ONLY ON THE WEB
Surgical towel found 6 years later...and more, at obgmanagement.com

Misplaced intubation results in brain damage

A TIGHT NUCHAL CORD WAS DISCOVERED at delivery. The newborn had a 1-minute Apgar score of 1 and abnormal umbilical cord blood gas values. Resuscitation began but the endotracheal tube was misinserted in the esophagus. By the time the endotracheal tube was reinserted into the trachea, the infant had suffered a prolonged period of hypoxia. The child has severe cognitive delays and is totally disabled with spastic quadriplegia and cerebral palsy. She requires 24-hour care, is not expected to be able to walk without assistance, and cannot speak.

PATIENT'S CLAIM The ObGyn and resident knew that fetal distress was evident 1 hour before delivery; a breakdown in communication between these two physicians caused a delay in delivery. A first-year intern attempted to insert the endotracheal tube; 40 minutes later, the tube was properly repositioned in the trachea and the infant was stabilized.

PHYSICIAN'S DEFENSE Mother and child were properly treated. A life care plan for the child should be based on institutional placement, not home care.

VERDICT An $11 million Hawaii settlement was reached.

Postpartum respiratory distress

TWO DAYS AFTER GIVING BIRTH to her third child, a woman experienced shortness of breath. She was given oxygen and antibiotics for pneumonia.

The next day, she began coughing up pink-tinged foamy sputum. An emergency department (ED) physician ordered 2 mg morphine, additional testing, and increased her BiPAP to 100% oxygen. She began to improve and stopped coughing up frothy sputum, but her blood pressure remained high.

The ED physician transferred her to the ICU immediately after 25 mg promethazine was administered. On the way to the ICU, the patient suffered cardiopulmonary arrest. The ED physician attempted to intubate the patient, but had difficulty because frothy secretions were coming from her trachea due to chest compressions. An anesthesiologist was eventually successful at intubation, but the woman was pulseless for 17 minutes. She suffered brain damage, now requires 24-hour care, and is unable to speak or walk.

PATIENT'S CLAIM The ED physician should have remained with the patient until she was in the ICU; promethazine was contraindicated and led to cardiopulmonary arrest; the ED physician failed to intubate the patient in a timely manner.

PHYSICIAN'S DEFENSE The physician's return to the ED was proper because he handed over care to the critical care physician; promethazine was not contraindicated; appropriate care was provided, including attempts at resuscitation. The nursing staff never informed the ED physician of the patient's history of congestive heart failure with a previous pregnancy.

VERDICT A Florida 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.*

Heated solution burns genital area

A WOMAN UNDERWENT endometrial ablation for menorrhagia. A few days later, she discovered infected and painful blisters in her genital area.

PATIENT'S CLAIM The gynecologist was negligent in how he performed endometrial ablation. He ignored several warning beeps from the machine while the wand was filling the woman's uterus with heated solution, and he removed the wand while it was still releasing hot liquid. The heated solution leaked from the uterus and damaged the vagina, rectal area, and other genital areas. The patient was not informed that the liquid had escaped, nor did she receive treatment for her second- and third-degree burns before she was discharged.

DEFENDANTS' DEFENSE The gynecologist admitted that he never reviewed the operator's manual for the procedure but denied negligence. He claimed two nurses assisting him failed to respond to his instructions to turn off the machine in time to avoid the incident. The nurses denied hearing any such instructions.

VERDICT The hospital was given a directed verdict and dismissed from the case. A $32,000 verdict was returned against the gynecologist.

>> READ ***Update on MIGS,*** on page 38.

PHOTO: SHUTTERSTOCK

Surgical towel found 6 years later

AFTER SUFFERING ABDOMINAL PAIN, a woman underwent a hysterectomy. She continued to report abdominal pain to her gynecologist for several years. Six years after the initial surgery, she sought care from another physician. During an exploratory laparotomy, a blue surgical towel was found adhered to the patient's abdominal wall and bowel.

PATIENT'S CLAIM The gynecologist was negligent in leaving the surgical towel in the abdomen, and in failing to appropriately respond to her complaints of postoperative pain.

DEFENDANTS' DEFENSE The hospital provides white radiopaque sponges for internal use during surgery, and those sponges were carefully counted. The blue towels were not counted because they are not intended for internal use; they are provided for medical personnel to wipe hands and medical equipment. The gynecologist claimed the hospital had not informed him that it was not counting blue towels, and that it was reasonable to expect that the blue towels had been counted.

VERDICT A $564,000 Indiana verdict was reached against the gynecologist; the hospital was vindicated.

Biopsy showed dysplasia; woman dies

AFTER AN ABNORMAL PAP SMEAR, a 27-year-old woman underwent colposcopy and cervical biopsy. When he received the test results, the gynecologist told her to return in 6 months. Three months later, she began having suspicious symptoms. When further testing yielded abnormal findings, she was referred to a gynecologic oncologist, who diagnosed cervical cancer. The woman underwent radical hysterectomy, radiotherapy, and chemotherapy, but the cancer had metastasized, and she died.

ESTATE'S CLAIM The gynecologist should have ordered additional testing when the original biopsy report was inconclusive. Advising 6-month follow-up was negligent.

PHYSICIAN'S DEFENSE The report indicated cervical dysplasia, making the 6-month time-frame proper.

VERDICT A South Carolina defense verdict was returned.

Premature baby succumbs

A PREGNANT WOMAN WAS REFERRED to a perinatal evaluation center for a full cervical examination because prior pregnancies had required cerclage. She was treated by Dr. A, a first-year intern, under the supervision of Dr. B, a fourth-year resident, and Dr. C, the attending ObGyn. Cerclage was not performed. Ten days later, the child was born at 19 weeks' gestation, and died shortly after birth.

PATIENT'S CLAIM The hospital should have had a policy mandating that an attending physician evaluate obstetric patients whose cervical exam is abnormal. Cerclage should have been performed; cervical weakness had been treated in her second and third pregnancies, resulting in successful deliveries at 29 weeks and 34 weeks, respectively. The attending ObGyn never examined the patient.

DEFENDANTS' DEFENSE The hospital claimed that a cervical examination showed that cerclage was unnecessary. Dr. C indicated that the correct decision and treatment were rendered; the intern and resident had reported their findings to him.

VERDICT A $3 million Pennsylvania verdict was returned.

Breast discharge during pregnancy

AT 7 MONTHS' GESTATION, a 29-year-old woman reported burning pain and clear discharge from her right breast. The ObGyn told her he believed the complaints were related to her pregnancy; he did not examine her breasts.

The ObGyn's partner palpated a lump in the woman's right breast at her 6-week postpartum visit. Triple negative breast cancer was diagnosed. She underwent chemotherapy, mastectomy, and radiotherapy, but died of metastatic breast cancer.

ESTATE'S CLAIM The ObGyn failed to conduct a breast examination when the woman first complained of symptoms. This caused a delay in diagnosis, which reduced her chance of survival.

PHYSICIAN'S DEFENSE The ObGyn first denied the patient reported breast symptoms at her 7-month visit, as his records did not indicate a complaint. However, in a documented telephone call 4 days before the visit, the patient complained of burning pain and clear fluid leaking from her right breast. The ObGyn admitted that he would have followed up on the phone call, and that she must have told him complaints had subsided, or he would have noted continuing symptoms and performed a breast exam. He claimed a 3-month delay in diagnosis did not change the outcome because hers was a highly aggressive type of tumor that 1) is unresponsive to treatment and 2) carries an extremely poor survival rate compared with other types of breast cancer.

VERDICT A $1.5 million Illinois verdict was reached.