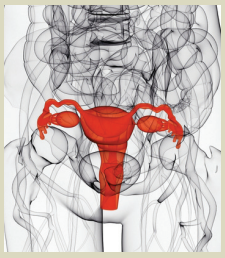


Uterine rupture after unplanned VBAC

A 34-YEAR-OLD WOMAN WENT INTO LABOR 9 days before a scheduled repeat cesarean. She gave birth vaginally to a healthy baby.

After delivery, the mother complained of sharp abdominal pain that she rated 10/10 on the pain scale; pain was unrelieved by morphine. Moderate bleeding was noted. After the ObGyn performed a manual exploration and curette procedure, uterine scar rupture was ruled out and the patient was treated for uterine atony. For 90 minutes, the patient was hypotensive and tachycardic with moderate bleeding. Her hemoglobin and hematocrit levels dropped lower than before delivery, and she went into cardiac arrest. After resuscitation, she received a blood transfusion. A second ObGyn took over her care.

Although the patient received 7 U each of packed red blood cells (PRBC) and fresh frozen plasma (FFP) over the next 5 hours, she continued to have low hemoglobin and hematocrit values. Bleeding was noted as sporadic. Shortly after a decision was made to perform a hysterectomy, the patient experienced cardiac arrest and was successfully resuscitated. At surgery, a uterine rupture was noted. She received 14 U each of PRBC and FFP during surgery. Bleeding stopped after the hysterectomy, but the patient remained on a ventilator for 9 days, suffered renal failure and adrenal insufficiency, and went into cardiac arrest twice more.

The patient suffered brain damage and has poor memory function. She had to relearn to walk, talk, and perform normal life tasks. She underwent a kidney transplant because of permanent kidney damage and will require additional kidney transplants during her lifetime.

PATIENT'S CLAIM The ObGyn failed to recognize uterine scar rupture and perform an immediate hysterectomy. The operative report from the hysterectomy used the words uterine scar "rupture" and "dehiscence" interchangeably as the source of bleeding and hemorrhagic shock.

DEFENDANTS' DEFENSE The patient's injury was a prior uterine scar "dehiscence" and not a complete rupture; conservative measures were appropriate.

VERDICT A $4 million Virginia verdict was returned that was reduced to $2 million under the state cap.

Woman in vegetative state after cystectomy

TWO DAYS after ovarian cystectomy, a 55-year-old woman was returned to the operating room for primary repair of a colon injury. Postoperatively, a colovesical fistula developed. During a third operation, the patient suffered cardiac arrest and sustained brain damage due to lack of oxygen. She remains in a vegetative state.

PATIENT'S CLAIM The colon injury was not detected or treated in a timely manner. A temporary colostomy should have been performed. Metoprolol tartrate, given after the third operation, caused cardiac arrest.

DEFENDANTS' DEFENSE A settlement was reached during trial.

VERDICT A $2.725 million New Jersey settlement was reached with two physicians, a nurse, and the hospital. A third physician was released from liability.

Breast surgery leaves triangular areola

COSMETIC BREAST SURGERY on a 37-year-old woman included insertion of implants, a mastopexy, and reduction of the areolae. After surgery, one areola appeared triangularly shaped. After several months, the patient saw another plastic surgeon who surgically removed the undesirable tissue to reshape the areola.

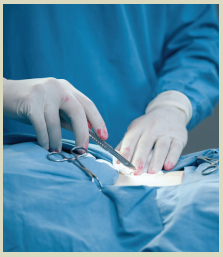
PATIENT'S CLAIM Postoperatively, the plastic surgeon explained that the patient's nipples were surrounded by hyperpigmented tissue that had to be removed during a second operation. The patient signed a consent to surgery, but the document did not explain that additional procedures could be necessary.

PHYSICIAN'S DEFENSE The signed consent form included language that additional procedures could be necessary. The plastic surgeon would have performed a free correction of the areola, but the procedure could not occur until the patient's breasts had healed. In the meantime, the patient went to another surgeon.

VERDICT A New York 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 (www.verdictslaska.com). 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.*

PHOTO: SHUTTERSTOCK



Operative report contested

A GYNECOLOGIST PERFORMED A HYSTERECTOMY on a 43-year-old woman. Two days after surgery, she was found to have an obstruction of the left ureter and a bladder injury. Extensive treatment was required to treat the injury.

PATIENT'S CLAIM Surgery was performed in a negligent manner. The surgical report states that the arteries were clamped and sutured before the ureters had been identified. The ureter injury was caused by the improper use of a clamp.

DEFENDANTS' DEFENSE The gynecologist claimed that the proper sequence was used during surgery; an assisting physician may have erroneously documented the sequence of events. Surgery was complicated by fibroids that distorted the patient's anatomy. The injury was a known risk of the procedure. Damage to the ureter could have been caused by a kink in the ureter or by treatment given later by a urologist.

VERDICT A $526,088 verdict was returned.

Was CP a result of poor communication?

THE ON-CALL OBGYN WAS NOTIFIED that a woman was about to deliver at the hospital. The attending resident monitored labor and delivery until the ObGyn arrived. A cesarean delivery was performed. The child suffered hypoxic ischemic encephalopathy with brain damage and cerebral palsy.

PARENTS' CLAIM A delay in performing cesarean delivery caused the child's injuries. The ObGyn, who was not present during labor, failed to properly instruct the resident.

DEFENDANTS' DEFENSE The ObGyn claimed the resident's interpretation of the fetal monitoring strips misled her to believe that there was no emergency. Cesarean delivery was immediately performed upon the ObGyn's arrival.

VERDICT The hospital and resident settled for an undisclosed amount before trial. An Ohio defense verdict was returned for the ObGyn.

Was excessive electrocautery used?

A 52-YEAR-OLD WOMAN underwent supracervical hysterectomy with bilateral salpingo-oophorectomy. She developed a vaginal-peritoneal fistula and a chronic abscess with pain; additional operations were required.

PATIENT'S CLAIM The ObGyn used excessive electrocauterization during the first operation, leading to fistula development. An adhesive barrier prevented fistula healing. The patient would not have had her ovaries removed had she known the consequences, including hot flashes and painful sexual intercourse.

PHYSICIAN'S DEFENSE Surgery was properly performed; excessive electrocautery was not used. The adhesive barrier was correctly applied and did not cause injury. Fistula development is a known complication of the procedure. Appropriate consent was obtained.

VERDICT An Illinois defense verdict was returned.

Why did child have brain damage?

AT 25 WEEKS' GESTATION, a mother was found to have genital herpes and received medication. Gestational diabetes was diagnosed at 29 weeks' gestation and treated with diet. At 38 weeks' gestation, the patient came to her prenatal visit with scabies on her abdomen, hands, and feet; a scabicide was prescribed. The resident in charge of her care planned to induce labor between 39 and 40 weeks' gestation.

Meconium was present when the membranes were broken. When fetal heart-rate monitors showed nonreassuring heart tones, an emergency cesarean delivery was performed.

The baby required resuscitation due to a low heart rate. She experienced a seizure at 4 hours of life. Head imaging was consistent with a herpes infection or an hypoxic ischemic event. The child has cerebral palsy with speech and motor deficits.

PATIENT'S CLAIM The resident failed to respond to signs of fetal distress and call in the attending physician. Cesarean delivery should have been performed earlier.

DEFENDANTS' DEFENSE The baby recovered well after being slightly depressed at birth; umbilical cord blood gases were in the normal range. There was no hypoxic ischemic event during labor. The baby's injuries were due to infection.

VERDICT A New York defense verdict was returned.

PHOTO: SHUTTERSTOCK

Diaphragmatic hernia missed on fetal US

AT 19 WEEKS' GESTATION, a 25-year-old woman underwent fetal ultrasonography at a radiology clinic. The radiologist's report indicated that the standard fetal structural survey was "unremarkable." When the child was born, catastrophic impairment and deformity were present due to a diaphragmatic hernia.

PARENTS' CLAIM The parents claimed wrongful birth. The radiologist missed a diaphragmatic hernia that was evident on the ultrasound.

DEFENDANTS' DEFENSE The case was settled before trial.

VERDICT A $333,664 net Florida settlement was reached after deduction of attorney's fees.

Was breast cancer missed on screening mammogram?

SCREENING MAMMOGRAPHY conducted in July 2009 was reported by a radiologist as being unchanged when compared to studies from the previous 2 years. Several months later, the patient discovered a lump in her right breast that was diagnosed as cancer. She underwent a lumpectomy in July 2010, followed by chemotherapy. The patient's cancer metastasized and she developed lymphedema.

PATIENT'S CLAIM The 2009 mammography showed an abnormality in the right breast that was not present on earlier films. Further testing and treatment in 2009 would have prevented metastasis.

PHYSICIAN'S DEFENSE There was no negligence; the 2009 mammogram was properly read. Treatment and outcome would have been the same regardless of the timing of diagnosis.

VERDICT A $140,919 Michigan verdict was returned.

Premature twin has CP

BORN AT 26 WEEKS' GESTATION, one twin was in critical condition. She was taken to the pediatric intensive care unit, where she remained for 46 days, and was then transferred to a long-term care center. She suffers from cerebral palsy.

PARENTS' CLAIM Prompt treatment would have reduced or eliminated some of the effects of cerebral palsy. The birth hospital did not have pulmonary surfactant or nitric oxide with high-frequency jet-ventilation therapy that would have improved the newborn's respiration. The baby should have been immediately transferred to a facility where this treatment was available. The parents requested a transfer, but it was denied.

DEFENDANTS' DEFENSE The child was given every appropriate method of treatment; she was adequately oxygenated. Nitric oxide was not FDA-approved for use in this case. The child's disabilities were a result of her prematurity.

VERDICT A New York defense verdict was returned.

Benign findings after radiation had started

AFTER A 45-YEAR-OLD WOMAN FOUND a lump in her right breast in October 2006, a pathologist interpreted biopsy results as ductal carcinoma in situ. A general surgeon and an oncologist both recommended partial mastectomy and lymphadenectomy with radiotherapy and possible tamoxifen treatment. Surgery was performed in November 2006, and radiation treatment began in early December.

The oncologist required that slides be reviewed by pathologists at her cancer center before determining if tamoxifen was appropriate. The pathology report indicated that the patient did not have breast cancer, but had atypical ductal hyperplasia. When the patient learned she did not have cancer, she immediately halted radiation therapy, but had already suffered radiation burns on her breast.

PATIENT'S CLAIM The oncologist was notified that the patient did not have cancer in mid-December, but did not tell the patient until January, when they met to discuss tamoxifen therapy. The patient is now at risk for sarcoma, changes in breast tissue, and rib fractures because of radiation therapy. Partial mastectomy and lymphadenectomy are proper treatment for atypical ductal hyperplasia, but radiation therapy is not. The patient is depressed and anxious.

DEFENDANTS' DEFENSE The oncologist claimed the patient was not informed of the change in diagnosis because radiation treatment is acceptable treatment for atypical ductal hyperplasia; there was no reason for treatment to be stopped.

The pathologist stated that cell variation between ductal carcinoma and atypical ductal hyperplasia is so slight that two pathologists could reach different conclusions reading the same slide. His interpretation was appropriate. The patient was not clinically depressed; she never sought treatment.

VERDICT A $150,000 Pennsylvania verdict was returned against the oncologist. A defense verdict was returned for the pathologist.