BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: LESLIE KAY BROWDER, M.D., Respondent.	Case No. 24-12686-1

FILED

FEB 26 2024

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through William P. Shogren, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Leslie Kay Browder, 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. 12359). Respondent was originally licensed by the Board on July 6, 2007.

2. Patient A[2] was a forty-seven (47) year-old female at the time of the events at issue.

3. On February 6, 2017, Patient A was admitted to the hospital for a diagnostic laparoscopy and pelvic mass removal. The procedure was converted to an exploratory laparotomy with lysis of adhesions, resection of Patient A's rectosigmoid, and resection of the pelvic mass, due to the extensive nature of the adhesive disease that was found during the procedure.

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[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 Victor M. Muro, M.D., Chowdhury H. Ahsan, M.D., Ph.D., FACC, and Ms. Pamela Beal.

[2] Patient A's true 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.

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4. As a result of the surgery, on or about February 6, 2017, Patient A suffered an anastomotic leak.

5. Respondent assumed care of Patient A starting on February 10, 2017. Respondent documented that Patient A had low-grade fevers and a high white blood cell count (leukocytosis) starting after the surgery. Respondent did not order any further evaluations of Patient A's condition, such as a computed tomography (CT) of the abdomen and pelvis.

6. On February 11, 2017, Patient A had a concerning drop in white blood cell count, from leukocytosis to leukopenia, indicating possible sepsis. That same day, a supine abdominal x-ray was obtained, showing the possible presence of air in Patient A's abdominal cavity (pneumoperitoneum).

7. The same day, the radiologist who reviewed the x-ray noted "diffuse central lucency that could represent pneumoperitoneum." The radiologist recommended "further evaluation with either upright or decubitus film."

8. On February 11, 2017, Respondent did not order an upright abdominal x-ray or CT of the abdomen and pelvis. Respondent further did not order or perform an exploratory laparotomy. Respondent's notes from this date do not indicate the possibility of an anastomotic leak.

9. Between February 6, 2017, and February 12, 2017, Patient A also did not have any bowel movements.

10. On February 12, 2017, Patient A's sepsis progressed to shock, deoxygenation, and admission to the intensive care unit. After taking diagnostics, Respondent's pre-operative diagnosis listed free air intraperitoneal and perforated viscus. Respondent then performed an exploratory surgery. Respondent's post-operative diagnosis listed an anastomotic leak and feculent peritonitis.

11. Between February 17, 2017, and March 10, 2017, Patient A's condition worsened and she developed acute respiratory distress syndrome. On March 1, 2017, Patient A began hemodialysis.

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12. On March 10, 2017, Patient A's dialysis was stopped because of a clogged port. Patient A did not receive surgery for a new port and was taken off life support measures, subsequently dying on March 14, 2017.

COUNT I

NRS 630.301(4) - Malpractice

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

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

15. 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."

16. 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 when rendering medical services to Patient A, by failing to timely consider and treat Patient A's anastomotic leak. Respondent's failure to address Patient A's condition included (1) not appropriately and timely ordering x-rays and a CT scan of the abdomen, despite clear evidence of leukocytosis; and (2) failure to consider an exploratory laparotomy prior to additional imaging that Patient A received.

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

COUNT II

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

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

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

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20. Respondent failed to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to correctly document the possibility of an anastomotic leak on the evening of February 11, 2017, and by failing to correctly document the possibility of pneumoperitoneum on February 11, 2017.

21. 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 her and give notice that she 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 26th day of February, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

WILLIAM P. SHOGREN
Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: shogrenw@medboard.nv.gov
Attorney for the Investigative Committee

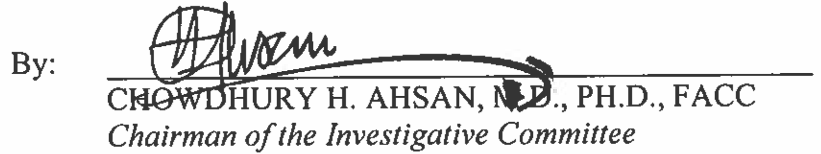
VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Chowdhury H. Ahsan, M.D., Ph.D., FACC, 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 26th day of February, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

CHOWDHURY H. AHSAN, M.D., PH.D., FACC
Chairman of the Investigative Committee

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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 26th day of February, 2024, I served a file-stamped copy of the foregoing **COMPLAINT** and **PATIENT DESIGNATION** via USPS Certified Mail postage pre-paid, to the following parties:

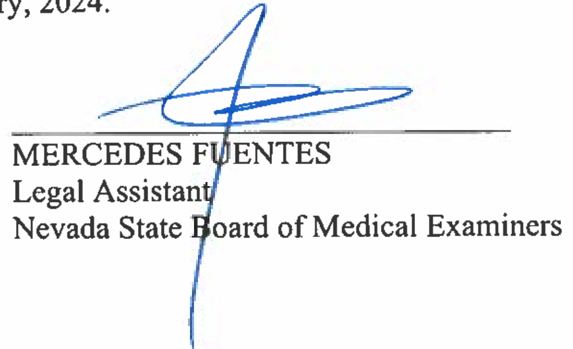
LESLIE KAY BROWDER, M.D.
700 Shadow Lane, #370
Las Vegas, NV 89106

Tracking No.. 9171 9690 0935 0241 6159 85

With courtesy copy by email to:

LESLIE KAY BROWDER, M.D.: lesliebrowder99@gmail.com

DATED this 26th day of February, 2024.



MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners