MALPRACTICE COUNSEL

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Failure to Timely Perform CT Scan and Diagnose Abdominal Aortic Aneurysm

An 80-year-old man was transported by ambulance to a Virginia emergency department in May 2008. He had severe back and right hip pain, nausea, and vomiting. He was awake and alert and screaming for morphine. He gave a history of hypertension, longtime tobacco use, chronic back pain, and COPD. His two adult daughters were at his bedside. The defendant emergency physician ordered a series of lab tests and radiology studies. All of the results were normal.

Four and one-half hours after the man's arrival, the emergency physician called the defendant internist and asked him to assess the patient for admission. The internist was at the bedside within 15 minutes. After two and a half hours, while still in the emergency department, the man became acutely hypotensive and tachycardiac. A "stat" CT scan confirmed a ruptured abdominal aortic aneurysm (AAA). The man was airlifted to another hospital for emergent endovascular aneurysm repair. He died shortly after surgery.

The plaintiff alleged negligence by the emergency physician and internist for failing to timely diagnose the AAA, order a CT scan earlier, and transfer the patient sooner. The plaintiff maintained that a transfer prior to the rupture would have prevented the death.

The emergency physician contended that the decedent's presentation was not consistent with an AAA. The internist claimed that while the AAA was in the differential diagnosis, there was a low index of suspicion, since the decedent did not give a history of such an aneurysm. Evidence was presented that the decedent and the decedent's daughter had known of the aneurysm since 2004 and that a CT scan had been recommended every six months.

Outcome

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

Comment

Beware of back and flank pain in elderly men with a history of hypertension and tobacco use. While degenerative joint disease, muscle strain, kidney stone, and infection may be in the differential diagnosis, AAA should be as well.

It is not clear from the case description why the emergency physician never obtained the history of the AAA (known for four years). This certainly would have placed AAA at the top of the list and resulted in a more timely diagnosis. As the use of bedside ultrasound in the emergency department increases, it is hoped that cases such as this one will become more rare. **FLC**

Failure to Provide Treatment to Woman With Abdominal Pain

A 25-year-old woman with severe pain in the abdomen, side, and back sought care at an emergency department in southern Nevada in November 2009. She was not given any medical attention for about six hours. Eventually, tests were performed and she was determined to be pregnant. By the time the results were returned, however, the patient had left and gone to another emergency department, where she was not seen because she did not want to fill out any paperwork.

She then went home, where she gave birth to a girl who weighed 1 lb 6 oz. Emergency medical technicians transported her and the child to an emergency department, where the child was pronounced dead. It was estimated that the plaintiff had been about six months pregnant when she gave birth.

The plaintiff alleged negligence and violation of the Emergency Medical Treatment and Active Labor Act (EMTALA). The plaintiff claimed that pregnancy was not considered in her first emergency department visit despite the fact that pregnancy should be considered in any woman of childbearing age with complaints of abdominal pain. The plaintiff was about to obtain video footage from the first emergency department showing the plaintiff and her fiancé (the father of the child) pleading with emergency department staff for help. An eyewitness who was in the emergency department at the time claimed that she was surprised by the nursing assistant's coldness; the eyewitness said that she and other patients requested that the plaintiff be seen before them.

The hospital claimed that its response was proper, considering that the emergency department was ex-

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tremely busy at the time. The defendant emergency physician maintained that the child would have died in any event due to an untreatable placental infection.

Outcome

The hospital settled for a confidential amount prior to trial. According to a published account, a $225,000 settlement was reached.

Comment

This case illustrates a problem that emergency physicians know all too well: prolonged emergency department wait times can result in increased patient morbidity and mortality. While it is unlikely that the outcome of this case could have been different, nobody, including physicians, nurses, or patients, wants prolonged emergency department wait times.

While the problem is clear, solutions are much less so. Some measures to partially address this problem include placing your best nurses in triage (rather than new, inexperienced nurses) to appropriately assess patients; and re-triaging patients in the waiting room after a certain time period has elapsed (eg, four hours). These, however, are a Band-Aid approach to a much larger problem—timely access to primary care physicians, family medicine physicians, internists, and pediatricians. **FLC**

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