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## BREAST CANCER- LEGAL ISSUES

By Bobbie Lebeda , RN, BSN

For the last decade, failure to detect breast mass has remained the most common reason for medical negligence litigation; the usual defendant is the radiologist, who is charged with missing a lesion on a breast study. Less commonly, a primary caregiver, such as an obstetrician or gynecologist (OB/GYN) may be sued.

A diagnosis of breast cancer may be missed or delayed for the following reasons:

**1. Assumptions regarding breast cancer diagnosis:** One such assumption is that only women over the age of fifty with a family history of breast cancer are at risk. Because younger women are at a lower risk for developing breast cancer, surveillance may be reduced in that age group. Another assumption is that a negative mammogram or biopsy is conclusive. When health care practitioners are over-reliant on negative mammogram results, breast cancer may go undiagnosed. This may be true even in situations where the woman reports that she feels a lump. Similarly, health care practitioners may rely solely upon a negative biopsy aspiration, even when the biopsy finding belies the evidence of cancer in the other diagnostics performed.

**2. cursory physical examinations.** Signs of breast cancer that can be missed when only a perfunctory physical examination is conducted include: lumps in the outer quadrants of the breast; palpable axillary nodes; evidence of tenderness; unilateral or asymmetric changes in the breast; nipple discharge; and, changes in the skin of the breast, nipple or areola. When warning signs, such as a retracted nipple or discharge from a nipple, are not recognized or not properly investigated, breast cancer can go undiagnosed

**3. Inadequate history taking.** A complete and thorough history is important in the diagnosis of breast cancer. In addition, spending time with a patient during the history and physical exam can engender a trusting relationship between a patient and her health care provider. A trusting relationship between practitioners and patients not only improves the quality of information exchanged in history-taking, but reduces the chance that a patient will want to engage in litigation against a caregiver she perceives as caring and providing quality care.

**The most common allegations of negligence in breast cancer cases include failure to:**

- Perform a breast exam or perform an adequate breast exam;
- Identify a palpable mass during breast examination;

*Continued on page 3*

## A Message from our President of 2003 - Sondra Fandray

This is a thank you note. The Pittsburgh Chapter of AALNC is thriving, and there could only be one reason - YOU. Your energy, commitment, collegiality, congeniality, and sharing have been the perfect recipe for success.

I hesitate to thank individual members for fear of missing someone, but all of you are important to me and to this Chapter.

♥ To the Board of Directors - THANK YOU

♥ To those who managed the web site - THANK YOU

♥ To those who published the newsletter - THANK YOU.

♥ To those who planned the regular educational meetings - THANK YOU.

♥ To those who planned the special meetings - THANK YOU.

♥ To those who worked so long and hard to make the annual conference a success

- THANK YOU.

♥ To every member who made the effort to attend a meeting - THANK YOU.

Please continue your efforts to keep this Chapter viable. You are empowered to make this experience a beneficial one for you - both personally and professionally. Make it a personal goal to become active on at least one level higher. If you don't come to meetings, plan to come to a few; if you come to meetings, get involved in at least one committee, if you work on the sidelines, consider a board position, if you are a board member, think about a higher position, maybe president-elect.

I can only relate to you what this organization has done for me - many years ago. I, like every one of you, felt all alone in the huge legal arena. AALNC has enabled me to grow as an LNC and as a leader. You all deserve a share in these benefits.

Here's to a great 2004 under the leadership of Linda Fowler.

*Sondra*

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### **Clinical Point:** by Nursine Jackson, MSN, RN

#### **– Adjuvant Drug Therapies in Breast Cancer Treatment**

Adjunctive therapy with antiestrogens, specifically Tamoxifen therapy, has been an integral part of breast cancer treatment since the 1970's. Its purpose is to suppress estrogen receptive cells present in the body. Unfortunately, because of its non-selective nature, i.e., that it stimulates other hormone receptive tissue, such as uterine tissue, it is a less than optimal option. In addition, Tamoxifen eventually loses its effectiveness over time. The exact reason for this is unclear, but it is thought that some tumors become resistant to antiestrogen drugs.

The group of drugs to which Tamoxifen belongs is called *selective estrogen receptor modulators*, or SERMs, because they selectively stimulate or inhibit the estrogen receptors of different target tissues. The search for even more selective SERMS has been ongoing. In 1997, another drug in this group, raloxifene, was FDA approved and has been used clinically to increase bone density. In addition to its beneficial effects on bone, there is evidence suggesting that raloxifene may exert beneficial effects on heart and blood vessels, lowering cholesterol slightly, without the unwanted stimulation of uterine cell division that is exhibited by tamoxifen. Its efficacy in lowering the risk of breast cancer still needs to be determined. The National Cancer Institute (NCI) is currently sponsoring a trial, STAR (Study of Tamoxifen and Raloxifene), to directly compare the effects of tamoxifen and raloxifene in postmenopausal women.

*Continued on page 3*

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- Diagnose a tumor as potentially malignant;
- Consider surgical excision or lumpectomy as a viable and reasonable option;
- Schedule high-risk patient follow up at appropriate intervals;
- Provide education and support to avoid patient complacency;
- Recognize warning signs in high risk patients;
- Investigate a history of acute breast pain;
- Perform a diagnostic work-up for lumps in pregnant or lactating women;
- Prescribe additional diagnostic testing, e.g., ultrasound and/or biopsy, on equivocal or suspicious testing scenarios;
- Order a follow up mammogram if indicated by prior suspicious findings.

Diagnostic delays can lead to significant damage that may have been avoided had the mass been diagnosed and properly treated in a timely manner (e.g., disfiguring mastectomies or radical surgeries, metastatic disease that changes prognosis and chance of cure, axillary dissection that results in lymphedema, life altering chemotherapy regimens, and radiation regimens, severely diminished quality of life, or even death).

**In order to ensure timely diagnosis, the following guidelines should be followed:**

- Assessments should be thorough, accurate and complete;
- Every breast complaint should be appropriately evaluated;
- Established breast cancer screening guidelines should be adhered to;
- Office tracking systems for cancer screening & testing follow-up should be utilized;
- Premenopausal women should be referred for evaluation of any breast mass that persists through a menstrual cycle;
- Asymmetric breast findings should be considered as a cause for concern and in need of follow-up;
- Treatment plans and follow- up interventions should be timely;
- Documentation should include a thorough medical history and physical assessment, clinical impression, and follow- up plans.

Breast cancer is the most common malignancy in women and the second leading cause of death due to cancer in women. A complete and thorough medical history and physical examination, appropriate diagnostic testing, and timely treatment plans and follow-up interventions can significantly improve a practitioner's ability to avoid diagnostic errors.

END

**Clinical Point:** *continued from page 2*

While Raloxifene holds promise for the treatment of breast cancer, it is still not a panacea. It does not help with symptoms of menopause like estrogen does. In fact, the most common side effects of raloxifene are hot flashes and leg cramps. Also, raloxifene is thrombogenic, and slightly increases the risk of blood clots.

Because Tamoxifen (and possibly the other SERMS) loses its effectiveness after a five year course, complementary drug therapies are needed and are also under investigation. A group of drugs, called aromatase inhibitors, work via a different biological mechanism to suppress the production of estrogen. One such drug, Letrozole, reduced the risk of cancer recurrence and deaths in a study comparing letrozole to placebo. (This study was published in the New England Journal of Medicine in October 2003, and the full text article can be viewed at: <http://content.nejm.org/cgi/content/abstract/NEJMoa032312v1>.) Participants in this study were post-menopausal women with estrogen receptor-positive forms of early breast cancer, who had completed an initial five years of tamoxifen therapy. Though this second line endocrine therapy is already being used in women with advanced breast cancers, the long term effects of total body estrogen suppression (e.g., it may cause osteoporosis), its optimal timing following SERM therapy, and other factors optimizing its effectiveness and reducing its risks require additional research.

*References continued on Page 11*

## BREAST IMAGING: CURRENT CHALLENGES AND ROLE OF BREAST ULTRASOUND

By Cathy S. Tyma, M.D.

When I read my first xeromammogram in 1984, the detail wasn't great and the decision process was simple and straightforward. If you saw something, you'd better biopsy it. We have come a long way in our sensitivity and specificity in identifying breast cancer. This has resulted in earlier detection, with reduction in the size and stage of breast cancer at the time of diagnosis.

As a women's imaging specialist who interprets over 5000 mammograms per year, I have two perspectives on which I would like to focus this article. The breast imager must be very careful to adhere to strict evidence-based criteria with regard to which lesions are appropriate to be followed, and which require biopsy. Diagnosis should not be based merely on intuition. Second, the breast imager ideally would establish a rapport with the patient and take a hands-on approach to evaluating imaging detected abnormalities, or clinical symptoms.

Mammography is first of all a *screening* technology, with additional views obtained, as indicated, for diagnosis. The bulk of mammography interpretation consists of recognizing three types of lesions (masses, calcifications, and architectural distortion) and placing them into one of four categories (Category 1: negative):

Category 2: benign

Category 3: probably benign

Category 4: suspicious

Category 5: highly suspicious

A small percentage of the time, lesions fall into the first (benign) category or last (highly suspicious) category, and mammography can give a definitive diagnosis. Some examples of the benign category are cases of classic calcified fibroadenomas, lipomas, some forms of fat necrosis related to previous trauma or surgery, classic layering fibrocystic calcifications, and intramammary lymph nodes. Routine screening follow-up for age is recommended. The last category (highly suspicious) consists of classic features of malignancy such as spiculated masses associated with obviously malignant pleomorphic or fine linear branching calcifications.

Much of the time, however, mammography alone is insufficient to determine definitively whether a lesion is benign or malignant, and morphologic criteria must be used to develop probabilities. There are many criteria that may place a lesion into the suspicious category (i.e., chance of malignancy ranging in degree of likelihood from 2% to 90%) requiring tissue sampling for a definitive diagnosis. A full list is beyond the scope of this article, but common ones are indistinct or microlobulated margins, irregular shape, architectural distortion, or calcifications that are amorphous. However, even if a lesion is characterized as probably benign based on morphologic criteria, it still has a slight risk (less than 2%) of being malignant and short-term (six month) mammographic follow-up is considered a safe alternative to immediate tissue diagnosis. These statistics have been established based on two large prospective trials (by Sickles and Varas in the early 1990's). Lesions appropriate for this category are (a) noncalcified solid masses with an oval or lobular shape and circumscribed margins, (b) clustered calcifications that are round or oval on magnification, and (c) focal asymmetric densities that resemble normal fibroglandular

tissue on additional mammogram views. These lesions should not be new or significantly increasing when compared to any previous studies. They also should not be palpable. Strict adherence to these criteria is mandatory to achieve the published outcomes.

Breast ultrasound is primarily a *diagnostic* procedure. The role of breast ultrasound has significantly advanced over the past few years with advances in technology, so that ultrasound now plays a major role in further characterizing breast masses and improving our diagnostic accuracy. It is now often the sonogram that points the direction to the appropriate management of mammographically and/or clinically detected masses. Some probably benign masses on a mammogram may upon further evaluation by ultrasound have more suspicious features, and it will be the ultrasound that will prompt a biopsy.

**The current indications for breast ultrasound are to:**

1. Supplement a mammogram study to
  - a. characterize mammographically detected masses (not clearly benign),
  - b. evaluate lesions seen only on one mammographic view,
  - c. search for secondary lesions in dense breasts,
  - d. evaluate areas of clinical concern, such as a palpable mass or thickening, localized pain, infection, spontaneous nipple discharge, or suspicion of implant rupture.
2. Serve as the primary imaging modality if
  - a. the patient is symptomatic and is under 30 years old, or is pregnant;
  - b. there is a new palpable finding within 6 months of a negative mammogram.
3. Guide interventional procedures.
4. Supplement screening mammography\*
  - a. if there is a dense or complex breast parenchymal pattern,
  - b. in high risk patients with dense tissue,
  - c. for patients with implants.

*\*Screening sonography is a new, but I believe valuable tool to supplement a mammogram in a patient with mammographic limitations due to dense breast tissue or implants. Its acceptance is not yet universal in practice, but a recent (2002) study by Kolb supports its use. The study broke down mammographic sensitivity based on the density of the breast tissue in 27,825 consecutive asymptomatic patients and found that the sensitivity of mammography in detecting breast cancer in fatty breasts was 99%, while the sensitivity drops to 47.8% in markedly dense breasts. This is due to the fact that, on a mammogram, a common presentation of cancer is as a white mass, and this can blend imperceptibly within a background of dense white breast tissue. Conversely, on ultrasound a cancer (if visible) is usually dark and contrasts with a background of dense white breast tissue. In the study, screening ultrasound detected an additional 42% of cancers in women with dense breasts (yielding a 73% increase in cancer detection), with a false positive rate of only 2.4%. Physical examination, on the other hand, detected only 27% of cancers, and they were later stage cancers.*

Ultrasound of the breast must be performed with a high resolution (7 mHZ or greater) linear array transducer with near field focusing capability. A relatively new sonographic technique, called tissue harmonics, appears to further improve the diagnostic accuracy of ultrasound. Breast ultrasound is an operator-dependent study, and depends upon the skill of the person performing the study. Normal breast tissue can at times simulate masses, and some abnormalities are subtle and not easily appreciated.

*Breast Imaging, Continued from page 5*

If a **cyst** is seen, strict adherence to the sonographic criteria that define a simple cyst is essential, as some cancers can resemble a cyst.

**These sonographic criteria that define a simple cyst consist of:**

- (a) circumscribed margins
- (b) sharply defined anterior and posterior walls
- (c) absence of internal echoes
- (d) distal acoustic enhancement.

If all the criteria are met, no further workup is necessary. The cyst may be aspirated if it is symptomatic, but aspiration will not be necessary to prove that it is a cyst. If the cyst is complex or otherwise equivocal, one should go beyond the diagnostic ultrasound to needle aspiration.

If a solid nodule is discovered, real-time scanning by the radiologist is in my opinion necessary to carefully search for any malignant findings.

**Stavros (1995 study) describes features of malignant and benign masses:**

***Malignant***

Spiculation  
 Angular margins  
 Shadowing  
 Taller than wide  
 Markedly hypoechoic  
 Microlobulation  
 Calcifications  
 Duct extension  
 Branch pattern  
 Disruption of tissue planes

***Benign***

Absence of any malignant features  
 Markedly hyperechoic (compared to fat)  
 Elliptical or teardrop shape  
 3 or fewer lobulations  
 Thin echogenic capsule

- If even a single malignant feature is present, Stavros classifies the nodule as at least moderately suspicious (50% or greater risk of cancer), and needle (or surgical) biopsy performed.
- If there are no malignant features but also no clearly benign features, the lesion is considered indeterminate (3-49% chance of malignancy) and biopsy should be performed.
- If at least two benign features are found, the nodule can be classified as probably benign (< 2% chance of malignancy). In my practice we discuss this with the patient and offer her the option of six month follow-up with ultrasound. However, we do offer core biopsy for these lesions and the final decision whether to biopsy or follow the solid breast nodule is made by the patient and her referring physician.

Finally, the addition of a hands-on modality such as breast ultrasound to aid in breast diagnosis allows the radiologist to further establish a rapport with the patient. In a symptomatic patient with a lump, simultaneous palpation of the area in question by the radiologist is an essential component of breast ultrasound. Correlating the examination directly with any areas of clinical concern allows us to assure the patient that her concerns are being addressed, as well as involve her in the management process. Often a finding that the patient is feeling can be normal, such as a fibrous ridge, and this can be demonstrated to the patient on the ultrasound screen. If a solid mass is discovered, it should be determined whether this correlates with and explains a lump reported by the patient. Finally, the radiologist is in a good position to explain the finding that requires further evaluation, demonstrating it to the patient on the ultrasound screen, and explain any interventional procedures and respond to her questions. There is no one better qualified for this management role than the breast imaging specialist. END

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## SELECT INTERNET RESOURCES FOR BREAST CANCER RESEARCH

**www.ahrq.gov/clinic/3rduspstf/breastcancer/brcanrr.htm#consideration:**

“Recommendations and Rationale Screening for Breast Cancer” by the U.S. Preventive Services Task Force (USPSTF)

**www.cdc.gov:** a government resource for information on breast cancer awareness, screening guidelines, information on NBCCEDP (National Breast and Cervical Cancer Early Detection Program);

**www.cancer.gov:** another government resource, use search term “breast” for “best bet” articles and over 12,000 other references;

**www.guideline.gov:** sponsored by the Agency for Healthcare Research and Quality (AHRQ) in partnership with the American Medical Association and the American Association of Health Plans - a public resource for evidence-based clinical practice guidelines;

**www.oncolink.com:** sponsored by the Abramson Cancer Center of the University of PA, basic public information and some technical articles;

**www.nationalbreastcancer.org:** sponsored by the National Breast Cancer Foundation, Inc., a philanthropic and informational site for public information;

**www.nabco.org:** sponsored by the National Alliance of Breast Cancer Organizations, non-profit informational and educational resource;

**www.cancercares.org:** a non-profit organization dedicated to providing emotional support, information and practical help to cancer patients and their families;

**http://www.medscape.com**

*Medscape post dated 11/24/2003*

From Annals of Surgery, “BREASTAID: Clinical Results From Early Development of a Clinical Decision Rule for Palpable Solid Breast Masses,” by Janet Rose Osuch, MD, MS, Mathew J. Reeves, BVSc, PhD, Dorothy R. Pathak, PhD, MS, Tosca Kinchelow, MD

**www.canceradvocacy.org:** sponsored by the National Coalition for Cancer Survivorship, a survivor-led advocacy organization;

**www.komen.org:** sponsored by the Susan B. Komen Breast Cancer Foundation, one of the best informational sites for the general public.

## Educational Opportunity

**Who:** The Cyril H. Wecht Institute of Forensic Science and Law

**What:** A National Conference on the Science and Law of Combating Terrorism

**Where:** Duquesne University

**When:** Thursday, October 21 - Saturday, October 23, 2004

**Contact:** Ben Wecht, Manager of Program Development and Communication

Phone: 412-396-1049; FAX: 412-396-1331; E-mail: wechtben@duq.edu

## Another Role for the LNC: Assessing a Case for Merit A Case Study: failure detect a breast mass

By Nursine S. Jackson, M.S.N., R.N.

The following is the scenario of an actual case that was just litigated in N.Y. It is not a theoretical construct, but is the real thing.

### Medical Scenario:

At the time of her first perception of breast mass, Mrs. M, a well-educated Middle Eastern woman was in the first trimester of her second pregnancy, and was 38 years old. She had been going to her OB/GYN for nearly a decade, and from his office notes, it appeared that his attention to obtaining regular PAP smears and breast exams was, as Mrs. M reported, haphazard. His notes were sparse.

Hesitantly, Mrs. M. recounted the specifics of the events surrounding her discovery of the breast mass, in which she had just discovered she was pregnant after a seven year bout of infertility. Her husband was delighted, and in the midst of the resulting marital intimacy, (a very difficult story to report even privately as a result of her conservative and private Persian Jewish ethnicity), the lump was discovered. Mrs. M. described the mass, as feeling like a little pea that she could feel with the tip of her little finger, and was of like size.

She stated that she reported this mass to her OB the same week she discovered it, to which he replied, "Pregnant breasts are always lumpy." She reported that he did not examine her breast or attempt to palpate the lump. After he reassured her that her breasts were engorged and lumpy – just as he expected they should be, she quit worrying about the lump.

The office notes are mute to any discussion of a mass, as they are silent about a severe viral illness she suffered in the third month of her pregnancy. The illness passed in a few days, and the remainder of her pregnancy was unremarkable. Likewise, the labor was uneventful; however this pregnancy produced a profoundly neurologically-impaired infant. Placental pathology revealed an infection with a cytomegalovirus, which in hindsight, was likely the infection that rendered her so sick in her first trimester, and interrupted her fetus' neurological development. \*

Following a long, complicated course in neonatal intensive care with never-ending problems, Mrs. M. was able to bring her baby home. But it was tough going. He couldn't suck, so she pumped her breasts to make sure she gave him the best nutrition she could, and spent hours on each feeding. After a couple of months of pumping, she started seeing streaks of blood in the milk in the pump. Concerned about feeding her fragile baby her own blood, she called her OB and received instructions about nipple care to avoid cracks in the breast, but she was not offered or recommended to have a physical examination. When the blood in her breast milk continued, her OB told her by phone, to quit pumping, which she did after three or four months of lactation. In spite of her efforts, her infant was endlessly colicky, and had seizures, and innumerable respiratory and ear infections, and he failed to thrive. She was consumed by grief and fear, and this fragile infant got her full attention for the eighteen months he survived.

*Continued on page 9*

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*\*This issue further complicated the legal analysis of this case, which entailed obtaining the baby's extensive medical records, and getting another set of experts to analyze whether a diagnostic study, such as a TORCH test, was the standard of care when a mother develops a serious viral illness early in her pregnancy. The plaintiff's experts in obstetrics and infectious disease stated that the OB was not negligent when he failed to perform any additional diagnostic studies for this mother's illness in her first trimester. (Had the infection been diagnosed, there would have been no treatment for a TORCH infection; but the mother could have been given the option of a medical abortion.)*

After his death, she began to think about her own needs, and again became aware of this breast mass, but found it was significantly larger than it was than upon her original discovery. A co-worker encouraged her to go to a different gynecologist who would be more responsive to her, and this time, to insist on mammography, which she did. More than two years from the point of her initial detection of a mass, and following the hormone storms of pregnancy and breastfeeding, a mammogram revealed a five centimeter, suspicious mass. By the time she had her original diagnostic procedures, she had Stage 4 breast cancer, i.e., a five centimeter mass of infiltrating ductal carcinoma, multifocal, poorly differentiated, intermediate nuclear grade, low mitotic rate, with vascular invasion and 26 out of 26 nodes positive. Her pathology report revealed Estrogen Receptor for protein was positive, Progesterone Receptor for protein was positive, and the HER2/NEU was negative.

### **Is this a case?**

The question for legal analysis was: Was there a missed opportunity for timely diagnosis and intervention that would “to a reasonable degree of medical certainty” have changed her destiny?

The LNC was an integral member of the legal team in assessing this case for merit. (In this case, the team was composed of a senior attorney, an associate attorney, a paralegal and the legal nurse, all of whom were involved throughout the course of the case.)

### **Some of the Issues Considered:**

Mrs. M’s care, as it was reported, reflected a clear deviation by the OB in his failure to perform diagnostics at the time of a report of breast mass, but we feared it would be a challenge to identify damages from a delay in diagnosis, in light of the confounding effects of pregnancy.

Because the records did not reflect the facts the patient reported, this case hinged on the client’s credibility, a suboptimal posture for any case. Hence, the importance of the patient’s demeanor, communication skills, consistency in reporting event, and credibility were critical considerations as to whether the case was worth pursuing any further. Mrs. M. was articulate and appealing and immensely credible, and the injuries were so devastating that the legal analysis of the case’s merit continued. . . but with Stage 4 cancer would she survive until trial to touch the jury? We felt that her live testimony would be very important for the jury to find the story credible.

Though an OB’s notes made no mention of breast mass, and he denied her reporting the mass in his depositions, his plan in her first postpartum office visit, at the very bottom of the page in a nearly illegible and inexplicable script stated: “Mammo.” Certainly mammography is not a “standard” study to perform on freshly milk-engorged breasts. Perhaps the OB *was* aware of her mass during her pregnancy, so had ordered a mammogram as an afterthought, after her delivery. Maybe the “mammo” was a chart falsification to insert a question of patient noncompliance and contributory negligence, inserted after the doctor became aware of her breast cancer diagnosed in its late stages. Mrs. M. had no recollection of having had a mammogram recommended at her postpartum visit, but how reliable was her memory at a time when she had been so overwhelmed with caring for a critically ill infant? This weird twist in the facts of the case were never explained and remained one more confounding issue.

In hearing her speak of important facts to the case with such discomfort, the legal team was concerned about whether Mrs. M would be able to relate over and over again, in deposition, to the experts, and then to a jury, how this breast cancer had damaged her, and if she could speak of it. As it turned out, she couldn't. After deposition the husband's derivative claim had to be dismissed, since neither Mrs. or Mr. M could discuss sexual details that would demonstrate damages suffered from loss of consortium or other marital problems that evolved as a result of the cancer surgery and treatment.

### **Weighing the Case**

The team discussed first why the case should not be put into suit. The cons included:

- The aspect of the case with the catastrophic damages, the failure to diagnose the cytomegalovirus or the wrongful life case disappeared after the expert review;
- The case was further devalued after her husband's derivative claim was dismissed;
- The he said-she said element of the case made it suboptimal;
- Concerns that the unpredictable effects of the hormones of pregnancy and breast feeding resulting in rapid growth of the tumor could arguably have made Mrs. M's prognosis terrible even with timely treatment;
- The need for multiple experts would make the case development very costly;
- Mrs. M's objective work loss was very minor;
- A possible perception by the average juror that an educated woman who had been raised around doctors, should have known better than to ignore a breast lump.

The pros in the analysis of this case include:

- Mrs. M was a credible and consistent client AND defendant doctor's disorganized and indifferent demeanor reinforced Mrs M's reports;
- The sequence of events probably would make the mother more sympathetic than negligent in not seeking more timely follow-up of her breast mass;
- An initial mammogram showing patterns of calcifications indicated that the tumor had to have been present for a significant period of time, and was not just a result of a burst of growth during a hormone storm;
- We readily found high quality academic experts who would causally relate the negligent care to a terrible injury and damages that resulted from the delay in diagnosis;
- Finally, some of her treating doctors believed that she had been treated negligently and were willing to support her case.

The plaintiff's team proceeded with the challenge of developing this case for trial.

Roles of the legal nurse consultant included performing an initial interview, specifying medical records that would need to be obtained, then organizing them and developing a chronology that entailed determining which facts needed to be pulled out to illustrate facets of the case that could support the plaintiff's perspective and which support the defense.

The LNC also had a crucial role in identifying which experts should be used and then in communicating with treating physicians and professional experts to assure that they were

knowledgeable as to the facts of the case (as per medical records and deposition testimony) and would provide the testimony needed to support the elements of the case. The experts would testify that the OB was **negligent** in not pursuing a report of breast mass in his patient by ordering an ultrasound when Mrs. M first reported it, that this negligent act **caused an injury** with significant **damages** flowing from this injury, i.e., a worsened prognosis with a need for special medical care due to her advanced stage at the time of the diagnosis of her breast cancer. (With 26 of 26 nodes positive at the time of diagnosis, Mrs. M. had lost her chance for cure or for conservative therapy. She faced chronic drug therapy with unpleasant side effects for the remainder of her life and had almost no chance of long-term survival, though she did survive with very poor health until the case settled.) Expert and treating physicians agreed to testify that the mass was most likely present at the time that Mrs. M. first reported it, and that treatment at that time, would have changed her prognosis. They felt that the two year delay in diagnosis and treatment were significant in setting her poor prognosis and tough clinical course after this late diagnosis.

### The Experts:

The experts used to develop the case included the treating mammographer who found the tumor, the treating surgical oncologist who performed the mastectomy, and an obstetrician and oncologist. Had the case gone to trial, a psychiatrist would have been brought in to demonstrate this aspect of damages in this case, and probably a handwriting or ink analyst to determine when the entry of “mammo” was placed in the chart as a part of the plan on the first postpartum visit.

### The Outcome:

The case was in litigation for three years and settled just prior to trial. The defense expert reports were never made available, so that the defense of the case cannot be included in this case study. Three years post-diagnosis, Mrs. M. has lung metastases by CT and has been unable to work for the past year due to fatigue and general ill-health, as well as a resulting major depression.

END

### Clinical Point, Continued from Page 3

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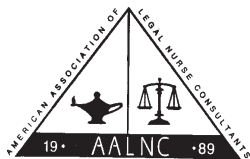
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## Pittsburgh Chapter AALNC

PO Box 97104  
Pittsburgh, PA 15229-0104



Phone:  
412.939.3426

Fax:  
412.939.3427

E-mail:  
kesrehab@aol.com

Website:  
[http://  
www.PittsburghChapterAALNC.org](http://www.PittsburghChapterAALNC.org)

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## about THE LiNC

The LiNC will be published three times yearly: in Winter, Summer, and Fall.

Please send articles and submissions (500 words or less) for publication in the next newsletters by the second week of January, May, and September to our **Editor:**

**Nursine S. Jackson, MSN, RN**

**E-mail:** [Nursine@JacksonLaw.net](mailto:Nursine@JacksonLaw.net)

### **LiNC Editorial Board:**

Jane Collins, RN, BSN, JD  
Sondra Fandray, BS, RN  
Luevonue M. Lincoln, RN, PhD

## ABOUT OUR CHAPTER

### **Monthly Meeting Information**

The Pittsburgh Chapter meets the second Wednesday of every month (except during the summer). The Law Offices of Dickie McCamie have graciously hosted our monthly meetings, however please confirm the meeting location each month on the Calendar of Events page of our website to verify the meeting location has not been changed due to a special event. Non-members are welcome to educational presentations. If you have questions about upcoming events, contact Costantini Rehab: 412.939.3426, or visit our Website: <http://www.PittsburghChapterAALNC.org>.

### **Educational Programming**

If you have a topic that you would like to have presented at a meeting, recommendations for a speaker, a new site, or other idea for enhancing our monthly meetings, please speak with our Programming Chairperson, Patty Costantini.

### **Membership Inquiries**

Information about joining this organization is available through our Membership Chairperson, Patty Costantini at Costantini Rehab. Call 412.939.3426; FAX 412.939.3427, or e-mail: [kesrehab@aol.com](mailto:kesrehab@aol.com).

### **Speaker's Bureau Inquiries**

Do you need a speaker for an upcoming meeting? The Speakers Bureau is a free service to Medical-Legal Community. The Pittsburgh Chapter of AALNC provides experienced LNC's who are prepared to speak on a variety of nursing healthcare and legal topics.

### **Pittsburgh Chapter Business Directory**

Are you seeking a nurse expert, or an LNC to consult with or to develop a case for you? You may find an LNC within our chapter who has the specific expertise you need, and who is interested in providing consultative services. Peruse our Business Directory on our Webpage. A Pittsburgh Chapter LNC may very well have the skills you need.

*The Pittsburgh Chapter does not, in any way guarantee the work of the members who are listed in this directory.*