Learning from the Mistakes of Others in Actual Malpractice Cases Resulting in Blindness and in 4 Cases of Death

Abstract: Many of us practice optometry daily and rarely think that the patient in your chair could go blind or even could die. But it does happen, thankfully infrequently. This course presents 12 (or more) cases of malpractice allegations and stresses what the clinician should have been considering, could have done differently and how the outcome could have perhaps been altered. Some believe that exploring the mistakes of others could result in changes of behavior and hopefully prevent these tragic outcomes.

1. Introduction
2. The evolving standard of care
3. The role of technology
4. The role of new knowledge
5. “Cover your bases”
6. **Case Presentations that have resulted in death**
7. 33 y.o. in her 33rd week of pregnancy
8. Seen in ER 5 days earlier because of severe headaches on her left side
9. CT performed and read as normal resulting in Dx of Migraines treated with Imitrex and hydration
10. Patient seen next day by her ENT doc who reviews the CT and diagnoses sinus involvement and treats
11. Seen 3 days later by her OD who finds anisocoria, occasional diplopia and refers to PCP the next morning recommending neural eval
12. PCP examines patients and refers neural eval next available
13. Patient dies 2 days prior to neural eval from sub-arachnoid bleed
14. What could have been done differently? Culpable?
15. 52 y.o with symptoms of mild vision blur in both eyes
16. BCVA 20/25 OD and OS with normal pupils & normal fundus exam
17. Symptoms and VA reduction diagnosed as due to early nuclear cats- fields not performed on this or any subsequent visit
18. As instructed, patient returns in 2 years with same findings and disposition
19. Patient is evaluated every 2 years for a total of 4 exams
20. Patient than goes to cat surgeon who finds only mild nuclear cats, but a bitemporal field loss on screening
21. A large chiasmal mass is discovered on MRI
22. Patient agrees to trans-sphenoidal surgery which is only partially successful and then agrees to a more major surgical intervention
23. Patient never regains consciousness following 2nd surgery and dies in hospital a month later due to complications
24. After death, his health diary is reviewed by family members
25. 6 years prior to his death, his recorded symptom was blurred vision in both eyes, worse in his left eye and left field of his left eye
26. This symptom does not match the ODs recorded symptoms
27. Is the OD culpable? What routine test could have most likely avoided this death?
28. 50 year old moderate myope presents to a new OD for new glasses
29. No symptoms, BCVA 20/20 OD/OS
30. fundus exam reveals a 1 disc diameter “nevus” supero-temporal to disc in right eye and lattice degen OU
31. Patient states he knew about the lattice but no previous doc mentioned the “freckle”
32. Patient told to RTC 1yr or ASAP if flashes/floaters because of risk of RD
33. about a year later, patient experiences flashes and is seen by a retinal doc in the large practice who finds a large amelanotic malignant melanoma
34. patient is treated with proton beam irradiation –
35. dies several years later due to metastasis
36. Culpable ?
37. A high strung 35 year presents with blurred vision in one eye
38. Exam reveals normal VA but a minimally pigmented retinal lesion about one DD in size and one DD from the disc
39. Patient referred to retinal specialist for consult in same facility
40. Patient difficult to examine and retinal specialist gives up on a 3 mirror lens exam and performs a FA
41. The lesion leaks somewhat and the consensus Dx is CSCR in this type A patient
42. No treatment offered but re-eval scheduled in 6 months
43. Follow-up within a year reveals no significant change
44. A year later, different OD notices the disc is slightly blurred
45. A B-scan ultrasound reveals a mass contiguous with the retinal lesion (which was not elevated ) and the disc
46. Dx is now malignant choroidal melanoma – eye is enucleated
47. Follow-up by oncologist is unremarkable for several years
48. On a 5 year follow-up, patient is told he is likely cancer free
49. Several months later, liver ultrasonography reveals a mass
50. Patient dies within a year
51. Is anyone culpable?

1. **Case Presentations that have resulted in blindness**
2. 14 yo presents for first exam with VA 20/40 and 20/20
3. No significant refractive error and no strabismus
4. No APD, normal color vision, normal confrontations
5. Dilated exam and fundus photos WNL
6. Dx: Amblyopia: mom and patient told lazy eye
7. OD states glasses will not help, and too old for VT
8. RTC 1yr
9. Patient sees colored lights about 11 months later in RE
10. Eval by same OD next day reveals VA 20/800 and 20/20
11. MRI reveals large pre-chiasmal mass
12. Parents told only option is major surgery
13. Surgery successful but develops hydrocephalus hrs later
14. Shunt into frontal cortex performed
15. VA next day NLP OD and OS

Was the Dx of amblyopia appropriate at the time?

1. Culpable ??
2. A 55 yo female presents with a Cat’s Eye Pupil OD
3. History reveals ICE (irido-corneal endothelium) OD 10 years earlier and patient being treated for Gl in same eye
4. Different doc states slight vision blur (20/30 OD) due to cat and recommends cat extraction
5. Patient has difficulty contacting OD who diagnosed ICE
6. Endothelial cell counts were under 1,000 in the RE and over 2,000 in the left 10 years earlier but not considered by the recent docs
7. Corneal decompensation after surgery – treated w Steroids
8. 3 PKs and 3 glaucoma surgeries later, VA is still below 20/400
9. In addition to poor vision, the eye is cosmetically disturbing even from across the room
10. Are any of these docs culpable?

Other cases of blindness :

1. Prolonged Steroids resulting in blindness due to undetected glaucoma
2. VA reduction to 20/30 diagnosed as amblyopia but one month later VA drops and actual Dx is POHS and CNVM-
3. Red eye in diabetic diagnosed as kerato-uveitis and treated- IOPs not measured and fundus never evaluated - VA drops from 20/20 to NLP because of neovascular glaucoma in 10 weeks
4. Corneal scratch from patients’ dogs’ nose treated with TobraDex but blindness results caused by fungal keratitis
5. Metallic foreign body removed from corneal FB in retina missed resulting in retinal toxicity and blindness
6. Bilateral angle closure in a highly hyperopic malpractice attorney who had been involved previously in glaucoma cases- he consumed an entire bottle of Nyquil which contains 3 sympathomimetic agents that dilate the pupil- but statute of limitations had expired and he could not sue his optometrist