

# MILLION DOLLAR CASES - WHAT CAN BE LEARNED?

## Million Dollar Cases – What Can be Learned?



Figure 1.

## CASE #1

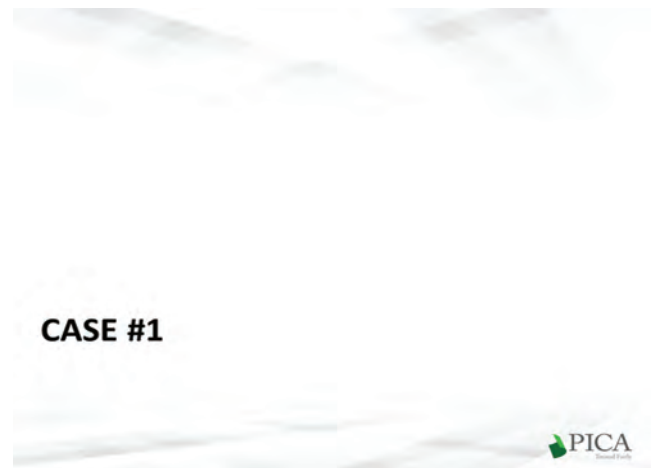


Figure 2.

### The Patient

- 68-year-old male, married, retired
- Medical history
  - Insulin dependent diabetes
  - Hypertension
  - Chronic renal failure (on hemodialysis)
  - Peripheral neuropathy
  - Peripheral vascular disease (s/p femoral artery bypass)
  - Anemia
  - Hyperparathyroidism
  - Hyperlipidemia
  - Diverticular disease
  - Mild pulmonary hypertension
  - Past smoker

Figure 3.

### Initial Visit

- C/O right heel pain of one year's duration and visible limp
- Palpable mass and atrophy of the fat pad, R heel, but x-rays did not reveal mass
- Diagnosis – probable plantar fibrolipoma
- Treatment plan – chemical sclerosing injections

Figure 4.

### Treatment

- 7 injections every 2 wks. for 6 months
  - Pt. had progressive significant improvement
- Pt. returned four months after completion of chemical sclerosing injection therapy stating localized sharp heel pain returned with weightbearing one month ago.
  - Vascular status
    - CFT < 3 seconds
    - Bilateral & symmetrical warmth
    - Dorsalis pedis & posterior tibial pulses 1 / 4 on right foot
  - Treatment options discussed – decided on surgery
  - Pt. referred to PCP for medical clearance

Figure 5.

### Pre-op Visit Day Prior to Surgery

- PCP clearance report reviewed
  - “No palpable pulses in feet”
  - Did clear pt. for podiatric surgery
- Exam
  - Non palpable dorsalis pedis and posterior tibial pulses

Figure 6.

## Surgery & Post-op

- Excision soft tissue on plantar aspect of R heel
  - Uneventful surgery
  - Vicodin & prophylactic Keflex prescribed post-op
- 6 days post-op
  - Pt. c/o sharp pain on bottom of R heel when walking
  - Pain level 5/10
  - Podiatrist advised he was putting too much weight on the heel - Prescribed Percocet in addition to the Vicodin
- 11 days post-op
  - Continued pain in R heel – pain meds not helping
  - Pt. admitted to walking and placing weight on his heel
  - Podiatrist prescribed knee walker for complete non-weightbearing



Figure 7.

- Pt. missed next appt.
  - Office mgr. called pt's wife
    - Pt. had had been admitted to hospital
    - Wife was informed the podiatrist did not have privileges at that hospital and should ask someone there to look at the wound
    - Asked wife to call when pt. was discharged from hospital
- Patient never returned



Figure 8..

## Subsequent Treatment

- Hospital Admission – Acute CVA
- Two days later - transferred to another hospital
  - LE eval. remarkable for open wound on R heel with a cool foot, nonpalpable pulses and inaudible with Doppler
  - Next day – Right BKA due to wound infection and osteomyelitis in heel
  - Developed acute vascular compromise on left with failed to improve with artherectomy
  - L transmetatarsal amputation → L BKA



Figure 9.

## Lawsuit Filed Against Podiatrist

- Pt. alleged he required bilateral below knee amputations as a result of complications from the elective surgery performed by the podiatrist
- Allegations against podiatrist
  - Negligent performance of elective surgery on a patient who lacked palpable pedal pulses
  - Failure to obtain a vascular consult or additional diagnostic testing



Figure 10.

## Defense Expert Witness Opinions

- Podiatrist
  - fell below the standard of care in not obtaining vascular clearance before performing elective surgery.
- Vascular
  - could not support decision to perform heel surgery & surgery was cause of right BKA
    - Too many red flags: Previous bypass, diabetes, older patient, on dialysis – indicated need for vascular consult prior to surgery.
  - felt L BKA was unrelated to surgery



Figure 11.

## Subsequent Treater's Opinion

- Breach of standard of care to perform elective foot surgery on patient lacking palpable pedal pulses.



Figure 12.

### Defense Team's Conclusions

- Clear liability for the insured based on his decision to proceed with an elective surgical procedure on a diabetic patient with documented non palpable pulses.
- It could be argued that the PCP shares liability based on his clearance of the patient for surgery, it is not possible or prudent to attempt to argue away the insured's ultimate responsibility for the decision to proceed with surgery. Doing so would likely inflame a jury and result in a significant adverse damage award.
- Case should be resolved expeditiously.



Figure 13.

### Outcome

Resolved for \$1,000,000



Figure 14.

### What Can We Learn From This Case?

- Perform and document thorough H&P prior to surgery
- Obtain appropriate pre-surgery consultations and medical clearance
- Don't proceed with surgery against your better judgment even if you have "clearance"



Figure 15.

### CASE #2



Figure 16.

### The Patient

- 60-yr-old married male, employed
- To podiatrist for 2<sup>nd</sup> opinion re: ankle fusion
- 6'2"/ 265 lbs.
- Family history
  - Older brother died from blood clot
  - Younger brother died from MI
- Medical history
  - Hypertension
  - Elevated cholesterol



Figure 17.

### Initial Visit

- Pt. c/o severe pain around the anterior talofibular ligament and the calcaneal fibular ligament
- R ankle pain, swelling, instability
- X-rays →
  - severe sharpened fused ostrigonum causing posterior impingement syndrome
  - large dorsal exostosis on the talus causing anterior impingement syndrome
  - large spur on the lateral aspect of the talus causing lateral impingement syndrome



Figure 18.

### Initial Visit (cont.)

- Treatment options discussed including:
  - Conservative care (bracing and more supportive shoe gear)
  - Surgery, including associated risks and benefits
- Pt. elected surgery
- MRI ordered →
  - Moderate combination of brawny edema
  - Reactive synovitis and synovial hyperplasia in soft tissues around lower leg & ankle
  - Significant and progressive degenerative arthritic changes involving the ankle mortise, subtalar joints, mid-tarsus & tarsometatarsal articulations



Figure 19.

### PCP Visit 4 Days Later

- Regularly scheduled appt. for check-up and to review blood work that had been drawn a few days earlier



Figure 20.

### 3 Days Later

- Back to podiatrist for pre-op consultation - informed consent obtained
- Surgery Center called the PCP's office asking them to fax the patient's H&P and recent blood work
- PCP instructed his staff to send the latest progress note and results of the latest blood work.



Figure 21.

### Surgery Performed The Following Week

- Right ankle arthroscopy
  - Excision of os trigonum
  - Excision of calcaneal spur
  - Excision of talar spur, dorsal and lateral
  - Excision of fibular spur
  - Hypertrophic synovectomy
  - A Brostrom of ATFL
  - Drilling of osteochondral defect
- Pt. placed in below knee cast and instructed to return in 1 wk. for initial post-op appt.



Figure 22.

### 1 Day Post-op

- Podiatric assistant called patient to check on him.
  - Pt. reported no pain or swelling
  - He was keeping his foot elevated and using walking aids
  - Stated his general condition was "great"



Figure 23.

### 2 Days Post-op

- Patient's wife called podiatry office – spoke with staff member.
  - Patient "feeling weird" - foot did not hurt, but his body "felt funny"
  - Wife thought husband's symptoms could be related to anesthesia wearing off, but could also be related to a blood clot since her husband's brother died of a blood clot after knee surgery.
  - Staff member told wife that the podiatrist was not in the office, but another doctor was present and could see the patient or she could take her husband to the ED (patient chose not to go to the office or the ED)



Figure 24.

### 8 Days Post-op

- Patient passed out in his home
- EMS found pt. to be in cardiac arrest → CPR
- To ED via ambulance
  - Noted to have R lower leg edema
  - Resuscitation efforts unsuccessful
  - Wife stated pt. had complained of pain & swelling of the right leg that morning
- Autopsy → death resulted from PE that originated as a DVT in the right lower extremity.



Figure 25.

### Lawsuit Filed Against Podiatrist & Corporation

- Allegations
  - Failure to order preoperative testing for coagulation disorders given family history of blood clots
  - Failure to place patient on anticoagulants postoperatively
  - Failure to provide adequate follow-up care postoperatively
  - Failure of office staff to instruct patient to go to the hospital emergency department immediately when wife called to report unusual symptoms



Figure 26.

### Problems with Defense

- Defense podiatric expert did not think pre-op testing for coagulation disorders or post-op anticoagulants was required by SOC, but if pressed, would have to admit he would have prescribed post-op anticoagulants in this case.
- Defendant podiatrist testified in deposition:
  - Pt. had risk factors for development of DVT/PE
  - He did not communicate his concerns to the pt's PCP either verbally or in writing
  - Pt. did not receive formal medical clearance for surgery



Figure 27.

### Problems with Defense (cont.)

- PCP testified in deposition:
  - He was aware pt. would soon have foot/ankle surgery, but did not think he had come to see him for preoperative medical clearance.
  - No one from the podiatrist's office contacted him or his office staff about the patient's upcoming surgery
  - If it had been a pre-surgical visit, he would have ordered additional tests and would not have cleared him for surgery until those tests were completed.
- Office staff member who spoke to the patient's wife did not insist that the pt. come to the office or go to the ED, nor did she relay importance of seeking immediate care



Figure 28.

### Outcome

Resolved during mediation for \$1,500,000

- \$1,000,000 on behalf of podiatrist
- \$500,000 on behalf of corporation



Figure 29.

### What Can We Learn From This Case?

- Obtain & document thorough H&P and screen pts for DVT/PE risk factors
- Include risk of DVT/PE in informed consent discussions
- If pt. is at risk for DVT/PE, consider implementation of DVT prophylaxis based on level of risk
- Be aware of signs & symptoms DVT/PE
- Educate patients regarding signs & symptoms and what to do if they occur
- If DVT/PE is suspected, immediately refer pt. to hospital for further testing



Figure 30.

## What Can We Learn From This Case?

- Instruct staff to consult physician whenever doubts about proper instructions
- Timely review & co-sign documentation of advice given to patients by staff members.
- Clearly communicate reason for referral with referral physician
- Develop system to track referrals
- Develop system to ensure patients scheduled for surgery have appropriate paperwork prior to surgery



Figure 31.

## CASE #3



Figure 32.

## The Patient

- 32-yr-old female, married, salesperson
- Charcot-Marie-Tooth disease
- Smoker
- Hx.
  - Triple arthrodesis, bilat.
  - Jones tenosuspension, right



Figure 33.

## Initial Visit – 3/19/06

### Actual Note

This 32 year old female with Charcot-Marie Tooth diagnosed at Children's Hospital.

Patient seen for complaint of pain in bilateral feet.

Objective findings: Vascular: DP 2/4 bilateral PT 2/4 bilateral

Cyst on anterior ankle/dorsal foot

HT 2-5 with tight EDL

Prominent met 1, pain

+ callous

Hammertoe 2-5, tight EDL

Coleman block test – heel comes out of various

X-ray: previous triple with Jones teno suspension

Osteo with bone resection Left

Assessment: CMT

Plan: Discuss options with patient; discuss surgery with patient.



Figure 34.

## 4/13/06 – Surgery Right Foot

- Dorsiflexory osteotomy of 1<sup>st</sup> metatarsal with plate fixation
- Partial resection of the 5<sup>th</sup> metatarsal base
- Hammertoe repair of the 2<sup>nd</sup> – 5<sup>th</sup> digits
- Removal of a ganglion



Figure 35.

## Post-op

- Tissue necrosis distal aspect of the 3<sup>rd</sup> & 5<sup>th</sup> toes, eventually resolved
- By 7/10/06 (3 mos. Post-op), noted recurrent contractures of toes 2-4



Figure 36.

### 9/5/06 – Surgery Left Foot

- Cole osteotomy
- Dwyer calcaneal osteotomy
- Jones tendosuspension
- Fusion of the hallux interphalangeal joint
- Hammertoe repair of 2<sup>nd</sup> – 5<sup>th</sup> digits
- Exostectomy of bone from 5<sup>th</sup> metatarsal base
- Application of external fixator



Figure 37.

### Post-op

- “Blue toe 3<sup>rd</sup> digit → wire removed with success
- 10/12/06 – external fixator removed
- 2wks. later, screw started to back of L hallux & was removed.
- 11/6/06 – pt. diagnosed w/stress fracture of L 5<sup>th</sup> metatarsal base
- 2wks. later, noted screws backing out of calcaneus
- 12/8/06 – screws removed from calcaneus & entire remaining segment of the 5<sup>th</sup> metatarsal was removed



Figure 38.

### 4/3/07 – Surgery Right Foot

- Revisional fusion of the 2<sup>nd</sup> toe
- Ostectomy of 3<sup>rd</sup> toe
- Additional removal of bone from 5<sup>th</sup> metatarsal base & cuboid
- Removal of painful screw
- Excision of a ganglion



Figure 39.

- 4/16/07 – pt. complained of pain with weight bearing on the left foot.
- 1 mo. Later – pt. stated her left foot felt sprained
- 7/13/07 – podiatrist diagnosed nonunion of the L Cole osteotomy



Figure 40.

### 10/23/07- Surgery Left Foot

- Repair of nonunion of the Cole procedure
- Dwyer osteotomy
- Bunionectomy
- Hammertoe repair of 4<sup>th</sup> toe
- Application of external fixator



Figure 41.

### Post-op

- The bone never healed
- Pt. developed a rocker bottom foot with subluxation at the naviculo-cuneiform interface medially & the cuboid 4<sup>th</sup> metatarsal interface laterally
- 6/9/08 – significant instability at the anterior ankle noted



Figure 42.

## Subsequent Treatment

- Pt. saw three orthopedic foot and ankle surgeons – all recommended a left below knee amputation
  - Left foot grossly deformed and dramatically smaller and shorter than the right
  - Left foot has little to no functional value



Figure 43.

## Lawsuit Filed Against Podiatrist

- Allegations
  - Failure to obtain and document an adequate history and perform and document an adequate initial physical examination
  - Performance of a major reconstructive surgery on a patient who was relatively stable in the absence of sufficient indication to do so.
  - Removal of too much of the navicular during the 9/5/06 surgery, and being otherwise negligent in his surgical technique



Figure 44.

## Allegations (Cont.)

- Failure to be more aggressive in his efforts to get the patient to stop smoking
- Negligence in performing surgery on a heavy smoker
- Prescribing steroids and NSAIDS within close proximity to the initial left foot surgery.
- Failure to diagnose a nonunion in a timely fashion following the 9/5/06 left foot surgery



Figure 45.

## Allegations (Cont.)

- Failure to obtain adequate correction of the deformity and being otherwise negligent in his surgical technique in the revision surgery.
- Failure to diagnose a non-union in a timely fashion following the 2007 revision surgery.



Figure 46.

## Problems with Defense

- The plaintiff identified highly qualified, nationally and internationally recognized standard of care experts who fully supported the allegations
- The defense had the case reviewed by 2 orthopedic foot and ankle surgeons and two podiatric physicians for defense – none could support care
- The defendant's documentation was sorely lacking – did not justify decision to perform extensive surgery
- Significant damages – grossly deformed foot with specter of a looming amputation



Figure 47.

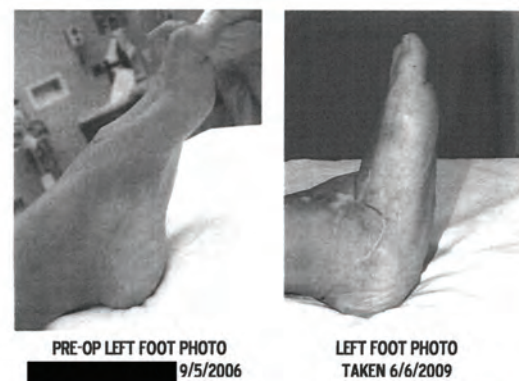


Figure 48.



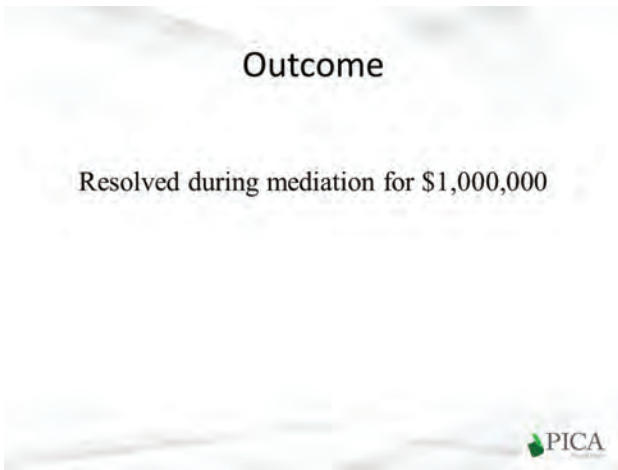


Figure 49.

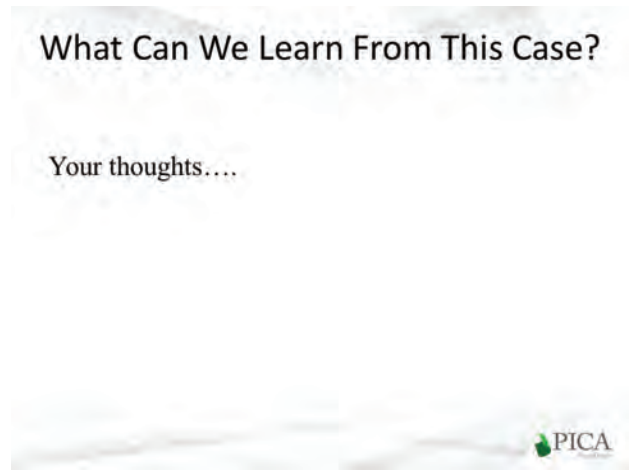


Figure 50



Figure 51.