WHAT'S THE VERDICT?

Medical judgments and settlements

Lack of CT follow-up delays cancer diagnosis

SEVERAL WEEKS OF ABDOMINAL PAIN in the lower left quadrant prompted a 58-year-old woman to visit her doctor in March. A colonoscopy performed in July showed 2 small polyps, which were removed. The woman returned in August complaining of feeling weak and again in early September with pain and rectal bleeding. An abdominal computed tomography (CT) scan performed 11 days later revealed a 4 × 3-inch left pelvic mass.

Believing that the CT results suggested an inflammatory process, the doctor prescribed antibiotics. The patient subsequently developed anemia, but didn't undergo small bowel follow through and barium enema because of equipment failure and scheduling difficulties. She was told to diet and exercise and follow up in 3 months. She returned in a few days with the same complaints and was started on Levaquin and Flagyl.

The patient was seen again the following May, 8 months after the CT scan. A barium enema and small bowel follow through performed in July were negative.

In November, the patient went to a hospital complaining of abdominal pain. A CT scan showed a diffuse abdominal and pelvic mass; a needle biopsy diagnosed a gastrointestinal stromal tumor. Disease was widespread; the patient's chance of survival was estimated at <50%.

PLAINTIFF'S CLAIM A diagnosis should have been made at the time of the first abdominal CT scan.

DOCTOR'S DEFENSE No information about the doctor's defense is available.

VERDICT $700,000 Virginia settlement.

COMMENT *Whenever a mass—potentially cancer—is involved, effective follow-up is key. Even when the risk is deemed small, repeat imaging is usually the prudent path.*

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COMMENTARY PROVIDED BY **Jeffrey L. Susman, MD,** Editor-in-Chief

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PE recognized too late

TWO MONTHS AFTER UNDERGOING KNEE SURGERY, a 35-year-old man was hospitalized for diverticulitis. A week and a half later, he went to an emergency room complaining of chest pain, shortness of breath, and heart palpitations. The ER physician performed an electrocardiogram (EKG), which he read as normal. He diagnosed a panic attack, prescribed lorazepam, and discharged the patient.

Two days later, the patient visited a psychiatrist complaining of panic attacks. Believing that the man had a medical condition, the psychiatrist told him to see his personal doctor or go to an ER. The patient went to his primary care physician, who suspected angina and admitted him to a local medical center.

In the 12 hours before he was seen, the patient's pain and breathing problems increased and his calf swelled. By the time his doctor and a cardiologist noted the swelling and diagnosed pulmonary embolism (PE), a clot had traveled to his heart. He was airlifted to another hospital, where he died within 8 hours.

PLAINTIFF'S CLAIM The doctors were negligent in failing to promptly diagnose and treat PE. The ER physician failed to read the EKG correctly and take a detailed history; he diagnosed a panic attack without ruling out PE. The patient's increased heart rate, shortness of breath, and abnormal EKG should have raised suspicion of an embolism.

DOCTORS' DEFENSE The diagnosis was reasonable.

VERDICT $1.26 million Pennsylvania verdict.

COMMENT *PE should be in the differential diagnosis of any patient with chest pain or shortness of breath.*

"GERD" turns out to be heart disease

INDIGESTION AND PAIN IN HIS ARMS FOR 2 MONTHS led a 38-year-old man to consult his primary care physician, who diagnosed gastroesophageal reflux disease (GERD) and prescribed medication. The patient called the doctor to express satisfaction with the reflux medication and symptom relief, but the doctor doubled the dosage and told the patient he would refer him to a gastroenterologist. (The plaintiff later claimed that the medication never worked, and other medical records appeared to support that claim.)

About 6 weeks after the initial visit, the primary care physician referred the patient to a gastroenterologist, who also diagnosed GERD and scheduled an endoscopy. The gastroenterologist noted that a cardiac stress test should be considered if the symptoms worsened or the endoscopy was negative.

Six days later, before the endoscopy, the patient died after complaining of chest pain and temporary loss of vision. An autopsy attributed death to a fatal arrhythmia caused by idiopathic cardiomyopathy. The pathologist who performed the autopsy testified that the patient had dilated cardiomyopathy with a noncontributing component of ischemic change.

PLAINTIFF'S CLAIM The doctors failed to diagnose and treat the patient's cardiac condition. The patient should have been referred for an EKG or other cardiac evaluation when he was first seen; doing so would have revealed the cardiomyopathy, which could then have been treated.

DOCTORS' DEFENSE The patient's symptoms were consistent with GERD and didn't require cardiac testing. The autopsy report and evidence from the tissue slides were inconsistent with heart disease.

Additionally, the gastroenterologist claimed that cardiac disease could not have been diagnosed and treated in 6 days even if he'd referred the patient for evaluation. He also claimed that the patient died of a stroke.

VERDICT $2.3 million Virginia verdict against the primary care physician only.

COMMENT *The misdiagnosis of cardiac disease is common; remember coronary artery disease when confronted with unresponsive GERD.* ■

FAST TRACK

The primary care physician and gastroenterologist both diagnosed the patient with GERD. Weeks later, the patient suffered a fatal arrhythmia.

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.*