

## Part 2: Undifferentiated shock

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Bruce Way talks to Dr Rob Hislop about an approach to the management of undifferentiated shock in Part 2 of this two-part series. [Listen to Part 1: Undifferentiated shock here.](#)

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### About Dr Robert Hislop

Robert Hislop is a senior intensivist at [Royal Prince Alfred Hospital](#) and the director of the ICU at the Mater Hospital (North Sydney). He is a Clinical Lecturer at the University of Sydney with a strong interest in medical education. He is also an active volunteer with [Open Heart International](#).

## Part 2: Undifferentiated shock

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*With Dr Rob Hislop Intensive Care Unit consultant, Royal Prince Alfred Hospital and Dr Bruce Way, Emergency Physician and Director of Prevocational Education and Training at Prince of Wales Hospital*

### Introduction

Shock is a state where there is inadequate perfusion of tissues. Causes can be broadly categorised into vasodilatory, cardiogenic, hypovolaemic and obstructive shock. These categories and an approach to undifferentiated shock will be explored here.

### Case

**A 78-year-old man on the cardiac ward has been admitted for either pneumonia or heart failure, the diagnosis is unclear. He is now febrile, BP 99/68, HR 80, SaO<sub>2</sub> 93 on 2L, RR 24.**

**He has not breached any parameters and the nurses ask for review because he is due for his evening metoprolol and his BP has steadily been decreasing.**



#### 1. Initial questions over the phone?

- Is oxygen application recent?
- Hold metoprolol until review.
- Recognise a possible deteriorating patient.

## 2. Outline your assessment approach by the bedside

- **History:**

- Past medical history, especially cardiac function.
- BP trend - is this patient normally hypertensive or is this BP close to his normal?
- RR trend over admission.
- Recent investigations: Renal function trend, inflammatory markers, CXR's.
- Recent ECHO.

- **Examination:**

- Examine peripheries for perfusion.
- Auscultation - bilateral vs unilateral crepitations may help indicate cardiac vs pneumonic process.
- JVP + Fluid status- this can often be difficult to determine on clinical examination alone.
- Remember patient is beta-blocked and may have a masked tachycardia.

## 3. Initial investigations

- Venous blood gas including lactate
- CXR
- EUC

## 4. Management

- Discuss with medical registrar.
- Consider other causes and consider if patient is shocked.
- Withhold metoprolol.
- Paracetamol for fever.
- Assess risk of fluid bolus (history and examination) and unless significant LV dysfunction trial of 500mL of crystalloid.

## Take home messages

- Recognise a potentially shocked patient.
- Prioritise clinically examining this patient yourself. This is probably more important than your 10 pending cannulas.
- Discuss with senior for assistance in decision making, or for review if you are worried about the patient.
- If initial bolus of fluid is not effective consider discussion with ICU early.

## Related Podcasts

- [Part 1: Undifferentiated shock](#)
- [Private: Sepsis](#)
- [IV fluids](#)
- [Oliguria](#)

**Tags:** #cardiogenic,#hypovolaemic,#medical management,#obstructive,#patient centred care,#shock,#undifferentiated shock,#vasodilatory