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Gynecology Sample Case

Delayed diagnosis of ovarian cancer.

According to the records, the patient was admitted to Hospital #1 from April 10 through April 11, because of unstable angina. The patient had had previous angioplasty operations, had an elevated cholesterol, and at age 52 had repetitive episodes of chest pain radiating to the left arm and then developing pain in the chest. This hospitalization was appropriate to rule out a heart attack. The abdomen examination was "benign," and it would be contraindicated and inappropriate to perform a pelvic examination during that hospitalization. Her care appears to have been appropriate at that time.

The next hospitalization was exactly one year later, from April 10 through April 11. She was transferred to Hospital #1 from the Emergency Room of Hospital #2, with pneumonia involving the lower lobes of both lungs. She also had some diffuse abdominal pain, but had not had a bowel movement in a few days. The abdomen was slightly distended and diffusely tender, more in the upper abdomen. She responded to intravenous antibiotics, enemas and was sent back to the family practice clinic to see Dr. #1.

Since the patient had pneumonia documented by x-rays, had received intravenous antibiotics for her documented pneumonia, plus considering the fact that the patient did develop bowel movements following enemas and the rectal exam was negative with no blood in the stool, that could be considered reasonable care. However, there was no pelvic examination performed. Depending upon the amount of discomfort the patient had in the lower abdomen, it would have been appropriate to perform a pelvic examination.

Before discharge, they were considering getting an abdominal ultrasound as an outpatient. That was after the abdominal pain had decreased, on April 11, when she was discharged to the clinic.

Five weeks later, she was re-hospitalized, and they noted that her abdominal pain had been present for about three weeks and had become increasingly more severe. During this admission, the abdomen was diffusely tender in its lower half, and they noted a mass to palpation (by feeling) in the left lower quadrant of the abdomen. A CAT scan was obtained which revealed a thickening of the omentum, which is the large fat pad that hangs down from the stomach and large intestine. Because of this mass and the abnormality on the CAT scan, operative intervention was indicated.

Surgery was performed by Dr. #2 on May 22. The patient had previously had a hysterectomy operation and had had her appendix and gallbladder removed. There were adhesions in the abdomen (scar tissue), and they noted "the mass was the omentum which was very caked and firm to palpation. This was adherent not only to the abdominal wall, but to the sigmoid colon and superior rectum." A biopsy revealed that to be metastatic adenocarcinoma (spreading cancer). Dr. #2 noted "the patient's ovaries were still in place. The right ovary was somewhat larger than the left."

He removed her ovaries, the omentum, as much tumor as possible, and a segment of the large intestine. This was a "debulking" operation to remove as much cancer as possible so that the patient would have a better opportunity for any response with subsequent chemotherapy.

The Pathologist confirmed the vast amount of adenocarcinoma removed, and that was consistent with a primary cancer involving the ovary. The left ovary was normal in size, measuring 3 x 2.5 x 2 centimeters (1 inch = 2.54 centimeters). There were three segments removed on the right side, one of which most likely was a fallopian tube, according to the pathologist. The largest segment removed measured 4.2 x 1.7 x 1.5 centimeters. This is only slightly enlarged.

There was no large ovarian tumor that subsequently spread by bursting through the capsule, with the cancer cells implanting throughout the abdomen. This appears to have been a tumor that began on the surface of the right ovary and spread very quickly into the abdominal cavity.

Therefore, even if a pelvic exam would have been performed earlier in time on this 130-lb. patient, most likely there would not have been any mass to discern by pelvic examination. The ovary was not even two times its normal size. The omentum does not hang down in the pelvis, and generally that would not be felt by a routine pelvic examination. Only when the tumor mass began to grow dramatically in size, after it had spread, was an abdominal mass discernible during this hospitalization. In my opinion, that cancer had already spread from the ovary many months before in time and began to

grow slowly over time. As the cancer grows, and as the cells duplicate, there is an exponential growth in the size with each doubling of the tumor subpopulation.

They also noted that her abdominal pain was approximately three weeks in duration, and getting worse prior to the admission. However, in retrospect, it was probably about five or six weeks considering the previous hospitalization in April of the same year.

On July 30, she was hospitalized for the insertion of a Port-A-Catheter for chemotherapy. The patient received chemotherapy and had a remarkable response. The cancer marker, CA 125, dropped from the elevation of over 300 down to approximately 35.

The patient had some abdominal discomfort and was hospitalized on May 29, with partial small bowel obstruction, and she responded to stomach suctioning and intravenous fluids. That was proper care.

She was hospitalized in August with some abdominal discomfort. An ultrasound revealed some thickening of the descending colon (large intestine), and a CAT scan also showed what appeared to be enlarged lymph nodes and a mass deep within the pelvis. Because of that, exploratory surgery was performed on April 26, by Dr. #2. After dissecting through extensive adhesions involving the intestines, he found no residual cancer. The mass in the pelvis, adjacent to the rectum, was a collection of fluid entrapped by the intestines. There was no evidence of recurrent cancer at that time. That was consistent with the diminishment of the cancer antigen described above.

On September 20, she had a CAT scan of the abdomen and pelvis, and that did not find any recurrent cancer (mass).

In the office records of the Family Practice Clinic, beginning two years earlier, all the office visits related to her cardiac condition, her anticoagulation, and the past history of thrombophlebitis (clots in the leg veins). Unless she was seen for full gynecological care, it appears that she was only seen for chest pain. However, a family practice clinic should take care of the entire patient. In my opinion, it is a departure from the accepted standards of care, in a patient age 53, not to perform at least an annual pelvic examination. However, as I described above, even if that would have been done, it most likely would have been negative. I say this because, as I mentioned, at surgery the right ovary was only slightly enlarged. Therefore, earlier in time, it would not have been enlarged at all. On pelvic examination, where one hand is placed deep into the vagina and the other on the anterior abdominal wall, unless there were a significant enlargement, a slight enlargement would not be detectable. The failure to detect such a small enlargement would not be a departure from the accepted standards of care.

So, even though, in my opinion, they departed from the standards of care in not doing a pelvic examination, with a high level of medical certainty, it would have been negative.

On November 18, six months before surgery, her weight was stable at 129 lb., as it had been for a long period of time; there was some tenderness in the right lower quadrant of the abdomen; the abdomen was not distended; and there were good bowel sounds. In my opinion, because of localized pain, Dr. #1 should have performed a pelvic examination on November 18, 1995. Even at that point, with cancer having most likely spread to the omentum, I do not believe that she would have felt a mass. The omentum is high up in the abdomen, and the ovaries, as I mentioned, would not have felt enlarged.

When she saw Dr. #1 on April 19, there was tenderness over the right half of the abdomen and some guarding (muscular rigidity) secondary to internal pathology. The x-rays showed a distended colon and possible small bowel obstruction, and she was sent over to the Emergency Room for further evaluation. The patient responded to conservative care and within a month was diagnosed as having diffuse metastatic ovarian cancer. It was only in the middle of May when the abdominal mass was detectable by one of the physicians. In the initial evaluation during that admission to the emergency room, they did not detect any abdominal mass.

In October, she was hospitalized for anemia and depression of her platelet count, which are the clotting particles produced by the bone marrow. Most likely, this was secondary to the chemotherapy, and she received blood transfusions and proper medical attention.

Although some Physicians would have obtained an ultrasound in April, and that may have shown some enlargement of the right ovary and possibly would have shown a mass developing in the greater omentum, in my opinion that is a judgement call. Even if it would have been done and if she would have had surgery a month earlier in time, I do not believe it would have made any significant difference to the outcome. When they did the "debulking" operation, there was still studding of tumor in her abdomen, and that would have been present earlier in time. They removed as much tumor as possible, and basically left her at the same stage as if the operation would have been performed four weeks earlier.

In brief summary, this patient had ovarian cancer, but most likely it spread from a tumor on the surface of the right ovary, rather than being a large tumor that eventually burst through its containing outer membrane. This cancer spread into the abdomen, and as it grew over time, gave the patient symptoms and was eventually detected as an abdominal mass. That is, the cancer that had spread to the omentum had grown into such a large size that it was detectable by the abdominal examination. She underwent major surgery that was indicated, and apparently had a remarkable response to the chemotherapy.

Based upon my review of all the above, although there were some discrepancies which I would call departures from the accepted standards of care, I do not believe that they made any significant difference to the final outcome of the case, for all the reasons stated above.

As I reviewed the records I placed paper clips on the more relevant pages and highlighted the most significant facts. I believe this will assist you in understanding the problems associated with this complex case. The records will be returned to you under separate cover.