NEVADA STATE BOARD OF MEDICAL EXAMINERS

IN THE MATTER OF CHARGES AND COMPLAINT AGAINST

HAI THANH NGUYEN, M.D.

ADJUDICATION

Case No: 21-3884

Date: September 16, 2022

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OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: **HAI THANH NGUYEN, M.D., Respondent.**	**Case No. 21-38084-1**

FILED
NOV 03 2021
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Robert G. Kilroy, Esq., Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Hai Thanh Nguyen, M.D., (Respondent) violated the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act), hereby issues its Complaint, stating the IC's charges and allegations as follows:

1. Respondent was at all times relative to this Complaint a medical doctor holding an active license to practice medicine in the State of Nevada (License No. 13702). Respondent originally licensed by the Board on September 15, 2010.

2. On November 11, 2016, Patient A[2] along with her parents went to HealthCare Partners Urgent Care, because she was suffering from coughing, wheezing, phlegm, and vomiting. Respondent evaluated the 2-year-old girl with "croup." Respondent started Patient A on prednisolone orally and also recommended a "steroid shot." Respondent successfully injected Kenalog into Patient A's lateral buttocks after two (2) unsuccessful attempts by Respondent's medical assistant. Patient A's medical record indicates "Kenalog 40mg/ml…Inject 0.5ml

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[1] The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal Complaint was authorized for filing, was composed of Board members Rachakonda D. Prabhu, M.D., Ms. Sandy Peltyn, and Victor M. Muro, M.D.

[2] Patient A's true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint. on this entry.

intramuscularly once...pt is given Kenalog 20mg IM." When asked by the IC, Respondent provided his written reply that he administered 0.5ml of Kenalog 20mg/ml IM. Respondent did not obtain an informed consent from Patient A's parents for the invasive procedure of a steroid shot (injection of the Kenalog). The medical record is not clear as to whether Patient A received an injection of 20mg or 10mg of Kenalog intramuscularly. There was no "shot record" section of Patient A's medical record as there was no documentation of the Kenalog vial's identification, lot number, nor date of expiration. Moreover, there was no indication of the specific injection shot location nor who delivered the shot (Respondent) to Patient A.

3. Approximately, two (2) weeks later, Patient A's parents noticed that Patient A's injection spot upon her buttocks had become a "divet" and eventually a "crater" that was sensitive to the touch. Skin atrophy is a known complication of a steroid intramuscular injection. Standard of care for toddlers (Patient A) who cannot "keep anything down" due to constant vomiting is an intramuscular or intravenous administration of steroids. Here, Patient A indicated only vomited once a day in the mornings, and not constantly though out the day, and should have been given an oral steroid. Respondent should have offered to Patient A's parent an oral option first, prior to the injection shot and discussed the risks and benefits of the steroid medication with them. For toddlers, such as Patient A, the proximal lateral thigh is the appropriate location for intramuscularly injections, not into a toddler's buttocks.

COUNT I

NRS 630.301(4) (Malpractice)

4. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

5. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.

6. NAC 630.040 defines malpractice as the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.

7. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when

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Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

he provided medical services to Patient A, because he failed to obtain and document an informed consent for the injection of Kenalog, and when he failed to properly inject the Kenalog into the proximal lateral thigh instead of Patient A's buttocks.

8. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNT II

NRS 630.3062(1)(a) (Failure to Maintain Proper Medical Records)

9. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

10. NRS 630.3062(1)(a) provides that the failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient is grounds for initiating disciplinary action against a licensee.

11. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to document his actions when he treated Patient A, whose medical records were not timely, legible, accurate, and complete. Respondent failed to document an informed consent for Patient A's Kenalog injection from her parents and discuss the risks and benefits of the medication before giving it to the child. Additionally, Patient A's medical records of having the shot, including the information from the vial, do not exist making Patient A's medical records inaccurate and incomplete.

12. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

WHEREFORE, the Investigative Committee prays:

1. That the Board give Respondent notice of the charges herein against him and give him notice that he may file an answer to the Complaint herein as set forth in NRS 630.339(2) within twenty (20) days of service of the Complaint;

2. That the Board set a time and place for a formal hearing after holding an Early Case Conference pursuant to NRS 630.339(3);

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9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

3. That the Board determine what sanctions to impose if it determines there has been a violation or violations of the Medical Practice Act committed by Respondent;

4. That the Board award fees and costs for the investigation and prosecution of this matter as outlined in NRS 622.400;

5. That the Board make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 3 day of November, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

ROBERT G. KILROY, J.D.
Senior Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: rkilroy@medboard.nv.gov
Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Victor M. Muro, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the Complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

DATED this 3rd day of November, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: V M Muro MD
VICTOR M. MURO, M.D.
Chairman of the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

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BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against

HAI THANH NGUYEN, M.D.,

Respondent.

Case No. 21-38084-1

SYNOPSIS OF RECORD[1]

1. Introduction

This matter was heard on May 26, 2022. Present in the Reno office of the Nevada State Board of Medical Examiners (the "Board") were Sarah Bradley, J.D. on behalf of the Investigative Committee (the "IC") and the undersigned hearing officer. Appearing and present on behalf of Respondent in the Las Vegas office of the Nevada Board of Medical Examiners were T. Charlotte Buys, Esq. on behalf of Respondent, and Respondent Hai Thanh Nguyen, M.D. Respondent, witness Sheila Marie Del Grosso, and Eduardo Angora, M.D. were present and appeared from the Las Vegas office. The remaining witnesses were present and appeared in the Reno office. All witnesses were sworn. The rule of exclusion was not invoked by either party.

2. Allegations

The Complaint alleges: Count I, NRS 630.301(4), Malpractice; and Count II, NRS 630.3062(1)(a), Failure to Maintain Proper Medical Records. *See* Exhibit 3 of **Exhibit B.** The Malpractice charge is premised upon the allegations that Respondent failed to obtain and document informed consent from the minor patient's parent regarding the administration of a Kenalog injection, and that Respondent administered the injection in the patient's buttock as

[1] Incorporated herein by reference is the full Transcript of the Hearing Proceedings, May 26, 2022, which is provided herewith as **Exhibit A** and referred to herein under the designation "TR," as well as the exhibits admitted at the hearing, which are indexed and provided herewith as **Exhibit B** for the IC Exhibits and **Exhibit C** for Respondent's Exhibits.

opposed to the patient's proximal lateral thigh, which is alleged to have ultimately caused a divot on the patient's left buttock. Id. The Failure to Maintain Proper Medical Records charge is premised upon the allegations that Respondent failed to document informed consent by the minor patient's parent by not documenting the discussion of risks and benefits of the Kenalog injection, and that the injection records were non-existent or incomplete. Id.

3. Witnesses and Testimony

In relation to the IC's case, the undersigned hearing officer heard from Ernesto Diaz, Chief of Investigations of the Nevada State Board of Medical Examiners (TR 24-46); Sheilamarie Del Grosso ("Ms. Del Grosso"), the minor patient's mother (TR 48-79); and Expert Witness Scott Hall, M.D. (TR 80-174). In relation to Respondent's case, the undersigned hearing officer heard from Melissa Vogt, R.N., a Clinical Educator at Intermountain Healthcare (TR 177-184); Ellen Aliberti, R.N., a Clinical Educator at Intermountain Healthcare (TR 184-196); Respondent Hai Thanh Nguyen, M.D. (TR 197-234); and expert witness Eduardo Angora, M.D. (TR 234-285).

The first witness called by the IC was Ernesto Diaz, Chief of Investigations of the Nevada State Board of Medical Examiners, who the IC called to authenticate exhibits. TR 27-31. Cross-examination of Investigator Diaz was utilized primarily to demonstrate his limited knowledge of the medical matters at issue in the case, save and except for the common utilization of third parties for record management (TR 39-41), and to inquire about a delay of several years from when the initiating complaint was received to when the formal complaint was issued, which was objected to and argued to be irrelevant by the IC. The objection to relevance was overruled to allow Respondent to establish a relevant basis for the line of questioning but it culminated with pointing out the delay with nothing more. TR 35-38.

The second witness called by the IC was Ms. Del Grosso, who is the minor patient's mother, and who testified that she initiated a complaint to the Board based upon the divot on her child's left buttock that had been attributed by the minor patient's pediatrician to the Kenalog injection administered by Respondent approximately four months prior (although the date that the divot actually occurred was never established). TR 49, 53. The divot was demonstrated in authenticated and admitted photographs. TR 52-54; IC Exhibit 6.

Ms. Del Grosso summarized the visit very tersely, acknowledging that she did not remember any discussion about the Prednisone or oral treatment; that she consented to the Kenalog injection; and that she was informed of at least some risk that she identified as being soreness at the injection site. TR 55-56, 61, 63, 66-67, 75-76. Ms. Del Grosso further testified that the divot filled in and there are no lasting affects other than a dark spot. TR 57.

On cross-examination, Ms. Del Grosso acknowledged that her child's symptoms, which were indicative of croup, had been worsening and that her child (also referred to as "Patient A," the minor patient, or the patient) had been hospitalized once prior for croup and was not required to be hospitalized after the Kenalog injection. TR 58-60, 75.

Overall, Ms. Del Grosso's recollection was poor. Ms. Del Grosso recalled asking that the injection be administered by a doctor as opposed to another health professional (TR 56, 78); was reminded and agreed that she had indicated that a prior oral prescription was insufficient to aid the minor patient (TR 62); and indicated the assistant in the room was a female, which none of the records support (TR 68). Ms. Del Grosso also spontaneously and emphatically indicated that Respondent, who was present in the same hearing room Ms. Del Grosso was testifying from, was not the doctor who treated the minor patient on the visit in question despite the records reflecting otherwise and Respondent later testifying that he was the treating physician. TR 63-66, 73, 77-78.

The IC's final witness was Scott Hall, M.D. who specializes in Family Medicine with an emphasis on acute musculoskeletal injuries and is further certified in Sports Medicine. TR 82; *see also* IC Exhibits 18-19. Dr. Hall acknowledged that the medical records reflect that the patient had been vomiting and indicated that he would have only given "oral corticosteroids" and not done an injection because it is the "preferred method" and an injection was "redundant." TR 85-86; 92-94. Dr. Hall repeated the word "preferred" when addressing the administration of oral medication as the sole treatment, contrasting that with the addition of the Kenalog injection, and referred to how he would have treated with only oral administration versus treatment with the oral administration coupled with the injection as a "subtle difference," although I believe he meant to distinguish as a subtle difference only the oral administration and the injection administration, individually. TR 86-87.

Dr. Hall's only other stated concern with Respondent's treatment of Patient A was the assertion that Respondent should have included a description of "what you did to inform the individual and acknowledge their consent." TR 88-89, p. 89, lines 8-11. Dr. Hall also interpreted a reference in the medical records regarding the patient's consent, specifically IC Exhibit 5, "[p]atient agrees with treatment plan and verbalizes understanding," as reflecting that the minor patient, who was only 23 months old, consented versus the patient's parent giving the consent. TR 91; 153. In further questioning, Dr. Hall indicated that it was his practice to have a separate sheet of paper signed by a parent or guardian of a minor patient to verify that they would like to proceed with an intramuscular or joint injection but further indicated that written consent was not required and "verbal may suffice." TR 91-92.

As to the divot alleged to have been caused by the Kenalog injection, Dr. Hall described it as atrophy of the subcutaneous tissue, which is a known complication. TR 95. Dr. Hall acknowledged records that he interpreted as indicating that the injection was administered intramuscularly in the right gluteal region by "Hampton, Chanel," who is Respondent's usual medical assistant but who was not working that day and noted that IC Exhibit 6 and Ms. Del Grosso's testimony indicated that the divot was present on Patient A's left buttock. TR 97-98; 147-49; 164-65; 221. Dr. Hall could not reconcile the picture of the divot (IC Exhibit 6) with the records demonstrating that the injection was administered in the right buttock versus the left buttock (Respondent Exhibit 12) except to say that the divot was consistent with "the kind of complication that would happen from a Kenalog injection." TR 167-68. Under continued questioning by the IC thereafter, Dr. Hall testified that the "most likely explanation" is that the Kenalog injection records identified the wrong injection site. TR 169.

Notably, some of the medical records alleged not to have been properly made were actually undertaken but had not been timely provided to and obtained by the IC because they were held by a third party records administrator. TR 120-21; 126; 130-31. As such, Dr. Hall had not reviewed them until the morning of the hearing, upon review of which Dr. Hall conceded that there were sufficient records demonstrating how the injection was administered, leaving only his concerns with giving oral combined with intramuscular treatment, and not documenting informed

consent to include a written reflection of "more discussion about the risks and benefits and alternatives." Id.; TR 122-23; 155; 166.

In defense, Respondent called both Melissa Vogt and Ellen Aliberti who are registered nurses employed by Intermountain Healthcare to authenticate records, which was unnecessary given the records had already been stipulated to and admitted, and training as provided to Respondent's medical assistants, which also was not at issue. As such, Respondent was allowed to proffer testimony, which the IC accepted, that Respondent's medical assistants were properly trained in providing patient injections and were also trained to properly document patient records. TR 192-93.

Respondent then testified on his own behalf. Respondent testified that Patient A had respiratory symptoms of cough, congestion, and nausea and had been vomiting for four days, for which Respondent had initially considered prescribing Prednisone to be administered orally. TR 197-98; 206. However, Patient A's mother was concerned about one of the Prednisone side effects, that being vomiting, compounding the vomiting Patient A was already experiencing. Id. Patient A's mother asked if there were any other treatment options, in response to which Respondent discussed an injectable form of medication, i.e., the Kenalog injection, and presented its side effects as being scarring, swelling, redness, and pain and bleeding at the injection site. TR 198; 208. According to Respondent, after his explanation of the side effects and benefits and alternatives of the injection, Patient A's mother was agreeable to the injection. Id. To this end, the patient records indicate that "[p]atient agrees with treatment plan and verbalizes understanding." IC Exhibit 5; Respondent's Exhibit 5, HCP 0002.

Respondent testified that he personally gave the injection after a failed attempt by medical assistant Barry Misiuk to administer the injection in Patient A's right buttock and that he remembers the injection he administered also being in the right buttock as a result of him being right handed and the position of the table in the room, specifically testifying that "[b]ecause the table in that room is positioned so that when the patient is lying on her stomach, her right buttock would be to the left side of the bed. And I'm right handed, so it would make it easier for me to place my hand on the right buttock and push down to help stabilize the patient and give [] the

injection with my right hand into the right buttock or gluteal area." TR 203-04; TR 228-30. Respondent testified that he diagnosed Patient A with a cough and possible croup based upon Patient A's history and the exam. TR 205. Respondent further reiterated that while he initially was intending to prescribe an oral treatment of Prednisone, it was after he came back to address the potential side effects with Patient A's mother that Patient A's mother asked about any alternative treatments and the injection was discussed, upon which Patient A's mother had indicated that Patient A had croup previously and required an injection to recover. TR 206. Respondent also testified that because of concerns about Patient A's vomiting and vomiting being a side effect of Prednisone, that an injection would help Patient A's recovery. TR 206. Per Respondent, it was reasonable to give the first dose of medicine via an injection so that he could ensure that Patient A would receive the medicine, not vomit up an oral dose, and recover quicker. TR 207-08; 216. Respondent explained this practice as a "loading dose." TR 218.

With regard to the specifics of the administration of the injection, Respondent stated that medical assistant Barry Misiuk first attempted to give the injection in Patient A's lateral thigh but was but unsuccessful because Patient A, who, again, was 23 months old, was moving quite a bit and so he inquired of Respondent as to an alternative injection site and Respondent suggested Patient A's gluteal area. TR 208-09. Per Respondent, he attempted to aid Barry Misiuk to give the injection in Patient A's right buttock but Patient A squirmed and the injection was not successfully administered. TR 209. Respondent testified that Patient A's mother then asked Respondent to himself give the injection, which he did. TR 210; 213.

Respondent's final witness was Eduardo Angora, M.D., whose CV can be found at Respondent's Exhibit 8. Dr. Angora testified that a divot is a rare and minor (as in not serious) complication of a steroid injection that usually resolves itself within a year (TR 238-39); that steroid injections are safe (TR 240); that Respondent met the standard of care (TR 241); that an oral steroid may be spit up by a young child or vomited back up if the child is nauseous (TR 241-42); that the injection was a definitive treatment, the administration and the success of which is not subject to guess work at a subsequent appointment (TR 242-44); and that there was no risk of overdosing given the amounts of steroids prescribed by Respondent (TR 258). Dr. Angora further

testified that it is common to obtain verbal only consent for a steroid injection and that every single complication from a steroid injection is not documented and that only the major complications or the ones that are more striking would be discussed as opposed to rare or uncommon complications. TR 249. Dr. Angora further testified that he would have expected there to be an impact on Patient A's gait, i.e. her walking as in with a limp, if the divot had been caused by muscular atrophy form the injection, which there was no mention or evidence of, and that the divot pictured in IC Exhibit 6 could have been caused by spontaneous lipodystrophy or post-traumatic lipodystrophy and not just an injection. TR 253-54; 266. Dr. Angora also found the medical records to be sufficiently documented. TR 259.

4. Further Dispositive Testimony.

Dr. Hall testified that croup is deadly and Patient A was not hospitalized after being treated by Respondent. TR 139-40.

Dr. Hall testified that injections could lead to muscular atrophy regardless of how they are administered. TR 140-41.

Dr. Hall relied upon several articles in rendering his testimony, the publication of some of which post-dated the treatment of Patient A by Respondent, the majority of which were not discussed in any real depth, and the most relevant of which, as Dr. Hall acknowledged on cross-examination, established that prior to 2018 the recommended injection site for a Kenalog injection was into the gluteal muscle. TR 141-46; Respondent's Exhibit 11, p. 17, which is a complete copy of IC Exhibit 10. The same publication additionally acknowledged the approved administration of Kenalog injections for pediatric patients. Respondent's Exhibit 11, p. 13.

Assuming the divot was located on the buttock on which the Kenalog injection was administered, Dr. Hall acknowledged that the divot could have been caused by trauma including a fall. TR 147-52, 150-51.

Dr. Hall conceded it would be reasonable to consider an injection when "oral steroids alone had previously not helped worsening symptoms." TR 157.

Dr. Hall testified that muscular atrophy from a Kenalog injection is a rare complication and that, while it is the responsibility of a physician to discuss common and serious side effects, it

is not the standard of care to document every single complication. TR 169-70. This same standard was also testified to by Dr. Angora. TR 249.

The medical records provide that "Patient agrees with treatment plan and verbalizes understanding." Respondent's Exhibit 5; TR 211; 215. This would have obviously been a reference to Patient A's parent given that Patient A was 23 months old and clarifying it was the parent and not the two year old patient would be unnecessary. TR 211-12; 250; IC Exhibit 5; Respondent's Exhibit 5.

Respondent's Exhibit 12 reflects that injection was ordered by Respondent to be given by Chanel Hampton, which was the result of an auto-population in the record keeping program given that Chanel Hampton was Respondent's assigned medical assistant (TR 230), but Chanel Hampton had called in sick that day and Barry Misiuk was filling in. TR 221-22; Respondent's Exhibit 6. Respondent testified that the notation did not mean that Chanel Hampton herself gave the injection but that she was ordered to and that a separate notation that gives Respondent's name and indicates "complete" is the relevant record that references Respondent gave the injection. TR 223. Respondent's reference in the records indicating he gave the injection is found at Respondent's Exhibit 5, HCP 0017, which is a Medication List and provides for the Kenalog injection and under Provider Status reads "HAI NGUYEN Complete." Similar references are found in the same Exhibit at CHP 0002 under Plan and at Respondent's Exhibit 12, on the second page in the progress notes to the left. Respondent also relied upon Respondent's Exhibit 6. While the "Admin By" referenced to Chanel Hampton in Respondent's Exhibit 12 seemed to cause some confusion and Dr. Angora somewhat acknowledged the same, Dr. Angora further noted that Respondent addressed the confusion in his testimony and provided documentation demonstrating that he gave the Kenalog injection. TR 277-78.

5. Veracity of Witnesses.

Undersigned found Respondent to be credible in his testimony and the account of the treatment of Patient A. While the time that had passed certainly caused difficulty as demonstrated by Ms. Del Grosso's testimony, Respondent, whether he had an independent recollection, which Respondent testified was the case (TR 202-03), or his memory was refreshed by the medical

records, his account was clear and his testimony came across as genuine as did his sincere expressions of concern and passion for his practice as came through when he testified.

As Ms. Del Grosso testified, this matter was commenced based upon the divot on Patient A's buttocks and the concern raised by a third party physician that what was presumed to be the Kenalog injection was not administered to children "anymore." TR 49. There was absolutely no testimony given that substantiated the statement to Ms. De. Grosso by the third party physician that Kenalog injections were no longer administered to children and, in fact, guidance relevant to the time-frame at issue established otherwise. Respondent's Exhibit 11, p. 17.[2]

Given the recollections as between Ms. Del Grosso as contrasted with that of Respondent, undersigned also cannot conclude that the medical records have the location of the injection recorded wrong, nor was that allegation stated in the Complaint, rendering there being no notice of the same and, therefore, no basis upon which to hold Respondent responsible for such even if it had been determined to be credible. Testimony as to the explanation of the conflicting location of the injection was based upon speculation that the medical records *could* have been wrong and both expert physicians addressed that there were other potential causes of the divot.

Even assuming that the divot was caused by the injection, given the seriousness of the symptoms displayed by Patient A, Patient A's vomiting, and Patient A's mother's indication that an injection was previously necessary to aid Patient A, I find it wholly credible that the injection was reasonably administered regardless of whether a divot may have resulted, particularly as it is a rare, not serious, and self-correcting complication. Further, neither of the expert witness physicians noted that the potential of the injection causing a divot should have been discussed as a common and serious potential side effect. Even further, the injection seems to have contributed to the improvement of Patient A's symptoms as evidenced by the fact that Patient A was not thereafter hospitalized.

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[2] IC Exhibit 11 is a subsequent version of Respondent's Exhibit 11, which had been revised as of June 2018. Respondent's Exhibit 11 is also the whole version of IC's Exhibit 10, which was revised June 2011 and represented as applicable in the relevant time frame of November 4, 2016.

With regard to the credibility of the expert witness physicians, I found both to naturally advocate for the side for which they were retained. Having said that, I noted that while Dr. Hall testified in favor of an alleged breach of the standards necessary to find Respondent responsible for both counts against him, Dr. Hall did so when asked for conclusory statements to that effect. When asked as to the specifics underlying such claims, Dr. Hall chose his words cautiously and did not support the allegations with the substance of his testimony.

As to Court I Malpractice, Dr. Hall merely called an oral administration of medications "preferred" and seemed to fail to take into account or minimized the effect of the patient's vomiting, which was quantified in the Complaint to imply that vomiting must be "constant" throughout the day to support an injection, as to which there was no supporting testimony. Dr. Hall also failed to account for how a "redundant" administration of the Kenalog injection could be deemed malpractice, particularly where, as here, every indication is that is aided with Patient A's recovery as it had in the past as indicated by Patient A's mother Ms. Del Grosso who consented to the injection as evidenced by her testimony, the records, and her participation in the treatment. Dr. Hall further conceded that administration of the Kenalog injection to a pediatric patient was acceptable as was injection to the gluteal area, which was the most common location for administration. TR 144-146. Dr. Hall also never took issue with the dosage as would have resulted from the Kenalog injection followed thereafter by oral medication.

There was emphasis in questioning as to consent versus informed consent; however, the situation as addressed through Ms. Del Grosso's testimony and as further clarified by Respondent credibly demonstrated that consent for the injection was obtained. In fact, the treatment was instigated by Ms. Del Grosso's own inquiry and statement with regard to a prior injection, and there was no evidence that the injection was required to be given in the lateral thigh as opposed to the buttocks. Further, the relevant Bristol-Myers Squibb Company Information for Intramuscular or Intra-Articular Kenalog Injection guideline provided for a gluteal injection. *See* Respondent's Exhibit 11, p. 17 (which is the full version of IC Exhibit 10). Notably, the remainder of the Malpractice claim allegations were conceded as being unsubstantiated based upon the late

production of the relevant treatment records, which also impacted the Failure to Maintain Proper Medical Records claim as set forth below. TR 122-23.

Given the late production of the medical records and Dr. Hall's review of the same, Dr. Hall testified that his only remaining concern was Respondent not documenting informed consent to include a written reflection of "more discussion about the risks and benefits and alternatives." TR 122-23. This position; however, is contrary to his testimony that verbal consent is sufficient (TR 92), which was also testified to by Dr. Angora. TR 249. Undersigned also does not find it credible that any reasonable person reviewing the medical records would deem consent to have been given by a 23 month old child as opposed to a parent or guardian who was recorded to be present.

Respondent testified that he informed Patient A's mother of potential side effects for both the Prednisone and the Kenalog injection, the very discussion of which prompted the Kenalog injection being administered; and, while Ms. Del Grosso's recollection was not good, she did recall some such discussion as to which Respondent notated that "[p]atient agrees with treatment plan and verbalizes understanding," which documents a treatment plan discussion and consent thereto. IC Exhibit 5. This belies the Complaint allegation that "Respondent failed to document an informed consent . . . and discuss the risks and benefits of the medication before giving it to the child." IC Exhibit 3. As to the remainder of the allegations in support of Count II Failure to Maintain Proper Medical Records, they have been conceded as disproven by the medical records recently produced.

6. Conclusion.

Undersigned is tasked with providing a synopsis of the testimony and making a recommendation on the veracity of witnesses if there is conflicting evidence or the credibility of a witness is a determining factor. I have done so. With that, I submit that it is within the purview of the Board to determine if the charges have been established by a preponderance of the evidence. To the extent my authority allows me to weigh in on that via a determination of

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credibility, I submit such a burden has not been met in this matter as to either count alleged in the Complaint against Respondent for the reasons set forth herein.

RESPECTFULLY SUBMITTED this 21st day of July 2022.

Patricia Halstead, Esq., Hearing Officer for the
Nevada State Board of Medical Examiners
615 S. Arlington Ave.
Reno, NV 89509
(775) 322-2244
phalstead@halsteadlawoffices.com

CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 22nd day of July, 2022, I served a file-stamped copy of the foregoing **SYNOPSIS OF RECORD (with Exhibits)**, via USPS Regular Mail and electronic mail, to the following parties:

HAI THANH NGUYEN, M.D.
c/o T. Charlotte Buys, Esq.
McBride Hall
8329 West Sunset Road, Suite 260
Las Vegas, NV 89113
Email: tcbuys@mcbridehall.com
Attorney for Respondent

PATRICIA HALSTEAD, ESQ.
Halstead Law Offices
615 S. Arlington Ave.
Reno, NV 89509
Email: phalstead@halsteadlawoffices.com
Hearing Officer

DATED this 22nd day of July, 2022.

MEG BYRD
Legal Assistant
Nevada State Board of Medical Examiners

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EXHIBIT A

EXHIBIT A

In the Matter Of:

Nevada State Board of Medical Examiners

TRANSCRIPT OF HEARING PROCEEDINGS

May 26, 2022

Job Number: 870731

BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

In the Matter of the Charges and Complaint Against:	)	Case No. 21-38084-1
HAI THANH NGUYEN, M.D.,	)	
Respondent	)	

TRANSCRIPT OF HEARING PROCEEDINGS

Held at the Nevada State Board of Medical Examiners

9600 Gateway Drive

Reno, Nevada

Thursday, May 26, 2022

REPORTED BY:
NICOLE J. HANSEN
NV. CCR NO. 446
CAL. CSR 13909
RPR, CRR, RMR

Job No.: 870731

APPEARANCES:

The Hearing Officer:

PATRICIA HALSTEAD, ESQ.
Halstead Law Offices
615 South Arlington Avenue
Reno, Nevada 89509

For the Investigative Committee
of the Nevada State Medical
Board of Examiners:

SARAH BRADLEY, ESQ.
Deputy Executive Director
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
Bradleys@medboard.nv.gov

For the Respondent, Hai Thanh Nguyen, M.D.:

T. CHARLOTTE BUYS, ESQ.
8329 W. Sunset Road, Suite 260
Las Vegas, Nevada 89113

Also Present:

MARGARET BYRD & MERCEDES FUENTES
Legal Assistants
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

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RENO, NEVADA; THURSDAY, MAY 26, 2022; 8:25 A.M.

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HEARING OFFICER HALSTEAD: This is Case Number 21-38084-1, in the matter of the charges and complaint against -- and correct me if I pronounce this wrong -- Hai Thanh Nguyen, M.D.

Is that correct, Mr. Nguyen?

DR. NGUYEN: That is correct. Yes, Dr. Nguyen. Yes.

HEARING OFFICER HALSTEAD: Dr. Nguyen. Thank you. We're here on the complaint filed on November 3rd, 2021. There's two counts alleged. The first is malpractice, and the second is failure to maintain proper medical record.

Can the parties please state their appearances for the record.

MS. BRADLEY: Sarah Bradley, Deputy Executive Director, on behalf of the Investigative Committee of the Nevada State Board of Medical Examiners.

HEARING OFFICER HALSTEAD: Thank you.

MS. BUYS: And Charlotte Buys, on behalf of respondent, Dr. Hai Nguyen.

HEARING OFFICER HALSTEAD: And Dr. Nguyen is

the person, I think, on your right. He would be my left.

DR. NGUYGEN: That is correct.

HEARING OFFICER HALSTEAD: All right. And I understand that there are witnesses in both locations at this time. I would like to have everyone raise their right hand and be sworn in, all of the witnesses who are appearing, and I can't see all of the witnesses.

Ms. Buys, can you confirm that they're going to take the oath or have them stand behind you?

MS. BUYS: There we go. Certainly.

HEARING OFFICER HALSTEAD: Thank you. And the witness you have present again, can you state his name for the record?

MS. BUYS: Certainly. It is Dr. Eduardo Anorga.

HEARING OFFICER HALSTEAD: Thank you. And your witness?

MS. BRADLEY: Ernesto Diaz. I do have other witnesses that aren't present yet. Ms. DelGrosso, I believe is going to be attending in Las Vegas, and then I also have Dr. Hall, who is not here yet.

HEARING OFFICER HALSTEAD: Okay. So for the witnesses who are here whose arms are probably getting tired because they're still up, do you swear to tell the

truth, the whole truth and nothing but the truth?

MR. DIAZ: I do.

HEARING OFFICER HALSTEAD: Sorry. Dr. Anorga, was it? I didn't quite hear you.

DR. ANORGA: I do.

HEARING OFFICER HALSTEAD: Thank you. All right. Was anyone going to invoke the rule of exclusion?

MS. BRADLEY: No, I don't invoke that at this time.

MS. BUYS: No, not at this time. Thank you.

HEARING OFFICER HALSTEAD: Thank you.

Ms. Bradley, with that, did you want to proceed with opening statement?

MR. BRADLEY: I did. I do think we have a couple of preliminary matters though that we may want to discuss before we get started. The first is there is a typographical error in the complaint on the first page of that which is at number two, Paragraph Number 2. It says on November 11th, 2016, and it really should be November 4, so if we could just cross out the 11 and make that a 4. And I believe Ms. Buys is in agreement to that amendment.

HEARING OFFICER HALSTEAD: Ms. Buys?

MS. BUYS: That is correct.

HEARING OFFICER HALSTEAD: Thank you.

MS. BRADLEY: The other stipulation I believe that we have based on the answer that Dr. Nguyen provided to the complaint, he did agree with Paragraph 1 in the complaint, which is: Respondent was, at all times relative to this complaint, a medical doctor holding an active license to practice medicine in the State of Nevada. That's License Number 13702, and respondent was originally licensed by the Board on September 15th, 2010. So I think we can actually stipulate to the truth of that statement before we get started.

HEARING OFFICER HALSTEAD: Ms. Buys?

MS. BUYS: Yes, Your Honor.

MS. BRADLEY: The other stipulations that we have have to do with exhibits. So I believe Ms. Buys is willing to stipulate to Exhibits 1 through 5 for the Board. So that's the allegation letter that was sent to Dr. Nguyen, his response, the complaint that was filed on November 3rd, 2021, the answer to the complaint, and then the Patient A's medical records, Exhibit 5 for the Board.

HEARING OFFICER HALSTEAD: Ms. Buys?

MS. BUYS: Yes, we did agree to Exhibits 1 through 4, and as well as to the admission of the medical records, but we also wanted to introduce Respondent's

exhibit which is a more complete set of the records that was provided.

MS. BRADLEY: Yeah. I was going to get to that next.

MS. BUYS: Perfect. Just wanted to clarify that for the record.

MS. BRADLEY: And so we would also agree to admit -- and by my count, oh, yeah, I do have 12. Okay. So we would stipulate to the admission of Respondent's Exhibits 1 through 12, but I do want to put a note on the record that pages 5 through 17 of Exhibit 5 from the Respondent were not provided to the Board with Dr. Nguyen's initial response into the investigation. They were provided at the prehearing conference, but it would have been nice if they were provided prior to that.

HEARING OFFICER HALSTEAD: Which exhibit?

MR. BRADLEY: Exhibit 5, pages five through 17, and which she says is more complete. For whatever reason, the Board received, I think, three pages of medical records, but this is actually 17 pages of medical records.

In addition, the items in Exhibit 6 from Respondent were not provided to the Board with regard to the investigation. We do still stipulate that they be

admitted, which is that note that we didn't have them at the time of the investigation, and it would have been nice to have them.

Exhibit 7, we do agree to have it be admitted. However, we think it has limited relevance, but given that the standard is so low, we're not going to object. But we would just note that Exhibit 7 is an operating procedure at HealthCare Partners of Nevada. You know, we don't really think a procedure is at issue here. It's really what Dr. Nguyen did or didn't do.

The other concern that we have with that exhibit is that it was last revised on January 13, 2020, and of course the incident in this case occurred on November 4, 2016. But just to speed things along, we would stipulate to the admission of all of the exhibits from Dr. Nguyen.

HEARING OFFICER HALSTEAD: Ms. Buys, is there anything you wanted to add?

MS. BUYS: Certainly. We also share in the Board's frustration regarding the additional records that were located and then I believe Ms. Bradley and I corresponded back and forth on Respondent's objections to Board's exhibits, specifically the articles which are, you know, were written after the date of care is not

relevant as to the standard of care, so they didn't exist at the time the care and treatment was provided back in 2016. And certainly, you know, require foundation.

MS. BRADLEY: Yeah. I don't know that we have to talk about that because I'll get those in when I call my witnesses. I was trying to go through the things that we agreed on. And I did want to note for the record that Exhibit 12 was provided to me on Monday, May 23rd, and I believe that our Madame Hearing Officer also does have a copy of that, Exhibit 11 and 12. So 11 is the administration record of the shot that was provided to Patient A.

And also, just if we could, throughout the hearing, we would prefer to refer to the patient as Patient A. I believe there was a patient designation provided to Mr. Nguyen ahead of time. I think we all know looking at the records, but just because the transcript does end up potentially becoming a public document, normally we don't include the patient's name when we don't have to.

So, yeah, Exhibit 11 was provided on Monday, which was, I think, three days ago, if my math is right. And so we will ask our expert about that because we didn't have it before and we actually didn't even have it

at the prehearing conference. But I think based on Exhibit 12, which is an affidavit from a nurse working for the facility, there's at least an attempt to address the good cause argument, so if we could stipulate to that being admitted. Thank you.

HEARING OFFICER HALSTEAD: Okay. I note for the record that I don't have numbered Respondent's exhibits. I have all of the exhibits which I've printed out which were provided to me with the prehearing conference disclosures. So if you guys were going to number them in the order they were disclosed and stipulate to them, then I need a minute to mark them on my end because I don't have marked exhibits for Respondent.

MS. BRADLEY: Okay. Do you want me to for the record just say what they are? Would that help?

HEARING OFFICER HALSTEAD: Well, I'll say them on the record. So Respondent's Exhibit 1 will be the Board of Medical Examiners of the State of Nevada complaint filed November 3rd, 2021.

MS. BRADLEY: Oh, I have that as Exhibit 34 for Dr. Nguyen. I have -- well, at least Tab 1 was the prehearing conference disclosure. Did you want that to be an exhibit?

MS. BUYS: That's fine.

MS. BRADLEY: I was just looking at, I think, the binder cover page. So I was labeling that Dr. Nguyen's prehearing conference disclosure as Exhibit 1.

HEARING OFFICER HALSTEAD: Did that include the supplement?

MS. BRADLEY: I believe it -- Well, this one, the copy I have doesn't, but it should.

HEARING OFFICER HALSTEAD: Okay. All right. So maybe you can just give me your cover and I can print it out.

MS. BRADLEY: Okay. I'll give you what I have. And then I would have to add the 9 because 9, 10, 11 and 12, I don't have on this cover page, but I do have them tabbed in my binder.

HEARING OFFICER HALSTEAD: This is just 1 through 8.

MR. BRADLEY: Yeah.

HEARING OFFICER HALSTEAD: But you were stipulating from 1 through 12.

MS. BRADLEY: Yeah, because 9 was added later. It's an article that was provided. The title of the article is Comparison of Corticosteroids for Treatment of Respiratory.

HEARING OFFICER HALSTEAD: Okay. Well, let me ask you this. If I go with the conference, the prehearing conference disclosures and I go with the second supplement that has them all listed 1 through 12, is it really going to be 2 through 13 and then disclosures will be 1? Are they in the same order?

MS. BRADLEY: I think so.

HEARING OFFICER HALSTEAD: All right. Just give me a moment and I'll mark them, please.

Okay. So for the record, I have Respondent's Exhibit 1 is Dr. Nyugen's prehearing conference disclosure on the first and second supplements thereto; Respondent's Exhibit 2 is the complaint; Respondent's Exhibit 3 is Dr. Nyugen's answer; Exhibit Number 4 is what's marked as Dr. Nyugen's Board response letter dated April 24th, 2017. Respondent's Exhibit 5 is the medical records from HealthCare Partners. Exhibit Number 6 is the Medical Administration Log, and that commences with a Certificate of the Custodian of Records. Respondent's Exhibit Number 7 is the Standard Operating Procedure for Injectable Medication Administration.

Respondent's Exhibit Number 8 is the Curriculum Vitae of Dr. Eduardo Anorga. So sorry I have this mental block with names, and I'm just paranoid of

saying them badly, so I apologize. Respondent's Exhibit Number 9 the IBM Micromedex information for pediatric administration of Kenalog. Respondents --

MR. BRADLEY: I have something else for 9. Do you have the same, Ms. Buys, for Number 9? Because I have Comparison of Corticosteroids for Treatment of Respiratory Syncytial Virus.

MS. BUYS: I have for Number 9 IBM Micromedex Information for Pediatric Administration of Kenalog.

MR. BRADLEY: No, it doesn't seem to be flipped. I can check with my assistant. Maybe she can get me that copy. Can we look at your cover page real quick just to see what it looks like? Maybe I have it in there. Maybe I used a different binder. Okay. All right. I think I do have it.

HEARING OFFICER HALSTEAD: Okay. Exhibit Number 10, I have the American Society for Microbiology Comparison of Corticosteroids for Treatment of Respiratory Synctial Virus, Bronchiolitis and Pneumonia in Cotton Rats. And for Respondent's Exhibit Number 1, I have Bristol-Myers Squibb Company information for intramuscular or Intraarticular Kenalog Injections revised June 2011.

For Respondent's Exhibit 12, I have

Medication Administration Details. And for Exhibit Number 13, I have the Declaration of Melissa, I think Vogt, RN, regarding Medication Administration Details.

Ms. Buys, is that correct on your end?

MS. BUYS: Yes, that is correct.

HEARING OFFICER HALSTEAD: Do you need a minute?

MR. BRADLEY: Maybe at the break, we'll just adjust them because for some reason, I have 12. I don't think it's a big deal at this point given that we'll be presenting our case first, and I don't really have any questions about most of these exhibits anyway.

HEARING OFFICER HALSTEAD: Okay.

MR. BRADLEY: But if I do happen to refer to the wrong number, hopefully, I'll be corrected.

HEARING OFFICER HALSTEAD: And all of the exhibits have been stipulated to; correct?

MS. BRADLEY: Yes.

HEARING OFFICER HALSTEAD: Then for the record, those are all admitted.

MR. BRADLEY: Thank you.

HEARING OFFICER HALSTEAD: Anything before we commence?

MR. BRADLEY: No, not from me, thank you.

THE COURT: Ms. Buys, anything further?

MS. BUYS: Not from us. Thank you.

HEARING OFFICER HALSTEAD: Thank you. All right. Go ahead, Ms. Bradley.

MR. BRADLEY: So the Investigative Committee of the Board authorized the filing of a formal complaint against Dr. Nguyen charging --

HEARING OFFICER HALSTEAD: Just go slow.

MR. BRADLEY: Oh, sorry. Charging one count of malpractice in violation of NRS 630.301 Sub 4 and one count of failure to maintain timely, legible, accurate and complete medical records regarding the diagnosis, treatment and care of a patient in violation of NRS 630.3062, Sub 1, Sub A.

Part of the reason that we're here today is that Dr. Nguyen failed to provide complete and accurate medical records to the Board in 2017 when responding to the Board regarding this investigation. In fact, on Monday, May 23rd, 2022, Dr. Nguyen provided a record of the injection for Patient A which resolves part of the concerns originally identified in this case. Still, the Board's peer reviewer, Dr. Hall, has concerns regarding Dr. Nguyen's care of Patient A in this case, and the Investigative Committee believes that a preponderance of

the evidence will show that the violations of law alleged in the complaint support the claim of malpractice which is the failure to use reasonable care, skill or knowledge ordinarily used under similar circumstances and failure to maintain timely, legible, accurate and complete medical records.

Specifically, Dr. Hall will testify that Dr. Nguyen failed to obtain informed consent from Patient A's parents for a Kenalog injection, the Kenalog injection was unnecessary both because it was a duplicate medication, and the medical records do not support that oral therapy for Patient A was not feasible and Dr. Nguyen injected Patient A superficially with the Kenalog which caused local atrophy. The IC will also ask Patient A's mother to testify regarding the care that her daughter received from Dr. Nguyen and will admit exhibits that support the allegations as contained in the complaint. So thank you.

HEARING OFFICER HALSTEAD: Thank you.

Ms. Buys, did you want to have an opening now or would you prefer do that at the opening of your case ?

MS. BUYS: We can do the opening now. Thank you very much, Madame Hearing Officer. My name is Charlotte Buys, and I have the honor of representing Hai

Nguyen, M.D. I want to thank everyone for their time here today.

Dr. Nguyen has practiced as a family medicine specialist in Las Vegas since 2010 and treats urgent care patients, many of whom don't have the luxury of going to a primary care physician or pediatrician and who, if left untreated, may have their condition rapidly become a crisis or an emergency condition. Dr. Nguyen takes his responsibilities as a physician very seriously.

The evidence will demonstrate that Dr. Nguyen met the standard of care providing care and treatment to Patient A. Patient A's parents brought her to an urgent care clinic on November 4, 2016, seeking care for their child following days of coughing, wheezing, a runny nose, vomiting, congestion, and worsening symptoms even though she had a scheduled pediatrician appointment in a few days, all in the backdrop of it being reported that the patient had two prior instances of croup.

The evidence will show that Dr. Nguyen appropriately examined the patient and came to formulate a treatment plan to prescribe the patient with an oral steroid, Prednisone. Dr. Nguyen explained the risks, benefits and treatment alternatives to that treatment. However, the evidence will also show that after this

initial treatment plan, Dr. Nguyen was told additional information by the patient's mother that the child did not get better when she previously had these respiratory symptoms until she received an injection of an antiinflammatory medication.

Based upon that new information, Dr. Nguyen will testify that he felt that it was reasonable to prescribe an injection of a steroid to help decrease inflammation and provide a faster treatment until the oral medication could take effect.

The evidence will show that prior to any administration of Kenalog that Dr. Nguyen discussed the risks, benefits and alternatives to treatment of the Kenalog injection and that the patient's parent agreed with the treatment plan, verbalized understanding, and even helped hold her child to assist in the administration of the injection.

Moreover, the evidence will show that this verbal consent given by Patient A's pediatric patient's mother was documented in the patient's medical record. However, while a medical assistant attempted to give the injection with the help of the patient's mother and holding the patient still, he was unable to press the plunger of the syringe to administer the medication

because Patient A, a pediatric patient, was like most children: Fussy and not too crazy about getting an injection.

The evidence will demonstrate that the patient's mother then specifically requested that Dr. Nguyen himself administer the injection and that the patient's mother helped hold and position the child so that the injection could be administered safely.

The child was then monitored for an appropriate period of time before leaving the clinic. At no time did the child demonstrate any adverse effects of the injection nor did the patient's mother raise any concerns. This single visit on November 4th, 2016, was the only time Dr. Nguyen treated this patient.

There are only two issues in this matter: Whether it was reasonable to administer a steroid injection to the patient based upon the information that Dr. Nguyen had available when he provided care back on November 4th, 2016, and whether there was consent for the administration of the steroid injection. The evidence will show Dr. Nguyen met the standard of care and that it was reasonable administering the Kenalog injection and that Dr. Nguyen received consent prior to administering the medication and that consent was documented.

There was also originally another allegation regarding failure to document the specific details of the medication such as the vials' identification, lot number, expiration.

However, days before this hearing, of medication administration detailed record for Patient A was located as it is kept separately from the rest of the patient's medical record. It seems that with treating the record, a person from the medical records retrievable company, which was a third party who obtained the records, only pressed some of the checkboxes to get all of the documentation and missed pressing an additional button. Both Dr. Nguyen and the Board independently sought these records, and once the record was located, the same day Dr. Nguyen received that record, it was sent to the Board.

What is important and the entire purpose of this proceeding is to show the truth, and the evidence will show Dr. Nguyen met the standard of care. Thank you very much.

HEARING OFFICER HALSTEAD: Thank you, Ms. Buys. Based on Ms. Buys' representation about Count 2, are you still proceeding on that?

MR. BRADLEY: Yeah, no. We believe that the

records are still deficient. They just aren't deficient in all of the ways we originally identified.

HEARING OFFICER HALSTEAD: Okay. And so just for me so I can pinpoint as we go through testimony, what are you relying on with regard to the records?

MR. BRADLEY: Dr. Hall will testify that the informed consent was not documented properly. I believe there's also concerns regarding the injection location and how that was documented, so we're not willing, at least at this time, to dispense with the record. I think initially, the most glaring error was the omission of the information regarding the injection, but we have that now, but we still have concerns regarding the record.

HEARING OFFICER HALSTEAD: Ms. Buys, does that clarify for you as well? Were you aware of that?

MS. BUYS: Thank you for the clarification from Ms. Bradley. And as the evidence will show, the location of the administration is documented in that additional record as well.

HEARING OFFICER HALSTEAD: All right. Ms. Bradley, would you like to call your first witness?

MS. BRADLEY: I would. I would call Ernesto Diaz.

DIRECT EXAMINATION

BY MS. BRADLEY:

Q Mr. Diaz, would you please state your name and spell your list name for the record.

A Ernesto Diaz: D-I-A-Z.

Q And who is your employer?

A The Nevada State Board of Medical Examiners.

Q What is your job title?

A I'm the Chief of Investigations.

Q How long have you had that position?

A Approximately two years and three months.

Q Do you have any other investigations experience?

A I do.

Q With where and when?

A I was a border patrol agent for four years in San Diego, California. After that, I was an ATF special agent for approximately 21 years throughout the U.S., retiring as a senior management assistant special agent in charge.

Q And as a Chief of Investigations for the Nevada State Board of Medical Examiners, what are your duties?

A I oversee the day-to-day operations of the

Investigations Division, I review all complaints that come to the Division, to the Board, I determine jurisdiction of those complaints, I assign complaints that are open. I assign investigators. I also report disciplinary actions to government entities and other agencies.

Q And do you also investigate cases that come into the Board?

A I do.

Q When a complaint comes in, what happens?

A I review the complaint, number one, to determine if they are a licensee of our Board. Number two: I review the allegations to see if they fall within the Medical Practice Act. Number three: We open the case if it's within our jurisdiction, and then it's assigned to an investigator.

Q And when an investigation is opened, does the Board create a file for that matter?

A Yes, we do create a hard copy case file.

Q Are you familiar with Investigation 17-17109 regarding Dr. Nguyen?

A Yes, I am.

Q And is that this case?

A That is correct.

Q Just for the record, were you the original investigator on this case?

A I was not.

Q Do you know who was?

A I do.

Q Who was that?

A It was Laura Ward.

Q And as the Chief of Investigations, what do you do with cases after an investigator is no longer employed by the Board?

A I reassign those cases to other investigators or myself.

Q Did you take over this case?

A I did.

Q And as the Chief of Investigations, are you familiar with the procedure used by the Board when investigating cases?

A Yes, I am.

Q Have you reviewed the file for this case?

A I have.

Q And based on your review, does this case appear to be similar to other investigations handled by the Board?

A Yes, it does.

Q Okay. So let's go ahead and at least get some information regarding the exhibits that we have. So they've already been admitted, at least the first few that we're going to talk about. Would you turn to your binder to what's been admitted as the Board's Exhibit 1.

HEARING OFFICER HALSTEAD: Just for the record, I just admitted Respondent's exhibits because I thought they were duplicative, so I know you stipulated through the Board's Exhibits 1 through 5, so those will be admitted.

MR. BRADLEY: Okay. Thank you.

HEARING OFFICER HALSTEAD: Ms. Buys, any issue with that?

MS. BUYS: No. Thank you very much, Madame Hearing Officer.

Q (BY MR. BRADLEY:) So what is Exhibit 1?

A Exhibit 1 is an allegation letter that investigators send to licensees of the Board that describe the allegations in the complaint that was filed with the Board.

Q Okay. And what were the allegations in this allegation letter?

A That there were failed attempts to provide injections on the patient, when it was subsequently

administered to the patient, there was indentation provided or indentation as a result of the injection site.

Q Okay. Let's go to what's been admitted as the Board's Exhibit 2. Do you recognize this document?

A Yes, I do.

Q And what is it?

A It's a response letter from Dr. Nguyen to Investigator Ward.

Q And what's the date? I guess just for the record, what's the date of the allegation letter which was Exhibit 1 and what's the date of the response?

A The date of the allegation letter is March 28th, 2017, and the date of the response from Dr. Nguyen is April 24th, 2017.

Q Okay. Perfect. And then let's go to Exhibits 3 and 4 that have also been admitted. What is Exhibit 3?

A Exhibit 3 is the formal filing of a complaint that the medical board files after the Investigative Committee has reviewed the case.

Q Okay. And what's Exhibit 4?

A Exhibit 4 is Dr. Nyugen's response to the formal complaint that was filed.

Q And let's turn to Exhibit 5 that has also been admitted. What is Exhibit 5?

A Exhibit 5 are patient records from Patient A that are submitted as part of the response when we send an order to produce healthcare records.

Q Okay. And how many pages do you show that Exhibit 5 is?

A I show approximately three pages.

Q And then I'm going to ask you about some exhibits that have not been admitted, and I'm not intending to have them be admitted at this time, but I just want to lay a little bit of foundation for them before we proceed. So would you please turn to what's been pre-marked as the Board's Exhibit 6.

A Okay.

Q Do you recognize that document?

A I do.

Q What is it?

A Exhibit 6 was an attachment or a supplemental information that the complainant provided to the Board as part of their complaint, and it's a photograph.

Q Okay. And so does this appear to be a true and correct copy of what the Board has in the investigative file for this matter?

A Yes, it does.

Q Okay. Thank you. Would you turn then now to Exhibit 7 through 17.

A Okay.

Q Do you recognize those exhibits?

A I do.

Q And what are they?

A Exhibit 7 through 17 are referenced materials, articles that were written, reviewed or submitted with the peer-reviewed report.

Q And is it unusual for the Board to receive articles when there's a peer review?

A No, we ask peer reviewers to cite any reference material they've used in writing their report.

Q Okay. And these appear to be true and correct copies of the articles that were received from Dr. Hall?

A Yes, they do.

Q And then let's turn to Exhibits 18 through 19, premarked, not admitted. Do you recognize these documents?

A I do.

Q And what are they?

A Curriculum vitae of Dr. Scott Hall.

Q And how did the Board receive them?

A When we select someone to be a peer reviewer, we request a CV from them, and then in addition, when they do a report for us, a peer-review report, we request that they submit an updated CV as well.

Q Okay. And do these appear to be a true and correct copy of the CV's on file for Dr. Hall?

A Yes.

MS. BRADLEY: I have no further questions for Mr. Diaz at this time.

HEARING OFFICER HALSTEAD: Ms. Buys?

MS. BUYS: Yes. Thank you so much. Mr. Diaz, can you hear me all right?

THE WITNESS: Yes, I can hear you.

CROSS-EXAMINATION

BY MS. BUYS:

Q Perfect. I always want to make sure with, you know, video technology. Mr. Diaz, I believe that you just testified that you have been employed by the Board of Medical Examiners for about two years, three months. Is that correct?

A That is correct.

Q So would that be approximately March of 2020

is when you were first hired?

A That is correct.

Q Perfect. I like to double-check my math. And other than working for the Nevada Board of Medical Examiners, are you currently employed anywhere else?

A No.

Q So the Nevada Board of Medical Examiners is your sole source of employment at this time; is that correct?

A No.

Q Where else are you employed?

A I'm retired. I'm a retired federal agent, so I get a monthly annuity.

Q Gotcha. I just wanted to double-check on your current employment. So just the Nevada Board of Medical Examiners, right?

A That is correct.

Q All right. Thank you for clarifying. And, Mr. Diaz, have you ever attended medical school?

A No.

Q All right. So you would agree with me that you're not a medical doctor; correct?

A I am not a medical doctor. Correct.

Q All right. And as Chief of Investigations,

is it your experience that most of the investigators are also not medical doctors?

A That is correct.

Q Is Laura Ward a medical doctor?

A No.

Q And I believe that you testified that she had been the original investigator on the case. Is that correct?

A Yes.

Q And in your experience, do the investigators primarily take the allegations that are written in an underlying consumer complaint and use them as the allegations in the, you know, initial letters of inquiry that are sent by the Board to a physician?

A Yes, the investigators review the complaint and then they draft an allegation letter based on what the complainant has provided.

Q You testified that you reviewed that letter of inquiry that was sent to Dr. Nguyen. I believe that was marked as the Investigative Exhibit Number 1. Is that correct?

A Yes.

Q And it appears that that first paragraph on that first page lists a number of allegations. Do you

see that?

A Yes.

Q All right. And towards the bottom of that first paragraph, it reads quote, "The parents requested that you administer the shot." Did I read that correctly?

A Yes, you did.

Q All right. Mr. Diaz, is it your understanding that the "you" stated when saying the parents requested "you" administer the shot refers to Dr. Nguyen?

A Yes.

Q All right. So is it correct to say that one of the allegations alleged is that the parents of Patient A requested that Dr. Nguyen give the patient a shot?

A Yes.

Q All right. And since you were only hired by the Nevada State Board of Medical Examiners in 2020, is it fair to say that you were not part of the Investigative Committee of the Board at the time the formal complaint of this matter was authorized?

A I need to look at the date of the filing of the Investigative Committee. If you'd give me a minute.

Q Certainly.

A No, I was employed when this was filed on November 3rd, 2021.

Q All right. And let's take a look at it is the IC's Exhibit Number 3. It appears at Footnote Number 1 of the page towards the bottom. It states quote, "The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal complaint was authorized for filing, was composed of Board members" -- and I apologize if I mispronounce the name -- Rachakonda D. Prabhu, M.D., Ms. Sandy Peltyn, and Victor M. Muro, M.D." Did I read that correctly?

A Yes, you did.

Q Have you ever discussed this formal complaint or investigative process that led to it with Ms. Sandy Peltyn?

A Did I? I didn't hear you. I'm sorry.

Q Oh, certainly. Let me restate the question. Did you ever discuss this formal complaint or the investigative process that led to it with Ms. Sandy Peltyn?

A No.

Q But Ms. Sandy Peltyn was on the Board when the formal complaint was authorized; is that correct?

A That is correct.

Q All right. Are you aware that Ms. Sandy Peltyn passed away in December of 2018?

A I am.

Q Okay. And that would have been before you began your position as the Chief of Investigations. Is that correct?

A That is correct.

Q Do you know when the formal complaint was authorized for filing in this matter?

A I don't have the date in front of me of when the Investigative Committee met to discuss this actual case, but I do know when it was filed on November 3rd, 2021, I was employed by the Board.

Q Gotcha. And since Ms. Peltyn was a member of the Board and passed away in 2018, is it your understanding that the authorization for the filing of this complaint would have been prior to December of 2018?

A That is correct.

Q All right. And you just testified that the formal complaint was filed November 3rd, 2021. Is that right?

A Yes.

Q Do you know why there was a delay between at some point in 2018 and when the complaint was actually

filed November 3rd of 2021?

A No, I do not.

Q All right. Would there be any other individual aside from yourself that would have access to that information as to why there was a delay in filing a formal complaint?

A Not to my knowledge.

MR. BRADLEY: I'm going to object. I don't know that it's relevant, the delay, in filing the complaint. I'm not sure what the purpose of the questioning is.

HEARING OFFICER HALSTEAD: Ms. Buys, do you have a response?

MS. BUYS: Certainly. It's relevant to establish, you know, the basis for proceeding forward with a formal complaint against Dr. Nguyen based upon the investigation and the investigation process.

MR. BRADLEY: Well, there's no statute of limitations and there's no timeline prescribed in NRS Chapter 630. And I don't, I mean, Mr. Diaz is the Board's only actually employed witness, so I'm not sure if this is information he even has.

HEARING OFFICER HALSTEAD: I'm going to allow it. Go ahead, Ms. Buys.

Q (BY MS. BUYS:) Thank you very much. And so to rephrase my question, Mr. Diaz, is there another individual aside from yourself who would have knowledge as to why the complaint would have been authorized prior to December of 2018, and it was not filed until November 3rd, 2021?

A I would not know who that person would be if in fact they do have knowledge of that information.

Q Thank you, sir. And what was the date the care at issue was rendered to Ms. Patient A?

A November 4th, 2016.

Q And do you know what the date was that the Board received the underlying consumer complaint?

A I would have to look through the case file to get the exact date that the complaint was filed. I don't have that actual complaint in front of me.

Q As part of your role as an investigator in this matter, have you reviewed the consumer complaint?

A I have.

Q All right. I just would like to make a note for the record that that information was requested and a motion was filed and it was denied, and I just wanted to make that point for the record.

Mr. Diaz, in your role, you review documents

that were received as part of the investigation process; is that correct?

A Yes.

Q As part of the investigatory process, does the Board independently obtain the patient's medical records?

A We do.

Q All right. And what medical records were obtained during the investigation?

A The ones that we received from Dr. Nguyen when we sent an order to produce healthcare records.

Q Were any medical records prior or subsequent to November 4th, 2016 obtained as part of the investigation?

A No.

Q Why not?

A We normally request a period of time when there was treatment that a patient was seen. In this case, it was only a one-time visit with Dr. Nguyen.

Q And did you receive any certificates of a custodian of records for Patient A's medical records that you received?

A I remember seeing the custodian of records. I just have to find it in the Exhibit Number, if you give

me a second.

Q Certainly.

A I don't have it in front of me. I don't have a copy of it in our exhibits.

MR. BRADLEY: I mean if I may, I believe the only ones that were provided are in Dr. Nyugen's response. So I think if you look at the exhibits that were admitted for Dr. Nguyen, which was 12 or 13, I suppose, I think you'll see it.

MS. BUYS: And I believe, for the record, it was admitted as Respondent's Exhibit Number 6, which is Bates the bottom right-hand corner Med Admin Log 0001.

THE WITNESS: Okay. I do see a certificate of custodian of records dated November 7th. I'm sorry. That's dated March 7th, 2022.

Q (BY MS. BUYS:) And who is listed as custodian of records?

A Marla Saulsberry.

Q So is it fair to say that Dr. Nguyen is not the custodian of records for Patient A's medical records that have been admitted?

A For the records that were received with this certificate of custodian of records, it would appear to be Marla Saulsberry.

HEARING OFFICER HALSTEAD: And just for the record, we're referring to Respondent's Exhibit Number 6.

Q (BY MS. BUYS:) Thank you. Are you aware that Marla Saulsberry is an employee of MED-R, a medical records retrieval company?

A I am not.

Q As Chief of Investigations, are you aware that some facilities and physician groups use medical records retrieval services to obtain a patient's medical records to respond to a request for a record?

A Yes, I am.

Q And in your experience, is that a normal and accepted practice?

A It's common. Yes.

Q All right. And going back to the Investigative Committee's Exhibit Number 1, does it specifically state in there a request that a certificate of a custodian of records accompany records that are provided to the Board as part of their inquiry?

A Not in the allegation letter. It's usually included in the order to produce healthcare records though.

Q And is there an order to produce healthcare records attached to this Exhibit Number 1?

A No, there is not.

Q All right. And today in 2022, does the Board regularly request that the certificate of a custodian of record be included with the medical records it obtains?

A Yes, we always send out a certificate of records, custodian of records with an order to provide healthcare reports.

Q And why is that?

A It's to insure that all of the records that we received are true and accurate copies and everything included during the time period that the records were requested.

Q And in this case, it does not appear that there is an attached additional page aside from this March 28th, 2017 letter to Dr. Nguyen requesting his response. Is that correct?

A Not with Exhibit 1.

Q All right. Are you aware of an additional document requesting the records that was sent to Dr. Nguyen?

A Yes.

Q Do you have a copy of that document?

A I do not. Not in front of me.

Q All right. Neither do we. And as Chief of

Investigations, have you seen occasions where medical records have been received by the Board without a certificate of a custodian of records?

A Yes. In the past when we requested records, they were either requested in the allegation letter or they were requested through an order to produce healthcare records and some were not -- the custodian of records was something that was not utilized way back. It's something that's been utilized at least since I've been with the Board.

Q And that's in March of 2020; correct?

A Yes.

Q All right. And aside from this one matter, are you aware of any other complaints that have been alleged against Dr. Hai Nguyen?

MR. BRADLEY: I'm going to object because I don't think that's public information. NRS Chapter 630.336 says that complaints that aren't basically acted on or don't have a filed formal complaint are not public record.

Q (BY MS. BUYS:) I'll rephrase the question. Aside from this one matter, has the Board ever sent Dr. Nguyen an additional letter of inquiry based upon allegations that he fell below the standard of care?

MR. BRADLEY: I'm going to object. I think that's the same question. You're asking now whether or not he was ever sent an allegation letter. We know he was sent an allegation letter in this case. Any other allegations letters that he was sent would not be a matter of public record pursuant to NRS Chapter 630.336.

MS. BUYS: Well, it's relevant to determine whether or not Dr. Nguyen has ever been put on notice that there are other allegations against him.

MS. BRADLEY: I'm not saying it's not relevant. I'm saying it's confidential as a matter of law.

HEARING OFFICER HALSTEAD: Well, I'm going to rule on that. Actually, I'm only here for the allegations that are in the complaint and whether there has or hasn't been any other allegations is irrelevant to what I need to address.

MS. BUYS: Thank you for your time, Mr. Diaz.

THE WITNESS: Thank you.

MR. BRADLEY: I have a couple of redirect for Mr. Diaz, if I might.

HEARING OFFICER HALSTEAD: Go ahead.

REDIRECT EXAMINATION

BY MS. BRADLEY:

Q So, Mr. Diaz, in your experience, how would you know if an outside entity was the custodian of records for a provider?

A We wouldn't. We would send it to the doctor first, and in their response, they would either let us know that they are not the custodian of records and they would direct us to who would be the custodian of records. At that point, we would then send a request for medical records to either a third party or a medical facility if the doctor was not the true custodian of records.

Q So would you please turn to the Board's Exhibit 2, which has already been admitted. And if you look at that first paragraph on that exhibit, could you read the sentence that starts with "Copies of" and redact the name to be Patient A?

A This is from the April 24th, 2017 response --

Q Yeah.

A -- letter from Dr. Nguyen. "Copies of Patient A's medical records which I have obtained are enclosed for your review and file."

Q So does that let you know that there's an outside entity that may be a custodian of records?

A No.

Q Can you review this letter? And I know you've already reviewed it. Is there anything else in here that lets you know that there's another entity that may have records regarding Patient A?

A No, there is not.

Q Does the statute provide an obligation on the part of a physician to respond to a complaint?

A Yes, it does.

Q And does it also require that they provide records?

A Yes.

MS. BRADLEY: I have no further questions at this time.

THE COURT: Okay. Thank you. Would you like to call our next witness?

MR. BRADLEY: I would. I believe Ms. DelGrosso is there in Las Vegas, and she has not been sworn previously. And I'm hoping Mr. Swank can bring her in.

HEARING OFFICER HALSTEAD: Before we do that, anyone need a break?

MS. BUYS: Actually, yes, we will take maybe a five-minute break, if that's all right.

HEARING OFFICER HALSTEAD: Okay. So we'll come back -- why don't we come back at 9:30. It's 9:18. Sorry. Yeah, let's do 9:30 so everyone can stretch their legs.

MS. BRADLEY: Okay. Thank you.

(Recess.)

HEARING OFFICER HALSTEAD: The time is now 9:31. We're going to go back on the record in Case Number 21-38084-1. I'll note that the parties are still present via remote means. Ms. Bradley left off calling her second witness, Ms. DelGrosso, I believe was the name?

MR. BRADLEY: Uh-huh. Yes.

MR. SWANK: Should I bring Ms. DelGrosso in?

MR. BRADLEY: Yes, please.

THE COURT REPORTER: Who is that?

HEARING OFFICER HALSTEAD: He's the IT guy.

MS. BRADLEY: Mr. Swank. Ryan: R-Y-A-N S-W-A-N-K.

HEARING OFFICER HALSTEAD: Ms. Buys, in case you can't hear us, we've been identifying the gentleman who was just speaking for the record. The court reporter was asking his name.

MS. BUYS: Thank you.

MR. BRADLEY: So I would call Ms. DelGrosso as a witness. I'm not sure where is best for her to sit.

MR. SWANK: I was thinking right about here. Would this be good for you guys?

MS. BRADLEY: Perfect. Can you see her okay if she sits there, Ms. Buys?

MS. BUYS: I can. Yes.

MS. BRADLEY: And I believe this witness has not been sworn yet.

HEARING OFFICER HALSTEAD: That is correct.

Ms. DelGrosso, if you could raise your right hand, please.

(The witness was sworn.)

HEARING OFFICER HALSTEAD: Thank you. You may be seated. And if you could start by having her state her name and spell her name for the record.

DIRECT EXAMINATION

BY MS. BRADLEY:

Q Yes. Ms. DelGrosso, would you please state your name and spell your name for the record.

A Shielamarie DelGrosso. First name is: S-H-I-E-L-A-M-A-R-I-E. Last name is D-E-L-G-R-O-S-S-O.

Q Thank you. And did you file the consumer

complaint in the Board's Investigation 17-17109?

A Yes.

Q Why did you file that complaint?

A Because we went to our pediatrician. I noticed there was a divot on my two-year-old's bottom, and it was getting bigger, so we went to my pediatrician and had him look at it, and he was pretty concerned about it.

He asked if she had been administered a shot, and I said yeah, a couple of months prior. He asked what it was, and I remember the name of the shot starting with a K or a C. It was a Kent (sic) shot. And then I said that to my pediatrician, and he became even more concerned saying that they don't administer that shot to children anymore, especially children that young, so he was quite concerned about it.

So my husband -- right after that appointment, my husband had gone back to the urgent care office asking for any kind of records, which shot it was, any kind of information, asking to talk to a doctor or a nurse that was in the office, and they brushed him off. So after that happened, I had filed a complaint.

MS. BRADLEY: Okay. And I believe we have a copy of exhibits there. I don't know if we can make

sure. I wanted to let the witness see what's been premarked as the Board's Exhibit 6.

THE COURT: Hold on a minute. Someone walked in. I don't know if it's a witness or --

MR. BRADLEY: Oh, I think that's Dr. Hall.

DR. HALL: Yes.

MR. BRADLEY: Yes, he will be a witness.

HEARING OFFICER HALSTEAD: For the record, Dr. Hall has come into the room. He's not in view, and I know he's a witness, so I'm noting that for the record.

MR. BRADLEY: So, Mr. Swank, do we have exhibits available for Mrs. DelGrosso?

MR. SWANK: Yes. Let me see if I can find those for you.

MR. BRADLEY: I apologize for the delay.

MS. BUYS: No worries. Do we want to go off the record as Mr. Swank looks for those exhibits?

MR. BRADLEY: Yeah, if we might.

(WHEREUPON, an off-the-record discussion ensued.)

HEARING OFFICER HALSTEAD: We're back on the record in Case Number 21-38084-1. All of the previously present parties and those noted on the record are still present, and Ms. DelGrosso has been provided with the Board's exhibits.

Ms. Bradley?

Q (BY MR. BRADLEY:) Thank you. So, Ms. DelGrosso, do you see something that's labeled as Exhibit 6 in there? Is there a tab that says 6?

A There's no tabs in here.

Q Okay. Look for it should be Bates stamp page 17. If you look on the very bottom, there should be small little numbers.

MR. SWANK: What is the document? Maybe I can help her find it. There's no Bates stamp on there. Is it the HealthCare Partners Medical Group Medication List?

MR. BRADLEY: No. It's a photograph that I believe Ms. DelGrosso has knowledge about, so that appears to maybe not even be our exhibits. I'm not sure.

HEARING OFFICER HALSTEAD: Does your copy have Bates stamps?

MR. BRADLEY: Mine does.

HEARING OFFICER HALSTEAD: Do you want to scan it and email it down real quick? Would that be the quickest way to do this?

THE WITNESS: The original email with the attachment.

MR. BRADLEY: Oh, you have the original

email?

THE WITNESS: Uh-huh. And then original pictures.

MR. BRADLEY: Okay.

THE WITNESS: I'm not seeing it in this binder.

HEARING OFFICER HALSTEAD: Do you want to go off the record again?

MR. BRADLEY: Yeah, if we could go off the record.

(WHEREUPON, an off-the-record discussion ensued.)

HEARING OFFICER HALSTEAD: We're back on the record in Case Number 21-38084-1. All of the previously indicated persons are in the hearing rooms.

And, Ms. DelGrosso, I'll remind you that you remain under oath.

THE WITNESS: Yes.

Q (BY MR. BRADLEY:) So, Ms. DelGrosso, before you, you have what has been premarked as the Board's Exhibit 6. Have you seen that before?

A Yes.

Q What is it?

A These are pictures of my daughter, her bottom.

Q And did you take those photos?
A I did. That's my hand in the picture.
Q Okay. Do you recall what date and time the photos were taken?
A Yes. They were March 25th, 2017, at 10:11 a.m.
Q And are they true and correct copies of how your daughter's, I guess, backside looked when you took the photos on March 25th, 2017 at 10:11 a.m.?
A Yes.
Q Did you provide those photos to the Board with your complaint?
A I did.
MS. BRADLEY: I'm going to ask for admission of Exhibit 6.
HEARING OFFICER HALSTEAD: Ms. Buys?
MS. BUYS: We'll just make a note that we object as to the fact that the photos themselves are still undated and taken at such a significant period after the care and treatment, but otherwise, that's our objection.
HEARING OFFICER HALSTEAD: Thank you. Board Exhibit 6 is admitted.
Q (BY MR. BRADLEY:) Thank you. So,

Ms. DelGrosso, when you look at those photos, there's -- Can you describe the photo for us as far as the injury that shows?

A Yes. So on the left, I guess her left side, right, it's like a quarter-sized divot. And it was pretty deep. You can't really see how deep it looked like in person from the pictures, but my daughter was standing towards the headboard right after her bath, and I took the photo.

Q Did your daughter complain of soreness in that area?

A She did after the shot was administered. So it was red and it was puffy for a while. But then I started noticing the swelling go down, and then this started forming and this -- it became this deep in a short period of time from what I recall. And then right after I discovered it, we had taken her to the pediatrician.

Q Okay. Do you recall approximately when that pediatrician visit occurred?

A I don't know the exact date.

Q Let's go back to the visit with Dr. Nguyen on November 4, 2016. Do you remember that visit?

A I do.

Q What do you remember about that visit?

A On that visit, we had taken her into the urgent care because my pediatrician was not available on that date. She was sick, and we were concerned enough to take her in. We waited -- both my husband and I were there with the baby -- and then we waited in the waiting room for a bit and then got called back.

The doctor that came in started asking a bunch of questions as far as symptoms, had his back turned to us the entire time and was just typing everything into the computer, and it was a fairly quick visit.

And then he had said: All right. Well, it sounds like she's sick, so if, you know, really sick. I don't know what the diagnosis was exactly, but he said, you know, we have a steroid shot and we can give it to her and she should be better the next couple of days and then go from there. And I said: Okay, is what I told him. And so he comes back in, gives a shot and then we're sent on our way.

Q Okay. Do you recall him providing you information regarding that shot?

A As far as verbally or?

Q Well, did he tell you -- he told you -- so

from what you just testified to, he told you the shot would make her better in a couple of days.

A Yep.

Q Did he tell you any risks for that shot?

A A little bit of soreness on the site; that she should start to see relief in a couple of days.

Q Okay. Did you consent to him to provide that shot?

A We were going along with what he said. We said okay.

Q Did you understand that the shot could cause longer-term effects than just soreness?

A Absolutely not.

Q So was there just one attempt to give her the shot?

A Yes.

Q Who provided the shot?

A The doctor that we saw.

Q Did you ask him to provide that shot?

A I believe the option was given for the nurse to administer the shot, and we requested the doctor instead because we figured they were more qualified than a nurse to give a shot to our baby.

Q Okay. Does your daughter still have an

injury on her left side today?

A Not like this. There's a darker spot on her left side from where that spot is, but it filled in.

Q Does she have any sensitivity or pain?

A No, not that she complained about.

Q Did you sign anything prior to the admission or -- sorry -- the injection?

A I don't remember signing anything. No.

MS. BRADLEY: I have no further questions for Ms. DelGrosso at this time.

HEARING OFFICER HALSTEAD: Thank you.

Ms. Buys?

MS. BUYS: Thank you. Yes.

CROSS-EXAMINATION

BY MS. BUYS:

Q Hello, Ms. DelGrosso. Do you understand that the oath you took requires that you tell the truth under penalty of perjury?

A Yes.

Q And I believe you testified, but I just want to clarify. Did you take your daughter to the urgent care?

A Yes.

Q And when you went to the clinic on November 4th, 2016, did you have a pediatrician appointment scheduled for your daughter a few days later?

A Yes.

Q And did you go to the urgent care clinic because you wanted your daughter to be seen by a doctor and treated if she required medical care?

A Yes.

Q Did you report to anyone at the clinic that your daughter had been coughing, had a runny nose, you know, vomiting, congestion, with some phlegm for about four days?

A Yes.

Q And did you report that those symptoms had been worsening?

A I believe so. Yes.

Q And do you recall if you reported that they seemed to be worsening at night?

A Yes.

Q And do you recall reporting that she already had an Albuterol nebulizer at home?

A (Indicating.)

Q I'm sorry, just for the record.

A Oh, yes.

Q No worries. Just because they're taking everything down, I want to make sure we have verbal responses. So not meaning to be rude or anything. I just wanted to make sure. And do you recall why your daughter had a prescription for an Albuterol nebulizer?

A Yes. So prior to that previously, she had croup. And then my pediatrician had prescribed a nebulizer at home.

Q And do you remember the name of that pediatrician?

A Yes. Dr. Wesley Robertson.

Q Perfect. And Dr. Robinson, is he local in Las Vegas?

A Robertson.

Q Oh.

A Yes, he is part of Sunshine Valley Pediatrics.

Q Thank you. And I believe you just testified that your daughter had croup before; is that correct?

A (Indicating.)

Q Is that a yes?

A I'm sorry. Yes.

Q No worries. Thank you so much. And do you recall if she had had croup on more than one occasion?

A No. So she was hospitalized for croup prior to that but only once.

Q Do you remember when that hospitalization was?

A I don't remember the exact date.

Q Just that it was before November 4th of 2016?

A Yes, I believe so.

Q And had your daughter been walking by the time that you took her to the urgent care clinic on November 4th, 2016?

A Yes.

Q Do you recall when she began walking?

A I believe she was about 13 months when she started walking.

Q And do you have more than one daughter?

A I do.

Q Busy, busy. And I believe the Board counsel had asked you questions about your recollection of your visit with Dr. Nguyen. Do you remember just testifying to that right now?

A Yes.

Q And do you recall Dr. Nguyen examining your daughter?

A Yes.

Q And after he examined your daughter, did Dr. Nguyen prescribe or recommend Prednisone?

A I don't remember the Prednisone.

Q Do you remember any discussion about an oral medication?

A No.

Q And just to clarify, no, you don't remember? Or no, it didn't happen?

A I'm going to say no, it didn't happen. Otherwise, we probably wouldn't have done the shot.

Q Okay. And if there is a record of Dr. Nguyen prescribing Prednisone, do you have any evidence to refute that he didn't offer a Prednisone prescription?

A No.

Q And do you recall after -- just for the record as well -- there is notation that there is a prescription for Prednisone in the medical record. And just to clarify, you don't have any evidence as you sit here today to refute that; is that correct?

A Correct.

Q If Dr. Nguyen testifies that after, you know, recommending an oral Prednisone, do you recall if you'd asked any questions about treatment recommendations?

A I don't recall.

Q And 2016 was a while ago, wasn't it?

A Yeah.

Q And do you recall ever telling Dr. Nguyen that after your daughter had been treated, these sort of respiratory symptoms before that oral medication alone was not enough?

A I'm sorry. Can you repeat that?

Q Certainly. Do you recall ever telling Dr. Nguyen when your daughter was previously treated for respiratory symptoms that just an oral prescription is not enough to help take care of the symptoms?

A Now that you say that, yes, I do recall that.

Q What do you recall of that?

A That was pretty much it.

Q And that occurred back on the visit on November 4th, 2016, that you had stated to Dr. Nguyen that your daughter had had these symptoms before and oral medication alone did not seem to resolve them. Is that fair?

A Well, at that point, she was already sick for four days, so we needed to get her better. He had said that a shot will do it.

Q Okay. And do you remember Dr. Nguyen having a discussion with you that an oral medication that's

Prednisone may have a side effect like nausea?

A I don't remember that.

Q Do you remember, prior to the Kenalog injection being brought up, Dr. Nguyen discussing that there could be risks or side effects to the injection?

A No, just the site would be sore and she might be a little bit cranky because of how tender it will be at that site.

Q All right. Do you recall if Dr. Nguyen had stated that an injection of Prednisone may cause scarring or -- sorry -- an injection of Kenalog may cause scarring?

A No.

Q If there is evidence that Dr. Nguyen did discuss that with you, do you have any evidence as you sit here today to refute that?

A No.

Q Do you recall there being a medical assistant during the November 4th, 2016 visit?

A Yes. And can I just -- and on the record, can I just say that the doctor that gave came in, quote unquote the doctor, actually was not Dr. Nguyen. It was a much younger gentleman, Asian gentleman at that time. So I'm a little bit confused here because now that I'm

looking at him, it was a younger gentleman. And now that he's saying medical assistant, it was just the medical assistant. That's who it is in the office with -- not this gentleman.

Q Okay. So as you sit here today -- and you've seen this gentleman sitting to my right?

A Right.

Q Do you recognize him?

A I actually don't, to be completely honest and under oath. Because the gentleman that came in, I remember him being much younger, and then he was the one that I was talking to.

Q Okay. And so is it your testimony that you do not recall seeing this gentleman on my right-hand side who I am going to represent to you is Dr. Hai Nguyen?

A I'm going to say that I do not recognize him. And I am not sure what that's going to do, but that's not the guy who gave my daughter a shot.

Q Thank you for clarifying that for the record. So the gentleman who you were talking to about the shot, can you describe him a little bit further?

A He was a younger gentleman. He was of Asian descent, and he had black hair. He did look a bit frazzled and confused, but he was the one that said that

we should do the shot.

Q Do you remember if he was wearing scrubs or a lab coat?

A I remember a white top. Maybe it was a lab coat.

Q Gotcha. And do you remember the name of this gentleman? Do you remember what he told you his name was?

A I don't remember. He came in and introduced himself real quick, and we thought he was the doctor.

Q All right. And when you say that, you're referring to you and your husband; is that right?

A Yes.

Q During any point of your visit, did your husband leave the appointment or was he there the entire time?

A He was there the entire time.

Q Okay. The gentleman who came in, and I believe you testified you don't recall his name, but does the name Barry Misiuk ring any bells?

A It was quite a while ago, so --

Q As you sit here today, you can't tell for certain whether or not you recognize the name Barry Misiuk?

A Right.

Q And I apologize if I jump around a little bit.

A No, that's okay.

Q Thank you again for your time today. Did you ever speak with this gentleman right here, Dr. Nguyen, after November 4th, 2016, before maybe some niceties in the hallway today?

A No.

Q Okay. While you were there at the urgent care clinic on November 4th, 2016, if the person you thought was a physician had recommended some sort of clearly egregious form of treatment such as, you know, putting a lit cigarette out on the baby's hand -- I know that's a bad example, but if say that was one of the recommended forms of treatment, would you have allowed your baby to sit there and be subjected to that?

A Absolutely not.

Q Okay. And in this case, when they had the Kenalog injection, did you help assist the positioning of the baby when they were giving the injection?

A Yes.

Q You held her, right?

A Right. She's my baby.

Q Gotcha. And if you did not want the baby to have an injection, would you not have sat there and held her?

A Right.

Q If you did not want the baby to have an injection of that medication, you would have left the clinic. Is that fair to say?

A That's fair.

Q And then I believe that you had testified that this divot -- and I believe you had referred to it as a divot. Is that fair enough?

A Yes.

Q So that we're talking about the same thing.

A Right.

Q Perfect. So that is on the left buttock cheek. Is that correct?

A Yes.

Q And I believe you testified as well those photos were taken March 25th of 2017. Is that correct?

A Yes.

Q So that would have been a few months after that November 2016 appointment. Fair enough?

A Yes.

Q And I believe you also said that the

indentation resolved. Is that correct?

A Yes.

Q All right. And do you remember when that resolved?

A It took a while. It took probably up to a year for it to fully come back, but there's still a little bit of discoloration there.

Q Gotcha. And do you recall if -- Strike that. Do you recall if when they were administering the injection if there was more than just you and your husband present in the room when that gentleman that we don't know his name?

A It was the three of us, the baby, and then I believe there was an assistant.

Q And that assistant that you recall, can you describe him or her, please?

A It was a female.

Q As you sort of sit here today, do you recall any other occasions where your baby has been administered an injection in the buttock?

A No. Usually they have a shot that's given in their thigh or arm.

Q How many times has your baby had an injection in her arm?

A She's not a baby anymore, but after that or before that?

Q You know, I'll clarify the question a little bit further. Do you recall any other occasions where your daughter has been administered a steroid injection apart from November 2016?

A Yes, last year.

Q And why did she get a steroid injection last year?

A Because she was sick. It was during COVID, the pandemic.

Q Gotcha. And do you recall if she had been diagnosed with COVID or was it just respiratory illnesses again?

A It wasn't respiratory. It was something else. So she had I believe it was the flu or something similar to the flu.

Q Do you remember who administered that injection?

A Our pediatrician, Dr. Wesley Robertson.

Q Gotcha. And apart from those occasions, as you sit here today, do you recall any other injections of a steroid? Not a vaccination, but a steroid?

A No.

Q Okay. And I believe you had also testified that you had noticed this divot develop. Do you remember when you first noticed the divot, the exact date?

A I don't remember the exact date. But before this was taken, this was after our appointment with our pediatrician. So this was taken, I believe, after I -- around the same time that I filed the complaint is when this was taken. And then this one started to form before that, but I believe it escalated rather quickly and became deep. So I want to say probably a couple of weeks before this was taken. Probably three weeks.

It started as a small dimple, and we thought it was just a baby dimple like she has underneath her butt cheeks right there underneath her buttocks. That's what it looked like when it first started. Kind of like a cellulite dimple.

Q And you know how babies have cellulite or other dimples on their buttocks; correct?

A Uh-huh. Yes.

Q Perfect. And then just to sort of clarify, so is it your recollection that the divot started to form about three weeks before that photo was taken in March 25th of 2017, so would that have been about Februaryish?

A Yes.

Q Okay. Gotcha. And just to clarify as well for the record, this is a photo of your daughter who we've been referring to as Patient A. I just want to make sure that everybody is on the same page. Is that your understanding as well?

A Yes.

Q Okay. Perfect. Not another daughter, right?

A Right.

Q Okay. I just wanted to make sure of that as well. And then I believe you had also testified about your husband going and getting or requesting the patient's records?

A Yes.

Q Do you recall, did you go with him when he requested those records?

A I went with him, but I stayed in the vehicle with the baby, and then he ran in and then had requested them.

Q Okay. Do you recall if he requested it in writing?

A What he told me is he went in and then had asked for any kind of record from our appointment. They said the doctor wasn't there, and they said that they couldn't give him anything or provide any information,

and then that's pretty much it and that he had walked out because they brushed him off.

Q Okay. But just to sort of clarify as well, is it your understanding that he did not write a sort of written request for the records, right?

A I wasn't there, so I can't say if he did or not.

Q And to clarify, you did not submit a written request for records; is that correct?

A Correct.

Q And the gentleman that you testified that you recall discussing the risks and benefits or, you know, the risk/benefit of the Kenalog injection, is it your understanding that --

MR. BRADLEY: I'm going to object. I don't believe she actually ever testified that the risks and benefits were discussed. She testified that she was told there would be soreness at the site. I don't think she used the words "risks and benefit." I think that's words you're using.

Q (BY MS. BUYS:) Ms. DelGrosso, if I in my question refer to risks and benefits, would it be fair to assume that that means the soreness that could occur after an injection? Do you understand that?

A Right.

Q Okay. So I'll rephrase the question based on Counsel's objection. So when that gentleman discussed that there could be soreness, that was before he gave the injection, right?

A Yes.

Q And is it your testimony here today that the person who discussed that, you don't recall it being this gentleman, right?

A Right.

Q Okay. And for the record, I'm pointing to my right at Dr. Hai Nguyen. And I believe you also testified that your daughter does not have any sensitivity or pain to the injection site currently; correct?

A Currently, no.

Q Looking back at some of the records, I believe you had testified that you submitted these two photos to the Nevada Board of Medical Examiners; is that correct?

A Yes, I have Laura Ward on my email attachment.

Q Did you submit any other photos to the investigator?

A Not on my email. These ones.

Q Okay. So is it fair to say that you didn't submit any photographs of your daughter's buttocks that was taken prior to these March 25th, 2017 photos, right?

A No.

Q Okay. And have you produced any photographs subsequent to these March 25th, 2017 photos?

A After the fact?

Q Correct.

A No.

Q Okay. And have you ever consulted with an attorney about, you know, this divot or this dimple?

A I did.

Q All right. And who did you consult with?

MS. BRADLEY: I'm going to object. I don't think it's relevant if she was going looking into a civil matter. We're not here in a civil matter. We're here regarding the Board's complaint filed in this case.

MS. BUYS: I believe it's relevant as to the investigation and for the purpose of bringing the complaint against a physician as well as if legal counsel was involved which was not disclosed to Dr. Nguyen.

HEARING OFFICER HALSTEAD: I'm going to sustain the objection.

Q (BY MS. BUYS:) Following the November of 2016 visit, did your daughter have to be admitted to a hospital for treatment for those respiratory symptoms?

A She was admitted for the croup that she had.

Q When was she admitted?

A I believe it was prior to that is what we had discussed, right? What we testified.

Q Okay. And I'll clarify my question.

A Okay. You're confusing me.

Q Sorry about that. After this November 4th, 2016 visit, was your daughter hospitalized for her respiratory symptoms?

A No.

Q Okay. Thank you for clarifying that. I just want to make sure I had that record. So when that gentleman discussed the Kenalog injection with you, was your husband present?

A Yes.

Q And is it your understanding that your husband did not object to the Kenalog injection?

A Correct.

Q And you also did not object to the Kenalog injection being administered; correct?

A Correct.

Q And you don't recall any other details regarding any other side effects that could potentially be as a result of the Kenalog injection being discussed with you; is that correct?

A That we were warned about? Just besides the soreness on the site?

Q Correct. That you recall.

A No.

MS. BUYS: I'm just going to review my notes, but I believe those are the questions that I currently have.

HEARING OFFICER HALSTEAD: When you're done reviewing your notes, do you have any further?

MS. BUYS: Nothing further at this time.

HEARING OFFICER HALSTEAD: Thank you.

MS. BRADLEY: If I could do a couple of redirect.

HEARING OFFICER HALSTEAD: I was just going to go to you.

MR. BRADLEY: Thank you.

REDIRECT EXAMINATION

BY MS. BRADLEY:

Q Mrs. DelGrosso, you testified that you don't recognize Dr. Nguyen, who is sitting by Ms. Buys. Is that correct?

A Correct.

Q Okay. Is it possible that five years ago, Dr. Nguyen may have looked different and that's why you're not recognizing him today?

MS. BUYS: Objection. Calls for speculation.

MS. BRADLEY: Okay. I don't know. I guess do you want to rule on that? I mean, I guess I would say that most people know that people change their hair color and appearance sometimes over the years.

HEARING OFFICER HALSTEAD: I think everyone gets your point. I'm sure we all looked -- you know, people age. I don't know what to say about that. Your point -- I don't think the point needs to be belabored.

Q (BY MS. BRADLEY:) So it possible that -- because your testimony was it was a younger Asian man with black hair, I believe. Is that what you said?

A Yes. Yes.

Q So is it possible if Dr. Nguyen was five years younger and still had darker hair that that could

be the person that you saw?

A No.

MS. BRADLEY: Okay. I have no further questions.

HEARING OFFICER HALSTEAD: Thank you.

MS. BUYS: If I may, I just have one other question.

RECROSS EXAMINATION

BY MS. BUYS:

Q Do you recall an MA attempting to give the injection or just a physician?

A Just the physician. Wait. I'm sorry. Let me back up. I believe they wanted the nurse to give the injection, and then I requested the physician give it because I didn't want a nurse to do it.

Q Gotcha. Thank you for clarifying that point. And then I believe you also had testified earlier that you remember one attempt at the injection. Is that correct? Just one attempt?

A Correct.

MS. BUYS: Okay. Thank you very much. I appreciate your time today, Ms. DelGrosso.

HEARING OFFICER HALSTEAD: Does that lead to

anything further?

MS. BRADLEY: No. I have no further questions for Ms. DelGrosso, and I would ask that she be excused.

HEARING OFFICER HALSTEAD: Ms. Buys, I don't know if she's on your witness list. If she is, do you agree with her being excused?

MS. BUYS: She is on our witness list, but we agree that she may be excused.

HEARING OFFICER HALSTEAD: All right. Thank you, Ms. DelGrosso. We appreciate your time today.

THE WITNESS: Thank you.

HEARING OFFICER HALSTEAD: Ms. Bradley, did you want to excuse Ms. Diaz as well? I know he's still here, but do you want to relieve him?

MS. BRADLEY: I can excuse Mr. Diaz, I think.

HEARING OFFICER HALSTEAD: I meant to ask you earlier. Your next witness?

MR. BRADLEY: I would call Dr. Hall.

And I think, Dr. Hall, if you want to sit maybe to the left of Meg.

HEARING OFFICER HALSTEAD: Dr. Hall, were you sworn?

DR. HALL: No.

HEARING OFFICER HALSTEAD: Can you please raise your right hand.

(The witness was sworn.)

HEARING OFFICER HALSTEAD: Thank you. And and can you please state your name and spell your name for the record.

THE WITNESS: I can. Scott Hall. Last name is: H-A-L-L.

DIRECT EXAMINATION

BY MS. BRADLEY:

Q All right. Thank you. So, Dr. Hall, are you licensed as a medical doctor in the State of Nevada?

A Yes.

Q How long have you been licensed?

A Since 2006, so roughly 16 years.

Q And are you licensed in any other states?

A Yes. California and Utah.

Q How long have you been licensed in those states?

A In California, since 2008. In Utah, it's this year, so recently.

Q Where did you go to medical school?

MS. BUYS: I apologize. Would it be possible

to take a quick comfort break?

HEARING OFFICER HALSTEAD: Yes. Absolutely. Are you okay with that?

MS. BRADLEY: Yeah, that's fine. I could use one too.

HEARING OFFICER HALSTEAD: So it's 10:22. Sorry. I know you just got started.

THE WITNESS: No problem.

HEARING OFFICER HALSTEAD: We're going to take a small break, and let's come back again at -- How long do you think you need, Ms. Buys? Do you want to do 10:30?

MS. BRADLEY: That's all I would need.

MS. BUYS: Yeah, 10:30 would be fine. I appreciate it. Just five minutes.

HEARING OFFICER HALSTEAD: Thank you. We'll be off the record until then.

(Recess.)

HEARING OFFICER HALSTEAD: We're back on the record in Case Number 21-38084-1. At the time we broke, Dr. Hall was testifying on direct, and he had just gotten past his licensing.

I remind you, Dr. Hall, that you remain under oath.

Q (BY MS. BRADLEY:) So where did you go to medical school, Dr. Hall?

A Ohio State.

Q And what was your residency in?

A Family medicine.

Q Are you certified by the American Board of Medical Specialties?

A Yes.

Q In what specialty?

A Family medicine. I also have a certificate of added qualifications in sports medicine.

Q And what kind of medicine do you practice?

A Full spectrum family medicine with an emphasis on acute musculoskeletal injuries.

Q And are you currently clinically practicing?

A Yes.

Q And seeing patients?

A Yes.

Q So if you would turn in the exhibits to what's been pre-marked as the Board's Exhibit 18 and 19. So it's probably towards the bottom of your stack there. Have you seen these documents before?

A Yes.

Q And what are they?

A They're my CV.

Q Do they appear to be a true and correct copy of your CV as provided to the Board?

A Yes.

Q And do they accurately summarize your education and experience?

A Yes.

HEARING OFFICER HALSTEAD: I'm sorry. What exhibit is it?

Q (BY MS. BRADLEY:) Eighteen and 19.

Did you prepare those documents?

A Yes.

Q And you did provide them to the Board?

A I did.

MS. BRADLEY: Okay. Based on that, I would ask that eighteen and 19 be admitted.

HEARING OFFICER HALSTEAD: Ms. Buys?

MS. BUYS: No objection.

HEARING OFFICER HALSTEAD: Thank you. Board Exhibits eighteen and 19 are admitted.

MR. BRADLEY: And can I clarify? My apologies. Is Exhibit 6 admitted? I believe I asked, but I just want to make sure.

HEARING OFFICER HALSTEAD: I think it was,

but if it wasn't, it will be.

MS. BRADLEY: Okay. I thought I asked, but --

HEARING OFFICER HALSTEAD: Pretty sure it was. Yes.

Q (BY MR. BRADLEY:) Okay. Have you served as a peer reviewer for the Board before, Dr. Hall?

A Yes.

Q Do you recall how many cases you may have reviewed for the Board?

A I would estimate about eight.

Q And how long have you been reviewing cases for the Board?

A I would estimate since 2010, so approximately 12 years.

Q Okay. And are you familiar with Investigation 17-17109 regarding Dr. Nguyen?

A Yes.

Q So let's look at Exhibit 5, and that has been admitted, and that's the Board's exhibit. So why does the record show that Patient A was taken to see Dr. Nguyen?

A So the medical record indicates that chief complaint of cough and congestion.

Q And what else? Is there any other information?

A Yes. There is a description of the history of present illness including cough, runny nose, vomiting/congestion with yellow-green phlegm for four days.

Q How often is vomiting noted on that record?

A Vomiting is mentioned one, two, three times that I read.

Q Okay. And does it say how often that the patient was vomiting?

A Vomiting once a day for four days.

Q Do you see anything noted that says that oral steroids would not -- was mentioned to not be enough for this patient?

A I do not.

Q So based on your review of the records in this case, what treatment would you have provided to the patient?

A I also would have chosen corticosteroids.

Q Okay. Oral or?

A Yes, I would have chosen oral corticosteroids.

Q But you would not have done an injection?

A I would not have done an injection.
Q And why would you not do an injection?
A The medical evidence indicates that when oral medication is reasonable or feasible, that is the preferred method.
Q Okay. And so in this case, why do you think that it's reasonable or feasible for the oral medication?
A Well, Dr. Nguyen chose to prescribe oral corticosteroids.
Q So he chose to prescribe oral?
A Yes.
Q And the injection?
A That is correct.
Q And that's what the records shows?
A That's what the record shows. Yes.
Q Okay. And do you have concerns with that?
A I do have some concern given the potential complications from an intramuscular injection. I would note that the medical evidence and the references I provided will allow for an intramuscular injection, but oral is preferred.
Q Okay. And so the treatment you would have prescribed is different than what Dr. Nguyen did in this case?

A There is a subtle difference. Yes.

Q Okay. What dose of Kenalog did the patient receive according to the medical records? I don't know if you can tell in those.

A The dose was by my recollection was approximately 20 milligrams. Let me confirm that here. The medical record in Exhibit 5 indicates: Administer Kenalog 40 milligrams per milliliter. It does not specifically give me the exact dosing, but I believe in other exhibits, it's 20 milligrams.

Q Okay. And I think you can also turn, if you want, to Respondent's exhibit, and I believe it's 12. It's the newer shot administration record. I believe you're familiar with that?

A Yes. I may not have that one.

Q We can provide you with a copy because I know we have one for you. And I think we may have a color copy; at least mine is color. Yeah, there we go.

A Yes.

Q Does that provide the dosing, that record?

A So the dose listed here is one milliliter, and that, according to the Kenalog description here, or I should say the Kenalog description in Exhibit 5 lists 40 milligrams per milliliter. It's difficult to for me to

confirm that exact dosing, but this record would suggest if Exhibit 5 is also correct that administration of 1 milliliter would be approximately 40 milligrams of Kenalog.

Q Okay. So they're consistent then at least with regard to the dosing?

A It's a little hard to say because under the display name -- well, at the top, it says, "Kenalog, 40 milligrams per milliliter injection." So I'm going to say yes. It appears that there was one milliliter administered which would be 40 milligrams of Kenalog.

Q Okay. So I think you identified you had concerns regarding the treatment. Let's talk about informed consent. So what is informed consent?

A So informed consent would be where the risks, benefits and alternatives are discussed with the patient and they have the option to elect to receive or not receive a certain treatment.

Q Is that the same as requesting a treatment?

A I would draw a distinction between requesting and consenting or providing informed consent.

Q Okay. And what is informed consent when you have a patient who is a minor?

A So when you have a minor, obviously you would

obtain informed consent from their parent or legal guardian.

Q And then what do you do when you get informed consent? Is that documented?

A Yes. So medical treatment, there should be informed consent and it should be documented.

Q And how would you document it?

A So typically how would I document it in the medical record, you would have a discussion or include a description of what you did to inform the individual and acknowledge their consent.

Q So let's go back to Exhibit 5, and I'm looking at a page that's marked NSBME 014. I think it's the top page in Exhibit 5.

A Okay.

Q And so if we go right above, there's a heading that says, "Chief complaint." Right above that, there's a line that starts with, "Patient." Could you read that for us?

A Yes. It says, "Patient agrees with treatment plan and verbalizes understanding."

Q So what does that mean to you?

A So that to me would mean that the patient is going to agree with the treatment plan and understands

it.

Q Okay. And who is the patient in this case?

A So the patient in this case is listed on the document is Patient A DelGrosso.

Q And how old is Patient A?

A Patient A at the time --

HEARING OFFICER HALSTEAD: Excuse me. I thought we were --

MS. BRADLEY: Patient A. I'm sorry.

HEARING OFFICER HALSTEAD: So I will direct that she be referenced as Patient A and that any prior references to her name in the record be reflective of that designation.

Q (BY MS. BRADLEY:) Thank you, and I apologize. So how old is Patient A?

A Patient A is approximately three years old. Just under three years old.

Q Or just under two?

A Excuse me. Just under two years old.

Q Okay. So just under two years old. So is she capable of consenting?

A No.

Q So in this case, I think you already testified, but who should be consenting in this case?

A The parents.

Q And this documentation here, I mean, do you think that's documenting an informed consent?

A No, I do not.

Q Why?

A Well, because the statement here suggests the patient was providing consent and we -- the patient's incapable of providing informed consent in this case.

Q Okay. Because the patient is a minor?

A Correct.

Q And then what about the parents? Would this sufficiently document informed consent on behalf of parents in your view?

A No, because it does not state parents.

Q Okay. But what about risks and benefits?

A I do not see a description of the risks and benefits.

Q I mean, and I think again, you said you would document -- I mean, what would your sentence look like if you were documenting informed consent in a case like this?

A So in my practice, we would typically have a separate sheet that would document this is the treatment proposed, these are the potential risks, this is the

benefits and these are the alternatives. So in my practice, we would include a document that a patient would elect to sign if they wanted to proceed with an intramuscular or what's more commonly for me is a joint injection.

Q Okay. So you would have a separate written document that the patient signs?

A Yes.

Q Or the guardian?

A Yes.

Q Is it required that it be a written document?

A No. My study of this question indicates that written or verbal may suffice for informed consent. So I have encountered this clinically. I have some -- I have physician situations who choose to do it like I do, which is to have written consent, and there are other physicians who choose to use a verbal consent.

Q Okay. But based on the documentation in this case, do you think the verbal consent was complete?

A I do not.

Q Okay. Do you believe that the Kenalog injection was necessary in this case?

A No.

Q And why was that?

A The reason being is the medical references recommend oral therapy when that's feasible. And in this case, oral therapy was prescribed, and so it appears redundant to also administer an intramuscular injection.

Q And is there a concern with prescribing, I guess, double prescribing the medication or prescribing it in two different ways?

A There is a concern. Essentially, if you were going to administer both oral and intramuscular corticosteroids, dosing considerations would be relevant.

Q What could happen if a patient got too much steroid?

A There's a fairly -- there are a number of things that can happen. Obviously, corticosteroids, we are primarily using in medicine to -- and what's applicable in this case is to reduce or treat inflammation, but it also influences the endocrine system and other organ systems within the body. So an excess dose of corticosteroids could have a detrimental effect.

Q Okay. So in your view then, the standard of care would not include prescribing medication, two different versions of the same medication?

A That would --

MS. BUYS: I'll just make an objection. Oh,

sorry. Objection, as the question's vague. When you're referring to the two types the same medication, we're referring to Prednisone and Kenalog, so I just want to make a clarification for the record.

Q (BY MS. BRADLEY:) Okay. I'll rephrase. What would the standard of care have dictated the patient be prescribed in this case?

A So as I reviewed the medical literature, the standard of care in this case and under the diagnosis that I'm using is croup.

Obviously, Dr. Nguyen, in his documentation, he lists cough with possible croup. And I think that's a very reasonable diagnosis, but under a diagnosis of croup, corticosteroids are recommended. And the medical literature states that one can use oral or intramuscular corticosteroids for treatment of croup, so that would be the standard medical care. I did not find references that would support both oral and intramuscular corticosteroids.

Q Okay. And are there concerns, separate concerns for giving an injection like Kenalog to a child versus an adult?

A Honestly, I don't know that there would be more concern with administering it in a pediatric

situation versus an adult situation. I think the risks and benefits would be roughly the same.

Q Okay. Do you believe -- so let's go to Exhibit 6, which has been admitted, and that's a photograph. So looking at this exhibit, does that appear to you to be possibly the result of a Kenalog injection?

A Yes.

Q Have you seen something like that before?

A Yes.

Q And so what happens? Why are we seeing a photo with a divot like that?

A So a known complication of Kenalog administration when it's done intramuscularly is where if the medication gets into subcutaneous tissues, it can lead to atrophy of those tissues. And so this type of complication is a known complication from a Kenalog injection.

Q So even if it was done in the muscle, this could still happen?

A So according to the manufacturer, that risk is minimized if the injection is done intramuscularly. But this could happen if that medication reached the subcutaneous tissues.

Q Okay. So it sounds like then but just -- I'm

going to ask anyway. So does it look like the injection was provided appropriately based on this photo?

A Based on the photo, one would question the depth of the injection.

Q Let's go back to Exhibit 5. And again, I'm looking at page 014, that first page. There's a line kind of in the middle under plan that starts with, "Administer." Could you read that for us, please?

A Yes. It says: "Administer Kenalog 40 milligrams per milliliter injection suspension," in parentheses, "(Triamcinolone acid)" -- I'm going to miss this name.

Q Sorry.

A It's Triamcinolone.

Q Okay. I guess what I'm really interested in that last part. It says: After once.

A Oh, got it. It says: "Inject 0.5 milliliters intramuscularly once to be done November 4th, 2016."

Q So when this was documented, had the injection occurred based on that sentence?

A I would read this as an order from Dr. Nguyen for his staff to provide the injections, the way I would read this.

Q Okay. So it was documented that it was going to be done intramuscularly?

A Yes.

Q But how it was actually injected, is that documented?

A Not on this form.

Q Okay. If we go to the Exhibit 12, I believe, which is the Respondent's color copy.

A It may in the main, the other binder. Got it. Okay. I'm on Exhibit 11. Is that the one you're referring to?

Q I think so, yeah. It's the color copy of the injection record.

HEARING OFFICER HALSTEAD: Just for the record because you had the actual conference, prehearing conference disclosure marked as Exhibit 1, that actually comes out as Exhibit 12. I know it's marked different in your binder, but that's how we did it.

Q (BY MS. BRADLEY:) Okay. Twelve. I apologize. Okay. So looking at that, does it show where the injection was provided?

A Yes. So this injection register states the right gluteal region.

Q And does it say, under route, it tells us the

kind of injection?

A It does. It states intramuscular.

Q Interestingly, there's a date and time for the injection. Do you see that?

A I do.

Q And what is that?

A So I would assume that that would represent the date of documentation and the time which would roughly correlate with when the injection was administered.

Q Okay. So what does it show just for the record on here?

A It's listed at 4 November 2016, at 6:56 p.m.

Q Okay. And there is even an administered by.

A Yes.

Q What's that name for the record?

A The medical record states Hampton, Chanel.

Q And if we go back though to Exhibit 5 and the Board's exhibits, on the top of that page, that top page 14, there's something that says DOS. What is that?

A Date of service is 11-4-2016. November 4th, 2016.

Q And at what time?

A 10:45 a.m.

Q So those times don't correlate, do they?
A No.
HEARING OFFICER HALSTEAD: I'm sorry. Where are you looking at 10:45 a.m.?
THE WITNESS: It's at the very top.
HEARING OFFICER HALSTEAD: That's Exhibit 5?
MS. BRADLEY: Yeah.
THE WITNESS: It's the upper right-hand corner of Exhibit 5, page 14.
Q (BY MR. BRADLEY:) Okay. And I'm just checking Exhibit 5. Do you see that same name, that Chanel Hampton? I don't see that name on this record. I'm just --
A I do not. The medical assistant listed on page 16 of Exhibit 5 is Glenisha Barner.
Q Okay. And the time for Glenisha's note, what time is that?
A 10:42 a.m.
Q And then what's the time for Dr. Nyugen's note?
A 5:19 p.m.
Q Okay. So do we know when the patient was seen by this record?
A I would follow the date of service listed on

the medical record which, is listed as November 4, 2016, at 10:45 a.m.

Q Okay. So then it sounds like the patient was seen earlier in the morning and then perhaps by the end of the day, Dr. Nguyen signed the note?

A Uh-huh.

Q And then perhaps by the end of the day, that's also when that shot administration record was created?

A That would be logical. Yes.

Q Is it more painful to receive an injection intramuscularly or superficially? Which one?

A They hurt. Yeah, they hurt.

Q Would the bruising that Ms. DelGrosso described in her testimony, would that have occurred for an intramuscular shot?

A It could.

MS. BUYS: Objection, misstates testimony. She did not actually testify regarding bruising as she testified here today.

Q (BY MR. BRADLEY:) I'll withdraw the question. Would you please turn to what's been pre-marked as the Board's Exhibit 7 through 17. These haven't been admitted yet. So have you seen these

documents before?

A Yes.

Q And what are they?

A So that's the medical literature I reviewed to assist with rendering an opinion.

Q Okay. So let's look at the first one, which is Exhibit 7. And I believe it's titled, "Clinical Practice," and then it says, "Croup" from the New England Journal of Medicine. So did you provide this to the Board?

A I did.

Q Does this appear to be a true and correct copy of the article, one of the articles that you relied on when assessing Dr. Nguyen's care in this case?

A Yes.

Q Did you provide this document to the Board?

A Yes.

Q Does this article articulate the standard of care that would have been in effect as of November 4, 2016, when Dr. Nguyen saw the patient in this case?

A Yes.

MS. BUYS: I'll just lodge a late objection as to vague as to what the standard of care is as this is regarding just the treatment of what appears to be croup.

So I just wanted to make an objection for the record. Apologize for the delay.

MR. BRADLEY: So I'd ask that Exhibit 7 be admitted.

HEARING OFFICER HALSTEAD: Ms. Buys, noting your objection, do you stipulate to the exhibit being admitted at this point?

MS. BUYS: Correct, with the objection noted. Thank you.

Q (BY MR. BRADLEY:) Let's turn to Exhibit 8. So this one is called "Acute Management of Croup in the Emergency Department." Is this a document you've seen before?

A Yes.

Q And is this something that you relied on when providing your opinion to the Board?

A Yes.

Q Now, if you look at the bottom, it appears -- Can you tell us what the copyright date is there?

A Yes. It's 2017.

Q All right. And do you recall the date of service that Dr. Nguyen saw the patient?

A Yes. It was the 4th of November, 2016.

Q Okay. And I think you testified that you

relied on this article to make your opinion to the Board?

A It's one of the articles that I used. Yes.

Q Would the standard of care articulated in this article, was it different at the time that Dr. Nguyen saw the patient?

A No.

Q And this appears to be a true and correct copy of the article that you provided to the Board?

A Yes.

MS. BRADLEY: So based on Dr. Hall's testimony, I'd ask that Exhibit 8 be admitted.

MS. BUYS: And we would further like to lodge objection, as this refers to acute management of croup in the emergency department and the care rendered was at an urgent care facility. And again, it looks like, even at the top, it is a 2017 article. So we would just like that noted for the record.

HEARING OFFICER HALSTEAD: Okay. With that notation, do you stipulate to the admission?

MS. BUYS: Yes, we stipulate to that is what Dr. Hall relied upon in forming his opinion.

HEARING OFFICER HALSTEAD: Thank you.

Q (BY MR. BRADLEY:) All right. In Exhibit 9, this is called, "Croup Diagnosis and Management." Have

you seen this document before, Dr. Hall?

A Yes.

Q And this is an article that you provided to the Board with your review of this case?

A Yes.

Q Do you see the date at the bottom of the article for the copyright? What is that?

A Yes. The date is 2018.

Q And would anything in this article have been different? Like would the standard have changed from 2016 to 2018, when this was published?

A No.

Q And how do you know that?

A Well, the way that these articles are written, as I've been an author for the American Family Physician, for example, for this article, these articles are typically in process about two years before an article is published. So, in other words, the authors are going to write this article. They're going to submit it for peer review. It's going to be peer reviewed, it's going to come back for editing, and that process takes a year or two. So yes, it would be consistent with the medical literature in 2016.

Q Okay. And so this appears to be a true and

correct copy of the article that you provided to the Board?

A Yes.

MS. BRADLEY: I would ask that Exhibit 9 be admitted.

HEARING OFFICER HALSTEAD: Ms. Buys?

MS. BUYS: And we'd further note for the record our objection that this article appears to have been written May 1st of 2018, and therefore would not have been in existence at the time Dr. Nguyen provided care in 2016. But with that objection on the record, we can stipulate as to admissibility as this was a basis of Dr. Hall's opinion in this case.

HEARING OFFICER HALSTEAD: Thank you. Number 9 will be admitted. I note the objection.

Q (BY MR. BRADLEY:) Thank you. Going to Exhibit 10, have you seen Exhibit 10 before? I think the next one, probably.

A Yes.

Q Okay. And so it's titled, "Kenalog-40 Injection." Do you know where this came from?

A Yes. So it's the reference as provided by the manufacturer relative to the use and administration of Kenalog.

Q And is this something that you found in your research?

A Yes.

Q How did you find it?

A So these documents are included with the medication, and you can search for them and they're available free online, too.

Q Okay. And did you find this one?

A Yes.

Q Where did you find this one?

A So good question. I believe it was from the FDA website, is my belief.

Q Okay. And you reviewed this document and provided it to the Board?

A Yes.

Q Based on -- and this appears to be a true and correct copy of what you provided?

A Yes.

MS. BRADLEY: Based on Dr. Hall's testimony, I would ask that Exhibit 10 be admitted.

HEARING OFFICER HALSTEAD: Ms. Buys?

MS. BUYS: We further note for the record our objection that this document appears to be updated. Ms. Bradley may be referencing the next exhibit with

regard to the date, as this is labeled as incomplete or partial, and the IC's Exhibit Number 11 is labeled as complete, but to the extent that it is updated, it is unclear and speculative as to whether it was in effect, the guidance provided at the time Dr. Nguyen provided care and treatment in 2016.

HEARING OFFICER HALSTEAD: Thank you.

MS. BUYS: Otherwise, we do. Thank you.

HEARING OFFICER HALSTEAD: All right. So noting that objection, Exhibit 10 will be admitted.

Q (BY MR. BRADLEY:) Okay. So let's turn to Exhibit 11. Have you seen this before, Dr. Hall?

A Yes.

Q And what is this?

A So this is further documentation from the manufacturer of Kenalog regarding the use and administration of that particular medication.

Q Okay. And I do think if we turn to the last page of this exhibit, we do see a date on there. What's the date on this one?

A June 2018.

Q And you located this document?

A The same process. I went to the FDA website.

Q Okay. And do you recall if it differs from

the previous one? Because they have the same title, at least. I can tell the print is different.

A I do not recall the distinction between these two.

MS. BUYS: To clarify for the record, when you say "The previous one," are you referring to IC's Exhibit Number 10?

MR. BRADLEY: Yeah.

MS. BUYS: Okay. Thank you for clarifying.

Q (BY MR. BRADLEY:) Okay. So is this something then that you provided to the Board when you reviewed this case?

A Yes.

Q And this appears to be a true and correct copy of what you provided to the Board?

A Yes.

MS. BRADLEY: Based on Dr. Hall's testimony, I'd ask that Exhibit 11 be admitted.

HEARING OFFICER HALSTEAD: Ms. Buys?

MS. BUYS: And consistent with our prior objections, we object that the date of this document is after the date of care. This is labeled June of 2018, and the care provided was in 2016, but we stipulate as to the admissibility that this was a document relied upon by

Dr. Nguyen.

HEARING OFFICER HALSTEAD: Thank you. I do note the objection, and Exhibit 11 is admitted.

Q (BY MS. BRADLEY:) So let's go to Exhibit 12, what's been pre-marked as 12 and not yet admitted. And this is titled, "Documenting Vaccination." Dr. Hall, have you seen this before?

A Yes.

Q And what is this?

A So this is information I obtained from an immunization website to provide information regarding how documentation would occur in the medical record.

Q Okay. And so this is about documenting a vaccination. Is there a vaccination in this case?

A There is no vaccination in this case.

Q So why did you pull this one?

A So I pulled this one because I was trying to find several references that would describe how when something is administered to a patient, how that would be documented in the medical record.

Q And so you felt that documenting the vaccination might be similar to documenting an injection?

A Yes.

MS. BRADLEY: Based on Dr. Hall's testimony,

I'd ask that Exhibit 12 be admitted.

HEARING OFFICER HALSTEAD: Ms. Buys?

MS. BUYS: And we'd just lodge further objection regarding the date of this article appears to be updated, and relevance as it refers to vaccination as opposed to a steroid injection but do stipulate as to its admissibility to show that this is a document that Dr. Hall relied upon in forming his opinions.

HEARING OFFICER HALSTEAD: Thank you. With that, I note the objection, and Exhibit 12 will be admitted.

Q (BY MR. BRADLEY:) Okay. And Exhibit 13, Dr. Hall, do you see that one?

A I do.

Q And it's titled, "Evaluating Medical Decision Making Capacity in Practice." Do you see a date for this article?

A Yes. So the article was published on July 1st, 2018.

Q And does this appear to be a true and correct copy of what you provided to the Board with your review?

A Yes, it does.

Q And you relied on this as part of your review of this case?

A Yes.

Q And I think you already testified, but what's contained in here would not be different than what was the standard of care as of November 4th, 2016?

A Yes.

MS. BRADLEY: Based on Dr. Hall's testimony, I'd ask that Exhibit 13 be admitted.

HEARING OFFICER HALSTEAD: Ms. Buys?

MS. BUYS: Thank you. Respondent further objects that the date of this article appears to be July 1st, 2018, which was almost two years after the care provided in 2016, and therefore not in existence at the time but does stipulate that this is an article that Dr. Hall relied upon in forming his opinions in this matter.

HEARING OFFICER HALSTEAD: Thank you. I note the objection, and Exhibit 13 is admitted.

Q (BY MR. BRADLEY:) Then let's look at Exhibit 14 next, please. So this is titled, "Croup." What does this appear to be from?

A So this is an article published in the Lancet, which is a medical journal.

Q Okay. And then I think we can look at the date on top there as well.

A Yes. This article was published in January or February of 2008.

Q Okay. And does this appear to be a true and correct copy of an article that you provided to the Board?

A Yes.

Q And this is something that you relied on in your review of this case?

A Yes.

MS. BRADLEY: Based on Dr. Hall's testimony, I'd ask that Exhibit 14 be admitted.

HEARING OFFICER HALSTEAD: Ms. Buys?

MS. BUYS: And we stipulate that this is an article that Dr. Hall relied upon in forming his opinions in this matter and therefore stipulate to its admissibility.

HEARING OFFICER HALSTEAD: Thank you. Exhibit 14 will be admitted.

Q (BY MR. BRADLEY:) So now we are on Exhibit 15. This is titled, "Chapter 15: Intramuscular Subcutaneous and Intradermal Injections." Have you seen this before, Dr. Hall?

A Yes.

Q And what is that?

A So this is one of the chapters from a textbook on current procedures in pediatrics, and it's information from that particular publication.

Q Okay. Do we have a date for this, I wonder? Let's see from the back.

A I think I should be able to find it here. So this particular book was published in 2007.

Q Okay. 2007?

A Yes.

Q Okay. And does this appear to be a true and correct copy of the chapter that you reviewed when forming your opinion in this case?

A Yes.

MS. BRADLEY: Based on Dr. Hall's testimony, I'd ask that Exhibit 15 be admitted.

HEARING OFFICER HALSTEAD: Ms. Buys?

MS. BUYS: And then we further also go and object to the extent we can't find a date on the copy of the article that we have. It appears to be updated to us as well as object to the reference to intradermal injections. It's not relevant to the care at issue in this case. We do stipulate as to its admission to show that this is a document Dr. Hall relied upon in forming his opinions in this case.

HEARING OFFICER HALSTEAD: Thank you. I note the objection, and Respondent's Exhibit 15 is admitted.

Q (BY MS. BRADLEY:) Dr. Hall, why did you pull this document? Do you remember in your review?

A Yes. I was trying to find the most relevant information I could regarding the clinical situation presented, which was an intramuscular injection in a pediatric patient.

Q And you testified that this is from a book called -- What was the name of the book again?

A The name of the book is Current Procedures; Pediatrics."

Q Okay. Thank you. All right. And then let's go to Exhibit 16. This is titled, "Musculoskeletal Injections - a Review of the Evidence." Have you seen this before?

A Yes.

Q And what is this?

A So this is an article written in the American Family Physician regarding musculoskeletal injections.

Q And it appears it's dated October 15, 2008?

A That is correct.

Q And does this appear to be a true and correct copy of an article that you provided to the Board?

A Yes.

Q And you relied on this in forming your opinion in this case?

A Yes.

Q And it's about musculoskeletal injections. Is that the same kind of injection that we had in this case?

A There's a distinction I would draw between generally what we would call a musculoskeletal injection versus what was administered to Patient A in this case. Having said that, there are some similarities.

Q And so you felt like it was relevant to review?

A It was relevant. Yes.

MS. BRADLEY: Okay. Based on Dr. Hall's testimony, I would ask that Exhibit 17 be admitted.

HEARING OFFICER HALSTEAD: Exhibit 16.

MS. BRADLEY: Sorry. Yeah. Sixteen. I apologize. Gosh, I'm already jumping ahead.

HEARING OFFICER HALSTEAD: Ms. Buys?

MS. BUYS: Yes, and Respondent further objects that again, we're dealing with an intramuscular injection rather that a musculoskeletal injection and therefore objects to the relevance of this article as to

the standard of care; both its reference to treatment of conditions such as bursitis and carpal tunnel which are not at issue in this matter. But we do, however, stipulate to the admissibility to demonstrate this was an article relied upon by Dr. Hall in forming his opinions in this case.

HEARING OFFICER HALSTEAD: Thank you. I note the objection and I admit Respondent's Exhibit 16.

Q (BY MS. BRADLEY:) Okay. I then would go to Exhibit 17, which is titled, "Joint and Soft Tissue Injection." Have you seen this before, Dr. Hall?

A Yes.

Q And what is it?

A So it is an article written for the American Family Physician describing joint and soft tissue injections.

Q And is that the same kind of injection we have in this case?

A It is, yes, generally speaking, yes.

Q Okay. Maybe can you explain that for me? Because a joint injection sounds different to me than an intramuscular one, but I'm not a doctor.

A Yeah. So the difference that I would describe is a joint injection is what you would imagine,

and that involves putting a needle into a joint and administering a medication. A soft tissue injection would be different. That would be placing medication into the soft tissues. And by definition in this article, that would include into subcutaneous tissues or into the muscles.

Q Okay. And this appears to be a true and correct copy of an article that you provided to the Board in your review of this case?

A Yes.

Q And then for the record, I think on the bottom of the first page there, there's a date of this article. Do you see that?

A Yes. July 15th, 2002.

MS. BRADLEY: Based on Dr. Hall's testimony, we would ask that this article be admitted into evidence.

HEARING OFFICER HALSTEAD: Ms. Buys?

MS. BUYS: And yes, we further object as to the relevance of this article as it deals with again joint and soft tissue injections as opposed to intramuscular injection for treatment of respiratory symptoms, and we therefore object to the relevance as to the standard of care. However, we do stipulate to the admissibility to show that there was an article relied

upon by Dr. Hall in forming his opinions in this matter.

HEARING OFFICER HALSTEAD: Okay. I note the objection. I admit Respondent's Exhibit 17. Thank you.

Q (BY MR. BRADLEY:) So, Dr. Hall, I think you've looked at the Board's Exhibit 5 a lot, and we've also looked at the Board's Exhibit 11 or -- sorry -- Respondent's Exhibit 11, which is that shot record. If we go to --

HEARING OFFICER HALSTEAD: Respondent's Exhibit 12.

Q (BY MS. BRADLEY:) Oh, Respondent's Exhibit 12. I apologize. I need to change these. I'll do that at lunch. If we go to Respondent's Exhibit I think it's 5 and 6, I'm looking at medical records. Is that what we have for 5 and 6 for Respondent?

MS. BUYS: Are you referring to a certain Bates stamped page?

MS. BRADLEY: No, I'm just referring to the exhibits and I'm hoping I have the exhibit numbers right.

HEARING OFFICER HALSTEAD: Respondent's 5?

MS. BRADLEY: Respondent's 5 and Respondent's 6.

HEARING OFFICER HALSTEAD: And Respondent's 6.

MS. BRADLEY: Yes. Okay. I'm looking at the right thing, and I think that you have them in your binder too.

HEARING OFFICER HALSTEAD: Ms. Buys, I have Respondent's 5 is the HealthCare Partners Medical Group-700 building with the address of Warm Springs Road, and then Exhibit 6 starts with a certificate of the custodian of records, and its corporate office and it says: "Allscripts" on the top right.

MS. BUYS: Thank you. That's what we have in front of us as well.

HEARING OFFICER HALSTEAD: Okay. Thank you.

Q (BY MR. BRADLEY:) Have you seen these before, Dr. Hall?

A I may be out of order here because I think mine are a little different. I just need to make sure I'm on the right record.

Q Okay. That's 5.

A We're going to use this one. All right. I got it. Number five.

Q Yeah. Have you seen those before?

A This first page, I have not seen before or at least I don't recall seeing it before. I do recall -- so the first page, I've not seen before. The subsequent

pages are consistent with what I reviewed regarding the medical record from the date of service November 4th, 2016.

Q And I guess I just want to talk about the records a little bit. Are you familiar with a standard in Nevada regarding what consists of timely, legible accurate and complete medical records?

A I would say your description is somewhat self-evident to me that medical records should be legible, they should be completed in a timely manner, so yes.

Q Okay. And I know I've had you look at a lot of the Board's exhibits, and the reason I wanted you to look at the Respondent's is I think there's a handful more pages of medical records that Dr. Nguyen has provided than what we had initially obtained.

A Yeah, I agree. Yes, I agree.

Q Okay. Because my question really is: Based on what we've talked about today, would you say these records are timely, legible, accurate and complete?

A What I reviewed previously, so that for the record is pages 2, 3, and 4, appear to me to be timely, legible and accurate in the sense that there are -- Well, I'm aware that there are some additional pages now,

so I would question if we had all of the medical records with my original review. That's what I would question.

Q Okay. But, for example, I think we talked about the informed consent documentation.

A Yes.

Q Do you think that should have been more complete in the record?

A Yes.

Q And so if informed consent isn't documented as completely, I mean, does that make the record now not complete?

A Yes. One would need to document informed consent. Yes.

Q And if it's not documented, I've heard people say if it's not documented, it didn't happen. Is that something --

A I've heard the same thing.

Q And where have you heard that?

A Well, in my medical training and certainly from a medical/legal perspective, I've heard the same principle discussed.

Q Okay. Why is documentation so important in patient records?

A Well, I think this is a great example, is

we've heard testimony today from Mrs. DelGrosso, and it's difficult to recollect an event that happened years ago. And so to provide an accurate, timely and legible medical record provides an opportunity to support a treatment plan and provide an appropriate indication for the recommendations provided.

Q Okay. And then as far as the Board's standard for malpractice, are you familiar with that?

A I've read through it.

Q Okay. And is it your understanding that it's different perhaps than it might be in a civil case?

A Yes.

Q Do you know how it's different?

A I don't.

Q So the Board's standard for malpractice is that a person has failed to use reasonable care, skill, or knowledge ordinarily used under similar circumstances. So do you believe that Dr. Nyugen's care constitutes malpractice as defined by the Board?

A So yes, so my written statement, yes, I stated that.

Q Okay. And what was the reason for that?

A There were three reasons that I made that statement. Number one: I could not find documentation

of informed consent for administration of Kenalog intramuscularly. Number two: I didn't understand the reasoning behind providing both oral and intramuscular corticosteroids. And finally, there wasn't -- in the medical record I initially reviewed -- there was not a description of how the injection was administered.

Q Okay. And but now we have that?

A We now have that.

Q Okay. But also too, just to clarify, I think you talked about the two, both the oral and the injection, but there's also the question of whether so there's the redundant medication.

A Yes.

Q But there's also the question of whether the shot was necessary at all.

A Yes.

MS. BRADLEY: All right. I have no further questions for Dr. Hall at this time.

MS. BUYS: I believe it's about 11:15 now. Would everyone be all right breaking for lunch a little bit earlier than noon?

MS. BRADLEY: No. I'm not sure Dr. Hall is going to be available much after lunch, and so I would suggest that if you have cross-examination for him that

it be done now.

HEARING OFFICER HALSTEAD: Do you need a small break, Ms. Buys?

MS. BUYS: Yes, that would be great.

HEARING OFFICER HALSTEAD: Okay. So it's 11:16, so why don't we come back at 11:25.

MS. BRADLEY: Okay. Thank you.

(Recess.)

HEARING OFFICER HALSTEAD: I noted that everyone is back present. Are you prepared to continue?

MS. BUYS: Yes. Can everybody hear us okay?

HEARING OFFICER HALSTEAD: We can now.

MS. BUYS: Yes, we're ready to go back.

HEARING OFFICER HALSTEAD: We're back on the record. It is now 11:29 a.m., and I remind Dr. Hall that you remain under oath.

Go ahead, Ms. Buys. Thank you.

CROSS-EXAMINATION

BY MS. BUYS:

Q Thank you so much. Dr. Hall, I believe that you testified that you've been a consultant for the Nevada State Board for cases other than this matter; is that correct?

A So I've been a peer reviewer for other cases, yes.

Q And how many of those cases have you reviewed for the Nevada Board of Medical Examiners?

A I would estimate around eight.

Q And how many years have you been a consultant to the Nevada State Board?

A I would estimate since approximately 2010.

Q And, Dr. Hall, to your understanding, were you the only physician to have conducted a review of this case pursuant to the request of the Nevada Board of Medical Examiners Investigative Committee?

A I'm aware of no other physicians who have looked at this case. Yes.

Q Apart from the documents that have been disclosed by the Investigative Committee which I believe were marked as exhibits, they were investigative exhibits 5 through I believe it's 17, if I have that correctly, did you rely on any other documents or information in formulating your opinions about this case?

A No.

Q Have you ever seen Patient A or had an opportunity to examine Patient A?

A No.

Q Is it fair to say that you have not directly observed any skin -- I believe we referred to it as a divot on Patient A yourself; is that correct?

A That's correct.

Q And, Dr. Hall, did you review all of the care and treatment received by Patient A or just care that was provided by Dr. Nguyen?

A So I was given additional medical records which I included a list of in my review, so there were additional medical records that I reviewed as requested as provided by the State Medical Board.

Q All right. I'll just make a note that we were not provided a list of any written documents that you had reviewed or a written statement. Is it your testimony that you had a written list of documents you reviewed as well as a written report that you provided to the Investigative Committee?

A Yes, that is correct. So I received additional medical records beyond the date of service in question as part of my review.

Q All right. And I just want to make a note for the record that those documents were requested by Dr. Nguyen, a motion was filed, and that objection was overruled. And I just wanted to make that clear for the

record that we had not had an opportunity to review any of those additional documents.

So, Dr. Hall, I just want to clarify as well. Would you agree that the date Dr. Nguyen provided care to Patient A was November 4th of 2016?

A Yes, that's the date of service on the medical record.

Q All right. Do you know where the date of November 11, 2016 came from? Do you have any understanding?

A I do not.

Q Okay. Would you agree with me that the Nevada State Board of Medical Examiners should list all of the testimony and facts of the case before determination is made about Dr. Nguyen both from the Respondent and all expert witnesses called to testify?

A You're going to have to forgive me. I am not experienced legally, but obviously, the principle of providing evidence, complete evidence is, I think, important.

Q Gotcha. So is it fair to say if you were sitting to the right of me where Dr. Nguyen is, you would want the Board to consider evidence from the Respondent as well as the Investigative Committee; is that fair

enough?

A Yes.

Q Okay. Are we in agreement that this child, Patient A, was so sick that on November 4th, 2016, her parents thought she needed to be seen at an urgent care clinic because they didn't want to risk waiting a few days to see her pediatrician at an appointment?

A That was the testimony of Patient A's mother. Yes.

Q All right. And I believe you had testified to this earlier, but can we agree that the illness the patient complained of principally presented as a respiratory illness?

A Yes.

Q Okay. And would you agree with me that the standard of care for a physician is determined based upon the date the care was provided?

A Yes.

Q All right. And what is your definition of the standard of care just for the record?

A Well, I would agree with what was stated previously. I don't have the exact definition in front of me, but to follow generally accepted medical standards and to provide appropriate documentation.

Q All right. And that's the definition you relied upon in forming your opinions in this case; is that correct?

A So I relied upon the statement that Ms. Bradley read previously.

Q All right. And you had also testified that you had reviewed the records that were, I believe, admitted as the IC's Exhibit Number 5 as well as Respondent's exhibits I believe they're listed as Exhibits Number 7 and 8 which have both Bates stamps at the bottom: HCP 001 through 17 and the admin log 1 through 7 as well as Respondent's Exhibit -- I believe it's Number 13 with patient administration details. Do you have those documents in front of you?

A We're trying to find those, so we might need you to go back through them and list them. So I do have, on the State Medical Board Exhibit 5, that's the medical record. And then from the -- this would be from the Respondent's exhibit binder under 5, I've got the HealthCare Partners Medical Group. It's part of medical record. And pages two, three, and four are consistent, are the same documents that are under Exhibit 5 for the State Medical Board's record. And then which were the other ones that you wanted to ask about?

MS. BUYS: I also wanted to talk about the medical administration log, which I believe we now have listed as Respondent's Exhibit Number 6, as well as the medication administration details, which is Respondent's Exhibit Number 12.

MS. BUYS: So I believe we have the same document as listed as Number 6, and we have a declaration, under Exhibit 12, we have a declaration from Melissa Vogt. That's what I have.

HEARING OFFICER HALSTEAD: So they're going to be one number, I think. Like if she says 12, it's going to be 13. If she says it's six, it's going to be seven.

THE WITNESS: Oh, okay. Sorry. So with clarification, we also have standard operating procedure for HealthCare Partners of Nevada. We do have that exhibit, but it's under a different number on my binder.

HEARING OFFICER HALSTEAD: Can you just clarify each exhibit, and if it's Respondent as or the Board's, and I'll clarify for everyone on this end.

Q (BY MS. BUYS:) Thank you. I was referring also to it is Respondent's Exhibit -- I believe we stipulated to its admission as Respondent's Exhibit Number 12, and it's Medical Administration Details, Bates

stamped Med Admin Details 00001 through 2.

A Yes, I have that one.

Q Okay. Perfect. And have you had an opportunity to review all of these documents before your testimony here today?

A So the document that you just referenced, I received this by email the night of May 23rd, and I did review that. Under Exhibit 5, so on Exhibit 5, I have not reviewed until today or have not seen until today pages 1, 5, and 6. So I did not receive 1, 5 or 6 previous to today.

Q All right. And when you say Exhibit Number 5, are you referring to it's medical records from HealthCare Partners and Bates stamped at the bottom HCP 01 through 17?

A Yeah, so that is correct. I'm referring to the medical record from HealthCare Partners under Respondent's Exhibit 5, and I'm referring to HCP 1, 5, 6, and 7 are the ones that I have not previously reviewed.

Q All right. Thank you for clarifying. I just wanted to make that point for the record. If you could please go and take a look at that it's Respondent's Exhibit Number 12, the Medication Administration Details.

A Yes.

Q Do you have that in front of you?

A I do. Thank you.

Q Thank you. I believe Ms. Bradley had asked you earlier about the dosage for the Kenalog injection, and if I recall your testimony correctly, you believed you had stated it was one mL. Is that correct?

A So there -- I was a little confused, and there is a distinction between what is documented under Tab 5 and what is documented under Tab 12. So under Tab 5, if you look at the Kenalog order, the order says Kenalog, 40 milligrams per milliliter, and it says: Inject 0.5 milliliters intramuscularly. That dosing would be 20 milligrams. However, on Exhibit 12, the documentation here lists a dose of 1 milliliter, which would be 40 milligrams of Kenalog. So there is a little distinction.

Q All right. Just to clarify for the record, Doctor, where do you see that 1 milliliter on this documentation? I believe -- actually, strike that. Do you see at the top of the page under it says, "Administration details"?

A Yes.

Q There is a statement right there. It looks like it reads inject --

A Yes.
Q -- 0.5 mL intramuscularly once.
A Yes. So that --
Q Do you see that?
A I do. Yes.
Q All right. And did I read that correctly?
A Yeah, that is correct.
Q All right. And the notation: Inject 0.5 milliliters intramuscularly once, would that be consistent with the records that you reviewed in Exhibit Number 5 regarding the .5 milliliter injection?
A Yes, it would.
Q All right. So to clarify -- Strike that. Would .5 milliliters of a 40 milligram per milliliter injection, would that be 20 milligrams per milliliter?
A Yes, it would be 20 milligrams.
Q Twenty milligrams. Thank you for clarifying. And so would it be consistent that Dr. Nyugen's documentation indicates that it was 20 milligrams that was administered?
A Yes, I believe that is correct. That is what is stated in Exhibit 5. And also, as you pointed out in that section right underneath administration details, that is the exact same description there. So yes, I

believe the correct dosing is going to be 20 milligrams that was administered of Kenalog.

MS. BUYS: Thank you.

HEARING OFFICER HALSTEAD: Sorry. Can you point out to me the reference that you're both referring to on Exhibit 5 just so I can make sure that I'm in the same place?

THE WITNESS: Yeah, it's --

MS. BUYS: Certainly. I was referring to it looks like it's that paragraph that --

HEARING OFFICER HALSTEAD: Okay. I see Exhibit 5. I'm sorry I misspoke. Exhibit 12.

THE WITNESS: Yeah, right here. So if you look right there.

HEARING OFFICER HALSTEAD: Where it says dose: 1 unit milliliter.

THE WITNESS: I'm sorry. Look above that.

HEARING OFFICER HALSTEAD: Okay. Injection of 0.5 milliliter.

THE WITNESS: There you go.

HEARING OFFICER HALSTEAD: Thank you.

Q (BY MS. BUYS:) Thank you. For the record, that's on Bates stamp page Med Admin Details 00001 just for the record to make sure we're all on the same page.

Dr. Hall, I believe you had testified regarding your opinions as to the care and treatment that Dr. Nguyen provided when Mr. Bradley was asking you questions. Do you remember that?

A Yes.

Q Did you express all of the opinions and criticisms that you had had about Dr. Nyugen's care at the time that she was asking you questions?

A Can you repeat that?

Q Certainly. Let me rephrase.

HEARING OFFICER HALSTEAD: Would you like that read back, Ms. Buys?

MS. BUYS: Yes, that would be great.

(Requested portion read by the reporter.)

THE WITNESS: So my recollection is I brought up three specific concerns, and those represent the three concerns that I had when I reviewed the medical record.

Q (BY MS. BUYS:) Thank you. But you don't have any additional concerns or criticisms other than those three that you had testified to; is that correct?

A That is correct. Yes.

Q Okay. And, Dr. Hall, how many patients with croup have you treated in your office?

A Over what time period?

Q Over the course of your career as a family medicine/sports medicine physician.

A Oh, gosh. Hundreds. Somewhere -- quite a few.

Q All right. And all of those patients, were they treated in your private office or were they seen in hospitals?

A So if you extend all of my medical training, in my medical training, I saw them both in the office and in the hospital. I've not done hospital medicine for more than ten years, so recently, it's just been in my office.

Q And of those patients, how many specifically did you see at your office? Can you estimate a number?

A More than 100.

Q All right. And in your experience, Doctor, how many two-year-olds resist having medication injected?

A All of them.

Q And how many require additional assistance from a parent to help kind of stabilize them during an administration of an injectable medication?

A All of them.

Q In your experience, Doctor, has a child who has had a history of vomiting ever thrown up medication

that was taken orally?

A Yes.

Q And if a child vomits up oral medication, how is the parent supposed to know how much medication they threw up?

A That's difficult to estimate.

Q And I believe when you reviewed -- you had stated that you had reviewed the records for Patient A. On November 4th, 2016, what percentile was Patient A for weight for a three-year-old child?

MS. BRADLEY: I'm going to object. That misstates the evidence. She wasn't three years old.

Q (BY MS. BUYS:) Right. I just would like to know for a three-year-old though.

A And the question is percentile?

Q Correct. What percentile was Patient A?

MS. BRADLEY: I'm still going to object. I don't understand why we're asking about a three-year-old when the patient wasn't three. The patient was not quite two.

HEARING OFFICER HALSTEAD: Ms. Buys --

MS. BRADLEY: So what's the relevance of a three-year-old?

HEARING OFFICER HALSTEAD: -- can you repeat

the question for me, please?

MS. BUYS: Certainly. I was inquiring as to the percentile for this child's weight as in a three-year old's percentile. She appears to me to be rather large even for a two-year-old. However, I could certainly go and rephrase the question as to what percentile this child was for a two-year-old.

HEARING OFFICER HALSTEAD: Go ahead.

THE WITNESS: So I don't have the percentile chart in front of me, so I don't know that I can answer that question as to what percentile this child would fall under.

Q (BY MS. BUYS:) All right. And so leading to my other question, do you recall if the weight of the child was documented in the medical record?

A Yeah. So as documented here, the child was 33 pounds.

Q All right. And just to clarify, it's your testimony that at this time, as you sit here today, you cannot state what percentile weight the child would be in as you would need to refer to a chart; is that correct?

A That is correct.

Q All right. And in your experience treating pediatric patients, how often are two-year-old pediatric

patients ambulating for, you know, approximately six, nine months?

A How often are they ambulating?

Q Correct.

A So two-year-olds, if they were following normal development, would be walking.

Q You were present during Ms. DelGrosso's testimony. Do you recall her stating that her daughter was walking at the time?

A I don't recall for sure, but it would make sense to me that that would be the case.

Q All right. And switching gears a little bit, Doctor, based on your experience, can children be hospitalized due to croup?

A Absolutely.

Q Or croup-like symptoms?

A Yes.

Q And was this child hospitalized following her November 4th, 2016 urgent care visit with Dr. Nguyen due to croup?

A Not according to the medical records I reviewed.

Q Can children die from croup?

A Yes.

Q And based on your review and your investigation, this child, Patient A did not die; is that correct?

A That is correct.

Q Could it be that the treatment provided by Dr. Nguyen prevented this child from being hospitalized or, you know, suffering a more serious outcome like death?

A Yes.

Q And have you seen any cases of a single injection leading to a gluteal muscle atrophy?

A Yes.

Q How many times have you seen a single injection leading to a gluteal muscle atrophy?

A The number that comes to my mind is about four.

Q Were any of these pediatric patients?

A No.

Q Were any of those patients administered a series of steroid injections?

A I don't recall.

Q And I believe when you had testified earlier that I apologize -- Strike that. I believe you had testified earlier that complications can occur despite a

steroid injection being administered intramuscularly appropriately, that that's an issue that can still occur. Is that correct?

A That is correct.

Q All right. And I also believed that you had referenced some FDA guidance regarding Kenalog injections as the basis of your opinion. Is that correct?

A That is correct.

Q All right. And I believe we had discussed earlier that the FDA guidance that you had referred to was revised in 2018. Do you recall that?

A So just for clarification, the FDA stores the information as provided by the manufacturer of the medications, and I think it was referenced -- and I'm trying to find it, but one of the references did list a date of publication of 2018. Yes.

Q All right. And I believe that you had provided two copies of that FDA guidance. One seems like it was partial and the other one was sort of labeled as a complete. Do you recall seeing those exhibits?

A I do. Yes.

Q And you provided both of those exhibits to the investigative committee; is that correct?

A I believe I did. Yes.

Q Are those the same document as the partial exhibit a, you know, direct copy of the more complete exhibit, it's just missing some of the pages?

A I would have to look. I am not sure exactly what the distinction is between those two documents. They appear fairly similar to me.

Q And my next question would be for that partial document, would it be your understanding that that shows part of the revised 2018 guidance for a Kenalog injection?

A I'm trying to see if I can answer that here.

Q Certainly. Take your time reviewing.

A So what I'm seeing under Exhibit 10 is a partial copy of the manufacturer's information regarding Kenalog, and under Exhibit 11 -- so Exhibit 10 is a larger in size and so it's a little easier on my eyes, and so Exhibit 11 is a smaller but essentially similar document, but it is not -- it is not complete in terms of every page. That's what I'm seeing.

Q All right. And just to clarify and come back to my question, is it your understanding that that IC Exhibit 10 is documentation that was revised in 2018 similar to the IC's Exhibit 10?

A I cannot testify as to when this was revised.

I can testify that the date listed is 2018.

Q Okay. Thank you, Doctor. And do you recall when you pulled this FDA guidance?

A Yeah, somewhere I wrote it down. So I accessed the information on July 21st, 2018.

Q Thank you. And I'd like to draw your attention to it was Respondent's Exhibit Number 11. Specifically, it is Bates stamp BMS underscore (2011) underscore 000017.

A I think we have that one.

Q Perfect. And it should have that Bates stamp at the bottom of BMS underscore (2011) 00001.

A I do have that. Yes.

Q All right. And, Doctor, under the header "Dosage, Systematic," could you please read the first sentence of the paragraph that appears directly after the words "dosage systematic" on that page? Just the first sentence.

HEARING OFFICER HALSTEAD: It's going to be page 17.

THE WITNESS: Seventeen. Okay. Yes, I can. "The suggested initial dose is 60 milligrams injected deeply into the gluteal muscle."

Q (BY MS. BUYS:) All right. And just for the

record as well, Doctor, this was the FDA guidance that was available in 2016, revised in 2011. The date of that is on the back on Bates stamp page 20 of that exhibit. Based on that first sentence -- actually, strike that. Have you ever seen this document before, Dr. Hall?

A I have not seen this particular version, but my initial thought is it looks very similar to the document in the exhibits from the State Medical Board.

Q Gotcha. And based upon this document, which is I'll represent to you the FDA guidance that was revised in 2011 for a Kenalog 40-milligram injection -- make sure I have it correctly. The title is "Kenalog 40 Injection." In 2016, Doctor, did the FDA approve the use of a Kenalog injection by administering it deeply into the gluteal muscle?

A Yes.

Q And, Doctor, I'd also like to draw your attention on that same exhibit, but it is on page 14. So it's Bates stamp BMS underscore (2011) 000014. Do you have that in front of you?

A I do.

Q All right, Doctor. And do you see that there is a second paragraph on that page?

A I do.

Q All right. And at the top of that second paragraph, does it state quote, "The efficacy and safety of corticosteroids in the pediatric population are based on the well-established course of effect of corticosteroids which is similar in pediatric and adult populations"?

A Yes, I see that.

Q All right. And I read that correctly; correct?

A Yes.

Q All right, Doctor. And based on that FDA guidance, in 2016, did the FDA approve of the use of Kenalog injections in pediatric patients?

A Yes.

Q All right. And based on your review of this, Doctor, in 2016, did the FDA approve of the use of Kenalog injections for a respiratory illness?

A Yes. Yes. I believe that is listed here.

Q All right. And you previously testified regarding the FDA guidance on the location of a Kenalog injection is gluteal muscle. Is that correct?

A Yes.

Q All right. Which is the exact location this injection was given. Is that correct?

A That is the location listed on the medical record. Yes.

Q Okay. And does the standard of care require that a doctor ignore an approved process by the FDA on where an injection should be administered?

A There are different sites of administration that can be utilized, and I would reference one of the other exhibits described some other locations that Kenalog may be administered, and especially in the pediatric population, but administering it into the gluteal area is probably the most common place that these medications are administered.

Q So would it be the standard of care for a reasonable physician to administer this type of Kenalog injection into the gluteal muscle?

A Yes.

Q Okay. And, Doctor, what is the percentage of people who get a cutaneous or subcutaneous atrophy from a single steroid injection?

A I would estimate it's very low.

Q And, Dr. Hall, I can't quite put my hands on it, but can you please tell me the Nevada case, regulation or statute that says that standard of care requires that consent for a Kenalog injection be written?

A I could not cite that.

Q And I believe you had testified as to your opinions regarding consent in this matter. Do you recall that?

A I do.

Q In your experience, Doctor, do patients sometimes forget every single side effect or risk of a treatment that you've gone through with them?

A Patients' recollections can be incomplete.

Q And in your experience, is it possible that, you know, a patient could go and understand the risks and benefits and alternatives to treatment at the time you provide them care and then, you know, approximately five or so years later, they can't recall specifically what was discussed?

A I think that yes, that can happen.

Q And I believe there was also testimony that this divot is on the left buttock of Patient A. Is that correct?

A Yes.

Q And you had testified that you reviewed photographs which I believe it was the IC Exhibit Number 6?

A Yes.

Q Is that correct?

A That is correct.

Q And your understanding is that it shows a divot on the left buttock?

A Yes.

Q Okay. And then going back to Respondent's Exhibit Number 13, if I can pull that in front of you, it's the Medication Administration Details.

A Yes. Okay. I've got that as number 12.

Q Yeah, I think the numbering was off, so just to clarify for the record, do you have the document in front of you? It's Bates stamped med admin details --

A Yes.

Q -- 001?

HEARING OFFICER HALSTEAD: That's going to be Respondent's Exhibit 12.

Q (BY MS. BUYS:) Okay. Thank you for clarifying.

Doctor, do you see where it lists a site where a Kenalog injection was administered for the Patient A?

A I do.

Q And where is the site documented?

A It's documented as the right gluteal region.

Q All right. And in your experience, Doctor, if an injection is given on the right gluteal muscle intramuscularly, can that lead to a divot on the left buttock?

A No, I would not expect that.

Q All right. How quickly after a steroid injection would you expect a divot like this to occur in a patient?

A It takes some time. I would generally agree with the description from Ms. DelGrosso. The atrophy occurs -- you wouldn't necessarily see initially, and it would take a little time to develop, and I would estimate weeks to months for it to fully mature.

Q Can you estimate more specifically the time that you would believe it would mature?

A I would say in my experience, one to two months.

Q Okay. And so just to clarify as well, when you mentioned the word "atrophy," are you referring to muscle atrophy or subcutaneous atrophy?

A Well, I've not seen medical evidence that makes a distinction there. We generally feel the atrophy is more related to the subcutaneous tissue rather than the muscle, but I've not seen evidence to help us answer

that question as to which part of the body atrophies more.

Q All right. So to clarify, your opinions in this case do not draw a distinction between a muscle atrophy or a subcutaneous atrophy?

A Right. I don't think I can tell you which one it was. Yes.

Q Okay. And, Doctor, are there occurrences where a patient can have spontaneous lipodystrophy or a subcutaneous dystrophy?

A I've never seen it.

Q And my question is a little bit different. Not necessarily if you've ever seen it, but are you aware if there are any occurrences of spontaneous lipodystrophy or subcutaneous dystrophy?

A I'm unaware of spontaneous atrophy.

Q All right. And to clarify, that's spontaneous lipodystrophy or subcutaneous atrophy; correct?

A That is correct.

Q All right. And would it be possible that subcutaneous atrophy could occur as a result of trauma?

A It would be possible.

Q All right. And would that trauma include a

patient falling?

A It could.

Q All right. And I believe you had also testified regarding your criticisms as to the consent documentation. Do you remember that testimony?

A Yes.

Q And if you recall correctly, your criticism was that Dr. Nguyen only documented that the patient verbalized and agreed with the treatment plan and that it was your understanding that that was referring to Patient A as opposed to the patient's proxy or parent. Is that right?

A That is correct.

Q Okay. Is it common for a physician to refer to a pediatric patient just as patient mean that to encompass the patient's proxy like a patient?

A I would say no, I would not say that's common.

Q All right. And what do you base that opinion on?

A My medical experience. Normally, the medical record will draw a distinction between a pediatric patient and the adult parents.

Q All right. And in your review of the medical

record in this case, did you see a reference to any of the patient's parents by name?

A In looking at Exhibit 5, I'll go back and look when I referenced it. I do not see a direct reference to the parents in the medical record I was provided.

HEARING OFFICER HALSTEAD: Are you looking at Board's Exhibit 5?

THE WITNESS: I am. Yes.

HEARING OFFICER HALSTEAD: Okay. Maybe you want to take a moment to read through that before you --

THE WITNESS: Unless I'm missing something, I don't see a discussion about the parents.

Q (BY MS. BUYS:) All right. And I'll go clarify, Doctor. You have the Board's Exhibit 5 in front of you. Is that correct?

A That is correct.

Q All right. On that first page under history of present illness slash review of symptoms, do you see a paragraph towards the bottom?

A Yeah, I do. And I see at the top of that, there is a description: "Toddler here with her parents."

Q Okay. And so there is reference to the patient's parents being there as part --

A Yes.

Q -- of the visit; is that correct?

A That is correct.

Q All right. And then I also wanted to draw your attention, Doctor, to Respondent's exhibit. We'll pull this one, and it is going to be Respondent's Exhibit Number 5 that was admitted. And at the bottom, Bates stamp HCP 007. Do you see that?

A Yes, I do.

Q And is it your understanding, Doctor, that the medical insurance and driver's license that are included as part of Patient's A record are her parents'?

A Yes.

Q Okay. And so your criticism of Dr. Nguyen regarding consent is that it appeared to you that it was documented that it was the two-year-old giving the consent; is that correct?

A That is correct.

Q All right. But there is reference that the patient's parents were there as the patient's proxy; correct?

A That is correct.

Q Okay. And, Doctor, in your experience in treating a pediatric patient with croup, have you ever

done so in an urgent care setting?

A I have not worked in an urgent care, but we see urgent acute appointments in our office.

Q Gotcha. And was that a private office that you sort of ran as the solo practitioner?

A So I have worked in a couple different practice settings, but all of my practice settings have involved more than one provider.

Q And when you're treating a pediatric patient with possible croup, do you conduct a literature search every time that you see that type of patient to make sure you're adhering to the standard of care?

A I don't search literature with every patient, no.

Q All right. And would you agree that when completing a timely, accurate and complete medical record that it's appropriate for a doctor to finish signing his note after he reviews it?

A That is appropriate. Yes.

Q Okay. And do you sign your, I guess, narrative or progress note immediately after you see a patient?

A Not always.

Q Is it reasonable for a physician to wait

until the end of the day to finish signing and documenting his note?

A Yes, it is.

Q And when you had reviewed this document, I guess this case originally, you did not have the documentation that was the Respondent's Exhibit Number 12; correct?

A That is correct.

Q Okay. And so for the record, the prior criticisms regarding failure to document the lot number, failure to document expiration date, has that been satisfied based upon the production of this document?

A Yes, it has.

Q Okay. And when you were testifying regarding the standard of care in providing a Kenalog injection in a patient with respiratory illness, I believe you had testified that your criticism was that it was redundant to the oral medication. Is that correct?

A That is correct.

Q Okay. And is it your opinion that a reasonable provider who had been told that a patient previously did not get better with oral steroids alone would want to go and move towards considering an injection of a steroid?

A Can you ask that question again? I didn't quite understand.

Q Certainly. You know, and I'll strike that and rephrase. Could you please go ahead and pull up, I believe it was the IC's Exhibit 8. I believe it was titled, "Acute Management of Croup in the Emergency Department."

A Yeah.

Q Okay. Perfect. This is one of the documents you testified was the basis for your opinions; correct?

A That is correct.

Q All right. In the abstract, there appears to be a statement towards the bottom and it says quote, "Despite the evidence supporting the use of steroids as the cornerstone of croup treatment, there is significant practice variation among physicians treating croup in the emergency department." Did I read that correctly?

A Yes.

Q Based upon that sentence in this article that you relied upon, is there a significant practice variation among physicians on treating croup?

A So this author stated that there was.

Q And this was one of the articles that you relied upon --

A Yes.

Q -- in reviewing this case?

A Yes.

Q Okay. Gotcha. And so if a patient had respiratory illness, you know, possible croup and a physician had been told that oral steroids alone had previously not helped worsening symptoms, would it be reasonable for a physician to consider an injection of a steroid?

A It would.

Q Okay. And, Doctor, I believe you had testified as well that you had not previously treated patients in an urgent care setting. Is that correct?

A I generally don't work in the urgent care. I have done some urgent care work, but it's been -- that was many, many years ago. So not recently, I've not treated patients in an urgent care.

Q In your practice now, do you primarily focus on sports medicine?

A So I'm about 50/50, so I do general family medicine about 50 percent and about, I would say, acute musculoskeletal injuries about 50 percent.

Q And when you refer to acute musculoskeletal injury, are you referring to arthritis or more orthopedic

injuries?

A Typically, yes.

Q Okay. Have you ever treated a patient that has developed a divot as a result of a steroid injection?

A Yes.

Q How many patients have you seen treated with that?

A It's pretty rare. I think I mentioned it previously, I've encountered it four times. It's something around that.

Q And when you have treated a patient and recommended administration of a steroid injection, I believe you had also testified that you provide a written document as well as a verbal consent. Is that correct?

A That is correct.

Q Is that a pre-printed form that you provide your patients or is that -- Do you type a new written to form out every time?

A The way I currently do it, I have a macro that has standard language and includes some relevant information from the current situation, but you could roughly consider it a pre-printed form.

Q All right. How about in 2016?

A Yeah, we did the same approach at that point.

Yes.

Q Okay. And when you're referring to injections, that includes steroid injections as well as vaccinations; is that correct?

A So it would include when we're administering a medication. Vaccine, I've seen different practices use different styles, and I'm trying to think back on 2016 for vaccines. I don't know that we asked for written consent for a vaccine.

Q All right. And when you testified earlier, I believe you had stated that either verbal or written consent is appropriate. Did I recall that correctly?

A Yes, that is correct.

Q All right. And in this case, in your review of the records, is there a documentation referencing that the patient understood and verbalized the treatment plan?

A So according to the medical record I reviewed, it states the patient agrees with treatment plan and verbalizes understanding. Yes.

Q All right. And for purposes of my question, so we're on the same page, if patient is referring to the patient's proxy or the parent, would that be documentation of a consent discussion that was held prior to, you know, treatment?

A I think that would be a fairly weak description of consent for a Kenalog injection.

Q My question is a little bit different. Is that documentation of consent?

A That is documentation of consent.

Q Okay. Thank you, Doctor. And looking back, I believe you had also stated that there was a subtle difference in treatment between, I think you said, oral and Kenalog injections. Is that correct?

A Yes.

Q Okay. Could you explain further what you mean by "subtle difference"?

A Well, it's primarily a difference in the route of administration. So administering oral corticosteroids or intramuscular corticosteroids, both are very reasonable treatment approaches, and the distinction being the route of administration, and they're considered roughly equivalent in the context of providing care in the acute setting.

Q And I believe we had also sort of discussed a question as to the depth of the injection that was provided in this case. Do you remember testifying that there was a question regarding the depth of the injection?

A Yes.

Q All right. Can you state to a reasonable degree of medical probability what the depth of the injection was on the right gluteal muscle?

A I cannot.

MS. BRADLEY: I'm going to object because that's not the standard that the Board uses. I mean, the burden of proof in this case is a preponderance of the evidence which is not reasonable degree of medical certainty.

Q (BY MS. BUYS:) Well, I'll go and use the Board's phrasing if that makes it easier.

Doctor, can you state by a preponderance of the evidence the depth of the injection that was administered in the right gluteal muscle?

A There is no indication in the medical record as to the depth of the injection.

Q And since you haven't administered -- sorry. Since you have not seen the patient and you weren't present during the administration, can you testify to that?

A I cannot testify to the depth of the injection.

Q Okay. And it appears going back through that

the patient in this case has received potentially additional injections. Is that your understanding?

A Yes, during Ms. DelGrosso's testimony, she mentioned that there had been a second injection provided.

Q All right. And do you know the date of that second injection that was provided?

A She estimated fairly recently, but I couldn't give you a date.

Q You haven't reviewed any medical records regarding that injection, right?

A I have not.

Q All right. Us neither, Doctor. And another question I had regarding documentation. Do you document the depth of an injection of a steroid in your notes?

A So we do. We document it by the length of the needle that we use.

Q All right. And so where is that portion documented? Is it in the narrative or is it an additional shot record?

A So in my medical record, we have a procedure note, and it would be documented as part of your procedure note.

Q Is that a narrative where you can type in or

is that a checkmark box?

A So the way I document it, it's narrated.

Q Okay. And, Doctor, do you have medical assistants in your practice that assist you in providing patient care?

A Yes, I do.

Q All right. And is it reasonable for a physician to rely upon a medical assistant to administer a steroid injection?

A Yes.

Q Is it reasonable for a physician to rely upon a medical assistant to document the administration of a steroid injection?

A Yes.

Q Is it reasonable for a physician to rely upon a medical assistant to document the lot number, expiration and details from the vial?

A Yes, it is.

MS. BUYS: Okay. I believe I'm going to just review my notes right now. I believe that's all I have for you, Doctor, at this time. Thank you.

THE WITNESS: Thank you.

MS. BRADLEY: So for the record, I do have a couple redirect questions, but it is 12:25.

THE WITNESS: How long do you need?

MS. BRADLEY: I have just a few questions.

THE WITNESS: Do it.

REDIRECT EXAMINATION

BY MS. BRADLEY:

Q All right. So the first question in the medical records, whether it's the Board's or the Respondent's, did you see it documented that the oral medication in this case was thrown up, was vomited?

A No.

Q And if parents or a patient asks you for duplicate medication, is that something you would do just because they ask?

A No.

Q Is it documented in this case that -- Did Dr. Nguyen document that he was told that the patient didn't get better before from a respiratory illness?

A Not that I saw in the medical record.

Q Okay. And I think we talked about you talked about it in cross, but I want to double-check. On Exhibit 12 for Respondent is the administration record for the shot. Right?

A Yes.

Q And does it say who injected that shot?
A Yes. Chanel Hampton.
Q Is that reflected anywhere in the other medical record, that name?
A I do not see it under Exhibit 5. There was some narrative I was recently reviewing that it could be reflected on, but I did not see it on the other components of the medical report.
Q And I think the other narrative you might be referring to is Respondent's Exhibit 6 perhaps where there's some notes regarding --
A Yes, yes, yes. Yeah, so she is referenced or her name is included in Exhibit 6.
Q Okay. Would you consider that part of the medical record? I'm not quite sure what 6 is.
A I would consider it part of the medical record. To me, it represents a description of the work flow regarding the task that Dr. Nguyen had ordered. So I would consider it. Yes.
Q Okay. And then I think you talked about consent on cross, and we talked about the sentence on Exhibit 5 that says: "Patient agrees with treatment plan and verbalized understanding."
A Yes.

Q Is that still sufficient though for informed consent in your view?

A Yes.

Q Why?

A So the distinction --

MS. BUYS: I just wanted to lodge an objection that the question asked for what appeared to be a personal preference as opposed to reference to the standard of care issue which is a reasonable physician.

Q (BY MS. BRADLEY:) Okay. Would a reasonable physician note only that the patient agrees with treatment plan, verbalizes an understanding and that constitutes informed consent?

A I would say no. I would expect more discussion about the risks and benefits and alternatives.

Q Okay. Is informed consent the same as actual consent?

A No. That's one of the distinctions I would draw is that there is consent, and then there's informed consent which includes the elements that I just described regarding the risks, the benefits and alternatives and insuring a patient or their proxy recognizes those before a treatment is administered.

Q So, in other words, you can say that

something is okay and that might be consent, but if you don't fully understand what you're saying okay to, that might not be informed consent?

A That is right.

Q Okay. And I think you answered on cross about the patient's recollection or the mother's recollection might be incomplete. Does that highlight for you the importance of complete documentation?

A It does.

Q Because if we had better documentation in this case, do you think we'd be here today?

A I do not.

Q And then earlier, you were talking about spontaneous atrophy and perhaps an injury could have caused it. But what would be more likely than not that would cause an injury that you see in Exhibit 6?

A The most likely explanation for what I see pictured in Exhibit 6 is a Kenalog injection. I'm not sure it's --

Q Yeah, Exhibit 6.

A Exhibit 6 in the Board's is very consistent with atrophy secondary to Kenalog injection.

Q Okay. So there's other possibilities, but given the fact that the patient had a Kenalog injection,

the parents are complaining about the Kenalog injection, filed the complaint and took the photo, you think it's most likely --

A Yes, I do.

Q -- it's related to that. And what about the fact that this is shown on the left side and the shot administration says right side?

A Yes. So there's a conflict in the medical record regarding the site of administration. I mean, I've got the picture as evidence and I'm trying to reconcile that with what we see on Exhibit 12 from the Respondent, and there's a difference there. So I can't reconcile that other than this picture looked like the kind of complication that would happen from a Kenalog injection.

Q Okay. And so it sounds like maybe then in your mind, there's a question as to the accuracy of the records --

A Yes, that is correct.

Q -- that we have?

MS. BUYS: I would object that as it calls for speculation. The question is vague. I apologize for the late objection.

Q (BY MS. BRADLEY:) Okay. What does that

discrepancy mean to you with regards to the records in this case?

A Well, when I went through -- and I will admit I've just recently been provided with Exhibit 12 -- I think the most likely explanation is the Kenalog injection was provided into the left, but that's what I think is most likely.

Q And so then that would mean -- Does that mean the medical record is accurate?

A I am correct, it means the medical record is inaccurate in regards to the location of the injection.

MS. BRADLEY: Okay. Thank you. I have no further questions for Dr. Hall at this time.

MS. BUYS: I just do briefly because I know the doctor has to leave, so if I may.

RECROSS EXAMINATION

BY MS. BUYS:

Q Doctor, is it standard of care for a physician to have to document every single side effect from the a potential treatment in the medical record?

A So that is not generally what happens. If you look at the exhibits, you can see that there are a number of side effects that can happen, but I do think it

is the responsibility of the physician to discuss common and serious side effects.

Q And you've testified that this type of side effect is rare. Is that correct?

A Yes.

Q All right. And then to clarify my prior question, again, is it the standard of care for a physician to have to document in the record every single potential complication that can occur from administration of a steroid injection?

A I do not think it is the standard of care to document every single complication.

Q All right. And, you know, we'll get into this one later. I know you have to leave, but if the administration of the medication was on the right buttock, could that have caused a divot on the left?

HEARING OFFICER HALSTEAD: That's been asked and answered.

MS. BRADLEY: That's been asked and answered.

HEARING OFFICER HALSTEAD: And normally, I wouldn't cut you off for that, but you're already on recross, which I've already given you leeway to do.

Q (BY MS. BUYS:) Thank you. And, Doctor, have you ever reviewed another physician's notes regarding the

consent obtained for a Kenalog injection?

A Yes, I have.

Q Aside from this case, how many times have you reviewed it?

A Once. One other case.

Q Was that for a physician who was in your same practice?

A No, it was another peer review case.

Q And that was in the State of Nevada?

A Yes.

Q All right. Do you remember what year that was?

A I would estimate 2015.

Q And you had also testified regarding documentation and why you feel that documentation is important. What is the purpose of documentation for an urgent care physician treating a patient?

A Well, the purpose is there are several purposes. Number one: To provide an accurate description of what took place. There are purposes of consent and accurate documentations of the recommendations made, so there are a number of purposes that are relevant to medical documentation regardless of the setting.

Q And my question was a little bit different which was: Why do you need to document what took place? What's the purpose of that?

A Well, so there are -- why you would document what took place includes providing an accurate description of the patient's complaints, a physical exam and treatment recommendations along with an assessment or a diagnosis. It's also going to include other elements like follow-up if there are recalls from a pharmacy or questions that arise later as to what took place during the medical visit.

Q And so just to clarify your answer a little bit, Doctor, is it your testimony that the reason why you document is in case there is a recall of medication as well as to help refresh recollection of the physician?

A Those are some of the reasons, yes.

Q What are the other reasons?

A Well, there would be a number, which would include an accurate description of the situation including the patient's history and examination along with medical decision making so that a clear thought process could be understood as to why a physician or provider recommended a certain treatment.

Q Why is it important to document the medical

history accurately? What is the purpose of that?

A Because it forms the foundation for medical decision making.

Q Medical decision making at the time they provide care or --

A Yes.

Q -- in the future?

A Well, it would be relevant in both situations.

Q Documentation after the fact would be relevant to care being provided at the time that the physician sees the patient. Is that your testimony?

A That is my testimony because it lets the reader know what the physician was hearing and how they were making their decisions. Yes.

MS. BUYS: Thank you, Doctor. That's all I have.

HEARING OFFICER HALSTEAD: Any follow-up on that?

MS. BRADLEY: If I could ask one.

FURTHER REDIRECT EXAMINATION

BY MS. BRADLEY:

Q Dr. Hall, and I think I asked you this, but

because it came up again. If you look at page -- Exhibit 5, page 14: "Patient agrees with treatment plan and verbalizes understanding." Could you amend that so that you think it meets the standard of care for documenting informed consent? What would you add?

A Yeah. So what I would add would be discuss the risks and benefits of a Kenalog injection which can include serious complications, and the patient's parents agreed with this treatment plan to proceed.

Q Okay. So it sounds like the key things you think are missing is this idea that risks and benefits were discussed because it doesn't say that in the note.

A That's right.

MS. BRADLEY: Okay. I have no further questions. Thank you. And just for the record, I am going to excuse Dr. Hall for today. He is available tomorrow afternoon if we need him to come back.

THE WITNESS: Yes.

MS. BRADLEY: I, of course, am ever optimistic that we won't, but he does have patients to see this afternoon.

MS. BUYS: Understood. Thank you so much for your time, Doctor.

THE WITNESS: Thank you.

HEARING OFFICER HALSTEAD: So how long would you all like to break for what would essentially be a lunch?

MS. BUYS: Would 45 minutes or an hour suffice?

MS. BRADLEY: That works for me.

HEARING OFFICER HALSTEAD: Which do you prefer: 45 minutes or an hour?

MS. BUYS: I'm fine with an hour. I didn't know if you had any preference for anything.

HEARING OFFICER HALSTEAD: Do you have a preference?

MS. BRADLEY: I don't have a preference.

HEARING OFFICER HALSTEAD: Ms. Buys, if you want an hour, you get an hour.

MS. BUYS: If we come back earlier, we'll all be here.

HEARING OFFICER HALSTEAD: So it's 12:40, so we'll back by -- well, I expect people will be back by a little bit before so we can start right at 1:40.

(Recess.)

HEARING OFFICER HALSTEAD: We're back on the record in Case Number 21-38084-1 in the matter of charges and complaint against Hai Thanh Nguyen, M.D. I note that

Dr. Nguyen is present in the Las Vegas Medical Board Office with his attorney, Ms. Buys. He is under oath. There are two new witnesses for Dr. Nguyen who have appeared.

Ms. Buys, can you please introduce them and we'll have them sworn in.

MS. BUYS: Certainly. Thank you very much, Madame Hearing Officer. We have present Ms. Ellen Aliberti and Ms. Melissa Vogt, both of whom are registered nurses.

HEARING OFFICER HALSTEAD: Can you please spell those names for me, please?

MS. BUYS: Certainly. Ellen: E-L-L-E-N. Last name Aliberti: A-L-I-B-E-R-T-I. And Melissa: M-E-L-I-S-S-A. Vogt: V, as in Victor, O-G, T as in Tom. Excuse me.

HEARING OFFICER HALSTEAD: Okay. Thank you. If you could please raise your right hands. Why don't you go ahead and stand so we can observe some formalities.

(The witnesses were sworn.)

HEARING OFFICER HALSTEAD: Okay. Thank you. You may be seated. And I'll note that the rule of exclusion has not been invoked, and so they are allowed

to be present for the hearing.

We left off with Dr. Hall, who finished his testimony on behalf of the Investigative Committee, so we're back to you.

MS. BRADLEY: And I would rest at this time.

HEARING OFFICER HALSTEAD: Okay. All right. So the IC rests. So, Ms. Buys, it's your case.

MS. BUYS: Thank you very much. And Respondent, Dr. Nguyen, would like to call Ms. Melissa Vogt first to this matter. And if we could have her go to this chair over here. I apologize. I mispronounced things. Vogt just like voting.

HEARING OFFICER HALSTEAD: And so it's Ms. B-O-U-G-H-T; correct?

MS. BUYS: V-O-G-T.

HEARING OFFICER HALSTEAD: V-O-G-T. Okay. Got it.

DIRECT EXAMINATION

BY MS. BUYS:

Q Perfect. And I apologize for mispronunciation there. I'm terrible with names. All right. And, Ms. Vogt, you just raised your right hand and swore to tell the truth. Do you understand that that

is under the penalty of perjury?

A I do.

Q Perfect. And please state and spell your name for the record just in case I mispronounced it.

A My name is Melissa Vogt. M-E-L-I-S-S-A. My last name is V as in Victor, O, G as in good, T as in Tom.

Q Thank you so much, Ms. Vogt. And can you please tell us where you work?

A I'm a clinical educator at Intermountain Healthcare.

Q And how long have you worked there?

A I've worked for this company for three years, in the education department for one.

Q And you're a registered nurse; is that correct?

A I am.

Q And as an employee of Intermountain Healthcare, is it your understanding that HealthCare Partners of Nevada had merged with Intermountain Healthcare a few years ago?

A They were. I was actually hired by when it was HealthCare Partners, uh-huh, and then we've merged with Intermountain Healthcare.

Q Got you. And as an employee of Intermountain Healthcare, are you familiar with how electronic medical records are kept and accessed?

A I am.

Q All right. And is it your understanding that Intermountain uses a third-party medical records retrieval to scan and help them respond to requests for medical records?

A Medical records of the department, you mean? Yeah.

Q Correct.

A Yes.

Q Okay. And on Monday, May 23, 2022, did you locate a medication administration details record for what we're referring to as Patient A?

A I did.

MS. BUYS: All right. And I'd like to show you what was marked as, I believe it is Respondent's Exhibit 12. And just for the record, Bates numbers on that is med admin details 001 and 2.

If I may approach the witness, I'd like to show her that record.

HEARING OFFICER HALSTEAD: Sure.

MS. BUYS: Thank you. Here you go. I'll

just set this right here for you.

HEARING OFFICER HALSTEAD: Is that other binder from the prior binder issue confusion?

MS. BUYS: I believe so, yes.

HEARING OFFICER HALSTEAD: Can you just remove it, please?

Q (BY MS. BUYS:) Thank you so much, sir.

And, Ms. Vogt, can you take a look at those two pages?

A I'm familiar with these. I printed these.

Q That was going to be my question. Are these the pages that you printed?

A They are.

Q All right. And did you make a true and accurate copy of the record?

A I did. This first one actually is the exact copy from the medical record. This one is just I zoomed in so you could see the numbers better, but this is the original.

MS. BRADLEY: I don't know if it helps, but we've already stipulated to the admission, and we're not objecting to the fact that it's accurate, so I don't know if that helps you at all, Ms. Buys. We're also not objecting to the fact that Ms. Vogt provided a

declaration explaining the delay in providing the report. So if you want to move on from those areas, we're glad, but it's up to you.

Q (BY MS. BUYS:) Certainly that definitely helps. It will make it a whole lot shorter.

I just wanted to confirm on the record, Ms. Vogt, did you alter or change any of the details of the record in any way before you printed it?

A I did not.

Q Okay. And if someone was asking for a patient's medical record, how is it that this document might not be included with the rest of the records?

A So I have a little knowledge of this because it's happened before not to me but I've heard other people talk about it. I think the part of the medical record that has office notes, labs and things like that is separate from the medication administration record. And I think when whoever provided the medical records didn't include the medication administration record.

MS. BUYS: Thank you so much for clarifying that. And that was the extent of my questions. I just wanted to verify that for the record.

HEARING OFFICER HALSTEAD: You just referred to a document where she made a statement. Has that been

marked and admitted into evidence?

MS. BRADLEY: It has been admitted, at least based on my records.

HEARING OFFICER HALSTEAD: Oh, is that what we've marked as Respondent's Exhibit 13?

MS. BRADLEY: I think so. It's an affidavit from Ms. Vogt or declaration, excuse me, for Ms. Vogt.

HEARING OFFICER HALSTEAD: So that's a declaration that hasn't been -- well, it's been made under penalty of perjury. Did you just want to confirm that with her?

MS. BRADLEY: And I apologize. I think because my numbering is off, I thought we stipulated to this one being admitted because in my mind, I did, so if you have it as 13, we would stipulate that it can be admitted.

HEARING OFFICER HALSTEAD: Okay. I think they've all been -- all of the Respondent's exhibits have been admitted.

MS. BRADLEY: Yeah.

Q (BY MS. BUYS:) Perfect. And just to clarify for the record as well, if I may show Ms. Vogt the declaration just so she could verify that is her declaration. I've made an extra copy. Here we go.

And this was what had been disclosed as Respondent's Exhibit Number 13. At the top, does it say "Declaration of Melissa Vogt"?

A It does.

Q All right. And is this the declaration that you prepared regarding how you found the record?

A It is.

Q All right. And that's your signature at the bottom; correct?

A That's my signature.

Q All right. And the information contained in that declaration, that is true and accurate; is that correct?

A It is true and accurate.

MS. BUYS: Thank you so much, Ms. Vogt. Those are all of the questions.

HEARING OFFICER HALSTEAD: Thank you.

Ms. Bradley?

MS. BRADLEY: Oh, I have no questions. Thank you.

HEARING OFFICER HALSTEAD: All right. Thank you, Ms. Vogt. We appreciate your time. We know that was very short and hope that works out for you.

THE WITNESS: That's okay. Like to help.

HEARING OFFICER HALSTEAD: Thank you for your time.

MS. BUYS: And then just for the record, I'd request that Ms. Vogt be excused from the proceedings.

HEARING OFFICER HALSTEAD: Thank you. Ms. Vogt, that means you can leave right now.

THE WITNESS: Okay.

HEARING OFFICER HALSTEAD: You can stay, but you're not subject to testify again if that's what you choose to do.

THE WITNESS: Okay. Thank you.

MS. BUYS: Thank you so much. And then Respondent would also like to go and call Ms. Ellen Aliberti at this time.

THE WITNESS: Thank you.

DIRECT EXAMINATION

BY MS. BUYS:

Q And Ms. Aliberti, do you understand that when you raised your right hand, that you swore to tell the truth in this proceeding?

A Yes.

Q Okay. Will you please state and spell your name for the record.

A Ellen: E-L-L-E-N. Last name Aliberti: A-L-I, B as in boy, E-R-T-I.

Q Thank you very much, Ms. Aliberti. Can you please tell us where you work?

A Intermountain Healthcare.

Q Perfect. And what is your position there at Intermountain Healthcare?

A I'm a clinical educator, registered nurse.

Q Thank you. And how long have you worked there?

A Too long. Thirteen -- this is my 13th year.

Q Thank you. And, Ms. Aliberti, can you please run us through your educational history.

A Me personally or the organization?

Q You personally. Where did you go to nursing school?

A Okay. Sorry. So I graduated from Mt. St. Mary's College in Los Angeles, California in 1978. I have a Bachelor's of Science in nursing, and then I later went back to school in 1993 and got a Master's in gerontology, study of aging.

Q Thank you.

A Wait. I'm a certified case manager, too.

Q Perfect. And as an educational coordinator

with HealthCare Partners for Intermountain Health, are you familiar with the training that was provided to medical assistants at HealthCare Partners of Nevada in 2016?

A I absolutely am. Since I've been there 13 years, it's the only position I've held, and I've actually developed that department from scratch.

MS. BRADLEY: I'm going to object if this line of questioning is going to continue. I don't know what a medical assistant has to do with the allegations against Dr. Nguyen.

MS. BUYS: The allegations, at least in the complaint initially, were regarding a medical assistant assisting with the administration of this injection.

MS. BRADLEY: Okay. But, I mean, the allegations are that Dr. Nguyen acted improperly. I guess I'm just not sure what this witness knows about the incident that happened and why it's relevant. That's all.

MS. BUYS: And in response, it's to explain the training provided to the medical assistant, as it's alleged that a medical assistant was involved in the care and Dr. Nguyen supervised the medical assistant.

MS. BRADLEY: Okay. I'm looking at the

complaint, and I don't see medical assistant referenced, but I'll read through it again just to make sure I'm not missing something. I see Respondent. Okay. "Respondent successfully injected the Kenalog into the buttocks after two unsuccessful attempts by the medical assistant." So she's here to talk about the two unsuccessful attempts?

MS. BUYS: She's here to testify regarding the training provided to medical assistants to assist physicians on administering injections to patients.

HEARING OFFICER HALSTEAD: Is that applicable to the medical assistant that is alleged to have acted in this case?

MS. BUYS: I'm sorry. It seems to have broken up a little bit. What was the question?

HEARING OFFICER HALSTEAD: Is that applicable to the medical assistant that was alleged to have acted in the complaint in this case?

MS. BUYS: Yes, back in 2016.

HEARING OFFICER HALSTEAD: Okay. Well, let me just give me a moment here because I see where you're both going, and I just want to try to find an intersection here. Obviously, there's been different testimony about there's the allegations of how the shot occurred, and then there was the testimony about how the

shot occurred and who was there and who wasn't, who could be identified as being there, I guess.

So I'm just wondering if you could clarify for me, Ms. Bradley, if the IC is relying on the fact that a medical assistant may or may not have tried two injections before the actual injection was given.

MS. BRADLEY: No. I mean, I realize that's contained in the complaint, but I don't know that, I mean, our concern is what Mr. -- I'm sorry -- Dr. Nguyen did.

We're not concerned about a medical assistant. I think that's just in there for context because the records show that there was an attempt and then an injection was done by Dr. Nguyen. So I don't know that I care that there were two unsuccessful attempts. I guess if they want to talk about that. I just don't really see medical assistant as being relevant to this case at all.

HEARING OFFICER HALSTEAD: So where is the language that -- Ms. Buys, where is the language that you're having concerns with within the complaint?

MS. BUYS: Certainly. And I believe it was also originally back even the underlying response to the letter of 8-3 where Dr. Nguyen had explained his

recollection of the incident as well as the medical assistant and also as to documentation of the shot record by a medical assistant which has been produced.

HEARING OFFICER HALSTEAD: So with regard to the language on the complaint, I'll just note that on the first page, starting at line 23, it says: "Respondent successfully injected Kenalog into Patient A's lateral buttocks after two unsuccessful attempts by Respondent's medical assistant." There hasn't been any -- I don't know that that -- Do you just want to strike that part of the complaint or do you want to go down this road?

MS. BRADLEY: Yeah. I mean, I think we can strike it. I mean, just Respondent successfully injected Kenalog into patient in the lateral buttocks is fine with me, period, and we can strike that.

HEARING OFFICER HALSTEAD: Ms. Buys, what is your --

MS. BUYS: And, Ms. Aliberti, if we were also going and striking that and we can stipulate that that's no longer a concern of the Board's, she was also to testify as to the training provided to medical assistants as to documentation and the documentation --

HEARING OFFICER HALSTEAD: Okay.

MS. BRADLEY: I guess our belief, the Board's

position is it doesn't -- we don't license medical assistants, and we don't charge them with allegations, and so anything that occurred in this case is Dr. Nyugen's responsibility. So that's our position. He's responsible for what medical assistants do or don't do. So, I mean, I don't know. Was Ms. Aliberti there on that day on November 4, 2016? So she doesn't have personal knowledge of what occurred on that day, it sounds like.

MS. BUYS: She was employed at the time and was going to testify as to the training provided to medical assistants regarding documentation policies and procedures.

MS. BRADLEY: Okay. I mean, I don't have a huge objection. I just don't see a reason to provide testimony that I don't think is relevant. But, I mean, I guess, Madame Hearing Officer, whatever you prefer.

HEARING OFFICER HALSTEAD: Okay. So let's just go back to the issue of the two unsuccessful attempts. So I don't want to push you one way or the other on that because I think you can also argue that it showed, you know, potentially why the Respondent would have ended up doing it and why there could have been some tenderness because it shows that the Patient A was

potentially difficult to give an injection to.

I don't think you -- If the IC and you want to agree to strike that language so that we don't -- no one has to prove it up, that's up to you guys. With regard to the training, I don't know if that's something you just want to proffer. I agree that Ms. Aliberti wasn't there. I'm assuming that these people were properly trained in it. I don't think that's an issue.

MS. BRADLEY: We're willing to stipulate that the medical assistants were trained, you know. That's required by the NAC, that any task medical assistants are delegated, that there has to be training, it has to be included in their file. We've never sent an allegation letter to Dr. Nguyen alleging that his medical assistants were not properly trained or that that documentation wasn't there, so we're not concerned with the medical assistants or their training.

HEARING OFFICER HALSTEAD: So why don't you just go ahead and make a proffer so you can have your record.

Q (BY MS. BUYS:) Thank you. And, Ms. Aliberti, just to sort of clarify, what we're doing back and forth was you had just testified that you were there in 2016 as the educational coordinator and that you

had -- Is it true that you provided training to medical assistants and HealthCare Partners to verify that they were competent in assisting a physician to provide care?

A Yes, it's true.

HEARING OFFICER HALSTEAD: Ms. Buys, Ms. Buys, do you understand what I'm asking you to do when I'm asking you to make a proffer?

MS. BUYS: If you could clarify.

HEARING OFFICER HALSTEAD: So what I'm asking you to do is to stand up and summarize -- well, you don't have to stand up, but to summarize what Ms. Aliberti would be testifying to in lieu of going through all of the questioning with her and then --

MS. BUYS: Oh, certainly.

HEARING OFFICER HALSTEAD: -- if the IC is willing to accept that, we can move this along.

MS. BUYS: Certainly. Ms. Aliberti was going to testify that the medical assistants that assisted Dr. Nguyen on November 4th, 2016, were appropriately and adequately trained to assist physicians in providing an injection. They were also trained regarding documentation procedures and assisting the physician in documenting the medical care provided to the patient including the medication administration.

She was also going to testify regarding the competencies that are required of the staff at HealthCare Partners of Nevada to insure that everyone has received in-service education and was competent to provide appropriate medical care and documentation to the patients.

HEARING OFFICER HALSTEAD: Okay. Ms. Bradley, do you have --

MS. BRADLEY: I just ask a question. You said "everyone." What do you mean? Doctors and MA's or who are you talking that is having that training?

MS. BUYS: So it was medical assistants as well as physicians could attend the education sessions.

MS. BRADLEY: Okay. Because I'm willing to accept that, but that doesn't mean that I accept that everything was done correctly in this case. I believe that they trained their people and they tell them to do the right thing. I have no problem with that.

MS. BUYS: And as well, that a physician is able to rely on a medical assistant regarding documentation of medication administration.

MS. BRADLEY: No. I mean, the law doesn't allow a physician to obfuscate his or her responsibility and rely fully on an MA, but certainly, MA's are allowed

to assist them. So I will agree with you they can be trained and assist. But no, just because an MA is trained in documentation doesn't mean that the physician just gets to rely on that person and walk away. So I'm not sure what you're trying to say.

MS. BUYS: So we were going to establish via Ms. Aliberti's testimony that the medical assistants do provide assistance with the documentation and that the physician reviews the documentation.

MS. BRADLEY: Okay. That's fine. They can assist with documentation. I have no issue with that.

HEARING OFFICER HALSTEAD: And the last proposition that she's suggested, can you repeat that, Ms. Buys, that they do -- Well, maybe we can read it back. I don't want to misstate it.

MS. BUYS: Certainly.

HEARING OFFICER HALSTEAD: So let me just clarify. So the issue of whether a doctor can rely on their medical assistants' entry is really a legal question, right, like I can't have someone come in and tell me whether that's legally viable or not if that defeats a physician's obligation.

To the extent that I think aside from that, everything else that you've proffered, I think, is being

accepted. So I don't think that you need to walk through all of that with your witness. It's on the record as you stated it. Is there anything you would like to clarify or add to that?

MS. BUYS: Yes. And I believe the last statement was about that the medical assistants are trained regarding documentation and that a physician reviews that documentation after it is entered by a medical assistant.

HEARING OFFICER HALSTEAD: That's the one.

MS. BRADLEY: Okay. Well, they're trained to do that. I mean, I don't know that you can say as a matter of, you know, that they do it every single time, but I'll concede that they're trained to do that.

MS. BUYS: All right. That there's a procedure in place that HealthCare Partners of Nevada, that that is the procedure that is trained --

MS. BRADLEY: Sure.

MS. BUYS: -- for the medical assistants as well as the physicians.

HEARING OFFICER HALSTEAD: Right. So I think that -- and I don't want to misstate. She can obviously speak for herself, but I think her point is that she's agreeing with everything you're saying, and she concedes

to the training. And so the question would be if you want to continue down this line as to whether that training was actually followed in this case, and that would have to be by people who are actually there and participated.

MS. BUYS: Understood, Madame Hearing Officer, in which case, we will agree to the stipulations provided by counsel for the IC as to the training and procedures in place.

HEARING OFFICER HALSTEAD: Okay. Thank you.

Thank you, Ms. Aliberti. We fast-tracked that for you, but we certainly appreciate you showing up and being willing to testify today.

THE WITNESS: Thank you. Thanks.

MS. BUYS: Thank you so much. And for the record, they're both excused for the purposes of this proceeding.

HEARING OFFICER HALSTEAD: Thank you.

THE WITNESS: Thank you.

MS. BUYS: Thank you. And so Respondent would now like to call Dr. Nguyen to the stand.

HEARING OFFICER HALSTEAD: Would you prefer that he stay seated next to you or does it matter? We don't have an official --

MS. BRADLEY: Yeah, I'm fine either way.

HEARING OFFICER HALSTEAD: Wherever you're more comfortable, Dr. Nguyen.

THE WITNESS: Thank you.

DIRECT EXAMINATION

BY MS. BUYS:

Q Thank you very much. Now, Dr. Nguyen, did you use your reasonable medical judgment to take into consideration Patient A's history, exam, risk factors, treatment benefits and alternatives in your decision to administer a Kenalog steroid injection to Patient A?

A Yes, I did.

Q Tell us why.

A The parent had told me that the child was having respiratory symptoms of cough, congestion and nausea and vomiting for four days. Initially, I prescribed her oral Prednisone. And after doing an exam on the patient, I assessed her to have a respiratory illness, possibly croup or other respiratory conditions, and felt that the oral steroid would be adequate.

But when I came back to give her -- the parent -- the medication and talk to her about the possible side effects of the medication, I went over with

her and let her know that there are side effects, and she became concerned that the side effect of the oral Prednisone could lead to further vomiting or increased vomiting, and she asked me if there was any other treatment options.

And I did let her know that there was an injectable form of medication, and we discussed the possible side effects of the injectable medication, specifically that it can cause some scarring, swelling, redness and pain and bleeding to the area that is injected.

Q And did you obtain informed consent prior to administering a Kenalog steroid medication to Patient A?

A Yes, I did. I let the mom know that there are side effects and benefits and alternatives to the medication, and she was agreeable with proceeding with the treatment.

Q And did you use your reasonable medical judgment as a family medicine specialist based on your background, training and experience in treating Patient A with Kenalog due to what you believed was respiratory illness that was possibly croup?

A Yes, I did.

Q All right. And if you had not given the

patient a Kenalog injection, what might have happened?

A As I told the parent, the alternative is to give oral medication, the Prednisone that I prescribed. Possible side effects of the oral Prednisone is vomiting, weakness of the tendons, tendon rupture, weakness of the bones, elevation of blood sugar and GI side effects which include vomiting.

Q And at the time you provided care to Patient A, did you make a reasonable effort to keep and maintain an accurate, timely, legible and complete record?

A Yes, I did.

Q Please explain.

A The progress note or medical record has everything that it needs to to continue care of the patient if she were to follow up with her pediatrician or if she were to come back to see another provider at my urgent care or myself at the urgent care.

Q And I'd like to touch briefly on your background, Doctor. Where were you born and raised?

A I was born in Saigon, Vietnam, but I was raised in Colorado.

Q And where did you attend college?

A I attended college at Cal State-Fullerton.

Q And what year did you graduate?

A From Cal-State Fullerton, I graduated in 1995.

Q What degree did you receive?

A I received a Bachelor of Arts in Science, in particular, biology.

Q And when did you decide you wanted to go to medical school?

A My junior year in college.

Q And where did you attend medical school?

A I attended medical school at University of Colorado in Denver, Colorado.

Q And what did year did you complete medical school?

A I completed it in 2008.

Q And where did you go your internship?

A I did my internship in Denver, Colorado at the University Hospital.

Q And where did you do your residency?

A The same facility.

Q And was that residency focused on family medicine?

A Yes.

Q And how did you decide to specialize in family medicine at an urgent care setting?

A I enjoyed family medicine because it allows me to care for the whole family from infant to elderly, grandparent, and it allows me to make a difference in patients' lives.

Q And just to clarify, how long have you been practicing medicine, Doctor?

A I finished my residency in 2003, so 19 years.

Q And can you estimate how many patients you've seen up to that time?

A I would estimate possibly 35,000 patients.

Q All right. And during your residency, were you trained in administering Kenalog injections?

A Yes, I was.

Q What training did you receive?

A Under my attending physicians, I was trained to inject children, adults, elderly patients with Kenalog for minor reasons such as respiratory illnesses.

Q And did you experience treating pediatric patients with respiratory illnesses that resembled croup?

A Yes, I do.

Q And how many of those patients have you seen?

A If I had to guess, I would say approximately 300 patients.

Q And did you hear Dr. Hall testify this

morning?

A Yes, I did.

Q And do you disagree with each of these opinions that you fell below the standard of care?

A Yes, I disagree with his thoughts.

Q And can you briefly explain why?

A My care of the patient was and does meet the standard of care. I did examine the patient. I assessed her, and I did get verbal consent from the parent, and I did keep a timely record and a complete record for continuation of care for the Patient A.

Q And let's go over your note for Patient A's November 4th, 2016 visit. Do you have a recollection of Patient A's visit?

A Yes, I do.

Q All right. And I would like to go and refer for your review, I believe it is Respondent's Exhibit, and I'll tell you the exact number. I believe we had this marked as Respondent's Exhibits 5 and 6 as well as Respondent's Exhibit Number 12. And I'd like to directly refer your attention to what's been Bates stamped H18002 of the Exhibit Number 5. Is that your narrative note of Patient A's November 4th, 2016 visit?

A Yes, it is.

Q All right. And I believe you just testified you have an independent recollection. I believe you just testified that you have an independent recollection of treating the patient on November 4th of 2016?

A I do.

Q All right. What do you recall about your visit with Patient A on November 4th, 2016 at the urgent care clinic?

A It was notable that there was an attempt by the medical assistant to give the Kenalog injection, but he failed to do so. And afterwards, the mother asked me in particular to give the injection instead of having another medical assistant or other RN or other nurse give the injection.

Q And while you were treating the patient on November 4th of 2016, did you review Patient A's medical history?

A Yes, I did.

Q What did you review?

A I asked in particular if the child had asthma and I asked her if she had any allergies to any medications or any other substances, and I also reviewed her family history of maternal grandmother having asthma. And the mother did mention that she had prior croup

several months prior to her visit with me.

Q And did you discuss with Patient A's parents what her symptoms were?

A Yes, I did. I gathered the history from the mother, as the patient was a 23-month-old and wasn't able to respond.

Q And I believe you just testified regarding the patient's mother. Do you recall the patient's father was also present for the visit?

A Initially, the father was present also, but I had to excuse him after I finished my physical exam. He was late for work and had to leave.

Q And did you just testify that you performed a physical exam of Patient A?

A That is correct. I did.

Q And what did you find on exam of Patient A?

A I found that she had some nasal symptoms of erythema, clear rhinorrhea. Her lungs were clear, she had good air exchange, she was walking and she was a vigorous child.

HEARING OFFICER HALSTEAD: Ms. Buys, what is Dr. Nguyen looking at?

MS. BRADLEY: I was just going to ask that same thing because I don't see erythema on the records

I'm looking at or vigorous child. So just curious where that's coming from.

MS. BUYS: It's HCP 003 is the Bates stamp. I believe that's still Respondent's Exhibit 5.

MS. BRADLEY: Oh, okay. I see erythema there.

THE WITNESS: Clear rhinorrhea.

MS. BUYS: No worries. Just for the record. And just for the record, it's on that Bates stamp HTP 003 about -- towards the bottom of the page, maybe around the middle lower half, there is documentation regarding the erythema as well.

MS. BRADLEY: Yeah, I just saw the erythema. I don't see vigorous child. So is that just from his memory or --

THE WITNESS: That was from my memory.

HEARING OFFICER HALSTEAD: Okay. Thank you.

Q (BY MS. BUYS:) Thank you. And, Doctor, did you come to a possible diagnosis of Patient A during her November 4th, 2016 visit?

A Yes. According to my medical documentation, cough with possible croup.

Q What was that based on?

A Based on the medical history provided by the

appearance of the child, my physical exam, and her previous history.

Q And based upon that diagnosis, did you develop a potential treatment plan for Patient A?

A Yes, I did.

Q What was that treatment plan?

A Initially, it was oral Prednisone treatments that I was going to give the child, but once I came in to inform the mom, the parent of Patient A of possible side effects of that medication, she expressed a lot of concern that one of the side effects of the medication was vomiting and asked me if there was any other treatment that I could possibly give.

At that point, I did let her know that an intramuscular injection is one possibility, and she mentioned that previously, her daughter had croup and the daughter needed an injection during that time to resolve her symptoms. So I thought it was a good idea since the child was vomiting and the medicine can cause vomiting to give her an injection of the medication of a steroid at that time. I wasn't sure if she would adequately take the medicine and it would help her in her recovery.

Q And just to clarify for the record, did you discuss with the patient's parent the risks, benefits and

alternatives to treatment were the oral steroid, the Prednisone?

A Yes, I did. I let her know that the medication has side effects, and she had questions and I answered those questions for her.

Q And do you recall what the side effects were that you explained to the patient's parent regarding the oral Prednisone?

A Yes. I mentioned that the medication could increase the patient's blood sugar level, cause increased risk of infection, it could cause upset in the GI tract or vomiting, it can cause weakness of the bones and tendon rupture.

Q And then after you received that additional information from the patient's parent, is that when you considered giving the Kenalog injection? Is that correct?

A That is correct. The mother told me that she was concerned that the medicine I was going to give the child can cause vomiting and the child is vomiting already, that it would make her vomit more and, you know, the child would not take down the medicine or not get adequate amounts of the medicine, so I thought that was a very valid concern. And I thought a reasonable treatment

option would be to give the first dose as a steroid injectable medicine so that we could insure that the child receives the medicine and she would get better quicker.

Q And prior to the Kenalog injection, did you discuss the risks and benefits and alternatives with Patient A's parent?

A Yes, I did let her know that in addition to what the oral steroid can do, since it is an injectable, that it can cause swelling, redness, pain, bleeding and even scarring to the area where it's injected.

Q And did someone other than you attempt to administer the injection?

A Yes, Mr. Barry Misiuk, who was my medical assistant for that day, attempted to give the injection.

Q All right. And what do you recall happened when he attempted to give the injection?

A The parent was helping to position and stabilize the patient for the injection. She was at the head of the bed and facing the child and trying to comfort the child, and Barry cleaned the area. Sorry. Strike that.

Initially, he came in and thought about giving the injection in the lateral thigh of the patient,

but he mentioned that he didn't think he could do that because he saw her moving quite a bit, and she was not stabilized to give the injection in the lateral thigh. He came in to let me know that he didn't think that was possible, and I asked if there was any other spot he could give the injection. And I let him know that the gluteal area is an alternate site if he didn't think it was safe to give it into the lateral thigh.

And he asked me for help in giving the injection, so I went into the room with him. We assessed the patient, and with the mother's cooperation, we positioned and stabilized the child. Mr. Barry tried to give the injection into the right buttock, but when he went to inject the child, the child moved and he pierced the skin but didn't push down on the plunger, and then she moved again and he pierced her skin a second time without giving the injection, and then she moved again and the needle came out.

Q And why on the gluteal -- excuse me. Why was the injection attempted on the gluteal area?

A At the time, we had the information and there was an FDA recommendation that the medication, Kenalog, could be given in the gluteal area.

Q And in your experience providing care to

pediatric patients over 19 years, how often are children willing and accepting and sitting still when you try and give an injection?

A Not very often.

Q And do they often require a parent to help position the child for an injection?

A Yes, often they do.

Q And, Doctor, after the medical assistant's attempts to administer the injection, what happened then?

A Like I said, the needle had come out. I applied pressure to the area because there was a small amount of blood coming from the perforation sites where the needle went in.

I apologized to the mom and let her know that I'm sorry that the medication wasn't given despite her daughter being poked by the medical assistant. At that time, I let her know that I could get another medical assistant or RN to give the injection. She let me know that she didn't want a medical assistant or a nurse to do it. She asked me if in particular if I could give the injection because she trusted me.

Q And prior to -- actually, strike that. And, Doctor, do you document every detail of your encounter with a patient?

A I document the details that are needed to help any other provider or provider like myself coming back; if a patient were to come back to continue her care or if she were to go back to a different pediatrician, he would understand the care that I gave to the patient.

Q And was it your understanding that Patient A had a pediatrician appointment scheduled a few days into the future?

A That is correct.

Q And was this the first visit that you had with Patient A?

A Yes.

Q And was this the only visit that you had with Patient A?

A Yes.

Q And I'd like to go and refer your attention still on Respondent's Exhibit Number 5, but what is Bates stamped as HCP 002. Doctor, it appears that it says at the bottom of -- look at the first paragraph after a list of plans, and right at the last part of that paragraph, it says: "Patient agrees with treatment plan and verbalizes understanding." Do you see that?

A Yes, ma'am, I do.

Q Did I read that correctly?

A Correct.

Q And is this a reference to the consent that you received prior to administering the Kenalog injection?

A Yes, it is.

Q And when you say "patient," are you referring to the child or are you referring to the patient's proxy or parent?

A I was referring to the parent.

Q When you were getting the patient's medical history, that came from the parent as well; is that correct?

A Correct.

Q All right. And when you are discussing with a patient different treatments, do you pressure patients what to choose: one option other another?

A No. I offer them my medical advice and let them know that there are alternatives, and it was her decision that would be honored.

Q And did your care and treatment of Patient A meet the standard of care?

A Yes, it did.

Q Why is that?

A I did what a reasonable physician would have

done for a patient with the symptoms that the parent told me about. After doing an assessment of the Patient A, I feel that any physician would have done the same thing that I would have done.

Q And have you ever had a patient react to a Kenalog injection by developing a divot?

A No, I have not.

Q Following the administration of the Kenalog injection, did you provide any instructions for the patient or the parent?

A Yes. I let the parent know that she should apply ice to the area because there may be some swelling and discomfort for the child and to fill a prescription for the Prednisone or medication that I did give her and to follow up with her pediatrician and then also to come in if there were any increased symptoms or further symptoms that she needed to have me look at.

Q After the administration of the medication, did you have a patient remain in your office for any period of time?

A Yes. We had her stay after the injection for approximately ten minutes to make sure she didn't have any adverse reactions to the injection.

Q And do you know if Patient A sought any

additional medical care for her symptoms?

A I don't know.

Q And prior to receiving correspondence from the Board, did anyone ever tell you Ms. Patient A had developed a divot or a complication related to a steroid injection?

A No, I don't recall.

Q And just because a patient has a skin reaction to a medication that's administered, does that mean you deviated from the standard of care?

A No, ma'am.

Q And just because there are multiple attempts to administer medication to a crying, kicking pediatric patient, does that mean you fell below the standard of care?

A No.

Q And have all of your opinions today been stated by a preponderance of the evidence?

A Yes, it has.

MS. BUYS: Thank you.

HEARING OFFICER HALSTEAD: Ms. Bradley?

CROSS-EXAMINATION

BY MS. BRADLEY:

Q Okay. Good afternoon, Dr. Nguyen. You didn't document the conversation with Mrs. DelGrosso regarding her concerns with the prescription for oral steroids, did you?

A No, I did not.

Q And you testified that you discussed the benefits of the Kenalog shot with the parents, but you didn't document that you discussed the benefits of the Kenalog shot with the parents, did you?

A I believe I did. I stated: The patient agrees with the treatment plan and verbalized an understanding of the treatment plan.

Q So it's your testimony that that covers the benefits of the Kenalog shot?

A It would cover the benefits, the risks and alternatives because that's part of the treatment plan.

Q Okay. Well, and I'm confused about the treatment plan because maybe you can tell me then what it ended up being because initially, you testified that the treatment plan was oral steroids.

A That is correct.

Q And what was the treatment plan at the end of

the visit?

A After receiving further information from the parent that she was very concerned that the medicine caused her daughter to vomit further and that her daughter in fact had previous injection of a steroid medication, I adjusted my treatment plan to include the Triamcinolone or Kenalog injection because I was worried that the patient might not get an adequate dose of the medication because she is vomiting, and her mother was concerned that the medication caused additional vomiting, and I know that the Prednisone is known to cause vomiting in patients.

Q Okay. You just testified that you were worried. Did you document anywhere in the patient's records that you were worried about the ability to --

A No, I did not document that.

Q Okay. So just to we're clear then, so you started out with initially an oral steroid was the plan, and then you modified it. So in the end, the treatment plan was both the oral steroids and the Kenalog shot. Is that true?

A That's correct.

Q Did you document in the patient's medical records that the patient stayed for ten minutes after the

shot was provided?

A No, I did not document that, but that is a standard of care for patients to make sure that they don't have adverse reaction after they receive an injectable medication.

Q And I just want to clarify when the medical assistant attempted the injection. So were you present when that occurred? You saw it happen?

A Yes, ma'am, I was there. I was at the child's foot at the time.

Q And you testified that the Patient A had croup several months prior to her visit with me. Did you document that in the medical records?

A Yes. I'm referring to my history of present illness. It states the patient had croup twice already, last one seven months ago. It's HCP 0002.

Q Yeah. Thank you. I saw it. I was looking above with the family history, but I do see it there where you pointed it out. Thank you. Did you give the parents instructions about when to give the oral steroids?

A Yes, I did let them know that they were to give it once a day as soon as they were able to give the medication because with respiratory illnesses like croup,

inflammation can worsen her symptoms, so the sooner they gave the medicine, the sooner the child, the patient, would improve.

Q So just to clarify then, so your intent was that first day, Patient A would have both a shot and an oral dose of steroids?

A That is correct, ma'am. Physicians often will give injections to make sure that the parent gets the first dose to help resolve sooner. It's called a loading dose.

MS. BRADLEY: Okay. I believe you have hopefully in front of you the standard operating procedure for HealthCare Partners. I think it's Exhibit 7, but it might be 6 because my exhibits seem to be off.

HEARING OFFICER HALSTEAD: It's Exhibit 7.

MS. BRADLEY: Exhibit 7. Okay.

THE WITNESS: Yeah, I do have it.

Q (BY MS. BRADLEY:) Okay. Have you seen that before, Dr. Nguyen?

A I believe I have.

Q Okay. If we go to page three, it's number 23. Can you read that for us, number 23?

A Vastus lateralis is the preferred side for children, thigh, from birth to 36 months of age for

intramuscular and subcutaneous injections.

Q And I think you testified that the MA is the one that decided to deviate from this procedure? I just want to make sure.

A That's correct, ma'am.

Q Okay. So the medical assistant made the decision that the thigh was not appropriate, and then you're the one that said that the gluteal area would be appropriate.

A That's correct, ma'am. Let me clarify. It would be an alternate site for intramuscular injection.

Q Okay. Isn't it true that NRS 630.30621A, which is one of the alleged statutes in this case, places the obligation on maintaining timely, legible, accurate and complete medical records for patients on you as the physician?

MS. BUYS: And I'll just object that it calls for a legal conclusion.

HEARING OFFICER HALSTEAD: Sustained. It's, I mean, also the statute speaks for itself.

Q (BY MS. BRADLEY:) Okay. So, Dr. Nguyen, is it your testimony today that the medical assistant is responsible for documentation of a patient's medical records?

A Medical assistants assist physicians in completing documentation such as providing the lot number, medication and the expiration date of medications when they inject the medications.

Q Okay. But who is licensed by the Board? The medical assistant or the physician?

A The physician is licensed by the Board. And when they do document these records, other physicians like me do review those records to make sure that they're accurate and timely.

Q So whose fault is it if there's an error in the records?

MS. BUYS: Objection. Vague as it's unclear what you mean by if there's --

Q (BY MS. BRADLEY:) I'll rephrase. If there was an error in Patient A's medical records, who caused that error?

MS. BUYS: Same objection.

MS. BRADLEY: I think he can say who he thinks is the cause of an error in a record for a patient.

HEARING OFFICER HALSTEAD: Well, I guess my concern is if there's error, I mean, this is a hypothetical that doesn't necessarily apply to the case,

so if there's an error in these records.

MS. BRADLEY: Well, I think there is an error in these records. I think we've heard testimony about conflicting information in the records.

HEARING OFFICER HALSTEAD: Then I would suggest the question should be if there was an error in these records.

Q (BY MS. BRADLEY:) Okay. So, for example, Dr. Nguyen, if we go to Exhibit 12, and that's your exhibit 001, med admin details. Are you there?

A Yes, ma'am. I am. I'm looking at med details 00001.

Q Do you see the name Hampton, Chanel on that page?

A Yes, ma'am, I do.

Q Do you know who that is?

A That is my medical assistant that I normally work with.

Q Okay. Did you work with Ms. Hampton on November 4th, 2016?

A No, I did not work with her that day.

Q So if this says "admin by," what does that mean typically?

A When the physician generates a computer order

in the EMR for an injection, we'll often send that order to his normal -- his medical assistant that he normally works with, which is Ms. Chanel Hampton.

Q So I guess I'm misunderstanding here. So you're saying if you order medication, the order goes to someone that you normally work with but that you may not be working with on that day? Is that what you're saying?

A Yes, ma'am. During that day, Mrs. Hampton, she had to call out sick that day because her daughter was ill and she was not there. So Mr. Barry Misiuk was called up as a float medical assistant that HealthCare Partners had hired to substitute if there's a member of a staff medical assistant that's absent that day.

Q Okay. Well, because it says, "Admin by." What does "admin by" mean? Does that mean administered? Is that short for administered?

A It says that I had ordered Chanel Hampton to give the injection, and it says the date that it was given.

Q Okay. So your testimony is then that the name on there doesn't mean who administered the vaccine?

A That is correct, ma'am.

Q Okay. But I thought this is supposed to be the medication administration details.

A It has a lot of the details such as the amount, the area injected and where it was given.

Q Okay. But how are we supposed to know looking at this who provided the injection? I thought that was the purpose of this record.

A The person often also gives the injection can also be seen in the progress note.

Q Okay. So where does it show me in the progress note who gave the injection?

A It does say that I completed the injection, Kenalog 40 milligrams 0.5 by mouth, intramuscular was completed by Dr. Nguyen.

Q Where did it say that? I'm sorry. What page are you on?

A It is HCT 0017.

Q 0017? Okay. So you're referring to then on the bottom, kind of the bottom of the page, I mean, I guess the middle, but the bottom of the entry of that page?

A That's correct, ma'am. Is says Nguyen, Hai complete.

Q Complete. So that's what you're saying is proof that you administered the injection?

A That's correct, ma'am.

Q Okay. And if we go back to Exhibit 5 though, if we go to page HCP 00006 in Exhibit 5.

A Yes, ma'am.

Q That Gleneisha Barner, is that the person you said you were working with that day?

A I believe she was the triage medical assistant. So in urgent care, we may have more than one medical assistant. We have one that triages the patient, takes their initial complaint, and then she may take the vitals and then a medical assistant helps in the back of the office.

Q So where do we see reference to the medical assistant that you said that you were working with on that day? I believe it was a gentleman's name. Oh, I think I might see it on Exhibit 6, med admin log 0003. Was it Barry, you said, Misiuk?

A Yes, ma'am, that's correct. It's right down there at the end of the near the bottom of the page.

Q Okay.

HEARING OFFICER HALSTEAD: I'm sorry. What page?

Q (BY MS. BRADLEY:) It's med admin log 00003. It's in Exhibit 6 for the Respondent. Have you seen this Exhibit 6 before, Dr. Nguyen?

A Yes, ma'am.

Q Okay. What would you call this? It says, "Allscripts" at the top. I wasn't sure what kind of record it was.

A It's part of the electronic medical record in regards to a billing the insurance and with trying to complete the record.

Q Okay. Because when I read this, and I don't know -- maybe you disagree -- but would you agree that it sounds like there was some confusion over this shot and what happened with it?

A The confusion was that the biller thought Ms. Hampton was there that day to give the injection, and I let her know that Ms. Hampton was not there and it was actually Mr. Misiuk, Barry, that was present with me that day.

Q Okay. Yeah, because I'm just reading in the middle. Do you see where it says: "Hello"? Could you read that?

A "Hello. Did you administer this injection? If not, can you send it back? Thanks."

Q So it sounds like there was a question of whether it was given or not and maybe that the injection was somewhere in the office? I don't know.

A I would have to speculate as far as why that message was sent to Mrs. Hampton.

Q Okay. But it looks like at the end, it is documented that Barry Misiuk was the one that provided it or at least helped.

A Yes, he did help in drawing up the medication and helping with the injection.

Q Okay. Would you agree with me that there's a difference between consent and informed consent?

A Sorry. Could you repeat the question?

Q Would you agree with me that there's a difference between consent and informed consent?

A Yes.

Q How would you distinguish those two?

A Consent would be just saying okay versus being informed of possible risks, alternatives, and side effects of a medication.

MS. BRADLEY: Thank you. I have no further questions.

REDIRECT EXAMINATION

BY MS. BUYS:

Q Thank you. Dr. Nguyen, I believe counsel for the Investigative Committee asked you questions regarding

what was Respondent's exhibit, I believe we are at, I believe, Respondent's Exhibit Number 6, which has "Allscripts" written at the top. Do you recall that?

A Yes, I do.

Q Were you aware of this conversation with the medical assistants that's documented here?

A Yes, I was.

Q All right. When did this take place?

A That happened on November 8th, 2016.

Q And that was after the care that was provided to the patient. Is that correct?

A Correct.

Q And I believe you also testified that this document is for purposes of billing. Is that correct?

A I believe.

Q All right. And I believe you were also asked questions regarding Respondent's Exhibit Number 12, the medication administration details. And, Doctor, just to clarify for this patient in 2016, were the medical records electronic or paper?

A They were electronic.

Q Okay. And in your practice in working at HealthCare Partners in 2016, was it normal for the medical assistants to assist you in filling out the

electronic health record regarding the shot record?

A Yes, it was.

Q Okay. And in this case, it looks like on that medication administration details page, the injection site is listed as right gluteal region. Is that correct?

A That is correct.

Q All right. Do you have an independent recollection apart from this document where you gave the injection?

A I do because I remember giving the injection in the right buttock.

Q How do you know that?

A Because the table in that room is positioned so that when the patient is lying on her stomach, her right buttock would be to the left side of the bed. And I'm right handed, so it would make it easier for me to place my hand on the right buttock to push down to help stabilize the patient and to give the injection with my right hand into the right buttock or gluteal area.

Q And I believe you had testified about the medical assistant attempting to administer the injection. Is that correct?

A That is correct, ma'am.

Q Do you recall where he attempted to give the injection?

A He also tried to give the injection to the right gluteal buttock.

Q And that is based upon your observation of him?

A That is correct. I was there when he tried to inject the medication and failed to give the injection.

Q All right. And I believe there was also some testimony regarding documentation as to the dosage of the Kenalog injection. Can you please clarify for the record what was the dosage that was administered to Patient A?

A The dosage which I ordered on my progress note states: Kenalog, 40 milligrams per mL injection suspension. Inject 0.5 mL intramuscularly once. And that's from CP 0002.

Q And that's Respondent's Exhibit Number 5; is that correct?

A I believe so.

Q All right, Doctor. And it looks like on that page as well, there is notation as to your name regarding a treatment plan for the Kenalog injection. Is that correct?

A Yes, it does.

Q All right. And is it your understanding that when you're documenting an electronic medical record that the record can autopopulate a provider's name?

A It can.

Q And do you recall the electronic health record that was in effect at HealthCare Partners on November 4th, 2016? Was it Cerner or a specific type of electronic healthcare record?

A I believe it was Allscripts.

Q And you had also testified regarding Chanel Hampton. Was it your testimony that she was your regular medical assistant?

A Yes, Ms. Chanel Hampton worked for me for approximately three years at HealthCare Partners.

Q And to clarify, when you prescribe a Kenalog injection through the electronic healthcare record, was it your testimony that it can autopopulate the typical medical assistant that you worked with?

A Yes, it can autopopulate the name of the medical assistant that normally works there.

Q Okay. And, Doctor, I believe there was also some testimony earlier regarding the timing of this documentation. Do you recall what time you finished

authoring your progress note for the patient?

A What happens sometimes is I'm busy at the -- I have another patient that I have to see in the urgent care, and then I'll go back at the end of the day to complete my progress note and to make sure everything is accurate as possible and reflects my care of the patient.

Q And does the documentation that has been provided in this proceeding appear to indicate that you authored your progress note on November 4th of 2016?

A Yes, it does.

Q Which is the same day that you saw Patient A; correct?

A Correct.

Q And then I also believe Board counsel asked you questions regarding your documentation of the consent given by Patient A's parents. Do you remember those questions?

A I believe -- Can we have a read back of that? Sorry.

Q Otherwise, I'll rephrase my question.

Doctor, you had testified that you documented that you had received consent from Patient A's parent in your note. Is that correct?

A Correct.

Q And is it your testimony that you received verbal consent from Patient A's parent prior to the Kenalog injection?

A Yes, I did.

Q And is it also your testimony that you received verbal consent from Patient A's parent for the oral medication that was prescribed?

A Yes, I did.

MS. BUYS: All right. That is all I have. Thank you.

HEARING OFFICER HALSTEAD: I know we've been doing redirect and recross. Do you want to engage in that?

RECROSS EXAMINATION

BY MS. BRADLEY:

Q I just have one question related to timing. Dr. Nguyen, do you recall approximately when you saw Patient A on November 4, s 2016?

A I believe it was right around 11:00 a.m. because usually, the triage nurse sees the patient first, gets their initial complaint, some of the symptoms and does vital signs, so I believe that the note started at 10:45 a.m., so I would have seen her shortly thereafter.

Q Okay. And so is it fair to say that probably she and her parents would have gone home by noon that day?

A Likely, ma'am.

MS. BRADLEY: Okay. That's all. Thank you.

MS. BUYS: Thank you. And would it be possible to take another comfort break? I apologize. I've been drinking water.

HEARING OFFICER HALSTEAD: Yes. Let's see what time. It's 3:04. So do you want to come back at 3:15?

MS. BUYS: That would be great. Thank you very much.

(Recess.)

HEARING OFFICER HALSTEAD: We're back on the record in Case Number 21-389084-1.

Ms. Buys, would you like to continue with your case?

MS. BUYS: Yes, thank you. Respondent would like to next call Dr. Eduardo Anorga. I believe he's sitting right here.

HEARING OFFICER HALSTEAD: Thank you. And I believe he was previously sworn; correct?

MS. BUYS: Correct.

THE WITNESS: Yes.

MS. BUYS: Perfect.

HEARING OFFICER HALSTEAD: Can you spell the last name for me, please?

THE WITNESS: Sure. It's A, N, as in Nancy, O-R-G-A. First name Eduardo: E-D-U-A-R-D-O.

HEARING OFFICER HALSTEAD: Thank you. I'll remind you that you remain under oath from when you were sworn in this morning.

THE WITNESS: Thank you.

HEARING OFFICER HALSTEAD: Go ahead, Ms. Buys. Thank you.

DIRECT EXAMINATION

BY MS. BUYS:

Q Thank you so much, Madame Hearing Officer. Good afternoon, Dr. Anorga. I believe you just stated and spelled your name for the record, but could you please let us knows what is your educational background?

A I went to UC Santa Cruz, graduated with a degree in biology with honors, went to the University of Vermont for medical school, and then I did my residency at Long Beach Memorial Hill. And subsequent to that, I did a certificate of added qualification in sports

medicine, but I didn't renew it after the first seven years. Decided not to renew it. I also got a certificate in utilization management and quality management, early career. And that I haven't renewed either.

Q Gotcha, Doctor. And I'd like to go and show you what has been marked as I believe it is Respondent's Exhibit Number 8, if I can approach you. And, Dr. Anorga, is this a copy of your Curriculum Vitae?

A Yes, it is.

Q And is it an accurate copy of your CV?

A Yes, actually it is. Yes.

Q Doctor, in your practice, have you had occasion to deal with pediatric patients?

A Yes.

Q And how often have you treated pediatric patients over your years of practicing medicine?

A Well, through my training, I've treated pediatric patients as part of family practice training. And subsequent to that, as I started my practice, I had a fairly robust pediatric population being that I had kids, all of my friends were having kids, and so I took care of a lot of children early on.

As we got probably in the last 15 years, I've

seen fewer kids in my practice primarily because they've all grown up. Although now, occasionally I get calls on their kids, and I also have had a lot of pediatric experience going to Haiti. I've been to Haiti 25 times for medical care, and I also worked with for over ten years working with a group of pediatric nurses in Haiti and would be their kind of resource person for difficult cases.

In addition to that, I was on the Board of Directors for West Side Neighborhood Clinic which was a family medicine clinic which included a lot of pediatrics. I would be involved in regular oversight of the care there. And then subsequent to that, I joined the board for Long Beach Children's Clinic, and was there for three years when they actually absorbed West Side Neighbor and again was involved with oversight, planning, care with regards to pediatrics.

Q Thank you. And aside from your trips to Haiti, have you practiced medicine anywhere else on mission trips?

A I went to Honduras after Hurricane Mitch; I've been down to Mexico. I also for many years worked for a company Newmatic that's now called UnitedHealthcare Global and participated in the management of over a

thousand traveling patients, and basically my role there was to give a report in Spanish and assess for the adequacy of care and make a decision as to whether or not the patient needed to be evacuated, for example, with an air ambulance or whatnot. So that would be the regular routine. They'd call me, I'd talk to the doctor, review the records and then make a decision as to whether they were safe to stay where they were or whether we needed to evacuate them by one means or another.

Q Thank you, Doctor. And over the course of your career, have you treated patients that have had symptoms of croup?

A Yes. Croup, asthma. Many, many, many.

Q And what are the symptoms of croup?

A Croup is primarily a barking cough. It's pretty striking and it is kind of frightening. Actually, I even took my -- when I was a physician, I actually took my daughter to the emergency room when she had croup one night.

We actually didn't get into the emergency room because by the time we got there, the cool night air had kind of, you know, we'd already tried walking around in the cool night air. It finally kicked in and she was relieved. But when it happens, it's pretty frightening

because you wonder okay, are they going to go into respiratory arrest or not.

Q And so in your experience then in your treating patients with croup, can their symptoms worsen suddenly?

A Yes. Typically, it happens during the night.

Q Thank you, Doctor. And how many times have you administered steroid injections in your practice?

A Upwards hundreds if not thousands.

Q And have you seen any major complications from administering steroid injections?

A I've never had a complication from administrating a steroid injection.

Q Have you seen any cases where a patient has developed atrophy in the thousands of injections that you've provided?

A Not in my practice, no. I did see one case one time on one of the people that went to Haiti with us got a shot in her deltoid and she had a small divot. I didn't give the shot, and it wasn't part of the trip. She had gone somewhere else.

Q Understood. And, Doctor, is a divot a rare complication of a steroid injection?

A I would say that it is.

Q All right. Is it a serious complication?

A I would say that it's not. It typically resolves over the course of the year by itself.

Q And if a patient would develop a divot after undergoing a steroid injection, when would you expect to see the divot develop?

A As I understand it, it would be within the course of a month.

Q So hypothetically speaking, if an administration of an injection was given on November 4th of 2016, you would expect to see a divot develop by December 4th or so of 2016?

A That would be reasonable.

Q And in your practice in administering thousands of Kenalog injections, have you ever seen a case where a patient has been administered an injection on, say, the right gluteal muscle and developed a divot on the left?

A No. And just a correction. All of this steroid injections I've given have been a variety of different types of steroids not just Kenalog. I use -- I tend to like Celestone, but it's kind of like to-may-toes and to-mat-os.

Q Thank you for clarifying, Doctor. And in

your practice, have you had occasion to administer Kenalog injections to pediatric patients?

A I don't think I've ever administered a Kenalog injection. I've given steroids. I've used IV steroids and other injectable steroids to pediatric patients but not Kenalog itself.

Q And is it your understanding that Kenalog injections are generally safe to administer?

A They're very safe.

Q And why do you say that?

A Well, it's a steroid. Your body produces very similar compounds to it. The only thing about the Kenalog is that it's bound to acetonide which is an agent that kind of keeps it in its place so that it doesn't become systematic and it makes its absorption more gradual so when you give the injection, you kind of get a low-level slow absorption of the medicine over many, many days if not weeks.

Q And in this case, have you had occasion to review the medical records that were produced by Respondent, Dr. Nguyen?

A Yes, I have.

Q All right. And in your review of medical records, did you come to an opinion as to whether or not

Dr. Nguyen met the standard of care in prescribing Kenalog to Patient A?

A Yes, he definitely met the standard of care easily.

Q Please explain.

A Again, the standard of care is what a reasonable doctor would do given similar circumstances. And in this particular case, we're in an urgent care setting where he doesn't really have the same advantage that I do where he might know the patient and their grandparents and everybody in the chain. And so he doesn't know exactly.

The mother sounds like she was very reliable and presented herself very well today, but you don't really know. You don't have that advantage and are they going to give the child the medicine, are they going to administer it properly orally or are they going to forget to do it. All of those things, it's kind of hard to tell. So certainly giving an injection eliminates all of those possibilities.

Also, I'm sure many of you have had two-year-olds in trying to administer a medication, oral medicine to two-year -olds can be very difficult. They'll spit it out. And then again, as Dr. Hall

mentioned, once they spit it out, it's really hard to know how much did they keep, how much did they spit out. So you create all of this, you know, this unknown.

And then as he mentioned, Prednisone, oral Prednisone can cause nausea, can cause GI upset. That's a very known common thing. And so even if you succeed in getting the right amount down, they may just give it back to you a little later. So the injection pretty much gets the job done.

And not only that, it's not completely clear whether this young child had croup because we're trying to construct what's going on based on history. It's possible that the child had some form of asthma. And as we know, asthma usually once you get an acute exacerbation, you're entering like a 12-week window of chronic asthmatics symptoms that will present with cough, wheezing and other symptoms. And again, to give this little longer level of treatment is actually superior than giving a short burst of steroids.

I think I had one other thought. This is also definitive treatment. So again, a lot of times, doctors, we're not completely sure what's going on. We're thinking well, it could be croup. It could be asthma. It could be a lot of other things.

And so if you provide definitive treatment and then the patient comes back or goes to see another doctor and they're not better, then that causes everybody to stop, look and listen and say well, maybe it's a foreign body. Maybe the child has some other problem that we need to consider. Maybe it's time for a chest x-ray.

But if you don't provide definitive treatment well, maybe they didn't get enough steroid. Maybe they threw it up. Let's try giving them an injection now and you could possibly delay another diagnosis. And so I think the standard of care here was excellent. I see no question at all in terms of the care that was provided, and it was probably superior than just giving oral medication.

Q And I believe that, you know, there was also some testimony regarding an oral Prednisone prescription. In your experience, Doctor, do patients forget to fill their prescriptions?

A Sometimes that happens. Sometimes they forget. I mean, you know, this week, I forgot my medicine. And so yeah, that's a very common thing. And so that's a possibility.

Q And in a patient that's being seen in an

urgent care setting, you know, with a patient's parent, are there instances where a parent would try and fill a prescription but there might be a delay in getting her medication filled at the pharmacy?

A That's always a possibility. It could be, you know, insurance issues, stocking issues. All kinds of things that can come up that would keep the patient from getting medication, plus there's also the misunderstanding factor. Even though you say like oh, five mL's once a day, well, maybe the parent doesn't know what 5 mL's is, and maybe they're afraid to ask. You know, maybe it's the spouse that's going to give the medicine and they really didn't get the message and something could go wrong.

Q Gotcha. And when you're testifying regarding definitive treatment, in this case, based upon your review of the records, did the patient have prior hospitalization due to croup?

A That is my understanding, yes, and from the testimony that I heard this morning as well.

Q And so when you're trying to use definitive treatment, is the sort of rationale behind that to provide coverage to avoid a potential hospitalization for a patient?

A That's one of the main goals, yeah, prevent hospitalizations, severe disease and death.

Q And in this case, have you seen any evidence that the Patient A had any sort of severe hospitalization or --

A Not after this episode.

Q -- death? And, Doctor, would it be reasonable for a physician to have to rethink their initial treatment plan based upon additional information provided by a patient's parent?

A Yes.

Q And in this case, as you've sat here today, did you hear testimony that the patient's parent had reported that she had not gotten better after having just a normal dose of oral steroids for symptoms?

A That's what I understood. Yes.

MS. BRADLEY: You're really muffled all of a sudden -- I'm not sure why -- the last part of that question.

MS. BUYS: Certainly. And could you read it back? I apologize.

THE COURT REPORTER: Sure.

(Requested portion read by the reporter.)

Q (BY MS. BUYS:) And the same question,

Doctor.

A Sorry. I spaced out.

Q And I'll rephrase as well, Doctor. As you sat here today, did you hear evidence that the patient's parent had reported that she had not gotten better after an oral course of steroid prescriptions?

A That's what I understood. Yes.

Q And would a reasonably prudent physician take the patient's parent at her word regarding that?

A That would be reasonable.

Q And why is that?

A Well, it certainly it's a logical possibility in terms of yes, you gave them oral steroids and it didn't work for whatever reason. That's certainly a logical possibility and wouldn't be surprising if that would occur, so it's reasonable to believe them.

Q And in your experience, Doctor, would a patient's parent have more knowledge about that patient's, you know, medical conditions of course than, say, someone in an urgent care facility seeing a patient for the first time?

A Well, the question is, is he in a different --

Q To clarify, and I'll rephrase. If -- and

I'll strike that and I'll go in a different area, Doctor. In this case, have you seen or heard any testimony regarding what the dosage was for the Kenalog injection?

A I understood that it was a total dosage of 20 milligrams which would be well under the 1.6 milligram per kilogram recommended dose and that it was administrated by the right gluteal region.

Q And in this case, was Patient A in a higher percentile for her weight when she presented on November 4th, 2016?

A Oh, yes. She would have been in the 75th percentile for a three-year-old. So by percentile is you line up 100 kids and, you know, where would they spread out. So she would be above the 50th percentile for a three-year-old in terms of her weight.

Q And when determining whether to give an injection in the lateral thigh or in the gluteal muscle, do you take into account that patient's weight?

A Yes.

Q And what else do you take into account when making that determination as to location of an injection?

A Well, maybe the idea is the size of the gluteus muscle and that happens, begins to develop once they walk. So once they've been walking for a while, the

gluteus muscle is adequately developed. So in a child that's under the age of walking and underweight, the gluteus muscle is not as well developed and there's the risk for gluteal atrophy which again is another very rare condition.

Q And in this case, have you heard testimony that the patient, Patient A, was walking at the time she saw Dr. Nguyen?

A Yes.

Q And based upon your review of the records and the testimony you've heard, would it be fair to say that you would expect that Patient A's gluteal muscle was well developed on November 4th of 2016?

A I think it would be reasonable to conclude that she had an adequate gluteal muscle based on her weight, her age, and her walking history.

Q And, Doctor, there's also been opinions regarding Dr. Nyugen's documentation in this case. Is there a difference between the standard of care and standard of documentation?

A Yes, I believe there is. There's a standard of care is what actually happened, and then there are standards for documentation that are independent of what actually happened.

Q And is it the standard of care to document every single possible complication a patient may have from a steroid injection?

A It is not.

Q Why is that?

A Number one, we usually give the major complications, the ones that would be more striking, but rare or uncommon complications we just don't go through those.

Q And in your practice, Doctor, have you ever had occasion to give a patient a written consent form for a steroid injection?

A No.

Q Why not?

A We always just do a verbal consent. It's pretty straightforward. General risks are kind of like Dr. Nguyen talked about: Local irritation, redness, possibility of infection, bleeding, bruising, allergic reaction. That's going to be for any injection. That's pretty common sense. Most adults know what an injection is, know it can happen. Most adults understand when you give an injection or even an oral medicine, you can have an allergic reaction. But we go over the top and explain it to them anyways.

Q And in this case, did you see any reference in the documentation that you reviewed that Dr. Nguyen had received informed consent from the patient's parent before he administered a Kenalog injection?

A Yeah, I think that was the statement there in his record that he received informed consent from the quote, unquote "patient" which in my mind, of course, language is very contextual, and I don't think anybody in their right mind could think that he spoke to the little two-year-old and obtained informed consent. It was really referring to the patient's parents.

Q And based on your review of the records in this case, Doctor, is it also your understanding that the patient's medical history and symptoms were information that was also provided by Patient A's parents?

A Right.

Q And in your practice or based upon your practice, is it the standard of care to rely on a pediatric patient parents to provide informed consent before there is an injection?

A Every circumstance -- I think you might be able to find an exception here or there, but for most cases, yes.

Q And there was some reference to articles that

Dr. Hall relied upon in making his opinions regarding this case that refer to vaccinations. Do you remember that?

A Yes.

Q Is there a difference between needing written consent for a vaccination versus a steroid injection?

A In our practice for many years, we always do a written consent for vaccination. I thought that was part of some code. I mean, because there was a time when we didn't do it. Then all of a sudden they said hey, you guys have to do a written consent for vaccination. I didn't argue. I said fine. We'll do that. But I think it was just some regulation or legislation that came out that said you need to get a written.

And at the same time, here we have somebody that's fine who you might make sick with a shot. This is the opposite. You have somebody that's sick, you know, you're hoping will get better. And in this case, certainly, she did get better. So it's a little different.

Q And in this case, Doctor, as you reviewed the records and heard the testimony here today, have you seen any evidence Patient A was given a steroid injection by Dr. Nguyen on the left gluteal muscle?

A Not on the left.

Q And there was also a discussion regarding documentation by medical assistants today. Do you recall that testimony?

A Yes.

Q Is it within the standard of care for a physician to rely on a medical assistant to help document the expiration lot number and, you know, information from the vial?

A Yes, that's a daily occurrence in our office.

Q And is it also within the standard of care for a physician to rely upon a medical assistant to attempt to give a steroid injection?

A In some circumstances. In this circumstance, yes. In some circumstances, no.

Q And have you had occasion to use electronic health records in your practice?

A I've gone through five EMR systems in the last like eight years, so I'm very familiar with it.

Q And in your experience with electronic health records systems, can it sometimes autopopulate different pieces of information?

A Yes. They have little -- all kinds of little things that happen in the background without you

specifically needing to include them.

Q And just to clarify, when you were reviewing the records in this case as well, was it your understanding that there was only 20 milliliters per milligram of the Kenalog that was administered?

A Well, I understood the Patient A received 0.5 milliliters, which is a half of a milliliter of Kenalog 40, and so for a total of 20 milligrams of Kenalog.

Q Thank you for clarifying the non-clinical when I'm asking questions. And so in your experience, Doctor, and based upon your understanding, was it within the standard of care for Dr. Nguyen to prescribe that dosage of a Kenalog injection?

A That's a very reasonable dose. It's what's in my little handout for dosage for that age and weight.

Q And did you have an opportunity to review the literature regarding, you know, potential muscle atrophy or subcutaneous atrophy from a steroid injection?

A It's actually I don't think I -- I think I saw something regarding muscle atrophy, but it's so incredibly rare that it's just like hard to believe. And there was no evidence of muscle atrophy. I think it would have been -- if she had muscle atrophy, it would have reared itself as a gait disturbance, and there was

no mention by anybody or --

MS. BRADLEY: I'm going to object. He's saying there's no evidence of muscle atrophy. He's not saying which side, and I think it misstates what's in the record. We have an exhibit showing an injury that appears to be muscle atrophy or some sort of atrophy.

THE WITNESS: So yeah, it's the preponderance of the evidence there would be that it is subcutaneous fat atrophy. And if it was muscle atrophy, you would expect to hear complaints of a gait disturbance because the muscle is involved in gait, and so those things are readily apparent even to the parent.

Hey, my kids is limping, you know. Why is my kid limping? And so, you know, there was no mention of that either by Dr. Hall or by the parent. And again, it's a very rare event, so there would be no reason to suspect that muscle atrophy actually occurred.

Q (BY MS. BUYS:) And it's relevant to draw the distinction between muscle atrophy versus subcutaneous atrophy as well as what the records that have been disclosed indicate?

A So skin, fat, fascia, muscle. So there's the skin on the outside, there's the fat underneath, there's the covering of the muscle, and then there's the muscle

itself. So that's just the usual anatomic layer.

Q And, Doctor, are you aware of any FDA guidance that would have been in effect in 2016 where a Kenalog injection is recommended to be administered to the patient's body?

A I saw the ones that you guys provided. Well, actually, who provided those? I'm not sure if you guys provided them or they provided them.

MS. BUYS: Certainly. And let me clarify, Doctor. I'm going to draw your attention to Respondent's exhibit, and I'll pull that up for you. Actually, we have the wrong binder, so let me go grab the correct binder. And I'm just going to put in front of you for the record, it was Respondent's Exhibit Bates stamped BMS underscore (2011) 00001 through 20.

MS. BRADLEY: Do you have an Exhibit Number? Because I don't --

HEARING OFFICER HALSTEAD: It's going to be Respondent's Exhibit 11.

MS. BRADLEY: Eleven. Okay.

Q (BY MS. BUYS:) Thank you. And, Doctor, based upon the FDA guidance that was provided and in effect in 2016, was there a recommendation of the location for a Kenalog injection?

A Yes, there was.
Q And where was that location?
A Lateral gluteus.
Q And in this case, have you seen evidence that there was an injection in the gluteal muscle of Kenalog?
A Yes, that's what the record reflects --
HEARING OFFICER HALSTEAD: Before you move on --
THE WITNESS: -- and the testimony.
HEARING OFFICER HALSTEAD: Thank you. You referred to Exhibit 11 saying that, but where in Exhibit 11, please?
MS. BUYS: Certainly. I believe it's on Bates stamp number 17.
MS. BRADLEY: I think it's under dosage systematic, and then it says the suggested.
HEARING OFFICER HALSTEAD: Yeah. That's page 17. Thank you.
Q (BY MS. BUYS:) Thank you. In the bold print. Now, Doctor, is it the standard of care for a physician to have to review the medical literature every time he sees a patient?
A Absolutely not.
Q And is it the standard of care for a

physician to review literature that hasn't even been written yet before he sees a patient?

A That's a pretty obvious question. Absolutely not.

Q And based on the documents that you've reviewed, which is Respondent's FDA guidance as well as I believe the Investigative Committee's guidance, would you say that the FDA guidance in effect at the time was not the revised guidance that was written in 2018?

A I'd have to go through that, but I think that's the case. Yeah, certainly. Yes. It doesn't matter because 2018 is yet a future date from the time of the event.

Q Gotcha. And looking at the FDA guidance that was in effect that was written in 2011, which I believe is at -- get the Bates stamp. It's Bates stamp BMS (2011) 00014.

HEARING OFFICER HALSTEAD: And for the record, that's Respondent's Exhibit 11.

Q (BY MS. BUYS:) All right. Thank you very much. And, Doctor, based on that documentation on that page, was the FDA approving the use of Kenalog injections for medications as of 2011?

A Yes.

Q And based upon your testimony here today, is it fair to say that it's your opinion that it was within the standard of care to prescribe a Kenalog injection to a patient, a pediatric patient?

A Yes, it is.

Q Even though Patient A had also received a prescription for a steroid; is that correct?

A I did some quick math on that. You can use four times the dose of Prednisone in the hospital or equivalent Prednisone because they're a little bit different. They have their different equivalents. You can use four times the dose on a given day.

And again, the child is not going to absorb all of the 20 milligrams on that day. It's going to be spread out over weeks. So if you have a child in the hospital and you need to give them an equivalent steroid that's more rapid acting, you can go up to four times the dose. So we've got all kinds of room here. There's no argument -- there's no reasonable argument here that somehow we're overdosing or that Dr. Nguyen was overdosing the patient with Prednisone. It's just there's just no reason why.

Q Gotcha. And is it within the standard of care for a reasonable physician to rely on a third-party

medical records retrieval company to assist them in responding to a request for a patient's records?

A Yes.

Q In your practice, is that something that is common?

A Yes.

Q And in this case, you've reviewed Dr. Nyugen's documentation. Is that correct?

A Yes, I have.

Q Is it your opinion that Dr. Nguyen met the standard of care in his documentation?

A Yeah, he met the standard for doc -- well, what's reflected within his documentation is solidly within the standard of care, and his documentation is also solidly within the standards of documentation.

Q And you've heard Dr. Nguyen testify as to the risks, benefits and alternatives to treatment that he recalled telling Patient A and her parents. Is that correct?

A Yes.

Q And is it within the standard of care -- is it the standard of care that Dr. Nguyen disclosed those particular risks and benefits and alternatives to treatment?

A Yes.

Q And, Doctor, have all of the opinions you've given today been by a preponderance of the evidence?

A Yes.

MS. BUYS: All right. And then I will review my notes but defer to Ms. Bradley regarding cross-examination.

HEARING OFFICER HALSTEAD: I just want to note for the record that there was no objection placed, but whether that standard is met is up to me. All right. Thank you. Did you have anything further for this witness?

MS. BUYS: Not at this time. I'm just reviewing my notes.

HEARING OFFICER HALSTEAD: Thank you.

MS. BUYS: And I do actually have one other question if I may.

HEARING OFFICER HALSTEAD: Sure. Of course.

Q (BY MS. BUYS:) Thank you. Dr. Anorga, do you have patients sometimes forget some of the side effects that you've mentioned to them?

A Yes. I think I've heard statistics of patients probably remember about 50 percent of what we tell them. That doesn't seem unusually different from my

experience.

MS. BUYS: Thank you very much, Doctor. I appreciate that.

HEARING OFFICER HALSTEAD: Did you have any cross?

MS. BRADLEY: Yeah.

CROSS-EXAMINATION

BY MS. BRADLEY:

Q Dr. Angora, are you being paid a fee to appear here today by Dr. Nguyen?

A I'm not sure exactly who it is that's paying me, but yes, I am being paid a fee.

Q And what are you being paid?

A $4,000 for today.

Q Are you licensed in Nevada?

A I'm not.

Q Have you ever been licensed in Nevada?

A I have not.

Q And I'm looking at your CV. Let me turn to it. I believe the most recent professional experience, there's two listed sort of toward the top of the second page of your CV. One says private practice, 1988 to February 2017. Is that accurate?

A Yeah, that was with my own private practice.

Q Okay. And then I see Torrance Memorial Physician Network, 2017 to 2020. January 2020. Is that accurate?

A That is correct. Yes.

Q So are you doing clinical practice at this time?

A Yes, I am.

Q Oh, maybe that next one. Kind of hard to see here because there's occupational and health physician. Is that where you're currently practicing?

A No. I'm working at Beach Cities Orthopedic.

Q I don't see that on here. Could you tell us that again?

A Oh, let's see. Yeah. It's right there. It's the third line: Professional experience.

Q Yeah.

A Beach Cities Orthopedics and Sports Medicine. 2990 Lomita Boulevard, Suite B, Torrance, California.

Q I don't see a date there. Okay. So Beach Cities.

A That's my current employment. From 2020 until now, that's my current employment. Sorry.

Q And then I do see that there's occupational

health physician. Are you not doing that then for Allied --

A I am still doing six hours of occupational health for a company called Torrance Refining, and so I do some oversight work there as well.

Q And how --

A It may not be on there.

Q And how many hours a week do you do at Beach Cities Orthopedics?

A Thirty-two.

Q Thirty-two. Okay.

A That's -- I'm seeing patients. That doesn't include all of my administrative time finishing up notes, calling patients. Probably far more than that.

Q Sure. So you're still doing clinical practice then, it's fair to say?

A Yes, I'm definitely working more than full time.

MS. BRADLEY: If we turn to the Board's Exhibit 6, which I think should be there somewhere, there was a binder. I'm not sure it's in that folder because I think that's the Respondent's exhibits, and I know we had this issue earlier because I believe we provided one for witnesses.

HEARING OFFICER HALSTEAD: Just maybe clarify it's the pictures.

MS. BRADLEY: Yeah, it's the pictures.

HEARING OFFICER HALSTEAD: Because they didn't have their own marking.

Q (BY MS. BRADLEY:) Do you see those there?

MS. BUYS: I think it's a different binder.

MS. BRADLEY: Okay.

MS. BUYS: It's over here.

MS. BRADLEY: Yeah, because we had one for our exhibits and one for yours that we had for the witnesses, so somehow the Board one seems to have gone missing.

MS. BUYS: Just on a different table.

MS. BRADLEY: Okay.

HEARING OFFICER HALSTEAD: Well, let me ask because there was a binder that was supposed to be the exhibits that wasn't, and then the pictures were used independently. So was there a binder made at lunch?

MS. BRADLEY: There was a binder made yesterday, and I don't know what happened, but --

HEARING OFFICER HALSTEAD: Well, Ms. Buys had that binder, and she wrote in it.

MS. BRADLEY: Yeah. I was under the

impression she was bringing --

HEARING OFFICER HALSTEAD: I just want to make sure he's not being given a binder with something that isn't exhibits.

MS. BRADLEY: Yeah.

MS. BUYS: No. The binder that was given was over on this additional table away from --

HEARING OFFICER HALSTEAD: Right.

MS. BUYS: -- respondent and had the pages taken out. I believe that's what we had stipulated to earlier, that that was Exhibit 6 after we reviewed it.

MS. BRADLEY: Okay.

HEARING OFFICER HALSTEAD: I don't recall that.

Q (BY MS. BRADLEY:) Well, so, Dr. Anorga, you're looking at a binder. It's hard to see. We can't see the whole binder in this photo or on our screen. Okay. Is that a picture? It should be. What I'm hoping you're looking at is Exhibit 6. That's a photo.

A I have those right here. Yes.

MS. BRADLEY: Okay.

HEARING OFFICER HALSTEAD: So they're not in the binder. So I think that binder was the one that we've removed from the table because it wasn't properly

there.

So since you have the pictures, I just want to make sure you don't have anything in front of you that you're not supposed to. So I want to put that binder to the side, if we could, because I don't know what's in there. Thank you.

Q (BY MS. BRADLEY:) So, Dr. Anorga, what you're looking at is a copy of what's been admitted as the Board's Exhibit 6, and there should be two different pages. For me, they're labeled NSB 017 and NSB 018. Yours may not be labeled because I think we had to print them earlier, but are you seeing two photos?

A I have two photos.

Q Okay. And if you look at those photos, there appears to be an injury on the left side of the child's buttocks. Would you agree with me?

A Yes, in the left lateral gluteal region.

Q And do you have any idea what might have caused that injury?

A Possibly could be a spontaneous lipodystrophy. It could be a posttraumatic lipodystrophy. It could be as a result of an injection.

Q Okay. So it could be the result of an injection.

A Could be.

Q So you've testified today that you believe that the injection in this case occurred on the right side of the Patient A; is that correct?

A That seems to be what the medical record documents, what the testimony documents.

Q One second. We've got a weird message on our video.

HEARING OFFICER HALSTEAD: If for some reason we lose you, we have a message that says "This call has exceeded the maximum time. Call in."

(Brief interruption.)

HEARING OFFICER HALSTEAD: Sorry about that. We had a message we might be disconnected, and as I was explaining that to you that we will call you back if that happens, we got disconnected. But we are back on the record now. Well, we haven't gone off the record. We're back on video, I guess I should say.

Q (BY MS. BRADLEY:) So, Dr. Anorga, your testimony was that you believe that the injection in this case was in Patient A's right-hand side or right side?

A Yes, I think that's what was documented and also Dr. Nyugen's recollection. Yes.

Q Okay. Have you ever seen an instance where

the medical records don't match what actually happened?

A That is correct. Yeah. And I think in response to that, I would say that even if there was some -- I'm sorry? Even if there was some left/right documentation error, it still does not warrant a deviation from the standard of care or warrant anything to have to do with informed consent.

Q Okay. I didn't ask you that, but okay.

A Just trying to make it easier.

Q All right. Thanks. I appreciate your help. You testified that you believe that the patient had been hospitalized prior due to croup. Where are you getting that information?

A Good question. I thought I heard it from the testimony sometime today.

Q Okay. Is it documented in the medical records?

A I'd have to look and see. I didn't memorize them.

Q You can look at Exhibit 5 for the Respondent. That's probably a more complete set of medical records or you can look at Exhibit 5 for the Board.

A I don't think that was hospitalizations. The medical records said croup.

Q Yeah. I see. Are you looking at HCP 0002?

A Exactly.

Q Okay. And it says patient had croup twice already with last one seven months ago. Is that what you're looking at?

HEARING OFFICER HALSTEAD: Can we clarify which exhibit and which page that is?

Q (BY MS. BRADLEY:) It's Respondent's Exhibit 5, HCP 0002. At least that's what I think he's looking at. Is that correct, Dr. Anorga?

A That is correct. Yes.

Q Okay. Does it say hospitalization for the croup?

A It does not say hospitalization.

Q Okay. And is it documented in the record that the patient previously did not get better after taking just oral steroids from croup?

A It does not. I don't see that.

Q And earlier, you testified that if you were going to give a steroid injection that you would take the weight of the patient into account for the location of the shot. Is that documented that Dr. Nguyen made a judgment similar to what you might make in this record?

A Well, the weight is documented in the chart,

so it would be reasonable whether it be through discursive processes or through just direct apprehension to be able to decide to give a shot like this.

Q So you're saying that because he documented the way you think then that he would have taken that into account when deciding where the shot should be given?

A I did not get into his mind, but it would be my testimony would be that it would be based on the child's weight and the other historical factors that we mentioned. And if the child was resisting a glut, a thigh injection, that this was reasonable. That is my testimony.

Q Okay. And you testified earlier that you believe Dr. Nguyen met the standard of care for documentation. Do you know what that standard of care is in Nevada?

A Well, standard of care for documentation would be that the note would reflect the major points of the visit.

MS. BRADLEY: Okay.

HEARING OFFICER HALSTEAD: Sorry, but can you just scoot over? It would be to your left because you're just a little tiny bit cut off on my screen.

THE WITNESS: There we go. Okay.

HEARING OFFICER HALSTEAD: Your left. Thank you. I appreciate that.

Q (BY MS. BRADLEY:) Are you aware that Nevada law provides a requirement for physicians in maintaining records under --

A Absolutely.

Q Okay. And so could you tell us what the requirement is?

A I probably couldn't quote it. No.

Q If I told you that Nevada law requires that physicians maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient, does that sound like an appropriate --

A That sounds perfectly reasonable.

Q And your belief is that the records in this case are timely; is that true?

A Yes, I do.

Q It's your opinion that the records in this case are legible?

A Yes, they are.

Q Okay. It's your opinion that the records are accurate?

A They appear to be accurate, yes, to a

reasonable degree.

Q Okay. So does that mean there are some inconsistencies in the records?

A No. It just means that not every detail in any medical record is fully documented, and so there's a reasonable degree of documentation that entails your goal of being accurate.

Q Well, I think so you're answering the wrong question because accuracy implies that it's correct. The next thing I was going to ask you about is completeness. So are you saying the records in this case are accurate in every instance?

A They're reasonably accurate. Yes.

Q Okay. So you're saying there maybe are some instances where they're not accurate. Is that fair?

A Again, I think there is a dispute as to whether this was a right/left issue. And if that occurred, then it's possible that it occurred. I'm not convinced that that occurred, but is that logically possible? Yes. Does that fall below the standard of care? No. Does it fall -- Does it not meet some standard of documentation? Perhaps.

Q But would you agree there also is a discrepancy at least regarding the administration record

regarding who provided the injection?

MS. BUYS: Objection. Misstates testimony.

BY MS. BRADLEY: Okay. Well, let's look at Exhibit 12 from Respondent or my 13 -- I'm sorry. I keep doing the wrong one.

HEARING OFFICER HALSTEAD: It's going to be Respondent's Exhibit 12.

Q (BY MS. BRADLEY:) Respondent's Exhibit 12, and it's med admin detail 00001. Have you seen this before? Oh, what are you looking at there? Is that an electronic copy?

A These are electronic copies, so where would you like for me to look so I can help you?

Q I just want you to look at the Respondent's Exhibit 12, and the title of that document is, "Medication Administration Details."

HEARING OFFICER HALSTEAD: It should be in the binder next to you.

Q (BY MS. BRADLEY:) Yeah. I believe it's in one of the binders there. Hopefully, it's Tab 12.

A I think that there is a frame shift alteration in all of the records here. Just kind of curious because 12 here is -- Exhibit 12 in this binder is -- it has to do with the details regarding Kenalog.

HEARING OFFICER HALSTEAD: Yeah, it's probably 11 because what happened was at the beginning of the hearing, we marked an exhibit as 1 and did not and so they're all one off.

MS. BRADLEY: That might be also be the Board's ones.

THE WITNESS: Eleven for me is "Comparison of Corticosteroids for Treatment of Respiratory Syncytial Virus." I'm sorry.

MS. BRADLEY: It's Respondent Exhibit 12. Perhaps is it in the binder in front of you? I'm kind of confused because I can't really see what binders you're looking at.

MS. BUYS: May I approach the witness just to see if I could help clarify the binder situation?

HEARING OFFICER HALSTEAD: Yes. Yes. That would be great.

THE WITNESS: Is it okay to look at this other binder? I know there was some concern about me looking at the other binder.

HEARING OFFICER HALSTEAD: I don't know what binder that is.

MS. BRADLEY: Maybe Ms. Buys can help us find -- Oh, I think she's got it right there.

MS. BUYS: And this binder in front of Dr. Anorga reads: "Respondent's Formal Hearing Exhibits, the Investigative Committee of the Nevada State Board of Medical Examiners" on the title.

Would you like me to move that out of the front of the doctor, Ms. Bradley?

MS. BRADLEY: Yes. If you could give it to Ms. Barbieri in the back, that would be awesome. Thank you.

MS. BUYS: May I also remove the photographs that I believe we had stated were Exhibit 6 of the IC?

MS. BRADLEY: Yeah. I don't think we need that at this point.

HEARING OFFICER HALSTEAD: Thank you, Ms. Buys.

MS. BUYS: Thank you. And then just to clarify as well, right in front of Dr. Anorga, I believe we have what has been stipulated to as Respondent's Exhibit Number 13, and it's Bates stamped med admin details 0001. Is that the document you would like, Ms. Bradley?

MS. BRADLEY: That is what I would like him to look at. I think Madame Hearing Officer and I both had that listed as 12, but okay.

HEARING OFFICER HALSTEAD: Just so you know for the record, I'm working from the set of exhibits that were marked. I'll provide them to the court reporter to go with hers, and so because the exhibit you're referencing was marked as Respondent's Exhibit 12, that's how it will be marked on the record for reference so it corresponds with my marked documents. So even if he's looking at one that says something different, it will be correct as marked in the record because we're still referring to the same thing.

MS. BUYS: Thank you for clarifying that, Madame Hearing Officer.

Q (BY MS. BRADLEY:) So have you seen this before, Dr. Anorga?

A I'm not certain that I have. I read a lot of documents.

Q Does it purport to be a medical record for Patient A?

A It appears to be a combination of it has some billing information on there, it has the charges, it has some administrative, so I don't know if this is an actual looks like a combination of both billing and medication which there is some overlap.

Q Okay. Well, at the top, it says:

"Medication Administration Details." Do you see that?

A Yes.

Q Okay. And I believe that the Respondent has provided this to show that there was a record of a shot that was provided to Patient A which included the lot number, the expiration of that vial. Do you see that there in the middle?

A Yes, I do.

Q Okay. And if you look at the admin by, do you see a name there?

A I do.

Q And what's that name?

A Chanel Hampton.

Q Okay. And what would "admin by" mean to you if you were just reading that?

A It could mean administered by.

Q Okay. And so in this case, do you know whether or not Ms. Hampton provided the injection?

A I think we just heard Dr. Nyugen's testimony that he provided the injection, and we also saw documentation in the medical record that he documented that he provided the injection.

Q So then it sounds like this record is inconsistent with the other records that we have for this

case then.

A Yes, on the surface it does but again, I'd have to have probably a little bit more information about how this record was generated and so forth.

MS. BRADLEY: Okay.

MS. BUYS: And I'd like to lodge a late objection. Calls for the speculation.

MS. BRADLEY: Okay. I apologize. What question calls for speculation? Whether or not Ms. Hampton did the injection? What did I ask that was speculative? I don't remember.

MS. BUYS: The last sentence. I believe if the court reporter reads it back, the question was whether or not this is inconsistent with the documentation.

MS. BRADLEY: Okay. I don't think it speculates because we have information that's been admitted that says that Dr. Nguyen provided the injection. And if this says someone else provided the injection, I mean, would that not be inconsistent to you then, Dr. Anorga?

THE WITNESS: If that what's referred to as this -- was that the injection was administered by Chanel Hampton, then that would be inconsistent, yes.

Q (BY MS. BRADLEY:) All right. Thank you. Do you see the date and time at the top? Not at the top. Right above Ms. Hampton's name. Can you read that date for us?

A November 4, 2016.

Q Yeah. Then there's a time. Do you see that?

A Yes.

Q What time does it say?

A 06:56 p.m.

Q Okay. Earlier, you testified that the documentation for this case said that Dr. Nguyen obtained informed consent. Can you show me where informed consent is contained in the medical records?

A Well, there is the progress note that I've got back and forth here already. "Patient agrees with treatment and plan, verbalizes understanding."

Q But I think your testimony was that he obtained informed consent. So nowhere on this documents does it say informed consent. Would you agree with me?

A So you're equivocating between literal and figurative. So I would say this figuratively includes the idea of informed consent, plus we also have his testimony.

Q Okay. And would you agree with me that

informed consent is not the same as consent?

A Yes.

Q Okay. You testified that patients remember approximately 50 percent of what doctors tell them, you've read. Do you think that might be a reason why careful documentation is important as a physician?

A In what sense do you mean? In terms of the actual care that was provided or in terms of defending yourself against an accusation?

Q Both.

MS. BUYS: And I'll just object as it misstates the standard of care.

Q (BY MS. BRADLEY:) Well, my question to Dr. Anorga was you testified that you've read a study that says patients remember approximately 50 percent of what we tell them. Is that not true?

A Yeah, I've heard that. I'm not sure exactly where I remember reading that. It's not unreasonable to believe that there is a lot -- there is a lot of what we tell patients that they just don't either understand it or they're thinking of something else or they're distracted or that they just by the time they leave forget.

Q Okay. The question was whether or not you

remember saying that, so thank you for that explanation. So because that is likely true, is that not a reason that documentation in patient records might be important?

A In a sense, yes. In a sense, no.

Q Okay. Can you explain the in a sense yes?

A In a sense, yes, certainly for medical/legal reasons, it's very important to document all of those things in detail. In terms of prospective care, it probably has minimal if any relevance in terms of like the future care that the patient is going to get. It may have some small impact on it, but it would be relatively minor.

MS. BRADLEY: Okay. I have no further questions.

REDIRECT EXAMINATION

BY MS. BUYS:

Q Doctor, you're aware you're still under oath; correct?

A Yes.

Q I believe Ms. Bradley asked you a question regarding the fee that you have received coming to testify here today. Do you recall that?

A Yes, I do.

Q All right. And is that fee supposed to go and compensate you for time away from treating patients?

A Yes.

Q And I believe there was also some testimony regarding whether or not there was any evidence that the patient's daughter had been admitted to the hospital prior to November 4th of 2016 for croup. Do you, as you sit here today, did you hear earlier that the patient's mother had testified that her daughter had been hospitalized prior to November 4th, 2016?

A That was my understanding, yes.

Q And I believe you were also just asked a question by Ms. Bradley as to whether or not documentation, you know, was important and your response was: Yes and no. Can you please explain the no?

A Well, the reality is that medical records have become incredibly voluminous, and we do not have the ability to go back and review all of these medical records every time we walk in a room to see a patient.

We basically have 20, 30 minutes to kind of get to the point, get to all of the details and make a decision. And there are times where we have to stop, go back and look and say: Was it the right kidney or the left kidney? Was the lesion here or there? Because of

matters of grave substance. But again, most doctors can't go back and review the entirety of the medical record before they walk in to see the patient. It just doesn't -- it's not part of what reasonable doctors do in the community.

I get records to review, and they'll send me 10,000 pages. It will take me many, many, many hours to review. And so again, medical records in our current state have been somewhat just become non-informative as far as what's necessary for the patient's care to a great degree. I'm not saying that it's always, but they're generally not very informative.

Q Thank you, Doctor. And I believe you were also asked a question by Ms. Bradley regarding documentation as to who administered the injection. Do you recall that line of questioning?

A Yes.

Q All right, Doctor. If I may also, I'd like to go and I believe it is Respondent's Exhibit Number -- I believe it's number 7, HCP 0007.

A I now have that highlighted in my electronic copy.

Q So you do have a copy of that in front of you?

A Right. I do. We're talking about the same one. It starts with -- It looks like this.

Q I believe that's correct. And just for purposes of the record, Doctor, if I may have you refer to the binder.

A Okay. And which tab is it?

Q The tab is Tab Number 6 and HCP 00017 on the bottom right-hand corner.

HEARING OFFICER HALSTEAD: I think it's going to be Respondent's Exhibit. I believe just for the record, it's going to be Respondent's Exhibit 5. Are you talking about the one at the top it says HealthCare Partners Medical Group-700 building and the Bates stamp is HCP 0001?

MS. BUYS: Correct.

HEARING OFFICER HALSTEAD: Okay. That is Respondent's Exhibit 5.

Q (BY MS. BUYS:) Thank you. Now, Doctor, based upon this record, does it appear that there is documentation that Dr. Nguyen is the one who administered the injection?

A Yes, that's what it says. I believe that's what he testified to.

MS. BUYS: Thank you very much, Doctor.

Those are my questions.

HEARING OFFICER HALSTEAD: Do you have recross?

MS. BRADLEY: No questions. Thank you.

HEARING OFFICER HALSTEAD: Okay. No questions from the IC.

Do you have any further witness, Ms. Buys?

MS. BUYS: I do not. No.

HEARING OFFICER HALSTEAD: Okay. I would like to take a small break. Did you want to release -- I don't want to say your name wrong --

THE WITNESS: Dr. Anorga.

HEARING OFFICER HALSTEAD: Thank you. Do you want to release him right now or would you like to --

MS. BUYS: Yes.

HEARING OFFICER HALSTEAD: Okay. Sir, you are released. You are welcome to stay. We're going to take a short break, and then do you want to do closing arguments?

MS. BRADLEY: Yes.

THE WITNESS: Great. Thank you very much.

HEARING OFFICER HALSTEAD: How long would you like to break before we come back to close? Because I know sometimes it's nice to have a few minutes to put

those together in your mind.

MS. BUYS: Thank you. Perhaps maybe ten or 15 minutes.

MS. BRADLEY: I would agree, ten or 15 minutes would be great. My only concern is I don't know how long you're planning on talking. I don't think mine will be very long. I just don't want anyone to be upset about staying past 5:00. Would that be okay?

MS. BUYS: That's fine.

MS. BRADLEY: I just wanted to make sure. I wasn't sure of our court reporter's situation.

HEARING OFFICER HALSTEAD: So let's come back at a quarter to 5:00. And so we will go past 5:00, but everyone seems to be okay with that.

(Recess.)

HEARING OFFICER HALSTEAD: So we're going to go back on the record in Case Number 21-38084-1.

Ms. Buys, I know you indicated you were done with your presentation. I don't know if you officially closed your case.

MS. BUYS: I concluded calling all of the witnesses and just reserve closing arguments.

HEARING OFFICER HALSTEAD: Okay. And then I consulted with Ms. Bradley, who had no rebuttal.

MS. BRADLEY: No rebuttal, no.

HEARING OFFICER HALSTEAD: And so we decided we were going to proceed to closing. We took a break. We're back on the record, and Ms. Bradley will start us off.

MS. BRADLEY: Okay. Thank you. So just to summarize the hearing that we had today, the Investigative Committee admitted 19 exhibits, we had testimony from three witnesses, and we would submit that we believe that the allegations contained in the complaint have been proven.

And I do want to go into those in more detail, but before we do, as you will recall, the mother, Ms. DelGrosso, did not remember Dr. Nguyen, but as I think we all know, time has passed. Dr. Nguyen is listed on the records as the treating physician in this case, and he is not disputing that he provided the care in this case. And so I just wanted to kind of put that on the record so that there's no question with that regard.

And so if we were to go through the complaint, so the first allegation in the complaint is Respondent was at all times relative to this complaint a medical doctor holding an active license to practice medicine in the State of Nevada, License Number 13702,

and Respondent was originally licensed by the Board on September 15th, 2010. And so we did stipulate to the truth of that fact.

And then next, we have an allegation regarding the November 4th, and it has been amended to November 4 from November 11, 2016. Patient A was not well, and she went to HealthCare Partners Urgent Care with her parents because she had coughing, she had vomiting and other symptoms as identified in the medical records, and her parents were concerned that she was not well.

The medical records support that she received an injection, a Kenalog injection that was administered by Dr. Nguyen. The Investigative Committee alleges that informed consent was not provided, and we believe that the testimony today has proven that.

Informed consent is different than consent. Consent is simply yes, you may; no, you may not. But it doesn't necessarily mean that a person fully understands what they're saying yes to. Informed consent is a legal concept, and I know the hearing officer is aware that requires that more information is provided prior to the person providing a so-called consent, and so it's kind of a two-part situation. There's the explanation of risks,

benefits, alternatives, other kinds of explanations given before the consent is provided.

And in this case, the Investigative Committee believes that informed consent was not provided. If it was provided, it was not documented. And that's really where we're at today is we have two allegations in the complaint. One is malpractice and the other is that medical records were not timely, legible, accurate or complete.

And I think with several of the issues we have is if it was done correctly, it wasn't documented, and so that means we've proven the medical records issue or perhaps it wasn't done at all. And so I think that's where we maybe have some issue with regard to malpractice because we've heard some testimony, I think, that's different than what's documented in the medical records.

In the complaint, we would -- and I think we didn't do this initially, and I apologize. So on page two of the complaint, line five to seven, there's a statement that says there was no shot record section of Patient A's medical record as there was no documentation of the Kenalog's vial identification, lot number or a date of expiration.

We will strike that from the complaint

because we know that that late-provided exhibit that we got on Monday, May 23rd, does have that information, and so it was and it appears to have been documented at that time, was not provided to the Board until May 23rd. And so we would go ahead and strike that. And I believe that same information is included on the third page of the complaint which says on line 17: Additionally, Patient A's medical records of having the shot including the information from the vial do not exist. We know they exist. Again, we still have concerns regarding records, but at least as to that part, that has been provided.

And I think again, this goes back to if we had more complete responses initially from Dr. Nguyen, we may have had a different result than coming here for this hearing. So the facts that you've heard that we believe support the claim of malpractice is Dr. Hall doesn't believe that the informed consent was obtained because it's not documented.

And there is a saying in medicine that everyone has heard, and I think it does come from medical school because I've heard many of the doctors we work with say this: If it's not documented, it did not occur. And that's how you prove that something happened, is documentation.

Also, there's evidence in the record that the injection was not administered properly. And that evidence really comes from the testimony of Mrs. DelGrosso and the photograph that she provided that she took of her daughter. Her testimony was that after the injection, she was sore and a little bit swollen. The swelling went down, and then a crater or a divot began to appear. Her testimony is that occurred after the injection and that that was a result of the injection.

And so our belief is the medical records -- there's some belief there was testimony -- I'm not sure the records show it, but there was testimony that there was more than one attempt to give the shot, and so it's possible maybe one of them went in a little bit and did it incorrectly on one side, you know. Again, we don't know exactly that, but we do know there was more than one attempt and we have this injury developing after the doctor visit.

And then Dr. Hall's opinion that there's a duplicate medication here. He testified that he didn't think he has concerns with the Kenalog shot for two reasons. One, he thinks it's duplicative of the oral steroid, and so he testified that he wouldn't have done

them together. He doesn't think that would be necessary. He also said because of the possible risks of a Kenalog injection that he thinks the first thought would have been to try an oral steroid. And the records are not documented. It does say that Patient A was vomiting once a day, her symptoms were getting worse at night, but it doesn't say she was unable to keep anything down.

I will note that it says on Exhibit 5 for the Respondent, HCP 0002, it says: Appetite is decreased, but it doesn't say that she was not eating or not able to keep things down. And then it does say that vomit once a day for four days, coughing causing patient to vomit. And Dr. Hall's testimony was that this isn't the thing you do first, the Kenalog injection. You would try oral steroids first and then perhaps that Kenalog injection if the oral medication was not sufficient.

Dr. Nguyen testified today that Mrs. DelGrosso told him that her daughter in the past was not getting better with a similar infection through just the oral steroids, but that's not documented in the record, and we don't have that documentation. So, you know, perhaps that conversation occurred and that's just another example of the records failing to be timely, legible, accurate and complete.

So in going to that count, Nevada law is pretty clear, and Nevada law says it's an absolute requirement that records are timely, legible, accurate and complete. There's no wiggle room there. And part of the reason for requiring that is so that anybody reviewing a case as well as the patients, everybody is able to actually fully understand what occurred in that visit, what the diagnosis was, what the patient's vital signs were, the reason for the diagnosis and the treatment plan.

And so here we had testimony today that Dr. Nguyen says he obtained the informed consent. The documentation we have says patient agrees with treatment plan and verbalizes understanding.

I think it's clear that the patient -- well, her parents consented to the shot occurring. They were in the room. They saw it happen. If they were really concerned about it, they could have stopped it. They didn't, so I think there was a consent, but it wasn't an informed consent. And the IC's position is that it was not informed consent. It wasn't documented that way, and so even if it was obtained, perhaps it was. Perhaps he did explain in detail the risks, benefits, etcetera, to this injection. It's not documented. So either it

happened and it's not documented and we have a records violation or it didn't happen and that would support the malpractice claim.

The conversations with the mother. So Dr. Nguyen testified today that he had conversations with Patient A's mother regarding again a previous hospitalization. Also, the fact that oral steroids alone weren't enough in the past. That's not documented in the record. And if something like that occurs and it changes a physician's treatment plan, we would expect to see that noted in the record. We would also expect to see that helps again understand what occurred in a case. So that's not documented. It's also not documented that the treatment plan was changed. It just says that the plan is to administer this Kenalog 40 injection, and then it also says that there was going to be the Prednisone prescribed. And so again, there is not a documentation that there was a change or even a reason for the change.

I think that also would have helped us understand the reason for the two prescriptions, both the ordering of the injection and the prescription Prednisone, if that had been documented.

And if we look at Exhibit 12 in the Respondent's exhibits -- and that's the med admin detail

00001, I think we see that there's information that's not accurate in that record. And granted, at least we have a shot record and we're glad for that because we did not have that until Monday, this past Monday, however, it says it's administered by Chanel Hampton.

Dr. Nguyen says she wasn't working that day. He says he did the shot. I believe the other records show that he provided the shot. There's also a time listed on here, and I understand that perhaps this was signed or finished at the end of the day, but you would still expect a shot record to say the date and the correct time or approximate time that the shot was provided as well as who did it.

And again, why does the time matter? Well, Dr. Nguyen testified that they have patients stay for about ten minutes to make sure that the injections don't cause any problems.

Let's say there has been had been an issue later. It would have been helpful to know when that injection was provided, and we don't have that in that record, at least not accurately. I believe Dr. Nguyen said that most likely, the family would have left by 12:00 p.m. The records show that they appeared at the clinic approximately 10:45 a.m. And so we have some

again, lack of completeness, a lack of accuracy in the records.

Also, there's no documentation regarding the change of location for the shot, so it's not documented in here why it was instead of the thigh it was decided to be injected into the gluteal muscle.

In looking at the procedure that Dr. Nguyen provided, it's a standard operating procedure from HealthCare Partners, and it's SOP injectable meds 001, and then there's some more pages of that. But in that documentation, on SOP injectable med 002, it does talk about the right location. It says the right route is one of the things they look at; seven rights of medication administration. Also on that same procedure, it says: "Educate the patient prior to the injection regarding the reason and possible side effects and secure informed consent."

And then if we go to the next page, which is SOP injectable meds 0003, number 23 says: Vastus lateralis is preferred site for children, and then it says (thigh) in parentheses from birth to 36 months of age for intramuscular and subcutaneous injections.

And we don't dispute Dr. Nyugen's testimony that maybe in this case the gluteal area was better, but

we would still expect that route to be documented, especially when it's going against a policy that purportedly was in place at the location regarding injections. And so again, there should be documentation as to why the policy wasn't followed at the facility.

And we talked about the difference in the name on that shot record that it's not accurate, and I think there was some testimony and questions regarding autopopulation and other things in electronic medical records. And that might be true.

Electronic medical records try to help people out, and they may put information, but it's still the obligation absolutely of the physician to insure that those records are timely, legible, accurate and complete. So if autopopulated information is not correct, it needs to be updated. It needs to be changed. It needs to be amended. Somehow that needs to be fixed because it's not an excuse for inaccurate information in a medical record.

In this case, if we go to Exhibit 5, we have information that this record was signed off on. There's, you know, medical assistants that weren't actually providing care to the patient that reviewed, I think it's this Glenisha Barner. And I think she may have maybe seen the patient initially but didn't actually provide a

shot. So as far as who was involved in signing off treatment, nothing in this part actually shows that this Barry Misiuk was involved, and that should be in there.

I do believe it's in this Exhibit 6 that was provided by Respondent med admin log 00001 and following pages, but even that record is interesting because it implies that there was some confusion at the location four days later as to what happened with that vial because on November 8, 2016, there was this question of: Hey, did you give this? If not, please send it back. And there was a question as to who was working with Dr. Nguyen, as to what happened with that vial, and then I think later, it says that this Barry Misiuk was involved and that it was -- and then there's even a comment that the order wasn't there. So again, we're not totally sure what happened with the records, but it just seems like we have issues with accuracy and completeness, you know, maybe even four days later because here there's questions about what happened in this vial and where it was.

There's a possible issue of the location of the shot because we have a photo from the mother saying that it was on the left side, and she says that's the injection site and that's what she saw and that's what

prompted her to file the complaint, and the records document the right side.

Errors happen. People are human. But at the same time, if that was an error, that's not accurate. That's not complete. And either way, it's not documented, the multiple attempts that the injection was provided at least not in Exhibit 5. You know, it talks about the fact that the injection was given, but it doesn't say what happened there with regard to that. So that should have been documented, especially if there was a chance that the child was poked in more than one place. And I think we heard testimony that there may have been a partial poking before they tried again where Dr. Nguyen did the injection.

So and then another issue that we have is bias. We would argue that being paid $4,000 a day by Dr. Anorga, that's a large fee, particularly compared to the fact that the Board, the Investigative Committee pays $150 an hour to its expert witnesses. So certainly, I think if we look at the amount that was paid, there could be a bias to provide an opinion that is more favorable to Dr. Nguyen than to the Investigative Committee. And I think if you look at Dr. Hall, you know, he doesn't really have at least not a large financial incentive to

provide us a favorable opinion.

And then as far as the medical assistants, there's some talk about that and not a lot of the investigation or -- sorry -- the evidence today went into this, but I do note that in Dr. Nyugen's response to the Board initially, so this is in the Board's exhibits. I believe it's also in the Respondent's exhibits. The Board's Exhibit 2 and -- it's pages two to three -- we have Dr. Nyugen's response, and he does talk about the medical assistant and what they did or didn't do.

It doesn't matter. The goal, you know, the responsibility here is on the physician. The physician is the captain of the ship. He's responsible for the conduct and the actions of medical assistants. He delegates the tasks that they provide. He insures and he supervises them, particularly when it's an invasive procedure. And documentation, sure, they can assist with that, but they're not the licensee. They're not the one that the Board issues the privilege to practice medicine in the State of Nevada. And so any issues that may be attributable to staff or other individuals at HealthCare Partners are Dr. Nyugen's responsibility ultimately at the end of the day because he is the one that is the licensed physician and he is responsible for that. And

with that, I would thank everyone for their time today and my statement. Thank you.

HEARING OFFICER HALSTEAD: Thank you.

Ms. Buys?

MS. BUYS: Thank you very much. I'd like to again thank everyone for their time here today. It's truly been an honor to be here representing Dr. Nguyen in this matter.

Patient A complains that she developed a divot in her left buttock approximately three months after undergoing an injection that is documented as being administered intramuscularly in the right buttock area and that the divot has since resolved.

Patient A became a patient of Dr. Nguyen because her parents were concerned that she had worsening respiratory symptoms and had previously been hospitalized due to croup. They were so worried, in fact, they did not even want to wait until their scheduled pediatrician appointment a few days later and took her to an urgent care facility.

The claims in this case have been for a breach of a standard of care and a failure to maintain records. The Board's compliant initially alleged Dr. Nguyen should not have administered the medication in

the gluteal area. However, based upon FDA guidance that has been provided, the expert testimony of Dr. Anorga, Dr. Nguyen and even the Investigative Committee's own peer reviewer, Dr. Hall, administration in the gluteal area was within the standard of care. Moreover, Dr. Hall has testified here today that a divot could form with appropriate administration to the gluteal area and that it is a very rare side effect.

There has been no testimony by the patient's mother that the injection was on the left side. However, there has been testimony and documentation provided here today that the administration was on the right buttock. There has also been testimony here today by expert Dr. Anorga that if this divot were to occur, it would occur close in time to the administration of the medication.

The Investigative Committee counsel has rested upon captain of the ship doctrine which has been outdated in the State of Nevada pursuant to Nevada case law. However, notwithstanding that, there has been evidence presented here today that based on the testimony of the patient's mother, there was even a question as to whether Dr. Nguyen was providing the care and treatment at the time. Patient's mother also did not recall that

there had an been an additional attempt to provide an injection.

And as to allegations of bias, Dr. Hall has been regularly retained by the Board to opine as to peer review matters and is regularly employed by the Board for such purposes.

Today, there has been evidence presented that the patient's parent never filled an oral steroid but because there was an injection, the patient received medication and treatment close in time to when she presented at an urgent care facility with worsening symptoms in the backdrop of prior history of hospitalization due to croup.

The standard of care which has been stated by the experts in this case is what a reasonable physician would do under the circumstances. And even in this case, the Investigative Committee has agreed in their closing argument that consent was given by the patient's parents.

You've heard testimony from Dr. Nguyen that he advised patient's parents of the risks, benefits and alternatives to this treatment plan. And the Board relies upon Dr. Hall's review which is based on the allegation that he should have documented the patient's parents understood the risks and benefits as opposed to

just the patient because she was a toddler. However, the testimony here today by Dr. Anorga and Dr. Nguyen is that it's reasonable to assume that that means that it is the patient's parents providing consent for care.

The other allegation that has been seen here today was that Dr. Nguyen failed to document. Based upon the Investigation Committee's expert, Dr. Hall, there has been testimony provided about additional details that potentially could be provided.

However, Dr. Nguyen and Dr. Anorga have provided testimony here today that the standard of care is not that every single detail that could be added into a record must be documented. It is again going back to whether or not there was reasonable documentation. And in this case, there has been testimony that that has been provided.

Moreover, the IC's expert has provided testimony that his opinions in this matter have been formed as a result of relying on documents and articles that did not exist at the time Dr. Nguyen provided care and treatment to the patient on November 4th, 2016. He therefore could not have even had access to such documents. There's also been testimony that there is a difference between the standard of care in providing

medical care and treatment to a patient and the standard of documentation.

In this case, we're dealing with allegations regarding semantics and hair splitting. There has been testimony provided that Dr. Anorga -- even through Dr. Anorga and Dr. Nguyen -- that it is documented consistently in the record that Dr. Nguyen provided and administered this injection.

There has been further testimony regarding Michelle (sic) Hampton's appearance being there because it automatically autopopulates because she was his physician assistant. However, the documentation in this case which has been shown through the experts and on the plain face detail the correct administration of the injection. I mean, even in the complaint in this matter, there has been a typographical error of the date the care was provided which is certainly a relevant, important date to this proceeding.

And this is not a case where you have allegations involving harms of multiple patients. It is a case alleging form over substance. It's not a matter where Dr. Nyugen's medical license should be affected or revoked or suspended in any way.

Indeed, the allegations that have been

brought to the testimony provided here today show that at best, documentation and whether additional documentation could be provided is a matter of opinion. However, all of these inconsistencies are more questionable as to the allegations. It's regarding standard of care affecting this physician's license.

Moreover, the IC, the Investigative Committee has failed to meet its burden to present evidence that Dr. Nguyen breached the standard of care in his treatment of Patient A. It has been established that Patient A did not require further hospitalization, did not undergo additional care for respiratory symptoms. Indeed, even Dr. Hall testified that it is possible that in this case because there was that injection of medication that that prevented her from being hospitalized.

There's also been testimony presented here today that it was consistently documented in the medical record that the dosage was the 20 milligrams or .5 or 40, which was half, and that is consistent throughout the records that have been provided in this case.

And moreover, to the extent that documentation could be better, documentation, while important, still has not fallen below the standard of care. Dr. Nguyen has testified and Dr. Anorga has

testified that the documentation that was provided was the appropriate documentation that was needed to provide continuity of care for Patient A.

Moreover, the allegation which I believe that has been struck by Ms. Bradley's closing argument regarding the shot record. Those details were indeed documented. Whether or not Dr. Nguyen documented that at the end of the day or immediately in the patient room, even Dr. Hall testified that it is appropriate for a physician to finish authoring his note certainly at the end of the day, as that's close in time to the care that was provided. And in this case, the evidence shows that the documentation was entered the very same day of treatment which was November 4th, 2016.

There's also been documentation provided that shows the lot, the expiration, the vial number and the anatomical site where the injection was administered. And again, you've heard testimony here today that Dr. Nguyen provided the administration of the medication into the right gluteal muscle. There has been no objective evidence provided here today that shows that there was any administration in the left gluteal muscle of Patient A. Indeed, relying back on figurative versus literal analogies that if it wasn't documented it didn't

happen, you've heard testimony here today that not only is it documented, it did happen in the right side.

Moreover, there has been no preponderance of the evidence showing that there was again that injection into the left gluteal muscle. It has further been explained that again, Ms. Hampton's name appeared in the record because it appears when an order is entered. She was his medical assistant. This is not a failure to maintain timely, accurate or complete medical records or legible medical records for the patient. I mean, as mentioned earlier, there was a typographical error in the complaint that has been brought against Dr. Nguyen here today.

Additionally, with regard to his response, again, we're dealing back multiple, multiple years back in time. The initial response was provided in 2017, and we sit here today five years later even with members of the Investigative Committee and team who are no longer part of the Board or are deceased. Dr. Nguyen has also not been provided any sort of records that show that there was this gluteal muscle being documented or gluteal injury being documented in any other medical record.

Because the Investigative Committee has failed to meet its burden as to allegations of

substandard care and for failure to maintain medical records, the only result that is supported by the evidence that was shown here today is a finding in favor of Respondent, Dr. Nguyen, and dismissing the claims against him.

This is not a case where the Board needs to be concerned that this is a physician that will harm patients. At best, the allegation is that there could have been more details provided in the documentation. That is not a breach of the standard of care as set forth by Dr. Anorga, Dr. Nguyen and also in reference to the guidance that has been provided, the location of the administration of the injection is the standard of care that has been supported not only by FDA guidance but also physicians that care for these patients and given the Investigative Committee's own expert in this matter.

Therefore, we respectfully request that the charges brought against Dr. Nguyen be dismissed and that there be no finding of malpractice on behalf of Dr. Nguyen or failure to maintain timely, accurate or legible medical records, especially since this is a case which at best could have -- at best is nothing and certainly not one where the Board needs to be concerned that there is a physician what could cause harm to the

public. Thank you for your time.

HEARING OFFICER HALSTEAD: Thank you, Ms. Buys. Did you want to do --

MS. BRADLEY: No, thank you?

HEARING OFFICER HALSTEAD: -- a reply closing? Okay. Ms. Bradley has chosen not to reply closing, so that will close this matter. I believe I have 60 days to issue a written finding.

I am going to -- Miss Reporter, do you want originals or do you want copies of the originals? I'm going to give the originals to the court reporter of the exhibits. I'm going to make copies for me. As soon as I get the transcript, I will begin writing. I know that everyone is on pins and needles waiting for these things. I understand that, and I will try to undertake this as timely as possible.

I want to thank everyone for their professionalism today and their presentations on both sides. Very good advocacy on both ends, and that's very much appreciated. Thank you, everyone, for your time today and that will conclude this proceeding.

(The hearing concluded at 5:19 p.m.)

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STATE OF NEVADA)
COUNTY OF WASHOE)

I, Nicole J. Hansen, Certified Court Reporter, State of Nevada, do hereby certify:

That prior to being examined, the witness in the foregoing proceedings was by me duly sworn to testify to the truth, the whole truth, and nothing but the truth;

That said proceedings were taken before me at the time and places therein set forth and were taken down by me in shorthand and thereafter transcribed into typewriting under my direction and supervision;

I further certify that I am neither counsel for, nor related to, any party to said proceedings, not in anywise interested in the outcome thereof.

In witness whereof, I have hereunto subscribed my name.

Dated: June 1, 2022

Nicole J. Hansen

Nicole J. Hansen
NV. CSR No. 446, RPR, CRR, RMR
CA. CSR 13,909

HEALTH INFORMATION PRIVACY & SECURITY: CAUTIONARY NOTICE

Litigation Services is committed to compliance with applicable federal and state laws and regulations (“Privacy Laws”) governing the protection andsecurity of patient health information.Notice is herebygiven to all parties that transcripts of depositions and legal proceedings, and transcript exhibits, may contain patient health information that is protected from unauthorized access, use and disclosure by Privacy Laws. Litigation Services requires that access, maintenance, use, and disclosure (including but not limited to electronic database maintenance and access, storage, distribution/ dissemination and communication) of transcripts/exhibits containing patient information be performed in compliance with Privacy Laws. No transcript or exhibit containing protected patient health information may be further disclosed except as permitted by Privacy Laws. Litigation Services expects that all parties, parties’ attorneys, and their HIPAA Business Associates and Subcontractors will make every reasonable effort to protect and secure patient health information, and to comply with applicable Privacy Law mandates, including but not limited to restrictions on access, storage, use, and disclosure (sharing) of transcripts and transcript exhibits, and applying “minimum necessary” standards where appropriate. It is recommended that your office review its policies regarding sharing of transcripts and exhibits - including access, storage, use, and disclosure - for compliance with Privacy Laws.

EXHIBIT B

EXHIBIT B

IC's HEARING EXHIBITIS

No.	TITLE	BATES RANGE
1	Allegation Letter to Dr. Nguyen, M.D dated 3/28/2017	NSBME001
2	Dr. Nguyen's Response to Allegation Letter, dated April 24, 2017	NSBME002 - NSBME003
3	Complaint, Filed 11/3/2021	NSBME004 - NSBME008
4	Answer to Complaint filed 11/23/21	NSBME009 - NSBME013
5	Patient A's Medical Rec	NSBME014 - NSBME016
6	Injection Site Photos Patient A	NSBME017 - NSBME018
7	Article: Croup	NSBME019 - NSBME027
8	Article: Acute Management of Croup in the Emergency Department	NSBME028 - NSBME021
9	Article: Croup: Diagnosis and Management	NSBME032 - NSBME037
10	Article: Kenalog – 40 Injection (Partial)	NSBME038 - NSBME043
11	Article: Kenalog – 40 Injection (Complete)	NSBME044 - NSBME048
12	Article: Documenting Vaccination	NSBME049 - NSBME051
13	Article: Evaluating Medical Decision-Making Capacity in Practice	NSBME0052 - NSBME058
14	Article: Croup (Seminar)	NSBME059 - NSBME069
15	Article: Chapter 15. Intramuscular, Subcutaneous, and Intradermal Injections	NSBME070 - NSBME077
16	Article: Musculoskeletal Injections: A Review of the Evidence	NSBME078 - NSBME083
17	Article: Joint and Soft Tissue Injection	NSBME084 - NSBME089
18	Scott Hall M.D. – Curriculum Vitae	NSBME0090 - NSBME091
19	Scott Hall M. D. Updated CV	NSBME092 - NSBME093

Nevada State Board of Medical Examiners

March 28, 2017

Hai Nguyen, M.D.
[redacted]

RE: BME CASE #: [redacted]
PATIENT: [redacted] **DOB:** [redacted]

Dear Dr. Nguyen,

We have received information regarding the medical treatment of the above named patient. The complaint alleges that the patient presented to you for medical treatment on or around November 04, 2016. Allegedly, after performing an evaluation, you advised the patient's parents that you were going to administer a "steroid shot." Reportedly, you allowed an assistant to administer the shot. After two failed attempts the patient cried and screamed in pain and had to be restrained by her parents. The parents requested that you administer the shot. It has been further alleged that the patient developed a bruise around the injection site and a few weeks later a "crater" then formed and the area continues to be "sensitive to the touch." Therefore, your care and treatment of the patient may have fallen below the standard of care.

In order to determine whether or not there has been a violation of the Medical Practice Act, **please provide a written response to the allegation noted above, including your treatment plan, as well as complete copies of the medical records for this patient. Include copies of any x-ray or other films you produced during treatment of this patient.** Please include any further information you believe would be useful for the Board to make a determination in this matter. **Please reply to this request within 21 days.**

The Nevada State Board of Medical Examiners investigates all information received concerning possible violations of the Nevada Revised Statutes, Chapter 630. We make no determination as to whether or not there has been a violation of the Medical Practice Act, prior to the completion of our investigation. Providing the requested information is deemed a professional obligation of any physician under investigation by the Board and shall not be deemed to be cooperation subject to the whistle-blower protections provided to physicians in NRS 630.364 (3).

Please be advised that the particular allegation referenced above, if in fact it did occur, and depending on the facts associated with the situation, could be a violation of the codes, including, but not limited to: NRS 630.301(4).

Respectfully,

Lara Ward
Investigator
Las Vegas Office

4-28-17

■ LAS VEGAS OFFICE
Board of Medical Examiners
Building A, Suite 2
6010 S. Rainbow Boulevard
Las Vegas, NV 89118
Phone: 702-486-3300
Fax: 702-486-3301

☐ RENO OFFICE
Board of Medical Examiners
Suite 301
1105 Terminal Way
Reno, NV 89502
Phone: 775-688-2559
Fax: 775-688-2553

HealthCare Partners
Medical Group

RECEIVED
APR 28 2017
NEVADA STATE BOARD OF MEDICAL EXAMINERS

April 24, 2017

Lara Ward, Investigator
NEVADA STATE BOARD OF MEDICAL EXAMINERS
6010 South Rainbow Blvd.,
Complex A, Building 1, Ste. 2
Las Vegas, Nevada 89118

Re: BME Case No.: [redacted]
PATIENT: [redacted]

Dear Mr. Ray:

I am in receipt of your letter dated March 28, 2017 concerning the above-named patient, [redacted]. I appreciate the opportunity to respond to the allegations related to the care I provided to her and additional time in which to do so. Copies of [redacted]'s medical records which I have obtained are enclosed for your review and file.

According to your letter, the complaint alleges that "the patient presented to you for medical treatment on or around November 04, 2016. Allegedly, after performing an evaluation, you advised the patient's parents that you were going to administer a "steroid shot." Reportedly, you allowed an assistant to administer the shot. After two failed attempts the patient cried and screamed in pain and had to be restrained by her parents. The parents requested that you administer the shot. It has been further alleged that the patient developed a bruise around the injection site and a few weeks later a "crater" then formed and the area continues to be "sensitive to the touch." Therefore, your care and treatment of the patient may have fallen below the standard of care."

I adamantly deny that my care and treatment of [redacted] fell below the standard of care and I will address each of these allegations in turn.

I did see patient [redacted] on November 4th, 2016 at HealthCare Partners Urgent Care. I evaluated the patient and did get a history of cough and wheezing from the parent. The child's parent mentioned her symptoms had worsened overnight from a prior occurrence of croup. The patient also had a family history of asthma.

After doing an examination on the child, I thought there may be a chance she had croup again. I informed the mother of the child that the standard treatment for croup is steroids. I prescribed prednisolone oral steroids for the patient, and in addition, I obtained verbal consent from the parent to give the child a steroid injection. I asked the medical assistant, Barry Misiuk, to give the patient an injection of Kenalog 20 mg IM. As you are aware, one of the many of

HealthCare Partners
Medical Group

duties for medical assistants is to give injections of medications ordered by physicians.

Mr. Misiuk, who was not my regular medical assistant for that day, used an alcohol swab to clean the skin on the patient's lateral buttock where the injection was to be placed. Mr. Misiuk apparently tried to give the shot but the child squirmed and moved unexpectedly when the assistant tried to give the injection. As such, Mr. Misiuk informed me he was unable to inject the Kenalog due to the child's apprehension and movement.

At that point, I asked Mr. Misiuk to assist the parent to hold the child. I then administered the Kenalog injection of 0.5 mL (Kenalog 20mg/mL) to the lateral buttock. A bandage was applied at the injection site and I did apologize to the patient's parent that the injection took more than one try to give.

I asked the parent to place a cold pack on child's buttock to relieve any discomfort or swelling that might occur. I discussed with the parent prescriptions we were sending and care instructions with the parent. I also encouraged the parent to follow up with child's pediatrician.

I believe my care and treatment of [redacted] was within the standard of care. It is appropriate to utilize a medical assistant to administer an injection, and at times one may have to administer an injection more than once, and in particular when a patient does not hold still during the procedure. This type of occurrence is a known complication of this type of procedure, and certainly not below the standard of care.

I trust that the information and summary I have provided will assist you in your review of this matter. However, should you require any additional information, please do not hesitate to contact me.

Respectfully,

Hai Nguyen, M.D.

Enclosures

9449 W. Charleston Blvd., Ste. 150
Las Vegas, NV 89117

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **HAI THANH NGUYEN, M.D., Respondent.**	**Case No. 21-38084-1**

FILED
NOV 03 2021
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Robert G. Kilroy, Esq., Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Hai Thanh Nguyen, M.D., (Respondent) violated the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act), hereby issues its Complaint, stating the IC's charges and allegations as follows:

1. Respondent was at all times relative to this Complaint a medical doctor holding an active license to practice medicine in the State of Nevada (License No. 13702). Respondent originally licensed by the Board on September 15, 2010.

2. On November 11, 2016, Patient A[2] along with her parents went to HealthCare Partners Urgent Care, because she was suffering from coughing, wheezing, phlegm, and vomiting. Respondent evaluated the 2-year-old girl with "croup." Respondent started Patient A on prednisolone orally and also recommended a "steroid shot." Respondent successfully injected Kenalog into Patient A's lateral buttocks after two (2) unsuccessful attempts by Respondent's medical assistant. Patient A's medical record indicates "Kenalog 40mg/ml...Inject 0.5ml

[1] The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal Complaint was authorized for filing, was composed of Board members Rachakonda D. Prabhu, M.D., Ms. Sandy Peltyn, and Victor M. Muro, M.D.

[2] Patient A's true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint. on this entry.

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Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

intramuscularly once...pt is given Kenalog 20mg IM." When asked by the IC, Respondent provided his written reply that he administered 0.5ml of Kenalog 20mg/ml IM. Respondent did not obtain an informed consent from Patient A's parents for the invasive procedure of a steroid shot (injection of the Kenalog). The medical record is not clear as to whether Patient A received an injection of 20mg or 10mg of Kenalog intramuscularly. There was no "shot record" section of Patient A's medical record as there was no documentation of the Kenalog vial's identification, lot number, nor date of expiration. Moreover, there was no indication of the specific injection shot location nor who delivered the shot (Respondent) to Patient A.

3. Approximately, two (2) weeks later, Patient A's parents noticed that Patient A's injection spot upon her buttocks had become a "divet" and eventually a "crater" that was sensitive to the touch. Skin atrophy is a known complication of a steroid intramuscular injection. Standard of care for toddlers (Patient A) who cannot "keep anything down" due to constant vomiting is an intramuscular or intravenous administration of steroids. Here, Patient A indicated only vomited once a day in the mornings, and not constantly though out the day, and should have been given an oral steroid. Respondent should have offered to Patient A's parent an oral option first, prior to the injection shot and discussed the risks and benefits of the steroid medication with them. For toddlers, such as Patient A, the proximal lateral thigh is the appropriate location for intramuscularly injections, not into a toddler's buttocks.

COUNT I

NRS 630.301(4) (Malpractice)

4. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

5. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.

6. NAC 630.040 defines malpractice as the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.

7. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when

he provided medical services to Patient A, because he failed to obtain and document an informed consent for the injection of Kenalog, and when he failed to properly inject the Kenalog into the proximal lateral thigh instead of Patient A's buttocks.

8. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNT II

NRS 630.3062(1)(a) (Failure to Maintain Proper Medical Records)

9. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

10. NRS 630.3062(1)(a) provides that the failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient is grounds for initiating disciplinary action against a licensee.

11. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to document his actions when he treated Patient A, whose medical records were not timely, legible, accurate, and complete. Respondent failed to document an informed consent for Patient A's Kenalog injection from her parents and discuss the risks and benefits of the medication before giving it to the child. Additionally, Patient A's medical records of having the shot, including the information from the vial, do not exist making Patient A's medical records inaccurate and incomplete.

12. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

WHEREFORE, the Investigative Committee prays:

1. That the Board give Respondent notice of the charges herein against him and give him notice that he may file an answer to the Complaint herein as set forth in NRS 630.339(2) within twenty (20) days of service of the Complaint;

2. That the Board set a time and place for a formal hearing after holding an Early Case Conference pursuant to NRS 630.339(3);

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Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

3. That the Board determine what sanctions to impose if it determines there has been a violation or violations of the Medical Practice Act committed by Respondent;

4. That the Board award fees and costs for the investigation and prosecution of this matter as outlined in NRS 622.400;

5. That the Board make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 1 day of November, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

ROBERT G. KILROY, J.D.
Senior Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: rkilroy@medboard.nv.gov
Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Victor M. Muro, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the Complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

DATED this 3rd day of November, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: V M Muro MD
VICTOR M. MURO, M.D.
Chairman of the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA
* * * * *

In the Matter of Charges and Complaint Against HAI THANH NGUYEN, M.D., Respondent.	**Case No. 21-38084-1**

FILED
NOV 23 2021
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

HAI THANH NGUYEN, M.D.'S ANSWER TO COMPLAINT

COMES NOW, Respondent HAI THANH NGUYEN, M.D., by and through his counsel of record, ROBERT C. McBRIDE, ESQ. and T. CHARLOTTE BUYS, ESQ., of the law firm of McBRIDE HALL and for his Answer to the State of Nevada Board of Medical Examiners' (hereinafter "Board") Complaint, admits, denies, and alleges as follows:

1. This answering Respondent admits those allegations contained in Paragraph 1 of the Board's Complaint.

2. Answering Paragraph 2 of the Board's Complaint, this answering Respondent denies each and every allegation of malpractice contained therein. As to the remainder of Paragraph 2, this answering Respondent is without sufficient knowledge or information upon which to base a belief as to the truth or falsity of the allegations contained in Paragraph 2, and upon said grounds denies each and every allegation contained therein.

3. Answering Paragraph 3 of the Board's Complaint, this answering Respondent denies each and every allegation of malpractice contained therein. As to the remainder of Paragraph 3, this answering Respondent is without sufficient knowledge or information upon which to base a belief as to the truth or falsity of the allegations contained in Paragraph 3, and upon said grounds denies each and every allegation contained therein.

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COUNT I

NRS 630.301(4) (Malpractice)

4. Answering Paragraph 4 of the Board's Complaint, this answering Respondent repeats and realleges each and every response to Paragraphs 1 through 3, inclusive, and incorporates the same by reference as though set forth fully herein.

5. Answering Paragraph 5 of the Board's Complaint, this answering Respondent admits that Nevada Revised Statute Section 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee, but this answering Respondent specifically denies committing malpractice.

6. Answering Paragraph 6 of the Board's Complaint, this Answering Respondent admits that Nevada Administrative Code Section 630.040 defines malpractice, but this answering Respondent specifically denies committing malpractice.

7. Answering Paragraph 7 of the Board's Complaint, this Answering Respondent denies each and every allegation contained in paragraph 7 of the Board's Complaint.

8. Answering Paragraph 8 of the Board's Complaint, this Answering Respondent denies each and every allegation contained in paragraph 8 of the Board's Complaint.

COUNT II

NRS 630.3062(1)(a) (Failure to Maintain Complete Medical Records)

9. Answering Paragraph 9 of the Board's Complaint, this answering Respondent repeats and realleges each and every response to Paragraphs 1 through 8, inclusive, and incorporates the same by reference as though set forth fully herein.

10. Answering Paragraph 10 of the Board's Complaint, this answering Respondent admits that Nevada Revised Statute Section 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee, but this Answering Respondent specifically denies committing malpractice.

11. Answering Paragraph 11 of the Board's Complaint, this answering Respondent denies each and every allegation contained in paragraph 11 of the Board's Complaint.

12. Answering Paragraph 12 of the Board's Complaint, this answering Respondent denies each and every allegation contained in paragraph 12 of the Board's Complaint.

FIRST AFFIRMATIVE DEFENSE

Respondent alleges that The Nevada State Board of Medical Examiners' Complaint on file herein fails to state a claim upon which relief can be granted.

SECOND AFFIRMATIVE DEFENSE

The Board's Complaint is in whole or in part, void for vagueness, violative of Respondent's due process rights under the Constitutions of the State of Nevada and the United States of America and cannot serve as a basis for discipline of Respondent.

THIRD AFFIRMATIVE DEFENSE

The Nevada State Board of Medical Examiners has failed to comply with the requirements of N.R.S. 630, *et seq.* and N.A.C. 630 *et seq.*

FOURTH AFFIRMATIVE DEFENSE

Respondent fully performed and discharged all obligations owed to the patient, including satisfying the applicable standard of care to which the patient was entitled.

FIFTH AFFIRMATIVE DEFENSE

If a violation occurred it was the result of intervening and/or superseding events, factors, occurrences or conditions, which were in no way caused by Respondent, and for which Respondent is not responsible.

SIXTH AFFIRMATIVE DEFENSE

The Nevada State Board of Medical Examiners' Complaint is time barred.

SEVENTH AFFIRMATIVE DEFENSE

The Nevada State Board of Medical Examiners' Complaint does not comply with NRS 630.301.

EIGHTH AFFIRMATIVE DEFENSE

Each and every service rendered to the patient by this answering Respondent was expressly and/or impliedly consented to and authorized by the patient and/or the patient's authorized representative on the basis of a full and complete disclosure to the patient of all material facts

known or reasonably believed be true concerning the patient's physical condition and the appropriate alternative procedures available for treatment of such condition

NINTH AFFIRMATIVE DEFENSE

All possible affirmative defenses may not have been alleged herein so far as sufficient facts were not available after reasonable inquiry upon filing of this answering Respondent's Answer and, therefore, this answering Respondent reserves the right to amend his Answer to include additional affirmative defenses if subsequent investigation so warrants.

WHEREFORE, the Respondent prays that The Nevada State Board of Medical Examiners take nothing by way of the Complaint on file herein; and that Respondent recover all costs, attorneys' fees, and damages incurred as a result of the Complaint.

DATED this 23rd day of November 2021.

McBRIDE HALL

By: */s/ T. Charlotte Buys*
ROBERT C. McBRIDE, ESQ.
Nevada Bar No.: 7082
T. CHARLOTTE BUYS, ESQ.
Nevada Bar No.: 14845
8329 W. Sunset Road, Suite 260
Las Vegas, Nevada 89113
Attorneys for Respondent
Hai Thanh Nguyen M.D.

CERTIFICATE OF SERVICE

I hereby certify that on the 23rd day of November 2021, I served a true correct copy of **RESPONDENT'S ANSWER TO COMPLAINT**, by mailing via United States mail to the following:

Robert Kilroy, Esq.
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
Attorneys for the Investigative Committee

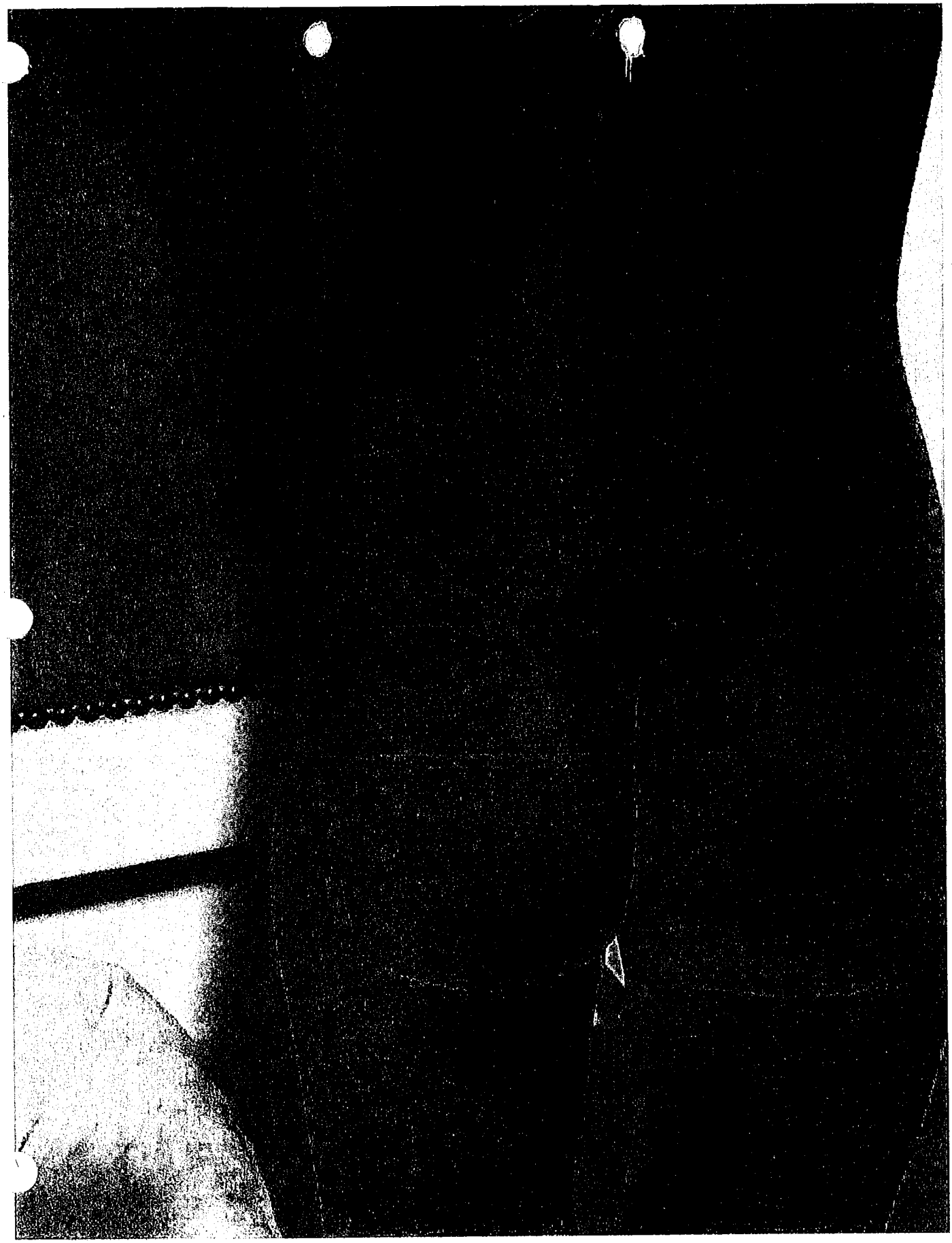
/s/ Natalie Jones
An Employee of McBride Hall

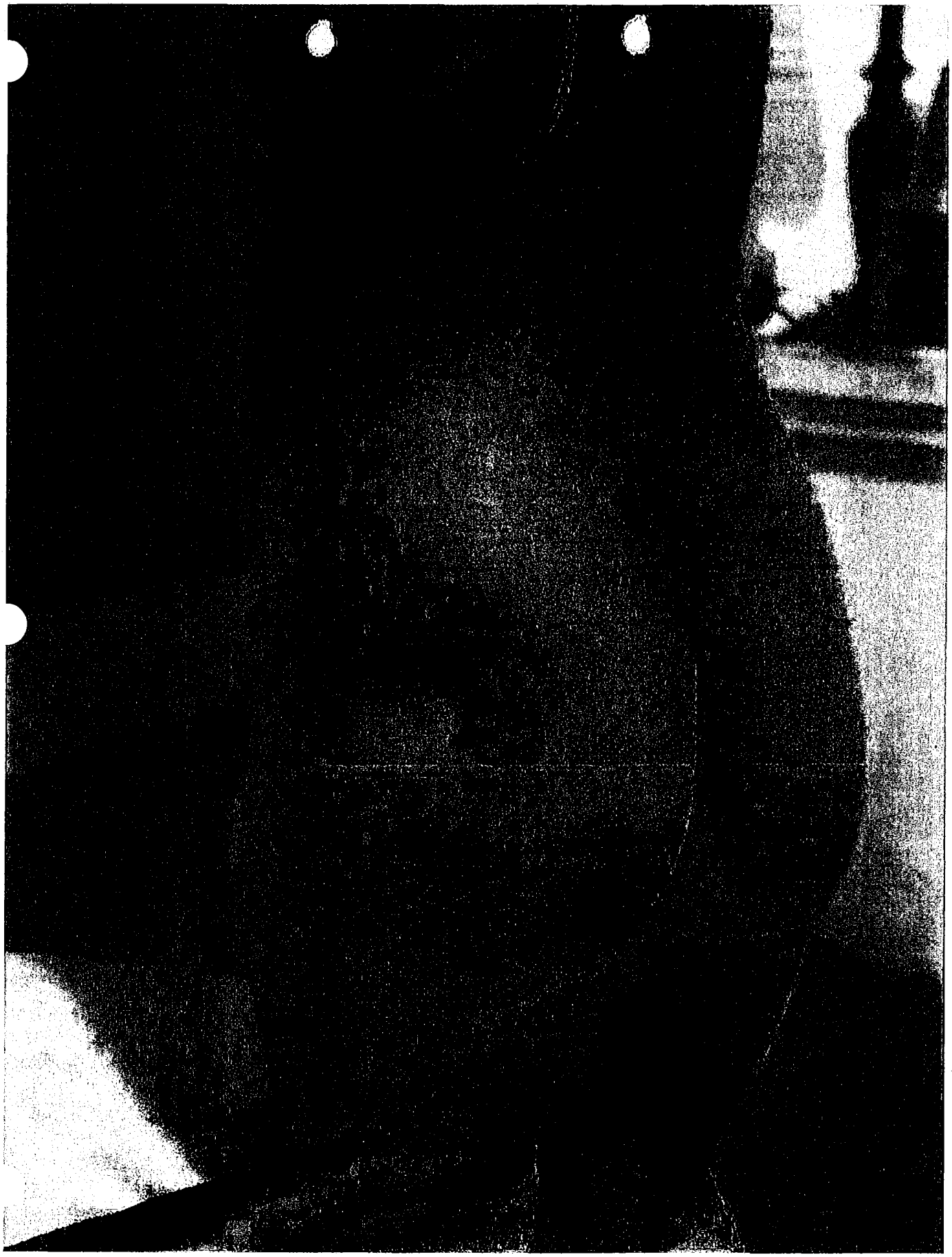
“No. 5 Patient A’s Medical Record”

MEDICAL RECORDS

This exhibit contains person medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310

“No. 5 Patient A’s Medical Record”





CLINICAL PRACTICE

Croup

James D. Cherry, M.D., M.Sc.

This Journal feature begins with a case vignette highlighting a common clinical problem. Evidence supporting various strategies is then presented, followed by a review of formal guidelines, when they exist. The article ends with the author's clinical recommendations.

Crouplike symptoms develop in a previously healthy 2-year-old girl at 11 p.m. She is seen in an emergency department 2 hours later with a barking cough and, when upset, inspiratory stridor. Her temperature is 36.1°C, respiratory rate 20 breaths per minute, heart rate 151 beats per minute, and oxygen saturation 94% while she is breathing ambient air. She has mild sternal retractions but no cyanosis. How should she be evaluated and treated?

THE CLINICAL PROBLEM

From the Division of Infectious Diseases, Mattel Children's Hospital UCLA, and the Department of Pediatrics, David Geffen School of Medicine at UCLA — both in Los Angeles. Address reprint requests to Dr. Cherry at the Dept. of Pediatrics, David Geffen School of Medicine at UCLA, 10833 Le Conte Ave., MDCC 22-442, Los Angeles, CA 90095-1752, or at jcherry@mednet.ucla.edu.

N Engl J Med 2008;358:384-91.

Before the 20th century, all crouplike illnesses were thought to be diphtheria.[1] Today, the word "croup" is used to refer to a number of respiratory illnesses that are characterized by varying degrees of inspiratory stridor, barking cough, and hoarseness due to obstruction in the region of the larynx.[1-4]

CLASSIFICATION

The terminology for croup illnesses has evolved over time, but unfortunately, some classifications have been imprecise.[1-7] For example, the term "laryngotracheobronchitis" is often used to describe either spasmodic croup or laryngotracheitis. A classification scheme with definitions and clinical features is presented in Table 1. The vast majority of cases of croup are either laryngotracheitis or spasmodic croup.[8]

EPIDEMIOLOGIC FEATURES

Croup (laryngotracheitis and spasmodic croup) is an illness of infants and children younger than 6 years of age,[9,10] with a peak incidence between 7 and 36 months of age. During the second year of life, about 5% of children have croup. The incidence in boys is about 1.5 times that in girls. In a 14-year study of hospitalizations for croup in Ontario, Canada, between 1988 and 2002, a biennial midautumn peak and an annual summer trough were observed.[10]

PATHOLOGICAL FEATURES AND PATHOGENESIS

In acute laryngotracheitis, there is erythema and swelling of the lateral walls of the trachea, just below the vocal cords.[11,12] Histologically, the involved area is edematous, with cellular infiltration in the lamina propria, submucosa, and adventitia. The infiltrate contains histiocytes, lymphocytes, plasma cells, and neutrophils.[13,14] In bacterial croup — laryngotracheobronchitis and laryngotracheobronchopneumonitis — the tracheal wall is infiltrated with inflammatory cells, and in addition, ulceration, pseudomembranes, and microabscesses are present.[2,15] There is thick pus within the lumen of the trachea and the lower air passages.[2,16] In spasmodic croup, there is noninflammatory edema in the subglottic region.[11]

Table 1. Classification, Definition, and Clinical Features of Croup Illnesses.

Definition and Characteristic	Spasmodic Croup	Acute Laryngotracheitis	LTB and LTBP (Including Bacterial Tracheitis)*	Laryngeal Diphtheria
Definition	Sudden nighttime onset of inspiratory stridor; associated with mild upper respiratory tract infection, without inflammation	Inflammation of the larynx and trachea	Inflammation of the larynx, trachea, and bronchi or lung; usually similar in onset to laryngotracheitis, but with more severe illness	Infection involving the larynx and other areas of the airway due to *Corynebacterium diphtheriae*, resulting in progressive airway obstruction
Typical age at occurrence	3 mo to 3 yr	3 mo to 3 yr	3 mo to 3 yr	All ages
Individual and family history	Possible family history of croup; possible previous attack	Possible family history of croup	Possible family history of croup	Lack of immunization or inadequate immunization
Prodrome	Minimal coryza	Usually coryza	Usually coryza	Usually pharyngitis
Onset (time to full-blown disease)	Sudden, always at night; the characteristic presentation is that of a child who at bedtime was thought to be well or perhaps to have mild cold symptoms but who awakened suddenly with croupy cough and stridor	Moderately rapid but variable; onset mimics that of a cold, with nasal irritation, cough, and coryza; fever occurs within the first 24 hr; within 12 to 48 hr, signs of obstructed upper airway and symptoms occur	Usually gradually progressive over a period of 12 hr to 7 days	Slow, progressing over a period of 2 to 3 days
Symptoms on presentation	Hoarseness and barking cough, no dysphagia, minimal-to-moderate inspiratory stridor; nontoxic presentation	Hoarseness and barking cough, no dysphagia, minimal-to-severe inspiratory stridor; usually minimally toxic presentation	Hoarseness and barking cough; no dysphagia; inspiratory stridor, usually severe; typically toxic presentation	Hoarseness and barking cough; usually dysphagia; minimal-to-severe inspiratory stridor; usually nontoxic presentation
Signs on presentation	No fever; no pharyngitis; normal epiglottis	Fever, generally 37.8 to 40.5°C; usually minimal pharyngitis; normal epiglottis	Fever, generally 37.8 to 40.5°C; usually minimal pharyngitis; normal epiglottis	Fever, generally 37.8 to 38.5°C; membranous pharyngitis; epiglottis usually normal but may contain membrane
Radiographic findings	Subglottic narrowing on posterior–anterior view	Subglottic narrowing on posterior–anterior view	Subglottic narrowing on posterior–anterior view, irregular soft-tissue densities in trachea on lateral view, bilateral pneumonia	Not useful
White-cell count	Normal	Mildly elevated, with >70% polymorphonuclear cells	Usually elevated or abnormally low, with >70% neutrophils and increased percentage of band forms	Usually elevated, with increased percentage of band forms
Microbiologic findings	Etiologic agents similar to those in laryngotracheitis	Most commonly caused by parainfluenza virus 1 (responsible for frequent fall outbreaks); many other viruses also implicated, including other parainfluenza viruses and influenza viruses (influenza virus A and parainfluenza virus 3 often cause severe cases), respiratory syncytial virus, measles virus, adenoviruses, and rhinoviruses	Although may be caused by a virus (e.g., parainfluenza virus 1, 2, or 3 or influenza virus A or B), in most instances the illness is due to secondary bacterial infection, particularly from *Staphylococcus aureus;* other bacteria include group A streptococci, *Streptococcus pneumoniae, Haemophilus influenzae,* and *Moraxella catarrhalis*	*C. diphtheriae* (identified on smear and culture of membrane)

* LTB denotes laryngotracheobronchitis, and LTBP laryngotracheobronchopneumonitis.

Table 2. Assessment of the Severity of Croup.*

Level of Severity†	Characteristics
Mild	Occasional barking cough; no audible stridor at rest, and either mild or no suprasternal or intercostal indrawing (retractions of the skin of the chest wall)
Moderate	Frequent barking cough, easily audible stridor at rest, and suprasternal and sternal retractions at rest, but little or no agitation
Severe	Frequent barking cough, prominent inspiratory and, occasionally, expiratory stridor, marked sternal retractions, and agitation and distress
Impending respiratory failure	Barking cough (often not prominent), audible stridor at rest (occasionally hard to hear), sternal retractions (may not be marked), lethargy or decreased level of consciousness, and often dusky appearance in the absence of supplemental oxygen

* Adapted from the Alberta Medical Association.[4]
† Corresponding Westley scores for level of severity would be 0 to 2 for mild croup, 3 to 5 for moderate croup, 6 to 11 for severe croup, and 12 to 17 for impending respiratory failure.[8]

Host factors appear to be important in pathogenesis, since parainfluenza virus infections (particularly type 3) are common in infants and young children,[17] yet croup develops in only a small percentage of those exposed.[18] A number of studies have indicated that allergic factors play a role in recurrent croup.[5,19,20] It is possible that primary infection with parainfluenza virus type 3 (which may go unrecognized) leads to sensitization to the parainfluenza virus group rather than to type 3 alone,[5] setting the stage for spasmodic croup due to parainfluenza virus types 1 and 2.

STRATEGIES AND EVIDENCE

EVALUATION

Differential Diagnosis

Since the croup illnesses discussed above and presented in Table 1 differ in severity as well as in their treatment, the differential diagnosis is important. Correct diagnosis of other acute obstructive illnesses in the region of the larynx (e.g., epiglottitis, foreign body, angioneurotic edema of the epiglottis) is also essential and lifesaving.[2,6]

Epiglottitis rather than croup is suggested by the absence of a croupy cough (which sounds similar to a barking seal or sea lion); the sitting posture of the child, with the chin pushed forward and a reluctance or refusal to lie down; and greater apprehension and anxiety on the part of the child than the degree of inspiratory difficulty would suggest. A lateral neck radiograph will confirm the diagnosis of epiglottitis but is rarely necessary, since the clinical findings noted above are often diagnostic.

Both foreign-body and angioneurotic edema can cause upper-airway obstruction. They usually occur suddenly, without fever or other signs and symptoms of infection.

Laryngotracheobronchitis and laryngotracheobronchopneumonia can be differentiated from spasmodic croup and laryngotracheitis by signs of lower-airway involvement (crackles, air trapping, wheezing, and pneumonia seen on a radiograph).[2,6,15,21,22] A bacterial cause should be suspected in these cases and also in cases of laryngotracheitis when symptoms and signs persist or worsen despite treatment with corticosteroids and epinephrine. In both laryngotracheobronchitis and laryngotracheobronchopneumonia, a lateral neck radiograph may reveal soft densities indicating purulent exudate within the trachea. Laryngeal diphtheria should be considered in unimmunized patients with possible exposure.

Laboratory studies are rarely useful in the evaluation of routine croup. If clinical findings suggest laryngotracheobronchitis or laryngotracheobronchopneumonia, white-cell and differential counts and posterior–anterior and lateral chest and neck radiographs are indicated. In these cases, intubation is commonly required, and a tracheal bacterial culture should be obtained at the time of intubation. Also useful in cases of laryngotracheobronchitis or laryngotracheobronchopneumonia, as well as in severe cases of laryngotracheitis, is a specimen (from nasal wash or tracheal secretions) for the direct identification of influenza virus, which can help guide decisions about the use of antiviral therapy.

Assessment of Severity

A variety of scoring systems have been developed to evaluate the severity of croup.[8,23,24] The most commonly used scoring system has been that of Westley et al.,[24] which evaluates the severity of croup by assessing five factors: level of consciousness, cyanosis, stridor, air entry, and retractions. This system has been extremely valuable in treatment trials but has little use in the routine clinical setting.[8] However, a clinically useful severity-assessment table has been developed by an Alberta Clinical Practice Guideline Working Group[4] (Ta-

ble 2). Based on this classification scheme, 85% of children seen in 21 general emergency departments in Alberta, Canada, had mild croup, and less than 1% had severe croup.[8]

TREATMENT

During the past 50 years, there has been considerable controversy regarding many therapies for croup, including the role of humidified air and the optimal type (warm vs. cold) and the roles of corticosteroids and racemic epinephrine.[2] However, the marked success of corticosteroids in the outpatient management of croup and the effectiveness of nebulized epinephrine in more severe cases have led to the resolution of many of the controversies.

Acute Laryngotracheitis and Spasmodic Croup

Humidified Air

During much of the 20th century, treatment with humidified air (mist therapy) was the cornerstone of the management of croup.[1,2] More recently, however, the effectiveness of mist therapy has been questioned.[4,8,25] In a recent trial[26] comparing the effects of high humidity (100%), low humidity (40%), and blow-by humidity (in which a plastic hose is held near the child's nose and mouth) in children with mild croup, there were no significant differences in the croup-score responses among the three groups; each group had significant improvement (about 33%) over baseline in the croup score 60 minutes after administration. In two other small trials, control subjects who received nebulized saline also had improvement in their croup scores over the baseline values.[23,24] Since none of these studies included an untreated control group, it is not possible to know whether the improvements were due to the moist air. A recent Cochrane Collaboration review of data from three other studies concluded that there was no evidence that inhalation of humidified air in children with mild-to-moderate croup resulted in a substantial improvement in the croup score.[27]

Corticosteroid Therapy

Corticosteroid therapy is now routinely recommended by all experts.[4,5,8,10,25] In a cotton-rat laryngotracheitis model,[18] corticosteroids reduced the degree of inflammation and cell damage; although the viral load was increased, the duration of shedding was not prolonged. Meta-analyses of randomized trials[28-30] have consistently demonstrated significant improvement in patients treated with corticosteroids as compared with controls. For example, in a meta-analysis of 37 trials, patients who were given corticosteroids had significantly lower croup scores at 6 hours, a decrease in return visits, and a decrease in time spent in emergency rooms or hospitals.[30]

Trials of corticosteroids in croup have involved a variety of drugs, dosages, and routes of administration.[30-33] The regimens studied most frequently have been single-dose dexamethasone (0.6 mg per kilogram of body weight given orally or intramuscularly) and nebulized budesonide (2 mg in 4 ml of water); some studies have involved additional doses (up to four doses of dexamethasone or nebulized budesonide given over a period of 2 days). No studies have directly compared the outcomes of single-dose therapy with the outcomes of 2-day treatment schedules.

The 1992 recommendation by the Canadian Paediatric Society to use dexamethasone for treatment was followed by a marked decrease in hospitalizations for croup in Ontario, providing further support for the use of corticosteroids.[10,34,35] Similar findings were noted in Perth, Australia.[36]

A potential concern with corticosteroids, however, is their immunosuppressive effects, which might predispose the patient to infectious complications.[2,5-7] Trials have not been powered to assess these risks, but such complications would be expected to be rare with standard (single-dose) therapy.

Epinephrine

Nebulized epinephrine has been extensively studied for the treatment of croup.[2,5,8,23-25,37-42] Early controlled trials demonstrated that the administration of 2.25% racemic epinephrine (0.5 ml in 2.5 ml of saline) by intermittent positive-pressure breathing resulted in a significant reduction in the croup-severity score,[24,37] but this benefit lasted for less than 2 hours. Subsequent trials showed that the administration of racemic epinephrine by nebulization alone was as effective as its administration by intermittent positive-pressure breathing.[41] Later trials also showed that nebulized L-epinephrine diluted in 5 ml of saline at a ratio of 1:1000 was as effective as racemic epinephrine in the treatment of croup.[42] In severe croup, repeated treatments with epinephrine have been used and have often decreased the need for intubation.

Other Treatments

Children with moderate or severe croup and hypoxia (oxygen saturation while breathing ambient air, <92%) should receive oxygen.[4] This is best administered with the blow-by technique.

A helium–oxygen mixture (heliox) has been shown in a small study to improve croup-severity scores in hospitalized children with croup.[43] However, this treatment was no better — and was more expensive — than treatment with racemic epinephrine.

Antitussive and decongestant agents have not been studied in children with croup, and their use is not indicated.[4] Since laryngotracheitis and spasmodic croup are viral illnesses, there is no reason to treat them with antibiotics unless clinical manifestations or laboratory values suggest secondary bacterial infection. In severe croup due to infection with influenza A or B virus, treatment with neuraminidase inhibitors should be considered, although there are no data demonstrating the efficacy of such treatment in reducing the severity of croup.[44] Since influenza immunization is now routinely recommended for children, the occurrence of croup due to influenza viruses will probably become less common.

Laryngotracheobronchitis and Laryngotracheobronchopneumonitis

Since most children with laryngotracheobronchitis or laryngotracheobronchopneumonia have bacterial disease, antibiotics should be administered after appropriate cultures have been obtained. Treatment should be directed against *Staphylococcus aureus, Streptococcus pyogenes, Streptococcus pneumoniae, Haemophilus influenzae,* and *Moraxella catarrhalis.* Most cases of laryngotracheobronchitis or laryngotracheobronchopneumonia in children require the placement of a mechanical airway and treatment in an intensive care unit.

AREAS OF UNCERTAINTY

Efforts are warranted to improve the use of corticosteroids in the treatment of croup. In practice, many children continue to receive prolonged courses of corticosteroids for croup rather than single-dose therapy. I and others have observed viral, bacterial, and fungal complications in association with corticosteroid treatment[2,5-7,45-48]; in all cases, these complications occurred in children who had received multiple doses.

GUIDELINES

The American Academy of Pediatrics has no guidelines for the management of croup. The Infectious Diseases and Immunization Committee of the Canadian Paediatric Society published a brief statement in 1992, recommending corticosteroid therapy for children admitted to the hospital with croup.[34] The Alberta Medical Association published a guideline for the diagnosis and management of croup in 2004, which was updated in 2007.[4] An algorithm for the management of croup in the outpatient setting is shown in Figure 1.

CONCLUSIONS AND RECOMMENDATIONS

Croup — both spasmodic croup and laryngotracheitis — is a common illness of early childhood that is frightening for both patients and their parents. For children such as the one described in the vignette, the standard of care is short-course corticosteroid therapy. This is most practically accomplished by the administration of a single dose of oral dexamethasone (0.6 mg per kilogram).[4,8,49] I would not recommend additional corticosteroid doses in children who do not have a response to this therapy, given the lack of data showing the efficacy of repeated doses and the potential risks associated with longer-term therapy. Depending on the severity of symptoms, children who do not have a response to dexamethasone should be evaluated in an emergency room or admitted to the hospital; further testing may be useful in such cases, including chest radiography for possible laryngotracheobronchitis or laryngotracheobronchopneumonia, as well as rapid influenza testing in the appropriate season. Children with severe symptoms should be treated with nebulized epinephrine (0.5 ml of 2.25% racemic epinephrine in 4.5 ml of normal saline or L-epinephrine diluted in 5 ml of normal saline at a ratio of 1:1000). If treatment is given in an outpatient setting, it should be followed by at least 2 hours of observation for a return of obstructive symptoms before discharge. Nebulized epinephrine treatments may need to be repeated many times in children with severe laryngotracheitis, but in many cases, this will prevent the need for endotracheal intubation.

If the evaluation suggests laryngotracheobronchitis or laryngotracheobronchopneumonia

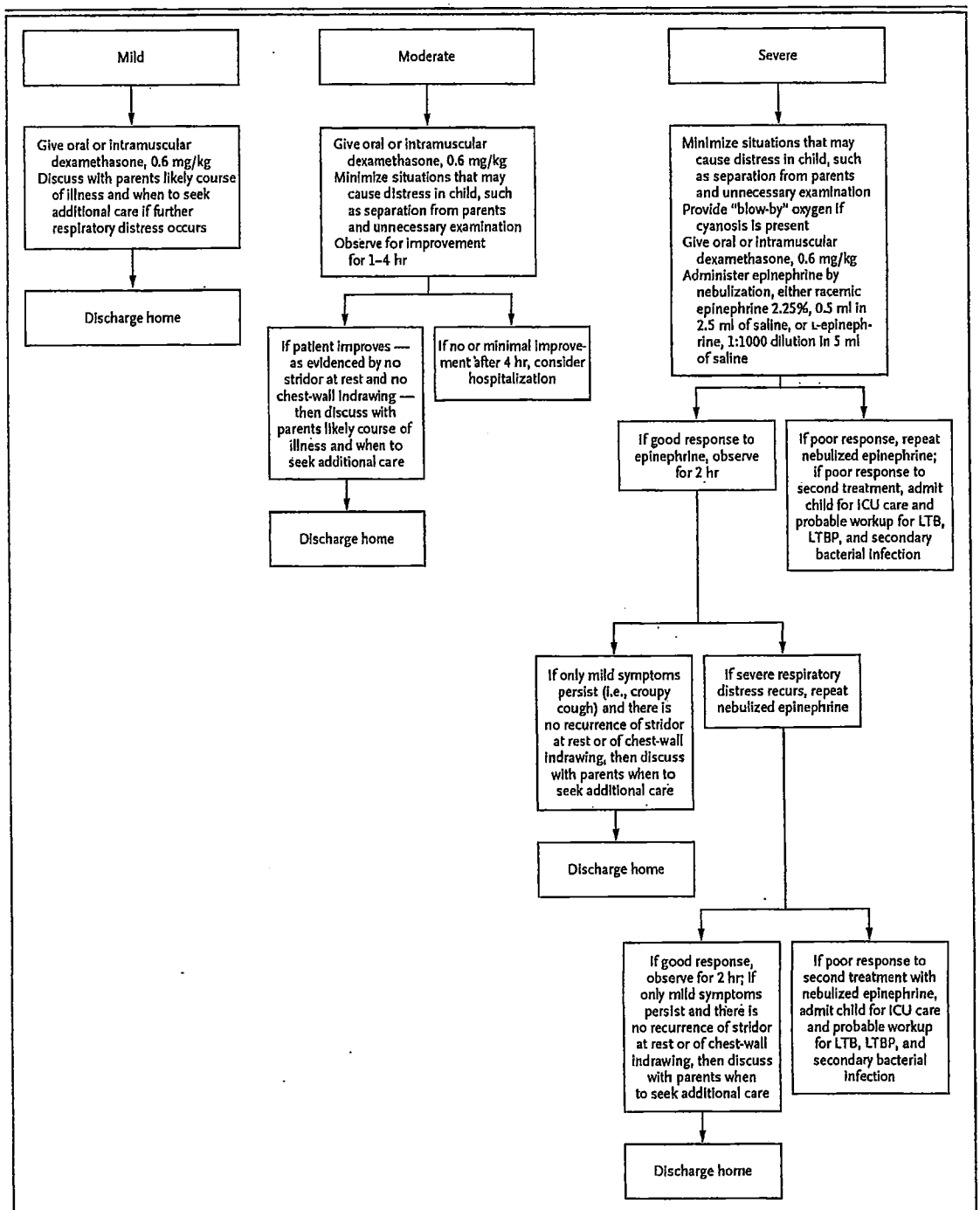


Figure 1. Management of Croup in Outpatients.

Treatment guidelines are based on the severity of croup at the time of initial assessment. ICU denotes intensive care unit, LTB laryngotracheobronchitis, and LTBP laryngotracheobronchopneumonitis.

(i.e., an increased or low white-cell count with an increase in band forms, or radiographs showing pneumonia or soft densities within the trachea), treatment with antibiotics (e.g., vancomycin and cefotaxime) should be instituted, and in most instances, endotracheal intubation should be performed. In cases of severe croup occurring during documented epidemics caused by influenza viruses, treatment with neuramidase inhibitors is appropriate.[44]

Dr. Cherry reports receiving consulting and lecture fees from Sanofi Pasteur and consulting fees from GlaxoSmithKline and MedImmune. No other potential conflict of interest relevant to this article was reported.

I thank Candice Bjornson and David Johnson, who supplied the case vignette, and Paul Krogstad, who offered helpful comments.

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Canadian Paediatric Society

Paediatrics & Child Health, 2017, 166–169
doi: 10.1093/pch/pxx019
Practice Point

OXFORD

Practice Point

Acute management of croup in the emergency department

Oliva Ortiz-Alvarez MD; Canadian Paediatric Society, Acute Care Committee, Ottawa, Ontario

Correspondence: Canadian Paediatric Society, 100-2305 St. Laurent Blvd., Ottawa, Ontario K1G 4J8
e-mail: info@cps.ca website: www.cps.ca.

Abstract

Croup is one of the most common causes of upper airway obstruction in young children. It is characterized by sudden onset of barky cough, hoarse voice, inspiratory stridor and respiratory distress caused by upper airway inflammation secondary to a viral infection. Published guidelines for the diagnosis and treatment of croup advise using steroids as the mainstay treatment for all children who present to emergency department (ED) with croup symptoms. Dexamethasone, given orally as a single dose at 0.6 mg/kg, is highly efficacious in treating croup symptoms. Despite the evidence supporting the use of steroids as the cornerstone of croup treatment, there is significant practice variation among physicians treating croup in the ED. This practice point discusses evidence-based management of typical croup in the ED.

Keywords: *Corticosteroids; Croup; Dexamethasone; Epinephrine; Heliox*

BACKGROUND AND EPIDEMIOLOGY

Most children with croup have mild and short-lived symptoms, with <1% of cases experiencing severe symptoms (1,2). However, croup accounts for significant rates of ED visits and hospitalizations in Canada, with one population-based study in Alberta reporting that 3.2% to 5.1% of all ED visits in children <2 years of age were related to croup (3). Less than 6% of children presenting to ED with croup symptoms require hospitalization and when they are admitted, it is usually for a short stay (3). Endotracheal intubation is rare (at 0.4% to 1.4% of hospitalized cases) and death is exceptionally rare (at 0.5% of intubated cases) (4). There is considerable variation in clinical practice for croup. In small Canadian centres, children with croup are less likely to receive steroids than in larger centres, while the use of antibiotics and beta-agonists (which are rarely indicated in the care of children with croup) is more frequent than in larger centres (5,6).

ETIOLOGY AND PATHOPHYSIOLOGY

Croup is caused by viral infections of the respiratory tract and most commonly by parainfluenza types 1 and 3 viruses. Other implicated viruses are influenza A and B, adenovirus, respiratory syncytial virus and metapneumovirus (7). These infections cause generalized airway inflammation and edema of the upper airway mucosa. The subglottic region becomes narrowed, causing upper airway obstruction and the symptoms typically associated with croup.

CLINICAL PRESENTATION

Classical croup symptoms have a rapid onset and include barky cough, inspiratory stridor, hoarseness and respiratory distress. Nonspecific symptoms of an upper respiratory illness usually precede the typical croup symptoms, which often worsen at night. Typical croup usually affects children between 6 months and 3 years of age. Symptoms are short-lived, usually lasting 3 to 7 days. In 60% of patients, the barky cough disappears after 48 hours (1). In <5% of cases, symptoms may last longer than five nights and <5% of children experience more than one episode. In Canada, croup season peaks over the fall and winter (3,8,9).

DIFFERENTIAL DIAGNOSIS

Children who present with croup at <6 months of age or whose symptoms are recurrent, prolonged or unusually severe require further assessment to rule out congenital or acquired airway narrowing (1). Prolonged duration of croup symptoms associated with fever may be seen with secondary bacterial infection (1). Less than 1% of children with croup have severe or life-threatening symptoms (1,2), but there are several other life-threatening conditions that may present with stridor. Toxic appearance, drooling and dysphagia are important red flags suggestive of more serious conditions (Table 1).

TREATMENT

The severity of the child's respiratory distress on presentation to the ED should guide management (Table 2). Clinical scores used in research studies have not been shown to improve clinical care (10,11). Most clinicians characterize respiratory distress as mild, moderate, severe or impending respiratory failure. Using this classification, an algorithm for the outpatient management of croup in children was developed through expert consensus (12). Children presenting with severe distress or impending respiratory failure should be referred to paediatric intensive care or to anaesthesia for advanced care when clinical response to initial treatment is poor or not sustained.

Overall, the recommended treatment for croup involves the following measures (Figure 1).

General care

Children should be made comfortable and health care providers must take special care not to frighten them during assessment and treatment. There is

Table 1. Differential diagnosis

Condition	Characteristics
Bacterial tracheitis	High fever, toxic appearance and poor response to nebulized epinephrine
Retropharyngeal, parapharyngeal, peritonsillar abscesses	High fever, neck pain, sore throat and dysphagia followed by torticollis, drooling, respiratory distress and stridor
Epiglottitis	Absence of barky cough, sudden onset of high fever, dysphagia, drooling, toxic appearance, anxious appearance and sitting forward in the 'sniffing' position
Aspiration or ingestion of a foreign body	Croupy cough, choking episode, wheezing, hoarseness, biphasic stridor, dyspnea and decreased air entry
Acute allergic reaction (anaphylaxis or angioneurotic edema)	Rapid onset of dysphagia, wheezing, stridor and possible cutaneous allergic signs, such as urticarial rash

Adapted from Bjornson and Johnson (9)

Table 2. Croup severity

Feature	Mild	Moderate	Severe	Impending respiratory failure
Barky cough	Occasional	Frequent	Frequent	Often not prominent due to fatigue
Stridor	None or minimal at rest	Easily audible at rest	Prominent inspiratory and occasionally expiratory	Audible at rest, but may be quiet or hard to hear
In-drawing suprasternal and/or intercostal	None to mild	Visible at rest	Marked or severe	May not be marked
Distress, agitation or lethargy (CNS hypoxia)	None	None to limited	Substantial lethargy may be present	Lethargy or decreased level of consciousness
Cyanosis	None	None	None	Dusky or cyanotic without supplemental oxygen

CNS Central nervous system. Modified from Bjornson and Johnson (1).

no evidence to support the treatment of croup with the use of humidified air (13). Mist tents separate children from their caregivers, can disperse fungus and therefore are not recommended (13). The use of antipyretics is beneficial for reducing fever and discomfort.

Corticosteroids

The clinical benefit of corticosteroids in croup is well established (2,14–16) and should be considered for treating all children presenting with croup and symptoms ranging from mild to severe. Improvement generally begins within 2 to 3 hours after a single oral dose of dexamethasone and persists for 24 to 48 hours (2,15,16). One recent Cochrane review analyzed results from 38 randomized controlled trials (n=4299) associating corticosteroids with clinical improvement as measured by Westley croup scores at 6, 12 and 24 hours (14). Dexamethasone was the corticosteroid tested in most (31/38) of these clinical trials. Two studies compared oral dexamethasone with oral prednisolone. In one study, dexamethasone was found to be superior, and in the other, both therapies were equally effective (14).

Administering corticosteroids by the oral or intramuscular route is as efficacious or superior to the nebulized form of medication (1,14). Adding inhaled budesonide to oral dexamethasone was not found to provide extra benefit in children admitted with croup (17). From a practical perspective, oral dexamethasone is less associated with vomiting (14). The oral route is preferred. When the child with croup has persistent vomiting or significant respiratory distress, administering corticosteroids by the intramuscular route may be indicated (1). The dexamethasone dose used in most clinical trials is 0.6 mg/kg/dose (14). It is unclear from studies using doses of 0.15 mg/kg to 0.3 mg/kg whether these smaller doses are equally effective (18). One meta-analysis of six studies suggested that a higher dose could be more beneficial in children with severe disease (15).

Overall, children treated with corticosteroids have fewer return visits or admissions to the hospital. Fully one-half of children with mild croup treated with corticosteroids are unlikely to need further medical care for ongoing symptoms. Their sleep is improved and their parents report less stress (2). In children with moderate to severe croup treated with corticosteroids, there was a reported average reduction of 12 hours in length of stay in the ED or hospital. There was a 10% reduction in the need for treatment with nebulized epinephrine and a 50% reduction in both the number of return visits and in hospitalization rates (14). There have been no adverse events associated with a single dose of corticosteroids for treatment of croup.

Epinephrine

Nebulized epinephrine is recommended for moderate to severe croup. Reports of administering epinephrine in children with severe croup have demonstrated a lower number of cases requiring intubation or tracheotomy (19). When compared with a placebo, nebulized epinephrine improved signs of respiratory distress within 10 to 30 minutes of initiating treatment. Clinical effect is sustained for at least 1 hour, but disappears after 2 hours (19). The first prospective trial assessing safe discharge after treating paediatric outpatients with a combination of dexamethasone and nebulized epinephrine, and including observation for 2 to 4 hours, supported the safety of this measure (20). There were no adverse outcomes. These results, along with data from two retrospective cohort studies, clearly support the safe discharge of children, providing that symptoms of croup do not recur 2 to 4 hours after treatment (1,21,22).

Traditionally, racemic epinephrine has been used to treat children with croup. Racemic epinephrine is not readily available in Canada. However, one randomized controlled trial demonstrated that nebulized 1:1000 L-epinephrine is safe and equally effective. Equivalent doses of either 0.5 mL racemic epinephrine or 5 mL of 1:1000 L-epinephrine are equally effective. These standard doses can be used in all patients irrespective of their age and weight (23).

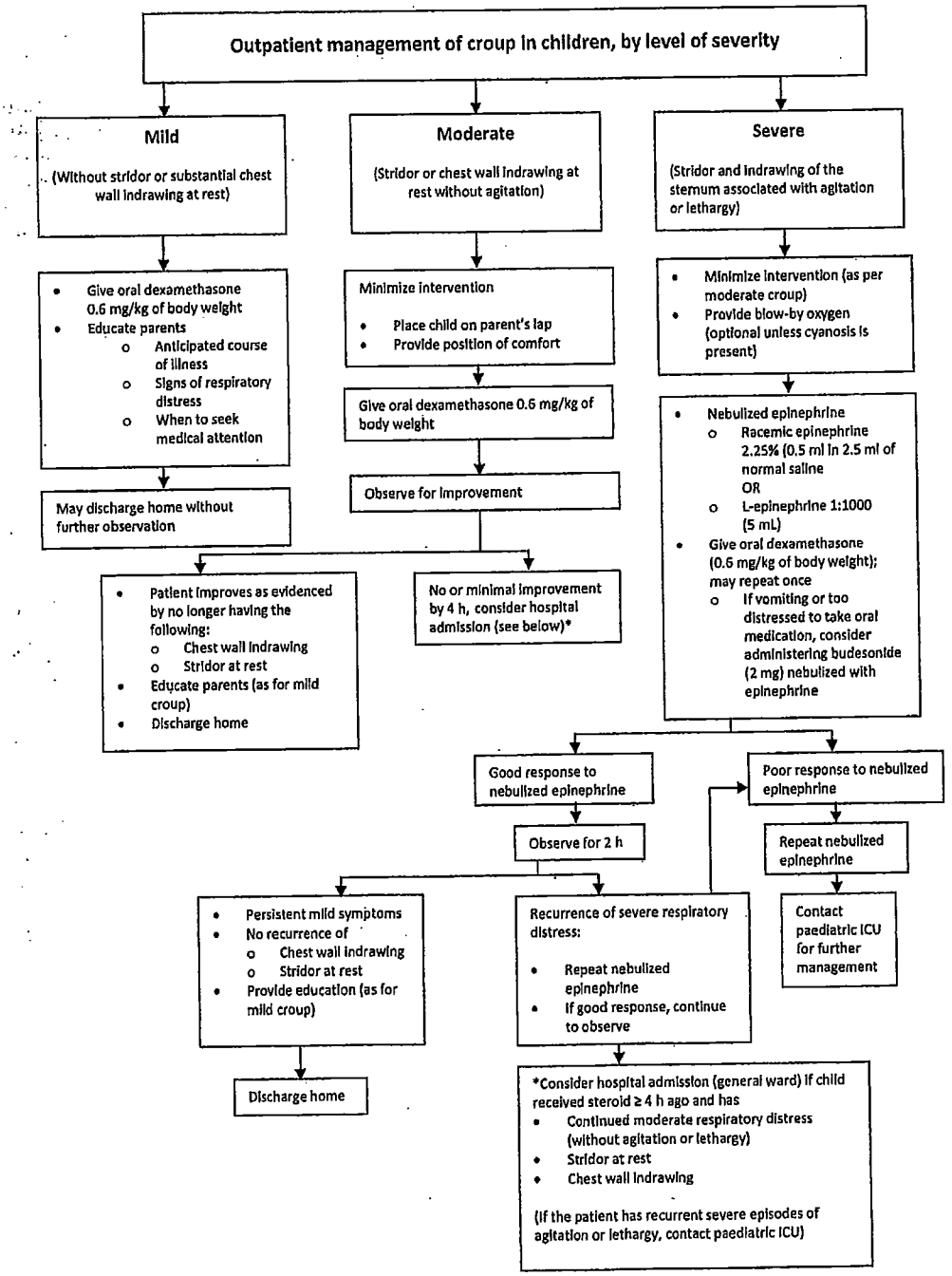
Heliox

A heliox or helium-oxygen mixture can reduce respiratory distress in children with severe croup. A possible mechanism of action is that the lower density of helium gas decreases airflow turbulence in a narrowed airway. Heliox is occasionally used in severe cases to avoid intubation. Heliox has not been shown to improve croup symptoms when compared with standard treatments and therefore is not routinely recommended (24).

Other therapies

The use of antibiotics and short-acting beta-2-agonist bronchodilators in children with typical croup are rarely indicated because of the low incidence of bacterial infection (<1:1000 cases of croup) as well as for physiological reasons. An otorhinolaryngology (ORL) consultation for airway evaluation is indicated when croup symptoms are persistently severe despite treatment. Outpatient referral to ORL is recommended for children with multiple

Figure 1. Algorithm for the outpatient management of crop in children, by level of severity.



Source: reference 12

croup episodes and for those who present outside the usual age group for typical croup (Figure 1).

Acknowledgements

This practice point has been reviewed by the Community Paediatrics and Infectious Diseases and Immunization Committees of the Canadian Paediatric Society, as well as by the CPS Paediatric Emergency Section Executive.

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Croup: Diagnosis and Management

Dustin K. Smith, DO; Andrew J. McDermott, MD; and John F. Sullivan, DO
Naval Hospital Jacksonville, Jacksonville, Florida

Croup is a common respiratory illness affecting 3% of children six months to three years of age. It accounts for 7% of hospitalizations annually for fever and/or acute respiratory illness in children younger than five years. Croup is a manifestation of upper airway obstruction resulting from swelling of the larynx, trachea, and bronchi, leading to inspiratory stridor and a barking cough. Many patients experience low-grade fevers, but fever is not necessary for diagnosis. Less commonly, stridor can be associated with acute epiglottitis, bacterial tracheitis, and foreign body airway obstruction. Laboratory studies are seldom needed for diagnosis of croup. Viral cultures and rapid antigen testing have minimal impact on management and are not routinely recommended. Radiography and laryngoscopy should be reserved for patients in whom alternative diagnoses are suspected. Randomized controlled trials have demonstrated that a single dose of oral, intramuscular, or intravenous dexamethasone improves symptoms and reduces return visits and length of hospitalization in children with croup of any severity. In patients with moderate to severe croup, the addition of nebulized epinephrine improves symptoms and reduces length of hospitalization.
(*Am Fam Physician.* 2018;97(9):575-580.

Illustration by Jonathan Dimes

Croup is a common respiratory illness of the larynx, trachea, and bronchi that leads to inspiratory stridor and a barking cough. Laryngotracheitis, laryngotracheobronchitis, and laryngotracheobronchopneumonitis are included in the croup spectrum and affect 3% of children six months to three years of age.[1,2] Each year in the United States, croup accounts for 7% of hospitalizations for fever and/or acute respiratory illness in children younger than five years.[3,4]

Epidemiology

Croup is typically self-limited in immunocompetent children, occurring predominantly during the fall and winter. It is more common in boys than in girls (1.5:1 ratio). Although the incidence of croup is highest between six months and three years of age, it can occur in children up to six years of age, or earlier than six months in atypical cases.[5-7] Approximately 85% of cases are defined as mild, and less than 1% meet criteria for severe croup, which can be distinguished by signs of hypoxia.[8,9] Less than 5% of all children with croup are hospitalized, and of those only 1% to 3% require intubation.[10]

In patients with recurrent croup (more than two episodes per year), clinically significant bronchoscopy findings are associated with risk factors such as prior intubation, prematurity, and age younger than three years. Although gastroesophageal reflux disease and asthma are highly prevalent in patients with recurrent croup, neither is associated with significant bronchoscopy findings.[11]

Outcomes are favorable; croup has a mortality rate of less than 0.5%, even for intubated patients.[10]

Etiology

Viruses are detected in up to 80% of patients who have croup with identifiable pathogens.[12]

Patient information: A handout on this topic, written by the authors of this article, is available at https://www.aafp.org/afp/2018/0501/p575-s1.html.

CME This clinical content conforms to AAFP criteria for continuing medical education (CME). See CME Quiz on page 565.

Author disclosure: No relevant financial affiliations.

SORT: KEY RECOMMENDATIONS FOR PRACTICE

Clinical recommendation	Evidence rating	References
Diagnosis of croup is based on clinical findings of barking cough, stridor, and hoarseness. Diagnostic testing is typically not necessary.	C	5, 6
Humidified air inhalation does not improve symptoms in patients with moderate croup.	B	27
Corticosteroids should be administered to patients with croup of any severity.	A	21, 22
Epinephrine should be administered to patients with moderate to severe croup.	A	25, 26

A = consistent, good-quality patient-oriented evidence; B = inconsistent or limited-quality patient-oriented evidence; C = consensus, disease-oriented evidence, usual practice, expert opinion, or case series. For information about the SORT evidence rating system, go to http://www.aafp.org/afpsort.

Parainfluenza virus (types 1 to 3) accounts for 75% of all cases, and human parainfluenza virus 1 is the most common type.[9,13] Other viral etiologies include influenza A and B, adenovirus, respiratory syncytial virus, rhinovirus, and enterovirus. Viral infection of the subglottic region and laryngeal mucosa causes inflammation and edema, which significantly decrease air movement and lead to respiratory distress and stridor.[9,13] Bacterial croup is less common and may be caused by *Mycoplasma pneumoniae* and *Corynebacterium diphtheriae*.[8,12] The type of infectious agent does not affect outcomes or initial management.

Presentation and Clinical Course

Viral croup often presents similarly to an upper respiratory infection, with 12 to 72 hours of low-grade fever and coryza. Narrowing of the larynx leads to stridor, increased respiratory rate, respiratory retractions, and a barking cough. Symptoms may be exacerbated by emotional distress, are worse at night, and peak between 24 and 48 hours. Croup typically resolves spontaneously within 48 hours to one week; however, the abrupt onset and harsh cough can be concerning.[5,6]

Diagnosis

HISTORY AND PHYSICAL EXAMINATION

Croup is primarily a clinical diagnosis, with typical findings of abrupt onset of a barking cough, inspiratory stridor, and hoarseness (https://www.youtube.com/watch?v=RXJxtAHtkcs). Many patients will also have dyspnea and fever,[5,6] but the absence of fever should not reduce suspicion for croup.

Respiratory rate is often increased in patients with croup. Clinicians should use age-appropriate rates; for patients six months to three years of age, a normal rate is 20 to 30 breaths per minute. Additionally, patients can present with tachycardia. If pulse oximetry is performed, low oxygen levels may be noted in patients with more severe cases.[12-15]

Visual inspection can reveal clues to the severity of illness. Retractions and nasal flaring may indicate more severe cases. Although cyanosis is absent in most patients with croup, its presence suggests severe disease.[12,13,16]

The most common auscultatory finding is overt inspiratory stridor in the neck. If wheezing is present, it is typically mild; substantial wheezing should prompt evaluation for alternate diagnoses. Rhonchi may be present but are not typical. Rales are generally not present in croup, so this finding should prompt further evaluation.[12,13,16]

WHAT IS NEW ON THIS TOPIC

Croup

A community-based randomized trial of children with mild to moderate croup found no difference in symptom scores between a single dose of dexamethasone and three daily doses of prednisolone.

In patients with more than two croup episodes per year, clinically significant bronchoscopy findings are associated with risk factors such as prior intubation, age younger than three years, and prematurity. Although gastroesophageal reflux disease and asthma are highly prevalent in patients with recurrent croup, neither is associated with significant bronchoscopy findings.

DIFFERENTIAL DIAGNOSIS

More than 99% of children with abrupt stridor have croup, but the differential diagnosis is broad[6] (*Table 1*[2,5,6,14,16-18]). Differentiating croup from other acute illnesses can be challenging. Specifically, distinguishing it from epiglottitis is important because the treatment and prognosis of these conditions are substantially different.[7] Although both conditions commonly present as cough, fever, and dyspnea, epiglottitis is 10 times more likely to present as sore throat.[7] The incidence of epiglottitis has decreased 10-fold with widespread *Haemophilus influenzae* type B vaccination, but it is still important to distinguish it from croup because of potentially rapid deterioration in patients with epiglottitis.[19] In patients admitted to the intensive care unit, cough is highly sensitive and specific for distinguishing croup from epiglottitis, whereas drooling is highly sensitive and specific for distinguishing epiglottitis.[20]

DIAGNOSTIC TESTING

Laboratory studies are seldom needed to diagnose croup. Viral cultures and rapid antigen testing should be reserved for patients in whom initial treatment is ineffective.[6] A complete blood count may help distinguish croup from bacterial etiologies of stridor (e.g., bacterial tracheitis, epiglottitis, peritonsillar abscess, retropharyngeal abscess), but it is nonspecific. Lymphocytosis may suggest a viral etiology.[5,6] A carboxyhemoglobin level may be helpful in identifying cases of thermal injury/smoke inhalation, but the history alone is typically sufficient for this diagnosis.

TABLE 1

Differential Diagnosis of Croup and Associated Clinical Features

Condition	Typical age range	Presentation	Diagnostic tests
Bacterial tracheitis	< 6 years	High fever, barking cough, respiratory distress, and rapid deterioration	Neck radiography (irregular tracheal mucosa) and CBC
Croup	6 months to 3 years	Acute onset of barking cough, stridor, and hoarseness	None required
Epiglottitis	3 to 12 years	Acute onset of dysphagia, odynophagia, drooling, high fever, anxiety, and muffled voice	Neck radiography (thickened epiglottis) and CBC
Foreign body aspiration	< 3 years	Acute onset of choking and/or drooling	Neck radiography, neck CT, and airway endoscopy
Hemangioma	< 6 months	Stridor worse with crying	Airway endoscopy
Large airway lesions*	< 6 months to 4.5 years	Recurrent episodes of barking cough and stridor	Airway endoscopy
Neoplasm	No age predilection	Progressive airway symptoms	Lateral neck radiography and CT
Peritonsillar abscess	6 months to 3.5 years	Sore throat, fever, "hot potato" voice	Neck radiography, neck CT, and CBC
Retropharyngeal abscess	2 to 4 years	Fever, drooling, dysphagia, odynophagia, and neck pain	Neck radiography (bulging posterior pharyngeal wall), neck CT, and CBC
Thermal injury/smoke inhalation	No age predilection	Exposure to heat, smoke, or chemical	Direct laryngoscopy

CBC = complete blood count; CT = computed tomography.

*—Large airway lesions include subglottic stenosis, laryngeal cleft, tracheomalacia, and laryngomalacia.

Information from references 2, 5, 6, 14, and 16 through 18.

Although radiographic imaging is not routinely indicated, croup is often associated with the steeple sign, which indicates glottic and subglottic narrowing (see http://www.aafp.org/afp/2004/0201/p535.html#afp20040201p535-f1). However, this finding is neither specific nor sensitive for croup and may be present in patients with epiglottitis, bacterial tracheitis, neoplasm, or thermal injury.[18] Computed tomography of the neck can be considered for patients with suspected abscess, tumor, or foreign body aspiration.[5]

Laryngoscopy should be reserved for atypical presentations or when alternate diagnoses are suspected.[16] If epiglottitis is suspected, laryngoscopy should be performed with caution because of concern for rapid airway obstruction.[6]

Management

Management of croup is based on the severity of illness. Although a scoring system is not necessary, the most widely studied and commonly used is the Westley Croup Score (*Table 2*).[15] *Figure 1* provides an outpatient management algorithm for children with croup.[6,14,21-26] Minimizing agitation in a symptomatic child can help improve symptoms. Placing the child in a comfortable position may help improve the evaluation and treatment process.

Oxygen should be administered to children with hypoxemia or severe respiratory distress. Although humidified air inhalation has been historically used for management of croup, a meta-analysis of three studies (N = 125) found no statistically significant effect on croup scores or hospital admission in patients with moderate croup.[27] Treatment with specifically designed humidity droplets that deposit in the larynx is no better than controlled delivery of 40% humidity or humidity via blow-by administration.[28]

Heliox is a helium and oxygen mixture used for respiratory conditions that theoretically improves airflow resistance by decreasing gas density (helium is a low-density gas). Data are limited on the benefit of heliox in the treatment of croup, and based on a Cochrane review of three conflicting trials, it is not recommended.[29]

CORTICOSTEROIDS

Corticosteroids should be used in patients with croup of any severity. Treatment with dexamethasone results in faster resolution of symptoms and decreased return to medical care.[21] Corticosteroids are thought to work by decreasing laryngeal mucosal edema through their anti-inflammatory effects. A Cochrane review showed improved symptom scores at six and 12 hours after treatment with a corticosteroid (dexamethasone, budesonide [Rhinocort], or methylprednisolone).[22] Patients treated with corticosteroids have a lower rate of return visits, as well as decreased length of stay in the emergency department or hospital. There is no statistically significant difference between corticosteroids and epinephrine, although patients treated with corticosteroids require less epinephrine.[22] Another review showed that corticosteroids are safe to use in children with acute respiratory conditions.[23]

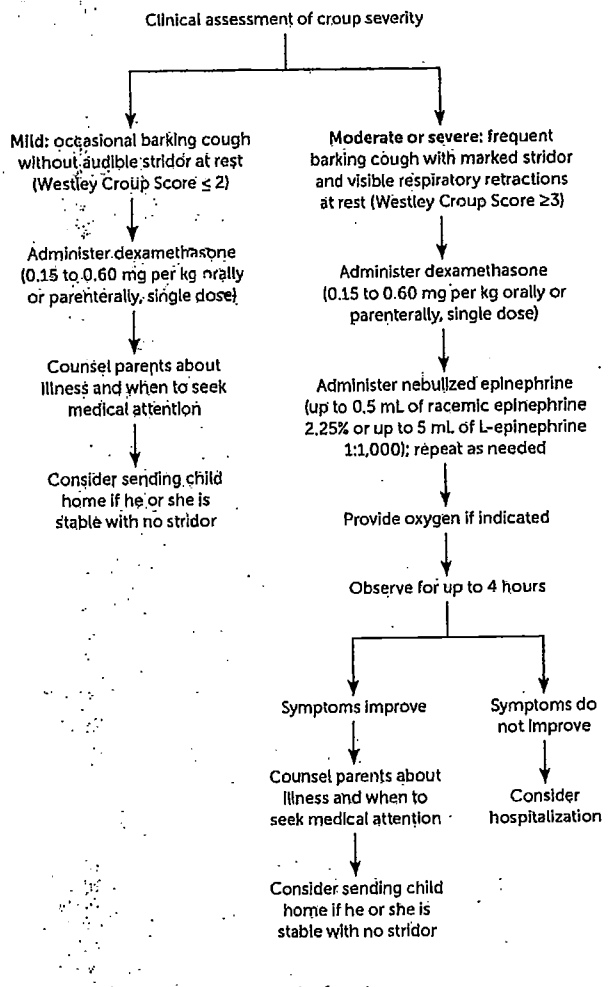
TABLE 2

Westley Croup Score

Clinical sign	Score
Level of consciousness	
Normal (including sleep)	0
Disoriented	5
Cyanosis	
None	0
With agitation	4
At rest	5
Stridor	
None	0
When agitated	1
At rest	2
Air entry	
Normal	0
Decreased	1
Markedly decreased	2
Retractions	
None	0
Mild	1
Moderate	2
Severe	3
Total score	**Croup severity**
≤ 2	Mild
3 to 7	Moderate
8 to 11	Severe
≥ 12	Impending respiratory failure

Adapted with permission from Westley CR, Cotton EK, Brooks JG. Nebulized racemic epinephrine by IPPB for the treatment of croup: a double-blind study. Am J Dis Child. *1978;132(5):485.*

FIGURE 1



Algorithm for the management of croup.

Adapted with permission from Zoorob R, Sidani M, Murray J. Croup: an overview. Am Fam Physician. 2011;83(9):1071, with additional information from references 6, and 21 through 26.

Dexamethasone is the preferred corticosteroid because it is given as a single dose and can be given orally, intramuscularly, or intravenously. Although the optimal dose is unclear, 0.6 mg per kg is the most commonly used.[13,24] Dexamethasone is superior to budesonide for improving symptoms scores, but there is no significant difference in return visits or readmissions. Compared with prednisolone, dexamethasone use in the emergency department or hospital may decrease rates of return visits or readmissions.[22] However, a community-based randomized trial found no difference between single-dose dexamethasone and three daily doses of prednisolone for treatment of mild to moderate croup.[24]

EPINEPHRINE

Epinephrine is thought to improve symptoms in patients with croup through arteriole vasoconstriction in the upper airway mucosa, which eventually leads to decreased edema. Epinephrine is typically used in conjunction with corticosteroids because it has a quick onset of action but a short half-life, whereas corticosteroids have a slower onset of action but a longer half-life. Epinephrine decreases symptom scores in children with moderate or severe croup and should be given at the recommended dose of 0.05 mL per kg of racemic epinephrine 2.25% (maximum dose = 0.5 mL) or 0.5 mL per kg of L-epinephrine 1:1,000 via nebulizer (maximum dose = 5 mL).[25,26]

A Cochrane review showed that nebulized epinephrine reduces symptom scores at 30 minutes, but not at two and six hours; however, it is associated with reduced length of hospitalization.[25] There was no initial difference between nebulized racemic epinephrine and L-epinephrine, although L-epinephrine was more effective at two hours because of its longer effects. The effects of epinephrine wane after one to two hours, so patients should be monitored for at least two hours after administration before they are discharged.[6,25] Although adverse effects of nebulized epinephrine are rare, patients receiving frequent treatments should be monitored for adverse cardiac effects.

This article updates previous articles on this topic by Zoorob, et al.,[14] and by Knutson and Aring.[17]

Data Sources: A PubMed search was completed using the key terms croup and pediatric respiratory infection. The search included meta-analyses, randomized controlled trials, clinical trials, and reviews. We also searched the Cochrane database, Essential Evidence Plus, and the National Guideline Clearinghouse. In addition, references in these resources were searched. Search dates: November 7, 2016; July 19, 2017; and December 27, 2017.

The views expressed in this article are those of the authors and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense, or the U.S. government.

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The Authors

DUSTIN K. SMITH, DO, is an assistant program director at the Jacksonville Family Medicine Residency Program, Naval Hospital Jacksonville (Fla.).

ANDREW J. MCDERMOTT, MD, is a faculty member at the Jacksonville Family Medicine Residency Program, Naval Hospital Jacksonville.

JOHN F. SULLIVAN, DO, is a second-year resident at the Jacksonville Family Medicine Residency Program, Naval Hospital Jacksonville.

Address correspondence to Dustin K. Smith, DO, Naval Hospital Jacksonville, 2080 Child St., Jacksonville, FL 32214 (e-mail: dustin.k.smith16.mil@mail.mil). Reprints are not available from the authors.

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KENALOG®-40 INJECTION
(triamcinolone acetonide injectable suspension, USP)

NOT FOR USE IN NEONATES
CONTAINS BENZYL ALCOHOL

For Intramuscular or Intra-articular Use Only

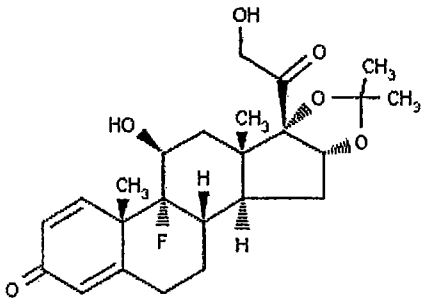
NOT FOR INTRAVENOUS, INTRADERMAL, INTRAOCULAR, EPIDURAL, OR INTRATHECAL USE

DESCRIPTION

Kenalog®-40 Injection (triamcinolone acetonide injectable suspension, USP) is a synthetic glucocorticoid corticosteroid with anti-inflammatory action. THIS FORMULATION IS SUITABLE FOR INTRAMUSCULAR AND INTRA-ARTICULAR USE ONLY. THIS FORMULATION IS NOT FOR INTRADERMAL INJECTION.

Each mL of the sterile aqueous suspension provides 40 mg triamcinolone acetonide, with 0.66% sodium chloride for isotonicity, 0.99% (w/v) benzyl alcohol as a preservative, 0.63% carboxymethylcellulose sodium, and 0.04% polysorbate 80. Sodium hydroxide or hydrochloric acid may be present to adjust pH to 5.0 to 7.5. At the time of manufacture, the air in the container is replaced by nitrogen.

The chemical name for triamcinolone acetonide is 9-Fluoro-11β,16α,17,21-tetrahydroxypregna-1,4-diene-3,20-dione cyclic 16,17-acetal with acetone. Its structural formula is:



MW 434.50

Triamcinolone acetonide occurs as a white to cream-colored, crystalline powder having not more than a slight odor and is practically insoluble in water and very soluble in alcohol.

CLINICAL PHARMACOLOGY

Glucocorticoids, naturally occurring and synthetic, are adrenocortical steroids that are readily absorbed from the gastrointestinal tract.

Naturally occurring glucocorticoids (hydrocortisone and cortisone), which also have salt-retaining properties, are used as replacement therapy in adrenocortical deficiency states. Synthetic analogs such as triamcinolone are primarily used for their anti-inflammatory effects in disorders of many organ systems.

Kenalog-40 Injection has an extended duration of effect which may be sustained over a period of several weeks. Studies indicate that following a single intramuscular dose of 60 mg to 100 mg of triamcinolone acetonide, adrenal suppression occurs within 24 to 48 hours and then gradually returns to normal, usually in 30 to 40 days. This finding correlates closely with the extended duration of therapeutic action achieved with the drug.

INDICATIONS AND USAGE

Intramuscular

Where oral therapy is not feasible, injectable corticosteroid therapy, including Kenalog-40 Injection (triamcinolone acetonide injectable suspension, USP) is indicated **for intramuscular use** as follows:

Allergic states: Control of severe or incapacitating allergic conditions intractable to adequate trials of conventional treatment in asthma, atopic dermatitis, contact dermatitis, drug hypersensitivity reactions, perennial or seasonal allergic rhinitis, serum sickness, transfusion reactions.

Dermatologic diseases: Bullous dermatitis herpetiformis, exfoliative erythroderma, mycosis fungoides, pemphigus, severe erythema multiforme (Stevens-Johnson syndrome).

Endocrine disorders: Primary or secondary adrenocortical insufficiency (hydrocortisone or cortisone is the drug of choice; synthetic analogs may be used in conjunction with mineralocorticoids where applicable; in infancy, mineralocorticoid supplementation is of particular importance), congenital adrenal hyperplasia, hypercalcemia associated with cancer, nonsuppurative thyroiditis.

Gastrointestinal diseases: To tide the patient over a critical period of the disease in regional enteritis and ulcerative colitis.

Hematologic disorders: Acquired (autoimmune) hemolytic anemia, Diamond-Blackfan anemia, pure red cell aplasia, selected cases of secondary thrombocytopenia.

Miscellaneous: Trichinosis with neurologic or myocardial involvement, tuberculous meningitis with subarachnoid block or impending block when used with appropriate antituberculous chemotherapy.

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Ophthalmic diseases: Sympathetic ophthalmia, temporal arteritis, uveitis, and ocular inflammatory conditions unresponsive to topical corticosteroids.

Renal diseases: To induce diuresis or remission of proteinuria in idiopathic nephrotic syndrome or that due to lupus erythematosus.

Respiratory diseases: Berylliosis, fulminating or disseminated pulmonary tuberculosis when used concurrently with appropriate antituberculous chemotherapy, idiopathic eosinophilic pneumonias, symptomatic sarcoidosis.

Rheumatic disorders: As adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in acute gouty arthritis; acute rheumatic carditis; ankylosing spondylitis; psoriatic arthritis; rheumatoid arthritis, including juvenile rheumatoid arthritis (selected cases may require low-dose maintenance therapy). For the treatment of dermatomyositis, polymyositis, and systemic lupus erythematosus.

Intra-Articular

The intra-articular or soft tissue administration of Kenalog-40 Injection is indicated as adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in acute gouty arthritis, acute and subacute bursitis, acute nonspecific tenosynovitis, epicondylitis, rheumatoid arthritis, synovitis of osteoarthritis.

CONTRAINDICATIONS

Kenalog-40 Injection is contraindicated in patients who are hypersensitive to any components of this product (see **WARNINGS: General**).

Intramuscular corticosteroid preparations are contraindicated for idiopathic thrombocytopenic purpura.

WARNINGS

Serious Neurologic Adverse Reactions with Epidural Administration

Serious neurologic events, some resulting in death, have been reported with epidural injection of corticosteroids (see **WARNINGS: Neurologic**). Specific events reported include, but are not limited to, spinal cord infarction, paraplegia, quadriplegia, cortical blindness, and stroke. These serious neurologic events have been reported with and without use of fluoroscopy. The safety and effectiveness of epidural administration of corticosteroids have not been established, and corticosteroids are not approved for this use.

General

Exposure to excessive amounts of benzyl alcohol has been associated with toxicity (hypotension, metabolic acidosis), particularly in neonates, and an increased incidence of kernicterus, particularly in small preterm infants. There have been rare reports of deaths, primarily in preterm infants, associated with exposure to excessive amounts of benzyl alcohol. The amount of benzyl alcohol from medications is usually considered negligible compared to that received in flush solutions containing benzyl alcohol. Administration of high dosages of medications containing this preservative must take into account the total amount of benzyl alcohol administered. The amount of benzyl alcohol at which toxicity may occur is not known. If the patient requires more than the recommended dosages or

other medications containing this preservative, the practitioner must consider the daily metabolic load of benzyl alcohol from these combined sources (see **PRECAUTIONS: Pediatric Use**).

Rare instances of anaphylaxis have occurred in patients receiving corticosteroid therapy (see **ADVERSE REACTIONS**). Cases of serious anaphylaxis, including death, have been reported in individuals receiving triamcinolone acetonide injection, regardless of the route of administration.

Because Kenalog-40 Injection (triamcinolone acetonide injectable suspension, USP) is a suspension, it should **not** be administered intravenously.

Unless a **deep** intramuscular injection is given, local atrophy is likely to occur. (For recommendations on injection techniques, see **DOSAGE AND ADMINISTRATION.**) Due to the significantly higher incidence of local atrophy when the material is injected into the deltoid area, this injection site should be avoided in favor of the gluteal area.

Increased dosage of rapidly acting corticosteroids is indicated in patients on corticosteroid therapy subjected to any unusual stress before, during, and after the stressful situation. Kenalog-40 Injection is a long-acting preparation, and is not suitable for use in acute stress situations. To avoid drug-induced adrenal insufficiency, supportive dosage may be required in times of stress (such as trauma, surgery, or severe illness) both during treatment with Kenalog-40 Injection and for a year afterwards.

Results from one multicenter, randomized, placebo-controlled study with methylprednisolone hemisuccinate, an intravenous corticosteroid, showed an increase in early (at 2 weeks) and late (at 6 months) mortality in patients with cranial trauma who were determined not to have other clear indications for corticosteroid treatment. High doses of systemic corticosteroids, including Kenalog-40 Injection , should not be used for the treatment of traumatic brain injury.

Cardio-Renal

Average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention, and increased excretion of potassium. These effects are less likely to occur with the synthetic derivatives except when they are used in large doses. Dietary salt restriction and potassium supplementation may be necessary (see **PRECAUTIONS**). All corticosteroids increase calcium excretion.

Literature reports suggest an apparent association between use of corticosteroids and left ventricular free wall rupture after a recent myocardial infarction; therefore, therapy with corticosteroids should be used with great caution in these patients.

Endocrine

Corticosteroids can produce reversible hypothalamic-pituitary-adrenal (HPA) axis suppression with the potential for glucocorticosteroid insufficiency after withdrawal of treatment.

Metabolic clearance of corticosteroids is decreased in hypothyroid patients and increased in hyperthyroid patients. Changes in thyroid status of the patient may necessitate adjustment in dosage.

Infections

General

Patients who are on corticosteroids are more susceptible to infections than are healthy individuals. There may be decreased resistance and inability to localize infection when corticosteroids are used. Infection with any pathogen (viral, bacterial, fungal, protozoan, or helminthic) in any location of the body may be associated with the use of corticosteroids alone or in combination with other immunosuppressive agents. These infections may be mild to severe. With increasing doses of corticosteroids, the rate of occurrence of infectious complications increases. Corticosteroids may also mask some signs of current infection.

Fungal Infections

Corticosteroids may exacerbate systemic fungal infections and therefore should not be used in the presence of such infections unless they are needed to control drug reactions. There have been cases reported in which concomitant use of amphotericin B and hydrocortisone was followed by cardiac enlargement and congestive heart failure (see **PRECAUTIONS: Drug Interactions:** *Amphotericin B injection and potassium-depleting agents*).

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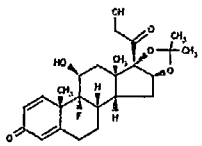

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Serious neurologic events, some resulting in death, have been reported with epidural injection of corticosteroids (see WARNINGS: Neurologic). Specific events reported include, but are not limited to, spinal cord infarction, paraplegia, quadriplegia, cortical blindness, and stroke. These serious neurologic events have been reported with and without use of fluoroscopy. The safety and effectiveness of epidural administration of corticosteroids have not been established, and corticosteroids are not approved for this use.

General

Exposure to excessive amounts of benzyl alcohol has been associated with toxicity (hypotension, metabolic acidosis), particularly in neonates, and an increased incidence of kernicterus, particularly in small preterm infants. There have been rare reports of deaths, primarily in preterm infants, associated with exposure to excessive amounts of benzyl alcohol. The amount of benzyl alcohol from medications is usually considered negligible compared to that received in flush solutions containing benzyl alcohol. Administration of high dosages of medications containing this preservative must take into account the total amount of benzyl alcohol administered. The amount of benzyl alcohol at which toxicity may occur is not known. If the patient requires more than the recommended dosages or

other medications containing this preservative, the practitioner must consider the daily metabolic load of benzyl alcohol from these combined sources (see PRECAUTIONS: Pediatric Use).

Rare instances of anaphylaxis have occurred in patients receiving corticosteroid therapy (see ADVERSE REACTIONS). Cases of serious anaphylaxis, including death, have been reported in individuals receiving triamcinolone acetonide injection, regardless of the route of administration.

Because Kenalog-40 Injection (triamcinolone acetonide injectable suspension, USP) is a suspension, it should not be administered intravenously.

Unless a deep intramuscular injection is given, local atrophy is likely to occur. (For recommendations on injection techniques, see DOSAGE AND ADMINISTRATION.) Due to the significantly higher incidence of local atrophy when the material is injected into the deltoid area, this injection site should be avoided in favor of the gluteal area.

Increased dosage of rapidly acting corticosteroids is indicated in patients on corticosteroid therapy subjected to any unusual stress before, during, and after the stressful situation. Kenalog-40 Injection is a long-acting preparation, and is not suitable for use in acute stress situations. To avoid drug-induced adrenal insufficiency, supportive dosage may be required in times of stress (such as trauma, surgery, or severe illness) both during treatment with Kenalog-40 Injection and for a year afterwards.

Results from one multicenter, randomized, placebo-controlled study with methylprednisolone hemisuccinate, an intravenous corticosteroid, showed an increase in early (at 2 weeks) and late (at 6 months) mortality in patients with cranial trauma who were determined not to have other clear indications for corticosteroid treatment. High doses of systemic corticosteroids, including Kenalog-40 Injection , should not be used for the treatment of traumatic brain injury.

Cardio-Renal

Average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention, and increased excretion of potassium. These effects are less likely to occur with the synthetic derivatives except when they are used in large doses. Dietary salt restriction and potassium supplementation may be necessary (see PRECAUTIONS). All corticosteroids increase calcium excretion.

Literature reports suggest an apparent association between use of corticosteroids and left ventricular free wall rupture after a recent myocardial infarction; therefore, therapy with corticosteroids should be used with great caution in these patients.

Endocrine

Corticosteroids can produce reversible hypothalamic-pituitary-adrenal (HPA) axis suppression with the potential for glucocorticosteroid insufficiency after withdrawal of treatment.

Metabolic clearance of corticosteroids is decreased in hypothyroid patients and increased in hyperthyroid patients. Changes in thyroid status of the patient may necessitate adjustment in dosage.

Infections

General

Patients who are on corticosteroids are more susceptible to infections than are healthy individuals. There may be decreased resistance and inability to localize infection when corticosteroids are used. Infection with any pathogen (viral, bacterial, fungal, protozoan, or helminthic) in any location of the body may be associated with the use of corticosteroids alone or in combination with other immunosuppressive agents. These infections may be mild to severe. With increasing doses of corticosteroids, the rate of occurrence of infectious complications increases. Corticosteroids may also mask some signs of current infection.

Fungal Infections

Corticosteroids may exacerbate systemic fungal infections and therefore should not be used in the presence of such infections unless they are needed to control drug reactions. There have been cases reported in which concomitant use of amphotericin B and hydrocortisone was followed by cardiac enlargement and congestive heart failure (see PRECAUTIONS: Drug Interactions: *Amphotericin B injection and potassium-depleting agents*).

Special Pathogens

Latent disease may be activated or there may be an exacerbation of intercurrent infections due to pathogens, including those caused by *Amoeba, Candida, Cryptococcus, Mycobacterium, Nocardia, Pneumocystis*, or *Toxoplasma*.

It is recommended that latent amebiasis or active amebiasis be ruled out before initiating corticosteroid therapy in any patient who has spent time in the tropics or in any patient with unexplained diarrhea.

Similarly, corticosteroids should be used with great care in patients with known or suspected *Strongyloides* (threadworm) infestation. In such patients, corticosteroid-induced immunosuppression may lead to *Strongyloides* hyperinfection and dissemination with widespread larval migration, often accompanied by severe enterocolitis and potentially fatal gram-negative septicemia.

Corticosteroids should not be used in cerebral malaria.

Tuberculosis

The use of corticosteroids in patients with active tuberculosis should be restricted to those cases of fulminating or disseminated tuberculosis in which the corticosteroid is used for the management of the disease in conjunction with an appropriate anti-tuberculosis regimen. If corticosteroids are indicated in patients with latent tuberculosis or tuberculin reactivity, close observation is necessary as reactivation of the disease may occur. During prolonged corticosteroid therapy, these patients should receive chemoprophylaxis.

Vaccination

Administration of live or live, attenuated vaccines is contraindicated in patients receiving immunosuppressive doses of corticosteroids. Killed or inactivated vaccines may be administered. However, the response to such vaccines cannot be predicted. Immunization procedures may be undertaken in patients who are receiving corticosteroids as replacement therapy, *e.g.*, for Addison's disease.

Viral Infections

Chicken pox and measles can have a more serious or even fatal course in pediatric and adult patients on corticosteroids. In pediatric and adult patients who have not had these diseases, particular care should be taken to avoid exposure. The contribution of the

underlying disease and/or prior corticosteroid treatment to the risk is also not known. If exposed to chicken pox, prophylaxis with varicella zoster immune globulin (VZIG) may be indicated. If exposed to measles, prophylaxis with immunoglobulin (IG) may be indicated. (See the respective package inserts for complete VZIG and IG prescribing information.) If chicken pox develops, treatment with antiviral agents should be considered.

Neurologic

Epidural and intrathecal administration of this product is not recommended. Reports of serious medical events, including death, have been associated with epidural and intrathecal routes of corticosteroid administration (see ADVERSE REACTIONS: *Gastrointestinal* and *Neurologic/Psychiatric*).

Ophthalmic

Use of corticosteroids may produce posterior subcapsular cataracts, glaucoma with possible damage to the optic nerves, and may enhance the establishment of secondary ocular infections due to bacteria, fungi, or viruses. The use of oral corticosteroids is not recommended in the treatment of optic neuritis and may lead to an increase in the risk of new episodes. Corticosteroids should not be used in active ocular herpes simplex.

Adequate studies to demonstrate the safety of Kenalog-40 Injection use by intraturbinal, subconjunctival, sub-Tenons, retrobulbar, and intraocular (intravitreal) injections have not been performed. Endophthalmitis, eye inflammation, increased intraocular pressure, and visual disturbances including vision loss have been reported with intravitreal administration. Administration of Kenalog-40 Injection intraocularly or into the nasal turbinates is not recommended.

Intraocular injection of corticosteroid formulations containing benzyl alcohol, such as Kenalog-40 Injection, is not recommended because of potential toxicity from the benzyl alcohol.

PRECAUTIONS

General

This product, like many other steroid formulations, is sensitive to heat. Therefore, it should not be autoclaved when it is desirable to sterilize the exterior of the vial.

The lowest possible dose of corticosteroid should be used to control the condition under treatment. When reduction in dosage is possible, the reduction should be gradual.

Since complications of treatment with glucocorticoids are dependent on the size of the dose and the duration of treatment, a risk/benefit decision must be made in each individual case as to dose and duration of treatment and as to whether daily or intermittent therapy should be used.

Kaposi's sarcoma has been reported to occur in patients receiving corticosteroid therapy, most often for chronic conditions. Discontinuation of corticosteroids may result in clinical improvement.

Cardio-Renal

As sodium retention with resultant edema and potassium loss may occur in patients receiving corticosteroids, these agents should be used with caution in patients with congestive heart failure, hypertension, or renal insufficiency.

Endocrine

Drug-induced secondary adrenocortical insufficiency may be minimized by gradual reduction of dosage. This type of relative insufficiency may persist for months after discontinuation of therapy; therefore, in any situation of stress occurring during that period, hormone therapy should be reinstituted. Since mineralocorticoid secretion may be impaired, salt and/or a mineralocorticoid should be administered concurrently.

Gastrointestinal

Steroids should be used with caution in active or latent peptic ulcers, diverticulitis, fresh intestinal anastomoses, and nonspecific ulcerative colitis, since they may increase the risk of a perforation.

Signs of peritoneal irritation following gastrointestinal perforation in patients receiving corticosteroids may be minimal or absent.

There is an enhanced effect of corticosteroids in patients with cirrhosis.

Intra-Articular and Soft Tissue Administration

Intra-articularly injected corticosteroids may be systemically absorbed.

Appropriate examination of any joint fluid present is necessary to exclude a septic process.

A marked increase in pain accompanied by local swelling, further restriction of joint motion, fever, and malaise are suggestive of septic arthritis. If this complication occurs and the diagnosis of sepsis is confirmed, appropriate antimicrobial therapy should be instituted.

Injection of a steroid into an infected site is to be avoided. Local injection of a steroid into a previously infected joint is not usually recommended.

Corticosteroid injection into unstable joints is generally not recommended.

Intra-articular injection may result in damage to joint tissues (see ADVERSE REACTIONS: *Musculoskeletal*).

Musculoskeletal

Corticosteroids decrease bone formation and increase bone resorption both through their effect on calcium regulation (*i.e.*, decreasing absorption and increasing excretion) and inhibition of osteoblast function. This, together with a decrease in the protein matrix of the bone secondary to an increase in protein catabolism, and reduced sex hormone production, may lead to inhibition of bone growth in pediatric patients and the development of osteoporosis at any age. Special consideration should be given to patients at increased risk of osteoporosis (*i.e.*, postmenopausal women) before initiating corticosteroid therapy.

Neuro-Psychiatric

Although controlled clinical trials have shown corticosteroids to be effective in speeding the resolution of acute exacerbations of multiple sclerosis, they do not show that they affect the ultimate outcome or natural history of the disease. The studies do show that relatively high doses of corticosteroids are necessary to demonstrate a significant effect. (See DOSAGE AND ADMINISTRATION.)

An acute myopathy has been observed with the use of high doses of corticosteroids, most often occurring in patients with disorders of neuromuscular transmission (*e.g.*, myasthenia gravis), or in patients receiving concomitant therapy with neuromuscular blocking drugs (*e.g.*, pancuronium). This acute myopathy is generalized, may involve

ocular and respiratory muscles, and may result in quadriparesis. Elevation of creatinine kinase may occur. Clinical improvement or recovery after stopping corticosteroids may require weeks to years.

Psychiatric derangements may appear when corticosteroids are used, ranging from euphoria, insomnia, mood swings, personality changes, and severe depression to frank psychotic manifestations. Also, existing emotional instability or psychotic tendencies may be aggravated by corticosteroids.

Ophthalmic

Intraocular pressure may become elevated in some individuals. If steroid therapy is continued for more than 6 weeks, intraocular pressure should be monitored.

Information for Patients

Patients should be warned not to discontinue the use of corticosteroids abruptly or without medical supervision, to advise any medical attendants that they are taking corticosteroids, and to seek medical advice at once should they develop fever or other signs of infection.

Persons who are on corticosteroids should be warned to avoid exposure to chicken pox or measles. Patients should also be advised that if they are exposed, medical advice should be sought without delay.

Drug Interactions

Aminoglutethimide: Aminoglutethimide may lead to a loss of corticosteroid-induced adrenal suppression.

Amphotericin B injection and potassium-depleting agents: When corticosteroids are administered concomitantly with potassium-depleting agents (*i.e.*, amphotericin B, diuretics), patients should be observed closely for development of hypokalemia. There have been cases reported in which concomitant use of amphotericin B and hydrocortisone was followed by cardiac enlargement and congestive heart failure.

Antibiotics: Macrolide antibiotics have been reported to cause a significant decrease in corticosteroid clearance.

Anticholinesterases: Concomitant use of anticholinesterase agents and corticosteroids may produce severe weakness in patients with myasthenia gravis. If possible, anticholinesterase agents should be withdrawn at least 24 hours before initiating corticosteroid therapy.

Anticoagulants, oral: Coadministration of corticosteroids and warfarin usually results in inhibition of response to warfarin, although there have been some conflicting reports. Therefore, coagulation indices should be monitored frequently to maintain the desired anticoagulant effect.

Antidiabetics: Because corticosteroids may increase blood glucose concentrations, dosage adjustments of antidiabetic agents may be required.

Antituberculars drugs: Serum concentrations of isoniazid may be decreased.

Cholestyramine: Cholestyramine may increase the clearance of corticosteroids.

Cyclosporine: Increased activity of both cyclosporine and corticosteroids may occur when the two are used concurrently. Convulsions have been reported with this concurrent use.

CYP3A4 inhibitors: Triamcinolone acetonide is a substrate of CYP3A4. Ketoconazole has been reported to decrease the metabolism of certain corticosteroids by up to 60%, leading to an increased risk of corticosteroid side effects. Co-administration of other strong CYP3A4 inhibitors (e.g., ritonavir, atazanavir, clarithromycin, indinavir, itraconazole, nefazodone, nelfinavir, saquinavir, telithromycin, cobicistat-containing products) with Kenalog-40 Injection may cause increased plasma concentration of triamcinolone leading to adverse reactions. (See ADVERSE REACTIONS.) Drug postmarketing use, there have been reports of clinically significant drug interactions in patients receiving triamcinolone acetonide and strong CYP3A4 inhibitors (e.g., ritonavir). (See WARNINGS, Endocrine and PRECAUTIONS, Endocrine.) Consider the benefit-risk of concomitant use and monitor for systemic corticosteroid side effects.

Digitalis glycosides: Patients on digitalis glycosides may be at increased risk of arrhythmias due to hypokalemia.

Estrogens, including oral contraceptives: Estrogens may decrease the hepatic metabolism of certain corticosteroids, thereby increasing their effect.

Hepatic enzyme inducers (e.g., barbiturates, phenytoin, carbamazepine, rifampin): Drugs which induce hepatic microsomal drug metabolizing enzyme activity may enhance the metabolism of corticosteroids and require that the dosage of the corticosteroid be increased.

Nonsteroidal anti-inflammatory drugs (NSAIDs): Concomitant use of aspirin (or other nonsteroidal anti-inflammatory drugs) and corticosteroids increases the risk of gastrointestinal side effects. Aspirin should be used cautiously in conjunction with corticosteroids in hypoprothrombinemia. The clearance of salicylates may be increased with concurrent use of corticosteroids.

Skin tests: Corticosteroids may suppress reactions to skin tests.

Vaccines: Patients on prolonged corticosteroid therapy may exhibit a diminished response to toxoids and live or inactivated vaccines due to inhibition of antibody response. Corticosteroids may also potentiate the replication of some organisms contained in live attenuated vaccines. Routine administration of vaccines or toxoids should be deferred until corticosteroid therapy is discontinued if possible (see WARNINGS: Infections: Vaccination).

Carcinogenesis, Mutagenesis, Impairment of Fertility

No adequate studies have been conducted in animals to determine whether corticosteroids have a potential for carcinogenesis or mutagenesis.

Steroids may increase or decrease motility and number of spermatozoa in some patients.

Pregnancy

Teratogenic Effects

Corticosteroids have been shown to be teratogenic in many species when given in doses equivalent to the human dose. Animal studies in which corticosteroids have been given to pregnant mice, rats, and rabbits have yielded an increased incidence of cleft palate in the offspring. There are no adequate and well-controlled studies in pregnant women. Corticosteroids should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Infants born to mothers who have received corticosteroids during pregnancy should be carefully observed for signs of hypoadrenalism.

Nursing Mothers

Systemically administered corticosteroids appear in human milk and could suppress growth, interfere with endogenous corticosteroid production, or cause other untoward effects. Caution should be exercised when corticosteroids are administered to a nursing woman.

Pediatric Use

This product contains benzyl alcohol as a preservative. Benzyl alcohol, a component of this product, has been associated with serious adverse events and death, particularly in pediatric patients. The "gasping syndrome" (characterized by central nervous system depression, metabolic acidosis, gasping respirations, and high levels of benzyl alcohol and its metabolites found in the blood and urine) has been associated with benzyl alcohol dosages >99 mg/kg/day in neonates and low-birth-weight neonates. Additional symptoms may include gradual neurological deterioration, seizures, intracranial hemorrhage, hematologic abnormalities, skin breakdown, hepatic and renal failure, hypotension, bradycardia, and cardiovascular collapse. Although normal therapeutic doses of this product deliver amounts of benzyl alcohol that are substantially lower than those reported in association with the "gasping syndrome," the minimum amount of benzyl alcohol at which toxicity may occur is not known. Premature and low-birth-weight infants, as well as patients receiving high dosages, may be more likely to develop toxicity. Practitioners administering this and other medications containing benzyl alcohol should consider the combined daily metabolic load of benzyl alcohol from all sources.

The efficacy and safety of corticosteroids in the pediatric population are based on the well-established course of effect of corticosteroids which is similar in pediatric and adult populations. Published studies provide evidence of efficacy and safety in pediatric patients for the treatment of nephrotic syndrome (>2 years of age), and aggressive lymphomas and leukemias (>1 month of age). Other indications for pediatric use of corticosteroids, *e.g.*, severe asthma and wheezing, are based on adequate and well-controlled trials conducted in adults, on the premises that the course of the diseases and their pathophysiology are considered to be substantially similar in both populations.

The adverse effects of corticosteroids in pediatric patients are similar to those in adults (see ADVERSE REACTIONS). Like adults, pediatric patients should be carefully observed with frequent measurements of blood pressure, weight, height, intraocular pressure, and clinical evaluation for the presence of infection, psychosocial disturbances,

thromboembolism, peptic ulcers, cataracts, and osteoporosis. Pediatric patients who are treated with corticosteroids by any route, including systemically administered corticosteroids, may experience a decrease in their growth velocity. This negative impact of corticosteroids on growth has been observed at low systemic doses and in the absence of laboratory evidence of HPA axis suppression (*i.e.*, cosyntropin stimulation and basal cortisol plasma levels). Growth velocity may therefore be a more sensitive indicator of systemic corticosteroid exposure in pediatric patients than some commonly used tests of HPA axis function. The linear growth of pediatric patients treated with corticosteroids should be monitored, and the potential growth effects of prolonged treatment should be weighed against clinical benefits obtained and the availability of treatment alternatives. In order to minimize the potential growth effects of corticosteroids, pediatric patients should be *titrated* to the lowest effective dose.

Geriatric Use

No overall differences in safety or effectiveness were observed between elderly subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

ADVERSE REACTIONS

(listed alphabetically under each subsection)

The following adverse reactions may be associated with corticosteroid therapy:

Allergic reactions: Anaphylaxis including death, angioedema.

Cardiovascular: Bradycardia, cardiac arrest, cardiac arrhythmias, cardiac enlargement, circulatory collapse, congestive heart failure, fat embolism, hypertension, hypertrophic cardiomyopathy in premature infants, myocardial rupture following recent myocardial infarction (see WARNINGS), pulmonary edema, syncope, tachycardia, thromboembolism, thrombophlebitis, vasculitis.

Dermatologic: Acne, allergic dermatitis, cutaneous and subcutaneous atrophy, dry scaly skin, ecchymoses and petechiae, edema, erythema, hyperpigmentation, hypopigmentation, impaired wound healing, increased sweating, lupus erythematosus-like lesions, purpura, rash, sterile abscess, striae, suppressed reactions to skin tests, thin fragile skin, thinning scalp hair, urticaria.

Endocrine: Decreased carbohydrate and glucose tolerance, development of cushingoid state, glycosuria, hirsutism, hypertrichosis, increased requirements for insulin or oral hypoglycemic agents in diabetes, manifestations of latent diabetes mellitus, menstrual irregularities, postmenopausal vaginal hemorrhage, secondary adrenocortical and pituitary unresponsiveness (particularly in times of stress, as in trauma, surgery, or illness), suppression of growth in pediatric patients.

Fluid and electrolyte disturbances: Congestive heart failure in susceptible patients, fluid retention, hypokalemic alkalosis, potassium loss, sodium retention.

Gastrointestinal: Abdominal distention, bowel/bladder dysfunction (after intrathecal administration [see WARNINGS: Neurologic]), elevation in serum liver enzyme levels (usually reversible upon discontinuation), hepatomegaly, increased appetite, nausea, pancreatitis, peptic ulcer with possible perforation and hemorrhage, perforation of the small and large intestine (particularly in patients with inflammatory bowel disease), ulcerative esophagitis.

Metabolic: Negative nitrogen balance due to protein catabolism.

Musculoskeletal: Aseptic necrosis of femoral and humeral heads, calcinosis (following intra-articular or intralesional use), Charcot-like arthropathy, loss of muscle mass, muscle weakness, osteoporosis, pathologic fracture of long bones, post injection flare (following intra-articular use), steroid myopathy, tendon rupture, vertebral compression fractures.

Neurologic/Psychiatric: Convulsions, depression, emotional instability, euphoria, headache, increased intracranial pressure with papilledema (pseudotumor cerebri) usually following discontinuation of treatment, insomnia, mood swings, neuritis, neuropathy, paresthesia, personality changes, psychiatric disorders, vertigo. Arachnoiditis, meningitis, paraparesis/paraplegia, and sensory disturbances have occurred after intrathecal administration. Spinal cord infarction, paraplegia, quadriplegia, cortical blindness, and stroke (including brainstem) have been reported after epidural administration of corticosteroids (see WARNINGS: Serious Neurologic Adverse Reactions with Epidural Administration and WARNINGS: Neurologic).

Ophthalmic: Exophthalmos, glaucoma, increased intraocular pressure, posterior subcapsular cataracts, rare instances of blindness associated with periocular injections.

Other: Abnormal fat deposits, decreased resistance to infection, hiccups, increased or decreased motility and number of spermatozoa, malaise, moon face, weight gain.

OVERDOSAGE

Treatment of acute overdosage is by supportive and symptomatic therapy. For chronic overdosage in the face of severe disease requiring continuous steroid therapy, the dosage of the corticosteroid may be reduced only temporarily, or alternate day treatment may be introduced.

DOSAGE AND ADMINISTRATION

General

NOTE: CONTAINS BENZYL ALCOHOL (see PRECAUTIONS).

The initial dose of Kenalog-40 Injection may vary from 2.5 mg to 100 mg per day depending on the specific disease entity being treated (see Dosage section below). However, in certain overwhelming, acute, life-threatening situations, administration in dosages exceeding the usual dosages may be justified and may be in multiples of the oral dosages.

IT SHOULD BE EMPHASIZED THAT DOSAGE REQUIREMENTS ARE VARIABLE AND MUST BE INDIVIDUALIZED ON THE BASIS OF THE DISEASE UNDER TREATMENT AND THE RESPONSE OF THE PATIENT. After a favorable response is noted, the proper maintenance dosage should be determined by decreasing the initial drug dosage in small decrements at appropriate time intervals until the lowest dosage which will maintain an adequate clinical response is reached. Situations which may make dosage adjustments necessary are changes in clinical status secondary to remissions or exacerbations in the disease process, the patient's individual drug responsiveness, and the effect of patient exposure to stressful situations not directly related to the disease entity under treatment. In this latter situation it may be necessary to increase the dosage of the corticosteroid for a period of time consistent with the patient's condition. If after long-term therapy the drug is to be stopped, it is recommended that it be withdrawn gradually rather than abruptly.

Dosage

SYSTEMIC

The suggested initial dose is 60 mg. injected deeply into the gluteal muscle. Atrophy of subcutaneous fat may occur if the injection is not properly given. Dosage is usually adjusted within the range of 40 mg to 80 mg. depending upon patient response and duration of relief. However, some patients may be well controlled on doses as low as 20 mg or less.

Hay fever or pollen asthma: Patients with hay fever or pollen asthma who are not responding to pollen administration and other conventional therapy may obtain a remission of symptoms lasting throughout the pollen season after a single injection of 40 mg to 100 mg.

In the treatment of acute exacerbations of multiple sclerosis, daily doses of 160 mg of triamcinolone for a week followed by 64 mg every other day for one month are recommended (see PRECAUTIONS: Neuro-Psychiatric).

In pediatric patients, the initial dose of triamcinolone may vary depending on the specific disease entity being treated. The range of initial doses is 0.11 to 1.6 mg/kg/day in 3 or 4 divided doses (3.2 to 48 mg/m²/day).

For the purpose of comparison, the following is the equivalent milligram dosage of the various glucocorticoids:

Cortisone, 25	*Triamcinolone, 4*
Hydrocortisone, 20	*Paramethasone, 2*
Prednisolone, 5	*Betamethasone, 0.75*
Prednisone, 5	*Dexamethasone, 0.75*
Methylprednisolone, 4	

These dose relationships apply only to oral or intravenous administration of these compounds. When these substances or their derivatives are injected intramuscularly or into joint spaces, their relative properties may be greatly altered.

LOCAL

Intra-articular administration: A single local injection of triamcinolone acetonide is frequently sufficient, but several injections may be needed for adequate relief of symptoms.

Initial dose: 2.5 mg to 5 mg for smaller joints and from 5 mg to 15 mg for larger joints, depending on the specific disease entity being treated. For adults, doses up to 10 mg for smaller areas and up to 40 mg for larger areas have usually been sufficient. Single injections into several joints, up to a total of 80 mg. have been given.

Administration

GENERAL

STRICT ASEPTIC TECHNIQUE IS MANDATORY. The vial should be shaken before use to ensure a uniform suspension. Prior to withdrawal, the suspension should be inspected for clumping or granular appearance (agglomeration). An agglomerated product results from exposure to freezing temperatures and should not be used. After withdrawal, Kenalog-40 Injection should be injected without delay to prevent settling in the syringe. Careful technique should be employed to avoid the possibility of entering a blood vessel or introducing infection.

SYSTEMIC

For systemic therapy, injection should be made deeply into the gluteal muscle (see WARNINGS). For adults, a minimum needle length of 1½ inches is recommended. In obese patients, a longer needle may be required. Use alternative sites for subsequent injections.

LOCAL

For treatment of joints, the usual intra-articular injection technique should be followed. If an excessive amount of synovial fluid is present in the joint, some, but not all, should be aspirated to aid in the relief of pain and to prevent undue dilution of the steroid.

With intra-articular administration, prior use of a local anesthetic may often be desirable. Care should be taken with this kind of injection, particularly in the deltoid region, to avoid injecting the suspension into the tissues surrounding the site, since this may lead to tissue atrophy.

In treating acute nonspecific tenosynovitis, care should be taken to ensure that the injection of the corticosteroid is made into the tendon sheath rather than the tendon substance. Epicondylitis may be treated by infiltrating the preparation into the area of greatest tenderness.

HOW SUPPLIED

Kenalog®-40 Injection (triamcinolone acetonide injectable suspension, USP) is supplied in vials providing 40 mg triamcinolone acetonide per mL.

40 mg/mL, 1 mL vial	NDC 0003-0293-05
40 mg/mL, 5 mL vial	NDC 0003-0293-20
40 mg/mL, 10 mL vial	NDC 0003-0293-28

Storage

Store at controlled room temperature, 20° to 25°C (68° to 77°F); protect from temperatures below 20°C (68°F). Store vial in carton to protect from light. Store vial upright.

Bristol-Myers Squibb Company
Princeton, NJ 08543 USA

[print code] Revised: June 2018

Ask the Experts

Documenting Vaccination

Documenting Vaccination

Is there any plan to change the Influenza Vaccine Information Statement (VIS) for the 2017–2018 influenza season?

The current influenza vaccine VIS may be used for the 2017–2018 influenza season. No changes are planned.

In the past, CDC has recommended to only accept patient-reported history for influenza and pneumococcal polysaccharide vaccines. Is the recommendation to not accept a patient-reported history of pneumococcal conjugate vaccine?

ACIP's recently published "General Best Practice Guidelines for Immunization" still states that a patient's undocumented history can be accepted as proof of vaccination only for influenza and pneumococcal polysaccharide vaccines. See https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/programs.html. CDC intends to collect data to determine if patients can distinguish between the two pneumococcal vaccines, or if records should be sought for all pneumococcal vaccines.

Where can I find a list of vaccines currently licensed for use in the U.S.?

CDC maintains a list of vaccine names at www.cdc.gov/vaccines/vpd/vaccines-list.html.

When we are giving multiple injections in a limb, what is the best way to accurately document the injection site?

One way to handle this is to indicate if the vaccination was given either in the "upper" or "lower" portion of the injection area selected (e.g., DTaP: right thigh, upper; Hib: right thigh, lower; or PCV13: left thigh, upper; HepB: left thigh, lower). It is helpful if everyone in your office or clinic uses the same sites for each vaccine. Use of a standardized site map can facilitate this. Here are some helpful site maps for different ages so you can record where shots were given:

For infants and toddlers: www.eziz.org/assets/docs/IMM-718.pdf

For adults: www.eziz.org/assets/docs/IMM-718A.pdf

We frequently see patients, such as immigrants, who do not have records of past vaccination or who insist they or their children are up to date. Should we accept their undocumented vaccination history?

Vaccination providers frequently encounter people who do not have adequate documentation of vaccinations. Providers should only accept written, dated records as evidence of vaccination. With the exception of influenza and pneumococcal polysaccharide vaccines, self-reported doses of vaccine without written documentation should not be accepted. An attempt to locate missing records should be made whenever possible by contacting previous healthcare providers, reviewing state or local immunization information systems, and searching for a personally held record. However, if records cannot be located or will definitely not be available anywhere because of the patient's circumstances, people without adequate documentation should be considered susceptible and should be started on the age-appropriate vaccination schedule. Serologic testing for immunity is an alternative to vaccination for certain antigens (e.g., measles, rubella, or hepatitis A).

In general, although it is not ideal, receiving extra doses of vaccine poses no medical problem. Receiving excessive doses of tetanus toxoid (DTaP, DT, Tdap, or Td) can increase the risk of a local adverse reaction, however. For details, consult the ACIP's Best Practice Guidelines for Immunization chapter titled Timing and Spacing of Immunobiologics, available at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html.

We sometimes encounter patients with foreign vaccination records. We suspect that some of these records are not valid. What should we do?

If a provider suspects an invalid vaccination, including those from persons vaccinated outside the U.S., one of two approaches can be taken. Repeating the vaccinations is an acceptable option. Doing so is generally safe and avoids the need to obtain and interpret serologic tests. If avoiding unnecessary injections is desired, judicious use of serologic testing might be helpful in determining which immunizations are needed. This may be particularly helpful in determining tetanus and diphtheria antitoxin levels for children whose records indicate 3 or more doses of DTP or DTaP. This issue is discussed in detail in the ACIP's General Best Practice Guidelines for Immunization chapter titled Special Situations, available at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/special-situations.html.

Where can I find names of vaccines used outside the U.S.?

Appendix B of the CDC publication Epidemiology and Prevention of Vaccine-Preventable Diseases ("The Pink Book") contains a list of vaccines used outside the U.S. You'll find Appendix B at www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/foreign-products-tables.pdf.

Since the Health Insurance Portability and Accountability Act (HIPAA) went into effect, we are unsure if we can share immunization information on our pediatric patients with staff in schools or daycare facilities.

Healthcare providers (or other covered entities) may share immunization information with schools or daycare facilities, without authorization, if permitted or required by state law. These state laws would not be preempted by the HIPAA Privacy Rule [45 CFR 160.203(c)].

If a patient or parent refuses recommended vaccinations, is it necessary for them to sign a refusal form, or is the provider's documentation sufficient?

There is no federal law requiring such documentation. Several major medical organizations, including the American Academy of Pediatrics, have stated that healthcare providers may decide it is in their best interest to formally document a parent's refusal to accept vaccination for their (minor) child. To read a discussion on this topic and to access a prototype refusal form, see "Decision to not vaccinate my child" that can be accessed at www.immunize.org/catg.d/p4059.pdf.

How can I find out if our state or locality has an Immunization Information System (IIS), or registry, in which I might participate?

To find out the status of the IIS in your state you should contact your state IIS manager. CDC maintains a listing of contact information for all state IIS managers at www.cdc.gov/vaccines/programs/iis/contacts-registry-staff.html.

If my state has an Immunization Information System (IIS, or registry) do I still need to give the patient a vaccine record card?

Yes. Patient-held cards are an extremely important part of a person's medical history. The person may move to an area without a registry, and the personal record may be the only vaccination record available. In addition, even within a state, all healthcare providers may not participate in the registry, and the personal record card would be needed.

Please explain the federal requirements for all healthcare providers that administer vaccines under the National Childhood Vaccine Injury Act.

The National Childhood Vaccine Injury Act (NCVIA), enacted in 1986, set forth 3 basic requirements for all vaccination providers, which are:

- Providers must give the patient (or parent/legal representative of a minor) a copy of the relevant federal "Vaccine Information Statement" (VIS) for the vaccine they are about to receive.
- Providers must record certain information about the vaccine(s) administered in the patient's medical record or a permanent office log.
- Providers must document any adverse event following the vaccination that the patient experiences and that becomes known to the provider, whether or not it is felt to be caused by the vaccine, and submit the report to the Vaccine Adverse Event Reporting System (VAERS).

What do we legally need to record when giving an immunization to a patient?

It is important to know the federal requirements for documenting the vaccines administered to your patients. The requirements are defined in the National Childhood Vaccine Injury Act enacted in 1986. The law applies to all routinely recommended childhood vaccines, regardless of the age of the patient receiving the vaccines. The only vaccines not included in this law are pneumococcal polysaccharide, zoster, and certain infrequently used vaccines, such as rabies and Japanese encephalitis.

The following information must be documented on the patient's paper or electronic medical record or on a permanent office log:

1. The vaccine manufacturer.
2. The lot number of the vaccine.
3. The date the vaccine is administered.
4. The name, office address, and title of the healthcare provider administering the vaccine.
5. The Vaccine Information Statement (VIS) edition date located in the lower right corner on the back of the VIS. When administering combination vaccines, all applicable VISs should be given and the individual VIS edition dates recorded.
6. The date the VIS is given to the patient, parent, or guardian.

The federally required information should be both permanent and accessible.

Federal law does not require a parent, patient, or guardian to sign a consent form in order to receive a vaccination; providing them with the appropriate VIS(s) and answering their questions is sufficient under federal law.

Which vaccines are covered by NCVIA?

NCVIA requirements apply to diphtheria, tetanus, pertussis, measles, mumps, rubella, polio, hepatitis A, hepatitis B, Haemophilus influenzae type b (Hib), varicella, seasonal influenza (inactivated and live attenuated), pneumococcal conjugate, meningococcal, rotavirus, and human papillomavirus (HPV) vaccine.

When and to whom is it required to give Vaccine Information Statements (VISs)?

The National Childhood Vaccine Injury Act requires that a VIS must be given to parents, legal representatives, or adult patients before administering the vaccine. A VIS must be provided prior to each dose, not just the first dose. Providers should be sure they are using the most current version of each VIS. Current VISs and their dates are available from on the CDC's website at www.cdc.gov/vaccines/hcp/vis/index.html and from IAC's website at www.immunize.org/vis.

Where can I get instructions on how, why, and when to use the federally-mandated VISs?

Instructions on the use of VISs and many additional items are available on the CDC website at www.cdc.gov/vaccines/hcp/vis/index.html or from your state immunization program. You can also visit IAC's website at www.immunize.org/vis for links to many important documents about the use of VISs.

When are VISs released for new vaccines?

An interim VIS can sometimes be released soon after licensure of the vaccine or after the official vote by ACIP is taken. The interim VIS is not replaced with a final version until the ACIP recommendations have been published and the new VIS has been developed according to legally-mandated procedures.

Is it required to use a VIS in an emergency room when we give Td/Tdap to a patient?

Yes. The National Childhood Vaccine Injury Act requires that a VIS be given to people of any age before they receive a dose of any vaccine included in the Act. Tetanus and diphtheria toxoids (and pertussis vaccine) are included in the Act. If the patient is unaccompanied and unable to clearly read and understand the information in the VIS (e.g., the patient is unconscious), this should be noted in the patient's chart.

Does the federal law that requires providing patients with VISs apply when administering influenza vaccine to employees and volunteers in hospitals or other workplaces?

Yes. Employees and volunteers are considered patients, and you need to provide them with a VIS. If a vaccine is covered under the National Childhood Vaccine Injury Act—and almost all vaccines routinely administered to adults are (with the exception of PPSV and zoster)—it is mandatory under federal law to give the VIS for that vaccine to the patient. So when you give influenza vaccine to employees and staff, you are required by law to provide them with a VIS.

You can find more details about the requirements for using VISs at www.cdc.gov/vaccines/hcp/vis/about/required-use-instructions.html. For VISs in multiple languages, go to www.immunize.org/vis.

Our large pediatric practice is struggling with the requirement to provide VISs to the parents of every child we vaccinate. We would like to create a re-usable packet of laminated VIS sheets (fastened together on a ring). We plan to place a packet in each exam room for parents to read prior to vaccine administration. On the bottom of each sheet would be a statement, "If you would like a copy of this sheet to take home, please ask our staff." This will ensure that parents are given the VIS sheets to read prior to vaccine administration. It will also help save paper. Our experience is that many parents throw out the VIS documents or leave them behind in the waiting room. Is this an acceptable procedure?

Many clinicians are looking for ways to reduce paper use. Your solution will meet the spirit of the federal law, as long as you make sure to encourage the patient (or parent) to take home a paper copy of the VIS and to refer to it if needed (e.g., if they need to know what to do if there is an adverse event or how to contact VAERS).

We operate an acute care hospital and commonly give vaccinations to our employees and patients. Are we required to use VISs, or does that apply only to patients seen in outpatient settings?

VISs must be given to all people, including adults, before administering HPV, Td, Tdap, MMR, varicella, hepatitis A, hepatitis B, meningococcal, influenza, or polio vaccine. Current VISs are available from the CDC's website at www.cdc.gov/vaccines/hcp/vis/index.html and from the Immunization Action Coalition's (IAC) website at www.immunize.org/vis. You'll also find many VIS translations on IAC's website at www.immunize.org/vis.

When using VISs and providing vaccines, is a parent/guardian signature required?

No. There is no federal requirement for signed consent for any dose of vaccine. The federal requirement is to provide all adult patients or parents/legal representatives of minor children with the appropriate VIS for each dose of vaccine administered. Federal law also requires that you record the date you gave the VIS to the patient or minor child's parent/legal representative and the edition date of the VIS, among other items, in the patient's medical record. Some clinics, agencies, and/or state immunization programs may have requirements for signatures. Contact information for your state health department is available at www.immunize.org/coordinators.

Where can I get VISs for some of the newer combination vaccines?

CDC currently has no plans to develop VISs for Pediarix, Twinrix, Kinrix, or Pentacel. When administering these combination vaccines, use the VISs for all component vaccines. For certain combination vaccines given to children, you can use the multi-vaccine VIS and check the appropriate box(es), just as you would if you were administering the individual vaccines. If the multi-vaccine VIS is unavailable, you should use the individual vaccine VISs. A VIS was developed for MMRV vaccine because of its unique adverse reaction profile.

It seems CDC is changing the format of VISs. Do we have to throw our old supply away and use the new ones?

Not necessarily. CDC is in the process of re-releasing all VISs in a slightly modified format. The modified VISs have a consistent look and use consistent language in the sections common to all VISs. Modified VISs will not necessarily be new, but may simply be redesigned versions of existing VISs and have the

Evaluating Medical Decision-Making Capacity in Practice

Craig Barstow, MD; Brian Shahan, MD; and Melissa Roberts, MD

Womack Army Medical Center, Fort Bragg, North Carolina

Medical decision-making capacity is the ability of a patient to understand the benefits and risks of, and the alternatives to, a proposed treatment or intervention (including no treatment). Capacity is the basis of informed consent. Patients have medical decision-making capacity if they can demonstrate understanding of the situation, appreciation of the consequences of their decision, and reasoning in their thought process, and if they can communicate their wishes. Capacity is assessed intuitively at every medical encounter and is usually readily apparent. However, a more formal capacity evaluation should be considered if there is reason to question a patient's decision-making abilities. Such reasons include an acute change in mental status, refusal of a clearly beneficial recommended treatment, risk factors for impaired decision making, or readily agreeing to an invasive or risky procedure without adequately considering the risks and benefits. Any physician can evaluate capacity, and a structured approach is best. Several formal assessment tools are available to help with the capacity evaluation. Consultation with a psychiatrist may be helpful in some cases, but the final determination on capacity is made by the treating physician. If a patient is found not to have capacity, a surrogate decision maker should be identified and consulted. If the patient is unable to give consent and identifying a surrogate decision maker will result in a delay that might increase the risk of death or serious harm, physicians can provide emergency care without formal consent. (*Am Fam Physician*. 2018;98(1):40-46. Copyright © 2018 American Academy of Family Physicians.)

Informed consent involves providing patients with accurate and adequate information about the risks, benefits, and alternatives of a treatment in a manner that is free from coercion. It also requires that patients have medical decision-making capacity. Medical decision-making capacity has four key elements. Patients must be able to (1) demonstrate understanding of the benefits and risks of, and the alternatives to, a proposed treatment or intervention (including no treatment); (2) demonstrate appreciation of those benefits, risks, and alternatives; (3) show reasoning in making a decision; and (4) communicate their choice.[1,2]

Capacity differs from competence. Although the terms are often used interchangeably, competence is a legal term that is determined by the court system, whereas capacity is a medical term that is determined by the treating physician. According to their strict definitions, lack of competence refers to global decision-making impairment (e.g., finances, property, wills), whereas lack of capacity refers to the inability to make decisions about proposed medical treatments and other aspects of care. Capacity can vary with circumstance; for example, a patient can have the capacity to make small, straightforward decisions such as consenting to take a new medication, but may lack the capacity to consent to a high-risk abdominal surgery.[3]

Generally, a patient's capacity is readily apparent, and physicians intuitively assess capacity at every medical visit. Because the four elements of capacity (understanding, appreciation, reasoning, and communication) are built into everyday dialogue and interactions, it can be assumed that patients have the capacity to make medical decisions if their conversation demonstrates basic logic. However, a patient's capacity may come into question if the dialogue does not proceed in a logical fashion, if there are abrupt changes in the patient's mental status, or if the patient refuses an obviously beneficial treatment, has a risk factor for impaired decision making (*Table 1*[3-5]), or readily agrees to an invasive or risky procedure without discussing or considering the risks and benefits.[3] If the physician has doubts about a patient's ability to make a decision, a

CME This clinical content conforms to AAFP criteria for continuing medical education (CME). See CME Quiz on page 18.

Author disclosure: No relevant financial affiliations.

SORT: KEY RECOMMENDATIONS FOR PRACTICE

Clinical recommendation	Evidence rating	References
A structured approach should be used when assessing a patient's decision-making capacity. This should include an assessment of any language or communication barriers interfering with the patient's understanding; identification and treatment of any reversible causes of incapacity; a directed interview to assess the elements of consent; and, if needed, the use of a formal tool to assess capacity and cognition.	C	3, 7, 8
Use of a formal assessment tool such as the Aid to Capacity Evaluation improves accuracy in determining a patient's decision-making capacity.	C	2, 8
Use of a standard cognitive assessment instrument is helpful in assessing for capacity when patients score at the extremes of the scale (very high score favors capacity and very low score favors incapacity).	C	2, 15

A = consistent, good-quality patient-oriented evidence; B = inconsistent or limited-quality patient-oriented evidence; C = consensus, disease-oriented evidence, usual practice, expert opinion, or case series. For information about the SORT evidence rating system, go to https://www.aafp.org/afpsort.

more formal evaluation of capacity should be undertaken. The results can either give the physician confidence to adhere to the patient's wishes or, if a lack of capacity is indicated, to take steps to restrict the patient's autonomy in order to prevent unintended and irreparable harm.

Prevalence

Physicians tend to underdiagnose lack of capacity in their patients. An analysis of eight studies showed that physicians could identify only 42% of patients with incapacity as determined by a formal evaluation.[2] It is not clear whether underdiagnosis is the result of physicians' inability to recognize incapacity or their reluctance to make the diagnosis.

Knowing the prevalence of incapacity in various populations may raise awareness by helping physicians determine the pretest probability. In populations with a higher pretest probability, physicians should be more alert for incapacity and more readily consider performing a capacity evaluation. The prevalence of incapacity in healthy older adults is estimated at 2.8%.[6] However, the prevalence is higher in other patient populations: inpatients on a medical ward have an incapacity prevalence of 26%, and those with Alzheimer disease (considering those at all stages) have a prevalence of 54%.[6] The highest rate (68%) is among persons with learning disabilities.[6]

Evaluation

INITIAL STEPS

The causes of incapacity are numerous, and the thought of restricting a patient's autonomy can be intimidating. A stepwise approach to evaluation is recommended.[3,7,8]

The first step is to ensure that there are no communication barriers impairing the patient's ability to understand information and communicate with the physician. These might include physical barriers, such as hearing and vision impairments, dysarthria, or dysphagia.[9] Language barriers may also be present, including the use of medical jargon that can confuse patients and cause "pseudo-incapacity."[2] Jargon and complicated explanations can also cause confusion, but further inquiry and rewording can improve their understanding and allow them to make informed decisions.

If there are no communication barriers, the next step is to evaluate for reversible causes of incapacity, such as infection, medication adverse effects, illicit drug use, hypoxia, metabolic derangements, acute neurologic and psychiatric disorders, delirium, and critical illness. The third step is to consider the patient's values and culture; these can weigh heavily on his or her decision and may cause some physicians to question capacity. A Jehovah's Witness who refuses a blood transfusion is a classic example of a value-based decision that should be honored as long as the patient demonstrates the four elements of capacity.

TABLE 1

Risk Factors for Impaired Medical Decision-Making Capacity

Acknowledged fear of or discomfort with institutional health care setting
Age < 18 years
Age > 85 years
Chronic neurologic condition
Chronic psychiatric condition
Low education level
Significant cultural or language barrier

Information from references 3 through 5.

DIRECTED CLINICAL INTERVIEW

If no communication barriers or reversible causes of incapacity are identified, the next step is a capacity assessment with a quick and informal directed clinical interview. This process can help determine whether the patient demonstrates the four elements of capacity. *Table 2* provides suggested questions to use in evaluating these four elements.[3] When evaluating a patient's responses to these questions, keep in mind that patients do not have to make the "right" choice; they need only to demonstrate a rational examination of pertinent information in arriving at their decision.[10] A high burden of proof is needed to restrict autonomy. Therefore, if the evaluation indicates that the patient's understanding and rationale are adequate, that generally establishes capacity, even though someone else in the patient's situation might make a different decision.[11]

FORMAL CAPACITY ASSESSMENT TOOLS

If the directed interview does not clearly demonstrate capacity, or if additional information is required, the use of a formal assessment tool is the next step. Several tools are available to evaluate capacity, and each has a unique approach. Common assessment tools include the Aid to Capacity Evaluation (ACE; *Figure 1*[3]), the Hopkins Competency Assessment Test (HCAT; available at http://criminal-justice.iresearchnet.com/forensic-psychology/hopkins-competency-assessment-test-hcat), the Understanding Treatment Disclosure, and the MacArthur Competence Assessment Tool for Treatment.[12]

The ACE is a formal, directed, clinical interview that objectively assesses the four elements of capacity. It is widely used and considered the best available online tool. It comes with instructions and is specific to each medical decision. The ACE was validated in a large study that showed that a positive evaluation had a likelihood ratio of 8.5 for predicting decision-making incapacity.[2,8]

The HCAT is also quick and effective, but it evaluates for generalized incapacity rather than capacity to make specific decisions.[13] The HCAT can be helpful if there is concern about the need to transfer decision-making authority to a surrogate, but it is not as helpful if the goal is evaluating for capacity in a specific clinical scenario.

If uncertainty about capacity remains after an evaluation using the ACE, HCAT, or other instrument, consultation with another clinician can be considered. Consultation with a psychiatrist can be particularly helpful and is prudent if the patient has a history of schizophrenia or other psychiatric or delusional disorder. However, the final determination of the patient's capacity should be made by the treating physician.

COGNITIVE TESTING

Assessing cognition can be useful but is not required to determine capacity. The Mini-Mental State Examination (available at https://www.uml.edu/docs/Mini%20Mental%20State%20Exam_tcm18-169319.pdf) and the Montreal Cognitive Assessment (available at http://www.mocatest.org)

TABLE 2

Questions to Ask During an Evaluation of Medical Decision-Making Capacity

Questions to determine the patient's ability to understand treatment and care options
What is your understanding of your condition?
What are the options for your situation?
What is your understanding of the benefits of treatment, and what are the odds that the treatment will work for you?
What are the risks of treatment, and what are the odds that you may have a side effect or bad outcome?
What is your understanding of what will happen if nothing is done?
Questions to determine the patient's ability to appreciate how that information applies to his or her own situation
Tell me what you really believe about your medical condition.
Why do you think your doctor has recommended (specific treatment/test) for you?
Do you think (specific treatment/test) is best for you? Why or why not?
What do you think will actually happen to you if you accept this treatment? If you don't accept it?
Questions to determine the patient's ability to reason with that information in a manner supported by the facts and the patient's own values
What factors/issues are most important to you in deciding about your treatment? What are you thinking about as you consider your decision?
How are you balancing the pluses and minuses of the treatments?
Do you trust your doctor? Why or why not?
What do you think will happen to you now?
Questions to determine the patient's ability to communicate and express a choice clearly
You have been given a lot of information about your condition. Have you decided what medical option is best for you right now?
We have discussed several choices. What do you want to do?

Adapted with permission from Tunzi M. Can the patient decide? Evaluating patient capacity in practice. Am Fam Physician. 2001;64(2):301.

FIGURE 1

Name of patient: _____

Record observations that support your score in each domain, including exact responses of the patient. Indicate your score for each domain with a check mark.

1. Able to understand medical problem
(Sample questions: What problem are you having right now? What problem is bothering you most? Why are you in the hospital? Do you have [name problem here]?)
Observations: _____
☐ Yes ☐ Unsure ☐ No

2. Able to understand proposed treatment
(Sample questions: What is the treatment for [your problem]? What else can we do to help you? Can you have [proposed treatment]?)
Observations: _____
☐ Yes ☐ Unsure ☐ No

3. Able to understand alternative to proposed treatment (if any)
(Sample questions: Are there any other treatments? What other options do you have? Can you have [alternative treatment]?)
Observations: _____
☐ Yes ☐ Unsure ☐ No ☐ None disclosed

4. Able to understand option of refusing proposed treatment (including withholding or withdrawing proposed treatment)
(Sample questions: Can you refuse [proposed treatment]? Can we stop [proposed treatment]?)
Observations: _____
☐ Yes ☐ Unsure ☐ No

5. Able to appreciate reasonably foreseeable consequences of accepting proposed treatment
(Sample questions: What could happen to you if you have [proposed treatment]? Can [proposed treatment] cause problems/side effects? Can [proposed treatment] help you live longer?)
Observations: _____
☐ Yes ☐ Unsure ☐ No

6. Able to appreciate reasonably foreseeable consequences of refusing proposed treatment (including withholding or withdrawing proposed treatment)
(Sample questions: What could happen if you don't have [proposed treatment]? Could you get sicker/die if you don't have [proposed treatment]? What could happen if you have [alternative treatment]? [If alternatives are available])
Observations: _____
☐ Yes ☐ Unsure ☐ No

Note: for questions 7a and 7b, a yes answer means the person's decision is affected by depression or psychosis.

7a. The person's decision is affected by depression.
(Sample questions: Can you help me understand why you've decided to accept/refuse treatment? Do you feel that you're being punished? Do you think you're a bad person? Do you have any hope for the future? Do you deserve to be treated?)
Observations: _____
☐ Yes ☐ Unsure ☐ No

7b. The person's decision is affected by delusion/psychosis.
(Sample questions: Can you help me understand why you've decided to accept/refuse treatment? Do you think anyone is trying to hurt/harm you? Do you trust your doctor/nurse?)
Observations: _____
☐ Yes ☐ Unsure ☐ No

continues

Aid to Capacity Evaluation assessment form.

FIGURE 1 *(continued)*

Overall impression

☐ Definitely capable ☐ Probably capable ☐ Probably incapable ☐ Definitely incapable

Comments

(For example: need for psychiatric assessment, further disclosure and discussion with patient, or consultation with family)

The initial ACE assessment is the first step in the capacity assessment process. If the ACE is definitely or probably incapable, consider treatable or reversible causes of incapacity (e.g., drug toxicity). Repeat the capacity assessment once these factors have been addressed. If the ACE result is probably incapable or probably capable, then take further steps to clarify the situation. For example, if you are unsure about the person's ability to understand the proposed treatment, then a further interview that specifically focuses on this area would be helpful. Similarly, consultation with family, cultural and religious figures, and/or a psychiatrist may clarify some areas of uncertainty.

Never base a finding of incapacity solely on your interpretation of domain 7a and 7b. Even if you are sure that the decision is based on a delusion or depression, you should always get an independent assessment.

Time taken to administer ACE: Minutes: _____

Date: Day: _____ **Month:** _____ **Year:** _____ **Hour:** _____

Assessor: _____

Instructions for scoring

1. Domains 1-4 evaluate whether the person understands his or her current medical problems, the proposed treatment, and other options (including withholding or withdrawing treatment). Domains 5 and 6 evaluate whether the person appreciates the consequences of his or her decision (see sample questions above).
2. For domains 1-6, if the person responds appropriately to open-ended questions, score yes. If the patient needs repeated prompting by close-ended questions, score unsure. If the patient cannot respond appropriately despite repeated prompting, score no.
3. For domain 7, if the person appears depressed or psychotic, then decide if the decision is being affected by the depression or psychosis. For domain 7a, if the person appears depressed, determine if the decision is affected by depression. Look for the cognitive signs of depression such as hopelessness, worthlessness, guilt, and punishment. For domain 7b, if the person may be psychotic, determine if the decision is affected by delusion/psychosis.
4. Record observations that support your score in each domain, including exact responses of the patient.
5. Remember that people are presumed capable. Therefore, for your overall impression, if you are uncertain, then err on the side of calling a person capable.

From reference 3.

are two tools that are commonly used to evaluate cognition. They can be helpful in evaluating capacity when patients score at the extremes of the scoring scale.[14] For example, patients who score less than 20 on the 30-point Mini-Mental State Examination are 6.3 times more likely to have incapacity, whereas patients who score 25 or higher are unlikely to have incapacity (likelihood ratio = 0.14).[2] Similarly, the 30-point Montreal Cognitive Assessment has been shown to predict incapacity. In one study of 90 patients with Parkinson disease, a score of less than 22 had a 94% sensitivity and 90% specificity for identifying incapacity.[15]

FINAL DECISION

Determining that a patient lacks capacity and restricting his or her autonomy require clear and convincing evidence that the patient's decision will cause unintended and irreparable harm. If there is uncertainty after conducting a full capacity evaluation, the final judgment should err on the patient's side.[4,16,17] Each state has its own definition of capacity. Although laws are similar among states and incorporate the four elements of capacity, there may be slight differences. Thus, if an evaluation leads to a diagnosis of incapacity and legal proceedings are involved, consultation with a medical attorney is prudent.

Surrogate Decision Makers

If a physician determines that a patient does not have the capacity to make a treatment decision, consent for treatment must be obtained from other sources. If the patient has an advance directive applicable to the clinical situation, it should be used to guide decisions. If not, the physician should determine whether the patient has designated a medical power of attorney. If there is no valid medical power of attorney, the closest relative usually becomes the surrogate. The priority of relatives varies by state, but the typical order is spouse, adult children, parents, siblings, and other relatives.

Up to 16% of patients in intensive care units do not have a known relative or medical power of attorney, so a court-appointed health fiduciary is an option.[18] If the patient is not able to give consent and delaying care to identify a surrogate will increase the risk of death or serious harm, the physician can provide emergency care without formal consent under the assumption that a reasonable person would have consented to the treatment.[4]

Documentation

When performing a capacity assessment, it is important to document the evaluation in the medical record. Exact responses to the questions are helpful, along with a brief summary of the interview. If a formal assessment tool is used, it should be included in the medical record. Ultimately, the clinician must document the rationale used in determining the patient's capacity.[3]

Clinical Application

CASE 1

An 88-year-old woman who lives alone presents to the emergency department after a fall. Her sodium level is 120 mEq per L (120 mmol per L), and she is admitted to the hospital. Her outpatient records show that she has not refilled her heart failure medications in more than six months. On day 3 of hospitalization, she states that she is feeling better and wants to go home. Physical examination reveals global muscle weakness and inability to get out of bed without assistance. The inpatient team recommends transfer to a rehabilitation facility, but the patient refuses.

CASE 2

A 56-year-old man with schizophrenia is brought to the emergency department by his brother. He has a large, nonhealing ulcer on his left lower leg that is obviously infected. His brother reports that the patient has diabetes mellitus and stopped taking his medications six months ago. On examination, the patient demonstrates disorganized thinking and describes auditory hallucinations. He refuses treatment and says the government is trying to kill him.

CASE DISCUSSION

Case 1 is an example of a patient who may understand her situation and treatment options, but may not appreciate the consequences of her decision. If she is discharged home, where she lives by herself, she will not be able to perform activities of daily living. She does not realize that this will lead to harm. From this informal assessment, she seems to lack appropriate decision-making capacity. A formal assessment using the ACE will likely confirm this conclusion. If she continues to insist on hospital discharge, steps can be taken to involve family members or other surrogate decision makers to arrive at a decision that will be acceptable to the patient and is appropriate for her safety.

Case 2 is an example of poor reasoning due to psychiatric illness. The patient cannot synthesize complex data to make an informed decision; therefore, he lacks decision-making capacity. Psychiatric consultation should be obtained and appropriate treatment instituted.

This article updates a previous article on this topic by Tunzi.[3]

Data Sources: A literature search was performed in PubMed using the terms capacity and evaluating capacity. We also searched the National Guideline Clearinghouse and the Cochrane database. Search date: January 2017.

The opinions or assertions contained herein are the private views of the authors and are not to be construed as official or as reflecting the views of the Department of Defense.

The Authors

CRAIG BARSTOW, MD, is program director of the hospital medicine fellowship at Womack Army Medical Center, Fort Bragg, N.C., and an assistant professor of family medicine at the Uniformed Services University of the Health Sciences, Bethesda, Md.

BRIAN SHAHAN, MD, is a hospital medicine fellow at Womack Army Medical Center.

MELISSA ROBERTS, MD, is a faculty member in the Family Medicine Department at Womack Army Medical Center.

Address correspondence to Craig Barstow, MD, Womack Army Medical Center, 2817 Reilly Rd., Fort Bragg, NC 28310 (e-mail: craig.h.barstow.mil@mail.mil). Reprints are not available from the authors.

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Croup

Candice L Bjornson, David W Johnson

Most children who present with acute onset of barky cough, stridor, and chest-wall indrawing have croup. A careful history and physical examination is the best method to confirm the diagnosis and to rule out potentially serious alternative disorders such as bacterial tracheitis and other rare causes of upper-airway obstruction. Epinephrine delivered via a nebuliser is effective for temporary relief of symptoms of airway obstruction. Corticosteroids are the mainstay of treatment and benefit is seen in children with all levels of severity of croup, including mild cases.

Lancet 2008; 371: 329–39

Departments of Paediatrics, Faculty of Medicine, University of Calgary, Calgary, AB, Canada (C L Bjornson MD, D W Johnson MD)

Correspondence to:
Dr David W Johnson, Child Health Research Group, Alberta Children's Hospital, 2888 Shaganappi Trail NW, Calgary, AB, Canada T3B 6A8
David.Johnson@CalgaryHealthRegion.Ca

Croup is a common childhood disease characterised by sudden onset of a distinctive barky cough that is usually accompanied by stridor, hoarse voice, and respiratory distress resulting from upper-airway obstruction. Although most children with croup are deemed to have a mild and short-lived illness, the distress and disruption that families undergo is well known. Perhaps this upset is because of the nature of croup: the presentation is so unusual and frightening and predominantly affects young children, with symptoms that are usually worse during the early hours of the morning. Historically, before the advent of treatment with corticosteroids and racemic epinephrine for severe croup, intubation, tracheotomy, and death were typical outcomes. Treatment has evolved from barbaric methods including bleeding and application of leeches, through mist kettles (pot of boiling water), mist rooms, and mist tents, to the current evidence-based practice of corticosteroids and epinephrine delivered via nebuliser.[1]

Many unanswered questions linger. Why are croup symptoms worse at night? What predisposes some children to severe croup and others to a mild barky cough? What accounts for the stubbornly predictable biannual peak in the occurrence of croup? Is the cause of croup evolving as new viral triggers are identified? Is bacterial tracheitis a new emerging complication of croup? In this Seminar, we summarise the most current published work about the epidemiology, diagnosis, and management of this important childhood disease and propose future research pathways for exploration.

Epidemiology, clinical course, and pathophysiology

Croup is one of the most frequent causes of acute respiratory distress in young children. The disease mainly affects those aged between 6 months and 3 years old, with a peak annual incidence in the second year of life of nearly 5%.[1] However, croup does occur in babies as young as 3 months old and in adolescents.[2] Although rare, adults can also develop croup symptoms.[3] Boys are more susceptible than girls to the disorder, with an overall male/female preponderance of 1·4/1.[2] In North America, croup season peaks in late autumn (September to December), but cases are recognised throughout the year, even during the summer.[2] In odd-numbered years, the number of children admitted with croup during the peak season is about 50% more than during even-numbered years,[4] which closely correlates with the prevalence of parainfluenza virus infection in the community (North America).

Symptom onset is typically abrupt and most usually happens at night, heralded by the appearance of a very characteristic and distinctive barky cough. Stridor, hoarse voice, and respiratory distress are seen frequently, as a result of upper-airway obstruction. These symptoms are frequently preceded by non-specific upper-respiratory-tract symptoms for 12–48 h before development of the barky cough and difficulty breathing. Croup symptoms are generally short-lived, with about 60% of children showing resolution of their barky cough within 48 h.[5] However, a few children continue to have symptoms for up to 1 week.[1]

Croup symptoms nearly always become worse during night-time hours, and in our experience they fluctuate in severity depending on whether the child is agitated or calm.[1] We do not know why croup symptoms tend to worsen at night, but a physiologically plausible explanation might lie with the known circadian fluctuations in endogenous serum cortisol, concentrations of which peak at about 0800 h and reach a trough between 2300 h and 0400 h.[6,7] In asthma, another frequent respiratory disease in which night-time symptoms generally prevail, postulated mechanisms include detrimental effects of nocturnal airway cooling, gastro-oesophageal reflux, and increased tissue inflammation in addition to the effect of endogenous plasma cortisol and epinephrine cycling.[8] Perhaps similar physiological factors are at play in croup.

The symptoms of croup result from upper-airway obstruction caused by an acute viral infection, most

typically parainfluenza types 1 and 3.[1] Other viruses implicated in the disorder include influenza A, influenza B, adenovirus, respiratory syncytial virus, and metapneumovirus.[7-9] In published work, a strong association has been described between both human metapneumovirus and coronavirus HCoV-NL63 infection and croup in children.[8-11] Whether or not new pathogens are emerging is unknown. However, a likely possibility is that the increasing number of viruses seen in association with croup is merely a reflection of improvements in methods of detection. Work is ongoing to develop an effective vaccine against parainfluenza virus.[12,13]

Laryngeal diphtheria is a well-known historical cause of croup, the occurrence of which is now very rare in immunised populations. However, outbreaks of diphtheric croup have been reported in case series from Russia[14-16] and India.[17] Measles remains an important cause of croup in non-immunised children. Treatment with vitamin A has been assessed and reported to be effective for prevention of secondary infections, especially croup, in children with severe measles.[18,19] The rarity of croup associated with measles and diphtheria in immunised children suggests that substantial progress could be made in the developing world with continued aggressive immunisation programmes against these pathogens.

Infection with a recognised pathogen leads to generalised airway inflammation and oedema of the upper-airway mucosa, including the larynx, trachea, and bronchi, then epithelial necrosis and shedding.[20] Parainfluenza virus also activates chloride secretion and inhibits sodium absorption across the tracheal epithelium, contributing to airway oedema.[21] The subglottic region becomes narrowed and results in the barky cough, turbulent airflow and stridor, and chest-wall indrawing. Further narrowing can lead to asynchronous chest-wall and abdominal movement, fatigue, and eventually to hypoxia, hypercapnia, and respiratory failure.[20,21]

Why do some children develop severe symptoms or recurrent episodes of croup whereas others show only mild symptoms or can even be asymptomatic when faced with the same infection? Perhaps individual anatomy plays a part, since some children might have an intrinsically narrower subglottic space. Individual immune factors could be important too, with a range of severity of inflammatory response to infection. The peak incidence of croup at the age of 2 years is also somewhat unexplained and could be attributable to increased exposure to viral pathogens combined with the toddler's smaller subglottic space, leaving them at greater risk for airway narrowing. Current published work on these topics does not mention these questions.

Although the major concern for both clinicians and parents is the potential for severe respiratory distress, morbidity, and mortality,[4] most children have mild short-lived symptoms.[1] Of all children presenting to 24 general emergency departments in the province of Alberta, Canada, about 85% were classified as having mild croup and fewer than 1% as having severe croup (unpublished data). Even though most children have fairly mild symptoms, the sudden onset of croup symptoms during the night causes many parents to bring their child to an emergency department.[2,4,5] Consistent with these findings, fewer than 5% of children with croup are admitted to hospital in population-based studies.[2,3,6] Of those with croup who are admitted, 1–3% are intubated.[2,6,7] Mortality seems to be very rare. By extrapolation of data from several sources,[2,3,7] we estimate a mortality rate of about 1 in 30 000 cases.

Differential diagnosis

In a child presenting with classic signs and symptoms of croup, alternate diagnoses are uncommon (panel). However, clinicians must remain vigilant because other serious diseases can present with stridor and respiratory distress.

Panel: Differential diagnosis of croup

- Epiglottitis
- Bacterial tracheitis
- Foreign-body aspiration
  - Tracheal
  - Oesophageal
- Retropharyngeal abscess
- Peritonsillar abscess
- Angioneurotic oedema
- Allergic reaction
- Laryngeal diphtheria

Bacterial tracheitis is a serious, life-threatening bacterial infection that can arise after an acute, viral respiratory-tract infection.[4-6] The child usually has a mild-to-moderate illness for 2–7 days but then becomes acutely worse.[6] If they are febrile, have a toxic appearance (ie, look unwell and have reduced interaction with their environment), and do not respond favourably to treatment with nebulised epinephrine, bacterial tracheitis should be considered.[4,5,7,8] Treatment includes close monitoring of the airway and broad-spectrum intravenous antibiotics, because intubation and respiratory support might be needed during the early stages of treatment when thick tracheal secretions can occlude the airway. The most frequently isolated pathogen is *Staphylococcus aureus*, but others include group A streptococcus, *Moraxella catarrhalis*, *Streptococcus pneumoniae*, and *Haemophilus influenzae*.[4,5,7,8,22] Anaerobic bacteria have also been cultured from tracheal secretions of children with tracheitis.[4]

A second potentially life-threatening alternate diagnosis is epiglottitis. This disease is now seen rarely owing to widespread immunisation against *H influenzae* B.[4,23] The sudden onset of high fever, drooling,

dysphagia, anxiety, and a preference to sit upright and in the so-called sniffing position (ie, sitting forward with their head extended) to open the airway should prompt consideration of epiglottitis, as should a cough that does not have the characteristic barking sound of croup.[28] In the case of possible epiglottitis or bacterial tracheitis, the most important aspect of treatment is maintenance of a secure airway by a doctor highly skilled in airway management.

Other very rare causes of stridor that should be considered in children presenting with atypical croup symptoms include foreign-body aspiration in the upper airway or oesophagus, peritonsillar or retropharyngeal abscess, angio-oedema, and laryngeal diphtheria.[29] In the case of foreign-body aspiration, onset is usually sudden with no prodrome or fever (unless secondary infection occurs). Hoarseness and barking cough are usually absent. Dysphagia could be present and stridor is noted variably. Children who have stridor secondary to the presence of a foreign body usually present with a clear history of ingestion.[29] Peritonsillar or retropharyngeal abscess could present with dysphagia, drooling, stridor, dyspnoea, tachypnoea, neck stiffness, and unilateral cervical adenopathy, and a lateral neck radiograph can show posterior pharyngeal oedema and retroflexed cervical vertebrae.[4] Acute angioneurotic oedema or allergic reaction can present at any age and with rapid onset of dysphagia and stridor and possible cutaneous allergic signs such as urticarial rash. Children might have a history of allergy or previous attack.[29] Laryngeal diphtheria has arisen historically in people of all ages, and a record of inadequate immunisation can be seen. Usually, a prodrome of pharyngitis symptoms is noted and onset is gradual over 2–3 days. Low-grade fever is present, hoarseness and barking cough occur along with dysphagia and inspiratory stridor, and the characteristic membranous pharyngitis is seen on physical examination.[29]

Diagnosis and ancillary testing

Croup is a clinical diagnosis. Key features include acute onset of a seal-like barky cough, stridor, hoarseness, and respiratory distress.[29] Children might have fever, occasionally reaching a temperature as high as 40°C;[29] however, they should not drool nor appear toxic. Laboratory tests are not needed to confirm the diagnosis in a child presenting with the typical clinical features of croup, but if tests are judged necessary they should be deferred if the child is in respiratory distress.[4] Notably, rapid antigen tests and viral cultures do not aid in the routine acute management of a child with croup.[4]

Similarly, radiological studies are not recommended in a child who has a typical history of croup and who responds appropriately to treatment.[4] Radiographs are not indicated if there is a clinical picture of epiglottitis or bacterial tracheitis. In children in whom the diagnosis is uncertain, however, an anteroposterior and lateral soft-tissue neck radiograph can be helpful in supporting an alternative diagnosis.[29] If radiographs are obtained, however, epiglottitis is suggested by a thickened epiglottis and aryepiglottic folds.[29,30] A retropharyngeal abscess is indicated by bulging soft tissue of the posterior pharynx.[29] Bacterial tracheitis can manifest as a ragged tracheal contour or a membrane spanning the trachea.[29,30,31] However, radiographs can also be completely normal in children with these diagnoses.[31] If radiographs are justified by an atypical clinical picture, the child must be closely monitored during imaging by skilled personnel with appropriate airway management equipment, because airway obstruction can worsen rapidly.

Cardiorespiratory monitoring, including continuous pulse oximetry, is indicated in children with severe croup but it is not necessary in mild cases.[4] Also, children without severe croup could occasionally have low oxygen saturation, presumably as a result of intrapulmonary involvement of their viral infection; thus, ongoing assessment of overall clinical status is important.[4,6]

Assessment of severity

Determination of disease severity relies on clinical assessment. Various proposed methods for objective assessment of respiratory distress in children with croup are either impractical or insensitive to change across the full range of disease severity.[32,33] Consequently, in clinical trials of treatment effectiveness, outcome measures have mainly included clinical scores and health-care use.[4,11] Although such scores are useful for research studies, none has been shown to enhance routine clinical care, at least in part, because they are not reliable when used by a wide range of clinicians.[32] Features useful in routine clinical assessment of children with croup as outlined in the figure.

General care

General consensus is that children with croup should be made as comfortable as possible, and clinicians should take special care during assessment and treatment not to frighten or upset them because agitation causes substantial worsening of symptoms.[4] Sitting the child comfortably in the lap of a parent or caregiver is usually the best way to lessen agitation.[4]

Although we could not find any published evidence that oxygen should be administered to children who are showing signs of respiratory distress, widespread consensus indicates that oxygen treatment is beneficial in this circumstance.[4,34,35] Oxygen can generally be administered without causing the child to be agitated via a plastic hose with the opening held within a few centimetres of the nose and mouth (referred to as blow-by oxygen).[4]

Humidified air

Treatment of croup with humidified air is not effective, despite its long history of use. Humidification of air is

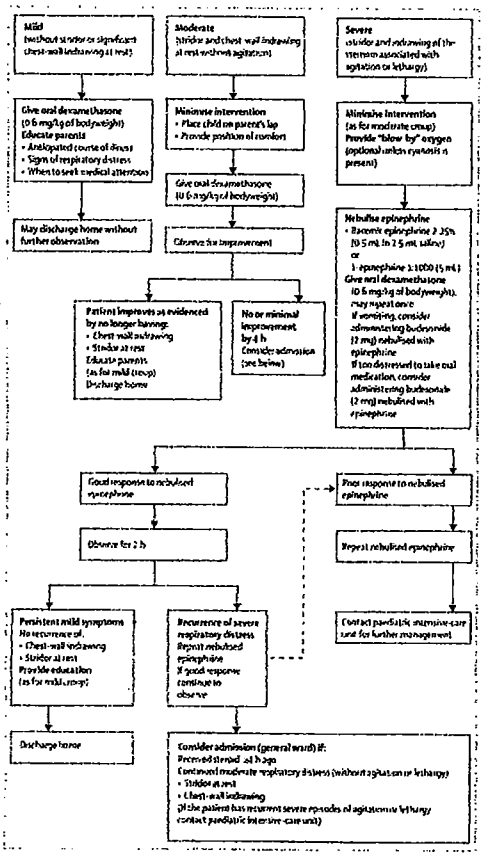

Figure: Algorithm for management of croup in the outpatient setting
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neither completely benign nor does it improve respiratory distress.[6,9,11,12,17] A systematic review of findings of three randomised controlled trials of humidified air treatment in emergency settings in a total of 135 children with mild-to-moderate croup concluded that there was no difference in croup score after such treatment.[6] This systematic review did not include a later randomised controlled trial of 140 children with moderate-to-severe croup in a paediatric emergency department who were randomised to three arms: traditional standard humidified blow-by oxygen; 40% humidified oxygen; or 100% humidified oxygen, with a particle size generated to target the larynx.[9] Measurement of humidified blow-by oxygen showed that this technique did not raise humidity above that of ambient room air, thus effectively serving as a placebo arm. The findings showed no difference in croup score, treatment with epinephrine or dexamethasone, or admission to hospital or additional medical care between the three groups.[9]

Apart from the lack of noted benefit, several potential difficulties with administration of humidified air have been identified. Hot humidified air can cause scald injuries;[9] mist tents can disperse fungus and moulds into the environment unless they are properly cleaned;[9] and most importantly, mist tents are cold and wet and separate the child from the parent, which usually causes them to be agitated and worsens their symptoms.[9]

Heliox

Helium is an inert low-density gas with no inherent pharmacological or biological effects. Administration of helium-oxygen mixture (heliox) to children with severe respiratory distress can reduce their degree of distress since the lower density helium gas (*vs* nitrogen) decreases airflow turbulence through a narrow airway. Heliox was compared with racemic epinephrine in a prospective randomised controlled trial of 29 children with moderate-to-severe croup who had received treatment with humidified oxygen and intramuscular dexamethasone.[9] Clinical outcomes included a clinical croup score, oxygen saturation, and heart and respiratory rates. Both heliox and racemic epinephrine were associated with similar improvements in croup score over time.[9] Findings of a second prospective, randomised, double-blind controlled trial in 15 children with mild croup presenting to an emergency department indicated a trend towards greater improvement in a clinical croup score in the heliox group versus the oxygen-enriched air group, although the scores did not differ significantly.[9]

However, since heliox has yet to be shown to offer greater improvements than standard treatments and can be difficult to use in unskilled hands, there is insufficient reason to recommend its general use in children with severe croup.[9,43] Furthermore, there are practical limitations to heliox use, including limited fractional concentration of inspired oxygen in a child with significant hypoxia.

Pharmacotherapy

In this next section, we will review the use of two conventional treatments, corticosteroids and epinephrine,

[illegible]

and several other categories of drugs, such as antipyretics, analgesics, antibiotics, β agonists, and decongestants. The rationale for review of this latter group of drugs is that, although these treatments are not recommended, they are sometimes used in children with croup.[44]

Corticosteroids

Corticosteroids have a long history of use in childre[n] with croup; evidence for their effectiveness for treatment of croup is now clear (tables 1–4). Children with severe croup and impending respiratory failure who are treated with corticosteroids have about a fivefold reduction in the rate of intubation;[46] if they are intubated, they remain ventilated for about a third less time and have a sevenfold lower risk for reintubation than patients not treated with these drugs.[47] In moderate-to-severe croup patients who are treated with corticosteroids, an average 12-h reduction in the length of stay in the emergency department or hospital, a 10% reduction in the absolute proportion treated with nebulised epinephrine, and a 50% reduction for both the number of return visits and admissions for treatment.[48]

Compared with children not treated with corticosteroids, those with mild croup who are treated with these drugs are 30% less likely to return for medical care because of ongoing symptoms and lose 30% less sleep during the course of their illness, and their parents report less stress than do parents of children not treated with corticosteroids.[49] Treatment with these drugs also yields small but clinically important societal economic benefits (family and health-care system), resulting in a total saving of CAN$21 per child.[50] The benefits of treating children with mild croup arise irrespective of the duration of the child's symptoms or severity of illness.[49]

To date, no adverse effects have been associated with use of corticosteroids in children with croup.[51] However, difficulties arise when attempting to identify and prove that rare adverse effects arise with any drug treatment; thus, remaining vigilant about this possibility is important.

Route of administration

The best route of administration of corticosteroids in children with croup has been investigated extensively.

	Patients (n)	Croup severity	Setting	Route of administration and medication	Primary outcome	Results
Bjornson (2004)[49]	720	Mild	Emergency department	Oral dexamethasone vs placebo	Return to medical care within 7 days	Reduction (7% vs 15%, p<0·001)
Geelhoed (1996)[52]	100	Mild	Emergency department	Oral dexamethasone vs placebo	Return to medical care within 7–10 days after study treatment	Reduction (0% vs 37%, p<0·01)
Johnson (1998)[53]	144	Moderate to severe	Emergency department	Nebulised budesonide/intramuscular dexamethasone vs placebo	Rate of admission	Reduction ([illegible] vs 67%, p<0·001)
Tibballs (1992)[54]	70	Respiratory failure or intubated	Intensive-care unit	Oral prednisolone vs placebo	Duration of intubation	Reduction (median 98 vs 138 h, p<0·003)
Geelhoed (1995)[55]	80	Moderate to severe	Admitted to hospital	Nebulised budesonide or oral dexamethasone vs placebo	Duration of admission	Reduction ([illegible] vs 20 h, p<0·03)
Klassen (1994)[56]	54	Mild to moderate	Emergency department	Nebulised budesonide vs placebo	Clinical croup score at 4 h	Improvement (18% vs 6%, p=0·005)

Table 2: Selected randomised controlled trials of corticosteroid versus placebo in the treatment of croup

NSBME 063

	Patients (n)	Croup severity	Setting	Route of administration	Primary outcome	Results
Nebulised vs oral or intramuscular administration						
Geelhoed (1995)[47]	80	Moderate to severe	Admitted children	Nebulised budesonide Oral dexamethasone	Duration of admission	No difference between budesonide (33 h) and dexamethasone (33 h vs 32 h)
Johnson (1998)[48]	144	Moderate to severe	Emergency department	Nebulised budesonide Intramuscular dexamethasone	Rate of admission	No difference between dexamethasone and budesonide (17% vs 35%; p=0·18)
Klassen (1998)[49]	198	Moderate	Emergency department	Oral dexamethasone vs nebulised budesonide vs oral dexamethasone vs nebulised budesonide	Clinical croup score at 4 h	No difference between groups (p=0·79)
Oral vs intramuscular administration						
Rittichier (2000)[51]	277	Moderate	Emergency department	Intramuscular vs oral dexamethasone	Return to medical care	No difference between groups (intramuscular 32%, oral 25%, p=0·198)
Donaldson (2003)[50]	96	Moderate to severe	Emergency department	Intramuscular vs oral dexamethasone	Croup symptom resolution at 24 h	No difference between groups (intramuscular 2%, oral 8%)
Amir (2006)[52]	52	Mild to moderate	Emergency department	Intramuscular dexamethasone vs oral betamethasone (note: investigator aware of study treatment)	Clinical croup score at 4 h	No difference between groups (p=0·18)

Table 3: Selected randomised controlled trials of corticosteroid treatment of croup by route of administration

	Patients (n)	Croup severity	Corticosteroid and dose	Route of administration	Primary outcome	Results
Elliott (2007)[53]	95	Mild to moderate	Dexamethasone 0·15 or 0·6 mg/kg, or prednisolone 1 mg/kg	Oral	Change in clinical croup score at 4 h	No difference between groups (p=0·479)
Geelhoed (1995)[47]	120	Moderate	Dexamethasone 0·15, 0·30, or 0·60 mg/kg	Oral	Median duration of admission	No difference between groups (9 h in 0·15 mg/kg, 7 h in 0·30 mg/kg, 8 h in 0·6 mg/kg)
Alshehri (2006)[54]	72	Moderate	Dexamethasone 0·15 or 0·60 mg/kg	Oral	Change in clinical croup score at 12 h	No difference between groups (p=0·15)
Chub-Uppsalam (2007)[55]	41	Moderate to severe	Dexamethasone 0·15 or 0·60 mg/kg	Intravenous	Change in clinical croup score at 12 h	No difference between groups (p=0·40)

Table 4: Comparison of dosing in selected randomised controlled trials of corticosteroid treatment of croup

The oral or intramuscular route is either equivalent or superior to inhalation.[47,48,50,51] The addition of inhaled budesonide to oral dexamethasone in children admitted with croup did not confer any additional advantage.[49]

In two trials in which oral and intramuscular administration of dexamethasone were compared, no difference was recorded in resolution of croup symptoms,[51] return for medical care,[51,52] admission to hospital,[51,52] or further treatment with corticosteroid or epinephrine.[52] Findings of a study comparing intramuscular dexamethasone to oral betamethasone noted no difference in reduction of croup score after treatment, hospital admission, time to symptom resolution, or return for medical care.[50]

Studies in which corticosteroids have been administered orally have mainly incorporated dexamethasone. Two comparator studies have been published of oral agents in the treatment of croup. In the first, one oral dose of prednisolone was compared with dexamethasone, and the findings showed superiority of dexamethasone in reducing rates of return for medical care.[53] In the second study, oral dexamethasone was compared with oral prednisolone; no difference was noted in reduction of croup score or rates of return for medical care.[54] A more practical consideration could be that oral dexamethasone is associated with less vomiting than oral prednisone, a substantial advantage.[54]

Practical issues should also be considered. For instance, for a child with persistent vomiting, the inhaled or intramuscular route for drug delivery might be preferable. In cases of severe respiratory distress, oral administration could be more difficult for the child to tolerate than an intramuscular dose. In a child with hypoxia, decreased gut and local tissue perfusion can impair absorption via the oral or intramuscular route, respectively. In these cases, the inhaled route should be considered and would also allow for administration of oxygen or racemic epinephrine concurrently. The cost of each treatment route should also be thought about.

Drug dosing

With respect to dosing of corticosteroids, two important questions should be asked. First, is one dose of dexamethasone sufficient or will several be required? Second, what is the appropriate size of dexamethasone dose: 0·15 mg/kg, 0·30 mg/kg, or 0·60 mg/kg?

We did not find any randomised trials via our literature search in which single and multiple doses of corticosteroids were compared. Published randomised trials of the effectiveness of corticosteroids are roughly split in terms of using either one dose or several. Theoretically, since most children's croup symptoms resolve within 72 h, and the speculated duration of

anti-inflammatory effect of dexamethasone is 2–4 days,[95] the necessity of a second dose would seem unlikely in most children with the disorder.

The conventional dose of dexamethasone is deemed to be 0·60 mg/kg. Alternatively, doses of 0·30 and 0·15 mg/kg have been proposed. Conflicting evidence for dose size is provided by a meta-analysis and the findings of four randomised trials. In the meta-analysis of six studies of children admitted to hospital, the higher the dose of hydrocortisone equivalents used the higher the proportion of children who responded to corticosteroid treatment compared with placebo.[96] However, since the design of all included studies differed, the possibility of bias exists. On the other hand, four other studies in which different doses of oral dexamethasone were compared have been published; a range of croup severity and both inpatient and outpatient settings were included (table 4).[96–99] None of the trials was designed as a non-inferiority study and all had small sample sizes; none of the four studies showed a significant difference in primary outcome measures between corticosteroid dose sizes. The findings of these four randomised controlled trials suggest a dose of 0·15 mg/kg might be adequate whereas the systematic review meta-analysis of six studies indicates a higher dose could provide greater benefit in children with more severe disease.[96]

Risks of corticosteroids

Although steroid treatment of children with croup is generally known to be safe, potential concerns exist with respect to possible adverse events. First, children treated with steroids after exposure to varicella virus can have an increased risk of developing complications of varicella, such as disseminated disease or bacterial superinfection. Published case-control studies addressing this issue have yielded conflicting results. Whereas in one study, an increase in risk of complicated varicella in immunocompetent children treated with steroids was noted,[100] in another this finding was not seen.[101] The US Food and Drug Administration, the American Academy of Pediatrics, and the American Academy of Allergy and Immunology advise caution in the use of steroids in children who have been exposed to varicella virus.[102–104] On a related issue, there is potential concern that corticosteroid use could prolong viral shedding; however, we were unable to find evidence that addresses this issue.

With steroid treatment, potential complications that have yet to be proven include bacterial tracheitis,[34,37] pneumonia, and gastrointestinal bleeding.[36,105–107] Bacterial tracheitis has been proposed to be related to previously unsuspected immune dysfunction.[105] With respect to pneumonia, in a retrospective case review of 3577 immune-suppressed stem-cell transplant recipients, the most important factor associated with development of parainfluenza pneumonia was dose of corticosteroid at the time of infection acquisition.[106] Gastrointestinal bleeding would seem to be unlikely in otherwise healthy children, but it could be more of a concern in a child with severe disease who requires care in the intensive-care unit, endotracheal intubation, and repeated high doses of steroids.[107]

Epinephrine

In children with moderate-to-severe croup, treatment with epinephrine via a nebuliser has a long history and has been well studied (table 5). Using historical comparisons, the administration of epinephrine in children with severe croup has been reported to have reduced the number needing intubation or tracheotomy by a substantial amount.[108] Nebulised racemic epinephrine (2·25%), compared with placebo, improved croup scores within 10–30 min of initiation of treatment in three randomised controlled trials.[97–109] In a fourth placebo-controlled trial, a clear benefit was not recorded; however, this trial was not well-designed nor well-reported.[111] Objective pathophysiological measures of severity have also shown substantial improvement after epinephrine treatment in five prospective cohort studies.[95–97,112] Clinical effect is sustained for at least 1 h,[97–99,107,109,113] but it is essentially gone within 2 h of administration.[107] Reassuringly, as the effect of epinephrine wears off, the patient's symptoms return—on average—to their baseline severity and do not seem to worsen.[98,107] Combined data from five prospective clinical trials in outpatients treated with epinephrine and dexamethasone (or budesonide) who were observed for 2–4 h are also reassuring. Of 253 children, only 12 (5%) who were discharged home returned for care within 48–72 h and only six of these were admitted to hospital (2%). No children had adverse outcomes.[97,114–117] This prospectively derived data along with findings of two retrospective cohort studies provide favourable support for children to be safely discharged home after treatment with epinephrine, as long as their symptoms have not recurred within 2–4 h of treatment.[118,119]

The administration of one dose at a time of nebulised epinephrine to children has not been associated with any adverse effects nor a clinically significant increase in either heart rate or blood pressure.[95,97,107,108,113,116] The conclusions of a critical review of seven clinical trials of 238 children treated with nebulised epinephrine (1/1000, with 184 patients receiving doses of 3 mL or greater) for either croup or acute bronchiolitis noted that epinephrine was a safe treatment and identified only mild side-effects, including, most frequently, tachycardia and pallor.[111] One case report has been published of a previously healthy child with severe croup who developed ventricular tachycardia and myocardial infarction after treatment with three doses of epinephrine via nebuliser within 1 h.[112]

Racemic epinephrine has traditionally been used to treat children with croup. However, epinephrine 1/1000 is as effective and safe as the racemate form, as shown by

	Patients (n)	Croup severity	Epinephrine dose	Primary outcome	Results
Tarnig (1975)[95]	13	Moderate to severe	0·25–1·5 mL (by weight) of 2·25% epinephrine	Clinical croup score 10 min after treatment	Improvement (p=0·011)
Eriksson (1994)[96]	54	Mild to moderately severe	Racemic epinephrine (10 mg/mL) at 0·5 mg/kg	Clinical croup score 30 min after treatment	Greater improvement in epinephrine group (p=0·003)
Westley (1978)[97]	20	Moderate	0·5 mL of 2·25% epinephrine	Clinical croup score 10, 30, and 120 min after treatment	Greater improvement in epinephrine group at 10 and 30 min (p=0·01); No difference at 120 min

Table 2: Selected randomised controlled trials of nebulised epinephrine versus placebo in the treatment of croup

findings of a randomised trial in 31 children aged 6 months to 6 years with moderate-to-severe croup.[118] In most studies, the same dose has been used in all children irrespective of size (0·5 mL of 2·25% racemic epinephrine or 5·0 mL of epinephrine 1/1000). Data derived from use of aerosolised medications in lower-airway disease supports this approach, in that the effective dose of drug delivered to the airway is regulated by every individual's tidal volume.[119–126]

Analgesics, antipyretics, antibiotics, antitussives, decongestants, and short-acting β2 agonists

We retrieved no controlled trials of the effectiveness of any of these drugs in the treatment of croup with our literature search. The use of analgesics or antipyretics is reasonable for the benefit of reduction of fever or discomfort in children with croup.[64,65,127] Most types of croup have a viral cause. Although so-called superinfections, such as bacterial tracheitis and pneumonia, are described, the rare frequency (<1 per 1000 cases of croup) makes use of prophylactic antibiotics unreasonable.[64,65,127] No physiologically rational basis exists for use of antitussives or decongestants, and they should not be administered to children with croup.[64,65,42] Similarly, in view of the pathophysiology of croup as an upper-airway disease, there is no clear reason to use short-acting β2 agonists for treatment of the disease.[64,65,42]

Indications for admission and discharge from medical care

Although most children with croup can be managed safely as outpatients, little published evidence is available to guide clinicians as to which individuals should be admitted to hospital.[40,117,128] Data from a retrospective cohort of 527 children admitted to Royal Children's Hospital, Melbourne, for persistent stridor at rest (before routine treatment with corticosteroids) showed that those with persistent sternal indrawing at presentation to an emergency department had a 6% risk for endotracheal intubation, whereas those without sternal and chest-wall indrawing recovered rapidly without any specific treatment.[118] In a study comparing dexamethasone with placebo,[6] recorded reductions in admissions in the dexamethasone-treated group were first noted 3 h later, with increasing differences shown up to 10 h after treatment. The rate of admission in the dexamethasone-treated group was half that of those given placebo. This finding suggests that observation in an emergency department for at least 3 h, and ideally up to 10 h after treatment with corticosteroid, would reduce admission rates, presumably as the beneficial effects of corticosteroids become evident with time. In a published report looking at length of stay in the emergency department and admission, a substantial reduction was recorded in admissions after implementation of a clinical pathway mandating 6 h of observation in the emergency department after corticosteroid treatment before a child with croup was admitted to hospital.[129] Based on this evidence and combined with expert opinion, the Alberta Medical Association clinical pathway committee has developed and implemented the management algorithm outlined in the figure.[40]

Conclusion

After 50 years of controversy, corticosteroids have been firmly established as the treatment of choice for children with croup. Although comparatively fewer reports have been published on epinephrine, sufficient data exist to support the drug's role in short-term symptom relief until corticosteroids take effect. Conversely, after more than a century of use, definitive evidence is available to show the ineffectiveness of mist. Apart from heliox, no new therapeutic interventions are on the horizon. Nonetheless, corticosteroids and epinephrine have greatly reduced health-care use and enhanced outcomes in children with croup.

Although effective treatment for croup is well-established, several mysteries remain unexplained with respect to the cause and pathophysiology of the disease. Exploration of these questions could ultimately yield novel and even more effective treatments or vaccines.

Conflict of interest statement

We declare that we have no conflicts of interest. DJ received an unrestricted research grant in 1993 from Astra Pharma, Mississauga, ON, Canada, to undertake a randomised controlled trial comparing nebulised budesonide, intramuscular dexamethasone, and placebo for moderately severe croup.[6]

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Chapter 15. Intramuscular, Subcutaneous, and Intradermal Injections

Renee Dietz, RN; Sandra M. Sanguino, MD, MPH

Intramuscular Injection

Indications

- Administration of medications or immunizations.
- Immunizations commonly administered intramuscularly include the following:
- Diphtheria.
- Tetanus and pertussis.
- *Haemophilus influenzae* type b.
- Hepatitis A.
- Hepatitis B.
- Pneumococcal conjugate.
- Influenza.

Contraindications

Relative

- Known bleeding disorder or thrombocytopenia.
- Erythema or swelling at the injection site.

Equipment

- Alcohol wipe.
- Gauze pad.

• Syringe with medication or immunization.

• Appropriate size needle.

• Bandage.

Risks

• Pain, swelling, bleeding, or infection at the injection site.

Pearls and Tips

• It may be necessary to enlist the help of a second person to hold the child.

Patient Preparation

• Position the child and assess the injection site.

• Clean the injection site with an alcohol wipe.

Anatomy Review

• In infants and toddlers, it is recommended that intramuscular injections be given in the middle one-third of the lateral aspect of the vastus lateralis muscle (anterolateral upper thigh).

• In older children, intramuscular injections are given in the deltoid muscle.

• The ventrogluteal site can be used in children over age 2. This site is used less commonly because of the risk of nerve damage.

Procedure

• Pinch muscle and quickly insert 1-inch 23- or 25-gauge needle at a 90-degree angle (Figure 15–1).

• Larger adolescents and adults may require the use of a 1.5-inch needle.

• Aspirate to check for possible blood vessel entry.

• Aspirate for at least 5 seconds.

• This ensures that the needle is not in a small blood vessel.

• If blood is obtained, withdraw the needle, discard the medication and syringe, and start again.

• If blood is not obtained, slowly inject the medication.

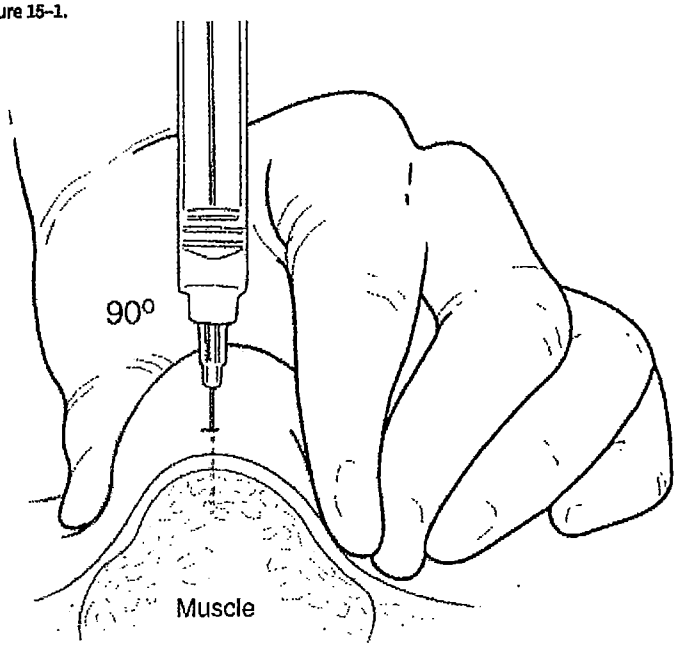
• Do not recap the needle.

• Dispose of the needle in the proper container.

• Apply pressure to the injection site with a gauze pad.

• Apply bandage and comfort the child.

Figure 15–1.



Intramuscular injection.

Monitoring

• Watch the patient for any reaction to the medication.

Complications

• Bleeding, pain, or swelling at the injection site.

Subcutaneous Injection

Indications

• Administration of medications or immunizations.

• Immunizations commonly administered subcutaneously include the following:

• Inactivated polio.

• Measles, mumps, and rubella.

Contraindications

Relative

• Erythema or swelling at the injection site.

Equipment

• Alcohol wipe.

• Gauze pad.

• Syringe with medication or immunization.

• Appropriate size needle.

• Bandage.

Risks

• Pain, swelling, bleeding or infection at the injection site.

• Lipohypertrophy or lipoatrophy may develop after repeated injections.

Pearls and Tips

• A second person may be necessary to help hold the child.

Patient Preparation

• Position the child and assess the injection site.

• Clean the injection site with an alcohol wipe.

Anatomy Review

• In infants and toddlers, it is recommended that subcutaneous injections be given in the outer aspect of the upper thigh.

• For older children, the upper outer arm is the preferred spot.

Procedure

• Gently pinch the skin at the injection site.

• Insert a 25- or 27-gauge ⅝-inch needle into the subcutaneous layer.

• The needle should be directed at a 45-degree angle (Figure 15–2).

• Aspirate to check for entry into a blood vessel.

• If blood is obtained, withdraw the needle, discard the medication and syringe, and start again.

• If blood is not obtained, slowly inject the medication.

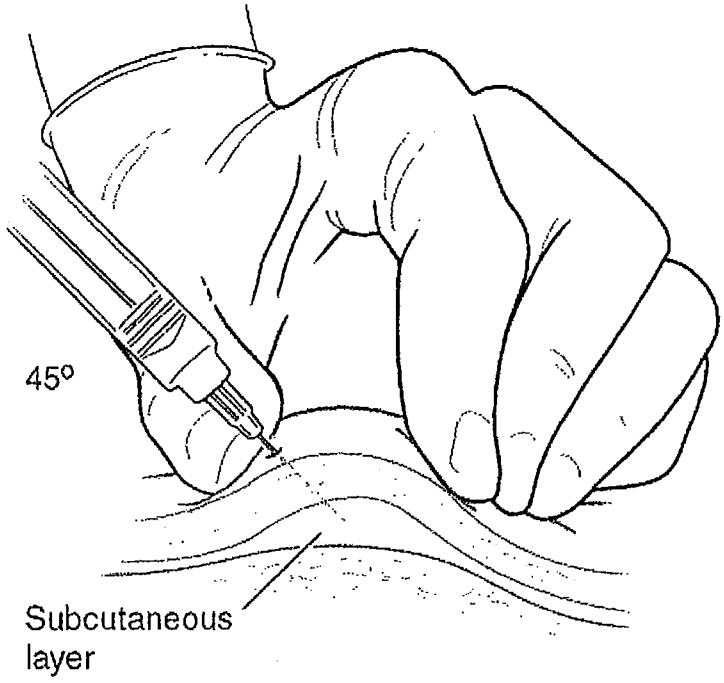
• Do not recap the needle.

• Dispose of the needle in the proper container.

• Apply pressure to the injection site with a gauze pad.

• Apply bandage and comfort the child.

Figure 15–2.



Subcutaneous injection.

Monitoring

• Watch the patient for any reaction to the medication.

Complications

• Bleeding, pain, or swelling at the injection site.

Intradermal Injection

Indications

• Medication administration.

• Placement of a tuberculosis skin test (purified protein derivative [PPD]).

Contraindications

• Erythema at the proposed injection site.

Equipment

• Alcohol wipe.

• Gauze pad.

• Syringe with medication or immunization.

• Appropriate size needle.

Risks

• Pain, swelling, bleeding, or infection at the injection site.

Pearls and Tips

• A second person may be necessary to help hold the child.

Patient Preparation

• Locate the injection site.

• Clean the site with an alcohol wipe.

Anatomy Review

• The most common site for intradermal injections is the inner lower arm.

• Other possible sites include the upper chest and the back (between the scapulae).

Procedure

• Hold the skin tautly with the syringe bevel up at a 15-degree angle to the skin.

• Use a 0.5-inch 27-gauge needle.

• Insert the needle just below the surface of the skin of the forearm (Figure 15–3).

• The needle should go through the epidermis into the dermis.

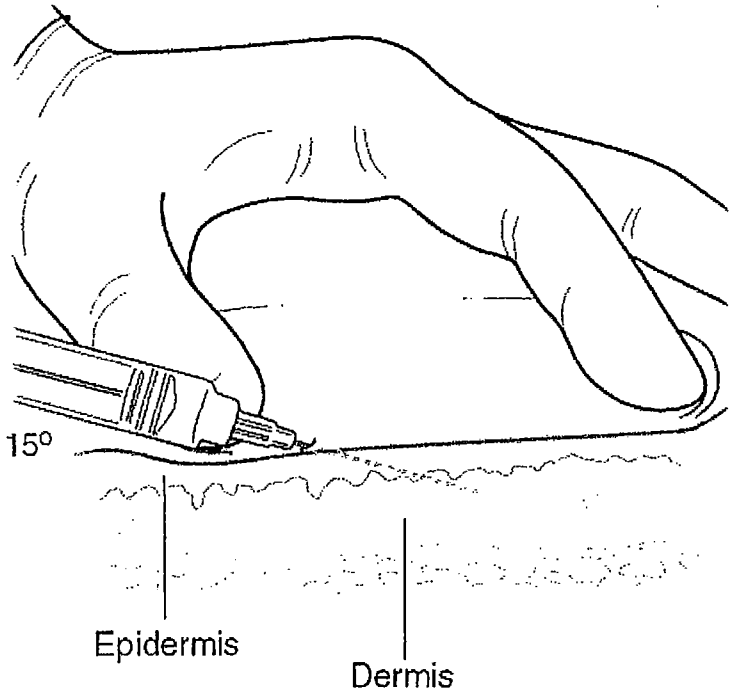
• Slowly inject the fluid.

• The medication should form a small bleb under the skin.

• Do not recap the needle.

• Dispose of the needle in the proper container.

Figure 15–3.



Intradermal injection.

Monitoring

• Watch the patient for any reaction to the medication.

Complications

• Bleeding, pain, or swelling at the injection site.

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Musculoskeletal Injections: A Review of the Evidence

MARK B. STEPHENS, CDR, MC, USN; ANTHONY I. BEUTLER, MAJ, USAF, MC; and FRANCIS G. O'CONNOR, COL, MC, USA, *Uniformed Services University of the Health Sciences, Bethesda, Maryland*

Injections are valuable procedures for managing musculoskeletal conditions commonly encountered by family physicians. Corticosteroid injections into articular, periarticular, or soft tissue structures relieve pain, reduce inflammation, and improve mobility. Injections can provide diagnostic information and are commonly used for postoperative pain control. Local anesthetics may be injected with corticosteroids to provide additional, rapid pain relief. Steroid injection is the preferred and definitive treatment for de Quervain tenosynovitis and trochanteric bursitis. Steroid injections can also be helpful in controlling pain during physical rehabilitation from rotator cuff syndrome and lateral epicondylitis. Intra-articular steroid injection provides pain relief in rheumatoid arthritis and osteoarthritis. There is little systematic evidence to guide medication selection for therapeutic injections. The medication used and the frequency of injection should be guided by the goal of the injection (i.e., diagnostic or therapeutic), the underlying musculoskeletal diagnosis, and clinical experience. Complications from steroid injections are rare, but physicians should understand the potential risks and counsel patients appropriately. Patients with diabetes who receive periarticular or soft tissue steroid injections should closely monitor their blood glucose for two weeks following injection.
(*Am Fam Physician.* 2008;78(8):971-976.

Injections have been an important adjunct for the management of musculoskeletal disease for more than 50 years. As with any procedure, success depends on knowing the right diagnosis (who to inject), performing the correct procedure (how to inject), and using the most appropriate pharmacologic agent (what to inject).

Who to Inject?

The most common indications for therapeutic injections are presented in *Table 1*. In general, injections can be within the joint space (intra-articular), around the joint space (periarticular), or within specific soft tissue structures. Injections can be used to definitively treat a condition, to provide a pain-free window for rehabilitative therapy (which is ultimately curative), or to provide episodic pain and symptom relief.

Injections for Definitive Treatment

DE QUERVAIN TENOSYNOVITIS

Corticosteroid injections are curative for de Quervain tenosynovitis, a common overuse tendon injury of the hand and wrist. Steroid injections provide the highest cure rate compared with nonsteroidal anti-inflammatory drug (NSAID) therapy, splinting, or combination therapy.[1,2] A pooled analysis of seven observational studies found that steroid injection alone was curative in 83 percent of cases compared with splinting alone (14 percent), rest (0 percent), or NSAID therapy (0 percent).[2] Most patients are symptom free after a single injection, and injection for the treatment of de Quervain tenosynovitis is safe during pregnancy, postpartum (when the incidence increases), and while breastfeeding.[3]

TROCHANTERIC BURSITIS

Trochanteric bursitis is the second leading cause of hip pain in adults. Trochanteric steroid injection is simple, safe, diagnostic, and usually therapeutic.[4] Patients treated with a steroid-anesthetic injection report rapid and prolonged improvement of pain and disability,[5] often after a single injection. A retrospective cohort study comparing treatments for trochanteric bursitis showed a 2.7-fold increase in the number of patients who were pain free five years after a single corticosteroid injection compared with those who did not receive an injection.[6]

Because it is safe, simple, and effective, physicians should offer steroid injection as

SORT: KEY RECOMMENDATIONS FOR PRACTICE

Clinical recommendation	*Evidence rating*	*References*
Corticosteroid injection without splinting is the preferred initial treatment for de Quervain tenosynovitis.	B	1, 2
Corticosteroid injection for trochanteric pain is safe and highly effective. With trochanteric pain, satisfactory pain relief often is achieved with a single corticosteroid injection.	C	4, 5
Subacromial corticosteroid injection provides short-term pain relief that is greater than placebo and at least equal to nonsteroidal anti-inflammatory drug therapy.	B	9, 11, 12
Corticosteroid injection reduces short-term (less than six weeks) symptoms from lateral epicondylitis, but physical therapy is superior to steroid injection after six weeks.	A	13, 15, 16
Intra-articular steroid injections reduce pain and swelling in osteoarthritis of the knee.	A	17
The addition of local anesthetics to steroid injections improves pain relief and can be used to differentiate local from referred pain.	C	30, 46, 47

A = consistent, good-quality patient-oriented evidence; B = inconsistent or limited-quality patient-oriented evidence; C = consensus, disease-oriented evidence, usual practice, expert opinion, or case series. For information about the SORT evidence rating system, go to http://www.aafp.org/afpsort.xml.

first-line treatment for trochanteric bursitis, particularly in older adults. Physical therapy modalities and NSAIDs are second-line agents for pain relief in patients with trochanteric bursitis. Therapeutic strengthening and stretching exercises are helpful for younger or more athletic patients and for those with recurrent symptoms.

INJECTION FOR PAIN CONTROL DURING REHABILITATION

Injected corticosteroids decrease swelling and reduce pain, permitting improved range of motion and facilitating rehabilitative and strengthening exercises that resolve many forms of tendinopathy or bursitis.[7-10]

SUBACROMIAL PAIN

Definitive treatment of subacromial pain (rotator cuff syndrome) always involves physical therapy to strengthen the rotator cuff. Shoulder pain prevents many patients from adequately performing rehabilitative exercises, carrying out activities of daily living, and obtaining uninterrupted sleep. Therefore, a common clinical dilemma is how to best control pain to allow for adequate rehabilitative physical therapy. Systematic reviews of treatments for subacromial pain, subacromial impingement, and rotator cuff syndrome favor corticosteroid injection over the following options: ergonomic changes, nonsteroidal drug therapy, acupuncture, range of motion and strengthening exercises, ultrasound, ice, heat, and physical therapy.[11,12] Subacromial injection is particularly helpful in differentiating between shoulder weakness caused by impingement (shoulder strength improves after injection) and a true rotator cuff tear (no change in strength is noted following injection).

LATERAL EPICONDYLITIS

Lateral epicondylitis (i.e., tennis elbow) is a common cause of elbow pain. Corticosteroid injection yields a predictable short-term (less than six weeks) decrease in pain[13,14] that is superior to nonsteroidal drug therapy[15] and physical therapy.[16] After six weeks, however, physical therapy reduces symptoms more than corticosteroid injection.[16] Therefore, corticosteroid injection should be reserved for patients whose symptoms limit participation in physical therapy or activities of daily living.

Table 1. Common Indications for Therapeutic Injections

Inflammatory arthritides
Adult and juvenile rheumatoid arthritis
Crystal-induced arthritis (gout, pseudogout)
Spondyloarthropathies (Reiter syndrome; psoriatic arthritis)
Noninflammatory arthritides
Osteoarthritis (most commonly of knee, distal interphalangeal, proximal interphalangeal, carpometacarpal and metatarsophalangeal joints)
Periarticular/soft-tissue injections*
Bursitis
Carpal tunnel syndrome
Epicondylitis
Tenosynovitis

**—Therapeutic injections can be used for other nonarticular conditions as well.*

Injection for Pain Relief: Arthritis

The most common indication for intra-articular injection is arthritis. For short-term treatment of osteoarthritis of the knee, intra-articular steroid injection improves function and reduces swelling and pain.[17] The onset of action is rapid (typically within 24 hours) and clinical effects last four to eight weeks. Repeated steroid injections for osteoarthritis of the knee are safe and do not accelerate disease progression.[18] Although steroid injections are effective for osteoarthritis of the hip,[19] technical challenges with this procedure preclude its routine use. Intra-articular corticosteroids are less effective for treating osteoarthritis of the thumb[20] and shoulder.[11]

Injection for Symptom Relief: Carpal Tunnel Syndrome

Carpal tunnel syndrome affects nearly 4 percent of the general population. Local corticosteroid injections provide greater symptom relief for one month after injection compared with placebo (number needed to treat [NNT] = 2) and oral corticosteroids. However, significant symptom relief after one month has not been demonstrated following injection.[21] Also, as many as one third of patients will improve spontaneously. Prospective data suggest that for patients who fail initial therapy with bracing or oral anti-inflammatory medications, clinical outcomes at one year are similar in patients treated with corticosteroid injections versus surgery.[22]

How Often to Inject?

Data from studies of patients with rheumatoid arthritis[23] suggest it is safe to perform multiple steroid injections on the same joint. The recommended interval between intra-articular injections is three months.[24] Injection frequency should be guided by the underlying disease process, the response to past injections, the availability of other treatment options, patient preferences, and clinical judgment.

What about Diabetes?

A clinical concern is the effect of steroid injection on blood glucose levels in patients with underlying diabetes. Single intra-articular steroid injections have little or no effect on glycemic control.[25] However, injection of soft tissues or peritendinous injections can cause elevations in blood glucose[26,27] that persist from five to 21 days. Patients with diabetes who undergo soft tissue injections require closer glycemic monitoring and follow-up in the weeks following the procedure.

How to Inject?

A series of articles reviewing the technical aspects of joint and soft-tissue–specific injections has been published in *American Family Physician*.[28-30] Contraindications to intra-articular injection are presented in *Table 2*. If the underlying diagnosis is unknown, aspiration and synovial fluid analysis should be performed for diagnostic purposes. Although ultrasound imaging can be used to direct or confirm injection location,[31] the use of standard anatomic landmarks results in correct needle placement in most uncomplicated cases.[32]

Informed consent should always be obtained before performing the procedure. Injections should be performed using aseptic technique. A 1.5 inch, 21-gauge needle is typically used to inject larger joints such as the knee or shoulder. Smaller (0.5 inch) 23- or 25-gauge needles suffice for smaller joints. The viscosity of some steroid preparations precludes injection through smaller-bore needles. To perform aspiration and injection consecutively, physicians can either use a reciprocating device[33] or the joint injection technique described in *Table 3*.

The most common complications of intra-articular injection are a postinjection flare of pain (2 to 10 percent), skin atrophy (1 percent), fat atrophy (1 percent), and facial flushing (less than 1 to 12 percent) *(Table 4)*.[34-36] Less commonly reported side effects include iatrogenic infection (risk of 1 in 1,000) and tendon rupture (less than 1 percent). The risk of tendon rupture is highest with soft tissue injections around the Achilles tendon and plantar fascia.[37]

What to Inject?

SELECTING CORTICOSTEROIDS

There is little systematic evidence to guide corticosteroid selection for therapeutic injections. Most recommendations are based on a combination of clinical experience

Table 2. Contraindications to Intra-Articular Injection

Broken skin at injection site
Known hypersensitivity to intra-articular agent
Osteochondral/intra-articular fracture
Prosthetic joint*
Severe joint destruction
Skin infection overlying injection site
Unstable coagulopathy

*—Relative contraindication.

Table 3. Joint Injection Procedure

Steps for combined intra-articular aspiration and injection

1. Determine indication for procedure.
2. Obtain informed consent; discuss risks, benefits, and alternatives with the patient.
3. Prepare equipment, including laboratory requests, needles, syringes, and medication.
4. Identify and mark the appropriate anatomic landmarks to guide needle placement.
5. Clean overlying skin using isopropyl alcohol (povidone iodine [Betadine] also can be used).
6. Use cooling spray or local anesthetic for patient comfort (as needed).
7. Select appropriate length and gauge of needle; judiciously guide needle into intra-articular space.
8. Gently aspirate fluid (procedure should not be painful).
9. Anchor needle with hemostat to prevent migration from the intra-articular space.
10. Remove aspirant syringe and replace with syringe containing steroid and/or anesthetic for injection.
11. Inject medication into the intra-articular space (fluid should move freely into the joint space); if resistance is met, try rotating or repositioning syringe to ensure that the needle is still in the correct space.
12. Remove needle and apply bandage.
13. Provide post-procedural counseling.

Table 4. Complications of Intra-Articular Steroid Injections

Complication	*Incidence (%)*
Joint effects	
Post-injection flare	2 to 10
Steroid arthropathy	0.8
Joint infection	< 0.001 to 0.072
Surrounding tissue effects	
Pericapsular calcification	43
Tendon rupture	< 1
Skin atrophy/depigmentation	< 1
Systemic effects	
Vasovagal reaction	10 to 20
Facial flushing	< 1
Hypersensitivity reaction	< 1

Information from references 34 through 36.

and personal preference. However, knowledge about the mechanism of action of individual steroids can guide steroid selection in various situations.

The clinical effects of steroids result from several different mechanisms of action. Intra-articular corticosteroids reduce synovial blood flow,[38] lower the local leukocyte and inflammatory modulator response,[39] and alter local collagen synthesis.[40] These effects combine to reduce pain and inflammation. Hydrocortisone esters are more effective in producing these effects than their parent compounds. Branched esterification further reduces solubility, allowing steroids to remain at the injection site longer.[38] Clinically, insoluble steroids have a longer duration of action and a higher incidence of cutaneous side effects. Triamcinolone hexacetonide (Aristospan) is the least soluble of the commonly used injectable steroids, followed by triamcinolone acetonide (Kenalog).

In the United States, methylprednisolone acetate (Depo-Medrol) is the most commonly used intra-articular steroid, followed by triamcinolone hexacetonide and triamcinolone acetonide.[41] Many physicians empirically use triamcinolone hexacetonide (low solubility, longer duration of action) for intra-articular injection, and betamethasone (high solubility, shorter duration of action, fewer cutaneous side effects) for soft tissue injections.

Early trials of intra-articular corticosteroids showed equal systemic absorption of methylprednisolone in patients with rheumatic and osteoarthritic hands[42] and knees.[43] This suggests that steroid pharmacokinetics, rather than disease-related factors, should guide steroid selection. A recent review by the National Health Service of the United Kingdom[44] recommends triamcinolone and methylprednisolone as preferred agents for injection of large joints (e.g., knee). For smaller joints (e.g., finger), either hydrocortisone or methylprednisolone (Hydeltrasol, brand no longer available in the United States) is recommended. *Tables 5 and 6*[45] compare commonly available steroid preparations.

ADDING ANESTHETICS

Local anesthetics are often combined with corticosteroids for intra-articular injection. Local anesthetics relieve pain and can be used diagnostically to differentiate between local and referred pain.[30,46,47] They also add volume to the injectate and help to distribute corticosteroid within the joint space. Most local anesthetics are short-acting *(Table 7)*.

As with the choice of corticosteroids, the choice of local anesthetic for injection is based more on clinical preference than evidence. When corticosteroids and local anesthetics are used together, many patients will experience relatively rapid relief of symptoms following the injection. This is the initial action of the local anesthetic. Patients then often experience a transient increase in pain as the local anesthetic wears off. Longer-term symptom relief results as the injected corticosteroid takes effect. It is helpful to provide this anticipatory guidance to patients before the injection.

Table 5. Steroid Dosing and Equivalents

Steroid	Common concentration (mg per mL)	Common equivalent dose* (mg)	Approximate duration of action (days)
Methylprednisolone acetate (Depo-Medrol)	40 or 80	40	8
Triamcinolone acetonide (Kenalog)	10 or 40	40	14
Triamcinolone hexacetonide (Aristospan)	20	40	21
Dexamethasone acetate (Decadron-LA†)	8	8	8
Dexamethasone sodium (Decadron†, Solurex†)	4	8	6

NOTE: Steroid agents listed in order of prevalence of use.

*—Dose equivalent to 40 mg of methylprednisolone acetate or triamcinolone acetonide (the most commonly used intra-articular steroid; see Table 6[45]).

†—Brand no longer available in the United States.

Table 6. Joint Specific Injections (Proximal to Distal)

Joint	Steroid dose* (mg)	Anesthetic dose† (mL)	Needle length (inch)	Needle gauge
Shoulder	20 to 40	5	1.5	21
Elbow	20	3	1.0	23
Wrist	20 to 40	3	0.5 to 1.5	23 or 25
Knee	20 to 80	5	1.5	21
Ankle	20 to 40	3 to 5	1.0 to 1.5	23

*—Dosing for methylprednisolone acetate (Depo-Medrol).

†—Dosing for 1% lidocaine (Xylocaine).

Information from reference 45.

Table 7. Local Anesthetics for Joint Injection

Medication	Onset of action (minutes)	Duration of action (hours)	Max volume of injection*
0.25% Bupivacaine (Marcaine)	30	8	60 mL
0.5% Bupivacaine	30	8	30 mL
1% lidocaine (Xylocaine)	1 to 2	1	20 mL
2% lidocaine	1 to 2	1	10 mL

*—Increased risk of cardiac toxicity or arrhythmia above these dosages.

The opinions and assertions contained herein are those of the authors and are not to be construed as official or as reflecting the views of the U.S. Navy Medical Department, the Navy at large, the U.S. Air Force Medical Department, the U.S. Air Force at large, the U.S. Army Medical Department, the Army at large, or the Department of Defense.

The Authors

MARK B. STEPHENS, CDR, MC, USN, is an associate professor of Family Medicine at the Uniformed Services University of the Health Sciences in Bethesda, Md. He received his medical degree from Case Western Reserve University in Cleveland, Ohio, and completed a family medicine residency at the Puget Sound Family Medicine Residency, Bremerton, Wash. Dr. Stephens earned a master's degree in exercise physiology from The Pennsylvania State University, Hershey.

ANTHONY I. BEUTLER, MAJ, USAF, MC, is an assistant professor of Family Medicine at the Uniformed Services University of the Health Sciences. He received his medical degree from Duke University School of Medicine, Durham, NC, and completed a family medicine residency at David Grant USAF Medical Center, Travis Air Force Base, Calif.

FRANCIS G. O'CONNOR, COL, MC, USA, is the medical director of the Human Performance Laboratory at the Uniformed Services University of the Health Sciences. He received his medical degree from the State University of New York Upstate Medical University, Syracuse, and completed a family medicine residency at St. Joseph's Medical Center, Syracuse, NY. Dr. O'Connor completed a primary care sports medicine fellowship at Virginia Sports Medicine Institute, Arlington.

Address correspondence to Mark B. Stephens, MD, MS, FAAFP, CAQAM, 4301 Jones Bridge Rd., Bethesda, MD 20814 (e-mail: mstephens@usuhs.mil). Reprints are not available from the authors.

Author disclosure: Nothing to disclose.

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Joint and Soft Tissue Injection

DENNIS A. CARDONE, D.O., C.A.Q.S.M., and ALFRED F. TALLIA, M.D., M.P.H., University of Medicine and Dentistry of New Jersey, Robert Wood Johnson Medical School, New Brunswick, New Jersey

Injection techniques are helpful for diagnosis and therapy in a wide variety of musculoskeletal conditions. Diagnostic indications include the aspiration of fluid for analysis and the assessment of pain relief and increased range of motion as a diagnostic tool. Therapeutic indications include the delivery of local anesthetics for pain relief and the delivery of corticosteroids for suppression of inflammation. Side effects are few, but may include tendon rupture, infection, steroid flare, hypopigmentation, and soft tissue atrophy. Injection technique requires knowledge of anatomy of the targeted area and a thorough understanding of the agents used. In this overview, the indications, contraindications, potential side effects, timing, proper technique, necessary materials, pharmaceuticals used and their actions, and post-procedure care of patients are presented. (Am Fam Physician 2002;66:283-8,290. Copyright© 2002 American Academy of Family Physicians.)

A patient information handout about joint and soft tissue injection, written by the authors of this article, is provided on page 290.

This article is one in a series of "Office Procedures" articles coordinated by Dennis A. Cardone, D.O., C.A.Q.S.M., associate professor, and Alfred F. Tallia, M.D., M.P.H., associate professor, Department of Family Medicine, UMDNJ–Robert Wood Johnson Medical School, New Brunswick, New Jersey.

Injection of joints, bursae, tendon sheaths, and soft tissues of the human body is a useful diagnostic and therapeutic skill for family physicians. With training, physicians can incorporate joint and soft tissue injection into daily practice, yielding many benefits. For example, a lidocaine (Xylocaine) injection into the subacromial space can help in the diagnosis of shoulder impingement syndromes, and the injection of corticosteroids into the subacromial space can be a useful therapeutic technique for subacromial impingement syndromes and rotator cuff tendinopathies. Evidence-based reviews of joint and soft tissue injection procedures have found few studies that support or refute the efficacy of common joint interventions in medical practice.[1-3] However, substantial practice-based experience supports the effectiveness of joint and soft tissue injection for many common problems.

These injections are most useful in instances of joint or tissue injury and inflammation. History of pain, local and referred, will provide important clues to the underlying pathology. Physical examination is extremely helpful in ascertaining the diagnosis. Knowledge of the anatomy of the area to be injected is essential. Intratendinous injection should be avoided because of the likelihood of weakening the tendon. Corticosteroid injections also should be avoided in cases of Achilles or patella tendinopathies.

Joint and soft tissue injection is most useful in instances of joint and tissue injury and in inflammatory conditions.

Therapeutic responses to corticosteroid injections are variable.[4] The patient's response to previous injection is important in deciding whether and when to proceed with reinjection. Most patients, if they are going to respond, will respond after the first injection. If the patient has achieved significant benefit after the first injection, an argument can be made to give a second injection if symptoms recur. However, patients who have gained no symptom relief or functional improvement after two injections should probably not have any additional injections, because a subsequent positive outcome is low.

If therapeutic effect is achieved, a maximum of four injections per year is recommended. There is some concern that corticosteroid preparations, with repeated use, may accelerate normal, aging-related articular cartilage atrophy or may weaken tendons or ligaments. When symptoms are resistant, or when there is a history of trauma, a radiograph or other imaging study should be performed to help assist in the diagnosis.

Patients who have not gained any symptom relief after two steroid injections should probably not have any additional injections.

Indications

The indications for joint or soft tissue aspiration and injection fall into two categories: diagnostic and therapeutic. A common diagnostic indication for placing a needle in a joint is the aspiration of synovial fluid for evaluation. Synovial fluid evaluation can differentiate among various joint disease etiologies including infection, inflammation, and trauma. A second diagnostic indication involves the injection of a local anesthetic to confirm the presumptive diagnosis through symptom relief of the affected body part.

Therapeutic indications for joint or soft tissue aspiration and injection include decreased mobility and pain, and the injection of medication as a therapeutic adjunct to other forms of treatment.[5] Caution must be exercised when removing fluid for pain relief because of the possibility of introducing infection and precipitating further or new bleeding into the joint. Also, early reaccumulation of fluid can occur in many cases.

Therapeutic injection with corticosteroids should always be viewed as adjuvant therapy.[6] The improper or indiscriminate use of corticosteroids is likely to have a bad outcome. These injections should never be undertaken without diagnostic definition and a specific treatment plan in place. Physicians should resist external pressure for a quick return of athletes to playing sports by the use of joint or soft tissue injections. *Table 1* lists soft tissue and joint condition indications for diagnostic and therapeutic injections.

TABLE 1
Indications for Diagnostic and Therapeutic Injection

Soft tissue conditions
Bursitis
Tendonitis or tendinosis
Trigger points
Ganglion cysts
Neuromas
Entrapment syndromes
Fasciitis
Joint conditions
Effusion of unknown origin or suspected infection (only diagnostic)
Crystalloid arthropathies
Synovitis
Inflammatory arthritis
Advanced osteoarthritis

Contraindications

As with any invasive diagnostic or therapeutic injection procedure, there are absolute and relative contraindications *(Table 2)*.[7] Drug allergies, infection, fracture, and tendinous sites at high risk of rupture are absolute contraindications to joint and soft tissue injection. Relative contraindications are less well defined and should be considered on a case-by-case basis. Physicians should be aware that the contraindications listed are for therapeutic injection and do not apply for diagnostic aspiration of joints or soft tissue areas. For instance, suspected septic arthritis is a contraindication for therapeutic injection, but an indication for joint aspiration.

Timing of Injections

Appropriate timing can minimize complications and allow a clear diagnosis or therapeutic response. For diagnostic injections, the procedure should be performed when acute or chronic symptoms are present, when the diagnosis is unclear or needs to be confirmed, when consideration has been given to other diagnostic modalities, and when septic arthritis has been ruled out (by aspiration and fluid analysis). For therapeutic injections, the procedure should be performed when acute or chronic symptoms are present, after the diag-

nosis and therapeutic plan have been made, and after consideration has been given to obtaining radiographs. Therapeutic injection should be performed only with or after the initiation of other therapeutic modalities (e.g., physical therapy). In the absence of an underlying chronic inflammatory arthritis, any joint with an effusion should be radiographed to rule out a fracture or other intra-articular pathologic process.

Corticosteroids

MECHANISM OF ACTION

After intra-articular injection, corticosteroids function to suppress inflammation and decrease erythema, swelling, heat, and tenderness of the inflamed joint. These effects are believed to result from several mechanisms, including alterations in neutrophil chemotaxis and function, increases in viscosity of synovial fluid, stabilization of cellular lysosomal membranes, alterations in hyaluronic acid synthesis, transient decreases in synovial fluid complements, alterations in synovial permeability, and changes in synovial fluid leukocyte count and activity.[8] Whether this is exactly the same mechanism of action that occurs with orally or parenterally administered corticosteroids is uncertain.[4]

SELECTION OF CORTICOSTEROID

Many corticosteroid preparations are available for joint and soft tissue injection. The agents differ according to potency *(Table 3)*, solubility, and crystalline structure. Potency is generally measured against hydrocortisone, and ranges from low-potency, short-acting agents such as cortisone, to high-potency, long-acting agents such as betamethasone (Celestone).

Few studies have investigated the efficacy or duration of action of the various agents in joints or soft tissue sites. The duration of effect is inversely related to the solubility of the preparation: the less soluble an agent, the longer it remains in the joint and the more prolonged the effect. Consequently, suspensions are longer acting. A short-acting solution, such as dexamethasone sodium phosphate (Decadron), is less irritating and less likely to cause a postinjection flare than a long-acting dexamethasone suspension. Many clinicians use injectables that combine short-acting compounds with long-acting suspensions (e.g., betamethasone sodium phosphate and acetate suspension),

TABLE 2
Absolute and Relative Contraindications to Therapeutic Joint and Soft Tissue Injection

Absolute contraindications	Relative contraindications
Local cellulitis	Minimal relief after two previous corticosteroid injections
Septic arthritis	Underlying coagulopathy
Acute fracture	Anticoagulation therapy
Bacteremia	Evidence of surrounding joint osteoporosis
Joint prosthesis	Anatomically inaccessible joints
Achilles or patella tendinopathies	Uncontrolled diabetes mellitus
History of allergy or anaphylaxis to injectable pharmaceuticals or constituents	

TABLE 3
Corticosteroid Agents by Relative Potencies, Duration, and Dose

Agent	*Potency*	*Duration*	*Dose/site*
Hydrocortisone acetate (Hydrocortone)	Low	Short	10 to 25 mg for soft tissue and small joints 50 mg for large joints
Methylprednisolone acetate (Depo-Medrol) or triamcinolone acetonide (Aristocort)	Intermediate	Intermediate	2 to 10 mg for soft tissue and small joints 10 to 80 mg for large joints
Dexamethasone sodium phosphate (Decadron)	High	Long	0.5 to 3 mg for soft tissue and small joints 2 to 4 mg for large joints
Betamethasone sodium phosphate and acetate (Celestone Soluspan)	High	Long	1 to 3 mg for soft tissue and small joints 2 to 6 mg for large joints

Low-solubility corticosteroid agents should not be used for soft tissue injection because of the increased risk of surrounding tissue atrophy.

thereby obtaining the beneficial effects of both types of preparations. Mixing the corticosteroid preparation with a local anesthetic is a common practice for avoiding the injection of a highly concentrated suspension into a single area. The anesthetic provides early relief of symptoms and helps confirm the diagnosis.

Low-solubility agents, favored for joint injection, should not be used for soft tissue injection because of the increased risk of surrounding tissue atrophy. Methylprednisolone (Depo-Medrol) is often the agent selected for soft tissue injection.

PRECAUTIONS

Several precautions should be taken when using steroid injections. Care should be taken to avoid direct injection of tendons because of the danger of rupture. Avoid injection into adjacent nerves of the target area (e.g., ulnar nerve when injecting for medial epicondylitis). Allow adequate time between injections, generally a minimum of four to six weeks. Pay attention to the depth of needle insertion to avoid needle trauma to articular cartilage. Finally, avoid injecting several large joints simultaneously because of the increased risk of hypothalamic-pituitary-adrenal suppression and other adverse effects.[9]

DOSAGE

Dosing is site dependent. As a rule, larger joints require more corticosteroid. *Table 3* lists general corticosteroid dosing guidelines.

Local Anesthetics

Before injection of a joint or soft tissue, a small quantity of 1 percent lidocaine or 0.25 to 0.5 percent bupivacaine (Sensorcaine) can be injected subcutaneously with a 25- to 30-gauge needle to provide local anesthesia. For the actual joint or soft tissue injection, most physicians mix an anesthetic with the corticosteroid preparation. This provides temporary analgesia, confirms the delivery of medication to the appropriate target, and dilutes the crystalline suspension so that it is better diffused within the injected region. Manufacturers advise against mixing corticosteroid preparations with lidocaine because of the risk of clumping and precipitation of steroid crystals. However, the authors have never experienced this as a major problem.

For most injections, 1 percent lidocaine or 0.25 to 0.5 percent bupivacaine is mixed with a corticosteroid preparation. The dose of anesthetic varies from 0.25 mL for a flexor tendon sheath (trigger finger) to 5 to 8 mL for larger joints. On rare occasions, patients exhibit signs of anesthetic toxicity, including flushing, hives, chest or abdominal discomfort, and nausea. It can take as long as 20 to 30 minutes following the injection for these symptoms to present. For this reason, and to monitor for allergic reactions, patients should be observed in the office for at least 30 minutes following the injection.

Potential Complications

A number of potential complications can arise from use of joint and soft tissue proce-

The Authors

DENNIS A. CARDONE, D.O., C.A.Q.S.M., is associate professor and director of sports medicine and the sports medicine fellowship in the Department of Family Medicine at the University of Medicine and Dentistry of New Jersey (UMDNJ)–Robert Wood Johnson Medical School, New Brunswick, N.J. He is a graduate of New York College of Osteopathic Medicine and completed a residency at the UMDNJ–Robert Wood Johnson Medical School Family Medicine Residency program, New Brunswick. He completed his sports medicine fellowship at UMDNJ.

ALFRED F. TALLIA, M.D., M.P.H., is associate professor and vice chair in the Department of Family Medicine at UMDNJ–Robert Wood Johnson Medical School. He is a graduate of the UMDNJ–Robert Wood Johnson Medical School and completed a residency at the Thomas Jefferson University Family Medicine Residency program, Philadelphia. He received his public health degree from Rutgers University, New Brunswick, N.J.

Address correspondence to Dennis A. Cardone, D.O., Department of Family Medicine, University of Medicine and Dentistry of New Jersey, Robert Wood Johnson Medical School, 1 Robert Wood Johnson Pl. MEB288, New Brunswick, NJ 08903 (e-mail: cardonda@umdnj.edu). Reprints are not available from the authors.

dures.[10] Local infection is always possible, but it can be avoided by following the proper technique. Joint injections should always be performed using sterile procedure to prevent iatrogenic septic arthritis. Local reactions at the injection site may include swelling, tenderness, and warmth, all of which may develop a few hours after injection and can last up to two days. A postinjection steroid flare, thought to be a crystal-induced synovitis caused by preservatives in the injectable suspension, may occur within the first 24 to 36 hours after injection.[11] This is self-limited and responds to application of ice packs for no longer than 15-minute intervals.

Soft tissue (fat) atrophy and local depigmentation are possible with any steroid injection into soft tissue, particularly at superficial sites (e.g., lateral epicondyle). Periarticular calcifications are described in the literature, but they are rare. Tendon rupture can be avoided by not injecting directly into the tendon itself.

Systemic effects are possible (especially after triamcinolone acetonide [Aristocort] injection or injection into a vein or artery), and patients should always be acutely monitored for reactions. Alterations in taste have been reported for one to two days after steroid injection. Hyperglycemia is possible in patients who have diabetes.

To avoid direct needle injury to articular cartilage or local nerves, attention should be paid to anatomic landmarks and depth of injection. Other rare, but possible, complications include pneumothorax (when injecting thoracic trigger points), perilymphatic depigmentation, steroid arthropathy, adrenal suppression, and abnormal uterine bleeding.

Informed Consent

Informed consent should always be obtained for any invasive procedure. Discussion with the patient should include indications, potential risks, complications and side effects, alternatives, and potential outcomes from the injection procedure. Patients should sign documentation that informed consent for the procedure was given and understood. A third party should witness the patient's signing. Documentation is kept as part of the patient's record.

Necessary Equipment

All joint and soft tissue injection or aspiration techniques should be performed wearing gloves. When injecting or aspirating a joint space, sterile technique should be used. Nonsterile gloves can be used when injecting or aspirating soft tissue regions. Necessary equipment for joint and soft tissue injection or aspiration is listed in *Table 4.*

Site Preparation

The entry point for injection or aspiration should be identified. The point of entry can be marked with an impression from a thumbnail, a needle cap, or an indelible ink pen. The important goal is to minimize risk of infection at the site. Prepare the area with an alcohol or povidone-iodine (Betadine) wipe. For all

TABLE 4

Equipment Tray Contents for Joint or Soft Tissue Injection or Aspiration

Alcohol wipes
Povidone-iodine (Betadine) wipes
Sterile and nonsterile gloves
Sterile drapes
25- to 30-gauge 0.5- to 1.0-inch needle for local skin anesthesia
18- to 20-gauge 1.5-inch needle for aspirations
22- to 25-gauge 1.0- to 1.5-inch needle for injections
1 mL- to 10 mL-syringe for injections
3 mL- to 60 mL-syringe for aspirations
Local anesthetic
Corticosteroid preparation
Laboratory tubes for culture or other studies (aspiration)
Hemostat (if joint is to be aspirated and then injected using the same needle)
Adhesive bandage or other adhesive dressing

intra-articular injections, sterile technique should be used.

Steps for Injection and Joint Aspiration

When possible, the patient should be placed in the supine position. This will help prevent or mitigate the effects of a vasovagal or syncopal episode. Palpate the soft tissue or bony landmarks. Follow the steps for site preparation. For soft tissue injections, the following modalities may be used for short-term partial anesthesia: applying ice to the skin for five to 10 minutes; applying topical vapo-coolant spray; or firmly pinching the skin for three to four seconds at the injecting site.[12] Once the skin is anesthetized, the needle should be inserted through the skin to the site of injection. To prevent complications, adhere to sterile technique for all joint injections; know the location of the needle and underlying anatomy; avoid neuromuscular bundles; avoid injecting corticosteroids into the skin and subcutaneous fat; and always aspirate before injecting to prevent intravascular injection.

The injection should flow easily and should not be uncomfortable to the patient. Most pain is the result of tissue stretching and can be mitigated by injecting slowly. If there is strong resistance while injecting, the needle may be intramuscular, intratendinous, or up against bone or cartilage, and it should be repositioned.

Postinjection Instructions and Care

An adhesive dressing should be applied to the injection site. To minimize pain and inflammation after leaving the office, the patient should be advised to apply ice to the injection site (for no longer than 15 minutes at a time, once or twice per hour), and nonsteroidal anti-inflammatory agents may be used, especially for the first 24 to 48 hours. The affected area should be rested from strenuous activity for several days after the injection because of the small possibility of local tissue tears secondary to temporarily high concentrations of steroid. This risk lessens as the steroid dissipates. Patients should be educated to look for signs of infection including erythema, warmth, or swelling at the site of injection, or systemic signs including fever and chills. The patient should keep the injection site clean and may bathe.

The authors indicate that they do not have any conflicts of interest. Sources of funding: none reported.

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12. Scott W. Injection techniques and use in the treatment of sports injuries. Sports Med 1996;22:406-16.

Scott Hall MD

14669 Gold Run Drive
Reno Nevada 89521
Hall_651@yahoo.com
Ph # (775) 853-4196

Board Certified Family
and Sports Medicine
NV License #12023
Cell # (775) 338-7638

Education

[1998 - 2002] The Ohio State University — Columbus, OH
Doctor of Medicine

[1992 - 1998] Brigham Young University — Provo, UT
Bachelor of Science

Post-Graduate Education

[2005 - 2006] Sportsmedicine Grant — Columbus, OH
Sports Medicine Fellowship

[2004 - 2005] Grant Family Medicine — Columbus, OH
Chief Resident

[2002 - 2005] Grant Family Medicine — Columbus, OH
Family Medicine Residency

Professional experience

[2005 - 2006] Physician Staffing Inc. — Cleveland, OH
Hospitalist for two Ohio hospitals

[2006- 2007] Renown Health Reno, NV
Family Physician

[2007- current] SpecialtyHealth Reno, NV
Sports, occupational, and family medicine

[2007- current] University of Nevada School of Medicine Reno, NV
Sports and family medicine

Presentations

"Joint Examinations," Workshop presented at 50th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2018.

"Joint Examinations" and "Joint Injections," Workshop presented at 48th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2016.

"Joint Examinations," Workshop presented at 47th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2015.

"Joint Examinations," Workshop presented at 46th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2014.

"Evaluation of the Impact of a Paleolithic Diet on Cardiovascular Risk Factors and Lipoproteins in a Law Enforcement Population," Presented at the Ancestral Health Symposium 2013 in Atlanta GA, *46th Annual Nevada Academy of Family Physicians Winter CME Meeting* in South Lake Tahoe, NV, and Washoe County Obesity Forum 2013 in Reno, NV.

"Spine Examination," Workshop presented at 45th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2013.

"Neck and Shoulder Exam," Workshop presented at 44th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2012.

"Joint Injections," Presented at 40th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2008.

"Presyncope in a Division III Cross-Country Runner," Presented at *AMSSM National Meeting*, Miami Florida, April 2006.

"Community-acquired MRSA in Athletes – What You Need to Know," Presented at *11th Current Concepts in Sports Medicine Conference*, Columbus Ohio, August 2005.

"The Preparticipation Physical Exam," Presented at *Grant Medical Center Grand Rounds*, Columbus Ohio, March 2005.

"Management of the Abnormal Pap Smear," Presented at *Colposcopy for the Primary Care Physician,* Columbus Ohio, May 2004.

Sports Medicine

Team Physician, Reno Aces, AAA baseball, Reno, 2009-current
Team Physician, University of Nevada, Reno, 2006 - current
Team Physician, Damonte Ranch High School, 2006 – current
Volunteer Physician, Tahoe Rim Endurance Run, 2010 - current
Volunteer Physician, Marathon De Mayo, Reno, NV 2006
Volunteer Physician, Ohio District and Sectional Wrestling Tournament, Feb. 2006
Team Physician, Columbus Destroyers (Arena Football) 2006
Team Physician, Denison University, 2005 - 2006
Team Physician, Central Crossing High School, Columbus OH,2002- 2003, 2005
Team Physician, Whitehall High School, Columbus OH, 2004
Volunteer Physician, Columbus Marathon, Nov. 2005
Volunteer Physician, Great Ohio Bicycle Adventure, 2004 – 2006.

Publications

Pommering T, Kluchurosky L, Hall S. Ankle and Foot Injuries in Pediatric and Adult Athletes. *Prim Care Clin Office Pract* 2005; 32: 133 – 161.

Rodenberg RE, Cayce K, Hall S. Your Guide to a Dreaded Injury: the ACL Tear. *Contemp Pediatri*, Jul 2006.

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Hall S and Lorenc T. Secondary Prevention of Coronary Artery Disease. *Am Fam Physician.* 2010 Feb 1;81(3):289-296.

Fiore D, Hall S, and Shoja P. Altitude Illness: Risk Factors, Prevention, Presentation, and Treatment. *Am Fam Physician.* 2010 Nov 1;82(9):1103-1110.

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Peer Reviewer for the American Family Physician journal: http://www.aafp.org/afp/2009/1101/p930.html.

Professional Societies

American Academy of Family Physicians, 2002 - present

SCOTT HALL, MD CAQSM

Associate Professor of Family Medicine
University of Nevada School of Medicine
Family Medicine Department

EDUCATION

Doctor of Medicine, Ohio State University, 2002
Bachelor of Science, Brigham Young University, 1998

MEDICAL TRAINING

Sports Medicine Fellowship, Grant Sports Medicine, 2006

Chief Resident, Grant Family Medicine, 2005

Family Medicine Residency, Grant Family Medicine, 2002-2005

MEDICAL EXPERIENCE

2007-current	Associate Professor of Family Medicine, *University of Nevada, Reno School of Medicine, Department of Family Medicine*
2018-current	State of Nevada Rating Physician, *Scott Hall, MD, PLLC*
2007-2019	Clinical Physician and Medical Director, *SpecialtyHealth*
2006-2007	Family Medicine Physician and Hospitalist, *Renown Health*
2005-2006	Hospitalist, *Physician Staffing*

PRESENTATIONS

"Pre-Participation Exams in the COVID Era," Lecture presented at 53rd Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2021.

"Joint Examinations" and "Joint Injections" Workshops presented at 52th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2020.

"MRSA and Athletes," presentation for the Renown Sports Medicine conference in April 2019 and Project ECHO University of Nevada, Reno in May 2019

"Joint Examinations," Workshop presented at 50th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2018.

"Joint Examinations" and "Joint Injections," Workshop presented at 48th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2016.

"Joint Examinations," Workshop presented at 47th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2015.

"Joint Examinations," Workshop presented at 46th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2014.

"Evaluation of the Impact of a Paleolithic Diet on Cardiovascular Risk Factors and Lipoproteins in a Law Enforcement Population," Presented at the Ancestral Health Symposium 2013 in Atlanta GA, *46th Annual Nevada Academy of Family Physicians Winter CME Meeting* in South Lake Tahoe, NV, and Washoe County Obesity Forum 2013 in Reno, NV.

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"Management of the Abnormal Pap Smear," Presented at *Colposcopy for the Primary Care Physician*, Columbus Ohio, May 2004.

EXHIBIT C

EXHIBIT C

RESPONDENT'S HEARING EXHIBITS

No.	TITLE	BATES RANGE
1	Hai Thanh, M.D.'s Second Supplemental Prehearing Conference Disclosure	N/A
2	Complaint	N/A
3	Respondent Hai Thanh Nguyen, M.D.'s Answer to Complaint	N/A
4	Respondent's letter of response to Medical Board, dated 4/24/2017	N/A
5	Medical Records from Healthcare Partners	HCP0001 – HCP0017
6	Medical Administration Log	Med Admin Log 00001 – Med Admin Log 00007
7	Standard Operating Procedure for Injectable Medication Administration	SOP INJECTABLE MEDS 0001- SOP INJECTABLE MEDS 0004
8	CV Edwardo Anorga M.D.	N/A
9	IBM Micromedex Information for Pediatric Administration of Kenalog	MICROMEDEX000001 – MICROMEDEX0000025
10	American Society for Microbiology, comparison of Corticosteroids for Treatment of Respiratory Syncytial Virus Bronchiolitis and Pneumonia in Cotton Rats	ASM 000001 – ASM000004
11	Bristol-Myers Squibb Company Information for Intramuscular or Intra-articular Kenalog Injection, Revised 2011	BMS_(2011) 000001 – BMS_(2011) 0000020
12	Medical Administration Details	Med Admin Details 000001 – Med Admin Details 000002
13	Declaration of Melissa Vogt, RN	N/A

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA
* * * * *

In the Matter of Charges and Complaint Against HAI THANH NGUYEN, M.D., Respondent.	**Case No. 21-38084-1**

HAI THANH NGUYEN, M.D.'S SECOND SUPPLEMENTAL PREHEARING CONFERENCE DISCLOSURE

COMES NOW, Respondent HAI THANH NGUYEN, M.D., by and through his counsel of record, ROBERT C. McBRIDE, ESQ. and T. CHARLOTTE BUYS, ESQ., of the law firm of McBRIDE HALL and in accordance with Nevada Administrative Code § 630.465 and the Hearing Officer's Scheduling Order filed on February 7, 2022 and Order Rescheduling Pretrial Hearing filed on April 5, 2022, hereby provides the following Second Supplement to Hai Thanh Nguyen, M.D.'s Prehearing Conference Disclosure **(supplemental information in bold)**:

I.

WITNESSES

1. Hai Thanh Nguyen, M.D.
   c/o Robert C. McBride, Esq.
   T. Charlotte Buys, Esq.
   McBRIDE HALL
   8329 W. Sunset Boulevard, Suite 260
   Las Vegas, Nevada 89113
   (702) 791-5855

Respondent will testify regarding the care and treatment provided to Patient A, his custom and practice, and his medical records documenting Patient A's care and treatment. He will also provide testimony regarding the Board's Complaint and the allegations therein. Respondent will also testify that he complied with the standard of care.

Resp Ex 1

2. Eduardo Anorga, M.D.

[redacted]

Dr. Anorga is a physician board-certified in family medicine and is expected to testify regarding his review of this case and the standard of care applicable to Dr. Nguyen's care and treatment of Patient A, and documentation of the same. Dr. Anorga will also provide expert testimony regarding the Board's Complaint and the allegations contained therein.

3. Ellen Aliberti

[redacted]

Ms. Aliberti is a Clinical Educator. Ms. Aliberti is expected to testify regarding the clinical education and policies and procedures provided to Medical Assistants at Healthcare Partners of Nevada. **Ms. Aliberti may also testify as to her knowledge regarding the Medication Administration Details Record for Ms.** [redacted] **and her knowledge regarding the record keeping practices of Intermountain Healthcare (previously Healthcare Partners of Nevada).** She is also anticipated to testify to any relevant knowledge she may have regarding the facts and circumstances surrounding this matter.

4. Glenisha Barner, MA
(Current Address Unknown)

Ms. Barner is anticipated to testify regarding her care and treatment of Patient A, and as to any relevant knowledge she may have regarding the facts and circumstances surrounding this matter.

5. Barry Misiuk, MA
(Current Address Unknown)

Mr. Misiuk is anticipated to testify regarding his care and treatment of Patient A, and as to any relevant knowledge he may have regarding the facts and circumstances surrounding this matter.

6. Sheilamarie DelGrosso
c/o Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Ms. Delgrosso and Mr. Delgrosso are the parents of Patient A and are expected to testify as to the consent for medical care and medical treatment provided to Patient A and any relevant knowledge she may have regarding the facts and circumstances surrounding this matter.

7. **Melissa Vogt, RN**
[redacted]

Ms. Vogt is a Learning Coordinator-RN. Ms. Vogt located and made a true and correct copy of the Medication Administration Details record for Ms. [redacted] **and is expected to testify regarding the authenticity of the record and her knowledge regarding the record keeping practices of Intermountain Healthcare (previously Healthcare Partners of Nevada). She is also anticipated to testify to any relevant knowledge she may have regarding the facts and circumstances surrounding this matter.**

Respondent reserves the right to call as expert witnesses any and all of the Board's designated expert witness(es) or any other witness designated by any other party. Respondent further reserves the right to amend and supplement this list as discovery continues and as necessary for rebuttal and/or impeachment.

II.

DOCUMENTS

1. Board of Medical Examiners of the State of Nevada Complaint filed November 3, 2021.
2. Respondent Hai Thanh Nguyen, M.D.'s Answer to Complaint
3. Respondent Hai Thanh Nguyen, M.D.'s Board Response Letter dated April 24, 20017
4. Medical Records from Healthcare Partners (HCP 0001-17)
5. Medical Administration Log (MED ADMIN LOG 0001-7)

6. Standard Operating Procedure for Injectable Medication Administration (SOP INJECTABLE MEDS 0001-4)

7. Curriculum Vitae of Eduardo Anorga, M.D.

First Supplement

8. IBM Micromedex Information for Pediatric Administration of Kenalog (MICROMEDEX000001-25).

9. American Society for Microbiology, Comparison of Corticosteroids for Treatment of Respiratory Syncytial Virus Bronchiolitis and Pneumonia in Cotton Rats (ASM 000001-000004).

10. Bristol-Myers Squibb Company Information for Intramuscular or Intra-articular Kenalog Injection, Revised June 2011, (BMS_(2011)_000001-20).

Second Supplement

11. Medication Administration Details (MED ADMIN DETAILS 00001-2).

12. Declaration of Melissa Vogt, RN. Regarding Medication Administration Details.

Respondent reserves the right to use any and all of the documents, exhibits, reference materials and records disclosed by the Board or any other party. Respondent further reserves the right to amend and supplement this list as discovery continues and as necessary for rebuttal and/or impeachment.

DATED this 23rd day of May, 2022.

McBRIDE HALL

/s/ T. Charlotte Buys

ROBERT C. McBRIDE, ESQ.
Nevada Bar No.: 7082
T. CHARLOTTE BUYS, ESQ.
Nevada Bar No.: 14845
8329 W. Sunset Road, Suite 260
Las Vegas, Nevada 89113
Attorneys for Respondent
Hai Thanh Nguyen M.D.

CERTIFICATE OF SERVICE

I hereby certify that on the 23rd day of May 2022, I served a true correct copy of **HAI THANH NGUYEN, M.D.'S SECOND SUPPLEMENTAL PREHEARING CONFERENCE DISCLOSURE** by sending electronically and mailing via United States mail to the following:

Sarah Bradley, J.D., MBA
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
Attorneys for the Investigative Committee

/s/ Madeline VanHeuvelen
An Employee of McBride Hall

DECLARATION OF MELISSA VOGT

STATE OF NEVADA)
)
COUNTY OF CLARK)

I, MELISSA VOGT, declare under penalty of perjury pursuant to NRCP 34(c) and NRS 53.045 as follows:

1. I am over the age of eighteen. I am competent to testify on the matters set forth herein. I make this declaration based upon my personal knowledge.

2. I am a Registered Nurse and currently am a Learning Coordinator employed by Intermountain Healthcare.

3. On May 23, 2022, I located Medication Administration Details for patient, [redacted], and I made a true and exact copy of that record, which has been batestamped MED ADMIN DETAILS 00001 – MED ADMIN DETAILS 00002.

4. It is my understanding that the original of the records was made at or near the time of the act and/or event recited therein.

5. The Medication Administration Details are kept as part of the patient's designated record set, however, they are maintained separately from the patient's other medical records. It is my understanding that this Medication Administration Details record was inadvertently not printed and included in a copy of the patient's medical records that were previously disclosed in the Nevada Board of Medical Examiners Formal Complaint against Hai Thanh Nguyen, M.D. (Case No. 21-38084-1), as such record are maintained separately from the other portions of the patient's medical record.

6. I declare under penalty of perjury under the laws of the State of Nevada that the foregoing is true and correct.

DATED this 23 day of May, 2022.

Melissa Vogt RN.
MELISSA VOGT

MEDICAL RECORDS

This exhibit contains person medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA
* * * * *

In the Matter of Charges and Complaint Against HAI THANH NGUYEN, M.D., Respondent.	Case No. 21-38084-1

HAI THANH NGUYEN, M.D.'S FIRST SUPPLEMENTAL PREHEARING CONFERENCE DISCLOSURE

COMES NOW, Respondent HAI THANH NGUYEN, M.D., by and through his counsel of record, ROBERT C. McBRIDE, ESQ. and T. CHARLOTTE BUYS, ESQ., of the law firm of McBRIDE HALL and in accordance with Nevada Administrative Code § 630.465 and the Hearing Officer's Scheduling Order filed on February 7, 2022 and Order Rescheduling Pretrial Hearing filed on April 5, 2022, hereby provides the following First Supplement to Hai Thanh Nguyen, M.D.'s Prehearing Conference Disclosure **(supplements are in bold)**:

I.

WITNESSES

1. Hai Thanh Nguyen, M.D.
   c/o Robert C. McBride, Esq.
   T. Charlotte Buys, Esq.
   McBRIDE HALL
   8329 W. Sunset Boulevard, Suite 260
   Las Vegas, Nevada 89113
   (702) 791-5855

Respondent will testify regarding the care and treatment provided to Patient A, his custom and practice, and his medical records documenting Patient A's care and treatment. He will also provide testimony regarding the Board's Complaint and the allegations therein. Respondent will also testify that he complied with the standard of care.

2. Eduardo Anorga, M.D.
[redacted]

Dr. Anorga is a physician board-certified in family medicine and is expected to testify regarding his review of this case and the standard of care applicable to Dr. Nguyen's care and treatment of Patient A, and documentation of the same. Dr. Anorga will also provide expert testimony regarding the Board's Complaint and the allegations contained therein.

3. Ellen Aliberti
[redacted]

Ms. Aliberti is a Clinical Educator. Ms. Aliberti is expected to testify regarding the clinical education and policies and procedures provided to Medical Assistants at Healthcare Partners of Nevada. She is also anticipated to testify to any relevant knowledge she may have regarding the facts and circumstances surrounding this matter.

4. Glenisha Barner, MA
(Current Address Unknown)

Ms. Barner is anticipated to testify regarding her care and treatment of Patient A, and as to any relevant knowledge she may have regarding the facts and circumstances surrounding this matter.

5. Barry Misiuk, MA
(Current Address Unknown)

Mr. Misiuk is anticipated to testify regarding his care and treatment of Patient A, and as to any relevant knowledge he may have regarding the facts and circumstances surrounding this matter.

6. **Sheilamarie DelGrosso**
c/o Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Ms. Delgrosso and Mr. Delgrosso are the parents of Patient A and are expected to testify as to the consent for medical care and medical treatment provided to Patient A and any relevant knowledge she may have regarding the facts and circumstances surrounding this matter.

Respondent reserves the right to call as expert witnesses any and all of the Board's designated expert witness(es) or any other witness designated by any other party. Respondent further reserves the right to amend and supplement this list as discovery continues and as necessary for rebuttal and/or impeachment.

II.

DOCUMENTS

1. Board of Medical Examiners of the State of Nevada Complaint filed November 3, 2021.
2. Respondent Hai Thanh Nguyen, M.D.'s Answer to Complaint
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7. Curriculum Vitae of Eduardo Anorga, M.D.
8. **IBM Micromedex Information for Pediatric Administration of Kenalog (MICROMEDEX000001-25).**
9. **American Society for Microbiology, Comparison of Corticosteroids for Treatment of Respiratory Syncytial Virus Bronchiolitis and Pneumonia in Cotton Rats (ASM 000001-000004).**

10. Bristol-Myers Squibb Company Information for Intramuscular or Intra-articular Kenalog Injection, Revised June 2011, (BMS_(2011)_000001-20).

Respondent reserves the right to use any and all of the documents, exhibits, reference materials and records disclosed by the Board or any other party. Respondent further reserves the right to amend and supplement this list as discovery continues and as necessary for rebuttal and/or impeachment.

DATED this 11th day of April, 2022.

McBRIDE HALL

By: */s/ T. Charlotte Buys*
ROBERT C. McBRIDE, ESQ.
Nevada Bar No.: 7082
T. CHARLOTTE BUYS, ESQ.
Nevada Bar No.: 14845
8329 W. Sunset Road, Suite 260
Las Vegas, Nevada 89113
Attorneys for Respondent
Hai Thanh Nguyen M.D.

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA
* * * * *

In the Matter of Charges and Complaint Against HAI THANH NGUYEN, M.D., Respondent.	**Case No. 21-38084-1**

HAI THANH NGUYEN, M.D.'S PRE-HEARING CONFERENCE DISCLOSURE

COMES NOW, Respondent HAI THANH NGUYEN, M.D., by and through his counsel of record, ROBERT C. McBRIDE, ESQ. and T. CHARLOTTE BUYS, ESQ., of the law firm of McBRIDE HALL and in accordance with Nevada Administrative Code § 630.465 and the Hearing Officer's Scheduling Order filed on February 7, 2022, hereby provides the following disclosures:

I.

WITNESSES

1. Hai Thanh Nguyen, M.D.
   c/o Robert C. McBride, Esq.
   T. Charlotte Buys, Esq.
   McBRIDE HALL
   8329 W. Sunset Boulevard, Suite 260
   Las Vegas, Nevada 89113
   (702) 791-5855

Respondent will testify regarding the care and treatment provided to Patient A, his custom and practice, and his medical records documenting Patient A's care and treatment. He will also provide testimony regarding the Board's Complaint and the allegations therein. Respondent will also testify that he complied with the standard of care.

2. Eduardo Anorga, M.D.
   [redacted]

Dr. Anorga is a physician board-certified in family medicine and is expected to testify regarding his review of this case and the standard of care applicable to Dr. Nguyen's care and treatment of Patient A, and documentation of the same. Dr. Anorga will also provide expert testimony regarding the Board's Complaint and the allegations contained therein.

3. Ellen Aliberti
[redacted]

Ms. Aliberti is a Clinical Educator. Ms. Aliberti is expected to testify regarding the clinical education and policies and procedures provided to Medical Assistants at Healthcare Partners of Nevada. She is also anticipated to testify to any relevant knowledge she may have regarding the facts and circumstances surrounding this matter.

4. Glenisha Barner, MA
(Current Address Unknown)

Ms. Barner is anticipated to testify regarding her care and treatment of Patient A, and as to any relevant knowledge she may have regarding the facts and circumstances surrounding this matter.

5. Barry Misiuk, MA
(Current Address Unknown)

Mr. Misiuk is anticipated to testify regarding his care and treatment of Patient A, and as to any relevant knowledge he may have regarding the facts and circumstances surrounding this matter.

Respondent reserves the right to call as expert witnesses any and all of the Board's designated expert witness(es) or any other witness designated by any other party. Respondent further reserves the right to amend and supplement this list as discovery continues and as necessary for rebuttal and/or impeachment.

II.

DOCUMENTS

1. Board of Medical Examiners of the State of Nevada Complaint filed November 3, 2021.

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6. Standard Operating Procedure for Injectable Medication Administration (SOP INJECTABLE MEDS 0001-4)
7. Curriculum Vitae of Eduardo Anorga, M.D.

Respondent reserves the right to use any and all of the documents, exhibits, reference materials and records disclosed by the Board or any other party. Respondent further reserves the right to amend and supplement this list as discovery continues and as necessary for rebuttal and/or impeachment.

DATED this 31st day of March, 2022.

McBRIDE HALL

By: */s/ T. Charlotte Buys*
ROBERT C. McBRIDE, ESQ.
Nevada Bar No.: 7082
T. CHARLOTTE BUYS, ESQ.
Nevada Bar No.: 14845
8329 W. Sunset Road, Suite 260
Las Vegas, Nevada 89113
Attorneys for Respondent
Hai Thanh Nguyen M.D.

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **HAI THANH NGUYEN, M.D., Respondent.**	**Case No. 21-38084-1**

FILED
NOV 03 2021
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Robert G. Kilroy, Esq., Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Hai Thanh Nguyen, M.D., (Respondent) violated the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act), hereby issues its Complaint, stating the IC's charges and allegations as follows:

1. Respondent was at all times relative to this Complaint a medical doctor holding an active license to practice medicine in the State of Nevada (License No. 13702). Respondent originally licensed by the Board on September 15, 2010.

2. On November 11, 2016, Patient A[2] along with her parents went to HealthCare Partners Urgent Care, because she was suffering from coughing, wheezing, phlegm, and vomiting. Respondent evaluated the 2-year-old girl with "croup." Respondent started Patient A on prednisolone orally and also recommended a "steroid shot." Respondent successfully injected Kenalog into Patient A's lateral buttocks after two (2) unsuccessful attempts by Respondent's medical assistant. Patient A's medical record indicates "Kenalog 40mg/ml...Inject 0.5ml

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[1] The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal Complaint was authorized for filing, was composed of Board members Rachakonda D. Prabhu, M.D., Ms. Sandy Peltyn, and Victor M. Muro, M.D.

[2] Patient A's true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint. on this entry.

intramuscularly once...pt is given Kenalog 20mg IM." When asked by the IC, Respondent provided his written reply that he administered 0.5ml of Kenalog 20mg/ml IM. Respondent did not obtain an informed consent from Patient A's parents for the invasive procedure of a steroid shot (injection of the Kenalog). The medical record is not clear as to whether Patient A received an injection of 20mg or 10mg of Kenalog intramuscularly. There was no "shot record" section of Patient A's medical record as there was no documentation of the Kenalog vial's identification, lot number, nor date of expiration. Moreover, there was no indication of the specific injection shot location nor who delivered the shot (Respondent) to Patient A.

3. Approximately, two (2) weeks later, Patient A's parents noticed that Patient A's injection spot upon her buttocks had become a "divet" and eventually a "crater" that was sensitive to the touch. Skin atrophy is a known complication of a steroid intramuscular injection. Standard of care for toddlers (Patient A) who cannot "keep anything down" due to constant vomiting is an intramuscular or intravenous administration of steroids. Here, Patient A indicated only vomited once a day in the mornings, and not constantly though out the day, and should have been given an oral steroid. Respondent should have offered to Patient A's parent an oral option first, prior to the injection shot and discussed the risks and benefits of the steroid medication with them. For toddlers, such as Patient A, the proximal lateral thigh is the appropriate location for intramuscularly injections, not into a toddler's buttocks.

COUNT I

NRS 630.301(4) (Malpractice)

4. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

5. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.

6. NAC 630.040 defines malpractice as the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.

7. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when

OFFICE OF THE ...ERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

he provided medical services to Patient A, because he failed to obtain and document an informed consent for the injection of Kenalog, and when he failed to properly inject the Kenalog into the proximal lateral thigh instead of Patient A's buttocks.

8. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNT II

NRS 630.3062(1)(a) (Failure to Maintain Proper Medical Records)

9. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

10. NRS 630.3062(1)(a) provides that the failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient is grounds for initiating disciplinary action against a licensee.

11. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to document his actions when he treated Patient A, whose medical records were not timely, legible, accurate, and complete. Respondent failed to document an informed consent for Patient A's Kenalog injection from her parents and discuss the risks and benefits of the medication before giving it to the child. Additionally, Patient A's medical records of having the shot, including the information from the vial, do not exist making Patient A's medical records inaccurate and incomplete.

12. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

WHEREFORE, the Investigative Committee prays:

1. That the Board give Respondent notice of the charges herein against him and give him notice that he may file an answer to the Complaint herein as set forth in NRS 630.339(2) within twenty (20) days of service of the Complaint;

2. That the Board set a time and place for a formal hearing after holding an Early Case Conference pursuant to NRS 630.339(3);

///

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

3. That the Board determine what sanctions to impose if it determines there has been a violation or violations of the Medical Practice Act committed by Respondent;

4. That the Board award fees and costs for the investigation and prosecution of this matter as outlined in NRS 622.400;

5. That the Board make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 1 day of November, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

ROBERT G. KILROY, J.D.
Senior Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: rkilroy@medboard.nv.gov
Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Victor M. Muro, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the Complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

DATED this 3rd day of November, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: V M Muro MD
VICTOR M. MURO, M.D.
Chairman of the Investigative Committee

OFFICE OF THE ATTORNEY
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **HAI THANH NGUYEN, M.D.,** **Respondent.**	**Case No. 21-38084-1** **(FILED UNDER SEAL)**

FILED
NOV 03 2021
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

PATIENT DESIGNATION

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) hereby submits its **PATIENT DESIGNATION** to identify the true and correct identity of the patient(s) referenced in the filed formal Complaint, Case No. 21-38084-1.

1. Patient A's true and correct identity is as follows:

Name: [redacted]
DOB:

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA
* * * * *

In the Matter of Charges and Complaint Against HAI THANH NGUYEN, M.D., Respondent.	Case No. 21-38084-1

HAI THANH NGUYEN, M.D.'S ANSWER TO COMPLAINT

COMES NOW, Respondent HAI THANH NGUYEN, M.D., by and through his counsel of record, ROBERT C. McBRIDE, ESQ. and T. CHARLOTTE BUYS, ESQ., of the law firm of McBRIDE HALL and for his Answer to the State of Nevada Board of Medical Examiners' (hereinafter "Board") Complaint, admits, denies, and alleges as follows:

1. This answering Respondent admits those allegations contained in Paragraph 1 of the Board's Complaint.

2. Answering Paragraph 2 of the Board's Complaint, this answering Respondent denies each and every allegation of malpractice contained therein. As to the remainder of Paragraph 2, this answering Respondent is without sufficient knowledge or information upon which to base a belief as to the truth or falsity of the allegations contained in Paragraph 2, and upon said grounds denies each and every allegation contained therein.

3. Answering Paragraph 3 of the Board's Complaint, this answering Respondent denies each and every allegation of malpractice contained therein. As to the remainder of Paragraph 3, this answering Respondent is without sufficient knowledge or information upon which to base a belief as to the truth or falsity of the allegations contained in Paragraph 3, and upon said grounds denies each and every allegation contained therein.

///

///

///

COUNT I

NRS 630.301(4) (Malpractice)

4. Answering Paragraph 4 of the Board's Complaint, this answering Respondent repeats and realleges each and every response to Paragraphs 1 through 3, inclusive, and incorporates the same by reference as though set forth fully herein.

5. Answering Paragraph 5 of the Board's Complaint, this answering Respondent admits that Nevada Revised Statute Section 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee, but this answering Respondent specifically denies committing malpractice.

6. Answering Paragraph 6 of the Board's Complaint, this Answering Respondent admits that Nevada Administrative Code Section 630.040 defines malpractice, but this answering Respondent specifically denies committing malpractice.

7. Answering Paragraph 7 of the Board's Complaint, this Answering Respondent denies each and every allegation contained in paragraph 7 of the Board's Complaint.

8. Answering Paragraph 8 of the Board's Complaint, this Answering Respondent denies each and every allegation contained in paragraph 8 of the Board's Complaint.

COUNT II

NRS 630.3062(1)(a) (Failure to Maintain Complete Medical Records)

9. Answering Paragraph 9 of the Board's Complaint, this answering Respondent repeats and realleges each and every response to Paragraphs 1 through 8, inclusive, and incorporates the same by reference as though set forth fully herein.

10. Answering Paragraph 10 of the Board's Complaint, this answering Respondent admits that Nevada Revised Statute Section 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee, but this Answering Respondent specifically denies committing malpractice.

11. Answering Paragraph 11 of the Board's Complaint, this answering Respondent denies each and every allegation contained in paragraph 11 of the Board's Complaint.

12. Answering Paragraph 12 of the Board's Complaint, this answering Respondent denies each and every allegation contained in paragraph 12 of the Board's Complaint.

FIRST AFFIRMATIVE DEFENSE

Respondent alleges that The Nevada State Board of Medical Examiners' Complaint on file herein fails to state a claim upon which relief can be granted.

SECOND AFFIRMATIVE DEFENSE

The Board's Complaint is in whole or in part, void for vagueness, violative of Respondent's due process rights under the Constitutions of the State of Nevada and the United States of America and cannot serve as a basis for discipline of Respondent.

THIRD AFFIRMATIVE DEFENSE

The Nevada State Board of Medical Examiners has failed to comply with the requirements of N.R.S. 630, *et seq.* and N.A.C. 630 *et seq.*

FOURTH AFFIRMATIVE DEFENSE

Respondent fully performed and discharged all obligations owed to the patient, including satisfying the applicable standard of care to which the patient was entitled.

FIFTH AFFIRMATIVE DEFENSE

If a violation occurred it was the result of intervening and/or superseding events, factors, occurrences or conditions, which were in no way caused by Respondent, and for which Respondent is not responsible.

SIXTH AFFIRMATIVE DEFENSE

The Nevada State Board of Medical Examiners' Complaint is time barred.

SEVENTH AFFIRMATIVE DEFENSE

The Nevada State Board of Medical Examiners' Complaint does not comply with NRS 630.301.

EIGHTH AFFIRMATIVE DEFENSE

Each and every service rendered to the patient by this answering Respondent was expressly and/or impliedly consented to and authorized by the patient and/or the patient's authorized representative on the basis of a full and complete disclosure to the patient of all material facts

known or reasonably believed be true concerning the patient's physical condition and the appropriate alternative procedures available for treatment of such condition

NINTH AFFIRMATIVE DEFENSE

All possible affirmative defenses may not have been alleged herein so far as sufficient facts were not available after reasonable inquiry upon filing of this answering Respondent's Answer and, therefore, this answering Respondent reserves the right to amend his Answer to include additional affirmative defenses if subsequent investigation so warrants.

WHEREFORE, the Respondent prays that The Nevada State Board of Medical Examiners take nothing by way of the Complaint on file herein; and that Respondent recover all costs, attorneys' fees, and damages incurred as a result of the Complaint.

DATED this 23rd day of November 2021.

McBRIDE HALL

By: */s/ T. Charlotte Buys*
ROBERT C. McBRIDE, ESQ.
Nevada Bar No.: 7082
T. CHARLOTTE BUYS, ESQ.
Nevada Bar No.: 14845
8329 W. Sunset Road, Suite 260
Las Vegas, Nevada 89113
Attorneys for Respondent
Hai Thanh Nguyen M.D.

CERTIFICATE OF SERVICE

I hereby certify that on the 23rd day of November 2021, I served a true correct copy of **RESPONDENT'S ANSWER TO COMPLAINT**, by mailing via United States mail to the following:

Robert Kilroy, Esq.
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
Attorneys for the Investigative Committee

/s/ Natalie Jones
An Employee of McBride Hall

HealthCare Partners
Medical Group

April 24, 2017

Lara Ward, Investigator
NEVADA STATE BOARD OF MEDICAL EXAMINERS
6010 South Rainbow Blvd.,
Complex A, Building 1, Ste. 2
Las Vegas, Nevada 89118

Re: BME Case No.: [redacted]
PATIENT: [redacted]

Dear Mr. Ray:

I am in receipt of your letter dated March 28, 2017 concerning the above-named patient, [redacted] I appreciate the opportunity to respond to the allegations related to the care I provided to her and additional time in which to do so. Copies of [redacted]'s medical records which I have obtained are enclosed for your review and file.

According to your letter, the complaint alleges that "the patient presented to you for medical treatment on or around November 04, 2016. Allegedly, after performing an evaluation, you advised the patient's parents that you were going to administer a "steroid shot." Reportedly, you allowed an assistant to administer the shot. After two failed attempts the patient cried and screamed in pain and had to be restrained by her parents. The parents requested that you administer the shot. It has been further alleged that the patient developed a bruise around the injection site and a few weeks later a "crater" then formed and the area continues to be "sensitive to the touch." Therefore, your care and treatment of the patient may have fallen below the standard of care."

I adamantly deny that my care and treatment of [redacted] fell below the standard of care and I will address each of these allegations in turn.

I did see patient [redacted] on November 4th, 2016 at HealthCare Partners Urgent Care. I evaluated the patient and did get a history of cough and wheezing from the parent. The child's parent mentioned her symptoms had worsened overnight from a prior occurrence of croup. The patient also had a family history of asthma.

After doing an examination on the child, I thought there may be a chance she had croup again. I informed the mother of the child that the standard treatment for croup is steroids. I prescribed prednisolone oral steroids for the patient, and in addition, I obtained verbal consent from the parent to give the child a steroid injection. I asked the medical assistant, Barry Misiuk, to give the patient an injection of Kenalog 20 mg IM. Above and beyond the standard of

9480 W. Charleston Blvd. Suite 150 Las Vegas, NV 89117
Ph. (702)228-5477 Fax (702)225-7981

duties for medical assistants is to give injections of medications ordered by physicians.

Mr. Misiuk, who was not my regular medical assistant for that day, used an alcohol swab to clean the skin on the patient's lateral buttock where the injection was to be placed. Mr. Misiuk apparently tried to give the shot but the child squirmed and moved unexpectedly when the assistant tried to give the injection. As such, Mr. Misiuk informed me he was unable to inject the Kenalog due to the child's apprehension and movement.

At that point, I asked Mr. Misiuk to assist the parent to hold the child. I then administered the Kenalog injection of 0.5 mL (Kenalog 20mg/mL) to the lateral buttock. A bandage was applied at the injection site and I did apologize to the patient's parent that the injection took more than one try to give.

I asked the parent to place a cold pack on child's buttock to relieve any discomfort or swelling that might occur. I discussed with the parent prescriptions we were sending and care instructions with the parent. I also encouraged the parent to follow up with child's pediatrician.

I believe my care and treatment of [redacted] was within the standard of care. It is appropriate to utilize a medical assistant to administer an injection, and at times one may have to administer an injection more than once, and in particular when a patient does not hold still during the procedure. This type of occurrence is a known complication of this type of procedure, and certainly not below the standard of care.

I trust that the information and summary I have provided will assist you in your review of this matter. However, should you require any additional information, please do not hesitate to contact me.

Respectfully,

Hai Nguyen, M.D.

Enclosures

“No. 5 Patient A’s Medical Record”

MEDICAL RECORDS

This exhibit contains person medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310

“No. 5 Patient A’s Medical Record”

CERTIFICATE OF CUSTODIAN OF RECORDS

STATE OF NEVADA)
)
COUNTY OF CLARK)

COMES NOW, **Marla Saulsberry**, being duly sworn deposes and
(Full Name)
says as follows:

1. That the deponent is the **Authorized Agent** for **Intermountain Health Care**,
(Job Title) (Employer)
and in such capacity is the custodian of records of the office or institution.

2 That on the 7 day of March 2022, the deponent received a HIPAA Compliant Records Authorization for the release of records:

3. That the deponent has examined the originals of any and all records and has made a true and exact copy of the records and provide a true and complete copy of those documents are attached hereto.

4. That the original of the records was made at or near the time of the act and/or event recited therein by or from information transmitted by a person with knowledge in the course of a regularly conducted activity of the deponent, or the office or institution in which the deponent is engaged.

Patient Name: [redacted]

Date of Birth: [redacted]

☒ Medical Records ☐ Billing Records ☐ Medical and Billing Records

☐ Radiology & Diagnostics ☐ Film Breakdown ☐ No Internal X-rays ☐ No X-rays

☐ Billing records are pending, charges take 45 to 65 days to post from the date of service. Please submit a new request within the allotted time.

☐ Other: (specify) _____.

☐ This office has no record on file of the above-named individual.

☐ Records have been purged.

SIGNATURE

This instrument was acknowledged before me
on this 7 day of March 2022.

NOTARY PUBLIC in and for
said COUNTY and STATE

CHRISTOPHER LOPEZ
Notary Public - State of Nevada
County of Clark
APPT. NO. 16-3574-1
My App. Expires Aug. 23, 2024

“No. 6 Medical Administration Log”

MEDICAL RECORDS

This exhibit contains person medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310

“No. 6 Medical Administration Log”

HealthCare Partners Nevada. an Intermountain Healthcare company	**STANDARD OPERATING PROCEDURE**	SOP No.	CLSOP 60
		Page No.:	1 of 4
		Date Originated:	01/25/2011
		Effective Date:	01/25/2011
Injectable Medication Administration	Department: HCPNV Clinical Division	Date Reviewed:	03/04/2014
	Prepared By: Kellie Crawford, RN and Ellen Aliberti, RN	Date Revised:	01/13/2020
	Approved By:  **Steven Evans, MD Sr. Medical Director UM and Quality, Chairperson QMMC** Date: 01.07.2020	Revision No:	2
		Supersedes No:	N/A
Operational Areas: All Clinical Areas			

I. **PURPOSE:** To ensure proper storing, handling, preparation and administration of injectable medications are followed. All staff must adhere to the "7 Rights of Medication Administration", the "3 Safety Checks" and the "One Needs, One Time and One Patient" standards of practice.

II. **SCOPE:** Providers, Medical Assistants, RN, LNP

III. **DEFINITIONS:**

Aseptic Technique: Aseptic technique is a procedure used by medical staff to prevent the spread of infection. The goal is to reach asepsis, which means an environment that is free of harmful microorganisms.

IV. **EQUIPMENT:**

A. Biohazard container: Bio-hazardous waste containers must be rigid and leak proof with a tight fitting lid. They must be labeled with either the words "Biohazardous Waste", or with a biohazard symbol and the word "Biohazard". The labels must be placed on both the lid and the sides of the container. The labels must be visible from all sides of the container.

B. Pharma Waste and RCRA containers: In order to be in compliance with all E.P.A. and OSHA standards certain pharmaceutical waste is considered either hazardous to our environment and/or incompatible when disposed of improperly. Pharma waste and RCRA containers are clearly labeled and Pharma Waste Job Aids are available in all clinics to assist teammates with proper disposal.

C. Sharps container: A puncture-resistant and leak-proof container with a one-way top used to dispose of sharps. These containers are required to be in every clinic and is regulated by the Occupational Safety and Health Administration (OSHA). These containers must be replaced promptly when it is approximately 3/4ths full or up to the indicated level.

V. **PROCEDURE/ACTION:**

A. Handling of medication:

1. All medication vials must be handled per manufacturer's direction.
2. All medication containers/vials must be disposed of properly.
3. Any single and multi-dose vials (MDV's)/bottles with medication present should be disposed of in the wet pharma waste bin.
4. Empty medication containers should be disposed of in a trash receptacle.
5. Non-glass or glass medication container/vial with medication still present should be placed in the proper pharma waste container.

6. Any pre-filled syringe where medication needs to be wasted prior to administration should be placed in the appropriate pharma waste container.

B. Medication Quality Assurance Check:

1. Glass ampules require filtered needles for withdrawing medication. Once drawn up in a syringe, remove and discard filtered needle and replace with a non-filtered and the appropriate gauge needle before administering to the patient.
2. All Multi-dose vials (MDV's) must be initialed, have a documented date, time opened, and expiration date. (Use 28-day medication expiration calendar)
3. Discard properly within 28 days from date vial was opened.
4. All vials must be handled using aseptic technique.
5. Once medication is drawn up from a multi-dose vial, the needle needs to be changed prior to administering the medication to the patient.
6. If the medication vial is compromised in any way, the vial must be discarded.

C. Injection Administration:

1. Administration must be under the order of the provider, if written order is unclear, clarify order with provider.
2. Clinical teammates may take a verbal order from a provider but need to repeat the order back to the provider to ensure full understanding and document if before the medication preparation is completed.
3. Medication preparation will adhere to the three safety checks.
4. Medication administration will follow the "7 Rights of Medication Administration": Right Patient, Right Medication/Vaccine, Right Dose, Right Route, Right Time, Right Reason, Right Documentation.
5. A clinician must be onsite during the administration of any medication.
6. Verify allergy history of the patient via the medical record and document any new allergies in the medical record and notify clinician prior to administering medication.
7. If allergy information contraindicates medication administration, inform clinician immediately.
8. Educate the patient prior to the injection regarding reason for medication, and possible side effects and secure informed consent.
9. Prepare all medication for administration per manufacturer's direction via product insert.
10. Prior to administration of insulin or medications requiring calculations, another clinical team member must validate by checking:
    - Provider order.
    - Label on the medication container.
    - Calculation/dosage in the syringe.
11. Prior to a first time administration of a contraceptive injection or if the patient is outside of the timeframe for subsequent injections a clinical team member must validate that the patient is not pregnant by:
    - Performing a urine pregnancy test
12. Ensure that any medication that requires reconstitution is properly diluted based on manufacturer's directions.
13. Diluent must be specifically written as an order if it is a medication itself such as Lidocaine.
14. Mixing, rolling between palms, etc. must be done per manufacturer's direction via package insert.
15. Do not pre-fill syringe prior to immediate contact with patient.
16. Pre-filled syringes are only acceptable when packaged by pharmacist/manufacturer.
17. Medication should be prepared in patient room if feasible.

18. Select needle size and length based on injection location and size of the patient.
19. If more than one injection has been ordered do not use same injection site.
20. Adult intramuscular injection sites include the vastus lateralis, ventrogluteal, dorsogluteal deltoid. See diagram A below.
21. Adult subcutaneous injection sites include the abdomen, let and buttock area. See diagram B below.
22. Always aspirate intramuscular injections before administration to prevent injecting directly into vein. If blood is withdrawn during aspiration, remove needle, discard syringe and draw up medication in new syringe. EXCEPTION: Vaccines and Immunizations do NOT require aspiration according to CDC guidelines.
23. Vastus lateralis is preferred site for children (thigh) from birth to 36 months of age for intramuscular and subcutaneous injections.
24. Injectable medications using the deltoid muscle must be limited to no greater than 1cc/ml.
25. Document in EHR all of the following: the date, time, medication, NDC number, dosage, site, needle gauge patient's consent and patient's tolerance of procedure and any adverse reactions and patient education.

Diagram A

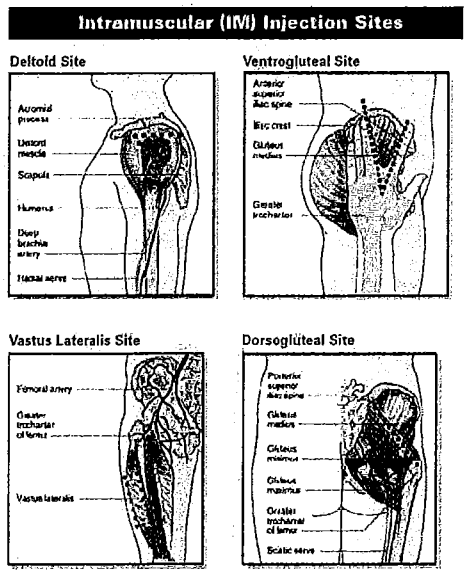
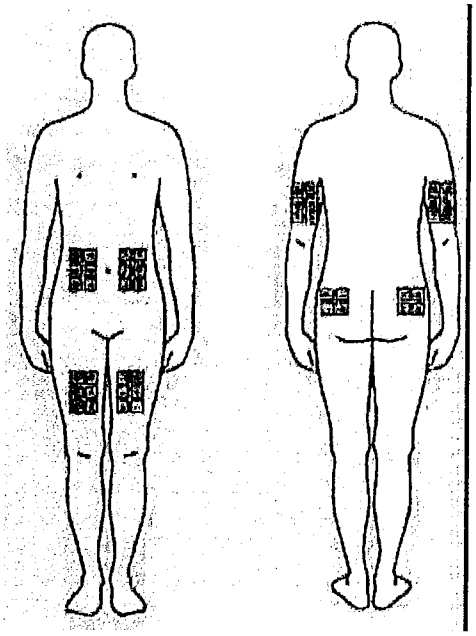


Diagram B



VI. DOCUMENTATION/REFERENCES:

A. The "7 Rights of Medication Administration": 1.) Right Patient, 2.) Right Medication/Vaccine, 3.) Right Dose, 4.) Right Route, 5.) Right Time, 6.) Right Reason, 7.) Right Documentation.

B. Multi-dose Vials SOP

C. HCP Vaccination Form

D. Controlled Substance Log

VII. HISTORY:

Date	Prior SOP No.	Superseded By	Reason for Revision
01/25/2011			New SOP
04/02/2014			Revised
02/28/2018			Revised to update practices.
01.07.2020			Information added to CLSOP in regards to contraceptive injections.

Eduardo Añorga, M.D.
8 Pony Lane
Rolling Hills Estates, Ca 90274
c. 310-701-7485 f. 310-544-2411

Curriculum Vitae

Eduardo Añorga, M.D.
Board Certified Family Physician

Education:

Bachelors of Arts in Biology, with Honors
University of California, Santa Cruz
1980

Doctor of Medicine
University of Vermont
1984

Family Practice Residency
University of California, Irvine/
Memorial Medical Center of Long Beach
1987

Certifications:

American Board of Family Practice
Certified 1987
Re-certified 1994, 2001, 2008, 2015

American Board of Family Practice
Certificate of Added Qualification, Sports Medicine
1993-2000

American Board of Quality Management and
Utilization Review Physicians
1991-1994

California State License
G56001

Drug Enforcement Administration
BAO164133

Professional Experience:

Private Practice
1988- February 2017

Torrance Memorial Physician Network (Office address: 2640 Lomita Blvd, Suite 200, Torrance, Ca 90505)
2017-January 2020

Beach Cities Orthopedics and Sports Medicine (Office address: 2990 Lomita Blvd. Suite B, Torrance, Ca 90505)

Occupational Health Physician
Allied Signal Corporation, Torrance, CA 1988-1998
ExxonMobil-Torrance Refining independent contractor, Torrance, CA 2000-Present

Clinical Instructor of Family Medicine
University of California, Los Angeles
1997-2014

Clinical Assistant Professor of Family Medicine
Western University of Health Sciences
College of Osteopathic Medicine of the Pacific
2002-2018

International Travel Medicine Consultant
Medex, Inc., Baltimore, MD (Now United Health Care Global)
1997- Present

Athletic Team Physician
University of Southern California
1997- 2000

Utilization Review Chairman
Torrance Hospital Independent Physicians Association
1989-1991

Torrance Memorial Medical Center:

- Utilization Review Chairman 1991-1992
- Department of Family Practice, Quality Management Committee 1994-2003
- Chairman of the Miracle of Living Community Education Program 2001-2018
- Executive Committee 1991, 1992, 2004, 2005, 2006
- Chairman of the Medical Education/Library Committee 2004
- Chairman of the Department of Family Practice 2005, 2006
- TMPN Quality Management Committee 2017-2019

Consulting Physician:
Oceanaire- Center for Discovery Residential Treatment for Eating Disorders
2007-March 2020

Hospital Privileges:

Torrance Memorial Medical Center
Torrance, CA
1988-Present

Community Service:

Westside Neighborhood Clinic, A Non-profit Organization
Long Beach, CA
Board of Directors
1990-2014
President of the Board of Directors
1995-2014

Children's Clinic of Long Beach, A Non-profit Organization
Long Beach CA
Board of Directors
2014-2017

Child Hope International, A Non-profit Organization
Port Au Prince, Haiti
2008-2016

Languages:

English
Spanish

Hobbies and Activities:

Sports: Surfing, cycling, skiing, Jiu-Jitsu.
Writing: The Smarter Athlete: Your Guide to Peak Performance

Triamcinolone Acetonide

DrugPoint Summary

DOSING/ADMINISTRATION

Pediatric Dosing

General Dosage Information

- Safety and effectiveness of the nasal inhaler has not been established for children under 2 years of age [3].
- Safety and effectiveness of the oral dental paste has not been established in children [12]
- (Zilretta(TM)) Not interchangeable with other injectable formulations of triamcinolone acetonide [13]

Allergic rhinitis, Perennial or seasonal

- Nasal inhalation (12 years and older) initial and MAX dose, 2 metered sprays (55 mcg/spray) in each nostril once a day (220 mcg/day) [2][3]
- Nasal inhalation (12 years and older), maintenance, 1 metered spray (55 mcg/spray) in each nostril once a day (110 mcg/day) [2][3]
- Nasal inhalation (6 to 12 years) initial and maintenance dose, 1 metered spray (55 mcg/spray) in each nostril once a day (110 mcg/day); MAX dose 220 mcg/day [2][3]
- Nasal inhalation (2 to 5 years) initial and maintenance dose, 1 metered spray (55 mcg/spray) in each nostril once a day (110 mcg/day); MAX dose 110 mcg/day [3]
- IM, 0.11 to 1.6 mg/kg/day in 3 or 4 divided doses dose may vary upon severity of symptoms [1]

Disorder of skin

- TOPICAL, apply cream, ointment, lotion or aerosol to affected areas 2 to 4 times a day [5][6][7][8]

Gout, acute, Short-term to tide patient over acute episode or exacerbation; Adjunct

- (Kenalog(R)-40, IM) Initial, 0.11 to 1.6 mg/kg/day IM injected deeply into the gluteal muscle in 3 or 4 divided doses (3.2 to 48 mg/m(2) body surface area/day) [1]

Inflammatory disorder of musculoskeletal system, Short-term to tide patient over acute episode or exacerbation; Adjunct

- (Kenalog(R)-40, IM) Initial, 0.11 to 1.6 mg/kg/day IM injected deeply into the gluteal muscle in 3 or 4 divided doses (3.2 to 48 mg/m(2) body surface area/day) [1]

Leukemia

- 1 month and older, IM, initial, 0.11 to 1.6 mg/kg/day in 3 or 4 divided doses injected deeply into the gluteal muscle, dose may vary upon severity of symptoms [1]

Malignant lymphoma

- 1 months and older, IM, initial, 0.11 to 1.6 mg/kg/day in 3 or 4 divided doses injected deeply into the gluteal muscle, dose may vary upon severity of symptoms [1]

Nephrotic syndrome, Idiopathic or lupus erythematosus-induced

- older than 2 years, IM, initial, 0.11 to 1.6 mg/kg/day in 3 or 4 divided doses injected deeply into the gluteal muscle, dose may vary upon severity of symptoms [1]

Tight foreskin

- 0.1% cream applied twice daily for 8 weeks [14] OR 0.02% cream applied twice daily for 6 weeks (off-label dosage) [15]

FDA Uses

- Acquired hemolytic anemia
- Allergic rhinitis, Perennial or seasonal
- Asthma
- Collagen disease
- Disorder of endocrine system
- Disorder of eye
- Disorder of gastrointestinal tract
- Disorder of respiratory system
- Disorder of skin
- Ganglion cyst, of synovium, tendon and bursa
- Gout, acute, Short-term to tide patient over acute episode or exacerbation; Adjunct
- Inflammatory disorder of musculoskeletal system, Short-term to tide patient over acute episode or exacerbation; Adjunct
- Leukemia
- Malignant lymphoma
- Multiple sclerosis
- Nephrotic syndrome, Idiopathic or lupus erythematosus-induced
- Osteoarthritis of knee - Pain
- Stomatitis

Non-FDA Uses

- Macular retinal edema
- Pain
- Proliferative retinopathy due to diabetes mellitus; Adjunct
- Tight foreskin

Dose Adjustments

No results available

Administration

General Information

- (Zilretta(TM)) For intraarticular use only; not for administration by epidural, intrathecal, IV, intraocular, intramuscular, intradermal, or subQ routes [13]

Intra-articular

- (Kenalog(R)) Shake vial well before withdrawing medication; do not use if clumping occurs [9] [1].
- (Kenalog(R)) Inject immediately following withdrawal into syringe [9][1].
- (Zilretta(TM)) Must be prepared with the diluent included in the single-dose kit [13]
- (Zilretta(TM)) It is normal for residue of the suspension product to remain on the vial walls following withdrawal of contents [13].
- (Zilretta(TM)) Promptly inject following preparation to avoid settling of the suspension. If necessary, prepared suspension may be stored in the vial for up to 4 hours in ambient conditions; gently swirl to resuspend any settled microspheres prior to administration[13].
- (Zilretta(TM)) Not suitable for administration into small joints (eg, hand) [13]

Intralesional

- shake vial well before withdrawing medication; do not use if clumping occurs [9]
- inject immediately following withdrawal into syringe [9]

Intramuscular

- shake vial well before withdrawing medication; do not use if clumping occurs [1]
- inject immediately following withdrawal into syringe [1]
- inject deeply into gluteal muscle; use alternate sites for subsequent injections [1]
- use a minimum needle length of 1.5 inches; a longer needle may be necessary in obese patients [1]

Intravitreal

- refrigerate, do not freeze, protect from light [4]
- visually inspect prefilled syringe; do not is use if discoloration or particulate matter is identified [4]
- adequate anesthesia and a broad-spectrum antibiotic should be given prior to injection; the injection procedure should be done under controlled aseptic conditions [4]
- use 1 syringe per eye; change sterile field, gloves, drapes, eyelid speculum, filter, and injection needles before administration to the other eye [4]

Nasal

- shake pump well before using [3]
- prime pump prior to first use by actuating 5 times or until a fine mist appears; reprime with 1 spray if pump has not been used for more than 14 days [3]

- discard after the labeled-number of actuations have been reached (after 120 actuations) even if the bottle is not completely empty [3]

Oral

- (dental paste) press a small amount onto the lesion until a thin film develops; do not rub in [12]
- (dental paste) bedtime application is optimal; apply after meals if used during the day [12]

Topical

- apply thin film to affected area and rub in gently [6][7][8]
- do not use occlusive dressings unless otherwise directed by physician [5][6][7][8]
- (aerosol spray) contents are flammable [5]

Comparative Efficacy

No results available

Place In Therapy

No results available

MEDICATION SAFETY

Contraindications

- Concomitant administration of live or live, attenuated vaccines [16][17]
- Hypersensitivity to triamcinolone acetonide or any other component of the product [18][13] [16][17][3][19][20]
- IM injection for idiopathic thrombocytopenic purpura [16][17]
- Primary treatment for status asthmaticus or acute asthma [19]
- Suprachoroidal injection for active or suspected ocular or periocular infections including most viral diseases of the cornea and conjunctiva, including active epithelial herpes simplex keratitis (dendritic keratitis), vaccinia, varicella, mycobacterial infections, and fungal diseases [18]

Precautions

- Administration: Not for IV [17], epidural, intrathecal, intraocular, IM, intradermal, or subQ administration [13]
- Administration: Unmasking of latent conditions (eg, eczema, rhinitis, conjunctivitis) may occur with transfer from systemic to aerosolized corticosteroid therapy, with increased risk following surgery, trauma, infection, or other stress; monitoring recommended [19]
- Cardiovascular: Use with caution in patients with recent myocardial infarction due to risk of left ventricular free-wall rupture [16][17]

- Cardiovascular: Blood pressure elevations may occur with average to large doses of corticosteroids; monitoring recommended [13][16][17]
- Cardiovascular: Fluid retention or edema may occur with average to large doses of corticosteroids; use cautiously in patients with congestive heart failure, hypertension, or renal insufficiency [13][16][17]
- Dermatologic: Kaposi sarcoma has been reported with corticosteroid use, especially with long-term therapy; clinical improvement may occur with discontinuation [16][17]
- Dermatologic: Injection-site atrophy may occur; avoid injection into deltoid [16]
- Dermatologic: Conditions which augment systemic absorption of topical corticosteroids (eg, use over large surface areas, prolonged use, and addition of occlusive dressings) [20]
- Dermatologic: Discontinue topical administration if dermatological infections do not respond to antifungals or antibacterials [20]
- Endocrine and metabolic: Fatal adrenal insufficiency has been reported in patients with asthma transferred from systemic to aerosolized corticosteroid therapy [19]
- Endocrine and metabolic: Adrenal insufficiency may occur with transfer from systemic to aerosolized corticosteroid therapy, with increased risk following surgery, trauma, infection, or other stress; monitoring recommended [19]
- Endocrine and metabolic: Hyperthyroidism or hypothyroidism may increase or decrease metabolic clearance of corticosteroids, respectively; dose adjustment may be required [13][16][17]
- Endocrine and metabolic: Increased risk of metabolic acidosis in premature or low-birthweight neonates (off-label use) due to benzyl alcohol exposure; monitor daily benzyl alcohol metabolic load from all sources with high doses or concomitant medications [16][17]
- Endocrine and metabolic: Reversible hypothalamic-pituitary-adrenal axis suppression may occur after treatment withdrawal, with potential progression to glucocorticosteroid insufficiency [18][13][16][17][20], especially in susceptible patients or with doses higher than recommended [19][3]
- Endocrine and metabolic: Hypothalamic-pituitary-adrenal (HPA) axis suppression, Cushing syndrome, and hyperglycemia may occur with corticosteroid use; monitoring recommended with chronic use [18]
- Endocrine and metabolic: Increased potassium excretion or sodium retention may occur with average to large doses of corticosteroids; use cautiously in patients with congestive heart failure, hypertension, or renal insufficiency [16][17]
- Endocrine and metabolic: Metabolic clearance of corticosteroids is decreased in hypothyroid patients and increased in hyperthyroid patients; dosage adjustments may be necessary with changes in thyroid status [18]
- Gastrointestinal: Patients with diverticulitis, active or latent peptic ulcer, fresh intestinal anastomoses, or nonspecific ulcerative colitis may be at increased risk of gastrointestinal perforation [13]; monitoring recommended [16][17]
- Hematologic: Increased risk of hypotension in premature or low-birthweight neonates (off-label use) due to benzyl alcohol exposure; monitor daily benzyl alcohol metabolic load from all sources with high doses or concomitant medications [16][17]
- Hepatic: Patients with cirrhosis may have increased risk of toxicity [16][17]
- Immunologic: Anaphylactoid reactions, including fatalities, have rarely been reported with corticosteroid therapy [13][16][17]
- Immunologic: Increased risk of infection (eg, viral, bacterial, fungal, protozoan, helminthic) [13]

- Immunologic: Activation of latent disease or worsening active infection may occur (ie, viral, bacterial, fungal, protozoan, or helminthic) [3][19]; amebiasis screening recommended before therapy initiation in at-risk patients [16][17]
- Immunologic: Tuberculosis reactivation may occur; monitoring recommended [16][17][3][19]
- Immunologic: Exposure to chicken pox or measles during corticosteroid treatment may result in a more serious or fatal disease course, particularly in patients with no history of these infections [13][16][17][3][19]
- Immunologic: Use cautiously in patients with Strongyloides (threadworm) infestation, as life-threatening enterocolitis and septicemia may develop [16][17]
- Immunologic: Avoid use in patients with systemic fungal infection [16][17]
- Immunologic: Impaired wound healing may occur with use with recent nasal ulcer, surgery, or trauma [3]
- Immunologic: Localized Candida albicans infections of the nose, mouth and pharynx have been reported; dose interruption may be required [3][19]
- Musculoskeletal: Avoid injection into an infected site, previously infected joint, or unstable joint [13].
- Musculoskeletal: Decreased bone formation and increased bone resorption may occur [13]
- Musculoskeletal: Risk of bone growth inhibition in pediatric patients; monitoring recommended [16][17][3][19]
- Musculoskeletal: Osteoporosis may occur, especially in postmenopausal women; monitoring recommended [16][17]
- Musculoskeletal: Intraarticular administration may damage joint tissues or cause septic arthritis; injection into joints that are unstable or with history of infection not recommended [13][16][17]
- Neurologic: Life-threatening and fatal neurologic events (eg, stroke, cortical blindness, quadriplegia, paraplegia, spinal cord infarction) have occurred with epidural or intrathecal corticosteroid administration (off-label use), with or without fluoroscopy [13][16][17]
- Neurologic: Avoid use with cerebral malaria [16][17]
- Neurologic: Increased risk of kernicterus in premature or low-birthweight neonates (off-label use) due to benzyl alcohol exposure; monitor daily benzyl alcohol metabolic load from all sources with high doses or concomitant medications [16][17]
- Neurologic: Avoid use [16] or high doses [17] in patients with traumatic brain injury
- Neurologic: Increased risk of acute myopathy in patients with neuromuscular transmission disorders (eg, myasthenia gravis) or concurrent use of neuromuscular blockers (eg, pancuronium) [16][17]
- Ophthalmic: Increased risk of secondary ocular infection, cataracts, glaucoma [18][16][17][3], and increased intraocular pressure [18] with corticosteroid use [18][16][17][3]; monitoring recommended [16][17][3]
- Ophthalmic: Oral use for optic neuritis not recommended [16][17]
- Ophthalmic: Avoid use with active ocular herpes simplex [18][16][17][3][19]. Use caution in patients with a history of ocular herpes simplex [18].
- Ophthalmic: Intraocular administration not recommended, as inflammation (eg, endophthalmitis), increased intraocular pressure, and vision loss have occurred [16][17]
- Ophthalmic: Intraocular pressure elevations may occur with long-term use (ie, longer than 6 weeks); monitoring recommended [13][16][17]

- Ophthalmic: Benzyl alcohol toxicity may occur with intraocular administration [16][17]
- Psychiatric: New onset or worsening of preexisting emotional instability or psychotic tendencies; monitoring recommended [13][16][17]
- Respiratory: Intranasal administration (ie, nasal turbinates) not recommended [16][17]
- Special populations: Increased risk of fatal "gasping syndrome" in premature or low-birthweight neonates (off-label use) due to benzyl alcohol exposure; monitor daily benzyl alcohol metabolic load from all sources with high doses or concomitant medications [16][17]
- Special populations: Pediatric patients increased risk of systemic toxicity with topical administration [20]

Adverse Effects

Common

- **Endocrine metabolic:** Cushing's syndrome
- **Neurologic:** Headache (Allergic rhinitis, 5.5% ; ; macular edema, 5%)
- **Ophthalmic:** Pain in eye (Macular edema, 3% to 12%), Raised intraocular pressure (Macular edema, 6% to 14%)
- **Respiratory:** Pharyngitis (5.1% to 25%)
- **Other:** Influenza-like illness (2% to 8.9%)

Serious

- **Endocrine metabolic:** Electrolytes abnormal, Hyperglycemia, Hypocortisolism secondary to another disorder
- **Gastrointestinal:** Gastrointestinal perforation
- **Immunologic:** Anaphylaxis (Rare), Angioedema
- **Musculoskeletal:** Infectious disorder of joint, Osteoporosis
- **Ophthalmic:** Cataract (Macular edema, 7%), Glaucoma (Rare)
- **Psychiatric:** Disturbance in mood, Unusual change in behavior
- **Respiratory:** Perforation of nasal septum

Black Box Warning 

No results available

REMS

No results available

Drug Interactions (single)

Drug-Drug Interactions (49)

Drugs:	Severity:	Documentation:	Summary:
ROTAVIRUS VACCINE -- CORTICOSTEROIDS	Contraindicated	Excellent	Concurrent use of ROTAVIRUS VACCINE and CORTICOSTEROIDS may result in an increased risk of infection by the live vaccine.
DESMOPRESSIN -- GLUCOCORTICOIDS	Contraindicated	Fair	Concurrent use of DESMOPRESSIN and GLUCOCORTICOIDS may result in increased risk of severe hyponatremia.
RITONAVIR -- GLUCOCORTICOIDS METABOLIZED BY CYP3A	Major	Excellent	Concurrent use of RITONAVIR and GLUCOCORTICOIDS METABOLIZED BY CYP3A may result in increased glucocorticoid exposure and decreased plasma cortisol, and increased risk of Cushing syndrome and adrenal insufficiency.
NIRMATRELVIR/RITONAV -- SYSTEMIC CORTICOSTEROIDS	Major	Excellent	Concurrent use of NIRMATRELVIR/RITONAV and SYSTEMIC CORTICOSTEROIDS may result in increased corticosteroid exposure; increased risk of Cushing syndrome and adrenal suppression.
SELECTED CORTICOSTEROIDS -- SELECTED FLUOROQUINOLONES interact(s) with: **Interacting substances**	Major	Excellent	Concurrent use of SELECTED CORTICOSTEROIDS and SELECTED FLUOROQUINOLONES may result in an increased risk of tendon rupture.
TRIAMCINOLONE [Systemic] --	Major	Fair	Concurrent use of COBICISTAT and TRIAMCINOLONE may

COBICISTAT [Systemic]			result in increased triamcinolone exposure and increased risk for systemic corticosteroid effects.
LUTETIUM LU 177 DOTATATE -- GLUCOCORTICOSTEROIDS	S Major	Fair	Concurrent use of LUTETIUM LU 177 DOTATATE and GLUCOCORTICOSTEROID may result in decreased lutetium Lu 177 dotatate efficacy.
MACIMORELIN -- AGENTS AFFECTING GROWTH HORMONE	S Major	Fair	Concurrent use of MACIMORELIN and AGENTS AFFECTING GROWTH HORMONE may result in false-positive or false-negative adult growth hormone deficiency diagnosis.
NADROPARIN -- GLUCOCORTICOIDS	S Major	Fair	Concurrent use of NADROPARIN and GLUCOCORTICOIDS may result in increased risk of bleeding.
SARGRAMOSTIM -- CORTICOSTEROIDS	S Major	Fair	Concurrent use of SARGRAMOSTIM and CORTICOSTEROIDS may result in increased myeloproliferative effects of sargramostim.
CERITINIB -- CYP3A SUBSTRATES	S Major	Fair	Concurrent use of CERITINIB and CYP3A SUBSTRATES may result in increased exposure of CYP3A substrate.
BEMIPARIN -- GLUCOCORTICOIDS	S Major	Fair	Concurrent use of BEMIPARIN and GLUCOCORTICOIDS may result in increased risk of bleeding.
ALDESLEUKIN -- GLUCOCORTICOIDS	S Major	Fair	Concurrent use of ALDESLEUKIN and GLUCOCORTICOIDS may result in reduced antitumor effectiveness.

PRIMIDONE [Systemic] -- TRIAMCINOLONE [Systemic]	Moderate	Good	Concurrent use of PRIMIDONE and TRIAMCINOLONE may result in decreased triamcinolone effectiveness.
SAIBOKU-TO -- CORTICOSTEROIDS	Moderate	Good	Concurrent use of SAIBOKU-TO and CORTICOSTEROIDS may result in enhanced and prolonged effect of corticosteroids.
HEXAFLUORENIUM [Systemic] -- TRIAMCINOLONE [Systemic]	Moderate	Good	Concurrent use of TRIAMCINOLONE and HEXAFLUORENIUM BROMIDE may result in decreased hexafluorenium bromide effectiveness; prolonged muscle weakness and myopathy.
AURANOFIN -- CORTICOSTEROIDS	Moderate	Good	Concurrent use of AURANOFIN and CORTICOSTEROIDS may result in increased risk of auranofin-related adverse effects.
ASPIRIN [Systemic] -- TRIAMCINOLONE [Systemic]	Moderate	Good	Concurrent use of ASPIRIN and TRIAMCINOLONE may result in an increased risk of gastrointestinal ulceration and subtherapeutic aspirin serum concentrations.
TRIAMCINOLONE [Systemic] -- ALCURONIUM [Systemic]	Moderate	Good	Concurrent use of ALCURONIUM and TRIAMCINOLONE may result in decreased alcuronium effectiveness; prolonged muscle weakness and myopathy.
PHENYTOIN -- TRIAMCINOLONE	Moderate	Good	Concurrent use of PHENYTOIN and TRIAMCINOLONE may result in decreased

interact(s) with:

Interacting substances			
			triamcinolone effectiveness.
LICORICE -- CORTICOSTEROIDS	Moderate	Good	Concurrent use of LICORICE and CORTICOSTEROIDS may result in increased risk of corticosteroid adverse effects.
ATRACURIUM [Systemic] -- TRIAMCINOLONE [Systemic]	Moderate	Good	Concurrent use of ATRACURIUM and TRIAMCINOLONE may result in decreased atracurium effectiveness; prolonged muscle weakness and myopathy.
METOCURINE [Systemic] -- TRIAMCINOLONE [Systemic]	Moderate	Good	Concurrent use of TRIAMCINOLONE and METOCURINE may result in decreased metocurine effectiveness; prolonged muscle weakness and myopathy.
TRIAMCINOLONE [Systemic] -- GALLAMINE [Systemic]	Moderate	Good	Concurrent use of TRIAMCINOLONE and GALLAMINE may result in decreased gallamine effectiveness; prolonged muscle weakness and myopathy.
GLUCOCORTICOIDS -- TRETINOIN	Moderate	Fair	Concurrent use of GLUCOCORTICOIDS and TRETINOIN may result in decreased efficacy of tretinoin.
TRIAMCINOLONE [Systemic] -- ROCURONIUM [Systemic]	Moderate	Fair	Concurrent use of ROCURONIUM and TRIAMCINOLONE may result in decreased rocuronium effectiveness; prolonged muscle weakness and myopathy.
TRIAMCINOLONE [Systemic] --	Moderate	Fair	Concurrent use of PIPECURONIUM and

PIPECURONIUM [Systemic]			TRIAMCINOLONE may result in decreased pipecuronium effectiveness; prolonged muscle weakness and myopathy.
HYDROCHLOROTHIAZIDE [Systemic] -- TRIAMCINOLONE [Systemic]	Moderate	Fair	Concurrent use of HYDROCHLOROTHIAZIDE and TRIAMCINOLONE may result in hypokalemia and subsequent cardiac arrhythmias.
ANTHRAX VACCINE ADSORBED -- CORTICOSTEROIDS	Moderate	Fair	Concurrent use of ANTHRAX VACCINE ADSORBED and CORTICOSTEROIDS may result in an inadequate immunological response to the vaccine.
WARFARIN [Systemic] -- TRIAMCINOLONE [Systemic]	Moderate	Fair	Concurrent use of TRIAMCINOLONE and WARFARIN may result in increased risk of bleeding or diminished effects of warfarin.
MA HUANG -- CORTICOSTEROIDS	Moderate	Fair	Concurrent use of MA HUANG and CORTICOSTEROIDS may result in decreased effectiveness of corticosteroids.
PHENOBARBITAL [Systemic] -- TRIAMCINOLONE [Systemic]	Moderate	Fair	Concurrent use of PHENOBARBITAL and TRIAMCINOLONE may result in decreased corticosteroid effectiveness.
PANCURONIUM [Systemic] -- TRIAMCINOLONE [Systemic]	Moderate	Fair	Concurrent use of PANCURONIUM and TRIAMCINOLONE may result in decreased pancuronium effectiveness; prolonged muscle

			weakness and myopathy.
RIFAMPIN [Systemic] -- TRIAMCINOLONE [Systemic]	Moderate	Fair	Concurrent use of RIFAMPIN and TRIAMCINOLONE may result in decreased triamcinolone effectiveness.
GLYCEROL PHENYLBUTYRATE -- CORTICOSTEROIDS	Moderate	Fair	Concurrent use of GLYCEROL PHENYLBUTYRATE and CORTICOSTEROIDS may result in increased plasma ammonia levels.
TRIAMCINOLONE [Systemic] -- MIVACURIUM [Systemic]	Moderate	Fair	Concurrent use of MIVACURIUM and TRIAMCINOLONE may result in decreased mivacurium effectiveness; prolonged muscle weakness and myopathy.
VECURONIUM [Systemic] -- TRIAMCINOLONE [Systemic]	Moderate	Fair	Concurrent use of VECURONIUM and TRIAMCINOLONE may result in decreased vecuronium effectiveness; prolonged muscle weakness and myopathy.
TRIAMCINOLONE [Systemic] -- DOXACURIUM [Systemic]	Moderate	Fair	Concurrent use of DOXACURIUM and TRIAMCINOLONE may result in decreased doxacurium effectiveness; prolonged muscle weakness and myopathy.
TRIAMCINOLONE [Systemic] -- DICUMAROL [Systemic]	Moderate	Fair	Concurrent use of DICUMAROL and TRIAMCINOLONE may result in increased risk of bleeding or diminished effects of dicumarol.
ECHINACEA --		Fair	Concurrent use of

CORTICOSTEROIDS	**Moderate**		ECHINACEA and CORTICOSTEROIDS may result in decreased effectiveness of corticosteroids.
CORTICOSTEROIDS -- VACCINES interact(s) with: **Interacting substances**	**Moderate**	**Fair**	Concurrent use of CORTICOSTEROIDS and VACCINES may result in an inadequate immunological response to the vaccine.
CORTICOSTEROIDS -- INSULIN LISPRO, RECOMBINANT	**Moderate**	**Fair**	Concurrent use of CORTICOSTEROIDS and INSULIN LISPRO, RECOMBINANT may result in may decrease blood glucose lowering effect of insulin lispro.
TESTOSTERONE -- CORTICOSTEROIDS	**Moderate**	**Fair**	Concurrent use of TESTOSTERONE and CORTICOSTEROIDS may result in increased risk of edema.
TRIAMCINOLONE [Systemic] -- PHENPROCOUMON [Systemic]	**Moderate**	**Fair**	Concurrent use of PHENPROCOUMON and TRIAMCINOLONE may result in increased risk of bleeding or diminished effects of phenprocoumon.
TRIAMCINOLONE [Systemic] -- TUBOCURARINE [Systemic]	**Moderate**	**Fair**	Concurrent use of TUBOCURARINE and TRIAMCINOLONE may result in decreased tubocurarine effectiveness; prolonged muscle weakness and myopathy.
TRIAMCINOLONE [Systemic] -- CISATRACURIUM [Systemic]	**Moderate**	**Fair**	Concurrent use of CISATRACURIUM and TRIAMCINOLONE may result in decreased cisatracurium effectiveness; prolonged muscle weakness and myopathy.

TRIAMCINOLONE [Systemic] -- FLUINDIONE [Systemic]	Moderate	Fair	Concurrent use of FLUINDIONE and TRIAMCINOLONE may result in increased risk of bleeding or diminished effects of fluindione.
TRIAMCINOLONE [Systemic] -- ACENOCOUMAROL [Systemic]	Moderate	Fair	Concurrent use of ACENOCOUMAROL and TRIAMCINOLONE may result in increased risk of bleeding or diminished effects of acenocoumarol.
TUBERCULIN -- CORTICOSTEROIDS	Minor	Fair	Concurrent use of TUBERCULIN and CORTICOSTEROIDS may result in decreased reactivity to tuberculin.

Drug-ALLERGY Interactions (None found)

Drug-FOOD Interactions (None found)

Drug-ETHANOL Interactions (None found)

Drug-LAB Interactions (None found)

Drug-TOBACCO Interactions (None found)

Drug-PREGNANCY Interactions (1)

Drugs:	Severity:	Documentation:	Summary:
PREGNANCY -- TRIAMCINOLONE [Systemic]	Unknown	Unknown	No US FDA rating is available for Triamcinolone.

Drug-LACTATION Interactions (1)

Drugs:	Severity:	Documentation:	Summary:
LACTATION -- TRIAMCINOLONE	Major	Unknown	Infant risk cannot be ruled out: Available evidence and/or expert

[Systemic]

consensus is inconclusive or is inadequate for determining infant risk when Triamcinolone is used during breast-feeding. Weigh the potential benefits of treatment against potential risks before prescribing Triamcinolone during breast-feeding.

Definitions

Severity:

Contraindicated	The drugs are contraindicated for concurrent use.
Major	The interaction may be life-threatening and/or require medical intervention to minimize or prevent serious adverse effects.
Moderate	The interaction may result in exacerbation of the patient's condition and/or require an alteration in therapy.
Minor	The interaction would have limited clinical effects. Manifestations may include an increase in the frequency or severity of the side effects but generally would not require a Major alteration in therapy.
Unknown	Unknown.

Documentation:

Excellent	Controlled studies have clearly established the existence of the interaction.
Good	Documentation strongly suggests the interaction exists, but well-controlled studies are lacking.
Fair	Available documentation is poor, but pharmacologic considerations lead clinicians to suspect the interaction exists; or, documentation is good for a pharmacologically similar drug.
Unknown	Unknown.

IV Compatibility (single)

Solution

Common Solutions

Common Solutions

D5W (Dextrose 5% in water)	Not Tested
D10W (Dextrose 10% in water)	Not Tested

D5LR (Dextrose 5% in lactated Ringers)	– Not Tested
D5NS (Dextrose 5% in sodium chloride 0.9%)	– Not Tested
D5W - 1/2 NS (Dextrose 5% in sodium chloride 0.45%)	– Not Tested
NS (Normal saline (Sodium chloride 0.9%))	– Not Tested
1/2 NS (Sodium chloride 0.45%)	– Not Tested
Lactated Ringer's Injection	– Not Tested
Ringer's injection	– Not Tested

Other Solution(s) Results	Status	Solution Information

No other drug-solution combinations have been tested.

Y-Site

"Not Tested"

Admixture

"Not Tested"

Syringe

"Not Tested"

TPN/TNA

TPN (2-in-1) Results Summary	Status

There are no TPN Results.

TNA (3-in-1) Results Summary **Status**

There are no TNA Results.

Definitions

Compatible | Incompatible | Caution:Variable | Uncertain | Not Tested

Pregnancy Category

- Triamcinolone: May cause fetal harm (MDX)

Breast Feeding

- Triamcinolone: Micromedex: Infant risk cannot be ruled out.

Monitoring

- Improvement in the signs and symptoms of osteoarthritis of the knee-related pain may indicate efficacy [13].
- Cushing syndrome: With chronic use [18].
- Hyperglycemia: With chronic use [18].
- Hypothalamic-pituitary-adrenal (HPA) axis suppression: With chronic use [18].
- Imbalance in serum electrolytes in patients with congestive heart failure, hypertension, or renal insufficiency [13]
- Edema or weight gain in patients with congestive heart failure, hypertension, or renal insufficiency [13]
- Potential treatment adjustment: Patients with elevated intraocular pressure [13]
- Elevation of intraocular pressure (eg, perfusion of optic nerve head, tonometry): Immediately following suprachoroidal injection [18]

Do Not Confuse

No results available

MECHANISM OF ACTION

Mechanism of Action

- Triamcinolone acetonide is a synthetic glucocorticoid with immunosuppressive and anti-inflammatory activity. The primary mechanism of action for triamcinolone acetonide is as a corticosteroid hormone receptor agonist [18].Triamcinolone acetonide has anti-inflammatory, antipruritic and antiallergic properties. It also exerts a profound and varied metabolic effects, and changes the body's immune responses to different stimuli. The precise mechanism of action for its antiallergic activity is unknown [21][22][23][24].

PHARMACOKINETICS

Pharmacokinetics

Absorption

- Intranasal: time to peak concentration, 1.5 h [21]
- Oral: time to peak concentration, 1.5 h to 2 h [22]

Distribution

- Vd: 99.5 L (+/- 27.5 L) [21][22]
- Protein binding: approximately 68% [22]

Metabolism

- Extensively metabolized [22]
- Metabolites: 6beta-hydroxytriamcinolone acetonide, 21-carboxytriamcinolone acetonide, 21-carboxy-6beta-hydroxytriamcinolone acetonide [22]

Excretion

- Fecal: approximately 60% [22]
- Renal: approximately 40% [22]

Elimination Half Life

- (IV), 88 minutes [21][22]
- (Intranasal), 3.1 hours [21]

PATIENT EDUCATION

Medication Counseling

- Tell patient to report fever or other symptoms of infections [25].
- Instruct patient to report exposure to chicken pox or measles [25].
- Advise patient to avoid live or live attenuated vaccines during therapy due to drug-induced immunosuppression [26].
- Intraarticular side effects may include sinusitis, cough, contusions, and joint swelling [25].

- Suprachoroidal side effects may include headache [18].
- Counsel patient to report new or worsening behavioral or mood disturbances [25].
- Tell patient to report if the eye becomes red, sensitive to light, painful, or develops a change in vision [18].

Patient Handouts

Triamcinolone (Injection route, Suspension, Suspension, Extended Release)
Triamcinolone (Intraocular route, Suspension)

TOXICOLOGY

Clinical Effects

CORTICOSTEROIDS

- USES: Antiinflammatory agents used to treat a variety of clinical conditions, including adrenal insufficiency, asthma, various allergy disorders, Duchenne muscular dystrophy, and autoimmune disorders (eg, hemolytic anemia, rheumatoid arthritis, systemic lupus erythematosus). Corticosteroids are available in oral, parenteral, inhalational, and topical formulations. PHARMACOLOGY: Multiple mechanisms of action including anti-inflammatory activity, immunosuppressive properties, and antiproliferative actions. Anti-inflammatory effects result from decreased formation, release and activity of the mediators of inflammation (eg, kinins, histamine, liposomal enzymes, prostaglandins, leukotrienes) which reduced the initial manifestations of the inflammatory process. The immunosuppressive properties decrease the response to delayed and immediate hypersensitivity reactions (eg, type III and type IV). The antiproliferative effects reduce hyperplastic tissue characteristic of psoriasis. TOXICOLOGY: Corticosteroids decrease calcium absorption, increase calcium excretion, and inhibit osteoblast formation, leading to a decrease in bone formation and an increase in bone resorption, thereby contributing to the development of osteoporosis. EPIDEMIOLOGY: Acute toxicity following overdose is rare. OVERDOSE: Acute ingestion is rarely a clinical problem. Acute adrenal insufficiency rarely reported after overdose. ADVERSE EFFECTS: Cardiac dysrhythmias (ie, atrial fibrillation)(methylPREDNISolone), seizures (methylPREDNISolone), anaphylaxis. CHRONIC EXPOSURE: Cushingoid appearance, muscle wasting and weakness, hypertension, hyperglycemia, subcapsulary cataracts and glaucoma, osteoporosis, psychosis. ABRUPT WITHDRAWAL: Dysphoria, irritability, emotional liability, depression, fatigue, anxiety, depersonalization, myalgia, and arthralgia.

Range of Toxicity

CORTICOSTEROIDS

- TOXICITY: Acute ingestion is rarely a clinical problem; effects rarely occur with administration of less than three weeks duration. An adolescent ingested 30 mg dexamethasone and subsequently developed acute adrenal insufficiency. Patient recovered following administration of methylPREDNISolone. CHRONIC EXPOSURE: Six infants (aged 3 to 8 months) who were treated with large amounts (up to 10 tubes for 1.5 to 5 months) of topical corticosteroids for diaper dermatitis developed Cushing's syndrome and adrenocortical insufficiency. Hepatomegaly

and hepatosteatosis were observed in 5 and 3 patients, respectively. THERAPEUTIC DOSE: Varies with drug and indication.

Treatment

CORTICOSTEROIDS

- Supportive care: MANAGEMENT OF TOXICITY: Treatment is symptomatic and supportive. Seizures have been reported with IV pulse methylPREDNISolone therapy. If seizures occur, administer IV benzodiazepines, barbiturates.
- Decontamination: PREHOSPITAL: Serious toxicity is not expected after ingestion of corticosteroids alone, and prehospital gastrointestinal decontamination is not routinely required. HOSPITAL: Significant toxicity is not expected after overdose; gastrointestinal decontamination is generally not necessary. Activated charcoal should be considered after extremely large ingestions or if more toxic coingestants are involved.
- Airway management: Endotracheal intubation and mechanical ventilation may be required in patients with severe allergic reactions, but this is rare.
- Antidote: None
- Allergic reaction, acute: MILD/MODERATE: Monitor airway. Administer antihistamines with or without inhaled beta agonists, corticosteroids or epinephrine. SEVERE: Oxygen, aggressive airway management, antihistamines, epinephrine, corticosteroids, ECG monitoring and IV fluids.
- Monitoring of patient: Routine laboratory studies are not likely to be necessary after acute overdose. Serum electrolytes and glucose are useful to assess for adverse effects from chronic therapy. Monitor vital signs, fluid and electrolyte status as indicated. Monitor neurologic status as indicated in symptomatic patients. Plasma concentrations are not readily available or clinically useful in the management of overdose.
- Enhanced elimination procedure: Hemodialysis and hemoperfusion are UNLIKELY to be of value because of the high degree of protein binding and large volume of distribution.
- Patient disposition: HOME CRITERIA: Patients with a minor unintentional exposure who are asymptomatic or have mild symptoms can likely be managed at home. OBSERVATION CRITERIA: Moderate to severely symptomatic patients and those with deliberate overdose should be sent to a healthcare facility for evaluation and treated until symptoms resolve. ADMISSION CRITERIA: Patients who remain symptomatic despite adequate treatment should be admitted. CONSULT CRITERIA: Consult a Poison Center for assistance in managing patients with severe toxicity or in whom the diagnosis is unclear.

ABOUT

How Supplied

Generic

- Injection Suspension: 10 MG/1 ML, 40 MG/1 ML
- Mucous Membrane Paste: 0.1 %
- Nasal Spray: 55 MCG/1 Actuation
- Topical Cream: 0.025 %, 0.1 %, 0.5 %

- Topical Lotion: 0.025 %, 0.1 %
- Topical Ointment: 0.025 %, 0.05 %, 0.1 %, 0.5 %
- Topical Spray: 0.147 MG/1 GM

DermacinRx Silazone PharmaPak

- Topical Cream: 0.1 %

Good Neighbor Pharmacy 24 Hour Nasal Allergy

- Nasal Spray: 55 MCG/1 Actuation

Good Sense Nasal Allergy

- Nasal Spray: 55 MCG/1 Actuation

Kenalog

- Topical Spray: 0.147 MG/1 GM

Kenalog-10

- Injection Suspension: 10 MG/1 ML

Kenalog-40

- Injection Suspension: 40 MG/1 ML

Kenalog-80

- Injection Suspension: 80 MG/1 ML

Leader Nasal Allergy

- Nasal Spray: 55 MCG/1 Actuation

Nasacort Allergy 24HR

- Nasal Spray: 55 MCG/1 Actuation

Nasacort AQ

- Nasal Spray: 55 MCG/1 Actuation

Nasal Allergy

- Nasal Spray: 55 MCG/1 Actuation

Oralone

- Mucous Membrane Paste: 0.1 %

PremierPro Rx Triamcinolone Acetonide

- Injection Suspension: 40 MG/1 ML

Pro-C-Dure 5 Kit

- Injection Suspension: 40 MG/1 ML

Pro-C-Dure 6 Kit

- Injection Suspension: 40 MG/1 ML

Sila III

- Topical Ointment: 0.1 %

Triamcinolone Acetonide Novaplus

- Injection Suspension: 40 MG/1 ML

Trianex

- Topical Ointment: 0.05 %

Triderm

- Topical Cream: 0.1 %, 0.5 %

Triesence

- Injection Suspension: 40 MG/1 ML

Xipere

- Intraocular Suspension: 40 MG/1 ML

Zilretta

- Injection Powder for Suspension, Extended Release: 32 MG

Drug Properties

No results available

Storage & Stability

No results available

Trade Names 

- Aristocort A
- Azmacort
- Cinolar
- Kenalog
- Kenalog In Orabase
- Kenalog-10
- Kenalog-40
- Nasacort

All Trade Names

Regulatory Status

- RX/OTC

References

1. Product Information: KENALOG(R)-40 intramuscular intra-articular suspension for injection, triamcinolone acetonide intramuscular intra-articular suspension for injection. Bristol-Myers Squibb Company (per FDA), Princeton, NJ, 2011.

2. Product Information: triamcinolone acetonide intranasal spray, triamcinolone acetonide intranasal spray. Barr Laboratories, Inc (per FDA), Pomona, NY, 2009.

3. Product Information: Nasacort(R) AQ nasal spray, triamcinolone acetonide nasal spray. Sanofi-Aventis US LLC, Bridgewater, NJ, 2008.

4. Product Information: TRIVARIS(TM) intravitreal, intra-articular, IM injectable suspension, triamcinolone acetonide intravitreal, intra-articular, IM injectable suspension. Allergan, Inc. (per FDA), Irvine, CA, 2008.

5. Product Information: KENALOG(R) SPRAY topical aerosol, triamcinolone acetonide topical aerosol. RANBAXY (per FDA), Jacksonville, FL, 2011.

6. Product Information: triamcinolone acetonide 0.025%, 0.1% topical ointment, triamcinolone acetonide 0.025%, 0.1% topical ointment. E. Fougera & Co, Melville, NY, 2008.

7. Product Information: triamcinolone acetonide 0.025%, 0.1% topical lotion, triamcinolone acetonide 0.025%, 0.1% topical lotion. E. Fougera & Co, Melville, NY, 2008.

8. Product Information: triamcinolone acetonide 0.025%, 0.1%, 0.5% topical cream, triamcinolone acetonide 0.025%, 0.1%, 0.5% topical cream. E. Fougera & Co, Melville, NY, 2008.

9. Product Information: KENALOG(R)-10 intra-articular intralesional suspension for injection, triamcinolone acetonide intra-articular intralesional suspension for injection. Bristol-Myers Squibb Company (per FDA), Princeton, NJ, 2011.

10. Khanna D , Khanna PP , Fitzgerald JD , et al: 2012 American College of Rheumatology guidelines for management of gout. Part 2: Therapy and antiinflammatory prophylaxis of acute gouty arthritis. Arthritis Care Res (Hoboken) 2012; 64(10):1447-1461.
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11. Product Information: ZILRETTA(R) extended-release intra-articular injectable suspension, triamcinolone acetonide extended-release intra-articular injectable suspension. Flexion Therapeutics Inc (per manufacturer), Burlington, MA, 2020.

12. Product Information: ORALONE(R) dental paste, triamcinolone acetonide 0.1% dental paste. TaroPharma (per DailyMed), Hawthorne, NY, 2010.

13. Product Information: ZILRETTA(TM) extended-release injectable suspension, triamcinolone

acetonide extended-release injectable suspension. Flexion Therapeutics, Inc (per manufacturer), Burlington, MA, 2017.

14. Moreno G, Corbalan J, Penaloza B, et al: Topical corticosteroids for treating phimosis in boys. Cochrane Database Syst Rev 2014; 2014(9):1.
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16. Product Information: KENALOG(R)-40 intramuscular injection suspension, intra-articular injection suspension, triamcinolone acetonide intramuscular injection suspension, intra-articular injection suspension. Bristol-Myers Squibb Company (per FDA), Princeton, NJ, 2014.

17. Product Information: KENALOG(R)-10 intra-articular injection suspension, intralesional injection suspension, triamcinolone acetonide intra-articular injection suspension, intralesional injection suspension. Bristol-Myers Squibb Company (per FDA), Princeton, NJ, 2014.

18. Product Information: XIPERE(TM) suprachoroidal injectable suspension, triamcinolone acetonide suprachoroidal injectable suspension. Clearside Biomedical Inc (per FDA), Alpharetta, GA, 2021.

19. Product Information: AZMACORT(R) inhalation aerosol, triamcinolone acetonide inhalation aerosol. Kos Pharmaceuticals Inc, Cranbury, NJ, 2008.

20. Product Information: triamcinolone acetonide topical cream, triamcinolone acetonide topical cream. Vintage Pharmaceuticals,LLC, Huntsville, AL, 2006.

21. Product Information: NASACORT(R) AQ nasal spray, triamcinolone acetonide nasal spray. Aventis Pharmaceuticals Inc, Bridgewater, NJ, 2004.

22. Product Information: AZMACORT(R) inhalation aerosol powder, triamcinolone acetonide inhalation aerosol powder. Aventis Pharmaceuticals Inc, Bridgewater, NJ, 2003.

23. Product Information: KENALOG(R)-40 injection suspension, triamcinolone acetonide injection suspension. Bristol-Myers Squibb Company, Princeton, NJ, 2001.

24. Product Information: triamcinolone acetonide dental paste, USP, triamcinolone acetonide Mucous dental paste, USP. TARO Pharmaceuticals Inc, Downsview, Ontario, Canada, 1992.

25. Product Information: ZILRETTA(R) extended-release intra-articular injectable suspension, triamcinolone acetonide extended-release intra-articular injectable suspension. Flexion Therapeutics Inc (per FDA), Burlington, MA, 2020.

26. Product Information: KENALOG(R)-40 intramuscular, intra-articular injection, triamcinolone acetonide intramuscular, intra-articular injection. Bristol-Myers Squibb Company (per FDA), Princeton, NJ, 2018.

Last Modified: February 23, 2022

ANTIMICROBIAL AGENTS AND CHEMOTHERAPY, July 2002, p. 2299–2302 Vol. 46, No. 7
0066-4804/02/$04.00+0 DOI: 10.1128/AAC.46.7.2299–2302.2002

Comparison of Corticosteroids for Treatment of Respiratory Syncytial Virus Bronchiolitis and Pneumonia in Cotton Rats

Martin G. Ottolini,[1]* Spencer J. Curtis,[2]† David D. Porter,[3] Amy Mathews,[2] Joann Y. Richardson,[1] Val G. Hemming,[4] and Gregory A. Prince[2]

Department of Pediatrics[1] and Office of the Dean,[4] F. Edward Hébert School of Medicine of the Uniformed Services University of the Health Sciences, Bethesda, and Virion Systems Inc., Rockville,[2] Maryland, and Department of Pathology of the University of California at Los Angeles, Los Angeles, California[3]

Received 17 October 2001/Returned for modification 7 January 2002/Accepted 26 March 2002

Triamcinolone acetonide, methylprednisolone, and dexamethasone were each evaluated in combination with palivizumab (Synagis) for the therapy of established respiratory syncytial virus infection in the cotton rat. Triamcinolone and methylprednisolone proved to be more effective than dexamethasone in reducing lung pathology. No recurrence of viral replication or pulmonary pathology followed the cessation of therapy.

The cotton rat model of respiratory syncytial virus (RSV) infection has been used for over 20 years to study the pathogenesis and potential therapy of RSV (7). This animal model was invaluable in proving the protective efficacy of anti-RSV antibody (6) and led to the development of RSV immunoglobulin (RespiGam; Medimmune, Inc., Gaithersburg, Md.) and palivizumab (Synagis; Medimmune) for the prevention of severe RSV infection of the lower respiratory tract (1, 2, 5). These preparations have been less effective when used therapeutically (9, 10). Recent experiments with cotton rats demonstrated that combined systemic therapy with palivizumab and triamcinolone acetonide, a potent glucocorticoid, greatly reduced inflammatory changes and viral replication in animals infected with RSV but that palivizumab alone reduced viral titers without altering the degree of inflammation (8). Systemic triamcinolone acetonide is rarely used in the treatment of pediatric respiratory disease, and therefore we examined the comparative efficacies of triamcinolone acetonide, methylprednisolone, and dexamethasone when each was used in combination with palivizumab in the treatment of experimental RSV infection.

(This work was presented in part at the 70th Meeting of the Society for Pediatric Research, Baltimore, Md., May 2001 [Pediatr. Res. Program issue APS-SPR **43**:A1359].)

Animals. *Sigmodon hispidus* cotton rats were obtained from a breeding colony maintained at Virion Systems, Incorporated, Rockville, Md.

Virus. A pool of the prototypic Long strain of RSV (American Type Culture Collection, Manassas, Va.) which contained $10^{7.5}$ PFU/ml was used for all experiments. Pulmonary virus titers were determined by plaque assay as described previously (7).

Monoclonal antibody and glucocorticoids. Palivizumab was provided by Medimmune, Inc. Triamcinolone acetonide (Steris Laboratories, Phoenix, Ariz.) was administered as a single daily intramuscular (i.m.) dose of 16 mg/kg of body weight, a dose previously found to be highly effective in reducing pulmonary pathology (8). Dexamethasone (Elkins-Sinn, Cherry Hill, N.J.) was administered in a single daily intraperitoneal (i.p.) dose of 0.6 or 1.2 mg/kg. Methylprednisolone (Solu-Medrol; Phamacia and Upjohn, Kalamazoo, Mich.) was administered in a total daily dose of 4 or 8 mg/kg divided into four equal i.p. injections.

Histopathology. Lungs were inflated to their normal volume with 10% formalin. Hematoxylin- and eosin-stained slides were prepared from coronal paraffin-embedded sections and scored for peribronchiolitis (inflammatory cells around small airways), interstitial pneumonitis (inflammatory cell infiltration and thickening of alveolar walls), and alveolitis (inflammatory cells within the alveolar spaces). Slides were scored in a blind manner by three investigators using a scale ranging from 0 (no inflammatory changes) to 100 (maximum inflammation).

Statistical analysis. A viral titer was expressed as the geometric mean ± standard error for all animals in a group. The two-tailed Student *t* test, using summary data, was used to determine the significance of differences between groups. The number of histologic lesions was expressed as an arithmetic mean ± the standard error of the numbers of lesions for all animals in a group. Statistical analysis of composite histology scores was not done, since the data are disparate.

Comparative efficacies of different steroids. Six groups of eight or nine cotton rats were intranasally infected with $10^{6.5}$ PFU of RSV Long and given one i.m. dose of palivizumab (15 mg/kg) 3 days later. Five of these groups received glucocorticoid therapy as described above on days 3, 4, and 5 postinfection. All animals, including those in a seventh uninfected group, were sacrificed for histopathological evaluation on day 6 after infection, and the results are summarized in Fig. 1A. As we reported earlier, therapy with palivizumab alone did not reduce pathology (8). Triamcinolone acetonide and either dose of methylprednisolone reduced the pathologic changes to nearly baseline levels. Dexamethasone at either dose was less

* Corresponding author. Mailing address: Department of Pediatrics, F. Edward Hébert School of Medicine, The Uniformed Services University of the Health Sciences, Bethesda, MD 20814-4799. Phone: (301) 295-3130. Fax: (301) 295-3898. E-mail: MOTTOLINI@USUHS.MIL.

†Present address: The Uniformed Services University of the Health Sciences, Bethesda, Md.

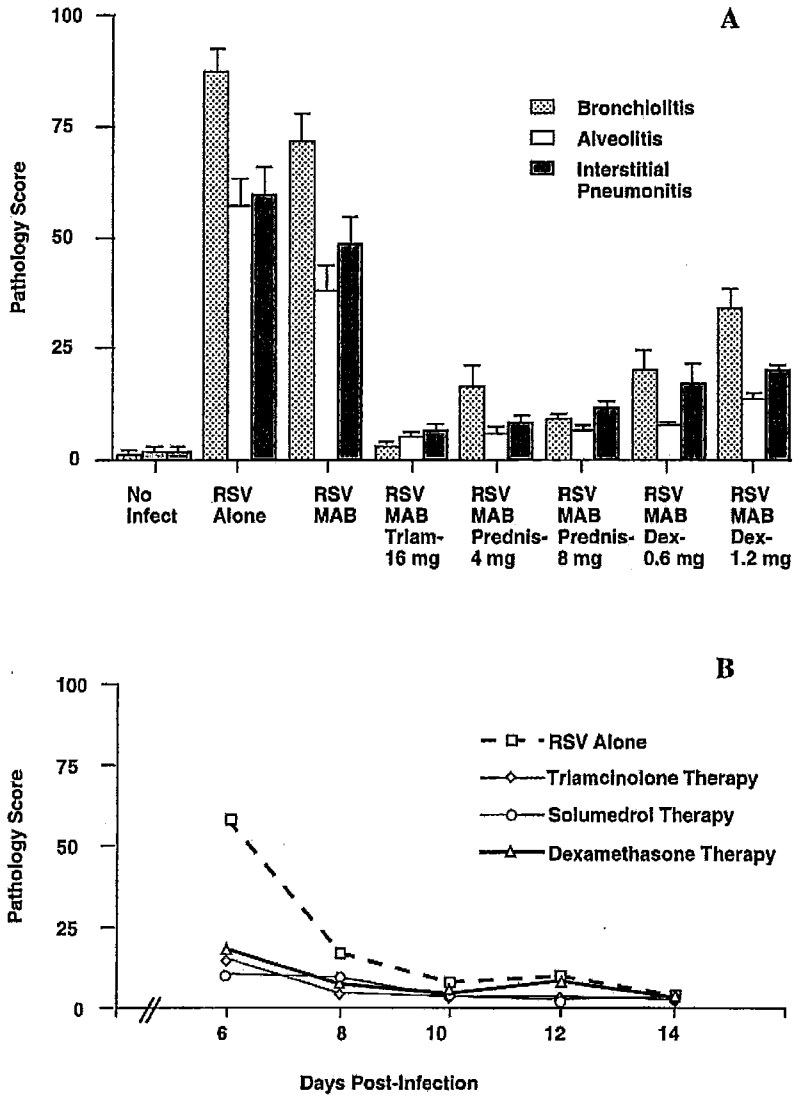

FIG. 1. (A) Arithmetic mean pulmonary pathology scores (plus standard errors) for degrees of bronchiolitis, alveolitis, and interstitial pneumonitis seen in cotton rats on day 6 after experimental infection with $10^{6.5}$ PFU of RSV (excluding values for the uninfected controls) after receiving the therapy indicated. Each group contained eight or nine animals. No Infect, uninfected controls; MAB, monoclonal antibody; Triam, triamcinolone; Prednis, methylprednisolone; Dex, dexamethasone. (B) Composite pathology scores (arithmetic means) after infection with $10^{6.5}$ PFU of RSV, with sampling of pulmonary histopathology on days 6, 8, 10, 12, and 14 after the rats received the therapy indicated. Each indicated data point represents a mean value for three or four animals.

effective in reducing inflammation, particularly peribronchiolitis. Representative lung photomicrographs are shown in Fig. 2.

Recurrence of virus replication or pathologic changes. Four groups of 20 cotton rats each were infected intranasally with $10^{6.5}$ PFU of RSV Long. On the third day postinfection, animals in three of the groups received one i.m. dose of palivizumab (15 mg/kg) and concurrent glucocorticoid therapy on days 3, 4, and 5 in the following doses: for triamcinolone acetonide, 16 mg/kg i.m. once daily; for methylprednisolone, 4 mg/kg administered as 1 mg/kg i.p. every 6 h; or for dexamethasone, 0.6 mg/kg i.p. once daily. Animals were sacrificed on days 6, 8, 10, 12, and 14 postinfection for viral titration and histopathology.

Inflammation following untreated RSV infection was significant on day 6 postinfection and slowly abated over the subsequent 8 days (Fig. 1B). All three glucocorticoid-treated groups had greater reductions in pathology; no group had a recurrence of histopathology over the 2-week period. On day 6, $10^{2.5}$ PFU of RSV per g was recovered from the lungs of untreated animals, while 10^3 PFU/g was recovered from the lungs of triamcinolone-palivizumab-treated animals on days 6 and 8 of experimental infection. No further viral replication was detected in any groups during the remainder of the experiment. This scant level of viral replication eliminated the need for comparative statistical analysis of viral titrations.

In recent years, there has been a realization that the therapy of certain infectious diseases needs to target both the infectious agent and host inflammation. The results of trials using glucocorticoids to treat RSV disease are mixed, with some trials suggesting the efficacy of such treatment and others

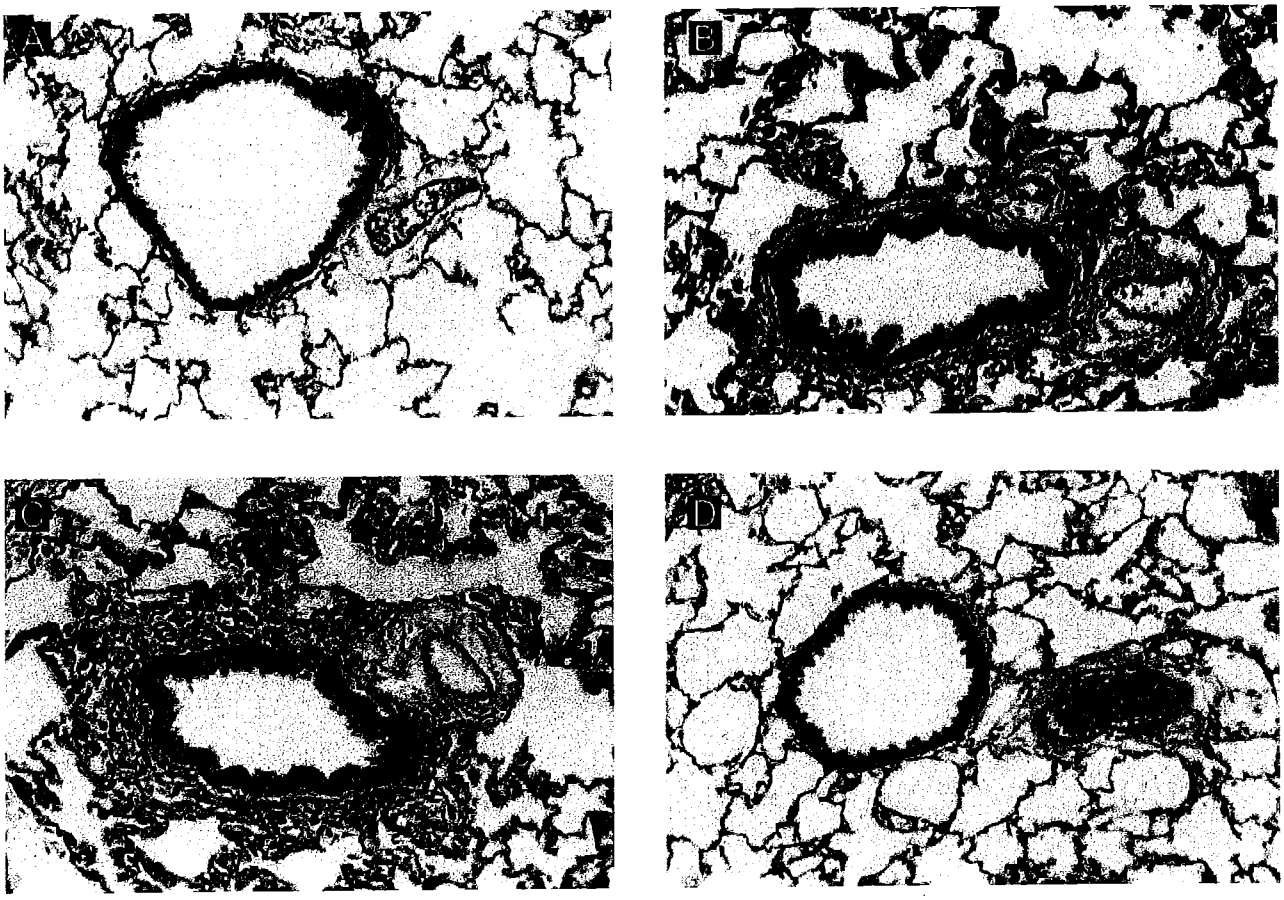

FIG. 2. (A) Uninfected cotton rat lung. (B) Untreated RSV infection on day 6. Note the significant components of peribronchiolitis, interstitial pneumonia, and alveolitis with a predominating mononuclear infiltrate. (C) RSV infection on day 6 after treatment with palivizumab alone on day 3. Little or no improvement is apparent compared to untreated infected lung tissue. (D) RSV infection on day 6, after treatment with palimizumab on day 3 and methylprednisolone (4 mg/kg) on days 3, 4, and 5. Note the reduction in inflammatory infiltrates to levels near those of the uninfected control in panel A. All photomicrographs are of hematoxylin- and eosin-stained lung at a magnification of ×64.

showing no benefit (4). The types and doses of corticosteroids have been sufficiently varied to make the interpretation of results extremely difficult. A similar long-standing debate about the effectiveness of corticosteroid treatment of viral croup was resolved in 1989 when a meta-analysis of all reported clinical trials suggested that the type and dose of corticosteroid were critical factors in determining the outcome (3), a conclusion reinforced by the publication of a well-designed, double-blind, placebo-controlled study which demonstrated a significant benefit from a large dose of dexamethasone (11). In this series of experiments, triamcinolone and methylprednisolone were more effective than dexamethasone and lacked adverse effects; they also reduced pulmonary histopathology in RSV-infected cotton rats by equal amounts.

These experiments were conducted with drugs already licensed by the Food and Drug Administration and in common pediatric usage. The novelty of our approach is the combination of these two types of drugs, an antiviral agent along with an anti-inflammatory agent, to treat viral pneumonia. Though cotton rats do not exhibit overt clinical disease, this animal model has a proven track record of predicting the outcomes of several RSV interventions. We feel that the findings of this study demonstrating the efficacy and safety of our approach in the cotton rat model, provide the rationale for clinical trials of combined therapy.

The opinions and assertions contained herein are those of the authors alone and do not reflect the views of the Uniformed Services University, The United States Air Force, or The Department of Defense.

This work was supported in part by USUHS research grants RO86CM and RO86DM.

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KENALOG®-40 INJECTION
triamcinolone acetonide injectable suspension, USP

NOT FOR USE IN NEONATES
CONTAINS BENZYL ALCOHOL

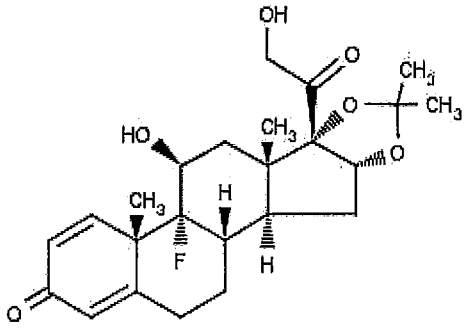
For Intramuscular or Intra-articular Use Only
NOT FOR INTRAVENOUS, INTRADERMAL, INTRAOCULAR, EPIDURAL, OR INTRATHECAL USE

DESCRIPTION

Kenalog®-40 Injection (triamcinolone acetonide injectable suspension, USP) is a synthetic glucocorticoid corticosteroid with anti-inflammatory action. THIS FORMULATION IS SUITABLE FOR INTRAMUSCULAR AND INTRA-ARTICULAR USE ONLY. THIS FORMULATION IS NOT FOR INTRADERMAL INJECTION.

Each mL of the sterile aqueous suspension provides 40 mg triamcinolone acetonide, with sodium chloride for isotonicity, 0.99% (w/v) benzyl alcohol as a preservative, 0.75% carboxymethylcellulose sodium, and 0.04% polysorbate 80. Sodium hydroxide or hydrochloric acid may be present to adjust pH to 5.0 to 7.5. At the time of manufacture, the air in the container is replaced by nitrogen.

The chemical name for triamcinolone acetonide is 9-Fluoro-11β,16α,17,21-tetrahydroxypregna-1,4-diene-3,20-dione cyclic 16,17-acetal with acetone. Its structural formula is:



MW 434.50

Triamcinolone acetonide occurs as a white to cream-colored, crystalline powder having not more than a slight odor and is practically insoluble in water and very soluble in alcohol.

CLINICAL PHARMACOLOGY

Glucocorticoids, naturally occurring and synthetic, are adrenocortical steroids that are readily absorbed from the gastrointestinal tract.

Naturally occurring glucocorticoids (hydrocortisone and cortisone), which also have salt-retaining properties, are used as replacement therapy in adrenocortical deficiency states. Synthetic analogs such as triamcinolone are primarily used for their anti-inflammatory effects in disorders of many organ systems.

Kenalog-40 Injection has an extended duration of effect which may be sustained over a period of several weeks. Studies indicate that following a single intramuscular dose of 60 mg to 100 mg of triamcinolone acetonide, adrenal suppression occurs within 24 to 48 hours and then gradually returns to normal, usually in 30 to 40 days. This finding correlates closely with the extended duration of therapeutic action achieved with the drug.

INDICATIONS AND USAGE

Intramuscular

Where oral therapy is not feasible, injectable corticosteroid therapy, including Kenalog-40 Injection (triamcinolone acetonide injectable suspension, USP) is indicated **for intramuscular use** as follows:

Allergic states: Control of severe or incapacitating allergic conditions intractable to adequate trials of conventional treatment in asthma, atopic dermatitis, contact dermatitis, drug hypersensitivity reactions, perennial or seasonal allergic rhinitis, serum sickness, transfusion reactions.

Dermatologic diseases: Bullous dermatitis herpetiformis, exfoliative erythroderma, mycosis fungoides, pemphigus, severe erythema multiforme (Stevens-Johnson syndrome).

Endocrine disorders: Primary or secondary adrenocortical insufficiency (hydrocortisone or cortisone is the drug of choice; synthetic analogs may be used in conjunction with mineralocorticoids where applicable; in infancy, mineralocorticoid supplementation is of particular importance), congenital adrenal hyperplasia, hypercalcemia associated with cancer, nonsuppurative thyroiditis.

Gastrointestinal diseases: To tide the patient over a critical period of the disease in regional enteritis and ulcerative colitis.

Hematologic disorders: Acquired (autoimmune) hemolytic anemia, Diamond-Blackfan anemia, pure red cell aplasia, selected cases of secondary thrombocytopenia.

Miscellaneous: Trichinosis with neurologic or myocardial involvement, tuberculous meningitis with subarachnoid block or impending block when used with appropriate antituberculous chemotherapy.

Neoplastic diseases: For the palliative management of leukemias and lymphomas.

Nervous system: Acute exacerbations of multiple sclerosis; cerebral edema associated with primary or metastatic brain tumor or craniotomy.

Ophthalmic diseases: Sympathetic ophthalmia, temporal arteritis, uveitis, and ocular inflammatory conditions unresponsive to topical corticosteroids.

Renal diseases: To induce diuresis or remission of proteinuria in idiopathic nephrotic syndrome or that due to lupus erythematosus.

Respiratory diseases: Berylliosis, fulminating or disseminated pulmonary tuberculosis when used concurrently with appropriate antituberculous chemotherapy, idiopathic eosinophilic pneumonias, symptomatic sarcoidosis.

Rheumatic disorders: As adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in acute gouty arthritis; acute rheumatic carditis; ankylosing spondylitis; psoriatic arthritis; rheumatoid arthritis, including juvenile rheumatoid arthritis (selected cases may require low-dose maintenance therapy). For the treatment of dermatomyositis, polymyositis, and systemic lupus erythematosus.

Intra-Articular

The intra-articular or soft tissue administration of Kenalog-40 Injection is indicated as adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in acute gouty arthritis, acute and subacute bursitis, acute nonspecific tenosynovitis, epicondylitis, rheumatoid arthritis, synovitis, or osteoarthritis.

CONTRAINDICATIONS

Kenalog-40 Injection is contraindicated in patients who are hypersensitive to any components of this product (see **WARNINGS: General**).

Intramuscular corticosteroid preparations are contraindicated for idiopathic thrombocytopenic purpura.

WARNINGS

General

Exposure to excessive amounts of benzyl alcohol has been associated with toxicity (hypotension, metabolic acidosis), particularly in neonates, and an increased incidence of kernicterus, particularly in small preterm infants. There have been rare reports of deaths, primarily in preterm infants, associated with exposure to excessive amounts of benzyl alcohol. The amount of benzyl alcohol from medications is usually considered negligible compared to that received in flush solutions containing benzyl alcohol. Administration of high dosages of medications containing this preservative must take into account the total amount of benzyl alcohol administered. The amount of benzyl alcohol at which toxicity may occur is not known. If the patient requires more than the recommended dosages or other medications containing this preservative, the practitioner must consider the daily metabolic load of benzyl alcohol from these combined sources (see **PRECAUTIONS: Pediatric Use**).

Rare instances of anaphylactoid reactions have occurred in patients receiving corticosteroid therapy (see **ADVERSE REACTIONS**). Cases of serious anaphylactic reactions and anaphylactic shock, including death, have been reported in individuals receiving triamcinolone acetonide injection, regardless of the route of administration.

Because Kenalog-40 Injection (triamcinolone acetonide injectable suspension, USP) is a suspension, it should **not** be administered intravenously.

Unless a **deep** intramuscular injection is given, local atrophy is likely to occur. (For recommendations on injection techniques, see **DOSAGE AND ADMINISTRATION**.) Due to the significantly higher incidence of local atrophy when the material is injected into the deltoid area, this injection site should be avoided in favor of the gluteal area.

Increased dosage of rapidly acting corticosteroids is indicated in patients on corticosteroid therapy subjected to any unusual stress before, during, and after the stressful situation. Kenalog-40 Injection is a long-acting preparation, and is not suitable for use in acute stress situations. To avoid drug-induced adrenal insufficiency, supportive dosage may be required in times of stress (such as trauma, surgery, or severe illness) both during treatment with Kenalog-40 Injection and for a year afterwards.

Results from one multicenter, randomized, placebo-controlled study with methylprednisolone hemisuccinate, an intravenous corticosteroid, showed an increase in early (at 2 weeks) and late (at 6 months) mortality in patients with cranial trauma who were determined not to have other clear indications for corticosteroid treatment. High doses of systemic corticosteroids, including Kenalog-40 Injection, should not be used for the treatment of traumatic brain injury.

Cardio-Renal

Average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention, and increased excretion of potassium. These effects are less likely to occur with the synthetic derivatives except when they are used in large doses. Dietary salt restriction and potassium supplementation may be necessary (see **PRECAUTIONS**). All corticosteroids increase calcium excretion.

Literature reports suggest an apparent association between use of corticosteroids and left ventricular free wall rupture after a recent myocardial infarction; therefore, therapy with corticosteroids should be used with great caution in these patients.

Endocrine

Corticosteroids can produce reversible hypothalamic-pituitary-adrenal (HPA) axis suppression with the potential for glucocorticosteroid insufficiency after withdrawal of treatment.

Metabolic clearance of corticosteroids is decreased in hypothyroid patients and increased in hyperthyroid patients. Changes in thyroid status of the patient may necessitate adjustment in dosage.

Infections

General

Patients who are on corticosteroids are more susceptible to infections than are healthy individuals. There may be decreased resistance and inability to localize infection when corticosteroids are used. Infection with any pathogen (viral, bacterial, fungal, protozoan, or helminthic) in any location of the body may be associated with the use of corticosteroids alone or in combination with other immunosuppressive agents. These infections may be mild to severe. With increasing doses of corticosteroids, the rate of occurrence of infectious complications increases. Corticosteroids may also mask some signs of current infection.

Fungal Infections

Corticosteroids may exacerbate systemic fungal infections and therefore should not be used in the presence of such infections unless they are needed to control drug reactions. There have been cases reported in which concomitant use of amphotericin B and hydrocortisone was followed by cardiac enlargement and congestive heart failure (see **PRECAUTIONS: Drug Interactions:** *Amphotericin B injection and potassium-depleting agents*).

Special Pathogens

Latent disease may be activated or there may be an exacerbation of intercurrent infections due to pathogens, including those caused by *Amoeba*, *Candida*, *Cryptococcus*, *Mycobacterium*, *Nocardia*, *Pneumocystis*, or *Toxoplasma*.

It is recommended that latent amebiasis or active amebiasis be ruled out before initiating corticosteroid therapy in any patient who has spent time in the tropics or in any patient with unexplained diarrhea.

Similarly, corticosteroids should be used with great care in patients with known or suspected *Strongyloides* (threadworm) infestation. In such patients, corticosteroid-induced immunosuppression may lead to *Strongyloides* hyperinfection and dissemination

with widespread larval migration, often accompanied by severe enterocolitis and potentially fatal gram-negative septicemia.

Corticosteroids should not be used in cerebral malaria.

Tuberculosis

The use of corticosteroids in patients with active tuberculosis should be restricted to those cases of fulminating or disseminated tuberculosis in which the corticosteroid is used for the management of the disease in conjunction with an appropriate anti-tuberculosis regimen. If corticosteroids are indicated in patients with latent tuberculosis or tuberculin reactivity, close observation is necessary as reactivation of the disease may occur. During prolonged corticosteroid therapy, these patients should receive chemoprophylaxis.

Vaccination

Administration of live or live, attenuated vaccines is contraindicated in patients receiving immunosuppressive doses of corticosteroids. Killed or inactivated vaccines may be administered. However, the response to such vaccines cannot be predicted. Immunization procedures may be undertaken in patients who are receiving corticosteroids as replacement therapy, eg, for Addison's disease.

Viral Infections

Chicken pox and measles can have a more serious or even fatal course in pediatric and adult patients on corticosteroids. In pediatric and adult patients who have not had these diseases, particular care should be taken to avoid exposure. The contribution of the underlying disease and/or prior corticosteroid treatment to the risk is also not known. If exposed to chicken pox, prophylaxis with varicella zoster immune globulin (VZIG) may be indicated. If exposed to measles, prophylaxis with immunoglobulin (IG) may be indicated. (See the respective package inserts for complete VZIG and IG prescribing information.) If chicken pox develops, treatment with antiviral agents should be considered.

Neurologic

Epidural and intrathecal administration of this product is not recommended. Reports of serious medical events, including death, have been associated with epidural and intrathecal routes of corticosteroid administration (see **ADVERSE REACTIONS:** *Gastrointestinal* and *Neurologic/Psychiatric*).

Ophthalmic

Use of corticosteroids may produce posterior subcapsular cataracts, glaucoma with possible damage to the optic nerves, and may enhance the establishment of secondary ocular infections due to bacteria, fungi, or viruses. The use of oral corticosteroids is not recommended in the treatment of optic neuritis and may lead to an increase in the risk of new episodes. Corticosteroids should not be used in active ocular herpes simplex.

Adequate studies to demonstrate the safety of Kenalog Injection use by intraturbinal, subconjunctival, sub-Tenons, retrobulbar, and intraocular (intravitreal) injections have not been performed. Endophthalmitis, eye inflammation, increased intraocular pressure, and visual disturbances including vision loss have been reported with intravitreal administration. Administration of Kenalog Injection intraocularly or into the nasal turbinates is not recommended.

Intraocular injection of corticosteroid formulations containing benzyl alcohol, such as Kenalog Injection, is not recommended because of potential toxicity from the benzyl alcohol.

PRECAUTIONS

General

This product, like many other steroid formulations, is sensitive to heat. Therefore, it should not be autoclaved when it is desirable to sterilize the exterior of the vial.

The lowest possible dose of corticosteroid should be used to control the condition under treatment. When reduction in dosage is possible, the reduction should be gradual.

Since complications of treatment with glucocorticoids are dependent on the size of the dose and the duration of treatment, a risk/benefit decision must be made in each individual case as to dose and duration of treatment and as to whether daily or intermittent therapy should be used.

Kaposi's sarcoma has been reported to occur in patients receiving corticosteroid therapy, most often for chronic conditions. Discontinuation of corticosteroids may result in clinical improvement.

Cardio-Renal

As sodium retention with resultant edema and potassium loss may occur in patients receiving corticosteroids, these agents should be used with caution in patients with congestive heart failure, hypertension, or renal insufficiency.

Endocrine

Drug-induced secondary adrenocortical insufficiency may be minimized by gradual reduction of dosage. This type of relative insufficiency may persist for months after discontinuation of therapy; therefore, in any situation of stress occurring during that period, hormone therapy should be reinstituted. Since mineralocorticoid secretion may be impaired, salt and/or a mineralocorticoid should be administered concurrently.

Gastrointestinal

Steroids should be used with caution in active or latent peptic ulcers, diverticulitis, fresh intestinal anastomoses, and nonspecific ulcerative colitis, since they may increase the risk of a perforation.

Signs of peritoneal irritation following gastrointestinal perforation in patients receiving corticosteroids may be minimal or absent.

There is an enhanced effect of corticosteroids in patients with cirrhosis.

Intra-Articular and Soft Tissue Administration

Intra-articularly injected corticosteroids may be systemically absorbed.

Appropriate examination of any joint fluid present is necessary to exclude a septic process.

A marked increase in pain accompanied by local swelling, further restriction of joint motion, fever, and malaise are suggestive of septic arthritis. If this complication occurs and the diagnosis of sepsis is confirmed, appropriate antimicrobial therapy should be instituted.

Injection of a steroid into an infected site is to be avoided. Local injection of a steroid into a previously infected joint is not usually recommended.

Corticosteroid injection into unstable joints is generally not recommended.

Intra-articular injection may result in damage to joint tissues (see **ADVERSE REACTIONS:** *Musculoskeletal*).

Musculoskeletal

Corticosteroids decrease bone formation and increase bone resorption both through their effect on calcium regulation (ie, decreasing absorption and increasing excretion) and inhibition of osteoblast function. This, together with a decrease in the protein matrix of the bone secondary to an increase in protein catabolism, and reduced sex hormone production, may lead to inhibition of bone growth in pediatric patients and the development of osteoporosis at any age. Special consideration should be given to patients at increased risk of osteoporosis (ie, postmenopausal women) before initiating corticosteroid therapy.

Neuro-Psychiatric

Although controlled clinical trials have shown corticosteroids to be effective in speeding the resolution of acute exacerbations of multiple sclerosis, they do not show that they affect the ultimate outcome or natural history of the disease. The studies do show that relatively high doses of corticosteroids are necessary to demonstrate a significant effect. (See **DOSAGE AND ADMINISTRATION.**)

An acute myopathy has been observed with the use of high doses of corticosteroids, most often occurring in patients with disorders of neuromuscular transmission (eg, myasthenia gravis), or in patients receiving concomitant therapy with neuromuscular blocking drugs (eg, pancuronium). This acute myopathy is generalized, may involve ocular and respiratory muscles, and may result in quadriparesis. Elevation of creatinine kinase may occur. Clinical improvement or recovery after stopping corticosteroids may require weeks to years.

Psychiatric derangements may appear when corticosteroids are used, ranging from euphoria, insomnia, mood swings, personality changes, and severe depression to frank psychotic manifestations. Also, existing emotional instability or psychotic tendencies may be aggravated by corticosteroids.

Ophthalmic

Intraocular pressure may become elevated in some individuals. If steroid therapy is continued for more than 6 weeks, intraocular pressure should be monitored.

Information for Patients

Patients should be warned not to discontinue the use of corticosteroids abruptly or without medical supervision, to advise any medical attendants that they are taking corticosteroids, and to seek medical advice at once should they develop fever or other signs of infection.

Persons who are on corticosteroids should be warned to avoid exposure to chicken pox or measles. Patients should also be advised that if they are exposed, medical advice should be sought without delay.

Drug Interactions

Aminoglutethimide: Aminoglutethimide may lead to a loss of corticosteroid-induced adrenal suppression.

Amphotericin B injection and potassium-depleting agents: When corticosteroids are administered concomitantly with potassium-depleting agents (ie, amphotericin B, diuretics), patients should be observed closely for development of hypokalemia. There have been cases reported in which concomitant use of amphotericin B and hydrocortisone was followed by cardiac enlargement and congestive heart failure.

Antibiotics: Macrolide antibiotics have been reported to cause a significant decrease in corticosteroid clearance.

Anticholinesterases: Concomitant use of anticholinesterase agents and corticosteroids may produce severe weakness in patients with myasthenia gravis. If possible, anticholinesterase agents should be withdrawn at least 24 hours before initiating corticosteroid therapy.

Anticoagulants, oral: Coadministration of corticosteroids and warfarin usually results in inhibition of response to warfarin, although there have been some conflicting reports. Therefore, coagulation indices should be monitored frequently to maintain the desired anticoagulant effect.

Antidiabetics: Because corticosteroids may increase blood glucose concentrations, dosage adjustments of antidiabetic agents may be required.

Antitubercular drugs: Serum concentrations of isoniazid may be decreased.

Cholestyramine: Cholestyramine may increase the clearance of corticosteroids.

Cyclosporine: Increased activity of both cyclosporine and corticosteroids may occur when the two are used concurrently. Convulsions have been reported with this concurrent use.

Digitalis glycosides: Patients on digitalis glycosides may be at increased risk of arrhythmias due to hypokalemia.

Estrogens, including oral contraceptives: Estrogens may decrease the hepatic metabolism of certain corticosteroids, thereby increasing their effect.

Hepatic enzyme inducers (eg, barbiturates, phenytoin, carbamazepine, rifampin): Drugs which induce hepatic microsomal drug metabolizing enzyme activity may enhance the metabolism of corticosteroids and require that the dosage of the corticosteroid be increased.

Ketoconazole: Ketoconazole has been reported to decrease the metabolism of certain corticosteroids by up to 60%, leading to an increased risk of corticosteroid side effects.

Nonsteroidal anti-inflammatory drugs (NSAIDs): Concomitant use of aspirin (or other nonsteroidal anti-inflammatory drugs) and corticosteroids increases the risk of gastrointestinal side effects. Aspirin should be used cautiously in conjunction with corticosteroids in hypoprothrombinemia. The clearance of salicylates may be increased with concurrent use of corticosteroids.

Skin tests: Corticosteroids may suppress reactions to skin tests.

Vaccines: Patients on prolonged corticosteroid therapy may exhibit a diminished response to toxoids and live or inactivated vaccines due to inhibition of antibody response. Corticosteroids may also potentiate the replication of some organisms contained in live attenuated vaccines. Routine administration of vaccines or toxoids should be deferred until corticosteroid therapy is discontinued if possible (see **WARNINGS: Infections: Vaccination**).

Carcinogenesis, Mutagenesis, Impairment of Fertility

No adequate studies have been conducted in animals to determine whether corticosteroids have a potential for carcinogenesis or mutagenesis.

Steroids may increase or decrease motility and number of spermatozoa in some patients.

Pregnancy

Teratogenic Effects: Pregnancy Category C

Corticosteroids have been shown to be teratogenic in many species when given in doses equivalent to the human dose. Animal studies in which corticosteroids have been given to pregnant mice, rats, and rabbits have yielded an increased incidence of cleft palate in the offspring. There are no adequate and well-controlled studies in pregnant women. Corticosteroids should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Infants born to mothers who have received corticosteroids during pregnancy should be carefully observed for signs of hypoadrenalism.

Nursing Mothers

Systemically administered corticosteroids appear in human milk and could suppress growth, interfere with endogenous corticosteroid production, or cause other untoward effects. Caution should be exercised when corticosteroids are administered to a nursing woman.

Pediatric Use

This product contains benzyl alcohol as a preservative. Benzyl alcohol, a component of this product, has been associated with serious adverse events and death, particularly in pediatric patients. The "gasping syndrome" (characterized by central nervous system depression, metabolic acidosis, gasping respirations, and high levels of benzyl alcohol and its metabolites found in the blood and urine) has been associated with benzyl alcohol dosages >99 mg/kg/day in neonates and low-birth-weight neonates. Additional symptoms may include gradual neurological deterioration, seizures, intracranial hemorrhage, hematologic abnormalities, skin breakdown, hepatic and renal failure, hypotension, bradycardia, and cardiovascular collapse. Although normal therapeutic doses of this product deliver amounts of benzyl alcohol that are substantially lower than those reported in association with the "gasping syndrome," the minimum amount of benzyl alcohol at

which toxicity may occur is not known. Premature and low-birth-weight infants, as well as patients receiving high dosages, may be more likely to develop toxicity. Practitioners administering this and other medications containing benzyl alcohol should consider the combined daily metabolic load of benzyl alcohol from all sources.

The efficacy and safety of corticosteroids in the pediatric population are based on the well-established course of effect of corticosteroids which is similar in pediatric and adult populations. Published studies provide evidence of efficacy and safety in pediatric patients for the treatment of nephrotic syndrome (>2 years of age), and aggressive lymphomas and leukemias (>1 month of age). Other indications for pediatric use of corticosteroids, eg, severe asthma and wheezing, are based on adequate and well-controlled trials conducted in adults, on the premises that the course of the diseases and their pathophysiology are considered to be substantially similar in both populations.

The adverse effects of corticosteroids in pediatric patients are similar to those in adults (see **ADVERSE REACTIONS**). Like adults, pediatric patients should be carefully observed with frequent measurements of blood pressure, weight, height, intraocular pressure, and clinical evaluation for the presence of infection, psychosocial disturbances, thromboembolism, peptic ulcers, cataracts, and osteoporosis. Pediatric patients who are treated with corticosteroids by any route, including systemically administered corticosteroids, may experience a decrease in their growth velocity. This negative impact of corticosteroids on growth has been observed at low systemic doses and in the absence of laboratory evidence of HPA axis suppression (ie, cosyntropin stimulation and basal cortisol plasma levels). Growth velocity may therefore be a more sensitive indicator of systemic corticosteroid exposure in pediatric patients than some commonly used tests of HPA axis function. The linear growth of pediatric patients treated with corticosteroids should be monitored, and the potential growth effects of prolonged treatment should be weighed against clinical benefits obtained and the availability of treatment alternatives. In order to minimize the potential growth effects of corticosteroids, pediatric patients should be *titrated* to the lowest effective dose.

Geriatric Use

No overall differences in safety or effectiveness were observed between elderly subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

ADVERSE REACTIONS

(listed alphabetically under each subsection)

The following adverse reactions may be associated with corticosteroid therapy:

Allergic reactions: Anaphylactoid reaction, anaphylaxis including anaphylactic reactions and anaphylactic shock, angioedema.

Cardiovascular: Bradycardia, cardiac arrest, cardiac arrhythmias, cardiac enlargement, circulatory collapse, congestive heart failure, fat embolism, hypertension, hypertrophic cardiomyopathy in premature infants, myocardial rupture following recent myocardial infarction (see **WARNINGS**), pulmonary edema, syncope, tachycardia, thromboembolism, thrombophlebitis, vasculitis.

Dermatologic: Acne, allergic dermatitis, cutaneous and subcutaneous atrophy, dry scaly skin, ecchymoses and petechiae, edema, erythema, hyperpigmentation, hypo-pigmentation, impaired wound healing, increased sweating, lupus erythematosus-like lesions, purpura, rash, sterile abscess, striae, suppressed reactions to skin tests, thin fragile skin, thinning scalp hair, urticaria.

Endocrine: Decreased carbohydrate and glucose tolerance, development of cushingoid state, glycosuria, hirsutism, hypertrichosis, increased requirements for insulin or oral hypoglycemic agents in diabetes, manifestations of latent diabetes mellitus, menstrual irregularities, secondary adrenocortical and pituitary unresponsiveness (particularly in times of stress, as in trauma, surgery, or illness), suppression of growth in pediatric patients.

Fluid and electrolyte disturbances: Congestive heart failure in susceptible patients, fluid retention, hypokalemic alkalosis, potassium loss, sodium retention.

Gastrointestinal: Abdominal distention, bowel/bladder dysfunction (after intrathecal administration [see **WARNINGS: Neurologic**]), elevation in serum liver enzyme levels (usually reversible upon discontinuation), hepatomegaly, increased appetite, nausea, pancreatitis, peptic ulcer with possible perforation and hemorrhage, perforation of the small and large intestine (particularly in patients with inflammatory bowel disease), ulcerative esophagitis.

Metabolic: Negative nitrogen balance due to protein catabolism.

Musculoskeletal: Aseptic necrosis of femoral and humeral heads, calcinosis (following intra-articular or intralesional use), Charcot-like arthropathy, loss of muscle mass, muscle weakness, osteoporosis, pathologic fracture of long bones, post injection flare (following intra-articular use), steroid myopathy, tendon rupture, vertebral compression fractures.

Neurologic/Psychiatric: Convulsions, depression, emotional instability, euphoria, headache, increased intracranial pressure with papilledema (pseudotumor cerebri) usually following discontinuation of treatment, insomnia, mood swings, neuritis, neuropathy, paresthesia, personality changes, psychiatric disorders, vertigo. Arachnoiditis, meningitis, paraparesis/paraplegia, and sensory disturbances have occurred after intrathecal administration. Spinal cord infarction, paraplegia, quadriplegia, cortical blindness, and stroke (including brainstem) have been reported after epidural administration of corticosteroids (see **WARNINGS: Neurologic**).

Ophthalmic: Exophthalmos, glaucoma, increased intraocular pressure, posterior subcapsular cataracts, rare instances of blindness associated with periocular injections.

Other: Abnormal fat deposits, decreased resistance to infection, hiccups, increased or decreased motility and number of spermatozoa, malaise, moon face, weight gain.

OVERDOSAGE

Treatment of acute overdosage is by supportive and symptomatic therapy. For chronic overdosage in the face of severe disease requiring continuous steroid therapy, the dosage of the corticosteroid may be reduced only temporarily, or alternate day treatment may be introduced.

DOSAGE AND ADMINISTRATION

General

NOTE: CONTAINS BENZYL ALCOHOL (see PRECAUTIONS).

The initial dose of Kenalog-40 Injection may vary from 2.5 mg to 100 mg per day depending on the specific disease entity being treated (see **Dosage** section below). However, in certain overwhelming, acute, life-threatening situations, administration in dosages exceeding the usual dosages may be justified and may be in multiples of the oral dosages.

IT SHOULD BE EMPHASIZED THAT DOSAGE REQUIREMENTS ARE VARIABLE AND MUST BE INDIVIDUALIZED ON THE BASIS OF THE DISEASE UNDER TREATMENT AND THE RESPONSE OF THE PATIENT. After a favorable response is noted, the proper maintenance dosage should be determined by decreasing the initial drug dosage in small decrements at appropriate time intervals until the lowest dosage which will maintain an adequate clinical response is reached. Situations which may make dosage adjustments necessary are changes in clinical status secondary to remissions or exacerbations in the disease process, the patient's individual drug responsiveness, and the effect of patient exposure to stressful situations not directly related to the disease entity under treatment. In this latter situation it may be necessary to increase the dosage of the corticosteroid for a period of time consistent with the patient's condition. If after long-term therapy the drug is to be stopped, it is recommended that it be withdrawn gradually rather than abruptly.

Dosage

SYSTEMIC

The suggested initial dose is 60 mg, **injected deeply into the gluteal muscle**. Atrophy of subcutaneous fat may occur if the injection is not properly given. Dosage is usually adjusted within the range of 40 mg to 80 mg, depending upon patient response and duration of relief. However, some patients may be well controlled on doses as low as 20 mg or less.

Hay fever or pollen asthma: Patients with hay fever or pollen asthma who are not responding to pollen administration and other conventional therapy may obtain a remission of symptoms lasting throughout the pollen season after a single injection of 40 mg to 100 mg.

In the treatment of acute exacerbations of multiple sclerosis, daily doses of 160 mg of triamcinolone for a week followed by 64 mg every other day for one month are recommended (see **PRECAUTIONS: Neuro-Psychiatric**).

In pediatric patients, the initial dose of triamcinolone may vary depending on the specific disease entity being treated. The range of initial doses is 0.11 to 1.6 mg/kg/day in 3 or 4 divided doses (3.2 to 48 mg/m^2bsa/day).

For the purpose of comparison, the following is the equivalent milligram dosage of the various glucocorticoids:

Cortisone, 25	*Triamcinolone, 4*
Hydrocortisone, 20	*Paramethasone, 2*
Prednisolone, 5	*Betamethasone, 0.75*
Prednisone, 5	*Dexamethasone, 0.75*
Methylprednisolone, 4	

These dose relationships apply only to oral or intravenous administration of these compounds. When these substances or their derivatives are injected intramuscularly or into joint spaces, their relative properties may be greatly altered.

LOCAL

Intra-articular administration: A single local injection of triamcinolone acetonide is frequently sufficient, but several injections may be needed for adequate relief of symptoms.

Initial dose: 2.5 mg to 5 mg for smaller joints and from 5 mg to 15 mg for larger joints, depending on the specific disease entity being treated. For adults, doses up to 10 mg for smaller areas and up to 40 mg for larger areas have usually been sufficient. Single injections into several joints, up to a total of 80 mg, have been given.

Administration

GENERAL

STRICT ASEPTIC TECHNIQUE IS MANDATORY. The vial should be shaken before use to ensure a uniform suspension. Prior to withdrawal, the suspension should be inspected for clumping or granular appearance (agglomeration). An agglomerated product results from exposure to freezing temperatures and should not be used. After withdrawal, Kenalog-40 Injection should be injected without delay to prevent settling in the syringe. Careful technique should be employed to avoid the possibility of entering a blood vessel or introducing infection.

SYSTEMIC

For systemic therapy, injection should be made **deeply into the gluteal muscle** (see **WARNINGS**). For adults, a minimum needle length of 1½ inches is recommended. In obese patients, a longer needle may be required. Use alternative sites for subsequent injections.

LOCAL

For treatment of joints, the usual intra-articular injection technique should be followed. If an excessive amount of synovial fluid is present in the joint, some, but not all, should be aspirated to aid in the relief of pain and to prevent undue dilution of the steroid.

With intra-articular administration, prior use of a local anesthetic may often be desirable. Care should be taken with this kind of injection, particularly in the deltoid region, to avoid injecting the suspension into the tissues surrounding the site, since this may lead to tissue atrophy.

In treating acute nonspecific tenosynovitis, care should be taken to ensure that the injection of the corticosteroid is made into the tendon sheath rather than the tendon substance. Epicondylitis may be treated by infiltrating the preparation into the area of greatest tenderness.

HOW SUPPLIED

Kenalog®-40 Injection (triamcinolone acetonide injectable suspension, USP) is supplied in vials providing 40 mg triamcinolone acetonide per mL.

40 mg/mL, 1 mL vial	NDC 0003-0293-05
40 mg/mL, 5 mL vial	NDC 0003-0293-20
40 mg/mL, 10 mL vial	NDC 0003-0293-28

Storage

Store at controlled room temperature, 20°–25°C (68°–77°F), avoid freezing and protect from light.

Bristol-Myers Squibb Company
Princeton, NJ 08543 USA
Product of Italy

1221153A5 Rev June 2011

Medication Administration Details

[redacted]

Kenalog 40 MG/ML Injection Suspension (Triamcinolone Acetonide)

For [1] Cough

Order Entry | Record Administration | Administration Details | Charging

Record w/o Ordering

Inject 0.5ml intramuscularly once. To Be Done: 04Nov2016 Status: Complete

Dose: 1 Unit: ML

MFG: B-M SQUIBB U.S. (PRIM...

Lot: AAJ6426

Route: Intramuscular

Site: Right Gluteal Region

NDC: 00003029328

Exp: 01-Mar-2018

Date/Time: 04-Nov-2016 06:56 PM Now

Admin By: Hampton, Chanel

Charging

Medical Necessity Checking: CPT-4:J3301 Code Status:

Medical Necessity Details:

Verify charges being submitted for: None Specified Encounter

Type	Code	Display Name	Modifiers	Units	When To Cha...	Time Based
☑	J3301	INJ, TRIAMCINOLONE ACETONIDE, PER 10 MG (KENALOG-10,40, TRI-KORT)			Upon Completion	N/A

Override Encounter Details:

Special Billing:

Account #:

Billing Provider: NGUYEN-INACTIVE, HAI

Perf. Provider: NGUYEN-INACTIVE, HAI

Injury Date: 23-May-2022

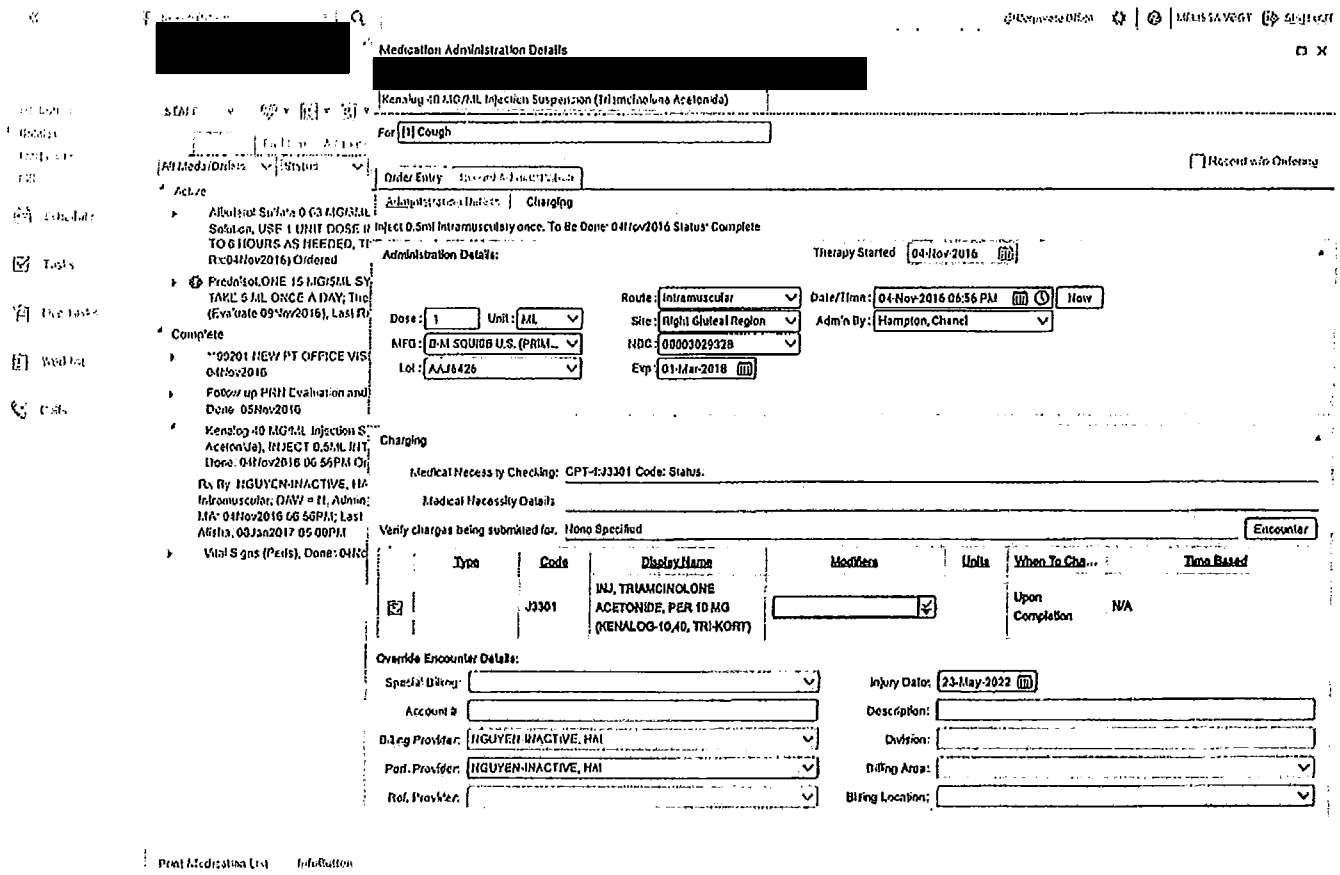
Description:

Division:

Billing Area:

DUR Alerts: Drug-Drug (0) | Prior Adverse Reactions (0) | Disease (0) | Duplicate Therapy (0) | Dose (0)

Medication Logs



MED ADMIN DETAILS 00002

DECLARATION OF MELISSA VOGT

STATE OF NEVADA)
)
COUNTY OF CLARK)

I, MELISSA VOGT, declare under penalty of perjury pursuant to NRCP 34(c) and NRS 53.045 as follows:

1. I am over the age of eighteen. I am competent to testify on the matters set forth herein. I make this declaration based upon my personal knowledge.

2. I am a Registered Nurse and currently am a Learning Coordinator employed by Intermountain Healthcare.

3. On May 23, 2022, I located Medication Administration Details for patient, [redacted], and I made a true and exact copy of that record, which has been batestamped MED ADMIN DETAILS 00001 – MED ADMIN DETAILS 00002.

4. It is my understanding that the original of the records was made at or near the time of the act and/or event recited therein.

5. The Medication Administration Details are kept as part of the patient's designated record set, however, they are maintained separately from the patient's other medical records. It is my understanding that this Medication Administration Details record was inadvertently not printed and included in a copy of the patient's medical records that were previously disclosed in the Nevada Board of Medical Examiners Formal Complaint against Hai Thanh Nguyen, M.D. (Case No. 21-38084-1), as such record are maintained separately from the other portions of the patient's medical record.

6. I declare under penalty of perjury under the laws of the State of Nevada that the foregoing is true and correct.

DATED this 23 day of May, 2022.

Melissa Vogt RN.
MELISSA VOGT

3

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **HAI THANH NGUYEN, M.D.,** **Respondent.**	**Case No. 21-38084-1** **(FILED UNDER SEAL)**

FILED
NOV 03 2021
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

PATIENT DESIGNATION

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) hereby submits its **PATIENT DESIGNATION** to identify the true and correct identity of the patient(s) referenced in the filed formal Complaint, Case No. 21-38084-1.

1. Patient A's true and correct identity is as follows:

Name: [redacted]
DOB:

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA
* * * * *

In the Matter of Charges and Complaint Against HAI THANH NGUYEN, M.D., Respondent.	**Case No. 21-38084-1**

HAI THANH NGUYEN, M.D.'S ANSWER TO COMPLAINT

COMES NOW, Respondent HAI THANH NGUYEN, M.D., by and through his counsel of record, ROBERT C. McBRIDE, ESQ. and T. CHARLOTTE BUYS, ESQ., of the law firm of McBRIDE HALL and for his Answer to the State of Nevada Board of Medical Examiners' (hereinafter "Board") Complaint, admits, denies, and alleges as follows:

1. This answering Respondent admits those allegations contained in Paragraph 1 of the Board's Complaint.

2. Answering Paragraph 2 of the Board's Complaint, this answering Respondent denies each and every allegation of malpractice contained therein. As to the remainder of Paragraph 2, this answering Respondent is without sufficient knowledge or information upon which to base a belief as to the truth or falsity of the allegations contained in Paragraph 2, and upon said grounds denies each and every allegation contained therein.

3. Answering Paragraph 3 of the Board's Complaint, this answering Respondent denies each and every allegation of malpractice contained therein. As to the remainder of Paragraph 3, this answering Respondent is without sufficient knowledge or information upon which to base a belief as to the truth or falsity of the allegations contained in Paragraph 3, and upon said grounds denies each and every allegation contained therein.

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COUNT I

NRS 630.301(4) (Malpractice)

4. Answering Paragraph 4 of the Board's Complaint, this answering Respondent repeats and realleges each and every response to Paragraphs 1 through 3, inclusive, and incorporates the same by reference as though set forth fully herein.

5. Answering Paragraph 5 of the Board's Complaint, this answering Respondent admits that Nevada Revised Statute Section 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee, but this answering Respondent specifically denies committing malpractice.

6. Answering Paragraph 6 of the Board's Complaint, this Answering Respondent admits that Nevada Administrative Code Section 630.040 defines malpractice, but this answering Respondent specifically denies committing malpractice.

7. Answering Paragraph 7 of the Board's Complaint, this Answering Respondent denies each and every allegation contained in paragraph 7 of the Board's Complaint.

8. Answering Paragraph 8 of the Board's Complaint, this Answering Respondent denies each and every allegation contained in paragraph 8 of the Board's Complaint.

COUNT II

NRS 630.3062(1)(a) (Failure to Maintain Complete Medical Records)

9. Answering Paragraph 9 of the Board's Complaint, this answering Respondent repeats and realleges each and every response to Paragraphs 1 through 8, inclusive, and incorporates the same by reference as though set forth fully herein.

10. Answering Paragraph 10 of the Board's Complaint, this answering Respondent admits that Nevada Revised Statute Section 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee, but this Answering Respondent specifically denies committing malpractice.

11. Answering Paragraph 11 of the Board's Complaint, this answering Respondent denies each and every allegation contained in paragraph 11 of the Board's Complaint.

12. Answering Paragraph 12 of the Board's Complaint, this answering Respondent denies each and every allegation contained in paragraph 12 of the Board's Complaint.

FIRST AFFIRMATIVE DEFENSE

Respondent alleges that The Nevada State Board of Medical Examiners' Complaint on file herein fails to state a claim upon which relief can be granted.

SECOND AFFIRMATIVE DEFENSE

The Board's Complaint is in whole or in part, void for vagueness, violative of Respondent's due process rights under the Constitutions of the State of Nevada and the United States of America and cannot serve as a basis for discipline of Respondent.

THIRD AFFIRMATIVE DEFENSE

The Nevada State Board of Medical Examiners has failed to comply with the requirements of N.R.S. 630, *et seq.* and N.A.C. 630 *et seq.*

FOURTH AFFIRMATIVE DEFENSE

Respondent fully performed and discharged all obligations owed to the patient, including satisfying the applicable standard of care to which the patient was entitled.

FIFTH AFFIRMATIVE DEFENSE

If a violation occurred it was the result of intervening and/or superseding events, factors, occurrences or conditions, which were in no way caused by Respondent, and for which Respondent is not responsible.

SIXTH AFFIRMATIVE DEFENSE

The Nevada State Board of Medical Examiners' Complaint is time barred.

SEVENTH AFFIRMATIVE DEFENSE

The Nevada State Board of Medical Examiners' Complaint does not comply with NRS 630.301.

EIGHTH AFFIRMATIVE DEFENSE

Each and every service rendered to the patient by this answering Respondent was expressly and/or impliedly consented to and authorized by the patient and/or the patient's authorized representative on the basis of a full and complete disclosure to the patient of all material facts

known or reasonably believed be true concerning the patient's physical condition and the appropriate alternative procedures available for treatment of such condition

NINTH AFFIRMATIVE DEFENSE

All possible affirmative defenses may not have been alleged herein so far as sufficient facts were not available after reasonable inquiry upon filing of this answering Respondent's Answer and, therefore, this answering Respondent reserves the right to amend his Answer to include additional affirmative defenses if subsequent investigation so warrants.

WHEREFORE, the Respondent prays that The Nevada State Board of Medical Examiners take nothing by way of the Complaint on file herein; and that Respondent recover all costs, attorneys' fees, and damages incurred as a result of the Complaint.

DATED this 23rd day of November 2021.

McBRIDE HALL

By: */s/ T. Charlotte Buys*
ROBERT C. McBRIDE, ESQ.
Nevada Bar No.: 7082
T. CHARLOTTE BUYS, ESQ.
Nevada Bar No.: 14845
8329 W. Sunset Road, Suite 260
Las Vegas, Nevada 89113
Attorneys for Respondent
Hai Thanh Nguyen M.D.

CERTIFICATE OF SERVICE

I hereby certify that on the 23rd day of November 2021, I served a true correct copy of **RESPONDENT'S ANSWER TO COMPLAINT**, by mailing via United States mail to the following:

Robert Kilroy, Esq.
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
Attorneys for the Investigative Committee

/s/ Natalie Jones
An Employee of McBride Hall

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: HAI THANH NGUYEN, M.D., Respondent.	**Case No. 21-38084-1**

FILED
NOV 30 2021
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By: _____

AFFIDAVIT OF SERVICE

STATE OF NEVADA)
) ss.
COUNTY OF WASHOE)

I, Margaret F. Byrd (Meg), being first duly sworn upon oath, hereby depose and state under penalty of perjury under the laws of the state of Nevada as follows:

1. I caused to be served the Complaint, Patient Designation and Fingerprinting Package (Complaint Package) to Respondent at the following address:

Hai Thanh Nguyen, M.D.
9000 Las Vegas Blvd. S, Suite 1108
Las Vegas, Nevada 89123

2. Service was performed via USPS Certified Mail Tracking No. 9171 9690 0935 0252 1578 87.

3. I reviewed the tracking information for this parcel which indicated and currently indicates "In Transit, Arriving Late" with no signature verification upon delivery to the Respondent.

4. I received a call from the Respondent on or about November 9, 2021 confirming he had received the package and requesting patient identification information (which was provided with the package).

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

5. On or about November 23, 2021, I received an Answer to the Complaint from counsel for the Respondent. This further confirms Respondent's receipt of the Complaint Package.

Further your affiant sayeth naught.

MARGARET F. BYRD (MEG)

SUBSCRIBED and SWORN to before me
This 30th day of November, 2021
by Margaret F. Byrd (Meg).

NOTARY PUBLIC

LATHA VEERAPPAN
NOTARY PUBLIC
STATE OF NEVADA
My Commission Expires: 04-09-25
Certificate No: 09-19697-2

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and

Complaint Against

HAI THANH NGUYEN, M.D.,

Respondent.

Case No. 21-27350-1

Early Case Conference Date: January 13, 2022 @ 10:00 a.m.

ORDER SCHEDULING EARLY CASE CONFERENCE

TO: Robert G. Kilroy, J.D.
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Hai Thanh Nguyen, M.D.
c/o Robert McBride, Esq. and
T. Charlotte Buys, Esq.
8329 W. Sunset Road, Ste 260
Las Vegas, NV 89113

NOTICE IS HEREBY GIVEN that, in compliance with NRS 630.339(3), **an Early Case Conference will be conducted on January 13, 2022, beginning at the hour of 10:00 a.m.** The Early Case Conference will be held via conference call. The conference call number is 1-605-475-2200 and the access code is 8792457.[1]

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[1] NRS 630.339(3) provides as follows:

> Within 20 days after the filing of the answer, the parties shall hold an early case conference at which the parties and the hearing officer appointed by the Board or a member of the Board must preside. At the early case conference, the parties shall in good faith:

The scheduled Early Case Conference shall be attended by the parties in person or by any party's legal counsel of record and will be conducted by the undersigned Hearing Officer to discuss and designate the dates for the Pre-Hearing Conference and Hearing and the other procedural matters established in NRS 630.339.

At the Pre-Hearing Conference, in accordance with NAC 630.465,[2] each party shall provide the other party with a copy of the list of witnesses they intend to call to testify, including therewith, the qualifications of each witness so identified, and a summary of the testimony of each witness. If a witness is not on the list of witnesses, that witness may subsequently not be allowed to testify at

---

(a) Set the earliest possible hearing date agreeable to the parties and the hearing officer, panel of the Board or the Board, including the estimated duration of the hearing:

(b) Set dates:

(1) By which all documents must be exchanged;
(2) By which all prehearing motions and responses thereto must be filed;
(3) On which to hold the prehearing conference; and
(4) For any other foreseeable actions that may facilitate the timely and fair conduct of the matter.

(c) Discuss or attempt to resolve all or any portion of the evidentiary or legal issues in the matter;
(d) Discuss the potential for settlement of the matter on terms agreeable to the parties; and
(e) Discuss and deliberate any other issues that may facilitate the timely and fair conduct of the matter.

[2] NAC 630.465 provides as follows:

1. At least 30 days before a hearing but not earlier than 30 days after the date of service upon the physician or physician assistant of a formal complaint that has been filed with the Board pursuant to NRS 630.311, unless a different time is agreed to by the parties, the presiding member of the Board or panel of members of the Board or the hearing officer shall conduct a prehearing conference with the parties and their attorneys. All documents presented at the prehearing conference are not evidence, are not part of the record and may not be filed with the Board.

2. Each party shall provide to every other party a copy of the list of proposed witnesses and their qualifications and a summary of the testimony of each proposed witness. A witness whose name does not appear on the list of proposed witnesses may not testify at the hearing unless good cause is shown.

3. All evidence, except rebuttal evidence, which is not provided to each party at the prehearing conference may not be introduced or admitted at the hearing unless good cause is shown.

4. Each party shall submit to the presiding member of the Board or panel or to the hearing officer conducting the conference each issue which has been resolved by negotiation or stipulation and an estimate, to the nearest hour, of the time required for presentation of its oral argument.

the Hearing unless good cause is shown for omitting the witness from said list.[3] Likewise, all evidence, except rebuttal evidence, that is not provided to each party at the Pre-Hearing Conference may also not be introduced or admitted at the Hearing unless good cause is shown.

It is further ordered that legal counsel for the Nevada State Board of Medical Examiners and the Respondent shall keep undersigned Hearing Officer advised of each issue which has been resolved by negotiation or stipulation, if any. At the Early Case Conference the parties must also provide an estimate, to the nearest hour, of the time required for presentation of their respective cases.

ACCORDINGLY, NOTICE IS HEREBY GIVEN that the possible sanctions authorized by NRS 630.352, NAC 630.555, and NRS 622.400 upon a finding of guilt to one or more of the Counts raised in said Board Complaint include the following:

A. Placement on probation for a specified period on any of the conditions specified in an order issued by the Board;

B. Administration of a public reprimand;

C. Placement of a limitation on Respondent's practice, or exclusion of one or more specified branches of medicine from Respondent's practice;

D. Suspension of Respondent's license for a specified period or until further order of the Board;

E. Revocation of Respondent's license to practice medicine;

F. A requirement that Respondent participate in a program to correct alcohol or drug dependence or any other impairment;

G. A requirement that there be specified supervision of Respondent's practice;

---

[3] In identifying a patient as a witness the parties are cautioned to omit from any pleadings filed with undersigned Hearing Officer any addresses, telephone numbers, social security numbers or other personal information regarding such individual and to confine their submissions in this regard to the name of the witness, the relevancy of any testimony sought to be elicited from that witness and a summary of their anticipated testimony.

H. A requirement that Respondent perform public service without compensation;

I. A requirement that Respondent take a physical or mental examination, or an examination testing Respondent's competence;

J. A requirement that Respondent fulfill certain training or educational requirements, or both, as specified by the Board;

K. A fine not to exceed $5,000.00;

L. A requirement that the Respondent pay all costs incurred by the Board relating to this disciplinary proceeding, as more fully set forth in NRS 622.400.

DATED this 5th day of January 2022.

By: _____

Patricia Halstead, Esq.
Hearing Officer
(775) 322-2244

CERTIFICATE OF SERVICE

I certify that on this day, I personally delivered or mailed, postage pre-paid, at Reno, Nevada, a true file-stamped copy of the foregoing ORDER SCHEDULING EARLY CASE CONFERENCE addressed as follows:

Robert G. Kilroy, J.D.
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Hai Thanh Nguyen, M.D.
c/o Robert McBride, Esq. and
T. Charlotte Buys, Esq.
8329 W. Sunset Road, Ste 260
Las Vegas, NV 89113

DATED this 10th day of January 2022.

Signature

Meg Byrd
Print

Legal Assistant
Title

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and

Complaint Against

HAI THANH NGUYEN, M.D.,

Respondent.

Case No. 21-27350-1

Early Case Conference Date: February 4, 2022 @ 11:30 a.m.

AMENDED ORDER SCHEDULING EARLY CASE CONFERENCE

TO: Sarah Bradley, J.D.
Deputy Executive Director
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Hai Thanh Nguyen, M.D.
c/o Robert McBride, Esq. and
T. Charlotte Buys, Esq.
8329 W. Sunset Road, Ste 260
Las Vegas, NV 89113

NOTICE IS HEREBY GIVEN that, in compliance with NRS 630.339(3), **an Early Case Conference will be conducted on February 4, 2022, beginning at the hour of 11:30 a.m.** The Early Case Conference will be held via conference call. The conference call number is 1-605-475-2200 and the access code is 8792457.[1]

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[1] NRS 630.339(3) provides as follows:

> Within 20 days after the filing of the answer, the parties shall hold an early case conference at which the parties and the hearing officer appointed by the Board or a member of the Board must preside. At the early case conference, the parties shall in good faith:

The scheduled Early Case Conference shall be attended by the parties in person or by any party's legal counsel of record and will be conducted by the undersigned Hearing Officer to discuss and designate the dates for the Pre-Hearing Conference and Hearing and the other procedural matters established in NRS 630.339.

At the Pre-Hearing Conference, in accordance with NAC 630.465,[2] each party shall provide the other party with a copy of the list of witnesses they intend to call to testify, including therewith, the qualifications of each witness so identified, and a summary of the testimony of each witness. If a witness is not on the list of witnesses, that witness may subsequently not be allowed to testify at

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(a) Set the earliest possible hearing date agreeable to the parties and the hearing officer, panel of the Board or the Board, including the estimated duration of the hearing:

(b) Set dates:

(1) By which all documents must be exchanged;
(2) By which all prehearing motions and responses thereto must be filed;
(3) On which to hold the prehearing conference; and
(4) For any other foreseeable actions that may facilitate the timely and fair conduct of the matter.

(c) Discuss or attempt to resolve all or any portion of the evidentiary or legal issues in the matter;
(d) Discuss the potential for settlement of the matter on terms agreeable to the parties; and
(e) Discuss and deliberate any other issues that may facilitate the timely and fair conduct of the matter.

[2] NAC 630.465 provides as follows:

1. At least 30 days before a hearing but not earlier than 30 days after the date of service upon the physician or physician assistant of a formal complaint that has been filed with the Board pursuant to NRS 630.311, unless a different time is agreed to by the parties, the presiding member of the Board or panel of members of the Board or the hearing officer shall conduct a prehearing conference with the parties and their attorneys. All documents presented at the prehearing conference are not evidence, are not part of the record and may not be filed with the Board.

2. Each party shall provide to every other party a copy of the list of proposed witnesses and their qualifications and a summary of the testimony of each proposed witness. A witness whose name does not appear on the list of proposed witnesses may not testify at the hearing unless good cause is shown.

3. All evidence, except rebuttal evidence, which is not provided to each party at the prehearing conference may not be introduced or admitted at the hearing unless good cause is shown.

4. Each party shall submit to the presiding member of the Board or panel or to the hearing officer conducting the conference each issue which has been resolved by negotiation or stipulation and an estimate, to the nearest hour, of the time required for presentation of its oral argument.

the Hearing unless good cause is shown for omitting the witness from said list.[3] Likewise, all evidence, except rebuttal evidence, that is not provided to each party at the Pre-Hearing Conference may also not be introduced or admitted at the Hearing unless good cause is shown.

It is further ordered that legal counsel for the Nevada State Board of Medical Examiners and the Respondent shall keep undersigned Hearing Officer advised of each issue which has been resolved by negotiation or stipulation, if any. At the Early Case Conference the parties must also provide an estimate, to the nearest hour, of the time required for presentation of their respective cases.

ACCORDINGLY, NOTICE IS HEREBY GIVEN that the possible sanctions authorized by NRS 630.352, NAC 630.555, and NRS 622.400 upon a finding of guilt to one or more of the Counts raised in said Board Complaint include the following:

A. Placement on probation for a specified period on any of the conditions specified in an order issued by the Board;

B. Administration of a public reprimand;

C. Placement of a limitation on Respondent's practice, or exclusion of one or more specified branches of medicine from Respondent's practice;

D. Suspension of Respondent's license for a specified period or until further order of the Board;

E. Revocation of Respondent's license to practice medicine;

F. A requirement that Respondent participate in a program to correct alcohol or drug dependence or any other impairment;

G. A requirement that there be specified supervision of Respondent's practice;

---

[3] In identifying a patient as a witness the parties are cautioned to omit from any pleadings filed with undersigned Hearing Officer any addresses, telephone numbers, social security numbers or other personal information regarding such individual and to confine their submissions in this regard to the name of the witness, the relevancy of any testimony sought to be elicited from that witness and a summary of their anticipated testimony.

H. A requirement that Respondent perform public service without compensation;

I. A requirement that Respondent take a physical or mental examination, or an examination testing Respondent's competence;

J. A requirement that Respondent fulfill certain training or educational requirements, or both, as specified by the Board;

K. A fine not to exceed $5,000.00;

L. A requirement that the Respondent pay all costs incurred by the Board relating to this disciplinary proceeding, as more fully set forth in NRS 622.400.

DATED this 6th day of January 2022.

By: _____

Patricia Halstead, Esq.
Hearing Officer
(775) 322-2244

CERTIFICATE OF SERVICE

I certify that on this day, I personally delivered or mailed, postage pre-paid, at Reno, Nevada, a true file-stamped copy of the foregoing AMENDED ORDER SCHEDULING EARLY CASE CONFERENCE addressed as follows:

Sarah Bradley, J.D.
Deputy Executive Director
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Hai Thanh Nguyen, M.D.
c/o Robert McBride, Esq. and
T. Charlotte Buys, Esq.
8329 W. Sunset Road, Ste 260
Las Vegas, NV 89113

DATED this 10th day of January 2022.

Signature

Meg Byrd
Print

legal assistant
Title

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against

HAI THANH NGUYEN, M.D.,

Respondent.

Case No. 21-38084-1

Hearing Date: May 26-27, 2022 @ 8:30 a.m.

SCHEDULING ORDER

TO: Sarah Bradley, J.D.
Deputy Executive Director
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Hai Thanh Nguyen, M.D.
c/o Robert McBride, Esq. and
T. Charlotte Buys, Esq.
8329 W. Sunset Rd., Ste 260
Las Vegas, NV 89113

On February 4, 2022, an Early Case Conference was conducted in this matter and held via conference call. Participating in the Early Case Conference were Sarah Bradley, J.D. on behalf of the Investigative Committee (the "IC"); T. Charlotte Buys, Esq. on behalf of Respondent Hai Thahn Nguyen, M.D.; and the undersigned Hearing Officer. The parties proceeded through counsel and agreed to relevant dates including, but not limited to, dates for the pre-hearing conference; the exchange of witnesses and documents; motion practice; and the hearing date.

Accordingly, in compliance with NAC 630.465, a pre-hearing conference will be conducted on **April 1, 2022**, beginning at the hour of 10:00 a.m., Pacific Standard Time, and will be held via a conference call. Unless directed otherwise prior to the scheduled date and time of

the pre-hearing conference, the conference call number will be 1-605-475-2200 and the access code will be 8792457. The parties shall participate in the conference call by and through counsel and the conference will be conducted before the undersigned hearing officer.

By the pre-hearing conference, each party shall provide the other party with a copy of the list of witnesses he intends to call to testify, including the witness' qualifications as well as a brief summary of the witness' anticipated testimony. If a witness is not included in the list of witnesses, that witness may not be allowed to testify at the hearing unless good cause is shown. Likewise, all documentation sought to be relied upon at the formal hearing shall be exchanged. If at the formal hearing any party seeks to rely upon documentation not previously produced as ordered, such documentation will not be permitted unless good cause is shown.

Any and all pre-hearing motions shall be served and submitted to the undersigned hearing officer on or before **April 15, 2022**. Any oppositions or responses thereto shall be served and submitted to the undersigned hearing officer on or before **April 26, 2022**. Any and all replies shall be served and submitted to the below hearing officer on or before **May 5, 2022**.

The formal hearing in this matter is hereby scheduled for **May 26, 2022 through May 27, 2022**, starting at 8:30 a.m. on each date. Unless otherwise determined, the undersigned hearing officer shall attend from the Reno office of the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521. Counsel for the IC Sarah Bradley, J.D.; Respondent's counsel Robert McBride, Esq. and/or T. Charlotte Buys, Esq.; and Respondent Hai Thanh Nguyen, M.D. shall attend from the Las Vegas Office of the Nevada State Board of Medical Examiners, 325 E. Warm Springs Road, Suite 225, Las Vegas, Nevada 89119. Unless stipulated to, permission for the remote appearance by any witness must be sought from and approved by the undersigned hearing officer, and any such request shall be in writing and submitted on or before 5:00 p.m. **May 5, 2022**.

Following the hearing, the undersigned hearing officer will submit to the Board a synopsis of the testimony taken at the hearing and make a recommendation on the veracity of witnesses if there is conflicting evidence or if credibility of witnesses is a determining factor, and thereafter the Board will render its decision. NAC 630.470.

Should the parties deem a status conference necessary at any juncture of the proceeding, they shall coordinate at least three proposed dates and times and may jointly email the undersigned hearing officer with the proposed dates and times and request a status conference and state the basis for the request.

Both parties shall keep the undersigned hearing officer apprised of each issue that has been resolved by negotiation or stipulation or any other change in the status of this case.

DATED this 4th day of February 2022.

By: _____

Patricia Halstead, Esq.
Hearing Officer
(775) 322-2244

CERTIFICATE OF SERVICE

I certify that on this day, I personally delivered or mailed, postage pre-paid, at Reno, Nevada, a true file-stamped copy of the foregoing ORDER SCHEDULING EARLY CASE CONFERENCE addressed as follows:

Sarah Bradley, J.D.
Deputy Executive Director
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Hai Thanh Nguyen, M.D.
c/o Robert McBride, Esq. and
T. Charlotte Buys, Esq.
8329 W. Sunset Rd., Ste 260
Las Vegas, NV 89113

DATED this 7th day of February 2022.

Signature

Meg Byrd
Print

Legal Assistant
Title

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA
* * * * *

In the Matter of Charges and Complaint Against HAI THANH NGUYEN, M.D., Respondent.	**Case No. 21-38084-1**

FILED
MAR 31 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

HAI THANH NGUYEN, M.D.'S PRE-HEARING CONFERENCE DISCLOSURE

COMES NOW, Respondent HAI THANH NGUYEN, M.D., by and through his counsel of record, ROBERT C. McBRIDE, ESQ. and T. CHARLOTTE BUYS, ESQ., of the law firm of McBRIDE HALL and in accordance with Nevada Administrative Code § 630.465 and the Hearing Officer's Scheduling Order filed on February 7, 2022, hereby provides the following disclosures:

I.

WITNESSES

1. Hai Thanh Nguyen, M.D.
   c/o Robert C. McBride, Esq.
   T. Charlotte Buys, Esq.
   McBRIDE HALL
   8329 W. Sunset Boulevard, Suite 260
   Las Vegas, Nevada 89113
   (702) 791-5855

Respondent will testify regarding the care and treatment provided to Patient A, his custom and practice, and his medical records documenting Patient A's care and treatment. He will also provide testimony regarding the Board's Complaint and the allegations therein. Respondent will also testify that he complied with the standard of care.

2. Eduardo Anorga, M.D.
   [redacted]

Dr. Anorga is a physician board-certified in family medicine and is expected to testify regarding his review of this case and the standard of care applicable to Dr. Nguyen's care and treatment of Patient A, and documentation of the same. Dr. Anorga will also provide expert testimony regarding the Board's Complaint and the allegations contained therein.

3. Ellen Aliberti
[redacted]

Ms. Aliberti is a Clinical Educator. Ms. Aliberti is expected to testify regarding the clinical education and policies and procedures provided to Medical Assistants at Healthcare Partners of Nevada. She is also anticipated to testify to any relevant knowledge she may have regarding the facts and circumstances surrounding this matter.

4. Glenisha Barner, MA
(Current Address Unknown)

Ms. Barner is anticipated to testify regarding her care and treatment of Patient A, and as to any relevant knowledge she may have regarding the facts and circumstances surrounding this matter.

5. Barry Misiuk, MA
(Current Address Unknown)

Mr. Misiuk is anticipated to testify regarding his care and treatment of Patient A, and as to any relevant knowledge he may have regarding the facts and circumstances surrounding this matter.

Respondent reserves the right to call as expert witnesses any and all of the Board's designated expert witness(es) or any other witness designated by any other party. Respondent further reserves the right to amend and supplement this list as discovery continues and as necessary for rebuttal and/or impeachment.

II.

DOCUMENTS

1. Board of Medical Examiners of the State of Nevada Complaint filed November 3, 2021.

2. Respondent Hai Thanh Nguyen, M.D.'s Answer to Complaint
3. Respondent Hai Thanh Nguyen, M.D.'s Board Response Letter dated April 24, 20017
4. Medical Records from Healthcare Partners (HCP 0001-17)
5. Medical Administration Log (MED ADMIN LOG 0001-7)
6. Standard Operating Procedure for Injectable Medication Administration (SOP INJECTABLE MEDS 0001-4)
7. Curriculum Vitae of Eduardo Anorga, M.D.

Respondent reserves the right to use any and all of the documents, exhibits, reference materials and records disclosed by the Board or any other party. Respondent further reserves the right to amend and supplement this list as discovery continues and as necessary for rebuttal and/or impeachment.

DATED this 31st day of March, 2022.

McBRIDE HALL

By: */s/ T. Charlotte Buys*
ROBERT C. McBRIDE, ESQ.
Nevada Bar No.: 7082
T. CHARLOTTE BUYS, ESQ.
Nevada Bar No.: 14845
8329 W. Sunset Road, Suite 260
Las Vegas, Nevada 89113
Attorneys for Respondent
Hai Thanh Nguyen M.D.

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and

Complaint Against

HAI THANH NGUYEN, M.D.,

Respondent.

Case No. 21-38084-1

Pretrial Hearing Date: April 11, 2022 @ 3:30 p.m.

ORDER RESCHEDULING PRETRIAL HEARING

TO: Sarah Bradley, J.D.
Deputy Executive Director
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Hai Thanh Nguyen, M.D.
c/o Robert McBride, Esq. and
T. Charlotte Buys, Esq.
8329 W. Sunset Rd., Ste 260
Las Vegas, NV 89113

A pre-hearing conference for this matter was previously scheduled to take place on April 1, 2022. By request of the parties, that date was vacated. The pre-hearing conference will now be held on April 11, 2022 beginning at the hour of 3:30 p.m., Pacific Standard Time, and will be held via a conference call. Unless directed otherwise prior to the scheduled date and time of the pre-hearing conference, the conference call number will be 1-605-475-2200 and the access code will be 8792457. The parties shall participate in the conference call by and through counsel and the

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conference will be conducted before the undersigned hearing officer. With the exception of this change all other previous orders remain controlling pending further order.

DATED this 4th day of April 2022.

By: _____

Patricia Halstead, Esq.
Hearing Officer
(775) 322-2244

CERTIFICATE OF SERVICE

I certify that on this day, I personally delivered or mailed, postage pre-paid, at Reno, Nevada, a true file-stamped copy of the foregoing ORDER RESCHEDULING PRETRIAL HEARING addressed as follows:

Sarah Bradley, J.D.
Deputy Executive Director
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Hai Thanh Nguyen, M.D.
c/o Robert McBride, Esq. and
T. Charlotte Buys, Esq.
8329 W. Sunset Rd., Ste 260
Las Vegas, NV 89113

DATED this 5th day of April 2022.

Signature

Meg Byrd
Print

Legal Assistant
Title

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: HAI THANH NGUYEN, M.D., Respondent.	**Case No. 21-38084-1**

FILED
APR - 8 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

PREHEARING CONFERENCE STATEMENT OF THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) submits the following Prehearing Conference Statement in accordance with NAC 630.465 and the Hearing Officer's Order Rescheduling Pre-Hearing Conference, filed on April 5, 2022.

I. LIST OF WITNESSES

The IC of the Board lists the following witnesses whom it may call at the hearing on the charges in the Complaint against Respondent filed herein:

a. Ernesto Diaz, Chief of Investigations
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Mr. Diaz is expected to verify documentary evidence obtained during the investigation of this case and testify regarding the investigation of this matter.

b. Robert and Shielamarie DelGrosso
c/o Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

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Mr. and Mrs. DelGrosso are the consumer complainants in this case and they are expected to testify regarding the photos of Patient A that were submitted with the consumer complaint as well as other related facts regarding Dr. Nguyen's care of Patient A.

c. Scott Hall, M.D.
c/o Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Dr. Hall is licensed as a physician in the State of Nevada, and he is Board-certified in Family Medicine by the American Board of Family Medicine. Dr. Hall has conducted a review of this case. He is expected to testify regarding his review of this case and the standard of care required in Nevada.

d. Hai Thanh Nguyen, M.D.
c/o T. Charlotte Buys, Esq.
McBride Hall
8329 West Sunset Road, Suite 260
Las Vegas, NV 89113

Dr. Nguyen is expected to testify as to his conduct and to respond to the allegations in the Complaint.

e. All witnesses identified by Respondent in his prehearing conference statement and/or in any subsequent amended, revised or supplemental prehearing conference statement, or list of witnesses disclosed by Respondent of persons he may call to testify at the hearing herein.

The IC reserves the right to amend and supplement this list as required for prosecution of this case.

II. LIST OF EXHIBITS

The IC of the Board lists the following exhibits that it may introduce at the hearing on the charges and formal Complaint against the Respondent. Additionally, the IC of the Board reserves the right to rely on all exhibits listed in Respondent's prehearing conference statement and any supplement and/or amendment thereof.

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OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

EXHIBIT NO.	DESCRIPTION	BATES RANGE (NSBME)
1.	Allegation Letter to Dr. Nguyen, dated March 28, 2017	001
2.	Dr. Nguyen's Response to Allegation Letter, dated April 24, 2017	002-003
3.	Complaint, filed on November 3, 2021	004-008
4.	Answer to Complaint, filed on November 23, 2021	009-013
5.	Patient A's Medical Records	014-016
6.	Injection site photos of Patient A	017-018
7.	Article : *Croup*	019-027
8.	Article : *Acute Management of Croup in the Emergency Department*	028-031
9.	Article: *Croup: Diagnosis and Management*	032-037
10.	Article: *Kenalog -40 Injection (partial)*	038-043
11.	Article: *Kenalog -40 Injection (complete)*	044-048
12.	Article: *Documenting Vaccination*	049-051
13.	Article: *Evaluating Medical Decision-Making Capacity in Practice*	052-058
14.	Article: *Croup (Seminar)*	059-069
15.	Article: *Chapter 15. Intramuscular, Subcutaneous, and Intradermal Injections*	070-077
16.	Article: *Musculoskeletal Injections: A Review of the Evidence*	078-083

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

17.	Article: *Joint and Soft Tissue Injection*	084-089
18.	Scott Hall, M.D. – Curriculum Vitae	090-091

The IC reserves the right to amend and supplement this list as required for prosecution of this case.

DATED this 8th day of April, 2022.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Sarah A. Bradley

SARAH A. BRADLEY, J.D., MBA
Deputy Executive Director
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: bradleys@medboard.nv.gov
Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 8th day of April, 2022, I served a file-stamped copy of the foregoing **PREHEARING CONFERENCE STATEMENT OF THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS**, as well as required disclosure of documents, via Fed Ex Priority Mail – First Overnight, with a courtesty copy by electronic mail, to the following parties:

HAI THANH NGUYEN, M.D.
c/o T. Charlotte Buys, Esq.
McBride Hall
8329 W. Sunset Road, Ste. 260
Las Vegas, NV 89113
tcbuys@mcbridehall.com
Tracking No.: 7765 3564 4270

Additionaly, I served by electronic mail, file-stamped copies of the same to:

PATRICIA HALSTEAD, ESQ.
phalstead@halsteadlawoffices.com
Hearing Officer

DATED this 8th day of April, 2022.

MEG BYRD
Legal Assistant
Nevada State Board of Medical Examiners

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **HAI THANH NGUYEN, M.D.,** **Respondent.**	**Case No. 21-38084-1**

FILED
APR 11 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

PROOF OF SERVICE

I, Meg Byrd, Legal Assistant for the Nevada State Board of Medical Examiners, hereby certify that on April 8, 2022, I shipped by Federal Express First Overnight Tracking No. 776535644270 (adult signature required) to the following recipient(s):

T. Charlotte Buys, Esq.
McBride Hall
8329 West Sunset Road, Suite 260
Las Vegas, NV 89113

the IC's Prehearing Conference Statement with Exhibits which delivery was confirmed on April 11, 2022 at 7:43 a.m. *See* **Exhibit 1**.

DATED this 11th day of April, 2022.

MEG BYRD, Legal Assistant
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

EXHIBIT 1

EXHIBIT 1

FedEx® Tracking

776535644270

ADD NICKNAME

Delivered
Monday, 4/11/2022 at 7:43 am

DELIVERED

Signed for by: M.CHRISTINE

GET STATUS UPDATES

OBTAIN PROOF OF DELIVERY

Adult signature required

FROM	TO
Reno, NV US	LAS VEGAS, NV US

MANAGE DELIVERY

Travel History

TIME ZONE
Local Scan Time

Monday, April 11, 2022		
7:43 AM	LAS VEGAS, NV	Delivered
6:38 AM	LAS VEGAS, NV	At local FedEx facility
6:38 AM	LAS VEGAS, NV	On FedEx vehicle for delivery
6:12 AM	LAS VEGAS, NV	Shipment arriving On-Time
5:59 AM	LAS VEGAS, NV	At local FedEx facility
Saturday, April 9, 2022		
7:12 AM	LAS VEGAS, NV	At local FedEx facility
3:36 AM	LAS VEGAS, NV	At destination sort facility

2:32 AM	OAKLAND, CA	Departed FedEx hub
Friday, April 8, 2022		
9:38 PM	OAKLAND, CA	Shipment arriving On-Time
9:27 PM	OAKLAND, CA	Arrived at FedEx hub
5:50 PM	RENO, NV	Left FedEx origin facility
4:01 PM	RENO, NV	Picked up
4:02 PM		Shipment information sent to FedEx

Expand History

Shipment Facts

TRACKING NUMBER
776535644270

SERVICE
FedEx First Overnight

WEIGHT
2 lbs / 0.91 kgs

DELIVERED TO
Receptionist/Front Desk

TOTAL PIECES
1

TOTAL SHIPMENT WEIGHT
2 lbs / 0.91 kgs

TERMS
Shipper

PACKAGING
FedEx Envelope

SPECIAL HANDLING SECTION
Deliver Weekday, Adult Signature Required

SHIP DATE
4/8/22

SIGNATURE SERVICES
Adult signature required

STANDARD TRANSIT
4/11/22 before 8:00 am

ACTUAL DELIVERY
4/11/22 at 7:43 am

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against

HAI THANH NGUYEN, M.D.,

Respondent.

Case No. 21-38084-1

Hearing Date: May 26-27, 2022 @ 8:30 a.m.

ORDER FOLLOWING PRE-HEARING CONFERENCE

TO: Sarah Bradley, J.D.
Deputy Executive Director
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Hai Thanh Nguyen, M.D.
c/o Robert McBride, Esq. and
T. Charlotte Buys, Esq.
8329 W. Sunset Rd., Ste 260
Las Vegas, NV 89113

A pre-hearing conference for this matter was held on April 11, 2022. The pre-hearing conference was held via conference call and present on the conference call were Sarah Bradley, J.D. on behalf of the Investigative Committee of the Board of Medical Examiners of the State of Nevada (the "IC"); T. Charlotte Buys, Esq. on behalf of Respondent Hai Thanh Nguyen, M.D.; and the undersigned Hearing Officer.

Based upon the continuance of the pre-hearing conference from its original date, the parties stipulated to extend the previously ordered briefing schedule. As such, any and all pre-hearing motions shall be served and submitted to the undersigned hearing officer on or before **April 22, 2022**. Any oppositions or responses thereto shall be served and submitted to the undersigned hearing officer on or before **May 3, 2022**. Any and all replies shall be served and

submitted to the below hearing officer on or before **May 12, 2022**. Either party's request for additional documentation not already disclosed shall be briefed pursuant to the foregoing schedule after the review of applicable statutory and administrative code provisions as well as case law addressing the same, the applicability or non-applicability of which shall be addressed in any submitted briefing.

The formal hearing in this matter remains scheduled for **May 26, 2022 through May 27, 2022**, starting at 8:30 a.m. on each date. Unless otherwise determined, the undersigned hearing officer shall attend from the Reno office of the Nevada State Board of Medical Examiners, located at 9600 Gateway Drive, Reno, Nevada 89521, as shall counsel for the IC Sarah Bradley, J.D. Respondent's counsel Robert McBride, Esq. and/or T. Charlotte Buys, Esq. and Respondent Hai Thanh Nguyen, M.D. shall attend from the Las Vegas Office of the Nevada State Board of Medical Examiners, located at 325 E. Warm Springs Road, Suite 225, Las Vegas, Nevada 89119.

Unless stipulated to, permission for the remote appearance by any witness must be sought from and approved by the undersigned hearing officer, and any such request shall be in writing and submitted on or before 5:00 p.m. **May 5, 2022**. Ms. Buys indicated her intent to file such a request on behalf of Respondent's expert witness. The undersigned will consider the same upon written request, which the IC may have until the close of business on **May 9, 2022** to respond.

The parties shall confer regarding the admissibility of exhibits and be prepared to address the stipulated admissibility of exhibits at the commencement of the evidentiary hearing. Any exhibits not stipulated to be admitted will be individually addressed as they are sought to be admitted.

It remains that, following the hearing, the undersigned hearing officer will submit to the Board a synopsis of the testimony taken at the hearing and make a recommendation on the veracity of witnesses if there is conflicting evidence or if credibility of witnesses is a determining factor, and thereafter the Board will render its decision. NAC 630.470.

Should the parties deem a status conference necessary prior to the scheduled evidentiary hearing, they shall coordinate at least three proposed dates and times and may jointly email the

undersigned hearing officer with the proposed dates and times and request a status conference and state the basis for the request.

IT IS SO ORDERED.

DATED this 11th day of April 2022.

By: 

Patricia Halstead, Esq.
Hearing Officer
(775) 322-2244

CERTIFICATE OF SERVICE

I certify that on this day, I personally delivered or mailed, postage pre-paid, at Reno, Nevada, a true file-stamped copy of the foregoing ORDER FOLLOWING PRE-HEARING CONFERENCE addressed as follows:

Sarah Bradley, J.D.
Deputy Executive Director
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Hai Thanh Nguyen, M.D.
c/o Robert McBride, Esq. and
T. Charlotte Buys, Esq.
8329 W. Sunset Rd., Ste 260
Las Vegas, NV 89113

DATED this 27th day of April 2022.

Signature

Meg Byrd
Print

Legal Assistant
Title

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA
* * * * *

In the Matter of Charges and Complaint Against HAI THANH NGUYEN, M.D., Respondent.	**Case No. 21-38084-1**

HAI THANH NGUYEN, M.D.'S FIRST SUPPLEMENTAL PREHEARING CONFERENCE DISCLOSURE

COMES NOW, Respondent HAI THANH NGUYEN, M.D., by and through his counsel of record, ROBERT C. McBRIDE, ESQ. and T. CHARLOTTE BUYS, ESQ., of the law firm of McBRIDE HALL and in accordance with Nevada Administrative Code § 630.465 and the Hearing Officer's Scheduling Order filed on February 7, 2022 and Order Rescheduling Pretrial Hearing filed on April 5, 2022, hereby provides the following First Supplement to Hai Thanh Nguyen, M.D.'s Prehearing Conference Disclosure **(supplements are in bold)**:

I.

WITNESSES

1. Hai Thanh Nguyen, M.D.
   c/o Robert C. McBride, Esq.
   T. Charlotte Buys, Esq.
   McBRIDE HALL
   8329 W. Sunset Boulevard, Suite 260
   Las Vegas, Nevada 89113
   (702) 791-5855

Respondent will testify regarding the care and treatment provided to Patient A, his custom and practice, and his medical records documenting Patient A's care and treatment. He will also provide testimony regarding the Board's Complaint and the allegations therein. Respondent will also testify that he complied with the standard of care.

2. Eduardo Anorga, M.D.

[redacted]

Dr. Anorga is a physician board-certified in family medicine and is expected to testify regarding his review of this case and the standard of care applicable to Dr. Nguyen's care and treatment of Patient A, and documentation of the same. Dr. Anorga will also provide expert testimony regarding the Board's Complaint and the allegations contained therein.

3. Ellen Aliberti

[redacted]

Ms. Aliberti is a Clinical Educator. Ms. Aliberti is expected to testify regarding the clinical education and policies and procedures provided to Medical Assistants at Healthcare Partners of Nevada. She is also anticipated to testify to any relevant knowledge she may have regarding the facts and circumstances surrounding this matter.

4. Glenisha Barner, MA
(Current Address Unknown)

Ms. Barner is anticipated to testify regarding her care and treatment of Patient A, and as to any relevant knowledge she may have regarding the facts and circumstances surrounding this matter.

5. Barry Misiuk, MA
(Current Address Unknown)

Mr. Misiuk is anticipated to testify regarding his care and treatment of Patient A, and as to any relevant knowledge he may have regarding the facts and circumstances surrounding this matter.

6. **Sheilamarie DelGrosso**
c/o Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Ms. Delgrosso and Mr. Delgrosso are the parents of Patient A and are expected to testify as to the consent for medical care and medical treatment provided to Patient A and any relevant knowledge she may have regarding the facts and circumstances surrounding this matter.

Respondent reserves the right to call as expert witnesses any and all of the Board's designated expert witness(es) or any other witness designated by any other party. Respondent further reserves the right to amend and supplement this list as discovery continues and as necessary for rebuttal and/or impeachment.

II.

DOCUMENTS

1. Board of Medical Examiners of the State of Nevada Complaint filed November 3, 2021.
2. Respondent Hai Thanh Nguyen, M.D.'s Answer to Complaint
3. Respondent Hai Thanh Nguyen, M.D.'s Board Response Letter dated April 24, 20017
4. Medical Records from Healthcare Partners (HCP 0001-17)
5. Medical Administration Log (MED ADMIN LOG 0001-7)
6. Standard Operating Procedure for Injectable Medication Administration (SOP INJECTABLE MEDS 0001-4)
7. Curriculum Vitae of Eduardo Anorga, M.D.
8. **IBM Micromedex Information for Pediatric Administration of Kenalog (MICROMEDEX000001-25).**
9. **American Society for Microbiology, Comparison of Corticosteroids for Treatment of Respiratory Syncytial Virus Bronchiolitis and Pneumonia in Cotton Rats (ASM 000001-000004).**

10. Bristol-Myers Squibb Company Information for Intramuscular or Intra-articular Kenalog Injection, Revised June 2011, (BMS_(2011)_000001-20).

Respondent reserves the right to use any and all of the documents, exhibits, reference materials and records disclosed by the Board or any other party. Respondent further reserves the right to amend and supplement this list as discovery continues and as necessary for rebuttal and/or impeachment.

DATED this 11th day of April, 2022.

McBRIDE HALL

By: */s/ T. Charlotte Buys*
ROBERT C. McBRIDE, ESQ.
Nevada Bar No.: 7082
T. CHARLOTTE BUYS, ESQ.
Nevada Bar No.: 14845
8329 W. Sunset Road, Suite 260
Las Vegas, Nevada 89113
Attorneys for Respondent
Hai Thanh Nguyen M.D.

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **HAI THANH NGUYEN, M.D.,** **Respondent.**	**Case No. 21-38084-1**

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

FIRST SUPPLEMENTAL PREHEARING CONFERENCE STATEMENT OF THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) submits the following Supplemental Prehearing Conference Statement in accordance with NAC 630.465 and the Hearing Officer's Order Rescheduling Pre-Hearing Conference, filed on April 5, 2022 (**New items are in bold font**).

I. LIST OF WITNESSES

The IC of the Board lists the following witnesses whom it may call at the hearing on the charges in the Complaint against Respondent filed herein:

a. Ernesto Diaz, Chief of Investigations
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Mr. Diaz is expected to verify documentary evidence obtained during the investigation of this case and testify regarding the investigation of this matter.

b. Robert and Shielamarie DelGrosso
c/o Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

///

Mr. and Mrs. DelGrosso are the consumer complainants in this case and they are expected to testify regarding the photos of Patient A that were submitted with the consumer complaint as well as other related facts regarding Dr. Nguyen's care of Patient A.

c. Scott Hall, M.D.
c/o Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Dr. Hall is licensed as a physician in the State of Nevada, and he is Board-certified in Family Medicine by the American Board of Family Medicine. Dr. Hall has conducted a review of this case. He is expected to testify regarding his review of this case and the standard of care required in Nevada.

d. Hai Thanh Nguyen, M.D.
c/o T. Charlotte Buys, Esq.
McBride Hall
8329 West Sunset Road, Suite 260
Las Vegas, NV 89113

Dr. Nguyen is expected to testify as to his conduct and to respond to the allegations in the Complaint.

e. All witnesses identified by Respondent in his prehearing conference statement and/or in any subsequent amended, revised or supplemental prehearing conference statement, or list of witnesses disclosed by Respondent of persons he may call to testify at the hearing herein.

The IC reserves the right to amend and supplement this list as required for prosecution of this case.

II. LIST OF EXHIBITS

The IC of the Board lists the following exhibits that it may introduce at the hearing on the charges and formal Complaint against the Respondent. Additionally, the IC of the Board reserves the right to rely on all exhibits listed in Respondent's prehearing conference statement and any supplement and/or amendment thereof.

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OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

EXHIBIT NO.	DESCRIPTION	BATES RANGE (NSBME)
1.	Allegation Letter to Dr. Nguyen, dated March 28, 2017	001
2.	Dr. Nguyen's Response to Allegation Letter, dated April 24, 2017	002-003
3.	Complaint, filed on November 3, 2021	004-008
4.	Answer to Complaint, filed on November 23, 2021	009-013
5.	Patient A's Medical Records	014-016
6.	Injection site photos of Patient A	017-018
7.	Article : *Croup*	019-027
8.	Article : *Acute Management of Croup in the Emergency Department*	028-031
9.	Article: *Croup: Diagnosis and Management*	032-037
10.	Article: *Kenalog -40 Injection (partial)*	038-043
11.	Article: *Kenalog -40 Injection (complete)*	044-048
12.	Article: *Documenting Vaccination*	049-051
13.	Article: *Evaluating Medical Decision-Making Capacity in Practice*	052-058
14.	Article: *Croup (Seminar)*	059-069
15.	Article: *Chapter 15. Intramuscular, Subcutaneous, and Intradermal Injections*	070-077
16.	Article: *Musculoskeletal Injections: A Review of the Evidence*	078-083

17.	Article: *Joint and Soft Tissue Injection*	084-089
18.	Scott Hall, M.D. – Curriculum Vitae	090-091
19.	**Scott Hall, M.D. – Updated Curriculum Vitae**	**092-093**

The IC reserves the right to amend and supplement this list as required for prosecution of this case.

DATED this 12th day of April, 2022.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Sarah A. Bradley

SARAH A. BRADLEY, J.D., MBA
Deputy Executive Director
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: bradleys@medboard.nv.gov
Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

EXHIBIT 19

EXHIBIT 19

SCOTT HALL, MD CAQSM

Associate Professor of Family Medicine
University of Nevada School of Medicine
Family Medicine Department

EDUCATION

Doctor of Medicine, Ohio State University, 2002
Bachelor of Science, Brigham Young University, 1998

MEDICAL TRAINING

Sports Medicine Fellowship, Grant Sports Medicine, 2006

Chief Resident, Grant Family Medicine, 2005

Family Medicine Residency, Grant Family Medicine, 2002-2005

MEDICAL EXPERIENCE

2007-current	Associate Professor of Family Medicine, *University of Nevada, Reno School of Medicine, Department of Family Medicine*
2018-current	State of Nevada Rating Physician, *Scott Hall, MD, PLLC*
2007-2019	Clinical Physician and Medical Director, *SpecialtyHealth*
2006-2007	Family Medicine Physician and Hospitalist, *Renown Health*
2005-2006	Hospitalist, *Physician Staffing*

PRESENTATIONS

"Pre-Participation Exams in the COVID Era," Lecture presented at 53rd Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2021.

"Joint Examinations" and "Joint Injections" Workshops presented at 52th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2020.

"MRSA and Athletes," presentation for the Renown Sports Medicine conference in April 2019 and Project ECHO University of Nevada, Reno in May 2019

"Joint Examinations," Workshop presented at 50th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2018.

"Joint Examinations" and "Joint Injections," Workshop presented at 48th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2016.

"Joint Examinations," Workshop presented at 47th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2015.

"Joint Examinations," Workshop presented at 46th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2014.

"Evaluation of the Impact of a Paleolithic Diet on Cardiovascular Risk Factors and Lipoproteins in a Law Enforcement Population," Presented at the Ancestral Health Symposium 2013 in Atlanta GA, *46th Annual Nevada Academy of Family Physicians Winter CME Meeting* in South Lake Tahoe, NV, and Washoe County Obesity Forum 2013 in Reno, NV.

"Spine Examination," Workshop presented at 45th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2013.

"Neck and Shoulder Exam," Workshop presented at 44th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2012.

"Joint Injections," Presented at 40th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2008.

"Presyncope in a Division III Cross-Country Runner," Presented at *AMSSM National Meeting*, Miami Florida, April 2006.

"Community-acquired MRSA in Athletes – What You Need to Know," Presented at *11th Current Concepts in Sports Medicine Conference*, Columbus Ohio, August 2005.

"The Preparticipation Physical Exam," Presented at *Grant Medical Center Grand Rounds*, Columbus Ohio, March 2005.

"Management of the Abnormal Pap Smear," Presented at *Colposcopy for the Primary Care Physician,* Columbus Ohio, May 2004.

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA
* * * * *

In the Matter of Charges and Complaint Against HAI THANH NGUYEN, M.D., Respondent.	**Case No. 21-38084-1**

FILED

APR 22 2022

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

HAI THANH NGUYEN, M.D.'S MOTION TO APPLY "CLEAR AND CONVINCING" AS THE BURDEN OF PROOF

COMES NOW, Respondent HAI THANH NGUYEN, M.D., by and through his counsel of record, ROBERT C. McBRIDE, ESQ. and T. CHARLOTTE BUYS, ESQ., of the law firm of McBRIDE HALL and hereby submits his Motion to Apply the Appropriate "Clear and Convincing" Standard.

This Motion is made and based and based upon the attached Memorandum of Points and Authorities, the papers and pleadings on file herein, any oral argument that may be adduced at the time of a hearing set for this matter, and any other evidence that the Hearing Officer deems just and proper.

DATED this 22nd day of April, 2022.

McBRIDE HALL

By: */s/ T. Charlotte Buys*
ROBERT C. McBRIDE, ESQ.
Nevada Bar No.: 7082
T. CHARLOTTE BUYS, ESQ.
Nevada Bar No.: 14845
8329 W. Sunset Road, Suite 260
Las Vegas, Nevada 89113
Attorneys for Respondent
Hai Thanh Nguyen M.D.

MEMORANDUM OF POINTS AND AUTHORITIES

I.

INTRODUCTION

Approximately seven (7) years after Dr. Hai Nguyen treated a pediatric patient ("Patient A") in an urgent care clinic, Dr. Nguyen is being asked to defend his care as a result of a formal Complaint which was filed by the Nevada State Board of Medical Examiners ("the Board"). While the Board has a duty to protect the public and enforce Nevada's Medical Practice Act, it cannot do so while violating a physician's constitutional due process rights. *See Potter v. State Bd. of Med. Exam'rs*, 101 Nev. 369, 371, 705 P.2d 132, 134 (Nev. 1985). The Nevada Supreme Court has expressly held:

> "Generally, the right to practice medicine is a property right protected by the due process clauses of the United States and Nevada Constitutions, and a license to practice medicine may not be arbitrarily abridged or revoked. *See Molnar v. State, Board of Medical Examiners*, 105 Nev. 213, 216, 773 P.2d 726, 727 (1989); *Potter v. State, Board of Medical Examiners*, 101 Nev. 369, 371, 705 P.2d 132, 134 (1985). As a result, due process protections obtain in administrative hearings to revoke a medical license. *See Molnar*, 105 Nev. at 216, 773 P.2d at 727-28 (due process requires Board to base decision on conclusions of hearing officer who heard testimony); *Potter,* 101 Nev. at 371, 705 P.2d at 134 (voting process violated due process); *Cf. Bivins Constr. v. State Contractors' Bd.*, 107 Nev. 281, 283, 809 P.2d 1268, 1270 (1991) (cross examination in administrative hearing may not be curtailed)." *See Minton v. Bd. of Med. Exam'rs*, 110 Nev. 1060, 1082, 881 P.2d 1339, 1354 (Nev. 1994) (overruled in part, *Nassiri v. Chiropractic Physicians' Bd. of Nev.*, 130 Nev. 245, 327 P.3d 487 (Nev. 2014)).

Pursuant to the Fourteenth Amendment of the United States Constitution and Article 1, §8(5), of the Nevada Constitution, Dr. Nguyen has the right to receive adequate due process during a penal administrative proceeding as "...[t]he interest in practicing one's profession is a valuable property right which cannot be arbitrarily abridged or revoked." *See Potter v. State Bd. of Med. Exam'rs*, 101 Nev. 369, 371, 705 P.2d 132, 134 (Nev. 1985) (*citing Burleigh v. State Bar of Nevada*, 98 Nev. 140, 145, 643 P.2d 1201, 1204 (Nev. 1982)).

The purpose of this Motion is to obtain a determination that any recommendation made to the members of the Nevada State Board of Medical Examiners shall be subject to the

requirements and limitations of the "clear and convincing" burden of proof, as such is required to protect Dr. Nguyen's due process rights.

II.

ARGUMENT

A. THE NEVADA STATE BOARD OF MEDICAL EXAMINERS HAS A BURDEN OF PROOF OF "CLEAR AND CONVINCING EVIDENCE" IN ORDER TO PROVE A BREACH OF THE STANDARD OF CARE.

In Nevada, and generally elsewhere, when a State Board of Medical Examiners Complaint involves a matter which can affect the livelihood, reputation, and insurability of a physician, the Board must prevail by demonstrating "clear and convincing" evidence.[1] In *Minton v. Bd. of Med. Exam'rs*, the Nevada Supreme Court stated that in professional discipline cases, "...the burden on the prosecuting authority is to establish violations by **clear and convincing evidence**...". *See Minton v. Bd. of Med. Exam'rs*, 110 Nev. 1060, 1079, 881 P.2d 1339, 1352 (Nev. 1994) ("In medical license revocation proceedings, 'clear and convincing evidence' is required before a license may be revoked.") (overruled in part, *Nassiri v. Chiropractic Physicians' Bd. of Nev.*, 130 Nev. 245, 327 P.3d 487 (Nev. 2014)). (Emphasis added).

Nearly everywhere and anywhere that the issue has arisen, the "burden of proof" placed upon a professional board seeking to sanction a licensed professional is "clear and convincing" evidence. Nevada has enacted a statute, NRS 630.346, which indicates that the quality of the evidence to be offered at a professional penal hearing must at a minimum satisfy the lesser standard of a preponderance of the evidence. That appears to be due to the fact that an administrative hearing (even a penal hearing) may allow admittance of evidence which may not otherwise be permitted in a district court trial. The statute appears directed to the quality of evidence allowed. The statute does not command that the "burden" of proving the case is a standard less than clear and convincing evidence. *See Nassiri v. Chiropractic Physicians' Bd. of*

[1] In civil cases, the burden of proof is "preponderance of the evidence." In criminal cases, the burden of proof is "beyond any reasonable doubt." In penal administrative cases by professional boards, the burden is in between, requiring at least "clear and convincing evidence."

Nev., 130 Nev. 245, 327 P.3d 487 (Nev. 2014), where the Nevada Supreme Court makes a point of indicating that the "burden" of proof and "standard" of proof, or quality of review, are different concepts. To satisfy constitutional muster, the Hearing Officer (whose recommendation generally must be accepted) is required to apply the "clear and convincing" burden.[2]

Moreover, a decision by the Nevada Board of Medical Examiners which did not determine whether there was "clear and convincing evidence" that the physician was guilty of the charges alleged has been previously reversed due to use of an incorrect, lesser burden of proof. *See* attached hereto as "Exhibit A," a Las Vegas Review Journal article regarding reversal of a Nevada State Board of Medical Examiners decision restricting the practice of Nevada Surgeon, Nathaniel Tippit, M.D.

Such a burden of proof of clear and convincing evidence is similarly placed on other professional boards in Nevada, including attorneys. "In bar disciplinary matters, a higher degree of proof is required than in ordinary civil proceedings. Clear and convincing evidence must support any findings of misconduct." *See In re Drakulich*, 111 Nev. 1556, 1566, 908 P.2d 709, 715 (Nev. 1995).

Many other jurisdictions also require the "clear and convincing" burden of proof" in professional discipline hearings. For example, the Court of Appeal of California has held:

> "Since it is apparent that the underlying purpose of disciplining both attorneys and physicians is protection of the public, it would be anomalous to require a higher degree of proof in disciplinary hearings involving attorneys or real estate agents than in hearings involving physicians. Accordingly, we hold that the proper standard of proof in an administrative hearing to revoke or suspend a doctor's license should be *clear and convincing proof to a reasonable certainty* and not a mere *preponderance of the evidence*." *See Ettinger v. Bd. of Med. Quality Assurance*, 135 Cal. App. 3d 853, 856, 185 Cal. Rptr. 601, 603 (1982).

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[2] Accordingly, the Hearing Officer, respectfully, has two responsibilities. First to apply a preponderance of the evidence standard in determining what evidence may be admitted into the hearing. Second, at the conclusion of the hearing and upon reviewing all of the admitted evidence, the Hearing Officer is charged with the duty of determining whether the Board satisfied its "burden" of proving its case to a "clear and convincing" level. To argue otherwise, would render the language in *Nassiri* void where the Nevada Supreme Court stated that "burden" of proof and "standard" of evidence are distinct concepts (the *Nassiri* opinion was issued after the passage of the amendment to NRS 630.346). *See Nassiri v. Chiropractic Physicians' Bd. of Nev.*, 130 Nev. 245, 249 327 P.3d 487 (Nev. 2014).

Florida similarly requires "clear and convincing proof" in order to impose professional discipline for revocation or suspension of a physician's license. *See Nair v. Dep't of Bus. & Prof'l Regulation, Bd. of Med.*, 654 So. 2d 205, 207 (Fla. Dist. Ct. App. 1995); *see also Fla. Bar v. Rayman*, 238 So. 2d 594, 598 (Fla. 1970) (the Florida State Bar also has "... a continuing duty to require charges such as these to be supported by clear and convincing evidence where the charges have been denied by reputable members of the Bar"). *See e.g. Devous v. Wyo. State Bd. of Med. Exam'rs*, 845 P.2d 408, 416 (Wyo. 1993) (charges must be established by clear and convincing evidence); and *Davis v. Wright*, 243 Neb. 931, 937, 503 N.W.2d 814, 818 (1993) (the burden of proof in disciplinary proceedings shall hereinafter be by clear and convincing evidence).

It is anticipated that Board counsel may reference NRS 630.346, in order to argue that the standard of proof set forth statutorily is preponderance of the evidence. While the "standard of proof" may be preponderance of the evidence, the overall burden of proof (an entirely different concept) is "clear and convincing" evidence. In *Nassiri*, the Nevada Supreme Court explains the standard of proof, but carefully notes that it did not address the higher "burden" of proof when a physician is facing sanction on his license because in *Nassiri*, the Appellant did not argue for the higher burden. *See Nassiri v. Chiropractic Physicians' Bd. of Nev.*, 130 Nev. 245, 251 n.4, 327 P.3d 487, 491 (Nev. 2014). Here, Dr. Nguyen is requesting that "clear and convincing" be the burden of proof and such "standard" is necessary to satisfy the "burden" under Nevada, Florida, California, Nebraska, and Wyoming law, as well as the United States Supreme Court to satisfy the due process requirements of a professional, penal sanction proceeding against a physician's license.

As this matter affects Dr. Nguyen's livelihood, insurability and reputation, the Board must be required to meet its burden of proof demonstrating "clear and convincing" evidence.

III.

CONCLUSION

As set forth above, Dr. Hai Nguyen respectfully requests that the foregoing Motion be granted and that any recommendations made to the members of the Nevada Board of Medical

Examiners and the determination as to the charges made against Dr. Nguyen be framed using the "clear and convincing evidence" burden of proof.

DATED this 22nd day of April, 2022.

McBRIDE HALL

By: */s/ T. Charlotte Buys*

ROBERT C. McBRIDE, ESQ.
Nevada Bar No.: 7082
T. CHARLOTTE BUYS, ESQ.
Nevada Bar No.: 14845
8329 W. Sunset Road, Suite 260
Las Vegas, Nevada 89113
Attorneys for Respondent
Hai Thanh Nguyen M.D.

CERTIFICATE OF SERVICE

I hereby certify that on the 22nd day of April 2022, I served a true correct copy of **HAI THANH NGUYEN, M.D.'S MOTION TO APPLY "CLEAR AND CONVINCING" AS THE BURDEN OF PROOF**, by sending electronically and mailing via United States mail to the following:

Sarah Bradley, J.D., MBA
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
Attorneys for the Investigative Committee

/s/ Natalie Jones
An Employee of McBride Hall

EXHIBIT “A”

EXHIBIT “A”

Wynn wants Hilton offer reconsidered

By Jane Ann Morrison
Review-Journal

Not one to easily accept rejection, Golden Nugget boss Stephen Wynn on Friday asked the executor of the estate of Conrad Hilton to reconsider his stock purchase offer.

In his original offer last week to purchase 6.8 million shares of Hilton Hotels Corp. stock for $488.3 million or $72 a share, Wynn set the deadline for Bates' response at 5 p.m. Friday.

But the day after his offer to purchase 25 percent of the common stock was made, Bates said it was "inadequate" and questioned whether he had the authority to sell the shares which were willed by Conrad Hilton to the charitable foundation bearing his name that was started in 1944.

In his letter to Bates, released Friday, Wynn said he was "dismayed" by Bates' April 8 letter rejecting the offer. "I want you to know that we remain ready to consummate a transaction," Wynn said, adding that all the terms are negotiable.

Although the Internal Revenue Service tentatively ruled in favor of Barron Hilton's position that he may buy the shares for $24.20 (the market price at the time of Conrad Hilton's death in 1979), Wynn rejects that position.

Wynn claimed that the shares should be sold now, otherwise the Conrad Hilton Foundation would be deprived of at least $320 million and Barron Hilton would be enriched by the same amount.

"The only people being hurt are the potential beneficiaries in the Foundation including the Sisters of Loretto and the Sisters of the Sacred Heart, and, of course, the shareholders of Hilton."

"We can't understand you allowing this perversion of Conrad Hilton's intent to go unchecked," Wynn concluded.

The Internal Revenue Service has tentatively agreed with Barron Hilton that the stock would constitute "excessive business holdings" for the foundation," but Golden Nugget legal counsel Bruce Levin said the IRS ruling was a "non-event."

"If the shares were to be sold now, the question of Barron Hilton's option would be mooted as cash clearly would not constitute 'an excess business' holding," Wynn wrote.

Bates was unavailable for comment.

Hilton stock, which jumped from $63.75 a share to 72¼ by the end of that day, had dipped down to 67⅛ when the stock closed on the New York Stock Exchange on Friday.

Golden Nugget Inc. stock remained the same at 12¼.

In an effort to prevent the takeover by Golden Nugget, Hilton announced Wednesday it has increased its line of credit by $360 million and now has a $600 million line of credit.

Hilton holds its annual stockholders meeting on May 6 in Beverly Hills, Calif., and the corporation is proposing three bylaw changes which will make a hostile takeover by Wynn more difficult.

That meeting will take place in the midst of a rehearing in New Jersey concerning Hilton's suitability for licensing to operate a $308 million hotel-casino. The corporation was denied a license, but has obtained permission to present new evidence.

Lemons is fifth Reno brokerage to collapse

Lemons and Associates is the fifth Reno-based mortgage brokerage to collapse in recent years.

The brokerage, which has a $1 million mortgage portfolio in the Las Vegas area, has a deficit of between $6 million and $7 million.

Lemons' owner Stephen Sather filed for reorganization last week in U.S. Bankruptcy Court rather than try to liquidate the company immediately to repay investors.

State officials estimate that many investors may get about 50 cents back on the dollar on their investments in the brokerage.

Many of the problems involving mortgage brokerages in Reno and Las Vegas involve misuse of trust accounts. Some brokerages have been the victims of outright embezzlement. Others have continued to distribute money to investors despite cash shortages.

The Legislature is considering several proposals that would tighten the regulations governing mortgage brokerage operations and the abuse of trust account funds.

"We need to find some way to protect those trust accounts," said Glen Walquist, deputy director of the Financial Institutions Division in Southern Nevada.

Administrator Scott Walshaw of the state Financial Institutions Division said there is no evidence of criminal conduct by former owner Steven Lemons, but said the records are "highly suspect."

According to a source close to the banking industry, the late Sam Calabrese, a controversial figure with underworld connections, borrowed about $3 million from Lemons.

UNLV students want nuke dump blocked

A majority of UNLV students taking part in elections this week supported a referendum calling for state officials to take action blocking the location of a nuclear waste dump in Nevada.

Figures released Friday by the Consolidated Students of the University of Nevada show 68 percent of the 1,174 undergraduate students who cast ballots think action should be taken against a dump. Yucca Mountain, located 100 miles northwest of Las Vegas, is a proposed nuclear waste disposal site.

Students were asked to express their opinions on other issues as well.

Surprisingly, 55 percent of the student voters opposed a referendum calling for Nevada's elected representatives to oppose Reagan budget cuts in higher education.

The administration's proposed cutbacks could mean UNLV students would lose an estimated $1 million next year in student aid.

James Ohriner, a spokesman for CSUN, said the ballot question on budget cuts was poorly worded, which could have led to confusion.

A majority of students, 57 percent, called for the University of Nevada System to maintain its present grade point average requirement of 2.3 for admission of out-of-state students, instead of 2.5 which has been discussed by some officials.

Students also opposed the establishment of a parking fee to pay for more police patrols of parking lots and they favored student ownership of the privately operated student bookstore.

Jury returns guilty verdict in attempted murder case

Despite his girlfriend's testimony that she was the culprit, a 26-year-old man has been convicted by a District Court jury of shooting another man in the forehead.

After deliberating a little more than two hours, the jury found Willie Moore guilty of attempted murder with the use of a deadly weapon in the Sept. 26, 1984, shooting of Carol Williams, 30.

The jury returned the verdict late Thursday night in the courtroom of Judge Myron Leavitt. The judge has scheduled sentencing for May 10. Moore faces a maximum prison sentence of 40 years.

Moore was found guilty of shooting the victim in the forehead with a .22-caliber pistol at the foot of a staircase at the Holiday Royale apartments, 4505 Paradise Road.

Deputy District Attorney Dave Schwartz said the bullet went through Williams' brain and lodged in the back of his skull. Surgeons, he said, decided it would be too dangerous to remove the bullet. The victim's right side remains paralyzed.

In a surprising move, Peggy Engles, a 23-year-old woman identified as Moore's girlfriend, testified that she shot the victim.

The woman, a defense witness, said she shot Williams in self-defense after the victim grabbed her ring and tried to beat her.

The victim, however, positively identified Moore as the person who shot him at point-blank range. He said Moore had accused him of stealing his money and his girlfriend's jewelry.

The prosecutor argued that the woman could not have shot Williams because she is much shorter than the victim and the bullet was fired straight into Williams' forehead.

Schwartz said he will seek perjury charges against the woman once she can be located and arrested.

Law enforcement records indicate the woman, a reputed prostitute, uses a number of aliases and has outstanding arrest warrants against her.

Malpractice charges dropped

Former Las Vegas breast surgeon Nathaniel G. Tippit, charged with numerous counts of medical malpractice, agreed Friday never again to practice in Nevada.

In return, the state Board of Medical Examiners and the attorney general's office agreed to drop the malpractice charges against Tippit, who is now practicing in Texas.

The deal was spelled out in a four-page stipulation and agreement accepted jointly by the Board of Medical Examiners, the attorney general's office and Tippit through his Las Vegas attorney, Sherman Mayor.

The state Board of Medical Examiners put Tippit on 10 years' probation March 31, 1984, after finding him guilty of 19 incidents of malpractice and five charges of unprofessional conduct.

Among the charges against Tippit was performing unnecessary mastectomies.

The board's decision, however, was reversed by District Judge Thomas Foley who ruled that the board failed to determine whether there was "clear and convincing evidence" that the surgeon was guilty of the charges, but instead erroneously used a less stringent degree of proof.

Foley therefore ordered the board to rehear the entire case.

Deputy Attorney General Ellen Whittemore then requested the judge amend his decision to permit the board to review the transcripts of the testimony and then decide whether there was clear and convincing evidence of the surgeon's guilt, thereby avoiding the need to have a new hearing.

Under the deal approved Friday, Tippit and the attorney general's office agreed to mutually dismiss those court actions.

Tippit's attorney said he plans to provide Texas licensing officials with a copy of the stipulation agreement.

Vegan vies for council seat

Lois Larson, a 30-year Las Vegas resident, has announced her candidacy for Ward 4 of the Las Vegas City Council.

Active in business and charitable organizations, Larson said she has gained a knowledge of the city's budget and finances through involvement at City Council meetings.

A graduate of Augustana College, she developed and directed the first non-profit residential organization for mentally retarded adults in Southern Nevada.

Larson, who resides at 2112 Jaynie Way, has been a supporter and participant in arts programs, university associations, church activities and social programs for the handicapped.

She said she would bring administrative skills to the elected position and help sustain growth in Las Vegas.

She is married and has three children.

LOIS LARSON
City Council candidate

PAUL HOLDER
City Council candidate

Businessman announces bid

Las Vegas businessman Paul Holder has announced his candidacy for Las Vegas City Council Ward 4.

Holder said his campaign will key on zoning ordinances, adding he would prevent residential areas from being "rezoned for the convenience of insensitive land developers intent on turning every vacant lot in Ward 4 into a dumping ground."

Holder said land developers are developing projects in one part of the city and then dumping debris in another part of the city.

He also said he favors fiscal restraint in the city budget process and is a "strong advocate of crime control," favoring strong communication ties between police and the community.

Holder said he would vigorously support flood control legislation if elected.

Officials identify house fire victim

A 77-year-old woman who died in a house fire early Wednesday has been identified as Emma Lockett.

Lockett was killed when a fire swept through her single-story home at 606 W. Adams Ave. shortly after midnight. Her four dogs were also killed in the blaze.

Man sentenced in assault

A 49-year-old Las Vegas man who is a convicted sex offender in California was sentenced Friday to four life prison terms and an additional 10 years for sexually assaulting a young boy in baby-set.

District Judge Myron Leavitt meted out the maximum sentence to Edwin Chartier, who was convicted by a jury of four counts of sexual assault and one count of lewdness with a minor.

Leavitt sentenced Chartier to four life prison terms for the sexual assault counts and 10 years for the lewdness charge. The judge ordered the sentences to run consecutively.

Chartier must serve 45 years before he can apply for release on parole.

Chartier was convicted of sexually abusing the 5-year-old boy on separate incidents from April 15, 1984, to July 15, 1984. The boy's mother left her son in Chartier's care while she was working.

The sexual assaults occurred in Chartier's van, according to court documents. Chartier lived at the Stardust R.V. Park.

In 1972, Chartier was convicted in California of a sexual crime against a young girl and spent some time in a mental hospital.

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA
* * * * *

In the Matter of Charges and Complaint Against HAI THANH NGUYEN, M.D., Respondent.	**Case No. 21-38084-1**

FILED
APR 22 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

HAI THANH NGUYEN, M.D.'S MOTION TO COMPEL

COMES NOW, Respondent HAI THANH NGUYEN, M.D., by and through his counsel of record, ROBERT C. McBRIDE, ESQ. and T. CHARLOTTE BUYS, ESQ., of the law firm of McBRIDE HALL and hereby submits his Motion to Compel Consumer Complaint and Investigation File.

This Motion is made and based and based upon the attached Memorandum of Points and Authorities, the papers and pleadings on file herein, any oral argument that may be adduced at the time of such hearing for this matter, and any other evidence the Hearing Officer determines to be just and proper.

DATED this 22nd day of April 2022.

McBRIDE HALL

By: */s/ T. Charlotte Buys*
ROBERT C. McBRIDE, ESQ.
Nevada Bar No.: 7082
T. CHARLOTTE BUYS, ESQ.
Nevada Bar No.: 14845
8329 W. Sunset Road, Suite 260
Las Vegas, Nevada 89113
Attorneys for Respondent
Hai Thanh Nguyen M.D.

MEMORANDUM OF POINTS AND AUTHORITIES

I

INTRODUCTION/FACTS

This matter arises out of the care provided by Hai Nguyen, M.D. to a pediatric patient ("Patient A") at an urgent care clinic approximately seven (7) years ago. Dr. Nguyen disclosed his Pre-Hearing Conference Disclosure on March 31, 2022, and produced a First Supplement to his Prehearing Conference Disclosure on April 11, 2022. The Investigative Committee of the Nevada State Board of Medical Examiners disclosed its Prehearing Conference Statement on April 8, 2022, and produced a First Supplemental Prehearing Conference Statement on April 12, 2022. On April 11, 2022, prior to the Prehearing Conference, counsel for Dr. Nguyen sent a written request to counsel for the Investigative Committee for the Nevada State Board of Medical Examiners requesting a copy of the Consumer Complaint and the investigative file that were created and considered as part of the investigative process. *See* April 11, 2022, Email Correspondence, attached hereto as **"Exhibit A."** However, counsel for the Investigative Committee denied Respondent's request. *See* **"Exhibit A."**

As set forth below, as this matter involves Dr. Nguyen's constitutionally protected due process right to practice his profession, he should be afforded the opportunity to see the underlying claims brought against him by Patient A and the investigative materials serving as the foundation of the charges asserted against him.

II.

ARGUMENT

A. DUE PROCESS REQUIRES THAT A PHYSICIAN BE ABLE TO REVIEW AND CONFRONT THE UNDERLYING COMPLAINT AND INVESTIGATION MATERIALS.

It is well established that a fundamental right may not be impaired without due process of law. *See Chudacoff v. Univ. Med. Ctr., of S. Nev.*, 609 F. Supp.ed 1163, 1172-73 (D.Nev. 2009); *Maiola v. State*, 120 Nev. 671, 674-75, 99 P.3d 227, 229 (2004). Moreover, the Nevada Supreme Court has recognized that a physician's interest in practicing medicine is a property right that

must be afforded due process. *See Minton v. Bd. of Med. Exam'rs*, 110 Nev. 1060, 1082, 881 P.2d 1339, 1354 (Nev. 1994) (overruled in part, *Nassiri v. Chiropractic Physicians' Bd. of Nev.*, 130 Nev. 245, 327 P.3d 487 (Nev. 2014)).

In order to prepare for the adjudicatory, penal administrative proceeding in this matter, Dr. Nguyen must be afforded the opportunity to review the underlying complaint showing the allegations actually made by Patient A, as well as the investigatory materials, including the report of the Board's reviewer, and the facts contained therein, underlying the formal Complaint at issue in this matter. The "facts" contained in such materials are neither privileged nor confidential. While Board counsel contends that the underlying complaint document filed by Patient A is not discoverable under NRS 630.336, such statute is meant as an exception to Nevada's open meeting law requiring all meetings of public bodies to be public meetings, not to exclude a professional who is the subject of a penal administrative hearing from fully understanding and assessing the allegations and facts alleged against him. *See McKay v. Bd. of Cty. Comm'rs*, 103 Nev. 490, 492, 746 P.2d 124, 125 (Nev. 1987).

Additionally, while counsel for the Board may further contend that the investigative file is not discoverable, pursuant to NRS 622A.330, the statute states as follows:

> "The investigative file for the case is not discoverable **unless** the prosecutor intends to present materials from the investigative file as evidence in support of the case..." *See* NRS 622A.330(2). (Emphasis added).

Here, counsel for the Board has stated that they intend to use certain portions of the investigative file. *See* "**Exhibit A.**" This is especially pertinent here where the Board intends to call the Complainant and Board reviewer to testify. Certainly, the Board reviewer examined the materials in the investigatory file (and the facts contained) therein, and Dr. Nguyen and his expert should similarly be afforded the same opportunity. Therefore, it is axiomatic that if the Board intends to use portions of the investigative file, then the entire file should be disclosed (especially the facts contained therein) to Dr. Nguyen pursuant to his written request before he is subject to an adjudicatory, penal hearing which can affect his livelihood, reputation, and insurability as a physician. This is particularly apparent in a penal administrative hearing, such as this, where the

Respondent is not permitted to conduct prehearing formal discovery of evidence, such as the taking of depositions. *See* NAC 630.470(4).

Accordingly, since an administrative proceeding before the Board can involve a deprivation of livelihood and insurability, due process must be met. Due process requires that when a physician-Respondent formally requests in writing that the underlying Complaint and investigative file (from which the Board intends to present portions) should be disclosed to the physician prior to the formal administrative proceeding.

III.

CONCLUSION

Dr. Nguyen respectfully requests that the underlying complaint filed by Patient A and investigative materials serving as the foundation of the Board's Complaint be compelled to be disclosed so that he may confront the charges asserted against him in accordance with his due process rights under the law.

DATED this 22nd day of April, 2022.

McBRIDE HALL

By: */s/ T. Charlotte Buys*
ROBERT C. McBRIDE, ESQ.
Nevada Bar No.: 7082
T. CHARLOTTE BUYS, ESQ.
Nevada Bar No.: 14845
8329 W. Sunset Road, Suite 260
Las Vegas, Nevada 89113
Attorneys for Respondent
Hai Thanh Nguyen M.D.

CERTIFICATE OF SERVICE

I hereby certify that on the 22nd day of April 2022, I served a true correct copy of **HAI THANH NGUYEN, M.D.'S MOTION TO COMPEL**, by sending electronically and mailing via United States mail to the following:

Sarah Bradley, J.D., MBA
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
Attorneys for the Investigative Committee

/s/ Natalie Jones
An Employee of McBride Hall

EXHIBIT “A”

EXHIBIT “A”

From:	Sarah A. Bradley
To:	Teyla Charlotte Buys
Cc:	Robert McBride; Candace P. Cullina; Natalie Jones; Meg Byrd; Mercedes Fuentes; Kristy Johnson
Subject:	RE: Hai Thanh Nguyen, MD; Case No. 21-38084-1
Date:	Monday, April 11, 2022 3:24:26 PM
Attachments:	image001.png

Dear Charlotte:

That information is confidential pursuant to NRS 630.336. We are not planning on admitting the consumer complaint as an exhibit at the hearing. Nor will we be admitting any documents in the investigative file other than the documents that you have already received. I provided you with copies of the articles that Dr. Hall reviewed when completing his Peer Review of this case. His report to the Investigative Committee is confidential and will not be admitted at the hearing.

Sincerely,

Sarah A. Bradley, J.D., MBA
Deputy Executive Director
Nevada State Board of Medical Examiners
Telephone: (775) 324-9365
bradleys@medboard.nv.gov

From: Teyla Charlotte Buys <tcbuys@mcbridehall.com>
Sent: Monday, April 11, 2022 3:19 PM
To: Sarah A. Bradley <bradleys@medboard.nv.gov>
Cc: Robert McBride <rcmcbride@mcbridehall.com>; Candace P. Cullina <ccullina@mcbridehall.com>; Natalie Jones <njones@mcbridehall.com>; Meg Byrd <mbyrd@medboard.nv.gov>; Mercedes Fuentes <fuentesm@medboard.nv.gov>; Kristy Johnson <kjohnson@mcbridehall.com>
Subject: Hai Thanh Nguyen, MD; Case No. 21-38084-1

Good Afternoon Sarah,

I did receive the Investigative Committee's Prehearing Conference Statement today, April 11, 2022, for this matter. In reviewing the documents disclosed by the Committee, it appears that the Consumer Complaint submitted by Mr. Robert and Ms. Sheilamarie Delgrosso was not included in the Committee's disclosure. Could you please provide a copy of the consumer complaint documentation submitted by Mr. and Ms. Delgrosso? Additionally, could you please provide a copy of any written reports, notes or witness statements by Dr. Scott Hall, Lauren Ward, or Ernesto Diaz, so that Dr. Nguyen has all materials that were created or considered as part of the investigative process? Thank you.

Very truly yours,

Charlotte

T. Charlotte Buys, Esq.
tcbuys@mcbridehall.com | mcbridehall.com
8329 West Sunset Road
Suite 260
Las Vegas, Nevada 89113
Telephone: (702) 792-5855
Facsimile: (702) 796-5855

MCBRIDE HALL
ATTORNEYS AT LAW

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **HAI THANH NGUYEN, M.D., Respondent.**	**Case No. 21-38084-1**

FILED
APR 26 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS' RESPONSE IN OPPOSITION TO RESPONDENT'S MOTION TO APPLY "CLEAR AND CONVINCING" AS THE BURDEN OF PROOF

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) submits the following Opposition to Respondent's Motion to Apply "Clear and Convincing" as the Burden of Proof.

MEMORANDUM OF POINTS AND AUTHORITIES

I. Introduction

In the State of Nevada, the burden of proof in an administrative hearing is clear and it is a preponderance of the evidence. This burden is clearly stated in both statutes, NRS 233B.121(9) and NRS 630.346, and case law, *Nassiri v. Chiropractic Physicians' Bd.*, 130 Nev. 245, 327 P.3d 487 (2014). Respondent's reliance on an outdated case, *Minton v. Bd. of Medical Exam'rs*, 110 Nev. 1060, 881 P.2d 1339 (1994), that relies on a previous version of NRS 630.352(1), that was changed in 1997, is inappropriate and disingenuous.[1] Respondent's arguments must be rejected and Respondent's motion must be denied outright as a matter of law. Accordingly, this matter must proceed with the IC proving the allegations in this case by a preponderance of the evidence.

///

[1] Respondent was not licensed by the Board until September 15, 2010. It is insulting to the Board for opposing counsel to argue that such an outdated version of the statute applies to Respondent's conduct in this case. In 2014, the Nevada Supreme Court clarified the appropriate burden of proof in an administrative hearing (preponderance of the evidence), and by a reviewing court substantial evidence is required in a petition for judicial review. The *Nassiri* Court clearly stated in 2014 that *Minton* was disapproved to the extent that it conflicted with *Nassiri*.

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

II. Legal Argument

"Agency adjudication should use the standard of proof set out in the agency's governing statutes." *Nassiri*, 130 Nev. at 250. Here, the Nevada statute, NRS 630.346 provides that a finding of the Board in a disciplinary hearing must be based on a preponderance of the evidence. It could not be more clear, and Respondent's motion is disingenuous. Further, NRS 233B.121(9) governs all contested cases in the State of Nevada, setting the minimum requirements to protect the due process rights of licensees, and states that findings of fact in contested cases must be "based exclusively on a preponderance of the evidence and on matters officially noted." There is no other option. The plain language of both of these statutes requires that the IC prove its case against Respondent by a preponderance of the evidence. *See Harris Associates v. Clark County Sch. Dist.*, 119 Nev. 638, 641–42, 81 P.3d 532, 534 (2003). Further, *Nassiri* is clear that, absent a higher burden of proof in an agency specific statute, the burden in disciplinary proceedings involving an occupational license is a preponderance of the evidence. *Nassiri*, 130 Nev. at 251. Here, there is no other higher burden of proof required in the NRS chapters governing the Board, NRS or NAC 630, and the allegations in the instant matter must be proved by a preponderance of the evidence. *See* NRS 630.352(1), as currently amended and codified (containing no reference to the burden of proof in an administrative matter before the Board).

Respondent's arguments regarding the burden of proof in administrative hearings in other states is not relevant, merely persuasive, and without merit because Nevada law is clear about the burden of proof in an administrative hearing via both statutes and case law as cited above. The issues that Respondent raises in his motions are not issues of first impression in Nevada. The Board must follow the burden of proof set out by Nevada law in NRS 630.346, NRS 233B.121(9), and *Nassiri*.

Respondent's motion is devoid of valid and current legal authority in Nevada. With two statutes and case law directly on point in Nevada that are entirely contrary to Respondent's arguments, it is impossible to view Respondent's antiquated motion as being filed for any substantive or legally valid purpose. Outdated arguments in motions serve only to increase fees and costs, vex opposing parties, and cause unnecessary obstacles to the resolution of the case.

Respondent's motion should be denied its entirety.

III. Conclusion

For the foregoing reasons, Respondent's motion must be denied as a matter of law. Further, the IC respectfully requests that the hearing officer request that Respondent's future arguments are supported by current Nevada law.

DATED this 26th day of April, 2022.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Sarah A. Bradley

SARAH A. BRADLEY, J.D., MBA
Deputy Executive Director
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: bradleys@medboard.nv.gov
Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 26th day of April, 2022, I served a file-stamped copy of **THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS' RESPONSE IN OPPOSITION TO RESPONDENT'S MOTION TO APPLY "CLEAR AND CONVINCING" AS THE BURDEN OF PROOF** via U.S. Mail, to the following parties:

T. CHARLOTTE BUYS, ESQ.
MCBRIDE HALL
8329 West Sunset Road, Suite 260
Las Vegas, NV 89113

Courtesy copy by electronic mail to:

T. CHARLOTTE BUYS, ESQ.
tcbuys@mcbridehall.com

DATED this 26th day of April, 2022.

MEG BYRD
Legal Assistant
Nevada State Board of Medical Examiners

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **HAI THANH NGUYEN, M.D.,** **Respondent.**	**Case No. 21-38084-1**

FILED
APR 26 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS' RESPONSE IN OPPOSITION TO RESPONDENT'S MOTION TO COMPEL

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) submits the following Opposition to Respondent's Motion to Compel.

MEMORANDUM OF POINTS AND AUTHORITIES

I. Introduction

In contested cases in the State of Nevada, the only discovery that respondents are entitled to receive is that the agency's attorney (prosecutor) intends to rely on in the hearing on the matter. *See* NRS 622A.330. The remainder of the investigative file is confidential. *Id.* In addition, NRS 630.336 specifically states that the investigative file, including the consumer complaint, is confidential. In the instant matter, the IC appropriately provided Respondent the exhibits that it intends to rely on as part of its pre-hearing conference statement and Respondent is not entitled to any additional discovery. *See* NAC 630.465. As a matter of law, Respondent's motion must be denied.

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OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

II. Legal Argument

The Nevada Supreme Court has already addressed the issue contemplated in Respondent's motion.[1] Specifically, in *Sarfo v. Board of Medical Examiners*, the Court held that NRS 630.336(4) "is unambiguous" and the Board's interpretation that it prohibited the Board from providing the name of the complainant and the consumer complaint in a disciplinary matter "falls 'within the plain language of the statute.'" 134 Nev. 709, 714, 429 P.3d 650 (2018) (quoting *Dutchess Bus. Servs., Inc. v. Nev. State Bd. of Pharmacy*, 124 Nev. 701, 709, 191 P.3d 1159, 1165 (2008)).

In *Sarfo*, the Respondent sought additional discovery from the Board outside the discovery authorized by statute and regulation. Specifically, the Respondent in that case wanted to know the identity of the complainant and to receive a copy of the consumer complaint. The Board did not provide this information pursuant to NRS 630.336, and the *Sarfo* Court held that the Board's interpretation of the confidentiality provided in NRS 630.336 was "a reasonable interpretation of the statute's plain language." 134 Nev. at 715. "[W]hen the language of a statute is plain and unambiguous, and its meaning clear and unmistakable, there is no room for construction, and the courts are not permitted to search for its meaning beyond the statute itself." 134 Nev. at 714 (quoting *Dykema v. Del Webb Cmtys., Inc.*, 132 Nev. 823, 826, 385 P.3d 977, 979 (2016)).

There is no case law construing NRS 622A.330, but the plain language is clear. However, Respondent misreads this statute in his motion. NRS 622A.330(1) authorizes the respondent in a contested case to submit a written discovery request for "a copy of all documents and other evidence intended to be presented by the prosecutor in support of the case and a list of proposed witnesses." NRS 622A.330(2) provides that "[t]he investigative file for the case is not discoverable *unless* the prosecutor intends to present materials from the investigative file as evidence in support of the case." (emphasis added). Respondent incorrectly relies on only subsection 2 of NRS 622A.330 in support of his motion. Instead, NRS 622A.330 should be read in its entirety to give plain meaning to all of its parts. *Gilman v. Nevada State Bd. of Veterinary*

[1] It appears that Respondent is unaware of the *Sarfo* case given that Respondent does not cite this case in his motion. The case is quite easy to find when looking for cases citing or interpreting NRS 630.336, and it is concerning that Respondent filed the instant motion without addressing this case given that it construes the statute at issue in Respondent's motion. Instead, Respondent argues that NRS 630.336 is meant only as an exception to Nevada's Open Meeting Law. This argument is belied by the Nevada Supreme Court's decision in *Sarfo*.

Medical Examiners, 120 Nev. 263, 271, 89 P.3d 1000, 1005–06 (2004), *disapproved of on other grounds by Nassiri v. Chiropractic Physicians' Bd.*, 130 Nev. 245, 327 P.3d 487 (2014). Reading NRS 622A.330 in its entirety, it is clear the discovery available in subsection 1 is the exception to the general confidentially of the investigative file provided in subsection 2.

Respondent's motion lacks sufficient support and strangely omits the leading case on-point that clearly addresses the issue raised in Respondent's motion. It is hard to conceive that this motion was filed for any substantive or legally valid purpose. Motions without substance serve only to increase fees and costs, vex opposing parties, and cause unnecessary obstacles to the resolution of the case.

Respondent's motion should be denied its entirety.

III. Conclusion

For the foregoing reasons, Respondent's motion must be denied as a matter of law. Further, the IC respectfully requests that the hearing officer request that Respondent's future arguments are not contrary to the plain language in current Nevada statutes and the holdings in binding Nevada Supreme Court precedent.

DATED this 26th day of April, 2022.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Sarah A. Bradley

SARAH A. BRADLEY, J.D., MBA
Deputy Executive Director
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: bradleys@medboard.nv.gov
Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 26th day of April, 2022, I served a file-stamped copy of THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS' RESPONSE IN OPPOSITION TO RESPONDENT'S MOTION TO COMPEL via U.S. Mail, to the following parties:

T. CHARLOTTE BUYS, ESQ.
MCBRIDE HALL
8329 West Sunset Road, Suite 260
Las Vegas, NV 89113

Courtesy copy by electronic mail to:

T. CHARLOTTE BUYS, ESQ.
tcbuys@mcbridehall.com

DATED this 26th day of April, 2022.

MEG BYRD
Legal Assistant
Nevada State Board of Medical Examiners

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA
* * * * *

In the Matter of Charges and Complaint Against HAI THANH NGUYEN, M.D., Respondent.	**Case No. 21-38084-1**

HAI THANH NGUYEN, M.D.'S REPLY IN SUPPORT OF MOTION TO COMPEL

COMES NOW, Respondent HAI THANH NGUYEN, M.D., by and through his counsel of record, ROBERT C. McBRIDE, ESQ. and T. CHARLOTTE BUYS, ESQ., of the law firm of McBRIDE HALL and hereby submits his Reply in Support of Motion to Compel Consumer Complaint and Investigation File.

This Reply is made and based and based upon the attached Memorandum of Points and Authorities, the papers and pleadings on file herein, any oral argument that may be adduced at the time of such hearing for this matter, and any other evidence the Hearing Officer determines to be just and proper.

DATED this 12th day of May 2022.

McBRIDE HALL

By: */s/ T. Charlotte Buys*
ROBERT C. McBRIDE, ESQ.
Nevada Bar No.: 7082
T. CHARLOTTE BUYS, ESQ.
Nevada Bar No.: 14845
8329 W. Sunset Road, Suite 260
Las Vegas, Nevada 89113
Attorneys for Respondent
Hai Thanh Nguyen M.D.

MEMORANDUM OF POINTS AND AUTHORITIES

I.

ARGUMENT

This is a formal, penal, adjudicatory administrative proceeding following the filing of a formal Complaint by the Nevada Board of Medical Examiners against Hai Nguyen, M.D., arising out of an allegation that a single pediatric patient developed skin dimpling following administration of a Kenalog injection for her respiratory condition. "The Nevada Constitution requires that '[n]o person shall be deprived of life, liberty, or property, without due process of law.'" *See Sarfo v. State*, 134 Nev. 709, 712, 429 P.3d 650 (2018) (citing Nev. Const. art. 1, § 8(5)).

In order to prepare hearing of this matter, Respondent, Dr. Hai Nguyen, requested that he be able to review the underlying complaint that was filed by the consumer in this matter and the investigative file in order to see whether there is exculpatory material contained within the same. This request was denied by counsel for the Investigative Committee. As such, Dr. Nguyen filed the underlying Motion to Compel so that he may be given the opportunity to review the complaint by the consumer, whom the Investigative Committee has named as a witness they intend to call during the hearing of this matter, as well as the investigative file from which counsel for the Investigative Committee intends to present evidence. *See* The Investigative Committee's Prehearing Disclosure, attached hereto as "**Exhibit A.**"

The Investigative Committee, in its Opposition, cites to *Sarfo v. State*, 134 Nev. 709, 712, 429 P.3d 650 (2018), which is inapplicable to the matter at hand, as the *Sarfo* matter only involved a question as to whether a physician could review a complaint submitted by a consumer to the Board during the investigatory phase **prior** to the filing of a formal complaint. *See Sarfo v. State*, 134 Nev. 709, 712, 429 P.3d 650 (2018) ("Here, Dr. Sarfo is alleging a due process violation stemming from an initial complaint, not a formal complaint."). As such, the Nevada Supreme Court found that due process protections did not attach at the investigatory phase as the agency was not performing an adjudicatory role. *Id.* at 713. Indeed, the Nevada Supreme Court upheld the District Court's finding that "...Dr. Sarfo could not prevail on the merits because due

process was not implicated in this matter, as the IC was merely performing investigatory fact-finding with no power to deprive Dr. Sarfo of his liberty interest." *See Sarfo v. State*, 134 Nev. 709, 712, 429 P.3d 650 (2018).

Here, however, a formal complaint has been filed against Dr. Nguyen and he is entitled to due process protection before a formal adjudicatory process affecting his liberty interest in his professional medical license. As such, *Sarfo* is inapplicable to the instant matter that has progressed past a mere investigatory stage to a formal proceeding.[1]

Moreover, NRS 622A.330, expressly provides that there is an exception to the prohibition of disclosure:

> "The investigative file for the case is not discoverable **unless** the prosecutor intends to present materials from the investigative file as evidence in support of the case..." *See* NRS 622A.330(2). (Emphasis added).

Here, counsel for the Board has stated that they intend to use certain portions of the investigative file. *See* "**Exhibit A.**" Moreover, since an administrative proceeding before the Board can involve a deprivation of livelihood and insurability, due process must be met. Due process requires that when a physician-Respondent formally requests in writing that the underlying Complaint and investigative file (from which the Board intends to present portions) should be disclosed to the physician prior to the formal administrative proceeding.

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[1] Respectfully, if undersigned counsel or some other attorney, were charged with an allegation of substandard legal care by the State Bar of Nevada in a penal hearing, it would be instinctive and first nature to want to see the complaint alleging such contention and materials used in the investigation prior to a formal hearing for their professional license. It is troubling that the Investigative Committee does not want the Respondent to see the underlying complaint and materials, as such may contain exculpatory information that can be used for impeachment.

III.

CONCLUSION

Based upon the foregoing, Respondent Dr. Nguyen respectfully requests that Respondent's Motion to Compel be granted.

DATED this 12th day of May 2022.

McBRIDE HALL

By: */s/ T. Charlotte Buys*
ROBERT C. McBRIDE, ESQ.
Nevada Bar No.: 7082
T. CHARLOTTE BUYS, ESQ.
Nevada Bar No.: 14845
8329 W. Sunset Road, Suite 260
Las Vegas, Nevada 89113
Attorneys for Respondent
Hai Thanh Nguyen M.D.

CERTIFICATE OF SERVICE

I hereby certify that on the 12th day of May 2022, I served a true correct copy of **HAI THANH NGUYEN, M.D.'S REPLY IN SUPPORT OF MOTION TO COMPEL**, by sending electronically and mailing via Email and United States mail to the following:

Sarah Bradley, J.D., MBA
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
Attorneys for the Investigative Committee

/s/ Madeline VanHeuvelen
An Employee of McBride Hall

EXHIBIT A

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **HAI THANH NGUYEN, M.D.,** **Respondent.**	**Case No. 21-38084-1**

FIRST SUPPLEMENTAL PREHEARING CONFERENCE STATEMENT OF THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) submits the following Supplemental Prehearing Conference Statement in accordance with NAC 630.465 and the Hearing Officer's Order Rescheduling Pre-Hearing Conference, filed on April 5, 2022 (**New items are in bold font**).

I. LIST OF WITNESSES

The IC of the Board lists the following witnesses whom it may call at the hearing on the charges in the Complaint against Respondent filed herein:

a. Ernesto Diaz, Chief of Investigations
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Mr. Diaz is expected to verify documentary evidence obtained during the investigation of this case and testify regarding the investigation of this matter.

b. Robert and Shielamarie DelGrosso
c/o Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

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Mr. and Mrs. DelGrosso are the consumer complainants in this case and they are expected to testify regarding the photos of Patient A that were submitted with the consumer complaint as well as other related facts regarding Dr. Nguyen's care of Patient A.

c. Scott Hall, M.D.
c/o Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Dr. Hall is licensed as a physician in the State of Nevada, and he is Board-certified in Family Medicine by the American Board of Family Medicine. Dr. Hall has conducted a review of this case. He is expected to testify regarding his review of this case and the standard of care required in Nevada.

d. Hai Thanh Nguyen, M.D.
c/o T. Charlotte Buys, Esq.
McBride Hall
8329 West Sunset Road, Suite 260
Las Vegas, NV 89113

Dr. Nguyen is expected to testify as to his conduct and to respond to the allegations in the Complaint.

e. All witnesses identified by Respondent in his prehearing conference statement and/or in any subsequent amended, revised or supplemental prehearing conference statement, or list of witnesses disclosed by Respondent of persons he may call to testify at the hearing herein.

The IC reserves the right to amend and supplement this list as required for prosecution of this case.

II. LIST OF EXHIBITS

The IC of the Board lists the following exhibits that it may introduce at the hearing on the charges and formal Complaint against the Respondent. Additionally, the IC of the Board reserves the right to rely on all exhibits listed in Respondent's prehearing conference statement and any supplement and/or amendment thereof.

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OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

EXHIBIT NO.	DESCRIPTION	BATES RANGE (NSBME)
1.	Allegation Letter to Dr. Nguyen, dated March 28, 2017	001
2.	Dr. Nguyen's Response to Allegation Letter, dated April 24, 2017	002-003
3.	Complaint, filed on November 3, 2021	004-008
4.	Answer to Complaint, filed on November 23, 2021	009-013
5.	Patient A's Medical Records	014-016
6.	Injection site photos of Patient A	017-018
7.	Article : *Croup*	019-027
8.	Article : *Acute Management of Croup in the Emergency Department*	028-031
9.	Article: *Croup: Diagnosis and Management*	032-037
10.	Article: *Kenalog -40 Injection (partial)*	038-043
11.	Article: *Kenalog -40 Injection (complete)*	044-048
12.	Article: *Documenting Vaccination*	049-051
13.	Article: *Evaluating Medical Decision-Making Capacity in Practice*	052-058
14.	Article: *Croup (Seminar)*	059-069
15.	Article: *Chapter 15. Intramuscular, Subcutaneous, and Intradermal Injections*	070-077
16.	Article: *Musculoskeletal Injections: A Review of the Evidence*	078-083

17.	Article: *Joint and Soft Tissue Injection*	084-089
18.	Scott Hall, M.D. – Curriculum Vitae	090-091
19.	**Scott Hall, M.D. – Updated Curriculum Vitae**	**092-093**

The IC reserves the right to amend and supplement this list as required for prosecution of this case.

DATED this 12th day of April, 2022.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Sarah A. Bradley

SARAH A. BRADLEY, J.D., MBA
Deputy Executive Director
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: bradleys@medboard.nv.gov
Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

EXHIBIT 19

EXHIBIT 19

SCOTT HALL, MD CAQSM

Associate Professor of Family Medicine
University of Nevada School of Medicine
Family Medicine Department

EDUCATION

Doctor of Medicine, Ohio State University, 2002
Bachelor of Science, Brigham Young University, 1998

MEDICAL TRAINING

Sports Medicine Fellowship, Grant Sports Medicine, 2006

Chief Resident, Grant Family Medicine, 2005

Family Medicine Residency, Grant Family Medicine, 2002-2005

MEDICAL EXPERIENCE

2007-current	Associate Professor of Family Medicine, *University of Nevada, Reno School of Medicine, Department of Family Medicine*
2018-current	State of Nevada Rating Physician, *Scott Hall, MD, PLLC*
2007-2019	Clinical Physician and Medical Director, *SpecialtyHealth*
2006-2007	Family Medicine Physician and Hospitalist, *Renown Health*
2005-2006	Hospitalist, *Physician Staffing*

PRESENTATIONS

"Pre-Participation Exams in the COVID Era," Lecture presented at 53rd Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2021.

"Joint Examinations" and "Joint Injections" Workshops presented at 52th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2020.

"MRSA and Athletes," presentation for the Renown Sports Medicine conference in April 2019 and Project ECHO University of Nevada, Reno in May 2019

"Joint Examinations," Workshop presented at 50th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2018.

"Joint Examinations" and "Joint Injections," Workshop presented at 48th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2016.

"Joint Examinations," Workshop presented at 47th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2015.

"Joint Examinations," Workshop presented at 46th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2014.

"Evaluation of the Impact of a Paleolithic Diet on Cardiovascular Risk Factors and Lipoproteins in a Law Enforcement Population," Presented at the Ancestral Health Symposium 2013 in Atlanta GA, *46th Annual Nevada Academy of Family Physicians Winter CME Meeting* in South Lake Tahoe, NV, and Washoe County Obesity Forum 2013 in Reno, NV.

"Spine Examination," Workshop presented at 45th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2013.

"Neck and Shoulder Exam," Workshop presented at 44th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2012.

"Joint Injections," Presented at 40th Annual Nevada Academy of Family Physicians Winter CME Meeting, Stateline Nevada, January 2008.

"Presyncope in a Division III Cross-Country Runner," Presented at *AMSSM National Meeting*, Miami Florida, April 2006.

"Community-acquired MRSA in Athletes – What You Need to Know," Presented at *11th Current Concepts in Sports Medicine Conference*, Columbus Ohio, August 2005.

"The Preparticipation Physical Exam," Presented at *Grant Medical Center Grand Rounds*, Columbus Ohio, March 2005.

"Management of the Abnormal Pap Smear," Presented at *Colposcopy for the Primary Care Physician*, Columbus Ohio, May 2004.

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA
* * * * *

In the Matter of Charges and	**Case No. 21-38084-1**
Complaint Against	
HAI THANH NGUYEN, M.D.,	
Respondent.	

FILED
MAY 13 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By: _____

HAI THANH NGUYEN, M.D.'S REPLY IN SUPPORT OF MOTION TO APPLY "CLEAR AND CONVINCING" AS THE BURDEN OF PROOF

COMES NOW, Respondent HAI THANH NGUYEN, M.D., by and through his counsel of record, ROBERT C. McBRIDE, ESQ. and T. CHARLOTTE BUYS, ESQ., of the law firm of McBRIDE HALL and hereby submits his Reply in Support of Motion to Apply the Appropriate "Clear and Convincing" Standard.

This Reply is made and based and based upon the attached Memorandum of Points and Authorities, the papers and pleadings on file herein, any oral argument that may be adduced at the time of a hearing set for this matter, and any other evidence that the Hearing Officer deems just and proper.

DATED this 12th day of May 2022.

McBRIDE HALL

By: */s/ T. Charlotte Buys*
ROBERT C. McBRIDE, ESQ.
Nevada Bar No.: 7082
T. CHARLOTTE BUYS, ESQ.
Nevada Bar No.: 14845
8329 W. Sunset Road, Suite 260
Las Vegas, Nevada 89113
Attorneys for Respondent
Hai Thanh Nguyen M.D.

MEMORANDUM OF POINTS AND AUTHORITIES

I.

ARGUMENT

This formal adjudicatory proceeding arises out of a contention that approximately seven (7) years ago, Dr. Hai Nguyen treated a pediatric patient in an urgent care setting for a respiratory condition. It is alleged that Dr. Nguyen did not properly document the consent that was given prior to administration of the steroid, Kenalog, and that subsequent to that care, the patient developed skin dimpling at or near the site of an injection. A formal complaint regarding this singular patient was then filed against Dr. Nguyen.

A respondent in a penal administrative proceeding that affects their professional license and insurability must be afforded due process as "...[t]he interest in practicing one's profession is a valuable property right which cannot be arbitrarily abridged or revoked." *See Potter v. State Bd. of Med. Exam'rs*, 101 Nev. 369, 371, 705 P.2d 132, 134 (Nev. 1985) (*citing Burleigh v. State Bar of Nevada*, 98 Nev. 140, 145, 643 P.2d 1201, 1204 (Nev. 1982)).

Here, the Investigative Committee's sole basis for opposing Respondent's Motion is premised upon conflating the "burden of proof" and the "standard of proof," which the Nevada Supreme Court has expressly made clear are separate, distinct concepts. *See Nassiri v. Chiropractic Physicians' Bd. of Nev.*, 130 Nev. 245, 327 P.3d 487 (Nev. 2014)). "The two concepts are actually distinct." *Id.* 489.

The "standard of proof" refers to evidence standard in determining what evidence may be admitted at the time of hearing to prove a specific allegation. However, the Hearing Officer, respectfully, is charged with the duty of determining whether the Board satisfied its "burden" of proving its case to a "clear and convincing" level. *See Minton v. Bd. of Med. Exam'rs*, 110 Nev. 1060, 1079, 881 P.2d 1339, 1352 (Nev. 1994); *see also In re Drakulich*, 111 Nev. 1556, 1566, 908 P.2d 709, 715 (Nev. 1995).

While the "standard of proof" may be preponderance of the evidence, the overall burden of proof (an entirely different concept) is "clear and convincing" evidence. In *Nassiri*, the Nevada Supreme Court explains the standard of proof, but carefully notes that it did not address the

higher "burden" of proof when a physician is facing sanction on his license because in *Nassiri*, the Appellant did not argue for the higher burden. *See Nassiri v. Chiropractic Physicians' Bd. of Nev.*, 130 Nev. 245, 251 n.4, 327 P.3d 487, 491 (Nev. 2014).

Here, Dr. Hai Nguyen respectfully requests that that any recommendations made to the members of the Nevada Board of Medical Examiners and the determination as to the charges made against Dr. Nguyen be framed using the "clear and convincing evidence" burden of proof. As this matter affects Dr. Nguyen's livelihood, insurability and reputation, the Board must be required to meet its burden of proof demonstrating "clear and convincing" evidence.

III.

CONCLUSION

Based upon the foregoing, Dr. Nguyen respectfully requests that his Motion to Apply "Clear and Convincing" as the Burden of Proof be granted.

DATED this 12th day of May 2022.

McBRIDE HALL

By: */s/ T. Charlotte Buys*
ROBERT C. McBRIDE, ESQ.
Nevada Bar No.: 7082
T. CHARLOTTE BUYS, ESQ.
Nevada Bar No.: 14845
8329 W. Sunset Road, Suite 260
Las Vegas, Nevada 89113
Attorneys for Respondent
Hai Thanh Nguyen M.D.

CERTIFICATE OF SERVICE

I hereby certify that on the 12th day of May 2022, I served a true correct copy of **HAI THANH NGUYEN, M.D.'S REPLY IN SUPPORT OF MOTION TO APPLY "CLEAR AND CONVINCING" AS THE BURDEN OF PROOF**, by sending electronically and mailing via Email and United States mail to the following:

Sarah Bradley, J.D., MBA
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
Attorneys for the Investigative Committee

/s/ Madeline VanHeuvelen
An Employee of McBride Hall

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against

HAI THANH NGUYEN, M.D.,

Respondent.

Case No. 21-38084-1

Hearing Date: May 26-27, 2022 @ 8:30 a.m.

ORDER DENYING HAI THAN NGUYEN, M.D.'S MOTION TO COMPEL

Respondent has moved to compel the production of the underlying complaint filed by Patient A as well as the investigative materials relied upon in filing the complaint against Respondent (referred to collectively as the "Investigative File"). In so moving, Respondent relies upon a general assertion of due process and the fact that the Investigative Committee for the Board of Medical Examiners of the State of Nevada (the "IC") has indicated it will use identified and already disclosed portions of the Investigative File.

In opposition, the IC cites NRS 622A.330 for the proposition that only the portions of the Investigative File that the IC intends to use in an evidentiary hearing are discoverable. The IC further cites Safro v. Board of Medical Examiners, 134 Nev. 709, 429 P.3d 650 (2018) in support of maintaining the Investigative File's confidentiality.

In reply, Respondent distinguishes Safro by pointing out that its holding is only applicable to the investigatory phase of a Medical Board proceeding and argues that its holding is inapplicable upon the filing of a complaint resulting from the investigation. Respondent further reiterates reliance upon due process and states that the ability to properly defend the complaint mandates the compelled discovery of the Investigative File. Respondent also again argues that because a portion of the Investigative File has been disclosed and is being relied upon, the entirety of the Investigative File is discoverable.

NRS 630.336(4) provides, in part, "a complaint filed with the Board pursuant to NRS 630.307, all documents and other information filed with the complaint[,] and all documents and other information compiled as a result of an investigation conducted to determine whether to initiate disciplinary action are confidential."[1] While Respondent is correct that Safro addressed the confidentiality of the Investigative File with respect to the investigative phase and prior to the filing of a formal complaint, Safro nonetheless made it clear that the confidentiality provisions apply to a responding licensee such as Dr. Nguyen. Therefore, the question that remains is whether a responding licensee remains subject to such confidentiality after a formal complaint is filed based upon considerations of due process.

"Although proceedings before administrative agencies may be subject to more relaxed procedural and evidentiary rules, due process guarantees of fundamental fairness still apply." Dutchess Bus. Servs., Inc. v. Nevada State Bd. of Pharmacy, 124 Nev. 701, 711, 191 P.3d 1159, 1166 (2008). To effectuate this, "[a]dministrative bodies must follow their established procedural guidelines and give notice to the defending party of 'the issues on which decision will turn and . . . the factual material on which the agency relies for decision so that he may rebut it." Id.

To facilitate notice of formal allegations brought against a respondent in a matter deemed sufficient to allow a responding party to defend, NRS 630.339 establishes that the formal complaint must: 1) include a written statement setting forth the charges alleged and setting forth in concise and plain language each act or omission of the respondent upon which the charges are based; 2) be prepared with sufficient clarity to ensure that the respondent is able to prepare a

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[1] A complaint as contemplated by NRS 630.307 is not the formal complaint against a respondent; rather, pursuant to NRS 630.307, a complaint is the grievance submitted to the Board of Medical Examiners (the "Board") that is reviewed and investigated as a preface to what may result in a formal complaint lodged pursuant to NRS 630.399. A complaint lodged pursuant to NRS 630.339 is specifically referenced in the statutory scheme as a "formal complaint." Thus, NRS 630.336(4) deems confidential the initiating complaint, documents submitted with the initiating complaint, and "other information compiled as a result of an investigation conducted to determine whether to initiate disciplinary action."

As to reconciling subsection 5 of NRS 630.336 with subsection 4 as quoted herein, this Hearing Officer has previously ordered that subsection 5 would render items from the Investigative File public only if relied upon by the Board to impose discipline after the conclusion of the hearing on the formal complaint, which would be unlikely to include any items from an Investigative File that were not relied upon by the IC for the evidentiary hearing.

defense; and 3) specify any applicable law or regulation that the respondent is alleged to have violated. In this respect, the Nevada Supreme Court has recognized that so long as these standards are met, the minimum standard of due process with regard to notice are met. Dutchess Bus. Servs., Inc., 124 Nev. at 711, 191 P.3d at 1166 (2008) (the filing and service of accusations against a licensee that sets forth in writing the charges alleged and the acts or omission with which the respondent is charged such that the respondent may prepare a defense comports with due process).

In the formal complaint against Respondent, the IC alleges specific charges, those being Malpractice and Failure to Maintain Proper Medical Records. The basis of each charge is stated with sufficient clarity in that the circumstances underlying each of the charges is articulated, and each charge identifies the applicable law or regulation alleged to have been violated. As such, pursuant to recognized standards of due process applicable to the instant proceeding, Respondent's due process rights have been met and Respondent may not rely upon the same to overcome the confidentiality provisions as applicable to the Investigative File.

As to NRS 622A.330, its relevant provision provides that the Investigative File "is not discoverable unless the prosecutor intends to present materials from the investigative file as evidence in support of the case." Respondent argues that because portions of the Investigative File have been disclosed and are to be relied upon by the IC, the entire Investigative File is discoverable. Respondent does not cite any authority for the proposition other than the statute itself. [2]

The IC cites to section 1 of the statute, which provides for Respondent to make a written discovery request for a copy of all documents and other evidence intended to be presented by the

[2] The Investigative File generally includes, but is not limited to, the initiating complaint, supporting documentation for the initial complaint, medical records, interviews, and expert/peer reports. Here, pursuant to the emails between the IC and Respondent that have been submitted with the briefing, what has been disclosed from the Investigative File are articles relied upon by an individual by the name of Dr. Scott Hall who presumably participated in the peer review portion of the investigation. *See* Motion, Exhibit A. Based upon the disclosure of the articles, Respondent sought disclosure of the initial complaint and supporting documentation as well as all written statements including, but not limited, to that of Dr. Hall. Id.

IC and argues that section 2, which Respondent relies upon, is an exception to "the general confidentiality of the investigative file provided in subsection 2."[3] Opposition, p. 3, lines 2-4.

"Under long established principles of statutory construction, when a statute is susceptible to but one natural or honest construction, that alone is the construction that can be given. . . . This means that if a statute clearly and unambiguously specifies the legislature's intended result, such result will prevail even if the statute is impractical or inequitable." Randono v. CUNA Mut. Ins. Grp., 106 Nev. 371, 374, 793 P.2d 1324, 1326 (1990) (citations omitted). However, where more than one interpretation can be reasonably drawn from its language, it is ambiguous, and the plain meaning rule has no application. Hotel Emps. & Rest. Emps. Int'l Union, AFL-CIO v. State ex rel. Nevada Gaming Control Bd., 103 Nev. 588, 591, 747 P.2d 878, 880 (1987)

When construing an ambiguous statutory provision, one is required to determine the meaning of the words used in a statute by examining the context and the spirit of the law or the causes that induced the Legislature to enact it. Leven v. Frey, 123 Nev. 399, 405, 168 P.3d 712, 716 (2007). To this end, the entire subject matter and policy underlying the enactment of the statute may be utilized as an interpretive aid, and a statute's multiple legislative provisions as a whole may be considered. Id. In rendering such an interpretation, no part of the statute should be rendered meaningless, and the statute's language "should not be read to produce absurd or unreasonable results." Id. (citations omitted).

The wording of the statute providing that the Investigative File "is not discoverable unless the prosecutor intends to present materials from the investigative file as evidence in support of the case," arguably implies that the production of any material opens the way for production of the remainder of what it may hold. However, it is just that, an implication. The statute is not abundantly clear. It does not plainly provide that the entire Investigative File is discoverable if the prosecutor intends to use *any* materials from the file. As such, one could just as easily argue, as has been done here, that if any portion of the Investigative File is to be used in prosecution, that

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[3] In Safro, the Nevada Supreme Court recognizes that an agency's interpretation of its governing statutes and regulations must be given deference in the interpretation is within the language of the statute. Safro, 134 Nev. at 714, 429 P.3d at 654 (2018) (*citing* Dutchess Bus. Servs., Inc., 124 Nev. at 709, 191 P.3d at 1165 (2008)).

portion is discoverable and such production does not render the remainder discoverable given it will not be relied upon for prosecution.

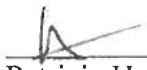
Based upon the ambiguity, one is left to rely upon the context and spirit of the law, which favors confidentiality in support of the public policy of promoting those aggrieved to come forward. *See, e.g.*, Mansour v. State Med. Bd. of Ohio, 32 N.E.3d 508, 514 (Ohio 2015) ("The purpose of that statute is to 'protect[ ] the confidentiality of patients and persons who file complaints with the board.'"). Such confidentiality also invokes a privilege extended to those who have participated in the investigatory process to enjoy such protections. In that regard, case law routinely recognizes that the privilege that attaches to the confidentiality of an Investigative File belongs to many and includes investigation witnesses, patients, physicians under investigation, and any other person whose confidentiality right is implicated by a board investigation and, therefore, not any one of those who hold the privilege may waive it given the impact to the other privilege holders. Id.; *see also* State ex rel. Wallace v. State Med. Bd. of Ohio, 732 N.E.2d 960, 965 (Ohio 2000) (recognizing that, in the context of investigative files, the Medical Board cannot unilaterally waive others' privileges to confidentiality, because the Medical Board is not the holder of those privileges).

"A document created for the purpose of an investigation, and not otherwise a public record, and placed in the Board's investigative file, is a confidential document." State ex rel. Oklahoma State Bd. of Med. Licensure & Supervision v. Rivero, 489 P.3d 36, 60 (Ok. 2021). Here, articles that were presumably relied upon in peer review were not created for investigation. They are documents at the ready in public discourse that have been placed in the Investigative Filed based upon reliance upon them by an individual who participated in the investigation. As such, they are not *per se* confidential, and their disclosure does not impact the privilege of any other party who may claim a privilege as to the Investigative File. *See, e.g.*, Mansour v. State Med. Bd. of Ohio, 32 N.E.3d 508, 515 (Ohio 2015) (recognizing that the confidentiality attached to a medical board's investigative file was not breached by a medical professional's waiver as to his own interrogatory responses). On the other hand, reliance upon such articles to mandate the disclosure of the remainder of the Investigative File does implicate such privileges and the IC is

not at liberty to alone make that waiver. Nor do the statutes delineating confidentiality by which the IC is bound allow the IC to disclose the portions of the Investigative File sought by Respondent.

Based upon the foregoing, disclosure of the articles does not waive the privilege of others entitled to confidentiality of the Investigative File and render the entirety of the file discoverable, nor does it relieve the IC of its statutory duty to honor the confidentiality of the Investigative File save and except for any portion it relies upon for prosecution, which in this case is the articles. Accordingly, Respondent's Motion to Compel is DENIED.

DATED this 18th day of May 2022.

By: 

Patricia Halstead, Esq.
Hearing Officer
(775) 322-2244

CERTIFICATE OF SERVICE

I certify that on this day, I personally delivered or mailed, postage pre-paid, at Reno, Nevada, a true file-stamped copy of the foregoing ORDER DENYING HAI THAN NGUYEN, M.D.'S MOTION TO COMPEL addressed as follows:

Sarah Bradley, J.D.
Deputy Executive Director
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Hai Thanh Nguyen, M.D.
c/o Robert McBride, Esq. and
T. Charlotte Buys, Esq.
8329 W. Sunset Rd., Ste 260
Las Vegas, NV 89113

DATED this 18th day of May 2022.

Signature

Mercedes Fuentes
Print

Legal Assistant
Title

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against

HAI THANH NGUYEN, M.D.,

Respondent.

Case No. 21-38084-1

Hearing Date: May 26-27, 2022 @ 8:30 a.m.

ORDER DENYING HAI THAN NGUYEN, M.D.'S MOTION TO APPLY "CLEAR AND CONVINCING" AS THE BURDEN OF PROOF

Respondent has moved to apply "clear and convincing" as the burden of proof that the Investigative Committee for the Board of Medical Examiners of the State of Nevada (the "IC") is charged with meeting in pursuing its administrative complaint against Respondent. In support Respondent cites Minton v. Board of Medical Examiners, 110 Nev. 1060, 881 P.2d 1331 (1994), and advocates that, where a licensure and livelihood are at issue, and following the lead of other administrative bodies and other jurisdictions, a "clear and convincing" burden of proof should be applied. The IC opposes Respondent's motion, arguing that applicable statutory framework and Nevada case law support the application of a "preponderance of the evidence" burden of proof, and that such authority post-dates the holding in Minton. Respondent replies by arguing that the IC conflates "burden of proof" with "standard of proof" and reiterates Respondent's position.

Minton, which was adjudicated in 1994, is an appellate case whereby the Supreme Court of Nevada addressed the review standard applicable to a final decision of an administrative agency. The opinion provides, "in a professional discipline case such as this one, where the burden on the prosecuting authority is to establish violations by clear and convincing evidence, this court will not engage in independent—or de novo—review." In making this statement, the Court explicitly relies upon NRS 630.352, which, at the time, provided:

> Any member of the board, except for an advisory member serving on a panel of the board hearing charges, may participate in the final order of the board. If the board, after a formal hearing, determines from *clear and convincing evidence* that a violation of the provisions of this chapter or of the regulations of the board has occurred, it shall issue and serve on the physician charged an order, in writing, containing its findings and any sanctions. [Emphasis added.]

The italicized clear and convincing language was modified to "a preponderance of the evidence" by legislative action in 1997 as the legislative history of the statue provides. As such, Respondent's reliance upon Minton is, as pointed out by the IC, outdated.

Applicable to the present matter is NRS 630.346(2), which is titled, in part, "burden of proof," and which provides that "[a] finding of the Board must be supported by a preponderance of the evidence." The "finding of the Board" reference is a finding as to the sufficiency of the complaint as determined from a synopsis and recommendation made to the Board by the hearing officer. *See* NAC 630.470. As such, NRS 630.346(2) states the burden of proof applicable to consideration of the complaint as opposed to the "standard of proof" applicable to "the quality of evidence allowed" as advocated by Respondent. Motion, p. 3, lines 23-24; Nassiri, 130 Nev. 245, 249, 327 P.3d 487, 489 (2014) (distinguishing between the terms "burden of proof" and "standard of proof").

This conclusion is further supported by NAC 630.410, which applies to physician's assistants and is in the same administrative code section applicable to physicians, and which specifically delineates the preponderance of the evidence burden of proof. NAC 630.410 ("[i]f the Board finds, *by a preponderance of the evidence*, after notice and a hearing in accordance with this chapter that" the charges of a complaint are true, identified sanctions may be imposed) (emphasis added). NAC 630.237(4)(c) and NRS 630.555 likewise reference a preponderance of the evidence burden of proof.

Even further, the preponderance of the evidence burden of proof is in accordance with the general civil standard and is applicable to professional administrative proceedings absent an otherwise statutorily established burden of proof. Nassiri, 130 Nev. at 251, 327 P.2d at 491 (holding that a preponderance of the evidence standard of proof applies in an agency's occupational license revocation proceeding in the absence of a specific governing statute). As

such, even assuming the applicable statutory scheme did not delineate a preponderance of the evidence burden of proof (which is not the case) or, as Respondent has argued, is directed instead to a standard of proof as that term may be distinguished, Nassiri would mandate its application.

Based upon the foregoing, Respondent's Motion to Apply "Clear and Convincing" as the Burden of Proof is DENIED.

DATED this 19th day of May 2022.

By: _____

Patricia Halstead, Esq.
Hearing Officer
(775) 322-2244

CERTIFICATE OF SERVICE

I certify that on this day, I personally delivered or mailed, postage pre-paid, at Reno, Nevada, a true file-stamped copy of the foregoing ORDER DENYING HAI THAN NGUYEN, M.D.'S MOTION TO APPLY "CLEAR AND CONVINCING" AS THE BURDEN OF PROOF addressed as follows:

Sarah Bradley, J.D.
Deputy Executive Director
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Hai Thanh Nguyen, M.D.
c/o Robert McBride, Esq. and
T. Charlotte Buys, Esq.
8329 W. Sunset Rd., Ste 260
Las Vegas, NV 89113

DATED this 18th day of May 2022.

Signature

Mercedes Fuentes
Print

Legal Assistant
Title

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA
* * * * *

In the Matter of Charges and Complaint Against HAI THANH NGUYEN, M.D., Respondent.	**Case No. 21-38084-1**

FILED
MAY 24 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

HAI THANH NGUYEN, M.D.'S SECOND SUPPLEMENTAL PREHEARING CONFERENCE DISCLOSURE

COMES NOW, Respondent HAI THANH NGUYEN, M.D., by and through his counsel of record, ROBERT C. McBRIDE, ESQ. and T. CHARLOTTE BUYS, ESQ., of the law firm of McBRIDE HALL and in accordance with Nevada Administrative Code § 630.465 and the Hearing Officer's Scheduling Order filed on February 7, 2022 and Order Rescheduling Pretrial Hearing filed on April 5, 2022, hereby provides the following Second Supplement to Hai Thanh Nguyen, M.D.'s Prehearing Conference Disclosure **(supplemental information in bold)**:

I.

WITNESSES

1. Hai Thanh Nguyen, M.D.
c/o Robert C. McBride, Esq.
T. Charlotte Buys, Esq.
McBRIDE HALL
8329 W. Sunset Boulevard, Suite 260
Las Vegas, Nevada 89113
(702) 791-5855

Respondent will testify regarding the care and treatment provided to Patient A, his custom and practice, and his medical records documenting Patient A's care and treatment. He will also provide testimony regarding the Board's Complaint and the allegations therein. Respondent will also testify that he complied with the standard of care.

2. Eduardo Anorga, M.D.
[redacted]

Dr. Anorga is a physician board-certified in family medicine and is expected to testify regarding his review of this case and the standard of care applicable to Dr. Nguyen's care and treatment of Patient A, and documentation of the same. Dr. Anorga will also provide expert testimony regarding the Board's Complaint and the allegations contained therein.

3. Ellen Aliberti
[redacted]

Ms. Aliberti is a Clinical Educator. Ms. Aliberti is expected to testify regarding the clinical education and policies and procedures provided to Medical Assistants at Healthcare Partners of Nevada. **Ms. Aliberti may also testify as to her knowledge regarding the Medication Administration Details Record for Ms.** [redacted] **and her knowledge regarding the record keeping practices of Intermountain Healthcare (previously Healthcare Partners of Nevada).** She is also anticipated to testify to any relevant knowledge she may have regarding the facts and circumstances surrounding this matter.

4. Glenisha Barner, MA
(Current Address Unknown)

Ms. Barner is anticipated to testify regarding her care and treatment of Patient A, and as to any relevant knowledge she may have regarding the facts and circumstances surrounding this matter.

5. Barry Misiuk, MA
(Current Address Unknown)

Mr. Misiuk is anticipated to testify regarding his care and treatment of Patient A, and as to any relevant knowledge he may have regarding the facts and circumstances surrounding this matter.

6. Sheilamarie DelGrosso
c/o Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Ms. Delgrosso and Mr. Delgrosso are the parents of Patient A and are expected to testify as to the consent for medical care and medical treatment provided to Patient A and any relevant knowledge she may have regarding the facts and circumstances surrounding this matter.

7. **Melissa Vogt, RN**
INTERMOUNTAIN HEALTHCARE
6355 S. Buffalo Drive
Las Vegas, Nevada, 89113

Ms. Vogt is a Learning Coordinator-RN. Ms. Vogt located and made a true and correct copy of the Medication Administration Details record for Ms. [redacted] and is expected to testify regarding the authenticity of the record and her knowledge regarding the record keeping practices of Intermountain Healthcare (previously Healthcare Partners of Nevada). She is also anticipated to testify to any relevant knowledge she may have regarding the facts and circumstances surrounding this matter.

Respondent reserves the right to call as expert witnesses any and all of the Board's designated expert witness(es) or any other witness designated by any other party. Respondent further reserves the right to amend and supplement this list as discovery continues and as necessary for rebuttal and/or impeachment.

II.

DOCUMENTS

1. Board of Medical Examiners of the State of Nevada Complaint filed November 3, 2021.
2. Respondent Hai Thanh Nguyen, M.D.'s Answer to Complaint
3. Respondent Hai Thanh Nguyen, M.D.'s Board Response Letter dated April 24, 20017
4. Medical Records from Healthcare Partners (HCP 0001-17)
5. Medical Administration Log (MED ADMIN LOG 0001-7)

6. Standard Operating Procedure for Injectable Medication Administration (SOP INJECTABLE MEDS 0001-4)

7. Curriculum Vitae of Eduardo Anorga, M.D.

First Supplement

8. IBM Micromedex Information for Pediatric Administration of Kenalog (MICROMEDEX000001-25).

9. American Society for Microbiology, Comparison of Corticosteroids for Treatment of Respiratory Syncytial Virus Bronchiolitis and Pneumonia in Cotton Rats (ASM 000001-000004).

10. Bristol-Myers Squibb Company Information for Intramuscular or Intra-articular Kenalog Injection, Revised June 2011, (BMS_(2011)_000001-20).

Second Supplement

11. Medication Administration Details (MED ADMIN DETAILS 00001-2).

12. Declaration of Melissa Vogt, RN. Regarding Medication Administration Details.

Respondent reserves the right to use any and all of the documents, exhibits, reference materials and records disclosed by the Board or any other party. Respondent further reserves the right to amend and supplement this list as discovery continues and as necessary for rebuttal and/or impeachment.

DATED this 23rd day of May, 2022.

McBRIDE HALL

/s/ T. Charlotte Buys

ROBERT C. McBRIDE, ESQ.
Nevada Bar No.: 7082
T. CHARLOTTE BUYS, ESQ.
Nevada Bar No.: 14845
8329 W. Sunset Road, Suite 260
Las Vegas, Nevada 89113
Attorneys for Respondent
Hai Thanh Nguyen M.D.

CERTIFICATE OF SERVICE

I hereby certify that on the 23rd day of May 2022, I served a true correct copy of **HAI THANH NGUYEN, M.D.'S SECOND SUPPLEMENTAL PREHEARING CONFERENCE DISCLOSURE** by sending electronically and mailing via United States mail to the following:

Sarah Bradley, J.D., MBA
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
Attorneys for the Investigative Committee

/s/ Madeline VanHeuvelen
An Employee of McBride Hall

DECLARATION OF MELISSA VOGT

STATE OF NEVADA)
)
COUNTY OF CLARK)

I, MELISSA VOGT, declare under penalty of perjury pursuant to NRCP 34(c) and NRS 53.045 as follows:

1. I am over the age of eighteen. I am competent to testify on the matters set forth herein. I make this declaration based upon my personal knowledge.

2. I am a Registered Nurse and currently am a Learning Coordinator employed by Intermountain Healthcare.

3. On May 23, 2022, I located Medication Administration Details for patient, [redacted], and I made a true and exact copy of that record, which has been batestamped MED ADMIN DETAILS 00001 – MED ADMIN DETAILS 00002.

4. It is my understanding that the original of the records was made at or near the time of the act and/or event recited therein.

5. The Medication Administration Details are kept as part of the patient's designated record set, however, they are maintained separately from the patient's other medical records. It is my understanding that this Medication Administration Details record was inadvertently not printed and included in a copy of the patient's medical records that were previously disclosed in the Nevada Board of Medical Examiners Formal Complaint against Hai Thanh Nguyen, M.D. (Case No. 21-38084-1), as such record are maintained separately from the other portions of the patient's medical record.

6. I declare under penalty of perjury under the laws of the State of Nevada that the foregoing is true and correct.

DATED this 23 day of May, 2022.

Melissa Vogt RN.
MELISSA VOGT

Medication Administration Details

[redacted]

Kenalog 40 MG/ML Injection Suspension (Triamcinolone Acetonide)

For [1] Cough

Record w/o Ordering

Order Entry | Record Administration

Administration Details | Charging

Inject 0.5ml intramuscular once. To Be Done: 04Nov2016 Status: Complete

Dose: 1 Unit: ML

Route: Intramuscular Date/Time: 04-Nov-2016 06:56 PM Now

Site: Right Gluteal Region Admin By: Hampton, Chanel

MFG: B-M SQUIBB U.S. (PRIM... NDC: 00003029328

Lot: AAJ6426 Exp: 01-Mar-2018

Charging

Medical Necessity Checking: CPT-4:J3301 Code: Status:

Medical Necessity Details:

Verify charges being submitted for: None Specified Encounter

Type	Code	Display Name	Modifiers	Units	When To Cha...	Time Based
☑	J3301	INJ, TRIAMCINOLONE ACETONIDE, PER 10 MG (KENALOG-10,40, TRI-KORT)			Upon Completion	N/A

Override Encounter Details:

Special Billing: Injury Date: 23-May-2022

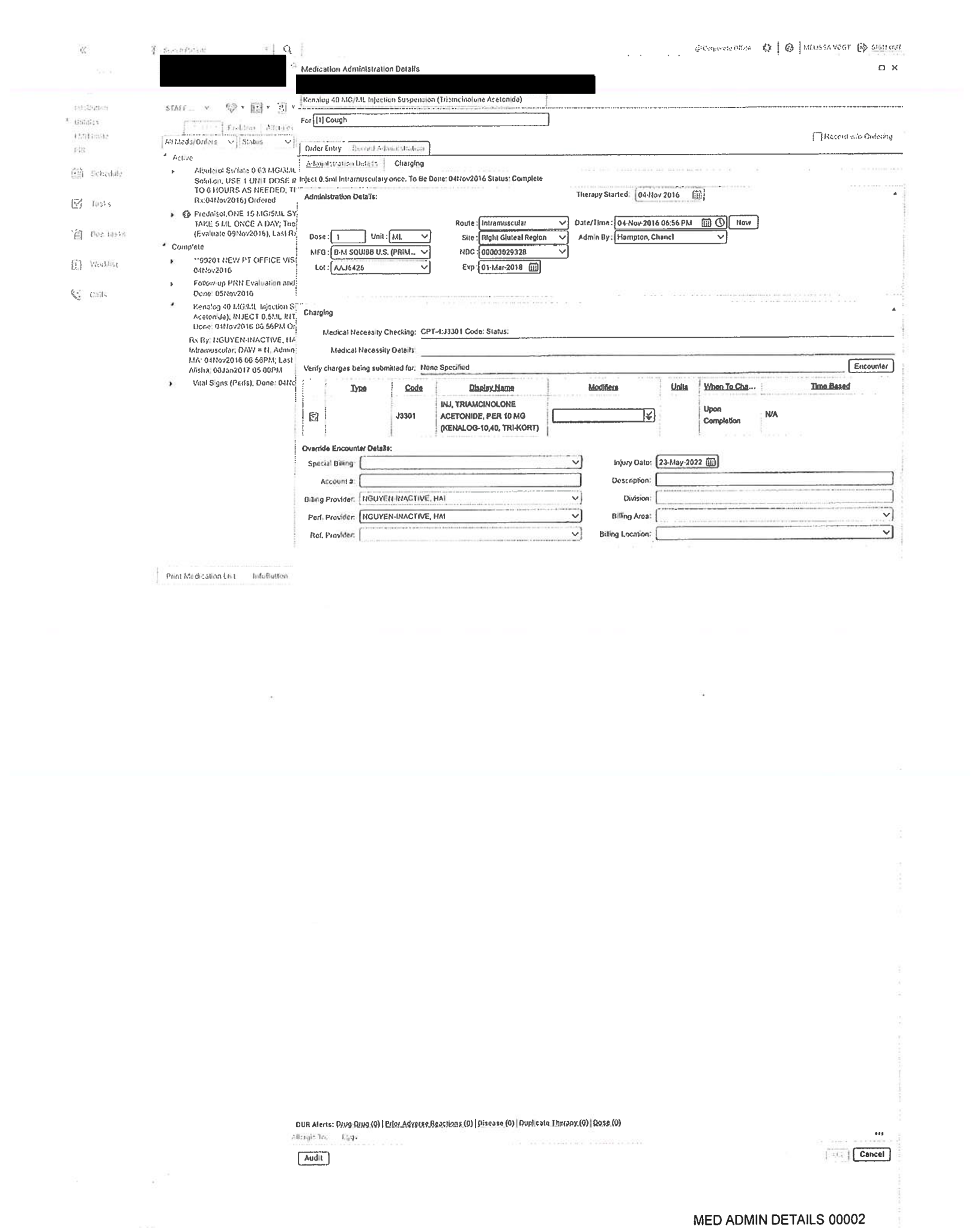
Account #: Description:

Billing Provider: NGUYEN-INACTIVE, HAI Division:

Perf. Provider: NGUYEN-INACTIVE, HAI Billing Area:

DUR Alerts: Drug-Drug (0) | Prior Adverse Reactions (0) | Disease (0) | Duplicate Therapy (0) | Dose (0)

Allergic To: Eggs



MED ADMIN DETAILS 00002

4

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **HAI THANH NGUYEN, M.D., Respondent.**	**Case No. 21-38084-1**

FILED

AUG 05 2022

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS' MOTION FOR RECONSIDERATION

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) hereby requests reconsideration of the findings and recommendations of the Hearing Officer pursuant to NRS 622A.390(1)(b).

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

On November 3, 2021, the IC filed a Complaint charging Respondent with: Count I, a violation of NRS 630.301(4), Malpractice; and Count II, a violation of NRS 630.3062(1)(a), Failure to Maintain Timely, Legible, Accurate, and Complete Medical Records (records count).

The hearing on the Complaint was held on May 26, 2022, and the Hearing Officer has now issued a Synopsis of Record (Synopsis) pursuant to NAC 630.470(8), filed July 22, 2022. In pertinent part, the Hearing Officer submits that the burden had not been met as to either count alleged in the Complaint. Synopsis at 12:1–2. Respectfully, the IC asserts error in the finding and recommendation with respect to the records count, and further asserts that this error constitutes grounds for the Hearing Officer to reverse her findings with respect to the records count. *See* NRS 622A.390(5)(b). Accordingly, the IC requests the Hearing Officer reconsider her assessment and recommendation with respect to Count II and to issue an amended Synopsis in conformance therewith.

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

II. LEGAL ARGUMENT

NRS 233B.121(2)(c) and (d) require that the IC's notice prior to a hearing provide Respondent with a reference to the statutes and regulations involved and provide "[a] short and plain statement of the matters asserted." In the instant matter, Respondent was on notice that the IC alleged both a violation of NRS 630.301(4) (Malpractice) and the records count, NRS 630.3062(1)(a) (Failure to Maintain Timely, Legible, Accurate, and Complete Medical Records). Further, NRS 233B.121(9) and NRS 233B.125 require that the Board's findings of facts and decision be based on a preponderance of the evidence. The IC respectfully asserts that Respondent was on notice that the IC asserted that he had violated NRS 630.3062(1)(a) and that this violation was proven at the hearing by a preponderance of evidence. Put simply, the extended testimony and confusion at the hearing regarding Respondent's treatment of Patient A, as recorded in the medical records, proves that Respondent failed to maintain timely, legible, accurate, and complete records for Patient A.

The Hearing Officer points out that some of the medical records at issue were not timely provided to the IC and instead were provided to the IC shortly before the hearing. With respect to the records count, the Hearing Officer concludes that Respondent's note that Patient A's mother agreed with the treatment plan and verbally stated her understanding was sufficient to document informed consent; while the IC maintains that Respondent's reference to agreeing to the treatment plan does not adequately evidence *informed* consent, the IC does not request reconsideration of this conclusion. However, the Hearing Officer further concludes that the "remainder of the allegations" as to the records count had "been conceded as disproven by the medical records recently produced." *See* Synopsis at 11:18–20. This conclusion is incorrect, as the IC did not and does not concede that the late-produced medical records were adequate to meet the requirement that Respondent maintain accurate and complete medical records, NRS 630.3062(1)(a), and respectfully requests the Hearing Officer to reconsider her findings and recommendation in this regard.[1]

///

[1] When asked about the records count at the hearing, counsel for the IC stated "We believe that the records are still deficient. They just aren't deficient in all the ways we originally identified." Tr. 22:24–23:2.

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Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

Like all physicians licensed in Nevada, Respondent is required to "maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient." *See* NRS 630.3062(1)(a). The hearing demonstrated that Respondent failed to clearly document the who, when, where, and why of the Kenalog shot given to the patient in this matter—specifically, who administered the shot, when the shot was administered, where on the patient's body it was administered, and why it was given in addition to an oral steroid. Records failing to document such key information and causing the confusion apparent in this matter do not meet the standard of being accurate and complete.

In discussing a similar requirement to maintain accurate patient records in the context of physician discipline, a New York court has noted that "[t]he purpose behind the requirement that a proper record be kept for each patient is in part to ensure that meaningful information is recorded in case the patient should transfer to another professional or the treating practitioner should become unavailable." *See Mucciolo v. Fernandez*, 599 N.Y.S.2d 757, 759 (App. Div. 1993) (internal quotations and citations omitted). Thus, "[a] medical record that fails to convey objectively meaningful medical information concerning the patient treated to other physicians is inadequate." *Id.* The importance of accurate medical documentation has also been recognized in other contexts. Like physicians, correctional facilities "must maintain adequate, complete, and accurate medical records." *See Ginest v. Bd. of Cnty. Comm'rs.*, 333 F. Supp. 2d 1190, 1200 (D. Wyo. 2004). In that context, it has been recognized that "[m]aintaining proper medical records is no less important to inmate health than providing proper physician care. The two go hand in hand." *Id.*; *see also Goforth v. Sec'y of Health & Hum. Servs.*, No. 14-1128V, 2021 WL 6337672, at *22 (Fed. Cl. Nov. 19, 2021) ("With proper treatment hanging in the balance, accuracy [of medical records] has an extra premium." (internal quotation omitted)).

At the hearing, Respondent acknowledged that the record of his interaction with the patient in this matter reflected that he ordered a medical assistant who was not even present that day to administer the shot:

> Q . . . if we got to Exhibit 12, and that's your exhibit 001, med admin details. Are you there?
>
> A Yes, ma'am. I am. I'm looking at med details 00001.

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Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

Q Do you see the name Hampton, Chanel on that page?

A Yes, ma'am, I do.

Q Do you know who that is?

A That is my medical assistant that I normally work with.

Q Okay. *Did you work with Ms. Hampton on November 4th, 2016?*

A *No, I did not work with her that day.*

Q So if this says "admin by," what does that mean typically?

A When the physician generates a computer order in the EMR for an injection, we'll often send that order to his normal—his medical assistant that he normally works with, which is Ms. Chanel Hampton.

Q So I guess I'm misunderstanding here. So you're saying that if you order medication, the order goes to someone that you normally work with but that you may not be working with on that day? Is that what you're saying?

A Yes, ma'am. During that day, Mrs. Hampton she had to call out sick because her daughter was ill and she was not there. So Mr. Barry Misiuk was called up as a float medical assistant that HealthCare Partners had hired to substitute if there's a member of a staff medical assistant that's absent that day.

Q Okay. Well, because it says, "Admin by." What does "admin by" mean? Does that mean administered? Is that short for administered?

A *It says that I had ordered Chanel Hampton to give the injection, and it says the date that it was given.*

Q *Okay. So your testimony is then that the name on there doesn't mean who administered the vaccine?*

A *That is correct, ma'am.*

Tr. 221:9–222:22 (emphasis added). Respondent went on to explain that the person who actually administered the injection—himself—was reflected in the progress note. Tr. 222:6–24. However, the records did not explain this discrepancy and the nature of what actually occurred was only clarified by Respondent's testimony—underscoring that the records themselves were not accurate or complete. Indeed, Respondent further testified that the medical "biller thought Ms. Hampton was there that day to give the injection." Tr. 225:12–13. The Synopsis notes that the reference to Ms. Hampton "seemed to cause some confusion and [Respondent's expert] Dr. Angora somewhat

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
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acknowledged the same," however, "Dr. Angora further noted that Respondent addressed the confusion in his testimony and provided documentation demonstrating that he gave the Kenalog injection." Synopsis at 8:20–23. Of course, the requirement for accurate and complete medical records applies to the records themselves, not the records as explained and clarified years later.

Neither did the records clearly reflect when the shot was administered:

> Q . . . do you recall approximately when you saw Patient A on November 4, 2016?
>
> A I believe it was right around 11:00 a.m. because usually, the triage nurse sees the patient first, gets their initial complaint, some of the symptoms and does vital signs, so I believe that the note started at 10:45 a.m., so I would have seen her shortly thereafter.
>
> Q Okay. And so is it fair to say that probably she and her parents would have gone home by noon that day?
>
> A Likely, ma'am.

Tr. 232:16–233:4. This testimony is in contrast to Respondent's Exhibit 12, which indicates that the shot was administered at 6:56 p.m. If Patient A's symptoms had gotten worse and her care was assumed by another professional late that evening or the next day, the several-hour time difference could have made a difference in treatment, rendering the record inadequate for purposes of accurate recordkeeping. *See Mucciolo*, 599 N.Y.S.2d at 759.

The records were also unclear as to where on Patient A's body the shot was administered. While a divot appeared on the patient's left buttock, Respondent indicated that he administered the shot in her right buttock. While there was indeed testimony that the divot might have been caused by other factors, Respondent's expert, Dr. Angora conceded that the documentation may not have been accurate:

> Q Okay. So you're saying there maybe are some instances where they're not accurate. Is that fair?
>
> A Again, I think there is a dispute as to whether this was a right/left issue. And it that occurred, then it's possible that it occurred. I'm not convinced that occurred, but is that logically possible? Yes. Does that fall below the standard of care? No. Does it all – *Does it not meet some standard of documentation? Perhaps.*

Tr. 272:14–22.[2]

Perhaps most importantly, Respondent failed to document why he rendered the treatment that he did to Patient A. During the hearing, Respondent testified that after the patient's mother told him that she was concerned about the oral steroid causing vomiting and that the patient had received a steroid injection in the past, he adjusted his treatment plan to include both oral steroids *and* a steroid shot. *See* Tr. 215–16. Respondent specifically admitted that he did not document his conversation with the patient's mother about her concerns with the oral steroid prescription, *see* Tr. 215:7, nor did he document the change in his treatment plan, *id.* at 215:24–216:16. Thus, if the patient had been transferred to the care of another professional and Respondent was unavailable, that professional would not know of the mother's concerns or why Respondent had decided to administer what otherwise appeared to be redundant treatments.

When reviewed on their own, as they must be, and not in the context of later clarification and explanation, the records here were inaccurate, contradictory, and confusing, and Respondent therefore failed to "maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient." *See* NRS 630.3062(1)(a). The late production of a shot record that contained more details than previously provided did not render the records in this matter accurate and complete.

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[2] Dr. Angora is not and never has been licensed in the State of Nevada. Tr. 261:16–19. When asked, Dr. Angora was unable to provide the requirements for documentation of medical records in Nevada. Tr. 271:7–9.

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

III. CONCLUSION

For the foregoing reasons, the IC respectfully requests the Hearing Officer reconsider her recommendations in this matter with respect to Count II as contained in the IC's complaint and issue an amended Synopsis in conformance therewith.

DATED this 5th day of August, 2022.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Sarah A. Bradley

SARAH A. BRADLEY, J.D., MBA
Deputy Executive Director
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: bradleys@medboard.nv.gov
Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the ___ day of August, 2022, I served a file-stamped copy of **THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS' MOTION FOR RECONSIDERATION** via U.S. Mail, with courtesy copy by email, to the following parties:

HAI THANH NGUYEN, M.D.
c/o T. Charlotte Buys, Esq.
McBride Hall
8329 West Sunset Road, Suite 260
Las Vegas, NV 89113
Email: tcbuys@mcbridehall.com
Attorney for Respondent

PATRICIA HALSTEAD, ESQ.
Halstead Law Offices
615 S. Arlington Ave.
Reno, NV 89509
Email: phalstead@halsteadlawoffices.com
Hearing Officer

DATED this 5th day of August, 2022.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA
* * * * *

In the Matter of Charges and	**Case No. 21-38084-1**
Complaint Against	
HAI THANH NGUYEN, M.D.,	
Respondent.	

FILED
AUG 16 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

HAI THANH NGUYEN, M.D.'S OPPOSITION TO THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS' MOTION FOR RECONSIDERATION

COMES NOW, Respondent HAI THANH NGUYEN, M.D., by and through his counsel of record, ROBERT C. McBRIDE, ESQ. and T. CHARLOTTE BUYS, ESQ., of the law firm of McBRIDE HALL and hereby submits his Opposition to Motion for Reconsideration.

This Opposition is made and based and based upon the attached Memorandum of Points and Authorities, the papers and pleadings on file herein, any oral argument that may be adduced at the time of a hearing set for this matter, and any other evidence that the Hearing Officer deems just and proper.

DATED this 16th day of August 2022.

McBRIDE HALL

By: */s/ T. Charlotte Buys*
ROBERT C. McBRIDE, ESQ.
Nevada Bar No.: 7082
T. CHARLOTTE BUYS, ESQ.
Nevada Bar No.: 14845
8329 W. Sunset Road, Suite 260
Las Vegas, Nevada 89113
Attorneys for Respondent
Hai Thanh Nguyen M.D.

MEMORANDUM OF POINTS AND AUTHORITIES

I.

PREFATORY NOTE

It should first be noted that in seeking reconsideration of the Hearing Master's Synopsis of the Record, the Investigative Committee has failed, completely, to offer **any new facts or authority** to serve as a basis for reconsideration. Merely because the Investigative Committee pursues a Complaint, does not automatically mean that the Committee has met its burden on proving that a physician violated the Nevada Medical Malpractice Act. That, respectfully, is the reason why a formal hearing process takes place. Here, there is no basis to support reconsideration of the honorable Hearing Officer's Synopsis of the Record or recommendations set forth therein, that the Investigative Committee has not met its burden in bringing either of the two counts alleged against Hai Nguyen, M.D.

II.

ARGUMENT

A. FACTS

This formal adjudicatory proceeding arises out of a contention that approximately seven (7) years ago, Dr. Hai Nguyen treated a pediatric patient in an urgent care setting for a respiratory condition. It is alleged that Dr. Nguyen did not properly document the consent that was given prior to administration of the steroid, Kenalog, and that subsequent to that care, the patient developed skin dimpling at or near the site of an injection.

A thorough formal hearing regarding these allegations took place on May 26, 2022. Subsequently, on July 22, 2022, the honorable Hearing Officer submitted a Synopsis of the Record with a recommendation for the Nevada Board of Medical Examiners' consideration that based upon presentation of the evidence, the Investigative Committee had not met its burden in this matter as to either count alleged in the Complaint against Respondent, Dr. Hai Nguyen.

The Investigative Committee now brings a Motion for Reconsideration on the Hearing Officer's recommendation concerning Count II for Failure to Maintain Proper Medical Records by contending Dr. Nguyen "failed to clearly document the who, when, where and why of the

Kenalog shot given to the patient in this matter." *See* page 3, lines 3-4 of the Investigative Committee's Motion for Reconsideration.

However, such argument has already been thoroughly addressed not only by the medical records that were discovered and produced in this matter, but also clearly and unambiguously during the formal hearing and in the Synopsis of the Record. As such, the Investigative Committee's Motion for Reconsideration must be denied in its entirety.

B. THE INVESTIGATIVE COMMITTEE HAS NOT MET ITS BURDEN TO SUPPORT COUNT II FOR FAILURE TO MAINTAIN PROPER MEDICAL RECORDS AGAINST DR. HAI NGUYEN

The Nevada Supreme Court stated "...only in very rare instances in which new issues of fact or law are raised supporting a ruling contrary to the ruling already reached should a motion for rehearing be granted." *See Moore v. City of Las Vegas*, 92 Nev. 402, 405, 551 P.2d 244, 246 (Nev. 1976). Generally, in Nevada, a previously decided issue can be reconsidered only if "substantially different evidence is subsequently introduced or the decision is clearly erroneous." *See Masonry and Tile Contractors Ass'n. of So. Nev. v. Jolley, Urga & Wirth, Ltd.*, 113 Nev. 737, 741 (Nev. 1997)

As noted, the Investigative Committee has not offered any new facts, authority, or arguments in seeking reconsideration. Instead, the Investigative Committee appears to argue that the honorable Hearing Officer's recommendation is clearly erroneous. However, as will be demonstrated in the next section of these Opposing Points and Authorities, the Hearing Officer's recommendation to the Nevada Board of Medical Examiners that the Investigative Committee has not met its burden in proving that Dr. Hai Nguyen breached the Nevada Medical Malpractice Act is not erroneous, but instead, entirely consistent with the facts and evidence presented in this matter.

In this case, it was documented consistently in the medical records that Dr. Hai Nguyen administered 0.5ML of Kenalog 40 MG/ML (also written 20 MG)[1] intramuscularly in the patient's right buttock on November 4, 2016 during her 10:45 a.m. appointment, due to her

[1] Half or 0.5 of 40 MG/ML is 20 MG/ML. *See* Synopsis of the Record at Page 131:3-134:2, attached hereto as **"Exhibit B."**

respiratory symptoms and medical history, and completed his documentation at 6:56 p.m. on November 4, 2016. *See* Excerpt of Medical Records at HCP 0002, 0017 and MED AMDIN DETAILS 00001-2, attached hereto as **"Exhibit A."** While the name of Dr. Nguyen's usual Medical Assistant is listed in the record due to auto-population from the Electronic Medical Record, under the section entitled "Override Encounter Details," the record shows that the "Perf. Provider" or "Performing Provider" is Dr. Hai Nguyen. *See* Excerpt of Medical Records at MED AMDIN DETAILS 00001-2, attached hereto as **"Exhibit A."** *See also* Synopsis of the Record at Page 230:2 – 231:24, attached hereto as **"Exhibit B."**

Here, even the Peer Reviewer retained by the Investigative Committee clarified that his criticism of Dr. Nguyen's documentation was that it appeared the consent for the Kenalog injection was documented as being requested from Patient A, a minor, rather than Patient's A's parent. *See* Synopsis of the Record at Page 91: 5 – 91:14, 120:12 - 121:2, 153:14 - 153:18, attached hereto as **"Exhibit B."**

Moreover, Dr. Hall further testified that it was reasonable for a physician to enter his documentation and that his other criticisms regarding Dr. Nguyen's documentation had been satisfied upon production of the rest of the medical and billing records:

> "Q Is it reasonable for a physician to wait until the end of the day to finish signing and documenting his note?
>
> A Yes, it is.
>
> Q And when you reviewed this document, I guess this case originally, you did not have the documentation that was the Respondent's Exhibit Number 12; correct?
>
> A That is correct.
>
> Q Okay. And so for the record, the prior criticism regarding failure to document the lot number, failure to document the expiration date, has that been satisfied based upon the production of this document?
>
> A Yes, it has." *See* Synopsis of the Record at Pages 154: 24 – 155:13, 120:12 – 121:2, attached hereto as **"Exhibit B."**

Indeed, Dr. Hall even conceded that there was documentation of consent in the patient's medical record:

> "Q My question is a little bit different. Is that documentation of consent?
>
> A That is documentation of consent." *See* Synopsis of the Record at Page 160:4 – 160:5 and 146:21 – 147:1, attached hereto as **"Exhibit B."**

Furthermore, Eduardo Anorga, M.D. clearly testified that Dr. Nguyen's documentation met the requirements of Nevada law with regard to his documentation and maintenance of his medical records:

> "Q If I told you that Nevada law requires that physicians maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient does that sound like an appropriate - -
>
> A That sounds perfectly reasonable.
>
> Q And your belief is that the records in this case are timely; is that true?
>
> A Yes, I do.
>
> Q It's your opinion that the records in this case are legible?
>
> A Yes, they are.
>
> Q. Okay. It's your opinion that the records are accurate?
>
> A They appear to be accurate, yes, to a reasonable degree." *See* Synopsis of the Record at Page 271:10 – 271:18, attached hereto as "**Exhibit B.**"

In Nevada, the standard of care is not whether there is a difference of opinion concerning treatment and documentation of such treatment, but whether there was a "failure of a provider of health care, in rendering services, to use the reasonable care, skill or knowledge ordinarily used under similar circumstances by similarly trained and experienced providers of health care." *See* NRS 41A.015. Moreover, the purpose of having a regulatory agency evaluate a licensed professional for discipline is to protect the public, but the Board cannot do so while violating a

physician's constitutional due process rights. *See Potter v. State Bd. of Med. Exam'rs*, 101 Nev. 369, 371, 705 P.2d 132, 134 (Nev. 1985).

In this case, there has been no evidence to demonstrate that Dr. Nguyen violated the Nevada Medical Malpractice Act with respect to his care and treatment of Patient A or his documentation of his care, and certainly no new evidence to warrant reconsideration of the Hearing Officer's recommendations set forth in the Synopsis of the Record.

The Hearing Officer's July 22, 2022 Synopsis of the Record and recommendations contained therein, that the Investigative Committee failed to meet their burden to demonstrate Dr. Nguyen violated the Nevada Medical Malpractice Act, was not "clearly erroneous" and should not be reversed.

III.

CONCLUSION

Based upon the foregoing, Dr. Nguyen respectfully requests that the Investigative Committee's Motion for Reconsideration be denied. The Investigative Committee has not offered any new facts, authority, or theories in bringing the Motion for Reconsideration. The IC has failed to demonstrate that the recommendation of the Hearing Officer set forth in the Synopsis of the Record was "clearly erroneous." To the contrary, the Hearing Officer's recommendations, respectfully, are entirely consistent with the facts, evidence, and law of Nevada.

DATED this 16th day of August 2022.

McBRIDE HALL

By: */s/ T. Charlotte Buys*

ROBERT C. McBRIDE, ESQ.
Nevada Bar No.: 7082
T. CHARLOTTE BUYS, ESQ.
Nevada Bar No.: 14845
8329 W. Sunset Road, Suite 260
Las Vegas, Nevada 89113
Attorneys for Respondent
Hai Thanh Nguyen M.D.

CERTIFICATE OF SERVICE

I hereby certify that on the 16th day of August 2022, I served a true correct copy of **HAI THANH NGUYEN, M.D.'S OPPOSITION TO THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS' MOTION FOR RECONSIDERATION**, by sending electronically and mailing via Email and United States mail to the following:

Sarah Bradley, J.D., MBA
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
Attorneys for the Investigative Committee

/s/ Madeline VanHeuvelen
An Employee of McBride Hall

EXHIBIT A

Medication Administration Details

[redacted]

Kenalog 40 MG/ML Injection Suspension (Triamcinolone Acetonide)

For [1] Cough

Record w/o Ordering

Order Entry | Record Administration

Administration Details | Charging

Inject 0.5ml intramuscularly once. To Be Done: 04Nov2016 Status: Complete

Dose: 1 Unit: ML

MFG: B-M SQUIBB U.S. (PRIM...

Lot: AAJ6426

Route: Intramuscular

Site: Right Gluteal Region

NDC: 00003029328

Exp: 01-Mar-2018

Date/Time: 04-Nov-2016 06:56 PM Now

Admin By: Hampton, Chanel

Charging

Medical Necessity Checking: CPT-4:J3301 Code: Status:

Medical Necessity Details:

Verify charges being submitted for: None Specified Encounter

	Type	Code	Display Name	Modifiers	Units	When To Cha...	Time Based
☑		J3301	INJ, TRIAMCINOLONE ACETONIDE, PER 10 MG (KENALOG-10,40, TRI-KORT)			Upon Completion	N/A

Override Encounter Details:

Special Billing:

Account #:

Billing Provider: NGUYEN-INACTIVE, HAI

Perf. Provider: NGUYEN-INACTIVE, HAI

Injury Date: 23-May-2022

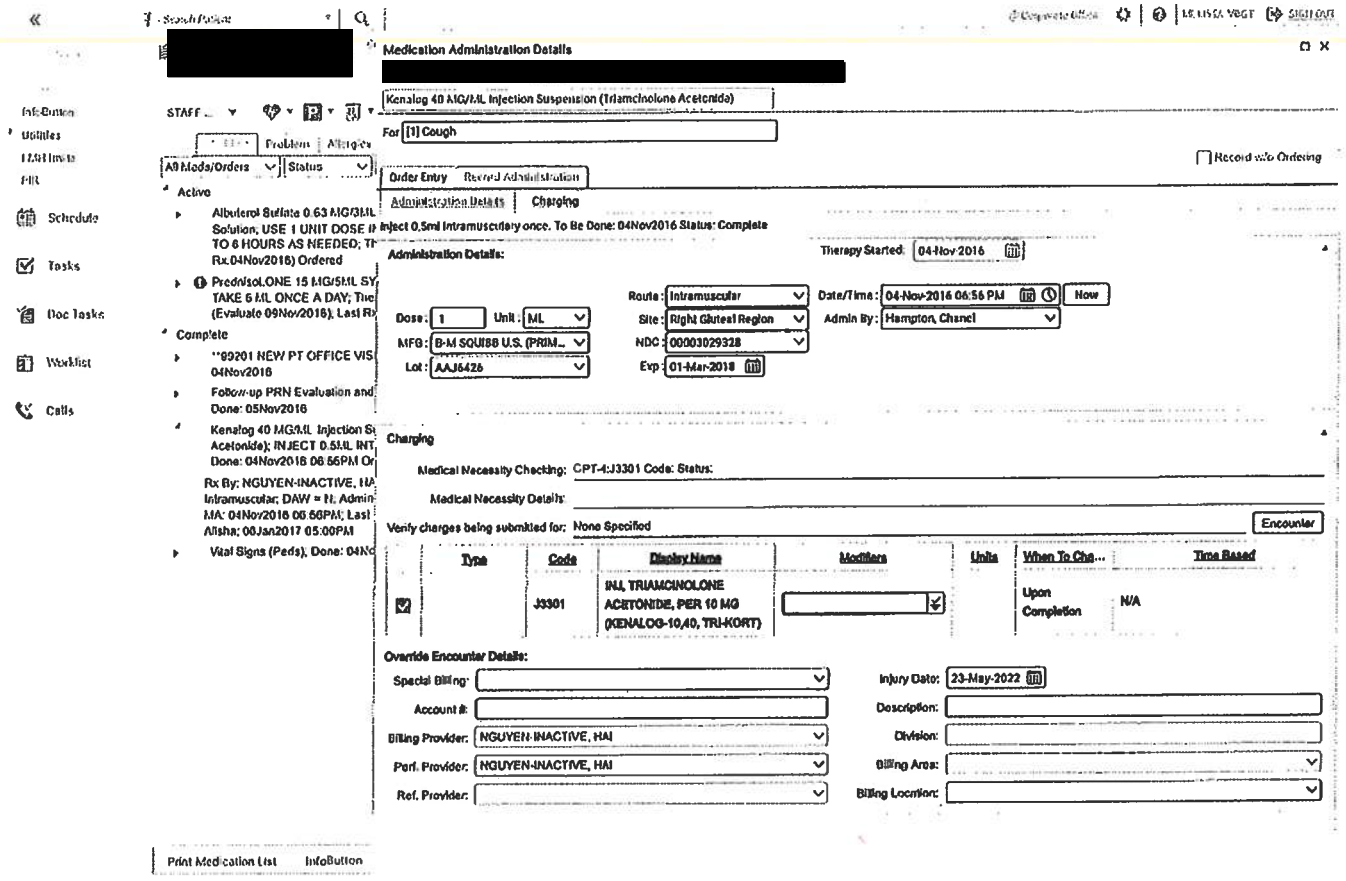
Description:

Division:

Billing Area:

DUR Alerts: Drug-Drug (0) | Prior Adverse Reactions (0) | Disease (0) | Duplicate Therapy (0) | Dose (0)

Allergic To: Eggs



MED ADMIN DETAILS 00002

HealthCare Partners Medical Group - 700 Building

700 E Warm Springs Rd Ste 110
Las Vegas,NV 89119-4311
(702) 318-2400

HealthCare Partners Nevada

HCP 0001

Patient: [redacted]
EMRN: 80-1748263
OMRN: 80-1748263

Age/DOB: 2 years [redacted]
Home: [redacted]
Work:

All Problems

Problem Description	Managed By	Category Severity	Impression
Cough			
Fam Hx: **Family history of asthma**		Family history of Maternal Grandmother	

MEDICAL RECORDS

This exhibit contains person medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310

EXHIBIT B

In the Matter Of:

Nevada State Board of Medical Examiners

TRANSCRIPT OF HEARING PROCEEDINGS

May 26, 2022

Job Number: 870731

Litigation Services | 800-330-1112
www.litigationservices.com

A The parents.

Q And this documentation here, I mean, do you think that's documenting an informed consent?

A No, I do not.

Q Why?

A Well, because the statement here suggests the patient was providing consent and we -- the patient's incapable of providing informed consent in this case.

Q Okay. Because the patient is a minor?

A Correct.

Q And then what about the parents? Would this sufficiently document informed consent on behalf of parents in your view?

A No, because it does not state parents.

Q Okay. But what about risks and benefits?

A I do not see a description of the risks and benefits.

Q I mean, and I think again, you said you would document -- I mean, what would your sentence look like if you were documenting informed consent in a case like this?

A So in my practice, we would typically have a separate sheet that would document this is the treatment proposed, these are the potential risks, this is the

pages are consistent with what I reviewed regarding the medical record from the date of service November 4th, 2016.

Q And I guess I just want to talk about the records a little bit. Are you familiar with a standard in Nevada regarding what consists of timely, legible accurate and complete medical records?

A I would say your description is somewhat self-evident to me that medical records should be legible, they should be completed in a timely manner, so yes.

Q Okay. And I know I've had you look at a lot of the Board's exhibits, and the reason I wanted you to look at the Respondent's is I think there's a handful more pages of medical records that Dr. Nguyen has provided than what we had initially obtained.

A Yeah, I agree. Yes, I agree.

Q Okay. Because my question really is: Based on what we've talked about today, would you say these records are timely, legible, accurate and complete?

A What I reviewed previously, so that for the record is pages 2, 3, and 4, appear to me to be timely, legible and accurate in the sense that there are -- Well, I'm aware that there are some additional pages now,

so I would question if we had all of the medical records with my original review. That's what I would question.

Q Okay. But, for example, I think we talked about the informed consent documentation.

A Yes.

Q Do you think that should have been more complete in the record?

A Yes.

Q And so if informed consent isn't documented as completely, I mean, does that make the record now not complete?

A Yes. One would need to document informed consent. Yes.

Q And if it's not documented, I've heard people say if it's not documented, it didn't happen. Is that something --

A I've heard the same thing.

Q And where have you heard that?

A Well, in my medical training and certainly from a medical/legal perspective, I've heard the same principle discussed.

Q Okay. Why is documentation so important in patient records?

A Well, I think this is a great example, is

MS. BUYS: I also wanted to talk about the medical administration log, which I believe we now have listed as Respondent's Exhibit Number 6, as well as the medication administration details, which is Respondent's Exhibit Number 12.

MS. BUYS: So I believe we have the same document as listed as Number 6, and we have a declaration, under Exhibit 12, we have a declaration from Melissa Vogt. That's what I have.

HEARING OFFICER HALSTEAD: So they're going to be one number, I think. Like if she says 12, it's going to be 13. If she says it's six, it's going to be seven.

THE WITNESS: Oh, okay. Sorry. So with clarification, we also have standard operating procedure for HealthCare Partners of Nevada. We do have that exhibit, but it's under a different number on my binder.

HEARING OFFICER HALSTEAD: Can you just clarify each exhibit, and if it's Respondent as or the Board's, and I'll clarify for everyone on this end.

Q (BY MS. BUYS:) Thank you. I was referring also to it is Respondent's Exhibit -- I believe we stipulated to its admission as Respondent's Exhibit Number 12, and it's Medical Administration Details, Bates

stamped Med Admin Details 00001 through 2.

A Yes, I have that one.

Q Okay. Perfect. And have you had an opportunity to review all of these documents before your testimony here today?

A So the document that you just referenced, I received this by email the night of May 23rd, and I did review that. Under Exhibit 5, so on Exhibit 5, I have not reviewed until today or have not seen until today pages 1, 5, and 6. So I did not receive 1, 5 or 6 previous to today.

Q All right. And when you say Exhibit Number 5, are you referring to it's medical records from HealthCare Partners and Bates stamped at the bottom HCP 01 through 17?

A Yeah, so that is correct. I'm referring to the medical record from HealthCare Partners under Respondent's Exhibit 5, and I'm referring to HCP 1, 5, 6, and 7 are the ones that I have not previously reviewed.

Q All right. Thank you for clarifying. I just wanted to make that point for the record. If you could please go and take a look at that it's Respondent's Exhibit Number 12, the Medication Administration Details.

A Yes.

Q Do you have that in front of you?

A I do. Thank you.

Q Thank you. I believe Ms. Bradley had asked you earlier about the dosage for the Kenalog injection, and if I recall your testimony correctly, you believed you had stated it was one mL. Is that correct?

A So there -- I was a little confused, and there is a distinction between what is documented under Tab 5 and what is documented under Tab 12. So under Tab 5, if you look at the Kenalog order, the order says Kenalog, 40 milligrams per milliliter, and it says: Inject 0.5 milliliters intramuscularly. That dosing would be 20 milligrams. However, on Exhibit 12, the documentation here lists a dose of 1 milliliter, which would be 40 milligrams of Kenalog. So there is a little distinction.

Q All right. Just to clarify for the record, Doctor, where do you see that 1 milliliter on this documentation? I believe -- actually, strike that. Do you see at the top of the page under it says, "Administration details"?

A Yes.

Q There is a statement right there. It looks like it reads inject --

A Yes.
Q -- 0.5 mL intramuscularly once.
A Yes. So that --
Q Do you see that?
A I do. Yes.
Q All right. And did I read that correctly?
A Yeah, that is correct.
Q All right. And the notation: Inject 0.5 milliliters intramuscularly once, would that be consistent with the records that you reviewed in Exhibit Number 5 regarding the .5 milliliter injection?
A Yes, it would.
Q All right. So to clarify -- Strike that. Would .5 milliliters of a 40 milligram per milliliter injection, would that be 20 milligrams per milliliter?
A Yes, it would be 20 milligrams.
Q Twenty milligrams. Thank you for clarifying. And so would it be consistent that Dr. Nyugen's documentation indicates that it was 20 milligrams that was administered?
A Yes, I believe that is correct. That is what is stated in Exhibit 5. And also, as you pointed out in that section right underneath administration details, that is the exact same description there. So yes, I

A That is the location listed on the medical record. Yes.

Q Okay. And does the standard of care require that a doctor ignore an approved process by the FDA on where an injection should be administered?

A There are different sites of administration that can be utilized, and I would reference one of the other exhibits described some other locations that Kenalog may be administered, and especially in the pediatric population, but administering it into the gluteal area is probably the most common place that these medications are administered.

Q So would it be the standard of care for a reasonable physician to administer this type of Kenalog injection into the gluteal muscle?

A Yes.

Q Okay. And, Doctor, what is the percentage of people who get a cutaneous or subcutaneous atrophy from a single steroid injection?

A I would estimate it's very low.

Q And, Dr. Hall, I can't quite put my hands on it, but can you please tell me the Nevada case, regulation or statute that says that standard of care requires that consent for a Kenalog injection be written?

A I could not cite that.

Q And I believe you had testified as to your opinions regarding consent in this matter. Do you recall that?

A I do.

Q In your experience, Doctor, do patients sometimes forget every single side effect or risk of a treatment that you've gone through with them?

A Patients' recollections can be incomplete.

Q And in your experience, is it possible that, you know, a patient could go and understand the risks and benefits and alternatives to treatment at the time you provide them care and then, you know, approximately five or so years later, they can't recall specifically what was discussed?

A I think that yes, that can happen.

Q And I believe there was also testimony that this divot is on the left buttock of Patient A. Is that correct?

A Yes.

Q And you had testified that you reviewed photographs which I believe it was the IC Exhibit Number 6?

A Yes.

A Yes.

Q -- of the visit; is that correct?

A That is correct.

Q All right. And then I also wanted to draw your attention, Doctor, to Respondent's exhibit. We'll pull this one, and it is going to be Respondent's Exhibit Number 5 that was admitted. And at the bottom, Bates stamp HCP 007. Do you see that?

A Yes, I do.

Q And is it your understanding, Doctor, that the medical insurance and driver's license that are included as part of Patient's A record are her parents'?

A Yes.

Q Okay. And so your criticism of Dr. Nguyen regarding consent is that it appeared to you that it was documented that it was the two-year-old giving the consent; is that correct?

A That is correct.

Q All right. But there is reference that the patient's parents were there as the patient's proxy; correct?

A That is correct.

Q Okay. And, Doctor, in your experience in treating a pediatric patient with croup, have you ever

done so in an urgent care setting?

A I have not worked in an urgent care, but we see urgent acute appointments in our office.

Q Gotcha. And was that a private office that you sort of ran as the solo practitioner?

A So I have worked in a couple different practice settings, but all of my practice settings have involved more than one provider.

Q And when you're treating a pediatric patient with possible croup, do you conduct a literature search every time that you see that type of patient to make sure you're adhering to the standard of care?

A I don't search literature with every patient, no.

Q All right. And would you agree that when completing a timely, accurate and complete medical record that it's appropriate for a doctor to finish signing his note after he reviews it?

A That is appropriate. Yes.

Q Okay. And do you sign your, I guess, narrative or progress note immediately after you see a patient?

A Not always.

Q Is it reasonable for a physician to wait

until the end of the day to finish signing and documenting his note?

A Yes, it is.

Q And when you had reviewed this document, I guess this case originally, you did not have the documentation that was the Respondent's Exhibit Number 12; correct?

A That is correct.

Q Okay. And so for the record, the prior criticisms regarding failure to document the lot number, failure to document expiration date, has that been satisfied based upon the production of this document?

A Yes, it has.

Q Okay. And when you were testifying regarding the standard of care in providing a Kenalog injection in a patient with respiratory illness, I believe you had testified that your criticism was that it was redundant to the oral medication. Is that correct?

A That is correct.

Q Okay. And is it your opinion that a reasonable provider who had been told that a patient previously did not get better with oral steroids alone would want to go and move towards considering an injection of a steroid?

A I think that would be a fairly weak description of consent for a Kenalog injection.

Q My question is a little bit different. Is that documentation of consent?

A That is documentation of consent.

Q Okay. Thank you, Doctor. And looking back, I believe you had also stated that there was a subtle difference in treatment between, I think you said, oral and Kenalog injections. Is that correct?

A Yes.

Q Okay. Could you explain further what you mean by "subtle difference"?

A Well, it's primarily a difference in the route of administration. So administering oral corticosteroids or intramuscular corticosteroids, both are very reasonable treatment approaches, and the distinction being the route of administration, and they're considered roughly equivalent in the context of providing care in the acute setting.

Q And I believe we had also sort of discussed a question as to the depth of the injection that was provided in this case. Do you remember testifying that there was a question regarding the depth of the injection?

A Yes, it does.

Q All right. And is it your understanding that when you're documenting an electronic medical record that the record can autopopulate a provider's name?

A It can.

Q And do you recall the electronic health record that was in effect at HealthCare Partners on November 4th, 2016? Was it Cerner or a specific type of electronic healthcare record?

A I believe it was Allscripts.

Q And you had also testified regarding Chanel Hampton. Was it your testimony that she was your regular medical assistant?

A Yes, Ms. Chanel Hampton worked for me for approximately three years at HealthCare Partners.

Q And to clarify, when you prescribe a Kenalog injection through the electronic healthcare record, was it your testimony that it can autopopulate the typical medical assistant that you worked with?

A Yes, it can autopopulate the name of the medical assistant that normally works there.

Q Okay. And, Doctor, I believe there was also some testimony earlier regarding the timing of this documentation. Do you recall what time you finished

authoring your progress note for the patient?

A What happens sometimes is I'm busy at the -- I have another patient that I have to see in the urgent care, and then I'll go back at the end of the day to complete my progress note and to make sure everything is accurate as possible and reflects my care of the patient.

Q And does the documentation that has been provided in this proceeding appear to indicate that you authored your progress note on November 4th of 2016?

A Yes, it does.

Q Which is the same day that you saw Patient A; correct?

A Correct.

Q And then I also believe Board counsel asked you questions regarding your documentation of the consent given by Patient A's parents. Do you remember those questions?

A I believe -- Can we have a read back of that? Sorry.

Q Otherwise, I'll rephrase my question.

Doctor, you had testified that you documented that you had received consent from Patient A's parent in your note. Is that correct?

A Correct.

HEARING OFFICER HALSTEAD: Your left. Thank you. I appreciate that.

Q (BY MS. BRADLEY:) Are you aware that Nevada law provides a requirement for physicians in maintaining records under --

A Absolutely.

Q Okay. And so could you tell us what the requirement is?

A I probably couldn't quote it. No.

Q If I told you that Nevada law requires that physicians maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient, does that sound like an appropriate --

A That sounds perfectly reasonable.

Q And your belief is that the records in this case are timely; is that true?

A Yes, I do.

Q It's your opinion that the records in this case are legible?

A Yes, they are.

Q Okay. It's your opinion that the records are accurate?

A They appear to be accurate, yes, to a

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against

HAI THANH NGUYEN, M.D.,

Respondent.

Case No. 21-38084-1

ORDER DENYING MOTION FOR RECONSIDERATION

1. Introduction

On July 21, 2022, undersigned issued a Synopsis of Record that included findings as to two counts alleged in the Complaint filed against Respondent Hai Thanh Nguyen, M.D. ("Respondent") on November 23, 2021. The Investigative Committee of the Nevada Board of Medical Examiners (the "IC") has moved for reconsideration of the findings as they relate to Count II, Failure to Maintain Property Medical Records (the "Records Count"). Respondent has opposed the IC's Motion for Reconsideration (the "Motion"). Having considered the briefing, which, pursuant to NRS 622A.390, provides for a motion and opposition, the undersigned adjudicates the Motion by denying reconsideration as a basis for a rehearing, other proceedings, or further relief for the reasons set forth herein.

2. Summary

By and through the IC's Motion, the IC asks for reconsideration of undersigns' representation that "[a]s to the remainder of the allegations in support of Count II Failure to Maintain Proper Medical Records, they have been conceded as disproven by the medical records recently produced." Synopsis of Record, p. 11, lines 18-20. In taking issue with the conclusion, the IC maintains that Respondent's medical records, specifically Respondent's Exhibit 12, remains in violation of NRS 630.3062(1)(a) in that it reflects the name of medical assistant Chanel Hampton as having administered the Kenalog injection at issue even though Ms. Hampton was

not present that day and the injection was indisputably administered by Respondent. The IC also maintains that the time reflected on Respondent's Exhibit 12 is not reflective of the time the injection was given. According to the IC, clarifying testimony is insufficient to redeem the records as the records themselves must be clear on their face to be deemed accurate and complete. The IC further argues that the injection records were "unclear as to where on Patient A's body the shot was administered" (Motion, p. 5, line 18), and that "Respondent failed to document why he rendered the treatment that he did." Motion, p. 6, lines 2-3.

In Opposition, Respondent argues that the IC has failed to raise any legally recognized basis to support reconsideration and that the medical records reflect that Respondent gave the injection in what was an override of the auto population of Respondent's medical assistant Chanel Hampton's name. Respondent also relied upon testimony by Dr. Hall, the IC's peer review expert, who addressed the sufficiency of the records.

3. Standard for Reconsideration

Pursuant to NRS 622A.390, a motion requesting reconsideration of the findings and recommendations of a hearing officer may be filed no later than fifteen days after the date of service of the findings and recommendations. A motion requesting a rehearing or reconsideration may be based only on one of the following grounds:

(a) Newly discovered or available evidence.

(b) Error in the hearing or in the findings and recommendations or the decision that would be grounds for reversal of the findings and recommendations or the decision.

(c) The need in the public interest for further consideration of the issues or evidence, or both.

Here, the IC relies upon the premise that undersigned's findings and recommendations as to the Records Claim were made in error, which, presumably, also supports grounds for reversal. Having timely filed the Motion, and citing a valid basis therefore, undersigned addresses the merits of the Motion to further aid the Nevada Board of Medical Examiners in rendering a decision.

4. Context of the Statement of Concession

Relevant to the IC's Motion is the fact that the Complaint bases Count II, the Records Claim, on the following:

a. Respondent's alleged failure to maintain records relating to the diagnosis and treatment by failing to document his actions;

b. Respondent's alleged failure to document informed consent and discuss the risks and benefits of the injection; and

c. there being no records reflecting the specifics of the injection.

See IC Exhibit 3. In the body of the Complaint, there is reference to the injection records not being clear as to the milligrams administered and there being no injection record evidencing the vial identification, lot number date or expiration, injection location, or who delivered the shot, all of which was addressed with documentation that was produced just before the hearing, and which addressed the concerns pleaded in the Complaint as was conceded by Dr. Hall. TR 120-21.

Specifically, in responding to questioning by the IC as to why Dr. Hall believed Respondent committed malpractice, Dr. Hall testified,

> There were three reasons I made that statement. Number one: I could not find documentation of informed consent for administration of Kenalog intramuscularly. Number two: I didn't understand the reasoning behind providing both oral and intramuscular corticosteroids. And finally, there wasn't - - in the medical record I initially reviewed - - there was not a description of how the injection was administered.
>
> IC: Ok, but now we have that? [Referring to the newly produced injection record.]
>
> Dr. Hall: We now have that.

As such, Dr. Hall addressed the three concerns he had with the matter and conceded that he was satisfied that the injection record as it evidenced how the injection was administered. It was this statement by Dr. Hall upon which undersigned premised the conclusion that the remainder of the allegations in support of Count II, Failure to Maintain Proper Medical Records, were conceded. In context, the statement, which specifically references the Complaint allegations, is accurate; and, while the IC itself may not have intended to concede the point, the IC is not a witness and cannot proffer testimony, and the testimony proffered on behalf of the IC by

its peer review expert Dr. Hall was indeed a concession by which he was clear that he was no longer concerned about the records as they related to the injection administration.

5. Documentation of Respondent's Administration of the Injection

Given that the injection records were produced late, it was not known at the time the Complaint was filed that Respondent's Exhibit 12, which was part of the late production, would contain the name of Respondent's medical assistant Chanel Hampton or that the time listed would reflect a time later than when the injection was administered. As such, the allegation that the records are inaccurate because they contained such notations was never alleged in the Complaint and Respondent had no notice of the same. Regardless, no objection was raised by Respondent who addressed the allegations despite any lack of notice; and, in defending against the same, relied upon records that he advocated reflect that he gave the injection and that the time entry is reflective of when he created the record.

With respect to the time entry, Dr. Hall acknowledged that the later time entry was explained by an end of day creation of the injection record (TR 100), and that it "is appropriate" to wait address such records until the end of the day. TR 154-55. This testimony was consistent with Respondent's own testimony that sometimes he gets busy in the urgent care and has to go back at the end of the day to complete progress notes and make sure his records are accurate and reflect the care provided. TR 230-31. As such, undersigned concluded there was nothing to be made of the later time notation on Respondent's Exhibit 12, which was the same day, only later.

As to Chanel Hampton's name being listed in Respondent's Exhibit 12, Respondent testified that the "Admin By" notation that contained her name was part of a computer generated order to his medical assistant, who is Chanel Hampton, and that her name was placed through an auto population. TR 221-23. In clarifying whether it was a notation that was meant to indicate that Chanel Hampton administered the injection, Respondent testified that it meant that Chanel Hampton was ordered to give the injection as opposed to a notation of who administered the injection. Id. Respondent further testified that while the person ordered to give the injection is often times the person who administers the injection, that is not always the case, and the person

who administers the injection is noted in the progress notes, where, in this instance, it is noted that Respondent gave the injection. Id.

To demonstrate that Respondent is recorded has having given the injection, Respondent relied upon Respondent's Exhibit 5, HCP 0017, which is a Medication List and provides for the Kenalog injection and under Provider Status reads "HAI NGUYEN Complete;" Respondent's Exhibit 5 at HCP 0002 under Plan where it reads "Rx by: NGUYEN, HAI" (*see also* Respondent's Exhibit 5 at HCP 0005); Respondent's Exhibit 12, on the second page in the progress notes to the left, which reads Rx by: NGUYEN-INACTIVE HAI. Respondent also relied upon Respondent's Exhibit 6, which addresses the administration of the injection and references the "task" being previously assigned to Respondent.

Absent such testimony, and not being familiar with medical records, undersigned may have assumed that each of the notations Respondent relies upon to show that he administered the injection reflect that the injection was *prescribed* by Respondent. However, based upon Respondent's uncontroverted testimony, undersigned must accept the representation that the notations relied upon by Respondent reflect that the injection was *administered* by Respondent. Notably such testimony was supported by Dr. Hall who, before Respondent even testified, acknowledged that he would read Respondent's Exhibit 12, "as an order from Dr. Nguyen for his staff to provide the injections," which is consistent with Respondent's explanation of why Chanel Hampton was in the "Admin By" notation of that record. TR 96; TR 222. Dr. Hall additionally acknowledged that there "was some narrative" he recently reviewed in which Respondent was reflected as having given the injection. TR 165.

Given the foregoing, in conjunction with Dr. Hall's concession addressed *supra* that he had no remaining concerns about the medical documentation other than as related to informed consent, it remains that undersigned cannot conclude that a violation of the Records Claim has been established based upon either the generally accepted practice of entering records later in the day, or based upon an entry on Respondent's Exhibit 12 reflecting the name Chanel Hampton in light of Respondent testifying that such entry reflected who was initially ordered to administer the injection, which Dr. Hall agreed with, and additional records establishing that Respondent was the

one who ultimately administered the injection, including the very record that had Chanel Hampton's name.[1]

6. The Remainder of the Basis Upon Which the IC Seeks Reconsideration

In addition to the foregoing, the IC advocates that the injection record was "unclear as to where on Patient A's body the shot was administered." Motion, p. 5, line 18. This is belied by the injection record itself, which clearly provides that the injection was administered in the "Right Gluteal Region." Respondent's Exhibit 12. The discrepancy is not the medical records as alleged in the Motion, but the location of the divot on the left gluteal region as photographed by the patient's mother months later (*see* IC Exhibit 6) and, therefore, whether the divot can be attributed to the injection. This issue was addressed in the Synopsis of Record and need not be reiterated again herein. As to the basis for which reconsideration is sought, the location of the injection, per the injection record, is clearly provide for.

The IC's final concern supporting its request for reconsideration is that Respondent "failed to document why he rendered treatment that he did." Motion, p. 6, lines 2-3. In support of this statement, the IC takes issue with Respondent not noting the conversation with the patient's mother that led him to administer the Kenalog injection in addition to the Prednisone. Respondent did, however, document why he rendered the recorded treatment. Respondent noted family history; the complaints presented; history and symptoms, inclusive of vomiting and the patient having had croup already twice in the last 7 months; and he noted that he treated the patient with the Kenalog injection and the Prednisone prescription based upon the symptoms and having discussed the treatment plan with the patient, i.e., Ms. Del Grosso, who agreed and verbalized understanding. Reference that "[p]atient agrees with treatment plan and verbalizes

[1] Certainly the Medical Board has better knowledge of medical records than the undersigned and can choose to reject this finding if it deems doing so appropriate and concludes that entry alone is sufficient to render the injection record inaccurate to an extent it rises to the level of supporting discipline.

understanding" (IC Exhibit 5) demonstrates a discussion with Ms. Del Grosso that supported the treatment plan.[2]

Even had this not been the case, there was no prior adjudication of the allegation that Respondent's documentation as to why he rendered the treatment he did was deficient (and, again, the only alleged deficiency Dr. Hall took issue with was the documentation of informed consent). As such, it is not proper to raise the contention for the first time in a request for reconsideration. *See, e.g.,* Achrem v. Expressway Plaza Ltd. Partnership, 112 Nev. 737, 742, 917 P.2d 447, 450 (1996) ("Points or contentions not raised in the original hearing cannot be maintained or considered on rehearing"). The closest Complaint allegation is that Respondent failed to document his actions, which was not ultimately established given the late production of the injection record, and stating that Respondent failed to document his actions is not akin to alleging that Respondent failed to justify his treatment.

7. Conclusion

As was addressed in the Synopsis of Record, this matter was brought to the Board's attention based upon a divot that was not definitively attributed to the Kenalog injection; but, even if it was, it was a known side effect that cannot be credited to any wrongdoing, that is not considered serious, and that corrected itself by filling in. Ms. Del Grosso's concern with regard to the divot was provoked by the misrepresentation that Kenalog injections were no longer given to children, which was established to be false; and, in the end, the treatment provided by Respondent appears to have aided the patient, leaving the notation of when Respondent entered the injection record and an auto-population of his medical assistant's name for the injection order as opposed to its administration for reconsideration.

For the reasons set forth herein, the Motion will not be granted and, therefore, no further rehearing or other proceedings will be ordered hereby. It remains undersigned's recommendation

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[2] Dr. Angora, Respondent's expert, touched upon the level of detail that is standard for medical records in his testimony at TR 282-83, noting that medical records are not tediously detailed due to time constraints. Dr. Angora also testified that "not every detail in a medical record is fully documented." TR 272.

that the IC take no action on the Complaint against Respondent based upon the IC having failed to meet its burden of proof as to either of the alleged Counts lodged against Respondent in the Complaint.

RESPECTFULLY SUBMITTED this 18th day of August 2022.

Patricia Halstead, Esq., Hearing Officer for the
Nevada State Board of Medical Examiners
615 S. Arlington Ave.
Reno, NV 89509
(775) 322-2244
phalstead@halsteadlawoffices.com