filename: OMC Report Sample - Cardio.pdf
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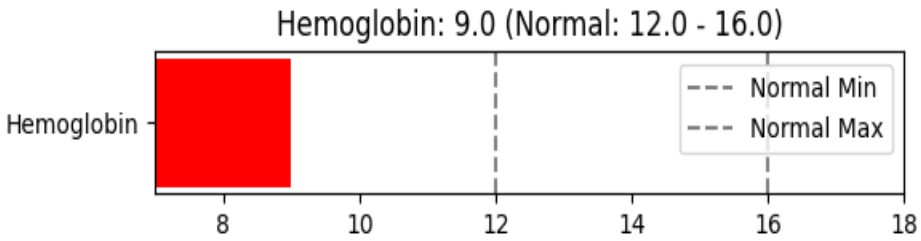
title: OMC Report Sample - Cardio.pdf
patient_name: Unknown
gender: Unknown
dob: Unknown
report_date: Unknown
lab_name: ■emergency■department■on■03/16/2006■with■the■chief■
test_type: Unknown

Hemoglobin Chart



Doctor Summary

Based on the information provided, it appears that there was a failure to thoroughly evaluate a patient (Ms.) who experienced syncope and had a thoracic aneurysm. The patient also had a 4.9 cm aortic aneurysm at the level of the diaphragm along with celiac artery involvement. When this aneurysm was discovered, the rest of the aorta should have been imaged.

Had this been done, there is a high probability that the outcome would have been much more favorable. The Board's allegation of "failure to evaluate a patient with syncope and thoracic aneurysm for abdominal aortic aneurysm" has merit. The care this patient received fell below the standard of care in this aspect.

The radiologist reading and/or performing the pulmonary artery CT scan should have continued imaging the rest of the aorta at that juncture, as they did not need an order or permission for same. It is unfortunate that the very large infrarenal abdominal aortic aneurysm was not discovered and the patient was discharged, as this aneurysm is urgent, bordering on emergent indication for repair.

In conclusion, while the focus on the patient's syncope was totally appropriate and wonderfully worked up, when the 4.9 cm aortic aneurysm was discovered at the level of the diaphragm along with celiac artery involvement, the rest of the aorta should have been imaged. Had this been done, there is a high probability that the outcome would have been much more favorable.

Patient Summary

In this case, it appears that the patient, Ms., was not fully worked up to exclude an infrarenal abdominal aortic aneurysm. Most degenerative or atherosclerotic aneurysms develop in the infrarenal segment of the aorta. Knowing that the patient had significant ectasia and eccentric calcification of the aortic wall, along with a rather discrete aneurysm of the distal thoracic to proximal abdominal aorta and celiac

artery, it was an indication for imaging the rest of the intraabdominal aorta, regardless of the patient's symptoms.

The vast majority of infrarenal aneurysms are asymptomatic. Another fact that is difficult to reconcile is the lack of physical findings on multiple abdominal examinations which the patient underwent by several different physicians. When the 4.9 cm aortic aneurysm was discovered at the level of the diaphragm along with celiac artery involvement, the rest of the aorta should have been imaged. Had this been done, there is a high probability that the outcome would have been much more favorable.

In conclusion, this is a most unfortunate case, and although the primary focus was on the patient's syncope, which was totally appropriate and wonderfully worked up, when the 4.9 cm aortic aneurysm was discovered at the level of the diaphragm along with celiac artery involvement, the rest of the aorta should have been imaged. Had this been done, there is a high probability that the outcome would have been much more favorable. The Board's allegation of "failure to evaluate a patient with syncope and thoracic aneurysm for abdominal aortic aneurysm" has merit, and the care which this patient received on this point fell below the standard of care.