5 December 2002

Mr A
Consumer's husband

Dear Mr A

As you have not responded to my provisional opinion, I have now finalised my decision regarding the complaint made by your wife, Mrs A, about the care she received from Dr B, general practitioner.

Your wife's complaint was that Dr B did not provide services of an appropriate standard, and in particular:

- When your wife continued to complain of abdominal pain and vomiting after a normal barium meal examination in April 2000 Dr B did not order any further investigations.
- Dr B did not refer your wife for specialist assessment when her symptoms continued and her general health deteriorated.
- Dr B did not discuss the option of gastroscopy with your wife after she developed abdominal pain and vomiting. In particular Dr B did not discuss gastroscopy when your wife was first referred for a barium meal in April 2000.

My opinion is that Dr B did not breach the Code of Health and Disability Services Consumers' Rights. In reaching this decision I considered information obtained from you, Mrs A and Dr B. I also obtained advice from an independent general practitioner, Dr Tessa Turnbull.

Background
Your wife transferred to Dr B's practice in 1993. Between 1993 and 1998, she attended occasionally for minor problems, hay fever injections and contraception/smear examinations.

On 10 March 1998 your wife consulted Dr B and reported that she had been experiencing burning epigastric discomfit on first wakening and with bending during the preceding month. Dr B noted epigastric tenderness and considered that gastritis or an early ulcer could be the cause of the symptoms. She prescribed Zantac twice daily

for two weeks and suggested that your wife return for review if the symptoms did not settle quickly or recurred.

The next consultation was on 6 September 1998. It was directly related to contraception and the continued use of Nordiol. A breast and pelvic examination was done and there was a general health enquiry and examination. Gastrointestinal symptoms were not discussed.

In 1999, Dr B provided your wife with prescriptions for Nordiol in June and August, and your wife attended for a routine cervical smear on 8 September.

On 4 October your wife spoke with Dr B on the telephone and reported having the "same symptoms" as she had complained about in March 1998. She requested more Zantac. During that telephone conversation Dr B emphasised to your wife that she must be seen if her symptoms did not settle, but prescribed a further 30 Zantac for her.

On 22 November 1999 your wife consulted Dr B and said that the Zantac was helping but she was taking it only sporadically. Dr B suggested that she take the Zantac twice daily and if this did not resolve her symptoms she was to return to discuss further options.

On 31 March 2000, your wife saw Dr B. She reported ongoing abdominal pains "like butterflies in her stomach" for six to twelve months. She said that she felt "seedy" and would occasionally vomit. Your wife told Dr B that she had brought up "frothy sputum" that morning. She said that she would occasionally vomit up small quantities of bile, that she felt better after she had vomited and that her symptoms were worse first thing in the morning or after bending. Dr B noted that there was no haemoptysis (blood staining), and that your wife's diet and bowel habits were normal and her weight was steady.

Dr B noted:

> "O/e [on examination] looks well no palor, abdomen soft, some tenderness in the epigastrium but no guarding, rebound nor masses, no tenderness. Impression probable reflux plus or minus peptic ulcer disease but after discussion with her suggest we do some bloods. I also talked about the pros and cons of doing gastroscopy versus barium meal. Suggest at this stage do a barium meal with a tilt table to try to check for a reflux, realising the limitations of this versus gastroscopy."

Dr B took a blood sample, amongst other things for a *Helicobacter pylori* serum test, which is a diagnostic test for peptic ulcer disease. Dr B prescribed Losec 20mg for gastro-oesophageal reflux.

Dr B recorded that she had a telephone consultation with your wife on 3 April 2000, and that she reported that her stomach symptoms had settled with the Losec. Dr B recommended that your wife have the barium meal as discussed. Dr B also recorded the results of the blood cholesterol tests (which were elevated) and that she had advised your wife on her diet.

Your wife had the barium meal on 13 April. Dr B recorded that the result of this investigation was entirely normal although it was noted "the amount of resting juice in the stomach is moderately increased" and there was no gastrointestinal reflux. However, your wife returned a positive serum *H. pylori* test. Dr B noted that your wife was feeling better and started her on a course of Klacid 7 to treat her peptic ulcer disease.

On 18 July, following an episode of severe, bilateral, low abdominal pain, your wife consulted Dr B. She informed Dr B that she had had intermittent right lower abdominal discomfit for the last six weeks. Dr B conducted a detailed consultation in relation to these symptoms, and also noted that your wife had a respiratory infection and required further contraception.

Your wife was seen next on 3 October for a repeat smear, contraceptive advice and a left arm and shoulder injury. She was seen again on 25 October for a consultation specifically about osteoporosis management.

On 15 December your wife had a hayfever injection and told Dr B that she had a lump in her neck. Dr B thought that this was a thyroid cyst and referred her to the thyroid clinic at a public hospital for further investigation. Your wife was seen at this clinic on 6 March 2001 and the cyst was scanned, scintigrammed and then biopsied. The lump was believed to be a benign colloid cyst and follow-up and rescanning at a later date was arranged by the clinician concerned.

On 22 January 2001 your wife reported a two-week history of vaginal bleeding. Dr B took a detailed history and examination and referred your wife to a gynaecologist for possible endometrial biopsy. The gynaecologist advised a "wait and see" approach.

Dr B provided a three-month prescription for daily Losec to your wife on 14 March and a hayfever injection was given on 12 November 2001.

Your wife next saw Dr B on 14 February 2002. She reported that for the previous four months she had been getting up once or twice in the night to pass urine, and had been experiencing brief left lower abdominal pain when she passed urine. Your wife told Dr B that she had no discomfort passing urine during the day, that her bowels were normal and she felt well. Dr B examined her and found that she was tender in the epigastric area and over the bladder. An examination of the urine showed microscopic haematuria (blood in the urine). Dr B discussed with your wife a number of management options and sent a urine specimen to the laboratory for further testing.

On 15 March your wife returned to see Dr B with persistent and worsening urinary symptoms. She told Dr B that she was tired but put this down to the fact that she was working longer hours than previously. Dr B examined your wife's pelvis and abdomen but did not find anything of note. She reordered blood and urine tests and referred her to a urologist for a detailed urological examination.

Dr B telephoned your wife on 23 March to tell her the results of her blood tests. Your wife's iron count was low and Dr B recommended iron tablets. Your wife said she would buy some.

On 27 March your wife telephoned Dr B and told her that she had vomited violently all night after taking an iron tablet and had been given an anti-emetic injection (for vomiting) at an after hours medical centre. Dr B agreed that your wife should discontinue the iron tablets that she was taking and try an alternative brand.

On 11 April, your wife reported to Dr B that she had vomited violently several times the preceding two nights after developing a deep aching abdominal pain. She said that she felt well during the day and apart from a feeling of fullness in the stomach, had no other gastro-intestinal symptoms. Dr B recorded in the notes that your wife had had a barium meal two years previously, the results of that test and that she was considering whether the poor gastric emptying that was found at that time was the cause of your wife's continuing problems. Dr B prescribed a course of Motilium, which relieves nausea and vomiting.

On 24 April, you took your wife to see Dr B. Your wife had developed severe vomiting at work that morning and was acutely distressed and unwell. Dr B noted that your wife had seen the urologist the preceding day, and that he had ordered a scan and was to undertake a cystoscopy. Dr B gave your wife an anti-emetic injection, inserted an intravenous line and arranged for her admission to the public hospital.

Your wife had a gastroscopy that day which showed that she had a deep ulcer at the greater curve of her stomach. Biopsies showed this to be an infiltrating carcinoma. Your wife was discharged the next day with surgical follow-up in two weeks organised at outpatients when she was to be given further results.

Dr B readmitted your wife to the public hospital on 13 May 2002 when her condition deteriorated further. She underwent a laparoscopy on 27 May and it was found that she had a large stomach tumour with associated metastatic disease and ascites. Sadly, your wife died in July 2002.

Conclusion

Your wife was concerned that when her symptoms continued after a normal barium meal in April 2000, Dr B did not order any further examinations or refer her to a specialist. My general practitioner advisor stated that stomach cancer is relatively rare in New Zealand, whereas gastro-intestinal reflux and peptic ulcer disease is quite common. Dr B would have been reassured about the low possibility of serious stomach disease by the barium meal report. Dr B tested your wife for *Helicobacter pylori* to detect peptic ulceration, which was positive, and prescribed a course of 'triple therapy' Klacid 7 to eradicate the bacteria. I am advised that it is likely that Dr B would have reiterated the need for follow-up if your wife's symptoms did not settle after completing the course of Klacid 7. In the following seven consultations that your wife had with Dr B between April 2000 and March 2002, she did not report any further stomach problems. I am advised that Dr B's management of your wife's symptoms at this time was entirely appropriate.

Your wife was also concerned that Dr B did not discuss with her the option of a gastroscopy examination when she was referred for the barium meal and later when her symptoms persisted. My advisor stated that neither barium meal nor gastroscopy is necessarily a definitive diagnosis, and that although a gastroscopy is more accurate, it is a more invasive technique, with long waiting times in the public system. Dr B

informed me that "gastroscopy was discussed in full with [Mrs A] during the consultation 31.3.00 as you will see in my notes". Unfortunately this issue was not able to be discussed further with your wife.

I am persuaded that Dr B did discuss gastroscopy with your wife in March 2000, and that two years later when her symptoms became acute in March/April 2002 the management was largely taken out of Dr B's hands by the rapid deterioration in your wife's condition.

I am guided by my expert's advice that Dr B provided your wife with services with reasonable care and skill in relation to the follow-up of the continuing gastric symptoms and her discussions with your wife about her options for further treatment, and that she acted ethically and professionally. Therefore, in my opinion Dr B did not breach the Code of Rights.

Again, I offer my condolences on the death of your wife and trust that this independent investigation of the matter has addressed your concerns.

Yours sincerely

Ron Paterson
Health and Disability Commissioner

Ref: 02/08972

Enc

REPORT TO THE HEALTH AND DISABILITY COMMISSIONER

COMPLAINT FILE 02/08972
To provide independent advice about whether Dr B provided an appropriate standard of treatment to Mrs A.

Supporting Information:
- "A": Letter of complaint and clinical records to the Commissioner received 5/7/02
- "B": Telephone conversation with Mr A 19/7/02
- "C": Dr B's response and attached documents 10/9/02

Background:
Mrs A was born on 6/7/1949 and she transferred to Dr B's practice in 1993.

Her ongoing health needs at that time were seasonal hayfever and she was on nordiol for contraception. There was no preceding hospital admissions or other ongoing medical or health related problems.

Between 1993 and 1998, she attended occasionally for minor problems, hay fever injections and contraception/smear examinations.

Mrs A consulted Dr B on 10/3/1998 and reported burning epigastric discomfit for the preceding month on first wakening and with bending.

Dr B noted epigastric tenderness and wondered about gastritis or an early ulcer. She prescribed twice daily zantac for 2 weeks and suggested reviewing this if the symptoms did not settle quickly or recurred.

The next consultation was on 6/9/98. It was directly related to contraception and the continued use of nordiol. A breast and pelvic examination was done and there was a general health enquiry and examination. Gastrointestinal symptoms were not noted.

In 1999, prescriptions were provided for nordiol in June and August and Mrs A attended for a routine cervical smear on 8/9/99.

A telephone consultation is recorded on 4/10/99 recording "same symptoms" as 15/3/98 and requesting more zantac. It was emphasised to Mrs A that she must be seen if her symptoms did not settle. A prescription for 30 zantac was issued. A further telephone call is noted on 22/11/99 saying that zantac was helping but she was taking this sporadically. It was suggested that Mrs A take zantac twice daily and come in if this did not resolve her symptoms.

On 31/3/00, Mrs A attended Dr B. She reported ongoing abdominal pains "like butterflies in her stomach" for 6-12 months. She would feel seedy and would occasionally vomit. That morning she had bought up "frothy sputum" and would also vomit up small quantities of bile. Her symptoms would clear after vomiting and she would feel well for the remainder of the day. He symptoms were worse first thing in the morning or after bending. There was no haemoptysis (blood staining), her diet and

bowel habit was normal and her weight was steady. Eating seemed to help, as would zantac but her symptoms were recurring.

Dr B examined Mrs A and found some epigastric tenderness only. She felt gastro-oesophageal reflux was the likely diagnosis with the possibility also of peptic ulcer disease.

Dr B discussed investigations with Mrs A and a barium meal was decided upon. Dr B noted that this test had some limitations compared to gastroscopy which was also discussed. A variety of blood tests were ordered including an H pylori serum test. Losec 20mg one daily was prescribed.

A telephone consultation is recorded on 3/4/00, noting that the stomach symptoms had settled with losec but suggesting a barium meal. Blood results were also noted.

A barium meal was done on 13/4/00. It was reported to be entirely normal although it was noted "the amount of resting juice in the stomach is moderately increased". There was no gastrointestinal reflux found.

There is a further annotation in the notes on 13/4/00 detailing the normal barium meal and a positive serum H pylori test and the fact that Mrs A was feeling better. A course of Klacid 7 was prescribed.

On 18/7/00, there was a detailed consultation involving 3 specific areas i.e. continuing contraception, a respiratory infection and a six-week history of intermittent right lower abdominal discomfit. This followed an episode of severe, bilateral low abdominal pain, which had lasted about 5 minutes.

Mrs A was seen next on 3/10/00 for a repeat smear, contraceptive advice and a left arm and shoulder injury.

She was seen again on 25/10/00 for a consultation specifically about osteoporosis management. On 15/12/00 she had a hay fever injection and mentioned a lump in her neck. This was thought to be a thyroid cyst and she was to have blood tests and be referred to the local thyroid clinic at the public hospital.

She was seen at this clinic on 6/3/01 and the cyst was scanned, scintigrammed and then biopsied. The outcome was believed to be a benign colloid cyst and follow-up and rescanning at a later date was arranged by the clinician concerned.

On 22/1/01 Mrs A reported vaginal bleeding for the preceding 2 weeks. A detailed history and examination was undertaken and a referral made to a gynaecologist, Dr …, for possible endometrial biopsy. He advised a "wait and see" approach.

Dr B provided a three-month prescription for daily losec to Mrs A on 14/3/01 and a hay-fever injection was given on 12/11/01.

Mrs A attended on 14/2/02 with a four-month history of getting up at night to pass urine once or twice. For the previous month brief left lower abdominal pains followed this. During the day she had no problems, her bowels were normal and she felt well.

She was tender in epigastrium on examination and over the bladder and her screening urine showed microscopic haematuria.

Various methods of management were discussed and the urine was sent for formal testing.

Mrs A returned on 15/3/02 with persistent urinary symptoms, which had got rather worse. She reported being tired but was working longer hours at work than previously. She had an abdominal and pelvic examination, which did not show anything in particular. Blood and urine tests were ordered and she was referred for a detailed urological examination.

A phone call is recorded on 23/3/02 in which the blood test results were discussed. A low iron was recorded and Mrs A said she would buy some iron tablets.

There was a further telephone consultation on 27/3/02 reporting that Mrs A had vomited violently all night after taking an iron tablet and had been given an anti-emetic injection at an after hours centre. It was agreed that the iron tablets would be discontinued and a new brand tried.

On 11/4/02, Mrs A reported that she had vomited violently several times the preceding two nights after developing a deep aching tummy pain. During the day she felt quite well and apart from a feeling of fullness in the stomach, had no other gastro-intestinal symptoms.

Dr B noted the result of the barium meal 2 years previously and wondered whether poor gastric emptying was the cause. She prescribed motilium for this.

On 24/4/402, Mrs A presented to Dr B acutely distressed and unwell. She had developed severe vomiting at work that morning and felt really lousy.

Dr B noted that Mrs A had seen Dr …, a urologist the preceding day, and he had ordered a scan and was to undertake a cystoscopy.

She gave Mrs A an antiemetic injection, inserted an IV line and arranged her admission to hospital by ambulance.

Mrs A was admitted acutely to the public hospital on 24/4/02. Gastroscopy that day showed a deep ulcer at the greater curve of her stomach and biopsies then showed this to be an infiltrating poorly differentiated adenocarcinoma.

Mrs A was discharged the next day with surgical follow-up in 2 weeks organised at outpatients for the histology results.

On 2/5/02 the urologist biopsied a lesion on the back wall of the bladder which turned out to be chronic inflammation rather than a metastatic deposit.

A telephone call between Dr B and Mr and Mrs A regarding the diagnosis and management is recorded on 3/5/02.

Dr B admitted Mrs A acutely to the public hospital on 13/5/02 after further severe vomiting, weight loss and possible dehydration.

On 27/5/02 Mrs A underwent a laparoscopy which showed the large stomach tumour and associated metastatic disease and ascites.

Mrs A died on 17/7/02.

Did Dr B provide Mrs A with services with reasonable care and skill in relation to:

- **the follow-up of Mrs A's continuing gastric symptoms**

I believe that she did. Stomach cancer is relatively rare in New Zealand whereas gastro-intestinal reflux is very common and peptic acid disease is quite common. Mrs A's stomach ulcer may have been present for a considerable time before it developed its malignant nature.

Mrs A consulted Dr B with the onset of her gastric intestinal symptoms on 10/3/1998. Dr B noted epigastric tenderness and wondered about gastritis or an early ulcer. She prescribed zantac for 2 weeks and suggested review if the symptoms did not settle quickly or recurred.

This is normal New Zealand practice which tends to be conservative with investigations and prescriptions for such a short history. There was advice for follow-up if the symptoms did not resolve.

Gastrointestinal symptoms were not noted at the next consultation on 6/9/98 and the next record is a telephone consultation on 4110/99 noting "same symptoms" as 15/3/98 with a request for more zantac. It was emphasised to Mrs A that she must be seen if her symptoms did not settle.

It can reasonably be assumed that in the two years between March 1998 and 2000, Mrs A's upper gastro-intestinal symptoms were minimal.

On 31/3/00, Mrs A attended Dr B with much more ominous symptoms. Mrs A reported ongoing abdominal pains "like butterflies in her stomach" for 6-12 months. She would feel seedy and would occasionally vomit. That morning she had bought up "frothy sputum" and would also vomit up small quantities of bile. Her symptoms would dear after vomiting and she would feel well for the remainder of the day. He symptoms were worse first thing in the morning or after bending. There was no haemoptysis (blood staining), her diet and bowel habit was normal and her weight was steady. Eating seemed to help, as would zantac but her symptoms were recurring.

Dr B examined Mrs A and felt gastro-oesophageal reflux was the likely diagnosis with the possibility of peptic ulcer disease.

Dr B discussed investigations with Mrs A and a barium meal was decided upon. A variety of blood tests were ordered including an H pylori serum test.

Dr B's management at this time was entirely appropriate. She recognised the need for follow-up, toyed with the options for diagnosis and elected upon a barium meal and associated blood tests.

A barium meal was done on 13/4/00. It was reported to be entirely normal although it was noted "the amount of resting juice in the stomach is moderately increased". There was no gastro-oesophageal reflux found.

At this point a GP would be reassured about the possibility of serious stomach disease. A barium meal may miss a small peplic or malignant ulcer but the likelihood is relatively small in good radiology bands. The "moderately increased resting juice" has no special implications.

At that time, i.e. 13/4/00, blood tests were available to detect peptic ulceration due to a bacteria called Helicobacter pylori i.e. the H pylori serum test. This test cannot differentiate between past and present peptic ulcer disease. A specific test, i.e. the breath urea test, is now funded and available to differentiate between past and present Helicobacter disease. Dr B recognised the positive serum test by prescribing a course of "triple therapy" i.e. Klacid 7, to eradicate the Helicobacter bacteria. She was likely to have linked the bacteria to Mrs A's symptoms but to have reiterated the need for follow-up if they did not resolve.

On 18/7/00, there was a detailed consultation involving 3 problems, none of which had any upper gastro-intestinal implications. These again were not mentioned at the consultations on 3/10/00, 25/10/00, 15/12/00, 22/1/01, 14/2/02 and 15/3/02. These were also detailed consultations involving a variety of health problems all of which were carefully detailed and appropriate examinations, investigations and referrals made.

From these consultations it is clear that Dr B and Mrs A had a trusting and professional relationship with good communication on both sides.

In March 2002, it becomes clear in retrospect that the gastric cancer was advancing. A low iron was recorded and Mrs A started to vomit regularly and violently.

The blood test results were not provided in the notes so it is difficult to comment on the significance of these. However, a low iron may reflect many different medical problems.

Dr B noted the result of the barium meal 2 years previously and wondered whether poor gastric emptying was the cause. She prescribed motilium for this.

It is at this point that Dr B may have reviewed her original diagnosis and the need for urgent gastroscopy and arranged this. It would not have made any difference to Mrs A's eventual outcome but it would have detected the gastric cancer a little earlier. However, Mrs A was still having other investigations i.e. for her bladder symptoms and this would have been reflected in Dr B's decision making at that lime. Because gastric cancer is a very uncommon diagnosis, and a relatively silent one in its early stages, it is difficult to detect and can very rarely be cured. Gastroscopy is also very difficult to arrange in New Zealand hospitals as a routine investigation and most hospitals have long waiting limes for this test.

On 24/4/02, Mrs A presented to Dr B acutely unwell She gave Mrs A an anti-emetic injection, inserted an IV line and arranged her admission to hospital by ambulance.

Mrs A was admitted to the public hospital on 24/4/02 and discharged the next day. Gastroscopy showed a deep ulcer at the greater curve of her stomach and biopsies then showed this to be an infiltrating poorly differentiated adenocarcinoma.

Surgical follow-up in 2 weeks was organised at outpatients for the histology results.

Dr B admitted Mrs A acutely to the first public hospital on 13/5/02 after further severe vomiting, weight loss and dehydration. On 27/5/02 she underwent a laparoscopy which showed the large stomach tumour and associated metastatic disease and ascites.

Dr B cannot be criticised for her management from this lime, as it was largely taken out of her hands. The hospital admission was very brief indeed and the outpatient appointment lime was two weeks later. Although, no mention is made of the details of follow-up it was another acute admission that revealed the extent of the tumour and its metastases.

- **the discussion with Mrs A about her options for further treatment**

On 31/3/00 Dr B discussed investigations with Mrs A and a barium meal was decided upon. Dr B noted that this test had some limitations compared to gastroscopy which was also discussed.

Neither a barium meal or a gastroscopy is necessarily a definitive investigation. Barium meals may miss early or small lesions but may pick up gastro-oesophageal reflux more exactly. A gastroscopy is much more accurate for detecting stomach wall lesions but is a much more invasive investigation. Although easy to access privately it is rationed as a routine investigation in public hospitals by long waiting times.

I believe Dr B discussed the options for investigation and management in a very reasonable and professional way with Mrs A.

Are there any other professional, ethical and other relevant standards apply in this case and did Dr B meet those standards?

Dr B is a well qualified GP undertaking ongoing professional development. I believe she acted ethically and professionally in this case. It seems likely that she will have reflected on the potential to order a gastroscopy in late March 2002 and make the diagnosis a little earlier especially as Mrs A appeared willing or able to have private treatment.

The case is a good one for all GPs to reflect on and use as an educational exercise. This would be an attempt to make an early diagnosis in gastric carcinoma, however, not an easy task as I have outlined.

Any other comments?

The follow-up care by the public hospital after Mrs A's admission on 24/4/02 might also bear a little reflection as a quality assurance exercise. Two weeks seems a long time to wait in someone very ill by that stage.

Dr Tessa Turnbull
26/10/02