Hemorrhage; bladder laceration during hysterectomy

A 46-YEAR-OLD WOMAN reported increasingly frequent and painful menstrual periods to her Gyn. Estrogen-progestin contraceptives were relatively contraindicated because of the patient's hypertension. The Gyn performed hysteroscopic resection of a submucosal fibroid, dilation and curettage, and endometrial ablation. He attempted to morcellate the 2-cm fibroid from the anterior wall. Blood loss during surgery was noted to be less than 100 mL.

The patient began to hemorrhage immediately after surgery; nurses informed the Gyn of this multiple times over the next several hours. After 7 hours, the Gyn examined the patient, found that she was in hemorrhagic shock, and advised a hysterectomy was necessary. During surgery, the Gyn lacerated the patient's bladder twice, which required a urologist to repair. Postoperatively, the patient had a stroke, respiratory failure, and kidney failure.

PATIENT'S CLAIM: The Gyn's morcellation technique was negligent. He did not respond to the nurses for 7 hours. If he had responded earlier, she might not have lost her uterus. He was also negligent for injuring the patient's bladder during the second surgery.

PHYSICIAN'S DEFENSE: The case was settled during mediation.

VERDICT: A confidential North Carolina settlement was reached.

Bowel injured during BSO

IN 2013, A 52-YEAR-OLD WOMAN underwent bilateral salpingo-oophorectomy (BSO) performed by a Gyn. Postoperatively, she was found to have a 1.5-cm bowel perforation. After surgical repair, she developed a wound infection and wound breakdown. She was treated with a vacuum-assisted wound closure device. She later developed a ventral hernia and an intra-abdominal abscess leading to a colostomy, which eventually was reversed. At trial, she had a low-output bowel-to-skin fistula and extensive abdominal scarring.

PATIENT'S CLAIM: The surgeon should have known to perform open BSO rather than laparoscopic surgery based on her 3 prior abdominal surgeries that would have left severe adhesions. He caused a perforation and/or thermal injury to the sigmoid colon during the BSO. He should have consulted a general surgeon when encountering the adhesions. The surgeon failed to readmit her on a timely basis for treatment of the suspected bowel injury.

PHYSICIAN'S DEFENSE: The severe adhesions encountered during BSO surgery could not have been predicted; no adhesions were noted during a 2004 surgery. The adhesions precluded procedure completion. He attempted to lyse the adhesions to create a visual field for removing the ovaries but they could not be visualized. After using a harmonic scalpel for lysis, he inspected the bowel portions that he could see and found no thermal injury or perforation.

VERDICT: An Illinois defense verdict was returned.

Multiple injuries after LVH

A WOMAN WAS FOUND to have a 4-cm uterine fibroid in April 2007. She received medical management.

In May 2008, she reported left lower quadrant pain to her Gyn. A pelvic ultrasound showed an increase in the fibroid's diameter to 5.8 cm. On December 4 she underwent laparoscopic-assisted vaginal hysterectomy (LVH). The Gyn performed intraoperative cystoscopy. The patient was discharged the following day.

Over the next several weeks, the patient experienced urinary tract symptoms that progressed to rust-colored urine and incontinence. On December 31 she was found to have bilateral vesicovaginal fistulas. By early April 2009, urologists had placed ureteral stents on 2 separate occasions and performed 2 bilateral reimplantation procedures. On April 28, 2009, a urologist placed a stent in the right ureter but was unable to place a stent in the left ureter. The right stent was removed prior to another reconstructive surgery on August 18. Two stents were also placed on August 26 and were removed on October 6. She underwent annual ultrasounds that revealed minimal hydronephrosis. Except for urinary frequency, the patient's symptoms had subsided by trial.

PATIENT'S CLAIM: The Gyn fell below the standard of care during the LVH when he negligently cauterized and/or burned the patient's ureters.

PHYSICIAN'S DEFENSE: The Gyn denied negligence. She argued that, following the cystoscopy, both of the patient's ureteral orifices discharged indigo carmine–stained urine, an indication that there was no injury to the ureters.

VERDICT: A Nevada defense verdict was returned. ●

These cases were selected by the editors of OBG MANAGEMENT *from* Medical Malpractice Verdicts, Settlements, & Experts, *with permission of the editor, Lewis Laska. The information available to the editors about the cases presented here is sometimes incomplete. Moreover, the cases may or may not have merit. Nevertheless, these cases represent the types of clinical situations that typically result in litigation and are meant to illustrate nationwide variation in jury verdicts and awards.*