MALPRACTICE COUNSEL

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Failure to Diagnose Testicular Torsion in Young Man

A 25-year-old man experienced sudden, severe testicular pain while lying in bed. He went to a Massachusetts ED, where the emergency physician ordered a testicular ultrasound for what he believed to be a hernia. The radiologist who interpreted the ultrasound reported findings consistent with a hernia. The plaintiff was discharged with instructions to follow up with the surgical service for hernia repair.

Less than two days later, the plaintiff returned with even more severe pain. He was initially thought to have an incarcerated hernia, but an examination revealed that the spermatic cord could be palpated above the scrotum. The plaintiff underwent surgery, which revealed that his left testicle had twisted 720° and was necrotic. The testicle, which could not be saved, had to be surgically removed.

The plaintiff claimed that the testicular ultrasound showed absent blood flow to the left testicle. The emergency physician testified that he personally viewed "videotape" of the testicular ultrasound shortly after it was performed. A deposition of the hospital's chief technology officer revealed that the hospital did not own or operate equipment that would have enabled the ultrasound to be recorded on tape or any other media that would have allowed the defendant to review recorded results.

The defendants further claimed that the plaintiff did not present to the ED with a classic presentation of testicular torsion and that torsion was ruled out by the ultrasound, which revealed a hernia-like mass.

Outcome

According to a published account, a $550,000 settlement was reached.

Comment

Testicular torsion can be difficult to diagnose clinically and frequently results in loss of the testicle, despite our best efforts. Patients may provide a history of similar pain that resolved spontaneously.

Patients should always be examined standing up. This helps to determine if a *bell clapper deformity* (the anatomic abnormality that predisposes to torsion) is present, by comparison with the opposite testicle (ie, involved testicle higher riding and with a transverse lie). On examination, typically the scrotum is firm, exquisitely tender, and swollen on the affected side.

A useful diagnostic maneuver is to check for a cremasteric reflex. Gently scratch the proximal inner thigh of the patient; normally, the testicle should retract. Absence of this reflex suggests torsion. (Similarly, a normal reflex argues strongly against torsion).

While a complete blood count and urinalysis are frequently ordered, they usually are not helpful in making this diagnosis. Testicular ultrasound (especially color doppler) is considered the gold standard for diagnosing testicular torsion.

Emergency physicians must rely on their consultants to provide the correct interpretation of their studies, whether ultrasound or stress echo. This patient received the appropriate evaluation and testing from the physician perspective; the problem was in the radiologist's interpretation of the ultrasound.

The physician's alleged subsequent actions, however, raise an important point: Your defense must be honest and based on fact. Once you have been shown to lie under oath (either at deposition or trial), you lose all credibility and sympathy. Similarly, never go back and alter the medical record in a malpractice case. This will usually be detected and result in a verdict for the plaintiff. The lesson here is the same we learned in kindergarten—be honest. **FLC**

Failure to Provide Proper Care to Teenager With Miscarriage

A 15-year-old girl went to a Georgia ED complaining of vaginal bleeding. She was approximately 20 weeks pregnant at the time. The plaintiff's mother accompanied her to the hospital.

The on-duty emergency physician treated the plain-

tiff and consulted with the on-call obstetrician/gynecologist. The emergency physician diagnosed a spontaneous or inevitable miscarriage and told the teenager to return home and allow the process to continue. He also told her to follow up the next day to schedule a dilation and curettage (D&C), but no instructions were given regarding what to expect if the miscarriage occurred at home or how to deal with the fetal remains.

After returning home, the plaintiff began experiencing contractions and more vaginal bleeding, so she returned to the ED. The nurse on-call at that time allegedly refused to admit the plaintiff because the hospital did not have an obstetrics facility. The nurse allegedly directed the plaintiff to a hospital restroom, where the fetus was delivered while the plaintiff was straddling the toilet. Her mother assisted in the delivery of the stillborn fetus by catching it and keeping it from falling into the toilet.

The plaintiff was then admitted to the ED, where she was seen by the same emergency physician. She was then transferred to another hospital that could provide obstetric care. The plaintiff claimed that the emergency physician and on-call ob/gyn were negligent in discharging her from the ED and in failing to arrange for her to be treated at a facility with obstetric care.

Outcome

The case was ultimately tried against the hospital and nurse. According to a published account, a defense verdict was returned.

Comment

This case encompasses multiple problems, and some aspects of it are simply unbelievable (ie, that the patient was directed to a hospital restroom for the fetus to be delivered). Stable patients with inevitable abortion (ie, miscarriage) and pre-viable fetuses are usually treated as outpatients, with follow-up for D&C, as in this case.

This case, however, emphasizes the importance of discharge instructions. Both the physician and the nurse need to provide the patient with the necessary information (ie, follow up with a gynecologist for a D&C), including the specific reasons to return to the ED—increased bleeding with passage of clots and/or tissue, dizziness, etc. Discharge instructions need to be understandable and action-specific. "Return prn" means absolutely nothing.

Hopefully, the accusations regarding the patient being directed to the restroom to complete the miscarriage were baseless. The fact that the jury returned a defense verdict suggests this as well. **FLC**

Boy Dies From Brain Herniation During Lumbar Puncture

A 12-year-old boy went to a Michigan hospital's ED with complaints of disorientation, confusion, and lethargy. The emergency physician suspected meningitis and ordered a lumbar puncture. During the procedure, the child suffered a brain herniation and died instantly. It was determined that the decedent had a subdural empyema.

The plaintiff claimed that the lumbar puncture was contraindicated for a patient with empyema and that CT should have been performed to rule out other causes of the boy's disorientation and confusion prior to performing the lumbar puncture. The plaintiff claimed that CT would have resulted in a proper diagnosis.

The defendant contended that the actions taken were appropriate and that the decedent's symptoms were consistent with meningitis, for which a lumbar puncture was the standard of care. The defendant also claimed that empyema is a rare condition.

Outcome

According to a published account, a $360,000 settlement was reached.

Comment

Although a subdural empyema may not be a common complication, when meningitis is suspected in adults or

children other than infants, the correct order for treating and evaluating the patient is IV antibiotics first, then CT, and afterwards, if not contraindicated by CT, lumbar puncture. **NF**

Failure to Diagnose Ruptured Aorta Following Auto Crash

A 59-year-old woman was a passenger in a vehicle involved in a crash. The plaintiff suffered apparent chest wall trauma and was taken to a hospital. She was then transferred to a university medical center, where she was evaluated by two emergency physicians.

A chest wall x-ray, which was reviewed by two radiologists, was interpreted as normal. The patient was anemic and had an elevated heart rate but was otherwise evaluated as normal. She was released from the hospital and died 36 hours later of a ruptured aorta.

The plaintiff alleged negligence by the defendants in failing to diagnose and treat the aortic rupture. The plaintiff claimed that chest CT should have been performed. The defendants claimed that the decedent was mostly asymptomatic at admission, although her color was not good. The defendants claimed that they were told that the decedent was normally pale. The defendants also claimed that hemocrit levels were stable, although they were low.

Outcome

According to published reports, a defense verdict was returned.

Comment

This patient was transferred to and managed at a regional trauma center and a defense verdict was returned. Nevertheless, it is worth remembering that *chest wall* and *skull* radiographs interpreted as "normal" cannot exclude significant injuries to the soft tissues contained within. **NF**

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