**A Surgeon Reminisces (2)**

In my surgical training I had just started a rotation of posts involving general surgery, orthopaedic surgery and cardiothoracic surgery. In 1975 I was doing my orthopaedic surgery training which lasted six months. Once a week there was a major ward round involving 5 consultant surgeons, 2 senior registrars, 3 registrars, of which I was one, 4 senior surgical house officers and 3 house surgeons. At this time I was about 3 months into my training. The junior staff had to introduce the patients to the consultant and give a potted version of their history and progress. The senior consultant, who led the ward round, was an Australian who was bad tempered and was known as ‘Wild Bill’. Most of the juniors feared the ward round as he had no qualms about belittling you in front of the patients. In the city in which I was working, there were two large teaching hospitals. In one head injuries were looked after by the general surgeons, and in the other, where I was working, they were looked after by the orthopaedic surgeons. I had no idea why this was the case, but the patients were only referred to the neurosurgeons if they developed severe complications of the head injury.

On one occasion, while we were on the ward round, a young man of 19 who had been admitted the night before with a head injury, suddenly deteriorated. He had been in a fight and had been hit on the left side of his head with a bottle. He had been unconscious for about 5 minutes, but was fully conscious by the time he reached hospital. We had just got near his bed when he suddenly collapsed and became unconscious again. A quick examination revealed that he was unreactive and the pupil of his left eye had become dilated and became unresponsive to light (the pupil normally constricts if light is shone in to it). He had a classical history of an extradural brain haemorrhage, i.e. a bleed between the skull and the dura mater (the tough outer layer of the meninges). This was a life threatening emergency. As the bleeding continues, the pressure in the cranial cavity increases and eventually, if not treated, would push the brainstem down the spinal canal, a process known as ‘coning’. The brainstem is responsible for many important functions, particularly respiration. If urgent action is not taken, the patient stops breathing and dies.

Wild Bill suddenly started shouting at everybody, telling them to get the matter sorted out and ring the neurosurgeon on call. The neurosurgeons worked at the other hospital in the city and regrettably no neurosurgeon could be located. The patient needed an urgent craniotomy (an opening of the skull cavity) via Burr holes which at that time were made in the skull with a brace and bit. In those days, CT scanning was not available and it was not possible to accurately locate exactly where the haemorrhage was. ‘Who has done Burr holes before?’ shouted Wild Bill. Everybody looked at the floor. ‘Bloody Hell’ shouted Wild Bill. ‘Somebody must have been involved or at least seen them done’.

I had never seen Burr holes performed, let alone performed them myself, but I was one month off doing my final Fellowship of the Royal College of Surgeons (FRCS) examination and had been reading up all the operations which were frequently asked. I knew all the steps and the relevant anatomy. Suddenly the words came out of my mouth ‘ I have done Burr holes Sir’. Wild Bill said ‘Well don’t bloody stand there, Doc, get to theatre and get on with it. Somebody else keep ringing and see if you can find the neurosurgeon’. It transpired that the neurosurgeon who was on call was 30 miles away, operating on an emergency at another hospital in Yorkshire.

An extradural haemorrhage usually occurs due to a tear in the middle meningeal artery, which is close to the under surface of the bone in the region of the temple. The surface marking of it roughly corresponds to a point midway between the superior margin of the eye socket and the upper part of the external ear (lobe) and a Burr hole should initially be made at this point.

We got the patient to theatre, shaved the left side of the scalp, towelled up and were ready to go. Fortunately, the Sister who scrubbed up was very experienced and had seen Burr holes performed before, earlier in her career. ‘Knife please Sister’ I said. I cut through the layers of the scalp down to bone, dealing with the bleeding from the skin edges with haemostatic forceps. I then asked for the brace and bit and carefully bored a hole into the skull at the appropriate place. The extra dural space was entered and there was a large haematoma, which I carefully removed but I could not see where the bleeding was coming from. I asked for another instrument ,namely a bone rongeur.A rongeur is a heavy duty instrument with a scoop- shaped tip used for gouging out bone. It is used for opening a ‘window’ in bone, usually the skull, to gain access to the tissue underneath, by cracking bits of bone from the edge of the Burr hole, thus enlarging the hole. (Rongeur is French for rodent or ‘gnawer’). Eventually I saw a small spurt of blood coming from a branch of the middle meningeal artery. I cauterised this with diathermy to stop the bleeding and then I evacuated the rest of the haematoma. I inserted a drain to allow egress of any residual bleeding and I closed the wound. At this point, a breathless neurosurgeon arrived in theatre. He looked over my shoulder ‘Oh’ he said ‘you’ve finished, I needn’t have hurried. I was told that there was nobody who knew how to do Burr holes’. I said nothing.

The patient went to the intensive care unit and was sedated and ventilated for 24 hours and was then woken up. He made a full recovery. None of the consultants enquired how I had got on with the operation.

A month later, I went down to London to do the oral part of the examination for FRCS. I had to ask Wild Bill for permission to take leave. When I asked he said ‘Bloody Hell, Doc – you stand as much chance of passing that exam as I do of becoming Pope, but I suppose I can’t stop you going’. One part of this exam involved an operative surgery viva where we were asked to describe 2 operations by the examiners. I went into the examination room where I was asked my name and examination number. One of the examiners was sitting reading the Times. The other explained that I would be asked the details of 2 operations and he would start the questioning. ‘Raftery’ he said ‘can you tell me how you would deal with a patient with an extra dural haemorrhage? I couldn’t believe my luck.

I passed the exam. On returning to work, only one of the consultants congratulated me on passing the exam at the first attempt. About 2 weeks later I was going into the hospital when Wild Bill was coming out of the main entrance. He walked with his head down as always and didn’t look at me, but just after he had gone past, I heard him say ‘Congratulations Doc. They must be giving that FRCS diploma away with Green Shield Stamps’. Remembering what he had said earlier I muttered ‘Thank you, Your Holiness’.