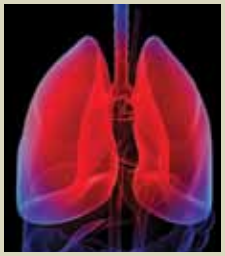

New mother dies from pulmonary embolism

A 39-YEAR-OLD WOMAN'S SECOND CHILD WAS BORN by cesarean delivery. The mother died the next day from a pulmonary embolism.

ESTATE'S CLAIM Physicians and nurses at the hospital were negligent in failing to recognize the mother's risk factors for pulmonary embolism, including obesity, being over age 35, and hypertension. They failed to ensure that compression boots were in place and working prior to delivery. Although orders had been given for the woman to walk within 8 hours of delivery, she did not get out of bed and walk for 24 hours after delivery.

DEFENDANTS' DEFENSE The case was settled before trial.

VERDICT A $3.5 million Illinois settlement was reached.

Woman told "Biopsy isn't urgent"

TWO MONTHS AFTER HER INITIAL VISIT, a 58-year-old woman returned to the gynecologist with vaginal bleeding. In March 2004, ultrasonography (US) showed slight thickening of the endometrial lining and a "pin dot" described as being a prepolyp. Vaginal bleeding was determined to be due to thinning of the vaginal wall with menopause.

The patient reported daily vaginal bleeding when she saw the gynecologist in January 2005. A new, large, rounded, solid mass within the endometrial cavity consistent with a large endometrial polyp was seen on US. The radiologist recommended hysteroscopic biopsy with excision, but the gynecologist told the patient it was not urgent.

In March 2005, hysteroscopy confirmed carcinosarcoma of the uterus. The patient underwent a hysterectomy followed by pelvic radiation and brachytherapy.

Eight months later, metastasis was found in the lungs; she died in October 2006.

ESTATE'S CLAIM The gynecologist failed to react when the patient first reported vaginal bleeding. An earlier diagnosis could have prevented her death.

PHYSICIAN'S DEFENSE The case was settled before trial.

VERDICT An $820,000 Massachusetts settlement was reached.

US report misses fetal abnormalities

A PREGNANT WOMAN UNDERWENT US. The preliminary report indicated echogenic cardiac focus and unilateral pyelectasis. Twenty-five days later, the mother underwent a level II US. A radiologist wrote that fetal anatomy was normal in both reports. The mother had two additional sonograms, with no reported abnormality.

The baby was born with aplasia and hypoplasia with both arms absent below a short humerus, an absent left leg, and a shortened right leg with a remnant foot and three small toes.

PARENTS' CLAIM The radiologist's US reports failed to accurately describe the fetal anatomy, depriving the parents of the chance to terminate the pregnancy.

DEFENDANTS' DEFENSE Proper treatment was given.

VERDICT A $4.5 million Florida verdict was returned. Fault was assigned to the radiologist (85%) and the level II technologist (15%).

Forceps delivery injures mother's pelvic floor

DURING A TRIAL OF LABOR, a 34-year-old woman experienced deep transverse arrest and lack of progress due to pelvic restriction. The ObGyn proceeded to deliver the baby vaginally using forceps, which caused pelvic floor injuries to the mother.

Several months later, she underwent corrective repair surgery for pelvic floor prolapse. She has continuing vaginal and rectal pain and dysfunction.

PATIENT'S CLAIM A cesarean delivery should have been performed as soon as pelvic restriction was found. The injuries reduce the woman's chances of having another child.

PHYSICIAN'S DEFENSE A trial of labor was proper. The patient's continuing fertility problems are related to chronic yeast infections and prescription birth control.

VERDICT A $1,716,469 Illinois verdict was returned, which included $484,000 to the patient's husband for loss of consortium.

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

7 cases of injured bowel

1 Woman dies from bowel injury

DURING A SLING PROCEDURE for vaginal prolapse, a 50-year-old woman required a transfusion. The next day, she was nauseated and constipated. A day later, she went to the ED with shortness of breath and chest and abdominal pain. Her symptoms persisted for 8 days before an injury to her transverse colon was found during exploratory surgery. She suffered massive organ failure caused by sepsis and died 3 weeks after the initial surgery.

▸ **ESTATE'S CLAIM** The gynecologist should have investigated why she needed a transfusion during surgery. He should have reacted earlier to her postsurgical complaints.

▸ **PHYSICIAN'S DEFENSE** Bowel injury is a known risk of the procedure. The patient suffered multiple strokes after being readmitted to the hospital.

▸ **VERDICT** A $2.4 million South Carolina verdict was returned.

2 Colostomy, coma after hysterectomy

DUE TO FIBROID TUMORS and pelvic pain, a 39-year-old woman's ObGyn suggested laparoscopic-assisted vaginal hysterectomy. A third-year resident performed most of the procedure. The ObGyn's associate covered postsurgical care.

When the patient reported increasing pain and rectal bleeding, an exploratory laparotomy was performed 3 days after surgery. Bowel and ureter injuries were repaired and a permanent colostomy was created. The patient developed septic shock with multiple organ failure, and was placed in a chemically induced coma for 3 weeks, after which she had to relearn to walk, talk, and care for herself.

▸ **PATIENT'S CLAIM** The ObGyn was negligent in performing the surgery. He failed to obtain consent for the resident's participation. The associate failed to respond to her declining postoperative condition in a timely manner.

▸ **DEFENDANTS' DEFENSE** Surgery was properly performed and postoperative care was appropriate. The bowel injury was a thermal or pressure necrosis that occurred 3 days after surgery. Two different consent forms signed by the patient included notification that a resident might assist; the resident was introduced to the patient prior to surgery. The patient's injury claims were exaggerated; her future medical bills would be limited to colostomy supplies.

▸ **VERDICT** A $1,926,069 Texas verdict was returned.

3 Were physicians qualified on robot?

A 48-YEAR-OLD WOMAN UNDERWENT robotic-assisted total hysterectomy and oophorectomy for uterine fibroids and cysts. During surgery, the physicians realized that the sigmoid colon had been perforated. A general surgeon repaired the injury with a loop ileostomy, which was successfully reversed 3 months later. The patient continues to have constipation, with occasional bleeding, pain, and burning.

▸ **PATIENT'S CLAIM** The risks of robotic surgery were never fully explained to her. Failure to properly visualize her internal organs led to the injury; the extent of damage exceeded what is considered "acceptable risk" of the procedure. The physicians had little experience and training in robotic surgery.

▸ **PHYSICIANS' DEFENSE** The case was settled before trial.

▸ **VERDICT** A $350,000 Massachusetts settlement was reached.

4 Adhesions limit view of bowel

A 76-YEAR-OLD WOMAN UNDERWENT surgical removal of an ovarian cyst. The ObGyn attempted a laparoscopic procedure but converted to laparotomy when extensive adhesions were encountered. The next morning, the patient discovered that her navel was discharging fecal matter. Exploratory surgery determined that the bowel had been perforated. She required additional surgery and had a long recovery.

▸ **PATIENT'S CLAIM** The ObGyn was negligent in failing to diagnose and treat bowel perforation in a timely manner. An intraoperative bowel inspection should have occurred due to the likelihood of a bowel injury related to the adhesions.

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PHYSICIAN'S DEFENSE Adhesions restricted inspection of every area.

VERDICT A $225,000 New York settlement was reached.

5 Skydiver's ongoing postop pain

AFTER REPORTING DYSMENORRHEA and menometrorrhagia, a 34-year-old woman underwent dilatation and curettage, thermal endometrial ablation, and diagnostic laparoscopy. A day later, she reported increasing pain. The ObGyn's examination revealed minimal abdominal distension, sluggish bowel sounds, and some guarding, with no rebound tenderness or acute distress. US showed a 3-cm pocket of fluid in the abdomen. Two hours later, an exam revealed a soft abdomen and normal bowel sounds. She was sent home with instructions to return the next day or, if her condition worsened, to go to the ED.

Her husband called the next day to report she was feeling better. The patient woke the following morning with massive distension, worse pain, and severe shortness of breath. At the ED, a CT scan revealed a large amount of abdominal fluid. During emergency laparotomy, an injury was found in the jejunum, necessitating a 3-inch resection.

PATIENT'S CLAIM The ObGyn was negligent in not treating her postoperative symptoms in a more proactive manner. Adhesions developed from peritonitis, leading to chronic abdominal pain. Several operations were required.

PHYSICIAN'S DEFENSE Bowel injury is a known complication of the procedure. There was no indication during surgery or at the office visit that the jejunum was injured. Adhesions were not the cause of the patient's ongoing pain; very few adhesions were found during subsequent operations. The woman was an avid skydiver who had completed 200 jumps since her initial surgery.

VERDICT An Illinois defense verdict was returned.

6 Bowel injury at laparoscopy

WHEN THE GYNECOLOGIST recognized a bowel injury during laparoscopic salpingectomy, he called a general surgeon, who repaired three areas of bowel. The patient was released 2 days after surgery. She called the gynecologist 2 days later to report fever and vaginal bleeding. She was told to come to the office, but she cancelled when the fever subsided. The next day, she went to the ED, where sepsis was diagnosed. She was flown to another hospital for surgery. A 1-cm small-bowel perforation was found in an area of earlier repair because a suture had been disrupted. A temporary colostomy was reversed 3 months later.

PATIENT'S CLAIM The gynecologist was negligent in performing laparoscopic salpingectomy. The patient should not have been discharged because her white blood cell count and heart rate were elevated.

DEFENDANTS' DEFENSE Performance of a laparoscopic procedure was proper. Discharge was reasonable, as there was only a potential for complications with no evident problems.

VERDICT An Missouri defense verdict was returned.

7 Was treatment of abscess delayed?

A 49-YEAR-OLD WOMAN with menorrhagia underwent cryoablation. Two weeks later, she went to the ED with pain and constipation. Following CT scans and US, she was found to have a tubo-ovarian abscess. After an enema and subsequent bowel movement, her pain improved. She was discharged with instructions to follow-up with her gynecologist. Six days later, the gynecologist prescribed triple antibiotics, analgesics, and weekly visits for the abscess. Two weeks later, she reported unbearable pain and was sent to the ED. She was found to have a microperforation of the sigmoid colon and multiple gynecologic pathologies, including myomata, right serous cystadenoma, and left tubo-ovarian complex suggestive of endometriosis. Hysterectomy and colostomy were performed; the colostomy was reversed several months later.

PATIENT'S CLAIM She should have been hospitalized when the abscess was found so that the infection could be treated properly. She alleged lack of informed consent for the cryoablation.

PHYSICIAN'S DEFENSE Hospitalization was unnecessary; the patient had initially improved, and the outcome would not have changed with intravenous antibiotics. The patient was fully informed of the risks of the procedure.

VERDICT A Pennsylvania defense verdict was returned.