Valedictory

What on earth was that!!

A 'roast' delivered by Dr. Geoff Parkin at the dinner commemorating the 23rd (and last) Short Course on Intensive Care Medicine organised by Dr. Lindsay Worthley (held at the 'Old Lion' Hotel, Adelaide 13.4.05).

A city still confined to the hot unyielding Adelaide plain, hemmed in to the east and south by those timeless hills. To the north, Elizabeth and other parts of the never-never. To the west the extremity of the gulfs and the Nullabor. People shading under verandas, behind tall hedges and Germanic sandstone pillars, at dinner parties, in Burnside, Unley and St Georges. A thick strata of conservatism with an over-burden of Anglicanism. Exciting weekends spent regenerating the water softener or motoring to unlikely places like Dry Creek or Paradise. Hot, wide, quiet streets; infinitely predictable, numbingly rectangular in the manner of the Colonel; Hans Heysen criss-crossed with Stobie poles.

But with the Stobie poles came light and power for some - if automotive destruction for others - light to shine in the darker corners of that bastion of conservatism, the venerable institution of the Royal Adelaide Hospital. With the 70's - the social and medical revolutions were about to begin.

Enter our hero.

When we first heard a chap in Adelaide was giving acid to his patients we thought he was either winding us up or taking a lead from the then popular flower power generation – and that free love would soon follow. The acid turned out to be of the hydrochloric rather than the lysergic kind, available at any hardware store as 'spirits of salts'. Some say it actually came from a hardware store and was used as paint stripper. He thus set a trend for treating South Australians with acid long before this became popular with the criminal classes at places like Snowtown and whatever.

In this sense he was a visionary. Apparently a range of i.v. cannulae would just dissolve into the circulation, with this stuff - this is where the idea of the Teflon coated politician came from - but eventually one that could withstand it was found. Then a rash of papers appeared (probably a number of rashes also appeared), I expect by way of absolution, to show that hydrochloric acid was a naturally occurring antibiotic substance. You could sterilise i.v. lines with a concentrated HCl infusion. Really? What was next: DRANO®?

I can hear you thinking that - hey! isn't oxygen the great acid generator? Isn't the oxide of many elements an acid when hydrated? And doesn't the kidney dump bicarbonate like there's no tomorrow if you have a screaming metabolic alkalosis in a well oxygenated and well hydrated patient? Well of course it does. So would you ever have to infuse HCl into a patient?

Well in 30 plus years I would have said 'no' until last Friday week. An anaemic, thrombocytopaenic, HITTS patient, I won't bore you with the details, was being volume depleted on CVVHD while anticoagulated with a sodium citrate infusion. He became progressively more alkalaemic and hypochloraemic. Nothing to do with Mr. Stewart mind you. So without a flicker of a smile I said we'd have to start him on i.v. hydrochloric acid, looking at the assembled registrars as much as to say this was "bog" standard stuff. What did they mean they couldn't get it from pharmacy?

It worked like a dream Tub - and the registrars think that there's life left in the old bloke yet (the consultant that is).

As everybody knows things were better in the old days, just ask any grumpy old man. ARDS was more hypoxic, the calcium went down more with pancreatitis and hyperosmolar coma was more hypertonic. Sadly it doesn't seem to happen as much any more.

Lindsay had this idea that if you were embarrassed by the magnitude of glycaemia in diabetic hyperosmolar coma with severe hypernatraemia, maybe you could run straight water from the tap into the circulation rather than bother with isoosmolar 5% dextrose or hypotonic saline. Fortunately, he didn't have to run the gauntlet of anything like an ethics committee in those days. This is just as well because it never struck me that administrators were his long suit. He would have had to explain to them how turbulent mixing in the right atrium would save the thin walled red cell from an osmolar shock of 5000 mmHg, or so. To be fair I think he measured the haptoglobin and methaemalbumin levels.

The word soon got round that water for injection was 'all the go' in diabetic hyperosmolar coma with hypernatraemia and hyperglycaemia. Inevitably, somebody missed the part about the right atrial catheter. I was impressed by the honesty of the Melbourne unit who, having infused the water for injection into a peripheral vein, reported that - yes - haematuria occurred pretty much instantaneously, just as you might expect. Well Tub it wasn't your fault and the patient was fine.

On the positive side, taking Tub's lead on one occasion we ran 11 litres of water in as many hours into a patient with an initial plasma osmolality of 462 mOsm/Kg. The Melbourne man who had been deaf since birth now regularly gives lectures in French. We were subsequently rewarded with some superb French cooking. As they say we have been dining out on the story ever since. When it came to the case report one

journal replied to the effect that it was a fascinating idea but might be hazardous for widespread applicability. They had to be joking! We referred them to a chap in South Australia.

Now a lesser man might have drawn some caution from these tales. But fortune favours the brave and it was no time before we were in for further osmolar shocks. Why mess around with 3N saline, it was reasoned, when you could give brine (it was 29% saline) for symptomatic hyponatraemia - solutions where, if you tapped the bottle, crystals would come out of solution. No point in doing things by halves. By now I realised what was happening. Having thrashed the limits of sodium and hydrogen ion metabolism, Worthley was slowly working through the first column of the periodic table. Papers on lithium intoxication and potassium appeared in short order (while unbridled human experimentation was still permitted) and inevitably, as he turned to the second column, calcium and magnesium got a run. Undoubtedly, this was the era that he must have enjoyed and a paper on the role of beryllium in ICU is eagerly expected anytime soon.

As we all know at the end of Act I, there has been a kaleidoscope of excellent papers on just about any ICU subject that you would choose to mention. There was even one on humility, or the need for it, which, not being easily classifiable under a body system, I have temporarily placed under "papers not in the author's immediate area of expertise".

Forthright, incisive, plain speaking are the qualities we've come to love. Not one to mess with when he's in his ground or even when he's on yours. I always remember that he showed up one day at Monash, saw that the lights were on, just dropping by as it were, and we happened to have a closed loop controller working to deliver fluid in a patient who was being dialysed. He studied it with interest. Next day he called from Adelaide to say 'thank you' and that he'd got home safely. "About that controller", he said. "It was interesting but I would have put the set point way higher". Obviously it had been bothering him. I suggested that maybe he could determine the set point using the internet from Adelaide, if he felt strongly about it. No doubt, as far as he was concerned, such an idea will have its day.

Others, I am sure, will reflect upon Tub's signal role in the creation and administration of ANZICS, his fulsome time as president, his truly mighty contributions to the development of postgraduate ICU education and the enormous amount of fun and good fellowship many of us had in the creation of a respected ICU examination system. And then there's the journal. A huge joint effort by Lindsay and his wife Janice. Properly emerging as the voice of Intensive Care in Australasia. A magnificent effort. I'm sure the registrars at Flinders Medical Centre will be pleased to know however that at least in the short term, their errors and omissions will not quickly appear in the current Editorials - I sure wouldn't have wanted to be the guy who didn't put that 'Swan' in.

No doubt with maturity (the journal's maturity that is), the editorials will become as balanced as some of the equations - what was that acid-base guy's name again? Tub you have always been my complete intensivist, and I often say to students there's a guy in Adelaide who, in a sometimes demanding profession, gives us as an example of how to achieve it all with style. This latest move by you and Janice (spending more time smelling the roses) is probably showing even more wisdom. We look forward to Act II.

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