THE SULLIVAN GROUP

TSG NEWSLETTER

SAVING LIVES - REDUCING RISK

From The Editor

Dr. Dan Sullivan is a Board Certified Emergency Physician and President and CEO of The Sullivan Group which is dedicated to patient safety and medical error reduction.

Traditionally, our newsletters bring forward cases with bad or unfortunate outcomes to highlight specific risk management issues. In this issue, we would like to flip that paradigm and present instead some heartwarming success stories that we've received from our learners. These are real stories from medical professionals like you, for whom having taken our courses has made a real difference in a patient's life. So we dedicate this issue to you heroes on the front lines of medicine every day, who devote yourselves tirelessly to healing the sick, speeding recoveries, and saving lives.

Thank you for all that you do, and keep up the good work! ■

Wishing you and your families a safe, peaceful and joyous holiday season

From The TSG Family

Abdominal Aortic Aneurysm (AAA)

By Gary Fagan, MD

Nancy Byrnes,

I know you have to make many difficult decisions every day and I wonder if you get the satisfaction of knowing when those decisions have a meaningful impact on someone's life.

The Education Program that Annette Steiner brought to our attention, that could help to lower our insurance premiums and you decided to implement was a wonderful opportunity for the nurses and the doctors. The physicians had their choice from many different topics, and the feedback from the doctors was excellent (they even have a course on EMTALA that looks good). I decided to do thoracic and abdomi-

nal aneurysms and was very impressed with the quality of the programs.

We can fast-forward to this weekend when we received an EMS call on a mid 60's gentleman with low back pain and hypotension. When I heard the report on the radio, I was thinking of an abdominal aortic aneurysm. When the patient arrived he was sweaty and did not look well. His ECG showed evidence of heart strain and possible mild MI. We immediately took blood pressures in all four extremities, found a decrease in the legs, and immediately called Dr. Phillip Jones. He agreed that with the symptoms and that we had to worry about an AAA. We would have had to call in CT and we would have been lucky to get it done in two hours. Dr. Jones felt we should transfer the patient since we had no way to quickly assess the patient. We called Hillcrest Hospital in Waco and had acceptance with administrative approval in 10 minutes; we then called the helicopter.

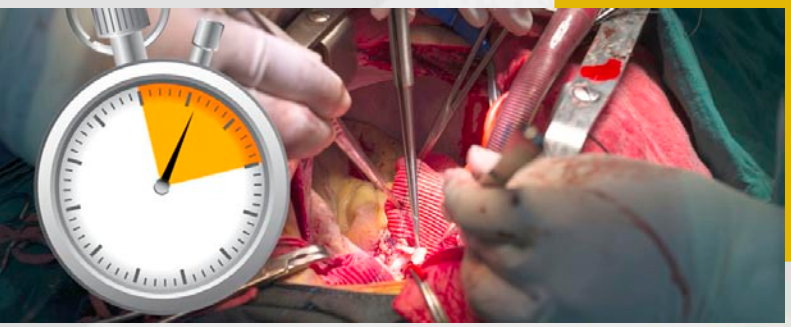
While waiting for the transfer, patient dropped his blood pressure to 70/50; we used fluid boluses to raise his pressure and morphine for his pain. We made ready to transfuse the patient. The helicopter arrived 50 minutes after the patient presented to our ED, and the patient was in the helicopter 70 minutes after presentation. I worried about him all night; the next day-expected to hear the worst.

On my arrival I had a note to call one of the local EMS stations for some information. You can imagine how happy I was to hear that the patient made it safely to Hillcrest, and that they found a large 7 1/2cm aneurysm and were able to repair it. The patient was resting comfortably and did indeed have a mild heart attack. The family had wished to convey their thanks to the surgeon; here is what he said:

> "What we did was easy...you need to thank the people at Navarro Regional for `getting him here so quickly...so that we had a chance"

I am not ashamed to tell you that there was a lump in my throat and it brought tears to my eyes - these special moments do not come as often as we would like.

Would I have recognized this process if I had not recently completed the AAA course? Yes...but would I have recognized it so quickly? Would I have acted fast enough to get him on the operating table



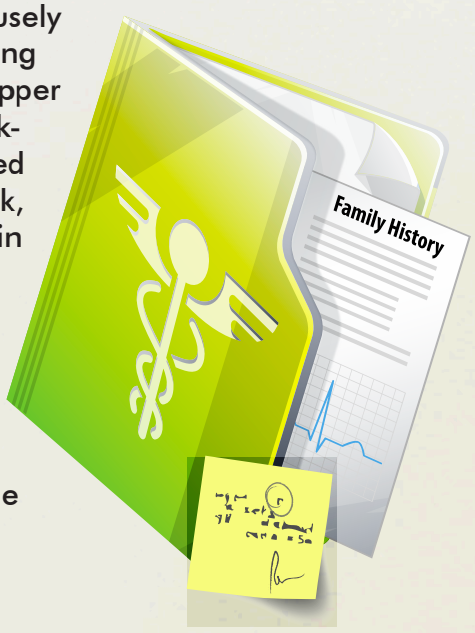
before he would have died? I can't be sure. I do know this. A life was saved. There are many hospitals where he would not have been diagnosed so quickly and he would have died. I bought dinner for everyone that had participated in his care because I was so happy. So, when you reflect on your many daily decisions, remember they do help people - and they do save lives. We will probably never hear the heartfelt thanks of this family. They will not go around town telling everyone Navarro Regional saved his life. But we know the truth and can take pride in the job we do safeguarding the lives of our community.

Sincerely,
Gary Fagan ■

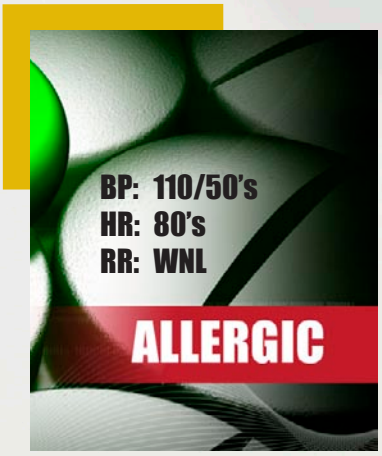
Syncope

By Moshe Engel, MD

Towards the end of my shift at a small community hospital one evening, EMS brought in a 74-year-old male after a syncopal episode. As they wheeled him by, I was told that his brief syncopal episode was followed by right upper extremity weakness. Having just completed some CME online the night before (I kid you not), I decided to keep aortic aneurysm in the differential of this syncopal patient with an obvious CVA, as the course had recommended keeping aortic aneurysm in the differential of any syncope. When seen, the patient described acute left jaw pain just prior to his losing consciousness, and waking with sharp non-radiating substernal chest pain that resolved spontaneously prior to transport. I started wondering if maybe this wasn't a thoracic aortic dissection (TAD) after all. He was alert, oriented, sweating profusely and complaining only of right upper extremity weakness. He denied any chest, back, abdominal pain or headache. Past medical history included atrial fibrillation, hypertension and the



dreaded diagnosis of fibromyalgia. I decided to ask about family history since the course I had completed the night before pointed out that family history for TAD was one of the major risk factors for this condition (along with Marfan's and connective tissue disease). Family history was positive for aortic aneurysm in 2 brothers, and despite the fact that the patient reported having had a normal US of the aorta within the last 6 months, TAD was now no longer a maybe in the differential. Current medications included lyrica, HCTZ and coumadin. Allergy to aspirin was listed in the chart. He was afebrile, BP=110/50's, HR=80's, and RR-WNL. On exam, heart was irregularly irregular, and his right upper extremity was weak, cool, cyanotic and pulseless. ECG showed atrial fibrillation with controlled rate. The usual syncope work-up was initiated, and CTA aorta was added to rule out dissecting thoracic aortic aneurysm. Portable chest x-ray was normal. INR was 2.3; other labs were essentially normal. Soon after return from CT, radiology called to notify me that the CTA aorta was positive for ascending aortic dissection originating at the aortic root and extending to the level of the aortic arch with mediastinal hematoma, adding for emphasis that I should "get that guy out of there." Labetolol drip titrated to keep SBP ~100, Type & Cross for 2 units PRBC and 2 units of FFP were ordered, and the patient received Vitamin K 10mg IV. The patient remained stable throughout the course of his ED stay, and it was decided not to delay treatment waiting for blood products. He was flown by AirEvac to Banner Good Samaritan Medical Center where he received 2 units FFP prior to undergoing successful graft of ascending aorta and aortic arch. The patient did well post-operatively, and I was able to enjoy a visit with him after one of my shifts there. Interestingly, pathology of aortic arch showed giant cell arteritis. The patient was started on prednisone for this and added a Rheumatologist to his list of follow-ups on discharge. ■



More Success Stories

While working on this material today, during an urgent care shift, I realized a 19 y.o pt. fit the criteria for SIRS (2 out of 4). Pt was admitted for 23 hr obs. ■

Susan Shepard, ISMIE, Sepsis

This truly was one of the best modules that I have done in the past 3-4 years. Interestingly, I was working the ED when I was doing this module on down time. I saw a 76 y.o. gentleman who was diagnosed with new onset a fib 5 days prior and had a follow-up appt with Cardiology next week. He went

back into fib without the benefit of coumadin. I treated his fast ventricular response and initiated coumadin right in the ED with a strong recommendation to the admitting family doc to continue this long term. Great timing, eh? ■

Tim Gutshall, Iowa Health, AFib & Stroke

I had a case where a 45 y.o. woman presented with her worst headache of her life and felt like something had "popped in her head." The neuro exam was nl as was her CT. The LP showed three tubes xanthochromic. I consulted the on-call neurosurgeon, who said its less than one in a 100 that she had an SAH, but ordered an angiogram, which was positive. He took the patient to surgery the next day and said I did a good job. Thank God for good education and my willingness to proceed with an LP. The surgeon was guilty of anchoring on the possibility of a bloody LP! ■

Eric English, Chippenheim/ Johnston Willis, Cog. Errors 1

Okay, this goes back to the module I completed yesterday. Last evening I had a 16 year old female with a one-week history of fever, cough and shortness of breath. Her initial vital signs were pulse of 140 and temp of 100.8°F, resp rate of 16. She didn't look particularly ill and was in only mild respiratory distress. Scattered ronchi and wheezes and decreased breath sounds in the RT base. CXR with bilateral basilar infiltrates. NL WBC. I'd sent off a D-dimer due to the discrepancy between the pulse rate and the fever. The D-dimer came back moderately elevated. She got a CTA of the chest to rule out PE and none was found. She was treated with ceftriaxone and azithromycin and admitted. I recalled the cross examination of the physician who had missed a PE by diagnosing pneumonia. So at least it got me thinking, and ordering the CTA was a direct change in my practice based on the module content. ■

Gregory Palmer, Northridge Emergency Medicine Group, RSQ Overview 2

Editor's Note

There are many more similar stories, but we can only take so much of your time during this busy holiday season! Thanks to all of you who have shared your stories of 'lives saved.' This is truly what makes our world go around here at The Sullivan Group. Have a Happy and Wonderful New Year. And please continue to share your successes with us and let us know how we can better serve you and meet your needs.

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