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

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In the Matter of Charges and Complaint Against: **GUIDO ALBERT TORRES, M.D., Respondent.**	**Case No. 25-7212-1**

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 Guido Albert Torres, 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 physician holding an active license to practice medicine in the State of Nevada (License No. 6294). Respondent was originally licensed by the Board on July 1, 1991.

2. Patient A[2] was a forty-three (43) year-old female at the time of the events at issue.

3. On January 2, 2020, Patient A was seen by Respondent's Physician Assistant (PA), for symptoms of "cramping all the time, menses lasting 8-9 days, and mild dysmenorrhea." The PA reviewed the case with Respondent, and Respondent discussed treatment options with Patient A; however, this discussion is not documented.

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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 Aury Nagy, M.D., Nick M. Spirtos, M.D., F.A.C.O.G., and Ms. Maggie Arias-Petrel.

[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. On June 22, 2020, a preoperative examination of Patient A was performed by Respondent.

5. On July 20, 2020, a laparoscopically assisted vaginal hysterectomy was scheduled, however, the procedure was cancelled because the Respondent did not submit the necessary paperwork to support insurance authorization for the procedure.

6. On February 23, 2021, Patient A was seen again at Respondent's office and reported worsening symptoms. Patient A stated that she was having heavy periods with clots, pelvic pain, cramping, and dyspareunia. A Robotic-Assisted Laparoscopic Hysterectomy (RALH) with possible bilateral salpingo-oophorectomy was recommended.

7. On April 6, 2021, Patient A was seen by Respondent for a pre-operative visit. Patient A complained of daily cramping, menses lasting nine (9) days, and she requested sterilization. Informed consent was given for a RALH with possible bilateral salpingo-oophorectomy for the diagnoses of pelvic pain, dysmenorrhea, menorrhagia, and dyspareunia. Respondent documented that he explained the procedural risks, complications, and the failure rate in detail; however, there is no mention of any discussion regarding more conservative approaches and/or alternative treatments or procedures.

8. On April 23, 2021, the RALH was performed by Respondent at Henderson Hospital. The procedure was uncomplicated until the paracervical tissue was taken down with the vessel sealer to the level of the uterosacral ligaments. The operative report states, "[a]t this point, we then realized that the monopolar scissors had been accidentally inserted into the peritoneum in the mid abdomen and we did note that there was significant bleeding."

9. Respondent converted the robotic surgical approach to an open laparotomy and made a Pfannenstiel incision (a horizontal incision made in the lower abdomen) and completed the hysterectomy. Respondent then attempted to locate the source of the bleeding, but he could not localize the source and the Pfannenstiel incision was converted to a vertical midline incision. Laceration of the aorta was noted, and two (2) general surgeons and a vascular surgeon were consulted for repair of the aorta and to gain control of the large hemorrhage.

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10. An 8-10 mm ragged and nonlinear laceration of the aorta was noted on the anterior surface of the aorta superior to the bifurcation of the iliac vessels. Patient A went into hemorrhagic shock, requiring a massive blood transfusion, and went into disseminated intravascular coagulation (DIC). It is estimated that Patient A lost 4000 cubic centimeters of blood from this event.

11. Patient A went into pulse less electrical activity (PEA) cardiac arrest, and resuscitation with CPR and epinephrine was performed. Patient A received ten (10) units of packed red blood cells, five (5) units of fresh frozen plasma, and two (2) units of platelets. She was then transferred to Valley Hospital Medical Center (Valley Hospital) for further intensive care management. Patient A remained hospitalized at Valley Hospital from April 23, 2021, to May 3, 2021, and was discharged home with orders for home health care.

12. On April 26, 2021, the pathology report from the procedure was returned. It stated, "[d]iagnosis: Uterus, cervix, fallopian tubes, and ovaries. Secretory endometrium, negative for hyperplasia and malignancy, chronic cervicitis, squamous metaplasia and nabothian cyst. Bilateral fallopian tubes with benign paratubal cysts. Right ovary with hemorrhagic corpus luteum and cystic follicles. Left ovary with large hemorrhagic cyst with very attenuated/atrophic lining." The uterus weighed two hundred and twenty-six (226) grams and measured 11.0 cm x. 7.5 cm x 5.0 cm. The "large" left hemorrhagic cyst measured 2.0 cm.

13. On May 6, 2021, Patient A was seen at Green Valley OB/GYN and the staples from her incision were removed. The wound was reported to be intact.

14. On May 17, 2021, Patient A transferred care to a different OB/GYN for treatment of wound dehiscence.

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 by inserting the monopolar scissors into Patient A's aorta during a scheduled robotic assisted laparoscopic hysterectomy which resulted in Patient A suffering life-threatening blood loss, transfer to another medical facility, severe post-surgical complications and a longer hospital stay than would have been necessary if the surgery was conducted and completed correctly.

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

COUNT II

NRS 630.301(8) - Failure to Provide Procedures, Studies, Services, Referrals

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

21. NRS 630.301(8) provides that the failure to offer appropriate procedures or studies, to provided necessary services or to refer a patient to an appropriate provider, when the failure occurs with intent of positively influencing the financial well-being of the practitioner are grounds for discipline.

22. As demonstrated by, but not limited to, the above-outlined facts, Respondent violated NRS 603.301(8) with regard to Patient A's medical conditions when Respondent scheduled and performed an unindicated procedure on Patient A, specifically a robotic assisted laparoscopic hysterectomy. This is evinced by an April 26, 2021, pathology report that returned findings that are considered normal and common and were not supportive of an indication for surgery. Furthermore, Respondent failed to offer alternative, more conservative, treatment options that could have addressed Patient A's presenting symptoms. Thus, Respondent's diagnosis and

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scheduling of the procedure occurred without a recognized medical purpose and with the intent of positively influencing the financial well-being of Respondent and his practice.

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 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

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

DATED this 12th day of March, 2025.

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)

Nick M. Spirtos, M.D., F.A.C.O.G., 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 12th day of March, 2025.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
NICK M. SPIRTOS, M.D., F.A.C.O.G.
Chairman of the Investigative Committee

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