"All in his head" Dx leaves boy limping for more than a year

A 9-YEAR-OLD BOY developed pain in his ankle and a resulting limp. Despite several visits to his pediatrician at a local clinic and consultations with specialists, the limp became worse. A work-up in the emergency department (ED) led to a diagnosis of dystonia and a follow-up visit with a specialist.

The specialist, whose area of expertise wasn't dystonia, concluded that the symptoms were "in the boy's head" and changed the diagnosis to conversion disorder without consulting the ED records or the physician who diagnosed dystonia. The boy was admitted to a rehabilitation hospital, where, according to his parents, he underwent a bizarre and punitive behavior regimen. The physician in charge at the hospital ordered removal of the crutches the patient needed to walk and directed that the boy do sit-ups and push-ups whenever he fell or lost his balance.

When the boy hadn't improved after 30 days in the rehabilitation hospital, the treatment team ordered that he return to school on the condition that the school be informed that the child had a psychiatric condition and could walk normally if he wanted to. The school staff was instructed to forbid the boy to use crutches and not to help him up if he fell.

The situation continued for a year despite repeated questions from the boy's parents and visits to the clinic. The family was dissuaded from seeking additional testing on the grounds that it would further "medicalize" his condition. A blood test done more than a year after the limp started confirmed the original diagnosis of dystonia.

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

THE DEFENSE No information about the defense is available.

VERDICT $890,000 Ohio verdict

COMMENT *Although many unusual symptoms do have a psychiatric basis, in this case, poor communication and follow-up resulted in an almost $900,000 verdict.*

When a migraine isn't a migraine

WEAKNESS, LOSS OF BALANCE, AND HEARING LOSS prompted a 45-year-old woman to visit the emergency department (ED). An ED physician diagnosed a migraine headache and discharged her.

Five days later the woman returned to the ED with similar complaints, including imbalance, facial droop, dizziness, and weakness in the left arm. She was admitted to the hospital, where she had a stroke and died 5 days later.

PLAINTIFF'S CLAIM The ED doctor diagnosed a migraine headache and discharged the patient from the hospital when she really had a transient ischemic attack. The patient should have been referred for a neurologic evaluation, which would have revealed cardiomyopathy, which often shows no symptoms before precipitating a massive stroke.

THE DEFENSE No information about the defense is available.

VERDICT $3 million Illinois settlement.

COMMENT *Faced with the hectic pace of practice, we need to carefully evaluate even the most routine complaints such as headache and perform a careful general physical, which in this case might have disclosed a murmur and raised the index of suspicion.*

Confusion over warfarin Rx ends badly

A 48-YEAR-OLD MAN who had suffered a patellar tendon rupture to the left knee underwent bilateral patellar tendon repair by an orthopedic surgeon; long leg cylinder casts were applied to both legs. The patient started taking 5 mg warfarin the following day.

Two days later he was transferred to a skilled nursing facility for physical therapy

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

The school was told to forbid the use of crutches and not to help the boy if he fell. A blood test a year later confirmed that he had dystonia.

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The nurse left a message for the primary care physician; 25 days later, the patient suffered a pulmonary embolism and died.

and warfarin adjustment and assigned a primary care physician. During his stay in the nursing facility, the patient's blood tests never showed a therapeutic warfarin level. He saw the orthopedist, who prescribed 4 to 6 more weeks of warfarin therapy and scheduled a return appointment for 2 weeks later.

The day after the patient saw the orthopedist, his primary care physician increased the warfarin dose to 6 mg. When a blood test 3 days later showed a nontherapeutic level, she increased the dose to 7 mg.

Twelve days later, the leg casts were removed and knee immobilizers applied. The doctor who removed the casts recommended that the patient keep taking warfarin for at least 6 more weeks until removal of the knee immobilizers and the start of range of motion exercises. The patient was given a prescription to take to the skilled nursing facility to continue warfarin at the discretion of the primary care physician. That same day, the primary care doctor ordered by telephone that the patient continue to receive the same dose of warfarin.

The patient was discharged home 2 days later with orders for physical therapy and a blood draw for prothrombin time/international normalized ratio (INR). Physical therapy began 3 days before the blood draw was to be performed. The blood draw was actually done a day later than ordered and one day after the patient had taken his last dose of warfarin.

The home health nurse notified the orthopedist that the patient had taken his last dose of warfarin and faxed him the results of the blood test, showing an INR of 1.3. Six days later, the nurse contacted the orthopedist again about the exhausted warfarin supply. The orthopedist told the nurse to get in touch with the primary care physician who had followed the patient during his stay at the skilled nursing facility. The nurse left a voicemail message on the phone of the primary care physician's nurse. Twenty-five days later, the patient suffered an embolism in his main pulmonary artery and died.

PLAINTIFF'S CLAIM The home health agency and physicians were negligent in failing to properly monitor the patient's warfarin therapy.

THE DEFENSE The home health nurse acted properly in contacting the doctor. The orthopedist claimed that he had no duty to monitor the patient's warfarin therapy because that was the responsibility of an internist. The primary care physician claimed that she wasn't responsible for monitoring the warfarin after the patient was discharged from the skilled nursing facility.

VERDICT $76,760.12 net California verdict against the primary care physician with confidential post-trial settlement. The orthopedist received a defense verdict.

COMMENT *Another example of lack of coordination of care, noncompliance, and inadequate follow-up. Although we can only partially improve adherence, we should shoulder responsibility for coordinated care!* **JFP**