The Case

For a period of two years, a male in his mid thirties made multiple visits to his primary care physician’s (PCP’s) office with various complaints, including fatigue and dizziness which the PCP suspected was stress-related. The patient developed periodontal complaints after a wisdom tooth extraction. He subsequently developed rectal bleeding, cough and night sweats. The patient's WBC was noted to be critically low at 1.7 and his hemoglobin had dropped to 13.1 from a prior result. These results were documented in the medical record, but there was no follow up by the PCP. The PCP treated each complaint symptomatically, and referred the patient to a colorectal surgeon for management of a thrombosed external hemorrhoid which was felt to be related to the rectal bleeding. The patient underwent an outpatient hemorrhoidectomy without immediate complication, and was discharged home. Later that day the patient was rushed to the hospital Emergency Department (ED), with altered mental status and a fever of 105 degrees. He deteriorated rapidly with respiratory failure, necessitating mechanical ventilation. A hematology/oncology consult was expedited. In view of severe anemia, thrombocytopenia, and immature cells containing Auer rods, acute leukemia was the working diagnosis. The patient went into asystolic cardiorespiratory arrest and was pronounced dead shortly afterward.

In the autopsy report, the pathologist documented findings of acute myeloblastic leukemia with infiltration to lungs, heart, spleen, liver, small bowel, and rectum; anoxic ischemic encephalopathy; acute hemorrhagic leukoencephalopathy; hemorrhage and leukemic infiltrates in the skeletal muscles; acute subarachnoid cerebral and cerebellar hemorrhage; and acute subdural hemorrhage.
Allegations

The plaintiff alleged the PCP

1. did not properly follow up on the abnormal CBC
2. should have suspected leukemia given the critically low WBC
3. failed to communicate the results to the patient and other health care providers
4. inappropriately allowed the patient to proceed with surgery

Disposition

After aggressive negotiations, the case was settled for a very large amount.

Clinical Risk Management Commentary

Experts who reviewed this case remarked on the PCP's thorough medical record and extensive pattern of referrals for the patient's various clinical issues. However, the failure of the PCP to evaluate the cause of the patient's abnormal WBC, by either repeating the WBC (if not the entire CBC) or by obtaining a consult, led to a critical delay in diagnosis and treatment of this rare, but serious illness. The expert reviewers for both the plaintiff and the defense considered this to be a deviation in the standard of care.

It is true the patient presented to his PCP at intervals with seemingly different sets of complaints. Case reviewers believe if systems and protocols supporting timely review and follow-up of all test results had been in place, the PCP may have been able to have overcome narrow diagnostic focus, and view the patient's complaints from a broader perspective. An expert witness commented that the patient's clinical presentation was suspicious for acute leukemia, given the rectal bleeding, periodontal complaints, and night sweats prior to the final event.

Interesting, but not a factor in the defense of this PCP, two experts questioned the role of the colorectal surgeon (not named in the lawsuit) in the patient's deterioration, and recommended a thorough review of the procedure records to determine the degree of pre-op evaluation, which may or may not have taken place.

Cases involving "delayed diagnosis" or "failure to diagnose" reflect an upward nationwide trend in malpractice litigation. Errors in diagnosis are usually recognized in retrospect, with the bias of hindsight. Diagnoses become much clearer when you have all the information, which of course, the provider doesn't always have at the time a decision is made.

In an interview with Kathleen Dwyer, Harvard Risk Management Foundation, Dr. Lucian Leape suggests the following1:

1. Diagnostic errors result from some very straightforward mechanisms that we can do something about. One of the common causes is failure to think of a diagnosis. Even experts, at times, forget things that we know. Therefore, one of the ways to deal with the failure to think of a diagnosis is to have and to use diagnostic aids such as computer-assisted diagnosis.
2. A second way in which providers tend to make errors in diagnosis is to pursue an incorrect hypothesis. This is related to a very normal human cognitive function. Many providers tend to not think twice, but rather go with the first thing that comes to mind that appears to be the solution to the problem. If that happens to be wrong, and the provider pursues it relentlessly in spite of evidence to the contrary, an incorrect diagnosis will be made. Dr. Jerome Goodman discusses this mode of thinking using many patient examples in his book, "How Doctors Think."2
3. A third factor is the failure to follow through. Providers can't always make a diagnosis, but everyone should have learned to pursue a problem until it is ultimately solved. One way that's done is by bringing the patient back, ordering recommended tests, making sure they are done accurately, knowing the results, and following through. Having reliable tracking and communication systems will help ensure that patients don't fall through the cracks.
4. A fourth reason for diagnostic errors is bad information, such as labs that should be repeated, imaging studies with technical deficiencies, etc.

With regard to the phenomenon of narrow diagnostic focus, the provider's responsibility is to be aware that the diagnostic process is one of grounding assessments, and is not necessarily clinically certain. This can be a difficult concept for patients to understand. Critical to diagnosis is creating a personal connection and trust with the patient. When we align the goals of better outcomes and healthy patients, healthcare systems will see increased patient satisfaction, successful organizations, and satisfying careers for those that provide healthcare.

References

1 The Role of Human Factors Research in Reducing Medical Errors: A Conversation with Dr. Lucian Leape, Conducted by Kathleen Dwyer, MSN, Forum Winter 1997, Risk Management Foundation of the Harvard Medical Institutions, Inc.

2 How Doctors Think, Jerome Groopman, MD, Houghton Mifflin Company 2007

3 The Inevitability of Narrow Diagnostic Focus and Trust, Andrew L. Epstein, MD, Forum Winter 1997, Risk Management Foundation of the Harvard Medical institutions Inc.

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