General Practitioner, Dr B

A Report by the

Health and Disability Commissioner

(Case 11HDC00843)

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Executive summary

1. This report is about the failure of a general practitioner, Dr B, to initiate timely investigations, leading to a delayed diagnosis of bladder cancer in his patient, Mr A, aged 48 years at the time.

2. Mr A consulted Dr B on three occasions (December 2008, June 2009 and October 2009) complaining of blood in his urine (macroscopic haematuria[1]) but with no accompanying pain. At the first and second consultations, Dr B put this down to a urine infection and prescribed Mr A an antibiotic. Dr B did not order any investigations until Mr A presented to him a third time in October 2009 with the same complaint. On that occasion, Dr B ordered investigations and referred Mr A to a urologist.

3. An ultrasound in November 2009 revealed that Mr A had a large bladder tumour, which was subsequently treated surgically. He required several resections of the bladder before having his bladder removed in 2011.

4. When Mr A first presented with painless macroscopic haematuria, Dr B should have ordered laboratory tests to exclude infection. If infection was absent, secondary investigations should have been carried out. The need for action to be taken to investigate Mr A's haematuria was even greater when Mr A presented for a second time, six months later, with the same concerns.

Decision summary

5. Dr B's failure to investigate Mr A's macroscopic painless haematuria or refer him to a specialist, first in December 2008 and again in June 2009, was a breach of Right 4(1)[2] of the Code of Health and Disability Services Consumers' Rights (the Code).

Complaint and investigation

6. The Commissioner received a complaint from Mr A about the services provided by Dr B. The following issue was identified for investigation:

   - *Whether Dr B provided Mr A with an appropriate standard of care between December 2008 and November 2009.*

7. After a period of assessment, an investigation was commenced on 20 February 2012.

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[1] Macroscopic haematuria is the presence of blood in the urine where the blood is visible to the naked eye; microscopic haematuria is the presence of blood in the urine where the blood is not visible to the naked eye.

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

8. The parties directly involved in the investigation were:

Mr A	Consumer/complainant
Dr B	General practitioner

9. Information was reviewed from urologist, Dr C, and the District Health Board.

10. Clinical advice was obtained from general practitioner, Dr David Maplesden, and is set out in Appendix 1.

Information gathered during investigation

Mr A's previous medical history

11. Mr A transferred his primary medical care to Dr B in July 2007.

12. At his first consultation in July 2007, Mr A consulted Dr B regarding a transilluminable[3] left testicular lump, which he had had since 1997 and which had recently grown. Dr B referred him to the urology department at the public hospital, where Mr A saw urologist Dr C in November 2007. A large left epidydimal cyst (a smooth, spherical cyst on the testicle) was confirmed by ultrasound. Mr A was placed on the waiting list for excision of the cyst, which was performed by Dr C at the hospital on 17 April 2008. On 11 September 2008, Mr A was reviewed by Dr C, who recorded in a letter to Dr B that he had "reassured [Mr A] of the benign nature of the pathology".

First GP visit for haematuria

13. On 17 December 2008, Mr A (then aged 48 years) consulted Dr B, with concerns about blood in his urine. Dr B's clinical record indicates that Mr A had been passing blood in his urine for three days and noted "no pain or frequency".

14. Dr B advised that, on examination, there was no tenderness in Mr A's abdomen, kidneys, or bladder. Dr B explained that he did not think that the haematuria was "anything sinister" because: he did not consider Mr A to be in the high risk age range; Mr A had been seen by a urologist just three months previously; Mr A had had a normal scan "only a few months prior", which Dr B assumed would have included the testicles, bladder and prostate; and Mr A was fit, young, healthy, and a non-smoker. Dr B stated:

> "[Mr A's] age, his recent operation and follow up under the care of a Urologist just a few months earlier led me to consider the symptoms were that of a urinary tract infection possibly cystitis and I prescribed him Augmentin 500mg three times daily for seven days."

[3] Transillumination is a technique where light is transmitted through tissues of the body and will differentiate between a solid and a fluid-filled swelling. If the light shining through the tissue glows red it is said to transilluminate. Fluid-filled lumps are transilluminable, and more likely to be benign.

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15. Dr B documented "?? Cystitis"[4] in Mr A's medical records. In response to my provisional decision, Dr B advised that this note meant that he suspected bladder infection but was not excluding other possibilities.

16. No tests were performed on that occasion.

17. Mr A told HDC that he understood his presenting complaint was put down to a urine infection.

18. Dr B prescribed Mr A an antibiotic and advised him to drink more fluids. As per the clinical notes, Dr B asked Mr A to return in two days' time if the haematuria had "not cleared". In response to my provisional opinion, Dr B said that he had stressed to Mr A that he must return if the bleeding persisted, and that he is "certain that [he] made this very clear to [Mr A] and that there was no misunderstanding between [them]".

19. Mr A told HDC that when he drank more fluids as suggested by Dr B, this seemed to help clear the blood, and he did not think it was necessary to return to Dr B.

20. In the course of the HDC investigation, Dr B reviewed the bookings he had on 17 December 2008, and noted that he had "a very busy and heavy patient workload with various demands from patients including one who was in a serious condition and required an ECG". He further noted that most of his patients are "high needs" and he was under extreme pressure to see a lot of people just a few days from Christmas. Dr B told HDC that this busy time had distracted him from doing tests immediately.

Ongoing haematuria

21. Mr A did not return to Dr B for approximately six months. Mr A told HDC that he experienced blood in his urine "on and off" following the 17 December 2008 appointment, although he could not recall the frequency with which this occurred. Dr B said he was not aware of this. Mr A noted that each time it occurred he drank more fluids and his urine cleared.

22. Dr B acknowledged to HDC that he incorrectly believed that Mr A had been successfully treated with antibiotics. In response to my provisional decision, Dr B said that he was very concerned to learn that Mr A had experienced further episodes of bleeding. Dr B said that he endeavours to ask open questions regarding symptoms to allow patients to give their history, and that had he known this he would have certainly acted differently and undertaken further investigations. Dr B told HDC that had Mr A returned to him with "continuing haematuria" he would have undertaken a full blood test and urine tests, including cytology.[5]

Second GP visit for haematuria

23. Six months later (on 8 June 2009), Mr A saw Dr B again for blood in his urine. The clinical note reads:

[4] Cystitis is inflammation of the bladder, commonly due to infection.
[5] Cytology is microscopic examination of cells to look for abnormality.

HDC

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> "[H]as a small lump right testicle with blood in urine. for 4 days. had same problem a year ago."

24. No investigations were undertaken and there is no record of a physical examination.

25. Again, Dr B prescribed an antibiotic for Mr A. Mr A understood that his presenting concerns were put down to another urine infection. Dr B said that:

> "based on his previous episode of haematuria on [17 December 2008] where it appeared to have been successfully treated with antibiotics, I presumed, incorrectly that he had another episode of urinary tract infection which I treated with further antibiotics".

26. Dr B stated that he advised Mr A to return in two days' time if his symptoms had not resolved. Mr A did not return to Dr B until October 2009. Again, in response to my provisional opinion, Dr B advised that he is certain he made it "very clear" to Mr A that he should return if bleeding persisted.

27. Mr A noted that he experienced blood in his urine more and more frequently, but that the blood usually cleared within a few days when he drank water. He understood that he needed to return to Dr B if the blood did not clear within a few days for each episode.

Third GP visit for haematuria

28. On 23 October 2009, Mr A saw Dr B for a third time regarding blood in his urine. Dr B documented his findings as "[p]assing blood in the urine [for] no apparent reason". There is no record of a physical examination.

29. On that occasion, Dr B initiated further investigations, including requesting a full blood count and urine tests including cytology, and referring Mr A to the urology department for specialist review, and to the radiology department for an ultrasound.

Results of further investigations

30. On 27 October 2009, Dr B received the results of the tests ordered on 23 October 2009. The urine cytology results were highly suspicious of transitional cell carcinoma.[6] On 30 October 2009, Dr B discussed the results with Mr A and faxed the results to the urology department at the hospital.

31. On 13 November 2009, Dr B was called by the radiologist, who reported that Mr A's ultrasound showed a large bladder tumour. Dr B contacted the urology department in an attempt to expedite Mr A's appointment. The urology department made an appointment for Mr A to see a urologist that day.[7]

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[6] Transitional cell carcinoma is a cancer that typically occurs in the urinary system. It is the most common type of bladder cancer.

[7] In response to Dr B's phone call and request for an earlier appointment for Mr A, the Hospital Administrator "double booked" Mr A into a urology clinic on 13 November 2009.

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Urology appointment & subsequent surgery

32. Mr A was seen by a urologist on 13 November 2009. The urologist placed Mr A on the waiting list for surgery, and organised a CT scan of Mr A's chest, abdomen and pelvis.

33. Mr A underwent a cystoscopic transurethral resection of the tumour[8] (and removal of a section of the prostate) on 19 November 2009.

34. Further resections of the tumour were carried out in 2010, after several superficial recurrences were noted.

35. On 20 June 2011, Mr A underwent an operation to remove his bladder, prostate and lymph nodes, and a new bladder was surgically formed.

Dr B's response

36. In response to Mr A's complaint, Dr B initially told HDC that he:

> "strongly [felt] that [his] medical care was adequate and appropriate. [...] [Mr A's] expectations of making instant diagnosis of his illness is inappropriate. […] The mere fact that [Mr A] is alive and kicking today is because of early diagnosis and treatment."

37. In a later response, Dr B apologised for the inappropriate statements made in his initial response and apologised for the delay in diagnosing Mr A with bladder cancer, noting that he should have sent Mr A for a mid-stream urine test (MSU) and cytology on his first presentation with haematuria.

Response to provisional opinion

38. Dr B accepted that he should have arranged an MSU for a male presenting with symptoms that might indicate cystitis. He acknowledged that he did not investigate Mr A's haematuria as early as he should have. He stated: "I only wish that I had carried out the tests earlier and not been misled by my assumptions and thought processes on his previous visits." Dr B advised that he is "profoundly sorry and devastated" that his "assumptions misled [him] with [Mr A's] situation".

39. Dr B said that his usual practice is to view all painless haematuria as potential urinary tract cancer unless proven otherwise. He said he is now vigilant with any cases of haematuria in all of his patients.

Changes to practice

40. Dr B told HDC that he has shared this case with his colleagues and will be discussing it with other general practitioners in the region.

[8] Transurethral resection of the bladder is a surgical procedure used to diagnose bladder cancer and to remove cancerous tissue from the bladder. A cystoscope is passed into the bladder through the urethra, and a tool called a resectoscope is used to remove the cancer for biopsy and to burn away any remaining cancer cells. Bladder cancer can come back after this surgery, so repeat transurethral resections are sometimes needed.

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41. Dr B also indicated that he has made some improvements to his practice. Specifically, Dr B:

- has undertaken a single pass clinical audit on male patients with MSU results in the past 12 months indicating haematuria (microscopic or macroscopic) to ensure management and follow-up had been consistent with current recommendations; and

- says he is now more alert in dealing with every case of haematuria in male patients; from the first presentation he will refer for MSU and cytology and, if the investigations do not confirm infection, he will then urgently refer on for specialist investigations including ultrasound, full blood count, renal function tests, and urea and electrolytes.

Opinion: Breach — Dr B

Introduction

42. Under the Code, consumers have rights, and healthcare providers have duties.[9] Mr A had the right to receive an appropriate standard of care from Dr B. Dr B, as Mr A's primary health care provider, had a duty to assess Mr A's condition adequately and perform examinations as appropriate. The key issue in this case is whether Dr B discharged that duty of care.

43. My in-house clinical advisor, general practitioner Dr David Maplesden, has advised me that standard local and international recommendations[10] provide that where a patient presents with painless haematuria, at the minimum, management should include laboratory tests (mid-stream urine and culture) to exclude infection and a referral for further investigation if there is no infection evident. Dr Maplesden advised that this is basic GP knowledge, and that while there are many causes for macroscopic haematuria, bladder cancer should be presumed until proved otherwise. Dr Maplesden advised that 30% of patients presenting with painless macroscopic haematuria are found to have urological cancer. A single episode of haematuria is as important as recurrent episodes.

44. My investigation has centred on the care provided by Dr B in relation to two of the three consultations (17 December 2008 and 8 June 2009) where Mr A presented to him with painless macroscopic haematuria. In my view, Dr B did not adequately investigate Mr A's haematuria at, or immediately following, these consultations, or refer Mr A to a specialist, and breached Right 4(1) of the Code, for the reasons set out below.[11]

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[9] Clause 1 of the Code.

[10] See, for example, the New Zealand Guidelines Group's "Suspected cancer in primary care" (published in June 2009).

[11] This Office has previously found doctors in breach of Right 4(1) of the Code for failing to undertake adequate investigations in light of a patient's symptoms (for example, see Opinions 10HDC00253 and

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First consultation — 17 December 2008

45. At the first appointment on 17 December 2008, Dr B noted a three-day history of painless haematuria, advised Mr A to drink more fluids, and prescribed an antibiotic for a suspected urinary tract infection (UTI).

46. Dr B should have carried out investigations at this point, initially by requesting a mid-stream urine (MSU) sample and culture to exclude infection. Dr Maplesden noted:

> "Even if infection is suspected, recommended best practice is for MSU to be performed, as suspected UTI in a male is defined as complicated infection and MSU [is] always indicated, although empiric antibiotic treatment may be commenced while awaiting the result."

47. Dr Maplesden noted that Mr A did not have any symptoms, other than haematuria, to suggest a UTI was likely.

48. If the results of the MSU were negative for infection, secondary investigations should have been carried out. In addition, if no nephrological disease[12] was evident, a referral for ultrasound and cystoscopy[13] should have been carried out to exclude renal tract malignancy.

49. One of the reasons Dr B gave for not undertaking further investigations was that Mr A had had an epidydimal cyst excised earlier in 2008. Dr Maplesden's view is that this is irrelevant, noting:

> "Treatment for the cyst [was] some months prior to the presentation in question, it did not involve instrumentation of the urinary tract (risk for infection), and an epididymal cyst would not present with painless haematuria. The urologists were treating him for the cyst, not investigating him for haematuria."

50. Dr B acknowledged that he was influenced by Mr A being fit, young, healthy, and a non-smoker. Dr Maplesden acknowledged that Mr A's age of 48 years at his initial presentation with painless haematuria was "somewhat unusual", but was nevertheless of the view that Dr B should have, at a minimum, requested an MSU to exclude infection as a cause of the haematuria. I accept Dr Maplesden's advice.

51. Dr B told Mr A to return in two days' time if the haematuria had "not cleared". Dr B's diagnostic reasoning was flawed. Nonetheless, because the alternative path could be sinister, he should have reinforced to his patient the importance of coming back if his symptoms recurred. Dr B advised HDC that he is certain he reinforced to Mr A the importance of returning if his bleeding did not clear. However, I find that Dr B did not warn Mr A sufficiently that the haematuria could indicate serious pathology, and that

03HDC11066). In both cases the doctor was found to have breached Right 4(1) of the Code for failing to examine the patient adequately and investigate symptoms, resulting in a failure to diagnose bowel cancer. See also Opinion 10HDC00610, where a doctor was found to have breached Right 4(1) of the Code for failing to investigate and manage a patient's respiratory symptoms appropriately.

[12] Disease of the kidneys.

[13] Examination of the bladder.

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Mr A should therefore be attentive to any recurrence. As a result, Mr A did not know why he should return, and the importance of doing so.

Second consultation — 8 June 2009

52. Mr A advised HDC that between his appointment with Dr B on 17 December 2008 and his appointment on 8 June 2009, he experienced blood in his urine "on and off", although he could not recall the frequency with which this occurred. Mr A advised HDC that each time he experienced blood in his urine, he drank more fluids and his urine would clear.

53. When Mr A presented to Dr B for a second time on 8 June 2009, Dr B recorded that Mr A presented with a four-day history of haematuria. Although Dr B advised that he endeavours to ask questions around symptoms in an open way, he does not appear to have asked Mr A about his intervening history of haematuria.

54. Again, no investigations were ordered. Dr B diagnosed a UTI and treated Mr A with antibiotics. Dr B says he again told Mr A to return in two days' time if the blood did not clear, although this is not documented. Mr A did understand he was to return if the blood did not clear within a few days, but evidently did not understand that he should return if blood re-appeared.

55. By that time, six months after Mr A's first presentation with painless haematuria, the need to undertake further investigation had become even greater. Not only did Dr B fail to undertake investigations or refer Mr A to a specialist at that time, he also failed to talk to his patient and ascertain Mr A's intervening history of haematuria.

Third consultation — 23 October 2009

56. On 23 October 2009, Mr A presented for a third time, 10 months after his first presentation with haematuria. On that occasion, Dr B did order further investigations and refer Mr A to a specialist. I accept Dr Maplesden's advice that Dr B's management of Mr A in relation to that consultation was consistent with expected standards.

Summary

57. Despite Mr A's relatively young age, Dr B should have undertaken investigations or referred Mr A to a specialist in December 2008.

58. In my view, by failing to undertake investigations or refer Mr A to a specialist in December 2008 and again in June 2009, Dr B failed to provide an appropriate standard of care. Accordingly, in my view, Dr B breached Right 4(1) of the Code.

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Opinion: Adverse comment — Dr B

Dr B's response to HDC

59. Dr B's first response to my Office was inappropriate. Not only did it lack insight into the substandard care he provided, it was unprofessional and showed a lack of empathy for Mr A.

60. Dr B has subsequently apologised for these comments, and accepts that his care of Mr A was inadequate.

Recommendations

61. On 12 December 2011, I referred Dr B to the Medical Council of New Zealand pursuant to section 34(1)(a) of the Health and Disability Commissioner Act 1994. In February 2012 the Medical Council of New Zealand resolved to require Dr B to undergo a performance assessment.[14] In October 2012, the Medical Council ordered Dr B to undertake a 12-month educational programme. Dr B advised that this includes working with a mentor to review and improve areas of his practice, and to reduce the professional isolation of being a very busy solo practice. He said that the performance assessment also included looking at his prescribing and investigation results.

62. I sent Dr B a copy of Dr Maplesden's clinical advice, which suggested that Dr B undertake a single pass clinical audit on his male patients with MSU results in the past 12 months indicating haematuria (microscopic or macroscopic), to ensure that management and follow-up has been consistent with current recommendations. Dr B undertook such an audit and provided this Office with the results showing his management of the identified patients. Dr Maplesden reviewed Dr B's audit findings, and commented that the audit appears to have been undertaken and analysed in a thorough and appropriate manner, and the results were consistent with the medical literature.

63. In my provisional opinion I recommended that Dr B undertake an audit of all cases of haematuria in male patients (including those in which no MSU was undertaken) in the past 12 months, to ensure that management and follow-up has been consistent with current recommendations. Dr B undertook such an audit and advised that there were no cases of haematuria where an MSU was not undertaken.

64. As per the recommendation in my provisional opinion, Dr B has provided a written apology, which will be forwarded to Mr A.

[14] The Medical Council of New Zealand has advised that a performance assessment is equivalent to a competency review, pursuant to the Health Practitioners Competence Assurance Act 2003.

Follow-up actions

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand, the Royal New Zealand College of General Practitioners, and the District Health Board and they will be advised of Dr B's name.

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

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Appendix A — Clinical advice to the Commissioner

The following expert advice was obtained from HDC's in-house clinical advisor, general practitioner Dr David Maplesden:

"1. Thank you for the request that I provide clinical advice in relation to the complaint from [Mr A] about the care provided to him by [Dr B] and [Dr C]. To my knowledge, I have no personal or professional conflicts of interest. I have examined the available documentation: complaint from [Mr A]; response from [Dr B] and GP notes; response from [Dr C]; [hospital] notes; [another hospital] notes. [Mr A] complains that [Dr B] failed to investigate his complaints of haematuria (December 2008 and June 2009) in a timely manner leading to a delayed diagnosis of bladder cancer. He complains that [Dr C] did not treat the cancer appropriately between November 2009 and February 2011, leading to the requirement for him to have his bladder removed in April 2011.

2. GP notes review

(i) 2 July 2007 — consultation for longstanding left testicular lump, transilluminable. Referred to urology. Seen by urologist 9 November 2007 and large left epidydimal cyst confirmed on subsequent ultrasound. Cyst excised 17 April 2008 and, at urologist review 11 September 2008, there were no ongoing symptoms referable to the cyst.

(ii) 17 December 2008 — GP notes are *passing blood in urine since Monday, no pain or frequency, no renal tenderness, no bladder tenderness ??cystits, put on* antibiotic*, see by Friday if it has not cleared.* No tests were performed. Augmentin prescribed. [Mr A] was 48 years old at this point.

(iii) Next consultation is 8 June 2009. Notes in their entirety read *Has a small lump right testicle with blood in urine. For 4 days. Had same problem a year ago.* No *investigations* undertaken. No record of physical examination. Ibuprofen and Augmentin prescribed.

(iv) Next consultation 23 October 2009. Notes read *Passing blood in urine for no apparent reason. Referred for cystoscopy, US kidneys.* On this occasion blood and urine tests are ordered with cytology showing cells suggestive of *transitional* cell cancer of the bladder. Results discussed with the patient 30 October 2009. Results conveyed to urology department with request to expedite appointment. When [Mr A] had not heard from the department by 6 November 2009 he contacted [Dr B] who rang the department and refaxed the referral. 13 November 2009 [Dr B] receives ultrasound report indicating a large bladder tumour. The same day he again contacts the urology department to try and expedite [Mr A's] appointment.

(v) In his response, [Dr B] states *I strongly feel that my medical care was adequate and appropriate. There is a chain of procedures that is followed with any illness. [Mr A's] expectations of making an instant diagnosis of his illness is inappropriate…the chain of events that followed and investigations provided*

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was timely and appropriate. The mere fact that [Mr A] is alive and kicking today is because of early diagnosis and treatment.

3. Urology management

(i) [Mr A] was seen by [another urologist] on 13 November 2009 (evidently in response to [Dr B's] call) and further staging investigations ordered. He was already booked for an urgent appointment with urologist [Dr C]. Staging investigations were clear. [Dr C] performed trans-urethral resection of the tumour (TURB) on 19 November 2009 and histology showed *papillary urothelial carcinoma, WHO grade III. In addition, invasion into the lamina propria is identified.*

(ii) The nature of the cancer was explained at a follow-up appointment on 17 December 2009 with further cystoscopy and TURB (several superficial appearing recurrences) undertaken on 18 February 2010. Histology result of the removed areas was similar to that of November 2009 and included the comment *no evidence of lymphatic or vascular invasion.* Histology and management recommendations (further cystoscopy and Mitomycin-C instillation) were explained at follow-up on 24 March 2010. Further cystoscopy, resection of superficial tumour recurrence, and Mitomycin-C instillation were undertaken on 16 April 2010. Histology showed *Papillary urothelial carcinoma, WHO grade 2* (no sign of infiltration).

(iii) [Mr A] was reviewed on 16 July 2010 when histology was explained and recent CT scan reviewed (no sign of infiltrative bladder lesion or metastatic disease). Follow-up cystoscopy 6 January 2011 identified further superficial recurrences that were removed followed by Mitomycin-C instillation. Histology revealed *Grade III papillary TCC invading into lamina propria.* At this point [Dr C's] temporary contract with [the] DHB ended and care was taken over by [another urologist]. Further management is as per [Dr C's] response and [the] DHB and [another] DHB notes.

4. Background information from selected sources:

(i) Recommendation from the relevant New Zealand primary care guideline[15] is that a person of any age presenting with painless macroscopic haematuria should be referred urgently to a specialist. In a younger person cancer is unlikely to be the cause of the bleeding. A person presenting with symptoms suggestive of a urinary infection who also presents with macroscopic haematuria should be urgently referred to a specialist if the investigations do not confirm infection.

(ii) The classic presentation in bladder cancer is painless macroscopic haematuria, which occurs in 80–90% of patients. While there are many causes for macroscopic haematuria, bladder cancer should be presumed, until proved otherwise (especially in the elderly, high risk occupations and smokers), and

[15] NZGG. Suspected Cancer in Primary Care. 2009.

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patients should undergo urinary cytology, imaging of the urinary tract by computed tomography or intravenous pyelogram, and cystoscopy. A small proportion of cases present instead with irritative bladder symptoms such as dysuria, urgency or frequency of micturition without macroscopic haematuria[16].

(iii) Macroscopic haematuria has a high diagnostic yield for urological malignancy. 30% of patients presenting with painless macroscopic haematuria are found to have a malignancy … In terms of the need for follow-up investigation, a single episode of haematuria is equally important as recurrent episodes. Baseline investigation in the ED includes full blood count, urea and electrolyte levels, midstream urine dipstick, β human chorionic gonadotrophin, and formal microscopy, culture and sensitivities[17].

(iv) Macroscopic haematuria has a high diagnostic yield for underlying malignancy, particularly in appropriate age groups; in men aged > 60 the positive predictive value of macroscopic haematuria for urological malignancy is 22.1%. In women aged > 60 the positive predictive value of macroscopic haematuria for urological malignancy is 8.3%. In all patients aged < 60, the positive predictive value falls to 2.6%. Given the high prevalence of malignancy, it is mandatory to further evaluate patients with suspected urological disease as the cause of macroscopic haematuria. Recommended investigations were culture of the urine to exclude infection. If infection was absent, further urinalysis and serum biochemistry to assess renal function. If no nephrological disease was evident, referral for ultrasound and cystoscopy to exclude renal tract malignancy[18].

5. Comments

(i) Despite [Mr A's] relatively young age, standard local and international recommendations for management of patients presenting with painless haematuria, as [Mr A] did on 17 December 2008 and 8 June 2009, is a minimum of MSU and culture to exclude infection with referral for further investigation if there is no infection evident. I would regard this as basic GP knowledge. [Mr A] did not have any classic symptoms suggestive of bladder infection in December 2008 or June 2009. No investigations were ordered on either occasion. A history of epidydimal cyst excision eight months prior to the December 2008 presentation is irrelevant.

(ii) When [Mr A] presented with painless macroscopic haematuria for the third time in October 2009, some 10 months after his initial presentation, he was managed by [Dr B] in a manner consistent with expected standards in that appropriate further investigations were ordered and specialist referral made in a timely fashion. [Dr B] was also conscientious in following up [Mr A's] specialist appointment. Unfortunately, [Mr A] had a large bladder tumour evident by this

[16] Occupational causes of Bladder Cancer. ACC Review. Issue 36, August 2007

[17] Hicks D and Li C. Management of macroscopic haematuria in the emergency department. Emerg Med J 2007;24:385–390

[18] Diagnostic pathway — macroscopic haematuria. Western Australia Department of Health 2007. Available at http://www.imagingpathways.health.wa.gov.au/includes/pdf/macro_haema.pdf

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time. Had [Mr A] been referred in December 2008, it is quite possible the tumour would have been detected at a less advanced stage.

(iii) [Mr A] should have had further investigations, beginning with MSU for culture and microscopy, initiated at his first presentation with haematuria in December 2008. The failure by [Dr B] to undertake further appropriate investigations or specialist referral at this point, and again when [Mr A] presented with painless macroscopic haematuria for the second time in June 2009, is a severe departure from expected practice. The rationale for these decisions outlined by [Dr B] in his response, together with his actions and misperception that his care was adequate, may raise some concerns over his clinical competence."

[Portion deleted as not relevant to the investigation.]

Further advice received from general practitioner Dr David Maplesden

"I have reviewed the response from [Dr B] to my original advice dated 4 November 2011 and make the following comments.

While [Mr A's] age of 48yrs at his initial presentation with painless haematuria in December 2008 was somewhat unusual, I remain of the view that [Dr B] should have sought to exclude infection as a cause of the haematuria with a minimum of an MSU at this time, and certainly when [Mr A] presented with painless haematuria again six months later. I cannot see the relevance of [Mr A] receiving surgical treatment for an epididymal cyst some eight months prior to his first presentation with haematuria as being a mitigating factor in [Dr B's] decision to treat [Mr A's] symptoms as an infection without further investigation. Treatment for the cyst being some months prior to the presentation in question, it did not involve instrumentation of the urinary tract (risk for infection), and an epididymal cyst would not present with painless haematuria. The urologists treating [Mr A] were treating him for the cyst, not investigating him for haematuria.

As far as I can determine, [Mr A] did not have any symptoms, other than haematuria, to suggest UTI was likely when he presented to [Dr B] in December 2008 and again in June 2009. Even if infection was suspected, recommended best practice is for MSU to be performed, as suspected UTI in a male is defined as complicated infection and MSU always indicated, although empiric antibiotic treatment may be commenced while awaiting the result[19]. An MSU is not required in uncomplicated infections, those being defined as a female with an unobstructed urinary tract presenting with classic symptoms of frequency, dysuria, urgency and suprapubic pain, and in the absence of any complicating factors.

[Dr B] has apologised to [Mr A] for his contribution towards the delay in diagnosing [Mr A's] bladder cancer. He defines his usual practice which is to perform MSU on patients presenting with haematuria, and states he is now more vigilant than ever to ensure this approach is used with all such patients. He now uses the PMS task manager tool to alert him if patients he is expecting to return for reviews do not do so.

[19] BPAC. Laboratory investigation of UTI. 2006. www.bpac.org.nz

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

These are all appropriate actions and should reduce the future risk of mismanagement in a case such as this. However, there are no particular mitigating factors presented in the additional response from [Dr B] and my original opinion, that his management of [Mr A] departed from expected standards to a severe degree, remains.

In addition to the steps [Dr B] has already taken, I recommend he undertake a single pass clinical audit on his male patients with MSU results in the past twelve months indicating haematuria (microscopic or macroscopic), to ensure management and follow-up has been consistent with current recommendations. Such an audit may be eligible for MOPS points. The result of the audit should be made available to the Commissioner. [Dr B] may also consider presenting this case (anonymised) to his peer group so his learnings may be shared."

Further comment received from general practitioner Dr David Maplesden

"*In your November 2011 advice on this file, you refer to guidelines which came into force in 2009 (Suspected cancer in primary care). I note that [Mr A's] first appointment was in 2008. Could you please advise what standards applied in 2008?*

The need to further investigate any episode of painless haematuria occurring in the absence of urinary tract infection in an older male patient, in order to exclude malignancy, I would regard as basic medical knowledge that well preceded the formalising of this management strategy in the 2009 Early Detection of Cancer guidelines."

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