



LEGALLY SPEAKING
Risk management in obstetrics and gynecology

CASE STUDY: ECTOPIC PREGNANCY

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THE FACTS:

A 39-year-old patient with a history of treatment for infertility presented to the defendant ob/gyn on February 24th with complaints of mid-cycle staining and diarrhea for approximately 10 days, and a last menstrual period 2 weeks prior to the visit. Transvaginal ultrasound (TVS) was significant for a thin endometrial lining and presence of a left corpus luteum cyst. The physician's impression was "functional bleeding," which he attributed to the patient's ovulation, and he instructed her to return in 1 month for a repeat ultrasound, or to call if her condition worsened or did not improve.

The patient then left for vacation, and while away, experienced the onset of abdominal pain that she did not report to the ob/gyn or to any other medical provider. She saw the ob/gyn again on March 4th, at which time she presented with a surgical abdomen. The physician performed TVS, which was significant for the presence of a left tubal pregnancy, and the woman's urine tested positive for pregnancy. She was sent to the hospital, where another member of the ob/gyn's group performed laparoscopy with salpingectomy. The patient recovered from surgery within a few weeks.

THE ALLEGATIONS:

The plaintiff alleged that the ob/gyn departed from good and accepted care in failing to perform a urine pregnancy test at the February 24th visit. The patient claimed that had the test been performed, it would have been positive, and she could have been treated with methotrexate rather than surgery. She further alleged that her fertility status was diminished as a result of the surgery.

DISCOVERY:

In her deposition, the patient revealed that she had taken a home pregnancy test a few days before her first visit to the physician and the results—which she failed to disclose to the ob/gyn—were equivocal. She also recalled the defendant physician suggesting, during the February 24th visit, that she "might be pregnant," to which she responded "no way, there is no way I am pregnant."

The operating physician, who was not a party to the case, testified at deposition that there were multiple adhesions in the woman's left fallopian tube and the fibrillated end was clubbed. It was his opinion that this was the result of chronic tubal disease, and added that the same condition was apparent on the right side. The operating physician opined that the tubes were essentially sealed and nonfunctional. Given the operative report and the testimony of the operating surgeon, before trial, the plaintiff withdrew her claim that her fertility status was diminished as a result of the surgery.

THE TRIAL:

At the time of trial, the patient's ob/gyn expert testified that the defendant physician's failure to perform a urine pregnancy test at the February 24th visit was a departure from the standard of care. He further testified that if a urine pregnancy test had been performed, it would have been positive, and the patient would have been instructed to return every 48 hours for serial beta subunit hCG tests to determine the pregnancy's viability. The physician testified that the serial hCG levels should have been obtained until a gestational sac was seen on ultrasound, but that if the levels did not double within 48 hours, an ectopic pregnancy could be presumed and then terminated with methotrexate.

The defendant's ob/gyn expert testified that methotrexate was not the standard of care in 1997, when the patient was treated. He further testified that the ectopic pregnancy was not diagnosed before March 4th because the pregnancy was too early and too small. In their testimony, the ob/gyn and his physician expert countered that even if the diagnosis had been made earlier, the treatment and outcome would have been the same: The physicians still would have recommended laparoscopy. They further argued that a urine pregnancy test was not indicated during the February 24th visit, given the history provided by the patient and the results of the physical exam and TVS. Because the patient did not report a missed or abnormal period, the index of suspicion for pregnancy was low at that time. In addition, the thin endometrial lining seen on TVS was consistent with a nonpregnant uterus, and both the defendant physician and the expert testified that mid-cycle bleeding is one of the more common complaints they receive from their patients.

The defendant's ob/gyn expert testified that the hCG level was not high enough that TVS would have detected either an intrauterine or extrauterine pregnancy. The March 4th hCG level obtained at the hospital was 2,222. Working backwards and assuming that the level doubled every 48 hours, he established that at the February 24th office visit, the patient's hCG level would have been around 150, well below the "discriminatory zone" for detecting a pregnancy on TVS. The defendant also had a radiology expert testify that the mean sac size of the pregnancy on March 4th was 6 mm. Given that a gestational sac grows at a rate of approximately 1.1 mm per day and again working backwards, he argued that on February 24th, the tubal pregnancy was microscopic, and therefore, undetectable. The defense argued that the gestational sac could not have been diagnosed until March 3rd at the earliest, and that the ob/gyn made a rather astounding diagnosis, only 1 day after it became possible to detect the tubal pregnancy.

Fortunately, after only brief deliberation, the jury returned a verdict in favor of the defendant physician.

ANALYSIS:

Even when it appears, at first blush, that a physician should be congratulated for recognizing a potentially detrimental situation before it deteriorates, that sometimes doesn't preclude a patient or her expert from suggesting that there was something the physician could and should have done to diminish the patient's discomfort even further. The court will always instruct jurors before they deliberate that the burden of proof lies with the patient. However, in reality, when a defendant argues that theories from the patient's experts are wrong, jurors look to the defense for a succinct explanation as to why they shouldn't find for the patient.

In this case, the defendant's care was vindicated by hindsight, although jurors often are cautioned during selection and trial not to use hindsight to render judgment. Thanks to excellent documentation by the treating physicians and the experts' ability to "work backwards" with scientific evidence to explain the near impossibility of earlier diagnosis, we were successful in convincing the jury that the defendant's diagnosis was extraordinary rather than negligent.

This case was tried by Craig P. Fenno, a partner at Aaronson, Rappaport, Feinstein & Deutsch, LLP, New York, N.Y. Mr. Fenno graduated from Albany Law School in 1981 and specializes in medical malpractice defense litigation.

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