

COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine

Adjudicatory Case No. 2014-032

 In the Matter of

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 KOSTANTINO AVRADOPOULOS, M.D.)
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STATEMENT OF ALLEGATIONS

The Board of Registration in Medicine (Board) has determined that good cause exists to believe the following acts occurred and constitute a violation for which a licensee may be sanctioned by the Board. The Board therefore alleges that Kostantino Avradopoulos, M.D. (Respondent) has practiced medicine in violation of law, regulations, or good and accepted medical practice, as set forth herein. The investigative docket number associated with this order to show cause is Docket No. 11-396.

Biographical Information

1. The Respondent was born on November 9, 1963. He graduated from the Northeastern Ohio Universities College of Medicine in May 1988. He is certified by the American Board of Surgery. He has been licensed to practice medicine in Massachusetts under certificate number 204941 since March 2000. He has privileges at St. Vincent Hospital and Harrington Memorial Hospital.
2. Between August 2007 and October 2011, Respondent performed approximately 2300 surgical procedures at St. Vincent's Hospital. Respondent has never been

disciplined by St. Vincent's or any other hospital. The Respondent was disciplined by his employer following his treatment of Patient A.

Factual Allegations

Patient A

1. On October 16, 2011, Patient A, a 50 year-old female, presented to St. Vincent Hospital's Emergency Department (ED) with worsening buttock pain and spontaneous purulent discharge from the right buttock area. She described her pain as 10 out of 10 with a heart rate of 110. Upon physical examination her right buttock was purple in color with foul-smelling discharge from the abscess and crepitus around the wound.

2. At the time of Patient A's admission, the Respondent was the on-call surgeon, for the third consecutive day.

3. The ED staff diagnosed Patient A with a necrotizing soft tissue infection.

4. The Respondent was contacted by the surgical resident regarding Patient A and her diagnosis at approximately 11:45 p.m. on October 16, 2011.

5. The Respondent did not come in to the hospital to perform emergent surgery.

6. The Respondent instructed the surgical resident to admit Patient A to the ICU and to initiate antibiotics and I.V. fluids, and to schedule Patient A for surgery on October 17, 2011 at 6 a.m.

7. ED staff transferred Patient A to another hospital after being informed that Respondent had scheduled surgery for the morning.

Patient B

8. Patient B was a 70-year-old man with a history of benign prostatic hypertrophy and urinary tract infections who sought care from the Respondent in May of 2009 for a right recurrent inguinal hernia repair.

9. On May 4, 2009, the Respondent performed an operation to repair Patient B's recurrent right inguinal hernia.

10. On May 16, 2009, the Respondent examined Patient B, who was suffering from urine retention and an apparent right inguinal hernia.

11. On June 3, 2009, the Respondent performed a laparoscopy to repair Patient B's recurrent right inguinal hernia.

Patient C

12. On September 6, 2007, Patient C, a 33-year-old female who was 32 weeks pregnant, was seen at the obstetrical outpatient station at St. Vincent Hospital with a complaint of a swollen right leg and pain that involved the back of the right knee, her lower back and her lower abdomen.

13. At 1 a.m. on September 7, 2007, Patient C was transferred to the ED.

14. At approximately 2:40 a.m. blood tests were taken, showing a bandemia, Patient C's laboratory results were suspicious for infection.

15. Between 2:40 a.m. and 4:15 p.m. on September 7, 2007, Patient C was seen by 2 OB physicians and a nurse midwife.

16. At approximately 4:15 p.m. on September 7, 2007, the nurse midwife requested a surgical consultation on Patient C.

17. Patient C was seen by the surgical P.A. who then consulted with Respondent, because the on-call surgeon was in the O.R.

18. As a result of that consultation, the Respondent was aware of Patient C's complaint and the results of her laboratory work.

19. The Respondent did not examine Patient C.

20. At approximately 6 p.m. on September 7, 2007, Respondent discussed the case with the attending OB physician who informed Respondent that Patient B wanted to go home because of the impending Sabbath but agreed to return if her condition worsened.

21. Patient C was discharged from St. Vincent Hospital, by the OB physician with Respondent's knowledge.

22. Two days later, Patient C returned to St. Vincent Hospital's ED and was transferred to another hospital where she was diagnosed with a necrotizing soft tissue infection.

Patient D

23. On August 28, 2009, Patient D, a 48-year-old woman, was diagnosed as having a 5x3 cm cystic mass in the anterior mediastinum below the thyroid gland.

24. A thoracic Surgeon at St. Vincent's Hospital performed a resection of the anterior mediastinum mass.

25. On September 15, 2009, a post-surgical pathologic examination of Patient D's mediastinal lymph node was positive for metastatic papillary thyroid cancer.

26. On October 28, 2009, the Respondent performed only a partial thyroidectomy on Patient D, after encountering scar tissue on the right side.

27. The standard of care generally dictates that a total thyroidectomy be performed in such circumstances.

Patient E

28. On January 30, 2010, Patient E, a 38-year-old woman who was 29 weeks pregnant with her third child, and a history of multiple sclerosis presented to the ED at St. Vincent Hospital with right side abdominal pain for 48 hours with nausea, vomiting, and fever.

29. On January 30, 2010, an MRI was performed. The MRI report stated a tubular structure was seen from the cecal pole with susceptibility artifact from the contained air, likely representing the appendix. Also visualized was a small amount of fluid in the pelvis. The conclusion by the radiologist from the MRI was that there was no evidence of acute appendicitis.

30. On January 30, 2010, the ED requested a consult from the surgery department's on-call physician, the Respondent; per the surgery department's standard procedure, Patient E was seen by a surgical physician assistant.

31. On February 2, 2010, at approximately 11:30 a.m., the Respondent was consulted and examined Patient E.

32. Patient E complained of escalating right lower quadrant pain and her physical exam was notable for fever of 101.7 degrees, with localized rebound tenderness.

33. On February 2, 2010, at approximately 3:55 p.m., an MRI was repeated that showed increasing fluid in the pelvis and the appendix was not visualized.

34. On February 3, 2010, the Respondent performed an exploratory laparoscopy on Patient E which included an appendectomy and irrigation of purulent fluid from the abdominal cavity.

35. The post-surgical pathology reports determined that the appendix was not the source of infection.

Patient F

36. In February 2009, Patient F, a 60-year-old female, sought out care from the Respondent for squamous cell carcinoma of the esophagus.

37. Before being diagnosed with cancer of the esophagus, Patient F had a one-year weight loss of 30 pounds, which brought her down to 96 pounds at 5 feet 8 inches, one month prior to surgery.

38. On May 20, 2009, the Respondent and a thoracic surgeon performed a three hole esophagectomy on Patient F. Immediately following the surgery the patient was admitted to the ICU.

39. On the fourth post-operative day, Patient F began to develop increased respiratory failure, which required ventilator support.

40. Also by the fourth post-operative day the patient developed severe thrombocytopenia and developed internal bleeding.

41. On post-operative day five, Patient F's hematocrit began to drop requiring two units of packed red blood cells.

42. By post-operative day nine, bright red blood was reported draining from Patient F's Jackson-Pratt drain in her neck as well her nasogastric tube which was placed at

the time of the May 20, 2009 operation. Respondent recommended conservative management with platelet and blood transfusions.

43. On post-operative days 10 and 11, the Respondent was not working. Patient F was in the Intensive Care Unit and, per the surgery department's protocol, Patient F was signed out to the covering attending surgeon for the weekend.

44. By post-operative day 11, Patient F had required multiple additional units of packed red blood cells with documented ongoing hypotensive episodes.

45. On post-operative day 12, the Respondent resumed his role as the attending surgeon.

46. On post-operative day 12, the patient hemorrhaged, suffered cardiac arrest and died.

47. The Respondent did not meet the standard of care in his treatment of Patients A, B, C, D, E and F.

Legal Basis for Proposed Relief

A. Pursuant to G.L. c. 112, §5, eighth par. (c) and 243 CMR 1.03(5)(a)3, the Board may discipline a physician upon proof satisfactory to a majority of the Board, that he engaged in conduct that places into question the Respondent's competence to practice medicine, including but not limited to gross misconduct in the practice of medicine, or practicing medicine fraudulently, or beyond its authorized scope, or with gross incompetence, or with gross negligence on a particular occasion or negligence on repeated occasions.

B. Pursuant to *Levy v. Board of Registration in Medicine*, 378 Mass. 519 (1979); *Raymond v. Board of Registration in Medicine*, 387 Mass. 708 (1982), the Board may discipline a

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physician upon proof satisfactory to a majority of the Board, that said physician has engaged in conduct that undermines the public confidence in the integrity of the medical profession.

The Board has jurisdiction over this matter pursuant to G.L. c. 112, §§ 5, 61 and 62. This adjudicatory proceeding will be conducted in accordance with the provisions of G.L. c. 30A and 801 CMR 1.01.

Nature of Relief Sought

The Board is authorized and empowered to order appropriate disciplinary action, which may include revocation or suspension of the Respondent's license to practice medicine. The Board may also order, in addition to or instead of revocation or suspension, one or more of the following: admonishment, censure, reprimand, fine, the performance of uncompensated public service, a course of education or training or other restrictions upon the Respondent's practice of medicine.

Order

Wherefore, it is hereby **ORDERED** that the Respondent show cause why the Board should not discipline the Respondent for the conduct described herein.

By the Board of Registration in Medicine,



Kathleen Meyer, Esq.
Board Vice-Chair

Date: August 6, 2014