OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **MELISSA MARIE MILES, M.D., Respondent.**	**Case No. 24-47082-1**

FILED
JUN 21 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 Donald K. White, Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Melissa Marie Miles, 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. 17221). Respondent was originally licensed by the Board on July 1, 2017.

2. Patient A[2] was a fifty (50) year-old male at the time of the events at issue. On December 23, 2020, Patient A was treated by a gastroenterologist, underwent a colonoscopy in which the findings were an ascending colon mass and he had a biopsy of an adenoma. He was referred to a surgeon because the colon mass was deemed not endoscopically removable by the doctor performing the colonoscopy.

///

[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 Chowdhury H. Ahsan, M.D., Ph.D., FACC, Ms. Pamela Beal, and Irwin Simon, M.D., FACS.

[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.

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

3. On February 15, 2021, Patient A presented to Respondent for the surgery and had preoperative labs that were within normal limits. Respondent chose to do a robotic right hemicolectomy which was documented as uneventful despite complications and/or significant deviations to accepted normal care and procedures.

4. Pathology showed a two-centimeter tubulovillous adenoma without high grade dysplasia or cancer and was pedunculated.

5. Soon after the operation, Patient A experienced hypertension followed by hypotension and tachycardia which gradually worsened throughout the day and into the evening.

6. On February 16, 2021, post-operative day (POD) one (1), Patient A experienced severe tachycardia with peaks of 180 bpm and 140 bpm sustained. Patient A's labs were hematocrit of 27 from 45 (hemoglobin of 15.3 and 8.6), creatinine 2.1 from 1.0, and estimated glomerular filtration rate of 41 from 99. Nursing notes reported dizziness and orthostatic hypotension. Respondent's progress note reported the leukocytosis was reactive and the acute renal failure was from dehydration. However, Patient A had an acute bleeding event resulting in acute renal failure.

7. On February 17, 2021, POD two (2), Patient A experienced dyspnea with hypoxia, tachycardia, worsening renal function (Cr 3.16), a lactate of 4, and decreasing hematocrit (23). Respondent's progress notes indicate a chest X-ray (CXR) showing fluid overload, but an echocardiogram was performed, and the results were normal. Respondent ordered a renal ultrasound which was also normal and reported that there were no signs of infection.

8. On February 18, 2021, POD three (3), nursing notes indicated an episode of ventricular tachycardia lasting about ten (10) seconds when Patient A arose from bed, but he was reportedly asymptomatic. However, labs showed abnormal creatine kinase of 1165, hematocrit of 23, and creatinine of 1.7.

9. On February 19, 2021, POD four (4), Patient A developed a fever of 102.4, and his hematocrit was critically low at 19. Lactic acid trended down to 1.8 and Patient A was given a blood transfusion. Another on-call provider ordered a CT of the chest, abdomen, and pelvis which showed fluid in the right abdomen, a single extra-luminal gas pocket, and dilated loops of bowel.

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

10. On February 20, 2021, POD five (5), Patient A's leukocytosis increased to 14.2 (10% bandemia) and antibiotics were started due to a concern for development of an intraabdominal abscess. Patient A had distension of the abdomen and a nasogastric tube was placed due to concern for small bowel obstruction or ileus. Pulmonary embolism was ruled-out with a negative VQ scan and Patient A's lactic acidosis normalized to 1.3.

11. On February 21, 2021, POD six (6), Patient A underwent CT guided drainage of right paracolic fluid collection (presumed abscess) which revealed dark blood mixed with purulent fluid. Patient A's mental status changed with delirium prompting a negative CT scan of his head and his lactic acid remained low at 1.2.

12. On February 22, 2021, POD seven (7), Respondent returned as the attending physician for Patient A.

13. On February 23, 2021, POD eight (8), Patient A's leukocytosis increased to 20.1, an increased volume and "change in fluid consistency" of the interventional radiology (IR) pigtail drain output, which prompted a robotic laparotomy converted to an open exploratory laparotomy, resection of anastomosis, placement of another anastomosis and evacuation of a "small hematoma" in Patient A's pelvis. Respondent noted severe omental adhesions caused by an anastomosis leak draining bilious fluid in the right paracolic gutter. According to Respondent, the anastomosis had "failure of staples" and pathology revealed a large anastomosis defect of 4.5 cm x 2 cm, resulting in a large amount of blood loss from Patient A.

14. Postoperatively on POD eight (8), Patient A developed worsening tachycardia (HR 126) and sanguinous output from the IR pigtail drain. After approximately two (2) hours postoperative, the CRNA reported Patient A somnolent and then he became unresponsive. A code white was called, Patient A was intubated and brought to the ICU, where a negative CT scan of his head was obtained and Patient A experienced cardiac arrest while in radiology. Staff performed CPR for thirty (30) minutes but unfortunately, Patient A succumbed to his medical condition.

///

///

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

COUNT I

NRS 630.301(4) - Malpractice

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

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

17. 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."

18. 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, when:

a. On POD 1, she failed to be more diligent when Patient A had an acute change in vital signs, a drop in hemoglobin, increased lactate, severe tachycardia, hypotension, and decreasing hematocrit, the latter three indicating active bleeding that should have been addressed;

b. On POD 4, she failed to adequately investigate for an anastomosis leak or respond to the anastomosis leak in a timely fashion and;

c. On POD 8, she delayed surgery, although Patient A remained hemodynamically unstable with tachycardia, increasing leukocytosis, and a CT scan indicated fluid and free air in the abdomen. Respondent's delay in treatment resulted in acute blood loss anemia, acute renal failure, and sepsis from a leaking anastomosis.

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

COUNT II

NRS 630.306(1)(g) - Continual Failure to Exercise Skill or Diligence

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

21. Continual failure by the Respondent to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field is grounds for disciplinary action against a licensee pursuant to NRS 630.306(1)(g).

22. Respondent continually failed to exercise skill or diligence as demonstrated by her repeated inability to appreciate the complications presented in Patient A, in addition to the multiple unstable laboratory results. Respondent also failed to adequately investigate for an anastomosis leak or respond to the anastomosis leak in a timely fashion. These issues were not addressed by Respondent until the delayed surgery on POD eight (8), even when Patient A remained hemodynamically unstable with tachycardia, had increasing leukocytosis, and a CT scan indicated fluid and free air inside Patient A.

23. 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 her 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

///

///

///

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

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

DATED this 21st day of June, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

DONALD K. WHITE
Senior Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: dwhite@medboard.nv.gov
Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

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 21st day of June, 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