COMMENTARY PROVIDED BY
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Older patients with a fever and no definite source of infection must be handled with great caution.

Missed case of group A strep results in amputation of limbs

A 53-YEAR-OLD WOMAN went to the emergency department (ED) with severe abdominal pain, a rapid heartbeat, and a 101.3° F fever. After 9 hours, the ED physician discharged her around midnight with instructions to contact her gynecologist in the morning for "fibroid issues." Later that day, the patient collapsed at home and was transported back to the hospital. She was treated for septic shock from a group A *Streptococcus* infection and had all 4 of her limbs amputated.

PLAINTIFF'S CLAIM The ED physician, who discharged the patient with a 102.9° F fever, should have spotted the infection and should have spent more time with her—given the complexity of her case. The physician should have given the patient alternative diagnoses, which would have prompted her to pursue other treatment.

THE DEFENSE The defendants denied any negligence.

VERDICT $25.3 million Wisconsin verdict.

COMMENT *Although we are not given many details of this case, I suspect there was a fairly thorough work-up with no specific source of infection discovered. While this was an emergency medicine case, it is a strong reminder that older patients with a fever and no definite source of infection must be handled with great caution.*

Patient dies following "routine" warfarin change

AN 80-YEAR-OLD WOMAN was taking warfarin for chronic pulmonary emboli. She saw her physician for a follow-up visit after being hospitalized for heart failure and shortness of breath. He ordered lab work, which revealed an elevated international normalized ratio (INR) of 3.7. The physician e-mailed a nurse to contact the patient and tell her to reduce her warfarin dosage. The nurse documented that she told the patient and called in a new prescription. Five days later, the patient was admitted to the hospital with a significantly elevated INR and a spinal bleed that caused paralysis. The patient was transferred to a nursing home, where she died 6 months after her initial follow-up visit.

PLANTIFF'S CLAIM The physician's instructions were ambiguous, and a repeat INR should have been performed in 2 or 3 days. The nurse did not properly instruct the decedent and should have notified the family and the visiting nurse of the medication change.

THE DEFENSE The instructions the physician gave were correct and the appropriate plan was to repeat the INR in 13 days. The decedent had managed her warfarin through 11 previous dose changes, so there was no reason to notify the family or visiting nurse.

VERDICT $40,000 settlement.

COMMENT *This case is a reminder of the difficulties one can encounter with warfarin dose adjustments. In view of the small settlement, it does not appear there was much physician liability. Most patients do not bleed with an INR of 3.7. It certainly would have been prudent to recheck in 2 to 3 days, however.*

Severe headache, but no CT scan, results in death

A HOSPITALIZED 57-YEAR-OLD MAN complained of a severe headache that he described as a 10 on a scale of 1 to 10. At the time, he was taking warfarin. After 6 days, he died from a brain herniation and hemorrhage.

PLAINTIFF'S CLAIM Despite the patient's complaint of severe headache, the physician failed to order a computed tomography scan of the head.

THE DEFENSE The patient's headaches had waxed and waned and were associated with a fever of recent onset. There were no focal neurologic deficits to suggest that there was any problem with the brain. The brain hemorrhage was a sudden and acute event.

VERDICT $250,000 Illinois verdict.

COMMENT *Have a high index of suspicion for intracranial hemorrhage in patients taking warfarin with severe headache. What more needs to be said?* **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.