Multiple presentations to ED before diagnosis of stroke
17HDC00725, 26 June 2019

District health board ~ Emergency department ~ Neck pain ~ Vertigo ~ Stroke ~ CT scan ~ Right 4(1)

A woman was seen by her GP because of worsening neck pain, a pulsing noise in her head, and a persistent headache. She had attended physiotherapy for her neck pain, but her pain had worsened. The GP referred her to the emergency department (ED) at the public hospital for further investigation.

Over the next three days, the woman presented to the ED four times. At the first visit, she was reviewed and discharged with treatment for an ear infection, neck pain, and a migraine.

The woman developed vertigo and vomiting, and presented to the ED for a second time. She was reviewed and her care was discussed with the ED consultants. She was referred to the Ear Nose and Throat (ENT) service for investigation, in accordance with protocols for patients who present with vertigo. She was reviewed by two ENT junior doctors and diagnosed with otitis media with labyrinthitis and migraine. No consultant review or CT scan was arranged, and she was discharged home.

At the third visit, an ED doctor discussed a CT scan with the admitting ENT registrar. The woman was referred to the ENT service for investigation, and was seen by the ENT doctor who had examined her previously. Again, she was discharged with a diagnosis of vertigo caused by a middle ear infection. No CT scan was performed, and her presentation was not discussed with a consultant.

That evening, the woman returned to the ED and was reviewed by a senior medical officer, who ordered a CT scan. The scan revealed a vertebral artery dissection and acute and subacute bilateral cerebellar infarcts (two strokes).

Findings

The district health board was found to have breached Right 4(1). There was a pattern of poor care across the presentations to the ENT service — in particular, the woman was not offered a CT scan at either her first or second ENT review, and no discussion with the ENT consultant took place. At her second ENT review, the ED doctor who referred her to ENT noted that a CT scan was indicated, but this was not communicated to the ENT registrar adequately, and no CT scan was performed at this time.

Recommendations

It was recommended that the district health board (a) provide a written apology; (b) confirm the procedures in place to oversee and support junior registrars who are failing to satisfy the requirements of their clinical placements; (c) use this report as a basis for training staff in the ED and ENT departments; (d) audit its compliance with the ENT guidelines to ensure that the escalation process is followed in situations where a consultant review is indicated; and (e) give consideration to developing ED guidelines for situations when a junior doctor has a different diagnosis from the referring GP, and where a patient with no definitive diagnosis re-presents to the ED with concerning symptoms that have not resolved.