Woman dies following cervical cone biopsy: $4.25M award

A 46-YEAR-OLD WOMAN UNDERWENT a cervical cone biopsy at a Veterans Administration (VA) hospital on July 18. Following the test, significant bleeding occurred. The gynecologic surgeon attempted to control the hemorrhage by injecting ferric subsulfate (Monsel's) solution into the patient's vagina. The bleeding abated, but the patient went into hypovolemic shock. During emergency laparotomy, a uterine perforation and injuries to both uterine arteries were detected. A hysterectomy was performed to stop the hemorrhage. The patient improved at first, but developed sepsis, small-bowel necrosis, and other complications. A bowel resection procedure was performed on July 26. She died on September 5.

▸ **ESTATE'S CLAIM:** The surgeon's actions were negligent. She removed too much tissue during the biopsy, injured the vaginal and uterine walls, and failed to timely diagnose and appropriately treat the injuries. The ferric subsulfate solution entered the abdominal cavity via the perforation, causing peritonitis and bowel injuries. A pathology report from the bowel resection surgery informed the surgeon that the bowel was not properly reconnected after the damaged portion was removed, but this condition was neither detected intraoperatively nor treated postoperatively.

▸ **DEFENDANTS' DEFENSE:** The surgeon moved for summary judgment, countering that, as a federal employee, she was exempt from personal liability for the services performed as an employee of the VA. That motion was denied. She then argued that injury to the vaginal/uterine wall is a known complication of the biopsy procedure.

▸ **VERDICT:** A $4.25 million Illinois verdict was returned in federal court.

Needle stick not reported to patient

A WOMAN DELIVERED A BABY assisted by an on-call ObGyn. When the baby developed fetal tachycardia, the ObGyn recommended expediting delivery and discussed various options and the risks of each option. The mother chose a vaginal forceps delivery. During the procedure, the mother experienced a 3rd-degree perineal laceration and a few minor lacerations, which were repaired. The mother was in pain, so the ObGyn performed a revision repair. During the procedure, the ObGyn accidentally stuck himself with a clean needle. He replaced the needle and changed his glove. The mother reported instant pain relief following revision and was discharged. After the needle incident, the ObGyn's thumb became red and swollen, so he took antibiotics.

Two days after discharge, the patient reported to the ObGyn's office with fever, pain, and a foul odor emanating from the surgery site. She was given the diagnosis of pelvic incisional cellulitis and was taken to the operating room for exploration and debridement. The patient developed septic shock and necrotizing fasciitis. She was placed on a ventilator and underwent 13 surgeries.

▸ **PATIENT'S CLAIM:** The ObGyn was negligent. The patient claimed breach of duty: the ObGyn did not disclose that his thumb was swollen and that he took antibiotics.

▸ **PHYSICIAN'S DEFENSE:** There was no breach of duty. He did not feel the need to concern the patient about an injury to himself that did not affect her.

▸ **VERDICT:** A Kansas defense verdict was returned.

Catheter removal, air embolism: $3.5M settlement

A 44-YEAR-OLD WOMAN underwent gynecologic surgery on April 22. She developed a rectovaginal fistula and other complications. Intravenous antibiotics were required and parenteral nutrition was delivered through a central venous catheter. On May 22, after a hospital nurse removed the catheter, an air embolism developed, causing a brain injury. The patient has a mental disability and residual leg tremors.

▸ **PATIENT'S CLAIM:** Because of the surgeon's negligence during surgery, a fistula developed. The nurse negligently removed the catheter, causing the embolism.

▸ **DEFENDANTS' DEFENSE:** The case settled during the trial.

▸ **VERDICT:** A $3.5 million Illinois settlement was reached, including payments of $1 million from the surgeon and $2.5 million from the hospital.

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