Missed diagnosis of chronic peptic ulcer with long-term use of NSAIDs (01HDC09589, 17 October 2002)

General practitioner ~ Peptic ulcer disease ~ NSAIDs ~ Missed diagnosis ~ Clinical examination ~ Record-keeping ~ Medical Council Guidelines ~ Rights 4(1), 4(2)

For approximately two and a half years a 60-year-old male patient was prescribed ibuprofen, a non-steroidal anti-inflammatory drug (NSAID), for arthritis of the spine. During a routine visit to the GP the patient reported pain in his chest, stomach and back, and complained of tiredness. The GP examined the man's spine and attributed the pain to softening of joints and increased curvature of the thoracic spine. The clinical notes record only the repeat prescriptions and the patient's blood pressure. About four months later, at the next routine visit, the patient complained of still feeling tired, continuing stomach pain, having black stools, and flu-like symptoms. The GP attributed this to the flu and to self-medicating with iron pills. The clinical notes do not record this visit. The pharmacist's record shows that at this visit the GP prescribed diclofenac sodium (Voltaren). A few weeks later, the patient was admitted acutely to hospital. The diagnoses were acute chronic gastrointestinal bleed secondary to NSAID, and myocardial infarction.

The Commissioner reasoned that:

1 when the patient complained of pain in the chest, stomach and back, and of feeling tired, the GP should have examined him further and in particular his abdomen and chest;
2 although routine blood tests are not helpful in predicting underlying gastric irritation from anti-inflammatory medication, at the later visit when the patient still complained of tiredness and dark stools while taking ibuprofen, the GP should have examined the abdomen, ordered blood tests, including a haemoglobin level, arranged follow-up if the symptoms had not resolved, and reviewed the blood test results;
3 dark stools should have been an alert to gastrointestinal bleeding; and
4 as an essential part of good primary care and in keeping with professional standards, the GP was required to keep clear, accurate, and contemporaneous patient records that report the relevant clinical findings, the decisions made, the information given to patients, and any drugs or other treatment prescribed.

It was held that the GP breached Right 4(1) in that he did not adequately assess the patient's condition based on his presenting history and clinical signs, and did not carry out the appropriate investigations or treatment; and breached Right 4(2) in that he failed to comply with professional standards of record-keeping.

The Commissioner recommended that the Medical Council consider whether a review of the GP's competence was warranted.