

## Sulfa Allergy: Judgment For Patient Affirmed.

The seventy-four year-old patient was sent to a rehab facility from the hospital after open reduction surgery with screws and metal plates for tibia and fibula fractures from a motor vehicle accident.

A rehab facility nurse applied the prescription antibiotic cream Silvadene as treatment for fracture blisters on the leg which had been operated upon.

Complications followed which led to below-the-knee amputation of the leg.

***There is no question the application of Silvadene to the patient's leg after orthopedic surgery without a physician's order and with a note in his chart about his sulfa allergy was a breach of the standard of care by the patient's nurse.***

COURT OF APPEALS OF TEXAS  
January 30, 2014

The Court of Appeals of Texas affirmed a judge's decision awarding damages to the patient from the rehab facility.

The Court recognized there were multiple co-morbidities that could have led to complications, the patient's age, his long history of Type II diabetes and the severity of the injury itself. Nevertheless the Court accepted the testimony of the patient's physician experts that it was the allergic reaction to the Silvadene that set the patient's downward course in motion.

The Court accepted the non-expert testimony of a friend who visited the patient. He said the nurse applied the cream twice, not once as was documented in the chart, and applied it to the entire lower leg from knee to ankle, not just on the fracture blisters as was documented.

The Court also credited the patient's testimony that the cream made his leg burn like it was on fire, which contradicted the documentation in the nursing progress notes that the leg felt better after the application of the cream. Integrated v. Kirkland, \_\_\_ S.W. 3d \_\_\_, 2014 WL 519842 (Tex. App., January 30, 2014).

## DVT: Court Faults Pre- And Post-Surgical Instructions.

A young woman collapsed in her physician's office at a follow-up appointment and died in the hospital from a pulmonary embolism several days after what was supposed to have been routine arthroscopic surgery to repair the anterior cruciate ligament in her knee.

The patient was obese and took birth control pills. Those factors raised the risk of deep vein thrombosis (DVT) in her lower leg, according to the court record.

***Neither the consent form for knee surgery or the post-surgical instructions informed the patient or her family that calf pain, redness or swelling could indicate a life-threatening deep vein thrombosis.***

SUPERIOR COURT OF NEW JERSEY  
APPELLATE DIVISION  
February 13, 2014

The Superior Court of New Jersey, Appellate Division, threw out the jury's verdict of no negligence.

After the surgery a nurse handed the patient generic pre-printed discharge instructions which warned her of post-operative pain in the reconstructed knee.

The printed discharge instructions, however, failed to mention that pain, swelling and redness in the calf on the same leg were potentially serious signs and symptoms which had to be reported to the doctor. When the nurse handed over the printed discharge instructions a family member asked if there was anything else they needed to know and the nurse said there was nothing else.

The Court faulted the surgeon for not getting truly informed consent by telling the patient beforehand that DVT is a rare but potentially fatal possible complication. The surgeon did not tell her what to look for or to contact him if it occurred. Ringstaff v. Eakin, \_\_\_ A. 3d \_\_\_, 2014 WL 656855 (N.J. App., February 13, 2014).

## Operating Room: Court Faults Perioperative Nurses.

The patient saw his orthopedist six weeks after elbow surgery because he was still having numbness and weakness in his hand.

The orthopedist sent him to the hospital for a second procedure that same afternoon.

After that procedure failed to correct the problem two independent neurologists concluded the ulnar nerve had been damaged in the first surgery.

***The perioperative nurses had a legal duty to question the unusual circumstances surrounding the patient's second surgery.***

COURT OF APPEALS OF TEXAS  
January 30, 2014

The Court of Appeals of Texas accepted expert medical testimony which, in part, faulted the perioperative nurses who were present on the second surgery.

The nurses did not question or try to stop what was happening. An elective procedure normally calendared in advance was being done on a rush basis without the patient NPO for at least eight hours, without the usual pre-surgery evaluation and apparently without the patient having been given an opportunity to consider and choose among his options which should have included foregoing entirely the risk of this second surgery.

The nurses also did not question why and did not document in the record that a second surgeon was assisting on a procedure which, for reasons of insurance and Medicare reimbursement, was normally done only by one physician.

The nurses were also responsible, according to the patient's experts, for knowing or finding out if the surgeon was listed at the hospital for this endoscopic procedure and were supposed to take steps to alert the chain of command because he was not. Columbia North Hills v. Bowen, 2014 WL 354658 (Tex. App., January 30, 2014).