IN RE:

MEDICAL REVIEW PANEL

OF

****

VERSUS

LOUISIANA STATE UNIVERSITY HEALTH AND HOSPITAL SYSTEMS
d/b/a MCLNO

PCF File No.

PANELISTS:

*****, M.D.**

*****, M.D.**

*****, M.D.**

ATTORNEY CHAIRPERSON:

*****, ESQ.**

THE FIRM

BY: _____
****

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EXHIBITS

PREFACE

On September 15, 2009, *** was admitted to the Medical Center Louisiana at New Orleans (MCLNO) where she underwent a transvaginal hysterectomy and cystoscopy for menometrorrhagia. No complications were noted and *** was discharged home, on pelvic rest for six weeks, on September 17, 2009.

On September 22, 2009, *** returned to the emergency room, complaining of abdominal and rectal pain. *** was admitted for observation and a CT scan was ordered, to rule out abscess. A CT scan was performed, and ***an abscess was in fact noted by the radiologist***. Despite this finding, *** was given an oral regimen of Ciprofloxacin during her 23 hour stay at the hospital and was ultimately discharged home with a prescription for Bactrim. Her discharge diagnosis was a urinary tract infection (UTI) status post transvaginal hysterectomy. This diagnosis was made even though the rectal pain complained of by *** should have indicated there was something else medically happening and ***in direct opposition to the radiologist noting an abscess on the CT scan results***. ***'s discharge instructions were to "resume normal activity" and "take antibiotics" even though just five days earlier she was placed on pelvic rest for six weeks, by the same facility.

*** was assessed with a white blood cell count of 18000, however, she was never re-assessed with regard to her response, if any, to the course of antibiotics administered to her during the 23 hours she was observed at MCLNO, nor was there a follow-up CT scan. At the time of her discharge on September 23, 2009, Mrs. Mossey had an identified pelvic abscess and the prescription of Bactrim (the patient's prescribed antibiotic upon discharge) provided inadequate treatment for that abscess.

On September 27, 2009, *** returned to the emergency department at MCLNO where she was admitted with a pelvic abscess, sepsis, and hypotension. *** became tachycardic and was ultimately placed on a mechanical ventilator for four days. Thus began a month-long hospitalization, replete with multiple line placements, multiple abdominal wash-out surgeries, placement of a wound-vac, and skin grafting procedures. These events were followed by years of discomfort and life-threatening conditions, while *** waited for circumstances to be correct for the repair of her ailments.

Had *** received the standard of care required for an abscess, at the time the abscess was identified on September 23, 2009, she would have avoided the entire harrowing experience, including the years of pain and fear that followed, along with the lifetime of medical problems she now faces.

STATEMENT OF FACTS

On September 22, 2009, *** presented MCLNO's emergency department, status post transvaginal hysterectomy on September 15, 2009, with the following complaints and receiving the following care:[1]

09/22/2009

ER: Complaints of abdominal/**rectal pain**

- CT ordered: rule out abscess
- Admit for 23 hour observation

09/23/2009

CT with contrast performed at 4:20 a.m.

[1] Exhibit A, Triage Notes MCLNO, 09/22/2009

- Fluid collection
- IMPRESSION: Findings consistent with pelvic abscess, as above.[2]
- ER doctors are aware of the finding of an abscess
- ***Oral antibiotics are administered (Cipro 500 mg)***
- ***Patient discharged 09/23/2009 at 18:20***
- Resume normal activity
- Take antibiotics (Meds: Bactrim x7/Motrin/Lortab)
- **Diagnosis: UTI s/p TVH** (Symptoms not consistent with UTI See, rectal pain)
- Follow up in one week with gynecological clinic

09/22/2009 – 09/23/2009

11:06 p.m.	Patient reports pain from superpubic region to rectum
12:30 a.m.	Patient's WBC is 18000
2:30 a.m.	Ob/Gyn Consult/pelvic exam deferred/CT ordered
4:20 a.m.	CT Scan performed
5:29 a.m.	**CT interpreted: Findings consistent with abscess**
6:30 a.m.	Ob/Gyn/staff/residents at bedside/Pelvic exam performed[3]

DISCUSSION OF MEDICAL CARE RENDERED

The medical providers at MCLNO determined that *** needed to be admitted for observation. During this time period, a CT scan was ordered to rule out a pelvic abscess. As evidenced by **Exhibit B**, at 5:29 a.m., the radiologist, ***, M.D. interpreted the CT Scan as

[2] Exhibit B, Radiology Report 09/23/2009
[3] Exhibit C, Admission Assessment

"***findings consistent with an abscess***." The doctors involved with ***'s care were made aware of this finding. These doctors then arranged for a course of treatment for their patient that consisted only of continued observation along with an oral course of Ciprofloxacin, 500 mg. Dr. *** made the decision to defer a pelvic exam of *** prior to her CT scan, but ultimately performed one after the findings of the CT scan were made known. According to a review of the records by Plaintiff's expert, ***, M.D., the exam ultimately performed by Dr. *** ***did not constitute a complete exam***:[4]

> **Q** Let me ask it this way: Can we tell what OB-GYN evaluation she gets between, say, midnight and the beginning of the next day on the 23rd?
> **A** No. That was the exam. She initially saw the patient, did a general physical exam without the pelvic exam when she wrote pelvic exam deferred, and then apparently she had a discussion with the House Officer 4 and/or attending, and they had her come back with the House Officer 4 and do a pelvic exam, but that pelvic exam seems **not to have included a bimanual exam**. (emphasis added)
> **Q** And that would have been the standard of care for finding out whether or not the patient responded to pain in the pelvis at the time at the site of the surgery based on what you said before, yes?
> **A** Yes. It would have been helpful to do that.
> **55:9-23**
>
> **A** They don't describe a bimanual exam where you put your hand in the vagina, feel to see if you feel a bulging of that cuff at the same time pressing down with the abdomen and see if you can feel a mass inside the pelvis, so there is no explanation of a bimanual exam.
> **28:5-9**

During her consultation Dr. *** notes the following:[5]

> ABDOMEN: Nondistended with positive bowel sounds.
> It is mildly tender in the suprapubic region, but is soft.
> **No guarding or no rebound were elicited.** (emphasis added)
> Pelvic exam was deferred.

[4] Exhibit D, Deposition of ***, MD pages indicated
[5] Exhibit E, Consultation Note of T. ***, MD

Dr. *** discussed this finding in his deposition, noting:[6]

> **A** When you look at the facts, she has a white count of 18.8, so she has an elevated white count.
>
> **Q** Okay.
>
> **A** And of course the CT scan itself came back showing an abscess, a 3.8-by-3.4-by-2-centimeter abscess, and then on the physical exam, you don't see any abdominal guarding or rebound. It means you don't have a diffuse peritonitis throughout the abdomen but that she is tender in the superpubic region in the low abdominal pelvis. So it tells you at this point it is probably at this point a walled-off abscess --
>
> **Q** Okay.
>
> **25:6-17**

> **Q** Okay. The lack of rebound pain, if I understood you correctly, in the abdomen meant she didn't have the peritonitis at that point at the time of the examination? That was the conclusion you drew; is that correct?
>
> **A** That's correct.
>
> **26:10-14**

Also, in that same consultation, Dr. *** references constipation along with a plan for dealing with it, even though the patient never complained of constipation.

Regardless of any physical examination, the diagnosis of an abscess had been made at 5:29 a.m. and the care administered to *** should have comported with that diagnosis.[7]

> **Q** Okay. So what do you do -- and let's assume these facts to be so, that you have a CT scan that suggests the potential of an abscess and you have a physical exam that doesn't reveal the abscess.
>
> **A** You still rely upon the CT scan.
>
> **Q** Okay. So the CT scan would essentially trump your lack of findings on physical examination?

[6] Exhibit F, Deposition of ***, MD pages indicated
[7] Exhibit G, Deposition of ***, MD pages indicated

A Yes, ma'am.

30:3-10

Q I am assuming from your testimony that we should assume based on the CT film that there is an abscess?

A There is an abscess present on the CT scan, so that -- in recognizing the CT scan, that is the standard of care for diagnosis because you have the diagnosis made.

Q There is no other conclusion that could be drawn from the CT other than that it is an abscess?

A ***No. The radiologist read it out as an abscess***. (emphasis added)

31:1-8

According to Dr. ***, had the patient been properly treated at this point in time, based on these findings, the potential "walled-off" abscess would never have had the opportunity to develop into the massive bowel edema, multiple pelvic abscess loculations, thickened sigmoid colon and other infections and problems caused by those infections, all of which caused great harm and suffering to ***. This breach in the standard of care directly caused a drainable, walled-off abscess to become a life threatening condition. The appropriate treatment at this juncture should have been to administer intravenous antibiotics and/or drain the abscess.[8]

Q Okay. So when -- what does the standard of care require for treatment under these types of circumstances that we have been describing?

A You can admit the patient and administer intravenous antibiotics and watch and see if the abscess resolves and gets better, but the preferred treatment for an abscess is to drain the abscess.

31:13-19

[8] Exhibit H, Deposition of ***, MD pages indicated

According to the MCLNO records, Dr. Tessie ***, Dr. ***, Dr. ***, Dr. ***, and Dr. ***, were all apprised of the radiological finding, indicating an abscess in ***'s abdomen. Despite the presence of an abscess, the course of treatment determined for *** was for her to receive Ciprofloxacin 500 mg, orally during her period of observation at MCLNO. This course of action was inadequate for the treatment of a known abscess:[9] Dr. *** explained:

> **Q** During that 23 hours, was she administered any antibiotics?
>
> **A** She was administered oral Cipro or ciprofloxacin.
>
> **Q** Is Cipro a medication that might be suitable for the purposes that you just described to me?
>
> **A** Not orally. **You can't get a high enough serum concentration with oral treatment**. (emphasis added)
>
> **32:15-22**
>
> **A** If you drain it, you can get cultures and find out exactly what organisms are causing the abscess or infection, so I favor drainage. That way you can direct your antibiotic coverage. In an abscess that drains, patients heal faster than in an abscess that is undrained. In other words, if we drain it and she gets to feeling better in a day or two, she can be discharged from the hospital where if you try to give IV antibiotics and observe it for three days or more, she is going to be in the hospital longer.
>
> **33:22-34:5**

*** was not given the proper care, in fact, the care she was given fell below the standard of care for a person with her condition. This breach led to the development of further infections, which placed *** at risk of death.

The physicians providing ***'s care discharged her, ***knowing she had a pelvic abscess***. *** was prescribed oral antibiotics (Bactrim DS, one tablet daily for seven days) for a presumed urinary tract infection upon her discharge on September 23, 2009. This diagnosis of a urinary

[9] Exhibit I, Deposition of ***, MD pages indicated

tract infection was made, despite the presence of rectal pain and despite the radiologist informing the doctors of the presence of an abscess. Per the deposition testimony of Plaintiff's expert, ***, M.D.:[10]

> **Q** Did she say where she was having pain?
>
> **A** They say it is down in the lower abdomen. Superpubic to the rectal area is the area that was commented.
>
> **Q** Okay.
>
> **A** And it is important to note they say to the **rectal area** (emphasis added).
>
> **Q** Why is that important?
>
> **A** Because that tells you it is not just the bladder -- if you have pain and UTI just in the bladder, usually your rectum doesn't hurt. It doesn't hurt that far down. It only hurts when you pee -- and that when she has Valsalva maneuvers like when she has a bowel movement, it hurts. When she does Valsalva maneuvers, that -- she is having pain in her pelvis which tells you there is some inflammatory process in the abdominal cavity down low in the pelvis like around the rectum; and when she comes in –
>
> **23:6-21**

Being discharged in her condition, with nothing more than an ineffective seven-day course of oral antibiotics, directly led to the spread of infection within ***'s abdomen. Resultantly, ***'s return to MCLNO's emergency department on September 27, 2009, at which time she was hypotensive, septic and tachycardic and required mechanical ventilation for four days, followed by a month-long hospital stay. During said hospitalization, *** endured five abdominal wash-out surgeries, wound-vac placement, multiple line placements, and painful skin graft procedures. As to the development of these terrible conditions, Dr. *** stated:[11]

> **Q** There were abscesses, other abscesses, later, correct?
>
> **A** Correct.

[10] Exhibit J, Deposition of ***, MD pages indicated
[11] Exhibit K, Deposition of ***, MD pages indicated

Q In your opinion, you believe that they came from that first one that is seen on the 22nd?

A Yes, ma'am.

39:8-13

Q I want to make sure I understand. If she had been offered and opted to the IV antibiotics route, in your opinion, there was a 50/50 chance that the secondary infections that we see on the 27th would not have occurred? Is that what you are saying?

A I think a very high likelihood of medical probability that it would not have spread, that we would have kept it contained to the pelvis.

41:9-16

Q What, in your opinion, was the probability that the infection would not have spread as was seen on the 27th?

A I mean, if we have had drainage on the 22nd?

Q Yes, sir.

A More likely than not, it would have been cured and not spread after it had been drained on the 22nd. There is always a small chance that the abscess may spread regardless of what you do, but within a reasonable degree of medical certainty, if you drain it and give intravenous antibiotics, the likelihood of it spreading is greatly reduced to less than 5 percent.

42:4-14

A But you can see from the thickened sigmoid, it takes a while for that colon to thicken like it did as a response to the inflammation.

44:8-10

The actions of the doctors and staff at MCLNO in connection with ***'s known and identified pelvic abscess constituted a breach of the standard of care for a patient with a CT scan confirmed abscess. This breach almost cost *** her life and was specifically responsible for the

medical nightmare her life became afterwards.[12] Dr. *** explained, in no uncertain terms, that the standard of care was breached:

> **Q** Okay. So tell me the opinions that you have about the standard of care as it relates to this case and that applied, in your view.
>
> **A** That the standard of care within a reasonable degree of medical certainty was not met in this case because they did not recognize that she had a postoperative intrapelvic abscess from her vaginal hysterectomy and did not receive appropriate antibiotics therapy and/or surgical drainage of this abscess; therefore, this abscess eventually spread to a generalized peritonitis that became a life-threatening infection in this lady; and within a reasonable degree of medical certainty, if she had had appropriate antibiotic therapy and/or surgical drainage when she presented on the 22nd of September 2009 to the 23rd of September 2009, within a reasonable degree of medical certainty, the subsequent peritonitis and life-threatening infection and all the medical complications that happened afterward would not have occurred.
>
> **46:9-47:1**

SPECIFIC ALLEGATIONS

DR. *

- Ignored the patient's complaint of rectal pain, contra-indicative of UTI
- Ignored radiologist diagnosis of pelvic abscess on CT scan
- Made a 6:15 a.m. decision to administer Cipro oral, 46 minutes after abscess confirmed
- Prescribed an ineffectual course of oral antibiotics, insufficient for treatment of an abscess
- Deferred a pelvic exam on a status post hysterectomy patient with abdominal pain
- Performed an incomplete pelvic exam

[12] Exhibit L, Deposition of ***, MD pages indicated

- Failed to re-assess response to antibiotic treatment
- Failed to reassess patient every four hours, as indicated on hospital assessment form
- Misdiagnosed patient with UTI, even after CT scan confirmed an abscess
- Failed to respond to patient's inquiry regarding oral antibiotics as only treatment
- Placed the life of the patient at risk by discharging with an untreated abscess
- Issued discharge instructions contrary to prior post-surgical instructions
- Directly caused the patient to become septic
- Directly caused the client to become hypotensive
- Directly caused the patient to become tachycardic
- Directly caused the patient to be subjected to multiple surgeries
- Directly caused the client to suffer ongoing, life-long medical problems
- Directly caused the client to incur, and continue to incur, medical expenses

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CONCLUSION

*** placed herself in the care of MCLNO's licensed medical professionals, believing she would receive quality care. Instead, she was subjected to a misdiagnosis of a pelvic abscess, even after a CT scan confirmed the presence of this abscess.

*** was given an ineffective course of oral antibiotics, which under no circumstances would ever have been capable of treating an abscess.

*** was not given intravenous antibiotics, nor was she provided with the proper treatment involving draining the abscess, thereby curing the problem well in advance of the life-threatening condition she was ultimately forced to endure.

*** was wrongly diagnosed with a UTI, contraindicated by her rectal pain.

*** was wrongly diagnosed as being constipated, when in fact she never complained of that condition. The hospital's own notes indicate her stools are normal.

*** was subjected to sub-par care, which breached the standard of care at every possible level. The doctors at MCLNO repeatedly failed *** in their treatment of her, to the detriment of ***'s immediate health as well as to the detriment of her long-term prognosis. In fact, On September 27, 2009, when *** returned to the hospital in dire straits, MCLNO's own paperwork indicates that her abscess had increased in size since September 23, 2009[13]; a full acknowledgement that the hospital previously discharged her with an untreated abscess.

As a result of the defendants' breaches of the standard of care, *** ultimately became septic, hypotensive, and tachycardic. *** suffered the placement of central lines, A-lines, foley catheters, intubation, mechanical ventilation, surgical abdominal wash-outs, and skin grafting.[14] *** then proceeded to live life in a constant state of fear, while awaiting the proper circumstances under which she would be able to have her condition repaired. A single unfortunate accident could have caused a rupture, with deadly consequences.[15] Lastly, ***

[13] Exhibit M, Interdisciplinary Notes, 09/27/2009
[14] Exhibit N, Select records 09/27/2009-11/03/2009
[15] Exhibit O, Photographs

ultimately underwent ventral hernia repair with bilateral component separation, muscle flaps, stratus dermal graft and extensive lysis of adhesions.[16]

Based on the facts contained within the medical records, as well as the expert testimony proffered herein, *** asks that you find in her favor that the defendants breached the standard of care in their treatment of her and that the breach caused her injuries.

[16] Exhibit P, Operative Report 05/10/2012 & Discharge Summary 05/27/2012