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## Did improper positioning during surgery cause neurologic injury?

After surgery for pubovaginal sling and possible cystocele and repair cystoscopy, patient alleges that positioning caused neurologic injury.

### Factual summary

The patient first presented to the defendant gyn on April 7, 2014, following a referral from her primary care physician (PCP). She presented with complaints of stress incontinence encumbered by urinary leakage with activity. An incontinence and prolapse questionnaire was filled out on the same date and a urinalysis was completed. The urinalysis was negative. At this appointment, defendant gyn examined the patient, including performing a pelvic exam in which she found that the patient leaked when she coughed. Following the evaluation, the defendant gyn discussed with the patient that her best option would be a vaginal sling. She also would have given her the option of either Kegel exercises or surgery, but defendant gyn did not believe the exercises would be effective. In a letter to the referring doctor, the defendant gyn described the situation as “fairly significant” and recommended that it be corrected.

The defendant gyn went over the

risks, benefits, and alternatives to surgery with the patient and gave the patient literature about the surgery. On May 12, 2014, the patient presented for a renal ultrasound for stress incontinence. The impression was “unremarkable bilateral kidneys.” A transvaginal ultrasound was also performed on this date, with the same indication. The impression was a right ovarian cyst and small fibroids.

The patient saw the defendant gyn again on May 15, 2014, and a urodynamic assessment was done. The plan at this visit was for a pubovaginal sling and possible cystocele repair. The defendant gyn again discussed the risks, benefits, and alternatives with the patient at this appointment, including the US Food and Drug Administration (FDA) warnings and a discussion about mesh. She noted the patient was aware of the risks, and literature was given regarding same. On the same date, the patient signed a consent for pubovaginal sling.

The patient presented to the defendant hospital on May 23, 2014, for the surgical insertion of a pubovaginal

sling. The patient signed a consent form on the morning prior to surgery, consenting to a pubovaginal sling and possible cystocele and repair cystoscopy. The surgery was performed by the defendant gyn with the assistance of codefendant resident. The pre- and postoperative diagnoses were uterine prolapse and stress incontinence. In her operative report, the defendant gyn stated that she discussed the risks, benefits, and alternatives relating to pelvic floor reconstruction. She also had discussed the FDA warnings and possible complications. With regard to the procedure, the patient was brought to the operating room and placed in a supine position. She was eventually put in a dorsal lithotomy position.

Per the operative report, a 3-cm incision was made in the midline and the tissues were dissected. The mesh kit was opened and the mesh was secured to the cervix and trimmed so that there was no mesh under the bladder. The vaginal canal was irrigated and closed with sutures. A midline incision was made and the

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tissues were dissected bilaterally until the symphysis pubis was identified. The Obtryx sling kit was opened and the trocars were placed bilaterally from the outside in through the vaginal mucosa without any perforation of the vaginal mucosa. The sling was positioned under the urethra. The vaginal mucosa was closed using sutures and the skin incision was closed. The Foley catheter was removed at the end of the surgery. The patient's legs were taken out of the dorsal lithotomy position, and the patient was awakened and taken to the recovery room in stable condition. The patient was brought to the postanesthesia care unit (PACU). From start to finish the procedure was 2 hours, with 1 hour and 20 minutes of operative time. The operating table had both a mattress and a gel pad.

Per the PACU nursing note, the defendant gyn was aware of the patient's complaints insofar as the PACU nursing note places the defendant gyn at the bedside being aware of the patient's complaints of numbness. Once the patient was able to ambulate to the bathroom and void, she was discharged home. Defendant gyn authored a note, after her first postoperative office visit note, on May 27, 2014, in which she indicated an Uphold transvaginal mesh and Obtryx sling were inserted on May 23, 2014, and the patient went home without a catheter. The patient's complaint was that her right big toe and top of her foot were numb. The whole foot was numb with tingling on the lateral side after the surgery, but it had gotten better, and she was able to walk. She was OK with sitting and walking. Her bladder and

bowel function were normal, with no leakage and minimal bleeding.

With regard to the surgery, the patient was placed in a dorsal lithotomy position with pressure points padded and joints at right angles. She was seeing her physical therapist that same day, and the defendant gyn was going to talk to the physical therapist after the patient was seen.

significant foraminal stenosis.

The patient emailed her PCP on June 3, 2014, indicating she had "gotten about half of my leg and foot back--but still have the foot drop." The email was included in the defendant gynecologist's chart and went on to explain that she still had pins and needles/tingling under the right peroneal nerve, and it went

**THE PATIENT SIGNED A CONSENT FORM ON THE MORNING PRIOR TO SURGERY, CONSENTING TO A PUBOVAGINAL SLING AND POSSIBLE CYSTOCELE AND REPAIR CYSTOSCOPY.**

On May 29, 2014, the patient was seen by her neurologist for an evaluation of her right lower extremity. The patient reported to her neurologist that she was unable to lift her foot while ambulating and had numbness in the foot. She also reported hypersensitivity. On evaluation the patient had weakness of the ankle dorsiflexion at 3/5 with toe extension 3/5 on the right side. Her plantar flexion was 4-/5, her eversion was 4+/5, and her inversion was 4-/5. She had decreased sensation over the dorsum as well as over the lateral aspect of the distal right lower extremity. She had steppage gait on the right side and was unable to walk toe to heel. Her neurologist's impression was that the weakness was suggestive of a sciatic nerve injury. She ordered imaging studies and would make recommendations once the results were received. An MRI of the spine was performed on the same date. The impression was minimal disc bulges at L3-L4 and L4-L5, with no disc protrusion, central spinal stenosis, or

down her shins to the front of her foot and big toe, and her second toe and half of her third toe also felt like pins and needles/tingling/ numb. On June 11, 2014, the patient underwent an electromyography (EMG) and nerve conduction study. The study showed "evidence of a right fibular mononeuropathy of uncertain localization, but likely proximal to the takeoff of the tibialis anterior and distal to the takeoff to the short head of the biceps femoris." Given the timing of the symptoms, it could have been premature, and a further study was recommended if the symptoms continued.

On June 16, 2014, the patient saw the defendant gyn again; the defendant gyn's handwritten note indicated the foot drop was resolving. On June 19, 2014, the patient underwent an MRI of the right knee. The impression was subtle signal elevation within fascicles of the common peroneal nerve and a suspicion of a small horizontal tear through the interior articular surface

of the junction of the posterior horn and body of the meniscus.

The patient presented to her neurologist again on June 20, 2014, following the above-mentioned electrodiagnostic studies. The studies showed evidence of right peroneal/fibular mononeuropathy of uncertain localization likely proximal to the takeoff at the tibialis anterior and distal to the takeoff at the short head of the bicep femoris. A repeat study was recommended because it was felt that the study showed premature signs of denervation. On exam there was no significant change in degree of weakness, but the patient did report increased sensation. She continued to have a steppage gait. Her neurologist suggested a further electrodiagnostic study and starting a trial of pregabalin (Lyrica).

On July 2, 2014, an MRI of the lumbosacral plexus was performed. The impression was “findings compatible with right sciatica distal to the right piriformis muscle, with suggestion of nerve entrapment at the anterior aspect of the piriformis muscle, which may be due to a subtle anatomic variant with close passage of the nerve along, possibly through the anterior surface of the piriformis muscle. Small focus of related edema in the anterior piriformis muscle consistent with inflammation.”

On July 9, 2014, the patient was seen by a new neurologist at the referral of her neurologist. His impression was that the patient had moderate residual, likely sciatic, neuropathy and likely was awaiting nerve regrowth from the axonal injury. He determined she might benefit from a brace and she was to continue physical therapy. In a note

dated August 5, 2014, defendant gyn indicated the patient’s foot was doing better, and she found physical therapy to be helpful. She was able to move her toes and walk with a normal shoe. She also had no urinary complaints or issues with leakage.

The patient saw the neurologist again on September 8, 2014. At this appointment, it was noted that she had recovered some strength in her ankle and was able to run wearing sandals. The neurologist commented she was “functioning reasonabl(y) normally despite the weakness.” On January 21, 2015, the patient returned for a follow-up appointment with the neurologist. Her leg strength had improved but remained somewhat affected. She was able to wear flip-flops. She reported increased sensory symptoms and starting to trip when her speed increased to 3.5 mph while running. The neurologist noted that the patient was still in a period of recovery and that activity was encouraged as she could tolerate it.

The patient saw the defendant gyn again on May 15, 2014, and a urodynamic assessment was done.

On May 19, 2015, the patient underwent another EMG study. The study showed evidence of a neurogenic process compatible with remote sciatic neuropathy. There was some improvement in the fibular motor response with persistent active denervation in the tibialis anterior compared with the June 2014 study.

### Allegations

The allegations include failure to

properly perform bladder sling surgery, failure to obtain proper informed consent, and failure to properly position the plaintiff.

### Discovery

The patient testified that she spoke with the defendant gyn in the recovery room. “She came in, she removed the gauze that they stuff there to control the bleeding, I guess. I told her about my leg. She said the same thing, ‘Sometimes that can happen.’”

Defendant gyn testified she would have told the patient: “The complications specific to the surgery but not specific to the mesh would include the sling being too tight, which would result in the inability to urinate or urinary retention; the sling being too loose, which would result in incomplete repair of the stress incontinence, pelvic pain, pain with intercourse, recurrence of the prolapse if a prolapse repair was done as well, which she did need. And then in here, there could be injury to neighboring structures, the bladder, the urethra, the bowel, the ureters. There can be narrowing of the vagina. There can be hip pain, back pain that could be related to the position on the table. Those are the complications and risks that I describe. They are the ones that are common, meaning within 1% or 2% of occurrences. Complications relating to other aspects to surgery in general are under 1%, so I generally don’t review those.”

Defendant gyn described dorsal lithotomy as “where the patient is on her back and her legs are in stirrups. In this surgery they were special stirrups that support the legs. And the hips are at a right angle and the

knees are at a right angle, and that allows access into the vaginal canal to perform the surgery.” The operating table had a mattress and a gel pad.

(from the patient’s overdeveloped piriformis from running) is associated with pain and not weakness. There would have been no preoperative

utilized by the defendants was taken off the market by the FDA and posed a future health threat and risk of sling failure to the patient. The court, seeing through plaintiff’s attempt to avoid dismissal by changing theories after we moved for dismissal, ruled that plaintiff had failed to oppose our motion and her new theory was late and unpled. The case was dismissed.

**WITH REGARD TO THE SURGERY, THE PATIENT WAS PLACED IN A DORSAL LITHOTOMY POSITION WITH PRESSURE POINTS PADDED AND JOINTS AT RIGHT ANGLES.**

Once a patient is under anesthesia, stirrups are placed on the operating table and the patient is then positioned under her direction by 5 people, 1 at each leg and 1 at each arm and the anesthesiologist at the head. The stirrups that are used are Allen stirrups, and they are padded and support the leg from the knee to the ankle and up the foot.

Defendant gyn testified that she did not have an independent recollection of the discussion she had with the patient in the PACU but knew the patient was having an issue with numbness in a foot.

The resident testified, “I don’t recall specifically what I did, but the general practice was to aid defendant gyn in performing the surgery in any way that she would direct me to help her.”

Our neurology expert believed the plaintiff suffered a sciatic nerve injury, which was a stretch injury from positioning and not padding. Although it is uncommon, it does happen and is a risk of the procedure. He indicated that there was nothing in the positioning that could have been done differently and as such he could defend the case. He does not believe that piriformis syndrome would be applicable here, as he indicated that piriformis syndrome

screening or testing that could have illustrated predisposition to such an injury.

Our expert in ob-gyn and female pelvic medicine and reconstructive surgery opined that the surgery was indicated and properly performed. He opined that proper consent was obtained based upon the notes, signed consents in the office, and hospital charts, as well as the patient’s own testimony, wherein she acknowledged being apprised of the risks of the proposed surgery. He further opined that positioning for the procedure was proper, as the dorsal lithotomy position was the proper position for this surgery. Standard of care required remaining in that position throughout surgery, and proper precautions regarding positioning and padding were employed. The neurologic compromise was a rare but known risk of the procedure. The procedure was properly performed and resolved the patient’s stress incontinence.

**Result**

We moved for summary judgment dismissal with expert support on behalf of our clients. Plaintiff opposed the motion but changed her theory. She now argued that the mesh

**Analysis**

It is always a bit trickier to work backward from a case once you know there has been irrefutable injury. Here, the patient had a documented nerve injury that could have occurred only during surgery. Some plaintiffs will argue that a nerve injury that occurs during surgery is per se negligence, or evidence of negligence on its face. To the contrary, however, there is a percentage risk of compression or positioning injury related to every surgery, particularly longer surgeries, and the most a careful, reasonable practitioner can do is take precaution to safely and properly position the patient with adequate padding of bony prominences and reassess that positioning during surgery in an effort to avoid complications. Here, that was done, and our expert felt strongly that the patient’s complication was not the result of negligence. Plaintiff could not find an expert to refute that position and so the case was dismissed. ■



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