Lung cancer found belatedly despite multiple chest radiographs

DURING AN ANNUAL PHYSICAL EXAMINATION by her primary care physician, a 68-year-old woman with a history of smoking for more than 30 years had an in-house chest x-ray. The physician didn't have a radiologist read the radiograph or order follow-up imaging.

The chest film was repeated the following year. A year after that, the patient developed pulmonary symptoms. A chest x-ray showed an abnormality. The doctor prescribed antibiotics for presumed bronchitis or pneumonia. When the antibiotics didn't relieve her symptoms, he referred her to a radiologist, who reported a large lesion suggestive of advanced lung cancer. Subsequent films confirmed stage IIIB lung cancer. After 16 rounds of chemotherapy, the patient died at age 73.

PLAINTIFF'S CLAIM The doctor missed an obvious lung lesion on the first radiograph; missed the lesion, which had grown and metastasized, on the second x-ray; and misinterpreted late-stage metastatic cancer on the third radiograph as bronchitis or pneumonia. The chest radiographs should have been over-read, especially when they showed an abnormality. A cancer diagnosis at the time of the first chest radiograph would have allowed a 75% possibility of cure with surgery alone. By the time of the diagnosis 2 years later, a surgical cure wasn't possible.

THE DEFENSE The lesion could be seen only on retrospective review of the radiographs. The first and second radiographs were consistent with pulmonary hypertension and didn't necessitate referral to a radiologist or additional imaging. The patient had many comorbid conditions, including obesity, hypertension, and stenosis of the carotid arteries. She also had a family history of heart disease and COPD.

VERDICT $2 million Virginia verdict.

COMMENT *This case illustrates that a simple test, a chest x-ray in this instance, has the potential for litigation if it isn't interpreted accurately and followed up. Failure to appropriately follow up on test results is one of the 2 major patient safety issues for family medicine; the other is medication errors/drug interactions.*

Otitis media? Not likely

A 3-MONTH-OLD INFANT was taken to the emergency department with a fever of 103°F. The ED physician discharged her with a diagnosis of otitis media and a prescription for amoxicillin. He didn't document which ear was infected or what he observed in the affected ear.

The following day, the infant was pale, cool to the touch, and lethargic. She was brought to her pediatrician, then transferred immediately to a local medical center, where she was diagnosed with pneumococcal meningitis, hypoxic brain injury, and hydrocephalus and hospitalized for nearly a month. She was subsequently taken to the hospital 10 times and evaluated by several specialists. The child died of respiratory complications linked to the infection almost 2 years after her initial hospitalization.

PLAINTIFF'S CLAIM The ED physician should have ordered a blood count and urinalysis to rule out bacteremia and meningitis. He should have scheduled a follow-up within 24 to 48 hours of the ED visit.

THE DEFENSE The doctor wasn't negligent; he couldn't have anticipated the infant's clinical course. The bacteremia and meningitis developed after the baby left the hospital, and the causative pneumococcal strain was resistant to amoxicillin.

VERDICT $1.72 million Pennsylvania verdict.

COMMENT *Does otitis media ever cause a fever of 103°F in a 3-month-old? Although no definitive studies exist, I doubt it. Otitis media is a closed-space infection like an abscess, and abscesses rarely cause fever. Furthermore, the physical findings of otitis media, although not recorded in this case, are highly unreliable in a 3-month-old. Attributing a fever of 103°F in a 3-month-old to otitis media is always a bad idea.* **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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