Delayed Dx leads to blindness

A WOMAN WITH DISABLING RHEUMATOID ARTHRITIS visited her long-time internist with pulmonary symptoms. Shortly thereafter the 59-year-old patient was diagnosed with lung cancer with a moderate prognosis and underwent surgery.

The following month, the woman complained of jaw pain to her internist. She also reported an "achy" temple to the nurse who saw her initially. The internist surmised that the cause of the pain might be an allergic reaction to dye used in a CT scan the patient had undergone because the patient said the pain had begun immediately after the scan. She was treated with methylprednisolone and the symptoms improved temporarily.

Within a few weeks, the patient complained of vision problems in her left eye. An ophthalmologist to whom she was referred thought the cause might be metastasis of the lung cancer. After an MRI of the optic area, a neuroradiologist reported to the ophthalmologist that the findings were consistent with metastatic cancer.

Before the patient could keep a follow-up appointment with the ophthalmologist, she lost all vision in her left eye. When she called the internist's office for the results of the MRI, she told the person who answered the phone about the vision loss. Her call wasn't returned.

The patient also told the ophthalmologist's office about her loss of vision when she received a call to remind her of her follow-up appointment. The person she spoke to claimed the patient was offered an appointment that same day with another doctor, but declined it.

On the day before the follow-up appointment, the patient lost all sight in her right eye, as well. She received emergency treatment with corticosteroids the next day, but her vision didn't return, leaving her completely blind. A temporal artery biopsy confirmed giant cell arteritis.

PLAINTIFF'S CLAIM The patient had classic symptoms of giant cell arteritis when she saw both the internist and ophthalmologist.

THE DEFENSE No negligence occurred because the patient had additional medical conditions; the patient didn't describe her symptoms effectively and was negligent in failing to seek emergency medical care when she lost vision in her left eye.

VERDICT $1.4 million Washington settlement.

COMMENT *This is a tough case with plenty of blame to go around, but it provides a good reminder to think of temporal arteritis whenever an older patient complains of jaw pain. Sedimentation rate measurements are cheap.*

Lack of vigilance ends badly

SHORTNESS OF BREATH, FATIGUE, AND DIARRHEA prompted a 36-year-old man with diabetes and hypothyroidism to consult his primary care physician. The doctor prescribed levofloxacin and told the patient to return in 4 weeks.

Three days later, the man went back to the physician, reporting weakness, diarrhea, and a fever of 103°F. The physician diagnosed bronchitis and prescribed extended-release amoxicillin tablets. Two days later, the patient went to the emergency department; a chest radiograph showed advanced bilateral pneumonia. He died about 2 weeks later.

PLAINTIFF'S CLAIM The physician was negligent in failing to order a radiograph, admit the patient to the hospital, and prescribe proper medication.

THE DEFENSE No information about the defense is available.

VERDICT $1 million New Jersey settlement.

COMMENT *Shortness of breath, fatigue, and diarrhea in a 36-year-old patient with diabetes sounds potentially serious to me. Presumably the physician diagnosed pneumonia on the initial exam, and one cannot fault him for that diagnosis or the treatment he prescribed. But return in 4 weeks? No way. Such patients require close follow-up and escalation of evaluation and treatment if they're not doing well.* **JFP**

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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