Dr. Sarosi presents a case in which repeated diagnostic errors led to serious delays in effective treatment [1]. The ensuing delay resulted in progressive morbidity for the patient and jeopardized his safety; a delay that could have been shortened if cognitive biases had been avoided. Unfortunately, flawed diagnostic reasoning is an under recognized cause of preventable patient harm, especially in common syndromic conditions such as CAP. In two studies that evaluated diagnostic correlation between an ED admitting diagnosis of pneumonia and discharge diagnosis, 26%–27% of cases were misdiagnosed at admission (over diagnosis) [2, 3]. In another study, autopsy data demonstrated that pneumonia is one of the 3 most common missed diagnoses (under diagnosis) [4].

In this case, an initial erroneous diagnosis (tick borne illness with pneumonitis) was rendered based on the fact that it occurred frequently and was a readily “available” diagnosis. Without diagnostic verification, premature closure of the diagnostic process took place and the patient was treated with an antibiotic for a misdiagnosis. In spite of failure to respond to therapy, recurrent courses of more aggressive and harmful antibiotics were prescribed. This is evidence of “anchoring bias”; intuitively sticking to the diagnosis and ignoring contrary evidence. Optimal reasoning would have led to a reiterative synthesis of the scenario and possibly deducing the correct diagnosis. Intuitive reflexive reasoning however continued. Finally, focal neurologic signs due to a brain abscess ensued. Work up defined a unifying correct diagnosis (Blastomycosis) that could have been considered, based on historical details, much earlier in the process. After 3 weeks of patient suffering, repeated clinic visits, and hospitalization, appropriate therapy was started.

The enormous cost of diagnostic reasoning plagued by cognitive bias is just beginning to be quantified. Such errors are amplified by multiple systemic factors that propagate such flawed reasoning; much to the detriment of our patients. I am thankful to Dr. Sarosi for reporting this case, and allowing us to reflect on the “true cost” to patient safety of such “cognitive short cuts”.

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