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General Surgery Sample Case

Repeat neck operation to remove lymph nodes for cancer diagnosis, causing damage to the spinal accessory nerve and paralysis to the trapezius muscle.

The spinal accessory nerve controls the trapezius muscle, which is located toward the side and rear of the neck, and helps you to shrug your shoulders and control the motion of the scapula (shoulder blade). Normally in surgery in that area, unless there are extenuating circumstances, that nerve should not be injured.

In 1973 at age 35, she had an obstetrical office record note that she had surgery in which glands were removed under arms for chronic lymphadenitis (lymph gland node inflammation). Did the inflammation also involve her neck? That could cause scar tissue, making any operation more complicated and increase the risk of nerve damage.

In 1993, she had a benign breast biopsy, and mammograms in 1993, 1994 and 1995 were "read" as negative. She was taking female hormones, the estrogen: Premarin, and the progesterone: Provera. That was acceptable.

In October 1996, she had enlarged lymph nodes (glands) in her neck and Dr. #1 referred her to Dr. #2 for consultation and surgery. He noted: "Status post removal of benign tumors from axilla (armpit) and neck" (where and when?). He found: "There are several 2-3 centimeter (one inch = 2.54 cm) in diameter, firm to rubbery, nonfixed but tender nodes palpable in the left posterior cervical and left supraclavicular fossa." He discussed the "risks, indications and outcomes associated with deep cervical lymph node biopsy."

Surgery by Dr. #2 took place on 10/28/96. He found: "A group of mottled (stuck together) deep posterior cervical lymph nodes identified. Using sharp (cutting) as well as blunt (forcing apart) technique, numerous lymph nodes were excised." This would be at

the location of the spinal accessory nerve over the trapezius muscle. He said: "This was accomplished while avoiding harm to surrounding neurovascular structures."

These nodes measuring 0.3 to 1.2 cm contained metastatic (spreading) breast cancer.

On 11/8/96, another mammogram showed a 3 cm irregular mass "more apparent" than 1994 and 1995. How more apparent?? Possibly the radiologist, Dr. #3, who interpreted it in 1994 and 1996, and Dr. #4, who interpreted it in 1995, were negligent, and that would have made a major difference to her loss of chance for survival. I would suggest that good copies (where you cannot tell the copies apart from the original when viewed side by side) be obtained, and you authorize us to have one of our Radiology Experts give you their professional opinion on whether or not they were misread.

On 11/12/96, a compression mammogram was done, and Dr. #3 said: "There appears to be a gradual development of a somewhat irregular shaped density with spiculated (pointed) margins in the left breast at about the six o'clock area on the craniocaudal view and it became more apparent on the current study." He had mentioned comparing it to 1993 and 1994. Was this special compression mammogram clearer than only the one four days before? Or also to the mass seen in 1993 and 1994? Again, this raises a serious question of negligent interpretation best addressed by a Radiology Expert viewing all those copies.

The CT scan needle localized breast biopsy revealed breast cancer that was inadequately excised ("The (cut) margins of this tumor tissue are diffusely involved by tumor.") However, it had already spread. She received chemotherapy.

By 4/97, a tumor mass in her femur (thigh bone) had decreased in size. The cancer was responding to the chemotherapy (Adriamycin and Cytoxan plus tamoxifen).

However, in 1998, she developed enlarged left posterior cervical (neck) lymph nodes again. There was a serious concern of recurrent cancer and a repeat biopsy was suggested and accepted. However, it could have been done by needle biopsy with much less risk. Was she advised of this option? The open incision technique would not cure her cancer, and if necessary, x-ray therapy could have been directed to that site after a needle biopsy, if needed to control its growth. Was she advised?

Dr. #2 noted on physical examination that the neck had: "Palpable but firm, relatively fixed masses of posterior cervical chain (lymph nodes) bilaterally (both sides). This operation was more predictably difficult than 1996.

Surgery took place on 10/21/98. He said: "Incision was carried through the skin and subcutaneous tissues to the surgical incision through which biopsy had been accomplished several years ago." That means the operation would proceed through scar tissue that was on top of or along side of the spinal accessory nerve (which is the size of a paper match stick).

He did not use an electrical nerve stimulator to try to locate that nerve. Some would consider it negligent and a "loss of a chance" to prevent injury to that nerve. The nerve could have been injured during the separation of the mass from the adjacent flesh, from the control of bleeding with the electrocautery, which could have burned the nerve (unseen), or from instruments (retractors) used to open up the incision by pulling. The assistant was a Physician Assistant. I suggest interviewing / deposing her. Did her shoulder jerk at any time during that operation from the nerve being stimulated by the electrocautery, or being hit by an instrument? The patient was sedated. Does she recall anything?

Dr. #2 does not mention the length of this incision in 1998, nor in 1996. The surgeon has to make a large enough incision in order to adequately see what he is doing. Obtain photographs of the scar on her neck if you also want to proceed to a General Surgery Expert review and opinion.

The mass removed consisted of four fragments of flesh measuring from 0.5 to 1.0 cm. It was recurrent breast cancer.

How long was the incision? What was her height and weight at that time? Do you have any photographs (copies) of her at that time to assess the shape and thickness of her neck?

Follow-up physical examination and an electrical study (EMG: electro-myogram, and NCV: nerve conduction velocity) proved that the spinal accessory nerve was partially damaged, and not severed. Its nerve injury (denervation) paralyzed the upper and middle trapezius muscle.

The question of metastatic cancer as the cause was raised. I strongly doubt that cause. It was noticed as soon as the local pain from surgery was gone, and no enlarging tumor mass was ever noted at that site. The Surgeon caused it.

The breast cancer spread to her liver, and grew, but then shrank from repeat chemotherapy. As of 6/99, there was no neck mass.

The defense would content that the injury is causing only minor problems since she is right handed and can reach high with that good and dominant arm. They will claim correctly that it is a judgment call at the time of surgery to use a nerve stimulator (a battery operated device that is harmless to the patient). How dense was the scar tissue? Obviously, too dense since the nerve was not identified above or below that mass and then visually (or electrically identified) and protected.

Was she advised of this specific risk, and not just abnormal nerve sensations as a potential complication?

The nerve injury did not and does not affect her cancer condition.

Since she has metastatic cancer, I would urge you to expedite this case and preserve her testimony by a videotaped deposition at this time, if you are going to proceed.