

# VIRGINIA LAWYERS WEEKLY

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## LARGEST VERDICTS OF 2019

# 13

## \$1.25 Million

### Surgical pad left inside cancer patient nets \$1.25M

**Adcock v. Blue Ridge Radiologists Inc.**

**Type of case:** Medical Malpractice

**Court:** Staunton Circuit Court

**Attorneys:** Brewster S. Rawls and  
Christopher P. Yakubisin, Richmond



RAWLS



YAKUBISIN

Having been diagnosed with colon cancer, plaintiff Waverly Adcock, a 47-year-old male, underwent a colon resection on Aug. 31, 2016, at Augusta Regional Medical Center. A week later he presented to the hospital, where an anastomotic leak was diagnosed. Adcock underwent emergency surgery on Sept. 7, 2016. A colostomy was done at that time. At the conclusion of the surgery, the counts of surgical pads were reported as correct. It was anticipated that six to 12 months later, the colostomy would be reversed.

Following the emergency surgery, Adcock remained an in-patient for more than 30

days and was in a rehabilitation unit for another month. He was discharged in mid-November 2016, but he continued to have problems and his wound did not heal. In early January 2017, Adcock noticed something protruding from his ostomy site. He went to the University of Virginia Medical Center emergency room and learned that the protruding object was a laparotomy pad from the Sept. 7, 2016, surgery. The pad was removed and Adcock improved quickly. Unfortunately, because of the extended inflammation and infection, his colostomy could not be reversed.

On four occasions following the Sept. 7, 2016, surgery, Adcock underwent abdominal CT scans. Two were read by one radiologist with the group and two were read by another. Although the radiopaque marker on the lap pad was clearly visible, neither of the defendant radiologists mentioned it in their reports. Plaintiff's expert opined that what was seen was an abnormal finding that needed to be reported as such. At trial, the doctors and their experts took the position that the area on the CT appeared to be "normal post-surgical changes" (suture line or staples) and therefore did not need to be mentioned in their reports.

Adcock's surgical expert had also been his treating doctor at U.Va. He testified both as to standard of care for the surgeon and causation issues. He testified that the surgeon had his own duty to review the CT scans and that a surgeon should have readily identified the retained foreign body. He also testified with regard to the issues pertaining to the pad being left in the patient. The surgeon defended his care, asserting reliance on the nursing staff for having reported the counts as correct, as well as the radiologists having interpreted the CTs but not reporting the object.

By the time of trial, Adcock's colon cancer had progressed, and he had a terminal diagnosis. This information became known to the jury. Adcock opted not to introduce evidence of medical expenses.

Over the course of two days, the jury deliberated for close to seven hours before returning a verdict in favor of Adcock against the radiology defendants and awarded damages of \$1,250,000. The jury found in favor of the surgeon and his group.

The radiology defendants moved to set aside the verdict claiming there was no evidence of causation. The court overruled that motion about a month after trial.