Management of woman with upper gastrointestinal symptoms subsequently diagnosed as ovarian cancer (03HDC04996, 29 June 2004)

General practitioner ~ Ovarian cancer ~ Standard of care ~ Professional standards ~ Gender bias ~ Rights 4(1), 4(2)

A man complained that over a six-month period (from January to early July) his wife consulted her GP on numerous occasions, reporting symptoms including bloating, stomach pain, indigestion, reflux, lower pelvic pain and diarrhoea, but the GP did not appropriately refer her for further tests, and did not diagnose her ovarian cancer. It was also submitted (by the man's lawyer) that the GP displayed gender bias in his management, in that she was a middle-aged woman (aged 52 years) presenting frequently to doctors with vague and ill-defined symptoms, which he did not actively manage or refer to a gynaecologist when asked to do so.

Ten years previously the woman had had a total hysterectomy following discovery of a cervical polyp during a routine smear test, and she was subsequently advised that she no longer required cervical smears. In January her therapeutic masseur advised her to consult her GP urgently about her symptoms of abdominal pain and stomach bloating, and to ask for a referral to a gynaecologist. The woman saw her GP three times during February, but there is no record in the notes about pelvic or abdominal pain or bloating, or a request to see a gynaecologist; indigestion was reported at the third consultation, and she was referred for blood tests, including hormone levels, as the GP considered her symptoms to be menopausal. She also saw an after-hours GP in late February because of indigestion and vomiting, and, after investigation, was prescribed ranitidine for a provisional diagnosis of gastritis. She returned in March as the medication was not helping, and was prescribed Maxolon. Her notes record that her GP was considering the possibility of a peptic ulcer or reflux disease, and he ordered liver function, pancreatitis and gastric ulcer tests, and placed her on Losec and antibiotics for a possible ulcer. The test results indicated no abnormality. While holidaying overseas during April, she continued to experience epigastric pain; a local GP increased her Losec and prescribed anti-nausea medication.

On her return she again consulted her GP, who prescribed further medication to treat her gastric symptoms, referred her to a general surgeon for a possible gastroscopy, and arranged an abdominal ultrasound and barium meal to exclude other causes. The ultrasound (which did not include the pelvic or ovarian areas) was reported as normal, with nothing unusual to indicate the necessity for a wider view, and the barium meal results were unremarkable. The general surgeon saw her in early May and took a specimen for histological examination; he recommended ongoing treatment with reflux suppressants until she found one that suited her. She did not mention her lower abdominal pain to the surgeon. The histology specimen reported a small number of *Helicobacter pylori* organisms with no evidence of malignancy, which was consistent with a diagnosis of gastritis. The woman continued to see her GP during April, May and June, as her symptoms continued; notes of the June consultation mention the symptom of bloating. In early July the woman began experiencing frequent bowel motions, and the GP advised her to take acidophilus tablets to counteract this; he also prescribed anti-diarrhoeal capsules and advised her to take the anti-spasmodic only when required.

Over the next six months the woman was seen at the medical centre on a number of occasions for different problems, though there was no further report of epigastric pain. In January she consulted an after-hours GP because she was concerned about sudden stomach bloating and related pain; examination revealed mild pain in the lower abdomen with no masses felt, and the GP prescribed a trial of domperidine for relief of nausea and flatulence and suggested an ultrasound if she felt no better. The following day she underwent an abdominal ultrasound, which revealed a pelvic mass. The GP informed the woman of the results and referred her to a gynaecologist, who saw her the following day. Further tests and surgery confirmed advanced ovarian cancer, from which she died a few months later.

It was held that the GP appropriately referred the woman for investigation and assessment of her epigastric problems and thus did not breach Right 4(1). Although his records of the consultations are sparse, a number of other doctors who saw her during the same period and kept accurate records also recorded only epigastric symptoms. There was also insufficient evidence that he had refused to refer her to a gynaecologist when asked; referrals to specialists were appropriately and readily made for her presenting problems. Unfortunately, ovarian cancer is difficult to detect in its early stages, and the woman's symptoms were not indicative of pelvis disease; thus it was held that the GP was not negligent in failing to diagnose the cancer.

However, it was held that the GP breached Right 4(2) in failing to accurately report clinical examinations in sufficient detail and thus meet professional standards for record-keeping; further, he did not have in place appropriate systems to ensure prompt follow-up of patient care, particularly on receipt of after-hours medical reports.

In relation to the alleged gender bias, it was held that the GP did not ignore the woman's various clinical symptoms or her personal circumstances, although he may not adequately have reflected on the frequency of her consultations and her unusual collection of health problems, which did not resolve as expected following appropriate treatment.