

Pitfalls To Avoid In The Diagnosis And Management Of Shock

- 1. "His blood pressure is normal. He can't be in shock."**
Focusing on blood pressure alone as an indicator of shock can lead to missing signs of occult shock. Impaired organ perfusion, as evidenced by acute renal failure, altered mental status and/or increased serum lactate concentration, is a sign of shock pathophysiology and obligates early, aggressive clinical management.
- 2. "Let's get the chest CT scan before deciding whether to give antibiotics or not."**
Failure to give antibiotics within 1 hour of presentation for all cases of possible septic shock may result in increased mortality. Early empiric antibiotic coverage is indicated for suspected septic shock with a target of administering (not just ordering) antibiotics within 1 hour of presentation.
- 3. "Her ejection fraction is 30%, so let's start norepinephrine instead of giving a second liter of fluid."**
Adequate volume resuscitation for hypovolemic patients is critical. Markers of tissue perfusion such as lactate clearance, ScvO₂, pulse pressure variation with passive leg raise, and ultrasonographic measures of intravascular volume are appropriate determinants of the need for further volume resuscitation. A history of a low ejection fraction or other hypothetical concerns may lead clinicians to underresuscitate hypovolemic patients and may result in inappropriate initiation of vasopressors.
- 4. "It could be a myocardial infarction, but let's wait for the troponin to come back before calling cardiology."**
Time-to-revascularization is one of the primary determinants of survival in patients with cardiogenic shock due to acute coronary syndromes. Delaying time to catheterization and revascularization will increase patient morbidity and mortality. When cardiogenic shock is possible, early consultation with cardiology and activation of the catheterization laboratory are necessary to optimize patient outcomes.
- 5. "Let's give a fifth liter of saline and see if her mean arterial pressure comes up to at least 60 mm Hg..."**
Starting vasopressors without adequately volume resuscitating a patient while following markers of tissue perfusion and intravascular volume status is inappropriate (see pitfall #3); however, not recognizing that vasopressors need to be started for patients who are not volume responsive is also inappropriate. Patients with a pathologically decreased systemic vascular resistance may require vasopressors to maintain mean arterial pressure even after volume resuscitation and normalization of intravascular volume status. Continuing to administer fluids and not recognizing the need for vasopressors can result in perpetuating complications of shock.

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