Children's Hospital

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Children's HOSPITAL

07/22/2001

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100 Franklin's Row
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Cleveland, Ohio 44139

Re: Forrest Greg Stone, a minor, by and through his mother and Natural Guardian Edna L. Stone, et al v. Corazon O. Go, M.D., et al.
MRR File: 990889

Dear Ms Harris:

At your request, I have reviewed the medical records of Forrest Greg Stone, and the depositions of Drs. Go. and Hudock. Based on this review, I am prepared to offer expert testimony that the medical care provided by Dr. Go met the standard of care for newborn infants.

Case Summary

Forrest Stone was born 3/25/99 to a 32 year old gravid 2 para 1 Hispanic mother after an uncomplicated pregnancy, spontaneous labor aiid vaginal delivery. The total time of labor was 9:38 hours. The EDC was 3/23/99. The Apgar scores were 3 at 1 minute and 9 at 5 minutes. The infant required only blow-by oxygen in the delivery room. Forrest weighed 3630 grams at birth, and a Ballard exam at 1-½ hours of age indicated that lie was 40 weeks gestation. The findings noted on physical examination at birth and later confirmed by Dr. Go were facial bruising and a heart murmur. Early the next morning a few facial petechiae were also noted. Throughout the first day of life, vital signs remained stable. He had some spitting with feeds, but this resolved. At 8:00 am on 3/26/99, the nurses noted some bruising aiid a ½ cm (1/5 inch) lump in tlie left upper thigh at tlie site of an injection of vitamin K. The heart murmur resolved spontaneously.

Dr. Hudock performed a circumcision sometime on tlie morning of 3/26/99. Early on the morning of 3/27/99, the nursing notes indicate that the "circumcision area" was "sl[ightly] oozing, Vaseline aiid Vaseline guaze [were] applied." Later that morning, the notes indicate that the posterior aspect of the circumcision area continued to ooze and adrenaline was applied to the site. Dr. Hudock had examined the site. Dr. Go

was present in the nursery that morning. The nursing notes also state that the bleeding stopped after "Hemastat" was applied to the site. In response to the bleeding, Dr. *Go* ordered a complete blood count, differential white cell count and a platelet count. A PT aiid PTT were also order if the nursing staff were "able to draw enough blood." These values were normal. The platelet count was "clumped" but appeared adequate on the blood smear according to the report. Tlie staff was unable to obtaiii enough blood for the PT and PTT. However, no further bleeding from the circumcision site was noted. The infant was discharged that afternoon with a home visit by the VNA staff scheduled, an appointment to see Dr. Go in 2 weeks, and instructions to "call if any problems occur prior to that time."

According to Dr. Go's office note of 3131/99, Mrs. Stone contacted her office on 3/30/99 concerned that Forrest was "looking yellow." Dr. Go made arrangements for a bilirubin level to be di-awn at the facility requested by Mrs. Stone. Dr. Go was notified later that night by tlie laboratory that Mrs. Stone left the facility after registering without Forrest's obtaining tlie ordered test. Dr. Go attempted to contact Mrs. Stone that evening and again the morning *of* 3/31/99. However, she was unsuccessful. Subsequently, Dr. Go was contacted by Mrs. Stone who said that Forrest's circumcision had bled again. Therefore she had taken him to the emergency room at Cleveland Metropolitan Health Center.

On 3/31/99 at approximately 09:00 am, Mrs. Stone presented Forrest to tlie Cleveland MetroHealth Center (CMHC) Emergency Department with the chief complaint of "bleeding from circuiiicisioii." At that time his vital signs were normal, and his weight was 3.7 kg. The triage staff noted that his upper extremities were slightly pale almost yellow. He exhibited slight jerking of upper extremities. His circumcision site was bleeding. The physician at 09:45 saw him. A urine bag was placed on Foi-rest at 10:20 am. A total serum bilirubin drawn at 10:30 am was 11.7-mg %. No additional notes are recorded by the emergency room staff until 12:20 pm when Forrest was noted to be lethargic in response to the insertion of a urinary catheter. Changes in his vital signs were noted. His heart rate was 104 and respiratory rate was 20. An Sa02 was 88%. Oxygen was applied and an intravenous drip started. The "jerking" continued. He was taken for a CT scan at 13:00. He received ½ ing of Ativan IV. His fontanelle was noted to be full at 13:15. Further twitching of left-sided arm aiid leg was noted. Forrest received additioiial Ativan. At 13:25, Foil-est'sblood pressure was 76/32. His oxygen was increased, and additional lab was obtained (arterial blood gas, PT and PTT.) At 13:52, Forrest received 70mg *of* phenobarbital IV. The CT scan revealed a right-sided subdural hematoma with a sltull fracture. At 14:10, Forrest was taken to the operating room for surgical drainage of the subdural hematoma.

Post-operatively, Forrest was admitted to tlie pediatric intensive care unit. He was diagnosed with hemophilia (Factor VIII deficiency). His mother is a carrier of this genetic disorder. His course was not unusual. He remained on the respirator until 4/10/99. The following day he as transferred to a general medical ward. He was discharged from CMHC on 4/15/99. His discharge medications included phenobarbital and Factor VIII replacement. His diet was Enfamil with Iron ad libitum. An auditory brainstem evoked response test prior to discharge indicated that Forrest's hearing was normal.

After discharge, Forrest had problems with infection at the craniectomy site in April 1999, and a retained suture in August 1999. Dr. Danish. a pediatric heinatologist saw him in follow up, in July 1999. At that time he was doing well and appeared to be developing normally.

Expert Opinion

In my opinion, I find no evidence in the medical records that I have reviewed that would indicate that Dr. Corazon Go failed in any way to provide an appropriate standard of newborn care for Forrest Greg Stone. Mrs. Stone provided no past history of bleeding that would suggest the possibility of familial bleeding disorder. She specifically denied having a family history of hemophilia. There is no indication in the records to suggest that the delivery was in any way traumatic. Dr. Elkousy described the delivery as "easy." Forrest did have facial bruising at birth, but this did iiot appear to be excessive. He later developed some facial petechia. However, both facial bruising and petechiae are not unusual in an uncomplicated delivery. The process of labor during a vaginal delivery creates pressure on the facial blood vessels. Facial bruising and petechiae are commonly tlie result.

Forrest apparently had some bruising and a lump at the site of a vitamin K injection. The amount of bruising is not described. I infer that it was not excessive. The lump at the injection site is really small, ½ cm or 1/5 of an inch in diameter. A small amount of bruising and swelling at an injection site is very common and of no concern.

The incidence of bleeding following a circumcision is variable, but it is certainly iiot uncommon. Usually, the application of a gentle pressure to the site and a hemostatic agent such as Surgicel or Gelfoain will stop the bleeding. In my experience, nursing staffs often contribute to the bleeding problem by "dabbing away" at tlie site during "circ checlts." This activity disrupts the clot and promotes bleeding. The bleeding described in the medical record does not appear to be excessive. It was characterized as "oozing." It was easily contained with topical adrenaline aiid "liemastat", an apparent clotting agent.

Although Dr. Go consider a coagulopatliy as part of the explanation €or Forrest's oozing at his circumcision site, when tlie blood clotted before the nurses obtained enough blood for analysis, she did not ask them to redraw the sample. In light of a lack of a family history of a bleeding disorder and evidence of uncontrollable or unusual bleeding, I would have done the same.

In my practice, infant's with skull fractures that occur at delivery exhibit large hematomas at tlie fracture site. There is usually an obvious history of a traumatic aiid difficult birth. This was not apparent in Forrest Stone's case. When he was seen it the emergency room at CMHC, the records do not indicate any urgency at the time of his initial presentation. The sudden change in his neurologic status during the visit, and tlie apparent increase in the "fulliiess" of his anterior fontanelle suggests an injury of a more recent onset than a vaginal delivery six days previously. During his hospitalization at CMHC, the Abuse team evaluated Forrest. Apparently his family was cleared of any intentional injury to Forrest.

I am also of the opinion that Mrs. Stone failed in her obligation to communicate with Dr. Go after discharge. She was provided a copy of the INFANT ASSESSMENT "Call Your Doctor if..." sheet.

a. Item #1 iiistructs her to call if the infant's "eating habits cliaiige (example – baby refuses to eat at two coiisecutive feedings and is behaving unusually.) Mrs. Stone liad to cliaiige from breast feeding to foniiula because Foi-rest was having problems. She did iiot call Dr. *Go.*

b. Item 5 iiistructs Mrs. Stone to call if "Convulsion occurs." Apparently, tlie Stones were concerned about Forrest's twitching, but they did iiot call Dr. *Go.*

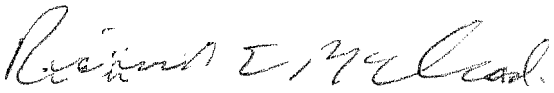
c. Item #6 instructs Mrs. Stone to call if "There is blood in baby's vomit or stool." If the bleeding from the circuiiicisioii site persisted, the diaper would have contained blood. She should have called Dr. Go as instructed.

d. Item # 7 instructs Mrs. Stone to call if the "baby is unusually sleepy or cries constantly and cannot be comforted for two or more hours." When Forrest was sleeping a lot, she did not call Dr. Go.

When Mrs. Stone did contact Dr. Go's office regarding Forrest's yellow color, she never followed through with Dr. Go's instruction to obtain a serum bilirubin level.

in conclusion, I ani of the opinion that Dr. Go met the standard of newborn care for Forrest Greg Stone expected of a primary care physician. By meeting tlie standard of care Dr. Go's action was iiot a proximate cause of injury to the child. Furthermore, Mrs. Stone failed in her obligation to follow through on problems and concerns identified after discharge from tlie maternity hospital. If you have any further questions regarding this case, please feel free to contact me.

Sincerely,



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