

Giant Cell Arteritis

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Purpose of risk management recommendations

OMIC regularly analyzes its claims experience to determine loss prevention measures that our insured ophthalmologists can take to reduce the likelihood of professional liability lawsuits. OMIC policyholders are not required to implement risk management recommendations. Rather, physicians should use their professional judgment in determining the applicability of a given recommendation to their particular patients and practice situation. These loss prevention documents may refer to clinical care guidelines such as the American Academy of Ophthalmology's *Preferred Practice Patterns*, peer-reviewed articles, or to federal or state laws and regulations. However, our risk management recommendations do not constitute the standard of care nor do they provide legal advice. Consult an attorney if legal advice is desired or needed. Information contained here is not intended to be a modification of the terms and conditions of the OMIC professional and limited office premises liability insurance policy. Please refer to the OMIC policy for these terms and conditions.

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A 77-year-old male patient presented for the first time to our insured ophthalmologist to report the sudden onset of intermittent diplopia six days prior, and a headache over his eyebrows for one day. Noting right inferior oblique muscle paresis but unable to determine its cause, and with no neuro-ophthalmologist in his region, the eye surgeon referred the patient to a neurologist. The patient told the neurologist that the headache had actually lasted for one month, and that he was also experiencing jaw pain. This additional information prompted the neurologist to include giant cell arteritis (GCA, also known as temporal arteritis) in the differential diagnosis and to order an MRI, CT, and lab work. When the patient saw the ophthalmologist about two weeks later, he reported ongoing headache and diplopia, with low-grade fever, which was a new symptom. Five days after that—a full three weeks after the initial visit to the ophthalmologist—the patient lost vision in his left eye. An emergency room physician diagnosed giant cell arteritis and began intravenous steroid treatment, but the patient never regained vision in that eye. The malpractice lawsuit against the ophthalmologist settled for \$85,000; we do not know the outcome of the suit against the neurologist.

Armed with hindsight bias, the classic signs and symptoms of giant cell arteritis jump out: older patient, vision changes, headache, jaw pain, and fever. It is hard to imagine how the definitive diagnosis and treatment were delayed for so long, and easy to erroneously conclude that both physicians must have been incompetent. The claims investigation showed instead that these physicians had treated patients with giant cell arteritis, knew its signs and symptoms well, and understood that emergent treatment is needed to prevent imminent, bilateral vision loss. What, then, led these physicians astray?

Severe vision loss, costly claims

To answer the question, we analyzed lawsuits filed by 18 patients diagnosed with GCA between 1993 and 2014.¹ In twelve of the eighteen cases (66%), no physician included GCA in the differential diagnosis. Four of these patients were only seen by an ophthalmologist; the rest were examined by an eye surgeon and from one to three additional physicians. And although GCA was considered by the ophthalmologists in each of the remaining six cases, symptoms in five patients progressed when either the ophthalmologists or other physicians did not follow through to confirm the diagnosis and coordinate treatment. All eighteen patients experienced severe vision loss, often bilaterally.

OMIC had to make settlements on twice as many of these GCA claims compared to OMIC claims overall, and the mean and median payments were both considerably higher (**Table 1**). The short window for diagnosis and treatment and the risk of severe bilateral vision loss make the high stakes of this relatively rare condition clear. This article will explore the reasons for these poor outcomes, the standard to which medical experts hold physicians who treat these patients, and the measures ophthalmologists can take to improve the likelihood of a correct and timely diagnosis.

Table 1. Indemnity payments made to settle GCA cases

	GCA claims	All OMIC claims
Closed with a payment (%)	44%	21%
Mean (average) payment	\$203,250	\$165,282
Median (middle) payment	\$335,000	\$81,875
Highest payment	\$450,000	\$3,375,000

Patients presenting with only visual problems

Giant cell arteritis, a systemic inflammation of the blood vessels that restricts blood flow causing organ and tissue damage, most commonly affects patients over the age of 50. In addition to the symptoms noted above and scalp tenderness, varied and non-specific constitutional symptoms may develop over time, such as fatigue, malaise, and weight loss. It can be difficult to diagnose GCA when the only symptom is a change in vision. Four of the eighteen patients presented this way. In two of these cases, defense experts supported the ophthalmologist's care and the claims closed without payment, even though the insureds did not diagnose GCA or such diagnosis was delayed. In one case, a patient with dense cataracts that explained her vision loss was appropriately referred for work-up of a choroidal mass; the jury returned a defense verdict. In the second case that closed without a payment, a patient who presented with intermittent blurry vision was diagnosed with amaurosis fugax, a temporary loss of vision in one eye caused by a lack of blood flow to the retina. Because the patient was 79, the ophthalmologist ordered an erythrocyte sedimentation rate (ESR). When the result was normal at six, he repeated the test and got the same result. He diagnosed GCA six days later when the patient complained of a shade over

¹ Pelton RM and Menke AM. Giant cell arteritis claims are costly and difficult to defend. *Ophthalmic Risk Management Digest*. 25:3, 2015. <https://www.omic.com/wp-content/uploads/2015/09/Digest-No-3-9-2-15-for-web.pdf>

the eye and developed a Marcus Gunn pupil and visual field deficit. OMIC declined the patient's settlement demand and the case was ultimately dismissed.

The two other cases where vision change was the only symptom were settled when OMIC could not find supportive defense experts. In one, the ophthalmologist noted papilledema in an 81-year-old who presented with sudden vision loss, but did not work up its cause. The case settled for \$275,000. In the other, the ophthalmologist was criticized for not clarifying the nature of the visual complaint. The 82-year-old patient had written on the history form that her vision "blacked out." The surgeon did not read the form and documented only "blurry vision" and diagnosed her with visual migraine. The case settled for \$350,000.

Problems eliciting a thorough and accurate history

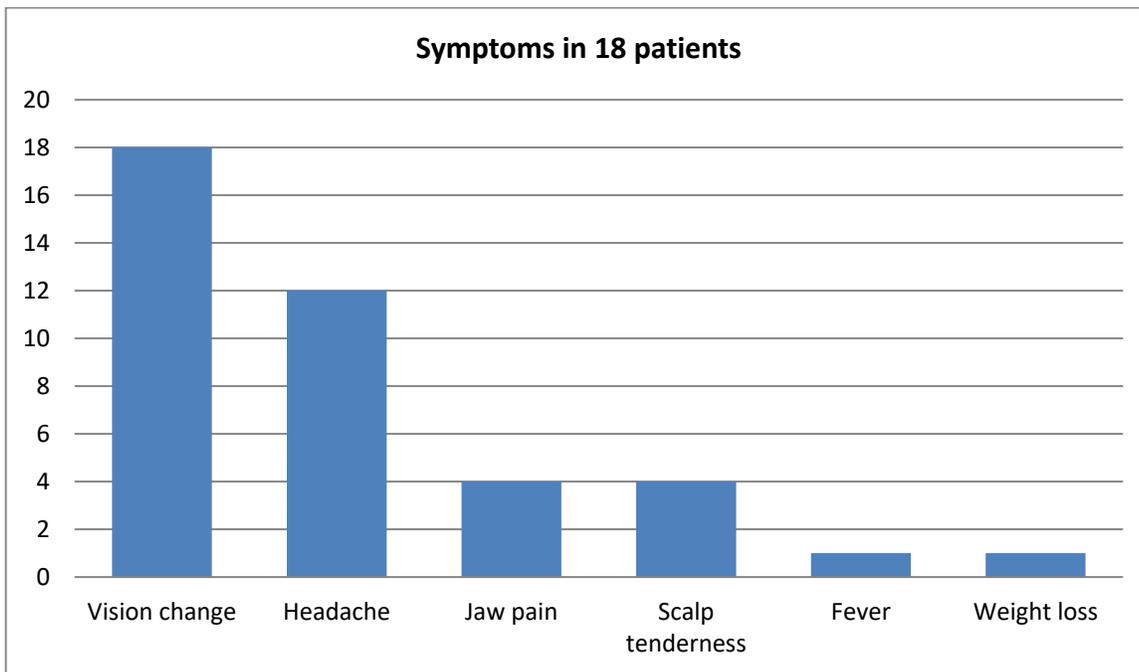
Exploring the precise nature of the vision change would have helped another ophthalmologist entertain a GCA diagnosis. His patient complained of a headache for two days and a "curtain," which he understood to be transparent. It was only during the investigation of the lawsuit that he learned that the patient had experienced a "dark" curtain that caused frank vision loss. He felt, in retrospect, that the combination of vision loss and headache in an elderly patient should have alerted him to GCA, and agreed to settle the claim for \$100,000.

While it is important to get accurate information about the eye complaint, it is crucial to query older patients about constitutional symptoms. A careful review of signs, symptoms, and systems can help distinguish the few patients who could have GCA from the large number of older patients with eye problems seen daily in ophthalmic practices. Which symptoms did the patients in our study exhibit? Consistent with GCA's usual appearance in patients over 50 years old, those in this study ranged from 62 to 86. As part of a claims investigation, defense attorneys obtain and review all of the patient's medical records. These reviews revealed that fifteen of the eighteen patients (83%) were experiencing GCA symptoms other than vision changes at the time of the initial visit to the ophthalmologist. Twelve of the fifteen patients reported headaches; of these, seven had additional symptoms (**Table 2**).

The ophthalmologists, however, failed to elicit non-vision related symptoms in ten of the fifteen patients (66%) who were experiencing them. Defense experts opined that this inadequate history contributed to the delay in diagnosis and was below the standard of care. The ophthalmologist in the first claim described above learned only of the vision complaints and headache, while the neurologist who saw the patient near the same time elicited the duration of the headache and the existence of jaw pain. Ironically, the ophthalmologist testified in his deposition that he did not consider GCA in his differential diagnosis since the patient did not complain of jaw pain. He did not explain why he relied upon the patient to offer this information instead of asking for it.

Why is obtaining an accurate history so difficult? First, patients often report their history differently to each healthcare provider based upon the questions asked and the time spent gathering the information. Often it was other physicians who obtained a more thorough history, but in two of our claims, the

Table 2. Symptoms in 18 patients



ophthalmologists' staff members obtained and documented the presence of GCA symptoms. Not only did the ophthalmologists not get the same information when questioning the patients a few minutes later, they also did not review the notes made by their staff members. This lapse was criticized by defense experts, and contributed to the decision to settle these claims. Second, patients presenting with eye complaints often do not think that it is important or pertinent to tell their ophthalmologist about non-ophthalmic problems they are experiencing. It is incumbent upon ophthalmologists to ask about these other symptoms.

More than in most diseases, therefore, prompt diagnosis of GCA depends upon the thoroughness and accuracy of the health history. In each claim, the plaintiff expert alleged that the diagnosis could have been made earlier if the ophthalmologist had obtained a more thorough history. Ophthalmologists examining older patients, especially those with vision changes and headache, need to take a more active role in obtaining the history. Dr. Ronald W. Pelton, a practicing oculo-facial surgeon who serves on OMIC's Board, has developed a GCA checklist to prompt ophthalmologists to ask key questions and document both positive and negative findings (<https://www.omic.com/giant-cell-arteritis-checklist/>).

Missed opportunities

So what happened in the first case analyzed above? While the ophthalmologist did not elicit a thorough history or include GCA in his differential diagnosis, the neurologist to whom he referred the patient did ask the appropriate questions. The combination of diplopia and pain in the temporal mandibular joint led the neurologist to a robust differential diagnosis, which included right fourth nerve palsy versus right

inferior oblique paresis, brain stem ischemia, myasthenia gravis, and vasculitis. He appropriately ordered an MRI, CT scan, and laboratory work, including an ESR. About a week after he examined the patient, the neurologist realized that the lab had not performed the ESR. He mailed the patient a prescription to have it done the next day. The patient never went. Six days later, the patient brought the results of the MRI, CT, and lab work (minus any ESR results) to his second visit to the ophthalmologist. The ophthalmologist skimmed the report which discussed the non-specific MRI and CT results and the normal lab results. He failed to notice that the lab had not performed the ESR. While he did see that the patient had been given a prescription to have the ESR repeated six days prior, he assumed the test had been done and was again normal. The ophthalmologist advised the patient to keep his follow-up appointment with the neurologist in four days' time. Experts who reviewed the claim felt that four opportunities for an earlier diagnosis that would have preserved the vision had been lost: when the lab didn't perform the first ESR ordered, when the patient did not go back to get the ESR lab test done, when the neurologist did not follow up to ensure it was done, and when the ophthalmologist failed to note the lack of ESR results. Had the ophthalmologist asked the patient, he would have learned that no ESR had been done. This information, combined with the new symptom of fever, could have prompted him to consider GCA and order a stat ESR.

Clear communication key to timely diagnosis

This review of GCA claims indicated that there was often poor communication among treating physicians and staff members. Here are some recommendations about ways to ensure that the necessary information is received from and communicated to the appropriate members of the healthcare team. The scenarios come from actual GCA claims, and some of the "advice" is from the defense experts who reviewed the claims.

Q: An Emergency Room physician from one of the local hospitals called me about a patient of mine. I don't take call at that hospital and told him to have the patient schedule an appointment with me. Now I'm being sued, along with the ER physician, who says he informed me that this 72-year-old had a headache and vision loss. The lawsuit says I should have at least warned the ER physician about GCA. What was I required to do?

A. You have no legal duty to provide assistance to a hospital when you are not on call for it that day.² As an ophthalmologist, however, you know more about the risk of severe vision loss from GCA than an ER physician. To protect the patient, urge the ER physician to contact the on-call ophthalmologist to evaluate the patient. Document this type of contact, however, briefly so your notes are available for your defense. Keep the notes in folder with other after-hour calls when on call to the ER or taking calls as part of a call group. Use our form to prompt you to ask questions and for easy documentation (<https://www.omic.com/after-hours-contact-form-and-recommendations/>). This claim closed without a payment.

² See Menke AM. EMTALA: An Overview for Ophthalmologists and EMTALA: On-Call Duties at <https://www.omic.com/emtala-emergency-medical-treatment-and-active-labor-act/>.

Q. I work in a practice that employs optometrists. One of them asked for my opinion about a 67-year-old patient who presented with vision loss, a headache, jaw pain, and scalp tenderness. The OD thought the patient had GCA. I agreed and told him to start steroids, and provided the starting and maintenance dose. The technician who was scribing made a mistake and wrote the prescription for 20 mg daily instead of four 20 mg tablets daily. Now I'm being sued for not taking over care of the patient from the OD and not adequately supervising the technician. What should I have done?

A. Optometrists often perform the initial evaluation for patients in a group practice. When a patient has a serious, vision-threatening condition such as GCA that requires urgent treatment and careful coordination of care, however, an ophthalmologist should assume responsibility. Your practice's written protocols should address this (see "Coordination of care with optometrists" at <https://www.omic.com/coordinating-care-with-optometrists/>). This optometrist did not have the legal authority to prescribe systemic steroids. In addition, while your technician may know the names and dosages of the eye drops you normally prescribe, she is obviously not familiar with oral steroids. It is prudent in this type of situation to write the prescription yourself, and provide written instructions to the patient on how much to take each day and when to see her primary care physician (PCP). Conduct a formal hand-off with the PCP to clarify that the PCP will be responsible for ongoing management of the steroids. It is helpful to give the patient a referral note that explains the reason for the referral and when it should take place, and send one with key information to the other physician (<https://www.omic.com/referral-form-for-patient-and-physician/>). The claim settled for \$350,000.

Q. A 76-year-old patient called our practice and spoke to my technician, who reported the conversation to me. I recall her telling me that the patient had pain in the back of his neck, so I instructed her to tell him to see his PCP. The lawsuit alleges that we were told that the pain was also in the temple area and accompanied by visual disturbances, and that given his age I should have seen him right away. Am I expected to speak to each patient myself or review each note about phone calls?

A. You obviously cannot talk to every patient who calls, so you need an efficient and effective way to share information within your practice. OMIC claims experience makes it clear that making medical decisions on the basis of the limited information obtained over the telephone is a risky—albeit necessary—aspect of ophthalmic practice. During the phone call, you and your staff need to gather the information necessary to assess the situation and determine the treatment plan, communicate the assessment and plan to the patient, and document the encounter and your decision-making process in the medical record. To ensure that you have the most accurate information, provide staff with a checklist of questions to ask and instruct them to document the answers. Review the contact form when you can give it adequate attention, and document the information you would like your staff to communicate to the patient. To assist you, OMIC developed a sample phone contact checklist and appointment scheduling guide called "Telephone Screening of Ophthalmic Problems" (<https://www.omic.com/telephone-screening-of-ophthalmic-problems-sample-contact-forms-and-screening-guideline/>). Use this guide to develop written protocols for telephone screening and treatment that are specific to your patient population, subspecialty, and staff; train staff in the use of the protocols

and verify competency; and willingly accept questions from staff members unsure of how to handle specific calls. This claim settled for \$200,000.

Take action to improve patient safety

This article shows that a constellation of incomplete history, poor coordination of care among physicians, and problems with patient adherence can lead to a delay in diagnosis of GCA. We recommend that ophthalmologists take actions to reduce this risk, such as proactively obtaining a more thorough history, to improve the likelihood of including GCA in the differential diagnosis when older patients present with vision changes. The checklist created by Dr. Pelton can prompt such questions, as well as help track the completion of key tests and consults. A robust appointment and test tracking system plays a pivotal role in preventing diagnostic error (see our noncompliance toolkit at <https://www.omic.com/noncompliance-guidelines-with-sample-missed-appointment-letter/>).

Need confidential risk management assistance?

OMIC-insured ophthalmologists, optometrists, and practices are invited to contact OMIC's Risk Management Department at (800) 562-6642, option 4, or at riskmanagement@omic.com.