Pain Out of Proportion to a Fracture

A 57-year-old woman sustained an injury to her left shoulder during a fall down stairs. She presented to the emergency department, where a physician ordered x-rays that a radiologist interpreted as depicting a simple fracture.

The patient claimed that the radiologist misread the x-rays and that the emergency medicine (EM) physician failed to realize her pain was out of proportion to a fracture. She said the EM physician should have ordered additional tests and sought a radiologic consult. The patient contended that she had actually dislocated her shoulder and that the delay in treatment caused her condition to worsen, leaving her unable to use her left hand.

In addition to the radiologist and the EM physician, two nurses were named as defendants. The plaintiff maintained that they had failed to notify the physician when her condition deteriorated.

OUTCOME

A $2.75 million settlement was reached. The hospital, the EM physician, and the nurses were responsible for $1.5 million and the radiologist, $1.25 million.

COMMENT

Although *complex regional pain syndrome* (CRPS, formerly known as *reflex sympathetic dystrophy*) is not specifically mentioned in this case synopsis, the size of the settlement suggests that it was likely claimed as the resulting injury. CRPS is frequently a source of litigation.

Relatively minor trauma can lead to CRPS; why only certain patients subsequently develop the syndrome, however, is a mystery. What is certain is that CRPS is recognized as one of the most painful conditions known to humankind. Once it develops, the syndrome can result in constant, debilitating pain, the loss of a limb, and near-total decay of a patient's quality of life.

Plaintiffs' attorneys are quick to claim negligence and substantial damages for these patients, with their sad, compelling stories. Because the underlying pathophysiology of CRPS is unclear, liability is often hotly debated, with cases difficult to defend.

> *"A sympathetic jury will see the patient's swollen, misshapen limb and hear about ever-present, exquisite pain ... and infer negligence."*

Malpractice cases generally involve two elements: *liability* (the presence and magnitude of the error) and *damages* (the severity of the injury and impact on life). CRPS cases are often considered "damages" cases, because while liability may be uncertain, the patient's damages are very clear. An understandingly sympathetic jury panel sees the unfortunate patient's red, swollen, misshapen limb, hears the story of the patient's ever-present, exquisite pain, and (based largely on human emotion) infers negligence based on the magnitude of the patient's suffering.

In this case, the patient sustained a shoulder injury in a fall that was initially treated as a fracture (presumptively proximal) but later determined to be a dislocation. Management of the injury was not described, but we can assume that if a fracture was diagnosed, the shoulder joint was immobilized. The plaintiff did not claim that there were any diminished neurovascular findings at the time of injury. We are not told whether follow-up was arranged for the patient, what the final, full diagnosis was (eg, fracture/anterior dislocation of the proximal humerus), or when/if the shoulder was actively reduced.

Under these circumstances, what could a bedside clinician have done differently? The most prominent element is the report of "pain out of proportion to the diagnosis." When confronted with pain that seems out of proportion to a limb injury, stop and review the case. Be sure to consider occult or evolving neurovascular injury (eg, compartment syndrome, brachial plexus injury). Seek con-

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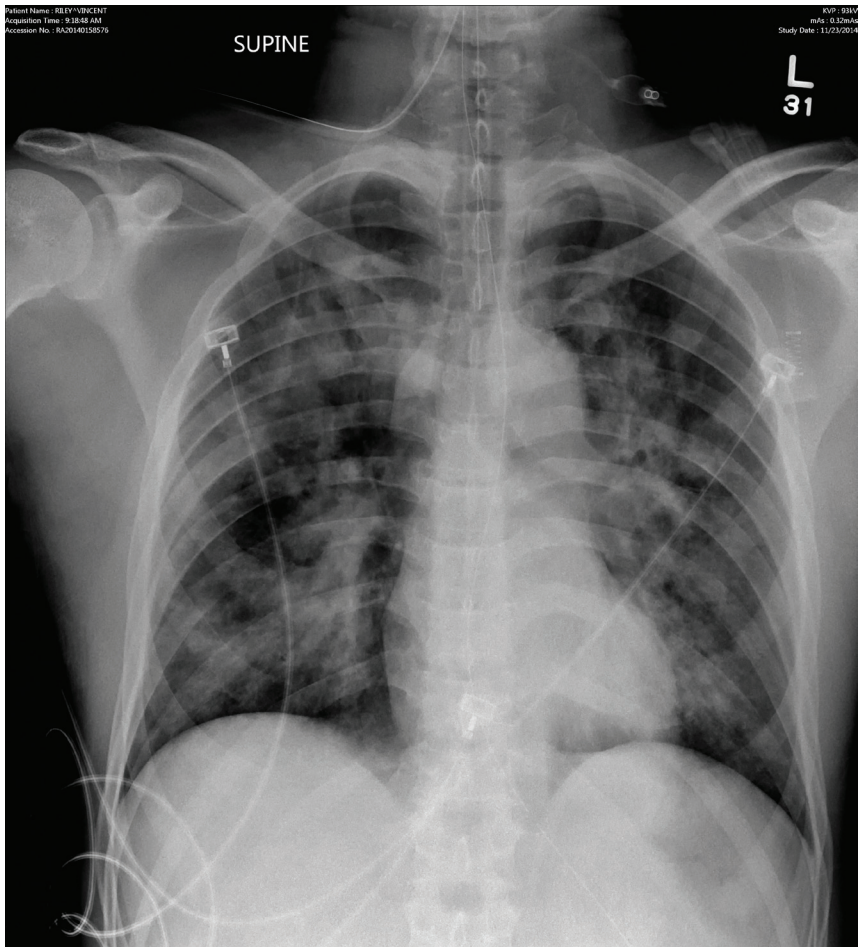

ANSWER

The radiograph demonstrates bilateral patchy, fluffy infiltrates as well as what is sometimes referred to as *ground-glass opacities*. In the setting of trauma and respiratory compromise, these areas are most suggestive of pulmonary contusions and early acute respiratory distress syndrome. Other possibilities in the differential diagnosis include pulmonary edema, atypical pneumonia, and pulmonary metastases. **CR**

sultation and a second opinion in cases involving pain that seems intractable and out of proportion.

One quick word about pain and drug-seeking behavior. Many of us are all too familiar with patients who overstate their symptoms to obtain narcotic pain medications. Will you encounter drug seekers who embellish their level of pain to obtain narcotics? You know the answer to that question.

But it is necessary to take an injured patient's claim of pain as stated. Don't view yourself as "wrong" or "fooled" if patients misstate their level of pain and you respond accordingly. In many cases, there is no way to differentiate between genuine manifestations of pain and gamesmanship. To attempt to do so is dangerous because it may lead you to dismiss a patient with genuine pain for fear of being "fooled." *Don't*. Few situations will irritate a jury more than a patient with genuine pathology who is wrongly considered a "drug seeker." Take patients at face value and act appropriately if substance misuse is later discovered.

In this case, recognition of out-of-control pain may have resulted in an orthopedic consultation. At minimum, that would demonstrate that the patient's pain was taken seriously and the clinicians acted with due concern for her. **—DML** **CR**