Failure to monitor INR leads to severe bleeding, disability

A MAN WITH A HISTORY OF DEEP VEIN THROMBOSIS was taking warfarin 10 mg every even day and 7.5 mg every odd day. His physician changed the warfarin dosage while the patient was taking ciprofloxacin, then resumed the original regimen once the patient finished taking the antibiotic.

No new prescriptions were written to confirm the change nor, the patient claimed, was a proper explanation of the new regimen provided. His international normalized ratio (INR) wasn't checked after the dosage change.

After 2 weeks on the new warfarin dosage, the patient went to the emergency department (ED) complaining of groin pain and a change in urine color. Urinalysis found red blood cells too numerous to count. Although the patient told the ED staff he was taking warfarin, they didn't check his INR. He was given a diagnosis of urinary tract infection (UTI) and discharged.

Three days later, the patient returned to the ED because of increased bleeding from his Foley catheter. Once again his INR wasn't checked and he was discharged with a UTI diagnosis and a prescription for antibiotics. Two days afterwards, he was taken back to the hospital bleeding from all orifices. His INR was 75.

The patient spent a month in the hospital, most of it in the intensive care unit, followed by 3 months in a rehabilitation facility before returning home. He remained confined to a hospital bed.

PLAINTIFF'S CLAIM The physician and hospital were negligent for failing to instruct the patient regarding the change in warfarin dosage and neglecting to check his INR.

THE DEFENSE No information about the defense is available.

VERDICT $700,000 Maryland settlement.

COMMENT *The management of anticoagulation has numerous pitfalls for the unwary. Careful monitoring can save lives—and lawsuits.*

Rash and hives not taken seriously enough

A HISTORY OF 3 SEIZURES in a 7-year-old boy prompted a neurologist to prescribe valproic acid. The neurologist later added lamotrigine because of the child's behavior problems. After taking both medications for 2 weeks, the child developed a rash, at which point the neurologist discontinued the lamotrigine and started diphenhydramine.

The following day, the child was brought to the ED with an itchy rash and hives on his torso and extremities. An allergic reaction was diagnosed and the child was discharged with instructions to take diphenhydramine along with acetaminophen and ibuprofen as needed. When informed of the ED visit, the neurologist requested a follow-up appointment in 4 weeks.

Two days later, the child was back in the ED because the rash had progressed to include redness and swelling of the face. Once again, he was discharged with a diagnosis of allergic reaction and instructions to take diphenhydramine and acetaminophen.

Two days afterward, the child was taken to a different ED, from which he was airlifted to a tertiary care center and admitted to the intensive care unit for treatment of Stevens-Johnson syndrome. The condition advanced to toxic epidermal necrolysis with sloughing of skin and the lining of the gastrointestinal tract. Several weeks later, the child died.

PLAINTIFF'S CLAIM The neurologist was negligent in prescribing lamotrigine for the behavior problem instead of referring the boy to a child psychologist. The lamotrigine dosage was excessive; the neurologist didn't respond properly to the report of a rash.

The pharmacist was negligent in failing to contact the neurologist to discuss the excessive dosage. Discharging the child from

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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.

COMMENTARY PROVIDED BY
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Management of anticoagulation has numerous pitfalls for the unwary. Careful monitoring can save lives—and lawsuits.

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the ED with a life-threatening drug reaction was unreasonable.

THE DEFENSE The defendants denied that they were negligent or caused the child's death. They were prepared to present the histories of the parents, whose backgrounds included drug abuse, and state investigations regarding the care of the child.

VERDICT $1.55 million Washington settlement.

COMMENT *When prescribing a drug with a potentially serious adverse effect, it's always prudent to document patient education and follow-up thoroughly. Even though hindsight is 20/20, an "allergic reaction" in a patient on lamotrigine should raise red flags.*

A cascade of mistakes (sometimes referred to as the Swiss cheese effect) occurs, and a preventable death results.

Delay in spotting compartment syndrome has permanent consequences

SEVERE NUMBNESS, TINGLING, AND PAIN IN HER LEFT CALF brought a 20-year-old woman to the ED. She couldn't lift her left foot or bear weight on her left foot or leg. She reported awakening with the symptoms after a New Year's Eve party the previous evening. After an examination, but no tests, she was discharged with a diagnosis of "floppy foot syndrome" and a prescription for a non-narcotic pain medication.

The young woman went to another ED the next day, complaining of continued pain and swelling in her left calf. She was admitted to the hospital for an orthopedic consultation, which resulted in a diagnosis of compartment syndrome. By that time, the patient had gone into renal failure from rhabdomyolysis caused by tissue breakdown. She underwent a fasciotomy, after which she required hemodialysis (until her kidney function returned) and rehabilitation. Damage to the nerves of her left calf and leg left her with permanent foot drop.

PLAINTIFF'S CLAIM The hospital was negligent in failing to diagnose compartment syndrome when the woman went to the ED. Proper diagnosis and treatment at that time would have prevented the nerve damage and foot drop.

THE DEFENSE No information about the defense is available.

VERDICT $750,000 Maryland settlement.

COMMENT *Compartment syndrome can be challenging to recognize. Recently I have come across several allegations of malpractice for untimely diagnosis. Remember this important problem when faced with a patient with leg pain.*

Multiple errors end in death from pneumonia

A 24-YEAR-OLD MAN WITH CHEST PAIN AND A COUGH went to his physician, who diagnosed chest wall pain and prescribed a narcotic pain reliever. The young man returned the next day complaining of increased chest pain. He said he'd been spitting up blood-stained sputum. He was perspiring and vomited in the doctor's waiting room. The doctor diagnosed an upper respiratory infection and prescribed a cough syrup containing more narcotics.

Later that day the patient had a radiograph at a hospital. It revealed pneumonia. Shortly afterward, the hospital confirmed by fax with the doctor's office that the doctor had received the results. The doctor didn't read the radiograph results for 2 days.

After the doctor read the radiograph report, his office tried to contact the patient but misdialed his phone number, then made no further attempts at contact. The patient's former wife found him at home unresponsive. He was admitted to the ED, where he died of pneumonia shortly thereafter.

PLAINTIFF'S CLAIM No information about the plaintiff's claim is available.

THE DEFENSE No information about the defense is available.

VERDICT $1.85 million net verdict in Virginia.

COMMENT *A cascade of mistakes (sometimes referred to as the Swiss cheese effect) occurs, and a preventable death results. Are you at risk for such an event? What fail-safe measures do you have in place in your practice?* **JFP**