7.5 mg EREM was not administered spinally because we did not attempt to aspirate CSF after administration of the drug. Our current system for safe EREM administration has safeguards that failed us and this patient. We use custom-assembled combined spinal–epidural kits with uniform assignment of syringes of different type and size filled with solutions with visibly different opacity (fig. 1). Because of this sentinel event, we are introducing additional safeguards to include withdrawal of EREM from the vial only after the spinal needle has been removed from the patient, and verbal confirmation of the drug and dose being given by two providers at the time the EREM is administered.

In conclusion, our practice of using a dose of EREM lower than recommended14 the patient’s previous use of opioid and possible opioid tolerance, and her good health may have contributed to this outcome. In any case, this single example of intrathecal EREM is not presented to imply that this practice is safe: The pharmacokinetics of EREM in the spinal space have not been published, and this route of administration has not been adequately studied. Rather, we believe this case does imply that preservation of an acceptable patient recovery is possible with appropriate and thoughtful management of known accidental spinal administration of EREM.

References


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