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$1.95 MILLION SETTLEMENT FOR 28-YEAR-OLD WOMAN CASTRATED BY DOCTOR WHO PERFORMED SURGERY WITHOUT WAITING FOR TEST RESULTS

Chicago-March 7, 2007-Miranda Richardson had always dreamed about having her own children. These dreams were shattered on June 11, 2001, when 28-year-old Richardson entered Gottlieb Memorial Hospital for surgical removal of a mass on her left ovary that had been discovered on a pelvic sonogram the previous February. When she woke up from surgery, she learned that her gynecologist had removed not only the ovary with the mass on it but also removed her right ovary, fallopian tube, and uterus. When Richardson sought follow-up treatment with a qualified gynecological oncologist, she learned that she had been unnecessarily sterilized. She also learned that the proper standard of care regarding a young woman who desired to have children in the future would have been for the doctor to perform a fertility-sparing procedure to remove the only affected ovary and tumor. The doctor she trusted to take care of her did not even have the requisite knowledge and experience necessary to handle her case.

Richardson's attorney, Jeffrey E. Martin, of Levin & Perconti (Chicago) said, "According to his Operative Report, when the doctor opened up Miranda's abdomen, he found a small amount of peritoneal fluid and sent it for a cytology exam to see if it contained any cancer cells. He took a biopsy of the tumor which had grown over the left ovary and sent it to pathology. The preliminary pathology report showed it was a "poorly differentiated tumor, probably granulosa cell tumor" [GCT]. Since Miranda wanted to preserve her fertility, the standard surgical intervention would have been to remove only the left ovary containing the mass, wait for the final pathology and cytology results, then discuss results and options with the patient. Unfortunately, the gynecologist performed a total abdominal hysterectomy (removal of uterus) and bilateral salpingo-oophorectomy (removal of both fallopian tubes and ovaries), thereby taking away Miranda's ability to conceive, her option for in vitro fertilization, and throwing her into immediate premature menopause at age 28 without seeking any other medical advice." Had the gynecologist waited for the final pathology and cytology results, he would have learned that the mass was, in fact, a granulosa cell tumor and that the peritoneal fluid contained no evidence of cancer." Instead of seeking an opinion from a gynecological oncologist that specialized in ovarian tumors, the gynecologist testified that he relied on a pathologist to tell him what surgery was necessary.

According to one of the Plaintiff's expert, obstetrician-gynecologist Patricia Boatwright, M.D., "the thought process of a surgeon even being guided surgically by a pathologist on a frozen section in a 28-year-old is out of my realm of reality. A good pathologist is not going to tell me, Boatwright, this is what you do surgically." Note that the pathologist denied ever telling the gynecologist what procedure to do. Dr. Boatwright added: "You know, when we graduate, as physicians we are told 'you do no harm.' If you don't know, you do no harm, close the patient up. If you don't know, get some help, you do no harm."

As Martin was developing evidence in this case, he uncovered the fact that the gynecologist had not seen a granulosa cell tumor since he finished his resident training in 1959 when he merely observed other doctors address 2 or 3 of these in women who were in their 40s and 50s. Richardson was the first patient upon whom the gynecologist ever made the decision regarding the nature and extent of the surgery for a GCT. Martin also learned that it is typical for GCTs to originate on ovaries, a well known fact amongst experienced gynecological surgeons.

Martin concluded, "Given his lack of experience with this type of tumor, the gynecologist should have sought consultation from an experienced gynecological oncologist. Other than the mass on her left ovary, all of the other reproductive organs that he removed did not contain evidence of cancer. Although GCTs are rare, they have certain features that make them less worrisome and aggressive than other types of tumors: GCTs are considered to have a low potential for malignancy, appear on one ovary 95% of the time, and have a low incidence of recurrence. In rare cases of recurrence, GCTs usually do not recur in the other ovary or in the uterus. They are also slow-growing, allowing ample time for a woman to have her family. The gynecologist never told Miranda about the option of having fertility-sparing surgery. If he had followed the standard of care and performed a fertility-sparing procedure, there would have been a 75% chance that Miranda could have conceived and carried children to term as well as have avoided the development of premature menopause."

The case was mediated the day before it was set for trial and settled for $1.95 million, an Illinois record.