Cerebral palsy due to too many embryos?

Bronx County (NY) Supreme Court

A 29-year-old woman underwent in vitro fertilization and 7 embryos were transferred to her uterus. She became pregnant with triplets and at 5 months developed cervical dilation noted by sonography. She was instructed to cease working. Four days later, the woman presented to the doctor's office, at which time she was admitted to the hospital.


In vitro fertilization

Four days after admission, the patient went into premature labor. Over the next 6 days she delivered the triplets, all of whom suffered cerebral palsy.

The plaintiffs sued the doctor who performed the implantation, alleging that no more than 2 embryos should have been transferred to the woman's uterus at 1 time. The transfer of 7 embryos, they argued, was negligent, as this increased the risk of a multigestation pregnancy, which in turn increased the risk of preterm birth. They also sued the physician who reviewed the abnormal ultrasound, arguing that the doctor should have ordered bed rest at that time.

- The 2 defendant physicians and the defendant hospital settled, agreeing to contribute $14 million into a structured settlement expected to pay more than $100 million.

Uterine rupture follows failed VBAC

Undisclosed County (Calif)

A woman at 41.5 weeks' gestation was admitted to a hospital for induction of labor after an ultrasound revealed vertex presentation and normal amniotic fluid volume, and a nonstress test was interpreted as nonreactive. The patient had delivered a child by emergency cesarean 4 and a half years earlier; however, she wished to attempt vaginal birth after cesarean (VBAC) for this delivery, and signed a consent form noting the procedure's risks.

The day following admission, after her membranes spontaneously ruptured and she was fully dilated, the woman began pushing. An hour later, the fetal heart rate dropped suddenly. The doctor began a cesarean delivery approximately 20 minutes later, at which time a uterine rupture was discovered in the lateral fundus. Six minutes after initiation of surgery, the infant was born.

Analysis of cord blood gas revealed severe metabolic acidosis. The newborn was diagnosed with hypoxic-ischemic encephalopathy and required a feeding gastrostomy. He underwent a tracheostomy 6 months later.

In suing, the plaintiffs alleged a negligent delay in both the physician's recognition of the uterine rupture and the initiation of cesarean delivery.

The defense denied negligence and maintained a timely delivery occurred.

- The case settled for $3.5 million at mediation.

Ureter sutured during myomectomy

Kings County (NY) Supreme Court

Pelvic examination and sonogram on a 40-year-old woman revealed a uterus 20 weeks in size due to multiple fibroids. The woman underwent myomectomy with uterine reconstruction, fulguration of endometrio-

sis, and resection of a right ovarian cyst.

While attempting to remove an irregular calcified fibroid 15 cm in diameter, the physician perforated the patient's uterine artery, which he repaired before completing the myomectomy and peritoneal and abdominal closure.

Multiple myomas

Following surgery, the patient experienced decreased urine output; it was discovered her right ureter had been sutured during the procedure. Multiple surgeries were needed to repair the obstruction. Recovery took 6 months, during 2 of which the woman was required to wear a nephrostomy bag.

The patient claimed that the physician conducted inadequate pre- and perioperative testing. Proper testing, she argued, could have prevented the suture injury—or at least alerted the physician to its presence prior to closure, allowing for timely repair.

The physician argued that it was during peritoneal closure—not the uterine artery repair—that the ureter was sutured, and that the woman's injury was a known risk of this closure. He maintained appropriate testing was conducted.

- The parties reached a posttrial settlement of $150,000.

Ob opts for monitoring instead of cerclage

Undisclosed County (Mass)

A woman at 10 weeks' gestation presented to an obstetrician in June; her history was significant for diethylstilbestrol exposure, laser conization of the cervix due to noninvasive cervical cancer, a cerclage placed at pregnancy 7 years earlier, and several years of in vitro fertility treatments leading to this conception.

Though her prior obstetrician—now retired—had anticipated a need for cervical cerclage with any future pregnancies, her current doctor opted for frequent monitoring via ultrasound in lieu of cerclage.

Sonograms at 14 and 18 weeks revealed a normal cervix. An ultrasound in late August, however, showed the cervix 1 cm dilated with membranes bulging into the vagina; an emergency cerclage was ordered. The woman was released home and ordered to bed rest.

The woman's membranes ruptured at 25 weeks' gestation. At 26 weeks, 3 days, contractions began; the child was delivered via cesarean section. He now suffers from spastic diplegia.

The plaintiff noted that the child's injuries stemmed from his premature birth.

The Ob/Gyn maintained that the mother's history did not warrant cerclage placement, and argued that regular monitoring was an appropriate course of action.

- The case settled for $1.4 million.

Sponge missed, second surgery needed

St. Louis County (Mo) Circuit Court

Several days after delivering a child by cesarean section, a woman began experiencing severe abdominal pain. Although no abnormality was noted on postoperative x-ray, a surgical sponge was later found in her abdomen, requiring surgical removal.

The woman claimed negligence was committed by the Ob/Gyn for not removing the sponge, the radiologist for not detecting its presence on x-ray, and the hospital team for inaccurately accounting for the sponges prior to surgical closure.

The Ob/Gyn testified that he relied on the surgical team to keep accurate track of the sponges used.

- The radiologist settled for an undisclosed sum. The jury awarded the plaintiff $175,000, with fault assigned at 20% to the Ob/Gyn, 20% to the radiologist, and 60% to the hospital. ■

The cases in this column are selected by the editors of OBG MANAGEMENT from Medical Malpractice Verdicts, Settlements & Experts, with permission of the editor, Lewis Laska, of Nashville, Tenn (www.verdictslaska.com). While there are instances when the available information is incomplete, these cases represent the types of clinical situations that typically result in litigation.