

**Surgeon – Mr Ian Breeze**

**A Report by the  
Health and Disability Commissioner**

**(Case 03/18935)**



Health and Disability Commissioner  
*Te Toiāhu Hauora, Hauātanga*



## Parties involved

Mrs A	Consumer/complainant
Mr Ian Breeze	Provider/general surgeon
Dr B	Surgical registrar
Dr C	Surgical registrar
Dr D	General practitioner
Dr E	General practitioner
Mr F	General surgeon

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## Complaint

On 12 December 2003 the Commissioner received a complaint from Mrs A about the care and treatment she received from Mr Ian Breeze. An investigation was commenced on 18 December 2003, as part of a Commissioner initiated inquiry into the quality of care provided by Mr Breeze to a number of patients on whom he performed surgery. The issue the Commissioner investigated was:

- *Whether Mr Breeze provided services of an appropriate standard to Mrs A, on whom he performed cholecystectomy surgery at Tauranga Hospital in October 1999, and who developed postoperative complications.*
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## Information reviewed

- Letter of complaint from Mrs A, dated 7 December 2003
- Transcript of interview with Mrs A on 23 March 2004
- Further information from Mrs A, dated 24 March 2004 and 17 August 2004
- Response to the complaint from Mr Breeze, dated 9 February 2004
- Further information from Mr Breeze, dated 19 April 2004
- Information from Dr B, dated 20 May 2004 and 5 November 2004
- Letter from Dr B, dated from 5 November 2004
- Information from Mr F, dated 28 April 2004
- Information from Dr D, dated 1 April 2004 and 20 May 2004
- Mrs A's medical records from Tauranga Hospital
- Mrs A's general practitioner records
- Response to provisional opinion from Mr Breeze, dated 24 August 2004

Independent expert advice was obtained from Mr Mischel Neill, colorectal and general surgeon.

## **Information gathered during investigation**

### *Diagnosis of acute cholecystitis*

In late August 1999 Mrs A, aged 60, consulted her general practitioner, Dr D, with abdominal pain. Dr D referred Mrs A for an ultrasound, which showed that she had an oedematous gallbladder, with the wall measuring up to 10mm in maximum thickness. The ultrasound also showed that within the gallbladder there were numerous calculi (stones) measuring 15mm or so, some of which were impacted in the region of the neck of the gallbladder. On 7 September 1999 Dr D referred Mrs A semi-urgently to the surgical outpatients department at Tauranga Hospital. However, before she received an appointment she was admitted acutely to hospital by her GP.

### *Acute admission to hospital*

On 15 September 1999 Mrs A consulted her general practitioner with increasing pain in her right upper abdomen through to her back. Dr D referred Mrs A to hospital, and she was taken to the Emergency Department by ambulance.

Mrs A was assessed and triaged at 6.40pm. The notes record that her temperature was 39 degrees, her blood pressure 153/80, her pulse 84 and oxygen saturation 98%. On examination, she was nauseated but not vomiting, and had no abdominal distension. She was tender in her right abdominal flank. Bloods were taken, and an ultrasound of her abdomen was arranged and taken. The ultrasound revealed a distended, grossly thick-walled gallbladder containing stones. Mrs A was treated conservatively. At 8.50pm she was given Augmentin (an antibiotic). At 9.25pm her temperature had decreased to 38.6 degrees. She was reviewed by the surgical registrar, and admitted to the ward at approximately 11pm. She was commenced on intravenous antibiotics.

On 16 September Mrs A had pain, but no analgesia was required. On 17 September she was seen by general surgeon Mr Ian Breeze during his ward round. He requested that she be placed on the waiting list for an urgent laparoscopic cholecystectomy. Mrs A was reviewed by a House Officer, who discussed with her the need for the operation, and that she had been listed as urgent. She was advised to maintain a low fat diet.

Mrs A was discharged on 18 September.

### *Admission to hospital for surgery*

On 23 September 1999 Mrs A had a pre-assessment appointment. Her history was noted, which included high blood pressure, chest pain, blood clots in her legs, anaemia, and atrial fibrillation. Mrs A told hospital staff that she bruises and bleeds easily.

On 26 October 1999 Mrs A was admitted to Tauranga Hospital for a laparoscopic cholecystectomy. The surgery was performed by Mr Breeze's registrar, Dr C, with Mr Breeze assisting. A laparoscopic cholecystectomy was attempted at 1.30pm, but it proved too difficult because of the presence of a large gallbladder mass, and was converted to open cholecystectomy. The operation note records:

“Indications: admitted acutely 16.09.99 with diagnosis of severe, acute cholecystitis. Earlier U/S had revealed gallstones. Patient improved with conservative treatment and listed for early interval cholecystectomy.

Procedure: Thrombo prophylaxis with Fragmin and intermittent calf compression. Antibiotic prophylaxis with oral Co-Trimoxazole and Rocephin 1 gram IV.

Palpation of the abdomen under anaesthesia confirmed a large mass in right upper quadrant. Primary Hassen cannula inserted through transverse supra-umbilical incision and camera introduced. This confirmed the presence of a large right upper quadrant mass involving the falciform ligament to such an extent it was not possible to safely insert a secondary epigastric port. Because of this and the general severity of the cholecystitis, we elected, without further ado, to convert to open cholecystectomy.

Kocher incision and peritoneal cavity entered. Laparotomy confirmed a right upper quadrant mass involving falciform ligament, hepatic flexor of colon, stomach, duodenum and gallbladder. These structures were dissected off the gallbladder which was found to be severely chronically inflamed, containing a large stone. The cystic artery and duct were ligated individually with 2/0 Dexon. Haemostasis was secured and the abdomen was lavaged with 3 litres of warm saline. A Redivac drain was inserted and the abdomen was closed with 0 Novafil to linea alba and staples to skin.”

The histology of the gallbladder showed appearances of acute/chronic cholecystitis.

Mrs A was returned to the ward at 5.30pm. She was reluctant to use her PCA (patient controlled analgesia), and her pain scores were therefore moderately high.

On 27 October Mr Breeze saw Mrs A during a ward round. No problems were noted. He recorded that she was stable and could take her medications with a small amount of oral fluid.

On 28 October Mrs A was comfortable and starting to eat and drink. Her observations were stable, and she was walking to the bathroom. It was noted that there was no drainage from her Redi-vac drain overnight, and her drain was removed. Mrs A advised me that although there had not been much drainage from her drains, the wound was still draining when the drain was removed. She recalled that one of the nurses was surprised when Mr Breeze directed the drains to be removed.

On 29 October Mrs A was seen by Mr Breeze during his ward round. He noted that she was becoming more comfortable and mobilising. The plan was to discharge her the next day. In the next entry in the progress notes, the physiotherapist recorded that Mrs A was mobilising, but that she was sore.

On 30 October the progress notes record that Mrs A slept intermittently until 4.30am, and was wakeful thereafter. It was noted that she had a rapid pulse, her temperature increased to 37.9 degrees, her pulse was 94 and irregular, her blood pressure was 164/82, her oxygen

saturation 94%, and she was feeling hot and cold. At 6am she was afebrile, with a pulse of 80, which was regular, blood pressure of 124/80, and oxygen saturation of 96%. Mr Breeze reviewed Mrs A later that morning. He recorded that she had been tachycardic in the evening, that her chest was clear, and her temperature 37.8 degrees. He requested an ECG, a test of cardiac enzymes, and for her temperature to be taken four times a day. After her ECG, it was noted that she felt well with no chest pain, and no further episodes of palpitations. It was noted later that morning that she was comfortable, moving well, and her observations were stable.

At 1.45am on 31 October, it was noted that Mrs A had noticed a slight smear of fresh blood on the toilet paper when she went to the bathroom. Mrs A was advised to report any further bleeding. Mr Breeze saw Mrs A during his ward round that morning, and advised that she was ready to be discharged.

Mrs A was discharged on 31 October. She was still in some pain at the time of discharge but expected it would dissipate over time.

#### *Development of wound infection*

Mrs A advised me that on 16 November the wound suddenly started to ooze while she was sitting at her table eating lunch. She consulted Dr D, who cleaned and dressed the wound, and prescribed a ten-day course of antibiotics. Mrs A recalled that during the appointment Dr D telephoned the outpatient clinic and left a message for Mr Breeze to call him, to tell him what had happened. She advised me that Mr Breeze did not return Dr D's telephone call.

Mrs A maintained a diary over this period. She advised that from November 1999 to March 2000 the seepage from her wound was so severe that it soaked through the dressings, and she had to return to her GP's clinic two to three times a day for dressing changes. Mrs A's GP records note that she had approximately 15 appointments with her GP at the medical centre between November 1999 and March 2000. However, Mrs A advised that she had approximately 75 visits to the medical centre during that period, specifically to attend the nurse's clinic for her dressings to be changed and her wound reviewed (appointments were not needed). Mrs A described the seepage from her wound as thick "milky, yellow ooze", with a putrid smell. Over this time her infection caused her significant pain. She was unable to walk erect, and she was constantly fatigued. Her appetite was poor, and she said that she lost over 20kgs in weight.<sup>1</sup> Because she required daily dressing changes, her skin became tender and sore where the dressing tape was applied.

Mrs A advised that on many occasions during her appointments with Dr D, he would phone the outpatient department to speak to Mr Breeze, who was not ever available. Despite

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<sup>1</sup> On 19 March 1999, prior to her cholecystectomy operation, Mrs A's weight was recorded by a cardiologist as 92.1kg. The anaesthetic chart for Mrs A's operation on 26 October 1999 records her weight as 79kg. On 29 November 2000 a cardiologist recorded Mrs A's weight as 83.3kg, but by 10 January 2001 it was noted on the anaesthetic record that her weight had dropped to 75kg.

leaving messages, Dr D's calls were not responded to. The only response she would get was an appointment card in the mail for an outpatient appointment. There is no record in Mrs A's GP records of Dr D attempting to contact Mr Breeze by telephone during appointments, and Mr Breeze has no recollection of being contacted by Dr D. I asked Dr D about his contact with Mr Breeze over this time. Dr D advised:

“Mrs A who I know well would be a very accurate reporter of the events. I therefore have no doubt that I must have attempted to contact Mr Breeze. Whether he was able to be contacted eg a day off or some other such, or whether he was unavailable and failed to return the calls I could not comment on. However, I did contact the acute surgical team of the day to arrange admission for attention to the abscess which we were not succeeding with ... I have no doubt that if Mrs A reported me attempting to reach Mr Breeze during that consultation then of course it would have happened.”

*Outpatient appointment – 23 November 1999*

Mrs A had an outpatient appointment with Dr C, surgical registrar to Mr Breeze, on 23 November 1999. Mrs A advised me that her wound was still oozing at the time of the appointment. Dr C explained to her the histology of her gallbladder, which showed acute/chronic cholecystitis with abscess formation. He noted that after the operation she developed a wound infection requiring drainage, but that the drainage was slowly settling. She still had a persistent small sinus, discharging purulent material, which had been packed. He noted that she was having regular dressing changes at a medical centre. On examination, the wound was clean apart from a small 5cm sinus in the middle, with no surrounding cellulitis, and Mrs A had no “constitutional” symptoms. Dr C wrote to Dr D after the consultation to advise of his review. He informed Dr D that he was hopeful her sinus would “heal up fairly soon”. Dr C advised Mrs A to continue regular daily dressings for her wound, and discharged her back into Dr D's care.

Mrs A recorded in her diary that she was given a further dose of antibiotics on 23 November, but it is not clear who prescribed them – there is no note of a GP consultation, and Dr C did not record a prescription being given in his consultation note.

*Consultations with GP – November 1999 to January 2000*

Mrs A recorded in her diary that on 25 November a blood vessel in her wound “burst”, and her seepage continued. There is no note of a consultation in Mrs A's GP records, but Mrs A noted in her diary that she was given another 10-day course of antibiotics, and the clinical records indicate that Dr D ordered a swab from Mrs A's abdomen on 25 November 1999, which was normal.

Mrs A's wound was redressed by Dr E, another general practitioner at the medical centre, on 4 December 1999. It was recorded that there was serous ooze from the wound. There is no record of a prescription being given, but Mrs A noted in her diary that she was given another 10-day course of antibiotics.

On 5 December Mrs A went to an after hours clinic to have her wound repacked and dressed. It was noted that there was moderate discharge from the wound.

On 18 December Mrs A visited the medical centre to have her wound dressing changed. It was noted that there was healthy granulation tissue, and a gradual improvement in condition.

Mrs A recorded in her diary that by 6 January 2000 the wound hole had closed, but a second painful area was developing and starting to ooze. Mrs A explained that a dark red line developed along the wound line, which became hot, changed colour to blue or purple, and began to ooze.

Mrs A was reviewed by Dr E on 10 January 2000. He ordered an abdominal ultrasound, because of her persistent abdominal pain post open cholecystectomy. The ultrasound was performed on 12 January. The radiologist noted:

“The biliary tree is non dilated and the liver appears normal. No associated fluid collection is identified adjacent to the liver, though I note there is a 1.5 to 2.0cm area of inflammatory change in the subcutaneous fat adjacent to the medial aspect of the surgical wound though no fluid collection is seen.”

The radiologist commented:

“I am uncertain as to the cause of the symptoms as ultrasound shows mild gastric wall thickening, which is a non specific finding and may represent inflammation or infiltration. Assessment for H. Pylori is suggested as the next initial investigation.”

Mrs A returned to Dr E on 14 January with pain in her right flank running down into her right groin. She also had some sore spots on her wound. It was recorded that Mrs A was sweating at night, and her appetite was intermittent. On examination, her abdomen was soft, and tender in the right lower quadrant. Dr E recorded that the scan showed Mrs A’s liver to be slightly enlarged. It was recorded that Mrs A had arranged an outpatient appointment the following week with Dr B, a registrar in the surgical outpatient department at Tauraunga hospital. Blood was taken for culture and testing, and an assessment of *Helicobacter pylori* ordered. An MSU (mid-stream urine) was also arranged. The MSU was normal. The blood results indicated an elevated ESR at 115,<sup>2</sup> her liver function was mildly raised, and she had a mildly increased platelet count. Serology showed the presence of *Helicobacter pylori*.

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<sup>2</sup> ESR is a measurement of blood sedimentation rate – the speed at which red blood cells settle at the bottom of a column of blood in a glass tube. The rate (speed) depends on the amount of certain proteins in the blood. ESR is a screening test for many different diseases. Conditions that may cause an elevated sedimentation rate include: infections; inflammatory diseases, such as rheumatoid arthritis and lupus; blood cancers, such as leukemia and lymphoma; and cancers that have spread (metastasized) to the lungs, kidneys, breast or colon. This test is not specific to one condition. An elevated sedimentation rate may be a sign of an underlying problem. Further testing is needed to identify the problem.  
(see: <http://www.mayoclinic.com/invoke.cfm?id=HO00025>).

On 17 January 2000 Dr E sent a letter of referral to the surgical outpatient department at Tauranga Hospital. He noted that Mrs A was having difficulties following her gallbladder surgery, which was complicated owing to adhesions, and an ultrasound scan showed inflammation around her liver.

*Outpatient appointment – 18 January 2000*

On 18 January 2000 Mrs A was reviewed by Dr B. Dr B noted that Mrs A had right-sided pain, which he attributed to constipation. Following the consultation, Dr B wrote to Dr D and stated:

“Thank you for referring Mrs A back to us three months following a laparoscopic cholecystectomy which had to be converted to an open cholecystectomy due to the gross inflammation of the gallbladder and surrounding structures which had been stuck to it. She has had a discharge from the wound which dried up a few weeks ago, but is complaining of a colicky right sided abdominal pain. She states her bowels have always been sluggish and her constipation has been worse since the antibiotics for the wound infection. The blood tests you performed last week showed mild derangement in LFTS however the bilirubin is normal and ALT has been raised for some time. Her WCC is normal and ESR 115 would suggest ongoing inflammation or post op changes. Urine test was clear and H-Pylori was just reactive. The U/S [ultrasound] also would be consistent with inflammatory change following the operation.

On examination the wound has now in fact healed. I can palpate her right colon which seems to me to contain a large amount of faeces. I have ordered a plain abdominal x-ray today and given her a script for some Metamucil. The pain is no doubt related to some post-operative inflammation. We would expect this to settle over the course of a year, however I also believe she is constipated and I have treated her with Metamucil. We will see her in clinic again in two weeks time to assess improvement.”

Mr Breeze advised me that Mrs A’s symptoms of colicky right-sided abdominal pain and constipation are also consistent with bowel cancer.

On 18 January Mrs A had a scan of her abdomen. The radiologist noted that there was no evidence of bowel obstruction, there was faecal content throughout the large bowel, and there was the impression of an “apple core” lesion (the term used to describe the X-ray shadow sometimes created by a large bowel cancer) in her right upper quadrant. Further ultrasound was recommended to assess the “apple core” lesion.

*Consultations with GP – 20 to 24 January*

Mrs A recorded in her diary that on 20 January another dark red and “very hot” line was developing on her wound scar. She consulted Dr D, who ordered a wound swab. On culture there was a light growth of coagulase-negative staphylococci. The notes recorded: “Ignore if wound improving and Rx [prescribe] if worse.” Mrs A was prescribed “Fluclox 250 (28)”, an antibiotic.

Mrs A recorded in her diary that on 21 January the wound “burst open again in the first location”.

On 22 January Mrs A’s abdominal wound dressing was changed at a medical centre. It was noted that there was serosanguinous fluid ooze from the wound. The wound was repacked, she was given antibiotics, and she was to have a further dressing change on 24 January (Monday).

On 23 January Mrs A went to an after hours clinic, where her dressing was changed. Mrs A advised that during one of her appointments at the after hours clinic in January (likely this appointment), the doctor tried putting a probe down into the wound, and noted that the wound was over two inches deep. She recalled that the doctor was “astounded” that she had not been called back to hospital for further surgery.

On 24 January Mrs A was reviewed by Dr E, who noted that she still had suppurative ooze from her wound.

Mrs A advised that she was in constant pain, was walking around doubled over, and could not eat. She contacted a surgeon friend of hers who is based in another city, and expressed her concern. He told her that her condition was “not good” and to insist on seeing Mr Breeze during her next outpatient appointment (arranged for 25 January). He also told her that she should contact him within 24 hours if she did not get any help following the appointment, and that he would “have [her] in hospital within 24 hours” to get her wound attended to.

*Outpatient appointment – 25 January 2000*

On 25 January Mrs A had an outpatient appointment with Dr B. She asked to see Mr Breeze during the appointment, and was reviewed by him. Following the consultation, as recommended by the radiologist in his ultrasound report of 18 January, Dr B requested an ultrasound of the possible ‘apple-core’ lesion.

Following the consultation Dr B wrote to Dr D and advised him:

“[S]ince I last saw her her wound sinus has once again broken down. It has been discharging some purulent fluid for which she has been treated with antibiotics. This wound sinus may well be due to a stitch and Mr Breeze feels we should therefore explore the wound under GA.”

Mr Breeze advised me that his opinion at that time was that the wound sinus was due to “a nidus infection of the nylon suture knot”. Accordingly, he recommended surgical exploration of the wound to remove the knot in the hope it would cure her infection.

On 25 January Mr Breeze completed a semi-urgent “notice for admission” form for Mrs A. The diagnosis was open cholecystectomy wound sinus, and the operation was for exploration.

*Further consultations with GP – late January and February 2000*

Mrs A advised that her bouts of pain continued, and she would walk around “bent over double”. The wound line would get very red and hot.

On 26 January Mrs A consulted Dr E, who noted that she had been seen by Mr Breeze and was for “re exploration”. Mrs A’s wound was repacked.

Mrs A returned to see Dr E on 28 January. Her wound was redressed, and it was noted that there was green/yellow ooze from the wound. On examination, her abdomen was soft and non-tender, and she felt well.

Dr E reviewed Mrs A again on 29 January, and her wound was redressed. Dr E recorded that there was still a lot of ooze, and that Mrs A felt that “there may be another area coming up”.

On 1 February Mrs A consulted Dr D, who gave a repeat prescription of “Fluclox (30)”.

Mrs A advised that by 7 February “a second bubble had appeared”. She consulted Dr D on 7 February, and he drained the wound abscess and took a swab. The swab cultured a light growth of *Salmonella enteritidis* group D, and Mrs A was commenced on a 20-day course of ciprofloxacin. On 8 February it was noted in the GP records that she was improving, although it is not clear whether she was seen on that date.

*Ultrasound scan 10 February 2000*

On 10 February 2000 Mrs A had a limited abdominal ultrasound for the applecore lesion identified on 18 January (as ordered by Dr B). The findings noted that a mass in the upper right quadrant or right-sided abdomen could not be excluded. A 30ml irregular heterogenous hypoechoic collection was demonstrated, probably within the peritoneal cavity lying anterior to the lower pole of the right kidney, as was a second smaller collection beneath her wound. The ultrasound report recommended further imaging of the large bowel with a double contrast barium enema to further investigate the mass.

I asked Mr Breeze about his management of Mrs A in light of the two small collections identified on the ultrasound. Mr Breeze gave conflicting accounts in relation to this issue. On the one hand, in a letter dated 19 April 2004, Mr Breeze advised me:

“At the time these [collections] were revealed, we were investigating Mrs A for a possible ‘apple-core’ lesion ...

The two small collections identified on ultra-sound on 10 February 2000 were incidental and asymptomatic. The superficial collection had a wick in situ and was therefore draining freely. The other collection was only 30mls in volume. Given that it was incidental and asymptomatic, together with non-specific ultrasound appearances, I

considered that it was probably a seroma.<sup>3</sup> For these reasons I considered that there were no clinical indications to arrange drainage, the potential risks of drainage exceeding the benefits. In the unlikely event that this collection was non-sterile, I considered treatment with antibiotics would have been curative. At that time Mrs A was on an extended course of the antibiotic *Ciprofloxacin* for her wound infection.”

Mr Breeze believed that the collections were sterile because Mrs A was asymptomatic, and the sonographic appearance of the collection lacked the thickened border typical of undrained chronic infection.

On the other hand, in a letter dated 24 August 2004 in response to my provisional opinion, Mr Breeze stated that it was Dr B’s decision not to drain the fluid. In this letter Mr Breeze said:

“The ultrasound scan performed on 10 February 2000 was suggested by the radiologist and was ordered by Dr B without my knowledge. The scan result was not discussed with me by Dr B, and Dr B made a judgement call that he would not arrange drainage of the fluid collection.”

Dr B confirmed that he requested the ultrasound scan on the recommendation of the radiologist. However, he denied that it was his decision not to arrange drainage of the fluid collection. He said that he had booked Mrs A for exploration of the “stitch” sinus on 25 January 2000. Mr Breeze was in charge of his operating lists and therefore it would have been Mr Breeze who decided not to proceed with surgery.

Dr B also said that copies of all investigations are sent to the consultant whose care the patient is under. Mrs A was under the care of Mr Breeze, and a copy of the ultrasound report should have been sent to him.

#### *Consultation with GP – 11 February 2000*

On 11 February 2000 Mrs A consulted Dr D, who incised the wound, and drained and packed it. He noted a further abscess of significance in the suture line. Mrs A was still on antibiotics.

Following the consultation, Dr D wrote to Mr Breeze and asked him for a further review of Mrs A. He advised, “I believe she has been seen by you subsequently and there are plans to explore the wound and remove her non dissolving suture.” He informed Mr Breeze that Mrs A’s wound was still a major problem, and that he had had to drain and pack a further abscess of significance in the suture line. Dr D advised Mr Breeze, “She remains on antibiotics full time which she doesn’t seem to be able to do without. Your attention to this problem on your return would be greatly appreciated.”

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<sup>3</sup> A seroma is a collection of sterile fluid in the tissue. The difference between a seroma and an abscess is that an abscess involves an infection.

*Outpatient appointment – 29 February 2000*

On 29 February 2000 Mrs A had an outpatient appointment with Dr B. In a letter to Dr D dated 29 February 2000, Dr B noted that Mrs A's original wound sinus had healed, but a second area had broken down over the wound. He noted that the wound swabs taken by Dr D on 7 February had grown the bacteria *Salmonella enteritidis*, and that she was on an extended course of ciprofloxacin.

It seems likely that it was at this consultation that a decision was made not to operate on Mrs A to drain or explore the wound, and that this decision was made by Mr Breeze in consultation with Dr B. Dr B advised me that his clinic note of 29 February 2000 to Dr D indicates that he discussed the results of Mrs A's ultrasound of 10 February with Mr Breeze at that consultation, and that a joint decision was made that surgery should not proceed. His clinic note to Dr D recorded:

“At this stage we are reluctant to explore the sinus as it is best just to try and treat it with antibiotics initially. Should they break down once again or not heal then we will revisit this option.”<sup>4</sup>

In his letter dated 19 April 2004, Mr Breeze advised me:

“On 16 February 2000, the hospital received a letter from Dr D dated 11 February 2000, informing me that Mrs A's wound remained a major problem, but that she had developed additional sites of discharge along her suture line. In response I arranged to see her at the next clinic, and this visit took place on 29 February 2000. ...

The new wound sinus involved a different segment of the wound, and the original sinus had healed. In light of this, it was clear to me that the basis of this new sinus couldn't have been an underlying nylon suture knot, as only one knot was used on the continuous nylon suture, and the knot was remote from the latest point of discharge. I therefore determined that removal of the nylon suture knot would not be beneficial, and that Mrs A's preferred treatment was with antibiotic Ciprofloxacin, effective against the organism identified to be *Salmonella Enteritidis*.”

In his letter of 29 February 2000, Dr B also stated that he had arranged an urgent barium enema to further investigate the “applecore lesion” that had been identified on the right side of Mrs A's colon on the ultrasound of 10 February.

Mrs A complained that her wound dressing was not replaced after her wound was reviewed during her outpatient appointment on 29 February, and that she had to drive straight from

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<sup>4</sup> The only other time Dr B used the first person *plural* pronoun “we” in recording consultations with Mrs A was in his letter of 25 January 2000 to Dr D to discuss the consultation at which Mr Breeze was present. By contrast, Dr B uses the first person *singular* pronoun “I” to describe consultations that do not appear to have involved Mr Breeze.

the outpatient appointment to a medical centre holding her dressing in place, to have the wound cleaned and the dressing changed.

Mrs A advised me that on 12 March the oozing stopped, and the wound closed.

On 22 March 2000 Mrs A had a double contrast barium enema to explore the possible applecore lesion. No intraluminal lesion was detected.

*Outpatient appointment – 28 March 2000*

On 28 March 2000 Mrs A had another outpatient appointment with Dr B. He noted that her “saga has finally come to a conclusion”, that her sinuses had healed and the barium enema looking at the applecore lesions seen on ultrasound was normal, with no intraluminal lesions visible. He reassured Mrs A and discharged her back to Dr D’s care.

In relation to Mr Breeze and Dr B’s response to her condition, Mrs A remarked, “They sort of make things quite as though it’s normal, you know, I suppose they see so much of it, I guess they get inured to it. But it’s different when it’s your body.”

*Subsequent problems and admission to hospital*

Mrs A advised that between March and December 2000 the wound gave her problems on and off – the wound line would become dark red and hot, and then would settle. There are no records in her GP notes of consultations with Dr D about her wound between March and November 2000. However, Mrs A advised that she had regular check-ups with her GP over that time for her hereditary heart condition, and that he always asked her if there had been further changes in the scar and generally checked her wound.

In December 2000 the wound became hot, swollen and discoloured, with acute pain. Mrs A consulted Dr D on 4 December 2000. Dr D recorded “GB [gall bladder] scar pres neuroma H/c 40mg + LA”.

On 12 December Mrs A consulted Dr D because her pain persisted, and she had developed a “big bubble” on the wound line. He noted that she looked unwell. There are no notes that any further investigations were requested, although it is recorded that on 15 December an X-ray result was received, which was “OK”.

Mrs A consulted Dr D on 15 December, and the consultation note recorded, “D/w [discussed with] radiologists ??? occult process. CT/MRI may be needed. Pt [patient] now desperate. BM [bowel motion] ok. Scar now ok but pain increasing ++. Admit TPH [Tauranga Public Hospital].”

Dr D referred Mrs A to the Emergency Department at Tauranga Hospital, because of chronic right abdominal pain radiating to her back. Mrs A was admitted under the care of Mr F. The differential diagnosis recorded on her admission on 15 December 2000 was “likely adhesions, ?new RUQ collection ?obstruction”. It was noted that she had a chronic sinus infection following her open cholecystectomy a year ago, which had closed.

On 17 December 2000 Mr F's plan was for Mrs A to undergo an endoscopic retrograde cholangiopancreatography (ERCP). An ERCP involves the injection of dye into the bile and pancreatic ducts using a flexible, video endoscope. X-rays are then taken to outline the bile ducts and pancreas. ERCP assists in the identification of gallstones, bile duct blockages, yellow jaundice, undiagnosed upper abdominal pain, cancer of the bile ducts or pancreas, and pancreatitis. The ERCP was booked for 10 January 2001. Ultimately the ERCP was not performed, as a CT scan on 18 December 2000 identified a fluid collection and Mr F decided to proceed to surgery.

On 18 December 2000 Mr F's house officer completed a form requesting a CT scan of Mrs A's abdomen and noted the provisional diagnosis as “?lost stone in abdo RUQ”.

The CT scan on 18 December identified a thick-walled, multiocular thin fluid collection in the musculature and deep soft tissues of the right flank wall, extending into the underlying peritoneum and retroperitoneum. Multiple fluid-filled cavities were identified, with the average fluid thickness measuring up to 1.1cm in diameter. The radiologist noted that the finding was likely to represent chronic infective change. No other obvious cause for her pain was demonstrated. The report concluded that it might be worth attempting percutaneous tube drainage, although the presence of multiple loculations might make complete elimination of the fluid difficult. A note in Mrs A's GP notes on 18 December records “X-ray – see!!”

Mr F discussed the results with the radiology department, and decided to operate to explore the wound and drain the collection of fluid. Surgery was booked for 10 January 2004 with Mr F. When asked about the circumstances surrounding his decision to operate on Mrs A, Mr F advised me:

“All the clinical indications were that this lady's protracted convalescence and failure to thrive was based on the old dictum ‘pus somewhere, pus under the diaphragm’. She was not severely toxic so we could call the infection of the wound and any subphrenic collection relatively low grade. These sort of subphrenic collections can literally drag on for years.”

Mrs A was discharged from hospital on 20 December 2000. She was booked for a pre-assessment clinic on 3 January 2001 for elective exploratory laparotomy surgery. She was advised to return to her GP if her pain worsened in the interim.

#### *Re-admission to hospital – 8 January 2001*

Mrs A consulted Dr D on 28 December 2000. He noted that she was infected, with a “hot bulge RUQ [right upper quadrant]”. He prescribed Synermox, an antibiotic, and queried admitting her.

On 8 January 2001 Mrs A consulted Dr D again. He referred her to the Emergency Department at Tauranga Hospital, after discussing her condition with Mr F's surgical registrar. It was noted that there was swelling beneath the wound, and she had developed an abdominal abscess that was about to rupture through her skin. She was admitted under the

care of Mr F. It was noted that she was already on the elective list for exploration/drainage of subphrenic and wound collections. She was given intravenous antibiotics and a decision was made to keep her in hospital until her planned operation on 10 January 2001 by Mr F.

*Operation – 10 January 2001*

On 10 January 2001 Mr F explored Mrs A's cholecystectomy wound and drained a perihepatic abscess. The operation note recorded:

“There were copious pockets of pus in the subcutaneous layer. The muscle layer was then opened and we entered in to the subphrenic abscess cavity with all its locules. These were broken down with blunt dissection using mainly the gloved finger, swab and sticks as well. This cavity extended down half way to the pelvic brim so therefore it was counter drained with a Belfield drain coming out from the right anterior axillary line from just below the umbilical level and a further Belfield drain coming out from over the dome of the liver and Rutherford Morrison's pouch. Yet a further drain comes out of the wound which was closed with three tacking sutures to the muscles layer and three tensions to the fat and skin. Pus swabs were taken. This must settle the problem and even although it might leave her a little weak and she may one day need repair of an incisional hernia, we have got to get her through this infection. 1 gram of Mefoxin given on the table. This is to be repeated 8 hourly. Standard post operative cares. These will be copious drains, draining at the moment in to Gamgee. Drainage bags can be applied to them if necessary.”

Mrs A had an unremarkable recovery from her operation, and was discharged on 21 January 2001. It is recorded in her discharge note that she was pain free on discharge. She was referred to the District Nursing service and given an appointment with Mr F for follow-up one month later.

Mrs A was reviewed by Mr F on 15 February 2001. Mr F wrote to Dr D following the consultation, and advised:

“This lady has done well after the drainage of a subphrenic abscess. At one of the drain sites there is still some discharge. The wound feels strong but I have told her not to be disappointed if it weakens up with time as it will eventually be able to be treated as an incisional hernia. However this may never be necessary.”

*Comment from Mr Breeze*

Mr Breeze advised me that in his view, Mrs A's postoperative sequelae was predicted by the severity of her cholecystitis and her co-morbidity. Mrs A had a particularly severely inflamed gallbladder, and he noted that “infective complications of the wound and subphrenic collections are well recognised to occur in a significant percentage of such cases, despite appropriate treatment”. He advised that antibiotics were given preoperatively to reduce the risk of infection.

*Complaint to Tauranga Hospital*

Mrs A advised me that in approximately February 2000 she sent Tauranga Hospital a letter of complaint about the care and treatment she received from Mr Breeze, but she never received a response. Mrs A did not keep a copy of the letter, and Tauranga Hospital does not have a record of receiving her complaint.

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**Independent advice to Commissioner**

The following expert advice was obtained from Mr Mischel Neill, colorectal and general surgeon:

**“Background**

[Mrs A] was referred to Tauranga Hospital Surgical Outpatients as a semi-urgent case on 7 September 1999. She had presented to the general practitioner with signs and symptoms of acute cholecystitis and this was confirmed by an ultrasound done by a private radiology company. [Dr D], her general practitioner wrote to Tauranga Hospital on 7 September outlining her problems of acute cholecystitis, and her co-morbidities of cardiac rhythm disturbance, ischaemic heart disease and hypertension. She was admitted to Tauranga Hospital under Mr Breeze on 16 September 1999 with a history of right upper quadrant and back pain, a temperature of 39 degrees Centigrade and a pulse of 84 beats per minute. The ultrasound had confirmed a distended thick walled gallbladder with multiple stones. She was commenced on intravenous antibiotics, and her systemic symptoms settled rapidly. She was discharged on 18 September 1999 on antibiotic cover and placed on the waiting list for cholecystectomy.

She was readmitted on 26 October 1999 for surgery. Under anaesthetic a mass was palpated in the right upper quadrant. The laparoscope was introduced with the thought of carrying out a laparoscopic cholecystectomy, but on assessment of the mass it was decided to convert the procedure to an open procedure. This was largely carried out by the registrar [Dr C], the assistant was Mr Ian Breeze. A large mass was found involving the gallbladder, and surrounding organs. The mass was carefully dissected off the surrounding organs and after ligation of the cystic duct and cystic vessels the gallbladder was removed. The abdominal cavity was washed out with saline and a Redi-vac drain inserted. The wound was closed in a routine manner.

The histology showed an acute on chronic inflammation of the gallbladder with a grossly thickened wall. There was mucosal ulceration and in the adjacent fat, small abscesses.

Post-operatively the surgical course was uneventful. There was minimal drainage from the Redi-vac. This was removed and she was discharged home on the 31 October 1999. She was seen for follow up in the Surgical Outpatient Clinic on 23 November 1999 where she complained of abdominal pain. On the 17 November 1999 she had developed a wound infection, which was discharging purulent material. A sinus had developed in

the scar from which the purulent material was discharging. At the Outpatient Clinic it was considered that this discharge was settling, that there were non constitutional symptoms and no surrounding cellulitis. She was advised to dress this daily and was discharged from the clinic. She returned to see her general practitioner on about 12 January 2000 because of continuing abdominal pain. She had an ultrasound of her abdomen carried out, which showed a normal biliary tree with no dilation and normal liver. There was no fluid collection within the abdomen, but a small area of inflammatory change in the subcutaneous fat in the wound. The gastric antrum and pylorus appeared slightly thickened. The remainder of the ultrasound was normal.

She was seen by [Dr B] in the Surgical Outpatients on 18 January 2000 when the wound was reported as being healed. The colicky abdominal pain was considered to be constipation and she was commenced on Metamucil. She was reassured by [Dr B] that her ultrasound findings were consistent with postoperative inflammation and he arranged an abdominal x-ray. Of note at this time blood results showed an ESR of 115 with a normal white count, but slightly raised liver function tests.

On 25 January 2000 she was again seen by [Dr B] where he recorded that the wound had broken down again and that Mr Breeze felt that the wound needed to be explored and she was placed on the waiting list. (It is not stated whether Mr Breeze saw her, or whether this was a decision made in consultation with the registrar.)

It does not appear from the notes that the wound was re-explored. The abdominal ultrasound, which had been carried out on 12 January 2000 suggested that there was an impression of an apple core lesion in the right upper quadrant and suggested a barium enema.

A limited ultrasound of the abdomen was carried out on 10 February 2000. It appears to have been referred by Mr Ian Breeze. This showed a 30ml irregular heterogeneous hypo-echoic collection probably within the peritoneal cavity lying anterior to the lower pole of the right kidney and inferior to the edge of the liver. A smaller collection was demonstrated beneath the wound within the anterior abdominal wall. On 11 February 2000 her general practitioner [Dr D] wrote a further letter to the Surgical Outpatients notifying them that the wound was still a major problem, and that he had opened the wound and packed a further abscess of significance in the suture line. She was seen in Surgical Outpatients by [Dr B] on 29 February 2000, where he records that the original sinus had healed, but a further one had opened up and a culture of this had grown *Salmonella Enteritidis*. She was started on an extended course of Ciprofloxacin 750 twice a day. She was sent for a barium enema on that appointment and the barium enema reported on 22 March 2000 was a largely redundant colon, but no intra-luminal lesion detected. She was seen again on 28 March 2000 where [Dr B] reported that the wound had healed and discharged her back to the general practitioner. There does not seem to be any recognition of the ultrasound report with respect to the intra-abdominal collection.

She continued to be unwell over the following year until she was admitted on 15 December 2000 with abdominal pain, becoming worse over the last three weeks, radiating into the back. A CT carried out on 18 December 2000 showed a multi-locular collection in the anterior wall extending into the peritoneal cavity and rectoperitoneal area. Multiple fluid filled cavities were recorded. She was discharged on 20 December 2000 and readmitted on 10 January 2001 where [Mr F] explored this area breaking down pockets of pus from the wound and subphrenic areas extending halfway down to the pelvic rim on the right. This area was cleaned out and multiple drains placed. She was discharged on 21 January 2001. Her recovery had been unremarkable.

### **Complaint**

The issue that the Commissioner is investigating is:

*Whether Mr Breeze provided services of an appropriate standard to [Mrs A], on whom he performed cholecystectomy surgery at Tauranga Hospital in October 1999, and who developed post-operative complications.*

### **Supporting Information**

[Mrs A's] medical records from Tauranga Hospital, relating to her cholecystectomy and post-operative care and treatment, marked "A" pages 1-204.

Letter of complaint from [Mrs A], dated 7 December 2003; transcript of interview with [Mrs A] on 23 March 2003; and additional information provided by [Mrs A] by letter dated 24 March 2003, marked "B" pages 205-227.

Letter to Mr Breeze, dated 18 December 2003 notifying him of the complaint and matters to be investigated; Mr Breeze's response to the complaint, dated 9 February 2002; request for further information from Mr Breeze, dated 14 April 2004; and Mr Breeze's response to the request for further information, dated 19 April 2004, marked "C" pages 228-242.

Request for information from [Mr F], dated 25 March 2004, and [Mr F's] response, dated 28 April 2004, marked "D" pages 243-248.

Request for information from [Dr D], general practitioner, dated 10 February 2004; [Dr D's] response, enclosing [Mrs A's] general practitioner records, received by facsimile on 16 March 2004; request for further information from [Dr D], dated 23 March 2004; [Dr D's] response, dated 1 April 2004; request for information from a general practitioner, dated 14 April 2004; and the general practitioner's response, dated 20 April 2004, marked "E" pages 249-342.

Request for information from [Dr B], dated 16 March 2004, and [Dr B's] response, dated 20 May 2004, marked "G" pages 517-520.

[Mrs A's] medical records from Tauranga Hospital relating to her heart condition. These documents are marked "F" pages 343-516.

Letter from [Mrs A's] general practitioner, [Dr D], 20 May 2004.

Bay of Plenty District Health Board outpatients letters.

### **Expert Advice Required**

To advise the Commissioner whether, in my professional opinion, Mr Ian Breeze provided services to [Mrs A] with reasonable care and skill and in accordance with professional standards, with particular interest in comments on the following matters.

### **The Operation**

*Whether the decision to proceed with surgery on 26 October 1999 was appropriate.*

The approach to this problem of a mass in the right upper quadrant involving an inflamed gallbladder has changed over the years. Originally this situation would have been left to settle completely prior to embarking on a cholecystectomy because of the risks of dividing the common bile duct or damaging major vascular structures in the vicinity. A cholecystotomy was often carried out where the fundus of the gallbladder was opened, the stones were removed, but the gallbladder was left in place and a catheter drain was brought out through the abdominal wall to drain the gallbladder. Once this had all settled down probably 3-6 months later the gallbladder was then removed by the open method. In more recent times with better anaesthetics a trial dissection is carried out, and cholecystectomy completed if the surrounding structures are well identified. This appears to be the case with [Mrs A], and I think the dissection, while it was difficult, was carried out well with no damage to the surrounding structures, in particular the common bile duct or the vascular supply to the liver or damage to the portal vein. I believe it was appropriate to proceed with the procedure.

*Whether the decision to convert to an open cholecystectomy operation was appropriate, or whether surgery should have been abandoned.*

The decision to convert to an open cholecystectomy operation was wise and appropriate. Clearly if identification of surrounding structures was not possible, then the procedure should have been abandoned. However, the common bile duct and vessels were identified and dissection of the gallbladder was carried out successfully.

*Whether the operation was performed in accordance with professional standards.*

I believe this procedure was performed in accordance with professional standards.

*Whether Mr Breeze's choice of drainage following [Mrs A's] surgery was appropriate.*

Most cholecystectomies are now carried out laparoscopically and a very small percentage are converted to an open procedure, probably in the order of 5%. It is routine in a laparoscopic cholecystectomy to insert a Redi-vac drain to drain any

lymphatic fluid or blood. From the operation note there did not appear to be a great deal of pus present within the dissected margins so I believe the insertion of a Redi-vac was to drain any blood collection. In hindsight clearly this was inappropriate and a large drain should have been placed. This is usually an open drain, either a corrugated type or a large diameter closed drain.

*Any other matters*

The decision to operate in this situation where there is a mass in the right upper quadrant is very much dependent on the experience of the surgeon. To leave the mass or even to place a catheter into the fundus of the gallbladder and leave the mass to settle usually means that the patient is not particularly well for a number of months. The surgeon is always keen to avoid this long chronic illness if at all possible, and a second operation. I believe this was the driving force in this case. The operation in removal of the gallbladder was within the range of professional standards.

**Post-operative care and treatment**

*Whether [Mrs A's] post-operative management by Mr Breeze was appropriate.*

[Mrs A] post-operative course prior to discharge was uneventful with respect to surgery, but she did have some cardiac problems, which were managed well. On discharge there was no recording of any discharge from the wound. The wound was reported as healthy, and there had been minimal drainage from the Redi-vac.

*Whether [Mrs A] received appropriate timely care for the treatment of her infected wound.*

[Mrs A's] post-operative wound care appears to have been managed by the two registrars, [Dr C] initially, and then [Dr B]. It is unclear from the notes whether Mr Breeze saw her during any of the appointments in Outpatients, or whether on 25 January 2000, the registrar just discussed the case with Mr Breeze. I do not know the procedure in Tauranga Hospital as to whether the registrars manage the post-operative cases, or whether it is a shared responsibility with the consultant surgeon. The early management of this lady's wound was appropriate. She was investigated with an ultrasound, which showed a small area of inflammation within the wound, but no collection. This was treated by antibiotics and the colicky abdominal pain about which she complained was thought to be constipation. However, the blood tests during that admission showed an ESR of 115, but a normal white count and mildly raised liver functions tests. I believe this should have raised the question of chronic inflammation. A decision was made to explore the wound, but this did not appear to have been carried out, mainly because the original sinus had healed, and another one had opened, which grew *Salmonella Enteritidis*.

*The action a reasonable surgeon would take to manage a wound infected by the organism *Salmonella Enteritidis*.*

It was appropriate to start the patient on Ciproxin as an antibiotic of choice, but I believe the wound should have been explored at this point.

*Whether appropriate action was taken in response to the ultrasound on 10 February 2000 that revealed two small collections.*

The ultrasound report appears to have been requested by Mr Breeze. However, there is no record in the notes of this having been seen or acted upon. A letter from the general practitioner asked for re-evaluation as the wound was still a major problem. She was reviewed by the registrar on 28 March 2000 when the wound was recorded as being healed, and she was discharged from the clinic. Had the ultrasound report been seen it would have been noted that there appeared to be an intra-abdominal collection of some 30ml in size situated at the lower pole of the right kidney below the inferior surface of the liver. There was also a small collection in the wound. These collections should have been drained by opening the wound and re-exploring the area or possibly by insertion of a drain via CT guidance. I believe with the chronicity of the inflammation that exploration of the wound and peritoneal cavity was the treatment of choice.

*The relationship between [Mrs A's] early post-operative treatment and the subsequent subphrenic abscess and wound collection, which [Mr F] drained on 10 January 2001.*

The ultrasound report of 10 February recorded a probable collection within the peritoneal cavity. As this remained untreated it is likely to have increased in size, and eventually developed into the intra-abdominal collection found on [Mr F's] laparotomy.

*Whether Mr Breeze's decision not to surgically explore [Mrs A's] wound was reasonable in the circumstances.*

It is always easy in retrospect to find the ideal treatment for a patient, which would have been early exploration of the wound. However, the management of the wound appears to have been managed by the two registrars [Dr B] and [Dr C]. I could not find any record of Mr Breeze having seen her in Outpatients. As this occurred in January and February 2000 it could have been that Mr Breeze was in fact on vacation. I believe it was quite reasonable to treat the wound by antibiotics initially up to the point of 10 February 2000 when the ultrasound suggested a mass in the peritoneal cavity and a further collection in the wound. At this point the wound should have been explored and drained as discussed above.

*The level of communication, if any, that would be expected between the surgeon and general practitioner regarding the care of an infected wound in these circumstances.*

The letters written by the registrars were very full and adequate and maintained good communication between the hospital and the general practitioner. He communicated his concerns as well via his letter.

*Any other matters*

[Mrs A's] cardiac condition may well have been a factor in treating the wound conservatively rather than by surgical exploration. The fact that this occurred around the New Year was probably also a further factor. I think there are several points within the history though that need mentioning, and that is the blood tests on 18 January 2000, which recorded an ESR of 115, and raised liver function tests. This should have suggested ongoing infection more significant than the wound infection. The second point was the ultrasound of 10 February which suggested an intra-peritoneal collection. It is my opinion that Mr Breeze acted with reasonable care and skill in the treatment of [Mrs A], there was a minor departure from a required standard of care in the wound management."

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**Response to Provisional Opinion**

In response to my provisional opinion, Mr Breeze accepted that, with the benefit of hindsight, it is possible that Mrs A's fluid collection contained sub-clinical infection. However, he submitted that Mrs A's clinical condition at the time indicated that the collection was sterile, and that accordingly the decision not to drain it was reasonable. In support of his position he submitted that:

1. Mrs A was asymptomatic. Although blood tests on 14 January 2000 showed an elevated ESR and abnormal liver function, both results are non-specific. An elevated ESR cannot differentiate between an infection confined to the wound or an infection also involving the abdomen. The results do not suggest ongoing infection beyond the wound;<sup>5</sup>
2. Mrs A's abdominal ultrasound of 12 January 2000 did not identify an intra-abdominal infection or fluid collection;
3. The sonographic appearance of the collection lacked the thickened border typical of undrained chronic infection; and
4. Mrs A's clinical course from 28 March 2000 was not that of a patient harbouring infection.

Mr Breeze also submitted that none of the doctors who treated Mrs A subsequently diagnosed an infective process. In particular, Dr D did not suspect that Mrs A had developed a fluid collection when he reviewed her in December 2000; Mr F's initial differential diagnosis was "likely adhesions ?new RUQ collection ?obstruction"; Mr F

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<sup>5</sup> Mr Breeze referred to a statement from Walter and Israel, *General Practice* (6<sup>th</sup> ed.) in support of his position – "The non-specific nature of the ESR limits its value in diagnosis, but nevertheless it is a useful investigation" (page 619).

initially booked Mrs A for an ERCP, an investigation used to detect bile duct stones; a CT scan requested by Mr F noted that the provisional diagnosis was “? Lost stone in abdo RUQ”; and when a collection was diagnosed on 18 December 2000 drainage was deferred until 10 January 2001 because the collection was not infected. Mr Breeze submitted that microbiological analysis confirmed that Mrs A’s collection was not infected, and that the absence of infection increased the diagnostic difficulties.

Mr Breeze disagreed with Mr Neill’s advice that the collection identified by ultrasound on 10 February 2000 developed into the intra-abdominal collection drained by Mr F on 10 January 2001 for two reasons. First, the evidence indicates that the collection identified on 10 February 2000 was sterile. Secondly, the collection was never demonstrated to be intra-abdominal. Accordingly, he argued that drainage of the collection in February 2000 would not have prevented the development of the later collection drained by Mr F on January 2001.

Mr Breeze advised that he does not accept Mr Neill’s criticism about his choice of drain following Mrs A’s cholecystectomy, or the suggestion that Mrs A’s fluid collection may have been prevented by using a large drain. He also submitted that what Mr Neill had called a “minor departure” from the required standard of care in Mrs A’s wound management is “not consistent with a finding of a breach of the Code of Patients Rights per se”. Mr Breeze noted the risk of forming an opinion with the benefit of hindsight.

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### **Further independent advice**

Mr Neill reviewed Mr Breeze’s response and provided the following additional expert advice:

“I find Mr Breeze’s response to your provisional opinion strange, as many of his points are contrary to the facts in the report. I propose answering a number of questions from his report.

1. Mr Breeze is incorrect in asserting that it was only [with the] benefit of hindsight that it can be said that there was evidence of wound infection in February 2000. To summarise the facts leading up to February 2000. After discharge from hospital [Mrs A] was seen on 3 November [1999] with abdominal pain. On 17 November the wound was recognized as being infected, and was discharging purulent material, a sinus developed. [Mrs A] was told that this infection would settle by itself. On 12 January 2000 she again consulted her general practitioner with continuing abdominal pain. Ultrasound at this stage showed infection in the wound, and she had an ESR of 115. This point will be dealt with later. The ultrasound on 12 January talked about an applecore lesion in the right upper quadrant. A barium enema was later carried out and showed normal colon and this applecore may have represented the early evidence of an abscess. On 25 January

2000 the wound again broke down and discharged purulent material. On 10 February 2000 an ultrasound was carried out and the report reads, 'that a 30 ml irregular heterogeneous, hypoechoic collection probably within the peritoneal cavity lying anterior to the lower pole of the right kidney and inferior to the edge of the liver. A smaller collection was demonstrated beneath the wound within the anterior abdominal wall'. This was the report reported by the radiologist. This is very different to Mr Breeze's comment that [Mrs A] had undergone an abdominal ultrasound and this did not demonstrate any intra-abdominal infection of fluid collection requiring drainage.

On 11 February 2000 [Mrs A's] general practitioner [Dr D] wrote a further letter to Surgical Outpatients notifying them that the wound was still a major problem, and that he had opened the wound and packed a further abscess of significance in the suture line. [Dr B] on 29 February recorded that a further sinus had opened, and that a culture of pus had grown Salmonella enteritidis. She was started on an extended course of Ciprofloxacin 750mg twice a day. I find it difficult to understand Mr Breeze's comments that the clinical feature[s], sonographic features, and disease course of this collection indicated that it was sterile.

2. The collection was not asymptomatic. The patient complained of abdominal pain on a regular basis. She had a discharging wound. It had cultured Salmonella enteritidis, which required large doses of a very strong antibiotic Ciprofloxacin.
3. The chronicity of the wound. Abscesses have a habit of becoming chronic if they are not drained, and often the only lab result which would indicate this is a raised ESR. The white count may frequently be normal, and the symptoms from the abscess may be few. I believe the raised ESR to 115 was very significant, and while one cannot differentiate between an abscess in the abdominal wall and in the intra-abdominal abscess from this result I would not expect the ESR to be as high as this from a wound infection.
4. The collection in the wound and in the abdominal cavity shown on ultrasound on 10 February 2000 if not treated, would slowly increase in size, and form the larger collection seen on the CT carried out on 18 December 2000. I do not follow Mr Breeze's argument with regard to this known early collection not developing into the larger one, and that had the early collection been drained it would not have prevented the larger collection. I think this is a rather naïve opinion.
5. 'The fact that none of the other doctors involved in [Mrs A's] care in early 2000 identified an infective collection indicates that there was no infective collection.' Mr Breeze in his report Page 2 states that in [Dr B's] judgement call, he would not arrange drainage of the fluid collection. The fact that pus had been draining from the wound directly above the collection and that it had grown bacteria, and continued to discharge, certainly does not suggest it was sterile.

6. Mr Breeze mentions in his notes that [Mrs A] did not contact her general practitioner [Dr D] about her wound [from] the end of March. However, in the notes the letter from [Dr D] says that she continued to be unwell over the following year until she was admitted on 15 December 2000 with abdominal pain etc. Also mentioned in the report that [Mrs A] states that [Dr D] repeatedly tried to contact Mr Breeze by phone to discuss [Mrs A's] wound infection, but was unable to contact him. Clearly if the wound was not causing problems then why was [Dr D] trying to contact Mr Breeze.
7. Drains. At operation the gallbladder was engulfed in a large mass, which was reported as acute on chronic inflammation and that there were abscesses within the fat. A Redi-vac was used for drainage, but with the pathology found the likelihood of post-operative infection with pus would be significant. A Redi-vac is good for draining serum, a little blood, bile, but does not function well when there is significant bleeding because of clotting blocking the drain sites. It does not drain pus well, or colonic contents. If there is a significant risk of pus collecting then a Redi-vac is not the best choice because of the poor drainage. This was why I suggested that an open drain or a large bore closed drain would have been a better choice.

Mr Breeze makes the point that there was little drainage from the Redi-vac and this may well have been because it was blocked, either from blood clot or from thickened pus. Had there been an open drain or a large bore drain then there may well have been a good deal more drainage. This is perhaps a minor point, but a good teaching point.

8. It appears from the notes and from Mr Breeze's response to your provisional report that much of [Mrs A's] management was unsupervised by Mr Breeze. For example:
  - (i) 'Ultrasound ordered by [Dr B] without my knowledge.'
  - (ii) '[Dr B] made a judgement call that he would not drain the fluid collection. No input from Mr Breeze.'
  - (iii) 'Scan result not discussed with me.'
  - (iv) Seen by [Dr B] on 18 January complaining of abdominal colicky pain, an ESR of 115, it was considered that constipation was the cause. There was no record of any input by Mr Breeze.
  - (v) There was very little in the notes about Mr Breeze's input and few recordings by Mr Breeze. In Outpatients she was invariably seen by the registrar [Dr B] who was a junior registrar needing close supervision."

## Code of Health and Disability Services Consumers' Rights

The following Right in the Code of Health and Disability Services Consumers' Rights is applicable to this complaint:

### *Right 4*

#### *Rights to Services of an Appropriate Standard*

*(1) Every consumer has the right to have services provided with reasonable care and skill.*

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## **Opinion: No Breach – Mr Ian Breeze**

### *Operation*

Mrs A consulted her general practitioner, Dr D, in August 1999 with abdominal pain. An ultrasound was ordered by Dr D, which revealed that she had an oedematous thick-walled gallbladder with stones. Dr D referred Mrs A semi-urgently to surgical outpatients at Tauranga Hospital. However, on 15 September, before she was seen in the surgical outpatient department, Mrs A experienced an attack of increasing pain in her right upper abdomen, and was referred by Dr D to the Emergency Department at Tauranga Hospital.

On 15 September Mrs A was admitted to Tauranga Hospital under the care of Mr Breeze. A further ultrasound was taken, and she was diagnosed with severe acute cholecystitis. Mrs A was treated conservatively with intravenous antibiotics. Her condition improved, and she was discharged on 18 September. Mrs A was placed on the waiting list for an urgent laparoscopic cholecystectomy.

A laparoscopic cholecystectomy was attempted on 26 October 1999 by Dr C, Mr Breeze's registrar, with Mr Breeze assisting. There was a large gallbladder mass present, which made laparoscopic surgery too difficult, and the procedure was converted to an open cholecystectomy. The procedure was difficult, but the severely and chronically inflamed gallbladder was successfully removed. Mrs A's abdomen was lavaged with three litres of warm saline, a Redi-vac drain was inserted, and the wound was closed.

There are risks in operating on an inflamed gallbladder, in particular, a risk of dividing the common bile duct and/or damaging major vascular structures. Traditionally, therefore, acute cholecystitis is treated conservatively, and gallbladder inflammation allowed to settle for three to six months prior to surgery being undertaken. However, my advisor informed me that in more recent times, with better anaesthetics, it is reasonable for a surgeon to trial dissection, and complete the dissection (cholecystectomy) if the surrounding structures are well identified.

The operation on Mrs A was performed approximately one month after her attack of acute cholecystitis, while her gallbladder was still severely and chronically inflamed. However, as noted by my advisor, it was nonetheless reasonable for Mr Breeze to trial dissection, and continue if the surrounding structures were well identified. In Mrs A's case, a laparoscopic cholecystectomy proved too difficult, and the cholecystectomy was converted to an open procedure. I accept my expert advice that the decision to convert to an open cholecystectomy was wise and appropriate. Once converted to an open cholecystectomy, the surrounding structures (common bile duct and vessels) were identified. Accordingly, as noted by my advisor, it was appropriate for the operation to proceed.

I am satisfied that the decision to proceed with surgery was appropriate in Mrs A's case. It appears that the procedure was carried out well, in accordance with professional standards. Accordingly, in my opinion Mr Breeze did not breach Right 4(1) of the Code in relation to Mrs A's surgery on 26 October 1999.

Following surgery Mrs A's abdomen was lavaged, and a Redi-vac drain was inserted to drain any blood collection. Because of the severity of her condition, Mrs A was at risk of forming a subphrenic abscess and developing a wound infection, and therefore a Redi-vac drain may not have been adequate. My advisor informed me that, in hindsight, Mr Breeze's choice of drain was inappropriate, and a large drain should have been placed – either a corrugated type open drain or a large diameter closed drain.

Mr Breeze disputed this aspect of my expert advice on the grounds that it could not be established that his failure to use a larger drain contributed to Mrs A developing a wound infection. Mr Breeze submitted that, whatever its size, the drain would have been removed within five days of the cholecystectomy surgery and therefore it could not be maintained that there was a causal connection between the size of the drain and the infection that was drained over a year later, in January 2001.

In response, my advisor stated that while a Redi-vac is good for draining serum, and a little blood and bile, it does not function well if there is significant bleeding because clots block the drain sites. Nor does a Redi-vac drain pus or colonic contents well. In Mrs A's case there was significant likelihood of postoperative infection with pus because the gallbladder was found at operation to be engulfed in a large mass, which was severely and chronically inflamed and abscesses were found within the fat. If there is a significant risk of pus collecting then a Redi-vac is not a good choice because of the poor drainage. Mr Neill therefore suggested that an open drain or a large bore closed drain would have been a better choice. Noting Mr Breeze's comment that there was little drainage from the Redi-vac, my advisor stated that this may well have been because the Redi-vac was blocked, either from a blood clot or from thickened pus. He felt that had there been a more open drain or a large bore drain then there might have been more drainage.

My role is to assess whether Mr Breeze acted reasonably in the circumstances that he faced at the time. That assessment must be free from the influence of hindsight bias. My advisor's comment that Mr Breeze's choice of drainage was inappropriate in this case is made with the benefit of hindsight. Accordingly, I am unable to conclude that at the time, Mr Breeze

acted unreasonably by inserting a Redi-vac drain. However, Mr Breeze should review his practice in light of my advisor's comment on the choice of drainage in this case.

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## **Opinion: Breach – Mr Ian Breeze**

### *Postoperative care and treatment*

Mrs A's postoperative course prior to her discharge from hospital on 31 October was uneventful with respect to her surgery, and appropriately managed. On discharge, her wound was noted to be healthy.

On 16 November, Mrs A's wound began to ooze. She consulted her GP, Dr D, who cleaned and dressed the wound and prescribed a ten-day course of antibiotics. Mrs A advised that between November 1999 and March 2000 she visited her GP's medical centre sometimes more than once a day to have her wound redressed and cleaned. During many of her consultations with Dr D, he attempted to contact Mr Breeze, who was never available and did not return Dr D's calls. While Mrs A's GP notes do not reflect that she visited the medical centre as often as she claims (nor do they record telephone calls to Mr Breeze at the surgical outpatient department) they do clearly indicate that Mrs A's wound was an ongoing problem and that she regularly consulted the medical centre to have her wound reviewed and redressed. I accept that Mrs A's wound was a chronic problem that required significant attention by her GP and other staff at the medical centre.

On 23 November Mrs A had an outpatient appointment with Mr Breeze's registrar, Dr C. Dr C noted the wound infection and persistent small sinus, which had been discharging purulent material. On examination Dr C felt that because the wound was clean with no surrounding cellulitis, and Mrs A had no "constitutional" symptoms, the sinus would heal up quickly and could be appropriately dealt with by her GP. Accordingly, Dr C discharged Mrs A back into Dr D's care.

My advisor informed me that the early management of Mrs A's wound was appropriate. Accordingly, I accept that it was appropriate for Mrs A to be discharged back into the care of her GP following the appointment on 23 November.

Mrs A's condition did not improve. It is clear that between November 1999 and January 2000:

- Mrs A was in regular contact with her GPs (Dr D and Dr E);
- the seepage from her wound was persistent and significant, and she received regular prescriptions of antibiotics; and
- the wound caused persistent pain and discomfort.

Because her condition was not improving, Dr E referred Mrs A for an ultrasound on 10 January 2001. The ultrasound was performed on 12 January, and showed a small area of inflammation within the wound. The ultrasound reported noted:

“No associated fluid collection is identified adjacent to the liver, though I note there is a 1.5 to 2.0 cm area of inflammatory change in the subcutaneous fat adjacent to the medial aspect of the surgical wound though no fluid collection is seen. ...

COMMENT: I am uncertain as to the cause of the symptoms as ultrasound shows mild gastric wall thickening, which is a non specific finding and may represent inflammation or infiltration. Assessment for H. Pylori is suggested as the next initial investigation.”

On 14 January Mrs A reported to Dr E that she was sweating at night and her appetite was poor. Dr E ordered blood tests, which showed that her white cell count was normal, but her ESR was 115 and her liver function was mildly raised. *Helicobacter pylori* serology was also positive. On the basis of her poor condition, ultrasound and blood tests results, Dr E referred Mrs A back to the surgical outpatient department.

Dr B, registrar, reviewed Mrs A in the surgical outpatient department on 18 January 2000. He noted that her wound had healed and her pain was probably due to postoperative inflammation. He ordered a plain abdominal X-ray to investigate her right-sided abdominal pain, which he thought was attributable to constipation. My advisor informed me that although Mrs A’s management at this stage was appropriate, the blood test results showed an ESR of 115 and mildly raised liver function, which should have raised the question of chronic inflammation.

The result of the ultrasound was not significant in terms of Mrs A’s wound infection, although it did show an “applecore” lesion, which can be suggestive of bowel cancer.

Between 20 and 24 January Mrs A’s wound deteriorated. The wound re-opened, and oozed serosanguinous fluid. She was in pain. Mrs A had a further outpatient appointment on 25 January, where she was reviewed by both Dr B and Mr Breeze. It was noted that her wound sinus had broken down again and was discharging purulent fluid. Mr Breeze felt that the sinus could be due to a nidus infection of the nylon suture knot, and completed a semi-urgent notice for admission to explore the wound. Dr B requested an ultrasound of the possible “applecore” lesion, identified on the ultrasound of 18 January.

Throughout late January and early February, Mrs A’s wound continued to ooze, and she remained in pain. A swab taken by Dr D on 7 February after he drained her wound abscess cultured a light growth of *Salmonella enteritidis*, and Mrs A was commenced on a 20-day course of ciprofloxacin (an antibiotic).

On 10 February Mrs A had a limited abdominal ultrasound to further investigate the “applecore” lesion. The ultrasound showed a 30ml irregular heterogenous hypoechoic collection in the peritoneal cavity, and a second smaller collection beneath the wound. A decision was made not to drain the collection.

On 11 February Dr D noted another abscess of significance in the wound, and referred Mrs A back to Mr Breeze. He advised Mr Breeze that her wound was still a major problem, and she remained on antibiotics.

Mrs A did not receive an outpatient appointment until 29 February. At this time, the original wound sinus had healed, but another area on the wound line had broken down. Mr Breeze stated:

“On 16 February 2000, the hospital received a letter from Dr D dated 11 February 2000, informing me that Mrs A’s wound remained a major problem, but that she had developed additional sites of discharge along her suture line. In response I arranged to see her at the next clinic, and this visit took place on 29 February 2000. ...

The new wound sinus involved a different segment of the wound, and the original sinus had healed. In light of this, it was clear to me that the basis of this new sinus couldn’t have been an underlying nylon suture knot, as only one knot was used on the continuous nylon suture, and the knot was remote from the latest point of discharge. <sup>6</sup> therefore determined that removal of the nylon suture knot would not be beneficial, and that Mrs A’s preferred treatment was with antibiotic Ciprofloxacin, effective against the organism identified to be *Salmonella Enteritidis*.”

The issue is whether Mr Breeze’s management of Mrs A’s wound was appropriate. My advisor informed me that Mr Breeze acted with reasonable care and skill in his treatment of Mrs A, although there was a minor departure from the required standard of care in his management of her wound. While it was reasonable to treat the wound with antibiotics initially, by 10 February 2000 there was sufficient evidence to indicate a significant infective process that required intervention, in particular:

- the blood tests taken on 14 January, and noted by Mr Breeze’s registrar on 18 January, recorded an ESR of 115, and raised liver function. These results suggested ongoing infection and inflammation, more significant than the wound infection;
- a wound swab taken on 7 February cultured *Salmonella enteritidis*. The area was clearly infected (therefore it is unlikely that Mrs A’s problems could be attributed to a sterile seroma as suggested by Mr Breeze in his response to this investigation); and
- the abdominal ultrasound on 10 February identified a heterogenous intra-abdominal collection of 30mls at the lower pole of the right kidney below the inferior surface of the liver, and a small collection in the wound.

My advisor informed me that, in light of the above factors, the fluid collections identified by ultrasound on 10 February should have been drained, either by opening the wound and re-

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<sup>6</sup> Commissioner’s emphasis.

exploring the area, or by inserting a drain via CT guidance. He advised that given the chronicity of the inflammation, exploration of the wound and peritoneal cavity was the treatment of choice.

Mr Breeze submitted that the ultrasound scan of 10 February 2000 was ordered by Dr B without his knowledge, and that the result of the scan was not discussed with him. In addition, while he accepted that with the benefit of hindsight it is possible that Mrs A's fluid collection contained sub-clinical infection, he argued that her clinical condition at the time indicated that the collection was sterile. In particular:

1. Mrs A was asymptomatic. Although blood tests on 14 January 2000 showed an elevated ESR and abnormal liver function, both results are non-specific. An elevated ESR cannot differentiate between an infection confined to the wound or an infection also involving the abdomen. The results do not suggest ongoing infection beyond the wound;
2. Mrs A's abdominal ultrasound of 12 January 2000 did not identify an intra-abdominal infection or fluid collection;
3. the sonographic appearance of the collection lacked the thickened border typical of undrained chronic infection;
4. Mrs A's clinical course from 28 March 2000 was not that of a patient harbouring infection; and
5. none of the doctors who treated Mrs A subsequently diagnosed an infective process.

I do not accept Mr Breeze's submission that he was unaware of the result of the ultrasound scan of 10 February 2000, or that the collection was sterile and that drainage was not indicated, for the following reasons.

A notation on the ultrasound scan report indicates that the report was to be sent to "Surgical Team Dr I Breeze". Dr B said that reports of all investigations are sent to the consultant under whose care a patient has been booked. Mrs A was under Mr Breeze's care and copies of her investigations would have been sent to Mr Breeze.

Mr Breeze gave conflicting reports about his response to the ultrasound report. In a letter dated 19 April 2004 in response to my request for additional information about his management of the two collections identified on ultrasound on 10 February 2000, Mr Breeze appeared to indicate that he was aware of the results of the ultrasound and actively involved in Mrs A's management in the light of those results. He stated:

"The two small collections identified on ultra-sound on 10 February 2000 were incidental and asymptomatic. The superficial collection had a wick in situ and was therefore draining freely. The other collection was only 30 mls in volume. Given that it was incidental and asymptomatic, together with non-specific ultrasound appearances, I considered that it was probably a seroma. For these reasons I considered that there

were no clinical indications to arrange drainage, the potential risks of drainage exceeding the benefits. In the unlikely event that this collection was non-sterile, I considered treatment with antibiotics would have been curative.”

However, in a letter dated 24 August 2004 in response to my provisional opinion, Mr Breeze said that it was Dr B’s decision not to arrange drainage of the fluid collection and that this decision was made without his knowledge. He said:

“The scan result was not discussed with me by Dr B, and Dr B made a judgement call that he would not arrange drainage of the fluid collection.”

I consider it probable that Mr Breeze was aware of the results of the ultrasound scan performed on 10 February 2000 and involved in the decision not to drain the fluid collection. Dr B was a junior registrar at the time and is therefore unlikely to have made the decision not to arrange drainage without consultation with Mr Breeze. The ultrasound report is marked for Mr Breeze’s attention and the results of all investigations are routinely sent to the responsible consultant. Mr Breeze’s earlier advice to me, in his letter of 19 April 2004, indicated that he saw the report of the 10 February 2000 ultrasound scan and made the decision that there were no clinical indications for drainage and that antibiotics would be curative. Further, Mr Breeze was in charge of his operating lists, making it unlikely that a patient would be removed from his list without his knowledge.

In addition, Mr Breeze reviewed Mrs A on 29 February 2000, at which point (at the latest) he would have been made aware of the results of the 10 February ultrasound by Dr B. Mr Breeze advised me that by 29 February 2000 the original wound sinus had healed but a new sinus involving a different segment of the wound had developed. This caused him to review his earlier supposition that the cause of the original sinus was a nylon suture knot underlying the wound, since the new sinus was remote from the single knot made in the continuous nylon suture. Mr Breeze said that he therefore determined that removal of the nylon suture knot would not be beneficial and that the preferred treatment was with the antibiotic ciprofloxacin.

Accordingly, I do not accept Mr Breeze’s statement that the result of the 10 February 2000 ultrasound scan was not discussed with him or that it was Dr B’s decision not to arrange drainage of the fluid collection.

My expert advisor did not accept that it is only with the benefit of hindsight that it can be said that there was evidence of infection in February 2000. Mr Neill summarised the evidence pointing to an infection in February 2000 as follows:

“After discharge from hospital Mrs A was seen on 3 November [1999] with abdominal pain. On 17 November the wound was recognized as being infected, and was discharging purulent material, a sinus developed. [Mrs A] was told that this infection would settle by itself. By February 2000 she again consulted her general practitioner with continuing abdominal pain. Ultrasound at this stage showed infection in the wound, and she had an ESR of 115. This point will be dealt with later. The ultrasound

on 12 January talked about an applecore lesion in the right upper quadrant. A barium enema later was carried out and showed normal colon and this applecore may have represented the early evidence of an abscess. On 25 January 2000 the wound again broke down and discharged purulent material. On 10 February 2000 an ultrasound was carried out and the report reads, 'that a 30 ml irregular heterogeneous, hypoechoic collection probably within the peritoneal cavity lying anterior to the lower pole of the right kidney and inferior to the edge of the liver. A smaller collection was demonstrated beneath the wound within the anterior abdominal wall'. This was the report reported by the radiologist. This is very different to Mr Breeze's comment that Mrs A had undergone an abdominal ultrasound and this did not demonstrate any intra-abdominal infection of fluid collection requiring drainage.

On 11 February 2000 [Mrs A's] general practitioner, Dr D, wrote a further letter to Surgical Outpatients notifying them that the wound was still a major problem, and that he had opened the wound and packed a further abscess of significance in the suture line. Dr B on 29 February recorded that a further sinus had opened, and that a culture of pus had grown salmonella enteritidis. She was started on an extended course of Ciprofloxacin 750mg twice a day. I find it difficult to understand Mr Breeze's comments that the clinical feature[s], sonographic features, and disease course of this collection indicated that it was sterile."

Mr Breeze also argued that the evidence pointed towards the collection identified by the 10 February 2000 scan being sterile. Mr Neill disputed this, saying:

"The fact that pus had been draining from the wound directly above the collection and that it had grown bacteria, and continued to discharge, certainly does not suggest that it was sterile."

Again, I accept Mr Neill's advice that there was evidence that should have suggested to Mr Breeze that the collection identified on 10 February 2000 was not sterile.

Mr Breeze disputed Mr Neill's advice that Mrs A's raised ESR of 115 on 14 January 2000 should have suggested ongoing infection beyond the wound. He said that "an elevated ESR is non-specific and cannot differentiate between an infection confined to the wound, or an infection also involving the abdomen". In response, Mr Neill advised:

"Abscesses have a habit of becoming chronic if they are not drained, and often the only lab result which would indicate this is a raised ESR. The white count may frequently be normal, and the symptoms from the abscess may be few. I believe the raised ESR to 115 was very significant, and while one cannot differentiate between an abscess in the abdominal wall and in the intra-abdominal abscess from this result I would not expect the ESR to be as high as this from a wound infection."

Mr Breeze also argued that the raised ESR had to be balanced against the results of the abdominal ultrasound scan performed on 12 January which, in his view, did not demonstrate

any intra-abdominal infection of fluid collection requiring drainage. The report of the ultrasound performed on 12 January 2000 stated:

“... I note that there is a 1.5 to 2.0 cm area of inflammatory change in the subcutaneous fat adjacent to the medial aspect of the surgical wound though no fluid collection is seen.

The gastric antrum and pyloric area appear slightly thickened, measuring up to 8mm in diameter and this persisted even after a fluid bolus. ...

COMMENT: I am uncertain as to the cause of the symptoms as ultrasound shows mild gastric wall thickening, which is a non specific finding and may represent inflammation or infiltration.”

Mr Neill was clear that this ultrasound indicated infection in the wound. He stated:

“On 12 January 2000 [Mrs A] again consulted her general practitioner with continuing abdominal pain. Ultrasound at this stage showed infection in the wound ...”

I accept that a raised ESR is non-specific insofar as it does not point to a particular problem or to the specific location of a problem. In Mrs A’s case the raised ESR did not indicate whether she had an infection that was confined to the wound or that also involved the abdomen. However, a raised ESR is a flag that an infection may exist and an indication that further investigations should be undertaken to confirm or exclude an infection and its location.

In my view, the ultrasound performed on 12 January 2000 also pointed to the possibility of an infection.

I do not accept that the fluid collection was asymptomatic as Mr Breeze states. As Mr Neill notes, Mrs A experienced abdominal pain on a regular basis, and had a discharging wound that cultured *Salmonella enteritidis* and required large doses of a very strong antibiotic, ciprofloxacin.

The following evidence suggests that the fluid collection was not asymptomatic:

- The report on the ultrasound scan performed on 12 January 2000 also noted that Mrs A had “persistent abdominal pain”.
- On 25 January 2000 Dr B recorded that Mrs A’s wound sinus had broken down and had been discharging purulent fluid for which she had been treated with antibiotics. Dr B indicated that the wound sinus might be due to a stitch and the wound was to be explored by Mr Breeze under general anaesthetic.
- On 11 February 2000 Mrs A’s general practitioner, Dr D, in a letter to Surgical Outpatients, said “... her wound is still a major problem and ... just today we have had to incise, drain and pack a further abscess of significance in the suture line. She remains on antibiotics full time which she doesn’t seem to be able to do without.”

- On 29 February 2000, Dr B recorded that the original sinus had healed up again but a second area of the wound had broken down and wound swabs had grown *Salmonella enteritidis*.

I do not accept that, as Mr Breeze submitted, it follows from the fact that none of the doctors involved in Mrs A's care in early 2000 identified an infective collection that there was no infective collection. It is clear from Mrs A's patient record that an infective collection was one of the possible diagnoses under consideration and had not been excluded by the other doctors involved in her care.

In my view, Mr Breeze's assessment and management of Mrs A following the ultrasound on 10 February was inadequate. I accept Mr Breeze's statement that the severity of Mrs A's cholecystitis and her co-morbidity predisposed her to infective complications from her surgery. However, my concern is not that Mrs A developed a postoperative wound infection, but the manner in which Mr Breeze managed that infection. My criticism of Mr Breeze's management of Mrs A's care is that he appears to have excluded the possibility of an infective process at an early stage and not to have reconsidered it when Mrs A's condition failed to improve. In my view, Mr Breeze should have kept the possibility of an infective process under review and considered it as a possible explanation for her ongoing problems.

It appears that Mr Breeze assessed the 10 February 2000 ultrasound report in isolation of Mrs A's history and physical presentation, and did not collate all the available information about her condition to ensure optimal management. His opinion that the collection was probably a seroma was not supported by the wound swab results taken three days before the ultrasound scan of 10 February, which indicated that the wound was infected with *Salmonella enteritidis*; nor was it consistent with Mrs A's raised ESR in January or the ultrasound finding that the fluid collection was heterogenous. His advice that antibiotics alone would be curative failed to acknowledge that antibiotic treatment over the previous three months had not improved her condition. Dr D's letter to Mr Breeze, dated 11 February, specifically requested a review in light of the fact that her wound was a major problem and she could not manage without full-time antibiotics. The insufficiency of antibiotic treatment alone was borne out by the fact that the fluid collection increased in size and eventually developed into the intra-abdominal collection drained by Mr F on 10 January 2001.

Mr Breeze submitted that there is no support for the theory that the 30 ml collection identified by the ultrasound scan performed on 10 February 2000 developed into the intra-abdominal infection drained by Mr F on 10 January 2001. My expert advisor was clear that the collection drained by Mr F had developed from the small collection identified by the 10 February 2000 scan. He stated:

“The collection in the wound and in the abdominal cavity shown on ultrasound on 10 February 2000 if not treated, would slowly increase in size, and form the larger collection seen on the CT carried out on 18 December 2000. I do not follow Mr Breeze's argument with regard to this known early collection not developing into the

larger one, and that had the early collection been drained it would not have prevented the larger collection. I think this is a rather naïve opinion.”

I accept Mr Neill’s advice that the smaller collection shown on ultrasound on 10 February 2000 would slowly have increased to form the larger collection that was ultimately drained by Mr F, and that earlier drainage of the smaller collection would have prevented development of the larger collection.

### *Conclusion*

My advisor stated that by not draining the collections identified by ultrasound on 10 February 2000, there was a minor departure from the required standard of care on Mr Breeze’s part. I accept that advice. In my view, a reasonable surgeon taking a holistic view of Mrs A’s condition and history would have identified that she was suffering from a significant infective process, and would have taken active steps to drain the collections identified by ultrasound on 10 February. In my opinion, Mr Breeze’s failure to drain the collections amounted to a minor failure by Mr Breeze to provide services to Mrs A with reasonable care and skill, and a breach of Right 4(1) of the Code.

Mr Breeze argued that a minor departure from the required standard of care does not constitute a breach of the Code. In my view, although the departure was minor, it was nevertheless a breach of the Code. The Code does not restrict the power to find a breach to major failures to provide an appropriate standard of care. Both minor and major failures may constitute breaches of the Code. The fact that the failure amounts to only a minor departure from the required standard of care is reflected in my recommendations below.

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## **Recommendations**

I recommend that Mr Breeze take the following actions:

- Apologise in writing to Mrs A for his breach of Right 4(1) of the Code. Mr Breeze’s apology should be sent to my Office, and will be forwarded to Mrs A.
  - Review his practice in light of my report.
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## **Follow-up actions**

- A copy of my report will be sent to the Medical Council of New Zealand and the Royal Australasian College of Surgeons.
- In light of the significant public interest in my inquiry into Mr Breeze's practice, a copy of my report, with details removed identifying parties other than Mr Breeze, my expert advisor and the hospital, will be released to the media and placed on the Health and Disability Commissioner website, [www.hdc.org.nz](http://www.hdc.org.nz), for educational purposes.