IN RE:

MEDICAL REVIEW PANEL

OF

****

VERSUS

*****, ET AL**

PCF File No. 2012-0***

PANELISTS:

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

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

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

ATTORNEY CHAIRPERSON:

*****, ESQ.**

THE ***

BY: _____
****

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PREFACE

***, a 21-year-old G3P1 (one previous miscarriage and one living child) became pregnant in late 2010 with twins. ***'s history included one spontaneous miscarriage in 2006 and one full term delivery via Cesarean Section in 2008.

On October 26, 2010, *** had her first prenatal visit with Dr. James ***. Her first trimester progressed without problems. *** was sent for a routine consultation with the maternal fetal medicine department of *** Hospital on January 14, 2011 when her pregnancy was at 18 6/7 weeks gestation. At this consultation it was discovered that her twins were monochorionic which placed the babies at risk for Twin to Twin Transfusion Syndrome (TTTS). *** therefore required follow up visits with the maternal fetal medicine specialists to make certain any complications could be addressed promptly.

*** placed herself in the care of specialists to ensure proper care for both of her unborn children. Unfortunately, the care that she and her children received fell below the standard of care and ultimately cost the life of one of her twins.

STATEMENT OF FACTS

On January 14, 2011, at a gestation of 18 6/7 weeks, *** was seen by Dr. ***. Dr. *** noted a discordance in the babies' growth of about 17% but stated in his notes that this level was not consistent with TTTS - the amniotic fluid levels remained reassuring.

> Ultrasound Findings:
> The estimated fetal weight is 292 grams for A and 242 grams for B. Comparing the estimated fetal weight, there is no significant pathological discordance of growth. The rate of discordance is 17%.
>
> Impression:
> Twin gestation is confirmed and appears to be monozygotic twins with diamniotic, monochorionic placentation. This type of placentation is associated with an increased risk of twin-twin

> transfusion syndrome but at the present time, there are no signs of this. However, this can develop relatively rapidly and I would like to see her back in two weeks for follow-up assessment. Twins are also at increased risk for preterm delivery and we would be assessing her cervical length at each visit.[1]

On January 28, 2011, *** had a follow up visit with Dr. ***. The following excerpt appears in the office note:

> Normal concordant growth is documented in twins that are thought to be diamniotic monochorionic. The amniotic fluid level is mildly discordant but the weights are concordant; so at the present time, there is no definite indication for the twin-transfusion syndrome. Because of this discordance of growth, I do feel we need to continue to watch her very carefully for development of twin-twin transfusion syndrome. I have asked her to return in two weeks for follow-up assessment. I have asked her to return in two weeks for a follow-up assessment (repeat sic). There are no signs or symptoms of premature labor but she is still at risk for this, and we will probably repeat her cervical length at that time. I forgot to mention that her cervical length today was normal with a cervical length of 47 mm. No funneling was seen.
>
> Comparing the estimated fetal weights between A and B, there is an 8% weight discordance, which is not a pathological discordance of growth and there is no indication of twin-twin transfusion syndrome.[2]

On ***'s fifth visit with the maternal fetal medicine specialists, on March 15, 2011, she was seen by Dr. *** in follow-up. *** was noted to be at 27 weeks and 3 days gestation. The office note reveals:

> Biometry reveals an estimated fetal weight of 970 grams (2 lb 2 oz) for twin A and 841 grams (1 lb 13 oz) for twin B. Although twin's B growth percentile is at the 20th percentile for twins, the abdominal circumference is in the 8th percentile. Because of this, umbilical artery SID ratios were obtained and these were extremely variable. There were some with intermittent absent end diastolic flow and some with elevated SID ratios from 3.38 to 5.50. A separate transvaginal ultrasound was performed and this showed a cervix which was 42 mm in length with no funneling and no changes with transfundal pressure.

[1] Office Note 01/14/11, attached hereto as Exhibit A
[2] Office note 01/28/11, attached hereto as Exhibit B

IMPRESSION:
1. Intrauterine pregnancy at 27 weeks and 3 days.
2. Diamniotic monochorionic twin gestation.
3. Possible growth abnormality of twin B.[3]

It was noted that baby B's growth continued to be less than baby A, but there was a significant difference in his abdominal circumference. This discovery led to Doppler studies of the cord which demonstrated intermittent end diastolic flow and elevated S/D (systolic/diastolic) ratios of the umbilical artery. This study suggested a possible problem with the growth and well-being of baby B and led to monitoring every week.

On March 29, 2011, at a gestational age of 29 weeks and 2 days, ***'s visit with the maternal fetal medicine specialist results in the following notation:

ASSESSMENT:
1. Intrauterine pregnancy at 29 weeks and 2 days.
2. Monochorionic diamniotic twin gestation.
3. Continued diminished fetal growth.
4. Abnormal Dopplers for twin B.

RECOMMENDATIONS:

1. In some ways, there was worsening of the Dopplers for twin B today since for the first time we demonstrated one run of reversed end diastolic flow. The full analysis of twin B's cord Dopplers continues to be heterogenous, however, as we are also getting some normal forward flow as part of the assessment. This is occasionally seen in twin gestation and likely has to do with location of the cord and possible compression from the other fetus. I am reassured, however, that the amniotic fluid volume is normal as is the biophysical profile and I performed ductus venosus Doppler, which was also normal.

2. Close surveillance is warranted and we will see her back here again in one week for a repeat evaluation. Should the rate of growth continue to diminish, likely we would be looking at admission to the hospital in the near future for more frequent Doppler assessments. Also can proceed with corticosteroids at that time.[4]

[3] Office note 03/15/11, attached hereto as Exhibit C
[4] Office note 03/29/11, attached hereto as Exhibit D

On April 12, at 31 and 2/7 weeks, *** saw Dr. *** for maternal fetal medicine follow-up. At this time the ultrasound Doppler studies results had significantly worsened in baby B demonstrating a few instances of reversed end diastolic flow in addition to absent end flow.

> IMPRESSION:
> 1. 31 3/7 weeks gestational age.
> 2. Worsening Doppler flow study values of the cord for twin B with no evidence of twin-to-twin transfusion.
> RECOMMENDATIONS: As we discussed by phone, this patient will be admitted today for more intensive ongoing fetal surveillance and I agree with your plan to complete her recently started course of Celestone.
>
> Timing of delivery will be most likely dictated by the ultrasound findings of twin B.[5]

*** was admitted to *** Hospital for "*intensive ongoing fetal surveillance.*" *She was to have an ultrasound every day* with MFM. The biophysical profile of baby B remained reassuring at 8/8. *For some reason, however, there was no fetal monitoring ordered, nor continuous fetal monitoring nor daily NSTs.*

*** had a repeat ultrasound performed with MFM on Wednesday, April 13, 2011. The results seemed slightly improved from the day prior. Whoever saw *** that day (Dr. *** and a Resident – it is unclear on the record) decided it would be okay to wait a day and repeat the ultrasound on Friday, April 15, 2011.

On April 14th there were only a few spot checks of fetal heart tones with a Doppler every 4-6 hours by the nurse. The nurses asked *** about fetal activity and she stated that she was feeling the babies move. This was documented as "stated active fetus". Baby B's heart tones were 'spot checked' at 2300 and 0357 and documented to be 160 bpm. This was the last fetal heart tone documented.

[5] Office note 04/12/11, attached hereto as Exhibit E

On the morning of April 15, 2011, at approximately 0800, *** went for her MFM visit. At that time, Baby B was noted to have died. Baby B had abdominal ascites. Baby A had nonreassuring heart tones. *** was taken for an emergency Cesarean Section.

> Dr. Newman had performed the scheduled ultrasound. At that time it was noted that there was intrauterine demise of twin B. For twin A there was some evidence of beginning ascites and pericardial effusion with decelerations. Decision was made to move to an emergency cesarean section.
>
> POSTOPERATIVE DIAGNOSIS:
> Intrauterine pregnancy at 31-6/7 weeks. Monochorionic twins. Fetal demise of twin B. Delivery of twin A, male infant, weight 3 pounds 11 ounces, vertex presentation. Delivery of twin B, male infant, intrauterine fetal demise in breech presentation. Bilateral short umbilical cords.[6]

Baby B, who was given the name Kyle, was stillborn and there were no abnormalities noted on autopsy. His chromosomes were normal.

> FINAL PATHOLOGIC DIAGNOSIS
> I. Stillborn male infant (1642 grams), monochorionic twin gestation.
> II. 31-6/7 weeks gestation,
> III. No congenital anomalies identified.
> IV. Skin tag, right ear.
> V. Normal chromosome evaluation (11-CH-186).
> VI. No evidence of infection.[7]

Baby A was named Calvin Jr. and was admitted to the NICU, where he required the assistance of a ventilator for one day.

DISCUSSION OF MEDICAL CARE RENDERED:

*** was carrying monozygotic monochorionic diamniotic twin boys. As a result, *** was under the care of maternal fetal medicine specialists beginning on January 14, 2011. The classification of this type of pregnancy is one where pre-term delivery is common and wherein

[6] Operative Report 04/15/11, attached hereto as Exhibit F
[7] Final Autopsy attached hereto as Exhibit G

there is an increased risk of the occurrence of Twin to Twin Transfusion Syndrome.

After ninety-two days of care under maternal fetal medicine specialists, *** was admitted to the hospital as an inpatient under the theory of providing intensive fetal monitoring. That intensive monitoring did not occur. In fact, the only ongoing surveillance was a quick 10 second Doppler spot check with maternal vital signs every 4-6 hours. This quick check of heart tones does not confirm fetal well-being; at best it only demonstrates that the heart rate is present. Ultrasound examinations were being performed every morning but for some reason this did not occur on the morning before the fetal demise. Perhaps the MFM doctors believed that she was on continuous fetal monitoring. Otherwise, why was she admitted? (She could have driven to the hospital every day for an ultrasound. There would be no reason to keep her admitted if not on continuous monitors.) The fact that there were no physical monitors in place would have been apparent to anyone who looked at the patient – to include all physicians who visited this patient after admission.

It was below the standard of care to fail to provide continuous fetal monitoring or even daily NSTs on the babies. The International Journal of Pediatrics outlines the following:

> When left untreated, TTTS has a mortality and morbidity of up to 90%, mainly due to preterm rupture of the membranes and miscarriage or severe preterm birth as a result of the massive polyhydramnios. ***However, intrauterine demise of one or both fetuses due to severe cardiac failure can also occur***. (Emphasis added).[8]

Knowing that *** was carrying monochorionic diamniotic twins should have been enough notice for these maternal fetal medicine specialists to be aware of the heightened need for ongoing fetal non-stress testing. In fact, *** was admitted to the hospital exactly for the purposes of monitoring. The failure to actually monitor her and her babies was a breach of the standard of care; especially in light of the episodes seen of reversed flow, which is usually a sign

[8] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2929591/#B10, attached hereto as Exhibit H

of impending complications.

Baby B "Kyle" was completely normal on autopsy. His death could have been avoided. It would have been incredibly easy and non-invasive to run the NST on the babies for thirty minutes a few times a day. When absent end flow or reversed end flow is seen, the biophysical profile should include evaluation of fetal heart tone (NSTs) along with ultrasound parameters.

Had *** been given the standard of care required for someone in her condition, her twins could have been delivered, both alive, well in advance of any tragic outcome. Because monitoring was not performed to the standard of care, Kyle Washington lost his life and Calvin Jr. lost his brother.

According to the final autopsy report, the deceased baby was at 31 6/7 gestational age. The standard of care indicates that at this stage of pregnancy, delivery of both babies was a viable option and would have prevented the loss of life of Kyle Washington.

SPECIFIC ALLEGATIONS

***, MD; ***, MD; ***, MD; ***, MD; ***, MD; ***, MD; and Dr. *** are all medical professionals who owed a standard of care to ***. Each of these doctors failed to meet that standard. *** was admitted for intensive monitoring, yet each and every doctor who encountered her as an inpatient failed to notice that she was not receiving that level of monitoring. Each and every one of those doctors had access to ***'s chart and could easily have ordered the monitoring she required, including fetal NST.

Each and every one of those doctors should have been checking fetal heartbeats due to the knowledge that cardiac issues are a known contributor to intrauterine demise (see, footnote 8, above).

Each and every one of those doctors knew that pre-term delivery of ***'s twins was already highly likely and that ***'s unborn twins were already at a viable gestational age of 32 weeks.

> 738 deaths occurred in 3760 infants born between 22 and 32 weeks' gestation during the study period, giving an overall survival rate of 80.4%. The survival rate for the 3489 (92.8%) infants admitted for neonatal care was 86.6%.[9]

None of ***'s doctors ordered the Cesarean Section delivery that would have saved the life of Kyle ***.

Upon information and belief, it is alleged that Dr.***, Dr. *** and Dr. ***, as employees of the *** failed to order continuous fetal monitoring, and or daily non stress tests to closely monitor the well-being of this twin pregnancy.

It is also alleged that Dr. ***, as ***'s admitting OB, failed to order continuous fetal monitoring and/or daily non stress testing in order to closely monitor the well-being of ***'s unborn twins. Based on available information, Dr. ***, is believed to have seen *** on April 14th, the day prior to the discovery of the fetal demise. He also failed to ensure that ***'s twins were being appropriately monitored and failed to order a daily non stress test.

It is also alleged that the employees of *** Hospital failed to conduct thorough and accurate monitoring of ***'s fetal heart tones, failed to clarify physicians orders for fetal monitoring, and failed to perform continuous fetal monitoring or daily NST's as required for the patient's condition. All of which contributed to the death of Kyle Washington.

CONCLUSION

*** was a fully compliant patient during the course of her pregnancy. *** faithfully kept her appointments with the maternal fetal medicine specialists, once a need for such was determined. *** allowed herself to be admitted to the hospital in order to receive the best possible monitoring and care for her unborn twins. ***'s condition, and that of her unborn twins, was not adequately monitored and as a result, her baby, Kyle ***, lost his life.

[9] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC28258/, attached hereto as Exhibit I

Intensive monitoring should have been conducted of ***'s twins; it was not. Fetal non stress testing should have been utilized; it was not. Lastly, and most importantly, ***'s viable twins should have been delivered in advance of the intrauterine demise of Kyle; it was not. The foregoing breaches of the standard of care resulted in the death of Kyle ***.

Accordingly, *** asks that you find in favor of her position, and against the defendants, for the loss of her beloved son, Kyle.