Closed Claim Review: Good Things Come for Those Who Persevere

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The rural surgeon took the patient to surgery around midnight. Her condition was miserable: relentless nausea, vomiting, and dry retching. The hour may have been late, but the patient was prepped and had been NPO after a previously done scope. The surgeon had placed the patient on several antiemetics, and he wanted to give those time to work, but the patient changed her mind and asked him to operate. She was tired of dry retching.

Approximately four years earlier, the patient had undergone an elective laparoscopic Roux-en-Y gastric bypass by a different surgeon. She was in her forties, morbidly obese, smoked two packs of cigarettes per day, and suffered from hypertension and chronic bronchitis. Her post-operative course after the gastric bypass surgery was uneventful. Prior to the gastric bypass, she was hospitalized for paresthesia of her right arm and leg. Approximately three years after her gastric bypass, the patient began a repetitive course of hospitalizations for nausea and vomiting.

During one of the hospitalizations, the surgeon in this case performed an EGD which showed gastric anastomotic ulcers at the site of the prior gastric bypass and the formation of a blind pouch at the site of the jejunum and the stomach pouch. An incisional hernia was also discovered. Several days later the surgeon performed a laparotomy in which he excised the blind pouch, explored the anastomosis, repaired the incisional hernia, and lysed adhesions. Her immediate postoperative course was uneventful; however, about two weeks later she was hospitalized for severe nausea and vomiting. The patient underwent numerous workups and tests. The anastomosis was narrowing; ulcers appeared to be the culprit. Thus, the surgeon cut the vagus nerves to the stomach to keep the ulcers from coming back, removed the old anastomosis, and created a new anastomosis so that food could pass through. Nonetheless, the patient's persistent nausea and vomiting continued.

During the surgery that is the focus of this suit, the surgeon considered that the patient could have an efferent blind loop of the residual stomach. A CT scan showed the residual nonfunctional stomach to be dilated and distended. A significant portion of the patient's stomach was disconnected from the gastric pouch. The residual nonfunctional stomach was created in the original gastric bypass surgery by stapling across the stomach and connecting the residual upper part of the stomach to the bowel thus creating the gastric pouch; it currently served no purpose. An informed consent was obtained, and the surgeon removed the stomach remnant –the gastric pouch the bariatric surgeon previously created was not removed. An examination of the stomach remnant by the surgeon did not reveal any obvious problems: no issues with the mucosa, no tumors, and the pyloris was grossly unremarkable. Pathology indicated active gastritis with reactive epithelial changes. The nausea and vomiting completely stopped for eight days.

However, eight days later the patient returned to the hospital with nausea and vomiting. During this encounter, the patient was observed by a nurse putting her finger down her throat to make herself vomit. The patient said this helped relieve pressure on her stomach. The patient continued to be hospitalized for nausea and vomiting. An allergy to Lortab was considered, and the surgeon noted that while the patient complained of persistent nausea, he never saw her vomit in his presence.

In the lawsuit the patient alleged that the surgeon failed to consider alternative surgical treatments that were less drastic than removing the stomach, failed to obtain informed consent before completely removing her stomach, and removed her stomach based on an erroneous assumption that she was suffering from an efferent blind loop of the residual

stomach.

Defending this case presented several challenges. The surgeon had treated the patient during several hospitalizations without success which could subject him to criticism for not referring her back to the bariatric surgeon. The surgery to remove the stomach remnant was only two weeks after the surgeon performed the reconstruction of the anastomosis. For this he could be criticized as being too aggressive, not allowing time for further evaluation and conservative treatments before performing another major surgery. Another potential criticism was whether surgery to remove the remnant was justified. Some words the surgeon used in his charting were problematic. In particular, in his records he stated that he performed a total gastrectomy or removal of the stomach when in fact he only removed the remnant portion—not the portion fashioned by the bariatric surgeon. The fact the surgery began so late in the evening seemed unorthodox for nonemergent surgery, and while the surgeon contended that he obtained informed consent, the patient had been on morphine and other drugs which could undermine the validity of the consent. The plaintiffs had expert witnesses to support their criticisms of the care.

Despite the challenges, there were strong points. Foremost, the surgeon was absolutely steadfast in his desire to go to trial. Two very good experts supported the surgeon on the standard of care and causation aspects of the case. They were very effective witnesses at trial as was the defendant surgeon. The surgeon is a long-term member of the community, is well-liked, and has earned a reputation for credibility. A defense verdict was returned after two hours of deliberation. Some comments after the trial included that the surgeon is considered to be an excellent physician, and a potential juror commented that this surgeon had prayed with him before he underwent surgery. Although the patient's treatment course had been long and complicated and certain aspects of the care were criticized, the jury believed that the surgeon had the patient's best interests at heart and used his skill and expertise to try to improve her condition. With the defense verdict, they confirmed the surgeon's belief that he had met the standard of care in his treatment of the patient. Defending the case took a great deal of time, effort, and an emotional toll on the surgeon, but it was worth it in the end when the jury confirmed that he had made the right decisions in treating the plaintiff and in defending his care through trial.
