Delayed heart attack diagnosis ends in disability and a huge verdict

DESPITE FEELING ILL ON AWAKENING, a 50-year-old woman went to work, where she suffered crushing chest pain radiating down her left arm and up to her jaw. Her coworker (and husband at the time) recognized the symptoms of a heart attack and drove her to the emergency department (ED).

An electrocardiogram (EKG) performed more than 4 hours later was read as not indicating a heart attack. The patient was given pain medication and an antianxiety drug because she had a history of anxiety. She spent the night at the hospital, lying on a gurney in a hallway at times.

In the morning, her husband called his own cardiologist, whose office was across the street from the hospital. The cardiologist came to the ED and immediately arranged to have the patient transferred by ambulance to the intensive care unit at another hospital.

Upon arrival, the patient was immediately sent to the hospital's cardiac catheterization lab, where a heart attack was diagnosed. She underwent immediate surgery, during which she suffered dissection of an artery. Because of damage to her heart, she couldn't return to work.

PLAINTIFF'S CLAIM The patient lost 70% of her heart's pumping capacity and would require a heart transplant eventually. A cardiologist should have evaluated the patient immediately upon her arrival at the first hospital; the EKG done at that hospital was misread. On the catheterization film taken before surgery at the second hospital, the front portion of the patient's heart was motionless.

THE DEFENSE The dissection during surgery caused the patient's injuries.

VERDICT $126.6 million New York verdict.

COMMENT *I do some malpractice case review and have seen 2 cases just like this one. If it sounds like a horse (myocardial infarction), it is a horse until proven otherwise. I've heard of men in their 40s seeking urgent care, being diagnosed with dyspepsia, and dying within 2 days.*

Inadequate INR monitoring implicated in woman's death

A 59-YEAR-OLD WOMAN was diagnosed with atrial fibrillation and heart failure by a cardiologist and put on warfarin, which the cardiologist discontinued after a few days. Warfarin was resumed when the patient underwent surgery to place a mechanical heart valve.

The patient's international normalized ratio (INR) was tested daily while she was in the hospital, and warfarin was stopped several times. She was discharged with a prescription for 2 mg warfarin because her INR was 2.2, below the therapeutic range.

At a follow-up visit, the cardiologist checked the INR, which was 3.1. He saw the patient in the office again 8 days later, and 6 days after that a call was made to him, but no further blood tests were performed.

Eight days after the call, the patient was found unresponsive, with indications of gastrointestinal (GI) bleeding, and taken to the emergency department. Her INR level was at least 24.4, the highest the equipment could measure. In addition to GI bleeding, she had bleeding in her lungs. She died the next day.

PLAINTIFF'S CLAIM The defendants didn't monitor INR properly; the doctor knew the importance of monitoring INR while the patient was taking warfarin.

THE DEFENSE The INR level was normal at the posthospital visit. That measurement, along with the monitoring done while the patient was hospitalized, was appropriate monitoring. The patient died of sepsis, not exsanguination.

VERDICT $386,648 net California verdict.

COMMENT *This could have happened to any of us. If you monitor warfarin in your practice, make sure the follow-up system is water tight. Use a registry and double checking system. Be sure you know who is responsible during care transitions.* **JFP**

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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