Fetal decapitation at 21 weeks

CERCLAGE WAS PERFORMED on a woman who had a short cervix. A week later, Dr. A, her ObGyn, found the cerclage weak, and placed her on bed rest. Three days later, she passed blood clots, and was admitted to the hospital, where Dr. B assumed her care. When membranes ruptured at 21 weeks' gestation, the fetal feet extended out of the vagina. The baby's head was amputated during delivery; the child weighed <1 lb. Nursing staff reattached the head with sutures and permitted the mother to hold the child.

PATIENT'S CLAIM Dr. A should have confirmed cerclage placement by ultrasonography. When he found the cerclage unstable, he should have hospitalized the patient. Dr. B used excessive force during delivery. The nurses failed to properly monitor the mother. She claimed psychological injury in having witnessed the infant's decapitation and being allowed to hold the corpse. Unreasonable death was claimed on behalf of the child's estate; with proper treatment, the child had a chance of survival.

DEFENDANTS' DEFENSE Cerclage was performed properly; Dr. A's care was appropriate. Dr. B did not use excessive force; the fetus had extremely thin skin that tore easily. The nurses' treatment was appropriate. The hospital was required to allow the mother to hold her baby when requested. A fetus is not viable at 21 weeks.

VERDICT A $1,362,499 Kentucky verdict was returned against the ObGyns; a defense verdict was returned for the hospital. The jury refused to address the claim of wrongful death because a fetus is not viable at 21 weeks.

Which breast was it? 1 error cascades

A WOMAN UNDERWENT RIGHT-BREAST biopsy in the 1970s. In 2002, an architectural distortion appeared in the left breast on mammogram. The radiologist concluded that the abnormality was related to the biopsy—but failed to note that the biopsy had been performed on the right, not the left, breast. Mammography films made in 2003 and again in 2004 were incorrectly read as normal.

In December 2005, a radiologist found no change in the left breast. In June 2007, a radiologist reported a large area of parenchymal distortion but concluded that it was related to the previous biopsy.

In May 2008, another radiologist read the films and recommended follow-up to determine which breast underwent biopsy. The patient was found to have stage III breast cancer in the left breast with a positive lymph node. She underwent double mastectomy followed by breast reconstruction surgery.

PATIENT'S CLAIM Her ObGyns never read the radiographs themselves and did not detect the left-right error after reading the reports. Errors cascaded because radiologists relied only on a previous record, not reviewing the entire chart, and confusing right and left films, even though the films were clearly marked. Had the cancer been found in 2002, treatment would have been substantially less extensive.

DEFENDANTS' DEFENSE The cancer was difficult to diagnose because it never changed in size. A double mastectomy was not required to treat the cancer.

VERDICT The statute of limitations restricted which radiologists were allowed to be included as defendants. A confidential settlement was reached with the ObGyn group and two of the radiologists.

OB's priorities tested; child has cerebral palsy

WHEN A WOMAN WENT to the hospital for induction of labor, her ObGyn ruptured the membranes. Shortly thereafter, the fetal heart rate dropped and fetal distress was noted. Emergency cesarean delivery was ordered.

The ObGyn left to attend to another patient while nurses prepared the patient and contacted the anesthesiologist. After delivering another child, the ObGyn returned and delivered the baby, who has cerebral palsy.

PATIENT'S CLAIM The ObGyn should have stayed with this mother instead of delivering the other child. The delay caused the child's brain damage.

PHYSICIAN'S DEFENSE Both patients' deliveries were being carefully monitored; proper action was taken.

VERDICT A Georgia 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.*

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PHOTO: SHUTTERSTOCK

Post-hysterectomy vesicovaginal fistulae

WHEN A 46-YEAR-OLD WOMAN reported irregular bleeding, her gynecologist performed dilation and curettage in February. The pathology report was negative for malignancy; abnormal bleeding ceased.

In July, after symptoms returned, she underwent abdominal hysterectomy. In September, she reported leakage of urine from her vagina; cystoscopy revealed four vesicovaginal fistulae that were repaired by a urologic surgeon. Another fistula developed and was repaired subsequently.

PATIENT'S CLAIM The gynecologist failed to provide information about less invasive options, including endometrial ablation and hormone treatment. The fistulae developed because the gynecologist did not adequately identify the bladder before suturing the vaginal cuff.

PHYSICIAN'S DEFENSE The patient was given sufficient information and requested a hysterectomy; other treatments were offered. A fistula is a known complication of the procedure.

VERDICT A California defense verdict was returned.

Placental abruption: Child has brain damage

WHEN A LABOR AND DELIVERY NURSE called, Dr. A decided a cesarean delivery was needed. The on-call anesthesiologist was at another cesarean delivery, so the procedure was delayed for longer than an hour. Dr. B delivered the child, who was born severely depressed, was resuscitated, and transferred to the NICU. The child suffered hypoxic encephalopathy, is quadriplegic, and has hypotonia.

PATIENT'S CLAIM The cesarean delivery was not performed in a timely manner. Fetal distress occurred because of placental abruption. The child would not have been injured if 1) the nursing staff had summoned a back-up anesthesiologist and 2) the procedure had started within 30 minutes of the decision.

DEFENDANTS' DEFENSE The hospital reported that Dr. A arrived at the hospital quickly, but decided to wait for Dr. B. Placental abruption occurred prior to the mother's arrival at the hospital.

VERDICT The ObGyns settled for an undisclosed amount before trial. A California defense verdict was returned for the hospital.

Necrotizing infection in abdominal hematoma

DYSMENORRHEA and abnormal uterine bleeding developed in a 40-year-old woman. Her gynecologist recommended abdominal hysterectomy because she had undergone two cesarean deliveries. During surgery, bladder injury was recognized and repaired.

After several days, the patient suffered complications and was referred to a urogynecologist, who found a 2-mm vaginal fistula. Three days later, she was found unresponsive at home. During exploratory surgery, the gynecologist found necrotizing infection related to an abdominal hematoma. The patient died 2 weeks later.

ESTATE'S CLAIM The gynecologist was negligent in failing to identify signs of infection at two postoperative visits.

PHYSICIAN'S DEFENSE The patient was properly monitored and referred in a timely manner to the urogynecologist. Death was due to the aggressive nature of the infection, which did not develop until after the last office visit.

VERDICT A Tennessee defense verdict was returned.

C diff infection after antibiotics for cough

AT 34 WEEKS' GESTATION, an ObGyn prescribed amoxicillin-clavulanate (Augmentin) for a woman's cough. She developed diarrhea that did not respond to antidiarrheal medication and a change in diet. Another ObGyn prescribed empiric sulfamethoxazole and trimethoprim (Septra), and referred her to an infectious-disease specialist. The specialist prescribed empiric cefpodoxime proxetil (Vantin) and ordered stool cultures.

Before culture results were received, the patient went into labor and delivered by cesarean section. Her illness progressed to fulminant *Clostridium difficile* pseudomembranous colitis that required total colectomy. Re-anastomosis was accomplished a year later. She continues to have difficulty controlling bowel movements, and reports abdominal pain, frequent dehydration, and weight loss.

PATIENT'S CLAIM Antibiotics should not have been prescribed without a culture-proven bacterial illness. *C. difficile* should have been suspected and treated when diarrhea first developed. Empiric antibiotic treatment during pregnancy is contraindicated. The group's practice model of having patients rotate among OBs impeded continuity of care.

PHYSICIANS' DEFENSE *C. difficile* infection was difficult to diagnose because it is not known to arise in young, healthy women outside a hospital. Use of antibiotics was proper. The group's practice model is appropriate; continuity of care was maintained.

VERDICT A Florida defense verdict was returned.