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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
JUANILITO SELDERA, M.D., RESPONDENT.	:	ORDER 0000654

[Division of Enforcement Case No. 09 MED 057]

The parties to this action for the purposes of Wis. Stat. § 227.53 are:

Juanilito Seldera, M.D.
146 E. Geneva Square
Lake Geneva, WI 53147

Division of Enforcement
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Wisconsin Medical Examining Board
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final decision of this matter, subject to the approval of the Medical Examining Board. The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Juanilito Seldera, M.D., Respondent, date of birth January 3, 1947, is licensed and currently registered by the Wisconsin Medical Examining Board to practice medicine and surgery in the state of Wisconsin pursuant to license number 23586-20, which was first granted on January 9, 1981.

2. Respondent's last address reported to the Department of Regulation and Licensing is 146 E. Geneva Square, Lake Geneva, Wisconsin 53147.

3. At the time of the events set forth below, Respondent was board certified in general surgery.

4. At the time of the events set out below, Respondent was employed as a physician at Aurora Health Center in Delavan, Wisconsin.

5. On June 3, 2004, Patient L.D., a 43 year-old female, presented to the Respondent upon referral from her primary care physician with a chief complaint of hoarseness of voice of three months duration. Patient L.D. had a medical history significant for a previous diagnosis of gastroesophageal reflux disorder ("GERD") with erosive gastritis and erosive esophagitis which had been unresponsive to medication (Prilosec and Nexium). Based on Patient L.D.'s history and the results of physical examination and diagnostic testing, Respondent recommended that the patient undergo a Nissen fundoplication procedure.

6. On July 14, 2004, Respondent performed Patient L.D.'s laparoscopic Nissen fundoplication procedure at Aurora Lakeland Medical Center. Respondent's operative report reflects that his pre- and postoperative diagnosis was severe reflux esophagitis with hiatal hernia. Intraoperatively, the greater curvature to the fundus of the stomach was sutured to the esophagus for anchorage and a total of three sutures were used for the wrap-around procedure for the fundoplication procedure. Respondent put a stitch in the crura, but failed to note that he had placed the stitch in his operative report. Respondent noted Patient L.D.'s postoperative condition to be satisfactory.

7. On June 16, 2004, Respondent discharged Patient L.D. at which time she reported no heartburn symptoms. Respondent instructed her to return the following week for evaluation. Patient L.D. was instructed to maintain a full liquid diet for three weeks and was prescribed Roxicet Oral Solution for pain. Respondent noted in his discharge summary that the laparoscopic Nissen fundoplication was successful.

8. On July 22, 2004, Patient L.D. presented to Respondent for follow-up evaluation. She reported that her heartburn had disappeared and that the hoarseness of voice was significantly improved. Physical examination showed that the trocar sites were healing well. Respondent instructed Patient L.D. to return in two weeks for re-evaluation.

9. On August 10, 2004, Patient L.D. returned to Respondent at which time she reported that her voice was back to normal and that the heartburn had more or less disappeared. She complained of being weak and that her appetite had not yet returned to normal. Respondent authorized Patient L.D. to return to work and to resume eating solid food again. He discharged her from his care back to her primary care physician or to the clinic, as needed.

10. From September 9, 2004 to November 10, 2004, Patient L.D. saw her primary care physician, Alex Canda, M.D., with complaints of sinus congestion, sneezing, runny nose and a cough which Dr. Canda initially diagnosed as acute rhinitis and sinusitis. However, a September 28, 2004 chest x-ray revealed a large hiatal hernia and an October 15, 2004 upper GI series and an esophagram revealed that the prior Nissen fundoplication had slipped through the esophageal hiatus

and was above the left hemidiaphragm. In addition, reflux was noted in the esophageal wrap and the distal esophagus.

11. On November 10, 2004, Patient L.D. underwent an upper GI endoscopy and esophagram which showed that the gastroesophageal junction had slipped through the hiatus into the chest cavity.

12. On December 2, 2004, Patient L.D. presented to the Respondent at which time he recommended that she undergo another operative procedure to reduce the hiatal hernia, but not the fundoplication as much as it was working. Physical examination revealed no discomfort or tenderness in the epigastric region. Respondent's impression was recurrent hiatal hernia with a slip through the gastresophageal junction toward the chest cavity. He explained the proposed re-do procedure in which he would bring down the gastroesophageal junction of the stomach below the hiatus and resuture the crura if visible. He advised that he would attempt the surgery laparoscopically but would convert it to an open procedure if necessary. He discussed the potential risks of the procedure and gave her an informational brochure. Respondent had never performed a re-do Nissen fundoplication prior to the proposed re-do on Patient L.D. Respondent should have either referred Patient L.D. to an experienced surgeon for the re-do procedure or had a surgeon experienced in re-do procedures assist him during the re-do procedure.

13. On December 21, 2004, Patient L.D. presented to the Aurora Lakeland Medical Center for the scheduled re-do procedure. Respondent's operative report reflects that he performed a reduction of the stomach, GE junction and the fundoplication as well as repair of hiatal hernia and reinforcement with an AlloDerm graft. The Respondent performed the procedures laparoscopically. Intraoperatively, Respondent observed extensive adhesions from the previous surgery in the gastroesophageal area as well as between the stomach on the omentum which were dissected. He also noted adhesions in the left crural area which required dissection. However, the Respondent was unable to dissect an area of adhesions in the posterior gastroesophageal area. At this point, the Respondent should have converted the laparoscopic procedure to an open procedure. Instead, he continued the procedures and next mobilized the stomach and the gastroesophageal junction below the diaphragm before repairing the hiatal hernia. He then tacked an AlloDerm graft to the crura and the diaphragm before placing a single suture in the diaphragm. Postoperatively, Respondent noted Patient L.D.'s condition to be satisfactory.

14. On December 27, 2004, Patient L.D. presented to the emergency room at Aurora Lakeland Medical Center with complaints of increasing left side and upper back pain with shortness of breath. A chest x-ray revealed pneumothorax. Respondent was consulted regarding an emergency chest tube placement. He reviewed the chest x-ray and inserted the chest tube at the level of the 6th intercostal space. After insertion of the chest tube, a large amount of serosanguinous fluid was recovered. A postoperative chest x-ray showed no significant expansion of the left lung. Respondent considered a mucus plug with atelectasis or pneumonia as possible causes. He ordered a chest CT scan to determine the etiology of the pleural effusion with pneumothorax. The CT scan showed post chest tube placement, a large area of increased density with numerous air bronchograms within the left mid and left lower lung posteriorly suggestive of atelectasis, and a large area of pneumonic infiltrate. Patient L.D. was admitted to the intensive care unit/telemetry.

15. On December 28, 2004, Respondent again saw Patient L.D. in consultation. His impression was that the pneumothorax and pleural effusion was possibly secondary to a ruptured bleb, to a diaphragmatic injury or to a mediastinal injury from the re-do procedure. An upper GI series with esophagram was obtained to rule out a perforation of the esophagus. Respondent noted an apparent communication between the stomach and the chest tube which Respondent felt could be due either to a rent of the gastric wall during the second surgery or to the chest tube penetrating the diaphragm and the stomach. Respondent concluded that the potential communication between the stomach and the pleural cavity required re-exploration and possibly repair of the area of the leak. He discussed this approach with Patient L.D. and her husband and recommended transfer to St. Luke's Medical Center where a thoracic surgeon was available.

16. On December 28, 2004, Patient L.D. was transferred from Aurora Lakeland Medical Center to St. Luke's where she was admitted by Nicholas Armstrong, M.D. Patient L.D.'s admitting diagnosis was a questionable perforated stomach, status post re-do laparoscopic hiatal hernia repair. A chest CT was ordered and demonstrated an apparent gastresophageal leak; status post hiatal herniorrhaphy with posterior mediastinal air collection and left hydropneumothrorax; almost complete collapse of the left lung, likely due to atelectasis; and atelectasis and/or infiltrate in the medial basal right lower lobe. Dr. Armstrong performed an exploratory laparotomy on that date which revealed recurrent migration of the wrap into the mediastinum and left-sided paraesophageal component with the fundus herniated in the left chest which was noted to be necrotic and perforated. He resected a portion of the greater curvature of her stomach and placed a Ponsky replacement gastrostomy tube into the upper portion of the stomach. He also performed a repair of the recurrent hiatal hernia and reinforced it with AlloDerm mesh. Postoperatively, Patient L.D. was taken to the intensive care unit and maintained on a ventilator for three days because of hypoxia from the previous two days. Patient L.D. was also seen by infectious disease and maintained on antibiotics and antifungals.

17. On January 4, 2005, Patient L.D. was discharged home with instructions to follow up in one week.

18. Respondent's conduct as herein described with regard to Patient L.D. fell below the minimum standards of competence established in the profession in the following respects:

a. Respondent failed to either refer Patient L.D. to another surgeon who had experience in performing re-do Nissen fundoplication procedures or to request that a surgeon experienced in re-do procedures assist him during the re-do surgery.

b. Respondent failed to convert the re-do procedure on December 21, 2004 to an open surgery after encountering extensive adhesions that he could not free up laparoscopically.

c. Respondent failed to note in his operative report that he had placed a stitch in the crura during the July 14, 2004 procedure.

19. Respondent has completed 4.5 hours of continuing education on advanced laparoscopy at the University of Chicago entitled "Minimally Invasive Treatment of Esophageal

Disorders" on December 3, 2010. Attached and incorporated into this document, identified as Exhibit A, is a copy of the certificate of credit verifying that the Respondent has participated in the course.

CONCLUSIONS OF LAW

1. The Wisconsin Medical Examining Board has jurisdiction over this matter pursuant to Wis. Stat. § 448.02(3) and authority to enter into this stipulated resolution of this matter pursuant to Wis. Stat. § 227.44(5).

2. Respondent's conduct as set forth in paragraphs 6 through 15 of the Findings of Fact is a violation of Wis. Stat. § 448.02(3) and Wis. Admin. Code § MED 10.02(2)(h).

ORDER

NOW THEREFORE IT IS ORDERED that the Stipulation of the parties is hereby accepted.

IT IS FURTHER ORDERED that:

1. Juanilito Seldera, M.D., is hereby REPRIMANDED.

2. The Board recognizes the aforementioned advanced laparoscopic course as the equivalent of the education the Board would have otherwise required.

3. Respondent is prohibited from applying the aforementioned educational credits toward satisfaction of continuing education requirements in any registration biennium.

4. Respondent shall within 90 days of this Order pay costs of this proceeding in the amount of two thousand three hundred ($2,300.00) dollars. Payment shall be made to the Wisconsin Department of Regulation and Licensing, and mailed to:

Department Monitor
Division of Enforcement
Department of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935
Telephone (608) 267-3817
Fax (608) 266-2264

5. Violation of any terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license. The Board in its discretion may in the alternative impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order. In the event Respondent fails to timely submit payment of the costs as ordered or fails to comply with the ordered continuing education as set forth above, the Respondent's license (No. 23586-20) may, in the discretion of the

board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied with payment of the costs or completion of the continuing education.

6. This Order is effective on the date of its signing.

MEDICAL EXAMINING BOARD

By: _____ 2·16·11

A Member of the Board Date