Gastrointestinal and Colorectal Surgeon, Dr B

A Report by the

Health and Disability Commissioner

(Case 01HDC01057)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer / Complainant
Dr B	Gastrointestinal Surgeon / Provider
Dr C	Gastroenterology Surgeon
Dr D	Consumer's General Practitioner
Dr E	Colorectal Surgeon
Dr F	Pathologist
Professor G	Expert
Professor H	Surgeon

Complaint

On 26 January 2001 the Commissioner received a complaint from Mrs A about the services provided to her by Dr B, a gastrointestinal and colorectal surgeon. The complaint was summarised as follows:

Dr B, general surgeon, did not provide appropriate health services to Mrs A. In particular, Dr B:

First operation

- *cut Mrs A's anus and rectum during a surgical operation in June 1999 to remove her diseased colon*
- *did not inform her of the risks of having her anus and rectum cut prior to the operation*
- *informed her that he had not cut her anus and rectum*
- *admitted to her, after the first operation, that he had suggested to the laboratory that she had Crohn's disease. When Mrs A contacted the laboratory she was told that she did not have any signs of Crohn's disease.*

Second operation

- *cut Mrs A's vagina during a second surgical operation in November 1999 to construct a J-pouch*
- *did not inform her of the risks of having her vagina cut prior to the operation*
- *did not inform her that he had cut her vagina*
- *did not take her concerns seriously after the second operation. In particular, Dr B*:
  - *did not adequately investigate the symptoms she described to him, such as pain and the repeated discharge of menstrual blood through her anus, which was later determined to be due to an anal/vaginal fistula;*
  - *told her that she did not need to have a scan to investigate whether she had an anal/vaginal fistula when she requested one for this purpose on the advice of her general practitioner.*

After clarifying the issues with Mrs A, an investigation was commenced on 12 September 2001. On 29 April 2002 the investigation was extended to include the private hospital where the surgery was performed.

Information reviewed

- Dr B's medical records for Mrs A
- Relevant medical records from the private hospital
- Dr D's medical records for Mrs A
- Relevant records from ACC

Independent expert advice was obtained from Dr Eva Jahusz, a colorectal surgeon.

Overview

Mrs A had suffered from ulcerative colitis for 27 years when Dr B performed surgery to remove her colon and rectum and created an ileostomy. Four months later a second operation was performed to create a J-pouch and a second ileostomy at the site of the first ileostomy. Postoperatively Mrs A developed an anal-vaginal fistula, which required corrective surgery. This surgery was not performed by Dr B. Mrs A submitted a claim to the Medical Misadventure Unit of ACC in respect of the second operation performed by Dr B. Her claim was declined.

Information gathered during investigation

Background
Mrs A began consulting Dr C, a gastroenterologist physician, for control of her ulcerative colitis. Under Dr C's care, Mrs A had periodic biopsies to check for the presence of cancer, and was regularly prescribed steroids to control her colitis symptoms. Dr C referred Mrs A to Dr B in 1995 for treatment of an anal fissure. Over the next few years Dr B performed a number of operations to repair anal fistulas. Dr C informed Mrs A that her ulcerative colitis could get progressively worse and turn to cancer, and he discussed surgical options with her.

In February 1999, Dr C requested Dr B to admit Mrs A to the private hospital after she had a severe exacerbation of her colitis. Dr B informed Dr C, by letter dated 23 February 1999, that Mrs A was "keen to pursue a surgical resolution". He discussed with her "the ileal-anal pouch procedure" but recommended waiting until Mrs A had discontinued her steroid

treatment. Dr B also confirmed that he agreed with Dr C's view that as Mrs A "has now had ulcerative colitis for so long, the risk of developing cancer is becoming of concern which leads one towards definite surgery at this stage".

Mrs A saw Dr B again in March accompanied by [Mrs A's husband], to discuss the possibility of "a restorative proctocolectomy[1] with ileal-pouch[2]". Dr B informed Dr C, by letter dated 22 March 1999:

> "[Mrs B's] husband came with her on this visit to discuss the possibility of a restorative procto-colectomy with ileal pouch.
>
> I think for [Mrs A] there are now many advantages for surgery. Firstly, over the last few years [Mrs A] has had difficulty staying off steroids and seems to be taking them every few months. Also, having had pan-colitis for 24 years, her subsequent risk of developing bowel cancer starts to become very high and therefore it could seem a good time to go ahead with surgery. [Mrs A] is certainly in agreement with this, but her husband is shortly due to go back [overseas] until late May, so [Mrs A] will contact me closer to the time when she would like to proceed."

The letter was copied to Mrs A's general practitioner, Dr D, and it was arranged to perform the surgery on 14 June 1999.

Dr B informed me that it was his intention to perform a restorative proctocolectomy pouch procedure where the small bowel is joined to the anus with an ileal pouch. However, owing to Mrs A developing anal sepsis (infection) and an anal fistula, the surgery was not possible. Mrs A was at risk of developing further infection and, therefore, the ileal pouch could not be formed at that time. Dr B therefore planned to remove the colon and rectum only and to create an ileostomy.[3] He informed Dr D by letter dated 19 May that Mrs A "will also need a temporary stoma[4] at the time of surgery" and he organised a stoma therapist to visit Mrs A at home prior to surgery.

Mrs A wanted to speak to someone who had undergone the operation. Dr B arranged for her to speak to a gentleman who had had similar surgery performed by Dr E, a colorectal and general surgeon.

Dr B then deferred the intended operation owing to Mrs A's low iron levels and elevated inflammatory markers. Dr B informed Dr D, by letter dated 10 June 1999, that the surgery had been re-booked for early July. He commenced Mrs A on intramuscular injections of iron as she could not tolerate oral iron.

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[1] Removal of colon and rectum.
[2] A pouch is formed with tissue from the ileum (small bowel) to collect and hold faecal matter. The pouch is anastomosed to the anus.
[3] Surgical opening of the small bowel onto the skin via a stoma to maintain faecal continence. A sealed bag is attached to the stoma to collect the faeces.
[4] A temporary stoma can be surgically removed and the bowel tissue rejoined once the wounds from the initial surgery have healed, usually after six weeks minimum.

Mrs A saw Dr B on 21 July after she developed perineal pain and discharge from an abscess adjacent to her anal canal. In his letter dated 21 June 1999 to Dr D, Dr B advised that the "present plan for surgery was an ileal-pouch and anal anastomosis would be unwise at this stage as it is likely to break down. Unfortunately, I would not be confident to do any restorative procedure in this area for some time, although if it completely healed the pouch procedure, in the future would be possible." Dr B also advised that "we should proceed to removing the colon and most of the rectum with a permanent stoma but leaving the option to reconnect at a later date. Understandably, this is a significant set-back for [Mrs A] psychologically as she had her heart set on avoidance of the stoma."

Mrs A informed my staff that she knew "it was critical to keep my anus and rectum intact. These were not diseased. I knew that if the rectum got cut, there would not be enough to reconstruct. [My husband] and I were very insistent that my rectum was not to be cut. I knew that if these were cut, the bowel could not be reconstructed."

First operation
On 12 July 1999, at the private hospital, Dr B performed a pan-proctocolectomy and ileostomy with preservation of the anal sphincter. Dr B reported in his operation note that the appearance of Mrs A's colon was "more consistent with Crohn's disease". The removed bowel and rectum were sent to a medical lab, which reported "large intestine − Crohn's disease".

Mrs A said that Dr B informed her that her disease had gone and, in response to a question from her husband, said that her rectum and anus were "all right". Mrs A states that she would never have agreed to the operation if she had known that she would have a bag on her stomach. It was abhorrent to Mrs A, and Dr B knew that. However, Mrs A knew and understood that she would have to have the bag for six weeks before reconstruction, and then for another six weeks after that.

Crohn's disease
Dr B was surprised that the appearance of Mrs A's colon suggested the presence of Crohn's disease and asked the pathologists to collectively review the bowel that had been removed. As there was no consensus of opinion, Dr B asked for the slides taken from the colon specimen to be sent to a colleague at a hospital overseas.

Dr F, a pathologist who had previously reviewed Mrs A's biopsies, advised me that the diagnosis by the medical lab of Crohn's disease was inconsistent with previous reports of ulcerative colitis taken from biopsy specimens. She wrote to Professor G of an overseas hospital for an expert opinion. Professor G informed the pathologist, in his letter dated 10 September 1999, that the findings were "consistent with ulcerative colitis". Professor G did not believe that the information shown was indicative of Crohn's disease and wrote that "this is a fulminant ulcerative colitis rather than Crohn's disease and should not represent a contra-indication to ileal-anal pouch surgery".

Dr B informed me that the possibility of Crohn's disease meant that it was unwise to rejoin Mrs A's bowel to the anus owing to the markedly increased risk of infection and complications that can be associated with the disease. Mrs A was very disappointed that

the stoma might need to be permanent. However, the report by Professor G confirmed that Mrs A had ulcerative colitis and she told Dr B that she wanted a reversal of the ileostomy as soon as possible.

Dr B advised me that he discussed the next intended surgery with Mrs A in depth, including the necessity of a new temporary ileostomy. The reason for the new ileostomy was the high risk of pelvic infection. In Dr B's view, Mrs A consented to the additional procedure of a temporary ileostomy and was fully informed of the risks, including the possibility of pelvic sepsis.

Dr B informed Dr D in his letter dated 4 October 1999:

> "… [T]here is no hold-up in proceeding to the next step. Therefore I will organise for her to come in shortly for an ileal pouch, although this will need to be covered with a temporary loop ilestomy which I would usually close after a further six weeks."

Second operation
On 1 November 1999, Dr B performed a restorative proctocolectomy and formation of an ileostomy. During the surgery, a J-pouch was fashioned. The operation notes record that there was an excellent pouch-anal anastomosis. A pelvic drain was inserted and Mrs A was prescribed antibiotics. In Dr B's view, the surgery was uncomplicated although it was a long procedure. He recalled that he paid particular attention to avoid damaging the vagina and therefore a hand-sown anastomosis of the pouch to the anus was performed. Mrs A recovered from her surgery and was discharged home.

When Mrs A saw Dr B at a postoperative consultation on 1 December, she had developed a small abscess associated with the pouch-anal anastomosis. The abscess had drained through the anastomosis to the anus. Dr B explained to Mrs A what had happened and drew four sketches for her to illustrate the situation. Dr B decided that as the abscess had drained, the best strategy was to allow the inflammation to settle. He was concerned that she might develop a vaginal fistula and arranged to review her after two weeks.

After the operation, Mrs A had her period and started bleeding from her anus. She made an appointment to see Dr B. He examined her and explained that the wound had not healed. Dr B drew a picture and informed her that there was a pocket of inflammation that had not healed and that they would have to wait until the New Year "for mother nature to do its deed".

Mrs A subsequently saw her general practitioner, Dr D, who told her that she had a fistula and that she must insist on having a scan when she saw Dr B. Dr D recorded in her notes that Mrs A had pustula discharge from her vagina and she questioned whether Mrs A had an abscess or fistula.

Dr B saw Mrs A again on 15 December. He observed that the pouch-vaginal infection had resolved and that Mrs A had recovered well physically from the surgery. There was no residual abscess cavity, but it was clear to Dr B that Mrs A had developed a pouch-vaginal fistula. He informed Mrs A that the correct strategy was to let all inflammation settle

before attempting a local repair of the fistula. He asked Mrs A to make a follow-up appointment early in the New Year.

Early in January 2000, Mrs A had another period and more bleeding from her anus. She consulted Dr E (who had performed similar surgery on the gentleman Mrs A spoke to before her surgery in July 1999) who suggested that she might have a surgical fistula. Mrs A then consulted Professor H, who ordered a series of tests and confirmed that she had a fistula. Mrs A required a number of operations to repair the fistula. The operations were performed by Dr E. Her ileostomy was closed in June 2000 by Dr E.

ACC

In December 2000 Mrs A submitted a claim to the Medical Misadventure Unit of ACC about the surgery performed by Dr B. ACC obtained independent expert advice from a general and endoscopic surgeon. The expert advised ACC:

> "Pouch surgery is notorious for its potential for septic complications. The presence of inflammatory bowel disease is a significant risk factor for sepsis and if the problem is Crohn's disease then this is a contraindication for pouch formation."

ACC declined Mrs A's claim. Mrs A requested a review of ACC's decision. Her solicitor sought information from Dr E, who advised as follows:

> "… [I]f there is doubt about the histological diagnosis and a colectomy is required for deteriorating colitis, it is standard practice to leave the rectum undisturbed so that if subsequent pouch surgery is feasible, the pelvis has been undisturbed and the surgery to place a colonic pouch onto the anal canal is significantly easier.
>
> I note at [Dr B's] first operation the rectal dissection was taken down towards the top end of the anal canal and there may be reasons for this of which I am not aware, in particular, there may have been very significant proctitis which necessitated removing the rectum at the first operation."

Mrs A later withdrew her request for a review of ACC's decision.

Independent advice to Commissioner

The following expert advice was obtained from Dr Eva Juhasz, a colorectal surgeon:

"Completed a Fellowship of the Royal Australasian College of Surgeons 1991 with subsequent training in colon and rectal surgery at the Mayo Clinic, Rochester, USA. Subsequent to returning to New Zealand in 1993 my practice has been predominantly colorectal. Currently I work in a colorectal unit at North Shore Hospital with a large volume of major surgical cases including ileal pouch anal anastomosis.

I have previously published a chapter entitled 'Surgery in Ulcerative Colitis' published in Surgery of the Colon, Rectum & Anus, 1994: Mazier P. AL, published by WB Saunders Co.

Documents used to provide report

My subsequent report has been based on the information provided to me by the Health & Disability Commissioner, namely:–

1. Letter dated 17 January 2001 to the Commissioner from [Mrs A], received 26 January 2001, marked 'A' (3 pages).

2. Transcript of interview with [Mrs A] on 12 April 2001 and HDC Investigation Officer, marked 'B'.

3. Clinical records provided by [Dr B] to [Mrs A's] solicitor, marked 'C' (55 pages).

4. Letter dated 18 May 2002 to the Commissioner from [Dr B], with accompanying documentation, marked 'D' (4 pages).

5. Letter dated 14 April 2003 to HDC Legal Advisor from [Dr B], marked 'E' (3 pages).

6. Letter dated 28 March 2003 to HDC Legal Advisor from [Dr …], and accompanying laboratory reports, marked 'F' (5 pages).

7. Letter dated 17 March 2003 to HDC Legal Advisor from [Dr F], and accompanying documentation, marked 'G' (6 pages).

8. Letter dated 3 February 2002 from [Dr E] concerning [Professor H's] examination of [Mrs A] under anaesthesia, marked 'H'.

9. Report of Pouchogram dated 27 January 2002, marked 'I'.

10. Report by [Professor H] dated 27 January 2000, marked 'J'.

11. [Dr E's] correspondence to [Mrs A's] GP concerning the surgery he performed and relevant operation notes, marked 'K' (24 pages).

12. Letter dated 10 April 2001 from [Dr …] to the Advisory Officer at ACC, marked 'L' (2 pages).

My report has been based on what I can determine as being the facts of the case.

I have responded to the specific issues raised by [Mrs A] as well as to the questions raised by the Commissioner.

I have included a list of references at the conclusion of the report which I have used to assist me in preparation of this report.

Summary of Clinical Events

[Mrs A] had a history of longstanding colitis going back for many years, probably as many as 25 to 30 years. She was originally seen by [Dr B] in January 1995 with severe anal pain and an acute fissure. On 5 January l995 she underwent EUA and lateral internal sphincerotomy. In 1996 she was seen with an anal abscess which was initially drained at [a public hospital] and she subsequently had a further operation for a perianal fistula in August 1996. In February 1999 [Dr C] referred [Mrs A] urgently to [Dr B] as she had quite severe unresponsive ulcerative colitis and was very unwell.

At this time she had been on oral steroid medication with little improvement and was very unwell. Her weight was low and I note that at this time she had not been menstruating for two years. She was admitted to hospital for intravenous steroids and after remission was achieved, was discharged home on oral steroids and olsalazine.

Prior to undergoing her major surgery to remove the colon she developed perianal sepsis and a further fistula requiring a delay in her surgery.

On 12 July 1999 [Mrs A] underwent an abdominal proctocolectomy with ileostomy. Her postoperative recovery was uncomplicated. She was discharged from hospital after 12 days.

Following this, the colon was examined by the pathologist and the diagnosis of Crohn's disease was made. This was consistent with the history of perianal sepsis, however following further consultation with pathologists overseas the diagnosis was changed to fulminant ulcerative colitis. At this time I understand there was still some perianal sepsis present and subsequent surgery was deferred in order to allow this to heal.

Following her reviews with [Dr B], [Mrs A's] surgery was deferred until 1 November 1999 when she underwent ileal pouch anal anastomosis (IPAA) and formation of ileostomy. Because the rectum had previously been excised the dissection was difficult and a hand-sewn technique was used to suture the pouch down to the anal canal. Her recovery subsequent to the surgery appeared to be straightforward and she was discharged home after 8 days. [Mrs A] was somewhat distressed about the degree of pain that she experienced following this surgery, and I understand this was due to an epidural not functioning properly.

It was following this second operation that [Mrs A] noted her menstruation re-commencing and passing blood through the anal canal. She had several visits with [Dr B]. Her last visit with [Dr B] was on 15 December 1999 at which time it was clear that a pouch-vaginal fistula had developed. [Dr B] planned to let the inflammation settle before attempting a repair. Following this, I note that most of the contact was by phone. [Mrs A] at this point obtained further opinion from [Dr E] and [Professor H] with regard to what appeared to be a pouch vaginal fistula. Examination under anaesthetic and pouchogram confirmed a pouch vaginal fistula. She was advised that she would require surgery for this. She decided to have further treatment by [Dr E]. Subsequently, she had a number of operations by [Dr E], eventually having a gracilis flap transposed to the fistula site. Following this she had her ileostomy closed in June 2000. She had further perianal fistulae and has required further surgery for this.

Subsequent to ileostomy closure she had several further perianal fistulas dealt with surgically. She also underwent a laparotomy for a small bowel perforation, thought to be on the basis of non-steriodal anti-inflammatory tablet ingestion.

She was last seen by [Dr E] in November 2001 at which time the fistulae were no longer a problem and she had good pouch function. As far as I am aware she has not required further surgical intervention.

Response to questions from the Health & Disability Commissioner and general comments

Expert Opinion in response to questions raised by [Mrs A]

Complaint: First Operation

1. *That [Dr B] lacerated [Mrs A's] anus and rectum during an operation in l999 to remove her diseased colon.*

[Dr B] removed her rectum during this surgery but left the anus intact. This was the intended operation for her as she had quite significant perianal sepsis and [Dr B] felt that the rectum required removal in order to help resolve the infection around the anus as outlined in his letter to [Dr D] on 21 June 1999.

2. *That [Dr B] did not inform [Mrs A] of the risks of laceration prior to surgery.*

[Mrs A] had a large number of clinic visits with [Dr B] totalling in excess of thirty over the years. Several of these visits were specifically to discuss the surgical aspects of her treatment. Having read [Dr B's] letters to the GP and a note at the time of these visits, it appears that he fully discussed various aspects of her surgery prior to undertaking it.

3. *That [Dr B] incorrectly informed [Mrs A] that he had not removed her anus and rectum.*

[Dr B] did in fact remove the rectum but not the anus. On reviewing his operation notes and clinic letters it appears that he removed the rectum as mentioned previously

because of the perianal infection and that this did not preclude further surgery in terms of a reconstructive J-pouch. It appears that there may have been some misunderstanding between [Dr B] and [Mrs A] with regard to the planned surgery. [Dr B] correctly informed [Mrs A] that he had not removed her anus.

4. *That [Dr B] admitted to her, after the first operation, that he had suggested to a laboratory that she has Crohn's disease. When she contacted the laboratory she was told that she did not have any signs of Crohn's disease.*

I think that [Mrs A] had been discussing a totally different set of biopsies, i.e. the biopsies that had been taken at previous colonoscopies. When [Dr B] submitted the colon specimen from the surgery he would have provided detailed clinical information about her condition. This would have included information about her perianal disease which is very strongly suggestive of Crohn's disease. In this way he provided information to the laboratory that clinically suggested Crohn's disease but that he would not have deliberately misled the laboratory with this regard. It is very important for the pathologist to have all the clinical information as this allows the pathologist to interpret the information in the correct clinical context. There was no subversive intent in providing this information to the laboratory. When [Mrs A] contacted the laboratory it is not clear with whom she discussed the biopsies but they may have been referring to the previous biopsies taken at previous colonoscopy which did not suggest any evidence of Crohn's disease.

Complaint – Second Operation

1. *That [Dr B] lacerated [Mrs A's] vagina during the surgical operation in November 1999, to construct a J-pouch.*

It may be that [Mrs A's] vagina was damaged during the surgery, however, it is also possible that as a result of pelvic infection the pelvic abscess may have contributed to the creation of the fistula. It is not possible to tell in retrospect whether there was a direct injury or whether infection has caused the fistula.

2. *That [Dr B] did not inform her of the postoperative risks, in particular, the possibility of a vaginal laceration.*

[Dr B] had a number of discussions with [Mrs A] and did discuss the risks of pelvic sepsis as documented in his letters.

3. *That [Dr B] failed to advise her that he had lacerated her vagina.*

If the vagina had been inadvertently lacerated during the surgery, it may not have been evident. [Dr B] may not have been aware that this had occurred. The fistula may not have been due to laceration of her vagina but due to infection and subsequent fistula formation.

4. *That [Dr B] did not take her concerns seriously after the second operation. In particular, [Dr B]:*

   - *did not adequately investigate the symptoms she described to him, such as pain and the repeat discharge of menstrual blood through her anus, which was later determined to be an anal-vaginal fistula.*

   - *Told her that she did not need to have a scan to investigate an anal-vaginal fistula when she requested one for this purpose on the advice of her general practitioner.*

[Dr B] did not proceed to investigate the symptoms, and initially put this down to bleeding from the surgical site in the bowel. It is not uncommon for patients to have some bleeding within the bowel after the surgery and this is passed as bowel motions containing blood. The repeated nature of this discharge of menstrual blood should have alerted him to the possibility that the pouch vaginal fistula was quite large and causing leakage of menstrual blood through the pouch to occur. After three menstrual cycles it appeared that he agreed with this occurrence and was planning on proceeding to further investigation and treatment. [Mrs A] did not see him again after 15 December 1999 (i.e. six weeks after surgery), therefore he did not have the opportunity to follow through with further treatment.

The issue of a scan to investigate an anal-vaginal fistula is one that the general practitioner raised. A scan does not necessarily show any fistula present, and is not in fact the best investigation. A better radiological investigation would be to do a pouchogram or an MRI study. [Dr B] was quite correct in that she did not need to have a scan to investigate the fistula as the diagnosis is essentially a clinical diagnosis.

Expert Opinion in response to questions raised by the Commissioner

First Operation

1. *Was it appropriate to remove [Mrs A's] rectum during the operation performed in July 1999?*

During this operation [Mrs A's] colon and rectum was removed down to the anal canal. [Dr B], in his letters at this time, made it fairly clear that there was quite significant infection around the anus and that he felt that removal of the rectum may help resolve the problem of infection around the anus. In an urgent situation such as this, where a patient's wellbeing is compromised by the severity of the disease, generally the standard operation would be to remove the entire colon and leave the rectum and anus intact. [Dr B] removed a significant part of the rectum, and although this does not preclude returning and proceeding with further surgery such as an ileal pouch, it does make subsequent surgery very difficult.

In summary, standard treatment would be to leave the rectum and the anus intact.

Second Operation

2. Was the formation of a J loop appropriate?

Yes. This is the standard operation that most people perform for an ileal pouch. There are other types of pouches such as S pouches and W pouches but these are less commonly performed.

3. Was it appropriate to perform a hand anastomosis of the pouch to the anus?

Yes. It is appropriate to perform either a hand-sewn anastomosis or a stapled anastomosis. Various reports will differ as to the incidence of leakage relating to these two procedures, however, fistulae can occur with either technique.

4. Was the plan to close the temporary ileostomy in approximately six weeks appropriate?

Yes. This would be the soonest possible time in which it would be appropriate to close an ileostomy. This is generally the plan in most patients in this situation.

5. Is the development of a postoperative abscess a recognised complication of this surgery? If so, what is the frequency?

Yes. Pelvic infection and postoperative abscesses occur in a number of patients and are the most common cause of pouch failure which is around 5%.

6. What steps can/should be taken to avoid an abscess occurring?

There are no specific steps that can be taken, this is very much a factor of:

- the patient's *wellbeing*, including their immune status;
- any *occurrence* of haematoma;
- soiling *through* spillage of gastro-intestinal contents at the time.

Even if these factors are taken into account, the formation of an abscess can occur even in the most straightforward operation.

7. Were these steps followed in the case of [Mrs A]?

Yes, as far as possible. Antibiotics were given and a drain was left in the pelvis post-operatively.

8. Was it appropriate to wait for the inflammation to settle before attempting local repair of the fistula?

Yes, it was appropriate. Often with time the inflammation will settle and the size of the fistula will actually decrease. Common practice would be to leave the inflammation to settle for at least three months.

9. Should a scan have been performed to ascertain the presence of the fistula?

No. A scan is not necessarily the best procedure to evaluate a fistula, possibly a pouchogram or fistulogram would be a better procedure, although the diagnosis can be made purely on the clinical presentation. When it is made on the clinical presentation it really does require confirmation by a contrast study or by an examination under anaesthetic.

10. Should any other tests have been performed at that time? If so, what?

There is no real requirement to have performed any other tests, but to provide further information about the fistula, a pouchogram or MR study may have been useful. An examination under anaesthetic may also have been informative.

11. Is it contraindicated to rejoin the bowel to the anus following this type of surgery when Crohn's disease is diagnosed? If so, why?

Yes. Most surgeons would advise that the bowel is not rejoined in the presence of Crohn's disease. The reason for this is that there is quite often a significant risk of subsequent involvement of Crohn's disease with the small bowel that is used for the anastomosis. This then results in further problems with fistulas and infection.

12. On the basis of the information provided, could you please advise whether, in your opinion, sufficient information was provided to [Mrs A] concerning the surgery she had performed?

Yes. [Mrs A] had quite a number of visits with [Dr B] over the years, and in particular, close to her surgery she had numerous visits. The discussions of surgery, including its risks, have been documented in the letters that [Dr B] provided to the general practitioner. The explanation of the probable abscess and subsequent formation for the fistula are outlined in diagrammatic form.

Other Comments

It appears that [Mrs A] developed a personal dislike to [Dr B] during the course of her treatment and there are several personal comments in her dealings with him that suggest this. This should not subsequently be the basis of any criticism of his professional standing.

It is very clear to me reading the notes that [Dr B] did not deliberately mislead her over the diagnosis of Crohn's disease, although it appears that she feels that this is the case.

On reviewing her clinical records, Crohn's disease has been and still is a definite possibility in terms of her diagnosis. Only time will tell in terms of whether she develops Crohn's disease elsewhere, whether or not this is the case.

By removing the rectum at the first operation, this made the second operation very difficult but not impossible. It is not standard practice to remove the rectum in this situation but does not necessarily lead to the types of complications that [Mrs A] has had. Even when the rectum is left intact initially and then removed at the second operation, abscesses and fistulas can occur.

[Mrs A] states during her interview, that she would rather be dead than have an ileostomy, however, most patients heading into this type of surgery should be made very aware that a permanent ileostomy is an outcome in approximately 5% of patients such as this. If she was not made aware of the possibility of a permanent stoma then it reflects either a failure of communication or a failure of information.

In patients whose first language is not English, it may be useful to use a specific medical interpreter so that there is no doubt that the appropriate medical information has been communicated effectively. This may be appropriate even when it appears that the patient's understanding of English is very good.

References

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Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.

RIGHT 6
Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –

...

b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; ...

Opinion: No breach – Dr B

First operation
Mrs A complained that Dr B lacerated (cut) her anus and rectum during the operation performed on 12 July 1999. The purpose of the operation was to remove Mrs A's diseased colon, and to create a temporary ileostomy to pass faecal matter. Once the anus had healed, the second operation could take place, which was designed to rejoin the small bowel to the anus.

Mrs A alleges that she did not want to have her rectum removed and that both she and her husband were aware of the need not to cut her rectum because that would make later reconstruction difficult.

Dr B, however, felt that the best strategy was to remove her rectum and colon, because of Mrs A's persisting anal infection. Dr B discussed the subject with Mrs A and her husband in March 1999 and wrote to Dr C to inform him about their discussion. The letter was copied to Dr D, Mrs A's general practitioner. Dr B saw Mrs A several times thereafter. From his letters to Dr D, it appears that Dr B discussed the intended surgery with Mrs A, including revising the operation date. In his letter dated 21 June 1999 to Dr D, Dr B advised that he intended to remove the colon and most of Mrs A's rectum and to leave a permanent stoma, although the bowel could be reconnected at a later stage. Dr B acknowledged in the letter that "this is a significant setback for [Mrs A] psychologically as she had her heart set on avoidance of a stoma".

My surgical advisor noted that standard treatment is to leave the rectum and anus intact in such a situation. Dr Juhasz stated that in an urgent situation such as Mrs A's, where a patient's well-being is compromised by the severity of the disease, generally the entire colon would be removed but the anus and rectum would not be removed. I note that Dr E, the surgeon who later performed corrective surgery on Mrs A, informed her solicitor that it is standard practice to leave the rectum undisturbed but he also acknowledged that there may be "very significant proctitis"[5] which necessitates removing the rectum.

While it may be standard practice to leave the rectum intact, there are also clinical reasons for its removal. Dr B considered that Mrs A's condition necessitated removal of the colon and rectum. This clinical decision was presumably borne out by his findings during the operation. There is no evidence to suggest that the scale or quality of Dr B's surgery in the first operation was inappropriate.

Information disclosure

Mrs A complained that Dr B did not inform her of the risks of her anus and rectum being cut. In fact Dr B did not remove Mrs A's anus. He did, however, remove Mrs A's rectum. As discussed above, Dr B advised Drs C and D by letter that he had discussed the intended proctocolectomy with Mrs A and her husband.

My advisor considered that sufficient information was provided to Mrs A about the proposed surgery and referred to the "numerous visits" Mrs A made to Dr B in the period leading up to her surgery. Having read Dr B's letters to Dr D and a note at the time of these visits, it appeared to my advisor that Dr B "fully discussed various aspects of her surgery prior to undertaking it".

Dr B had treated Mrs A for a number of years for her ulcerative colitis. Dr B and Dr C both considered that removal of her diseased colon was appropriate. According to Dr B, and as recorded in his letters to Drs C and D, Dr B discussed the surgery with Mrs A and her husband. Mrs A has acknowledged that there was discussion about the surgery, but says that she told Dr B that she did not want her rectum removed.

The specifics of Mrs A's conversations with Dr B cannot be determined, particularly given that they occurred over three years ago. However, I am satisfied from the evidence that Dr B did discuss the intended surgery. It is clear from the reference to proctocolectomy in his letters, that Dr B recommended removing a large part of Mrs A's rectum.

In the circumstances, it is difficult to sustain an argument that Dr B removed Mrs A's rectum without her knowledge or consent. He specifically mentioned his discussions with Mrs A in his letters to Drs D and C. On balance, I am satisfied that Dr B did not fail to inform Mrs A of his intention to remove her rectum or of the risks of laceration.

[5] Inflamed rectum.

Crohn's disease
Mrs A also complained that Dr B admitted to her that he had suggested to the laboratory that she had Crohn's disease and that when she later contacted the laboratory she did not have any signs of the disease.

For the previous 27 years, Mrs A had been treated for ulcerative colitis, which causes ulcers and irritation in the inner lining of the colon and rectum. Crohn's disease is another form of inflammatory bowel disease, which causes severe irritation of the gastrointestinal tract and the lower small intestine. A diagnosis of Crohn's disease was very relevant to Mrs A's planned severe surgery. Where such disease is present, it is unwise to rejoin the bowel to the anus because of the markedly increased risk of infection and complications.

According to my expert advisor, Mrs A's clinical information concerning her perianal disease was very strongly suggestive of Crohn's disease. In his operation note for 12 July 1999, Dr B stated that the appearance of Mrs A's bowel was "more consistent with Crohn's disease". However, his preoperative diagnosis was also recorded as a long history of ulcerative colitis. My advisor also said that most surgeons would advise that the bowel is not rejoined when there is Crohn's disease because of the often significant risk of subsequent involvement of Crohn's disease in the small bowel where it is used for anastomosis; it can lead to further problems with fistula and infection.

The result from the medical lab was that Mrs A had Crohn's disease of her large intestine. However, as that diagnosis was in conflict with the previous diagnosis of ulcerative colitis, Dr F, a pathologist, wrote to Professor G seeking an expert opinion. On 10 September 1999, Professor G informed Dr F that, in his view, Mrs A had a fulminant ulcerative colitis rather than Crohn's disease and that this should not be a contra-indication to performing ileal anal pouch surgery.

My advisor did not believe that Dr B would have deliberately misled the laboratory. She suggested that it was possible that, when Mrs A contacted the laboratory staff, they may have referred to previous biopsy results in stating that there was no evidence of Crohn's disease.

Having carefully considered the information, I am satisfied that Dr B did not intend to mislead the laboratory. Mrs A's bowel presented at surgery as possible Crohn's disease and the pathologist confirmed this. However, due to Mrs A's history, further information was appropriately sought. Mrs A's earlier diagnosis of ulcerative colitis was confirmed, so that further surgery was possible.

Second operation
Mrs A complained that Dr B cut her vagina during the surgical operation in November 1999 when a J-pouch was constructed, and did not tell her that he had cut her vagina during surgery.

It appears that the basis for this aspect of Mrs A's complaint is the postoperative development of a pelvic abscess, which developed into an anal-vaginal fistula requiring surgical repair.

My advisor noted that it was possible that Mrs A's vagina was inadvertently damaged during the surgery and that Dr B was unaware of the injury. A fistula could also have developed as a result of pelvic infection. However, it is not possible to determine what happened in retrospect. Pelvic infection and postoperative abscesses occur in a number of patients and are the most common cause of pouch failure. No specific steps can be taken to avoid an abscess occurring, and an abscess can occur even in "the most straightforward operation". In my advisor's view, the steps taken to prescribe antibiotics and leave a drain in site to drain the pelvis postoperatively were appropriate.

There is no doubt that Mrs A developed a fistula postoperatively. What is less clear is the cause and whether that was due to an error on the part of Dr B.

In the circumstances, there is insufficient evidence to conclude that Dr B inadvertently cut Mrs A's vagina during the operation in November 1999. It appears likely that the abscess that she developed was due to postoperative infection. Even if the fistula did develop from a cut to Mrs A's vagina, there is no evidence that Dr B was aware of the injury. He could not be expected to inform Mrs A about an injury of which he was unaware.

Mrs A also complained that Dr B did not inform her preoperatively of the risks of a cut to her vagina during surgery.

Dr B advised that at each visit he had an in-depth discussion with both Mrs A and her husband about the possibility of surgery. Mrs A's initial surgery was delayed because of the increased possibility of pelvic sepsis and complication. The sole reason for the formation of the second ileostomy in November was the risk of pelvic infection. Dr B informed me that Mrs A consented to the additional procedure of a second temporary ileostomy. As that part of the operation was to protect the anastomosis by preventing faeces from causing infection, Dr B believed that Mrs A was fully informed of all the risks, including the possibility of pelvic sepsis.

In my advisor's view, Dr B had a number of discussions with Mrs A and discussed the risks of pelvic sepsis and documented the discussions in his letters.

I acknowledge that the postoperative complications Mrs A suffered caused her considerable distress. However, the evidence suggests she was aware of the possibility of infection. Dr B informed Mrs A's general practitioner about his conversations with Mrs A prior to her surgery. He also deferred performing the first operation because of the presence of infection. It is possible that Mrs A may not have been aware about how infection could progress, but I am satisfied that she was aware of the risk of postoperative infection.

Adequate investigation of symptoms

Mrs A complained that following her second operation, when menstrual blood began to leak from her anus, Dr B did not adequately assess her symptoms.

Dr B advised that on 1 December Mrs A had developed a small abscess that had drained through the anastomosis of her pouch to the anus. Dr B explained what had happened to Mrs A in diagrammatic form and advised that, as the abscess had drained, the best strategy

was to let the inflammation settle. Despite this, Dr B was concerned that Mrs A might develop a vaginal fistula and explained the possibility in diagrammatic form. He arranged to review Mrs A after two weeks.

Dr B saw Mrs A again on 15 December. Mrs A had developed a pouch vaginal fistula. Dr B discussed his strategy with Mrs A, which was to allow the inflammation to settle before attempting a local repair of the fistula, and asked Mrs A to make a follow-up appointment in the New Year.

Mrs A also referred to the diagrams drawn for her by Dr B and acknowledged that he informed her there was some inflammation that had not healed, and that it was appropriate to wait. However, in early January when she had another period, she approached another surgeon, Dr E. Subsequently, under the care of Professor H, Mrs A underwent a number of tests, which confirmed a fistula. Mrs A did not return to Dr B for further treatment.

My advisor said that it was appropriate to wait for the inflammation to settle before attempting the local repair of Mrs A's fistula. Dr Juhasz advised that often with time the inflammation will settle and the size of the fistula will actually decrease. It is common practice to leave the inflammation to settle for at least three months.

With regard to performing a scan, my advisor stated that there was no real requirement to perform any other tests. A scan would not necessarily be the best procedure to evaluate a fistula – possibly a pouchogram or fistulagram would have been better.

In my opinion, Dr B was alert to the possibility of an abscess and subsequent development of a fistula. Although he could have undertaken further tests, a diagnosis can be made on clinical presentation. Dr B's plan – to wait for the inflammation to settle – was appropriate.

Mrs A did not return to Dr B for repair of the fistula or for further tests. Accordingly, Dr B was not afforded the opportunity to repair the fistula. However, I am satisfied, on the basis of the information before me, that Dr B treated Mrs A's concerns seriously and responded appropriately.

Actions

- A copy of this report will be sent to the Medical Council of New Zealand.
- A copy of this report, with details identifying the parties removed, will be sent to the Royal Australasian College of Surgeons and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.