



LEGALLY SPEAKING
Risk management in obstetrics and gynecology

CASE STUDY: OVARIAN CANCER

*By Susan Etra, Esq., and Andrew I. Kaplan, Esq.
Feb 3, 2003*

THE FACTS:

The patient was a 47-year-old single woman who presented to the offices of the defendant obstetrician/gynecologist in July of 1991 for evaluation of pelvic inflammatory disease/abscess. Two weeks earlier, she had been treated with antibiotics for bilateral ovarian abscesses at hospital #1 and checked herself out against medical advice. A recent sonogram reviewed at her initial visit to the ob/gyn indicated improvement in the patient's condition, and over the ensuing weeks, she returned for follow-up and ultrasonography, which revealed resolving PID.

In July of 1992, the patient complained of 4 days of lower abdominal pain and thick vaginal discharge. A CBC was obtained, a 10-day course of metronidazole and doxycycline was started, and the patient was referred for U/S, which revealed bilateral, complex, predominantly cystic masses with ill-defined tissue planes in both adnexal regions and no free fluid in the cul-de-sac. The sonographer noted that in comparison with the exam performed in August 1991, the U/S indicated that the masses might have increased in size and suggested that the differential diagnosis should include tubo-ovarian abscess (TOA) instead of endometriomas.

Because of the patient's bilateral TOAs and complaints of continuous localized abdominal pain, the defendant ob/gyn admitted the patient to hospital #2. U/S performed 1 week after admission revealed bilateral, complex adnexal masses with a small amount of free fluid in the cul-de-sac; at that time, the gynecologic resident noted a CA-125 of "181."

After the patient was discharged from the hospital in August 1992, she continued to see the defendant, who prescribed repeated follow-up U/S and CA-125 measurements. In September 1992, the CA-125 was

reported as "96"; in November 1992, it was "92."

In February 1993, examination was again notable for bilateral adnexal masses and blood work revealed a CA-125 of "387." Endometrial biopsy revealed focal adenocarcinoma in situ of the cervix and a focus of marked squamous metaplasia. The patient was admitted to hospital #2 for total abdominal hysterectomy/bilateral salpingo-oophorectomy; frozen section was consistent with stage IIIC ovarian carcinoma. The patient then began chemotherapy at hospital #3, which lasted nearly 3 months. Four more chemotherapy protocols were required when the cancer eventually spread to the woman's lymphatic system, and she died in August 1998.

DISCOVERY:

The most hotly contested issue during litigation was the contention by the defendant ob/gyn that she had discussed the results of each CA-125 test with the patient and had recommended hysterectomy and oophorectomy to the patient in August, September, and October 1992, but the patient refused each time because of a "new boyfriend" and a "new job." The patient refuted the defendant's testimony that she had ever been told the results of the CA-125 test or that surgery had ever been recommended, and her argument was supported by the lack of documentation of these conversations by the defendant in her chart.

The only documentation on the subject by the defendant was what was alleged to be a "self-serving" note written after the patient's diagnosis. However, entries in the hospital records by nursing staff supported the defendant's contentions, indicating that the patient had "verbalized apprehension about possible surgery" and that the staff "discussed the possibility of surgery" with her. After the woman's diagnosis, the defendant wrote in her hospital chart that the patient "cried and agonized about the fact that she had been postponing her surgery."

An additional focus of the discovery phase was the acquisition of all relevant CT scans and U/S in order to have an expert radiologist ascertain whether earlier diagnosis should have been made.

THE ALLEGATIONS:

The allegations surrounded delay in the diagnosis and treatment of ovarian cancer. Specifically, the patient alleged a failure to act in response to the growth of adnexal masses by virtue of serial sonography; to recommend and undertake biopsy earlier than February 1993; and that elevated CA-125 levels, in conjunction with abnormal sonography, were consistent with a differential diagnosis of ovarian cancer.

THE TRIAL:

At the time of trial, the decedent's sister testified that she was involved in the patient's course of care and treatment, and that to her knowledge, surgery had not been recommended before February 1993. At her previous deposition, however, the woman had denied all knowledge of any such information, and at the trial, she was extensively cross-examined about her prior testimony.

The patient's attorneys called an oncology expert to testify on the subject of causation (whether earlier diagnosis and treatment would have altered this patient's outcome). He opined that the ovarian cancer must have been there for 1 year, as it was stage III when it was discovered, and he provided more general testimony about cancer survival rates. The oncology expert also testified that the patient's elevated CA-125 levels and abnormal findings on U/S indicated she had ovarian cancer in the summer of 1992. On cross-examination, however, he acknowledged that those same findings were consistent with PID, for which the patient was being treated. The patient's gynecology expert testified that there was a failure by the defendant to include ovarian cancer in her differential diagnosis in the summer of 1992, and that the defendant departed from good and accepted medical practice by failing to perform laparoscopic biopsy of the ovary on the patient at that time. The defendant's expert, however, countered that given the diagnosis of probable chronic PID, biopsy of the ovary would have constituted gross departure from good care.

The defendant's expert radiologist testified first, using various radiologic films to demonstrate to the jury that the patient had, in fact, been suffering from PID during the time period in question. He also took great pains to explain to the jury that the U/S indicated the patient's condition was improving, and thus contradicted a diagnosis of ovarian cancer. Our gynecologic oncology expert supported the defendant's management and testified that this patient did not have ovarian cancer in 1992. In addition, the expert testified that even if the condition had been diagnosed 8 months earlier, the patient's course of treatment and disease process would have been the same because of the aggressive nature of the adenocarcinoma. The defendant then testified that ovarian cancer was not a consideration in July 1992 because of the diagnosis of PID and that she followed the radiologist's advice and continued to monitor the patient until the condition resolved.

Ultimately, the court ruled that the only question that would be proposed to the jury was whether the defendant gynecologist departed from good and accepted practice by not performing a biopsy in July 1992. After brief deliberation, a unanimous defense verdict was returned.

ANALYSIS:

This case illustrates a number of issues and potential complications that can arise in malpractice

litigation. First, and perhaps most obvious, is the issue of documentation and its importance. The defendant's failure to contemporaneously document her conversations with the patient about recommendations for surgery could have cost her the case, had the jury agreed with plaintiff's expert that such a recommendation was warranted in July 1992. In addition, the defendant's "self-serving" documentation of those conversations only after a diagnosis was actually rendered could have been seen by the jurors as an effort by the defendant to "cover up" her earlier failure to make such recommendations and an "admission of guilt" in having delayed recommendations for surgery. Fortunately, the significant radiology evidence supported the defendant's diagnosis and treatment, irrespective of whether earlier recommendation for surgery was warranted or made.

The case was also significant for the reliance on a "causation defense" aside from any theoretical departures. It is important to remember that even if a jury determines that a physician has departed from good and accepted medical practice in care and treatment, the patient must prove—and the jury must agree—that such a departure resulted in or exacerbated the patient's injury.

Because the jury answered "no" to the sole "departure" question, they never addressed the issue of causation, but strong expert testimony was given by the defendant's radiologist and gynecologic oncologist about the aggressive and chemotherapy-resistant nature of this cancer, which plaintiff's expert conceded. A word of caution, however: Absent "air-tight" evidence that the defendant's actions did not cause or worsen the patient's injuries, rare is the juror who will return a verdict in favor of a physician who has been found to have departed from good and accepted practice in care of a patient.

This case was tried by Susan Etra, a Partner in the New York firm of Aaronson Rappaport Feinstein & Deutsch, LLP. Ms. Etra graduated from Hofstra Law School in 1978 and spent 3 years with the Kings County District Attorney's office. She specializes in the defense of medical malpractice claims and is a clinical instructor at Hofstra Law School and The Benjamin Cardozo School of Law.

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.