An overlooked finding and missed opportunity

A WOMAN IN HER LATE 70s had an abdominal and pelvic computed tomography (CT) scan, which was reported as normal. Four years later she had a second abdominal and pelvic scan because of blood in her urine. A comparison with the previous scan noted that "the endometrium is thickened, measuring approximately 22 mm, compared to 17 mm" on the first scan.

Endometrial cancer was diagnosed, and the woman underwent a radical hysterectomy and other procedures before being discharged from the hospital. She died about 4 months later of complications from the cancer.

PLAINTIFF'S CLAIM The thickness of the endometrium on the first CT scan should have prompted follow-up because a thickness >10 mm almost always suggests possible endometrial cancer in postmenopausal women. Diagnosing and treating the cancer at the time of the first scan would have prevented metastasis.

THE DEFENSE No information about the defense is available.

VERDICT $600,000 Massachusetts settlement.

COMMENT *Incidental findings can be the bane of one's existence; make sure you read those imaging reports carefully.*

A headache, then death, for a 13-year-old

A COMPLAINT OF HEADACHE prompted a 13-year-old girl to seek treatment at a health center. She subsequently developed bacterial meningitis, attributed to sinusitis, and died.

PLAINTIFF'S CLAIM The physician who saw the girl at the health center failed to review records of a previous trip to an emergency room, ask the patient about the severity of her headache, or prescribe antibiotics.

THE DEFENSE No information about the defense is available.

VERDICT $3.75M Illinois verdict.

COMMENT *The old lesson of considering not only the most common but also the "have-to-make" diagnoses remains timeless.*

Did a failure to communicate cost this patient his life?

A MAN WITH A DRY, NONPRODUCTIVE COUGH and a long history of sinus problems and upper respiratory issues was seen several times by his family care group. One physician ordered a chest radiograph, which a technician performed in house and a radiologist read at another location of the practice. The radiologist compared the radiograph with a chest film done several years earlier and reported a new finding: a 1-cm lung nodule. He recommended further evaluation with a computed tomography (CT) scan.

On the same day as the chest radiograph, the patient was referred to an ear, nose, and throat specialist, who examined him the following day and ordered a CT scan of the sinus. The patient was never notified of the abnormality on the chest radiograph or the need for a follow-up CT scan.

Almost 2 years later, the patient began losing weight and experiencing shortness of breath and chest pain. He went to another medical group and was referred for radiologic evaluation. He was subsequently diagnosed with stage IV terminal lung cancer and died about 9 months later.

PLAINTIFFS' CLAIM The family care group was negligent for failing to communicate the results of the chest radiograph to the patient. Treatment at the time of the chest x-ray would likely have been curative.

THE DEFENSE No information about the defense is available.

VERDICT $900,000 Virginia settlement.

COMMENT *Another abnormal radiograph, another example of inadequate communication leads to a $900,000 settlement.*

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
Jeffrey L. Susman, MD,
Editor-in-Chief

The patient was never notified of the abnormality on the chest radiograph or the need for a follow-up CT scan.