DWK 47

Desmond Bramich

PMH – LBBB, Hep A, haemachromatosis, gastritis

Presented to DEM at 1946h on 25 Jul 04 via QAS, followed by trauma call.
Sustained crush injury to R chest after caravan fell on him for 10 mins.
Injuries were flail segment with multiple rib fractures.

O/A – RR 30bpm, O2 sat – 96%, PR 107 bpm, BP 147/93 mmHg, Hb 153

XR – Enlarged heart
RICC in situ
S/C emphysema
?Contusion or ? Inflammation
L Chest pathology
Probable # 6 and 7 ribs

CT – Bilateral # ribs
Bilat pneumothoraces
Pulmonary contusion
S/C emphysema

Admitted to ICU - stable overnight
R/V CXR – R collapse/consolidation
Begun on PCA – morphine and droperidol

Discharged to ward

27 Jul 04 – Approx 1300h – Attended by JG, JB and YI
Acute resp distress and associated shock
R ICC – not working – readjusted 500 -700ml blood out tube
CXR – R chest white out
T/F ICU - 1400-1430h

In ICU – 2nd ICC inserted with further 700mls blood drained.
Resuscitation – ETT, fluids, blood, FFP and inotropes.
Blood begun at 1330. Received 11 units RBCs, 4 U FFP, 3000ml crystalloid and 2000ml colloid.
CVP line inserted – ventric standstill – Atropine required.

Initially responsed to fluids on ward, became unstable in ICU.

ABGs – Resp acidosis with improvement.
Hb – As low as 60. WCC raised sec to stress.
Raised tropinon – secondary to many causes in this case – major concern is rhythm – nil probs.

Dir Anaes/ICU consulted – T/F required to Brisbane to access Thoracic Surgeon, LT vent spt and blood bank.

CT Chest/Abdo – No abdo pathology
Marked R haemothorax with shift to L
No pericardial effusion

Increasing instability
Obs - BP – 80mmHg –average systolic.
HR – 140bpm

Arrested after retrieval team arrived at 2215h
Further resuscitation efforts
Bedside US suggested fluid around heart – pericardiocentesis attempted multiple times – no effect.

Died at 0010 on 28 Jul 04.
Chest trauma caused intrathoracic injury and excess bleeding causing hypovolemic shock.

PM

3000ml of blood in R chest
R lung collapse
Source intercostal arteries
6,7 ribs plus # sternum
R ventricle – injury secondary to needle.

Retrieval Team

1620 – Requested
1930 – Despatched
2215 – Arrived
0010 – Arrest

No retrieval until bed available.
Initially TPCH rung with no beds available
Phone call from TPCH saying bed available at PAH at 1430h
Yet notes state no bed available at PAH, but as team on way, will find bed.

Claim that thoracic surgeon at PAH consulted. He believed no benefit from surgical intervention.

Problems

Claim that bed found – approx ? was it available ?
Only required handover between surgeons and retrieval request.

Why was CT ordered ? What would it tell that wasn't known ?

Who was in charge ? Who was making decision to send ? Who is organising transfer ?
Who was communicating ?

What was being said ?
Was it consistent ?

TH – Left at ?1630h – therefore all her statement is anecdoctal only.

For JG/JB

What were PAH's recommendations ?
Where was he during this episode ?

MC – Contacted and immediately intervened without min overview
Arranged T/F
Told treating specialist

JG – Was unsure of cause, hence CT.
Believed nurses were flapping and panicked
Definite attitude of not having patient die in ICU at any cost.