
CASE STUDY: STRESS INCONTINENCE

By Andrew I. Kaplan, Esq.
Oct 1, 2003

THE FACTS:

The 68-year-old woman first saw the defendant physician in August 1993 because of a 5-year history of "losing urine" with lifting, coughing, and sneezing. In the past, the patient had used a pessary for urethrocele, without success. After attempts at more conservative measures failed, the woman underwent Cooper's ligament suspension (Burch procedure) and concurrent total abdominal hysterectomy (TAH)/bilateral salpingo-oophorectomy in October 1993.

While in the postanesthesia care unit, the patient was noted to have copious drainage of clear fluid from the incision and drain site, and intravenous pyelography and cystography showed extravasation of dye. The woman was returned to the operating room by the attending urologist, whose operative note indicated that cystoscopy revealed suture material going through and through at the level of the left hemitrigone. In addition, several chromic sutures were noted from the Cooper's ligament suspension entering into the region of the right ureterovesical junction (UVJ). The sutures on the right side were cut and the ureter completely mobilized into the bladder. The left distal ureter, partially occluded by sutures, was also mobilized and intact. The patient was discharged 10 days later with no evidence of extravasation, but with complaints of urgency and frequency that occurred every 15 to 20 minutes.

Two weeks after discharge, the patient was readmitted to the hospital because of copious drainage of urine from the incision site. Cystography revealed extravasation to the anterior aspect of the bladder and pelvic CT scan revealed extravasation from the bladder surface. The attending urologist performed another cystogram and also inserted a catheter in the right ureter. He was not able to place a catheter in the left ureter, however, because of extensive edema at the left hemitrigone. Examination of the dome of the bladder revealed evidence of a tract and a 4-cm defect but no epithelialization to the level of the skin.

After placement of a drain over the cystostomy site, the patient was returned to recovery in stable condition.

Over the next few years, the woman continued to complain of stress urinary incontinence (SUI) and urge incontinence to physicians who subsequently treated her. Urodynamic studies revealed intrinsic sphincter deficiency (ISD).

THE ALLEGATIONS:

The patient's attorneys alleged that the physician misdiagnosed genuine SUI, when in fact, the patient suffered from ISD, which merited a different form of treatment. The plaintiff further alleged that had the defendant physician done preoperative urodynamic testing, he would have discovered the true nature of her incontinence. The woman also claimed that the Cooper's ligament suspension was improperly performed, in that the bladder, ureteral orifices, and bladder dome were injured; that after completing the suspension, the physician should have performed an indigo carmine infusion to make sure that her bladder had not been injured; and that the TAH the surgeon performed was contraindicated and unnecessary. The plaintiff also asserted that complications caused by an improperly performed and contraindicated procedure severely exacerbated her prior incontinence, affecting many facets of her daily life.

DISCOVERY:

The primary goal at the patient's deposition was to confirm that the procedures performed by the physician were indicated and that he had obtained informed consent for them. We also attempted to illustrate that the woman's postoperative complaints were no worse than her preoperative complaints. To that end, the patient testified that she suffered from SUI before the October 1993 surgery and also had previously complained of urgency. She confirmed that she was frequently incontinent of urine before October 1993, and that use of the pessary and exercises to strengthen her musculature did not correct the problem. The patient further admitted that the physician had discussed with her the nature of the Burch procedure and his recommendation for hysterectomy. Records revealed that the woman subsequently had told another physician treating her that postoperatively, her urge incontinence and SUI were the same as before the hysterectomy.

The attending urologist who had performed the two reparative procedures continued to see the patient postoperatively. He confirmed that cystostomy was performed after the woman's first surgery not because of any bladder injury caused by the defendant physician, but rather, because the extent of ureteral occlusion could not be visualized on cystoscopy. This physician also confirmed that the extravasation

suffered by the patient 2 weeks after discharge was not a result of injury caused during the first surgery, but was caused by breakdown of the cystotomy site. Because of changes in the patient's anatomy due to bladder prolapse, the urologist did not think the defendant was negligent in inadvertently placing suture material in or around the hemitrigones.

THE TRIAL:

At trial, plaintiff's expert conceded that the hysterectomy played no role whatsoever in damaging the bladder during the patient's first surgery.

Plaintiff's attorney insinuated that the surgery was unnecessary, and performed only for the defendant's financial benefit. The physician argued, to the contrary, that he recommended hysterectomy to prevent any possibility that subsequent uterine surgeries would affect the ligament suspension, and to eliminate the possibility of future uterine pathology.

Plaintiff's expert could not state with any reasonable degree of medical certainty that urodynamic testing would have eliminated the SUI diagnosis and he conceded that there was no relationship between the hysterectomy and the reopening of the cystotomy. Plaintiff's expert ob/gyn said the defendant's primary departure was in surgical technique: placement of a suture through and through the left hemitrigone and of several sutures in the vicinity of the right UVJ, which caused bilateral ureteral kinking. The expert further testified that he felt Cooper's ligament suspension was contraindicated, but conceded that urodynamic testing might have confirmed SUI and did not offer the jury an alternative diagnosis or treatment plan. As a result, the defense made a tactical decision not to call the urologist who had diagnosed ISD, to avoid giving the plaintiff—and the jury—that "missing piece of the puzzle."

A Memorandum of Law submitted to the court convinced the judge that the plaintiff had failed to offer evidence of any continued incontinence or permanency of her injuries that was related in any degree to the procedure performed by the defendant. As a result, the plaintiff reduced her demand for settlement. The case was settled before the defense expert took the stand, because of concern that he would equivocate about the failure to perform preoperative urodynamic testing and the acceptability of the complications from the first surgery.

ANALYSIS:

So often in the course of litigating malpractice cases, we never truly know what allegations will be pursued until the patient's attorney delivers his or her opening statement and lays out the plaintiff's theory of the case. During the course of discovery, the defense must anticipate and investigate all of the

potential roads that may be traveled, in order to amass enough support for taking the case to verdict. Quite often, as in this case, that is simply not the safest option.

While the patient's attorney pursued the "questionable" hysterectomy with vigor at trial, in the end, the testimony damaged his ability to establish the procedure's relevance to and the permanence of his client's claimed injuries. As a result, the potential value of a verdict in the plaintiff's favor was diminished. Nevertheless, the defense still had to explain why the patient suffered the rare complication of ureteral occlusion, and in not only one ureter but two. Given that hurdle and the defense expert's likely testimony that urodynamic studies were appropriate and available to the gynecologist before surgery, we—and the physician—felt that it was preferable to settle the case for a moderate amount rather than risk "pricing" by a jury. Sometimes, the best you can hope for is a reasonable resolution of the case, rather than victory.

This case was tried by Nicholas Marotta, a partner at Aaronson, Rappaport, Feinstein & Deutsch, LLP, New York, N.Y. A 1985 law school graduate, Mr. Marotta has specialized in medical malpractice defense since entering private practice. Before joining Aaronson, Rappaport, Feinstein & Deutsch, LLP, he spent several years with the office of the Corporation Counsel of the City of New York, where he was a senior trial attorney in the medical malpractice unit.

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. He was second co-chair to Mr. Marotta during this particular trial.