Down the Hatch: Competing Priorities in the ICU

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A 57 year-old professional guitar player gets in a car accident during a cross-country tour. Initial trauma survey in the emergency room includes a fracture to the bones around his right eye, some rib fractures, a contusion to the lung, and dozens of minor cuts and bruises.

After uneventful surgery to repair the bones of his face and clean out debris found in the wound, he does well in the hospital initially. He is very appreciative and asks when he can go back on tour.

About a week after admission the patient develops high fevers and progressively impaired cognition. He transitions from delirium to a stupor. The team admits him to the intensive care unit (ICU) as his mental status deteriorates enough to require mechanical ventilation with endotracheal intubation for airway protection.

Late the the first night of his admission to the ICU, the medical resident intubates the patient under the supervision of the critical care fellow.

Two days later, the patient develops severe hypoxia and a fever. The team starts broad spectrum antibiotics, and become more and more concerned about his prognosis. Testing shows worsening oxygen exchange and chest x-rays worsen accordingly. They diagnose adult respiratory distress syndrome.

Vasopressor medications are started to sustain fragile organ perfusion. His kidney function begins to decline.

The team holds a family meeting.