

Why wasn't bloody nipple discharge taken more seriously?

DUE TO BLOODY DISCHARGE from her left nipple, a woman in her thirties had a mammogram; results were suspicious for malignancy. Her surgeon's examination and biopsy were negative.

Two years later she found a lump in her left breast. Ultrasonography suggested a benign mass at 9 o'clock. Her surgeon could not find a mass at 9 o'clock, but detected a mass at 7 o'clock. He ordered US-guided core biopsy of the 9 o'clock area, but not the 7 o'clock mass—she was instructed to return for removal of the 7 o'clock mass regardless of the biopsy's outcome. She was impatient for the biopsy, and went to another surgeon. Biopsy results were negative for malignancy.

Months later, during right breast implant replacement, she had the left-sided mass excised. Pathology reported moderate to poorly differentiated infiltrating carcinoma. She underwent a left mastectomy, prophylactic right mastectomy, and chemotherapy.

▶ **PATIENT'S CLAIM** Further evaluation of her original complaint of bloody nipple discharge by her surgeon would have led to earlier diagnosis.

▶ **PHYSICIAN'S DEFENSE** The left breast mass was never biopsied because the patient didn't return as instructed.

▶ **VERDICT** A Pennsylvania defense verdict was returned.

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Uterine artery severed, new mother dies; court mandates changes

THE UTERINE ARTERY WAS SEVERED during cesarean delivery in a 32-year-old woman, causing severe hemorrhage. The ObGyn repaired the uterine vessels in the OR. The patient was sent to the recovery room and then to the surgical ICU, where she was in severe hemorrhagic shock, hypotensive, tachycardic, and had minimal urine output with metabolic acidosis. Exploratory surgery revealed massive blood clots. A trauma surgeon, called in by the ObGyn, found an extensive hematoma and 2 to 3 L of blood in the retroperitoneum. The woman died within 24 hours of delivery.

▶ **PLAINTIFF'S CLAIM** When repairing injuries that occurred during the cesarean, the ObGyn damaged retroperitoneal uterine arteries. Physicians in the recovery room and surgical ICU informed the ObGyn that the patient appeared to have internal bleeding, but he did not return her to the OR for over 6 hours. After consent for exploratory surgery was signed, the ObGyn left to deliver another baby. The recovery room's OBIX Perinatal Data System monitors failed to accurately record the patient's vital signs. Understaffing in the surgical ICU impaired treatment.

▶ **DEFENSE CLAIM** The ObGyn's responsibility for the patient was transferred to the recovery room's attending doctor, who claimed he had discharged his responsibility when he recommended exploratory surgery. After viewing the patient's chart in the surgical ICU, a surgeon told the ObGyn that immediate treatment was needed for internal bleeding. The

hospital claimed staffing issues did not cause the patient's death.

▶ **VERDICT** The burden of a \$5.2 million settlement was shared by the physicians and hospital. The hospital was mandated to 1) establish an annual lecture on patient safety; 2) purchase a maternal/neonatal simulator to train staff; and 3) change the default settings on all OBIX Perinatal Data System machines to prevent them from defaulting to record normal values for vital signs when the "add" button is pushed.

Severe pain and burns during biopsy and genital wart removal

BIOPSY AND GENITAL WART REMOVAL were performed on a 34-year-old woman without anesthesia. She screamed in pain when the ObGyn biopsied her labia. Pain increased when he removed warts using a trichloroacetic acid mixture. Acid ran into the patient's vagina and onto her buttocks, causing second-degree burns.

▶ **PATIENT'S CLAIM** The physician never offered anesthesia, nor did she refuse it. The acid should have been applied more discretely. The paper toweling used to clean up the acid was just moist and could not have caused the acid to spread.

▶ **PHYSICIAN'S DEFENSE** The ObGyn stated he preferred not to use anesthesia because it might affect the pathology slide quality, but that he offered it to the patient, and she refused. He also claimed that he applied the acid carefully, and attributed the spread and burn to a nurse who brought wet paper towels to dry the patient.

▶ **VERDICT** A Tennessee defense verdict was returned. ❌