

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

In The Matter of Charges and)
)
Complaint Against)
)
STUART MICHAEL HOFFMAN, M.D.,)
)
Respondent.)

Case No. 10-20386-1

FILED

JUN 16 2010

NEVADA STATE BOARD OF
MEDICAL EXAMINERS

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

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

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

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

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

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

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

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

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

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

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

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

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

5 16. On January 25, 2007 and post-operative day two, Patient B suffered significant
6 abdominal pain. Her heart rate climbed to 120. Her total bilirubin was rising, BUN 31, creatinine
7 1.5 all suggesting some acute renal failure and volume depletion.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 34. On July 6, 2005, her abdomen was again noted to be soft. Her fever increased to
5 102.9 on July 7, 2005. A CT scan was ordered that showed a pelvic abscess. CT guided drainage
6 was performed that drained about 200 cc of serosanguinous fluid. The fluid was not pus and did
7 not appear to be an abscess by description of the fluid.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

OFFICE OF THE GENERAL COUNSEL

Nevada State Board of Medical Examiners
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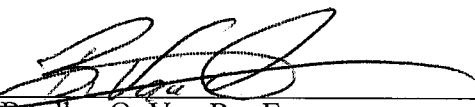
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Respondent its findings of facts, conclusions of law and order, in writing, that includes the sanctions imposed; and

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

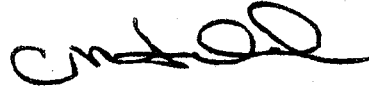
VERIFICATION

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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.



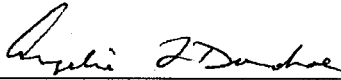
CHARLES N. HELD, M.D.

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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