Unexpected Outcome: Risk of the Procedure or Negligence?

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It has been said that the bone that separates the brain from the ethmoid sinus cavity is as thin as a potato chip. In this case the plaintiff had an ongoing and worsening sinus condition and elected to undergo sinuplasty. Since the ethmoid bone was more deteriorated than expected, our insured otorhinolaryngologist (ENT) had to remove or clean out the infected areas to a greater extent than planned. The ethmoid bone was described as “spongy”. After debriding the ethmoid cavity, the ENT noticed some dural dehiscence which he patched with a flap from the middle turbinate. The plaintiff appeared to tolerate the procedure well and regained consciousness but suddenly became unresponsive. The ENT ordered an emergency CT scan which revealed an intraparenchymal hematoma. The plaintiff was life-flighted to another hospital and underwent an emergency craniotomy in which the neurosurgeon evacuated a hematoma from the left frontal lobe, cauterized a bleeding branch of the anterior cerebral artery and repaired two small dural defects. This procedure went well, and the plaintiff went to recovery in critical but stable condition. While the plaintiff initially experienced confusion

and an altered mental state, a later CT showed significant improvement.

In the lawsuit that followed, the plaintiff alleged that the ENT penetrated his brain with either an instrument or caused the ethmoid bone to penetrate the brain. According to the plaintiff, penetration of the brain by either the ethmoid sinus bone or by an instrument was not a recognized risk of the procedure and was evidence of negligence by the ENT. The plaintiff maintained he suffered permanent and severe cognitive dysfunction.

Our ENT was adamant that he did not penetrate the plaintiff's brain with either an instrument or bone fragment. He characterized the ethmoid bone as so riddled with infection that debridement was the only proper way to treat the infection. The defense took the position that intracranial hemorrhage is a rare, but recognized risk of an ethmoidectomy. Counsel intended to prove that the cerebral artery was not lacerated by an instrument but was cut when the ENT was repairing the dural defect with a skin flap which contained a small piece of bone. This method of repair, the defense asserted, was appropriate. Further, if there was a cerebrospinal fluid leak after the surgery, it is not evidence of negligence by the ENT surgeon, but instead resulted from an ethmoid sinus bone that was so severely infected and deteriorated that it could not withstand the procedure.

Roadmap to Success

This case illustrates how early decisions, thorough preparation, commitment by the physician to defend his care, and good judgment calls can bring success in litigation. Very importantly, the ENT recognized the complication during the surgery and repaired the area in question. Then, when the patient's condition declined, a CT was emergently obtained showing the hemorrhage, and the patient was life-flighted to a facility where an emergency craniotomy was performed. The physician took emergent and appropriate action in handling the complication from the outset. These actions were not only lifesaving, but they helped minimize the patient's injuries as much as possible. Even though the patient's prognosis initially did not seem encouraging, he eventually made a very good recovery, and while he alleged that he was greatly compromised, other factors were identified that could be responsible for his complaints.

Defense counsel assembled an impressive lineup of experts. Four ENT surgeons including the defendant were prepared to testify for the defense. Their opinions included that the procedure was medically indicated for chronic and unresolved sinusitis and that the efficacy of ethmoidectomy for the treatment of this condition is recognized. There was good documentation that the defendant physician informed the patient of a variety of risks accompanying the procedure including the risk of bleeding, the possibility of additional surgeries and even death and obtained the patient's informed consent to move forward with the surgery. The defendant physician responded appropriately to the dural dehiscence during the surgery and the repair with a flap from the middle turbinate was appropriate. Further, the ENT took all necessary measures in responding to the patient's sudden decline following the ethmoidectomy. An injury to the dura occurred during the surgery, but injury to the dura during ethmoidectomy is a recognized risk as are

complications that can result from injury to the dura including intracranial hemorrhage. During an ethmoidectomy, it is necessary to remove small pieces of bone with the endoscope and removal of this bone can result in small defects in the dura which produce cerebrospinal fluid leaks. Contrary to the opinion of the plaintiff's experts, an injury such as this does not indicate the defendant ENT was negligent. Intracranial hemorrhage from ethmoidectomy is not a routine risk but it is a risk that is recognized in medical literature. One of the plaintiff's ENT experts asserted that the defendant ENT penetrated the patient's brain with an instrument, and opined that he saw necrotic brain tissue. In contrast, the defense had an ENT expert available to opine that the brain was not penetrated with an instrument and that what was seen was more likely inflamed dura that was healing.

A neurosurgeon expert for the defense was prepared to testify that the intracerebral hematoma resulted from the compromise of the cerebral artery following the repair of the dural dehiscence and despite the cerebral artery injury, the defendant's repair was appropriate. Violation of the dura, including an intracerebral hematoma, is a known risk of an ethmoidectomy. He refuted the plaintiff's experts that the laceration to the cerebral artery was caused by an instrument or that the defendant injured the patient's brain with the endoscope. A neuroradiologist for the defense opined that nothing on the CT or MRI following the ethmoidectomy showed that the brain was directly penetrated or damaged by an instrument or that the brain appeared to be "chewed up."

Preparation and training by the defendant physician gave him the stamina to face the rigors of trial. The defendant testified for one full day and half of the next. He not only survived this grueling challenge but did well. Stamina also became very important as the trial that was forecasted to last five days lasted nine. Throughout the entire litigation process, the physician remained resolute and insisted on having his "day in court."

Even with extensive planning, defense counsel must make judgment calls because of the unique situations that develop during trials, and react to situations, opportunities and events that are not foreseeable. They also must make judgments on how they think the jury is receiving the evidence and when the jury has heard "enough" evidence. Here, one expert testified all day and connected with the jury so strongly, the defense decided not to put on one of its other ENT experts. The defense felt like the jury "got it" and putting on the other expert would be counterproductive. In another instance, evidence presented by the plaintiff was admitted that the defense strongly believed should not have been admitted. Counsel and the defendant weighed their options. In their favor, they felt they had a good jury and their proof was going in well. The question arose: should they seek a mistrial or see the case through to the verdict? After careful consideration by the defendant and his defense attorney they decided to "take their chances" and continue with the trial. The choice was a good one. After nine days of trial, the jury returned a defense verdict in one and one-half hours. The plaintiff did not appeal the verdict, and our ENT was naturally very happy with the outcome.

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