ACTUAL CASE RESULTS AS REFERRED TO IN THIS WEBSITE DEPEND UPON A VARIETY OF FACTORS UNIQUE TO EACH CASE. THE RESULTS OBTAINED IN THESE CASES DO NOT GUARANTEE OR NECESSARILY PREDICT A SIMILAR RESULT IN ANY FUTURE CASES. (Notice pursuant to Virginia State Bar Rule 7.2(a)(3))

Medical Malpractice - Stroke - Failure to Anticoagulate

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Type of Action **Medical Malpractice** Type of Injuries Embolic cerebral stroke Name of case Strobel V. Rajan Court case No. Fairfax Circuit Court, Law No. 138127 Judge or Jury Jury Name of Judge Judge M. Langhorne Keith Special Damages Medical expenses $79,958.34; nursing home $135,260.42 Damages awarded or settled Awarded **Amount** **$2,500,000** Attorney for Plaintiff Roger L. Amole, Alexandria Insurance Carrier Medical Mut. Liability Ins. Soc. of Maryland Plaintiff's Experts Kenneth Allen Ellenhogan M.D.; Medical college of Virginia Defendant's Experts Ted Friehling M.D., Fairfax, Richard A. Schwartz, Alexandria

The plaintiff, at age 67, underwent an electrocardioversion performed by the defendant Narian Rajan of the Mount Vernon Cardiology Associates, because of atrial fibrillation, a type of irregular heartbeat. Approximately 36 hours after the procedure she suffered an embolic cerebral stroke, which left her partially paralyzed (left hemiparesis), unable to walk, partially incontinent, and with some cognitive impairments. The plaintiff alleged that the defendants failed in the standard of care by insufficiently anticoagulating her before and after her electrocardioversion, which caused her to suffer the stroke.

In approximately March 1992, the plaintiff began having increasing cardiac dysrhythmia. Her symptoms persisted and in January 1993, she was started on 2.5mgs. daily of Coumadin, and anticoagulant (blood thinning) drug by her primary care physician, presumably for the purpose of minimizing her risk for embolism because of atrial fibrilation. On the advice of defendant Mt. Vernon Cardiaology Assoc., the plaintiff was electively admitted to Mt. Vernon hospital on March 4, 1993, for observation and chemical cardioversion to a normal heart rate or "sinus rhythm." At that time her electrocardiogram showed bilateral enlargement. No clots were noted. The chemical cardioversion successfully returned her to sinus rhythm and she was released from the hospital on March 5, seemingly improved. However she reverted to atrial fibrilation and she was again admitted to Mt. Vernon hospital on March 14, 1993. Because she had also been experiencing chest pains, an exercise thallium study was performed showing no evidence of exercise induced ischemia. Dr. Rajan attempted to chemically cardiovert the plaintiff without success and on March 19 he electrocardioverted her twice, which succeeded in returning her to sinus rhythm. She was released from the hospital the following day and after returning home suffered her stroke.

The plaintiff's evidence established through Dr. Ellenbogen that stroke is the known risk associated with cardioversion and the absence of sufficient anticoagulation , and further that embolic episodes such as the one the plaintiff suffered within 36 hours of the electrocardioversion is well within the period when the embolic event would be expected to occur if related to the cardioversion. The standard of care required that the defendants should perform cardioversion only after fully anticoagulating the patient three weeks before the cardioversion and three to four weeks after the cardioversion. The plaintiff's recorded prothrombin (clotting) times during the period of Rajan's management through and including the date of the electrocardioversion indicated that virtually no theraputic anticoagulation was achieved for this patient at anytime before the electrocardioversion was performed.

The defendants admitted into evidence the unanimous finding of a medical-malpractice review panel that the evidence does not support a conclusion that the health care providers failed to comply with the appropriate standard of care. The defendant's expert, Dr. Friehling, testified that Rajan was within the standard of care in performing the procedure with the plaintiff's clotting time only "mildly elevated" in view of the fact that she presented significant risks of bleeding if given higher dosages of Coumadin. The plaintiff argued that she was not at high risk of bleeding and had no contraindications to receiving a theraputic dosage of Coumadin, and even if she did, the standard of care required that the cardiologist in charge of her management not perform the procedure, absent emergent circumstances, unless he concluded she could be safely anticoagulated within the theraputic range. All experts agreed that the electrocardioversion was not an emergency procedure and could have been deferred for a matter of weeks or even longer. This would have allowed time to elevate her prothrombin to theraputic levels.