

# A day in the life of a cardiology registrar

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It's 6am on a Monday morning and I'm already sweating. I love mornings on the beach; watching the sun rise, soaking up the relative peace and quiet. It's my insurance policy, never knowing what the day ahead might hold.

An hour and a coffee later and I'm at hospital, changing into scrubs, hurrying down to ICU to meet the team for the start of our round. I'm doing the Heart Failure/Heart Transplant job currently, and it's quite different to general cardiology. The patients are sicker, the on-call much more demanding, and there is a whole new language to learn with respect to the intricacies of transplant medicine and management of mechanical support devices (LVADs).

There are usually a fair few people on the Monday round. The previous week's on-call consultant and registrar, the coming weeks on-call consultant and registrar, two residents, the LVAD co-ordinator, a transplant co-ordinator, a CNC and a smattering of medical students. Because our hospital is the only transplant centre in NSW, not many cardiology registrars get the opportunity to do this subspecialty term. I often thank my lucky stars that I am one of them, because for me it encompasses all three of the things that drew me to cardiology in the first place: the critical care of very unwell patients, a large procedural component (both of which are intermixed with interesting cardiac physiology), and a strong grounding in medicine and patient care.

We begin our round on the sickest patients in the hospital in ICU. One young man is on ECMO as we wait and hope that his failing ventricle will recover enough to take him off it. There are two patients with severe cardiomyopathies who are recovering following insertion of an LVAD in one, and a BIVAD in the other, because they were too unwell to wait for a transplant without the additional support these devices provide. A middle-aged lady who had received a transplant several months before is intubated and recovering after a severe fungal infection of her aortic arch, requiring a hemi-arch replacement. And by far our most stable patient is a Japanese woman in her 40's who had a heart transplant only yesterday, but already looks well enough to come up to the ward. I think about how much pinker her cheeks are today than last week and marvel at what has happened in the interim.

The remainder of our round is conducted on the general ward and Coronary Care Unit. There's a big spectrum of acuity here, ranging from 'I just put a balloon pump in him and he's on dobutamine to an old transplant patient with a fungal nail infection. We are treating some with IV methylprednisolone for rejection after transplant, and others for infectious complications or viral reactivation following their heavy immunosuppressive regimens. Others are awaiting device implantation with our electrophysiology colleagues, or balloon angioplasty for severe thromboembolic pulmonary hypertension. There are patients with complex congenital heart disease and those recovering from fulminant myocarditis. Suffice to say, a heart failure round is rarely dull.

After the round is completed, coffee is a must, and then off to the procedure room to start the biopsy and right heart catheter list. This is definitely my favourite part of any day. It's just me, a nurse specialist and the patient. The soundtrack is whatever the patient wants to listen to, which gives us a wonderful musical journey as the day wears on. Unfortunately, my phone is usually ringing off the hook by this point, but as I'm scrubbed for much of the day, I just end up with a list of people I need to call back between cases. We start with The Beatles, followed by 90's hip hop.

Just as I've placed a sheath in a patient's neck, this time Cat Stevens playing in the background, I hear the unmistakable sound of a code blue on the ward. I pause, assuming it is likely to be one of mine. Sure enough, one of my residents soon bursts in to inform me that a 17 year old boy, recently diagnosed with dilated cardiomyopathy and an EF of 15%, had suddenly become even more hypotensive than his usual BP of 90/50, this time around 60/unrecordable. Apologising to the patient on the table, I quickly unscrub and race over to the patient's room, picking up the ward's portable echo probe en route. ICU is already at the bedside and together we quickly assess the situation. I put the probe on the patient's chest to rule out any kind of mechanical obstruction, such as a large effusion, but there's none. Bloods and x-rays are ordered. He looks grey and is cool to touch. I then realise that on the morning round, we had recently weaned his dobutamine, with the hope that his ventricle would be able to function well enough without it, and his profound hypotension is now a clear sign that this is unfortunately not the case. At least this is a relatively simple thing to rectify in the short term, even if it does pose some longer-term issues! This sorted, I return and finish my right heart catheter list, making sure there is a decent break between patients so that I can duck out to our Cardiology Journal Club at lunchtime.

It's now 3pm and I retreat to my little office I share with the other transplant registrar, who is holding the fort in clinics this week. He looks rather frazzled, and tells me that he has just finished organising for one of our LVAD patients to be admitted to ICU for lysis after a pump thrombus was suspected on his routine clinic visit. The patient is relatively stable and whilst all the logistics are being sorted I make myself a cup of tea and sit down at the computer to review all the patients' bloods. I adjust some immunosuppression doses as I go, and make a note of any surprising results. Then I return several calls from registrars at peripheral hospitals, giving advice or discussing the necessity or logistics of transferring patients across.

On my way to ICU, I pop in on the young boy, who looks much better following the reinstatement of his dobutamine. I feel a brief pang of sadness as I realise that this is not going to be an easy road for him or his family and knowing I'll have to tell them that there is now little chance that he will be going home without a new heart or a

mechanical pump. There's never too long for contemplation in this job however and within minutes I am warmly greeting the newly admitted LVAD patient, who I have become quite fond of over the past few months. I breathe a sigh of relief when I see that his LVAD flows and power are improving with the thrombolysis. A win for the day! However it's nearing 5pm now and I realise I still haven't met my residents for a paper round, so I text them and we meet shortly after to discuss all the bits and pieces they've had to sort out during the day.

As the day draws to a close, I receive a call from pathology with the results from the biopsies we've done that day, and as they are all pretty unremarkable, I decide to make a move toward home whilst the going is good. Knowing I'm on call for the night (as well as the rest of the week!), I try my best to relax in all the downtime I'm afforded. But soon enough, that dreaded sound of my phone is calling me across the house. I envisage my dinner lying there cold and uneaten as I rush back to hospital, the sleep I'll forfeit that night, the run I won't do in the morning. Except that it's my friend calling me to say hello. She gets a very heartfelt 'I'm so glad it's YOU calling!'

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