Delayed diagnosis of testicular cancer
17HDC01680, 26 September 2018

General practitioner ~ Medical centre ~ Testicular lump ~ Delayed diagnosis ~Follow-up ~ Right 4(1)

A man saw a general practitioner (GP) at a medical centre regarding a lump in his right testicle. On examining the man's testicles, the GP believed that the lump was in the man's epididymis, rather than the body of the testicle, because he could palpate a gap between the two. Given these examination findings and the man's history of a vasectomy, which can predispose men to epididymal cysts, the GP was reassured that the lump was an epididymal cyst.

Although not documented in his notes, the GP told HDC that he told the man to return for follow-up should he have concerns, or if his symptoms worsened or did not improve. By contrast, the man told HDC that the GP did not give him any follow-up advice, and that his impression was that the GP believed that the lump was related to his vasectomy.

Two months later the man saw another GP at the medical centre as the cyst had continued to grow, and the right testicle was now bigger than the left. The GP referred the man for an ultrasound. Following the ultrasound, the man saw the GP to review the ultrasound results, and was advised that the lump was likely to be testicular cancer.

As a result, the GP made an urgent urology referral to the public hospital. The man was seen the next day and the diagnosis was confirmed. The man's right testicle was removed, and a subsequent CT scan revealed two pulmonary metastases (lung cancer), which required chemotherapy treatment.

Findings

The first GP was found to have breached Right 4(1). It was held that he failed to provide services to the man with reasonable care and skill by not transilluminating (passing strong light through an area of the body for medical inspection) the lump in the man's right testicle, not identifying the possible diagnosis of testicular cancer and referring the man for an ultrasound and/or specialist review, failing to comply with the New Zealand Suspected Cancer in Primary Care guidelines, and failing to give follow-up advice to the man.

The GP's actions were considered to be matters of individual clinical judgement and practice, and there was no evidence that the policies or practices at the medical centre contributed to the GP's errors of clinical judgement. Accordingly, the medical centre was not found vicariously or directly liable for any breach of the Code.