

CASE REPORTS FOR 2016

CASE NO. 1

A 46 year old female presented with pain in the right hypochondrium, dyspepsia and fever. The total WBC count was raised; ultrasound of the abdomen revealed a gall stone with a normal bile duct. The liver function tests were normal.

Diagnosis: Acute Cholecystitis secondary to gall stone disease.

TREATMENT

- I.V. antibiotics
- Laparoscopic cholecystectomy: findings:
 - a) Omental adhesions to an intra – hepatic gall bladder were released.
 - b) Thickened gall bladder, intra hepatic, with a 2.0cm diameter gallstone.
 - c) Difficulty was encountered in dissecting the intra-hepatic gall bladder.
 - d) After the cholecystectomy an absorbable surgical sponge was placed on the raw surface of the liver bed.
 - e) Peritoneal washout was done.
 - f) The liver bed appeared dry and the abdomen was closed.

POST-OP PERIOD

- I.V. antibiotics continued
- Prolonged paralytic ileus; intermittent fever
- Diarrhea on 3rd to 5th postop day.
- She was discharged on 6th postop day.
- She returned on the 7th postop day with abdominal pain, bloating sensation and distended abdomen.
- Ultrasound of the abdomen revealed free fluid in the peritoneum and pelvis.
- The patient was advised to be re-admitted for further treatment
- She declined and sought treatment at another hospital where a C. T. scan of the abdomen confirmed she had a bile leak and 3 litres of fluid in the abdominal cavity .
- The 3 litres of fluid was drained and an ERCP was done and a stent inserted for the bile leak.
- Patient's daughter wrote a letter of complaint to the medical director of the hospital.

COMMENTS

1. In view of the omental adhesions and the intra-hepatic gallbladder an open cholecystectomy should have been done rather than to persist with the difficult dissection of an intra-hepatic gall bladder which could lead to complications – which did occur.
2. The gall bladder bed was raw and the surgeon should have been aware of the possibility of bleeding post operatively.
3. The post op prolonged paralytic ileus and diarrhea were not aggressively and timely investigated to a exclude perforated gut or a bleeding from the gall bladder bed or a bile leak.
4. C.T. scan or ultrasound of the abdomen should have been done earlier before her discharge
5. It is unlikely that the patient will file a civil suit as her post op complications have been successfully treated.

CASE NO. 2

A 61 year old man with diabetes mellitus, hypertension, dyslipidemia and coronary artery disease (CABG done in the past) presented on 5th December, 2013 with:

- a) Neck pain and right shoulder pain.
 - b) Low back pain; pain to the right lower limb on walking.
- MRI Cervical Spine: Multiple disc bulges, worse at C₃.C₄, to cause severe spinal stenosis.
Diagnosis: Cervical Spondylosis
 - MRI Lumbar Spine: Multiple disc bulges, worse at L₃.L₄, to cause spinal stenosis.
Diagnosis: Lumbar Spinal Stenosis
 - The cervical spondylosis did not respond to analgesics and physiotherapy. Cervical facet block with lignocaine and triamcinolone relieved the symptoms.
 - He was to be reviewed on 15th December, 2013.
 - He turned up on 14th December, 2013 with an acute low back pain.
 - Analgesics were prescribed. He was to be admitted on 16th December, 2013 for the lumbar spinal operation.

Admitted on 16th December, 2013:

- Afebrile
- Hb: 13.1 gm/l, WBC: 17,300, RBS: 17.4 mmol/l.
- Anaesthetist and physician cancelled the operation to control the diabetes and treat the infection.

17th December, 2013:

- Afebrile
- Pulse: 133/mins, BP: 158/103 mm, FBS: 15.0 mmol/l, WBC: 21,000, ESR: 73 mm/1st Hour
- Diagnosis: Septicemia – Parenteral antibiotics were started.

18th December, 2013:

- Repeat MRI Cervical Spine excluded infection in the neck.
- Primary site of infection could not be established.
- He was discharged on 27th December, 2013.

15th January, 2014:

- Reviewed by the orthopaedic surgeon.
- Planned for admission on 19th January, 2014 for lumbar spinal operation on the 20th January, 2014.

Admitted 19th January, 2014:

- Afebrile
- Wasted left calf muscles, grade 4; deep tendon reflexes of lower limb normal.
- Unable to extend the lower limbs due to pain.
- HB: 8.1 gm%, WBC: 10,900. HbA1c: 7.3%
- Two units of whole blood were transfused.

- Post transfusion HB 9.4 gm%.
- Febrile with spiking temperature.
- Operation again postponed as the patient was unfit.

23rd January, 2014: Patient requested to be transferred to a government tertiary hospital.

13th February 2014: Patient was seen at a government tertiary hospital.

- Diagnosed as Septic Arthritis of the left hip joint with the joint eroded!!
- Arthrotomy of the left hip joint, drainage of the pus and continuous irrigation to control the infection.

20th February, 2014: A left total hip replacement was successfully done.

COMMENTS

1. The clinical judgement of the orthopaedic surgeon was dismal.
2. The cause for sepsis should have been established before scheduling him for operation. MRI's have excluded infection in the cervical or lumbar spine.
3. Insufficient efforts were made to locate the source of infection.
4. The septic arthritis of the left hip joint was not treated appropriately for one year, resulting in destruction of the hip joint which required a total hip replacement.
5. The clinical examination was poor. Despite the patient's "inability to extend the left lower limb" he did not focus on this. If he had done a straight leg raising test, which is a normal procedure in a low back pain patient, he would have located the pain to arise from the hip joint. A plain X-ray would have shown the septic arthritis.
6. This patient suffered for more than a year.
7. It appears that the surgeon was too eager to operate on the lumbar spine despite the vague symptoms of a spinal stenosis.

CASE NO. 3

26th November, 2009: Orthopaedic surgeon treated a 33 year old man with pain in the right arm after pushing a car.

30th November, 2007: The man fractured his right humerus in a motor vehicle accident. This fracture was plated at another hospital and it has united.

4th December, 2009: In view of the persistent right arm pain the orthopaedic surgeon removed the plate from the humerus after taking INFORMED CONSENT (the risk of radial nerve palsy was categorically stated in the consent form).

The risk of radial nerve palsy was also forewarned to the patient and this was recorded in the clinical notes.

Postoperatively the right radial nerve palsy did develop.

He was referred to a neurologist. A nerve conduction test was done. It confirmed that the radial nerve was severed.

The patient was referred to a hand surgeon for a tendon graft to correct the nerve palsy – the patient declined.

4th September, 2014: The orthopaedic surgeon receives a WRIT OF SUMMONS.

COMMENTS

1. MDM defended the case as INFORMED CONSENT was taken – a very rare occasion.
2. The Judge in her judgement dismissed the patient's claim as there was no breach of duty of care as the informed consent was obtained and the orthopaedic surgeon has treated the patient to the best of his abilities during the course of the treatment given in accordance to Standard of Care and Skill required.
3. It is unusual to damage the radial nerve in removing a plate from a united fracture of the humerus.
4. MDM wishes that all member and doctors doing any invasive procedure should take INFORMED CONSENT. This will successfully help to defend medical negligence suits (Please see Case No. 5).
5. The Malaysian Courts are now relying on ROGERS V. WHITANER rather than BOLAM on consent. The former makes it easier to successfully sue doctors for negligence.

CASE NO. 4

17th December, 2009: an orthopaedic surgeon performed a lumbar laminectomy with fusion and pedicle screws insertion on a 43 year old female.

- 5 days postoperatively a haematoma was evacuated from the surgical site.
- She was discharged two days later.

2nd January, 2010:

- The sutures were removed.
- Back pain and leg pain persisted.

23rd January, 2010:

- Back pain and leg pain persisted.

17th February, 2010:

- Back pain and leg pain persisted.
- She was walking normally.
- There was no neurological deficit of the lower limb.

25th February, 2010:

- Fluctuant swelling over the spinal incision.
- The abscess was drained and the pedicle screws were removed.
- Antibiotic therapy was started.

15th April, 2010:

- A sinus persisted at the surgical site.
- Patient requested for referral for a second opinion.

3rd November, 2011:

- Sought treatment at a university hospital.
- Admitted for surgery to eradicate the infection.
- Operation was cancelled due to upper respiratory tract infection.

9th May, 2013:

- She returned to the university hospital with severe back pain and bilateral claudication of the lower limbs associated with a discharging sinus over the lower back.

MRI confirmed a left paravertebral psoas abscess extending to the subcutaneous region of the lumbo sacral area.

25th October, 2013:

- Drainage of the psoas abscess; removal of chronic sinus wall.
- Removal of “gauzes” from the left psoas.

- Debridement of the lumbar spine.
- A full course of antibiotics.

7th October, 2014: The orthopaedic surgeon received a letter of demand.

18th December, 2015: he received a Writ of Summons.

COMMENTS

1. The cause of the infection was the retained gauze (non-ray tagged gauze was used); despite the pedicle screws which were removed earlier.
2. Plain X-Rays of the L.S. Spine will not show non-ray tagged gauze.
3. The hospital and orthopaedic surgeon were liable for using non-ray tagged gauzes in such a major and deep operation. Ray tagged abdominal packs should have been used.
4. The orthopaedic surgeon should have done a repeat MRI which would have shown the “foreign bodies”.
5. The orthopaedic surgeon and the hospital are liable for the “incorrect” swab count.
6. The poor patient suffered for almost four years; partly due to her procrastination in the delay to seek timely treatment.
7. The member could not be defended. The hospital is also liable. The suit was settled out of court with a 50% contribution from MDM and a 50% contribution from the hospital.
8. In an infected surgical wound in the presence of foreign bodies (gauzes, pedicle screw in this case), ALL foreign bodies must be removed otherwise the wound will not heal and the infection cannot be controlled. (Please see Case No.5)

CASE NO. 5

4th September, 2009: An orthopaedic surgeon A did a total hip replacement on a 37 year old lady with a right dysplastic hip joint and a postero-superior wall defect. The defect was bone grafted.

Postoperatively the right hip pain was partially relieved.

On repeated follow ups the hip pain persisted.

10th March, 2011: Orthopaedic surgeon A referred the lady to orthopaedic surgeon B.

23rd April, 2011: Orthopaedic surgeon B did a revision total hip replacement under antibiotics cover. The operation took five and a half hours.

6th May, 2011: The patient was discharged.

11th May, 2011: The patient presented with wound discharge, fever and a WBC count of 20,000. The THR was infected.

13th May, 2011: Pus was drained from the wound; wound debridement was done and gentamicin and vancomycin cement inserted into the wound. C&S grew M.R.S.A.

19th May, 2011: The wound healed.

16th August, 2011: The patient presented with a pointing abscess at the hip wound.

From 18th August to 7th September, 2011 she had four debridements with incomplete removal of the components of the total hip replacement.

2nd July, 2013: The patient sought treatment in Australia. The hip joint was debrided and all components of the “hip joint” and foreign bodies were removed.

5th November, 2013: A revision THR was successfully done in Australia.

24th August, 2015: Dr. A & B were served a WRIT of SUMMONS.

COMMENTS

1. Infection in a joint replacement is a disaster.
2. One of the risks and complications in a joint replacement is infection.
3. The risk must be informed to the patient and this must be documented – INFORMED CONSENT.
4. Neither Dr. A or Dr. B took this INFORMED CONSENT.
5. The hospital is also liable for the “hospital acquired” infection – M.R.S.A. M.R.S.A. infection in a joint replacement invariably leads to a failure.

6. In debriding an infected implant all components of the implant must be removed. Otherwise the infection will not be controlled – as seen in this case. She had 4 debridements and not all the components were removed. (Refer to Case 4)
7. The suit could not be defended and it was settled with contribution from Dr. A and Dr. B and the hospital.
8. Had INFORMED CONSENT been taken the suit would have been successfully defended. Please see case study No. 3.