SCARY CASES
in Otolaryngology

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CONTENTS

Foreword: What We Learn From the Imperfect *George J. Annas*		ix
Preface: What Is a Scary Case? *Kenneth M. Grundfast*		xiii
Acknowledgments		xv
Contributors		xvii
Section 1	**AIRWAY**	**1**
Chapter 1	Anesthesia Foreign Body: It's Not Over Until It's Over *Daryl Colden and Christopher Jayne*	3
Chapter 2	Airway Foreign Body: Simulation in Action *Gi Soo Lee and David W. Roberson*	9
Chapter 3	Tracheostomy: An Unusual Indication *Edward J. Reardon*	15
Chapter 4	Airway Fire: Why Are They Called "Laser-Resistant" Tubes? *Timothy D. Anderson*	21
Section 2	**RISK MANAGEMENT**	**29**
Chapter 5	The Uninsured Patient: Maintaining the Standard of Care *Wendy B.R. Stern*	31
Chapter 6	Facial Plastic Surgery: The Case Without End *Jeffrey H. Spiegel*	39
Chapter 7	Malingering: An Unusual Stapedectomy Outcome *Terry J. Garfinkle*	47
Chapter 8	Four Things to Keep in Mind to Make Those Scary Cases a Little Less Formidable *Anthony E. Abeln*	53
Chapter 9	Malpractice Defense From the Expert Witness Perspective *R. William Mason*	57
Section 3	**MEDICAL ETHICS**	**63**
Chapter 10	Decision-Making Capacity: You Don't Want to Have Surgery, But You Have to Have Surgery *Kevin S. Emerick*	65

Chapter 11 Facial Excision: Maintaining Control in the Face of Cancer 73
Daniel G. Deschler

Chapter 12 Unrelenting Ménière Disease: Ear Surgery in an Only Hearing Ear 85
Daniel J. Lee and Samuel R. Barber

Chapter 13 Unexpected Lymphoma: The Routine Scary Case 97
Jerry M. Schreibstein

Chapter 14 Tracheotomy: A Scary Chief Complaint 105
Bruce R. Gordon

Section 4 NEURAL INJURY 113

Chapter 15 Orbital Hematoma: In the Public Eye 115
Ralph Metson and Christopher David Brook

Chapter 16 Facial Nerve Injury: The Service Recovery Paradox 125
Kimberly A. Russell and Robert W. Dolan

Chapter 17 Encephalocele: An Unexpected Finding 131
Jonathon Sillman

Chapter 18 Intracranial Extension: A Benign Disease? 139
Scharukh Jalisi, Avner Aliphas, Samuel J. Rubin, and Kenneth M. Grundfast

Chapter 19 Skull Base Injury: A Scary Harpoon 149
Ameer T. Shah and Walid I. Dagher

Chapter 20 Brain Herniation: A Delayed Complication 159
Scharukh Jalisi, Samuel J. Rubin, and Kevin Wu

Section 5 VASCULAR INJURIES 169

Chapter 21 Aberrant Carotid: A Bloody Myringotomy 171
Yehia Mohammed Ashry and Dennis S. Poe

Chapter 22 Radiation Therapy for Laryngeal Cancer: “Organ Preservation” 181
Jonathan C. Simmonds and Elie Rebeiz

Chapter 23 Helicopter Flight: A Scary Post-Tonsillectomy Bleed 187
Edward F. Caldwell and Hani Ibrahim

Chapter 24 Sentinel Bleed: The Saturday Night Bleeder 193
Barry J. Benjamin and Namita R. Murthy

Section 6 PROFESSIONALISM 197

Chapter 25 It Was Not Your Fault! 199
Charles W. Vaughan

Chapter 26 Tunnel Vision: Too Little . . . Too Late . . . 203
Scott Finlay and Mark S. Volk

Chapter 27 Chronic Traumatic Encephalopathy: Who Wants to Fight? 211
Michael P. Platt and Robert A. Stern

Chapter 28 Helping Your Colleague: No Good Deed Goes Unpunished 223
Aaron R. Dezube, Christopher W. Tsang, and Mark Vecchiotti

FOREWORD

What We Learn From the Imperfect

Surgeon-writer Richard Selzer observes in his *The Doctor Stories* that "doctors write [stories] every day in the charts of patients."[1] Storytelling is integral to the practice of medicine. The patient tells his or her story to the surgeon, who then explains the options available to address the patient's problem. Surgeons often repeat, and restructure, patient stories when consulting with other surgeons. Some storytelling is ritualistic and even superficial. Selzer, after he had retired from surgery to write full time, thought that "looking back, I cannot help but think that my best writing was done in the charts of my patients [because] it was devoid of the vanity of the author . . . and the life at risk was not my own."[1] The stories in this collection draw their power from the drama described in medical charts—but go well beyond the facts and diagnoses to provoke reflection on risk and uncertainty in surgery. They are surgeons' stories about their self-selected "scary" encounters with patients—often focused on a mistake or a bad outcome.

Bad outcomes are inevitable in surgery, as in every human endeavor. *To Err is Human*, the title of a well-known report from the National Academy of Medicine about medical errors, reflects this reality. Measures are contested, but medical errors have recently been ranked as the third leading cause of death in the United States, after heart disease and cancer.[2] Most of the scary cases in this book are based on the personal experiences of an otolaryngologist who is trying to treat a very sick patient, and were initially shared with colleagues at an annual Halloween conference. What makes the encounter "scary"—and Halloween worthy—is usually that the surgeon is worried that his or her actions could result in a bad medical outcome for the patient leading to a bad legal outcome for the surgeon: a malpractice suit. Surgeons often equate "scary" with "I could get sued," and there is almost always a ghost-like character lurking in the background of these stories: the malpractice attorney.

Fear is magnified by ignorance. The most innovative aspect of this collection is the invitation to malpractice lawyers to comment, and to make suggestions of how surgeons can avoid being sued. Perhaps surprisingly, physician-attorney

interactions are, at least usually, beneficial to both professions. As one of the first editors of the *New England Journal of Medicine*, Walter Channing, put it more than 150 years ago: "Medicine and law, two of the most diverse callings, may act in perfect harmony, and for the equal benefit of both." Channing also quoted medicolegal expert David Paul Brown who said, "A doctor who knows nothing of law, and a lawyer who knows nothing of medicine, are deficient in essential requisites of their respective professions."[3] I think the judgments of both Channing and Brown remain insightful today, and I also believe that education should begin early.

I have taught law at Boston University School of Medicine for 4 decades. (I also teach health law at the Law School.) Medical students are simultaneously eager to learn and leery of lawyers. Even as first-year medical students, at least some already see lawyers as predators and physicians as prey. Some of this suspicion can be traced to lawyers who advertise for business on television, and give physicians the impression that they are out to get them and are primarily motivated by money. This is partially true, but incomplete. Law supports the practice of medicine, and judges and juries identify with physicians.

There is much to know about the law, but for physicians generally, and surgeons in particular, there are two fundamental legal principles that can make their professional lives less stressful, and they can be easily summarized: Act consistent with the medical standard of care (what a reasonably prudent physician would do in the same or similar circumstances), with your patient's informed consent (including disclosure of the risks and alternatives—and their risks). And, in an emergency, treat first and ask legal questions later. The cases in this volume are written by surgeons who understand the importance of living up to the profession's "standard of care," and of obtaining the patient's informed consent before performing surgery. The case by William Mason illustrates how physicians and lawyers can learn from each other and work constructively together. Mason insightfully and lucidly uses his personal experience as a defendant in a lawsuit (he ultimately prevailed at a jury trial) to learn about the legal system, and to discover the high regard juries and judges have for physicians. Mason accepts an invitation to work with lawyers as an expert reviewer and witness in cases of alleged medical malpractice. He sees his work as an expert witness as rewarding in itself, but also as a service to the medical profession.

The thread running through these stories is fear of medical malpractice litigation, but the prospect of becoming a

defendant in a malpractice case is hardly the only reason a clinical encounter can be scary. The encounter can also be scary because it involves a surprising, emergency condition, or simply presents a very complex medical condition that has no simple or safe surgical solution. Specific examples presented include patients with Ménière disease and Munchausen syndrome; and especially unusual cases involving doing surgery on live TV, and having an uninsured patient who cannot afford treatment work at the physician's house in exchange for care. There is even one instance in which the case is scary for the surgeon because his violent patient, a former professional hockey player who had likely taken too many blows to the head in his hockey career, threatens to harm the surgeon and his family. And, of course, from the patient's perspective, head and neck surgery is always scary.

These stories also illustrate how much surgery—and health care in general—has evolved to take informed consent seriously, and to move, slowly but surely, beyond a "culture of silence" to a culture of safety. When mistakes happen, it is now seen as reasonable and ethical to inform the patient and try to make sure similar mistakes don't happen again. Open discussion of mistakes is critical to the patient safety movement. In one particularly bizarre story, Mark Volk recalls an incident from 1984 when he was a first-year surgical resident. Late at night a medical resident paged him to start an arterial line on a 63-year-old patient. Medical residents had been trying unsuccessfully for almost an hour to place the line. Volk began his attempt by telling the patient, "I'm Dr. Volk, and I'm going to try and see if I can place this line in your wrist." He could not, so he moved to the femoral artery. No pulse. He then noticed, among other things, that the patient's pupils were fixed and dilated, and realized that the patient had likely been dead for some time. Volk turned to the residents and nurses in the room and declared: "You can't get an art line because he doesn't have a radial pulse and he doesn't have a radial pulse because he's DEAD!" and walked out. Volk follows his almost perfect Halloween story by explaining how it could have happened (by being fixated on one particular task), and how he would react much differently today because the culture of medicine has changed: quality and safety have moved to the forefront, and "a root-cause analysis would have been convened."

At the 2012 Scary Cases conference, I spoke about "standard of care" and took advantage of the invitation to tell my own "old time medicine" story, this time from the patient's viewpoint. My story was from 1965, when I was a college stu-

dent. I was waiting in one of about 50 cubicles in a large room at a local hospital when I overheard part of a conversation in the next cubicle. I couldn't make it out, and apparently neither could the patient. The physician repeated it, slowly and very loudly: "You have a tumor in your ear, but it's ALL RIGHT because the doctor can't see you for SIX MONTHS." Whether or not this was scary to the patient—it was certainly scary to me and obviously did not reflect either good standard of care or informed consent, to say nothing of patient confidentiality. Practice really has changed, and not just because of the Health Insurance Portability and Accountability Act (HIPAA) and fear of malpractice lawsuits for failure to diagnose cancer while it may be treatable.

Halloween is celebrated by wearing costumes and trying to scare ourselves and others. Medicine is symbolized by a costume as well: a white coat. The purpose of the white coat is the opposite of the Halloween costume: to comfort and reassure patients who may be facing major life-changing conditions that the physician will put the patient's interests first, and is sworn to "do no harm." As scary as most of them are, I found the stories in this book strangely comforting. This is because, I think, they expose and reflect a practice of surgery, at least of otolaryngology, that is patient centered and populated by surgeons who take both the standard of care and the patient's informed consent seriously. From their 1860 perspective, Walter Channing and David Paul Brown might also add that otolaryngologists inviting lawyers to their Scary Cases conferences can provide "equal benefit to both."

—George J. Annas, JD, MPH
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PREFACE

What Is a Scary Case?

Physicians, especially surgeons, like to get good results. But, things do not always go well. There was a time when physicians were reluctant to discuss with others less than optimal outcomes of treatments provided for patients. A century ago in 1916, a leap forward occurred in the way that doctors discuss with each other outcomes from patient care when Dr. Ernest Codman introduced at the Massachusetts General Hospital the concept of having morbidity and mortality conferences. For the past hundred years, hospital-based morbidity and mortality conferences have became the standard method utilized by physicians to analyze problems that have occurred with patient care and to share information with each other.

The *Scary Cases* conferences that began on Halloween Day in Boston in 2010 represent another leap forward in the way that physicians exchange information about what has occurred in case management. The Scary Cases conferences have brought together academic physicians, community-based physicians, nonphysician providers, nurses, attorneys, specialists in risk management, and others who focus in a collegial way on errors, near-miss cases, and frightening situations in the management of patients with disorders affecting the head and neck. Somewhat ironically, even though the cases presented primarily are complicated involving actual untoward outcomes or risk of untoward outcomes, discussion about the cases is characterized by mutual respect, empathy, and candor. Presenters usually have tailored their PowerPoint presentations to have a Halloween theme, and some have even worn Halloween costumes while giving their presentations. This may seem incongruous, but, surprisingly, the Halloween theme and the focus on scariness has engendered a collegiality that encourages the presenters and the meeting attendees to share their individual experiences in way that makes the meeting highly informative and extraordinarily valuable.

While reading the cases in this book is not the same as sitting in the audience on Halloween Day listening to a world-renowned otolaryngologist dressed as a Frankenstein monster present a case, reading the cases does provide pithy insights

about what can go wrong in the practice of otolaryngology-head and neck surgery along with information about how to avoid trouble and how to get out of trouble. The stylized way in which the cases are written assures that the reader can acquire useful information from the description of each scary case. Life can be scary, the practice of otolaryngology can be scary—the key to success in life and in otolaryngology is to be prepared for whatever happens, not letting fear cloud judgment, and to strive always to do what is right.

—Kenneth M. Grundfast

ACKNOWLEDGMENTS

Scary Cases would only be an idea without the generous contributions of the many clinicians and patients who shared their scary experiences with us. It takes courage to expose our fears and perhaps shortcomings for the benefit of others to learn how to avoid or manage these scary situations. I dedicate this book to my mentors who have provided me with unlimited guidance and support, including Kenneth Grundfast, MD, Ralph Metson, MD, Steven Parnes, MD, Terrence Sweeney, PhD, and Howard Platt, MD.

—MPP

I dedicate this book to my mentors M. Stuart Strong, Charles W. Vaughan, Loring W. Pratt, to my lovely wife Ruthanne, and to all otolaryngologists who earnestly strive every day to help their patients even when confronted with scary situations. And, I want to let everyone know that working with Mike Platt on this book and the Scary Cases meetings has been fun, not scary.

—KMG

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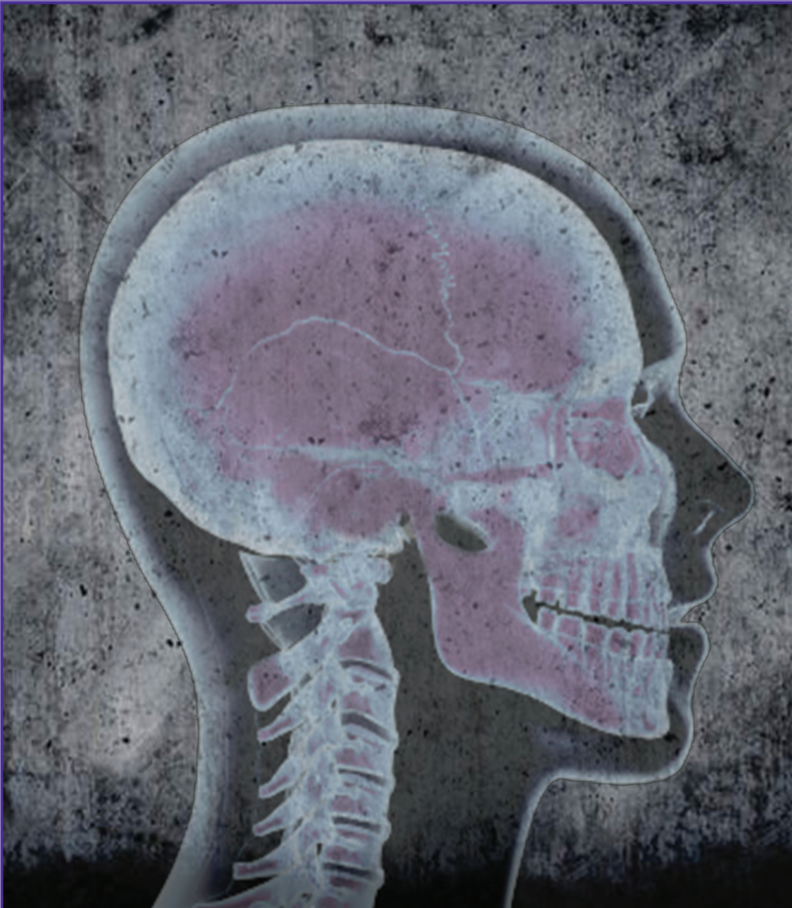
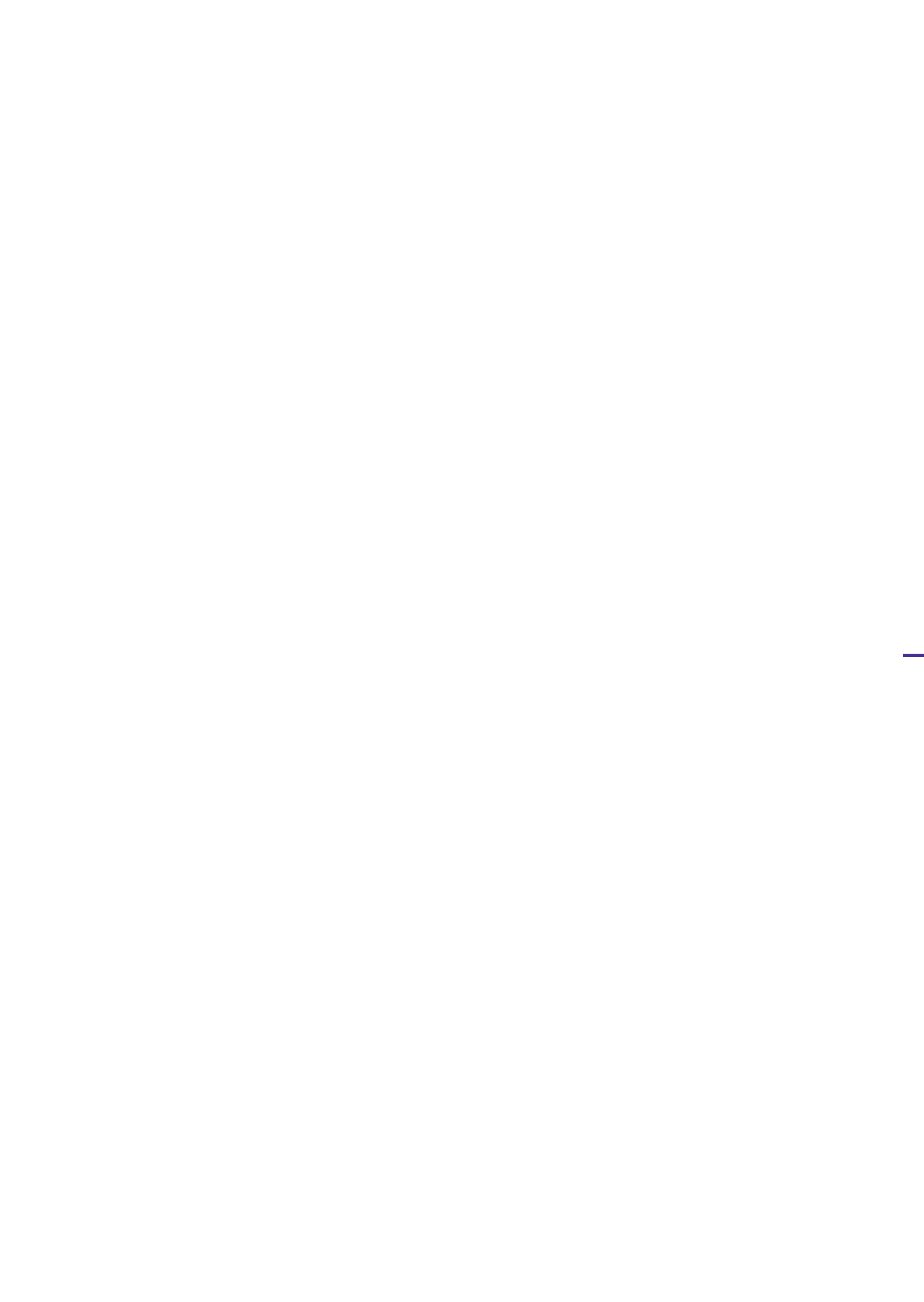
SECTION 1

Airway





CHAPTER 1

Anesthesia Foreign Body

It's Not Over Until It's Over

Daryl Colden
Christopher Jayne

THE CASE

A 34-year-old man with chronic sinonasal symptoms presented to the otolaryngology clinic. The patient complained of long-standing nasal congestion and trouble breathing through his nose. His symptoms had been present for 5 years and were unimproved with over-the-counter antihistamines and intranasal corticosteroids. His past history was significant for prior nasal trauma. Otherwise his past medical and family history were unremarkable.

Examination of the head and neck revealed a significant nasal septal deviation from the left to right, with approximately 80% obstruction of the nasal passages. There was concomitant bilateral inferior turbinate hypertrophy. Since the patient was symptomatic and not responsive to medical management, he was offered surgical intervention consisting of a septoplasty with an inferior turbinate reduction to be performed under general anesthesia. The patient was agreeable to this surgical plan, and informed consents were obtained. The surgical date was scheduled.

A ROUTINE SURGERY

A standard septoplasty and turbinate reduction using coblation technique were performed under general anesthesia. The patient was intubated without difficulty, and the surgical procedure lasting 50 minutes was uneventful. As my usual routine, silastic nasal splints were sutured to the septum and bilateral Merocel nasal packs were inserted into the nasal cavity to help with hemostasis and improve septal healing. As a resident, I was taught to tie the Merocel nasal packs together across the nasal columella to prevent aspiration. Many words of advice from my mentors came from surgeons who learned the hard way, including aspiration of nasal packs requiring bronchoscopy for removal.

IT’S NOT OVER UNTIL IT’S OVER

At this juncture, the procedure was turned over to the anesthesia team for extubation. I returned to the surgical lounge in order to write postoperative orders and dictate the operative report. Just as I began dictating, the operating room nurse rushed into the lounge stating that the patient was in respiratory distress and had aspirated one of the nasal packs!

I sprinted into the operating room to find the patient upright, unable to speak, and with both of his hands over his neck making the "universal choking sign." The anesthesiologist wasted no time in expressing his displeasure toward me, accusing that the patient had aspirated one of the nasal packs.

I quickly began to evaluate the patient. Evaluation of the nasal cavities revealed both Merocel nasal packs were still tied together and sitting in good position. To be certain, I pulled the two Merocel packs tied together out of the nose. In disbelief, the anesthesiologist noted that there was no improvement in the patient's condition and the patient continued to be in respiratory distress. The surgeon and anesthesiologist looked at each other with concern, both thinking "What's next?" The patient became cyanotic and his oxygen saturation levels started to plummet. I ordered a nurse to prepare the tracheostomy kit while the anesthesiologist began to deliver blow-by oxygen and IV fluids.

GETTING SCARIER

With both physicians unsure of the next step, the surgeon requested that the anesthesiologist administer sedation in order to better evaluate the airway. Sedation of a patient in respiratory distress is often not used, but with a rapidly declining respiratory status and signs of airway obstruction, I needed to be able to evaluate the airway. The anesthesiologist's laryngoscope with a Mack blade was placed and a white foreign body was noted emanating from between the vocal folds. The foreign body was sitting in the larynx—half above the vocal folds and half below the cords. Using Magill forceps, I was able to quickly remove the foreign body. Consequently, the patient was reintubated by the anesthesiologist and slowly extubated. A postoperative chest x-ray was obtained and demonstrated atelectasis but no pneumothorax or signs of pulmonary edema. The patient was treated with IV Unasyn for possible aspiration and he was monitored overnight for possible aspiration pneumonia. He was discharged the following day without any sequelae other than a very sore throat.

WHAT HAPPENED?

The mysterious foreign body that was removed from between the patient's vocal folds was a "fabricated" bite block (Figure 1–1). The bite block consisted of a small rolled-up gauze

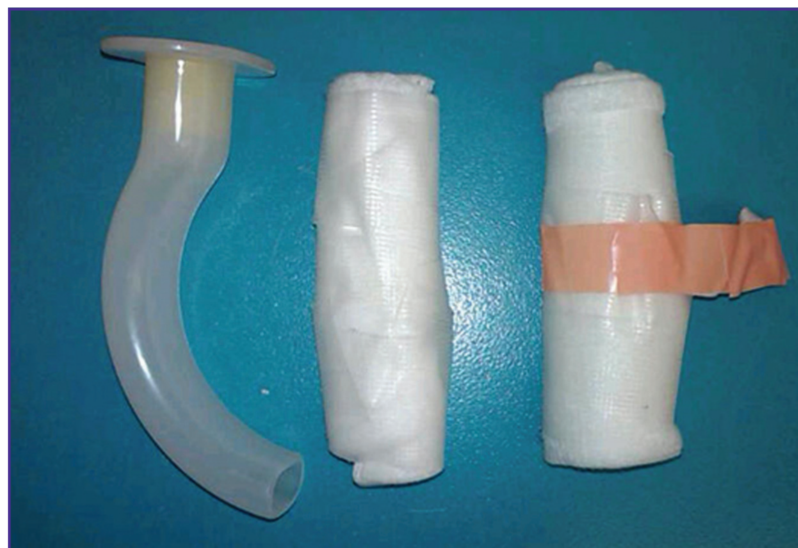


Figure 1–1. Examples of bite blocks used by anesthesiologists during general anesthesia. The variable size, omission from surgical counts, and lack of radiological markings make hand-made bite blocks a potential airway foreign body.

that was taped together. This was originally placed by one anesthesiologist at the beginning of surgery upon intubation. About halfway through the surgical case, a second anesthesiologist relieved the first anesthesiologist and proceeded to finish the surgical case. The bite block most likely had become displaced between the start of the surgical case and the second anesthesiologist taking over. The second anesthesiologist did not know that there was a bite block and would not have been aware that it had become displaced from its original location.

THIS CASE WAS SCARY BECAUSE

There is an old adage: "The lesser the indication, the greater the complication." While the patient certainly fulfilled all of the criteria for elective surgery for quality of life symptoms, the margin for complications is much more narrow in such a surgery compared to a procedure for a life-threatening diagnosis such as head and neck cancer. This patient was a strong, healthy man who was expected to have a favorable outcome from his nasal surgery. The potential for a devastating outcome was present with his airway obstruction.

The situational circumstances of being emergently called back into the room are scary because of the unknown. Sur-

geons generally are good at maintaining control in the operating room and such an unexpected scenario removes all control from the surgeon. Additionally, the anesthesiologist's accusations that I lost a nasal pack contributed to my fear that I was responsible for the deterioration in my patient's condition. It was ironic that it was his foreign body that caused the airway obstruction.

WHAT I LEARNED FROM THIS CASE

The moral of the story is: It's not over until it's over. One of the most routine ear, nose, throat (ENT) cases performed on an extremely healthy patient almost resulted in a terrible adverse event after the surgeon assumed the case was over. This case is illustrative of many aspects of risk management that the surgeon may assume that he or she is actually a part of. First, although the adverse event occurred mostly due to an error on the part of anesthesiology, the surgeon plays a major role in the recognition of the error and in helping to correct it. The importance of staying calm, acting quickly, and working collaboratively with the surgical team was likely the critical factor in this patient surviving.

In performing a root-cause analysis, there are many areas whereby the risk of this foreign body aspiration could have been avoided. First, the anesthesiologists created their own bite block rather than use the industry-made type. The makeshift bite block was much smaller than the industry-bought type, and therefore more likely to be aspirated and could be lodged between the vocal cords. Second, the bite block was never "counted" or noted. The surgical process these days takes great lengths to make sure everything that the surgeon uses during a procedure is counted and this process mitigates the possibility of a retained foreign body. Why not do the same for anesthesiology? Last, one could argue that during shift changes, there could be greater likelihood of errors as not every piece of critical information can be relayed from one anesthesiology provider to another. An operative case with a short duration, such as a septoplasty/inferior turbinate reduction, should ideally have the same anesthesiology provider present for the duration of the case.