
CASE STUDY: MOLLUSCUM CONTAGIOSUM OF THE BREAST

By Andrew I. Kaplan, Esq..

Aug 1, 2004

THE FACTS:

The patient, a 25-year-old college student of South-Asian descent, presented to the defendant gynecologist's practice in January 2000 with a complaint of multiple "bumps" on both nipples that had persisted for 3 months. Biopsy revealed molluscum contagiosum, an infectious disease characterized by small, pearly, papular epithelial lesions on the skin surface. At that time, the gynecologist began to treat the patient with bichloroacetic acid (BCA). For the next 6 months, through July 2000, the patient returned to the physician for recurrent or new lesions, and at each visit, she applied BCA. By May, the patient's records noted the presence of "old scabs" but there was no documentation of any discussion of the risks and benefits of BCA therapy or alternatives to it.

On July 10, 2000, the patient complained of new lesions for the sixth time in 6 months and was treated with BCA. The gynecologist then referred her to an infectious disease specialist, who subsequently sent the patient to a dermatologist. That physician noted scars and hyperpigmentation of the woman's breasts in the areas that had previously been treated with BCA. Despite treatment with curettage and cryotherapy, the patient was left with a 5- x 1.5-cm scar extending down the dorsal surface of her right breast.

THE ALLEGATIONS:

The patient alleged that application of BCA for molluscum contagiosum was contraindicated, particularly because of the elevated risk of hyperpigmented scars in an individual with dark skin, and that the defendant had carelessly applied the BCA, resulting in "dripping" and unsightly scarring. The patient

further alleged that the defendant did not appropriately inform her of the risks, complications, or alternatives to BCA, which she said exacerbated and worsened her condition rather than resolving it. The burns were significant enough, the woman said, to require triamcinolone injections and her permanent hypertrophic scarring was not amenable to surgical revision. Finally, the patient asserted that the defendant physician was negligent in failing to timely refer her to a specialist in infectious disease or dermatology, rather than undertaking treatment outside her own area of specialty.

DISCOVERY:

During deposition, the patient testified that on more than one occasion, the defendant was careless in applying the acid and allegedly said "oops" more than once when the liquid dripped further down the breast than she had intended. The patient insisted that the only reason she had ever been sent to a specialist was because the last time the defendant treated her, the gynecologist had become so frustrated with the patient's lack of progress that she had requested advice from a colleague in her practice, who immediately recommended a specialist. According to the patient, the dermatologist who treated her was critical of the defendant's management. The dermatologist's records, however, indicated that the patient was deferring local treatment of her scars pending resolution of her lawsuit, which the woman vehemently denied. The patient testified that she was no longer comfortable wearing a bikini or changing in front of others, and the location and nature of the scarring affected her intimate relationships.

Experts in gynecology and dermatology who reviewed the case on behalf of the defense were highly critical of the care rendered. The gynecological expert felt that it was outside a gynecologist's purview to "approach the breast" for matters not related to routine breast examination or palpation in conjunction with routine gynecological examinations. Furthermore, she felt that given the sensitivity of breast tissue and the patient's natural pigmentation, BCA was contraindicated for molluscum contagiosum, particularly by a gynecologist who lacked special training in that area. This expert added that treatment of molluscum contagiosum by gynecologists is routine only in the genital area. There, the condition typically resolves spontaneously but local treatment with cryotherapy and curettage can be used if necessary. The expert gynecologist felt that referral to a dermatologist was appropriate for a patient with persistent or pervasive molluscum contagiosum.

In the dermatologist's opinion, BCA should never be used on the breasts because the tissue is so sensitive and takes so long to heal. Scarring of the patient's breast, he said, was clearly a result of inadvertent dripping of the liquid down the breast, forming the burn pattern he saw when he examined the woman. A plastic surgeon who examined the patient noted that her scar was thick, hypertrophic, elevated, and more darkly pigmented than the adjacent skin. He felt the scar might be improved by excision, straight-line closure, and more steroid injections.

OUTCOME:

It was impossible to get any expert witnesses in gynecology, infectious disease, or dermatology to testify on the defendant's behalf. Given that and the defendant's admission that she was inexperienced in treating molluscum contagiosum of the breast, we decided to negotiate the case rather than allowing the physician to testify. Poor testimony and her clear lack of experience with BCA would only have increased the value of the case beyond what was warranted. Ultimately, the matter was settled for \$97,500.

ANALYSIS:

The defendant in this case may have been familiar with molluscum contagiosum as an entity, but she had no experience treating it on a patient's breasts. It goes without saying that a savvy clinician knows his or her limitations and does not put the desire to build a practice or ingratiate new patients above the obligation to practice appropriate medicine. Here, the appropriate decision under the circumstances would have been to refer the patient to a specialist in skin lesions or, at a minimum, to consult with a specialist or colleague knowledgeable about treating molluscum contagiosum of the breast in a woman with dark skin. The defendant then could have documented the expert's advice on treatment options and potential complications and risks of proceeding with therapy, and discussed all of that information with the patient. If at some point down the line, the patient had complications and sought legal recourse, the defendant would have been better prepared for a lawsuit. A conscientious physician doesn't have to practice medicine with litigation in mind, but it behooves you not to ignore the potential for litigation altogether.

Andrew I. Kaplan is a Partner at Aaronson Rappaport Feinstein & Deutsch, LLP. Mr. Kaplan graduated from Brooklyn Law School in 1993 and has specialized in medical malpractice defense and health-care litigation since entering private practice.