OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
(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 STUART MICHAEL HOFFMAN, M.D., Respondent.	**Case No. 10-20386-1**

COMPLAINT

The Investigative Committee of the Nevada State Board of Medical Examiners, composed at the time filing of Charles N. Held, M.D., Chairman, Theodore B. Berndt, M.D., Member, and Valerie J. Clark, Member, having a reasonable basis to believe that Stuart Michael Hoffman, M.D., hereinafter referred to as Respondent, has violated the provisions of NRS Chapter 630, hereby issues its formal Complaint, stating the Investigative Committee's charges and allegations, as follows:

1. Respondent is currently licensed in active status (License No. 9758), and has been so licensed since April 23, 2001 by the Nevada State Board of Medical Examiners pursuant to the provisions of Chapter 630 of the Nevada Revised Statutes.

2. Patient A was a forty-one year old (41) male at the time of the incidents in question. His true identity is not disclosed to protect his privacy, but his identity is disclosed in the Patient Designation served on Respondent along with a copy of this Complaint.

3. On June 10, 2005, Patient A presented with classic symptoms of cholecystitis or abdominal pain and vomiting. Respondent performed a laparoscopic cholecystectomy on Patient A.

4. Two days after the surgery, Patient A began to suffer increasing abdominal pain and tenderness in the right upper quadrant. The abdominal pain continued, and a CT scan of

Patient A's abdomen was performed on day three after surgery. An extensive amount of ascites and a probable ventral hematoma were identified.

5. Patient A remained in the hospital and by day five after the surgery began to suffer rising insulin requirements. This was a very unusual symptom for a routine laparoscopic cholecystectomy.

6. Patient A continued to worsen. Pain medication was given, and Patient A was fatigued and dizzy, exhibited a pulse rate of 125-140 and poor glucose control noted.

7. The pain continued, and an ERCP was performed and stenting added in order to relieve a questionable bile leak on day twelve after the original surgery.

8. By post-operative day 15, Patient A continued with increasing pain, and pain medication was prescribed. Patient A's heart rate was noted as 140. Increasing distension of the abdomen was taking place, and acute renal failure began.

9. On post-operative day 16, a critical care consult took place. Massive ascites were noted and a questionable diagnosis of biliary peritonitis was made. Patient A was admitted to intensive care. Paracentesis was performed that removed 4 liters of bile.

10. On post-operative day 18, Patient A underwent another surgery, a laparotomy and drainage. Diffuse reactive bowel peritonitis with multiple areas of fibrinous exudate was found. A #10 Jackson-Pratt drain was left in the gall bladder for drainage.

11. Patient A ultimately recovered and was discharged on July 11, 2005, thirty-one days after the laparoscopic cholecystectomy. He had acquired a MRSA infection while in the hospital and continued on vancomycin as an outpatient.

12. Patient B was a forty-nine (49) year old female at the time of the incidents in question. Her true identity is not disclosed to protect her privacy, but her identity is disclosed in the Patient Designation served on Respondent along with a copy of this Complaint.

13. Patient B was admitted for chest pain on January 19, 2007. An ultrasound of her gall bladder was positive for stones. A cystic duct obstruction was also found.

14. A laparoscopic cholecystectomy was performed on January 23, 2007.

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15. On post-operative day one, Patient B had increased liver function tests and increased abdominal pain with increased white count. Her temperature was 100 and urinary output was low. All of these findings were very abnormal for a routine laparoscopic cholecystectomy post-operative day one.

16. On January 25, 2007 and post-operative day two, Patient B suffered significant abdominal pain. Her heart rate climbed to 120. Her total bilirubin was rising, BUN 31, creatinine 1.5 all suggesting some acute renal failure and volume depletion.

17. The internal medicine physician was concerned about the abdomen and belly tenderness and guarding with decreased bowel sounds. But Respondent refused to get a CT scan of the abdomen and pelvis at this time.

18. Cardiology, renal and pulmonary consults were obtained that same day. The increased heart rate and blood pressure were believed to be secondary to pain. The patient was transferred to intermediate care and her fluids were increased.

19. Pain management was increased due to increasing abdominal pain on January 26, 2007. Her abdomen was noted as diffusely tender on deep palpation.

20. A CT scan was finally performed due to Patient B's progressive downward course on January 28, 2007. A duodenal rupture was identified. Respondent was notified of the CT scan results.

21. Respondent then performed the surgery. He noted that the edges of the duodenal injury were quite friable but still closed the defect any way. JP drains were added to get control of the leakage. This was not very successful. No attempt at diversion was made, and no attempt to place a feeding tube was made.

22. Patient B then underwent a prolonged and difficult post-operative course. During the course of the post-operative development, she developed enterocutaneous fistulas and multiple percutaneous drainages due to poor drainage of the duodenal fistula.

23. Patient B even required CT guided drainage on February 10, 2007. Further interventional radiology helped obtain adequate drainage, and she was discharged on May 17, 2007. This was four months after the initial laparoscopic cholecystectomy.

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24. Patient C was a fifty-nine (59) year old female at the time of the incidents in question. Her true identity is not disclosed to protect her privacy, but her identity is disclosed in the Patient Designation served on Respondent along with a copy of this Complaint.

25. Patient C was admitted for abdominal pain on June 16, 2005. This admission followed a laparoscopic sigmoid resection that was still causing pain.

26. The initial assessment was of potential peptic ulcer disease. An acid reducer, PPI, was prescribed. An EGD showed a hiatal hernia and some antral gastropathy on June 19, 2005.

27. A HIDA scan showed normal post-laparoscopic cholecystecomy with no evidence of a bile leak despite that no laparoscopic cholecystecomy was ever performed. This changed Respondent's diagnosis to acute cholecystitis that now required a laparoscopic cholecystectomy on June 20, 2005.

28. The gastroenterologist noted that the HIDA scan was questionably abnormal. She wished to discuss this with the radiologist. This never took place.

29. On June 22, 2005, the laparoscopic cholecystectomy was performed. The pathology report, however, came back a little strange. It showed acute and chronic serositis and peritonitis with minimal chronic inflammation and no gall stones. This was an odd pathology report for a gall bladder removal.

30. Two days later, on June 24, 2005, Patient C's temperature was noted at 101.7. Her abdomen was softly distended.

31. She began vomiting the next day, on June 25, 2005, and her temperature was noted at 102 the following day, June 26, 2005. Her abdomen was very soft, and a CT scan of the abdomen and pelvis was ordered to rule out an abscess. The CT scan showed moderate ascites and left hydronephrosis of uncertain etiology. This was missed by Respondent and was of medical significance.

32. Her temperature continued for a couple more days. She began to suffer from diarrhea on June 28, 2005.

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33. Patient C continued in the hospital. Her temperature continued to be high. It was measured at 101 on July 2, 2005. Her abdomen was soft with mild tenderness diffusely. Her condition continued as mentioned for several more days.

34. On July 6, 2005, her abdomen was again noted to be soft. Her fever increased to 102.9 on July 7, 2005. A CT scan was ordered that showed a pelvic abscess. CT guided drainage was performed that drained about 200 cc of serosanguinous fluid. The fluid was not pus and did not appear to be an abscess by description of the fluid.

35. Patient C's fevers continued and spiked to 104 on July 8, 2005. The drain started to be high output. This was very odd for drainage of a simple post-operative abscess. The infectious disease specialist questioned whether the fevers were secondary to an abscess or questionable bowel leak on July 9, 2005.

36. On July 10, 2005, the gastroenterologist noted that the pelvic abscess is high output of clear fluid that may be a urinary fistula. He ordered a creatinine on the drainage output. The creatinine was elevated on the fluid, so it was clear that Patient C had a urinary fistula. A possible bladder injury was suspected. A left ureteral injury was suspected as well. This diagnosis should have been made much earlier. The June 26, 2005 CT scan showed the left hydronephrosis that should have been followed up on and would have led to the correct diagnosis.

37. On July 13, 2005, Patient C underwent a left nephrostomy tube placement with ultrasound guidance. The left ureter was noted as obstructed. The obstruction was most likely secondary from the previous sigmoid resection which was the very reason Patient C was admitted on June 16, 2005 in the first place.

38. Finally, on July 30, 2005, a left ureteral repair was performed. The proper diagnosis led to the proper surgical repair. Patient C was discharged home on August 10, 2005.

39. Patient D was a seventy-one (71) year old female at the time of the incidents in question. Her true identity is not disclosed to protect her privacy, but her identity is disclosed in the Patient Designation served on Respondent along with a copy of this Complaint.

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40. Patient D was admitted for a two week history of hematemesis and melena on December 29, 2006. A prior CT scan showed a gastric wall thickness involving the antrum and pylorus with numerous sub-centimeter hypo-attenuating liver lesions.

41. On December 31, 2006, Respondent noted the gastric mass, GI bleed with anemia, likely adenocarcinoma. Surgery was scheduled for January 3, 2007.

42. An EGD biopsy showed mild chronic gastritis, neutrophilic fibrinous exudates consistent with the surface of an ulcer. There was no evidence of cancer in the pathology specimen. The pathology report states that the etiology of the ulcer cannot be determined from the sample and that surgery is planned for diagnosis and treatment.

43. On January 3, 2007, Respondent performed surgery on Patient D. Respondent found a large mass involving and extending through the pylorus into the first portion of the duodenum. The tissue appeared to be chronically inflamed with a mass adhered to the gallbladder, liver and periportal structures.

44. After extensive surgery and dissection of much of the stomach and pancreas, a gastrojejunostomy and a side-to-side choledochojejunostomy was performed by Respondent. No mention of any frozen sections being performed to determine whether this was a carcinoma or not. Additionally, no liver biopsy was performed despite the previous CT scan demonstrating multiple lesions in the liver.

45. Patient D was placed on a ventilator and was admitted to the ICU. She remained in the ICU and continued to worsen.

46. On January 6, 2007, Patient D was re-intubated. The renal consult found that the acute renal failure was stable, but noted possible sepsis of abdominal origin. He wished to order a CT with IV contrast.

47. Respondent found that Patient D's hemoglobin was 9.2, hematocrit 26.7 and white cell count 14.5. Despite this, Respondent thought that Patient D was having a post-operative MI or PE, and he canceled the abdominal CT scan.

48. Patient D remained severely acidotic with apparent sepsis. Yet, no further comment was made by Respondent as to a possible abdominal origin for the sepsis.

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49. On January 8, 2007, Patient D remained intubated and in critical condition. Respondent asked for another CT scan of the abdomen and pelvis.

50. On January 9, 2007, a CT scan of the abdomen and pelvis was performed. Several fluid collections were identified in the pelvis extending around the right kidney towards the porta hepatic. Patient D continued to deteriorate clinically with a heart rate in the 120-170s on multiple pressors.

51. She remained critical through January 10, 2007. Due to the poor prognosis and continued critical status, the family wished life-support withdrawn.

52. Patient D died on January 11, 2007.

Count I

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

54. 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.

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

56. Respondent failed to use the reasonable care, skill, or knowledge ordinarily used under the same or similar circumstances with Patient A when he failed and omitted to recognize a bile leak early on in the post-operative treatment leading to multiple medical deteriorations, including renal failure, hypotension and an exceedingly long hospital stay.

57. By reason of the foregoing, Respondent 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

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

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59. 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.

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

61. Respondent failed to use the reasonable care, skill, or knowledge ordinarily used under the same or similar circumstances with Patient B when he failed and omitted to timely recognize a bowel injury post-operatively, actively canceled a CT scan from being ordered which would have diagnosed the bowel injury easily, performed a surgery that was not likely to provide adequate drainage of a duodenal injury and did not provide access to the rest of the GI tract for feedings.

62. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

Count III

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

64. 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.

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

66. Respondent failed to use the reasonable care, skill, or knowledge ordinarily used under the same or similar circumstances with Patient C when he failed and omitted to discover an injury to the ureter that occurred prior to the laparoscopic cholecystectomy, improperly performed the laparoscopic cholecystectomy, missed the findings on the pathology report and on the CT scan and put Patient C at increased risks of sepsis and multiple organ failure from intra-abdominal urinoma.

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67. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

Count IV

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

69. 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.

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

71. Respondent failed to use the reasonable care, skill, or knowledge ordinarily used under the same or similar circumstances with Patient D when he failed and omitted to identify the true diagnosis pre-operatively, failed to identify the true diagnosis with frozen sections, performed an extensive surgery when a less aggressive approach may have been called for and canceled a post-operative CT scan ordered by another consultant.

72. By reason of the foregoing, Respondent 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 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 Section 630.339 of the Nevada Revised Statutes within twenty (20) days of service of the Complaint.

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

3. That the Nevada State Board of Medical Examiners determine what sanctions it determines to impose if it determines there has been a violation or violations of the Medical Practice Act (Nevada Revised Statutes Chapter 630) committed by Respondent; and

4. That the Nevada State Board of Medical Examiners make, issue and serve on

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Respondent 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 16th day of June, 2010.

THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
Bradley O. Van Ry, Esq.
Deputy General Counsel and Attorney for the Investigative Committee

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF DOUGLAS)

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

Dated this 16th day of June, 2010.

CHARLES N. HELD, M.D.

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CERTIFICATE OF MAILING

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on 16th day of June 2010; I served a file copy of the COMPLAINT, PATIENT DESIGNATION & Fingerprint Information, by mailing via USPS certified return receipt to the following:

Stuart Hoffman, M.D.
11160 Verismo St.
Las Vegas, NV 89141

Dated this 16th day of June 2010.

Angelia L. Donohoe
Legal Assistant

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