## Man treated for asthma dies of undiagnosed heart disease

**A MONTH AFTER HE BEGAN RECEIVING ASTHMA TREATMENT** from his physician, a 50-year-old man suffered a heart attack and died. An autopsy revealed idiopathic dilated cardiomyopathy.

**PLAINTIFF'S CLAIM:** The doctor negligently failed to examine the patient for heart disease; the patient was in congestive heart failure during treatment.

**DOCTOR'S DEFENSE:** The physician claimed that he twice recommended that the patient see a cardiologist. The plaintiff countered that the doctor didn't make a referral, despite chart notes to that effect.

**VERDICT:** California defense verdict.

**COMMENT:** *Clear documentation of the history, physical, and differential diagnostic thinking helps fend off unwarranted lawsuits.*



## Failure to confirm Echo result leads to cardiac arrest

**SUDDEN ONSET OF CHEST PAIN** radiating to the back, which had started during rest, brought a 49-year-old woman to the hospital. The patient also complained of pain radiating to her left jaw and ear, which became worse when she inhaled or moved. She had no shortness of breath, palpitations, diaphoresis, or history of trauma. She did have a history of gastroesophageal reflux disease (GERD), but said that the pain didn't resemble the pain of GERD. While in the triage area, she vomited.

Two electrocardiograms (EKGs) done in the emergency room showed sinus bradycardia and nonspecific T-wave abnormalities. A chest radiograph was reported as normal, but with a note of borderline heart enlargement and a tortuous aorta. A gastrointestinal (GI) cocktail of Nitropaste and Toradol didn't relieve the pain, nor did Ativan. No workup for aortic dissection was done.

After consultation with a doctor covering for the patient's primary care physician, the patient was hospitalized with orders for laboratory studies, a chest radiograph, and an EKG the next morning. The EKG again showed abnormalities, including a nonspecific T-wave abnormality, as did the chest radiograph (moderate cardiomegaly, tortuous aorta, mild prominence of the pulmonary vasculature without evidence of congestive failure, and small left

COMMENTARY PROVIDED BY **Jeffrey L. Susman, MD,** Editor-in-Chief

CONTINUED ON PAGE 52

CONTINUED FROM PAGE 44

pleural effusion or slight blunting of the left lateral costophrenic angle). But the radiograph wasn't compared to the one taken the night before. A GI consult—by which time the patient's hematocrit had dropped from 32 to 26—attributed the pain to GERD and recommended outpatient esophagogastroduodenoscopy.

The results of a routine echocardiogram—faxed to the patient's floor the same day—were worrisome: a dilated aortic root and ascending aorta accompanied by at least moderately severe aortic insufficiency and normal ventricular function.

The patient's primary care physician saw the patient and discharged her that evening. Fewer than 2 hours later, the patient suffered a cardiac arrest at home and couldn't be resuscitated after transport to the hospital. An autopsy found the cause of death to be cardiac tamponade resulting from dissection of an aortic aneurysm.

**PLAINTIFF'S CLAIM:** The patient shouldn't have been discharged without clarification of the echocardiogram results.

**DOCTOR'S DEFENSE:** The primary care physician's understanding was that the cardiologist had ruled out heart-related problems, including aortic dissection, and that the patient had been diagnosed with a stomach illness, which would be followed on an outpatient basis. Even if a diagnosis of aortic dissection had been made, the outcome would have been the same.

**VERDICT:** $560,000 Massachusetts settlement.

**COMMENT:** *Inadequate follow-up of testing—in this case, an inpatient echocardiogram—can have catastrophic results. Before discharge, each inpatient test should be reviewed and adjudicated, and a clear plan for follow-up delineated.*

**FAST** TRACK

**The patient returned a year later complaining of blood in his underwear, but the doctor did not test for occult bleeding**

## Cancer missed in patient with rectal bleeding

**A 44-YEAR-OLD MAN** went to his family physician, an internist, with complaints that included rectal bleeding. The physician performed a flexible sigmoidoscopy, which found hemorrhoids that weren't inflamed or bleeding. A hemoccult test at a physical exam before the sigmoidoscopy was positive for bleeding.

A year later, the patient returned to the doctor complaining of blood in his underwear almost every other day. The doctor noted a "slightly inflamed hemorrhoid" on anoscopy, but no bleeding from the hemorrhoid; he didn't test for occult bleeding.

Early the next year, the patient saw the physician for a complaint of blood in the stool and changes in bowel habits. A hemoccult test was positive, and the doctor diagnosed irritable bowel syndrome. The patient returned 6 months later with the same complaints and, he said, requested referral to a gastroenterologist. The doctor again attributed the complaints to irritable bowel syndrome.

Early the following year, the patient went to another internist because his insurance changed. This internist immediately diagnosed stage-3 rectal cancer. The patient underwent radiation, chemotherapy, and 2 surgeries, one to remove part of his rectum and a second to reverse an ileostomy done during the first operation. The patient was left impotent, with permanent, variable bowel dysfunction.

**PLAINTIFF'S CLAIM:** The diagnosis of hemorrhoids wasn't reasonable; the patient should have been referred to a gastroenterologist or for colorectal cancer surgery. Early detection and diagnosis would have resulted in removal of a polyp or early cancer, which could have been done during a colonoscopy or by transanal excision.

**DOCTOR'S DEFENSE:** The patient's doctor denied that the patient had requested a referral to a gastroenterologist and maintained that he believed the flexible sigmoidoscopy had ruled out a serious cause of bleeding.

**VERDICT:** $1 million Virginia verdict.

**COMMENT:** *When a patient has persistent rectal bleeding without a clear cause, no matter what the patient's age, further evaluation or referral is prudent.* ■

*The cases in this column are selected by the editors of* The Journal of Family Practice *from* Medical Malpractice: Verdicts, Settlements & Experts, *with permission of the editor, Lewis Laska (www.verdictslaska.com). The information about the cases presented here is sometimes incomplete; pertinent details of a given situation may therefore be unavailable. Moreover, the cases may or may not have merit. Nevertheless, these cases represent the types of clinical situations that typically result in litigation.*