The Little Things That Matter Most – Part III

Dear Readers,

This week I continue with the last of my three part series about extremely interesting patient encounters. It seems that many parents and grandparents were moved by the previous articles describing aspirated foreign objects. A few even stopped me in shul and promised to no longer allow popcorn or cloves in their houses. One of my friends suggested I should brand a "Dr. Simai – Childproof Clove Box" for Havdala. However, the main message I tried to deliver through these cases, is that sometimes we cannot rely on tests alone. Clinical history and examination findings are critical in making a proper diagnosis. There is one common challenge that parents and physicians share. While both sides want the best for the child, the art of being a good caretaker is to properly react to the medical situation. Many times, we allow our fears to overcome us and subject patients to unnecessary and sometimes even risky and harmful procedures. Attaining the proper balance requires first and foremost a close bond with your physician. When there is proper communication, a physician can attain a thorough history, and the parent will feel comfortable with follow up. The trust between both sides will ensure that the physician/patient relationship will stay calm and healthy. On occasion, I sense that there are parents that enter the office ready to battle. Instead of giving the medical history and asking for a medical opinion, they sometimes give a short history and demand that I prove their child does not have certain conditions theymay have looked up online or heard from their concerned and (very) anxious neighbor. In medicine, it is sometimes easy to diagnose certain illnesses, but proving to a parent that their child is not sick may involve tests that sometimes will endanger their health. This case took place on a Sunday afternoon while I was a third year resident at Schneider Children's Hospital (now known as Cohen's Children's Hospital). To put it lightly, being a resident is really not too much fun. At Schneider's we worked around the clock seeing patients, documenting, drawing bloods, starting IV infusions, writing orders, summarizing the hour by hour changes of the entire ICU ward, and communicating with attending physicians and parents. With all that work, there were rarely any glorious moments. Most residents looked forward to the end of their shift or hoped that they had a collegue/friend on their shift who would share some sympathy with them. Seeing the daylight was a real privilege especially when you were on call for 24-30 hours. During my residency at Schneider's, Long Island Jewish Hospital merged with Northshore Hospital. As a result, all the Northshore satellites referred their complicated pediatric cases to Schneider's. ICU residents were sometimes sent to transport unstable patients from satellite hospitals. On one particular Sunday in August of 2002, while on call in the Pediatric Intensive Care Unit (PICU), I was asked to travel via ambulance to Northshore Plainview Hospital and transfer a 17 year old male with apparent kidney failure to Schneider's. After a while, being on the ambulance was actually not so exciting, and it meant that I would have less time to write notes and gather information that day. Transfers usually took a few hours to conduct. One ICU resident and nurse, along with two paramedics comprised the crew on the ambulance. This was my first visit to the Plainview Hospital. I remember that I was very impressed by what seemed to be a newly renovated ER, equipped with updated machinery and a lot of high tech gadgets. The ER attending informed us that the boy was reported to be in good health until five days ago, when he developed a fever and a sore throat. He was checked for strep and the test came back negative. His doctor instructed him to stay hydrated and take Tylenol for the pain. Two days later, he returned to his pediatrician complaining of

higher fever and decreased urination. His doctor checked his throat and saw some blisters that were consistent with a coxsackie viral illness that is a very common summer illness. She instructed him to drink more fluids and continue taking Tylenol. A day later, the fever persisted and the boy looked more tired. He told his mom that he had not urinated in two days. She called her doctor and was sent to the ER. Usually, young patients that fail to hydrate themselves do not urinate much. Assuming that the patient was dehydrated, the ER physician started him on large amounts of IV fluids. However, instead of the expected improvement in his condition, the ER physician noticed that the patients condition was worsening. The blood tests showed that his kidneys were failing. CT scans of his entire body were performed and were reported negative. By the time we arrived, the extra fluids that the patient received were accumulating in his lungs and he required oxygen. The patient was overweight, and transferring him to the ambulance stretcher was quite a task. We had to resort to rolling him onto his side and then pushing him onto the ambulance stretcher. While performing this task, his lower back was exposed to me, and I noticed that it was quite red. I asked the ER attending whether the patient complained of back aches and the answer was no. Initially, I thought that his back was red from laying on his back for a while. But on the ride back to Schneider, I was pondering what caused the boy to get so sick. Kidney failure and now respiratory distress in an otherwise healthy 17 year old? It just did not make any sense. A thought came to my mind right there – in the ambulance. I did remember that several months prior, I heard on the radio about a patient with a flesh eating bacteria. Is it possible that this boy's red lower back was infected with flesh eating bacteria? I knew it was a long shot, but I did research this condition when I arrived back at Schneider's and learned that the proper medical terminology for this was necrotic fasciitis. As we arrived at Schneider's, the PICU team hovered around the boy. His respiratory distress was worsening, and the decision was made to insert a chest tube into his lungs and drain some of the fluid that accumulated there. The attending on call that night was a senior attending who is currently the chief of the PICU. My relationship with the attending was cordial, but I always felt a little religious tension in the air. As a second year resident, before leaving to Mincha, the Chief of the Department commented to me "you think I do not know your prayers? I can dictate all of them by heart." On Fridays, I had a very hard time leaving the hospital with enough time to drive home. I tried very hard not to judge them, after all, I was lucky to receive a Shomer Shabbos Residency position, and it was natural that some attendings had their reservations about this privilege. But while inserting the chest tube, I was asked to tie some surgical knots, and due to my father's mentoring in medical school, I was able to tie one handed knots. Noting this, the senior attending gave me a rare compliment, and I felt that maybe this was the beginning of a new chapter. So a few minutes later, I asked him: "Doctor S. what do you think is wrong with our patient?" "Well David, I think this is a Lymphoma until proven otherwise." The PICU fellow that night totally ignored my question. I suggested my opinion – "I think he has necrotizing fasciitis." The attending and the fellow laughed at me. "Why in the world would you say that?" Well, I did see that he has a deep red lower back when I transferred him, I said. "That's not enough David, his CT scan and blood tests were negative!!!! I think that's a waste of time". Luckily, and generally on Sundays, we have a few extra moments to spare around dinner time. I picked up the CT scan and went straight to the radiology department. I described the case to the radiologist on call. When I reviewed the CT scan initially, I did see mild thickening of the lower back, but the radiologist at the previous hospital reported that the CT was negative. The radiologist at Schneider agreed that there was some non-specific inflammation in that area, and said that I had a point. I thought to myself I have nothing to lose, no one will blame me if I call an Infectious Disease (ID) consult in the morning and

have them investigate this matter. The next morning, I wrote my note in the chart, suggesting in the assessment possible necrotic fasciitis. I did not want to irritate the senior attending again, so I did not mention this at our formal ICU rounds. But after rounds, I called my friend Nimrod Dayan, who was the ID fellow. “Nimrod, I know everyone thinks I am crazy, but I think I have a case of flesh eating bacteria in the PICU.” In my excitement, I forgot the medical name for the condition. Nimrod listened to the case and laughed at me. I knew that once I filled out the requisition for a consult, there would have to be a formal consult and discussion of the case with his attending. I respected the ID team a lot, and when I heard Nimrod’s reaction, I felt that my judgment was flawed.When I returned to the ICU on Tuesday morning, Nimrod Dayan saw me entering the ICU. He almost fell off his chair. I heard him scream “David you did it!! – How did you know the boy had necrotic fasciitis???” It took me a few seconds to digest the news. Nimrod recalled that his attending examined the boy’s back and decided to do a biopsy. As soon as the plastic surgeon cut the skin, black, necrotizing material came oozing out (sorry about the graphic description). The patient required an immediate, wide, deep excision as the infection was quickly spreading. Subsequently, he was intubated and remained in the ICU for 8 weeks. A special vacuum was used to bring the two free edges of his back together. Although weak, he was able to walk out of the ICU on his own at discharge. His mother was not aware that I diagnosed his illness. But the look on her face on the day of his discharge was unforgettable. To date, I feel that the thought of necrotic fasciitis was implanted in my head by G-d. There is a major lesson to be learned from this case. When fever or other symptoms do not disappear, it is not enough to order blood tests and CT scans. It is important to check the patient from head to toe. Even a routine and boring shift on a Sunday afternoon gives me goosebumps ten years later. I left the PICU with the feeling that said by heart or not, my prayers went straight where they belonged.

Wishing you the best of health,

David E. Simai M.D.