

# Bouncebacks

## A 45-Year-Old Man with Cough and Sore Throat: A Two-Step Approach to Avoiding a Bounceback

**Urgent message:** The clinician must address unexpected findings with further questions or testing.

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This is the first article in a series that will appear every other month in *JUCM*, in which we will recount scenarios of actual patients who presented to an emergency department or urgent care facility, were evaluated and discharged, and then “bounced back.”

Each of these cases is detailed in the book *Bouncebacks! Emergency Department Cases: ED Returns*, (2006, Anadem Publishing, [www.anadem.com](http://www.anadem.com)) which includes case-by-case risk management commentary by Gregory L. Henry, past president of The American College of Emergency Physicians (ACEP), and discussions by other nationally recognized experts.

The focus of the *JUCM* series will be a two-step process designed to improve patient safety and reduction in legal risk:

### Step 1

Identify high-risk patients—specifically, patients with the

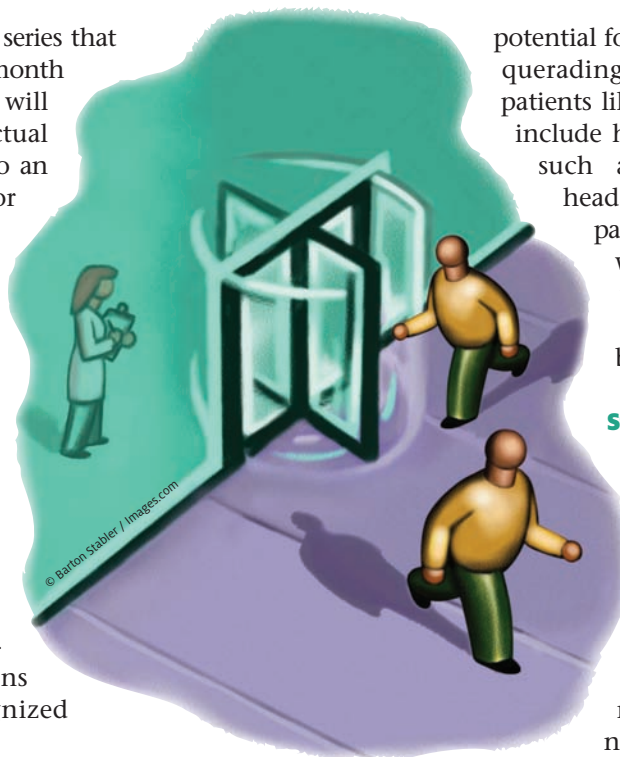
potential for serious medical illness masquerading as a benign problem—or patients likely to be litigious. Examples include high-risk discharge diagnoses such as chest pain, fever and headache, abdominal pain, upset patients, patients who have issues with billing, a long wait, or unmet expectations, and patients who have bounced back.

### Step 2

Review the chart *before* the patient leaves the urgent care. Affirm consistent documentation between the nurse/tech and physician, address all documented complaints in H&P, confirm that the history is accurate, review potentially serious diagnoses, explore abnormal findings, write a progress note explaining

the medical decision-making process (if unclear from the H&P), and assure that aftercare instructions are specific and that follow-up is timely and available.

The following case is an example of this approach. On the surface, the evaluation seems well thought out, but



a closer look reveals some serious documentation and evaluation issues. See how many you can spot!

Let's get started; remember that patient you saw last night?

### A 45-Year-Old Man with Cough and Sore Throat

#### Initial Visit

[Note: The following is the actual documentation by the providers, including punctuation and spelling errors.]

#### Chief complaint (00:39)

Sore throat.

#### Vital signs

Time: 00:39

Temp(F): 97.8

Pulse: 110

Resp: 16

Syst: 110

Diast: 82

Pos: S

O2 Sat: 98

O2%: RA

#### History of Present Illness (physician assistant)

45-year-old male c/o cough and throat pain x 1 month. Admits to past hx of GERD. States he has been taking Zantac for a week. His PCP prescribed a cough medicine and an antibiotic, but the cough has not improved. Denies known fever. Admits to feeling hot and having intermittent chills. Denies n/v/d, abdominal pain, ear pain, chest pain, peripheral edema, calf muscle pain, shortness of breath, rhinorrhea. The history is provided by the patient. He refuses an interpreter.

#### Past Medical History/Triage (at 00:26)

Medication, common allergies: No known allergies. Current meds: Zoloft and Tramadol HCl and Zantac, and Lipitor.

#### Past medical/surgical history:

Depression, headache. No significant surgical history.

#### Physical Exam (physician assistant)

**General:** Well-appearing; well-nourished; A&O X 3,

*“Each complaint  
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in no apparent distress.

**Neck:** No JVD or distended neck veins.

**Resp:** Normal chest excursion with respiration; breath sounds clear and equal bilaterally; no wheezes, rhonchi, or rales.

**Card:** Regular rhythm, without murmurs, rub.

**Abd:** Non-distended; non-tender, soft, without rigidity, rebound or guarding.

**Skin:** Normal for age and race; warm and dry without diaphoresis.

**Extremities:** No peripheral edema or calf muscle pain.

#### Results (01:43)

PA and lateral CXR. The heart size is enlarged. The pulmonary vasculature is within normal limits. No acute infiltrates or evidence of CHF is seen. Impression: Cardiomegaly.

#### Progress Note (03:23) (physician)

I spoke with his PCP and discussed the case including getting a cardiac ECHO and to ensure follow-up. I do not feel that he needs admission as there is no peripheral edema, crackles on exam, or pulmonary edema on CXR.

#### Diagnosis

Cough, gastritis.

#### Follow-Up

Prescriptions for Prilosec and Hycodan. Follow up with primary physician in 3 days. Outpatient testing for cardiac ECHO ordered with results to be sent to PCP. Discharge time was 03:44.

### Discussion of Documentation and Risk Management Issues in Visit 1

#### Error 1

**Error:** It is documented in the HPI “He refuses an interpreter.” Is our history accurate? Was the history given by the patient or elicited with yes/no questions (usually a less accurate history)? This brief sentence calls into question the reliability of the entire history.

**Intervention:** If there is a question about the patient's ability to adequately communicate, try to find other ways to obtain their history such as using an

interpreter (or language phone line), family members, writing questions and answers (hearing impaired). Document their understanding of the risks of refusing an interpreter.

**Summary:** If the patient is not able to communicate an accurate history, you will not be able to make an accurate diagnosis.

**Error 2**

**Error:** The chief complaint is not addressed in the history. The physical exam does not have a throat exam.

**Intervention:** The diagnosis can be determined 73% to 92% of the time from the history alone. Read the nurse's notes to ensure your evaluation reflects all of the patient's concerns.

**Summary:** Each complaint (and certainly the *chief* complaint) needs to be specifically addressed in the history and physical. The documentation of the nurse and physician need to be consistent. If this chart would have been reviewed before the patient left the ED, this major discrepancy may have been detected and addressed.

**Error 3**

**Error:** Heart failure was a concern of initial physician, but the patient was not questioned about symptoms specific for heart failure

**Intervention:** Patients and physicians have different understandings of the term "shortness of breath." Positive findings during evaluation may require more extensive H&P. After the cardiomegaly was found on CXR (an unexpected finding—the CXR was probably ordered to look for infiltrate), the physician should "close the loop" by returning to the bedside, and specifically asking about symptoms of heart failure such as dyspnea with exertion, orthopnea, and paroxysmal nocturnal dyspnea, as well as risk factors for heart failure (such as cardiac risk factors) in the patient or family history of coronary disease or heart failure. The most important thing is to make an accurate diagnosis, not to pad the chart with extraneous or inaccurate information.

**Summary:** *This is the most important lesson to be learned from this case:* When evaluation or testing reveals unexpected findings (in this case cardiomegaly), you need to

*"It is hard to justify a diagnosis if history and physical exam do not support it."*

address these findings with further questioning or testing.

**Error 4**

**Error:** Elevated pulse not addressed.

**Intervention:** Just as abnormal findings on testing need to be addressed, abnormal vital signs need to be rechecked and addressed by discussion in a progress note (unless obvious; i.e., tachycardia in a young patient with dehydration which resolves with IV fluids).

**Summary:** Abnormal vital signs need to be rechecked.

**Error 5**

**Error:** Patient was diagnosed with gastritis and prescribed omeprazole, but the history and exam do not support this diagnosis.

**Intervention:** If the thought process is not clear by reading the chart, then the medical decision-making needs to be explained in a progress note. For example, if you have a young patient with sharp chest pain and you document an extensive review of symptoms (ROS) for DVT/PE and document reproducible chest pain with palpation, then a diagnosis of "muscular strain" is supported in the H&P, and a progress note is probably not necessary. In this case, the chief complaint is not reflected in the H&P, and the H&P does not support the diagnosis. This chart needs either a progress note to explain the medical decision, or a more complete H&P to justify the diagnosis

**Summary:** It is hard to justify a diagnosis if history and physical exam do not support it.

**A 45-Year-Old Man with Cough and Sore Throat**

**Return Visit—36 Hours Later**

- Returned 36 hours later with chief complaint of difficulty breathing. Nursing documentation was that he was anxious and speaking in brief phrases only.
- Physical exam documented "severe respiratory distress" and marked JVD.
- Initial SBP was 85 which soon decreased to 59.
- He was intubated and given IV fluids with an initial diagnosis of pericardial effusion with possible tamponade.
- Dopamine drip started.

*“Our goal is to take good care of patients, not merely avoid lawsuits.”*

- ECHO results: Severely reduced left ventricular systolic function with ejection fraction (EF) of 15%.
- He had a stormy hospital course and was discharged to an ECF with tube feedings and DNR status.
- Final diagnoses
  - Cardiomyopathy of uncertain etiology
  - Acute renal failure, shock liver
  - Bilateral foot ischemia secondary to prolonged norepinephrine bitartrate and/or DIC
  - Encephalopathy

#### **Summary of Case and Risk Management Principles**

Our patient decompensated quickly—my wishes that you never have the misfortune to have this “time bomb” walk into your urgent care! He had been seen by two physicians (the PCP and the ED doc), but neither made this difficult diagnosis. The second physician came closer, and if an ECHO had been done, it would have likely revealed the diagnosis.

Symptoms often do not easily point to a diagnosis, but recognition of “red flags” sounds the alarm to explore more deeply.

Our patient was initially diagnosed with an infectious process and placed on antibiotics. On his first ED visit, his symptoms were cough and sore throat, and he specifically denied shortness of breath. It is noted that he refused an interpreter, but it is unclear if the communication during the interview was adequate.

In a busy urgent care, it is easy to string together a long list of ROS questions, and at the end if the patient answers “no,” to assume the infor-



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mation is accurate. It would be interesting to know the patient's understanding of the phrase "shortness of breath;" I have often had a patient answer "no" when asked about chest *pain*, but later learned he has chest *pressure*. Our patient had no SOB when seated on the gurney in the ED, but did he have dyspnea with exertion or orthopnea? We will never know for sure.

The initial physician did seem to be concerned about heart failure (HF), due to the cardiomegaly seen on CXR. A progress note was written before discharge to justify outpatient testing. If HF was a concern (using our "retrospect-o-scope"), it may have been helpful to confirm that the history was correct. If he had been re-questioned about dyspnea (or orthopnea) prior to discharge, the evaluation and outcome may have been different. In addition, an ECG could have been performed; a recent study showed that of 96 patients with HF, none had a normal ECG.<sup>1</sup> Unfortunately, he was sent home, decompensated quickly, and ended up in a nursing home on tube feedings.

Most likely, the defendant's case would stand up if brought to trial, but our goal is to take good care of patients, not merely to avoid lawsuits. ■

### Reference

1. Davie, AP, Love MP, McMurray JJ. Value of ECGs in identifying heart failure due to left ventricular systolic dysfunction. *BMJ*. 1996;313:300-301.

### Suggested Readings

Stapczynski JS. Respiratory distress. In: Tintinalli JE, et al. eds. *Emergency Medicine: A Comprehensive Study Guide*. 6<sup>th</sup> edition. New York: McGraw Hill;2004:437-445.

Gonzales R, Bartlett JG, Besser RE, et al. Principles of appropriate antibiotic use for treatment of acute respiratory tract infections in adults: Background, specific aims, and methods. *Ann Intern Med*. 2001;134:479-486.

Kline JA. Dyspnea: Fear, loathing, and physiology. *Emerg Med Practice*. 1999;1:1-20.

D'Urzo A, Jugovic P. Chronic cough: Three most common causes. *Can Fam Physician*. 2002;48:1311

Kosowsky JM, Kobayashi L. Acutely decompensated heart failure: Diagnostic and therapeutic strategies for the new millennium. *Emerg Med Practice*. 2002;2:1-28.

American College of Emergency Physicians (ACEP) Clinical Policy Statement: Clinical Policy: Critical issues in the evaluation and management of adult patients presenting to the emergency department with acute heart failure syndromes. From the American College of Emergency Physicians Clinical Policy subcommittee (writing committee) on acute heart failure syndromes: Scott M. Silvers, MD (subcommittee chair) October 18, 2006. Available at: <http://www.acep.org/NR/rdonlyres/88AD9E54-805B-4B86-BDA6-E861697BF734/0/AHFS.pdf>.



## Call for Articles

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