A day in the life of an Anaesthetic Registrar

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As I stumble into the changeroom at 7.15am on a Tuesday morning, I wonder what the day will have in store for me. Today I am the designated ward registrar for the morning in a busy public hospital. After changing into my scrubs, I head to the office to receive handover from the night registrar. She looks weary, having been up for most of the night operating on a series of urgent cases - a paediatric appendicectomy, an exploratory laparotomy, and an emergency caesarean section. There have been a few calls to follow up on about patients with acute pain, a couple of epidurals for women in the birthing suite, and several cases that have been booked for the emergency list the following day. One of those patients is an older man named Max. With a multitude of cardiac and respiratory comorbidities, he will need a perioperative review prior to his upcoming surgery. My day is starting to take shape...

My first job for the day will be to accompany the acute pain nurses on their ward round for the morning. There are about 20 patients that will need to be seen. For some patients, the consultation will be mercifully brief and may only require checking that their regional anaesthetic block has worn off, or switching from parenteral to oral analgesia. Inevitably, however, the acute pain team will be consulted to see patients with complex pain histories, and uncontrolled acute or chronic pain. One of these patients happened to be John, a 63 year old man who had recently undergone an above knee amputation for severe peripheral vascular disease. I can see that he is suffering, his face is tense, his brow sweaty. Despite his patient-controlled analgesia (PCA), Ketamine infusion, sciatic nerve infusion, and multitude of oral analgesics, his phantom leg pain is out of control. I feel somewhat helpless - I can't offer him an epidural because his antiplatelet therapy places him at high risk of bleeding around the spinal cord. An IV lignocaine infusion may help, but this would potentially cause local anaesthetic toxicity in combination with the sciatic nerve block. We realised we were caught between a rock and a hard place. After some discussion, we agree to trial calcitonin - it's expensive and it may not work, but we have run out of other options.

Toward the end of our visit with John, a 'Code Blue' rings out overhead. I apologise to John and hastily make my way to the medical emergency occurring on the other side of the hospital. As I arrive there are crowds gathered outside the gentleman's room. He has a small bowel obstruction, and his proximal gut is so distended that he is unable to use his diaphragm effectively to breathe. I introduce myself to the intensivist leading the charge, and gain a quick history of preceding events. The plan is to transfer the patient to the intensive care unit until a surgical theatre becomes available. But we could see the patient is tiring, and with impending respiratory failure evident, we make the decision to intubate the patient prior to transfer. Hands trembling from adrenaline, I gather my equipment together – laryngoscope -'check!' - endotracheal tube-'check!' - syringe -'check!' - bougie-'check!' -. With fluid pouring out of his nasogastric tube, he is at high risk of aspiration. I make a quick assessment of his airway, and deliver 100% oxygen via a non-rebreather mask - despite this, his oxygen saturation never makes it past 89%. "Are we ready to go?" I ask. The nurse beside me provides cricoid pressure as

the intensivist administers the drugs. ‘Propofol in’. ‘Sux in’. And then we wait. As the drugs take effect, I grasp my laryngoscope, and look into his airway. My heart sinks - all I can see is his epiglottis without any sight of his vocal cords to guide my tube placement. In the background, I can hear the tone of the oximeter changing as the man’s saturations fall. I take the tube and guide it underneath his epiglottis, hoping for the best. I connect the self-inflating bag and thankfully his chest moves as I squeeze the bag. My hands are shaking as I tie the tube into place and breathe a sigh of relief. I can’t help but feel that on this occasion I have made a lucky escape.

Having stabilised the patient in the intensive care unit, it was onto the next job of seeing Max who was booked for a laparoscopic cholecystectomy to treat his gallbladder infection. I take a look through his file - cardiac bypass grafts, heart failure, diabetes. Previous anaesthetic charts indicate that he has a “difficult airway” and when I walk into his room, I can see why. Obese, scarred bull neck, no chin. When I ask, Max tells me he has very severe sleep apnoea but hasn’t gotten around to organising a CPAP machine yet. As we talk, an anaesthetic plan starts coming together in my mind. Once done, I explain my plan of attack - because of his heart, we will need to order an echo preoperatively, and use an arterial line to keep a close eye on his blood pressure. Because of his sleep apnoea, he will need to be transferred to ICU postoperatively. I then advise him that because of his difficult airway, we will need to intubate his trachea using only local anaesthetic - while he is awake. Unfortunately, this last recommendation becomes a major sticking point, and after some thought, the patient withdraws his consent for the surgery. I am disappointed with the outcome, but the risk of any other technique for Max was simply too high.

Finally, it’s time to start my afternoon list - a single case - a laparoscopic left sided hemicolectomy for bowel cancer in an otherwise well woman. As I put in my drips and arterial line we chat about work, kids, holidays, and the excellent safety record of modern anaesthesia. Part of my job is reducing the anxiety that every patient feels when they enter the operating room. The conversation continues as I inject the propofol that renders her unconscious. I intubate the airway, set the ventilator, and position the patient for surgery while taking care of pressure areas. I administer a carefully balanced cocktail of medications to maintain anaesthesia, provide analgesia, prevent nausea, paralyse the muscles, and control her blood pressure. A warming blanket helps to keep her temperature normal. Lastly, I organise a plan for pain-relief and hydration for after the operation before sitting down to write my notes. I will continue to monitor her for the next three hours, making adjustments as necessary to maintain homeostasis until it is time to wake her up. Provided there are no intraoperative complications the remainder of the day should go smoothly, but after a hectic morning I am looking forward to a more predictable afternoon.

As I sit in my chair, I am reminded of why I love my job. Every day is unique, and every day offers an opportunity to try something different, learn something new, and make a small difference to someone who truly needs it.

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