



A Legal Quandary: Poor Care... or Malpractice?

Urgent message: Failure to consider subtleties and the context in which a patient presents can lead to insufficient differential diagnoses and, therefore, mis- or missed diagnoses that leave the patient at risk for poor outcomes and the provider at risk for litigation.

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Back pain is usually back pain, whether it's from a muscular strain or another self-limiting, non-serious cause. But there is potential danger lurking below the surface, ranging from renal cell carcinoma to acute pancreatitis to expanding or ruptured abdominal aortic aneurysm to a spinal epidural abscess (SEA).

The actual legal case described here highlights some of the ways we can be led astray—as well as some of the red flags which, if recognized, can help us avoid an adverse outcome and potential legal peril.

The Case

The patient is a 44-year-old man with a past history of hepatitis C and a remote history of neck surgery with implanted hardware. He is otherwise healthy and is employed.

Visit #1

He presents initially to his primary care physician with complaints of 3 to 4 days of headache, photophobia, and upper respiratory symptoms. On exam he has neck tenderness to palpation but there is no nuchal rigidity. He is discharged with a diagnosis of upper respiratory infection and instructed to use symptomatic management.

Visit #2

Three days later, the patient has worsening symptoms and is seen in the emergency department. He has a



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bedside evaluation and is diagnosed with viral URI and discharged.

Visit #3

Four days later he presents to his primary care physician again, now with worsening headache, nausea and vomiting, and photophobia. He is given a prescription for oxycodone and discharged.

Visit #4

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The patient presents to urgent care with a temperature of 101.4°F, hallucinations, and neck stiffness. He is sent emergently to the ED with concern for meningitis.

Visit #5

The ED shares the concern for meningitis and performs lab work including a CBC and chemistry panel which both return normal. A lumbar puncture is performed and shows 692 WBCs (80% polys), but no organisms are seen. He is diagnosed with viral meningitis and discharged with MS-Contin and ondansetron.

Visit #6

The next morning, the CSF culture returns negative, but blood cultures done in the ED are positive for *Staphylococcus aureus*. He is called and quickly returns to the ED, where antibiotic therapy is started. After 2 days in the hospital, he develops lower extremity paresthesias, inability to stand, and urinary retention. A Foley is placed and measures 1000 cc of urine. A cervical MRI reveals a spinal epidural abscess at C5-6 in the area of the implanted hardware. Despite surgical drainage and decompression, he is left with permanent arm and leg weakness and inability to work.

Neck Pain, Cervical Epidural Abscess, and the Legal Process That Followed

A lawsuit is filed, with allegations of failure to diagnose and delay of diagnosis. Before we see how the case was argued by each side, however, let's explore some facts on cervical epidural abscess.

Nontraumatic neck pain has many etiologies; one approach to differentiation is to classify as mechanical vs nonmechanical.

- *Mechanical* includes a muscular strain, arthritis, malignancy, cervical stenosis, cervical radiculopathy, osteolytic lesion, torticollis/extrapyramidal and spinal epidural abscess.

- *Nonmechanical* includes acute coronary syndrome, peritonsillar or retropharyngeal abscess, cervical artery dissection.

Factors suggesting a *strain* etiology include:

1. Mechanical – A strain-type mechanism (ie, sudden onset while lifting or turning head)
2. Subjective pain – Patient relates that pain is worse with range of motion
3. Objective pain – Pain is worse with palpation or when the patient is asked to move their neck

Factors which make strain *less* likely include presence of fever, unintentional weight loss, worsened discomfort with exertion (ACS), lack of defined mechanism, no pain with range of motion or palpation. Caution is warranted with patients with high risk factors, such as intravenous drug users (IVDU); for example, instead of asking *Do you use any drugs?* consider asking *Have you ever tried or experimented with injection drugs?*

The incidence of spinal epidural abscess is increasing; Artenstein, et al evaluated 162 patients with SEA compared with 88 controls and found:¹

- The incidence of SEA increased three-fold from 2005 to 2015.
- Cases were likely to have comorbidities of IVDU, diabetes, or alcohol abuse.
- Fever was present in 62%.
- Urinary retention or incontinence was present only 6%–9% of the time.
- Cervical SEA had a duration of 6 days of pain on presentation, while SEA of the back had duration of symptoms of 7 days.¹

Cervical epidural abscess is not a difficult diagnosis to make—provided that it is considered. Patel, et al evaluated 128 patients with diagnosis of cervical epidural abscess, with the following findings:²

- Although 100% had neck pain (site-specific pain), only 50% had fever and 47% had weakness.
- Risk factors included IV drug abuse (in 39%) and diabetes (22%); 23% had no risk factors.
- Most pathogens were *Staph* with 40% being methicillin-sensitive *Staph aureus* (MSSA) and 30% being methicillin-resistant *Staph aureus* (MRSA).

Davis, et al evaluated 55 patients over a 9-year period and found that 46 out of 55 (84%) had a diagnostic delay. Of the 55 patients, 45 (82%) had neurologic deficits. Risk factors included diabetes, IVDU, chronic liver or kidney disease, recent spine procedure or indwelling spinal hardware, recent spine fracture, indwelling vascular catheter, immunocompromised state, or other site of infection.³

Legal

If most patients, per the study above by Davis et al, had a diagnostic delay, is there a standard of care to make the diagnosis? The answer is...maybe. Certainly a patient who presents with neck pain after a football injury with subjective pain with range of motion and localized muscular pain with palpation would not even have SEA in the differential. By extension, this would be a very difficult case for the plaintiff. But in a patient with risk factors, and without a mechanism (ie, without a viable alternative explanation for the pain), we should maintain an index of suspicion to delve deeply into the history of present illness; past history, including recent surgeries; social history (IVDU); and exam.

Was that done in the case above?

The plaintiff's case could be summed up as follows: *You should have admitted me and treated me with IV antibiotics as soon as you saw the CSF results. They were grossly abnormal. I had risk factors for SEA and you dismissed them. You should have done an MRI and found my abscess before it was too late. Now I'm disabled and can't work.*

The defense could reasonably counter, *You had symptoms for 2 1/2 weeks. They weren't the classic triad for SEA.*

Discussion

Though both sides make a good argument, there are significant subtleties. Was there consideration of SEA and a medical decision-making (MDM) note detailing why this was *not* present? Were there findings suggestive of SEA which were discounted?

The best chance at a correct and timely diagnosis was on the fourth visit, when the patient was sent from the urgent care to the ED, only to have the ED send home a patient with a fever, "hallucinations," and a markedly abnormal CSF report. Though the ED clinician did not think there was a bacterial meningitis (and was correct with no organisms seen and a negative CSF culture), they did not extend the differential to the epidural space; it was only by a positive blood culture that the SEA was suspected and diagnosed... ultimately too late.

Remember, "If it's not in the differential, it won't be in the diagnosis."

Was This Malpractice?

Over the course of the first three visits, this would have been an extremely difficult diagnosis to make. Though fever is a component of SEA, per the studies listed previously, fever is only present 50% to 62% of the time, only a little better than a flip of a coin. Without being a "fly on the wall" at these first three evaluations, it seems like the standard of care was met; there was an

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alternative reason for the patient's symptoms and symptomatic management was appropriate.

When the fourth visit rolled around, however, the patient was sent from urgent care to the ED; and this was the foundation for the litigation. Good job for doing the lumbar puncture, but without a consideration of SEA, we have "won the battle but lost the war." In fact, had SEA been in the differential, an LP would be contraindicated. It is up to the attorneys, the insurance company, and the jury to determine if the standard of care was met.

The Legal Outcome

After more than 5 years of litigation, there was a large settlement, the details of which are confidential.

Takeaways

- *Staph* is the most common cause of SEA and a rare cause of meningitis. The CSF was grossly abnormal and inconsistent with viral meningitis. A negative CSF culture with positive blood cultures is not bacterial meningitis.
- The patient was not a current IV drug user, but had risk factors including chronic liver disease (hepatitis C) and spinal hardware, placing him at a higher risk of SEA.
- Though this was a difficult diagnosis to make initially, when the patient returned with fevers and hallucinations a concern for not only bacterial meningitis but SEA could have been considered.
- The "classic triad" for SEA (fever, back pain, and neurological symptoms) is present in less than 15% of patients. By the time all three are present, the chance to reverse neurologic damage is small. ■

References

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