Expert Medical Opinion for John Doe

Upon reviewing the available medical records of John Doe, I find medical negligence in his treatment.

- I find that the postoperative wound infection was not treated appropriately in his case.
- I find that the patient did show signs and symptoms of postoperative wound infection that was not evaluated appropriately.
- I also note that the wound culture was not done as per the prevailing standard. In similar cases, wound culture is the most important laboratory test that the treating physician should order. This was not ordered in a timely fashion and hence the patient missed opportunity to be treated with oral antibiotics for a minimal duration.
- The treating doctor failed to order CT abdomen when the patient presented to hospital with postoperative fever.
- There was about a fortnight delay in identifying the ongoing wound infection that resulted in delayed healing and multiple complications thereafter.
- I also find that the patient did have seroma that was not drained at the first opportunity.

SAMPLE

John Doe underwent bilateral component release – laparoscopic, diagnostic roboscopy, open repair of recurrent incisional hernia with Phasix mesh, bilateral TAP blocks on 03/27/20XX. Dr. Thomas Melville Blomquist, M.D. noted that mesh had not failed, was completely intact and that his failure was essentially an anterior failure and that there really was no fat protruding through as it has been previously reported by CT. With the assessment being that in fact, the mesh was intact and that the anterior closure had failed, and the mesh was essentially bulging into the anterior abdominal and subcutaneous space. Post operatively (03/27/20XX-03/28/20XX) the surgeon did notice serosanguineous exudate from surgical incision. Hence dressing was done with negative pressure/vacuum assisted closure. On 03/29/20XX wound was recovering well as expected. The drains were emptied, but still there were bloody output. However, the patient was discharged home.

On 04/05/20XX the patient reported to McKee Medical Center with post-operative fever. *Dr. Thomas Melville Blomquist, M.D.'s notes pertaining to this visit is missing. However, evidence in the flow sheet shows labs was drawn and they were reported normal.* Wound culture was not included in this list of laboratory tests that were performed. Hence in all likelihood, I believe the wound culture was not done during this particular visit.

In clinical practice, early identification of surgical site infection (SSI) begins with careful history and physical examination. The majority of the SSIs are diagnosed after discharge, but it is essential to keep this in mind when patient presents with postoperative fever. Postoperative fever is a clinical symptom that is suggestive of ongoing infection and in many cases; it is a forewarning of underlying serious infection. I find that the surgeon missed this important clue from this case and failed to diagnose the ongoing postoperative infection.

When presenting with systemic signs of infection, wound/tissue and blood samples for gram stain, culture, and susceptibility should be obtained and will help guide antibiotic therapy. Laboratory testing that may be necessary depending on the clinical presentation of the patient includes complete blood cell count with differential, C-reactive protein, creatine phosphokinase, and basic metabolic panel to assess for creatinine/renal insufficiency and any metabolic/electrolyte abnormalities. Furthermore, any drainage should be sampled and sent off for gram stain and culture. This important step was not followed in James' case.

SAMPLE

Additionally, it is important to note that SSI may present without change in blood counts and biochemical abnormalities. Hence a high index of suspicion is required, even if laboratory parameters returns normal. Unfortunately, in this case, the surgeon stopped the investigations with blood counts and biochemical tests only.

When working up deep and organ space SSI, computed tomography (CT) is particularly useful and more reliable in detecting hematoma of soft tissues and loculated collection if any. Furthermore, CT imaging helps guide procedural intervention (eg, interventional radiology percutaneous drainage). I believe the doctor did not order CT abdomen and failed to diagnose the underlying infected seroma. Hence the above said negligence resulted in delay of diagnosis of the ongoing postoperative infection and the patient ended up with multiple complications in the subsequent days.

On 04/18/20XX the surgeon found patient's midline incision intact with intact staples. However, the left side had significant erythema and he has essentially ballotable fluid throughout the anterior abdominal wall. The next day (04/19/20XX) exploration was done. During the procedure his midline incision

was opened and a large amount, approximately 500-600 mL of cloudy pinkish fluid consistent with infected seroma was extracted. The mesh was intact. The area was then irrigated with pulse lavage with 3 L of normal saline. Wound VAC was placed. The patient then had recurrence of seroma. He was in and out of hospital until April 20XX for wound healing.

Assuming that the doctor was diligent and identified the infection earlier; the patient had option to have oral antibiotics. He would not have had the complications if there was no delay in diagnosis of the wound infection.

In similar situations, postoperative fever with uncomplicated superficial SSI, may be effectively managed with oral antibiotics without surgical intervention and debridement. Antimicrobial therapy is recommended for 5 days and extended if clinical signs of infection persist or worsen. In other words, John Doe would have required only few days of oral medications to have his postoperative infection under control.

If a surgeon encounters SSI, the following standard treatment should be followed. During physical exam (eg, purulent drainage) and imaging, if there was suggestion of a deeper infection (ie, deep or organ space), then suture removal, incision and drainage, and debridement of necrotic tissue should be performed at the first opportunity. Empiric systemic antibiotics should be started as soon as a deep or organ space SSI is suspected and when clinical signs of infection are present (ie, fever >38.5°C, abnormal vital signs, erythema and induration extending >5 cm from the wound edge, white blood cell count >12,000/µL). The patient may then be offered a more specific antibiotic based upon expected pathogens which are determined by the microbial culture. The antibiotics are then tailored to culture results as soon as that data become available.

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In conclusion, I opine that the above-mentioned standard treatment protocol was not followed in John Doe's case when he presented with post operative fever and infection. I opine with a reasonable degree of medical probability / certainty that Dr. Thomas Melville Blomquist, M.D.'s negligence was the reason for worsening infection, multiple hospital visit, repeat surgeries and delayed wound healing (for almost a year).

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