COMMENTARY PROVIDED BY
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Culture results go undiscussed, man suffers stroke

TWO WEEKS AFTER PROSTATE SURGERY, a 76-year-old man went to the ED because he was having trouble urinating. The ED physician catheterized the patient, ordered a urine culture, and discharged him.

The culture results, showing methicillin-resistant *Staphylococcus aureus*, were sent to a printer in the ED twice, as was the usual practice, but evidently no one saw them.

The patient returned to the ED 2 weeks after his initial visit with the same complaint of difficult urination and was seen by the same physician. The physician again discharged him with a catheter but without mentioning the culture results. Two days later, the patient suffered a stroke, which paralyzed his left side.

PLAINTIFF'S CLAIM The bacteria had spread from the patient's urine to his bloodstream, sparking a cascade of events that led to the stroke.

THE DEFENSE No information about the defense is available.

VERDICT $2.25 million New Jersey settlement.

COMMENT *The repeated missed opportunities to diagnose and treat this patient's infection were regrettable—and costly.*

Inadequate differential proves fatal

SHORTNESS OF BREATH led a 52-year-old woman to visit her medical group, where she was a long-time patient. The family practitioner who saw her noted tachycardia and ordered an electrocardiogram, which was abnormal. The physician also ordered a chest x-ray and, because the woman had a history of anemia, a complete blood count and a number of other blood tests. He subsequently called the patient at home to tell her that the blood tests were normal and she didn't have anemia.

Three days later, the patient went to an urgent care center complaining of shortness of breath and tightness in her chest. A pulmonary embolism was diagnosed, and she was transferred to a hospital ED. Later that evening, a code blue was called and the patient was resuscitated. She died the following day.

PLAINTIFF'S CLAIM The doctor assumed that the patient had anemia and failed to develop a differential diagnosis. The patient had risk factors for pulmonary embolism—obesity and the use of an ethinyl estradiol-etonogestrel vaginal contraceptive ring—which should have prompted the doctor to consider that possibility. If he had done so, the pulmonary embolism would have been diagnosed and the patient's death prevented.

THE DEFENSE The patient's presentation wasn't typical for pulmonary embolism, and there wasn't any way to know whether an earlier diagnosis would have resulted in survival.

VERDICT $1.9 million California verdict.

COMMENT *Although pulmonary embolism can be a challenging diagnosis to make, it needs to be considered carefully in all patients with shortness of breath, chest pain, or poorly defined pulmonary or cardiac symptoms.*

The correct diagnosis comes too late

FLU-LIKE SYMPTOMS AND AN IRREGULAR HEART RATE prompted a man to go to the ED, where the physician diagnosed a viral infection, prescribed pain medication, and discharged him. The following day, a laboratory report indicating a staph infection was sent to an ED secretary, but the patient wasn't told the results.

The patient returned to the hospital 2 days later in a confused state. Tests revealed a staph infection and meningitis, for which the patient received antibiotics. A week later, the patient suffered a stroke, resulting in diminished cognitive ability, impaired vision, and right-sided motor deficits.

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.

PLAINTIFF'S CLAIM The white blood cell count and C-reactive protein level measured at the patient's first visit to the ED would have led to a diagnosis of bacterial infection. The patient should have been admitted to the hospital and given antibiotics at that time.

THE DEFENSE The original diagnosis was reasonable.

VERDICT Confidential settlement with the hospital. $900,000 net verdict against the physician in New Jersey.

COMMENT *Lab reports gone awry and the lack of a fail-safe for abnormal tests result in a $900,000 judgment. Do you have adequate systems in place to avoid a communication failure like this one?*

Slow response turns a bad situation into a disaster

A 66-YEAR-OLD MAN on warfarin therapy for chronic atrial fibrillation and a transient ischemic attack underwent lithotripsy for kidney stones. Three days after the lithotripsy, he went to the ED complaining of severe flank pain. A computed tomography (CT) scan of the abdomen showed a large retroperitoneal hematoma and prominent perinephric and pararenal hemorrhages.

The patient remained on a gurney in the hallway of the ED in deteriorating condition until he was admitted to the intensive care unit, by which time his condition was critical. He died the next day.

PLAINTIFF'S CLAIM The ED physician and admitting urologists failed to monitor and treat the patient's active hemorrhage for 9 hours. They didn't order coagulation studies or respond to signs of escalating hemorrhagic shock. They failed to seek timely consults from surgery and interventional radiology.

THE DEFENSE No information about the defense is available.

VERDICT $825,000 Virginia settlement.

COMMENT *Preventing complications of anticoagulation is hard enough; the lack of a timely response in this case made a bad outcome disastrous.*

Were steps taken quickly enough?

SEVERE LOWER ABDOMINAL PAIN prompted a 52-year-old woman to go to the ED. She said she hadn't had a bowel movement in almost a week. The ED physician, in consultation with the attending physician, admitted her to the hospital and ordered intravenous fluids and a soap suds enema, which didn't relieve the constipation. The patient's vital signs deteriorated, and she was crying and restless.

When the attending physician saw the patient almost 3 hours after admission, she had a fever of 101.4°F. He ordered additional tests, a computed tomography (CT) scan, and antibiotics, but didn't order them STAT.

About 1½ hours later, a house physician examined the patient, and, after speaking with the attending physician, transferred her to a step-down telemetry unit. About 1½ hours after the transfer, a nurse called the house physician to report that the patient's condition was worsening. The house physician ordered pain relievers and a second enema but didn't come to the hospital.

Because the patient wasn't in the intensive care unit, no one checked on her again for 3½ hours. When the nurse did check, she found the patient pale, cold, and turning blue. The nurse called the house physician, who came to the hospital. The patient had a fever of 102.4°F and her blood pressure couldn't be measured.

After speaking with the attending physician, the house physician had the patient admitted to the ICU and also ordered a STAT surgical consultation and CT scan. In the meantime, the patient went into cardiac arrest and couldn't be revived. Death was caused by peritonitis with sepsis resulting from a large intestinal obstruction.

PLAINTIFF'S CLAIM The patient showed early signs of sepsis. She should have undergone testing sooner and been transferred to the ICU earlier.

THE DEFENSE The doctors claimed that all their actions were appropriate and that the actions suggested by the plaintiff wouldn't have resulted in the patient's survival.

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The patient remained on a gurney in the hallway of the ED until he was admitted to the ICU, by which time his condition was critical. He died the next day.

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VERDICT $3.8 million Pennsylvania verdict.

COMMENT *Prompt evaluation and monitoring of this patient might have prevented death and a substantial verdict.*

2 analgesic calamities: Death by fentanyl patch . . .

AFTER A WEEK OF INCREASING BACK PAIN, which had begun to shoot down his right leg, a 37-year-old man went to the ED. He was examined and given prescriptions for pain killers, including acetaminophen and hydrocodone, and muscle relaxants and discharged with instructions to return in 3 days for magnetic resonance imaging (MRI).

While he was at the hospital for the MRI, the patient returned to the ED because he was still in pain and his acetaminophen-hydrocodone prescription was running out. The ED physician prescribed a 0.75-mg fentanyl transdermal patch and instructed the patient to put it on his chest.

Three days later, the patient filled the prescription and applied the patch. The following day, his girlfriend found him dead in bed. Postmortem toxicology results showed a blood fentanyl level of 9.85 ng/mL, markedly higher than the therapeutic level. Respiratory failure caused by fentanyl toxicity was cited as the cause of death.

Did the ED physician prescribe an excessive dose of fentanyl or was the patch defective or used incorrectly?

PLAINTIFF'S CLAIM The ED physician prescribed an excessive dose of fentanyl.

THE DEFENSE A defective patch or misuse of the patch caused the patient's death.

VERDICT $1.2 million Indiana verdict.

. . . and methadone

A 36-YEAR-OLD MAN started treatment with a pain specialist for pain arising from a back problem, for which he had taken pain medication previously. The pain specialist prescribed methadone, 360 10-mg tablets. The prescription limited the patient to 2 tablets every 4 hours for a maximum dosage of 12 tablets (120 mg) per day.

Three days after the patient filled the prescription, he was found dead. An autopsy determined the cause of death to be drug toxicity from methadone. At the time the patient died, the bottle of methadone tablets contained 342 tablets, indicating that he had taken only 18 tablets, well within the maximum dosage authorized by the prescription.

PLAINTIFF'S CLAIM The prescribed methadone dosage was excessive for a patient just beginning to use the drug. A proper initial dosage is between 2.5 and 10 mg every 8 to 12 hours for a maximum of 30 mg per day.

THE DEFENSE No information about the defense is available.

VERDICT Confidential Utah settlement.

COMMENT *These 2 cases have a common thread. The effects of opioids are often idiosyncratic. A plan for careful monitoring and follow-up should be prepared at initiation of treatment and when escalating the dosage.* **JFP**

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