Brief Report – Ms. Client

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RE: Ms. Client, injured

Dear Mr. Attorney:

Pursuant to your request, I have screened the hospital medical records of Ms. Client for the period 03/28/0000–04/05/0000 and have included my comments and recommendations for your consideration.

Ms. Client is a 33-year-old female who was admitted on 03/28/0000 at 1300 for right shoulder arthroscopy, right rotator cuff repair, and distal clavicle repair. During her perioperative course, she sustained a complication related to intravenous therapy.

In my opinion, this case is meritorious because there was a failure to timely diagnose and treat phlebitis, thrombophlebitis, and extravasation following administration of IV Anzemet®. These deviations resulted in compartment syndrome and permanent injury to Ms. Client's nerves and muscles in the left forearm and hand. She currently experiences pain, numbness, and inability to grasp objects.

Ms. Client's IV was initiated in the left hand at 1300 in the preoperative area and documented as such. The anesthesia provider later documented only "L #20," without specifying anatomical location. Anzemet® was administered intraoperatively, though the exact time was not documented. There is no documentation that the medication was diluted, despite manufacturer recommendations that IV Anzemet® be diluted in 50cc of a compatible solution (NS or D5W) and infused over 50 minutes. The IV solution in use was Lactated Ringers, which is not listed as compatible.

Ms. Client was transferred from the OR to the PACU at 1525. The PACU nurse documented the IV site as left forearm, which conflicts with both preoperative documentation and later ASU documentation identifying the IV in the left hand. This discrepancy in IV site location is significant and warrants further clarification.

At 1611, the PACU nurse administered Anzemet® 12.5 mg IV. According to Ms. Client, she experienced excruciating pain and burning immediately following administration. There is no documentation of these complaints in the PACU record. Additionally, there is no documentation that the IV site was assessed for complications, discontinued, or reported to the anesthesia provider.

Ms. Client was transferred to the Ambulatory Surgery Unit (ASU) at 1625. The PACU nurse did not document communication of IV site status to the ASU nurse. At 1630, the ASU nurse documented hives on the left hand and forearm. This finding strongly suggests that signs of IV complication were present prior to transfer from the PACU. The hives were localized to the left upper extremity, consistent with a complication of IV therapy.

At 1635, Benadryl 25 mg IV was administered through the existing left-hand IV site. The standard of care would require discontinuation of a potentially compromised IV site and administration of medication through a different site. The IV was documented as discontinued at 1740, with “no redness or swelling.” However, Ms. Client returned to the Emergency Department the following morning with an edematous left hand, ecchymosis, and coolness since the prior day. This clinical presentation calls into question the accuracy of the discharge assessment.

Ms. Client was discharged home at 1755 with instructions to call the physician for severe pain, numbness, or temperature of 101 or above. There were no documented instructions regarding care of the left hand or IV site. The discharge instructions were not signed by Ms. Client.

On 03/29/0000 at 0840, Ms. Client returned to the Emergency Department with swelling of the left hand. Examination revealed edema, ecchymosis, and coolness. Compartment syndrome was suspected. She was taken to the operating room for fasciotomy of the hand with carpal tunnel release and forearm fasciotomy. She subsequently underwent additional irrigation and debridement procedures on 03/31/0000, 04/02/0000, and 04/04/0000. She was discharged on 04/05/0000.

There is no evidence of significant deviations from the standard of care during the second hospitalization. The deviations occurred during the perioperative and immediate postoperative period on 03/28/0000.

The defense may argue that this was a rare and unavoidable adverse drug reaction. However, the primary issue is not the reaction itself, but the failure to timely recognize and appropriately respond to signs of IV complication. The documentation reflects multiple discrepancies in IV site location, lack of documented assessment, failure to discontinue a compromised IV site, and

continued use of the same site for medication administration. These failures likely contributed to the progression to compartment syndrome and permanent injury.

I recommend expert review of this case by a PACU nurse, an anesthesiologist, and a vascular surgeon. A more detailed moderate report including a comprehensive chronological timeline would assist in further development of this matter. Interviewing Ms. Client would also be valuable.

In conclusion, thank you for the opportunity to consult on this case. I will follow up within two days to address any questions and to determine the next steps you would like me to take.

Sincerely,

Chapman Thompson, RN, CLNC