MEDICAL MALPRACTICE
SCREENING REPORTS

copyright 2012 Pat Iyer

Patricia Iyer

www.patiyer.com

Pat Iyer.com

Med League Support Services

www.medleague.com
260 Route 202/31, Suite 200
Flemington, NJ 08822
Tel: (908)788-8227
Fax: (908)806-4511
ml@medleague.com

July 12, 2011

Frank Peterson, Esq.

County Fair Building

548 Oliver Ave, Suite 4
Bugsy, PA 19067

Re: Rita Quimby

Dear Mr. Peterson,

Thank you for the opportunity to screen the above matter. My board certified internal medicine physician reviewed the voluminous records we received. He looked at the following documents:

1. Complaint filed by Mr. Francis E. Peterson, Jr., Esq., Attorney for Plaintiffs, In the Court of Common Pleas of Philadelphia County, Pennsylvania, February Term 2011

2. Office Records of Pennsylvania Cardiology regarding Janice Quimby from 9/11/2007- 12/11/2008

3. Hospital Admission Records of Pennsylvania Hospital 4/15/2007-6/20/2007

4. Hospital Admission Records of Pennsylvania Hospital 1/17/2008-1/31/2008

The information included in this report represents our physician's opinions. He *did not find a viable claim.*

Since the records span a rather large time period and include two hospital admissions, the first of which is over two months long, there is no easy way to summarize the case though I will do my best.

Ms. Rita Quimby was an 82-year-old woman with numerous medical problems that included congestive heart failure, atrial fibrillation, end stage renal disease requiring dialysis, an ankle fracture, obstructive sleep apnea, severe pulmonary hypertension and breast cancer who had initially been admitted to Pennsylvania Hospital (referred to from now on as PAH) on 4/12/2008 from Liberty Court, a skilled nursing facility, for what was deemed a congestive heart failure exacerbation. She had severe right sided heart failure and severe pulmonary hypertension on this admission. She received IV Lasix to induce diuresis. While treatment improved her shortness of breath from her heart failure, her kidneys began to fail and she required dialysis. A left arm AV fistula was placed for dialysis access.

On this admission she had obstructive sleep apnea and a CPAP mask with breathing apparatus was recommended. She had a lung abscess secondary to pneumonia and was treated with IV antibiotics. Ultimately, she was discharged to her home with a home health aide and home health services on 6/20/2008.

There were no records supplied to us to me regarding the interim condition or outpatient medical course of the patient so I cannot comment on them other than to note that she had been discharged with understanding that she would receive dialysis Mondays, Wednesdays and Fridays from that point forward. During this hospitalization, it was noted by hospital staff that the patient's son, Peter, appeared to be the family member most involved with her care, and is the power of attorney. He requested that Ms. Quimby not be referred back to a skilled nursing facility and instead decided she should be discharged home with home health services. Moreover, it was documented that Mr. Quimby "gets loud and anxious when facilities are discussed."

Subsequent records submitted to me for review pick up at another admission (I assumed there were no interim admissions to PAH or other facilities though I have no documentation supporting or discrediting that) to PAH, this time on 1/19/2009. She was admitted at that time with a syncopal or "fainting" episode in dialysis that day. She was found to be in rapid atrial fibrillation with a fast heart rate and low blood pressure. She was admitted from the ER to a telemetry floor but went to dialysis first from the ER before she arrived on telemetry.

Due to the fast heart rate and low blood pressure when she arrived on the telemetry unit, she required monitoring in an intensive care unit setting which is referred to in the notes as the "Special Care Unit" or SCU which I'm assuming are one in the same though I would need more information regarding the level of care there. Based on the hospital records, the physician accepting care of Ms. Quimby to the SCU titled his accepting note "ICU Transfer Note". Over the next days, her heart rate was slowed with medications and her blood pressure remained on the low side anywhere from 70's-low 100's/40's-50's but she was asymptomatic and appeared to have an ongoing low blood pressure. Ms. Quimby was also anticoagulated with IV heparin and oral coumadin. Ultimately, Dr. Kerron Catlyn, her hospitalist physician during that admission, ordered on Wed 1/28/09 that patient could be transferred to a telemetry level of care. "Continue telemetry but transfer to floor".

The patient did well after this except for one episode on 1/30/09 where her blood pressure went down to a systolic number in the 70's and she was given 25% albumin solution. Her blood pressure went up to 93/54. She had reported feeling a "little sick" earlier in dialysis that day.

The main issues of negligence in the case as alleged by Mr. Peterson concerns Ms. Quimby's arrangements regarding home care services, when she was discharged and her level of care before discharge, monitoring of her anticoagulation now that she was on coumadin, discharge of Ms. Quimby to her elderly brother rather than son, Peter, and an arm infection which Mr. Peterson is alleging to have lead directly to her demise on 2/3/09 at PAH after being discharged 1/31/09.

I should note, there were no records submitted for my review from Ms. Quimby's presentation to PAH on 2/2/2009. Those records would be very helpful in evaluating Ms. Quimby's condition on that presentation and whether an arm infection was directly involved in her deteriorating condition and her overall medical status at that time. Should those records become available, I would be happy to review them and take them into consideration in formulating an opinion.

Careful review of Ms. Quimby's hospital records regarding the above charges of negligence revealed the following:

1. Ms. Quimby is documented as having low blood pressure on a number of occasions and was largely asymptomatic. She ran low blood pressures most of the time without any symptoms. Though it is alleged that she was discharged too soon without any step down unit in the interim, it is documented that she was ready to go to a floor bed with telemetry on 1/28/09, three days before discharge. Whether or not a telemetry floor became available is irrelevant as it did appear she was stable enough to go to a step down unit even though she may never have physically gone to the step down unit. Dr. Caitlon's actions appear to be within the standard of care here.

2. It is clearly documented by Social Worker, Jennifer Evans on 1/30/09, that she met with the patient, spoke with Ms. Quimby's son, Peter, and had gone over the discharge plans with him including where the patient was going, which Ms. Quimby would receive, and who would be providing the services. It is not clearly documented who the patient is supposed to leave with. She was supposed to be discharged on 1/31/09 at 11 AM, transported by Absolute Ambulance Co. and to have home health provided by Penn Care at home with dialysis at Davita Franklin dialysis. It would seem from this note that Peter Quimby was comfortable with this plan, or I believe Social Worker James would have documented otherwise. Penn Care at home was to start services on 2/3/09, 3 days after Ms. Quimby would have arrived home. This appears to my medical expertise to be within the standard of care.

   Only two days would have passed between her discharge and being seen by a home health provider. Moreover, it is unclear what type of supervision she had at home. I would assume that her son, as involved with her care as he was, would have made an effort to see her – if not on her day of discharge, than a day or so later at most. It was also possible for a family member, be that the patient's brother or son to call 911 and have her transported to the nearest hospital should she have fallen ill. It would appear that Ms. Quimby had adequate home health arranged for her, and it did not appear that her son specified that she should not be discharged to anyone but his care. According to the notes, the ambulance pick up on the day of discharge was scheduled for 11 AM and Peter Quimby was aware of that but apparently was not present at the time the ambulance arrived.

3. As far as an arm infection goes, again, there is no documentation that has been submitted for my review regarding the admission to PAH on 2/2/09 where this is alleged. Moreover, documentation by the RN discharging Ms. Quimby on 1/31/09 mentions no noting of decubiti, or sores. There is mention of ecchymoses on Ms. Quimby's arms but that is common after a hospitalization of an 83 year old woman where blood draws and IV sites are frequently followed by ecchymoses or "black and blue" marks. Given this information, I cannot say whether Ms. Quimby had an arm infection in the first place and hence should have been on antibiotics as alleged in the complaint, and certainly not whether it was causal in her demise.

4. It is alleged that Ms. Quimby's blood level of coumadin was very high at her presentation to PAH on 2/2/09. Again, I have no documentation of this. Moreover, it appeared that her protime and INR were monitored daily through her day of discharge, her last INR was 2.4 which is in the therapeutic range, and the standard of care regarding anticoagulation was followed as well.

In addition to all the aforementioned, the copious records reviewed revealed an elderly woman of 83 years on hemodialysis three days per week, severe pulmonary hypertension with a systolic pulmonary pressure of greater than100, atrial fibrillation, and obstructive sleep apnea whose quality of life and potential for a prolonged life, were in serious question. Moreover, it was documented that despite her need for CPAP machine support for her sleep apnea she almost always refused to wear it and hence, may have succumbed due to complications thereof.

Hence, although one could argue that PAH and Dr. Kerr Caitlon could have done a better job making sure Rita Quimby was discharged to a more appropriate caregiver, the standard of care was indeed followed and the sentinel allegations of negligence are *without merit*. Furthermore, even if there were deviations from the standard of care in this case, it would be hard to substantiate significant damages given Ms. Quimby's poor overall medical condition, quality of life and prognosis.

Should further records become available our physician would be happy to review them.

Sincerely,

Patricia Iyer MSN RN LNCC

Med League Support Services

www.medleague.com
260 Route 202/31, Suite 200
Flemington, NJ 08822
Tel: (908)788-8227
Fax: (908)806-4511
ml@medleague.com

May 12, 2009

Howard Fritz, Esq.

67 Rt. 23 North

Juniper, NJ 08112

RE: Michael Wriglevick

Dear Mr. Fritz,

Our physician screened this case for merit. This report includes his opinions. This case does not have merit. He reviewed these items:

Office records of Dr. Brian Nell 6/2/11 – 9/16/11

Same Day Surgery

Kelpman Surgical Center

7/12/11

Hospital Admission

Grasso Hospital

7/19/11 – 7/20/11

Emergency Room Records

Grasso Hospital

7/21/11

Office Records

Dr. Andres Quesa

7/22/11 – 8/30/11

Office Records

Roberts Pulmonary and Sleep Medicine

Steven Grundy, MD

7/24/11-8/25/11

Emergency Room Records

The Franklin Health System

7/31/11

According to the records reviewed, Mr. Wriglevick underwent a partial left medial menisectomy on his left knee 7/12/11. No problems were noted during the operation.

He returned for a routine post-operative visit on 7/19/11, one week later. At that time orthopedic surgeon Dr. Brian Nell noted calf swelling and stiffness. He ordered an ultrasound examination for deep venous thrombosis. The study was positive.

"*There is evidence for acute expansile nearly occlusive thrombus within the entire popliteal vein which extends distally into the deep calf veins. The popliteal vein is noncompressible. There is minimal color Doppler signal in the popliteal vein in the region of the junction of the small saphenous vein. The left common femoral, greater saphenous vein and femoral vein demonstrate normal compressibility and normal color and spectral Doppler without evidence for thrombus.*"

This is a large, clinically significant thrombosis.

Mr. Wriglevick was admitted the same day to Virtua West Jersey Hospital, Marlton, New Jersey. He spent one night in the hospital under the care of Michael Sendiski, D. O. In the hospital, he was treated with *Lovenox* and *Coumadin*. He was discharged in stable condition, but returned on 7/21/11 due to severe right pleuritic chest pain. He returned with normal vital signs; he was afebrile, heart rate of 77, blood pressure 114/67, respiratory rate 17, and pulse oximetry of 97% on room air. A CT angiogram showed a small right pulmonary embolism.

The patient was continued on Lovenox twice daily, and his dose of Coumadin was increased. Percocet was prescribed for pain. He was discharged that same day.

On July 22, Mr. Wriglevick saw Dr. Fraji Nistopalan, a hematologist. Dr. Nistopalan agreed with the plan of keeping him Lovenox with a transition to Coumadin therapy. His consult indicated he wanted the Coumadin to be fully active (achieving an "INR Value" of 2.0 -3.0) before discontinuing the Lovenox.

On July 31, Mr. Wriglevick was seen in the emergency department of Roberts Hospital. His INR was a bit too high (blood was too thin). An x-ray showed a "pleural based wedge compared to one week ago – likely small pulmonary infarct from PE." He was discharged with instructions to decrease the Coumadin dose, take pain medication, and have a recheck of his PT/INR.

On August 24, 2011, Dr. Stephen Grundy, M. D., wrote a consultation note. He indicated that Mr. Wriglevick was in Roberts Hospital for severe pleuritic pain towards the end of July. He noted Mr. Wriglevick had a chest x-ray at that time and told he had a "pulmonary infarction." He had a CT of the chest on August 18 showing a pleural effusion.

Dr. Grundy's impression was as follows:

1. *Small peripheral right pulmonary embolism associated with left popliteal deep venous thrombosis following arthroscopy.*

2. *Severe pleuritic pain which is not surprising giving the peripheral location, appears to have developed a right pleural effusion.*

3. *Apparent mild asthma (he was told when he was younger that he had some asthma.)*

The plan was to continue with pain medication and "wait this out."

Analysis

The deep venous thrombosis (DVT) that developed after the knee surgery could neither be predicted nor prevented. The incidence of this complication is substantially under one per cent. The literature does not support any specific prophylaxis against this complication other than avoiding complete immobilization.

The diagnosis of DVT was quickly recognized and treated. Despite proper therapy, consisting of anticoagulation with Lovenox, Mr. Wriglevick soon developed a pulmonary embolism. A pulmonary embolism results when a small piece of the clot in the leg breaks off and travels through the venous circulation, through the right side of the heart, and gets stuck in the lungs.

The treatment for a (non-massive) pulmonary embolism is the same as the treatment for a DVT; this treatment is anticoagulation, first with Lovenox, then with Coumadin.

Lovenox, also called "LMWH" (for Low Molecular Weight Heparin) works very quickly to thin the blood. Lovenox is given by subcutaneous injection every twelve hours.

Coumadin prevents the liver from making certain clotting factors, thus decreasing the ability of the blood to clot. It works by competing with Vitamin K in the production of these clotting factors. It takes days to work. Lovenox and Coumadin are given simultaneously until the Coumadin is working fully. There is a test to see how thin the blood has become from the administration of Coumadin. This test is called a *PT/INR*. The dose of Coumadin will be determined by measuring the results of this blood test; if the number is too low, more Coumadin is given, and if too high, less Coumadin is given.

The pulmonary infarction suffered by Mr. Wriglevick was a result of the DVT and the pulmonary embolism. A pulmonary infarction is the death to that portion of the lung that had been dependent on the blood supply from the (now blocked) vessel containing the embolism.

Conclusions

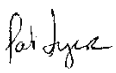
In summary, Mr. Wriglevick suffered an unusual complication of an arthroscopic outpatient procedure. He received prompt diagnosis and appropriate care for the DVT, and subsequently, for the pulmonary embolism.

He continued to have pain and was diagnosed as having a pulmonary infarction, as well as a pleural effusion (fluid in the pleural space, between the lung and the surrounding membrane lining the thorax). The pleural effusion was a result of the pulmonary embolism that could not be prevented.

To a reasonable degree of medical probability, there was no medical negligence. The problems suffered by Mr. Wriglevick could neither be predicted nor prevented. The treatment for his DVT was standard and appropriate. He developed a pulmonary embolism and a pulmonary infarction despite prompt and appropriate care for his pulmonary embolism.

Please advise us if you would like the records returned to you.

Respectfully,



Patricia Iyer MSN RN LNCC

May 18, 2005

Joseph Tribler

6590 Rt. 34

Greenbow, NJ 08000

Re: Jessica Ungbar

Dear Mr. Tribler:

My physician consultant has thoroughly reviewed the information you sent me, including the following:

1. Your cover letter dated April 25, 2005

2. Office records, Chipper Pediatrics 4/9/02 -- 11/2/04

3. A total of **six** admissions to Mounts Hospital for Children on the following dates

a. **5/1/03 -- 5/2/03**

b. **7/30/03 -- 7/31/03**

c. **10/12/03 -- 10/13/03**

d. **3/14/04 -- 3/16/04**

e. **6/22/04 -- 6/30/04**

f. **11/08/04 – 11/11/04**

My findings will be discussed in detail below. At the outset I should point out that there is merit in proceeding further with this case. Specifically, Ungbar's death was potentially avoidable if the anesthesiologist had better prepared for a very dangerous airway situation that was well-known prior to surgery. You should also be aware that her chronic skin condition appears severe enough that without the incident in the operating room, her lifespan would have been short. Finally, this is a relatively rare and unusual set of circumstances and at least two or three pediatric sub specialists will be required as expert witnesses.

Findings:

Shortly after birth, Ungbar was noted to have skin blistering and was transferred to Children's Hospital of Philadelphia where the initial diagnosis of Epidermolysis Bullosa was made. Despite her death at only 2 1/2 years of age, her medical records are quite extensive and her problems complicated. I'll summarize these as succinctly as possible and focus attention on the events leading up to her death.

During her life, Ungbar was seen frequently at various clinics and by various specialties, including pediatrics, dermatology, ophthalmology, otolaryngology, gastroenterology, and pulmonology. Her records show that she suffered from the following chronic problems almost all of which were related to her diagnosis of epidermolysis.

- multiple skin blisters and areas of scarring
- subglottic stenosis (narrowing) and stridor (difficult breathing)
- anemia
- growth failure
- recurrent skin infections both bacterial and viral
- possible reflux esophagitis and aspiration (at one point she vomited blood)

- asthma (positive family history)

Ungbar's skin condition involved different areas of her body. She had multiple problems with lesions on her face and extremities. Skin care required daily attention from her family who were required to watch for and needle new blisters, place wound dressings on injured areas, and try to prevent her from scratching -- an action that could create new lesions. She was on a number of courses of antibiotics. Her chronic medications included inhalers for her breathing, vitamins and iron, and Zantac for esophagitis.

Most of her admissions to hospital were for respiratory problems and she was frequently seen in the clinic as well because of noisy breathing and signs of difficulty breathing. Her episodes of respiratory distress were treated with typical asthma approaches but it was also clearly recognized that much of her noisy breathing was related to severe narrowing of the back of her throat. In fact, on 07/30/03 Dr. Dean, an otolaryngologist, performed a scope under general anesthesia and noted the following *"advancing the 4 mm telescope into the subglottic space revealed diffuse mucosal changes with narrowing in the supraglottic larynx which extended down to the vocal folds."* Further, *"There are no discrete scabs. However, the 4 mm telescope did not pass through the glottis and resistance is met. Therefore, for the safety of the child it was not advanced at this point. The immediate subglottis appeared satisfactorily patent."*

On 6/22/04, Ungbar was admitted to Mounts Hospital for Children with respiratory distress and mycoplasma pneumonia. At this time, as on some of her other hospitalizations, she was in the PICU (pediatric intensive care unit). She was again seen by otolaryngology who discussed the possibility of tracheotomy to help with her episodes of respiratory distress.

On 11/8/04, Ungbar was admitted to Mounts Hospital for Children after presenting to the emergency department with signs of infection in her feet. She was seen in consultation by plastic surgery who tried to perform simple wound debridement (removing badly infected and or other unhealthy tissue) at the bedside on 11/10/04 but had to abort because her oxygen levels dropped. At that time they had given her morphine intravenously. She was booked as an add-on case for the operating room on 11/11/04 with the intention of performing wounded debridement under general anesthesia.

On 11/11/04 she was taken to the operating room; the surgeon was Stephen Davis, M. D. and the anesthesiologist was Dr. Jaffe. The plan was to deliver a general anesthesia via mask while Dr. Davis debrided both feet. There are multiple entries in the chart regarding her history of subglottic stenosis, stridor, and episodes of respiratory distress. Further, information is available from prior Mounts Hospital records regarding the severity of her problem and the potential need for tracheotomy (as discussed by otolaryngology just five months before). The pre-surgical anesthesia

history and physical was performed by P. Mandato. It is noted that Ungbar had prior anesthetic experiences; the first was her endoscopy by Dr. Dean (see above); the second was performed at Children's Hospital of Philadelphia for *"eyes"* (I do not have the records for this but likely uneventful). Chest exam was reported as abnormal with stridor, and inspiratory and expiratory wheezes. During the surgery Dr. Davis first addressed the infected area on both feet. He then inspected other areas of the body where dressings had been placed and replaced the dressings with Vaseline gauze and Kerlix wraps. Blood loss was estimated to be less than 1 milliliter.

According to the anesthesia record, IV induction occurred at 11:28 a.m. and the procedure started 11:31 a.m. At 12:04 p.m. it was noted Ungbar was difficult to ventilate and the paralyzing agent (rocuronium)was given. The anesthesia note says *"plan not to into intubate for the risk of blistering of the airway"*. At 12:29 p.m. the surgery finished. At 12:48 p.m. 0.07 mg IV bolus glycopyrrolate was given followed by naloxone at 1:01 p.m. and 1:04 p.m. At 1:07 p.m. spontaneous respirations were noted. These were deemed to be "*unsatisfactory"*. Intubation was attempted with a 3.5 ETT (endotracheal tube). This was unsuccessful and a 2.5 ETT was placed instead. At around that time the anesthesia record shows an initial rise in heart rate to 180 and that no readings are present for approximately 10 minutes for heart rate or blood pressure; and no pulse oximetry record for at least 5 minutes after which the initial reading was in the 60%-70% range. From 1:21 p.m. to 2:30 p.m. CPR was performed in the operating room and was terminated unsuccessfully after more than one hour.

There is a death notice dictated by Dr. Davis on 1/26/05, more than two months after the event. In that note he adds that the cardiologist was present during CPR, that an echocardiogram was performed and a transcutaneous pacemaker placed. There is however no note from cardiology and no further documentation from anesthesiology other than the anesthetic record.

An autopsy was performed; however, I only have a neuro-pathology report in the records you sent. This report simply shows *"ischemic/anoxic"* damage to the brain, as would be expected with such prolonged CPR.

Standard of Care Issues and Impressions:

This is not a simple case. In her short life Ungbar unfortunately accumulated a number of problems related primarily to her skin condition. Epidermolysis Bullosa (EB) is a term used to describe an inherited family of disorders in which the skin blisters very easily. There are numerous types and subtypes within this family of diseases, and the determination of exactly which type a patient has is made using electron microscopy, genetic testing, and clinical observation. Fortunately EB is rare, and affects less than 25,000 people in the United States with a rate of less than 50 per million births.

Some subtypes are rapidly lethal with children dying in early infancy. Others are milder but are often associated with death and skin cancer in early adulthood. In some affected individuals the gastrointestinal tract is involved. This can include lesions in the mouth, and aspiration due to esophageal and gastric problems. Children with respiratory problems, as in Ungbar's case, appear to do worse. In her case there is even confusion regarding which subtype of EB she had. Initially the dermatologist diagnosed her as having the simplex type. On August 29, 2003, however, Dr. Yan notes "*These findings are atypical for normal EB simplex. This may be an uncommon variant of epidermolysis bullosa simplex or perhaps a form of dystrophic EB.*"

Nonetheless, her course was marked by multiple problems and deterioration on the growth curve. This information is likely to be used by the defense as an indication that Ungbar was severely affected by her skin disorder and that early death was imminent.

The medical legal issue in this case focuses on the standard of care for airway management by anesthesiology. There is no doubt in the record as to the problems Ungbar faced with her subglottic stenosis and asthma. The stridor she suffered was caused by narrowing of her upper airway as evidenced by a croupy sound every time she tried to breathe in. Indeed, otolaryngology had discussed the idea of a tracheotomy because this would relieve the obstruction to breathing and potentially reduce the episodes of respiratory distress that Ungbar was suffering.

Anesthesia would have to view this as a difficult airway, and fully appreciate the risk for a cardio-respiratory arrest, as occurred in this case. In order to be fully prepared for the worst, consultation should have been obtained by otolaryngology prior to attempting general mask anesthesia. Consideration should have been given to proceeding with a tracheotomy, as previously discussed. At the very least, it would have been much better to have an ENT surgeon in the operating room during anesthesia just in case of emergency tracheotomy was needed. In this regard, Dr. Davis is a plastic surgeon and would probably have little experience in emergency tracheotomy.

During the surgery it became difficult to ventilate Ungbar. At this point, the anesthesiologist gave her a paralytic agent and decided not to intubate her because of the risk of blistering the airway. This was another mistake. At that point, it should have been increasingly clear that the more secure airway was absolutely required. An intubation or tracheotomy should have been performed. This was the second missed opportunity to prevent the cardiac arrest that followed. Worrying about blistering the airway should be secondary, especially with the history of otolaryngology considering a tracheotomy in the recent past.

Once the airway is severely compromised and oxygen levels deteriorate it is only a matter of minutes before a patient will develop a cardiac arrest. And once this occurs the situation becomes desperate and lethal in a high percentage of cases. When

dealing with a child as complicated as Ungbar the worst can happen, even with the best of planning. Clearly, there is always room for judgment and defense will no doubt contend that the anesthesiologist exercised reasonable judgment in this case. They will likely raise the point that anesthesia was give earlier in 2004 for ophthalmologic reasons (you need these records – but this would have likely been very brief). Notwithstanding, there is no evidence that the above options were exercised; therein lies the difference between "bad luck" and bad judgment. Had the anesthesiologist involved otolaryngology before or during the early part of the case, there would be little to criticize about his management.

Summary and Conclusions:

1. Ungbar had epidermolysis bullosa simplex or dystrophic type.

2. She had multiple complications associated with this diagnosis including respiratory, gastrointestinal, eye and growth delays.

3. She had well-documented subglottic stenosis, associated with chronic stridor and episodes of shortness of breath. This was a complicated by asthma.

4. She was under consideration for tracheotomy.

5. Debridement under anesthesia was indicated in order to treat her infected feet.

6. More care should have been given to her airway evaluation prior to general anesthesia. They should have included a preoperative evaluation by otolaryngology.

7. When problems began in the operating room, otolaryngology should have been urgently consulted in order to help secure the airway.

8. It is difficult to comment on Ungbar's prognosis, but it is likely that she would have a number of future problems and a shortened life expectancy.

Recommendations:

1. This case should be reviewed first by a pediatric anesthesiologist.

2. If he/she agrees with the findings of this review you'll also need an expert in pediatric dermatology who has significant experience with epidermolysis bullosa.

3. Additional expertise may be required from a pediatric otolaryngologist.

4. It would be helpful to obtain the full autopsy report and not just the Neurologic component.

5. Also, records from Children's Hospital of Philadelphia should be obtained, especially the record of prior anesthesia.

Should you wish our help in finding experts, please let us know. Thank you for the opportunity to assist you.

Very truly,

Patricia Iyer MSN RN LNCC

February 1, 2005

Victor Dougherty, Esq.

97 Gilbert Street

Newton, NJ 07880

Re: Judy Smith

Dear Mr. Dougherty,

When this file was first forwarded to us in March 2004, we delayed reviewing it pending receipt of the retainer. After that check came in September 2004, I reviewed the file and left a message for you to tell you that records were missing. When I did not hear back, I decided to have our physician review the file and prepare a report. His conclusions are contained in this report. Based on the limited numbers of records available, this claim is without merit.

History

On or about 11/10/1999, Ms. Smith had a skin biopsy performed. According to the pathology report of Dr. Elvis Boundbrook on 11/15/1999, Dr. Emil Lundy is the dermatologist who performed the procedure. The biopsy was described to be from the left side of the nose and the margins of the biopsy revealed basal cell carcinoma.

There are no records from Dr. Lundy on the date of the 11/10/1999 biopsy - only the pathologist's report.

On 12/15/1999, Ms. Smith had further surgery to complete the removal of the lesion from the left side of the nose in order to remove the remaining basal cell carcinoma. The procedure was performed by Dr. Greg Hindu and Dr. Steven Thomas (Assistant). It appears that neither of these individuals was involved in the November biopsy and it is unclear how the patient came under their care. The operative report indicates that the area of the prior shave biopsy was completely excised and that two other lesions were removed: one on the face between the left side of the nose and left cheek, and the other on the neck. There is no copy of the patient consent form for review. The pathology report of Dr. Nina Chaffe documents the presence of three specimens but none of these revealed basal cell carcinoma. All lesions were benign.

On 1/20/2000, Ms. Smith was again operated upon by Dr. Emil Lundy using Moh's mapping, and according to his report, the site of the prior biopsy (presumably his biopsy of 11/10/1999) was completely excised. Following the excision of the tumor she underwent reconstructive surgery on the same day. There is no report available regarding the reconstructive procedure and there is no follow up report regarding outcome.

Standard of Care

Basal cell carcinoma is the most common form of skin cancer and is most often found on the face and neck. It is a very slow growing tumor and people who develop lesions are likely to have others in the future. It can grow quite large and erode into vital structures so complete removal is essential. Early/small lesions are often very superficial and can be readily removed with limited or no surgery. These lesions leave little or no residual scarring. Larger lesions require more extensive surgery and may even necessitate fairly involved plastic surgery. The results can be quite disfiguring. The standard of care requires histological/pathological confirmation that the lesion(s) have been completely removed. In the case of the Moh's procedure, microscopic analysis is used during the surgery to assure thorough removal.

Our physician assumed that informed consent is standard for all states and it should have been obtained prior to surgery in both December and January.

Assessment of this case

1. Potential for Damages

As far as the claim that Dr. Hindu removed lesions without authorization, this is impossible to comment on without reviewing the consent form. If this were the case, then Dr. Hindu could be taken to task. However, it is unlikely that the patient would have gotten as far as the operating room table without a valid consent being obtained and on the chart. Further, if there were any disfiguring scars from these "unapproved" removals they would serve as evidence of damage.

Since basal carcinoma grows very slowly it is inconceivable that the delay of one month between 12/15/1999 and final surgery of 1/20/2000 affected the final outcome of the cancer or the reconstruction. The only potential damages evident from the provided material are the expense and inconvenience caused to Ms. Smith.

2. Analysis

It is not clear why Ms. Smith changed physicians from the first to the second and from the second to the third procedure. According to Dr. Hindu's report he removed the area of the prior biopsy but this was unsubstantiated by pathology. Dr. Lundy's report of 1/20/2000 does not refer to Dr. Hindu's procedure on 12/15/1999 but confirms the presence of basal cell carcinoma by Moh's mapping and there is no independent report from a pathologist to support this. If a specimen was sent from this surgery to pathology, it would be nice to have their review.

It is quite possible that Dr. Hindu removed a different lesion than the one biopsied by Dr. Lundy on 11/10/1999 and this is strongly supported by the lack of carcinoma on the accompanying pathology report. But Dr. Hindu's operative note clearly states otherwise.

3. Anticipated Defenses

Dr. Hindu did remove the correct lesion (from the area of the apparent prior shave biopsy) on the left side of the nose, as he says in the operative report. And he did send the tissue for pathology to confirm removal. Pathologic analysis of tissue specimens is not 100% reliable.

As it is unclear how the patient ended up in the subsequent procedure and the issue of consent is not available with this review, it is impossible to say what other defensive postures might be taken.

4. In Conclusion

1. There is no documentation available for this review from Dr. Lundy from his 11/10/1999 biopsy.

2. Similarly, no consent form from 12/15/1999 was included. (We have only partial records.) It is impossible to comment on the claim regarding the removal of two extra lesions without patient approval. The consent would be needed in order to assess this, as well as evidence of scarring. If informed consent was not obtained from the patient, the standard of care would almost certainly be violated.

3. There is no independent pathology report from the 1/20/2000 excision. If one was performed it could be helpful in pursuing a case.

4. It is highly likely that on 12/15/1999 the wrong lesion from the left side of the nose was removed. This could be explained by the fact that a different physician was performing the operation than the one who did the original biopsy. The reason for switching doctors is confusing and is arguably an invitation to this type of error.

5. It is unclear why Ms. Smith returned for a procedure on 1/20/2000. If this occurred as a follow up from the negative pathology report of 12/15/1999 it indicates that the physicians were prudent.

6. Outside the expense and discomfort associated with a third procedure there is no clear evidence of injury from the information provided and there is no clear evidence that standards of care were violated.

Thank you for the opportunity to assist you with this case. I am returning the records to you along with the unused portion of the retainer.

Very truly,

Patricia Iyer RN MSN LNCC

May 18, 2001

Mary Quimby, Esquire

487 Kensington Dr.

Oxford, W. V. 26851

Re: Beaver, Michael

Dear Ms. Quimby,

Thank you for forwarding the medical records for the above matter. My physician consultant has reviewed this matter and I have incorporated his comments into this report. He concluded there is merit to the claim.

This 41 year old alcoholic apparently was in an altercation on 3/13/01, and was evaluated at Cooper Regional Healthcare by Dr. Hagar, M. D. and/or Steve Ingrid, D. O. The handwriting of the physician(s) cannot be interpreted.

Plain x-rays were done of the patient's nose and facial bones demonstrating a fracture of the left maxillary sinus. The patient was observed for a period of time in the emergency department where the effects of the alcohol he admitted ingesting appeared to be wearing off. He was discharged in good condition.

He presented again on 3/17 with signs of meningitis. He died of meningitis with a coroner's report which also showed a fracture of the middle crania fossa (part of the skull) hemorrhage, or bleeding, within the skull (adjacent to the left middle cranial fossa fracture).

The standard of care would require the emergency physician to have a high index of suspicion for any intoxicated patient who presents with a head injury. This patient presented with a head injury, and his neurologic examination would have been difficult due to his alcohol intoxication. A reasonable, prudent emergency physician would have obtained a CT scan of the brain to rule out intracranial injury, which was present but not detected in this case.

The plain x-rays showed a fractured maxillary sinus, the treatment of which must include antibiotics to prevent infection. While the charting is largely illegible, I can see no evidence of parenteral nor oral antibiotics being given, nor a prescription for antibiotics being given.

Patients who are "head-injured" should be discharged in the responsibility of an adult who can watch them, and that responsible adult should be advised of "head injury precautions," things to look out for which may be evidence of a worsening intracranial problem in a patient with a head injury. This was not done.

Had the emergency physician done a CT scan, he would have discovered the skull fracture and associated hemorrhage. The patient would have been admitted and evaluated by a neurosurgeon (or if there were no neurosurgeon on staff he would have been transferred). He

would have received antibiotics for the fractured sinus, which may or may not have prevented the meningitis.

It would be up to the neurosurgeon as to whether this type of skull fracture and associated injury would require operative management; I can't say. I doubt it.

Nonetheless, the patient would have been in an intensive care unit setting and signs and symptoms of meningitis would have been seen very early on; he would have received treatment for this meningitis, if it did occur, very early on. There is a better than average chance the patient would have survived this head injury. If the patient developed meningitis, it would have been treated promptly, and he would likely not have died as a complication of meningitis.

There was unquestionably a breach in the standard of emergency medical care (first, failure to do a CT scan and find the more significant injury, and second, the failure to prescribe antibiotics in a patient with a fractured sinus); the breach led to the patient's death.

The patient was an alcoholic who almost certainly was not taking good care of himself. He would be the type of patient with whom an emergency physician should be more careful, rather than less careful. "Normal" patients follow instructions (as this gentleman didn't, failing to seek follow-up care in 2 days as instructed) and exercise better judgment in self-care. The decedent apparently did not come back to the hospital until his condition was moribund and his fate could no longer be altered.

On the "flip side," any patient who comes to an ER after an altercation with an alcohol level of almost 400 (which would kill most of us!) is probably a chronic alcoholic and would not be a very sympathetic figure for a jury. Still, the patient presented for medical care, was given an inadequate

evaluation, and discharged without a crucial test- the CT scan, and the patient died as a result of this medical negligence.

Thank you for allowing us to assist you with matter.

Sincerely,

Patricia Iyer, MSN, RN, LNCC

President

Report on Louise Kunis

Date of Report: Wednesday, April 17, 2002

Attorney: Robert Young

Introduction: I received and reviewed Mrs. Kunis' information on 4/12/02. This was an expedited review because of Plaintiff time constraints and the preliminary findings were given by phone to Mr. Young on 4/12/02.

The following records provide the basis of this report:

- A cover letter from Mr. Young stating Mrs. Kunis died on 12/31/99. Also, that *"Mrs. Kunis' daughter believes there was a failure to diagnosis, since her mother's cancer was not diagnosed until 90 days prior to her death. She complains that there were lesions seen on CAT scans as early as 1994 and chest x-rays with abnormal densities seen since July of 1992, yet her cancer, Metastatic cancer to the lung and kidney was not diagnosed."*

- Summaries of 26 hospital admissions numbered 1 through 26 starting 7/10/92 and ending with an admission to Vicky Paul Medical Center on 12/31/99. These do not constitute complete medical records but do have pertinent procedure ad discharge summary information.

- Two complete and virtually duplicate files of all radiological procedures performed between 7/10/92 and 12/31/99 from both Vicky Paul Medical Center, Riverview Medical Center and Francis Heart and Lung Center. These reports are duplicates of those found in the summaries of 26 admissions.

- Attachment # 1 - A timeline summary (produced by ?) of all admissions between 1992 and 1999.

- Attachment # 4 (produced by ?) A summary of abstracted results of pertinent abnormal results from 1992 to 1999.

- Attachment # 5 (produced by ?) A summary of records from visits or admissions to Francis Heart and Lung Center from 1994 to 1999.

- Actual x-rays from 1992 to 1999

- Interrogatories from Steven Witt, MD

Summary of Patient's Chronic Health Care Problems from 1992 to 1999 (ages 74 to 81).

- Atrial Fibrillation (requiring coumadin)
- Mitral Valve Disease post Open Heart Valve Ring Repair
- Severe Triscupid Regurgitation
- Obesity
- Hypertension
- Ischemic Heart Disease
- Congestive Heart Failure
- Arthritis (?Rheumatoid)
- Peptic Ulcer Disease
- Colonic Diverticular Disease
- Interstitial Lung Disease

Summary of Principal Causes for Admission and significant findings from 1992 to 1999. Please note that NOT all findings are listed, only the ones I deem pertinent for summary purposes.

GI Bleeding/GI Upset/Abdominal Pain

-
  - 7/10/92 Findings of Benign Gastric Ulcer and Rectal Polyp
  - 4/23/93 Findings of Large Esophageal Ulcer on Endoscopy. Pathology Benign. Close follow up recommended
  - 11/03/93-11/26/93. Cholecystitis & Cholecystectomy performed. Endoscopy shows esophagus OK and healing gastric ulcer.
  - 3/14/94-3/25/94. Treated for diverticulitis. Chest x-ray shows mild increase in bibasilar markings.

- 9/22/97-10/01/97. GI Bleeding. Probably diverticulosis. No neoplasms seen, but poor prep. No Upper GI Endoscopy.
- 10/12/99-10/22/99. Abdominal pain. Upper endoscopy Gastritis (H Pylori). Esophagus OK. There is mention of a CT scan of chest showing right lung mass performed in 9/99. A CT scan of the abdomen shows no difference in renal cysts compared to 1994.

Neurological Problems

- 12/26/95-1/11/96. Vertigo, nausea and dehydration. CT Head OK.
- 4/22/99-4/30/99. Transient Ischemic Attack. Chest x-ray shows chronic changes at right lung base.

Chest Pain or Shortness of Breath from Congestive Heart Failure or Asthma

- 10/16/93-10/22/93. Improved with medical therapy. Chest x-ray – lungs clear
- 11/28/94-12/07/94. Treated Medically.
- 12/17/94-12/29/94. Treated Medically. Chest x-ray difficult to evaluate lung bases because of obesity and overlying breast shadows.
- 1/12/95-1/18/95. Treated Medically
- 5/10/96-5/18/96. No MI. Arthritis suspected. Renal Ultrasound shows no change from 1994.
- 7/14/97-7/17/97. MVA rule out fractured sternum.
- 5/26/98-6/1/98. Chest Pain & Shortness of Breath. Pulmonary Function tests show diffusing capacity (DLCO) at 43% otherwise OK. Chest x-rays still show bilateral changes
- 6/15/21/99-6/21/99. Shortness of breath. Treated for heart failure. Chest x-ray consistent with Congestive Heart Failure (CHF) rule out bilateral pneumonia
- 7/01/99-7/14/99. CHF

- 7/26/99-8/03/99. CHF & fluid overload. Pulmonary functions worse than in 1998 – restrictive disease.
- 10/30/99-11/01/99. Chest pain & hemoptysis. Transferred to Francis. Stays till 11/05/99. CT needle biopsy of lung shows non-small cell carcinoma. Squamous cell carcinoma is favored but adenocarcinoma also a possibility. Metastatic cancer from kidney was suspected.

Gynecological

- 10/21/94-10/22/94. Vaginal Bleeding. Benign Polyp found with hysteroscopy & D&C.

Elective Surgery & Post Surgical Problems

- 9/27/95-10/10/95. Total L Hip Arthroplasty. Chest X-ray – chronic bibasilar disease.
- 12/08/98-12/16/98. Right total knee arthroplasty. Seen by Dr. DeTullio who notes she has increasing symptoms of shortness of breath over past year and evidence for chronic pulmonary fibrosis. Also, being worked up at Francis Heart and Lung Center, and may need a lung biopsy in the future.
- 12/16/98-1/05/99. Riverview Medical Center for post knee surgery rehab.
- 1/22/99-3/15/99. Infected left hip prosthesis. Treated medically. UGI series (? reason for doing) shows severe esophageal dysmotility and evidence of stricture – consider endoscopy suggested. Also, hiatal hernia mentioned and duodenal and terminal ileum polyps.

Discussion of Various Pertinent Aspects:

First, there is no doubt that Mrs. Kunis had cancer and it is reasonable to say that it was the likely precipitant of her death. It is also likely that the cancer was contributing to her increasing shortness of breath during the latter half of 99.

Second, it is not at all clear that the cancer was metastatic from a renal cancer primary or that any lesions on her kidney scan represented metastases. No tissue was ever obtained from either kidney to document cancer. Other possibilities would likely include primary lung cancer, metastatic disease from esophageal cancer, metastases from uterus, and metastases from an unknown primary. I cannot fully appreciate the reason for assuming that the cancer is primary renal, but the record is an abbreviated one. In fact, one consult from Vicky Paul Medical Center raises the issue of increased risk of lung cancer due to her chronic interstitial lung disease. The esophagus, as the primary site of cancer needs to be considered because a 1993 endoscopy showing a suspicious ulcer and the UGI series findings of early 1999 showing a possible esophageal stricture.. Against the diagnosis of esophageal cancer is the October endoscopy showing a normal esophagus. She did not appear to have any follow up PAP smears or pelvic exam follow up after her benign vaginal bleeding in 1994, so this is also a possible focus. All this is, of course, speculative.

Third, her chest x-ray was reported as showing questionable changes in 1992 but subsequent films showed clearing. From 1994 on her films reports give slightly varying but fairly consistent evidence of bilateral lung disease that is worse on the right. There are a number of references to the impact of soft tissue densities secondary to her body habitus. What these interstitial changes represent is not at all clear. A presumptive diagnosis of chronic interstitial lung disease was made without a lung biopsy. Many of her films were consistent with a clinical picture of congestive heart failure (CHF). When was cancer first present on the films? Clearly the answer is "Before it was diagnosed by biopsy." Nonetheless, it was highly unlikely to have been present for 5 years - especially if metastatic. Therefore, her problems with interstitial fibrosis, CHF, body habitus and cancer all merged together. It is not clear why it was decided to proceed with knee surgery before following up with a lung biopsy toward the end of 1998.

Fourth, "What would have been done differently if cancer was diagnosed earlier?" This is a very tough question to answer especially without certainty as to tissue type and origin. It is highly likely that, given her age condition, even if cancer were diagnosed earlier, the outcome would remain the same, or even worse, due to complications of therapy.

Fifth, the presence of renal cysts was known as far back as 1988 and the report comparing the abdominal CT of October 99 to 1994 and finding it unchanged is somewhat contrary to the report from a similar study performed at Francis Heart and Lung one month later. The latter was reported without the mention of historical comparisons, however.

Finally, and importantly. Mrs. Kunis had a lengthy and complicated history. She was at high risk for cardiac, pulmonary, neurological and hematological problems, even from aggressive work up. For example, a thorough evaluation of the kidneys might have involved bilateral biopsies thereby increasing her risk of serious bleeding. And, in the face of stable x-rays, would this be wise? This is especially relevant in a woman who needs chronic anticoagulation. The decisions being made by her caregivers were clearly complex. One example was the delay in working up her lung infiltrates in order for her to proceed with knee surgery. Balancing risk and benefit is such situations are difficult, especially when quality of life functions are at issue.

Assessment/Conclusions:

From the information I have available

1. It is reasonably clear that Mrs. Kunis succumbed to lung cancer.

2. But, it is not clear where this cancer came from (i.e. whether it was primary or secondary).

3. It is also not clear when her radiological studies and clinical problems indicate that cancer was present.

4. Notwithstanding, it is certainly reasonable to say that the diagnosis of cancer was delayed.

5. It is not possible for me to determine, however, what impact this delay had on her well-being. Quite possibly it had none.

6. Also, it is hard to cite examples of clear-cut deviations from standard of care. Multiple medical problems affecting different organ systems impacted heavily on decision-making.

7. Unless there is further information that I have not been provided with, or evidence in this extensive record that I have overlooked, I would have to conclude that there is no merit in proceeding with a lawsuit.

8. If there was a desire to pursue this case further, I would suggest experts in medical oncology and radiology be asked to review the material. I do not believe, however that this would be a high yield venture.

September 26, 2011

Med League Support Services, Inc.

www.medleague.com
Liberty Court
260 US Highway 202/31, Suite 200
Flemington, NJ 08822
Tel: 908-788-8227
Fax: 908-806-4511
Email: ml@medleague.com

Karen Frodo, Esq.
56 Octavius Ave
Greenberg, NJ 07685

RE: Sharon Wright

Dear Mr. Murphy,

Our internist reviewed this case on behalf of your client. This report includes his perceptions. He did not find merit to the claim.

In short, this case involved a 52-year-old female with a history of hypertension, who was admitted to Britton Medical Center on 8/24/2011 for hypertensive crisis. She also had a history of an unresponsive episode at her work place a week prior. Over the next couple of days, her blood pressure, which had been as high as 248/169, was brought under control. However, the patient had multiple episodes of decreased responsiveness over the next couple of days and was noted to have a hemorrhage in her putamen (in the deep portion of her brain).

Over 8/29/2011 to 8/30/2011, it appears Ms. Wright's mental status continued to deteriorate to the point where she required intubation and transfer to the intensive care unit on 8/30/2011 for closer observation and management. She also received antiseizure medication and was believed to be in status epilepticus or having refractory seizures. It appears, by the end of the available records reviewed, that Ms. Wright was given a diagnosis of anoxic encephalopathy and never regained any meaningful brain function. She had a tracheostomy and PEG (percutaneous endoscopic gastrostomy) tube placed and was transferred to Queens Nursing Home on 12/8/2011.

Case Highlights

1. 8/24/11 - Ms. Wright presented to the ER with complaints of dizziness at work with possible loss of consciousness and a blood pressure of 248/169. The patient had not been taking her blood pressure medication because “she couldn’t afford her meds”. She had a head CT scan which showed a 3 mm left putamen bleed. Of note, Ms. Wright had been seen for high blood pressure and blood in her urine on 5/22/2011 as well. The patient was given blood pressure medication and admitted to a telemetry unit. A neurosurgical consult was ordered and she was seen by the Neurosurgical Service the same day. There did not appear to be any indication for neurosurgical intervention and a repeat head CT was recommended for the next day.

2. 8/25/11 - Ms. Wright’s blood pressure was getting better; it was 170/100. The cardiologist saw her and diagnosed her with an enlarged heart with markedly reduced heart strength according to an echocardiogram.

3. 8/26/11 - The patient had a witnessed complex partial seizure at 11:00 AM (witnessed by neurologist) and again at 7:00 PM. The staff called the Rapid Response Team. She received IV Ativan at the time of both seizures with “adequate response”. She had a brain MRI, which showed numerous scattered microbleeds in the cerebrum, brainstem and cerebellum. Ms. Wright was seen by Neurology and Nephrology Services and began receiving Keppra for seizures.

4. 8/27/11 - A Neurology note mentioned the possibility of cerebral amyloid angiopathy. (This refers to fibrous protein deposits in the blood vessels of the brain.) Dilantin was recommended (to better help control seizures). At 12:30 PM, Ms. Wright had another seizure which responded to 2 mg of IV Ativan.

5. 8/28/11 - The patient began receiving the anticonvulsant Dilantin by mouth.

6. 8/29/11 - Ms. Wright’s EEG was abnormal indicating “some degree of right sided cerebral dysfunction due to the asymmetric presence of alpha activity”. She also had worsening kidney function. The patient was lethargic on the 3 PM-11 PM nursing shift and Dr. Acharya was made aware. A repeat head CT was ordered. On the overnight shift (from 11 PM-7AM), the patient was repeatedly described as “lethargic and arouseable to deep pain stimuli” but little else in terms of her interaction.

7. 8/30/11 - The Rapid Response Team was called for the patient’s unresponsiveness; she was intubated and transferred to the ICU. She was also started on IV antibiotics for the possibility of meningoencephalitis.

8. 8/31/11 - The patient underwent lumbar puncture; she had a video EEG which showed non-convulsive status epilepticus. She was given more IV Keppra and put on a higher standing IV dose. Dilantin was continued. She remained on

continuous EEG monitoring. She also had rapidly worsening renal failure of unclear cause.

9. 9/1/2012 - A repeat MRI showed new acute infarcts involving white matter as well as the right frontal lobe and parasagittal occipital lobes. Due to the multiple infarcts, a transesophageal echocardiogram was ordered to rule out cardiac valve vegetations. It appears both her lumbar puncture and her transesophageal echocardiograms were negative based on the records available.

Analysis

In reviewing this case, it appeared, in retrospect that Ms. Wright was suffering from partial complex seizures, initially sporadic in nature, but becoming fulminant (progressive) and continuous during her hospitalization. It was unclear whether her seizures were due to the multiple bleeds she sustained in her brain, but one could assume this to be likely. The bleeds were likely caused by her severe hypertension, though the hypertension was better controlled

once she was hospitalized. The neurologist mentioned the possibility of cerebral amyloid angiopathy as the cause for the patient's many micro bleeds in the brain, but our physician did not see a definitive conclusion about this. Moreover, it appeared that the combination of bleeds in the brain and status epilepticus lead to her permanent decline in mental function, which was very unfortunate.

However, it is his opinion, as an internist, after carefully reviewing the records, that the physicians and other providers and consultants involved, delivered the standard of care. All the reasonable causes for her condition(s) were contemplated, diagnosed or ruled out, treated accordingly and in a timely fashion. Her blood pressure was kept under reasonable control during her hospitalization, and she was treated with antiseizure medications in a timely fashion. Consultants were called in a timely fashion and saw and made recommendations promptly.

Although it appeared that Ms. Wright's severe deterioration from 8/29/2012 to 8/30/2012 was not dealt with as quickly as it could have been, our physician did not believe there was anything more that could have been done or offered to her at that point regarding treatment. Proving that there was significant deviation from the standard of care, thereby causing her poor outcome, would be very difficult. Thus, he did not think this case has merit to proceed further. The only other suggestion I might have is to also have an expert neurologist review this case given the significant degree of neurologic pathology that was involved here.

Also of note is the fact that the patient was not compliant with her antihypertensive medications, a fact which the defense would raise in focusing on the etiology of the damage.

Our physician would be happy to review any further records or answer any other questions from you.

Best regards,

Patricia W. Iyer MSN RN LNCC