

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

3                                   \* \* \* \* \*

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

**Case No. 22-6386-1**

6 **Against:**

**FILED**

7 **FRANK VICTOR RUECKL, M.D.,**

**MAY 25 2022**

8 **Respondent.**

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 Frank Victor Rueckl, M.D. (Respondent) violated the  
14 provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code  
15 (NAC) Chapter 630 (collectively, the Medical Practice Act), hereby issues its Complaint, stating  
16 the IC's charges and allegations as follows:

17                   1.       Respondent was at all times relative to this Complaint a physician holding an active  
18 license to practice medicine in the State of Nevada (License No. 4409). Respondent was  
19 originally licensed by the Board on October 3, 1981.

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

21                   2.       Patient A<sup>2</sup> was a 39-year-old female when she first presented to Respondent for a  
22 cosmetic consultation.

23                   3.       On December 20, 2016, Patient A was seen by Respondent for a consultation  
24 regarding options for decreasing inner thigh fat. Respondent recommended utilizing mesotherapy

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27                   <sup>1</sup> The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal  
28 Complaint was authorized for filing, was composed of Board members Victor M. Muro, M.D., Ms. April Mastroluca,  
and Weldon Havins, M.D., J.D.

<sup>2</sup> Patient A's identity is not disclosed herein to protect her privacy but is disclosed in the Patient Designation  
served upon Respondent along with a copy of this Complaint.

1 treatments with Kybella to decrease inner thigh fat. Mesotherapy consists of numerous injections  
2 into the mesoderm aimed at diminishing excess fat.

3 4. Respondent's treatment plan was to use compounded deoxycholic acid at 4.75%  
4 with lidocaine which is not FDA approved as opposed to Kybella, which is solely composed of  
5 deoxycholic acid and is FDA approved for the treatment of submental fat of the upper neck only.

6 5. Listed side effects for Kybella include injection site problems such as hair loss,  
7 bruising, open sores, tissue damage, necrosis, and cell death around the injection site.

8 6. On January 5, 2017, Patient A signed a consent form for mesotherapy utilizing  
9 deoxycholic acid with lidocaine. No location on Patient A's body for the treatment was noted on  
10 the consent form.

11 7. The consent form provided: "[p]atients may experience redness, itching, and/or  
12 blistering, which is short lived and treated with mild topical cortisones. It does not leave any  
13 scarring or have any permanent effects."

14 8. Patient A was not given informed consent that compounded deoxycholic acid with  
15 lidocaine is not FDA approved, and injection of Kybella or compounded deoxycholic acid with  
16 lidocaine for any site other than submental fat of the neck is an off-label use.

17 9. Patient A was not given informed consent of any rare side effects associated with  
18 deoxycholic acid which include tissue damage, necrosis, and cell death around the injection site.

19 10. On January 5, 2017, Respondent administered a mesotherapy treatment consisting  
20 of 4.75% deoxycholate and lidocaine to Patient A's inner thigh area. Immediately following  
21 Respondent's treatment, Patient A experienced severe bruising and blisters at the injection site.

22 11. On January 11, 2017, at a follow-up appointment, Patient A presented with signs of  
23 infection, tenderness, redness, and inflammation. Respondent ordered antibiotics to treat the  
24 infections at injection sites.

25 12. By January 18, 2017, Patient A failed to improve with antibiotics. Patient A  
26 presented to Respondent, who noted Patient A's condition was worsening with tenderness and  
27 redness around the injection sites. Respondent prescribed steroids, and a second round of  
28 antibiotics and but did not refer Patient A for more specialized wound care.

1 13. Following the January 18, 2017, visit, Patient A did not return to Respondent for  
2 any follow-up appointments or care. Neither the Respondent or clinical staff made any attempt to  
3 contact Patient A or refer her to another physician after the January 18, 2017, to inquire about the  
4 Patient's rare and serious complications as a result of the Mesotherapy.

5 14. On January 23, 2017, Patient A sought a second opinion and received medical care  
6 from a Board-Certified Plastic Surgeon. It was determined that the wounds on Patient A's thighs  
7 were necrotic which required surgical debridement under general anesthesia.

8 **COUNT I**

9 **NRS 630.301(4) - Malpractice**

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

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

14 17. NAC 630.040 defines malpractice as "the failure of a physician, in treating a  
15 patient, to use the reasonable care, skill, or knowledge ordinarily used under similar  
16 circumstances."

17 18. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed  
18 to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when  
19 rendering medical services to Patient A by failing to provide informed consent for deoxycholic  
20 acid injections into a non-FDA approved injection site, and for failing to follow up with Patient A  
21 after January 18, 2017, despite the rare and serious complication after the mesotherapy treatment  
22 and resultant infection.

23 19. By reason of the foregoing, Respondent is subject to discipline by the Board as  
24 provided in NRS 630.352.

25 **COUNT II**

26 **NRS 630.3062(1)(a) - Failure to Maintain Proper Medical Records**

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

1 21. NRS 630.3062(1)(a) provides that the “failure to maintain timely, legible, accurate  
2 and complete medical records relating to the diagnosis, treatment and care of a patient” constitute  
3 grounds for initiating discipline against a licensee.

4 22. Respondent failed to maintain proper medical records relating to the diagnosis,  
5 treatment, and care of Patient A, by failing to correctly document his actions when he treated  
6 Patient A, whose medical records were not timely, legible, accurate, and complete. Respondent  
7 failed to document informed consent for Patient A’s mesotherapy and the associated risks of  
8 Kybella, and compounded deoxycholic acid injections.

9 23. By reason of the foregoing, Respondent is subject to discipline by the Board as  
10 provided in NRS 630.352.

11 **COUNT III**

12 **NRS 630.306(1)(b)(2) - Violation of Standards of Practice Established by Regulation**

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

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

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

20 27. Respondent failed to timely seek consultation with regard to Patient A’s medical  
21 condition after January 18, 2018, and Respondent should have consulted with an appropriate care  
22 provider to address the doubtfulness of the diagnosis of Patient A’s medical condition and such a  
23 timely consultation would have confirmed or denied such a diagnosis and may have enhanced the  
24 quality of medical care provided to the Patient with regard to the infection and resultant necrosis.

25 28. By reason of the foregoing, Respondent is subject to discipline by the Nevada State  
26 Board of Medical Examiners as provided in NRS 630.352.

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COUNT IV

**NRS 630.306(1)(f) - Lack of Specific Informed Consent**

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

30. According to NRS 630.306(1)(f) performing any procedure or prescribing any therapy which by the current standards of practice of medicine is experimental requires specific informed consent. These consents regularly include the goals, benefits, risks, and alternative therapies for the treatment being offered.

31. Respondent's records did not contain specific informed consent advising Patient A that compounded deoxycholic acid with lidocaine was not FDA approved nor advised Patient A of risks including the possibility of skin breakdown, scarring or necrotic tissue forming. Additionally, Respondent failed to obtain informed consent by failing to discuss the serious side effects for the mesotherapy treatments that were used off-label.

32. By reason of the foregoing, Respondent has violated NRS 630.306(1)(f) and 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

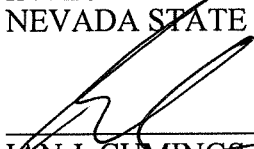
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6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 25 day of May, 2022.

INVESTIGATIVE COMMITTEE OF THE  
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:



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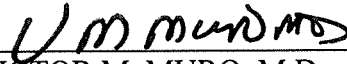
**VERIFICATION**

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 25<sup>th</sup> day of May, 2022.

INVESTIGATIVE COMMITTEE OF THE  
NEVADA STATE BOARD OF MEDICAL EXAMINERS

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