COMMENTARY PROVIDED BY
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Bladder and bowel function lost to cauda equina syndrome

LOWER BACK PAIN developed in a 34-year-old woman around the time she had fibroids removed by her obstetrician-gynecologist. The woman reported the pain at her first postoperative visit. The OB/GYN offered treatment, but the patient traveled to the Dominican Republic for 2 months instead.

The month after the patient's return, she experienced sharp pain in her legs and temporarily lost control of her bladder and bowels. Eight days later, she returned to the OB/GYN complaining of pain and occasional urinary incontinence. The doctor diagnosed neurogenic bladder, prescribed medication, and told the patient to follow up in a week. At some point over the next few days, the patient could not urinate, but didn't return to the doctor for a week. The doctor catheterized her and drained about 3000 mL of urine. He then sent her to a hospital.

The hospital staff suspected cauda equina syndrome and consulted a neurologist, who concluded that the patient didn't have the condition. The patient refused a magnetic resonance imaging (MRI) scan at that time because she didn't think she could assume the required position. The patient ultimately underwent an MRI scan a week later. Another neurologist reviewed the scan and diagnosed cauda equina syndrome. Despite surgery, the patient has permanent bowel and bladder dysfunction.

PLAINTIFF'S CLAIM The defendants were negligent in failing to diagnose cauda equina syndrome earlier.

DOCTORS' DEFENSE The OB/GYN claimed that the patient didn't undergo the recommended follow-up treatment after surgery. The neurologist claimed that his examination didn't reveal any objective indications of cauda equina syndrome.

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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.

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VERDICT $1.5 million New York settlement.

COMMENT *Suspicion of cauda equina demands prompt imaging and neurologic consultation. Failure to do so can lead to devastating consequences.*

Failure to suspect stroke results in brain damage

A 37-YEAR-OLD WOMAN went to a gastroenterologist for a postoperative consult. Her blood pressure was 180/100. Her medical history included recent symptoms of blurred vision, dizziness, nosebleeds, and tingling in the face and right arm. She was taking medications that increased her risk of stroke, had preexisting Crohn's disease, and smoked.

The day after the doctor visit, the woman went to a hospital, where she was diagnosed with a stroke from a left cerebral artery infarction and dissection with clot formation in the left internal carotid artery. She suffered brain damage with aphasia and right hemiparalysis.

PLAINTIFF'S CLAIM The doctor was negligent for failing to diagnose the patient's condition and provide treatment.

DOCTOR'S DEFENSE The doctor denied any negligence.

VERDICT Indiana defense verdict.

COMMENT *In this age of thrombolysis and aggressive stroke management, rapid diagnosis and intervention has gone from an academic exercise to a standard of care.*

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Suspicious finding + no follow-up = lawsuit

CONGESTIVE HEART FAILURE and atrial fibrillation prompted the hospitalization of a 79-year-old woman. A radiograph showed a density in the upper left lobe of her lung, and another x-ray was ordered. The same radiologist reviewed both films and recommended that the patient undergo a third radiograph after discharge from the hospital. Although informed of the radiologist's findings and recommendations, the patient's physician didn't order a radiograph or computed tomography (CT) scan. The patient wasn't notified of the findings.

The density was still visible on radiographs taken about 19 months after the original films. Seventeen months later, the patient complained of left chest wall discomfort and had another radiograph, which showed the density and a collection of pleural fluid. A CT scan suggested cancer. The patient was ultimately diagnosed with stage-III, poorly differentiated adenocarcinoma—which has a very low survival rate—in her left pleura. Because of the prognosis, a biopsy wasn't performed.

PLAINTIFF'S CLAIM The defendant was negligent in failing to follow up on the radiologist's report. Proper diagnosis and treatment at the time of the original radiographs would have meant targeting the cancer at stage I, when the survival rate would have been much higher.

THE DEFENSE The primary lung cancer wasn't in the upper left lobe, and the density was probably only a scar. The cancer was likely somewhere else, possibly the gastrointestinal tract.

VERDICT $500,000 Massachusetts arbitration award.

COMMENT *Poor handoffs in care, especially follow-up of abnormal imaging tests, such as a lung or breast mass, remain an all too common cause of malpractice claims.*

Doctor crosses line, pays the price

A WOMAN BECAME SEXUALLY INVOLVED with her family practitioner, an affair she claimed the doctor initiated while he was treating her for anxiety and depression. She said the physician-patient relationship had begun more than a year before the sexual involvement when she learned that her infant daughter had cerebral palsy; the doctor prescribed paroxetine and bupropion.

The affair ended about 10 months after it began. The patient said it caused her marriage to deteriorate.

PLAINTIFF'S CLAIM The patient couldn't exercise independent judgment because she was experiencing eroticized transference; the doctor mishandled the transference phenomenon.

THE DEFENSE The sexual relationship was brief and ended 6 months before the doctor treated the patient.

VERDICT $416,500 net verdict in New York.

COMMENT *It's never prudent to become involved sexually with a patient.*