

65-year-old male with a history of uncontrolled diabetes mellitus presenting with weakness, right lower extremity pain, and swelling for the last ten days. Patient reports working as a long-haul truck driver, was on the road, and unable to present to the ED for evaluation.

Pertinent Physical Exam

- Vitals: BP: 137/178 HR: 101 RR: 25 O2 saturation: 98% Temp: 100.4 F
- General: Ill-appearing obese male, lying in bed, odorous
- Neuro: CN II-XII intact, no motor
- HEENT: Dry mucous membranes
- Lungs: Clear to auscultation bilaterally, no increased work of breathing
- CV: tachycardic
- Extremities: Diffuse right leg erythema with bullous lesions to medial foot, crepitus to medial knee and multiple quarter sized ulcerations

Pertinent Lab Values

- WBC: 21.5, Neutrophils: 78%
- Potassium: 3.1
- Sodium: 128
- Lactate: 1.5
- ESR: 110
- CRP: 33.20

Questions

1. What are the significant findings in these x-rays?
2. What is the definitive intervention for this condition?

Answers

1. Gas to medial knee
2. Surgical debridement and removal of infected tissue

PEARLS

1. Persistent advocacy for dispositions on patient care
2. Timely re-evaluations with closed-loop communications are key
3. Individual providers are responsible for system quality improvement efforts



broad spectrum antibiotics. Within fifty minutes, the patient was at the bedside. After reviewing the x-rays, the orthopedics consult should go to the orthopedics and be isolated to the patient's extremity. When the orthopedics arrived bedside and agreed that the patient's condition was producing infection of the patient's leg, the orthopedics attempted to calculate a LRINEC score. The orthopedics ran labs excluding a CRP. The LRINEC score for the patient was low risk for necrotizing fasciitis (score incomplete) and stable vitals reassured the orthopedics that the patient did not need to be taken to the OR. The orthopedics team, we advocated to take the patient to the OR. The patient's room, feeling the patient would likely not be able to be moved was not quickly obtained.

One hour after arrival, the patient was taken to the OR. I gave the patient a LRINEC score of 9. The orthopedics suspected underlying condition of necrotizing fasciitis. I was re-engaged, agreeing the patient would be better managed in the ICU following his surgical debridement. The orthopedics were to code, would you want orthopedics to be the responding team?"

For the next 5 hours the disposition was discussed between MICU, BICU and ortho deliberated over the patient's need for surgery. Ultimately MICU admitted the patient and performed the surgical debridement and amputation. As the patient's disposition was finally decided, upon arrival, the patient began, as expected, to drop his blood pressures, initially in the 140's systolic and 70's diastolic after fluid resuscitation. The orthopedics were concerned about the patient's deteriorating condition and informed the MICU of the patient to the OR as their next case. The patient became hypotensive in the ED. After his surgical debridement, he eventually require IV pressers for two hours to maintain blood pressures below the knee amputation. He also required IV pressers during surgical debridement's without need for surgery.

This patient, for whom I had a discussion with the orthopedics minutes of arriving in the ER, took responsibility for the goal of definitive surgical debridement and amputation quickly that perseverance and strong communication and fighting opposition from consultants. The patient's evaluations are key and passing along information to the consulting services is necessary in rare cases. It is important to remember that scoring systems are incomplete. In this scenario, orthopedics' scoring system was missing initially, but the patient's clinical picture instead of this scoring system was missing initially, but our patient from low risk to high risk was determined by the clinical picture instead of this scoring system. The patient roughly one hour of waiting for a scoring system alone. In a disease process, and potentially the patient's life, one hour goes against our oath to "do no harm" and multiple systems issues that as a provider, a patient advocate, I believe must be addressed. Treatment such as these do not occur