# VITALS

For Medical Transport Professionals

A Weekly Safety Newsletter

## Case History:

### Not a Thomco client, but a real case with minor changes to maintain confidentiality.

A 37 year old stock broker, married with three children under ten, went to the dentist for what was described as a simple extraction. He had no significant medical history, but had not been seen by a physician for five years. He was five feet ten inches tall, weighs 235 pounds and had a neck size of 19 ½ inches.

The dentist sedated the man with a combination of intravenous Propofol, Versed, Demerol, and Lidocaine. As this pharmacologic cocktail was administered, the patient stopped breathing. The dentist attempted endotracheal intubation (ETI). The patient had clenched teeth so the dentist administered succinylcholine. The dentist performed the ETI and instructed his personnel to call the ambulance.

The ALS crew consisting of a Paramedic and EMT arrived at the scene in less than six minutes. There was no tandem fire department response.

As they approached the patient, they observe that he is in a sitting position in the dental chair with a dental assistant performing cardiac compressions and the dentist ventilating the patient with a bag attached to an endotracheal tube without supplemental oxygen. The dentist says that he will handle the airway. The patient is found to have a pulse and blood pressure. He remains apneic. The Medic supplies supplemental oxygen, starts an IV, does an EKG which reveals a sinus rhythm, and performs pulse oximetry which reveals an oxygen saturation of 68%.

The dentist stated that he will maintain the airway en route. The Medic auscultated breath sounds which were present in all lung fields and absent over the epigastrium. There was chest rise and fogging of the ET tube. During transport to the hospital, the dentist continued to bag the still apneic patient. The oxygen sats went up and down. Upon arrival at the ED the oxygen sats were low and the ED physician noted that there is significant resistance to bagging and removes the ET tube. He did not visualize that the tube was in the trachea upon removal. His attempts to intubate were unsuccessful. The patient received a tracheostomy. Although he had significant neurologic impairment, he began to breathe on his own. After a series of improvements and set backs he died in the hospital two months later.

What liabilities do you see for the ambulance service? Would this case have resulted in an Incident Report or a QA review at your service?

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