Crisis management during anaesthesia: water intoxication

M T Kluger, S M Szekely, R J Singleton, S C Helps

Background: Irrigation of closed body spaces may lead to substantial perioperative fluid and electrolyte shifts. A syndrome occurring during transurethral resection of prostate (TURP), and a similar syndrome described in women undergoing transcervical endometrial ablation (TCEA) are both characterised by a spectrum of symptoms which may range from asymptomatic hyponatraemia to convulsions, coma, and death. Such potentially serious consequences require prompt recognition and appropriate management of this “water intoxication” syndrome.

Objectives: To examine the role of a previously described core algorithm “COVER ABCD–A SWIFT CHECK”, supplemented by a specific sub-algorithm for water intoxication, in the management of this syndrome occurring in association with anaesthesia.

Methods: The potential performance of this structured approach for each of the relevant incidents among the first 4000 reported to the Australian Incident Monitoring Study (AIMS) was compared with the actual management as reported by the anaesthetists involved.

Results: From the first 4000 incidents reported to AIMS, 10 reports of water intoxication were identified, two from endometrial ablations under general anaesthesia and eight from male urological procedures under spinal anaesthesia. The “core” crisis management algorithm detected a problem in seven cases; however, it was deficient in dealing with neurological presentations. Diagnosis of the cause of the incident would have required a specific water intoxication sub-algorithm in eight cases and a hypotension algorithm in a further two cases. Corrective strategies also required a specific sub-algorithm in eight cases, while the hypotension and cardiac arrest sub-algorithms were required in conjunction with the water intoxication sub-algorithm in the remaining two.

Conclusion: This relatively uncommon problem is managed poorly using the “core” crisis management sub-algorithm and requires a simple specific sub-algorithm for water intoxication.
done is described elsewhere in this set of articles. The potential value of this structured approach (that is, the application of COVER ABCD–A SWIFT CHECK) to the diagnosis and initial management of the problem, followed by the application of the water intoxication sub-algorithm, was assessed in the light of AIMS reports by comparing its potential effectiveness for each incident with that of the actual management, as recorded in each report.

RESULTS
Ten incidents of water intoxication were identified. The majority had undergone transurethral procedures on either prostate (7) or bladder (1), all under spinal blockade. Two incidents involved TCEA, both of which were performed under general anaesthesia. The presenting features are shown in table 1.

When the COVER ABCD–A SWIFT CHECK algorithm was applied to each report, it was considered that the majority of cases (70%) would have been detected at the COVER portion of the algorithm. The actions recommended by the COVER portion (100% oxygen, turning off the vaporiser, and, if necessary, removing the patient from the anaesthetic machine, filter, and circuit) were all considered reasonable immediate steps. However diagnosis of the actual problem was only possible from COVER in two cases while the other eight required specific consideration. Effective treatment required a specific sub-algorithm (fig 1) in eight cases; one case required both hypotension and water intoxication sub-algorithms while the final case would have required the use of sub-algorithms for cardiac arrest, hypotension, and water intoxication.

<table>
<thead>
<tr>
<th>Table 1 Presenting features of water intoxication/hyponatraemia*</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>Confusion, seizure,</td>
</tr>
<tr>
<td>sedation/drowsiness</td>
</tr>
<tr>
<td>Chest pain, ECG changes</td>
</tr>
<tr>
<td>Hypotension</td>
</tr>
<tr>
<td>Bronchospasm</td>
</tr>
<tr>
<td>Desaturation</td>
</tr>
</tbody>
</table>

*Some patients presented with more than one symptom or sign.
†All endometrial ablations (n = 7) were performed under GA, and all TURP/bladder procedures (n = 8) were performed under RA.
‡There was one case each of hypertension and bradycardia in this subgroup.

WATER INTOXICATION

SIGNS
In the awake patient – CNS symptoms (1)*
| Drawnness and confusion |
| Nausea and vomiting |
| Coma |
| Convulsions |
In the anaesthetised patient – CVS symptoms (2)
| Circulatory overload |
| ECG changes |
| Delayed emergence from anaesthesia |

PRECIPITATING FACTORS
High risk procedures: closed cavity irrigation/prolonged operating time
Anaesthesia: administering large volumes of hypotonic fluids.

EMERGENCY MANAGEMENT
Inform surgeon
Cease irrigation/surgery
Increase FiO₂, monitor blood gases
URGENT, Na⁺, K⁺, Osmolarity (blood)
If symptomatic:
0.9% saline and furosemide 0.5–1.0 mg/kg IV
mannitol 0.25 g/kg may be considered if not hypervolaemic
If severe CNS depression/convulsions:
hypertonic saline (3) anticonvulsants

FURTHER CARE
Continue ECG/Spo₂ monitoring
Attention to fluid balance
Monitor electrolytes, asimolarity, blood gases
Mild symptoms – fluid restriction may suffice
Consider central venous line or pulmonary artery catheter
Consider HDU/ICU admission

The sub-algorithm forms a facing page of the Crisis Management Manual†‡.

* Numbers in brackets refer to Notes in the right hand panel.

Figure 1 Water intoxication.
The sub-algorithm (shown in fig 1, left hand panel) was estimated to be as effective as the actual management in seven cases; in the remaining three cases, earlier consideration and action may have improved outcome. In one incident there was a delay in diagnosis and the operation continued despite symptoms of confusion, nausea, vomiting, and chest pain. In another case pre-existing hyponatraemia (129 mmol/l) was left uncorrected, and this considerably worsened following a lengthy cystoscopy (98 mmol/l) and finally a protracted (three hour) resection led to increasing drowsiness and hypertension. The attending anaesthetist did not realise the significance of these signs until a relief consultant took over the case.

There was minor morbidity in three cases, with major morbidity in seven. There were no deaths. Half of the patients with water intoxication were admitted to intensive care or high dependency units. The management of these cases is summarised in table 2. Presenting blood pressure was variable; hypotension in three cases, hypertension in one; normotension in three, and unlisted in three.

**DISCUSSION**

The small number of reports analysed for this survey limits the conclusions that can be drawn. A significant proportion of presenting features of water intoxication appear to be neurological signs; these were poorly managed using the COVER ABCD algorithm and hence a specific sub-algorithm needed to be developed. The majority of cases of water intoxication present with neurological signs in awake patients or with cardiovascular signs in patients under general anaesthesia. Although the term ‘water intoxication’ is used, it is appreciated that the signs and symptoms may be related to fluid overload, hyponatraemia, glycine, or ammonia toxicity.\(^1\) It was judged that correct use of the sub-algorithm for water intoxication, once the possibility was considered, would have confirmed the diagnosis in all cases, by checking the serum sodium and osmolality, and would have led to definitive management in eight of 10 reports. The remaining two incidents also required a sub-algorithm for hypotension. Some general conclusions may be drawn from this small study.

**Precipitating factors**

The surgical procedures that predispose patients to water intoxication are chiefly transurethral resection of the prostate and endometrial ablation.

**Clinical features**

Under spinal anaesthesia, neurological signs appear early and include nausea, vomiting, confusion, and irritability. A high index of suspicion is needed when a patient’s neurological condition changes intraoperatively during one of these procedures. Further sedation should be avoided and the diagnosis of metabolic derangement considered; serum sodium and osmolality should be checked.

The earliest signs under general anaesthesia appear to be cardiorespiratory, including desaturation and ECG changes. These are well recognised as indicative of potential intraoperative problems in TURP.\(^12\) Full ECG monitoring therefore is advocated with lead positioning (for example, CM5) that enables ST segment analysis. In addition, oximetry should be mandatory for all patients.

**Management**

Avoidance of excessive resection time, irrigation fluid pressure, and administration of hypotonic fluids may prevent many cases of water intoxication. Immediate cessation of the procedure is warranted in all cases where this problem arises. Continuation may lead to a worsening of the clinical situation and potential complications. If the symptoms are mild, blood should be taken for urgent electrolyte and osmolality measurement. Often no further active treatment is required. If patients have neurological signs or exhibit signs of fluid overload, consideration needs to be given to the use of a diuretic (for example, frusemide), and fluid restriction. Mannitol has been found to be more effective than frusemide in the treatment of TURP syndrome as reflected in higher serum sodium and less need for postoperative fluid volume loading.\(^13\) However, in patients who are already fluid overloaded, mannitol may precipitate an initial worsening of this situation; in these, frusemide should be used.\(^14\) Normalisation of oxygenation and cardiovascular parameters should be sought. As the TURP patients are in an older age group, acute changes in intravascular fluid shifts may warrant invasive arterial and central venous or pulmonary artery pressure monitoring. Avoidance of hypotonic solutions and administration of isotonic saline is recommended. Hypertonic saline may occasionally be warranted, especially when the serum sodium falls below 120 mmol/l. Its use is required only in those cases where there is severe, acute neurological deterioration (for example, convulsions and coma); however overly rapid correction, especially with preexisting hyponatraemia, has been implicated in causing neurological problems such as central pontine myelinolysis.\(^15\) As half of these patients required ICU or HDU admission, consideration should be given to admission of these patients to the appropriate ward following the procedure.

The mainstays of treatment of water intoxication include awareness of the problem in high risk patient groups, intraoperative electrolyte and blood gas monitoring and early cessation of surgery if the complication is considered. Marker techniques such as ethanol added to irrigation fluid have

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**Table 2** Management of water intoxication/hyponatraemia/glycine intoxication

<table>
<thead>
<tr>
<th>Case</th>
<th>Anaesthetic</th>
<th>Case</th>
<th>Management</th>
<th>Lowest Na (mmol/l)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>GA</td>
<td>TCEA</td>
<td>CVP line, frusemide</td>
<td>99</td>
</tr>
<tr>
<td>2</td>
<td>SP</td>
<td>TURP</td>
<td>Frusemide; normal saline</td>
<td>121</td>
</tr>
<tr>
<td>3</td>
<td>SP</td>
<td>TURP</td>
<td>Frusemide; normal saline</td>
<td>115</td>
</tr>
<tr>
<td>4</td>
<td>SP</td>
<td>TURP</td>
<td>CPR; adrenaline; atropine</td>
<td>112</td>
</tr>
<tr>
<td>5</td>
<td>SP</td>
<td>TURP</td>
<td>Hypertonic saline; hydrocortisone</td>
<td>117</td>
</tr>
<tr>
<td>6</td>
<td>SP</td>
<td>BNI</td>
<td>Frusemide; GTN patch</td>
<td>98</td>
</tr>
<tr>
<td>7</td>
<td>SP</td>
<td>TURP</td>
<td>Frusemide; hypertonic saline; CVP line</td>
<td>115</td>
</tr>
<tr>
<td>8</td>
<td>SP</td>
<td>TURP</td>
<td>IPPV (convulsion)</td>
<td>130</td>
</tr>
<tr>
<td>9</td>
<td>SP</td>
<td>TURP</td>
<td>IPPV (pulmonary oedema); frusemide</td>
<td>&quot;low&quot;</td>
</tr>
<tr>
<td>10</td>
<td>GA</td>
<td>TCEA</td>
<td>Frusemide</td>
<td>123</td>
</tr>
</tbody>
</table>

GA, general anaesthesia; SP, spinal anaesthesia; TCEA, endometrial ablation; TURP, transurethral resection of prostate; BNI, bladder neck incision; CVP, central venous pressure; CPR, cardiopulmonary resuscitation; GTN, glyceryl trinitrate; IPPV, intermittent positive pressure ventilation.
There were 10 reports of water intoxication identified from the first 4000 reports to the Australian Incident Monitoring Study (AIMS).

Eight cases were associated with transurethral procedures under spinal anaesthesia. Two cases were associated with transcervical endometrial ablation (TCEA).

The lowest recorded serum sodium level was 99 mmol/L, during a TCEA.

There were no deaths but there was major morbidity in seven cases.

The commonest presenting signs in the awake patient were developing mental confusion, sedation, drowsiness, and seizures. The earliest signs under general anaesthesia appear to be cardiorespiratory (for example, desaturation, ECG changes). Presenting blood pressure was variable. Electrocardiographic and pulse oximetry monitoring are considered mandatory.

The commonest management strategies reported involved administration of frusemide, normal saline, and IPPV.

Half the patients required ICU or HDU admission postoperatively, indicating the need for admission to the appropriate ward following these procedures.

Risk situations during transurethral or TCEA procedures include prolonged surgical time and excessive pressures using hypotonic irrigation fluids.

The combined, correct application of the core algorithm and the specific sub-algorithm was considered likely to have improved the outcome for three of the patients.

ACKNOWLEDGEMENTS

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REFERENCES