In this issue of the *Journal*, Palaniappan and Sellke⁵ characterize the trends of malpractice litigations arising from aortic dissection over the past 25 years with the intent of educating the cardiothoracic community on the most common pitfalls leading to lawsuits. Within the online Westlaw legal research service,⁶ 135 cases were identified that made it to trial or documented settlement and analyzed to identify the most common allegations proceeding to litigation.

Although Westlaw is the most widely cited source for malpractice information, the authors readily acknowledge that its data are quite limited with respect to details of trials and resolution negotiations, with no information at all on the actual medicine. Realistically, the 135 cases at best represent less than 5% to 10% of all cases, as there is no tally for cases dismissed pretrial or resolved outside the legal system. This well-intended analysis unfortunately likely covers just “the tip of the iceberg” and therefore the possibilities for meaningful extrapolation are quite limited.

Despite the limitations, this work sheds some light on the larger trends in malpractice for dissection. The most common alleged bases of litigation were failure to diagnose (64.4%), delayed treatment (30.4%), and failure to test (28.1%). While testing for and diagnosing dissection are commonly outside the purview of surgeons, delay in treatment, the second most common alleged basis, is often within the cardiothoracic surgeon's control. Expedient transfer from the emergency

department to an operating room is now common practice and may mitigate a few of the issues related to delays. In terms of other possible measures to reduce the incidence of malpractice claims, the results also illustrate the importance of education of physicians who initially evaluate patients for dissection. Such education could include multidisciplinary Grand Rounds aimed at nonsurgical specialties and broad national education campaigns like Aortic Disease Awareness Day.

Just as for the prey of the snow leopard, quickly identifying and escaping this predator is the only way to survive. Brisk diagnosis and treatment are not only crucial keys for patient survival but also for minimization of potential legal liability.

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See Article page 600.

Commentary: Malpractice litigation and acute aortic dissection: What are the odds?

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CENTRAL MESSAGE

Good communication between ED physicians/primary care physicians and cardiovascular surgeons can minimize risk of litigations in cases of acute aortic dissections.

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The authors¹ are to be commended for their efforts to educate us about causes for litigation surrounding the diagnosis and treatment of acute aortic dissections. They have searched a commercially available legal database and extracted 135 cases over a 25-year period. However, given an incidence of ~7 cases per 100,000 population per year, there are ~23,000 cases per year, and certainly far more than 135 malpractice suits over a 25-year period, as the authors acknowledge. Nevertheless, the etiology of these claims may be representative and thus instructive.

The 3 most common bases for litigation were failure to diagnose, failure to test, and treatment delay. Other less commonly cited bases included failure to interpret tests, failure to refer, procedural error, and failure to properly discharge. These reasons illustrate the major weaknesses of this manuscript, namely the failure of a legal database to give us relevant medical information. For failure to test, it would be important to know what tests were performed, and specifically if a computed tomography angiography of the chest was performed. For treatment delay, it would help to know the actual interval from emergency department (ED) presentation to diagnosis, since the clock is ticking, with 1 death per hour for the first 48 hours. This may also be relevant to the 15 cases diagnosed only at autopsy, especially if the patient died shortly after presentation.

Keeping in mind that aortic dissections have been frequently described as the “Great Masquerader,” one must remain vigilant for the atypical presentation. While

we expect these patients to present with chest pain, or difficulty breathing, in fact fewer than 50% and 15%, respectively, do present in that manner. Although we are aware of the need to constrain resources, a computed tomography scan of the chest is a very effective diagnostic modality to rule out the 3 most common and potentially lethal diseases likely to be encountered in the ED, namely myocardial infarction, pulmonary embolus, and aortic dissection.

What, then, can a surgeon do to facilitate the diagnosis and minimize the possibility of litigation? Primarily, maintain good communication with your ED staff. With the exception of large referral centers, aortic dissections present relatively infrequently, and the average ED physician may see only a handful in a lifetime. Their index of suspicion could be increased if we emphasized other important features, such as any change in neurologic status, a poorly perfused extremity, a pulse deficit, the presence of a murmur of aortic insufficiency, or an enlarged aorta especially as visualized in the lateral chest radiograph.

If we work together, we can minimize these events. For me personally, going into any malpractice litigation with only a 50% likelihood of a favorable outcome is far from a comfortable situation!

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