Could Antibiotics Upon Presentation Have Prevented Asplenic Patient’s Death?

The Case

The patient presented to the hospital emergency department (ED) with fever, body ache, headache, nausea and vomiting. She had a history of Idiopathic Thrombocytopenic Purpura (ITP) and splenectomy. Her vital signs at triage were T 101.6, P 166, R 66, B/P 114/62. Her acuity level was considered emergent/urgent. According to the nursing staff, the patient appeared to be very ill. Two hours later she was receiving IV fluids, labs had been drawn, and she had received Reglan, Pepcid and Toradol. At this point, the patient begged the ED physician for antibiotics. The lab results yielded: white blood count 14.4; hematocrit 50.9; platelet count 139,000; granulocytes 90.6%; lymphocytes 8.7%; albumin 3.0; and alkaline phosphatase 168.

The physician ordered a second liter of fluids in an attempt to stabilize the patient's BP, which was 70/38; pulse was 138. The patient's blood pressure continued to drop to 68/34, and within 1.5 hours from the time she had received the second liter of fluids, a third liter was being administered. CT scans showed an enlarged gallbladder and infected sinus. Neither the patient's blood pressure nor her elevated temperatures responded to the fluids. She was diagnosed with a viral infection, and admitted to the hospital's Primary Care Unit (PCU), without having been administered antibiotics in the ED. The hospitalist's plan was to rule out sepsis. Critical care and surgical consults were obtained. The patient was started on Ceftriaxone and Clindamycin in the early evening.

The patient underwent emergency surgery that night to remove her gallbladder. She never regained consciousness.
following surgery, and expired 18 days later of Hemophilus Influenza B (HIB).

**Allegation**

Failure to administer antibiotics.

**Disposition**

The case was settled for a very large amount.

**Risk Management Commentary**

The experts who reviewed this case were unable to support the standard of care or causation defense of the ED physician.

- All the experts felt the patient should have been administered antibiotics upon presentation, and earlier intervention most likely would have saved the patient's life.
- While the initial concern of a viral syndrome was reasonable, the experts opined the prior splenectomy arguably required antibiotic treatment at the time of arrival at the ED. In addition, the progressive downhill course in the ED should have prompted antibiotics at a minimum and maybe even an Infectious Disease consult.
- The defense team believed the continued use of additional IV fluids in the face of refractory BP, tachycardia and continued fever indicated the patient needed antibiotics. The fact that the patient requested antibiotics, and had been treated in that same ED on two other separate occasions with antibiotics with good results, led the defense team to believe that this information could be inflammatory to a jury.
- Experts pointed out that if the patient, in fact, had a gangrenous gallbladder on admission, she would likely have had less than a 50% chance of survival. This information could be used to drive a causation defense. Although the surgeon's operative note describes the gallbladder consistent with the description of a gangrenous gallbladder, he did not specifically state that it was gangrenous. The pathology report might have cleared any discrepancy, but it did not state "gangrenous gallbladder," only "Chronic Cholecystitis with Cholelithiasis."
- One expert stated that the patient should have been getting triple vaccinations every five years due to the ITP and felt the ED physician should have elicited from the patient whether she was getting that type of treatment in his workup.

The hospital also had culpability in this case. Although the patient was triaged with acuity of level 3 and considered an urgent patient, the ED nurses did not manage the case accordingly, as evidenced by their lack of documentation, monitoring and communication with the ED physician.

ED physician assessment and treatment gaps, combined with ED department's systems problems and documentation gaps, contributed to the loss of this patient and, ultimately, to the adverse outcome of this case.

However, this cloud had a silver lining. As a result of this case, the ED physician group:

- instituted procedures to ensure the prompt transmittal of patient information to ED physicians, and from ED physicians to staff.
- developed a peer review process separate from that of the hospital's.
- developed strategies to reduce delays in the ED.
- developed preventive strategies to reduce diagnostic errors.
- developed criteria to identify "red flags" that could indicate potential liability exposure to the ED group.
- developed a system by which corrective strategies and educational intervention could be better implemented, tracked and measured.
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