

Delayed Diagnosis of Appendicitis in Female Teenager.

A summary of salient aspects of this case appears below.

- 1) This Patient was 14 years old on June 5, when she was evaluated by Dr. #1 for abdominal pain of seven to ten days in duration. Although no fever was noted on this June 5 visit, it is unclear if the patient was receiving acetaminophen or other agents that could explain the lack of a temperature elevation. Dr. #1 clearly noted that she suffered from right lower abdominal tenderness when he examined her. This exam finding is quite suggestive of acute appendicitis and this was the logical diagnosis on this date. Also notable on the June 5th visit was a 12 pound weight loss from her preceding office visit of November 29, which also should have suggested a more serious medical diagnosis than the diagnosis of “viral gastroenteritis” that Dr. #1 mistakenly assigned to this patient on this date.
- 2) Dr. #1 failed to obtain any blood tests such as a CBC (complete blood count) which would have been the standard of care for evaluating any young patient with lower abdominal pain and right lower quadrant exam findings.
- 3) Dr. #1 failed to include a practical differential diagnosis for this patient’s condition that should have included acute appendicitis. This omission led to his giving her incomplete discharge instructions. For example, the patient was not advised to take her temperature on a regular basis, to monitor her weight, or to report any symptoms of worsening abdominal pain. Such an incomplete discharge plan also represented substandard medical care which, more likely than not, adversely impacted her outcome.
- 4) When she was next evaluated by Dr. #1 on June 15, she now had fever, further impressive weight loss and an elevated white blood cell count. Emergency studies such as an abdominal ultrasound were obtained that culminated in her admission to the Hospital. Appropriate antibiotic therapy and a Surgical consultation as well as an abdominal CT scan were obtained.
- 5) On June 16 Dr. #2 brought her to the Operating Room where a diagnosis of a perforated appendicitis was made with multiple intra-abdominal abscesses found on exploration.
- 6) Following a 13-day hospitalization, she was discharged from the Hospital on June 27 and received a further course of antibiotic therapy as an outpatient.

It can be stated, within a reasonable degree of medical certainty that the prognosis of acute appendicitis is worsened by any delay in the recognition of this condition. During the course of acute appendicitis, the thin-walled appendix is at risk of rupturing which can cause spillage of bowel contents into the sterile peritoneal cavity with abscess formation, as occurred here and peritonitis.

Although the exact moment of this patient’s appendiceal perforation cannot be precisely delineated, it is likely that Dr. #1’s ten plus day delay significantly worsened the chances that this patient could have had an uncomplicated and non-perforated acute appendicitis operation. Such a delay also likely had psychological and other forms of repercussions and may have significantly increased the risks inherent in future intra-abdominal adhesions (scar tissue) such as the need for further surgery, and infertility because her fallopian tubes could become blocked from scar tissue cause by the peritonitis.

I suggest that the patient be evaluated by a local Clinical Psychologist with courtroom experience for any residual emotional (psychological) damages. Administration of standardized tests such as the M.M.P.I. (Minnesota Multiphasic Personality Inventory), which have been given to millions of people, would further support that opinion before a Jury.

It would appear that the above issues represent viable avenues of pursuit in this case and the potential to obtain supportive Expert opinions does exist, although no guarantees to that effect can be made. In this specific case, Expert opinions in the area of Pediatrics, General Surgery and Infectious Disease should be strongly considered.