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Experience

The Measure of Success – A Day in the Life of a Pediatric Surgeon

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The Experience

I often ponder about how to measure a surgeon's success. Is it the volume of surgeries done – being fast and furious, ticking off cases from a list; is it the complexity of surgery – beads of sweat on the forehead and blood on the floor or is it having a long line of patients waiting for you?

Ahmed (name changed) is a well-built, beautiful boy in intensive care with a persistent left sided lung collapse. He presented to the emergency room with a short history of breathlessness for 3 days which had progressively worsened such that he could no longer walk or perform his daily activities. On general examination, he was noted to be restless, irritable and tachypneic with a respiratory rate of 35/min. His pulse rate was 124/min and BP 150/100 mmHg and he had multiple small sub centimetric cervical lymph nodes. On systemic examination, he had reduced air entry on the left side with no other positive findings. His X-ray showed a complete collapse of the left lung with significant tracheo-mediastinal shift ***(Figure 1A).*** He was intubated, stabilized and moved to intensive care after which a contrast enhanced computed tomography (CT) of the chest was performed. Besides the findings seen on the X-ray, CT scan of the thorax showed right lung hyperinflation, a moderate right sided pneumothorax, conglomerate lymph node masses in the mediastinum and a cut off in the left main bronchus likely secondary to a mucus plug.

We are all now gathered in the intensive care unit. The flexible bronchoscopy confirms our worst fears – this is no mucus plug - it is a menacing, ugly polypoid growth obstructing the left main bronchus and threatening to grow into the right. As part of his treating team, my attending, Dr. Shalini Hegde (SH), and I from Pediatric Surgery, agree with the others against taking a biopsy. Ahmed was on maximal ventilatory parameters and yet his saturation hovered only around 80 - the risk of torrential bleeding due to the biopsy, could tip the delicate balance of life and death. As per standard care, an endobronchial procedure[1] would have been ideal for diagnosis, treatment or palliation, but as is often in critical situations, the decisions need to be based on the treating team's discretion.

Despite his one good lung, the affected lung is acting like a shunt, devouring precious blood supply but not returning sufficient oxygen. In midst of the discussion about the biopsy, Oncology opines that the tumor is unlikely to be chemo sensitive. All eyes turn towards SH as the boy desperately needs an airway. Open the bronchus and remove the tumor, remove the lung – Do something. I can read SH's mind as she contemplates the suggestions. Her decade long experience of surgery in children guides her to decline doing a major procedure. Although, it's exciting for a surgeon to have a challenge, she can tell that Ahmed is in too fragile a state to do anything heroic. Having completed my training in general surgery and now in my second year of pediatric surgery training, I find myself in agreement with her decision. Although I am ready to roll up my sleeves and get into the fray, as time goes by, I realize it is more important to learn when not to operate. These small but important learnings do not come under the surgical curriculum[2] but are best learnt through a mentor.[3]

We proceed to have a frank discussion with the parents about Ahmed. We gently tell them that their child is likely to have a malignancy and that it doesn't look good. For the parents, it is far easier to accept the diagnosis than to watch Ahmed struggle in intensive care and when we tell them of our inability to surgically help their child, they accept our failure with a grace far greater than our own. They agree to a lymph node biopsy for further diagnosis.

SH looks at me, thumps me on the back and says to do the biopsy. Everything now depends on it. I struggle during the procedure - only small shreds come out. I call SH for help, but our combined attempt is met with torrential bleeding and we hastily pack the wound. As I apply a compression dressing, I can't help feeling utter failure. In the ensuing days, I hear that Ahmed's condition has worsened and his parents have opted for chemotherapy.

A week later, I receive a picture of Ahmed's current x- ray ***(Figure 1B).*** Astonishingly, the left lung has opened completely, signaling that Ahmed will soon breathe on his own. I reflect on the miraculous turn of events and send the picture to SH with the caption – a successful lymph node biopsy. I knew we hadn't

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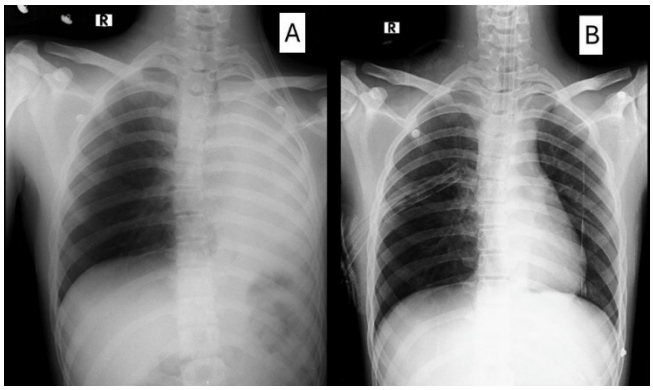
skillfully dissected out a perfectly oval shaped node, we'd abandoned mid procedure, and now we were faced with a diagnosis of high-grade cancer. Nevertheless, without a textbook biopsy, the x-ray meant that Ahmed would soon reunite with his family and his parents will cherish his homecoming.

Indeed, it's a lifetime of learning, but I now realize that the measure of success in surgery is doing the right thing at the right time

Figure 1. X-Ray A and B



Legend: A. Initial chest X-ray abdomen showing complete left lung collapse with mediastinal shift; B. Follow up chest X-ray showing bilateral expansion of lung fields post chemotherapy.

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