

## Case 3

### Description

Following successful graft revision surgery, a 62-year-old male experienced marked neurological deficits in both legs, the result of an epidural hematoma that led to permanent paralysis.

### Clinical Sequence

A 62-year-old diabetic patient underwent a graft revision. An epidural spinal catheter was used for anesthesia and maintained one day post-operatively for pain control. After removal of the epidural, the patient was kept on Heparin to prevent re-closure of the graft.

Four days post-op, the patient complained of back pain and tenderness in his left groin near his catheterization site. The covering surgical attending and chief surgical resident noted positive graft pulses; no hematoma was detected. The differential diagnoses included restenosis, retroperitoneal bleeding, or abdominal aortic aneurysm or dissection. An abdomen and pelvis CT scan noted a full bladder and a small left inguinal hernia. After placement of a Foley catheter, the patient's severe back pain continued.

At 4:00 p.m., the surgical resident was notified when the patient started to vomit and complain of low back pain (10/10) radiating to his left groin. At 8:00 p.m., the nurse noted the patient was unable to move either leg and notified the resident. The record contains no notes by the resident at this point.

At 11:30 p.m., the patient's blood pressure increased to 220/110. The surgical resident contacted the intensivist (first-year cardiology fellow), who was able to control the blood pressure with medication. Based on the patient's description of pain, a head CT scan was ordered to rule out an intracranial bleed or stroke; results were negative.

At 1:00 a.m., due to the patient's marked neurological deficits in both legs, the resident contacted the covering neurologist. Accounts differ regarding what happened next. According to the neurologist, he instructed the resident to obtain a stat spinal CT scan, call him with the results, and transfer the patient immediately to surgery if the scan revealed an epidural hematoma. However, the resident's documentation indicates the neurologist advised him that the patient's symptoms could be a result of a number of causes "including psychosomatic illness, Guillain-Barre, or cord compression syndromes ..." According to the resident, their plan rejected a CT scan of the spine in favor of the more optimal MRI, which was available in the morning when the neurologist planned to see the patient. The resident contacted the covering surgical attending, who voiced no opposition to the plan.

At 10:30 a.m. (close to 10 hours later), the MRI was performed, revealing an epidural hematoma, up to T9. The patient was immediately transferred for surgery, but by then suffered significant cord damage, resulting in paralysis below the waist.

### Allegation

The patient sued the covering surgeon, the surgical resident, the intensivist, and the consulting neurologist, alleging significant delay in diagnosis and treatment of an epidural hematoma, resulting in permanent injuries.

### Disposition

Following mediation, the case was settled (more than \$1 million) against the neurologist, the surgical resident, and the attending surgeons. The intensivist was dismissed from the case.