Management of suspected ectopic pregnancy (13HDC00487, 30 May 2014)

District health board ~ Public hospital ~ Obstetrician and gynaecologist ~ Gynaecology ~ Ectopic pregnancy ~ Fallopian tube ~ Differential diagnoses ~ Tissue disposal ~ Documentation ~ Rights 4(1), 7(9)

A woman had a history of an ectopic pregnancy resulting in the removal of her right fallopian tube. The woman became pregnant again and had an ultrasound, which showed a 15mm by 13mm left adnexal mass and no intrauterine gestation sac.

The woman was referred to the public hospital with a suspected ectopic pregnancy. Her β-hCG level was 334 IU/L. The woman consented to the removal of her fallopian tube but that this was on the understanding that the tube was abnormal. The woman repeatedly advised staff that she wanted the fetal tissue returned to her following surgery.

The woman's left fallopian tube was removed, and she underwent a LLETZ procedure at the same time. The subsequent histology showed no pregnancy tissue in the tube. The woman's β-hCG was rising and was now at 10,064 IU/L. A further ultrasound confirmed a live singleton intrauterine pregnancy at eight weeks' gestation.

The woman was uncertain whether she should continue the pregnancy. An obstetrician/gynaecologist advised the woman that while he would not expect any pregnancy complications from her recent surgery, he would offer her a surgical termination of pregnancy within the following four weeks.

The woman decided to terminate the pregnancy because of her concerns that the surgery may have harmed the fetus. She again requested that the fetal tissue be returned to her. Following the termination of pregnancy, the procedure for the return of the fetal tissue to the woman was not followed and the tissue was destroyed.

The DHB clinicians diagnosed the woman with a likely ectopic pregnancy without taking all reasonable steps required to allow them to conclude this definitively. The gestation was considered uncertain, and clinicians did not conduct a further serum β-hCG test and a vaginal ultrasound prior to surgery. As a result, they unnecessarily removed the woman's left fallopian tube when the fallopian tube was not unequivocally abnormal. The cumulative effect of a number of individual errors resulted in the woman receiving suboptimal care. Accordingly, the DHB failed to provide services to the woman with reasonable care and skill and breached Right 4(1).

The DHB breached the woman's right to make a decision about the return or disposal of any body parts or bodily substances removed or obtained in the course of a healthcare procedure and, accordingly, breached Right 7(9).

Adverse comment was made about the care provided to the woman by individual clinicians.