$400,000 VERDICT IN WRONGFUL DEATH CASE

Medical Malpractice Trial Report

WRONGFUL DEATH Medical Malpractice Lawsuit: Delay in Diagnosis Results in Wrongful Death.

Ms. Melanson had been a patient of Dr. William Damon. Prior to June 1995, Dr. Damon treated Ms. Melanson for a number of conditons.

In June 1995, Ms. Melanson was treated at the Emergency Room for complaints of abdominal pain. When Ms. Melanson went to see Dr. Damon on June 26, 1995 to follow up on her hospital visit, he referred her for a C.T. scan, which showed evidence of inflammatory changes surrounding her cecum. Lab tests conducted around that time indicated that Ms. Melanson had an elevated white blood cell count of 16,400. He also referred Ms. Melanson for a barium enema. A few weeks later when Dr. Damon met with Ms. Melanson to discuss her use of pain medication.

Upon Dr. Damon's instructions, Ms. Melanson visited four months later where she informed him that she was not feeling well; reporting recurrent fevers of up to 102 to 103 degrees over the preceding six weeks. At this time, Ms. Melanson had experienced an unexplained weight loss since her last examination and complained of malaise, constant thirst and the need to urinate frequently during the night. Dr. Damon referred Ms. Melanson for a series of blood tests that revealed an elevated white blood count of 15,000 and elevated glucose level of 210. Based upon her symptoms, Dr. Damon diagnosed Ms. Melanson as having the beginning stages of diabetes and prescribed Micronase.

While Dr. Damon acknowledged that Ms. Melanson's elevated white blood count and recurrent fevers were a cause of concern, he did not formulate a diagnosis of the cause of the problems. He did not order a repeat test of Ms. Melanson's white blood count, nor did he order any other available Dr. Damon was primarily concerned with her diabetic condition.

Dr. Damon examined Ms. Melanson again the next week where she complained of constant burning pain and a sensation of heat in her right groin, which she said had been constant for the past several weeks. She favored her right leg when she moved about and she demonstrated a reduced ability to raise her right leg during tests performed by Dr. Damon. (She also told Dr. Damon that could no longer tolerate the constant pain in her leg and she began to cry. Dr. Damon listed his primary diagnoses at that time as new- He prescribed Naprosyn for her right leg complaints and instructed her to return in a week. The next week, Ms. Melanson's complaints were much worse. She complained of pain in the right hip and anterior thigh. Her right leg was so weak that she was unable to walk or climb the stairs without assistance. Dr. Damon diagnosed her condition as weakness and pain in the right leg due to an undetermined cause. Dr. Damon discussed with Ms. Melanson the idea of going to the hospital as an inpatient so her leg complaints could be evaluated; she said she could not imagine doing that but she would think about it

Two days later, Ms. Melanson checked into the Heywood Hospital. Dr. Damon's admitting diagnosis of her condition was right-sided sciatica and new-onset diabetes. In the notes of his admitting examination.

Dr. Damon recorded that Ms. Melanson suffered from right lower extremity pain and recurrent fevers, both of which were due to undetermined causes. He also noticed that there was a reddened and tender area on Ms. Melanson's right buttock, which was consistent with cellulites. Dr. Damon requested that Dr. Rambler, an orthopedic surgeon, and Dr. Gaudet, a specialist in infectious disease, examine Ms. Melanson at the hospital.

Upon her examination by Dr. Ramble he diagnosed her condition as a soft-tissue infection of the low back with possible osteomyelitis of the pelvis and a septic sacroiliac joint. He recommended that she undergo a bone scan and other testing to evaluate the extent of her infection. When examined by Dr. Gaudet, he diagnosed her condition as cellulites of the right flank, and he recommended that she undergo a C.T. scan of her lower abdomen to rule out the presence of an abcess. The C.T. scan indicated that a major inflammatory process was present in the right lower quadrant of the adjacent to the cecum; this was the same area where inflammation had been shown on Ms. Melanson's first C.T. scan in June. The C.T. displayed symptoms consistent with necrotizing fasciitis, an extremely dangerous and fast-developing infection.

Ms. Melanson was transferred to the University of Massachusetts Medical center for emergency surgery to drain and remove her infected tissue. In the course of the operation the surgeons uncovered a large area of necrotizing fasciitis involving the fascia of her back extending around her iliac crest and up to the anterior abdominal wall. The surgeons attempted to debride the infected tissue, but were forced to discontinue the operation when her condition became unstable due to a combination of septic and cardiac shock. She was subsequently transferred from the Operating Room to the Intensive Care Unit, where her condition continued to deteriorate. She went into cardiac arrest and died on February 3, 1996.

The pathologist who performed the autopsy on Ms. Melanson concluded that she had died of a myocardial infarction in combination with septic shock brought about by necrotizing fasciitis in the subcutaneous and muscle mass of the gluteal and lumbar area with no apparent communication with the peritoneal cavity.

Following a trial a verdict was returned in the amount of $400,000.