2016

Case No. 9 - Death following Iatrogenic Bowel Perforation after Endoscopic G.I. Procedures

New York Law School

CASE NO. 9

DEATH FOLLOWING IATROGENCIC BOWEL PERFORATION AFTER ENDOSCOPIC G.I. PROCEDURES

FACTS

On May 1 of 2000 Mr. M underwent an endoscopic retrograde cholangio pancreatography ("ERCP") performed by his G.I. physician Dr. F. The endoscopic procedure was intended to locate and then remove a gallstone from Mr. M's common bile duct. During multiple cannulations involving movements of the ERCP to try to obtain an optimum position or doing a sphincterotomy incision into the hepatic pancreatic duct, Dr. F identified the fact that the steps produced a perforation of the patient's duodenum.

As such, postoperatively, Dr. F immediately referred the patient to Dr. P who was a general surgeon. Dr. P, however, did not reoperate until the morning of May 3rd of 2000 which was two days following the perforation. During the intervening time frame following the perforation, there was by the morning of May 2nd revealed in the medical record evidence of increased free-air in the retroperitoneum, abdominal guarding, increasing abdominal pain, the retention of vast amounts of water, and a dramatic distension of Mr. M's abdomen reflecting a worsening and deteriorating clinical picture.

Yet the surgical repair of the perforation was not undertaken until May 3rd, at which time a reversal of the continued deterioration unfortunately did not occur. Mr. M died on May 4th of 2000.

The autopsy pathologist listed Mr. M's cause of death as complications due to perforation of the duodenum following ERCP.