LETTERS TO THE EDITOR

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Shock: Early Recognition and Management

Dear Editor:

The clinical article published in the March 2010 issue of the *Journal of Emergency Nursing* by Wilmont titled “Shock: Early Recognition and Management,”1 though generally well written, is noted to have omitted some very important points regarding the assessment and treatment of patients with sepsis.

After a discussion of the systemic inflammatory response syndrome criteria, as well as their importance in the identification of septic patients and the initial treatment of potentially septic patients, the discussion turns to obtaining appropriate cultures (blood, urine, sputum, and other types as needed). This point, though mentioned briefly, requires further emphasis because this first set of cultures (especially blood) is of utmost importance in directing patient care. This is also an area where confusion exists among many ED staff members (physicians, nurses, and technicians). Inappropriate techniques, such as poor site preparation and drawing multiple cultures from a single site, abound in actual practice and have the potential to impact patient care significantly. It is also mentioned that as soon as potential sources of infection are identified, appropriate antibiotics should be administered. Actual identification of the source may in many cases be difficult, and administration of appropriate antibiotic coverage should be guided by clinical suspicion/presentation as well as local and institutional susceptibility guidelines. This is usually accomplished by broad-spectrum coverage administered within 1 hour of patient identification with severe sepsis or septic shock. In a critically ill patient with suspected infection, administration of antibiotics should never be delayed while awaiting the identification of “potential sources of infection.” A recently published article by Gaieski et al2 in *Critical Care Medicine* showed a significant relationship between duration of time from triage or time from qualification for early goal-directed therapy (EGDT) to administration of appropriate antibiotics and death in patients with severe sepsis or septic shock who were treated with a uniform, algorithmic resuscitation strategy. A significant reduction in mortality rate was found when appropriate antibiotics were administered within 1 hour of ED triage/qualification for EGDT.

The article by Wilmont1 also discusses various hemodynamic parameters that may be monitored in the septic patient. Central venous oxygen saturation (SCVO2) and central venous pressure (CVP) are briefly mentioned. Although some aspects of the importance of these monitoring parameters are highlighted, no actual values are provided to the reader to allow a better understanding of these very important parameters. The importance of SCVO2 in measuring the body’s oxygen consumption is discussed; however, no mention of the expected value (70%) is mentioned nor is any mention made of the factors that influence this value (<70% increased oxygen consumption or decreased delivery and >70% increased delivery or decreased consumption). All of these are important factors that allow correct interpretation of the SCVO2 value. A similar issue occurs in the brief discussion of measurement of the CVP. No normal or expected value is given (0-4 mm Hg in normal “healthy” individuals or the goal for CVP in EGDT of Rivers et al3 of 8 mm Hg in non-intubated patients and 8-12 mm Hg in intubated patients). The correct treatment for hypovolemia and a low CVP is given: vigorous fluid resuscitation.

An additional concern comes from the discussion on mean arterial pressure (MAP).1 The statement is made correlating “shock” with a MAP of less than 60 mm Hg or a drop of 40 mm Hg from baseline. As mentioned in the first paragraph of the article, shock is a lack of adequate tissue perfusion, not hypotension. Blood pressure or MAP only differentiates compensated shock from uncompensated shock. This confusing information, if it leads providers to equate shock with hypotension, may lead providers to miss a whole group of patients who may present in what Rivers et al3 called “cryptic shock,” that is, inadequate tissue perfusion without hypotension. The importance of a serum lactate level—one of the key laboratory parameters that may assist in identifying patients in “cryptic shock”—is also not mentioned. Lactate levels above 4 mmol/L indicate tissue hypoperfusion, even with “normal” vital signs. Early identification leads to more rapid treatment and, in the study of Rivers et al, a significant reduction in mortality rate.

The care of the patient with sepsis and septic shock has significantly evolved over the past several years. Although this article is a good overview of shock in general, any dis-

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0099-1767/$36.00
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discussion of sepsis and septic shock must clarify the above points for the emergency nurse because many of these more critical care interventions are now routinely being performed in many emergency departments through the world.—**Thomas T. Levins, BSN, RN, CCRN, CFRN, Clinical Coordinator/Flight Nurse, PennSTAR Flight, University of Pennsylvania Health System, Philadelphia, PA**

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doi: 10.1016/j.jen.2010.04.008

REFERENCES

**Thoughts on the Word “Seeker”**

**Dear Editor:**

“Seeker” is a word I used to treasure. To me, seekers are people with open minds looking for deep truths. My mental images, not to mention the images of much literature and movies, often depict seekers on arduous journeys into places of danger and wonder. Seekers are people with open minds looking for deep truths. My

If I make the argument that we are all seekers, an answer might be, “What they are seeking is harmful and illegal and they are weak, evil, and worst of all, trying to trick and manipulate us!” Perhaps that is the worst of it . . . the being tricked part. We do not want to look foolish. We do not wish to lose to a seeker.

Of course, the narcotics user is the real loser from the start. The user has given over his or her independence, his or her ability to seek truth and beauty, and his or her self-respect for a high he or she obviously found too tantalizing or numbing to choose to resist. Users probably have lost, or will lose, their families, friends, and possessions and possibly their lives. The user is the loser of any particular game, whether or not he or she gets what he or she came to the emergency department for. Whether he or she tricks us, hates us, or angers us, the user is the loser.

And what are we seeking out of the interaction with the seeker?

At times, are we assured of superiority because we did not make their particular bad choices?

Do we seek their contrition? Do we wish them to tell us that they know what they do is wrong and they want help? (Do we believe them if they do?) Are we seeking authority? Dominance?

Do we assert that we do not ever manipulate others simply to feel good?

Of course, there are degrees of everything, and most would object to comparing our own poor choices with the ongoing poor choice of a user. And, of course, when laws are broken and people are hurt, there are, and should be, consequences.

However, when we determine to judge and punish seekers the moment we lay eyes on their track marks or their quivering hands or smell their odor, we lose. We close down an opportunity to participate in a deep and abiding truth. Human beings are valuable, especially when treated as such. And human beings who treat other human beings well are happier, more satisfied people. How we treat drug seekers is about them, but it is even more about us. What kind of people are we at the end of the day? Are we people who condemn and judge? Or are we people who respectfully set firm limits and who reflect a bit of human decency and mercy to another who has lost most everything?

Without expecting change, sometimes decency and mercy provoke change. They certainly can change the heart of the giver of mercy.

Should it matter greatly to me whether the loss was the result of a personal choice or not? Would it matter if I already knew and loved the person? Would I withhold mercy and respect from someone I know who made a bad choice? Certainly the role of personal choice does matter to the user, because the user will have the hurdle of self-loathing to cross should he or she ever rehabilitate.

If I choose to condemn others for their poor choices, I will be very lonely indeed and will be stuck with only my condemnable, foolish self.

I wish to reclaim the word “seeker” and to be a seeker. I would like to find the deeper truths that give me strength to carry on and come back to the emergency department another day. I know that I can only find a glimpse of the vast capacity of the human soul to love, in the presence of others. In the presence of many others. All others. The harder to love the better. Because the ones who are easy to love do not really require much seeking or thinking or even loving.