
CASE STUDY: OBSTRUCTED URETER

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THE FACTS:

The 50-year-old patient presented to the defendant gynecologic oncologist on December 9, 1998, after being referred by her gynecologist for a diagnosis of well-differentiated adenocarcinoma of the endometrium. She had not had a regular menstrual period since September 1998 but had been experiencing persistent staining and daily vaginal bleeding since November 1998. Pelvic ultrasound revealed free fluid in the cul-de-sac and a cystic component adjacent to the left ovary. The patient had been on hormone therapy since June 1998, and endometrial biopsy was positive for "grade 1 endometrial cancer." The defendant physician performed total abdominal hysterectomy/bilateral salpingo-oophorectomy (TAH/BSO) on December 18, 1998.

According to the operative report, the procedure was intended as "Diagnostic laparoscopy and TAH/BSO," but had to be converted to an open procedure when a 10-cm cystic pelvic mass impeded visualization of the adnexa and adjacent anatomy. The patient's tubes and ovaries were found to be grossly normal and there was no evidence that the cancer had spread to the upper abdomen. The report also reflected that during isolation of the infundibulopelvic ligament, the ureter was dissected away, clamped with a Zeplin clamp, and then cut and tied. Examination of the pedicles revealed bleeding at the left pelvic sidewall, which could not be controlled despite the fact that several figure-of-eight sutures "were thrown." The bleeding finally was controlled after the defendant physician unroofed the left ureter and ligated the uterine artery and vein at the point of its origin at the level of the hypogastric artery. At the close of the procedure, the Foley was draining clear yellow urine.

The patient's urinary output in the postanesthesia care unit (PACU) was normal. Aside from complaints of incisional pain and a low-grade fever on December 19th and 20th, she was asymptomatic until December

21st. At 6:30 am that day, she complained of left upper-quadrant tenderness and had a temperature of 101.2°F. Urine culture was negative, but CT scan revealed a left distal ureteral obstruction with enlarged left kidney, distended bladder, and left hydronephrosis. A plain abdominal radiograph taken on December 22 revealed contrast in the mid and lower ureter to a point in the mid-left hemipelvis, where there was abrupt cutoff of dilatation of the mid and lower ureter. Surgical clips were seen adjacent to the site of the cutoff. A urology consult was obtained, and on December 23, the patient underwent cystoscopy, left retrograde pyelography, and urethroscopy. No suture material was found in the bladder or ureter, and the obstruction was described as "partial" as opposed to "complete." The patient was discharged home in good condition on December 24.

Because of hydronephrosis, attributed to compression from the initial stent, a new stent was placed in the woman's ureter on January 6, 1999. On June 23 of that year, she returned for ambulatory surgery for ureteral stricture, which the urologist indicated was the result of surgical clips in the area of the left ureter. On July 20, 1999, the patient was readmitted because of continued ureteral stricture, and underwent left neocystotomy and psoas hitch. She did well urologically but suffered what appeared to be a femoral nerve injury secondary to traction during the procedure. By October 1999, the problem appeared to have resolved, but "flared up" again in September 2000 and bothered the patient intermittently thereafter.

THE ALLEGATIONS:

The plaintiff primarily alleged that negligent intraoperative placement of surgical clips led to obstruction and stricture of the left ureter, leading to a need for multiple subsequent procedures, which culminated in femoral nerve injury and disability. She also asserted that the initial procedure was not necessary, given the self-contained nature of her cancer; that the defendant did not reasonably disclose the risks of the procedure; and that he delayed diagnosing and treating the obstruction, to her detriment.

DISCOVERY:

At deposition, the patient testified that given the diagnosis of endometrial cancer, she would have undergone the initial surgery regardless of the risks involved. Further, she confirmed that she did not recall reporting any physical complaints before December 21, 1998, thus eliminating both the "delay" and the "inadequate consent" theories. She confirmed that she was only occasionally troubled by her left leg, and her husband testified that she had not complained to him of physical problems in "a few years." Before the defendant was deposed, the case was reviewed by two separate gynecologic oncologists. The first opined that because of the difficulty during the initial TAH/BSO, the defendant should have recommended intravenous pyelography during the immediate postoperative period to rule out obstruction. He also felt the defendant should have suspected ureteral obstruction once the patient complained of

incisional pain that was unrelieved by pain medication, which was at midnight on postoperative day 2. He conceded that any theoretical "one-day" delay in diagnosis did not exacerbate the patient's condition or alter her treatment or prognosis.

It was the defendant physician's opinion that the obstruction was not caused by surgical clips or by the suture material causing adjacent tissue to "bunch up" and impinge upon the ureter. He felt it was either due to "kinking" of the ureter by the suture material or was secondary to inflammation caused by the suture material, and thus was unavoidable. The second gynecologic oncologist rejected that theory, insisting that suture-related inflammation significant enough to cause ureteral obstruction would not be evident within 48 to 72 hours after surgery. He was critical of the defendant's failure to unroof the ureter *before* placing suture material in the pelvic sidewall to control the bleeding and opined that this had resulted in inadvertent ureteral obstruction, devascularization, and narrowing secondary to scar tissue formation. He refuted the plaintiff's theory that the clips adjacent to the area of cutoff had caused the obstruction, and was comfortable defending the care if trial proceeded under that theory of negligence.

The plan at deposition was for the defendant physician to refute the plaintiff's allegations of malpractice, but to refrain from offering a definitive opinion about the mechanism of the obstruction. The idea was to avoid "educating" the plaintiff before trial and avoid any potential conflict with our expert's opinions. As his deposition uneventfully proceeded, the defendant became more emboldened and ultimately testified, in error, that he had *never* used surgical clips during the procedure. He then corrected himself and stated, definitively, despite the results of the abdominal radiograph and the documented opinion of the urologist, that the clips did not cause or contribute to obstruction. He concluded by offering his opinion that, in fact, it was inflammation from the suture material, and nothing else, that resulted in the ureteral obstruction. The case was settled before trial for \$55,000.

ANALYSIS:

Granted, the settlement was for a fairly reasonable amount, but this case, while borderline, potentially could have been successfully defended as "risk of the procedure." It is the plaintiff's burden to prove to a reasonable degree of medical certainty how the injury was caused and why the defendant's actions were a departure from good and accepted practice. By locking himself into a theory our experts could neither support nor defend, the defendant physician here essentially "shifted the burden," depriving himself of the opportunity to refute the plaintiff's claims of negligence while eventually offering reasonable explanations for what occurred. His opportunity to establish credibility with the jury—the most important factor in any jury trial—was gone, and without that, the case was already lost.

As an aside, the plaintiff testified that she didn't sue the urologist who injured her femoral nerve because "she liked him and he was forthcoming." To the contrary, she sued the defendant because, she claimed, "He was never up front with me about what happened or why I needed additional procedures." Words from which an important lesson can be learned!

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