In Appendicitis Case, Patient Sues Clinic, Clinic Sues NP

A 17-year-old girl with diminished appetite, abdominal pain, and vomiting presented to a pediatrics clinic in New York, where she was examined by an NP. She was found to have hematuria as well, and the NP diagnosed viral gastroenteritis.

Eight days later, the patient returned to the clinic with worsening pain. The pediatrician who examined her had her transported to a hospital, where a ruptured appendix was diagnosed. The patient underwent immediate surgery, which included resection of portions of her colon and intestines.

Despite a good recovery, the patient claimed that she suffers residual gastrointestinal dysfunction. She further claimed that the NP should have diagnosed appendicitis during her initial visit, which would have allowed for less invasive treatment.

Initially, the plaintiff brought suit against the clinic and several employees, but not the NP. She later moved to add the NP, but that motion was denied due to the statute of limitations. The clinic then impleaded the NP, arguing that it was her negligence in failing to diagnose the appendicitis.

The matter proceeded to trial against the NP and the clinic. The defendants claimed that the plaintiff's symptoms did not suggest appendicitis at the time of the NP's examination.

OUTCOME

A defense verdict was returned.

COMMENT

I used to tell students, "There are only two things in medicine that you need to know well: the common and the dangerous. For everything else, there is time." I realize now that I sound like that guy from the Dos Equis commercial.

Consider this, however: If we don't remember the difference between polymyositis and polymyalgia rheumatica, who cares? In such cases, we have time for review—and the patient will be better served by a clinician who has the intellectual curiosity to review conditions that he or she hasn't seen in a while.

But the diseases that are both common and dangerous require our full proficiency. Basic competence requires us to be well versed in common diseases. And dangerous conditions, even if relatively rare, must be recognized and managed immediately. Entities that are common *and* dangerous—such as appendicitis—should enter our thoughts often.

In this case, we have a 17-year-old girl presenting to an outpatient clinic setting with abdominal pain, vomiting, and anorexia. Unfortunately, we are not given some important historical information, including duration and location of the pain and the presence or absence of pain migration. Physical exam findings are not described.

The trouble with appendicitis is that there is no single sign or symptom that can effectively diagnose it or exclude it from the differential. When evaluating a patient in a setting in which real-time laboratory testing is not generally ordered, clinicians must distinguish between self-limiting and dangerous abdominal pain. Where does that leave us in this case? Abdominal pain and vomiting are common, and ill patients frequently report anorexia.

Other clinical features associated with appendicitis may be more helpful. For example, pain migration has been described as "the most discriminating feature of the patient's history,"[1] with a sensitivity and specificity of approximately 80%.[2] When present, psoas sign is fairly specific (0.95) but not sensitive (0.16).[3]

When evaluating patients in an outpatient setting, we have a snapshot of a disease process—a still frame of a movie. We are told what happened up to that point (with varying degrees of accuracy). But like the patient, we don't know what will happen after he or she leaves the office: The still frame is gone, but the movie continues.

It can be helpful to inform patients of the concerning diagnoses in your differential and alert them to patterns of clinical progression that warrant return or immediate emergency department evaluation. Calling the patient to see how he or she is doing can be very useful for clinicians and generally

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highly valued and appreciated by patients. Here, if gastroenteritis were suspected, a phone call after a few hours of antiemetic and rehydration therapy may have been helpful to determine if the patient's symptoms had improved. This, of course, would not be conclusive—but at least it would give the clinician additional information and the patient additional comfort.

In this case, the jury was persuaded that the NP provided good treatment and acted within the standard of care. Diagnosing appendicitis can be tricky, even under the best circumstances. The NP's defense was probably aided by good documentation showing that appendicitis seemed less likely at the time of her evaluation. Ultimately, she performed well enough that her care withstood scrutiny from the plaintiff, the plaintiff's expert witness, and eventually, her own practice.

This case was interesting from a legal perspective in that the plaintiff originally failed to file suit against the NP—probably resorting to liability under the theory of *respondeat superior* (generally, employer liability for employee actions). While the plaintiff was unsuccessful in adding the NP later, due to the statute of limitations, the NP was brought into the case by her own practice, through a procedure known as *impleader*. An impleader action is brought by a co-defendant. Under typical impleader rules, the defendant becomes a "third-party plaintiff" and brings suit against a "third-party defendant" (in this case, the practice and the NP, respectively).

IN SUM

Always keep important diagnoses in mind, and document well. Anticipate a changing clinical course, and instruct patients on how to respond to potential changes. In certain cases, we are well served to pick up the phone, check on the patient, and make the presentation less of a static picture and more of a dynamic movie. **—DML** **CR**

REFERENCES

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