



Woman loses hands and feet after cystectomy: \$109M award

On November 1, a 45-year-old woman underwent laparoscopic excision of a benign ovarian cyst performed by a minimally invasive gynecologic (MIG) surgeon. After surgery, the patient's blood pressure (BP) declined. She was given fluids, but her BP remained low. The next day, she became incoherent and her BP could not be stabilized. Twenty-seven hours after surgery, the 5-cm umbilical incision opened while the patient was attempting to stand up from the commode. A large amount of bloody discharge drained.

At 11:00 PM that day, her BP was so low that it could not be measured, and septic shock was suspected. She was transferred to the intensive care unit (ICU), but soon went into organ failure. ICU physicians suggested that she have an abdominal computed tomography (CT) scan but she had to be stabilized before transport; they administered vasopressors.

At 4:30 PM the next day, the surgeon called for a trauma surgery consult. The trauma surgeon immediately ordered exploratory surgery and cancelled the use of vasopressors. During surgery, he found a separation in her small intestine leading to the development of necrotizing fasciitis. He resected the injured intestine and areas affected by the bacteria, including abdominal muscles and wall.

The patient remained unconscious from the time of the exploratory operation until the end of January. She required additional surgeries to control the bacteria as well as amputation of both hands above the wrists and both feet above the ankles due to gangrene. Because she no longer had an abdominal wall, a skin sac was created to hold her intestines outside of her body. When a fistula developed, a colostomy was performed.

She went to a Maryland hospital for rehab, where she learned to walk with prosthetic feet and to use her prosthetic hands. Currently, she has constant abdominal pain, can walk a short distance, and uses a wheel-

chair. She requires 24/7 assistance for everyday tasks. She can no longer work and is on disability.

PATIENT'S CLAIM: The patient sued the university health system that employed the MIG surgeon. During the cystectomy, he almost completely transected her small intestine, but did not find the injury during surgery. This allowed bacteria to enter the abdominal cavity, causing sepsis and necrotizing fasciitis. The trauma surgeon referred to the injury as an enterotomy, not a tear.

During the procedure, the surgeon used ADEPT, a solution to prevent the formation of adhesions. The patient's ObGyn expert concluded that ADEPT created an environment that allowed the necrotizing fasciitis to flourish.

The ICU physicians concluded that the patient was stable enough to be transported for a CT scan, but the surgeon repeatedly delayed the procedure and did not call for a surgical consult until 12 hours later. Had the CT scan or exploratory surgery occurred earlier, the diagnosis would have been discovered, and the bacteria would have been prevented from spreading. She would not have required extensive doses of vasopressors, which increase BP by cutting off blood circulation to the 4 extremities. In this case, use of vasopressors led to gangrene and the subsequent amputations.

DEFENDANTS' DEFENSE: The defendants denied all allegations. The expert witness for the defense opined that the surgeon had only nicked the intestine and that the main injury was a tear that had occurred on its own. The defense also claimed that the surgeon did not call for a CT scan because it would not have shown the source of the patient's condition.

VERDICT: After 2 trials ended with hung juries, a \$109 million Florida verdict was returned against the university health system. Under Florida's sovereign immunity statute, the patient must seek recovery of all but \$100,000 of the award through the Florida legislature in a separate claims bill.

This case, and those on page 46, 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

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Child has hypoxic brain injury: \$7.75M settlement

At 41 weeks' gestation, a mother presented to the emergency department (ED) for delivery after an unremarkable pregnancy. During the last 90 minutes of labor, fetal heart-rate (FHR) monitoring showed nonreassuring findings. After a vaginal delivery, the infant was found to have a hypoxic brain injury.

PARENTS' CLAIM: Even though non-reassuring FHR monitoring findings occurred, the physicians did not offer cesarean delivery (CD). The pediatrician and ED physician were negligent in failing to provide proper neonatal resuscitation and in recognizing a problem with the infants' intubation. The delay in delivery and poor resuscitation procedure caused the child's injury.

DEFENDANTS' DEFENSE: All allegations were denied. There was no deviation from the standard of care.

VERDICT: A \$7.75 million Massachusetts settlement was reached.

Kidney failed after hysterectomy

A 46-year-old woman underwent a hysterectomy performed by her ObGyn. Surgery went well but the patient continued to report symptoms. A year later, she underwent an oophorectomy. Two years later, the patient reported blood in her urine and underwent a computed tomography scan, which revealed an obstructed left ureter that had caused injury to the left kidney. Seven months later, the kidney was removed.

PATIENT'S CLAIM: Her kidney loss was a direct result of the ObGyn's initial surgical procedure. He had placed several clips near the ureter and did not verify their position or protect the ureter. He also failed to address her reported symptoms in a timely manner.

PHYSICIAN'S DEFENSE: The damage to the ureter is a known risk of hysterectomy and oophorectomy. The obstruction developed over time, not as an immediate result of the surgery.

VERDICT: A Kentucky defense verdict was returned.

History of shoulder dystocia, Erb's palsy: \$1.2M settlement

An obese mother was admitted to the hospital at 39 weeks' gestation with signs of labor. She requested a CD and was advised that she had progressed too far for that to be an option, and that vaginal delivery would be safe. During the second stage of labor, shoulder dystocia was encountered. The ObGyn made several attempts to deliver using downward traction, but was unsuccessful. A second ObGyn swept the shoulder with an internal maneuver of his hand and delivered the baby. The child has a severe brachial plexus injury at multiple spinal levels resulting in Erb's palsy.

PARENT'S CLAIM: A CD should have been performed. The first ObGyn failed to provide a CD and repeatedly applied excessive downward traction, causing the infant's injury.

PHYSICIAN'S DEFENSE: Shoulder dystocia is unpredictable and an unpreventable obstetric emergency. The ObGyn used proper maneuvers

to release the shoulder dystocia. **VERDICT:** A \$1.2 million Virginia settlement was reached.

Ureter injured during hysterectomy

When a patient was found to have multiple, symptomatic fibroids and an enlarged uterus, her gynecologist suggested a total laparoscopic hysterectomy. During the procedure, when he inspected the pelvis and found multiple fibroids in and around the uterus, the gynecologist converted to a supracervical hysterectomy. Surgery was difficult because of a large myoma on the right broad ligament.

The patient tolerated surgery well and was released home the next day. At follow-up one week later, she had no signs or symptoms of ureter injury. Later that same evening, she experienced sharp flank pain and nausea. When she called the gynecologist, he sent her to the emergency department. A computed tomography scan showed extravasation of the right ureter. She underwent months of stent placements and replacements, nephrostomies, and ultimately ureteral reimplantation surgery.

PATIENT'S CLAIM: The gynecologist caused a thermal injury to her right ureter during the hysterectomy by misusing an electrocautery device. There was a delay in timely diagnosis postsurgery.

PHYSICIAN'S DEFENSE: The gynecologist contended that he employed proper surgical technique, and that he reacted properly when the patient reported the pain.

VERDICT: A Virginia defense verdict was returned. ●