

Lawsuit: Doctor's Doubts Lead to Missed Diagnosis

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A 30-year-old obese woman visited the emergency department with vaginal bleeding as well as numbness in her legs that was causing her to fall. The patient underwent a lumbar MRI and was admitted.

The next day, Dr FP, a family practitioner, evaluated the woman and ordered gynecologic and neurologic consultations. The MRI showed mild degenerative disc disease, but no evidence of significant stenosis. The gynecologist prescribed metronidazole (Flagyl) for vaginitis.



Dr N, the neurologist, charted numbness and tingling in the patient's hands and feet for the past 5 days. Dr N noted a "stocking and glove" distribution and a decreased deep tendon reflex. Dr N's initial impression was peripheral neuropathy, and he prescribed lorazepam and gabapentin (Neurontin). He also ordered an ESR (erythrocyte sedimentation rate) and antibody and thyroid tests. When Dr N saw the patient the next day, he noted persistent numbness and tingling in her hands, feet, and chest, extending to the legs. At that time, Dr N's impression was lumbar spondylosis, and his plan was to continue the gabapentin.

On Dr FP's referral, the patient saw an orthopedist who, while ordering a thoracic MRI for possible disk herniation, also noted that the "bilateral numbness and lack of any significant history of back pain or trauma also suggest a peripheral neuropathy, perhaps Guillain-Barré syndrome."

Medscape Editor's Key Notes:

- When ruling out a disease, make sure to include details of your reasoning.
- Document any developments that may change your original assessment.
- If a patient's condition fails to improve, consider testing for previously ruled-out diseases.

When Dr N saw the patient the next evening, the patient complained of pain in her lower back and "pins and needles" in her lower legs up to the breast level. The patient still had deep tendon reflexes and a downward toe sign. Dr N raised the question of hysterical conversion reaction and noted to rule out thoracic cord lesion and transverse myelitis. Dr N doubted Guillain-Barré syndrome and continued the gabapentin. In a consultation the next day, a spinal surgeon considered the thoracic MRI negative and commented that an elevated ESR was possibly caused by the patient's vaginitis.

On his next visit with the patient, Dr N's impression was peripheral neuropathy vs hysterical conversion reaction; rule out Guillain-Barré syndrome "(doubt)"; and rule out cervical spine compression, "also doubtful." Dr N recommended a cervical MRI and continued gabapentin.

The next day, the patient was able to move both legs but still complained of pain in her legs, back, and neck. Dr N charted stocking-and-glove numbness up to the chest. During the visit, the patient mentioned the possibility of getting a surgical weight reduction procedure, such as stapling or a lap band. Dr N continued the gabapentin and also ordered Cymbalta (duloxetine). Dr FP ordered a psychiatric evaluation.

By the next day, the MRI revealed a left disc protrusion at C6-7 causing a mild cord deformity. Dr N noted the possibility of fibromyalgia but again doubted Guillain-Barré syndrome, noting the patient's dominant symptom being pain. He recommended continuing the duloxetine and that discharge planning should begin. The psychiatrist's evaluation the next day diagnosed a somatic disorder. Later that day, Dr FP indicated the patient could be discharged with follow-up by the patient's family doctor.

Ten days later, the woman went to the county emergency department with numbness and tingling. A lumbar puncture revealed a protein level of 531 mg/dL (normal, 15-40 mg/dL). After an MRI, the patient was diagnosed with Guillain-Barré syndrome and underwent intravenous treatment and rehabilitation.

The woman later sued Dr N for failing to order proper tests for Guillain-Barré syndrome. The parties resolved the dispute informally.

In this case, better charting could have possibly helped the treating physicians to come to an accurate diagnosis more quickly. Physician charting is not only for the benefit of a patient's other healthcare providers. A discipline of charting why a certain differential diagnosis is doubtful while also writing down what developing conditions would change that outlook can help the physician avoid the need to rely on just memory when considering what steps to take next.

In this case, the physician noted several times that he doubted Guillain-Barré syndrome, but he did not expand on his reasons in the chart nor explain what might change this assessment. Such detailed charting may have changed his course of testing when the patient's condition did not improve. At the very least, a more thorough explanation in the chart for doubting Guillain-Barré syndrome could have provided a stronger defense when his care came under scrutiny.

This case comes from the "Case of the Month" column featured in the member newsletter published by the Cooperative of American Physicians, Inc. The article was originally titled "When Ruling Out Disease, Chart Your Findings Carefully."

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