



**COMMENTARY
PROVIDED BY**

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This case serves as a reminder that patients can have more than one disease of an organ system.

Why did testing stop at EKG—especially given family history?

AFTER COMPLAINING OF CHEST PAIN, a 37-year-old man underwent an electrocardiogram (EKG) examination. The doctor concluded that the pain was not cardiac in nature. Two years later, the patient died of a sudden cardiac event associated with coronary atherosclerotic disease.

PLAINTIFF'S CLAIM The decedent suffered from high cholesterol and had a family history of cardiac issues, yet no additional testing was performed when the patient's complaints continued.

THE DEFENSE No information on the defense is available.

VERDICT \$3 million settlement.

COMMENT *This is déjà vu for me. A colleague of mine had a nearly identical case a few years ago, but the patient died several days later. In the case described here, the high cholesterol and family history were red flags. A normal EKG does not rule out angina. I do wonder what happened, however, in the 2 years between the office visit and the patient's sudden death. The chest pain at the office visit may well have been non-cardiac, but it appears the jury was not convinced.*

2 FPs overlook boy's proteinuria; delay in Dx costs him a kidney

AN 11-YEAR-OLD BOY underwent a laparoscopic appendectomy that included a urinalysis. Following the surgery, the surgeon notified the family physician (FP) that the patient's urinalysis showed >300 mg/dL of protein. The result was unusual and required follow-up. The surgeon felt that the urinalysis result might be related to the proximity of the appendicitis to the boy's ureter. The boy was evaluated on several other occasions by the FP, but no work-up was performed.

Three years later, the boy saw a different FP, who noted that the child had elevated blood pressure and blurry vision—among other symptoms. The boy's renal function tests were documented as abnormal; how-

ever, the patient and his mother were never notified of this. Also, the patient was never referred to a nephrologist or neurologist and there was no intervention for a potential kidney abnormality.

Two years later, an associate of the FP ordered further blood tests that showed a clear abnormality with regard to the integrity of the child's kidney function. The boy was evaluated at a hospital and diagnosed with end-stage renal disease. He received a kidney transplant 3 months later and requires lifetime medical care as a result of the transplant. The boy will likely require further transplants in 10-year increments.

PLAINTIFF'S CLAIM Both FPs deviated from the accepted standard of care when they failed to order further testing as a result of the abnormal laboratory tests. Earlier intervention may have prolonged the life of the boy's kidney, thereby postponing the need for kidney replacements.

THE DEFENSE No information on the defense is available.

VERDICT \$1.25 million Massachusetts settlement.

COMMENT *300 mg/dL is a significant amount of proteinuria and requires further testing. Why didn't the FP follow up? Was a summary of the hospitalization sent to him/her? Certainly the diagnosis should have been made by the second FP, and the patient should've been referred to a nephrologist. A lawsuit would most likely have been averted had this happened. Delayed diagnosis accounts for a high proportion of malpractice suits against FPs.*

Duodenal ulcer mistakenly attributed to Crohn's disease

A 47-YEAR-OLD MAN with a history of Crohn's disease began experiencing persistent abdominal pain. He hadn't had symptoms of his Crohn's disease in over 12 years. Nevertheless, doctors diagnosed his pain as an aggravation of the disease and gave him treatment based on this diagnosis. In fact, though, the man had an acute duodenal ulcer that had progressed

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and perforated. The patient underwent 12 surgeries (with complications) and almost 2 years of near-constant hospitalization as a result of the misdiagnosis. He now requires 24-hour care in all aspects of his life.

PLAINTIFF'S CLAIM The doctors were negligent in their failure to consider and diagnose a peptic ulcer when the plaintiff's symptoms indicated issues other than Crohn's disease.

THE DEFENSE No information on the defense is available.

VERDICT \$28 million Maryland verdict.

COMMENT *I suspect this was a tough diagnosis, given the patient's prior history of Crohn's dis-*

ease. We are not told the nature of the abdominal pain. If the patient had classic epigastric pain, peptic ulcer disease should have been investigated. This case serves as a reminder that patients can have more than one disease of an organ system, and it reminds us of the need for a careful history and close follow-up if a complaint does not resolve.

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.

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