
Legally Speaking: Was this myomectomy botched?

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THE FACTS

The patient was then a 36-year-old married, African-American woman who had been treated by the defendant obstetrician/gynecologist for over 20 years. The woman suffered from chronic recurrent uterine fibroids and first presented to the defendant with complaints of fibroids and heavy bleeding in 1981. Two ob/gyns who treated her in the past had suggested hysterectomy, but the defendant physician recommended myomectomy, which was done for the first time in 1981, after a long consent discussion. In 1993, the patient returned once again complaining of fibroids and heavy bleeding for several months, and since the patient said she wanted to eventually have children, preserving her uterus was crucial. The defendant ob/gyn warned her that a second myomectomy would weaken her uterus, which meant that any future babies would have to be delivered via cesarean. The patient agreed to the second procedure nonetheless.

IN THE SPRING OF 2002, the patient again presented with complaints of painful fibroids. She had undergone a series of hormone treatments in an unsuccessful attempt to help her conceive, and the defendant ob/gyn planned for a third myomectomy at the defendant Hospital Center. The third myomectomy took place on August 6, and according to the operative report, although extensive adhesions were found and dissected, surgery was performed without complications. Postoperatively, her WBC count rose to 19,000, and although she was discharged feeling the need to "pass flatus," she was in good condition. Upon returning home, the patient said she ate soup but later that evening began to experience abdominal swelling, discomfort, nausea, and vomiting. She called the defendant ob/gyn and presented to the emergency department late on the evening of August 8, and was re-admitted early the next day.

On re-admission, the patient's WBC count was 16,400, and the admitting diagnosis was "rule out ileus versus small bowel obstruction." An abdominal x-ray revealed no free air in the abdominal cavity and a CT scan was consistent with the possibility of small bowel obstruction. It was felt that part of the small bowel had become either enmeshed in the incision, or attached to the abdominal wall. The theoretical complication was managed

conservatively with the insertion of an NG tube, and by August 10, the woman's WBC count had returned to normal. However, on the afternoon of August 11, she spiked a fever of 101.7°F, and a surgeon we'll call Dr. B planned on returning the patient to the OR because she wasn't improving.

On August 12, the defendant ob/gyn ordered a soapsuds enema, but the RN involved in the patient's care—under the impression that an enema would be contraindicated for a possible small bowel obstruction—objected to carrying out the defendant's orders. As a result, an attending physician, Dr. C, and the aforementioned surgeon Dr. B were consulted, along with the defendant ob/gyn; all three signed off on the order and felt that an enema would not be harmful to the patient under the circumstances. At 1:25 PM on August 12, the enema was administered, and almost immediately thereafter, the patient's condition changed dramatically. Within 4 hours of the administration of the enema, the patient was running a fever of 101.3°F, became diaphoretic, and complained of excruciating abdominal pain. Approximately 9 hours later, she was transferred to the ICU with signs and symptoms suggesting shock. She continued to complain of acute abdominal pain, manifested signs and symptoms of peritonitis, and had produced no urine since the enema was administered.

On the morning of August 13, the patient was taken to the OR by Dr. B, who located and released the small bowel obstruction, which was in the area of the prior surgical incision. In addition, although there was no compromise to the small bowel, on further exploration, the surgeon found a through-and-through perforation in the sigmoid colon, at the top of the uterus, precisely in the area of the defendant ob/gyn's most recent myomectomy. Dr. B oversewed the hole with no evidence of necrosis, and performed a temporary ileostomy, which was reversed 2 months later, on October 12. The patient by all accounts, did well thereafter.

ALLEGATIONS

Among the plaintiff's initial allegations were the claim that it was negligent to perform the third myomectomy, and that the defendant ob/gyn should have performed a hysterectomy instead. She also argued that her history increased the risk of postop bleeding, a weakened uterus, retained seedlings for fibroids, and postoperative bowel adhesions. The plaintiff further argued that the defendant should have recommended a total abdominal hysterectomy, and had failed to obtain the necessary informed consent. She added an allegation that the defendant negligently and carelessly performed the surgery, resulting in the perforation of the large intestine, and then failed to timely diagnose and repair that perforation before discharging the patient from the OR.

BY THE TIME THIS CASE REACHED TRIAL, the plaintiff had conceded that the recommendation for a third myomectomy was appropriate, that the perforation was a risk of the procedure, and was only pursuing the theory that the defendant negligently failed to appreciate the perforation by examining the bowel prior to concluding the myomectomy surgery and discharging her from the OR.

DISCOVERY

The plaintiff made a likeable, sympathetic, and truthful witness. She confirmed that she had been fully consented for the first, second, and third myomectomies, essentially taking that issue off the table. She also acknowledged awareness that bowel and bladder injury were possible complications of myomectomy. In a crucial piece of testimony, the patient also confirmed that after the enema was administered, she immediately began screaming in pain, and that even after the enema was ended, there was no relief. She confirmed that this led to her worsening symptoms. Insofar as damages were concerned, the patient testified that approximately once a month, she experiences a 3- to 4-day period where her stomach "grips" and episodes of vomiting follow.

BASED UPON OUR EVALUATION OF THE CASE, we felt that the enema and not the third myomectomy was the likely culprit behind the perforation of the large colon. Our expert ob/gyn evaluated the case and agreed. He felt that the myomectomy was clearly indicated, and that the patient's deterioration after the enema indicated that the enema likely caused the injury as opposed to the defendant's surgical technique.

At his deposition, the defendant ob/gyn articulated his position that the enema caused the perforation, which in turn caused the bowel to tear off the uterus, leaving a hole. He testified that he was present in the OR when the surgeon, Dr. B, performed his exploratory surgery, and that upon examination of the hole, both he and the surgeon agreed that the enema caused the perforation.

Unfortunately, during the course of discovery, the plaintiff subpoenaed Dr. B for deposition. First and foremost, in the section of his OR report that discussed the closure of the ileostomy in October, he suggested that the bowel perforation was iatrogenic. While the surgeon conceded that the patient did not have an acute abdomen when he evaluated her on the morning of the 12th prior to the enema, he did testify that he was "fairly convinced" that the injury was from the prior myomectomy. He stated that the insult probably occurred intraoperatively and then "the body did a good job in sealing the hole." He took the position that the iatrogenic injury he referred to in his October 2002 operative note was the myomectomy and not the administration of the enema. He did confirm, however, that he was consulted with regard to the administration of the enema prior thereto, and that there was no contraindication to giving the enema after the performance of a myomectomy, unless there was suspicion of injury to the rectum, which was not present in this instance. He also took the position that he "could not recall" whether the defendant physician was actually in the OR on August 13 when the bowel perforation was discovered. He conceded that damage to surrounding structures is always a risk of surgery.

TRIAL

The plaintiff demanded \$750,000 to settle the case. She contended that there was an injury during the operation to the serosa and muscularis that became a through-and-through hole over the next several days. She contended that the defendant's negligence was the failure to recognize an injury during the myomectomy. The defense took the position that the enema caused the bowel to tear off the uterus, causing the hole; he supported this with the argument that there was no damage seen on the August 9 CT scan, and that there was no evidence of necrosis upon performance of the surgery by Dr. B on August 12, when the perforation was discovered, which one would expect to exist, if the injury had occurred approximately 1 week earlier.

THE DEFENSE DEALT WITH THE HURDLE of Dr. B's testimony that perforation was caused iatrogenically by pointing out to the jury that he had a choice of either blaming the defendant ob/gyn for the perforation, or acknowledging the legitimacy of the defense position that the bowel was injured when the enema was administered, and that it was rather self-evident that he would choose to blame the defendant rather than accept responsibility for an enema that he had approved for the patient. The jury accepted the defense's arguments and returned a verdict in favor of the defendant physician.

ANALYSIS

This case illustrates the importance of discovery in a rather straightforward case. The patient's credibility actually worked to the defense's favor—her acknowledgement that she was fully consented on the risks of the procedure and was offered the opportunity for a partial hysterectomy but wanted "whatever procedure" would best preserve her uterus enabled us to eliminate informed consent and a contraindicated myomectomy from the primary allegations in the case. That left the plaintiff with the argument that the defendant caused the perforation and failed to recognize it, intraoperatively, necessitating another surgery. While the testimony of surgeon B was a significant hurdle to overcome, his involvement in the decision to recommend the enema gave us the opportunity to argue that he would err on the side of avoiding self-incrimination if forced to make a choice before a jury between the defendant causing the perforation or his involvement in the approval of a procedure that harmed the patient. Furthermore, we were able to use the absence of evidence of injury on a CT scan—and the absence of the type of ischemic necrosis the patient argued caused the perforation—to support the defendant's position. Fortunately, we had a jury that remained open-minded throughout and was willing to evaluate and consider medicine and science in addition to the testimony.

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