Medical Consultant Report and Summary

Case No: MD-09-[redacted] **Physician: [redacted] M.D.**
Date: 9/15/09 **Medical Consultant: [redacted], M.D.**

1. **Detailed (Chronological Analysis:** Mr.[redacted] presented to Dr. [redacted] on 8/6/07. He had ongoing pain and a total hip arthroplasty which had been placed November of 2005 by another physician. The patient was complaining of pain in his groin. The patient had been evaluated by a pain management institution and had previous blocks. After the first visit the patient was thoroughly evaluated with labs, bone scan and MRI of the lumbar spine. He had minimally elevated C-reactive proteins and his MRI did show degenerative changes in his lower back. These studies were completed to rule out the various etiologies of pain to be sure that the pain was actually coming from the total hip area. The patient returned in June of 2008 with ongoing complaints of hip discomfort. Hip revision was discussed with Mr. [redacted] at that time. The actual noted from June 11, 2008, mentions that the risks and benefits of the procedure were discussed with Mr. [redacted].

   Mr. [redacted] underwent the revision procedure July 15, 2008. A Zimmer implant was utilized. It has been noted in the records reviewed from Zimmer that Dr. [redacted] has actually completed a special course in using this implant and has been involved in instructing others in how to use it. The patient had follow up visits and healed without sign of infection. The patient complained of some numbness around the incision but otherwise was doing reasonably well. He returned to the office on September 22, 2008, with continual pains and left groin pain. Radiographs showed no acute abnormality of the implant. Dr. [redacted] proceeded to evaluate him more thoroughly to look for etiology of pain. He underwent an MRI of the lumbar spine. He also was started on physical therapy. In October the patient mentioned that he had increased trauma with a twisting injury to the leg. Apparently this happened on a construction site. Radiographs were repeated and noted to be negative and not show any acute sign of change. MRI's were reviewed and were consistent with arthritis in the lower back. The back issues were treated to see if this might not relieve some of his pain and he was sent for injections. In November the patient continued to have pain. The pain was located over the trochanter. An injection was given in this area to try to alleviate symptoms. In other words, Dr. [redacted] was trying to explain Mr. [redacted] pain and treat him adequately, hoping that the pain, possibly coming from the hip joint, would continue to improve and to rule out other etiologies for pain since the radiographs at that point had been normal. On November 19, 2008 the patient continued to have thigh pain and was non tender over the trochanter. He had little relief from injections. At this point the patient was thoroughly, once

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again, evaluated for infection. Blood work was obtained with a normal white cell count but the patient did have an elevated SED rate and C-reactive protein. In a dual isotope white blood cell scan was appropriately ordered and there was also the scan which was inconclusive for infection. Further investigation was performed with a CT scan to try to understand why this man was having symptoms. The CT scan was negative for prosthetic loosening and there was some question of a Pubic Ramus fracture which would be unrelated to the hip surgery.

A regular bone scan was actually obtained, looking and trying to understand why this man was having so much pain. The pain was being evaluated for all possible etiologies. At this stage, infection seemed unlikely with the studies being questionable. Lab work was again repeated and there was an elevated SED rate and C-reactive protein. To ensure that the patient had no infection, Dr. [redacted] took him to the operating room to aspirate fluid from the hip to try to be sure there was no infection and the specimens were negative for infection.

Notes were mentioned that phone calls were completed to phone the patient but Mr. [redacted] had gone to another physician, Dr. [redacted].

Mr. [redacted] was seen on January 27, 2009. Dr. [redacted] records mention the possibility of impingement of the iliopsoas muscle on the implant causing pain. Dr. [redacted] initial work up was not positive for infection though this still was considered a possibility. At this stage this man had been significantly evaluated for infection and continued to have pain.

The patient elected to continue his care with Dr. [redacted]. In March 2009, an exploration was completed and a biopsy at the time of surgery revealed white blood cells and later a culture showed Staph epidermitis. The patient had the implant removed and a cement spacer with antibiotics was placed. The patient was discharged and later returned with elevated temperatures and in April, the patient was placed on a PICC line approximately April 21, 2009.

The final procedure was completed on May 21, 2009. The cement spacer was removed and the revision implant placed.

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2. **Proposed Standards of Care:** The standard of care for evaluation of a painful total hip prosthesis is to rule out various etiologies of pain. The implant itself can be infected or loose. The pain can come from other soft tissues surrounding the implant such as the trochanteric bursa or lower back pain problems. To try to be more specific, standard of care requires a physician to try to be as specific as possible with the etiology of the pain. This includes appropriate evaluation with blood studies including white cell counts, C-reactive proteins and SED rate, bone scans as well as white cell label scans are sometimes necessary. MRI's or CT scans can be completed as well to evaluate the patient for other causes of pain. If the etiology of the pain is not specific with these studies, then certainly it is the standard for the physician to evaluate the patient over time and not be too aggressive with care. If the patient does not improve over a period of 4-6 months, then further studies would be indicated and consideration of exploration completed. If the studies are positive, including C-reactive protein and SED rate, then the appropriate studies should be completed to evaluate for infection including white cell scan studies and aspiration of the joint itself. If all fails then revision open procedures are indicated.

3. **Deviation from the Standard of Care:** There was no deviation from the Standard of care by Dr. [redacted]. All of the parameters set forth above were met extremely well. Unfortunately the patient had ongoing issues but they were appropriately addressed by Dr. [redacted] and he should be applauded for his significant and involved evaluation.

4. **Actual Harm Identified:** No actual harm was caused by the actions and evaluation of Dr. [redacted]. His evaluation was timely and appropriate for this man's ongoing symptoms. Problems known are complications related to such difficult tertiary surgery.

5. **Potential Harm Identified:** There are no criticisms in regard to Dr. [redacted] evaluation and treatment of this individual.

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6. **Aggravating Factors:** None identified.

7. **Mitigating Factors:** There is no deviation from the Standard of Care.

8. **Consultant's Summary:** Based on my professional opinion, Dr. [redacted] actions did meet the Standard of Care in caring for [redacted] with his significantly complicated issues. Judgment of Dr. [redacted] to use a Zimmer implant did not cause this man's infection to occur. The problems related to a complex revision total hip procedure can occur with any type of implant. Dr. [redacted] appropriately evaluated the ongoing pain issues that Mr. [redacted] presented to him over a period of time. He should actually be highly commended for the thorough job that he performed in evaluating and trying to understand why Mr. [redacted] continued to have symptoms. Ultimately Dr. [redacted] cared for Mr. [redacted] and Dr. [redacted] initial assessment was not the correct one. It was not the problem of positioning but an indolent, very difficult to diagnose infection that was occurring. Despite multiple studies including aspiration, this was not diagnosed until the actual open revision was performed by Dr. [redacted] This was the last resort treatment plan by a tertiary care physician being necessitated by a difficult diagnostic dilemma.

9. **Records Reviewed:**

   a. Complaint filed by [redacted], 6/15/08.
   b. Letters from [redacted] in regard to the implant utilized in his care, dated 6/26/09.
   c. Letter submitted on 6/29/09 from [redacted] Clinic in response to the complaint.
   d. Office and surgical records produced by Dr. [redacted] in regard to the treatment provided to Mr. [redacted] dating from 8/6/07 through March of 2009.
   e. Records from Dr. [redacted] office dating from January 2009 through June 2009.
   f. Hospital records from admissions for Dr. [redacted] care provided in March, April and May of 2009.

10. **Additional documentation and information necessary:** None.