MALPRACTICE COUNSEL

Commentary by Francis L. Counselman, MD, Associate Editor-in-Chief | Neal E. Flomenbaum, MD, Editor-in-Chief

Failure to Keep Man in ED on Reports of Ingestion of Unprescribed Hydrocodone and Klonopin

A 24-year-old man began acting strangely at dinner. His breathing became shallow, and he stopped breathing at one point. He told his wife that he'd taken two of her hydrocodone tablets and one klonopin tablet from her uncle's house before coming home. He said he'd taken the drugs about a half hour earlier, due to stress and headaches.

Over the next couple of hours, the man continued to appear drowsy and have trouble breathing. His lips turned slightly blue, his speech became more slurred, and his breathing stopped for longer periods of time. The man's wife called a poison control center and was told to call a local ED. When she called the ED, she was told to bring him in, if she was concerned. She called and asked her mother-in-law to take him to the ED, so she could stay home with their children.

The patient arrived at the Missouri ED shortly after midnight—about three and a half hours after the symptoms began. The man told the clerk that he thought he took two hydrocodone and one klonopin. He complained to the triage nurse that the room was spinning, he felt sedated, and he had been vomiting.

An emergency physician examined the decedent about 15 minutes later. According to the physician's notes, the man told him that his wife had insisted he come to the ED because he was breathing abnormally. The notes did not indicate that the man said he'd stopped breathing. At trial, however, a nurse testified that she had heard the man tell the physician that his wife had seen him stop breathing.

The man was discharged about 10 minutes after seeing the physician, with a diagnosis of medication reaction. His discharge instructions were to take only medications prescribed to him and to go home and go to bed. When he got home, his wife helped him into bed and watched him sleep until she fell asleep between 3 and 3:30 AM.

Around 5 AM, she woke up and found that her husband had aspirated his vomit and wasn't breathing. Paramedics were called, but they were unable to resuscitate him; he was pronounced dead shortly after 6 AM.

An autopsy revealed hydrocodone and methadone in the decedent's blood, but showed no trace of klonopin. The methadone level was consistent with the lower limit of reported fatal levels.

The plaintiffs argued that the decedent had mistakenly taken methadone instead of klonopin. While the health care providers could not know this, the plaintiffs claimed that the decedent's symptoms and complaints required that he be kept in the ED for four to five hours of observation.

The plaintiffs also claimed that the fact that the decedent had stopped breathing was particularly significant, because klonopin and hydrocodone in small amounts do not have this effect. The defendants argued that there was no negligence, that the man was not showing symptoms consistent with methadone intoxication, and that the man had taken methadone after his discharge. The plaintiffs claimed that all the methadone had been ingested prior to eating dinner; relying on the autopsy findings of a significant amount of food in his stomach and the fact that methadone inhibits the stomach from emptying.

Outcome

According to a published account, a $1,627,690 verdict was assessed, with a finding of 65% fault to the decedent and 35% of the fault to the defendant. A confidential settlement was reached.

Comment

Serious adverse reactions—especially breathing problems—following the nonprescribed use of opioids and other CNS depressants almost always mandate hours of patient observation after the patient is symptom free in the ED. This is true even if the patient insists on leaving. **NEF**

Failure to Promptly Diagnose and Treat Cauda Equina Compression

A 55-year-old woman went to a Massachusetts ED with complaints of low back pain, left-side leg neurologic deficits, and bladder dysfunction. The attending physician ordered an MRI, but it could not be completed due to the patient's inability to lie flat for the test. When the physician's shift ended, another emergency physician took over the patient's care and ordered another MRI, which could not be completed either, despite some sedation.

A third MRI was conducted later, under general anesthesia. It showed severe cauda equina compression at L2-L4 and a compression of the spinal nerves in the lower back. The plaintiff underwent emergency surgical decompression shortly after the MRI.

By the time of surgery, the plaintiff claimed she had become paralyzed below the waist on the left side and had lost complete bowel and bladder function on the right side. After surgery, the plaintiff continued to have impaired motor function with loss of sensation in her legs, as well as bowel and bladder dysfunction.

The plaintiff alleged negligence through the failure to timely and accurately diagnose her condition, failure to complete the MRI in a timely manner, and the failure to consult with a neurologist or neurosurgeon. The defendants denied any negligence.

Outcome

A defense verdict was returned.

Comment

Cauda equina syndrome is commonly caused by a massive central disc herniation and is characterized by low back pain, saddle anesthesia (decreased sensation of the perineum), bilateral sciatica, bowel and bladder dysfunction (usually urinary retention first), and variable motor and sensory loss in the lower extremities. The physicians involved in this case clearly recognized the problem and ordered the appropriate test, an MRI. While back pain is usually present, it is rare that general anesthesia is required to obtain the imaging study. Treatment is surgical decompression. This is an unfortunate case, but its outcome is not due to lack of timely recognition. **FLC**

Failure to Diagnose Detached Retina in Man's Only Eye With Vision

A 39-year-old man presented to a New Jersey ED with reports of spots and flashes and the loss of peripheral vision in his left eye. He was blind in the right eye due to a childhood incident. The attending physician gave the patient medication for elevated blood pressure and told him to see an ophthalmologist. The man saw an ophthalmologist four days later, at which time a detached left retina was diagnosed. Surgery to repair the retina was only partially successful, and the plaintiff is now legally blind with *20/200* vision in the left eye.

Outcome

According to a published account, a $1.25 million settlement was reached.

Comment

Retinal detachment usually presents as some combination of decreased vision, floaters, flashing lights, and visual field cuts (like a curtain being pulled up or down). It is normally painless. Retinal detachment is usually suspected based on the history; physical exam can be unremarkable unless it is a large detachment.

For those patients with visual disturbance(s) in their only functional eye, extra vigilance is required to preserve sight. Patients who present with complaints, as above, require a visual acuity, direct fundoscopic, and slit lamp examination. If retinal detachment is suspected (or diagnosed) following examination, an ophthalmology consult should be obtained to ensure timely follow-up within 24 hours. Treatment includes operative repair or photocoagulation. **FLC**

Failure to Perform CT Scan and Diagnose Appendicitis in Elderly Man

An elderly man was brought to a Minnesota hospital ED by his wife. An abdominal x-ray was performed,

and lab work was ordered. The defendant emergency physician diagnosed prostatitis, despite the patient's complaints of lower abdominal pain. The defendant claimed that he did not believe the plaintiff had appendicitis because he had no guarding or rebound on palpitation.

About 10 days after this ED visit, the plaintiff returned with the same complaints but with increased pain. He was seen by a different physician, who immediately ordered a CT scan and diagnosed a ruptured appendix, cecum, ileum, and possibly peritonitis. The plaintiff was transferred to another hospital for emergency surgery.

In surgery, a rupture of the appendix, ileum, and cecum, along with peritonitis, was found. The plaintiff had an ileostomy, which was not reversible due to the location of the ostomy bag. This was necessitated by the emergency surgeon's only location option at the time of surgery. The plaintiff spent a month in ICU and underwent a lengthy rehabilitation period.

Outcome

A $350,000 settlement was reached.

Comment

Whether or not practicing surgeons have decided that abdominal CT is now part of the standard of care for evaluating acute surgical abdomens, it is even more important in the elderly who, as in this case, tend to have few, if any, pathognomonic signs of abdominal catastrophes. Moreover, the radiation exposure from radiographs in this age-group should not be an issue. **NEF**

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