

Hospital discharge is followed by stillbirth

A 38-year-old woman's pregnancy was proceeding uneventfully. After about 7 months of prenatal care, she presented to her physician with persistent vaginal bleeding and abdominal and back pain. One hour of monitoring at the hospital indicated that she was not in labor and the signs of fetal well-being were reassuring. Despite continued bleeding and abdominal pain, the woman was discharged. She returned to her physician's office in early afternoon with increased bleeding and pain, and was sent to the hospital for delivery. On the way there, she suffered massive hemorrhaging due to placental abruption. Before an emergency cesarean section could be performed, the child was stillborn. The mother received transfusions for disseminated intravascular coagulation and blood loss.

Patient's claim She was discharged without a proper workup for the bleeding and abdominal pain. A sonogram should have been ordered, and she should not have been discharged.

Doctor's defense The mother's condition had improved and delivery was not imminent, so the discharge was proper. The sudden massive placental abruption could not have been predicted.

Verdict \$1,651,166 Illinois verdict.

Did MD cause kidney loss by injuring ureter?

A 36-year-old woman underwent a total hysterectomy performed by her ObGyn. A week later, she still complained about right flank pain. Additional surgery in-

dicated an atrophied right kidney and an injured ureter, and a nephrectomy was performed.

Patient's claim The physician injured the ureter during the hysterectomy, and this caused the loss of the kidney. He should have protected the ureter during the surgery—and identified the injury once it occurred.

Doctor's defense The ureter was not injured during the surgery; rather, the patient had a slow-developing ureteral blockage.

Verdict \$974,683 Kentucky verdict. Post-trial motions were pending.

\$57 million verdict after admission of fault

A 39-year-old woman was in labor for 8 hours under the care of an ObGyn, an anesthesiologist, and a nurse midwife. When the child was eventually delivered by cesarean section, he was limp and pale, with no heart rate. He was diagnosed later as quadriplegic with cerebral palsy. He has global developmental delay and both bladder and bowel incontinence, and will never walk or live on his own.

Patient's claim Despite significant abnormalities on the fetal heart monitor, labor was allowed to continue. A cesarean section should have been performed sooner. Also, it was negligent to not have specialists present at delivery; 11 minutes elapsed before a neonatologist arrived to resuscitate the infant.

Doctor's defense Before the start of the trial, all defendants conceded liability.

Verdict \$57,623,113 Pennsylvania verdict, which was reduced to \$23,000,000 under a high-low agreement.

CONTINUED

More on HIGH-LOW AGREEMENTS

Dr. Jeffrey Segal discusses whether to fight or settle lawsuits on [page 48](#) in this issue

Was hysterectomy overly invasive?

Following laparoscopic surgery, a 33-year-old woman reported vaginal bleeding to her ObGyn. Three weeks later, he performed a total hysterectomy.

Patient's claim The ObGyn made an improper diagnosis. Less invasive methods were available to address the vaginal bleeding.

Doctor's defense Treatment with less invasive procedures was unsuccessful. Also, the patient was informed of the risks before the surgery.

Verdict Kentucky defense verdict.

Undetected injury leads to extensive surgery

A woman underwent endometrial ablation, performed by an ObGyn. During the procedure, the uterus was perforated. The physician did not recognize the perforation. The ablation device was acti-

vated, and a thermal injury to the bowel occurred. Ten days later, the patient returned to the hospital with extreme abdominal pain. She was diagnosed with peritonitis and taken to surgery, where the removal of 32 cm of small intestine and repair of the colon and uterus were performed. She returned to the hospital 2 weeks after this and was hospitalized for another 2 weeks for peritonitis.

Patient's claim The physician was negligent for failing to recognize and treat the uterine perforation.

Doctor's defense Not reported.

Verdict \$245,000 Minnesota settlement was reached in mediation.

Mom blames injury on lack of cerclage

A woman who had already experienced preterm delivery was pregnant with twins and was being seen by both her ObGyn and a perinatologist. At 23 weeks' gestation, she was admitted to a hospital for bed rest. A month later, due to signs of immediate delivery, she was transferred to a hospital with a better neonatal intensive care unit. She gave birth the following day to both a healthy twin and a twin suffering an intraventricular brain bleed, leading to diplegia, microcephaly, cognitive defects, and visual problems.

Patient's claim She required cerclage for an incompetent cervix. If cerclage had been performed, the baby's injuries would have been avoided. She disputed the defendants' claim.

Doctor's defense A cerclage had been offered, but the mother declined.

Verdict California defense verdict. A posttrial motion was pending.

Did mother's behavior cause preterm births?

A woman pregnant with twins first sought prenatal care at 12 weeks' gestation, at which time she was smoking

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Anemia: Diagnosis and treatment options for women

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ANEMIA
Anemia, one of the most common disorders of the blood, is evidence of an underlying pathologic condition.

Iron deficiency, the most common type of anemia, affects up to 10% of nonpregnant women aged 12 to 49 years in the United States.

Other common types of anemia include thalassemia, chronic disease, and nutritional deficiencies of folic acid and vitamin B₁₂.

Proper therapy for anemia requires that the underlying pathology causing anemia be properly diagnosed.

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Anemia: Diagnosis and Treatment Options for Women

Anemia, defined as a deficiency in red blood cells (RBCs) or a decrease in hemoglobin (Hb), is a symptom that can result from many underlying pathologies. In clinical diagnosis and treatment, deficiencies of various nutrients may lead to the development, continuation, and deepening of the underlying pathology and be much more challenging. This newsletter uses a clinical approach to describe and explain the use of laboratory and clinical tests in the diagnosis and differentiation of various underlying pathologies of anemia, with focus on iron deficiency. An overview of the physiology of RBC production, the classification and differential diagnosis of anemia, and management of patients with anemia will also be presented.

PRESENTATION and initial examination
A 45-year-old woman, 5 feet 6 inches tall and weighing 200 pounds, presented because of decreased and irregular menses that began approximately 2 years ago. The patient complained that her menses stopped when she began over-to-be her stress and exhaustion might. She had a changing sensation in her feet and noted that she was frequently tired toward the end of the day. She does not have any positive symptoms on physical exam, except that she had lost 20 lbs in the last 2 years. She had been associated with some dizziness during the last 2 to 3 days of her menstrual cycle. This has been ongoing for the past 2 years. The patient had been separated from her husband for a year and lives alone. She has been unemployed and is somewhat depressed about the separation. On physical exam, she had a normal weight, normal blood pressure, normal heart and lung sounds, and normal abdomen. The abdomen does not show any organomegaly, but there is a normal size, and there is no splenomegaly. The central nervous system exam shows normal sensory function to light touch and the brain, cerebellum, and spinal cord, and the brain being normal.

DISCUSSION and clinical diagnosis
Anemia is a common clinical diagnosis because it is a symptom of many primary and secondary causes. The prevalence of iron deficiency anemia in the United States is about 10% in women aged 12 to 49 years.

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half a pack of cigarettes a day. At 27 weeks, ultrasonography indicated that both twins were growing normally, although twin B had duodenal atresia and polyhydramnios. It also showed that the mother had a shortened cervix. To avoid preterm delivery, she was placed on strict bed rest. She presented at the hospital a few weeks later with vaginal pressure with contractions. She was placed on a fetal monitor, given tocolytics to stop contractions, and prescribed betamethasone to mature the twins' lungs. Later records indicated that she had been non-compliant regarding bed rest and smoking cessation. She was discharged with no sign of contractions. Several weeks later, she was admitted to the hospital with diarrhea and contractions. Again she was administered tocolytics and betamethasone; a fetal monitor was placed and biophysical profiles were obtained. On day 4, the fetal monitor showed nonreassuring signs and did not always monitor both twins, so a cesarean section was scheduled for 4:10 PM. The

delivering OB arrived at 5:20 PM and delivered the twins, now at 30 weeks' gestation. Both showed signs of decreased oxygenation and were placed in the neonatal intensive care unit. Twin A developed meningitis 9 days later; a brain scan indicated hypoxic-ischemic encephalopathy. Twin B was discharged after 44 days, and twin A after 66 days.

Patient's claim The babies suffered metabolic acidosis, so they should have been delivered a few days earlier. The fetal monitors were not functioning properly all of the time. Also, the mother was compliant while she was hospitalized.

Doctor's defense Because of the twins' prematurity, an earlier delivery was contraindicated. Twin A's brain injury occurred 10 to 14 days before birth. The twins' deficits were due to both genetics and the mother's smoking and noncompliance. Twin B had no brain injury, and her mild condition was a result of prematurity.

Verdict \$2,250,000 Michigan settlement.

Midwife and nurse deliver CP baby

A 20-year-old primigravida went to the hospital in labor at term. A midwife and nurse examined her, conducted fetal monitoring, and administered oxytocin to enhance labor. The child was delivered about 24 hours later. He was diagnosed with spastic quadriplegic cerebral palsy, is almost blind, and will remain in diapers.

Patient's claim Failure to recognize signs of fetal distress and summon an obstetrician was negligent. Oxytocin contributed to a fetal heart rate deceleration, at which time an obstetrician should have been called and oxytocin discontinued.

Doctor's defense An obstetrician was not needed. The fetal heart rate never decreased to an unsafe level, and oxytocin did not affect the fetus. An infection caused the cerebral palsy, the onset of which occurred 24 hours prior to birth.

Verdict Pennsylvania defense verdict. A posttrial motion was pending. ■

Differentiating Leg Disorders

Understanding Impact and Improving Patient Outcomes

Supplement to
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Differentiating Leg Disorders

Understanding Impact and Improving Patient Outcomes

Introduction and Commentary
by Ronald T. Burfman, MD

- With Heavy Steps: Diagnosing Leg Edema
EMILE R. MOHLER III, MD
- Diagnosis and Management of Sleep-Disturbing Leg Cramps
W. LARRY SVETKEY, MD
- An Exhausting Urge to Move: Sleep and Leg Disorders
MICHAEL J. THOMPSON, MD

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