S.K.D.M.

Essay 16 November 2007

TOPIC: Patient who was expected to die but Survived

Patient Y, Age 30 years, Sex – female

This adult patient was seen in the ER by the emergency Doctor on the 13th of April 2004 at about 7pm. Patient was severely bleeding in the abdomen due to RTA. The Surgeon wants to take her in the OR to attempt to stop the bleeding. The patient is hypotensive and a bit confused. The best technique/induction chosen was General Anesthesia with an endotracheal tube, Ketamine and Succinylcholine.

Pre Anesthetic equipment check in 10 secs. Blood pressure machine on, SAT machine on, EKG machine available, suction hooked up with tubing and tonsil suction attached. Ambu bag available. Appropriate drugs drawn up. Pre-cordial stethoscope available. Endotracheal tube with stylet ready to go. Working laryngoscope available.

Patient woken up prior to induction done. Verification done on patient name, NPO status, current lab results, any known allergies, major medical history, physical exam done including breath, IV access obtained, BP cuff, SAT monitor and EKG monitor obtain initial readings. Pre-cordial Stethoscope to sternal notch to verify breath and heart sounds. Last but not the least pray for the Lord's touch and guidance.

Oxygen turned on during the induction phase at 3-4 l/m. Pt took 3-4 large breaths via the ambu mask "just before putting her to sleep. Lidocaine 1mg/kg IV about 2 min given before sedation, next was Ketamine at 1-2 mg/Kg as a sleep dose, followed by succinyecholine 1mg/Kg.. After the pt was asleep ambu bag was applied alone with ventilation. Normally the pt will exhibit some fasciculation within 30 sec of receiving sux. Intubation was successful.

At the middle of the case the patient develop ASYSTOLE.

Patient was been monitored via EKG, BP cuff and SAT monitor. The monitor was showing some kind of indications that things were not going well. The pt's BP was fluctuating widely, hypotension, changes in the EKG indicating ischemia or injury to the heart. Changes in the SAT readings and breath sounds indicating respiratory complications. Escape beats followed by an agonal rhythm leading to asystole or cardiac standstill. Carotid pulse check full 5 sec there is no pulse. Once no pulse (carotid) and leads are hooked up, start ventilating 5-6 bpm of O_2 via ambu and mask. I called for extra personnel as available and for a defibrillator to be brought. The surgeon began to do chest compressions at this time as well. When others arrived, the surgeon step back and let other qualified people do the work while he directs the events.

The 1st medication given was Epinephrine 1mg IV push. It was reported after 5 minutes. Chest compression was done. The next drug given was Atropine 1mg IV push a couple of minutes after, the 1st epinephrine was given.

I continued to ventilate with 5-6 bpm of Oxygen. After 2 minutes I stop compressions to see if the pt was any rhythm of his own, but to no avail. I continue with ventilations and chest compression. Epinephrine 1mg IV push given every 5 min, alone with Atropine 1mg IV push every 5 minutes. This procedure was continued with a stop every 2 minutes to check for pulse. Finally there was pulse which I was 100% satisfy with.

The surgery ended successfully and pt extubated taken to the recovery room later awake and taken on the female ward.