BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: THOMAS WALTER UMBACH, M.D., Respondent.	Case No. 24-33880-1

FILED
MAY 31 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By: [signature]

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 Alexander J. Hinman, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Thomas Walter Umbach, 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. 12712). Respondent was originally licensed by the Board on June 6, 2008, and has a specialty in surgery.

2. Patient A[2] was a thirty-eight (38) year-old female at the time of the events at issue.

3. On November 21, 2011, Patient was evaluated by Respondent for bariatric surgery. At this time, Patient A was classified as morbidly obese with a Body Mass Index (BMI) of forty point one (40.1) without any significant comorbid conditions.

4. On September 6, 2012, Patient A underwent laparoscopic adjustable gastric band placement of a "Realize-C" band.

[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 J. Beal, and Irwin B. Simon, M.D., FACS.

[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.

5. Patient was seen by Respondent for postoperative follow up visits over the next several years from July 9, 2012, until May 9, 2016. During that interval Patient A underwent twenty (20) band adjustment procedures by Respondent.

6. Patient A initially did well with weight loss although her "Realize-C" band adjustments were at very high volumes (near complete volume maximum).

7. Patient A began experiencing vomiting and esophageal symptoms and multiple adjustments in the band volume were performed.

8. In a subsequent visit with Respondent, Respondent noted that the band "slipped" despite a lack of radiographical evidence to confirm such a diagnosis.

9. On May 17, 2016, Respondent performed an upper endoscopy which did not describe findings consistent with band slippage. Additionally, his plan of care for Patient A was such that surgery to remove the band was delayed to electively plan for revision to the sleeve gastrectomy due to slippage.

10. On September 6, 2016, Respondent performed a revisional bariatric procedure on Patient A, which consisted of a gastric band removal and revision to a sleeve gastrectomy.

11. On September 8, 2016, Patient A presented to Respondent at Respondent's clinic for dehydration and an inability to tolerate liquids. Over the next week, Patient A continued to be unable to tolerate oral fluids adequately and was not progressing as expected.

12. Lap-band removal and revision to sleeve gastrectomy is a complex case associated with expected gastric adhesions and scarring from a long-standing gastric band. This is even more significant in a case where the patient is experiencing long-term reflux and vomiting, as this complicates the dissection required for proper exposure. The release of adhesions and removal capsular scar tissue is required to assure that the sleeve does not twist, kink, or become excessively narrowed or obstructed.

13. A standard evaluation of an adjustable gastric band patient with such complaints as Patient A was communicating to Respondent would include upper gastrointestinal imaging to assess the esophagus, degree of reflux, band position, and gastric pouch size. This can also be

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used to determine proper band adjustment, release, or add volume, to provide a more comfortable degree of adjustment.

14. Here, Respondent made no attempts to resolve Patient A's symptoms by decreasing the band volume, and the medical records do not describe a discussion with Patient A regarding other surgical options which would include band removal alone, band revision, additional adjustments, a staged approach to treatment, or other procedures such as gastric bypass.

15. Respondent's medical assessment of Patient A is highly questionable with regard to medical necessity. At this point, Patient A was no longer morbidly obese, as her BMI was now thirty-five (35) (severely obese) with no associated obesity related comorbidities classically accept to qualify patients for bariatric surgery under most health plans.

16. It was clear by September 8, 2016, that Patient A was not progressing normally with her repeated clinic visits for dehydration and her inability to tolerate liquids. A more detailed evaluation with upper gastrointestinal imaging would have identified the obstructive process sooner and certainly could have avoided the further use of steroids, additional inflammation, and further delay in treatment that directly contributed to Patient A's subsequent life-threatening complications.

17. On September 18, 2016, Patient A was brought by ambulance to Centennial Hills Hospital and was experiencing extreme sepsis. She was hypotensive with metabolic acidosis and emergency resuscitative measures were initiated.

18. An abdominal CT revealed findings consistent with peritonitis (inflammation of the lining of the abdomen) with significant fluid and free air present. Patient A was emergently admitted to the Intensive Care Unit (ICU) where she was treated and transferred to North Vista Hospital on September 19, 2016.

19. On September 19, 2016, Patient A was taken to the operative room by Respondent and was found to have extensive peritonitis with one (1) liter of purulent material in the abdomen which was washed out. Drains were placed and she was returned to the ICU; however, Patient A was in severe sepsis with multisystem organ failure and required intensive management from multiple medical specialists and mechanical ventilation.

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20. Due to the medications necessary to save Patient A's life, the circulation to her hands and feet were compromised and she developed necrosis.

21. On October 11, 2016, Patient A was discharged after a complex intensive course of treatment and life supportive measures. Patient A subsequently had to undergo several additional treatments, wound care, hospital admissions, and procedures on her necrotic extremities. Definitive wound management and treatment included partial amputation and skin grafting of her necrotic fingers, toes, and partial foot amputation.

COUNT I

NRS 630.301(4) - Malpractice

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

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

24. 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."

25. 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 he determined that Patient A was experiencing "band slippage", without any radiographical evidence to confirm the diagnosis, and his plan of care was such that surgery to remove the band was delayed to electively plan for revision to the sleeve gastrectomy. Further, there were no attempts to resolve Patient A's symptoms by decreasing band volume, and he failed to perform a more detailed evaluation with upper gastrointestinal imaging that would have identified the obstructive process sooner and could have avoided the further use of steroids, additional inflammation, and further delay in treatment that directly contributed to Patient A's subsequent life-threatening complications.

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

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COUNT II

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

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

28. 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.

29. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to document or order gastrointestinal imaging and by failing to record any clear documentation in the medical records of the specific risks or alternatives in this case of a long-term adjustable gastric band patient with complications. As a result, Patient A's medical records were not timely, legible, accurate, and complete.

30. 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;

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 31st day of May, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

ALEXANDER J. HINMAN
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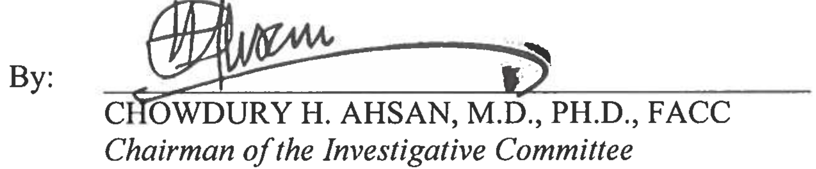
VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Chowdury 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 31st day of May, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: 

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