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OF COUNSEL

A report to clients and attorneys.

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$4.25 Million Settlement for Repeated Failures to Diagnose Pancreatic Cancer

Medical experts' failures to find and treat cancer results in death of 45-year-old

In 2002, John Doe was a 45-year-old man with a loving wife, three children, and a very exciting corporate career. As a young boy, he had immigrated to the United States from Communist Cuba and, with hard work and determination, had achieved an extraordinary level of success in both his personal and professional life. After holding executive positions at several companies, John accepted a position at a large corporation that eventually led to a promotion that would involve moving overseas and taking responsibility for the company's operations in Europe, the Middle East, and Africa. By all standards, John was in the prime of his life, in apparent good health, and looking forward to continued enjoyment in both work and family life.

In July 2002, John visited a medical clinic in Florida for a routine annual examination by Dr. X. John was concerned about his health and health history, and made every effort to live a healthy lifestyle. During the examination, John told Dr. X that both his mother and father had been diagnosed with colon cancer and this fact was clearly documented in the doctor's records. A month later, on August 18, John visited the medical clinic's emergency department complaining of abdominal pain, nausea, and vomiting. He was examined, diagnosed with gastritis, and discharged. Because of a trace amount of blood found in his urine, he was advised to return to Dr. X for further examination. John scheduled an appointment with Dr. X and, on September 4, the doctor began a workup to determine if John was suffering from kidney stones.

John's medical records at the clinic reflected a concern by the clinic's physicians *(Continued on page four.)*

$4.25 million settlement for repeated failures to diagnose pancreatic cancer

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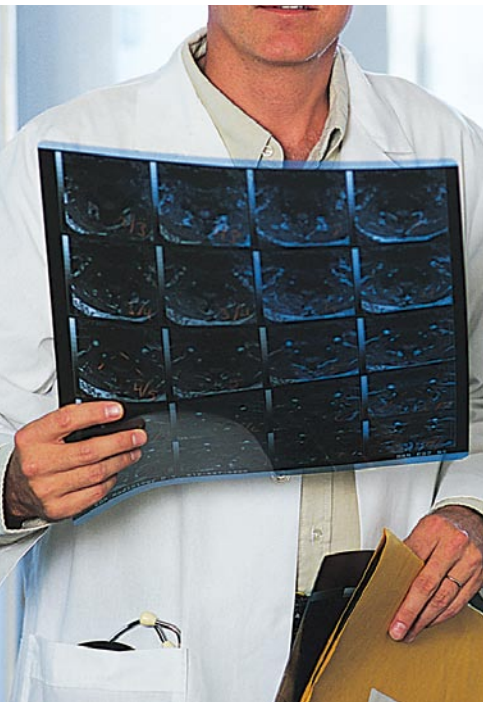
that John was allergic to iodine dye based on an apparent allergic reaction to iodine he had suffered some twenty years earlier. Therefore, a CAT scan of John's abdomen and pelvis was performed on September 5, 2002, without the iodine dye as contrast. The scan was unremarkable, although the radiologist noted that the scan was limited due to the absence of either an oral or intravenous contrast. During this time, John again discussed the history of cancer in his family and expressed his concerns to Dr. X about cancer as a possible cause of his abdominal problems. John was fully aware of the limitations of a scan performed without a contrast dye, and aware of the doctor's concern for his allergy. John specifically asked Dr. X if an MRI would be an appropriate examination for him. Dr. X told John that they would run all of the appropriate tests, and that he might refer John to a gastrointestinal specialist for appropriate tests.



During the September 2002 examinations, the clinic's urologist referred John to an allergy specialist to determine if an intravenous contrast could be safely used on John. The doctors felt that John's earlier allergic reaction might possibly have been a result of some osmotic change in the concentration level of the iodine. They decided upon a plan to use a lower strength contrast, and to pre-medicate John with prednisone and benadryl, per the clinic's protocol on such procedures.

John continued to suffer from unexplained abdominal pain. In November 2002, after determining that John was not suffering from kidney stones, Dr. X referred John to a gastrointestinal specialist at the clinic. John again brought up his concerns about his family's history of colon cancer, and his concerns about the limitations of the scan that had been performed without contrast. He also asked again about the possibility of an MRI in eliminating questions concerning cancer or another major illness. The gastrointestinal doctor assured John that they would run the appropriate tests in their efforts to determine the cause of his pain. At this time, the doctors noted that they wanted to conduct tests that would rule out pancreatic disease. Regardless of the fact that numerous experts would testify that the only way to conclusively rule out pancreatic disease was to administer a contrasted CAT scan and/or an MRI of the abdomen and pelvis, the doctors still did not schedule these tests.

In December 2002, the gastrointestinal specialist began a workup that included an upper endoscopy and a colonoscopy, both of which were negative for signs of cancer. Additional tests were performed, all of which were negative with regard to any explanation for John's continued abdominal pain. On January 3, 2003, the gastrointestinal specialist ordered a small bowel series of tests with oral contrast and an ultrasound examination. Both of these tests indicated a normal condition.

On May 2, 2003, John was back in the clinic's emergency room with abdominal pain, nausea, and vomiting. A CAT scan with oral contrast was ordered, but the clinic's radiologist failed to report an abnormality of the pancreas that was revealed by this latest test. Had this test been performed a year earlier during the July 2002 examinations, as the standard of care required, the cancerous lesion would have been identified and could have been treated successfully. Continuing to suffer from abdominal pain and nausea, John returned yet again to the clinic in July 2003, where another scan without contrast was performed and essentially read as negative. John's symptoms continued and he repeatedly sought treatment at the clinic, but the cause of his abdominal pain was never diagnosed. In June 2004, John returned to the clinic's emergency department and a scan with intravenous and oral contrast was performed. This latest scan revealed a large neuroendocrine tumor of the pancreas. John began intensive, state-of-the-art oncological treatment in the U.S. and in Europe.

In October 2004, after months of frustration and anxiety brought about by the medical experts' failure to find and treat John's cancer in a timely manner, the family sought representation by SDSBS attorney Bill Norton. Unfortunately, John's cancer continued to spread and he died of the disease on July 27, 2006. John's promising young life was over and his family was devastated. A wrongful death complaint was filed in March 2007, and the case was eventually settled for $4.25 million. ■