult. I was overly apprehensive when it came to evaluating patients, and I contacted my attendings often with updates and questions. Dr. Rosenberg, to her credit, did not treat me any differently, but I felt that I had disappointed her. I returned to the VA four more times over the course of the next two years. Each rotation, I felt an inordinate pressure to prove myself to the staff. I rounded on patients thirty minutes earlier than the rest of the team and made sure I was the last person to leave for the day. On my last rotation, the staff organized a going away party.

I cannot say that I learned a valuable lesson and moved on. Seventeen years later, and I still perseverate about the missed diagnosis. As Jacob Marley wears chains as penance for his greed in life, I carry this case as my own symbol of accountability. That is why I lie in bed at night staring at the ceiling wondering if I have done the best for my patients. While the answer is almost always a "yes," I will not stop asking.

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