***Patient Name*** ***DOB: MM/DD/YYYY***

# Expert Medical Opinion - XXXX

## DOD: 11/26/YYYY

**Summary of merit:**

From the available medical records, it is with a reasonable degree of medical certainty; I opine that there was a deviation from the standard of care provided to Ms. XXXX in XXXX Hospital. On 11/16/YYYY midnight, Ms. XXXX presented to XXXX Hospital with complaints of chest pain and shortness of breath. The patient was a known case of asthma and was post-partum. Since she had a history of asthma, she was thought to have acute exacerbation of asthma and was discharged home with bronchodilators.

The physician at XXXX Hospital failed to investigate the cause for chest pain. Myocardial infarction is one of the main causes for chest pain. The ER physician failed to rule out myocardial infarction. Performing a simple EKG would have shown any acute myocardial process. Moreover, the patient had recently delivered a baby and was positive for discoid lupus both of which are hypercoagulable conditions and risk factors for myocardial infarction.

**Defendant:** XXXX ER physician Dr. XXXX.

**Deviations from the standard of care:**

- Failure to suspect myocardial infarction as one of the causes of chest pain
- Failure to perform EKG or cardiac enzymes
- Failure to rule out myocardial infarction before discharging the patient
- Failure to diagnose impending acute myocardial infarction

**Damages:**

- Failure to diagnose and initiate treatment for myocardial infarction
- Anoxic brain injury and death of the patient

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**Case overview:**

Ms. XXXX was a 30-year-old female at the time of her death. She had medical history significant for asthma, discoid lupus/SLE, multiple STDs, G4P4 admitted to CVICU on 11/17 post cardiac arrest.

Patient had delivered on 10/24/YYYY (38wks, 2.8 kg). Peri/post-partum course was complicated by mild bleeding, but otherwise no infection or shock (vaginal delivery with epidural). Patient was doing fine post-partum until last night (11/16) when she presented to XXXX Hospital at midnight complaining of chest pain and SOB. Per phone conversation with XXXX Hospital ER, she was hemodynamically stable, labs were significant for K 3.1, Mg 1.4, Lactate 4. Was given albuterol nebulizers tx and discharged home with diagnosis of mild asthma exacerbation.

On 11/17/YYYY, per the partner, patient reportedly had chest pain/SOB and collapsed at home. She was unresponsive for 5 minutes (no CPR) before EMS arrived, found to be in VF arrest (Vfib>Vtach>asystole), shock + Amiodarone 300mg/Epinephrine x 4. Patient was brought to XXXX Hospital ER with CPR in progress. She had been down for approximately 40 minutes total including 5 minutes of no CPR. Intubated, arterial line and central access obtained. TPA (Tissue Plasminogen Activator) was given once due to concern for massive PE (Pulmonary Embolism). Peri-code echo showed marked biventricular dysfunction, no tamponade, no acute RV failure signs. She was also noted to be in complete heart block.

Patient was moving limbs (not purposefully/not following commands) after ROSC. Brought to CVICU intubated, sedated (versed), on low dose Epinephrine. Prelim CT was negative for PE. Patient was taken the cath lab and had two stents placed to the RCA. She arrived to the ICU intubated requiring Epinephrine and kept hypothermic. On 11/18/YYYY sedation was turned off in the morning that day. On 11/19/YYYY patient had not woken up. CT head was obtained which showed loss of cerebral grey and white matter differentiation and narrowing of ventricles consistent with hypoxic brain injury. Neurology was consulted. Over the next two days, sedation had continued to be held. On 11/21/YYYY, she was pronounced brain dead through the Mount Sinai protocol for death by neurologic criteria. On 11/26/YYYY, patient was terminally extubated with the family at the bedside. She became asystolic at 17:17 on 11/26/YYYY.

Autopsy revealed primary cause of death to be atherosclerotic cardiovascular disease.

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**Reference:**

**Ref 1:**

https://www.aafp.org/afp/2011/0301/p603.html

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