COMMENTARY PROVIDED BY
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## Would a colonoscopy have made a difference?

**ABDOMINAL PAIN, BURNING AND CRAMPING,** and inability to eat led a 31-year-old man to visit his primary care physician. A nurse practitioner (NP) examined the man, prescribed ranitidine, and gave him an appointment for a complete physical the following month.

The patient's history, as provided during the physical exam, included tobacco chewing, high coffee intake, and occasional abdominal pain and increased stools. He said that his mother had been diagnosed with colon cancer at 54 years of age. Neither a rectal exam nor colonoscopy was performed.

The NP substituted pantoprazole for ranitidine and ordered an upper gastrointestinal series with contrast to rule out gastritis or an ulcer. The results were negative. They were given to the primary care physician, who never saw the patient or reviewed his chart.

A month later, the patient saw a nurse for continued problems eating, despite symptom relief on pantoprazole. The nurse stuck with a diagnosis of gastritis and told the patient to follow up in 6 months and to call if problems arose.

Four months later, the patient returned complaining of worsening stomach cramps and burning. The NP changed his medication to lansoprazole and set up an appointment in 3 months with a gastroenterologist.

The patient returned a month afterward reporting increasing pain and loose stools. The GI consult was moved to an earlier date after discussion with the primary care physician, but the patient went to an emergency room before the scheduled consultation.

An abdominal computed tomography scan and colonoscopy revealed near obstruction of the right side of the colon by a stage IV tumor and metastasis to the peritoneum and lymph nodes. The patient underwent immediate surgery, followed by chemotherapy, more surgery, and a cingulotomy for pain relief. He died about 2 years later.

**PLAINTIFF'S CLAIM** The NP should have performed a rectal exam, obtained stool for occult blood tests, or ordered a colonoscopy. The patient's chances of survival would have been better if he'd been diagnosed and treated earlier.

**THE DEFENSE** The patient didn't need a colonoscopy; his tobacco chewing and excessive coffee drinking explained his eating difficulties. The NP was properly supervised and there was no independent duty to review individual patient charts and sign off on them regularly. The patient was already at stage IV when he was seen initially; nothing could have changed the treatment or outcome.

**VERDICT** $4.65 million Massachusetts verdict.

**COMMENT** *Regardless of the medical facts of this case, supervision of staff and other health professionals is tricky. Clear job descriptions, protocols for care, and expectations for consultation will help avoid legal pitfalls.*

**The patient complained of abdominal pain and the inability to eat, but neither a rectal exam nor a colonoscopy was performed.**

## Suicide blamed on failure to diagnose bipolar disorder

**A 29-YEAR-OLD WOMAN** spent about 6 months under the care of a psychiatrist, during which time she was diagnosed with severe depression. The psychiatrist prescribed a series of selective serotonin reuptake inhibitors (SSRIs). The patient took the medications as prescribed but eventually committed suicide.

**PLAINTIFF'S CLAIM** The psychiatrist misdiagnosed the patient; the patient's depression was one symptom of bipolar disorder. The US Food and Drug Administration has warned that SSRIs increase the risk of suicide in patients with bipolar disorder.

**THE DEFENSE** The last time the psychiatrist saw the patient was more than 30 days before her death; the diagnosis of depression was correct.

**VERDICT** $175,000 Michigan settlement.

**COMMENT** *Every patient with depressive features should be screened for bipolar disorder. As this case illustrates, the medical and legal consequences can be profound.* JFP

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