

Commentary by

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Did Missed Orbital Fracture Lead to Nerve Impingement?

During a softball game, the plaintiff, a 35-year-old New Jersey man, was struck in the eye by a line drive. He went to a medical center ED where he was seen by an emergency physician. The physician did not order a CT scan and, according to the plaintiff, failed to diagnose a fractured orbit. The plaintiff later developed an impinged infraorbital nerve as a result of untreated bone fragments, which allegedly resulted in permanent complications of the underlying injury. He claimed that a CT scan was required, given the nature of the injury, and that it would have revealed the fracture, allowing for timely treatment. The defendant claimed that a CT scan was not necessary.

Outcome

The jury found the physician negligent and also found that the physician's negligence was the proximate cause of the plaintiff's condition. The plaintiff received a \$240,000 judgment.

Comment

Direct trauma to the face can result in significant injury. A careful history and physical exam, including palpation, will usually suggest if a fracture is present. Assessing visual acuity and checking for extraocular motion (ie, muscle entrapment) and sensation (ie, nerve injury) are important to exclude common complications of orbital wall fractures. If an orbital or facial fracture is suspected, CT scan is considered the gold standard for imaging. **FLC**

CT Delay Blamed for Death

A 49-year-old Illinois man walked into the ED after fainting while he was working out. An emergency physician ordered a chest CT scan with contrast to rule out pulmonary embolism. The man died 4 hours later of pulmonary embolism. The plaintiff's decedent claimed that the hospital's

delay in performing the CT scan was unreasonable and that the emergency physician was negligent in failing to follow up to ensure that the CT scan was completed. The defendants claimed that a CT scan was not required earlier than 4 to 6 hours after the patient presented and that no treatment would have saved the man's life.

Outcome

The plaintiff received \$250,000 from the emergency physician and his practice under a high/low agreement.

Comment

Increasingly, regulatory agencies and malpractice juries are holding hospitals and emergency physicians responsible for timely completion of diagnostic studies—particularly radiologic exams, regardless of how busy the ED may be. It is difficult to convince a jury that 4 to 6 hours is an acceptable time frame for completion and interpretation of a chest CT when you are considering a symptomatic PE, or that earlier therapeutic interventions based on positive CT results would not make a difference. **NF**

Failure to Diagnose Dislocated Knee

A 38-year-old woman sustained a knee injury while staying at a hotel in Arizona. The plaintiff was taken to a regional medical center by ambulance, where an emergency physician diagnosed a tibial plateau fracture, but failed to diagnose a dislocated knee and did not perform an angiogram of the leg. The plaintiff claimed that if an angiogram had been performed, damage to the popliteal artery and peroneal nerve, which resulted in permanent foot drop, would have been identified and treated. The plaintiff also claimed that her x-rays were not given to her when she was discharged, and that if they had been, her treating physician in California would have diagnosed the dislocation. The plaintiff also claimed

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that the emergency physician failed to stress the knee, which would have shown ligament damage consistent with a knee dislocation.

The plaintiff additionally claimed that splinting was applied too tightly and that an orthopedic consult should have been ordered. The plaintiff required a one-month hospitalization for an occluded popliteal artery, which required a vein graft and fasciotomies of all four compartments. The plaintiff also claimed she developed an infection and subsequent sequelae related to poor blood flow. The plaintiff later underwent tendon transfer surgery in an attempt to stabilize the foot so that she could walk.

The defendants argued that the plaintiff had sustained a tibial plateau fracture, not a dislocation, and that the physical exam was inconsistent with a knee dislocation. The defendants also claimed that the x-ray showed only a tibial plateau fracture and corresponding damage. Further, the defendants maintained that the splint was applied properly. The defendants claimed that the peroneal nerve damage occurred at the time of the fracture but was not apparent in the ED, and that the resulting nerve deficit developed gradually. The defendants additionally argued that even if an angiogram had been performed, it would not have shown a tear.

Outcome

A defense verdict was returned. According to a published account, the hospital settled for a confidential amount during trial.

Comment

Knee dislocations (as opposed to patella dislocations) represent a serious injury with potential for significant complications. Most knee dislocations are secondary to motor vehicle accidents, but dislocations can also result from sport injuries, falls, or work-related injuries. Approximately 50% to 60% of dislocations are anterior. Although knee dislocations are uncommon, one must consider them in the differential diagnosis of traumatic knee pain, since nearly half of all knee dislocations reduce spontaneously or are reduced prior to arrival at the ED (as in this case). Patients demonstrating complete ligamentous disruption of the

knee on physical exam should be suspected of having a spontaneously reduced knee dislocation. While there is always associated capsule, ligament, and tendon injury, it is popliteal artery injury that is most concerning. Both anterior and posterior knee dislocations can result in popliteal artery injury, which occurs in approximately 25% to 33% of all knee dislocations. There is no uniformly agreed-upon pathway for evaluation of popliteal artery injury. Options include physical exam combined with measurement of the ankle-brachial pressure index, color-flow Doppler duplex scan, or arteriogram. The specific test used will depend on local custom, resources, and practice pattern. **FLC**

Missed Volvulus in Gastric Bypass Patient

The plaintiff's decedent, age 37, presented to an ED in Kentucky with nausea and vomiting. The emergency physician noted a soft abdomen. The decedent's vital signs were mostly normal; fluids were administered, and she was discharged. The decedent's discharge instructions included an admonition to return if her symptoms worsened.

The emergency physician had previously seen the decedent several times in the ED for various complaints. In the previous three years, the decedent had experienced weakness and other symptoms after successful gastric bypass, as a result of which her weight dropped from 300 to 93 lb.

The decedent returned to the ED that evening. The plaintiff claimed that the emergency physician was indifferent and dismissive, and claimed that in one exchange, the emergency physician asked, "What am I supposed to do for you?," and the decedent replied, "I'm not a doctor, I don't know." The decedent's symptoms were unchanged, and her vital signs were stable. The emergency physician suggested blood work, which the decedent refused. The decedent was released that night with a prescription for pain medication. The next day the decedent stayed in bed most of the day. She died during the night.

An autopsy revealed a volvulus of the jejunum, which had caused a fatal septic event. The plaintiff claimed that a CT scan should have been performed, as it would have led to detection of the

volvulus. The physician claimed that no CT scan was required, based on the decedent's presentation. The defendant hospital denied any negligence, arguing that the emergency physician was not an employee.

Outcome

According to a published account, \$2,192,000 was awarded against both defendants.

Comment

This case involves two types of high-risk patients: repeat users of the ED (ie, "frequent fliers"), and patients status post-gastric bypass surgery. The emergency physician must remember that frequent users of the ED are not immune to real disease. Every effort must be made to evaluate these patients for their presenting complaint that

day and not allow the evaluation to be colored by past interactions. It is easy to miss something if the initial history and physical exam are cursory. Patients presenting with abdominal pain and/or nausea and vomiting following gastric bypass surgery can harbor significant disease with only a few physical findings. Potential complications of gastric bypass that may present with these symptoms include internal hernia, stomal stenosis, and closed-loop obstruction, with attendant risk for strangulation and perforation. One must have a low threshold for ordering a contrast-enhanced CT scan of the abdomen/pelvis when evaluating these patients. **FLC**

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