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新界西·醫院聯網
New Territories West Cluster

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8 April 2004

Miss Flora TAI
Clerk to Select Committee
Legislative Council

Dear Miss TAI,

Select Committee to inquire into the handling of the Severe Acute Respiratory Syndrome outbreak by the Government and the Hospital Authority

I refer to your letter ref CB2/8C7 dated 26 March 2004 regarding the above subject.

As requested, please see attached the requested information.

Thank you.

Yours sincerely,

(Dr. Peggy TAN)
Senior Medical Officer
Intensive Care Unit
Tuen Mun Hospital
Hospital Authority

Statement of events surrounding the intubation of a SARS patient on 28 March 2003

At about 6:15 a.m. on 28 March 2003, I received a page from the ICU on call MO. The A5 ward (SARS Ward) would like to refer one of the SARS patients. The SpO2 had dropped to the 80's while on BiPAP with O2 flow 5 L/min. I advised to try increasing the O2 flow rate while I returned to the hospital for the assessment.

On arrival at the hospital, I was informed that the SARS patient's SpO2 had improved after increasing the O2 flow rate. I put on full PPE and took the bacterial/viral filters for possible use if intubation was required. I rang the Operation Theatre to get OT Assistant to go to the SARS ward.

At about 8:00 a.m., I met the OTA in A5 ward. The patient was a 44 year old female. The patient was breathing on BiPAP with O2 flow rate 15 L/min. The SpO2 was 96%. She was rousable and could obey commands. However she was becoming exhausted. The case notes and X-rays were checked and I took history about the patient from the patient's husband who was also a SARS patient.

At about 8:10 a.m., I explained to the patient and her husband about intubation and mechanical ventilation, the difference compared with BiPAP and the need to transfer the patient to the ICU. The couple agreed for intubation. I then performed intubation for the patient.

At about 8:30 a.m., intubation was completed with the manual resuscitator connected to ventilate the patient with the bacterial/viral filter in place from the outset. The procedure was accomplished without any difficulty. The OTA packed up his equipment and left. The pulse rate, blood pressure and SpO2 were rechecked and found stable. Sedation with midazolam was given.

While I hand ventilated the patient, I asked the A5 nurses for O2 cylinder and portable SpO2 monitor to transport the patient to the ICU. I asked the A5 nurse to ring the ICU to confirm if we could proceed to the ICU.

At about 8:40 a.m. I asked an A5 nurse to resume ventilation for me briefly while I made an entry in the case notes at the cubicle door. I resumed hand ventilation for the patient about 5 minutes later and then I awaited transfer to the ICU. The ICU would ring up when the bed was ready.

At about 9:00 a.m., Dr. Tse [redacted] came. She offered to ventilate the patient and escort the patient to the ICU. I replied that this would not be necessary. I then continued to ventilate the patient myself.

At about 9:30 a.m., noting that the ICU had not rung back to confirm when I might move the patient, I requested to use the telephone to ring the ICU. I therefore handed over ventilation for the patient temporarily to ward A5 staff, probably to Dr. Tse. The patient's condition had been stable with the SpO2 at 99% and PR ~70 and BP ~110/70. She was sedated.

At about 9:45 a.m., I returned to the patient and resumed hand ventilation.

At about 10:00 a.m., the ICU bed was ready. The patient was escorted to the ICU by me together with one female nurse and another female attendant/porter. The patient arrived at the ICU bed 5 isolation room at about 10:15 a.m.

In summary, the intubation was smooth. After intubation a bacterial/viral filter was in use from the outset. Most of the hand ventilation was done by me. I did not leave the patient's cubicle except during the episode when I went to the nursing station to use the telephone.

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