"Hemorrhoids" turn out to be cancer

A 49-YEAR-OLD WOMAN, whose husband was on active duty with the US Army, went to an army community hospital in March complaining of hemorrhoids, back pain, and itching, burning, and pain with bowel movements. A guaiac-based fecal occult blood test was positive; no further testing was done to rule out rectal cancer.

The woman was discharged with pain medication but returned the following day, reporting intense anal pain despite taking the medication and bright red blood in her stools. The symptoms were attributed to hemorrhoids, and the patient was given a toilet "donut" and topical medication. Although her records noted a referral to a general surgeon, the referral wasn't arranged or scheduled.

The patient returned to the hospital in April, May, and June with continuing complaints that included unrelieved constipation. A laxative was prescribed, but no further testing was done, nor was the patient referred to a surgeon.

In August, she went to the emergency department because of rectal bleeding for the previous 2 weeks, abdominal pain, blood in her urine, and difficulty breathing. Once again the symptoms were blamed on hemorrhoids even though the patient questioned the diagnosis.

The patient continued to see various providers at the army community hospital for the rest of the year, during which time she turned 50. None of them recommended a colonoscopy despite standard recommendations to begin colorectal cancer screening at 50 years of age and the woman's symptoms, which suggested colorectal cancer.

In March of the following year, the patient consulted a bariatric surgeon in private practice, who recommended evaluating the patient's bloody stools and offered to perform a diagnostic colonoscopy if authorized. The army hospital didn't immediately authorize the procedure, and it wasn't performed.

In late September, the patient consulted a surgeon at the hospital, by which time bright red blood was squirting from her anal region and appeared in the toilet water after every bowel movement. She had never undergone a full colon evaluation.

Less than a week after the surgery consult, the patient's husband was transferred to another military base. Her doctors said that a surgeon at the new base would be told about her medical condition, but that didn't happen.

Five months later, a surgery consultation at the new military base found a rectal lesion extending 8 cm into the rectum from the anal verge. Pathology confirmed stage IIIC mucinous adenocarcinoma that had spread to the lymph nodes. Two years later, after several surgeries, chemotherapy, and radiation, the patient died at 53 years of age.

PLAINTIFF'S CLAIM If testing to rule out rectal cancer, such as a colonoscopy, had been performed earlier, the cancer would have been diagnosed at a curable stage.

THE DEFENSE No information about the defense is available.

VERDICT $2.15 million Tennessee settlement.

COMMENT *Recurrent, unrelenting symptoms should prompt the alert clinician to explore alternative diagnoses.*

For want of diagnosis and treatment, kidney function is lost

A FEBRILE ILLNESS prompted a patient to visit his primary care physician. After 3 months of treatment by the primary care doctor, the patient sought a second opinion and treatment from a federally funded community health clinic, where he was treated for 2 more months. During that time, the patient developed signs and symptoms of impaired kidney function, which laboratory results confirmed.

The clinic staff didn't address the pos-

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

Despite repeated episodes of rectal bleeding and the patient turning 50, none of her health care providers recommended a colonoscopy.

Laboratory tests confirmed that the patient had impaired kidney function, but the clinic staff did not take action.

sible loss of kidney function. Three days after his last examination at the clinic, the patient went to a hospital emergency department, where he was promptly diagnosed with subacute bacterial endocarditis. His kidney function could not be restored.

PLAINTIFF'S CLAIM The primary care physician and the staff at the clinic were negligent in failing to diagnose and treat the kidney issues. Also, they didn't recognize and treat the signs and symptoms of subacute bacterial endocarditis.

THE DEFENSE The primary care physician claimed that the patient's injuries resulted solely from negligence on the part of the clinic staff. He maintained that the patient's kidney function was normal when the man left his care. The federal government, on behalf of the clinic staff, claimed that the primary care physician was at least 50% responsible for the patient's injuries.

VERDICT $1.45 million Texas settlement.

COMMENT *Subacute bacterial endocarditis can be a challenging diagnosis because of the subtlety and variety of presentations. Remember the zebras when confronted with unexplained symptoms and signs.*

Neuropathy blamed on belated diabetes diagnosis

A PATIENT IN A FAMILY PRACTICE was treated by several of the doctors and a physician assistant in the group over about a decade. After the patient developed neuropathy in his arms and legs, he was diagnosed with type 2 diabetes.

PLAINTIFF'S CLAIM Earlier diagnosis of the diabetes would have prevented development of neuropathy. High blood glucose levels identified on tests weren't addressed.

THE DEFENSE Only 3 tests had shown excessive levels of glucose; the patient had many comorbidities that required attention. A special diet had been prescribed that would have helped control glucose levels. This was an appropriate initial step to address a diagnosis of type 2 diabetes.

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VERDICT $285,000 New York settlement.

COMMENT *It's easy to overlook or postpone treatment of apparently less urgent issues such as glucose intolerance. Clear documentation and explicit discussion with patients might help mitigate the risk of adverse judgments.*

Too many narcotic prescriptions

A WOMAN TREATED FOR CHRONIC SINUSITIS by an ear, nose, and throat physician received prescriptions for oxycodone, acetaminophen and oxycodone, and methadone for years to relieve headaches and facial pain. She died at 40 years of age from a methadone overdose. The physician admitted in a deposition that he'd kept on prescribing the medications even after the patient's health insurer informed him that she was obtaining narcotics from multiple providers.

PLAINTIFF'S CLAIM No information about the plaintiff's claim is available.

THE DEFENSE No information about the defense is available.

VERDICT $1.05 million New Jersey settlement.

COMMENT *Strict tracking and oversight of opioid administration is essential. Clear documentation and regular follow-up remain very important.*

The physician admitted in a deposition that he'd kept on prescribing the medications even after the patient's health insurer informed him that she was obtaining narcotics from multiple providers.

Delayed Tx turns skin breakdown into a long-term problem

A NEARLY IMMOBILE WOMAN was discharged from a hospital—where she'd been treated for congestive heart failure, hypertension, diabetes, altered mental status, severe arthritis, and gout—and transported by ambulance to her home. Discharge diagnoses included possible obstructive sleep apnea and hypercapnia. Because the patient needed a great deal of help with activities of daily living, her physician ordered home health services.

Twelve days after discharge, a representative from the home health agency performed an initial assessment in the patient's home, at which time the patient's daughter reported that her mother had developed some skin breakdown on her buttocks that required care. The home health nurse allegedly told the daughter that the agency would need an order from her mother's physician before starting home treatment for the skin breakdown.

The daughter phoned the physician every day for the next few days to get treatment authorization, but the doctor didn't return her calls. The home health agency didn't seek authorization from the doctor.

When the home health nurse returned to the patient's home a week later to begin care, the daughter again mentioned the areas of skin breakdown, which by that time had become pressure sores. The nurse didn't treat the pressure sores. The home health agency tried to contact the patient's physician, who didn't return their calls.

The agency finally received an order to treat the pressure sores 6 days after the home health nurse had begun caring for the patient, by which time the sores were infected and considerably larger. Healing required more than a year of treatment.

PLAINTIFF'S CLAIM As a result of the delay in treating the pressure sores, the patient's condition was worse that it otherwise would have been.

THE DEFENSE The defendants denied any negligence.

VERDICT Alabama defense verdict.

COMMENT *Better communication and coordination of care between home health providers and a patient's medical home are important to provide optimal care—and avoid lawsuits.* **JFP**