for patients with refractory septic shock. Increased knowledge of the changes in vascular biology that characterise sepsis and the systemic inflammatory response syndrome may allow transient genetic manipulation of the expression of vasoactive mediators that control microvascular distribution of blood flow.

Renal failure

Acute renal failure is a common complication of sepsis and the systemic inflammatory response syndrome. This may reflect changes in the distribution of intrarenal blood flow between the cortex and medulla. The ability of patients to maintain intravascular homeostasis may also be impaired. The early use of haemofiltration to correct fluid imbalance and (possibly) remove circulating inflammatory mediators has been advocated, but the benefits are unproved. It is essential to restore circulating volume and achieve an adequate blood pressure and cardiac output to prevent and treat acute renal failure.

Dysfunction of gastrointestinal tract

The bowel is particularly susceptible to ischaemic insults. Hypoperfusion of the gastrointestinal tract is thought to be important in the pathogenesis of multiple organ failure as outlined above. Hepatic dysfunction, possibly resulting from reduced blood flow relative to metabolic demand, is also common in critically ill patients. Maintaining adequate flow and perfusion pressure are the only proved treatments to correct these deficiencies. Inotropic drugs with dilator properties such as dopexamine may selectively enhance splanchnic perfusion and oxygenation. Nevertheless, well controlled trials of augmented oxygen transport (possibly guided by gastric tonometry) are needed to establish the role of the gastrointestinal tract in multiple organ failure.

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Benefits of early haemofiltration are unproved

Key points

- Organ dysfunction probably arises from abnormalities of microvascular control and cellular metabolism
- Susceptibility to the effects of inflammatory activation may be determined genetically
- The gastrointestinal tract seems to be the “motor” of sepsis
- New supportive and therapeutic interventions are emerging as understanding of sepsis increases

The ABC of intensive care is edited by Mervyn Singer, reader in intensive care medicine, Bloomsbury Institute of Intensive Care Medicine, University College London and Ian Grant, director of intensive care, Western General Hospital, Edinburgh. The series was conceived and planned by the Intensive Care Society's council and research subcommittee.

An incident which changed my medical life Something to celebrate

It happened over three decades ago—1963 to be precise, the year that I became a doctor. That year the Medical Council of India decreed that six months of internship were to be completed before the one year as a house officer, a total of 18 months of preregistration jobs. My first was on a surgical unit.

A friend and I decided to celebrate passing our qualification by cooking a special meal in the doctors' canteen, and by contributing equally to a quarter bottle of rum, priced six rupees, which was all we could afford. My ward duties were from 7 00 am to midday and 5 30 to 7 00 pm. I arrived at the ward for the evening shift. It was quiet and there was little to do. My eyes were fixed on the clock; my mind in eager anticipation of the rum.

I then heard the lift coming up, and from it emerged a trolley carrying a frail old man of about 65 years. He had been seen in casualty with suspected intestinal obstruction. It was 6 35 pm. I took the appropriate history, examined him, clerked him in, and put him on a drip. Then, to my delight, the clock chimed seven. I was about to leave the ward when again I heard the lift coming up. I was by the ward door with my white coat in my hands when I saw our professor of surgery walking towards me. He asked me if there had been any new admissions. “Yes, sir,” I replied, and told him about the old man. “Let's take a look,” he said. I accompanied him to the bed and presented the case. He was impressed with my presentation and diagnosis, which had been made by the casualty officer and not me. He looked at the x ray films. Then he asked, “Have you sent his blood for grouping and cross matching?”

Summoning up my courage, I said “no.” I pointed out that my duties ceased at 7 00 pm and that the night senior house officer would be able to take care of it. He glanced at the clock over his half rim glasses and said, “Of course. It's gone 7 10. I am sorry I delayed you. Run away, my boy, and enjoy the evening.” Concealing my delight, I was about to leave the ward when he called me again. “Tell me, young doctor. What would have happened if instead of this poor old man it was your father? Would you have sent the blood for the necessary investigations?”

His words and his manner struck me like lightning. I was speechless. The bottle of rum no longer held any pleasure for me. The next thing I knew I was collecting the blood and cycling off to the blood bank. I secured two bottles, returned to see my chief performing the operation. I was third or fourth assistant in the operating theatre. We finished at about 3 00 am the following day when my chief said, “Well done.”

We enjoyed the rum the next day, when it felt that we really had something to celebrate.

Suresh Pathak, *general practitioner, Romford, Essex*

We welcome articles of up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or relative if an identifiable patient is referred to.