Neutral Citation: [2014] IEHC 43

THE HIGH COURT

[2011 No. 8272 P]

BETWEEN

STEPHEN HEFFERNAN

PLAINTIFF

AND

MERCY UNIVERSITY HOSPITAL CORK LIMITED

DEFENDANT

JUDGMENT of Mr. Justice Herbert delivered the 5th day of February 2014

1. In this case the witnesses as to fact were the plaintiff, Mr. O'Sulleabhain, Mr. Mohsin and Ms. O'Sullivan. The expert witnesses were three eminent practicing surgeons: Mr. Hyland, Mr. Miller and Mr. Scurr. Mr. O'Sulleabhain is and was, at the dates of the events which give rise to these proceedings, a Consultant General Surgeon with a specialist interest in the oesophagus, stomach, pancreas, liver and biliary tree at the defendant hospital. Ms. O'Sullivan is Director of Nursing at the defendant hospital. Mr. Moshin was at the relevant dates Surgical Registrar to Mr. O'Sulleabhain. Mr. Ronald Miller and Mr. John Henry Scurr gave evidence in the case for the plaintiff. The former is a Consultant Urologist practicing in the United Kingdom. The latter is a Consultant General and Vascular Surgeon and some-time senior lecturer in surgery at University Hospital London who practices in this state and also in the United Kingdom. Mr. John Hyland who gave evidence in the case for the defendant is a Consultant General and colo-rectal surgeon at St. Vincent's University Hospital, Dublin since 1982 and, is and has been for the past seven years Associate Professor of Surgery at University College Dublin. The curricula vitae of these distinguished surgeons are extraordinarily impressive. Ms. O'Sullivan's sole involvement in the case was to explain some terms and symbols employed in the hospital records.

2. Neither Mr. O'Sulleabhain or Mr. Mohsin, hardly surprisingly, had any personal recollection of the events involved in these proceedings. They gave their evidence by reference to the hospital records which were furnished consequent upon a discovery of documents. With one important exception – as regards a failure to record an analgesic drug prescribed for the plaintiff on first discharge from the defendant hospital – there was no criticism of the completeness of these records during the course of the hearing.

3. The plaintiff is now 62 years of age. He is separated from his original partner by whom he has four adult children. His present partner, he told the court, is about his own age. He is a manager in the Health Service Executive. Following a surgical procedure for the repair of a recurrent inguinal hernia on the 19th January, 2010, his left testicle, over the remainder of that year, progressively diminished in size to a point where at present it has no obvious mass. The initial inguinal hernia repair was carried out at the North Infirmary Hospital, Cork when the plaintiff was midway approximately through the third decade of his life. I find on the evidence, on the balance of probabilities, particularly having regard to the evidence of Prof. Hyland and Mr. Moshin, that this initial hernia was an indirect inguinal hernia into the spermatic cord through the deep or, as it is also designated, internal inguinal ring. Prof. Hyland told the court, and his evidence in this respect was not challenged, that 90% of inguinal hernias in young males are indirect hernias. This he said arises from a congenital defect associated with the descent of the testicles from the abdomen into the scrotum.

4. In the two to three weeks prior to the 19th January, 2010, the plaintiff noticed a scrotal swelling on the left side which was associated with pain and discomfort. He consulted his general medical practitioner, Dr. Ciaran Donovan and was referred on the 18th January, 2010, to the emergency department of the defendant hospital. He was seen by the Senior Surgical House Officer on call at 14:00 hours on that day. An ultrasound scan was carried out. The radiologist's report of this scan stated that the plaintiff's left testicle was normal. Differential diagnosis included: an oemental fat hernia, an incarcerated hernia, a haematoma or, less likely, a large lymph node. A computed tomography scan (CT scan) was carried out on the 19th January, 2010. The radiologist reported that the scan suggested the presence of a left inguinal hernia which contained fat from the sigmoid colon which had herniated through the deep inguinal ring and that the fat had become incarcerated and inflamed and was likely strangulated. I find on the evidence of all three expert witnesses and of Mr. O'Sulleabhain and Mr. Mohsin that this situation required urgent non-elective surgical intervention on that day.

5. I find on the evidence that the operation was carried out at approximately 18:30 hours on the 19th January, 2010, by Mr. Mohsin and not by Mr. O'Sulleabhain, but at his direction after they had discussed the case and the ultrasound scan report and viewed the CT scan images and considered the radiologist's report. I am satisfied on the evidence of Mr. O'Sulleabhain and on the evidence of Mr. Mohsin that he was fully competent to carry out what was described in evidence by Mr. O'Sulleabhain as a complex operation. This description of the operation was endorsed by Prof. Hyland, Mr. Miller and Mr. Scurr in giving evidence. Mr. Mohsin was not challenged on his evidence that in the 20 years prior to 2010 he had carried out more than 100 primary inguinal hernia repairs and more than 20 recurrent inguinal hernia repairs. Prof. Hyland gave evidence that recurrent inguinal hernias only occur in 5% to 10% of cases. He said that the surgical procedure in recurrent inguinal hernia cases was more complex because of changes in the anatomy and the presence of scar tissue and adhesions following from the previous surgery. This was also the evidence of Mr. Miller, Mr. Scurr and Mr. O'Sulleabhain. Prof. Hyland also adverted to the possibility of an additional difficulty in the instant case arising from the suggestion in the report of the CT scan carried out on the 19th January, 2010, that the contents of the hernial sack was inflamed. He told the court this would result in swelling of the tissue in the area and would make surgery more difficult.

6. An issue arose on the pleadings in this case as to when the form consenting to the surgery on the 19th January, 2010, was signed by the plaintiff. The plaintiff gave evidence that the form had been offered to him for his signature and that he had signed it as he was being brought to the operation suite on a trolley. He told the court that the risks involved in the operation had not been explained to him. All three expert witnesses, Prof. Hyland, Mr. Miller and Mr. Scurr were of opinion, and Mr. O'Sulleabhain concurred, that neither of these, had they occurred, would be an acceptable practice. The original consent form produced in evidence is signed by the plaintiff, as he acknowledged in evidence. It is countersigned by Mr. Mohsin who also identified and acknowledged his signature. Though it does refer to the "nature and effect of the operation" having been explained to the patient, it makes no reference whatsoever to risks associated with the particular surgery as having also been explained to the patient. There is no dedicated space on the form for the inclusion of such information. Prof. Hyland gave evidence that this particular type of form was

widely used in Irish hospitals. Mr. Mohsin gave evidence that on the consent form used in the N.H.S. in Great Britain there is a dedicated space reserved for the recording of this information. Mr. Mohsin told the court that it was standard practice in the defendant hospital in 2010 to explain the procedure and the risks associated with the particular procedure to a patient. He said that his own invariable practice was to do this. He stated that he had never asked a patient to sign a consent form on a trolley on the way to the operating suite. Mr. Mohsin also gave evidence that a nurse invariably accompanies a patient being transferred to the operation suite and this nurse would not allow a patient to sign or be asked to sign a consent form during the transfer. Prof. Hyland pointed to the fact that the plaintiff had been in the hospital as an inpatient for more than 24 hours prior to the operation. He expressed the view, but it was only his opinion, that it was altogether unlikely that Mr. Mohsin or some other member of the medical or surgical staff had not explained the intended procedure and its attendant risks to the plaintiff in that period.

7. Mr. Mohsin told the court that there are well recognised risks common to all types of surgery and specific risks attached to recurrent inguinal hernia repair. He identified the risks common to all surgery as infection, deep venous thrombosis and haematoma. He identified five risks as specific to recurrent inguinal hernia repair. These were: a further recurrence of the hernia in the future; that postoperative chronic pain might continue for several months; an increased danger of a scrotal or inguinal canal haematoma; that a scrotal haematoma might develop which could damage a testicle; and the possibility that a section of bowel might be included in the hernial sack so that part of the bowel would have to be resected. Prof. Hyland and Mr. Miller gave very similar evidence in this regard.

8. I am satisfied on the evidence that this was not an elective procedure and that it had to be carried out on the 19th January, 2010, as soon as the operations list for that day permitted. The CT scan suggested that the sigmoid colon fat in the hernial sack was incarcerated, inflamed and likely strangulated. The expert witnesses were agreed that this could lead to sepsis and then to necrotising fascitis which are life threatening conditions. I accept the evidence of Prof. Hyland and Mr. Scurr that the plaintiff in these circumstances had no reasonable option available to him but to permit the operation to proceed regardless of the several risks which I have previously mentioned and which were undoubtedly material to a decision to consent or not to consent to an operation.

9. I consider it unnecessary to determine the issue as to whether or not the plaintiff had been informed of the risks attaching to a recurrent inguinal hernia repair operation or the issue as to the circumstances in which he signed the form consenting to that operation. Even if the manner in which his consent was obtained to the carrying out of the surgery was substandard, and I make no finding as to this, I am fully satisfied on the evidence that this plaintiff, whom I find on the evidence and from my observation of him giving evidence to be an educated, intelligent, articulate and perspicacious man, and accustomed throughout his career to assimilating facts and making important decisions would, on the balance of probabilities, have signed the consent form at any other location in the defendant hospital and would have submitted to the surgery even after being made fully aware of the risks involved. The plaintiff did not in his evidence even suggest that if he had known of these risks – which he insists he did not – he would not have agreed to the surgery. The decisions made by him in the aftermath of the loss of his left testicle bears this out; that he would not risk his life in order to save a testicle, his other testicle and its functions never having been at any risk. On an objective basis I am satisfied that a reasonably prudent person in the plaintiff's position if properly informed of these risks would not refuse to sign the consent form or decline to undergo the operation because of these risks. Even if I were to find in favour of the plaintiff on the issue of the non explanation of risks and the issue of obtaining his consent in the manner in which he alleges, I am satisfied that the plaintiff could not establish a causal connection between any such breaches of duty on the part of the defendants and the injury suffered by him in respect of which these proceedings are taken. However, this does not mean that the plaintiff consented either expressly or impliedly to the exercise of anything less than the proper standard of care in the carrying out of the procedure.

10. The surgical procedure involved in the repair of a primary or a recurrent inguinal hernia is essentially the same but with some additional steps necessary in the latter case. Prof. Hyland and Mr. Mohsin gave detailed evidence of the procedure involved and I am satisfied that their descriptions were the same in all material respects. Both were cross examined at length, and I am satisfied that their description of the procedure involved was not shown to be inaccurate or insufficient. I accept that not every anatomical feature and step in the procedure was described and identified by them, nor was it necessary for the purpose of this litigation. But subject to this rider I find on their evidence that the generally accepted and appropriate method of carrying out this particular procedure is as follows:

11. A suprainguinal incision is made with the scalpel in the skin of the groin. Then the body fat is cut through followed by the fibrous tissue of the fascia. The incision through these layers is kept open by means of a ratcheted atraumatic retractor or a plastic disposable device. An incision is then made through the eponeurosis of the external oblique muscle, this is a thin sheet-like muscle. The flaps on each side of the incision remain open without the employment of any mechanical device for the purpose. The inguinal canal is now exposed longitudinally. I am satisfied on the evidence that the average length of this canal in an adult male is between 2cm and 4cm. This is a "canal" only in a very figurative sense; it is not a hollow space. Longitudinally within the inguinal canal, running obliquely downward and inward is the spermatic cord, the spermatic cord runs from the abdominal cavity to the testicles in the scrotum. The outer layer of the spermatic cord is of thin cremaster muscle. The next inner layer is the internal spermatic fascia. Inside this sheet is the vas deferens, the testicular artery, co-axial arteries supplying blood to the vas deferens and to the cremaster muscle and a network of veins commonly referred to as the venous plexus. With relevance to this action all of these structures run longitudinally and contiguously like fibres in a fibre-optic cable from the deep inguinal ring to the left testicle. I find on the evidence of Prof. Hyland that the testicular artery provides 90% of the blood supply to the testicle. All of the expert witnesses and Mr. Mohsin were in agreement that the co-axial arteries supplying the vas deferns and the cremaster muscle, might enable a testicle to remain viable even in the event of the blood flow in the testicular artery being reduced or even cut off entirely.

12. The evidence established, and there was no dispute as to this, that a direct inguinal hernia is a protrusion of portion of the peritoneal membrane of the abdominal cavity – which has the approximate consistency of a common decorative balloon cover – into the inguinal canal so that the hernial sack becomes positioned next to the spermatic cord. The evidence further established, equally without controversy, that an indirect inguinal hernia is a similar protrusion, but in this case through the deep inguinal ring into the spermatic cord itself, so that the hernial sack in this case becomes positioned between the internal spermatic fascia and the other structures within the spermatic cord, but generally closest to the vas deferens. In the case of a direct inguinal hernia, the hernial sack must be separated or dissected away from the spermatic cord and from the posterior wall of the inguinal canal. The hernial sack is then dissected with a scalpel to ascertain the contents and, if as in the instant case it does not contain bowel or inflamed or strangulated fat it is sutured closed and pushed back into the abdominal cavity and the weakness in the abdominal wall is then strengthened by laying on and suturing in place a prolene mesh.

13. Prof. Hyland explained that the inguinal canal is a very confined space. All the structures of and within the inguinal canal and the spermatic cord are contiguous without any intervening spaces, but are not a solid structure and are not normally adherent and are capable of being separated one from the other along regular planes.

14. To access the hernial sack in an indirect inguinal hernia a longitudinal opening near the deep inguinal ring must be made in the thin cremaster muscle and the internal spermatic fascia covering the spermatic cord. Prof. Hyland and Mr. Mohsin gave evidence that the

generally accepted manner of making this opening is to first grip and lift up a small section of these two structures together with an atraumatic surgical forceps and then to cut a small hole in this elevated portion with a blunt-nosed surgical scissors. This opening is then enlarged with the surgical scissors to approximately 1cm longitudinally. The hernial sack is then visible to the surgeon. Prof. Hyland described this as a safe method because the surgeon is dissecting only the surface of the spermatic cord. Mr. Mohsin gave evidence which was not challenged that this was the method he had employed on the 19th January, 2010. Prof. Hyland told the court that the vas deferens, which is almost invariably contiguous to the hernial sack, is readily identifiable to the touch because of its ropey consistency. The testicular artery which is identified by feeling rather than by sight is further away. This must be seen in perspective as Mr. Mohsin described the spermatic cord as generally having the circumference of the middle finger of an average adult male, though sometimes it might be larger. He told the court that the testicular artery is between 0.2mm and 1.9mm in calibre. All the experts and Mr. Mohsin were agreed that in carrying out any procedure within the inguinal canal one is working very close to the testicular artery and accordingly great care is required. The operation notes made by Mr. Mohsin on the 19th January, 2010, were accepted as satisfactory by the experts and as indicating that he had followed the above procedure on the day.

15. The report of the radiologist on the CT scan carried out on the plaintiff on the 19th January, 2010, stated that:

> "There is a left side injecting bowel hernia. The hernia contains fat which has herniated through the deep ring. On multi-pleanar imaging, the fat is arising from the sigmoid colon, ie. an epiploic appendage.
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> . . .
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> Impression: Left inguinal hernia containing incarcerated fat, likely epiploic appendage. This is inflamed, likely strangulated giving epiploic appendigitis."

16. A herniation through the deep inguinal ring signifies the protrusion of a hernial sack into the spermatic cord. On opening the plaintiff's inguinal canal Mr. Mohsin in fact found, as described in his operation notes, a "medial recurrent direct hernia", which had erupted through the posterior wall of the inguinal canal near to but outside the deep inguinal ring. However, I accept his evidence with which Prof. Hyland and Mr. Scurr agreed that having regard to the radiologist's report on the CT scan he was left with no alternative but to open the spermatic cord in the manner indicated above to eliminate the possibility that there was not also an indirect hernia into the spermatic cord as suggested by the CT scan.

17. I accept the evidence of Prof. Hyland that while ultrasound scans and computed tomography scans are undoubtedly of invaluable assistance in surgical procedures they are not totally reliable and, as in the present case, direct visual inspection by the surgeon is the only sure method of identifying the location, extent and exact nature of the problem. I accept the evidence of Mr. Mohsin that having ensured that no hernial sack was present in the spermatic cord, he closed the incision in the internal spermatic fascia and the cremaster muscle sheet with a suture.

18. In a letter dated the 23rd August, 2013, from the solicitors for the plaintiff to the solicitors for the defendant clarifying a particular of negligence pleaded in the personal injury summons dated the 15th September, 2011, it is stated that:

> "Insofar as the surgical procedure itself was concerned, the evidence clearly points to the likelihood that the failure of the blood supply to the testicle was due to the fact that the repair suturing was too tightly applied/sutured and/or that the blood supply was compromised and the testicle damaged as a result of the poor standard of the surgical procedure itself."

19. However, at the hearing of the action all three experts rejected a misplaced or too tightly applied suture as a probable cause of the damage to the plaintiff's left testicular artery. This rejection was based on two facts. All the experts were satisfied that the location of the suture necessary to close the incision in the spermatic cord would be well removed from the location of the testicular artery within that cord. They were all further agreed that if it had occurred the blood flow to the testicular artery would have been immediately totally obstructed or seriously reduced and the onset of very severe to excruciating ischaemic pain would have occurred within eight to twelve hours following the surgery.

20. As recorded in the operation notes, Mr. Mohsin freed the hernial sack and ascertained that it contained fat. He had to free the hernial sack from the spermatic cord and from the posterior wall of the inguinal canal. To achieve this he had to mobilise the spermatic cord. He told the court that the approved way of doing this, a way which he invariably adopted, was to first free the spermatic cord in the area of the pubic tubercle where there are few blood vessels and only underlying small fascia and bone. The spermatic cord is then gently lifted up with the fingers away from the posterior wall of the inguinal canal up to the level of the deep inguinal ring. Having been so freed a small nylon ribbon is wrapped like a sling around the cord, but never looped, and this is employed with the forceps like a sling to move the spermatic cord as required in order to keep it away from the repair zone. Prof, Hyland told the court that this was the generally accepted and approved procedure and he was not challenged on this. He told the court that any lifting or lateral movement of the spermatic cord would have to be done gently and carefully. Mr. Mohsin described the cord as being relatively elastic by which I understood him to mean that it was not rigid or taut.

21. A further important feature in this case is that the surgical procedure undertaken by Mr. Mohsin on the 19th January, 2010, was for the repair of a recurrent inguinal hernia. In such cases, Prof. Hyland said that the risk of complications arising was between 1% and 5% and he disagreed with Mr. Scurr's opinion that this only occurs if there is bizarre anatomy or negligence on the part of the surgeon. Prof. Hyland, Mr. Scurr and Mr. O'Sulleabhain were all agreed that anatomical distortion, scarring and adhesions are an inescapable product of a previous inguinal hernia repair no matter how carefully that is carried out, and were a complicating feature of such recurrent repair operations particularly where they have an occlusive effect. Mr. Scurr considered that they could add up to 25 minutes to the time taken to complete the procedure. Mr. Scurr told the court that a surgeon has to be more careful when there is scarring and adhesions inside the inguinal canal around the spermatic cord. Usually, he told the court, they are easy to deal with, but sometimes very difficult. All three experts considered that scarred tissue and adhesions must have been present in the instant case. Prof. Hyland told the court that the inflammation suggested by the CT scan would constitute an additional complication. Prof. Hyland told the court that it was his personal opinion that any such features should be briefly recorded in the operational notes. However, he accepted that this was not standard practice and that Mr. Mohsin could not be criticised for not so doing in his operation notes in the instant case. Mr. Mohsin in his evidence was very insistent that this was not a complex or complicated operation and no aspect of the repair caused him difficulties. He stated that if anatomical distortion, scarring or adhesions had caused the problem he would have immediately sought the advice or the intervention of Mr. O'Sulleabhain who was still present in the operations suite or in the surgical wards nearby. It seems significant that Mr. Miller, Mr. Scurr and Mr. O'Sulleabhain and particularly Prof. Hyland, all very senior consultants, considered recurrent inguinal hernia repair to be complex surgery, whereas Mr. Mohsin was adamant that there was nothing at all complex about the particular operation in the instant case.

22. Prof. Hyland gave evidence that the accepted and approved manner of dissecting adhesions, which following on previous surgery

can join two normally separate tissues with a fibrous band, was to shine a strong light through them to illuminate any blood vessels present. He told the court that adhesions, which he said were never more than 2cm in length can sometimes be teased apart with the fingers and a swab, but usually have to be cut with a blunt nosed surgical scissors. Small blood vessels severed in this process clotted spontaneously, but where there was bleeding from larger vessels, Prof. Hyland said they required to be tied off with a ligature. Prof. Hyland and Mr. Scurr were in agreement that it would be inappropriate and substandard practice to employ diathermy to staunch such bleeding by coagulation because of the proximity of the spermatic cord and the unavoidable danger of burn spread from the point of application of the diathermy forceps or instrument. Mr. Mohsin was adamant that he had never used and never would use diathermy for this purpose and he had not done so in this instance. The reference in his operation notes to, "closure done in layers after haemostasis" refers, he told the court, to the normal control of bleeding which would only include the employment of diathermy outside the inguinal canal. I am satisfied on the evidence and I find that for a surgeon of Mr. Mohsin's qualifications and experience to have employed diathermy in the vicinity of the spermatic cord would be so inexcusably substandard that the other medical personnel assisting in the procedure would protest and would have immediately drawn the matter to the attention of Mr. O'Sulleabhain whose own professional reputation could well be tarnished by such wholly inappropriate action on the part of his surgical registrar. As with the other three indicated means by which direct damage could have been caused to the plaintiff's left testicular artery, the possibility of clotting due to diathermy burn had to be explored by the three expert witnesses. However, having heard and considered their evidence and having seen and heard Mr. Mohsin giving evidence to the court, I am satisfied that however the flow of blood to the plaintiff's left testicle through the testicular artery was wholly arrested or significantly impaired, it is altogether improbable that this was caused by the inappropriate use by Mr. Mohsin of a diathermy instrument proximate to the spermatic cord in the course of the surgical procedure carried out by him on the plaintiff on the 19th January, 2010.

23. I am satisfied on the evidence and I find that the obstruction of blood flow through the plaintiff's left testicular artery occurred in the course of the surgical procedure which he underwent on the 19th January, 2010, and that obstruction increased progressively thereafter, causing atrophy and eventual necrosis of the left testicle by December 2010. Regrettably in this case, due to a genetic insufficiency or to some impairment suffered in the course of the primary inguinal hernia repair when the plaintiff was a young man, the coaxial arterial systems to which I have previously referred were insufficient to maintain the viability of his left testicle. All three experts, Prof. Hyland, Mr. Miller and Mr. Scurr were in agreement that as a matter of probability damage to the testicular artery occurred during the operation on the 19th January, 2010. Mr. Mohsin considered that it occurred subsequent to the operation and that the obstruction was caused or initiated by the unfortunate development and gradual build up of a left scrotal haematoma which he said was a recognised complication of inguinal hernia repair surgery. This was an opinion which Mr. O'Sulleabhain by his actions after the plaintiff was readmitted to the defendant hospital under his care on the 29th January, 2010, and his evidence with respect to them before this Court, appears to have shared. Mr. Scurr gave his expert opinion that damage to the plaintiff's left testicular artery occurred during the operation and that the most likely cause of that damage was diathermy used in proximity to the spermatic cord or rough handling of that cord. It was Mr. Miller's expert opinion that acute trauma had occurred to the testicular artery during the operation. He considered, on the balance of probabilities, that the most likely cause was a burn due to the use of diathermy to arrest bleeding in the vicinity of the spermatic cord which caused complete or partial blockage of the blood flow in the testicular artery, or rough handling of the spermatic cord during the course of the operation. In cross examination Prof. Hyland agreed that the damage to the plaintiff's left testicular artery probably occurred during the operation. He added the rider that one could not be certain at what stage of the operation it had occurred.

24. Prof. Hyland told the court that one had to act gently in moving the spermatic cord from side to side in the course of repairing the recurrent inguinal hernia. Mr. Scurr informed the court that a great deal of mobilisation of the spermatic cord goes on in the course of this operation which requires the surgeon to exercise particular care not to cause damage to the cord. In cross examination Mr. Scurr accepted that there would have to be an abnormal degree of rough handling to damage the spermatic cord and that this could not occur inadvertently. Mr. Miller stated that it was vital that a surgeon avoided damaging a structure such as the spermatic cord or the testicular artery and in his expert opinion there should be no difficulty in this. Mr. Miller and Mr. Scurr were of the opinion that the mere fact that the plaintiff's left testicular artery was damaged in the operation on the 19th January, 2010, was indicative of a substantial departure from the degree of care which a surgeon of Mr. Mohsin's qualifications and experience would have employed in carrying out this particular operation. Prof. Hyland disagreed. He stated that in his opinion damage to the testicular artery was not in itself evidence of a lack of care. It would depend on the circumstances of the case. He believed that there would have to be evidence of some poor procedure in the course of the operation. He instanced a case where even careful dissection in a situation where the planes of dissection had become difficult to identify because of scarring and adhesions due to a previous operation could necessitate such moving around of tissue as could cause minor damage to the intima of the testicular artery which in turn could lead to clotting and blockage of the blood flow. In the instant case, I am satisfied that there was no evidence of dissection in the area of the testicular artery or indeed anywhere inside the spermatic cord. There was an incision in the surface of the cord through the cremaster muscle and the internal spermatic fascia, but this was only on the surface of the cord and well removed from the testicular artery. In addition, Mr. Mohsin told the court that he had experienced no difficulty whatsoever in releasing the spermatic cord from the posterior wall of the inguinal canal and none is referred to in his operation notes. Prof. Hyland told the court that if the spermatic cord had to be opened and an indirect inguinal hernial sack within the cord dealt with, this could give rise to a small risk of devascularising the testicle. In the instant case, once the incision was made in the surface of the spermatic cord it was apparent that there was no hernial sack present within the cord. This very small incision in the surface of the cord was then closed with a suture. I am quite unable to accept that this procedure could have in any way traumatised the testicular artery as there was no movement of tissue necessary much less exceptional movement of tissue.

25. All three experts were agreed and in cross examination Mr. Mohsin also agreed that rough handling, as in pulling or pushing the spermatic cord, could cause excessive bending of that cord resulting in kinking damage to the intima – innermost lining – of the testicular artery. Platelets in the blood would then cause small thrombi (clots) to form. The fibrinolytic mechanism of the body would break down these clots. However, if this equilibrium of coagulation and fibrinolysis was not sustained a progressive blocking of the artery would occur until it became critically obstructed or totally blocked. Prof. Hyland and Mr. Scurr were in agreement that this process would be accompanied by progressively increasing levels of ischaemic pain, from severe to very severe to excruciating, due to the build up of lactic acid and other metabolites in the tissue of the testicle due to the ever decreasing exchange of oxygen. After a time the nerves would die and the excruciating pain would immediately cease, but the testicle would continue to atrophy. All three experts were in agreement that as a result of the operation on the 19th January, 2010, the plaintiff developed ischaemic pain which evolved and became progressively more severe as the blood supply was gradually cut off from the plaintiff's left testicle. This pattern continued until on the 29th January, 2010, the day when the plaintiff went back to his general medical practitioner and was readmitted to the emergency department of the defendant hospital. All three experts considered that at this point a critical level of blockage of the testicular artery occurred causing the plaintiff excruciating pain. After that the pain disappeared within 24 hours, but the left testicle continued to atrophy painlessly until it reached a terminal size of a tiny mass of scar tissue in December 2010.

26. If an acute vascular injury had occurred in the course of the operation on the 19th January, 2010, I am satisfied on the evidence and I find, that this would have resulted in an immediate catastrophic blockage of the blood flow in the plaintiff's left testicular artery and the plaintiff would have experienced excruciating ishaemic pain – the sort of pain which Prof. Hyland said causes people to

scream – within a period of six to twelve hours after the conclusion of the operation. I am satisfied on the evidence that this would have occurred despite the injection by Mr. Mohsin of Marcaine, a local anaesthetic, around the wound as recorded by him in the operation notes and the postoperative ministration to the plaintiff of 5mg of morphine as recorded in the anaesthetic postoperative instructions in the postoperative recovery nursing record. The ultrasound scans carried out on the 18th January, 2010, and the 1st February, 2010, demonstrate that the clotting off of the plaintiff's left testicular artery in fact occurred over that period. The radiologist report of the ultrasound scan carried out on the 18th January, 2010, stated: "The left testis is normal". The report of the ultrasound scan carried out on the 1st February, 2010, states: "Arterial flow is identified within the testis, predominantly in the upper pole region, with overall vascularity reduced as compared to the contra lateral testis". It was the opinion of Prof. Hyland that most of the blood supply to the left testicle had been cut off as of the 29th January, 2010, despite the reference in the report of the 1st February, 2010, to arterial flow being confirmed within the testis. This flow he considered was probably coaxial flow, an opinion shared by Mr. Miller, which in any event was not sufficient to keep the testicle viable as demonstrated by the ultrasound scan of the 1st April, 2010, and the ultrasound scan of the 15th December, 2010. The radiologist report of the 1st April, 2010, indicates that at that time the blood supply was insufficient to keep the left testicle alive and part of the testicle had already died. The report of the 15th December, 2010, was that the left testicle was smaller than previously and was essentially avascular – there was no blood supply. The radiologist reported that, "sequential scans changes suggest left testicular infarction and secondary testicular atrophy". At this time by reason of tissue death the left testicle had withered down to the size of a "small pea". I and satisfied and I find that this evidence accords with the pain pattern described by the plaintiff which I am satisfied is corroborated by the consultation notes from his general medical practitioner and by the hospital records.

27. The plaintiff's evidence to the court was that subsequent to the operation he experienced constant severe pain. He said he did not complain about this pain, because he reasoned that he should expect pain and discomfort at this level following such an operation. The nursing record for the 20th January, 2010, the day following the operation, records that the plaintiff had complained of pain on a pain scale of 7 out of 10 that morning. On the patient's chart the pain score is recorded as 8 out of 10 at 13:30 hours. As there is no objective means of measuring pain, medical personnel and in particular nurses employ a subjective patient self assessed pain score of 0 to 10 to assess pain. I am satisfied from the evidence of Prof. Hyland and Ms. O'Sullivan, Director of Nursing at the defendant hospital since 2009, that on this pain scale zero indicates no pain, 7, 8 and 9 very severe pain and 10 the most severe pain one can experience. The hospital drug cardex records shows that at 13:50 hours on the 20th January, 2010, the plaintiff was given Difene 75mg orally by a doctor. At 17:40 hours on the same day he was given Paracetamol 1gm by a doctor. I accept the evidence of Prof. Hyland that one must assume that this drug regime was sufficient to control the plaintiff's pain on that day. Difene is a powerful non-steroidal analgesic and anti-inflammatory drug.

28. On the 19th January, 2010, Oxycontin and Oxynorm had been approved for use in the postoperative care of the plaintiff. These were not in fact used, probably because Difene was effective to control the pain the plaintiff was experiencing. Mr. Miller explained that these are opiate-type drugs and accordingly can cause vomiting, nausea and constipation in 30% of patients which would be contra-indicated in a patient recovering from a recurrent inguinal hernia repair as likely to cause muscle straining. On the 21st January, 2010, prior to his discharge from the defendant hospital the record shows that the plaintiff was given Paracetamol 1gm and Difene 75mg. The nursing discharge details record the discharge time as 12:00 hours (noon). However, the final entry in the nursing record evaluation/critical event record is 13:45 hours. The evidence of the plaintiff was that on his way home from the hospital he obtained 21 Tramapine 50mg capsules at Irwins Pharmacy, 77 Shandon Street, Cork, which is close to the defendant hospital. The time at which the prescription was dispensed at this pharmacy was 14:18 hours. I find that the probable time of discharge of the plaintiff from the defendant hospital was in or about 13:45 hours and the noon entry may only indicate the commencement of the discharge procedure. The M.Q.H. pre-discharge check list contains the notation "pain control satisfactory". The nursing discharge details under the heading "Advice/Instructions on Discharge" record the following:

> "Attend Out Patients Department 4 – 6 weeks which will be posted to patient.
>
> Attend Accident and Emergency or General Practitioner if any problems arise.
>
> Advised re. wound care and extra dressings given to the patient."

29. The nursing discharge details record that a prescription sheet bearing an internal hospital record number, 407992 was given to the plaintiff on discharge. The hospital discharge form under the heading "Medication on Discharge" contains the entry "Paracetemol 1gm. po prn locally as required".

30. I find on the evidence, particularly the evidence of Mr. Miller and Mr. Scurr, that the episode of very severe pain which the plaintiff experienced at about 13:13 hours on the 20th January, 2010, the day following the operation, was on the balance of probabilities, the onset of ischaemic pain indicating that the blood supply to the plaintiff's left testicle was at that time impaired to such a degree as to cause this level of pain in a man, whom I accept was convinced that he would have to endure and did endure uncomplainingly moderate to severe postoperative pain. It is almost as if this complaint was unwillingly wrung from him by the exceptional level of this particular bout of pain.

31. I am fully satisfied on the evidence that the plaintiff was, on discharge from the defendant hospital, prescribed Tramapine 50mg capsules, one to be taken three times daily for one week. This prescription was dispensed by Irwins Pharmacy at 14:18 hours on the 21st January, 2010. I accept the plaintiff's evidence that this was on his way home from hospital. Prof. Hyland, Mr. Miller and Mr. O'Sulleabhain were in agreement that the fact that Tramapine had been prescribed should have been recorded, at least in the hospital discharge records. For some unexplained reason it was not. Hospital prescription sheet number 407992 was not disclosed in the discovery of documents and was not forthcoming during the hearing of this action. I am satisfied on the evidence and I find that Tramapine 50mg is an opiate type drug used for the prevention or control of severe pain. I accept the plaintiff's evidence that he had to take two of these Tramapine 50mg capsules on the 21st January, 2010, to control the pain he was suffering. The plaintiff gave evidence that on each successive day thereafter until the 21 capsules were exhausted, he took three capsules per day as prescribed. He told me and, having regard to the evidence of the three expert witnesses, I have no hesitation in accepting his evidence that the pain became progressively more severe as day followed day. He became unable to stand or walk and achieved a small measure of relief by sitting or lying with his left leg elevated. On the 29th January, 2010, he told the court that the pain became excruciating and unendurable and he was brought to the Parklands Surgery of his general medical practitioner. Having heard and carefully observed the plaintiff giving evidence, I am satisfied that this must indeed have been unendurable pain because I found the plaintiff to be a most modest man who consistently understated all his problems in this case.

32. Nurse Mary Leahy of the Parklands Surgery, in consultation notes recorded the following with respect to the plaintiff on the 29th January, 2010:

> "Complained of excruciating pain in left testis since left inguinal hernia repair in Mercy, 11 days ago getting very little

relief. Currently on Tramapine to no avail. Seen by Dr. White."

33. These consultation notes record that Dr. White having seen the plaintiff telephoned the defendant hospital and sent the plaintiff there immediately. He noted on the consultation notes that the plaintiff presented with a large tender indurate swelling in the left scrotum with a bluish colour. Dr. White's letter which accompanied the plaintiff to the defendant hospital is dated the 29th January, 2010, and stated as follows:

> "Please assess this patient. He had left inguinal hernia repair 11 days ago. Immediate postoperative swelling and pain on left side scrotum. Swelling increasing in size/pain now excruciating pain – only relief when sitting. On examination large indurate very tender swelling left side scrotum. Temperature 36.2 . . . 132 over 78 (on Diovan) suggests surgical consultation as soon as possible."

34. I assume that the reference to 132 over 78 is to the plaintiff's blood pressure on the occasion. Diovan is a drug used in the treatment and control of hypertension.

35. The defendant hospital's emergency department record of the plaintiff's readmission on the 29th January, 2010, states as follows:

> "Presents with painful swollen left testis/scrotum. Had left inguinal hernia repair about 6/7 days ago. Had mild swelling post-operation. Pain xxx last few days."

36. It was accepted in evidence by the expert witnesses that "pain xxx" indicates very severe pain. The plaintiff's history as noted at 13:51 hours by Dr. John Duddy, Senior House Officer to the emergency consultants Dr. Luke and Dr. O'Sullivan is recorded as follows:

> "Left inguinal hernia repair on the 19th January, 2010, under Mr. O'Sulleabhain. On day of discharged noticed increasing swelling of left testicle. This progressed in the last week. Also progressive pain over last week. Most severe when walking or standing. Severity 10 out of 10 when standing. Relieved when lying down. Also noticed redness over left testicle. No pain/inflammation over wound site. No abdominal pain. No urinary symptoms."

37. The emergency department nursing record under the heading "pain on admission" records as follows:

> "Pain score 10 out of 10, left testicle. Duration more than 24 hours pre hospital admission. Tramapine 50mg. Comments:- pain progressively worse since discharge the 21/1/10."

38. I accept the evidence of Mr. O'Sulleabhain that Tramapine 50mg was commonly prescribed at the defendant hospital as a "going home" drug for use on an "as required" basis in case of "breakthrough" pain where Paracetamol and other readily available non-prescription analgesics proved insufficient to control the pain being suffered by the patient. I do not however accept that this is what occurred in the instant case. I am satisfied on the evidence, particularly of the dispensing record from Irwins Pharmacy, that the plaintiff was prescribed Tramapine 50mg capsules, one to be taken three times daily for one week. This is a clear indication that the plaintiff was assessed on discharge from the defendant hospital as then suffering severe pain or as very likely to suffer severe pain on returning home. I accept the evidence of Prof. Hyland that for a patient enveloped in the protective environment of a hospital a lesser degree of analgesia will often be sufficient to control pain which might not at all be the case when the patient is mobilised and returns to his or her home and normal surroundings and activities.

39. I am satisfied on the evidence of Prof. Hyland, Mr. Miller and Mr. Scurr, that what the plaintiff was experiencing over this period was increasing ischeamic pain caused by the progressive obstruction of blood flow in his left testicular artery to the point where on the 29th January, 2010, it had become completely or very significantly cut off causing the excruciating pain which he then experienced. I consider it most significant that on the 1st February, 2010, there is an entry in the emergency department notes that the plaintiff's pain had resolved. It was the evidence of Mr. Scurr with which Prof. Hyland agreed that once an organ dies and consequently the nerves, from hypoxia, pain immediately ceases. This particular entry in the emergency department notes reads as follows:

> "Urology Consultant. Left inguinal hernia repair/1/10. Complained of pain and swelling left hami-scrotum since. Treated with intravenous Augmentin/Ciproxin since admission. Pain now resolved. Swelling decreased over weekend."

40. I find that in each and every respect, the onset, escalation and climaxing followed by an almost immediate cessation of pain corresponds with what the evidence of the three expert witnesses established one would expect in the case of ischaemic pain resulting from the progressive and ultimately total or significant obstruction of blood flow in the testicular artery.

41. It was put to Mr. Scurr in cross examination that a build up of interstitial fluid volume and consequently pressure in surrounding tissue cavities caused by a postoperative inflammatory process resulting in oedema could have exerted sufficient pressure on the testicular artery to obstruct the flow of blood through the arterial tube. Mr. Scurr emphatically rejected this proposition. When he came to give evidence Prof. Hyland told the court that Mr. Scurr was absolutely correct. Both experts were agreed that except in the case of a compartment syndrome this could not occur. Both were agreed that interstitial fluid pressure was normally 25 per millimetre of mercury but could become elevated to a maximum pressure of 40mm.Hg. in oedema. By comparison normal arterial pressure is 130mm.Hg. But in the case of this plaintiff it was in fact 156mm.Hg. by reason of his blood pressure problems.

42. I accept the evidence of Mr. Scurr and Prof. Hyland that pressure due to a build up of excess interstitial fluid in tissue could not in the absence of a compartment syndrome overcome or interfere with the blood flow in the plaintiff's left testicular artery. Mr. Miller who is a consultant urologist was of the same opinion. He did not address the issue of compartment syndrome. He told the court that Mr. Scurr as a vascular surgeon would be better able to address the issue of oedema. Mr. Scurr referred to and produced a photocopy of pp. 178 to 180 inclusive of a *Textbook of Medical Physiology* (1991, 8th Ed.) by Arthur C. Guiton M.D., Professor at the Department of Physiology and Biophysics of the University of Mississippi School of Medicine, (Publishers W.B. Saunders Company), and a photocopy of an article published by Prof. Guiton in 1965, entitled "Interstitial Fluid Pressure: II Pressure Volume Curves of Interstitial Space" published in "Circulation Research" a publication of the American Heart Foundation.

43. Prof. Hyland considered that the deep inguinal ring area might be a sufficiently confined space so as to give rise to a compartment syndrome. He accepted that this was no more than informed conjecture. Mr. Scurr who is a vascular surgeon and acknowledged to be a leading expert in the field of thrombo-embolic phenomena had no doubt that this could not arise because the inguinal canal he pointed out is surrounded by muscle which is not indurate. All three experts and Mr. Mohsin were in agreement that inflammation was a universally acknowledged possible complication in all surgical procedures. In the readmission record of the emergency department of the defendant hospital on the 29th January, 2010, it is noted that the plaintiff had no pain or inflammation over the wound site and

had no fever, rigour, sweating, nausea, vomiting, abdominal distension or abdominal pain. In Dr. White's letter to the defendant hospital dated 29th January, 2010, referring the plaintiff for urgent readmission, he records the plaintiff's temperature at 36.2 which is below the normal of 37. Mr. Miller told the Court that there was no evidence of epidimal orchitis (inflammation of the testis) in this case or of inflammation of the haematoma on the front of the left testicle.

44. I prefer the opinion of Mr. Scurr on this issue to what Prof. Hyland readily accepted was purely speculation on his part. Prof. Hyland surmised that if there was sufficient inflammation around the deep inguinal ring area due to a combination of pre-surgical inflammation referable to an inflamed hernia and inflammation caused by the surgery itself, the synthetic prolene mesh sutured into place in the operation to strengthen the weakness in the abdominal wall could possibly cause a narrowing of the deep inguinal ring which might result in some minor flow disturbance within the testicular artery which might give rise to clotting in the artery. Prof. Hyland told the court that this was pure speculation on his part in considering what might have been the mechanism which initiated the clotting in the plaintiff's left testicular artery.

45. Mr. Moshin gave evidence that when he opened the hernial sack with a scalpel he found (contrary to what was suggested by the CT scan on the 19th January, 2010), that it did not contain incarcerated fat which was inflamed and likely strangulated. He found that it in fact contained sigmoid colon fat globules which were entirely viable. He therefore closed the hernial sack with a suture and pushed it back into the abdominal cavity through the posterior wall before, as the operation notes record, laying on the prolene mesh and suturing it in place. Mr. Mohsin told the court that he had created an opening in the prolene mesh to accommodate the spermatic cord. There is no reference in Mr. Mohsin's operation notes to inflammation. Post-surgery the plaintiff was given Augmentin to prevent postoperative infection and Clexene to prevent clot formation.

46. I find that if the employment of the prolene mesh in the course of an inguinal hernia repair in the area of the deep inguinal ring could create a compartment syndrome such that in the event of an onset of postoperative oedema interstitial fluid pressure might result in a total or significant obstruction of blood flow through the testicualr artery with a risk of hypo vascularity and loss of a testicle this would long since have been recognised and written up in surgical text books and additionally or alternatively in articles in reputable medical journals. None such was produced in evidence. I am satisfied on the balance of probabilities that a compartment syndrome did not occur in this case for the foregoing reasons and particularly by reference to Mr. Scurr's evidence that the repair area in the instant case though adjacent to the deep inguinal ring did not constitute a sufficiently inelastic envelope so as to enable a compartment syndrome to develop.

47. Mr. Mohsin gave evidence that he considered that the loss of the plaintiff's left testicle was due to the development, postoperatively, of a scrotal haematoma which cut off the blood flow through the testicular artery. He considered that oedema in the inguinal canal was less likely to have been the cause. Mr. Mohsin was of the same opinion as Prof. Hyland that the initial inguinal hernia suffered by the plaintiff was most probably an indirect hernia. He considered that the failure of the coaxial arterial blood supply to maintain the viability of the plaintiff's left testicle after the blood supply through the testicular artery had become totally or effectively cut off was probably due to the coaxial system having been cut or severely compromised in the course of the initial inguinal hernia repair. While Mr. Mohsin agreed with Mr. Scurr that over vigorous handling of the spermatic cord could cause damage to the testicular artery, it was his evidence that the cord, even though it had to be kept at all times about one inch or so away from the area under repair, was pretty strong and could bend a great deal, so that any vigorous handing would have to be quite abnormal in order to cause damage to the testicular artery. He stated that it was his belief that damage to the testicular artery by over flexing would cause immediate total blockage of the artery and that the plaintiff's pain pattern was inconsistent with this. Having regard to the evidence, particularly of Mr. Miller, I accept that it is possible that over-flexing of the spermatic cord could cause a total and immediate blockage of the testicular artery. However, from the evidence of the pain pattern suffered by the plaintiff, I am satisfied that this did not occur in the instant case. I am satisfied on the evidence, particularly from the evidence of Mr. Scurr and Prof. Hyland, that the damage to the testicular artery in the present case was not catastrophic initially but rather kinking damage to the intima of the artery which initiated a gradual but progressive build up of thrombi which ultimately blocked or seriously obstructed the flow of blood through the testicular artery.

48. Mr. O'Suilleabhain considered that a build up of pressure due to blood oozing postoperatively under gravity from small vessels caused a restriction of testicular artery flow and stretching of sensitive tissue in the scrotal area. He attributed the plaintiff's progressively increasing pain to this stretching of sensitive tissue, but accepted that one could not rule out the additional involvement of ischaemic pain. He however accepted that the clotted blood mass on the plaintiff's left testicle was not evacuated and, that the scrotum can extend even to a quite enormous size. In Mr. Mohsin's letter to Dr. Donovan dated the 15th March, 2010, he had advised that the scrotal haematoma was then reducing in size. As indicated by the ultrasound scan report of the 15th December, 2010, by that date the entire of the clotted blood mass had been totally reabsorbed into the plaintiff's body.

49. I am satisfied on the balance of probabilities that the blockage or significant obstruction of the plaintiff's left testicular artery was not caused by the scrotal haematoma which developed postoperatively. I am satisfied on the evidence that the haematoma in this case was not nearly large enough, particularly having regard to the elasticity of the scrotum, to cause such a blockage or obstruction. I am also satisfied on the evidence that the plaintiff's pain pattern was entirely inconsistent with such a cause.

50. Mr. Miller, Mr. Scurr and Mr. O'Suilleabhain were agreed that the scrotum is both expandable and stretchable to an exceptional degree. It is not an inelastic or non-expandable space. Mr. Miller and Mr. Scurr gave evidence that it can expand to contain considerably more than a pint of blood; a not infrequent occurrence they said in road traffic accident cases involving motor cycle riders. Mr. Scurr gave evidence, based on the hospital records, that in the instant case on readmission of the plaintiff to the defendant hospital on the 29th January, 2010, the clotted blood mass on the front of the plaintiff's left testicle was no more than 5cm to 6cm in diameter, not quite sufficient to double the size of the testicle. Mr. Miller and Mr. Scurr accepted that a massive scrotal haematoma could indeed obstruct or significantly restrict the flow of blood in the testicular artery. However, I am satisfied on their evidence that the haematoma in the instant case was not even approaching the size necessary to cause such an obstruction or blockage. Mr. Miller was satisfied that the haematoma in the present case would not have been sufficient to cut off even the far weaker coaxial arterial flow. He considered that the coaxial arterial system in this case was probably genetically insufficient to maintain the viability of the plaintiff's left testicle after the blood supply from the testicular artery had failed or had been severely obstructed. In his opinion any arterial flow in the plaintiff's left testicle, predominantly in the upper pole, seen on the ultra sound scan on the 1st February, 2010, was coming from the coaxial arteries supplying the vas deferens and the cremaster muscle. Prof. Hyland was of the same opinion.

51. Mr. Miller gave evidence that tissue stretching in the scrotum due to a haematoma of the size present in the instant case would not have caused the pattern or the level of pain which the plaintiff experienced. Mr. Scurr told the court that the onset of pain referable to the obstruction of a testicular artery by a postoperative haematoma is gradual and generally starts days or even weeks after surgery. In his expert opinion the rapid onset and progressively more severe pain experienced by the plaintiff was entirely inconsistent with the development and size of the postoperative scrotal haematoma in the instant case. I am satisfied that this

evidence was not discredited or shown to be questionable in any way.

52. I am therefore satisfied, on the balance of probabilities that the damage to the plaintiff's left testicular artery, which resulted directly in the loss of his left testicle, was caused by some form of unduly vigorous handling of the spermatic cord during the course of the surgical procedure on the 19th January, 2010. It is not necessary to identify the exact nature of this over vigorous handling – whether it was lateral or vertical over-stretching of the spermatic cord or some other form of kinking – and indeed it would be almost impossible to do so even if the procedure was visually recorded. I am satisfied on the evidence that such handling is sub-standard, at least in the absence of evidence of some excusing circumstances. Nothing, however, appears in the operation notes or from the evidence adduced during the course of the hearing which would excuse such handling in the present case. The defendant, as vicariously responsible for the acts or defaults of each member of the operating team on the 19th January, 2010, is therefore answerable to the plaintiff in negligence.

53. By a letter dated the 29th June, 2010, from Mr. Khan, Consultant Urologist at the defendant hospital, to Mr. O'Suilleabhain, admitted into evidence, he records that the plaintiff ". . . is voiding normally and his erections are normal". Mr. Miller gave evidence that the plaintiff's testosterone hormone level was 13.8, despite the total loss of all functions of his left testicle. He stated that this was the normal testosterone level for a male aged 61-62 years and, given this testosterone level the plaintiff could not have suffered any libido or virility impairment from the loss of his left testicle. Having regard to the nature of his medical speciality, I am satisfied that Mr. Khan was referring solely to the physical aspects of an erection so that his finding does not preclude the existence of a psychosexual basis for the plaintiff's alleged erectile dysfunction.

54. Mr. Miller posited that any such dysfunction might be a side effect of the anti-cholesterol medication taken by the plaintiff. While sexual difficulties are identified and notified as possible side effects of some lipid controlling medication, the fact remains that the plaintiff was taking such medication prior to the 19th January, 2010, and his evidence was that prior to that date he had no sexual difficulties or erectile dysfunction. It is a reasonable inference that the plaintiff would have been informed by the prescribing physician of this possible side effect of the medication or would have become aware of it from the patient information leaflet which is invariably included in the package with the product. Had he been experiencing sexual difficulties or erectile dysfunction prior to the 19th January, 2010, I am satisfied that he would have brought this to the attention of the prescribing physician and sought a change of medication or of treatment. I am satisfied on the evidence, particularly the evidence of Mr. Miller, and I find that any, if any, erectile dysfunction which has been or is being experienced by the plaintiff is psychosexual in nature and most probably due to some reduction in sexual confidence resulting from the loss of his left testicle.

55. The plaintiff gave evidence that in or about April 2010, after he had returned to work, he noticed a lessening in his sex drive. He told the court that this had recovered to some extent, but in his opinion sexual intercourse with his partner was still reduced by up to 50% from pre 19th January, 2010, levels. His erections were less frequent and he had doubts about his ability to achieve and maintain a full erection. He was prescribed Viagra, a Phosphodiesterase-5 inhibitor, by his general medical practitioner on the 21st September, 2011. The plaintiff told the court that after discussion with his partner he decided not to take this medication as he said he did not wish to end up taking a "whole cocktail of drugs". He was at that time already taking four different separate drugs for heart related problems and required an injection every quarter for pernicious anaemia. The plaintiff told the court that he was worried that if his present relationship came to an end that a new partner might not be so understanding and supportive as regards his sexual problems. He also worried about what would happen if he sustained an injury to or had some problem with his remaining testicle. He decided against attending an erectile dysfunction clinic. He and his partner had discussed a cosmetic prosthesis to replace the absent left testicle and he had decided against it. He told the court that he was very reluctant and frightened to have another operation in this area in the circumstances. He said that the absence of a left testicle caused him embarrassment in dressing-room situations, such as at a gym.

56. No expert psychological evidence was called by either side in this case. No evidence was led by the defendant to indicate the success level of erectile dysfunction clinics in resolving the sort of psychosexual problems which I am satisfied were and are being experienced by the plaintiff and are the cause of any erectile dysfunction suffered by him. However, while I am satisfied that the plaintiff has since April 2010, suffered and continues to suffer some psychosexual related erectile dysfunction as a consequence of the loss of his left testicle, his voluntary decision not to attend an erectile dysfunction clinic or to take the P.D.E.-5 inhibitor medication prescribed by his general medical practitioner is an indication of his own assessment of the real impact of this problem on his relationship with his partner and his enjoyment of life.

57. Mr. Miller gave evidence that the insertion of a cosmetic prosthesis to replicate an absent testicle was a much used and simple operation and the result was very realistic. He told the court that the risks associated with the procedure were that the prosthesis might become dislocated and require repositioning, that in very rare cases it could rupture and, that if a gram-positive bacterial infection, such as streptococcus occurred the prosthesis would have to be urgently removed. Mr. Miller told the court that in his experience approximately 50% of persons who lost a testicle due to torsion injuries accepted a prosthesis. He acknowledged that some persons reasonably could not tolerate the presence of an artificial structure in their body. In the instant case, despite the minimally intrusive surgery involved and the low attendant risks, having regard to the events which had given rise to this litigation I do not find it unreasonable for the plaintiff to decide against a prosthesis. The plaintiff has suffered a disfigurement consequent upon the loss of his left testicle. However, I am satisfied that this, because of its location, although a cosmetic blemish is not a significant one, I am satisfied on the evidence that it is something of which the plaintiff is genuinely and reasonably very self conscious. I am satisfied that it is reasonable for the plaintiff to be concerned about the consequences of suffering an injury to or having a problem with his remaining right testicle.

58. For general damage to date, the court will award the plaintiff the sum of €55,000. For general damage into the future the court will award the plaintiff an additional sum of €20,000. Special damage has been agreed in the sum of €526. Though the plaintiff was absent from work for about three weeks or so, no claim for loss of earnings arises in this case.