

**ESTATE OF DENNIS ALLEN, *et al.***

**v.**

**UMMS, *et al.***

Circuit Court for Baltimore City

Case No.: 24-C-15-003384 MM

Hospitals cannot expose a patient to an unreasonable risk of injury. When a hospital's doctor chooses to expose a patient to an unreasonable risk of injury, the hospital is responsible for the harms and losses caused.

# **WHO WE ARE SUING AND WHY**

We are here to hold the hospital and Dr. Burks responsible for giving Mr. Allen a drug which caused his suffering and death.

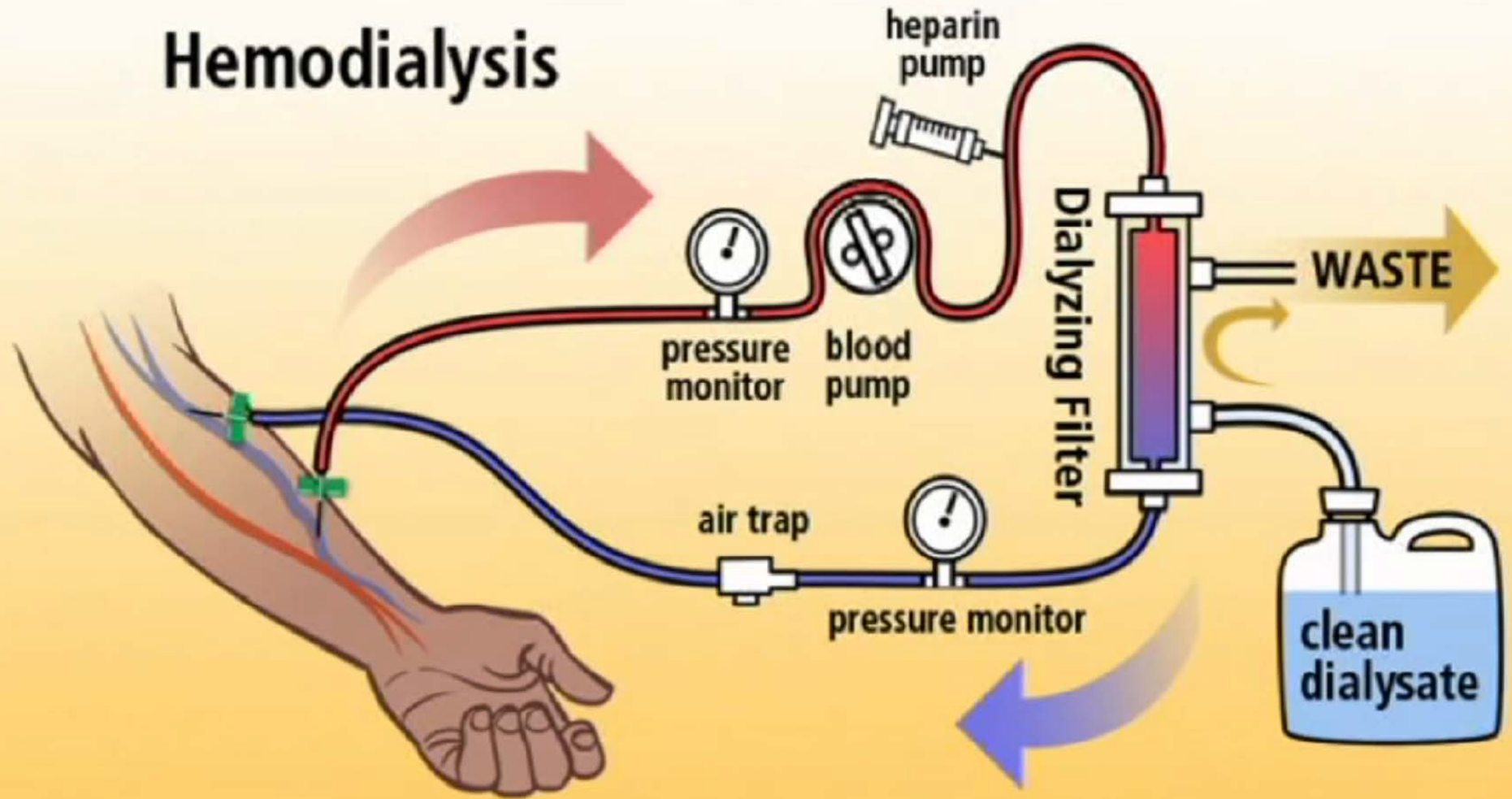
# Medical Terms

- Hyperkalemia
- Dialysis





# Hemodialysis

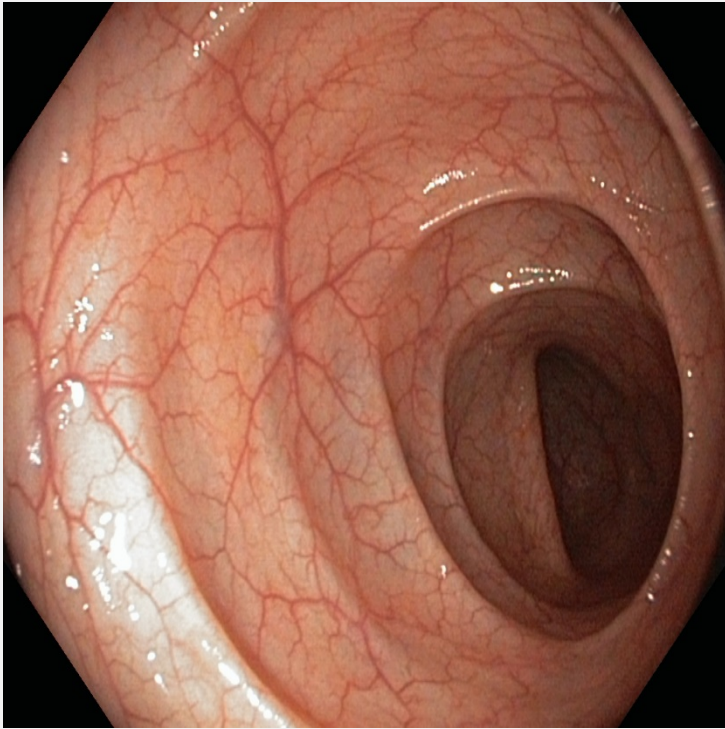


**DIALYSIS IS SAFE**

# Medical Terms

- Hyperkalemia
- Dialysis
- Intestinal Necrosis (Tissue Death)

# Intestinal Necrosis



**Healthy Colon**



**Necrotic Colon**

# Medical Terms

- Hyperkalemia
- Dialysis
- Intestinal Necrosis (Tissue Death)
- Kayexalate

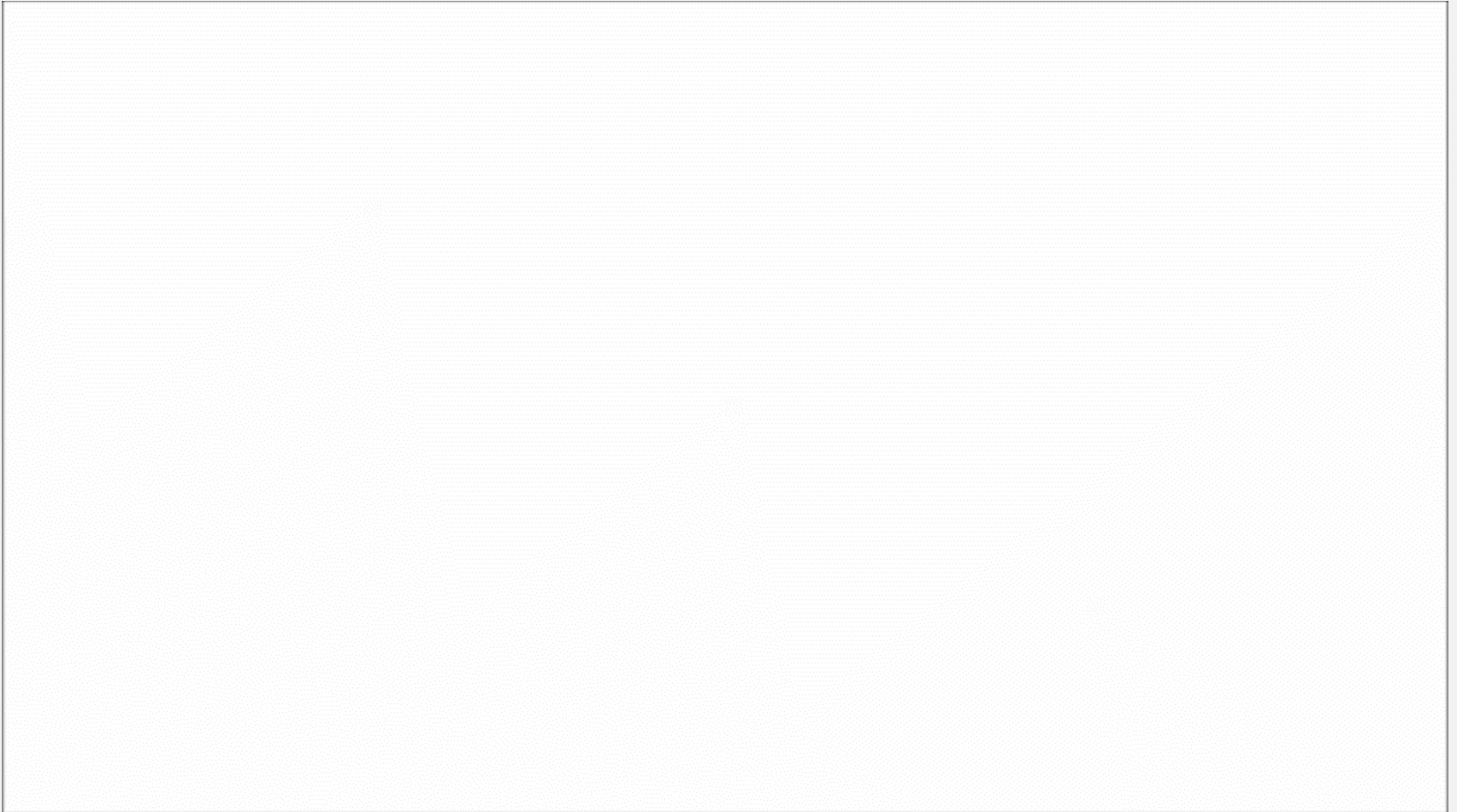
# What is Kayexalate/Sorbitol

- Removes Potassium
- 2009 & 2011 FDA warned of:
  - Intestinal Necrosis (tissue death)
  - Bowel Perforation
- Symptoms:
  - Abdominal pain
  - Bloody stool



**USE ONLY AS A LAST RESORT  
WHEN DIALYSIS IS NOT READILY AVAILABLE**

# Intestinal Necrosis from Kayexalate/Sorbitol Administration





# What the Hospital Knew

Sodium polystyrene sulfonate (Kayexalate®)

- Major complications are intestinal necrosis and bowel perforation

Sodium polystyrene sulfonate (Kayexalate®)	15-30g PO/NG/PR	Increase potassium excretion	<ul style="list-style-type: none"> <li>- Shake suspension well prior to administration</li> <li>- Repeat dose if needed</li> </ul>	≥2 hrs	4-6 hrs	Serum Na, K, and volume status  <i>Re-check Serum K after 2 hrs</i>	<ul style="list-style-type: none"> <li>- Should not be used exclusively to treat severe acute hyperkalemia</li> <li>- It is useful as monotherapy only for chronic hyperkalemia or for moderate acute hyperkalemia (Serum K &lt;6 mEq/L)</li> <li>- Oral/NG is more effective because of the longer transit time through the gut lumen</li> </ul>
							<ul style="list-style-type: none"> <li>- Major complications are intestinal necrosis and bowel perforation</li> <li>- Should not be used in patients with evidence of bowel obstruction, ileus or ischemia or to renal transplant patients in the early post operative stage</li> </ul>



# March 2013

- March 2, 2013 – Cholesterol medication changed
- March 10, 2013 – NW Hospital with Rhabdomyolysis
- March 11, 2013 – University of Maryland Hospital

# University Hospital

- Dr. Burks is Mr. Allen's attending physician
- Mr. Allen has hemodialysis (13<sup>th</sup>, 14<sup>th</sup>, 15<sup>th</sup>, 16<sup>th</sup>)
- March 18, 2013 – Dr. Burks arrives 7:00 am
- No blood drawn from Mr. Allen
- 12:00 noon – Irregular heartbeat/hyperkalemia
- Dr. Burks fails to order calcium
- Hemodialysis ordered on urgent basis
- Dr. Burks orders Kayexalate/Sorbitol

# What Happened Within 14 Hours After Kayexalate/Sorbitol

- The hospital and doctors were aware of:
  - 2 bowel movements during dialysis
  - Abdominal pain
  - Bloody stools
  - 8 more bowel movements after dialysis

**ALL SIGNS AND SYMPTOMS OF INTESTINAL NECROSIS**

**MR. ALLEN'S COLON IS DYING**

# What Mr. Allen Experienced

- March 18, 2013 through March 20, 2013:
  - Intestinal bleeding and bloody stools
  - 10 bowel movements in 14 hours
  - Abdominal Pain – crying out in pain
  - Rectal tube
  - Death of his colon
  - Transferred to ICU
  - First pain medication March 19<sup>th</sup> – 2:00pm

# March 19<sup>th</sup>, 2013 - AM

- Dr. Burks tells the family:
  - I'm sorry. I made a mistake.
  - I gave your husband Kayexalate that caused injury to his colon.
  - We caught it in time.
  - He will have to go to surgery. He'll only be there for an hour or two.
  - He will be okay.

# March 19, 2013 - PM

- Surgery takes 7 hours
- Entire colon is removed
- They left him open
- Told the family to pray

(Dr. Burks never saw the family again)

Mr. Allen dies on March 20<sup>th</sup> at 2:18 pm  
with his entire family by his side.



# MEDICAL NEGLIGENCE

A health care provider is negligent if the health care provider does not use that degree of care and skill which a reasonably competent health care provider, engaged in a similar practice and acting in similar circumstances, would use.

# MEDICAL NEGLIGENCE

- The hospital's doctor breached the standard of care by ordering and administering Kayexalate to Mr. Allen.
- The hospital's doctor also failed to obtain Mr. Allen's informed consent before administering Kayexalate/Sorbitol.

# FIVE REQUIRED ELEMENTS OF INFORMED CONSENT

1. Reveal the nature of the ailment **FAILED**
2. Reveal the nature of the proposed procedure **FAILED**
3. Reveal the probability of success **FAILED**
4. Reveal any alternatives **FAILED**
5. Reveal the material risks **FAILED**

# QUESTIONS WE ANSWERED

- Did the Kayexalate cause Mr. Allen's Intestinal Necrosis?

# Dr. Burks' Discharge Summary

University of Maryland Medical System

Patient Name: ALLEN, DENNIS V  
Medical Record Number: 240925  
Account Number: 1002867761  
Document Type: DISCHARGE SUMMARY

rule out SBP and the differential diagnosis for his blood values and  
decompensation include intestinal ischemia due to hepatitis C related  
vasculopathy ~~intestinal ischemia due to hepatitis C related~~  
lactulose **intestinal ischemia due to concomitant Kayexalate**  
GI bleed ~~hepatic decompensation with coagulopathy and low~~  
Condition

MEDICATIONS ON TRANSFER: As per Power chart, he was transferred on a  
Levophed drip as well as a bicarb drip. He had also received a dose of  
Flagyl 500 mg in addition to the aforementioned vancomycin 1.5 g and  
Zosyn 3.375 g.

----[ Related Clinicians: Docnum#: 3975548 ]-----  
BURKS, ALLEN C ( DICT )  
BURKS, ALLEN C ( SIGN 19-MAR-13 )

\*\*\*\*\* End of Dictated Report \*\*\*\*\*  
This document has been read and signed. Please contact the medical  
records department for any questions regarding this document.

# Hospital's Critical Care Note

3/19/2013

Assessment/Plan: 1) amount/complexity of data 2) number of Dx and treatment options 3) risk of complications

ABBREVIATION WARNING Do not use or write the following dangerous abbreviations or any variation of the abbreviation for any reason:			
trailing zero	MS, MgSO4, MSD4	Q0, or Q00, or q.o.d.	
lack of leading zero	EU	U or u	

LABS AP = HepC, cirrhosis, MPGN admitted to MICU = hypotension, GIB & rhabdomyolysis = renal failure.

GI PHEN Dark based per rectum, DDX: brisk venous bleed, venous colitis = ? perforation, less likely than brisk UGIB, K&IB much less likely. ? bowel ischemia due to Kayexalate. concerning resectability & massive transfusion protocol.

- to OR = ACCESS for emergent colap
- IR consulted deferred to GI/ACCESS

perforation, less likely than brisk UGIB, K&IB much less likely. ? bowel ischemia due to Kayexalate. concerning resectability & massive transfusion

- will need continued care, likely require dialysis after shock resolved

CV: shock - hemorrhagic v. septic; in shock & vasopressor.

- continue volume support & IV - blood products as needed
- attempts to wean off pressor
- troponin negative, xl EF on prior TTE 2/2013 but confirm current supporting wall on TTE
- $\checkmark$  SpO2 after OR
- aspirin / antiplatelet hold

HAEM: No SIRS, in remission, stable

- AECOPD, low tidal volume
- pna dx unclear

ID: ? Septic source from bowel source. An rxn from flagyl

- R. pneumoniae
- $\checkmark$  C diff. comp. panel

MSK: Rhabdomyolysis, postoperatively status induced. Anti/anti-jo neg.

- CRT pt normal
- cont to follow Rheum Med
- ? EKG / muscle biopsy & blood
- mind CPK

episodic hypotension within the operating room. There was no evidence of SMA thrombosis or embolic disease. Given the patient's significant hematochezia and lactic acidosis, we elected to perform on-table EGD and colonoscopy. The EGD revealed no evidence of esophageal varices or gastric ulceration. The colonoscopy revealed diffuse mucosal level of ischemia of the transverse colon, splenic flexure, descending colon, and sigmoid colon.

INDICATION FOR SURGERY: Dennis Allen is a 63-year-old male with a past medical history of chronic kidney disease with new-onset hemodialysis, hepatitis C cirrhosis, osteoarthritis, congestive heart failure, and gastroesophageal reflux disease, who presented to an outside hospital on March 10th with weakness and elevated CK and myoglobin. The patient was transferred to the University of Maryland Medical Center for further workup due to his proximal muscle weakness and myositis. The patient had been in his usual state of health when he developed the acute onset of abdominal pain overnight and early this

have significant abdominal pain with associated hypotension and pressor requirements. Given the constellation of symptomatology, we were concerned for mesenteric ischemia or ischemic colitis. The Medical Intensive Care Unit Team had pointed out that the patient had received Kayexalate the night before, and there were several case reports of

that exploratory laparotomy was warranted. Risks, benefits, and alternatives were discussed with the patient's family, and appropriate consent was obtained.

PROCEDURE: The patient was transferred to the operating room critically ill on multiple vasopressors despite resuscitation. HE placed on the table in the supine position. General anesthesia was administered through his existing endotracheal tube. His abdomen was then prepped and draped in a sterile fashion. A midline incision was made and deepened through the level of the subcutaneous tissue to the level of the fascia. There were multiple abdominal wall varices that were controlled with electrocautery and suture ligation. The fascia was then entered in the midline. The abdominal cavity was entered. There was no significant ascites. We then placed a retractor and immediately evaluated the small bowel. It all appeared viable, and there was a palpable pulse in the SMA. During this evaluation, the patient did develop episodic hypotension to SBP in the 60's with some associated low-flow state of the bowel that improved with improved blood pressure. Externally, the colon appeared normal. There appeared to be some slight evidence of potential ischemia within the transverse colon. As there was no clear evidence of a full-thickness ischemia, we elected to perform on-table esophagogastroduodenoscopy and colonoscopy given the patient's hematochezia and mucosal currant jelly-type stools.

# Hospital's Surgeon

3/19/2013

Patient Name: ALLEN, DENNIS V  
Medical Record Number: 240925  
Account Number: 1002867761  
Document Type: OPERATIVE REPORT

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Intensive Care Unit Team had pointed out that the patient had received Kayexalate the night before, and there were several case reports of mucosal level ischemia. Given his overall lability and state, we felt that exploratory laparotomy was warranted. Risks, benefits, and alternatives were discussed with the patient's family, and appropriate consent was obtained.

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Dr. Buchanan performed an esophagogastroduodenoscopy. There was no evidence of gastric ulceration, esophageal varices, or duodenal bulb



### Discussion

The decedent was a 63-year-old African-American man with a complicated past medical history notable for hepatitis C with cirrhosis (awaiting transplant), chronic kidney disease (stage IV), osteoarthritis, obesity, hypertension, and congestive heart failure. He was recently admitted with rhabdomyolysis and was treated with fluids and hemodialysis for acute renal failure. On 3/18/2013, the patient was noted to be bradycardic with peaked T waves seen on EKG; He was treated with an albuterol nebulizer, insulin, bicarbonate, and Kayexalate. Subsequently, he developed renal failure and lower intestinal bleed. His condition rapidly deteriorated and he developed hypotension resistant to fluids and albumin therapy. On 03/19/2013, colectomy was performed. Shortly thereafter, the patient went into pulseless electrical activity arrest and died at 2:18 pm on 03/20/2013.

showed extensive bowel necrosis and hemorrhage (see 1010-1007). Residual small intestine, with scattered basophilic crystals, consistent with recent kayexalate use. The findings may be suggestive of kayexalate colitis, which could have exacerbated the patient's underlying medical disease. Additional findings in this case include pulmonary congestion, mild to moderate coronary artery

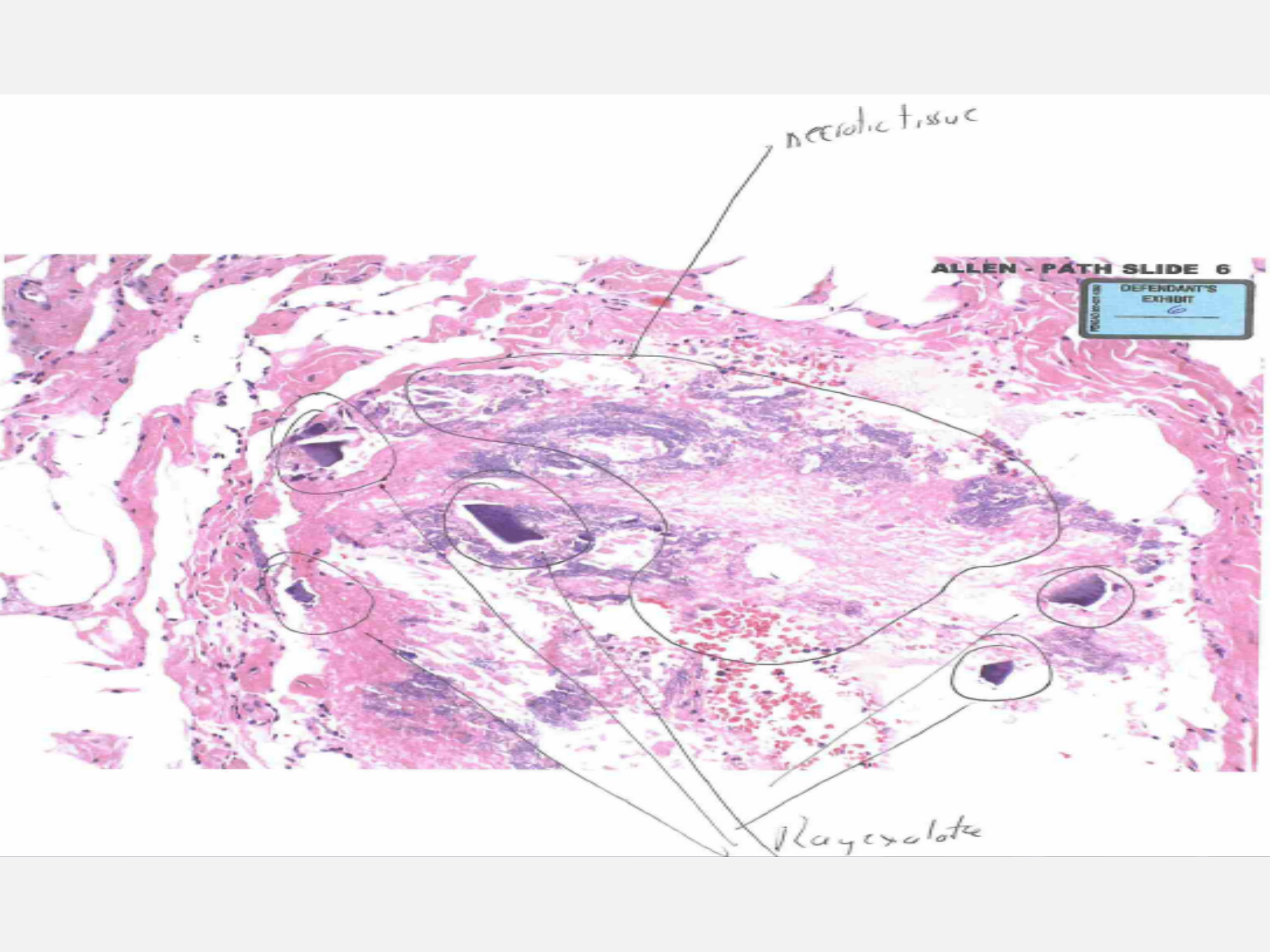
may be suggestive of kayexalate colitis, which could have exacerbated the patient's underlying medical disease. Additional findings in this case include pulmonary congestion, mild to moderate coronary artery disease, mild interstitial fibrosis and myocyte hypertrophy, consistent with hypertensive disease.

### Gross Description

An autopsy is performed at the University of Maryland Medical Center, Baltimore, MD on the body of Allen, Dennis on 3/22/2013. The body is identified by toe tag, which corresponds to the name and MRN/DOB on the accompanying chart and autopsy authorization form. An autopsy is authorized by Mrs. Cynthia Allen, the decedent's wife, who is contacted by telephone prior to the start of the autopsy for clarification of autopsy restrictions. Per request, autopsy is restricted to chest and abdomen only, with return of organs to the cavity.

#### EXTERNAL AND INTEGUMENT:

The deceased is a well-developed, well-nourished African-American man. The body weighs 303 lb; is 180 cm in height, and appears compatible with the stated age of 63 years. The body is cold, and rigor is present and fixed to an equal degree in all extremities. Lividity is present and fixed on the posterior surface of the body, except in areas exposed to pressure. Irides are brown. Each pupil measures 5 mm in diameter. Scleral icterus is present. The teeth are intact. The hair is black/brown. The thorax is symmetrical. A healing abdominal wound is present along the midline abdomen and measures 35 cm in length. The wound shows a partial staple line (intact) and is partially open with packed surgical sponges and overlying wound vac (intact). The adjacent skin



necrotic tissue

ALLEN - PATH SLIDE 6  
DEFENDANT'S EXHIBIT

fibrin exudate

# **Medical Doctors**

- Robert D. Odze, M.D.

# Dr. Odze

have seen over the years, 12 to 23 of them, you don't know if Sorbitol was administered with the

Q So you've said before, you teach about pathologic manifestation of ischemic bowel in association with Kayexalate?

A Yes.

Q Can you explain what you teach about that?

A I mean, could I explain what the findings are?

Q Yes. I mean, what would you tell your students, the fellows, or the residents, about how to make the diagnosis of ischemic colitis caused by or in association with Kayexalate; what do you look for specifically; and what evidence --

A Actually, I would show them this case 'cause it's a classic example.

Q -- what you would see.



# Dr. Odze

A Well, that's not exactly what I said, and so let me clarify.

Q Okay.

A It is well known amongst physicians and pathologists that Kayexalate, with Sorbitol, causes bowel necrosis and ischemia. That's well known.

A It is well known amongst physicians and pathologists that Kayexalate, with Sorbitol, causes bowel necrosis and ischemia. That's well known.

worked out and known. I said one of the hypotheses is it's related to the hyperosmotic effect of the Sorbitol.

That's not negating the fact that Kayexalate causes bowel necrosis. That's just asking me what is out there with regard to thoughts on how it does it. And what I also told you is that I don't know if there's animal studies. There may be animal studies, but I don't know of any. I can -- I can certainly find out by doing a literature search, but as I sit here right now, I don't know if that's the case.

Q And you've told me you don't plan to do a literature search, and you're not gonna rely on any

# **Medical Doctors**

- Robert D. Odze, M.D.
- Richard Goldstein, M.D.

# Dr. Goldstein

standard of care. So he did not die as a result of calcium deficiency, whether in the form of chloride or gluconate.

Q So Mr. Allen did not die as a result of not receiving

calcium chloride or calcium chloride in response to his

Q So can you describe for me the basis for your opinion that Mr. Allen's death was caused by the Kayexalate causing bowel ischemia?

A The Kayexalate led to bowel necrosis which led to emergency surgery which led to a lot of bleeding because of his portal hypertension, his liver disease, which resulted in irreversible shock and his ultimate demise. The instigating agent, the instigating event was the administration of the Kayexalate which lead to the ischemic necrosis of the colon.

Q So Mr. Allen experienced shock. Was the shock from sepsis, or was it from the bleeding, or do you know?

A It was probably from a combination of both. This is

# Medical Doctors

- Robert D. Odze, M.D.
- Richard Goldstein, M.D.
- James D. Leo, M.D.



# Dr. Leo

D. Leo, M.D. Cynthia Allen vs. Allen Burks, M.D. 1097081

trier of fact. My opinion will be that the standard of care required that it be ordered and administered.

I will opine that if, in fact, Dr. Burks -- well, let me back up. If, in fact, the trier of fact

D. Leo, M.D. Cynthia Allen vs. Allen Burks, M.D. 1097081

of the patient's ischemic colitis; and that ischemic colitis was the cause of the patient's death.

I will be further testifying that Dr. Burks did have a duty to inform Mr. Allen of the potential

of the patient's ischemic colitis; and that ischemic colitis was the cause of the patient's death.

I will be testifying that to a reasonable degree of medical probability Kayexalate was the cause of the patient's ischemic colitis; and that ischemic colitis was the cause of the patient's death.

I will be testifying that the lack of any documentation in the medical record in terms of continued alarming of the cardiac monitor regarding bradycardia suggests that, in fact, the initial treatment rendered to Mr. Allen in the form of glucose insulin, sodium bicarbonate and Albuterol was effective in reversing temporarily the adverse effects of the hyperkalemia, giving adequate time for dialysis to be undertaken.

I will be testifying that to a reasonable degree of medical probability Kayexalate was the cause

designation.

Q. So let's get a list of all of your global opinions right now since we started down that road. So under the expert witness designation that you referred to, there's a statement that Dr. Burks breached the applicable standard of care by ordering and administering Kayexalate when dialysis was readily available. That's similar to the opinion you just gave, that there was no reasonable basis to give Kayexalate given the known or thought to be availability of the dialysis?

# QUESTIONS WE ANSWERED

- Did the Kayexalate cause Mr. Allen's Intestinal Necrosis? **YES**
- Was Kayexalate urgently needed, or even necessary?

**Orders**

Order Date/Time 3/18/2013 12:43:04 PM

Mnemonic <b>Insulin Regular (Adult Hyperkalemia Kit) inj 100 units/mL 3 mL</b>	Order Status Completed
Ordering Physician Burks, Allen C MD	Order Placed By Sarg, Mohamed T, Pharmacist

**Mnemonic****Sodium Polystyrene Sulfonate oral susp udcup 15 gm/60 mL**

Order Date/Time 3/18/2013 12:37:59 PM

Mnemonic <b>Potassium</b>	Order Status Discontinued
Ordering Physician	Order Placed By

**Order Details**

30 gm PO, once, dispense as: oral susp, Do not use if patient has ileus., --Start 03/18/13 12:37:00, Routine priority, --Order ends 03/18/13 12:37:00

Mnemonic <b>Sodium Polystyrene Sulfonate oral susp udcup 15 gm/60 mL</b>	Order Status Completed
Ordering Physician Burks, Allen C MD	Order Placed By Burks, Allen C MD
Review Information Nurse Review, Accepted - Frock, Michele, RN, 3/18/2013 1:42:50 PM Pharmacist Verify, Accepted - Sarg, Mohamed T, Pharmacist, 3/18/2013 12:43:05 PM	
Order Details 30 gm PO, once, dispense as: oral susp, Do not use if patient has ileus., --Start 03/18/13 12:37:00, Routine priority, --Order ends 03/18/13 12:37:00	

Order Date/Time 3/18/2013 12:37:58 PM

Mnemonic <b>Sodium Bicarbonate inj 50 mEq/50 mL</b>	Order Status Completed
Ordering Physician Burks, Allen C MD	Order Placed By Burks, Allen C MD
Review Information Nurse Review, Accepted - Frock, Michele, RN, 3/18/2013 1:42:50 PM Pharmacist Verify, Accepted - Sarg, Mohamed T, Pharmacist, 3/18/2013 12:43:04 PM	
Order Details 50 mEq IV Push, once, Binds Calcium; do not administer with IV Calcium, --Start 03/18/13 12:37:00, STAT priority, --Order ends 03/18/13 12:37:00	

SUBJECT:  
 MEDICATION MANAGEMENT

 FUNCTION:  
 MEDICATION MANAGEMENT

- v. Name of patient
  - vi. Date of dispensing
  - vii. Expiration date
  - viii. Medication name, strength, amount
  - ix. Directions for use
  - x. Cautionary statements for handling and storage
- b) The nurse compares the discharge prescriptions and orders to the medication label on the multiple-dose product. The nurse gives the patient the multiple-dose medications that are ordered to continue after discharge. If there is any discrepancy with the order and the label, the nurse does not give the medication to the patient.
  - c) Some multiple-dose medications are not eligible for take home. These include, but may not be limited to: controlled substances and medications that require a Risk Evaluation and Mitigation Strategy (REMS) per the FDA. These medications are labeled "Not eligible for take home."
  - d) Pharmacist counseling is available upon request. If a patient requests medication counseling by a

7. Medications ordered as "STAT" are to be administered within two hours of the time the order is placed.

8. The goal for medications ordered as "Routine" (not ordered as "STAT") is to be administered at the next standard administration time unless otherwise indicated on the order. The dose will be available in the patient care area within two hours of the order being received by the pharmacy.

9. Orders are scheduled using the Standard Administration Times and/or the Medication Specific Schedule. There

8. The goal for medications ordered as "Routine" (not ordered as "STAT") is to be administered at the next standard administration time unless otherwise indicated on the order. The dose will be available in the patient care area within two hours of the order being received by the pharmacy.
9. Orders are scheduled using the Standard Administration Times and/or the Medication Specific Schedule. There are medications that are administered with set, specific administration times secondary to drug efficacy and/or interactions (See Attachment D and Attachment E, and refer to COP-003 Patient Care Orders in the hospital policy and procedure manual for more information).
10. The following "Time Critical" scheduled medications must be administered within 30 minutes before or after the scheduled administration time.
  - a) Rapid, short, and ultra short acting insulins
  - b) Oral hypoglycemics
  - c) Scheduled analgesics (opioids and non-opioids with the exception of topical and transdermal products)
11. "Non-Time Critical" scheduled medications are administered as follows:
  - a) Daily, weekly, or monthly medications are administered two hours before or after the scheduled administration time.
  - b) Medications that are administered more frequently than daily, but no more frequently than every four hours are administered within one hour before or after the scheduled administration time.
12. One time doses are administered within two hours of the order.
13. On-call doses are administered within 60 minutes of identification of indicated need.
14. As needed or PRN medications are administered within 60 minutes of identification of indicated need.
15. Two licensed health care professionals perform an independent double-check for the following medications:

# **WAS KAYEXALATE EVEN** **NECESSARY**

- Heart condition was under control
- No immediate effect on potassium levels

## Hospital Hyperkalemia Guidelines

Agent	Mechanism	Onset of Action	Duration of Action	Comments	Major Complications
Calcium: Calcium gluconate OR Calcium chloride	Stabilizes cardiac membrane	2 – 3 mins	30 – 60 mins	Requires administration of other agents to shift Potassium into cells and remove Potassium	
Sodium polystyrene sulfonate (Kayexalate)	Increase potassium excretion	≥2 hrs	4 – 6 hrs	Should not be used in patients with evidence of bowel obstruction, ileus or ischemia or to renal transplant patients in the early post operative stage	Intestinal Necrosis and Bowel Perforation
Hemodialysis	potassium from the body			Potassium It can lower Serum Potassium by 1 mEq/L in the first hr and another 1 mEq/L over the second hr Gold standard in eliminating potassium in renal failure patients	
Sodium polystyrene sulfonate (Kayexalate)	Increase potassium excretion	≥2 hrs	4 – 6 hrs	Should not be used in patients with evidence of bowel obstruction, ileus or ischemia or to renal transplant patients in the early post operative stage	Intestinal Necrosis and Bowel Perforation

# WAS KAYEXALATE EVEN NECESSARY

- Heart condition was under control
- No immediate effect on potassium levels
- Kidneys were already weak – At risk/FDA
- Dialysis was on the way
- Dialysis works immediately without harm

**NO NEED FOR KAYEXALATE**  
**ONLY GIVEN AS A LAST RESORT**

# QUESTIONS WE ANSWERED

- Did the Kayexalate cause Mr. Allen's Intestinal Necrosis? **YES**
- Was Kayexalate urgently needed, or even necessary? **NO**
- Was Mr. Allen going to die anyway?



“Before March 19<sup>th</sup> he did not have an indication for a critical care physician” – Page 28, Lines 16-28



4 Q (By Mr. Gaston) Well, were you Mr. Allen's  
5 attending physician?

6 A Yes, sir.

7 Q Did you serve the role as his critical care  
8 physician?

9 A No, sir.

A Before March 19th he did not have an  
indication for a critical care physician.

14 believe it was on March 19th --

15 Q We're talking about before March 19th.

16 A Before March 19th he did not have an  
17 indication for a critical care physician.

18 Q So --

19 A Therefore, no.

20 Q Would it be fair to say that the person who  
21 was in charge for managing his overall condition and  
22 course of treatment from the time you first saw him up  
23 until March 19th would be you?

24 MR. SHAW: Objection. He's already talked  
25 about the times that he was working or not working.

# Dr. Robert Odze, M.D. - Pathologist

So how and what actually happened in this patient, I couldn't tell you. I don't think

Q You can't rule out that other comorbidities in Mr. Allen's case contributed to his death, including his -- his cirrhosis of the liver and his stage four kidney disease, his --

A Well, they did not cause the death --

Q -- hypotension --

THE STENOGRAPHER: Wait.

Q I'm sorry.

A But they did not cause the death of this patient at that time on that day. What caused the death of this patient on that time on that day was ischemic colitis secondary to Kayexalate.

Q Have you looked at his lab studies from March 18, March 19, March 20?

A No.

Q Have you looked at his clinical course

# QUESTIONS WE ANSWERED

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- Was Kayexalate urgently needed, or even necessary? **NO**
- Was Mr. Allen going to die anyway? **NO**

# DENNIS ALLEN

## Pain, Suffering, and Mental Anguish

- March 18, 2013 through March 20, 2013:
  - Intestinal bleeding and bloody stools
  - 10 bowel movements in 14 hours
  - Abdominal pain – crying out in pain
  - Rectal tube
  - Death of his colon
  - Transferred to ICU
  - First pain medication March 19<sup>th</sup> – 2:00pm

**“Get me out of here,”**  
**“They are trying to kill me”**

