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Highland
Musculo Skeleta
Associates Inc.

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Orthopaedic Surgery

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fie: Jeffrey Dziegiel versus
William Brock, M.D. and
Ralph Kovach, M.D.

Dear Mr. Terry:

I have had the opportunity to review medical records from the Marymount Hospital, St. Luke's Hospital and office records and correspondence between Dr. William Brock and Dr. Ralph Kovach. These were all in reference to residuals of injury and a subsequent infection developed by the plaintiff, Jeffrey Dziegiel.

In summary, Mr. Dziegiel was injured at work on September 23, 1985. He was employed by The Auer Register Company. The claim number for this particular trauma is 85-27426. At that time the plaintiff sustained a twisting injury to his right hip region while pushing a large wooden crate weighing a couple hundred pounds across a wooden floor. The injury, according to the medical records, occurred approximately at 2:00 in the afternoon and he was able to work with increasing difficulty until later on in the afternoon, approximately 3:30. The following morning he had severe pain and decided to stay home from work. He was seen in the emergency room at The Marymount Hospital and examined by the emergency physician. No x-rays were taken but it was the assumption of the physician that he had a muscle injury. He subsequently came under the care of Dr. Brock, a family practice physician, who he initially saw in the emergency room on September 27, 1985. It was Dr. Brock's feeling that this was a soft tissue problem although diagnosis must have been quite hard to make considering this gentleman's size. He was in excess of 300 pounds in weight. Dr. Brock followed with him on September 30, 1985 where x-rays essentially were normal. Apparently there was a low-grade fever at that time. Dr. Brock advised him to continue with his pain medication (Percodan). In addition he prescribed penicillin for the fever. The patient apparently was not septic at all during this initial phase of his illness. Follow-up examination was carried out approximately one week later by Dr. Brock and the pain was about the same, constant and severe. Dr. Brock decided to send him to physical therapy for approximately three visits. He was then referred to Dr. Ralph Kovach, an orthopaedic surgeon.

Dr. Kovach first saw him on October 14, 1985 and recommended rest, only. Physical therapy was discontinued. Because of severe pain, on October 29, the plaintiff met Dr. Kovach in

the emergency room and full set of x-rays and ultrasound was ordered. Apparently these were normal. It was felt at that time that there was some subluxation of his hip and the plaintiff was admitted to the Marymount Hospital. Two surgical procedures were performed. Initially a closed reduction of the subluxed hip was attempted and it was noted that there was some intra articular fragments that were preventing complete relocation of the hip. The first open operation was performed approximately six to seven weeks post-injury. This was in the form of an arthrotomy of the hip. The [illegible] noted was somewhat unusual osteochondral fracture with multiple loose pieces in the joint. This was a very unusual injury and, in fact, intra operative photographs were taken. It should be noted that at no time was pus encountered in the hip joint nor was there any significant or gross destruction of either the acetabular or the femoral side. Degenerative changes were noted. In all likelihood, these were post-traumatic in nature from this grossly overweight male walking on a hip that contained multiple loose pieces. The arthrotomy was performed on 11-5-85. It should also be noted that in the pathology report, absolutely no mention was made of any potential infection in the hip joint. My personal review of the intra operative photographs confirm a purely traumatic condition. The only abnormal laboratory finding was an anemia (low blood count) as well as a mildly elevated white cell count. He was started on a broad spectrum antibiotic which is the common practice for any arthrotomy procedure. He also was kept on a continuous passive motion machine to assist in early range of motion. Initially the hemovac tubes were removed and there was a clear persistent drainage present. There was a positive culture at this point of staph aureus which was felt to be a wound infection but not a deep hip infection. His temperature remained fairly stable through this time period.

Several weeks after the surgery, a check x-ray taken revealed an apparent dislocation. He was taken beck to surgery on November 26, and placed in skeletal traction in an attempt to reiocate the hip. It was apparent at that time there was marked bony resorption and it was felt at this time that he may have a hip joint infection (septic hip). Blood cultures were negative. His sed rate was elevated with a shift to the left.

It was realized at this point that the patient had a rather significant infection and at that point the patient was transferred to The St. Luke's Hospital where he remained through the balance of this initial treatment period. At St. Luke's an arthrotomy was performed, again, and a girdlestone resection, that is removing the osteomylitic bone, was carried out.

DISCUSSION: I have had the opportunity to review the medical report of the plaintiff's expert, Dr. Lawrence Weis. I am in strong disagreement over quite a number of points. Mr. Dziegiel, in my opinion, developed a post-operative septic hip joint infection which led to his girdiestone procedure. I strongly disagree with plaintiff's expert that the plaintiff "developed an infection in his hip joint sometime immediately prior to his symptomatic episode of September 23, 1985". To use his words, any prudent orthopaedic surgeon would realize that a staphylococcus aureus infection of the hip joint would virtually destroy the hip within three to five days. It was quite apparent that at the time of the arthrotomy an 11-5-85, that there wes no gross bony destruction, no pus in the joint and no report by the pathologist that were compatible with a deep-seated hip joint infection of two month's duration. The traumatic diagnosis of intra articu-

fracture was initially missed. This is, in all likelihood, due to the patient's obesity. His history is entirely compatible with someone with loose pieces in the joint which, in my opinion, was the reason for his continuing pain. It is difficult to explain his "low-grade temperature". Individuals have elevated temperatures for a variety of reasons. One of the most common is a mild atelectasis (partial lung collapse) which occur when any obese person remains sedentary for long periods of time. Although penicillin would not have been my drug of choice, initially, an attempt was made to treat an occult minor infection on the part of Dr. Brock. Although this is not the best approach, it certainly is not substandard. There are many times when physicians treat suspected infections empirically without waiting for a positive culture.

CONCLUSION: Mr. Jeffrey Dziegiel sustained an intra articular osteochondral fracture at the time of his industrial injury on September 23, 1985. The intra articular fragments led to progressive pain and difficulty to the point that there was an increase in reactive joint fluid. In my opinion, this was the cause of the subluxation of the hip that was detected in late October/early November of 1985. The arthrotomy did reveal a non-infectious condition without the presence of pus or joint destruction. The intra operative findings were that of trauma and not of infection. Dr. Dziegiel subsequently developed a septic hip joint post-operative infection. This led to osteomyelitis of the femoral head and neck and subsequent girdlestone procedures.

It is my medical opinion that the standard of care offered by both Dr. Brock and Dr. Kovach, as well as the care given at The Marymount and St.Luke's Hospital were not substandard. Mr. Dziegiel had rather significant complications in the form of a post-operative wound infection and a septic hip joint. In all likelihood, the diagnosis of this was somewhat clouded by the patient's large size and the inability to obtain appropriate x-rays or aspirations. In my opinion, there is no aspect of medical negligence in this case.

Sincerely,

Robert C. Corn, M.D., F.A.C.S

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