



LEGALLY SPEAKING
Risk management in obstetrics and gynecology

Legally Speaking: Malpractice suit revolves around damaged ureter

By *Andrew I. Kaplan, Esq.*
Aug 1, 2008

In an effort to defend medical care, there is a risk of adhering too closely to an initial, and often shrewdly-crafted, defense. Physician and defense counsel alike are often better served by remaining flexible and keeping it simple, thus allowing for a credible response to changes in the plaintiff's theory of the case.

THE FACTS

The patient, a 45-year-old G3, P1-0-2-1 with a long history of uterine fibroids, was admitted to the defendant hospital center under the care of the defendant obstetrician/gynecologist on April 26 for a total abdominal hysterectomy (TAH) with bilateral salpingo-oophorectomy (BSO). The patient had been treated on and off by the defendant ob/gyn for over 5 years for left-sided fibroids and had tried leuprolide, oral contraceptives, and medroxyprogesterone acetate (MPA) in an attempt to avoid surgery. On April 26, however, her growing fibroids, worsening menorrhagia, and dysmenorrhagia prompted her request for more definitive treatment.

THE HOSPITAL RECORDS INDICATE that the physician discussed the patient's options with her, including a supracervical hysterectomy with or without BSO, continued attempts with OCs, or Provera, versus TAH/BSO; the patient agreed to TAH/BSO with resulting surgical menopause. The ob/gyn also discussed potential adverse reactions to the procedure and overall risks and benefits of surgery, including bleeding, infection, surgical menopause, injury to her ureters due to anatomical proximity, bowel injury, dyspareunia secondary to change in vaginal shape and size, dryness, possible transfusions, and possible bladder/vault drop in the future. The records show the patient was aware of the procedure and accepted the risks and benefits.

In his brief operative note, the gyn surgeon documented the presence of an assistant resident and noted there were no complications. Although the resident dictated the operative report, he failed to include the BSO portion of the procedure and as such, the attending dictated his own subsequent

operative report that wasn't dated until a month and a half after the procedure. However, the attending's dictated operative report indicated that there were no complications and, significantly, discussed dissections as follows:

"Anterior leaf of broad ligament incised along bladder reflection to midline on both sides—bladder gently dissected off lower uterine segment and conserved with a sponge stick. Posterior leaf of broad ligament incised and open. Ureters and their course identified. Infundibulopelvic ligaments doubly clamped with Kelly's, transected, and suture ligated with 0 Vicryl—same procedure done on both sides. Good hemostasis. The uterine arteries were skeletonized bilaterally and clamped with Heaney Clamps and suture ligated with 0 Vicryl. Hemostasis assured. Uterosacral ligaments clamped on both sides and transected and suture ligated in a similar fashion. Cervix and uterus amputated with Mayo scissors."

On April 27, 1 day post-op, the patient's white blood cell count was elevated to 16.2 (Normal: 4-11) and at 4:35 PM, she spiked a temperature of 102.8°. The wound was examined and was clean and dry, with no redness or edema, and the patient did not complain about pain. On the second postoperative day, the patient's 5:00 AM temperature was 101.8° with a WBC of 16. She made no complaints and both blood and urine cultures were negative. A 3:30 PM nurse's note indicates the patient was to be discharged, with stable vital signs, the ability to walk, and no complaints of pain or distress. The defendant gyn documented the fact that although the patient's WBC was still 16, her temperature was down to 97.4°. She was discharged home with Augmentin to follow-up in his office in 2 weeks.

On May 4, the patient presented to a local hospital emergency room complaining that 2 days earlier, she began experiencing aching pain in her lower abdomen and back. The examining physician noted that she had been on acetaminophen with codeine for incisional pain, and docusate sodium (Colace); she had been constipated for 2 days with no vomiting. Her abdomen was soft and non-tender, with good bowel sounds noted on examination. Both flat and upright abdominal x-rays indicated that the patient was "full of stool." She was given magnesium citrate, Fleet enemas, and lactulose and had a good bowel movement after the lactulose. She was discharged with a diagnosis of constipation and instructed to return to her primary-care physician.

On May 14, the patient returned to the defendant gyn with no complaints of bleeding or pain, indicating that she "now feels good." Her abdomen was soft and non-tender with a well healing incision, and she was to follow-up in 3 weeks. The following day, the patient presented to another local emergency room complaining of left-sided abdominal pain for 3 to 4 hours that was getting worse. Abdominal ultrasound did not reveal any hydronephrosis on the left, but on her right side there was grade-I hydronephrosis; the ureter could not be visualized. The scan also revealed moderate ascites. A gyn consultation was obtained, at which point the patient said she had complained of abdominal pain bilaterally "since the surgery," increasing since yesterday.

A CT scan revealed ascites around the liver and spleen, also within the interloop locations involving the left lower quadrant. A fluid collection in the left pelvic region extended to the cul de sac measuring 6.7x3.9cm, with a thick wall; it likely indicated an abscess. Hydronephrosis involving the left kidney and a left hydroureter were seen up to the mid-pelvic region, with a possible extrinsic compression of the left ureter by the fluid collection. The patient had a WBC of 23.1.

On May 20, an IV pyelogram revealed prominent left renal pelvis and dilatation of the left ureter without a focal area of stenosis or obstructing calculus. Moderate left hydronephrosis was noted, and cystoscopy, left ureteroscopy, and attempted insertion of a double stent were undertaken. The stents could not be placed because of complete obstruction of the left distal ureter 2 cm from the orifice. CT scan on May 22 revealed a worsening abscess. On May 24, left percutaneous nephrostomy placement was undertaken, as well as PICC placement, and the patient was discharged on May 26, with a diagnosis of pelvic abscess; left hydronephrosis; hydroureter; left ureteric fistula and obstruction, to follow-up with urology and gyn.

On July 12, the patient underwent cystoscopy performed by a urologist who was not involved in the subsequent lawsuit, along with attempted catheterization of the left distal ureter and exchange of the nephrostomy tube. At cystoscopy, it was noted that the left orifice was not effluxing urine, and that there was an impassable obstruction about 4 cm from the area of the orifice, but the retrograde pyelogram could not demonstrate that the distal part of the ureter was intact. On July 22, the patient began seeing a mental health counselor, claiming depression, anger, insomnia, anti-social behavior, and an inability to concentrate, exacerbated by her ureter being "cut."

On August 27, the patient underwent exploratory laparotomy with excision of the distal obstructed left ureter, and a left neoureterocystotomy with placement of a left ureteral stent at a local hospital. During the course of the procedure, the ureter was clearly identified and noted to be moderately dilated. It was followed down to the left approximately 2 cm from the bladder, but disappeared into a fibrotic, scarred region where the ureter appeared to be obliterated and could not be traced beyond that point. The ureter was transected, and the distal stump of the ureter was ligated with 2-0 Vicryl suture, the proximal segment dissected free from its surrounding attachments up to the level of the psoas muscle. There was "plenty of length" for the left ureter to reach the bladder, so no further surgical techniques to lengthen it were required, and the distal segment was stomatized for healing. The records reflect that despite recurrent urinary tract infections, the patient did well thereafter.

ALLEGATIONS

The plaintiff alleged negligence in damaging the left ureter during the course of the April 26 hysterectomy. She further alleged a failure to diagnose said injury before closing the surgical site and discharging her from the operating theater. Additionally, she alleged that the defendant gyn was negligent in failing to timely consult a urologist, order or timely recognize the significance of her postoperative symptomatology, and in discharging her less than 24 hours after spiking a fever. In addition, despite what was documented in the hospital record, the patient alleged a failure to obtain appropriate informed consent. It was alleged that, as a result, she suffered from the complications of the ureteral ligation, including but not limited to left ureteral stent placement, left percutaneous nephrostomy, hydronephrosis, hydroureter, pelvic abscesses and a ureteral fistula. Finally she alleged depression, pain and suffering, and loss of quality of life.

DISCOVERY

At her deposition, the plaintiff claimed that the defendant gyn simply told her that he "does this all the time, it's very simple and not to worry." Despite the fact that the surgery had been planned for over a year and deferred by the patient while she attempted more conservative treatment, she denied knowing anything about the surgery or questioning the physician at greater length regarding the risks or what she could expect. She testified that on May 4, she complained of constant pain on the left side

of her lower abdomen since the surgery, and that despite painkillers, this pain persisted through her May 14 visit with the defendant gyn.

DURING HER MAY 15 ADMISSION to the local hospital, the patient testified that she was told her ureter was "broken," but could not remember any of the other circumstances involved in the hospitalization. The patient testified that her depression had worsened significantly since these events, and that while she has no permanent urologic damage, the injury affected her activities of daily living, and worsened her sex life.

The defendant physician acknowledged that the patient did not have urinary complaints preoperatively, and that there was nothing he encountered intraoperatively that created unusual complications. He testified to his extensive preoperative discussions regarding the risks of the procedure, including damage to the ureters, bowel, and bladder. He testified that he was not aware of any intraoperative mishap.

It's important to note that the subsequent treating surgeon who repaired the ureter made clear in his operative report that there was no evidence of severance or suture, but, rather, that the ureter had become encased in scar tissue. Our gyn expert initially felt that the defendant gyn did not damage the ureter, but that the obstruction was caused by scar tissue. During the course of discovery, however, it became apparent that there was no explanation for the existence of the abscess, absent ureteral damage, and that the disappearance, as it were, of the fluid collection following placement of the nephrostomy tube supported the proposition that the damaged ureter was the cause of the pelvic or intra-abdominal collection. As such, the tenor of the defense became not that the ureter was encased in scar tissue and thus obstructed, but that there was a ureteral injury that occurred intraoperatively, which was a well-recognized and documented risk of performing hysterectomy.

After the defendant's deposition, the plaintiff added an allegation that the ureter should have been stented intraoperatively, but our expert was adamant that this course of action was unnecessary as well.

Insofar as the decision to discharge the patient was concerned, our expert felt that a single elevated temperature with elevated white blood cell count was insufficient to have required further investigation, but could be considered a normal postoperative finding. He felt that discharging the patient when afebrile was appropriate, and that neither an x-ray nor an ultrasound would have revealed anything of significance on the first or second postoperative date.

TRIAL

At trial, the plaintiff's theory coalesced into a single assertion, that by virtue of his failure to include or acknowledge identification and dissection of the cardinal ligament in the body of the operative report, the defendant gyn was clearly unfamiliar with the anatomy, had not appropriately identified and dissected anatomical structures imperative to the procedure, and had caused a distal ureteral injury in the area of the cardinal ligament. To the contrary, the defendant and his expert testified that injury to the ureter will occur in a certain percentage of abdominal hysterectomies, irrespective of surgical technique, in the absence of negligence. Furthermore, the defense pointed out that as a TAH had been performed and the cervix removed, the cardinal ligament had to have been identified and dissected, as it is this ligament that effectively "ties" the cervix to the pelvic wall. Finally, the defendant gyn was experienced in this procedure, having performed about 100 prior TAHs.

RESOLUTION

After brief deliberation, a verdict was returned in favor of the defendant gyn.

ANALYSIS

If nothing else, this case speaks to the importance of outlining the risks of a procedure, particularly when a physician has sufficiently and adequately documented, in a credible fashion, the consent conversation with the patient. It further underscores not only the mercurial nature of malpractice litigation, but the need for independent expert review by multiple specialties adjusting one's defense based on that expert review, and adaptation of the defense to their analysis. (In our case, not only did plaintiff's theory change shortly before or at trial, but based upon the additional evaluation by a surgical urologist, our ob/gyn's opinion changed, which allowed us to mount a more credible, responsive defense.)

THE PLAINTIFF'S INITIAL ALLEGATIONS concentrated on damage to the ureter that was unobserved by the physician and on improper discharge of the patient. At the time of trial, the allegation coalesced into a failure to identify and dissect the cardinal ligament, and thus, an injury occurring to the ureter at that anatomic location. Initially, our gyn expert felt that there was no damage to the ureter, but that an infection had occurred and the ureter had simply become encased in scar tissue. The presence of a pelvic abscess and ascites made us question this impression and refer the case to a urologic surgeon. The urologic surgeon said in no uncertain terms that this was a "classic textbook presentation of an unrecognized ureteral injury." He felt that the patient's postoperative leukocytosis was a result of inflammation and the percolating abscess rather than systemic postoperative infection, and that the absence of pain in the immediate postoperative period could be explained by an ambulatory patient, and the fact that urine is sterile and the patient was treated preoperatively with antibiotics. Armed with this information, we were able to return to our gyn expert, who re-focused his opinion and allowed us to prepare a new defense—to wit, that ureteral injury had, in fact, occurred, but that it was a known risk of the procedure, and certainly not the result of failure to identify, dissect, or navigate the adjacent anatomy.

Andrew I. Kaplan, a graduate of the University of Michigan and Brooklyn Law School, is a partner at Aaronson, Rappaport, Feinstein & Deutsch, LLP, specializing in medical malpractice defense and health-care litigation.

This case was tried by Robert S. Deutsch, a Senior Partner of Aaronson, Rappaport, Feinstein and Deutsch, LLP and one of New York Magazine's "Best Lawyers in New York."