SJS is diagnosed, but not quickly

AFTER MULTIPLE HOSPITAL VISITS FOR A RASH, a 34-year-old man was sent to a regional medical center for treatment. The rash was eventually diagnosed as a reaction to allopurinol, a potential side effect that was prominently noted in the drug warnings.

The patient developed Stevens-Johnson syndrome. He recovered after several days in the intensive care unit and was discharged with mild scarring over 80% of his body.

PLAINTIFF'S CLAIM The defendants negligently failed to diagnose a drug reaction after multiple reports of a known side effect.

DOCTORS' DEFENSE Rashes are a common complaint in an emergency room; delayed withdrawal of the drug caused no additional harm.

VERDICT $72,500 South Carolina settlement.

COMMENT *Although instances are rare, failure to diagnose and treat a dermatologic problem promptly can have catastrophic results. Stevens-Johnson syndrome needs to be included in the differential diagnosis of drug reactions and must be handled promptly.* *(See "Derm diagnoses you can't afford to miss" on page 298.)*

Lithium unmonitored, kidney failure followed

A WOMAN WAS STARTED ON LITHIUM, but the doctor who wrote the prescription never ordered follow-up blood tests for creatinine levels. When her blood was tested 7 years later by another physician for another medical problem, her creatinine levels were high.

The physician sent the woman to a nephrologist, who discontinued the lithium. Three years later the patient went into renal failure. She received a kidney transplant from her sister. The patient, 39 years of age, will have to take antirejection medication for the rest of her life. The plaintiff sued the doctor who wrote the original prescription as well as 2 other physicians who treated her.

PLAINTIFF'S CLAIM The 2 physicians who treated her saw blood test results showing a rise in creatinine, which should have prompted them to act.

DOCTORS' DEFENSE No information about the doctors' defense is available.

VERDICT $2 million New Jersey settlement.

COMMENT *Certain medications, such as lithium, require careful and frequent monitoring. Although such surveillance is seldom evidence-based, this is probably one of those times when covering yourself is a guiding precept.*

One more drug leads to one big problem

A 56-YEAR-OLD MAN WAS HOSPITALIZED WITH PNEUMONIA, for which his physician prescribed fluconazole (supplied by the hospital pharmacy). The patient was taking cyclosporine, prescribed after a kidney transplant 20 years earlier, and atorvastatin. Lab work performed a week later revealed renal function problems. The patient's medications weren't adjusted.

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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.*

COMMENTARY PROVIDED BY
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Editor-in-Chief

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The patient's wife had him transferred to another facility, where he was diagnosed with rhabdomyolysis resulting from the multiple medications. After extensive hospitalization and rehabilitation, the patient was left with debilitating muscle weakness, especially in his legs.

PLAINTIFF'S CLAIM The hospital and doctor were negligent in failing to recognize the potential for adverse interaction among atorvastatin, cyclosporine, and fluconazole, and in failing to discontinue the atorvastatin.

THE DEFENSE No information about the nature of the defense is available.

VERDICT $1.63 million gross verdict in West Virginia.

COMMENT *Can you remember all those CYP450 drug-drug interactions? Neither can I. So when a patient is on an unfamiliar medication (cyclosporine isn't a regular in my practice), it's worth looking up the drug and exploring potential problems.*

Necrotizing fasciitis leads to lost use of arm

REDNESS AND SWELLING OF THE RIGHT ARM, vomiting, and dehydration brought a 30-year-old woman to the family practice clinic at an Air Force base. The patient's medical history included endometriosis, hypothyroidism, insomnia, headaches, anxiety, and diffuse cellulitis. She took many drugs for pain associated with the endometriosis and cellulitis, including opioids such as hydromorphone. She also took lorazepam for anxiety.

About 2 weeks later she was seen by an endocrinologist at a hospital for testing related to hypothyroidism. She had a fever and skin lesions, which prompted the endocrinologist to refer her to the Air Force base emergency room for treatment of an infection.

A month later, the patient returned to the endocrinologist, who placed a peripherally inserted catheter on the inside of her right arm near the elbow to facilitate blood drawing for endocrine tests. After 10 days, the patient experienced redness, pain, and swelling in her right arm. A few days later, she saw a family practitioner at the Air Force family practice clinic, who told her to go home, take ibuprofen, and come back if the symptoms didn't improve.

Four days later, the patient was brought to the Air Force base emergency room and diagnosed with necrotizing fasciitis. After immediate aggressive debridement, she was transferred to another hospital, where she underwent 5 surgeries, including skin grafts. As a result, her right arm is withered and scarred and lacks the muscles and tendons necessary to sustain meaningful activity. The patient has to wear a prosthetic device over her forearm and wrist to provide support and compression, and she suffers continuous, debilitating pain, for which she wears a fentanyl transdermal patch. She is unable to work.

PLAINTIFF'S CLAIM Her arm was not properly examined when the redness and swelling developed; cellulitis should have been diagnosed during that first visit.

DOCTOR'S DEFENSE The patient didn't complain about her right arm during the initial visit to the family practice clinic, and neither the doctor nor his assistant noted any problems, as evidenced by the lack of mention of the arm in the chart notes. The chart recorded complaints of vomiting, dehydration, and "the same symptoms I always have" and noted that the patient had come to the clinic to refill a lorazepam/hydromorphone prescription to replace a lost bottle of pills. The infection occurred after the visit; once the process began, nothing could be done to alter the outcome.

VERDICT $8.6 million Illinois bench verdict.

COMMENT *It is crucial to recognize aggressive skin infections, including necrotizing fasciitis, and to initiate prompt treatment.* ■

FAST TRACK

The patient was told to take ibuprofen for the pain and swelling in her arm; 4 days later, she was diagnosed with necrotizing fasciitis.