HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Adequacy of examination and diagnosis of labial mass

1. This report relates to the care provided to Ms A by obstetrician and gynaecologist (O&G) Dr C at her local hospital, in particular the adequacy of Dr C's examination in October 2019 and the diagnosis of a Bartholin's cyst when she was reviewed for a suspicious mass. In March 2022, Ms A was diagnosed with vulval cancer.

2. At the outset, I express my sympathy to Ms A for her cancer diagnosis.

3. In September 2019, Ms A, then aged 77 years, developed a large symptomless swelling in her labia. She underwent an ultrasound scan (USS) on 18 September 2019. The results[1] showed a solid irregular mass, which was not typical of a Bartholin's cyst,[2] and two prominent lymph nodes, and a gynaecological review was recommended.

4. On 19 September 2019, Ms A's general practitioner (GP), Dr B, referred Ms A to the gynaecology service at her local hospital. The USS report was attached to the referral, and it was noted that there was a high suspicion of cancer regarding the solid labial mass.

5. On 23 September 2019, the referral was triaged as urgent, prioritised to be seen within 14 days, and high suspicion of cancer was ticked on the triage form.

Review by Dr C — 2 October 2019

6. On 2 October 2019, Ms A was seen by Dr C in the local hospital gynaecology clinic. Dr C was a locum who, at the time of seeing Ms A, had a short-term contract at the local hospital.

7. The hospital told the Health and Disability Commissioner (HDC) that the usual practice for clinicians seeing new patients is to review the referral letter, as that provides information about the concerns and symptoms sent by the GP. The hospital stated:

> 'Dr C performed an assessment that included a general health history and visual assessment of right vulva lump. We are unable to advise if the lump was palpated or if any further physical assessment occurred.'

8. Ms A stated that Dr C told her not to worry as it was just a Bartholin's cyst, and he gave her the option to have it drained surgically. She said that he did not tell her that it was a cancer or that it should be removed. She stated that, after seeing Dr C, she did not think that anything urgent would need to be done, and Dr C told her that she could see him in six months' time and that the hospital would contact her.

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[1] 'The non-tender and palpable region on the right in the paralabial area is not a typical Bartholin cyst. This is a solid irregular lesion measuring up to 33mm maximum diameter, and there is some increased vascularity. In addition, in the right groin there is slight prominence of two lymph nodes, which have mildly thickened cortices. The nodes are non-palpable and are not pathologically enlarged. COMMENT: Given the above findings, gynaecological review is recommended for the solid, suspicious right paralabial lesion.'

[2] A fluid-filled sac that develops in the Bartholin's glands when the opening of the gland is blocked.

9. Dr C's clinical record states:

> 'When I looked at it today it is a 2cm Bartholin cyst. I told her we could drain it and possibly put in a Word catheter (a flexible tube inserted into the cyst to drain the fluid), do marsupialisation (surgically open and drain the cyst) or she could just continue to watch it as it is not bothering her. She has decided to just watch it, but I will give her an appointment for one month if she decides on either of these other options she could come in and we would do what she would like at that point.'

10. Dr C told HDC that he diagnosed a Bartholin's cyst and considers that he treated Ms A appropriately for that diagnosis; he noted that Bartholin's cysts are never biopsied. He acknowledged and apologised for missing the diagnosis.

11. In response to my provisional opinion, Ms A said that she does not recall Dr C apologising to her directly.

Review by Dr D — 2020

12. On 31 January 2020, Ms A declined a follow-up appointment as there had been no changes to the swelling, and she had no concerns based on the information she had been given at the previous consultation. However, it was agreed to leave the referral open for a further three months in case follow-up was required.

13. On 29 April 2020, Ms A had a telephone consultation with a locum O&G consultant, Dr D (who has since retired). This was during COVID-19 alert level 3. Dr D documented that Ms A had been seen by Dr C and diagnosed with a small Bartholin's cyst. Ms A reported no change in her symptoms and no pain, and Dr D recommended a referral to the gynaecology team if an infection occurred.

14. The hospital told HDC that the working diagnosis was of a Bartholin's cyst during both Dr C's and Dr D's consultations, but it is difficult to provide the clinical rationale for that diagnosis, and further investigations into the cause were not actioned. The hospital stated:

> 'These could have included a biopsy to rule out cancer of the vulva as Ms A was over the age of 40 years and had a suspicious ultrasound scan. A differential diagnosis was not documented.'

Subsequent reviews and diagnosis — 2021–2022

15. On 7 December 2021, another GP made a referral to the local hospital for a 'symptomatic Bartholin's cyst' requesting excision but noting that there had been no increase in size of the cyst or infection. The referral was graded to be seen within four weeks. On 14 February 2022, this GP made a further referral for a recurrent infected Bartholin's cyst requesting surgical incision. The referral was graded 1, to be seen within 14 days.

16. On 22 February 2022, Ms A saw consultant O&G Dr E in the gynaecology clinic. Dr E reviewed the swelling and discussed with Ms A that there was a potential cancer diagnosis.

17. The reporting letter from Dr E states that initially she had been unable to see the results from the USS (from September 2019) because they were not included in the current referral, and the USS had been done privately. However, she had found the USS results in the referral

from 19 September 2019, and she noted that the USS findings were not consistent with a Bartholin's cyst.

18. Investigations were arranged, and, over the following weeks, Ms A underwent a CT scan and an examination and biopsy under anaesthetic. On 18 March 2022, Ms A saw O&G Dr F in the gynaecology clinic. Dr F explained that the diagnosis was a squamous cell carcinoma of the vulva, which was human papillomavirus dependent. On 11 May 2022, Ms A commenced weekly chemotherapy and daily radiation.

19. Ms A told HDC:

> 'I have had to go through chemotherapy and radiation, with all of the side effects which has caused me significant pain and anguish. I just wish I had had this diagnosed earlier so that it was curative at that stage. I will now need ongoing treatment and have daily pain.'

20. The hospital stated that it recognises that the differential diagnosis of a Bartholin's cyst falsely reassured Ms A and that, if further investigations, including a biopsy, had been completed, this may have led to an earlier diagnosis of cancer and treatment. The hospital said:

> 'We acknowledge that Ms A's cancer diagnosis and treatment would have been made even more difficult due to the delay in recognition of the cause to her original concern and for that we are sorry and extend a sincere apology.'

Response to provisional opinion

Ms A

21. Ms A was given an opportunity to comment on the 'information gathered' section of my provisional opinion, and her comments have been incorporated into the report where relevant.

22. Ms A said that, after her biopsy procedure, she saw Dr C while he was on rounds, and he offered his number should she have any questions. Ms A said they subsequently had a couple of phone conversations regarding the time it was taking for the biopsy results to come back. According to Ms A, Dr C acknowledged it was taking longer than usual but said that this likely indicated it was a non-cancerous diagnosis. Ms A said Dr C offered no apologies, nor did he indicate he had been involved in the initial diagnosis.

23. Ms A said that chemotherapy has caused significant issues with her balance and affects her mobility. Despite routine lymphatic drainage massage therapy,[3] Ms A said this only temporarily alleviates her symptoms. She said that she continues to suffer 'humiliation, loss of dignity, and injury to her feelings' as a consequence of these events.

[3] A specialised form of massage that focuses on stimulating the lymphatic system to promote fluid movement and reduce swelling.

Dr C

24. Dr C was given an opportunity to comment on relevant sections of my provisional opinion; he advised that he has no further comments and stands by the comments he has previously provided.

25. Dr C advised that he no longer lives in New Zealand and has been retired from practice for the last 18 months.

The hospital

26. The hospital was given an opportunity to comment on my provisional opinion and advised that it has no comments and accepts the proposed findings. The hospital said it appreciates the educational approach that is being taken.

Opinion: Dr C — breach

27. In my view, Dr C's examination and diagnosis of Ms A on 2 October 2019 was inadequate.

28. The referral letter available to Dr C on 2 October 2019 suggested that there was a high suspicion of cancer in the solid labial mass. My independent O&G advisor, Dr Sikhar Sircar, stated that a solid, vascularised mass larger than 3cm is not a typical presentation for a Bartholin's cyst, and with possible lymphadenopathy of the same side, in a post-menopausal woman, should have raised the possibility of a malignant condition. Consequently, a malignant mass should have been part of the differential diagnosis. I agree.

29. Dr C did not document any reference to the USS report attached to the referral letter. Dr Sircar noted that, if Dr C had reviewed it, the suspicious nature of the mass should have been apparent.

30. Dr C also did not document that he had performed a clinical examination of the mass; rather, he recorded that he had looked at it. Dr Sircar advised that if a proper clinical examination had been performed, then the solid nature of the mass should have been apparent. Furthermore, the referral letter indicated that there was a 'solid labial mass'. Dr Sircar advised that the solid nature of the mass would have negated the diagnosis of a Bartholin's cyst, which is fluid filled, rather than a solid mass. In addition, Dr Sircar stated that potentially the lymph nodes could have been detectable on clinical examination.

31. Dr C said that he saw Ms A's vulvar lesion, diagnosed it as a Bartholin's cyst, and treated her appropriately for that diagnosis. He stated: 'We never biopsy Bartholin cysts.' Dr Sircar noted that there is no record of the clinical rationale that supported that diagnosis and discounted the possibility of malignancy queried on the initial referral letter. Dr Sircar also disagreed that Bartholin's cysts are never biopsied. I accept that, if the diagnosis had been correct, then Dr C's treatment may have been appropriate. However, Dr C's response fails to acknowledge that he did not reasonably consider an alternative diagnosis and that the diagnosis of a Bartholin's cyst was incorrect.

32. Dr Sircar stated that the information provided in the referral letter, together with a proper clinical examination, should have resulted in an urgent biopsy being arranged. I agree.

33. Dr Sircar advised that these failings were severe departures from accepted standards. I accept that advice. For the reasons outlined above, I find that Dr C failed to provide services to Ms A with reasonable care and skill and breached Right 4(1)[4] of the Code of Health and Disability Services Consumers' Rights (the Code).

Opinion: The hospital — adverse comment

Access to referral information

34. The USS on 18 September 2019 was performed privately, and Ms A's GP appended the USS findings to her referral on 19 September 2019. This was available to Dr C on 2 October 2019, but it appears that the USS findings were not readily apparent to clinicians who saw Ms A subsequently; as outlined above, Dr E was able to locate the results only by reviewing the GP referral from 19 September 2019. Dr Sircar stated that, if the USS was requested by the GP to help with the referral to the hospital, the results along with the images should have been available to hospital clinicians, and their inability to review them suggested insufficient access to referral information. I agree.

35. It does appear that the USS was not outsourced by the hospital and, as such, the hospital does not automatically receive results from private facilities. However, I agree with Dr Sircar that the unavailability of the report and/or images could have serious consequences in planning clinical care. While it was available to Dr C via the referral, and the referral appears to have been accessible to subsequent staff, I encourage the hospital to reflect on how information is stored and whether any learnings can be taken from this and changes made to the process.

Recommendations

36. I recommend that Dr C and the hospital both apologise to Ms A for the criticisms in this report. The apologies are to be sent to HDC within three weeks of the date of this opinion, for forwarding to Ms A.

37. I recommend that the hospital consider implementing a system to ensure that all clinicians have ready access to prior investigations and records and report to HDC on the outcome within three months of the date of this opinion.

Follow-up actions

38. A copy of the sections of this report that relate to Dr C will be sent to the Medical Council of New Zealand.

39. A copy of this report with details identifying the parties removed, except the advisor on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Dr Vanessa Caldwell
Deputy Health and Disability Commissioner

[4] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'

Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from obstetrician & gynaecologist Dr Sikhar Sircar:

'**Report of Dr Sikhar Sircar**

Specialist field:	Obstetrics and Gynaecologist
On behalf of:	HDC
Claimant:	**Ms [A]**
Your Ref:	[24HDC01263]
Dated:	2 December 2023

Introduction

1.01 I am Dr Sikhar Sircar. My specialist field is Obstetrics and Gynaecology. Since 2009 I have been working as a consultant in Obstetrics and Gynaecology. I have the following post graduate qualifications: Doctorate of Medicine (MD), Fellowship of the Royal College of Obstetricians and Gynaecologists (FRCOG), Diploma of Faculty of Sexual and Reproductive Health of the RCOG (DFSRH, formerly DFFP), Post Graduate Certificate in Medical Education (PG Cert Med Ed), Cardiff University Law School Bond Solon Civil Expert Certificate (CUBS), European Society of Gynaecological Endoscopy (ESGE) Bachelor of Endoscopy diploma, and Fellowship of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (FRANZCOG).

I have clinical experience material to the overview report I have prepared. I have attended courses for Medico-legal report writing and attended relevant training. Full details are in Appendix 1.

1.02 Technical terms and explanation

I have indicated any technical terms in **bold type**. I have defined these terms in the glossary. I have **bold typed** any abbreviation when first used and included them in the glossary. I have also included extracts of published works I refer to in my report.

2 Summary of my opinion

2.01 I am of the opinion that there has been a severe departure from accepted clinical practice at the clinical consultation of 02.10.19. It is also my opinion that alternative diagnoses should have been considered at the first visit. I am of the opinion that the biopsy should have been arranged earlier based on the information provided on the referral letter of 19.09.12. I am also of the opinion that hospital clinicians had insufficient access to referral information.

3 Instruction from the Commissioner

I have been asked to provide an opinion to the Commissioner on case number **[24HDC01263]** as follows.

Please review the enclosed documentation and advise whether you consider the care provided to Ms [A] by [her local hospital] was reasonable in the circumstances, and why. In particular, please comment on:

1. The standard of care provided to Ms [A] during each consultation;
2. The assessments and investigations undertaken to form a diagnosis;
3. Whether alternative diagnoses should have been considered in light of Ms [A]'s symptoms;
4. The timing of the first biopsy and whether this could have been undertaken earlier;
5. The processes and policies in place at [the hospital] at the time of the events, particularly with regard to guidance provided to locum doctors;
6. The appropriateness of the follow-up and safety netting advice;
7. Whether specialist access to referral information was sufficient, and any other comments you wish to make about this; and
8. Any other comments you wish to make on the care provided.

For each question, please advise:

a. What is the standard of care/accepted practice?
b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do you consider this to be?
c. How would it be viewed by your peers?
d. Recommendations for improvement that may help to prevent a similar occurrence in future.

4 Documents received and used to assess the facts and reach an opinion are

1. Letter of complaint dated 1 December 2022
2. [The hospital]'s response dated 28 February 2023
3. Clinical records from [the hospital] from 18 September 2019 onwards
4. Policies from [the hospital]

5 The document suggests the following relevant facts and chronology of events.

5.01 19.09.19: The referral letter suggested high suspicion of cancer for solid labial mass. Ultrasound scan report from 18.09.19: (which was appended with the letter) suggested 3.3cm solid mass with increased vasculature, which is not a typical Bartholin's cyst. Comments made on slight prominence of lymph nodes in the right groin.

5.02 23.09.19: Grading form suggests [doctor] vetted Ms [A] for gynaecology clinic within 14 days for high suspicion of cancer.

5.03 02.10.2019: Clinical documentation by Dr [C]

5.04 Clinical letter suggests: *'She noticed a lump in the right vulva this has been asymptomatic; she does ride horses and it does not bother her. When I looked at it today it is a 2cm Bartholin cyst. I told her we could drain it and possibly put in a Word catheter, do marsupialisation or she could just continue to watch it as it is not bothering her. She has decided to just watch it but I will give her an appointment for one month if she decides on either of these other options she could come in and we would do what she would like at that point.'*

5.05 29.04.20 Clinical documentation regarding phone consult with Dr [D].

5.06 *'I had a telephone consultation with [Ms A] this morning. She was seen by my Colleague, Dr [C] last year in October. She was presenting with a swelling [in] her right labia. He diagnosed a small Bartholin cyst. She says the lump is still there. It has not increased in size and is not painful and she wants to leave things as it is. I explained to her in detail about the risk of infection. If that is the case, then she will need incision and drainage. I have not made any further follow-up appointment for her. Please do feel free to refer her back if the cyst gets bigger or if there is any sign of infection.'*

5.07 07.12.21 Gynaecology referral for excision of Bartholin's cyst. Grading form suggests low suspicion of cancer, to be seen within 4 weeks by a female gynaecologist.

5.08 14.02.22: Referral made for recurrent infected Bartholin's cyst. For consideration of excision of right vulval mass. Triaged to be seen within 14 days with low suspicion of cancer.

5.09 22.02.22: Gynaecology clinic with Dr [E]. Clinical letter suggests *'She saw my Colleagues in 2019 and elected not to have removal at that time. I note that she had an ultrasound and that ultrasound done in September 2019 not included in the current referral. This was done at […] privately so I did not see it on our system initially. I did find it in the referral from 2019, and it comments that in the right para-labial area a tender and palpable region not typical of Bartholin's cyst with a solid irregular lesion measuring 3.3 cm in maximum diameter with increased vascularity. There is also on the right groin slight prominence of two lymph nodes that have mildly thickened cortices, but they were not pathologically enlarged.'*

5.10 04.03.22 CT abdomen and pelvis: 7.1 cm mass noted in right labial region with lymphadenopathy. Likely to be malignant.

5.11 09.03.22: Incisional biopsy of right vulval mass.

5.12 18.03.22: Gynaecology clinic with Dr [F]. Referred to gynaecology oncology multi-disciplinary meeting (MDM).

5.13 30.03.23: MDM discussion — stage 3 SCC (squamous cell carcinoma) locally advanced SCC of vulva, chemo-radiation with curative intent.

5.14 Chemoradiation treatment finished on 29/06/22.

6 Assumptions or limitations

There is no correspondence from Dr [C] and Dr [D] as a part of the complaint process.

7 Literature and evidence review

7.01 RCOG: Guideline for the diagnosis and management of vulval carcinoma

Carcinoma of the Bartholin gland

This is a rare vulval cancer. Histologically, it is usually a squamous carcinoma or adenocarcinoma. The current evidence base is insufficient to suggest different management from squamous tumours. The lesions are often deep-seated or likely to be associated with metastatic disease. The close proximity to the anal sphincter may necessitate partial resection with reconstruction and this may necessitate a defunctioning temporary colostomy.[34,35] Any perimenopausal or postmenopausal woman with a persisting Bartholin abscess or cyst should be suspected of having a possible carcinoma. Appropriate biopsies and histological review should be undertaken. In general, these cancers have a poorer prognosis than squamous cell carcinoma of the vulva and often multiple treatment modalities are required.

There are no data regarding the use of selective lymphadenectomy in Bartholin gland carcinoma. These patients will require bilateral inguinofemoral lymphadenectomy (because of the proximity of the gland to the midline).

7.02 Up To Date: Bartholin's gland carcinoma

https://www.uptodate.com/contents/bartholin-gland-masses

For patients of any age in whom there is suspicion for malignancy of the Bartholin gland or other vulvar site, biopsy is required. (See "Vulvar cancer: Epidemiology, diagnosis, histopathology, and treatment", section on "Diagnostic evaluation".)

As risk factors for Bartholin gland carcinoma are not well established (see "Epidemiology and risk factors" above), it is not possible to select patients for biopsy based upon risk factors [19,20]. Some experts advise performing a biopsy in all patients with a Bartholin gland mass who are aged 40 years or older. In our practice, we perform a biopsy if **any** of the following are present:

- Mass with a solid component
- Cyst or abscess wall is fixed to surrounding tissue
- Mass is **persistent** (ie, unresponsive or worsening) despite treatment
- Patient is postmenopausal

To perform the biopsy, we biopsy from inside the gland at the time of I&D, marsupialisation, or gland excision (or perform biopsy alone if other procedures are not planned).

Management of Bartholin's gland mass:

Small mass (<3 cm)

- **Cyst** — Small Bartholin cysts may be managed expectantly. Other options, particularly for symptomatic cysts, are sitz baths or warm compresses with the goal of eliciting drainage of the cyst contents and resolution of the mass.
- **Abscess** — Small abscesses are managed with I&D. (See "Incision and drainage" below.)

Unlike a large mass (see "Large mass (≥3 cm)" below), it is often not possible to place a Word catheter to keep the tract open for drainage. Thus, sitz baths or warm compresses are advised until the swelling and pain resolve.

Large mass (≥3 cm) *— Large Bartholin cysts* ***and*** *abscesses should undergo I&D to allow evacuation of the contents of the mass*; cultures of the cyst contents are obtained in cases of cyst abscess. (See "Incision and drainage" below and "Abscess cultures" above.)

If the mass (ie, cyst or abscess) resolves, no further management is required.

If the mass (ie, cyst or abscess) is **persistent** despite treatment, biopsy is performed and then managed similarly to disease **recurrence**.

(See "Biopsy" above and "Management of recurrent masses" below.)

7.03 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9906066/#:~:text=Background,occurs%20in%20post%2Dmenopausal%20women.

8 My opinion

The standard of care provided to Ms [A] during each consultation.

8.01 Ms [A] had four gynaecological consultations. I am of the opinion that the standard of care for the last two consultations, namely with Dr [E] and Dr [F] meet expectations and follow accepted practices. I will limit my discussion [to] the first two consultations.

8.02 The standard practice would have been history taking, examination and arranging necessary investigations based on differential diagnosis.

8.03 **On 2 October 2019**, Dr [C] saw Ms [A]. The clinical letter and note suggests Bartholin's cyst and management of such. Bartholin's glands are located on each side of the vaginal opening. These glands secrete fluid that helps lubricate the vagina. Sometimes the openings of these glands become obstructed, causing fluid to back up into the gland. The result is a relatively painless swelling called a Bartholin's cyst. The actual management plan for a Bartholin's cyst meets expectation. It was also a good practice to offer a repeat appointment for follow up.

8.04 However, I am of the opinion that there has been severe departure from accepted clinical practice at the clinical consultation. I say so because

a. A solid, vascularised mass, more than 3 cm, with possible lymphadenopathy of the same side in a post-menopausal woman should have raised the possibility of a possible malignant condition (ref 7.01–7.03). This information was available from the referral letter and should have been considered as a risk factor for possible malignant mass.

   Based on the above, a malignant mass should have been a part of a differential diagnosis.

b. There has been no documentation of any clinical examination being performed. On balance of probability, if a proper clinical examination was performed, the solid nature of the mass should have been apparent. Please note the GP referral letter also clearly suggested "solid labial mass". Based on this, the solid nature of the mass should have been apparent rather than the diagnosis of Bartholin's cyst, which is essentially a cystic or fluid-filled as opposed to solid mass.

c. There has been no documentation of any reference to the ultrasound report (**US**) of 18.09.2019. If the US report was referenced, the suspicious nature of the mass, as mentioned above, should have been apparent.

d. It would be reasonable to believe that, based on the information provided on the referral letter and a proper clinical examination, an excisional or representative biopsy should have been offered. On balance of probability, this could have diagnosed the cancer earlier.

8.05 I am also of the opinion that the lymph nodes might or might not have been detectable on clinical examination alone in 2019.

8.06 I am of the opinion that my peers would have a similar opinion.

8.07 **The second telephone appointment was on 29 April 2020.** It is not very clear why a virtual consult was arranged instead of a follow-up after a month as originally planned. If this virtual consult was based on the clinical diagnosis of an asymptomatic Bartholin's cyst of 2 cm, then the consultation meets the standard.

8.08 I am of the opinion that there was a missed opportunity to note that the US results from the previous referral were not in keeping with the clinical diagnosis and management plan. However, clinical diagnosis from a face-to-face visit and consultation by a senior colleague is unlikely to be challenged or changed, especially by a virtual phone follow-up. Therefore, in my opinion, there was no deviation from accepted practice based on the above.

8.09 I am of the opinion that some of my peers would consider this as "mild departure from standard practice" in view of failure to consult the available information

during the consultation. However, I have considered my opinion based on the fact that the US report remained unavailable in the hospital system.

The assessments and investigations undertaken to form a diagnosis

8.10 I will limit my discussion [to] the first two visits as mentioned above. I am of the opinion that an excisional or representative biopsy should have been offered based on the risk factors as mentioned above.

8.11 I am of the opinion that there was a severe departure from accepted standards for the first consultation (dated 2nd Oct 2019) and no departure for the second virtual telephonic consult (dated 29th April 2020). I have explained my rationale as above.

8.12 I am of the opinion that my peers would have similar views.

Whether alternative diagnoses should have been considered in light of Ms [A]'s symptoms

8.13 In my opinion, alternative diagnoses (differential diagnoses) should have been considered at the first visit. I consider this to be a severe departure not to have considered malignancy with the risk factors as enumerated above.

8.14 I am of the opinion that my peers would have similar views.

The timing of the first biopsy and whether this could have been undertaken earlier

8.15 I am of the opinion that the biopsy should have been arranged earlier based on the information provided on the referral letter of 19.09.12. I am of the opinion that, after a proper clinical examination, an urgent biopsy (within two to four weeks depending on other variables) is the currently accepted standard. Failure to do so is a serious departure from accepted clinical practice.

8.16 I am of the opinion that the timing of the biopsy after the clinic visit from **22 February 2022** was as per clinical standard and accepted practice.

8.17 I am of the opinion that my peers would have similar views.

The processes and policies in place at [the hospital] at the time of the events, particularly with regard to guidance provided to locum doctors

8.18 There are several non-clinical factors that might have influenced the outcome of this case. They are (a) the effect of the COVID-19 pandemic and its effect on the health service provision and (b) effect of locum doctors working in the health system.

8.19 It is not my remit to go into details of the above; however, if a face-to-face consult was available on 29 April 2020, instead of a telephonic virtual consult, it is possible on the balance of probability that the suspicious solid labial mass would have been identified and biopsy arranged. However, this was not an option, with a

diagnosis of Bartholin's cyst and telephonic review. It is possible the COVID-19 pandemic had some influence on the type of clinic (virtual) that was offered.

8.20 I have no documentation or resource to suggest what guidance was available from the hospital regarding locum doctors. However, in my opinion, this was a departure from clinical practice and decision-making, and guidance on locum doctors is unlikely to prevent or recognise such departures.

8.21 I accept that my peers might have a difference of opinion about guidance for locum doctors and its effect on similar cases.

The appropriateness of the follow-up and safety netting advice

8.22 In my opinion, appropriate safety netting advice followed standard practice. I say so because a follow-up appointment after a month was offered when a conservative approach was taken for management of Bartholin's cyst after the clinic consult on 02.10.19.

8.23 I am of the opinion that my peers would have similar views.

Whether specialist access to referral information was sufficient, and any other comments you wish to make about this

8.24 It is neither usual nor easy to comment on standards of referral information, and I am not aware of any standards that exist for such referral.

8.25 There is a reliance on private health care providers within NZ public health. In this case, the all-important US from 05.09.19 was done at [private radiology provider], and the result was duly appended with the referral. This is to be expected.

8.26 The letter from Dr [E] (dated 22 February 22) states that she was unable to see the results from the said US initially as it was done privately. If the US was requested by the primary care provider to help with the referral to the hospital (in this case Ms [A]'s GP), the results along with the images should be made available for the hospital practitioner to see. Inability to do so would suggest insufficient access to referral information.

8.27 Unavailability of the report and or images might have serious consequences in planning clinical care. In this case, I am of the opinion that serious departures were made from accepted clinic practice by Dr [C], as the US report was appended with the referral letter; therefore, it was available for the initial visit.

8.28 I am not aware if the private US provider is outsourced to provide the care, or if Ms [A] went privately to pay for her US. If [the hospital] has outsourced the service, then it is imperative that the results of such become available to practitioners to institute care in a timely fashion.

8.29 I am of the opinion that my peers would have a similar view.

8.30 My recommendations for improvement that may help to prevent a similar occurrence in future would be to have contemporaneous and seamless access to investigations and records. Please be aware there are multiple providers of imaging services, so to have log in access to individual services is not relevant for locum doctors. In my opinion, the onus should lie on the (private) health provider to merge the results of the investigation with the existing health informatics.

8.31 Please be aware that this is my personal view, and I accept there might be other views depending on the actual working logistics that I might not be aware of.

Any other comments you wish to make on the care provided

8.32 None.

9 I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

10 I do not have a personal or professional conflict in this case.

Dr Sikhar Sircar, 2 December 2023'

Addendum 16 March 2025

'Instruction

To review Dr [C's] comments and advise whether any of the explanations change the initial advice or if there are other matters in this case that warrant comment.

Documents received

Letter from Dr [C]

My opinion

On 2 October 2019, Dr [C] saw Ms [A]. The clinical letter and note suggests Bartholin's cyst and management of such. As mentioned in the original report, it was a good practice to offer a repeat appointment for follow-up. I am still of the opinion that there has been severe departure from accepted clinical practice at the clinical consultation. I say so because a solid, vascularised mass, more than 3 cm, with possible lymphadenopathy of the same side in a post-menopausal woman should have raised the possibility of a possible malignant condition. This information was available from the referral letter and should have been considered as a risk factor for possible malignant mass.

The current letter suggests that a Bartholin's cyst was diagnosed. It does not record the actual clinical finding, which substantiates this diagnosis over the possible concern of malignancy based on initial referral letter. I do not agree that Bartholin's cysts are never biopsied. If undergoing surgical treatment like excision, tissue removed during such surgery is normally (and considered to be good medical practice) sent for biopsy. I agree that I have the benefit of hindsight but to my belief, it does not impact the content of the report.

I have read and agree to follow the Commissioner's Guidelines for Independent Advisors. I do not have a personal or professional conflict in this case apart from working with Dr [C] as a past colleague.

Dr Sikhar Sircar, 16 March, 2025'