

Errata List (updated 09/03/2015)

We apologize for this error. We will make every effort to notify our physicians of the corrections. Please contact us if you find any further discrepancies.

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Table 1: Effects on ECG with Increasing Potassium Concentration

| Potassium Concentration (mEq/L) | ECG Changes |
|--|---|
| 5.5-6.5 | Large amplitude T waves, peaked, tented symmetric |
| 6.5-8.0 | PR interval prolongation P wave flattening/disappearance QRS widening Conduction block with escape beats |
| >8.0 | Sine wave appearance Ventricular fibrillation Asystole |

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2. Arterial blood gases
 - a. Provide information regarding the seriousness and acuteness of airway compromise in the COPD patient
 - b. PaO₂ is generally low.
 - (1) Hypoxemia is common in these patients and worsens as the disease progresses, as well as with acute exacerbations.
 - (2) It is due to ventilation-perfusion mismatching and can usually be corrected by increasing the amount of oxygen being inspired.
 - c. PaCO₂
 - (1) Reflects the adequacy of ventilation
 - (2) Normocarbica may be present early on, but hypercarbia develops with disease progression and may worsen with acute exacerbations.
 - (3) A rapid rise in the PaCO₂ decreases the pH, whereas with a more gradual rise, the kidneys are able to compensate by retaining bicarbonate, which normalizes the pH. Therefore:
 - (a) An increased PaCO₂, a normal pH, and an increased bicarbonate level suggest chronic CO₂ retention.
 - (b) An increased PaCO₂, a decreased pH, and an increased bicarbonate level point to acute respiratory failure superimposed on chronic respiratory insufficiency.

P. 362 (see direction of highlighted error below)

D. Management: primarily supportive

1. **Definitive therapy is directed toward the underlying cause.**
2. **Supportive therapy involves maintenance of acceptable oxygenation and hemodynamic competence.**
 - a. **The patient with moderate to severe edema should be intubated and put on a mechanical ventilator.**
 - (1) **Incremental oxygen supplementation can be tried first but is frequently ineffective in improving pO_2 .**
 - (2) **The use of positive-end expiratory pressure (PEEP) can improve oxygenation deficits and should be instituted if administration of supplemental oxygen does not improve pO_2 .**
 - (a) **PEEP stabilizes fluid-filled alveoli that are susceptible to collapse and, therefore, increases the number of alveolar units that can participate in gas exchange during ventilation with PEEP. PEEP also allows reduction of FiO_2 to safer levels ($FiO_2 \leq 0.5$).**
 - (b) **As the level of PEEP is increased, observe the patient carefully for adverse effects.**
 - i. **↓ Venous return → ↓ cardiac output and oxygen delivery**
 - ii. **Pulmonary barotrauma (pneumothorax, pneumomediastinum)**
 - (c) **Optimal PEEP ranges between 0 and 20 mmHg.**
 - b. **Swan-Ganz catheterization is no longer standard practice for diagnosis of ARDS.**
 - c. **IV fluids may be needed to maintain cardiac output and peripheral perfusion, particularly because a decreased venous return may be precipitated by sudden increases of PEEP.**

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- d. **Airway management in patients with possible cervical spine injury**
 - (3) **Consider placement of an oropharyngeal (unconscious patient) or nasopharyngeal (conscious patient) airway.**

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4. **Additional facts regarding drug therapy**
 - a. **Both phenytoin and diazepam are erratically absorbed and should not be given IM. Lorazepam and fosphenytoin are rapidly absorbed when given IM.**
 - b. **Rapid infusion of phenytoin has been associated with hypotension, dysrhythmias, and heart block. This is an effect of the propylene glycol diluent and not of the drug itself. Even very high levels of phenytoin are not associated with cardiac dysrhythmias.**

- c. Full loading doses of phenobarbital are associated with respiratory depression. The need to administer a full loading dose for control of status epilepticus is a clear indication for intubation.
- d. Phenobarbital and chronic alcohol abuse → ↓ serum phenytoin levels

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Question 1 – Answer should be “c” (not “d” as currently listed)

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5. Cardioversion: initial dosage is 0.5-1 joules/kg.; if unsuccessful, increase the dosage, up to 2-4 joules/kg (currently listed as 24 joules/kg)

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G. Hypercalcemia

1. Definition: Serum Ca⁺⁺ > 10.5 mg/dL (>12 mg/dL = severe)

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Clinical Scenario D

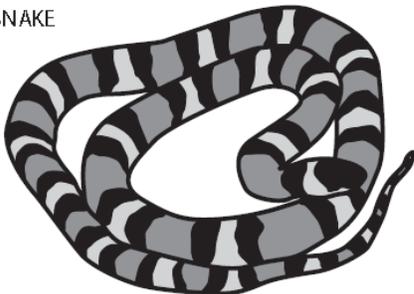
Diagnosis: snake bite: “red on black, venom lack”

Louisiana Milk Snake

Texas Coral Snake

TEXAS CORAL SNAKE

LOUISIANA MILK SNAKE



Red and Black
VENOM LACK

Red and Yellow
KILL A FELLOW



red | black | yellow | black | red

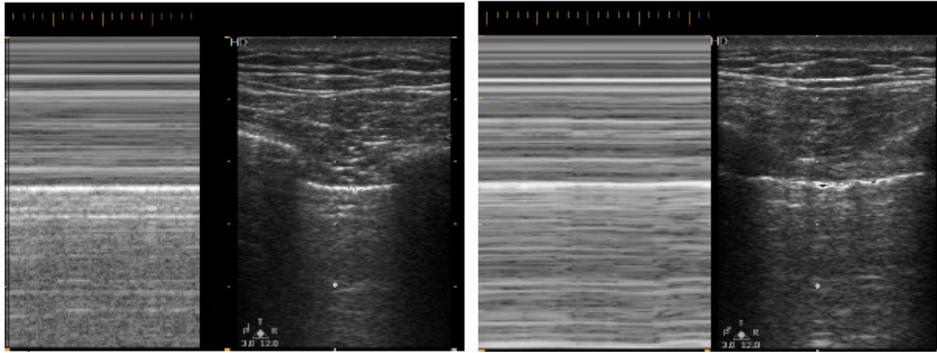
yellow | red | black | red | yellow

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C. Bleeding disorders and their clinical parameters

| Hemostatic Disorder | Clinical Findings | Platelet Function Studies | Platelets | PT | PTT | Fibrinogen | Clinical Disorder |
|---|--|---------------------------|-----------|--------|---------------------------------|----------------|---|
| Primary hemostasis: platelet mediated | | | | | | | |
| Thrombocytopenia | Purpura; petechia; epistaxis; GI, GU, and menstrual bleeding | Normal | ↓ | Normal | Normal | Normal | ITP, TTP, hemolytic uremic syndrome, heparin-induced thrombocytopenia (abnormal PTT if still on heparin), others |
| Platelet dysfunction | Purpura; petechia; epistaxis; GI, GU, and menstrual bleeding | Abnormal | Normal | Normal | Normal | Normal | ASA, clopidogrel, ticlopidine, inherited disorders, others |
| von Willebrand disease | Purpura; petechia; epistaxis; GI, GU, and menstrual bleeding; hemarthrosis and muscular bleeding ^a | Abnormal | Normal | Normal | Normal to ↑ ^a | Normal | von Willebrand disease |
| Secondary hemostasis: coagulation | | | | | | | |
| Warfarin therapy | Intramuscular, intracranial, GI, postoperative, and traumatic bleeding | Normal | Normal | ↑ | Normal to ↑ ^b | Normal | Warfarin therapy, rat poison (brodifacoum, others) |
| Heparin | | Normal | Normal | Normal | ↑ | Normal | Heparin therapy |
| Low-molecular-weight heparin (LMWH) | | Normal | Normal | Normal | Normal to mildly ↑ ^c | Normal | Enoxaparin, dalteparin, fondaparinux, tinzaparin |
| Hemophilia A | | Normal | Normal | Normal | ↑ | Normal | Factor VIII levels decreased |
| Hemophilia B (Christmas disease) | | Normal | Normal | Normal | ↑ | Normal | Factor IX levels decreased |
| Combined disorders of platelets and coagulation | | | | | | | |
| Disseminated intravascular coagulation | Thrombosis, microangiopathic hemolytic anemia, bleeding (purpura; petechial; epistaxis; GI, GU, menstrual, intramuscular, intracranial, postoperative, and traumatic bleeding) | Normal | ↓ | ↑ | ↑ | ↓ ^d | Sepsis, trauma, burns, acute promyelocytic leukemia, amniotic fluid embolism, placental abruption, snake bites (pit viper), liver disease |

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The image on the left demonstrates normal lung sliding in M-mode. A speckled pattern (seashore sign) is seen below the pleura (bright white line), consistent with normal lung sliding. In the image on the right, there are multiple straight lines beneath the pleura (stratosphere sign), indicating a lack of lung sliding and a pneumothorax.