HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Delayed diagnosis of bowel cancer

Complaint summary

1. On 15 September 2023 this Office received a complaint from Ms A about the care provided to her at her local general practitioners (GP). Ms A stated that she had 'horrendous stomach pains' that were ignored by doctors at her GP centre for two years,[1] and she was told that her symptoms were due to constipation or irritable bowel syndrome (IBS),[2] and she was not offered a colonoscopy.[3]

2. On 5 May 2022 Ms A raised her gastrointestinal (GI) symptoms and unintentional weight loss with an Ear, Nose and Throat (ENT) registrar at a follow-up appointment at a tertiary hospital for an invasive neck melanoma that had been excised in February 2021. Ms A also informed the ENT registrar that she had a node[4] on her neck, for which the ENT registrar arranged a fine needle aspiration (FNA). The FNA found metastatic adenocarcinoma (cancer),[5] and further investigation led to a diagnosis of colonic adenocarcinoma (bowel cancer).[6] Sadly, Ms A died in late 2024, aged 43 years.

Background

3. Ms A told HDC that at some (undetermined) time, she had suggested to a GP at her local GP centre that she had IBS, and the GP had agreed, but there was never any attempt to make a formal diagnosis. The earliest record of IBS in the clinical records from her local GP is from a consultation on 14 May 2020 with Dr B, who documented 'Eating problems with IBS also'.

4. On 2 July 2021 Ms A had a consultation with Dr C for GI issues. Dr C documented that Ms A had been crampy for three days with a bloated abdomen but had no diarrhoea, nausea or vomiting, and no lower urinary tract symptoms. Dr C noted that Ms A was improving on the day of the consultation. Dr C documented that Ms A thought she had had IBS over the 'last years' and coped very well when she was careful with her diet, but the previous week she had been away and had had a poor diet. Dr C recorded that Ms A was generally well and had no fever and 'no red flags.' Dr C's impression was a likely IBS flare-up, and Dr C prescribed Ms A Colofac.[7]

[1] From approximately July 2021 until May 2023.
[2] IBS was never diagnosed formally.
[3] A procedure in which the colon is examined using a flexible tube with a camera (a colonoscope).
[4] A mass of tissue resembling a knot.
[5] Cancer that has spread from its initial location to other parts of the body.
[6] A type of cancer that starts in the large intestine.
[7] A medication used to treat symptoms of IBS.

5. On 24 August 2021 Ms A had a phone consultation with Dr C to request her usual medication. Dr C documented that the Colofac had been helpful for Ms A's GI symptoms and ordered a blood test.

6. On 5 November 2021 Ms A had a consultation with Dr D. They discussed her GI symptoms, and Dr D documented that it was advised that IBS can be very painful at times. Dr D noted that they went over health pathways for any other treatment options, but that the Colofac seemed to be helping.

7. On 23 December 2021 Ms A had a consultation with Dr E. Dr E documented that Ms A presented with longstanding GI symptoms of abdominal pain, bloating, vomiting and loose stool, and that these symptoms were worse than previously. Dr E documented that Ms A was barely able to eat and had lost 6kg in four weeks. She was following a dairy free, low FODMAP[8] and 'gluten free(ish)' diet, and the Colofac was no longer helping. Dr E noted that Ms A was tearful at this appointment and felt that she had been 'fobbed off' and wanted answers. Dr E arranged for blood and stool testing and an abdominal ultrasound. He also started Ms A on a trial of amitriptyline[9] and omeprazole.[10]

8. On 12 January 2022 Dr E sent a text message to Ms A to inform her that her blood and stool tests had come back normal and to ask whether she had felt any benefit from the amitriptyline and/or omeprazole. Ms A responded that the omeprazole had worked well. She said that she was still experiencing 'diarrhoea constantly' but that her cramps had improved since starting omeprazole.

9. On 18 March 2022 Ms A had a phone consultation with Dr E. Ms A reported that the omeprazole was working well, and Dr E advised Ms A of an incidental finding from her abdominal ultrasound.[11]

10. Ms A had no further consultations with any doctors at her local GP centre until after she was diagnosed with cancer following the FNA of her neck node on 5 May 2022.

11. ACC accepted a claim for a treatment injury for '[f]ailure to treat in a timely manner resulting in progression of colon cancer from Stage 3B to Stage 4'.

Scope of investigation

12. The following issues arising from the complaint were investigated:

- *Whether her local GP centre provided Ms A with an appropriate standard of care between May 2020 and May 2022.*

[8] A group of carbohydrates that are poorly absorbed in the small intestine and ferment in the colon.
[9] An antidepressant that is sometimes used off-label for some types of pain.
[10] A medication used to treat gastro-oesophageal reflux.
[11] A likely liver haemangioma was identified, which required a follow-up scan but was unrelated to her GI symptoms.

- *Whether Dr E provided Ms A with an appropriate standard of care between December 2021 and May 2022.*

In-house clinical advice

13. To assist my assessment of this complaint, I sought in-house clinical advice from GP Dr Fiona Whitworth.

Response to provisional opinion

14. Dr E, Dr D, and Ms A's local GP centre were all given an opportunity to respond to the provisional opinion and had no further comments.

15. Ms F was nominated as the complainant following Ms A's death. Ms F was given an opportunity to comment on the information gathered in the provisional opinion and had no further comments.

Opinion: Dr E — Breach

16. Dr Whitworth advised that she is mildly to moderately critical that Dr E did not examine Ms A or document her weight at the consultation on 13 December 2021. Dr Whitworth noted that a weight loss of 6kg in four weeks is a red flag,[12] and it would be common practice to have referred Ms A urgently to gastroenterology for a review and a colonoscopy even if the results of the ultrasound and bloods ordered by Dr E at this consultation were normal. Further, Dr Whitworth advised that she is moderately critical that no referral was made on 13 December 2021, as this may have provided an opportunity for diagnosis.

17. Dr Whitworth also advised that the text messages between Ms A and Dr E on 12 January 2022 presented another opportunity for a referral and potential diagnosis, or at least a further in-person consultation. Dr Whitworth is moderately critical that neither occurred. Dr Whitworth also noted that Dr E did not enquire about further weight loss at that time.

18. Further, Dr Whitworth advised that the phone consultation on 18 March 2022 was another opportunity where a referral could have been made, Ms A could have been seen in person, or her symptoms could have been reviewed more fully.

19. Dr E told HDC that he felt that Ms A's weight loss could have been explained by her restrictive dietary practices and/or by her difficulties keeping food down. He stated that he had planned for follow-up once they had the results of the investigations he had ordered, with an option for a secondary care referral, based on the investigation results and the effect of the proposed interventions. Dr E told HDC that no secondary care referral was made as ultimately Ms A's IBS symptoms were longstanding, her blood tests and scans were reassuring, and she was responding to medication. Further, having reviewed the local criteria for colonoscopy on the secure health pathways website, Dr E does not believe that she fulfilled the criteria for colonoscopy.

[12] https://bpac.org.nz/BPJ/2014/February/ibs.aspx

20. Dr Whitworth acknowledged that there were 'significant obscuring factors' such as co-existent IBS[13] and the 'possibility of weight loss due to narrow dietary intake'. She also noted that several GPs were involved in Ms A's care over this time frame, and that there were limitations on face-to-face contact due to COVID-19. Further, Dr Whitworth acknowledged that Dr E did order the correct range of tests and investigations, the results of which were 'mainly normal', which may have led to some degree of false reassurance.

21. Dr E provided evidence to HDC that since receiving this complaint, he has completed learning modules on 'colorectal cancer' and 'early diagnosis of cancer in young adults' via the Royal College of General Practitioners.

Breach decision

22. Having reviewed all the information in this case, I consider that Dr E breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code). I have outlined the reasons for my decision below.

23. Right 4(1) states that every consumer has the right to have services provided with reasonable care and skill. In the circumstances of this case, Dr Whitworth identified two key departures from the expected standard of care:

1. No examination was undertaken or weight documented at the appointment on 13 December 2021; and
2. Ms A was not referred to gastroenterology on 13 December 2021, nor was she referred or reviewed in person on or soon after 12 January 2022.

24. I accept Dr Whitworth's advice and consider that Dr E did not provide services to Ms A with reasonable care and skill between December 2021 and May 2022.

25. I acknowledge that there were mitigating circumstances that made this a complex presentation (as outlined above). However, in my view, these do not sufficiently outweigh the fact that a referral was indicated from 13 December 2021, and that there were three separate missed opportunities for a referral and potential diagnosis between December 2021 and March 2022.

26. While I accept that a referral was indicated, I note that it is not possible to determine whether an earlier referral would have changed the outcome. With hindsight, it is understandable to question whether the course of Ms A's health would have changed had she been referred for specialist review at an earlier stage.

27. To achieve a timely and pragmatic resolution of the complaint, Dr E was provided with a copy of the complaint, a copy of Dr Whitworth's advice, and details of the identified departures from the accepted standard of care, together with the reasons why these departures were considered a breach of the Code. Dr E accepted these findings and the proposed breach of Right 4(1) of the Code.

[13] Dr Whitworth noted that it is unclear whether the GP team had made the diagnosis of IBS previously or whether Ms A had assumed it herself, which is a common occurrence in general practice.

Opinion: Dr D — Educational comment

28. Dr Whitworth advised that she is mildly to moderately critical that Dr D did not examine Ms A, review her weight, or discuss red flags at the consultation on 5 November 2021. However, Dr Whitworth noted that red flags may have been discussed as part of reviewing the health pathway. Dr Whitworth also noted that no safety-netting advice was documented.

29. Dr D stated that he reviewed health pathways with Ms A for IBS and colonoscopy referral to look for red flags and other treatment options. Dr D said that he went over each red flag[14] for IBS with Ms A and ruled them out, which included establishing that she had not lost weight. However, they could not rule out iron deficiency anaemia as a red flag at that time as Ms A had not had a blood test for this, although Dr C had ordered this on 24 August 2021. Dr D told HDC that he encouraged Ms A to have the blood test. Dr D also noted that Ms A's symptoms appeared to fall in the 'not seen' category for colonoscopy.

30. Dr D told HDC that he believes he did examine Ms A's abdomen at this consultation as he was following the IBS pathway, which includes examination of the abdomen along with obtaining a history of symptoms.[15] Dr D believes he did not perform a rectal or vaginal examination (also part of the pathway), as had he done so, he would have documented which chaperone was present. He stated that at that time he did not feel that these examinations were appropriate.

31. Dr D also told HDC that he is comfortable that having discussed the red flags with Ms A, she knew to re-attend if she developed any of them.

32. Dr D acknowledged that he ought to have documented the abdominal examination and regrets that he did not. He also acknowledged that just referencing health pathways in the clinical record rather than going into more detail could be misleading to another clinician. He told HDC that he now ensures that he documents examination findings and other pertinent history. He said that since his consultation with Ms A, he trialled using an AI[16] program to summarise notes (with patient consent), but he stopped using this as he felt that the program did not represent his notes adequately, although it improved his own note taking.

33. I acknowledge that by documenting that he went over health pathways with Ms A, Dr D intended to show that he had looked at and followed the relevant health pathways (in this case IBS and colonoscopy), including ruling out any red flags for IBS, carrying out an assessment (including abdominal examination), and checking whether Ms A met the criteria for referral for a colonoscopy. On the basis that Dr D documented that he went over health pathways at this appointment, I accept his account that he checked for red flags (including weight) and completed an abdominal examination at this consultation. Therefore, I consider that Dr D's care did not depart from accepted practice.

---

[14] Aged >50 years at first presentation; family history of colon cancer; unexplained rectal bleeding; unexplained iron deficiency anaemia; unintended weight loss; nocturnal symptoms.
[15] The pathway outlines an assessment that includes history of symptoms and examination of the abdomen.
[16] Artificial intelligence.

34. I consider that Dr D's documentation of this appointment was below the expected standard; however, I acknowledge that Dr D has reflected on his documentation and made changes to improve this. I consider these changes to be satisfactory.

Opinion: The general practitioners (GP) centre — No breach

35. Dr Whitworth advised that the consultations with Dr C on 2 July and 24 August 2021 were acceptable and did not identify any systemic issues or issues with earlier consultations.

36. As such, I find that the local GP centre provided Ms A with an appropriate standard of care between May 2020 and May 2022.

Recommendations

37. I note that Dr E has returned to live and work overseas and has proactively undertaken further education on colorectal cancer and early diagnosis of cancer in young adults. I recommend that Dr E provide a written apology to Ms A's family. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A's family.

Follow-up actions

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

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

Dr Vanessa Caldwell
Deputy Health and Disability Commissioner

Appendix A: In-house clinical advice to Commissioner

The following in-house advice was obtained from GP Dr Fiona Whitworth:

CLINICAL ADVICE — MEDICAL

TO	**:**	HDC
FROM	**:**	Dr Fiona Whitworth
CONSUMER	**:**	Ms A
PROVIDER	**:**	General practitioner centre (GP)
FILE NUMBER	**:**	C23HDC02521
DATE	**:**	9/1/2024

---

1. My name is Fiona Whitworth. I am a graduate of Oxford University Medical School and I am a practising general practitioner. My qualifications are: MA 1991, BM BCh 1994, DCH 1996, DCRCOG 1996, MRCGP 1999, PGCMed Ed 2011, FRNZCGP 2013, PGDip GP 2016, FAEG 2020. Thank you for the request that I provide clinical advice in relation to the complaint from Ms A about the care provided by her local GP 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. **Documents reviewed**

   15/9/2023 Complaint

   19/12/2023 S14 Clinical notes and Provider response

3. **Complaint**

Delayed diagnosis of cancer

4. **Provider response(s)**

There were a number of GPs involved however due to a number of them having left New Zealand there is only one GP response and a letter from the practice manager.

Dr D

He has noted — "*I reviewed the health pathways with Ms A for IBS and for colonoscopy referral. (I enclose a copy of the pathways we looked at), To look for red flags and other treatment options. There did not appear to be any red flags, and her symptoms appeared to fall into the category of 'not seen' for colonoscopy. I was aware that at that point Ms A had not attended for the blood tests requested by Dr C and encouraged her to do so. In view of the fact the colofac was working we elected to continue with the previously prescribed medication for her IBS.*"

5. **Review of clinical records with Comment**

Timeline

2/7/2021 GP consultation Dr C

"3 days crampy and bloated abdomen. NO diarrhea, no nausea or vomiting. No LUTS. Is improving today.

Thinks has had IBS over the last years, when she is careful with diet, she copes very well but last week was away at a friend's house and diet was terrible.

E generally well, afebrile. Abd bloated, tympanic, soft nontender no guarding.

imp likely IBS flare up, no red flags

discussed appropriate follow up

Colofac prescribed"

Comment This is a clinically acceptable consultation — the GP has reviewed for red flags and has made a diagnosis of an episode of IBS[1] due to a change in diet. Safety netting has been done and an appropriate medication issued.

27/7/2021 ENT follow up letter

Review post melanoma excision. Notes no lymph nodes in neck.

24/8/2021 Dr C phone consult — level 4 covid restrictions.

"Patient requesting usual meds.

1. *colofac has been helpful for IBS symptoms, which have flared up since last week — likely due to stress related to covid restrictions*

2. *coc working well for her*

3. *not taking pravastatin which was prescribed years ago. Advised to have BT done when possible and we will then reassess.*

Colofac 135mg Tab — 135 mg up 3 times daily, preferably 20 minutes before meals; as needed for symptom relief, may gradually reduce after several weeks when desired effect obtained"

Comment This is a standard GP consultation. There is no documented safety netting, however.

[1] https://bpac.org.nz/BPJ/2014/February/ibs.aspx

5/11/21 GP Consultation Dr D

In the consultation it is noted she has pain from IBS. States review of health pathways for other options — colofac tried and is helping, anxiety noted as a trigger. Other health matters discussed.

No examination documented.

Comment Age 40 He states in his provider reply that he was aware of the two previous consultations with Dr C.

This is a routine consultation and review. He states in his provider reply that he reviewed the clinical information and that she did not have symptoms according to health pathways that would have indicated the need for referral.[2]

I am mildly to moderately critical that this consultation is four months since the one with Dr C in which red flags were explored. These may have been discussed at the consultation as part of reviewing health pathways, however there is a lack of documentation to this fact. Additionally given the ongoing symptoms it would have been good practice to re-examine Ms A at this time.

There is no documented safety netting, however.

16/11/2021 OPD review — melanoma

No neck masses noted.

29/11/2021 GP Consultation Dr D

Mole excision.

Comment This was a minor surgery interaction, and it would not be common practice to have asked about her on going bowel symptoms at this time.

7/12/2021 Nurse

Removal of sutures post-surgery

13/12/2021 GP Consultation Dr E — COVID orange

Ms A is age 40. The notes state:

"abdo pain, bloating, vomiting, loose stool. Longstanding, but at present it is the worst it has ever been. Barely able to eat anything. Lost 6kg in 4 weeks. Currently gluten free(ish) dairy free low FODMAP. Colofac no longer helping. Tearful when discussing this problem. Feels she has been fobbed off & wants some answers."

[2] [link to local HealthPathways website removed]

Bloods, stool testing and an ultrasound organised and a trial of amitriptyline and a proton pump inhibitor were started.

A plan was made to review her with the results and to "*? refer to gastroenterology for further investigations"*

Comment I am mildly to moderately critical that there has not been any examination undertaken at this point or documented weight. Although I note the statement of a 6kg weight loss in four weeks.

This is a significant weight loss and would be classified as a red flag.[3] It would be common practice to have referred her urgently to gastroenterology, at this point for review and a colonoscopy even if the ultrasound and bloods were normal.

Blood results: LFTs Normal FBC Normal CRP Normal Ferritin normal Faecal PCR — normal H pylori Negative Coeliac screen negative

12/1/2022 GP Contact Dr E

Text message sent: Hi Ms A, your blood & stool tests are all looking normal. Have you felt any benefit from the two tablets I prescribed for you? Kind regards, Dr E, local GP centre.

Reply from Pt

From: Ms A <phone number>; Received at: Wed, 12 Jan 2022,

06:11 p.m.

Hi there. The omeprazole works well. Still have diarrhea constantly but since using omeprazole the cramps are down to a manageable level.

Comment I am moderately critical that the patient has not been referred at this point and has not been reviewed in person to follow up the results even though Ms A states some of her symptoms are improved. There has been no enquiry as to whether there has been further weight loss.

25/2/2022 Abdominal ultrasound Persistent abdominal pain, bloating. Vomiting and diarrhoea. Comparison Ultrasound dated 6/3/2019.

Findings Pancreas: Unremarkable Liver: Wedge-shaped area of echogenicity in the left lobe measuring 28 mm. Small focal echogenic lesion in the right lobe measuring 8 mm. No duct dilation. Gallbladder: Unremarkable CBD: Normal caliber (2 mm). Kidneys: Unremarkable Spleen: Unremarkable. Aorta: Normal caliber.

[3] https://bpac.org.nz/BPJ/2014/February/ibs.aspx

Comment Probable liver hemangioma, however these were not identified on the prior ultrasound from 2019. A follow up ultrasound in 3–6 months is recommended to check for interval change. unremarkable upper abdominal ultrasound.

18/3/2022 GP Consultation Telephone Dr E

Ms A has reported that omeprazole was working well if she takes it. Discussion re ultrasound scan only an incidental finding. Review planned for this in 6 months.

Comment This is another opportunity when referral could have been made or Ms A seen in person, or the symptoms more fully reviewed.

5/5/2022 GP Consultation in surgery Dr C

FNA on a lymph node on Left supraclavicular fossa has shown metastatic adenocarcinoma. Dr G has organized urgent CT neck — pelvis. "*Ms A has stated on going abdominal discomfort for months, and the past 10 days has had nausea and vomiting. E cryful adn unwell as just received the news Abd bloated, soft nontender no masses"*

Comment This is the first examination of her abdomen noted in the notes provided since 2/7/2021

12/5/2022 Letter Tertiary Hospital ENT

"*I met Ms A in the **ENT** Clinic for follow-up of her posterior right neck invasive melanoma that was excised in February 2021. She mentioned that she has had a change of bowel symptoms with diarrhoea and weight loss of approximately 12–14 kg in the past couple of months. She also notified me of a left supraclavicular neck node which I requested a FNA of. The results have come back showing it to be a metastatic adenocarcinoma. Subsequent hospital documentation states: Diagnosis Colonic adenocarcinoma at the hepatic flexure. Family history Maternal great uncle — bowel cancer aged 49. Paternal grandfather — bowel cancer aged 70/80."*

7 Conclusion

At initial presentation (age 40) with Dr C there were no noted red flags[4] i.e. No weight loss; No FH colonic cancer; No iron deficiency anaemia not aged >50; No nocturnal symptoms Appropriate health pathways were followed — bloods and abdominal examination — no PR noted however this would commonly not be done by a GP unless there were outlet symptoms or bleeding.

The subsequent consultations with Dr D did explore other therapeutic and investigative options. However, there was no examination and no documentation that her weight was reviewed alongside other possible red flags. I am mildly to moderately critical that this was not done.

[4] [link to local HealthPathways website removed]

The consultation on 13/12/2021 gave Dr E an opportunity to undertake a referral to investigate her symptoms more. Even though investigations were ordered no referral was made and no examination occurred. I am moderately critical of these omissions as this may have given an opportunity for diagnosis. The txt contact between Dr E and Ms A on 12/01/2022 presented another opportunity for a referral and potential diagnosis, or at least a further in-person consultation. I am moderately critical that neither occurred. I note that Dr E has not been given the opportunity to comment on her care — I feel it is important that this is undertaken prior to a final conclusion. I will be able to give further comment when this was received. I also note that there is a presumed historic diagnosis of IBS — we have no notes regarding this and I would recommend requesting clinical notes going back at least to 2015 to review any diagnostic process with regard to IBS. Again, I will be able to give further comment when this is received.

8/4/2024 Review following additional Information

Timeline

5/5/2016 GP consultation

RUQ pain and intermittent abdominal pain — blood tests ordered. — normal

13/10/16 GP Consultation

Discussion re stress

6/4/17 GP Consultation

Skin rash bloods ordered

11/5/17 GP Consultation Dr E

Discussion re high cholesterol and family history. Prescribed a statin and referred for genetic testing

12/9/2017 GP Consultation Dr E

Discussion re anxiety and panic — prescribed propranolol. Bloods — acceptable.

24/10/2017 GP Consultation Dr E

URTI and mental health discussion. Statin stopped.

26/1/2018 GP Consultation Dr E

Mental health discussion and increase of medication

10/10/2018 GP Consultation Dr E

URTI and side effects from statins. Fluoxetine has been stopped. Contraception review

26/2/2019 GP Consultation Dr E

Presented with a short history of abdominal pain epigastric area with nausea, loose stool? related to gluten. Imp of gastroenteritis/cholecystitis. Sent for blood tests and abdominal scan. Safety netting advice given

Bloods normal s elevation GGT 65.

6/3/2019 Abdominal ultrasound normal

6/6/2019 GP Consultation Centre doctor

URTI

25/10/2019 GP Consultation Dr E

Presentation with breast pain — mastitis diagnosed

14/5/2020 GP Consultation Centre doctor

Anxiety discussion — also "*eating problems with IBS"* also *"Referred to mental health for counselling"*.

Comment

This is the first documentation of IBS going from 2015 there is no note of any bowel symptoms specifically, so I am unable to comment further.

4/9/2020 GP Consultation Dr E

Ankle sprain

5/11/2020 GP Telephone Dr E

? chest infection

6/11/2020 GP Consultation Dr E

URTI

29/1/21 GP Consultation Centre doctor

Review mole and referral to GPwSI

25/2/2021 GP Consultation Dr E

Removal of mole

21/5/2021 GP Consultation Centre doctor

Discussion re periods.

The first documentation of possible IBS was in a consultation on 14/5/2020 by a centre doctor. This consultation was focusing on mental health issues and there is minimal information regarding the symptoms. The notes do not have a classification for IBS documented. I note it is common for a patient to have some abdominal cramping symptoms — bloating with an alteration in bowel habit that is affected by

food and it is common for a self-diagnosis to be made. It is unclear from the notes as to whether the GP team had previously made this diagnosis or if it is one that Ms A has assumed herself. This would be a common occurrence in GP. In conclusion we have been informed that Dr E is unable to be contacted. There may have been a previously assumed diagnosis of IBS however it is unclear who made this.

This does not change my previous opinion that with a significant weight loss that it would have been good clinical practice to initiate a referral after the consultation on 13/12/2021 for further investigation/clinical opinion from secondary care.'

'13/5/2024 addendum

I have been asked to comment — re whether earlier melanoma diagnosis should have raised further concerns when Ms A complained of abdominal symptoms and weight loss.

The symptoms that were present should have been investigated on their own merit. A previous cancer diagnosis of any nature does always raise the possibility of metastatic spread and would be borne in mind when considering a patient's symptoms. This does not change my previous opinion that with a significant weight loss that it would have been good clinical practice after the consultation on 13/12/2021 to initiate a referral for further investigation/clinical opinion from secondary care. This would have been done with a high suspicion of cancer priority.'

'19/8/2024 Addendum — Provider Response Dr E

It is stated that there was a consult 26/2/19 with epigastric pain, bloating, nausea and loose stool, examination had shown tenderness epigastric area and a positive Murphy's sign. A differential of gastroenteritis/cholecystitis or other serious cause was noted. Urgent bloods and abdominal scan were undertaken and were normal.

The next clinical contact by Dr E was 13/12/21 when it is stated she presented with multiple longstanding gastrointestinal symptoms which had become worse. It is stated Ms A was barely able to eat and had lost 6kg. Dr E states he felt that this could be due to her restrictive eating pattern. However, he ordered a comprehensive set of bloods and abdominal ultrasound, gave acid suppressant medication and planned for clinical review. It is noted that referral for secondary care review was to be considered based on the effect of the tests and interventions.

I note that on 13/1/2022 the GP checked in with Ms A and that things were improving but still had constant diarrhoea. On 18/3/2022 a telephone review — the scan was discussed and as she was improving no further action was taken. Dr E has given his clinical rationale for not referring on 13/12/21 as that the weight loss was due to Ms A's very low food intake over the preceding four weeks. He has noted that regarding a history of weight loss and previous melanoma that he did not feel he could comment given this was treated by secondary care (melanoma).

Considering the provider reply this does not change my opinion that I am moderately critical regarding a lack of urgent referral on 13/12/21. However, I note

that there were significant obscuring factors — co existent IBS and possibility of weight loss due to narrow dietary intake. These are in addition to the mitigating factors of several GPs involved over this time frame, limitations on face to face contact due to COVID. Dr E did however order the correct range of tests and investigations, and these were mainly normal which may have led to some false degree of reassurance.'