

## Have Water, Will Cardiovert

A Telemetry Unit in New York City

**A**s a third-year resident, I was working in the telemetry unit when a patient was transferred from the critical care unit. The patient was a young man who had suddenly passed out on a public bus. The emergency medical service had been quickly summoned, and the patient was cardioverted in the field from an apparent pulseless ventricular tachycardia, which was later interpreted as torsades de pointes. After two days of uneventful monitoring in the critical care unit, he was transferred to the telemetry unit.

Approximately one hour after the patient arrived in my unit, I was standing by the nurses' station when the monitor alarm for our new patient went off. Torsades de pointes was clearly visible on the monitor. As I ran to the patient's room I saw that in the hall outside his room, not yet put away from the previous occupant, was an external pacemaker with monitoring leads and small cardioversion paddles. I pulled the pacemaker into the room with me, and the nurses immediately followed me with a full code cart.

We were all surprised to find the patient quite awake, sitting up in bed, and smiling. We took his pulse, began to reach for the blood pressure cuff, and, to save time, used the cardioversion paddles from the external pacemaker in monitoring mode to confirm that his heart rhythm was indeed still in torsades de pointes. Then my intern and I began a mental status examination. After we had asked a few questions, the patient looked at us blankly and promptly slumped forward unconscious.

I turned around to reach for the full code cart. To my surprise, the four nurses and two doctors who had accompanied the code cart into the room, apparently

assuming that the patient appeared much too healthy to be in cardiac arrest, had left the room and had not broken the lock on the cart. I had the pacemaker/cardioverter's paddles in my hand, but no saline pads. From the patient's bedside table, I grabbed two handfuls of tissues, poured water from the plastic pitcher on the table, squeezed and slapped the wet tissues onto his chest, and set the cardioverter to 200 joules. I don't remember if I audibly yelled, "Clear!" but I remember thinking how unnecessary the warning would have been. The patient's rhythm went back to normal sinus.

My intern and I looked at each other across the bedside with a sigh of relief. The patient immediately regained consciousness and began complaining about the smell of singed chest hairs. After approximately 30 seconds of loud and somewhat irrational yelling out the door for everybody to get back in the room, I arranged for the intern to set up a magnesium infusion and I used the patient's bedside phone to call the critical care unit and see if they might not want to invite the patient back to intensive care.

From this code, I learned two lessons. The first and most trivial lesson was that just because a patient in ventricular tachycardia is awake and alert doesn't mean the patient's status will remain that way. The more valuable educational point I learned from this code, however, is that New York City water coming through our hospital pipes contains enough electrolytes to conduct adequate current for an emergent cardioversion.

—Craig Werner, MD, PhD  
New York, NY

Copyright 1999 by Turner White Communications Inc., Wayne, PA. All rights reserved.