MEDICALLY CHALLENGING CASES
PROFESSIONAL ISSUES

Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC54

Anesthesia Consultation for Non-Heart Beating Organ Donation: Timing, Documentation, and Anesthetic Pitfalls

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A 55 year-old male presented with intermittent vertigo for 2 weeks, n/v, severe headache, slurred speech, dizziness, and loss of motor function. On arrival, PEA developed and persisted for 2 minutes. MRI on 2nd day of admission, revealed complete posterior fossa infarction including brainstem. LUE movement was noted with painful stimulation therefore ruling out brain death. Family was notified and changed code status to DNR/NHBD. Anesthesia was consulted for non-heart beating organ donation and was transferred to OR by the liver transplant team leader, extubated, and transitioned to comfort care measures at 0959. Pt was declared dead at 1030.

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Opiate Theft in the Operating Room

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The security of controlled substances is an important responsibility of anesthesia personnel, who are often entrusted with large quantities of highly addictive pharmaceutical agents. This case report describes the attempted theft of fentanyl by operating room personnel while in the immediate vicinity of an anesthesiologist. The standardized performance of routine anesthesia tasks, including the labeling of syringes, contributed to the discovery of this attempt. Only in retrospect were several seemingly unrelated signs of ongoing opiate theft recognized. This unusual case imparts multiple lessons regarding the prevention and detection of intra-operative theft of controlled substances by non-anesthesiologists.

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