Rectal mucosa found in vaginal cuff closure

3 DAYS AFTER A HYSTERECTOMY by her ObGyn, a woman reported increasing pain. At an exploratory laparotomy, surgeons found serosanguineous pelvic fluid, partial dehiscence of the vaginal cuff with necrotic edges, and a suture line incorporating the anterior rectal wall in the vaginal cuff repair. They removed the sutures and repaired the vaginal cuff and several lacerations on the anterior rectal wall.

PATIENT'S CLAIM The ObGyn should have used peritoneal tissue to repair the vaginal cuff. Failure to do so caused lacerations and injuries to the anterior rectal wall and rectum.

PHYSICIAN'S DEFENSE The ObGyn denied negligence.

VERDICT A $3 million Virginia verdict was returned.

Colon injured when trocar is inserted

DIAGNOSTIC LAPAROSCOPY was performed on a 27-year-old woman to find the cause of rectal bleeding and pelvic pain. The ObGyn perforated her colon with the trocar; he immediately converted to laparotomy. The patient had a colostomy for 3 months, then developed paralytic ileus, small bowel obstruction, and incisional hernias. She required surgery for colostomy removal and hernia repair. It was later found that irritable bowel syndrome had caused the bleeding.

PLAINTIFF'S CLAIM Surgery was unnecessary; conservative treatment should have been tried first. The ObGyn blindly inserted the trocar instead of insufflating the abdomen with CO_2.

PHYSICIAN'S DEFENSE Laparoscopy was appropriate for the patient's symptoms; insufflation was used. The patient's transverse colon was low-lying (below the navel) rather than normal (above the navel), causing it to be in the way of the trocar. The patient had a good recovery and returned to good function.

VERDICT An Illinois verdict of $550,500 was returned.

Late cesarean blamed for newborn's CP

A WOMAN WITH PREECLAMPSIA was admitted to the hospital. When her membranes ruptured, oxytocin and magnesium sulfate were started. After several hours, she was only dilated to 5 cm. The fetal monitor showed normal baseline, but minimal variability with virtually no accelerations.

Hours later, when she was fully dilated, the ObGyn instructed the nurse to have her push and then went to his office. Immediately upon pushing, late fetal heart rate decelerations developed with every contraction. When the ObGyn returned 30 minutes later, he allowed pushing to continue. A resident attempted forceps delivery, but the forceps slipped several times. The ObGyn reapplied the forceps twice, then allowed the resident to apply vacuum. When the baby presented with shoulder dystocia, the ObGyn stepped in. The child was born with low cord blood pH and multiple skull fractures, and was given a diagnosis of cerebral palsy.

PATIENT'S CLAIM The ObGyn should have performed a cesarean when the fetal heart tracing became nonreassuring.

The child suffered CP because of distress during labor and delivery; a sinus venous thrombosis was never present. The baby's skull fractures were due to improper use of forceps.

PHYSICIAN'S DEFENSE The skull fractures could have occurred in normal delivery. Because the child did not have spastic quadriplegic CP, the injury was most likely from sinus venous thrombosis.

VERDICT A Wisconsin jury returned a $23.2 million verdict; the court added $187,402 in medical expenses.

OB exonerated following brachial plexus injury

WHEN SHOULDER DYSTOCIA occurred during delivery, the ObGyn performed a McRoberts maneuver and episiotomy; the baby was delivered in 3 minutes. She suffered C5–8 brachial plexus palsy, deformity of the right arm and hand, and limited use of her right hand.

She later had tendon transfer surgery to improve range of motion of her wrist, and tendon release surgery on her shoulder.

PLAINTIFF'S CLAIM Excessive traction to the head and neck and failure to use additional shoulder dystocia maneuvers caused the injury.

PHYSICIAN'S DEFENSE The maneuvers performed were appropriate. The injury was due to natural forces of labor. The baby was delivered easily in less than a minute after using proper techniques. No excessive traction or other maneuvers were needed.

VERDICT An Illinois 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.*

Did ovarian remnant + HRT cause DVT and pain?

A 33-YEAR-OLD WOMAN underwent a hysterectomy with salpingo-oophorectomy. Her ObGyn then prescribed hormone replacement therapy (HRT). Although pathology reported the left ovary and fallopian tube were not part of postoperative specimens, the ObGyn maintained that both ovaries and fallopian tubes had been removed. Ten months later, a CT scan revealed a pelvic neoplasm. No mass was found at exploratory surgery, but adhesions were lysed. Eighteen months later, an MRI revealed remnants of the left ovary and fallopian tube. Another gynecologist determined that the ovary was producing estrogen. Two months later, the patient developed deep vein thrombosis (DVT) in her left calf. The obstruction was resolved, but the patient reported residual leg pain.

PATIENT'S CLAIM Excessive levels of estrogen caused the DVT. The ObGyn was negligent in disregarding the initial pathologist's report. It was inappropriate to prescribe HRT if ovarian function was present after surgery.

PHYSICIAN'S DEFENSE There was no negligence. Dense adhesions and a previous bowel perforation did not allow total ovary removal. The remnant is a known risk of the procedure. Estrogen HRT was appropriately administered.

VERDICT A New York defense verdict was returned.

Severing uterosacral ligament relieved pelvic pain, but…

AFTER CONSERVATIVE THERAPY for several months, a 26-year-old woman underwent exploratory laparoscopy to determine the reason for her severe pelvic pain. Findings were negative, but the physician transected the uterosacral ligament to relieve pain. Four days after surgery, a ureteral injury was diagnosed, and a stent was placed. The patient required complex treatment for her urinary tract injury.

PATIENT'S CLAIM Severing the uterosacral ligament was performed without her consent. The ureter injury was caused by negligent use of electrocauterization. Now the patient was at high risk for future pregnancies.

PHYSICIAN'S DEFENSE The patient's pain warranted surgery; severing the ligament was appropriate. Injury to the ureter is a known complication.

VERDICT A Tennessee defense verdict was returned.

Why did it take so long to stop her bleeding?

AFTER DELIVERING HER THIRD CHILD, a 34-year-old woman reported significant vaginal bleeding to her ObGyn. Two weeks later, a sonogram was performed but the cause of bleeding was undetermined.

Bleeding continued. Sixteen days later, another sonogram revealed a 2-cm-long mass in the uterine cavity. The ObGyn decided to wait 4 or 5 days for another sonogram to make sure the mass wasn't a fibroid or placental remnant.

The next evening, the patient was admitted to a hospital with excessive bleeding. The ObGyn performed a hysteroscopy and found a fibroid and a placental remnant. After tissue was removed by dilation and curettage (D&C), the ObGyn reinserted the hysteroscope. She encountered severe bleeding but could not find any other suspicious matter. Pathology reported that the excised material was placental tissue. The patient was hospitalized for 2 more days.

Three days later, she returned to the ObGyn with continued bleeding; the ObGyn determined it was post-D&C bleeding.

Two weeks later, the woman suffered severe vaginal hemorrhage. She went to another hospital where the ED physician felt the woman's life was in jeopardy. A hysterectomy was performed, including the extraction of a placental fragment determined to be the cause of the hemorrhage.

PATIENT'S CLAIM The ObGyn was negligent in not diagnosing and treating the bleeding in a timely way after the first sonogram. The pathology report after D&C confirmed placental accreta, which should have prompted aggressive evaluation. Hysteroscopy and D&C did not effectively remove the deeply implanted placenta. She should not have been discharged from the hospital until the ObGyn had confirmed full removal of any placental remnants. Continued bleeding after D&C should have elicited further evaluation.

PHYSICIAN'S DEFENSE All the patient's reports of bleeding were quickly and appropriately addressed. The ObGyn denied being told that the patient was still bleeding heavily until 16 days following the first sonogram. It was reasonable to conclude that the D&C had excised all suspicious matters. Post-D&C bleeding was due to an intraoperative laceration of the cervix; medication and a clamp had halted bleeding. Intraoperative bleeding made failure to remove the placental remnant reasonable. Earlier treatment would not have changed the outcome.

VERDICT A New York jury returned a $625,000 verdict.