Documentation

The possibility of developing breast cancer is a haunting concern for most women. A perceived delay in diagnosis is one of the leading causes of malpractice litigation in the United States. Juries can be expected to sympathize with breast cancer victims, and these cases can be very challenging to defend. Nonetheless, the exercise of well-documented, appropriate clinical judgment can result in successful defense, as this case demonstrates.

At age 36 the patient underwent her first screening mammogram on referral from her primary care physician. She gave a history of longstanding breast pain, greater on the right. Family history included post-menopausal breast cancer in her paternal grandmother and great aunt. This initial mammogram showed dense breasts with some microcalcifications but no masses and no signs of malignancy. Follow-up was recommended at age 40.

About two years later the patient was referred to our insured general surgeon for evaluation of continued breast pain. Bilateral mammography had been done, showing “extremely” dense breast tissue without any change in previously noted microcalcifications and without masses. This study was noted as BI-RADS Category 2, and follow-up at age 40 was recommended. Detailed history was taken. Office exam showed no dimpling or retraction and no masses in either breast. A discrete, cystic-feeling mass was noted in the right breast, location approximately 3:30. Office ultrasound led to an impression of a probable cyst, and the patient declined aspiration of the mass. Mastodynia was diagnosed. About a month later the patient elected to accept aspiration of the mass, with cytology revealing no malignant or dysplastic cells.

Over the next six years the patient visited her surgeon eight times, undergoing five more mammograms (including a magnetic resonance imaging study) and four more ultrasounds. Her fibrocystic disease was closely monitored. Cysts were identified and treated, but no evidence of malignancy was found in any of these studies. BI-RADS classification was increased to category 3 in the later studies and recommended follow-up interval was reduced to six months. The patient did express increasing concern about the possibility of developing breast cancer.

About four months after her latest imaging study, the patient, now 44 years old, saw her gynecologist for a routine exam. That physician noted the possibility of a mass in the right breast and referred the patient back to the general surgeon. Bilateral mammography and ultrasound were again obtained. No masses or other indications of malignancy were noted by the radiologist. The radiologist specifically noted that the area of suspicion in the right breast underwent ultrasound, and no abnormality was noted. The surgeon’s physical exam noted breasts without skin dimpling, nipple retraction, or palpable discrete masses. Mild bilateral tenderness was noted with a nodular thickened area of tissue in the upper outer

quadrant of the right breast. Biopsy was not felt to be indicated. The patient was asked to check her breasts after her period and to return if she felt there was any persistent mass.

The patient saw the surgeon again five months later, noting no problems with her breasts other than a possible infection of the glands of the right nipple areolar complex. Breast exam showed no dimpling, retraction or palpable discrete masses. Three months after that exam, now eight months after the latest imaging study, the patient again presented to her surgeon, stating that “she just felt something different in her right breast.” Exam showed a right breast now larger than the left. The area of previously noted thickened tissue in the right breast now contained a hard central area that represented a distinct change from the prior exam, although still not a discrete mass. Office ultrasound was immediately done, and the area appeared very suspicious. Immediate mammography was recommended, to be followed by biopsy. Mammogram showed no architectural distortion or discrete mass in the area. Ultrasound showed the area to be poorly marginated and of low-echogenicity. Biopsy was recommended. The general surgeon’s biopsy noted extremely hard tissue very suspicious for malignancy. Path report confirmed invasive breast cancer. The patient went on to have right mastectomy, followed by chemotherapy. She later opted to undergo prophylactic left mastectomy.

Not surprisingly, the patient filed a lawsuit against her general surgeon, alleging that her cancer should have been diagnosed at least eight months sooner. She alleged that when her gynecologist raised the question of a right breast mass, a biopsy should have been done, or at least an MRI should have been performed to further test the suspicious area. Our insured surgeon strongly believed that his management of this patient had been in complete conformity with the standard of acceptable professional practice. The company’s internal review and independent expert reviews were in full agreement. Though a qualified general surgeon testified for the plaintiff that an MRI was required at the time the possibility of a palpable mass was raised, a jury unanimously determined that no malpractice had occurred and found in favor of the surgeon.

Several factors contributed to the successful defense of this case. Our insured surgeon testified with conviction that all reasonable steps had been taken over the years to monitor this patient’s longstanding fibrocystic disease. Perhaps as important as the surgeon’s own convictions, the medical records in this case were absolutely meticulous, carefully documenting the surgeon’s care and reasoning every step of the way. Communications between the surgeon, the primary care physician and the radiologists were timely and thorough, again with appropriate contemporaneous documentation. All these factors combined to enable the jury to overcome the very powerful sympathy that is always present in cases such as this and to render a verdict for the defense.
