Date: 9/1/2022

Arizona Medical Board

Re: [redacted]

Dear Board Members,

I have been asked to review the pertinent medical documents, imaging, and other pertinent medical records regarding the medical malpractice case of [redacted] versus Pitt. I have agreed to make a professional opinion as a practicing board-certified orthopedic surgeon with fellowship training in spinal surgery as to whether Dr. Pitt met the medical standard of care during his treatment of [redacted] I have agreed to do this in an honest manner, whether favorable or unfavorable to Dr. Pitt. I have been in private practice in the Phoenix area for 16 years. I have been a clinical instructor for the Mayo Clinic Arizona Orthopedic Surgery Residency since its inception 5 years ago and annually have the 4th year residents rotate for 6 weeks each on my service. I participate and help develop the didactics for the 3 month spine rotation. Prior to this I performed the same role with the Banner Phoenix Orthopedic Surgery Residency for 8 years. I have published clinical outcome papers regarding the developing dysphagia after anterior cervical fusion versus disc replacement and multiple other studies regarding various topics regarding spinal surgery over the years.

I am a professional colleague of Dr. Pitt's, but do not socialize with him. I am a financial partner in the Minimally Invasive Spine Surgery Center of Paradise Valley. I have made myself available to cover any on call needs for his practice on approximately 4-5 occasions over the last 16 years, but this did not result in any interaction with any of his patients. I am not a partner in practice with Dr. Pitt and have no other disclosures of potential conflicts of interest.

The first issue questioned in the malpractice claim is that of appropriate indication for surgical intervention at the C2-3 level or was the C2-3 level already fused/ankylosed and therefore fusion surgery would be unnecessary. I have reviewed the limited views presented to me from the patient's CT scan of the cervical spine performed on 6/21/2016, which show a degenerated disc at C2-3 and severe degeneration of the right facet joint without obvious findings of ankylosis. Reviewing these sagittal views, the C2-3 level was not ankylosed or fused on its own. It is well known that the adjacent levels above and below previous cervical fusions can have acceleration of the degenerative process and require surgical intervention. This adjacent level degeneration occurs at a higher rate than with normal aging in the non-fused spine. Tobert, et al (Clin Spine Surg 2017;30:94-101) noted that adjacent level degeneration happens 2-4% per year after a

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fusion and is a significant contributor to reoperation rates. Kong, et al (Medicine 2016; 95: E4171) reviewed adjacent level cervical spine disease in a large meta-analysis. The incidence appears to approach 3% per year of adjacent level degeneration on imaging, and 1.5% per year of symptomatic adjacent level disease. Hilibrand, et al (Spine 1997;22,1574-1579) reviewed their patients with adjacent level degeneration after anterior fusion treated with additional anterior ACDF or corpectomy with good outcomes. I find that an anterior fusion procedure at C2-3, which was not already fused, is a reasonable indication for adjacent level anterior fusion and is within the usual community medical standard of care.

The complication of an esophageal tear during revision anterior cervical surgery is a known complication and was part of documented pre-procedure consent. Dr. Pitt met the medical standard of care for consent for revision anterior cervical surgery that included esophageal tear. Esophageal tears in revision anterior cervical surgery can occur, but are rare. Foustas, et al (Spine 2007; 32:2310-17) in a review of 1015 patients encountered esophageal tears in 0.3% of the patients. This complication has been taught during the training of orthopedic surgeons and neurosurgeons because it is important to recognize this complication as soon as possible and repaired/treat as soon as possible because the consequences of late diagnosis of esophageal tears can be very difficult to treat, and in some instances deadly (Lee, et al. Spine J 2015;15:75-80). In a retrospective literature review looking at ACDF associated complications Foustas, et al (Spine 2007; 32:2310-17) found that the only death was related to an esophageal perforation that was not detected at the time of the surgery. Dr. Pitt recognized the tear immediately and after discussion over the phone with an ENT during the procedure, was able to competently repair it. The patient was then transferred to an acute hospital for formal ENT consult and continued management. Dr. Pitt met the medical standard of care for identification and management of the esophageal tear in this patient.

In the suit it has been asserted that performance of revision anterior surgery to the adjacent level to an anterior fusion should not be done in an ambulatory surgery center. The esophageal tear occurrence does not differ whether the surgery is performed in a hospital or ambulatory surgery center. Lee, et al (Evid Based Spine Care J 2014;5:101-111) noted in 2014 that a review of 5 studies meeting inclusion criteria showed no difference in complications regardless of where surgery was done. Helseth, et al (Br J Neurosurgery 2019;33:613-619) reviewed 1300 outpatient cervical spine surgery cases, with 1.2% major complications. The authors concluded outpatient surgery was safe, had a low complication rate, a low hospital admission rate, and a low re-operation rate at 1 year. Adamson, et al (J Neurosurgery Spine 2016;24:878-884) reviewed 1000 consecutive outpatient surgeries and noted a 2.2% hospital readmission rate within 30 days, and similar results compared to inpatient surgery. The authors concluded that anterior cervical surgery “can be safely performed in the outpatient surgery setting

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without compromising surgical safety." It has become standard of care to be able to perform ACDF procedures in an ambulatory setting in Phoenix, Arizona and also across the nation. I do not find that Dr. Pitt fell below standard of care in performing an ACDF procedure at a level not previously operated on adjacent to previous fusion. The ambulatory center that he was performing this surgery had a prearranged transfer agreement with a major trauma center in case of these rare complications that require further treatment or observation overnight.

After reviewing the facts that were presented in this case, I do not find that Dr. Pitt fell below a reasonable standard of medical care for [redacted] I respectfully disagree with the jury's findings that Dr. Pitt failed to provide [redacted] a reasonable standard of medical care during her treatment. My findings are:

1. Dr. Pitt had reasonable medical indications for the C2-3 ACDF for degeneration above her previous fusion.
2. The choice of performing revision anterior cervical surgery at an adjacent level not previously operated was medically reasonable and consistent with medical standard of care.
3. Dr. Pitt adequately consented the patient including the known risk of esophageal tear appropriately and the patient acknowledged the consent by signing.
4. Dr. Pitt immediately recognized the tear, involved ENT immediately by phone and then with appropriate transfer. This was within reasonable standard of care for managing the known complication of esophageal tear that can occur during anterior cervical surgery.

I am available if any additional information regarding this case needs to be reviewed or commented upon, please don't hesitate to contact me.

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