



120 Beulah Road, NE, Suite 200
Vienna, Virginia 22180
Toll Free: 800-336-0332
Fax: 703-255-6134
www.malpracticeexperts.com

Endocrinology Sample Case

An insulin dependent diabetic is sent home from an Emergency Room, and then hospitalized in a coma for weeks and has numerous complications including infections and bleeding.

This 39-year-old patient was an insulin-dependent diabetic with many of the problems common to a diabetic, including eye, kidney, artery and nerve damage and marked increased susceptibility to infection.

She had many previous trips to the Emergency Room. She was seen on 1/18 and had a negative head (brain) CT scan, but was diagnosed with a sinus infection (the CT scan did not note any sinus problem). She was given a pain medication (narcotic, Demerol) injection. It was believed she was lethargic from this injection. She was given a prescription for an antihistamine (Claritin) and an antibiotic, which she never filled. I am missing the records from that critical Emergency Room visit.

On 1/19 she was comatose at home and taken to the hospital again. She remained unconscious her entire stay at Hospital #1 from 1/19 through 2/10. Her diabetes was out of control and was properly stabilized. She had a history of high blood pressure and on arrival at the emergency room it was very high at 210/120. It came down quickly to 190/100 although it was initially difficult to control despite proper intravenous drug therapy. The CT scan on 1/19 was normal, as was the CT scan of 1/21.

Her out-of-control diabetes was properly treated. The spinal tap was negative for meningitis. She had a severe bladder infection, which was treated. She was admitted to the Intensive Care Unit where she remained unconscious the entire hospital stay of three and one half weeks.

Multiple Specialists saw her and the Neurologist thought she had a stroke involving damage to her brain stem and other areas of her brain. Time is the only treatment. She also had diffuse pneumonia, which was treated correctly. Her chronic diabetic kidney failure worsened but stabilized.

She had an endotracheal tube inserted for ventilation and suctioning of her trachea (windpipe) and bronchial tree. Usually after five to seven days, if the patient is still comatose, a tracheostomy operation is done to gain direct access for a ventilation tube to be inserted. This was finally done on 2/4. Because of that previous indwelling endotracheal tube there was inflamed scar (granulation) tissue build up above her vocal cords which were not directly damaged. After a few months, that healed without any problem for her voice.

Because of her multiple problems and the negative brain CT scans, it was hoped that her comatose state would resolve when her diabetic state and all her infections would be fully stabilized (when the metabolic encephalopathy would be resolved). Therefore, there was some justification for the delay in doing the tracheostomy operation.

That operation was more difficult because of bleeding from her thyroid gland that was controlled with sutures. Afterward she developed bleeding at that site, which was very difficult to control and required insertion of an endotracheal tube and gauze packing, which was proper care. She developed DIC (disseminated intravascular coagulopathy, a free bleeding state from her infections) and received proper blood clotting fraction therapy and blood.

The family requested she be transferred to Hospital #2 where she remained from 2/10 - 4/7. She remained comatose for weeks. Their MRI was consistent with strokes, most likely caused by her high blood pressure weeks before. She had a severe diabetic problem with impaired emptying of her stomach (gastroparesis) which required the insertion of a feeding tube into her small intestine: J tube jejunostomy operation (on 3/12). That was removed a few months later.

When they evaluated her throat and trachea, they found only easily bleeding scar tissue in her larynx/posterior pharynx (throat above the vocal cords) and that healed spontaneously. The previous tracheostomy operation was correctly done. They did not "cut too deep."

Her pneumonia and fungal blood infection was very difficult to cure, but finally resolved. Her swallowing problem resolved. It was related to her diabetic nerve damage and stroke.

After she finally awakened and her overall condition properly stabilized, she was transferred to their Rehabilitation Hospital for physical therapy to help her regain her strength.

She developed severe lower intestinal bleeding and was transferred back to the main hospital where she was evaluated and treated from 4/8 - 4/21. No source of that hemorrhage was found despite detailed examinations. She was stabilized and properly treated.

She was again treated in rehabilitation therapy for the residual effects of her stroke and finally discharged on 5/13 after the jejunostomy tube had been removed. All of their care was good.

I have not seen all of the 1/18 Emergency Room records from the Hospital #1, other than the CT scan report. All of those Emergency Room records including the Nurses notes and laboratory reports need to be obtained in order for me to be able to give you my final opinion on that critical aspect of her care. The only information I had was what they say occurred there after she was hospitalized on 1/19.

If they should not have discharged her and/or improperly treated her on 1/18, then it probably was the proximate cause of her condition going out of control. This would also have been responsible for her entire lengthy Hospital stays where she eventually was brought back to most of her pre - 1/18 condition.

Her overall health status was precarious because she did not eat (and probably did not take her insulin) and her diabetes was out of control contributing to her coma and severe infections. Because she probably did not take her medication for her high blood pressure secondary to her nausea from her out-of-control diabetes, her blood pressure was dangerously high at 210/120. This directly contributed to her brain damage and prolonged coma, which caused her pneumonia requiring the tracheostomy (that bled) and the need for the prolonged bladder catheter that resulted in further bacterial and fungal infections, which were very difficult to cure. It also contributed to a temporary worsening of her chronic diabetic nephropathy (kidney failure).

Therefore, please obtain all those missing 1/18 records from her Emergency Room visit and care at Hospital #1.