Care following melanoma diagnosis
(10HDC00540, 23 April 2012)

General Practitioner ~ Pathologist ~ Melanoma ~ Communication ~ Follow-up ~ Documentation ~ Rights 4(1), 4(2)

A 45-year-old man with a history of previous melanoma presented to his general practitioner (GP) with a suspicious lesion. The lesion was excised and sent for analysis by a pathologist. The histology report confirmed the lesion was a melanoma and stated that it had been "completely excised". Accepted practice in relation to melanomas of this type was to undertake a wider excision. The GP telephoned the laboratory and spoke to a pathologist, who advised again that the excision was complete. The GP recorded that no further surgery was required. A few days later, the GP removed the man's sutures and discussed the histology. The GP did not undertake further excision, and no other follow-up was arranged.

A year later, the man presented to the GP with a lump in his left armpit. The GP referred the man to a general surgeon, but did not include the man's melanoma history in the referral letter. The surgeon's records showed that the man told the surgeon about a melanoma he had had removed twenty years earlier, but the melanoma excised the year before was not noted or discussed. The surgeon sent the man for a fine needle aspirate test. The cytology report indicated that the sample was of "low cellularity" but that there was no sign of any malignant cells and that features were consistent with a lipoma (ie, benign). The surgeon arranged to see the man for a surgical excision of the lump when he returned from a planned trip abroad.

When the surgeon reviewed the man two months after their initial appointment, the lump was firmer in nature, and surgeon thought it might be a lymph node. The lump was removed under general anaesthetic. A biopsy confirmed that it was malignant, and further tests revealed the man had Stage IV malignant metastatic melanoma with brain, liver and lung metastases. He died a few months later.

It was held that when the GP identified a lesion suspicious for melanoma, he should have asked the man about his personal and family history of melanoma, and documented the response. The GP's referral to the pathologist was inadequate, with no description of the lesion or relevant patient history. The pathologist's written report, stating that the lesion had been completely excised, was accurate. However, without a wider excision, the lesion had not been adequately excised. It was not clear whether the GP interpreted the pathologist's verbal advice to mean further excision was not needed, or whether the pathologist explicitly said this. Irrespective of the need for wider excision, the GP should have arranged follow-up by a specialist, or at least had a clear documented plan to monitor the patient himself. When the man presented a year later with a lump in his armpit, the GP appropriately referred him to a surgeon, but failed to include the man's melanoma history in the referral. The GP's clinical documentation was also suboptimal. The GP was found in breach of Rights 4(1) and 4(2) of the Code. The GP has since retired from medical practice.

It was not clear whether the pathologist to whom the GP spoke on the telephone was the same pathologist who prepared the histology report. It was noted that pathologists are not required to provide treatment advice, and that there are potential risks in doing so given that there may be circumstances of which the pathologist is unaware. However, where such advice is provided, pathologists must ensure the accuracy of the

information they provide. Doctors must be careful not to misinterpret the absence of such information. It was held that in this case the pathologist's reporting was reasonable and there was insufficient evidence to conclude he had provided additional inaccurate verbal advice. Accordingly, the pathologist was not found to have breached the Code.