

The Not-So-Little Details

In the Emergency Department

Some codes I proudly relive because of successful procedural interventions or outcomes, but the bulk of them are a blur of CPR and death certificates. One code that I will never forget and that fits neither category should have never happened.

At the change of shift, I took over the care of an elderly woman with chronic obstructive pulmonary disease (COPD), pneumonia, and a high potassium level. According to the physician going off duty, the patient had a history of renal failure, was receiving hemodialysis, and still smoked about a half-pack of cigarettes daily. The patient was retaining carbon dioxide due to the combination of COPD and concurrent pneumonia. Although her respiratory issues were the most apparently life-threatening problems, the exiting physician stressed her comorbid problem: her potassium level was 7.2 mEq/L (nearing lethal levels), and she was being sent to the MICU for urgent dialysis to correct this definitively.

When my shift began, the patient was just beginning to tire out and become a bit sleepy. Fortunately, the respiratory therapist had just started CPAP and we all hoped she would turn around. I did a “fly-by” evaluation, verified her history, and then went to see some new patients. Within 15 minutes, the patient became increasingly hypoxic and did not respond to suctioning; in addition, she was also becoming more obtunded. The MICU resident team had just arrived, but it was clear that the patient would need to be intubated before transfer.

It was a calm preparation with all medications and equipment assembled, adequate staff available, and the patient pre-oxygenated. I felt the patient did not require the sedation typically used in a rapid sequence intubation due to her sleepiness, so I only administered succinylcholine, which is routinely used to paralyze a patient and facilitate an easy intubation. As

soon as I injected the medication, I realized what I had done—I had given the patient succinylcholine, which is contraindicated in hyperkalemic patients because it can cause potentially fatal cardiac dysrhythmia. I turned to one of the MICU residents and Socratically asked, “This patient is going to be dead in 30 seconds because of what I just gave her. Can you tell me what we need to do now?” It was not really a question to him so much as it was a question to myself.

As if on cue, the patient became bradycardic, and her pulse dropped to the low teens before the first dose of atropine was given. Then, she flatlined, and we began compressions as epinephrine, insulin, 50% dextrose, calcium gluconate, and more atropine were administered. After the first minute or so, I began to consider pacing her transcutaneously when I suddenly felt her femoral pulse return. With compressions held, the patient’s pulse rocketed to 150 to 160 bpm and the systolic blood pressure was amazingly in the 150 mm Hg range. Her vital signs normalized shortly thereafter, and she was taken upstairs in “stable but guarded” condition where the dialysis team was waiting.

I was incredulous at her recovery and incredibly shaken and embarrassed by my mistake. I found myself “confessing” to various people, and everyone reassured me and amplified the “success” of the code. Afterwards, I heard she was moving her extremities shortly after going on dialysis. She was, in fact, extubated a few days later and discharged. I have not yet reconciled with this code and do not know if I ever will. I still practice with conviction and success and will never make that specific mistake again, but I cannot help feel that I had in some way committed manslaughter, even if I also saved her life.

—Patrick Martin, MD, FACEP
Rochester, NY

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