BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In The Matter of Charges and	**Case No. 11-8513-1**
Complaint Against	
EUGENE GREGORY PORRECA, M.D.,	
Respondent.	

FILED
MAY - 6 2011
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

COMPLAINT

The Investigative Committee of the Nevada State Board of Medical Examiners, composed at the time filing of Benjamin J. Rodriguez, M.D., Chairman, Beverly A. Neyland, M.D., Member, and Donna A. Ruthe, Member, having a reasonable basis to believe that Eugene Gregory Porreca, 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's license is currently listed as active status (License No. 5987), and has been so licensed since December 2, 1989 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 seventy-two year old (72) 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.

3. On June 5, 2007, Patient A presented to St. Rose Dominican Hospital-San Martin Campus for elective revision of a left total knee arthroplasty. When the tourniquet was released from the original surgery, a lacerated popliteal artery was observed.

4. Respondent was called to repair the popliteal artery injury. A first surgery was performed at around noon where a Fogarty catheter was passed but couldn't go down more than a few centimeters because it was close to the presumed bifurcation.

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5. Surprisingly, Respondent left no details of how he performed the anastamosis, no description of the presence of back bleeding from the popliteal artery and no description of how he assessed distal perfusion during the procedure. Further, no mention is made that consideration was given to an intraoperative arteriogram.

6. Around 2:00 p.m. that afternoon, there was a decrease in sensation in Patient A's left foot and a change in the Doppler examination. An arteriogram was ordered.

7. The arteriogram showed thrombosis of the popliteal artery. Significantly, the anterior tibial, the peroneal and posterior tibial arteries were visualized and continuous to the distal calf. Attenuation of the proximal tibial vessels was noted by the radiologist likely representing extension of a clot into the aforementioned vessels.

8. A short time after the arteriogram, Patient A was returned to the operating room. Respondent then performed a bypass with Gore-tex.

9. Continued poor documentation of Patient A's surgeries continued. There is no mention of how Respondent assessed the distal perfusion. Respondent also failed to document that there was a pulse or Doppler signal in the artery beyond the Gore-tex graft. Finally, an arteriogram was not performed.

10. Over the next twenty-four (24) hours, there was documented absent Doppler flow with progressive numbness and a loss of sensation in Patient A's left lower leg. The continued inadequate perfusion indicated failure of the second bypass to reperfuse the leg.

11. The failure of Respondent to recognize and correct the inadequate perfusion and presumed failure of revascularization of the left lower leg led to progressive, irreversible tissue damage and compartment syndrome. It ultimately resulted in above the knee amputation of the left lower leg.

Count I

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

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13. 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.

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

15. Respondent failed to use the reasonable care, skill, or knowledge ordinarily used under the same or similar circumstances when, among other things, he failed and omitted to recognize the signs of profound, limb threatening ischemia, failed and omitted to act immediately following the second surgery to understand why the failure occurred, and failed and omitted to correct the failure following the second surgery.

16. 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

17. All of the allegations in the above paragraphs are hereby incorporated as if fully set forth herein.

18. Nevada Revised Statute Section 630.3062(1) 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 discipline against a licensee.

19. Respondent failed to ensure that Patient A's records were correctly and timely updated. Many significant details are not included in Patient A's records.

20. 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.

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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;

4. That the Nevada State Board of Medical Examiners make, issue and serve on 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 6th day of May, 2011.

THE INVESTIGATIVE COMMITTEE OF 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 CLARK)

Benjamin J. Rodriguez, 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 6th day of May, 2011.

BENJAMIN J. RODRIGUEZ, 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 9th day of May 2011, I served a file copy of the COMPLAINT, PATIENT DESIGNATION & Fingerprint Information, by mailing via USPS certified return receipt mail to the following:

Eugene Porreca, M.D.
2655 Box Canyon Dr., Ste. 110
Las Vegas, NV 89128

Dated this 9th day of May 2011.

Angelia L. Donohoe
Legal Assistant

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