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## Plaintiff alleges surgeons caused “severed” iliac artery injuries

Was this vascular injury the result of negligence?

### Factual Summary

The plaintiff was experiencing ongoing pelvic pain and presented to a nonparty physician on February 2, 2011, for laparoscopic lysis of adhesions, laparoscopic left salpingectomy, and laparoscopic ovarian cystectomy. The nonparty physician could not remove the cyst and concluded the surgery instead of converting to an open procedure.

The plaintiff then presented to her primary care doctor, who felt a suspected a mass on her left side. An ultrasound was performed, suggesting a large complex cystic mass. Based on the concern for cancer, the primary care doctor referred the plaintiff to the defendant, a gynecologic oncologist (Defendant Gyn-Oncologist).

On December 21, 2011, the plaintiff presented to Defendant Gyn-Oncologist’s office for a history of a complex 7-cm mass in the left pelvis. Defendant Gyn-Oncologist explained to the plaintiff that the risks of surgery included risk of injury to adjacent

organs and bleeding. Ultimately, the plaintiff agreed to proceed laparoscopically with possible conversion to open.

On January 8, 2012, the plaintiff presented to the Defendant Hospital for a left salpingo-oophorectomy via laparoscopic approach to address a left ovary encased in cyst and scar tissue. Prior to the surgery, Defendant Gyn-Oncologist reiterated the various risks of surgery and the plaintiff filled out consent forms. Defendant Gyn-Oncologist was assisted during surgery by Defendant Fellow and Defendant Chief Resident, as well as Defendant Anesthesiologist.

As per the operative note authored by Defendant Gyn-Oncologist, the surgery was difficult due to excessive scar tissue, and the left ovary was adhered to the left pelvic side wall and encased in scar tissue. Defendant Gyn-Oncologist used the Hasson technique, making a small incision before introducing her instrumentation. She also used a LigaSure device for cutting and lysis of adhesions. The

LigaSure was inserted via a port and the port incisions were made in the lower quadrant. During the surgery, Defendant Gyn-Oncologist needed to manipulate the infundibulopelvic (IP) ligament, medial to the left

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external iliac artery, in order to gain access to the left ovary. Because of the extensive scar tissue, dissection was required in the area of the left external iliac artery, IP ligament, and left ovary, as they were all adherent to the left pelvic side wall. Good hemostasis was achieved with no evidence of active bleeding at the site of the interrupted IP ligament or the left pelvic side wall following dissection

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to free up the left ovary. The plaintiff had an uneventful postoperative recovery in the postanesthesia care unit, aside from expected postoperative pain. She was discharged home on the same date.

The plaintiff called the hospital the following day and complained of “numbness and tingling in her left leg.” Defendant Gyn-Oncologist and Defendant Anesthesiologist were informed, and a nurse called the plaintiff back and the plaintiff indicated she had spoken with Defendant Gyn-Oncologist. Defendant Gyn-Oncologist spoke with the plaintiff on January 10, 2012, and told her that she could be experiencing paresthesia as a result of being placed in the dorsal lithotomy position during surgery and to call if the condition worsened. The next day the plaintiff called and complained of coldness and pain in her foot and was directed to return to Defendant Hospital or the nearest hospital. Defendant Gyn-Oncologist’s office referred her to the vascular lab, where ankle-brachial index and pulse volume recording studies were performed. These studies revealed diminished flow to the lower portion of the plaintiff’s left leg. As a result, she was admitted to

Nonparty Vascular Surgeon’s service, and surgery was performed

On January 12, 2012, Nonparty Vascular Surgeon performed a repair of the left external iliac artery and venous injuries. During this surgery, Nonparty Vascular Surgeon injured the venous structure while attempting to get access to the artery, given that all the vessels and surrounding tissues were amalgamated along the left pelvic side wall, secondary to scar tissue. The injury was noticed and repaired intraoperatively without incident. Nonparty Vascular Surgeon also found a “focal injury” (a “kink” in the artery per Defendant Gyn-Oncologist, who was present to observe the surgery) to the left external iliac artery, which was repaired with good return of blood flow.

The plaintiff was discharged home on January 15, 2012. She followed up with Nonparty Vascular Surgeon on January 23, 2012. At this visit, the plaintiff had no complaints and was walking around without difficulty. On February 2, 2012, the plaintiff saw Defendant Gyn-Oncologist for a postoperative checkup. Defendant Gyn-Oncologist’s note on this date described the procedure performed in extensive detail. She indicated that

the injury to the artery could have been thermal, or traction related.

Six months later, the plaintiff had another follow-up visit with Nonparty Vascular Surgeon. She was noted to be doing well with no complaints and had no difficulty walking around. The plaintiff’s last visit with Nonparty Vascular Surgeon was on June 10, 2013. At this appointment, she was walking without difficulty. Examination revealed a weak palpable right pedal pulse and Nonparty Vascular Surgeon could not appreciate the left pedal pulse. He recommended a non-invasive arterial study and encouraged her to refrain from smoking and to stay active. It did not appear that the plaintiff underwent this study as recommended or followed up with any vascular doctors. The record also makes note of an apparent “bug bite” that was not healing.

**Allegations**

Plaintiff alleged that the injury was a “severed” left external iliac artery. In the Amended Bill of Particulars, plaintiff claimed the defendants caused a retraction injury, failing to visualize the left iliac vessels, failing to check the lower extremity pulses prior to closure of the surgical site,



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and failing to tell the plaintiff to return to the hospital immediately.

The plaintiff alleged she sustained a “severed” left iliac artery requiring repair, extensive scarring, 3 large holes in the abdominal area, left leg nerve and motor damage, lack of feeling in the left thigh, pain when bending the left leg, increased pain when ambulating, inability to self-ambulate, need for physical therapy, pain and suffering, and loss of enjoyment of life. She also claimed she was experiencing ongoing extremity numbness and weakness.

### Discovery

The patient testified she had wanted an open procedure but agreed to have the surgery performed laparoscopically. On the day of the surgery, she woke up and was told the mass had been removed; she was given discharge instructions and went home. She first started experiencing pain in her abdomen and leg in the car on the way home. When she went into her bedroom her legs buckled and she fell asleep. When she got up to go to the bathroom in the middle of the night her leg felt numb. That morning she had pain and her leg felt as though it were falling asleep.

She called the hospital and an anesthesiologist called her back and said the stirrups could impact her nerves but it would resolve. When Defendant Gyn-Oncologist called her, her toes were turning blue and she was told to return to the hospital. Following surgery she went to the intensive care unit. She testified that while in the intensive care unit, she asked Defendant Gyn-Oncologist

what had happened, who replied that the “cyst” was caught in scar tissue which was why it looked so large, and that she had removed all the scar tissue and had “nipped” her and “did not see it.”

**IN HER DEPOSITION, DEFENDANT GYN-ONCOLOGIST NOTED** that although the primary concern for the referral was a palpable mass in the presence of history of metastatic colon cancer, the plaintiff was also dealing with chronic pelvic pain.

The patient also testified that the vascular surgeon told her that hers was “the most complicated case” he had done, but that he was not going to let her lose her leg. She returned to work 2 weeks later but testified that she continues to have numbness in her inner left thigh and groin pain.

In her deposition, Defendant Gyn-Oncologist noted that although the primary concern for the referral was a palpable mass in the presence of history of metastatic colon cancer, the plaintiff was also dealing with chronic pelvic pain. Defendant Gyn-Oncologist discussed the standard risks of surgery, including the risk to adjacent organs which would be secondary to expected findings of scar tissue, which can alter normal anatomy. The “usual” organs injured in a case such as this are the small bowel and ureters, which lie in close proximity to the mass.

Defendant Gyn-Oncologist later testified that there was an amalgamation of vessels and organs plastered to the left pelvic side wall secondary to extensive

scar tissue. Ultimately, the patient agreed to proceed laparoscopically, with possible conversion to open. As to the surgery, it was difficult, secondary to excessive scar tissue in the pelvis, especially the left pelvis.

The left ovary was adhered to the left pelvic side wall and encased in scar tissue. Defendant Gyn-Oncologist stated that “generally” these types of surgeries are performed in a “2-hour timeframe,” and that this surgery was slightly longer than that.

Notably, Defendant Gyn-Oncologist did not recall whether she had specifically visualized the left external iliac artery, although she insisted that she makes certain when she cuts that no organs or vessels are in the way. In this case, because of the extensive scar tissue, dissection was required in the area of the left external iliac artery, IP ligament, and left ovary, as they were all adherent to the left pelvic sidewall. She testified that the rationale for performing retraction and/or dissection and/or lysis of adhesions would have existed whether the procedure had been done via an open technique or laparoscopically. Defendant Gyn-Oncologist stated that although there was no “active” bleeding, there was a fair amount of oozing from the surgical site.

**THE DEFENDANT’S EXPERT BELIEVED** the cause of the injury was likely manipulation during surgery in the face of extensive adhesive tissue which was clearly necessary under the circumstances.

Defendant Gyn-Oncologist was not involved in the discharge but recalled speaking with the patient on the first postoperative day after being advised of her paresthesia of the left foot. Defendant Gyn-Oncologist recalled being made aware on the second postoperative day that the patient was now complaining of coldness and pain in her foot and directed her to immediately return to the hospital. She recalled there being a “kink” in the iliac artery that was repaired without incident and that the vein was injured—and repaired—during the vascular surgery. She opined that the etiology of the injury was either retraction or heat transference during cautery, thereby causing injury to the intima and allowing platelet propagation and development of thrombus.

Our expert felt the only way to perform this surgery was laparoscopically, as the plaintiff had an extensive surgical history and likely many adhesions. Additionally, use of the LigaSure device was appropriate, as it controls heat transference beyond the surgical site. Ideally, a surgeon would dissect all the way down to the vasculature. In this case, given the extensive scar tissue, once the mass was extricated there was no longer a reason to dissect further, as that would have exposed the patient to potential injury.

The patient’s expert opined that the vasculature and pulses should have been examined before closure

and discharge, but our expert opined that this was not the standard of care for a gynecologic surgery. Other than ordinary observation prior to closure, nothing else was required. There was also no indication for pulse checks prior to discharge; the patient herself testified that her problems began to manifest after she was discharged.

The defendant’s expert believed the cause of the injury was likely manipulation during surgery in the face of extensive adhesive tissue, which was clearly necessary under the circumstances. He also opined that because of the anatomy in this presentation (the artery sitting below the encased ovary in the presence of extensive adhesive tissue), the risk of a retraction injury to the vasculature existed regardless of surgical technique used. As to the plaintiff’s complaints of lack of sensation to the left thigh, there are sensory nerves that sit atop the ovaries. During an oophorectomy a patient may have an injury to these sensory nerves, but most regenerate and heal within 6 months. Nonetheless, these nerves do not have an effect on motor function or deep sensation.

The patient’s expert opined it was a departure from standard procedure that none of the physicians checked the patient’s pulses before closing or in the postanesthesia care unit prior to discharge. He also opined that failure to visualize the left iliac vessels was a departure from good surgical

practice. Moreover, he opined that the hospital staff should have insisted the plaintiff return to the hospital immediately after the first phone call.

**Result**

Dismissals were obtained as to the residents involved. The patient’s current records and surveillance belied her claimed permanent motor injuries. After negotiation, the case was settled for a moderate amount prior to trial.

**Analysis**

While the injury was a known risk of the surgery and essentially unavoidable, there was strategic concern that the vascular surgeon would testify at trial that neither of the injuries occurred at his hand, thus implicating Defendant Gyn-Oncologist in 2 vascular injuries during the same procedure. Given the significant diminution in the plaintiff’s demands to resolve the matter prior to trial, the decision was made by all concerned to settle the case fairly nominally rather than subject the physicians to trial.