# Rash erroneously attributed to codeine reaction when patient suffering from meningococcal disease (03HDC00575, 1 March 2005)

*General practitioner ~ House-call service ~ Diarrhoea and vomiting ~ Rash ~ Diagnosis ~ Meningococcal meningitis ~ Record-keeping ~ Disposal of syringes ~ Standard of care ~ Professional and ethical standards ~ Rights 4(1), 4(2)*

A woman complained that a general practitioner (GP) failed to diagnose meningococcal meningitis and meningococcaemia. She contacted her own doctor's surgery after 24 hours of diarrhoea, vomiting and dizziness. The receptionist arranged for a doctor from a house-call service to visit the woman.

The GP examined her and, on the basis of his examination, excluded a diagnosis of meningitis and concluded she was suffering from viral gastroenteritis. He gave her two codeine tablets and an injection of an anti-nausea drug, and left the syringe for the household to dispose of.

About half an hour after he had left the woman's house, a relative telephoned to say that the woman's head had begun to throb badly. Once he had ascertained that she was not showing signs of shock, he advised they wait until the immediate effect of the drug had passed. He did not hear anything further and so assumed all was well.

The following day the woman had developed a generalised rash and a stiff neck. She was photophobic and vomiting and thought she had contracted meningitis. She had developed a rash on her legs, but her temperature was within normal limits, and her pulse, throat, ears, chest and abdomen were all normal. The GP was called and came to the house at 1pm. He felt that her condition had improved and his fears with regard to meningitis were allayed. He attributed the rash to a reaction to the codeine.

It was not until a third house call, made by a different doctor, that the woman was referred to a hospital, where she was diagnosed with meningococcal meningitis and meningococcaemia.

It was held that the GP's assessment and diagnosis at the first visit were appropriate. It was not acceptable, however, to leave the used needle and syringe at the house. His clinical records did not meet professional standards and breached Right 4(2).

It was also held that the GP breached Right 4(1), as it was a serious error of judgement not to consider other diagnoses and, by advising the woman that the rash was a reaction to the codeine, he falsely reassured her about the cause of the rash.