Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Additional Quality of Care Issues
Marion VA Medical Center
Marion, Illinois

Report No. 08-00869-102 **March 26, 2008**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The purpose of this review was to follow up on three surgical cases that were not included in the January 28, 2008, report titled *Healthcare Inspection Quality of Care Issues, VA Medical Center, Marion, Illinois*, (Report No. 07-03386-65). In one case, the review was not completed when the initial report was published describing administrative and quality of care deficiencies at the medical center. A Congressional office submitted the allegation for the second case, and a medical center employee requested a quality review for a third patient. We did not substantiate quality of care issues in any of the three cases.

In the first case, we did not substantiate the allegation that clinicians missed a cancerous kidney mass during the patient's pre-operative physical examination for a total knee arthroplasty. The pre-operative physical evaluation documented that there was no abdominal organ enlargement. During a second hospitalization for a diagnosis of cellulitis of the right lower leg with possible infection of the right knee, the patient complained of severe abdominal pain and a CT scan identified a kidney mass. While treating physicians initially differed regarding the possibility of a knee joint infection, the final diagnosis was cellulitis of the right lower leg and this infection was treated appropriately.

In the second case, we did not substantiate the allegation that a surgeon erred by removing the upper lobe instead of the middle lobe of a patient's right lung. The pre-operative CT scan showed cancer in the right main stem bronchus and the base of the right upper lobe. The surgeon was not able to remove the tumor in the hilum because it was infiltrating the surrounding tissue.

In the third case, we did not substantiate the allegation that a patient received sub-standard quality of care. After admission to the VA nursing home care unit in Poplar Bluff, MO, the patient's condition worsened and he was transferred to the medical center where he underwent a sub-total colectomy. Based on our case review and consultation with two non-VA surgeons, we concluded that the care provided to this patient was appropriate.

Because we did not substantiate the allegations, we made no recommendations.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, Veterans Integrated Service Network (10N15)

SUBJECT: Healthcare Inspection – Additional Quality of Care Issues, Marion VA Medical Center, Marion, IL

Purpose

On January 28, 2008, the Office of the Inspector General's (OIG's) Office of Healthcare Inspections (OHI) published a report titled *Healthcare Inspection Quality of Care Issues, VA Medical Center, Marion, Illinois,* (Report No. 07-03386-65).[1] That report described administrative and quality of care deficiencies at the medical center and included an analysis of the care provided for patients who had undergone surgery during fiscal year 2007 and died within 30 days of surgery.

In one case reviewed in this report, the review was not completed when the initial report was published. In two additional cases, allegations of substandard care were received from a Congressional office and from a medical center employee. This report provides an assessment of the quality of care provided for these three patients.

Background

The medical center is part of VISN 15, with services offered at the main facility located in Marion, IL, an outpatient clinic in Evansville, IN, and four community based outpatient clinics (CBOCs) located in Effingham and Mt. Vernon, IL, and Hanson and Paducah, KY. The system provides primary, specialty, and extended care to 43,722 veterans in 27 Illinois counties, and 17 northwest Kentucky counties. The system operates 55 acute care beds and a separate 60-bed nursing home care unit.

Scope and Methodology

For these three cases, we reviewed pertinent medical records. In the case that was pending when the initial OIG report was published, two academic surgeons not affiliated with the VA assessed the patient's medical records and discussed their findings with OHI

[1] This report is available at http://www.va.gov/oig/54/reports/VAOIG-07-03386-65.pdf.

physicians. For the other two cases, we interviewed the complainants and, in one case, also interviewed a medical provider. This inspection was performed in accordance with *Quality Standards for Inspections* published by the President's Counsel on Integrity and Efficiency.

Inspection Results

Issue 1: Post-Operative Infection and Failure to Diagnose Renal Cancer

A veteran's wife submitted a letter to a member of Congress alleging that a surgeon performed total knee arthroplasty on a patient with kidney cancer, and that physicians disagreed about the cause of a subsequent infection the patient developed in his knee.

Case Review #1

The patient, a man in his fifties, has a medical history of renal cell carcinoma, osteoarthritis, hypertension, and obesity. In February 2007, his primary care physician (PCP) ordered blood work, a chest x-ray, and an electrocardiogram (EKG) for risk assessment prior to elective knee surgery. The PCP's history and physical examination noted that the patient's abdomen was soft, non-tender, and with no organ enlargement. The PCP gave medical clearance for the patient to have knee surgery. In March, the patient underwent right total knee arthroplasty. He was discharged home 3 days after surgery with instructions to report any increased shortness of breath, fever or chills, and increased redness or purulent drainage from his wound.

Six days after discharge, the patient was diagnosed with cellulitis of the right lower leg, with possible infection of the right knee prosthesis, and was admitted to the medical center. Culture of fluid taken from the right knee revealed no evidence of infection. While in the hospital, the patient experienced the sudden onset of abdominal pain. A computed tomography (CT) scan of the abdomen showed a mass in the right kidney. The patient was advised to see an oncologist, and the patient and his family stated they would see a private physician. The patient was discharged on the fifth hospital day with a peripherally inserted central catheter (PICC) for continued intravenous antibiotic therapy.

When the patient presented to the Orthopedic Clinic for his 3 week post-operative visit, the surgeon noted that the patient's calf was still erythematous, but that there was no marked heat or redness about the knee. He indicated that, "The knee is actually healed well…," changed the intravenous antibiotic to cefazolin, and instructed the patient to return in 1 week. The patient returned 1 week later and the surgeon discontinued the PICC line and intravenous cefazolin and prescribed an oral antibiotic.

In early May, approximately 3 weeks later, the surgeon documented that, "The knee incision is healed. No erythema. No palpable tenderness." At a subsequent visit, the patient reported that he had undergone removal of his right kidney at a private facility in

mid-June, and that surgery required that he discontinue physical therapy. In September, a nurse practitioner noted that the patient had limited range of motion of his right knee, but that he was, "…back to work and apparently able to perform." At a December follow-up visit to the Orthopedic Clinic, the patient complained of pain in his right leg with limited range of motion, and stated that he was unable to take time off work to resume physical therapy. He declined referral to the St. Louis VA Medical Center (VAMC) and plans were made for re-assessment in March 2008.

Findings

We did not substantiate the allegation that clinicians missed a kidney mass during the patient's pre-operative physical examination. The pre-operative physical examination documented that there was no abdominal organ enlargement. When the patient complained of severe abdominal pain during his second hospitalization, a CT scan of the abdomen identified a kidney mass. This mass would not be expected to be detectable on physical examination. While treating physicians initially differed regarding the possibility of a knee joint infection, the final diagnosis was cellulitis of the right lower leg and this infection was treated appropriately.

Issue 2: Management of Lung Cancer

A complainant alleged that a surgeon mistakenly removed the upper lobe instead of the middle lobe of a patient's right lung during surgery in February 2007 and, therefore, the patient's cancer was not adequately treated. The complainant reported that staff at the private hospice where the patient was being treated told him about a local newspaper article concerning the surgeon who had operated on this patient. He further reported that one of the patient's other providers at the medical center told him about concerns regarding the quality of care provided by this surgeon. That provider told us that the surgeon had not properly documented details about which lymph nodes he had biopsied. The provider did not believe this affected the patient's outcome.

Case Review #2

The patient, a man in his sixties, had a history of diabetes and of smoking at least two packs of cigarettes per day for more than 50 years. In mid September 2006, he was seen at a CBOC for a productive cough. A chest x-ray showed possible right upper lobe pneumonia. Following a repeat chest x-ray one month later, a radiologist recommended bronchoscopy and a contrast-enhanced CT scan of the chest.

In early November, the patient had the CT scan and underwent a bronchoscopy 2 weeks later. Bronchoscopy revealed a mass occluding most of the right upper lobe bronchus. Tissue biopsy of the mass showed squamous cell carcinoma, moderately differentiated. Subsequent imaging studies showed no evidence of metastatic disease. The patient underwent mediastinoscopy and pathologic examination of lymph nodes showed no cancer.

In mid-February 2007, the patient was taken to the operating room for a scheduled right lung lobectomy. The discharge summary from that hospitalization states, "At the time of the surgery, it was found that the tumor was in the hilum of the right upper lobe and it was spreading and infiltrating the surrounding tissue. The tissue was hard in consistency and was unable to mobilize because of the infiltration of the wall of the pulmonary artery." The surgeon removed the right upper lobe of the lung but was unable to dissect and remove the tumor in the hilum. Postoperatively, the patient received concurrent chemotherapy and radiation treatments. He completed the radiation therapy in June 2007 but continued the chemotherapy. In early September, the patient declined further chemotherapy because of side effects and entered hospice care. In mid-November, he died at home.

Findings

We did not substantiate the allegation that the surgeon erred by removing the upper lobe instead of the middle lobe of the right lung. The preoperative CT scan shows the cancer in the right mainstream bronchus and the base of the right upper lobe. The post operative pathology report documents, "Tissue from the upper lobe of the right lung, Biopsy: - Squamous carcinoma, moderately differentiated." However, the surgeon was not able to remove the tumor in the hilum because it was infiltrating the surrounding tissue.

While we did not find a detailed note discussing the number and location of the lymph nodes examined, the physician told us that the surgeon reported to him verbally that the nodes were negative. We found that details of the lung surgery were described in the patient's discharge summary. Further, the physician documented in a progress note that the surgeon called him after the patient's lung surgery and told him that the "…mass was big and adherent to the right hilar area and he was not able to remove much."

Issue 3: Management of Megacolon

This patient was one of the patients who had surgery in 2007 and died within 30 days of surgery. However, because the review was not completed for this patient in time for inclusion in our January 28, 2008, report, we are reporting it here.

Case Review #3

A man in his late fifties had a history of diabetes, hypertension, depression, chronic renal insufficiency, and a remote history of stroke. He had undergone amputations of both legs below the knee. In the first half of 2007, he had been seeing a private physician for headaches, for which he was taking a narcotic medication.

In mid 2007, the patient was admitted for long-term care at the VA nursing home care unit (NHCU) in Poplar Bluff, MO. He was initially well but, according to a gastroenterologist, soon developed, "uncontrolled diabetes mellitus and was noted to have nausea, vomiting and episodes of diarrhea." A CT scan of the abdomen revealed

marked thickening of the wall of the left colon. He was transferred to a medical unit and treated with intravenous antibiotics and given parenteral nutrition. Following improvement in his condition and while plans were being made for his return to the NHCU, his condition worsened abruptly and he was transferred to the Marion VAMC for urgent surgical evaluation. A surgeon performed colon decompression soon after transfer. After 5 days of management in the intensive care unit, he was taken to the operating room for sub-total colectomy.[2] At surgery, an anastomosis[3] was created between the ileum and the distal sigmoid colon. Eight days after surgery, the patient was transported back to the Poplar Bluff VAMC. Five days after transfer, he died of sepsis and diabetic ketoacidosis.

Findings

Based on our case review and consultation with the two non-VA surgeons, we concluded that the care provided this patient was appropriate.

Conclusions

We did not substantiate allegations of substandard care in any of the three cases we reviewed. Since patient care standards were met in each case, we did not make any recommendations.

Comments

The VISN and Medical Center Directors agreed with the findings (see Appendixes A and B, pages 6–7 for the full text of their comments).

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

[2] A sub-total colectomy is an operation to remove part of the colon.
[3] An operation to join together two hollow organs, usually to restore continuity after resection.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 13, 2008

From: Director, Veterans Integrated Service Network (10N15)

Subject: **Healthcare Inspection – Additional Quality of Care Issues, Marion VA Medical Center, Marion, IL**

To: Director, Kansas City Office of Healthcare Inspections (54KC)

Director, Management Review Office (10B5)

I have reviewed and concur with the findings and conclusions outlined in this report.

Peter L. Almenoff, M.D., FCCP

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 13, 2008

From: Director, Marion VA Medical Center (657A5/00)

Subject: **Healthcare Inspection – Additional Quality of Care Issues, Marion VA Medical Center, Marion, IL**

To: Director, Veterans Integrated Service Network (10N15)

We concur with the findings and conclusions.

(*original signed by*:)

WARREN E. HILL
Acting Medical Center Director

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Jerome Herbers, M.D. Associate Director Medical Consultation and Review (202) 461-4658
Acknowledgments	Reba B. Ransom James Seitz Marilyn Stones

Appendix D

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