PATIENT SAFETY RESOURCES

INCOMPLETE RECORD REVIEW DELAYS ENDOCARDITIS DIAGNOSES

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DESCRIPTION

A diagnosis of endocarditis was made 18 days after the patient, who had a (known) congenital bicuspid aortic valve, initially presented with fever and fatigue.

KEY LESSONS

- When patients return with repeated complaints, consider other causes for symptoms
- Communicating with patients in ways not captured in their health records may contribute to missed information and assessment opportunities
- Develop triggers for when to bring patients to the office when they call with unresolved complaints

CLINICAL SEQUENCE

A 43-year-old female saw her new primary care physician (PCP) one time. Shortly after that visit, she was seen by a covering physician for an urgent care appointment with complaints of intermittent fever and fatigue for one week. Her exam was unremarkable; no heart murmur was detected. Blood work, including Lyme serology, urinalysis, and urine culture were ordered. She was instructed to call or return if her symptoms worsened.

Two days later, the patient emailed her PCP with a complaint of continued fever, fatigue, and a new rash. She was scheduled for an appointment with her PCP for the following day. Her PCP did not see the patient's history of congenital bicuspid aortic valve, which was in her medical record. Lab work was repeated, and the patient was treated for a presumed urinary tract infection.

Initially, the patient improved, but eight days after her visit, she called the office—and emailed her PCP—with complaints of increased fever (to 102.5), joint pain, and a rash that had spread to her chest. The patient, who requested additional blood work and a treatment plan, was not seen in person, but her lab work was repeated. She was also referred to infectious disease for evaluation of her persistent fever and fatigue.

One week later, on exam by the infectious disease physician, a heart murmur was noted. A subsequent ECHO led to diagnosis of aortic valve endocarditis. The patient was admitted for IV antibiotics and required a valve replacement. She did not experience any long-term sequelae.

ALLEGATION

The patient filed an allegation that her PCP's failure to recognize her medical history led to the delayed diagnosis and treatment of endocarditis.

DISPOSITION

The case was settled in the medium range.

ANALYSIS

The PCP did not review the medical record and relied on the patient to share their medical history. A system that allows patient history to go unnoticed is a vulnerability. Situating medical histories and problem lists in easily accessible areas of the medical record might make it easier for clinicians to notice and address relevant patient risk factors.

The patient was not improving with antibiotics and had persistent fevers. When patients return or call with continued complaints or worsening symptoms, the differential diagnosis should be expanded by seeking additional information from the patient and their medical record.

The PCP should have considered evaluating the patient in the office when she emailed with continued complaints. The use of triage protocols and escalation processes for the care team can help identify when a patient should be seen in-person. One suggestion to help determine the appropriate care setting is by asking, Would I do anything different if the patient were in the office? If the answer is yes, then the patient should be seen in-person.

The patient emailed and called her PCP over the course of several weeks with worsening symptoms, but without a clear treatment plan. Patients rely on their health care teams to respond to repeated

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ANALYSIS

complaints that are not improving. Patients expect that clinicians will review their medical records and histories to develop a treatment plan which addresses their concerns. Adopt protocols and processes, including second opinions, if patients are not responding as expected.

Failure to appreciate the patient's relevant past medical history, and failure to establish a differential diagnosis, did not meet the standard of care. Systematically review the patient's medical record to ensure pertinent information is not missed. It may reduce the risk of delayed treatment and poor patient outcome.

REFERENCES AND HYPERLINKS

- Diagnostic Errors are Everyone's Problem
- Patient Safety Alerts
- Virtual Informed Refusal
- Reducing the Occurrence of Malpractice Cases Involving Insufficient Documentation
- Society for Improving Diagnosis in Medicine