

1 **BEFORE THE BOARD OF MEDICAL EXAMINERS**  
2 **OF THE STATE OF NEVADA**

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4  
5 **In the Matter of Charges and Complaint**

**Case No. 22-31575-1**

6 **Against:**

7 **DIETRICH VON FELDMANN, M.D.,**

8 **Respondent.**

FILED

MAR - 1 2022

NEVADA STATE BOARD OF  
MEDICAL EXAMINERS

By: \_\_\_\_\_

9  
10 **COMPLAINT**

11 The Investigative Committee<sup>1</sup> (IC) of the Nevada State Board of Medical Examiners  
12 (Board), by and through Ian J. Cumings, J.D., Deputy General Counsel and attorney for the IC,  
13 having a reasonable basis to believe that Dietrich Von Feldmann, M.D. (Respondent) violated the  
14 provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC)  
15 Chapter 630 (collectively, the Medical Practice Act), hereby issues its Complaint, stating the IC's  
16 charges and allegations as follows:

17 1. Respondent was at all times relative to this Complaint, a physician licensed to  
18 practice medicine in the State of Nevada (License No. 12002). Respondent was originally licensed  
19 by the Board on August 17, 2006.

20 **A. Respondent's Treatment of Patient A**

21 2. Patient A was an 80-year-old year-old male when he presented to the Respondent for  
22 medical care on June 20, 2018. Patient A's true identity is not disclosed herein to protect his privacy,  
23 but is disclosed in the Patient Designation served upon Respondent along with a copy of this  
24 Complaint.

25 3. Patient A presented to Respondent on June 20, 2018, for a surveillance colonoscopy  
26 due to a personal history of colon polyps.

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28 <sup>1</sup> 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 Victor M. Muro, M.D., Chairman,  
Ms. April Mastroluca, Weldon Havins, M.D., J.D.

1           4.       During the procedure, Respondent discovered a number of flat cecal polyps and  
2 performed an endoscopic mucosal resection on a 1 cm flat cecal polyp, in addition to a second  
3 ascending colon polyp.

4           5.       Patient A developed abdominal post-operative pain. Respondent informed Patient A  
5 that there was a risk of developing post polypectomy coagulation necrosis syndrome as a result of  
6 the procedure and that he would feel better after he passed some gas. Patient A was then  
7 discharged.

8           6.       Patient A's spouse contacted Respondent on the evening of June 20, 2018, when  
9 Patient A's abdominal pain had worsened (to a 10/10 on the pain scale). Respondent failed to order  
10 an immediate abdominal radiograph to rule out colon perforation, and only considered a diagnosis of  
11 post polypectomy coagulation necrosis syndrome and prescribed oxycontin for pain.

12          7.       Patient A continued to suffer with severe pain in his abdomen and returned to the  
13 Emergency Room on the morning of June 21, 2018, whereupon Patient A underwent a CT scan of  
14 the abdomen and pelvis, which showed a large amount of free air in the right upper quadrant of the  
15 abdomen.

16          8.       Respondent viewed Patient A's CT scan on June 21, 2018, and failed to recognize  
17 that the large amount of free air in Patient A's abdomen indicated possible colon perforation which  
18 warranted immediate surgical evaluation.

19          9.       Patient A was transferred by air ambulance to Renown Medical Center by his  
20 primary care provider due to the concerning findings on the CT scan, whereupon Patient A was  
21 taken for an exploratory laparotomy, right hemicolectomy, and partial omentectomy.

22          10.      The surgical report from Renown Medical Center showed a dilated proximal colon  
23 of at least 10cm. There was splitting of the serosa for at least 9cm along the ascending colon and  
24 extensive air within the pericolonic tissue consistent with a perforated colon due to iatrogenic injury.  
25 Patient A spent eight (8) days in the hospital and was discharged on June 29, 2018.

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COUNT I

**NRS 630.301(4) - Malpractice**

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

12. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.

13. NAC 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. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances with respect to the treatment of Patient A by failing to order an immediate abdominal radiograph to exclude the possibility of colon perforation when Patient A complained of severe pain on June 20, 2018, after the colonoscopy that Respondent performed. Furthermore, Respondent committed malpractice by his failure to recognize and appreciate the gravity of free air in the right upper quadrant which suggested colon perforation and warranted immediate surgical evaluation.

15. By reason of the foregoing, Respondent is subject to discipline by the Board 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;

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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 1 day of March, 2022.

INVESTIGATIVE COMMITTEE OF THE  
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:



IAN J. CUMINGS, J.D.  
Deputy General Counsel  
9600 Gateway Drive  
Reno, NV 89521  
Tel: (775) 688-2559  
Email: [icumings@medboard.nv.gov](mailto:icumings@medboard.nv.gov)  
*Attorney for the Investigative Committee*

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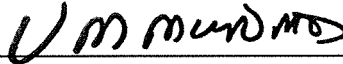
**VERIFICATION**

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 18<sup>th</sup> day of March, 2022.

INVESTIGATIVE COMMITTEE OF THE  
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:   
VICTOR M. MURO, M.D.  
*Chairman of the Investigative Committee*