$12,000,000 Recovery in Wrongful Death Failure to Diagnose and Treat Anaphylaxis/Allergic Reaction Case

Daryl L. Zaslow of Eichen Crutchlow Zaslow, LLP (Edison, Red Bank and Toms River), obtained a $12,000,000 settlement on behalf of the Estate of a 35 year old man who died on January 1, 2017 after being admitted to his local hospital's Emergency Department for a severe allergic reaction. A portion of the settlement is being used to purchase annuities which bring the projected total value of the recovery over $21,000,000. At the time of his death, Plaintiff left surviving a wife and 2 young children.

The Plaintiff was a 35 year old man when he presented to the Emergency Department on January 1, 2017. Although he had never previously had an allergic reaction, he complained that he felt he was having an allergic reaction to his wife's perfume and that he felt like his throat was closing. He also complained of having hives earlier in the day. Vital signs included a normal temperature, heart rate 108 beats/min, respiratory rate 20 breaths/min, blood pressure 142/107, and oxygen saturation on room air of 94%. He was noted to be 343 pounds. He was triaged as being unstable, with an ESI level of 2 and he was admitted to the Emergency Department under the care a defendant physician who was board certified in emergency medicine. There were also 2 defendant nurses involved in Plaintiff's care in the Emergency Department.

On exam, the emergency medicine physician noted moderate distress and a markedly swollen edematous hard palate and uvula. The nurses documented that the patient was in sinus tachycardia, had full motion of his neck, and had throat redness. He was alert, had clear speech, and was communicating appropriately with no neurological symptoms. However, Mr. Zaslow's client also had shortness of breath, shortness of breath at rest, and unlabored respirations. The defendant physician ordered Diphenhydramine (Benadryl), Famotidine (Pepcid) and Dexamethasone (Decadron). The defendant maintained during discovery that because the patient was not hypotensive or tachycardic, and because he was not in respiratory distress, he believed the patient was suffering from bradykinin-mediated angioedema. He further maintained that because epinephrine will not help a patient suffering from bradykinin-mediated angioedema and epinephrine could cause morbidity in obese patients like this patient, he chose not to order or administer epinephrine.

At 5:15 pm the patient complained of worsening difficulty breathing and he was noted to have significant respiratory distress and decreasing oxygen saturation. Anesthesia and surgery were called stat and preparations were made for intubation. Anesthesia arrived within a few minutes and noted the patient to be cyanotic and hypoxic with sats in the 40-60% range despite attempts at bag-valve mask ventilation. Despite repeated attempts, anesthesia could not successfully intubate the patient due to his swollen airway and large neck/body habitus. A Defendant resident from Surgery arrived and made two unsuccessful attempts to place a surgical airway. When these attempts at a surgical airway failed the resident called for surgical attending who arrived approximately 10 minutes later. The patient was then brought to the operating room for an attempt at a surgical airway. When the patient arrived in the operating room he was hypoxic and cyanotic. As the attending surgeon performed a cricothyrotomy the patient suffered a cardiac arrest. He could not be resuscitated and was pronounced dead.

Plaintiffs' emergency medicine experts maintained that the emergency physician failed to timely diagnose acute anaphylaxis and that he failed to administer or order epinephrine, which they

maintained is the most important first line treatment of acute anaphylaxis. Mr. Zaslow and the experts further maintained that the defendant did not properly anticipate and prepare for intubation and waited too long before deciding to intubate. Mr. Zaslow stressed intubation in this setting - with upper airway swelling, shortness of breath and an obese patient - is exceedingly difficult and high risk and must be timely ordered before the patient becomes hypoxic, cyanotic and in severe distress.

Plaintiffs nursing experts opined that the nurses deviated from the accepted standards of care by failing to immediately make they physician aware that she noted that the patient was experiencing shortness of breath. Mr. Zaslow and his experts further maintained that the nurses should have urged the emergency physician to administer epinephrine and if he refused they were required to circumvent physician's authority by executing the chain of command. Finally, Plaintiffs' nursing experts maintained that these nurses should have anticipated the need to intubate and, therefore, should have ensured all the medical equipment was available even before any physician ordered or requested the equipment.

Plaintiffs' experts opined that the third year surgical resident had never performed an emergent cricothyrotomy and lacked the experience that this situation called for. They asserted he deviated from the standards of care by attempting an emergent cricothyrotomy by using an improper technique. By doing so he wasted precious minutes while the patient was becoming more hypoxemic and at greater risk for permanent brain death and cardiac arrest. Mr. Zaslow and his experts maintained that the resident should have called for an attending surgeon immediately upon seeing the situation in the emergency room. Instead he caused at least a 10 minute delay before the attending surgeon arrived by first attempting 2 unsuccessful attempts at a surgical airway before calling for the attending surgeon.

The defense experts opined that because the Plaintiff was not hypotensive or tachycardic, and because he was not in respiratory distress, the emergency physician was correct in believing that the patient was not suffering from a severe allergic reaction. Instead, the defense experts maintained that the patient was suffering from bradykinin-mediated angioedema and because epinephrine will not help a patient suffering from bradykinin-mediated angioedema, the decision not to order or administer this medication was appropriate.

The defense experts on behalf of the defendant nurses and hospital maintained that the care and treatment of the patient was being handled by a board certified emergency physician. They further stressed that there was never an order for epinephrine and nurses are not permitted to administer epinephrine without an order to do so. Finally, they asserted they were at all times actively caring for this patient and following the management and orders of the physicians.