



**COMMENTARY
PROVIDED BY**

Jeffrey L. Susman, MD,
Editor-in-Chief



The doctor prescribed antibiotics and pain medication for a stubborn case of “pneumonia,” until the patient’s spine collapsed.

Stubborn pneumonia turns out to be cancer

AFTER RECEIVING ANTIBIOTICS FOR PNEUMONIA, a 37-year-old man improved but didn’t fully recover; his radiographs didn’t return to normal. He’d never smoked cigarettes.

During the several months after the pneumonia, the patient’s doctor ordered repeat radiographs and prescribed antibiotics and pain medication. When the patient’s spine collapsed, the doctor diagnosed metastatic lung cancer. The patient received palliative treatment and ultimately died.

PLAINTIFF’S CLAIM The doctor was negligent in failing to change the patient’s treatment after 2 or 3 months and failing to order a computed tomography (CT) scan or refer the patient to a pulmonologist.

THE DEFENSE No information about the doctor’s defense is available.

VERDICT \$1.25 million Washington settlement.

COMMENT *I’d like a nickel for every case of delayed diagnosis of lung cancer based on clearly abnormal chest radiographs. We can argue about whether diagnosis would make a difference, but we need to follow up assiduously on abnormal radiographs and document our actions.*

Rapidly raised serum sodium leads to osmotic demyelination

A 60-YEAR-OLD WOMAN went to her local medical center complaining of a cough for the previous 2 weeks, decreased appetite and oral intake, and generalized body aches. She first went to urgent care, where laboratory studies showed critically low levels of sodium and potassium. Based on these results, the woman was told to go to the facility’s emergency department (ED).

In the ED, she reported feeling very weak and tired and having body aches and pain. When laboratory tests showed that her sodium and potassium levels had fallen further, she was admitted to the intensive care unit (ICU).

The doctor who saw the patient in the

ICU ordered intravenous fluids with normal saline and potassium supplements. He then had the patient admitted to the ICU at another hospital. The physician at that hospital continued to prescribe IV sodium and potassium until the patient was discharged with diagnoses that included hyponatremia and hypokalemia.

Ten days later, the patient returned to the ED complaining of slurred speech for the previous 2 days. A CT scan of her head showed a possible basilar tip aneurysm. Subsequent magnetic resonance imaging with and without contrast and intracranial magnetic resonance angiography confirmed a basilar tip aneurysm and showed findings suggestive of osmotic demyelination. Neurologic examination revealed dysarthria, right upper extremity weakness without spasticity, and periods of confusion interspersed with lucid intervals.

A subsequent neurologic consultation confirmed osmotic demyelination syndrome (formerly known as central pontine myelinolysis). Neurologic examination at that time found continued mild dysarthria, problems standing, inability to walk unsupported, mild oral and pharyngeal dysphagia, and language and writing deficits.

PLAINTIFF’S CLAIM The patient’s sodium level was increased at an inappropriately rapid rate, which caused neurologically devastating osmotic demyelination. Serum sodium should have been monitored every 4 hours during the first 24 hours of treatment. The plaintiff also alleged negligence in continuing normal saline after the patient’s serum sodium was measured at 112 mEq/L.

THE DEFENSE The treatment provided was appropriate.

VERDICT \$550,000 California settlement.

COMMENT *Avoiding osmotic demyelination*

CONTINUED ON PAGE 244

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.

Online at

THE JOURNAL OF **FAMILY PRACTICE**

If you're not visiting us at jfponline.com, here's what you're missing

THIS MONTH

Type 2 diabetes and CV risk: A closer look at the new studies

John Hickner, MD, MSc,
Department of Family Medicine, Cleveland Clinic

Blog discussion: On January 1, 2010, CMS implemented a new policy on consultation billing; how does this change affect you?

Join the discussion on our blog at:
journaloffamilypractice.blogspot.com

GET UPDATES FROM US ON

FACEBOOK  AND TWITTER 

www.facebook.com/JFamPract <http://twitter.com/JFamPract>

ONLINE EXCLUSIVES (See left-hand navigation bar.)

- Insulin therapy for type 2 diabetes: Making it work
- Hospitalist Rounds: Fever, cough, and hypoxia in a pregnant woman

INSTANT POLL

Do you prescribe nitrofurantoin for the treatment of UTIs in women of reproductive age?

WEEKLY

PHOTO ROUNDS FRIDAY

Enjoy our popular monthly feature 4 times as often, with a new image and diagnostic challenge every Friday

TWICE DAILY

PHYSICIAN'S BRIEFING NEWS

Today's headlines in family practice, updated twice daily

24/7

JFPFINDIT:

A lightning-fast search tool for family physicians



Check us out today at jfponline.com

WHAT'S THE VERDICT?

CONTINUED FROM PAGE 236

syndrome requires careful treatment and monitoring. I have independently reviewed several allegations of malpractice involving this uncommon, but devastating condition. Two recent articles summarize the treatment of this disorder: Sterns RH, Silver S, Kleinschmidt-DeMasters BK, et al. Current perspectives in the management of hyponatremia: prevention of CPM. Expert Rev Neurother. 2007;7:1791-1797; and Lien YH, Shapiro JJ. Hyponatremia: clinical diagnosis and management. Am J Med. 2007;120:653-658.

Iodine contrast media kills man with known shellfish allergy

A 41-YEAR-OLD MAN WITH CHEST PAIN was admitted to his local hospital, where he received a diagnosis of acute coronary syndrome. After treatment in the emergency department, the patient was admitted to the telemetry unit by an internist, the partner of the patient's primary care physician. The patient's admission records noted that he had an allergy to shellfish.

The next morning, a cardiologist was called in. The cardiologist then called in an interventional cardiologist, who scheduled a cardiac catheterization. The interventional cardiologist ordered 1 dose of steroids, followed a few minutes later by contrast iodine. The patient immediately suffered a severe allergic reaction and died.

PLAINTIFF'S CLAIM The internist who admitted the patient to the telemetry unit took an incomplete history regarding the patient's allergies (although the admission records contained that information). No information about the claims against the 2 cardiologists is available.

THE DEFENSE No information about the defense is available.

VERDICT \$4.7 million gross verdict in Florida.

COMMENT *In addition to considering the risk of dye loads and carefully checking renal function, remember to assess for allergy when administering contrast agents. Failure to do so in this case led to the death of the patient and a multimillion-dollar verdict.*