Atypical Chest Pain – Work 'Em up or Sign 'Em out?

The Case

A patient in his mid-thirties presented to the emergency department (ED) on a Friday afternoon, accompanied by his wife, to obtain an evaluation of the intermittent chest pain he had been having three days prior. According to the patient, he had been digging outside at work and had developed chest and epigastric pain. At the time, he broke out into a sweat and had a headache as well. He first noted the pain at night while he was lying flat. The pain lasted 2-3 minutes. The patient stated that he had a history of GERD, for which he had been taking Zantac, and was a pack-a-day smoker. The physician ordered a chest x-ray and labs, including cardiac enzymes, a metabolic profile and EKG. All of these tests came back within normal limits. The patient remained stable in the ED with no signs or symptoms of distress while he was being evaluated. The physician rated his pain at “0” at triage and at discharge.

The triage notes indicated that the patient had normal respiratory effort, normal heart sounds with regular pulses and a normal sinus rhythm. He was noted to be anxious, but his skin was warm and dry with normal skin color. The physician documented that the pain was substernal in location and sharp. He noted exercise and lying down as exacerbating factors. He also noted that the patient was relatively young in age, and had provided a history of GERD. His only known cardiac risk factor was smoking.

The physician examined the patient again for discharge later that afternoon. He again noted in the record that the patient was in no current pain. The physician felt that the patient’s symptoms were most likely related to gastric reflux, and not typical for cardiac related problems. His final diagnosis was atypical chest pain. He discharged the patient with
a prescription for the reflux, and instructed him to return if the pain became worse or did not improve within 48 hours. He also instructed the patient to follow-up with his primary care physician the following week. At the time of discharge, the nurse’s notes indicated that the patient had experienced fluctuating pain while in the ED with a pain rating of “2”.

Two days later, the wife called EMS when she found the patient on the bathroom floor, unconscious and not breathing. The patient was pronounced dead upon EMS arrival.

She reported that the patient had complained of chest pain when he returned from fishing. She said that he had been complaining of severe, fluctuating chest pain all weekend, but that she did not consider calling the doctor because the pain did not appear to be worse than it had been the day before. She also had been unable to find a drug store that would fill the prescription the ED physician ordered for her husband.

The autopsy showed that the patient’s left anterior descending coronary artery was 95-99% blocked. The cause of death was listed atherosclerotic coronary disease.

The Allegations

The plaintiff claimed that the physician should have admitted the patient to the hospital and/or ordered serial cardiac markers and EKGs. The plaintiff further claimed that even if the serial tests had been negative, the physician should have ordered a functional cardiac stress test. The plaintiff also claimed that if the physician had complied with the standard of care, the patient’s coronary artery disease would have been discovered, measures would have been taken, and the patient would have survived.

Disposition

With the ED physician’s agreement, the case settled for a very large amount.

Physician Reviewers’ Commentary

In her deposition later, the wife testified that 6 months prior to the ED visit, her husband had experienced back pain, kidney stones and heartburn for which he took over-the-counter medications. She downplayed the fact that he also had been seen and evaluated for complaints of chest pain. It was her recollection that the tests the physician wanted to schedule at that time were never done. However, those medical records indicated that a stress test was performed and was normal.

Experts reviewing this case gave mixed reviews. Although everyone did agree that it was very unusual to see extensive coronary disease in a patient at such a young age, with relatively low risk for cardiac problems, who had undergone an unremarkable stress test 6 months prior the ED visit.

While some reviewers believed the ED physician’s care and treatment to be appropriate, other ED experts opined that the patient should be pain free before leaving the ER. Unfortunately, for the defense, the physician’s documentation of the level of pain as “0” differed from that in the nurse’s note of “2”. In addition, the ED physician’s conclusion documented that the patient’s problems were caused by his reflux does not really fit his symptoms. Reflux related pain does not normally occur upon exertion, and is not normally accompanied by sweating.

One ED expert opined that a stress echo is the standard of care. In his opinion, a stress test should have been done; the patient probably had ischemia for at least a year. Others mentioned that if a physician is worried about acute coronary problems, one negative test is not conclusive and that serial testing over a period of about two to four hours is necessary to completely rule out whether or not there is an acute coronary problem. It was also suggested that the patient’s outcome may have been different if he had returned to the ED the following day, but the patient was dead 48 hours after having been seen in the ED.

Risk Management Commentary
1. **Personal and family history taking often involves perseverance.** The ED physician did not explain anywhere in the chart why he thought this patient was at such low risk that he could be discharged without serial cardiac enzymes, EKGs or further chest pain workups. It was not clear that this physician was even aware of the fact that the patient had experienced a previous negative stress test, six months prior to this visit. Documentation in the patient chart is key to communicating the overall picture of the patient, his/her examination and treatment, as well as the provider’s medical decision-making. Chest pain, even in younger patients, may require longer observation and a more comprehensive diagnostic work up.

2. **The plaintiff alleged that inadequate testing was ordered, which prevented the patient’s MI from being diagnosed.** If your concerns do not match that of the patient, the patient is likely to feel marginalized. If your decision process is not well documented, an allegation of substandard care is difficult to defend. Clarifying the patient’s key concerns and his or her understanding of the diagnostic process can close any gaps between the patient’s expectations and yours. Explaining your uncertainty to the patient can initiate a discussion that closes any gaps in expectations.

3. **The ED physician’s medical decision-making, e.g., clinical rationale for not drawing serial enzymes and conducting a cardiac stress test, was not well documented.** To fully understand the circumstances surrounding a patient encounter is generally impossible without written evidence. Explaining why certain tests were ordered and others were not is instrumental in understanding the disposition of the patient. For example, even though myocardial infarctions would be infrequent in this age group, the reasons for not pursuing the possibility should be well-explained.

4. **The initial ED assessment appears to have stopped after the initial labs and EKG came back within normal limits.** Incomplete documentation can negatively impact future care. While the most likely diagnoses are usually the common diagnosis, especially in otherwise well appearing and younger patients, physicians should document differential diagnosis and their probability for that patient.

5. **A thorough discharge process includes patient/family feedback to verify comprehension of how to act on recurring or new symptoms, as well as a review of the record and nurse’s notes to make certain there are no discrepancies in vital signs, pain status or other key information.**

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