MEMORANDUM

TO: Sandy Koufax
FROM: Martin A. Ginsburg, BSN, RN
SUBJECT: Merit Screen – Johns
DATE: 23SEP16

Mr. Koufax,

Per your instructions and at your request, this memorandum is a summary of information noted during a perusal of available records relating to your client, including; admission, medical history, imaging study readings, treatments, and consults and evaluations related perforation of her small bowel during a laparoscopic hysterectomy during her hospitalization from 22APR16-07MAY16.

University Hospital of Chicago admitted Mrs. Johns with diagnoses of:

1. Uterine fibroids
2. Morbid obesity
3. Pre-renal hyponatremia, mild
4. History of (10 pack-year) tobacco abuse

The focus in this merit screening is, as requested, whether a delay in recognition of a perforated colon breached the duty of care causing damages to the patient.

These cases are difficult, at best, for plaintiffs and their legal team. While it is reasonable to see a time lag as a failure to timely respond, this is not always the case.

In this patient, the allegation is a delay in diagnosis of, or failure to diagnose, perforated bowel. The patient underwent a laparoscopic hysterectomy during which she suffered a bowel perforation and there is concern as to timely diagnosis and treatment of this known complication of this procedure.

Per the submitted records, the patient initially underwent the laparoscopic procedure on 22APR16 during which she suffered an injury to her bowel. The patient's

post-operative course was marred by increasing abdominal pain and an increasing white blood cell count (WBC).

A computed tomography scan (CT) with both oral and intravenous (IV) contrast was performed as well as pre-contrast images taken. This scan showed no definitive evidence of gastrointestinal (GI) bleeding or leakage of GI contents into the abdomen. This failure to demonstrate a bowel injury led to a recommendation by the medical team to perform a second procedure to identify the source of the patient's pain as perforated bowel is a leading complication of hysterectomy and presents much as this patient's symptoms.

During an exploratory laparotomy of her abdomen, a perforation of the small bowel was found and sutured closed. The patient's post-operative course following this second procedure was within expected norms and the patient was discharged home on 07MAY2016.

Patient reports of hernia related to open abdominal surgery identifies a known complication of open procedures in patients with concomitant morbid obesity. Wound dehiscence and other wound healing complications are known and difficult, at best, to prevent in this population.

Despite the adverse events reported by Mrs. Johns, there is insufficient evidence of a breach of the standards of care in this case. Rather; this presents as a case where known complications coincided and sequenced in such a way as to lead the overall outcome to appear as error. For the reasons explained herein a finding of no merit is warranted.

Please advise of additional information needed or questions I can answer.

Respectfully,

Martin A. Ginsburg, BSN, RN
Nurse Paralegal

MEMORANDUM

TO: Sandy Koufax
FROM: Martin A. Ginsburg, BSN, RN
SUBJECT: Merit Screen – Simpson
DATE: 20SEP16

Mr. Koufax,

Per your instructions and at your request, this memorandum is a summary of information noted during a perusal of available records relating to your client, including; admission, medical history, imaging studies and readings, treatments, and consults and evaluations related perforation of her sigmoid colon and diverticulitis during her hospitalization from 24SEP15-25NOV15.

WakeMed admitted Mrs. Simpson with diagnoses of:

1. Diverticulitis of large intestine with perforation and abscess without bleeding
2. Essential (primary) hypertension
3. Anxiety disorder, unspecified
4. Postmenopausal bleeding
5. Candidiasis, unspecified
6. Unspecified protein-calorie malnutrition
7. Morbid (severe) obesity due to excess calories

The focus in this merit screening is, as requested, whether a delay in recognition of a perforated colon breached the duty of care damages to the patient.

These cases are difficult, at best, for plaintiffs and their legal team. While it is reasonable to see a time lag as a failure to timely respond, this is not always the case. Mrs. Simpson, upon admission, underwent computed tomography (CT) scanning which diagnosed her diverticulitis but did not demonstrate any level of perforation of her colon. Mrs. Simpson reported abdominal pain and constipation upon admission and to relieve

constipation, enemas were ordered and administered. Micro-perforation was noted on a later scan and Mrs. Simpson continued to have her diverticulitis managed with conservative medical treatment.

There were indications of infection present during a large portion of the time between admission and her initial surgery. An elevated white blood cell count (WBC) is an early physiologic response to infection. It should be noted that trauma may also increase a WBC as it is a component of the inflammatory response. These elevated WBC findings were also, until the day of initial surgery, well controlled leading to a reasonable conclusion that conservative management was of value in this patient.

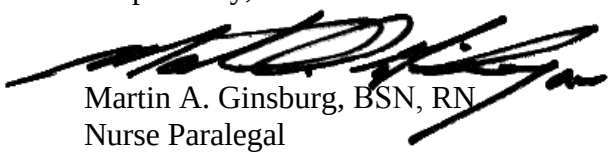
From the materials available it cannot be stated with any degree of certainty that there was a failure to timely diagnose or intervene related to a perforated diverticular colon. The delays are within the discretion of the treating physician and consist with recognized standards that strive to effectively treat disease without incurring unnecessary risks, such as those associated with any surgical procedure.

While not a part of the brief and focus in this case, results of the alleged delay were perused and grossly appear to be known consequences of the interventions undertaken. This is an approximation from a truncated examination and not in any way an opinion based upon thorough review. While it may be possible to argue a delay in treatment, the opposition will argue practitioner discretion, high risks of surgery in this patient due to co-morbid conditions, and likelihood of no change in outcome. This defense of the practitioner is within reason and presents a significant burden that may be insurmountable.

Mrs. Simpson has obviously suffered greatly because of this entire situation and process, however; MarGin finds no information sufficient to support an allegation of a delay I treatment or intervention.

Please advise of additional information needed or questions I can answer.

Respectfully,



Martin A. Ginsburg, BSN, RN
Nurse Paralegal

MEMORANDUM

TO: Sandy Koufax
FROM: Martin A. Ginsburg, BSN, RN
SUBJECT: Patient Medical Record Review and Summary
DATE: AUGUST 28, 2016

Mr. Koufax,

Per your instructions and at your request, this memorandum is a summary of care provided your client related to her diagnosis of terminal endometrial cancer.

In this patient, the allegation is a delay in diagnosis of, or failure to diagnose, endometrial (uterine) cancer. Attached is a "track changes" document appending in-line commentary to your email to supplement this memorandum. This attachment will demonstrate the details of investigation into this case.

This patient has a history significant for pelvic organ prolapse and breast cancer with partial left mastectomy to clear margins with follow-up examinations demonstrating no extension of disease.

Per the submitted records, the patient initially reported postmenopausal bleeding in July of 2013 and underwent endometrial biopsy at that time. In August of 2013 patient underwent ultrasound evaluation of her uterus that demonstrated myometrial fibroids. This ultrasound followed, rather than preceded, an endometrial biopsy that failed to yield a viable specimen. Had biopsy been repeated following the August ultrasound the fibroids could have been specifically targeted for biopsy in addition to endometrial tissue and the nature or the fibroids then identified.

Failure to conduct a repeat of specimen collection by biopsy, especially in a postmenopausal woman with a history of vaginal bleeding not linked to cervical disease, is a failure to perform to expected standards. If a biopsy was indicated simply for bleeding in a postmenopausal patient, there is no reason not to recommend, at the least, a

repeat attempt to collect a viable specimen. No such recommendation is found in the provided records.

There is a period of some ten months between the identification of myometrial fibroids and Hysteroscopy with endometrial biopsy and polypectomy with D&C to obtain specimens for evaluation by pathology. During this period, there was substantial opportunity for the cancer found to invade adjacent structures and adversely impact the potential for survival.

The patient is reported in the record (p. 508) to have "vacillated" regarding hysterectomy. Whether this hesitance may have changed in the face of a successful biopsy of myometrial fibroids that would, almost certainly, have identified a cancerous process in not knowable. That said, it is possible that the surviving spouse has knowledge regarding the patient's frame of mind regarding hysterectomy and whether she would likely have made a decision to proceed in the face of such information.

Recommendations:

1. Timeline creation of diagnostic and interventional events related solely to endometrial cancer from detailed records dating from last full gynecologic exam before spotting/bleeding to capture all reports of bleeding and diagnostic/intervention efforts;
    a. Production of a timeline focused solely on the visits and notes related to postmenopausal bleeding and uterine diagnostics and intervention would serve the purpose of demonstrating the lapses more clearly while preparing ADR/trial exhibits in advance of need;
2. Creation of a detailed chronology should be deferred unless an opinion expert witness requires such preparation before undertaking a review.
    a. Detailed chronologies, while informative, are costly and examine more information than is necessary for the production of a targeted timeline;
3. Given the likelihood of breach in this fact pattern, a detailed causation evaluation with supporting literature preparation performed concurrently with timeline creation would permit this matter to move forward more expeditiously should the timeline noted above support the strong suspicion of a breach;
    a. A nursing causation evaluation will capture relevant literature with annotations for testifying expert review to reduce expert witness review time, both calendar and billing;

4. An expert identification effort should begin at the earliest opportunity to locate and vet opinion experts and ensure their availability to assist.
    a. Opinion experts can be expected to include gynecology, gynecologic oncology, and radiology, with the caveat that a gynecologic oncologist would need to be prepared to opine on the impact of the breast cancer chemotherapy regimen on endometrial tissue and pathologies.

While your email suggests an initial reticence to prosecute this matter, as described above, this level review demonstrates the substantial likelihood of proof of breach sufficient to overcome Plaintiff's burden. The assessment of the economics of damages is not, as a matter of routine, included in this level report as this is a clinical review not designed to assess case or verdict history in the jurisdiction of concern. As such, costs of surgery, laboratory and radiology testing, additional chemotherapy, hospitalizations, and more represent identifiable economic damages. Non-economic damages are outside our purview and are, therefore, not assessed here.

Please advise of additional information needed or questions I can answer.

Respectfully,

Martin A. Ginsburg, BSN, RN
Nurse Paralegal