2019 CLM Midwest Conference
June 20 -21, 2019
Chicago, IL

The Intricacies of Defending a Spinal Epidural Abscess Case

I. Diagnosis Issues - How the anatomy can lead to differential diagnosis

Epidural spinal abscess vs another medical condition

There can be a variety of conditions that may lead a provider to not diagnose a Spinal Epidural Abscess (SEA). The incidence of SEA is less than 3 cases in every 10,000 patients. It is a rare but extremely dangerous medical condition. Similar presentations include epidural hematoma, multiple sclerosis, malignant spinal cord compression, intervertebral disk herniation/compression, meningitis and transverse myelitis. In addition other conditions that present as back pain may include cauda equina, pyelonephritis, abdominal aortic aneurysm, mass and fracture. Given the vast array of conditions possible, this is a difficult diagnosis to make.

The presentation of back pain in the Emergency Department is a very small percentage of all ER visits per year. It is usually classified as acute nonspecific back pain and can look similar to back strain/sprain, mechanical back pain and lumbago. Given the preponderance of visits with complaints of back pain, diagnosis of SEA is a challenge considering it could be so many other conditions. Physicians need to keep SEA in the back of their minds especially in the scenario of the patient having had the back pain for a number of days and they are experiencing neurological changes.

On average patients are usually seen multiple times in the ER prior to a diagnosis of SEA. Most diagnoses are picked up only after their condition continues to deteriorate from visit to visit.

Triad of symptoms not always present

The classic presentation of Back or neck pain, fever and neurological deficits are not always present in an epidural abscess. This occurs in a small percentage of the time. The triad of symptoms includes back pain, fever and neurological deficits but is present in less than half of the patients that present to a provider. Fever is present in about half of SEA cases. Localized pain is present in about three fourths of cases while neurological symptoms are only present in about one third of patients with paralysis being even rarer. Complaints of sphincter dysfunction

including urinary retention or incontinence should be treated with the utmost urgency as it is a sign of spinal cord compression or cauda equina and is considered a medical emergency.

The most common combination of findings are back pain and severe local tenderness to palpitation. Sometimes neurologic deficits are also part of their presenting symptoms to include paresthesia, pressure sensation and rarely complete paraplegia.

The difficulty in diagnosing a spinal epidural abscess

Given the low preponderance of SEA, most practitioners think of the usual suspects when dealing with a patient with complaints of back pain. There is a bias in the medical community of patient's presenting with neck and back pain. Is the back pain simply a strain or pulled muscle? Are they a drug seeker or frequent flyer to the ER? These types of thoughts can typically run through a provider's mind and they must approach each incident with a clear thought process and open mind. Sometimes this is easier said than done. It could be one of those pre-judged situations that can get a provider into hot water if they miss a diagnosis of SEA. The diagnosis of SEA is based on three criteria: 1) clinical suspicion; 2) lab and imaging testing; and 3) confirmation by surgical drainage.

Presentation of Symptoms

Symptoms of SEA usually progress in a standard fashion. It starts with back or neck pain and leads to paralysis over hours to days. There are 4 stages for the progression of symptoms. The usual common sequence in the evolution of SEA includes:

1) Localized spinal pain, tenderness and perhaps fever
2) Radicular pain, nuchal rigidity or paresthesia
3) Sensory abnormalities including muscle weakness, sensory loss and/or bowel/bladder dysfunction
4) Paralysis (permanent damage to the spinal cord usually due to compression.

Common Risk Factors

There are times when a patient may have SEA and not have any identifiable risk factors. Usually that is not the case and a patient will have one or more of the risk factors. Risk factor analysis is essential when evaluating patients that present with neck or back pain. Risk factors include recent spinal surgery or injection, an immunosuppressed individual, IV drug user or a MRSA infection of the skin. Another known risk factor is the presence of a tattoo over the site of pain. Other risk factors include diabetes mellitus, contiguous soft tissue or bony infection, cancer, renal failure/hemodialysis, urinary tract infections and alcoholism. There are cases where no risk factors were present in the face of a SEA diagnosis but that is not as common as an individual with one or more of the known risk factors mentioned above.

Delay in Diagnosis

Delay in diagnosis or misdiagnosis is common in these types of case. There are so many other diagnoses that the patient could suffer from and the fact that SEA is so rarely the diagnosis that often times the medical provider will overlook this as a possibility. They tend to lean toward the more common diagnosis of a non-life threatening condition. Once the diagnosis of SEA is made, it is an emergent condition and requires evaluation and possible intervention by a neurological specialist.

Delays in these situations can lead to dire consequences for the patient. They be left permanent neurological deficits including loss of bowel/bladder function, loss of motor function or paralysis. Timing is of the essence in making the diagnosis of SEA. Lost time will lead to further compromise of the patient's neurological function. Once SEA is suspected, MRI of the entire spine with gadolinium is the gold standard for diagnosis. If MRI is unavailable, a CT myelogram or CT with IV contrast may be useful but these tests are not as sensitive and may not be able to distinguish the size of the abscess or an early infectious process. Lab testing may also help is pinning down the exact bug and should a CBC, ESR (sed rate) and/or CRP (c-reactive protein).

Communication between Providers

In these types of cases, communication between providers is essential. Most of these cases come in through the ER. There are some circumstances where a patient may present to their primary care provider's office and are then sent to the hospital for further evaluation. Whatever the situation, once the patient enters the hospital, communication between providers is of the utmost importance as time is of the essence to saving neurological function. Since a multitude of providers will be participating in the care of the patient that includes the attending physician or hospitalist, radiologist, neurosurgeon and possibly infectious disease communication between these specialties will be of the utmost importance. Often times physician rely on progress notes to communicate. In a situation such as this, direct person to person communications is always best to ensure timely and accurate information is relayed to all the providers. In addition, this type of emergent crisis requires the least amount of time from suspicion to final diagnosis so direct communication is the best way to avoid delays in relaying crucial information directly from physician to physician or nurse to physician.

II. How to Defend Litigation

Defense Focus - Explaining the difficulty in making the diagnosis

Jurors tend to understand that physicians are human and aren't expected to get everything right. Plaintiff's experts will have offered evidence at trial that the physical findings, history, tests, etc., all pointed to the diagnosis of spinal abscess. The defense should establish that, in retrospect, the diagnosis may seem easy to reach, especially when working backwards in time from when the abscess was, in fact, ultimately diagnosed. Work through the evidence with the defense providers and experts prospectively, however, and establish how each sign, symptom or complaint along the way is actually consistent with a myriad of diagnoses. Defense experts will have to establish that literature is replete with articles on the challenge of reaching a correct diagnosis, especially when the "classic triad" of symptoms is not clearly tied up in a nice bow.

Finger pointing

Avoiding in-fighting by healthcare provider defendants is critical to keeping damages down. As all experienced trial attorneys and claims professionals know, if the defendants fight amongst themselves, the plaintiff's job is simple, and usually allows them to just stand back and watch as the defendants to do much of their work for them, establishing that one or all of the defendants deviated from the standard of care. That testimony, coming from a defendant or defendant's expert, is far more persuasive and compelling to the jury than coming from a plaintiff's expert alone. Most plaintiff attorneys don't care which of multiple defendants is found at fault by the jury, although they certain prefer a verdict to include the "deep pocket" defendants.

Unfortunately, there are situations where the defense of one healthcare provider requires establishing that appropriate information was given to another provider, etc. (e.g., having properly communicated signs and symptoms that warrant testing or evaluation, identifying radiographic findings that might raise the diagnosis of spinal cord abscess on the differential for others, etc.). The challenge for defense counsel is trying to establish that your particular provider client did nothing wrong without saying that someone else did. The risk is that a jury won't exonerate your client either, of course, but "finger-pointing" is only likely to anger a jury that might be otherwise looking for justification to keep a damage award lower.

Witness Preparation

As in any high-stakes trial, witness preparation is perhaps the most critically important aspect of defending spinal abscess cases. Defendants need to be prepared to stay calm in the face of extremely difficult and sympathetic evidence depicting a tragic outcome for their patient. While on the witness stand they must be both empathetic to the plaintiff and yet clinical in explaining the care spent in evaluating the plaintiff's condition and symptoms. A carefully laid out story, told chronologically, depicting how the defendant considered each element of the plaintiff's condition and history, evaluated the likelihood of different disease processes or causes for that presentation, and considered all "next step" options, will be the key to defending his actions. Even if the defendant did not order the ultimate test necessary, a compassionate explanation of what was missing from the history or physical that might have led to another test at that point helps the jury understand that each step in the decision tree is carefully thought through, and that medicine is not practiced in simple "cookbook" form.

Experts

Defense experts are often the key to a successful defense, but especially in cases involving complex diagnostic issues. Given the usually catastrophic damages involved in a spinal cord abscess case, it is important not to cut corners on defense experts. Spare no expense in obtaining a top expert in the field, preferably one who has authored some of the recognized literature on the topic, and who may even be cited by plaintiff's expert(s).

Trial

Can these cases be tried?

These cases can be taken to trial, and often must be, especially in those cases where plaintiff's damages evidence suggests astronomically high figures that make settlement unlikely. Care must be taken in evaluating prospective jurors for signs of hidden bias and sympathy for the plaintiffs. The difficult outcome that plaintiff had from otherwise proper care should be addressed up front. When faced with a "missed diagnosis" claim, the defense must be prepared to show why the diagnosis was not clear. When faced with a "failure to refer to a specialist" case, the defense must be prepared to establish that criteria for a specialty referral was not met, and that specialty evaluations are not the norm for the myriad of common medical complaints with which patients often present.

Trial preparation — From Initial Case Assignment

From the inception, defense counsel and claims personnel should approach these cases, in particular, as cases that will go to trial, and not simply assume that it need only be configured for mediation or settlement. As noted below, it is often the situation that damages far exceed insurance coverage, making it difficult for plaintiffs to accept even a policy limits offer from certain defendants. Assuming that the case will be tried, the defense team should work diligently to investigate damages (see above regarding life care plans, etc.) and retain the strongest defense expert(s) possible.

Working with co-defendants

As noted below, avoiding finger-pointing is critical. It also behooves all defendants to coordinate themes where possible, often on a central "defensible" issue (whether it is liability, causation, or damages) if one aspect of the case is beyond question. Try to coordinate defense experts as well, so that they likewise support each other's opinions and don't, instead, cancel each other out with contradictory theories, etc.

Causation

Timing of complaints to care provided and permanent Injury

Arguing proximate cause is always an essential part of any defense. In these types of cases, it becomes paramount. Once the patient presents with signs of leg weakness and incontinence, the time period of intervention is limited. While there may be a delay in ordering an MRI or CT, or even taking the patient to surgery, a thorough analysis must be made as to whether it would have made a difference. In creating a causation timeline, explain what would have occurred from the time of alleged negligence. Retain experts to assess what earlier imaging would have shown or how soon surgical intervention may have changed the outcome. Plaintiff's experts always say earlier is better. Force them to say how much earlier.

Causation experts must be retained

Plaintiff must link up every aspect of the negligent care to the damages. Spend no expenses in hiring causation experts. Often the defense causation experts will include a radiologist, surgeon and critical care specialist.

Damages

Defining the extent of the damages

The result of an epidural abscess is often catastrophic, resulting in loss of function, paralysis or death. The value of the case will be determined by the extent of disability and impact the disability has on the defendant and potentially a spouse or child. While dealing with disability is often difficult, the true extent of the injury must be analyzed and assessed fully during the discovery process. One must start with an examination of the patient's pre-existing conditions and work history. While often defense counsel does not question the extent of a disability, the opposite is true here. With the potential of huge damage, every claimed damage must be analyzed and assessed. This analysis must include an evaluation of the applicability of any medical care, the extent of any claimed loss wages and a true assessment of the disability. In some instances an independent medical exam may be necessary.

Damages experts must be retained

Defendants are often wary of hiring damage experts. This concern is with good cause. A defense damage expert potentially sets the floor for a life care plan and is often look on as a concession of fault. It also allows plaintiff's counsel an additional opportunity to discuss in great detail the horrific damages. While these may be strong reasons not to call your damage experts, there is no reason not to retain such experts. The potential damages in these types of cases are to big to ignore a complete analysis of plaintiff's case. Just as causation experts are essential, damage experts can be equally beneficial. Even if a decision is made not to call the damage witnesses at trial, they can be crucial in attacking plaintiff's damage case. The first line of

defense in attacking plaintiff's damages is an examination of the plaintiff's current care. Often the plaintiff's life care plan will include an enormous amount of cost to include modifications to home and car, special wheel chairs or other devises, medication and future care that the plaintiff is not currently receiving. If the treaters do not think it is necessary, why should the experts? The defense should retain an economist, life care planner and physical medicine and rehabilitation specialist to help assess plaintiff's needs and if necessary, provide an alternative dollar figure at trial. It is also essential to retain a life expectancy expert. Plaintiffs will always find someone to argue a normal life expectancy. The difference in life expectancy can result in a shift of millions of dollars.

Damages must be addressed in detail during trial

While confronting significant damages and death is often a difficult topic, it must be done in these types of cases. The defense attorney cannot appear afraid to acknowledge the damages. If discussed intelligently, the jury will listen to the defense arguments. Do not be afraid to discuss with plaintiff or the family the extent of the disability and if possible, look for things he or she can do. Try to establish the positives, while still acknowledging the problems. In death cases, discuss with the family the impact the decedent has had on them and how they remember their loved one.

Confront Plaintiff's monetary request in closing

The news media has conditioned our juries for high damage awards. The news is filled with athletes or artists signing contracts in excess of $50 million dollars. Huge class actions suits award more than double that amount. Magazines are constantly ranking the world's richest individuals. All of this has preconditioned our juries. No longer are they shocked when a plaintiff's attorney asks for $75 million. Nor do they have trouble rendering awards in the $40 to $60 million range. It is essential that in closing the defense attorney attacks these numbers head on. Use the jury instruction; explain what the plaintiff is being compensated for and that the verdict is one lump sum to be picked up at the time the verdict is read. The jury instruction does not discuss generational wealth.