

**Delay in diagnosis of streptococcal
infection in patient presenting with back pain
(04HDC20951, 25 January 2006)**

Physician ~ Orthopaedic surgeon ~ General practitioner ~ District health board ~ Gentamicin ~ Heart disease ~ Valve replacement ~ Gastroscopy ~ Gastrointestinal bleeding ~ Drug toxicity ~ Back pain ~ MRI ~ Streptococcus ~ Septicaemia ~ Blood cultures ~ Record-keeping ~ Right 4(4)

A 58-year-old man complained that serious symptoms were overlooked because of staff minimising the significance of his symptoms and contributing them to his back condition. The man had a history of congenital heart disease. He suffered a work-related back injury and, when acupuncture and manipulation were ineffective, he consulted his general practitioner. Blood tests were performed and analgesics prescribed. The pain did not settle and his general condition worsened.

A few days later he developed atrial fibrillation and was admitted to a public hospital, where this was treated. He was transferred to an orthopaedic ward at a second public hospital for further assessment of his back pain. He was seen by an orthopaedic surgeon, who ordered X-rays, physiotherapy assessment and pain relief. His condition stabilised and he was discharged. However, he remained unwell, developing anaemia, and was referred to the orthopaedic surgeon for further assessment.

The following month he was admitted to the first public hospital, where he was seen by the consultant physician for assessment of anaemia. Upper gastrointestinal bleeding was considered and he was transferred to the second public hospital for a gastroscopy examination. When the consultant physician learned that the gastroscopy was negative, he arranged for the man to have further diagnostic examinations and assessment as an outpatient.

The man was found to have bacterial endocarditis and was commenced on a short course of Augmentin. After one month of treatment with no improvement in his condition he was readmitted and further blood tests again identified Streptococcus B. He was started on a course of gentamicin before the decision was made to transfer him to a third public hospital for further management, which included a prolonged course of penicillin and gentamicin for suspected endocarditis. As a result of the antibiotic therapy he developed a toxic reaction to gentamicin.

It was held that the consultant physician's management of the man did not minimise potential harm and resulted in a three-week delay in diagnosis of the infection. He therefore breached Right 4(4).