Medical Opinion - Patient Name

DOB: MM/DD/YYYY

Summary of merit:

Upon reviewing the available medical records, it is with a degree of reasonable medical certainty; I opine that there was a deviation from the standard of care provided to Ms. XXXX in ABC Adult Hospital. The team which conducted delivery for the patient on 08/16/YYYY failed to make sure placenta was completely removed. Dilatation and curettage performed on 08/23/3019 showed fragments of placenta in the uterus.

Ms. XXXX had a spontaneous vaginal delivery on 08/16/YYYY. After giving birth, there as delayed cord clamping and placenta was removed via Schultz maneuver. However, after removing the placenta the team noticed atony of the uterus and bleeding continued which was about 1 liter. The patient was given Pitocin, Methergine and Cytotec and the bleeding was controlled. But the treating team failed to assess whether placenta was completely removed, or any fragments were left. It is important as retained placenta is known to cause both primary and secondary post partum hemorrhage. At times the bulk of the placenta will deliver spontaneously or manually, but small portions or an accessory lobe may be retained. This may be suspected when the placenta appears fragmented after delivery or when there is ongoing heavy uterine bleeding. In this situation, the uterine cavity may be evaluated with manual exploration or with ultrasound. **(Ref 1)** **(Ref 2)**

Defendants:

- XXXX, M.D.
- XXXX, CNM
- XXXX, RN
- XXXX, RN

Deviations from the standard of care:

- Failure to ensure placenta was completely removed
- Failure to document manual exploration of uterus to look for retained placenta
- Failure to document use of ultrasound to rule out retained placenta
- Failure to prevent secondary post partum hemorrhage

Damages:

- Secondary post partum hemorrhage 7 days after delivery
- Need for multiple procedures like dilatation and curettage and exploratory laparotomy with hysterectomy
- Severe blood loss and need for multiple blood transfusions, fresh frozen plasma and cryoprecipitate
- Need for intensive care admission

- Prolonged hospitalization and recovery period
- Pain and suffering
- Emotional distress
- Financial implications
- Morbidity from all the above

Case overview:

XX-year-old G5P3014 at 40weeks 4days by LMP complaints with 20 weeks US presenting for elective induction of labor at term. Pregnancy complicated by late entry to care, sporadic prenatal care, anemia (HCT 25 on 08/03), and GBS (Group B streptococcal) bacteriuria. On 08/15/YYYY, she was admitted in ABC Adult Hospital. She had an SVD on 08/16/YYYY at 40 weeks 5 days following an elective induction of labor. Her delivery was notable for a postpartum hemorrhage due to lower uterine segment atony. At that time, she received Pitocin, Cytotec 800 mcg PR, Methergine x 1, and Hemabate x1. Total EBL at the time of delivery was 1 liter. On postpartum day 1, she had symptomatic anemia and was transfused 2 units PRBC with resolution of symptoms. She was discharged home on postpartum day 2 in stable condition with a PCV of 25.

On 08/23/YYYY, she was postpartum day 7 status post spontaneous vaginal delivery and presents via EMS due to a postpartum hemorrhage at home. Per EMS, the patient was found sitting in her bathtub with a large volume of blood surrounding her. On arrival, she was hemodynamically stable but appeared pale, altered, and would only intermittently respond to questions. Large amount of clot was palpable in uterus but unable to manually extract it due to patient discomfort. Dilaudid 0.25 mg given and bimanual exam re-attempted, but still poorly tolerated by patient. Due to need for exam under anesthesia, possible dilatation and curettage, and possible resuscitation, decision was made to proceed to OR emergently. The patient was verbally consented and agreed with proceeding to OR.

In the OR, D and C was notable for 20-week size uterus filled with clots, cervix 4-5 cm dilated, retained fragments of placenta along anterior and posterior uterine walls, and uterine atony refractory to multiple uterotonics, TXA, and Bakri balloon placement. Given ongoing hemorrhage, decision was made to proceed with exploratory laparotomy and supracervical hysterectomy. Patient required 15u PRBCs, 5u FFP, 2u Cryo, 500cc albumin, 1u platelets, and 5200ml crystalloid with a total EBL of 6L. Patient tolerated the procedure and was taken to the SICU intubated and sedated. On POD 2, patient was transferred from the SICU to the postpartum floor in stable condition. She meets all postoperative milestones and was ultimately discharged home on POD 4 on 08/27 with Tylenol 1000mg every 8 hours, Gabapentin 100mg every 8 hours, Ibuprofen 600mg every 6 hours, Pericolace 2 times per day, Oxycodone 5mg every 4 hour, and ferrous sulfate. Patient educated on reportable signs and symptoms and instructed to follow up POD 7-10 for staple removal.

Reference:

Ref 1: https://www.aafp.org/afp/2017/0401/p442.html

Ref 2: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6789409/