Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A 37-year-old woman sustained a large disc prolapse as the result of a work-related injury. She was referred to a neurosurgeon, who recommended conservative treatment and referred her to a pain management specialist for a transforaminal injection. This procedure appeared to be effective initially but her condition deteriorated over the following week and she developed cauda equina. The woman contacted the pain management specialist, who assessed her and immediately contacted the neurosurgeon, who urgently referred her to a public hospital for spinal surgery. It was held that the treatment and care provided by the neurosurgeon met professional standards. The case is a reminder of the importance of warning patients about symptoms to watch out for.

21 March 2007

Dear Mrs A

Complaint: Dr C
Our ref: 06HDC06068

Thank you for your careful and detailed response to my provisional decision on your complaint against Dr C, and the further discussion you had with the HDC Investigator on 19 March 2007 about the information Dr C provided to you. In your response letter of 12 March 2007, you have asked me to consider the following points:

1) Why neurosurgeon Dr B's opinion was not sought.
2) Why the advice provided to ACC by a consultant neurosurgeon and a general practitioner was not included in the report.
3) My expert, consultant neurosurgeon Dr Arnold Bok's advice was based on "misrepresentations" provided by pain management specialist Dr D, and his receptionist.
4) The term "cauda equina syndrome" was not discussed with you until you spoke with Dr B at a postoperative check on 23 August 2005.
5) Dr C did not take the time or clearly communicate all the information that would be expected of an expert, and did not provide you with information about cauda equina syndrome symptoms.

I respond to points 1-3 below. My response to points 4 and 5 is incorporated into my decision re Dr C's care (pages 7-8 below). I obtained a copy of your clinical records from your District Health Board, which included a number of letters from Dr B and

his registrar Dr E that summarised your condition and treatment progress. I did not consider that there was any need for me to seek additional information from Dr B.

As the Investigator explained to you, experts advising ACC are asked to examine the treatment and care provided and report their opinion as to whether there was a causal link between the treatment and the injury. My experts are asked to report their opinion on whether the treatment and care was reasonable in the circumstances. I note that ACC's neurosurgeon expert was of the opinion that your injury was caused by a failure to treat your lumbar disc prolapse with surgical decompression. However, he did note that he had no personal experience of the value of cortisone injections in a lumbar disc prolapse of the size of yours. He concluded:

> "As this injury appears to have possibly been associated with a delay in surgical decompression, it is my belief that this patient would have a claim with the Corporation."

The general practitioner medical advisor to ACC is not an expert in the field of neurosurgery.

I obtained independent advice from Dr Arnold Bok, a consultant neurosurgeon. You are concerned that Dr Bok based his advice on "misrepresentations" provided to the investigation by Dr D and his receptionist. The care that Dr D provided to you was not the subject of this investigation. He was asked to provide a report to give context to the care provided by Dr C. On 28 May 2006, Dr D provided a detailed statement about the treatment he provided to you between 18 June and 1 July 2005, supported by copies of his contemporaneous clinical notes.

I note your belief, expressed in your telephone conversations with the HDC Investigator, that Dr D was incorrect in some matters he recalled, such as reporting that you had influenza when he saw you on 27 June 2005. His clinical records are pre-formatted with standard examination and treatment plans, and anatomical diagrams designed to record "Present complaints" and "Results of special examinations". On 29 June 2005 (the date that Dr D wrote up the examination that you both agree was conducted on 27 June), he added handwritten information to the formatted page which included, "? flu." He also circled "Advice" and noted the words "bowel bladder". In light of these clinical records, I believe it is unlikely that the information provided by Dr D misled my expert.

After considering all the available information, I have concluded that Dr C treated you appropriately and therefore did not breach the Code of Health and Disability Services Consumers' Rights. The reasons for my decision are set out below.

Your complaint

On about 13 January 2005, when you were aged 37, you tripped up the stairs at your place of work. At the time you experienced a sharp pain in your back, and two days later while on a camping holiday you developed a dull ache in your right leg. Over the next two weeks the pain became worse. You consulted a physiotherapist, who treated you for about a month with acupuncture, with little effect. The physiotherapist suggested that a trial of prednisone might relieve your symptoms, so you saw your

general practitioner, Dr F, on 22 March to discuss this. Dr F prescribed a course of anti-inflammatories, but when your symptoms increased, she referred you to neurosurgeon Dr C for further assessment.

Dr C saw you on 20 April 2005. He noted that you reported "excruciating pain with pins and needles in the right leg and foot". He observed that your leg pain appeared to be "fairly diffuse" and that you had some aching down the outer left leg, but no bowel or bladder disturbance or cauda equina syndrome. Dr C reported to Dr F on 20 April that your symptoms were "suggestive of some form of lumbar nerve root irritation". He stated:

> "In view of the increasing nature of the pain and its failure to settle or respond to conservative treatments, I agree that an MRI scan would be the next step and I will make arrangements for the patient to have this done and will review her with the result."

The MRI scan performed on 26 April was read by Dr G. Dr G's conclusion was that there was a large central protrusion at "L5/S1 [5th lumbar and 1st sacral vertebrae] with central canal and bilateral subarticular recess stenosis", and a "small central L4/5 protrusion".

You returned to see Dr C on 28 April. This appointment was "squeezed" in between Dr C's other appointments because reception had not booked an appointment for you to discuss the scan results and treatment options with him. You recall that Dr C remembered you. He told you that your disc prolapse was "very large" and reminded you that he was about to depart for a holiday. He said that if you wanted to take the option of surgery he would refer you to a colleague, but suggested that you see Dr D, a pain management specialist, to have "an epidural-like procedure". You recall that he seemed to want you to have this procedure, as he had mentioned it at the first consultation. You also recall that Dr C did not tell you to be aware of and report any altered bowel of bladder function or perineal sensation.

Dr C cannot clearly recall the conversation he had with you on 28 April 2005, but said that he is "invariably conscientious" about telling his patients what symptoms to be aware of and that it would have been uncharacteristic for him not to have done so in your case. Dr C pointed out that he noted in his letter to your general practitioner, Dr F, following that assessment, that you had "not had any overt incontinence". He said the information he records in his letters is his "short-hand" for noting the information he has provided to the patient.

On 28 April Dr C wrote to Dr F stating:

> "**Present condition**:
> The patient continues to be quite uncomfortable, she is taking Codeine, which is only just barely holding the pain at bay, but continues to have no overt neurological deficit, and although there is some subjective sensation tracking up the right leg as far as the gluteal area she has not had any overt incontinence, not anything to suggest cauda equina syndrome.

> **Assessment**:
> The patient has clinical and radiological evidence of a large disc prolapse. Given the size of the prolapse, she will require some further treatment. My inclination initially would be to suggest that she might respond to an epidural injection, although given the size of the prolapse she may eventually require semi-urgent decompression of the spinal canal and removal of prolapsed disc material.
>
> **Treatment Plan:**
> I will therefore initially arrange for her to see [Dr D] to see whether he would consider her as a candidate for epidural injection therapy.
>
> In the interim, given the size of the prolapse and her significant pain she would probably benefit from Prednisone treatment and I do think that oral Prednisone 40mg to be taken daily for a week or so would be a good idea.
>
> If she fails to respond to the Prednisone or to an epidural injection she may require semi-urgent decompressive surgery, as I will be out of the country until mid June she may need to be referred through to [Dr H], to see if he would consider her for lumbar surgery."

In his referral letter to Dr D, Dr C said that your prolapse might be "too large to be dealt with [by] nerve blocks and injection therapy, but I would be grateful if you would see her with a view to possibly doing a trial of epidural steroid therapy to see if this will alleviate some of her discomfort".

Dr D saw you on 1 June 2005. He examined you to assess the extent of your symptoms. He stated that he was "particularly impressed" by the size of the prolapse on the MRI scan. He changed your analgesics to paracetamol and tramadol, and asked you to stop taking codeine because of its constipating effect. Dr D advised:

> "I told the patient that a transforaminal might not cause the disc to fibrose off the nerve root given the size of the prolapse, but she was keen that it be tried. Patient information sheets on transforaminal injection are routinely given to all our patients undergoing such a procedure. Permission was immediately applied for from ACC in order to perform a transforaminal epidural at L5/S1 on the right. Approval was signed off by the ACC Medical Advisor on 10 June 2005, and she was booked on my next theatre list (24 June 2005) and written informed consent obtained."

You saw Dr D for a pre-procedure consultation on 18 June. At that assessment, you reported that the pain in your right leg had decreased and your main problem was low back pain, which was keeping you awake at night. Dr D noted that you had no urinary or bowel problems, numbness or motor weakness. You had driven yourself to the appointment and were still working long hours. You had reduced the amount of prednisone and codeine you were taking, but had increased your intake of paracetamol to 1000mg four times a day and tramadol 50mg four times daily.

Dr D performed the transforaminal epidural on 24 June at a private hospital and encountered no technical difficulties. You were discharged home that afternoon from

the ward, with instructions to telephone Dr D the following morning to report on your condition.

When you spoke to Dr D on the morning of 25 June, you reported that the pain returned as the local anaesthetic wore off and your bowel and bladder functions were normal. Dr D stated that some patients do have increased low back pain after the procedure, due to irritation of the muscles and soft tissue. You were instructed to contact Dr D if your pain increased, you experienced any motor weakness or if there was any alteration to your bladder function. You were also advised to increase the tramadol.

On 27 June you drove yourself to Dr D's rooms for a follow-up consultation. You had weaned yourself off the prednisone. Dr D recorded that you possibly had influenza. He recalls that you told him you were coughing and sneezing. The pain in your right leg was now only intermittent and better than it had been on 25 June. You still had some low back pain and occasional left-sided buttock pain. Dr D tested your reflexes and checked that your bowel and bladder function were still normal. He recorded that he advised you about bowel and bladder symptoms and recalls that he explained that coughing would put extra strain on the disc and warned you that any alteration to your urinary functions could be a sign of onset of cauda equina. However, as your pain was diminishing and you had no urinary symptoms or motor loss, Dr D considered that no further action was required at that stage. He gave you a letter to your employer supporting your request to work day shift only. You do not recall Dr D mentioning the term "cauda equina".

At 4.30pm on 1 July you telephoned Dr D's rooms to report that you had developed numbness around your vagina, which had started 36 hours earlier. Your buttocks were painful, you wanted to urinate but were only able to pass small amounts at a time, and had not had a bowel motion for two days. You were advised to go straight away to Dr D's rooms and your husband drove you there. Dr D started to examine you but stopped when he formed the opinion that you had developed cauda equina syndrome. He telephoned Dr C to report his impression. Dr C said he would see you immediately.

Instead of going straight to Dr C's rooms you had to divert to your home to pick up the scan images and reports. During the drive to your home and then to Dr C's rooms (which took 35 minutes) your back pain increased dramatically. You met Dr C in the car park. He looked at you through the car window and informed you and your husband that you required urgent admission to the nearest Emergency Department. Dr C telephoned the hospital to advise them he was admitting you and his concerns about your condition.

You were seen at the Emergency Department by Dr E, registrar for neurosurgeon Dr B, and admitted to the neurosurgical unit. Dr B operated on you the following day performing a L5/S1 discectomy. You were discharged home on 9 July 2006. Dr E's discharge report to Dr F stated:

> "The immediate postoperative period was uneventful. [Mrs A's] perianal sensation had improved remarkably and light touch and pinprick sensation had both improved significantly. Over the next few days her mobility improved

> but she had intermittent pain radiating along her L5 dermatome on the right leg. She also complained of the feeling of inadequate emptying of her bladder and some dribbling. She was then seen by the urologist regarding her urinary symptoms. Her urinary microscopy examination showed 20-50 white cells with moderate bacteria. She was then treated with a short course of Trimethoprim. A short course of Oxybutynin was also prescribed to improve her bladder function for a possible urgency and stress incontinence. She opted to be followed up by a private urologist upon discharge. She was discharged home to be followed up in the neurosurgical outpatients clinic in three months time."

Additional information

Dr C
On 30 June 2006, Dr C stated:

> "When [Mrs A] represented urgently [in] June I had only been back in the country for a few days, had heard that [Dr D] had carried out an epidural just a few days previously and thought it would be quite appropriate to wait a few days to see what response she made.
>
> I was quite mortified when she represented precipitously in a fairly perilous state and at that stage there was obviously very little I could do apart from referring her into the public hospital for emergency treatment. It is unclear to me how else I could have handled the situation as the ACC regulations will not allow me to manage urgent patients in the private sector. …
>
> [T]here is no doubt that [Mrs A] did suffer a very unsatisfactory outcome and I deeply regret that it has happened. I have communicated with my colleagues to try to arrange a more efficient cover system when one of us is away for longer periods to try and prevent cases like [Mrs A's] from occurring again."

Dr D
On 28 May 2006, Dr D stated:

> "Because of the large initial disc prolapse, its position and the presentation of chronic low back pain, this patient was at risk of developing cauda equina syndrome. This most likely followed coughing and sneezing from her influenza and was in no way related to the transforaminal injection. This patient was cared for in accordance with the current available evidence based medicine. The current best clinical practice guidelines were applied to her care and she was appropriately referred for urgent neurosurgical opinion immediately the symptoms and signs of the rare cauda equina syndrome became apparent."

Relevant Code provisions

RIGHT 4
Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.
(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

Decision

Diagnosis and treatment
You have complained that Dr C failed to refer you for immediate surgery. As a result of the six-month delay between your initial presentation to Dr C with spinal compression problems and the surgery to repair the lesions, your health and quality of life is significantly impaired.

My independent neurosurgical expert Dr Arnold Bok advised that you were properly examined; the problem of cauda equina syndrome was considered; and you were warned about the importance of any urinary symptoms, and advised to report these symptoms immediately.

Dr Bok stated that Dr C's recommendation of a trial of conservative management was reasonable in the circumstances, given that you did not present with any cauda equina symptoms when he saw you. Studies show that it is acceptable practice to treat even a large lumbar disc prolapse conservatively, where there is no neurological dysfunction, as long as the patient is aware of the importance of reporting any symptoms and arrangements are made for urgent surgery if this happens.

You had been experiencing back pain and altered sensation in your legs and feet for about three months when you were seen by Dr C, and Dr Bok's opinion is that the large disc prolapse had "most likely been there for that entire time". Dr C documented the absence of cauda equina, and Dr F was advised to seek an alternative surgical opinion if your clinical symptoms indicated that an operation was required.

I am satisfied that it was reasonable for Dr C not to recommend urgent surgery and to initially try an epidural injection and accordingly, I have decided that, in relation to his management of your disc prolapse, Dr C did not breach the Code of Rights.

Information disclosure
You have no recollection of being told by Dr C to be aware of and report any altered bowel or bladder function or perineal sensation. Dr C cannot (nearly two years ago) recall exactly what he told you, but believes he would have followed his usual practice of telling his patients what symptoms to be aware of. My expert, Dr Bok, advised that all patients who present with "acute radicular pain and/or back pain must be warned that the loss of bladder or bladder function may occur".

Because of the conflicting information about the information Dr C provided to you about these symptoms, and the period of time that has elapsed since these events occurred, I unable to resolve this matter. However, I am certain that your experience will be a reminder to Dr C of the importance of warning patients about symptoms to watch out for, and documenting having done this.

Thank you for bringing your concerns to my attention.

Yours sincerely

Ron Paterson
Health and Disability Commissioner

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