Decision 22HDC00068 (CAS-10612-D2Q3X6)
21 October 2025

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Delay in diagnosis and treatment of stomach cancer

Introduction and complaint

1. At the outset, I express my sympathy and heartfelt condolences to the late Mrs A's family for their loss. I note from the clinical records that prior to her diagnosis, Mrs A was described as in 'excellent health of body and mind' and was a retired nurse and caregiver for her husband. I acknowledge that Mrs A's misdiagnosis and subsequent delayed treatment would have had a profound impact on her extended family, and I commend their reasons for wishing to continue with an investigation to ensure that this does not happen to anyone else.

2. On 10 January 2022, the Health and Disability Commissioner (HDC) received a complaint from Mrs A's family about the care provided to the late Mrs A (aged 74 years at the start of the care concerned in April 2021) at Southland Hospital and in relation to subsequent biopsies reported on following gastroscopies[1] undertaken, which resulted in a delayed diagnosis of cancer. The complaint also related to concerns regarding the care received by Mrs A in relation to a heart condition, which has been dealt with under a separate HDC complaint.

Background

3. During 2021, Mrs A was referred to Southland Hospital by her local general practitioner (GP). Mrs A's GP reported that Mrs A had melaena[2] due to recurrent gastrointestinal (GI) bleeding and was referred to Dr C, a consultant general surgeon at Southland Hospital, Invercargill, and she had an appointment that day. Details of Mrs A's subsequent appointments during April to December 2021 at Southland Hospital, during which gastroscopies and a computed tomography (CT)[3] scan of her whole body was undertaken, and the biopsy results, are outlined below.

April gastroscopy and biopsy results

4. The first gastroscopy undertaken by Dr C was on 30 April 2021. Dr C's clinical notes include 'anaemia' and his finding of two gastric ulcers on the lesser curvature of the stomach and two large ulcers associated with surrounding inflammation. Dr C noted that these were '[s]uspicious for malignancy'. His summary stated: 'Oozing gastric ulcers.' However, the

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[1] A procedure to examine the upper part of the digestive system using an endoscope (an illuminated tubular instrument).
[2] Black, tarry stool that usually occurs as a result of upper gastrointestinal bleeding.
[3] A cross-sectional, three-dimensional image of an internal body part.

Names have been removed (except Health New Zealand Southern, Awanui Labs, and the independent advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

referral form sent by Dr C to Southern Community Laboratories Limited (now Awanui Labs)[4] listed only 'anaemia' in the clinical details.

5. The biopsy results carried out by consultant pathologist Dr D and reported on 5 May 2021 concluded that there was no evidence of 'metaplasia[5]', 'dysplasia[6]', or 'malignancy[7]', and Dr D told HDC that he did not seek a second opinion as this was a benign/non-malignant diagnosis.

May CT scan

6. On 8 May 2021, Mrs A had a follow-up CT scan of the chest, abdomen, and pelvis. The clinical details noted: 'Gastroscopy demonstrated significant area of ulceration suspicious for malignancy.' The results indicated no cancer at that time but noted what was thought to be a 'left atrial appendage thrombus[8]'.[9]

June gastroscopy and biopsy results

7. Mrs A's second follow-up gastroscopy was undertaken by Dr C on 18 June 2021. Dr C's clinical notes record the indication for the procedure as 'Personal history of peptic ulcer disease'. His findings included moderate inflammation in the gastric body and stomach, and his summary noted: 'Gastritis. Biopsied. A medium amount of food (residue) in the stomach.' The referral form sent to Awanui Labs by Dr C listed the clinical details as 'gastric ulcer'.

8. Dr D reported on the biopsy on 24 June 2021 and found no evidence of 'metaplasia, dysplasia or malignancy'. Dr D told HDC that, again, he did not seek a second opinion as this was a benign/non-malignant diagnosis.

October gastroscopy and biopsy results

9. In October, Mrs A was seen by Dr E, a consultant general and renal physician, when she was admitted to Southland Hospital's Day Surgery Unit with 'symptomatic iron deficiency anaemia, without overt GI bleeding symptoms, while on rivaroxaban[10]'. On 12 October 2021, Dr E referred Mrs A for a repeat gastroscopy.

10. Dr C performed the gastroscopy on 14 October 2021. Dr C's clinical notes record his concerns as 'localised severe inflammation' and ulcerations in the gastric body and stomach. His summary noted gastritis and a large amount of food (residue) in the stomach. The referral form sent to Awanui Labs by Dr C lists the clinical details as 'upper GI bleeding'.

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[4] Awanui Labs […] is contracted by Health New Zealand | Te Whatu Ora Southern (Health NZ) to provide laboratory testing for the Southern region. This includes tests referred from community-based and hospital referrers.

[5] An abnormal condition in which healthy cells are replaced by a different type of cell.

[6] Abnormal growth or development of organs or cells.

[7] A term used to describe cancer.

[8] A blood clot that forms within the left atrial appendage (a small, ear-shaped pouch connected to the left atrium of the heart).

[9] Later, following a re-review by a consultant cardiologist […] in December 2021, this was found not to be the case and that more likely it was a normal muscular band of tissue.

[10] A medication used to treat or prevent blood clots.

11. The biopsy result reported by anatomical pathologist Dr F and reviewed by consultant pathologist Dr G on 26 October 2021 again noted that there was no evidence of metaplasia, dysplasia, or malignancy.

December gastroscopy and biopsy results

12. In late December 2021, Mrs A continued to have concerning symptoms,[11] and Dr E referred her for a further gastroscopy and blood screening. The blood screening showed recurrent iron deficiency anaemia, and on 22 December 2021 Dr E referred Mrs A for a further gastroscopy.

13. The fourth and final gastroscopy took place on 24 December 2021 and was undertaken by Dr H. Dr H's clinical notes indicate concerns about a '30 mm nodular area of markedly inflamed mucosa around a partially healed ulcer scar … found at the incisura[12]'. Dr H's referral notes for the biopsy sent to Awanui Labs also note:

> [C]hronic gastritis — poorly healed ulcer — Previous H[elicobacter] Pylori.[13] Anaemia 1) Duodenum[14] — ? Coeliac[15] 2) Ulcer scar — malignant? Lymphoma[16] ? H[elicobacter] Pylorus 3) Random stomach — ? lymphoma ? H[elicobacter]pylori … Stomach — ? MALT[17].

14. The biopsy reported on by Dr D confirmed that gastric adenocarcinoma[18] had been found.

15. As a result of the December biopsy finding, and in line with Awanui Labs' routine quality assurance, Dr D undertook a 'hindsight review'[19] of the original three biopsies[20] and noted that gastric adenocarcinoma had been present in both the April and October 2021 biopsies.

16. On 6 January 2022, Dr E referred Mrs A for prioritised treatment following her 'significantly delayed diagnosis'. Dr E noted that a Serious Adverse Event Report would be submitted by him, amongst other actions taken.[21] Mrs A and her daughter-in-law, Mrs B, were updated with this information.

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[11] Her clinical records note: '[R]ecurrent [symptomatic iron deficiency] anaemia due to presumed upper GI bleeding. Early satiety, abdominal bloating, sensation of incomplete stomach emptying, unintentional weight loss of 10kg in a year.'

[12] A deep indentation or notch.

[13] A type of bacteria that infects the stomach.

[14] The first part of the small intestine.

[15] A disease that mainly affects the small intestine.

[16] A cancer of the lymphatic system.

[17] Mucosa-associated lymphoid tissue (tissue that is part of the immune system).

[18] Stomach cancer.

[19] Dr D realised that he had been involved in two of Mrs A's three previous biopsies, and he reviewed the slides with the benefit of hindsight.

[20] From April 2021, June 2021, and October 2021.

[21] These other actions were as follows: '1. A review of all biopsies in [gastrointestinal] [multi-disciplinary meeting (MDM)] 13/1/22 — why was cancer missed on two occasions? 2. I will submit ACC treatment injury claim after MDM. 3. I will submit SAC report after MDM. 4. I have advised Mrs A and her daughter-in-law of their right to lodge a complaint with the Health and Disability Commissioner. 5. Oncology/surgery to please kindly consider placing Mrs A at the top of their waiting lists, given misdiagnosis.'

17. Sadly, despite Dr E's urgent referral and the cancer treatment received after her diagnosis had been confirmed, Mrs A passed away on 17 May 2022.

Further information

18. In response to HDC, Awanui Labs acknowledged that there were errors in diagnosis of the biopsies from May and October 2021. Awanui Labs stated: '[The] May diagnosis missed a subtle area of cancer. The diagnosis of limited (small) amounts of poorly differentiated gastric adenocarcinoma is difficult.' In relation to the October incorrect diagnosis, Awanui Labs stated:

> There was no indication of high suspicion for cancer at this time in the clinical information provided, and the diagnosis was influenced by this information and the previous two negative biopsies.

19. Awanui Labs said that a copy of the endoscopy report was almost always provided by the clinical team from other locations in New Zealand, and Health NZ Southern gastrointestinal clinical teams had resisted this, having maintained that this information is available through Health Connect South. However, Awanui Labs stated: '[T]his only applies to endoscopy procedures undertaken in the public health system and are not available on cases from private endoscopy clinics.'

20. Awanui Labs further stated:

> Pathologists operate as part of the wider team (GP, medical physician surgeon, radiologist, and nurse specialist) involved in patient care and not in isolation. As such, the clinical information provided to the pathology team with any biopsy is vitally important in the biopsy assessment process, and assessment is strongly influenced by the information provided. In this case, none of the request forms (attached with reports) from the first three[22] biopsies in 2021 stated a high level of clinical concern for malignancy.

21. Awanui Labs also told HDC that where there is a discrepancy between clinical findings and histology reports, these cases should be submitted for clinical discussion at the regional multidisciplinary meeting (MDM), which did not happen in April, June, or October 2021. Awanui Labs also stated that anatomical pathologists cannot perform optimally unless they have access to all relevant clinical information, and if the request forms had been more fulsome, it is likely that the negative slides would have had more scrutiny back in May 2021 and the correct diagnosis of gastric adenocarcinoma made at that time. Awanui Labs confirmed that for the reporting of all new cancer diagnoses, these require a mandatory double read by a second pathologist, although for difficult cases, a second opinion is requested only at the discretion of the reporting pathologist.

22. Dr D offered his 'most sincere and unreserved apology to Mrs A's family that [he] did not make the correct diagnosis'.

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[22] April, June, and October.

23. In his response to HDC, Dr D stated that, had he known about the gastroscopic concern for malignancy, he would have had a second look at the biopsy, and cancer cells would have been picked up. However, Dr D also stated:

> Regardless of the difficulties and subtleties of recognising small amount of cancer cells on a background of inflamed mucosa and the incomplete clinical information, the cancer cells were nonetheless there, and I realised on review that I had missed them.

24. In her response to HDC, Dr F acknowledged that she had made a mistake in her findings on the October 2021 gastroscopy biopsy misdiagnosis and said she wished she 'could go back to that time and change things'. Dr F said that she takes full responsibility for the misdiagnosis leading to the delay in treatment, and she apologised sincerely for this.

25. Dr F also told HDC that her reason for reporting the case as she did was 'heavily influenced by the clinical details provided'.

26. In his response to HDC, Dr G apologised unreservedly for the error in diagnosis that led to a delay in treatment for Mrs A and caused distress for Mrs A and her family. As the lead GI pathologist, Dr G stated that he agreed with Dr F's diagnosis of 26 October 2021, having been shown the biopsy slide by her. Dr G noted that there are no official policies, protocols, or procedures in place regarding reviewing and reporting of histology cases at Awanui Labs.

27. Health NZ Southern responded to the comments made by Awanui Labs and stated:

> We agree that pathologists operate as part of the wider team and not in isolation and, whilst we accept that the information provided to the pathology team may influence the reporting of a biopsy sample, the underlying reason for providing a biopsy is to establish a diagnosis. We would not expect, therefore, the information provided on the referral request form to anchor the reporting clinician and to exclude any potential diagnoses. It is not reasonable to suggest that the request for analysis of a biopsy not stating a high suggestion of cancer is at the root cause of the cancer not being identified. We do however accept that, as per other diagnostic modalities, the analysis of pathology samples is challenging and always made easier in hindsight.

28. Health NZ Southern also told HDC:

> [G]iven the reliance on the biopsy result to provide a diagnosis, it is not reasonable to suggest that a patient should be referred to a multidisciplinary meeting when the tissue samples are reported as not being cancerous.

29. Dr C acknowledged in his response that he had not had the opportunity to offer his sincere condolences to Mrs A's family and said that he is sorry for their loss.

30. Dr C also told HDC that, while Mrs A's 'initial clinical response to medical treatment (omeprazole) did not strongly support a malignant diagnosis', his concern about her ongoing symptoms led him to arrange a repeat gastroscopy after her first procedure in April 2021. Dr C stated that the clinical assessment was also clouded by Mrs A's continuous use of rivaroxaban, which increases a patient's chance of gastric mucosal injury, peptic ulceration,

and upper GI bleeding. Dr C said that, based on Mrs A's clinical response to treatment and her presumed biopsy findings, he 'judged that [he] wrote down the appropriate indications on the pathology forms and [he] did not have reason to refer [Mrs A] for review at the gastrointestinal cancer [MDM] meeting'.

ACC expert advice

31. HDC was provided with expert advice dated 20 June 2022 obtained by ACC from pathologist Dr I in relation to the biopsy readings (the advice is attached to this letter and referred to as Appendix A [*removed*]). The advice was based on a blind review of the stained biopsy slides from April, June, and October 2021 by a panel of five histopathologists. Their findings concluded that there were no departures from a reasonable standard of care in relation to the April and June 2021 readings. It was also noted that the changes present in the April 2021 biopsy were extremely subtle and that only with appreciation of the changes in the later biopsies, with hindsight it becomes 'possible to pick out the very rare lesional cells in the inflammatory background'. Dr I commented that, in his opinion and supported by the blind review results for the April 2021 biopsy, there should not have been an expectation of a diagnosis of malignancy or a suspicion of malignancy.

32. However, in relation to the October 2021 biopsy slides, Dr I found that there was a failure to recognise the serious changes in the biopsies, which were highly suspicious for malignancy. He commented: '[T]here should have been an expectation that a pathologist examining the October biopsies not report these as negative for malignancy.'

33. Further evidence dated 3 October 2022 was obtained by ACC from Dr K, a medical oncologist, which is attached to this decision and referred to as Appendix B [*removed*]. Dr K provided an opinion on the progression of Mrs A's gastric cancer in a two-month period. He concluded that it was reasonable to contend 'that a two-month delay in diagnosis caused clinically meaningful cancer growth ***in [Mrs A's] specific situation** and had a negative impact on her outcome. This would likely not be the case in a typical case but is influenced by the aggressive nature of her cancer.'

Responses to provisional opinion

Mrs A's family

34. Mrs A's family were given an opportunity to respond to the 'Introduction and complaint', 'Background', 'Further information' and 'Changes made' sections of the provisional opinion and had no further comment to add.

Awanui Labs

35. Awanui Labs was given an opportunity to respond to the sections of the provisional opinion that relate to them. Awanui Labs accepted the proposed recommendations and stated that they are 'committed to providing safe and quality services to patients and will take this opportunity to implement learnings from this case to strengthen [their] systems and processes.'

Dr D

36. Dr D was given an opportunity to respond to the sections of the provisional opinion that relate to him and stated that he accepted the findings and had no further comments to make. Dr D also confirmed he would forward a letter of apology to HDC for Mrs A's family.

Dr F

37. Dr F was given an opportunity to respond to the sections of the provisional opinion that relate to her and stated that 'as planned, [she had] conducted an audit of all gastrointestinal biopsies [she had] reported for a three-month period in 2023.' Dr F confirmed that she found no discordance in the cases reviewed. Dr F also confirmed that she would forward a letter of apology to HDC for Mrs A's family.

Dr G

38. Dr G was given an opportunity to respond to the sections of the provisional opinion that relate to him and stated he had taken on board the criticisms made of his care. Dr G said this 'case and investigation process has been a salutary lesson' for him and he had no hesitation in apologising to Mrs A's family.

Dr C

39. Dr C was given an opportunity to respond to the sections of the provisional opinion that relate to him and had no further comments to make. Dr C also stated that he 'would like to express [his] deepest condolences to Mrs A's family for their loss.'

Health NZ Southern

40. Health NZ was also given an opportunity to respond to the sections of the provisional opinion that relate to them and stated that, while they acknowledged the benefits of additional information on pathology requests and noting improvements already made, they were concerned that the provisional report placed the 'the onus of accountability on the information contained on the histology request form and the safety netting (which is nuanced and subjective) rather than the core issue, which was that the histology was not correctly reported on several occasions.'

41. Health NZ also stated:

> Regardless of the information contained on the histology request form, we believe that there is a reasonable expectation that the sample will be examined using standard procedures and with the same amount of rigour.

Opinion: Awanui Labs — breach

42. Under Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code), Awanui Labs had a duty to ensure that services were provided to Mrs A with reasonable care and skill. In this regard, Awanui Labs failed Mrs A on two occasions in April 2021 and October 2021.

43. I consider that, ultimately, Awanui Labs was responsible for ensuring that its pathologists reported on the biopsy specimens appropriately. Given the number of gastroscopies

requested during April to December 2021, in my view this should have also raised suspicion for those carrying out the biopsies.

44. However, I note from the blind review carried out for ACC by the six pathologists involved that, for the April 2021 biopsy review, only three of the six pathologists would have found the gastric adenocarcinoma. I also note that the contributing factor to the missed diagnosis appears to be the lack of clinical information provided on the histology request by Dr C.

45. However, all pathologists have acknowledged that they missed the gastric adenocarcinoma in their reporting of the April and October 2021 biopsies. These were missed opportunities for Mrs A to have commenced chemotherapy at an earlier stage.

46. For the above reasons, I find that Awanui Labs failed to provide Mrs A with services with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

Opinion: Dr G — breach

47. Dr G has acknowledged the error in his review of the biopsy slide shown to him by Dr F in October 2021. As the lead GI pathologist and having been consulted for a second opinion by Dr F, I consider that Dr G is responsible for the misdiagnosis of the biopsy specimen for October 2021. In doing so, I consider that he failed to provide Mrs A with services with reasonable care and skill, and, accordingly, breached Right 4(1) of the Code.

Opinion: Dr F — adverse comment

48. Dr F acknowledged that she made a mistake in her findings on the October 2021 biopsy misdiagnosis, and she took full responsibility. While I am critical that Dr F also did not make the correct finding on the biopsy before her, in my view this is mitigated by her seeking a second opinion to ensure that her reading was correct. As outlined above, Dr G, as her senior, should have diagnosed the gastric adenocarcinoma found by all ACC experts in their blind review.

Opinion: Dr D — adverse comment

49. While I note Dr D's acknowledgment of the diagnostic error for the April 2021 biopsy, I have taken into consideration the blind review carried out by the ACC pathologists, in which half confirmed that they would have come to the same conclusion and noted that Dr C had not provided full clinical information with the histology request. On this basis, while I am critical that the diagnosis was missed at such an early stage, which may have affected Mrs A's outcome, I do not find that Dr D breached the Code.

Opinion: Dr C — adverse comment

50. Independent clinical advice was obtained from consultant general and colorectal surgeon and endoscopist Dr Linus Wu, dated 3 April 2025, 3 May 2025, and 7 July 2025, in relation to the care provided by Dr C. Dr Wu's advice is included as Appendix C.

51. Dr Wu noted that the gastroscopy procedures carried out by Dr C on 30 April 2021, 18 June 2021, and 14 October 2021 were done in a timely, competent and safe manner following receipt of the referrals, and, in his opinion, the 'interpretations of the endoscopic findings were accurate'. However, Dr Wu referred to the Laboratory Accreditation Program of the

College of American Pathologists and the Joint Commission on Accreditation of Healthcare Organisations Standards, which require that 'each surgically removed specimen is accompanied by pertinent clinical information and, to the degree known, by the preoperative and postoperative diagnosis'.

52. Dr Wu noted his concern that Dr C documented on the gastroscopy report dated 30 April 2021 that he felt that the two ulcers biopsied were suspicious for malignancy, yet this was not noted on the histology request form, and he stated only 'anaemia'. Dr Wu advised that the standard of care and accepted practice, especially when a malignant diagnosis is suspected, 'is to highlight this suspicion to the pathologist and the request should be marked "urgent"'. Dr Wu noted the following departures from the expected standard of care provided by Dr C (noting that there was no departure in relation to the request form completed by Dr E on 24 December 2021), as summarised below:

- Standard of information on the request form on 30 April 2021 — moderate departure
- Standard of information on the request form on 18 June 2021 — mild departure
- Standard of information on the request form on 14 October 2021 — mild departure

53. Dr Wu also considers that Dr C could have taken action when there was a discordance between the endoscopic impression and the histological diagnosis for the 30 April gastroscopy findings. In this regard, Dr Wu noted the following departures from the expected standard of care by Dr C (noting that there was no departure in relation to an early repeat gastroscopy and biopsy, given that he had done this on 18 June 2021):

- For failing to carry out a review of histology in the Pathology MDM or a discussion with the reporting pathologist — moderate departure
- For failing to obtain a second opinion from another endoscopist and/or pathologist — mild departure

54. Dr C was provided with the opportunity to comment on Dr Wu's report. In responding to HDC, Dr C said that, routinely, general surgeons 'will not expand on the clinical information provided on the pathology requisition forms', and he gave examples of this.[23] Dr C said that he was perplexed that in Mrs A's case a gastric cancer was missed by the pathologists on two separate occasions purportedly based on the general surgeon not being more specific about there being a possible malignancy.

55. In contrast to the views given by the pathologists and the advice of Dr Wu, Dr C stated: 'Regardless of what is written or not written on the request form I would have expected the pathologist to have examined the biopsy for the presence of cancer.'

56. While Dr C considers that the omission of information about the presence of gastric ulcers and a query about a mass suspicious of malignancy on the histology request did not

[23] For example, clinical information of 'acute appendicitis', 'symptomatic cholelithiasis', or 'hemorrhoidal disease'. Dr C said that '[s]pecific examples of instances where unexpected malignancy is found include appendiceal neuroendocrine tumour, gallbladder cancer or squamous cell carcinoma of the anal canal'.

contribute to the incorrect biopsy diagnosis being made, he acknowledged that 'provision of detailed, relevant information on request forms can be of assistance to the recipient'.

57. Dr C also told HDC that the findings from the CT carried out on 7 May 2021 were in keeping with his initial diagnosis of gastritis after the April 2021 gastroscopy, and so he considered that there was no discordance, although his plan was to undertake a follow-up gastroscopy for reassessment.

58. Dr C stated:

> [I]f the proper diagnosis had been established in April 2021, then Mrs A would have had the appropriate standard of care, including referral to the upper GI surgical oncology team [locally] as well as review at our regional GI cancer MDM.

59. While I am somewhat critical that further information was not included by Dr C on the histology request forms, particularly the 30 April 2021 histology request when he suspected malignancy, I have also taken into account Dr I's report for ACC, who said that it was unlikely due to the extremely subtle changes, that a report of malignancy or suspicion of malignancy would be expected for the April 2021 biopsy. I consider that, even if Dr C had provided extra information, there was a reasonable probability it would have been unlikely to have changed the reporting outcome at that time.

60. I agree with Health NZ Southern that the expectation of examination of the biopsies carried out by the pathologists should have been at a high level and thorough, regardless of whether the information on the histology request form is limited or not.

61. I accept Dr Wu's advice that it is important for all health professionals in the diagnostic process, including the endoscopists, pathologists, and radiologists, to work as a team to overcome the diagnostic challenges with diffuse-type gastric cancer.

Brevity in histology requests – other comment

62. I note that Awanui Labs has commented that brevity in histology requests is commonplace for Health NZ Southern as opposed to other districts across the country.

63. It would be my expectation that if the pathologists did not consider there was sufficient information contained on the request form, they would highlight this with the requestor. In addition, if there were concerns generally about the brevity of histology requests, I would expect this to be raised between Awanui Labs and Health NZ Southern at a high level to be addressed as a matter of patient safety.

64. I have considered Dr C's responses and accept Dr Wu's advice that, given Dr C's concerns and his suspicion of malignancy, despite the biopsy findings, it would have been prudent for Dr C to look at further action as outlined by Dr Wu in paragraph 53. Whilst I am critical that this did not happen, I also accept that he should have been reasonably confident to rely on the report findings and, as such, I do not find Dr C breached the Code.

Changes made

Awanui Labs

65. Awanui Labs has confirmed that subsequently it implemented a mandatory requirement for all pathologists to look up the Health Connect South endoscopy report at the time of reporting the histology, although it stated: 'Ideally, the endoscopy report would be provided to us at the same time as the specimen and laboratory request form.'

Dr D

66. Dr D told HDC that, as a result of his error, he has made the following changes to his practice with the intention of minimising risks of further misdiagnosis:

a) He audited and reviewed as many cases as he could obtain of gastric biopsies he reported in 2021 to look for other false-negative biopsies.

b) He undertakes a careful review of laboratory request forms.

c) He reviews endoscopy reports, if available, at the time of reporting GI biopsies.

d) He undertakes a second read of cases — usually the following day — before releasing the report.

e) He undertook several courses and lessons relevant to the area of GI pathology as a part of continuing medical education and professional development.[24]

f) He seeks a second opinion from a colleague where there is concern regarding ulceration or tumour in the stomach.

67. Dr D also told HDC that, since finding out about the misdiagnosis, he has reflected deeply on the different aspects of the error. Dr D stated that he 'feels a sense of profound regret that he missed the cancer cells in the April biopsy', which consequently limited Mrs A's treatment options. Dr D said that he chose to practise pathology with the intent of helping patients, so missing a diagnosis, even one that was clearly a challenge to diagnose correctly, does not meet the standards set for himself.

Dr F

68. Dr F confirmed that she has undertaken several continuing medical education courses on gastrointestinal pathology since these events[25] and attended a conference with GI topics. Dr F also told HDC that she would carry out an audit and review as many cases as she could obtain for gastric biopsies reported by her in 2023 to check for potential false negatives. Dr D also advised that she now has a much lower threshold for requesting broad-spectrum cytokeratin stains and levels in the setting of gastric ulceration.

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[24] 2022 United States and Canadian Academy of Pathology (USCAP) Diagnostic pathology update (attended lectures relevant to gastrointestinal pathology); Crash course in gastrointestinal, liver and pancreatobiliary pathology (USCAP); USCAP gastrointestinal and liver pathology (Wend Frankel).

[25] GI manifestation of systemic disease (USCAP); GI acute and chronic hepatitis (USCAP); Intraoperative diagnostic issues in GI pathology, part 1 and 2 (USCAP); 'The old and the new: A comprehensive approach to the GI tract' (12-lecture course) (USCAP); IBD-related dysplasia: a practical approach to the diagnosis (pathCast); Pancreas (USCAP).

69. Dr F said that she always correlates the clinical information available at the time of reporting on gastric biopsies. She also carries out a second read of a case before releasing the report, usually undertaken first thing in the morning or the following day, and continues to seek a second opinion from a colleague, particularly where there is concern regarding ulceration or tumour in the stomach.

Dr G

70. Dr G told HDC that since this incident he has undertaken two continuing medical education courses on GI pathology and that the team at Awanui Labs has retrospectively reviewed the histological slides of all the biopsies related to this case and acknowledged the difficulties in diagnosing gastric cancers. Dr G stated that with 'ulcerating lesions in the stomach there should be a low threshold for requesting immunohistochemistry for a cytokeratin as gastric cancers are well document[ed] as being sometimes difficult to see on regular stains'.

Dr C

71. Dr C told HDC that, since this incident, he has attached the printed Provation endoscopy reports and provided detailed, relevant information with the specimens on histology request forms that are sent to the pathology laboratory in the hope that this will help consultant pathologist colleagues with the analysis of specimens provided. Dr C also said that he advised his general surgery colleagues of Dr Wu's recommendations.

72. Dr C also stated that because of Dr Wu's report, for complex cases such as Mrs A's, he will be more liberal in seeking the opinion of upper GI surgical oncology colleagues [locally], as well as at the regional GI cancer MDM.

Recommendations

Awanui Labs

73. Taking account of the changes made, I recommend that Awanui Labs:

a) Provide a written apology to Mrs A's family for the care deficiencies identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs A's family.

b) Use this case as a basis for developing education/training on the importance of ensuring that appropriate, detailed, and relevant clinical information, including the endoscopy report, is provided with the biopsy specimen and histology request forms sent to the pathology laboratories. Evidence confirming the content of the education/training (eg, training material) and delivery (eg, attendance records) is to be provided to HDC within three months of the date of this report.

c) Implement a policy, protocol or procedure for pathologists to follow when reviewing and reporting histology cases to ensure that the options available for consideration[26] are clear, such as requesting a second opinion in uncertainty or a further biopsy if there are issues with obstruction. Evidence of implementation of the new policy, protocol or

[26] Taking into consideration the options for peer review, as outlined by Dr G in paragraph 3 of his response to HDC dated 4 August 2023.

procedure is to be provided to HDC by way of a copy of the same within 12 months from the date of this report.

Dr D

74. Noting the substantive changes made to his practice and the further training undertaken, I recommend that Dr D provide a written apology to Mrs A's family for the deficiencies identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs A's family.

Dr F

75. Noting the changes made to her practice and the further training undertaken, I recommend that Dr F provide a written apology to Mrs A's family for the deficiencies identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs A's family.

Dr G

76. Noting the changes made to his practice and the further training undertaken, I recommend that Dr G provide a written apology to Mrs A's family for the deficiencies identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs A's family.

Dr C

77. I recommend that Dr C:

   a) Provide a written apology to Mrs A's family for the deficiencies identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs A's family.

   b) Noting that Dr C has changed his practice by now providing the gastroscopy reports with the histology requests, reflect on how he can make improvements in the provision of pertinent clinical information on pathology request forms when submitting the specimen for analysis, and report back to HDC on his learning, within three months of the date of this report.

Health NZ Southern

78. Having regard to the information provided by Awanui Labs and referred to in my decision around all relevant clinical information being provided on gastrointestinal histology requests, as well as Dr Wu's advice on this, I recommend that Health NZ Southern change its process for all gastrointestinal histology requests to include a copy of the endoscopy report to provide pathologists with a more rounded view of the clinical diagnosis. Health NZ Southern is to provide HDC with a copy of the updated policy/process within six months of the date of this report.

79. I also recommend that Health NZ Southern:

   a) Encourage an open line of communication between the pathology and surgical departments at Southland Hospital.

b) Encourage reviews in Pathology MDM for all discordant results.

c) Encourage seeking a second opinion if there is any clinical uncertainty in similar cases of concern where malignancy is suspected.

Follow-up actions

80. A copy of the sections of this report that relate to Dr G, Dr D, Dr F, and Dr C will be sent to the Medical Council of New Zealand.

81. A copy of this report with the ACC expert advisor Appendices A and B removed and details identifying the parties removed, except Health NZ Southern, Awanui Labs, and the independent advisor on this case, will be sent to my independent advisor, Dr Wu; the Medical Council of New Zealand; Te Aho o Te Kahu, the Cancer Control Agency; and Manatū Hauora | Ministry of Health and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Vanessa Caldwell
Deputy Health and Disability Commissioner

Appendix A: Pathologist expert advice provided to ACC [removed]

Appendix B: Oncologist expert advice provided to ACC [removed]

Appendix C: Independent clinical advice to Commissioner

The following independent clinical advice was obtained from consultant general and colorectal surgeon and endoscopist Dr Linus Wu (dated 3 April 2025, 3 May 2025 and 7 July 2025):

'Complaint:	[Mrs A] (dec) | Dr [C]
Our ref:	22HDC00068
Independent advisor:	Dr Linus Wu

I have been asked to provide clinical advice to HDC on case number 22HDC00068. I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:	My qualifications are Bachelor of Medicine, Bachelor of Surgery (MBChB, University of Auckland, 2001) and Fellow of Australasian College of Surgeons (FRACS, 2010). I am a Consultant General and Colorectal Surgeon and Endoscopist at Waikato Hospital.
Documents provided by HDC:	1. Letter of complaint dated 10 January 2022 and attached letter from the then Southern DHB dated 06 January 2022 2. Gastroscopy Request April 2021 3. Consult request (internal) and Gastroscopy Request May 2021 4. Gastroscopy Request October 2021 and Hospital Lab Request Oct 21 5. Gastroscopy Request December 2021 6. Gastroscopy Report April 2021 7. Gastroscopy Report June 2021 8. Gastroscopy Report October 2021 9. Gastroscopy Report December 2021 10. Amended Pathology report April (amended 30-05-22) 11. Supplementary reported Pathology report Dec (26-01-22) 12. Pathology report June 13. Response from [Dr D] 02-08-23 14. Response from [Dr G] 02-08-23 15. Response from [Dr F] 02-08-23 16. Response from Awanui Labs 04-08-23 17. Response from Dr [C] 15-12-23 18. Response from HNZ — Southern District 22-12-23

Referral instructions from HDC:	Dr [C] 1. Whether the standard of clinical information provided by [Dr C] on the relevant request forms in April 2021, May 2021, October 2021 and December 2021 was consistent with accepted practice (in particular, the April 2021 form). 2. Whether discordance between the endoscopy observation and histology reports in April 2021, or at any other time, should have resulted in a request for review of histology (via MDM or other avenue). 3. Any other comments of the late [Mrs A]'s management by [Dr C]. 4. Any recommendations regarding appropriate remedial measures.

Factual summary of clinical care provided complaint

Brief summary of clinical events:	By way of some background, you will see the complaint is made by [Mrs B] (the daughter-in-law of the late Mrs [A]) and relates to a delayed diagnosis of her gastric cancer. The diagnosis was significantly delayed by 9 months due to the earlier gastric biopsies taken in April and October 2021 being misread. It was only on 24 December 2021, on the fourth gastroscopy carried out that [Dr D] confirmed that gastric adenocarcinoma was found in that biopsy. At that point, the original three biopsies taken from April, June, and October 2021 were revisited, and it was noted that the gastric adenocarcinoma was present in the April and October 2021 biopsies. Despite being prioritised for treatment following her diagnosis in January 2022, [Mrs A] sadly passed away on 17 May 2022 (though we are unsure if this is from the cancer or other cardiac conditions). **Please note that we are not seeking advice in relation to this aspect of care.** Responses to the investigation were received from the radiologists ([Dr D], [Dr F] and [Dr G]) and Awanui Labs, who acknowledge errors in the diagnosis of the biopsies, although you will see in Awanui Labs' comments on page 1 and 2 of their response, about how vitally important the clinical information is that is provided to the pathology team with any biopsy. They state that "assessment is strongly influenced by the information provided" and that "none of the request forms from the consultants involved in sending them stated a high level of clinical concern for malignancy" and instead listed "anaemia", "gastric ulcer" and "upper GI bleeding". They also responded that "anatomical pathologists cannot perform optimally unless they have access to all relevant clinical information".

	As a result, I sought a response to this from Health NZ | Te Whatu Ora — Southern District, and they accept that pathologists operate as a wider team but state that the "underlying reason for providing a biopsy is to establish a diagnosis". A response was also received from Dr [C] (Consultant General Surgeon), who made the initial referrals, who said that "Based on [Mrs A]'s clinical response to treatment and her presumed benign biopsy findings, [he] judged that [he] wrote down the appropriate indications on the pathology forms and [he] did not have reason to refer her for review at the gastrointestinal cancer MDM meeting." In Health NZ | Te Whatu Ora Southern District's response, you will note Dr [E] (Consultant General and Renal Physician) said that the gastroscopy requests made in October and December 2021 were made by resident doctors under his supervision. He responded that he felt the referral forms contained "accurate, relevant and detailed information to the endoscopist".
Question 1: Whether the standard of clinical information provided by [Dr C] on the relevant request forms in April 2021, May 2021, October 2021 and December 2021 was consistent with accepted practice (in particular, the April 2021 form).	
List any sources of information reviewed other than the documents provided by HDC:	1. Nakhleh RE, Gephardt G, Zarbo RJ. Necessity of clinical information in surgical pathology. Arch Pathol Lab Med 1999;123(7):615–619 2. Nakhleh RE. Error reduction in surgical pathology. Arch Pathol Lab Med 2006;130:630–632 3. Nakhleh RE. Patient safety and error reduction in surgical pathology. Arch Pathol Lab Med 2008;132(2):181–185
Advisor's opinion:	Dr [C] performed a gastroscopy on [Mrs A] on three occasions: 30 April 2021, 18 June 2021, and 14 October 2021. On each occasion, the gastroscopy procedures were done in a timely fashion following the receipt of the referrals. The report of the gastroscopy done on 30 April 2021 stated: "two oozing cratered gastric ulcers were found on the lesser curvature of the stomach. Biopsies were taken with a cold forceps for histology. Two large ulcers associated with surrounding inflammation,? mass in area. Suspicious for malignancy". The plans were: "Return to my office in

	3 weeks. Perform a CT scan of chest, abdomen and pelvis with contrast". I reviewed the endoscopic photos in the report and agreed that the gastric ulcer looked suspicious for malignancy. I was not provided with the clinic letter of the follow-up visit or the CT report. The report of the gastroscopy done on 18 June 2021 stated: "Diffuse moderate inflammation characterised by congestion (oedema), erythema, friability and granularity was found in the gastric body, antrum, prepyloric region of the stomach and at the pylorus. Biopsies were taken with a cold forceps for histology. Medium amount of food (residue) was found in the gastric body". The plans were: "Return to my virtual clinic in one month. Continue current medication". A suspicion for cancer was not mentioned in this report. I reviewed the endoscopic photos in the report and did not clearly see a suspicious lesion. The report of the gastroscopy done on 14 October 2021 stated: "Large amount of food (residue) was found in the gastric body. Localised severe inflammation characterised by congestion (oedema), friability and aphthous ulceration was found in the gastric body, on the greater curvature of the stomach, on the lesser curvature of the stomach, at the incisura and in the prepyloric region of the stomach. Biopsies were taken with a cold forceps for histology". The plans were: "Return to ward, omeprazole, soft diet, no aspirin or NSAIDS, and stay off rivaroxaban". A suspicion for cancer was not mentioned in the report. I reviewed the endoscopic photos in the report and did not clearly see a suspicious lesion. I was only provided with a copy of the pathology request form for the biopsies taken on 14 October 2021, on which the clinical information stated, "Upper GI bleeding". From the available amended pathology report for the specimen taken on 30 April 2021, and from the reports to HDC by other specialists, the clinical information on the pathology request form for the biopsies taken on 30 April stated "Anaemia". According to the reports to HDC by other specialists, the clinical information on the pathology request form for the biopsies taken on 18 June 2021 stated "Gastric ulcer".

	[Mrs A] underwent a fourth gastroscopy by Dr [H] on 24 December 2021. The report stated: "A 30mm nodular area of markedly inflamed mucosa around a partially healed ulcer scar was found at the incisura. Biopsies were taken with a cold forceps for histology. This was biopsied with a cold forceps for saline for possible flow cytometry if required. Diffuse nodular mucosa was found in the gastric fundus, on the greater curvature of the stomach, and on the lesser curvature of the stomach. Biopsies were taken with a cold forceps for histology. The examination of the stomach was otherwise normal". The plans were: "omeprazole 40mg BD [twice daily] indefinitely, await pathology report". The pathology request form was not available to me for the biopsies taken on 24 December 2021, but on the pathology report, it was stated that the clinical information given were "Chronic gastritis, poorly healed ulcer. Previous H Pylori. Anaemia. 1) ? coeliac, 2) Ulcer scar, malignant, ? lymphoma, ? H Pylori, 3) Random stomach, ? lymphoma, ? H Pylori" The difficulty of diagnosing the presence of malignant cells in the April 2021 and October 2021 biopsies has been addressed by the pathologists. It has been documented in the literature that providing accurate and relevant clinical information on the pathology request forms is essential in assisting the pathologists in making the correct diagnosis. These were codified in the laboratory accreditation standards outlined by the Laboratory Accreditation Program of the College of American Pathologists and the Joint Commission on Accreditation of Healthcare Organizations Standard (1) (note, this paper was published in 1999, and I was unable to obtain the latest copies of these standards). Both standards require that each surgically removed specimen is accompanied by pertinent clinical information and, to the degree known, by the preoperative and postoperative diagnosis (1). In a study by Nakhleh et al (1), the authors examined the effects of inadequate clinical information. In this study, cases were considered to have inadequate clinical data on the requisition slip if the pathologist required additional clinical information before a

	diagnosis could be made, regardless of the amount of information already present. The study results relevant to this case include that 7.4% of endoscopic biopsy cases in which requested clinical information led to a change in diagnosis or preparation of a revised report; 7.8% of cases with biopsy procedures in which requested clinical information led to a change in diagnosis to malignant neoplasm. Articles by Nakhleh in 2006 and 2008 (2,3) identified factors that contribute to errors, with "variable input" being a known factor. There are at least two aspects of variable input that may contribute to errors, first being incorrect or improper patient identification, and second is incomplete or incorrect clinical history. In the case of [Mrs A], there appears to be inadequate clinical information on the pathology request form for the biopsy taken on 30 April 2021. In the gastroscopy report, [Dr C] stated "? Mass in the area. Suspicious for malignancy". However, on the request form, the only clinical information stated was "anaemia". For gastroscopies done on 18 June 2021 and 14 October 2021, [Dr C] did not appear to have seen a suspicious lesion (which I agree with the available documents), and the clinical information on the request form stated "Gastritis" and "Upper GI bleeding", respectively. While the information was brief, they were not considered discordant with his endoscopic findings. For the request form for the biopsies taken on 24 December 2021, it appears that [Dr H] had provided adequate information.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	In my opinion, the standard care/accepted practice, especially when a malignant diagnosis is suspected, is to highlight this suspicion to the pathologist. In addition, the request should be marked "Urgent" if malignancy is suspected. As noted previously, pathology errors can occur when inadequate information is provided to the pathologist (2,3). Inadequate information has been shown to increase the risk of incorrect diagnosis (1).

Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	In my opinion: • Standard of information on the request form on 30 April 2021 — Moderate departure • Standard of information on the request form on 18 June 2021 — Mild departure • Standard of information on the request form on 14 October 2021 — Mild departure • Standard of information on the request form on 24 December 2021 — No departure
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I did not directly consult my peers but believe that my peers would agree with my opinion.
Please outline any factors that may limit your assessment of the events.	I do not have information on the workload, and potential distractions (e.g. [Dr C] may have had to attend other emergencies) at the time of these procedures and the potential limitations when writing out the pathology request forms. I am also interested to know if the CT scan of the chest, abdomen and pelvis had been performed as suggested by [Dr C] in the report on 30 April 2021, and if it had, what the result was. It would be possible that the CT report stated that the stomach appeared normal/unremarkable, which would further cloud the clinical picture.
Recommendations for improvement that may help to prevent a similar occurrence in future.	• Education on the importance of providing pertinent clinical information on pathology request forms for medical staff at Southland Hospital • Consider attaching endoscopy reports to the pathology request forms when submitting the specimen for analysis, which I believe [Dr C] has been doing since this case • Encourage an open line of communication between the Pathology and Surgical Departments at Southland Hospital • Prompt upload of endoscopy or operative reports to a digital clinical document system to allow early access of information by relevant healthcare providers

<table>
<tr><td colspan="2">Question 2: Whether discordance between the endoscopy observation and histology reports in April 2021, or at any other time, should have resulted in a request for review of histology (via MDM or other avenue).</td></tr>
<tr><td>List any sources of information reviewed other than the documents provided by HDC:</td><td>None. I have performed an extensive literature search and have not found any publications on standard of care on discordant clinical and pathological diagnosis.</td></tr>
<tr><td>Advisor’s opinion:</td><td>As previously outlined, in the Gastroscopy Report on 30 April 2021, [Dr C] had suspected a gastric malignancy. The initial histology report had stated a benign diagnosis, which is discordant with his endoscopic impression.

In my opinion, some actions that could have been taken when there was a discordance between the endoscopic impression and the histological diagnosis are:

1. A review of histology in the Pathology MDM or a discussion with the reporting pathologist
2. An early repeat gastroscopy and biopsy
3. A second opinion from another endoscopist and/or pathologist.

[Dr C] had organised a repeat gastroscopy and biopsy on 18 June 2021, which was within the timeline that I consider appropriate, especially in view of [Mrs A] suffering a stroke after the April procedure.

There was no evidence that the case was discussed with the reporting pathologist or was referred for review at the Pathology MDM. It also appeared that a second opinion was not obtained.</td></tr>
<tr><td>What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.</td><td>1. A review of histology in the Pathology MDM or a discussion with the reporting pathologist.
2. An early repeat gastroscopy and biopsy.
3. A second opinion from another endoscopist and/or pathologist.</td></tr>
<tr><td>Was there a departure from the standard of care or accepted practice?

• No departure;
• Mild departure;
• Moderate departure; or
• Severe departure.</td><td>• Histology review — Moderate departure
• Early repeat gastroscopy and biopsy — No departure
• Obtain a second opinion — Mild departure</td></tr>
</table>

How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I did not directly consult my peers but believe that my peers would agree with my opinion.
Please outline any factors that may limit your assessment of the events.	The lack of published literature and guidelines specific to this topic has meant that there was no "scientific evidence" to support my opinion.
Recommendations for improvement that may help to prevent a similar occurrence in future.	• Encourage reviews in Pathology MDM for all discordant results. • Encourage seeking a second opinion if there is any clinical uncertainty.

Question 3: Any other comments of the late [Mrs A]'s management by [Dr C].

List any sources of information reviewed other than the documents provided by HDC:	1. Safadi Mf, Shamma H, Berger M. The visible stomach: elusive diffuse-type adenocarcinoma presents with gastric outlet obstruction. Cureus. 2022;31;14(5):e25554 2. Iyer P, Moslim M, Farma JM, et al. Diffuse gastric cancer: histologic, molecular, and genetic basis of disease. Transl Gastroenterol Hepatol. 2020;5:52 3. Drubay V, Nuytens F, Renaud F, et al. Poorly cohesive cells gastric carcinoma including signet-ring cell cancer: Updated review of definition, classification and therapeutic management. World J Gastrointest Oncol. 2022;14(8):1406–1428 4. Kaur G, Vyas M. Stomach carcinoma — diffuse type. Online article. https://www.pathologyoutlines.com/topic/stomachdiffuse.html
Advisor's opinion:	With the benefit of hindsight, it is easier to see where and how the error had occurred in this challenging case. Diffuse-type gastric cancer can be difficult to diagnose endoscopically, radiologically and histologically. Early lesions may only show some pale discolouration or even grossly normal mucosa. Histologically, the cancer cells are often single and inconspicuous, making them difficult to distinguish from normal or reactive cells (1,2,3,4). This highlights the importance of teamwork in making the diagnosis. In terms of [Dr C]'s care, I believe that [Mrs A]'s procedures were done promptly after the referrals were received. The procedures were performed by [Dr C] in a competent and safe manner, and the interpretations of the endoscopic findings were accurate in my opinion.

	[Dr C] appropriately arranged a follow-up gastroscopy after the first procedure, and this was done within the appropriate timeframe. I have no concerns about [Dr C]'s technical ability to perform endoscopy and interpret findings, and to perform appropriate biopsies. In this particular case, given the challenging nature of the diagnosis of a diffuse-type gastric cancer, an error might have been able to be prevented with a more detailed pathology request form on 30 April 2021 and by a review of histology at an MDM or with a pathologist when the histology result and the endoscopic impression were discordant.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	As above
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	As above
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I did not directly consult my peers but believe that my peers would agree with my opinion.
Please outline any factors that may limit your assessment of the events.	As above

Recommendations for improvement that may help to prevent a similar occurrence in future.	As above

Name: Dr Linus Wu

Date of Advice: 3 April 2025'

Further independent clinical advice to Health and Disability Commissioner

'Complaint:	**[Mrs A] (dec) | Dr [C]**
Our ref:	**22HDC00068**
Independent advisor:	**Dr Linus Wu**

I have been asked to provide clinical advice to HDC on case number 22HDC00068. I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:	My qualifications are Bachelor of Medicine, Bachelor of Surgery (MBChB, University of Auckland, 2001) and Fellow of Australasian College of Surgeons (FRACS, 2010). I am a Consultant General and Colorectal Surgeon and Endoscopist at Waikato Hospital.
Documents provided by HDC:	1. Letter of complaint dated 10 January 2022 and attached letter from the then Southern DHB dated 06 January 2022 2. Gastroscopy Request April 2021 3. Consult request (internal) and Gastroscopy Request May 2021 4. Gastroscopy Request October 2021 and Hospital Lab Request Oct 21 5. Gastroscopy Request December 2021 6. Gastroscopy Report April 2021 7. Gastroscopy Report June 2021 8. Gastroscopy Report October 2021 9. Gastroscopy Report December 2021 10. Amended Pathology report April (amended 30-05-22) 11. Supplementary reported Pathology report Dec (26-01-22)

	12. Pathology report June 13. Response from [Dr D] 02-08-23 14. Response from [Dr G] 02-08-23 15. Response from [Dr F] 02-08-23 16. Response from Awanui Labs 04-08-23 17. Response from Dr [C] 15-12-23 18. Response from HNZ – Southern District 22-12-23 **19. Response from Dr [C] 24-7-23**
Referral instructions from HDC:	Dr [C] 5. Whether the standard of clinical information provided by [Dr C] on the relevant request forms in April 2021, May 2021, October 2021 and December 2021 was consistent with accepted practice (in particular, the April 2021 form); 6. Whether discordance between the endoscopy observation and histology reports in April 2021, or at any other time, should have resulted in a request for review of histology (via MDM or other avenue). 7. Any other comments of the late [Mrs A]'s management by [Dr C]. 8. Any recommendations regarding appropriate remedial measures.

Factual summary of clinical care provided complaint:

Brief summary of clinical events:	By way of some background, you will see the complaint is made by [Mrs B] (the daughter-in-law of the late Mrs [A]) and relates to a delayed diagnosis of her gastric cancer. The diagnosis was significantly delayed by 9 months due to the earlier gastric biopsies taken in April and October 2021 being misread. It was only on 24 December 2021, on the fourth gastroscopy carried out that [Dr D] confirmed that gastric adenocarcinoma was found in that biopsy. At that point the original three biopsies taken from April, June and October 2021 were revisited and it was noted that the gastric adenocarcinoma was present in the April and October 2021 biopsies. Despite being prioritised for treatment following her diagnosis in January 2022, [Mrs A] sadly passed away on 17 May 2022 (though we are unsure if this is from the cancer or other cardiac conditions). **Please note that we are not seeking advice in relation to this aspect of care.** Responses to the investigation were received from the radiologists ([Dr D], [Dr F] and [Dr G]) and Awanui Labs, who acknowledge errors in the diagnosis of the biopsies, although you will see in Awanui Labs' comments on page 1 and 2 of their response, about how vitally important the clinical information is that is provided to the pathology team with any biopsy. They

	state that "assessment is strongly influenced by the information provided" and that "none of the request forms from the consultants involved in sending them stated a high level of clinical concern for malignancy" and instead listed "anaemia", "gastric ulcer" and "upper GI bleeding". They also responded that "anatomical pathologists cannot perform optimally unless they have access to all relevant clinical information". As a result, I sought a response to this from Health NZ | Te Whatu Ora — Southern District, and they accept that pathologists operate as a wider team but state that the "underlying reason for providing a biopsy is to establish a diagnosis". A response was also received from Dr [C] (Consultant General Surgeon), who made the initial referrals, who said that "Based on [Mrs A]'s clinical response to treatment and her presumed benign biopsy findings, [he] judged that [he] wrote down the appropriate indications on the pathology forms and [he] did not have reason to refer her for review at the gastrointestinal cancer MDM meeting." In Health NZ | Te Whatu Ora Southern District's response, you will note Dr [E] (Consultant General and Renal Physician) said that the gastroscopy requests made in October and December 2021 were made by resident doctors under his supervision. He responded that he felt the referral forms contained "accurate, relevant and detailed information to the endoscopist".

Question 1: Whether the standard of clinical information provided by [Dr C] on the relevant request forms in April 2021, May 2021, October 2021 and December 2021 was consistent with accepted practice (in particular, the April 2021 form).	
List any sources of information reviewed other than the documents provided by HDC:	Nil further
Advisor's opinion:	I received the response from [Dr C] dated 24 July 2023 to […] regarding the case, and the below is my opinion in addition to my previous submission. The only significant additional information in this letter dated 24 July 2023 was that the CT scan performed on [Mrs A] after her first endoscopy on 30 April 2021 "did not demonstrate evidence of a mass in her stomach. Specifically, there was diffuse wall thickening in the gastric fundus/cardia and in the

	lower body. There was also no evidence of enlarged regional lymph nodes, a single node at the greater curvature and a few periportal lymph nodes were slightly enlarged but not considered pathological, and there was no lymphadenopathy elsewhere. There was no evidence of metastatic disease". In my opinion, the report of the CT scan, as well as the histology report showing no evidence of malignancy, would have reassured [Dr C] that the changes in the stomach were most likely secondary to benign conditions such as benign gastric ulcers or gastritis. As previously discussed, diffuse-type gastric cancer can pose a diagnostic challenge. I still maintain that this highlights the importance for all health professionals, including the endoscopists, pathologists, and the radiologists, to work as a team and overcome the difficulty. This would involve providing comprehensive clinical details on the pathology and radiology request forms, and a forum where discordant results can be reviewed. The letter from [Dr C] on 24 July 2023 had added some further details around the clinical management of [Mrs A]'s case. It is still my opinion that [Mrs A]'s procedures were done promptly after the referrals were received. The procedures were performed by [Dr C] in a competent and safe manner, and the interpretations of the endoscopic findings were accurate. Follow-up appointments were organised in a timely fashion, and there were no concerns about [Dr C]'s technical ability to perform endoscopy and interpret findings, and to perform appropriate biopsies.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	No change
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure;	No change

• Moderate departure; or • Severe departure.	
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	No change
Please outline any factors that may limit your assessment of the events.	No change
Recommendations for improvement that may help to prevent a similar occurrence in future.	No change
Question 2: Whether discordance between the endoscopy observation and histology reports in April 2021, or at any other time, should have resulted in a request for review of histology (via MDM or other avenue).	
List any sources of information reviewed other than the documents provided by HDC:	No change
Advisor's opinion:	No change
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	No change
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	No change
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	No change

Please outline any factors that may limit your assessment of the events.	No change
Recommendations for improvement that may help to prevent a similar occurrence in future.	No change
Question 3: Any other comments of the late [Mrs A]'s management by [Dr C].	
List any sources of information reviewed other than the documents provided by HDC:	No change
Advisor's opinion:	No change
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	No change
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	No change
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	No change
Please outline any factors that may limit your assessment of the events.	No change
Recommendations for improvement that may help to	No change

prevent a similar occurrence in future.	
Name: Dr Linus Wu Date of Advice: 3 May 2025'	

Further advice from Dr Wu

'**From:** Linus Wu

Sent: Monday, 7 July 2025, 10:04 pm
To: […]
Cc: […]
Subject: Re: Private and Confidential | 22HDC00068 [Mrs A] (dec)

Dear […] (and […])

Thank you for your email and [Dr C]'s response dated 14 May 2025.

In response to the below questions:

1. Whether [Dr C]'s comments change any aspects of your initial advice.

- It was my opinion that there was a moderate departure from the expected standard of care with respect to the care that [Dr C] provided, in particular, the histology request form of 30/4/21 only mentioned "anemia", not the suspicion of malignancy.

- [Dr C] explained in his response on 14 May 2025, that "as part of routine general surgery practice, general surgeons perform procedures for what would initially appear to be benign conditions only to find out after pathology review that there was an underlying malignancy present". Examples of these were given, such as "removal of colon polyps, cholecystectomy, appendicectomy, haemorrhoidectomy, and excision of skin lesions". [Dr C] explained that "routinely, general surgeons will not expand on the clinical information provided on the pathology requisition forms".

- I agree with his statements above. It occurs occasionally that a specimen removed from a procedure such as appendicectomy for appendicitis can have unexpected cancer in it.

- However, my comment regarding his request form on 30 April 2021, was that [Dr C] suspected a malignancy clinically (ie, from the endoscopic features of the gastric ulcers), and commented as such in the report, and requested a staging CT scan appropriately as part of the workup. This suspicion was not relayed to the pathologist on the request form.

  - This is "the other way around" from what he described.

- As presented in my initial advice, Mrs [A]'s type of gastric cancer can be very difficult to diagnose endoscopically, radiologically and histologically. I believe that, had the request form mentioned "gastric cancer" (as [Dr C] had suspected at the time of the gastroscopy on 30 April 2021), it might have prompted the pathologist to examine the specimen more closely and been able to identify the single cancer cell that was present.

- I therefore have not changed my opinion.

2. Whether there are any other matters in this case that you consider warrant comment; and

- I would like to commend [Dr C] for the changes that he has made, including [becoming] more liberal in seeking second opinions in complex cases, and for providing endoscopy reports with the pathology request forms.

3. Whether there are any recommendations that you can think of for future improvements for [Dr C].

- I do not have any further recommendations.

Kind Regards

Linus Wu'