

Assisting in endotracheal intubation nursing essay



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An ETT is an advanced measure of airway management, where a catheter is inserted in the trachea generally through the mouth. This creates a direct passage between mechanical ventilator, which simulates breathing, and the lungs, where gaseous exchange occurs. ETT is most commonly used in unconscious or sedated patients, where the patient may lose spontaneous breathing, also bringing about benefits like protection from aspiration of gastric contents into the lungs, which lead to infection and complications. Considerable amount of attention is given to the intubation procedure, avoiding trauma and infection.

Preparing a patient for intubation requires the patient to be positioned in the 'sniff in the morning', that being body straight with head slightly tilted to the front to obtain a straight airway. An anaesthetist will perform this procedure and the nurse prepares the necessary: an intubation set including an Ambu with face mask and other connectors and a laryngoscope with different blade sizes and muscle relaxant (Atracurium) and sedation (Propofol) medication are prepared.

Once everything is checked that is in perfect working order, the anaesthetist, positioned behind the patient's head, starts by giving the first IV bolus of Propofol later followed by the Atracurium. From this point onwards sedation will be administered by the nurse, and the anaesthetist will keep the head in position to maintain an open airway and bag the patient for 1-minute using the soft Ambu attached to the mask with 100% oxygen at 10-15l/min to hyper-oxygenate. After this 1-minute the first try for intubation is began and this should be no longer than 30seconds.

A laryngoscope is then inserted from the right side pushing the tongue to the side and lower, this will create physical space to see the epiglottis and the laryngoscope will be advanced slightly more to see the larynx. Once identified, the ETT is carefully advanced from the right side over the laryngoscope and straight between the larynxes. Then the tube is advanced up to 21-24cm from its markings, laryngoscope withdrawn and the soft Ambu is now connected with a specific connector to attach to the ETT. The anaesthetist will now bag and auscultate over the chest to check position of ETT, and to check that air is going into both sides of lung, or only a single side or worse the stomach. During the process the nurse may be requested to give more boluses of sedation, depending on what the anaesthetist encounters.

Once the position is confirmed, the ETT is secured using a tie or a facial adhesive. The patient is then connected to the ventilator, where the anaesthetist gives the initial setting and liaises with the nurse on the aims and guidelines needed to safeguard the patient's health and especially avoid unnecessary complications. Continuous sedation is as well started as now the patient is preferably left unconscious to stabilise, as a patient may extubated once semi-conscious and agitated. Parameters post-intubation are checked and charted, blood gases are taken and analysed. Shortly after insertion a chest X-ray is performed to verify positioning thanks to the radio-opaque strip incorporated in the ETT.

Indications for intubation may vary from hypoxemia, loss of consciousness, airway obstruction or manipulation of the airway. In one of the cases I had the opportunity to observe clearly, the patient was suffering from pneumonia

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and was losing consciousness as she could not maintain a decent pO₂ via a non-rebreather mask and started to get agitated and therefore continue lowering her oxygen saturation level. I took a blood gases sample and it resulted in a low enough result that the nurse decided to advise the anaesthetist to try intubation, apart from the fact that she was definitely in need to be sedated to reduce her agitation. In a pneumonia case a sedated patient may benefit more from care and obtain a healthier outcome as consciousness is then resumed when infection has started to clear.

Intubation as like all the other invasive procedures carries numerous risks for the patient. To start with is the high risk of infection, which may come from lack of attention to asepsis during the procedure, and there can even be trauma to the lungs if the anaesthetist goes in too far with the ETT, or can even cause trauma to the buccal cavity, where with the use of the laryngoscope, leverage over the teeth may be exerted leading to the breaking of teeth. Moreover, if the patient takes too long to be intubated hypoxia may result, since the patient is not breathing at all. Single-sided or stomach intubation may occur as well.

In the intubation procedure, precautions to prevent complications include patient sedation and muscle relaxation at the start of the procedure to avoid movements of any muscles. The patient is positioned to help the anaesthetist have an improved visualization of the larynx while using the laryngoscope. A measurement of the length of the airway is taken, to avoid inserting the ETT too much further down into the lungs. A patient is bagged for 1-minute prior to trial of intubation and no try takes longer than

30seconds, and ultimately a chest X-ray is performed to confirm ETT position.

Blood sampling through an arterial catheter

An arterial catheter is one of the most common lines required in ITU, indispensable for continuous intra-arterial blood pressure which is essential in a critically ill patient supported by vasoactive drugs. Moreover it aids in arterial blood sampling, being routines or ABG of an intubated patient, where if a patient doesn't have an arterial line would be pricked countless times during a single day, therefore is a benefit for the patient as well.

Taking a blood sample through an arterial line requires following step by step instructions, while always keeping in mind asepsis, as although it is not actual invasive procedure, we are dealing with arterial blood and colonising a cannula imposes great risks of infection. To start with, perform hand hygiene and prepare essentials within easy reach, including alcoholic 2%chlorohexidine wipes (clinell), a packet of sterile non-woven swabs, pair of non-sterile gloves, luer lock stopper, 5ml syringe, ABG syringe, appropriate vacutainers and luer lock adaptor.

Once everything is prepared and patency of line is checked by using the flushing device, perform hand hygiene once again and wear gloves. Place the open packet of sterile swabs under the area you will be working around, i. e. the 3-way tap on the arterial line. Wipe the stopper locked port at the 3-way tap for 15seconds using a clinell wipe. Now the 3-way tap ' OFF' position should be facing the port that has just been disinfected, remove the stopper and attach 5ml syringe using a non-touch technique, turn the 3-way tap to '

OFF' from flushing device and aspirate the first 3-5ml which will contain mostly heparinised saline. Turn the tap back to ' OFF' from the port being used. Now, remove the 5ml syringe and start from collecting blood sample for ABG, using the same non-touch technique attach the syringe to the port, turn the stopper ' OFF' from the flushing device. Withdraw small sample of blood (up to half of ABG syringe, approximately 1ml), if you require more blood samples turn the tap ' OFF' to port again and remove ABG syringe while attaching its stopper at its end, connect luer lock adaptor for vacutainer use. Now turn the tap ' OFF' to flushing device and start pressing each vacutainer until it stops filling, always changing the vacutainers using non-touch technique. It is suggested to leave for last any blood test sample that its result is affected by the amount of heparin in the sample, eg. APTT/INR.

Once finished from taking the necessary blood samples, turn tap ' OFF' to patient and flush using flushing device onto the packet of swabs. Once clear from blood, close with luer lock stopper using non-touch technique. Now turn the tap ' OFF' to port and flush the remaining part of the arterial line.

Avoiding leaving blood traces in the lines will ensure longer lifetime and patency of the arterial line itself.

Patients in a critical care setting most often need several blood sampling every day, one indication may be ABG monitoring due to the patient being supported by a mechanical ventilator. ABG sampling is also needed in the weaning off process, but can also be used to monitor any acidosis or alkalosis the patient may be suffering from, due to his admitting condition.

Other blood samples are mostly taken routinely in the morning and more investigations may be required throughout the day.

The withdrawal of blood via an arterial line is not an invasive procedure, though it is still a manipulation of a catheter leading to the bloodstream, therefore it exposes the patient to a high risk of acquiring a nosocomial infection through the line if asepsis is not maintained throughout the procedure. The colonisation of the line without adequate disinfection may eventually lead to life-threatening septicaemia.

Prevention of infection was applied using universal precautions like hand hygiene, disinfection using alcoholic 2%chlorohexidine wipes (clinell) and non-touch technique. This minimised drastically the chances of nosocomial infections.

Section B - INTERPROFESSIONAL COLLABORATION IN THE CRITICAL CARE SETTING

Describe the role of the nurse in each of the following units:

Intensive Therapy Unit (ITU)

Neonatal and Paediatric Intensive Care Unit (NPICU)

Burns and Plastic Surgery Unit

Renal Unit

Intensive Therapy Unit (ITU)

An Intensive Therapy Unit (ITU) nurse is required to work in a setting where patients are experiencing or at-risk of experiencing life-threatening conditions, thus require complex assessment, high-intensity therapies and interventions, continuous nursing care and high-tech monitoring. Critical care nurses trust upon a particular organization of knowledge, skills and experience to provide care to patients and families and create healing, humane and caring environments.

Patient advocacy is a major role in ITU nursing, as usually the conditions of a patient may be poor to the extent that the patient is unconscious or else is induced into unconsciousness. Therefore the nurse has to act on behalf of and in the patient's best interest as the patient's advocate and ensuring that the patient's family are well informed about the care that the patient is receiving. The necessary information needs to be given to help make highly personal decisions about the patient's care, and that the patient and family's decisions are respected in the development of any treatment plan for the patient.

Advanced and continuous assessment needs to be carried out to verify patient's health status; physical assessment may include Glasgow Coma Scale, eye sensitivity test, cardiac auscultation, abdominal palpation and more. Leading then to high-tech monitoring from highly specialised bedside monitors, requires critical nurses to be trained in telemetry. Telemetry is a computerized monitoring system that transmits essential information about the condition of the patient (heart and lung activity), and the nurse using this information can make healthcare judgements.

Therefore with the help of telemetry in conjunction with the extensive knowledge of pathophysiology of illnesses, nurses assess the need to perform any intensive interventions that the patient might need. For instance, take arterial blood gases of a patient if oxygen saturation are getting lower, or perform suctioning if certain breathing sounds are noticed.

More assessment may be done after certain interventions and therefore prevention of degrading in the patient's condition is another main responsibility of the ITU nurse. This requires the nurse to be able to interpret any result and respond with an appropriate intervention, these may include; titration with inotropic substances to maintain a pre-determined arterial pressure, increase oxygen supply through the mechanical ventilator or change the mode it is set to wean off from extra support.

ITU nursing in certain large-scale hospitals may be split in specialized sectors, like for instance the Cardiac Intensive Care Unit (CICU) in Mater Dei Hospital is a post-surgery intensive unit mostly dedicated to open heart surgery, leaving the ITU to take care of mostly post-laparotomy patients, serious trauma and other life-threatening cases, including severe infections.

Neonatal and Paediatrics Intensive Care Unit (NPICU)

Nurses working in Neonatal and Paediatrics Intensive Care Unit (NPICU) require being extremely careful and vigilant, as this field requires working with neonates which may have some sort of complication from birth (or even before) to kids up to four years. As with all patients of this age group, symptoms and conditions change drastically, due to the frailty of the neonates, therefore continuous assessment is of extreme importance. As

cases can differ from premature babies to post major operation neonates, the care is split into three: Intensive, High-Dependency, and Special Care.

Caring for this type of population, care is adopted to support the patient medically and physically, assess and monitor but a great input in supporting psychologically the parents is a major requirement in these cases as they will be going through a really rough period, especially in the most serious cases like complications. Necessary time and information is given to the parents to understand what is going on with their child, involvement in the baby's needs in special care.

In intensive and high dependency cases, the patients will be connected to high tech bedside monitors; monitoring vital signs like arterial blood pressure, ECG traces, respirations, oxygen saturation and pulse. Most often patient with such frailty will be in a temperature controlled and humidified incubator to keep a stable environment, promoting recovery. The need of certain accesses may be essential as well, an umbilical line (usually arterial) is needed in cases of drug and fluid therapy, intubation may be needed in some of the cases as well. Inputs and outputs are strictly monitored throughout all levels of care provided in the unit, but as blood gases and other blood investigations may also be essential in certain intensive cases, keeping the blood volume withdrawn as low as possible is of extreme importance as too much blood withdrawal in neonate may lead to serious complications.

For special care there is more the usual care of a baby, therefore involving basic feeding, bathing and nappy changes, but need some extra care

especially in calculation and handling due to their small structures. Nasogastric or oro-gastric tubes may be necessary in patients premature enough not to have a fully developed swallowing reflex or those too frail to suckle all the milk they need to maintain themselves. In this type of care, parents (especially the mother) are encouraged to handle and take care of the baby themselves as this has positive effects on both the mother and baby's health. The nurse is responsible to liaise with the mother to set appointment regarding washing her baby or nappy changes which the mother may wish to do herself. Monitoring of daily weight, measurement of Occipitofrontal Circumference (OFC) and nappy weighting are some of the documentation taken by the nurse apart from the regular vital sign like temperature and heart rate.

Plastic Surgery and Burns Unit

Nurses working on the Plastic Surgery and Burns Unit (PSBU) may encounter the extremes of wounds through skin layers, since those present in burns cases could involve from only skin to muscles, nerves, blood vessels and even bones. On the other hand, plastic surgery is more related to the surgical grafts done post-recovery from a burns accident, or superficial level surgery like the removal of melanomas and other skin disorders.

Burns nurses are responsible in fluid resuscitation given through wide-bore IV lines in severe cases of burns. In conjunction with fluid resuscitation, is a strict input and output charting to assess renal perfusion due to large volume loss from interstitial spaces due to loss of skin. Haemodynamic monitoring is another essential role, as the fluid loss from wounds may lead to

hypotension, inotropic substances may be needed to support the heart muscle in extreme cases.

Furthermore, the importance to keep sterility over wound and to aseptically cover using a special type of dressing containing paraffin oil, which does not allow water to transpire, is stressed in burns cases, as once the skin layer is lost, all the infection and water loss prevention which the integumentary system was responsible for, are now absent.

In the plastic surgery cases, nurses are mostly responsible in post-op wound reviews and change of dressings. The nurse also advises the patients to protect fresh wounds and prevent infections.

Renal Unit

Dialysis Nurses on the Renal Unit work with a patient population of solely End Stage Renal Disease (ESRD), therefore their insight into the illness and its treatment needs to be well-defined. Dialysis treatment, which is the process of removing waste from the blood of a patient whose kidneys lost this function, is available in two modalities, namely; Haemodialysis (HD) and Peritoneal Dialysis (PD).

Nurses in charge of PD patients conduct periodical reviews to collect blood, peritoneal fluid and swabs for investigations. Their main responsibility though, is to check progress from the personal log that the patient is encouraged to keep from the start of the treatment, this includes daily weight, oral intake, dialysate input (type and amount), dialysate output (colour/consistency and amount). Since PD is a self-care treatment at home, a high-quality nurse-patient relationship is required to assess for adherence

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to treatment. The nurse is responsible to liaise with patient and relatives if they are encountering any challenges during treatment. Advices about the necessity of any treatment changes and the importance of asepsis during treatment, to avoid unnecessary exposure to infection, i. e. peritonitis, are one of the key responsibilities of a PD nurse.

On the other hand, nurses responsible of HD patients, unlike PD, have a more direct responsibility with the patient's infection prevention. The nurse first responsibility is to inspect equipment, ensuring it is in perfect working order before use and all lines are new and sterile to minimize chance of infection. Review of the patient's previous session handover and preparation of any treatment needed during the dialysis is carried out by the nurse.

A typical dialysis treatment starts with morning weighting and then, the nurse, using strict aseptic technique, inserts two wide bore cannulas into the patient's AV access. Finally the patient is connected to an HD machine for 4 hours, set to target weight calculated by the physician, to remove excess water and waste products from the bloodstream. Before, during and after these 4 hours, vital signs are checked and charted. Routine blood investigations are also taken and any indicated medications from previous investigations are administered and documented. The patient is advised of the possible complications and suggested to notify as soon as any abnormal feelings set on. Any pain complaint reported by the patient during the dialysis is reported in the documentation for hand over and physicians are contacted in view of treatment changes requirements. Moreover, as HD patients have to attend these sessions 3-4 times weekly, the need of a quality nurse-patient relationship is essential. The dialysis nurse spends time

with the patient assessing any psychological or physical ill effects of the illness and documents an adequate handover to obtain successful treatment of this condition.

Compile a list of the different types of health care workers whom you encountered during this entire placement.

Physiotherapists

Anaesthetists

Midwives

Nurses

Nursing Aides

Care workers

Radiographers

Speech Language Pathologists

Occupational Therapists

Audiologists

Electrocardiogram (ECG) Technicians

Describe the role of THREE other (non-nursing) members of the ITU team.

Include key responsibilities of these persons for the patient. From your

observation, what is the nature of their interaction, if any, with the critical care nurse?

Physiotherapists

Physiotherapists in an intensive care setting are mainly responsible for clearing secretion from chest walls using positioning, percussion, manual hyperinflation and vibration. These methods clear the peripheries of the lungs and mobilize secretions to the central airways to be easily suctioned and therefore re-establish a larger lung capacity. Apart from chest-physio, they also work with conscious patients on the early movement of limbs to resume physical function and avoid muscle waste due to being sedated and bed-bound. Whilst encouraging the patient to do these exercises on his/her own initiative as needed, the physiotherapist reports to the nurse any result of his/her actions and reminds the nurse to encourage and observe the patient doing the exercise needed for further improvement in recovery.

Radiographers

Radiographers in the ITU setting are not mainly responsible for diagnosis, as in critically ill patients usually the underlying conditions of illness are discovered prior to admission. Though, with the use of portable X-ray machines, their help is essential in confirming the positions of any tubes or lines inserted in the unit or theatre, whilst minimizing discomfort of unnecessary transport to the Medical Imaging. Moreover through radiography any degradation of the ITU admission health insults may be identified, for example comparisons of previous chest x-ray to analyse if consolidations increased or decreased. The radiographer-nurse relationship is usually more concerned in helping to position the patient well to get a <https://assignbuster.com/assisting-in-endotracheal-intubation-nursing-essay/>

clear 'shot', giving the possibility to take the most out of the X-ray taken. Once published, X-ray are seen by medical staff to verify placement of any newly inserted central venous line or endotracheal tube, and the progression of the condition is also assessed.

Electrocardiogram (ECG) Technicians

ECG Technicians are indispensable in cardiac related admissions in ITU, this usually would be a post-MI patient with recurrent arrests. Their main responsibilities are into attaching leads at specific sites on the patient's body to the ECG machine, which in turn prints the signal it receives onto an ECG strip. Although patient in an ITU setting are generally attached to a continuous ECG monitor, this type of ECG gives a better picture of any arrhythmias and axis deviations of the pulse. The technician then analyses the result, identifies any emergencies and liaises with nursing staff and medical staff. Most often this involves cardiology staff as well, since decisions regarding treatment are usually deducted from these types of ECGs.

Section C - DOCUMENTATION

Why is documentation important in a critical care area?

Documentation in critical care, as in the all nursing field, is an essential role which enables a better continuation of care and assessment of progression or regression of the patient's condition. That said, the importance of precise information in the critical area is exponential to the fragility of the critically-ill patient, therefore this gives a valid reason for the necessity of hourly vital signs, urine output, continuous IV pump rate and more.

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Along the various types of documentation, comes in the rationale for certain actions taken leaving a pattern to be followed and leave good ground for recommendations to be given during handover. For instance, low oxygen saturation is monitored and the nurse decides to perform suctioning and an improvement is visible in the forthcoming readings, therefore one can suggest the following nurse to try this method as it has shown good results.

Moreover, importance of documentation increases as the risks for the patient increase leading to a more responsible practice. This helps to improve quality of care provided and safeguard the patient from malpractice.

Documentation is critical not only for nurses in this setting, but plays quite an enormous part in any of the doctor's actions, as strong and consistent rationale is needed to back up certain decisions taken in critical life-threatening moments to improve care given and obtain healthier outcomes.

List all forms of documentation which nurses perform in each of these units:

Intensive Therapy Unit (ITU)

Neonatal and Paediatric Intensive Care Unit (NPICU)

Burns and Plastic Surgery Unit

Renal Unit

Intensive Therapy Unit Chart (incl. Hourly Parameters, Investigation Results, I. V./Oral Intake, Ventilation (via type of Mask or Ventilator Mode (SIMV, CPaP, BiPaP) & FiO₂), Continuous I. V. Treatment, Output via N. G./Drains/Urinary Catheter), Handover Sheet

Neonatal Abstinence Scoring System, Investigation Flow Chart, Parameters + Intake/Output Chart, Fluid Prescription Chart, Apnoea Chart

Parameters + Intake/Output Chart, Chart for Estimating Severity of Burn Wound, PSBU 24hrs. Drain Output Chart

Haemodialysis Chart (incl. Parameters, Actual + Target Body Weight, Blood Test Results, Handover for next session)

Section D - ITU PROCEDURES

During your ITU placement, select one of the following procedures which you have observed and in which you have taken part:

Admission of a patient to ITU

Transport of a patient to the operating theatre or the medical imaging department

Discharge of a patient to another ward/unit

(a) DESCRIBE the nursing observations, actions and documentation during the procedure. Include a rationale for these activities.

(b) How did YOU participate in this event?

(c) REFLECT on what was done properly and what could have been done better.

Transport of a patient to the operating theatre or the medical imaging department

The transport of a critically ill patient is one of the most challenging and requires a lot of preparation, but thanks to the portable X-ray and Ultrasound (US) technology this occurs in only a few cases like Magnetic Resonance Imaging (MRI) or Computed Tomography (CT) scan, or else an essential need to transfer back to the operation theatres in case of complications.

In a case I had the opportunity to take part in; we had to take a patient to MRI for a brain and C-spine scan. The nurses I was with started from contacting an anaesthetist as the patient was intubated, contacted a radiographer to take girth measurements, since the patient was obese, to check if the patient would go through the scanner and contacted the family that their relative will go for a scan and may not be there when they come. Afterwards the nurse extended IV tubing to obtain enough length during the scan, while I started to collect all the portables needed for the transport including; oxygen cylinder, portable ventilator, crash pack, Ambu bag and monitor stand. Preparation of extra sedation, other IV treatments and necessary flushing solutions was done to prevent running out of medications during this transportation.

The nurse checked that the patient was stable enough on the current inotropic support and sedation. The nurse also checked the oxygen tank pressure, ventilator function and just before we left connected to portable machinery and evaluated condition of the patient again and charted the parameters. The anaesthetist gave a dose of muscle relaxant to avoid any unexpected movements from the patient while doing the transportation,

which could lead to lose the airway if the patient would extubate. Extra muscle relaxant was prepared as well.

Leaving off from the ITU, we continuously monitored the patient's parameters on the monitor, arrived securely at the medical imaging and started discussing what needs to be removed or replaced from the patient before we enter the MRI room. Certain machinery is not MRI-compatible, therefore the exposure to that magnetic field would damage it or cause malfunction. Following advises given by the radiographer, anything that needed to be removed was removed, leaving only essential monitoring to be removed and re-attached to appropriate machinery once in the MRI room. Patient was then transferred from the bed to the MRI table going straight into the MRI room, back on essential monitoring assessment of condition was done and we aligned MRI table to the scanner to start the procedure.

During all this time the nurse and anaesthetist gave necessary amount of sedation and muscle relaxation bolus to prevent accidental alertness of the patient and unexpected extubation. The moment when we were getting the patient inside the scanner, we realized he wouldn't get in because of his hands had to pass over his already enormous girth and he simply wouldn't fit. At that point we realized we made a lot of effort, but unfortunately we were still unsuccessful. Therefore all the process had to be reversed, and once out from the MRI room, settled the patient with adequate monitoring for transportation back to ITU.

Once back in ITU, we removed any unnecessary tubing, placed all transport equipment back in place and documented parameters post-transportation. A

note was added in the documentation regarding the failed MRI; the family was let in to see the patient and was given an explanation of what was done during the day.

Looking back and reflecting on the event, I realise the amount of things that are taken in consideration prior to leaving the ITU. The importance given to sedation and muscle relaxation to avoid extubation, Ambu bag for manual ventilation in case portable ventilator stops working or needs to be disconnected. The extension of the IV tubings was something, that actually didn't even cross my mind and though so important. Preparation of extra medication, not too run without during transport. These are all things that require effective thought as if omitted, the repercussions can be terrible.

I don't consider the unsuccessful try of getting the patient into the MRI has anything to do with being unprepared or unaware of something, as this fact was taken in consideration from the beginning. I do consider it as an unfortunate event, which left us all with another important lesson learned. I believe it is imprinted enough that, from now onwards when I hear that a patient is for MRI will be the first I will consider.

Section E - PATIENT CARE IN A CRITICAL CARE SETTING

In this account I will be focusing on a case I followed during my placement on the Renal Unit at Mater Dei Hospital. The case study involves an interview with a 27-year old male patient suffering from End Stage Renal Disease (ESRD). This gentleman is to date known to have lost renal function due to Focal Segmental Glomerulosclerosis (FSGS) with onset of illness symptoms

started at 17 years of age. Due to ethical reasons the patient involved in this account will have the pseudonym Mr. Frank Abdilla.

Mr. Abdilla has been treating this illness for slightly more than 10 years now and is currently following haemodialysis (HD) 3 times a week. I started this interview with getting to his medical history, and to tell me more about the onset of the illness and its treatment to date. Frank expressed that he suffered from nothing prior to the onset symptoms, which he referred to them as a "silent killer symptoms". "I only know that I started to feel less the urge to urinate and my breath had a foul smell, then after a couple of days I had an episode of loss of consciousness,