THE DEAD SEA AND SCHF PATIENTS WITH AN ICD

To the Editor:

We read with great interest the article of Gabizon and colleagues that appeared in a previous issue [1] and would like to comment on their conclusions about descent to and ascent from a Dead Sea resort. This study shows clearly that these trips are safe for cardiologic patients, the main advantages of this work being the choice and classification of the patients and their follow-up one week later.

However, the brief stay of the patients does not allow assessment about the safety of longer sojourns. Also, one cannot extrapolate these findings regarding any eventual beneficial aspects in patients with systolic congestive heart failure (SCHF) and an implantable cardioverter defibrillator because of the improbable effects of such a short "treatment." In our 30 year experience, we have never encountered any serious problems in patients with SCHF either while at the Dead Sea or just after leaving it. On the contrary, we can report on such cardiac patients who spent several weeks at the Dead Sea without any worsening. They always showed good acclimatization, at any season of the year, and enjoy coming back to the clinic. However, these observations are not supported by any cardiologic follow-up and, consequently, do not provide any clinical evidence.

Even if the slogan "Dead Sea is good for the heart" is not yet based upon scientific evidence, the study by Gabizon and colleagues contributes to the efforts to show that cardiology patients can also spend time at the Dead Sea with possible health benefits. These patients may also include those who seek relief for their skin or joint ailments. Thank to this publication, physicians need no longer discourage patients suffering from such cardiologic conditions to receive climatotherapy at the Dead Sea.

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To the Editor:

We thank Dr. Harari and Dr. Abu-Sirhan for their interesting comments regarding our recently published article [1]. We agree with them that our work supports the safety and possible benefits of the descent and stay at the Dead Sea resort for patients with systolic heart failure and an ICD. We acknowledge that the duration of the study was relatively short, although we evaluated the subjects both a week before and a week after their stay. It was chosen to represent the average length of stay at the Dead Sea resort (for a vacation rather than climatotherapy or balneotherapy which are usually longer) and of course was determined by technical limitations as well.

Based on our study and those of others [2-4] demonstrating the possible benefits for cardiopulmonary patients and the clinical experience of Drs. Harari and Abu-Sirhan, we believe that a longer stay would probably be safe as well. Nevertheless, a more prolonged evaluation is needed, preferably with a control group to minimize the effect of confounders, and measurement of additional important physiological parameters (e.g., hormones, metabolic and inflammatory markers) [5] that might shed some light on the mechanisms behind the clinical results. Meanwhile, we believe that physicians can tell their cardiac patients that staying at a Dead Sea resort is safe and could even be beneficial, especially when the patient suffers from other conditions in addition (e.g., dermatologic, rheumatologic, etc.) [6]. It is important, however, to emphasize and to warn patients – as was done in our study – against overeating, prolonged stay under extreme weather conditions (i.e., high temperatures) and other extreme changes in lifestyle that might accompany the vacation and endanger them.

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PLEASE, INTUBATE ME!

To the Editor:

I was just about to call out the daily instructions. Everything seemed so similar; it was all so familiar yet it seemed remote. The nurses were the same, the bed was identical, but the situation seemed so dislocated. The last thing I remember was me shouting "please intubate me, I'm choking."

Sixteen days earlier I experienced what an intensive care doctor does not want to even imagine. After a few days of progressive respiratory failure due to the combination of severe Epstein-Barr virus infection with acute streptococcal pharyngitis, intubation seemed inevitable.

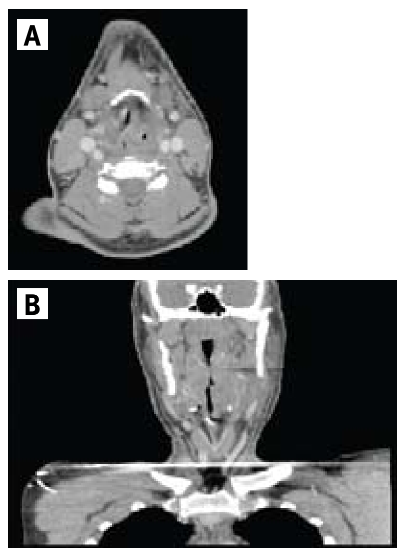
In the months prior to this, as the rotational resident of the respiratory intensive care unit I had to make many urgent medical decisions. Intubations are performed daily and are regarded as a medical issue. Many emotional and ethical dilemmas

evolve, but no thoughts are given to how an intubated patient feels.

While being weaned gradually from my sedation, I was still suffering from intense hallucinations. Surgical tracheostomy, two surgical abscess openings, three endotracheal intubations, two unsuccessful extubation attempts, and two major intensive care unit infections made up this unforgettable experience.

It all began with feelings of weakness and fatigue. Subsequently, fever evolved and throat pain joined my general feeling. Although I prescribed myself oral antibiotics, there was no improvement. My appearance at the emergency room was just the start of the deterioration. Following hospitalization to the medical intensive care unit (ICU), a parapharyngeal abscess was diagnosed. Although successful drainage was performed, my clinical status was worsening. A neck CT scan showed severe narrowing of the pharynx and a small parapharyngeal abscess [Figure 1]. Upon transfer to the respiratory intensive care unit, I was in severe respiratory stress. My thoughts at that moment were obscure and faint, but there was only one clear notion that I am sure of – I desperately wanted to be free of this overwhelmingly terrible feeling. With what was left of my voice, I shouted to the doctor, "please intubate me." That was the last vivid act I can recall making in the following 16 days. This experience has given me insight into being a patient and – no less important – into being a doctor.

CT scan: axial view **[A]** and sagittal reconstruction **[B]** of the neck showing significant airway obstruction at the pharynx



My colleague, Dr. Koslowsky, who treated me in those days, describes his feelings: "Treating seriously ill patients mandates an emotional detachment. The ability to act clearly and decisively is impaired when you're emotionally involved. Treating a close colleague, who had performed rounds with me just the other day, is an extraordinary experience: eagerness to help on the one hand mixed with fear and concern regarding the consequences of your decisions on the other. Dr. Livovsky was by no means my patient, he was my close friend. When I heard him call out 'please intubate me', I realized for the first time that one cannot treat a 'friend'. Only then did I understand that in order to actually function as a physician, one has to detach oneself from all distractions. The following course just showed me how important that transaction was."

My awakening was not smooth; for 3 days I suffered from hallucinations. Interestingly, the things I saw and heard were closely related to my own life: my religion, fears, education and profession [1]; for example, I hallucinated that a newly recognized incurable genetic disease was affecting me and some members of my family. Conversely, as I started to recognize the environment and understand the situation, the hallucinations slowly became more coherent.

After more than two weeks in bed under heavy sedation, like 25% of ICU patients who receive mechanical ventilation for at least 7 days [2], I was affected by ICU-acquired weakness (ICUAW) and suddenly was unable to perform the most basic tasks. Brushing my teeth and moving from my bed to the sofa required tremendous effort. My future was the source of fear and concern. Will I be able to go back to work? Will I be able to take care of my family? For more than a month I was unable to walk without assistance, and it took about four months to recover before I returned to work.

Nearly a month after my disease began the tracheotomy tube was extracted and I was discharged. Removing the tube was terrifying as I feared that at any moment I may choke to death. It took some time and several sleepless nights to recover a sense of safety without being continuously monitored. Friday night, the first night at home, was unforgettable. Almost every 20 minutes I awoke with a choking feeling, similar to the day of my intubation. Although I knew everything was perfectly fine, I was unable to control this distress.

Meditating on this I realize how unique each person is. Having insight into being a patient is inspiring. The ability to understand the patient as a whole entity, comprising not only the medical aspects but also their feelings and concerns, is a huge reward. Today, I try to perform based on these notions.

I've always thought of myself as a rationalist, in both my professional and personal life; during my illness I underwent a profound change that provided me with an understanding of the enormous importance of irrational issues in the practice of medicine and every other discipline that treats human beings. Does this make me a better doctor? I'm not sure, but it certainly provides me with a broader perspective of the profession that I practice.

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