

Failure to Diagnose Appendicitis

A 17-year-old man experiencing abdominal pain was taken to a Texas emergency department (ED). The emergency physician examined the young man and discharged him the same day, with instructions to follow up with a family physician or with a suggested internist. That evening, a family member reached the internist's answering service, but the plaintiffs had no direct contact with the internist or his office.

The young man's appendix burst eight days later. He spent a week in the hospital having the abscess drained. Two months after his initial ED visit, he underwent an open laparotomy and recovered well.

The plaintiffs claimed that the emergency physician failed to diagnose appendicitis and should have either run more tests or admitted him. The plaintiffs claimed that attempts were made to make an appointment with the internist for the day after the ED visit, but the answering service told them that the internist was unavailable for the next two weeks.

The emergency physician claimed that the plaintiff failed to follow the discharge instructions and that there were no signs or symptoms of appendicitis during the emergency visit. The answering service denied any negligence.

Outcome

According to a published account, a defense verdict was returned.

Comment

Clearly, this patient presented early in his disease process, since the appendix did not rupture until eight days following discharge. In the early stages of appendicitis, the symptoms are frequently non-specific and include periumbilical abdominal pain, nausea, low-grade fever, and decreased appetite. This results in a very wide differential diagnosis, and testing and imaging frequently produce "normal" results at this stage. It is only with some passage of time (and progression of disease) that the clinician can then make the diagnosis.

It is appropriate to instruct the patient with a non-

acute abdomen to follow up for reexamination within 12 to 24 hours. This case does emphasize, however, the importance of ensuring the patient can follow up with another provider; if this is not possible, having the patient return to the ED for reexamination can be the best strategy for both the patient and the physician. **FLC**

Was a Cardiac Work-Up Warranted?

A 43-year-old man experienced pain in his neck and upper back and sought medical attention at an Indiana ED. At the time of his visit, he had thoracic back pain radiating into his neck and shoulders. An emergency physician evaluated him and diagnosed mild cervical spasms. The physician prescribed pain medications and instructed the patient to follow up with his family physician. The man was sent home after being at the hospital for a little more than an hour and after being under the emergency physician's care for about 15 minutes.

That evening, the man was found unresponsive and could not be revived. An autopsy found the cause of death to be arteriosclerotic heart disease.

The plaintiff alleged that the emergency physician should have performed a cardiac work-up, particularly in light of the patient's history of smoking and elevated blood pressure and cholesterol level. The plaintiff claimed that the decedent's symptoms and history placed him in a high-risk category for coronary disease and acute coronary syndrome and that he should have been admitted to the hospital and monitored.

The defendant claimed that the decedent had denied any history of cardiac problems, hypertension, or respiratory problems and that the diagnosis and treatment given were reasonable. The defendant also claimed that the death was due to the underlying condition, not acute coronary syndrome.

Outcome

A defense verdict was returned.

Comment

As emergency physicians, we are aware that many patients will not present in the typical fashion with an

acute coronary syndrome. Atypical presentations are seen more commonly in women, the elderly, nonwhite patients, and those with a history of diabetes mellitus. Other than race, which is unclear in this case, this patient had none of the usual risk factors for an atypical presentation.

While it is important for the emergency physician to review the risk factors for coronary artery disease (ie, hypertension, diabetes, hypercholesterolemia, smoking, and family history of coronary artery disease) in patients that may be presenting atypically, it is the responsibility of the patient to tell us the truth. This was a very atypical presentation in an atypical patient. **FLC**

Was Woman Prematurely Removed From Backboard?

A 75-year-old woman was in an auto crash. Paramedics arrived at the scene of the accident, placed her in a cervical collar, and immobilized her on a backboard. She was then rushed to an Illinois ED. The treating emergency physician ordered an x-ray and a CT scan, both of which revealed an unstable spine.

The plaintiff claimed that miscommunication between a radiologist and the emergency physician caused the cervical collar to be removed and the patient taken off the backboard. The plaintiff contended that this led to a spinal cord injury, which resulted in quadriplegia. The woman died a few months later.

Outcome

According to a published account, a \$3.2 million settlement was reached.

Comment

Worse than failing to order an indicated radiographic exam is failing to obtain, appreciate, or act on the findings. This includes both miscommunications with the radiologist and failure to reconcile preliminary findings—your own, or those of a radiology resident—with final interpretations.

Also, in the past, different practice standards were

taken into account when emergency physicians in nonacademic settings had to rely initially on their own preliminary interpretations. But now that hospitals are employing “nighthawk” and/or remotely located radiologists to interpret studies in real time, during off-hours, the standards are becoming more uniform. **NF**

Failure to Test for Sepsis in IV Drug User With Neck Pain

A 38-year-old woman with a history of IV drug abuse went to a Michigan ED complaining of neck pain. She was diagnosed with neck strain and discharged. Four days later, she went to another hospital with similar complaints and was diagnosed with overwhelming sepsis. She died shortly thereafter.

The plaintiff claimed that the defendant failed to perform proper testing to diagnose sepsis and treat it in a timely manner. The plaintiff claimed that sepsis testing is required in IV drug users, even in the absence of symptoms consistent with sepsis.

The defendant claimed that no workup for sepsis is required when there are no symptoms present. The defendant also claimed that the sepsis was caused by an IV injection 24 to 48 hours before the patient died.

Outcome

According to Michigan Trial Reporter, a defense verdict was returned.

Comment

Although a defense verdict was returned in this case, it is important to remember that when evaluating IV drug abusers for pain of uncertain origin, an infectious etiology must always be considered and addressed. Difficulties in caring for such patients (and perhaps a lack of sympathy for them afterward) should not deter you from practicing emergency medicine to the highest standards. **NF**

Cases reprinted with permission from *Medical Malpractice Verdicts, Settlements and Experts*, Lewis Laska, Editor, (800) 298-6288.