Misdiagnosis of gastritis in patient with chest pain who subsequently died from myocardial infarction

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Public hospital ~ Senior house surgeon ~ Standard of care ~ Chest and stomach pain ~ Heart attack ~ Right 4(1)

A man complained that his 43-year-old wife had not been adequately assessed or treated by a senior house surgeon in an Emergency Department of a public hospital, with the cause of her stomach and chest pain remaining undiagnosed before her subsequent death. The woman had previously visited her GP because of tiredness with no obvious cause; her iron levels were low and this was treated. She returned to the GP five days later with chest pain, a tingling tongue and numbness in her neck and throat. An electrocardiogram (ECG) was normal. The GP recorded that she had "possible reflux" but organised further laboratory tests including a troponin-T and myocardial enzyme tests. He informed her that she could have a heart problem or her stomach could be affected by the iron tablets she was taking. While awaiting the results of the tests, he prescribed omeprazole to treat the reflux and suggested that if she had any further chest pains after hours she should present to the Emergency Department at the public hospital.

Later that night she had "severe chest/stomach pains" and vomit with blood present, and went to the Emergency Department. The senior house surgeon was told that she had a burning pain in her stomach after commencing iron tablets. He assessed her, reviewed her history, and diagnosed gastritis, advising her to stop taking the iron tablets, and increasing her medication for reflux. He did not request further tests to investigate possible cardiac causes of her pain or consult a more senior doctor, as he was confident of his diagnosis; he also did not realise that the results of the tests ordered by the GP were available on the hospital's computer system. He advised her to return if she did not improve. The following day the woman's symptoms appeared to improve but she was very tired. Shortly after midday she suffered a cardiac and respiratory arrest; an ambulance team tried without success to revive her. The post-mortem report concluded that she had died from myocardial infarction occurring approximately 12-24 hours before her death.

It was held that the senior house surgeon breached Right 4(1) in that his failure to rule out a cardiac cause for the woman's pain showed a lack of reasonable care and skill. Although it could be considered reasonable for him not to have consulted a more senior doctor because there was no policy in place at the Emergency Department concerning atypical chest pain or undifferentiated chest and abdominal pain, he should have ordered an ECG and checked the results of the troponin-T test (or ordered one himself).

It was further held that the public hospital breached Right 4(1) by not having in place a written policy, with an action plan, to guide Emergency Department medical staff on the management of chest pain, especially since junior doctors were not always under direct supervision from senior staff. The hospital has since taken suitable steps to ensure safe management of patients presenting to the Emergency Department with chest pain.