



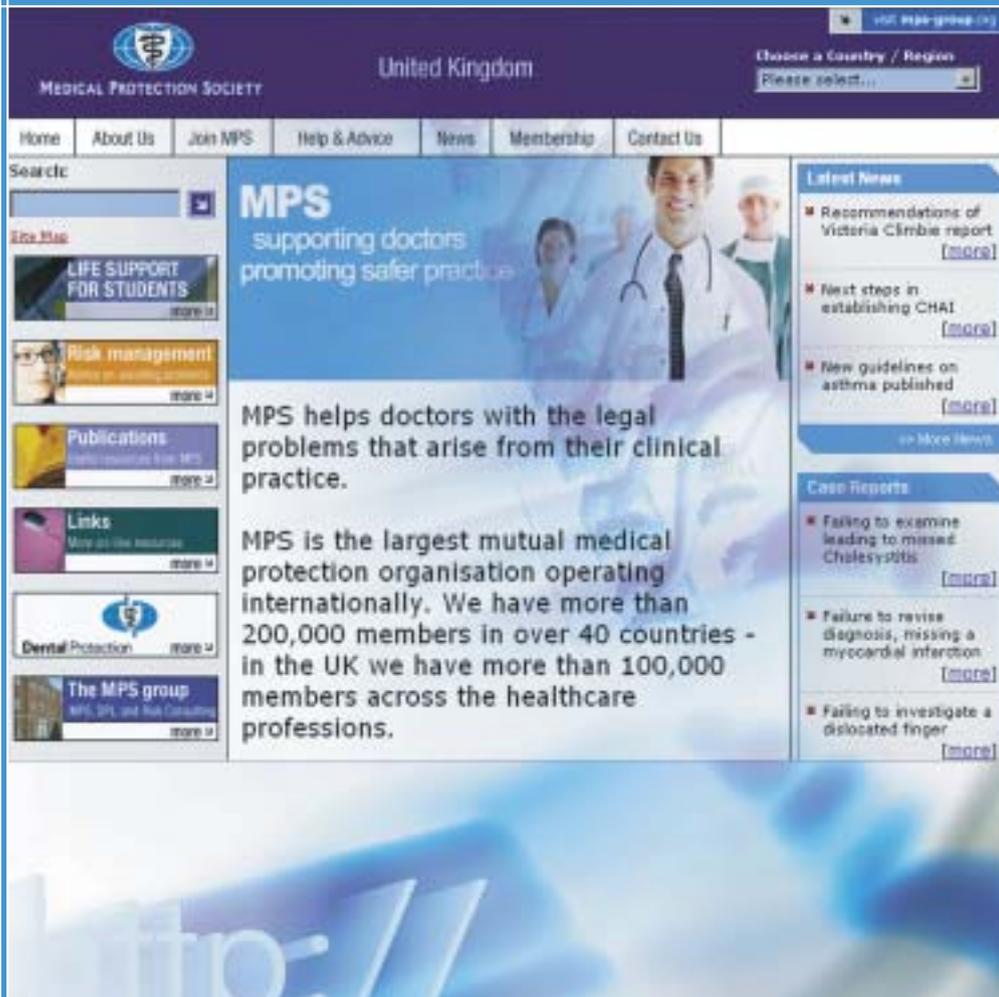
Casebook

Promoting patient safety

**Diagnosing acute
headaches**

**The rising cost
of injuries**

PLUS:
Our usual mix of case reports, letters and news



www.mps.org.uk

The MPS website has improved. It now features:

A search engine which enables you to find the information you want more quickly, whether on a particular specialty (e.g. anaesthesia), a precise issue (e.g. consent), or a specific procedure (e.g. cholecystectomy). It will quickly find all the related articles, case reports and news on the website.

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Second opinion



Dr Gerard Panting
 Communications and
 Policy Director

Sir Liam Donaldson's long-awaited report on reforming clinical negligence litigation in

England (*Making Amends*) has now been published. As a member of that working party, I am delighted to see that many of MPS's recommendations have been included but, as the CMO himself has pointed out, it has been impossible to reach a consensus and it is no surprise to see a number of proposals which we view as inappropriate.

Of the 19 recommendations, MPS fully supports the vast majority. In particular, we are pleased to see the proposal for a no-fault compensation system for patients suffering from severe perinatal injury – something MPS has campaigned for since 1990. MPS has also pressed for the establishment of specialist NHS centres to care for the profoundly injured in place of attempting to meet their needs at home on a private basis.

The suggestion that, within a new NHS Redress Scheme, claims below £30,000 should be assessed on a new basis of 'substandard care' rather than the existing Bolam test is flawed and, frankly, confusing. The Bolam test is the standard by which courts in England and Wales assess doctors' clinical practice. In essence, a doctor is not deemed negligent if he/she is acting in accordance with accepted medical practice. This already establishes the required standard of care, so it is difficult to see where the new notion of 'substandard care' will sit in relation to it. Will it be a higher or a lower standard? To accept a lower standard of care is inconceivable, but if the standard were to be set higher, all doctors providing care in accordance with accepted medical practice would be condemned as negligent.

In the first instance, the Redress Scheme would only apply to NHS hospitals and not to primary care, but, subject to evaluation after a period of time, it is proposed that consideration should be given to extending the NHS Redress Scheme to primary care.

Claims arising from primary care are very different to those in the NHS hospital sector. Primary care is a sector in which MPS has unrivalled expertise as well as the confidence of healthcare professionals working within it. Given our record of speedy resolution of low-value claims, there is no case for

changing the current indemnity system in primary care.

The report also recommends introducing a duty of candour. MPS has long advised doctors and dentists who have made a mistake to establish the full facts, provide an explanation, apologise to the patient and consider what they might do to prevent similar errors occurring in future. To meet the proposed duty of candour, the doctor or dentist first has to be aware that they have done something wrong. In medicine and dentistry, mistakes are not always immediately apparent and it can be the case that the practitioner is unaware that anything is amiss. In many cases, there is a fine line between negligent and non-negligent care that can be hard to discern, particularly for those who are involved in providing care to that patient.

MPS's full initial response can be viewed at www.mps.org.uk

Making Amends is a consultation paper which will lead to the publication of a White Paper towards the end of 2003. Any legislation that follows is unlikely to come into force before 2006.

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Noticeboard

The largest collection of free CME just got better

'Extremely interesting and good way of doing CME'

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Key features:

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- Bite-sized chunks of CME;
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- Case-based learning – based on real patients; and
- One click to add to your PDP or appraisal folder.

Think online learning is a thing of the future, or only for those who like computers? Think again! The fastest growing area of continuing medical education for doctors (CME) is that done through the internet or online – over 10% of UK doctors have already used online CME, with a staggering 93% saying they intend to do so in the next year.

So just why is this way of keeping your knowledge up to date so popular and how can you use online learning to get CME points or as part of your revalidation?

Simple to use

Well the good news is that it is very simple – indeed, if you can use Google you can use Doctors.net.uk online learning. Designed by doctors, for doctors, all you need is access to the internet – whether through NHSnet at work or a normal telephone line at home – and a comfortable chair. Indeed, one of the most popular features of online learning is the 'Martini factor' – you can choose to do your learning anytime, anyplace, anywhere. What this means is that you can start a course at work and choose to finish it at home – see more of the family and collect CME points from the comfort of your armchair!

Life and death decisions (virtually!)

The second reason for the popularity of online learning is that

it is actually fun and interesting, described by one GP as 'Very imaginative – it makes learning easy, fun and effective'. These are not words frequently associated with the endless trawling of journal articles or hours spent at the local postgraduate centre that used to be the only way of keeping your knowledge updated. Online learning is based on challenging, real-life case scenarios, complete with ECGs, x-rays or clinical findings. You have to make the decisions and you instantly see the results of your actions.

How do I start?

Simply go to www.Doctors.net.uk, click on 'Education' and select the module that meets your needs. You will find a huge range of subjects covered, whatever your specialty. In addition to modules of interest to all doctors, there are special courses for GPs, SHOs, physicians, psychiatrists, nephrologists and anaesthetists, with more learning being added every month.

Launching in August is a brand new collaboration between MPS and Doctors.net.uk. Designed specifically for house officers: the *MPS Foundation Course* meets the needs of new graduates but it may prove testing for those of us who graduated more than a few years ago!

Any questions?

All Doctors.net.uk CME is completely free of charge to you as a UK doctor. Simply go to www.Doctors.net.uk for more details and to start using your personal learning library.

Alternatively, phone the free helpdesk on 01235 828401; they will be happy to answer any questions you might have.

www.Doctors.net.uk –
by doctors for doctors

Neil Bacon MRCP

Founder and CEO, Doctors.net.uk

A mixed bag of reform

MPS has given qualified support to the Chief Medical Officer's report on clinical negligence reform, published on 30 June. *Making Amends* is a consultation document recommending a scheme that will offer a package of apologies, care and compensation to injured patients as an alternative to litigation. It includes our long-standing recommendation for the creation of a no-fault compensation scheme for children brain damaged at birth.

The report recommends setting up an NHS Redress Scheme that would investigate medical mishaps, arrange remedial treatment, rehabilitation and care for the patient and provide them with full explanations of what went wrong, with an apology. Financial compensation would also be an option.

A new national body would take over the work of the NHS Litigation Authority and would oversee the NHS Redress Scheme and manage the financial compensation element at a national level.

The report contains many other recommendations that would have a significant impact on healthcare practitioners. Among them is the proposal that reporting errors to patients should be mandatory – a so-called 'duty of candour'. We have some reservations about this proposal as it assumes that one is aware of errors at the time, which is not necessarily the case. View the full report at www.doh.gov.uk/makingamends. The MPS response can be viewed at www.mps.org.uk

Capacity to consent

The Department for Constitutional Affairs (previously the Lord Chancellor's Department) has published new guidance on consent. *Making Decisions: Helping People who have Difficulty Deciding for Themselves* offers advice on the care and treatment of adults who need

support to make decisions. They may need help because of learning difficulty, brain injury, dementia, mental health problems or any other illness or disability that affects the person's mental capacity.

Booklets have been produced for various groups, including legal practitioners, social care professionals and people with learning disabilities.

The booklet for health professionals includes guidance on a range of issues, including

- Defining and assessing mental capacity;
- Deciding on a patient's best interests;
- When to make an application to the High Court; and
- Advance statements.

It explains the current legal position and lists sources of further guidance and relevant organisations.

It does not include guidance for children and young people or the treatment of patients for mental disorder under the Mental Health Act. The information relates only to England and Wales.

A PDF copy of the guidance is on the Department for Constitutional Affairs website:

www.lcd.gov.uk/family/mi/mibooklets/guide3.pdf

Claims eating into budget

The NHS in Wales paid out £46.2 million for clinical negligence claims in 2001/02 – four times as much as the previous year. As a result, the service fell £16 million into debt from being £23.7 million in the black the previous year. This debt could rise to £44 million for 2002/03, which could swallow up the extra funds created by the 1p increase in National Insurance.

The Association of Welsh Community Health Councils said the NHS needed to raise standards in patient care and give medical staff sufficient time to address patients' concerns and questions to cut down on the margin of error.

www.makeashorterlink.com/?R371431D4

August deadline looms

All NHS bodies, among them NHS GPs, dentists, pharmacists and opticians, must submit a publication scheme to the Information Commissioner by 31 August.

The Freedom of Information Act 2000 gives the public a general right of access to all types of information and it imposes two main responsibilities on public authorities:

- To produce a publication scheme – a guide to the information the organisation holds that is available to the public. The scheme must be submitted to the Information Commissioner for approval by 31 August 2003 and be in place by 31 October 2003.
- To respond to individual requests for information – either by referring to the publication scheme or by providing a specific

response. This comes into force in January 2005.

Producing a Publication Scheme

There are two ways of producing a publication scheme – either by producing a bespoke scheme or by using a pre-approved ‘model’ version.

If you produce a bespoke publication scheme you will need to have it approved by the Information Commissioner. If you use a model scheme you will only need to send a declaration form to the Information Commissioner, confirming that you have produced a publication scheme.

The BMA and the NHS Freedom of Information Project Board have produced a model scheme for GPs. More details on the information you will need to include in this publication scheme

can be found on the MPS website at www.mps.org.uk.

Simply completing a model scheme does not fulfil your obligations under the Act. You must then make the publication scheme available (for example on your website if you have one). You must also publish information as promised in your publication scheme, and you will need to ensure that the scheme is kept up to date, for example as information changes or new publications are published.

The NHS Freedom of Information website – www.foi.nhs.uk – has some useful information on model publication schemes. More information on bespoke publication schemes can be found on the Information Commissioner’s website – www.dataprotection.gov.uk

if the software allows large screen fonts, contrasting colours and flashing messages. Pop-up messages should be reviewed on an ongoing basis and any that are no longer applicable should be deleted.

www.rcgp.org.uk/rcgp/quality_unit/docs/1.204ISHIssue2v15.pdf
ISMP Medication Safety Alert! 2 (7)



Free help with revalidation

Revalidation is a major change to the way that doctors in the UK are regulated. Every five years you will need to prove that you are fit to practise. Although this won’t begin until 2005 at the earliest, you need to start collecting evidence for revalidation now.

Revalidation need not be a worrying process. For the most part it simply means putting documents that you already have into a folder to build your body of evidence. However, there are a couple of important points that you should consider:

- You need to be organised.
- You need to start now.

To help you begin compiling the evidence you need, MPS has produced a free set of A4 dividers. They outline the information you need to collect in each section, provide some ideas on how to find the information and, of course, neatly divide your revalidation folder into logical sections.

Please call MPS Publications on 0113 241 0354 or e-mail publications@mps.org.uk for your copy.

GP errors – more research needed

A government study has found that as many as 2.8 million GP consultations every year result in a medical error – one in every 120. Researchers at Manchester University examined 15 studies on medical errors in primary care, including research by the Medical Protection Society, which found that 63% of all medical legal action stemmed from GPs’ errors in investigation and treatment. The study also suggests that over 60% of errors could have been prevented. However, the report admits the true frequency and nature of medical error is complicated by the different definitions and methods used in the studies, and more research is needed to discover the real picture.

The government hopes the National Patient Safety Agency’s adverse incident reporting scheme, which will encourage doctors to report errors and near-misses anonymously, will improve safety across the NHS and reduce

negligence claims, which currently cost £400 million a year.

<http://fampract.oupjournals.org/cgi/content/abstract/20/3/231>



Tackling prescription errors

The RCGP has called for the National Patient Safety Agency to work more closely with national computer suppliers to curb the number of prescribing errors. In the latest issue of *In Safer Hands*, the RCGP published a list of drugs most commonly prescribed incorrectly because they have a similar name to

another drug; these included Clobetasol and Clobetasone, and Lamisil and Lamictal. The college suggests including tick boxes in computer software for the doctor to confirm his/her choice of drug or to introduce a permanent reminder that the drug chosen has a similar name to another.

Meanwhile, the American Institute for Safe Medication Practices (ISMP) has issued a warning about the risk in having too many alerts built into prescribing software. They report that ‘the sheer number of warnings that appear on the screen during order entry can be overwhelming and slow the process. In many cases, clinically insignificant warnings are as likely to appear as those that are vital.’

The ISMP suggests that prescribers regularly refine and update their system’s list of significant alerts. ‘Use internal and external information on possible serious drug interactions, errors, duplications and so on, to guide this process.’ It also recommends making significant alerts as visible as possible

Continued from page 5



Patients don't always understand

Doctors are being urged to structure the advice they give to patients, as most people remember a 'strikingly small' amount of the information doctors tell them. In the May *Journal of the Royal Society of Medicine*, Dr Roy Kessels claimed most patients forgot up to 80% of what they were advised as soon as they left the clinic. This poses major risks to patient safety, especially with the trend towards shorter hospital stays and more outpatient care.

Research by the American Medical Association goes one step further, linking the 'health literacy' of patients to how much they might understand doctors' advice or medication directions. It found that almost 25% of all adult Americans read at or below 5th grade (8/9 years) age level, while medical information leaflets are written at 10th grade age reading level or above. It also found that more than 40% of patients with chronic illness were functionally illiterate and only half of patients take their medication as directed. So those with the greatest healthcare needs may have the least ability to comprehend the information necessary for their successful treatment.

www.roysocmed.ac.uk/new/pr132.htm
<http://jama.ama-assn.org/cgi/content/abstract/281/6/552>

CHCs stay until December

Community Health Councils, the NHS watchdogs for patients' complaints, are to stay functioning until 1 December. Three years ago the government announced plans to abolish CHCs from 1 September 2003 to make way for the new system

of NHS patient involvement, which includes patients' forums and the Patient Advice and Liaison Service (PALS). But, in June, the Commission for Patient and Public Involvement in Healthcare admitted it had yet to finalise arrangement for training its staff. Although the forums will operate a basic service from December, its staff will not be fully trained until Spring 2004. Health minister David Lammy responded to this news by extending the CHCs until December to facilitate a smooth handover between the two systems.

www.health-news.co.uk/showstory.asp?id=112960

Certifying death and the coroner service

The Luce Report has called for radical reforms to the death certification process to protect patients following the case of serial killer Harold Shipman. The Independent Review of Coroner Services was led by Tom Luce and took two years to complete. It makes 122 proposals to improve efficiency and bolster public confidence, including a call for all GP-certified deaths that do not go to a coroner to be countersigned by a second doctor, who will report to a new Statutory Medical Assessor (SMA). These SMAs will advise coroners on medical issues and oversee death certification. The report also recommends a more flexible death investigation system, offering bereaved relatives the right to request a review of certain decisions made by the coroner.

The full report can be seen at www.official-documents.co.uk/document/cm58/5831/5831.pdf

Euthanasia bill gets second reading

Legal voluntary euthanasia in Great Britain moved a step closer in June, as the House of Lords agreed to give the Euthanasia Bill a second reading. This means that Lord Joffe, who is promoting the legislation, can present more detailed proposals to parliament. If the bill becomes law, a

competent adult suffering from a terminal disease or incurable physical illness could ask for medical assistance to die. Karen Sanders, chair of the Royal College of Nursing's ethics forum, has given her support to the bill, but there is strong opposition from disabled rights groups and Catholic bishops, who fear a change in the law would put pressure on disabled people to seek an assisted suicide.

<http://news.bbc.co.uk/1/hi/health/2968078.stm>

Retention of organs without consent – a criminal offence?

HM Inspector of Anatomy, Sir Jeremy Metters, has said taking organs without consent should be made a criminal offence. This follows his investigation of the Cyril Isaacs case, where Mr Isaacs's brain was retained without the consent of his relatives following his suicide in 1987. As strict Jews, they would have refused permission. The report emphasised that 'complete openness' was needed from everybody involved in postmortem examinations to restore public confidence.

The Royal College of Pathologists stressed that retaining brain tissue from postmortems was vital for research, but that its own guidelines on organ retention, published in March 2000, had helped to remedy confusion over this issue of consent. The full report, conclusions and recommendations can be viewed at www.doh.gov.uk/cm0/isaacsreport

Letter imperfect

Research has shown there are often critical flaws in computer-generated letters sent to GPs from A&E departments after they have treated patients. Researchers found incomplete or misleading information in 29% of 300 letters sent by the Derriford Hospital in Plymouth. Inaccuracies or misleading diagnoses were found in 46% of these, while 22% did not include information vital for patient follow up.

Emergency Medical Journal 5/03

Recognising child abuse

The Northern Ireland branches of the NSPCC and Barnardo's have said A&E staff still need more training in diagnosing, detecting and reporting child abuse. Their report, *Child Protection is No Accident*, was produced with staff from A&E departments in Northern Ireland and the Department of Health, Social Services and Public Safety. It said that, although there was plenty of good child protection practice in A&E departments, staff were still uncertain about accessing the Child Protection Register and knowing the best people from whom to seek advice. It recommended staff induction and training in child protection, as well as full guidance for frontline A&E employees in identifying child abuse.

<http://www.nspcc.org.uk/html/home/informationresources/aandedetectchildabuse.htm>



NHS workers prone to accidents

A National Audit Office report says staff-related accidents in UK hospitals are increasing. In 2000, the Department of Health's Working Together initiative aimed to cut incidents like needlestick injuries and falls by 20% by 2001. But the NAO's report showed the total number of accidents had increased by 24%, with only 23% of NHS trusts meeting the reduction target. The findings and recommendations of the report can be seen at

www.nao.gov.uk/publications/nao_reports/02-03/0203623.pdf

Patients like jargon

A new study has shown that patients prefer medical terminology, rather

News in Brief

Correction

The contact details for the Royal Medical Benevolent Fund published in the last edition of Casebook were incorrect. The email and website addresses are:

info@rmbf.org / www.rmbf.org.

NICE has issued new guidance to regulate the use of electroconvulsive therapy (ECT). NICE restricts the use of ECT to the rapid and short-term relief of severe depressive or manic symptoms and catatonia after all other treatment options have failed and suicide is a risk. Doctors must also advise of the side-effects and patients must consent to treatment. The Royal College of Psychiatrists supported NICE's work with the launch of a new ECT accreditation service, but did not agree that ECT should only

be reserved for those with severe depression. For the full guidance and the RCP's viewpoint see

www.nice.org.uk/pdf/59ectfullguidance.pdf and http://www.rcpsych.ac.uk/press/preleases/pr/pr_413.htm

Healthcare workers in Scotland have been given new advice on improving treatment for the country's 240,000 osteoporosis sufferers. The Scottish Intercollegiate Guidelines Network (SIGN), backed by NHS Health Scotland and the National Osteoporosis Society, published its new guidance on 6 June 2003. Management of Osteoporosis can be viewed at

www.sign.ac.uk/pdf/sign71.pdf

The Department of Health has launched new guidance on safeguarding children. *What to do if you're worried a child is being abused* is a concise booklet for those concerned with the welfare of children.

The booklet has been published in response to the practice recommendations raised in the Victoria Climbié Inquiry Report.

www.doh.gov.uk/safeguardingchildren/index.htm

The Health and Safety Executive (HSE) has issued two new guidance booklets: *Safe Working and the Prevention of Infection in the Mortuary and Post Mortem Room* and *Safe Working and the Prevention of Infection in Clinical Laboratories and Similar Facilities*. They contain advice ranging from how to carry out a risk assessment to cleaning, disposal of waste and monitoring employee health. The new guidance revises the booklets first published in 1991. Call HSE's InfoLine on 08701 545500.

Doctors are reminded to check when completing cremation forms if the deceased patient has any artificial joints or

pacemakers fitted. There have been several cases recently where exploding pacemakers have damaged incinerators and where artificial hip joints have caused problems with grinders.

The following guidance has been published since the last issue of Casebook:

NICE – Use of electroconvulsive therapy

www.nice.org.uk/pdf/59ectfullguidance.pdf

SIGN – Management of obesity in children and young people

www.sign.ac.uk/pdf/sign69.pdf

SIGN – Diagnosis and management of epilepsy in adults

www.sign.ac.uk/pdf/sign70.pdf

DoH and RCGP – A framework for doctors and nurses with a special interest

www.doh.gov.uk/pricare/gp-specialinterests/

than the lay terms health professionals have been encouraged to use. The research, published in *Family Practice*, says that patients feel reassured that their problems have been taken more seriously if doctors apply the medical labels, such as 'tonsillitis' instead of 'sore throat'. The lay labels were seen as implying that the patient could take care of himself, that the problem would be short-lived and that it was the patient's fault.

<http://fampract.oupjournals.org/cgi/content/abstract/20/3/248>

Charter of Understanding

Doctors' and patients' organisations and individual doctors are being encouraged to sign up to the values contained in a new 'Charter of Understanding between Doctors and People affected by Medical Accidents'. The

charter was launched by the Royal Society of Medicine and the charity Action for Victims of Medical Accidents (AVMA) in June. It aims to change the 'blame' culture, so when doctors make mistakes the emphasis should be on learning to prevent similar accidents happening and supporting the affected people – not on punishing the doctor.

The charter, which has been well received by doctors' and patients' groups alike, says doctors 'should be supported in reporting errors honestly and openly without fear of unreasonable consequences'. Another of its principles is that if an injury has occurred due to human error, the patient or their next of kin should be informed and have the circumstances fully explained.

MPS has recommended this sort of open approach for more than 20 years, but it is worth reminding

doctors that the patient's consent is needed before explanations can be given to third parties. It is also important to make sure that you have established all the facts before you give the patient or family an explanation of what went wrong. The charter can be viewed in full at

www.avma.co.uk/news.htm

Leaflet for private patients

The Federation of Independent Practitioner Organisations (FIPO), which comprises professional committees and speciality groups involved in private practice, has produced an information leaflet on the rights and responsibilities of the private patient. Because the independent health sector works differently to the NHS, it tells patients what to expect from private care and their role in getting successful treatment.



FIPO's leaflet is intended for both patient and doctor as a guideline for promoting good practice and positive relationships. It is endorsed by the medical protection organisations and the Patient Liaison Group of the Royal College of Surgeons of England. Copies are available from mpsmarketing@mps.org.uk or www.fiipo.org

Diagnosing acute headache

Avoiding pitfalls – a guide to practice

By **Sean Kavanagh, MRCP(UK)**

This article uses cases dealt with by MPS to illustrate the potential pitfalls encountered in treating patients with acute headache. It is a general guide and is not exhaustive. Not all of the diagnoses discussed necessarily present acutely, but they may do so, or be time-sensitive, in terms of preventing avoidable sequelae.

Headache is a common symptom in primary and secondary care. The list of differential diagnoses is immense – numbering several hundred.¹ Most are benign, but there are conditions it is imperative not to miss – see box 1.

History

A useful template for taking a history in headache sufferers can be found at www.bash.org.uk (British Association for the Study of Headache's website). Box 2 (page 11) illustrates relevant historical and diagnostic factors, useful in differentiation of the important diagnoses in acute headache. The history needn't be overly detailed, depending on one's confidence in this field. It is important to establish the nature of the headache's onset and whether or not this type of headache is novel to the patient. At a minimum, one should ascertain the standard 'sieve' of information relating to the nature, site, character and aggravating/relieving factors of the pain. Useful associated features to ask about include photophobia, nausea, syncope, seizures and visual symptoms –

again, see box 2. Many headache diagnoses can be reached on the basis of history alone, but examination is essential – see box 3.

Diagnosis

The crucial thing is to assess the overall combination of symptoms and signs and come to the most likely diagnosis, with the 'not to miss' causes kept high in the differential list. This is illustrated by the following case.

Case 1

Temporal delay in temporal arteritis

Mrs K, a previously fit 75-year-old, went to see Dr C, her GP, because she'd felt generally unwell and lost her appetite. She'd recently lost several kilograms and had back and leg pains.

Dr C's notes don't record a history of headache but Mrs K's daughter later stated that her mother had suffered head and jaw pain from the start of her illness. When Mrs K later attended her local hospital, she gave a clear account of these symptoms. It may be that Mrs K didn't volunteer this information when she saw Dr C, but it would have been wise to ask specifically about these symptoms in an older lady with weight loss and myalgia.

Some weeks later, Mrs K went back to Dr C. She was suffering from 'black spots in front of her eyes' and had lost more weight. Dr C asked Dr R, a locum consultant geriatrician, to make a domiciliary visit.

Dr R noted a history of loss of half of Mrs K's visual field, which had apparently cleared up. Mrs K's daughter later disputed the resolution of this symptom. Dr R ordered tests, including ESR, suggesting referral to an ophthalmologist.

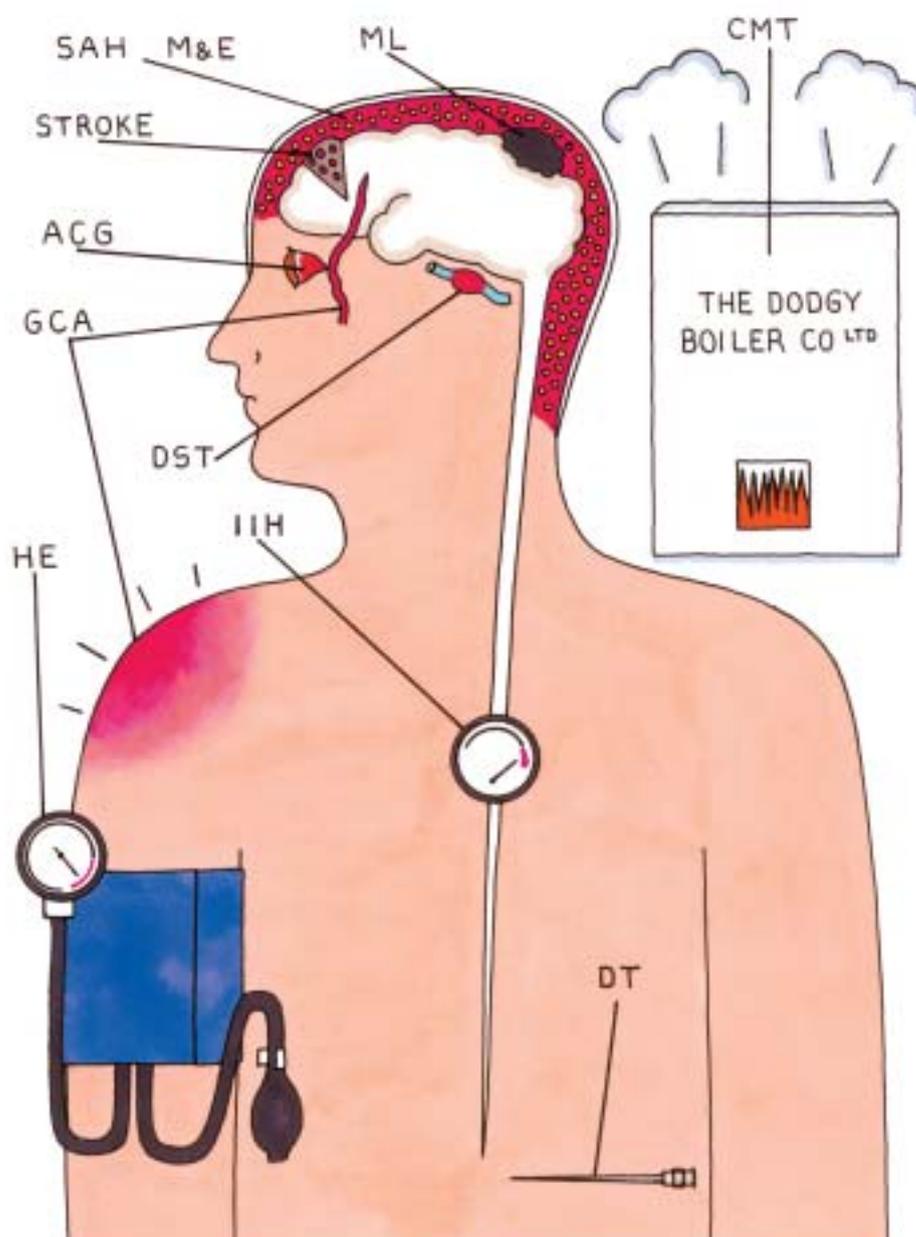
For reasons that are not clear, Mrs K went to an optician who noted right inferior visual field loss, suggesting Dr C seek an ophthalmological opinion. A non-urgent referral was sent that day. On the same day the ESR result came back – grossly elevated at 83 mm/hr. Dr C took no action on this result, nor did he forward it to the ophthalmologist.

Two more weeks passed before Mrs K was diagnosed as having giant cell arteritis in the ophthalmology clinic. Immediate steroid therapy relieved her symptoms, but she was left with permanent disabling visual impairment.

We consulted an expert in general practice. In her opinion, Dr C could be criticised for not acting upon the ESR result – as it was pathognomonic in combination with the history. An expert in geriatrics reported that Dr R should have had giant cell arteritis higher in the differential diagnosis list, and that he should have asked specifically about jaw claudication, formally examined the visual fields and palpated the temporal arteries. In light of these opinions, the claim was settled.

Often, intuition based on experience brings the clinician to the correct cause. A good rule to follow, if you feel you lack the pertinent expertise, is to ask yourself if any of the conditions in the 'not to miss' list (particularly the common ones), could possibly be to blame, referring the patient to a specialist if the answer is 'yes'.

Unfortunately, the specificity of headache symptoms and signs can be low. For example, nausea and photophobia are common to migraine, meningitis and intracranial haemorrhage, and can exist with any sudden, severe headache.



Box 1. Causes of acute headache not to miss

Relatively Common Condition/Acute Headache Presentation

- SUB-ARACHNOID HAEMORRHAGE (SAH)
- STROKE – HAEMORRHAGIC & ISCHAEMIC
- MENINGITIS & ENCEPHALITIS (M&E)
- GIANT CELL (TEMPORAL) ARTERITIS (GCA)
- PRIMARY ANGLE-CLOSURE GLAUCOMA (ACG)

Less Common Condition/Acute Headache Presentation

- IDIOPATHIC INTRACRANIAL HYPERTENSION (Formerly Benign Intracranial Hypertension/Pseudotumour Cerebri) (IHH)
- SUB-ACUTE CARBON MONOXIDE TOXICITY (CMT)
- DURAL TAP OR TEAR (DT)
- HYPERTENSIVE ENCEPHALOPATHY (HE)
- CEREBRAL VENOUS/DURAL SINUS THROMBOSIS (DST)
- MASS LESIONS PRESENTING ACUTELY (Tumour, Abscess, Parameningeal Infection, Intracranial haematoma of parenchymal, subdural or epidural types) (ML)

A point to remember regarding signs of meningeal irritation in meningitis is that, **where the illness is septicaemic, such signs will be absent**, as the meninges are not involved. In the following case, for example, the doctor was reassured by a lack of neck stiffness. Even where meningeal infection is present, it is common, especially amongst children, for neck stiffness and a positive Kernig's sign to be absent.² For this reason one should never rely on the absence of these signs as excluding meningitis or septicaemia.

Case 2

Suspecting septicaemia

Miss H was 17 when she became unwell one evening. Her parents arranged a home visit from the local GP co-operative. Dr M visited at 9pm, and elicited a history of sudden fever, headache and leg pains since 5pm. Dr M found a temperature of 37.8°C, tachycardia and an absence of neck stiffness. Dr M tested straight-leg raising, but didn't test for Kernig's sign. Dr M diagnosed viral illness.

By 5.30 in the morning, Miss H was vomiting and had a rapidly spreading, blotchy, purple rash. Her usual GP was now on duty and sent her to hospital with suspected meningococcal illness. The referral letter stated there was no photophobia or neck stiffness.

Miss H was drowsy but rousable when she got to hospital, where meningococcal septicaemia was confirmed. Miss H had a stormy course in ITU, needing bilateral above-knee amputations. She subsequently suffered hypo-adrenalism and epilepsy.

Miss H's parents launched legal proceedings against Dr M, alleging incomplete examination (failure to do Kernig's test), and a failure to heed their warnings that she had an altered level of consciousness.

We vigorously defended the case to trial, having expert GP and infectious diseases opinion that Dr M's clinical approach was reasonable. We asserted that neck-stiffness and photophobia would be absent as warning signs, this case being due to septicaemia, not meningitis. The crux of the case rested on the parents' statement that Dr M had discounted their concerns about Miss H's impaired consciousness level. Some expert opinion did concur that this should have warned Dr M that something was seriously wrong. The judgment was in favour of Miss H and she received a substantial settlement and costs.

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Reviewing the diagnosis

A common cause of claims is a failure to review the diagnosis, ending in death or disability due to fulminant meningitis. The signs of meningitis can develop in minutes to hours. Their absence, at an earlier assessment by yourself or a colleague, does not exclude their subsequent rapid emergence. One should always review the initial diagnosis in the light of changing clinical information. This is true of all cases of acute headache.

Nobody expects doctors to always diagnose meningitis in the early stages of every case, but a failure to re-assess a deteriorating clinical scenario is usually seen as sub-standard care. Burns' review³ gives this useful golden rule, *'If a patient presents twice within 24 hours to the same practice or hospital, with headache and vomiting, one should consider other causes, apart from migraine, before discharging the patient.'*

Failsafe follow-up arrangements and good communication between teams responsible for patients at different times, in both primary and secondary care sectors, are essential to avoid disaster when there is a rapid change in clinical condition. An informative article in *Casebook*⁴ discusses problems in the diagnosis of meningitis and is online at www.musa.org/couldb.htm.

Some examples from MPS files

Case 3

Drawbacks of telephone consultation

Mr L went home early from work one day, due to a bad headache. He vomited on the way home. His GP, Dr D, saw him there at 7.30 pm, finding him feverish and shaky with a bad headache, but no abnormal clinical signs. Dr D diagnosed gastric flu and advised fluids and paracetamol. Dr D told Mr L's wife to ring for another visit, if things hadn't improved within 24 hours.

Mr L deteriorated, so his wife telephoned Dr P the next evening. She told him of the previous visit, and Mr L's severe headache, vomiting and tummy cramps. Dr P asked if Mr L could flex his neck, which he could. Dr P advised continuing with fluids and taking some codeine that Mr L had at home.

Mr L was very ill by the next morning. A visit by a third doctor resulted in his immediate admission to hospital. He went to ITU and pneumococcal meningitis was diagnosed.

Mr L was left with a blind right eye, a right

sixth cranial-nerve palsy and bilateral facial weakness. He could walk only with a Zimmer frame. These deficits were due to Guillain-Barré syndrome. He suffered tinnitus due to direct cochlear damage.

Legal action against Dr P (but not Dr D), alleged failure to properly assess Mr L. Experts stated that Dr P faced a common set of symptoms and had acted reasonably, if both photophobia and neck stiffness had been asked about on the telephone. In the absence of a record about photophobia, it was impossible to defend Dr P's handling of the consultation.

One expert was dubious about the suitability of assessing suspected meningitis by phone – 'Dr P admitted that meningitis was in his mind by asking Mrs L to observe neck flexion, but failed, by not visiting and examining Mr L, to put himself in a position to make a reasonable assessment of the situation, and this was sub-standard care.'

The claimant was unable to establish causation for any injury other than the deafness. Expert opinion asserted that the neuropathic sequelae wouldn't have been improved by earlier treatment. On this basis, we settled the case for a small sum to compensate for loss of hearing.

The case above shows the need for communication and follow up, and the potential danger of relying on telephone consultations to exclude meningitis. When it comes to paediatric illnesses, the difficulty in providing appropriate, competent telephone-triage systems, even amongst trained and experienced operators, has been well documented.^{5,6,7}

One might conclude that telephone management of potential meningitis is foolhardy. However, febrile illness and headaches are common, and management of such problems with telephone advice is current standard practice. If it is possible, one should avoid assessment of acute headache by telephone. If this is not practicable, we recommend locating (or drawing up your own) protocols.

We have had no success in finding good-quality published protocols/guidelines for telephone assessment of acute headache. If any readers are aware of such publications, we would be grateful to hear from them. It is outside the scope of this article to provide guidelines for telephone consultation for headache. We recommend that practices find good guidance in this area, and subject their current procedures to a risk assessment.

An article on keeping records of telephone consultations can be found in *Casebook*.⁸ A recent paper on the use of an Australian telephone-triage system⁹ states that headache guidelines are in the 'top ten' that they use. A case discussed by the health and disability commissioner of New Zealand, regarding meningitis and telephone consultation, is illuminating.

Visit www.hdc.org.nz/opinions to view the commissioner's report.

The next two cases demonstrate the importance of listening to your patient, examining them properly, recording your findings and reviewing the diagnosis in the light of this information. Where acute headache persists, or becomes more severe, in a normally fit person without a history of previous troublesome headaches, you should hear alarm bells.

Case 4

Cerebrally impaired or just drunk?

Mr T had recently moved to the South of England. He liked a drink after work. One night, on his way home after a few pints in the pub, he injured his head and bruised his body. He couldn't recall how this had happened (a significant factor in his history). A week later he went to A&E, as he'd been unable to work due to somnolence, poor appetite, blurred vision and poor concentration.

Dr S saw him there and noted that Mr T appeared 'rough' and smelt of beer. Mr T freely admitted to enjoying four or five pints of beer a day. He was fully oriented with a GCS of 15/15. A full neurological examination, including fundoscopy, was normal. After seeing a normal skull x-ray, Dr S diagnosed a post-concussion syndrome with concomitant alcohol excess. He told Mr T to register with a local GP, giving him a copy of his A&E card.

Mr T visited Dr F, a local GP, two days later. He told of his severe headache. Dr F noted a healing laceration over the occiput and a smell of beer on Mr T's breath. Dr F gave advice about drinking, and prescribed co-proxamol.

There is no record of any neurological assessment.

Two weeks later Mr T went back to Dr F. He told Dr F of his headache, pain behind the eyes, neck pain, exhaustion and inability to rouse himself from bed for work. Dr F tested visual acuity, finding 6/6(R) and

Box 2. History taking/diagnostic pointers in acute headache

To establish the diagnosis of the following conditions, these features of the history, questions and investigations are useful (but not to be taken as absolutes).

	Classically	Ask	Distinguish from
SAH	Of abrupt 'thunderclap' onset, often occipital.	Worst headache ever? Any photophobia and neck stiffness? Any fits/fainting? Did it start during exertion/sexual intercourse or orgasm? (such headaches, if transient, are usually benign). ¹⁴	Migraine by absence of previous episodes and visual auras (get patient to draw it, it is very characteristic). ¹² Cluster headache by absence of unilateral ocular/nasal symptoms ¹³ . Positively diagnose with neuro-imaging +/- LP. ^{15,16,19}
Stroke	Of rapid and evolving onset, with speech impairment and unilateral limb and/or facial weakness.	About previous stroke and vascular risk factors, speech, visual fields, seizures, conscious level.	Migrainous paresis by absence of previous episodes and quicker resolution, but may need neuro-imaging to confirm.
M&E	Unwell, febrile, often confused or drowsy, with rash (meningococcal septicaemia), or herpes simplex stomatitis (rarely assoc. with pneumococcal).	About fever, conscious level, confusion, contact with illness, place of residence (e.g. student halls), short-term memory (HSV encephalitis), travel (tick-borne or unusual viral encephalitides, legionella infection).	Migraine/SAH by presence of symptoms of infection and evolving (rather than abrupt) confusion and altered consciousness. See previous <i>Casebook</i> . ⁴
GCA	Older patient (>50), evolving onset with temporal pain/tenderness and associated trunk-girdle myalgia and visual impairment.	About jaw claudication (virtually pathognomonic) and 'Are you able to brush your hair?' (very specific for polymyalgia rheumatica, where deltoid pain has prevented this), scalp pain, visual field loss.	Benign causes by presence of systemic illness/generally 'not right', visual symptoms and weight loss. Confirm diagnosis with ESR/temporal artery biopsy. ¹⁷
ACG	Accompanying monocular pain with visual disturbance and nausea.	About haloes around lights, previous episodes, medication (may be iatrogenic).	Non-ocular causes by presence of ocular symptoms and signs. From cluster headache by presence of corneal/pupillary signs.
IIH	Obese, young, female.	About speed of onset (but headache can appear acutely), visual acuity, oral contraceptive use, previous head injury.	ML by lack of associated localising signs, and presence of raised CSF pressure at LP with other investigations normal.
CMT	Notice drowsiness and confusion on cold winter evenings when at home, or worsening throughout day for the retired/unemployed.	About gas fires/boilers and colour of flame (orangey-yellow rather than blue). ¹⁸	Other causes by arterial blood gases to estimate COHb level, or presence of cherry-red mucous membranes in advanced cases.
DT	Following epidural, lumbar puncture or head/spinal trauma.	About procedures in other places and facial/head trauma in the past, CSF rhinorrhoea, relation of headache to upright posture (it gets worse).	Other causes by history of possible dural breach, and positive CSF rhinorrhoea identification.
HE	Older patient, undiagnosed/untreated hypertension.	About compliance with anti-hypertensive therapy, vascular risk factors, cognitive impairment.	Other causes on basis of presence of signs of malignant hypertension (particularly funduscopy), by use of neuro-imaging.
DST	Presents as stroke of whole cerebral hemisphere (where dural sinus involved); associated with cranial pathology (particularly orbital cellulitis), or surgery.	About association with cough – see box 4. About relevant risk factors – see right.	Arterial stroke by neuro-imaging/D-dimer estimation. Systemic associations include severe dehydration and hypernatraemia, septicaemia, pregnancy, oral contraceptive use, haematological pathology, vasculitis, androgen therapy, diabetes, CCF, malignancy, inflammatory bowel disease, anti-fibrinolytic therapy or nephrotic syndrome.
ML	Presents with headache noticed when coughing, stooping or straining with an evolving increase in severity.	About trauma, weight loss, visual acuity, fever, foreign travel, immunocompromisation, neurosurgical procedures.	Other causes by presence of a headache that improves as the day goes on. Positively diagnose with neuro-imaging.



6/9(L). There is no record of fundoscopy or a neurological assessment.

Twelve hours later Mr T lost consciousness and became paralysed on the left side. He had a left fronto-parietal chronic subdural haematoma with midline shift. He was left severely brain-damaged and unable to live independently.

This case was settled out of court. According to A&E and GP experts, the failure of duty was on Dr F's part, but firmer follow-up arrangements could have been made at A&E (also, a head-injury card

should have been given to Mr T, and this fact recorded). One expert commented, '... Dr F failed to examine Mr T adequately, or at all, and failed to refer him for a CT scan and/or neurological opinion.'

Another commented '... a more thorough examination of the eyes was indicated ... as a minimum ... pupils should have been checked to see if they were equal and reacting to light ... optic discs should have been checked to see if there was any evidence of papilloedema ... visual fields should have been checked by confrontation.'

Box 3. Suggested schema for examination of the acute headache sufferer

This schema will not suit the practice of all clinicians, and will require adaptation to suit your area of practice. It should serve well as an aide-memoire, but should not be considered comprehensive. It may seem lengthy, but with practice it can be done in a total of 5–10 minutes. The times in brackets estimate how long it normally takes to complete each part of the examination. Not all parts of the examination are necessary in every patient, depending on previous findings and the clinical context.

General

- Check temperature, BP & pulse. Quickly look for general signs such as anaemia (or cherry-red mucous membranes in CMT), jaundice, clubbing, cyanosis, rash, lymph drainage of the head and neck and tenderness of temporal arteries (GCA). If you suspect a stroke, listen for carotid bruits. (Total 30s.–1 min)
- Assess whether or not patient is systemically unwell by observing and talking to the patient. Check if they are ambulant and observe gait and balance. Ask carers/relatives if the patient is his/her normal self – and treat their responses as important clinical information – see case 2. (30s.)
- If you find abnormality in the above assessment, then formally test conscious level with Glasgow Coma Scale (see www.trauma.org/scores/gcs.html), and test higher cerebral functions looking for evidence of disorientation, confusion, dysphasia or dysarthria. (20–30s.)
- **Always** check for neck stiffness and photophobia (use pen torch to test objectively), and formally test Kernig's sign. Kernig's manoeuvre consists of the extension of a flexed knee, with the hip in flexion and the patient lying supine. The sign is positive if

it causes intense pain and distress to the patient, indicating meningeal irritation. See cases 2,3 & 4. (20s.)

- Examine any other systems that may be relevant if your findings on general assessment suggest it. (variable)
- Consider extra-cranial causes of headache e.g. related to alcohol excess/withdrawal or systemic infection. See case 6.

Neurological

CRANIAL NERVES

- **Nose** – Ask about change in smell perception, and test if positive reply/ (orange peel and granulated coffee are useful and often to hand; use an odiferous, non-volatile substance. 5–10s.) Check for nasal drip of CSF rhinorrhoea, and send fluid for testing to confirm as CSF, if relevant (DT).
- **Eyes** – Observe – For corneal clouding or pupillary outline irregularity/fixity (ACG). Check pupillary reactions. Formally test eye movements. Is there evidence of ptosis/ophthalmoplegia/nystagmus/Horner's syndrome? Check visual acuity with newsprint/Snellen chart if available. Examine visual fields by confrontation. *Ophthalmoscopy is mandatory and its omission is a frequent reason for failing to diagnose, leading to litigation.* Ensure that the optic cup and disc margins are clearly seen (if lost, suggests papilloedema – consider ML) and briefly examine the retina for evidence of flame/sub-hyaloid/vitreous haemorrhage (SAH) – photos of these retinal findings are available.¹⁹ In HE, typical retinopathic findings should be plain to see. In IHH, papilloedema may be the only abnormality in the whole examination. (2 mins)
- **Face** – Briefly test sensation in all three divisions of the trigeminal nerve (corneal

reflex testing is sensitive for subtle Vth nerve lesions), and assess VIIth nerve motor function in upper and lower face: 'screw up your eyes/give me a cheesy grin/keep your head still and look at the ceiling'. (30s.–1min)

- **Ears** – Check hearing with a whisper of a word 5–10cm from the ear. If it can't be heard, formally assess Weber/Rinne's tests with a tuning fork. (10s. for whisper, 30s. for Weber/Rinne.) Check balance by getting patient to stand with eyes closed. (10s.)
- **Mouth** – Observe palate and tongue movements – 'Say aaah', check masseter/pterygoid function, jaw jerk. (30s.)
- **Neck** – Test sternomastoid and trapezius function: 'lift up your head from the pillow/put your chin on your left then right shoulder/shrug your shoulders'. (30s.)

Limbs

- Test upper and lower limb tone, power, and reflexes. Ask about/test for any sensory disturbance. Check co-ordination using finger–nose pointing and by asking the patient to run their heel rapidly up and down the contralateral shin. (1–2 mins)
- If you find any abnormalities, attempt to localise the lesion within the CNS and arrive at a diagnosis, if possible.

Documentation

Record what you have found, including important negatives. Failure to record ophthalmoscopy, Kernig's sign, neck stiffness, photophobia and assessment of consciousness are recurring themes in litigation. As always, keeping a clear, full, contemporaneous record is the best way to avoid difficulties if a complaint or litigation ensues. In evidential legal terms, if something isn't recorded as being done, then it's virtually impossible to prove it *was* done.

Case 5

Missed subarachnoid haemorrhage

Mr V, a fit and healthy 26-year-old, became suddenly unwell. According to his wife he rapidly became confused, staggered about and complained of a very severe headache. He was visited at home by his GP, Dr E, but no notes were recorded for this visit.

Dr R, from the same practice, reviewed Mr V the next day. The notes state, 'Unwell with vomiting. O/E Abdo NAD. No neck stiffness. Rx domperidone 10mg, 4 tabs left.'

Mr V remained unwell and Dr R visited again the next day. Dr R noted that Mr V was still nauseated and had severe headache; his BP was normal and there was no fever or neck stiffness. Dr R diagnosed post-viral illness and gave simple analgesia.

A week later Mr V needed another home visit. Dr S attended and recorded a pain under Mr V's right ear and normal neck movements. Dr S diagnosed right otitis media and prescribed co-amoxiclav.

A week later, Mr V died after collapsing suddenly at home. A postmortem showed a large subarachnoid haemorrhage.

We were advised by GP and neurological experts. Absent or terse clinical notes made the case difficult to defend. All the experts were unhappy with the follow-up arrangements. They felt that if Mrs V's account of events was correct, the care received by Mr V fell below an acceptable standard.

Meningeal irritation was obviously suspected, but infection seems to have been the only cause considered, despite the characteristic history for subarachnoid haemorrhage. The case was settled for a six-figure sum.

SAH can be very hard to diagnose, even with the benefit of cerebral imaging. If there is any suspicion of this illness in a primary-care setting, with acute headache and associated symptoms/signs suggesting meningeal irritation, referral for further assessment is mandatory.

Following head trauma, retrograde amnesia of duration greater than an hour (as in case 4) is an indicator of severity. One should be aware that intoxication can cloud the clinical picture following head injury. It is important that it doesn't cloud your objectivity when assessing an intoxicated patient.

The last case shows how diagnoses can be missed if one fails to consider causes outside the typical anatomical/systematic culprits for a given set of symptoms.

Box 4. Smart handles and red flags useful in headache diagnosis *Adapted from a review by Dr Christopher Hawkes²⁰*

- Smart handles are shortcuts that suggest a particular diagnosis, or shorten the differential list.
- Red flags are warning signs that should alert you to the need to reconsider your diagnosis.
- Their combined use can allow one to reach a diagnosis more quickly.
- They are not scientifically validated, so they must be used with caution.
- **Cough headache** – Where a patient suffers a headache *initiated* by coughing, stooping or straining (all manoeuvres which raise intracranial pressure), there is about a 50/50 chance that they will have a posterior-fossa ML/cortical-venous thrombosis/raised intracranial pressure. Although it is not that common for mass lesions to present with acute headache, they can do so, and this can commence from an episode of coughing. Distinguish this from the common observation that pre-existing headaches may be worsened by coughing.
- **Unilateral headache and ipsilateral symptoms** If symptoms/signs are on the same ('wrong') side as a unilateral headache, then migraine is quite likely to be the cause. It is a cause for concern to find hemiparesis or hemianaesthesia with headache. One should put vascular abnormalities and tumours at the top of the list.
- **Persisting, severe headache in an older patient** Whilst this can be due to spondylosis or tension-type headache, it should be considered as GCA until proven otherwise. This is especially true if the patient is 'not herself', has lost weight, or appears depressed and downcast. Jaw claudication, visual disturbance or the presence of myalgia restricting limb-movements clinch the diagnosis. See box 2. GCA is confirmed by significantly raised ESR/PV, or typical pathology on examination of a temporal-artery biopsy. If these findings are not present, one should think of Paget's
- disease of the skull and ask about changes in head-shape/hat-size and order a skull x-ray.
- **'Thunderclap' headache** See box 2 & case 5. Such a headache starts abruptly and is likened to a blow to the head (as if by a hammer), usually over the occiput. One must exclude SAH with neuro-imaging and, if this is normal, an LP, looking for xanthochromia (at least 12 hours after headache onset, although a recent paper has suggested the utility of preceding CT with LP¹⁶), or high CSF red-cell count, not diluted over three serial samples. In the absence of confirmatory findings for SAH, migraine is the likely culprit. Ask about the relation of the headache's onset to coitus/orgasm/exertion – see box 2 and case 5.
- **'First and worst' headache** – If a patient not prone to headache complains of this, then this acts as a red flag for a serious cause, needing investigation. SAH or vascular tumours should be at the top of the list.
- **Unilateral excruciatingly painful eye and headache** – This suggests ACG or cluster headache. The eye may be red and sore in both. ACG sufferers will have a cloudy cornea and a fixed pupil. See box 2. Cluster headache (M:F preponderance of about 5:1), often causes severe lacrimation and/or nasal congestion. It occurs in bouts, and there is usually a clear history of previous episodes. A condition known as Short-lasting Unilateral Neuralgiform headache attacks with Conjunctival injection and Tearing (SUNCT) can present similarly. It is usually episodic and quite short-lived (minutes long). It is part of a group of relatively rare conditions known as the trigeminal autonomic cephalalgias, which include cluster headache. Their characteristics are well described in Flippen's review¹¹. One should consider trigeminal neuralgia where there are short (seconds long) episodes of excruciating unilateral headache/facial pain.

Case 6

Not all headaches come from the head

Mrs B had been suffering from acute, severe pre-menstrual headaches for three years. She'd consulted her GP, Dr J, on several occasions and he had prescribed pizotifen,

with little benefit, for suspected migraine.

When she developed colicky lower-abdominal pain and, later, heavy periods associated with acute, severe pain in her lower pelvis, she saw Dr J who, finding a mass in her left iliac fossa, arranged an urgent gynaecological referral.

Mrs B had had an IUCD in situ for 14 years, but this had never been checked. The

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consultant gynaecologist, suspecting actinomycosis, removed the IUCD and did a laparotomy, revealing a severely swollen fallopian tube and ovary, adherent to surrounding structures.

Mrs B underwent hysterectomy and bilateral salpingo-oophorectomy. Microbiological analysis confirmed actinomycosis, which was successfully treated with a month-long course of co-amoxiclav.

It later transpired that, within a few months of Mrs B first presenting to Dr J with pre-menstrual headache and bouts of abdominal pain, a routine cervical smear test had shown actinomyces-like organisms, for which Dr J had inappropriately prescribed metronidazole.

A claim was brought against Dr J for failing to act appropriately in response to the cervical smear report, and for a failure to check the IUCD. We settled the claim, advised by experts that the combined clinical information should have alerted the GP to a diagnosis of infection associated with the IUCD.

Mrs B's headaches were probably constitutional features of her pelvic infection. The association between headache and actinomycosis is described in a recent review,²¹ which can be found at www.familypractice.com.

Migraines can be associated with menses and don't always respond to prophylactic therapy, so it would be unfair to expect Dr J to have reached the diagnosis on this basis alone.

This was an unusual and quite rare cause of headache, and the legal action was based

on errors unconnected with its diagnosis, but it illustrates the difficulties involved in treating a condition without being absolutely sure of the correct therapy, and in failing to use all the available clinical information to review a diagnosis. If one isn't sure what the correct therapy is for a relatively uncommon condition, look it up or take advice; otherwise you invite complaints and litigation.

Conclusion

A previous article in *Casebook*¹⁰ gives an excellent overview of the common causes of all headaches, their characteristics and diagnostic criteria. Burns' review³ provides pertinent information for primary care doctors and non-physicians, and the articles by Flippen,¹¹ Steiner,¹² and Levin¹³ are recommended for those who want a more detailed overview. The International Headache Society's website – www.i-h-s.org – is also an extremely useful and detailed resource. The same is true of the website of The British Association for the study of Headache at www.bash.org.uk.

This brief overview of the approach to acute headache should help you to avoid the common pitfalls encountered in this area of practice. By digesting the lessons to be learnt from the cases, taking note of the pointers to diagnosis, and accessing the resources discussed in the article, we hope you derive benefit for yourself and your patients.

Acknowledgement

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The rising cost of injuries

By Ross Davies

'I won't take less than £37,500,' said the workman, minutes into the consultation at the lawyer's office.

The lawyer was retained by the workman's trade union, and the consultation was to see what grounds there were for suing the man's employer. The workman had stumbled at work, twisting an ankle. Had the lighting been poor, the corridor slippery, or negligence otherwise proved, the injury might have rated about £2,000 in compensation.

But as the conversation progressed, it became clear there were no possible grounds for negligence. It had been an accident, a minor misfortune, and indeed the case was never brought. Why, then, the grotesque inflation of expectation, from £2,000 to £37,500? 'Because,' the lawyer recalls, 'our client had read of a jury in America awarding the dollar equivalent of that sum for a similar injury, so in his mind that became the going rate.'

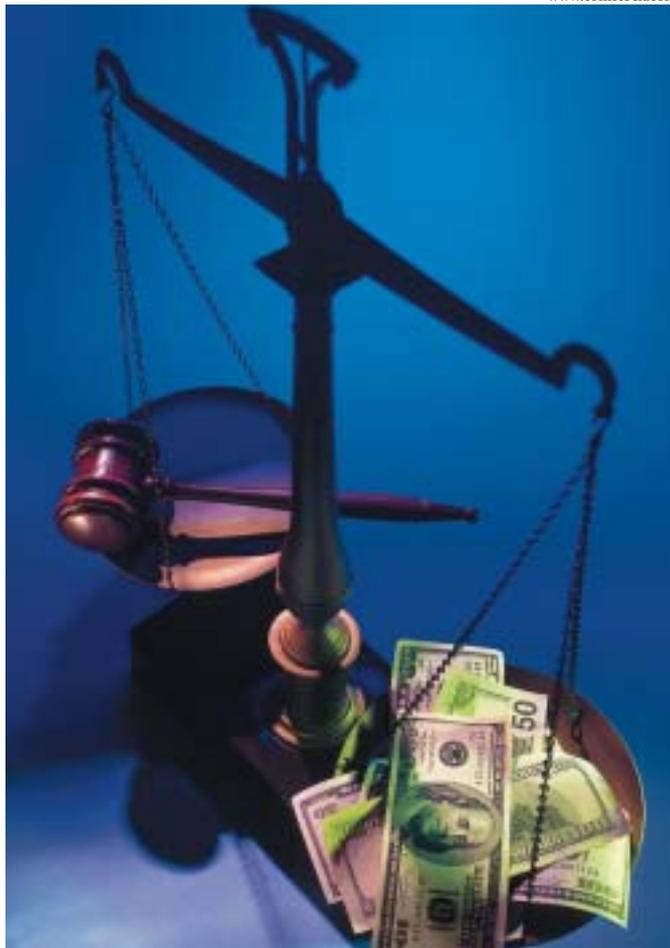
This story crystallises three assumptions central to what Frank Furedi calls the 'litigation culture'. Firstly, having been hurt, the man automatically assumed that it had to be somebody's fault, not just his bad luck. Secondly, he assumes that compensation is due and, thirdly, high expectations hold sway from the United States. The prospect is of a risk-free windfall profit, as his trade union would have funded any legal costs, had an action been brought.

Three-quarters of those polled by Mori in the UK say they are willing to sue for personal injury compensation.

Blame and gain

In *Courting Mistrust* (Centre for Policy Studies), Dr Furedi, a sociologist at the University of Kent at Canterbury, argues that the unremitting pursuit of someone or something to blame and seek compensation from, irrespective of liability, 'directly

Legal aid was granted to a British man to sue for 'personal injury and loss' because a local council was allegedly negligent in not having him adopted as a child.



undermines relations of trust and the sense of personal responsibility?'

In the US, litigation culture has precipitated a national crisis in medicine. In the UK, between 1989–90 and 2001–2002 the cost of clinical negligence claims against the National Health Service more than doubled, from £221 million to £446 million. In Australia, United Medical Protection, insurer of over half of the country's doctors, was driven into provisional liquidation.

The extent to which the litigation culture thrives is often hidden from those who, unlike doctors, are not its prime targets. In the UK, for example, all but a few personal injury cases are settled out of court. Unpleasant publicity is avoided, and many settlements are 'without prejudice' (no admission of responsibility). Insurers, with an eye to the bottom line, routinely 'roll over' to reduce legal costs, irrespective of the justice of a case. The exceptions are mutual organisations like MPS,

which make defending the reputation of the member a paramount concern.

Social attitudes to risk

Litigation avoidance is the flip side of litigation culture, and it blights everyday life.

Councillors ordered the removal of a children's swing, hanging from an oak tree for many years at Sheet, Hampshire. They fear parents will sue if a child is hurt. Schools close playgrounds, and give up rough sports. The idea that life involves an acceptable element of risk is no longer acceptable.

Litigation culture may make life harder, but it has its roots in positive social changes. The professions, medicine among them,

are more open nowadays and wish to be, and be seen as, accountable. The public is better educated, better-informed, and expects more from life. But politicians and lawyers are not in the business of discouraging expectations, with results in healthcare that benefit neither patient nor practitioner.

The American experience

US healthcare is cracking up under a legal system which encourages litigiousness with a conditional fee system, under which half or more of any award may go to the lawyer rather than the complainant. Prosecuting counsel also has a big say in the composition of the jury. US

In the UK, a cancer sufferer was granted legal aid to sue the NHS for loss of earnings and trauma because he was still alive three years after the diagnosis of his condition, when he had been told he might have as little as three months to live.

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juries are free to award ‘punitive’ damages, as well as ‘economic’ damages for loss of work or medical expenses. Juries use their freedom to punish, but will also inflate an award to see that the victim is left with something after the lawyers have taken their cut, especially as the payout is likely to be reduced at appeal.

It has gone into world folklore that an American jury awarded a woman US\$2.9 million because she scalded herself with McDonald’s coffee in a car. The jury awarded her US\$160,000 economic damages – accepting she was partly to blame – and US\$2.7 million punitive damages. What the woman actually received, we may never know: McDonald’s settled out of court. It is these sensational jury awards, not the more modest

A bodybuilder claimed £15,000 damages, alleging negligence by an MPS GP member, in failing to diagnose a lump on the chest which later proved to be an epigastric hernia. MPS fought and won the case, but because the claimant was legally aided, costs of about £15,000 could not be recovered. MPS defended, regardless of cost, because records showed that the claimant was a frequent attender at the surgery whose every complaint had been recorded, treated or referred to a hospital, and that he had never mentioned the lump.

final outcomes, that make headlines around the world.

Medicine is a high-risk profession in a full-blown litigation culture, such as that of the US, where the average medical liability award is now US\$3.5 million, and liability premiums have risen 45% in especially contentious fields such as orthopaedics and obstetrics.

One result, says a 2002 study by Wirthlin Worldwide, is that over three-quarters of Americans now worry that their access to medical care could suffer. In many cases, they are right. The American Medical Association now speaks of a ‘crisis’ of patient access in 18 states, and of ‘serious’ problems in the rest.

A dental patient claimed £4,000 for damage to a crown, allegedly when the anaesthetist intubated him with a Laryngeal Mask Airway tube before surgery. Having consulted the inventor of the soft, flexible LMA, MPS defended the case, refusing an offer to settle for £3,500 and costs. The court found for the MPS member, and MPS was able to recover its costs of £13,500.

Rising costs leave UK schools only £250 million of extra funding this year. Last year, schools paid out £200 million to litigious parents.

Emergency departments are losing staff; neurosurgery is delayed because practitioners find insurance cover hard to find or afford, now that St Paul and other insurers are moving out of medical cover. In ‘crisis’ states such as Pennsylvania, obstetricians and orthopaedics specialists are retiring early, limiting their practices or moving to another state.

The phenomenon spreads

American jury awards also boost expectations elsewhere, even where juries cannot be packed, and the scope for awarding punitive damages is limited by law. In the UK, the number of personal injury cases at county and High Court level has fallen over the last 20 years, but that is because most cases are settled out of court. Or, more accurately, in or out of other sorts of legal or administrative arenas. Industrial tribunals are one example.

According to the business intelligence group Datamonitor, the cost of personal injury compensation in the UK, £3.7 billion in 2002, may treble in five years. Psychiatric distress is now a basis for compensation claims, and it is now open to service-people and police officers to demand compensation for incidents previously held to go with the job. One in 220 British soldiers makes a claim, and police compensation has doubled in three years to £330 million, or 7% of payroll.

The incorporation into UK law of the European Convention on Human Rights allows individuals to pursue claims against public bodies in the UK courts, rather than having to go to the European Court of Justice. Experience in Canada and New Zealand with rights legislation, suggests the UK will see an increase both in litigation, and in the courts’ willingness to extend the number of grievances that can be pursued to qualify for punitive damages.

The costs

The litigation culture costs the UK about £10 billion a year, or about 1% of GDP, and is increasing by 15% annually, according to the Faculty and Institute of Actuaries. About a third of the costs go on ‘legal and administrative expenses’. Premiums for employers’ liability in the UK have risen by 100% in five years, says the Association of British Insurers: 40% of claim costs goes out in

legal fees. Unsurprisingly perhaps, the number of lawyers in England and Wales has doubled in the last 20 years. They can now compete, and chase business.

About 1,000 conditional fee personal injury firms have sprung up since 1996, when contingency fees were introduced. Members of the public have been approached by salespeople from at least one such firm, offering to act as witnesses in bogus bus-crash claims.

What next?

Ironically, litigation culture may be taking root beyond American shores at the same time as Americans tackle their crisis in medicine. A new federal health bill, passed by the House of Representatives, but currently stalled in the Senate, would allow unlimited economic

A British sailor returned home after service in the Iraq campaign to find that a neighbour was suing him for his share of the cost of mowing a communal lawn during his 86 days at sea.

damages, but cap punitive damages at US\$250,000, or twice economic damages, whichever is the greater.

In the UK, 2,500 employees of The Accident Group, a conditional fee personal injury group, were made redundant after questionable claims led to ‘continual battles with the insurance industry’. The litigation culture may have hit a snag here, however, as aggrieved employees were quickly offered representation by another conditional fee concern – for 33% of any award at employment tribunal!

A former labourer threatened to sue for loss of earnings and cost of care, asserting that his GP, an MPS member, had been negligent 10 years earlier in failing to diagnose spinal arthritis or refer him to hospital for back pain after an injury at work. MPS refused to settle pre-trial for £10,000, whereupon the complainant sued for £1.2 million. MPS had the man medically examined, and found no evidence of arthritis although there was mechanical back pain which had become chronic. Examination of the MPS member’s records disclosed that the GP had not seen him until after the alleged accident, by which time any untreated mechanical pain would have become chronic and untreatable. The case was withdrawn.

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KEY

 ANAESTHETICS	 DERMATOLOGY	 GENERAL PRACTICE	 GENERAL SURGERY	 HAEMATOLOGY
 OBSTETRICS & GYNAECOLOGY	 ONCOLOGY	 ORAL SURGERY	 ORTHOPAEDICS	 RADIOLOGY
 VASCULAR SURGERY				

We publish case reports as an aid to MPS members, to alert them to pitfalls that have caught their colleagues unawares. We believe that these are an invaluable risk-management tool and, as such, they should be rooted in fact – i.e. based on actual events. The following narratives are taken from MPS case files from around the world, with some alteration of the facts to preserve confidentiality.

Delayed diagnosis

Tardy surgical intervention

Mr W, a diabetic gentleman in his sixties, saw his GP because of abdominal pain and vomiting. His doctor suspected appendicitis and made an urgent referral to his local hospital. He was seen there by Mr T, a locum consultant. No notes were kept of the initial consultation.

Mr T later stated that he found

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Medication error

Inspect before you inject



Mr O had suffered with an anal fissure for some time. He'd been referred to Mr F, consultant surgeon, who'd decided on an examination under anaesthesia (EUA) with a view to lateral anal sphincterotomy, after a course of conservative treatment.

Mr F performed the EUA, attempting sigmoidoscopy, which was hampered by faecal loading. Mr F used a Parks anal retractor and found a benign-looking fissure, from which he took a biopsy. He also found moderate vascular haemorrhoids and decided to treat them by sclerotherapeutic injection.

He took a syringe of phenol, filled by his assisting theatre nurse. Mr F wasn't asked to check the ampoules from which the syringe had been filled, nor did he ask to see them. He started to inject the haemorrhoids, using a standard technique. After

injecting 7–8 ml of phenol solution, he stopped, noticing that the injected area was turning black.

It turned out that the solution was 80% phenol, not 5% in oil, which is the usual strength for this procedure. Mr F flushed the area with alcohol and copious quantities of water. Mr F spoke to the Poisons Unit, who advised overnight observation on ITU, due to the risk of adverse systemic reactions to the phenol. Mr O suffered some transient hepatic dysfunction, which settled spontaneously.

Four days later, Mr F and a colleague, Mr A, performed a further EUA, finding extensive confluent ulceration of the anal canal with indurated tissues at the level of the pelvic floor. Mr A performed a trephine-loop sigmoid-colostomy. Mr O remained under Mr F's care for

the rest of his inpatient stay.

When Mr O brought a claim of negligence, we settled out of court for a moderate sum, sharing half the liability with the theatre nurse's employer.

Comment

Although it may seem a tedious ritual to check the quantity and nature of an injectable substance before administration, there are extremely good reasons for doing so, as this case clearly shows. Even if you draw up an injection yourself, you should make it standard practice to double check what you are going to inject into a patient, by any route, before you do so. Many examples of maladministration of injectables feature in the medical and lay press each year. If you give the wrong substance, or give it by the wrong route, you can cause irreparable damage to your patients.

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Mr W to be jaundiced, with tenderness in the right upper and lower quadrants. Mr T suspected acute cholestatic disease, ordering an urgent ultrasound scan. He ordered a sliding-scale glucose/insulin infusion and prescribed IV cefuroxime, metronidazole and analgesia.

Mr W was pyrexial and hypotensive on admission. Initial investigations showed normal U&Es, an elevated bilirubin of 122 $\mu\text{mol/l}$ (NR 4–17), glucose 11 mmol/l and a white-cell count (WCC) of $5 \times 10^9/\text{l}$ (83% neutrophils, NR 4–11).

The scan showed no evidence of biliary obstruction. There were dilated loops of small bowel, also seen on a plain abdominal x-ray. Mr T was consulted about these findings and advised continuing conservative management.

The next day, Mr W was consistently pyrexial with generalised abdominal tenderness and absent bowel sounds. A possible mass was palpated in the right lower quadrant, but not investigated further. He was started on intravenous erythromycin. By the third day his urea had risen to 20 mmol/l, bilirubin falling to 37. His WCC was now 7.3 (87% neutrophils).

The notes say that on the fifth day Mr W was 'doing fine'. His WCC climbed to 12.6, and his fever persisted. On day six, WCC was 20.5. By day seven, Mr W was recorded as suffering from severe abdominal pain, but the examination records a soft abdomen with no mass. The WCC had risen to 23.3 (89% neutrophils).

Over the next five days there is no record of Mr W's temperature. For two of the days there is no record of clinical review, but the nursing notes do indicate visits by the surgical team. Mr B, consultant surgeon, returned from leave and repeated the ultrasound scan, which showed possible intra-

abdominal abscesses. He performed a rigid sigmoidoscopy but found nothing abnormal.

Eleven days after admission, Mr B decided to take Mr W to theatre where he carried out a laparotomy. He found intra-abdominal pus, a walled-off right-sided abscess and a thickened, hard appendix, which he removed.

Unfortunately, Mr W suffered septicaemic shock and multi-organ failure in the postoperative period. He died 22 days after his admission. His family sued, alleging clinical negligence by Mr T and Mr B.

We consulted a surgical expert who accepted that the jaundice was atypical and confusing, but was critical of the decision not to proceed to laparotomy, once imaging had excluded biliary obstruction. The expert commented, 'His temperature persisted in spite of antibiotics and the WCC steadily rose ... a mass was felt that should have been more thoroughly investigated. All signs indicated an abscess formation, which should have been explored at an earlier date before its rupture ... had surgical exploration been undertaken at an earlier time, his death in all probability would have been prevented.' We settled the case for a substantial sum.

Comment

The decision-making processes of the team in question appear to have been seriously impaired, leading to an avoidable death, caused by unnecessarily delayed surgery. The website of The National Confidential Enquiry into Perioperative Deaths (NCEPOD) contains useful information for surgical teams not wishing to fall prey to the same errors. Its document 'Functioning as a team?' can be viewed at www.ncepod.org.uk/2002.htm. The section 'Decision-Making and Surgery' is particularly pertinent to this case.

Failure to investigate

Treat pigmented skin

Mr F was a forester in his forties. He went to see Dr N, his GP, for advice about two skin lesions – one appeared to be a sebaceous cyst on the left shoulder, the other a pigmented lesion on his chest. Dr N booked Mr F in to have the lesions removed on the minor-surgery list at the practice.

The surgery was carried out a month later. The sebaceous cyst was removed in its entirety, and the lesion on the chest cauterised, in the belief that it was a naevus. No samples were sent for histology.

A year later, Mr F returned to the surgery where he consulted another of the practice partners. He had developed a swollen, inflamed cyst at the site of the original lesion on his chest. It was treated as an infected cyst and Mr F was given antibiotics and referred to the general surgical unit the next day to have the cyst removed.

Unfortunately, it transpired that the lesion was in fact a malignant melanoma. There was evidence of metastatic spread to lymph nodes in the axilla, and more distantly, confirmed by a CT scan. Despite treatment, Mr F died two years later.

An action against Dr N alleged sub-standard clinical management for cauterising a pigmented lesion which, it was claimed, was known to have bled. According to experts we consulted, the lesion should have been excised with a margin and sent for histological analysis, rather than cauterised. One expert commented, 'It has certainly been the case in the past that lesions sent down with a benign diagnosis have been found on histology to be



malignant. I therefore believe that all GPs who carry out minor surgery should send all lesions removed for histology.'

The case was settled, and an award made on the basis that Mr F's chances of 10-year survival of his melanoma had been reduced from about 50% when initially



in lesions with care

Wellcome Photo Library



Failure to recognise post-op complication

Post-operative hypotension

Mrs T, a 36-year-old mother of two young children, attended as an inpatient for an elective vaginal hysterectomy and repair of prolapse. She had no relevant past history and her preoperative assessment was unremarkable. During surgery, blood loss was greater than usual at 800 ml but no other problems were noted. In the recovery room she was well but noted to be pale and agitated, complaining of abdominal pain. She received patient-controlled opiate analgesia.

She was returned to the ward just under an hour after surgery, but nursing staff called the anaesthetics registrar, Dr E, an hour later as she had become unwell, pale and hypotensive with a borderline bradycardia (BP 100/60 mm Hg, pulse 52 bpm). Dr E prescribed 40% oxygen and 500 ml of colloid fluid over an hour.

A failed attempt to take venous blood was abandoned by her gynaecology registrar, Dr K, who called for Dr E to assist him. Dr E noted that the patient's vital signs were unchanged but her veins were collapsed. He asked the nurse in charge to give Mrs T one unit of whole blood over the next hour and to transfuse another unit of blood over the following four hours. Dr E reviewed the patient several times over the next few hours.

Two hours after the blood transfusion had been started, Mrs T had a BP of 95/55 mm Hg and a heart rate of 52 bpm. A urinary output of 100 ml since surgery was recorded. Dr E conferred with his consultant, Dr J, and they decided to return Mrs T to the recovery room to put her on a monitor and insert a CVP line. Before they could do this, however, the patient collapsed and stopped breathing. During resuscitation she was intubated and

received adrenaline, atropine and defibrillation. She was transferred to the recovery room, resuscitation continuing during the transfer.

On arrival in recovery Mrs T regained cardiac output and some respiratory effort. She remained hypotensive and had a heart rate of 130 bpm. Dr J was unsuccessful in attempting central venous and peripheral arterial cannulation. Another anaesthetic consultant, Dr Q, was able to insert a Swan-Ganz cannula and commence rapid transfusion. An enquiry into the possibility of coagulopathy was made at this stage, but laboratory confirmation of this only became available later. The patient did not respond well to the rapid transfusion so an infusion of adrenaline was started and there was a moderate improvement in her vital signs.

The team planned to move Mrs T to the ITU of a nearby hospital and to give fresh frozen plasma once clotting results were known. Haematological and biochemical results showed a severe coagulopathy with no obvious bleeding. A vaginal examination revealed no haematoma or other abnormality, and a chest x-ray was reported as normal. The fresh frozen plasma was instituted but during the transfusion Mrs T had a fit, developed bradycardia and cardiac arrest. She did not respond to attempts to resuscitate her.

At autopsy, the cause of death was given as 'haemorrhagic shock due to an intra-abdominal haemorrhage from pelvic operative site following hysterectomy and vaginal repair for uterine prolapse.'

Mrs T's family brought a claim for compensation and we asked an expert in anaesthetics for his opinion. He concluded that the doctors could be criticised for failing to appreciate that hypovolaemia was the cause of Mrs T's hypotension, and for not taking earlier, more aggressive measures to locate the site of the bleeding and initiate surgical repair. He said, 'Significant intra-abdominal

seen, to about 15% when the diagnosis was finally made.

Comment

Skin cancers can present with a variety of atypical appearances, making diagnosis difficult. As this case demonstrates, it is wise to obtain a histological diagnosis

after excision with a margin. Any pigmented skin lesion for excision, regardless of how long it is purported to have been present, should be treated as a potential melanoma. This is especially true if the lesion has bled, crusted, been itchy or developed satellite lesions.

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Unwitting use of unlicensed medical product

The downside of luscious

In the early 1990s Ms H wanted plumper lips and consulted Mr M, a cosmetic surgeon, who recommended silicone and collagen injections. After having three collagen injections over three months, she complained that the effect was too short-lived. Dr M suggested that she try silicone oil injections instead and she agreed.

Over the next 11 months, Ms H's lips were injected four times with silicone oil. These treatments were all well documented by Dr M, who kept excellent records of all patient encounters.

During the course of treatment, Ms H suffered an itching rash diagnosed as pityriasis rosea. In her subsequent claim against Mr M she described fatigue, disturbed sleep, malaise, back pain, nausea, blurred vision, slurred speech, disorientation and tremor of her trunk. She attributed these symptoms to the course of silicone oil injections.

About four years later Ms H suffered neurological symptoms and was diagnosed as having benign, non-progressive multiple sclerosis. Later that year she was diagnosed as suffering from Raynaud's phenomenon.

Ms H later became aware of the potential controversial association between the use of silicone in breast implants and some connective tissue diseases, particularly discussed in the USA. She alleged that Mr M had been negligent in using silicone injections despite the known risks of its use, which had led to her subsequent episodes of ill health.

The experts we consulted were supportive of Mr M; he had carried out the procedures according to standard practice



and kept careful records. They were satisfied with the quality of lip augmentation produced by the procedures.

Our lawyers, supported by experts in epidemiology and rheumatology, vigorously contested the unproven association between silicone use and Ms H's illnesses. Although there has, in recent years, been much controversy surrounding

the issue, there was no proven association between silicone use and multiple sclerosis.

Ms H's counsel accepted the argument and agreed that the claim should not proceed on that basis. However, it transpired that the silicone oil Mr M had been using was not licensed as a medicinal agent at that time in the UK.

Mr M had not been aware of

this, and had thought that the product was a bona fide medical-grade oil. Because of this we agreed to pay Ms H £5,000 as compensation for a small period of pain and suffering.

Comment

- *Mr M's defence was greatly aided by the quality of his notes.*
- *Clinical negligence claims are often brought years after the*



lips

www.photos.com



alleged negligent incident. Regardless of the current state of knowledge or beliefs, the claim can only be judged according to what was commonly accepted practice at the time of the incident.

- MPS indemnity for cosmetic surgery varies, depending on the procedure. We advise members to ensure we are fully informed of the nature of procedures they carry out.

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bleeding must be the number one differential diagnosis of sustained postoperative hypotension, in the absence of other differential diagnoses such as sepsis, anaphylaxis and myocardial depression.' The claim was settled for a substantial sum.

Comment

Sustained clinical indicators of hypovolaemia must not be ignored in a postoperative patient. Following surgery, in a scenario such as this, loss of blood at the operation site must be excluded, as early as possible, as the cause of the patient's symptoms and signs, in order to avoid tragedy.

Administrative error

Forgotten specialist referral

Mrs A suffered with depression and was seeing her GP, Dr P. During a consultation to review the efficacy of her lofepramine, Mrs A mentioned that she'd had a lump on the side of her face for a long time. Dr P examined Mrs A's face and noted the presence of a mobile, 1 cm diameter lump over the left mandible. Dr P intended to refer Mrs A to her local oral surgery service for advice. Unfortunately, she forgot to dictate the referral letter at the end of the surgery.

Dr P's normal practice was to tell patients to contact her if they had not heard about a referral once a month had passed. Mrs A had several further appointments at the surgery over the next few weeks, but failed to attend any of them. She eventually came to see Dr P to discuss other matters, four months after the first consultation about the lump. The lump, and its assessment by the oral surgeons, didn't come up in the consultation.

A month later, Mrs A was at the surgery again and saw Dr C. She mentioned that she'd heard nothing from the oral surgeons. Dr C left Mrs A's notes out for Dr P, with a note explaining the lack of an oral surgical opinion. Dr P realised her error and dictated the referral shortly after. Mrs

A was seen by the oral surgeon, Mr Q, within two weeks.

The lump was duly excised and a tissue diagnosis of acinic carcinoma made. This required further surgery, somewhat radical, involving bone grafting from the hip. Unfortunately this graft became infected, causing significant pain and disfigurement to Mrs A and necessitating further surgery.

Mrs A issued a legal action against Dr P, alleging negligence for failing to make a timely referral. It was obvious that Dr P was liable for her error in failing to refer Mrs A, and on this basis we made a small payment into court to cover Mrs A's claim for five months of pain and suffering.

However, expert maxillofacial-surgical advice was that this rare tumour was low grade and unlikely to have grown significantly in the period between its detection and excision. It was considered that the delay wouldn't have materially affected the treatment given, or the outcome. As much of the misfortune suffered by Mrs A was due to the postoperative infection, we argued that causation was not established.

There was conflicting expert opinion that, although the delay probably didn't affect survival, it may have worsened morbidity. This was due to a purported need for more extensive extra-oral (rather than intra-oral) surgery and an increased chance of the complications that ensued. We conceded this point and increased our offered payment to the client, but the offer was refused.

The case proceeded to trial, where Mr Q testified that, in his opinion, the delay had not affected his approach to the surgery, or the outcome for Mrs A. The judgment went against Mrs A, who received our original offer, but was not able to recoup legal costs, due to her rejection of a reasonable offer of compensation for her pain and suffering.

Comment

- *It's easy for a busy doctor to forget to complete an intended specialist referral, due to pressure of time.*

Keeping a record of intended referrals during a surgery could help to prevent such omissions. Some doctors dictate referral letters as they go along, with the patients in the room.

- *This case demonstrates the important difference between liability – a breach of a duty of care – and causation, i.e. any injury suffered by the claimant as a result of the breach of duty. Both of these must be established for a claimant to be eligible for compensation.*

Techniques and monitoring

Infusion risks

Mrs B was in her late fifties; she had been treated surgically for breast cancer and was to undertake a course of adjuvant chemotherapy and radiotherapy. When she attended for her first course of chemotherapy, she was given an infusion of anthracycline. This was set up by Dr P, SHO in oncology, using a butterfly needle in the dorsum of the left hand, and checked by the oncology consultant, Dr V.

The patient was placed in a side room and left alone. No-one came to monitor the state of the infusion and infusion site. After two hours Mrs B called for assistance because her left hand had swollen at the site of the infusion. The infusion was stopped and Dr P was called. She found the dorsum of Mrs B's left hand to be red and swollen and ordered a glycerin/ichthammol dressing. Mrs B was discharged from hospital the next day.

Mrs B suffered serious sequelae from this extravasation incident. She required surgical debridement of the area, when it ulcerated and became infected three months after the incident. The skin eventually healed but was tight, and there was damage to her extensor tendons, significantly impairing hand function.

An action against the hospital and Dr V was launched. The experts we consulted were very critical of the following aspects of management:

- The dorsum of the hand was a poor choice of site.

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- Using a needle instead of a flexible cannula was inherently dangerous and increased the risk of extravasation.
- The nursing staff's monitoring of the progress of the infusion was inadequate, and Mrs B's placement in a side ward was inappropriate.
- No attempt was made to aspirate excess solution from the dorsum of the hand after the incident.
- Subcutaneous hydrocortisone should have been administered to the affected area following the incident.

The case was indefensible and settled for a significant sum, liability being shared with the hospital's insurers.

Comment

- *The extravasation of irritant solutions, causing damage to adjacent tissues, accounts for several claims against MPS members each year.*
- *Cytotoxic infusions should always be administered with great care, and preferably by an experienced, trained and dedicated team who will know how to act appropriately should an extravasation incident occur.*
- *Any infusion containing an irritant drug given into the dorsum of the hand requires careful and close monitoring.*

Delayed diagnosis**Shouldering responsibility**

Mr W was a young dad with a wife and two small children. He developed pain in his neck and right shoulder and consulted his GP, Dr J. Finding some slight tenderness over the right shoulder with a full range of movement, Dr J prescribed ibuprofen.

Mr W attended the practice on many occasions over the next year, chiefly with right-shoulder pain, but also with episodes of back and neck pain. He saw other members of the practice, and the working diagnosis seems to have been muscular pain or 'mechanical backache'. He received a

variety of topical and systemic NSAID preparations, but without any discernible benefit.

At one point he saw a locum who requested an x-ray of his shoulders, which was reported as normal. Mr W remained troubled by his symptoms and saw Dr J at least once a month over the next six months.

By now the pain was affecting his left shoulder and he was experiencing pins and needles in his left arm. Dr J referred Mr W for physiotherapy. Two months of heat, mobilisation and ultrasound resulted in only a slight improvement in joint mobility and pain relief.

Dr J referred Mr W to a local orthopaedic surgeon, Mr O, for advice. Mr O noted a history of right-shoulder pain, on and off for two years, and found some local tenderness over the right acromion. A repeat x-ray showed a lytic lesion within the right acromion. Mr O compared this to the old x-ray and noticed that it had been present all along, despite the x-ray being reported as normal. Mr O arranged a non-urgent CT scan of the thorax.

Unfortunately, about six weeks after seeing Mr O, Mr W developed paraplegia and was admitted to hospital for urgent investigation.

It transpired that he had compression of his thoracic spinal cord, due to multiple myeloma. Mr W had surgical debulking and received chemotherapy. He recovered from the paraplegia but was left with some neurological disability. His myeloma recurred and he eventually needed an allogeneic bone-marrow transplant.

An action was launched against Dr J, alleging that his delay in referring Mr W to hospital had been negligent. GP experts criticised him for persisting with ineffective medication and physiotherapy without seeking an alternative diagnosis. They accepted, however, that he had been misled by the normal x-ray report, which had made his job more difficult.

We sought advice from a

radiologist. This proved to be critical of the diagnostic radiologist who failed to notice the lesion in the acromion. Orthopaedic experts were also critical of Mr O.

His decision to order non-urgent investigations compounded the delay. They thought that he should, at the least, have arranged for baseline bloods and an urgent bone scan. He might also have usefully arranged for a radiologically guided biopsy of the lesion to establish a histological diagnosis. According to an expert in haematology, if this had been done, and treatment initiated immediately, it was likely that Mr W would never have developed paraplegia and its sequelae.

We contributed a small sum on behalf of Dr J to settle this action. The hospital responsible for the x-rays and the orthopaedic consultation paid the remainder of a substantial settlement.

Successful defence**Maybe malaria?**

Before going on holiday to Kenya, Mr A visited his GP's surgery where he saw nurse J for advice on travel prophylaxis. She documented his previous immunisations and gave tetanus and polio boosters, noting that he already had some malaria prophylaxis tablets. The dosage regimen and type of tablets were not recorded. A short while after returning from his trip, Mr A was unwell. He saw his GP, Dr C, and gave symptoms of shivering, diarrhoea and bilateral back pain radiating to the lower abdomen. Dr C thoroughly examined Mr A and found only pyrexia, without specific clinical signs. Working on a diagnosis of gastroenteritis, Dr C recommended plenty of fluids and temperature-control methods.

Four days later, Dr C spoke to Mr A by phone. Mr A told him that his temperature was still up, he was constantly thirsty, sometimes confused and still vomiting. Dr C visited Mr A at his home and

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Consent – warning about complications



Duty to warn

In the mid 1990s, Mr L presented to hospital following a spontaneous rupture of his left Achilles tendon. Mr C, consultant orthopaedic surgeon, performed a percutaneous repair of the tendon, following which the tendon appeared to heal well.

At a follow-up consultation four months later, Mr L told Mr C that he was experiencing numbness and discomfort affecting the lateral skin of his left leg and heel. Six months after the injury, Mr L was becoming increasingly concerned by the numbness and paraesthesiae. Mr C suspected sural nerve injury as the cause and referred Mr L to his colleague, Mr R, a consultant plastic surgeon. Mr R explored the sural nerve and found it transixed by a suture, with an accompanying neuroma, requiring reconstructive repair.

Mr L alleged that his sural-nerve damage caused him ongoing discomfort, hampered his mobility and left him prone to neuropathic damage of his foot. Proceedings against Mr C alleged negligence in failing to identify and isolate the sural nerve during the operation.

We sought the advice of orthopaedic experts, who reported as follows: The technique of percutaneous repair of the Achilles tendon was first described in 1977 by Ma and Griffith. Previous research had shown that it carried a significantly higher risk of sural nerve damage than the more common technique of open repair (17% in one series, compared to about 2% for the open technique).

Given these research findings, the experts felt that it would be

wise to warn patients of potential damage to the sural nerve using the percutaneous technique.

One expert noted, 'It is clear that, while the percutaneous technique is well established and very acceptable, the main complication ... is damage to the sural nerve, and several researchers have adopted modifications specifically to avoid this ... the incidence suggests that it is uncommon but not rare in most people's hands.'

We decided to settle the claim for a moderate sum, on the basis that Mr L should have been warned of the potential risks before consenting to the procedure.

Comment

- *Recent research – Lim J, Dalal R, Waseem M. Percutaneous vs. Open Repair Of The Ruptured Achilles Tendon: A Prospective Randomised Controlled Study. Foot Ankle Int (2001) 22(7): 559–68 – suggests that the picture is not so clear when using a modified percutaneous technique. Lim et al. reported a low rate of sural nerve damage in a small series of cases, and some distinct outcome advantages, compared to the open technique.*
- *If using an alternative technique to treat a particular problem, it is important to be fully aware of how it may differ from a more common method, in terms of outcome and complications. Patients must be informed of how the risk of a certain complication differs, if it differs significantly, when compared to standard technique.*

Failure to recognise post-op complication

A tight situation

Mrs W, a retired lady in her seventies, had suffered from a painful and stiff left knee for some years. She saw an orthopaedic surgeon, Mr D, who recommended a left total-knee replacement. Mr D had some trouble operating on Mrs W's knee. He had to use a substantial medial release procedure, stripping the entire postero-medial aspect of the tibia.

Mr D applied a tourniquet around the left thigh to aid haemostasis. This was in place for 2 hours and 10 minutes. This time reflects the degree of difficulty Mr D had during surgery. The notes show that Mrs W's left foot turned pink on release of the tourniquet. Mrs W's postoperative care included a regional epidural infusion for analgesia.

In the early postoperative period, Mrs W's left foot was pale and pulseless with poor sensation. A little later it seemed pinker, but sensation remained impaired. Two days after the operation it was cool to the touch, numb and poorly perfused. Mr R, consultant vascular surgeon, came to see Mrs W, at her team's request. Mr R suggested some investigations, although the notes do not show that these were carried out.

Later that day, Mrs W was reviewed by her orthopaedic team. The notes show that the foot was pinker, but couldn't be actively dorsiflexed at the ankle. The team diagnosed neuropraxia of the left sciatic nerve. Mrs W was not doing so well the next day. Her left calf was intensely painful and hard. Passive dorsiflexion of the ankle caused severe muscle pain. Mr J arranged pressure gauging of the leg compartments, suspecting a diagnosis of compartment syndrome. This proved to be the cause of the problem. Mr J



performed an immediate fasciotomy, leaving the wounds open, and giving the patient IV antibiotics. Mrs W needed larval (maggot) therapy to treat her healing wounds, an experience she didn't relish.

Mrs W had significant sequelae from her compartment syndrome. Although the vascular and nerve supplies to her foot were intact, she had marked muscle necrosis. Mrs W was left with a disabling left-sided foot drop. She launched a legal action against Mr J, alleging negligence in the management of her postoperative vascular problems.

There was some debate amongst the orthopaedic and vascular experts we consulted. On the balance of probabilities, it was thought that ischaemic damage due to prolonged use of the tourniquet, followed by a reperfusion-related compartment syndrome, was the most likely clinical scenario.

Treatment after the diagnosis of compartment syndrome was deemed timely and appropriate. The tourniquet time was held to be at the upper end of the acceptable limit used by a responsible body of orthopaedic surgeons.

The question of liability centred on the speed with which diagnoses were made. One expert commented, '... there does appear to have been a period of about three days during which the muscle damage developed, and I am afraid that the impression given by the clinical notes ... is one of indecisiveness and uncertainty.

'It should, I think, have been clear that a serious complication was arising, and even though the clinical picture was variable and partially masked by the analgesia (epidural infusion), I believe that the diagnosis should have been made sooner.'

The case was settled for a moderate sum. Mr R was not held

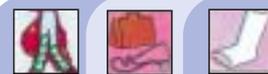
to be liable, in that he saw the patient only once, and gave advice appropriate to the clinical situation at that time.

Comment

The use of a tourniquet during orthopaedic surgery is not universal. When gaining consent from patients for a procedure where one will be used, it may be wise to give details of its use and the potential effects this could have.

Compartment syndrome is an extremely time-sensitive clinical problem. To prevent significant adverse long-term effects, it must be remedied early in its course. Its pathognomonic features include:

- Pain disproportionate to the clinical situation
- Pain on passive stretching of the involved muscles
- Disturbed skin sensation, in the distribution served by nerves traversing the compartment.



Continued from page 22

found a persistent pyrexia, tachycardia, tachypnoea and borderline hypotension, with signs consistent with consolidation at the right lung base. Dr C's differential diagnosis was pneumonia and/or malaria, prompting him to refer Mr A urgently to his local general medical team. Mr A needed to be admitted to ITU for ventilatory support; the diagnosis was confirmed as malaria with secondary pneumonia.

Dr C's records were of a high standard. He had noted all relevant findings and important negative ones. He did make one retrospective note, but this was clearly marked as

such. It concerned the history of Mr A having taken malarial prophylaxis. Dr C documented the date of entry and the date of finding out about the prophylactic medication. Once again, however, the exact nature of the prophylaxis taken wasn't detailed.

Mr A lodged proceedings against Dr C, alleging negligence in that he had diagnosed gastroenteritis on the first visit. Mr A also alleged that Dr C should have visited, diagnosed and treated him earlier in the four-day period. He alleged long-term psychiatric problems as a result of his malaria.

We sought the opinion of a GP expert, who had only one criticism of Mr A's treatment. This was directed at

nurse J and Dr C, and concerned the failure to fully elucidate the nature and suitability of the malaria prophylaxis used. However, he considered the rest of Dr C's actions as good, reasonable practice. The claim from Mr A was abandoned at trial, as the deficiencies he alleged were not supported by expert opinion.

Comment

- *The quality of Dr C's notekeeping made this action relatively easy to defend.*
- *A retrospective note is acceptable in clinical records, as long as it is clearly marked as such.*

- *When taking details of medication, it is important to record exactly what is being taken, the dose and its frequency.*
- *Malaria prophylaxis is a complex and rapidly changing area of knowledge. It is important to use up-to-date reference sources to decide on the appropriate prophylactic regimen, for travellers to any particular area. In the UK the Public Health Laboratory Service website at www.phls.co.uk contains relevant guidelines and lists of local resources to contact for advice.*
- *Assuming that old medication from previous trips will be adequate is a risky strategy.*

A valuable addition to a practice library

Promoting child health in primary care

Edited by **Anthony Harden** and **Aziz Sheikh**

Royal College of General Practitioners
£21.50

ISBN 085084 2824

Reviewed by **Jane Cowan**

In the foreword to this book, Professor Dame Lesley Southgate comments that, in the past, input from the general practitioner 'has often been separate from, and sometimes at cross-purposes with, that of other health and social work professionals'. The aims of the book, therefore, are to promote the primary role of the parents in the care of their children, encourage those working in primary care to consider the importance of multiprofessional working and to reflect on current changes in practice.

To a great extent the book achieves this. The 11 chapters cover a range of different topics, some in greater depth than others, providing insight into many of the problems that the GP has to deal with. This includes the management of the child (apparently, 30% of consultations are related to emotional and behavioural

problems), the dynamics of the family and how best to contribute to the welfare and wellbeing of the growing and developing individual. Importantly, the book includes chapters on medico-legal aspects of child health surveillance and child protection.

The roles of clinical risk management and clinical governance in child health in the modern primary care team are missing. This was perhaps intentional, but progress in the provision of healthcare of necessity includes these aspects.

Some of the important comments on safe practice – evaluating process and developing standards – are at times lost in the text and may have benefited from greater emphasis. Examples include the chapter on childhood immunisation, which is well written and contains a great deal of information about vaccines, including some historical perspectives. Whilst the organisation of a vaccination clinic is dealt with, more emphasis on the safe running of vaccination programmes within primary care would perhaps have been valuable. Parents are given opportunities to make informed choices but should expect that the

implementation process is safe in practice.

Training requirements are referred to on several occasions, reinforcing the need for evidence-based practice and consistent approaches. 'GPs and other members of the primary care team should have a working knowledge of the key recommendations and the management of the common problems, to help ensure parents are given advice that is evidence-based and consistent.' This is reaffirmed in the chapter on child protection as follows: 'GPs are under obligation to address their personal training needs in matters relating to child protection.'

Given the publication of Lord Laming's report into the death of Victoria Climbié in January of this year, the advice provided is valuable and indeed very relevant. The ten common pitfalls that the authors list are worthy of consideration by all practitioners in the primary-care team.

The chapter on child protection then leads into a chapter on the medico-legal aspects of child health surveillance, the content being broader than the title suggests. Various topics are addressed and

provide a basic overview of clinical negligence, consent, child protection and clinical documentation. There is little reference elsewhere in the book to the importance of maintaining good-quality documentation or the role of the personal child health record. Indeed, accountability for clinical decision-making and the need for supportable practice are rarely dealt with as a concept; perhaps this may have been assumed by the contributors.

The book would make a valuable addition to a practice library. Each chapter is sufficiently well contained to deal with areas of interest. GP registrars in particular would do well to familiarise themselves with this book. Taken in conjunction with the new Hall report (4th edition) and the recommendations for health in the Laming report (see www.victoria-climbié-inquiry.org.uk/finreport/finreport.htm), the GP should be well equipped to address parental and professional concerns in many aspects of child health.



Letters

Smooth v textured breast implants

Dear Editor,

I read the March 2003 edition of *MPS Casebook*, and was surprised that you had accepted an expert opinion that smooth implants were outdated and inferior to rough, textured implants. Smooth implants are usually placed behind the muscle, whereas rough implants are placed in front. The placement of implants behind muscle means that the pectoralis muscles are continually massaging the implant, compressing it, displacing its volume and pushing away any scar that might try to encapsulate and constrict it. This has probably done more to prevent capsular contracture than the advent of rough textured implants has done.

I would be grateful if you would discuss the scientific evidence that disputes this point of view, as a large number of our membership in South

Africa are achieving very satisfactory results with smooth implants.

Dr Thomas D Ford

Plastic and reconstructive surgeon,
Sandton, South Africa

Our decision to settle was based on the opinions of two experts in plastic surgery in the United Kingdom (where this operation took place).

They referred to a report from the Independent Review Group on silicone gel breast implants, published in July 1998, which noted that gel bleed and contracture rates were lower with textured implants, compared to earlier implants.

One expert referred to figures published by Grabbe and Smith in 2000, which showed that smooth implants have a contracture rate of between 40% and 60%, while textured implants have a contracture rate of about 10%. Both experts asserted that only a very small minority of surgeons in the United Kingdom would still use smooth implants as most had been using textured implants since the late 1980s.

Corneal damage and anaesthesia

Dear Editor,

I must vigorously protest your conclusions from the case of corneal damage (possibly) sustained under anaesthesia. You appear to say that artificial eye protection must be applied universally. I was taught never to say 'always' and never to say 'never'.

Despite, or perhaps because of, an extensive practice in ophthalmic anaesthesia, I also disagree that any artificial fabric or substance be applied to, or near, the eye without a clear clinical indication; these, in my opinion are relatively few e.g. prone position, head towels, etc. Under anaesthesia the best protection for the eye is a closed upper eyelid and repeated careful observation by the anaesthetist.

In training I observed (yet thankfully was not involved in) a corneal transplant following four hours of micropore tape adhering to a cornea, and blindness after a retinal artery occlusion during six hours

prone position on a neurosurgical headring, which slipped onto an eye shield. Artificial eye protection should be used only when necessary.

Dr KN Williams

Consultant Anaesthetist,
St Thomas' Hospital, London.

Our comments attached to the case report, and referred to by Dr Williams, were written to emphasise that eye care for patients under anaesthesia should be considered, conducted appropriately and documented. The actual protection used, be it physical, pharmacological or positional, should be appropriate to the procedure and patient, and in line with accepted current guidelines.

Lost IUCDs

Dear Editor,

Re: The case report in *Casebook*, March 2003, concerning a lost coil. This article raises other points regarding lost IUCDs. Firstly, a patient who has a lost IUCD should be sent to a family planning clinic,

Antibiotic prophylaxis

Dear Editor,

I feel I should write to make two comments about the case report in *Casebook* June 2003, titled 'Is arthroscopy a sterile procedure?'

If, as stated, there was a letter in the patient's notes recommending the use of antibiotic prophylaxis for oral or GU instrumentation, it must be assumed, at pre-operative assessment, that a potential endocardial defect is still present. A review of the previous medical notes should be a routine part of the anaesthetic assessment and guides potential questioning of patient and family. This information should then lead to an informed decision with the surgical and, possibly, cardiology teams, as to whether prophylaxis is appropriate. This decision should, of course, be discussed with the patient and fully documented.

As regards the choice of antibiotics, you do not state when or where this case occurred, and it is therefore difficult to decide on the appropriateness or otherwise of the choices made. However, for some years now, the *British National Formulary* has published referenced

and updated guidance on this issue, and I would commend this information to your readers. In the UK at present, had the decision been made to give antibiotic cover, the choice in this case would probably have been oral clindamycin or azithromycin.

Name and address supplied

This case occurred in the UK in 1988, and guidelines available at the time recommended the use of erythromycin where penicillins weren't suitable, due to a reported allergy. The allergy would appear to have been a red herring, as the patient was eventually treated with flucloxacillin – we have no information on this, as it wasn't relevant to the claim, and we can only assume that the nature of the allergy was elucidated and thought to be insignificant. As this correspondent and another reader, Dr David Mitchell from Ireland, have pointed out, this guidance has now been superseded, and we endorse the recommendation to use a national formulary. Where time-sensitive guidance occurs in our report, we do usually try to give the date to avoid confusion. We are sorry if our failure to do so in this instance has misled any readers.

who are successful in removing the majority of IUCDs. If the IUCD is unretrievable at such a clinic, then the patient should have an ultrasound scan to ascertain whether the IUCD is within the uterus. If it is not seen within the uterus, an x-ray of the pelvis should be taken to see if the IUCD has migrated to the pelvic cavity. If so, then a CT should be performed to identify the exact location of the IUCD.

Finally, most patients with IUCDs that are in the uterus, but not retrievable by conventional means, should be referred to an interventional radiologist, who will, under fluoroscopic control, and as an out-patient, remove the IUCD successfully. Thus patients do not need to be referred to a gynaecologist for this procedure and certainly do not need a general anaesthetic.

Drs EPH Torrie & M Gibson,

Consultant Interventional Radiologists, Royal Berkshire and Battle NHS Hospitals Trust

References

Gibson M and Torrie EPH. Fluoroscopically controlled removal of intrauterine contraceptive devices. *Clinical Radiology* (1996) 51:654–655.

Drs Torrie and Gibson raise a number of important points in their letter. In addition, as a matter of good practice, once it has been established by clinical examination and ultrasound that the IUCD is not in the uterine cavity, a pregnancy test would be a wise early precaution. This would exclude a very early pregnancy before exposure to ionising radiation, particularly where CT scanning is contemplated. Clearly, it is preferable if a general anaesthetic can be avoided. However, fluoroscopic retrieval is dependent on the availability of the necessary radiological expertise.

MEDICO-LEGAL BOOKLETS / FACTSHEETS

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Consent – Complete Guide for GPs
Consent – Complete Guide for Consultants
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