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General Surgery Sample Case

Mistreated diabetic foot ulcer resulting in amputation.

This obese, non-insulin dependent diabetes mellitus (NIDDM) patient of 25 years developed an ulcer/blister on the bottom of his right foot which became infected, and resulted in an amputation of his foot, and then leg below the knee.

Diabetics have an impaired immune system and large artery and small artery disease (blood vessels carrying the red oxygenated blood and antibiotics to their flesh). When there is any infection of the foot, all the pulses in both legs have to be assessed by feel (palpation). These include the femoral pulse in the groin, popliteal behind the knee, the posterior tibial inside side of the ankle and the dorsalis pedis on the top of the foot. If they can not be felt, or if there is any question, then a blood flow meter (doppler ultrasound) is used to measure the arterial flow. Also capillary refill, measuring the quality of blood flow to the toes is easily tested by pinching the toe nail and then seeing how many seconds it take to "pink up" again. Normal is a few seconds. None of this was done, and is negligent.

On 3/6 he initially had problems with his left leg (painful swelling from his knee to top of his left foot). There was 2+ (out of 4) edema (swelling) of his right lower leg (pre-tibial: shin bone). They did a venous (not arterial) study of his left leg and the veins were patent. There were no blood clots.

On 3/13 he had his nails trimmed and that podiatrist noted: "Vascular DP/PT (dorsalis pedis/posterior tibial) bil (bilaterally: both legs) CFT (capillary filling time) less than 3 seconds x 10 (all 10 toes). Based on this, his major arteries were patent, and the microcirculation to his toes was normal. Therefore, I would conclude that it would not dramatically change in 10 months. This means he had a much better opportunity to heal the neglected infection with proper intensive care.

He had varicose veins (distended veins with damaged one way valves) which most likely was the cause of his swelling. The fact that they noted it was "postural" is consistent with that chronic venous problem. Elastic stockings (Ted hose) were correctly prescribed.

The inflamed flesh (cellulitis) on the front of both knees was successfully treated with the antibiotic Keflex.

On 4/2 his venous stasis dermatitis, from his chronic venous insufficiency, was resolving.

On 7/28 the Podiatrist noted that he had flat feet and wears orthotics (arch supports). Did they cause the blister? Were they properly fitted? Did he use them?

On 9/8 blisters had popped and were draining on his left leg. He had a shallow ulcer on his left shin and was treated with the antibiotic Keflex. This is acceptable care. This ulcer had dried up by 9/18. They continued his diuretic medication (Lasix) to try to control his chronic fluid swelling (edema) condition. This is acceptable care. On 10/1 he was "doing better". His blood sugar levels were under good control at home. There was 3+ edema of his left leg and 2+ on the right.

On 10/1 the dermatologist ordered greater strength compression bandages to 30 millimeter pressure. This is good care.

On 10/2 the Podiatrist noted "Infected plantar area" of his right foot, prescribed the broad spectrum antibiotic Cipro. But, no pulses were tested. No capillary refill was evaluated. He was sent to the Primary Care Clinic that same day. The Physician Assistant noted that this was a new problem for this patient and: "bottom right foot is an = 4 centimeter (1 inch = 2.54 centimeters) blister type lesion with white skin - it appeared it possibly has pus but none was expressed (squeezed out). This appears to be a resolving blood blister". He continued the antibiotic and told him to keep his foot clean and to "stay off foot". No pulses or capillary refill were checked. He was to return on 10/9.

On 10/9 "No infection was noted and it appeared to be an old blister of some sort". It had resolved. Did his shoes and/or orthotics cause it??

On 10/23 he returned to the Primary Care Clinic and the doctor noted: "Area in right foot has now opened". It was 15 by 10 millimeters (25 millimeters = one inch). And "there is also an area where patient pulled off skin with tape". The loose skin was debrided (cut off). No therapy was prescribed and he was given an appointment to return in two weeks. Both are negligent. This raw open ulcer needed topical antibiotic therapy to prevent an invasive infection, and he should have been seen in a few days (or home

visiting nursing care arranged on a daily basis). No instructions to return if any change occurred was recorded in that clinic visit record.

He returned as scheduled on 11/10. Apparently he had been taking Afloxacin 400 milligrams, two times a day. Who prescribed it, where, and when? Was it the previous prescription, refilled? Antibiotics should not be given as a refill. Patients who need more antibiotics need to be seen by a doctor. That note said: "May need debridement". He had "right foot pain". That is an ominous change in a diabetic patient who often have nerve damage and decreased pain sensation.

The doctor said: "Patient was changed from Cipro to Ofloxacin more than two weeks ago". The Podiatrist said to continue the Ofloxacin. And the note says: "Patient feels the Ofloxacin not as good as Cipro. He's had increased drainage since medication change". And no doctor saw him for two weeks!

The note went on to say: "bottom right foot with black eschar (scab/dead skin), foul smelling wound, no change in size (except now it extended deeper into his foot)". The doctor planned to change the antibiotic to Cipro and "refer to dermal wound clinic" and RTC (Return to Clinic), which is a grossly negligent note and plan. He required immediate hospitalization, operative wound deep debridement and intensive intra-venous (by vein) antibiotics, so a higher blood level could be achieved to help kill the germs.

All of this had a strong chance of being avoided if, with a raw ulcer, he would have been seen more often and carefully instructed to return with any changes: pain, fever, red streaks up his foot or leg, drainage, or wider or deeper progression. This note above was certified by a Physician Assistant (PAC) #1. How did he ever become certified and put in that clinic? He was not fit for the purpose intended as it relates to this patient. Obtain all his schooling and previous and current employment records.

As is common in my experience in reviewing records from our government's hospital system, often key records are missing. Obtain the Dermal Wound Clinic and all records until his November 13 hospital admission. Also obtain the missing admitting history and physical, first operative report, both surgical pathology reports, and all nurses notes and all records until the day after the second operation. Have them sequentially number them, and certify them to be complete.

On November 13 he was admitted to the Hospital #1 with: "...a 3 to 4 centimeter (1 1/5 to 1 3/5 inch) ulcer on the plantar aspect of the right foot that was fluctuant (soft because of pus within) with necrotic (dead) muscle underneath, and a foul odor".

He received intra-venous antibiotics, and on November 14 his foot was amputated. On November 20, because of persistent fever and infection he had a below the knee amputation. His stump healed.

He was next hospitalized at the same hospital because of "osteomyelitis (bone infection) left ankle" and received six weeks of IV (intra-venous) antibiotics. He was admitted with left ankle pain and the x-ray showed osteomyelitis and his foot revealed an obvious charcot joint (bone destruction in a diabetic caused by decreased nerve sensation to feel pain and joint position while walking).

This time it appears they did the right thing and even cured osteomyelitis which is difficult to cure. Therefore, I also conclude that if they would have treated him properly (timely and intensively) for his right foot infection of "soft tissue" (skin and fat and eventually, from neglect, muscle) he would not have needed an amputation. He would be walking on his own two legs, instead of one leg and a prosthetic leg.

For all the reasons noted above, his treating Physicians and Physician Assistants, and the Hospital #1 and Clinic, were negligent, and their negligence was the proximate cause of his amputation.

I would recommend Experts in the fields of Infectious Disease, Podiatry and General Surgery. They are available through our Fee Schedule.