
CASE STUDY: WAS THIS MYOMECTOMY BOTCHED?

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THE FACTS:

The patient, a 43 year-old African-American woman, was referred to the defendant obstetrician/gynecologist in July 1998 for surgical management of menorrhagia that resulted from a fibroid uterus. Her past medical history was significant for development of fibroids as early as 1983. In 1994, she underwent myomectomy and left-sided salpingo-oophorectomy (LSO), but 6 months later, her symptoms, including heavy bleeding and pain, returned. After 3 to 6 months of leuprolide, which was prescribed by her gynecologist, her complaints persisted. The woman's subsequent referral to the defendant was done through correspondence from the original gynecologist, who indicated the patient wanted a "laparoscopic laser myomectomy."

In August 1998, the defendant performed myomectomy by laparotomy rather than laparoscopy on the patient, and the consent form in the hospital chart indicated that "laparotomy" was in fact the procedure proposed. According to the operative report, after the initial incision was made and carried down through the perineum, adhesions of the omentum, peritoneum, and uterus were dissected free from the right-side wall and uterus. A calcified fundal fibroid mass was dissected free from the surrounding muscular tissue and several other fibroids were removed through the same incision. The anterior wall then was incised and three large submucousal fibroids were removed. Two more incisions were made in the posterior wall and several fibroids were removed from that area. Several fibroids were also removed after incision of the right and left anterior wall of the lower quadrant. The total operating time was 4¹/₂ hours, with an estimated blood loss of 500 mL. The patient tolerated the procedure well and was discharged to recovery

in good condition. According to the pathology report, multiple round to ovoid fibroids ranging in size from 1.5 to 4.5 cm were identified.

On postoperative day 1, the patient's hemoglobin and hematocrit were low and her abdomen was moderately distended/tympanic. Her discharge was cancelled and an abdominal x-ray suggested the possibility of free fluid in the left flank. A CT scan of the abdomen and pelvis performed the next day revealed a large uterus with residual fibroids and a possible endometrial hematoma. Transabdominal ultrasound was consistent with hematoma, and on postoperative day 3, IV angiography revealed a right uterine artery bleed. Uterine artery embolization (UAE) was performed and the patient was discharged on postoperative day 4. An U/S performed 2 months after surgery revealed several well-defined masses within the myometrium of the uterus consistent with fibroid formation.

THE ALLEGATIONS:

The patient alleged that she had only consented to a laparoscopic procedure, and the defendant performed an open myomectomy without her consent and against her wishes. She further alleged, by virtue of subsequent radiological studies, that the defendant failed to remove all of the fibroids, resulting in continued pain and discomfort despite the operative procedure. Furthermore, the plaintiff argued that the postoperative bleeding that required UAE was a result of the defendant's negligence. She alleged that he had either closed the abdomen without identifying a right uterine artery bleed or precipitated postoperative bleeding by closing the abdomen too soon after administration of vasopressin.

DISCOVERY:

During the plaintiff's deposition, the defense discovered that she was a hospital chaplain and wore a clergy collar. The patient insisted that the defendant told her he would do a laser myomectomy and admitted she signed the consent forms for laparotomy in the office and hospital, but claimed she did not recall discussing or reading them, nor discussing any risks or benefits of the procedure. She claimed that the defendant told her only that there would be an incision to pass the laparoscopic instruments and that he believed he could remove all of the fibroids.

According to the patient, she woke up the day after surgery in pain and the defendant never told her about the postoperative complication or why she had UAE. She further claimed that at no point during her hospital stay did she become aware that she had undergone anything other than a laparoscopic myomectomy and it wasn't until 2 or 3 months later that she learned from her regular gynecologist that she had an open procedure. She said she believed the stitches and incision on her abdomen were the result of the incisions made for the laparoscopic instruments. The patient complained that incisional pain

and recurrent fibroids had caused her to curtail her activities of daily living and athletics and that the pulling and pain she felt on the right side of her abdomen were persistent.

At his deposition, the defendant testified that he never considered laparoscopic surgery for the patient, given her history of myomectomy and LSO through a vertical incision, because of the likelihood of adhesions and the potential for related complications. Furthermore, he testified that submucosal fibroids cannot be removed laparoscopically and that the procedure is not indicated in patients who have multiple fibroids or a prior history of pelvic surgery. A submucosal fibroid, he said, presents difficulties because the defect it leaves in the uterine cavity is difficult to close through a laparoscopic incision. The defendant added that because vasopressin is used to control bleeding during fibroid surgery and the medication lasts for only about 20 minutes, time is, to a certain degree, of the essence. Therefore, for multiple fibroids, an open procedure is the surgery of choice. He described in detail the preoperative discussion he had with the patient and his recommendation for an open rather than laparoscopic procedure because of her submucosal fibroids and prior surgical history. He was emphatic that he inspected the patient for bleeding before closing and found neither bleeding nor oozing upon inspection. He refuted the suggestion that there were residual fibroids after surgery.

THE TRIAL:

Before the trial started, the court granted the defense's motion to prevent the plaintiff from wearing her clergy collar in the courtroom, lest it unduly influence the jury about her credibility, and to preclude any evidence of prior charges of professional misconduct against the defendant, which were unrelated to the facts or issues in this case.

On cross-examination, the plaintiff conceded that she had consented to open myomectomy when she underwent the procedure in 1994, and ultimately acknowledged that although she had "no recollection" of the discussions with the defendant, she previously had been apprised of the risks and complications associated with the procedure and "had likely" been apprised of the same or similar issues before the surgery performed by the defendant. The plaintiff next was confronted with the absurdity of her testimony that she didn't realize she had undergone an open procedure until 2 months later, despite how her abdomen looked when she was in the hospital and the fact that she'd had stitches removed. She then abandoned the claim and the informed consent issue never was presented to the jury for deliberation.

At trial, the plaintiff ultimately focused on the issue of postoperative bleeding. She argued, through an expert, that when the vasopressin wore off, the artery began to bleed. If the defendant had delayed closing the surgical wound, it was alleged, he would have uncovered the bleed before the surgery ended. The plaintiff claimed that the defendant's failure to wait an adequate period of time (20 minutes) before closing to ensure hemostasis was a departure from good and accepted practice.

On cross-examination, plaintiff's expert all but conceded the medical and temporal improbability of this argument. He conceded that closure does not occur "immediately" after the procedure ends but rather through repair and suturing of layers of muscle and fascia, which would take at least 20 minutes before the patient was deemed "closed." Thus, the expert had to concede, on logic alone, that more than 20 minutes elapsed between the time the last fibroid was removed and the patient was taken to recovery. Therefore, any evidence of postoperative bleeding would have been observed during closure or before the patient was discharged from the operative suite.

Interestingly, the most significant hurdle the defense had to overcome at trial was a book written by the defendant, in which he indicated that postoperative bleeding could only be due to the fact that the operating surgeon was "lazy, sloppy, and careless." Plaintiff's counsel read this passage to the jury many times during the trial, to no avail. The defendant's expert in obstetrics and gynecology explained how the patient's case differed, testifying that as had been intended, a vessel was cut during the surgery as part of fibroid removal. As can happen in some cases, the vessel likely went into spasm and retracted, cutting off bleeding and making it impossible to visualize during surgical closure. The postoperative bleeding arose when the vessel came out of spasm, at some point after surgery.

In addition to covering the consent issue in its entirety and demonstrating that the plaintiff's allegation about postoperative bleeding made no sense, the expert used postoperative complete blood counts to support the defendant's proposition that the vessel had bled slowly after coming out of spasm. After a brief deliberation, the jury rendered a defense verdict.

DISCUSSION:

As has been mentioned previously in this column, the focus of a case often changes between discovery and trial because of the evidence accrued, the bent of the judge, and the way a case is "sold" to the jury. In our experience, the best defense is to be prepared not only for the allegations presented but for those that were not pled but have the potential to arise.

Even more critical to success, however, is maintaining the defendant's credibility in the face of incredible claims by the plaintiff. Something as innocuous as a clergy collar or as damning as prior misconduct findings can sway a jury. The first hurdle a patient must overcome is a jury's natural inclination to hold a defendant physician in high esteem because of his or her professional standing. The patient will always fight an uphill battle to win a "he said/she said" dispute unless the defendant comes across as incompetent or incredible or plaintiff's counsel can make their client appear more credible than the physician.

This case was tried by Philip D. Lerner, a partner at Aaronson, Rappaport, Feisntein & Deutsch, LLP and a 1977 graduate of Villanova Law School. Mr. Lerner is a former prosecutor with the Kings County District Attorney's Office who has devoted the last 20 years of his practice exclusively to insurance defense litigation.

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