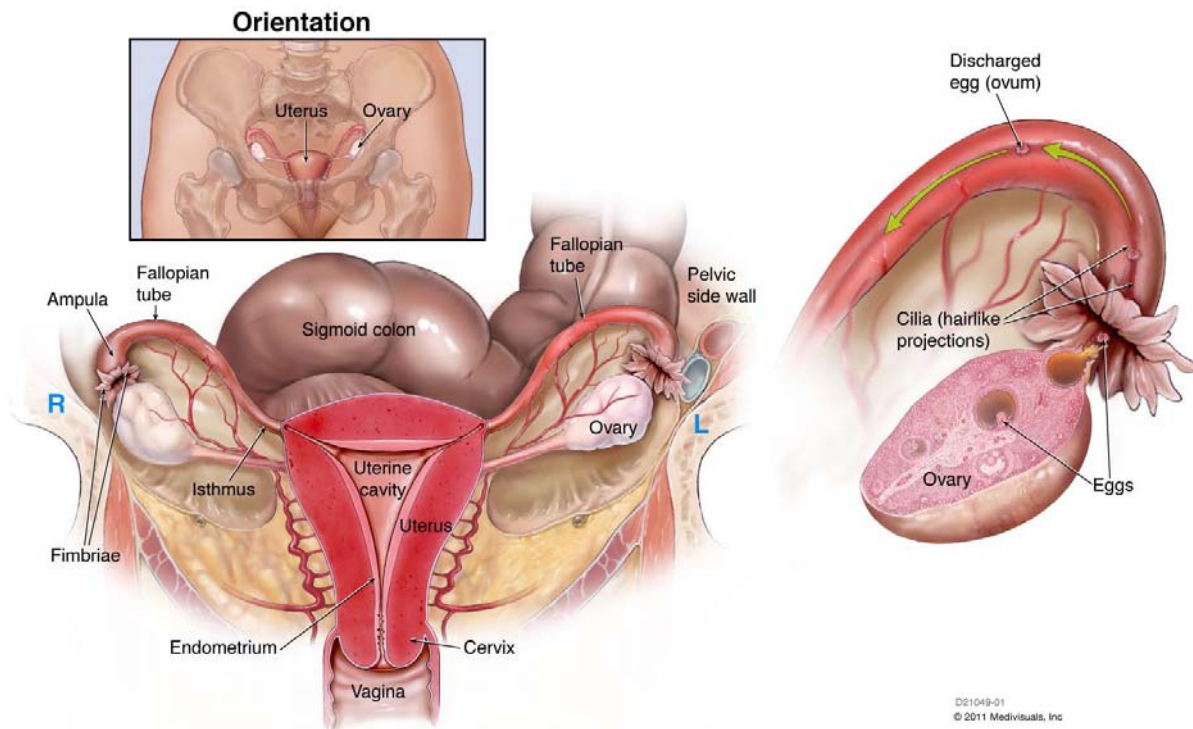


BHG073 - Mirza vs. Chang story

An OB-GYN client of Fonda & Fraser, who specializes in Reproductive Endocrinology and Infertility was recently sued by a patient who alleged she sustained a bowel perforation during a laparoscopic salpingectomy performed by our client.

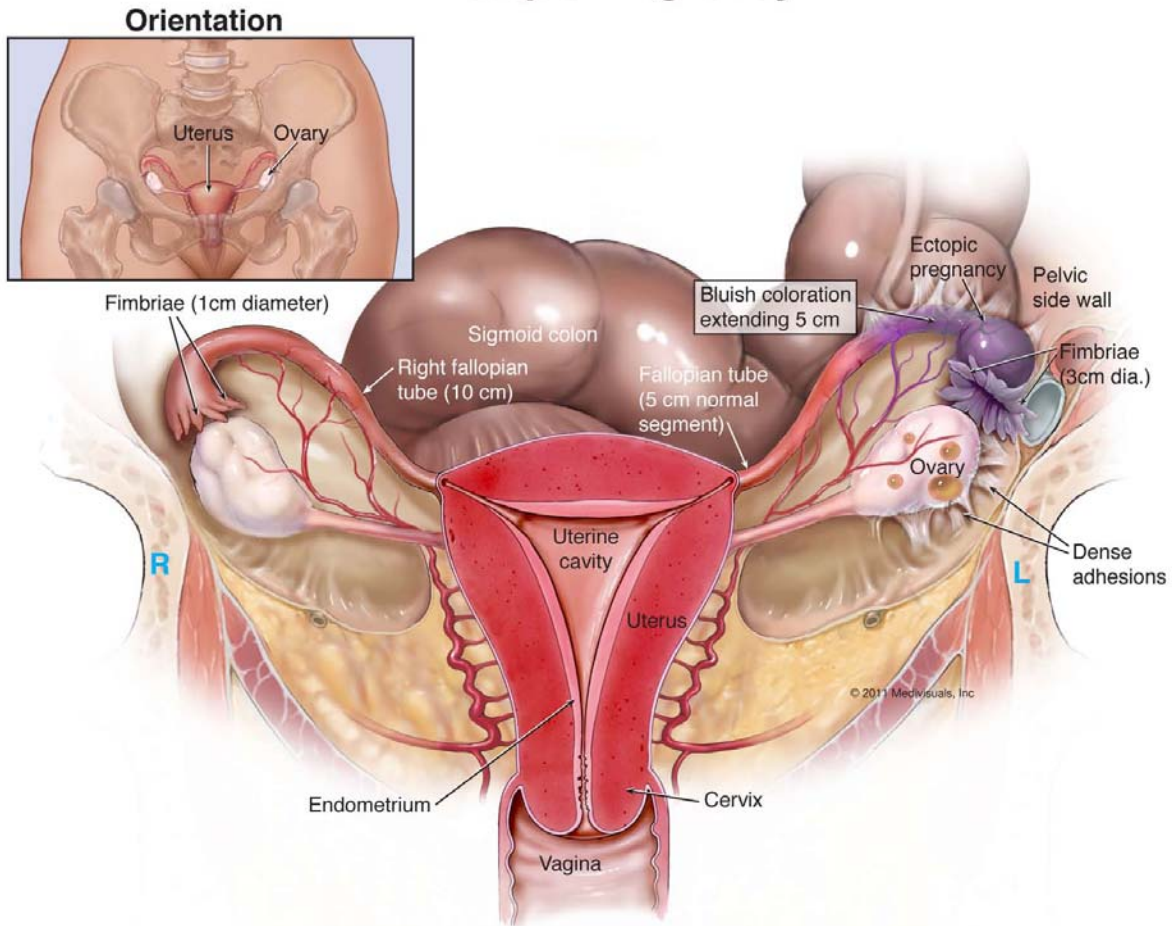
This 34-year-old patient had a history significant for multiple miscarriages and ectopic pregnancy, resulting in her inability to successfully carry and birth a child. As a result of her advancing age and concern she may never produce children, this patient sought the assistance of Fonda & Fraser's client infertility expert physician. The complex medical issues in this case required the enlistment of our friends at MediVisuals to illustrate this patient's medical story. In order to educate and orient the defense team, the patient/plaintiff, her attorney, the trial court judge and jury had the case gone that far, MediVisuals prepared the normal female reproductive anatomy illustration below.

Normal Female Reproductive Organs



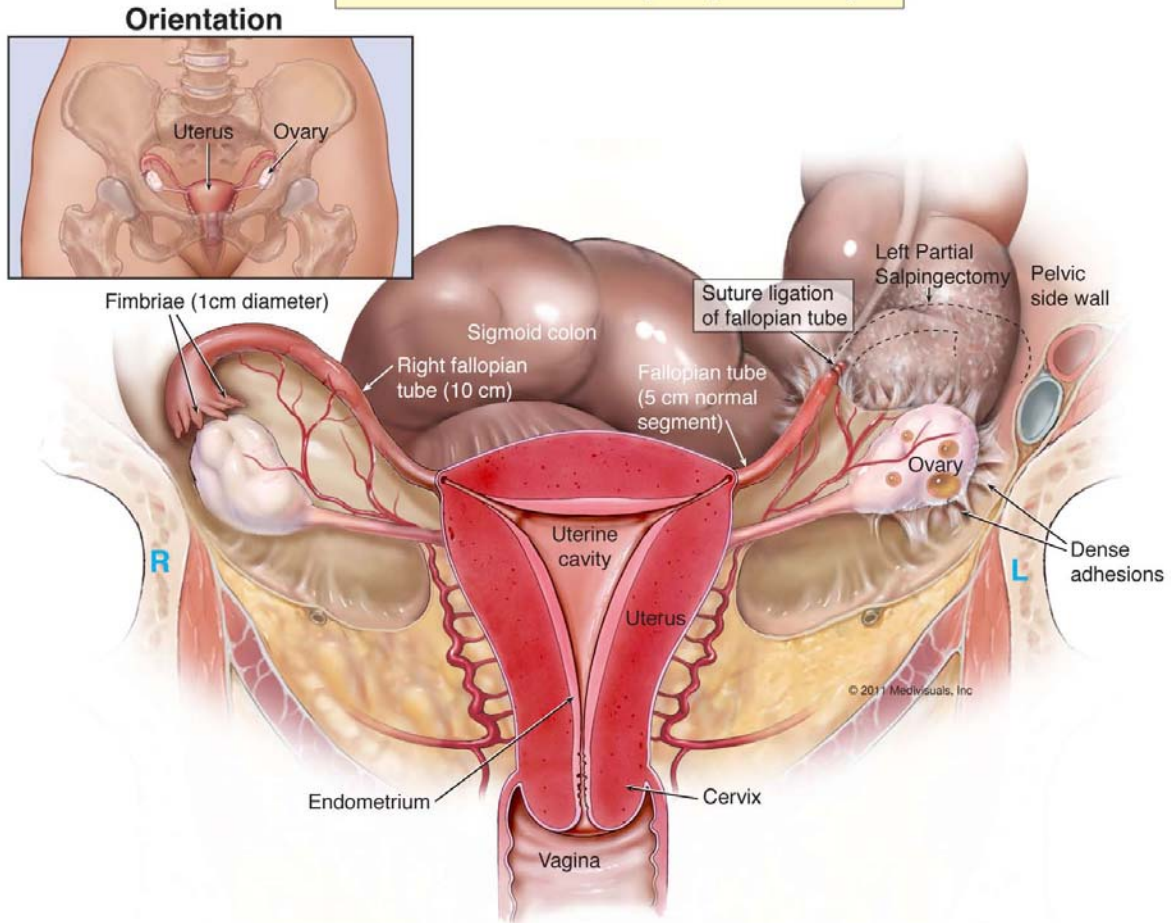
Approximately 15 months before treating with our client doctor, the patient developed an ectopic pregnancy (*embryo implanted and growing within the fallopian tube*) producing extreme pain. The patient presented to the hospital where ultrasound identified the problem, as illustrated below.

Ectopic Pregnancy



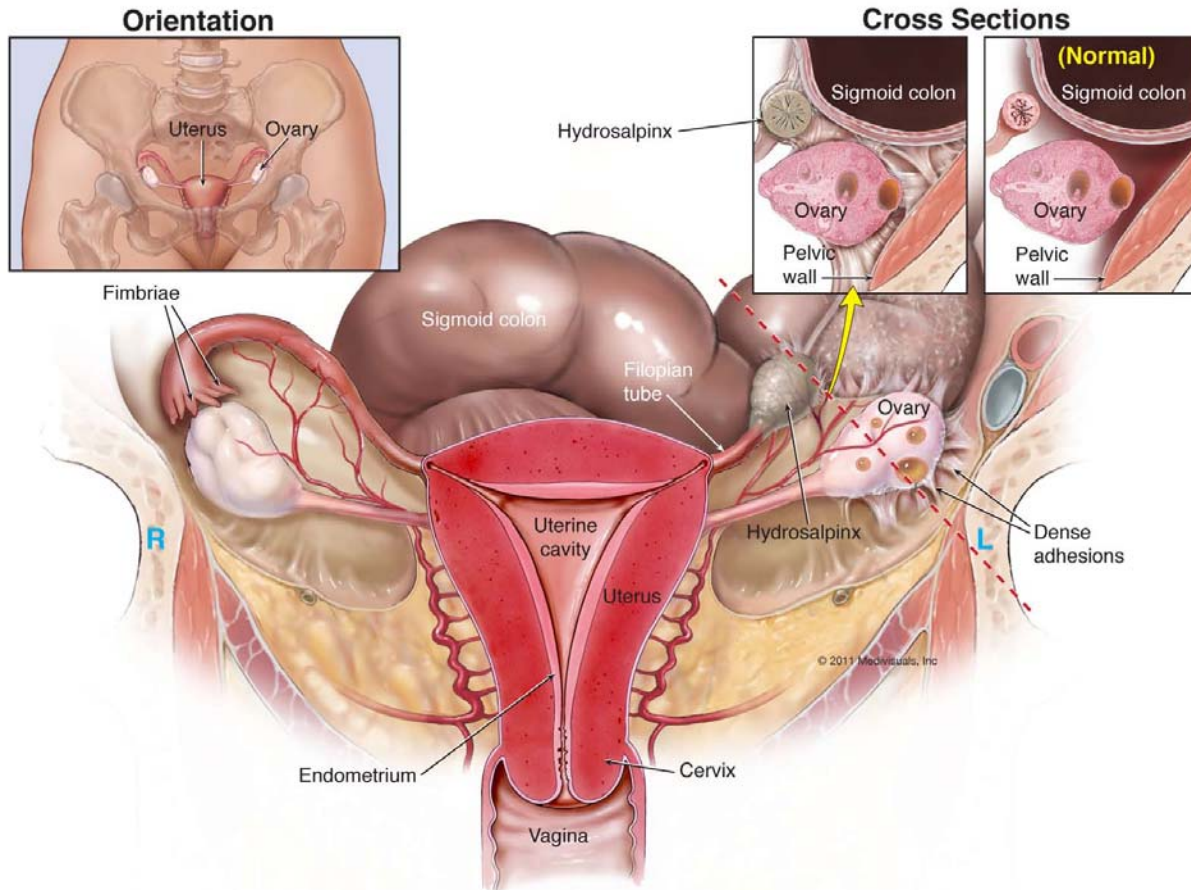
The patient underwent emergency partial salpingectomy (*partial removal of the fallopian tube and the ectopic pregnancy*). However, during the procedure, the surgeon identified dense adhesions binding the fallopian tube, ovary and sigmoid bowel together and to the pelvic sidewall. (*See above illustration of adhesions.*) It was felt the risk of injury to the sigmoid colon during adhesion takedown required to surgically remove the entire fallopian tube (*optimal in cases of ectopic pregnancies for reasons discussed below*), outweighed the risk of simply leaving behind a segment of the tube. As a result, postoperatively the proximal fallopian tube remained intact, but sutured closed distally and adhered to the sigmoid bowel, as illustrated below.

Left Partial Salpingectomy



Some 8 months later the patient remained unsuccessful in her attempts at pregnancy and was seen for the first time by our OB-GYN, Reproductive Endocrinologist and Infertility specialist, wherein the decision was made to proceed forward with uterine implantation of a donor egg. However, before doing so, a hysterosalpingogram (*radiographic procedure to evaluate the shape and patency of the reproductive tract*) was needed to assure the best chance of success of an implanted egg. Unfortunately, this study revealed a left hydrosalpinx (*distally blocked fallopian tube ballooned out and filled with serous fluid, as seen in the illustration below*). The left hydrosalpinx was not a surprise and resultant of the prior partial salpingectomy, illustrated above. Hydrosalpinxes can produce a potentially toxic environment to the implanted egg by expelling back down the fallopian tube and into the uterine cavity the stagnant, nasty fluid ballooning the distal end of the tube, thereby contaminating the donor egg. As a result, the standard of care requires surgical removal of hydrosalpinxes prior to the very expensive donor egg implantation.

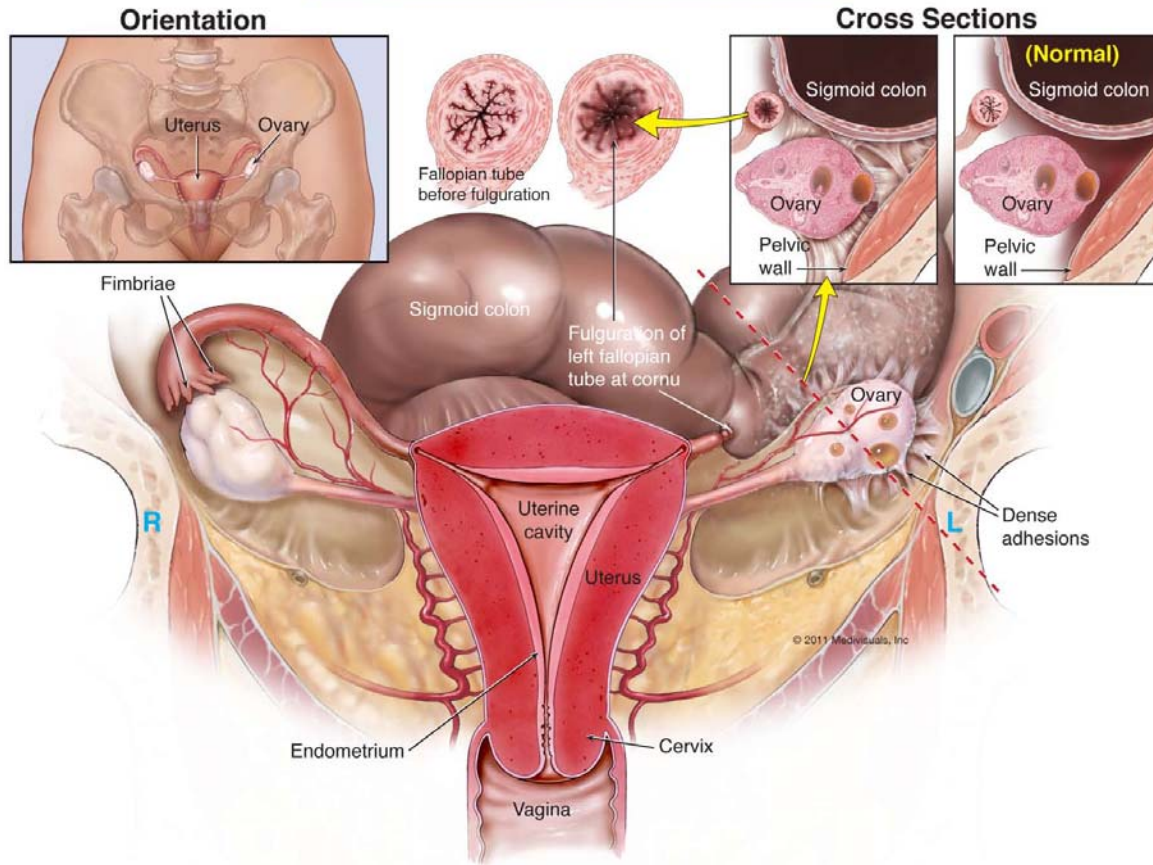
Hydrosalpinx



Ultimately, the patient elected to proceed with removal of the left hydrosalpinx (*repeat partial salpingectomy*) in anticipation of donor egg implantation. Our client doctor undertook and documented her extensive verbal discussion with the patient informing of the risks and possible surgical complications, including but not limited to, bowel (*sigmoid colon*) injury. This informed consent document was signed and dated by the patient. Separately, our client physician ordered the patient to undergo a bowel prep prior to the surgery to minimize the possibility of surgical complications in the case of injury to the colon.

The final illustration above reveals what our physician client saw upon commencement of surgery. Specifically, note how the hydrosalpinx, ovary and portions of the sigmoid colon are covered with adhesion tissue, sticking them not only together, but also to the pelvic sidewall, significantly increasing the difficulty of excising the hydrosalpinx and the risk of injury to all the organs. This normally relatively simple procedure was significantly complicated by our client having to first surgically takedown much of the massive adhesions before she could successfully remove the hydrosalpinx with fulguration (*burning closed*) the tip of the fallopian tube, as illustrated below.

Fulguration of Fallopian Tube



We now know that 4 days postoperatively, the patient was returned to the operating room, wherein she underwent exploratory surgery and repair of a 1cm perforation to the sigmoid colon, which may have occurred during hydrosalpinx removal. The patient subsequently had an extended hospitalization for peritonitis, sepsis, pulmonary embolism and placement of a temporary colostomy, but thankfully she has reportedly made a full recovery.

The defense of this case was successful, in part due to being able to tell the story visually with the help of MediVisuals above illustrations and due to our client appropriately taking every precaution to assure the best possible surgical outcome, as well as keeping the patient well informed of potential complications even with compliance with the standard of care.