

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of
3 **JAY R. MELLEN, M.D.**
4 Holder of License No. 15628
5 For the Practice of Allopathic Medicine
In the State of Arizona.

Case No. MD-20-0110A
ORDER FOR LETTER OF
REPRIMAND; AND CONSENT TO THE
SAME

6 Jay R. Mellen, M.D. ("Respondent") elects to permanently waive any right to a
7 hearing and appeal with respect to this Order for a Letter of Reprimand; admits the
8 jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order
9 by the Board.

10 **FINDINGS OF FACT**

11 1. The Board is the duly constituted authority for the regulation and control of
12 the practice of allopathic medicine in the State of Arizona.

13 2. Respondent is the holder of license number 15628 for the practice of
14 allopathic medicine in the State of Arizona.

15 3. The Board initiated case number MD-20-0110A after receiving notification of
16 a malpractice settlement regarding Respondent's care and treatment of a 65 year-old
17 female patient ("DM") alleging improper performance of an esophagogastroduodenoscopy
18 by biopsying gastric varices during the procedure leading to uncontrolled bleeding with
19 subsequent death.

20 4. DW presented to Respondent for evaluation of abdominal pain on April 22,
21 2017. DW had a past medical history significant for the following:

- 22 a. On August 4, 2015, DW underwent an esophagogastroduodenoscopy
23 ("EGD") at a Hospital that was notable for erythema in the antrum and small
24 to moderate gastric varices without any high risk stigmata seen on
25 retroflexed view in the cardia. The post-procedure diagnoses were small to

1 moderate gastric varices similar in description to previous EGD in 2013 done
2 elsewhere.

3 b. On July 11, 2016, DW had a CT scan of the abdomen and pelvis that
4 showed large paraesophageal and perigastric varices seen along with a
5 hepatorenal shunt.

6 c. On April 10, 2017, DW was evaluated at the Hospital for generalized
7 abdominal pain, bloating, nausea, and vomiting. DW was found to have
8 ascites and the diagnosis of decompensated non-alcoholic steatohepatitis
9 ("NASH") associated cirrhosis was established. DW's past medical history
10 was noted to include insulin dependent type 2 diabetes mellitus,
11 hypertension, obesity, hyperlipidemia, and chronic diarrhea. An abdominal
12 and pelvis CT scan showed "diffuse cirrhosis, splenomegaly, porto-systemic
13 collateral vessels in the esophageal gastric area, portal hypertension, and
14 moderate abdominal and pelvic ascites.

15 d. On April 20, 2017, a CT scan of the abdomen and pelvis with contrast
16 described "hepatic cirrhosis (nodular contour, right hepatic lobar atrophy)
17 with portal hypertension, splenomegaly (14cm) and moderate abdominal and
18 pelvic ascites. Portosystemic collateral vessels are evident in the splenic
19 hilum and the gastroesophageal junction"

20 5. On April 23, 2017, at 0920, Respondent performed an EGD on DW.
21 Respondent's post-operative diagnosis was normal esophagus, normal examined
22 duodenum, congested mucosa in the gastric cardia that was biopsied. At 1050,
23 Respondent noted "hypertopic (sic) mucosa" in the gastric cardia and obtained a
24 superficial biopsy. Respondent further noted that a continuous flow of active bleeding was
25 immediately evident at the biopsy site. Respondent attempted to place a clip but it did not

1 deploy correctly due to its position in the cardia. Respondent further noted that he was
2 unable to locate the bleeding due to bleeding. Respondent noted a normal esophagus
3 without evidence of esophageal varices and described in the gastric cardia area a
4 "diffusely congested mucosa" and evidence of a "hypertopic (sic) mucosa". Respondent
5 performed a superficial biopsy of the area with cold biopsy forceps. The pathology report
6 of the gastric cardia biopsy showed "mild chronic inactive gastritis and negative for
7 Helicobacter". DW was transferred to the ICU and received blood transfusions, fresh
8 frozen plasma ("FFP") units, and octreotide drip.

9 6. On April 25, 2017, DW's care team including Respondent, thought that the
10 bleeding had subsided and agreed that the patient may need a transjugular intrahepatic
11 portosystemic shunt ("TIPS") or a balloon-occluded retrograde transvenous obliteration
12 ("BRTO") procedure and she was made to transfer DW to the Hospital. While DW was
13 being prepared for her transfer to the Hospital she had a profuse hematemesis, dark red
14 clots per rectum, and became hypotensive. DW's hemoglobin dropped from 9 to 6. DW
15 was transferred to the Hospital by air ambulance and placed in ICU. At 2021, DW had an
16 asystolic arrest that responded to CPR.

17 7. On April 26, 2017, at 0356, DW underwent the placement of a Blakemore
18 tube and an emergent TIPS procedure that was deemed as "technically successful TIPS
19 with embolization of one of the varices. At 0815, Respondent documented that DW had
20 received over 50 units of packed red blood cells, over 40 units of FFP with additional units
21 of platelets, and cryoprecipitate. At 1828, the previously placed TIPS was revised "by
22 extending upper end where narrowing was seen". Subsequently, DW became asystolic
23 and advanced cardiac life support was not successful at return of spontaneous circulation.
24 DW expired and her death certificate described "post procedural hemorrhage of a
25

1 digestive organ or structure following a digestive system procedure" as the principal
2 diagnosis.

3 8. The standard of care prohibits a physician from performing a biopsy during
4 an EGD in an area where gastric varices have previously been identified. Respondent
5 deviated from this standard of care by performing a biopsy during an EGD in an area
6 where gastric varices had previously been identified.

7 9. Actual patient harm was identified in that the patient expired.

8 **CONCLUSIONS OF LAW**

9 a. The Board possesses jurisdiction over the subject matter hereof and over
10 Respondent.

11 b. The conduct and circumstances described above constitute unprofessional
12 conduct pursuant to A.R.S. § 32-1401(27)(r) ("Committing any conduct or practice that is or
13 might be harmful or dangerous to the health of the patient or the public.").

14 **ORDER**

15 IT IS HEREBY ORDERED THAT:

16 1. Respondent is issued a Letter of Reprimand.

17
18 DATED AND EFFECTIVE this 16th day of February, 2021.

19 ARIZONA MEDICAL BOARD

20
21 By Patricia E. McSorley
22 Patricia E. McSorley
23 Executive Director
24
25

1 **CONSENT TO ENTRY OF ORDER**

2 1. Respondent has read and understands this Consent Agreement and the
3 stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent
4 acknowledges he has the right to consult with legal counsel regarding this matter.

5 2. Respondent acknowledges and agrees that this Order is entered into freely
6 and voluntarily and that no promise was made or coercion used to induce such entry.

7 3. By consenting to this Order, Respondent voluntarily relinquishes any rights to
8 a hearing or judicial review in state or federal court on the matters alleged, or to challenge
9 this Order in its entirety as issued by the Board, and waives any other cause of action
10 related thereto or arising from said Order.

11 4. The Order is not effective until approved by the Board and signed by its
12 Executive Director.

13 5. All admissions made by Respondent in this Order are solely for final
14 disposition of this matter and any subsequent related administrative proceedings or civil
15 litigation involving the Board and Respondent. Therefore, said admissions by Respondent
16 are not intended or made for any other use, such as in the context of another state or
17 federal government regulatory agency proceeding, civil or criminal court proceeding, in the
18 State of Arizona or any other state or federal court.

19 6. Notwithstanding any language in this Order, this Order does not preclude in
20 any way any other State agency or officer or political subdivision of this state from
21 instituting proceedings, investigating claims, or taking legal action as may be appropriate
22 now or in the future relating to this matter or other matters concerning Respondent,
23 including but not limited to, violations of Arizona's Consumer Fraud Act. Respondent
24 acknowledges that, other than with respect to the Board, this Order makes no
25 representations, implied or otherwise, about the views or intended actions of any other

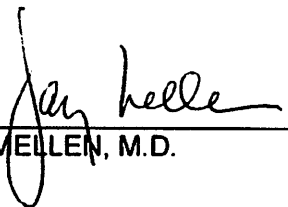
1 state agency or officer or political subdivisions of the State relating to this matter or other
2 matters concerning Respondent.

3 7. Upon signing this agreement, and returning this document (or a copy thereof)
4 to the Board's Executive Director, Respondent may not revoke the consent to the entry of
5 the Order. Respondent may not make any modifications to the document. Any
6 modifications to this original document are ineffective and void unless mutually approved
7 by the parties.

8 8. This Order is a public record that will be publicly disseminated as a formal
9 disciplinary action of the Board and will be reported to the National Practitioner's Data
10 Bank and on the Board's web site as a disciplinary action.

11 9. If the Board does not adopt this Order, Respondent will not assert as a
12 defense that the Board's consideration of the Order constitutes bias, prejudice,
13 prejudgment or other similar defense.

14 10. ***Respondent has read and understands the terms of this agreement.***

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17 _____
18 JAY R. MELLEN, M.D.

16 DATED: 2/8/21
17 _____

1 EXECUTED COPY of the foregoing mailed
2 this 16th day of February, 2021 to:

3 T. Scott King, Esq.
4 Broening, Oberg, Woods & Wilson, P.C.
5 2800 North Central Avenue, Suite 1600
6 Phoenix, Arizona 85004
7 Attorney for Respondent

8 ORIGINAL of the foregoing filed
9 this 16th day of February, 2021 with:

10 Arizona Medical Board
11 1740 West Adams, Suite 4000
12 Phoenix, Arizona 85007

13 Michelle Hobbes
14 Board staff
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