Rare neurosurgical emergency misdiagnosed as migraine (08HDC00248, 26 September 2008)

Physician ~ Public hospital ~ District health board ~ Emergency department ~ Clinical records ~ Migraine ~ Raised intracranial pressure ~ Right 4(1)

A woman in her forties had a long history of migraine headaches. She underwent successful neurosurgery, which alleviated her headaches.

The following year, she fell at home and her headaches returned. Although she was referred for a CT scan, it was not performed, as emergency department staff considered that her symptoms were related to her migraine. Notwithstanding this, staff noted the need to adopt a low threshold for a CT head scan if her headache persisted.

The woman presented at the hospital with a debilitating headache in the early hours of the morning. Her admitting consultant physician considered her symptoms migrainous in nature and prescribed her with medication for treating migraines. The consultant did not have access to the emergency department notes from an admission two months earlier, and was unaware of the need to adopt a low threshold for ordering a CT scan. Initially, the woman responded well to the medication. However, her level of consciousness deteriorated over the course of the day, which was attributed to the medication she had received. The following day, her condition deteriorated further, and she required resuscitation. Despite transfer to the intensive care unit, her condition continued to worsen, and she was pronounced brain dead.

A post-mortem examination found that the woman had suffered a very rare complication following the neurosurgery a year earlier.

It was held that the consultant breached Right 4(1) for omitting to review the woman on her second night in hospital, and for not requesting a CT scan at that point. He also breached Right 4(1) for failing to respond appropriately when she deteriorated further the following morning.

Various systems issues at the public hospital contributed to the tragic outcome, and the DHB was held to have breached Right 4(1). These included the absence of the woman's previous emergency department notes when she re-presented at the emergency department two months later, the length of time she spent at the emergency department before being transferred to the medical ward, and the reduced radiology services after hours.