Assessment of woman with severe abdominal pain
16HDC00751, 16 March 2018

Resident medical officer ~ Registrar ~District health board ~ Emergency department ~Abdominal pain ~Ovarian torsion ~ Assessment ~Right ~ 4(1)

In the early hours of the morning, a 33-year-old woman attended the Emergency Department at a public hospital with right lower quadrant abdominal pain, which she had been experiencing since the previous morning.

A senior house officer (SHO) ordered tests and an abdominal X-ray. The woman was discharged at 6.19am with a prescription for pain medication and medications for constipation. The (SHO) documented: "Next step ? [ultrasound scan] if ongoing symptoms."

Later that day, at 6.27pm, the woman re-presented to the Emergency Department. At 7.20pm, the woman was assessed by a resident medical officer (RMO), who documented that the woman had re-presented with the "same pain as before".

The RMO ordered tests and an abdominal X-ray. The X-ray, performed 10.37pm, identified no abnormality. At 10.44pm, a registered nurse documented the woman's pain score as four out of five. At 11.18pm, the RMO discharged the woman after diagnosing her with constipation.

The woman returned home and continued to experience pain and nausea. The following day she telephoned her medical centre, and an appointment with a registered nurse was arranged for 4.30pm.

Subsequently, the woman's GP spoke with her, assessed her, and arranged an urgent referral to the surgical assessment unit at the public hospital. A CT scan identified that the woman had an ovarian torsion (twisted ovary), and she underwent surgery to remove the ovary.

Findings
Following the woman's second presentation to the Emergency Department with a history of abdominal pain, the RMO had a responsibility to consider appropriate investigations and to discuss her presentation with a senior doctor. In addition, his diagnosis of constipation, based on the history and examinations performed, was inappropriate. Accordingly, the RMO failed to provide services to the woman with reasonable care and skill, and breached Right 4(1).

Recommendations
It was recommended that the RMO provide a written apology to the woman for his breach of the Code.

It was recommended that the DHB use an anonymised version of this case for the wider education of its medical registrars.