

VIEWPOINT

VOICES OF CARDIOLOGY

Learning From a Heart Transplant Patient



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I am currently a third-year emergency medicine resident physician in Philadelphia, and I love every minute of my job. I enjoy resuscitating septic patients. I like splinting the occasional fracture. I love calling those “STEMI” alerts. Amongst all of this chaos, I have become very interested in critical care medicine over the last few years. In fact, I had applied to critical care medicine fellowship programs and had gotten into a wonderful program a few months ago. I was supposed to be starting the rest of my training this summer, actually. But I will have to put it off for another year.

I had to take some time off to learn some new things. Why? For the last 5 months, I have been recovering from an urgent heart transplant that I needed to get because of an illness that I didn’t know I had.

It all started in October of 2018. Cough. Shortness of breath. Slight weight gain. Fatigue. Not sleeping well. Worsening cough. What did I diagnose myself with? A cold.

I was seeing patients in our emergency department, working with an ejection fraction that was barely compatible with life. Drinking 4 or 5 energy drinks daily because I just couldn’t stand how tired I had been lately. Pushing myself to continue exercising because I didn’t want a cold getting in the way of toned legs.

You are probably reading this as someone in the field of cardiology, probably shaking your head. “This is obviously heart failure, probably from myocarditis or cardiomyopathy since she’s so young and healthy otherwise,” you’re thinking. I wish that I had known you back then. But I didn’t. And I wish that I had thought more about my symptoms, but I didn’t. And here I am today to tell you my story. My

story taught me a lot. And I hope it can teach others as well.

Thus, the story continues:

Because of those symptoms, I finally decided to go to the emergency department to check myself in as a patient. I asked one of my attendings for “just a chest x-ray.” People said that I looked sick. I could tell that my colleagues were worried about me, but I was hesitant about getting admitted for a further work-up. Luckily, I decided to let them admit me.

That night, my heart rate suddenly shot down to the teens. A rapid response was called. I became altered, and was emergently intubated and taken to the intensive care unit. A day later, the doctors had figured out why that had happened to me on the medical floors—I had gone into cardiogenic shock.

You probably already know the pathophysiology of everything that happened, so I won’t bore you with the specifics. But I could tell you that I was eventually diagnosed with dilated cardiomyopathy. Thus, I was in cardiogenic shock secondary to acutely decompensated heart failure because of cardiomyopathy. I was told this after they extubated me in the intensive care unit and then gracefully shipped me off to the cardiac care unit.

You probably already know the treatment management, too. Milrinone. Dobutamine. Amiodarone for the ventricular tachycardia. Add the angiotensin-converting enzyme inhibitor. Perhaps nitroprusside.

You probably already know about all of the procedures that patients endure when they are in the state that I was in. The weekly right heart catheterizations. The thoracenteses. The possibility of a balloon pump.

You probably already know what ended up happening to me when nothing was working and I wasn’t doing well. I was put on the urgent heart transplant list and received my second chance at life just days later.

You probably already know about all of the management that I’m currently getting right now,

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several months later. Antibiotics, antivirals, antirejection medications. Atorvastatin. Weekly lab draws. A team that cares about every single step that I take.

What you probably don't know, though, is what the rest of this piece will be about. It comes from personal insight after a near-death experience followed by a month-long hospitalization. These things weren't taught in medical school and 2 and a half years of my residency training. But they're there, now sitting deep inside of my new heart.

We go to medical school. We learn the physiology of the organs, memorize the "next steps" for our boards, rotate in various specialties, get to deliver our first baby, ask questions about right atrial pressures, and graduate with a beautiful degree in hand.

Most of us, however, don't go to patient school, and hopefully, none of you will ever need to. But, unfortunately or fortunately (depending on how you look at it), I went to patient school. And here's what I took away—high-yield teaching points, if you will. They won't be on our boards, but I urge you to store them away in your heart as well.

- Look into your patient's eyes. After you look into your patient's eyes, tell them exactly what is going on. Your next step—remember this—is to be sure to look into the eyes of the family members sitting beside them. They are so much more worried than she is. She's tough, you can tell.
- Don't lie. Don't "beat around the bush." Tell your patient what is going on. Be direct, be confident. If they're dying, they're dying. If they are critically ill, they are critically ill. They deserve to know that.
- Give your patient an extra warm blanket when they're on the cath lab table.
- Give your patient an extra warm blanket at any time, really.
- If your patient is hungry, and wants to eat a cheesesteak sandwich "just this one time," let her eat the sandwich. It's rare for a critically ill patient to have an appetite. And she's probably going to eat it anyway, despite your advice. Having your validation "just this one time" means a lot to your patient.
- Cry with your patients if you want to. Don't cry with them if you don't want to.
- Laugh. Smile. Relax. Don't be so stern all of the time. Your patient could tell when you're stressed out. She hopes—she hopes every day—that you aren't stressed out about her.

- Know that it is okay to be wrong. Tell your patient the mistake, the miscommunication. Apologize. Move on.
- Be aware that everything that you write in your charts can be seen by your patients once they request their medical records.
- Do not order furosemide for a patient before taking her to the cardiac catheterization lab unless there is a Foley catheter in place.
- When your patient is arguing, let them argue for a bit. The fighters are the ones who are going to fight to live. It's in their nature.
- Remember that there are after-effects of all invasive procedures that you perform. She might have a hoarse voice for months after her 2 intubations during her stay. Her daily enoxaparin shots leave bruises that hurt for weeks.
- Lidocaine is your friend. Use it well. But remember, there will be pain in and around the area where her chest tubes are after the lidocaine wears off.

My last point, below, is an important one. You may need to highlight this one.

Do you remember the day that you graduated from medical school and felt invincible? You were going to save lives for a living. You smiled. Residency hardened you up, but you still loved your job. However, throughout the last few years, your love for medicine just isn't what it used to be. You question if you've made the right decision. I know, I know—the electronic medical record, the lawsuits, the ungrateful patients, the noncompliance, the so much you put in to get so little out. You wonder if it's all worth it. Over and over again.

So, the last thing that I want you to know is this:

- That it is all worth it. That you need to remind yourself that you do save lives for a living. Remind yourself that most of your patients are grateful for who you have become and what you so passionately do. Remind yourself that if it weren't for you, I wouldn't be here giving you these very important teaching points. And I thank you for that.

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