COMMENTARY PROVIDED BY
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Despite mid-chest discomfort, the patient had a normal EKG. He went home with a prescription for a GERD medication, and died 3½ hours later.

Death follows a normal EKG

MID-CHEST DISCOMFORT, A COUGH, AND SWEATING brought a 59-year-old man to his primary care physician. The patient had normal vital signs and reported that belching relieved the chest discomfort. He had a history of severe coronary artery disease and had undergone angioplasty and stenting several years earlier.

The primary care physician performed an electrocardiogram (EKG), which was normal and unchanged from one done the year before. The doctor suspected bronchitis, but prescribed omeprazole because the patient had previously been diagnosed with gastroesophageal reflux disease. He ordered a chemical stress test to be performed within a month and a chest radiograph to be done if the patient's symptoms didn't improve.

Two hours after returning home, the patient called an ambulance. He told paramedics that he'd been having chest pain for an hour. While they were putting the patient into the ambulance, he went into cardiac arrest. Four defibrillation attempts en route to the hospital and additional resuscitation attempts in the ED failed; he was pronounced dead 3½ hours after leaving his physician's office.

No autopsy was performed. The patient's widow found the omeprazole bottle, with one pill missing, and fast-food hamburger wrappers on the kitchen table.

PLAINTIFF'S CLAIM The primary care physician should have sent the patient to the ED to determine whether the chest pain had a cardiac cause; the patient was suffering from acute cardiac syndrome when the doctor saw him.

THE DEFENSE The patient's normal EKG and vital signs and the fact that belching relieved his chest symptoms indicated that the complaints did not arise from cardiac causes or require emergency assessment. The patient didn't report chest pain at the office visit; the later cardiac arrest probably resulted from a sudden plaque rupture unrelated to the earlier chest discomfort.

VERDICT $1.5 million Illinois verdict.

COMMENT *I hope most doctors won't have to learn this lesson from their own experience. A normal EKG does not rule out acute ischemia in a high-risk patient with chest pain and sweating. Admit such patients immediately to a cardiac observation unit.*

Kidney failure after multiple meds

A MAN WAS TAKING MULTIPLE MEDICATIONS: 3 blood pressure drugs prescribed by his primary care physician, an NSAID prescribed by another doctor, and sizable doses of BC Powder, an over-the-counter analgesic containing aspirin, salicylamide, and caffeine. After 4 years on this medication regimen, the patient's kidneys failed.

PLAINTIFF'S CLAIM The primary care physician failed to properly monitor kidney function with blood and urine tests while his patient was taking the medications. Proper testing would have resulted in a diagnosis of kidney disease before the patient's kidneys failed completely. In addition, the primary care physician failed to explain the risks and side effects of the medications to the patient.

THE DEFENSE The patient refused kidney function testing and did not follow medical advice. He consumed excessive amounts of alcohol against medical advice, did not tell the primary care physician about other drugs he was taking, and had allowed his supply of blood pressure medication to run out.

VERDICT $2 million gross verdict in Georgia, with a finding of 47% comparative negligence.

COMMENT *This case offers several lessons: First, each BC Powder packet contains the equivalent of 2 aspirin. Second, chronic, high-dose NSAIDs can cause renal failure, especially in patients whose renal function is compromised by hypertension. Third, all patients with hypertension should undergo periodic monitoring of renal function.* **JFP**

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