PATIENT SAFETY RESOURCES

INADEQUATE DIFFERENTIAL HINDERS CHANCE TO PREVENT PARALYSIS

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DESCRIPTION

A young adult with a history of IV drug use became paraplegic after repeated Emergency Department (ED) visits for a complaint of back pain.

KEY LESSONS

- When a patient is unable to communicate or give a history, seek collateral information from family members if possible.
- Unconscious biases can cloud judgment, leading to skewed differential diagnoses and the potential for a delay in treatment.
- Contemporary communication and documentation of a patient's status change is critical for acute care.

CLINICAL SEQUENCE

A 24-year-old with a history of methadone use, heroin abuse, and chronic back pain presented to the ED with chief complaint of back pain. The Emergency Medicine physician documented a normal neurological exam, with a differential diagnosis of lumbar strain, radiculopathy, fracture, abdominal aortic aneurysm, kidney stones, or acute pyelonephritis/urinary tract infection. The patient was discharged home with a diagnoses of acute lower back pain and acute narcotic withdrawal.

Five days later, the patient returned to the ED unable to walk or communicate. The patient's mother reported the patient to be lethargic and delusional over past 24 hours; she suspected a drug overdose. On examination, the patient was agitated, combative, and moving all four extremities. They were given Haldol. Lab work revealed urine positive for opiates and tricyclics, and an elevated white blood count. The patient was diagnosed with acute polydrug ingestion with altered sensorium and possible tricyclic overdose. They were admitted to the hospital.

The patient's mother told the admitting hospitalist that, two weeks prior, the patient experienced 3–4 days of stool incontinence (but no urine incontinence). Due to the patient's altered mental status, a neurological exam was not conducted. They were diagnosed with acute encephalopathy with known drug abuse, and admitted to Telemetry.

The patient initially remained disoriented and unable to follow commands. Not long after admission, they became agitated and were moving all extremities. The hospitalist ordered morphine. Later in the evening, the patient's temperature was 101.2 degrees; the staff did not notify the hospitalist.

Five hours later, the patient was noted to be groaning in pain. Staff notified the on-call physician who ordered an X-ray but did not examine the patient (the X-ray was negative). Two hours later, the nurse's note stated bilateral lower extremities flaccid and "patient complaining of severe lower and upper back pain." During discovery, Nursing stated the on-call physician was contacted, but there was no documentation of the call, and the physician denied a call was made. Approximately six hours after the noted change in symptoms, a second hospitalist rounded and assessed the patient to have no lower extremity movement. An MRI revealed a spinal epidural abscess (SEA), C5 to T2 with soft tissue abscess at T1-T2. The patient is now a paraplegic.

ALLEGATIONS

The patient alleges that their paraplegia is due to a failure to establish an appropriate differential diagnosis and miscommunication among providers regarding the patient's condition.

DISPOSITION

This case was settled in excess of $1M.

ANALYSIS

IV drug users are at high risk for SEA. At the initial ED presentation, the failure to obtain collateral information of the patient's progression of symptoms from their mother hindered the physician's differential diagnosis. Upon return to the ED—and subsequent admission to the hospital—the failure to communicate the patient's changes in status hindered treatment opportunities. The delay in diagnosis of SEA likely resulted in paraplegia.

REFERENCES/HYPERLINKS

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