Delayed diagnosis of ectopic pregnancy
(00HDC08633, 22 May 2002)

Obstetrician and gynaecologists ~ House officer ~ Public hospital ~ Differential diagnosis ~ Miscarriage ~ Ectopic pregnancy ~ Infertility ~ Follow-up care ~ Continuity of care ~ Co-ordination of providers ~ Review of histology ~ Rights 4(1), 4(5)

A 37-year-old woman complained about the treatment she received from two obstetricians and gynaecologists, a senior house officer and a public hospital. The complaint alleged that delays in diagnosing and treating the patient's ectopic pregnancy made it impossible for her to conceive. The apparent failure to highlight and act upon a histology report that clearly stated the possibility of ectopic pregnancy delayed definitive management by about 18 days, during which time the patient suffered continuing and worsening symptoms. The woman also sought reimbursement of her expenses incurred over two years, as well as the costs of any future IVF treatment. However, this matter was not within the Commissioner's jurisdiction.

It was held that the obstetrician and gynaecologist did not breach Right 4(1) in relation to the initial diagnosis and treatment at the patient's first admission. The presenting symptoms suggested miscarriage as the most likely (and most common) diagnosis, and the consultant appropriately performed an examination under anaesthetic and evacuation of the uterus. In light of the findings, the consultant appropriately addressed the possibility of ectopic pregnancy by suggesting a repeat BhCG (a pregnancy hormone) and ultrasound if symptoms persisted. The BhCG was very low, not suggesting an ongoing ectopic pregnancy and, since all the symptoms had subsided and the signs were normal, the woman was discharged without ultrasound scanning. There was a clear plan for follow-up with repeat BhCG to ensure that it was declining, and clear instructions to return if there were problems. This was acceptable management.

Although the process of recalling a patient with uncertain histology findings failed, the senior house officer did not breach Right 4(1) in relation to her involvement in the diagnosis and treatment of the patient because there was insufficient evidence to conclude that the senior house officer saw the results and failed to advise a consultant.

Nor did the second obstetrician and gynaecologist breach Right 4(1). She promptly interpreted the woman's symptoms as indicating a possible ectopic pregnancy, and performed a laparoscopy. The minilaparotomy and left salpingostomy undertaken when she discovered the ectopic pregnancy were necessary and appropriate, and performed without complication.

However, the public hospital breached Right 4(5) because it failed to have in place a system for reviewing histology reports and acting on abnormal results in order to ensure quality and continuity of care for patients. The hospital subsequently reviewed its histology follow-up protocols. The Commissioner recommended that patients receive written instructions about follow-up.