MEDICAL Verdicts

Misdiagnosis leads to unnecessary hysterectomy

MANCHESTER COUNTY (CONN) SUPERIOR COURT—A 32-year-old woman presented to a hospital for an exploratory laparotomy, during which an ovarian mass was discovered. To preserve the patient's fertility, her Ob/Gyn opted to perform an ovarian cystectomy. During the procedure, the physician resected some tissue and sent it to pathology for a frozen section. Shortly after, the pathologist reported back that the mass was "unequivocally malignant." As a result, the patient underwent a total abdominal hysterectomy and bilateral salpingo-oophorectomy. Postoperatively, the pathologist notified the physician of an error in the diagnosis; the woman did not, in fact, have cancer.

In suing, the patient claimed that the pathologist should have consulted with an oncologist or another pathologist to confirm the diagnosis. Further, she argued that he should have waited to diagnose permanent sections to verify malignancy, rather than rely on the frozen section only.

The case settled for $1 million.

Missed ectopic pregnancy blamed for loss of tube

MCHENRY COUNTY (ILL) CIRCUIT COURT—On July 15, a gravida at 6 weeks' gestation presented to her obstetrician with a complaint of light bleeding. The physician performed an ultrasound and a series of blood tests that revealed falling hCG levels, signifying a possible miscarriage or ectopic pregnancy. The obstetrician then performed a dilatation and curettage (D&C) because he believed the patient had miscarried. During the procedure, he resected a small amount of tissue for pathology. On July 18, the pathologist reported a preliminary finding of no chorionic villi, suggesting an ectopic pregnancy. Two days later, the patient was rushed to the hospital with a ruptured ectopic pregnancy that required the removal of her right fallopian tube.

In suing, the woman claimed that the physician should have performed a laparoscopy at the time of the D&C. Further, she maintained that he should have suspected an ectopic pregnancy.

The physician argued that since the ultrasound showed no mass in the fallopian tube and the patient did not complain of pelvic pain, he believed that she had suffered a miscarriage and, therefore, the D&C was well within the standard of care.

The jury returned a verdict for the defense.

Did delayed cesarean result in infant brain damage?

NEW YORK COUNTY (NY) SUPREME COURT—A gravida at term presented to a hospital in labor at 5:30 AM. Variable decelerations were noted at 8:45, with late decelerations beginning at 9:30. The baby was delivered in acute distress via cesarean at 12:46 PM.

The infant suffered brain damage, resulting in cerebral palsy with normal intelligence. In suing, the mother claimed on behalf of her child that the cesarean should have been initiated at 11 AM, not 12:15 PM.

The physician contended that the gravida suffered from chronic uteroplacental insufficiency throughout the pregnancy, which resulted in the infant's neurological damage.

The case settled for $2.75 million.

Did forceps delivery lead to infant brain damage?

WASHINGTON COUNTY (WIS) CIRCUIT COURT—A primipara presented to her Ob/Gyn in labor complaining of pain and fatigue. Because the fetal monitor strips suggested possible abnormal readings, the obstetrician opted to use a vacuum to expedite delivery but was unsuccessful. The physician recommended a cesarean, but the mother refused. After the vacuum device failed once again, the obstetrician attempted forceps delivery. At birth, both the placenta and umbilical cord were infected. The baby was born with severe brain damage. She now suffers from spastic cerebral palsy, requires the use of a wheelchair, and can only communicate via sign language.

In suing, the parents alleged that the physician improperly placed the forceps, causing an obstruction in the blood flow to the fetus' brain.

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The obstetrician contended that the forceps were properly placed and correctly used, and that the child's brain damage was a result of injuries sustained prior to labor and delivery.

The jury awarded the plaintiff $7.25 million.

Did ruptured bilateral masses lead to infertility?

QUEENS COUNTY (NY) SUPREME COURT—A 31-year-old woman presented to her physician with complaints of abdominal pain and nausea. A sonogram was performed, and she was diagnosed with irritable bowel syndrome (IBS). Three months later, however, large bilateral adnexal masses ruptured, resulting in tubo-ovarian abscesses and necessitating a bilateral salpingo-oophorectomy.

In suing, the woman claimed that the physicians did not review the sonogram report and erroneously diagnosed her with IBS. Had the clinician properly diagnosed the masses, he could have performed an ovarian cystectomy prior to their rupture, thus preserving her fertility. The physician contended that the woman's longstanding history of severe endometriosis and a prior myomectomy precluded her from having children naturally.

The case settled for $365,000.

Closed vagina after vaginal hysterectomy

QUEENS COUNTY (NY) SUPREME COURT—A 56-year-old woman underwent a vaginal hysterectomy with cystocele/rectocele repair. Six months postoperatively, she presented to her Ob/Gyn with a closed and shallow vagina. The physician then performed 4 unsuccessful dilatation procedures.

Another surgeon attempted vaginal reconstruction but also was unsuccessful. The woman now has a permanently closed vagina and cannot have sex.

In suing, the patient contended that the physician failed to prescribe estrogen preoperatively to pretreat atrophic vaginal tissue. Further, she maintained that the doctor excessively resected vaginal mucosal tissue.

The Ob/Gyn argued that the patient's closed vagina was a result of adhesions, a normal complication of this type of surgery.

The jury awarded the plaintiff $1.1 million.

Failure to relay Pap results leads to cancer, radiation

UKNOWN COUNTY (MONT) DISTRICT COURT—A 38-year-old woman underwent a routine Pap on November 5, 1997. The nurse assured her that she would be contacted if the results were abnormal. On November 10, the pathology report indicated "atypical squamous cells of undetermined significance" (ASCUS). However, the staff never notified the patient of her results and her chart was returned to central filing.

In February 2000, the woman returned for a routine gynecologic exam where she learned of her 1997 results. She underwent a colposcopy and biopsy that showed Stage IIA squamous cell carcinoma of the cervix and vagina. She was successfully treated with radiation therapy and chemotherapy.

The case settled for $750,000.

Did excessive oxytocin result in mother's death?

ORANGE COUNTY (NY) SUPREME COURT—A 35-year-old gravida presented to her obstetrician's office with irregular contractions and a cervical dilation of 2 to 3 cm. A nonstress test was performed, and the physician advised the patient to go home and come back when her contractions were more regular. When the gravida returned, she was dilated 3 cm, but her contractions remained mild. She was sent to the hospital at 1:30 PM, and her membranes were artificially ruptured at 2:30 PM. However, cervical dilation and mild contractions persisted until 4:30. At 5 PM, oxytocin was administered and increased at 5:15 PM and 5:30 PM. At 5:35 PM, the patient complained of heart palpitations. The nurse turned the woman on her side, gave her oxygen, and withdrew the oxytocin. However, the mother became less responsive and went into cardiac arrest. A Code Blue was ordered at 5:51 PM.

At 6:08 PM, the baby was delivered via cesarean section; the infant was later diagnosed with choreoathetoid cerebral palsy. Early the next morning, the mother died. The autopsy revealed an amniotic fluid embolism.

In suing, the woman's family claimed that the nurse should not have administered oxytocin and that the dosage was excessive. Further, the fetal monitor tracing showed abnormalities that warranted the withdrawal of the oxytocin prior to when it was finally discontinued. In addition, the plaintiffs argued that the physician should have been present when the oxytocin was administered. They also contended that the cesarean should have been performed earlier to reduce the risk of fetal damage.

The physician maintained that the augmentation of oxytocin was appropriate, given the patient's lack of progress during labor. In addition, the Ob/Gyn argued that once the mother went into cardiac arrest, and there was a minimal likelihood of successful resuscitation, it was then appropriate to perform the cesarean, which was completed within 17 minutes—well within the standard of care.

The jury returned a verdict for the defense.

The cases presented here were compiled by Lewis L. Laska, editor of Medical Malpractice Verdicts, Settlements & Experts. While there are instances when the available information is incomplete, these cases represent the types of clinical situations that typically result in litigation.