Summary Judgment Saves the Day

By Tim Rector, JD, MBA

Mary is a 60-year-old female who brought suit against a cardiologist alleging he failed to timely diagnose and treat her retroperitoneal hemorrhage following a cardiac catheterization. Unfortunately, for Mary, this alleged failure to diagnose and treat her resulted in a cascade of multiple medical/surgical conditions.

Mary arrived at the emergency department of a rural hospital on June 1 with complaints of chest pain, numbness, 9 of 10 pain in her left arm, shortness of breath, and diaphoresis. Mary had a prior history of hypertension, emphysema, atrial fibrillation, Coumadin therapy, prosthetic valve replacement, high cholesterol, and a heart catheterization two years prior. Mary was diagnosed with acute myocardial infarction (MI) and was given a heparin bolus and drip, Retavase, and Lopressor.

Mary was transferred to a larger hospital where she was taken for emergency left heart catheterization with coronary angiography which showed severe three vessel disease. Angioplasty was not performed because it was felt that Mary would be best served by a coronary artery bypass graft. The sheath was pulled with manual pressure applied for 25 minutes; hemostasis was noted. Heparin was restarted, and documentation in the nursing notes indicated several times that her groin site was without complication. An echocardiogram revealed an ejection fraction of 40-45% with inferior hypokinesis, mild to moderate mitral and tricuspid regurgitation, and a right ventricle systolic pressure measurement of 40-50 mm suggesting pulmonary hypertension. The CABG procedure was planned for the following week to allow Mary time to recover from her acute MI. The plan was to keep Mary on heparin while she was off Coumadin. On June 2, Mary complained of back pain. On June 3, she was noted to be hypotensive and complained of right groin pain. The cardiologist ordered discontinuation of the heparin drip, and an IV fluid bolus was given (normal hemoglobin of 14 and hematocrit of 41). The following day, June 4, the heparin drip was restarted. By June 7, Mary's hematocrit dropped to 24.8 (normal range 34.9-44.5) so she was transfused with red blood cells. Mary continued to complain of back pain and developed a decrease in urinary output with a WBC of 31,000 (normal range 3,500 to 10,500). On June 9, a CT of the abdomen reveraled a retroperitoneal hematoma compressing the bladder and rectum.

That day, a general surgeon recommended holding heparin for 12 hours with transfusion of packed red blood cells. The surgeon determined that Mary was not a good surgical candidate due to the recent MI. On June 10, the heparin drip was restarted and a renal consult was obtained due to worsening renal insufficiency. Over the next few days, Mary's condition gradually improved. However, her condition deteriorated on June 17 when she

developed hematuria and bloody diarrhea. A GI consult was obtained as well as a tagged red blood cell study, which revealed no evidence of bleeding. Her heparin drip was discontinued. An EGD showed a duodenal ulcer. On June 18, Mary developed a colovaginal fistula and underwent an exploratory laparotomy with colostomy and sigmoidectomy; the pathology report showed acute necrotizing colitis. She next developed a right pleural effusion requiring chest tube placement on June 28. Mary was ultimately discharged on July 8 with follow-up on her Coumadin, beta blocker and statin therapy, as well as physical therapy. On August 8, she was able to ambulate with a walker. A cystoscopy subsequently showed a vesicovaginal fistula and enterovaginal fistula. These conditions prompted the cardiologist to transfer Mary to a larger cardiology group practicing at a tertiary hospital that could provide her with more specialized care. Here, Mary underwent treatment for the fistulas including the new condition of pyelonephritis. In November, a cardio stress test showed no evidence of ischemia, so Mary was deemed an appropriate candidate for surgery for her cystectomy and ileal conduit, and a proctectomy that occurred four months later. During litigation, Mary did not yet have the CABG procedure."

What did the experts say after Mary filed her lawsuit? There was no real debate that the combination of Retavase, aspirin, Coumadin, and intravenous heparin likely contributed to the retroperitoneal hematoma. Retroperitoneal bleeding is a known, albeit relatively rare, complication of a cardiac catheterization. When the general surgeon was consulted, she believed that Mary was an inappropriate surgical candidate given her recent MI. Therefore, plaintiff's counsel argument that an earlier CT would have made a difference was a red herring. The debatable issue came down to a matter of opinion as to whether or not her heparin should have been discontinued and for how long.

The plaintiff's only expert on standard of care and causation was a cardiovascular surgeon, whose deposition testimony contained several mistakes that damaged the plaintiff's case. He stated he did not consider himself an expert in cardiology and, more importantly, he had no experience in dealing with fistulas, conditions involving vaginal and bladder ischemia, although he opined these were complications of the hematoma and could have been prevented. Based on these statements, the trial court excluded the plaintiff's expert from testifying on causation since his opinions lacked reliability. The expert was simply ill-prepared to give a deposition. As a result, our cardiologist was granted a summary judgment by the trial judge, thus ending the case. But for the summary judgment, this was a case that could have gone badly for the physician at trial, especially if Mary had a colostomy and was dependent upon a walker in the court room. The lesson learned here is to take seriously the preparation efforts in answering discovery or the giving of a deposition during the litigation process.