FRAGMENTED CARE DELAYED A DIAGNOSIS OF MENINGITIS

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DESCRIPTION

Six days after his initial visit to Urgent Care for ear pain and facial paralysis—and after three CT scans—a 28-year-old man was diagnosed with bacterial meningitis.

KEY LESSONS

- A patient's return for care with worsening symptoms should trigger a diagnostic questioning protocol
- Fragmented patient care increases the need for concurrent communication among providerst

CLINICAL SEQUENCE

A 28-year-old man presented to Urgent Care with complains of right ear pain and right-sided facial paralysis.

At this visit, impacted ear wax was noted and removed, and a CT scan was performed. The Radiology report read, "no acute intracranial abnormality and minimal non-specific, non-aggressive fluid R otomastoid cells." A diagnosis of Bell's palsy was made with a plan was for oral steroids and follow up with ENT.

Three days later, the patient presented to the ENT, now with complaints of dizziness, hearing loss, facial nerve weakness, ear discharge, and pain. The ENT concurred with the Bell's palsy diagnosis and increased the patient's steroids.

Two days later, at his home, the patient was found confused and banging his head on the floor. He was transferred to an emergency department (ED). The Emergency Medicine physician ordered a head CT to rule out injury/trauma. The CT report stated, "no acute abnormality."

Twelve hours later, the patient became unresponsive. A head CT scan was repeated and the Radiology report identified fluid in the right ear and opacification of mastoid air cells. He was admitted with a diagnosis of bacterial meningitis, with respiratory insufficiency, dysphagia, aphasia, and cognitive decline.

The patient remained in acute care for 10 months and was discharged to a rehabilitation facility. He has permanent brain damage, hemiplegia, and requires 24-hour care.

ALLEGATION

A claim was brought against the initial radiologist and ENT alleging delays in diagnosis and treatment of meningitis resulting in permanent brain damage. One plaintiff expert and two defendant experts determined that the radiologist fell below the standard of care when he failed to note mastoid disease, fluid, and bony erosion of the right ear. All three opined that earlier treatment would have changed the outcome.

DISPOSITION

This case settled for >$1M.

DISCUSSION QUESTIONS

1. What was the role of confirmation bias in this case?
2. How did the patient's fragmented care (Urgent Care, ENT, ED) impact his medical treatment?
3. What behaviors or processes may have allowed for an earlier diagnosis, even after the initial scan was misread?