Medication Mix-Up: Nurses Continue Demerol IV, Post-Appendectomy Patient Seizes, Dies.

The thirty-three year-old male patient came to the hospital E.R. with abdominal pain. He was diagnosed with acute appendicitis and admitted for a routine appendectomy.

IV Demerol for post-operative pain was started in the post-anesthesia recovery unit. 100 mg was given the first hour in divided doses.

The patient was transferred to a med/surg unit with orders for IV Demerol 75 mg q 3-4 hours prn for pain.

The morning after surgery the physician who had performed the appendectomy ordered the patient started on a clear liquid diet.

Vicodin Ordered
IV Demerol Not Discontinued

The next day, two days after surgery, the same physician ordered Vicodin, an oral medication, two tablets q 4-6 hours prn for pain.

However, when he wrote the order for Vicodin the physician apparently did not cancel or modify the two-day-old order for prn IV Demerol.

At this point the Demerol the patient had received totaled 675 mg from the time he first came out of surgery.

The coroner's post-mortem lab tests established acute meperidine toxicity as the cause of death with hypertensive cardiovascular disease (enlarged heart) as a contributing factor.

Demerol (meperidine) is metabolized into normeperidine, a chemical substance which tends to stay in the body and can build to toxic levels.

Normeperidine is a known neuro toxin which can cause a seizure.

Nurses at the hospital made the decision to continue the patient's IV Demerol for pain, even though the physician had written new orders for po Vicodin.

The surgeon at the hospital neglected to discontinue the Demerol expressly when he wrote the new order for po Vicodin.

SUPERIOR COURT, RIVERSIDE COUNTY
CALIFORNIA
January 17, 2008

Nurses Continued Giving IV Demerol

The nurse caring for the patient when the Vicodin order was written apparently believed that a patient on a clear liquid diet could not tolerate oral pain medication.

The patient was still having significant post-operative pain. The nurse made the decision to continue giving the IV Demerol prn instead of the Vicodin.

Nurses on successive shifts continued the IV Demerol prn for pain and did not give the Vicodin, sticking to the rationale that the patient sorely needed a narcotic for pain, while oral medication was not appropriate until the patient's diet had been advanced from clear liquids.

On the third day post-surgery the patient's p.m. nurse reported to the physician that the patient was still having severe abdominal pain. She gave the Vicodin.

When the p.m. nurse later tried to assess the Vicodin's efficacy by speaking with the patient he told her that the pills simply were not working. After speaking with the charge nurse the p.m. nurse gave still more IV Demerol.

The next afternoon the same p.m. nurse found the patient unresponsive and called a code. She told the code team he seemed to have been having a seizure. The fifty-minute code was not successful.

The family's lawsuit in the Superior Court, Riverside County, California reportedly settled for $3,500,000. **Confidential v. Confidential, 2008 WL 2020374 (Sup. Ct. Riverside Co., California, January 17, 2008).**