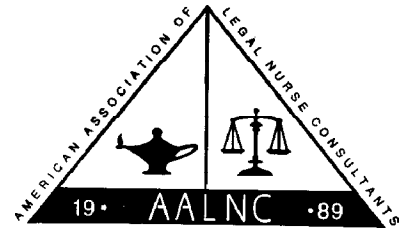


the LiNC



The Link between Health Care and the Legal Profession

Volume 10, Issue 2

Summer 2002

OPHTHALMOLOGY LITIGATION

By Nursine S. Jackson, M.S.N., R.N.

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About the author:

Nursine Jackson has been a legal nurse consultant in the Law Office of Ralston S. Jackson since 1987, and recently started her own independent practice as an LNC. She is a Master's prepared Cardiovascular Clinical Nurse Specialist with both her Master's and Bachelor's degrees in Nursing from the University of Pittsburgh, where she also serves as Adjunct Faculty.

An overview of ophthalmology seems timely and appropriate since litigation surrounding LASIK (Laser In-Situ Keratomileusis) is so prevalent, and because eye cases provide many opportunities for LNCs to provide valuable assistance. The LNC could be involved in translating these cryptic medical records, developing a life care plan, projecting future costs for a newly visually impaired patient, providing case management, or writing or reviewing policies and procedures for businesses or institutions using equipment where eye injuries pose as major risks. To assist in different aspects of working with an eye case from a medical-legal perspective, this issue of the LiNC will present two articles on ophthalmology. Following is a brief overview of legal cases involving eye injuries, in which an LNC may be involved.

LASIK eye surgery, America's new number one elective surgery, is a fountain of youth of sorts. This surgery, which involves reshaping the contour of the cornea with a LASER, can return an adult's uncorrected vision to 20/20. Sadly, LASIK consumers are often unaware of the prevalence of less than optimal results. Problems resulting from LASIK have included nighttime vision problems rendering people incapable of driving at night; incidences of blindness resulting from macular blowout caused by pressure differential during surgery; and permanent visual impairments such as starbursts, glare problems, near distance depth perception difficulties, ghosting, halos, and haze. LASIK litigation is often based on a lack of informed consent about the risk of these bad outcomes. Many suboptimal outcomes are caused by variations in the eye, e.g., large pupils,

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NAVIGATING OPHTHALMIC RECORDS

By Norman L. Edelstein, M.D.

About the author:

Dr Edelstein is an ophthalmologist in private practice in McKeesport, PA. He graduated from the University of Pittsburgh School Of Medicine, where he also completed his residency in the Department of Ophthalmology. Dr. Edelstein currently practices at McKeesport Hospital, where he is Chairman of the Department of Surgery and Chief, Division of Ophthalmology, and also at Eye and Ear Institute, UPMC, and South Hills Health System. He is currently Chairman of the Provider Relations Committee of Pittsburgh Ophthalmology Society.

Interpretation of ophthalmic records is hampered by terminology unique to eye care; by multiple abbreviations and acronyms, many of which are not universally accepted; and by the illegible handwriting of physicians trained to enhance visual performance. Fortunately, these obstacles are decreasing, not in an effort to make life easier for nurse legal consultants, but in response to third party payer demands for legible records with standardized examination formats.

Numerous ophthalmic terminology glossaries and guidelines are available both in print and on the Internet. The following examination template will hopefully allow nurse legal consultants to navigate eye care records with greater insight. (*Note: a formal explanation of terminology is beyond the scope of this article.*)

VISUAL ACUITY

(1.) **OD**-right eye; **OS**-left eye; **OU**-both eyes
 (2.) Visual acuity is measured under controlled lighting conditions and is recorded at distance in either feet (e.g., 20/20) or, less commonly, in meters (e.g., 6/6). Near vision is measured in terms of printing types, most commonly Jaeger with J-1 the smallest type size.

SC-visual acuity measured without corrective lenses

CC-visual acuity measured with corrective lenses, eyeglasses and/or contact lenses

(3.) Patients with acuity impaired to less than eye chart levels include:

CF (*counts fingers*);

HMO (*hand motion only*);

LP (*light perception*);

NLP (*no light perception*).

(4.) "Potential" acuity of an impaired eye can be estimated with varied examination techniques to include **PH** (by *pinhole*) or **PAM** (by *potential acuity meter/measurement*).

(5.) Visual acuity under less than ideal lighting conditions (e.g., snow, headlights, etc.) can be estimated under simulated conditions and reported as **BAT** (*brightness acuity test*), etc.

ADNEXA/EXTERNAL:

The ophthalmologist then examines the lids and the tissues surrounding the eyes:

UL-upper lid (e.g., RUL, LUL)

LL-lower lid (e.g., RLL, LLL)

NL-nasolacrimal (tear drainage system)

CONJUNCTIVA AND GLOBE:

The gross examination of the eye itself can include varied non-specific abbreviations.

PUPILS AND IRISES:

Pupillary responses are impaired by both eye and/or neurologic diseases.

PERRLA-normal *Pupils are Equal, Round, React to Light and Accommodation*

NR-non-reactive

APD-afferent pupillary defect (indicative of a neurologic problem)

MOTILITY:

Evaluation of eye movement

EOM-extraocular muscles

E or **ET** (*eyes turn in*)

X or **XT** (*eyes turn out*)

NPC-near point of convergence

NPA-near point of accommodation

Six muscles are attached to each eye:

MR (*medial rectus*);

LR (*lateral rectus*);

SR (*superior rectus*);

IR (*inferior rectus*);

SO (*superior oblique*);

IO (*inferior oblique*)

VISUAL FIELD:

Measurements of peripheral visual function—

Gross estimates of visual field function

GVF (*gross visual fields*) or
CVF (*confrontation visual fields*)
FTC-*full to confrontation*
HVF-*Humphrey visual field*; (Humphrey
 Instruments is the most common manufacturer
 of automated field units)

SLIT LAMP or SLE:

The examination now proceeds to the interior of the eye using a Slit-lamp biomicroscope.

(1.) Cornea-the window part of the eye

CA-*corneal abrasion*

(2.) Anterior chamber (**AC**)-the clear space between the back of the cornea and the front of the colored part of the eye (iris)

F&C-*flare and cells* (indicative of an inflammatory process in the eye)

PAS-*peripheral anterior synechiae* or **PS**-*posterior synechiae*—(Synechiae are adhesions.)

VH-an estimate of the depth of the anterior chamber space

(3.) Lenses-any clarity change in the human lens is cataract formation, which can be related to aging, trauma, etc.

NS-*nuclear sclerosis*

ASC-*anterior subcapsular*

PSC-*posterior subcapsular*

IOL-*intraocular lens*

PC-*posterior chamber* (the area behind the iris) or *posterior capsule* (the tissue intentionally left in the eye after cataract surgery)

INTRAOCCULAR PRESSURE MEASUREMENT (IOP)

TA or *Tapp-tension* measured by *applanation*

TP or *Ttp-tension* measured by *tonopen*

Examination of the posterior portions of the eyes is next performed, frequently after pupillary dilatation by drops (M 1 to 1% Mydriacyl; Neo 2 ½ Neosynephrine)

CENTRAL RETINAL AREA TO INCLUDE THE OPTIC DISCS (NERVES)

C/D-*cup to disc diameter* of the optic disc

NFL-*nerve fiber layer*

PERIPHERAL RETINAL EXAMINATION

(1.) **RD**-*retinal detachment*

F/F-*floaters and flashes*

PVD-*posterior vitreous detachment*

V or **VIT** -*vitreous*

(2.) Macula—the point of best vision

ARM-*age-related macular degeneration*

ERM-*epiretinal membrane*

CME-*cystoid macular edema*

CSME-*clinically significant macular edema*
 (3.) Retinal/macular vascular changes include a large number of abbreviations:

NVD-*neovascularization of the disc* (nerve)

NVE-*neovascularization elsewhere*

CRAO-*central retinal artery occlusion*

BAO-*branch artery occlusion*

CRVO-*central retinal vein occlusion*

BVO-*branch vein occlusion*

DIAGNOSES, ADDITIONAL TESTING, AND TREATMENT SUGGESTIONS FOLLOW THE EXAMINATION.

These common ophthalmologic problems are described using multiple abbreviations:

(1.) Glaucoma

COAG-*chronic open angle glaucoma*

NAG-*narrow angle glaucoma*

Gonio-gonioscopy (an instrument used to examine the drainage mechanism in the eye)

ALT -*argon laser trabeculoplasty*

Trab-*trabeculectomy* (a surgical procedure)

(2.) Cataract

Ks-*keratometry* (measurements of the front surface of the eye)

AL-*axial length* (the length of the eye)

ICCE-*intracapsular cataract extraction* (the entire lens is removed; this procedure is seldom performed today.)

ECCE-*extracapsular cataract extraction* (the lens is removed in portions, most commonly by phaco-phacoemulsification.)

YAG-a laser procedure occasionally needed after cataract surgery.

(3.) Diabetic eye disease

DR-*diabetic retinopathy*

BDG-*background diabetic retinopathy*

PDR-*proliferative diabetic retinopathy*

FA-*fluorescein angiogram*

PRP-*panretinal photocoagulation*

ETDRS-*early treatment diabetic retinopathy study*

The analysis of ophthalmic medical records should become less complex as more ophthalmologists find it necessary to structure examinations to comply with standardized templates, and as electronic records minimize the use of abbreviations. Thus, for these cases, data review by the nurse legal consultant may indeed become easier.

AN EYE FOR AN EYE...

HOW AMERICAN JURIES EVALUATE VISION LOSS CASES

by Terry C. Cavanaugh, Esq.

About the author:

Terry C. Cavanaugh is a shareholder of Dickie, McCamey & Chilcote, P.C., where he concentrates his practice in the defense of professional malpractice claims, with a particular emphasis in Health Care Law. He is a member of the Pennsylvania Bar Association and the Defense Research Institute. Mr. Cavanaugh graduated from The Pennsylvania State University in 1969 with a B.A. in English and Political Science and received his J.D. from the University of Pittsburgh in 1972. Mr. Cavanaugh is a frequent lecturer on trial tactics and the defense of medical claims and has written articles of interest to physicians, lawyers, nurses, and administrators in the health care field.

The American legal system does not, thankfully, follow the Old Testament admonition that if you cause the loss of someone's body part you must sacrifice that same part yourself. Instead, our jurisprudence provides compensation in the equivalent of dollars.

The American jury has practically unfettered discretion as to how much it can order as compensation for pain, humiliation, disfigurement, lost wages, loss of the pleasures of life, et cetera. Generally speaking, the standard for reversing a jury's verdict is whenever the verdict is so enormous that it "shocks the conscience of the Court," a fluid and moving standard, I can assure you.

One of the dreaded complications all of us fear is the loss of our vision. Many people seem to have, quite legitimately, concerns of contracting cancer or suffering a debilitating stroke, and our hearts go out to a severely disabled baby. Blindness is a phenomenon that not only provokes the sympathy of a jury, but plays upon one of those deep fears that we all have that our life would be ruined, if we could not see¹.

Putting aside the fact that some people can suffer a loss of sight yet do quite well, I submit that for most people the loss of vision is perceived as one of the ultimate catastrophes and one that may suggest to a jury that a generous verdict is in order. If so, how much? The purpose of this article is to offer some thought on how juries in this country (and this Commonwealth) value the loss of an eye or total loss of vision.

TOTAL BLINDNESS

First, awards and settlements for "total blindness" are of course, significantly higher than other types of eye injuries. Moreover, settlements are significantly lower than verdict awards. In "total blindness" cases, Plaintiff retained both eyes but received no benefit from their function. The award range for jury trial is as follows:

Total Blindness

| | |
|---------------------------|---------------------------|
| Verdict Median | \$3,695,000 |
| Verdict Probability Range | \$1,008,585 - \$6,634,250 |
| Verdict Range | \$52,000 - \$62,800,000 |
| Verdict Mean | \$6,833,218 |
| Awards of \$1,000,000+ | 81% |

| | |
|------------------------------|------------------------|
| Settlement Median | \$850,000 |
| Settlement Probability Range | \$240,000- \$1,500,000 |

Continued on Page 5

Visual Impairment continued:

| | |
|---------------------------|-----------------------|
| Settlement Range | \$30,000-\$10,800,000 |
| Settlement Mean | \$1,455,321 |
| Settlements \$1,000,000 + | 42% |

BLINDNESS IN ONE EYE

The next category is blindness in one eye. This category is defined as those individuals that retain the eye itself, but receive no benefit from its functions.

Blindness in One Eye

| | |
|------------------------------|-------------------------|
| Verdict Median | \$510,000 |
| Verdict Probability Range | \$226,250 - \$1,070,036 |
| Verdict Range | \$8,060 - \$9,900,000 |
| Verdict Mean | \$1,070,435 |
| Awards of \$1,000,000+ | 27% |
| Settlement Median | \$375,000 |
| Settlement Probability Range | \$142,500- \$750,000 |
| Settlement Range | \$5,001-\$3,664,900 |
| Settlement Mean | \$620,134 |
| Settlements \$1,000,000 + | 15% |

VISUAL IMPAIRMENT

The next category for evaluation would be visual impairment claims in which the injuries are severe enough to reduce a plaintiff's ability to see, but do not result in blindness. Included in this category are injuries that are frequently seen in ophthalmology malpractice claims following LASIK (Laser In-Situ Keratomileusis) or PRK (photorefractive keratectomy) procedures. Injuries include scarring of the cornea or retina, loss of the lens, corneal erosion, dislocation of the lens, a detached retina, permanent pupil dilation, alteration of the retinal pigment epitheliums, and a ruptured cornea.

Visual Impairment

| | |
|------------------------------|------------------------|
| Verdict Median | \$73,918 |
| Verdict Probability Range | \$22,110 - \$254,500 |
| Verdict Range | \$10,000 - \$5,100,000 |
| Verdict Mean | \$240,058 |
| Awards of \$1,000,000+ | 5% |
| Settlement Median | \$50,000 |
| Settlement Probability Range | \$15,000- \$172,500 |
| Settlement Range | \$1,500-\$2,500,000 |
| Settlement Mean | \$193,266 |

Settlements \$1,000,000 +
5%

MINOR EYE INJURIES

The final category is labeled "minor eye injuries". This examines cases of minor injuries to the eye ball and the surrounding area. Examples of minor eye injuries include contusion, laceration, scratches and abrasions to the cornea or lens, dry or irritated eyes, mild burns, lacrimal apparatus damage, etc. There is no permanent visual impairment suffered with the injuries included in this category.

Minor Eye Injuries

| | |
|------------------------------|--------------------|
| Verdict Median | \$13,054 |
| Verdict Probability Range | \$4,137 - \$62,854 |
| Verdict Range | \$279 - \$674,750 |
| Verdict Mean | \$68,625 |
| Awards of \$1,000,000+ | <1% |
| Settlement Median | \$11,450 |
| Settlement Probability Range | \$3,800- \$ 32,500 |
| Settlement Range | \$500-\$250,000 |
| Settlement Mean | \$31,742 |
| Settlements \$1,000,000 + | <1% |

An analysis of recent verdicts shows that vehicular accidents account for 26% of the cases of visual loss claims. Medical malpractice claims are 28% of the total.

Of those cases involving losses from a number of causes (premises liability, business negligence, personal

negligence, product liability claims and medical malpractice claims, only product liability claims causing blindness are larger than medical malpractice claims. The median malpractice claim for injuries of every sort is \$256,250.00.

Let's take a look at some of the cases:

The case of Fang v. Kremer was decided a year and a half ago in Philadelphia. A 30-year-old female CPA underwent LASIK to correct nearsightedness at her physician's office. After the surgery, Ms. Fang suffered from farsightedness and double vision. She brought suit after the second surgery failed to correct these problems. Plaintiff contended that the laser was off-center; the doctors countered that the plaintiff's condition was an unexpected reaction to the procedure.

A jury awarded \$800,000.00.

In the case of Wright v. DeAntonio, a 35-year-old man suffered permanent blindness due to medical malpractice. Mr. Wright had consulted a neurologist for treatment of headaches and vision problems and the neurologist diagnosed Mr. Wright's condition as pseudotumor cerebri, benign intracranial hypertension and referred Mr. Wright to ophthalmologists. Plaintiff claimed that he should have been referred to a neuro-ophthalmologist, who could have easily provided surgery to relieve the pressure in the eye. Instead, due to a lack of definitive treatment, the plaintiff sustained damage to his optic nerves and his blindness became irreversible.

A jury in Philadelphia awarded \$5,000,000.00.

The case was ultimately settled for \$3,500,000.00 in accordance with a \$1,500,000.00/\$3,500,000.00 high/low agreement.

Pittsburgh takes a more conservative view.

In Hatalsky v. Strand Attic, Inc. Trading and Doing Business as The Attic - A Gathering Place, an Allegheny County jury was faced with this factual scenario.

Mr. Hatalsky brought a negligence action against a bar. He was in a stall in the men's room when an individual either kicked or pushed open the stall door

causing the coat hook on the back of the door to pierce Mr. Hatalsky's eyeball. Significant injury ensued, including a right eye subretinal bleed, a choroidal rupture and a laceration of the right eyelid.

An Allegheny County jury thought that case was worth \$7,102.63.

My point is that although each case of course turns out different facts, there is a huge latitude in the value that different juries in different parts of the state and country place on the loss of an eye.

A legal nurse consultant might offer invaluable help to a lawyer by researching the value of a particular injury. Some excellent resources exist, including *Personal Injury Valuation Handbook, Jury Verdict Research Series* published by LRP Publications and *Pennsylvania Damages, Personal Injury Verdicts and Settlements, 2002 Edition* authored by Tracey R. Rich, Arthur S. Zanan and Suzanne N. Rosin and published by George T. Bisel Company, Inc.

End note by Terry Cavanaugh:

¹ One of our law clerks (who researched information for this article) is the granddaughter of a blind couple who raised five children. Not only did these fine people lead what appear to be normal lives, they had, in addition to daytime jobs, a band known as "Marge and Her Man" that entertained the citizens of Harrisburg for many years.

EDUCATIONAL RESOURCE FOR LNCs

The University of Pittsburgh School of Nursing now offers four courses for LNCs. These courses are available within the undergraduate and masters programs and are also available to nurses interested in taking a non-degree courses in LNC and Forensic Nursing.

The four 3-credit courses at Pitt are:

- Introduction to LNC and Forensic Nursing
- Advanced Forensic Nursing Practice
- LNC and FN Seminar and Practicum
- Forensic Psychiatric Mental Health Nursing and Correctional Nursing

For more information, please contact

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PHONE: 412-624-2063

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thin corneas, significant astigmatism, for which the patient should not have been accepted as a LASIK candidate, or for which special accommodations should have been made during the operation, and were not. Other problems that have lead to LASIK malpractice cases currently being handled by Ophthalmic Mutual Insurance Company (OMIC) include: equipment failures, a failure to sterilize the equipment, corneal flaps resulting from poor techniques or equipment problems, improperly performed surgery (e.g., LASIK performed on the incorrect axis of astigmatism), and more.¹

A brief review of legal resources yielded additional examples of ophthalmic medical negligence cases that the LNC may see:

- Failure to diagnose or to provide timely treatments for eye injuries, eye infections, eye tumors, and retinal detachments;
- Failure to diagnose retained foreign body that lead to severe inflammation or infection;
- Ocular exposure leading to corneal injury during hospitalization, e.g., while the patient is in a coma in intensive care;
- Wrong lens, wrong eye, wrong procedure, and yes, wrong patient;
- Nerve injuries during eye surgery, especially in administering anesthesia via a blind retrobulbar block;
- Botched operations performed by surgeons without training or without adequate training . . . to name a few of the more common issues that resulted in litigation.

Eye injuries are commonplace within personal injury cases as well, and a new age technologies are yielding old-fashioned and some new fangled eye injuries. Injuries resulting from new hazards include eye injuries from the impact of an airbag exploding in the face during a car crash that can result in corneal and/or retinal edema, which could lead to retinal detachments. Also corneal burns can result from the powder in the airbags getting into the eye. Paint ball games² result in serious eye injuries from either the impact of the paint ball striking the eye, or a chemical injury to the eye from the gelatinous paint inside the ball. Litigation has resulted from improper supervision, failure to provide protective head gear/eye guards, and even product failures, i.e., faulty design of the eye guards so that they fail to stay in place.

There are significant medical-legal implications in using LASER technology in business applications, as well. Most lasers are capable of causing eye injury to anyone who looks directly into the beam or specular reflections. In addition, diffuse reflections of a high-power laser beam can produce permanent eye damage. Businesses employing Class 2 and 3 LASERS, including hospitals using LASERS in their operating rooms, have employees at risk.⁴ LNCs could review the facilities policies and procedures to determine whether appropriate safety measures were employed, as well as work to define the injury and case manage its treatment.

Each specialty has its share of jargon and unique abbreviations, but an ophthalmologist's office note is rivaled only by a dentist's note in its nearly unintelligible notations. To assist the LNC and attorney in decoding a chart, Norman L. Edelstein, M.D. has provided a concise review of the structures of they eye evaluated in the eye examination, and a key to some ophthalmic shorthand. Next, to assist the LNC in assessing the value of a meritorious case, Defense Attorney Terry Cavanaugh has provided a review of verdicts in ophthalmology cases across Pennsylvania.

Both attorneys and plaintiffs should benefit from an LNC's involvement in these cases. The goal of this newsletter is to encourage and assist the LNC in supporting legal cases with eye injuries.

Endnotes:

1. Bezar, N.A. (Summer, 2002). Candidate for LASIK? *The Barrister*. 1, 13-14.
2. See: http://www.lifehealthenergy.com/htdocs/TheMall/paintball_has_risk_of_eye_injury.htm
3. See: <http://cc.ysu.edu/eohs/laserprog.htm>
4. See: http://www.med.nus.edu.sg/safety/chapter_11.htm

Our Business Directory is Now Online

Are you seeking an LNC to review a case or serve as an expert? Some LNCs from our Chapter may suit your needs. Visit or website to check out our members who have listed their areas of expertise, practice, and contact information:

<http://www.pittsburghchapteralnc.org/Business%20Directory.htm>

A MESSAGE FROM OUR PRESIDENT

Dear Chapter Members

We have two exciting educational and networking opportunities to look forward to in the near future.

On August 14th, our August Dinner Meeting will be held at Rico's in the North Hills. The topic, ***Allies or Adversaries: MD's and JD's Working Together in the Litigation Process***, will provide us with valuable insight into the dynamic relationship that develops between attorneys and physicians as they work together in the litigation process . . . Insights that will prove useful to any LNC who strives to understand the "big picture" in the law suit he or she is working on and who participates in making strategic decisions as the case unfolds.

Our Annual Conference will be held on October 12th at St. Francis Medical Center. Our theme this year is ***Litigation Strategies in High Risk Practice Areas***. In an effort to meet the needs of as many members as possible, we will again have two tracks: one for the novice and one for the experienced LNC. Our novice track will include: Medical Research; Locating Experts; and, Business Considerations in Starting an LNC Practice. Our advanced track will include topics such as: Liability Issues Associated with CRNP's; Brachial Plexus Injuries, the Role of the LNC; and, Liability Issues Surrounding Induction of Labor.

Thanks to all of you who have been attending our monthly meetings. You are a valuable asset to the Chapter and have made our meetings very enjoyable. For those of you who we have not seen in awhile, we hope to see you in August and October. We have a great Chapter and would love for you to be a more active member.

Sincerely,

Jane F. Collins, R.N., B.S.N., J.D.

Pittsburgh Chapter - Upcoming Events

July

Summer Break - No Meeting

August 14

Time: 5:30 pm Dinner with Educational Meeting

Topic: *Allies or Adversaries: MDs and JDs "Working*

Together(?)" in the Litigation Process

Location: Rico's in the North Hills. It is less than 5 min.

off 279, about 6 miles from downtown.

September 11

5:30 p.m. - Board Meeting

6:30 p.m. - Educational Meeting:

Topic: *Basic Introduction To Special Education Law-*

Twenty-two Frequently Asked Questions

October 12

Pittsburgh Chapter Annual Conference

Theme: *Litigation Strategies in High Risk Practice Areas*

Location: St. Francis Medical Center

Time: ~8 a.m. - 4 p.m.

November 13

5:30 Current Board

6:30 pm - *Annual Business Meeting* , Members Only

December 11

Holiday Party and Installation of our new President and Board of Directors

CLINICAL POINT: NATRECOR (nesiritide)

By Sophia Gardner, M.S.N., R.N.

about the author:

Mrs. Gardner earned a B.S.N. from Carlow College and an M.S.N. from the University of Pittsburgh. She is a faculty member at Carlow College in the undergraduate nursing program and developed and taught an Introduction to Legal Nurse Consulting course in the Paralegal Institute at Duquesne University. Mrs. Gardner has been doing consulting on an independent basis for 12 years and has spent more than 20 years as a staff nurse and educator. As an LNC she performs general consulting functions for both plaintiff and defense, gives expert testimony in cases involving medical malpractice litigation and does case management for workers' compensation and personal injury cases. She is a past president and member of the American Association of Legal Nurse Consultants Pittsburgh Chapter and served as a member of the editorial board for The Journal of Legal Nurse Consulting.

Natrecor is being promoted as the first acute care drug for congestive heart failure (CHF) in over a decade. Classified as a B-type natriuretic peptide (BNP), it is indicated for the treatment of patients with acutely decompensated CHF, who have dyspnea at rest or with minimal activity. It is contraindicated for patients with cardiogenic shock and in patients with a systolic blood pressure less than 90mm Hg.

Natrecor should be administered through either a peripheral IV or a centrally located non-heparin coated catheter. Because this drug binds to heparin it could bind to the heparin lining of a heparin-coated catheter, thus decreasing the amount of Natrecor delivered to a patient.

A bolus of 2ug/kg of Natrecor is the recommended starting dose. This is then followed by a continuous infusion of 0.01 ug/kg/min via an infusion pump. Natrecor reaches its therapeutic range quickly thus relief of symptoms related to CHF is speedy. In addition,

patients do not develop a tolerance to Natrecor, so it does not have to be administered in increasing doses as is often necessary with Lasix.

If administered at the recommended dosage, Natrecor is well tolerated. Adverse events include symptomatic and asymptomatic hypotension, ventricular tachycardia, headache, abdominal pain and nausea.

No clinical trials were conducted that specifically addressed drug interactions with Natrecor. There was concomitant use of drugs with patients in the trials. Those on ACE inhibitors did demonstrate increased hypotension.

Legal nurse consultants who review medical records should know that Natrecor is now available for the acute treatment of CHF, but that its use is not appropriate in all cases. In addition, be aware of the possibility for hypotension to develop and assess for its timely identification and treatment.

For more information on Natrecor visit: <http://www.natrecor.com>.

Select On-Line Ophthalmology Resources:

<http://www.emedicine.com/oph/cover.htm>

Ophthalmology. An on-line medical reference

<http://www.abop.org/>

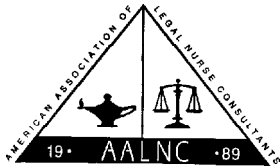
The American Board of Ophthalmology. Information on certification and re-certification of ophthalmologists in the United States.

<http://www.surgicaleyes.com/>

An organization founded by people with **longer-term complications from refractive surgery** to assist others who have had unsuccessful elective refractive surgeries

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About the LiNC

The LiNC will be published three times yearly: in Winter, Summer, and Fall.

Please send articles and submissions (500 words or less) for publication in the next newsletters by the second week of January, May, and September to our Editor:

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ABOUT OUR CHAPTER

Monthly Meeting Information

The Pittsburgh Chapter meets the second Wednesday of every month (except during the summer). The location of our meetings varies. Non-members are welcome to educational presentations. If you have questions about upcoming events, contact Costantini Rehab: 412.939.3426, or visit our Website: <http://www.PittsburghChapterAALNC.org>.

Educational Programming

If you have a topic that you would like to have presented at a meeting, recommendations for a speaker, a new site, or other idea for enhancing our monthly meetings, please speak with our Programming Chairperson: Joanne Boyd via e-mail @ JBoyd@dmcp.com.

Membership Inquiries

Information about joining this organization is available through our Membership Chairperson, Patty Costantini at Costantini Rehab. Call 412.939.3426; FAX 412.939.3427.

Speaker's Bureau Inquiries

Do you need a speaker for an upcoming meeting? Ask our Speaker's Bureau Chairperson: Patty Costantini at: 412.939.3426; or e-mail: kesrehab@aol.com. The Speakers Bureau is a free service to Medical-Legal Community. The Pittsburgh Chapter of AALNC provides experienced LNC's who are prepared to speak on a variety of nursing healthcare and legal topics.

Pittsburgh Chapter Business Directory

Are you seeking a nurse expert, or an LNC to consult with or to develop a case for you? You may find an LNC within our chapter who has the specific expertise you need, and who is interested in providing consultative services. Peruse our Business Directory on our Webpage. A Pittsburgh Chapter LNC may very well have the skills you need.

Disclaimer: The Pittsburgh Chapter does not, in any way guarantee the work of the members who are listed in this directory.