Change in cancer staging
15HDC01370, 8 June 2018

Gynaecologist ~ Oncologist ~ Women's clinic ~
Multidisciplinary meeting ~ Cancer ~ Rights 4(5), 6(1)

A woman had surgery carried out by a gynaecologist after a CT scan showed a large ovarian tumour. Histology and cytology results were reported by a pathologist and the report described the ovarian tumour as a "papillary serous carcinoma [an aggressive cancer] of mullerian origin with moderate to high grade features". It also stated "Sections of the deposits on serosa [on the uterus] and nodule on right ovary show high grade tumour similar to tumour in specimen 2 [the left ovary]."

The results were discussed at a multidisciplinary meeting (MDM) at a women's clinic (the clinic) a week after surgery, but the tumour was not staged. The gynaecologist and an oncologist were part of the group present at the MDM. After the MDM the pathologist reviewed the remainder of the histology slides and found evidence to confirm that there was some tumour on the serosa of the uterus. He asked for a further MDM to be convened to review the woman's case for the purpose of staging the tumour. He sent a copy of his report with his findings to the gynaecologist.

Prior to any further MDM, the woman had a follow-up appointment with the gynaecologist, who told her that her cancer had been graded as Stage 1 C 3 high grade serous carcinoma of the ovary and fallopian tube. The gynaecologist told the woman that she would require a course of six cycles of chemotherapy, and referred her to the oncologist at a cancer clinic. The gynaecologist's letter refers to Stage 1 C 3 high grade serous carcinoma of the ovary or tube. A copy of all the histology results and the operation note were also provided to the oncologist.

The woman had her initial consultation with the oncologist. The oncologist said that a Stage 1 C 3 tumour can be treated with three to six cycles of chemotherapy, and because of her understanding that the woman's cancer was predominantly low grade in nature, she recommended that they "stop at 3 cycles" of chemotherapy.

The woman had misgivings about having only three cycles of chemotherapy. The oncologist told HDC that she was unaware that the woman had such concerns.

The second MDM then took place. No formal notification was provided to the oncologist advising that the woman, specifically, was to be discussed at the MDM. At this MDM the woman's tumour was staged. The gynaecologist was present at the MDM, but the oncologist was not. The woman's cancer was classified as being Stage 2 C 3 serous carcinoma.

The MDM report was sent to the oncologist at the cancer clinic. The report sent made no reference to the fact that the gynaecologist had previously told the woman and the oncologist that the cancer was Stage 1 C 3 and that there had now been a change in staging. The oncologist did not receive any further communication from the gynaecologist about the second MDM and its outcome.

The oncologist said that she recalls receiving this MDM report for review, but because it had been scanned in with another patient's details attached, she organised for the administrative support team to remove the other patient's details. She expected that the

report would come back to her in due course, but it did not due to an administrative error. The oncologist also said that she thought the document related to the original MDM.

Neither the woman nor her GP were notified at this time that the woman's carcinoma had been classified as Stage 2 C 3 serous carcinoma. After these events, the gynaecologist told the woman that he had assumed that the oncologist knew, and he therefore assumed that she had told the woman.

The woman went on to have three cycles of chemotherapy. Following each appointment with the woman during treatment, when writing to the gynaecologist to provide an update on the woman's care, the oncologist referred to "Diagnosis: Stage 1 C 3 high grade serous carcinoma of the ovary".

In 2015, the gynaecologist referred the woman to the district health board's (DHB's) Gynaecology Oncology Services for monitoring. The referral letter mistakenly stated the woman's staging as Stage 1 C 3 high grade serous carcinoma. A few months later, the woman had her first appointment for follow-up. Her appointment was with the gynaecologist in his capacity as a consultant for the DHB's Gynaecology Oncology team.

The gynaecologist provided the woman with a blood test form to check her serum CA 125 (cancer marker) levels. The result showed a level of 43 (above the normal range). The woman was not told the result of this test.

A few months following, the woman went to her GP with discomfort in her right chest. Further tests were taken and the woman was found to have incurable cancer.

Findings

It was found that by failing to take steps to ensure that the oncologist was advised specifically of the change in the staging of the cancer and, having not done so, failing to notice that she continued to refer to the cancer stage as 1 C 3, and then referring to the incorrect stage himself in his referral letter to the DHB, the gynaecologist failed to co-operate with the oncologist and the DHB to ensure the quality and continuity of the services provided to the woman. Accordingly, he was found to have breached Right 4(5). In addition, for failing to advise the woman of the upgraded cancer stage, or to take appropriate steps to make sure that information would be communicated to her by someone else, and by failing to provide the woman with the result of her tumour marker test and the significance of that, the gynaecologist was found to have breached Right 6(1).

It was found that by failing to communicate effectively with the oncologist, as the woman's treating clinician, including failing to advise her in advance of the MDM that the woman specifically was to be discussed again (and the reasons for this) and, in these circumstances, for failing to advise the oncologist specifically of key clinical information arising out of that MDM, the company that owns the women's clinic breached Right 4(5).

Adverse comment was made in relation to the oncologist for not identifying the discrepancy between the stage she was advised of and the pathology information, and for not further pursuing the report she received following the second MDM after asking for the other patient's details to be removed. Other comment was made about the importance of clear and open communication with consumers.

Adverse comment was also made of the cancer clinic for the administrative error which meant that the MDM report from the second MDM was not sent back to the oncologist after she asked for the other patient's details to be removed.

Recommendations
It was recommended that the company that owns the women's clinic significantly review its MDM process. As recommended, the women's clinic provided the woman with a written letter of apology.

It was recommended that the gynaecologist provide the woman with a written letter of apology, and that the Medical Council of New Zealand consider whether a review of the gynaecologist's competence was required. It was also recommended that the DHB consider reviewing its protocols and procedures in relation to the treatment and follow-up of cancer patients who are transitioning between the private and public sector.