
Leave No Stone Unturned

By Tim Rector, JD, MBA

The wise old saying “leave no stone unturned” is said to mean that one should do everything possible to find something or to solve a problem. Well, we will see in the following claim that is very wise advice.

This case involved a 45-year-old male who underwent routine treatment for a left ureteral stone. The patient presented to the urologist on May 10 with a chief complaint of kidney stone. His past history was noteworthy for a well-documented episode of ureterolithiasis four years prior, high blood pressure, and asthma. In any event, the patient had an abnormal urinalysis so an Intravenous Pyelogram (IVP) was performed. This revealed a left ureteral calculus with obstruction. The urologist planned to perform cystoscopy with stent placement and Extracorporeal Shock Wave Lithotripsy (ESWL) on the following day (May 11). However, the procedure was rescheduled for May 12 because the patient was not NPO, and the plan called for use of general anesthesia. At this juncture, no antibiotics had been prescribed.

During the evening of May 11, EMS was called because of the patient’s seizure activity, nausea, vomiting, and left lower quadrant abdominal and back pain. The Emergency Department physician diagnosed pyelonephritis, left ureteral calculus, and hypertension. The supportive laboratory data revealed that the urinalysis was markedly abnormal with pyuria, proteinuria, and cultured positive for E. coli. The patient was discharged home after receiving fluid resuscitation, several injections of Dilaudid, Zofran, and IV Levaquin.

The following morning, on May 12, the patient then presented to the Outpatient Surgery Center. Upon arrival, his vital signs indicated a blood pressure of 118/81, pulse 95, respirations 18, temperature 97.6, and O₂ sats of 96%. He was given Cipro 500 mg p.o. The anesthesiologist performed a pre-anesthetic evaluation, noting a normal heart and lung examination, and the patient was classified ASA 1. He then underwent cystoscopy, left ureteroscopy, dilation of the mid-urethral stricture, laser stone ablation and extraction and stent placement without complication. Post-operatively, the patient began to have difficulty at 09:50. He was given Narcan repeatedly in an attempt to arouse him. Upon arousal, his respiratory rate was elevated at 40 breaths per minute, and he was coughing up pink frothy mucus. At 10:15, his oxygen saturation was low at 82, and the patient stated, “I can’t breathe. I’m working too hard.” The anesthesiologist was paged to the Recovery Room where it was noted that the patient’s lips were blue. Lasix 40 mg IV was administered along with Albuterol. By 11:00, the patient stated he was breathing better. However, the O₂ sats still remained low at 90% with a respiratory rate as high as 30 for the next two hours. At 14:00, a chest x-ray showed the presence of pulmonary edema. The

urologist made the decision to transfer the patient to a higher level of care hospital at 14:10. This was accomplished at 16:10.

Upon arrival at the hospital, the patient's vital signs indicated blood pressure of 84/50, pulse 107, respiratory rate 24, O₂ sats 83%, WBC of 13,300, and D-dimer was elevated at greater than 5,000. Arterial gases revealed hypoxemia and acidosis. The patient was clearly in shock.

He was admitted to the Intensive Care Unit for treatment of pulmonary edema, sepsis, and renal failure. A CT scan revealed the ureteral stent had perforated the proximal ureter. At 18:40, the patient coded, and he never recovered neurologic function. He expired 3 days later. An autopsy revealed no MI, no PE, no pneumonia, left pyelonephritis, and the ureteral stent perforation of the left ureter at the ureteropelvic junction, with abscess in the perirenal fat.

A lawsuit ensued naming the treating urologist and the anesthesiologist as defendants. The surgery center nurses had reportedly begged for the patient to be transferred to a higher level of care as the patient's situation continued to decline. The chief obstacle in defending the urologist was her absence of an abdominal examination at any time during the post-operative period. The urologist relied entirely on the anesthesiologist to manage the patient's obvious post-operative difficulty, and never did she consider an operative complication. Experts criticized the urologist for her lack of insight into this possibility. A low index of suspicion probably prevented her from obtaining a simple CBC with differential while the patient was in the Recovery Room. Had this been done, it would have indicated the presence of infection and sepsis. Consequently, this omission prevented the urologist from recognizing the need to transfer the patient to the hospital at an earlier time.

This case seems to exemplify a situation in which continuing to seek any conceivable explanation for the situation (or turning over more stones) would have been wise. Unfortunately for both the patient and the urologist, her false assumption that the patient's decline had to be anesthesia-related rather than a surgical complication resulted in the missed opportunity to reverse the outcome.

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