BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In The Matter of Charges and Complaint Against LANING ANDREWS, M.D., Respondent.	**Case No. 09-12260-1**

FILED
DEC 0 2 2009
NEVADA STATE BOARD OF MEDICAL EXAMINERS

COMPLAINT

The Investigative Committee of the Nevada State Board of Medical Examiners, composed at the time of approval of the filing of the instant complaint, of Charles N. Held, M.D., Benjamin J. Rodriguez, M.D. and Jean Stoess, having a reasonable basis to believe that Laning Andrews, M.D., hereinafter referred to as Dr. Andrews, has violated the provisions of NRS Chapter 630, hereby issues its formal Complaint, stating the Investigative Committee's charges and allegations, as follows:

1. Dr. Andrews is currently licensed in active status, and was so licensed by the Nevada State Board of Medical Examiners, on August 24, 1998 (License No. 8768), pursuant to the provisions of Chapter 630 of the Nevada Revised Statutes, and at all times addressed herein was so licensed.

2. Patient A was a forty-five year old female at the time of the incidents in question. Her true identify is not disclosed to protect her privacy, but her identity is disclosed in the Patient Designation served on Dr. Andrews along with a copy of this Complaint.

3. Patient A's medical history included hypothyroidism, hypertension, refractory migraines and strokes secondary to antiphospholipid antibody. She took Lovenox on a regular basis for anticoagulation.

4. Patient A presented to her primary care physician at MEDSchool Associates North on December 9, 2002 with complaints of the worst headache of her life. She reported falling a

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week prior and hitting the right side of her head. Her primary care physician was concerned about possible subarachnoid hemorrhage and contacted the emergency room physician at Saint Mary's Hospital about possibly performing a workup on Patient A that would include a CT scan and possible lumbar puncture.

5. Patient A was sent to the emergency room at St. Mary's Hospital where she was seen by Dr. Andrews. He performed an examination of Patient A and she underwent a CT scan which was reported as unremarkable.

6. Subsequent to the unremarkable CT scan, Dr. Andrews performed a lumbar puncture on Patient A, the results of which demonstrated only 2 red blood cells in the CSF. Patient A was subsequently discharged with the impression of acute viral meningitis and was directed to follow up with her primary care physician.

7. The medical records for Patient A do not indicate that Patient A's use of Lovenox was considered in the decision to perform a lumbar puncture nor do they indicate that any alternatives to a lumbar puncture were considered for Patient A. Furthermore, the medical records do not indicate that Dr. Andrews discussed with Patient A the risks and benefits associated with the lumbar puncture.

8. Patient A was transported by REMSA to the emergency room at Saint Mary's Hospital approximately seven hours after being discharged, with complaints of neck and back pain. She left the hospital against medical advice approximately one hour later, stating she felt better.

9. Patient A returned to MEDSchool Associates North on December 10, 2002 for follow up where she was noted as having viral meningitis as well as back pain and headaches.

10. Patient A again returned on December 11, 2002 to MEDSchool Associates where she reported the onset of severe lower back pain the night before as well as numbness which radiated down her left leg and occasionally her right leg. She was referred to Washoe Medical Center (currently Renown) for treatment of viral meningitis and evaluation of a potential lumbar epidural hemorrhage.

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11. Patient A was seen at Washoe Medical Center where she was diagnosed with an extensive epidural hematoma.

12. Patient B was a thirteen-year old male at the time of the incidents in question. His true identify is not disclosed to protect his privacy, but his identity is disclosed in the Patient Designation served on Dr. Andrews along with a copy of this Complaint.

13. Patient B presented to the emergency room at Saint Mary's on August 8, 2003 with complaints of a severe headache that he had been experiencing for the previous three weeks.

14. Patient B and his mother reported that he had been seen in the emergency room of Washoe Medical Center three times during that time period and that during his first visit he had undergone a CT scan which was apparently normal and was sent home. They reported that during the second visit, Patient B was diagnosed with sinusitis and given antibiotics and during the third visit he was diagnosed with migraines and given Vicodin.

15. At Saint Mary's, Patient B reported his pain was increasing and the location had moved from the frontal to temporal surfaces. He also reported nausea.

16. Patient B was initially seen by a physician assistant whose examination of Patient B indicated no remarkable or abnormal findings. Her examination noted no sinus tenderness and no meningeal signs.

17. Dr. Andrews did see Patient B and he concurred with the impression of the physician assistant of acute cephalgia. Patient B was prescribed a new pain medication and was directed to follow up with a neurologist. Patient B's mother was provided with a list of neurologists. No further workup of Patient B was conducted.

18. On August 13, 2003, Patient B was transported to Washoe Medical Center after being found unconscious by his mother at home. He arrived at Washoe Medical Center lethargic with right-sided hemiparesis. He was ultimately diagnosed with basilar meningitis with intraparenchymal abscesses and hydrecephalus. Sphenoid sinusitis was also found and was believed to have been the underlying cause of the basilar meningitis. Patient B underwent a lengthy hospital course for treatment.

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Count I

19. Nevada Administrative Code Section 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.

20. Nevada Revised Statute Section 630.301(4) provides that malpractice is grounds for initiating disciplinary action against a licensee.

21. Dr. Andrews failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances when he performed a lumbar puncture on Patient A without investigating alternatives to the lumbar puncture or taking any precautions to account for the fact that Patient A was on Lovenox and accordingly Dr. Andrews is subject to discipline by the Nevada State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

Count II

22. Nevada Administrative Code Section 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.

23. Nevada Revised Statute Section 630.301(4) provides that malpractice is grounds for initiating disciplinary action against a licensee.

24. Dr. Andrews failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances when he failed to consider complications associated with sinusitis and perform further workup on Patient B knowing that Patient B had been seen three previous times with the same complaints, had received treatment and had not improved and accordingly Dr. Andrews is subject to discipline by the Nevada State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

WHEREFORE, the Investigative Committee prays:

1. That the Nevada State Board of Medical Examiners fix a time and place for a formal hearing;

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2. That the Nevada State Board of Medical Examiners give Dr. Andrews notice of the charges herein against him, the time and place set for the hearing, and the possible sanctions against him;

3. That the Nevada State Board of Medical Examiners determine what sanctions it determines to impose for the violation or violations committed by Dr. Andrews; and

4. That the Nevada State Board of Medical Examiners make, issue and serve on Dr. Andrews its findings of facts, conclusions of law and order, in writing, that includes the sanctions imposed; and

5. That the Nevada State Board of Medical Examiners take such other and further action as may be just and proper in these premises.

DATED this 2nd day of December, 2009.

THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
Lyn E. Beggs, Esq.
General Counsel and Attorney for the Investigative Committee

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CERTIFICATE OF MAILING

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on the 2nd day of December 2009, I served a file copy of the COMPLAINT, PATIENT DESIGNATION, Original SETTLEMENT, WAIVER AND CONSENT AGREEMENT along with FINGERPRINT INFORMATION, by mailing USPS certified mail to the following:

Laning Andrews, M.D.
P.O. Box 21418
Reno, NV 89515-1418

Dated this 2nd day of December 2009.

Angelia Donohoe
Legal Assistant

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