

Inadequate management of PSA results

1. Mr A had a radical prostatectomy in 2010, aged 48 years. Following this, he underwent prostate-specific antigen (PSA) surveillance monitoring, initially managed by urologist Dr B, and then predominantly by Mr A's general practitioner (GP), Dr C, at his local medical centre from 2015.
2. Mr A's PSA results began to rise from 2012 onwards, but this was not flagged as a concern until December 2023, when the local medical centre's Clinical Lead, Dr D, conducted an in-house audit of Dr C's PSA results management. Dr D flagged Mr A's rising PSA results with Dr C on 14 December 2023 and tasked him with seeking urology advice.
3. By 18 January 2024, Dr C had not sought urology advice nor informed Mr A of his raised PSA level results. As Dr C was on leave by that time, Dr D asked Dr E (another GP at the centre) to arrange an appointment with Mr A to discuss the results and make a referral for urology review.
4. Dr C documented on 22 January 2024 that he had left messages twice with Mr A and could see that Mr A now had an appointment booked. Mr A told the Health and Disability Commissioner (HDC) that he has no recollection of messages being left by Dr C and suggested that if he received a message from a doctor telling him to come in for an appointment, he would do so promptly.
5. On 25 January 2024, Mr A was informed by Dr E that the PSA results were 'clearly abnormal and concerning' in view of his history of radical prostatectomy and that the results seemed to have been overlooked.
6. On 29 January 2024, Mr A saw urologist, Dr F, who advised Mr A that he had a recurrence of prostate cancer.
7. To assist in my assessment of this complaint, I sought in-house clinical advice from Dr David Maplesden. Dr Maplesden's advice is enclosed as **Appendix A** of this report and includes a table of Mr A's PSA results and a more detailed timeline of events.

Provider response

8. The organisation that owns/operates the local medical centre (the organisation), undertook a review of Dr C's care of Mr A regarding his PSA surveillance monitoring. The organisation's review found that, from 2016 onwards, Mr A's PSA level was 'unequivocally' above the threshold for referral back to urology and increased annually. Further, the organisation found that Dr C's care fell below the expected standard with regard to filing the PSA results without any comment, failing to communicate the PSA results to Mr A, failing to classify the radical prostatectomy in the patient record, not adding a recall for the PSA blood tests, and failing to discuss the missed referral with Mr A or to issue an apology at the time.

9. The organisation also found that the significance of Mr A's PSA levels was also missed by at least two of Dr C's colleagues. On 4 October 2022, Mr A had consulted a different GP at the local medical centre, who either had failed to check his previous PSA results or did not appreciate their significance. On 27 October 2022, a physician associate at the local medical centre, Ms G, recorded a PSA result as 'normal' when it was in fact elevated given Mr A's medical history. The organisation noted that this oversight may have been avoided if there had been accurate classification of the radical prostatectomy and an alert in place.
10. Dr C accepted that he should have referred Mr A for urology review from 2016 onward because of the rising PSA levels.

Expert advice

11. Dr Maplesden advised that he agrees with the organisation's conclusions following its review of this event. Specifically, he advised that there were clear indications for Dr C to refer Mr A for urology review from at least February 2016, noting that the 2015 result was borderline using the criteria in place at the time. Dr Maplesden advised that he believes Dr C's management of Mr A's PSA surveillance from 2016 onwards would be met with at least moderate disapproval by his peers.
12. Further, Dr Maplesden said that he would be mildly to moderately critical if no formal recall process was activated (although a PSA test was performed each year). He considers that the delay in Dr C openly disclosing his error to Mr A and apologising once notified of the required actions by Dr D was unacceptable. Dr Maplesden acknowledged that Dr C had apparently tried to call Mr A on two occasions and had taken some leave during this period. Dr Maplesden also noted that it appeared that Dr C did not recognise the PSA results as being abnormal and therefore did not comment on these in the records system nor communicate these results to Mr A. Dr Maplesden noted that this would be accepted practice for a 'normal' result (although as noted from at least 2016 such results were not normal in the context of radical prostatectomy).
13. Dr Maplesden noted that Ms G appears not to have considered Mr A's medical history of prostate cancer and radical prostatectomy adequately during her review of Mr A's PSA result on 27 October 2022. Dr Maplesden considers that this was a missed opportunity for an earlier diagnosis of Mr A's prostate cancer recurrence. Dr Maplesden advised that, as an isolated incident, Ms G's handling of this PSA result represents a moderate departure from accepted practice, but it is important to consider it in the overall management of Mr A's results, the majority of which was undertaken by Dr C.

Response to provisional opinion

14. Dr C was provided an opportunity to respond to my provisional opinion and had no further comments. Dr C is no longer practicing medicine or registered to do so.
15. The organisation was provided an opportunity to respond to my provisional opinion and accepted the provisional findings.
16. Ms G is no longer employed by the local medical centre and was unable to be reached for comment.

17. Mr A was provided an opportunity to respond to my provisional opinion but did not provide comment.

Opinion: Dr C – breach

18. Having reviewed all the information in this case, it is clear that Mr A should have been referred to urology for a review from at least February 2016 onwards because of his rising PSA levels. I note that Dr C has accepted this. I accept Dr Maplesden’s advice that the failure to refer for urology review would be met with at least moderate disapproval by his peers.
19. Further, Dr C filed multiple PSA results for Mr A without any comment, failed to communicate the PSA results to Mr A, failed to classify Mr A’s radical prostatectomy in the patient record, and failed to add a recall for Mr A’s PSA blood tests. I accept Dr Maplesden’s advice that he would be mildly to moderately critical if no formal recall process was activated. I also acknowledge Dr Maplesden’s advice that it appears Dr C did not annotate the PSA results as abnormal or communicate these results with Mr A as he does not appear to have recognised that the results were abnormal in the context of a radical prostatectomy. I am critical that Dr C did not recognise these results as abnormal. I am also critical that Dr C did not classify Mr A’s radical prostatectomy in the patient record, and I note that this likely contributed to the delay in identifying the subsequent abnormal PSA results as this would have been important context for any other clinicians who entered Mr A’s PSA results into the system.
20. Noting the failures identified above, I consider that Dr C did not provide Mr A with services with reasonable care and skill, and, as such, breached Right 4(1)¹ of the Code of Health and Disability Services Consumers’ Rights (the Code).
21. Additionally, Dr C failed to apologise for or discuss the missed referral with Mr A at the time that it was identified, and Dr Maplesden advised that the delay in Dr C openly disclosing and apologising for the error once identified was unacceptable. I accept Dr Maplesden’s advice and am critical that Dr C did not contact Mr A in a timely manner once the issue had been brought to his attention. Specifically, I note that the missed abnormal results were brought to Dr C’s attention on 14 December 2023, and he was again tasked with making the urology referral on 5 January 2024. Although Dr C says he attempted contact with Mr A twice, by 18 January there had still been no contact by Dr C with either Mr A or a urologist, and (noting that Dr C was on leave at that time) it was Dr D who sought to arrange an appointment with another doctor so that disclosure and referral could be made. Dr D also contacted a urologist for advice. I do not accept Dr C “leaving messages twice” as a sufficient effort to engage with Mr A, given the seriousness of the issue to be addressed, and I am also critical that he did not seek urology advice in a timely manner.
22. Information about the missed PSA levels and need for urology referral was information that a reasonable consumer in Mr A’s circumstances would expect to receive in a timely fashion, and I consider that Dr C had a clear responsibility to openly disclose the error. I find that, by

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

failing to do so within a timely period following his awareness of the concerns, Dr C breached Right 6(1)² of the Code.

Opinion: Ms G – adverse comment

23. Ms G filed one of Mr A’s abnormal PSA results on 7 October 2022 and recorded the result as ‘normal’. Dr Maplesden advised that Ms G appears not to have considered Mr A’s medical history of prostate cancer and radical prostatectomy adequately during her review of this PSA result and considers that this was a missed opportunity for an earlier diagnosis.
24. I accept Dr Maplesden’s advice that as an isolated incident, Ms G’s handling of this PSA result represents a moderate departure from accepted practice. However, I also accept Dr Maplesden’s advice that it is important to consider this incident in the context of the overall management of Mr A’s results by Dr C. Further, I acknowledge that the organisation noted that this oversight may have been avoided if there had been accurate classification of the radical prostatectomy and an alert in place.
25. I am concerned about Ms G’s handling of the PSA result of 27 October 2022, and I consider that this was a missed opportunity for an earlier diagnosis of Mr A’s prostate cancer recurrence. However, I accept that there were mitigating factors — the lack of classification of radical prostatectomy and that the overall management of Mr A’s PSA levels was undertaken by Dr C. I remind Ms G of the importance of reviewing PSA results in the context of the consumer’s medical history.

Changes made

26. As a result of PSA audits, the organisation issued guidance to all medical centres within its network recommending a double recall system for all PSA results; an alert to be added to patient files on the practice management system for any patient post-prostatectomy or in active surveillance; any text messages sent to patients asking them to do a PSA blood test to state clearly that the request is for prostate monitoring, and to ask the patient to contact the medical centre if they have not been informed of their result within two weeks; and for the patient’s classifications and alerts to be checked prior to filing any PSA results. The organisation confirmed that the local medical centre has implemented these changes. In response to my provisional opinion, the organisation also noted that it intends to conduct a follow-up check on all the medical centres within its network in October/November 2025 to ensure that these changes are actively in place.
27. Dr C stated that he considered the findings of this review and used this to reflect on his practice and areas that can be improved upon.
28. I note that, in late 2024, Dr C underwent a performance assessment by the Medical Council of New Zealand (the Medical Council) and subsequently an educational programme with set objectives to address the areas of concern identified in the assessment. Further, Dr C has since retired from the local medical centre and stopped practising medicine. Dr C is no longer registered as a medical practitioner.

² Right 6(1): Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive.

Recommendations

29. I consider the changes made by the local medical centre should, at a practice level, reduce the risk of such an incident recurring. However, if the local medical centre offers a patient portal allowing patients to view their results, I recommend that it consider encouraging patients (with appropriate education regarding reassuring or concerning PSA levels) who have undergone radical prostatectomy to use this portal to check their own test results as an additional 'safety net' in the event of contextually abnormal PSA results being perceived by a clinician as normal.
30. I recommend that Dr C provide a formal written apology to Mr A for the breaches of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A.

Follow-up actions

31. A copy of the sections of this report that relate to Dr C will be sent to the Medical Council of New Zealand.
32. A copy of this report with details identifying the parties removed, except my clinical advisor, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Morag McDowell
Health and Disability Commissioner

Appendix A: In-house clinical advice to Commissioner

The following in-house advice was obtained from vocationally registered GP Dr David Maplesden:

'CLINICAL ADVICE — MEDICAL

TO : [...] / INV
FROM : David Maplesden
CONSUMER : [Mr A]
PROVIDER : Dr [C]
FILE NUMBER : C24HDC00748
DATE : 24 February 2025; **Addendum 25 March 2025 (s11)**

1. My name is David Maplesden. I am a graduate of Auckland University Medical School, and I am a vocationally registered general practitioner holding a current APC. My qualifications are MB ChB 1983, Dip Obs 1984, Certif Hyperbaric Med 1995, FRNZCGP 2003. 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 [C] of [the local] medical centre. In preparing the advice on this case, to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the following information:

- Complaint from Mr [A]
- Responses from [the organisation] per chief clinical advisor [...] and medical advisor Dr [...]
- Response from Dr [C]
- Response from Dr [E]
- Clinical notes [the local medical centre]
- Clinical notes [...] Urology (Dr [F])
- Results of PSA audits undertaken at [the local medical centre]
- **Clarification from [the local medical centre] re specific result handling (see s11)**

3. Mr [A] complains about delays in diagnosis of biochemical recurrence of his prostate cancer. He underwent radical prostatectomy (RP) and obturator lymph node dissection (urologist Dr [B]) on 3 May 2010 at age just under 49 years. Postoperative monitoring of PSA was undertaken by Dr [B] until 2012 (see Appendix 2). PSA screening was recommenced and performed approximately annually, predominantly by Mr [A]'s GP, Dr [C], from 2015. Results from 2016 onwards fulfilled criteria (at that time) for referral back to the urologist for

consideration of salvage radiotherapy,¹ but on each occasion the result was filed without further action by the requester. An independent audit of Dr [C]'s PSA management was undertaken in late 2023 after concerns were raised by colleagues regarding his performance in this area. This revealed the oversight regarding management of Mr [A]'s PSA, who was subsequently referred to urologist Dr [F] by Dr [E] on 25 January 2024. Dr [F] reviewed Mr [A] on 25 January 2024, noting sequential elevation of the PSA since 2012 and the delayed referral in this regard (see previous discussion). A firm nodular area was palpable in the area of the previous prostatectomy, and referral was made for imaging. Dr [F] initiated an ACC Treatment Injury claim in light of the delayed referral. A PMSA [prostate-specific membrane antigen] scan on 15 February 2024 was suspicious for a small area of local recurrence in the pelvis. On 20 February 2024, Dr [F] referred Mr [A] for consideration of salvage radiotherapy to the area of local recurrence. I understand Mr [A] has since undergone radiotherapy and PSA levels (as at September 2024) were trending downwards.

4. The [organisation] report includes a detailed timeline that I have assessed against the contemporaneous clinical notes and regard as accurate. Rather than duplicate the work undertaken in the report, I have reproduced it as Appendix 1, and my subsequent comments are based on the findings of the report with additional information as required. I note Mr [A] did not report any symptoms suspicious for recurrent prostate cancer during the period in question.

5. Dr [C] was conscientious in repeating the elevated PSA result noted in December 2008 and referring Mr [A] for urologist review when the follow-up result remained elevated. There is no reference to Mr [A] having an increased risk of prostate cancer (eg, first-degree relative), and he had minimal lower urinary tract symptoms (LUTS). Best practice would be to have performed a DRE [digital rectal examination] (with consent) as part of the referral process (an abnormal result might have increased priority for specialist review), but it could be reasonably anticipated that the urologist would perform the examination (as he did — unremarkable). I note Dr [B] was initially rather dismissive, noting in his report dated 6 April 2009, *I am not [at] all sure why his [Mr A's] PSA was tested.*

6. Dr [C] subsequently followed Dr [B]'s advice regarding repeating the PSA and Mr [A] was reviewed by Dr [B] in October 2009 with the slowly increasing PSA leading to prostate biopsies (7 December 2009), which revealed high-grade prostate cancer on one side (recorded in a clinic letter as Gleason 8). Subsequent MRI [magnetic resonance imaging] showed disease apparently confined to the prostate, and following discussion of management options in January 2010 Mr [A] proceeded to radical prostatectomy and obturator node dissection on 3 May 2010. Report of the first follow-up visit on 20 May 2010

¹ BPAC Best Tests. Following up prostate cancer in primary care. October 2012.
<https://bpac.org.nz/BT/2012/October/prostate.aspx> Accessed 24 February 2025.

Follow-up recommendations at this time included (see over):

- *PSA testing starting from six weeks at the earliest, and at least every six months for the first two years, and then annually*
- *Rises in PSA level must also be interpreted in the context of the specific treatment received. During a radical prostatectomy, almost all the prostate tissue is removed and PSA should become undetectable within three to six weeks. PSA levels > 0.2 ug/L (or > 0.05 ug/L if an ultrasensitive PSA assay is used) after this time, would indicate that there may be residual or recurrent cancer, and this should be discussed with a urologist.*

includes: *His prostatectomy was uneventful, and histology appears to demonstrate organ-confined disease and negative lymph nodes ... I will see him in two months with a PSA. Dr [F] subsequently reviewed the histology report (not sent to GP) in 2024, noting there is mention of a tiny circumferential positive margin. It is not clear whether this was low grade or intermediate risk disease at the site.*

7. It appears Dr [B] took responsibility for monitoring Mr [A] until December 2012. The last PSA ordered by Dr [B] was 7 December 2012 (0.1 ug/L) although it appears this result was not copied to Dr [C] and there is no report on file from Dr [B] in relation to this result. I have reproduced below the last three follow-up letters on file from Dr [B] to Dr [C]:

(i) 23 July 2010: *I reviewed this nice man following his radical prostatectomy and I am delighted to report that he is continent, potent and his PSA is zero. This is as good a result as you can get following radical prostatectomy, and I am happy just to see him in six months' time with a repeat PSA.*

(ii) 14 March 2011: *I reviewed this nice man in my rooms today. We are now almost a year following his radical prostatectomy. He is entirely well. He is continent, has normal erections and his PSA remains unrecordable. We will just repeat the PSA in a year and, if it is remaining stable at that stage, follow up can be in the community by yourself.*

(iii) 12 March 2012: *I reviewed this nice man in my rooms today, now nearly two years following radical prostatectomy, and his PSA remains 0.1. I am just going to see him if the blood test goes up, and will arrange to have six monthly PSAs only.*

8. It appears a PSA of 0.1 ug/L post RP was regarded as acceptable in 2012 (see reference 1). If there was no letter to Dr [C] from Dr [B] following the December 2012 result and Dr [C] was not copied into the result (as appears to be the case), I would regard the handover of care from Dr [B] to Dr [C] as being deficient. The final letter on file implied Dr [B] was undertaking ongoing review of Mr [A]'s PSA and appeared to conflict with the advice provided in the preceding letter. There is no reference in any of the letters on file from Dr [B] to a specific surveillance regimen for Mr [A] (there is conflicting reference to both six monthly and annual testing) or to a specific PSA level on which re-referral should be considered. On the other hand, there had been education provided to primary care regarding surveillance following prostate cancer diagnosis (reference 1) although there is no obligation for a GP to access this information with accepted practice being provision of personalised follow-up advice (influenced by factors influencing risk of recurrence such as prostate cancer histological grade, stage and clearance).

9. Although I believe some of my colleagues may have proactively sought clarification of Mr [A]'s surveillance recommendations from Dr [B] or to have applied the recommendations outlined in the cited guidance, I regard the standard of handover from Dr [B] as being a significant mitigating factor when assessing Dr [C]'s actions at this stage. I note Dr [B] apparently retired from urology practice in 2012 and no longer features in the MCNZ medical register and therefore there is probably little value in seeking external advice regarding the handover process. Under the circumstances and noting Mr [A] did not re-present to the local medical centre until 2015 (see below), I think it is difficult to be critical of Dr [C]'s inaction between 2013 and 2015 with respect to Mr [A]'s surveillance. It is unclear

what Dr [B] may have told Mr [A] regarding access to repeat PSA tests. Best practice would be for Dr [C] to have recorded a classification of prostate malignancy requiring RP at this time, but I see marked variability of such recording in practice.

9. It does not appear Mr [A] attended the local medical centre between the end of 2010 and March 2015 (at least there are no consultation notes recorded for this period). On 18 March 2015, Mr [A] presented for a routine checkup and Dr [C]'s notes include: *Needs annual blood work up with previous prostate issues. Had removed 5 yrs ago. Has been discharged from urologist.* There were no particular current health issues recorded. Dr [C] entered a classification *Malignant neoplasm of prostate (B46.00) — Gleasons 3+4.* A form was provided for blood tests, including PSA. The [organisation's] response notes *there does not appear to have been any recall system in place.* I note PSA levels were tested at 11- to 18-month intervals over the next eight years. I believe use of a formal recall or reminder system represents accepted practice in the clinical scenario presented by Mr [A] and this may form part of the practice policy on handling of results (not yet provided). I am mildly to moderately critical if there was no formal recall process activated although a PSA was performed in each of the next eight years.

10. Subsequent PSA results are summarised in Appendix 1: Dr [C] requested, reviewed and filed the results obtained between 2015 and 2021 inclusive. The result obtained in February 2016 was annotated "0.3" but otherwise there is no annotation of the results. The PSA levels slowly increased, with sequential testing with referral for urologist review/advice indicated from the 2015 result onwards, although all results remained within the reference range for a patient with no history of prostate cancer. With the benefit of hindsight and applying later guidelines, there was suspicion of biochemical recurrence of cancer in 2012, with the results in March and December of that year (while under the care of Dr [B]) being 0.1 ug/L on each occasion having been undetectable in the earlier postoperative period. There was a consultation note dated 24 May 2016 (driver medical) that included *Annual bloods only now (previous prostate issues)* but Mr [A] was an infrequent attender with no reference to presentation of symptoms that might have raised suspicion of prostate cancer recurrence. The PSA by 18 June 2021 was 1.7 ug/L. My comments follow in section 13.

11. On 4 October 2022 Mr [A] saw [the local medical centre] GP Dr [I] regarding an inguinal hernia. Dr [I]'s notes include *He has had rx prostate cancer prostatectomy age 49.* Mr [A] was apparently well apart from his hernia (referral made for repair). A series of blood tests were ordered under Dr [I]'s name with results received on 27 October 2022. PSA was 2.3 ug/L and has been annotated *2.3 normal* with Dr [I]'s initials alongside the result (usually signifying who has filed the result). The [organisation] response refers to the inbox audit (result not viewed), indicating the result may have been signed by a Dr [H] but was also later updated by physician associate Ms [G]. It is unclear to me exactly how this result was managed, and clarification should be sought together with a copy of the practice results management policy. The handling of the PSA result on this occasion represents a missed opportunity to identify Dr [C]'s preceding management errors and requires further review. Although the absence of a formal classification or alert regarding Mr [A]'s history of RP for prostate cancer might be regarded as a mitigating factor, the fact there was a classification of prostate malignancy and the most recent clinical notes referred to this history and requirement for prostate surgery, and the PSA result includes the generic comment *In men*

who have undergone radical prostatectomy any detectable PSA is abnormal and should prompt specialist referral, might be regarded as aggravating factors.

To assist in clarification of handling of this result, questions are:

(i) Did Dr [I] generate/sign the request form for the repeat blood test or was this done on his behalf by another staff member? Was Dr [I] aware the tests were requested?

Dr [I] generated and signed the request form but was on leave when the results were imported. The result was reviewed by his assigned “buddy” (per practice policy) physician associate (PA) Ms [G].

(ii) Who annotated the result “2.3 normal”? (I would have thought if staff involved are still employed at the medical centre this should be reasonably simple to resolve).

It is believed Ms [G] annotated the result. Ms [G] was in a supervisory arrangement with the local medical centre GP Dr [H], and a PA was required to put the name of their supervising GP in the “status” dropdown box of results they reviewed. However, there is no documentation to suggest Dr [H] was aware of the result or was consulted in relation to the result.

(iii) Why do Dr [I]’s initials appear alongside the result (usually signifying the provider filing the result)?

Dr [I]’s initials appear in the “Provider” box as he ordered the blood test. They do not signify that he reviewed the test result.

(iv) Was management of this result consistent with the practice policy on results management in force at the time?

Management was consistent with practice policy. I have reviewed the relevant practice policy, and it appears robust and fit for purpose. My final comment is that it appears Ms [G] may have reviewed the result of 27 October 2022 without adequately considering Mr [A]’s medical history of prostate cancer and radical prostatectomy and there was a missed opportunity for an earlier diagnosis of Mr [A]’s prostate cancer recurrence. However, as discussed below, this is in the context of Dr [C]’s similar recurring error over the preceding six years. Ms [G]’s error has contributed to the delayed diagnosis and, if possible, she should be made aware of the error. As an isolated incident, I believe her handling of Mr [A]’s result represents a moderate departure from accepted practice, but it is important to consider it in the overall management of Mr [A]’s results, the majority of which was undertaken by Dr [C].

12. The final PSA prior to a clinical audit being performed was requested by Dr [C] as part of routine bloods on 30 June 2023. Result was 2.11 ug/L and was filed by Dr [C] without annotation or action. On 14 December 2023, the clinician performing the PSA audit (Dr [D]) noted her findings, including *Note that has had slowly rising PSA since 2017. Should be undetectable following radical prostatectomy. PF tasked and asked to seek urology advice about rising PSA in context of radical prostatectomy in 2010 for Gleasons 3+4 carcinoma with microscopic focus circumferential margin. Recall for PSAs entered.* Dr [D] entered a

classification *Radical prostatectomy with pelvic node sampling (7B366.00)* and obtained a copy of the original histology report. On 18 January 2024, Dr [D] has documented: *No documentation that [Dr C] has discussed with patient or urology or done referral as requested by me. Discussed with [Dr F] — definitely needs referral. [Dr C] on leave. Have asked nurses to arrange appt for [Mr A] to see [Dr E] to discuss and refer. I have requested paper file to augment information about original procedure etc.* Mr [A] was contacted by a practice nurse the same day and an appointment arranged with Dr [E] for review. Review by Dr [E] was undertaken on 25 January 2024, PSA repeated (2.4 ug/L) and referral made to Dr [F] that day. Notes indicate there was open disclosure by Dr [E] of the management error. Mr [A]'s subsequent management is summarised in section 3.

13. I believe there were clear indications for Dr [C] to refer Mr [A] for urology review from at least February 2016 noting the 2015 result was borderline using the 2012 criteria referred to in reference 1 but noting in hindsight that current guidance might have resulted in detection of biochemical recurrence and consideration of salvage radiotherapy from March 2012 when care was being provided by Dr [B]. Dr [C] was aware of Mr [A]'s prostate history (although the recurrence risk associated with disease being present at a surgical margin was not conveyed in Dr [B]'s reports) and (at least from 2015) the need for annual PSA monitoring. It appears Dr [C] was not cognisant of the fact that any detectable PSA (but certainly levels over 0.2 ug/L) was suspicious for cancer recurrence following RP despite the availability of educational resources discussing this issue and pathologist comment from 2017 onwards (albeit generic) emphasising the issue. Under the circumstances, I believe Dr [C]'s management of Mr [A]'s PSA surveillance from 2016 onwards would be met with at least moderate disapproval by my peers. It appears that because Dr [C] did not recognise the PSA results as being abnormal, the results were not annotated as abnormal and not communicated to Mr [A]. This is accepted practice (not conveying "normal" result) if it is consistent with the practice policy on handling of results. The delay in Dr [C] openly disclosing his error to Mr [A] and apologising once notified of the required actions by Dr [D] was in my view unacceptable (although made little difference from a clinical perspective) although I note he had apparently tried to call Mr [A] on two occasions (unclear when) and had taken a period of leave.

14. [The organisation] has undertaken a thorough review of this incident, and I agree with the conclusions in their report. The remedial measures listed should, at a practice level, reduce the risk of such an incident recurring. An educational approach is appropriate for Dr [C], and I understand a formal programme is being implemented in this regard. I presume [the local medical centre] offers a patient portal allowing patients to view their results and with appropriate education regarding reassuring or concerning PSA levels following RP, the patient themselves might be encouraged to provide an additional "safety net" in the event of contextually abnormal PSA results being perceived by a clinician as normal.

Appendix 1: Sequential PSA levels Mr [A]

Date	PSA (ug/L)	Referrer	CC	Action
1/12/2008	4			Repeat 1/12
16/01/2009	4.9			Ref urology (
2/04/2009	5			Awaiting urology review
29/05/2009	5.1			Per urology advice
30/07/2009	5.4			Per urology advice
10/09/2009	5.4			
23/07/2010	0			First post-op PSA. No copy in GP notes. Referred to in report
14/02/2011	0			No copy in GP notes. Referred to in report
12/03/2012	0.1			No copy in GP notes. Referred to in report
7/12/2012	0.1			No copy in GP notes. No report from in notes
18/03/2015	0.2			Fulfilled criteria for urology advice/referral
18/02/2016	0.3			Annotated by '0.3'
27/01/2017	0.3			No annotation
1/02/2018	0.55			No annotation
29/07/2019	0.95			No annotation
12/06/2020	1.1			No annotation
18/06/2021	1.7			No annotation
27/10/2022	2.3			Annotated '2.3 normal'
30/06/2023	2.11			No annotation
25/01/2024	2.4			Done as part of urology referral by
7/05/2024	0.99			Post radiotherapy surveillance
6/09/2024	0.41			Post radiotherapy surveillance

Notes:

- Referrer: [...] Dr [C]; [...] — Dr [B]; [...] — Dr [I]; [...] — Dr [E]
- PSA reference range: 0–2.4 ug/L for results 1/12/08–29/7/19; < 4.0 subsequently. NB This does not apply to post-radical prostatectomy patients
- From the result of 27/01/2017, PSA results included the generic pathologist comment: ***In men who have undergone radical prostatectomy any detectable PSA is abnormal and should prompt specialist referral.***

Appendix 2.	Timeline of events provided by [the organisation]
Date	Event
01/12/2008	PSA blood test ordered by Dr [C]: elevated at 4.0mcg/L (range 0/0–2.4). Handwritten note on paper result stating “Rep 1/12”.
02/12/2008	Transcription handwritten entry in paper notes: “Talked to [...] re increased PSA. Dr wants [Mr A] to repeat test in 1/12. Rang and left message on landline – [...]”
16/01/2009	PSA blood test ordered by PFIN: elevated at 4.9 mcg/L (range <2.5).
10/02/2009	Transcription of handwritten entry in paper consult notes: “[Dr B]” followed by a tick.
06/04/2009	Letter from [Dr B], Urologist: noted history of elevated PSA on two occasions, no significant outflow symptoms and normal prostate on examination. Advised checking PSA 2 monthly for six months then seeing Dr [B] for review to reassess if should have biopsy.
02/04/2009	PSA 5.0; 29/05/2009 — PSA 5.1; 30/07/2009 — PSA 5.4, results to Dr [C], copied to [Dr B].
22/10/2009	Letter from [Dr B]: reviewed in his rooms, persistently high PSA noted, transrectal US-guided prostate biopsy arranged.
07/12/2009	Transrectal US-guided biopsies performed under LA.
23/12/2009	Letter from [Dr B]: biopsies showed “quite high grade” cancer on one side, Gleason 8, staging MRI requested.
28/01/2010	Letter from [Dr B]: MRI suggested disease organ confined, discussed treatment options with Mr [A], to get back to [Dr B] with his thoughts.
04/03/2010	Letter from [Dr B]: further discussion about treatment options, agreed to proceed with radical prostatectomy.
20/05/2010	Letter from [Dr B]: seen for catheter removal following radical prostatectomy. Surgery was noted to have been uneventful and histology “appears to demonstrate organ confined disease and negative lymph nodes”. Plan to see Mr [A] again in two months with a PSA.
23/07/2010	Letter from [Dr B]: review post radical prostatectomy, notes indicated a good recovery with PSA zero. Plan to review with [Dr B] in six months with a repeat PSA.
14/02/2011	Letter from [Dr B]: review post radical prostatectomy, notes indicated a good recovery with PSA zero. Plan to review with [Dr B] in six months with a repeat PSA.
12/03/2012	Letter from Dr [B]: reviewed in rooms, nearly two years following radical prostatectomy. “PSA remains 1.0. I am just going to see him if the blood test goes up and will arrange to have six monthly PSA’s only”.
07/12/2012	PSA 0.1, result not in GP records, retrieved by me from [online portal], ordered by [Dr B].
18/03/2015	Consult notes Dr [C]: “Needs annual blood work up with previous prostate issues. Had removed 5 years ago. Has been discharged from Urologist ... Doing well. No issues. See as required”.

18/03/2015	Classification added to patient record by Dr [C]: "Malignant neoplasm of prostate, Gleasons 3+4".
18/03/2015	PSA 0.2. Filed by Dr [C], no comment made in inbox or daily record.
18/02/2016	PSA 0.3. Filed by Dr [C], no comment made in inbox or daily record.
24/05/2016	Consult notes Dr [C]: Mr [A] attended for renewal of driving licence. "No issues. Feels well. Annual bloods only now (previous prostate issues)".
01/12/2016	Consult notes Dr [C]: Mr [A] presented with skin lesion. "No other issues. Still having 6/12ly PSA levels. Feels well."
27/01/2017	Consult notes, Dr [C]: Patient presented with flu-like illness.
29/07/2019	Consult notes Dr [C]: Patient attended "for general check. No issues". Bloods requested.
12/06/2020	Consult notes Dr [C]: "General check-up. Feels well." Bloods requested and advised review in six months.
23/07/2020	Consult notes Dr [C]: attended re skin lesion.
18/06/2021	Consult notes Dr [C]: "attends for annual bloods". Bloods requested and referred to ENT re a suspicious skin lesion.
04/10/2022	Consult notes Dr [I]: presented with skin issue. Notes "He has had rx prostate cancer prostatectomy age 49".
27/10/2022	PSA 2.3. Filed with comment "2.3 normal". Inbox "status" box says "[Dr H] signed" (Dr [H], GP) but inbox audit function states the result was last updated by "[Ms G]" ([Ms G], Physician Associate) on 02/11/2022 ² .
22/06/2023	Consult note [Ms G]: punch biopsy skin lesion.
30/06/2023	Consult notes [Dr C]: "General check-up ... No Issues" Bloods requested. "Review as necessary".
14/12/2023	Notes entry Dr [D]: PSA audit identified rising PSAs on a background of radical prostatectomy. Noted that the histology result and Urologist letters were not in the electronic records. Histology report from 04/10/2010 retrieved by Dr [D] from [online portal]: reported as showing Gleason 3+7 adenocarcinoma of the prostate, perineural invasion present, with "very tiny focus" of involvement at circumferential margin. ([reviewer] comment: the histology report states the specimen was documented as being collected and received on 04-May-2010, but the report was produced on 04-Nov-2019. I am not sure if there is any significance in this discrepancy.) Noted no Urology letters were available in [online portal]. Task sent to Dr [C] asking him to seek Urology advice re the rising PSA, given the history of radical prostatectomy. Recall for PSAs entered. Classification added to patient record: "Radical prostatectomy with pelvic node sampling."
05/01/2024	Task from Dr [D] to Dr [C] asking him again to refer the patient to Urology.
08/01/2024	Reply from Dr [C] to Dr [D] that he had rung the patient twice and left messages, and "will try again this week".

² See addendum s11.

18/01/2024	Notes entry by Dr [D] commenting that there was no documentation that Dr [C] had contacted the patient or Urology. Dr [D] phoned [Dr F], Urologist for advice, who advised "definitely needs referral". Dr [C] on leave. Dr [D] asked nurses to arrange appointment for patient to see Dr [E] to discuss and refer. Dr [D] requested paper file to look for historical information.
18/01/2024	Nurse phoned Mr [A] to advise PSA was elevated and that he should be referred to Urology. Appointment booked with Dr [E].
22/01/2024	Notes entry by Dr [C] stating "Have left messages twice with [Mr A]. I see he has been booked in."
25/01/2024	Consult notes Dr [E]: discussed rising PSA with Mr [A], documented that this was "clearly abnormal and concerning" in view of the history of radical prostatectomy and that "it seems to have been overlooked". History taken; digital rectal examination revealed a malignant-feeling nodule. Updated blood result arranged urgently. Dr [E] apologised that results were overlooked. Private referral sent to [Dr F], Urologist.
25/01/2024	PSA 2.40
26/01/2024	Notes entry Dr [E]: telephoned patient to inform him of PSA result, no reply on landline or mobile so SMS message sent.
29/01/2024	Letter from [Dr F], Urologist: He comments that around the time of Mr [A]'s prostate surgery, "[Dr B] would have been close to retiring I am not sure what communication you would have had but it sounds as though it was put on to an annual PSA surveillance at the General Practice. In 2012 his PSA was no longer undetectable and was 0.1 which would have been a point where further investigation could have been initiated" ([reviewer] comment: note the PSA tests in 2012 were in fact ordered and managed by [Dr B], not the GP). [Dr F] commented on the rising PSA and that the latest PSA and rate of increase "almost certainly represents disease which is outside of the pelvis but there is the vague possibility that he could just have local recurrence in the pelvis". He stated that the patient was not aware that he had a recurrence of his prostate cancer and so was very upset, observing that the patient's wife had just died from cancer "which compounded his emotions today". [Dr F] arranged a PET scan to show the extent of disease, completed an ACC Treatment Injury claim and suggested that, once Mr [A] felt less angry about the situation, he book in with the medical centre for a discussion on why the PSA had been overlooked for so long.
15/02/2023	PMSA PET/CT scan to assess extent of disease: "Focal activity at the left posterior aspect of the bladder, adjacent to a prostatectomy clip lies more inferiorly than the expected course of the ureter (this being the alternative explanation). Given the absence of expression elsewhere, it is suspicious for a small focus of local recurrence/residual disease."
20/02/2024	Letter from [Dr F]: referral to Radiation Oncologists for consideration of radiation treatment. Commented that the PSMA PET scan "only shows an area of avidity next to some surgical clips in the pelvis below the bladder ... and it appears as though he could just have a local recurrence".

22/04/2024	Letter Dr [...] Radiation Oncologist: Wrote that “the rate of PSA rise is very slow” and that the PET scan showed an area of local disease recurrence with no avidity elsewhere, which “allows us the opportunity to offer late salvage therapy, and still achieve excellent oncologic outcomes due to the indolent nature of his disease”. Mr [A] opted not to have neoadjuvant androgen deprivation. Radiotherapy planning made with treatment likely to start in late March.
15/03/2024	Consult notes Dr [E]: Mr [A] presented with headache and tinnitus; head CT arranged. Mr [A] expressed his anger about the PSA management, asked how to lodge a complaint and was advised accordingly. Dr [E] noted that the [the local medical centre] Senior Management Team had been supposed to contact Mr [A] “without delay” following receipt of his clinic letters, but that this had not happened. Dr [E] apologised to the patient for this and wrote that he was going to take this further with the Senior Team.
20/03/2024	Note from Dr [E] to Mr [A], informing him that his head CT scan was normal.
24/04/2024	Letter from Dr [...] [Radiation Oncologist]: completed radiotherapy to prostate bed 23/04/24. Review scheduled for 23/05/24.
30/04/2024	SMS sent to Mr [A] stating “your GP has requested a blood test. We have sent this form electronically to the lab”, followed by advice on how to book an appointment. Does not mention that the test requested is a PSA.’