

I was the on-call anaesthetist on the night of Wednesday 12th April, 2000. At approx 03.40 on Thursday 13th April, I was phoned by switchboard and told I was needed urgently in the childrens ward — no reason was given. I arrived in childrens ward shortly after 03.50, to find a child in a side bed being manually ventilated by Dr. J. O'Donoghue. I was told that the child had been admitted the previous evening with vomiting, and had had some profuse diarrhoea — presumptive diagnosis being gastroenteritis. There was a cannula in the right hand or arm, and i.v. fluids were being administered. The child was pale and unresponsive. Apparently, the child had had some type of "fit" about 03.00. The child had had some type of "fit" and was noted to have gone rigid. However, I was informed that at no time was the pulse absent, and no cyanosis had occurred. The child had had pyrexia of 38°-39°C — ?? febrile convulsion.

I took over hand ventilation from Dr. O'Donoghue and noted that the pupils were fixed and dilated, unresponsive to light. I then proceeded to intubate the child with a Portex 4.5mm uncuffed tracheal tube, which was secured with tape, and manual ventilation resumed with 100% O₂.

The child had been given rectal diazepam 2.5 mg after the "fit", so I asked for 100 micrograms of Clomazepam (Anexate) to be given i.v. - There was no improvement in neurological status or level of consciousness. Throughout all this, the B.P. was stable at between 80/50 and 90/60, and there was a sinus tachycardia of 130-135/min. SaO_2 was 98-100. U+E $\text{Na}^+ 127$, $\text{K}^+ 2.5$ - ? when sample taken

A portable CXR and abdominal XR revealed that the chest was a normal chest and lung fields (no signs of aspiration), but the stomach and bowel were distended with gas. I passed a nasogastric tube to deflate the stomach - doubtably filled with air due to the manual ventilation earlier.

The child needed CT scan of brain and a distal ICD - a bed in P.I.C.U. in RBHSC arranged. In the meantime, I decided to keep him on our ICD for stabilisation etc. prior to transfer.

Unfortunately, we had no paediatric ventilator suitable for a 17-month child who weighed approx 10 kg, but with some difficulty I was able to ventilate the child on a Puritan Bennett jet ventilator ($V_T 200$, $f 20$, $\text{FiO}_2 1.0$) due to the fact that the RD

was 80-90 (s.e.), I was unable to palpate⁽³⁾ peripheral pulses, and was unsuccessful in cannulating either femoral artery. I did not insert a central line, due to lack of recent experience with patients of this size - however, the peripheral I.V. line was satisfactory.

At this stage I replaced the oral E.T.T. with nasal E.T.T. of the same size, without difficulty in order to make the airway more secure during transport to RBHSC. Also, 25mls 20% Mannitol given slowly I.V., and an I.V. antibiotic (Cefora [I remember correctly]) was given.

The next problem was that none of my colleagues were available to cover me in the event of my going to RBHSC with the child. Fortunately, Dr. Asghar was available to cover Dr. Donohue, so kindly agreed to go with Lucy to Belfast.

The child remained haemodynamically stable, and no pain during the above became hypoxic.

The ambulance arrived at approx. 06.10, and I left the Eme with Lucy, and Dr. Donohue advised manual ventilation with an Ambu Bag, and an ICU nurse, at approx. 06.30.

At approx 08.30, I rang RBHSC P.I.C.U.

I was informed that Lucy had arrived safely
and was being stabilised on a ventilator. Sadly,
there had been no improvement in neurological
status, and this persisted until approx 12.00
next day (Friday 14th April) when brain stem
death was confirmed, and ventilation was discontinued.

This is as accurate a description of events
that I can remember.

T.N. Anderson,

DR. T.N. ANDERSON F.F.A.R.C.S

T.A.