BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **RANDY HITT BUTLER, M.D., Respondent.**	**Case No. 21-8922-1**

FILED
AUG 31 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 BRANDEE MOONEYHAN, J.D., Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that RANDY HITT BUTLER, 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. 6224). Respondent was originally licensed by the Board on March 16, 1991.

2. Patient A[2] was a thirty-seven (37) year-old male when the events at issue began.

3. On or about April 21, 2015, Patient A presented to Respondent for an examination due to a "non-tender knot on th[e] right testicle" that had been present for several months.

4. Respondent's notes of the April 21, 2015, visit indicated that Patient A's "[r]ight testicle [was] smaller than left and probably atrophic," and that Patient A had a "[s]mall 2-3mm raised lump in inferior aspect of right testicle." At this visit Respondent ordered an ultrasound of

[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., Victor M. Muro, M.D., and Ms. Sandy Peltyn.

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

Patient A's scrotum and blood tests to measure Patient A's prostate-specific antigen (PSA) and human chorionic gonadotropin (hCG) levels.

5. The ultrasound revealed, in part, that Patient A's "right testicle demonstrates 3 separate solid hypoechoic lesions with some associated calcifications." The ultrasound report stated that the lesions and/or calcifications on Patient A's right testicle were "suspicious in nature."

6. The test results of Patient A's PSA and hGC levels were within normal ranges.

7. On or about May 10, 2015, Respondent and Patient A had a telephone conversation to discuss the results of the ultrasound and PSA/hCG tests, during which he told Patient A that he had "nothing to worry about" with respect to the lump in his right testicle and that no follow-up care was necessary.

8. In September 2015, Patient A sought a second opinion from a different doctor regarding the knot in his right testicle.

9. It was not until he was seeking a second opinion that Patient A received a copy of his April 30, 2015, ultrasound.

10. Pursuant to the direction of the doctor providing a second opinion, Patient A had a second scrotal ultrasound on September 15, 2015. This ultrasound indicated that two (2) of the lesions on Patient A's right testicle had grown since the April 2015 ultrasound.

11. The doctor providing a second opinion immediately referred Patient A to a urologist.

12. The urologist recommended that Patient A undergo a radical orchiectomy of his right testicle, which he did on October 2, 2015.

13. Subsequent pathology showed that the lesions in Patient A's testicle were cancerous, specifically, they were eighty per cent (80%) seminoma and twenty per cent (20%) embryonal carcinoma with microvascular invasion indicated.

14. Respondent's failure to recognize that an ultrasound showing hypoechoic lesions required immediate referral to a urologist resulted in Patient A's diagnosis and treatment for testicular cancer being delayed by at least four (4) months.

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COUNT I

NRS 630.306(1)(b)(2) – Violation of Standards of Practice Established by Regulation

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

16. Violation of a standard of practice adopted by the Board is grounds for disciplinary action pursuant to NRS 630.306(1)(b)(2).

17. NAC 630.210 requires a physician to "seek consultation with another provider of health care in doubtful or difficult cases whenever it appears that consultation may enhance the quality of medical services."

18. Respondent failed to seek consultation with a urologist to determine the appropriate treatment after an ultrasound showing hypoechoic lesions in Patient A's right testicle, which were deemed "suspicious in nature," and such consultation likely would have enhanced the quality of medical care provided to Patient A by resulting in a more prompt diagnosis and treatment for testicular cancer.

19. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners 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);

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 case 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 31st day of August, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Brandee Mooneyhan

BRANDEE MOONEYHAN, J.D.
Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: mooneyhanb@medboard.nv.gov
Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
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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 31 day of August, 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

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Nevada State Board of Medical Examiners
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CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 31st day of August, 2021, I served a file-stamped copy of the foregoing **COMPLAINT**, via U.S. Certified Mail to the following parties:

RANDY HITT BUTLER, M.D.
c/o John H. Cotton, Esq.
7900 West Sahara Avenue, Suite 200
Las Vegas, NV 89177
Certified Mail Receipt No.: 9171 9690 0935 0252 1563 30

DATED this 31st day of August, 2021.

MERCEDES FUENTES
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
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