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Case No. 1 - Anoxic Encephalopathy in a 7 year old Experiencing Hemorrhagic Shock following Liver Biopsy

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CASE NO. 01

ANOXIC ENCEPHALOPATHY IN A 7 YEAR OLD EXPERIENCING
HEMORRHAGIC SHOCK FOLLOWING LIVER BIOPSY

Jill age seven was admitted to the University Hospital on March 18, 2003 with a history of an autoimmune disorder presumed to be Lupus.

The medical work up during admission reflected evidence of liver dysfunction associated with coagulopathy reflected by prolonged bleeding times.

An attending pediatric gastroenterologist recommended a liver biopsy which was scheduled for Thursday, March 20, 2003 to be performed by Dr. West who is an interventional radiologist. The gastroenterologist entered in the record that Jill would need fresh frozen plasma during the procedure as such contains clotting factors that Jill would be lacking because of her liver problem.

In the morning of March 20, 2003 Nurse Jones came on duty at 7:00 a.m. Prior to sending Jill to the interventional radiology suite Nurse Jones did not obtain a sample of blood for a pre-procedure coagulation study. Nurse Jones stated that Jill was a "difficult stick" making it difficult to obtain a sample of blood.

As such, Jill went to the interventional radiology suite without a pre-procedure sample of blood that would include coagulation studies.

Jill was off of the pediatric floor from 11:00 a.m. to 3:15 p.m. while she was at the interventional radiology suite. During that time frame Nurse Jones was placing entries in the record reflecting observations of Jill which concluded that Jill's condition was good even though Nurse Jones was not observing Jill.

When asked to explain why she was documenting that the child looked good at points in time when she was not even on the floor, Nurse Jones claimed that such was a "mistake".

At the interventional radiology suite neither the interventional radiologist, Dr. West nor the anesthesiologist, Dr. East noted that there was no pre-operative coagulation test. Neither Dr. West nor Dr. East noted the recommendation that Jill be given fresh frozen plasma during the procedure. As such, the

liver biopsy was done without an awareness of what the risk was for bleeding based on a current lab value and without the administration of the fresh frozen plasma.

Jill arrived back on the floor at 3:15 p.m. and again came under the care of Nurse Jones. There was no house physician involved in the transfer of Jill from the floor to the interventional radiology suite in the morning of March 20, 2003. There was no house physician involved in the care and evaluation of Jill when she returned to the floor at 3:15 p.m. No physician was aware that there was or might be any risk for bleeding as a consequence of the liver biopsy on a child who was or might be vulnerable to a bleeding disorder.

At 4:30 p.m. Nurse Jones documented that Jill's heart rate was elevated at 134 beats per minute. Still no doctor was involved.

Nurse Jones stated that for the next hour and a half Jill's vital signs were rechecked as many as 50 times during that time interval and Nurse Jones stated that such vital signs were all normal. That information was derived from Nurse Jones' memory as Nurse Jones maintained that the paper that she wrote that information down on was "lost".

By 6:00 p.m. Jill's blood pressure was falling and still no doctor was called. At 6:41 p.m. Jill had a cardiac arrest resulting in a "code" response and resuscitation in which there was no heart beat for approximately 20 minutes.

Jill's abdomen had massively filled with blood as a result of postoperative bleeding due to a coagulopathy. The coagulopathy was "fixed" by means of the administration of fresh frozen plasma.

Unfortunately, Jill sustained severe hypoxic-ischemic brain damage and now is wheelchair dependent, unable to propel herself and is dependent on others for all her activities of daily living.