Title: Diabetic Patient With Acute Gallbladder Disease Develops Severe Pancreas Infections and Death from Failure to Perform Gallbladder Surgery.

I have prepared the following confidential Case Evaluation for you at your request. This report sets forth our professional opinion based upon the medical records that were submitted. These records included a Statement of Facts as well as outpatient, Emergency Ward and multiple inpatient entries that spanned from 1991 to 2007. In all, approximately 663 pages of medical records were reviewed. Unfortunately, although the records were voluminous, it appears that all available records were not received as indicated by the comment in the Statement of Facts that the patient died but records leading up to his death are unavailable.

Salient aspects of this case are as follows:

1) The patient, formerly of the Kentucky area and now deceased was a 60 year old diabetic when a CT scan of the abdomen was ordered in the evaluation of right flank pain by his family practice physician. On November 2, 2006 this CT scan was obtained and demonstrated gallstones. The official report of this CT scan indicated that Dr. #1 had ordered the study and he would be the medical person responsible for its follow-through which should have included a Surgical consultation.

2) Indeed, it is well known that diabetics, unlike the rest of the population at large, are at a heightened risk for complications of gallstones. Whereas it is often acceptable to observe nondiabetics with asymptomatic gallstones for indications for cholecystectomy (gallbladder removal), a diabetic even if asymptomatic should be considered for gallbladder removal pre-emptively to avoid dreaded complications such as occurred in this case. The fact that the patient had already been symptomatic in October 2006 further heightened the need for Surgical evaluation for gallbladder removal at that time.

3) On May 5, 2007 he developed severe abdominal pain, nausea, vomiting and presented to the Medical Center the following day where he was diagnosed with gallstone pancreatitis. His amylase and lipase were markedly elevated at 1946 for his serum amylase and 8281 for the lipase. These enzymes are released during pancreatic inflammatory conditions and were elevated 20-200x baseline normal values.

4) He suffered from numerous acute relapses of his pancreatitis which required Emergency Ward and inpatient stays on May 28, 2007, June 7, 2007, August 1, 2007 and others and he had a myocardial infarction (heart attack) which required stent placement in his coronary arteries on a July, 2007 hospitalization.

His acute pancreatitis eventually was complicated by chronic pancreatitis, necrotizing (gangrene and self-digesting) pancreatitis with pseudocyst and abscess formation. He underwent appropriate drainage, pancreatic resection and cholecystectomy (gallbladder removal) on September 24, 2007 by Dr. #2. He received antibiotic therapy and parenteral (intravenous) nutrition on several of his hospitalizations.

5) Further details surrounding his death are not available at this time.
In summary, an abdominal CT scan performed under the direction of Dr. #1 indicated that this patient suffered from symptomatic gallstones as early as November 2, 2006. The standard of care for diabetics with gallstones required that a Surgical consultation be obtained to electively consider gallbladder removal as diabetics are at increased risk of gallstone-associated complications including gallstone pancreatitis and cholangitis (bile duct infection), potentially fatal conditions that are completely prevented with gallbladder removal.

The failure to consider the patient for elective cholecystectomy (gallbladder removal) was the direct cause of his acute and chronic pancreatitis as well as contributing to his heart attack and necrotizing pancreatitis. Further, the failure to obtain an ERCP or similar procedure to remove the patient’s gallstones on each of his hospitalizations prior to September, 2007 were further examples of deviations from existing standards of care that caused or significantly contributed to his severe pancreatic inflammatory conditions.

Since the gallbladder sits anatomically near the pancreas, and the outflow tracts (“ducts”) are joined to each other, the presence of a stone within the gallbladder wall can acutely inflame the nearby pancreas and such inflammation is often accompanied by pancreatic phlegmons, pseudocysts and abscesses, all of which were present at various times in this case. Furthermore, until removal of the gallbladder, or, at the least, its stones is performed with procedures such as cholecystectomy (gallbladder and stone removal), cholecystostomy (removal of a portion of the gallbladder with stone drainage) or ERCP (an x-ray dye study, plus internal removal of common bile duct gallstones by cannulation of drainage ducts), the problem of acute pancreatitis with all of its attendant complications may recur, as happened in this case, over and over again.

While the presence of coronary artery disease can be a contraindication to some of these drainage procedures, it is not an absolute contraindication and a Surgeon, in conjunction with the appropriate Medical caretakers such as a Cardiologist should have been consulted to weigh the risks and benefits and timing of the procedures listed above as early as November 2006.

The failure of these procedures to have been considered were deviations that, more likely than not, caused this patient’s multiple bouts of pancreatitis with its complications and contributed to his death. However, as noted, further information regarding the circumstances relating to his death is awaited.

Based upon the information in the records received it would appear that the above issues represent viable avenues of pursuit in this case and the potential to obtain supportive Expert Witness opinions supporting the issues of negligence does exist, and should not be difficult, although no guarantees to that effect can be made.

We continue to remain available to assist you in this case and have the Expert Witness specialties you require for this case. Expert Witness Reports are available through our Firm with the submission of appropriate funds as per our current Fee Schedule.

In this specific case, Expert reports should be strongly considered in the areas of Family Practice, Gastroenterology, General Surgery and Infectious Disease preferably after obtaining a more complete set of medical records as described above.